

# Assessing Network Adequacy in the Medicare Advantage Program

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# Introduction

Effective with Application Cycle for the 2011 contract year, 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

# Network Criteria Development

- Average distances and travel times determined using geo mapping tool
  - Track beneficiaries to closest provider of each specialty type
  - 90% of network must meet time/distance requirements
- 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 plans in that category of geographic area have county penetration rates equal to or less than the established rates

# Benefits of the Standardized Criteria & Automated Review Process

- Standardizes process for reviewing information 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

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

# 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 under limited circumstances when Applicant does not meet network criteria
- Request is by individual provider type by county
- Select from a pre-defined list of allowable exceptions
  - Must submit supporting documentation for each provider/facility type for which an exception is requested
- Applicants are required to contract with available providers in the service area

# Benefits of the Formal Exceptions Process

- Allows for network model of care proposals that differ from that under the standardized criteria
- Ensures exceptions are granted uniformly across the country
- 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

# Exception Categories

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

**Applicants must still ensure access to all Medicare services**

# Industry/Provider Concerns

- Downstream contracting, e.g., hospital based providers
- Pushing other issues into exceptions process, e.g., submitting exceptions where still contracting
- Concerns re: “unique” network and treatment approaches

# Recent Clarifications

- February 12, 2010 – Exception requests should be submitted in good faith, not to protect against --
  - potential failure to secure sufficient numbers of available providers or facilities in a particular county or
  - submission of unrecognizable provider/facility addresses
- February 11, 2010 – System methodology for measuring network adequacy, including address analysis and geocoding, beneficiary census data file and time and distance calculations
  - Sample beneficiary census file posted on HPMS
- January 27, 2010 – FAQs on HSD Submissions including provider/facility address format

# Looking Forward

- Expand network adequacy assessments to
  - Current contractors
    - Perennial review
  - Employer/Union Group products
- Rely on audits to ensure validity of application submissions

# Contact Information

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