Responses to Comments Received
Federal Register Notice on CMS-10636:
Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans

CMS received comments from three organizations on the April 7, 2020, notice on the renewal for the collection, *Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans*. The commenters were HealthPartners, Kaiser Permanente and UnitedHealthCare.

Timeframes: Three commenters referenced the timing of triennial network reviews. Several commenters requested that CMS send out the HSD upload request letters earlier, giving MAOs as much advance notice of their qualification for a network review as possible. Some commenters requested that CMS establish a formal timeline for formal network reviews. One commenter ask that CMS update the Reference Files and Supply Files in October prior to Consultation. One commenter asked that CMS provide advance notice when a new template is released.

CMS Response: CMS agrees that the reference file and supply file should be made available to plans earlier. CMS provides plans selected for triennial notification formal notice in January giving plans the opportunity to participate in an informal review process to prepare. Plans are also given notification that triennial reviews will occur in June.

CMS Action: CMS will communicate timeframes of upcoming reviews and submission deadlines to plans through both their CMS Account Managers, and via HPMS as soon as those details are available. CMS will release the updated reference files, supply files and Sample Beneficiary Files to plans as soon as they are updated, so that plans can adequately prepare.

Methodology: Two commenters asked CMS to clarify the methodology used in triennial reviews. Both commenters requested that CMS clarify compliance actions taken by CMS after reviews are completed and asked for clarity around exception dispositions. One commenter asked CMS to clarify the expectations for Service Area Expansion (SAE) applications as part of the review process.

CMS Response: CMS has revised the *Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance* to reflect the policies codified in CMS-4190-F1. We have also revised Section 3.1 Triggering Events, Section 3.2 Timing of Network Adequacy Reviews and Section 4 Exceptions to Network Adequacy Criteria, to clarify network adequacy review processes.

CMS Action: CMS has updated the *Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance* to clarify the expectations for SAE applications during network reviews. CMS allows plans a second opportunity to cure deficiencies during triennial network review. During this time organizations may re-submit denied exceptions and include additional information for review.

Exception Requests: Three commenters discussed exception requests and made recommendations or asked questions. Two commenters requested that plans be given an additional opportunity for feedback during the formal review exception period. One commenter suggested CMS reformat the Exception Request template and post it in a Word document or Excel Spreadsheet format.

CMS Response/Actions: CMS has revised the format for the Exception Request Template. The new template allows for plans to select "Provider contracts exclusively with another organization" under the "Reasons for Not Contracting" drop-down.

CMS has revised the Supporting Statement to include the above Exception Request Template clarifications, and has replaced the information collection instrument "Exception Request Template" with the current version. CMS has programmed an error return code in the Exception Request Template pdf, whereby if a plan attempts to enter a specialty code that is not captured on HSD tables, they will not be able to complete the remainder of the field. As a result, CMS will continue to provide the template in pdf format.

Document Formats: One commenter suggested changes to CMS reference documents. The commenter requested that the Provider Supply File include the last update date and information regarding sources. The commenter also requested that CMS provide the updated HSD tables that include a column specific to Regional Preferred Provider Organizations (RPPOs).

CMS Response: CMS appreciates the comments regarding Regional Preferred Provider Organization HSD table submissions and has updated the table accordingly. The provider and facility HSD tables included in this package have been updated to include a column where RPPOs must select "yes" or "no" if the RPPO provided exceptions to the written agreement. CMS includes the last update date for every public use file document posted to HPMS, details regarding the sources of providers and facilities listed has been codified in the *2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program* Rule CMS-4190-F.

CMS Actions: CMS has included the most recent versions of the HSD tables in the 30-day Notice.

Language Revisions: Three commenters made suggestions regarding language revisions or the inclusion of language to the Supporting Statement. Commenters also requested CMS align language in the PRA package to the Final Rule and include clarifications regarding RPPO's.

CMS Response/Actions: CMS has revised the Supporting Statement to include language specific to RPPO's and the informal review period. CMS has also included references to the codified Network Adequacy Standards in the Supporting Statement.

Burden Estimates: One commenter noted that CMS may have significantly underestimated the hour burden for information collection due to the way CMS posed the questions and aggregated

the results of the responses received. The commenters felt that the median number of hours for each information collection instrument may not be representative of the true effort.

CMS Response: CMS understands the concerns about the methodology for estimating the hour burden for HSD tables and Exception Requests. CMS sampled MAOs with various contract sizes and therefore varying numbers of counties included in the HSD tables and the number of Exception Requests. As a result, and noted in section 12.4 of the Supporting Statement, 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. If CMS had used the mean number of hours for HSD tables and Exception Requests, then the data would have been significantly skewed and not representative of the actual MAO hour burden for these tasks.

CMS Action: As a result of an additional column to the Provider and Facility HSD tables, CMS has increased the estimated hours per response from 15 hours to 16 hours. This change is only applicable to Regional Preferred Provider Organizations, who are required to select Yes or No to "Exceptions to the Written Agreement".

Comments Outside of the Scope of This Collection: Two commenters submitted comments outside of the scope of this collection. One commenter recommended that CMS provide sources for the provider and facility supply file. One commenter asked for clarification regarding withdrawing pending counties prior to formal network reviews.

CMS Response: Data sources used in the provider and facility supply file are referenced in 42 CFR 422.116 (A), the date the last file was updated is included with every public use file posted to the HPMS guidance website. CMS requires all MAOs to submit drop county requests by the bid deadline, which is the first Monday in June each year.
CMS requires that organizations maintain a network of appropriate providers that is sufficient to provide adequate access to covered services and meets the needs of the enrollees at all times. Applicants that are found deficient during their formal network review have until the contract is operational to resolve network failures. If organizations are still deficient, they may be subject to compliance actions.

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