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August 8, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Predictive Modeling Program

Dear Administrator Berwick:

On behalf of the physician and medical student members of the American Medical Association (AMA), I write regarding the Centers for Medicare and Medicaid Services (CMS) predictive modeling program. As a general matter, we support the concept of a targeted, precise method to identify fraudulent activity, rather than overly burdensome program integrity requirements for all physicians. In light of President Obama's Executive Orders 13563 and 13579, which call upon the Agencies to identify and streamline regulations that are excessively burdensome, we think that CMS' effort to develop a seamless fraud detection method has the potential to maximize CMS' efficiency in detecting fraud, and is a positive reflection of the Administration's Campaign to Cut Waste. However, we do have concerns about the program as it moves forward, and appreciate your review of our comments.

The AMA was present at CMS' Philadelphia announcement of the program on June 17, 2011,¹ and at a recent hearing where Peter Budetti, MD, JD, Director of CMS' Center for Program Integrity (CPI), testified on the program.² The AMA also participated in a meeting with CPI on July 8, 2011 to discuss the program. After learning about the program in these forums, it is our understanding that the program is focused solely on identifying fraudulent activity. The example provided by CMS is as follows: a provider who bills for two complex surgeries in two geographically distant states on the same day, several days in a row, would trigger an alert and be assigned a risk score. The provider would then be subject to review, and could be suspended or excluded from the Medicare program.

¹ CMS. (June 17, 2011). *New Technology to Help Fight Medicare Fraud* [press release]. Available at <http://www.cms.gov/apps/media/press/release.asp?Counter=3983>.

² *Harnessing Technology and Innovation to Cut Waste and Curb Fraud in Federal Health Programs*: Hearing before the United States Senate Committee on Homeland Security and Governmental Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security (July 12, 2011) (Statement of Peter Budetti, MD, JD, Deputy Administrator and Director, Center for Program Integrity, CMS). Available at http://hsgac.senate.gov/public/index.cfm?FuseAction=Hearings.Hearing&Hearing_ID=fefef393-0b8f-4fca-9bd9-6298b5fda386

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We support CMS' use of predictive technology to identify egregious fraud, as in the aforementioned example.

CMS has also communicated that currently, the program is not denying claims prior to payment. Rather, CMS is undergoing a process of refining and honing the algorithms and metrics used to identify fraudsters, and has expressed a commitment to "get it right" before using the process to deny claims. We support this judicious approach. The program should be free from false positives or inaccurate results before CMS begins to deny payment based on its findings.

We strongly urge CMS not to use the program to identify improper payments unrelated to fraud. We recognize that CMS is committed to minimizing improper payments due to erroneous coding or insufficient documentation, and may view the program, as it matures, as a mechanism for doing so.³ However, CMS' experience with the Medicare Recovery Audit Contractor (RAC) program evidences why determinations of improper payments unrelated to fraud cannot be done in "real time," and should not be undertaken by the program. RAC overpayment reviews employ voluminous record gathering and lengthy manual review. In spite of the resources and time devoted to RAC review, RAC overpayment determinations are often overturned on appeal: 64.4 percent of provider-appealed RAC determinations are overturned.⁴ We have long advocated that many issues that give rise to improper payments, or "vulnerabilities," are recently-decided matters of policy, and are most productively addressed by provider education and outreach. We feel strongly that, irrespective of the precision of the program, employing the program to identify improper payments unrelated to fraud would pose innumerable problems for CMS and physicians, including high false positive rates, erroneous payment denials, and a proliferation of costly appeals. We also note that CMS already has several programs to identify improper payments on a prepayment basis: the National Correct Coding Initiative (NCCI) edits; the Medically Unlikely Edits (MUEs); and Carrier/Fiscal Intermediary/Medicare Administrative Contractor (MAC) Medical Review.⁵ Employing the predictive modeling program for this purpose would be duplicative.

We also strongly urge CMS not to waive prompt payment in furtherance of the program. We understand that the Secretary is statutorily authorized to waive prompt payment for claims reviewed by the program.⁶ We anticipate that, in the case of fraudulent activity, CMS could deny payment, and would not need to waive prompt pay. We are concerned that if the program is used to identify improper payments unrelated to fraud, and if prompt payment is waived for that aim, many honest physicians' payments could be subject to lengthy delays. We also are mindful of CMS' intent to allow the program to grow and develop over time by including additional algorithms and metrics through which claims are run.⁷ While this fluid approach will hopefully allow for improvements to

³ *Reducing Improper Payments in Medicare*: Hearing before the U.S. House Committee on Oversight and Government Reform, Subcommittee on Government Organization, Efficiency, and Financial Management (July 28, 2011) (Statement of A. Michelle Snyder, Deputy Chief Operating Officer, CMS). Available at

http://oversight.house.gov/images/stories/Testimony/7-28-11_synder_medicare_payments_testimony.pdf

⁴ CMS. *The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration*. June 2010. Available at <https://www.cms.gov/Recovery-Audit-Program/Downloads/DemoAppealsUpdate61410.pdf>

⁵ CMS. *Medicare Claims Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC*. Available at https://www.cms.gov/MLNProducts/downloads/MCRP_Booklet.pdf

⁶ Small Business Jobs Act, Public Law No: 111-240, § 4241(g), Page 124 STAT. 2599

⁷ *Harnessing Technology and Innovation to Cut Waste and Curb Fraud in Federal Health Programs*: Hearing before the United States Senate Committee on Homeland Security and Governmental Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security (July 12, 2011) (Statement of Peter Budetti, MD, JD, Deputy Administrator and Director, Center for Program Integrity, CMS). Available at http://hsgac.senate.gov/public/index.cfm?FuseAction=Hearings.Hearing&Hearing_ID=fefef393-0b8f-4fca-9bd9-6298b5fda386

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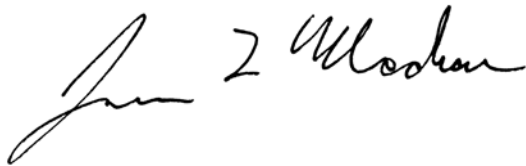
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the program, it is likely that unforeseen challenges will present themselves, resulting in numerous errors and glitches. Timely physician payment should not be subject to the program's growing pains. As physicians face payment cuts and other regulatory requirements as a result of health system reform, any infringement on prompt payment would further exacerbate an already tenuous environment for physician participation in Medicare. Moreover, certainty regarding timely reimbursement is imperative for physicians who seek to participate in and lead innovative delivery models and are currently marshalling their resources to do so.

We request that CMS consider the complexity of claims coding and processing, and how that complexity may be challenging for the program. CMS has repeatedly likened the predictive modeling program to technology used by credit card companies to identify fraud.⁸ We appreciate that CMS is striving to identify fraudulent activity in real time, as the credit card industry does with suspicious transactions. However, we caution that medical coding is not as straightforward as a typical credit card transaction. We are concerned that physicians who treat our Nation's most vulnerable populations may appear to be outliers, and could raise alerts in the program; claims review should be fine-tuned to take into account risk factors such as the ethnic and racial health disparities of patient populations. We also remind CMS that the transition to ICD-10-CM and ICD-10-PCS codes will be challenging for physicians, and will add additional complications to claims review.

To conclude, we support CMS' expeditious and diligent work on the predictive modeling program. In an effort to ensure the success of this program, we urge CMS to consider and address the concerns we discuss above while the program is still in its infancy. We seek to be CMS' partner in educating physicians about the program as it moves forward. Should you have any questions about this letter, please contact Carol Vargo, Assistant Director, Division of Federal Affairs, at carol.vargo@ama-assn.org.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with the first name "James" written in a larger, more prominent script than the last name "Madara".

James L. Madara, MD

⁸ CMS. (June 17, 2011). *New Technology to Help Fight Medicare Fraud* [press release]. Available at <http://www.cms.gov/apps/media/press/release.asp?Counter=3983>.