COLLEGE of AMERICAN PATHOLOGISTS

February 19, 2016

Andrew M. Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1653-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-1653-NC/Medicare Program: Request for Information Regarding the Awarding and the Administration of Medicare Administrative Contractor Contracts.

Dear Acting Administrator Slavitt,

The College of American Pathologists (CAP) appreciates the opportunity to provide comments on the Request for Information (RFI) CMS 1653-NC entitled "Awarding and the Administration of Medicare Administrative Contractor (MAC) Contracts". The CAP is a medical society representing more than 18,000 physician members and the global laboratory community. It is the world's largest association composed exclusively of board-certified pathologists and the worldwide leader in quality assurance. The CAP advocates for accountable, high-quality, and cost effective patient care. The CAP's Laboratory Accreditation program is responsible for accrediting more than 7,000 clinical laboratories worldwide.

The CAP applauds CMS for considering alternative approaches to processes and procedures to incentivize optimal MAC performance and encourage much needed transparency. Our comments focus on appropriate MAC performance incentives and measures, particularly in coverage and related areas. Our motivation for honing in on this area is that we have found it to be variable and problematic in recent times, and to be continuing to deteriorate. Throughout our comments, we recommend that incentives be applied only for truly exceptional performance that is both measurable and transparent to all stakeholders. We also recommend specific performance standards and identify corresponding current problem areas which, if effectively assessed and improved, would serve to enhance the MAC's relationships with providers and their services to and coverage of Medicare beneficiaries.

Incentivizing MAC Performance

As you know, CMS currently uses a cost-plus award fee type contract for MACs as a financial incentive for "exceptional" performance on specific quality measures and evaluation criteria. However, to our knowledge, CMS does not define the threshold for exceptional performance, nor does it make available to the public specific quality performance data for each contractor.

Under the cost-plus-award regime, where MACs are financially incentivized and rewarded with additional profit for exceptional performance in areas critical to the success of the Medicare fee-for-service program, transparency regarding methodology for evaluating quality performance and of thresholds for determining exceptional performance is essential. We recommend this information be made available to the public on the CMS website not in aggregate, but by MAC.

Alternatively, CMS may wish to reward truly exceptional performance based on the criteria characterized above by extending a MAC's contract. These incentive contracts would be in the form of up to five, one-year options for renewal of an initial five year contract, amounting to a maximum duration of 10 years contingent upon annual assessments and continuous attainment of exceptional performance by the MAC. Under no circumstance would

contracts afford an automatic renewal. Annual contract extensions would be granted only based on rigorous performance assessment of enhanced standards and metrics including those identified below, that are publicly reported and readily accessible to interested stakeholders are met. This would otherwise do a disservice to CMS and to stakeholders including providers and Medicare beneficiaries, and serve to potentially engender MAC complacency.

MAC performance metrics

Performance measurements are a cornerstone of contracts between CMS and its Medicare Part A/B contractors, and provide key insights into MAC behavior and performance, particularly in terms of whether MACs conform to contract requirements. These measures are also used in the cost-plus award fee plan to motivate exceptional performance beyond what is specific in the contract's statement of work. In addition to the existing MAC performance metrics, the CAP believes that additional performance metrics are needed to assess performance effectiveness and adherence to specific CMS guidelines. We therefore suggest that CMS consider adopting the following performance metrics.

Local Coverage Determination (LCD) advisory and development process: The CAP has long supported the need for improvements in the LCD process and MAC adherence to LCD guidelines outlined in Chapter 13 of the Medicare Program Integrity Manual (PIM). Current performance metrics do not include measures to assess whether a MAC is fulfilling these requirements in substance or in form only, and we therefore recommend that the following key LCD process measures be added to the current MAC performance metrics.

- Contractor education to the medical community should be provided at the outset for a new or revised LCD before a MAC solicits public comments. This education would at a minimum describe the rationale for and evidence behind the development of an LCD that specifies limitations or denies coverage for a service or services.
- MACs should timely post to the MAC's website a summary of all comments received concerning a draft LCD along with the MAC's corresponding responses. Doing so communicates critical information for understanding the rationale for the adoption or rejection of recommendations made by the provider community and other stakeholders.
- While CMS currently measures the timeliness and notice accuracy of LCD reconsideration requests, the CAP recommends that CMS also measure the rate (number) of reconsideration requests of LCDs and claims appeals that are received annually by each MAC, and report the final decisions by a MAC or an administrative law judge to retire, revise, or make no changes to the LCD.
- Timely publication of the minutes of the Contractor Advisory Committee (CAC) meetings by the MACs should be made to demonstrate that meaningful discussions of draft LCDs by MAC medical directors and/or meaningful solicitation of input from subject experts and the general medical community have indeed occurred. Timely publication of CAC meeting minutes also ensures that CAC representatives are given the opportunity to participate in an advisory capacity as intended.
- The CAP has witnessed the "carbon copy" adoption of MAC LCDs by other MACs without the benefit of meaningful solicitation or independent assessment of comments and concerns in their jurisdiction, from either the public or the medical community of the adopting MAC. We are opposed to this shortcutting of the LCD process that is required of all MACs by the Protecting Access to Medicare Act. This also has the practical effect of establishing national coverage policies without having complied with the more rigorous national coverage determination requirements. It is the responsibility of MACs to operate within their charter under CMS guidelines and not bypass the LCD process or arrogate to themselves other responsibilities, such as attempting to determine the validity of laboratory testing as already otherwise provided for under CLIA. We recommend including a metric to measure the rate of adoption of MAC LCDs by other MACs that do not fully conform to the requirements for, and limitations of, development of local coverage determinations.

Gapfill process*:* The CAP remains concerned with the lack of transparency and disclosure associated with the use of gapfill methodology. The opaque use of the gapfill process for molecular pathology services makes gathering accurate information exceedingly difficult for the CAP. In particular, the CAP has noted widely disparate pricing among MACs, and there has been a failure to report any gapfill prices at all in the material CMS has published for several codes designated for the 2015 Clinical Laboratory Fee Schedule (CLFS). The lack of transparency and disclosure involved in the gapfill process has left unclear what data was utilized, and how each MAC determined its prices. We recommend that MAC performance metrics include timely public disclosure of the

methodology used by a MAC in gathering information and determining pricing for new CPT codes that are reimbursed under the CLFS.

Physician assessments of MACs*:* Data from the CMS annual Medicare Contractor Provider Satisfaction Survey should be made publicly available as a measure of quality of service, specifically with regards to the level and quality of MAC public engagement and responsiveness to providers. This information would then provide an opportunity not only for CMS, but also for providers to receive feedback on their responses and compare performance among MACs. It also may result in an increase in subsequent survey responses across a broad spectrum of provider specialties and types.

Assessments by appointing organizations: In each MAC jurisdiction, there are designated organizations which appoint the members of the CAC. These organizations have been deemed by CMS to have both interest and expertise in the activities of the MAC. We propose that these organizations also be surveyed annually on their assessment of the appropriateness and responsiveness of the MAC's in its activities that come within the ambit of the CAC's advisory responsibilities

Timelines of Assessments and Transparency: In addition to the metrics outlined above, the CAP urges timely and transparent MAC performance reviews by CMS. In its April 2015 report to Congressional requestors, the Government Accounting Office found that, while CMS's performance assessments of MACs were extensive, they were not always completed in a timely manner. To achieve effective performance assessment that will support awarding or withholding incentives based thereupon, CMS must provide timely contractor performance assessment reports as part of MAC quality metric evaluations and incentive awards. Furthermore, under current practice only minimal information is released to the public about MAC performance data. CMS currently reports overall performance scores only for each contractor, which does not provide the necessary transparency for key stakeholders, especially providers and Medicare beneficiaries, to understand how their local contractor is performing in each of the key metrics and how it compares to other A/B MACs. The CAP recommends that evaluation ratings criteria for each key performance element be made available to the public, to the extent feasible.

MAC consolidation

The CAP does not offer a recommendation on the final consolidations of the A/B MAC jurisdictions, but expresses the same concerns it previously raised about further MAC consolidation in the clinical laboratory services space. The College expressed concern for further consolidation of MAC coverage and/or payment, particularly where a MAC has to implement and justify nominally local policies which it did not itself develop. Particularly in the coverage space, a MAC is hamstrung attempting to effectively respond to stakeholder comments for an LCD authored by another MAC. The overall result under current operations and rules is a process that obviates meaningful stakeholder exchange and potentially renders a MAC's decision to deny coverage to beneficiaries under a policy it did not develop and possibly for beneficiaries outside of its jurisdiction a fait accompli.

In closing, the CAP is pleased to have the opportunity to respond to CMS on this request for information and appreciates your consideration of our recommendations to expand MAC performance metrics to help improve transparency and support the integrity of the CMS LCD and other processes all relying on effective CMS oversight of MACs to ensure performance compliance.

Should you have any questions regarding the CAP's comments, please do not hesitate to contact Nonda Wilson, MS, at nwilson@cap.org, 202-354-7116 or Sharon West, JD, at swest@cap.org, 202-354-7112.