Kaiser Permanente Comments on CMS-10636, OMB 0938-1346: TRIENNIAL NETWORK ADEQUACY REVIEW FOR MEDICARE ADVANTAGE ORGANIZATIONS AND 1876 COST PLANS

Kaiser Permanente appreciates the opportunity to submit comments regarding the Triennial Network Adequacy Review for Medicare Advantage and 1876 Cost Plans documentation and process (CMS-10636, OMB 0938-1346). We thank CMS in advance for consideration of these comments. If there are any questions, please contact Jamie Brandi, Executive Director, Medicare Compliance at (510) 271-6933 or Jamie.L.Brandi@kp.org.

- The "Supporting Statement" document states: "CMS has developed a compliance methodology for network adequacy reviews that will ensure a consistent approach across all organizations". We seek clarification as to whether this methodology is newly developed or was leveraged for past review cycles. In the interest of transparency, we recommend that CMS publish this methodology and moving forward, share updates with plans. This mirrors standard practice with respect to CMS Program Audit protocols and the CMS Civil Monetary Penalties methodology, both of which are published and shared with plans (and released for public comment). Sharing the Triennial Review compliance methodology would not only promote transparency and ensure plans are educated on the specific ramifications of non-compliance, but it would also potentially strengthen compliance outcomes by establishing a clearer framework for risk analysis and mitigation efforts.

- We encourage CMS to develop and publish a clear overview of the Triennial Review process that articulates the overarching timeframe, expected deadlines, and specific required actions/submissions. Based on our experience in 2019, it seems that CMS largely relies on automated HPMS communications to convey required actions and deadlines to plans—often with little context nor indication as to what subsequent steps may be required. Similar to how CMS publicizes the Program Audit process and timeline, clear process documentation for the Triennial Reviews will promote preparedness and reduce unnecessary follow-up and re-submissions—particularly on account of the tight turnaround timeframes that were required to re-submit network data and Exception Requests.

  CMS should also clearly communicate their expected review timeframes for Exception Requests and Partial County Justifications and commit to an end-date for the overarching review cycle. Moreover, we urge CMS to outline the circumstances under which re-submissions of data and/or Exception Requests may be required—this allows plans to ensure the necessary staff/resources are available to support such efforts. We also encourage CMS to consider adding a step in which plans are afforded the opportunity to formally rebut Exception Request denials. There was no mechanism to do so and although we eventually were able to submit feedback via the mailbox/portal, there was not a forum in which we could engage in a meaningful dialogue with CMS about the substance of our Exception Requests nor solicit feedback as to how we could strengthen our rationales. In many cases, CMS denied Exception Requests citing the availability of providers that were either not available or were already addressed in the submitted narratives.

  Overall, a more defined and documented review process would serve to benefit both plans and CMS by fostering greater efficiency, transparency, and coordination.