JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

August 17, 2017

Office of Management and Budget
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer,
Submitted via Email: OIRA_submission@omb.eop.gov

Re: Document Identifier CMS-10636. OMB Control No. 0938-New
Three-year network adequacy review for Medicare Advantage Organizations

Justice in Aging appreciates the opportunity to comment on the above-referenced information collection proposal.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources.

We appreciate and support the CMS initiative to ensure that all Medicare Advantage plans are subject to a full network adequacy review at least once every three years. The growth of enrollment in Medicare Advantage plans, now at close to one-third of Medicare beneficiaries, has elevated the importance of ensuring that plans meet network adequacy requirements. Further, the review of online provider directories released by CMS in January of this year showed that 31% of providers were not found in the locations listed in provider directories, which the agency noted "raises concerns about whether these providers are even part of the network."[1] The deficiencies revealed in the CMS review further highlight the importance of robust and regular network reviews.

We are concerned, however, about the removal of the network review from the application process. We believe review of network adequacy should remain an essential part of the new contract application process, even if tri-annual review of the entire network at the Medicare Advantage Organization level is implemented. Evaluating a new plan's network adequacy at the contract level as part of the application process is important in ensuring that all plans have adequate provider resources to serve Medicare enrollees.

We also ask specifically that, when CMS conducts its network adequacy reviews, it look especially at adequacy where plans use delegated models. Particularly in California, advocates are seeing increasing use of delegation where Medicare Advantage plans provide

[1] CMS, Online Provider Directory Review Report (Jan. 13, 2017), available at www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Final_01-13-17.pdf .

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per-member per-month fees to independent physician associations (IPAs) or physician provider groups (PPGs). In some cases these IPAs and PPGs in turn may sub-capitate even further to other physician groups and providers. Although the beneficiary may theoretically use a provider outside of the delegated or sub-delegated entity, a decision to do so requires that the beneficiary change her Primary Care Provider (PCP) and also lose the services of the entire constellation of providers in the delegated network associated with the PCP. Thus, at any point in time, the plan member only has access to one delegated entity's sub-network of providers.

For there to be genuine network adequacy in such a system, CMS should require that each delegated network fully meet network adequacy standards.[2] Allowing plans to use a delegated model without these protections has the practical effect of denying beneficiaries the rights promised by the network adequacy regulations, specifically 42 CFR 422.112(a)(1).

Thank you again for the opportunity to comment. If you need additional information, please do not hesitate to contact me at gburke@justiceinaging.org.

Sincerely,

Georgia Burke
Directing Attorney
Justice in Aging

[2] Though beyond the scope of this notice, it also is critically important that plan provider directories are designed so beneficiaries can understand which providers belong to which delegated entities.