CMS Health Services Delivery Tables – Exceptions and Required Documentation for Medicare Advantage Applicant Plans

CMS recognizes that, under limited circumstances, applicants' networks may not meet the network adequacy criteria for a particular provider/facility type in a specific county. In order to mitigate valid situations in which an applicant's network is not able to meet specific criteria, CMS has incorporated a process for requesting exceptions into the network submission and review process. Applicants can request an exception from the network adequacy criteria where these limited circumstances exist.

To request an exception, applicants must select from the pre-determined exceptions below and submit a narrative explanation, along with formal documentation described in detail below, as to why the standard network adequacy criteria cannot be met for the specific provider/facility type in a specific county. **Applicants will <u>only</u> be able to request exceptions during the initial application submission. Late exception requests will not be accepted.**

I. Types of Exceptions

The list of pre-determined provider/facility exceptions include:

1. ***Insufficient number of providers/beds in service area -*** *This* exception would apply in counties where there are insufficient numbers of providers/facilities/beds to meet the standard network adequacy criteria. Please note that this exception cannot be used where the Applicant has merely failed to obtain a sufficient number of contracts for the specific provider/facility type or where a provider/facility has simply refused to contract.

2. ***No providers/facilities that meet the specific time and distance standards in service area -*** *This* exception would apply in counties where there are no providers/facilities in the service area. Please note that approval of an exception on this basis does not relieve the Applicant from demonstrating access to the specific service provided by the provider/facility type.

3. ***Patterns of care in the service area do not support need for the requested number of provider/facility type - This*** exception would apply in instances where applicants are able to provide sufficient documentation to demonstrate a pattern of care different from CMS' standards.

4. ***Services will be provided by an alternate provider type/Medicare-certified facility*** - This exception would apply where the Applicant has arranged for a different provider/facility type to provide the services at issue. For example, such an exception might be appropriate where the Applicant has insufficient numbers of standard primary care providers (Geriatrician's, Internal Medicine, GPs) but has contracted with another provider type to provide these services and that other provider type is duly li**c**ensed or certified to provide these services.

5. ***Alternative Arrangements for Regional PPOs*** - *Pursuant* 42 CFR 422.112(a)(1)(ii), RPPOs can use methods other than written arrangements: to meet access requirements as approved by CMS. RPPOs will still need to demonstrate that the network overall is comprehensive. This exception can **only** be used by RPPOs.

II. Required Documentation from Applicants

The following tables detail the specific documentation that applicants must submit in supporting each exception request. For each requested exception, applicants must submit information on the time and distance to the nearest alternative provider/facility and local patterns of care for the specific service. In order to meet the documentation requirements, applicants must also submit one of the other types of documentation listed in the table, as well as other documentation CMS specifically requests during the application process. Applicants will have a limit of 2,000 characters (approximately one typed page) for the narrative portion for each exception requested for each provider/facility type, per county.

Applicants can submit as many exception requests as needed. However, only one exception request needs to be submitted for each provider or facility type in a given county that does not meet CMS' criteria. Additional exceptions for the same provider or facility type in that county can be included in one discussion.

Please note that exception requests do not relieve applicants from submitting accurate and complete HSD tables or from contracting with available providers/facilities that exist in the relevant service area within the time/distance requirements. Inaccurate or incomplete information submitted in HSD tables will result in a deficiency requiring re-submission of those tables.

A. Provider/Facility Exceptions

Exception Selected: Insufficient Number of Providers in Service Area

This exception is used when there are an insufficient number of providers in a particular service area.

	Health Plan Documentation
Required	• Provide distance and travel time points that members would have to travel beyond the required criterion (e.g., 20 minutes and 10 miles for a Primary Care Physician (PCP) in a metropolitan service area) to reach the next closest contracted provider of this type outside of the service area • Provide contact information including names, addresses, and phone numbers for next closest contracted providers/facilities
	• Provide data on local patterns of care (e.g., using claims data, referral patterns, local provider interviews, use of telemedicine) indicating where members currently seek this type of care and/or where doctors currently refer members for this type of care • Indicate data sources (e.g., dates for source data, interviews)
	• Provide other documentation as requested by CMS
Select One	• ***For Providers Only,*** provide data sources used to confirm the total number of practicing (not contracted) providers in the service area (e.g., Medicare.gov, Physicianfinder.com, other health plan networks)
	• ***For Facilities Only,*** provide the capacity of contracted Medicare Certified facilities availability to serve the number of expected Medicare members (e.g., number of beds) and any expected facility additions in the next year.

	• Provide a detailed description of contracting alternatives (e.g., physician extenders, telemedicine, coverage of transportation costs) that will help to address the insufficient number of providers in the service area, in addition to details on potential contracting alternatives that were explored by the health plan, but could not be pursued
	  • Include any relevant health plan policies and procedures that address contracting alternatives
	  • Describe any special accommodations and/or reimbursement (including transportation arrangements used to meet the needs of members) and any corresponding health plan policies and procedures

	• Provide any additional documentation that supports the exception request

Exception Selected: No Providers/Facilities Meet the Specific Time and Distance Standards in Service Area

This exception is used when there is a lack of providers that meet the specific time and distance standards in a particular service area.

	Health Plan Documentation
Required	• Provide distance and travel time points that members would have to travel beyond the required criterion (e.g., 20 minutes and 10 miles for a PCP in a metropolitan service area) to reach the next closest contracted provider/facility of this type outside of the service area • Provide contact information including names, addresses, and phone numbers for next closest contracted providers/facilities
	• Provide data on local patterns of care (e.g., using claims data, referral patterns, local provider interviews, use of telemedicine) indicating where members currently seek this type of care and/or where doctors currently refer members for this type of care • Indicate data sources (e.g., dates for source data, interviews)
	• Provide other documentation as requested by CMS
Select One	• Provide data sources used to confirm that there are no practicing (not contracted) providers in the service area (e.g., Medicare.gov, Physicianfinder.com, other health plan networks)

	• Provide a detailed description of contracting alternatives (e.g., physician extenders, telemedicine, coverage of transportation costs) that will help to address the lack of providers in the service area, in addition to details on potential contracting alternatives that were explored by the health plan, but could not be pursued
	  • Include any relevant health plan policies and procedures that address contracting alternatives
	  • Describe any special accommodations and/or reimbursement (including transportation arrangements used to meet the needs of members) and any corresponding health plan policies and procedures

	• Provide any additional documentation that supports the exception request

Exception Selected: Patterns of Care in the Service Area Do Not Support Need for Requested Number of Providers/Facilities

This exception is used when the patterns of care in the service area do not support a need for the required number of providers.

	Health Plan Documentation
Required	• If members access providers/facilities of this type in another service area, provide distance and travel time points that members would have to travel beyond the required criterion (e.g., 20 minutes and 10 miles for a PCP in a metropolitan service area) to reach the next closest provider(s) of this type outside of the service area • Provide contact information including names, addresses, and phone numbers for next closest contracted providers/facilities

	• Provide data on local patterns of care (e.g., using claims data, referral patterns, local provider interviews, use of telemedicine) indicating where members currently seek this type of care and/or where doctors currently refer members
	  • Indicate data sources (e.g., dates for source data, interviews)
	  • Provide justification or clarify reasons that utilization does not support the need for the requested number of providers

	• Provide other documentation as requested by CMS
Select One	• Provide the total number of available Medicare providers and the data sources used to confirm the total number of practicing (not contracted) providers in the service area (e.g., Medicare.gov, Physicianfinder.com, other health plan networks)
	• Provide any additional documentation that supports the exception request

Exception Selected: Services Will Be Offered at an Alternate Provider/Medicare Facility Type

This exception is used when services can be offered at an alternate type of provider.

	Health Plan Documentation
Required	• Provide distance and travel time points that members would have to travel beyond the required criterion to reach the alternate provider • Provide contact information including names, addresses, and phone numbers for next closest contracted providers/facilities
	• Provide data on local patterns of care (e.g., using claims data, referral patterns, use of telemedicine) indicating at which providers members currently seek relevant services • Indicate data sources (e.g., dates for source data, interviews)
	• Provide other documentation as requested by CMS
Select One	• Provide data sources used to confirm the total number of practicing (not contracted) providers in the service area (e.g., Medicare.gov, Physicianfinder.com, other health plan networks)
	• Provide documentation to confirm the availability of the requested services at the alternative type of provider/facility that are appropriately licensed and /or certified • Provide data on local patterns of care (e.g., using claims data, referral patterns, use of telemedicine) indicating where members currently seek this type of care and/or where doctors currently refer members for this type of care • Provide contact information including names, addresses, and phone numbers for this alternative type of provider/facility
	• Provide the capacity of alternate providers including the availability to serve the number of expected Medicare members (e.g., number of beds)
	• Provide any additional documentation that supports the exception request

Exception Selected: *Alternative* Arrangements for Regional PPOs

This exception may only be used by RPPOs when using alternative arrangements to meet access standards

	Health Plan Documentation
Required	
	• Provide data on local patterns of care (e.g., using claims data, referral patterns, local provider interviews, use of telemedicine) indicating where members currently seek this type of care and/or where doctors currently refer members for this type of care • Indicate data sources (e.g., dates for source data, interviews)
	• Provide a narrative description of the type of alternative arrangements that will be used to meet access standards (i.e. beneficiaries can obtain services out of network for in-network cost sharing)
	• ***For Providers Only,*** provide data sources used to confirm the total number of practicing (not contracted) providers in the service area (e.g., Medicare.gov, Physicianfinder.com, other health plan networks)
	• Provide other documentation as requested by CMS