Service Area Expansion Guidelines

The following criteria address geographically contiguous county expansion and are intended to provide guidance to a Plan contemplating gradual expansion of its health delivery system beyond its approved service area. The Department of Health needs to review HMO or Gatekeeper PPO service area expansions. The documentation submitted must indicate that there is no significant difference in quality of care, management, or health service delivery arrangements from the Plan's current existing approved service area.

Please note that if a Plan is considering a systematic expansion of health services and marketing in a new county, it is requested that the Plan obtain prior approval from the Department of Health prior to initiating its activities. For non-contiguous area expansion, please contact the Bureau of Managed Care for further information and technical assistance. Expansion for Medicaid and Medicare products would also require additional considerations, if arrangements for these products are different from commercial products.

A Plan that is simply contracting physicians in a non-approved service area is not required to obtain approval until such time as marketing activities in that county are anticipated.

The Plan need only provide one or two paragraphs of explanation, although additional information and attachments can be submitted at the Plan's discretion. Please submit the requested documentation in duplicate to the Bureau.

1. **Description of Proposed Service Area** - provide a definition of the expansion area and its geographic relationship to the existing service area. The Department will consider counties or "portions of counties" as a service area expansion wherever a combination of new delivery system arrangements and new marketing initiatives are anticipated.

2. **List of Participating Physicians** - list only fully credentialed and contracted primary care physicians and specialists by county and specialty, and indicate the participating hospitals at which they have admitting privileges. The Department of Health is committed to assure access, and in this regard looks for evidence of arrangements for the ten most commonly used specialties, such as OB/GYN, cardiology, orthopedics, ENT, ophthalmology, urology, etc.
   Include list of mental health and substance abuse providers, or contracting arrangements (such as IDS) for behavioral health services. [See HMO-IDS Statement of Policy]

3. **Geographic Presentation of Service Area and Provider Locations** - attach a map which graphically describes the items in #1 and #2 above. The Department looks for basic access criteria (20 minutes/20 miles urban area and 30 minutes/30 miles suburban area), if these criteria are not met, please explain how members will access services. Include explanation of capacity to accept new members.

4. **Description of Contractual Arrangements** - provide an explanation of the contractual arrangements which will extend your provider network (if terms of agreement differ from existing provider contracts, copies of the modified agreements should be submitted as part of the service area expansion for Bureau review and approval).

5. **Quality Assurance** - provide an explanation of any differences in how the Plan will provide for and monitor quality of care in the expanded service delivery system as part of its ongoing quality assurance program.

6. **Utilization Review** - explain any differences in how medical services will be reviewed for appropriateness in this expansion as part of your existing delivery system. ASAM or Cleveland Criteria should be utilization criteria for substance abuse, or other criteria as approved by the Department of Health. Please check with the Bureau of Managed Care and Office of Drug and Alcohol Programs for technical assistance concerning the utilization criteria for substance abuse for publicly funded products.

7. **Member Services** - describe how subscribers in the expanded area will be afforded the same services as members in the existing service area (such as toll-free telephone access to the Plan, etc.). How will member grievances be handled (Level 1 and Level 2) if travel time to Plan offices is beyond 30 minutes?

8. **Anticipated Increase in Enrollment** - provide an estimate of the number of additional subscribers to the Plan as a result of the expansion during the first year of expansion operation.

These eight points pertain to the areas of mandated responsibilities of the Department of Health for approval of HMO service area expansions. The Bureau's goal is to approve service area expansions within 45 days of submission.

Pennsylvania Insurance Department Requirements

At the same time the above service area expansion information is submitted to the Department of Health, the Plan shall submit a copy of the submission letter, the description of the proposed service area, and the premium rates that will be used in the expanded area. If the premium rates are different from those currently on file with the Department, a rate filing is necessary and shall be included with the filing. If the premium rates do not change for the expanded area, they do not need to be submitted. The submission letter shall reflect that the premium rates for the service area expansion are the same as the premium rates on file with the Department.

Additional Information

Should any additional information be required, or if a Plan has concerns not addressed in these guidelines, please contact either the Bureau of Managed Care or the Pennsylvania Insurance Department.

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