June 30, 2015

Terry Lied
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–10261; OMB 0938-1054

Filed via email: http://www.regulations.gov/

RE: CMS–10261–2016 Part C Medicare Advantage Reporting Requirements and Supporting Regulations; 80 FR 24934 (May 1, 2015)

Dear Mr. Lied:

Health Care Service Corporation (HCSC) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed **2016 Part C Medicare Advantage Reporting Requirements and Supporting Regulations** as announced in the *Federal Register*[1] and posted on the Paperwork Reduction Act[2] website on May 1, 2015.

HCSC is the largest customer-owned health insurance company in the United States. The company offers a wide variety of health and life insurance products and related services, through its operating divisions and subsidiaries including Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Montana, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas. HCSC employs more than 21,000 people and serves more than 14 million members. HCSC has established Medicare Advantage (MA) plans and Part D Prescription Drug (Part D) stand-alone plans in all five of the HCSC states.

General Comments

CMS is proposing new Reporting Section 16, "Mid-Year Network Changes." The new proposed reporting requirements are in addition to the Pilot on Provider Network Adequacy that CMS is beginning in the late summer or early fall of 2015. In the pilot, CMS will require Part C plans to load Health Services Delivery (HSD) tables in the Network Management Model and evaluate network adequacy to identify deficiencies based on the minimum standards in the HSD Reference File. CMS will apply compliance standards based on the requirements.

[1] http://www.gpo.gov/fdsys/pkg/FR-2015-05-01/pdf/2015-10208.pdf
[2] https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10261.html?DLPage=2&DLEntries=10&DLSort=1&DLSortDir=descending

The Pilot on Provider Network Adequacy will inform CMS through an established process with published standards whether MAOs are maintaining adequate network access for beneficiaries. No additional tools are needed to make this evaluation.

CMS states the following in the Technical Specifications Document with respect to item 16, Mid-Year Network Changes:

> CMS is increasing its oversight and management of MAOs' network changes in order to ensure that changes made during the plan year do not result in inadequate access to care for enrolled beneficiaries and that MAOs are provided timely and appropriate notification to providers and enrollees. The data collected in this new measure will provide CMS with a better understanding of how often Medicare Advantage Organizations (MAOs) undergo mid-year network changes and how many enrollees are affected. Collecting these data will help to inform us as we determine how broadly to use the new Network Management Module (NMM) in the Health Plan Management System (HPMS) to verify that plans' networks meet CMS network adequacy standards. In addition, responses from MAOs will enhance CMS' ability to improve our network change protocol.

HCSC believes that the proposed reporting requirements would create a significant and unnecessary burden on Part C sponsors without added value to CMS. The proposed reporting requirements would not inform CMS as to whether changes result in inadequate access to care or whether providers or enrollees are provided with timely and appropriate notification. None of the data elements could assess these issues, which are adequately assessed through analysis of the HSD table submissions in the Pilot on Provider Network Adequacy.

In addition, CMS sites the following as the legal basis for the proposed Mid-Year Network Changes section:

> In accordance with 42 CFR § 422.112 (a)(1)(i), each MA organization under Part C Medicare that offers a coordinated care plan is required to "maintain and monitor a network of appropriate providers that is…sufficient to provide adequate access to covered services to meet the needs of the population served."

HCSC believes the reporting requirements will not inform CMS as to whether a plan is maintaining and monitoring a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served as required in §422.112 (a)(1)(i). We reiterate that analysis of HSD table submissions in the Pilot on Provider Network Adequacy is the appropriate tool for this purpose. It would not be an efficient use of CMS or MAO resources to create a duplicative reporting structure for this purpose and ultimately will add cost for enrollees without adding any value.

CMS states that the agency is seeking a better understanding of how often MAOs undergo mid-year network changes and how many enrollees are affected. HCSC would be happy to discuss these issues with CMS to provide information about how and why changes occur throughout the year. As a normal course of business, providers terminate and health plans add other providers.

Contract negotiations occur throughout the year in an effort to optimize networks, improve quality of care and provide efficient services. This is especially true as health plans strive to meet the HHS Secretary's goals to move toward greater use of alternative payment models and population-based payments.

In addition, providers terminate for a variety of reasons outside of the control of the health plan including for example, retirement, relocation, death, refusal to accept quality or payment terms or acquisition by a hospital system. New providers are added as they move into the area, become part of a new system, when new contracts are negotiated, etc. All of these changes could theoretically affect every member in the contract; however, access requirements generally are not affected by these changes as the bulk of providers remain constant and provide sufficient access according to the CMS network adequacy standards.

For the reasons above, HCSC strongly recommends that CMS eliminate the proposed Mid-Year Network Changes reporting section from the 2016 Part C Reporting Requirements. The more appropriate tool for monitoring network adequacy will be implemented soon through the CMS Pilot on Provider Network Adequacy that requires loading of HSD tables and evaluation based on published CMS standards.

Specific Comments

Reporting Section 6, Organization Determinations/Reconsiderations

- **Data Elements – Page 14**

  CMS proposes to add two new data elements, 6.10 - Number of Requests for Organization Determinations - Dismissals and 6.20 - Number of Requests for Reconsiderations – Dismissals.

  HCSC appreciates the addition of these data elements, which align with the audit protocols going forward.

Reporting Section 16, Mid-Year Network Changes

If CMS decides to move forward with the proposed Reporting Section 16, Mid-Year Network Changes, HCSC has the following specific comments and recommendations.

- **Data Elements - Pages 34 - 35**

  - **16.1**: In the previous contract year, did you make any mid-year network changes? ("0"="No"; "1" = "Yes")

    Mid-year network changes are a normal course of the health insurance business for the reasons stated previously. As such, this element does not add value to understanding network adequacy as it would be an anomaly for an MAO to not experience network

changes. Further, it is unclear whether this is intended to include provider-initiated changes, plan-initiated changes, or both.

Recommendation: HCSC recommends CMS eliminate data element 16.1. Alternatively, if CMS decides to retain the data element, we recommend that CMS restate the question as follows: In the previous contract year, were there any mid-year changes?

- **16.2**: How many PCP contracts were terminated?
- **16.6**: How many specialist contracts were terminated?
- **16.10**: How many facility contracts were terminated?

It is unclear what constitutes a contract termination. For example terminations could include or exclude providers/specialists that retired, relocated, died, were acquired by a hospital system, refused to accept quality or payment terms, were terminated for cause, or terminated for other reasons.

Recommendation: HCSC recommends CMS clarify which providers would be included in the definition of a terminated PCP contract.

- **16.3**: How many enrollees were affected by termination of PCPs?
- **16.7**: How many enrollees were affected by termination of specialists?
- **16.11**: How many enrollees were affected by termination of facilities?

It is unclear how CMS is defining "affected" in data elements 16.3, 16.7, and 16.11. While any enrollee could be affected by a termination, in practice we suggest several items to consider. Many enrollees, especially those in a PPO health plan, do not have a PCP and are not required to select and report one to the MAO. MAOs do not typically attribute enrollees to specialists or facilities. In these cases the MAO would have no way of knowing whether a member would need to choose a new provider when one is terminated. Also, it is unclear if a member would be considered affected if the provider is outside of the distance access requirements.

Recommendation: HCSC recommends that the term "affected" in these data elements is defined to mean that the beneficiary has visited the provider within the last six months.

- **16.5** How many enrollees were affected by addition of new PCPs?
- **16.9** How many enrollees were affected by addition of new specialists?
- **16.13** How many enrollees were affected by addition of new facilities?

It is unclear how CMS is defining "affected" in data elements 16.5, 16.9, and 16.13. Any enrollee could be affected by the addition of a provider since they have more choice of providers. However, for practical purposes enrollees are likely affected only if they utilize the new provider within a specified period of time or if they live within the distance access requirements.

Recommendation: HCSC recommends that the term "affected" in these data elements is defined to mean that the beneficiary has visited the provider within the last six months of the reporting time period.

We appreciate the partnership we have with CMS in serving beneficiaries through Medicare Advantage and Part D programs. In addition, we especially appreciate the ongoing effort CMS is making to improve the Reporting Requirements to ensure beneficiaries are well-served by these programs. If you would like additional information or have questions about these recommendations, please contact me at 202-249-7222 or Sue_Rohan@hcsc.net.

Sincerely,

Sue Rohan
Vice President, Health Policy – Government Programs