April 24, 2017

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

Re: Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information; Attachment 1, Request for Information

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 request for information included in the 2018 Medicare Advantage (MA) Final Call Letter. We are pleased that among the items for which you seek comment is support of the doctor-patient relationship in care delivery. **ASCRS is committed to ensuring that all Medicare beneficiaries, both those with traditional Part B and those who have chosen to join an MA plan, have continued access to timely specialty care.**

We encourage CMS to consider and implement policies that maintain a strong relationship between physicians and their patients, including:

- Easing administrative burden on practices by reforming the risk adjustment audit process and discouraging the increased use of prior authorization;
- Ensuring adequate coverage of specialists in MA plan networks, or requiring plans to offer out-of-network options;
- Prohibiting plans from making network changes in the middle of the benefit year;
- Requiring up-to-date provider directories; and
- Implementing appeal processes for physicians and practices who have been terminated from plans without cause.

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 cost practices 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 who are overwhelmingly 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 tactics, such as prior authorization, to deny coverage for certain services. We urge CMS to provide additional oversight on MA Plans to ensure these requests do not overly burden physician practices.

Risk Adjustment Audits

- Ophthalmology practices are frequently required to provide patient charts to MA plans who are undergoing risk adjustment audits. 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.

- While we understand that these audits are for the MA plans themselves, and thus not punitive to the practices, they are an added burden to practices already facing many other regulatory requirements. MA plans must be able to provide a letter from CMS confirming the chart audit, but there is no standardization across plans to indicate how many and in what time frame the charts must be submitted. **We recommend CMS act to ensure that MA plans undergoing risk adjustment audits do not shift undue administrative burden to practices in their networks.**

Prior Authorization

- ASCRS and our partners in the Alliance of Specialty Medicine, a coalition of 13 medical specialty organizations, recently surveyed our combined membership and found that an overwhelming majority of our members have noted an increase in the use of prior authorization by private plans, including MA. Eighty-nine percent of Alliance members have seen an increase in prior authorization for procedures, 82% have seen an increase for diagnostic tools, 60% for site of service, and 79% for prescription medications.

- Ninety-four percent of Alliance members noted that increased administrative burdens by insurers have influenced their ability to practice medicine, and 93% have prescribed a different course of treatment due to delay tactics by insurers related to the original or first-choice prescription.

- **MA plans are required to provide the same covered services as Medicare Part B. Delay tactics, such as prior authorization, unfairly deny timely and needed care to beneficiaries who are entitled to coverage of certain services. The doctor-patient relationship can be supported and**

strengthened by discouraging the increased use of delay tactics, such as prior authorization, and trusting physicians to make the best treatment decisions for their patients.

MA Plan Networks: Ensuring Access to Specialty Care

ASCRS is dedicated to ensuring patients have continued timely access to specialty care. 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 who 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 that all MA plans offer some options for out-of-network benefits to beneficiaries whose physicians may have been removed from the plan during the benefit year.**

- Many practices complain that MA plan directories are inaccurate or incomplete. Without accurate provider directories, beneficiaries will not be able to choose plans that meet their

needs. **CMS must ensure MA plans keep provider directories up to date so that beneficiaries have assurance that they will be able to see the physician of their choice.**

- Frequently, when MA plans make network coverage decisions, they do so without consulting the participating physicians and do not provide any means of appealing or re-negotiating the decisions. Physicians have no opportunity to demonstrate how these decisions will affect their patient population or limit beneficiaries' access to care. **CMS must ensure physicians have a clear and reliable method to repeal network participation decisions.**

Conclusion

ASCRS again thanks CMS for the opportunity to provide input on MA reforms to support the doctor-patient relationship. As more beneficiaries choose MA plans, it is incumbent upon CMS to ensure they receive the same covered benefits and timely access to care as they would under Part B. Burdensome audit and prior authorization requests are costly and labor intensive for small practices and take time away from patient care; and narrow networks and confusing provider directories limit or deny beneficiaries the ability to use their MA benefits. MA plan tactics are frustrating for physicians, but ultimately, they mean patients suffer the most. 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,

Kerry D. Solomon, MD
President, ASCRS