Sound Policy. Quality Care.

February 19, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1653-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-1653-NC; Medicare Program; Request for Information Regarding the Awarding and the Administration of Medicare Administrative Contractor Contracts (CMS-1653-NC)

Dear Acting Administrator Slavitt:

As the Alliance of Specialty Medicine (Alliance), our mission is to advocate for sound federal health policy that fosters patient access to the highest quality specialty care. It is for this reason we write to you today about our concerns with Medicare Administrative Contractors (MAC). Alliance member organizations have noted significant performance deterioration on key administrative activities by multiple MACs. In the paragraphs that follow, we outline our concerns and provide recommendations for performance standards that may improve MAC performance and hold MACs accountable in key areas.

MAC incentives for exceptional performance and MAC performance transparency

Local Coverage and Payment Policy Development and Implementation

The Alliance is concerned about the process by which MACs develop and implement local coverage and payment policies.

As outlined in the Medicare Program Integrity Manual, Chapter 13 – Local Coverage Determinations (LCD), Section 13.1.3, MACs are required to *" … develop LCDs by considering medical literature, the advice of local medical societies and medical consultants, public comments, and comments from the provider community...*" and *"…ensure that all LCDs are consistent with all statutes, rulings, regulations, and national coverage, payment, and coding policies…"* CMS also emphasizes that MACs

"…should adopt LCDs that have been developed individually or collaboratively with other contractors…" Section 13.7.2 further requires MACs to employ a notice and comment period for new LCDs and for substantively revised LCDs.

Alliance member organizations maintain that MACs have not lived up to these requirements. Specifically, MACs have not considered the most current and available peer-reviewed evidence; sought feedback from local medical societies, or in the absence of a local society, the national medical society; or sought input from recognized leaders in the specialty that are practicing in MACs jurisdiction, even when they have availed themselves to the contractor medical director (CMD). We also note that MAC LCDs can vary significantly across regions without any clear rationale or supportive evidence to justify the stark differences in coverage for certain items and services.

In addition, MACs are developing "other" coverage and payment policies, which they deem are not LCDs, and as a result, circumvent the required notice and comment period. For example, one MAC issued a policy related to coverage for certain Part B drugs, however there was no opportunity for beneficiaries or the provider community to weigh in on the policy. As a result, countless beneficiaries who were stable on their medication were forced to switch to another drug.

Furthermore, MACs vary significantly when it comes to other coding and billing policies. For example, some MACs will allow providers to bill for bilateral services using Modifier 50, where other MACs require the provider to bill each side on a separate line with RT and LT modifiers.

We recognize and appreciate that health care is local–reflective of important cultural and regional differences in patient populations, attitudes toward care, and care delivery. However, this does not account for stark differences in the process used by MACs to engage stakeholders in the development of local coverage and payment policy. Nor does it explain some of the coding and billing policies that MACs have established.

We strongly oppose these practices and urge CMS to implement new performance standards that would address these issues. Toward that end, CMS should:

- Perform annual audits of MACs coverage and payment policy development and implementation processes;
- Identify MACs that did not follow Medicare's LCD development requirements as outlined in the Medicare Program Integrity Manual, including "other" coverage and payment policies where the MAC circumvented the required notice and comment period;
- Require MACs to correct its coverage and payment policies and, in some cases, rescind coverage and payment polices where notice and comment was not employed or where policies are grossly inconsistent with other MACs;
- Develop a reward/penalty structure for those MACs who consistently/inconsistently follow Medicare's LCD development process; and,
- Publicly report the audit and evaluation results in an online "score card" format that is easily accessible by beneficiaries and providers.

In addition, we strongly urge CMS to require MACs to establish a "MAC ombudsman" to investigate beneficiary and provider complaints and resolve issues in a reasonable time frame (i.e., 30-90 days vs. 180 and longer).

We also suggest that Medicare revise beneficiary Medicare cards to reflect important information, such as contact phone numbers, addresses, and other key information that would better direct beneficiaries to their MAC for a variety of coverage and payment issues.

Finally, we urge CMS to make the Medicare Coverage Database available on the Medicare.gov site so it is more accessible to beneficiaries who may have questions about local coverage of items and services recommended by their physician. It should also list opportunities for beneficiaries to provide comment on draft local coverage and payment policies under consideration.

Potential MAC jurisdictional changes

Alliance member organizations are concerned with the consolidation of MACs. It is unclear whether MAC consolidation has produced any financial savings and/or efficiencies to the Medicare program, the trust fund, or taxpayers. We do, however, note a sharp decrease in provider customer service and exceedingly long wait times for assistance on various provider issues, including enrollments, revalidations and appeals.

We note that several MACs are owned and operated by a single entity, which is of equal concern. For example, Novitas Solutions (which includes the former Highmark Medicare Services) and First Coast Service Options are owned and operated by Diversified Service Options, Inc., a wholly-owned subsidiary of Blue Cross and Blue Shield of Florida. Similarly, Celerian Group owns and operates Palmetto GBA and CGS Administrators, LLC. Coincidentally, these MACs are among those that have been identified by Alliance organizations as posing significant challenges in each of the aforementioned areas, as well as in the development of local coverage and payment policies discussed above.

Until there is robust evidence to support proceeding, we urge CMS to delay the final two jurisdictional consolidations.

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Thank you for considering our comments on these important issues. Please let us know if you have any questions or if we can provider more detail about our recommendations. Should you have any questions, please contact Emily Graham, RHIA, CCS-P, at egraham@hhs.com or 703-975-6395, if we can be of further assistance.

Sincerely,

American Academy of Facial Plastic & Reconstructive Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society of Echocardiography
American Society of Cataract and Refractive Surgery
American Society of Plastic Surgeons
American Society for Dermatologic Surgery Association
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
National Association of Spine Specialists
Society for Cardiovascular Angiography and Interventions