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Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1653-NC,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850

Submitted Electronically: http://www.regulations.gov

RE: [CMS-1653-NC] Medicare Program; Request for Information Regarding the Awarding and the Administration of Medicare Administrative Contractor Contracts

Dear Administrator Slavitt:

The American College of Radiology (ACR), representing more than 36,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to provide comment on the request for information (RFI) regarding the awarding and the administration of Medicare Administrative Contractor (MAC) contracts.

The ACR applauds the Centers for Medicare and Medicaid Services (CMS) in soliciting feedback on processes and procedures that could help incentivize and reward exceptional MAC contract performance; encourage legal authorities to administer a set of tasks, which include publishing performance information on each MAC; and make the much needed MAC jurisdictional changes.

CMS relies on approximately 16 MACs for Medicare claims processing. This includes 12 MACS that provide both Part A and B claims and 4 MACs responsible for processing Durable Medical Equipment (DMEPOS) Part B claims. Based on CMS reports, MACs are the operational contact for more than 1.5 million healthcare providers and suppliers in the country registered in the Medicare Fee-For Service (FFS) program. In addition, CMS reports indicate MACs are responsible for more than 4.9 million Medicare claims averaged daily.

Considering the breadth of the MAC's role and responsibilities, as well as, the consolidation effort resulting in fewer MAC entities covering more states, there remains concern with the level of local effectiveness, availability for provider input, transparency, quality, and performance.
Provided below are the ACR comments and response to the CMS solicitation of public comment on the following questions regarding MAC incentives for exceptional performance:

MAC RFI Questions:

1. **Do you have any concerns or suggestions related to development of a potential "award term" strategy and plan?**

The award system metrics must consider quality of actual care delivery in addition to issues of economics. The ACR recommends that CMS establish metrics and an evidence and value based award system that identifies better patient outcomes, higher satisfaction scores, and/or fewer hospital stay days (i.e., based on Medicare claims data), as a result of the MAC changes in LCDs and coverage policies.

2. **Do you have any other suggestions for incentivizing and rewarding exceptional MAC performance?**

Recognizing that contract extensions equate to dollars added as the significant incentive, the ACR encourages CMS to also consider rewarding MACS with innovation opportunities. Piloting local innovation/ideas that capture outcomes data and emphasis on value sequence would support the end goal of quality drivers/incentives for MAC awards.

3. **Are there any specific metrics or evaluation criteria that would be valuable in measuring the level and quality of the service provided by a MAC?**

The ACR recommends the following metrics and evaluation criteria:

- Provider relations: Turnaround time on payments and claims adjudication, feedback on denials, consideration of appeals, percentage of appeals, percentage of appeals overturned, enrollment turnaround time and reasons for identified delays, contractor audit turnaround and response time (i.e., often inordinate delays or no response at all when there are provider queries or information is submitted).

- Patient care: Verify denials are communicated to patients and capture granular data that measures how. Track and evaluate when and why exceptions are allowed. Track and evaluate why physician/clinician orders and requests are not allowable by the MAC.

4. **Are there any specific metrics or evaluation criteria that would be valuable in measuring the level and quality of the MAC's relationships (including education and outreach) with providers?**

The ACR recommends the following metrics and evaluation criteria:

- Benchmarked adherence to recommended screening exams and labs.
- MAC communication (responsiveness/timeliness, turnaround times for enrollments/appeals/audits, process notification etc.)
- Provider, CAC, and professional organization input on local Medicare coverage policies and processes. Better communication and content expert input is needed for establishing clinically appropriate medical coverage policies and processes. These processes should be transparent and public.

Section 509(c) of MACRA directs us to make some MAC performance metrics available to the public, to the extent that doing so can be done in a manner that does not compromise the competitive procurement process. Therefore, we are requesting comment on the following questions regarding MAC performance transparency:

5. **With regard to the MAC's quality and level of service and performance, what types or kinds of information should be published for public release?**

The ACR recommends that public release information include the percentage of pass through dollars actually going to direct patient care versus DME, administrative costs etc. However, these areas could also be reported.

6. **If we were to publish the results of the evaluation of a MAC's performance on our website, which types of metrics or information should be made available for public release?**

The ACR recommendations for the aforementioned questions also are applicable to this question regarding published metrics and evaluation of MAC performance. In addition, we ask that CMS evaluate the coverage and policy variants between MACs and address the significant provider level and CMS level financial and administrative burdens as a result of MAC performance issues, MAC award turnovers, and MAC policy changes (e.g. inconsistencies between MACs in LCDs).

We are also soliciting public comment on potential MAC jurisdictional changes. Currently, there are 12 A/B MAC jurisdictions; in 2010, we announced a plan to consolidate FFS claims operations to 10 A/B MAC jurisdictions over the course of several years. However, in 2014, we announced that we were postponing the consolidation of Jurisdictions 8 (which encompasses the states of Indiana and Michigan) and 15 (which encompasses Kentucky and Ohio) to form "Jurisdiction I" and the consolidation of Jurisdictions 5 (Iowa, Kansas, Missouri and Nebraska) and 6 (Illinois, Minnesota, and Wisconsin) to form "Jurisdiction G." ….Accordingly, we are requesting comment on the following question:

7. **What would the advantages and disadvantages be if CMS completed the last two MAC consolidations?**

The ACR and Radiology and Radiation Oncology Carrier Advisory Committee representatives in each state are concerned that with the MAC consolidation and fewer rotating meetings among each MAC jurisdiction, and increased conference calls with increased amount of participants and consolidated states and CAC representatives, there is an ever increasing lack of face to face meeting opportunity for each state. Increased numbers of states, means reduced face time and reduced ability to have bi-directional discussions among the state level CAC representatives and MACs.

Conclusion

The ACR appreciates the opportunity to provide comments in response to this Medicare Program RFI regarding the awarding and administration of MAC contracts. We encourage CMS to continue to work with physicians and their professional organizations as well as the Carrier Advisory Committee Network representatives in establishing best incentives and rewards for exceptional MAC contract performance; publishing of MAC performance information; and in establishing meaningful MAC jurisdictional changes. The ACR is hopeful that the RFI will help enable identification of additional contracting metrics and strategies that can be introduced in the future for improving MAC performance.

If you have any questions or comments, please contact Anita McGlothlin at (800)227-5463 ext.4923 or email amcglothlin@acr.org.

Respectfully Submitted,

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Chief Executive Officer

Cc: Robert Zeman, MD, FACR, Chair, Radiology CAC Network
W. Shawn Conwell, MD, Vice-Chair, Radiology CAC Network
Geraldine McGinty, MD, FACR, Chair, Commission on Economics