January 29, 2015

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS' Improper Payments Initiatives [CMS-10421]

Dear Administrator Tavenner:

The undersigned organizations are writing to express our strong concern with the extension and potential continuation of both the Recovery Audit Prepayment Review Demonstration and the prior authorization requirement for Power Mobility Devices (PMDs). Our combined experiences with these programs suggest that they threaten patient access to care and divert clinical resources to administrative tasks. We urge the Centers for Medicare & Medicaid Services (CMS) to find less burdensome and more effective ways to deter fraud and abuse so that patient care is not jeopardized.

While prepayment review and prior authorization may help ensure appropriate Medicare payment, these approaches necessarily interfere with patient access to care. Under these programs, policy and procedure dictate that care for patients undergo a high level of burdensome scrutiny related to cost, rather than to a patient's need for a particular treatment. Delays in treatment and interruptions of the patient-physician relationship are also likely to occur. Patients are often confused by prior authorization requirements and may not seek care if they face obstacles in obtaining needed services. These approaches also complicate physician workflow and divert physician resources to clerical functions and away from patient care.

Despite these concerns, CMS continues to expand prepayment and prior authorization programs, including new proposals for certain durable medical equipment, prosthetics, orthotics, and supplies, hyperbaric oxygen therapy, and repetitive scheduled non-emergent ambulance transport. CMS justifies these actions by citing the need to reduce payment error rates and combat fraud and abuse. We agree that these are important goals but do not accept that these broad brush approaches are the best or only way to achieve these objectives. We ask that CMS carefully consider the implications—for both patients and physicians—of these blunt approaches before expanding and continuing their use.

Recovery Audit Prepayment Review Demonstration

Based on CMS' data and the experience of our members, the findings of Recovery Audit Contractors (RACs) are often inaccurate, and their bounty hunter-like tactics have caused physician practices undue hardship and expense. The Recovery Audit Prepayment Review Demonstration only adds to these problems by expanding the reach of these contractors to perform prepayment review, a task for which they have neither experience nor expertise. RACs not only lack the clinical knowledge to perform these complex medical reviews but are also grossly inefficient in providing timely resolution of, and correspondence regarding, audit activities. Continuing the prepayment demonstration means that physicians may fight for months, or years due to the existing appeals backlog, to rectify an erroneous improper payment determination. Based on these significant challenges facing the RAC program, we strongly urge CMS to discontinue the Prepayment Review Demonstration.

Prior Authorization Demonstration for Power Mobility Devices

We strongly urge CMS to revise this prior authorization demonstration to focus on extreme statistical outliers, rather than on every provider who orders PMDs in each of the identified states. This demonstration initially only targeted a few states with the highest populations of fraud and error prone providers. CMS has since expanded the demonstration to cover a much broader region, including a total of 19 states. Due to this expansion, the demonstration includes more and more physicians who have not demonstrated any inaccuracies in ordering PMDs.

Extending prior authorization requirements to more providers without cause increases administrative costs for all stakeholders without achieving the stated goal of fraud reduction. If, as we expect, the overwhelming majority of these prior authorizations are for legitimate care and are ultimately approved, program expansion just delays needed care and increases administrative costs for both providers and CMS. We strongly believe that prior authorization should only be used when a physician's resource utilization pattern consistently and significantly deviates from his or her peers. Even this more targeted approach can unnecessarily burden physicians without cause, as physicians with certain patient populations may still be unfairly subject to additional scrutiny. Accordingly, if CMS expands its demonstrations, it should continue to refine and seek more targeted approaches that do not result in unnecessary burdens for patients and physicians.

Moreover, CMS is expanding these programs without promoting administrative simplification. Studies have shown that waste related to administrative simplification is potentially greater than that associated with fraud and abuse initiatives, with one studying estimating the lack of administrative simplification to cost Medicare between $107 billion to $389 billion in 2011 alone.[1] While we appreciate that CMS is offering an opportunity for providers to electronically submit prior authorization requests via esMD, this is a CMS-specific solution. The lack of a standardized electronic prior authorization process for medical services across the industry has

[1] Donald M. Berwick, MD, MPP and Andrew D. Hackbarth, MPhil, "Eliminating Waste in US Health Care" *JAMA* (April 2012). Available at http://jama.jamanetwork.com/article.aspx?articleid=1148376.

led to the creation of payer-specific portals and solutions. We urge all payers to streamline and standardize the electronic prior authorization process and adopt a single industry standard for sending medical documentation.

We have attached our previous comments and recommendations on these two demonstration programs to provide CMS with more detail on how to improve these initiatives. Overall, we thank you for your consideration of our concerns and seek to be CMS' partner in identifying clinically-sound, non-burdensome means of reducing the improper payment rate. Should you have any questions regarding this letter, please contact Margaret Garikes, Vice President, Federal Affairs, American Medical Association, at Margaret.Garikes@ama-assn.org.

Sincerely,

American Medical Association
American Academy of Otolaryngology—Head and Neck Surgery
American Society of Echocardiography
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Osteopathic Surgeons
American College of Physicians
American College of Rheumatology
American College of Surgeons
American Society of Anesthesiologists
American Society for Clinical Pathology
American Society for Radiation Oncology
American Society of Cataract and Refractive Surgery
American Urological Association
College of American Pathologists
Medical Group Management Association
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions

Enclosure