February 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

Submitted electronically

RE: Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

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) Calendar Year (CY) 2024 Policy and Technical Changes to the Medicare Advantage Program (the "regulation"). APTA Private Practice is an organization of physical therapists in private practice who use our 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 that we 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 covered by the Medicare Advantage program. They chafe at burdensome and duplicative administrative tasks as the 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, decrease pain, and prevent the need for avoidable health care services.

The regulation would implement changes to the Medicare Advantage (Part C) and prescription drug (Part D) programs. APTA Private Practice members have been frustrated by their experience with the Medicare Advantage program. This APTA Private Practice comment focuses on "Utilization Management" under 42 CFR §§ 422.101, 422.112, 422.137, 422.138, and 422.202. The letter is structured to respond to each relevant solicitation of comment by CMS in the Utilization Management section starting at 87 Fed Reg 79497 ("E. Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools").

In the regulation, CMS proposes to:

1) require MA plans to follow Traditional Medicare National Coverage Determinations, Local Coverage Determinations, statutes and regulations when making medical necessity determinations

> *APTA Private Practice comment: Strongly support and argue for strengthened required adherence/clear penalties for plans that fail to comply.*

"We solicit comment on whether our proposed regulatory provisions sufficiently address the requirements and limits that we describe in the preamble."

> *APTA Private Practice comment: Please see above. MA Plans have demonstrated their unwillingness to comply with current rules on prior authorization and the best clinical evidence for physical therapy interventions. Clear, significant penalties should be set by CMS for continued non-compliance with the expectation that MA plans will continue to limit care - to the detriment of patients - unless they are penalized for non-compliance.*

2) require plans to provide a public summary of evidence that was considered during the development of the internal coverage criteria used to make medical necessity determinations,

> *APTA Private Practice comment: Strongly support, and require that the evidence summary be supported with hypertext links, be presented in plain language that is accessible for both providers and Medicare beneficiaries, and also be subject to modification through a defined public notice and comment structure.*

"We solicit comment about the specificity of the coverage conditions in Traditional Medicare regulations and whether we should consider, and under what circumstances, allowing MA organizations to have internal coverage criteria in addition to requirements in current regulations."

> *APTA Private Practice comment: We respectfully request that any additional criteria used by MA plans be required to be disclosed to beneficiaries during Open Enrollment in order to increase transparency and beneficiary choice/agency.*

“CMS solicits comment on the definition of widely used treatment guidelines and clinical literature that would justify internal coverage criteria used in the absence of NCDs, LCDs, or Traditional Medicare statutes or regulations along with the other requirements proposed in new §422.101(b)(6).”

> *APTA Private Practice comment: We respectfully suggest that CMS require MA Plans to base all musculoskeletal (MSK) coverage criteria on APTA-supported/published guidelines in the context of any MSK interventions.*

“We solicit comments on when it would be appropriate for the MA organization’s medical director to be involved, in light of how § 422.562(a)(4) requires the medical director to be responsible for ensuring the clinical accuracy of all organization determinations and reconsiderations involving medical necessity.”

> *APTA Private Practice comment: We respectfully suggest that CMS require the Medical Director to be involved with all MSK coverage criteria and base those decisions on APTA-supported/published guidelines in the context of any MSK interventions interventions. Links to APTA guidelines may be found here: https://www.apta.org/patient-care/evidence-based-practice-resources/cpgs. In addition, see below, where we respectfully urge that Medical Directors be required to embed physical therapist expertise in the context of any coverage decisions regarding MSK care.*

“…when an enrollee or provider requests a pre-service determination and the plan approves this pre-service determination of coverage, the plan cannot later deny coverage or payment of this approval based on medical necessity. We solicit stakeholder input on the reasonableness of this assumption.”

> *APTA Private Practice comment: We strongly suggest that CMS provide clarification to increase understanding throughout the health system that flexibilities regarding payer approval should be limited to whether a plan of care is approved, and not for a specific number of visits. In regards to the rest of the health system, in Medicaid MCO coverage provided by the same payer as MA plans, many smaller providers are told when verifying benefits that prior authorization is not required only to find out post-treatment denial that authorization is handled by a different company. In particular, United Health Care has repeatedly stated that a patient has coverage and no authorization is needed. Then care is denied and the practice is told that Optum is in charge of authorizations. In addition, it is imperative in the context of best practices for physical therapy care that payers not dictate the frequency of visits per week within a plan of care. Granting payers flexibility in either of these cases - to limit care to a specific number of visits, require re-authorization for a fraction more, etc. - has led to delayed patient care in many physical therapy practices. The serious abuses by MA plans, as unearthed by a recent OIG Report examining the frequent denial of care that purported to rely on evidence-based guidelines, prove that MA plans limit care in ways that are not beneficial to either patient health or improved outcomes. This must stop for the benefit of patients and their health.*

“We also solicit comment whether combining all of our proposals on prior authorization (here and in section III.E.4 of this proposed rule) in proposed new § 422.138 would make applying and understanding these requirements clearer for the public and MA organizations.”

APTA Private Practice comment: We agree with CMS that regulatory consolidation will bring a number of eventual benefits to patient care by decreasing administrative burden, increasing ease of understanding and improving litigation decisions in the courts.

3) require that an approval granted through PA processes must be valid for the duration of a prescribed course of treatment and that plans are required to provide a minimum 90-day transition period when an enrollee who is currently undergoing transition to a new MA plan, switches from Traditional Medicare to an MA plan, or is new to Medicare,

APTA Private Practice comment: We agree with CMS and support this proposal.

“We solicit comment on whether the prior authorization should be required to be valid for the duration of the prescribed order or ordered course of treatment provided that the criteria in proposed § 422.101(b) and (c) are met.”

APTA Private Practice comment: We respectfully urge that CMS reconsider this structure because the physical therapist's recommendation of treatment based on their evaluation, should be the standard for MSK care, not the referral from the physician. Care should not be solely based on physician recommendations/ orders, as physician experience and expertise in MSK care is not as broad as that of the physical therapist, who are now widely educated to the doctoral level. Additionally, the duration of the prescribed treatment period as recommended by the physical therapist should be the standard upon which treatment limitations should be defined. The proposed structure places the physical therapist below the physician on the care team, which is not the most effective structure for patient care.

“We solicit public comment on alternative timeframes for transition periods of ongoing treatment, including the clinical and economic justification for alternative proposals.”

APTA Private Practice comment: We support CMS’s proposed 90-day time frame for patients to transition from one plan’s coverage to another.

4) require MA organizations to establish a committee, led by the Medical Director, that reviews utilization management, including PA, policies annually and keeps current of LCDs, NCDs, and other Traditional Medicare coverage policies.

APTA Private Practice comment: Strongly support and urge that physical therapists must be included as a Committee leader whenever a decision concerns physical therapy utilization and management.

“We solicit comment on whether we should also require the UM committee to ensure that the UM policies and procedures are developed in consultation with contracted providers; whether the UM committee should ensure, as required by § 422.202(b)(2),

that MA organization communicates information about practice guidelines and UM policies to providers and, when appropriate, to enrollees; and whether the UM committee should have an ongoing or active oversight role in ensuring that decisions made by an MA plan throughout the year are consistent with the final, approved practice guidelines and UM policies."

> *APTA Private Practice comment: Strongly support each of these recommendations.*

"We solicit comment as well on the extent to which the proposed regulation text sufficiently and clearly establishes the standards and requirements discussed here."

> *APTA Private Practice comment: We support at least annual review of all coverage determinations by the plan as discussed in the regulation.*

"We solicit comment on whether to require the UM Committee to review all internal coverage criteria used by the MA plan."

> *APTA Private Practice comment: We support UM Committee review of all internal coverage criteria used by the MA plan.*

"We solicit comment on recommendations for other types of providers, practitioners, or other health care professionals that should also be included on the UM committee and whether additional standards for composition of the UM committee are necessary with regard to expertise, freedom of conflicts of interest, or representation by an enrollee representative."

> *APTA Private Practice comment: We support required inclusion of physical therapists on any and all UM Committees. APTA has hosted numerous meetings with MA plans whose Medical Directors demonstrate a general lack of understanding of physical therapist practice.*

"[W]e also solicit comment on whether we should include a requirement, that when the proposed UM committee reviews UM policies applicable to an item or service, that the review must be conducted with the participation of at least one UM committee member who has expertise in the use or medical need for that specific item or service."

> *APTA Private Practice comment: We strongly support this proposal and believe its implementation would lead to better patient care and significantly lower costs through avoidable imaging and unnecessary surgery.*

"We also solicit comment on whether to explicitly permit an MA organization, or the parent organization of one or more MA organizations, to use one UM committee to serve multiple MA plans, including whether that should be limited to MA plans that are offered under the same contract."

> *APTA Private Practice comment: We support this proposal as it should decrease regional and plan variation, allowing the flexibility the treating physical therapists needs to achieve the best outcomes for their patients.*

"We solicit comment on whether and how existing requirements at §422.503(b)(4)(vi) may be adjusted to better account for these medical review and system errors."

APTA Private Practice comment: We believe that payment suspensions have not been effective as a decision-altering deterrent to MA Plans who have been repeatedly shown to interrupt and deny medically necessary patient care. More severe penalties should be available to those seeking to bolster access to medically necessary care, and we urge that CMS consider imposing Civil Monetary Penalties including treble damages, such as those providers are subject to in the case of fraud or abuse. These types of structures may provide a more effective and appropriate deterrent to care interruptions or denials.

"In addition, we solicit comment whether proposed § 422.137 should include a provision for the UM committee to develop, implement and oversee activities by MA organizations related to utilization policies and procedures."

APTA Private Practice comment: We support this proposal.

CONCLUSION

Thank you for the opportunity to comment on the Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program Proposed Rule. We hope our insight and perspective will prompt CMS to strengthen patient protections available to beneficiaries who choose to enroll in the Medicare Advantage program. It is far past time that beneficiaries be able to access the care to which they are entitled as Medicare Advantage enrollees. Too many times in the Medicare Advantage program, beneficiaries are forced to delay or forgo medically necessary care. Inappropriate denials of care lead to negative health outcomes and greater overall cost to the system, especially in the context of physical therapy, which is a low-cost, conservative solution for musculoskeletal problems that are too often addressed through drastic interventions like surgery. The federal government, as well as patients and taxpayers, are better served in the long run by ensuring that the Medicare program supports appropriate access to physical therapy and enables physical therapists to readily participate in the timely care of beneficiaries. APTA Private Practice welcomes the opportunity to work with CMS to identify solutions that will safeguard the financial health of the Medicare program while ensuring that beneficiaries have adequate access to high-quality physical therapy services in safe, cost-effective community-based settings.

Thank you for your attention to the recommendations and feedback informed by the experiences of private practice physical therapists.

Sincerely,

Mike Horsfield, PT, MBA
President, Private Practice Section of the
American Physical Therapy Association