Supporting Statement – Part A
TRIENNIAL NETWORK ADEQUACY REVIEW FOR MEDICARE ADVANTAGE ORGANIZATIONS AND 1876 COST PLANS
CMS-10636, OMB 0938-New

Note: This package was formerly entitled, "Three-Year Network Adequacy Review for Medicare Advantage Organizations." In this post-30-day iteration, CMS has revised that title to read, "Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans."

In addition, we use the term "organization" throughout this Supporting Statement and other attached documents to refer to both Medicare Advantage organizations and 1876 cost plan organizations.

Background

CMS regulations at 42 CFR 417.414, 417.416, 422.112(a)(1)(i), and 422.114(a)(3)(ii) require that all Medicare Advantage organizations (MAOs) offering coordinated care plans, network-based private fee-for-service (PFFS) plans, and network-based medical savings account (MSA) plans, as well as section 1876 cost organizations, maintain a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served. To enforce this requirement, CMS has developed network adequacy criteria which set forth the minimum number of providers and maximum travel time and distance from enrollees to providers, for required provider specialty types in each county in the United States and its territories. Organizations must be in compliance with the current CMS network adequacy criteria guidance, which is updated and published annually on CMS's website. Additional network policy guidance is also located in chapter 4 of the Medicare Managed Care Manual. This proposed collection of information is essential to appropriate and timely compliance monitoring by CMS, in order to ensure that all active contracts offering network-based plans maintain an adequate network.

Currently, CMS verifies that organizations are compliant with the CMS network adequacy criteria by performing a contract-level network review, which occurs when CMS requests that an organization upload provider and facility Health Service Delivery (HSD) tables for a given contract to the Health Plan Management System (HPMS). CMS has historically performed network reviews during the application cycle, beginning with CY 2011 applications. From CY 2011 through CY 2017, CMS reviewed all initial applicants' contract-level networks and all service area expansion (SAE) applicants' expansion counties. In the CY 2016 and 2017 application cycles, CMS reviewed all SAE applicants' existing counties in addition to their expansion counties (i.e., entire contract-level network).

Outside of the application, CMS *may* perform an entire network review after specific triggering events, such as certain provider/facility contract terminations, change of ownership transactions, network access complaints, and organization-disclosed network deficiencies. However, some of

the triggering events may warrant only a partial network review. For example, CMS may review a select set of specialty types or counties, instead of reviewing the entire network with all specialty types and counties. Currently, unless one of the triggering events occurs and an entire network review is prompted, an organization's entire contract-level network will not be formally reviewed by CMS unless the organization comes through the application process. Therefore, CMS is proposing this collection of information in order to improve monitoring of organizations' network adequacy.

CMS proposes to remove network reviews from the application process. CMS will instead review networks on a three-year cycle, unless there is an event that triggers an intermediate full network review, thus resetting the organization's triennial review. The triennial review cycle will help ensure a consistent process for network oversight and monitoring. Our goal is to make this change beginning with CY 2019 applications, pending OMB approval of this proposed information collection. If this information collection is approved by OMB, then the network review would be removed from the application process.

When selecting contracts for the triennial review period, CMS will pull a random sample from the list of active contracts, including both contracts that have never undergone a full network review in the Health Plan Management System (HPMS) and other active contracts (regardless of when the contract's last full network review occurred in HPMS). CMS will review all contracts that have never undergone a full network review in HPMS within the first two years of this initiative. CMS will provide all selected organizations with advance notice at least 60 days before the deadline.

Please note the following:

- Initial applications will require a full network review.
- Service area expansion (SAE) applications will require a partial network review of only new counties, and CMS will review the full network during the contract's triennial review.
- Both initial/SAE applicants and organizations due for their triennial review will have until June to formally submit HSD tables to CMS.

Since at least 1995, CMS required organizations to have their full networks negotiated and finalized during the application cycle, providing them with only three months to establish their full networks. Under the proposed procedural change, both initial and SAE applicants will have more time before their first year of operation/expansion to negotiate and establish their networks. CMS is currently discussing a proposed timeline for reviews internally and will release guidance to the industry as soon as review timeframes and activities are defined.

A. Justification

1. Need and Legal Basis

This collection of information is authorized by the Code of Federal Regulations, Title 42, Chapter IV, Subchapter B, Part 422, Subpart C – Benefits and Beneficiary Protections, §422.112(a)(1)(i)

and §422.114(a)(3)(ii), and Part 417, Subpart J – Qualifying Conditions for Medicare Contracts, §417.414(b) and §417.416(a):

§422.112 Access to services.

(a) *Rules for coordinated care plans.* An MA organization that offers an MA coordinated care plan may specify the networks of providers from whom enrollees may obtain services if the MA organization ensures that all covered services, including supplemental services contracted for by (or on behalf of) the Medicare enrollee, are available and accessible under the plan. To accomplish this, the MA organization must meet the following requirements:

(1) *Provider network.* (i) Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.

§422.114 Access to services under an MA private fee-for-service plan.

(a) Sufficient access. (1) An MA organization that offers an MA private fee-for-service plan must demonstrate to CMS that it has sufficient number and range of providers willing to furnish services under the plan.

(3) For plan year 2011 and subsequent plan years, an MA organization that offers an MA private fee-for-service plan (other than a plan described in section 1857(i)(1) or (2) of the Act) that is operating in a network area (as defined in paragraph (a)(3)(i) of this section) meets the requirement in paragraph (a)(1) of this section only if the MA organization has contracts or agreements with providers in accordance with paragraph (a)(2)(ii)(A) of this section.

(ii) Network-based plan is defined as a coordinated care plan as described in §422.4(a)(1)(ii), a network-based MSA plan, or a section 1876 reasonable cost plan. A network-based plan excludes a MA regional plan that meets access requirements substantially through the authority of §422.112(a)(1)(ii) instead of written contracts.

§417.414 Qualifying condition: Range of services.

(a) Condition. The HMO or CMP must demonstrate that it is capable of delivering to Medicare enrollees the range of services required in accordance with this section.

(b) Standard: Range of services furnished by eligible HMOs or CMPs—(1) Basic requirement. Except as specified in paragraph (b)(3) of this section, an HMO or CMP must furnish to its Medicare enrollees (directly or through arrangements with others) all the Medicare services to which those enrollees are entitled to the extent that they are available to Medicare beneficiaries who reside in the HMO's or CMP's geographic area but are not

enrolled in the HMO or CMP.

§417.416 Qualifying condition: Furnishing of services.

(a) Condition. The HMO or CMP must furnish the required services to its Medicare enrollees through providers and suppliers that meet applicable Medicare statutory definitions and implementing regulations. The HMO or CMP must also ensure that the required services, additional services, and any other supplemental services for which the Medicare enrollee has contracted are available and accessible and are furnished in a manner that ensures continuity.

2. Information Users

The information will be collected by CMS through HPMS. CMS measures access to covered services through the establishment of quantitative standards for a predefined list of provider and facility specialty types. These quantitative standards are collectively referred to as the network adequacy criteria. CMS requires that organizations contract with a sufficient number of providers and facilities to ensure that at least 90 percent of enrollees within a county can access care within specific travel time and distance maximums. Network adequacy is assessed at the county level, and counties are classified into five county type designations: Large Metro, Metro, Micro, Rural, or CEAC (Counties with Extreme Access Considerations).

Organizations will be required to demonstrate network adequacy through the submission of HSD tables in the NMM, which is an automated tool located on the HPMS website. The NMM allows organizations to upload two HSD tables per contract—a provider HSD table and a facility HSD table. On their HSD tables, organizations must list the providers and facilities they are currently contracted with for CMS's required specialty types. Key data fields on the HSD tables include: SSA State/County Code, Name of Provider/Facility, National Provider Identifier (NPI) Number, Specialty Code, and Address.

Using an embedded mapping software, the NMM reviews the HSD tables against default network adequacy criteria for each required provider and facility type in each county for a given contract. CMS provides these default values publicly in the current HSD Reference File, located on CMS's website. These criteria are updated and refined annually to account for various year-to-year changes, such as the most recent number of Medicare beneficiaries per county and updates to county type designations to reflect the most recent population and density per county.

After the organization uploads its HSD tables, the NMM will generate an Automated Criteria Check (ACC) report indicating the organization's results of the network review. The ACC report lists passes and fails for the network adequacy criteria, which shows CMS where the organization's current contracted provider network has met and/or not met the minimum provider/bed number and maximum time and/or distance standards for each provider/facility type in each county in the organization's service area. CMS uses the organization's ACC results to make a network adequacy determination.

CMS acknowledges that the continuously evolving patterns of care in certain service areas may necessitate exceptions to the network adequacy criteria. Current CMS policy states that an organization that does not pass the network adequacy criteria for a particular provider or facility type in a given service area may request an exception. If the contracted provider network is consistent with the current pattern of care and provides enrollee access to covered services that is equal to or better than the prevailing original Medicare pattern of care, then an exception may be granted. For detailed information on Exception Requests, please refer to the network adequacy criteria guidance.

As part of this information collection, organizations may submit new Exception Requests to CMS for consideration following the HSD table upload, and organizations must resubmit all previously approved Exception Requests using the *current* Exception Request template. There is no guarantee that a previously approved Exception Request is still necessary, given the continuously evolving patterns of care and the dynamic nature of the health care market landscape. CMS expects that organizations continuously monitor their networks and that they address network deficiencies when they arise. If the organization believes an exception to the current CMS network adequacy criteria is warranted in a given service area, they are to alert their CMS account managers and submit Exception Requests at that time. In addition to submitting previously approved Exception Requests, organizations must also resubmit all previously approved Partial County Justifications using the *current* Partial County Justification template. For detailed information on partial counties, please refer to chapter 4 of the Medicare Managed Care Manual and the network adequacy criteria guidance.

Once CMS staff reviews the ACC reports and any Exception Requests and/or Partial County Justifications, CMS then makes its final determination on whether the organization is operating in compliance with current CMS network adequacy criteria. If the organization passes its network review for a given contract, then CMS will take no further action. If the organization fails its network review for a given contract, then CMS will take appropriate compliance actions. CMS has developed a compliance methodology for network adequacy reviews that will ensure a consistent approach across all organizations.

3. Use of Information Technology

This collection of information involves the use of automated/electronic information technology through the NMM, a currently functioning module in HPMS. Organizations will download the provider and facility HSD tables from the NMM, complete the tables for each contract, and upload the tables back into the NMM. Both the data entry and the HSD table submission into the NMM are electronic. In addition, some organizations will electronically submit any new and/or previously approved Exception Requests for each contract. Although the Exception Request template also requires download from the NMM, many organizations will already have the forms on file and will only need to resubmit them electronically to the NMM.

In compliance with the Government Paperwork Elimination Act (GPEA), CMS notes that this collection of information is currently available for completion electronically only, and no

signature is required from the respondent(s). Although CMS does not have the capability of accepting electronic signatures, this could be made available to respondents in the future, if necessary to satisfy GPEA requirements.

4. Duplication of Efforts

Although there is similar information in the organization's ACC reports from prior network reviews that were performed by CMS during any of the triggering events, that information cannot be used or modified for the purposes described in section 2 above because it is outdated. For all contracts, CMS has network adequacy information that was submitted at the time of an initial or SAE application, which often occurred more than three years ago, deeming this information out of date. CMS will not be collecting duplicate information (i.e., information that is less than three years old) through this proposed collection of information. This proposed collection only requires information from contracts for which CMS has no network adequacy information from the past three years (unless a triggering event occurs).

Organizations' networks change continuously as they engage in ongoing contract negotiations with their providers. The day-to-day business decisions that an organization makes inherently affect their relationships with their contracted providers, and provider terminations sometimes occur, which may or may not be initiated by the organization. This results in an ever-changing network that CMS believes it should check regularly for adequacy. We cannot rely on network adequacy information that was collected long in the past through either the Application Tracking Module or the NMM because of the likelihood that the network has changed substantially over time.

5. Small Businesses

This collection of information will have a minimal impact on small businesses since applicants must possess an insurance license and be able to accept substantial financial risk. Generally, state statutory licensure requirements effectively preclude small businesses from being licensed to bear risk needed to serve Medicare enrollees.

6. Less Frequent Collection

If this collection of information is not conducted or is conducted less frequently than every three years (i.e., only during triggering events), then there will be consequences to CMS's program and policy activities. In addition, there is the potential for beneficiary harm related to undetected network deficiencies that could be prevented by this required reporting. At this time, CMS believes that some organizations are not compliant with current CMS network adequacy criteria and that this collection of information will provide CMS with the necessary information to determine the extent of noncompliance as well as potential beneficiary harm. Organizations may be operating out of compliance with program requirements, as their networks may not be adequate.

An organization's first review would occur after their initial application is conditionally approved, but prior to the start of the first year in which the plan is offered. In the case of an SAE, CMS would review only the new service area's network (i.e., the expansion counties), and the entire network review would occur at the contract's triennial review, unless in the intervening time, another triggering event required CMS to initiate an entire network review.

Every organization that holds a contract that is due for its triennial network review will receive a letter from the Director of the Medicare Drug and Health Plan Contract Administration Group, addressed to the organization's Medicare Compliance Officer. The letter will specify which contracts are due for review, the reason for the request, a description of CMS's network adequacy requirements, instructions on how to upload current HSD tables for the specified contract(s), a notation that CMS may take compliance actions if network deficiencies are found, and pertinent contact information for the organization's reference.

CMS will continuously track contracts' triennial network review dates in an HPMS report. CMS anticipates making an organization-specific version of this report available in HPMS. The report will list when the next network submission is due. An organization could reference the report at any time and see data for contracts affiliated with its user ID, in order to tell when each contract is due for its next triennial network review.

After receiving their letters, each organization will have at least 50 days before the NMM gates open and then the gates will remain open for 10 days. Thus, organizations will have at least 60 days to prepare their HSD tables and test their networks prior to the CMS-specified deadline. CMS will then assess the contract's network adequacy and determine whether any network deficiencies exist. If CMS finds network deficiencies, then CMS will take appropriate compliance actions, and the organization will be required to come into compliance.

Each time an organization's contract undergoes an entire network review for any of the triggering events, the triennial network review date for that contract will be reset.

This collection of information presents no technical or legal obstacles to reducing burden.

7. Special Circumstances

There are no special circumstances that would cause this collection of information to be conducted in a manner:

- Requiring respondents to report information to the agency more often than quarterly;
- Requiring respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Requiring respondents to submit more than an original and two copies of any document;
- Requiring respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- In connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study;

- Requiring the use of a statistical data classification that has not been reviewed and approved by OMB;
- That includes a pledge of confidentiality that is not supported by authority established in statue or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Requiring respondents to submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect die information's confidentiality to the extent permitted by law.

8. Federal Register Notice/Outside Consultations

Federal Register Notice

The 60-day notice published in the Federal Register on November 4, 2016 (81 FR 76946). In addition, the 30-day notice published in the Federal Register on July 19, 2017 (82 FR 33131). Comments were received during both comment periods and are attached to this package along with our responses. The package has been revised subsequent to the publication of both the 60-day and 30-day notices.

Changes include revisions to this Supporting Statement and updated information collection instruments and instructions/guidance documents. Our burden estimates remain unchanged.

The changes made subsequent to the publication of the 60-day notice were based on both public comment and internal review. For example, CMS replaced the HSD table templates, Exception Request Template, and Partial County Justification Template based on internal review of subsequently released application materials. Other changes made based on internal review include minor language revisions for clarification purposes or to align with the subsequently released MA Network Adequacy Criteria Guidance. CMS replaced the information collection instruments and instructions/guidance because these documents are updated annually; CMS released the documents to the industry for the CY 2018 application cycle.

The changes made subsequent to the publication of the 30-day notice were based solely on public comment. CMS revised the Supporting Statement, the "Notice of Entire Network Review" HSD Upload Request Letter, and the Exception Request Template based on a comment requesting that CMS adopt nomenclature that clearly identifies requirements that are applicable to Medicare cost plans. Since this information collection applies to both MAOs and 1876 cost plan organizations, we have removed all references to MAOs and instead use the term "organizations" to account for both MA plans and cost plans. CMS also revised the Supporting Statement based on comments requesting more clarification on the timeline and process.

The attached versions of the Provider HSD Table and Facility HSD Table are currently approved by OMB in the information collection entitled Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits (OMB control number:

0938-0935). That package is in the process of removing the HSD network review attachments and provisions while moving them into this New collection of information request. The attached version of the Partial County Justification Template has been updated with minor revisions to the OMB-approved version, to incorporate subsequently released guidance.

Outside Consultations

CMS consulted with a sample of nine potential respondents to estimate the hour burden on organizations for a contract-level network submission. Nine CMS account managers were contacted and asked to pose the following question to one of the organizations they oversee:

> CMS Central Office is consulting with a sample of MAOs to determine the average hour burden on an organization for an entire network submission for a single contract. We would like to find out the approximate total number of hours it takes an organization to both complete and submit to CMS: (1) provider and facility HSD tables for one contract, and (2) new and previously approved exception requests for one contract. We are also interested in how the size or type of contract impacts the length of time it takes for the entire network submission process for a single contract.

CMS also consulted with a different sample of eight potential respondents to estimate the hour burden on health plans for a Partial County Justification. These eight respondents were organizations who have submitted a Partial County Justification in the recent past. Eight CMS account managers were contacted and asked to pose the following question to the specified organizations they oversee:

> CMS Central Office is consulting with a sample of MAOs to determine the average hour burden on an organization for filling out a partial county justification document. We identified [MAO Name] [Contract #] as an MAO that has applied for a partial county in the past two years. We would like to find out the approximate number of hours it takes them to complete a single partial county justification.

The responses that CMS received for these two questions varied, depending on the size of organization and the contract. Some respondents were outliers in that they estimated either very few hours or very many hours, which skewed the data and the mean. Therefore, CMS aggregated the results and used the median number of hours for each information collection instrument. The following table describes the results, broken down by median number of hours for HSD tables, Exception Requests, and Partial County Justifications. Also included is the approximate number of hours CMS estimates it takes an organization to use the HPMS web-based application (i.e., the NMM) to submit these materials for one contract.

# of Hours for Provider HSD Table	**# of Hours for Facility HSD Table**	**# of Hours for Exception Requests**	**# of Hours for Partial County Justifications**	**# of Hours for HPMS/NMM Submission**
15	15	8	37	1

9. Payments/Gifts to Respondents

There are no respondent payments or gifts associated with this collection of information.

10. Confidentiality

Consistent with federal government and CMS policies, CMS will protect the confidentiality of the requested proprietary information. Specifically, only information within submitted HSD tables and Exception Requests (or attachments thereto) that constitutes a trade secret, privileged, or confidential information, (as such terms are interpreted under the Freedom of Information Act and applicable case law), and is clearly labeled as such by the organization, and which includes an explanation of how it meets one of the expectations specified in 45 CFR part 5, will be protected from release by CMS under 5 U.S.C. 552(b)(4). Information not labeled as trade secret, privileged, or confidential or not including an explanation of why it meets one or more of the FOIA exceptions in 45 CFR part 5 will not be withheld from release under 5 U.S.C. 552(b)(4).

11. Sensitive Questions

There are no sensitive questions associated with this collection. Specifically, the collection does not solicit questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

12. Burden Estimates (Hours & Wages)

12.1 Wages

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2016 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). We selected the position of Compliance Officer because this position is a key contact identified by organizations. CMS typically interacts with the Compliance Officer in matters related to network adequacy.

The following table presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage. As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative, and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Occupation Title	**Occupation Code**	**Mean Hourly Wage**	**Fringe Benefit**	**Adjusted Hourly Wage**
Compliance	13-1041	$33.77/hr	$33.77/hr	$67.54/hr

Officer				

12.2 Burden Estimates

CMS used HPMS data from the Application Tracking Module and the NMM from a recent 12-month period (June 2015 through June 2016), as well as data from HPMS's Contract Summary Report, to estimate the number of contracts that have not received an entire network review in the previous 12 months. Based on the Contract Summary Report, in total there are currently 484 active contracts offering network-based plans. Between June 2015 and June 2016, CMS performed entire network reviews on 180 of the 484 contracts, either through the Application Tracking Module or the NMM or both. This leaves 304 contracts that did not receive an entire network review during the 12-month look-back period.

The frequency of response for this information collection would be one time per year, however, the number of contracts submitting each year will vary. The burden estimates are based on the approximate expected number of contracts for the first year (304). However, this number will fluctuate each year depending on the number of applicants and how many contracts are due for a network review. CMS will resubmit this information collection to OMB annually since CMS updates the network adequacy criteria and guidance annually and the burden estimates will change each year as well, depending on the anticipated number of network reviews.

The following table describes the types of network-based health plans that are required to meet current CMS network adequacy criteria, showing the current estimated number of contracts, by health plan type and total. The table then breaks down how many contracts of each type and how many contracts total are expected to be subject to this information collection in Year 1.

Number of Respondents

	Local Coordinated Care Plan	**Regional Coordinated Care Plan**	**1876 Cost Plan**	**Network-based PFFS Plan**	**Network-based MSA Plan**	**Total # of Contracts**
Estimated # of Network-Based Contracts	453	11	15	5	0	484
Expected # of Contracts for Year 1*	278	9	14	3	0	**304**

* Please note, CMS is setting out this burden to apprise the public and OMB as to what we are currently projecting. We will seek OMB approval of subsequent years' burden when ready.

Based on the small sample studies (see Outside Consultations under section 8, above) as well as internal record keeping from the CY 2017 application cycle, CMS estimates that it will take organizations various numbers of hours to complete an entire network submission for one contract. There will be approximately 304 respondents (contracts) for the initial information collection year. However, the annual number of responses for two of the collection instruments

(i.e., Exception Request Template and Partial County Justification Template) are different because not all respondents submit these instruments during a given submission window, and not all respondents submit just one of each of these instruments. The below table shows a breakdown of the estimated annual hour burden for each information collection instrument for Year 1.

Time Estimates

Information Collection Instrument	Hour Per Response	Annual # of Responses	Annual Hour Burden
Provider HSD Table	15	304	4,560
Facility HSD Table	15	304	4,560
Exception Request Template	8	728*	5,824
Partial County Justification Template	37	12**	444
HPMS Web-Based Application: NMM	1	304	304
TOTAL	varies	1,652	15,692

* 104 contracts submitted Exception Requests during the CY 2017 application cycle, and the median number of Exception Requests submitted per contract was 7. This results in approximately 728 Exception Requests during a single submission window. Therefore, we are using this estimate for the annual number of responses for the Exception Request Template.
** Only 6 contracts submitted Partial County Justifications during the CY 2017 application cycle, and the median number of Partial County Justifications submitted per contract was 2. This results in approximately 12 Partial County Justifications during a single submission window. Therefore, we are using this estimate for the annual number of responses for the Partial County Justification Template.

For each information collection instrument, the hour per response was multiplied by the adjusted hourly wage of $67.54/hr (see section 12.1, above) to determine the cost per response.

Cost Per Response

Information Collection Instrument	Hour Per Response	Hourly Wage	Cost Per Response
Provider HSD Table	15	$67.54/hr	$1,013.10
Facility HSD Table	15	$67.54/hr	$1,013.10
Exception Request Template	8	$67.54/hr	$540.32
Partial County Justification Template	37	$67.54/hr	$2,498.98
HPMS Web-Based Application: NMM	1	$67.54/hr	$67.54

Next, the cost per response was multiplied by the annual number of responses to determine the annual cost burden for each information collection instrument. The estimated total annual cost burden for this information collection is $1,059,837.68.

Annual Cost

Information Collection Instrument	Cost Per Response	Annual # of Responses	Annual Cost Burden

Provider HSD Table	$1,013.10	304	$307,982.40
Facility HSD Table	$1,013.10	304	$307,982.40
Exception Request Template	$540.32	728	$393,352.96
Partial County Justification Template	$2,498.98	12	$29,987.76
HPMS Web-Based Application: NMM	$67.54	304	$20,532.16
			$1,059,837.68

12.3 Information Collection Instruments (attached)

Provider HSD Table The Provider HSD Table is a form that captures specific information required by CMS on the providers in the organization's current contracted network. All organizations are required to complete this form and upload the information into HPMS, whenever CMS performs a network review.

Please note, the attached template is the current CY 2018 Provider HSD Table, approved in the information collection entitled Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits (OMB control number: 0938-0935). That package is in the process of removing the HSD network review attachments and provisions while moving them into this New collection of information request.

Facility HSD Table The Facility HSD Table is a form that captures specific information required by CMS on the facilities in the organization's current contracted network. All organizations are required to complete this form and upload the information into HPMS, whenever CMS performs a network review.

Please note, the attached template is the current CY 2018 Facility HSD Table, approved in the information collection entitled Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits (OMB control number: 0938-0935). That package is in the process of removing the HSD network review attachments and provisions while moving them into this New collection of information request.

Exception Request Template The Exception Request Template is a form that an organization may complete and submit to CMS to request an exception to the current CMS network adequacy criteria for a particular county/specialty type. For example, if an organization does not meet the minimum number and maximum time/distance criteria for a specific specialty type in a given county, then the organization may submit an Exception Request for CMS to review. An organization may submit multiple Exception Requests, depending on how many deficiencies are found in its network, and CMS has discretion to approve or deny Exception Requests. Organizations must resubmit all previously approved Exception Requests using the *current* Exception Request template.

Please note, the attached template is the current CY 2018 Exception Request Template (Adobe

fillable form), approved in the information collection entitled Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits (OMB control number: 0938-0935). That package is in the process of removing the HSD network review attachments and provisions while moving them into this New collection of information request. The attached template includes minor revisions based on public comments received during the 30-day comment period, as discussed in section 8 above and in our attached response document.

Partial County Justification Template The Partial County Justification Template is a form that an organization may complete and submit to CMS if it is requesting a service area that includes one or more partial counties, as opposed to serving a full county. Only a small percentage of organizations submit Partial County Justifications because, per the county integrity rule (42 CFR 422.2), it is CMS's expectation that a service area consists of a full county or counties. However, CMS may approve a partial county if the organization presents valid evidence on its Partial County Justification that the partial county is necessary, nondiscriminatory, and in the best interests of the beneficiaries. Organizations must resubmit all previously approved Partial County Justifications using the *current* Partial County Justification Template.

Please note, the attached template is the CY 2018 Partial County Justification Template, approved in the information collection entitled Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits (OMB control number: 0938-0935), with minor revisions. That package is in the process of removing the HSD network review attachments and provisions while moving them into this New collection of information request.

HPMS Web-Based Application: NMM The HPMS web-based application that organizations will use for this collection of information is the NMM, as discussed in the Background section. The NMM is a module located under the Monitoring tab in HPMS. CMS has previously used this module—separate from the Application Tracking module—for ad-hoc HSD table submissions/network reviews requested by CMS for various reasons, including significant network changes, organization-self-disclosed network deficiencies, CMS-suspected network issues, and provider-specific plan network reviews. In addition to CMS's interest in providing closer monitoring of organizations' networks, its intention for implementing the three-year network review is to reduce the need for these ad-hoc network reviews by requiring more regular organization network reviews. Attached are the relevant screen shots associated with the NMM, contained in the current NMM Org Quick Reference Guide.

12.4 Information Collection Instructions/Guidance (attached)

In addition to the five information collection instruments listed in section 12.3 above, respondents will have access to documents containing instructions and guidance related to the CMS network review process.

HSD Instructions The HSD Instructions document provides detailed instructions to organizations

on how to complete and submit the Provider and Facility HSD Tables in HPMS. These instructions are updated annually. The attached version is the current version contained in the network adequacy criteria guidance that CMS released to the industry for the CY 2018 application cycle.

"Notice of Entire Network Review" HSD Upload Request Letter Each year, CMS will issue the "Notice of Entire Network Review" HSD upload request letter, to organizations that are due for their contracts' triennial network review, and CMS will continuously track contracts' triennial network review dates in an HPMS report. The attached letter includes minor revisions based on public comments received during the 30-day comment period, as discussed in section 8 above and in our attached response document.

13. Capital Costs

We do not anticipate additional capital costs for organizations. CMS requirements do not necessitate the acquisition of new systems or the development of new technology to complete HSD tables.

All organizations already possess the capabilities to comply with this collection of information. System requirements for submitting HSD tables are minimal, and organizations must already be able to interface with HPMS to obtain a contract and to submit annual bids, for example. Organizations already have the following access to HPMS: (1) Internet or Medicare Data Communications Network (MDCN) connectivity, (2) use of Microsoft Internet Explorer web browser (version 5.1 or higher) with 128-bits encryption, and (3) a CMS-issued user ID and password with access rights to HPMS for each user within the organization who will require such access. CMS anticipates that all organizations currently meet these system requirements and will not incur additional capital costs.

14. Cost to Federal Government

As CMS makes the procedural change to move the network review out of the MA application and into this triennial review, we are shifting the annualized cost to the federal government from the information collection entitled Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits (OMB control number: 0938-0935) to this New information collection request.

To derive average costs, we used data from the U.S. Office of Personnel Management's 2017 Salary Table for the Washington-Baltimore-Northern Virginia locality (https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2017/DCB_h.pdf). This is an update from last year's OMB #0938-0935, which used the 2016 table. We selected the positions of Central Office Health Insurance Specialist/Regional Office Account Manager because the primary review of networks is the responsibility of both Central and Regional Office staff, which are usually at the GS-13 level with these occupation titles.

The following table presents the hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage. As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative, and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Hourly Wage Rate

Occupation Title	Grade/Step	Hourly Wage	Fringe Benefit	Adjusted Hourly Wage
Central Office Health Insurance Specialist/Regional Office Account Manager	13/5	$51.48	$51.48	$102.96

With this adjusted hourly wage and the projected hours estimated from OMB #0938-0935, the table below presents the annualized cost to the federal government for this information collection.

Projected Hours and Costs

CMS Staff	Projected Hours/Hourly Rate /# of Contracts	Projected Costs
Central Office Health Insurance Specialist/Regional Office Account Manager	20 hours x $102.96/hr x 304 Contracts	$625,996.80

15. Changes to Burden

CMS has moved the network review burden out of the information collection entitled Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits (OMB control number: 0938-0935) and into this New information collection request. In shifting the network review from one information collection to another, CMS also updated the burden estimates. The following table provides a summary comparison of burden estimates between *OMB 0938-0935* and *OMB 0938-New*. These changes to burden resulted because the burden estimates in *OMB 0938-0935* were incorrect, outdated, and did not account for all information collection instruments.

	OMB 0938-0935			OMB 0938-New		
Information Collection Instrument	Hour Per Response	Annual # of Responses	Annual Hour Burden	Hour Per Response	Annual # of Responses	Annual Hour Burden
Provider HSD Table	6	155	930	15	304	4,560
Facility	6	155	930	15	304	4,560

HSD Table						
Exception Request Template	3	155	465	8	728	5,824
Partial County Justification Template	N/A	N/A	N/A	37	12	444
HPMS Web-Based Application: NMM	N/A	N/A	N/A	1	304	304
TOTAL	**varies**	**465**	**2,325**	**varies**	**1,652**	**15,692**

16. Publication/Tabulation Dates

This collection of information will not publish results.

17. Expiration Date

CMS is not requesting an exemption from displaying the expiration date. The expiration date is displayed on the Provider HSD Table, the Facility HSD Table, the Exception Request Template, the Partial County Justification Template, and the HSD Instructions. The expiration date and PRA Disclosure Statement are displayed on the "Notice of Entire Network Review" HSD Upload Request Letter. We are displaying the PRA Disclosure Statement solely on the letter and not on the other documents because this letter is the first document the organization receives from CMS. It introduces the information collection request, the reason for the request, and the process for submitting network information to CMS. The letter references all of the information collection instruments as well as the website where organizations are required to submit their HSD tables (the NMM in HPMS). We are looking into the feasibility of adding the PRA Disclosure Statement to the NMM website also.

18. Certification Statement

There are no exceptions to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submissions," of OMB Form 83-I.

B. Collection of Information Employing Statistical Methods

There will be no statistical method employed in this collection of information.