

November 19, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Attention: CMS-3346-P
P.O. Box 8010
Baltimore, MD 21244

Re: Medicare and Medicaid Programs: Regulatory Provisions To Promote Program Efficiency,
Transparency, and Burden Reduction (CMS-3346-P)

Dear Administrator Verma:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am pleased to offer our comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to modify Medicare regulations to promote program efficiency, transparency, and burden reduction, published in the *Federal Register* on September 20, 2018 (CMS-3346-P). We applaud the efforts of CMS to identify unnecessary, obsolete, and excessively burdensome regulations on health care providers, suppliers, and beneficiaries. The AMA believes that eliminating and streamlining reporting, monitoring, and documentation requirements will improve the health care delivery system and make the health care system more effective, simple, and accessible.

Ambulatory Surgical Centers

Hospitalization Requirements

The AMA supports the proposal to remove the requirements of 42 CFR § 415.41(b)(3) for a written hospital agreement or hospital physician admitting privileges. Currently, to participate in Medicare, Ambulatory Surgical Centers (ASCs) must have written transfer agreements with a hospital that meets Medicare requirements or ensure that all physicians performing surgeries in the ASC have admitting privileges in a hospital that meets Medicare requirements. ASCs are already required to have effective procedures in place for the immediate transfer to a hospital for patients requiring medical care that surpasses the capabilities of the ASC. They are also required to have personnel trained and available on site for an emergency response. Moreover, the Emergency Medical Treatment and Labor Act (EMTALA) addresses emergency transfers from an ASC to a nearby hospital. We therefore agree with CMS that the written hospital agreement and physician admitting privileges requirements create an administrative burden to ASCs without any improvement in patient care or safety, and should be removed.

Patient Admission, Assessment, and Discharge

The AMA supports the proposal to remove the requirements of 42 CFR § 416.52(a)(1) for a comprehensive medical history and physical assessment be completed not more than 30 days before the date of surgery. The AMA also supports the proposal to replace these requirements with ones that defer to the ASC's established policies for pre-surgical medical history and physical examination and the operating physician's clinical judgment to ensure each patient receives the appropriate pre-surgical assessments. The current requirements are burdensome because certain patients are healthy and receive minimally invasive procedures that are performed under minimal sedation or local anesthesia. Moreover, the 30-day requirement can be arbitrary and burdensome for the patient. Accordingly, the current patient admissions, assessment, and discharge requirements should be replaced with requirements that defer to established policies and physician judgment.

Hospitals

Unified and Integrated QAPI Program for Multi-Hospital Systems

Under the proposed rule, the multi-hospital system governing body would be responsible and accountable for ensuring that each of its separately certified hospitals met all of the requirements for the unified and integrated Hospital Quality Assessment and Performance Improvement Program (QAPI program) for multi-hospital systems. Currently, medical staff are not required to be included on the governing body. As we have noted in previous correspondence to CMS, the governing body and the medical staff share a mutual responsibility for the provision of quality care and a safe environment for patients. **Medical staff members of each individual hospital bring a unique clinical perspective to the activities of the governing body, especially with regard to discussions of important quality and/or safety issues.** Medical staff members not only bring their clinical perspectives to the discussion, but also can speak to unique geographical differences, patient populations, and services offered at specific hospitals within the system.

We strongly urge CMS to amend its proposed regulatory language at 42 CFR § 482.21(f)(2) as follows:

- (2) the unified and integrated QAPI program establishes and implements policies and procedures to ensure that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated QAPI program has mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed, including consulting with each of its separately certified hospital's medical staff;

In addition, **we urge CMS to provide clarification that it will ensure that any Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation are not a part of a multi-hospital systems QAPI program.** The review of privileges is a critical and sensitive process. This responsibility falls on each individual hospital's medical staff, which monitors the performance of all physicians and other practitioners who are granted privileges, and makes recommendations to the governing body of the hospital concerning which medical staff members should be granted privileges.

CMS stated in the proposed rule that there is an expectation on the part of the Agency “that the focus on quality assessment, performance improvement, and patient safety within a certified hospital that is part of a unified and integrated QAPI program would be maintained and enhanced through the benefits of such integration.” We urge CMS to include language in the final rule so that focus is also maintained through consultation and collaboration with the medical staff.

Unified and Integrated Infection Control Program for Multi-hospital Systems

Under the proposed rule, the multihospital system governing body would be responsible and accountable for ensuring that each of its separately certified hospitals met all of the requirements for the unified and integrated infection control program for multi-hospital systems. As mentioned, we remain concerned about the lack of inclusion of medical staff perspective during these important discussions regarding the unification and integration of quality and safety programs within multi-hospital systems. To be clear, the local-level input and clinical experience which medical staff members bring to these discussions, especially regarding infection control, is critical. As a result, **we strongly urge CMS to amend its proposed regulatory language at 42 CFR § 482.42(c)(3) as follows:**

- (3) had mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed, including consulting with each of its separately certified hospital’s medical staff.

The input and clinical experience which medical staff members bring to policy discussions is critical for multi-hospital systems with a single governing body overseeing all of the separately certified hospitals in the system. As mentioned before, medical staff members not only bring their clinical perspectives to the discussion, but can also speak to unique geographical differences, patient populations, and services offered at specific hospitals within the system.

An alternative to the recommendation above would be for CMS to require the governing body of a multi-hospital system to establish a committee consisting of medical staff representatives from each separately certified hospital to provide oversight with regard to the surveillance, prevention, and control of infection.

Each Member Hospital’s Unique Circumstances

In the proposed rule, in the sections regarding the *Hospital QAPI Program* and the *Hospital Infection Control Program*, CMS seeks to require each separately certified hospital within the multi-hospital system to demonstrate that the unified and integrated QAPI or infection control program was established in a manner that took into account each member hospital’s unique circumstances and any significant differences in patient populations and services offered in each hospital. **We ask CMS to clarify the term “unique circumstances” (e.g., staff, budgets, personnel, committees) and how these unique circumstances would be taken into account with regard to these two programs.**

Special Requirements for Psychiatric Hospitals

In the proposed rule, CMS states that non-physician practitioners, when acting in accordance with state law, their scope of practice, and hospital policy, should have the authority to record progress notes of psychiatric patients for whom they are responsible. The AMA seeks clarification of the term “hospital policy.” Specifically, **we ask CMS to confirm that hospital policy in this instance means the policy or procedures established by the hospital’s medical staff.**

Medical Staff, Medical Records Services, and Surgical Services

The AMA supports the proposal from CMS to provide an alternative simplified assessment to the requirement of completing a complete medical exam and history and physical prior to surgery or a procedure requiring anesthesia services. Allowing the medical staff the option to develop and maintain a policy that identifies specific patients that may have a simplified assessment in place of a comprehensive medical history and physical examination would greatly reduce regulatory burden and provide flexibility to a medical staff to exercise this option based on procedure, patient, guidelines and standards, and applicable state and local health and safety laws. Accordingly, the AMA supports this alternative option.

Additional Regulatory Reforms

While the AMA generally supports many of the proposals to reduce burden, we note that all the proposed eliminated or reduced requirements are facility-based and not focused on individual physicians or independent practices. The increasing amount of administrative responsibility forced upon physicians adds unnecessary costs not only to physicians and the Medicare program but also to patients. Unnecessary administrative tasks undercut the patient-physician relationship. For example, studies have documented lower patient satisfaction when physicians spend more time looking at the computer and performing clerical tasks.¹ Moreover, for every hour of face-to-face time with patients, physicians spend nearly two additional hours on administrative tasks throughout the day. The increase in administrative tasks is unsustainable, diverts time and focus away from patient care, and leads to additional stress and burnout among physicians.

By reducing administrative burden, CMS can support the patient-physician relationship and let physicians focus on an individual patient's welfare and, more broadly, on protecting public health. In addition, CMS should review subregulatory guidelines, which create additional burdens on physicians, and reduce the number of subregulatory guidance documents that are issued.

Accordingly, the AMA believes CMS should address the following concerns to reduce the regulatory burden for physicians, while also simplifying the health care system and ensuring patients receive optimal care.

Quality Payment Program

The AMA strongly believes that improvements must be made to the Merit-based Incentive Payment System (MIPS) program that will reduce complexity and allow physicians to spend less time on reporting and more time with patients. We are committed to working with CMS on ways to reduce the number of quality measures that clinicians are required to report. Overall, we believe the recommendations in our [Quality Payment Program comment letter](#), and our [Regulatory Relief Dashboard](#) would help encourage physicians to focus on more clinically relevant measures that lead to quality improvement and better care for patients. These recommendations include:

¹ Street RL et al., *Provider Interaction with the Electronic Health Record: The Effects on Patient-Centered Communication in Medical Encounters*. Patient Educ. Couns., 2014; Kazmi Z, *Effects of Exam Room EHR Use on Doctor-Patient Communication: A Systematic Literature Review*. Inform Prim Care, 2013; Farber NJ et al., *EHR Use and Patient Satisfaction: What We Learned*. J Fam Pract 2015.

- Simplifying the MIPS scoring methodology;
- Reducing the overall performance threshold;
- Returning the small-practice bonus to overall score rather than the quality category;
- Allowing physicians and groups the option to submit a minimum of 90 days' worth of quality data;
- If CMS reduces the number of quality measures in MIPS, the agency should also reduce the number of requirements for the quality category;
- Providing timely notification to practices that qualify for special treatment and exceptions;
- Ensuring methodology and data are sound before scoring physician improvement;
- Providing maximum flexibility for virtual groups;
- Maintaining the quality data completeness criteria and do not increase the reporting threshold;
- Modifying the quality provisions on topped-out measures and benchmarks;
- Eliminating requirements related to outcomes measures, all-payer data and administrative claims measures;
- Keeping weight in the cost category low during next three years while better measures are developed;
- Revising or eliminating cost measures carried over from the value-based modifier;
- Simplifying and reducing burden through yes/no measure attestation;
- Reducing reporting requirements on physicians by leveraging health information technology vendor reporting on utilization of certified electronic health record technology (CEHRT) functionality; and
- Providing a more robust APM pathway under the Quality Payment Program (QPP).

Prior Authorization (PA) and Utilization Management (UM)

According to a recent AMA survey of 1,000 practicing physicians, 64 percent of surveyed physicians reported waiting at least one business day for PA decisions from health plans, while 30 percent reported waiting at least three business days.² Not surprisingly, 92 percent of physicians said that PA can delay a patient's access to necessary care. These delays may have serious implications for patients and their health, as 78 percent of physicians reported that PA can lead to treatment abandonment, and 92 percent indicated that PA can have a negative impact on patient clinical outcomes. These physician burdens and patient care barriers are routinely experienced by Medicare Advantage (MA) beneficiaries. According to a U.S. Department of Health and Human Services (HHS) Office of Inspector General review of MA service denials in 2014-2016, more than 116,800 PA requests were denied and eventually overturned on appeal for drugs/services to which the patient was entitled, a total that is particularly concerning because beneficiaries and providers appealed only one percent of denials.³

In 2017, the AMA, working with organizations representing physicians, hospitals, patients, and other health care stakeholders, released reform principles identifying problems with and recommending improvements to prior authorization, step therapy, and other utilization management programs. Additionally, the AMA recently partnered with groups including the American Hospital Association,

² Survey summary available at <https://www.ama-assn.org/sites/default/files/media-browser/public/arc/prior-auth-2017.pdf>.

³ HHS OIG, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*, (Sept. 2018), available at <https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp>.

American's Health Insurance Plans, the American Pharmacists Association, the Blue Cross Blue Shield Association, and the Medical Group Management Association on a consensus statement for reducing prior authorization burdens. Notably, the consensus statement includes several recommendations on reducing the overall volume of prior authorizations.

Recommendations:

- **CMS should reinstate its 2012 policy prohibiting MA plans from using step-therapy protocols for Part B physician-administered medications;**
- **CMS should not follow the recommendations in the May 2018 Government Accountability Office on PA efforts,⁴ but rather carefully consider the care delays associated with PA and the resulting impact on beneficiaries and their health and well-being when evaluating any additional PA requirements for the Medicare program;**
- CMS should require Part D plans to accept and respond to pharmacy PA and step therapy override requests through the NCPDP standard electronic PA transactions;
- CMS should accelerate automation of medical services PA by (a) issuing a rule for an electronic clinical attachment standard and (b) enforcing health plan compliance with the X12 278;
- CMS should ensure that all UM requirements are based on accurate and up-to-date, publicly available clinical criteria and never cost alone;
- CMS should require all MA and Part D plans to publicly disclose to both patients and physicians in a searchable electronic format all drugs and medical services that are subject to coverage restrictions (PA, step therapy, formulary restrictions, quantity limits) and provide this information to vendors to be displayed in electronic health record systems;
- CMS should require a 60-day grace period for UM requirements when a patient changes MA and Part D plans, align PA approvals with the duration of the prescribed/ordered treatment, and prohibit plans from requiring patients to retry therapies failed under previous plans;
- MA and Part D plans should abide by PA decisions and pay for any services approved in a PA request by performing eligibility and all other medical policy coverage determinations as part of the PA process and not revoking or restricting coverage for authorized care provided within 45 business days from the date the authorization was received;
- Except where there is evidence of widespread misuse, PA should not be required for drugs that are standard treatment for the patient's condition and/or have been previously approved for treatment of an ongoing/chronic condition;
- CMS should ensure that any "peer-to-peer" reviews utilize physicians from the same specialty/subspecialty as the ordering or prescribing physician;
- CMS should restrict PA requirements to "outlier" providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix; and
- CMS should reconsider a recent policy change that allows Part D sponsors to use indication-based formulary design, as this increased formulary complexity will complicate plan selection for Medicare patients and exacerbate existing transparency issues and administrative burdens for physicians.

⁴ GAO, *Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending*, (May 2018), available at <https://www.gao.gov/products/GAO-18-341>.

Virtual Credit Card Payments

Because of virtual credit cards (VCC), physicians are faced with increased administrative burden and up to a five percent payment cut and increased administrative burdens. Health plans and their vendors are increasingly issuing claims payments to physicians and other health care professionals using VCCs, a nonstandard form of electronic payment.

CMS issued guidance via Frequently Asked Questions (FAQs) in 2017 that provided critical protections to health care providers by pushing back on coercive and unfair practices by health plans regarding virtual credit cards. Unfortunately, CMS' FAQs have been removed from its website for the second time in six months, leaving physicians with uncertainty, potential administrative hassles, and the challenge of fighting coercive payer business tactics. Physicians need appropriate industry safeguards to successfully run their businesses as they see fit. The CMS FAQs endorsed honest, fair business in the health care industry by enabling physicians to make informed, independent choices regarding the appropriate payment method for their practice. Moreover, the ambiguity left in the wake of the FAQs' removal undermines widespread industry efforts to increase voluntary adoption of the EFT standard, reduce manual burdens, and achieve significant cost savings. **Accordingly, CMS should reaffirm physicians' right to refuse virtual credit card payments and receive basic standard electronic funds transfer without fees imposed by health plans or their vendors by issuing "Go-to" guidance on this topic.**

Certification and Documentation

Eliminating and streamlining reporting, monitoring, and documentation requirements will improve the health care delivery system by reducing unnecessary burdens for physicians and making the health care system more effective, simple, and accessible. Medicare documentation requirements are a major imposition that delay care with redundant requirements for verifying physician orders and voluminous medical records, where the salient patient information is buried in reams of purposeless, formulaic language. In particular, CMS should review subregulatory guidance documents and the burden they can have on physicians.

Recommendation:

- CMS should reduce certification requirements and standardize forms.

Unique Device Identifier (UDI) and Claims

The UDI for medical devices aims to improve post-market surveillance and patient safety. While the AMA strongly supports the incorporation of the UDI on medical devices, there is some debate about the most appropriate place to capture this information. CMS and the Food and Drug Administration (FDA) have called for including part of the UDI in the next claims form template update—slated for 2021. However, new certification requirements that will allow EHRs to capture and transmit the full UDI will be implemented throughout 2018 and 2019. The AMA views EHRs and registries as the most appropriate method to capture and manage the UDI. Capturing UDI information in administrative claims represents a significant cost to providers, as well as the industry, and claims information does not follow a patient as they switch insurers. The claims form changes would also not require the capture of the full UDI, instead capturing only the device identifier ("DI") portion and excluding the product identifier portion. Both the Production Identifier and DI are key in providing the complete picture about a medical device when

safety issues arise. Capturing this information in a patient's EHR allows the full medical device information to follow patients, and their longitudinal medical history, regardless of changes in insurance.

Recommendation:

- CMS should not require the capture of the device identifier portion of the UDI on administrative claims forms. The full UDI should be captured instead within a patient's electronic medical record and managed by EHRs and appropriate registries. Registries that collect data from electronic health records could gather this UDI data from the EHRs in the aggregate to support comparative studies and post market surveillance.

Medicare Advantage Star Ratings

As the Star Ratings program has expanded and plays a larger financial role on health plans' bottom lines, the administrative demand has simultaneously increased on physicians and is impeding clinical care and thus does not provide a beneficiary benefit. A large percentage of the measures within the MA Star Ratings program are based completely on physician action and compliance. In order for health plans to increase their Healthcare Effectiveness Data and Information Set (HEDIS) scores and earn greater incentives from CMS, plans are requiring practices as part of their clinical data submission requirements to submit data on all patient lab results and tests and the plans state it is due to the Star Ratings HEDIS requirements. Many of the measures, particularly the HEDIS Effectiveness of Care measures, have more to do with physician quality than assessment of a health plan. The Effectiveness of Care measures are really targeting clinical quality, which is a physician or facility issue—and therefore physicians and facilities have the data. Without a better focus the MA ratings program is just one more burden on physicians and does not provide beneficiaries with the information they need to determine the most appropriate and high quality MA or drug plan.

Recommendations:

- CMS should refine Star Ratings to better measure the quality of plans and things over which the plan has control and the supporting data (e.g., access);
- CMS should require health plans to allow practices to respond at-will at a time of their choosing, at a minimum allow for at least 90 days to respond, support use of electronic methods of data submission, and adequately compensate physicians for the time and burden;
- CMS should allow for more general exclusions for patients with specific conditions, comorbidities or allergies from measures to ensure patient and clinical differences are accounted for and do not interfere with clinical decision making; and
- Denominators of quality measures should be appropriately defined to ensure patients for whom the treatment may not be appropriate are excluded from measurement.

Data Requests to Support MA Risk Adjustment Scores

MA plans routinely demand medical records from physician practices as a means of identifying information plans use to support increases in payments from CMS that are tied to the health status of plan enrollees. Only a small fraction of these requests is linked to CMS audits of MA risk adjustment data. Plans generally provide no compensation for staff time required to pull records and make copies. Physicians frequently complain that charts are demanded for large numbers of patients and that the same

practices are repeatedly subject to these demands, often for the same patients. MA plans frequently subcontract the chart audits to third parties so the medical practice has no idea which plan is making these demands, and misleading statements are made that the audits are required by CMS when they are not. Although having more complex patients involves more physician work, physicians do not receive any additional compensation from MA plans that have higher risk adjustment scores. Instead, those practices that are able to help plans increase their scores are likely to face repeated demands for risk information in the future, adding to their regulatory burdens.

Recommendations:

- CMS should accept physician attestations to support MA beneficiaries' diagnoses instead of requiring documentation from medical records;
- Once beneficiaries have been diagnosed with a permanent condition (e.g., multiple sclerosis, quadriplegia, arthritis), this diagnosis should follow them from year-to-year and not have to be re-designated each year; and
- To eliminate ambiguity as to the authority, regulation, policy, and MA plan contract that is the basis for medical record requests, CMS should require all MA plans to use a standard letter.

2-Midnight/Observation Care

The "2-Midnight" rule has had significant unintended negative consequences that burden Medicare beneficiaries. It remains an artificial construct reflecting a flawed approach that gets in the way of the patient-physician relationship and unnecessarily increases the administrative burden of admitting physicians. The Medicare Payment Advisory Commission voted unanimously on a draft recommendation to withdraw the "2-Midnight" rule as it detracts from admission criteria that depend upon clinical judgment.

Recommendation:

- CMS should rescind the "2-Midnight" rule and instead rely on physicians' clinical judgment to determine a patient's inpatient/outpatient status.

Positive Incentives for Cybersecurity

Cybersecurity is a national priority and physicians, other health care providers, and patients need tools to secure sensitive patient information in the digital sphere. Cybersecurity is also a patient safety issue, as recognized by the FDA, the Healthcare and Public Health Sector Coordinating Council (HPHSCC), and HHS' own Cybersecurity Task Force's report to Congress. As clinical adoption of digital medicine tools accelerates with new innovations, and in light of increased public and commercial insurer coverage of digital medicine tools and services, there is increased urgency to advance policies that remedy vulnerabilities in cybersecurity. To protect practice continuity and patient information, this conversation should be seen as an opportunity to encourage cybersecurity activities rather than punitive requirements.

Recommendations:

- Create a cybersecurity anti-kickback safe harbor/Stark exception; and
- Create improvement activities for the Medicare Quality Payment Program that promote good cyber hygiene.

Modernizing the Stark Law

Significant changes in health care payment and delivery have occurred since the enactment of Stark. Numerous initiatives are attempting to align payment and coordinate care to improve the quality and value of care delivered. The delivery of care is going through a digital transformation. However, Stark—in its almost 30 years of existence—has not commensurably changed. Tying compensation to the value of care provided, equipping providers with tools to improve care, and investing in tools to clinically and financially integrate all may run afoul of these laws. For example, the Stark law impedes care coordination. Specifically, in certain circumstances, it prohibits physicians from coordinating care on behalf of their patients.

Recommendations:

- Create a Stark exception to facilitate coordinated care and promote well-designed Alternative Payment Models (APMs). This exception should be broad, covering both the development and operation of a model to allow physicians to transition to an APM model, and provide adequate protection for the entire care delivery process to include downstream care partners;
- Revise the definition of group practice or create a new type of value-based care bonus that allows physicians to receive shared savings or incentive payments that directly take into account the volume or value of referrals and still qualify as a group practice; and
- Repeal the ban on physician-owned hospitals that reduces and restricts competition and choice in health care markets.

Medicare Contractor Transparency and Oversight

CMS should demonstrate operational flexibility by eliminating or streamlining the audits and reviews by pre- and post-payment contractors. The AMA appreciates the efforts of CMS in implementing the Targeted Prove and Educate program for Medicare Administrative Contractors (MACs). However, physicians are facing an increasing amount of pre-payment and post-payment scrutiny from a variety of government entities and contractors.⁵ The amount of reviews and types of reviewers is confusing, adds unwarranted physician burden and unnecessary costs, and disrupts and distracts from delivering patient-centered care. Furthermore, some contractors are auditing and attempting to recoup against services that Medicare does not require or are not adhering to CMS requirements surrounding the approval of Local Coverage Determinations (LCD). **Physicians need a single transparent, consistent, and fair review process to reduce administrative burden.**

CMS can simplify rules and policies for physicians surrounding these reviews.

⁵ This entities and contractors include CMS, MACs, Recovery Audit Contractors (RAC), Unified Program Integrity Contractors (UPIC) (combining program safeguard, zone program integrity, and Medicaid integrity contractors), Quality Improvement Organizations (QIO), Comprehensive Error Rate Testing (CERT), and Supplemental Medical Review Contractors (SMRC).

Recommendations:

- Develop a uniform approach for reviewers in notifying physicians of a review, requesting records, informing physicians of the specific reason why a claim is denied, and conspicuously stating a physician's appeal rights and avenues;
- Apply consistent and clear Medicare and Medicaid payment and coverage policies including having contractors follow the proper notice and comment process regarding LCDs;
- Work with HHS to eliminate duplicate review of claims among different Federal government reviewers;
- Clarify the function and scope of authority of the contractors;
- Establish an internet portal for consolidating information on program integrity efforts including contractor sampling and extrapolation methodologies;
- Publish data on an annual basis about contractor activities including the number of denials and appeals, net denials (defined as total denials minus denials overturned on appeal), each contractor's appeal rate, and common coding and billing errors and omissions (e.g., error type, omission type, physician specialty, contractor, and region);
- Increase its physician education efforts on how to avoid common coding and billing mistakes and work with physician practices to address internal deficiencies that may have led to a high volume of coding and billing errors;
- Refine reviews using predictive analytics to focus on claims that are at high risk for improper payments and providers that are identified as outliers;
- Capture and consider specialty, patient mix, and site of service;
- Ensure that audits are reviewed by a practicing physician of the same specialty;
- Apply a financial penalty on contractors when denials are overturned on appeal; and
- Replace financial penalties with corrective action plans.

While CMS needs to streamline the amount and type of all reviewers, focusing on Recovery Audit Contractors (RACs) will reduce burden for physicians, decrease costs, and ensure physicians are focused on providing patient-centered care and improving outcomes. RAC auditors retain a percentage of the amount they recover for the government with little regard for the burden and accuracy of the audits. These audits are a great source of frustration for the physician community.

RACs are tremendously inaccurate. In FY 2016, 65 percent of Medicare RAC Part B determinations appealed were decided in the provider's favor.⁶ This is an unacceptable rate and cannot continue.

Recommendations:

With RACs, the AMA recommends that CMS:

- Allow for settlements for Part B claims to ease appeal backlog;
- Require RACs to reimburse the costs (including interest) to physicians who win on appeal of a RAC audit;

⁶ CMS, *Recovery Auditing in Medicare Fee-For-Service for Fiscal Year 2016*, p.16, available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2016-Medicare-FFS-Report-Congress.pdf>.

The Honorable Seema Verma

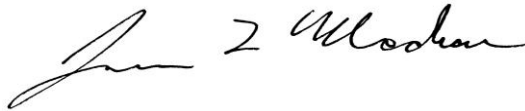
November 19, 2018

Page 12

- Implement meaningful financial penalties and fines for RACs who make errors;
- Repeal the contingency fee structure of the RAC audits;
- Retain the current RAC medical record request limits to ensure audits are not overly burdensome; and
- Ensure that RAC audits are reviewed by a practicing physician of the same specialty or subspecialty and in the same jurisdiction.

The AMA appreciates the opportunity to provide comments and thanks CMS for considering our views. If you should have any questions regarding this letter, please feel free to contact Margaret Garikes, Vice President for Federal Affairs, at margaret.garikes@ama-assn.org, or 202-789-7409.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is written in a cursive style with a large initial "J" and a long horizontal stroke.

James L. Madara, MD