SNP Alliance A National Nonprofit Leadership Organization

The National Voice for Special Needs and Medicare-Medicaid Plans

SNP Alliance Comments on Three-Year Network Adequacy Review for Medicare Advantage Organizations CMS-10636, OMB 0938-New
August 17, 2017

The SNP Alliance is pleased to have an opportunity to submit comments on proposed changes to the CMS Medicare Part C network review data collection and review process. We understand that CMS is proposing that MA plans submit networks every three years. We have not taken a position on that provision specifically but we have a number of related comments that we hope can be considered.

- **Population and SNP Specific Based Standards:** In its' 2018 Call Letter, CMS announced interest in exploring the potential benefits of establishing separate network adequacy evaluations of SNP-specific networks. We assume these would consider the needs and numbers of enrollees in each SNP type (I-SNP, D-SNP and C-SNP). We continue to support this proposal and are aware that there are a number of highly technical operational processes that must be considered in order to implement this option most efficiently. However, it is not clear how the proposal to move to three year network reviews with its continuation of reviews at the contract level will accommodate SNP specific network reviews because SNP specific networks may require PBP level network variations to best meet the needs of different groups of beneficiaries that each SNP type is designed to serve. (Please see comments submitted on this topic as part of the SNP Alliance response to the 2018 Call Letter, February 2017.)

  There are advantages in CMS mapping SNP networks against the appropriate underlying SNP population rather than the entire Medicare distribution, as SNP beneficiaries may not be geographically distributed in line with general Medicare beneficiaries and SNP specific networks may be better able to align with member needs and for integrated D-SNPs, with State Medicaid networks. SNP specific networks will be useful in tailoring network access more closely to the number and types of providers needed by the SNP population which could facilitate improvements in care outcomes while reducing administrative burdens in certain circumstances. However, depending on how this is done, it can also create additional burdens on plans. We look forward to working with CMS in a collaborative process to facilitate constructive advice from members into the development of the SNP specific network criteria including how to make this accommodation meaningful and as efficient as possible.

  As part of this process, we believe that CMS should continue to move toward supply-based time and distance criteria that result in a more accurate review of local access for the targeted population, including removing the need for year-over-year exceptions in some counties. CMS should assess access using supply based network methodologies in a manner that is appropriate to the population the plan is applying to serve. Supply based network requirements should reflect the needs of specific target populations in specific service areas rather than being based on all available Medicare providers in the service area. For example, I-SNPs may utilize a smaller number of physicians specializing in institutional populations. In addition, network adequacy for a D-SNP target population of 50,000 dual eligibles age 18-64 with disabilities might be different from that needed for a general Medicare Advantage population of 500,000.

  However, MA networks are submitted and reviewed at the contract level while many SNP plans are organized at the PBP level. CMS will need to develop operational mechanisms that allow for some PBP level variations to accommodate differences in relation to those special needs. CMS will need to

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have systems in place to accommodate these tweaks and/or additional submissions and should consider looking for additional efficiencies in other parts of the submission process to make room for incorporating important changes.

We believe that CMS' successful review of Provider Specific Plan (PSP) networks for CY2017 demonstrated HPMS ability to review networks at the PBP level. This process lends itself to establishing criteria and reviewing networks specific to SNP PBPs and should provide some guidance for application to the SNP specific networks. In addition to the PSP level experience we recommend that CMS look to the approach to population specific network modification used by MMCO for the Medicare Medicaid Plans (MMPs) participating in the Financial Alignment Demonstration and the Minnesota D-SNP Administrative Alignment demonstration for approaches to SNP specific networks. The MCCO has been successful in modifying network adequacy requirements for MMPs and the MN D-SNP demonstration to address appropriate provider access that considers the numbers of the specific target populations expected to be served within the service area. In addition, where there are multiple SNPs and or SNP types under a contract, CMS could consider using market reviews to determine which method works best in a given situation. The SNP Alliance recommends that CMS build on learnings from these approaches to develop SNP specific network standards based on the needs and numbers of beneficiaries to be enrolled.

- **Update Criteria based on Changing Modes of Service Delivery:** As part of any changes in the network processes impacting SNPs, it is critical that CMS update its approach to network adequacy by accommodating more modern methods of service delivery such as telemedicine, mobile clinics, and in home delivery such as physician and other provider practices that do not see patients in a clinic, but visit them in individual residences, group homes, and assisted living entities. Given the shortage of mental health professionals, telehealth is particularly important for assuring appropriate access to behavioral health services such as psychiatry. In rural areas specialists are often not available and geographic barriers may pose problems for meeting time and distance standards. CMS should also work to recognize that primary care providers with specialties such as Family Practice and Internal Medicine often meet the specialty needs of enrollees for services such as allergy and dermatology services. For SNPs serving dually eligible members in particular, where state Medicaid networks rely on these methods of service delivery it is important that Medicare also consider these options to improve network alignment and service delivery coordination.

  In addition, CMS should consider how network criteria can support and be compatible with plan efforts to utilize value based contracting tied to criteria for improved outcomes, costs and quality of services. Providers that specialize in care for populations with chronic care needs may be able to achieve better results under these arrangements than are typical under contracts with a large number of providers not well equipped or particularly devoted to serving special needs groups.

- **Continue to Improve the Exceptions Process:** The SNP Alliance appreciates changes in the Exceptions form that streamline the process and provide more options on the drop down menu for explanations of discrepancies and problems related to the exceptions request.

  CMS should continue to increase transparency, communications and information sharing around exception requests. For example, CMS should identify and inform plans of the specific providers plans need to contract with to close access gaps, provide a better path for communication/resolution about exceptions, and in general provide specific feedback to plans about network submissions via HPMS. Further, CMS could consider a method for avoiding resubmission of exceptions in situations that are not going to change year over year (such as those related to geographic barriers.)

In some cases CMS has not approved the network for some counties even where there is no remedy available. CMS should notify plans in advance to allow plans enough time to appeal adverse CMS network adequacy decisions especially where there is disagreement on the accuracy of the "source of truth" used in the decision. For D-SNPs, CMS should identify a realistic remedy or allow the request to move forward if there is agreement with the state that the network is otherwise adequate.

- **Improving Transparency, Accuracy of Sources and Efficiency of Reviews:** While we understand and appreciate the improvements that have been made, CMS still lacks a clear process for correcting factual errors in the underlying provider data and methodologies or "source of truth" required for populating HSD tables. If data CMS is using on its compare tools is outdated, it needs to be validated and then updated on an ongoing basis, and this process and its sources should be made transparent to plans, providers, states, other stakeholders. Correction of factual errors may be even more important when reviews occur more frequently and where SNP specific networks tailored to smaller populations may result in more compact networks. In addition, for integrated D-SNPs, providers enrolled in Medicare may not be enrolled in Medicaid and as a result, using sources such as Physician Compare for a dually eligible population misstates actual access for this population.

  While members appreciate the new network management module CMS has made available allowing plans to test network before the official filings, this has not resolved all of the factual problems. CMS should still consider publishing its provider and facility supply files in advance of the application cycle, clarify its sources for data, and develop a more efficient process to allow MAOs and providers to submit to CMS updated requests on attributes known to be vulnerable to inaccuracies, such as specialty type and address without having to go through the entire exceptions process.

- **Efficiency of Reviews:** The proposed three year review process could increase administrative responsibilities for both CMS and MA plans. CMS should look for additional methods of improving the administrative efficiency of the network approval process for SNPs such as those below.

  - Clarify criteria for defining some provider types. Where there is disagreement with respect to D-SNPs, CMS could also rely on state agreements in these instances. For integrated D-SNPs, as allowed under the FAI and D-SNP demonstrations, CMS should allow joint plan and CMS consultation with states partnering with plans on D-SNP development to resolve problems based on network disagreements prior to denying a contract or service area expansion request.
  - CMS could enable improved communications by creating (and staffing for quick turnaround), a mailbox specific to network questions e.g., similar to the DMAO Mailbox used to respond to other types of application questions.
  - CMS must adequately staff network review functions to allow comprehensive analysis and consideration of SNP specific networks, including time for consultation with state agencies where disagreements on D-SNP networks impact state contracting arrangements.
  - CMS could provide periodic "basic training" on the on use of HPMS network modules and any changes in the criteria, methodologies and exception process.

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