CMS’s Crackdown on Network Adequacy: Strategies for Medicare Advantage and Medicaid Insurers

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MICHAEL ADELBERG
Senior Director
FaegreBD Consulting

HELAINE FINGOLD, J.D.
Senior Counsel
Epstein Becker & Green, P.C.

MICHELLE STROLLO, Dr.Ph.
Associate Director
NORC
About the Speakers

MICHAEL ADELBERG is Senior Director at FaegreBD Consulting in Washington, D.C. He has more than 20 years of high-level experience with the Medicare, Medicaid and health insurance exchange programs. Before joining the consulting unit of the major law firm, Mr. Adelberg served at CMS concurrently as director of the Insurance Programs Group and acting director of the Exchange Policy and Operations Group in the Center for Consumer Information and Insurance Oversight (CCIIO), setting policy and implementing exchange operations in multiple areas, including plan management. In his prior years at CMS, he was director of Medicare Advantage operations, leading monitoring of MA contractors. In both CMS roles, Mr. Adelberg was responsible for setting CMS’s network-adequacy policy and building approaches to assess provider networks. In between the two CMS stints, he was a vice president at prominent MA plan sponsor Universal American Corp., where he, among other things, helped negotiate agreements with strategic and preferred providers. Contact Mr. Adelberg at Michael.Adelberg@faegrebd.com.

HELAINE FINGOLD, J.D., is a Senior Counsel in the Health Care and Life Sciences practice of the law firm Epstein Becker Green, serving in the Baltimore office in her second stint with the firm. She has more than 20 years of broad health law and regulatory experience, including service in the legislative and executive branches of the federal government. Ms. Fingold now represents a wide range of payers, providers and other stakeholders on issues including Medicare and Medicaid managed care programs. Previously, she worked in CMS’s CCIIO, with responsibility for defining and interpreting requirements for and overseeing exchange plans. From 2004 to 2012, Ms. Fingold had responsibilities in CMS for the MA program’s plan application review and approvals and denials, appeals, contracting, plan surveillance, oversight and marketing. She began her career as an attorney in HHS’s Office of the General Counsel assigned to CMS’s predecessor agency. Ms. Fingold also served as general counsel for the Medicare Payment Advisory Commission. Contact Ms. Fingold at hfingold@ebglaw.com.

MICHELLE KITCHMAN STROLLO, Dr.Ph., is the Associate Director of NORC’s Health Care Department and a Principal Research Scientist at the independent research institution. She has nearly two decades of experience in health services research; policy making and analysis; and program development, administration and evaluation. Dr. Strollo leads and provides consultation on a number of CMS projects related to public and private insurance, including the Financial Alignment Initiative, the Nationwide Adult Medicaid Survey and exchange-plan certification activities. She is also senior advisor to CMS’s CCIIO in developing a monitoring strategy for exchange and Medicaid eligibility determinations. She oversees the development of NORC’s Provider Network IQ, a data analytics tool powered to generate market reports comparing exchange plan provider-network structure by provider specialty and geographic location. Before joining NORC, Dr. Strollo held positions in federal and state government, including director of eligibility and enrollment policy and operations at CCIIO and associate director at the D.C. Department of Health Care Finance. Contact Dr. Strollo at strollo-michelle@norc.org.

Moderator: Jim Gutman, managing editor at AIS

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WEBINAR MATERIALS

Increase in Scrutiny of Network Adequacy Across Federal Programs .................................................................page 1
Implications of Marketplace Network Transparency Efforts on Medicaid and Medicare Advantage............................................................................................................................page 16
Strategies for Medicare Advantage and Medicaid Insurers .................................................................................................page 29
Selected Articles From Medicare Advantage News ................................................................................................................page 39

WEBINAR OUTLINE

Part 1: Helaine Fingold, Epstein Becker & Green, P.C.

- New Actions on Network Adequacy
- Medicare Advantage: Various Requirements and Standards
- Medicare Advantage: Oversight and Enforcement
- Medicaid Managed Care: Various Requirements and Standards
- Medicaid Managed Care: Time and Distance Standards
- Medicaid Managed Care: Oversight and Enforcement
- Medicaid Managed Care: Information Requirements

Part 2: Michelle Strollo, Dr.Ph., NORC

- What Do Exchange Provider Networks Look Like in 2016?
- NORC’s Research Into Provider Networks
- The Provider Participation Rate
- Focus on Narrow Networks Is Here to Stay
- What Comes Next?
- Provider Network Requirements
- Long-Term Considerations

Part 3: Michael Adelberg, FaegreBD Consulting

- 2017: The Year of Provider Network Oversight?
- From the Regulator’s Vantage Point
- The Regulatory Backlash Has Begun
- Coming Soon…Machine-Readable Directories
- Health Plans Should…Self-Assess
- Health Plans Should…Implement Strategies
- Health Plans Should…Network Oversight SOP
- Concluding Thoughts

Part 3: Questions and Answers
CMS's Crackdown on Network Adequacy: Strategies for Medicare Advantage and Medicaid Insurers

Increase in Scrutiny of Network Adequacy Across Federal Programs

An AIS Webinar
November 15, 2016

Helaine I. Fingold, J.D.
Epstein Becker Green
Baltimore, MD
Agenda

1. Drivers of Network Adequacy Concerns
2. Medicare Advantage Network and Related Requirements
3. Medicaid Managed Care Network and Related Requirements
New Actions on Network Adequacy

DRIVERS OF CONCERN

- Federal programs reacting to
  - Narrow networks
  - Surprise bills/Transparency of network information
  - Provider terminations
  - Accuracy of provider directories
  - Pressure from providers and consumers/advocacy groups
New Actions on Network Adequacy

REGULATORY AND OTHER INITIATIVES

April 2015: CMS announces efforts to verify adequacy of MA networks and accuracy of MA provider directories

May 2015: CMS releases first proposed rule for Medicaid managed care in 12 years, including quantitative network adequacy standards

November 2015: NAIC releases updated network adequacy model act to address surprise bills and other issues

April 2016: Final Medicaid managed care rule published

March 2016: CMS/CCIIO defers adopting more prescriptive network adequacy standards for QHPs on the federal Exchange

New for MA in 2017 – Increased scrutiny of network adequacy in expansion applications, narrower allowance for partial counties

CMS implements use of MA time & distance standards based on type of provider and county demographics

NAIC = National Association of Insurance Commissioners; CCIIO = Center for Consumer Information and Insurance Oversight; QHPs = Qualified Health Plans
Vary by

- Provider/facility type
- County designation (based on population and density)
  - Large Metropolitan
  - Metropolitan
  - Micropolitan
  - Rural
  - Counties with Extreme Access Considerations (CEAC)

Providers do not need to be located within physical boundaries of county being assessed, but must be within time and distance requirements of at least one beneficiary within the county.

Specific 2017 criteria and guidance for each county are published in the HSD Criteria Reference Table, available at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html.

HSD = Health Services Delivery
Medicare Advantage

TIME/DISTANCE AND OTHER NETWORK-RELATED REQUIREMENTS

- Minimum of one provider/facility per type, based on 95th percentile of beneficiaries served by Medicare Advantage in the county
  - Minimum provider ratios (#/1000 beneficiaries) based on utilization patterns & clinical needs
- Maximum travel time/distance such that 90% of beneficiaries must be able to access within time & distance constraints for at least 1 provider/facility
- Exceptions process available where lack of providers in county and/or pattern of care supports different network configuration
- Significant changes in network require 90-days notice to CMS
  - CMS may also require
    - Network adequacy assessment
    - Plan for outreach to enrollees to help them find new providers and/or address continuity-of-care issues
    - Special enrollment period (SEP) for affected enrollees
Medicare Advantage

PROVIDER DIRECTORY REQUIREMENTS

- Effective for 2016, plan sponsors required to establish and maintain a structured process to keep provider directories current
  - Regular (at least quarterly) contact with providers to ascertain availability, acceptance of new patients, current contact information
  - Effective protocol to address denial of access to contracted providers and required changes to provider directories
  - Real-time updates to online directories
- Must include:
  - Provider medical group
  - Provider institutional affiliation
  - Non-English languages spoken by provider
  - Provider website address
  - Accessibility for people with physical disabilities
  - Acceptance of new patients
- Machine-readable content is a best practice
Medicare Advantage
OVERSIGHT AND ENFORCEMENT

- Provider directories presently assessed more for accuracy than adequacy
  - Direct monitoring by contractors to verify accuracy
  - Plans have opportunity to cure
  - Compliance and/or enforcement actions, including CMPs or enrollment sanctions
    - Aetna fined $1 million for inaccuracy of provider directory
  - Intent to issue future rules with additional requirements for MA provider directories consistent with Medicaid and QHPs
    - Potential future standardized electronic submission of network information for inclusion in a nationwide provider database

- Network adequacy oversight has been complaints driven
  - Data collected through directory monitoring “could drive additional reviews of network adequacy”

CMPs = Civil Monetary Penalties
Medicaid Managed Care

NETWORK ADEQUACY REQUIREMENTS

- Apply to plan years beginning on or after July 1, 2018
- Moves states toward time and distance approach like MA and QHPs
  - But puts burden on states to develop standards for plans
- Many states already had time and distance standards, but network adequacy was still lacking
  - Some states also have appointment wait-time standards for primary and specialist care needed on a routine or urgent basis
  - Concerns that continuing to leave it to the states may be insufficient
- States must set time and distance standards for providers of:
  - Pharmacy
  - Primary care (adult and pediatric)
  - OB/GYN
  - Mental health/substance use disorder (adult and pediatric)
  - Pediatric dental
  - Specialists (adult and pediatric) (can be further defined by states)
  - Hospital
  - Other providers if applying such standards “promotes the objectives of the Medicaid program”

Exceptions allowed if monitored by the state
Medicaid Managed Care

TIME AND DISTANCE STANDARDS

- Considerations in developing these standards:
  - Expected Medicaid enrollment
  - Expected utilization of services
  - Characteristics & health needs of covered population
  - Number & types of health care professionals required to provide covered services
  - Number of network providers not accepting new patients
  - Geographic location & accessibility of providers & enrollees
  - Ability of providers to communicate in a culturally competent manner
  - Disability accommodations
  - Use of telemedicine

- States are also advised to look to
  - The state’s network adequacy standards for commercial insurance
  - MA plan network adequacy standards
  - Historical patterns of Medicaid utilization
Medicaid Managed Care

NETWORK ADEQUACY VALIDATION/OVERSIGHT

- Timeliness would be assessed as routine, urgent, or emergency care
- State must publish network adequacy standards for transparency
- Medicaid managed care (MMC) entity must document network adequacy for state review at least yearly ... and when a significant change to operations would affect capacity/services
- External Quality Review Organization must validate plans’ network adequacy for the previous 12 months
- MLTSS must have distinct network adequacy standards
  - Based on the same factors as for medical services
  - May vary, based on whether the enrollee or provider must travel to provide services
  - Should consider strategies “to ensure the health and welfare of enrollees using LTSS and to support community integration of individuals receiving LTSS”

MLTSS = Managed Long Term Services and Supports
Medicaid Managed Care

OTHER NETWORK-RELATED REQUIREMENTS

- Female enrollees must have direct access to women’s health specialists
- Enrollees can get a second opinion from an in-network provider or out-of-network provider if necessary
- Ability to go out-of-network if necessary for medically necessary services without paying more
- Timely access to family planning services
- Network providers cannot have lesser hours of operation than for commercial/Medicaid FFS enrollees
- 24/7 services when medically necessary

FFS = Fee For Service
Medicaid Managed Care

OVERSIGHT AND ENFORCEMENT

- Requires state monitoring and oversight of provider/network management
  - Collect plan documentation and certify the adequacy of MMC plan networks
  - The rule does little to enhance federal oversight and accountability
  - Enforcement will likely look similar to Medicare enforcement — “secret shopper” calls and visits to providers listed in plan directories

- Must publish network adequacy standards to ensure transparency

- States required to assess networks at least annually and when there is a substantial change to the program design that may impact access
Medicaid Managed Care

INFORMATION REQUIREMENTS

- Changes made to strengthen MMC beneficiary information dissemination rules, more closely align with MA and commercial, better reflect technology advances, recognize cultural/linguistic diversity of Medicaid beneficiaries
- Apply consistently across MMC plan types with respect to enrollee materials
- States and MMC entities must make materials available in prevalent languages
  - To include taglines on availability of written materials in those languages and oral interpretation in understanding the materials
- MMC entities must also make available vital documents in each prevalent non-English language in the MMC’s service area, to include
  - Provider directories
  - Member handbooks
  - Formulary
  - Other notices critical to obtaining services
- MMC entities also must post provider directories on their websites in a CMS-specified machine-readable file and format
Helaine I. Fingold
Senior Counsel
Epstein Becker & Green, P.C.
hfingold@ebglaw.com
443-663-1354
Baltimore, MD
Implications of Marketplace Network Transparency Efforts on Medicaid and Medicare Advantage

CMS’s Crackdown on Network Adequacy: Strategies for Medicare Advantage and Medicaid Insurers

An AIS Webinar
November 15, 2016

Michelle K. Strollo, Dr.Ph.
Associate Director | NORC
Email: strollo-michelle@norc.org
Phone: 301-634-9537
Today’s Presentation Will Explore:

- Why are Marketplace network transparency efforts relevant to Medicaid and Medicare Advantage?
- What do Marketplace provider networks look like in 2016?
- What should Medicare and Medicaid plans expect next?
- What does this mean for consumers?
What Do Exchange Provider Networks Look Like in 2016?

Assessing Network Breadth on the Exchanges Using the Provider Participation Rate
CMS began requiring Qualified Health Plans (QHPs) in the Federally Facilitated Marketplace (FFM) to publish JSON machine-readable provider network files for the 2016 plan year.

- Machine-readable ≠ usable
- Machine-readable ≠ clean or complete

NORC downloaded, aggregated, cleaned, and linked these JSON files with other QHP and provider files.

Our dataset contains data for nearly 1.2 million unique providers and facilities across 233 QHP issuers in the FFM.
The Provider Participation Rate

- The Provider Participation Rate (PPR) is the proportion of all providers in a given county in a given specialty that are participating in an issuer’s network.

- A network with a PPR:
  - More than one standard deviation above the mean in the county is classified as broad;
  - More than one standard deviation below the mean is basic; and
  - Everything in between is classified as standard.

- PPR is a relative, not absolute benchmark, allowing for even comparisons within counties but uneven ones across counties.

- CMS is piloting network classifications for plans on healthcare.gov for three specialties in 2017 (adult primary care, pediatric primary care, and hospital facilities) in four states (Maine, Ohio, Texas, and Tennessee).
Overview of Exchange Provider Networks

- Most primary care networks nationally are standard (74%), with 15% basic and 11% broad.

- A higher PPR is needed to achieve a broader network in rural counties (95%) than in urban counties (74%).

- Within states, a network that is broad in one county can often be basic in another, and vice versa.

- Networks for Blues plans tend to be distributed similar to the national average, while those for integrated health systems and Medicaid managed care plans tend to be skewed more toward the basic end of the spectrum, offering far more basic plans relative to broad ones.
Implications for the Market

What impact does network size have in practice?
Focus on Narrow Networks Is Here to Stay

- Expect scrutiny of provider networks to continue at the state and federal level, especially as more markets begin to mandate the release of machine-readable network data.

- Narrow networks can receive negative publicity if providers are dropped from networks or if consumers are restricted on their choices.

- However, are narrow networks necessarily bad for consumers? It’s uncertain!
Are Narrow Networks Consumer-Friendly?

- Narrow network plans on the Marketplaces are cheaper than broad-network plans (McKinsey), and consumers prefer narrow networks with lower premiums to broader networks with higher premiums (Kaiser Health Tracking Poll).

- A study of California hospital networks found that narrow networks do not substantially reduce geographic access to care or quality (Haeder).

- However, narrow networks may impose a burden on vulnerable populations in Medicaid managed care, especially for children with special health care needs (Office of Inspector General).
What Comes Next?
Provider Network Requirements

- Medicaid managed care plans will soon be required (by summer 2018) to make available provider network information in a machine-readable format.

- The data will include provider names, contact information, languages spoken, and information about whether the provider is accepting new patients.

- Data must be updated monthly (for paper) or within 30 days of receiving updated provider information (electronic).

- Key challenge is to address errors and inaccuracies in the network data
  - Many pilots currently underway to address poor data quality
The nature of the Provider Participation Rate means that what constitutes a broad or basic network can vary widely across geographies, and we also find that the distribution of network sizes on the Exchanges varies by issuer group.

Challenge in coming years will be to improve upon metrics of network size (like the PPR) to better reflect network quality:

- Narrow networks not necessarily bad for consumers, but network data need to be accurate and up-to-date
- Consider integrating measures of provider quality, time and distance standards, cost of care, or performance on certain health conditions

Network transparency is expanding into Medicare Advantage and Medicaid managed care, which will lead to specific new metrics for consumers and other stakeholders to assess networks.
Thank You

Thanks for the interest. We’d be happy to continue the conversation.

Michelle K. Strollo, Dr.Ph.
Associate Director | NORC
Email: strollo-michelle@norc.org
Phone: 301.634.9537
CMS's Crackdown on Network Adequacy:

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November 15, 2016
Mike Adelberg, FaegreBD Consulting
2017: The Year of Provider Network Oversight?

How did we get here?
Here’s what we know…

- Networks are narrowing
- The ACA accelerates this trend
- Provider terminations aggrieve members and attract national attention
- Providers and consumer advocates are now mobilized and aligned in pushing for action
- Researchers are showing unprecedented level of interest in provider networks
From the Regulator’s Vantage Point

Taking shots from all sides…

► Unflattering media attention
► Researchers are documenting narrowing
► Advocates are forwarding examples
► Legislators are sponsoring bills

The result is predictable… Provider network oversight will be hot in 2017 and types of inquiries will expand…

► Now: Adequacy — are there enough providers?
► Now: Accuracy — are consumers correctly informed of their providers?
► Coming: Competitor Breadth — how do networks look vs. each other?
► Coming: Stability — are networks fluctuating unusually?
The Regulatory Backlash Has Begun

► CA: Fines up to $600,000 for provider directory inaccuracies
► CMS fines national MA plan $1 million for pharmacy directory errors
► Other states have issued smaller fines for not verifying providers are still in network and accepting new patients
► CMS is actively auditing provider directories in Medicare Advantage and exchanges
  ► Medicare Advantage provider directory error rate based on pilot – 45%

At least five lawsuits are pending against health plans for misrepresenting provider access — one recently settled for $15M
Coming Soon… Machine Readable Directories

► Already in use in most health insurance exchanges
► Medicaid requirement for 2018
► Not required in Medicare Advantage, but…
  ► In previous Call Letters CMS discussed a “national provider database”
  ► In 2017 Call Letter, CMS spoke of machine-readable directories as a good practice
  ► Good chance of being required for 2018

Trend toward “Harmonization”: new Medicare Advantage and Medicaid guidance discusses CMS desire to “harmonize” provider network standards and oversight across Medicare, Medicaid and the Exchanges. Generally, moving requirements to the strictest standard of the three.
Health Plans Should... Self-Assess

► Provider Directory Accuracy
  ► What is our standard for directory accuracy?
  ► What is our baseline directory accuracy?
  ► Who is tasked with correcting our weaknesses?
  ► How do we know we are improving?
  ► How do we know our docs are telling patients what they’re telling us?
Health Plans Should… Implement Strategies

► Implement a provider network oversight program
  ► Re-examine provider contracts for directory accuracy language
  ► Collect and investigate feedback from members and providers
  ► Document decisions when terminating providers
  ► Document network adequacy re-review after terminations
  ► Document provider termination appeals decisions
  ► Validate the accuracy of provider directories
  ► Develop an ongoing provider network oversight SOP
Should… Network Oversight SOP

► Implement a provider network oversight SOP
  ► Assures ongoing compliance with new guidance from CMS and state regulators
  ► Policies & Procedures (P&Ps) for receiving and investigating network issues
  ► P&Ps for provider terminations and network adequacy checks
  ► P&Ps for notifying CMS or other regulator of significant network changes
  ► P&Ps for notifying members of network changes
  ► Document actions and rationales for situations not covered in guidance
  ► Implement a directory accuracy solution with ongoing data
Concluding Thoughts…

► Provider networks will be among the hot compliance issues in 2017
  ► New requirements and new modes of oversight
  ► Cross-market harmonization
  ► Machine-readable directories create new opportunities
► Researchers are looking at your directories and publishing results
► The Coming “Machine Readable Revolution”
  ► Regulators can check your networks at any time
► Providers, by and large, are not focused on the need to keep directories accurate — health plans will need to help them focus
► In the short run, the road ahead will be hard…
  ► New rules, enforcement actions, fights w/ providers, unflattering reports
► In the long-run, more integrated ops and better market intelligence
To continue the discussion…

Michael S. Adelberg
Senior Director, FaegreBD Consulting
Direct: 202-312-7464
Fax: 202-312-7461
Michael.Adelberg@faegrebd.com

Provider Network Oversight Publications:
“Regulators React to Debate Over Narrow Networks,” Managed Healthcare Executive, May 2016.
Two-Thirds of Providers Aren’t at Listed Locations, CMS Finds


The first phase of a new provider directory accuracy pilot conducted by CMS’s Medicare Drug & Health Plan Contract Administration Group (MCAG) has turned up some concerning findings, namely the “excessive number” of providers listed in online directories that aren’t at those locations, according to officials who spoke at the agency’s Medicare Advantage and Prescription Drug Plan fall conference on Sept. 8. And if those deficiencies aren’t corrected, plans could be subject to enforcement actions once the verification portion of the project is completed.

The pilot was launched this year in response to beneficiary complaints, congressional inquiries and other sources, prompting the agency to enhance its oversight of provider networks, including the accuracy of directory information provided to beneficiaries (MAN 4/7/16, p. 1).

“Provider directories are simple tools used to connect beneficiaries and their caregivers to your contracted providers so that they can get the care that they need,” asserted Jeremy Willard, technical advisor with the Division of Surveillance, Compliance, and Marketing within MCAG, at the conference. “The accuracy of that information is paramount for that happening. If any of that information is wrong, they’re not able to get to that contracted provider.” But based on its recent review, CMS found that when a beneficiary chooses a provider via a plan’s online directory, there is a 46% chance that something is inaccurate.

MCAG selected 54 parent organizations to review, and focused on 108 providers evenly split between four provider types (primary care physicians, oncologists, ophthalmologists and cardiologists) for one randomly selected contract per organization, or more than 5,800 providers with multiple locations for a total of 11,646 locations. Contractor Booz Allen Hamilton contacted nearly 6,000 providers to verify certain information such as provider names, practice names, street addresses and whether the provider works at the location listed and accepts the selected plan at that location.

The CMS contractor conducted the review in a transparent manner, explaining the purpose of the call to the providers, stated Willard. The information collected by the contractor was then sent back to CMS via a spreadsheet containing all the data elements, which CMS reviewed. CMS then shared the initial deficiencies identified with the plans. Plans were given two weeks to issue a response, in which they were asked to concur or disagree and provide additional information in areas with which they did not concur.

CMS found some common problems with the plan responses, such as failing to actually verify the information that was flagged as inaccurate, relying on source data alone and issuing “cut and paste” responses for the sake of time, said Willard. Furthermore, he suggested that plans improve their provider-level data vs. simply including information about the location of a group practice. “Our expectation is that plans put their best foot forward as far as reviewing the data,” he said. “We really want you to do what is necessary to hear from the provider themselves, [to] get solid responses if you are disagreeing with us.”
Once a final determination on the deficiencies is made, plans are notified and have 30 calendar days to make the requested changes, such as removing a provider from the online directory if the entity is not at that location or accepting new patients. In Phase II of the pilot, CMS will validate that the deficiencies have been corrected and the directory has been properly updated, and when applicable, will look at Health Services and Delivery tables “to see if providers have been removed appropriately,” said Willard.

Nearly Half of Locations Had Errors

Of the 11,646 total locations reviewed, CMS identified 5,257 locations (46%) with deficiencies, meaning at least one or more items in the directory pertaining to that location was inaccurate, and a total of 5,352 final deficiencies, reported Christine Reinhard, health insurance specialist and technical advisor with the same division at CMS. While there were a couple of outlier organizations that did extremely well or had an extraordinary number of deficiencies, the bulk of organizations had online directories that were 20% to 60% inaccurate.

CMS excluded practice names from its report on the final deficiencies. Reinhard said the initial review turned up “hundreds if not thousands of inaccurate practice names,” but pointed out that CMS doesn’t have firm requirements on the exact meaning of “practice name. It’s rather nuanced considering there could be four doctors at a practice but it’s not necessarily misleading to list the names of all four doctors instead of its proper practice name,” she said.

One finding that was particularly surprising to Reinhard and her team was the abundance of listed providers that were found not to be at their locations. This occurred in 3,544 instances, accounting for 66.2% of all deficiencies. “We had providers that had been retired for years still in the directory, providers that had passed away over a year ago or more, [and] we had a lot of provider practices that said, ‘I don’t even know who this person is. He or she has never worked here,’ so that was a surprise to us,” she noted.

The other four most common errors, in descending order, were:

◆ Inaccurate phone number, which occurred 521 times, or 9.7% of all deficiencies. And CMS found that in most instances these were disconnected or out-of-service phone numbers. In some cases, the number turned out to be a physician’s cell phone and there were even a few calls that went to beneficiaries.

◆ Incorrect address, which happened 450 times, or 8.4% of all deficiencies. Reinhard suggested this was potentially more egregious than a wrong suite number, because in the case of the former, the patient is at least in the right building.

◆ Provider is not accepting new patients, which happened 338 times, or 6.3% of all deficiencies. Reinhard said CMS recognizes this can be a “fluid item” in the directory. “While we did look at this, we were pretty lenient on those deficiencies because providers do change, possibly month to month, [and] this is one of the areas that is a little more difficult to keep to date.”

◆ Incorrect address-suite number, which occurred 221 times, or 4.1% of all deficiencies.

In addition, CMS is concerned about the number of providers who were not aware of their contracted status with the provider organization. “Especially when you expand or add providers to your network, please make sure you educate those providers about the acceptance of your plan,” she advised.
CMS Considered Link to Network Adequacy

CMS in its review also considered the implications of provider directory errors on network adequacy, and asked the parent organizations if they used the same underlying database for their online provider directories as for their HSD tables. The majority of plans said they do, reported Reinhard. “With so many providers not being where they’re listed, we are concerned that that’s going to have an effect on HSD tables,” she told attendees. “Given that a provider may practice at five locations and four of them are correct and one is incorrect, that’s going to have less of an effect vs. a provider that’s listed at 10 locations and eight of them are incorrect and the provider’s not actually there. So it’s something to consider and be aware of.”

CMS Is Still Weighing Compliance Approach

According to the March 16 memo that told plan sponsors of the pilot, if the selected plans’ directories continue to show deficiencies, they may be “subject to possible enforcement action, including civil money penalties or enrollment sanctions.” Reinhard said CMS has not taken any actions, but that it will weight the deficiencies based on egregiousness (i.e., reflecting CMS concerns about a provider not being at a location vs. an inaccurate suite number). “If there’s more than one deficiency, we are not making a cumulative weighting. We’re taking the most egregious deficiency and counting it as the weight of that most egregious finding and not adding other deficiencies,” she explained. Compliance actions can result from Phase I or Phase II and CMS is “still working on that,” she added.

Moreover, CMS recognizes that there are challenges with keeping online provider directories up-to-date and that not all data are going to be 100% accurate all of the time, said Reinhard. But a 46% inaccurate rate is “unacceptable,” she said, and given the importance of the directory for beneficiaries, CMS expects that accuracy must improve.

View a replay of the session at www.youtube.com/watch?v=TPgv9k0TZCc. ♦

MA Provider Network Exceptions Should Be Few and Far Between, CMS Officials Stress


CMS this year made several major network review changes that have reportedly caused headaches for some Medicare Advantage organizations (MAOs) requesting service area expansions (SAEs) for contract year 2017 (MAN 8/4/16, p. 1). During a session of the CMS Medicare Advantage and Part D fall conference on Sept. 8, officials from the Medicare Drug & Health Plan Contract Administration Group (MCAG) emphasized the rarity of network exceptions and shared a slew of common findings from its new streamlined review process that may prove useful for MAOs submitting SAEs and partial county requests for 2018 and beyond.

Prior to this year, CMS reviewed MAO networks only during the initial application and when there was a beneficiary complaint, but for contract year 2017, CMS began reviewing entire networks of plans requesting SAEs in an effort to provide greater oversight of MA provider networks. Stacy Davis, an analyst with the MCAG Division of Medicare Advantage
Operations, confirmed that “curative actions” for plans whose “active/existing” counties did not meet Health Services Management and Delivery (HSD) table criteria included removing an active county. This can be done through a “service area reduction” module via the automated Health Plan Management System (HPMS). Davis did not disclose how many plans had to remove existing counties.

Also new for 2017, CMS created a centralized team to review network exception requests and partial county justifications, whereas this process historically had been handled across 10 regional offices. Davis explained that this was done in part to “increase the consistency in the decisions we were making in the application as it related to network review.”

But while CMS recognizes that “continuously evolving patterns of care” in certain service areas may require exceptions to network adequacy criteria, those “exceptions should be rare and must be warranted,” emphasized Theresa Wachter, an analyst with the Division of Policy, Analysis & Planning (DPAP) within MCAG who also spoke at the session.

For example, if a plan were to request an exception on the basis that it’s attempted to contract with a provider, but the contract negotiations have not concluded, that is not likely to be accepted, said Davis. To CMS, that rationale is like saying, “There is a provider there within your criteria. We just haven’t contracted with them yet,” she explained. Therefore, applicants should not submit exception requests as “placeholders” while contracting is still in progress, Davis advised.

Other unacceptable exception requests occur when applicants do not appear to fully understand the HSD instructions, suggested Wachter. For example, applicants may need to contract with providers outside of their plan service area, such as those in adjacent counties or even in neighboring states. But CMS has found that some applicants have failed to do this when it appeared to be necessary in order to meet adequacy criteria, she observed. So if a doctor is within CMS time and distance criteria for County A in one state but is located in County B in a neighboring state, the applicant should list that provider on its HSD table to provide access for enrollees in County A, even if the provider’s office location is not within the service area, clarified Wachter.

Davis added that CMS often sees exception requests being submitted when no attempt is being made to contract with another provider in order to provide access to beneficiaries. “We still expect applicants to meet network adequacy criteria in that 90% of beneficiaries are being covered through a contract network,” she stated. “If because supply isn’t there [and] you have to go outside the network criteria to do it, then that’s what we expect you to do and that’s what you explain with your exception request.”

CMS Streamlines Partial County Reviews

CMS this year also made some adjustments to the templates for submitting partial county justifications. But CMS continues to expect that MA plans serve entire counties as opposed to selecting certain ZIP codes in the county and excluding the remainder, “except for extraordinary circumstances,” asserted Marty Abeln, another analyst with DPAP. He indicated that partial county requests are most likely to be granted in areas that are “very sparsely populated” and have very few providers, such as counties that contain a large non-residential area of national park space. To the extent that there are available providers in a service area, CMS’s expectation is that plans serve the entire county, he added.
When submitting partial county justifications, applicants must provide conclusive evidence showing that their request presents no discrimination, stressed Wachter. Therefore, if an applicant provides information to illustrate the demographics for an entire county, but offers no evidence showing that the health care costs and racial/demographic makeup of the population in the excluded parts of the county are comparable to the proposed partial county, that is not an acceptable rationale.

Similar to exception requests, when reviewing partial county justifications, CMS compares the service area to that of other MAOs as part of its review. So if one MAO is operating in an area as a full county and another MAO is proposing to serve the same area as a partial county, “then that may indicate that the partial county is discriminatory and that is not warranted,” clarified Davis.

Moreover, the inability to establish economically viable contracts is not a valid rationale for requesting a partial county, emphasized the speakers, referring to a policy clarification that was made in a January 2016 HPMS memo. “This is because CMS does not get in the business of contract negotiations between an entity and a provider. If a provider won’t accept your rates, we’re not going to grant you the partial county,” stated Davis. CMS is also unlikely to grant partial county justifications to plans that request to serve a ZIP code that exists in two counties but the plan wants to serve it in only one, she added.

When asked by MAN how many partial county requests have been filed for CY 2017 and how many were approved, the panelists responded that they do not yet have those data.

The good news for plans submitting SAEs and partial county justifications is that they may not be subject to a two-year ban on introducing a new contract if they are unable to resolve any inadequacies identified by CMS and end up not renewing their contract as a result. Current regulations permit CMS to consider exceptions to the two-year contracting ban under certain circumstances. As part of a recent policy change, applicants can use a new template to request a waiver of the two-year ban, and CMS will assess whether their withdrawal was “in the best interest of beneficiaries,” added Abeln.

View a replay of the Sept. 8 conference at www.cms.gov/live.

On Heels of Secret Shopping Success, CMS May Turn Elsewhere to Find Deficiencies


A program integrity report posted by CMS last month showed that of the 1,320 marketing events secretly shopped during the contract year 2014 Annual Election Period, an impressive 85.5% had no validated deficiencies, compared with 65.7% of 1,781 events and 57.8% of 1,562 events shopped during the CY 2013 and 2012 AEPs, respectively. While these data indicate that CMS has come closer to eradicating the deficiencies that were once rampant at marketing events, they don’t necessarily mean CMS will give up secret shopping altogether but rather shift its focus during the AEP marketing period that kicks off on Oct. 1, sources suggest.

“When you contrast the agency’s secret shop findings with those of six or seven years ago, the improvement is remarkable. CMS made agent-broker oversight a priority, and the
industry responded,” observes Mike Adelberg, a former top CMS MA official who is now senior director at FaegreBD Consulting.

CMS in late 2008 initiated a “comprehensive surveillance program” to ensure that insurers and their agents, brokers or plan representatives were complying with final regulations designed to protect Medicare beneficiaries from deceptive or high-pressure marketing tactics. The program involved not just secret shopping of marketing events, but mystery shopping of customer service call centers, the use of a “clipping service” that scanned local media for advertisements and the analysis of complaints data. CMS found during the CY 2009 AEP that more than half of the MA and Part D organizations it evaluated through “secret shops” were in violation of marketing guidelines and subsequently issued compliance notices to 28 organizations.

Later that year, CMS imposed sanctions on several high-profile insurers based on the initial surveillance program. For example, Arcadian Management Services, Inc. (which was acquired by Humana Inc. in 2012) had to suspend enrollment and marketing after it failed to resolve issues identified in a notice of non-compliance and three warning letters. CMS called out Arcadian for violating the marketing guidelines in several ways, including failing to discuss the coverage gap, employing “scare tactics” and providing inaccurate information about drug coverage. Universal American Corp. was also hit with an enrollment-and-marketing freeze for a slew of violations, including a failure to exercise appropriate oversight of its agents and brokers, who CMS found had enrolled beneficiaries in plans without their prior knowledge or consent, marketed through door-to-door solicitation and cold calls and engaged in aggressive sales tactics that were not in compliance with the guidelines.

**Plan Reps Have Become More Compliant**

But much of the scare tactics and “strong-arming” used by representatives has fallen by the wayside, observes Chad Losey, director of business development, and Kathy Wallis, senior client service director, of Second To None, Inc., an Ann Arbor-based firm that provides customer experience research, sales and operations compliance audits and mystery shopping for a variety of clients, including Medicaid and Medicare plans. “At the marketing events, one of the things that we used to see a lot is just the nature of how they phrased certain things,” Wallis tells *MAN*. “For example, they can’t say anything that makes their plan stand out above the others, ‘Our plan is the best,’ etc. So that’s a big area where we’ve seen improvements. And it doesn’t happen as often, but we have seen reports come through where statements have been made like, ‘If you don’t sign up with this plan, you’re not going to have anything available and will have to wait until next year,’ and that’s simply not true.”

Losey adds that he’s seen a dramatic decrease in unapproved marketing materials that the agents themselves were developing and handing out, and very little offering of food or propaganda that may sway a consumer’s decision to select a particular plan.

Second To None develops questionnaires and tools for its secret shoppers that are based on CMS and corporate guidelines. The company is currently in the process of onboarding new managed care clients for open enrollment and developing questionnaires and shopper training materials with them, as well as revising those tools with existing clients. But Wallis says based on CMS’s most recent update to the marketing guidelines, it hasn’t had to make many changes to its materials.

Plans are, however, increasing their sample size and have been expanding the number and type of scenarios that they’re doing, including evaluating call centers, face-to-face
appointments, and formal and informal events, says Losey. And while Second To None continues to work with plans that have been sanctioned by CMS, he says by and large the company conducts secret shopping as part of plans’ ongoing efforts “to show CMS that they are doing everything they can in order to be compliant.” The company had about two managed care organization clients eight years ago; that number has since grown to 20.

Meanwhile, CMS has continued to grow its surveillance efforts, monitoring more organizations and adding new assessment categories for secret shoppers. And although CMS is now finding fewer deficiencies during the AEP, plans should “continue to monitor their AEP marketing efforts, particularly those conducted by external agents and brokers, as CMS secret shopping will be occurring during the 2017 AEP,” asserts Helaine Fingold, senior counsel in the Health Care and Life Sciences practice at the law firm Epstein Becker & Green, P.C.

Provider Directory Accuracy Is New Target

At the same time, plans should be “especially diligent” with their provider directories, she advises. “CMS has expressed continuing concern with the inaccuracies of provider directories and will maintain its vigilance in working to encourage improvements through compliance and enforcement actions.” Plans are required to provide updated directories to enrollees by Sept. 30 of each year, and must submit those materials to CMS at least five days prior to sending the documents to enrollees.

“Provider network accuracy, at marketing events and in provider directories, appears to be the area of expanding oversight,” weighs in Adelberg. As a result, it’s possible that CMS will “secret shop” provider directories.

Recognizing that CMS is taking a greater interest in provider network oversight, Second To None says it is in the process of launching a “first to market, multichannel solution” that will evaluate on behalf of plans various types of data to confirm the accuracy of provider information. Activities will include sending secret shoppers into the provider’s office to verify information ranging from cultural competency to whether they’re taking new patients, as well as conducting phone-based research.

Another area where plans should be careful to ensure accuracy during the CY 2017 AEP is with the summary of benefits (SB) provided to current and potential enrollees, adds Fingold. Although it is a “file and use” document and CMS has granted new flexibility to plans by allowing them to develop their own approach or follow CMS’s model summary, “CMS will certainly be watching closely to ensure that SB information is accurate,” she advises.

“Based on the importance of this document, CMS may adopt a process whereby plans have to self-report SB inaccuracies, similar to that used for the ANOC/EOC,” says Fingold, referring to the Annual Notice of Change and Evidence of Coverage documents that plan sponsors must send to members by Sept. 30 of each year. “This could represent a new area on which CMS could annually issue compliance notices or even enforcement actions, as happens with the ANOC/EOC. Accordingly, plans should take great care in ensuring that the structure of their SB complies with CMS requirements and the benefit and cost-sharing information included is accurate.”

Contact Adelberg at michael.adelberg@faegrebd.com, Fingold at hfingold@ebglaw.com and Losey at chadl@second-to-none.com.
Under CMS’s New Network Review Policy, 2017 MA Applicants Are Coming Up Short


As CMS carries out a new policy of reviewing Medicare Advantage plans’ entire provider networks for adequacy if they request service area expansions, MAN has learned that plans are dealing with a stricter-than-ever exceptions process and in some cases are having to drop legacy counties in order to expand. And the new system puts existing plans in a tough spot, since the alternative to accepting CMS’s demands is to withdraw their application altogether and face a two-year lockout from the program.

A spokesperson for CMS declined to provide any estimates of how many service area reductions plans will make and pointed out that contracts for 2017 have not yet been finalized. But sources say they know of plans that have been asked to drop certain counties in order to preserve their larger application. And one source who asked not to be identified says some plans aren’t getting their expansion requests approved because they came up short on providers in those areas. While plans used to be able to secure an exception when the only provider in part of a rural county, for instance, refuses to contract with MA plans, that rationale no longer passes CMS muster, adds the source.

“CMS has gotten very demanding about service area network adequacy, and we hear that they have even rejected some expansions from well-established, well-respected plans,” weighs in Stephen Wood, a principal with Clear View Solutions, LLC. “You really have to think twice about going after new service areas if you have any concerns whatsoever about your current service area.”

During the current application cycle for 2017, CMS for the first time began reviewing the adequacy of plans’ entire networks if they requested service area expansions, whereas CMS historically reviewed the networks of only new applicants or in new service areas requested by existing plans. The change was largely in response to criticism from the Government Accountability Office and members of Congress over CMS’s oversight and enforcement of network requirements for MA plans (MAN 10/1/15, p. 4). And during CMS’s annual audit and enforcement conference in Baltimore on June 16, Deputy Administrator and Director of the Center for Medicare Sean Cavanaugh acknowledged that the new process has led to some confusion and frustration among plan sponsors (MAN 7/7/16, p. 1).

“CMS and [Medicare Advantage organizations] find themselves in a strange position this year — needing to service area reduce in order to service area expand,” observes Michael Adelberg, a former top CMS MA official who is now senior director at FaegreBD Consulting. “It would be interesting to know how many MA plans have given up counties that they’ve served for many years without complaints about provider access.”

Sources suggest that part of the problem is the automated system that CMS began using several years ago that leaves little room for error or exceptions. CMS relies on mapping software that measures how long it takes to get to a provider in terms of both time and distance. Those standards are based on the population size and density parameters of individual counties.
“For example, there’s one county we work with where the eastern part of the county is very urban, and the western part of the county is really rural, and this county’s really big,” explains Wood. “So the county’s classified as urban, but when you get out into the western part, there are no providers out there. But you have to abide by urban standards, so we’ve taken a run at that particular county two years in a row and have come up short every time. And it boils down to one or two holdout doctors, or they just don’t exist.”

For a plan that has long served a particular county, where the only dermatologist in a “fringe” area retires, thus making it impossible to meet CMS standards, it’s potentially a big loss to the plan to have to drop a county, observes Washington, D.C., attorney Mark Joffe. “If a plan’s probably fairly entrenched and has fairly large enrollment, giving up an existing county is a pretty big change,” he suggests to MAN. “Moreover, you might have two or three competitors in the exact same county who have that same issue and who also don’t have that provider, so the question then becomes what happens to the other Medicare Advantage organizations, and is this in the best interest of the program? There are all kinds of implications.”

Joffe says he knows of plans that actually decided not to submit service area expansions for 2017 in anticipation of this issue. Meanwhile, Wood says some of his MA clients proactively dropped counties for 2017 even though their internal analysis showed that they would have had adequate networks, but the health services delivery tables updated by CMS shortly before the application deadline indicated a gap.

**Physician Shortage Is Impacting Adequacy**

A new analysis from America’s Health Insurance Plans (AHIP) suggests that there may not even be enough physicians in certain states for plans to meet their federal and/or state network adequacy requirements. Specifically, AHIP found that 14 states have physician supply rates that are less than 90% of the national rate, and seven of those states have supply rates less than 80% of the national rate.

The AHIP data brief, “Impact of Physician Workforce Supply on Health Care Network Adequacy,” evaluated data on the current geographic distribution of physicians in four specialties whose services are in increased demand as a result of the Affordable Care Act and identified states where the ratio of physicians to population falls below the national average for one or more of those specialty areas. In Iowa, for example, the psychiatrist-to-population ratio (5.6 per 100,000) is well below the national average (8.9 per 100,000), with 64% of counties having no practicing psychiatrists at all.

Moreover, HHS-designated health professional shortage areas — which factor into the MA exception process — vary greatly from state to state, which limits the ability of plans to establish “high-value” provider networks, points out AHIP. As a result, the report concludes that federal and state network adequacy standards “should take into account differences in physician supply and distribution across geographic areas, such as differences in the number of providers in urban versus rural areas,” and expresses support for the enhanced use of telemedicine in federal health care programs and the increased use of nurse practitioners and physician assistants in care delivery.

“Certainly this has become a bigger challenge, and I think it requires a much broader look into our workforce challenges and solutions to address that, from workforce education to scope-of-practice laws,” remarks AHIP spokesperson Clare Krusing. “And I think this is
an issue that needs a much bigger focus, other than pointing to the plans and saying, ‘Your networks aren’t adequate,’ when the plans are doing everything they can do to meet those requirements.”

View the AHIP report at http://tinyurl.com/gmqwnyr. Contact Adelberg at michael.adelberg@faegrebd.com, Joffe at marksjoffe@gmail.com, Krusing at ckrusing@ahip.org or Wood at stephen.wood@clrviewsolutions.com.

First Broad-Based Study on MA Networks Highlights Inconsistencies


A new report detailing a study of hospital networks used by more than 400 Medicare Advantage plans across the country may contain few surprises about the composition of the networks and the spotty quality of information about them being distributed by the plans. But the research, conducted by the Kaiser Family Foundation (KFF) and posted June 20, provides the first-ever broad-based look at MA provider networks, and highlights some key considerations for CMS as it intensifies efforts to maintain network adequacy and for plans as they consider launching narrow and/or high-value networks.

The report, “Medicare Advantage Hospital Networks: How Much Do They Vary?” analyzed data from 409 plans, comprising 307 HMOs and 102 local PPOs, serving members in 20 diverse counties that together represented 14% of MA enrollees nationwide in 2015. The report was compiled by Gretchen Jacobson, Ariel Trilling and Tricia Neuman of the Kaiser Family Foundation and independent consultants Anthony Damico and Marsha Gold, who reviewed provider directories used for the 2015 Annual Election Period, in addition to information from the CMS “Landscape” file for 2015 and the American Hospital Association’s 2014 survey of hospitals.

The report found that in all 20 counties studied, provider directories were “riddled with errors,” from including outdated names and addresses to listing hospitals that have been closed for several years. Researchers also observed that accessing and using the provider directories made available by plans was “challenging” based on variations in their overall format and how they were organized. While the analysis was limited to hospitals, the authors pointed out that it “adds to a growing body of literature that shows that provider directories currently have a number of problems that limit their value in helping to inform beneficiaries.”

The report also cites an August 2015 report from the Government Accountability Office (GAO) that criticized CMS’s oversight and enforcement of network requirements for MA plans (MAN 10/1/15, p. 4). GAO estimated that CMS reviews less than 1% of all networks and “does little to assess the accuracy of the network data” in applications from MA organizations (MAOs). Instead, CMS relies largely on complaints from beneficiaries and their caregivers to identify problems with networks, the report suggested. GAO recommended that CMS, among other things, improve its oversight of MA provider networks to address provider availability and conduct more periodic reviews of MAO network information. Likewise, the KFF report suggested that CMS could take additional steps to improve the accuracy of
directory information by, for example, reviewing the directories more frequently for errors and for compliance with network adequacy requirements.

**CMS Commits to Greater Network Review**

During opening remarks given at CMS’s annual audit and enforcement conference in Baltimore on June 16, Deputy Administrator and Director of the Center for Medicare Sean Cavanaugh highlighted new aspects of the application process for 2017 that included: (1) reviewing a plan’s entire network adequacy if it requests service area expansions and not just for new applications, and (2) centralizing network exception reviews in the Center for Medicare central office.

Cavanaugh acknowledged that the new changes had led to some confusion and frustration among plan sponsors during the recent application process. “We had received a lot of feedback from our colleagues on the Hill and from GAO and others that we need to more consistently review networks, and so this was the beginning of that process,” he explained. “We want to be clear about why we’re doing this: We do think it’s very important that we review networks more frequently and…that we be more consistent about how we implement [network] exceptions.”

While counties in the study ranged in size and the number of hospitals, analysts found that all of the plans were selective in some way when including hospitals in their network and that, on average, plans included about half (51%) of the hospitals in the county in their network. Moreover, KFF found that 23% of MA plans had broad networks, defined in the study as including at least 70% of the hospitals in the county, 61% had medium-sized networks (i.e., between 30% and 69% of hospitals in the county), and 16% had narrow hospital networks (i.e., fewer than 30% of all hospitals in the county). Only eight plans, or 2% of those in the study, had “ultra-narrow” networks that included less than 10% of hospitals in the county.

The most significant piece of the KFF report, however, may be that researchers did not observe a correlation between quality and size, which could “lead to new thinking about high value networks that raise quality, rather than broader panels that are quality-neutral,” suggests Michael Adelberg, senior director at FaegreBD Consulting and a former top CMS MA regulatory official. For example, star quality ratings did not appear to vary greatly by network size among HMOs, and overall, the star rating for narrow network plans tended to be similar to the average ratings for medium or broad network plans, respectively.

“This study is narrow, but still important, because everyone’s wondering if narrow networks map to lower quality ratings,” Adelberg tells MAN. “At least as far as this study goes, it did not find a correlation. This fuels the emerging debate about measuring network effectiveness instead of network size.”

Broad and narrow network HMOs also appeared to have similar average premiums, while average premiums for local PPOs ranged from $28 for narrow networks to $87 and $79 for medium and broad networks, respectively.

Other key findings included:

- **In nine of the 20 counties, none of the plans offered a broad hospital network.** And in 12 of the 20 counties, one or more MA plans had narrow networks, including more than one-third of plans in three counties.
On average, 80% of all MA plans in the study included at least one Academic Medical Center. And while these hospitals were featured in 92% of broad network plans, only 51% of narrow network plans included an Academic Medical Center.

Two in five plans in areas with a National Cancer Institute (NCI)-Designated Cancer Center did not include the center in their networks. But among the 15 counties with an NCI cancer center, 43% of plans included the Academic Medical Center with which the center was affiliated but did not explicitly indicate that the cancer center was included.

CMS in the Medicare Plan Finder does not currently post each plan's provider network, pointed out the study authors. To allow for easier plan comparison, they recommended that CMS require all plans to publish network information in a uniform format as well as categorize the size of plans' networks. “While the size of the network would likely not be the sole factor used to select a plan, it could be an important, relevant consideration when deciding between two otherwise similar plans,” the authors suggested.

But there is a danger in “throwing more information” at consumers, especially seniors, points out Helaine Fingold, senior counsel in the Health Care and Life Sciences practice at the law firm Epstein Becker Green. “The key piece, as with the provider directory front, is ensuring that people understand what their options are, as long as it’s an adequate network,” she tells MAN. “So if they want a broader network, they should be able to select that if that’s available, but they just have to be able to understand. Maybe it is a matter of some sort of notification or type of terminology so a beneficiary would understand what they’re reading when they’re pulling things up on the website, that there’s some indication of how broad or how narrow the network is.”


New 2016 MA Reporting Requirements Highlight CMS Provider Network Scrutiny


In an annual effort to gain a better understanding of certain areas of the Medicare Advantage program, CMS in a new technical specifications document unveils three additional areas Medicare Part C plans will be required to report on for contract year 2016. While two of the new reporting sections relate to emerging areas — rewards and incentives (R&I) programs and alternative provider payment models — new reporting requirements on midyear provider network changes reflect CMS's increasing oversight of provider-network adequacy and will support its use of the new Network Management Module (NMM).

“This is another in a string of new guidance and requirements to put CMS in a better position to regulate provider networks in a data-driven manner, and to help CMS understand how much networks fluctuate after approval,” observes Mike Adelberg, a former top CMS MA official who is now senior director at FaegreBD Consulting.
Starting in February 2017, MA plans must begin annually providing to CMS certain details relating to their provider networks and changes made to those networks after their plans are approved by CMS. In the April 22 document, “Medicare Part C Plan Reporting Requirements: Technical Specifications Document, Contract Year 2016,” CMS makes clear that it is “increasing its oversight and management of [Medicare Advantage organizations’] network changes in order to ensure that changes made during the plan year do not result in inadequate access to care for enrolled beneficiaries and that MAOs are [providing] timely and appropriate notification to providers and enrollees.”

Through the collection of 52 data elements, CMS is looking to get a better understanding of how often plans make mid-year network changes and how many enrollees are affected. Plans must report on no-cause mid-year terminations of primary care physicians, certain specialists (e.g., cardiologists, endocrinologists, oncologists) and facilities such as acute inpatient hospitals and skilled nursing facilities made by the MAO during the reporting period.

“We know the agency is very concerned about mid-year network changes; it has already required SEPs,” adds Adelberg, referring to a requirement in the 2015 final Call Letter that there be Special Enrollment Periods when an MA enrollee is affected by substantial mid-year provider network terminations (MAN 4/24/14, p. 1). “This data will help the agency understand what is normal industry practice, and, at some point, informal ways to curb outliers,” he suggests.

CMS said collecting the data will help guide the agency in determining how broadly to use the new NMM in CMS’s Health Plan Management System to verify that plans’ networks meet CMS network adequacy standards, as well as “enhance CMS’ ability to improve [its] network change protocol.” CMS last year launched a “more robust version” of the NMM to better assess on a year-round basis whether the plan sponsors are meeting CMS’s access standards for MA beneficiaries (MAN 5/21/15, p. 1).

“I think they’re trying to see to what extent mid-year network changes is an issue and whether it really is a problem,” weighs in Tom Kornfield, vice president at consulting firm Avalere Health LLC and another former CMS official. In doing so, CMS wants to “ensure that plans don’t use a bait-and-switch with respect to how plans create their networks. So saying they have a really good network and later on it gets changed, the beneficiary feels shortchanged as a result of that.” Collecting and evaluating these data could be difficult, however, since not all provider contracts are done on the same cycle, he points out.

CMS Is Seeking Provider Payment Data

“The most interesting item from my perspective is on what’s happening around alternative payment models and to what extent are plans actually paying based on value,” continues Kornfield. CMS is planning to collect data from MAOs about the proportion of their payment to providers made based on four categories: (1) fee for service with no link to quality; (2) FFS with a link to quality; (3) alternative payment models built on FFS architecture (e.g., those arrangements where some pay is tied to the effective management of a population or an episode of care, even though payment is triggered by delivery of service; and (4) population-based payment (i.e., some payment not directly triggered by service delivery). The section includes 10 data elements.

“The definitions, though, are fairly broad and it’s all being done on an aggregate basis, which wouldn’t necessarily allow you to figure out what plans are doing with physicians vs.
certain specialty groups or hospitals, etc.,” observes Kornfield. “I think it’s interesting that they’re collecting the data. I think it’ll be more interesting to see how they choose to report it out. But at the same time, will this actually affect the policies about how they do payment?”

“Moving traditional Medicare toward value-based payment is probably the No. 1 goal of the agency; it only makes sense that the agency is curious how much value-based payment is going on in MA,” adds Adelberg.

Finally, CMS is seeking to collect data on R&I programs in order to track which MAOs are offering such programs and how those programs are structured. The agency said this will “inform future policy development and allow CMS to determine whether programs being offered adhere to CMS standards and have proper beneficiary protections in place.”

Reading between the lines, Kornfield says he suspects one of the reasons CMS is collecting information around them is to make sure plan sponsors are not abusing newly permitted R&I programs and that “the intent of the regulation is being met by the actual programs.”

But because CMS is asking for more general than specific information like what services are included, what reward enrollees may earn and how plans calculate the values, he adds, “I think they’re going to get a lot of different information here and it might be difficult for them to analyze the information collected in a really meaningful way.”

Contact Adelberg at michael.adelberg@faegrebd.com and Kornfield at tkornfield@avalere.com.

**Final Medicaid Managed Care Rule Retains MLR, Network Adequacy Standards**


CMS on April 25 issued a long-awaited Medicaid managed care rule, finalizing a sweeping set of provisions for states and health plans intended in part to better align Medicaid with other health care programs, strengthen actuarial soundness payment provisions and improve the quality of care for Medicaid and Children’s Health Insurance Program beneficiaries. While industry observers say the regulations provide a proper update — the first major one to the Medicaid program since 2002 — and reflect the changes that have occurred in Medicaid since then, there’s much work to be done to implement and comply with the far-reaching rule.

The final rule, slated for publication in the May 6 *Federal Register,* came nearly a year after its May 2015 proposal (*MAN 6/4/15, p. 1*). The fact that it more than doubled in length to 1,425 pages to accommodate the 900 or so comments it received from stakeholders yet contained very few changes “indicates that CMS clearly had an idea where they wanted to go and spent a lot of time thinking about it,” observes Jeff Myers, president and CEO of the Medicaid Health Plans of America (MHPA) trade group.

Among some of the many key provisions, CMS with only one minor tweak finalized a requirement that the medical loss ratio be calculated, reported and used in the Medicaid managed care rate setting by establishing an 85% minimum MLR. Instead of requiring that...
fraud prevention activities be included in the numerator of the MLR calculation, the agency specified that expenditures on fraud prevention activities adopted for the private market would be incorporated into the Medicaid MLR calculation only if such regulations were amended in the private market.

MHPA, however, “respectfully disagrees” with a standardized MLR, says Myers. “We continue to view that a federalized MLR is unnecessary and arbitrary in the Medicaid system because the MLR is already built into health plans’ contracts and that the states have an incentive to ensure the plans are spending appropriately on the medical loss side and on the administrative side because of the needs that Medicaid enrollees have,” he argues.

Since the majority of states with MLR mandates require at least an 85% MLR, a federal-level requirement is not a dramatic shift for plans. But in the long term it could have some impact on states’ efforts to innovate care management, suggests Myers. “As the feds do more and more to define what is an MLR and what is an ALR [administrative loss ratio] — which has traditionally been a state prerogative — to make decisions about how...to divvy up the cost of services, it makes it more and more standardized,” he tells MAN. “And one of the underlying principles that MHPA fully supports is that state Medicaid programs should be tailored to their citizens, and our belief [is] that over time this is going to have an impact on how states design future programs.”

MLR Minimum May Impact Innovation

So if a plan, for example, uses text messaging to reach beneficiaries who are between residences, some states could consider the phone and potentially the data charges as administrative costs, whereas others may view them as part of care management that would be included in the cost of providing medical services. “I know that’s a small issue, but it’s becoming more of an important issue and it illustrates why a national MLR where it’s already in state contracts makes very little sense,” he adds.

But CMS acknowledged it lacks statutory authority to enforce the MLR standard through remittances, points out Bob Atlas, president of the EBG Advisors unit of health care law firm Epstein, Becker & Green. CMS had initially proposed that states impose a remittance requirement on plans that fail to meet the state-established MLR, but in response to comments said that enforcing the minimum MLR by demanding remittances will be up to state discretion. Still, CMS “encourages” states to impose remittance requirements on plans that fail to meet the state-established MLR and determine the methodology for doing so, according to the rule. Eliminating the remittance requirement “substantially takes the teeth out of the MLR minimum,” remarks Atlas.

“It appears that CMS will use their rate approval authority under the rubric of actuarial soundness to assess whether proposed rates are likely to yield at least an 85% MLR,” he continues. “If a set of rates suggests an MLR will come in low, CMS may judge the rates to be actuarially unsound. That, presumably, would nudge the state to lower the capitation amounts and thus increase the expected MLR.”

The rule did not, however, establish a specific upper MLR limit, on the basis that “states are better positioned to establish and justify a maximum MLR threshold, which takes into account the types of services being delivered, the state’s administrative requirements, and the maturity of the managed care program.”
Rule Specifies Pediatric, Specialty Providers

The rule also establishes a first-ever federal mandate that states put in place network adequacy standards with time and distance requirements. While network adequacy has always been a “general requirement” and this is nothing new given that 31 states have time and distance standards for primary care, the new requirement is significant because it specifies providers at a high level of detail beyond primary and specialty care, observes Megan Renfrew, a former CMS technical director who now is a director in Medicaid IT firm Cognosante’s Solutions Lab. “What CMS has done in this new rule is specify a list of providers for whom it thinks it is particularly important that adequate access be provided,” she says. For example, it distinguishes between pediatric and adult providers in a number of settings, including dental care, and mentions pharmacy providers.

“Plans are going to have to…see if networks are adequate for these types of providers,” she recommends. “So the initial burden on plans may be just evaluating their own networks, but if they feel like they’re not close, they’re going to have to go out and find other providers to contract with.”

Myers points out that this is another change that doesn’t necessarily support innovation. While MHPA is generally in favor of time and distance standards, “they don’t take into account MCO innovations like telehealth,” he says. MHPA was pleased, however, to see that a provision that states may make a capitation payment for enrollees with a short-term stay in an Institution for Mental Disease (IMD) was finalized as proposed. “It shows that CMS realizes the importance of access to behavioral health services for this population,” he adds.

In addition, the rule adopted several proposed changes to the way grievances and appeals are handled by managed Medicaid plans. These include adding prepaid ambulatory health plans to the types of entities subject to grievance and appeals standards, eliminating time limits for filing grievances, and allowing an enrollee or provider 60 days from the time of receiving notice of an adverse benefit determination to request an appeal.

The rule also clarified as proposed that plans must cover any drug deemed medically necessary under a prior authorization process if the drug is not included on the plan’s formulary. Myers says that provision basically “makes clear something that plans have always believed, which is that if you provide outpatient drugs to Medicaid you have to comply with the requirements of [Section] 1927” of the Social Security Act, which authorized the Medicaid Drug Rebate Program.

Meanwhile, plans are “breathing a small sigh of relief” now that CMS has ditched a proposal to keep newly eligible Medicaid beneficiaries in fee-for-service for 14 days before putting them into a managed Medicaid plan, adds Atlas. “That’s also a relief for states, which might not want to maintain a whole fee-for-service processing infrastructure for people who are only going to be on there for 14 days. And the plans would just as soon get people from the first day they’re eligible.”

The final rule also calls for the creation of the first-ever quality rating system in Medicaid. During a news briefing held April 25, CMS Center for Medicaid and CHIP Services Director Vikki Wachino said that system will align with the ratings system currently in place for health insurance marketplace coverage. The ratings system will be developed and implemented over the next five years to give CMS time to work with stakeholders, she said. Wachino added that most of the changes will be implemented in phases beginning in 2017.
View the final rule under the May 2 From the Editor entry at MAN’s subscriber-only Web page: https://aishealth.com/newsletters/medicareadvantagenews.

Contact Atlas at batlas@ebgadvisors.com, Myers via Joe Reblando at jreblando@mhma.org or Renfrew via Liz Goar at liz@npccs.com.