



CMS Medicare Advantage Industry Conference: MA Application Network Criteria Review Training

October 19, 2009



Discussion Outline

Introduction
Jerry Mulcahy

Methodology and Reference Tables
Daniella Stanley

Exceptions
Daniella Stanley

Application & Technology Changes
Helaine Fingold

Questions & Answers

Introduction - Key Objectives

Automate and establish empirical standards to review of proposed MA networks

- Create clear quantitative criteria
- Facilitate streamlined network review process
- Increase the clarity of CMS requirements
- Ensure consistent reviews

Introduction

Why Project is Critical

1. Simplify HSD submissions and reviews
2. Establish empirical standards
3. Increase Transparency of CMS standards

Introduction – Network Analysis in 2011 Applications

- Networks must meet two critical adequacy criteria
 - minimum number of providers/beds
 - time/distance requirements
- Required number of providers based on market share assumptions for new applicants
- Exception requests considered under limited circumstances, if supported by appropriate documentation

Roll Out of New Process

- October 19, 2009 – First public discussion
- October 26, 2009 – Network adequacy reference tables publicly available
- Late November 2009 – Detailed training for new applicants and other interested parties.
- January 2010 – Applicants allowed to upload prospective networks against criteria to determine if they pass prior to final submission

Introduction

Benefits of the New Process

The new process:

- Formalizes process for reviewing HSD tables and allowing exceptions to the network adequacy criteria
- Increases transparency in procedures and review criteria
- Takes into account differences in utilization, patterns of care, and supply of providers in urban and rural areas

- Improves evaluation of beneficiary access to providers
- Automates review of the HSD tables, allowing CMS resources to focus on exceptions and other sections of the MA application

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Methodology and Reference Tables Provider Network Criteria

Access criteria are to be measured by:

- Maximum distance to the closest provider
 - Maximum travel time to a provider
 - Minimum number of providers
-
- By specialty type (e.g., cardiology, ophthalmology)
 - By geography type (e.g., metro, rural)

Methodology and Reference Tables

Network Criteria Development

- Average distances and travel times were determined by geographic mapping tool and analyzing percentage of beneficiaries with access
 - Tracked beneficiaries to the closest provider using a geo-access tool
 - By provider specialty type
 - By geography type
- Analysis performed on different geographic settings including metro, micro, rural and large metro locations
- Sample of over 12 million beneficiaries across 97 statistical metropolitan areas

Methodology and Reference Tables

Examples of Network Adequacy Criteria

PCP Criteria				
County	County Type	Minimum # of Req'd Providers	Maximum Time	Maximum Distance
Fayette, TX	Rural	1	45 minutes	25 miles
McLeod, MN	Micro	1	20 minutes	15 miles
Jefferson, CO	Metro	15	20 minutes	10 miles
Nassau, NY	Large Metro	26	20 minutes	5 miles

General Surgery Criteria				
County	County Type	Minimum # of Req'd Providers	Maximum Time	Maximum Distance
Fayette, TX	Rural	1	60 minutes	60 miles
McLeod, MN	Micro	1	30 minutes	30 miles
Jefferson, CO	Metro	3	20 minutes	20 miles
Nassau, NY	Large Metro	5	20 minutes	5 miles

Methodology and Reference Tables

- Locations of providers are not restricted to the beneficiaries' county boundaries
- Feasibility of criteria has been successfully tested

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Exceptions

- May be requested when Applicant does not meet network criteria under limited circumstances
- Request is by individual provider type by county
- Applicants are required to contract with available providers in the service area
- Applicants will have two chances to submit network information for preassessment prior to application submission deadline

Exceptions

Benefits of the Formalized Process

- Allows plans to qualify for MA status, despite challenges in meeting specified network criteria
- Eliminates “informal” exceptions across CMS Regional Offices
- Provides clear guidance to applicants on what types of exceptions are allowed by CMS
- Ensures that all applicants are submitting the same types of documentation
- Provides consistency for CMS reviewers in reviewing requests and documentation

Exceptions

Exception Requests For Providers and Facilities

- Plans will select from a pre-determined list of exceptions within HPMS and upload required supporting documentation for each provider or facility type for which an exception is requested
- If needed, plans may select more than one exception for each provider or facility type
- Since plans will have knowledge of specific requirements for each county prior to submission, plans will **only** be able to submit exception requests **during the initial application upload**
- Burden on applicant to prove validity of request

Exceptions

Specific Exceptions Within HPMS

- Insufficient number of providers/beds in service area
- No providers/facilities that meet the specific time and distance standards in service area
 - Applicants will still be required to arrange access to an alternative type of provider
- Patterns of care in the service area do not support need for the requested number of and/or provider/facility type

- Services will be provided by an alternate provider type/ Medicare-certified facility
- Alternative arrangements for Regional PPOs. (RPPOs Only)

Exceptions

Required Documentation Within HPMS

Sample Required Documentation

- 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 of this type outside of the service area
- 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
- Other documentation as requested by CMS

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Application & Technology Changes Revised HSD Tables

- HSD tables have been streamlined to eliminate duplicative information.
- New information required to facilitate automation of the HSD table review process

Application & Technology Changes Revisions to HSD-2

Revision	Rationale
Addition of SSA County Code, Specialty Code, and National Provider Identifier (NPI) Number	<ul style="list-style-type: none">• Facilitate automation of HSD table review• Ensure providers are not listed multiple times by providing a unique identifier
Addition of County Name and State Name	<ul style="list-style-type: none">• Assist reviewers in identification of the name and state of service area
Addition of row to identify whether table was previously submitted	<ul style="list-style-type: none">• Assist reviewers in identifying whether table is a re-submission
Deletion of column indicating whether provider may serve as a PCP	<ul style="list-style-type: none">• Potential PCP categories are addressed in provider specialty rows

Application & Technology Changes Revisions to HSD-3 Detail

Revision	Rationale
Addition of SSA County Code, Specialty Code, National Provider Identifier (NPI) Number, and Medicare Certification Number (CCN)	<ul style="list-style-type: none"> • Facilitate automation of HSD table review • Ensure providers are not listed multiple times • Ensure providers are Medicare-certified
Addition of County Name and State Name	<ul style="list-style-type: none"> • Assist reviewers in identification of the name and state of service area
Addition of Number of Staffed, Medicare-Certified Beds	<ul style="list-style-type: none"> • Reflects new network adequacy criteria
Addition of Hours of Operation	<ul style="list-style-type: none"> • Provides reviewers information about capacity
Addition of row to identify whether table was previously submitted	<ul style="list-style-type: none"> • Assists reviewers in identifying whether table is a re-submission
Addition, revision, and deletion of specialties	<ul style="list-style-type: none"> • Best describe beneficiary clinical needs • Efficiently allow for plans to describe the submitted networks • Facilitate the efficient and thorough review of the submitted networks by the CMS Reviewers

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Changes to HPMS

- MA reference file
- Automated mapping component to HPMS
- Automation of HSD-2 and HSD-3 tables
- Exceptions module
- Pre-assessment process Creation of standardized error report
- System-generated Error Report
 - Accessible through HPMS
 - Will convey pass/fail for meeting required providers/facility numbers and time/distance and status of Exception request

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Questions

General Questions:

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