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To: Centers for Medicare and Medicaid Services
Submitted electronically via: regulations.gov

From: Shannon Schuster
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Date: June 8, 2020

Re: *Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans*

Attached are comments regarding the Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans (CMS-10592).

Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans

Comments Submitted by
UnitedHealthcare
6/8/2020

UnitedHealthcare (UHC) appreciates this opportunity to provide input to the Centers for Medicare and Medicaid Services (CMS) regarding the Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans.

Earlier Release of Updated Reference Files, Sample Beneficiary Files, and Templates for Network Adequacy

UHC recommends CMS release the annual updated Reference Files and the Sample Beneficiary Files in early October. CMS's release of the updated Reference Files and the Sample Beneficiary Files currently occurs in January. This release date can create a situation where all the counties and specialties in a service area may be meeting the health service delivery (HSD) criteria throughout the year leading up to the January release date, but then the updates by CMS lead to new network variations (HSD failures) due to changes in maximum time and distance criteria and shifts among the beneficiary sample being assessed. We recognize the need for and value of updating these files, but an earlier release date of October would allow MA plans more time to contract with providers and facilities needed for both a Service Area Expansion (SAE) or Network Adequacy Review (NAR) and ultimately to comply with CMS network rules and regulations. For instance, plans are determining whether to apply for an SAE before January and the adequacy of the network being proposed for the expansion is part of that decision. A delay in releasing the updated files until January impacts that decision making, whereas an earlier release of October will eliminate an unnecessary administrative burden when plans are considering expansion.

Similarly, UHC proposes that any modifications to the templates MA plans use to submit data to CMS should be shared with plans with enough advance notice to adapt to the new template. MA plans need sufficient time to change their internal systems when CMS modifies the format of the templates that plans must populate with data and upload to the Health Plan Management System (HPMS) or otherwise submit to CMS. For instance, CMS changed the format of the MA provider and MA facility templates for network adequacy on June 14, 2019, but MA plans received no advance notice of this change. Then one business day later, on June 17, 2019, CMS sent plans a notice to upload their SAE or NAR HSD tables. To reduce unnecessary administrative burdens, UHC recommends template changes like this occur with notice to plans preferably in early quarter one/January but no later than mid-April, so that plans are prepared for submissions to CMS in June. We also recommend no further changes be made to the templates once released for that calendar year's submission.

Communication Process and Timing Related to Informal Network Review and Consultation Process

Since the introduction of the Triennial Network Adequacy Review, CMS has included an Informal Network Review process in which MA organizations are encouraged to participate. The Informal Network Review provides an opportunity to submit HSD Tables via the Network Management Module (NMM), receive Automated Criteria Check (ACC) reports from CMS, and then submit network exception

requests to CMS for feedback prior to the Formal Network Review submissions in June. Because the Informal Network Review process has been incorporated into the Triennial Network Review process by CMS, we recommend CMS include explicit reference to this process in the Triennial Network Review Supporting Statement.

In addition, we reiterate two recommendations that we submitted in our comment letter in response to CMS-6082-NC, Reducing Administrative Burden to Put Patients over Paperwork. These relatively easy-to-implement recommendations will reduce the administrative burden associated with the informal network review and consultation process that CMS currently offers MA plans. The informal review process itself is a highly useful tool for CMS and MA plans to have a more meaningful dialogue and help achieve the mutual goal of improving network adequacy outcomes. However, certain minor but critical enhancements to the current communication process will further support that goal.

First, UHC recommends CMS communicate to MA plans sufficient advance notice of the specific timing for the plans' submissions of HSD tables and exception requests, specifically a notice with timeline in early January for the February informal review and consultation process. During the 2020 submission process, CMS notified the MA plans selected for triennial network reviews on February 12, 2020 that they could begin uploading HSD tables the next day. This notice timeframe can create challenges for MA plans to fully utilize the process. By providing earlier notice to plans of upcoming submission windows, both CMS and MA plans will benefit from improved network-related submissions during the informal review and consultation process. We request CMS publish this timing guidance in early January in advance of submissions being due.

Second, UHC recommends CMS provide written feedback and then schedule consultation discussions with MA plans no later than the first half of April. We particularly appreciated the written feedback in 2019, as it was helpful to review CMS's specific details regarding noted variances followed by a consultation call with CMS. The feedback and discussions are the MA plan's opportunity to obtain crucial feedback from CMS on their informal network adequacy submissions before plans perform their formal submissions in June. An earlier—that is, no later than the first half of April—consultation discussion gives MA plans the necessary time to address any issues identified by CMS (e.g., if additional provider contracting is needed) before the formal submission deadline.

Provider Supply File

We appreciate the Provider Supply File as a source to identify providers and facilities to contract with. To improve transparency, we recommend CMS provide the sources CMS leverages to compare HSD tables and exception requests and the date the file was last updated. This will greatly improve efficiency for both CMS and MA organizations as MA organizations can proactively address all of the identified providers.

Justification Section of Supporting Statement
Information Users (HSD Tables and Network Adequacy Guidance)

In the Information Users section of the Supporting Statement, CMS references language that was included in the last Office of Management and Budget (OMB) release of the Three-Year Network Adequacy Review for MAOs:

> Organizations will be required to demonstrate network adequacy through the submission of HSD tables in the Network Management Module (NMM), which is an automated tool located on the HPMS website. The NMM allows organizations to upload two HSD tables per contract—a provider HSD table and a facility HSD table. On their HSD tables, organizations must list the providers and facilities they are currently contracted with for CMS's required specialty types. Key data fields on the HSD tables include: SSA State/County Code, Name of Provider/Facility, National Provider Identifier (NPI) Number, Specialty Code, and Address.

CMS further states, in the crosswalk document released as part of 2020 OMB 0938-1346 Revisions, that HSD Instructions have been removed because the current instructions for HSD table submission are included in the Network Adequacy Guidance, also included in the package. However, the HSD Tables and the Network Adequacy Guidance included in this PRA package are several years old and as such, have not been updated with guidance that CMS has issued within the last two years as part of the Triennial Network Adequacy Review process.

To the extent not finalized when CMS issues the final rule on Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, we recommend CMS revise and release for comment the tools and guidance (i.e., HSD Tables and Network Adequacy Guidance) released in the PRA package. This will ensure it is consistent with the verbal and written guidance that has been issued to MA organizations over the past two years. The continual release of inconsistent guidance and tools by CMS may result in confusion on the part of CMS reviewers and the MA organizations trying to meet CMS requirements as well as result in inaccurate and inconsistent reviews and adequacy measurements across MA organizations.

Information Users (Compliance Actions)

Within this section of the Supporting Statement, CMS also states:

> Once CMS staff reviews the ACC reports and any Exception Requests and/or Partial County Justifications, CMS then makes its final determination on whether the organization is operating in compliance with current CMS network adequacy criteria. If the organization passes its network review for a given contract, then CMS will take no further action. If the organization fails its network review for a given contract, then CMS will take appropriate compliance actions. CMS has developed a compliance methodology for network adequacy reviews that will ensure a consistent approach across all organizations.

If CMS determines that an MA organization is not in compliance with the current CMS network adequacy criteria, an opportunity should be available for the MA organization to have a dialogue with CMS regarding the specific and detailed reasons why CMS determined the MA organization is not in compliance. In the current process, CMS is using many different sources of data to make these determinations, and currently no accurate source of data is available. Unless CMS provides the MA organization with detailed information, including the specific data that CMS used to make the deficiency determination, the MA organization has great difficulty in attempting to cure the deficiency.

Background Section of Supporting Statement

In the Background section of the Supporting Statement, CMS states, "Revisions to the package include removing references to procedural changes that separated triennial network reviews from the application cycle, that was included in the 2017 approved iteration of this collection. There are no changes to the requirements for Network Adequacy, this includes the collection instruments (Provider and Facility HSD Templates, Exception Request Template and Partial County Justification Template) or the instructions (Network Adequacy Guidance)."

As stated earlier, CMS has released more updated HSD Templates. In addition, CMS has released more recent guidance that conflicts with language in the 2018 Network Adequacy Guidance. Specifically, with regard to the use of the RRPO-Specific Network Exception Request Template, the current 2018 Network Adequacy Guidance states that RPPOs may continue to utilize the Regional Preferred Provider Organization (RPPO) Upload Template (Appendix K):

> 8.2.2. RPPO-Specific Exception Request for the Network Management Module
> RPPOs that undergo a CMS network review in the NMM have the opportunity to request CMS review and approval of the network exception at 42 CFR 422.112(a)(1)(ii) through the submission of the Regional Preferred Provider Organization (RPPO) Upload Template provided in Appendix K. RPPOs must submit the completed template to CMS's website portal.

While the reference to the 2018 Network Adequacy Guidance is consistent with language provided by CMS in the January 2020 selection of contracts selected for CY 2020 Triennial Network Review (i.e., "Your contract has been selected for the Centers for Medicare & Medicaid Services' (CMS) Triennial Provider Network Adequacy Review, as described in the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance found at https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance-pdf.pdf."], it is not consistent with guidance provided in a voicemail message by CMS in the summer of 2019 to our organization's Chief Medicare Compliance Officer, nor is it not consistent with the Network Management Plan User Guide dated 1, 2020.

To date, CMS has not released clear, consistent written guidance to the industry regarding expectations for RPPO-Specific Exception requests. Therefore, we ask that CMS confirm the guidance issued in the Medicare Advantage Network Adequacy Criteria Guidance dated February 20, 2018 governs the RPPO-Specific Exception process since this is the guidance issued to the industry in this comment opportunity and is the guidance provided to health plans selected for CY 2020 Triennial Network Reviews.

If you have any questions on these comments, please feel free to contact me at 920-661-6217.

Respectfully,

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UnitedHealthcare