Department of Health & Human Services
Centers for Medicare & Medicaid Services
Medicare+Choice
Operational Policy Letter #90
REVISED - OPL99.090

Date: **Revised -- August 15, 2001**

Subject: **Service Area Requirements for Medicare+Choice (M+C) Coordinated Care Plans**

Introduction: In this operational policy letter, we address several questions about the service area(s) of M+C plan(s) offered by an M+C organization. The definition of service area is in the M+C regulations at 42 CFR section 422.2. The general requirements for approval of M+C plan service areas are discussed in the preamble to the M+C final rule published in the *Federal Register* on June 29, 2000 (See *Federal Register* Vol. 65, No. 126, pages 40204 - 40206.) The final rule preamble cites four factors the Centers for Medicare & Medicaid Services (CMS) will consider before approving a proposed service area:

- Whether proposed service areas are consistent with community patterns of care;
- Whether proposed service areas are consistent with an M+C organization's commercial or state-licensed service area;
- Whether the proposed service area discriminates against certain groups of Medicare beneficiaries; and
- Whether the proposed service area meets access and availability requirements.

These criteria provide an overview of factors CMS will consider before approving a proposed service area for an M+C plan.

In general, CMS does not approve service areas that do not consist of at least an entire county, unless special circumstances justify an exception to this "county integrity" rule. Because many M+C organizations are facing increased difficulties in establishing provider contracts, this OPL includes an additional exception to the county integrity requirement. This new exception will allow an M+C organization to establish a partial county service area for an M+C plan when it cannot establish an economically viable contract with sufficient providers to serve an entire county. Details on the requirements for this new exception are provided below in the answer to question 1.

It may help in understanding the county integrity policy to provide a context by citing several

reasons why the service area designation is such an important element in the structure and design of a M+C coordinated care plan.

M+C organization--M+C plan & service area: M+C organizations including provider-sponsored organizations (PSOs), can offer multiple coordinated care plans. However, each M+C plan offered by an M+C organization must have a CMS-approved service area. The M+C plan service area:

- Determines CMS's payment rate to the M+C organization based on the counties included in the service area;

- Affects which benefits will be provided under the M+C plan, because benefits and premiums must be uniformly available to Medicare beneficiaries residing in the plan's service area;

- Determines which Medicare beneficiaries are able to elect the plan, because organizations are obligated to enroll any eligible resident in the service area who elects the plan;

- For coordinated care plans, designates the geographical area within which the plan's covered services must be "available and accessible"; and

- For coordinated care plans, designates the boundaries beyond which the organization assumes liability for urgently needed care.

Service Area Questions & Answers

Question 1: Will CMS maintain a "county integrity" rule for M+C coordinated care plans?

Yes. We will adhere to the county integrity rule in most cases, but there are exceptions (described below) that may be approved by CMS's Central Office on a case-by-case basis. The county integrity policy described below reflects current practice.

Generally, an M+C plan service area will consist of whole counties. CMS pays M+C organizations based on Medicare expenditures at the county level, and we can assume that M+C plans offered by an M+C organization will be available to enroll the range of beneficiaries both high and low cost residing in the county. There are some exceptions to the county integrity rule (discussed below); however, it is never acceptable for an M+C organization to devise an M+C plan service area that excludes portions of a county because it anticipates enrollees with higher health care needs.
Historically, CMS has approved section1876 risk plans at less than a county level based on their ability to meet the exceptions criteria presented below, and we will allow these extant plans to

continue in their current configurations based on their continued ability to meet these criteria. For new M+C plan service area proposals which include a partial county (or a service area reduction to less than a county), the burden of proof is on the M+C organization to demonstrate to CMS why the M+C plan in question is unable to provide services to the entire county. To ensure consistency across our ten regional offices, CMS's Central Office will approve partial county service areas on a case-by-case basis by applying the criteria listed above. We will evaluate requests for partial counties, in part, by comparing M+C organizations' proposals with census and other demographic data at our disposal. We are taking these steps to support the policy objective of ensuring that some beneficiaries (e.g., those with lower socioeconomic indicators) are not excluded from exercising choice under the M+C program.

Exceptions under which we will approve an M+C plan with a partial county service area include cases where the M+C organization offering that plan demonstrates that:

- The proposed exception is consistent with community patterns of care. For example, geographic features such as mountains, water barriers and exceptionally large counties may create situations where the pattern of care in the county justifies less than a complete county because covered services are not available and accessible throughout the entire county. (The M+C organization's commercial or state-licensed service area also provides examples that support exceptions based on community patterns of care.)

- The M+C organization cannot establish a provider network to make health care services available and accessible to beneficiaries residing in the excluded portion of the county. Examples of this situation include: (1) A Provider Sponsored Organization or other type of M+C plan may initially have a health care network that is local in nature and cannot be readily extended to encompass an entire county; (2) A section of a county may have a insufficient number of providers (or insufficient capacity among existing providers) to ensure access and availability to covered services. (3) The M+C organization is unable to serve a complete county because it cannot establish economically viable contracts with sufficient providers to serve an entire county. An M+C organization's request for a county integrity exception under this provider contracting provision must include the following information to permit CMS to evaluate the appropriateness of approving a partial county service area in this situation:

    + Information about the anticipated enrollee health care costs in both the portion of the county that makes up the proposed service area and in the excluded portion of the county. Given that payment rates are set based on average Medicare expenditures for an entire county, as discussed above, this information is necessary to ensure that the excluded portion of the county is not populated by individuals with higher health care expenses than those in the proposed service area. Thus, the M+C organization must demonstrate that the anticipated enrollee health care costs in the proposed service area are not systematically and significantly different than the costs in the excluded area. *Example--If the M+C*

organization is requesting a service area reduction (creating a new partial county area), the organization can demonstrate its anticipated costs of care by using data from the previous year of M+C contracting comparing the health care costs of its enrollees in the excluded area to the area of the county it proposes to continue to serve.

+ Information about the racial and economic composition of the population in the portion of the county it wants to serve as compared to the excluded portion of the county. Although the presence of demographic disparities does not necessarily preclude approval of a partial county service area, we believe it is appropriate to consider the impact of establishing such an area on minority and low-income groups. *Example--The M+C organization can use U.S. census data to show the demographic make-up of the included portion of the county as compared to the excluded portion.*

+ An explanation (with available supporting documentation) of why the M+C organization was unable to establish viable contracts with providers in order to serve the proposed excluded portion of the county. *Example--The M+C organization would indicate what provider groups are available in the portion of the county the M+C organization is proposing to exclude from its service area, discuss the anticipated provider costs and negotiations with the provider groups in question, and document its unsuccessful efforts to establish contracts in order to serve the area.*

Note: These are only intended to represent examples of the types of information or documentation an M+C organization can furnish to validate its requests. In making its determination as to whether a request for a partial county service area will be approved, CMS will accept all relevant evidence from the M+C organization that credibly addresses the three areas above.

Question 2: Can Medicare+Choice organizations offer multiple plans within the same service area?

Yes. Medicare+Choice organizations may offer multiple M+C plans within the same service area. Each M+C coordinated care plan offered by a M+C organization must:

- Have its own adjusted community rate (ACR);
- Have a CMS-approved service area within which the M+C plan offers a uniform benefit package and charge structure to enrolled beneficiaries; and
- Have a CMS-approved service area adequate to provide the required access and

availability to health care services for beneficiaries enrolled in the plan.

Also note that CMS remains concerned about the possibility that some M+C plans could be designed to discourage certain (less healthy) beneficiaries from enrolling in particular plans. We will therefore pay particular attention to an M+C organization's multiple offerings within the same service area to ensure they encourage beneficiaries to choose from among all plans offered by the organization.

Question 3: Can different M+C plans offered by an M+C organization use the same health care network?

Yes. An organization may offer one or more M+C plans that employ the same provider network. However, as discussed above, each plan must have its own CMS-approved service area and the provider network supporting the plans must meet Medicare standards for access and availability of health care services. The provider network capacity must be sufficient to sustain the aggregate enrollment of the M+C organization's plans.

Question 4: Can M+C organizations market M+C plans based on a particular provider group attached to the plan?

Yes. As long as an M+C plan has a CMS-approved service area and provides the required access to health care services, an M+C plan may be marketed as providing access to a particular group of providers. This option must be made available to all eligible Medicare enrollees who reside within the M+C plan's service area.