



April 10, 2018

**VIA ELECTRONIC MAIL**

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

Re: **Extensive Use of Prior Authorization in Medicare Advantage Plans Restricts Access to Medical Rehabilitation for Medicare Beneficiaries**

Dear Administrator Verma:

The undersigned members of the Coalition to Preserve Rehabilitation (“CPR”) write to ask the Centers for Medicare and Medicaid Services (CMS) to eliminate the administrative barriers to patient access to medically necessary rehabilitation services and devices that are often imposed through the use of prior authorization in Medicare Advantage (MA) plans. CPR is greatly concerned that prior authorization requirements in MA plans may be sources of increasing barriers to accessing needed care, particularly inpatient and outpatient rehabilitation services and devices, for beneficiaries nationwide.

CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function. CPR is comprised of organizations that represent beneficiaries who are frequently inappropriately denied access to rehabilitative care in a variety of settings, as well as the providers who serve them.

Medicare Advantage served almost 19 million Medicare beneficiaries in 2017 comprising 32 percent of the total Medicare population, according to MedPAC. MA plans were paid approximately \$210 billion in this same year. By 2028, MedPAC estimates that 32 million beneficiaries will participate in the MA program. The fast pace of growth of this program suggests the need for greater scrutiny of mechanisms imposed by these plans to manage service utilization, such as prior authorization.

While prior authorization requirements may be appropriate in some limited circumstances to ensure that patients are receiving medically necessary care, the use of such requirements has become increasingly routine in MA plans. Often, the use of prior authorization in these

circumstances is difficult to justify. Many plans utilize prior authorization processes for items and services that are routinely approved. Additionally, the use of prior authorization to approve care including rehabilitation services and devices, transplantation, non-elective surgeries, and cancer care is especially hard to justify, given that these and many similar medical services are unlikely to be over-utilized and often need to be provided in a timely manner in order to maximize their medical efficacy.

In these cases and others, prior authorization often serves as an unnecessary delay for beneficiaries seeking medically necessary care, and often results in no cost savings to the plan. CPR is especially troubled to have learned of reports of some managed care plans' use of benefits management companies that are incentivized based on the number or dollar amount of services they deny.

Federal law states that MA beneficiaries are entitled to the same benefits available under Medicare fee-for-service (FFS). (*See id.* § 422.100(f)(1)-(3).) Medicare regulations also stipulate that MA Plans must comply with FFS coverage guidelines and national and local coverage determinations subject to limited exceptions for coverage uniformity across geographic areas. (*See*, 42 C.F.R. § 422.101(b)(2).) Rather than abiding by Medicare coverage criteria, MA plans typically impose prior authorization and utilize proprietary admission or coverage guidelines, such as those marketed by Milliman and Interqual, to justify a denial of rehabilitation coverage.

These guidelines often contradict well-established best practices in medicine, such as the American Heart Association and American Stroke Association's (AHA/ASA) guidelines for stroke recovery. AHA/ASA "strongly recommends that stroke patients be treated at an in-patient rehabilitation facility rather than a skilled nursing facility." In fact, the Medicare Payment Advisory Commission found that 2015 MA admissions to inpatient rehabilitation hospitals were one third of admissions to this same setting under Medicare fee-for-service. (*See*, MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY, P. 298 (Mar. 2017).

Recently, private insurers have begun focusing on ways to limit the negative impact of prior authorization on access to medically necessary care while ensuring beneficiaries do not receive medically unnecessary services. CPR urges CMS to consider implementing similar policies in MA plans as well, to ensure that prior authorization processes do not prevent beneficiaries who elect to participate in MA plans from accessing needed care, especially rehabilitation services and devices in both the inpatient and outpatient settings.

To do so, CPR recommends that CMS increase oversight of the use of prior authorization in MA plans. Such oversight should include stronger directives to MA plans to limit the use of prior authorization to services that are demonstrably over-utilized. CMS should also review the list of services that each MA plan subjects to prior authorization, prohibit the use of proprietary coverage guidelines as a substitute for fee-for-service coverage criteria, and ensure that MA beneficiaries are provided with comprehensive information disclosing the use of prior authorization in their plan.

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CPR appreciates the opportunity to comment on the use of prior authorization in MA plans. For more information, please contact Peter Thomas, coordinator for CPR by e-mailing [Peter.Thomas@PowersLaw.com](mailto:Peter.Thomas@PowersLaw.com) or by calling 202-466-6550.

Sincerely,

Academy of Spinal Cord Injury Professionals (ASCIP)  
ACCSES  
American Association of People with Disabilities (AAPD)  
American Academy of Physical Medicine and Rehabilitation (AAPM&R)  
American Association on Health and Disability (AAHD)  
American Congress of Rehabilitation Medicine (ACRM)  
American Medical Rehabilitation Providers Association (AMRPA)  
American Occupational Therapy Association (AOTA)  
American Physical Therapy Association (APTA)  
American Spinal Injury Association (ASIA)  
American Therapeutic Recreation Association (ATRA)  
Amputee Coalition  
The Arc  
Association of Academic Physiatrists (AAP)  
Association of University Centers on Disabilities (AUCD)  
Brain Injury Association of America (BIAA)  
Center for Medicare Advocacy  
Christopher & Dana Reeve Foundation  
Clinician Task Force (CTF)  
Disability Rights Education and Defense Fund (DREDF)  
Epilepsy Foundation  
Falling Forward Foundation  
Lakeshore Foundation  
The Michael J. Fox Foundation for Parkinson's Research  
National Association for the Advancement of Orthotics and Prosthetics (NAAOP)  
National Multiple Sclerosis Society (NMSS)  
National Association of State Head Injury Administrators  
Paralyzed Veterans of America (PVA)  
United Spinal Association

Cc:

Demetrios Kouzoukas, Principal Deputy Administrator for Medicare, CMS  
Cathy Baldwin, Director, Division of Medicare Advantage Operations