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Before the

U.S. State Congress Joint Economic Committee

On

"Reducing Waste, Fraud and Abuse Through Innovation:
How AI & Data Can Improve Government Efficiency."

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Chairman Schweikert, Vice Chairman Schmitt, and distinguished members of the Joint Economic Committee:

My name is Brian Miller, and I practice hospital medicine at the Johns Hopkins Hospital. As an academic health policy analyst, I serve as an Associate Professor of Medicine and Business (Courtesy) at the Johns Hopkins University School of Medicine and as a Nonresident Fellow at the American Enterprise Institute. My research focuses on how we can build a more competitive and vibrant health sector to make healthcare more efficient, flexible, and personalized for patients. This perspective is based upon my prior regulatory experience at four federal regulatory agencies. Through my current role as a faculty member, I regularly engage with regulators, policymakers, and businesses in search of solutions to help create a better healthcare system for all. Today I am here in my personal capacity, and the views expressed are my own and do not necessarily reflect those of the Johns Hopkins University or the Johns Hopkins Health System, the American Enterprise Institute, the North Carolina State Health Plan, or the Medicare Payment Advisory Commission (MedPAC).

Administrative waste pervades health care public and private, with some estimates of unaddressed administrative waste as high as $265.6 billion[1] out of an estimated $3.8 trillion in annual health care spending,[2] or 6.9% of annual expenditures (2019 dollars). In a financially unsustainable system that now comprises nearly one-fifth of the gross domestic product and is dependent upon high cost clinical labor, policymakers, regulators, and industry must work together to address waste.

In my testimony today, I will focus on three operational areas where technology and innovation can improve governmental efficiency, combating fraud, waste, and abuse:

1. Reducing improper payments in Medicaid: automation of eligibility determination and redetermination
2. Making diagnostic coding accurate again: increasing administrative efficiency in Medicare
3. Improving prior authorization

Each section will lay out the scope of the problem, policy options, and operational steps to solve the problem at hand.

1. Reducing improper payments in Medicaid: Automation of Medicaid eligibility determination and redetermination

As part of the 2020 Families First Coronavirus Response Act, Congress increased the federal Medicaid matching funds by 6.2% if states implemented continuous Medicaid coverage for enrollees, with redetermination for an estimated 20 million Americans starting on April 1, 2023.[3,4] Initial eligibility and redetermination are two sides of the same process, each with a different policy constituency.

Historically, both the GAO[5] and policy analysts have highlighted challenges with enrollment, with the Kaiser Family Foundation and others[6] as far back as 2000 denoting that 72% of beneficiaries had difficulty getting the required papers and 62% found the process complicated and confusing.[7] While this improved in the early-2010s,[8] challenges grew anew during the pandemic,[9] with concerns about swelling unemployment rolls, stressed state budgets due to

[1] Shrank WH, Rogstad TL, Parekh N. Waste in the US Health Care System: Estimated Costs and Potential for Savings. JAMA. 2019;322(15):1501–1509. doi:10.1001/jama.2019.13978

[2] Martin AB, Hartman M, Lassman D, Catlin A; National Health Expenditure Accounts Team. National Health Care Spending In 2019: Steady Growth For The Fourth Consecutive Year. Health Aff (Millwood). 2021 Jan;40(1):14-24. doi: 10.1377/hlthaff.2020.02022. Epub 2020 Dec 1

[3] Medicaid Enrollment and Unwinding Tracker. Kaiser Family Foundation. May 23, 2024. https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-national-federal-unwinding-and-enrollment-data/

[4] "CMCS Informational Bulletin: Conducting Medicaid and CHIP Renewals During the Unwinding Period and Beyond: Essential Reminders." *CMS* March 15, 2024. Available from: https://www.medicaid.gov/federal-policy-guidance/downloads/cib03152024.pdf

[5] "District of Columbia: Barriers to Medicaid Enrollment Contribute to Hospital Uncompensated Care." *GAO* HRD-93-28. December 29, 1992. Available from: https://www.gao.gov/products/hrd-93-28

[6] Stuber, Jennifer P.; Maloy, Kathleen A.; Rosenbaum, Sara; and Jones, Karen C., "Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?" (2000).Health Policy and Management Issue Briefs. Paper 53. http://hsrc.himmelfarb.gwu.edu/sphhs_policy_briefs/53

[7] See page 9 of "Medicaid and Children: Overcoming Barriers to Enrollment Findings from a National Survey." *KFF* January 2000. Available from: https://www.kff.org/wp-content/uploads/2013/01/medicaid-and-children-overcoming-barriers-to-enrollment-report.pdf

[8] Galewitz P. "States Ease Barriers to Medicaid, CHIP Enrollment, Survey Says." *KFF* 2012. Available from: https://kffhealthnews.org/news/states-ease-barriers-to-medicaid-chip-enrollment-survey-says/

[9] Brooks T. "Medicaid and CHIP Eligibility Verification Flexibilities Help States Keep up with Increased Application Volume due to COVID-19." *Georgetown Center for Children and Families* 2020. Available from: https://ccf.georgetown.edu/2020/04/14/medicaid-and-chip-eligibility-verification-flexibilities-help-states-keep-up-with-increased-application-volume-due-to-covid-19/

economic carnage, and access to COVID-19 care prompting an increase in federal match rates and continuous eligibility. With redetermination for over 20 million Americans ongoing, the prior administration harnessed CMS to drive rulemaking targeting administrative barriers to beneficiary entry.[10]

At the same time, longstanding reporting emphasizes the massive role that eligibility plays in driving federal government improper payments in the Medicaid program, where it accounts for ~76% or $61.3 billion in CY2022.[11] To put this number in perspective, improper payments due to eligibility in Medicaid could cover all 2022 gross drug generic drug costs for all 43.3 million beneficiaries in Medicare Part D who filled at least one generic prescription drug, estimated at $32.9 billion.[12]

Noting that the features that define Medicaid eligibility are defined in statute (categorical – low-income children and their parents, pregnant women, people with disabilities, etc.; financial)[13] leaving little discretion, both initial eligibility and redetermination offer an opportunity to deploy AI/automation in order to improve both sides of the same process.

In accordance with the Federal Activities Inventory Reform Act of 1998, the Office of Management and Budget Circular A-76 and the Office of Procurement Policy Letter 11-01,[14] inherently governmental functions must be performed by government personnel, while other functions are designated as commercial functions and are able to be performed by contractors. Two tests determine this, namely the nature of function test (is the function an exercise of sovereign power?) and the exercise of discretion.

While most AI tools are used to empower governmental users, more questions arise as software increasingly becomes autonomous. Ideally, AI would be best deployed performing functions that are discrete and specific functions that would not be defined as inherently governmental. As Medicaid eligibility requirements are codified in statute with little discretion, the initial eligibility and redetermination of eligibility processes are ripe for using AI to improve the efficiency of state administrative Medicaid operations, reducing administrative costs and combating improper payments. Simultaneously, automation of eligibility would make it easier for beneficiaries to enroll in times of economic distress.

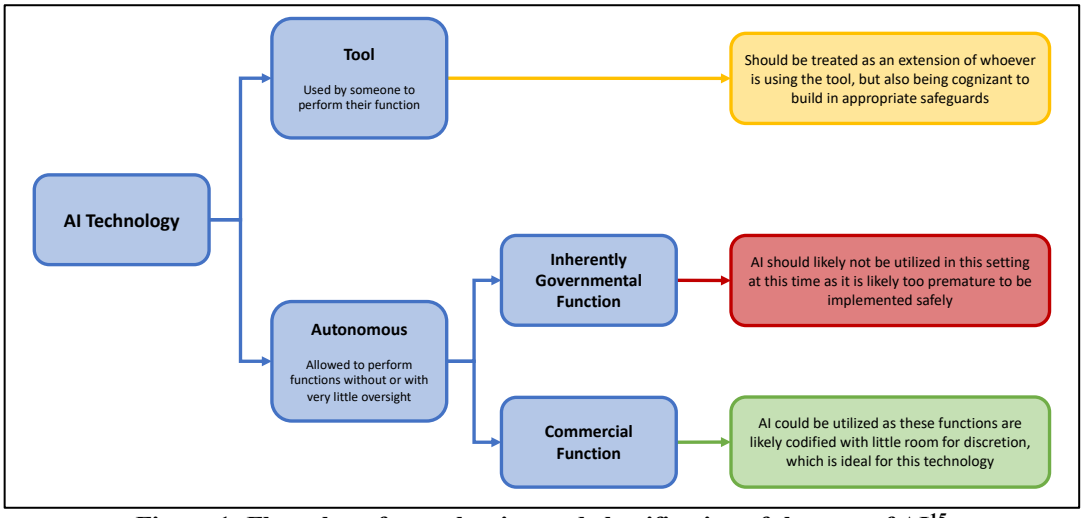

Figure 1: Flow chart for evaluation and classification of the uses of AI[15]

[10] Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes Final Rule Fact Sheet. Centers for Medicare & Medicaid Services. March 27, 2024. https://www.cms.gov/newsroom/fact-sheets/streamlining-medicaid-childrens-health-insurance-program-and-basic-health-program-application

[11] See Table S1 on page 19 in 2022 Medicaid & CHIP Supplemental Improper Payment Data. Centers for Medicare & Medicaid Services. November 2022. https://www.cms.gov/files/document/2022-medicaid-chip-supplemental-improper-payment-data.pdf-0
It is also important to denoted that Managed Care had $106 million in improper payments during the same period.

[12] Feyman Y, et al. "Generic drug utilization and spending among Medicare Part D enrollees in 2022." *ASPE Issue Brief* March 7, 2024. Available from: https://aspe.hhs.gov/sites/default/files/documents/6a76dfa8551bf25dc98ca62553dde90e/generic-drug-landscape-ib.pdf

[13] "Medicaid 101: Eligibility." *MACPAC* Available from: https://www.macpac.gov/medicaid-101/eligibility/

[14] Congressional Research Service. Definitions of "Inherently Governmental Function" in Federal Procurement Law and Guidance. 2014. Accessed October 30, 2023. https://www.everycrsreport.com/files/20141223_R42325_ba76864808b1cfc5b92720461b225702a81ac71d.pdf

[15] Ted Cho, Brian J Miller, Using artificial intelligence to improve administrative process in Medicaid, *Health Affairs Scholar*, Volume 2, Issue 2, February 2024, qxae008, https://doi.org/10.1093/haschl/qxae008

While AI is still in its early stages and there exists concerns regarding hallucinations and improperly constructed AI (incomplete, low quality, or improper training data), automated Medicaid eligibility should initially still be subject to human review. After a period of auditing and iterative improvement, algorithmic or fully autonomous review of eligibility could be permitted to proceed.

Policymakers could require CMS to move the entire Medicaid eligibility process towards automation. Alternatively, CMS could approve state waivers to implement automated eligibility determinations, issue guidance to states on the use of AI in eligibility determination, hold public workshops, contract with vendors to begin developing this technology, or a variety of combination of policy options. Recognizing that there is bipartisan frustration with Medicaid enrollment and eligibility determination, regardless of one's perspective the specific and discrete qualifying criteria for Medicaid along with the codification in statute of eligibility groups presents an ideal opportunity to automate eligibility and ensure appropriate access while reducing federal improper Medicaid payments.

2. Making diagnostic coding accurate again: Increasing administrative efficiency in Medicare

Beneficiaries have two formulations through which they can receive their Medicare benefits–either through participation in the Medicare Advantage (MA) program or Traditional Fee For Service (FFS) Medicare. Payment methodology across the two programs differs. MA plans are paid on a population basis, receiving a risk-adjusted capitated payment or per member per month (PMPM). Risk adjustment is currently based upon the CMS hierarchical condition categories (HCC) model implemented in 2004.[16] From 1985-1999, payment was based upon the adjusted average per capita cost (AAPCC) model, which paid 95% of the AAPCC adjusted for demographic factors such as age, sex, Medicaid, institutional status, working age status; and was found to predict only 1% of beneficiary expenditures.[17]

While imperfect, the continuously iteratively updated, post-2004 diagnosis-based risk adjustment addressed the low predictive value of prior risk adjustment models, and based upon the 2016 21st Century Cures Act, utilized 2 years of data. Adjusting payment for health status ideally rewards plans for covering seriously ill beneficiaries and discourages risk selection in favor of only healthy beneficiaries. Practically, diagnostic categories should be clinically meaningful, predict medical expenditures, and characterize a beneficiary's illness level within a disease process. As part of the HCC model, over 72,000 ICD-10 diagnosis codes are narrowed into diagnostic groups representing a specified condition, and then further condition categories describing broader set of diseases. Hierarchy is then imposed, so that if a beneficiary has multiple conditions with a condition that the risk score only includes the most severe manifestation (see below).

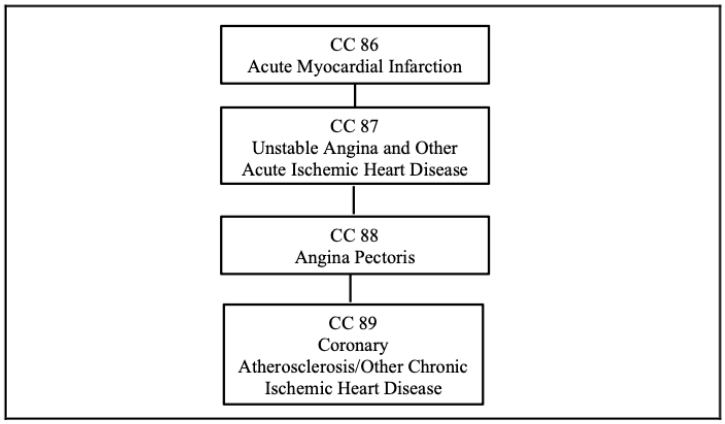

Figure 2: HCC classification (under prior V24 model)[18]

[16] Pope GC, Kautter J, Ellis RP, Ash AS, Ayanian JZ, Lezzoni LI, Ingber MJ, Levy JM, Robst J. Risk adjustment of Medicare capitation payments using the CMS-HCC model. Health Care Financ Rev. 2004 Summer;25(4):119-41.
[17] Pope GC, et al. "Evaluation of the CMS-HCC Risk Adjustment Model: Final Report." RTI Project Number 0209853.006 March 2011 available from: https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/evaluation_risk_adj_model_2011.pdf
[18] Page 18 of "Report To Congress: Risk Adjustment in Medicare Advantage." CMS. December 2021.

HCCs are assigned to the beneficiary using multiple data sources for ICD-10 diagnosis codes (hospital principal and secondary diagnoses, outpatient visits), noting that some HCCs are excluded from payment.

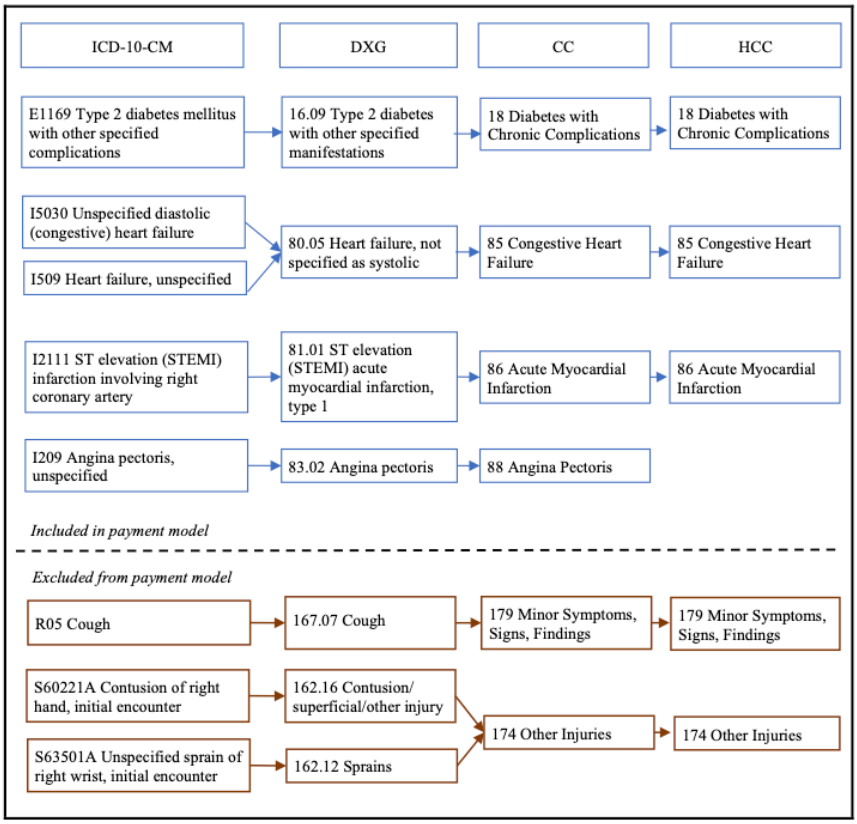

Figure 3: Crosswalk from ICD-10 to HCC (under prior V24 model)[19]

The risk adjustment factor can vary for the same patient depending upon how well they are coded, with MA plans having a natural market incentive to code for more diagnoses, diagnostic specificity, and disease severity. Consider the example of a hypothetical 76 year old woman enrolled in Medicare Advantage, coded differently in three scenarios resulting in different plan payments as demonstrated below.

[19] Page 21 of "Report To Congress: Risk Adjustment in Medicare Advantage." CMS. December 2021.

No conditions coded		Some conditions coded – poor specificity		All conditions coded appropriately	
76 year old female	0.468	76 year old female	0.468	76 year old female	0.468
Medicaid eligible	0.177	Medicaid eligible	0.177	Medicaid eligible	0.177
No diabetes coded		Diabetes w/o complications (HCC 19)	0.181	Diabetes w/vascular complications (HCC 15)	0.608
No vascular disease coded		Vascular disease w/o complications (HCC 105)	0.324	Vascular disease w/complications (HCC 104)	0.645
CHF not coded		CHF not coded		CHF (HCC 80)	0.395
No Disease Interaction		No Disease Interaction		Disease Interaction (DM + CHF)	0.204
Total RAF	0.645	Total RAF	1.15	Total RAF	2.497
PMPM Payment	**$516**	**PMPM Payment**	**$920**	**PMPM Payment**	**$1,998**
Annual Payment	**$6,192**	**Annual Payment**	**$11,040**	**Annual Payment**	**$23,971**

Figure 4: Risk Adjustment Factor based upon an $800 county rate (example from prior V12/22 models)[20]

In contrast, FFS Medicare coding is based upon a more limited data set. For example, payment for inpatient hospitalization is based upon the diagnosis-related group (DRG), a prospective payment system relying upon an episode-based grouper introduced in 1983,[21] a model with analogs in other countries.[22] The DRG is based upon a principal diagnosis or procedure, secondary diagnoses, adjusted for complications/comorbidities, age, and sex.[23] Consequently, full capture of the range of diagnoses, specificity, and severity of clinical conditions are not fully captured as the incentive to do so is absent.

In contrast, outpatient physician care in FFS Medicare is even less tied to diagnostic coding and is not explicitly tied to diagnostic specificity or severity. Instead, payment for "evaluation and management" services is based upon one of two pathways. First, physicians may bill on "medical decision making" based upon the number and complexity of problems, amount or complexity of data analyzed, and level of risk. Alternatively, physicians may bypass this framework and instead bill based purely upon time (e.g. a new 30-minute patient visits is a 99203).[24] While there are functional adjustments to physician payment for elements such as professional liability insurance and practice expense,[25] even more so that acute hospital care, outpatient physician care lacks incentive for coding for diagnostic complexity, severity, and completeness.

In this setting, it is no surprise that there are coding differences between the populations of beneficiaries enrolled in MA and FFS Medicare. Policymakers and regulators have attempted to address this differential, with the continuation of the application of the 5.9% coding pattern adjustment. Under the Biden administration, CMS updated the risk adjustment model and moved to the V28 HCC model over a 3 year period starting in 2024, with a full transition anticipated in 2026.

[20] Slide 15 from Wilson, Marja. "Medicare Part C." Lecture at UNC. April 12, 2019.
[21] "Design and development of the Diagnosis Related Group (DRG)." *CMS*. 2019. Available from: https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf
[22] Mihailovic N, Kocic S, Jakovljevic M. Review of Diagnosis-Related Group-Based Financing of Hospital Care. Health Serv Res Manag Epidemiol. 2016 May 12;3:2333392816647892
[23] "Hospital Acute Inpatient Services Payment System." *MedPAC Payment Basics* October 2024. Available from: https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_hospital_FINAL_SEC.pdf
[24] "Evaluation and Managed Services Reference Guide." *IDSA* February 2024. Available from: https://www.idsociety.org/globalassets/idsa/clinical-practice/2024-em-services-reference-guide-final.pdf
[25] "Physician and Other Health Professional Payment System." *MedPAC Payment Basics* October 2024. Available from: https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_physician_final_sec.pdf

Despite these and other changes, many analysts still have concerns[26] about coding differentials in MA v. FFS Medicare. Researchers such as Richard Kronick[27] have estimated that coding intensity has grown over the intervening years,[28] with other analysts such as Jeffrey Kang, M.D., the former Chief Medical Officer of CMS noting that FFS Medicare is undercoded and lacks program-level risk adjustment, suggesting that a more pragmatic policy goal is to improve the accuracy of risk adjustment in both programs.[29] Other bodies such as MedPAC have noted that coding intensity represented ~7-10% in increased payments annually from 2007 – 2021, partially offset by the statutory downward payment adjustment of 5.9%.[30] While a subsequent MedPAC methodological change[31] resulted in this update being revised upwards to 16-17%,[32] it remains inconvertible that there are coding differences between MA and FFS, some of which are clinically appropriate and others which are not, noting that both raise costs for the Medicare program.

In contrast to the above debate, other experts including myself noted a practical middle ground, denoting that there are three components of coding intensity[33] due to the differing incentives between MA and FFS Medicare:

1. Fraudulent coding (e.g. adding diagnoses unsupported by medical documentation)
2. Diagnostic upcoding (debatable by reasonable people, albeit likely inappropriate)
3. Clinically appropriate diagnostic coding intensity (the reciprocal of FFS undercoding)

While MedPAC notes that "part of the cause of coding intensity is that providers do not report all possible diagnosis codes for their FFS beneficiaries," no analyst nor CMS has yet to clearly and accurately measure the three components of coding intensity in MA.[34] Instead, most stakeholders label all differential payment as overpayment, which is incorrect.

While the first category of coding intensity should result in civil or criminal enforcement as statute dictates and the second component represents a gray likely in need of further examination and enforcement, the third category– clinically appropriate coding intensity – represents appropriate diagnostic descriptive specificity and sound clinical care. The idea that some coding intensity is appropriate and some is not, and that different market participants behave differently fits with recent applied work, wherein researchers noted that coding intensity varies significantly in MA, with rates varying from 3.4 to 12.7%.[35]

At the same time as plans and regulators wrestle with coding intensity, in a clinical environment electronic health record (EHR) data is frequently inaccurate, comprised of copy and pasted content, with one study of over 104 million clinical notes denoting that 50.1% of documentation was duplicated from prior notes[36] while another study note that structured event data missed 27% of psychiatric study diagnoses.[37]

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[26] Skopec L, et al. "Reimagining the Medicare Advantage Risk Adjustment Program." *Urban Institute* May 2023. Available from: https://www.urban.org/sites/default/files/2023-05/Reimagining%20the%20Medicare%20Advantage%20Risk%20Adjustment%20Program_0.pdf

[27] Kronick R, Welch WP. Measuring coding intensity in the Medicare Advantage program. Medicare Medicaid Res Rev. 2014 Jul 17;4(2):mmrr2014.004.02.a06. doi: 10.5600/mmrr2014-004-02-a06

[28] Kronick, Richard and Chua, F. Michael, Industry-Wide and Sponsor-Specific Estimates of Medicare Advantage Coding Intensity (November 11, 2021). Available at SSRN: https://ssrn.com/abstract=3959446 or http://dx.doi.org/10.2139/ssrn.3959446

[29] Kang J, et al. "Making The Right Diagnosis: A Response To Berwick And Gilfillan." *Health Affairs Forefront*, July 8, 2022.

[30] See Figure 11-2 on page 353, "The Medicare Advantage Program: Status report." *MedPAC* March 2023. Available from: https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf

[31] "Estimating Medicare Advantage coding intensity and favorable selection." *MedPAC* March 2024. Available from: https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch13_MedPAC_Report_To_Congress_SEC.pdf

[32] See Figure 11-7 on page 356, "The Medicare Advantage Program: Status report." *MedPAC* March 2025. Available from: https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf

[33] Debusk B, Miller BJ, Craig Samitt, Kan K. "The Need for Holistic Policy Thinking in Medicare." *Health Affairs Forefront* May 23, 2024.

[34] Page 364 of "The Medicare Advantage program: Status report." *MedPAC* 2025. Available from: https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf

[35] Curto VE, Politzer E, Anderson TS, Ayanian JZ, Souza J, Zaslavsky AM, Landon BE. Coding intensity variation in Medicare Advantage. Health Aff Sch. 2025 Jan 16;3(1):qxae176

[36] Steinkamp J, Kantrowitz JJ, Airan-Javia S. Prevalence and Sources of Duplicate Information in the Electronic Medical Record. *JAMA Netw Open.* 2022;5(9):e2233348

[37] Madden JM, Lakoma MD, Rusinak D, Lu CY, Soumerai SB. Missing clinical and behavioral health data in a large electronic health record (EHR) system. J Am Med Inform Assoc. 2016 Nov;23(6):1143-1149. doi: 10.1093/jamia/ocw021. Epub 2016 Apr 14

Unsurprisingly, as part of the quest to improve diagnostic accuracy, health plans have undertaken both chart review and in-home health risk assessments, with research[38] suggesting that this drives higher risk scores. In contrast, others have claimed that FFS Medicare is undercoded, with one study utilizing historical data from 2017-2019, finding that FFS Medicare is undercoded by 2.85% or $8.1 billion,[39] a measure of magnitude that is worthy of repeat independent analyses with updated data.

Regardless of the magnitude, it is clear that both MA has greater coding intensity, some appropriate and some inappropriate while FFS Medicare is undercoded, with both factors contributing to a coding intensity gap between the two programs. A problem debated for over 20 years, coding intensity in MA can be solved through automation to improve data and payment accuracy.

Diagnosis coding can and should be automated

Automation of diagnosis coding would allow the simultaneous achievement of reducing clinician burden, enhance trust in the coding process, and improving accuracy of diagnostic coding in both MA and FFS Medicare in tandem. Doing so would address coding inflation that can occur when beneficiaries enter MA, ensure accurate payment to plans, and improve clinical communication.

Recognizing that competition is critical to product and service innovation, automation of diagnosis coding should not be centralized at CMS or completed by a CMS-contracted vendor, as vendors would have an incentive to undercode in order to reduce plan payments and thus win or maintain contracts/preferred status. Instead, policymakers should work to ensure both precision and accuracy through promotion of an organically grown, decentralized competitive market to drive competition with multiple third-party organizations/vendors approved or recognized by CMS. As a regulator, CMS could ensure that software products under appropriate validation by an independent third party standards development organization(s), tying this process to regulatory recognition.

Providers would select (or alternatively seek guidance from other providers or plans) and purchase software from an approved vendor or alternatively build the software internally and validate it across MA and FFS Medicare, ideally compared to a chart review control group. Alternatively, for some providers that may not have deep technological expertise such as small independent physician groups or critical access hospitals, plans may recommend but not require providers to use a recommended software vendor(s).

Operationally, while there are many potential solutions this could be executed as a "copilot" model in clinical practice, with a real-time validation and review by the clinician permitting correction or adjustment of suggested diagnoses. This de-burdens clinicians from the administrative task of diagnostic coding imposed on them by both health systems and plans, an important consideration with 62.8% of physicians reporting at least one manifestation of burnout[40] and time-motion studies showing that physicians spend as little as 25.8% - 44%[41,42] in direct patient care not engaged in the EHR. Furthermore, engagement of the clinician in review of automated diagnosis generated from AI-review of charts, labs, and imaging will further increase trust in diagnosis coding, while simultaneously eliminating gaps between FFS Medicare and MA coding.

The current MA risk adjustment model is calibrated on FFS experience and data. If diagnostic coding is improved and more uniform across both FFS Medicare and MA, given the increasing completeness of MA encounter data[43] and that MA now comprises just over half of the Medicare program, policymakers could consider transitioning the basis of MA risk adjustment from FFS experience and data to MA encounter data alone. Doing so would eliminate the

[38] Jacobs PD. In-Home Health Risk Assessments And Chart Reviews Contribute To Coding Intensity In Medicare Advantage. Health Aff (Millwood). 2024 Jul;43(7):942-949

[39] Ghoshal-Datta N, Chernew ME, McWilliams JM. Lack Of Persistent Coding In Traditional Medicare May Widen The Risk-Score Gap With Medicare Advantage. Health Aff (Millwood). 2024 Dec;43(12):1638-1646

[40] Shanafelt TD, West CP, Dyrbye LN, Trockel M, Tutty M, Wang H, Carlasare LE, Sinsky C. Changes in Burnout and Satisfaction With Work-Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic. Mayo Clin Proc. 2022 Dec;97(12):2248-2258.

[41] Ching MM, et al. "A Time-motion study of Emergency and hospitalist Physicians in a Community Hospital Setting." *Journal of Wellness* 2023;5(7):1-6.

[42] Young RA, Burge SK, Kumar KA, Wilson JM, Ortiz DF. A Time-Motion Study of Primary Care Physicians' Work in the Electronic Health Record Era. Fam Med. 2018 Feb;50(2):91-99.

[43] See Table 3-2, "Assessing data sources for measuring health care utilization by Medicare Advantage enrollees: Encounter data and other sources." *MedPAC* June 2025. Available from: https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_Ch3_MedPAC_Report_To_Congress_SEC.pdf

statutory, arbitrary minimum 5.9% coding intensity adjustment (per 1853 of SSA, (a)(1)(C)(ii)(IV))[44] and transition the program to improved data-driven risk-adjustment and more accurate plan payments, eliminating an artificial FFS anchor that distorts MA payment.

Plans would no longer have an economic incentive to engage in chart reviews and home health risk assessments, as Medicare beneficiaries would be subject to more precise, complete, and accurate diagnostic coding as part of routine clinical care regardless of whether they receive their health benefits through MA or traditional FFS Medicare. Accordingly, financial capital could be more efficiently redirected towards clinical care for beneficiaries and away from administrative operational activities targeting diagnosis code harvesting. Automation of diagnosis coding would improve accuracy and precision of both diagnosis and payment levels across programs, setting the stage for later risk adjustment of the FFS Medicare plan. Automation would also provide plans with less coding discretion, while addressing coding inflation that can occur when beneficiaries enter MA.

CMS could also work to undertake these efforts. Alternatively, Congress could require CMS to undertake action to transition diagnosis coding to an automated copilot or some other operational automated model, with internal or random audits of charts to validate special populations of regulatory concern, such as high cost or rare diseases. Regardless, execution via negotiated rulemaking could ensure that the interests of regulators, clinicians, health systems, and plans are balanced equally.[45]

This would mark a desperately needed transition of the 20+ year policy policy discussion around MA coding intensity from a debate over models towards operational solutions.

3. Improving prior authorization

Prior authorization remains a pervasive practice across all plan markets, encompassing both publicly-funded, privately-delivered health benefits markets such as MA and Medicaid MCOs in addition to private markets. With high administrative costs in the delivery, some experts have proposed a variety of changes such as:

- Elimination of or opposition to implementation of step therapy for drugs[46,47] and medical services
- Requiring review by a relevant clinical specialty[48,49]
- Elimination of prior authorization for low cost services
- Implementation of gold card programs[50]

And other interventions.

In contrast, other stakeholders have denoted prior authorization as an essential tool[51,52,53] to direct appropriate utilization, control cost, and steer care.

Regardless of where stakeholders, regulators, and policymakers sit, it is clear that both inappropriate and appropriate prior authorization generate administrative waste in the current system. The average physician fills out 37 prior

[44] https://www.ssa.gov/OP_Home/ssact/title18/1853.htm
[45] Similar actions could be undertaken to support automation of other components of FFS Medicare such as time-based billing for ambulatory care as a valid alternative to MDM billing.
[46] "PhRMA comments to administration on Medicare Part D proposed rule." *PhRMA* January 25, 2019. Available from: https://phrma.org/blog/phrma-comments-to-administration-on-medicare-part-d-proposed-rule
[47] "Step Therapy: Clinician's Concerns and Challenges." *American Academy of Ophthalmology EyeNet Magazine* April 2022. Available from: https://www.aao.org/eyenet/article/step-therapy-clinicians-concerns-and-challenges
[48] "Fixing prior auth: Give doctors a true peer to talk with—stat." *AMA* May 6, 2024. Available from: https://www.ama-assn.org/practice-management/prior-authorization/fixing-prior-auth-give-doctors-true-peer-talk-stat
[49] Walker M. "True peer-to-peer conversations will improve prior authorization." *STAT* April 6, 2025. Available from: https://www.statnews.com/2024/04/26/prior-authorization-true-peer-to-peer-conversations/
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authorization forms weekly[54] while the average oncologist's office has 6 full time staff to manage prior authorization.[55] Prior authorization affects a significant share of clinical visits, with a survey of an academic dermatology department finding that 6.6% of visits generated a prior authorization.[56]

Recent CMS rulemaking[57] has focused on prior-authorization reform,[58] with the 2024 final rule requiring payers to implement a payer-to-payer application programming interface (API) for continuity, a prior authorization API, and a patient access API in conjunction with standards for prior authorization decisions timeframes, provider notice, and denial reason. These nonpartisan and practical goals are to be admired, however, oversight and accountability for the plan, hospital, and physician industries will be critical to finally achieving operational success.

CMS could also require through rulemaking attached to Conditions of Participation, a requirement for payment, or some other method; Congress could exercise oversight of, or the Office of National Health Coordinator for Health IT could through the promulgation of meaningful use regulations, facilitate the retirement of fax,[59] paper, and separate submission of PDFs through third party web portals for prior authorization.

Ideally, CMS or ONC should require and Congress should exercise oversight to ensure that on a predetermined timeline that all prior authorizations are conducted through the electronic health record, with minimal burden for submission of clinical data (notes, labs, imaging) coupled with a regulatory requirement for the use of algorithms/automation for *approval only* in order to speed patient access, with health plan denial still being subject to human review prior to execution. While prior authorization will exist across Medicare and Medicaid for years to come, improving the process so that it is not unduly burdensome for patients and physicians and thus wasting taxpayer dollars is a critical first step.

4. Conclusions

Automation and AI offers us an incredible opportunity to improve government efficiency and simultaneously reduce waste, fraud and abuse in the Medicaid and Medicare programs. While there a litany of other operational opportunities, policymakers should focus on statutory change, oversight, and encouragement of CMS to target three operational areas:

1. Reducing improper payments in Medicaid: automation of eligibility determination and redetermination
2. Making diagnostic coding accurate again: increasing administrative efficiency in Medicare
3. Improving prior authorization

These are nonpartisan policy areas for operational improvements that will reduce costs, expand access, and unburden patients and clinicians. With the advent of DOGE and a renewed focus on operations, now is the time to act.

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