

July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-2442-P** and **CMS-2439-P**
P.O. Box 8016
Baltimore, MD 21244-1850

Submitted electronically

**RE: Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP)
Managed Care Access, Finance, and Quality, and
Medicaid Program; Ensuring Access to Medicaid Services**

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) Proposed Rules referenced above (the [Medicaid Access Rule](#) and the [Medicaid Managed Care Rule](#); together, the Rules). 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 financed by the Medicaid 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 Medicaid program. Our members are proud of the quality of care they provide, but are quick to realize the

impact of the low payment rates and the deleterious administrative hurdles they encounter in both the initiation of care, and continuance of the provision of clinically appropriate care covered by payers, under Medicaid fee for service and Medicaid managed care. Payment rates are widely believed to be the lowest of any payer in almost all states. A new [APTA resource](#) available to the public aggregates and publishes Medicaid payer data by state and proves that, at least within fee for service, Medicaid pays below almost all other payers.

Physical therapists often report that the payment rates offered by Medicaid do not meet the cost of providing care. As a result, physical therapy care for Medicaid patients is often provided without a corresponding request for reimbursement from the program. Physical therapists feel a responsibility to provide care to this particularly disadvantaged community, which is often [less healthy](#) than any other insured population in their catchment area. But providing care with no expectation of reimbursement shows the fundamental failure of the program in many states. It is widely believed that a Medicaid card does not guarantee access to physical therapy.

In addition, the burdensome and duplicative administrative tasks imposed by Medicaid unnecessarily impose time demands, which have significant implications for cost of care, and take time away from the care physical therapists would otherwise use to care for patients. Whether it is the demand to fill out online paperwork, report duplicative quality measures, or the inability of electronic medical records to seamlessly interact, APTA Private Practice members are too often frustrated by their experience with Medicaid.

Physical therapists report that they become “triangulated” between state programs and State contractors who may verify through online systems that patients have Medicaid coverage, but whose coverage is later determined to have lapsed. Physical therapists are concerned that due to the sunset of the public health emergency and the corresponding end of flexibility granted to states regarding Medicaid redeterminations, coverage by the Medicaid program can be illusory. Until Medicaid programs and their associated State contractors are held to account for these types of gaps, Medicaid will continue to be associated with the perception of high risk for the provision of physical therapy services.

As a result, APTA Private Practice welcomes the attempt in the Rules by CMS to improve Medicaid payment and more rationally align it with the needs of underserved communities. While little progress seems to be made in the Rules in the context of administrative burden, a more active posture from CMS in guaranteeing access to Medicaid patients to physical therapy services is critical.

Ensuring Access to Care

Physical therapists appreciate that Medicaid is now a larger program in terms of number of enrollees (93 million were enrolled in Medicaid and CHIP as of [January, 2023](#)) than Medicare (59.82 million as of [January, 2023](#)). Medicaid has become the core of the US health system and its inner workings are critical to the health of lower income adults and children, pregnant people, and the disabled, as well as the health of the US budget.

The [Medicaid Access Rule](#) takes appropriate steps to confirm that states are being vigilant in managing their Medicaid programs to the benefit of Medicaid patients and not only to their state budgets. States that have more adversarial relationships with the program have some of the worst health outcomes in comparison to those states that have taken steps to expand eligibility to lower income adults through Affordable Care Act funding. For instance, the Commonwealth Fund's newest [report](#) on health outcomes in 2023 exposes a strong correlation between non-expansion states and the negative effects of the COVID-19 pandemic.

The next section of this comment responds to specific proposals in the Medicaid Access Rule as noted below.

Payment transparency requirements for states: proposed § 447.203(b). This new section of the Code of Federal Regulations would require disclosure of provider payment rates in both fee-for-service and managed care, with the goal of greater insight into how Medicaid payment levels affect access to care.

APTA Private Practice supports this proposal, but would urge inclusion of physical therapy services in the list of services that must be published. We note that while physical therapy is not a guaranteed benefit beyond the pediatric population in Medicaid, 26 states covered physical therapy in 2018 according to the [Kaiser Family Foundation's HMA Survey](#). We urge that CMS require states to include payment rates for the following list of physical therapy service CPT codes: 97012, 97014, 97016, 97032, 97035, 97110, 97112, 97113, 97116, 97124, 97140, 97150, 97161, 97162, 97163, 97164, 97530, 97535, 97750, 97761, 97762, and G0283. Physical therapy is an important health care service for all populations. Physical therapy may be accessed directly in every state, is cost-effective, and can have a critical impact on pain management (and thus opioid misuse), weight management, imaging overuse, and unnecessary surgeries.

A new two-tiered analysis process when a rate reduction or restructuring is proposed to ensure access is maintained: proposed § 447.203(c)(1). The analysis would demonstrate that any state plan amendment proposals to reduce provider payment rates or restructure provider payments will not put access to care at risk. Under the new system, States would need to provide a more extensive Access analysis if any of the following conditions are not met:

- Aggregate Medicaid payment rates are at or above 80 percent of the most recently published Medicare payment rates.
- Changes to Medicaid payment rates result in no more than a 4 percent reduction in aggregate FFS Medicaid expenditures for each affected benefit category during the state fiscal year.
- Public processes do not raise significant access-to-care concerns from beneficiaries, providers, or other interested parties; or, if these parties do raise concerns, the state is able to address them.

APTA Private Practice supports these proposals, but would urge inclusion of physical therapy services in the list of services that must be published.

Managed Care

We are deeply appreciative that CMS is clearly recognizing that the care of 70% of Medicaid enrollees is funded through managed care arrangements. Managed care is becoming the core of the Medicaid program, as Medicare Advantage is becoming the core of the Medicare program. This means that the federal government must be even more vigilant in monitoring the functions and finances of both programs, which ultimately exist to help patients access medically necessary care. That care is not fostered by attenuated relationships between the ultimate payer – the federal taxpayer – and the eventual beneficiaries of those tax dollars.

Physical therapists also deeply appreciate the work that CMS has done to highlight the physical and occupational therapy needs of the pediatric population, and urges CMS to more closely track the implementation of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program in the States by Medicaid managed care companies. Payers have expressed repeatedly their desire to limit the pediatric Medicaid benefit, and CMS' language has been very helpful in reminding them of their legal responsibility to fund habilitative, not just rehabilitative, care under EPSDT. In particular, physical therapists have reminded payers of the language on page 24 of CMS's [EPSDT Guide for States](#):

For example, while a state may place in its State Plan a limit of a certain number of physical therapy visits per year for individuals age 21 and older, **such a “hard” limit could not be applied to children**. A state could impose a “soft” limit of a certain number of physical therapy visits annually for children, but if it were to be determined in an individual child's case, upon review, that additional physical therapy services were medically necessary to correct **or ameliorate** a diagnosed condition, those services would have to be covered. *[Emphases added]*

Because payers have requested to work with physical therapists to ignore this requirement, we would also urge that the actual provision and receipt of medically necessary physical therapy services be included in any revision of the Form 416 so that CMS can receive a more complete picture of whether medically necessary physical therapy services guaranteed on paper are actually being received. More fundamentally, we would also urge the removal of the “soft” limits referenced above based on the fact that they are limiting access to medically necessary services by way of red tape and paperwork. The simple fact is that limiting access to care is what soft limits are designed to do.

Beyond EPSDT, it is important to provide context for the low payments and red tape physical therapists experience every day. Physical therapists are burdened far too often by trivial administrative minutia. Incentives are mis-aligned between managed care plans and physical therapists: for managed care plans, 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.

Physical therapist frustrations with managed care claims processing red tape 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. Physical therapists have attempted to work directly with payers and TPAs in a proactive manner to resolve this problem, however when both the payer and TPI are involved in discussions, neither will take responsibility and accountability is compromised, thus resolution is not achieved.

The proliferation of quality assurance structures wastes an enormous amount of time for physical therapists attempting to provide high quality patient care, but it also raises an important consideration for the implementation of the Rules. 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.

Medicaid Managed Care Rule

The remainder of our comment focuses on specific aspects of the [Medicaid Managed Care Rule](#).

CMS proposes to require states to use an independent entity to conduct annual secret shopper surveys: proposed §438.68(f). The surveys would be published to validate managed care plans' compliance with appointment wait time standards and the accuracy of provider directories to identify errors as well as providers that do not offer appointments.

APTA Private Practice strongly supports this proposal and urges CMS to require that physical therapists also be included in the secret shopper studies.

CMS proposes to require states to submit an annual payment analysis that compares managed care plans' payment rates for certain services as a proportion of Medicare's payment rate and, for certain home and community-based services, the state's Medicaid state plan payment rate: **proposed §438.6(c)(7)(iii).**

APTA Private Practice strongly supports this proposal and urges CMS to require that physical therapists also be included in the annual payment analysis.

CMS proposes to eliminate written prior approval for state directed payments that are minimum fee schedules at the Medicare payment rate and include non-network providers in state directed payments: **proposed §438.6(c)(5)(iii)(A)(5).**

APTA Private Practice supports this proposal, which should encourage states to pay more adequately (at least at Medicare rates) for services.

CMS proposes to require states to condition state directed payment fee schedule payments upon the delivery of services within the contract rating period and prohibit the use of post-payment reconciliation processes: proposed §438.6(c)(2)(vii)(B).

APTA Private Practice supports this proposal and urges CMS to examine the use of post-service reconciliation processes that rob physical therapists who have provided care to patients whose Medicaid enrollment has been verified but retroactively denied, especially as Medicaid unwinding continues.

CMS proposes to specify that states must provide medical loss ratios for each managed care plan: proposed §438.8.

APTA Private Practice supports this proposal, but notes that taxpayer funds that are paid to Medicaid plans do not come solely from patients or employers, as they do in private insurance, but instead mostly from states and the federal government. MLR rebates thus have a different purpose in the context of Medicaid, but MLR incentives in the Medicaid context still force providers to bear the burden of the payer drive to avoid returning funds to state and federal coffers. Medicaid managed care plans may still vertically integrate by contracting with utilization management groups to limit access to medically necessary care through excessive prior authorization requirements. These vertically integrated structures should be limited by CMS if not banned outright. Far from encouraging access to medically necessary patient care, these structures force providers to spend unreimbursed time on interminable peer-to-peer calls and PA paperwork that limits access to services that the provider, in their clinical judgment, has determined are necessary to rehabilitate function.

CONCLUSION

Thank you for the opportunity to comment on the Rules. *APTA Private Practice* welcomes the opportunity to work with CMS to identify solutions that will safeguard the financial health of the Medicaid program and use taxpayer dollars wisely 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: a Section of the American Physical Therapy Association