MA Health Services Delivery Provider & Facility Specialties and Network Adequacy Criteria Guidance

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MA HSD Provider & Facility Specialties and Network Adequacy Criteria Guidance

Summary of Significant Changes to the CY2013 MA Provider and MA Facility Criteria

CMS continues to evaluate the process, guidance, and assumptions governing its oversight of the adequacy of Medicare Advantage (MA) provider networks. Further refinements have been made for the CY2013 MA application, and are summarized in this section. Greater detail describing re-designation of the county types and the submission of Exception Requests is found within the body of this document.

The following revisions have been made to the CY2013 MA Provider and MA Facility network criteria.

- County Type – The methodology for designating counties into the county types: Large Metro, Metro, Micro, Rural, and CEAC has been revised, resulting in the re-designation of a number of counties. The county type affects both the minimum number of providers and the maximum time/distance criteria.
- Total Beneficiaries – These values were updated to reflect the most recently published number of Medicare beneficiaries in each county. This affects the minimum number of providers criteria.
- Maximum Time and Distance requirements – The requirements for a number of specialty types for some of the county types have been revised (e.g. Cardiology, General Surgery, Ophthalmology, Orthopedic Surgery in Large Metro; Outpatient Dialysis in Micro, Rural, CEAC; etc).
- Removal of required specialty types – Two Facility specialty types have been removed; Laboratory Services (058) and Intestinal Transplant Program (063) While applicants must ensure that beneficiary have reasonable access to these covered services, it is no longer required that they be reported to CMS on the MA Facility table:
- Applicants are required to use the Exception Request Template when submitting an Exception Request.

MA Provider and Facility Criteria – County Types

The county type (Large Metro, Metro, Micro, Rural, or CEAC), is a significant component of the network access criteria. CMS has evaluated the county type designation methodology, based upon the Office of Management and Budget's (OMB) Core Based Statistical Areas (CBSAs) used to determine county type during previous application cycles. Due to variations in the patterns of care and access to health services across the counties within a given CBSA, CMS has decided to apply a designation methodology that is based upon the population size and density parameters of individual counties for future application cycles.

Table 1 lists the population and density parameters generally applied to determine the revised county type designations. These parameters are based on approaches taken by the Census Bureau in its delineation of "urbanized areas" and "urban clusters", and OMB in its delineation of "metropolitan" and "micropolitan". A county must meet both the population and density thresholds for inclusion in a given designation. For example, a county with a population greater than one million *and* a density greater than or equal to 1,000/mi^2 is designated Large Metro. Any of the population-density combinations listed for a given county type may be met for inclusion within that county type (i.e., a county would be designated Large Metro if *any* of the three

Large Metro population-density combinations listed in Table 1 are met; a county is designated as Metro if any of the five Metro population-density combinations listed in Table 1 are met; etc.).

Table 1: Population and Density Parameters

	Populations	Density
Large Metro	≥ 1,000,000	≥ 1,000/mi^2
	500,000 – 999,999	≥ 1,500/mi^2
	Any	≥ 5,000/mi^2
Metro	≥ 1,000,000	10 – 999.9/mi^2
	500,000 – 999,999	10 – 1,499.9/mi^2
	200,000 – 499,999	10 – 4,999.9/mi^2
	50,000 – 199,999	100 – 4,999.9/mi^2
	10,000 – 49,999	1000 – 4,999.9/mi^2
Micro	50,000 – 199,999	10 – 99.9 /mi^2
	10,000 – 49,999	50 – 999.9/mi^2
Rural	10,000 – 49,999	10 – 49.9/mi^2
	<10,000	10 – 4,999.9/mi^2
CEAC	Any	<10/mi^2

MA Provider and MA Facility Specialty Codes

CMS has created specific specialty codes for each of the physician/provider and facility types. Applicants must use these codes when completing MA Provider and Facility HSD tables.

Specialty Codes for the MA Provider Table

001 – General Practice
002 – Family Practice
003 – Internal Medicine
004 – Geriatrics
005 – Primary Care – Physician Assistants
006 – Primary Care – Nurse Practitioners
007 – Allergy and Immunology
008 – Cardiology
009 – Cardiac Surgery
010 - Chiropractor
011 – Dermatology
012 – Endocrinology
013 – ENT/Otolaryngology
014 – Gastroenterology
015 – General Surgery
016 – Gynecology, OB/GYN
017 – Infectious Diseases
018 - Nephrology
019 - Neurology
020 - Neurosurgery

021 - Oncology - Medical, Surgical
022 - Oncology - Radiation/Radiation Oncology
023 – Ophthalmology
024 - Oral Surgery
025 - Orthopedic Surgery
026 - Physiatry, Rehabilitative Medicine
027 - Plastic Surgery
028 - Podiatry
029 - Psychiatry
030 - Pulmonology
031 - Rheumatology
032 - Thoracic Surgery
033 - Urology
034 - Vascular Surgery
000 – OTHER

Specialty Codes for the MA Facility Table

040 – Acute Inpatient Hospitals
041 - Cardiac Surgery Program
042 - Cardiac Catheterization Services
043 - Critical Care Services – Intensive Care Units (ICU)
044 - Outpatient Dialysis
045 - Surgical Services (Outpatient or ASC)
046 - Skilled Nursing Facilities
047 - Diagnostic Radiology
048 - Mammography
049 - Physical Therapy
050 - Occupational Therapy
051 - Speech Therapy
052 - Inpatient Psychiatric Facility Services
053 – NOT IN USE
054 - Orthotics and Prosthetics
055 - Home Health
056 - Durable Medical Equipment
057 - Outpatient Infusion/Chemotherapy
058 - NOT IN USE
059 – NOT IN USE
060 – NOT IN USE
061 - Heart Transplant Program
062 - Heart/Lung Transplant Program
063 - NOT IN USE
064 - Kidney Transplant Program
065 - Liver Transplant Program
066 - Lung Transplant Program
067 - Pancreas Transplant Program

Two Facility specialty codes have been removed from the Table: Laboratory Services (058) and Intestinal Transplant Program (063).

MA Provider and Facility Network Criteria

Guidance for Select Specialty Types

To further assist applicants, this section contains additional information on the appropriate information to submit for a number of the MA HSD Provider and MA HSD Facility Table specialty types. These are issues about which CMS receives frequent questions.

MA Provider Table – Guidance for Select Provider Specialty Types

Primary Care Providers – The following six specialties are reported separately on the MA Provider Table, and the criteria, as discussed below, are published and reported under "Primary Care Providers (S03):

- General Practice (001)
- Family Practice (002)
- Internal Medicine (003)
- Geriatrics (004)
- Primary Care – Physician Assistants (005)
- Primary Care – Nurse Practitioners (006)

Applicants submit contracted providers using the appropriate individual specialty codes (001 – 006). CMS sums these providers, maps them as a single group, and evaluates the results of only those submitted providers whose office locations are within the prescribed time and distance standards for the specialty type: Primary Care Providers. These six specialties are also summed and evaluated as a single group against the Minimum Number of Primary Care Providers criteria. In order to apply toward the minimum number, a provider must be within the prescribed time and distance standards, as discussed below. There are HSD network criteria for the specialty type: Primary Care Providers, and not for the individual specialties that make up the category. The criteria and the results of the Automated Criteria Check (ACC) are reported under the specialty type: S03.

Primary Care – Physician Assistants (005). The purpose of this specialty's inclusion, and its inclusion in the MA Provider Table, is to inform CMS of the rare contracting with non-MD primary care providers in underserved counties to serve as the major source of primary care for enrollees. Applicants include submissions under this specialty code only if the contracted individual meets the applicable state requirements governing the qualifications for assistants to primary care physicians and is fully credentialed by the applicant as a provider of primary care services. In addition, the individuals listed under this specialty code must function as the primary care source for the beneficiary/member, not supplement a physician primary care provider's care, in accordance with state law and be practicing in or rendering services to enrollees residing in a state and/or federally designated physician manpower shortage area.

Primary Care – Nurse Practitioners (006). The purpose of this specialty's inclusion, and its inclusion in the MA Provider Table, is to inform CMS of the rare contracting with non-MD primary care providers in underserved counties to serve as the major source of primary care for enrollees. Applicants include submissions under this specialty code only if the contracted registered professional nurse is currently licensed in the state, meets the state's requirements governing the qualifications of

nurse practitioners, and is fully credentialed by the applicant as a provider of primary care services. In addition, the individuals listed under this specialty code must function as the primary care source for the beneficiary/member, not supplement a physician primary care provider's care, in accordance with state law and be practicing in or rendering services to enrollees residing in a state and/or federally designated physician manpower shortage area.

Geriatrics (004) – Submissions appropriate for this specialty code are internal medicine, family practice, and general practice physicians who have a special knowledge of the aging process and special skills and who focus upon the diagnosis, treatment, and prevention of illnesses pertinent to the elderly.

Cardiac Surgery (009) - A cardiac surgeon, or cardiovascular surgeon, is a medical doctor who focuses on the surgical treatment of heart and great vessels and treats conditions such as:

- Coronary artery disease or blockages of the arteries in the heart
- Blockages in one of the heart valve(s)
- Leaking heart valve(s)
- Abnormal enlargement or aneurysms of the large arteries in the chest
- Heart failure
- Atrial fibrillation

Oral Surgery (024) – There are conditions covered by Medicare that require the expertise of an oral surgeon. Discussion of these conditions may be found in the following chapters of the Medicare Benefit Policy Manual:

https://www.cms.gov/manuals/Downloads/bp102c15.pdf , §150
https://www.cms.gov/manuals/Downloads/bp102c16.pdf , §140

Physiatry, Rehabilitative Medicine (026) – A physiatrist, or physical medicine and rehabilitation specialist, is a medical doctor who is trained in the diagnosis and treatment of patients with physical, functionally limiting, and/or painful conditions. These specialists focus upon the maximal restoration of physical function through comprehensive rehabilitation and pain management therapies.

Thoracic Surgery (032) - Differentiating from the inclusive term cardiothoracic surgeon, a thoracic surgeon is a medical doctor who focuses on the surgical treatment of diseases of the lungs, esophagus, chest wall, and mediastinum, treating such conditions as:

- Lung cancer
- Severe emphysema
- Cancer of the esophagus
- Gastroesophageal reflux disease
- Hiatal hernias
- Swallowing disorders
- Excess sweating called hyperhydrosis

MA Facility Table – Guidance for Select Facility Specialty Types

Contracted facilities/beds must be Medicare-certified.

Acute Inpatient Hospital (040) – Applicants must submit at least one contracted acute inpatient hospital. Applicants may need to submit more than one acute inpatient hospital in order to satisfy the time/distance criteria.

> There are Minimum Number criteria for the acute inpatient hospital specialty. Applicants must demonstrate that their contracted acute inpatient hospitals have at least the minimum number of Medicare-certified hospital beds. The minimum number of Medicare-certified acute inpatient hospital beds, by county, is found on the Facility Minimum Number and the Provider Minimum Number tabs of the HSD Reference Table.

Cardiac Surgery Program (041) – A hospital with a cardiac surgery program provides for the surgical repair of problems with the heart. A common procedure performed in a cardiac surgery hospital program is the coronary artery bypass graft (CABG) procedure. Cardiac surgery procedures also include cardiac valve repairs, repairs to abnormal or damaged heart structures, and heart replacement.

Orthotics and Prosthetics (054) – A prosthetist is a healthcare professional trained to measure, design, fit, and adjust prostheses/prosthetic devices as prescribed by a physician. Prosthetic devices replace all or part of an internal body organ or all or part of the function of a permanently inoperative or malfunctioning internal body organ. An orthotist is a healthcare professional trained to plan, design, fit and adjust orthotic devices as prescribed by a physician. Orthotic devices are rigid/semi-rigid devices applied to the outside of the body to support a weak or deformed body part, or to restrict motion in an area of the body. Applicant's contracts for orthotics and prosthetics ensure access for beneficiaries/members to the fitting and modification and services to the devices (orthotics and prosthetics) and to the healthcare professionals (orthotists and prosthetists).

Home Health (055) – Applicants must list at least one home health provider. An Applicant's submissions for this specialty must provide home health services throughout the entire area of the county.

Durable Medical Equipment (056) – Applicants must list at least one durable medical equipment provider. A submission under this specialty type can be limited to one provider, so long as that provider covers the full range of Medicare covered durable medical equipment services. An Applicant's contracted providers for this specialty must provide durable medical equipment services that are accessible and available to beneficiaries residing anywhere in the county, not just in a portion of the county.

Outpatient Infusion/Chemotherapy (057) – Appropriate submissions for this specialty include freestanding infusion / cancer clinics and hospital outpatient infusion departments. While some physician practices are equipped to provide this type of service within the practice office, applicants should only list a contracted office-based infusion service if access is made available to all members and is not limited only to those who are patients of the physician practice.

Transplant Programs (061, 062, 064, 065, 066, 067) - Applicants must list at least one contracted program for each of the six transplant program types: Heart, Heart/Lung, Kidney, Liver, Lung, and Pancreas.

MA Provider and Facility Criteria – Minimum Number of Providers

MA applicants must demonstrate that their networks have sufficient providers to allow adequate access for beneficiaries.

MA Provider and Facility specialty types: MA organization networks must contract with sufficient numbers of each provider and facility specialty type to meet the criteria for the minimum number of provider specialties. Specialized hospitals, other than inpatient psychiatric facilities that are listed under Inpatient Psychiatric Facility Services (052), and pediatric/children's hospitals contracted with the applicant for its commercial, Medicaid, or other products do not count toward meeting these criteria.

> Hospital-based providers: The specialty types of Anesthesiology, Pathology, Radiology, Critical Care Medicine, and Emergency Room Physicians are not listed as MA Provider Specialty Types; however, MA applicants are expected to ensure that all Medicare-covered services rendered to beneficiaries during an admission to a contracted hospital are covered at the in-network benefit level and cost sharing.

Through the automated HPMS process, an Applicant's status in meeting minimum provider numbers is assessed based on the number of submitted providers that are located within the time/distance criteria, as discussed below. The minimum number of providers needed varies by county type designation. Applicants are only permitted to include in their application providers that are under *contract at the time of their submission* to CMS in order to meet these requirements.

MA Provider and Facility Criteria – Maximum Travel Time and Distance to Providers/Facilities

MA organizations must demonstrate that their networks do not unduly burden beneficiaries in terms of travel distance and time to network providers. These time and distance metrics speak to the access requirements pertinent to the approximate locations of beneficiaries, relative to the locations of the network providers.

MA applicants must demonstrate that 90 percent of beneficiaries in a given county have access to at least one provider/facility, for each specialty type, within established time and distance requirements.
The practice locations of an applicant's contracted providers are not limited to the boundaries of the county or counties in question. Applicants may include contracted providers located outside of the application's requested service area/counties if those providers are within the time and distance requirements.

Methodology for Determining Network Adequacy Criteria and HSD Reference Table

This section addresses how the network adequacy criteria are calculated and applied to Applicants. As mentioned previously, assessments of network adequacy call for an Applicant's networks to be evaluated based on two primary criteria that vary by provider specialty and county type designation (e.g., Large Metro, Metro, Micro, Rural, and CEAC):

- Minimum number of providers/inpatient beds
- Maximum travel distance and time to provider sites based upon beneficiary residence

Criteria for each county and specialty type are published in the MA HSD Reference Table.

A. Required Minimum Number of Providers

The methodology for calculating the minimum number of providers criteria is presented below. The criteria for minimum number of providers were calculated taking into account two determinants: 1) the 95th percentile base population; and 2) the minimum provider-to-enrollee ratio.

i) 95th percentile of beneficiaries served by MA Organizations

The "95th Percentile Base Population Ratio" represents the 95th percentile of MA market penetration rates of CCP and network-based PFFS MA organizations by county for each county type (Large Metro, Metro, Micro, Rural and CEAC). Each year CMS updates the 95th percentile (e.g., 95% of MA organizations have county penetration rates equal to or less than the calculated rates.) For CY2013, also taking into consideration the revised designation of county types, the percentiles are as follows:

Medicare Advantage
95th Percentile of County
Penetration by County Type

County Type	95th %-ile
Large Metro	0.065
Metro	0.109
Micro	0.103
Rural	0.097
CEAC	0.129

ii) Beneficiaries required to cover

To determine the base population that an applicant is required to cover, "Beneficiaries Required to Cover," the number of Medicare beneficiaries in a specific county is multiplied by the applicable percentage of beneficiaries served by MA organizations (described above).

Example:

County:	Muscogee, GA
County Type:	Metro
Total Beneficiaries:	28,215
95th %-ile Ratio:	.109

Beneficiaries Required to Cover: (28,215 x .109) = 3,079

iii) Minimum Number of Required Network Providers

In addition to knowing the number of beneficiaries required to cover in a county, determining the minimum number of providers required to ensure network adequacy also requires the minimum provider-beneficiary ratios for each specialty. Based upon primary and secondary research of the utilization patterns and clinical needs of Medicare populations, CMS has established ratios of providers per 1,000 beneficiaries for the specialty types in the MA Provider Table. These ratios vary by county type. To calculate the minimum number of each specialty type in each county, the number of beneficiaries required to cover is multiplied by the provider-beneficiary ratio.

CMS publishes detailed minimum provider per 1,000 beneficiary ratios for each county type for the applicable specialty types in the HSD Reference Table. When applicants for new or expanded MA organizations submit information about their proposed network, that information is compared with provider/practitioner/supplier addresses maintained by CMS. Using a mapping program, CMS determines whether an applicant's proposed network meets the minimum provider adequacy standards. If an applicant believes that local patterns of care

are such that its network cannot meet provider adequacy standards, it can request consideration for an exception through the HSD Exception Request process.

To ensure beneficiary access to appropriate care and to accommodate true patterns of care seeking, contracted providers/facilities do not need to be physically located within the boundaries of the county being served by the proposed network. Applicants may include providers outside of the application county/ies boundaries if those providers also fall within the travel time and distance requirements. In order to meet the time and distance requirement, discussed below, the number of providers that an applicant must submit may need to exceed the minimum number of required providers criteria, depending upon the office location of the providers.

MA organizations must have at least one of each HSD facility type. At this time, CMS has not established additional criteria for the minimum number of required providers for most of the specialty types on the CMS MA Facilities HSD Table. The one exception is for the requirements concerning acute inpatient hospitals. CMS has established a requirement for the minimum number of acute inpatient beds per 1,000 beneficiaries residing in the county (12.2 inpatient hospital beds per 1,000 beneficiaries residing in a county). This criterion was calculated using the same type of determinants as those described above and varies by geographic designation.

B. Maximum Travel Distance and Time to Provider and Facility Sites

The maximum time and distance criteria were developed by mapping beneficiary locations juxtaposed with provider practice locations. The maximum network time and distance criteria vary by county type and specialty type. In addition to meeting the minimum number of providers criteria, MA organizations must demonstrate that, taking into consideration the geographic distribution of beneficiary locations within the county of application, at least 90% of the Medicare beneficiaries residing in that given county have access to at least one provider, for a given specialty, *within the time and distance requirements*. The time and distance requirements, as indicated above, may necessitate the inclusion of more than the 'minimum number of required providers' criteria, depending upon the location of an applicant's contracted providers/facilities. Provider's clinical practice locations may be outside the boundaries of the county but must fall within the prescribed time and distance requirements.

MA Provider and MA Facility Exception Requests

CMS will consider requests for exceptions to the required minimum number of providers and/or maximum time/distance criteria under definite and limited circumstances. Each Exception Request must be supported by information and documentation as specified in the Exception Request template, which is published with the CY2013 Medicare Advantage Application document.

A. Timing of Exception Requests

Following the initial submission of the MA Provider and MA Facility tables, Applicants with network shortfalls whose networks do not successfully meet the criteria will receive a Deficiency Notice indicating the shortfall deficiencies. Applicants then prepare and submit a response to the Deficiency Notice, including the submission of revised MA Provider and MA Facility tables. Subsequent to the submission of the Deficiency Notice response, Applicants have the opportunity to review the updated CMS-generated Automated Criteria

Check (ACC) report before developing and submitting an Exception Request(s) based on results of that ACC report.

Note: ***i)*** Applicants do not submit Exception Requests with their initial application submission.

ii) There is one opportunity to submit an Exception Request. This opportunity, as described above, occurs immediately following the issuance of the CMS-generated Automated Criteria Check (ACC) report generated after the receipt by CMS of the Applicant's response to the Deficiency Notice.

Opportunity to submit a corrected Exception Request - An Applicant that receives a Notice of Intent to Deny (NOID) that identifies a previously submitted Exception Request (as discussed in Note # *ii)* may submit a corrected Exception Request. To do so, the Applicant must submit revised MA Provider and MA Facility tables (following receipt of the NOID), review the subsequent ACC reports reflecting the revised tables, and then submit a corrected Exception Request for the same contract id, county, and specialty code as was originally submitted.

A calendar listing the dates when the exception requests are due will be posted with the final CY2013 Application materials.

B. Use of Exception Request Template

To streamline requirements for Exception Request submissions, Applicants must meet the following requirements and must use the Exceptions Request Template:

i. Exception Request Template and the MA Provider and MA Facility tables

a) The Exception Request Template must be used for both initial and corrected Exception Requests.

b) MA Provider and MA Facility tables must list all contracted providers within and outside of the county that will be available to serve the county's beneficiaries.

c) Exception Requests must include a listing of the Provider(s)/Facility(ies) that are intended to provide access to the specialty type service in question.

d) Providers and Facilities referenced in an Exception Request must also be listed on the appropriate MA Provider/MA Facility table.

e) The Provider/Facility referenced in the Exception Request that is intended to provide access to the specialty type service in question must be listed in the MA Provider or MA Facility table

- Under the specialty type code of the specialty for which an Exception Request is being submitted, except
- Applicant must list the Provider/Facility using the OTHER specialty code (000) when submitting an Exception Request that involves an alternate provider/facility type.

f) Applicants may not simply refer to a Provider/Facility listed in the MA Provider/MA Facility tables for a different county when submitting an Exception Request. Any Providers/Facilities referenced in the Exception Request must be listed in that same county's MA Provider/MA Facility tables.

ii. An Applicant can submit only one exception request per contract id, county, and specialty code.

iii. Justification narratives must be included in the Exception Request document, not submitted as a separate file attachment.

iv. Applicants must ensure that Providers/Facilities referenced in the Exception Request match the listings on the MA Provider/MA Facility tables for the county in question.

v. Applicants submitting an Exception Request must name each Exception Request document (for a unique contract id/county/specialty type) using the following naming convention:

Contract ID (5 characters)_County Code (5 characters)_Specialty Code (3 characters)

15 characters total. Example: H9999_98765_032.xxx