AMA
AMERICAN MEDICAL ASSOCIATION

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October 1, 2012

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Public-Private Partnership to Prevent Health Care Fraud

Dear Secretary Sebelius:

On behalf of the physician and medical student members of the American Medical Association (AMA), I write to you regarding the recently announced Public-Private Partnership to Prevent Health Care Fraud. We understand that this partnership is currently under development, with insurance industry stakeholder members providing input through engagement with an executive board. **We request that the AMA and its physician representatives also be included in the development, planning, and implementation of the Public-Private Partnership.**

The AMA is firmly committed to eradicating fraud and abuse from health care, and shares many of the goals of the Department of Health and Human Services (HHS) in this regard. We recently published a white paper entitled, *Medicare & Medicaid Program Integrity: Recommendations for Greater Value and Efficiency* (enclosed), and have submitted comments to several congressional committees in the last few months on this topic. In each of these communications, we have recommended that stakeholders move beyond the historic "pay and chase" model to a methodology that utilizes responsibly developed data analytics and predictive modeling to enable targeted, clinically-informed fraud identification and prevention.

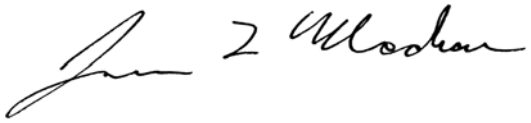
We believe the ongoing, meaningful input of physicians is essential to the development of an accurate data analytics system within the Centers for Medicare & Medicaid Services (CMS), and to a successful Public-Private Partnership. Considering the advanced data analytics capabilities of both CMS and the private insurers, the number of complex, clinical issues presented by these systems are, and will continue to be, diverse and significant. Therefore, the expertise of agency or contractor medical directors alone is insufficient. The input of a broad representation of physicians from medical specialties, subspecialties, practice sizes, and geographic areas is required. And, as new payment and delivery models are adopted, rapid and specific physician input will be essential to ensure that CMS' data analytics capabilities—including those generated through the Public-Private Partnership—remain relevant and accurate.

In addition to the issue of clinical input, we are concerned about initial reports regarding increased data sharing among CMS and private insurers. **We urge you to ensure that individual physician**

and beneficiary information, including Medicare claims data, remains confidential. We caution that legal barriers may exist to such information sharing, and there may be significant policy considerations. Any proposal to share Medicare claims data with private insurers or entities should be carefully considered with the input of all stakeholders, including the AMA.

Thank you for your consideration of our request that the AMA and its physician representatives be included in the development, planning, and implementation of the Public-Private Partnership. We look forward to working with you on this important initiative as it moves forward. Please contact Carol Vargo, Assistant Director, Federal Affairs, at carol.vargo@ama-assn.org or (202) 789-7492 with any questions.

Sincerely,



James L. Madara, MD

Attachment

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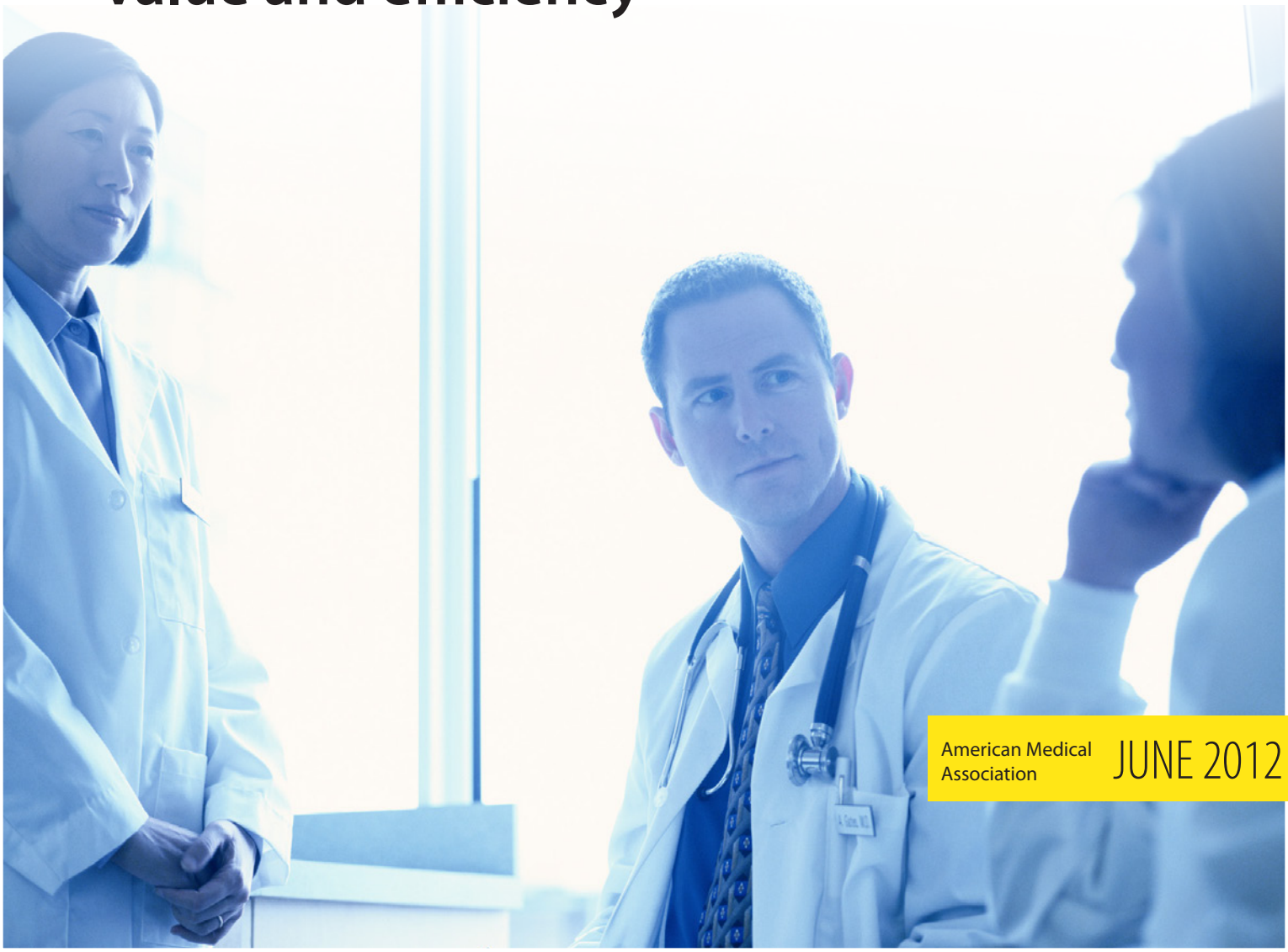
Medicare and Medicaid program integrity

Recommendations for greater value and efficiency



American Medical Association JUNE 2012

Executive summary

The AMA and its physician members are firmly committed to eradicating fraud and abuse from health care. The following multi-pronged approach can reach this goal in an efficient and cost-effective way:

- Move beyond the historic "pay and chase model" to a methodology that utilizes responsibly developed data analytics to enable targeted, clinically-informed fraud identification and prevention.
- Streamline and integrate federal and state program integrity initiatives and audits to produce impactful results.
- Increase oversight of federal and state government contractors to ensure that taxpayer funds are being utilized in a cost-efficient manner.
- Avoid improper payments before they occur by placing a greater emphasis on physician education and outreach.
- Develop and test innovative solutions to decrease overall costs to the health care system by minimizing administrative burdens and targeting law enforcement resources.

Many stakeholders, including physicians, patients, hospitals and other providers, law enforcement, legislators, and regulators share the goal of rooting out fraud and abuse from health care. While Congress, federal agencies, and the states have recently made unprecedented investments in improving health care program integrity, significant challenges remain. This white paper seeks to serve as a resource for all stakeholders as they consider how to more effectively combat fraud and abuse.

Introduction

Financial losses due to health care fraud are estimated to range from $75 billion to $250 billion a year.[1] In the area of Medicare improper payments, the Centers for Medicare & Medicaid Services (CMS) estimate that $34.3 billion is misspent annually.[2] While there is an important distinction between fraud and waste, which often results from inadvertent coding or documentation errors, these numbers are far too high.[3]

Efforts to fight health care fraud, or to identify areas of *waste*, have a tangible impact on physician practices. To comply with anti-fraud rules and regulations, physicians proactively conduct internal audits and adopt compliance programs at their own cost.

When a federal or state audit is initiated, physicians often face significant costs to respond to medical documentation requests, consult with external accountants and attorneys, and navigate the appeals process. A recent survey estimated that the cost of appealing an audit was $110 *per claim*, with additional costs for complying with auditor requests for records and time spent.[4] Even in cases where auditors do not find fraud or improper billing, these costs are never recovered by physician practices.

Broad brush regulations that impose burdens on all providers, rather than focusing on those providers who have demonstrated a propensity to commit fraud or abuse, inequitably affect physicians and providers who are good actors, and result in unnecessary costs to the health care system.

Data analytics

In the area of fraud identification, the utility of data analytics, or "predictive modeling," is increasingly coming to the fore.

The "pay and chase" model for fraud identification has been widely criticized as inefficient. Under "pay and chase," law enforcement and the federal health care programs spend resources pursuing claims that have already been paid. This approach puts fraud enforcers in the position of tracking down fraudsters and stolen funds after the fact, which is particularly challenging in cases where crime rings or international actors are involved.

The federal health care programs and law enforcement are now moving to a "fraud prevention" model that utilizes data analytics to identify aberrant claims in real time, and cross references such claims with other data sets to recognize fraudulent activity. This focused, streamlined approach, if clinically-informed and carefully developed, has the potential to prevent funds from being fraudulently misappropriated from the health care system.

Importantly, data analytic systems also have the potential to decrease the administrative burden that has traditionally accompanied the "pay and chase" model. The concept is that if fraud enforcers and those that oversee the federal health care programs can identify and prevent fraud on the front end, then post-payment activities, which have historically inequitably impacted many non-fraudulent physicians and other providers, may be minimized.

Implicit in the success of data analytics in fraud identification is the ongoing clinical input of physicians. Such expertise is required to enable data analytic systems to operate

properly and reach a zero false positive rate. While federal program integrity regulators have described Medicare claims data analysis systems as "similar to technology used by credit card companies,"[5] the methodologies are dissimilar in that medical claims data analysis requires complex clinical knowledge. Just as appropriate claims coding and documentation implicate complicated clinical issues that require clinical acumen, review or analysis of such claims also necessitates the clinical lens of physician education and training.

Section 4241 of the Small Business Jobs Act of 2010[6] authorizes the Secretary of the Department of Health and Human Services (HHS) to use predictive modeling and other analytics technologies to identify improper claims for reimbursement and to prevent the payment of such claims under the Medicare fee-for-service program. In 2011, CMS implemented a data analytics system for fraud prevention, and is currently developing and refining the system's algorithms. Importantly, CMS has committed to working closely with clinical experts across the country and from every provider specialty to develop and refine algorithms that reflect the complexities of medical billing.

To maximize the accuracy and effectiveness of CMS' data analytics system for fraud investigation, CMS should formalize a process for ongoing, independent clinical review of its data analytics system.

Audit integration

Physicians today face a voluminous number of federal and state auditors. Currently CMS contracts with Zone Program Integrity Contractors (ZPICs), Comprehensive Error Rate Testing (CERT) contractors, Medicare Recovery Auditors (Medicare RACs), Medicaid Recovery Audit Contractors (Medicaid RACs), Program Safeguard Contractors (PSCs), Payment Error Measurement Rate (PERM) Contractors, Medicaid Integrity Contractors (MICs), Medicare Administrative Contractors (MACs), and others.[7]

While some of these programs have unique functions, there is considerable overlap and duplication among them. The same claim may be subject to a Medicare RAC audit, a MAC audit, and a CERT audit, and there are few safeguards to ensure that the same claim—and the same physician—is not concurrently audited by multiple entities.

Physician confusion often accompanies an audit request because even though many of these contractors have the same goal—the identification of fraud or improper payments—audit contractors largely employ divergent operational guidelines and standards. The appeals processes, documentation limits, and look back periods vary among audit contractors.

For example, while the Medicare RACs may not request more than 10 medical records in a 45-day period for small physician practices, the MACs have discretion to require an unlimited number of medical records. And, while the Medicare RACs have similar appeals processes to the MACs, each Medicaid RAC may have a different appeals process.

Consequently, physicians spend a great deal of time determining which contractor is auditing them, under what authority, and what the guidelines are for response. This confusion and misspent time unduly burdens physicians and contravenes the swift recoupment of improper payments to the federal government.

In direct response to a request by the AMA, and in response to this inefficiency, CMS has committed to undertake an "Audit of Audits" to review the myriad federal audit contractors and identify areas of duplication. This effort is strongly supported by the AMA.

To alleviate physician confusion and best utilize federal funding, the result of CMS' "Audit of Audits" should be a reduction in duplicative program integrity audits for physicians and the adoption of streamlined audit policies and procedures.

Contractor oversight

In addition to an overall reduction in the number of federal program integrity audits, the contractors that conduct these audits should be subject to vigorous CMS oversight. While the AMA has worked productively with CMS program integrity audit staff, in general, it appears that many contractors proceed without sufficient CMS guidance or ongoing supervision.

For example, in June 2012, the Government Accountability Office (GAO) reported that over a five year period, the MIC contractors cost $102 million and returned less than $20 million, resulting in an overall loss to the federal government of $82 million.[8] Following this report, CMS committed to end the contracts of three of the five MIC contractors. While we welcome CMS' response, this report is very troubling and signifies that there is a lack of appropriate oversight by CMS of program integrity auditors.

RACs

In particular, physicians continue to have concerns about the Medicare and Medicaid RAC programs. The programs' contingency fee structure inappropriately incentivizes the RACs to conduct "fishing expeditions" that are exceedingly burdensome to physician practices. Physicians who seek to comply with RAC audits spend a significant amount of time and money to produce documents and appeal erroneous RAC determinations.

The RACs are also often inaccurate: CMS' FY2010 Recovery Auditor Report to Congress reported that 46 percent of the Medicare RAC determinations appealed were decided in the provider's favor.[9] This number is far too high. These errors result in needless expense for Medicare appeals tribunals and physicians. To promote efficiency and the best use of federal funds, greater oversight of RAC contractors and safeguards for physicians are needed.

The Medicaid RAC program also suffers from a lack of CMS supervision and transparency due to the complexity of running a program across all 50 states. While most states have finalized Medicaid RAC contracts, many states encountered operational, state-specific issues along the way that led to delays. Consequently, to date, there is no CMS resource where a physician can find which RAC is operating in their state, the contact information for that RAC, or any information regarding what issues the RAC is permitted to audit.

These issues highlight the complexities associated with enacting national audit programs across all 50 states and should be understood by policy makers when utilizing federal auditors for Medicaid claims.

To decrease inaccuracy, the RACs should be subject to a penalty for incorrect overpayment determinations. To reduce improper payments before they occur, the RACs should be incentivized to educate physicians regarding common payment errors.

Education

An essential function of any program integrity auditor is physician education. Heretofore, CMS has largely employed listservs or transmittals to relay areas or issues prone to improper coding or documentation to physicians. To have greater impact, CMS should develop innovative, dynamic approaches to program integrity education, because such education can be a first line of defense against improper payments.

One such method of physician education is the employment of physician Contractor Medical Directors (CMDs). CMDs facilitate clinical-based discussions and serve as a bridge between physicians and federal programs on coverage and coding matters. Physician CMDs are a valuable resource for physicians to obtain education about Medicare's payment and coverage policies, and a venue for physician-to-physician discussion of Medicare policies that impact patient care.

However, the interaction between physicians and CMDs has been inhibited by the overall reduction of CMDs. Since the transition from carriers and fiscal intermediaries to the MACs, and the subsequent reduction of the number of MACs nationwide, the number of CMDs at the MAC-level has also decreased, leading to confusion in the medical community.

CMS should develop innovative approaches to meaningful physician education. To further strengthen the role of the CMD as communicator, CMS should require a minimum of one physician CMD per state who is devoted to Medicare Part B issues for each program integrity audit program, unless a state medical society decides that a regional, multi-state CMD is appropriate.

Additional solutions

Smart cards: Appropriate policies for smart cards to provide physicians with accurate and real time verification of patient eligibility, co-payments due, deductible payable information, and claims processing should be adopted. CMS currently has a demonstration project in place to test smart card technology. That demonstration should be allowed to run its course to identify methodologies in which smart cards can and cannot work.

Law enforcement access to claims data: Currently, law enforcement agencies have access to Medicare claims data to investigate and prosecute fraud. Because these agencies have expertise in fraud investigation, their access to Medicare claims data is an appropriate and vital tool for fighting fraud. Some law enforcement agencies report that they have had difficulty in analyzing Medicare claims data because they receive the data too late to effectively investigate and pursue leads. To enable swift fraud investigation, law enforcement agencies should have access to Medicare claims data in real time.

Increased outreach from CERT contractors: In February 2011, the Office of Inspector General of the Department of Health and Human Services (HHS/OIG), published a report showing that, if the CERT contractor had increased outreach

to physicians and other providers when conducting CERT audits, the HHS improper payment rate would have been decreased by 34 percent.[10] CMS should heed this report and ensure that its CERT contractors are conducting appropriate outreach and not unwittingly inflating the improper payment rate.

Consistency among prepayment requirements: Prepayment and prior authorization requirements can be burdensome for physicians because payers require varied and disparate administrative documentation and addenda. Any proposals to employ prepayment or prior authorization must examine the administrative burdens and impact on patient care of such programs prior to adoption. For example, a recent AMA survey showed that nearly two-thirds (63%) of physicians typically wait several days to receive preauthorization from an insurer for tests and procedures, while one in eight (13%) wait more than a week.[11] Proposals that address prepayment review or prior authorization should be focused on extreme statistical outliers and should be informed by the clinical knowledge and ongoing input of physicians with expertise in the procedure or service in question prior to development and throughout implementation.

Wheelchair advertisements: Deceptive advertisements that promise "free" wheelchairs "paid for by Medicare," and assure seniors that they will be covered for such supplies, do not promote program integrity. Physicians have reported patient inquiries regarding such advertisements, and some incidences of "physician shopping" by seniors—at the urging of wheelchair suppliers—to solicit a wheelchair order. Advertisements by wheelchair suppliers should be subject to greater oversight.

HEAT: Over the last few years, HHS, the Department of Justice (DOJ), and state law enforcement agencies have teamed up to work in a collaborative manner on fraud investigations via the Health Care Fraud Prevention and Enforcement Action Team (HEAT). The result has been an increased in fraud prosecutions and a greater recoupment of funds to the federal government. This targeted, focused method of investigation should continue to be supported by stakeholders.

Home health company bundles: Home health companies are increasingly utilizing "bundled" service orders wherein a physician cannot elect to order individual services for a beneficiary, but instead, may only order a bundle of several services. This practice puts physicians in the untenable position of either not ordering individual services because they are bundled with non-necessary services, or trying to make clear to the home health company that the order only applies to some of the services in the bundle. Home health companies should accord physicians the discretion to order the individual, specific services that are medically necessary for the beneficiary.

Program integrity law waivers: The "program integrity laws" (e.g., the Ethics in Patient Referrals Act, the federal anti-kickback statute) may be inappropriately triggered by new efforts to improve quality and lower costs . For example, a physician who shares savings with a team of other providers may violate the federal anti-kickback law. Or, a physician who provides services like care management or telephone consultations may implicate the civil monetary penalty prohibiting beneficiary inducements. These laws must be addressed for innovative payment and delivery reforms to succeed.

Conclusion

The AMA is committed to engaging with other stakeholders going forward to identify and inform focused and efficient program integrity measures. Clinically-developed data analytics systems, streamlined and integrated audits, increased contractor oversight, a greater emphasis on physician education, and the additional solutions discussed in this white paper can produce cost-efficient results that decrease physician burden and increase savings.

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2. The most recent Medicare Fee-for-Service Improper Payment Report was released in 2011, and reported on improper payments in 2010. See Centers for Medicare & Medicaid Services. Medicare FFS 2010 Improper Payment Report. Available at cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/Medicare_FFS_2010_CERT_Report.pdf.
3. The term "waste" refers to improper payments unrelated to fraud. According to the Government Accountability Office, an improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This definition includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. See Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note). GAO cite available at gao.gov/assets/600/591601.pdf. Page 1.
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