AMA AMERICAN MEDICAL ASSOCIATION

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G 200
Independence Avenue, SW
Washington, DC 20201

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate this opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information (RFI) on the potential consolidation of Medicare Administrative Contractor (MAC) jurisdictions and increasing contract award periods of performance. Specifically, CMS proposes to combine Jurisdictions J5 and J6 into "Jurisdiction G" and Jurisdictions J8 and J15 into "Jurisdiction Q" and increase contract award periods from seven to 10 years. In addition, the Agency is considering raising the current contract award limit, which currently stipulates that a single contractor cannot control more than 26 percent of the total Medicare A/B claims workload.

Need for Additional Transparency

In the RFI, CMS explains that in the early 2000s it pursued MAC jurisdiction consolidation for the same four jurisdictions. However, it paused consolidation in 2014 "in the interest of promoting long-term program stability by building a competitive pool of contractors." CMS never states its reasoning for resuming consolidation at this time nor clarifies whether previous concerns regarding competitiveness have been sufficiently alleviated or superseded by other considerations. Further, the Agency does not provide justification or supporting data for why it selected these specific four MAC jurisdictions for consolidation, or whether it has anything to do with the performance of the MACs that currently manage them. Notably, two MACs (Wisconsin Physicians Service (WPS) and CGS Administrators, LLC (CGS)) would have all their jurisdictions subject to consolidation. CMS does not provide insight into its plans for reassigning these jurisdictions, whether it would be to one of the two MACs whose jurisdictions would be consolidated, or whether it would be assigned to a new MAC entirely, or how workloads would be distributed. Several questions in the RFI coupled with CMS' proposal to increase the contract award limit suggest that CMS is considering awarding contracts for newly consolidated jurisdictions to new MACs. Equally unclear is whether CMS' ultimate goal is to reduce the total number of MACs. **CMS needs to provide justification and data supporting these changes and the benefit they would bring to Medicare beneficiaries and physicians followed by another feedback opportunity.**

MAC Concerns Remain Unresolved

The lack of responsiveness by CMS and the MACs regarding concerns that the AMA has previously raised over the MACs lack of transparency and stakeholder input into the coverage determination process makes the AMA concerned that these problems could be exacerbated under an increasingly monopolized environment if these problems are not addressed prior to consolidation.

We have received repeated examples of MACs leveraging local coverage articles (LCAs) to implement substantive coverage changes bypassing the need for input from physicians or other experts, which can lead to serious patient safety concerns. This largely began in 2019 when CMS moved diagnosis and procedure codes from local coverage determinations (LCDs) to LCAs. Unlike LCDs, LCAs are not subject to notice and comment, nor the same criteria as LCDs, including reasonable and necessary and evidentiary support standards. These changes are often implemented with little advance notice, leading to billing issues and burden on practices. Importantly, these changes can lead to disparate access to care across the country depending on where a Medicare beneficiary is located. As the number of LCA-based coverage restrictions are on the rise, the AMA fears that further consolidation could make these existing coverage limitations more widespread while making MACs even less responsive to physician concerns.

Another point of concern is the lack of clinical input into the Medicare coverage determination process. Prior to the 2019 changes, MACs were required to hold a minimum of three Contractor Advisory Committee (CAC) meetings per year to discuss draft LCDs and other Medicare coverage-related issues with physicians and other experts. Since the 2019 changes went into effect, CAC meetings occur intermittently at the discretion of the MAC often at inconvenient times for practicing physicians while MACs have also moved increasingly towards informal meetings on narrow topics with "subject matter expert (SME) panels," with limited advance notice, transparency, or public engagement. Medical state societies and specialties are often not made aware of such meetings, or if they are, the process to nominate participants remains informal and opaque. When nominations are offered, they are often denied without justification. The CAC meetings themselves are limited to "evidence only" discussions, as physician specialty societies are often reminded, which begs the question why are these discussions limited to evidence base only in the first place? Shouldn't a clinical understanding of patient and outcomes be equally if not more important? If CAC meetings are not the appropriate venue, then shouldn't there be another point in the process where physician input is considered?

The AMA understands from CMS that MACs are under pressure to move LCDs quickly and that CAC meetings can belabor the process. However, while we understand the need to advance LCDs in timely fashion, industry pressure should never supersede patient safety. Moreover, it can take more time to rectify poor coding changes on the backend, often taking several months or even years to resolve. We also understand from CMS that MACs report difficulty getting sufficient physician recruits to volunteer for CACs. However, we hear from medical state societies and specialties that the process can be opaque and they are often unaware of how CAC members are selected or when meetings occur, and that the process varies substantially from MAC-to-MAC. The AMA believes all these concerns could be alleviated and the process substantially improved with more transparency and consistency across MACs. **We urge CMS to convene MACs, physicians, and other interested parties to agree on a set of standards for selecting members of CACs and SMEs and standardized processes for soliciting stakeholder engagement in general. We offer our willingness to engage medical state societies and specialties to this end.**

To be clear, these experiences all substantially differ across MACs, therein lies the point. The AMA appreciates that CMS is soliciting feedback about criteria to measure the level and quality of the service

provided by MACs in this RFI. We believe these potential changes present an opportunity to ensure MACs are providing a consistent, high caliber service on behalf of Medicare beneficiaries. However**, it is critical that previous concerns over lack of transparency and stakeholder engagement into the Medicare coverage determination process be addressed before CMS consolidates jurisdictions or market power amongst MACs, including increasing the prime contract award limit and extending contracts. Additionally, any changes to the size or length of MAC contracts should only move forward if they are tied to transparent, concrete criteria to ensure MACs are meeting contract requirements and providing high-caliber service, which should be subject to stakeholder input before being finalized and regularly evaluated regardless of contract duration.** The AMA reiterates our willingness to work with CMS, MACs, and others to develop workable solutions to this end.

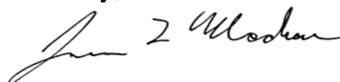
Transparent Evaluation Criteria Needed

Regarding what criteria should be considered, the AMA offers the following, which incorporates previous AMA recommendations, as well as feedback from several medical state societies and specialties:

- MACs should be required to subject all Medicare coverage determinations (i.e., coding changes) to reasonable and necessary parameters, patient safety considerations, and evidentiary support standards regardless of whether they are advanced through an LCA or LCD;
- MACs should be required to solicit feedback from clinical experts via a mandatory public notice and comment process and at least one public meeting (CAC or otherwise) where parties may offer insights on scientific evidence, as well as clinical practice and patient need for any change in Medicare coverage where access to services would be affected, regardless of whether this change occurs through an LCD or LCA;
- MACs should be required to select and vet participants for CACs and SME panels based on transparent, objective criteria via a formal, transparent process which could include publicly posting rosters (like MedCAC does for NCDs) and/or making a public call for new members (which would be consistent with MedCAC policies);
- MACs should be required to respond to stakeholder determination or redetermination requests for both LCDs and LCAs as part of a timely, transparent process; and
- Contract renewals/extensions should be subject to physician satisfaction scores and other metrics of the efficacy and timeliness of claims payment and Medicare coverage determinations such as processing time, level of stakeholder engagement and transparency, degree to which patient access was positively or negatively impacted by coverage or coding changes, etc. The AMA welcomes opportunities to work with CMS and stakeholders to develop this criteria.

Thank you for this opportunity to comment on these important potential changes to MAC jurisdictions and contracts that could shape future Medicare coverage policies. We believe this juncture presents a critical opportunity to meaningfully improve the integrity and accuracy of the Medicare coverage determination process and improve patient access to care and safety in the process, and we reiterate our offer to serve as a conduit to this end. To further discuss the content of this letter, please contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org.

Sincerely,



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