ICRC Integrated Care Resource Center

Medicare Advantage Network Adequacy Requirements, D-SNPs, and State Contracting Options

Purpose/Overview

The Integrated Care Resource Center (ICRC) is a national initiative of the Centers for Medicare & Medicaid Services (CMS) to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The ICRC provides frequent opportunities for states working on integrated care initiatives to come together to discuss topics of interest with other states and with CMS.

This document summarizes a recent discussion of Medicare Advantage (MA) network adequacy requirements and their application to Dual Eligible Special Needs Plans (D-SNPs). Participants in the discussion included staff from eight states, CMS, ICRC, and the National Association of Medicaid Directors (NAMD).

CMS staff began the discussion by describing the processes for determining network adequacy in MA for D-SNPs and other MA plans. A question and answer session followed the presentation. ICRC has summarized the main points from the call below.

Medicare Advantage Network Adequacy Requirements and Their Application to D-SNPs

- CMS reviews network adequacy at the contract level, rather than the plan level. Once an organization's MA contract is approved, the legal entity can offer multiple plan benefit packages (PBPs) under the approved contract, one of which could be a D-SNP plan. For example, an organization might apply for a MA prescription drug (MA-PD) contract and only offer one non-SNP PBP initially, but it could apply to offer a D-SNP the next year, or vice versa.
- Each year CMS, with the help of a contractor, updates a set of Health Services Delivery (HSD) tables[1] that specify the required number of providers and facility types for every county in every state as well as time and distance requirements. These requirements are based on the population size and demographics of Medicare beneficiaries by county.
- MA entities must compare their networks against the sample beneficiary file and submit completed HSD tables to CMS.
- HSD tables are reviewed at the MA contract level; network adequacy is evaluated against an entire contract's service area. CMS reviews these tables to determine whether the contract meets network adequacy standards.
- CMS considers three measures of network adequacy: (1) minimum number of providers by type; (2) maximum travel distance to providers and facilities; and (3) maximum travel time to providers/facilities within the service area. For a contract to pass, each county must meet at least a 90 percent threshold for each of these three standards.
- The threshold for meeting these standards is that 90 percent of beneficiaries in a county have access to the appropriate number of providers and facilities within the required time and distance.
- To count toward the threshold, a provider or facility does not need to be in the same county as the beneficiary as long as it is within the required proximity specified in the HSD table.
- While all counties must meet the standards in order for the application to be approved, MA entities may drop a particular county from their service area if it does not meet the standards rather than have the whole contract be disapproved.
- Applicants may request exceptions to the network standards based on local patterns of care by using an exceptions template.[2] The requests are reviewed and granted on a case-by-case basis by the appropriate CMS Regional Office (RO).

- CMS revises the HSD tables every year to reflect changes in population density, demographics, and service patterns, as well as a review of the prior year's exception requests.
- Currently, network adequacy is checked only during the legal entity's initial application and for service area expansions, and in this case only for the expansion area. However, CMS is testing an annual review of network adequacy under the financial alignment initiative.

State Questions/Discussion

State Question	CMS Response
May states withdraw a county before or after the exception process?	Either, counties can be withdrawn at any time before the bid submission in June.
If a provider in a given county refuses to contract with an MA entity, are they still counted in the determination of network adequacy?	CMS looks at this from the beneficiary's perspective. CMS looks at the overall number of providers needed to serve beneficiaries. If a specific provider is refusing to contract with the MA entity, that does not reduce the number of providers needed to serve beneficiaries in that service area.
It is clear that the application is at the contract level. Is there anything in regulation that would prevent the network review from being done at the plan level for D-SNPs, since this population is different than the general population?	Current MA regulations would prohibit that. Networks are reviewed during the application process and plan benefit packages are not submitted until after that application process. As such, the networks are reviewed at the contract level and cannot be reviewed at a plan level or for a different population at this time.
Are there specific types of providers or instances in which network adequacy exceptions may be granted generally?	No, exceptions are always case-by-case and are reviewed by the ROs. They depend on local patterns of care. CMS updates the network requirements each year based on a review of exception requests and to reflect changes in patterns of care and populations over the year.
Will there be technical assistance (TA) for MA plans regarding how to meet network adequacy requirements? How about TA for states?	CMS provides TA in a variety of different ways to MA entities through group calls, training, regular calls with individual plans, and a TA mailbox. The ICRC and CMS are working on ways of providing TA to states on these and other issues related to D-SNP contracting.
We've had the experience of plans being told they must contract with a provider that does not exist. Can this be fixed through the exception process?	CMS would not tell a plan that they had to contract with a specific provider. However, if an entity tells CMS there are only three providers in the area and the network requirements are for four, for example, an exception can be requested via the exception process.
I understand that the network adequacy criteria is the same for D-SNPs and regular MA plans, but duals have non-emergency transportation available to help bring them to providers. Is there anything in the works to ease the time and distance standards considering this?	CMS is testing how the Medicaid transportation benefit can be taken into account when assessing MA networks in the context of the financial alignment initiative. However, this is not an option for Medicare Advantage plans since the network review is at the contract level.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided within the ***Integrated Care Resource Center*** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.

Endnotes

[1] This file provides the CY2015 minimum number, time, and distance for every county for the providers and facilities that are checked under Medicare Advantage. (See the downloads section at the bottom of the page). http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/.

[2] The exceptions template is public as part of the 2014 application package, at http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html (click on the “CY 2014 Part C Application (Updated 01-24-13)” link under “Downloads” at the bottom).