January 3, 2017

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via https://www.regulations.gov

Re: CMS—10636 (OCN 0938-New)

To Whom It May Concern:

Health Care Service Corporation (HCSC) appreciates the opportunity to submit comments in response to the notice under the Paperwork Reduction Act concerning the "Three-Year Network Adequacy Review for Medicare Advantage Organizations" published by the Centers for Medicare & Medicaid Services (CMS) in the *Federal Register* (81 FR 76946) on November 4, 2016.

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 serves more than 15 million members, and has established Medicare Advantage Prescription Drug (MAPD) plans and Part D Prescription Drug (Part D) stand-alone plans in all five of the HCSC states. In addition, HCSC operates a Medicare-Medicaid Plan (MMP) contract in the State of Illinois as well as Medicaid contracts four of the HCSC states.

COMMENTS

Supporting Statement – Part A

- ***Initial Implementation Approach.*** Currently, a Medicare Advantage (MA) organization's entire contract-level provider network is not formally reviewed by CMS after the initial contract application process, unless one of several CMS-specified "triggering events" occurs. We note that the timing of these triggering events and duration between such events varies across contracts, resulting in an inconsistent review approach where some contracts may be subject to network adequacy reviews more frequently than others or not at all after the initial application. In an effort to improve monitoring of MA organization compliance with CMS' network adequacy requirements, CMS is proposing to require organizations to upload Health Service Delivery (HSD) tables to the HPMS Network Management Module (NMM) for any contract that has not had an entire network review performed by the agency in the previous three-years of contract operation. Each affected contract will be assessed against the current MA network adequacy criteria at the time of the review. In general, we support the proposal and believe if implemented appropriately and in an equitable manner among all

contracts, this process will permit the agency to take a more balanced and uniform approach to evaluating and determining MA organization compliance with network adequacy requirements as all contracts will be subject to the three-year review cycle. This approach also may better position CMS to determine whether there is potential for beneficiary harm related to undetected network deficiencies in a manner that is consistent across all, rather than a subset of contracts.

As CMS continues to refine the proposed approach, such as determining the implementation timeline and identifying any needed systems and other modifications, HCSC recommends that the agency work in close and ongoing collaboration with MA organizations in a transparent manner. These steps will allow CMS to benefit from the range of MA organization practical experience and knowledge, and ensure any operational issues or considerations are identified as early as possible in the development process and well in advance of implementation. In addition, given the increased scale and scope of the proposed approach in comparison to the current review process, it will be important for CMS to take a flexible approach to initial implementation of the new process to accommodate the significant system, administrative, and timing resources that will be required on the part of the agency and plans.

- ***Exception Requests.*** Under the 3-year MA network adequacy review approach, CMS proposes that for each affected contract subject to the review, MA organizations may submit Exception Requests to the agency for consideration following the HSD table upload, and must resubmit all previously approved Exception Requests. We believe it is important that MA organizations have the ability to submit requests when an exception to the current network adequacy criteria is warranted, especially given the continuously evolving patterns of care in certain service areas, and we appreciate that CMS is proposing to maintain this process under the revised network adequacy review approach. In addition, our understanding is that organizations will not be required to submit new requests for previously approved exceptions during the 3-year adequacy reviews although, as noted above, previously approved Exception Requests must be resubmitted. For clarity, we recommend that CMS confirm whether our understanding is accurate. We also recommend that rather than require organizations to upload and resubmit the approved request templates and any related supporting documentation, the agency should consider implementing a more streamlined approach (e.g., a "check box" or similar functionality) 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. Lastly, we further recommend that CMS implement a process to make available to all organizations 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.

- ***Significant Network Changes.*** CMS requires MA organizations to notify the agency of any no-cause provider termination that the organization deems to be a "significant" change to the provider network, at least 90-days prior to the effective date of the change[1]. The agency believes that MA organizations "may be in the best position to determine whether or not a provider termination without cause is significant" and expects organizations to take a conservative approach in making such determinations and notifying CMS accordingly. The

[1] See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf

agency notes that an organization that does not notify CMS of network changes that are ultimately determined by CMS to be significant will be subject to appropriate compliance actions. While CMS guidance broadly defines "significant" changes as those changes to provider networks that go beyond individual or limited provider terminations that occur during the routine course of plan operations and affect, or have the potential to affect, a large number of enrollees, the agency does not provide specific guidelines or criteria organizations may follow when making such determinations. To promote a common understanding across MA organizations of the agency's expectations, as well as to ensure compliance with CMS' requirements, HCSC recommends 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.

We have appreciated the opportunity to comment. 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