American College of Radiology™

October 4, 2024

Electronically Submitted: MAC_Procurement@cms.hhs.gov

Department of Health and Human Services
Centers for Medicare & Medicaid Services (CMS)
Medicare Contractor Management Group (MCMG)

Re: Request for information (RFI) to obtain public feedback for consideration to consolidate Medicare Administrative Contractor (MAC) jurisdictions.

Dear Ms. Clark:

The American College of Radiology (ACR), representing more than 41,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians, and medical physicists, appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on the Request for Information (RFI) for consideration to consolidate Medicare Administrative Contractor (MAC) jurisdictions and contract award period of performance. The ACR does not support the consolidation of MACs and feels it will impede access to care for Medicare beneficiaries and halt meaningful engagement between the Contractor Medical Directors and the physician community. Our Contractor Advisory Committee (CAC) representatives in National Government Services, Inc., Wisconsin Physicians Service GHA, and CGS Administrators, LLC jurisdictions would be impacted by the proposed consolidation plan. CMS proposes the Consolidation of A/B MAC Jurisdiction 5 and A/B HH+H MAC J6 to form "Jurisdiction G" and A/B MAC Jurisdictions 8 and A/B HH+H MAC J15 to form "Jurisdiction Q". The following ACR recommendations respond to questions outlined in this RFI:

MAC Consolidation

As consolidation of jurisdictions currently served by different MACs could potentially decrease the number of MACs serving the remaining consolidated jurisdictions, competition in this market will be restricted. The involvement of a higher number of MACs has intrinsic value beyond simple market effects as collaboration of the MACs in several settings, including multijurisdictional meetings, can help the MACs share ideas, improve operations, and add diverse perspectives.

Moreover, local concerns for beneficiaries may easily take a back seat. For example, meetings involving local physicians of multiple specialties to review the scientific literature demonstrating the efficacy of a procedure or to learn about local payment issues may be curtailed. This could lead to a reduced representation of local practice patterns in LCDs and LCD reference articles. Additionally, radiology groups report that the MACS do not always interpret NCDs the same.

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1892 Preston White Drive
Reston, VA 20191
703-648-8900

GOVERNMENT RELATIONS
505 Ninth St. N.W.
Suite 910
Washington, DC 20004
202-223-1670

CENTER FOR RESEARCH AND INNOVATION
50 South 16th St., Suite 2800
Philadelphia, PA 19102
215-574-3150

ACR INSTITUTE FOR RADIOLOGIC PATHOLOGY
1100 Wayne Ave., Suite 1020
Silver Spring, MD 20910
703-648-8900

CMS must consider all positive and negative effects of such a merger against any factors that initially began the RFI process.

Based on the ACR's experience with MACs over the last few years, we are concerned that consolidation of MACs will lead to further communication challenges between the physician community and the MACs. Larger jurisdiction size is likely to lead to fewer CMDs per capita or, at a minimum, decreased CMD availability. This presents several challenges for the MAC, as well as patients and physicians in the new larger jurisdiction. From our perspective, decreased CAC representative engagement is the primary concern.

The RFI suggests there are advantages to MAC consolidation. From our perspective, leveraging economies of scale could have value, but balancing the efficiencies gained from this change with the need to consider local practice patterns in local coverage determination (LCD) and LCD reference article development is an important consideration. Economies of scale suggest that decreasing overall administrative costs would be utilized to improve benefits to beneficiaries. However, if there are not enough personnel to appropriately manage benefits and resources, these potential savings could easily be lost.

The ACR has specific concerns with MACs considering further consolidation of other jurisdictions, with the ability of the carrier to respond to stakeholder issues as the primary issue. There would need to be a limit to the population size each CMD of a MAC could oversee, likely requiring a MAC to hire more CMDs in order to expand. Maximum times for MACs to respond to stakeholder issues would need to be set so issues are addressed promptly. Regular outreach activities would need to be mandated to update stakeholders on policy changes and regularly address stakeholder concerns. In summary, as previously noted, we are concerned about the potential monopolistic effects of greater consolidation with less competition in the market.

MAC Contract 10-Year Period Performance

The ACR recommends CMS consider the advantages and disadvantages of awarding MAC contracts with longer periods of performance. Some of the advantages include MACs having time and incentives to develop more user-friendly systems and stakeholders and MACs having time to develop better working relationships. One major disadvantage of this change we foresee is that poorly performing MACs would not be incentivized to improve. With the current 7-year contracts, we already see the advantages and disadvantages of the relatively lengthy contract terms (beyond the original 5 years). Longer-term contracts would only magnify these effects. With the implementation of the changes to the development of LCDs under the 21st Century CURES Act, we have seen some MACs redouble their efforts to engage with stakeholders. For example, in JE, Noridian has continued its engagement with physician stakeholders by initiating Informal Medicare Physician Advisory Council (IMPAC) meetings at least 3 times a year to replace the previous CAC meetings. On the other hand, other MACs have ceased regular

meetings with physician stakeholders, leading to dissatisfaction in those jurisdictions and knowledge gaps on the part of the MACs in terms of local practice patterns.

It is our understanding that, if the regular contract remains at 7 years as it is currently, the contract can be extended to a maximum of 10 years without a new bidding process. We believe a 10-year contract could negatively affect innovation and development since there is a decreased incentive to perform, especially in the early years of the contract. Although the current contract period is 7 years, the norm for many government contracts has been 5 years (FAR 17.204). [1] Stretching the duration of contracts to 10 years would be an exceptional change in government practice and would significantly decrease incentives to provide exceptional service to Medicare enrollees.

Transparency Regarding Contractor Performance Standards

Contractors have not always fulfilled their obligations in the past. For example, radiology groups that are in WPS Jurisdiction 8 report that the MAC is not following proscribed rules when it comes to reimbursement for radiopharmaceuticals. Also, CGS denies claims of medical necessity for procedures where no LCD is published and is notoriously nonresponsive to inquiries as to the reason for denial. It is next to impossible to have the determination justified or reversed.

The ACR recommends that CMS update Chapter 13 of the Medicare Program Integrity Manual [2] to provide greater clarity and transparency regarding Contractor performance standards, including standards related to CAC engagement and timelines for developing and issuing draft LCDs following a request for a new LCD or redetermination. Additionally, CMS should implement and publicly report performance metrics that hold Contractors accountable for adhering to applicable LCD timelines, standards for CAC engagement, and other process improvements. This information should be publicly reported and available on demand. A coalition of 18 national medical societies has developed a set of "Principles for Sound Local Coverage Policies" which is provided. This set of Principles describes a set of metrics that can be used to evaluate the quality of service a MAC provides. Additionally, specific approaches to meaningful physician inclusion in the development of sound coverage policies are described.[3] Transparency is crucial in the MAC evaluation process. Having a MAC performance dashboard (or other evaluations) available for public view would help to ensure this transparency.

Lastly, the ACR would like CMS to address how consolidation of MACs would impact physician credentialing in Medicare. Specifically, would groups who are merged into a new MAC jurisdiction G or jurisdiction Q require re-credentialing?

[1] https://www.acquisition.gov/far/17.204
[2] https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c13.pdf
[3] https://www.acr.org/-/media/ACR/Files/Advocacy/Medicaid/PRINCI_1.pdf

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Philadelphia, PA 19102
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The ACR appreciates the opportunity to provide comments on this RFI. We encourage CMS to continue to work with physicians and specialty societies to assess the benefits and challenges of MAC consolidation. Please contact Alicia Blakey, ACR Principal Economic Policy Analyst at ablakey@acr.org with any questions.

Sincerely,

Dana H. Smetherman, MD, MPH, MBA, FACR
Chief Executive Officer
American College of Radiology

cc: Gregory Nicola, MD, FACR
Sammy Chu, MD, FACR
Laeton Pang, MD, FACR
Mark Alson, MD, FACR
Mark Yeh, MD, FACR
Roy Fertakos, MD
Benjamin Northrup, MD
Katie Keysor
Angela Kim

Enclosures

Appendix A: Principles for Sound Local Coverage Policies

The development of sound and effective local coverage policies is driven by a framework that supports successful and consistent communication between Contractor Advisory Committee (CAC) representatives and Contractor Medical Directors (CMDs); inclusion of the most diverse and qualified candidates for input; transparency and adequate opportunities for comment; clear definition of articles and other supporting materials; and Contractor accountability that is measurable and enforceable, as further detailed in the principles below. These principles allow for Medicare providers to meaningfully participate in the process for developing policy that affects the care they can deliver, and ultimately ensure that Medicare beneficiaries receive the medically necessary care to which they are entitled.

Regular, Timely, and Accessible CAC Meetings

• Meaningful engagement of CAC representatives can be ensured through policies that establish minimum meeting frequency requirements for the full CAC to meet, and minimum CAC member participation thresholds.
• In-person or virtual CAC meetings between CMDs and CAC representatives should be provided on at least a quarterly basis, with sufficient notice and access for CAC representatives.
• In the case of in-person meetings, meetings should be set at a time and location that accommodates the majority of CAC representatives in that state or jurisdiction. Consideration should be given to limiting meetings to a state or narrowed geographic basis to provide for easier access for CAC representatives.

Meaningful Opportunity for CAC Representatives to Advise Contractors and CMS on Coverage and Billing Issues

• CMDs should cultivate an environment of open, frequent, informal, and productive contact with CAC representatives.
• Opportunities for formal contact between CMDs, CAC representatives, and other Contractor officials should be sufficiently frequent to allow for a sharing of ideas and two-way feedback.
• CAC representatives should be meaningfully engaged early and often throughout the local coverage policy development process, thereby allowing adequate review and input from CAC representatives on determinations and accompanying articles.
• Contractors should notify all CAC members of the convening of subject matter expert (SME) panels and offer CAC representatives the opportunity to work with their societies to nominate panelists.
• Contractors should allow all CAC representatives to comment, ask questions, and actively participate during multi-jurisdictional SME panels.
• CMS should establish an Ombudsman to field questions and concerns from the stakeholder community regarding local coverage policies and processes across all Contractor jurisdictions.

• Contractors and CMS should be responsive to CAC representatives' questions and feedback – including to address concerning coverage policies and related billing and coding guidance documents – in a timely manner.

Use of Objective Criteria in the Vetting and Selection of Individuals Included on Expert Panels
• Contractors should publicly announce plans to convene expert panels and utilize an open nomination process.
• Contractors should define and employ objective criteria in vetting and selecting SMEs to participate on expert panels, including clearly stating minimum necessary qualifications.

Transparency through Public Notice and Comment Opportunities for Local Coverage, Payment, or Other Policy Articles
• Articles that accompany LCDs and identify billing codes (e.g., Current Procedural Terminology (CPT) codes and International Classification of Diseases (ICD) codes) to designate procedures and diagnoses that are covered pursuant to the LCD inherently dictate coverage and should be subject to notice and comment.
• Articles accompanying draft LCDs should be issued at the same time as draft LCDs to allow for concurrent notice and comment.
• Other new articles, or any updates to existing articles reflecting non-routine changes in coding, such as elimination of diagnosis or procedure codes that would have the effect of limiting coverage, should also be subject to notice and comment.

60-Day Public Notice Period Before Policy Changes are Effectuated, including Changes to Covered CPT and ICD Codes
• Contractors should allow for a public notice period before policy or article changes take effect, to provide for adequate response, education, and preparation.

Clarity Regarding the Nature and Purpose of Any Local Coverage, Payment, or Other Policy Article, as Well as Regarding the Center and Group within the Centers for Medicare and Medicaid Services (CMS) Responsible for the Article
• Articles published by Medicare Administrative Contractors (MACs) to educate providers on local coverage, payment, and other policies should be clearly labeled by article "type" (e.g., "Billing and Coding," LCD-related, etc.).
• Articles that are not directly tied to an LCD should be removed from the Medicare Coverage Database and housed in a separate location on CMS' and Contractor's web sites.
• Articles should identify the Center and Group within the Agency responsible for promulgating each article, along with a named individual point of contact and corresponding contact information for submitting questions and concerns.

Transparency Regarding Contractor Performance Standards

• CMS should update Chapter 13 of the Medicare Program Integrity Manual to provide greater clarity and transparency regarding Contractor performance standards, including standards related to CAC engagement, timelines for developing and issuing draft LCDs following a request for a new LCD or redetermination request.
• Contractors should be required to issue draft LCDs within 180 days of a determination that a request is complete or valid.

Contractor Accountability for Meeting Performance Standards

• CMS should implement and publicly report performance metrics that hold Contractors accountable for adhering to applicable LCD timelines, standards for CAC engagement, and other process improvements. Accountability metrics should be tied to the items listed previously.

Stakeholder Coalition Members

American Podiatric Medical Association
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Ophthalmology
American Association of Orthopaedic Surgeons
American College of Foot and Ankle Surgeons
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Occupational Therapy Association
American Orthopaedic Foot & Ankle Society
American Physical Therapy Association
American Society of Hand Therapists
American Society of Podiatric Surgeons
College of American Pathologists
Alliance of Wound Care Stakeholders
Coalition of State Rheumatology Organizations

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