United States Government Accountability Office

Report to the Committee on Finance, U.S. Senate

April 2018

MEDICARE

CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending

GAO-18-341

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GAO Highlights

Highlights of GAO-18-341, a report to the Committee on Finance, U.S. Senate

Why GAO Did This Study

CMS required prior authorization as a demonstration in 2012 for certain power mobility devices, such as power wheelchairs, in seven states. Under the prior authorization process, MACs review prior authorization requests and make determinations to approve or deny them based on Medicare coverage and payment rules. Approved requests will be paid as long as all other Medicare payment requirements are met.

GAO was asked to examine CMS's prior authorization programs. GAO examined 1) the changes in expenditures and the potential savings for items and services subject to prior authorization demonstrations, 2) reported benefits and challenges of prior authorization, and 3) CMS's monitoring of the programs and plans for future prior authorization. To do this, GAO examined prior authorization program data, CMS documentation, and federal internal control standards. GAO also interviewed CMS and MAC officials, as well as selected provider, supplier, and beneficiary groups.

What GAO Recommends

GAO recommends that CMS (1) subject accessories essential to the power wheelchairs in the permanent DMEPOS program to prior authorization and (2) take steps, based on results from evaluations, to continue prior authorization. The Department of Health and Human Services neither agreed nor disagreed with GAO's recommendations but said it would continue to evaluate prior authorization programs and take GAO's findings and recommendations into consideration in developing plans or determining appropriate next steps.

View GAO-18-341. For more information, contact A. Nicole Clowers at (202) 512-7114 or clowersa@gao.gov or Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

Prior authorization is a payment approach used by private insurers that generally requires health care providers and suppliers to first demonstrate compliance with coverage and payment rules before certain items or services are provided to patients, rather than after the items or services have been provided. This approach may be used to reduce expenditures, unnecessary utilization, and improper payments. The Centers for Medicare & Medicaid Services (CMS) has begun using prior authorization in Medicare through a series of fixed-length demonstrations designed to measure their effectiveness, and one permanent program. According to GAO's analyses, expenditures decreased for items and services subject to a demonstration. GAO's analyses of actual expenditures and estimated expenditures in the absence of the demonstrations found that estimated savings from all demonstrations through March 2017 could be as high as about $1.1 to $1.9 billion. While CMS officials said that prior authorization likely played a large role in reducing expenditures, it is difficult to separate the effects of prior authorization from other program integrity efforts. For example, CMS implemented a durable medical equipment competitive bidding program in January 2011, and according to the agency, it resulted in lower expenditures.

Many provider, supplier, and beneficiary group officials GAO spoke with reported benefits of prior authorization, such as reducing unnecessary utilization. However, provider and supplier group officials reported that providers and suppliers experienced some challenges. These include difficulty obtaining the necessary documentation from referring physicians to submit a prior authorization request, although CMS has created templates and other tools to address this concern. In addition, providers and suppliers reported concerns about whether accessories deemed essential to the power wheelchairs under the permanent durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) program are subject to prior authorization. In practice, Medicare Administrative Contractors (MAC) that administer prior authorization programs review these accessories when making prior authorization determinations, even though they are not technically included in the program and therefore cannot be provisionally affirmed. As a result, providers and suppliers lack assurance about whether Medicare is likely to pay for these accessories. This is contrary to a CMS stated benefit of prior authorization—to provide assurance about whether Medicare is likely to pay for an item or service—and to federal internal control standards, which call for agencies to design control activities that enable an agency to achieve its objectives.

CMS monitors prior authorization through various MAC reports. CMS also reviews MAC accuracy and timeliness in processing prior authorization requests and has contracted for independent evaluations of the demonstrations. Currently, prior authorization demonstrations are scheduled to end in 2018. Despite its interest in using prior authorization for additional items, CMS has not made plans to continue its efforts. Federal internal control standards state that agencies should identify, analyze, and respond to risks related to achieving objectives. CMS risks missed opportunities for achieving its stated goals of reducing costs and realizing program savings by reducing unnecessary utilization and improper payments.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
HHS	Department of Health and Human Services
MAC	Medicare Administrative Contractor

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

April 20, 2018

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

Dear Mr. Chairman:

Prior authorization is a payment approach used by private insurers that generally requires health care providers and suppliers to first demonstrate compliance with coverage and payment rules before certain items or services are provided to patients, rather than after the items or services have been provided. This approach may be used to reduce expenditures, unnecessary utilization, and improper payments.[1] The Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers the Medicare program—has begun using prior authorization to help ensure program integrity for selected items and services with high levels of unnecessary utilization and improper payments. In fiscal year 2017, the federal government made an estimated $36.2 billion in improper payments for the Medicare fee-for-service program.[2] Since 1990, we have designated Medicare a high-risk program because of its size, complexity, and susceptibility to mismanagement and improper payments.[3]

[1]In general, improper payments include payments made in error, such as payments that should not have been made; payments made in incorrect amounts, including overpayments and underpayments; and payments for claims that were not properly documented.

[2]Improper payment estimates are calculated from claims processed from July 2015 to June 2016. Department of Health and Human Services, FY2017 Agency Financial Report (Washington, D.C.: Nov. 14, 2017). Medicare is the federally financed health insurance program for persons aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare fee-for-service, or original Medicare, consists of Medicare Parts A and B. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional insurance and covers physician, outpatient hospital, home health care, certain other services, and the rental or purchase of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

[3]See GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, GAO-17-317 (Washington, D.C.: February 2017).

CMS required prior authorization as a demonstration in 2012 for certain power mobility devices in seven states. CMS conducts demonstrations to test or measure the effect of program changes, such as new or innovative payment approaches. Since that time, CMS has expanded this demonstration to additional states and implemented three additional demonstrations for other items or services, such as non-emergency hyperbaric oxygen therapy, and established a permanent program for certain types of power wheelchairs.[4] For the purposes of our report, we refer to the demonstrations and the permanent program collectively as prior authorization programs unless otherwise noted.

You asked us to review CMS's use of prior authorization in Medicare, including findings from current programs, benefits and challenges, and any opportunities for expansion. This report examines

1. the changes in expenditures and the potential savings for items and services subject to prior authorization demonstrations.
2. the reported benefits and challenges of prior authorization.
3. CMS's monitoring of prior authorization programs and its plans for future prior authorization.

To determine changes in expenditures and the potential savings for items and services subject to prior authorization demonstrations, we analyzed Medicare monthly expenditure data. We did not analyze expenditure data for the permanent program because it was implemented in March 2017. We calculated monthly expenditures for each demonstration for 2 time periods: 1) the 6 months prior to implementation of each demonstration and 2) the start of implementation of each demonstration through March 2017, the month for which the most recent reliable data were available at the time of our analysis. We analyzed these data separately for three groups of states: initial demonstration states (states that were part of the initial implementation), expansion demonstration states (states added after the initial implementation of the demonstration), and non-

[4]Hyperbaric oxygen therapy is a treatment in which the entire body is exposed to oxygen under increased atmospheric pressure.

demonstration states (states that were never part of the demonstration).[5] We calculated average monthly expenditures by state for each of the three groups of states. We then estimated potential savings by comparing average monthly expenditures before and after implementation in initial and expansion demonstration states. For the power mobility device demonstration, we also estimated potential savings from reduced expenditures in non-demonstration states, since CMS officials stated that savings may occur in all states—even those not part of the demonstration—in part because they think that larger nationwide suppliers could have improved their compliance with CMS policies in all states based on their experiences with prior authorization. Finally, we analyzed the effect of prior authorization over time by determining the percentage of the total reduction in expenditures that took place in the first 6 months of implementation for each demonstration.[6] We did not independently verify the accuracy of these data on CMS's Medicare expenditures; however, we checked these data for obvious errors and omissions, compared analyses results to CMS's publicly reported information about expenditures, and interviewed CMS officials to resolve any identified discrepancies. On the basis of these actions, we determined that these data were sufficiently reliable for the purpose of our reporting objectives. We also interviewed CMS officials and reviewed CMS documents, such as CMS's annual program integrity report, to identify other program integrity efforts that may have affected expenditures.

[5]For each demonstration, we considered the implementation month to be the same for all initial demonstration states. For the power mobility device and repetitive scheduled non-emergency ambulance services demonstrations, CMS increased the number of states covered under the demonstration after the initial implementation. We considered the implementation month to be the same for all expansion demonstration states for each demonstration. Implementation was delayed for the non-emergency hyperbaric oxygen demonstration from March 2015 to July 2015 for two states. CMS refers to the various prior authorization programs as the certain power mobility devices and home health services demonstrations and the repetitive scheduled non-emergent ambulance transport services and non-emergent hyperbaric oxygen models. For the purposes of this report, we refer to all of these as demonstrations.

[6]We calculated total expenditures in the 6th month after implementation and total expenditures in March 2017 for initial demonstration states for the repetitive scheduled non-emergency ambulance services, power mobility devices, and non-emergency hyperbaric oxygen therapy demonstrations. We then used these data, as well as average monthly expenditures for the 6 months prior to each demonstration's initial implementation, to determine—from implementation through March 2017—the percentage of the total reduction in expenditures that took place within the first 6 months.

To identify reported benefits and challenges of prior authorization, we interviewed multiple stakeholders. First, we interviewed a non-generalizable sample of officials from nine Medicare beneficiary and provider and supplier groups to learn about their experiences with Medicare prior authorization, including challenges they faced and their views on program benefits. Second, we interviewed officials from CMS and the six Medicare Administrative Contractors (MAC) that administer the Medicare prior authorization programs about program benefits and challenges implementing and conducting the programs. When possible, we reviewed relevant documentation, such as the prior authorization programs' operational guides, to corroborate information reported by stakeholders. Third, we interviewed a sample of four private health insurers and two associations that represent health insurers about their experiences with prior authorization. To identify private health insurers, we considered which insurers had the greatest market share among large group insurers in states with Medicare prior authorization programs and which offered Medicare Advantage plans, as well as whether the insurer had been discussed in stakeholder interviews as having particularly relevant experience.[7] We then compared CMS's efforts to mitigate reported challenges to federal standards for internal controls related to control activities.[8]

To determine the monitoring CMS conducts of prior authorization and its plans for future prior authorization, we obtained and reviewed CMS and Medicare contractor documents including Federal Register notices, proposed and final rules, and CMS prior authorization demonstration status updates. We interviewed CMS officials regarding the agency's monitoring of prior authorization and the extent to which the agency has plans for future prior authorization. We also interviewed private health insurers about their prior authorization programs and the evaluations they conduct, including how they determine whether to add or remove items and services from prior authorization. We then compared CMS's efforts in

[7]The Medicare Advantage program—also known as Medicare Part C—is the private plan alternative to the traditional Medicare program.

[8]See GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

these areas to identified federal standards for internal control related to risk assessment.[9]

We conducted this performance audit from November 2016 through April 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Since September 2012, CMS has subjected selected items and services to prior authorization and pre-claim reviews—a process similar to prior authorization where review takes place after services have begun—through four fixed-length demonstrations and a permanent program.[10] The prior authorization demonstrations are for certain power mobility devices, repetitive scheduled non-emergency ambulance services, non-emergency hyperbaric oxygen therapy, and home health services; while the permanent program is for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items. By using prior authorization, CMS generally seeks to reduce expenditures, unnecessary utilization, and improper payments, although specific objectives for the programs vary based on the statutory authority CMS used to initiate each.

Medicare Prior Authorization Programs

Power mobility devices demonstration: In September 2012, CMS implemented prior authorization for certain scooters and power wheelchairs, items the agency has identified with historically high levels of fraud and improper payments, for Medicare beneficiaries in seven states: California, Florida, Illinois, Michigan, New York, North Carolina, and Texas. The demonstration, established under Section 402(a) of the Social Security Amendments of 1967, is intended to develop or demonstrate improved methods for the investigation and prosecution of fraud in providing care or services under Medicare.[11] In October 2014, CMS

[9]See GAO-14-704G.

[10]For the purposes of this report, we refer to prior authorization and pre-claim review as prior authorization.

[11]Pub. L. No. 90-248, § 402(a), 81 Stat. 821, 930 (1968) (codified, as amended, at 42 U.S.C. § 1395b-1(a)(1)(J)).

expanded the demonstration to 12 additional states: Arizona, Georgia, Indiana, Kentucky, Louisiana, Maryland, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, and Washington. CMS also extended the program, which was originally scheduled to end in 2015, until August 2018.

Repetitive scheduled non-emergency ambulance services demonstration: In December 2014, CMS implemented prior authorization for repetitive scheduled non-emergency ambulance services in three states the agency has identified with high utilization and improper payment rates, based on the garage location of the ambulance: New Jersey, Pennsylvania, and South Carolina. A repetitive ambulance service—which is defined as medically necessary ambulance transportation that is furnished three or more times during a 10-day period or at least once per week for at least 3 weeks—is most typically associated with transportation to services like dialysis or chemotherapy, according to CMS officials. According to CMS, previous analysis shows that non-emergency ambulance services to and from dialysis facilities have grown noticeably in recent years and now represent a large share of non-emergency ambulance claims. The demonstration, established under Section 1115A of the Social Security Act, is intended to reduce expenditures while preserving or enhancing quality of care.[12] In January 2016, CMS increased the number of states included in the demonstration in accordance with Section 515(a) of the Medicare Access and CHIP Reauthorization Act of 2015: Delaware, District of Columbia, Maryland, North Carolina, Virginia, and West Virginia.[13] In December 2017, CMS

CMS officials reported that since the prior authorization programs' implementation, the agency made more than 100 referrals to its contractors that investigate fraud. However, due to the length of time fraud investigations typically take, results from these referrals are not yet available.

[12]42 U.S.C. § 1315a.

[13]Pub, L. No. 114-10, § 515(a) 129 Stat. 87, 174 (2015). For purposes of this report, we refer to the increase in the number of states included in the demonstration as a demonstration expansion.

extended the program, which was originally scheduled to end in 2017, through November 2018.[14]

Non-emergency hyperbaric oxygen therapy demonstration: In March 2015, CMS implemented prior authorization for non-emergency hyperbaric oxygen therapy in three states the agency has identified with high utilization and improper payment rates, based on the therapy facility's location: Illinois, Michigan, and New Jersey. Medicare covers hyperbaric oxygen therapy for certain conditions, such as diabetic wounds of the lower extremities, after there have been 30 days of no measurable signs of healing during standard wound care treatment. According to CMS, previous experience indicates that hyperbaric oxygen therapy has a high potential for improper payments and raises concerns about beneficiaries receiving medically unnecessary care. The demonstration, established under Section 1115A of the Social Security Act, is intended to reduce expenditures while preserving or enhancing quality of care. The demonstration ended in February 2018.

Home health services demonstration: In August 2016, CMS implemented prior authorization for home health services in Illinois. The demonstration, established under Section 402(a) of the Social Security Amendments of 1967, is intended to develop or demonstrate improved methods for the investigation and prosecution of fraud in providing care or services under Medicare. The demonstration was originally scheduled to incorporate other states the agency has identified with high rates of fraud and abuse: Florida, Massachusetts, Michigan, and Texas. However, as of April 2017, CMS paused the demonstration while it considered making improvements. As of February 2018, the demonstration has not resumed.

Permanent DMEPOS program: In December 2015, CMS established a permanent prior authorization program for certain DMEPOS items under Section 1834(a)(15) of the Social Security Act.[15] This program aims to

[14]Section 515(b) of the Medicare Access and CHIP Reauthorization Act of 2015 provides that the Secretary shall expand the demonstration nationally if the Secretary determines that such an expansion (1) is expected to reduce spending without reducing quality of care or improve the quality of care without increasing spending, (2) would reduce net program spending, and (3) would not deny or limit Medicare coverage. 42 U.S.C. §§ 1395m(l)(16), 1315a(c).

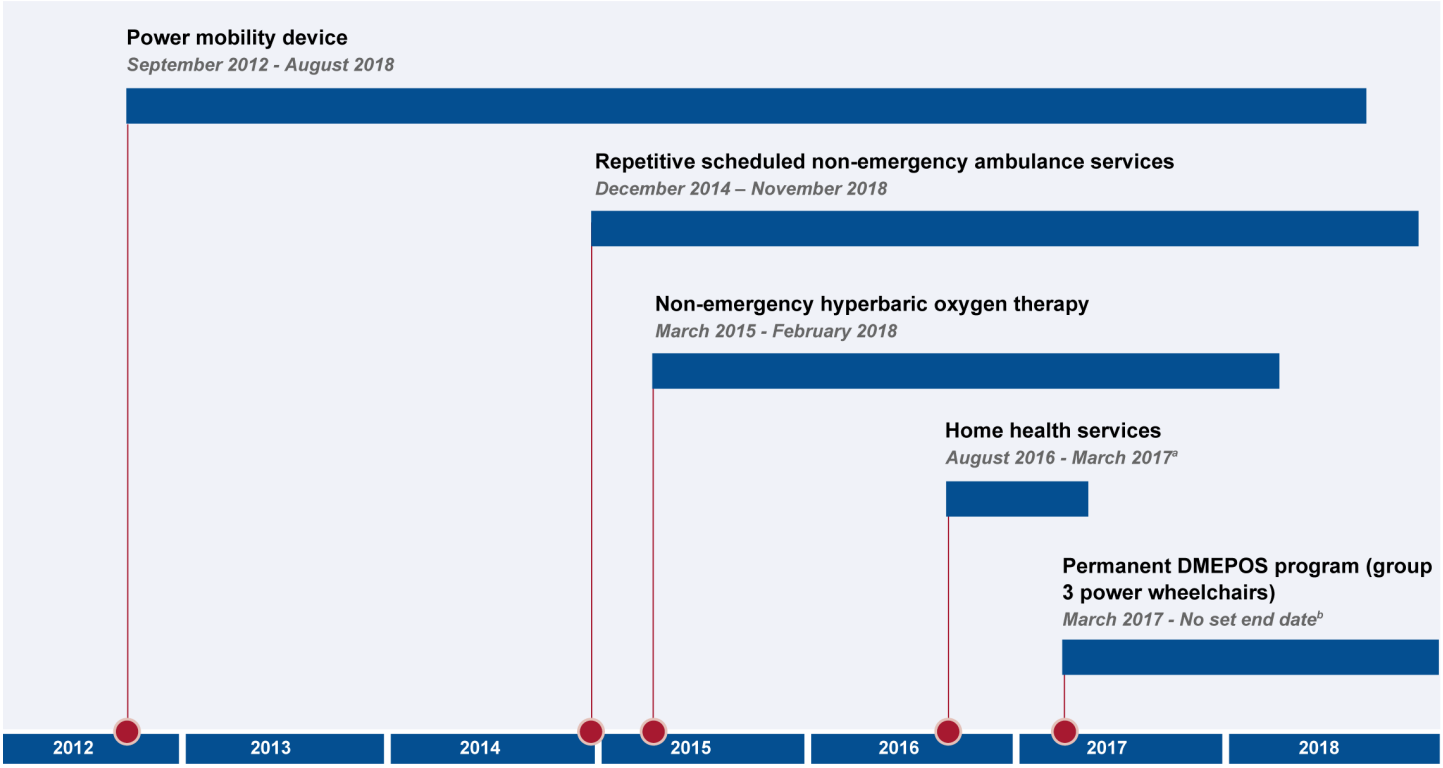
[15]Section 1834(a)(15) of the Social Security Act authorizes the Secretary to develop and periodically update a list of DMEPOS items that are frequently subject to unnecessary utilization and to develop a prior authorization process for these items. 42 U.S.C. § 1395m(a)(15).

reduce unnecessary utilization for certain DMEPOS items. To select the items that would be subject to prior authorization, CMS compiled a Master List of items that 1) appear on the DMEPOS Fee Schedule list, 2) have an average purchase fee of $1,000 or greater (adjusted annually for inflation) or an average rental fee schedule of $100 or greater (adjusted annually for inflation), and 3) meet one of these two criteria: the item was identified in a GAO or HHS Office of Inspector General report that is national in scope and published in 2007 or later as having a high rate of fraud or unnecessary utilization, or the item is listed in the 2011 or later published Comprehensive Error Rate Testing program's annual report.[16] CMS may choose specific items from this Master List to include on the required prior authorization list, and there is no set end date for requiring prior authorization for those items. CMS may suspend prior authorization for those items at any time. (See app. I for the items on the Master List.) In March 2017, CMS began requiring prior authorization for two types of group 3 power wheelchairs from the Master List for beneficiaries with a permanent address in selected states (Illinois, Missouri, New York, and West Virginia) and expanded the program nationwide in July 2017.[17] As of February 2018, CMS has not identified any other items from the Master List for prior authorization. See figure 1 for each prior authorization program's implementation and end dates.

[16]See Medicare Program; Implementation Of Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items and Publication of the Initial Required Prior Authorization List of DMEPOS Items That Require Prior Authorization as a Condition of Payment, 81 Fed. Reg. 93636 (Dec. 21, 2016). CMS updates the Master List annually. As of February 2018, it included 135 items that have high rates of fraud, unnecessary utilization, or improper payments.

[17]CMS defines group 3 wheelchairs as those that can accommodate complex rehabilitative technology accessories. Group 3 power wheelchairs accommodate beneficiaries with limited mobility due to certain neurological conditions, among other things. The wheelchairs selected for the permanent DMEPOS program were not included in the power mobility device demonstration.

Figure 1: Prior Authorization Programs' Implementation and End Dates



Source: GAO analysis of Centers for Medicare & Medicaid Services information. | GAO-18-341

[a]The home health services demonstration was scheduled to run through July 2019, but the Centers for Medicare & Medicaid Services (CMS) paused the demonstration in April 2017. As of February 2018, the demonstration had not resumed.

[b]There is no set end date for requiring prior authorization for these durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items. CMS may suspend prior authorization for these items at any time.

Medicare Prior Authorization Process

MACs that administer the prior authorization programs review prior authorization requests for items and services, along with supporting documentation, to determine whether all applicable Medicare coverage and payment rules have been met. CMS expects requests for prior authorization to include all documentation necessary to show that coverage requirements have been met, for example face-to-face examination documentation or the detailed product description.[18] The referring physician—or the physician who conducts the face-to-face

[18]CMS's documentation requirements did not change under the prior authorization programs.

examination of the beneficiary and orders the item or service—provides this documentation to a provider or supplier who subsequently furnishes the item or service. According to multiple MACs' officials, the provider or supplier who furnishes the item or service typically submits the prior authorization request.[19] CMS has specified that MACs review initial prior authorization requests and make a determination within 10 business days.[20] MACs make one of the following decisions:

- Provisionally affirm (approve) – Documentation submitted meets Medicare's coverage and payment rules. A prior authorization provisional affirmation is a preliminary finding that a future claim submitted to Medicare for the item or service meets Medicare's coverage and payment requirements and will likely be paid.[21]
- Non-affirm (deny) – Documentation submitted does not meet Medicare rules or the item or service is not medically necessary. However, a non-affirmed request may be revised and resubmitted for review an unlimited number of times prior to the submission of the claim for payment. CMS has specified that MACs make a determination on a resubmission within 20 business days.

For the demonstrations, claims that are submitted without a prior authorization provisional affirmation are subject to prepayment review, which is medical review before the claim is paid.[22] In addition, for the home health services and power mobility devices demonstrations, claims submitted without a prior authorization provisional affirmation that are determined payable during the medical review will be subject to a 25 percent reduction in payment. For the permanent program, claims that are submitted without a prior authorization provisional affirmation are denied. (See fig. 2 for the prior authorization process.)

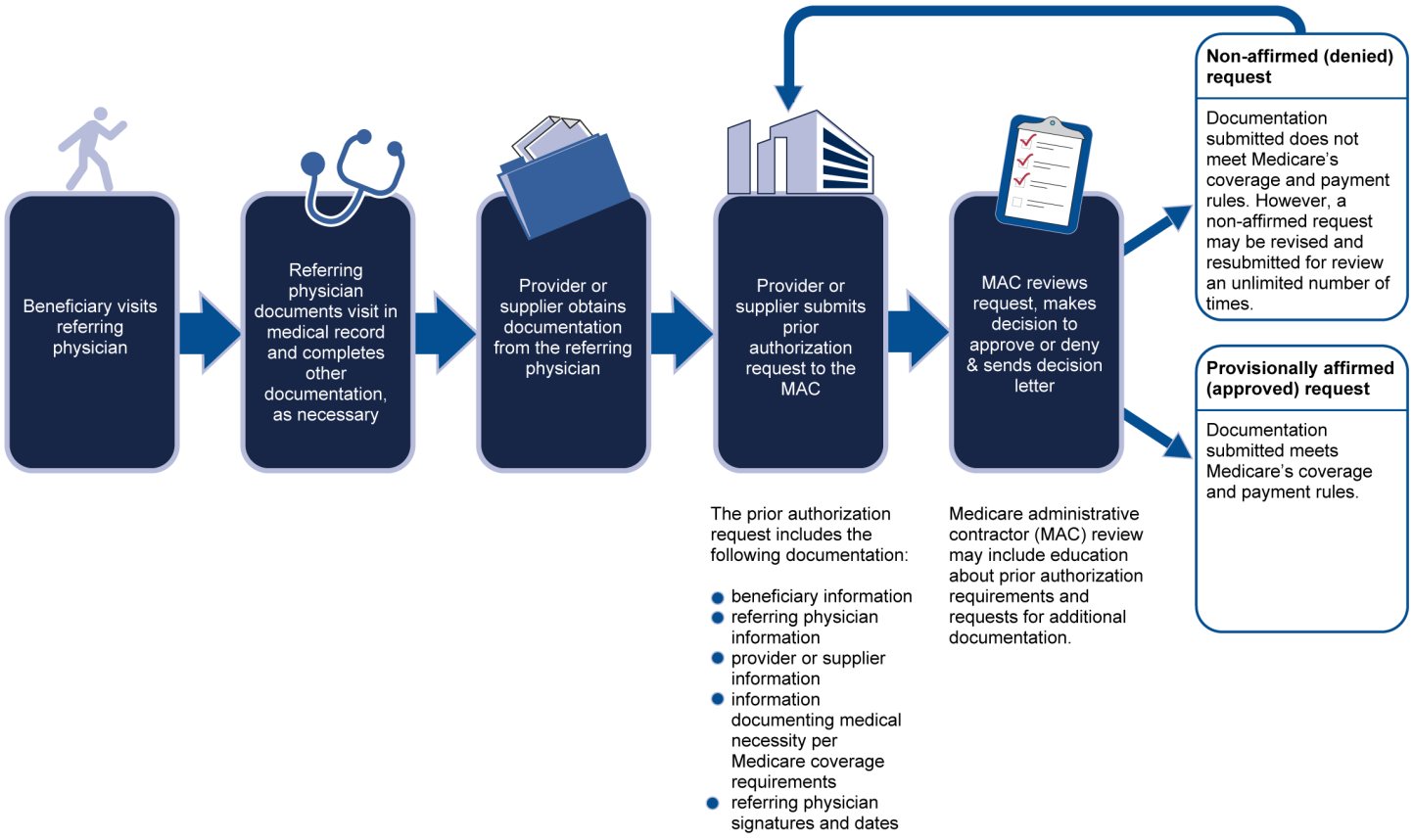
[19]Beneficiaries may also submit prior authorization requests for the repetitive scheduled non-emergency ambulance service, non-emergency hyperbaric oxygen therapy, and home health services demonstrations; and referring physicians may submit them for the power mobility device demonstration. However, CMS and some of the MACs told us that beneficiaries and referring physicians rarely submit prior authorization requests.

[20]An expedited review process of 2 business days is available for cases where the beneficiary's health could be jeopardized without timely access to the item or service.

[21]Other requirements necessary for payment can only be determined after a claim is submitted, such as proof of delivery of an item or whether it is a duplicate claim.

[22]Medicare claims are typically not subject to medical review, which includes a review of medical records. Less than 1 percent of claims are selected for a medical review.

Figure 2: Prior Authorization Process



Source: GAO analysis of Centers for Medicare & Medicaid Services information. | GAO-18-341

As of March 31, 2017, MACs had processed over 337,000 prior authorization requests—about 264,000 initial requests and about 73,000 resubmissions, as shown in table 1.[23]

[23]Numbers of decisions do not include 34,976 rejected submissions for all demonstrations. Numbers of decisions for power mobility device demonstration do not include decisions made by one of the MAC contractors administering the demonstration from September 2012 through June 2016.

Table 1: Number of Initial and Resubmission Approval and Denial Decisions for Each Demonstration from Implementation through March 2017

		Initial submissions		Resubmissions	
Demonstration	**Time period**	**Avg. per month**	**Total requests**	**Avg. per month**	**Total requests**
Power mobility device	Sep 2012 - Mar 2017	1,861	**102,341**	628	**34,543**
Repetitive scheduled non-emergency ambulance services	Dec 2014 - Mar 2017	1,200	**33,588**	579	**16,203**
Non-emergency hyperbaric oxygen therapy	Mar 2015 - Mar 2017	105	**2,620**	24	**611**
Home health services	Aug 2016 - Mar 2017	15,767	**126,132**	2,703	**21,623**
Total			**264,681**		**72,980**

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-341.

Notes: Numbers of decisions do not include 34,976 rejected submissions for all demonstrations. Numbers of decisions for power mobility device demonstration do not include decisions made by one of the MAC contractors administering the demonstration from September 2012 through June 2016.

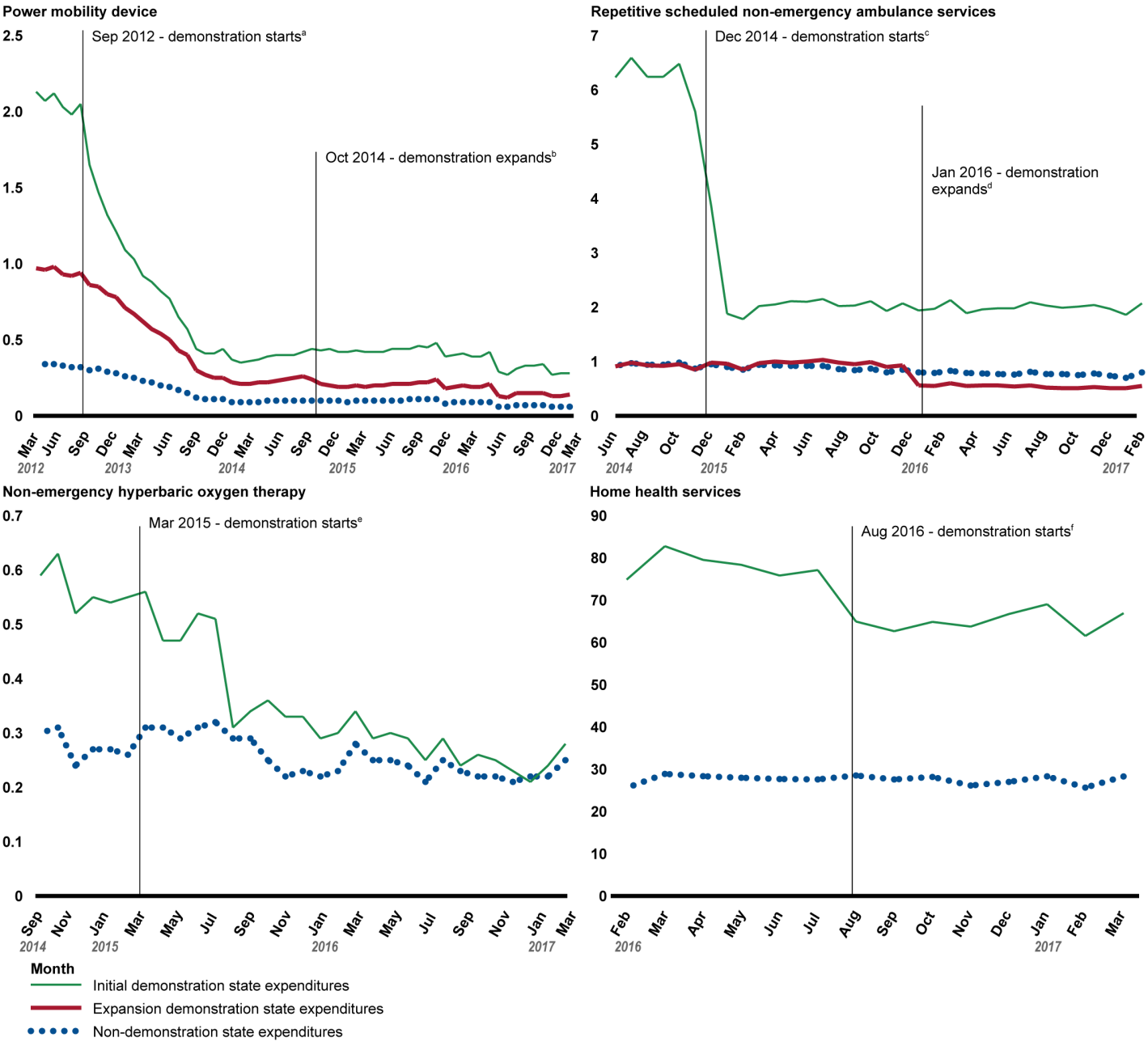
MACs' provisional affirmation rates for both initial and resubmitted prior authorization requests rose in each demonstration between their implementation and March 2017, often by 10 percentage points or more. For example, the provisional affirmation rate for initial submissions for repetitive scheduled non-emergency ambulance services rose from 28 percent in the first 6 months after implementation (December 2014 through May 2015) to 66 percent in the most recent 6 months for which data are available (October 2016 through March 2017). Some MAC officials attributed this rise in part to provider and supplier education, which improved documentation being submitted.

Medicare Expenditures Decreased After Prior Authorization Began in Four Demonstrations

Expenditures Decreased After Prior Authorization Began and Estimated Savings May be as High as About $1.1 to $1.9 Billion, with Most Occurring Soon After Implementation

According to our analysis, expenditures decreased for items and services subject to prior authorization in four demonstrations. For example, expenditure decreases in initial demonstration states from implementation through March 2017 ranged from 17 percent to 74 percent. Figure 3 shows the average monthly expenditures per state from 6 months prior to the start of each demonstration through March 2017 for each of three groups of states: states that were part of the initial demonstration, states that were part of the demonstration expansion, and non-demonstration states. (See app. II for monthly expenditures for items and services covered under each demonstration from their implementation through March 2017.)

Figure 3: Average Monthly Expenditures per State for Four Prior Authorization Demonstrations in Initial Demonstration States, Expansion Demonstration States, and Non-Demonstration States from Six Months Prior to Initial Implementation through March 2017 (in millions)



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-341

Notes: This analysis includes the 50 states and the District of Columbia. The total number of non-demonstration states in each demonstration is: 32 in the power mobility device demonstration, 42 in

the repetitive scheduled non-emergency ambulance services demonstration, 48 in the non-emergency hyperbaric oxygen therapy demonstration, and 50 in the home health services demonstration.

[a]Demonstration initially implemented in September 2012 in 7 states: California, Florida, Illinois, Michigan, New York, North Carolina, and Texas.

[b]Demonstration expanded in October 2014 to 12 additional states: Arizona, Georgia, Indiana, Kentucky, Louisiana, Maryland, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, and Washington.

[c]Demonstration initially implemented in December 2014 in 3 states: New Jersey, Pennsylvania, and South Carolina.

[d]Demonstration expanded in January 2016 to 6 additional states: Delaware, District of Columbia, Maryland, North Carolina, Virginia, and West Virginia.

[e]Demonstration implemented in March 2015 in 3 states: Illinois, Michigan, and New Jersey.

[f]Demonstration implemented in August 2016 in 1 state: Illinois.

Our analysis also shows potential savings for items and services subject to prior authorization, based on the difference between actual expenditures and estimates of what expenditures would have been in the absence of the demonstrations. For each demonstration, we estimated expenditures had the demonstration not been implemented by assuming that expenditures would have remained at their average for the 6 months prior to the demonstration starting in each state. We then compared actual expenditures to these estimated expenditures and found that potential savings could be as high as about $1.1 to $1.9 billion.[24]

- Estimated potential savings in states that were part of the demonstrations since either their initial implementation or expansion may be as high as $1.1 billion. For items and services subject to prior authorization in these states, estimated expenditures in the absence of the demonstrations would have been over $2.1 billion, while actual expenditures were about $1.0 billion.
- Estimated potential savings may be as high as about $1.9 billion if, for the power mobility device demonstration, we estimate savings in both demonstration states and non-demonstration states since implementation. With this method, estimated savings since the power mobility device demonstration's implementation change from over $600 million in demonstration states since each state's implementation to about $1.4 billion in all states since the

[24]CMS has also estimated savings for the demonstrations. However, these estimated savings are not comparable to GAO's estimates because they do not cover the same period of time. For example, CMS's most recent savings estimate for the non-emergency hyperbaric oxygen therapy demonstration is $5.3 million from March 2015 through March 2016.

demonstration began in September 2012, a nearly $800 million increase. This increase is due to including non-demonstration states in the analysis and changing the assumptions for expanded demonstration states in the analysis.[25] CMS officials have reported that certain power mobility device expenditures have declined significantly in both demonstration states and non-demonstration states in part because they think that larger nationwide suppliers improved their compliance with CMS policies in all states based on their experiences with prior authorization. CMS did not make a similar statement for the other demonstrations, and in December 2017, CMS officials said that the agency has not analyzed expenditures in non-demonstration states for the other demonstrations. See table 2 for estimated potential savings for prior authorization demonstrations from implementation through March 2017.

[25]Of the nearly $800 million increase in estimated savings, about $370 million of the increase is due to including estimated savings in non-demonstration states from September 2012 through March 2017. The remainder of the increase is due to calculating estimated savings in demonstration expansion states beginning in September 2012 (demonstration implementation) instead of October 2014 (demonstration expansion) and calculating the average expenditures for the 6 months prior to the demonstration starting in September 2012 instead of 6 months prior to the demonstration expanding in October 2014.

Table 2: Estimated Potential Savings for Prior Authorization in Four Demonstrations from Implementation through March 2017

Group of states (number of states)	Estimated savings (in millions)
Estimated potential savings in demonstration states[a]	
Repetitive scheduled non-emergency ambulance services	
Initial demonstration states (3)	$349.5
Expansion demonstration states (6)	38.0
Non-emergency hyperbaric oxygen therapy	
Initial demonstration states (3)	17.6
Home health services	
Initial demonstration state (1)	104.2
Power mobility device	
Initial demonstration states (7)	590.1
Expansion demonstration states (12)	17.8
Total estimated savings	**1,117.2**
Additional estimated potential savings for power mobility device demonstration in expansion and non-demonstration states[b]	
Power mobility device	
Expansion demonstration states (12)[c]	411.1
Non-demonstration states (32)[c]	367.5
Total estimated savings, including additional estimated savings for power mobility device demonstration	**1,895.8**

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-341.

[a]Estimated potential savings in states that were part of the demonstrations since either their initial implementation or expansion, assuming that total expenditures would have remained at their average for the 6 months prior to the demonstration starting in each state.

[b]Because CMS stated that the power mobility device demonstration may result in savings in all states—even those not part of the demonstration—we also estimated potential savings for that demonstration in non-demonstration states.

[c]Additional estimated potential savings in expansion demonstration states is due to calculating estimated savings in demonstration expansion states beginning in September 2012 (demonstration implementation) instead of October 2014 (demonstration expansion) and calculating the average expenditures for the 6 months prior to the demonstration starting in September 2012 instead of 6 months prior to the demonstration expanding in October 2014.

According to our analysis, more than half of the reduction in monthly expenditures took place within the first 6 months of each demonstration. We calculated the average monthly expenditures for the 6 months prior to the start of each demonstration, the monthly expenditures in the 6th month after implementation, and the monthly expenditures in March 2017 for initial demonstration states in the power mobility device, repetitive scheduled non-emergency ambulance services, and non-emergency

hyperbaric oxygen therapy demonstrations. We compared these expenditures and found that 58, 99, and 91 percent of the reduction in monthly expenditures during this time took place during the first 6 months of each demonstration, respectively.[26]

Other CMS Efforts May Have Contributed to Expenditure Reductions

CMS had other program integrity efforts underway before implementing prior authorization, and these efforts may have also contributed to the reduction in expenditures for items and services subject to prior authorization in these demonstrations. CMS officials said that it is likely that prior authorization played a large role in the expenditure reduction for those select items and services. However, CMS officials also reported that it is difficult to separate the effects of prior authorization from other program integrity efforts, and the agency has not developed a methodology for determining the independent effect of prior authorization on expenditures. We found that some of these other program integrity efforts have addressed provider screening and enrollment and certain durable medical equipment, and these may have contributed to the reductions in Medicare expenditures.[27]

Provider screening and enrollment: CMS has taken steps to keep potentially fraudulent providers and suppliers from billing Medicare. For example,

- in September 2011, CMS began revalidating providers' and suppliers' enrollment in Medicare to ensure that they continue to be eligible to bill Medicare. Revalidation involves confirming that the provider or supplier continues to meet Medicaid program requirements, including ensuring that a provider or supplier does not employ or contract with individuals who have been excluded from participation in federal health care programs.[28] We previously reported that screening all providers and suppliers—not just the ones subject to prior authorization—resulted in over 23,000 new applications being denied

[26]For purposes of this analysis, we excluded the home health services demonstration because it was in effect for only 8 months before it was put on pause in April 2017. As of February 2018, the demonstration has not resumed.

[27]We recently reported on some of these efforts as steps CMS has taken to target high-risk areas within the Medicare program. See GAO *Medicare and Medicaid: CMS Needs to Fully Align Its Efforts with Fraud Risk Framework*, GAO-18-88 (Washington, D.C.: December 2017).

[28]42 CFR 424.515.

or rejected and over 703,000 existing enrollment records being deactivated or revoked from March 2011 through December 2015.[29] We also reported that CMS estimated the revised process avoided $2.4 billion in total Medicare payments to ineligible providers and suppliers from March 2011 to May 2015, some of which may have been payments for items and services subject to prior authorization.

- in July 2013, CMS implemented moratoria on enrollment of new providers for home health services and for repetitive, scheduled non-emergency ambulance transport in select counties. As of January 2018, CMS had extended the home health services moratoria statewide to Florida, Illinois, Michigan, and Texas and the repetitive, scheduled non-emergency ambulance transport moratoria statewide to Pennsylvania and New Jersey. During a moratorium, no new applications to enroll as a billing provider of the affected service types are reviewed or approved.[30] In October 2017, CMS officials said that home health and non-emergency ambulance services' expenditures may have been affected by provider enrollment moratoria.

Certain durable medical equipment pricing, payments, and education and outreach: CMS has taken steps to change how certain durable medical equipment is paid for and to provide ongoing durable medical equipment education and outreach. For example,

- in January 2011, CMS implemented a DMEPOS competitive bidding program required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[31] Under the program, only competitively selected contract suppliers can furnish certain durable medical equipment items at competitively determined prices to Medicare beneficiaries in designated areas. CMS began the program in 9 of the largest metropolitan areas, and in July 2013 expanded to an additional 100 large metropolitan areas.[32] In January 2016, CMS

[29]See GAO, *Medicare: Initial Results of Revised Process to Screen Providers and Suppliers, and Need for Objectives and Performance Measures*, GAO-17-42 (Washington, D.C.: November 2016).

[30]CMS may impose temporary moratoria on a particular provider or supplier type or a particular geographic area as a program integrity effort to prevent fraud, waste, and abuse. See 42 U.S.C. § 1395cc(j)(7).

[31]Pub. L. No. 108-173, § 302(b), 117 Stat. 2066, 2224 (2003) (codified at 42 U.S.C. § 1395w-3).

[32]The metropolitan areas are metropolitan statistical areas or a part thereof. Metropolitan statistical areas are designated by the Office of Management and Budget and include major cities and the suburban areas surrounding them.

implemented competitive bidding program-based adjusted prices for non-designated areas for durable medical equipment items that were previously, or are currently, included in the competitive bidding program. According to CMS, the program—which generally results in lower competitively bid prices—is reducing expenditures for approximately half of the beneficiaries receiving power mobility devices nationwide. We have previously reported that prices decreased for power mobility devices in the competitive bidding program; some of these devices are also subject to prior authorization.[33]

- in January 2011, CMS eliminated the lump sum purchase option for standard power wheelchairs. This change reduced expenditures for power wheelchairs used on a short-term basis because payments for short-term rentals are lower than for the purchase of these items.
- durable medical equipment MACs and CMS provide continuous DMEPOS education and outreach. According to CMS, the education and outreach may have contributed to reducing expenditures for power mobility devices by helping providers and suppliers to understand how to bill correctly and to submit fewer claims that do not meet Medicare coverage and payment requirements.

[33]See GAO, *Medicare: Bidding Results from CMS's Durable Medical Equipment Competitive Bidding Program*, GAO-15-63 (Washington, D.C.: November 2014).

Providers and Suppliers Reported that Prior Authorization Is an Effective Tool, but They Face Difficulty Obtaining Documentation, and Concerns Exist for One Program

Many Providers and Suppliers Reported Prior Authorization Benefits, and CMS Has Addressed Some of Their Initial Concerns

Many of the officials we interviewed representing provider, supplier, and beneficiary groups, as well as CMS and MACs, reported benefits to prior authorization. Officials from some of these groups said that prior authorization is an effective tool to reduce unnecessary utilization and improper payments. Some officials who reported benefits said that prior authorization helps educate providers and suppliers about allowable items and services under Medicare and improves providers' and suppliers' documentation. Some officials also said that providers and suppliers appreciate the assurance of knowing that Medicare is likely to pay for these items and services. Officials from three provider and supplier groups said that by getting provisional prior authorization, their claims will likely not be denied, and they can thus avoid the appeals process, for which there are significant delays.[34] In addition, officials from two provider and supplier groups believe that prior authorization may deter fraudulent suppliers from participating in Medicare. Because of these benefits, these provider and supplier group officials recommended that CMS expand its use of prior authorization.

In addition, CMS has improved the prior authorization programs by responding to some of the providers' and suppliers' initial concerns. For

[34]See GAO, *Medicare Fee-For-Service: Opportunities Remain to Improve Appeals Process*, GAO-16-366 (Washington, D.C.: May 2016).

example, for the power mobility device demonstration, CMS and MAC officials that process DMEPOS claims reported that providers and suppliers were initially confused about whether beneficiaries with representative payees—persons or organizations authorized to accept payment on a beneficiary's behalf—were exempt from the prior authorization program.[35] To address this issue, CMS revised and clarified its guidance related to representative payees. In addition, for the non-emergency hyperbaric oxygen therapy demonstration, officials from CMS and a MAC administering the demonstration said that providers and suppliers raised concerns that a Medicare-covered condition (compromised skin grafts) included in the demonstration required immediate care and therefore should not be subject to prior authorization. In response, CMS removed the condition from the list of conditions subject to prior authorization.

Providers and Suppliers Report Difficulty Obtaining Documentation for Prior Authorization Requests, and CMS Is Taking Steps to Address This Challenge

Some provider and supplier group officials we interviewed reported that obtaining the documentation necessary to submit a prior authorization request can be difficult. For example, some of these officials told us that providers and suppliers may spend 3 to 7 weeks obtaining necessary documentation from referring physicians and other relevant parties before submitting a prior authorization request. While CMS's documentation requirements did not change under prior authorization, officials from a provider and supplier group we spoke with said that prior authorization exacerbates existing documentation challenges because they must obtain all required documentation before providing items and services to beneficiaries. As we noted in a previous report, two durable medical equipment MACs said that referring physicians may lack financial incentives to submit proper documentation since they are unaffected if a durable medical equipment or home health claim is denied due to insufficient documentation, while the provider or supplier submitting the claim loses the payment.[36]

Furthermore, according to some provider and supplier group representatives, CMS's documentation requirements can be difficult to meet. Representatives from one supplier and provider group said that

[35]Beneficiaries may require a representative payee if they are deemed incapable of managing their finances, for example, due to a cognitive impairment.

[36]See GAO, *Medicare Provider Education: Oversight of Efforts to Reduce Improper Billing Needs Improvement*, GAO-17-290 (Washington, D.C.: March 2017).

there is a high standard of proof to meet the information needed to support their medical necessity requirements. For example, documentation in the medical record is required to show whether the referring physician considered other options. Also, representatives from another provider and suppler group said that, unlike private insurers, CMS has more requirements that providers and suppliers consider administrative. For instance, MACs deny prior authorization requests for missing physician signatures.

In addition, representatives from a provider and supplier group said it may be necessary to collect documentation from multiple providers that treated the beneficiary in order to meet CMS's medical necessity requirements. However, officials from one private insurer said that their medical necessity requirements for certain items and services may necessitate receiving documentation from several providers as well, although this does not occur often.

CMS officials acknowledged that the agency's requirements may be more difficult to meet than those of private health insurers. However, this scrutiny may be beneficial because, unlike private insurers, Medicare must pay for health care delivered by any eligible physician willing to accept Medicare payment and follow Medicare requirements.

We found that CMS and the MACs have taken some steps to assist providers and suppliers in obtaining documentation from referring physicians. For example, CMS has created e-clinical templates for home health services and power mobility devices that can be incorporated into progress notes to help ensure physicians meet medical necessity requirements. CMS and the MACs have also created documentation checklists, prior authorization coversheets, and other tools to assist providers and suppliers in verifying that they have obtained the documentation necessary to meet CMS's documentation requirements. Agency officials have stated that they are working on additional changes to reduce provider and supplier burden, for example, developing e-clinical templates for additional items and services.

Furthermore, representatives from each of the MACs said that they call providers and suppliers that receive certain prior authorization non-affirmations to ensure suppliers and providers understand what

information is required to obtain a provisional affirmation.[37] Some MAC representatives said that having a phone conversation with suppliers allows them to resolve non-affirmations more expediently and reduces the number of resubmissions. Representatives from one MAC estimated that when they call providers and suppliers, they are able to resolve 50 to 80 percent of the issues that led to the non-affirmations. Several MAC representatives also said calling helps providers and suppliers gain a better understanding of CMS's documentation requirements, which will increase their likelihood of having future requests provisionally affirmed. In addition, CMS officials said that the agency encourages MACs to call referring physicians directly, when necessary, to remedy curable errors or obtain additional documentation needed to affirm a request because non-affirmation may be resolved faster without providers and suppliers serving as intermediaries.[38]

Providers and Suppliers Report Concerns about Whether the Permanent DMEPOS Program Includes Essential Accessories

Providers and suppliers reported concerns about whether accessories deemed essential to group 3 power wheelchairs are subject to prior authorization and can be provisionally affirmed under the permanent DMEPOS program. According to CMS, the permanent DMEPOS program requires prior authorization for power wheelchair bases, but not for their accessories. CMS officials said this is because accessories do not meet the criteria for inclusion on the Master List. However, according to CMS, the MACs must review these accessories when they make prior authorization determinations because their decision to provisionally affirm a wheelchair base is based in part on their view of the medical necessity of the accessories. Therefore, if an essential accessory does not meet medical necessity requirements, a MAC will deny a prior authorization request for a power wheelchair base. In other words, in practice these accessories are subject to prior authorization, even though they are not technically included in the permanent DMEPOS program and therefore cannot be provisionally affirmed. As a result, providers and suppliers lack assurance about whether Medicare is likely to pay for these accessories.

[37]CMS requires the MACs to call providers and suppliers participating in the home health demonstration and the permanent DMEPOS program. The MACs that administer the other demonstrations call as a best practice.

[38]CMS officials said that, for example, a curable error for the home health pre-claim review would be when the medical record supports that the person is homebound and needs skilled services, but the documentation for the face-to-face examination between the person and referring physician is missing or has not been signed by the referring physician.

In December 2017, CMS officials stated that there have been preliminary discussions regarding the feasibility and effect of subjecting accessories essential to the group 3 power wheelchairs in the permanent DMEPOS program to prior authorization. However, CMS officials did not provide a timeframe for reaching a decision about whether they would do so. Federal internal control standards state that agencies should design control activities that enable an agency to achieve its objectives and should respond to any risks related to achieving those objectives.[39] By not including essential accessories in prior authorization so they can be provisionally affirmed as appropriate, CMS may hinder its ability to achieve one of the stated benefits of the prior authorization program—to allow providers and suppliers to know prior to providing the items whether Medicare will likely pay for them.

CMS Monitors Prior Authorization But Has Not Made Plans for Prior Authorization in the Future

CMS Monitors Prior Authorization and Has Contracted for Evaluations of the Demonstrations

We found that CMS monitoring includes reviewing MAC reports of the results of prior authorization requests, examining MAC timeliness and accuracy, and contracting for independent evaluations of the prior authorization demonstrations.

- CMS officials told us that they review weekly, monthly, and annual MAC reports that include information such as numbers of requests received, completed, approved, denied, and resubmitted.
- According to CMS officials, they monitor MAC timeliness through these reports and separately have a contractor review MAC accuracy in processing requests. According to these officials, they have not identified any issues with MAC timeliness, as the MACs currently meet the standards for processing initial requests within 10 business days and resubmissions within 20 business days. In addition, CMS officials said that a sample of MACs' prior authorization decisions is

[39]See GAO-14-704G.

reviewed each month for accuracy for each of the prior authorization demonstrations, and the reviews have not identified any issues with these decisions.

- CMS officials said that they meet with providers and supplier groups regularly to solicit feedback, to identify issues that need to be addressed, and to determine whether there are any problems, such as reduced beneficiary access to care. According to CMS officials, they have not identified any negative impact on beneficiary access to care as a result of implementing prior authorization.
- CMS has contracted for independent evaluations of the power mobility device, repetitive scheduled non-emergency ambulance services, and non-emergency hyperbaric oxygen demonstrations. In December 2017, CMS officials told us that evaluations will be completed and results available after the demonstrations end.[40] In December 2017, officials told us that they also plan to contract for an evaluation of the permanent program after more time has passed.

Although Most Prior Authorization Is Scheduled to End in 2018, CMS Does Not Have Plans to Continue Efforts

Most prior authorization programs are scheduled to end in 2018, with all the demonstrations concluding and only the limited permanent program remaining.

- The non-emergency hyperbaric oxygen demonstration ended in February 2018, the power mobility device demonstration in August 2018, and the repetitive scheduled non-emergency ambulance services demonstration in November 2018.
- The home health services demonstration has been on pause since April 2017 with no plans to resume as of February 2018, although CMS stated that they are considering improvements to the demonstration.
- The permanent program, which currently consists of two group 3 power wheelchairs, is the only prior authorization program that will remain. According to CMS officials, these wheelchairs are very low volume, and the HHS Office of the Inspector General reported that

[40]For the power mobility device and repetitive scheduled non-emergency ambulance demonstrations, CMS officials provided us interim reports of the independent evaluations. An interim report of the non-emergency hyperbaric oxygen therapy demonstration was not available at the time of our review. In August 2017 CMS officials told us that they had not contracted for an evaluation of the home health services demonstration because it had been paused.

these wheelchairs represent just a small percentage of all durable medical equipment claims.[41]

CMS has not made plans for continuing expiring or paused prior authorization programs or expanding prior authorization. However, officials told us that they would like to see prior authorization for additional items. For example, CMS officials said that they have considered prior authorization for items such as hospital beds and oxygen concentrators, because these have high utilization or improper payment rates. In addition, in December 2017, CMS officials said that the agency is evaluating whether it has met the requirements for nationwide expansion of the repetitive scheduled non-emergency ambulance services demonstration established by the Medicare Access and CHIP Reauthorization Act of 2015. However, CMS officials also said that have not yet determined the next steps for the use of prior authorization. Federal internal control standards state that agencies should identify, analyze, and respond to risks related to achieving objectives.[42] By not taking steps, based on results from the evaluations, to continue prior authorization, CMS risks missed opportunities for achieving its stated goals of reducing costs and realizing program savings by reducing unnecessary utilization and improper payments.

Conclusions

Since September 2012, CMS has begun using prior authorization to ensure that Medicare coverage and payment rules have been met before the agency pays for selected items and services. During this time, expenditures for items and services subject to prior authorization have been reduced. We estimate potential savings may be as high as about $1.1 to $1.9 billion, although other CMS program integrity efforts may have contributed to these reductions. Many stakeholders, including providers, suppliers, and MAC officials, support prior authorization, citing benefits such as reduced unnecessary utilization. However, providers and suppliers report concerns about whether accessories deemed essential to group 3 power wheelchairs are subject to prior authorization and can be provisionally affirmed. By not including essential accessories in prior authorization, CMS may hinder its ability to achieve one of the stated benefits of the prior authorization program—to allow providers and

[41]See HHS Office of the Inspector General, Medicare Power Wheelchair Claims Frequently Did Not Meet Documentation Requirements, OEI-04-07-00401 (Washington, D.C.: December 2009).

[42]See GAO-14-704G.

suppliers to know prior to providing the items whether Medicare will likely pay for them.

All four prior authorization demonstrations are either paused or will end in 2018, and CMS does not have plans to extend these programs or expand the use of prior authorization to additional items and services with high rates of unnecessary utilization or improper payments. By not taking steps, based on results from the evaluations, to continue prior authorization, CMS risks missed opportunities for achieving its stated goals of reducing costs and realizing program savings by reducing unnecessary utilization and improper payments.

Recommendations for Executive Action

We are making the following two recommendations to CMS.

- The Administrator of CMS should subject accessories essential to the group 3 power wheelchairs in the permanent DMEPOS program to prior authorization. (Recommendation 1)
- The Administrator of CMS should take steps, based on results from evaluations, to continue prior authorization. These steps could include:
  - resuming the paused home health services demonstration;
  - extending current demonstrations; or,
  - identifying new opportunities for expanding prior authorization to additional items and services with high unnecessary utilization and high improper payment rates. (Recommendation 2)

Agency Comments

We provided a draft of this report to HHS for comment, and its comments are reprinted in appendix III. HHS also provided technical comments, which we incorporated as appropriate.

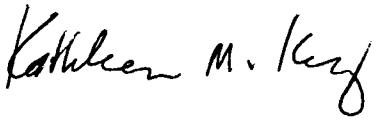
HHS neither agreed nor disagreed with the recommendations but said it would continue to evaluate prior authorization programs and take our findings and recommendations into consideration in developing plans or determining appropriate next steps. In addition, in response to our recommendation to take steps to continue prior authorization, HHS noted that the President's fiscal year 2019 budget for HHS included a legislative proposal to extend its statutory authority to permanently require prior authorization for specified Medicare fee-for-service items and services to all Medicare fee-for-service items and services.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact A. Nicole Clowers at (202) 512-7114 or clowersa@gao.gov or Kathleen M. King at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix IV.

Sincerely yours,

A. Nicole Clowers
Managing Director, Health Care



Kathleen M. King
Director, Health Care

Appendix I: List of Items That May Be Selected for Prior Authorization

In December 2015, the Centers for Medicare & Medicaid Services (CMS) established a permanent prior authorization program for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).[1] To select the items subject to prior authorization, CMS compiled a Master List of items that 1) appear on the DMEPOS Fee Schedule list, 2) have an average purchase fee of $1,000 or greater (adjusted annually for inflation) or an average rental fee schedule of $100 or greater (adjusted annually for inflation), and 3) meet one of these two criteria: the item was identified in a GAO or Department of Health and Human Services Office of Inspector General report that is national in scope and published in 2007 or later as having a high rate of fraud or unnecessary utilization, or the item is listed in the 2011 or later published Comprehensive Error Rate Testing program's annual report.[2] The information presented in this appendix was reprinted from information in a December 2015 final rule. We did not edit it in any way, such as to spell out abbreviations. (See table 3 for the Master List.)

Table 3: Master List of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Subject to Frequent Unnecessary Utilization for Prior Authorization

Healthcare Common Procedure Coding System Code	Item Description
E0193	Powered air flotation bed (low air loss therapy).
E0260	Hosp bed semi-electr w/matt.
E0277	Powered pres-redu air mattrs.
E0371	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width.
E0372	Powered air overlay for mattress, standard mattress length and width.
E0373	Nonpowered advanced pressure reducing mattress.
E0470	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e. g. , nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0601	Continuous Airway Pressure (CPAP) Device.
E1390	Oxygen Concentrator.

[1]Medicare Program; Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, 80 Fed. Reg. 81674 (Dec. 30, 2015).

[2]Section 1834(a)(15) of the Social Security Act authorizes the Secretary to develop and periodically update a list of DMEPOS items that are frequently subject to unnecessary utilization and to develop a prior authorization process for these items. CMS updates the Master List annually. As of February 2018, it included 135 items that have high rates of fraud, unnecessary utilization, or improper payments.

Healthcare Common Procedure Coding System Code	Item Description
E2402	Negative pressure wound therapy electrical pump, stationary or portable.
K0004	High strength, lightweight wheelchair.
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds.
K0814	Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds.
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds.
K0816	Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds.
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds.
K0821	Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds.
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds.
K0823	Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds.
K0824	Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds.
K0825	Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds.
K0826	Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds.
K0827	Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds.
K0828	Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more.
K0829	Power wheelchair, group 2 extra heavy duty, captains chair, patient weight 601 pounds or more.
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pound
K0836	Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds.
K0837	Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds.
K0838	Power wheelchair, group 2 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds.
K0839	Power wheelchair, group 2 very heavy duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds.
K0840	Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more.
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0842	Power wheelchair, group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds.

Healthcare Common Procedure Coding System Code	Item Description
K0843	Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds.
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds.
K0849	Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds.
K0850	Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds.
K0851	Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds.
K0852	Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds.
K0853	Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds.
K0854	Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more.
K0855	Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more.
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pound
K0857	Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds.
K0858	Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds.
K0859	Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds
K0860	Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds.
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0862	Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds.
K0863	Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds.
K0864	Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more.
L5010	Partial foot, molded socket, ankle height, with toe filler.
L5020	Partial foot, molded socket, tibial tubercle height, with toe filler.
L5050	Ankle, symes, molded socket, sach foot.
L5060	Ankle, symes, metal frame, molded leather socket, articulated ankle/foot.
L5100	Below knee, molded socket, shin, sach foot.
L5105	Below knee, plastic socket, joints and thigh lacer, sach foot.
L5150	Knee disarticulation (or through knee), molded socket, external knee joints, shin, sach foot.
L5160	Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, sach foot.

Healthcare Common Procedure Coding System Code	Item Description
L5200	Above knee, molded socket, single axis constant friction knee, shin, sach foot.
L5210	Above knee, short prosthesis, no knee joint (‘stubbies’), with foot blocks, no ankle joints, each.
L5220	Above knee, short prosthesis, no knee joint (‘stubbies’), with articulated ankle/foot, dynamically aligned, each.
L5230	Above knee, for proximal femoral focal deficiency, constant friction knee, shin, sach foot.
L5250	Hip disarticulation, canadian type; molded socket, hip joint, single axis constant friction knee, shin, sach foot.
L5270	Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, sach foot.
L5280	Hemipelvectomy, canadian type; molded socket, hip joint, single axis constant friction knee, shin, sach foot.
L5301	Below knee, molded socket, shin, sach foot, endoskeletal system.
L5312	Knee disarticulation (or through knee), molded socket, single axis knee, pylon, sach foot, endoskeletal system.
L5321	Above knee, molded socket, open end, sach foot, endoskeletal system, single axis knee.
L5331	Hip disarticulation, canadian type, molded socket, endoskeletal system, hip joint, single axis knee, sach foot.
L5341	Hemipelvectomy, canadian type, molded socket, endoskeletal system, hip joint, single axis knee, sach foot.
L5400	Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee
L5420	Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension and one cast change ‘ak’ or knee disarticulation
L5500	Initial, below knee ‘ptb’ type socket, non-alignable system, pylon, no cover, sach foot, plaster socket, direct formed.
L5505	Initial, above knee—knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, sach foot, plaster socket, direct formed
L5510	Preparatory, below knee ‘ptb’ type socket, non-alignable system, pylon, no cover, sach foot, plaster socket, molded to model.
L5520	Preparatory, below knee ‘ptb’ type socket, non-alignable system, pylon, no cover, sach foot, thermoplastic or equal, direct formed.
L5530	Preparatory, below knee ‘ptb’ type socket, non-alignable system, pylon, no cover, sach foot, thermoplastic or equal, molded to model.
L5535	Preparatory, below knee ‘ptb’ type socket, non-alignable system, no cover, sach foot, prefabricated, adjustable open end socket.
L5540	Preparatory, below knee ‘ptb’ type socket, non-alignable system, pylon, no cover, sach foot, laminated socket, molded to model.
L5560	Preparatory, above knee—knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, sach foot, plaster socket, molded to model
L5570	Preparatory, above knee—knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, sach foot, thermoplastic or equal, direct formed
L5580	Preparatory, above knee—knee disarticulation ischial level socket, non-alignable system, pylon, no cover, sach foot, thermoplastic or equal, molded to model

Healthcare Common Procedure Coding System Code	Item Description
L5585	Preparatory, above knee—knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, sach foot, prefabricated adjustable open end socket
L5590	Preparatory, above knee—knee disarticulation ischial level socket, non-alignable system, pylon no cover, sach foot, laminated socket, molded to model
L5595	Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, sach foot, thermoplastic or equal, molded to patient model.
L5600	Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, sach foot, laminated socket, molded to patient model.
L5610	Addition to lower extremity, endoskeletal system, above knee, hydracadence system.
L5611	Addition to lower extremity, endoskeletal system, above knee—knee disarticulation, 4 bar linkage, with friction swing phase control.
L5613	Addition to lower extremity, endoskeletal system, above knee—knee disarticulation, 4 bar linkage, with hydraulic swing phase control.
L5614	Addition to lower extremity, exoskeletal system, above knee—knee disarticulation, 4 bar linkage, with pneumatic swing phase control.
L5616	Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control.
L5639	Addition to lower extremity, below knee, wood socket.
L5643	Addition to lower extremity, hip disarticulation, flexible inner socket, external frame.
L5649	Addition to lower extremity, ischial containment/narrow m-l socket.
L5651	Addition to lower extremity, above knee, flexible inner socket, external frame.
L5681	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code l5673 or l5679)
L5683	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code l5673 or l5679)
L5700	Replacement, socket, below knee, molded to patient model.
L5701	Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model.
L5702	Replacement, socket, hip disarticulation, including hip joint, molded to patient model.
L5703	Ankle, symes, molded to patient model, socket without solid ankle cushion heel (sach) foot, replacement only.
L5707	Custom shaped protective cover, hip disarticulation.
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control.
L5726	Addition, exoskeletal knee-shin system, single axis, external joints fluid swing phase control.
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control.
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control.
L5781	Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system.

Healthcare Common Procedure Coding System Code	Item Description
L5782	Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty.
L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal).
L5814	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock.
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase control.
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control.
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control.
L5826	Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame.
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control.
L5830	Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control.
L5840	Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase control.
L5845	Addition, endoskeletal, knee-shin system, stance flexion feature, adjustable.
L5848	Addition to endoskeletal knee-shin system, fluid stance extension, dampening feature, with or without adjustability.
L5856	Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type
L5857	Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type
L5858	Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type
L5930	Addition, endoskeletal system, high activity knee control frame.
L5960	Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal).
L5964	Addition, endoskeletal system, above knee, flexible protective outer surface covering system.
L5966	Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system.
L5968	Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature.
L5973	Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion and/or plantar flexion control, includes power source
L5979	All lower extremity prosthesis, multi-axial ankle, dynamic response foot, one piece system.
L5980	All lower extremity prostheses, flex foot system.
L5981	All lower extremity prostheses, flex-walk system or equal.
L5987	All lower extremity prosthesis, shank foot system with vertical loading pylon.
L5988	Addition to lower limb prosthesis, vertical shock reducing pylon feature.
L5990	Addition to lower extremity prosthesis, user adjustable heel height.

Source: Medicare Program; Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, 80 Fed. Reg. 81674 (Dec. 30, 2015). | GAO-18-341.

Appendix II: Expenditure Data for Items and Services Subject to Prior Authorization

Tables 4 through 7 present monthly expenditures for items and services subject to prior authorization in initial demonstration states, expansion demonstration states, and non-demonstration states from 6 months prior to each demonstration's implementation through March 2017, the most recent month for which reliable data is available.

Table 4: Monthly Power Mobility Device Expenditures from March 2012 through March 2017, by Initial Demonstration States, Expansion Demonstration States, and Non-Demonstration States

Dollars in millions												
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
						2012						
Initial demonstration states[a]			$14.9	$14.5	$14.8	$14.2	$13.9	$14.3	$11.5	$10.3	$9.3	$8.5
Expansion demonstration states[b]			11.6	11.6	11.7	11.2	11.0	11.2	10.4	10.2	9.6	9.3
Non-demonstration states[c]			11.0	10.8	10.8	10.6	10.3	10.3	9.7	9.8	9.3	9.0
						2013						
Initial demonstration states	$7.6	$7.2	6.4	6.2	5.7	5.4	4.5	4.0	3.1	2.9	2.9	3.1
Expansion demonstration states	8.5	8.0	7.5	6.9	6.4	6.0	5.1	4.8	3.7	3.3	3.0	3.0
Non-demonstration states	8.3	8.0	7.4	6.9	6.4	6.1	5.5	4.9	4.0	3.6	3.4	3.4
						2014						
Initial demonstration states	2.6	2.5	2.5	2.6	2.8	2.8	2.8	2.8	2.9	3.1	3.0	3.0
Expansion demonstration states	2.6	2.6	2.6	2.6	2.6	2.7	2.9	3.0	3.1	2.9	2.5	2.4
Non-demonstration states	3.0	2.9	3.0	3.0	3.1	3.1	3.1	3.1	3.2	3.3	3.2	3.2
						2015						
Initial demonstration states	2.9	2.9	3.0	2.9	2.9	2.9	3.1	3.1	3.1	3.3	3.2	3.4
Expansion demonstration states	2.3	2.3	2.4	2.3	2.4	2.4	2.5	2.5	2.6	2.6	2.6	2.9
Non-demonstration states	3.1	3.0	3.1	3.1	3.1	3.1	3.2	3.3	3.6	3.5	3.4	3.5
						2016						
Initial demonstration states	2.7	2.8	2.9	2.8	2.8	2.9	2.0	1.9	2.2	2.3	2.3	2.4
Expansion demonstration states	2.2	2.3	2.4	2.3	2.3	2.5	1.6	1.4	1.7	1.8	1.8	1.8
Non-demonstration states	2.7	2.8	2.9	2.8	2.8	3.0	2.0	1.8	2.2	2.2	2.2	2.3

Dollars in millions												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
					2017							
Initial demonstration states	1.9	2.0	1.9									
Expansion demonstration states	1.6	1.6	1.7									
Non-demonstration states	2.0	1.8	2.0									

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-341.

Note: This analysis includes the 50 states and the District of Columbia.

[a]Demonstration initially implemented in September 2012 in 7 states: California, Florida, Illinois, Michigan, New York, North Carolina, and Texas.

[b]Demonstration expanded in October 2014 to 12 additional states: Arizona, Georgia, Indiana, Kentucky, Louisiana, Maryland, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, and Washington.

[c]There are 32 non-demonstration states for the demonstration.

Table 5: Monthly Repetitive Scheduled Non-Emergency Ambulance Services Expenditures from June 2014 through March 2017, by Initial Demonstration States, Expansion Demonstration States, and Non-Demonstration States

Dollars in millions												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
					2014							
Initial demonstration states[a]						$18.7	$19.8	$18.7	$18.7	$19.4	$16.8	$11.6
Expansion demonstration states[b]						5.5	5.9	5.6	5.5	5.7	5.1	5.9
Non-demonstration states[c]						38.5	40.6	39.4	39.5	41.1	36.4	40.0
					2015							
Initial demonstration states	$5.6	$5.3	$6.1	$6.2	$6.3	6.3	6.4	6.1	6.1	6.3	5.8	6.2
Expansion demonstration states	5.7	5.1	5.8	6.0	5.9	6.0	6.2	5.9	5.7	5.9	5.4	5.6
Non-demonstration states	37.9	35.8	39.4	39.2	38.7	38.5	38.8	36.1	35.3	36.4	33.4	35.8
					2016							
Initial demonstration states	5.8	5.9	6.4	5.7	5.9	6.0	5.9	6.3	6.1	6.0	6.0	6.1
Expansion demonstration states	3.4	3.3	3.6	3.3	3.3	3.4	3.3	3.3	3.1	3.1	3.1	3.2
Non-demonstration states	33.6	33.2	34.8	33.3	33.0	32.5	32.0	34.1	32.3	32.2	31.7	32.6
					2017							
Initial demonstration states	5.9	5.6	6.2									

Dollars in millions												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Expansion demonstration states	3.0	3.1	3.3									
Non-demonstration states	31.0	29.5	33.4									

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-341.

Note: This analysis includes the 50 states and the District of Columbia.

[a]Demonstration initially implemented in December 2014 in 3 states: New Jersey, Pennsylvania, and South Carolina.

[b]Demonstration expanded in January 2016 to 6 additional states: Delaware, District of Columbia, Maryland, North Carolina, Virginia, and West Virginia.

[c]There are 42 non-demonstration states for the demonstration.

Table 6: Monthly Non-Emergency Hyperbaric Oxygen Therapy Expenditures from September 2014 through March 2017, by Initial Demonstration States and Non-Demonstration States

Dollars in millions												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2014												
Initial demonstration states[a]									$1.8	$1.9	$1.6	$1.6
Non-demonstration states[b]									14.2	14.9	11.6	13.1
2015												
Initial demonstration states	$1.6	$1.7	$1.7	$1.4	$1.4	$1.5	$1.5	$0.9	1.0	1.1	1.0	1.0
Non-demonstration states	12.7	12.6	15.1	15.0	13.7	15.0	15.2	14.2	14.0	12.0	10.6	11.2
2016												
Initial demonstration states	0.9	0.9	1.0	0.9	0.9	0.9	0.7	0.9	0.7	0.8	0.7	0.7
Non-demonstration states	10.4	11.3	13.3	12.2	12.1	11.3	10.1	11.9	10.9	10.4	10.5	10.2
2017												
Initial demonstration states	0.6	0.7	0.8									
Non-demonstration states	10.4	10.4	11.9									

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-341.

Note: This analysis includes the 50 states and the District of Columbia.

[a]Demonstration implemented in March 2015 in 3 states: Illinois, Michigan, and New Jersey.

[b]There are 48 non-demonstration states for the demonstration.

Table 7: Monthly Home Health Services Expenditures from February 2016 through March 2017, by Initial Demonstration States and Non-Demonstration States

Dollars in millions												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
						2016						
Initial demonstration states[a]		$74.9	$82.8	$79.5	$78.4	$75.8	$77.1	$64.9	$62.7	$64.9	$63.8	$66.7
Non-demonstration states[b]		1,279.3	1,444.6	1,417.6	1,399.0	1,384.1	1,379.3	1,426.2	1,378.8	1,408.5	1,307.1	1,349.9
						2017						
Initial demonstration states	$69.0	61.5	66.9									
Non-demonstration states	1,416.2	1,282.4	1,414.7									

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-341.

Note: This analysis includes the 50 states and the District of Columbia.

[a]Demonstration implemented in August 2016 in 1 state: Illinois.

[b]There are 50 non-demonstration states for the demonstration.

Appendix III: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

MAR 30 2018

Kathleen King
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending*" (GAO-18-341).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Matthew D. Bassett
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - MEDICARE: CMS SHOULD TAKE ACTIONS TO CONTINUE PRIOR AUTHORIZATION EFFORTS TO REDUCE SPENDING (GAO-18-341)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report. HHS is committed to providing Medicare beneficiaries with access to high quality health care while protecting taxpayer dollars.

As part of HHS's program integrity strategy, HHS implemented several prior authorization programs, including one permanent program and three demonstrations/models. Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before an item or service is furnished to a beneficiary and before a claim is submitted for payment. Prior authorization helps to make sure that applicable coverage, payment, and coding rules are met before items and services are furnished. HHS also implemented one pre-claim review program. Pre-claim review is a process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment. Pre-claim review helps make sure that applicable coverage, payment, and coding rules are met before the final claim is submitted.

Two of the Medicare prior authorization programs (repetitive, scheduled non-emergent ambulance transport and non-emergent hyperbaric oxygen therapy) were models developed to reduce expenditures, while maintaining or improving quality of care. One of the Medicare prior authorization programs (power mobility devices) and the Medicare pre-claim review program (home health services) were demonstrations that helped develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services. Pursuant to section 1834(a)(15) of the Social Security Act, HHS also implemented a permanent Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) prior authorization program for certain DMEPOS items that are frequently subject to unnecessary utilization.

HHS has been closely monitoring the impact of the prior authorization and pre-claim review programs on beneficiaries, suppliers, providers, and Medicare expenditures to evaluate the results of each program and help inform next steps. HHS appreciates the GAO's review in this area and will consider findings from this report as we continue to evaluate the use of prior authorization and pre-claim review in Medicare.

Recommendation 1
The Administrator of the Centers for Medicare & Medicaid Services (CMS) should subject accessories essential to the group 3 power wheelchairs in the permanent DMEPOS program to prior authorization.

HHS Response
HHS continues to evaluate ways to improve the program and will take the GAO's recommendation into consideration when developing plans in this area.

Recommendation 2
The Administrator of CMS should take steps, based on results from evaluations, to continue prior authorization. These steps could include:

- resuming the paused home health services demonstration;

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GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - MEDICARE: CMS SHOULD TAKE ACTIONS TO CONTINUE PRIOR AUTHORIZATION EFFORTS TO REDUCE SPENDING (GAO-18-341)

- extending current demonstrations; or.
- identifying new opportunities for expanding prior authorization to additional items and services with high unnecessary utilization and high improper payment rates.

HHS Response

HHS will continue to evaluate the prior authorization programs and will take the GAO's findings and recommendations into account when determining appropriate next steps.

In addition, HHS only has statutory authority to permanently require prior authorization for specified Medicare Fee-For-Service (FFS) items and services. The Fiscal Year 2019 President's Budget for HHS included a legislative proposal to extend that authority to all Medicare FFS items and services, specifically those items that are at high risk for fraud, waste, and abuse. By allowing prior authorization on additional items and services, as appropriate, HHS can ensure in advance that, in those circumstances, the correct payment goes to the right provider for the appropriate service, and avoid future audits on those payments.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Martin T. Gahart (Assistant Director), Lori Achman (Assistant Director), Peter Mangano (Analyst-in-Charge), Sylvia Diaz Jones, and Mandy Pusey made key contributions to this report. Also contributing were Sam Amrhein, Muriel Brown, Eric Wedum, and Jennifer Whitworth.