



January 16, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Program, and the PACE Program

Dear Ms. Verma:

The American Society of Cataract and Refractive Surgery (ASCRS) is a medical specialty society representing nearly 9,000 ophthalmologists in the United States and abroad who share a particular interest in cataract and refractive surgical care.

We appreciate this opportunity to provide comments in response to the requests for information included in the proposed rule. We are pleased that among the items for which you seek comment are strategies for reducing physician burden related to Medicare Advantage (MA) risk adjustment audits and opportunities for improving the information provided to beneficiaries selecting (MA) plans as part of the Star Ratings program.

Specifically, we encourage CMS to consider and implement the following policies related to these requests for information, including:

- Reduce administrative burden on practices by limiting MA plans' ability to require plan participants to provide beneficiary records as part of risk adjustment audits not initiated by CMS.
- Improve the Star Ratings program to rate MA plan network adequacy, including access to specialists.

Easing the Burden on Physician Practices

We appreciate the emphasis this administration has placed on reducing regulatory burdens in all sectors. The healthcare industry is no different than any other industry coping with complex, overlapping, and punitive regulations that not only drain practice resources, but ultimately take away from time spent providing patient care. As ophthalmologists, our members primarily practice in office-based settings of solo or small groups of practitioners. In addition, ophthalmologists treat a relatively older patient population that overwhelmingly participates in the Medicare program, either Part B or C.

We hear frequently from practices that MA plans are the source of frustration due to overly burdensome and confusing audit requests and increasingly narrow plan networks that exclude many specialists. Not only do these issues impose significant regulatory burdens on practices, but they also risk limiting beneficiaries' access to care.

Risk Adjustment Audits

We appreciate CMS' inclusion of an RFI related to chart audit requests in this proposed rule. Many of our members have expressed concern about a recent increase in the magnitude and frequency of requests made by various MA plans. We have brought this issue to the attention of HHS and CMS, and have continued to provide details about the tactics used by these insurers.

- **Ophthalmology practices are frequently required to provide patient charts to MA plans conducting risk adjustment audits to improve their own chances of receiving additional funding from CMS.** In many cases the requests are for a hundred or more charts with deadlines to comply in as little as a few days or a week. Pulling relevant patient charts and preparing them for submission is a labor-intensive activity, and small practices generally do not have enough staff to devote to complete the task in the required time.
- **Ophthalmology practices have reported receiving conflicting information, incomplete instructions, and an inability to receive additional information or have questions answered from insurers.** Frequently, practices note the requests for charts include beneficiaries not treated by the practice. In addition, the chart audit requests are generally conducted by an outside vendor who may not be able to respond to reasonable questions from the practice, such as whether the audit is being conducted at CMS' direction or only to improve a plan's risk adjustment scores.
- **In response to requests from HHS earlier this year, ASCRS reached out to several members who had reported a high volume of chart audit requests.** Selected responses from members are included in Appendix A of our comments on this proposed rule.

Strategies for Reducing Physician Practice Burden

CMS' RFI asks for specific recommendations to improve the process and reduce physician burden.

- **Our chief recommendation is to limit MA plans' ability to conduct risk adjustment audits that are outside of CMS' Risk Adjustment Data Validation (RADV) audits.** ASCRS believes the RADV audits provide adequate information to determine a plan's individual risk levels. However, given that many plans require physicians to comply with additional audits as a condition of their provider agreements, **CMS should act to limit the scope and frequency of these audits to reduce provider burden.**
- **Require MA plans to provide specific details on the audit they are conducting, indicating whether the audit is required by CMS or not.** Frequently, plans or their survey vendors send misleading letters to practices demanding the charts and noting that CMS requires plans to conduct chart audits. While CMS may require the RADV audits in general, there is rarely any indication that a specific chart request is part of a CMS-initiated audit. This may cause practices

to believe they will be penalized by CMS in some way if they do not comply with the audit. **The MA plans should be required to include notification with all chart requests stating the reason for the audit and whether the chart request is a direct requirement from CMS.**

- **CMS should limit the frequency and number of charts an MA plan can request from a practice within a specific timeframe, such as a year.** Frequently, practices report that if they have complied with a plan's initial request for charts, it is often followed by another large request within a short period of time. CMS should set a limit on the number of times an MA plan may contact a practice with a chart request, such as once per year, as well as the number of beneficiaries' charts that may be accessed.
- **CMS should require standardized requests from MA plans seeking chart audits.** Many practices report that each insurer or survey vendor has different formats, time limits, or other requirements. Complying with multiple different chart audit requests seeking varying information in several different formats contributes significantly to the administrative burden in small and solo practices. CMS should work with MA plans to develop standardized forms and submission mechanisms to streamline physician response to chart audit requests.

Again, we thank CMS for including this RFI in the proposed rule and willingness to address physician regulatory burden caused by these audits. We have provided extensive information about these audits from our members in Appendix A and encourage CMS to contact ASCRS if additional information is needed.

MA Star Ratings: Ensuring Access to Specialty Care through Adequate Networks

ASCRS is dedicated to ensuring patients have continued timely access to specialty care, and we appreciate that CMS is seeking recommendations for ensuring beneficiaries have the most relevant and useful information available through the Star Ratings program. While the current information provided allows beneficiaries to weigh each plan's relative quality ratings, affordability, and other factors, many of our members have reported that beneficiaries are frequently surprised when a physician whom they believed was in a network is no longer included, or that there are only a few or, in some cases, no specialists in the network who treat certain conditions. **ASCRS recommends CMS include the plan's network adequacy, specifically access to specialty care, as a key determinant of a plan's star rating.**

Ophthalmologists not only provide surgical care, such as for cataract surgery, but also provide ongoing care for chronic diseases, such as glaucoma and age-related macular degeneration. Patients with chronic eye disease need intensive, specialized, and uninterrupted care to prevent disease progression or complete blindness. We have heard frequently from practices who have been removed from MA plan networks in the middle of the benefit year, without cause, or who are not accurately listed in MA plan directories. These changes by MA plans risk worsening the condition of beneficiaries who are in stable condition under the care of a doctor whom they expected to be in-network.

Narrow Networks

- Physicians and beneficiaries alike have long expressed frustration at insurer tactics that narrow their provider networks to the point that beneficiaries either have no choice of in-network

providers, or even have no in-network providers treating certain diseases. Many times, these network decisions come in the middle of the benefit year, and so beneficiaries who selected specific plans to ensure they had continued in-network access to their physicians may be left with the choice of not using their plan's benefit or finding a new doctor. Disruptions during treatment for chronic diseases, such as glaucoma, diabetic retinopathy, or macular degeneration, could severely impact the progression of the disease. Glaucoma patients who do not receive regular pressure checks, and diabetic retinopathy or macular degeneration patients who do not receive scheduled injections, all risk losing their sight completely. If a physician treating these patients is removed from a plan unexpectedly, it may result in a delay of care for the beneficiary.

- In some cases, insurer efforts to narrow their networks have left plans without specialists who treat certain diseases. For example, we heard from some practices who were dropped from plans and are the only practices in their area with corneal or uveitis specialists. Often, sub-specialists treat the sickest and most complex patients. MA plans that remove these sub-specialists from their networks are limiting access to beneficiaries who need the most care.
- **CMS has acted in the past to discourage plans from engaging in tactics to narrow networks in the middle of the benefit year, but we encourage CMS to prioritize ensuring MA plan networks are robust enough to offer beneficiaries a choice of physicians and the assurance that they will be able to use their MA benefits for the treatments they require. We recommend CMS take steps to ensure beneficiaries are aware of which physicians are in-network, and incorporate a measurement of the plan's access to specialists in the star ratings.**

Conclusion

ASCRS again thanks CMS for the opportunity to provide input on this proposed rule. CMS must act to implement policies that mitigate the regulatory burden related to risk adjustment chart audits and must provide beneficiaries with information about an MA plan's network adequacy as part of the Star Ratings program. We encourage CMS not only to implement our recommendations, but to work further with the specialty medical community to ensure all beneficiaries have timely access to the specialty care they need.

If you have questions, please contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

Sincerely,



Bonnie An Henderson, MD
President, ASCRS

Appendix A

ASCRS and American Society of Ophthalmic Administrators (ASOA) member responses to July 2017 request from HHS for examples of MA plan chart audit requests:

Following conversations with HHS staff in the summer of 2017, ASCRS•ASOA reached out to some of our members who have received several onerous chart audit requests from MA plans.

Not all requests are the same, but they do tend to follow some patterns:

- Two vendors, CiOX and ArroHealth, seem to be conducting most of the audits for BC/BS plans, such as Highmark, UnitedHealth, and Humana.
- None of the examples sent reference-specific CMS-initiated audits, but many of the letters mentioned CMS, making it seem like they are being requested by the agency.
- The requests generally ask for specific patient charts but don't reference particular diagnoses. ASCRS asked the practices that responded if they suspected there was a common factor in the patients whose charts were requested. Not all could establish one, but those who did mentioned that the patients tend to be diabetic, some with other ocular disease, such as glaucoma.

Documentation provided by the practices is included in the following pages. Below is a summary of each practice.

Practice 1, Jenkintown, PA:

The audit comes from Highmark BC/BS through Arrohealth, asking for 13 charts from dates of service in 2016. The practice refused to supply the charts until the contractor or plan produces a letter from CMS authorizing the audit.

Practice 2, Allentown, PA:

The practice administrator said that he couldn't determine if there were common diagnoses, but that Highmark tended to ask for family members/spouses when identifying patients. He provided the following list of recent requests:

- Capital Blue Cross: 25 charts
- Aetna: 8 charts
- Coventry: 4 charts
- Well Med: 2 charts
- United HealthCare: 84 records
- Highmark: 260 records
- **Since March–May, a total of 383 records were requested. We have not complied with these last two large requests. They have not responded to my reply.**
- There is also correspondence included from the practice back to the contractor or plan.

Practice 3, Ypsilanti, MI:

Received a request for 256 charts from BC/BC of Michigan. The practice will ask for \$5/per chart to comply. The request did not specify how many charts; the practice only found out when calling to discuss the charge for providing the patient records. Most of the patients in the request are diabetic, but the practice has no retina specialists, so its patients don't tend to have severe diabetic-related eye disease.

The practice received another request from Priority Health through the vendor Altegra Health for 100 patients; this was followed up with a request for 25 more charts of diabetic patients.

This practice also noted that it frequently gets audit requests for beneficiaries who are not the practice's patients.

The practice always asks for additional time to fulfill the requirements because it is necessary to wait until the doctor is out of the office to have staff available to do it.

Practice 4, Birmingham, MI:

Recent chart request in June from BC/BS of Michigan asking for 87 charts. Another from Humana with 65 charts. The administrator for this practice said that she initially got occasional requests for 3 to 5 charts and always complied. Now that she has done that, she's getting more frequent requests for increasing large numbers of charts. Directly quoting ASCRS' conversation with her, she said that she feels "penalized for being cooperative."

Practice 5, Honolulu, HI

A smaller request for 17 charts was received from UHC, but the administrator had a good example. Quoting from email: "I've attached one of the requests that we have received from UHC. Based on the patients they requested, they are requesting over a range of things, but the bulk of it is DM. They have been pretty sneaky with the way that they send records request to us, (i.e., one request with 17 charts, two weeks later another request for three charts, one week later another request for two to five charts)."