GREGORY V GRAY

February 27, 2024

My name is Gregory Gray. I am 72 years old and a member of a Medicare Advantage Plan. I am writing this in full support of the idea that patient treatment decisions, in this case physical therapy, be based on the expectations as described under Medicare. These expectations are: "the circumstances of each specific individual, including the patient's medical history, physician recommendations, and clinical notes." ("Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F)" Department of Health & Human Services. Centers for Medicare & Medicaid Services. February 6, 2024)

I have been a patient of Sasha Kolbeck, DPT, for five post-surgery treatments since 2013. During the first treatment period in 2013 following a right rotator cuff surgery, I was still under my former school district's insurance policy, Blue Shield. Throughout this time, I experienced no interruptions in therapy for insurance approval. Sasha's therapy fully determined the full course of my rehab and when I was finished with therapy.

In 2016, I turned 65 and switched over to a Medicare Advantage plan, Regence Blue Cross/Blue Shield. Since then, I've had four surgeries that required post-surgery physical therapy: left rotator cuff, left hip, full joint replacement, laminotomy and spinal fusion at L4-5, and right hip full joint replacement. In all four cases, treatment was either delayed or denied by the third part administrator, Evicore, which required me to file appeals to continue therapy. In each situation, the difference between my Medicare Advantage treatment plans compared to my first period of physical therapy under Blue Shield were completely different. This had nothing to do with the quality of care I received from Sasha Kolbeck and my surgeons: Dr. Derek Lamprecht, Dr. Andrew Bryan, and Dr. Emily Nguyen.

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Patients under Medicare Advantage plans should not be treated differently from patients under sixty-five with insurance plans. Patients should that there are not barriers to the timely medically necessary care they need. They should also not have to face any questionable decisions based on "utilization controls."

Embedded in this is the use of algorithms to make treatment decisions. The use of AI/algorithms should not override the care providers who are collaborating with patients in determining their individual needs, based on widely used treatment guidelines and clinical literature. This should apply to any patient regardless of their health care plan.

On February 6, 2024, the Center for Medicare and Medicaid Services released a document entitled, "("Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F)." This document was developed and released due to a number of recent lawsuits against Medicare Advantage Plans. Regarding the use of algorithms, the document stated:

An algorithm or software tool can be used to assist MA plans in making coverage determinations, but **it is the responsibility of the MA organization to ensure that the algorithm or artificial intelligence complies with all applicable rules for how coverage determinations by MA organizations are made**. For example, compliance is required with all of the rules at § 422.101(c) for making a determination of medical necessity, including that the MA organization base the decision on the individual patient's circumstances, so an algorithm that determines coverage based on a larger data set instead of the individual patient's medical history, the physician's recommendations, or clinical notes would not be compliant with § 422.101(c).

MA organizations may only deny coverage for basic benefits based on coverage criteria that are specified in § 422.101(b) or (c) or for other expressly permissible bases, such as network limitations or failure to comply with prior authorization requirements. Therefore, the algorithm or software tool should only be used to ensure fidelity with the posted internal coverage criteria which has been made public under § 422.101(b)(6)(ii). Because publicly posted coverage criteria are static and unchanging, artificial intelligence cannot be used to shift the coverage criteria over time. And, predictive algorithms or software tools cannot apply other internal coverage criteria that have not been explicitly made public and adopted in compliance with the evidentiary standard in § 422.101(b)(6).

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Furthermore, we are concerned that algorithms and many new artificial intelligence technologies can exacerbate discrimination and bias. We remind MA organizations of the nondiscrimination requirements of Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. MA organizations should, prior to implementing an algorithm or software tool, ensure that the tool is not perpetuating or exacerbating existing bias, or introducing new biases.

"In a 2019, APTA (The American Physical Therapy Association) commissioned a nationwide survey. Responding to the survey, physical therapists reported many Medicare Advantage health plans' use of prior authorization is excessive, creating needless treatment delays and denials which, in turn, are likely to have a negative impact on patients' health." In my experience with each of my four post-surgical treatments, I know I could have benefited from additional therapy, but the onerous and emotional requirement for me to appeal and wait for an answer along with the time my therapist has had to spend on the phone with the third-party administrator is completely unnecessary. Sasha has experienced these problems with many of her patients and not any one Medicare Advantage provider.

Sincerely,

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