



January 16, 2018

The Honorable Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
2000 Independence Avenue, SW
Washington, DC 20201

RE: Proposed Policy Changes and Updates for Medicare Advantage and the Prescription Drug Benefit Program for Contract Year 2019 (CMS-4182-P)

Dear Administrator Verma:

The Medical Group Management Association (MGMA) submits the following comments in response to the proposed rule entitled, “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,” published on Nov. 16, 2017, with file code CMS-4182-P.

MGMA is the premier association for professionals who lead medical practices. Since 1926, through data, advocacy and education, MGMA empowers medical group practices to create meaningful change in healthcare. With a membership of more than 40,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 organizations of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

Implementation of Medicare Part D Drug Management Programs

While MGMA recognizes that steps need to be taken to address the nation’s opioid epidemic, we urge the Centers for Medicare & Medicaid Services (CMS) to balance this against the potential administrative and clinical burden on medical practices that may result from these proposed new drug management protocols. Among other proposals, CMS proposes to perform more frequent prescriber credentials checks and inquiries into the appropriateness, medical necessity and dosage of the prescription, as well as requiring sometimes numerous phone conversations

between the prescribing clinician and the sponsor or other clinicians prescribing medications to the same patient. Any one of these could pose an undue administrative burden on the prescribing clinician and possibly delay patient access to critical medications and we urge CMS to keep this important consideration in mind and to keep required paperwork and phone conversations to an absolute minimum.

We appreciate CMS noting in the proposed rule the importance of being “judicious in contacting prescribers telephonically in order to not unnecessarily disrupt their practices” and acknowledging “the benefit of not aggravating prescribers with unnecessary telephonic communications,” particularly for emergency room clinicians. However, the agency ultimately leaves it up to the description of the sponsors to determine the “usefulness” of attempting to call or contact opioid prescribers on a case-by-case basis and further suggests a rather strict definition of “unresponsive” of three attempted contacts over ten business days, after which claims would be subjected to “editing,” potentially hindering patients’ access to critical medications. We have already received numerous reports of clinician practices being inundated with copious amounts of paperwork requests from (as outlined later in this letter), and we fear that encouraging Medicare Advantage (MA) plans to require clinicians take unscheduled time out of very tight schedules for phone conversations with the threat of restricting patient access to his or her medications is potentially very disruptive and only adds to the demanding requests already being made on clinicians and their staff by MA plans.

We support the agency’s proposal to include all prescribers associated with a single Tax Identification Number as a single prescriber, as it supports recognizing that the clinical staff work together cohesively as part of a care delivery team and is critical to effectively targeting truly at-risk patients. Counting multiple prescribing clinicians from the same practice would only add significantly more patients to this list who are not necessarily at risk at all, and simply received a prescription from another doctor at the same practice because a clinician was unavailable on a particular day, or any host of other valid reasons.

Replacing Parts C and D Prescriber and Provider Enrollment Requirement with Preclusion List

MGMA supports the use of a preclusion list to replace the provisions in § 423.120(c)(6) and § 422.222 that would require eligible professionals to enroll in or validly opt out of Medicare by Jan. 1, 2019 in order for Part D drugs prescribed and Part C services administered by that professional to be covered by Medicare. We agree with CMS that using this targeted approach more appropriately balances CMS’ responsibility to protect Medicare beneficiaries and Trust Funds while minimizing the burden on medical practices and professionals. Focusing its efforts on professionals who pose a more elevated threat to the Medicare program is a more effective strategy and more efficient use of agency staff time and resources. We appreciate the agency recognizing the importance of the specific circumstances of each case and proposing to institute an appeals process, which is critical to the transparency and legitimacy of CMS’ determinations. We also support efforts to avert disruptions in patients’ access to prescriptions through a

provisional coverage requirement or requiring sponsors to transfer patients to a new provider in the event their existing provider is listed on the preclusion list.

Removal of Quality Improvement Project for Medicare Advantage Organizations

MGMA supports CMS' proposal to remove the QIP and agrees with the agency that it is duplicative and redundant of many quality improvement activities already underway. We appreciate CMS recognizing that the massive quantities of data being reported was often duplicative and unhelpful and imposing a burden on MA organizations, which in turn imposed an unnecessary burden on practices to report that initial data.

Soliciting Comment on Reducing Provider Burden

We appreciate the agency's interest in learning more about the magnitude of MA record requests and the burden it has on medical groups, as well as possible solutions to this growing problem. MGMA reached out to several members to gather feedback on this specific area who confirmed that the requests are "continuous" and the volume "immense," in many cases amounting to several thousands of records requested on an annual basis. Many practices hire multiple full-time staff solely to respond to documentation requests from payers, a substantial amount of which are MA plans. One 15-physician specialty practice employs three full-time staff specifically to manage record requests, mostly from MA carriers, despite having an electronic medical record system in place for years. Another 11-physician single-specialty group fielded nearly 6,000 records requests last year alone, over one-third of which needed signature verifications after-the-fact. The burden imposed by MA documentation requests is nothing short of staggering.

There are several common-sense solutions CMS could employ that would greatly help to reduce the administrative burden on physician practices resulting from these records requests.

We offer the following specific recommendations:

- **Standardize submission templates across MA plans, ideally streamlining all requests through one government-run portal.** MA plans often have their own formats or specifications for record submissions. Because of this variance, EHRs do not have a functionality to submit records to MA plans electronically, and instead require practice staff to manually print and submit each record individually, costing practices time and money. Standardizing submission templates across MA carriers would greatly diminish burden on practices in the near-term and spur development of EHR functionalities to share patient records electronically. The efficiency of this process could be further improved if the government mediated the electronic collection of MA documentation requests through a single, encrypted portal similar to the Electronic Records Express Secure Website used by the Social Security Administration (SSA). This would greatly streamline the records collecting process for MA plans and practices alike and allow for one record submission to potentially satisfy multiple inquiries for different claims or payers, saving time and money, all while ensuring patient data is protected.

- **Compensate practices for fulfilling medical record requests.** MA plans have little incentive to limit record requests, as they slow payment of claims (or in some cases eliminate the need to pay claims altogether), or can increase a patient’s risk score, thereby increasing Medicare’s reimbursement rate. Meanwhile, medical practices bear the burden, spending a significant amount of resources complying with increasingly demanding record requests often to the point of having to employ several full-time, dedicated staff. A simple solution that would both bring the total number of requests to a more manageable level and address the growing drain on resources for medical groups would be to require MA plans to financially compensate practices for completing each record request. This policy is not unprecedented; the SSA pays a “reasonable amount” for medical reports requested from providers.¹
- **Require MA plans conduct documentation requests on a rolling, or at least quarterly basis.** A majority of MA plans operate on a biannual submission basis that can result in hundreds if not thousands of records being requested by the same deadline that often aligns with other key reporting deadlines, such as for the Merit-Based Incentive Payment System. Practices report having to hire temporary staff to fulfill requests during these busy months, or staff having to “drop everything” to accommodate them, creating a major disruption to the daily operations of the practice during certain months.
- **Set parameters on non-time-sensitive records requests.** A substantial portion of requests are for more routine updates, such as updating HCC risk scores, and are not tied to payment for a specific claim. Practices should be given more time to comply with routine requests so they can prioritize claims-specific requests and more effectively manage staff workflow. Additionally, record-updating requests should be limited to one request every year or two years.
- **Prohibit MA plans from requesting the same records for the same patient if a new claim has not been filed.** MA plans currently have no incentive to streamline records requests and as a result will often request the same patient record multiple times for different claims. Imposing an annual limit on records requests for the same patient would force payers to organize and track documentation requests in a more efficient manner.

MGMA thanks CMS for the opportunity to offer these comments. Please direct any questions to Suzanne Falk at sfalk@mgma.org or 202.293.3450.

Sincerely,

/s/

Anders M. Gilberg
Senior Vice President

¹ <https://www.ssa.gov/disability/professionals/answers-pub042.htm>