

March 4, 2022

Meena Seshamani, MD, PhD
Director
Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS-2022-0021; Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Dr. Seshamani,

On behalf of the American Society of Retina Specialists (ASRS), we write to you today to:

- Express our ongoing opposition to Medicare Advantage (MA) plans' use of medical records reviews to improve their risk adjustment scores. These requests are administratively burdensome, take away from patient care, and result in no benefit for physicians or beneficiaries. **We urge CMS to eliminate or significantly restrict plans' ability to conduct these chart reviews.**
- Provide feedback on CMS's request to develop an MA plan star rating measure based on beneficiary complaints about the plan. ASRS is concerned that plans are not making beneficiaries adequately aware of certain policies, such as prior authorization and step therapy, therefore a measure that tracks beneficiary complaints could prompt plans to better educate beneficiaries on potential downsides of joining the plan.

ASRS is the largest retina organization in the world, representing over 3,500 board certified ophthalmologists who have completed fellowship training in the medical and surgical treatment of retinal diseases. The mission of the ASRS is to provide a collegial open forum for education, to advance the understanding and treatment of vitreoretinal diseases, and to enhance the ability of its members to provide the highest quality of patient care.

MA MEDICAL RECORDS REQUESTS

Burdens on Retina Practices

Retinal disease disproportionately impacts elderly patients; therefore, the majority of retina specialists' patients are Medicare-eligible, with a growing proportion of those beneficiaries choosing MA plans. Over the last several years, retina specialists have received medical record audit and review requests at increased volumes and frequencies from these MA plans. Typically, these requests are for an excessive number of charts—perhaps 100 or more at a time—and must be fulfilled within extremely short timelines. In addition, each payer tends to have its own procedures and format for responding to the requests.

Gathering and assembling the information required as part of these chart reviews is time-consuming, labor-intensive and unreimbursed. To protect patient privacy, practices are generally hesitant to allow outside vendors to come into the practice to access the records, and therefore, must dedicate staff time that would otherwise be focused on patient care responding to these requests.

Current practice patterns for chronic retinal disease, such as age-related macular degeneration and diabetic retinopathy, mean that patients see their retina specialist roughly every month. Because of this frequency of treatment, medical records for these patients can be particularly voluminous. When MA plans request full information on these patients, including exam notes, consultation correspondence, diagnostic information, or operative notes, practices must collate significant amounts of information. One retina practice noted that it was typical to send back the requested charts to the plan in “several case-size copy paper boxes.” Retina practices see a high volume of elderly patients facing potential vision impairment, coupled with other existing co-morbidities. Responding to MA plan chart requests are major disruptions in providing care to these vulnerable beneficiaries.

Concerns with MA Plan Tactics

Perhaps more troubling than the burdens these chart reviews place on practices, is that MA plans appear to be using them to improve their own profitability rather than ensure adequate care for their beneficiaries. ASRS strongly supports risk-adjustment actions to safeguard access to care for the sickest patients, however, through these chart reviews, MA plans have abused their position and are potentially being unjustly rewarded with additional funds.

Despite the burden and lack of financial return from these chart audits, retina practices are hesitant to ignore them for fear of retribution from the plans. As sub-specialists, retina specialists tend to have a wide catchment area for their patient population and thus need to participate in as many plans as possible to ensure all their patients will be covered. Refusing to comply with an MA plan chart request risks the plan removing the physician or practice from the network in retaliation and thus endangering patient access to care.

Furthermore, many plans use deceptive language in their chart requests to make it seem that the audit is at the direction of CMS. Physicians are not willing to question what are made to appear as legitimate audit requirements because they assume they could face penalties or loss of enrollment in the Medicare program at large. *Examples of some deceptive cover letters are included in the appendix of this comment letter.*

ASRS is not alone in questioning MA plan tactics related to risk adjustment chart reviews. HHS’ OIG recently published a report that found many of the risk-adjustment payments these plans received are unwarranted and are a key source of improper payments in the MA program.¹ Based on the OIG’s findings, the 3.5% increase from risk scores CMS is proposing for plans in 2023 appears highly suspect. CMS must use its authority to ensure that these chart reviews are meeting the intended purpose of ensuring access to care for sicker patients, rather than providing an incentive to plans to pad their bottom lines.

Reducing the Burden on Practices

¹ “Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments;” HHS Office of the Inspector General; September 20, 2021; <https://oig.hhs.gov/oei/reports/OEI-03-17-00474.asp>

ASRS and other medical specialties have long expressed opposition to MA chart review requests due to the burden on physician practices and recent OIG findings make plain that plans are only undertaking them because of the financial incentive. We recognize that CMS has little ability to regulate the contractual obligations between payers and participating providers, however, it can reduce or eliminate the financial incentive that plans have to conduct these requests.

To reduce the administrative burden on physician practices and ensure plans are good stewards of Medicare funds, we strongly urge CMS to take action and restrict the use of medical records review requests immediately. At a time when practices are facing significant obstacles in staffing shortages and dealing with the ongoing impacts of the COVID-19 pandemic, Medicare dollars are also stretched thin. CMS must prevent further abuses by MA plans.

MA STAR RATINGS REQUEST FOR INFORMATION

Beneficiary Complaint-Based Measure

ASRS strongly supports and recommends CMS develop an MA plan star ratings measure based on beneficiary complaints about the plan. As CMS notes in this Advance Notice, many of the beneficiary complaints it has investigated stem from deceptive marketing practices that, among other things, may not inform consumers about plan limitations. ASRS views prior authorization and step therapy as the greatest limitation of MA plans. Plans should be held accountable when they do not disclose to potential beneficiaries both the advantages and disadvantages of joining an MA plan.

As noted above, patients with retinal disease have a significant treatment burden. Sight-threatening chronic diseases such as wet AMD and diabetic retinopathy require regular office visits, imaging, and injections with anti-vascular endothelial growth factor (VEGF) drugs. MA plans further complicate this situation by subjecting these patients to almost universal step therapy requirements for anti-VEGF drugs and prior authorization requirements that often force both the patient and an escorting friend or family member to return for another visit to receive treatment.

ASRS is not aware of any widespread efforts by the plans to educate their potential beneficiaries on their utilization management processes and how they might limit access to treatments covered by original Medicare Part B. We are aware, however, that plans are marketing directly to their beneficiaries with the intent to switch them to a less costly treatment.

In 2021, both United and Humana sent flyers to patients receiving treatment with FDA-approved branded anti-VEGF drugs suggesting they speak to their doctor about switching to the cheaper drug, Avastin (bevacizumab) or, in the case of Humana, one of its biosimilars. Patients expressed outrage to their physicians about these flyers because the plans were asking them to return to a drug that they had likely already tried and failed. Furthermore, Avastin is off-label for ocular use and must be repackaged. Neither of its biosimilars have been tested in the eye and CMS has separately forbidden plans from using the off-label biosimilars in their step therapy policies.

As new drugs and treatment options come onto the market, ASRS expects these tactics to continue and likely worsen. We have long-stated our opposition to these utilization management policies because they interfere in the doctor-patient relationship and create additional, unreimbursed administrative

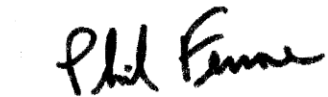
burdens for practices. However, they become particularly problematic when a beneficiary, who did not intend to join a plan with these limitations, finds out after the fact and must cope with the consequences.

When those beneficiaries rightly complain to CMS about deceptive marketing practices, the plans should take accountability. While we continue to oppose utilization management across the board, a new star rating measure aimed at beneficiary complaints would be positive first step.

CONCLUSION

Thank you for this opportunity to provide comments. If you have questions or need additional information, please contact Allison Madson, Vice President of Health Policy, at allison.madson@asrs.org.

Sincerely,

A handwritten signature in black ink that reads "Phil Ferrone". The signature is written in a cursive, flowing style.

Philip J. Ferrone, MD, FASRS
President
American Society of Retina Specialists

Appendix- Examples of deceptive medical records requests.