NARA
The National Association of Rehabilitation Providers and Agencies

August 31, 2024

FILED ELECTRONICALLY

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments [CMS-1807-P]

Dear Administrator Brooks-LaSure:

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 90,000 physical therapists (PT), occupational therapists (OT), and speech language pathologists (SLP) through our member organizations who provide therapy across the United States to Medicare beneficiaries. They provide therapy in all settings across the continuum such as outpatient clinics, skilled nursing facilities (SNFs), assisted living facilities (ALFs), retirement communities, hospital inpatient and outpatient, and in the beneficiary's home. As a member-driven organization, NARA promotes best practice and business success of physical therapy, occupational therapy, and speech-language pathology providers through education, support, and advocacy. NARA's membership demographics give us a unique insight into payment and quality programs for the payment policies under the Physician Fee Schedule. We appreciate the opportunity to provide the following comments related to the above proposed rule.

Reimbursement Reductions

In this proposed rule, there is a proposed net decrease in the conversion factor for CY2025 of $0.93 or 2.80% - which includes the expiration of the increase Congress passed effective earlier this year. PAYGO is also set to expire, which would be an additional decrease of 4.00% effective January 1, 2025, for the potential total of a 6.80% decrease. Rehabilitation providers have not received an increase in reimbursement since 2010. In fact, since 2011, physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP)

services have been **disproportionately affected by Medicare Physician Fee Schedule reductions.** These therapy specific payment reductions include (see table summary below):

- Multiple Procedure Payment Reduction (MPPR) of the practice expense (PE) which began in 2011 with a 25% reduction and increased in 2013 to a 50% reduction in PE. The estimated impact of MPPR is a 6-7% reduction in reimbursement annually for rehabilitation providers. In the CY 2024 proposed rule, CMS indicated that 19 codes primarily used by therapists had been misvalued since 2017. We appreciate the adjustments proposed in this rule for 16 of the 19 codes, however, the MPPR reduction should be reviewed for applicability on all therapy codes.
- Physical Therapist Assistant and Occupational Therapy Assistant reduction of 15% on reimbursement effective January 1, 2022.
- Fee Schedule Reductions since 2021 (including this proposed decrease for CY2025) of nearly 12.5% which has been used to fund the new G2211 code and increase reimbursement for evaluation and management (E/M) codes primarily used by primary care physicians.

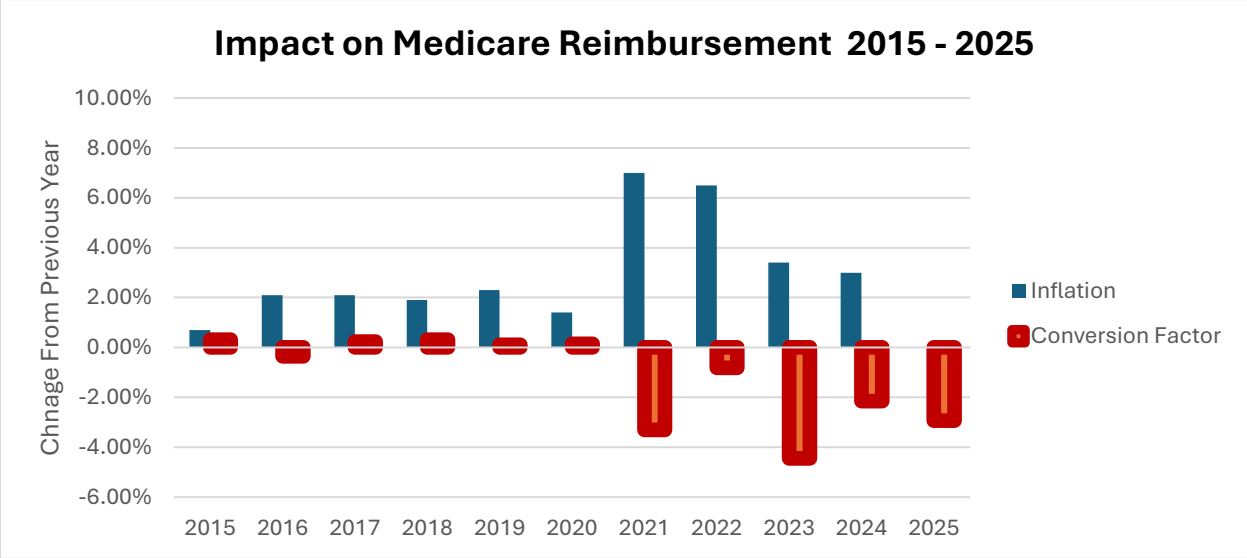
Policy/Year	Therapists	Therapy Assistants
MPPR 2011-2012 (initially 25%)	-7%	-7%
Sequestration (2011-2030)	-2%	-2%
MPPR 2013-Current (increase to 50%)	-7%	-7%
Physician Fee Schedule 2021	-4%	-4%
Physician Fee Schedule 2022	-0.75%	-15.75%
Physician Fee Schedule 2023	-1.35%	-1.35%
Physician Fee Schedule 2024	-1.69%	-1.69%
Scheduled Physician Fee Schedule 2025	*-2.80%*	*-2.80%*
PAYGO Reinstated January 2025	*-4.00%*	*-4.00%*
TOTAL	**-30.59%**	**-45.59%**

When combined with the proposed reductions in this year's CY 2025 Proposed Rule and sequestration, the total cuts to therapy payments amount to nearly 33% and soars to 52% when you factor in the reduction for services provided by physical therapist or occupational therapy assistants as of January 1, 2022, and anticipated expiration of PAYGO. These substantial cuts are not unique to Medicare as a payer as commercial payers' reimbursement is often calculated on the Medicare Physician Fee Schedule.

The cuts are untenable at any time but particularly over the past few years due to the financial impact of the COVID-19 Public Health Emergency, the rise in inflation and

significant wage increases. These year-over-year reductions have created an unsustainable challenge for rehabilitation providers, and if imposed will severely reduce the number of providers, particularly those in rural and underserved areas. Unlike other industries, rehabilitation providers cannot increase prices for services commensurate with the increase in expenses because it does not equate to revenue that covers the expense increase due to reimbursement constraints.

The services provided by rehabilitation providers are essential for Medicare beneficiaries who wish to age in place, particularly for the growing demographic with chronic conditions. In June 2023, the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary[1] estimated that Medicare beneficiaries totaled 63.6 million in 2022 and by 2031 this would increase to 76.4 million. **Since 2015, inflation has increased by over 30%, while CMS has decreased the conversion factor by 13.21% (including the decrease from this proposed rule) as shown in the graphic below.** Simply put, this is not sustainable for providers and the combination of year over year reimbursement cuts will undoubtedly lead to a significant access to care challenges for Medicare beneficiaries in need of physical therapy, occupational therapy, and speech-language pathology services. Our members have expressed they have longer wait times for many Medicare beneficiaries to receive care due to the capacity challenges and with the projected number of Medicare beneficiaries expected to climb steadily through 2031, the wait times for care will continue to worsen.



We strongly urge CMS to reform the Physician Fee Schedule (PFS), including annual inflation updates to the conversion factor based on the Medicare Economic Index (MEI)

[1] CMS Office of the Actuary Releases 2022-2031 National Health Expenditure Projections https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2022-2031-national-health-expenditure-projections

and eliminating the outdated budget neutrality requirement that continues to create untenable instability for the PFS. The PFS is broken and detrimental to the future of access to the growing number of Medicare beneficiaries who need services from therapy practitioners to age in place and maintain their quality of life. According to a study conducted by the Moran Company, use of PT as a first intervention for lower back pain resulted in 19% lower costs to the Medicare program when compared with injections as a first intervention, and 75% lower costs when compared with surgery as a first intervention. Beneficiaries who received PT within the first 15 days of their diagnosis had lower average treatment costs than those who began PT later. One year after the incident diagnosis with therapy treatment, spending for the therapy episode of care was 36% lower than those who started with injections and 66% lower than those who started with surgery.[2] Rehabilitation providers can provide relatively low-cost and non-invasive skilled therapy treatment to reduce healthcare costs for Medicare.

Supervision

NARA was very pleased to see the proposed rule includes an update to the supervision requirement for physical and occupational therapy assistants in private practice to be consistent with the standard of general supervision that exists in other therapy settings such as a rehabilitation agency, hospitals and SNF's. The modernization of the supervision standards creates consistency across all settings and will decrease administrative burden and confusion. As we have shared previously, physical and occupational therapy assistants are critical members of our profession and help provide access for patients in need of therapy services. Providers have demonstrated the ability to provide safe and effective care with general supervision of physical and occupational therapy assistants in all other therapy settings for many years. NARA applauds CMS for reconsidering this outdated supervision requirement and its proposal to modernize this requirement for general supervision.

Certification of Therapy Plans of Care

NARA appreciates CMS clarifying that even though statute 424.24(c) does not specifically address Occupational Therapy services for certification of plans of care, they are referenced elsewhere in statute and the Medicare Benefit Policy Manual; thus, OT plans of care must follow the same requirements for signature as PT and SLP plans of care. We believe that making the recommended changes to the paragraph headings and text will help eliminate confusion in the future and promote the appropriate consistency between therapy disciplines.

NARA supports CMS's proposal to amend the regulation at § 424.24(c) for cases when a patient has a signed and dated order/referral from a physician/NPP combined with

[2] Physical therapy episodes for low back pain: Medicare spending and intensity of physical therapy services. The Alliance for Physical Therapy Quality and Innovation. aptqi.com/wp-content/uploads/2019/03/APTQI-Complete-Study-Physical-Therapy-Episodes-Lumbago-October-2017.pdf. Published October 2017.

documentation of such order/referral in the patient's medical record was transmitted to the ordering/referring physician/NPP as being sufficient to demonstrate the physician/NPP's certification of these required conditions. CMS (and their contractors) would treat the signature on the order or referral as equivalent to a signature on the plan of treatment. **NARA recommends education to providers and the MACs that carve out this change should CMS include this change in the final rule. NARA also recommends that CMS provide specific examples of documentation in the medical record that the therapy plan of treatment was transmitted to the physician to ensure both providers and MACs have a visual understanding of what "evidence" looks like for this process.** Some examples of this could include a timestamp from an electronic health record or fax transmission of these plans of care. Due to the diverse methods rehabilitation providers use to communicate information to physicians/NPPs and the ongoing advancements in technology, **NARA recommends that CMS permit flexibility in how this requirement is fulfilled, if the necessary information is clearly provided. Additionally, NARA requests that CMS clarify, to eliminate any uncertainty among providers or MACs, that payment will not be denied based on a physician/NPP signature on a plan of treatment, provided there is an appropriately signed and dated order/referral and evidence that the therapy plan of treatment was transmitted to the referring physician/NPP.**

RFI on Amount of Time for Changes to Plans of Treatment

According to our members, most therapists have regular communications with the referral sources about the care of patients they share. This occurs in a variety of ways and typically whenever needed over the course of the treatment episode. Any time a referring physician/NPP has a recommended change to a therapy treatment plan and shares that with the treating therapy provider, applicable changes would be implemented. NARA members find that once referring a patient for therapy and reviewing the plan of treatment created by a therapist, a physician/NPP rarely makes a request for modification. Assigning an arbitrary timeline, for example 10 days, to make any changes to a plan of care by the referring physician/NPP seems unnecessary, given the ability for these requests to be made throughout the treatment duration. Therefore, setting this strict timeline requirement creates an unnecessary administrative burden on the physician and therapist to track and may delay care. CMS has clarified[3] that a therapy plan of care is established when it is developed, and that therapy treatment becomes effective when the plan of care is created. **NARA recommends that CMS does not assign a timeline for a physician/NPP to request a modification to a therapy plan of treatment.** NARA also requests CMS clarifies for providers and/or MACs**, that any changes which are received from a physician/NPP after care has been provided would be reflected in the care moving forward not retroactively and care provided prior to recommended changes by the physician would be considered medically necessary.**

RFI on 90 Calendar Day Time Limit on Referral for Outpatient Therapy Services

[3] 42CFR 410.61 and found in chapter 15 of Medicare Benefit Policy Manual section 220.1.2

NARA opposes implementing a time limit of any kind on a referral for outpatient therapy services. When presenting for therapy with an order or referral, therapy providers have a process of evaluating the patient's status and assessing if therapy is indicated. When it is, a therapy treatment plan is created and shared with the referring physician/NPP. As a comparison, there is currently no expiration placed on referral of other services, for example in most states a prescription for a non-controlled substance is generally valid for 12 months from the date written[4]. NARA recommends that that an order or referral for therapy services be treated the same way. According to a study from 2020 – 2021 of over 25,000 patients, approximately 63% of the patients who had not yet attended a physical therapy visit within 90 days of the referral eventually attended after 90 days[5]. Patients who did not attend right away stated the condition had improved or they were waiting for the condition to improve with time. By not setting an expiration date on therapy service prescriptions, it allows patients more flexibility in managing their own care.

Telehealth

NARA along with other professional and trade associations is working closely with Congress in the hopes of passing the Expanded Telehealth Access Act (HR 3875/S 2880) or Telehealth Modernization Act of 2024 (HR 7623) which would make PT, OT and SLP permanent providers of telehealth services. **NARA urges CMS to act swiftly in updating Medicare benefits related to telehealth provided by PT, OT, and SLP providers for reimbursement when this legislation is enacted.** Telehealth integration into rehabilitation therapy represents a significant advancement in healthcare accessibility and efficiency. The ability for therapy providers to utilize telehealth is positively impactful when treating beneficiaries in rural and underserved areas and to address the workforce shortage.

NARA requests clarification that the codes primarily used by PT, OT and SLP providers will remain on the provisional list as they have since the PHE.

Caregiver Training Codes

NARA supports CMS' proposal to allow verbal consent from the patient or patient representative for caregiver training services. Further, we support CMS adding caregiver training service codes (CPT codes 97550, 97551, 97552, 96202, and 96203) to the Medicare Telehealth Services list for CY 2025 on a provisional basis as outlined in Table 8.

MIPS

NARA strongly encourages CMS to determine avenues to allow all eligible rehabilitation providers regardless of setting or billing methodology to have a cost-effective method

[4] https://www.ama-assn.org/practice-management/sustainability/how-does-extended-prescription-duration-help-your-patients-and

[5] Hunter SJ, Woodfield D, Minick K, Snow GL, JB Poll Why don't patients attend orthopedic PT after physician referral? J Orthop Sports Phys Thera 2022;52(1):OPL21

of participating in the Merit-based Incentive Payment System (MIPS) to help mitigate the continuous cuts to Part B reimbursement.

Currently, PTs, OTs, and SLPs who provide outpatient therapy services under Medicare Part B and bill through rehabilitation agencies, skilled nursing facilities (SNFs), and hospital outpatient departments are unable to participate in MIPS because they bill on the UB-04 Institutional Claim form (CMS 1450). Therapists in private practice bill for services under their own NPI on the CMS 1500 form, and as such, can participate in MIPS. Per the MedPAC report on outpatient therapy services payment system in November 2021[6], 61% of therapy providers spending for Part B services was submitted by providers on the UB-04 (CMS 1450) form and, as a result, MIPS applies to less than 39% of Part B therapy providers. **NARA recommends modifying the current program to allow the vast majority (61%) of therapy providers, who cannot currently participate in MIPS, solely due to billing methodology, to have the opportunity to provide patient outcome data and share in the opportunity for higher reimbursement.** NARA welcomes the opportunity to work with CMS to provide feedback on how to make these changes.

NARA encourages CMS to explore ways that all eligible clinicians can participate in the evolution of the value-based payment systems. Facility-based therapists could participate in MIPS under the group reporting option. However, due to current billing practices, this may pose a challenge for tracking the individual therapist. One potential solution is to allow facility-based groups with rehabilitation providers to participate in MIPS as a group using the revenue code to identify services and track the group as a whole rather than the individual therapists. Another potential solution would be to modify the UB-04 (CMS1450) to include a box on each service line for the treating therapist's NPI. This would require more therapists to apply for provider NPIs which could cause a strain on the NPPES system for a brief time. However, CMS would be able to continue tracking performance based on the individual therapist as they do with other eligible providers.

Should CMS make accommodations to allow facility-based therapy providers to participate in the program in the future, we encourage CMS to consider allowing therapy providers in facilities to report measures relevant to their respective settings like their physician colleagues. For example, therapists billing for services for a Medicare Part B beneficiary in a skilled nursing facility (SNF) may wish to report the same functional measures they report under the SNF Quality Reporting Program. This would enable CMS to begin to align the new Improving Medicare Post-Acute Care Transformation (IMPACT) Act measures with the MIPS program. Again, NARA welcomes the opportunity to work with CMS to determine how to add facility-based providers to the MIPS program and other future programs such as advanced alternative payment models (APM). NARA recommends that CMS engage with therapy practitioner stakeholders to develop and approve MIPS Value Pathways (MVPs) with measures available to therapists.

[6] https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_opt_final_sec.pdf

MIPS Value Pathways for Therapy Practitioners

NARA supports CMS's efforts to improve MIPS by continuing to transition to the MVP framework as it may lead to greater value for the program while reducing the burden to clinicians. We request that CMS partner with stakeholders to develop other MVPs for physical therapy, occupational therapy, and speech language pathology practitioners. We encourage CMS to continue to review other measures such as the IROMs measures that can be included in the MVPs. Currently, there are no MVPs specific for SLPs thus preventing them from participating in this model. CMS should determine if traditional MIPS should remain to allow providers without cost measures or other factors that preclude participation in MVPs to earn an annual payment update.

Additionally, we encourage CMS to make necessary reforms to MIPS, so the incentive payments are aligned with the administrative burden that comes with participation. NARA supports payment models that reward therapy practitioners for the quality of their services and achieving positive outcomes for beneficiaries; however, these models should not create an excessive administrative burden that negatively offsets the incentive. For the therapy industry, cost barriers (registries, staff training, etc.) and eligibility to participate exist making it difficult to separate the "winners" and the "losers". If CMS can find a way for facility-based therapy providers to participate in MIPS and MVPs, where most of these practitioners practice, then it would allow more providers to participate in quality payment programs and easily identify providers who are not providing quality services.

Administrative Burden from Medicare Advantage Plans

~~In the past year the administrative burden with Medicare Advantage plans has become intolerable for our members. The impact of this burden has resulted in increased administrative staff costs for payers who are already reimbursing less (far less in some cases) than the Medicare allowable amount. We wanted to provide you with just a handful of examples from our members:~~

Over the past year, the administrative burden associated with Medicare Advantage plans has become overwhelming for our members. This burden has led to increased costs for administrative staff, while payers continue to reimburse at rates that are often significantly lower than the Medicare allowable amount. We would like to share a few examples from our members to illustrate this impact:

Audit Increases

- **Anthem:**
  - From January – June 2024: member received 732 claim audits for the period of 1/28/2022 through 6/17/2024. All these audits required medical records to be sent. To accommodate this request volume, the member had to hire additional staff in compliance and revenue cycle to assist with assembling the medical records and creating appeals related to this audit.

  - Between 4/2023 – 4/2024, approximately 4,000 claims were submitted to Anthem OH, KY, and IN. Of those, medical records requests for 2,285 were received prior to Anthem adjudicating our claims. This equates to 57% of the claims being initially pended for medical records. There was approximately a 70% overall denial rate associated with these claims, most indicating RARC code 150 – indicating that the services were not medically necessary – resulting in additional appeal letters.
- **Blue Cross Blue Shield:**
  - BCBS NC: Audit for dates 1/1/2023- 12/31/2023- 57 charts requested to review appropriate billing. The Medical Records Specialist focused on this task for over 1 week working 40 hours a week to meet the deadline.
  - BCBS MS auditing approximately 50% of claims including Medicare supplement policies. Members must call after medical records are submitted because previously BCBS would deny stating they never received the records – but in most cases they found them.
- **Humana:**
  - Audit dates 1/1/2023 to 7/31/2024 - 240 charts requested to review 2024 Star Measure Guidelines for HEDIS – required additional staff to assist as well as requested an extension due to volume. States where services were provided include IL, NC, IN, FL, VA, TX, KS, GA, CO.
  - In Alabama: auditing claims twice – once on the front end during the episode and then pre or post payment after the claim is submitted
  - Cancelled contract with Humana effective 2023 and then received 102 ADRs from them from 2023.
- **Aetna:**
  - Risk Adjustment Review (aka medical records review): 1/1/2023 – 7/31/2024 a total of 81 charts requested for review. Required 2 extensions due to small department.
- **UnitedHealthcare:**
  - Prepayment audits for every claim received even when there was a prior authorization
  - Auditing approximately 10% of all claims submitted – prior to the September 1, 2024, prior authorization requirement change
  - In April 2023, eliminated all prior authorizations. In August 2024, reinstated requirement for prior authorizations for all MA beneficiaries – current patients and new patients - effective September 1st. Providers had 14 days to put this requirement back in place. UHCs system was not ready to go on or before September 1st. Providers are required to submit forms completed by the beneficiaries with the prior authorization. Each discipline requires a separate submission (each submission takes approximately 30-40 mins including downloading documentation required to submit). All UHC patients had to be put on hold till a response

is received on the authorization request. Beneficiaries were not informed of this new requirement and many members report patients upset because their therapy was put on hold. Some members have reported denials for patients who were already receiving therapy because the form requests initial start date which exceeds the 10-day requirement to submit for authorization – these cases will not have to be appealed with written letters from physician and beneficiary.

- **Non-Payer Specific**
  - In 2023 received 520 claim audits and through July 31, 2024, have received 235 claim audits (has 8 FTEs dedicated to working appeals and denials
  - Managed Care ADRs make up approximately 51.5% of all ADR requests but they are only 1/3 of the total claims
  - Received 79 audits for 2023 from Managed Care payer stating it was a CMS Audit

Not Following Medicare Process

- Baylor Scott & White Health Plan in Texas – does not always recognize the KX modifier when a patient exceeds the therapy threshold amount
- Misapplying NCCI Coding Edit rules – denying CPT codes as bundled with another code when the NCCI coding edit has not existed for several years
- Requiring medical review of all documentation related to 59 modifier usage
- Applying Medicare LCD coding sets incorrectly
- Retro prior authorizations are not granted when beneficiaries tell providers they do not have the Medicare Advantage plan and do not have a card, and providers are unable to find the member information; or beneficiary does not communicate they changed insurance coverage outside the normal open enrollment period.
- Requiring prior authorizations for beneficiaries without clear instructions or guidance
- Only authorizing 8 visits at a time for beneficiaries who are receiving maintenance therapy then denying authorization request for additional visits
- Denying authorization for beneficiaries who are a fall risk
- Online portals for prior authorizations only allowing 1 or 2 diagnosis codes and returning a limited number of visits based on those 2 diagnosis codes
- Varying appeal submission times based on whether you are a participating provider or not
- Routinely receiving notification that the appeals or documentation was not received but they are requiring the submissions to be faxed in
- Denials for single line items and requiring the entire chart be submitted

- Denials for exceeding the allowed units not based on Medicare NCCI Medically Unlikely Edits for example Aetna will only pay 4 units per visit – anything over 4 units per visit is denied
- Denying line items because another provider has billed the same CPT code except that it was a physical therapist and occupational therapist providing separate services – this was indicated on the claim with a GO and GP
- Delays in receiving prior authorization can be up to 14 days
- Timely filing periods are significantly reduced
- UnitedHealthcare requires start and stop times for treatment sessions – this becomes challenging when beneficiaries do not indicate they have changed coverage
- Appeals processes are all different
- Not communicating to beneficiaries what services require prior authorization
- Not allowing ALJ hearings
- Humana eliminated level 3 appeals effective January 10, 2024
- Denials based of lack of documentation even though documentation is submitted and highlighted and outlined in cover letter provided. Examples:
    - Example 1- HMOs saying the BIMS wasn't completed in a timely manner; however, it was, and documentation provided.
    - Example 2-HMOs saying they cannot validate ST case mix due to unable to confirm mechanically altered diet, even though it is in the chart. I have had a few go to level 1 and 2 even though we wrote a letter and provided extensive documentation for support.
- Sending letters stating that is the second requests for medical records when a first request was never received
- Sending requests or denials to the wrong organization and then having to track down why they are taking money back for a date of service that was from over a year ago. Then your appeal is denied for timely response.
- Cancelling audit after the required submission date – resources have already been expended to pull and submit required documentation
- HMO often issue a last covered day when the patient continues to meet medical necessity and skilled care per Medicare guidelines.
- UHC only gives 30 days for an appeal versus Medicare 120/180 depending on stage. By the time the letter is received we often only have 3 weeks left to write a robust and persuasive appeal letter while navigating ADR's and denials from other payers

Credentialing Issues with Medicare Advantage

- UnitedHealthcare has incorrectly credentialed several of our members by their DBA rather than the legal business name which has been provided – then deny the claims since the information does not match. They tell members to submit the claim with their DBA as their legal business name

- Will not credential Speech Language Pathology Clinical Fellows
- Take on average 90 – 180 days to credential and make eligible providers – Medicare only takes 30 days, and the effective date is retroactive. MA payers will not retroact an effective date to the date of the application. In some cases, the effective date once the contract is received is 30 – 45 days in the future – after the organization/provider has waited 90 days to get the application processed
- Requiring duplicative information be completed in different formats – word document and excel formats
- Requiring CAQH to be completed in addition to forms that ask for the same information that is in CAQH
- When adding a new location, you must submit a Letter of Intent or initiate a new "contract"
- Do not recognize Rehab Agencies as facility providers – require Rehab Agencies to credential as professional groups thus requiring credentialing of all providers
- Closed Aetna and Humana networks for approved Medicare providers – no opportunity to appeal the decision
- Humana is sending payments for services payable to a therapist not even on record for that beneficiary
- Requiring a Medicare PTAN for all providers – Rehab Agencies are not required to credential their providers individually, therefore do not have individual PTANs for providers
- Humana, BCBS Missouri, BCBS Kansas, Tufts NH and MA, BCBS GA – no responses from the credentialing departments
- Humana randomly removes locations where a therapist is credentialed without communication from the provider that this is accurate
- Disenrolling therapists stating they did not receive recredentialing information when it has been uploaded or emailed to them – then requiring the provider to be recredentialed.
- Some states for BCBS/Anthem require you to complete applications via Availity (per the website) but then after waiting the required 30 days to contact payer since you did not receive a response, you are told they do not use Availity and send you the application in word and/or excel formats which is the exact same information you spent an hour filling out in Availity
- Not credentialing organizations/providers with all available plans when requested, you do not find out until a claim is denied and then you have to go through the full credentialing process which takes up to 180 days (and effective date is not retroactive)
- Using systems that providers cannot access, with no response from payer IT departments—such as Elevance/Anthem in Virginia, which began encrypting all emails with attachments. This requires credentialing staff to log in to

retrieve them, but the session times out, and the system won't reset passwords to access the information. Elevance's IT department fails to resolve the issue during phone calls, claiming they will call back. Instead, they send an email days later stating the support ticket has been closed, though the issue remains unresolved. Contract representatives are unable to assist providers.

NARA acknowledges the benefits Managed Care plans offer to beneficiaries; however, Managed Care payers consistently fall short as reliable partners for organizations. They frequently:

- Fail to adhere to Medicare guidelines for claims processing, NCCI edits, MUEs, credentialing, appeals, and beneficiary services;
- Do not effectively communicate plan requirements to beneficiaries;
- Deny or limit the therapy services beneficiaries are entitled to;
- Reimburse at rates below the Medicare allowable amount.

Several of our members have reported that they have either stopped or are considering no longer accepting Medicare Advantage plans, which will limit seniors' access to these essential services. We strongly urge CMS to listen to our providers' concerns regarding the overwhelming administrative burden and insufficient reimbursement for medically necessary services that comply with Medicare guidelines.

We thank you for the opportunity to provide comments related to this proposed rule. Should you have any questions concerning these comments, please contact Christie Sheets-Covington, NARA Executive Director at christie.sheets@naranet.org.

Respectfully submitted,

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