May 26, 2021

The Hon. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Subject: Expanded Prior Authorization Requirements in the Hospital Outpatient Prospective Payment System

Dear Administrator Brooks-LaSure,

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we are writing to share our concerns with the expanded prior authorization requirements scheduled to be implemented on July 1, 2021 under the Medicare Outpatient Prospective Payment System (OPPS). As physicians who work tirelessly to ensure high quality patient care and value to the healthcare system, it is disconcerting that the Centers for Medicare and Medicaid Services (CMS) continues expanding prior authorization requirements without adequately studying the positive or negative effects on patients' safety and physicians' quality of care.

We are concerned the rate at which CMS has expanded prior authorization vastly outpaces confirmation that patient safety is positively impacted. In the calendar year (CY) 2020 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Final Rule (CMS-1717-FC), CMS finalized a national prior authorization policy for five hospital outpatient department services that have both cosmetic and therapeutic indications. This requirement was implemented on July 1, 2020 and a mere five months later, CMS added prior authorization requirements to two more service categories, Cervical Fusion with Disc Removal and Implanted Spinal Neurostimulators, in the CY 2021 OPPS/ASC Final Rule (CMS-1736-FC). Despite fervent stakeholder concerns surrounding the inability of Medicare Administrative Contractors (MACs) to process prior authorization requests in a timely fashion and the potential for adverse impacts on patient care, CMS still intends to implement requirements for these two additional service categories on July 1, 2021.

In comment letters to CMS on the CY 2020 and CY 2021 OPPS/ASC Rules, AAOS has consistently expressed concern that the continued use of prior authorization approaches will supersede attending physician autonomy, increase administrative burden, and negatively impact patient care. Our primary concerns are highlighted below:

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Superseding Physician Autonomy

Orthopaedic surgeons complete years of specialized education and training to gain the expertise to perform these complex procedures. To become an AAOS Fellow requires Board Certification by the American Board of Orthopaedic Surgery (ABOS) and practicing Fellows must participate in an ABOS-directed rigorous Maintenance of Certification. To perform complex spine procedures, Fellows must also be licensed by their respective State Medical Boards and meet stringent local hospital credentialing standards. We are concerned that those individuals that are performing prior authorization using current protocols do not meet these same requisite standards. Attending surgeons that provide important, high level Orthopaedic spine care for patients are not being reviewed by surgeons of commensurate training. Delaying treatment of cervical spine conditions results in devastating consequences to the patient and society. An equally important element to achieving optimal outcomes is the patient perspective, guided by their own experiences which informs treatment plans. AAOS is concerned that requiring approval from a third-party, removed from clinical decision-making devalues the doctor-patient relationship which results in loss of the important autonomy to make decisions that are in the best interest of the patient. Furthermore, these secondary reviews also devalue "Shared Decision Making" by wedging a third party with monetary interest between the doctor and patient.

Increasing Administrative Burden

Providers already face significant operational challenges to ensure patients receive appropriate, timely and effective care. Requests from MedPAC and coalitions of industry and clinician partners for CMS to thoroughly analyze the burden of prior authorization on providers and patients have yet to be adequately addressed. If the Agency's intent is truly to "ensure that Medicare beneficiaries continue to receive medically necessary care while protecting the Medicare Trust Funds from improper payments"[1], as purported in the CY 2020 OPPS final rule, then these prior authorization requirements are duplicative to existing quality reporting programs, which are designed to disincentivize unnecessary care. We believe the resources of the Agency and clinicians would be better spent improving upon and encouraging participation in these quality programs.

Negative Impacts on Patient Care

The push to expand prior authorization requirements is alarming because it illustrates a shifting focus from ensuring patient safety and well-being to cutting costs above all else. Per a recent survey by the American Medical Association (AMA), 30% of physicians report that prior authorization has led to a serious adverse event (e.g., death, hospitalization, disability/permanent

[1] Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Revisions of Organ Procurement Organizations Conditions of Coverage; Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Changes to Grandfathered Children's Hospitals Within-Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity To Apply for Available Slots, 42 CFR Parts 405, 410, 412, 414, 416, 419, and 486 (2019).

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bodily damage, or other life-threatening event) for a patient in their care.[2] Such a significant outcome must call into question whether reduction in cost truly outweigh the benefits of accessible, necessary care to patients.

For these reasons, we urge the agency to delay prior authorization requirements for the Cervical Fusion with Disc Removal and Implanted Spinal Neurostimulators service categories past July 1, 2021 and abstain from further expansion of prior authorization requirements until CMS has conducted a thorough analysis of the impact of prior authorization for the five procedures implemented in July 2020. Results of the analysis should be made publicly available on the CMS website and address the extent to which the MACs have been able to meet the timeframes for processing prior authorization requests, any effects on patient safety and access to care, and the administrative burden on physicians.

Now more than ever, pausing further efforts to expand Medicare prior authorization is needed to ensure the recovery of our healthcare system. While the number of Americans who are fully vaccinated grows each day, the impact of the pandemic on physicians and patients will be felt long after the public health crisis ends. Now is not the time to put up roadblocks to patients receiving surgical care that may have been delayed by the pandemic.

Thank you for your time and attention to the concerns of the members of the American Association of Orthopaedic Surgeons (AAOS). We look forward to working closely with CMS on further improving the payment system, and to enhancing the care of musculoskeletal patients in the United States. Should you have questions on any of the above comments, please do not hesitate to contact Graham Newson, Director, AAOS Office of Government Relations at newson@aaos.org.

Sincerely,

Daniel K. Guy, MD, FAAOS
President, AAOS

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[2] American Medical Association. (2021). *2020 AMA prior authorization (PA) physician survey*. AMA Prior Authorization Survey. https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf