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August 18, 2017

SUBMITTED VIA EMAIL TO: OIRA_submission@omb.eop.gov

Office of Management and Budget (OMB)
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer

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* (82 FR 33131) on July 19, 2017.

BACKGROUND

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 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 in 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. As we have previously noted, 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 remove the network review from the application process and instead, create a separate and distinct operational function that would 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. HCSC continues to be generally supportive of the agency's proposal and we believe if implemented appropriately and in an equitable manner among all contracts, this process will permit CMS 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 further refine the proposed approach, such as 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.

- ***Implementation Timing***. While the CMS Supporting Statement indicates that the agency's goal is "to make this change beginning with the CY 2019 applications, pending OMB approval" it is unclear whether the initial 3-year network reviews would *begin* in 2019. In addition, we note that during the prior 60-day comment opportunity, CMS indicated that the agency would issue HSD upload request letters to organizations "at the same time each year (preferably in September, after application cycle is over)." However, under the current 30-day comment opportunity, CMS was silent on the anticipated timing of these requests. For clarity, we recommend that CMS confirm when the agency will begin the network adequacy reviews under the revised approach, as well as the timing of when the HSD upload request letters will be provided to organizations in the initial and subsequent years of implementation. As a practical consideration, we encourage CMS to establish a timeline that avoids implementation early in the year, and to ensure that the sample beneficiary file against which an organization's networks must be compared is available well in advance of that timing.

- ***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 *new* Exception Requests to the agency for consideration following the HSD table upload, and must resubmit all previously approved Exception Requests using the *current* Exception Request template. As previously indicated, 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. However, rather than require organizations to upload and resubmit previously approved requests and any related supporting documentation (which often may be substantial), the agency should consider implementing a more streamlined approach (e.g., a "check box" or similar functionality) that would balance the need for CMS to determine whether a previously approved request is still necessary, with the effort to promote efficiency, minimize administrative burden and limit duplication. In

addition, 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 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 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 reiterates our previous recommendation 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 202-249-7214 or Dana_Mott-Bronson@hcsc.net.

Sincerely,

Dana Mott-Bronson
Executive Director, Health Policy – Government Programs

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