

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard, Mail Stop C4-21-26
Baltimore, Maryland 21244-1850



MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

November 27, 2013

Ms. Margaret Garikes
Director of Federal Affairs
American Medical Association
25 Massachusetts Avenue, NW
Washington, DC 20001

Dear Ms. Garikes:

Thank you for your letter on behalf of the American Medical Association and many other medical associations throughout the country regarding how some Medicare Advantage organizations (MAOs), including United Health Care (UHC), have implemented changes to their provider networks. You express concerns about the timing of these “no-cause” contract terminations, whether the MAOs have complied with applicable requirements, and the effect of these terminations on Medicare beneficiaries as they make Medicare Advantage plan selections during the annual enrollment period. You also ask that the Centers for Medicare & Medicaid Services (CMS) direct UHC and other MAOs to delay the effective date of their contract terminations for the 2014 contract year.

CMS shares your interest in ensuring that MAOs’ networks meet our standards on adequacy and accessibility to Medicare beneficiaries enrolled in MA plans. Thus, we are currently reviewing UHC’s networks against CMS standards in each county affected by UHC’s multi-state network changes. In addition to reviewing county-specific contracted provider data, we are working closely with UHC to investigate allegations from the provider community and other stakeholders about inadequate numbers of specialists or other barriers to access to care. We have recently received a few beneficiary complaints and are in the process of addressing them with UHC. We are also meeting with UHC on a regular basis to discuss complaints and inquiries they are receiving and are coordinating our responses to ensure that we are providing accurate information to providers and enrollees.

We would also note that, based on information reported to CMS, UHC has met or exceeded CMS’ notice requirements, specifically 60 days’ advance notice to affected providers, and 30 days’ advance notice to affected enrollees. In addition, consistent with CMS’ requirements, UHC has a process for providers to appeal their terminations and is reviewing and processing those appeals. UHC’s scripting for its customer service representatives includes language about how members who are undergoing treatment from a specialty provider can request to continue services from that provider for a period of time to ensure a smooth transition to an alternate provider.

As you may know, MAOs have the flexibility to establish and manage contracted provider networks as they choose, as long as they continue to furnish all Medicare Part A and B services, fully meet Medicare access and availability standards, and have a process in place to ensure that, in the case of a provider termination, continuity of care is maintained for patients affected by those terminations. I have provided more details below regarding several of CMS' standards and requirements that specifically relate to the concerns expressed in your letter.

Enrollee notification requirements: Medicare regulations require MAOs to provide at least 30 days' advance notice to enrollees, in writing, of any changes to their provider network. CMS strongly encourages MAOs to furnish enrollees with a longer notification period when that is possible. In the case of large network changes, CMS approves both written and verbal communications sent to enrollees regarding their provider changes, monitors enrollee and provider complaints, and ensures that MAOs promptly resolve issues that arise. In some cases, as is the case with UHC, CMS meets on a regular basis with the MAO's leadership to review the organization's ongoing management of its network changes and compliance with Medicare rules.

Continuity of care: Managing continuity of care for enrollees during a network change is a priority. We require MAOs to furnish direct assistance to enrollees who are affected by network changes to ensure that their selection and transition to new providers is as seamless as possible. The MAO may be required to contact non-contracted providers on behalf of its enrollees, to arrange for care and/or to contact terminating or terminated providers to arrange continuing care for its enrollees already scheduled for evaluations, procedures, treatment and/or therapies from those providers. With respect to some of the current network changes, CMS has required the reinstatement of providers for access and cultural competence reasons.

Review of network adequacy: The CMS network access standards are based on local patterns of care and are evaluated using the following criteria: a) the number of providers by county and specialty type; b) the travel distance to providers and facilities by county and specialty type; and c) in some counties, the travel time to providers and facilities by county and specialty type. If CMS find deficiencies in an MAO's network, we will require the organization to ensure adequate coverage by allowing enrollees to continue to see non-contracted providers at in-network cost-sharing until the deficiencies are corrected. During that time, the MAO would pay non-contracted providers rates equivalent to what they would have received under Original Medicare. We also require MAOs, including, in this case, UHC, to report to CMS as to how they have addressed enrollee and provider complaints related to network adequacy issues.

Culturally Competent Care: In your letter, you raised specific concerns regarding MAOs' compliance with requirements that they provide culturally competent and appropriate care to all enrollees, including those with limited English proficiency and the disabled. CMS regulations require that all MAOs' networks provide adequate access to covered services to meet the needs of the population served, including the disabled. In addition, our guidance, at Chapter 4 of the Medicare Managed Care Manual, specifies that MAOs must:

Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited

English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how an MAO may meet these accessibility requirements include, but are not limited to, provision of translator services, interpreter services, teletypewriters or TTY (text telephone or teletypewriter phone) connection.

As a specific example, CMS requires that MAOs operating in areas with populations of non-English speakers above a specific threshold make all plan materials available in translation and have staff and providers available who can assist non-English-speaking enrollees. We also investigate complaints and reports that an MAO is not meeting the CMS requirements with respect to furnishing culturally competent care and requires MAOs to make network changes as necessary to fully meet our access and availability standards and to furnish culturally competent care.

Provider notification: We have specific rules in our regulations and guidance (at Chapter 6 of the Medicare Managed Care Manual) that MAOs must follow in terminating their contracts with providers, including the following:

Suspension, Termination, or Nonrenewal of Physician Contracts

Specific requirements for an MA organization that operates a coordinated care plan or network MSA plan providing benefits through contracting physicians and that suspends, terminates, or non-renews a physician's contract are as follows:

1. The MA organization must give the affected physician written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by the MA organization.
2. The MA organization must allow the physician to appeal the action, and give the physician written notice of his/her right to a hearing and the process and timing for requesting a hearing.
3. The MA organization must ensure that the majority of the hearing panel members are peers of the affected physician.

Physicians who have been terminated without cause and who believe they have not received appropriate appeal rights should notify CMS so we can investigate the MAO's compliance with our regulations. We are not releasing specific numbers regarding provider terminations at this time, but, as noted above, are investigating all complaints relating to network changes.

Thus, we believe that our current requirements related to provider contract terminations address many of your concerns related to potential beneficiary harm, and we continue to work closely with UHC to ensure that they are responding to complaints from providers and enrollees and are adhering to CMS' requirements.

With respect to your request that we direct MAOs to hold in abeyance all terminations initiated just prior to the annual enrollment period, CMS does not have the authority to impose such a requirement. This action would require a change to our regulations that cannot be achieved outside of the notice and comment rulemaking process. However, as we have explained above,

CMS is carefully overseeing the network changes and will require MAOs, including UHC, to make adjustments, as needed.

Lastly, you ask that CMS extend the annual election period. We do not believe that a special election period is warranted at this time, but will continue to monitor the situation. In addition, affected enrollees have the opportunity to leave their MA plan and return to Original Medicare during the Medicare Advantage (MA) Disenrollment Period, which runs from January 1 through February 14 of each year.

I appreciate your sharing your concerns about MA enrollees' ability to access care in the event that there are changes to their provider network, and hope this information is helpful to you and your membership.

Sincerely,

A handwritten signature in cursive script that reads "Danielle R. Moon". The signature is written in black ink and is positioned above the printed name and title.

Danielle R. Moon, J.D., M.P.A.
Director