DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

CENTER FOR DRUG AND HEALTH PLAN CHOICE

DATE: January 19, 2010

TO: All Medicare Advantage Private Fee-for-Service Contractors

FROM: Danielle R. Moon, J.D., M.P.A.
Director
Medicare Drug & Health Plan Contract Administration Group

RE: Transition of Private Fee-for-Service Contractors to Network-Based Access Requirements and Update – Revised to correct date of issuance

Beginning with contract year 2011, employer/union sponsored Private Fee-for-Service (PFFS) plans and non-employer PFFS plans in certain parts of the country must meet Medicare Advantage (MA) access standards through a contract-based network. As required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), in contract year 2011 and subsequent contract years, PFFS plans that are operating in network areas (as defined in Section 1852(d)(5)(B) of the Act) must meet the network-based access standards described in Section 1852(d)(4)(B) of the Act.

The purpose of this memorandum is to provide an update to the list of network areas for contract year 2011 and describe the steps that impacted PFFS organizations must take if they seek to continue to offer PFFS products in contract year 2011. Current PFFS contractors that fail to demonstrate compliance with the new network-based access standards will be non-renewed at the end of contract year 2010, and members of those plans will be disenrolled to Original Medicare.

Update to the list of network areas for contract year 2011

We announced the list of network areas for contract year 2011 and described the methodology used to identify these network areas in the *2010 Advance Notice* and the *Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies*.

"Network area" is defined by MIPPA, for a given plan year, as the area that the Secretary identifies (in the announcement of the risk and other factors to be used in adjusting MA capitation rates for each MA payment area for the previous plan year) as "having at least 2 network-based plans with enrollment as of the first day of the year in which the announcement is made." "Network-based plan" is defined by MIPPA as (1) an MA plan that is a coordinated care plan as described in section 1851(a)(2)(A)(i) of the Act, excluding non-network regional PPOs; (2) a network-based MSA plan; or (3) a section 1876 cost plan.

As discussed in the 2010 Announcement, regional PPOs (RPPOs) meet the definition of a network-based plan only in those areas where the plan is meeting access requirements through written contracts with providers. Due to the limited amount of time we had available prior to the release of the list of network areas for contract year 2011, we used data in our analysis that was obtained directly from the RPPOs on how these plans met our network adequacy requirements in each of the counties in their service area. The data reported to us by the RPPOs was the best available data we had for identifying the location of the network areas for contract year 2011 at that time.

Since the release of the list of network areas for contract year 2011, we have validated the accuracy of the RPPO-submitted data. Specifically, we reviewed the 2009 Health Service Delivery (HSD) tables for all RPPOs in 601 counties where the presence of a network RPPO was the deciding factor in the county being considered a network area in 2011. Upon validation, we found that none of the RPPOs offered in these counties had contracted providers for all Medicare Part A and Part B services; therefore, these RPPOs should not have been considered network-based plans in our initial analysis of the network areas for contract year 2011. Based on these findings, we plan to take additional steps to assess the adequacy of the networks of all RPPOs.

In addition, we are excluding these 601 counties from the list of network areas for contract year 2011 that we announced in the 2010 Advance Notice and 2010 Announcement. These 601 counties will be considered non-network areas in 2011, meaning that PFFS plans may operate in these counties without a provider network. The updated list of network areas for contract year 2011, which now excludes these counties, can be downloaded from http://www.cms.hhs.gov/PrivateFeeforServicePlans.

Employer/Union Sponsored PFFS Plans

In order to continue offering Employer/Union Sponsored PFFS plans for 2011, organizations must complete the initial application process. Moreover, organizations may not offer network and non-network PFFS plans under the same contract. This means that even those organizations that may offer non-network individual market PFFS plans in areas designated as non-network for 2011 must complete the initial application process if they seek to continue to offer 800 Series PFFS plans.

Employer/Union Sponsored PFFS plans that operate on a non-calendar year schedule must complete the initial application process on the same timeline as other MA applicants,(i.e., with a submission deadline of February 25, 2010 and pursuant to the same requirements as indicated in the initial application and related materials. Organizations are not required to offer the approved network-based PFFS products, however, until the beginning of the organization's 2011 plan year. For example, if an organization's 2011 plan year begins on July 1, 2011, then the organization must offer the network-based plan as of that date.

In order to move a non-network employer group plan to a network based product, the MAO will need to file a 2011 network PFFS application (an initial application) in accordance with the set MA-PD application timeline (e.g., submission deadline of February 25, 2010), submit a bid for this plan on the first Monday in June 2010, and meet all other application and bid requirements in order to have this contract approved.

Non-Employer or Individual Market Plans Operating in Network Areas

Current MA PFFS contractors whose service area lies solely in network areas must complete the initial application process in order to qualify to offer their MA PFFS product to current (and new) enrollees. Please note that current PFFS contractors operating in network areas may NOT meet the PFFS network-based access requirements through reliance on or creation of Health Maintenance Organization or Preferred Provider Organization products and will NOT be allowed to move affected enrollees from the PFFS product into other types of MA products. Current PFFS contractors operating in network areas that fail to complete the initial application process apply will be non-renewed or have their service area reduced and the affected enrollees will be disenrolled to Original Medicare.

CMS will issue additional guidance to those PFFS contractors transitioning to network-based products regarding the process for moving current enrollees to newly approved network-based PFFS contracts.

Non-Employer or Individual Market Plans Operating in Both Network and Non-Network Areas

Current PFFS contractors with service areas spanning both network and non-network areas must complete the initial application process in order to bring the network portions of their service area into compliance with the network-based access requirements outlined in MIPPA. These organizations will be issued a new contract (H) number through the application process to encompass the network portions of the service area. If the application is approved, the organization will be authorized to move the affected enrollees to the new contract number. The current contract will continue to operate in the non-network areas.

Non-Employer or Individual Market Plans Operating in Non-Network Areas

Current MA PFFS plans whose service areas lie solely in non-network areas can continue to operate as non-network plans, where the plans meet access standards by establishing payment rates that are not less than the rates that apply under Original Medicare (42 CFR §422.114(a)(2)(i)). PFFS plans in non-network areas may choose to operate as full network plans (42 CFR §422.114(a)(2)(ii)) or partial network plans (42 CFR §422.114(a)(2)(iii)). No new application is required.

Notice of Intent to Apply Filing

Current PFFS contractors that need to file an initial application to enable them to transition to some or all of their products to network-based access requirements must first file a Notice of Intent to Apply (NOIA) in accordance with the October 2, 2009 HPMS memorandum entitled "Posting of the 2011 Notice of Intent to Apply to Expand Service Area or Become a New Part C Medicare Advantage, Part D Prescription Drug Benefit and Employer/Union-Only Group Waiver Plan (Direct Contract or "Employer" (800) Series) Sponsor." While the initial recommended deadline for these submissions has passed, CMS will continue to accept NOIA filings and must receive such a filing in order to establish a new application/contract number for transitioning PFFS plans. Organizations that have not filed the appropriate NOIA should do so as soon as possible, as a delay in filing could jeopardize the timely issuance of contract number assignments and ultimately have a negative impact on an organization's application. CMS will

work to complete the contract number assignment process in a timely manner as NOIAs are received.

CMS will only accept NOIAs submitted electronically through its on-line web tool. Organizations must use the following link to access and complete the Notice of Intent to Apply web tool:

https://vovici.com/wsb.dll/s/11dc4g40129

If you have any questions regarding the PFFS transition to network-based access requirements, please contact Helaine Fingold at 410-786-5014 or helaine.fingold@cms.hhs.gov.