Supporting Statement – Part A
Triennial Network Adequacy Review for Medicare Advantage Organizations
and 1876 Cost Plans
(CMS-10636, OMB 0938-1346)

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 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 regulations at 42 CFR 422.116 outline 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. This 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.

CMS verifies that organizations are compliant with the CMS network adequacy criteria by performing a contract-level network review, which occurs when CMS requests an organization upload provider and facility Health Service Delivery (HSD) tables for a given contract to the Health Plan Management System (HPMS). CMS reviews 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.

Please note the following:

- Initial applications will require a full network review, and will need to demonstrate that they meet network adequacy standards at § 422.116 as part of an MA application
- Service area expansion (SAE) applications will require a partial network review of only new counties and will need to demonstrate that they meet network adequacy standards at § 422.116 as part of an MA application.CMS will review the full network during the contract's triennial review.
- Organizations due for their triennial review will submit HSD tables to CMS in June.

When selecting contracts for the triennial review period, CMS will pull from the list of active contracts, based primarily on when the contract's last full network review occurred in HPMS.

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.

Revisions to this 2022 collection of information consist of adding references to procedural changes made by CMS-4192-P (January 12, 2022; 87 FR 1842). The proposed rule changes would amend § 422.116 to require that applicants (initial and service area expansions) demonstrate that they meet the network adequacy standards for the pending service area as part of the MA application process. The Network Adeqaucy Guidance has been updated to reflect changes in the proposed requirements. While the

proposed changes carry no additional burden, we propose to adjust our cost estimates by using updated BLS wages figures.

A. Justification

1. Need and Legal Basis

This collection of information is authorized under the statute Section 1852(d)(1) of the Act and 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) and (e):

§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.

(e) *Standard: Accessibility and continuity*. (1) The HMO or CMP must ensure that the required services and any other services for which Medicare enrollees have contracted are accessible, with reasonable promptness, to the enrollees with respect to geographic location, hours of operation, and provision of after-hours service. Medically necessary emergency services must be available twenty-four hours a day, seven days a week.

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. Network adequacy is assessed at the county level and 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 for Large Metro and Metro county types and that at least 85 percent of enrollees within a county can access care within specific travel time and distance maximums for Micro, Rural and CEAC (Counties with Extreme Access Considerations county types.

Organizations will be required to demonstrate network adequacy through the submission of HSD tables in the Network Management Module (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.

Organization's offering telehealth benefits for any of the specialty types finalized in 422.116, will be required to select the applicable specialty on the NMM submission page in order to receive the credit towards network adequacy standards.

Regional Preferred Provider Organizations submitting provider or facility HSD tables, will be required to indicate if the provider has an alternative to written agreements. RPPOs must indicate Yes (Y) or No (N) for every row in 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). All other organization types may leave the column blank.

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. Organizations that do 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 *Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance.*

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. Organizations may submit new exception requests to CMS for consideration following the HSD table upload, and must resubmit all previously approved exception requests using the *current* template.

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 the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance for additional instructions.

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.

Organizations identified for the triennial reviewwill have at least 60 days to prepare their HSD tables and test their networks prior to the CMS-specified deadline . CMS provides organizations the opportunity to upload their networks in the Network Management Module during this time for an informal review and

technical assistance, also referred to as "consultation". This review is voluntary, and plans are not required to submit Exception Requests during this period.

Plans will be notified by their Account Manager and HPMS with instructions for submission of HSD tables in the NMM during this period. Plans will have the option to submit Exception Requests for feedback from CMS.

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.

Network submission gates in HPMS will remain open for at least 10 days of this period.

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

Organization's 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 occur, which may or may not be initiated by the organization. Due to the dynamic nature of MAO networks, we require plans to submit networks that capture their current networks.

Although there is similar information in the organization's ACC reports from prior network reviews performed by CMS during any of the triggering events, the information cannot be used or modified for the purposes of triennial network review because the information captures an organization's adequacy at a specific point in time. For all contracts, CMS has network adequacy information that was submitted at the time of an initial or SAE application, which may have 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.

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. Organizations may be operating out of compliance with program requirements, as their networks may not be adequate.

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

Serving as the 60-day notice, our proposed rule (CMS-4192-P, RIN 0938-AU30) filed for public inspection on January 6, 2022, and published in the Federal Register on January 12, 2022 (87 FR 1842). Comments are due on/by March 7, 2022.

Outside Consultations

As part of the initial burden estimate determination in 2017, 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 consulted with a sample of MAOs to determine the average hour burden on an organization for an entire network submission for a single contract. The sample survey included general questions around form completion time, including:

“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 submitted

a Partial County Justification in the 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 2020 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 BLS' mean hourly wage, our estimated cost of fringe benefits and overhead (calculated at 100 percent of salary), and our 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, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Compliance Officer	13-1041	36.35	36.35	72.70

12.2 Collection of Information Requirements and Associated Burden Estimates

CMS used HPMS data from the NMM 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 years. Between June 2018 and June 2019, CMS performed entire network reviews on 438 of the active contracts at that time.

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 of the triennial review cycle (140). However, this number will fluctuate each year depending on the number of applicants and how many contracts are due for a network review.

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 one.

Number of Respondents

	Local Coordinated Care Plan	Regional Coordinated Care Plan	1876 Cost Plan	Network-based PFFS Plan	Total # of Contracts
Estimated # of Network-Based Contracts	591	28	9	5	633
Expected # of Contracts for Year 1 (2018)*	128	1	8	3	140
Expected # of New Applicant Contracts	276	varies	varies	varies	276

* 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), CMS estimates that it will take organizations various numbers of hours to complete an entire network submission for one

contract. There will be approximately 140 respondents (existing contracts) for the initial information collection year and 276 respondents submitting networks as initial applicants. 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.

The Exception Request Template annual hour burden estimate remains unchanged with the addition of the rationale "Provider contracts exclusively with another organization" listed in the "Reason for Not Contract" drop-down and the change to the County/SSA Code, County Name, State, Specialty Code and Specialty Name fields. While this additional rationale selection may reduce burden for some plans, we do not believe that the reduction is significant enough to change the hour per response estimate. The change to the Exception Request Template fields will have minimal to no impact on the hour burden estimate. Plans will no longer be required to enter text into the County/SSA Code and Specialty Code fields but will still need to select values from a drop down list.

The Provider and Facility HSD Table annual hour burden estimate has increased from 15 hours per response to 16 hours per response. This adjustment factors in the "exceptions to the written agreement" column that is only applicable to Regional Preferred Provider Organizations (RPPO). In CY 2020, there were 28 active RPPO's. CMS expects a small number of RPPO's will be selected in the triennial review process who will be required to complete the data entry in the column.

On June 2, 2020 CMS finalized "Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program" CMS-4190-F1. MA plans will be eligible to receive a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards when they contract with telehealth providers in the specific provider specialty types. Plans must select the specialty for which telehealth is offered on the NMM submission page. We do not believe that this change is significant enough to increase the annual hour burden estimate previously provided for the "HPMS Web-Based Application: NMM" collection instrument.

Time Estimates

Information Collection Instrument	Hours Per Response	Total # of Responses per Year	Total Time (Hours) per Year
Provider HSD Table	16	416***	6,656
Facility HSD Table	16	416***	6,656
Exception Request Template	8	1,215*	9,720
Partial County Justification Template	37	32**	1,184
HPMS Web-Based Application: NMM	1	416	416
TOTAL	varies	2,495	24,632

* 1,215 exception requests were submitted during the CY2020 formal review. 1,732 exception requests were submitted during the CY2019 formal review. 726 exception requests were submitted during the 2018 formal review. We took the average of exceptions submitted during one triennial cycle to estimate the number of exceptions completed.
** 32 Partial County Justifications were submitted during the CY 2018-2019 application cycle, with an average of 16 justifications submitted per cycle. Therefore, we are using this estimate for the annual number of responses for the Partial County Justification Template.
*** Changes to the Provider and Facility HSD tables only impact Regional Preferred Provider Organizations.

In 2020, there were 28 active RPPO's that may be impacted by the change. This does not increase the number of annual responses, the hour per response has been adjusted to reflect the potential additional entry for RPPO's.

For each information collection instrument, the hour per response was multiplied by the adjusted hourly wage of $72.70 /hr. (see section 12.1, above) to determine the cost per response.

Cost Per Response

Information Collection Instrument	Hours Per Response	Hourly Wage	Cost Per Response
Provider HSD Table	16	$72.70/hr.	$1,163.20
Facility HSD Table	16	$72.70/hr.	$1,163.20
Exception Request Template	8	$72.70/hr.	$581.60
Partial County Justification Template	37	$72.70/hr.	$2,689.90
HPMS Web-Based Application: NMM	1	$72.70/hr.	$72.70

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 $1,706,381.36

Annual Cost

Information Collection Instrument	Cost Per Response	Total # of Responses per Year	Total Cost per Year
Provider HSD Table	$1,163.20	416	$483,891.20
Facility HSD Table	$1,163.20	416	$483,891.20
Exception Request Template	$581.60	1,215	$706,644.00
Partial County Justification Template	$2,689.90	32	$86,076.80
HPMS Web-Based Application: NMM	$72.70	416	$30,243.20
Total	Varies	2,495	$1,790,746.40

12.3 Information Collection Instruments

Provider HSD Table (No Changes)
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.

Facility HSD Table (No Changes)
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.

Exception Request Template (No Changes)
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.

Partial County Justification Template (No Changes)
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.

12.4 Information Collection Instructions/Guidance Documents

In addition to the 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.

Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance (Revised)
Changes to reference the proposed changes to 422.116 in CMS-4192-P have been added to the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance. That is, the proposed changes to require that organizations demonstrate they meet network adequacy standards at such time of any MA application for new or SAE.

Additionally, language to reference the proposed addition of 422.116(d)(7) was added to the guidance document. 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, the MA organization must be in full compliance with network adequacy standards and the credit would no longer apply.

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

To derive average costs, we used data from the U.S. Office of Personnel Management's 2022 Salary Table for the Washington-Baltimore-Northern Virginia locality (https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2022/DCB.pdf).

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 OPM's hourly wage, our estimated cost of fringe benefits (calculated at 100 percent of salary), and our 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, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Federal Wage Estimates

Occupation Title	Grade/Step	Hourly Wage	Fringe Benefits and Overhead	Adjusted Hourly Wage
Central Office Health Insurance Specialist/Regional Office Account Manager	13/5	$58.01/hr	$58.01/hr	$116.02/hr

With this adjusted hourly wage and the adjusted projected hours estimated from the 2017 approved iteration, 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 $116.02/hr. x 416 Contracts	$965,286.40

We estimate the projected hours for triennial network review to include: downloading HSD tables, ensuring contracts are in compliance with network adequacy standards, conducting outreach and delivering results to contracts.

15. Changes to Burden

Our January 12, 2022 (87 FR 1842) rule (CMS-4192-P, RIN 0938-AU30) proposes to amend § 422.116(a)(i)(ii) to require compliance with CMS' network adequacy standards for initial and service area expansion (SAE) applicants as part of the MA application process. Therefore, our proposal would require that initial and SAE provider networks be submitted and reviewed by the application deadline instead of June (with plans being reviewed for the triennial review). Consequently, the number of reviews and the amount of work is the same; rather, it is being re-distributed. The changes proposed by CMS-4192-P carry no additional burden. However, burden estimates have been updated to reflect current wages.

Changes to reference the changes proposed in CMS-4192-P have been added to the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance. No changes have been made to information collection documents as part of this update.

16. Publication/Tabulation Dates

This collection of information will not publish results.

17. Expiration Date

The expiration date and the PRA disclosure statement are displayed on the Provider HSD Table, the Facility HSD Table, the Exception Request Template, and the Partial County Justification Template.

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.