

Contract Year 2012 Medicare Advantage Health Services Delivery Guidance

I. Introduction

The purpose of this document is to provide guidance on the MA network adequacy process and to highlight refinements for CY 2012. As a part of the Medicare Advantage (MA) application process, applicants who apply to offer Coordinated Care plans (CCPs) and network Private Fee-For-Service (PFFS) plans must demonstrate that they have an adequate contracted provider network that is sufficient to provide access to covered services, as required by 42 CFR 422.112(a)(1). MA organizations are required to “maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served.” New MA organizations seeking to enter a market or existing MA organizations who wish to expand their service area are required to submit an application to the Centers for Medicare and Medicaid Services (CMS) which includes, among many items, the contracted network of providers that would serve their enrollees.

Prior to the CY 2011 application cycle, CMS assessed whether MA organizations met this network requirement through a largely manual process. This process was labor intensive and lacked concise and standardized definitions of an “appropriate” and “adequate” network.

During 2008 and 2009, CMS developed criteria to define “adequate” provider access that MA organizations need to satisfy when applying to serve new markets and/or applying for market expansions. These criteria simplify health services delivery (HSD) submissions and their reviews and increase transparency of CMS standards. These criteria were initially released on November 20, 2009 and were relied upon in assessing applications starting with the CY 2011 MA application process. This new network adequacy analysis process included the following changes:

- Revised HSD tables and increased automation. CMS revised the format of the HSD tables, including changes to the specialties and facilities included on the tables, and automated the review of the HSD tables.
- Minimum enrollment levels. CMS established minimum enrollment levels based on average MA market penetration rates (discussed in detail in Section III).
- Network adequacy criteria. CMS established network adequacy criteria, specific to specialty types and geographic areas, for MA provider networks. CMS allowed MA organizations to include contracted providers practicing outside county boundaries to meet the network adequacy criteria.
- Formal Exception Request process. When applicants were unable to meet the criteria, CMS allowed applicants to submit formal exception requests.

Standardized access criteria consist of three components: a) the minimum number of providers by county and specialty type; b) the travel distance to providers and facilities by county and specialty type; and c) the travel time to providers and facilities by county and specialty type. The automated HSD review employs various analytical tools to measure applicants' submitted networks against these access criteria, as described below.

Based on the experience of the CY 2011 MA application process, CMS has made some changes to the network adequacy review process for CY 2012.

II. Overview of MA Network Adequacy Criteria

This section identifies the types of providers and facilities reviewed by CMS and offers an overview of the criteria used by CMS to measure adequacy.

A. Minimum Number of Providers

MA applicants must demonstrate that their networks have sufficient providers to allow adequate access for beneficiary/potential enrollees.

- HSD Provider Specialty types: MA organization networks must contract with sufficient numbers of each provider specialty type to meet the criteria for the minimum number of provider specialties.
- Facility Specialty types: MA organizations must contract with sufficient numbers of each HSD facility type to ensure access for enrollees at the average MA penetration rate for the geographic county type. For contracted acute care facilities, MA organizations must meet the criteria for the minimum number of Medicare-certified beds required. Specialized hospital and pediatric/children's hospitals contracted with the applicant for its commercial, Medicaid, or other products do not count toward meeting this criteria.
- Hospital-based providers: The specialty types of Anesthesiology, Pathology, Radiology, Critical Care Medicine, and Emergency Room Physicians are not included on the 2012 HSD Provider Table. MA applicants are expected to ensure that all Medicare-covered services rendered to beneficiaries during an admission to a contracted hospital are covered at the in-network benefit level and cost sharing.

Through the automated HPMS process, applicants' status in meeting minimum provider numbers are assessed based on the number of the submitted providers that are located within the time/distance criteria, as discussed below. The minimum number of providers needed varies by county geographic type designation. Applicants are only permitted to include in their application

providers that are under *contract at the time of their submission* to CMS in order to meet these requirements.

B. Maximum Travel Time and Distance to Providers/Facilities

MA organizations must demonstrate that their networks do not unduly burden beneficiaries in terms of travel distance and time to network providers. These time and distance metrics speak to the access requirements pertinent to the approximate locations of beneficiaries, relative to the locations of the network providers.

MA applicants must demonstrate that 90 percent of beneficiaries have access to at least one provider/facility, in each specialty type, within established time and distance requirements.

It is important to note that the practice locations of an applicant's contracted providers are not limited to the boundaries of the county or counties in question. Applicants may include contracted providers located outside of the application's requested service area/counties if those providers are within the time and distance requirements.

III. Methodology for Applying Network Adequacy Criteria and Reference Table

This section addresses how the network adequacy criteria are calculated and applied to applicants. As mentioned previously, assessments of network adequacy call for applicants' networks to be evaluated based on two primary criteria that vary by provider specialty and county geographic designation (e.g., large metro, metro, micro, rural, and critical access):

- A minimum number of providers/inpatient beds within a designated county.
- A maximum travel distance and time to provider sites based upon place of beneficiary residence.

A. Required Minimum Number of Providers

Below we present the methodology for calculating the minimum number of providers criteria. The criteria for minimum number of providers were calculated taking into account two determinants: 1) the average enrollment of beneficiaries served by MA organizations; and 2) the minimum provider-to-enrollee ratio.

1. Average Enrollment of Beneficiaries Served by MA Organizations

The "Average Enrollment of Beneficiaries Served by MA Organizations" metric represents MA market penetration rates by county geographic designation (Large Metro, Metro, Micro, Rural and Counties with Extreme Access Considerations (CEAC)). CEACs are a new recommended 2012 county designation that takes into account unique areas, characterized by few beneficiaries and/or providers, which are unable to meet existing time and distance criteria. This and other revisions to county designations are summarized in Section IV.

The “Average Enrollment of Beneficiaries Served by Health Plans” metric is a calculation of the 95th percentile of MA organizations’ market penetration (i.e., 95% of all MA organizations have county penetration rates equal to or less than the rates shown in Figure 1, below). The 95th percentile varies by county geographic designation.

Figure 1: Medicare Advantage Market Penetration Rates by County Designation

County Designation	95th Percentile
Large Metropolitan	7.3%
Metropolitan	13.4%
Micropolitan	9.5%
Rural	9.8%
CEAC	10.9%

The county geographic designations used in calculating the average number of MA beneficiaries are driven by Core Based Statistical Areas (CBSAs). CBSAs are Census Bureau-defined core metropolitan areas or urban clusters of 50,000 or more people and core micropopulation urban clusters of between 10,000 and 50,000 people. Metropolitan and micropolitan CBSAs consist of one or more counties. These include counties containing the core urban clusters, as well as adjacent counties that demonstrate a high degree of social and economic integration with the core urban clusters. For example, many residents of selected counties located in suburban Chicago commute to work in that core metropolitan area. As a result, these counties are included in the Chicago CBSA by virtue of their level of economic and social integration with the larger core urban cluster.

Once the county designation for the proposed provider network has been identified, the associated MA market penetration rate(s) is then multiplied by the number of Medicare beneficiaries residing in a specific county, based upon CMS enrollment data, to calculate the average enrollment of MA beneficiaries. Figure 2 below presents a sample calculation of the average MA beneficiary enrollment in the metropolitan county of Calhoun, Alabama.

Figure2: Calculation of Average MA Beneficiary Enrollment

<p>Number of Beneficiaries Residing in Calhoun County X 95th Percentile for Metro Counties (23,662 beneficiaries X 0.134) = 3,171 MA Beneficiaries enrolled</p>

Based on CMS’ Medicare enrollment data and a market penetration of 95% of MA organizations in metropolitan counties, MA organizations serving Calhoun County have an average enrollment of 3,171 MA beneficiaries. Thus, new applicants to Calhoun would be expected to provide

3,171 MA beneficiaries with access to at least one provider/facility within the required time and distance requirements.

2. Minimum Number of Required Network Providers

Figure 3 below illustrates the calculation for the minimum number of required providers to serve beneficiaries residing in a given county by bringing the two calculations together (the average enrollment of beneficiaries and the minimum number of required providers). The example is for cardiologists providing services to beneficiaries residing in Calhoun County, Alabama, which has a geographic designation of “metro.”

In addition to knowing the average number of beneficiaries enrolled in a county, determining the minimum number of providers required to ensure network adequacy also requires knowing the minimum provider-beneficiary ratios for each medical specialty. Based upon primary and secondary research of the utilization patterns and clinical needs of Medicare populations, CMS has established ratios of required providers per 1,000 beneficiaries for most specialty types in the CMS MA Provider HSD Table. These ratios vary by county geographic designation type.

CMS publishes detailed minimum provider per 1,000 beneficiary ratios for each region of the country for most specialty types in the CMS MA Provider HSD Table and for most facility types in the MA Facilities HSD Table.

When applicants for new or expanded MA organizations submit information about their proposed network, that information is compared with provider/practitioner/supplier addresses maintained by CMS. Using a mapping program, CMS determines whether an applicant’s proposed network meets the minimum provider adequacy standards. If organizations do not meet the provider adequacy standards, they can request an exception through a process further described in Section IV.

To help ensure beneficiary access to appropriate care and reflect true patterns of care, providers/practitioners/suppliers do not need to be located within the boundaries of the county being served by the proposed network. Applicants may include providers outside of the application county/ies if those providers also fall within travel time and distance requirements.

Figure 3 below summarizes the final calculation necessary to determine the minimum number of required Cardiologists providing services to beneficiaries in metropolitan Calhoun County, Alabama.

Figure 3: Minimum Number of Required Providers Calculation

$$\begin{aligned} & (\text{Average Enrollment of Beneficiaries Served by Health Plans} \div 1,000) \times \text{Minimum Provider Ratio} \\ & (3,171 \div 1,000) \times (0.27 \text{ cardiologists per } 1,000 \text{ beneficiaries residing in a metro county}) \\ & = 1 \text{ Cardiologist Required}^1 \end{aligned}$$

MA organizations must have at least one of each HSD facility type. At this time, CMS has not established criteria for the minimum number of required providers for most of the specialty types on the CMS MA Facilities HSD Table. The one exception is for the requirements 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 determinants as those described above and varies by county geographic designation (the same formula presented in Figure 3).

B. Maximum Travel Distance and Time to Provider and Facility Sites

The maximum time and distance criteria were developed using a process of mapping beneficiary locations juxtaposed with provider practice locations and were thoroughly tested. The maximum network time and distance criteria vary by county geographic designation and medical specialty. MA organizations must demonstrate that 90% of their provider network meets the time and distance requirements (90% of beneficiaries must have access to at least one provider, for a given specialty, within the time and distance requirements). In addition, as described above, the criteria allow for the location of contracted providers serving beneficiaries in a given county to extend beyond county boundaries based on local established patterns of care and other reasonable access considerations.

An example of the time and distance criteria for cardiology and skilled nursing facilities serving beneficiaries residing in Wharton County, Texas, a “micro” county, is shown in Figure 4 below.

Figure 4: Maximum Travel Time and Distance Criteria

Provider Type	Time Criteria	Distance Criteria
Cardiology	45 minutes	35 miles
Skilled Nursing Facilities	75 minutes	60 miles

¹ Although the actual calculation equals 0.85617, each result is rounded up to the next whole number.

IV. Changes to CY 2012 Network Adequacy Criteria and Methodology

Following the CY 2011 MA application cycle, CMS conducted an assessment of the newly implemented network adequacy process. This included an in-depth review and analysis of application processes, guidance, and criteria. Specifically, CMS -

- Reviewed the outcome of the CY2011 application network review process, including the submission of exception requests against the provider network criteria and needed refinements to the criteria.
- Identified opportunities to further streamline the process for submitting and reviewing the HSD tables.
- Assessed current HSD guidance and determined where additional clarification is needed.

Based on this assessment, CMS has implemented changes to the overall process and timeframes, reference tables, HSD tables and criterion, minimum number of providers, and exceptions process, each of which are discussed in more detail below.

A. *Pre-Check Submission Opportunities*

To assist MA applicants with understanding how their HSD tables may compare against the review criteria, CMS has provided the pre-check process. The pre-check process for the 2012 application will allow for **weekly** HSD table submissions prior to the application due date to enable applicants to identify those areas in which their networks fall short as compared to the set criteria.

Results of the pre-check process are not a guarantee of the approval or denial of an applicant's network, but, rather, serve as a mechanism to assist applicants in determining whether additional providers need to be added to the provider network before final submission in order to meet CMS' requirements.

CMS expects that applicants will fully utilize these application pre-check opportunities, thereby enhancing their ability to submit more accurate and complete HSD tables at the time applications are due. Applicants must completely review the HSD reports generated as a result of these pre-check opportunities. Applicants' failure to address errors identified in the reports or other technical errors made have not proved to be a successful basis for appeal of a CMS application denial. If an applicant believes a CMS technical issue is the cause of an HSD table (or other application) error, the applicant must fully document the issue with screen shots and call(s) to the HPMS helpdesk, and include that documentation when reporting the problem to CMS.

B. HSD Provider Specialty and Facility Criteria Reference Tables

The HSD reference tables for CY2012 applications have been updated based on the 2009 beneficiary enrollment counts. Annually, the reference table will be updated and posted.

C. Changes to HSD Tables and Criteria

Changes and updates for CY2012 applications resulting from CMS’ assessment of the prior year’s process and applications, as well as regularly scheduled updates, include:

- Changes to HSD provider specialty and facility types
- Revised criteria
- Addition of new county type

1. Changes to HSD Provider Specialty and Facility Types

In order to streamline submission, and because we believe that access to these services are adequately ensured through other mechanisms, several provider specialty and facility types have been removed from the HSD tables and the Criteria Reference tables. Several other facility types, while subject to the manual review process, have been added to the Criteria Reference tables to clarify that these facility types must be included on submitted HSD tables.

Figure 5: Changes to HSD Provider Specialty and Facility Types for CY2012

Specialty/Facility Type	Description of CY 2012 Change
Facility-based providers (includes anesthesiology, radiology, pathology, and emergency medicine)	Removed from HSD tables
Outpatient substance abuse	Removed from HSD tables
Inpatient substance abuse	Removed from HSD tables
Outpatient mental health	Removed from HSD tables
Home health	Included on reference tables
DME	Included on reference tables
Transplants	Included on reference tables

2. Revisions to Criteria

- “Micro” county types: These counties, that have a population between 10, 000 and 50,000 people, present unique access challenges. Therefore, we adjusted the travel distance and time criteria to allow for longer maximum distances and times to address these challenges.

- Outpatient infusion: In the large metro geographic counties due to provider availability issues, the maximum travel distance and time criteria was changed to allow for a longer travel distance and time for this specialty.
- Cardiac surgery, neurosurgery, plastic surgery, rheumatology, endocrinology, thoracic surgery, and vascular surgery: The criteria for these specialty types have been revised to be less restrictive because of provider availability and location issues.

3. Addition of New County Type

CMS found, through the 2011 review process, that certain counties posed extreme access challenges in all provider specialty types that could not be overcome by the adjustments made to the criteria for micro counties, warranting creation of a separate county type with its own criteria.

The new county designation, called “Counties with Extreme Access Considerations” or CEACs, has been added to the HSD table, along with its own minimum number, time and distance criteria. Criteria for counties with this designation appear on the CY 2012 MA Network Criteria Reference tables.

D. Assessment of “Minimum Number” Network Adequacy Criterion

In the CY 2011 application process, the adequacy calculation for minimum number included all providers included on an applicant’s submitted HSD tables and did not indicate which ones were within the prescribed time/distance criteria. For CY 2012 MA applications, HPMS programming will map providers against the maximum time and distance criteria, and only providers meeting the time and distance criteria will be counted toward the minimum number requirement. This change more appropriately reflects the intent of the beneficiary coverage criteria.

E. Revised Exception Request Submission

To streamline the submission and review of Exception Requests, CMS has made changes in the following areas:

- Timing of Exception Requests
- Use of model Exception Request Template
- Exception Request Types

1. Timing of Exception Requests

For the 2012 application review process, MA applicants **will not** submit Exception Requests with their initial application submission. Instead, applicants will submit Exception Requests only **after** they have received and responded to the HSD table/network shortfalls identified by

CMS in the Deficiency Notice. After submitting their Deficiency Notice response, including revised HSD tables, applicants will have the opportunity to review the updated CMS-generated Automated Criteria Check (ACC) report before developing and submitting exception requests based on that report. This process should ensure that applicants submit only the exception requests that are appropriate given the most recent HSD table submission and network status. Similarly, any applicant receiving a Notice of Intent to Deny (NOID) that has an exception request problem identified will be able to first submit revised HSD tables and then review the most recent ACC reports before submitting the corrected exception request(s).

It is CMS' intent that this new process will greatly reduce the number of overall exception requests as applicants will be expected to only submit the exception requests directly responding to deficiencies identified in the ACC reports based upon the HSD tables they most recently submitted. A calendar listing the dates when the exception requests are due will be posted with the final CY2012 application materials.

2. Use of Exception Request Template

To streamline and clarify requirements for exception request submissions, CMS expects that MA applicants will meet the following requirements and strongly encourages the use of the newly developed Model Exceptions Request Template (to be released along with the final 2012 application):

- HSD tables **MUST** list all contracted providers within and outside of the county who will serve the county's beneficiaries (including those providers who fall outside of the time and distance criteria and discussed on the Exception Request Template).
- Applicants may submit only one exception request per plan/county/and provider specialty/facility.
- Justification narratives must be included in the exception request document, not submitted as a separate file attachment.
- Applicants must identify in the exception request those contracted providers/facilities listed on its HSD table that will provide access to enrollees that live in the given county in the absence of any or sufficient numbers of contracted providers/facilities of the specific type that fall within the time distance criteria.

3. Exception Request Types

CMS will consider requests for exceptions to the stated minimum number and time/distance criteria under limited circumstances. For CY 2012, the available exception request categories

have been collapsed into 2 categories (instead of 5), and each exception request must be supported by required documentation as specified by CMS.

Figure 6 shows the differences from CY 2011 and the upcoming CY 2012 applications in the types of exceptions that may be requested by applicants:

Figure 6: Exception Types

Exception Types (CY2011)	Exception Types (CY2012)
1. Insufficient numbers of providers/beds/facilities within the proposed service area to meet the standard network adequacy criteria.	<p style="text-align: center;">Exception Type 1: Patterns of Care Exceptions types 1-4 have been collapsed into one exception type. Organization must provide for details on how it will ensure access to services.</p>
2. Lack of providers/facilities within the proposed service area that meet the specific time and distance standards.	
3. The presence of patterns of care in the proposed service area that differ from CMS standards.	
4. Applicant arranging for services to be provided by an alternate duly licensed or certified provider type/Medicare certified facility when insufficient numbers of particular provider types are available within the service area.	
5. An alternative arrangement for regional PPOs to meet access requirements may be approved by CMS if the regional PPOs can demonstrate the presence of a comprehensive network.	<p style="text-align: center;">Exception 2: RPPOs No changes were made to this exception type.</p>