# Medicare Advantage Application Operational Changes

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# Qualification of Entities to Serve as Medicare Advantage Organizations

- 42 CFR 422, Subpart K establishes CMS' requirements to qualify entities as Medicare Advantage Organizations, or MAOs.
- CMS qualifies entities through the Medicare Advantage application process.
- CMS updates the application each year.

# Overview of the Medicare Advantage Application

- Three Major Components:
  - Attestations
  - Licensure and Solvency
  - Health Services Management and Delivery Tables
- Automated in the Health Plan Management System (HPMS)

# Changes to the CY 2017 Application

- **Administrative Management**
  - Template for Waiver Request of Two-Year Ban
- **Network Review Changes**
  - Health Service Delivery
  - Service Area

# Administrative Management Change: Contracting Policy

- CMS may deny an application for a period of up to two years when an organization has a non-renewed or terminated a contract.
  - CMS' regulations also permit CMS to consider special circumstances to this "two-year contracting ban."
- CHANGE: Applicants submit template to request a waiver of the two-year contracting ban.

REFERENCES: 42 CFR 422.506(a)(4), 422.508(c), 422.512(e)

# Polling Question

**The two-year ban applies when an organization non-renews a MA contract for an effective date of January 1, 2016, and then applies for a contract with an effective start date of:**

a) January 1, 2017

b) January 1, 2018

c) January 1, 2019

d) Both a and b

# Network Review Changes to CY 2017 MA Application

1. **Health Service Delivery Changes**
   - Network Management Module
   - Full Network Reviews for Service Area Expansion (SAE) Applications
   - Exception Process
2. **Service Area Changes**
   - Partial Counties

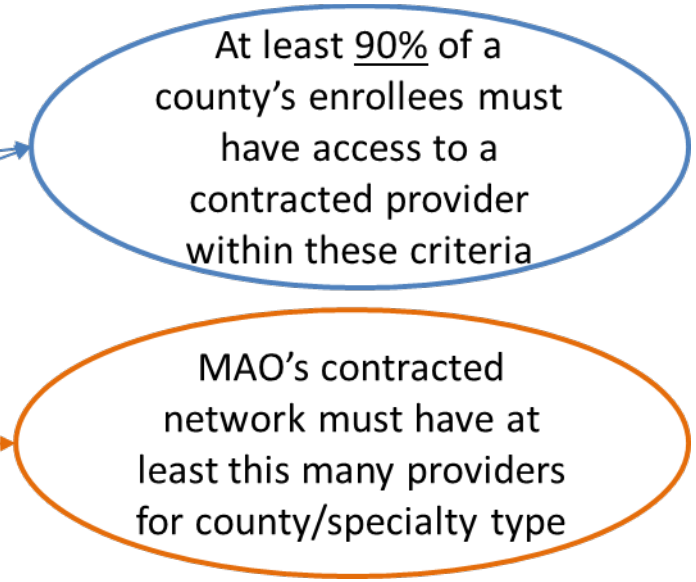
# Driver for Network Review Changes

- August 2015 Government Accountability Office (GAO) Report
  - **Relevant recommendation**: Conduct more periodic reviews of MAO network information.
  - **CMS response**: Require full network reviews for CY 2017 SAE applications.

REFERENCE: GAO-15-710 (August 2015), *Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy*

# What is Network Adequacy Criteria?

- Each U.S. county/territory has criteria for:
  - Maximum travel **time** from enrollees to providers
  - Maximum **distance** from enrollees to providers
  - Minimum **number** of providers per county/specialty
- CMS updates the network adequacy criteria every year.




REFERENCE: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/

# Network Management Module for Network Self-Checks

- Provide applicants with an unlimited ability to test their contracted networks prior to the application submission deadline.
  - Updated in January with recent network adequacy criteria

REFERENCE: December 23, 2015, HPMS memo, *Release of Network Management Module in the Health Plan Management System*

# Full Network Reviews for SAE Applications

- Existing MAOs seeking to expand their service area under a respective contract uploaded their full, contracted network.
  - CMS announced this change through the PRA process (between June and October 2015).

# What did the Full Network Review mean for the Applicant?

- SAE applicants received HSD county results labeled as “active/existing” or “pending/expansion.”
- Curative actions varied for applicants deciding to remove a county from their CY 2017 service area (based on HSD failures).

REFERENCE: April 12, 2016, HPMS e-mail, *Reminder regarding Contract Year 2017 Medicare Advantage Applications and Service Area Expansion Requests*

# Exception Regulation

- MAOs may request an exception to CMS' network adequacy criteria, if warranted.
- Justifications for an exception are based on "other factors that CMS determines are relevant in setting a standard for an acceptable health care delivery network in a particular service area."

REFERENCE: 42 CFR 422.112(a)(10)(v)

# Exception Requests – Policy Clarification

- MAOs may request an exception if there is an insufficient number of providers available within the criteria for a given county/specialty and the contracted provider network:
  - Is consistent with the current pattern of care; and
  - Provides enrollee access to covered services that is equal to or better than the prevailing original Medicare pattern of care.

REFERENCE: January 15, 2016, HPMS memo, *Exception Requests and Partial Counties Policy Clarifications*

# Exception Requests in the Application – Format

- CMS streamlined the Exception Request template to standardize information collected across applicants.
- Applicants were required to resubmit all previously approved Exception Requests.
  - TEMPLATE: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/

REFERENCE: January 15, 2016, HPMS memo, *Exception Requests and Partial Counties Policy Clarifications*

# Exception Requests in the Application – Timing

- CMS required that applicants request and submit Exception Requests on March 1, 2016.
- CMS communicated dispositions on Exception Requests in the Notice of Intent to Deny.

REFERENCE: February 26, 2016, HPMS e-mail, *Exception Requests for Contract Year 2017 MA Application Cycle – Due March 1, 2016*

# Partial County Regulation

- Local MA plans must meet the “county integrity rule” that a service area generally consists of a full county or counties.
- CMS may approve a partial county if it is:
    1. Necessary,
    2. Nondiscriminatory, and
    3. In the best interests of the beneficiaries.

REFERENCE: 42 CFR 422.2

# Partial Counties – Policy Clarification

- The inability to establish economically viable contracts is **not** an acceptable justification for approving a partial county service area.

REFERENCE: January 15, 2016, HPMS memo, *Exception Requests and Partial Counties Policy Clarifications*

# Partial County Justifications in the Application

- Applicants were required to resubmit all previously approved Partial County Justifications.
  - TEMPLATE: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/

REFERENCE: January 15, 2016, HPMS memo, *Exception Requests and Partial Counties Policy Clarifications*

# CMS Exceptions and Partial County Review – Centralized Team

- Contractor Support
- Central Office Staff
- Regional Office Staff

# Exception Requests – CMS Team Review

- Verified the number of providers/facilities available to meet CMS network adequacy criteria
  - Considered information submitted by the applicant on the Exception Request template
  - Reviewed various public data

REFERENCE: April 28, 2016, HPMS e-mail

# Polling Question

**Which of these exception requests present a valid exception request rationale?**

a) Attempting to contract with a provider, but contract negotiations have not concluded.

b) Provider is under sanction.

c) Provider is no longer practicing at a specific location.

d) Both b and c

e) All of the above

# Exception Requests – Common Findings

**Applicants should not submit Exception Requests as placeholders while contracting is underway.**

| | |
|---|---|
| REASON FOR NOT CONTRACTING WITH PROVIDER: | _X_ Other (please define): *(Note, Inability to contract is not a valid reason for submission of an Exception Request)*<br><br>We have been and will continue to attempt to contract with Dr. John Jones. If members in this county have difficulty locating a network provider within a reasonable distance (consistent with CMS standards), we have a network exception process to allow our members to access medically necessary care for covered benefits from out-of-network providers at the in-network cost sharing levels. |

# Exception Requests – Common Findings (cont.)

**Applicants should not submit Exception Requests as placeholders for incorrect HSD table submissions (Example 1).**

| HSD Instruction | CMS Finding |
|---|---|
| Applicants must list providers for every specialty for which they provide a service. | Dr. John Jones is credentialed to provide primary care services and cardiology services. The applicant only identifies Dr. Jones for cardiology services on the HSD table. |
| Applicants must list providers for every county they will serve. | Dr. John Jones is located in the southwest portion of Baltimore County, close to the borders of Carroll and Howard Counties. The applicant lists Dr. Jones to provide cardiology services in Baltimore County only. The applicant passes the criteria for cardiology in Baltimore County but fails in Carroll and Howard Counties. |

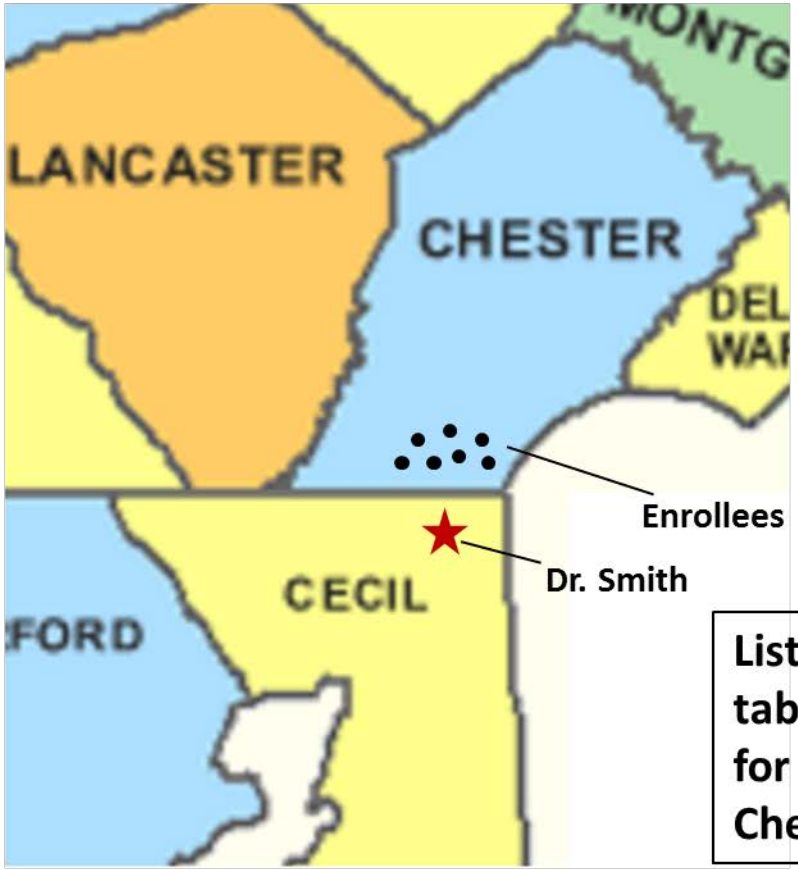
# Exception Requests – Common Findings (cont.)

**Applicants should not submit Exception Requests as placeholders for incorrect HSD table submissions (Example 2).**

| HSD Instruction | CMS Finding |
|---|---|
| Applicants may need to contract with providers outside of their plan service area (in adjacent counties/states) in order to meet current CMS network adequacy criteria. | The applicant has a service area comprised of all Pennsylvania counties. The applicant is failing HSD for endocrinology in Chester County, PA. Based on the deficient zip code report, enrollees in southern Chester County, PA, do not have adequate access to care.<br><br>Dr. Sam Smith is credentialed to provide endocrinology services. Dr. Smith is located in northern Cecil County, MD, within time and distance of enrollees in Chester County, PA. The applicant does not identify Dr. Smith on their HSD tables for Chester County, PA. |

# Contracting Outside of Your Service Area

**Service area:**
**Chester County, PA**




**Dr. Smith is within CMS time & distance criteria for Chester County.**

**Provider location:**
**Cecil County, MD**

**List Dr. Smith on HSD table to provide access for enrollees in southern Chester County.**

# Exception Requests – Common Findings

**CMS does not grant exceptions to providing 90% of beneficiaries with adequate access to care.**

| | |
|---|---|
| REASON FOR NOT CONTRACTING WITH PROVIDER: | _X_ Provider does not provide services at the office/facility address listed in database<br><br>The applicant identifies three providers who are no longer practicing for the cardiology specialty within time and distance for Cecil County. |
| **Question 3.a.** Did the applicant contract with providers who are outside CMS' current time and distance criteria? | The applicant answers no to this question, stating that they did not contract with any providers for cardiology outside CMS' current time and distance criteria. |

# Partial County Justifications – CMS Team Review

- Reviewed and verified information submitted by the applicant on the Partial County Justification template
  - Assessed the service area of other MAOs

REFERENCE: 42 CFR 422.2; Medicare Managed Care Manual, Chapter 4, Section 140.3

# Polling Question

**Which of these partial county justifications present a valid rationale to demonstrate that a partial county is "necessary"?**

a) Providers refused to accept our negotiated rates.

b) Beneficiaries residing in a zip code cross county boundaries.

c) A section of the county has an insufficient number of providers to provide adequate access to care.

d) Both a and c

e) All of the above

# Partial County – Is it Necessary? Common Findings

**CMS does not consider the inability to contract as an acceptable partial county justification.**

| Applicant Rationale | CMS Finding |
|---|---|
| We have attempted to contract with several providers, but those providers have not accepted our proposed rates. | CMS does not accept the inability to establish a contract as the sole rationale for requesting a partial county. |
| CMS has approved our partial county in the past due to a "zip code crossover." | The applicant's rationale is not sufficient because all applicants were required to resubmit all previously approved Partial County Justifications for re-review. The applicant needs to explain why a partial county remains necessary. |

# Is it Nondiscriminatory? Common Findings (Example 1)

**Applicants must provide conclusive evidence showing that their partial county request presents no discrimination.**

| Applicant Rationale | CMS Finding |
|---|---|
| The applicant provides information to show the demographics for the entire county, but offers no comparison based on the excluded parts of the county. | The applicant's claim that the partial county is nondiscriminatory is not supported by any evidence showing that that the healthcare costs and racial/economic composition of the population in the excluded portion of the county is comparable to the included portion of the county (proposed partial county). |

# Is it Nondiscriminatory? Common Findings (Example 2)

**The existence of other MA plans operating in the entire county may provide evidence that approving a partial county service area would be discriminatory.**

| Applicant Rationale | CMS Finding |
|---|---|
| There is a higher percentage of Whites and lower percentage of Asians in the partial county we are proposing than in the excluded portion of the county. However, we don't believe the Asian population in the excluded portion of the county is unfairly disadvantaged due to the existence of other MA plans. | The applicant's rationale is not acceptable. It does appear racially discriminatory, and there are currently three other MA plans that are able to serve the full county. This is an indication to CMS that it may be discriminatory to approve this partial county service area. |

# Is it in the Best Interests of Beneficiaries? Common Findings

**Applicants must provide conclusive evidence showing that their partial county request is in the best interests of beneficiaries.**

| Applicant Rationale | CMS Finding |
|---|---|
| To address if the partial county is in the best interests of beneficiaries, the applicant only discusses utilization in general terms. | The applicant's claim that the partial county is in the best interests of beneficiaries is not supported by enough reasonable supporting documentation (e.g., enrollee satisfaction surveys, grievance and appeal files). |
| We are a 5-star plan and want to continue to only serve the partial county. CMS has approved us for the past 5-10 years, and we want to avoid disenrollment from a 5-star plan, enrollee disruption of continuation of care, and enrollee confusion. We intend to apply for a full county in CY 2018. | The applicant has valid concerns about enrollee protection, but the disenrollment could be avoided if they had applied for full counties. The applicant says that they intend to apply for full county expansion next year; however, they should have applied for full counties this year if they knew that they could meet the network adequacy criteria. |

# Review of Goals

- Promote enrollee confidence in their access to robust, quality healthcare
- Maintain network criteria that is fully transparent, objective, and establishes a level playing field for all network-based MA plans
- Strengthen CMS' qualification of applications based on contracted networks

# Questions?

Division of Medicare Advantage Operations (DMAO) Mailbox

https://dmao.lmi.org

Medicare Part C Policy Mailbox:

Division of Policy, Analysis, and Planning (DPAP)

https://dpap.lmi.org