



American College of Physicians  
Leading Internal Medicine, Improving Lives

August 22, 2016

Andy Slavitt  
Acting Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201

Dear Acting Administrator Slavitt:

The American College of Physicians (ACP), based on a recent resolution by our Board of Regents, requests the Centers for Medicare and Medicaid Services' (CMS) assistance in addressing the current misuse of the American Geriatric Society's (AGS) Beers Criteria<sup>1</sup> (aka Beers List) by a number of Medicare Part D, Medicare Advantage and State Medicaid programs. This guideline regarding the use of potentially harmful medications for the elderly is being used inappropriately by a number of programs as a prescriptive standard, rather than, as intended, as a voluntary guideline that the AGS recommends should be considered by all physicians and other healthcare professionals within the context of the circumstances and unique needs of each patient. This inappropriate use has adverse effects on patient care, penalizes physicians in certain programs for addressing the unique needs of their patients, as well as increases the already significant administrative burden on practicing physicians.

ACP is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 148,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The Beers Criteria, most recently updated in 2012, identifies medications with risks that may be greater than their benefits for people 65 and older. The AGS clearly defines the use of this list as:

The updated [Beers] criteria should be viewed as a guideline for identifying medications for which the risks of their use in older adults outweigh the benefits ...This list is not meant to supersede clinical judgment or an individual patient's values and needs.

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<sup>1</sup> American Geriatrics Society. Updated Beers Criteria for potentially inappropriate medication use in older adults. J Am Geriatr Soc. 2012 Apr; 60(4):616-31. doi: 10.1111/j.1532-5415.2012.03923.x. Epub 2012 Feb 29.

Prescribing and managing disease conditions should be individualized and involve shared decision-making.<sup>2</sup>

While the ACP commends the AGS for their efforts to develop and update this list of potentially harmful medications, and recommends that our members consider the potential risks in their use in treating elderly patients, we strongly oppose the practice of a large number of Medicare and Medicaid programs that use this list as a form of prescriptive standard. This practice can be characterized under four different categories; listed in order of their negative effect on patient care:

Category 1: Routine sending to the prescribing physician of a notice that indicates that the prescribed medication has been deemed by the AGS as being potentially harmful to individuals 65 or over and for the physician to consider tapering, discontinuing or switching to an alternative medication.

Category 2: Using Beers list medication prescribing as a metric in a quality pay-for-performance program offered by the plan with financial penalties linked to the use of these medications.

Category 3: The refusal to fulfill a prescription for a medication on the Beers list for a patient 65 or older without additional documentation or through the implementation of a prior authorization protocol.

Category 4: The removal of medications on the Beers list from their formulary for use with older patients or the refusal to fulfill a prescribed medication on the Beers list for a patient 65 and over under any circumstances (other than engaging in time-consuming reconsideration and appeal processes).

Activities in category 1, in moderation, can serve as an effective reminder to the clinician to consider the potential risks involved in using Beers list medications in the treatment of older patients. Unfortunately, many programs send the notice each time the medication is prescribed, which not only contributes to an unwarranted additional administrative burden to the practices but also likely has the unintended effect of lessening the effectiveness of the cautionary notice through repeated exposure. **The College recommends that CMS encourage their Medicare and Medicaid programs to institute processes that reduce the excessive, routine sending of these notices. These processes can include only sending these notices to prescribers defined as outliers regarding the use of these medications; sending these notices only the first time a Beers list medication is used for a specific elderly patient; or sending a general notice to all participating prescribers once a year recommending consideration of the Beers criteria.**

Category 2 activities have the potential to unfairly penalize prescribers for recognizing the circumstances and unique needs of their patients, and can potentially serve as a factor that contributes to patients being placed on less than optimal medications given their clinical

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<sup>2</sup> Ibid

situation. Thus, **the College recommends that the use of Beers criteria metrics within a Medicare or Medicaid quality pay-for-performance plan be discontinued or only take effect in situations where the prescribing physician is a clear, unsupportable, outlier.**

Category 3 activities not only add to the already substantial administrative burden experienced by prescribing professionals but also lead to unnecessary delays in patients receiving the medications they require. This is particularly true when calls for additional documentation, or prior authorization requirements, are implemented each time the Beers list medication is prescribed to a given patient. Our members report that the same documentation is often required multiple times in a given year, despite no evidence of any harmful effects from the medication or changes in the patient's circumstances. **The College recommends that routine use of additional documentation or prior authorization requirements just because a medication is on the Beers list be eliminated, or only employed in situations in which a prescriber is found to be an unsupportable outlier regarding the use of these medications.**

**Category 4 activities, which eliminate the availability of Beers Criteria medications to elderly patients, have the greatest negative effect on patient care and should be eliminated from all Medicare and Medicaid programs.** The College has received multiple complaints from members regarding situations in which patients have had to be discontinued from medications that they have been successfully on for many years without the ability to adequately taper the medication prior to discontinuing or switching it; or had to be placed on a less effective medication alternative. **The College further recommends that all programs have processes that allow for adequate time to taper current medication prior to discontinuation or switching and that timely processes, with minimal administrative burden, be available to ensure that patients are able to receive medications on the Beers list that are preferred given their circumstances and unique clinical needs.**

The College appreciates you serious consideration of our concerns and recommendations. The inappropriate use of the Beers Criteria as described in this letter truly erodes the ability of our members to provide the best care to the patients they serve. I encourage you to contact ACP's Vice President for Governmental Affairs and Medical Practice, Shari Erickson, at [serickson@acponline.org](mailto:serickson@acponline.org) or 202 261-4551 to arrange a time to discuss this issue in greater detail.

Respectfully,



Robert McLean, MD, FACP, FACP  
Chair, Medical Practice and Quality Committee  
American College of Physicians

Cc: Dr. Jeffrey Kelman, Medical Director, Medicare Part D