March 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-0057-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically

RE: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program

Dear Administrator Brooks-LaSure:

On behalf of the almost 4,000 members of APTA Private Practice, a Section of the 100,000+ member American Physical Therapy Association (APTA), I write to provide feedback on the Centers for Medicare and Medicaid Services' (CMS) Interoperability Proposed Rule referenced above (the Rule). APTA Private Practice is an organization of physical therapists in private practice who use their expertise to restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities in patients with injury or disease. The rehabilitative, maintenance, and habilitative care that they provide restores, maintains, and promotes overall fitness and health across the age span to a range of patient types.

Representing physical therapists who are also independent small business owners, APTA Private Practice encourages and supports policies that enable our members to focus on providing high-quality, cost-effective, and clinically appropriate outpatient physical therapy. Our members are proud of the quality of care they provide, but as small business owners are quick to realize the impact of deleterious administrative hurdles they encounter after providing clinically appropriate care covered by the Medicare Advantage program. They chafe at burdensome and duplicative administrative tasks; time they spend on these unnecessary tasks is time they are not able to be caring for their patients. If they had more time to care for patients, physical therapists know that the care they provide would improve overall health and prevent the need for avoidable health care services.

APTA Private Practice members have been frustrated by their experience with the Medicare Advantage program. The Rule would implement changes to the Medicare Advantage (Part C), Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the

Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program. This APTA Private Practice comment focuses on **Utilization Management under 42 CFR §§ 422, 431, 435, 438, 440, and 457**.

General Reaction

APTA Private Practice is strongly supportive of the goals of the Rule and we believe that many of its aspects are positive. Initially, we are deeply appreciative that CMS accepted stakeholder input, including from APTA Private Practice, calling for Medicare Advantage plans to operate under Utilization Management (MA) rules that are parallel to those governing other federally-financed programs. Creating uniformity and simplicity will help physical therapists provide care more efficiently to their patients.

It is important to provide context for the red tape private practice physical therapists experience every day. As small business owners, private practice physical therapists are burdened far too often by trivial administrative minutia. Incentives are mis-aligned between insurers and physical therapists: for insurers, administrative waste can boost their profits, and for physical therapists, the time and hassle involved in appeals to payers may not be worth the relatively meager payments that can result.

MA plans are only growing and will soon include the majority of Medicare beneficiaries. In addition, more PT providers are choosing to stay out of network with MA plans due not only to oppressive administrative burdens imposed by the plan, but also due to low per diem payment rates. If these issues are not addressed, it stands to reason that MA beneficiaries will have less access to quality PT as fewer practices take the insurance. A higher out-of-pocket cost for quality PT care will be the result for patients.

Adding insult to injury, insurers have had some of their most profitable quarters in history as utilization plummeted due to the COVID-19 pandemic, while premium payments from members remained relatively stable. Since the end of the pandemic, profits, especially in Medicare Advantage plans, have remained high.

> We find that, by the end of 2021, gross margins per enrollee had returned to pre-pandemic levels in the Medicare Advantage market, while gross margins in the individual and group markets were lower than pre-pandemic levels and Medicaid margins were higher than pre-pandemic levels. Medicare Advantage plans have far higher per person gross margins—more than double those seen in other markets in 2021.

And while MA plan profits can be difficult to measure, our current health care system incentivizes payers to avoid paying claims, even terming such payments “medical losses.” The stumbling interaction between payer and provider, repeated daily across the country, has a direct cost on providers and their patients. It is well documented that frustrating interactions with insurers stoke burn-out across the medical profession by stealing time available for actual patient care, and amplifying health issues for providers. The costs and burdens of payer red tape are real.

Physical therapists are most appreciative of the Rule’s focus on decreasing administrative burdens on practitioners as well as the broad-based nature of the Rule’s applicability to multiple types of insurance products. Beneath plan structure, market dominance and funding streams for

government and private payers, care is being delivered by physical therapists to patients. Physical therapists want to provide that care with the least administrative burden possible, but care that is not impacted by administrative red tape is becoming harder and harder to provide.

Physical therapist frustrations with insurance claims processing are further exacerbated by post-care denials even if a prior authorization adjudication from the payer has been received by the physical therapy practice. In their daily work, physical therapy clinics often attempt to check with payers to verify insurance benefits. As part of this confirmation, practices typically ask if prior authorization is required prior to treatment. When they are told it is not, they proceed in good faith with treatment. However, many claims continue to be denied after treatment is delivered because prior authorization is outsourced to a third party, which is not disclosed when verifying coverage, while the insurer itself ultimately adjudicates (and often denies) payment.

Another frustrating situation occurs when third parties are contracted to conduct post-care utilization reviews. We believe this problem is growing because of one aspect of the ACA's medical loss ratio (MLR) regulations. The MLR regulations allow for the functional definition of "medical loss" to include quality improvement programs. In practice, insurers have instead implemented quality assurance structures – which often function by simply denying payment for pre-approved, medically necessary services similar to the example above – and mischaracterizing them as quality improvement programs.

The proliferation of quality assurance structures wastes an enormous amount of time for private practice physical therapists attempting to provide high quality patient care, but it also raises an important consideration for the implementation of the Rule. When prior authorization is granted, but an insurer or third-party quality assurance organization ultimately bars payment, physical therapists are caught in a bewildering limbo where it is unclear whether pre-approved care really is pre-approved. It would be much more efficient and ultimately highly beneficial to patient care if, when either prior authorization is granted or a confirmation that prior authorization is not required is provided, a safe harbor required prompt payment by insurers that also bars third party retrospective utilization review recoupment.

Specific Responses to the Rule

Enforcement

MA Plans have repeatedly violated rules in the past related to utilization management and prior authorization. The serious abuses by MA plans, as unearthed by a recent OIG Report examining the frequent denial of care that purported to rely on evidence-based guidelines, prove that MA plans limit care in ways that are not beneficial to either patient health or improved outcomes. This must stop for the benefit of patients and their health.

CMS should build in appropriate enforcement mechanisms to the Rule to ensure payer compliance with the requirements it is setting forth in the Rule. Ultimately, physical therapists rely on CMS to address overreaching UM policies, but patients do as well. And in the context of PT care, the patient impact of prior authorization can often not be corrected. For physical therapy, missed or delayed care exacerbates suboptimal health outcomes because early intervention is associated with fewer visits and better outcomes. Additionally, delayed access to medically necessary PT commonly results in patient setbacks that require additional visits, creating pain and costs for patients, providers, and payers alike. Claims denials based on noncompliant internal clinical criteria are as much a threat to patient health as they are a needless burden on providers. At a minimum, we urge CMS to clarify its enforcement rules around the requirements it is proposing in the Rule.

Partial Denials – duration and frequency
We urge CMS to clarify its rules around adverse medical necessity coverage determinations. In particular, CMS sets forth in the Rule a 72 hour and 7-day standard for reconsideration of denials. We would urge these time limits to be truncated to maximize the chances for the best patient outcomes to 48 hours and 5 days.

In addition, we are concerned that payers are granted the room under the Rule to deny services for varying and overlapping reasons, which can impact appeal rights. PTs in private practice often report that UM contractors will limit the number of visits or the frequency a patient may receive care, but that this change from the plan of care is not appealable because it is not a medical necessity determination by the plan. This situation, which is relatively common, limits rights for patients to access the care for which they have contracted with the plan. We urge CMS to contrast the frequent limitations on very low-cost services like PT visits, which can sometimes be paid under an $80 day rate, versus the UM burden associated with $10,000 surgical procedures, which are often unnecessary according to NIH analyses. Access to PT first and/or early in the care stream can help avoid significant cost to the health system and pain for patients. In addition, it is imperative in the context of best practices for physical therapy care that payers not dictate the frequency of visits per week within a plan of care. Granting payers flexibility in these cases - to limit care to a specific number of visits, limit how many visits are reimbursable within a span of time, require re-authorization for a fraction more, etc. - has led to delayed patient care in many physical therapy practices. In addition, we urge CMS to require that any denial of any form, whether from a UM vendor, a Peer to Peer consultation, or a direct denial for medical necessity, be appealable both internally and through external review.

In addition, we strongly suggest that CMS provide clarification that flexibilities regarding payer approval should be limited to whether a plan of care is approved, and not for a specific number of visits. In regards to the rest of the health system, in Medicaid MCO coverage provided by the same payer as MA plans, many smaller providers are told when verifying benefits that prior authorization is not required only to find out after treatment, payment is then denied because authorization is adjudicated by a different company. In particular, United Health Care has repeatedly stated that a patient has coverage and no authorization is needed, but then care is denied and the practice is told that Optum is in charge of authorizations.

APTA has set forth several recommendations that, while not specific or exclusive to MAOs, address inappropriate visit limits that severely impact and limit provision of medically necessary therapy services:

> **Separate Visit Limits:** Ensure adequate access to necessary services by requiring **separate** visit limits for physical therapy, occupational therapy, and speech therapy, as each discipline provides distinct services focused on different functional goals. Currently, plans have broad latitude to count all three therapy types toward the same visit limits, meaning that plans with identical visit limits may have a vastly different benefit. These therapies are complementary, and patients may need multiple types of therapy for the same or related issues during their rehabilitation, maintenance, or habilitation. For individuals with significant rehabilitative or maintenance needs such as those after a cerebral vascular accident (i.e., stroke), traumatic brain injury, or multiple traumas who may need all three disciplines, the medically necessary care for which a combined limit inappropriately limits recovery. In the past, CMS has recognized and codified limitations that ensured visit limits and benefit parity for rehabilitative, maintenance, and habilitative benefits, to guarantee that care is distinctly dictated

by the needs of the patient, and the skills and function they present with at evaluation. A similar restriction is necessary between these therapy disciplines. Without such change, plans that do not distinguish between therapies in their benchmark visit limits will force patients to choose between therapies that may all be necessary, or risk increased out-of-pocket costs for medically necessary care.

Eliminate Arbitrary Visit Limits: In addition to the need for separate visit limits between therapy disciplines, the quantity of visit limits must be supported by clinical rationale. Again, rehabilitative, maintenance, and habilitative care are dictated by the needs of the patient, and the skills and function they present with at evaluation. Visit limits not anchored to clinical reasoning and rationale are dangerous and may recklessly limit medically necessary care. CMS should establish rules to eliminate arbitrary limitations on services by requiring clinical reasoning behind visit limits, commonsense exceptions for medically necessary care, or other methods to ensure individuals are not arbitrarily limited in their access to these essential services. Paid care should be dictated by the functional needs of patients and the clinicians' scope of practice. Services should underscore the importance of the therapeutic alliance between clients and providers and service limits should not interfere with or prevent access to a range of treatment options or cause services to be discontinued prematurely.

Gold-Carding Programs in Medicare Advantage Plans

In this proposed rule, CMS requests information regarding stakeholders' perspectives on so-called "Gold Carding" and how to ensure equity under the programs. Gold-carding programs can allow providers exemption from prior authorization requirements and offer more streamlined medical necessity review processes for providers who have demonstrated compliance with plan requirements. While Gold Carding can be a positive step toward administrative simplification, it is important that Gold Card programs be transparent, be updated regularly, and should never be used to justify cuts to payment rates.

APTA Private Practice supports wider adoption of gold-carding as a tool to reduce administrative burden, create efficiencies within the medical necessity review process, and reward providers who consistently and correctly use their services. Gold Carding is proliferating, as in 2019 only 32% of insurance plans used gold-carding programs, while this percentage nearly doubled to 58% in 2022.

Because of this rapid adoption, we urge CMS to heavily prioritize an evaluation of these programs, and consider regulatory standards and protections that establish an equitable framework accounting for providers' variable needs, and to ensure compliant clinicians are accurately identified and excepted from burdensome utilization management. Without such standards, gold-carding will only serve to rewards select groups of providers and further drive inequity in shouldering the immense administrative burden associated with prior authorization and other UM policies.

APTA Private Practice offers several concerns and recommendations below that CMS might consider, which can help ensure that gold-carding programs employ fair and equitable standards:

Use Transparent and Standardized Outcomes Data to Set Benchmarks. APTA Private Practice urges CMS to ensure MAOs use standardized outcomes

in gold-carding programs, and ensure comparisons between similarly-situated providers to qualify for exemption from prior authorization. Additionally, using longitudinal analyses of outcomes data would promote more equitable comparison within these programs. Regardless of how CMS elects to address the issue, PTs and other non-physician providers cannot reasonably or fairly be subject to identical standards to physicians. PTs are already subject to more frequent prior authorization requirements, and have more limited resources to address administrative burden associated with prior authorization in comparison to other services. It is imperative that broad adoption of gold-carding among MAOs also provide clinicians a more nuanced and equitable comparison with their clinical peers. Finally, ensuring that these criteria are transparent, explicit, and well-understood by in-network providers is imperative in ensuring meaningful opportunity to meet these benchmarks.

Consider Practice-Wide Gold Cards. Physical therapists report that gold-carding programs can create administrative challenges when some providers in a practice are gold-carded, and others are not. Specifically, this challenge arises when, for example, a gold-carded provider is unavailable, and patients are moved from the gold-carded provider to a non-gold-carded provider. A patient otherwise deemed appropriate under the gold-carded providers' care, in this scenario, would remain subject to prior authorization and thus create a burden for administrative staff that could have otherwise been avoided. Practice-wide standards and credentialing are potential solutions to mitigate these scenarios and utilize gold-carding programs more equitably.

Regular Benchmark Updates: Though the gold-card review is typically an annual process for plans, providers would benefit from regular updates throughout the year to improve or maintain eligibility. Annual gold-carding does not maximize the potential for reducing costs within the system unless providers receive ample education and opportunity to meet these benchmarks.

CEHRT (Certified Electronic Health Record Technology) in the context of MIPS

We would urge CMS to acknowledge the significant financial and administrative risk that physical therapists and other nonphysician providers face when purchasing Electronic Health Record systems. These systems may include multiple modules and add-ons that have no applicability to PT practices yet are required to be purchased, adding significant cost for non-functional capability. As CMS works towards finalizing these and other policies in the future, we encourage CMS to bear in mind the risks facing physical therapists, and consequently, how their needs may differ from other providers.

CEHRT is designed for prescribing professionals and doesn't adequately capture tasks performed by nonphysician professionals using different types of EHRs. If CMS intends to require PTs and nonphysician EHR vendors to fully participate in the interoperability parameters of MIPS, it should reflect the realities of non-physician providers either by lowering the CEHRT standards for nonphysicians or by providing funding for upgrades. We recommend that CMS consider mechanisms by which the agency may promote physical therapist and other nonphysician provider participation by modifying CEHRT standards. Currently, physical therapists and other nonphysician providers are essentially barred from participating in many programs due to the lack of applicable CEHRT, placing them at a significant disadvantage. This further hinders their ability to succeed in a value-based care system going forward. We

recommend that CMS consider, to the greatest extent possible, modifying the CEHRT requirement to better accommodate participation by physical therapists and other nonphysician providers. Additionally, it is critical that CMS assist physical therapists and other specialty providers, particularly small and rural providers, in the form of funding and technical support to help them prepare for and participate in CEHRT. We respectfully request that CMS provide appropriate resources and support, including implementation assistance and/or consultant support, to physical therapists as they adopt certified EHRs, to better enable these practices to participate in these new models of care.

CONCLUSION

Thank you for the opportunity to comment on the Rule. We hope our insight and perspective will prompt CMS to bolster some of its proposals and remember that when access to care is diminished, beneficiaries will be forced to delay or forgo necessary care which leads to negative health outcomes and greater overall cost to the system. The federal government, as well as patients and taxpayers, are better served in the long run by ensuring that the Medicare program supports providers and empowers them to readily participate in the timely treatment of beneficiaries. APTA Private Practice welcomes the opportunity to work with CMS to identify solutions that will safeguard the financial health of the Medicare program while ensuring that beneficiaries have adequate access to high-quality physical therapy services in safe, cost-effective community-based settings.

Sincerely,

Mike Horsfield, PT, MBA
President, Private Practice Section of the
American Physical Therapy Association