DEPARTMENT OF HEALTH & HUMAN SERVICES
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MEDICARE-MEDICAID COORDINATION OFFICE

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TO: Medicare-Medicaid Plans and MN Senior Health Options D-SNPs

FROM: Tim Engelhardt
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SUBJECT: MMP Medicare Network Adequacy Standards

As part of the Medicare-Medicaid Plan Reporting Requirements, Section VII Provider Networks indicates that Medicare-Medicaid Plans (MMPs) must demonstrate on an annual basis an adequate contracted provider network sufficient to provide access to covered services in each demonstration. To ensure that the Medicare portion of the network accurately reflects the population served by each demonstration, the CMS is releasing updated access standards for demonstrations under the Medicare-Medicaid capitated financial alignment model and a separate demonstration in Minnesota.

These standards were developed using the same methodology that is used to develop the network standards for Medicare Advantage but were adapted to reflect the population served under the demonstrations. Specifically:

- Utilization Patterns and Minimum Number of Providers – Medicare Advantage network standards are based on analysis of service utilization patterns in fee-for-service Medicare. The new standards use the same analysis but based exclusively on utilization rates for dual eligible individuals.
- Total Beneficiaries – In Medicare Advantage, network standards are set based on current market penetration in MA. In the new standards, we will use actual or projected enrollment based on the enrollment policies for each demonstration. This affects the minimum number of providers and acute inpatient hospital beds criteria.
- Time and Distance – The Medicare Advantage standards require that 90% of beneficiaries are able to reach the minimum number required for a certain provider type within the time and distance standards established. These new network standards adjusted the time and distance for certain provider and facility types in certain counties

where the 90% threshold could be met in a different distance or time based on the mapping of the demonstration population.

- County Types – These designations were updated, as needed, to reflect the most recently published population and density in each county.

CMS plans for MMPs to make their annual network submissions through the CMS Health Plan Management System (HPMS) in the Fall of 2015. In preparation for the annual submission, CMS will establish multiple dates at which MMPs can check their networks against the new standards in the HPMS Network Management Module. Further guidance will be forthcoming on those pre-check dates.

The CY2015 MMP HSD Criteria Reference Table can be found on the CMS website at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html. Please send any questions regarding these standards to MMCOCapsModel@cms.hhs.gov.