Responses to 30-day Comments Received
Federal Register Notice on Revised CMS-10636:
Three-Year Network Adequacy Review for
Medicare Advantage Organizations and 1876 Cost Plans

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, "Three-Year Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans."

CMS received 13 comment letters on the July 19, 2017, 30-day notice Three-Year Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans (0938-New, CMS-10636). The commenters included: American College of Mohs Surgery, America's Health Insurance Plans, BlueCross BlueShield Association, Fallon Health, Health Care Service Corporation, Humana, Justice in Aging, Medicare Cost Contractors Alliance, Medicare Rights Center, Molina Healthcare, SNP Alliance, UCare, and UnitedHealthcare.

Some comments were resubmitted or duplicative of comments received during the 60-day comment period. These included comments on the exception request process, burden estimates, CMS transparency, implementation flexibility, and significant network changes. Note, CMS's responses to these repeated comments have not changed and are located in the 60-day response document.

Regarding other 30-day comments, the majority of commenters supported this new information collection, expressing positive feedback on CMS's more standard, fair approach to network adequacy compliance monitoring. Some commenters expressed more concern about the burden estimates and the provider/facility supply file. CMS understands their concerns, but is confident in its estimations and approach to the supply file. As CMS removes network reviews from the application process, it will continue to make policy and procedural improvements surrounding the supply file and other aspects of network oversight. Several other commenters posed questions about the network review timeline and details, and CMS has provided clarification below. CMS will consider all questions and recommendations as it solidifies the operational, policy, systems, and other details surrounding this information collection. CMS is currently discussing these details internally and will release more guidance to the industry as soon as possible.

COMMENTS

General Comments:

Comment: Eight commenters supported CMS's proposal. One believed, if implemented appropriately and in an equitable manner among all contracts, this process will permit CMS to take a more balanced and uniform approach to evaluating and determining organization compliance with network adequacy requirements, as all contracts will be subject to the three-year review cycle. Another commenter urged OMB to approve this proposed collection of information. One commenter said that eliminating the network review from the application process helps to reduce the overall annual burden on CMS and organizations.
Response: CMS appreciates the positive feedback and support. CMS will strive for appropriate, equitable implementation of this information collection.

CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter questioned whether this three-year network review system is necessary.
Response: CMS believes the three-year network adequacy review cycle is necessary in order to apply a consistent process for conducting oversight and monitoring of networks. The new three-year review cycle will put all organizations on a level playing field by requiring them to submit their networks to CMS for review on a more regular basis than under current policy.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: Two commenters expressed concern about the removal of the network review from the application process. They believed review of network adequacy should remain an essential part of the new contract application process, even if tri-annual review of the entire network is implemented.
Response: CMS appreciates the concern and would like to clarify that this is simply a procedural change, and an organization's first review would occur after their application is conditionally approved, but prior to the start of the first year in which the plan is offered. This gives new plans and existing plans that are expanding their service area additional time to secure a compliant network prior to the start of the year. CMS will give careful thought to the compliance approach when an initial applicant is found to have network deficiencies or when an existing applicant applying for a service area expansion has deficiencies. CMS is currently discussing these details internally and will release guidance to the industry as soon as possible.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter said that the addition of a three-year network review imposes undue burden on organizations when they are already required to notify their CMS account manager of network deficiencies.
Response: In its monitoring of network adequacy, CMS cannot solely rely on organization-disclosed network deficiencies. CMS requires a consistent process for conducting regular oversight and monitoring of networks, and this new three-year review cycle will be the avenue for that requirement.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter suggested CMS use Complaints Tracking Module (CTM) and grievance data to identify organizations with access issues and target them for network reviews instead of implementing the three-year review cycle.
Response: CMS agrees that beneficiary complaints about access issues can be used to prompt a network review. CMS currently uses existing CTM data to identify network access complaints, which is one of the identified triggering events. However, this proposed information collection will ensure a standard review process for all organizations and CMS to confirm organization compliance with network adequacy criteria.

CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter noted that this information collection will require a great deal of time and effort for organizations every three years, while there is already sufficient network guidance in place and triggers to generate a review. The commenter noted that the seven triggering events provide CMS with sufficient opportunity to monitor network adequacy without adding additional work for organizations. In addition, two of the triggering events (Potentially Significant Provider/Facility Contract Termination and Organization-Disclosed Network Deficiency) require more specificity and possibly discussion with the industry.
Response: A significant portion of current contracts have not experienced a triggering event nor previously applied for a service area expansion (SAE) in recent application cycles, and therefore have not had their networks reviewed by CMS since their initial application. For example, in the Supporting Statement, CMS estimated that 304 out of 484 contracts never received an entire network review between June 2015 and June 2016. If this information collection is approved, then CMS could prevent undetected network deficiencies and possible beneficiary harm. In addition, CMS is reducing organization effort by removing network reviews from the application and modifying how it has operationalized network reviews based on triggering events. Per the Supporting Statement, each time a contract undergoes an entire network review for any of the triggering events, the three-year network review anniversary date for that contract will be reset. In terms of the two triggering events mentioned, CMS will consider additional discussion with the industry about these two events. However, organizations also may submit any specific questions to the Medicare Part C Policy Mailbox, located at: https://dpap.lmi.org.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: Three commenters expressed concerns about the burden estimates for this information collection. One commenter noted that the burden estimates may understate the costs of network reviews and recommended that CMS engage with organizations to ensure the best possible burden estimate. Another commenter encouraged CMS to incorporate a reasonable assessment of the costs associated with technology upgrades and maintenance costs related to the management and collection of this information.
Response: CMS considered the feedback from organizations concerning the methodology for estimating the hour burden for submitting Health Service Delivery (HSD) tables and Exception Requests to CMS, but after further review of its internal process, CMS is confident in its estimation. There may be minimal burden associated with this change for those contracts that have never expanded beyond their original footprint or experienced an event that would trigger a full network review since they joined the program. 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 three-year anniversary. With regard to burden on the federal government, as CMS makes the procedural change to move the network review out of the application and into this three-year review, CMS has simply shifted the annualized cost to the federal government from the application PRA package to this new PRA package. Therefore, no new cost to CMS has been added.
CMS Action: CMS has not revised any requirements or burden estimates as a result of this comment. CMS has revised the Supporting Statement to clarify its approach for SAEs.

Comment: One commenter inquired as to when CMS would release for comment draft documents related to network submission. They requested the opportunity for organizations to review and comment on proposed network submission guidance, including HSD instructions, HSD tables, the Exception Request Template, and the network adequacy criteria guidance, before they are released in final form. The commenter asked when CMS plans to update and release these documents since they will no longer be linked to the application. In addition, the commenter asked when CMS plans to release the HSD Reference File and when it will be effective.

Response: Through both the 60-day and 30-day comment periods for this proposed information collection, CMS has already provided organizations with the opportunity to review and comment on the Provider HSD Table, Facility HSD Table, Exception Request Template, Partial County Justification Template, and "Notice of Entire Network Review" HSD Upload Request Letter. The network adequacy criteria guidance document, which includes the HSD instructions, will be updated outside of this information collection package. Once OMB approves this information collection, CMS will update the comprehensive guidance document to reflect the new changes in network adequacy requirements. CMS does not anticipate releasing this document for public comment. With regard to the HSD Reference File, CMS anticipates releasing this document in January 2018 after the network adequacy criteria has been updated.

CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Timeline/Process Comments:

Comment: Five commenters inquired about the network review timeline. One recommended that CMS confirm when it will begin the network adequacy reviews under the revised approach as well as when CMS will send the HSD upload request letters to organizations. The commenter encouraged CMS to establish a timeline that avoids early year implementation. Another commenter requested that CMS release a proposed timeline for network reviews based on initial or SAE applications. They proposed specific timeframes for review, grace periods, and lead-time for changes. Another commenter suggested CMS include guidance on the submission schedule as part of the annual Call Letter.

Response: 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 three-year anniversary, unless in the intervening time, another triggering event required CMS to initiate an entire network review. Previously, 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 (i.e., entire networks for initial applicants and new service area networks for SAE applicants). Currently, they only have the length of the application review cycle (traditionally February through May before the first year of operation) to establish their networks before they are subject to CMS review. Applicants would be reviewed in the year in which the application was approved, regardless of where the contract was in its three-year cycle before the application.

In addition, initial applicants would undergo their first entire network review, and CMS would request the next review at least three years later. 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.
CMS Action: CMS has not revised any requirements or burden estimates as a result of this comment. CMS has revised the Supporting Statement to clarify its approach for SAEs.

Comment: One commenter suggested that CMS clarify how organizations would be chosen for the network review should they have already had a review in the last three years in the application. Similarly, another commenter specifically recommended that CMS exempt contracts submitted in the CY 2017 and CY 2018 applications from the first year of review, and then incorporate these contracts into the three-year cycle if they are not subject to their review sooner based on a triggering event.
Response: Per the Supporting Statement, for the first year of data collection, CMS will review the networks of all organizations with contracts that have not received an entire network review in the previous 12 months. This will be the starting point for those contracts, which will then be subject to their next entire network review by CMS three years later (i.e., if the contract does not have a triggering event sooner than the three-year mark). The remaining contracts would be subject to their entire network review three years after the corresponding date within 12-month period when they last received an entire network review (i.e., if the contract does not have a triggering event sooner than the three-year mark). This is the approach CMS had planned to take as outlined in the Supporting Statement, however, it will consider the commenter's recommendations as discussion continues on operational, policy, and systems concerns.
CMS Action: CMS has not revised any requirements or burden estimates as a result of this comment. CMS has revised the Supporting Statement to clarify that it may reassess its methodology for selection of contracts for the first year of data collection.

Comment: One commenter requested that CMS account for recently conducted full network reviews. They also recommended that CMS coordinate these network reviews with other audit activities to ensure that there are no simultaneous audits and that organizations have adequate preparation time.
Response: CMS will account for recently conducted full network reviews and will coordinate with the audit team as necessary. Per the Supporting Statement, "organizations will have at least 60 days to prepare their HSD tables and test their networks prior to the CMS-specified deadline."
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter requested clarification on whether applicants will still have the option to withdraw expansion counties when their currently contracted network does not meet the criteria. They supported retaining this expansion and new county contract exit mechanism for network reviews triggered by applications and recommended at least two correction periods to correct network deficiencies. In addition, the commenter requested clarification on whether final exception determinations will be followed by an opportunity for the organization to correct or withdraw from a proposed initial or SAE application.
Response: CMS will consider this comment as it develops the details surrounding this information collection.

CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter requested that if an organization has more than two contracts due for a review in the same year, CMS stagger this process over the course of a submission window.
Response: CMS will consider this comment as it develops the details surrounding this information collection.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter asked whether CMS will perform a full contract network review or a network review of only expansion counties for an SAE application. Similarly, for an Initial Offering of a Provider-Specific Plan (PSP), they asked whether CMS will perform a full contract network review or a network review of only the PSP network. Finally, they asked whether CMS will no longer require existing PSPs to file either the full contract network or the PSP network for CMS review on an annual basis to obtain approval of an existing PSP.
Response: CMS appreciates the commenter's questions. CMS will perform a network review of only expansion counties for an SAE application. However, this review will take place after the application is approved, but before the start of the year. Note that the entire network review would occur at the contract's three-year anniversary. With regard to PSP network reviews, CMS is still discussing the details internally and will release guidance to the industry as soon as possible.
CMS Action: CMS has not revised any requirements or burden estimates as a result of this comment. CMS has revised the Supporting Statement to clarify its approach for SAEs.

Comment: One commenter stated that if CMS determines that an organization is not in compliance with the network adequacy criteria, then there needs to be an opportunity for the organization to have a dialogue with CMS regarding the specific and detailed reasons why CMS determined the noncompliance. Unless CMS provides the organization with detailed information, including the specific data that CMS used to make the determination that there is a deficiency, it is very difficult for the organization to cure the deficiency
Response: As a reminder, CMS has made all materials used in network reviews publicly available, including the network adequacy criteria guidance, the HSD Reference File, and the provider/facility supply file. However, CMS will consider this comment in its development of a compliance protocol for this information collection. It is anticipated that an open dialogue between CMS and the organization will be more feasible due to the removal of the network review from the application process. CMS will release further guidance as soon as possible.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter asked CMS to clarify that the sequence of events is to submit the HSD table, receive the HSD table results, and then submit the Exception Request as needed. The commenter would also like to clarify that organizations would have at least 10 days after receipt of HSD table results before Exception Requests are due.

Response: CMS confirms that the stated sequence of events is correct. CMS is still determining the specific timeframe between receipt of HSD table results and the Exception Request deadline and will release further guidance as soon as possible.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Supply File Comments:

Comment: Three commenters discussed the provider/facility supply file and the "source of truth" required for populating HSD tables. One commenter noted that organizations frequently find that CMS's provider/facility supply file is not always up to date and lacks accuracy at any given time. They recommended that CMS make every effort to maintain the accuracy of the supply file. Another commenter indicated that CMS still lacks a clear process for correcting factual errors in the underlying provider data and methodologies or "source of truth." If CMS is using outdated data, it needs to be validated and then updated on an ongoing basis. In addition, CMS should consider publishing the supply file in advance, clarify its sources for data, and develop a more efficient process to allow organizations and providers to submit to CMS updated requests on attributes known to be vulnerable to inaccuracies (e.g., specialty type and address) without having to go through the exceptions process. Finally, CMS should collaborate with organizations to ensure the accuracy of provider data.
Response: Per the network adequacy criteria guidance, "given the dynamic nature of the market, the database may not be a complete depiction of the provider and facility supply available in real-time. Additionally, the supply file is limited to CMS data sources – organizations may have additional data sources that identify providers/facilities not included in the supply file used as the basis of CMS's network adequacy criteria. As a result, organizations should not rely solely on the supply file when establishing networks, as additional providers and facilities may be available. CMS uses the supply file when validating information submitted on Exception Requests. Therefore, CMS and its contractor may update the supply file periodically to reflect updated provider and facility information and to capture information associated with Exception Request submissions." This updated supply file and additional organization-provided information is used in the acquisition of the Exception Requests. As CMS makes the procedural change of removing network reviews from the application process, it will look to improve policies and procedures surrounding the supply file in order to increase efficiency and data accuracy.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter noted that the same factors that affect the accuracy of the supply file (e.g., provider death, relocations, retirements) also affect provider directory accuracy. If HSD tables are a means to verify the accuracy of a provider directory, then this is a concern. 100 percent accuracy is not realistic given ongoing changes in the provider community. Also, HSD tables are a subset of the provider directory and a finite snapshot in time, while the provider directory may be updated more frequently and will not match HSD tables 100 percent of the time.
Response: CMS currently allows organizations up to 30 calendar days to update provider directories, and organizations may determine the best method to ensure up-to-date directories.

CMS recognizes that an organization's HSD tables are a subset of a full provider directory, and the two may not align 100 percent of the time. However, each organization must provide accurate information to enrollees in its provider directory (42 CFR 422.111(a)(2)). Similarly, each organization must maintain a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served (42 CFR 422.112(a)(1)(i)).
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Exceptions Comments:

Comment: One commenter said that CMS's exceptions process lacks consistency and standardization. They recommended that CMS solicit industry comment on the operational aspects of networks reviews.
Response: CMS currently has a standard exception review process and reviews and responds to Exception Requests as consistently as possible across organizations. CMS has recently expanded its network adequacy criteria guidance to provide organizations with examples of valid and invalid exception rationale. CMS is also working to improve the deficiency language provided to organizations in order to increase transparency. CMS will consider soliciting industry comment on operational aspects of the network review, upon approval of this information collection. In the meantime, if there are questions on the standard process, organizations may submit questions to the CMS mailbox, located at: https://dmao.lmi.org.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter indicated that often there is not a recognition of county designation as "rural" or "urban," meaning the required number of providers/facilities might not reflect the availability of actual services in an area, sparking a CMS denial and exception request.
Response: Per the network adequacy criteria guidance, "the quantitative criteria take into account differences in utilization across provider/facility types and patterns of care in urban and rural areas." In addition, CMS has customized the network adequacy criteria to reflect the current availability of providers and facilities and to potentially reduce the burden associated with the preparation and review of Exception Requests. In rare instances, an organization may provide Exception Request rationale for not contracting with available providers because the pattern of care in a rural, micro, or CEAC[1] county is exceptionally unique and the organization believes their contracted network is consistent with or better than the original Medicare pattern of care. When validating a pattern of care rationale on an Exception Request, CMS may use and compare original Medicare claims data and Medicare Advantage (MA) encounter data through the Integrated Data Repository.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter suggested that CMS should establish a process in which it is able to provide specific feedback to the organization on network adequacy findings. If CMS denies an

[1] Counties with Extreme Access Considerations

Exception Request, CMS should specify the providers and/or facilities with which the organization must contract to meet the network adequacy requirements.
Response: CMS cannot dictate which providers an organization must contract with because CMS cannot assume the role of arbitrating or judging the bona fides of contract negotiations between an organization and available providers. However, in its deficiency codes, CMS will specify provider/facility names if the organization provides an invalid rationale on its Exception Request. All organizations should consult the supply file and other available data sources to identify providers available for contracting.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter referenced the Automated Criteria Check (ACC) report generated by the Network Management Module, which tells the organization whether the contract passed or failed the network review. The commenter expressed support for "the continued publication of this information" and recommended that CMS release the information at least twice annually.
Response: CMS would like to clarify that each ACC report is specific to each organization's contract that undergoes a network review and, therefore, is only viewable by that specific organization and CMS. CMS does not publish this information publicly and does not anticipate doing so in the future.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Special Needs Plans (SNPs) Comments:

Comment: One commenter noted it is unclear how three-year network reviews at the contract level will accommodate SNP-specific network reviews (discussed in the CY 2018 Call Letter), which may require plan-level reviews. CMS will need to develop operational mechanisms that allow for some plan-level variations to accommodate differences in relation to those special needs. They recommended that CMS look to the approach to population-specific network modification used by the Medicare-Medicaid Coordination Office (MMCO).
Response: CMS is still researching its development of SNP-specific network adequacy evaluations and is considering relevant policy and operational implications, including contract-level versus plan-level network reviews.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter recommended that CMS continue to move toward supply-based time and distance criteria that result in a more accurate review of local access for the targeted population, including removing the need for year-over-year exceptions in some counties.
Response: CMS is currently researching the development of population-specific (e.g., SNP-specific) network criteria as well as customizing the network adequacy criteria based on provider supply and previously granted exceptions. Network criteria customization inherently reduces the volume of exceptions needed. CMS updates and publishes the network adequacy criteria annually.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter suggested that CMS look for additional methods of improving administrative efficiency of the network approval process for SNPs. For example, CMS should clarify criteria for defining some provider types, enable improved communications by creating a mailbox specific to network questions, adequately staff network review functions, and provide periodic training on the use of HPMS network modules and any process changes.
Response: CMS is committed to continuous improvement of network adequacy policies and procedures. CMS appreciates the feedback and will consider these recommendations.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter requested that in evaluating different SNP network standards, CMS emphasize flexibility and appropriateness, focusing for example on the locations of eligible beneficiaries relative to the locations of providers that serve them.
Response: CMS appreciates this comment and will consider the requested methodology in its research on SNP-specific network adequacy evaluations.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter strongly encouraged CMS to grant exceptions when all providers within the network adequacy criteria have been contacted, but do not participate in Medicaid. This circumstance is specific to the SNP exceptions process, as SNP populations are different than the general MA population. Not all providers accept Medicaid and therefore will not accept dual eligibles.
Response: CMS will consider this as it further researches SNP-specific network adequacy evaluations and exceptions processes.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Other Comments:

Comment: Two commenters mentioned telehealth and value-based contracting. One said that CMS should update its approach to network adequacy by accommodating more modern methods of service delivery, such as telemedicine, mobile clinics, and in-home delivery. In addition, CMS should consider how network criteria can support and be compatible with plan efforts to utilize value-based contracting tied to criteria for improved outcomes, costs, and quality of services. Another commenter suggested that CMS update the current exceptions criteria and process to include, for example, exceptions that will encourage the use of higher value providers and those that incorporate the use of telehealth services.
Response: CMS appreciates these suggestions and agrees on the importance of considering modern methods of service delivery. CMS is currently looking into telemedicine flexibilities with regard to network adequacy, as well as other factors that may impact population-specific network criteria. This information collection would not modify the current exceptions criteria and process. However, CMS will consider these comments as it continues to develop and refine its exceptions policy and operations.

CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter asked that CMS look especially at network adequacy where plans use delegated models, in which they provide per-member, per-month fees to independent physician associates or physician provider groups. CMS should require that each delegated network fully meet network adequacy standards.
Response: The commenter is referring to sub-networks. Per the network adequacy criteria guidance, "a plan with sub-networks must allow enrollees to access all providers/facilities in the CMS-approved network for the plan's service area; that is, the enrollees may not be locked in to the sub-network." CMS will consider clarifying its guidance on sub-networks to ensure that enrollees' rights to adequate access are protected.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter had several questions regarding the network adequacy criteria for home health, durable medical equipment, transplants, and orthotics and prosthetics. These questions were specific to the criteria and not related to this proposed information collection.
Response: CMS recommends that the commenter submit their specific questions to the CMS mailbox, located at: https://dmao.lmi.org.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter was concerned with organizations' move toward "narrow networks." They suggested that CMS expand its network adequacy requirements to ensure beneficiary access to specialists and subspecialists.
Response: This information collection would not modify the current network adequacy criteria. However, CMS will consider this comment as it updates the criteria.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter referred to their recommendation regarding network adequacy in their recent response to CMS in the Request for Information on improvements in MA and Part D. They indicated that their response might be applicable to this new information collection.
Response: CMS appreciates the comments and is continuously reviewing its policies and procedures surrounding network adequacy.
CMS Action: CMS has not revised any requirements, documents, or burden estimates as a result of this comment.

Comment: One commenter requested that in the guidance for this information collection, CMS adopt nomenclature that clearly identifies requirements that are applicable to Medicare cost plans. It has been an ongoing challenge understanding which requirements explicitly identified as applying to the MA program also apply to the Medicare cost plan program.
Response: CMS agrees and will revise the necessary documents accordingly.

CMS Action: CMS has not revised any requirements or burden estimates as a result of this comment. However, CMS has revised the Supporting Statement and the following information collection instruments/instructions:

- Exception Request Template, and
- Notice of Entire Network Review HSD upload request letter.