COLLEGE of AMERICAN PATHOLOGISTS

Issue Brief

Issue: Medicare Local Coverage Determination Reform Proposal

CAP Position: The CAP's goal is to ensure that coverage decisions are made by qualified health experts through a transparent process that is based on sound medical evidence. In order to reach this goal, improve transparency, and boost accountability in the Local Coverage Determination (LCD) process, changes are necessary. By changing the LCD process, Congress can ensure that medical and scientific evidence is not used selectively to deny appropriate coverage to seniors. Furthermore, reforms are necessary to ensure that LCDs do not impede a physician's medical judgment and deny patients access to medically necessary care.

Legislative Ask: Cosponsor S.794, the Local Coverage Determination Clarification Act of 2017, introduced by Senators Isakson (R-GA), Carper (D-DE), Boozman (R-AR) and Stabenow (D-MI) to increase transparency and boost accountability in the LCD process.

S. 794 would improve the LCD process by:

1. **Open Meetings**: Requiring that Medicare Administrative Contractors' (MACs) Carrier Advisory Committee (CAC) meetings be open, public, and on the record. Minutes taken and posted to the MAC's website for public inspection. The gravity of limiting or precluding coverage for both beneficiaries and practitioners heightens the need for transparency where meetings are currently closed. Requiring these increased levels of transparency will facilitate an improved forum for information exchange between MACs and interested parties and, ultimately, will strengthen accountability by demonstrating to stakeholders that the CAC process is being followed.

2. **Upfront Disclosure**: Requiring MACs to include – at the outset of the process – a description of the evidence the MAC considered when drafting an LCD, as well as the rationale they are relying on to deny coverage. If this information is not provided until the final LCD, it hinders meaningful stakeholder exchange and can make a MAC's decision to deny coverage a *fait accompli*.

3. **Meaningful Reconsideration and Options for Appeal**: Creating an appeals process for providers and suppliers to appeal a MAC's decision to CMS. Under current Centers for Medicare & Medicaid Services (CMS) rules, MAC LCDs are essentially unreviewable once they become final. In order to have an LCD to be reconsidered, providers or suppliers have to present new evidence to the MAC that issued the LCD, which in turn is empowered to make a decision on the validity of the request. S.794 gives providers and suppliers an opportunity to have a qualified third party make a decision about the validity of their reconsideration requests in limited circumstances.

4. **Stopping the Use of LCDs as a Backdoor to NCDs**: Prohibiting CMS from appointing a single MAC, either expressly or in practice, from making determinations to be used on a nationwide basis in a given specialty. The CAP has witnessed the carbon copy adoption of LCDs by other MACs without the benefit of meaningful solicitation or independent assessment of comments and concerns from the public or medical community of the adopting MAC. This has the practical effect of establishing national coverage policies without having followed the more rigorous national coverage determination (NCD) requirements.

5. **Creating an Ombudsman:** Creating an Ombudsman to provide providers and suppliers with administrative and technical assistance in filling appeals, make publicly available information about the number of appeals filed with the MAC and with CMS each year, the actions taken by the MACs with respect to appeals filed, the number of times the Secretary took action in response to appeals filed with HHS, responsiveness of the MACs, and providing recommendations to the Secretary on ways to improve the efficiency of the appeals process.

Background: The 2003 Medicare Prescription Drug Improvement and Modernization Act (MMA) reformed the Medicare contracting process. In addition to other reforms, MMA requires the Secretary to replace private health insurers, previously known as Part A Fiscal Intermediaries (FI), and Part B carriers into a single organization called Medicare Administrative Contractors. MACs contractors responsible for adjudicating both Part A and Part B claims and local coverage determinations. An LCD is a decision by a MAC whether to cover a particular item or service on a MAC-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act, which is the primary authority for all coverage provisions and subsequent policies. Additionally, MACs enroll providers, educate them on the program's billing requirements, and answer provider and beneficiary inquiries.