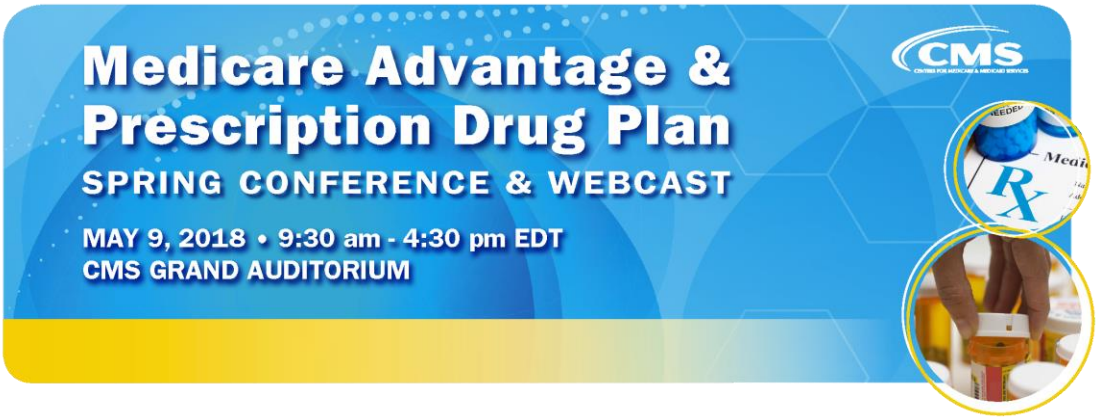

Network Adequacy Review Roundtable Discussion

Theresa Wachter, CM
Kelley Ordonio, CM
Christine Reinhard, CM
Nyetta Patton, CM

Stacey Plizga: Our next session features a panel discussion with representatives from CMS who will provide an overview of the 2018 Medicare Advantage Network Adequacy Review Process and provide a behind-the scenes look at the timeline of CMS's network review activities.

Please help me to welcome Theresa Wachter, Kelley Ordonio, Christine Reinhard and Nyetta Patton.

Theresa Wachter: Okay, good afternoon, everyone. My name is Theresa Wachter, and we're going to start off with a polling question. How familiar are you with CMS's Network Adequacy Review activities? A, not at all familiar or beginner level. Familiar, Intermediate, or Very Familiar, Expert.

Okay, it looks like most of you are not at all familiar. So hopefully we will teach you something today.

So we're going to start out with the basics here. What is a network? Well, from the organization perspective, they would say our network is all providers and facilities we contract with to provide healthcare services to our enrollees. And then the alternative, the enrollee perspective, is the providers and facilities I can choose from to get the healthcare that I need. Often enrollees review their provider directory to figure out which providers are in their network.

And there are various types of network-based plans. Most common is the standard Medicare Advantage coordinated care plan, which could include PPOs, HMOs, and HMOs with a point-of-service option, etc. Other types of plans with networks include Section 1876 cost plans, network-based private fee-for-service plans, and network-based medical savings account plans.

Per the CMS regulations, all network-based plans must maintain a network that is sufficient to provide adequate access to covered services to meet the needs of the population served.

In order to measure the adequacy of a plan's network, CMS has developed quantitative network adequacy criteria. And we update this criteria annually to reflect any changes in the healthcare market landscape, industry trends, and enrollee healthcare needs.

The network adequacy criteria encompass a variety of elements listed here on the slide. Most of you are familiar with our basic minimum number and time-and-distance criteria. We have requirements for minimum number of providers and maximum travel time and distance for enrollees to reach these providers.

We also have the beneficiary coverage ratio and the county type designations, which are Large Metro, Metro, Micro, Rural, and CEAC, or Counties with Extreme Access Considerations.

And also very important are the provider and facility specialty types, which are currently listed in our Network Adequacy Criteria guidance.

We're not going to go into the detail of the actual network adequacy criteria here today, but if you'd like to learn more, you can reference our

health service delivery reference file and our network adequacy guidance document. These are both currently posted on the MA applications website at the link on this slide. And just to note, we will also be posting a network adequacy training webinar for organizations on this website very soon, so keep an eye out for that.

Organizations must meet current CMS network adequacy requirements. Using the network adequacy criteria as a measure, CMS reviews plan networks regularly to ensure a consistent process for network oversight and monitoring.

New for 2018, we review full contract-level networks on a triennial basis, or every three years. For more information on this new process, you can reference our January 10th HPMS memo where we made this announcement.

In addition to the triennial network adequacy review, CMS may perform a network review after specific events which we call triggering events. The potential triggering events are listed here. First and foremost is the initial application, which is the most obvious triggering event. This is the organization's very first full contract-level network review. So very important.

Next is a Service Area Expansion, or SAE, application. And instead of a full network review here, this event prompts a partial review of only the new counties that the organization is expanding into.

And please note an application's approval is not contingent on the network review.

And then the last four triggering events could prompt either a full or a partial review depending on the case. These are significant provider

facility contract termination, a change in ownership transaction, a network access complaint, and finally an organization-disclosed network gap.

Okay, so now that we've covered the basics of networks, network criteria, and network reviews, let's jump into the meat of our presentation today. We will essentially be doing an overview of the 2018 Medicare Advantage Network Adequacy Review process. We will show you a behind-the-scenes look at the timeline of CMS's network review activities.

So here is our basic timeline illustrating the major network-related events throughout the year.

First, in January we released the HSD reference file, which I mentioned before. And then from February through June, organizations have the opportunity to come in for an informal network consultation with CMS. Some key dates in June include the deadline to remove counties, or service area reduction, service area verification, and of course the famous bid submission deadline, the first Monday in June.

Next, June through September is the formal network review, so this is coming up soon, when organizations must formally submit their networks to CMS for review. For any applicants, contracts are signed in September. And then CMS's compliance assessment takes place from September through the following January.

So I will now turn it over to Kelley Ordonio from the MA Operations Division who will walk you through each of these points on the timeline.

Kelley?

Kelley Ordonio: Thank you, Theresa.

As shown in the timeline, the network review process begins in January with CMS issuing the reference file. The reference file is the product of the methodology that sets the criteria for the upcoming year. We use a county-type designation method that is based upon population size and density. The method is similar to approaches used by the Census Bureau and the Office of Management and Budget. We recently enhanced this method to include provider supply within each county.

The reference file is published on CMS's website and programmed into HPMS for all organizations to use.

The supply file is a cross-sectional database that includes information on provider and facility name, address, and NPI, National Provider Identifier, and specialty type and is posted by state and in certain circumstances specialty type. It was developed by CMS and the network contractor using the Medicare claims data and publicly-available sources on Medicare.gov website. And is located in HPMS under the Network Management Module section using the references link.

Next I'm going to turn it over to Nyetta to discuss the Regional Office role as CMS begins the informal consultation review period.

Nyetta Patton: So the account managers play a vital role in the consultation phase by conducting an ongoing communication with the organizations specifically after the release of the contract year 2018 changes to network review process for Medicare Advantage plans and Section 1876 cost plans HPMS memo that was released, as Theresa mentioned, on January the tenth, 2018.

The goal of the account management communication is to ensure the following: Remind organizations that CMS announced a consultation opportunity and to provide technical assistance to those organizations in

building their provider and facility networks. Organizations would have the opportunity to upload their health service delivery tables for consultation until February the 20th, 2018.

And while the consultation phase was optional, account managers strongly encourage organizations to use the opportunity to engage with CMS and request technical assistance. There would only be one opportunity to upload HSD, or Health Service Delivery, tables for an informal or consultation review.

And that CMS would release updated network adequacy guidance, which was actually released in February, 2018.

And also reminded organizations that if they were selected for the formal triennial network review, they would receive notification 60 days prior to the review in June.

Because this procedure is new, the account managers realized that organizations would have questions and instructed them to direct their questions to the DMAO mailbox portal. And they also shared the location of that portal. And I will share it with you in case you don't have it. It's https://dmao.lmi.org. And also, they were instructed to copy their account managers.

Regional office staff's role in the consultation phase is to communicate basic network information to organizations in a consistent and timely manner in collaboration with Central Office.

I'll turn it back to Kelley to finish the discussion of consultation.

Kelley.

Kelley Ordonio: Thank you, Nyetta.

At this point, the network adequacy guidance is available for organizations to use as they are building their networks to meet CMS's network adequacy criteria of 90% of providers available to the beneficiaries residing in that county.

CMS has an event ID for consultation that allowed all organizations the opportunity to upload their provider and facility tables in HPMS.

Once the tables were submitted, the organization received their ACC report which tells them in which county and specialty combinations they are either passing and/or failing. If they are failing, they would need to work to fill – to try to fill the gap to meet CMS's network adequacy standards to ensure that 90% of beneficiaries are reaching access to care.

Organizations participating in the consultation would be discussing these gaps in their provider network and would not be subject to compliance. This consultation allows organizations a technical assistance opportunity where organizations can receive guidance and engage in dialogue with CMS as organizations work to build their networks to meet CMS's network standards.

The next step in the network review is the organizations submitting their HSD tables, then uploading their exceptions, and it begins like this.

Organizations upload their HSD tables into the network management module prior to the deadline. Once HSD submission gates close– the automated criteria reports are generated. Organizations are able to see the pass/fail results of their networks for each county/specialty combination. As organizations are aware of their networks of contracted

providers, they should also be aware of any gaps that they may potentially have where an exception to the network standards could be requested. The exception request allows organizations, on a case-by-case basis, the opportunity to tell CMS if they believe the supply of providers is insufficient and when they cannot meet the published criteria due to a change in the healthcare market landscape.

The Exception Review team is a centralized team dedicated to the network reviews and is comprised of staff from the Policy Division, Operations Division, Regional Office, and the Network Adequacy contractor. Everyone works together and has roles within the team to allow CMS to provide industry with the most current network standards and criteria as organizations work to provide enrollees with adequate access to covered services.

Once the team receives the exception request, our work begins. The team is taking the exception requests and validating the information provided by first conducting provider validation calls and validating the information that the organization has presented to CMS as to why they are unable to meet the network standards.

Next, the team is looking to see if the organization contracted with the providers we identified in the supply file. The supply file is a comprehensive list of providers that CMS has identified as available providers across all counties to include the identified specialty types.

Once we take all these points into consideration, we work to make a determination.

An exception request approval is a point-in-time determination. It's a real-time update to provider facility supply in the service area. CMS updates

its network adequacy criteria to include the most current supply of providers and specialties each year.

Organizations must resubmit an exception request when CMS requests a network upload for the corresponding county and specialty. A previously-approved exception request does not guaranty that you will be approved for the following year.

And now we have another polling question. True or false. Only CMS Central Office staff review exception requests. That is correct, false. Now it's changing.

So the correct answer is false. The CMS Exception Review Team is comprised of Central Office staff, Regional Office staff, and our Network Adequacy contractor.

As the team works to validate providers and exception requests. Here are some valid reasons for exception requests that can be used for all county types.

Providers moved or retired or the facilities have closed. Provider or facility may cause enrollee harm. Provider and facility are inappropriately credentialed under MA regulations. Provider and facilities do not contract with any organizations. Or the provider and facility contract exclusively with another organization.

And please note that CMS has the right to validate all the statements made on the exception requests. And please keep these two things in mind. That these reasons are not exhaustive and there may be some other extenuating circumstances under which you might not be able to meet the criteria. CMS may validate information listed on the organization's exception request and HSD tables.

Here are some additional valid reasons for exception requests in Micro, Rural, and CEAC counties.

The first one is the pattern of care. The organization would provide evidence demonstrating that the contracted network is consistent or better than the original Medicare pattern of care.

Telehealth. The organization may use telehealth to meet healthcare access requirements so long as it is furnished in a manner consistent with original Medicare.

And mobile providers. The organization may request CMS approval to provide access in rural areas using mobile providers.

So next we'll – so valid reasons for exception requests are times when organizations cannot meet the published criteria due to a change in the healthcare market landscape.

Now that we've talked about valid reasons for an exception request, here are some invalid reasons for an exception request.

The inability to successfully negotiate and establish a contract with the provider or being in the process of negotiating a contract with the provider. This includes having rate disputes. However, it does not include times when providers only contract with one organization or refuse to contract with any organization.

It is invalid reason if the organization does not want to cross state or county borders to contract with the provider.

And with pattern of care, telehealth, and mobile providers, exception requests for Large Metro and Metro counties.

As the consultation comes to a close and organizations are aware of their networks and continuing to contract with available providers, there are a couple of important events to remember.

First, it is – first is for organizations choosing to remove counties. The action to remove a pending county occurs within the application process, and those deadlines are stated in the Notice of Intent to Deny. The action to remove an active county in your service area occurs by using the Service Area Reduction module, and organizations are notified through HPMS.

The Service Area Verification event is for all organizations to verify their service area for the upcoming contract year. The action is completed through HPMS in the Bid Submission module prior to the bid submission deadline.

Then the final important event is the bid submission. All organizations will be submitting their bids for the service area they plan on operating in the upcoming contract year, and the deadline is the first Monday in June.

Once organizations have submitted their bids that is the service area that they have committed to serving their beneficiaries and meeting CMS's network adequacy standards.

So we have another polling question. If your organization wants to remove an active county from your service area, what action do you take?

And so the correct answer is B, the Service Area Reduction module.

And then we have – we have one more polling question. Is your organization scheduled for your formal network review this June? And A is yes, I'm an initial applicant. B is yes, I'm an SAE applicant. C, yes, I was selected for my triennial review. D, no. And E, not sure.

So it looks like some – some organizations know and some organizations are still – maybe have some questions about that piece. So we can – before we touch on – so now we'll touch on the formal review that occurs in June.

In June, all organizations that are selected for their triennial review have been notified at least 60 days in advance of the event. All applicants have received their determinations and are aware of their networks being reviewed during this time.

Organizations have utilized the resources CMS has provided. And if you participated in the informal consultation review, you received feedback on your networks and have been working to build your provider network to meet CMS's network adequacy standards.

The formal network review process will follow that of the consultation that we just discussed. Organizations will upload their HSD tables, receive their ACC results, and have the opportunity to submit exceptions.

CMS will then provide organizations with the dispositions on exception requests in writing along with one cure opportunity prior to issuing any compliance action on an organization's network.

At this point I'll turn it over to my colleague Christine Reinhard for her piece.

Christine Reinhard: Thank you, Kelley.

Good afternoon. I'm going to talk about compliance when it comes to initial applications, SAEs, and also the triennial review. I'm going to go ahead and start with those initial applications.

You put your initial application in. You put the HSD tables in. And in the June time period we make determinations whether or not you meet network adequacy requirements. If you fail to meet our network adequacy requirements, we may suppress you from Medicare Plan Finder. That's going to happen in two particular cases with initial applications. The first case is if you have no CMS history with managing a network. And what we mean here, primarily, is you're an organization who has never had a contract with CMS, we don't know your history, you do not have a network that meets our requirements, so we are looking at suppressing you from Plan Finder for the fall.

The next one is a plan initial application that has had prior compliance issues with networks. And this will take effect in future years. What we're talking about right – right here is that organizations who have had history of not meeting our network adequacy standards through the triennial reviews who we have had to issue compliance actions on, those organizations, their initial applications and contracts will – may also be suppressed from Medicare Plan Finder. But, again, that's going to happen in future reviews when we've got that history to look back upon.

Now, can you get unsuppressed from Medicare Plan Finder? Yes. If you're an initial application and you have been suppressed, once you demonstrate compliance with our network adequacy standards, we will go ahead and unsuppress you from Medicare Plan Finder so your plan will be available for beneficiaries to look at.

Now, with initial applications there's also the compliance phase. We've got compliance dealing with initial applications and SAE app – SAE applications. We require all organizations to have a network that meets our requirements on January 1st that is the beginning of the new year, for beneficiaries electing that plan and enrolling in that plan.

So if your organization fails to meet our network adequacy standards by January 1st, we may take compliance actions. And these would include anywhere from no compliance action to a notice of noncompliance, warning letter, warning letter with business plan, and a corrective action plan. And that is our normal process of compliance actions. All of you are probably familiar with having received at least one compliance action over the course of your contracting with CMS.

Moving on to the triennial reviews. Again, failure to meet our network adequacy standards may result in a compliance action. They are the same compliance actions that you would receive if you were an initial application or an SAE application that fails to meet network adequacy standards.

The difference here I think we need to talk about is with a new application, you're not providing services until January 1st. So that's when we're going to look at compliance for new applications and those service area expansions.

As an existing contractor, you're required to meet our network adequacy standards 365 days a year. It doesn't change on January 1st. It's the current requirements. So we will be looking at compliance in those cases at the time we're reviewing the networks or after we review the networks and we've taken a look at all the organizations.

So I think your real question is, how – how are we really going to determine compliance? And we are in the process of developing a data-driven database that we will push all of the data through. We are going to be looking at the counties that you're serving. The number of providers that you have. The num – the – whether or not you meet the 90% threshold for each of those provider sets. We've developed a formula that's going to take into account, it's a consistent data-driven formula which will take into account the requirements. It's going to normalize it for organizations or contracts that have few counties versus contracts that have many counties. And we're – we will be doing this after we look at all the exceptions.

The factors. I just mentioned them before, but the two primary factors in this compliance methodology will be the failure to have the required number of providers. So if you're required to have ten providers and you only have eight, that – that fact – that will factor into the compliance formula. If you – since we have a 90% threshold that 90% of the benes need to have time – access to providers in time and distance, if you have a provider specialty that only meets it at 60%, that's going to factor into it. And, again, we're going to be looking at the provider type, the county, the number of providers required, and whether or not it meets the 90% threshold.

And resources. A couple of these were already mentioned. Questions can go to the DMAO mailbox. The application website that's got the HSD file and the network adequacy guidance. And then the Health Plan Management System has the network management module.

And that, I think, concludes our presentation.

Kaye Rabel: Okay. At this time we do have some time for questions, so we're going to open up the floor to our in-house participants. Remember to step to the

mic in the center of the room and let us know who you are and where you're from.

Diane Kortsch: Good afternoon. I'm Diane Kortsch from Anthem. And we're just basically seeking some clarification here. We know that the network adequacy criteria states that if a provider contracts exclusively with another organization, that's a valid reason for an exception. But we're wondering if a provider's refusal to contract with additional organizations would be a valid reason. And so basically we – we have a provider who is stating that they aren't signing contracts with any new MAOs. And we're just not sure if that's documentation enough for a valid exception.

Theresa Wachter: I'll take that one. So I would suggest that you submit that on your exception request and we'll certainly consider it. CMS encourages plans to submit as much information as possible including letters from the provider's office, etc. So we can't give you an answer right now, but we'll certainly consider whatever you submit.

Diane Kortsch: Thank you very much.

Theresa Wachter: Thanks.

Kaye Rabel: Are there any additional questions? Okay.

Well, thank you Theresa, Kelley, Christine, and Nyetta for an overview of the Medicare Advantage network adequacy review process.

If you would like to evaluate this session, take out your phones to text your response or go to the poll EV link on your iPad, tablets or computer, and enter A in response to the question, I would like to evaluate this session, and send your response. Remember to click on the link and follow the instructions.