

MA Applications: Automated Network Review Process and Standardization of Access Criteria

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Introduction

Effective with 2011 Application Cycle,
changes in review of Medicare Advantage
network adequacy

- Use of access criteria standardized by provider/facility type and geographic designation
- Review of network submission done largely through automated process
- Criteria and background discussion posted at <http://www.cms.hhs.gov/MedicareAdvantageApps/>

Standardized Network Criteria

- 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
- Not intended to standardize network approaches or limit innovation, just to ensure adequate access for enrollees

Roll Out of Criteria & Automated Review Process

- October 19, 2009 – First public discussion
- November 20, 2009 – Network Criteria reference tables publicly released, along with discussion of methodology and Exceptions Guidance
- Mid-December 2009 – Detailed training for new applicants and other interested parties
- January-February 2010 – Applicants allowed two opportunities to upload data on prospective networks for assessment against standard criteria prior to final application submission
- Final application submission due – February 25, 2010

Benefits of the Standardized Criteria & Automated Review Process

- Standardizes process for reviewing HSD tables while allowing for 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
- Allows CMS staff to focus on exceptions requests and other sections of the MA application

Provider Network Criteria

For average number of enrollees in county, criteria establish

- Minimum number of providers
 - Maximum travel distance to the closest provider
 - Maximum travel time to a provider
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- Criteria vary by specialty type (e.g., cardiology, ophthalmology) and geographic area (e.g., metro, rural)

Network Criteria Development

- Average distances and travel times determined using geo mapping tool
 - Tracked beneficiaries to the closest provider of each specialty type
- Geographic areas categorized as metro, micro, rural and large metro locations
- Average number of enrollees calculated as the 95th percentile of MA plans' market penetration in that category of geographic area (i.e., 95% of all MA have county penetration rates equal to or less than the established rates)

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

- Providers/facilities need not be located within the boundaries of the county being served.
- Feasibility of criteria has been successfully tested against a sample of over 12 million beneficiaries across 97 metropolitan statistical areas

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 opportunities to submit network information for pre-assessment prior to application submission deadline

Benefits of the Formal Exceptions Process

- Allows applicants to offer network model of care proposals that differ from identified 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 Process

- Plans to select from a pre-determined list of exceptions 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 criteria for each county prior to application due date, exception requests may **only** be submitted during the **initial** application upload (i.e., by Feb. 25, 2010)
- Burden is on applicant to prove validity of request

Exception Categories

- Insufficient number of providers/beds in service area
- No providers/facilities that meet the specific time and distance standards in county/surrounding area
- Pattern of care in county does not support need for the requested number of provider/facility type
- Services to be provided by an alternate (qualified) provider type
- Alternative arrangements for Regional PPOs (only applies to RPPOs)

Applicants must still ensure access to all Medicare services

Documentation Required -- Exceptions

Sample Required Documentation

- Distance and travel time points that members would have to travel beyond the required criteria (e.g., 20 minutes and 10 miles for a PCP in a metro service area) to reach the next closest provider of this type outside of the service area
- 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

Application & Technology Changes

- Changes to the Health Services Delivery tables
 - Streamlined to eliminate requests for duplicative information (e.g., no need for summary information)
 - New information required to facilitate automation of the HSD table review process
 - Tables renamed for clarity (Provider Table, Facility Table, etc.)

Changes to Requested Provider Information

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 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

Changes to Requested Facility Information

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 review • Ensure providers not listed multiple times • Ensure providers are Medicare-certified
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 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 • Allows for plans to more efficiently describe the submitted networks • Facilitate the efficient and thorough review of the submitted networks

Changes to HPMS

- MA reference file (transparent to applicant)
- Automated mapping component
- Automation of (former) HSD2 and HSD3
- Exceptions module
- Pre-assessment process
- System-generated Error Report
 - Accessible through HPMS
 - Shows Pass/Fail for meeting criteria on minimum numbers of providers/facility and time/distance
 - Also includes status of Exception request(s)

Questions

General Questions:

MA_Applications@cms.hhs.gov

Specific Issues:

Helaine Fingold at 410-786-5014 or

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Lessons Learned: Simple Ways to Improve your MA Application Submission (and Review Experience)

*2009 ICE Conference
December 8, 2009*

Ann Duarte

Manager, Medicare Advantage Branch
CMS San Francisco Regional Office



CY2010 Application Statistics

- CMS received 240 applications
- CMS approved 18% without issuing Notice of Intent to Deny (NOID)
- 30% applicants withdrew during review process
 - 42% before issuing NOID
- 68% applicants received NOID
 - 26% withdrew following NOID
 - 74% ultimately received application approval

Most Common Deficiencies

- Appropriate State License / Certification
- Provider Contract Provisions
- Provider Contract Execution
- HSD Table Accuracy
- Network Adequacy
- Service Area Accuracy

State License / Certification

- Application fails to include approved State License / Certification (per State requirements)
- Applicant fails to submit or submits incomplete CMS State Certification Form.
- Applicant starts State licensing process after submitting MA application to CMS.

State License / Certification

WORDS OF ADVICE

- *Communicate with the State licensing agency early and often! Inform them of CMS deadlines. Provide them with CMS RO contact information.*

Provider Contract Provisions

- Direct contracts (between applicant and provider / provider group) fail to include all CMS required contract provisions
- Common error: 6-year record retention requirement (vs. 10-year requirement)
- No evidence that downstream contracts include provisions in direct contracts
- Unable to match provider signature with contract templates provided in application.

Provider Contract Provisions

WORDS OF ADVICE

- *Update old contracts (and templates) at all levels of contracting to include required provisions. Start working on this early.*
- *Submit ALL contract templates so that CMS can match signature pages with full contract.*

Provider Contract Execution

- Especially for downstream contracts, no evidence that actual provider of care has agreed to serve MA membership.
- Provider contracts not signed or will expire before MA contract execution.
- Filing of Letters of Understanding/Intent rather than executed contract.

Provider Contract Execution

WORDS OF ADVICE

- *Do not include un-executed contracts as part of your provider network.*
- *If contract is set to expire, notify CMS of progress toward renewal.*
- *Do not submit Letters of Understanding / Intent (or include provides in HSD table)*
 - *Letters of Agreement are fine if they include all the required contract provisions.*

HSD Table Accuracy

- Information (e.g., provider counts) on one table does not match the same information on another table.
- Tables are incomplete.
- Tables provide information (provider contract type – employed, direct, downstream) contradicted by other application details.

HSD Table Accuracy

WORDS OF ADVICE

- *Cross-check the data on all the tables to ensure that it matches.*
- *Cross-check the data with information included elsewhere in the application.*
- *Follow the instructions carefully.*
- *Do NOT list providers with whom you are still negotiating contracts.*

Network Inadequacy

- Contracted network unable to provide Medicare-covered services.
- Insufficient explanation of how applicant will arrange for Medicare-covered services through alternative provider arrangements.
- Contracted physicians do not have admitting privileges at contracted and/or accessible hospitals.

Network Inadequacy

WORDS OF ADVICE

- *Ensure contracted network can provide all covered services and meets local patterns of care.*
- *Explain why alternate provider arrangements are necessary and how they meet enrollees' needs*
- *Ensure contracting physicians have appropriate admitting privileges to network facilities.*

Network Inadequacy

WORDS OF ADVICE

- *Refer to facilities identically when referencing multiple times in an application (e.g., ABCD Hospital vs. ABCD Medical Center).*
- *Submit full network early to allow for time to cure deficiencies.*

Service Area Accuracy

- Requested service area in HPMS does not match the application submission.
- Information on HSD tables does not match the application (wrong counties / states)

Service Area Accuracy

WORDS OF ADVICE

- Double (and triple) check the service area in HPMS to ensure it matches your application. Request necessary corrections through the RO immediately.
 - You will not be able to add counties/states to your service area after the submission deadline.
- Before submitting, make sure your documentation is appropriate for the application.

Summary Advice

- Start working early, especially with State licensure and provider contracting.
- Check your data carefully to ensure accuracy.
- Don't include providers in your network until they are under contract.
- Justify anything that is outside the norm.
- Don't submit "placeholder" applications that you are not committed to.