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January 08, 2018

Ms. Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4182-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8013

Re: File Code CMS-4182-P: **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 Programs, and the PACE Program*; Proposed Rule (Federal Register Vol. 82, No. 227)***

Dear Administrator Verma:

We appreciate the opportunity to provide comments on the proposed changes to the Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program rule published in the Federal Register on November 28, 2017. Mayo Clinic is a not-for-profit health care system dedicated to medical care, research and education. With more than 8,000 eligible clinicians under the Quality Payment Program and 60,000 employees, Mayo Clinic demonstrates a relentless and unwavering commitment to excellence which has spawned a rich history of health care innovation. Each year, more than one million people from all 50 states and 140 countries come to Mayo Clinic to receive the highest quality care at sites in Minnesota, Arizona and Florida. In addition, Mayo Clinic Health System, a family of clinics, hospitals and health care facilities, serves communities in Iowa, Minnesota and Wisconsin. We respectfully submit the following comments to this proposed rule.

II. Provisions of the Proposed Regulations

B. Improving the CMS Customer Experience

13. Reducing Provider Burden – Comment Solicitation

In this proposed rule, CMS requests recommendations on ways the Agency can address unnecessary burdens physicians experience when producing medical record documentation for Medicare Advantage (MA) plans. The Agency specifically requested information on the extent of the record requests and ideas for improving the overall MA record request process. In this letter, ASTRO seeks to respond to CMS' solicitation for comments on reducing provider burden associated with medical record documentation requests made by MA

organizations, particularly requests made by third party organizations such as radiation oncology benefit management companies (ROBMs).

Radiation Oncology Benefit Management (ROBM) Companies

We appreciate CMS' interest in reducing administrative burden when it results in higher quality care and a more efficient health care system. In recent years, ROBMs have entered the radiation oncology marketplace to manage private insurer payments to providers for radiation therapy services. Through their proprietary medical policies and authorization procedures, ROBMs evaluate and approve radiation treatment courses as a condition of payment to the provider. Some private payers, such as UnitedHealth Care, have also incorporated ROBMs into the management of Medicare Advantage populations.

We expect this trend to expand, which is troublesome for Medicare beneficiaries and their providers, because frequently these ROBMs are disregarding existing National and Local Coverage Determination policies in favor of more restrictive policies that result in delayed care and high rates of inappropriate denials that are frequently overturned.

ROBMs that operate on behalf of Medicare Advantage Plans should be required to acknowledge the National and Local Coverage Determinations issued by CMS. This is consistent with the Social Security Act Section 1852(1)(A) that states,

> In general.—Except as provided in section 1859(b)(3) for MSA plans and except as provided in paragraph (6) for MA regional plans, each Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1854(f)(1)(A))
>
> (B) Benefits under the original medicare fee-for-service program option defined.—
>
> (i) In general.—For purposes of this part, the term "benefits under the original medicare fee-for-service program option" means those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or, subject to clause (iii),an actuarially equivalent level cost-sharing as determined in this part.

Medicare guidance also requires MA plan benefits to include at a minimum the same benefits that are covered under Original Medicare. The Managed Care Manual (100-16) Chapter 1, Section 10 – Introduction

> *CMS encourages MA organizations* to *design packages that provide a variety of high quality* benefits *at a* reduced *cost to Medicare beneficiaries. Under an MA plan, at minimum,* beneficiaries *receive the same benefits that are covered under Original* Medicare, *and in most cases, also receive* Part D *prescription* drug *benefits through the plan. Effective in 2011 for contract year 2012, a*ll beneficiaries have the opportunity to *change MA* plans or to *return to Original* Medicare during the annual election period (*fall* open season) *from October 15 through* December *7.*

These coverage policies are adhered to by the various Medicare Administrative Contractors and should also be adhered to by Medicare Advantage plans, as well as the ROBMs they employ.

We endorse professionally developed and vetted clinical practice guidelines, appropriateness of care criteria and consensus-based model policies when they are developed in a transparent manner with peer review and input as the foundation for clinical decision making. However, too often physicians face overly restrictive ROBM guidelines that oversimplify the process of individual patient management and abrogate the professional judgments that are often only possible within the private boundaries of a direct patient-doctor relationship.

Additionally, we support the Prior Authorization and Utilization Management Reform Principles[1] developed by the AMA and other physician groups. These Principles emphasize the clinical validity of benefit manager policies, allow needed care to continue during reviews, complete transparency and fairness on policies and process, timely reviews that don't add administrative burden, and a focus on outlier physicians only.

We are aware of complaints regarding ROBMs increases in denials and delays in preauthorization of services, patient treatment or provider payment. These activities have often caused distressing delays in care for cancer patients, as well as increased costs for providers and their practice staff who must navigate the ROBM authorization processes and inadequate peer-to-peer reviews of contested cases. We urge CMS to reign in this activity through its authority to regulate Medicare Advantage plans, as ROBM activity is increasingly burdensome and ultimately jeopardizes the quality of cancer care. We request CMS implement the SSA requirement for MA plans that use ROBMs to provide coverage for the same services Medicare fee-for-service patients receive coverage as identified in the national coverage determination (NCD) and local coverage determination (LCD) process.

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Thank you for the opportunity to comment on the proposed rule and for consideration of our comments. If you should have any questions, please contact Donald Hertel at (507) 284-8605 or me at (507) 284-4627.

Very truly yours,

Ronald Grousky

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cc: Jennifer Mallard, Mayo Clinic
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[1] https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf

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