American Society of Cataract & Refractive Surgery (ASCRS)
Statement for the Record
House Ways and Means Committee
Subcommittee on Health
"Hearing on Status of and Quality in the Medicare Advantage Program"

Tuesday, May 8, 2018

Chairman Roskam, Ranking Member Levin, and members of the Subcommittee, thank you for the opportunity to provide feedback on ophthalmologists' experiences and recommendations for the Medicare Advantage (MA) program.

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 a statement for the record for this hearing on the MA program. We were disappointed that the hearing did not include any witnesses representing the medical community or address the issues ASCRS and our colleagues across the medical community—from both specialty and primary care providers—have identified related to the burden many MA plans place on physician practices, particularly ophthalmologists, who tend to work in solo or small group practices.

Specifically, we encourage Congress to provide oversight of CMS' policies related to MA plans and encourage the agency to address these issues or implement the following, 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;
- Limit the use of, and streamline the prior authorization process;
- Ensure adequate coverage of specialists in MA plan networks, or require plans to offer out-of-network options;
- Prohibit plans from making network changes in the middle of the benefit year;
- Require up-to-date provider directories; and
- Implement 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 subcommittee has placed on reducing regulatory burdens on physician practices. Physician practices are 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, increasingly narrow plan networks that exclude many specialists, and increased use of prior authorization. Not only do these issues impose significant regulatory burdens on practices, but they also risk limiting beneficiaries' timely access to specialty care. **We urge the subcommittee to provide further oversight of the MA plan to ensure that insurers' requirements are not overly burdensome on physician practices and do not limit beneficiaries' timely access to specialty care.**

Risk Adjustment Audits

Many of our members have expressed concern about a recent increase in the magnitude and frequency of requests to review patient charts made by various MA plans. These audits are not directed by CMS and serve only to improve the MA plans' risk adjustment scores. Physician practices are being inundated with additional work that provides them with no benefit. We have brought this issue to the attention of HHS and CMS, and raised it during recent roundtable discussions with Ways and Means Committee members. We 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 completing 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.

Recommendations for Reducing Burden from Chart Audit Requests

- **ASCRS recommends Congress work with CMS 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, **Congress should encourage CMS to limit the scope and frequency of these audits to reduce provider burden.**

- **MA plans should be required to provide specific details on the audit they are conducting, indicating whether the audit is at the direction of 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.**

- **Congress should encourage CMS to 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.

- **MA plans should be required to use standardized requests when 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.

In response to requests from HHS last 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 this statement for the record.

Ensuring Access to Specialty Care through Adequate MA Plan Networks

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. 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. **We urge Congress to work with CMS to ensure that MA plan networks are sufficiently robust to ensure beneficiary access to specialty care.**

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, 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. 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. **Congress should encourage CMS to 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.**

Finally, physicians often have no recourse for appealing when MA plans make network coverage decisions that affect beneficiaries' access to care. Frequently, MA plans make these decisions 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. **Congress must work with CMS to ensure physicians have a clear and reliable method to repeal network participation decisions.**

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 Congress to work with 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.

Reducing the Burden of Prior Authorization Requests

ASCRS and our coalition partners in the Alliance of Specialty Medicine, in addition to the entire medical community, have frequently commented to this committee and to CMS that MA and Part D plans' increased use of prior authorization requests has become a key source of physician regulatory burden. Practices are inundated by prior authorization requests from plans for nearly every treatment or drug—even for generics. The tactics employed by these plans not only increase the administrative burden for practices, but delay—and may ultimately deny—beneficiaries' needed care. **We recommend Congress work with CMS to encourage plans to limit their use of prior authorization and to standardize and streamline requests.**

In 2017, ASCRS and our coalition partners in the Alliance of Specialty Medicine, a coalition of 14 medical specialty organizations, 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 the last five years 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.

Key Recommendations Related to Prior Authorization

- **Congress should work with CMS to streamline the prior authorization process used by Medicare Advantage and Part D plans by requiring standardized forms and electronic transactions.** Practices report that not only do they have difficulty in keeping up with the volume of requests from plans, but that each requires the response in a different format or method of communication. The process should be streamlined with standardized forms that can be submitted and adjudicated through electronic means to reduce the burden on practices and ensure beneficiaries receive timely treatment.

- **We encourage sparing use of prior authorization to ensure timely delivery of standard, evidence-based treatment for given conditions that is not based solely on cost criteria.** Physicians cannot control the cost of the drugs they prescribe. At a time when even the cost of generic drugs is increasing steeply, physicians who may strive to use the most cost-effective treatments for their patients may have no other option than to prescribe high-cost drugs. **MA plans must be mindful of the costs physicians can reasonably be able to control and not require prior authorization for standard, evidence-based care.**

- **To ensure MA plans are covering the evidence-based care, we recommend that prior authorization requests be reviewed by a specialist of a similar discipline.** Encouraging this review through true "peer-to-peer" dialogues would ensure that patients receive the care they need without delay. Ophthalmology, for example, is highly specialized and medical students are not routinely instructed in the treatment of ocular disease. A primary care physician, or even in some cases a pharmacist, reviewing the prior authorization request submitted by an ophthalmologist is unlikely to have the requisite knowledge to evaluate the appropriateness of the treatment the ophthalmologist is recommending. **Prior authorization for pharmaceutical therapy on behalf of a patient should be routed to a specialist in the same or similar discipline with expertise in the given condition to discuss the request—not a physician or pharmacist who is unfamiliar with disease processes and care management.**

Conclusion

ASCRS again thanks the subcommittee for the opportunity to provide a statement for the record. We ask that Congress work with CMS to implement policies that mitigate the regulatory burden related to risk adjustment chart audits, ensure adequate MA plan networks, and to reduce the burden on practices

from prior authorization requests. We encourage Congress 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.

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, UnitedHealthCare, 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.

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
- UnitedHealthCare: 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 increasingly 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)."