Responses to Comments Received
Federal Register Notice on Revised CMS-10636:
Three-Year Network Adequacy Review for Medicare Advantage Organizations

CMS received five comments on the November 4, 2016, notice on the new proposed information collection, Three-Year Network Adequacy Review for Medicare Advantage Organizations. The commenters were UnitedHealthcare, UCare, Blue Cross Blue Shield Association, America's Health Insurance Plans, and Health Care Service Corporation. Some of the comments were identical and others were distinctive. Several commenters recommended CMS give Medicare Advantage organizations (MAOs) more notice before the network review. CMS agrees with commenters that a longer time period between MAO notification and the Health Service Delivery (HSD) upload deadline is necessary, and the Supporting Statement has been revised accordingly. Another comment amongst several submitters asked CMS to be more transparent and communicative with the industry during the implementation of this new process. CMS agrees and intends to work in close collaboration with the industry.

Burden Estimates

Two commenters noted that CMS may have significantly underestimated the hour burden due to the way CMS posed the questions and aggregated the results of the responses received. The commenters felt that the median number of hours for each information collection instrument may not be representative of the true effort.

CMS Response

CMS considered the feedback from MAOs concerning the methodology for estimating the hour burden for HSD tables and Exception Requests, but after further review of our internal process, CMS is confident in its estimation. Therefore, CMS has not revised the burden estimates as a result of these comments.

Exception Requests

Three commenters discussed Exception Requests and made recommendations or asked questions.

Two of the commenters proposed solutions to MAOs having to resubmit previously approved Exception Requests. One recommended that CMS retain previous Exception Requests so that MAOs do not have to repeatedly submit the same information. The other commenter recommended that rather than require MAOs to upload and resubmit the approved Exception Requests, the agency should consider implementing a more streamlined approach (e.g., a check box) that would balance the effort to minimize administrative burden and limit duplication, with the need to signal to CMS that an exception to the network adequacy criteria has previously been approved. It was also requested that CMS streamline the process by utilizing the same Exception Request template every year and by constructing the Exception Request to give MAOs the ability to submit provider-specific information.

The third commenter asked CMS to confirm whether it is true that MAOs will not be required to submit new requests for previously approved exceptions during the three-year network reviews.

CMS Response

CMS believes that retaining previous Exception Requests or having MAOs simply check a box to signal a previously approved Exception Request would not be appropriate. The MAO must resubmit the request using the *current* Exception Request template. There is no guarantee that a previously approved Exception Request is still necessary, given the continuously evolving patterns of care and the dynamic nature of the health care market landscape.

With regard to the template, CMS has recently improved the format and does not anticipate significant changes in the future. The new template does allow for a listing of provider-specific information. CMS reiterates that organizations must resubmit all previously approved Exception Requests using the *current* Exception Request template, which can be found both in HPMS and in the Medicare Advantage Network Adequacy Criteria Guidance, located at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf.

CMS has revised the Supporting Statement to include the above Exception Request clarifications and has replaced the information collection instrument 'Exception Request Template' (section 12.3.3) with the current version. CMS has also revised and combined the information collection instructions "Notice of Entire Network Review" Initial and Standard Letters into one HSD upload request letter (section 12.6.2).

Compliance Actions for Network Deficiencies

Two commenters inquired about potential CMS compliance actions for any discovered MAO network deficiencies. They recommended that CMS elaborate on: (1) the linkage between network deficiencies and subsequent compliance actions; (2) the possibility of an opportunity to respond to any finding before it is finalized; (3) the process for MAO appeal; (4) the compliance continuum; (5) the consideration to be given to contracting efforts to come into network compliance; and (6) the fair and appropriate application of enforcement actions.

CMS Response

As part of CMS's network reviews, MAOs receive initial findings and have the opportunity to request exceptions to address findings, prior to CMS making final determinations. Once CMS makes final determinations, CMS may, as with any deficiency identified, take compliance actions. The level of compliance action will be based on a number of factors, including the number of deficiencies, types of deficiencies, how long the deficiency has existed, and any extenuating circumstances, which may include contracting efforts. For more serious infractions, CMS may impose an enforcement action (e.g., sanction). The CMS regulatory appeals processes may be found in 42 CFR 422.

Timeframes

Several commenters requested that CMS send out the HSD upload request letters earlier, giving MAOs as much advance notice as possible of their qualification for a network review. Some commenters requested at least 60 days (or preferably 90 days) to prepare and test networks before the Network Management Module (NMM) gates open for uploading HSD tables. One commenter asked that CMS not require completion of the review until after the application season, and another alternatively recommended establishing a static due date for the upload.

CMS Response

CMS agrees that more preparation time (i.e., than the 30 days initially proposed) is appropriate and has revised the Supporting Statement to say that CMS will issue HSD upload request letters to MAOs at least 60 days in advance of the required upload of current HSD tables. CMS has also revised and combined the information collection instructions "Notice of Entire Network Review" Initial and Standard Letters into one HSD upload request letter (section 12.6.2).

Transparency/Communication with Industry

Several commenters expressed concerns regarding CMS transparency and communication with the industry during the rollout of the three-year network adequacy review. The commenters recommended that CMS provide additional information regarding the actual timing of the initial comprehensive reviews and produce continuing guidance in a transparent manner throughout the implementation process. It was also recommended that CMS work in close and ongoing collaboration with MAOs in a transparent manner and take a flexible approach to initial implementation of the new process.

CMS Response

CMS appreciates these concerns and agrees that detailed guidance and transparency are key to the success of the three-year network adequacy reviews. CMS will communicate to the industry additional information on the exact timing of the reviews as soon as dates are determined. Ongoing technical assistance will also be provided as needed throughout the review process. CMS intends to work closely and transparently with MAOs.

Provider Exclusivity Contracts

One commenter requested that CMS consider approving exceptions for providers/facilities that contract exclusively with another MAO.

CMS Response

Since the initial publication of the Supporting Statement, CMS has added this consideration to its examples of valid rationales for exceptions in section 5.3.2 of the Medicare Advantage Network Adequacy Criteria Guidance, located at https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_

Document_1-10-17.pdf. Note that CMS has not revised the Supporting Statement as a result of this comment. CMS references this guidance document in the Supporting Statement.

Original Medicare Pattern of Care

One commenter recommended that CMS remove the language "equal to or better than the prevailing original Medicare pattern of care" and instead use the language from 42 CFR 422.112(a)(10), which states that when CMS is evaluating MA networks, CMS must consider prevailing patterns of community health care delivery.

CMS Response

Since the initial publication of the Supporting Statement, CMS has clarified its guidance by stating that in evaluating an exception, CMS will consider whether there are "other factors" present, in accordance with 42 CFR 422.112(a)(10)(v), including: (1) the proposed exception reflects access that is consistent with or better than the original Medicare pattern of care, and (2) the proposed exception is in the best interests of beneficiaries. 42 CFR 422.112(a)(10)(v) states, "Factors making up community patterns of health care delivery that CMS will use as a benchmark in evaluating a proposed MA plan health care delivery network include...Other factors that CMS determines are relevant in setting a standard for an acceptable health care delivery network in a particular service area." In its updated guidance, CMS has articulated the "other factors" it has determined to be relevant, which include "the proposed exception reflects access that is consistent with or better than the original Medicare pattern of care." Therefore, CMS will not change its policy as a result of this comment. We have determined that the original Medicare pattern of care is a critical consideration when evaluating community patterns of health care delivery. An MA enrollee in a particular service area must have access that is consistent with or better than an original Medicare beneficiary's access in the same geographic area, because it is the nature of MA plans to provide health care services that are often an advanced alternative to original Medicare. Thus, an MA provider network should not be of lower quality than the provider options in original Medicare.

For more details, please refer to section 5 of the Medicare Advantage Network Adequacy Criteria Guidance, located at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf. Note that CMS has not revised the Supporting Statement as a result of this comment. CMS references this guidance document in the Supporting Statement.

HPMS Report

One commenter requested that CMS make the "Contract Anniversary Date" reports downloadable from HPMS, which would ensure that MAOs are prepared with their HSD tables and Exception Requests.

CMS Response

CMS anticipates making an organization-specific version of this report available in HPMS. The report will list when the next network submission is due. An MAO could reference the report at any time and see data for contracts affiliated with their user ID, in order to tell when each contract is due for its next three-year network review. CMS has revised the Supporting Statement to include these details about the HPMS report.

Full Network Review in Application

One commenter recommended that CMS eliminate the full contract-level review from the Service Area Expansion (SAE) application process.

CMS Response

CMS plans to review Medicare Advantage provider and facility networks under this collection, at a minimum every three years or possibly sooner if there is a network review triggering event, rather than our previous process of reviewing networks at the time of application. Our goal is to make this change beginning with CY 2019 applications, pending OMB approval of this proposed information collection. If this information collection is approved by OMB, then the network review would be removed from the application process. CMS has revised the Supporting Statement to include these details.

Cost to Federal Government

One commenter noted that CMS may not be properly estimating the cost to the federal government, such as work hours and staff needed, which might potentially result in process delays and quality issues.

CMS Response

As CMS makes the procedural change to move the network review out of the MA application and into this three-year review, we are shifting the annualized cost to the federal government from the information collection entitled Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits (OMB control number: 0938-0935), to this New information collection request. CMS has revised the Supporting Statement to include these costs to the federal government.

Network Submission Criteria

One commenter requested that CMS provide MAOs with as much detailed submission criteria as possible.

CMS Response

Since the initial publication of the Supporting Statement, CMS has consolidated and significantly enhanced all guidance, including detailed submission criteria, in the Medicare Advantage Network Adequacy Criteria Guidance, located at: https://www.cms.gov/Medicare/Medicare-

Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf. For specific information on HSD table upload instructions, please refer to sections 4, 10.4, 11, and 12 of the guidance document. CMS has replaced the information collection instructions/guidance 'HSD Instructions' (section 12.6.1) and the information collection instruments 'Provider HSD Table' (section 12.3.1) and 'Facility HSD Table' (section 12.3.2) with the current versions.

Phase-In for Large MAOs

One commenter requested that CMS consider phasing in the three-year network adequacy review for large MAOs with many contracts.

CMS Response

CMS understands the concern regarding this new requirement for large MAOs with many contracts. However, all MAOs must be held to the same standards in order to maintain a level playing field. In addition, it is CMS's expectation that all MAOs continuously monitor their networks to ensure compliance with the current CMS network adequacy criteria. The network adequacy review process is not new, and a phase-in is not necessary so long as large MAOs are practicing the continuous monitoring CMS expects.

Partial Counties

One commenter requested that CMS indicate whether adequacy will be measured at the zip code level or globally, regarding partial counties.

CMS Response

If an MAO with partial counties fails the network adequacy criteria in a certain area, then the MAO may submit an Exception Request. Exception Requests are submitted at the county level as network adequacy is assessed at the county level for each contract.

Triggering Events

One commenter requested that CMS provide more details about the criteria used for determining when a triggering event warrants a full network review.

CMS Response

As described in the Medicare Advantage Network Adequacy Criteria Guidance, the extent of the CMS network review varies based on the specific circumstances of the triggering event. Some events may warrant a partial network review if only certain specialty types and/or counties are impacted, however, CMS makes this determination on a case-by-case basis. CMS has revised the Supporting Statement to include these details.

Coordination of Audits/Monitoring

One commenter noted that there is a need for greater coordination of MA and Part D audits and monitoring efforts to increase efficiency, reduce redundancy, and minimize administrative burdens.

CMS Response

CMS understands the importance of coordination and will strive to increase efficiency, reduce redundancy, and minimize administrative burdens whenever possible.

Exception Process Improvements

One commenter recommended that, prior to finalizing its proposal on three-year network adequacy reviews, CMS work with the industry to develop improvements to the current exceptions criteria and process.

CMS Response

Since the initial publication of the Supporting Statement, CMS has consolidated and significantly enhanced all guidance, including the exceptions guidance, in the Medicare Advantage Network Adequacy Criteria Guidance, located at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf. CMS has significantly improved the exceptions criteria and process based on lessons learned with the industry during the CY 2017 application cycle and appeals process. CMS has replaced the information collection instrument 'Exception Request Template' (section 12.3.3) with the current version.

Approved Exceptions

One commenter recommended that CMS implement a process to make available to all MAOs in a given service area, information regarding all approved Exception Requests for certain provider types in the service area, in an effort to increase transparency and consistency in the application and review process.

CMS Response

CMS notes that this information is already available to the industry in the current HSD Reference File, on the 'Criteria Changes' tab, which includes county/specialty instances where criteria has changed between the CY 2016 and CY 2017 application cycles. These criteria changes resulted from approved Exception Requests during the CY 2017 application cycle. CMS will update this information every year in the HSD Reference File, which is located at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html.

Significant Network Changes

One commenter recommended that CMS further clarify and refine the definition of "significant" network changes, for example, by providing guidelines and/or criteria organizations may use to make accurate and appropriate determinations.

CMS Response

CMS recognizes the industry's concern regarding defining "significant" network changes. CMS believes that the guidance currently provided in chapter 4 of the Medicare Managed Care Manual is sufficient. CMS also reiterates the fact that every network change is different and must be assessed on a case-by-case basis.