CY2015 MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance

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Summary of Significant Changes to the CY2015 MA Provider and MA Facility Criteria

CMS continues to evaluate the process, guidance, and assumptions governing its oversight of the adequacy of Medicare Advantage (MA) provider networks. Further refinements have been made for the CY2015 MA application:

- Total Beneficiaries - These values were updated to reflect the most recently published number of Medicare beneficiaries in each county. This affects the calculation of the minimum number of providers and acute inpatient hospital beds criteria.
- County Types - These designations were updated to reflect the most recently published population and density in each county.

HSD Provider and Facility Criteria

MA applicants must demonstrate that they are able to provide adequate access to current and potential beneficiaries through a contracted network of providers and facilities. Access to a given provider/facility is considered "adequate" when the following three criteria are met (described in detail throughout this document):

Table 1: Description of the Three Provider and Facility Criteria

Criteria	Description
1. Minimum number of providers/facility	MA applicants must demonstrate that their networks have sufficient numbers of providers/facilities to meet minimum number requirements[1] and allow adequate access for beneficiaries/potential enrollees. Specialized and pediatric/children's hospitals as well as providers/facilities contracted with the applicant only for its commercial, Medicaid, or other non-Medicare Advantage products do not count toward meeting HSD criteria and should not be listed on the HSD tables.
2. Maximum travel time ***3. Maximum travel distance***	MA organizations must demonstrate that their contracted networks do not unduly burden beneficiaries in terms of travel time and distance to network providers/facilities. These time and distance metrics speak to the access requirements pertinent to the approximate residence locations of beneficiaries, relative to the locations of the network provider/facilities. MA applicants must demonstrate that 90 percent of beneficiaries (or more) have access to at least one provider/facility, for each specialty type, within established time and distance requirements.

These criteria vary by "county type" to account for differences in patterns of care (Large Metro, Metro, Micro, Rural, CEAC).[2]

[1] Although the minimum number requirement for each facility specialty is one (with the exception of Acute Inpatient Hospital Beds), applicants may need to list more than one of each facility type in order to meet time and distance requirements.

[2] County type designations are discussed in detail in Appendix A of this document.

Calculating Network Adequacy Criteria

Criteria for each county and specialty type are published in the MA HSD Reference Tables, available for download at http://cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html.

Minimum Number of Providers

The minimum number of providers criterion involves three calculations:

1. 95th percentile of beneficiaries served by MA Organizations
2. Beneficiaries required to cover
3. Minimum provider ratios

95th percentile of beneficiaries served by MA Organizations

The "95th Percentile Base Population Ratio" represents the 95th percentile of MA market penetration rates of CCP and network-based PFFS MAO contracts by county for each county type (Large Metro, Metro, Micro, Rural and CEAC); i.e., 95% of CCP and network-based PFFS plans have county penetration rates equal to or less than the calculated rates.[3] Each year CMS updates the 95th percentile based on current enrollment. For CY2015, the percentiles are as follows:

Table 2: 95th Percentile by County Type

County Type	95th %-ile
Large Metro	0.068
Metro	0.110
Micro	0.103
Rural	0.105
CEAC	0.132

Beneficiaries required to cover

To determine the base population that an applicant is required to cover, "Beneficiaries Required to Cover," the number of Medicare beneficiaries in a specific county is multiplied by the applicable 95th percentile.

Table 3: Example of Beneficiaries Required to Cover Calculation

County:	*Muscogee, GA*
County Type:	*Metro*
Total Beneficiaries:	*30,162*
95th %-ile:	*.110*
Beneficiaries Required to Cover:	*(30,162 * .110) =* ***3,318***

[3] Penetration is calculated by dividing the number of Medicare beneficiaries enrolled in an MA plan by the number of eligible Medicare beneficiaries in that county. For example, in a county with 1,000 eligible Medicare beneficiaries, an MA CCP plan with 100 members would have a penetration of 100/1,000, or 10%.

Minimum Provider Ratios

Based upon primary and secondary research of the utilization patterns and clinical needs of Medicare populations, CMS has established ratios of providers required per 1,000 beneficiaries for the specialty types in the MA Provider Table and also for the Facility type - "Acute Inpatient Hospital" (# of required beds). These ratios vary by county type and are published for the applicable specialty types in the HSD Reference Tables. To calculate the minimum number of each specialty type in each county, the number of beneficiaries required to cover is multiplied by the Minimum Provider Ratio and rounded up to the nearest whole number.

Table 4: Example of Minimum Provider Calculation

County:	*Muscogee, GA*
County Type:	*Metro*
Beneficiaries Required to Cover:	*3,318*
Specialty:	*Primary Care*
Minimum Provider Ratio:	*1.67 /1,000*
Minimum Number of Providers:	*(1.67/1,000) *3,318 =* ***6***

Maximum Time and Distance

The maximum time and distance criteria were developed using a process of mapping beneficiary locations against provider practice locations. Applicants must ensure that at least 90% of the beneficiaries residing in the county being applied for have access to at least one provider/facility of each type within the published time and distance criteria. The maximum network time and distance criteria vary by county type and specialty type.

Applying Network Adequacy Criteria to MA Applicants

CMS uses a mapping software program to evaluate MAOs' submitted networks. The software evaluates contracted networks against beneficiary locations across an entire county, which allows CMS to determine whether an applicant's proposed network meets HSD adequacy standards (i.e., minimum number, maximum time, maximum distance). If an applicant believes that local patterns of care in a particular county are such that its network cannot meet HSD adequacy standards, the applicant can request an exception through the HSD Exception Request process.[4]

Applicants are only permitted to include in their application providers and facilities that are *under contract at the time of their submission* to CMS. To meet the network adequacy criteria, contracted providers do not need to be located within the geographic boundaries of the county for which application is being made.

Minimum Number of Providers/Facilities

Through the automated HPMS process, applicants' progress in meeting minimum provider/facility numbers is assessed based on the number of submitted providers/facilities that are located within the

[4] Guidance on submitting exception requests is available in Appendix B of this document.

time/distance criteria of at least one beneficiary in a given county. A submitted provider/facility does not count toward the minimum number of providers/facilities unless that provider/facility is within the time and distance requirements of at least one beneficiary in the county for which the applicant is applying. For example, a cardiologist located in Tennessee will not count toward the minimum number requirements for a network for an application covering Florida counties.

MA organizations must have at least one of each HSD facility type. At this time, CMS has not established additional criteria for the minimum number of required providers for most of the specialty types on the CMS MA Facility Table. The one exception to this is the requirement concerning acute inpatient hospitals. CMS has established a requirement for the minimum number of acute inpatient beds per 1,000 beneficiaries residing in the county (12.2 inpatient hospital beds per 1,000 beneficiaries residing in a county). This criterion was calculated using the same type of factors as those described above and varies by county geographic designation.

Maximum Travel Time and Distance

In addition to meeting the minimum number of providers criteria, MA organizations must demonstrate that, taking into consideration the geographic distribution of beneficiary residency locations within the county of application, at least 90% of the Medicare beneficiaries residing in that given county have access to at least one provider, for a given specialty, *within the time and distance requirements.*

In order to meet the time and distance requirements, the number of providers/facilities that an applicant must submit may need to exceed the minimum number requirements, depending upon the actual clinical office locations of the providers/ facilities. Applicants may include contracted providers/facilities located outside of the application's requested service area/counties if those providers are within the time and distance requirements.

HSD Provider and Facility Specialty Details

Specialty Codes

CMS has created specific specialty codes for each of the provider and facility types. Applicants must use the codes when completing MA Provider and Facility HSD tables.

Table 5: List of specialty codes for provider table

Specialty Codes for the MA Provider Table

001 – General Practice
002 – Family Practice
003 – Internal Medicine
004 – Geriatrics
005 – Primary Care – Physician Assistants
006 – Primary Care – Nurse Practitioners
007 – Allergy and Immunology
008 – Cardiology
009 – NOT IN USE
010 – Chiropractor
011 – Dermatology
012 – Endocrinology
013 – ENT/Otolaryngology
014 – Gastroenterology
015 – General Surgery
016 – Gynecology, OB/GYN
017 – Infectious Diseases
018 – Nephrology
019 – Neurology
020 – Neurosurgery
021 – Oncology - Medical, Surgical
022 – Oncology - Radiation/Radiation Oncology
023 – Ophthalmology
024 – NOT IN USE
025 – Orthopedic Surgery
026 – Physiatry, Rehabilitative Medicine
027 – Plastic Surgery
028 – Podiatry
029 – Psychiatry
030 – Pulmonology
031 – Rheumatology
032 – NOT IN USE
033 – Urology

034 – Vascular Surgery
035 – Cardiothoracic Surgery
000 – OTHER

Table 6: List of specialty codes for facility table

Specialty Codes for the MA Facility Table
040 – Acute Inpatient Hospitals
041 – Cardiac Surgery Program
042 – Cardiac Catheterization Services
043 – Critical Care Services – Intensive Care Units (ICU)
044 – Outpatient Dialysis
045 – Surgical Services (Outpatient or ASC)
046 – Skilled Nursing Facilities
047 – Diagnostic Radiology
048 – Mammography
049 – Physical Therapy
050 – Occupational Therapy
051 – Speech Therapy
052 – Inpatient Psychiatric Facility Services
053 – NOT IN USE
054 – Orthotics and Prosthetics
055 – Home Health
056 – Durable Medical Equipment
057 – Outpatient Infusion/Chemotherapy
058 – NOT IN USE
059 – NOT IN USE
060 – NOT IN USE
061 – Heart Transplant Program
062 – Heart/Lung Transplant Program
063 – NOT IN USE
064 – Kidney Transplant Program
065 – Liver Transplant Program
066 – Lung Transplant Program
067 – Pancreas Transplant Program

Specialty Guidance

To assist applicants further, this section contains additional guidance as to the appropriate submissions for a number of the MA HSD Provider and MA HSD Facility Table specialty types, about which CMS periodically receives questions.

MA Provider Table – Select Provider Specialty Types

Primary Care Providers – The following six specialties are reported separately on the MA Provider Table, and the criteria, as discussed below, are published and reported under "Primary Care Providers (S03):

- General Practice (001)
- Family Practice (002)
- Internal Medicine (003)
- Geriatrics (004)
- Primary Care – Physician Assistants (005)
- Primary Care – Nurse Practitioners (006)

Applicants submit contracted providers using the appropriate individual specialty codes (001 – 006). CMS sums these providers, maps them as a single group, and evaluates the results of those submissions whose office locations are within the prescribed time and distance standards for the specialty type: Primary Care Providers. These six specialties are also summed and evaluated as a single group against the Minimum Number of Primary Care Providers criteria. Take note that in order to apply toward the minimum number, a provider must be within the prescribed time and distance standards, as discussed below. There are HSD network criteria for the specialty type: Primary Care Providers, but not for the individual component specialties. The criteria and the results of the Automated Criteria Check (ACC) are reported under the specialty type: S03.

Primary Care – Physician Assistants (005). Applicants include submissions under this specialty code **only if** the contracted individual meets the applicable state requirements governing the qualifications for assistants to primary care physicians and is duly certified as a provider of primary care services. In addition, the individuals listed under this specialty code must function as the primary care source for the beneficiary/member, not supplement a physician primary care provider's care, in accordance with state law and be practicing in or rendering services to enrollees residing in a state and/or federally designated physician manpower shortage area.

Primary Care – Nurse Practitioners (006)- Applicants include submissions under this specialty code **only if** the contracted registered professional nurse is currently licensed in the state, meets the state's requirements governing the qualifications of nurse practitioners, and is duly certified as a provider of primary care services. In addition, the individuals listed under this specialty code must function as the primary care source for the beneficiary/member, not supplement a physician primary care provider's care, in accordance with state law and be practicing in or rendering services to enrollees residing in a state and/or federally designated physician manpower shortage area.

Geriatrics (004) – Submissions appropriate for this specialty code are internal medicine, family practice, and general practice physicians who have a special knowledge of the aging process and special skills and who focus upon the diagnosis, treatment, and prevention of illnesses pertinent to the elderly.

Physiatry, Rehabilitative Medicine (026) – A physiatrist, or physical medicine and rehabilitation specialist, is a medical doctor trained in the diagnosis and treatment of patients with physical, functionally limiting, and/or painful conditions. These specialists focus upon the maximal restoration of physical function through comprehensive rehabilitation and pain management therapies. Physical Therapists are NOT Physiatry/Rehabilitative Medicine physicians and are not to be included on the MA Provider tables under this specialty type.

Cardiothoracic Surgery (035) – Cardiothoracic surgeons provide operative, perioperative, and surgical critical care to patients with acquired and congenital pathologic conditions within the chest. This includes the surgical repair of congenital and acquired conditions of the heart, including the pericardium, coronary arteries, valves, great vessels and myocardium. Cardiologists, including interventional cardiologists, are not cardiothoracic surgeons, and may not be included under this specialty type.

MA Facility Table – Select Facility Specialty Types
Contracted facilities/beds must be Medicare-certified.

Acute Inpatient Hospital (040) – Applicants must submit at least one contracted acute inpatient hospital. Applicants may need to submit more than one acute inpatient hospital in order to satisfy the time/distance criteria. There are Minimum Number criteria for the acute inpatient hospital specialty. Applicants must demonstrate that their contracted acute inpatient hospitals have at least the minimum number of Medicare-certified hospital beds. The minimum number of Medicare-certified acute inpatient hospital beds, by county of application, can be found on the "Minimum Facility #s" tab of the HSD Reference Table.

Cardiac Surgery Program (041) – A hospital with a cardiac surgery program provides for the surgical repair of problems with the heart, traditionally called open-heart surgeries. Procedures performed in a cardiac surgery hospital program include, but are not limited to: coronary artery bypass graft (CABG), cardiac valve repair and replacement, repair of thoracic aneurysms and heart replacement, and may additionally include minimal access cardiothoracic surgeries. (Please note – not all cardiac surgery programs include heart transplant services. Medicare-approved heart transplant facilities are listed under facility table category 061 (heart transplant) and 062 (heart/lung transplant), as appropriate.)

Orthotics and Prosthetics (054) – A prosthetist is a healthcare professional trained to measure, design, fit, and adjust prostheses/prosthetic devices as prescribed by a physician. Prosthetic devices replace all or part of an internal body organ or all or part of the function of a permanently inoperative or malfunctioning internal body organ. An orthotist is a healthcare professional trained to plan, design, fit and adjust orthotic devices as prescribed by a physician. Orthotic devices are rigid/semi-rigid devices applied to the outside of the body to support a weak or deformed body part, or to restrict motion in an area of the body. Applicants' contracts for orthotics and prosthetics must ensure access for beneficiaries/members to the fitting and modification and services to the devices (orthotics and prosthetics) and to the healthcare professionals (orthotists and prosthetists).

Home Health (055) – Applicants must list at least one Medicare certified home health agency (HHA) serving each specific county included in the application. Each Medicare certified HHA is licensed for defined service areas and may only serve a portion of a given county; additionally, HHAs vary significantly in the types of home health services provided. Thus, an applicant may be required to contract with more than one HHA in order to ensure adequate coverage of HHA services across the entire county.

Durable Medical Equipment (056) – Applicants must list at least one durable medical equipment provider. A submission under this specialty type can be limited to one provider, so long as that provider covers the full range of Medicare covered durable medical equipment services. Applicants' submissions for this specialty must provide durable medical equipment services throughout the entire area of the county.

Outpatient Infusion/Chemotherapy (057) – Appropriate submissions for this specialty include freestanding infusion / cancer clinics and hospital outpatient infusion departments. While some physician practices are equipped to provide this type of service within the practice office, applicants should only list a contracted office-based infusion service if access is made available to all members and is not limited only to those who are patients of the physician practice.

Transplant Programs (061, 062, 064, 065, 066, 067) – Applicants must list at least one contracted program for each of the six transplant program types: Heart, Heart/Lung, Kidney, Liver, Lung and Pancreas.

Appendix A: Designating County Types

The county type, Large Metro, Metro, Micro, Rural, or CEAC, is a significant component of the network access criteria. CMS uses a county type designation methodology that is based upon the population size and density parameters of individual counties.

Table B.1 lists the population and density parameters applied to determine county type designations. These parameters are foundationally based on approaches taken by the Census Bureau in its delineation of "urbanized areas" and "urban clusters", and the OMB in its delineation of "metropolitan" and "micropolitan". A county must meet both the population and density thresholds for inclusion in a given designation. For example, a county with a population greater than one million *and* a density greater than or equal to 1,000/mi^2 is designated Large Metro. Any of the population-density combinations listed for a given county type may be met for inclusion within that county type (i.e., a county would be designated Large Metro if *any* of the three Large Metro population-density combinations listed in Table 7 are met; a county is designated as Metro if any of the five Metro population-density combinations listed in Table 7 are met; etc.).

Table 7: Population and Density Parameters

County Type	Population	Density
Large Metro	≥ 1,000,000	≥ 1,000/mi^2
---	500,000 – 999,999	≥ 1,500/mi^2
---	Any	≥ 5,000/mi^2
Metro	≥ 1,000,000	10 – 999.9/mi^2
---	500,000 – 999,999	10 – 1,499.9/mi^2
---	200,000 – 499,999	10 – 4,999.9/mi^2
---	50,000 – 199,999	100 – 4,999.9/mi^2
---	10,000 – 49,999	1,000 – 4,999.9/mi^2
Micro	50,000 – 199,999	10 – 99.9 /mi^2
---	10,000 – 49,999	50 – 999.9/mi^2
Rural	10,000 – 49,999	10 – 49.9/mi^2
---	<10,000	10 – 4,999.9/mi^2
CEAC	Any	<10/mi^2

CMS applies these parameters to US Census Bureau population estimates to determine, annually, appropriate county type designations. Current population and density estimates (calendar year 2012) are available at http://quickfacts.census.gov/qfd/download_data.html .

Appendix B: MA Provider and Facility Exception Requests

CMS will consider requests for exceptions to the required minimum number of providers and/or maximum time/distance criteria under definite and limited circumstances. Each Exception Request must be supported by information and documentation as specified in the Exception Request template, which is published with the CY2015 Medicare Advantage Application document. The template should be followed in all regards.

Timing of Exception Requests

Following the initial submission of the MA Provider and MA Facility tables, Applicants whose networks do not successfully meet the criteria will receive a Deficiency Notice indicating the network deficiencies. Applicants then prepare and submit a response to the Deficiency Notice, including the submission of revised MA Provider and MA Facility tables. Subsequent to the submission of the Deficiency Notice response, Applicants have the opportunity to review the updated CMS-generated Automated Criteria Check (ACC) report before developing and submitting an Exception Request(s) based on results of that ACC report.

Note:

i) Applicants do not submit Exception Requests with their initial application submission.
ii) There is one opportunity to submit an Exception Request. This opportunity, as described above, occurs immediately following the issuance of the CMS-generated Automated Criteria Check (ACC) report generated after the receipt by CMS of the Applicant's response to the Deficiency Notice.

Opportunity to submit a corrected Exception Request - An Applicant that receives a Notice of Intent to Deny (NOID) that identifies a previously submitted Exception Request (as discussed in Note # *ii)* may submit a corrected Exception Request. To do so, the Applicant must submit revised MA Provider and MA Facility tables (following receipt of the NOID), review the subsequent ACC reports reflecting the revised tables, and then submit a corrected Exception Request for the same contract id, county, and specialty code as was originally submitted.

A calendar listing the dates when the exception requests are due will be posted with the final CY2015 Application materials.

Use of Exception Request Template

To streamline requirements for Exception Request submissions, Applicants must meet the following requirements and must use the Exceptions Request Template:

i) Exception Request Template and the MA Provider and MA Facility tables
  a) The Exception Request Template must be used for both initial and corrected Exception Requests.
  b) MA Provider and MA Facility tables must list all contracted providers within and outside of the county that will be available to serve the county's beneficiaries.

c) Exception Requests must include a listing of the Provider(s)/Facility(ies) that are intended to provide access to the specialty type service in question.

d) Providers and Facilities referenced in an Exception Request must also be listed on the appropriate MA Provider/MA Facility table.

e) The Provider/Facility referenced in the Exception Request that is intended to provide access to the specialty type service in question must be listed in the MA Provider or MA Facility table

- Under the specialty type code of the specialty for which an Exception Request is being submitted, except
- Applicant must list the Provider/Facility using the OTHER specialty code (000) when submitting an Exception Request that involves an alternate provider/facility type.

f) Applicants may not simply refer to a Provider/Facility listed in the MA Provider/MA Facility tables for a different county when submitting an Exception Request. Any Providers/Facilities referenced in the Exception Request must be listed in that same county's MA Provider/MA Facility tables.

i. An Applicant can submit only one exception request per contract id, county, and specialty code.

ii. Justification narratives must be included in the Exception Request document, not submitted as a separate file attachment.

iii. Applicants must ensure that Providers/Facilities referenced in the Exception Request match the listings on the MA Provider/MA Facility tables for the county in question.

iv. Applicants submitting an Exception Request must name each Exception Request document (for a unique contract id/county/specialty type) using the following naming convention:

Contract ID (5 characters)_County Code (5 characters)_Specialty Code (3 characters)

15 characters total. Example: H9999_98765_032.xxx

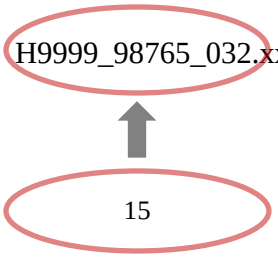

Figure 1: The 15 characters are shown circled