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January 04, 2021

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-9123-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically

RE: Medicaid Program; Patient Protection and Affordable Care Act; Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-facilitated Exchanges; Health Information Technology Standards and Implementation Specifications [CMS-9123-P] RIN 0938-AT99.

Dear Administrator Verma:

On behalf of the over 4,000 members of the Private Practice Section (PPS) of the 100,000 member American Physical Therapy Association, I write to provide feedback on the Office of the National Coordinator (ONC) and Centers for Medicare and Medicaid Services' (CMS) latest proposed rule targeting administrative burden: [CMS-9123-P] (the "Rule").

PPS 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 and habilitative care they provide restores, maintains, and promotes overall fitness and health to a range of patient types. Representing physical therapists who are also independent small business owners, PPS 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 our members experience on a daily basis the impact of overburdening red tape, whether implemented by any level of government or private sector payers. As private insurer payments often make up more of our members' revenues, our members often find that the administrative burden imposed by private payers creates more problems for our businesses and our patients than do government rules.

General Reaction
PPS is strongly supportive of the goals of the Rule and we believe that many of its aspects are positive, including its focus on patients and their data access and the portability of information if they change insurers (45 CFR §156.221). In regards to physical therapists, we are strongly supportive of, even if we are not directly impacted by, the proposed Exchange plan (45 CFR §156.22) and Medicaid (42 CFR §431.60) standards set for electronic adjudication of prior authorizations, as well as the requirements for disclosure of the reasons for denial and the standardized structure to allow for appeals of such denials (45 CFR §156.22 and 42 CFR §431.60). We suggest two changes that should appear in any final rule: the inclusion of Medicare Advantage plans and the creation of a safe harbor to require payment if prior authorization is waived or granted. First, however, it is important to provide context for the red tape private practice physical therapists experience every day.

Context for Red Tape Relief
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.

Adding insult to injury, insurers have had some of their most profitable quarters in history as utilization has plummeted due to the COVID-19 pandemic, but premium payments from members have remained relatively stable (https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-through-september-2020/).

> At the end of the third quarter of 2020, average gross margins among individual market and fully-insured group market plans were 21% and 24% higher, respectively, than at the same point last year... Average gross margins for managed care organizations (MCOs) in the Medicaid market were more than twice as high through the third quarter of 2020 as they were through the third quarter of 2019 (a 109% increase).

Payers are incentivized to avoid paying claims, even terming such payments "medical losses." The stumbling interaction between payer and provider, repeated on a daily basis across the country, has a direct cost on physical therapists and the health system. 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 stoking depression and suicidality (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2773831) among providers. The costs and burdens of payer red tape are real.

Medicare Advantage (MA)
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. Nevertheless, we believe these standards would be more impactful for physical therapy practices if they also applied to MA plans and we are puzzled as to why they are excluded. Government is at its best when it sets broad-based rules and standards for

industry to work within. Excluding MAfrom the Rule seems shortsighted and against the intent of the Rule to create industry-wide standards. In addition, it would be much more efficient and ultimately highly beneficial to patient care if a confirmation that prior authorization is not required were to grant a safe harbor from insurer or third-party post-treatment payment denials.

Three data points are important to consider when deciding whether CMS should include MA in any Final Rule. First, MA is important to patients and to physical therapists, and enrollment in the program is growing quickly (https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/):

> In 2020, more than one-third (36%) of all Medicare beneficiaries – 24.1 million people out of 67.7 million Medicare beneficiaries overall – are enrolled in Medicare Advantage plans; this rate has steadily increased over time since the early 2000s. Between 2019 and 2020, total Medicare Advantage enrollment grew by about 2.1 million beneficiaries, or 9 percent – nearly the same growth rate as the prior year.

Second, MA enrollment is highly concentrated within a handful of large insurers. The same source notes:

> UnitedHealthcare and Humana together account for 44 percent of all Medicare Advantage enrollees nationwide, and the BCBS affiliates (including Anthem BCBS plans) account for another 15 percent of enrollment in 2020. Another four firms (CVS Health, Kaiser Permanente, Centene, and Cigna) account for another 23 percent of enrollment in 2020.

Third, "Medicare Advantage plans can require enrollees to receive prior authorization before a service will be covered, and nearly all Medicare Advantage enrollees (99%) are in plans that require prior authorization for some services in 2020." (https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/). The percentage of MA plans that required prior authorizations for some services in 2019 was 79% - 20% growth in just one year.

Based on all of these important facts about the growth, increasing market share, and prevalence of prior authorizations, PPS believes it is imperative that MA plans be included in any Final Rule setting forth requirements for prior authorizations. The dominance of certain firms within the MA space has important implications for physical therapists in private practice, as large market shares cause insurers to act with even greater impunity against smaller practices. While physical therapy practices are regulated by antitrust law, MA plans are not and in certain counties, MA plans account for more than 60% of Medicare enrollment. The actions of large insurers can have a large impact on small and large physical therapy practices and the red tape burden they create can reverberate throughout local physical therapy markets. The growth in MA enrollment is only poised to accelerate, and regulating these plans in the same way as other private plans funded by the government (Exchange-listed plans and Medicaid MCOs) will have important smoothing effects for the insurance market as a whole.

Experience with Administrative Burden

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.

One recent example may be helpful to illustrate the frustration that physical therapists experience from red tape. Based on CMS's collaboration with the national correct coding initiative (NCCI), edits were included for codes frequently billed by physical therapists. These edits necessitated the use of the -59 modifier for these commonly used codes. We are very appreciative that CMS and NCCI recently rescinded the edits. But prior to this rescission, physical therapists would file claims with the -59 modifier as coding rules dictate. In turn, and based on this frequent use of the -59 modifier, payers would flag the claims for denial. This meant that thousands of denials had to be appealed even though the coding was correct. Private practice physical therapists across the country were forced to appeal a significant portion of their claims even though they were coded correctly. And Humana – one of the largest insurers in the country – has been flagging the use of the appropriate use of the modifier -59 for denial for years.

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 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. In particular, AIM Specialty Health has denied payment for pre-approved, medically necessary care provided in many states. AIM is a wholly-owned subsidiary of WellPoint.[1] Physical therapists in the states AIM operates in have reported the negative impact of AIM's payment policies on patient care. They believe that AIM limits access to medically necessary care through unreasonable audits designed to limit medical losses rather than pay appropriately for medically necessary care. Raising administrative burden issues to payers that share ownership in the reviewing entity that is restricting care is a fool's errand.

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[1] See WellPoint Press Releases available at https://ir.antheminc.com/news-releases/news-release-details/wellpoint-completes-acquisition-american-imaging-management?field_nir_news_date_value[min]= and https://ir.antheminc.com/news-releases/news-release-details/anthem-and-wellpoint-complete-merger-0?field_nir_news_date_value[min]=

The proliferation of AIM and other 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 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 about 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**.

Conclusion

We appreciate the opportunity to comment on the Rule and support its intent to decrease administrative burden. Red tape burdens do not improve patient care, increase frustration and burn out and make it harder to run effective and profitable small businesses. We urge CMS to include Medicare Advantage in any Final Rule and also to create a safe harbor to require payment for pre-approved care by physical therapists. For questions related to this or other private payer issues, please contact Robert Hall, PPS Senior Consultant, at RHall@ppsapta.org.

Sincerely,

Mike Horsfield, PT, MBA
President, Private Practice Section of APTA