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August 31, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically

RE: Medicare Program; Request for Information on Medicare Advantage [RIN 0938–AV01]

Dear Administrator Brooks-LaSure:

On behalf of the over 17,670 members of the Academy of Orthopaedic Physical Therapy (AOPT) of the more than 100,000 member American Physical Therapy Association (APTA), I write to provide feedback on the Request for Information from the Centers for Medicare and Medicaid Services (CMS) focusing on health equity: [C4-26-05] published in the August 1, 2022 Federal Register (the "RFI").

AOPT leads the physical therapy field in research, practice and education so that members deliver care that is evidence-based, innovative, and effective. The mission of AOPT is to empower members to excel in orthopaedic physical therapy. AOPT is committed to insuring access to services that are shown to reduce the burden of musculoskeletal (MSK) conditions on society. AOPT members know that payer bureaucracy and administrative burden have important impacts on health equity because they steal the time that PTs could be spending with patients. AOPT members also know that physical therapy services provide one of the best values in the US health system.[1]

AOPT deeply appreciates the Administration's focus on health equity, which is an issue that has been an afterthought in health policy debates for far too long. Physical therapists address health equity in many different ways, but are too often overlooked as critical care providers poised to bridge many of the health equity gaps in the US health care system.

[1] Juliet M. Spector, Olga Genina, David Doiron, "Impact of Physical Therapist Services on Low Back Pain Episodes of Care," https://ppsapta.org/userfiles/File/ImpactofPhysicalTherapistServicesonLowBackPainEOC.pdf, Milliman, Inc., accessed August 29, 2022.

Physical Therapists and Musculoskeletal Care in the US

An estimated 92% of the global burden of disease—measured in terms of attributable years of life lost—is related to causes requiring some level of physical rehabilitation.[2] Musculoskeletal disorders are a major source of morbidity in the United States. Healthy People 2010, 2020 and 2030 all list physical activity or movement as one of the leading health indicators,[3] and musculoskeletal disorders are among the most common causes of disability and subsequent lack of physical activity.[4] Musculoskeletal disorders represent a burden on society in both direct costs to the health care system and indirect costs through loss of work and productivity.[5]

Physical therapists see the result of the US health system's lack of focus on health equity every day as they care for patients. In its 2003 report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Care, The Institute of Medicine defined "disparity" as a variation in the quality of care provided to racial and ethnic minority patients that is not due to factors such as access to care, ability to pay or insurance coverage.[6] Hundreds of studies and publications continue to document the disparate care provided to racial and ethnic minorities and the extent of inequalities in treatment for common chronic diseases.[7] The COVID-19 pandemic only multiplied inequities in the health system, with ARHQ's annual National Health Disparities Report demonstrating that many disparities worsened significantly or remained the same during the pandemic.[8]

Arthritis provides a good example of musculoskeletal need frequently treated by physical therapists that is more prevalent in socially at-risk populations.[9] African-Americans have a higher prevalence of knee symptoms, radiographic knee Osteoarthritis (OA), and symptomatic

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[2] Jesus TS, Landry MD, Hoenig H. Global Need for Physical Rehabilitation: Systematic Analysis from the Global Burden of Disease Study 2017. Int J Environ Res Public Health. 2019 Mar 19;16(6):980. doi: 10.3390/ijerph16060980. Erratum in: Int J Environ Res Public Health. 2020 Dec 04;17(23): PMID: 30893793; PMCID: PMC6466363.

[3] Healthy People 2010. 2 vol. Washington, DC: US Dept of Health and Human Services; 2000. Available at https://www.cdc.gov/nchs/healthy_people/hp2010.htm, accessed August 29, 2022. See also US Dept of Health and Human Services. Healthy People 2020 objective topic areas. Updated February 7, 2011, https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2020. See also https://health.gov/healthypeople, access August 29, 2022.

[4] Chan G, Chen CT. Musculoskeletal effects of obesity. Curr Opin Pediatr. 2009;21(1):65–70. See also Merikangas KR, Ames M, Cui L, et al. The impact of comorbidity of mental and physical conditions on role disability in the US adult household population. Arch Gen Psychiatry. 2007;64(10):1180–1188.

[5] Côté P, van der Velde G, Cassidy JD, et al. The burden and determinants of neck pain in workers: results of the Bone and Joint Decade 2000–2010 Task Force on Neck Pain and Its Associated Disorders. Spine. 2008;33(4 suppl):S60–S74.

[6] Nelson A. Unequal treatment: confronting racial and ethnic disparities in health care. J Natl Med Assoc. 2002 Aug;94(8):666-8. PMID: 12152921; PMCID: PMC2594273.

[7] David Elton, Meng Zhang, Amy Okaya, "Geographic variation in the treatment of spinal disorders: association with health care professional availability, and population socioeconomic status, race, and ethnicity. A retrospective cohort study," doi: https://doi.org/10.1101/2022.08.15.22278722.

[8] https://www.ahrq.gov/research/findings/nhqrdr/nhqdr21/index.html accessed August 29, 2022, and https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2021qdr-final-es.pdf

[9] https://www.arthritis.org/health-wellness/treatment/complementary-therapies/physical-therapies/physical-therapy-for-arthritis accessed August 29, 2022.

knee OA compared to whites. Additionally, a significantly higher proportion of African-Americans compared to whites suffer from severe radiographic knee OA.[10] According to estimates from the Centers for Disease Control and Prevention (CDC), nearly three million Hispanic adults in the U.S. (13% in Colorado, 18% in Montana, and 26% in Wyoming) report diagnosed arthritis, while millions more live with chronic joint symptoms but have not seen a care provider. [11] Despite a lower population prevalence of arthritis, Hispanics with arthritis have more severe joint pain and a higher proportion of arthritis-attributed work limitations than non-Hispanics. [12] Hispanics were 50% more likely than non-Hispanic whites to report needing assistance with at least one instrumental activity of daily living, and reported difficulty walking.[13] Musculoskeletal care for these and other underserved populations must improve.

Physical therapists also treat chronic pain, which afflicts communities of color to a greater degree than other communities.[14] A 2011 IOM report presented chronic pain as a pressing public health issue and offered recommendations to improve its prevention and treatment. These recommendations formed the basis for a comprehensive National Pain Strategy (NPS),[15] but the NPS focuses on the impact that physical therapists can make on the treatment of pain mainly through training, not through practice or insurance-created administrative burdens. Chronic pain is highly prevalent in the United States, affecting nearly one-third of the American population.[16,17] Twenty percent of Americans live with chronic pain that interferes with employment, family responsibilities, and wellness,[18] and disabling chronic pain disproportionately affects socially at-risk populations.[19] PTs treat chronic pain, but they also care for patients with many different other MSK challenges. Access to chronic pain care is only one example of health inequity addressed by PTs.

[10] Arthritis Program Health Disparities Activities – Centers For Disease Control and Prevention. https://www.cdc.gov/arthritis/data_statistics/disparities.htm accessed August 29, 2022.
[11] Study Reveals Disparities: Hispanics Impacted More Severely By Joint Pain, Work Limitations – Arthritis Foundation, Oct 2007
[12] Ibid.
[13] "Effect of Race and Ethnicity on Outcomes in Arthritis and Rheumatic Conditions," Current Opinions in Rheumatology 1999
[14] Coronado RA, Bialosky JE. Manual physical therapy for chronic pain: the complex whole is greater than the sum of its parts. J Man Manip Ther. 2017 Jul;25(3):115-117. doi: 10.1080/10669817.2017.1309344. Epub 2017 Jun 12. PMID: 28694673; PMCID: PMC5498791.
[15] National Pain Strategy. US Department of Health and Human Services, 2016, accessed August 29, 2022 https://www.iprcc.nih.gov/node/5/national-pain-strategy-report.
[16] Johannes CB, Le TK, Zhou X, et al.. The prevalence of chronic pain in United States adults: results of an internet-based survey. J Pain. 2010;11(11):1230–1239. 10.1016/j.jpain.2010.07.002
[17] Institute of Medicine (U.S.) Committee on advancing pain research care and education. Relieving pain in America: a blueprint for transforming prevention, care, education, and research. Washington (DC): National Academies Press; 2011. Xvii:p. 364.
[18] Dahlhamer J, Lucas J, Zelaya C, et al. Prevalence of Chronic Pain and High-Impact Chronic Pain Among Adults - United States, 2016. MMWR. Morbidity and mortality weekly report 2018;67(36):1001-06.
[19] Janevic MR, McLaughlin SJ, Heapy AA, Thacker C, Piette JD. Racial and Socioeconomic Disparities in Disabling Chronic Pain: Findings From the Health and Retirement Study. J. Pain 2017;18(12):1459-67.

PTs Can Improve Health Equity

The American Physical Therapy Association has developed a position paper entitled Physical Therapists' Role in Prevention, Wellness, Fitness, Health Promotion, and Management of Disease and Disability.[20] This Position Paper states that physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals and populations. This means that although physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals and populations improve overall health and avoid preventable health conditions. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

Physical therapists, like most health professionals, are educated to provide services in the health services delivery environment. Physical therapists also are uniquely educated and trained to adapt health recommendations to the community environment where individuals live, work, learn, and play. Importantly, physical therapists consider and account for the social determinants of health in the provision of clinical and community services. This knowledge and ability enables physical therapists to adapt medical recommendations to specific environments, to meaningfully interpret health recommendations, to create targeted approaches to help individuals modify their health behaviors, and to ensure clinical and community services are integrated, available, and mutually reinforcing.

For their role in prevention, wellness, fitness, and health promotion, physical therapists:

1. Integrate decision-making skills across all dimensions and contextual factors of the International Classification of Function
2. Incorporate health history into a plan of care that includes data related to body functions and structures, activities and participation, and relevant personal and environmental factors, including social determinants of health (economic stability, education, social and community context, health and health care, neighborhood, and built environment)
3. Integrate scientific principles of movement, function, and exercise progression to promote physical activity and improve health outcomes for individuals and populations
4. Incorporate concepts of prevention, wellness, fitness, and health promotion with every patient or client as appropriate
5. Integrate and interpret the elements of medical, biopsychosocial, and health promotion models that allow them to monitor health status over time
6. Design and develop integrated clinical and community screening programs to prevent and manage disease and disability, and refer as appropriate, as part of a community-based integrated team that is focused on healthy lifestyles

[20] Physical Therapists' Role in Prevention, Wellness, Fitness, Health Promotion, and Management of Disease and Disability HOD P06–19–27–12 [Amended: HOD P06-16-06-05; Initial: HOD P06-15-23-15] https://www.apta.org/siteassets/pdfs/policies/pt-role-advocacy.pdf accessed August 29, 2022.

7. Apply the best available evidence in selecting and prescribing exercise for individuals, and planning physical activity and injury prevention programs for individuals and communities
8. Use skills in behavior change to promote healthy lifestyles in individuals and communities
9. Adapt tasks and the environment to promote healthy behaviors and improved health outcomes for individuals and populations of all ages, including those with complex health and functional needs, as part of a community-based integrated team
10. Adopt healthy lifestyle choices for themselves that include engaging in active forms of transportation and meeting national guidelines for participation in physical activity and exercise

For their role in management of disease and disability, physical therapists:

1. Recognize the risk factors for, and the course of, chronic diseases and the potential impact on quality of life and on activities and participation
2. Establish and facilitate collaborative, interprofessional, patient- and client-centric relationships that empower individuals and populations in self-management across the lifespan and through the health continuum, with an emphasis on movement and function
3. Apply best available evidence in selecting, prescribing, and using intervention and measurement strategies to establish exercise prescription for individuals to help them prevent primary, secondary, and tertiary conditions or optimize functional mobility
4. Apply best available evidence in planning programs to educate populations to help them prevent primary, secondary, and tertiary conditions or restore functional mobility
5. Provide nonsurgical and nonpharmacological services as a hallmark of physical therapist practice[21]
6. Predict and interpret health outcomes and functional needs in the context of where people live, work, learn, and play

For their role as a dynamic link between health and health services delivery, physical therapists:

1. Apply their expertise in exercise and physical activity to adapt health recommendations for individuals and populations, from clinical settings to the home and community
2. Function as a member of an interprofessional team of health providers, wellness and fitness providers, community health workers, public health providers, and other diverse professionals to help individuals and populations reduce their disease risk and improve their health and quality of life
3. Communicate and collaborate with relevant health professionals to help individuals and populations receive appropriate health services

For their role as advocates for prevention, wellness, fitness, health promotion, and management of disease and disability, physical therapists:

1. Support scientific, educational, legislative, and other policy initiatives that promote regular physical activity and exercise to enhance health and prevent disease

[21] Please note that nonsurgical/ nonpharmacological care is the current standard for front-line MSK care (guideline concordant).

2. Advocate for physical education, physical conditioning, and wellness instruction at all levels of education, from preschool through higher education
3. Advocate for community design that promotes opportunities for safe physical activity and active forms of transportation for individuals and populations of all ages and abilities
4. Advocate for strategies that reduce inequities and barriers related to social determinants of health

In addition, the APTA's House of Delegates recently passed a resolution that may impact the above position statement. The relevant content of that resolution follows:

Physical therapists make unique contributions to the health care system and participation in society. Physical therapists, as part of a comprehensive management plan:

- Deliver a broad range of services including, but not limited to, examination, evaluation, diagnosis, prognosis, intervention, coordination of care, prevention, wellness, and referral to other health care practitioners when indicated.
- Identify the cause and/or nature of an individual's injuries, symptoms, emergent conditions, impairments, activity limitations, participation restrictions, biopsychosocial factors, environmental barriers, and facilitators.
- Render diagnoses, using relevant diagnostic tests and classification labels.
- Determine an individual's functioning and extent of physical disability in all aspects of life (such as health, recreation, employment, daily living, transportation), and for regulatory, insurance, and legal purposes.
- Prescribe or recommend physical activity, accommodations, adaptive and assistive technology, diagnostic tests, and other interventions to optimize functioning and participation in society.[22]

PT Administrative Burden Magnifies Health Inequity

Health equity is closely linked to what providers have the time to do. Physical therapists and other care providers are unfortunately too often spending time not on patient care or addressing equity gaps in the health system through advocacy, but on filling out paperwork and fighting with payers for adequate reimbursement. 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.

Medicare Advantage plans are incentivized to avoid paying claims, even terming such payments "medical losses." The stumbling interaction between Medicare Advantage plan and provider, repeated on a daily basis across the country, has a direct cost on patients and magnifies inequities in the health system. It is well documented that frustrating interactions with insurers

[22] See RC-11-22, Access to Physical Therapists as Entry-Point Practitioners for Activity Participation, Wellness, Health, and Disability Determination. Available at

stoke burn-out across the medical profession by stealing time available for actual patient care, and stoking depression and suicidality.[23] The costs and burdens of payer red tape are real.

Ban Medicare Advantage (MA) Plan Prior Authorizations to Improve Health Equity. The RFI focuses on health equity in MA, and we appreciate the opportunity to tighten the focus on many MA plans' inappropriate use of prior authorizations. Four data points are important to consider when addressing MA plans' impact on health equity through the use of prior authorizations. First, MA is important to patients and to physical therapists, and enrollment in the program is growing quickly. 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.[24]

Second, MA enrollment is highly concentrated within a small group of large insurers. The same source notes that 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) accounted for another 23 percent of enrollment in 2020.[25]

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."[26] The percentage of MA plans that required prior authorizations for some services in 2019 was 79%, representing a 20% growth in just one year.

Fourth, prior authorizations imposed by many MA plans are hurting patients and undermining health equity. A recent and highly-publicized Office of the Inspector General report examining the use of prior authorization by Medicare Advantage Organizations (MAOs) states:

> Although MAOs approve the vast majority of requests for services and payment, they issue millions of denials each year, and CMS annual audits of MAOs have highlighted widespread and persistent problems related to inappropriate denials of services and payment… MAOs sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules. MAOs also denied payments to providers for some services that met both Medicare coverage rules and MAO billing rules. Denied requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers. Although some of the denials that we reviewed were ultimately reversed by the MAOs,

[23] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2773831, accessed August 29, 2022.
[24] https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/, accessed August 29, 2022.
[25] ibid.
[26] ibid.

> avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs. Examples of health care services involved in denials that met Medicare coverage rules included advanced imaging services (e.g., MRIs) and post-acute facility stays (e.g., inpatient rehabilitation).[27]

The same report found that 13% of PAs were denied inappropriately. What the report did not focus on, however, is the amount of time required by PTs to comply with MA plan-imposed PA requests. Provider BIR (Billing Insurance Related) costs have risen. In fact, the Healthcare Financial Management Association reports that PA burdens amounted to a $528 million administrative cost for providers in 2019.[28] Much of these costs could be avoided were prior authorizations to be eliminated.

Based on all of these important facts about the growth, increasing market share, and prevalence of prior authorizations, **MA plans should be required to eliminate 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 117 counties, MA plans account for more than 60% of Medicare enrollment.[29] 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 requiring these plans to foster health equity through decreased administrative burden will have important smoothing effects for the insurance market as a whole.

Decrease Administrative Burden Through Uniform Data Standards. Administrative burden could also be decreased through increased standardization. Currently, MA programs effectively move individuals from one plan to another, often without the patient knowing they have been shifted. In addition, MA programs create their own PA processes and their own post-treatment review processes. Even the alternative dispute resolution processes differ among MA plans, including how PTs can submit documents to them and engage in each plan's appeals and review processes. Adding to this struggle is the mixed appeal processes which are different for each of the payers. Patients would greatly benefit from increased standardization of data flows between plans and providers. Physical therapists respectfully urge that four technical changes be made to increase standardization beyond the elimination of prior authorizations.

First, each MA plan's submission process should be required to utilize a single website/portal (such as the QIES), or at a minimum a single site per state (if there are state-related Medicaid issues with use of a single national site). This requirement could apply to PAs, Post-Document Review, and Claims Tracking. This change would allow CMS to more closely monitor and

[27] See https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp, accessed August 29, 2022.
[28] https://www.hfma.org/topics/news/2020/01/prior-authorization-cost-and-time-burdens-increase-for-providers.html, accessed August 29, 2022.
[29] https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/, accessed August 29, 2022.

identify noncompliance among Medicare Advantage payers, including plans that routinely delay prior authorizations or denials of basic services to beneficiaries. A single portal would allow for a significant reduction in burden on both providers and their software vendors, who currently spend significant time tracking down where and how to submit information requested by MA programs. Reducing this burden would unlock countless hours of provider and practice time which could then be used to address issues like inequities in the health system, improve care, and innovate new workflow and care processes.

Second, any MA plan's submission process should be required to utilize standardized transport mechanisms, such as Fast Healthcare Interoperability Resources (FHIR) or application programming interfaces (APIs). This change alone would eliminate faxes, phone calls, and the completion of disparate and time-consuming forms.

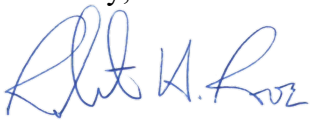
Third, any MA plan's submission process should be required to utilize agreed-upon standardized processes, such as utilizing USCDI standards. Currently, the government creates standardized processes that providers must follow and vendors must maintain through its EHR certification. As an added benefit to this policy change, providers would predictably urge software vendors to meet these new requirements or processes, increasing standardization across the health system and promoting health equity. Currently, private payer information formatting requirements or processes are often distinctly different from government requirements.

Fourth, other health care providers must meet certain standards such as those for Skilled Nursing Facilities ("Requirement of Participation") or hospitals ("Conditions of Participation"). We encourage CMS to create Conditions of Participation for every MA program (and every Medicare Subcontractor). Just as is in place for providers, these CoPs should be made publicly available and should be open for public comment whenever any revisions are proposed by an MA plan.

Conclusion

We appreciate the opportunity to comment on the RFI and support its intent to improve health equity by decreasing 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 more effectively regulate MA plans so that physical therapists can spend more time caring for patients. For questions related to this or other health equity issues, please contact Robert Hall, at Robert@sabreadvocacy.com.

Sincerely,



Robert H. Rowe, PT, DPT, DMT, MHS
President, Academy of Orthopaedic Physical Therapy