Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance

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1. Introduction

The Centers for Medicare & Medicaid Services (CMS) regulations at 42 C.F.R. 417.414, 42 C.F.R. 417.416, 42 C.F.R. 422.112(a)(1)(i), and 42 C.F.R. 422.114(a)(3)(ii) require that all Medicare Advantage (MA) organizations offering coordinated care plans (CCP), network-based private fee-for-service (PFFS) plans, 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[1]. These organization types must provide enrollees health care services through a contracted network of providers that is consistent with the prevailing community pattern of health care delivery in the network service area (see 42 C.F.R. 422.112(a)(10)).

On June 2, 2020, CMS published MA and Cost plan network adequacy rules at 42 C.F.R. 422.116 to codify our existing network adequacy methodology and finalize policies that address maximum time and distance standards in rural areas, telehealth, and Certificate of Need (CON) laws. The standards identified at § 422.116 define how CMS quantifies prevailing community patterns of health care delivery for each provider and facility specialty type in each county in a service area.

On January xx, 2022, CMS published proposed revisions at 42 C.F.R. § 422.116 [Link] which would establish the requirement beginning for contract year 2024, that applicants for a new or expanding service area must demonstrate compliance with network adequacy standards as part of an MA application and that CMS may deny an application on the basis of an evaluation of the applicant's network.

The purpose of this document is to provide additional information related to network adequacy reviews and how they are conducted in accordance with the standards set at § 422.116. Please note that the guidance contained in this document does not apply to the following product types: Medicare/Medicaid Plans (MMPs), section 1833 cost plans, non-network PFFS plans, and MSA plans.

2. Network Adequacy Requirements

Organizations must meet current network adequacy requirements as defined under 42 C.F.R. 422.116[2] [3] CMS requires that organizations continuously monitor their contracted networks throughout the respective contract year to ensure compliance with the current network adequacy criteria.

CMS network adequacy criteria includes provider and facility specialty types that must be

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[1] MA regional preferred provider organizations (RPPOs) are an exception and, under specified conditions and upon CMS pre-approval, can arrange for care in portions of a regional service area on a non-network basis (42 C.F.R. 422.112(a)(1)(ii)).

[2] The term "organization" used throughout this document refers to both MA organizations and section 1876 cost organizations.

[3] Provider-Specific Plans (PSPs) are also subject to CMS network adequacy requirements. As part of the bid submission process that begins in June, an organization offering a PSP must confirm and attest that the PSP's network meets current CMS network adequacy standards.

available consistent with CMS number, time, and distance standards. Access to each specialty type is assessed using quantitative standards based on the local availability of providers and facilities to ensure that organizations contract with a sufficient number of providers and facilities to furnish health care services without placing undue burden on enrollees seeking covered services.

CMS programs network adequacy criteria into the Network Management Module (NMM) in the Health Plan Management System (HPMS) to conduct an automated review of an organization's network adequacy. CMS also provides organizations an opportunity to request exception(s) to the network adequacy criteria.

2.1. Specialty Types

CMS measures 27 provider specialty types and 13 facility specialty types to assess the adequacy of the network for each service area. CMS has created specific codes for each of the provider and facility specialty types which may be found in Appendix A. Organizations must use the codes when completing Provider and Facility HSD Tables. Additional information on specialty types and codes is available in the current HSD Reference File posted on CMS's website and in the Network Management Module HPMS User Guide.

2.2. Provider and Facility Health Service Delivery (HSD) Tables

Contracts are required to demonstrate network adequacy through the submission of provider and facility Health Service Delivery (HSD) Tables in the Network Management Module (NMM) in HPMS. An organization must list every provider and facility with a fully executed contract in its network in the HSD Tables[4]. Organizations can refer to the NMM Plan User Guide, sections "Specialty Types" and "Preparing Your Submission," for detailed instructions on populating HSD tables.

In order for the NMM to process the information, organizations must submit provider and facility names and addresses exactly the same way each time, including spelling, abbreviations, etc. Providers should be listed at the address(es) where they see patients in an office-based setting for consultations and not at a location where they solely perform procedures, (e.g. an orthopedic surgeon should be listed at his/her office location, not the hospital where he/she performs surgical procedures). Any differences will result in problems processing data and may result in network deficiencies. CMS expects all organizations to use the NMM to check their networks and to review the results to ensure that their provider and facility HSD Tables are accurate and complete.

The following providers and facilities do not count toward meeting network adequacy criteria:

- Specialized, long-term care, and pediatric/children's hospitals
- Providers that are only available in a residential facility.
- Providers and facilities contracted with the organization only for its commercial, Medicaid, or other products.

2.3. Provider and Facility Supply File

[4] RPPOs may list on their HSD tables those non-contracted providers and facilities for which they have a CMS pre-approved exception to the written agreement (42 C.F.R. 422.112(a)(1)(ii)).

The supply file is a cross-sectional database that includes information on provider and facility name, address, national provider identifier, and specialty type and is posted by state and specialtytype. The supply file is segmented by state to facilitate development of networks by service area.Contracts with service areas near a state border may need to review the supply file for multiple states, as the network adequacy criteria are not restricted by state or county boundaries. The current supply file is published in HPMS>Monitoring>Network Management>Documentation>Reference Files.

Given the dynamic nature of the market, the file is a resource and may not be a complete depiction of the provider and facility supply available in real-time. MA organizations remain responsible for conducting validation of data used to populate HSD tables, including data initially drawn from the supply file. MA 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 may update the supply file periodically to reflect updated provider and facility information and to capture information associated with exception requests.

3. Triennial Network Adequacy Reviews

CMS monitors network compliance by reviewing contract-level networks on a triennial basis. This requires each contract to upload its full network into the NMM in HPMS. For more information, please see the Office of Management and Budget (OMB)-approved information collection "*Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans*" (OMB 0938-1346, CMS-10636).

3.1. Triggering Events

CMS may perform a network review after specific triggering events. Triggering events include:

1. **Application:** Any organization seeking to offer a new contract or to expand their service area must demonstrate compliance with network adequacy requirements in the proposed service area at the time of such MA applications
2. **Significant provider/facility contract termination:** When a contract between an organization and a provider or facility is terminated, and CMS determines it to be significant, then CMS may request to review the network to ensure ongoing compliance with network adequacy requirements. For more information on significant network changes, please refer to chapter 4 of the MMCM.
3. **Network access complaint:** If CMS receives complaints from an enrollee, caregiver, or other source that indicates an organization is not providing sufficient access to covered health care services, CMS may elect to review the organization's contracted network.
4. **Organization-disclosed network gap:** CMS requires organizations to monitor their networks for compliance with the current network adequacy requirements. CMS requires organizations to notify their CMS Account Managers upon discovery that their network is out of compliance. Once notified, CMS may request that the organization upload its contracted network for CMS review.

CMS will provide organizations with specific instructions for submitting their contracted networks and identify a specific submission timeframe. **If an organization experiences a triggering event requiring a full network review, then the timing of that organization's subsequent triennial review may be reset.**

3.2. Timing of Network Adequacy Reviews

Prior to the formal triennial network review, CMS provides organizations the opportunity to upload their networks in the NMM for an informal review and technical assistance, also referred to as Consultation.

Applicants and contracts due for their triennial review will be prompted to upload their health service delivery (HSD) tables into the NMM as part of the application process, and in mid-June, respectively, for CMS review. Initial and service area expansion (SAE) applicants must upload their tables for the **upcoming** contract year, while organizations due for their triennial review must upload their tables for the **current** contract year.

CMS may deny an organization's application if they fail to meet network adequacy requirements. Contracts that fail to meet network adequacy requirements during the contract year may be subject to compliance or enforcement actions.

3.3 Organization-Initiated Testing of Contracted Networks

Organizations with a contract ID number have the opportunity to test their contracted networks' compliance with network adequacy criteria at any time via the NMM in HPMS. Once an organization initiates its HSD table upload, the NMM will automatically review the contracted network against CMS network adequacy criteria for each required provider and facility type in each county.

Organizations can refer to *Organization Initiated Submissions* section in the NMM User Guide for detailed instructions on how to submit an Organization Initiated Upload, and *ACC Extracts* section for instructions on how to view the Automated Criteria Check (ACC) report in HPMS. The ACC report displays the results of the automated network review for each provider and facility. The results are displayed as either "PASS" or "FAIL." The NMM also contains the *ZIP Code Report for Failed Counties* that lists the areas where enrollees do not have adequate access.

Organizations may find the ZIP Code Report for Failed Counties using the following navigation path: **HPMS Home Page>Monitoring>Network Management>ACC Extracts**.

4. Exceptions to the Network Adequacy Criteria

Although the time and distance standards vary by county and specialty type, and are generally attainable across the country, there are unique instances where a given county's supply of providers/facilities is such that an organization would not be able to meet the network adequacy criteria. The exceptions process allows organizations to provide evidence to CMS when the health care market landscape has changed or does not reflect the current CMS network adequacy criteria. The exceptions standards are outlined at 42 C.F.R. § 422.116(f).

The organization must include conclusive evidence in its exception request that the CMS network adequacy criteria cannot be met because of changes to the availability of providers/facilities, resulting in insufficient supply. The organization must then demonstrate that its contracted network (i.e., providers/facilities included on its HSD tables) furnishes enrollees with adequate access to covered services and is consistent with or better than the Original Medicare pattern of care for a given county and specialty type.

4.1. Criteria for Submitting Exception Requests

Generally, organizations use the exception process to identify when the supply of providers/facilities is such that it is not possible for the organization to obtain contracts that satisfy CMS's network adequacy criteria.

Per 42 C.F.R. § 422.116(f)(1), an MA plan may request an exception to network adequacy criteria when both of the following occur:

- Certain providers or facilities listed in the Provider Supply file are not available for the organization to meet the network adequacy criteria for a given county and specialty type.

The organization has contracted with other providers and facilities located beyond the limits in the time and distance criteria, but are available and accessible to most enrollees, consistent with the local pattern of care.

Valid rationales to submit exception request may include, but are not limited to:

- Provider is no longer practicing (e.g., deceased, retired).
- Does not contract with **any** organizations or contracts **exclusively** with another organization.
- Provider does not provide services at the office/facility address listed in the supply file.
- Provider does not provide services in the specialty type listed in the supply file.
- Provider has opted out of Medicare.
- Sanctioned provider on List of Excluded Individuals and Entities.
- Use of Original Medicare telehealth providers or mobile providers
- Specific patterns of care in a community

There are instances when CMS will consider an organization's reason for not contracting with an available provider/facility. For example, based on substantial and credible evidence, CMS will consider an organization's claim that an available provider may cause beneficiary harm. On the exception request, from the "Reason for Not Contracting" drop-down list, the organization must select "Other," and provide evidence in the "Additional Notes on Reason for Not Contracting" field.

On the exception request, from the "Reason for Not Contracting" drop-down list, an organization could select either "Provider does not contract with any organization" or "Other" if the provider/facility contracts exclusively with another organization. The organization must provide evidence in the "Additional Notes on Reason for Not Contracting" field.

An organization could provide substantial and credible evidence that an available provider is inappropriately credentialed under MA regulations (42 C.F.R. 422.204, Chapter 6 of the MMCM). On the exception request, from the "Reason for Not Contracting" drop-down list, the organization must select "Other" or "Provider does not provide services in the specialty type listed in the database and for which this exception is being requested," as appropriate. The organization must then provide evidence in the "Additional Notes on Reason for Not Contracting" field.[5]

[5] CMS will generally not accept an organization's unwillingness to contract with an otherwise qualified provider/facility due to the organization's own internal standards.

An organization could provide substantial and credible evidence that they use Original Medicaretelehealth providers or mobile health providers to fulfill network adequacy requirements.

For organizations using Original Medicare telehealth providers, services must meet the requirements for “Medicare telehealth services” under section 1834(m) of the Social Security Act (the Act) (e.g. provider types, eligible originating sites, geography, and currently approved list of Medicare telehealth services), as well as the requirements for “communication technology-based services” not subject to the section 1834(m) limitations (brief communication technology-based service/virtual check-in, remote evaluation of pre-recorded patient information, and inter-professional internet consultation). The organization must demonstrate that it meets all applicable requirements.

If an organization uses Mobile Providers (e.g., mobile x-ray suppliers, orthotics and prosthetics mobile units), they must be qualified and furnish services in a scheduled manner.
Organizations requesting an exception using the “Pattern of Care” rationale should provide substantial and credible evidence that shows there is an insufficient supply of providers/facilities, as well as why they do not contract with available providers/facilities. The organization must show that the pattern of care in the area is unique and the organization believes their contracted network is consistent with or better than the Original Medicare pattern of care.

On the exception request PDF, an organization must compare the non-contracted providers/facilities closer to enrollees in terms of time and distance to other providers/facilities that may be located farther away. From the “Reason for Not Contracting” drop-down list, an organization could select “Other” and then provide evidence in the “Additional Notes on Reason for Not Contracting” field that demonstrates that the organization did not contract with the available provider/facility because the organization’s current network is consistent with or better than the Original Medicare pattern of care. For this pattern of care rationale, CMS will consider the following in the “Additional Notes on Reason for Not Contracting” field:

- Internal claims data with an explanation that demonstrates the current pattern of care for enrollees in the given county for the given specialty type, or
- Detailed explanation that supports the rationale that the contracted network provides access that is consistent with or better than the Original Medicare pattern of care.

4.2. Standards for Evaluating Exception Requests

Per § 422.116(f)(2), in evaluating exception requests, CMS considers whether:

- The current access to providers and facilities is different from the HSD reference and Provider Supply files for the year;
- There are other factors present that demonstrate that network access is consistent with or better than the Original Medicare pattern of care (§ 422.112(a)(10)(v)); and
- Approval of the exception is in the best interests of beneficiaries.

Finally, CMS will generally not accept an organization’s assertion that it cannot meet current CMS network adequacy criteria because of an “inability to contract,” meaning they could not successfully negotiate and establish a contract with a provider/facility. The non-interference provision at section 1854(a)(6) of the Act prohibits us from requiring any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and

services or require a particular price structure for payment under such a contract. As such, we cannot assume the role of arbitrating or judging the bona fides of contract negotiations between an MA organization and available providers or facilities.

4.3. Exception Request Upload Instructions

Please refer to the NMM User Guide sections *How to Request Exceptions, How to Upload Documentation for Exceptions* and *How to Check the Status of an Exception Request* for detailed instructions on how to upload an exception.

Organizations must resubmit all previously approved exception requests whenever CMS requests an organization to upload its HSD tables. Organizations must use the current exception request template and submit the template in accordance with CMS communications. The current exception request template is located in *HPMS>Monitoring>Network Management>Documentation>Templates*

Organizations should submit supplemental documentation (e.g., maps, screenshots, letters) at end of the exception request template. For exception requests with more than 25 providers in *Part V: Table of Non-Contracted Providers* on the exception request template, organizations should submit two separate exception request PDFs to ensure that all provider rows are captured. In these cases, organizations should submit a second exception request PDF with the following naming convention: HXXXX_12345_001_Part 2.

5. Specific Circumstances

This section provides guidance on specific circumstances or flexibilities that may apply depending on the organization’s contracted network and service area.

5.1 Partial Counties

Organizations submitting networks for CMS review against the current network adequacy criteria may have full county service areas or partial county service areas.
If an organization offering a local MA plan has an approved partial county service area, it means that they have an approved exception to the CMS county integrity rule as outlined at 42 C.F.R. 422.2. Specifically, the inclusion of a partial county service area must be determined by CMS to be:

1) Necessary,
2) Nondiscriminatory, **and**
3) In the best interests of the beneficiaries.

CMS may also consider the extent to which the proposed service area mirrors the service area of existing commercial health care plans or MA plans offered by the organization.

Necessary

For CMS to determine that a partial county is necessary, an organization must be able to demonstrate that it cannot establish a provider network to make health care services available and accessible to beneficiaries residing in the portion of the county to be excluded from the service area.

The following examples illustrate how a local MA plan may have a health care network that is limited to one part of a county and cannot be extended to encompass an entire county.

- A section of a county has an insufficient number of providers or insufficient capacity among existing providers to ensure access and availability to covered services. For example, the organization can submit evidence demonstrating insufficient provider supply (e.g., list of non-contracted provider names/locations and valid reasons for not contracting).
- Geographic features (e.g., mountains, water barriers, large national park) or exceptionally large counties create situations where the local pattern of care in the county justifies less than a complete county because covered services are not available and accessible throughout the entire county. For example, the organization can demonstrate the geographic features or characteristics of the county using a clear, current map showing the barriers creating access issues.

The inability to establish economically viable contracts is not an acceptable justification for approving a partial county service area, as it is not consistent with CMS regulations. **CMS may validate statements made on the Partial County Justification**. However, CMS will consider an organization's justification for a partial county if a provider/facility either:

- Does not contract with **any** organizations, or
- Contracts **exclusively** with another organization.

CMS will consider these two justifications if the organization provides substantial and credible evidence. For example, an organization could submit letters or e-mails to and from the providers' offices demonstrating that the providers were declining to contract with any MA organization; thus no MA organizations could be offered in the area in question. Where this evidence is present, CMS would consider this information when reviewing the partial county request.

Nondiscriminatory

In order for CMS to determine if a partial county is nondiscriminatory, an organization must be able to demonstrate the following:

- The anticipated enrollee health care cost in the portion of the county it proposes to serve is comparable to the excluded portion of the county. For example, the organization can demonstrate its anticipated cost of care (in the partial county area) by using data from the previous year of contracting, comparing the health care costs of its enrollees in the excluded area to those in the area of the county it proposes to serve; **and**
- The racial and economic composition of the population in the portion of the county it proposes to serve is comparable to the excluded portion of the county. For example, the organization can use current U.S. Census data to show the demographic make-up of the included portion of the county as compared to the excluded portion.

Note: The existence of other MA plans operating in the entire county may provide evidence to CMS that approving a partial county service area would be discriminatory.

In the Best Interests of the Beneficiaries
In order for CMS to determine whether a partial county is in the best interests of the beneficiaries, an organization must provide reasonable documentation to support its request. Examples of reasonable documentation include reliable and current enrollee satisfaction surveys, grievance and appeal files, utilization information, or other credible evidence.

5.1.1. Partial County Justification Submission Instructions

Organizations may request an exception to the county integrity rule at 42 C.F.R. 422.2 by completing and submitting a Partial County Justification. Organizations must submit separate justifications for each county in which the partial county is being requested. Organizations with **current** partial county service areas must resubmit their previously approved Partial County Justification(s) whenever CMS requests a network upload for those service areas in the NMM. Organizations must complete the Partial County Justification template in Appendix B and submit the completed template to CMS's website portal. If an organization with partial counties fails the network adequacy criteria in a certain area, then the organization may submit an exception request. Please see section 5 for information on exception requests.

5.1.2 Partial County Request in the Application Module

Organizations requesting partial county service areas for the first time (initial and SAE applicants) and organizations expanding a current partial county by one or more zip codes (when the resulting service area will continue to be a partial county) must submit their Partial County Justifications with their applications. For the Application Module, organizations must use the Partial County Justification template in HPMS and submit the template in accordance with CMS's application instructions defined in HPMS and available on our website. Please note that organizations expanding from a partial county to a full county do NOT need to submit a Partial County Justification template.

5.2. Regional Preferred Provider Organizations

Regional Preferred Provider Organizations (RPPOs) offer MA regional plans, which are a type of MA coordinated care plan. Unlike other MA coordinated care plans, 42 C.F.R. 422.2 defines the service area of an MA regional plan as one or more entire regions. Regions consist of one or more states as opposed to counties. The list of current RPPO regions is available on CMS's website.

Following successful HSD table uploads RPPOs will receive the automated results of their review as discussed in section 4. In the event that an RPPO's contracted network receives one or more failures on the ACC reports, the RPPO may submit an ER. However, unlike other organizations, the MA regulation allows RPPOs to request an exception to written agreements (i.e., operate by non-network means) in those portions of the regional service area where it is not possible to build a network that meets CMS network adequacy criteria.

5.2.1. RPPO-Specific Exception to Written Agreements

RPPOs have the flexibility under 42 C.F.R. 422.112(a)(1)(ii), subject to CMS pre-approval, to operate by methods other than written agreements in those areas of a region where they are unable to establish contracts with sufficient providers/facilities to meet CMS network adequacy criteria. RPPOs that use this RPPO-specific exception must agree to establish and maintain a

process through which they disclose to their enrollees in non-network areas how the enrollees can access plan-covered medically necessary health care services at in-network cost sharing rates (see 42 C.F.R. 422.111(b)(3)(ii) and 42 C.F.R. 422.112(a)(1)(ii)). As discussed in Chapter 1 of the MMCM, CMS expects that the RPPO-specific exception to written agreements will be limited to rural areas.

Please note that, while this flexibility exists, CMS expects that RPPOs will establish networks in those areas of the region when there are a sufficient number of providers/facilities within time and distance criteria available to contract with the RPPO.

1. When the RPPO contract is due for its CMS network review in the NMM, for the providers and/or facilities for which the RPPO is requesting exceptions to written agreements, the RPPO must (1) list these providers/facilities on its HSD tables, and (2) enter 'Y' under the column labeled 'RPPO-Specific Exception to Written Agreements.' This serves as the RPPO's official request to CMS for the RPPO-specific exception per 42 C.F.R. 422.112(a)(1)(ii).
2. The RPPO will receive information regarding the approval or denial of the RPPO request in CMS's formal network review notification.
3. If the RPPO receives CMS's approval to use methods other than written agreements to establish that access requirements are met, then the RPPO must follow all guidance pertaining to this RPPO-specific exception, including the attestations above.

Please note, any RPPO with a CMS-approved, RPPO-specific exception per 42 C.F.R. 422.112(a)(1)(ii) must resubmit its request whenever the RPPO contract undergoes a CMS network review in the NMM. In addition, if there is an indication of enrollee access issues, the RPPO's disclosure to enrollees residing in non-network areas is subject to CMS review as necessary (e.g., EOC and/or provider directory).

5.3 Sub-Networks

A sub-network occurs when the network provider group they join guides enrollee access to providers/facilities. Each provider group furnishes primary care and may furnish specialty and institutional care. For example, a plan with sub-networks has more than one provider group, and referrals by an enrollee's primary care provider (PCP) are typically made to providers/facilities in the same group.

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**.

If an enrollee wants to see a specialist within their plan's overall network, but that is outside of the referral pattern of their current PCP in a sub-network, then the plan can require the enrollee to select a PCP that can refer the enrollee to their preferred specialist. However, each plan must ensure that it has a network that meets current CMS network adequacy criteria.

5.4 Certificate of Need Credit

CMS's network adequacy requirements also account Certificate of Need (CON) laws, or other

anticompetitive restrictions, as described at 42 C.F.R. 422.116(d)(6). In a state with CON laws, or other state imposed anti-competitive restrictions that limit the number of providers or facilities in the state or a county in the state, CMS will either award the organization a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards for affected providers and facilities or, when necessary due to utilization or supply patterns, customize the base time and distance standards. CMS conducted extensive analyses to identify all counties and specialties where the CON credit is applicable and created a CON reference file. Networks submitted to the NMM will automatically be reviewed for the CON criteria and receive the credit as applicable. Please note, in accordance with § 422.116(d)(6), the 10% credit will not be applied if the county maximum time and distance standards are customized. For more information about customization, see § 422.116(d)(3).

If an organization determines there are additional county/specialty combinations that are not reflected in the CON reference file, they may request an exception related to the CON criteria and must provide substantial and credible evidence that a provider or facility type is adversely affected by a CON law. Organizations must use the current exception request template. Organizations should select "other" as the reason for not contracting on the exception request template and include supplemental documentation at the end of the PDF. Organizations can find the MA Exception template at the following navigation path: **HPMS Home Page>Monitoring>Network Management>Templates**

5.5 Telehealth Credit

Organizations will receive a 10% credit towards the percentage of beneficiaries that must reside within required time and distance standards when they contract with telehealth providers in the following specialties: Dermatology, Psychiatry, Cardiology, Otolaryngology, Neurology, Ophthalmology, Allergy and Immunology, Nephrology, Primary Care, Gynecology/ OB/GYN, Endocrinology, and Infectious Diseases.

Detailed technical instructions on reporting telehealth providers during a MA organization's network submission are outlined in the HPMS NMM Plan User Guide. Organizations can find the Plan User Guide at the following navigation path: **HPMS Home Page>Monitoring>Network Management>Guidance**.

5.6 New or Expanding Service Area Applicant Credit

On January xx, 2022, CMS published proposed changes [Link] to § 422.116. We understand that organizations may have difficulties with building a full provider network almost one year prior to being approved for an MA contract. Therefore, we proposed that beginning for contract year 2024, an applicant for a new or expanding service area will receive a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards for the contracted network in the pending service area, at the time of application and for the duration of the application review. If the application is approved, at the beginning of the contract year, the MA organization must be in full compliance with network adequacy standards and the credit would no longer apply.

Networks submitted in the NMM, by initial and SAE applicants, will automatically receive the credit as applicable.

Appendix A: Crosswalk of HSD Specialty Code to Provide and Facility Specialties

Provider Type Specialties

HSD Specialty Code	HSD Specialty Name	Medicare Specialty Codes Included
S03	Primary Care	General Practice (01) Family Practice (08), Internal Medicine (11), Geriatric Medicine (38)
007	Allergy and Immunology	Allergy/Immunology (03)
008	Cardiology	Cardiology (06)
010	Chiropractor	Chiropractic (35)
011	Dermatology	Dermatology (07)
012	Endocrinology	Endocrinology (46)
013	ENT/Otolaryngology	Otolaryngology (04)
014	Gastroenterology	Gastroenterology (10)
015	General Surgery	General Surgery (02)
016	Gynecology, OB/GYN	Obstetrics & Gynecology (16)
017	Infectious Diseases	Infectious Disease (44)
018	Nephrology	Nephrology (39)
019	Neurology	Neurology (13)
020	Neurosurgery	Neurosurgery (14)
021	Oncology - Medical, Surgical	Hematology (82), Hematology-Oncology (83), Medical Oncology (90), Surgical Oncology (91), Gynecological Oncology (98)
022	Oncology - Radiation/Radiation Oncology	Radiation Oncology (92)
023	Ophthalmology	Ophthalmology (18)
025	Orthopedic Surgery	Orthopedic Surgery (20), Hand Surgery (40)
026	Physiatry, Rehabilitative Medicine	Physical Medicine and Rehabilitation (25)
027	Plastic Surgery	Plastic and Reconstructive Surgery (24)
028	Podiatry	Podiatry (48)
029	Psychiatry	Psychiatry (26)
030	Pulmonology	Pulmonary Disease (29)
031	Rheumatology	Rheumatology (66)
033	Urology	Urology (34)
034	Vascular Surgery	Vascular Surgery (77)
035	Cardiothoracic Surgery	Thoracic Surgery (33), Cardiac Surgery (78)

Facility Type Specialties

HSD Specialty Code	HSD Specialty Name
040	Acute Inpatient Hospitals
041	Cardiac Surgery Program
042	Cardiac Catheterization Services
043	Critical Care Services – Intensive Care Units (ICU)
045	Surgical Services (Outpatient or ASC)
046	Skilled Nursing Facilities
047	Diagnostic Radiology
048	Mammography
049	Physical Therapy
050	Occupational Therapy
051	Speech Therapy
052	Inpatient Psychiatric Facility Services
057	Outpatient Infusion/Chemotherapy

Appendix B: Partial County Justification Template

Instructions: Organizations requesting service areas that include one or more partial counties must upload a completed Partial County Justification template into HPMS for each partial county in the organization's current and proposed service area.

This template is appropriate for organizations (1) offering a current partial county, (2) entering into a new partial county, or (3) expanding a current partial county by one or more zip codes when the resulting service area will continue to be a partial county. This template applies for any organization that has a partial county as part of its service area. Organizations must complete and upload a Partial County Justification for any active/existing partial county or pending/expanding partial county.

Organizations expanding from a partial county to a full county do NOT need to submit a Partial County Justification.

HPMS will automatically assess the contracted provider and facility networks against the current CMS network adequacy criteria. If the ACC report shows that an organization fails the criteria for a given county/specialty, then the organization must submit an exception request using the same process available for full-county service areas.

NOTE: CMS requests that you limit this document to 20 pages.

SECTION I: Partial County Explanation

The organization must provide CMS short description (two to three sentences) regarding why they are proposing a partial county service area.

SECTION II: Partial County Requirements
The *Medicare Advantage Network Adequacy Criteria Guidance* provides guidance on partial county requirements. The following questions pertain to those requirements.
The organization must explain how and submit documentation to show that the partial county meets **all three** of the following criteria:

1. **Necessary** – It is not possible to establish a network of providers to serve the entire county.
   Describe the evidence provided to substantiate the above statement and (if applicable) attach it to the template.
2. **Non-discriminatory** – The organization also must be able to demonstrate the following:

   - The anticipated enrollee health care cost in the portion of the county you are proposing to serve is comparable to the excluded portion of the county. Describe the evidence provided to substantiate the above statement and (if applicable) attach it to the template.

- The racial and economic composition of the population in the portion of the county the organization is proposing to cover is comparable to the excluded portion of the county.

  Describe the evidence provided to substantiate the above statement and (if applicable) attach it to the template.

3. **In the Best Interests of the Beneficiaries** – The partial county must be in the best interests of the beneficiaries who are in the pending service area. Organizations must describe the evidence substantiating the above statement and (if applicable) attach it to the template.

SECTION III: Geography

The organization must describe the geographic areas for the county, both inside and outside the proposed service area, including the major population centers, transportation arteries, significant topographic features (e.g., mountains, water barriers, large national park), and any other geographic factors that affected the service area designation.

Appendix C: External Links

- *CMS-10636 Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans (OMB 0938-1346)*
  https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202010-0938-003
- *CMS-4190-F Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program*
  https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf

- *CMS-4192-P Contract Year 2023 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Programs [Link]*

- *CMS Medicare Advantage Applications*
  https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index

- *CMS Medicare Plan Finder*
  https://www.medicare.gov/find-a-plan/questions/home.aspx

- *DMAO Portal*
  https://dmao.lmi.org/

- *Medicare Managed Care Manual:*
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326
  Chapter 4 Benefits and Beneficiary Protections
  Chapter 6 Relationships with Providers
  Chapter 11 Medicare Advantage Application Procedures and Contract Requirements

- *HPMS NMM User Guide:* instructions on how to populate and submit HSD tables and exception requests
  https://hpms.cms.gov ~ Monitoring ~ Network Management ~Guidance
- *HPMS NMM Reference Files:* MA Reference File and MA Supply File
  https://hpms.cms.gov ~ Monitoring ~ Network Management~ Reference File

- *HPMS NMM Templates*: Provider, Facility and Exception Templates
  https://hpms.cms.gov ~ Monitoring ~ Network Management~ Template