Shannon Schuster
Director, Regulatory Affairs
Government Programs
UnitedHealthcare
3100 AMS Blvd
Green Bay, WI 54313
920-661-6217

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

From: Shannon Schuster
UnitedHealthcare
UnitedHealth Group

Date: September 6, 2016

Re: *Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits*

Attached are comments regarding the Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits (CMS-10237).

Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits

Comments Submitted by
UnitedHealthcare
9/6/16

UnitedHealthcare is pleased to provide the Centers for Medicare & Medicaid Services (CMS) comments regarding the Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits.

General Comments

In the past, CMS has held listening sessions to discuss industry feedback and opportunities for improvement based on the most recent application cycle. These listening sessions were helpful in improving the application process. Therefore, UnitedHealthcare respectfully requests that CMS schedule another listening session to discuss feedback on the 2017 application process as soon as possible.

When CMS promulgated the contract determination regulations, CMS intended for the application process to be clear and transparent, stating:

> We agree that in order for applicants to have a consistent understanding of the expectations on which we base our contract approval and denials, we must ensure the clarity and transparency of the program requirements and review criteria. Applicants receive up to three communications which explain our application requirements and provide clear instructions on how to be a successful applicant. . . . All application communications include contact information for CMS subject matter specialists. We are always willing to work with applicants to ensure a complete understanding of program and contracting requirements.

During the 2017 Service Area Expansion (SAE) application process, CMS staff involved in the review generally refused to engage in a dialogue with Medicare Advantage Organizations (MAOs), leaving MAOs with only generic and vague reason codes for denials that did not allow the MAO to pinpoint and address the alleged deficiency. We respectfully request that CMS consider improving the clarity and transparency of the information provided to MAOs during the SAE application process. We also request that CMS consider opportunities to improve their responsiveness to questions submitted through the CMS mailbox. We believe that more timely and detailed responses would assist MAOs in completing the application process.

Part C – Medicare Advantage and 1876 Cost Plan Expansion Application

Timeline for Release of Final CY 2018 CMS Application Instructions and Forms

In 2016, the final 2017 CMS Application, forms, and Health Services Delivery (HSD) table instructions were issued in January with applications due February. This timeline is problematic for large organizations that submit high volumes of HSD tables. In order to develop HSD Tables by the CMS deadline, UnitedHealthcare begins to build them well in advance of the CMS deadline, several weeks before the date that final application information is made available by

CMS. As a result, this requires revising/repeating work and could also require programming changes that are difficult to accomplish in advance of the CMS application deadline. We respectfully ask that CMS provide HSD criteria and final instruction/forms earlier, with an October timetable being optimal, so that organizations have sufficient time to review and ask questions before they begin implementing changes.

CMS State Certification Form

We recommend CMS amend the state certification form to delete question 3. Specifically, the nomenclature creates confusion for states that use different terminology for benefit plans. For example, a state may use the terms "closed panel" to describe products, rather than the term "HMO." From a state's perspective, an HMO is typically a type of entity license. The certification form is effective without the question in that the state's obligation is to certify that the applying entity is licensed and solvent. Alternatively, regulatory changes could be made to describe the products more broadly to improve the alignment with the terminology used by the states. We would welcome the opportunity to work with CMS on this issue and provide additional examples.

Health Services Management & Delivery (3.11)
Attestation 5

There are some types of providers that are on the list of types of providers to include in the MA Facility Table that are not required to be Medicare certified, such as Speech Therapy. We recommend the insertion of "if applicable" in this attestation, as follows:

Applicant has verified that contracted providers included in the MA Facility Table are Medicare certified, if applicable, and the applicant certifies that it will only contract with Medicare certified providers in the future, if applicable.

Attestation 9

We recommend a revision to Attestation 9, which relates to regional preferred provider organization (RPPO) applicants. We are proposing these revisions to make the attestation consistent with the governing regulation that is cited as the basis for this attestation. Specifically, we advise removing the language relating to the Applicant "only operat[ing] on a non-network basis in those areas of a region where it is not possible to establish contracts with a sufficient number of providers to meet Medicare network access and availability standards" and instead using the language set forth in 42 CFR 422.2. Although this draft language purportedly relies on 42 CFR 422.2, that regulation does not in fact contain these additional requirements for operating on a non-network basis (nor does the applicable section of the Social Security Act; see 42 U.S.C. 1395w–28(b)(4)). Importantly, this draft Attestation 9 language is also inconsistent with what the Social Security Act and regulations allow: RPPOs may use methods other than written agreements to establish that access requirements are met. (See 42 U.S.C. 1395w–22(d)(5)(c)(ii); 42 CFR 422.112(a)(1)(ii).) We suggest the following language for Attestation 9 as it more closely tracks what 42 CFR 422.2 requires: "Applicant is an RPPO that has established a network of contracting providers that have agreed to a specific reimbursement for the plan's covered services and will pay for all covered services whether provided in or out of the network (see 42 CFR 422.2)."

Service Area

Our CMS contract H0543 includes Los Angeles County, California in its service area. Los Angeles (LA) County is comprised of two state and county codes (SCCs); 05210, which has four zip codes (although it shows in our HPMS service area as a full county), and 05200, which has dozens of zip codes, but not the four in 05210.

The 05210 zip codes are in the middle of the county and it is not clear why they comprise an SCC separate from the 05200 zip codes. Historically, when our organization has operated in only parts of LA County, 05200 would show as a partial county. As a result, we have filed bids with both 05210/full county and 05200/partial county included. While our bids were initially filed as full county for 2017, the bids still included both SCCs; both showed as "Full" LA County.

Having two SCCs with different zip codes associated with this single county makes it difficult for our organization, as well as other health plans that operate in LA County, to interpret the ACC report results used to evaluate network adequacy. We do not believe that health plans are required to meet network adequacy requirements in the four 05210 zip codes separately from the rest of the county. Instead, it is our understanding that health plans are required to meet the requirements in the county as a whole with all zips included. However, the reports are not produced that way.

We are unclear as to why LA County has two county codes associated with it and respectfully request that CMS collapse the two county codes into one. Having the LA County service area listed as a single county code would greatly simplify internal monitoring, reporting, and tracking associated with this county. Alternately, we request that CMS explain why they are separate and provide further detail around how to interpret the ACC reports for these two ACCs, CMS' expectations, and any difference in exception request rules if the expectation is that we meet network adequacy in the four 05210 zip codes independently in addition to meeting adequacy in the rest of the county zip codes.

Health Services Delivery (HSD) Instructions for CY 2018 Applications
HSD Table Filing Requirement to Include Existing Counties within Contract

CMS has proposed to continue the new requirement implemented for the 2017 application process, which required that SAE applications to include HSD Tables for the entire network, not just the counties that an applicant is proposing to expand into with the SAE request. We understand and fully support CMS' intent to monitor network adequacy more frequently, and we believe CMS has other more appropriate, effective, and consistent means to monitor MAO network adequacy outside of the expansion application process.

Specifically, on April 28, 2016, CMS updated Section 110.1 of Chapter 4 of the Medicare Managed Care Manual, which now states, "CMS expects that if an MAO becomes aware of network deficiencies at any time or believes that an exception is warranted for a particular specialty in a given service area, then the MAO will alert its CMS Account Manager." This new expectation provides CMS a more appropriate and effective way to conduct network adequacy assessments than monitoring the network adequacy of all existing counties on an MAO contract associated with an SAE application because it will allow CMS to focus on potential network deficiencies. The new requirements in the 2017 application process subjected MAOs to network

adequacy monitoring based on the MAO's decision to expand a service area and did not apply to MAOs that did not submit expansion applications. This is an inconsistent and non-uniform means of monitoring network adequacy that does not address concerns that network adequacy needs to be monitored across all active plans, not just those seeking to expand. Nor does it meet CMS' stated goal of "consistently" reviewing networks. Further, because this requirement only applies to those MAOs submitting expansion applications and may result in action taken against an MAO for failure to comply with network adequacy requirements, the requirement to submit HSD tales for existing counties as part of the expansion application submission violates the Administrative Procedure Act by creating inequitable treatment of similarly situated plans. We strongly recommend that CMS omit this requirement from the CMS application process.

HSD Table Exception Request Template and Criteria for Approving Exceptions

The criteria for approving or denying exceptions should be consistent with the regulations at 42 CFR §422.112(a)(10), which state that when CMS is evaluating MA networks, CMS must consider prevailing patterns of community health care delivery including the "number and geographical distribution of eligible health care providers available to potentially contract with an MAO…." and the "prevailing market conditions in the service area of the MA plan" such as "the number and distribution of health care providers contracting with other health care plans (both commercial and Medicare) operating in the service area of the plan." In the 2017 application process, CMS inappropriately applied a standard in the exception request review process that was inconsistent with these regulations. Specifically, CMS denied exception requests on the basis that the MAO was unable to contract with a provider without consideration of the factors making up community patterns of health care delivery listed in 422.112(a)(10), including whether the provider is available to contract with the MAO or the prevailing market conditions in the service area. Examples of inappropriate denials include hospitals run by county government agencies that do not contract with any managed care organizations, and providers employed by Kaiser, a staff-model HMO, that do not, under any circumstances, contract with other MA organizations. These providers are not actually "available to potentially contract with an MAO," and CMS failed to consider this factor and the prevailing market conditions in making these denial determinations. We respectfully request that CMS consider clarifying and publishing the criteria that will be used for making approval and denial determinations going forward, to ensure consistency with the regulations, consistent application of the criteria by CMS reviewers, and transparency of the expectations for MAOs participating in the program.

The draft HSD instructions and exception request template for 2018 that CMS released for comment do not include instructions for completing exception requests or the criteria CMS will use to approve or deny exception requests. UnitedHealthcare respectfully requests that CMS issue revised exception request instructions and template as well as provide MAOs a review and comment period to ensure the revised instructions and template are clear, correct, and internally consistent. It is critical that MAOs have an opportunity to review and comment on these components of the application materials and process because for the last application cycle, CMS made numerous changes to the instructions, exception request template, and process that were unclear, incomplete, and inconsistent with the regulations. This resulted in confusion and frustration for MAOs. This confusion and frustration was acknowledged by Sean Cavanaugh, the CMS Deputy Administrator and Center for Medicare Director, in his opening remarks at an industry conference hosted by CMS conference in June 2016, where he recognized that CMS may need to do a better job helping MAOs understand CMS expectations and improve the

exception request process. MAOs can provide valuable feedback to CMS to help avoid similar confusion and frustration during the next application cycle.

In particular, the exception request instructions have been removed from both the draft 2018 exception request template and from the draft general HSD Instructions that were released for comment. We respectfully ask for these exception request instructions to be shared with MAOs for a review and comment period.

Additionally, information regarding the exception request template itself is missing from the version released for comment. It does not include the drop-down menu options that MAOs would be required to use. We request that CMS share the draft Excel version of the template for comment, as applicants need to be able to view the drop down menu options to fully comment and provide feedback on the clarity and completeness of these options. Notably, we are unable to review the specific "Reason for Not Contracting" drop down menu options. We believe more detailed and additional options could streamline the review process for CMS and reduce the need for MAOs to develop detailed narrative descriptions for the most common reasons for exception requests. Following are additional drop down options we recommend CMS include:

- provider/facility has notified MAO they do not contract with MAOs
- provider/facility is employed or managed by a government entity that does not contract with MAOs (e.g., county hospital, Indian Health Services clinic, Federal prison facility)
- provider/facility has notified MAO they are at full capacity and not contracting with any additional MAOs
- provider/facility is employed or owned by a staff-model HMO that does not contract with other MAOs (e.g., physician employed by Kaiser Permanente)

Releasing the instructions and an Excel version of the exception request template would help reduce potential confusion for MAOs, like some of the confusion that arose from the 2017 HSD table instructions. For example, those instructions contained contradictory instructions about which providers to include on the HSD tables. CMS first instructed MAOs, in the HSD instructions on page 7, to "only list providers with whom they have a fully executed updated contract." CMS later instructed MAOs, in the instructions for the exception request process on page 12 that "providers listed on the Exception template must be listed in the HSD table in the county for which the exception is being requested." The exception request template requires applicants to list non-contracted providers in the exception request form. CMS verbally confirmed for UnitedHealthcare that the instructions in the exception request process section on page 12 were incorrect and should not be followed, but CMS did not issue written guidance to correct these contradictory statements. We respectfully request that CMS issue revised exception request process instructions that correct these contradictory instructions and provide MAOs a review and comment period to ensure the revised instructions are clear and consistent.

We respectfully request that CMS provide more clarity on the specific information MAOs should include in their exception requests, so that MAOs can provide the required information with their initial submissions. CMS appears to have specific expectations for information that should be included based on the CMS exception request denial rationales for the 2017 SAE process, and the 2017 exception request instructions did not clearly outline these expectations. For example, as part of the exception request process for the 2017 applications, CMS used the following

rationale for denied exceptions: "Applicant failed to submit narrative and/or data in support of its exception request." This denial rationale was used in response to exceptions when we answered Yes to Question 1 on the exception request form, No to Question 2, Yes to Question 3a and No to Question 3b, which indicated there are no additional providers available that are not contracted in our network. The 2017 exception request instructions did not require MAOs to submit narratives or supporting data in this circumstance, yet these exceptions were denied for that reason. In the draft 2018 exception request form, the section titled, Part IV: Narrative Text (Optional), is clearly marked as optional. The section titled, Part V: Table of Non-Contracted Providers, includes clear instructions to list "any providers/facilities you have identified within CMS' network adequacy criteria with whom you have not contracted." These instructions do not direct MAOs to include narrative or supporting data unless they actually identify additional providers that are not contracted. We respectfully request that CMS clarify for the CMS reviewers how and when this denial rationale should be used, or revise the instructions to explain the specific expectations to MAOs and clarify the type of data or narrative needed to support the fact that there are no additional providers.

In addition, the CMS exception request denial rationales need to be clarified and applied in a more consistent manner by CMS reviewers. For example, as part of the exception request process for the 2017 applications, CMS used the following rationale for denying exceptions: "You failed to include on its HSD table the next available contracted provider(s)/facility(ies) that will ensure access for your plan's enrollees to the provider/facility under this exception." In every case, we included the next available contracted provider/facility on our HSD table. We discussed some examples with CMS asking for clarification on the reason for their denial. In those discussions, it appeared that the reason CMS denied our exception was not consistent with the stated denial rationale, and CMS was instead seeking information about non-contracted providers. We respectfully request that CMS consider revising this denial rationale statement for clarification and providing more direction to CMS reviewers on how this denial rationale should be applied.

Finally, we believe that CMS' criteria for evaluation in the exception request process should focus on where beneficiaries reside. If there are certain zip codes that do not meet CMS HSD criteria, but there are no beneficiaries in those zip codes, then we respectfully request that CMS consider whether it is still expected that MAOs provide a detailed list of providers in those zip codes with narrative descriptions for each provider explaining why they are not contracted. Alternatively, if this is CMS' expectation, then we respectfully request that CMS clearly explain the reason for this in the exception request instructions.

Inaccurate and Outdated Sources of Data on Providers and Facility Services

The provider and facility data sources CMS is relying on to determine if there are deficiencies in an MAO's network are inaccurate and outdated. Every one of the provider and facility data sources listed by CMS in the April 28, 2016 document titled, "CMS Data Sources for Supply Mapping" has issues with inaccurate addresses, provider specialties and facility services, providers that are retired, deceased or moved out of the area, or facilities that are out of business, changed their name or merged with another entity. For example, we have noticed that the Medicare.gov website often lists services available at an acute inpatient hospital even though the hospital operating certificate may not be approved by Department of Health to provide those

services. Additionally, it appears a hospital can remain on these lists even after CMS is notified that it does not actually provide those services.

Even more concerning, we understand that CMS is also relying on network data submitted by other MAOs during the application process as an additional source of provider / facility data. We have serious concerns with this practice, as it is widely known that the insurance industry is also struggling with significant issues related to maintaining accurate and up-to-date provider network data. We confirmed that CMS is not validating the accuracy of network data submitted by competitors, and this data source is not publicly available for other MAOs to review and validate. The unintended consequence of this practice is that an MAO that submits HSD tables with inaccurate and outdated network data including providers / facilities that are no longer available may be approved by CMS, while another MAO operating in the same area that made a good-faith effort to remove outdated provider information and submitted accurate HSD tables will be denied based on the comparison of its HSD table to the inaccurate HSD table submitted by a competitor.

Given CMS' reliance on other MAOs' submitted network data, we respectfully request that CMS identify the specific providers and facilities that CMS contends will cure a network deficiency when MAOs ask for this information. In situations where MAOs do not have access to competitor MAOs' HSD table submissions, yet CMS is relying on providers listed in those submissions, it would be fundamentally fair and reasonable for CMS to share the provider name and location with the MAO whose application is being denied based on that specific provider. Moreover, with specific provider information coming from any source (whether the sources listed by CMS or from a competitor's submissions), an MAO would be able to research and verify whether the provider is truly available (for example, if the provider practices the specialty associated with the alleged network deficiency, if the provider's office is located at an address that would resolve the alleged deficiency, etc.). This would result in more accurate provider data. Providing specific provider information will support competition because an MAO is not left to guess who the provider might be that would cure the network deficiency and therefore be without any option but to drop its MA plan in that service area. This result stifles competition, ultimately reducing the available MA choices for Medicare beneficiaries.

Due to these significant concerns related to the accuracy of the data sources used by CMS, we respectfully request that CMS consider ways to ensure that all provider data sources used are accurate, up-to-date and publicly available. UnitedHealthcare believes it would be beneficial for all MAOs if CMS released one centralized and updated source of providers / facilities / suppliers (e.g., enhancing or improving Medicare.gov) rather than multiple data sources. This may make it easier for CMS to maintain accurate and updated provider data. A future, centralized data source should include processes to remove providers who are no longer practicing the specialties listed, who are no longer accepting Medicare, whose office locations are no longer correct, or who are otherwise not available.

In the absence of one source of truth, we request that CMS release any updates or clarifications to the list of the publicly available data sources, with links and instructions for how each source is used by CMS for specific provider types, at the same time the final application instructions and forms are released. MAOs need time to understand and process the source information; for example, last year the Provider of Services file included crosswalks and required navigating through numerous fields of data, and the CMS Supplier list was provided without instructions on

the last day submissions were due to CMS. Providing as much time and detailed instruction as possible will allow MAOs to focus their research and better meet CMS expectations.

HSD Table Instructions/MA Provider Table

UnitedHealthcare has concerns regarding CMS' removal of the descriptions of Primary Care provider types and MA Facility Types. Instead, in the HSD Guidance and Methodology document, CMS refers applicants to information posted on their website. Without a direct link to a currently posted document or excerpts from the applicable document included in the HSD instructions, it becomes difficult to determine whether there are proposed changes in CMS' definitions regarding these providers and facilities. Additionally, a cross-reference to another document may create additional burden or confusion for applicants if CMS alters the relevant definitions of the HSD Guidance and Methodology document at a later date without notice. We recommend that CMS include the applicable definitions and instructions related to these providers and facilities in the HSD instructions instead of providing a cross-reference to CMS' website.

We continue to support CMS' inclusion of Physician Assistants and Nurse Practitioners as Primary Care Providers. While the Descriptions of the MA Provider Types section has been removed from the draft 2018 HSD instructions, we want to ensure that physician extenders (assistants and practitioners) will still be counted as Primary Care Providers in applicants' submissions in accordance with state requirements.

Transplant Facilities List Format

UnitedHealthcare appreciates CMS' inclusion of a downloadable certified transplant facilities list. However, the list is currently only available in a PDF format, which requires considerable manual manipulation to convert to Microsoft Excel or Access for automated reporting. We request that CMS produce the certified transplant list in a .txt or Excel/Access format similar to the other website posted downloadable files of CMS certified providers (e.g., Hospital, Home Health, Suppliers) in order to streamline this process and eliminate the need for manual manipulation.

While the 2018 instructions list a specialty code of 062 for Heart/Lung Transplant Programs, the list of Medicare-Approved Transplant Programs on CMS' website does not include heart/lung transplant programs (only heart-only and lung-only). We request additional clarification regarding the availability of a heart/lung transplant program list or if CMS is not currently using this category.

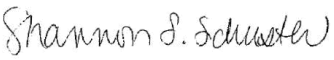
Facility Table Services – Access to CMS Information

CMS often requires information regarding facilities that is not readily available to all MAOs for use in an automated fashion; for example, the number of Medicare certified beds for hospitals, skilled nursing facilities, intensive care units, and inpatient psychiatric facilities. CMS should provide a central resource from which MAOs can obtain bed counts, by hospital location, so that this information is consistent and available to all health plans. We request that CMS provide information so that it is downloadable in Excel or other downloadable data formats. This will

assist plans in their automated production of HSD tables and population of these fields with accurate CMS information.

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

Respectfully,



Shannon Schuster
Director, Regulatory Affairs
UnitedHealthcare