

March 18, 2015

The Honorable Sylvia Mathews Burwell
Secretary
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell and Acting Administrator Slavitt:

The undersigned national medical organizations are writing to express concerns regarding the Centers for Medicare and Medicaid Services (CMS) implementation of Section 218 (b) of Public Law 113-93, entitled the *Protecting Access to Medicare Act* (PAMA). Specifically, our concerns are related to the possible consideration of Radiology Benefit Management (RBM) companies as potential sources for the establishment of applicable appropriate use criteria, as well as any use of RBMs for the enforcement of the prior authorization section for ordering professionals who are outliers. We would also caution against CMS using this part of the statute as a gateway to expand the use of prior authorization into other areas of physician payment policy.

Selection of Criteria Developers

As it pertains to Section 218 (b) (q) (2) (A), entitled *Establishment of Applicable Appropriate Use Criteria*, our organizations strongly oppose the inclusion of Radiology Benefit Management (RBM) companies as suitable criteria developers because we believe they do not qualify as a “provider-led entity.” In our view, qualifying provider-led entities must be actively engaged in the delivery of health care services, as well as unaffiliated with any insurance company. We also believe it is important that the criteria used by CMS only be developed by national physician organizations and we do not support the creation of any new federal bureaucracy to develop appropriate use criteria.

Several medical specialty societies already have a process in place for the development and ongoing update of appropriate use criteria based on a comprehensive review of the most recent clinical evidence. We are concerned that RBM-developed appropriate use criteria will focus primarily on the reduction of utilization of tests from a resource perspective and will not properly take into account the medical necessity of tests on a patient-by-patient basis. Denial of medical

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services solely based on the cost of a procedure runs counter to the underlying goal of the PAMA appropriate use criteria policy.

Administration of Prior Authorization Program

In addition, our societies strongly oppose an RBM prior authorization model being applied to outliers starting on January 1, 2020 pursuant to Section 218 (b) (q) (6). We further request that CMS take a prudent approach to the implementation of this section of PAMA. For example, CMS should not target a specific percentage of physicians to be subjected to prior authorization. Over time, the overall number of outlier ordering professionals is likely to decrease based on continued consultation with clinical decision support. PAMA stipulates that prior authorization should involve “**no more** than five percent of the total number of ordering professionals.” This would not preclude a lower percentage and we urge CMS to apply this requirement only to those physicians whose practice patterns significantly misalign with the appropriate use criteria relevant to their practice.

Prior Authorization Administrative Burden

Our opposition to prior-authorization programs, in general, is a common concern strongly held by the undersigned organizations. Prior authorization programs present considerable administrative costs and operate in a non-transparent manner. In fact, the underlying goal of prior authorization programs is to limit utilization of services, thus impeding patient access to needed care at the right time. These types of policies present huge administrative burdens on physicians and, most importantly, have not been shown to reduce costs over time. The results of a May 2010 American Medical Association (AMA) online survey of 2,400 physicians support these conclusions. In fact, 63 percent of the physician survey respondents reported that they typically wait *several days* for a response to private insurers’ prior authorization requests, while 13 percent generally wait *more than a week*.

We firmly believe that as physicians become more accustomed to both the imaging appropriate use criteria and decision support mechanisms, the total percentage of outlying physicians will undoubtedly decline. When this inevitable trend commences, we recommend CMS modify the program and implement this policy in a manner that closely mirrors Congress’ initial intent to manage imaging utilization through the use of evidence-based, physician specialty society developed appropriate use criteria.

We appreciate your attention to this matter and stand ready to assist with this process.

Sincerely,

American Medical Association
American Academy of Dermatology Association
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology - Head and Neck Surgery

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American Association of Clinical Endocrinologist
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Allergy, Asthma and Immunology
American College of Cardiology
American College of Emergency Physicians
American College of Physicians
American College of Radiology
American College of Surgeons
American Gastroenterological Association
American Osteopathic Association
American Osteopathic College of Radiology
American Society for Radiation Oncology
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Hematology
American Society of Nuclear Cardiology
American Urological Association
College of American Pathologists
Congress of Neurological Surgeons
Medical Group Management Association
Renal Physicians Association
Society for Vascular Surgery