Medicare Advantage Network Adequacy Questions & Answers

General Network Adequacy

1. Does an organization have to credential a provider before they enter into a contract agreement?

Answer CMS expects organizations to follow the credentialing process described in 42 CFR 422.204 and in Chapter 6 section 60.3 of the Medicare Managed Care Manual (MMCM). Section 60.3 of the MMCM provides the procedures that an organization must follow when initially credentialing providers and determining that providers are eligible for a contract to provide health care services. Given that an organization can only list contracted providers on their tables, it also stands that those providers must also be credentialed as a pre-requisite to the existence of that contract.

2. Will CMS consider a "letter of agreement" as equivalent to a contract between an organization and a provider/facility?

Answer CMS will consider a “letter of agreement” between an organization and a provider/facility as equivalent to a contract for MA network adequacy purposes if the letter of agreement contains all of the elements described in Chapter 11 at section 100.4 - Provider and Supplier Contract Requirements of the MMCM.

3. What contract year must be reflected in a MAO’s network/service area submission for Initial, SAE, or Triennial reviews?

Answer All organizations submit their bids by the first Monday in June reflecting their assumed service area for the upcoming coverage year.

Initial and 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.

4. What is the timing for MAOs to withdraw pending counties from their application?

Answer CMS requires all MAOs to submit any drop county requests by the bid deadline, which is the first Monday in June each year.

CMS requires organizations to 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 to be deficient during their formal network review have until the contract is operational to resolve network failures. If

active contracts are deficient, they may be subject to compliance actions. Organizations must ensure access to specialty care by allowing enrollees to see out of network specialists at the in network cost sharing and may need to make alternate arrangements if the network of primary care providers is not sufficient to ensure access to medically necessary care.

Specialty Types

1. Home health, durable medical equipment, transplant programs, orthotics & prosthetics, and outpatient dialysis are not included in the HSD Reference File. Am I still obligated to contract for the services of these specialty types?

Answer Yes, organizations are obligated to ensure access to all medically necessary services for enrollees, including Medicare-covered home health, durable medical equipment, transplant programs, orthotics & prosthetics, and outpatient dialysis services. However, these specialties do not need to be included in your HSD table. Instead, in the application you will attest that your organization is able to provide adequate beneficiary access to the services furnished by these specialty types. Enrollee access to these services must be consistent with the community pattern of care for these services. That is, the enrollee access to services must be at least as good as the access that is available to enrollees in Original Medicare residing in the same area.

The network adequacy criteria in the HSD Reference File sets a baseline for minimum compliance and does not list every possible provider/facility specialty or subspecialty type, even though enrollees are entitled to coverage of care provided by those specialty types when medically necessary. Therefore, organizations are required to meet the requirements at 42 CFR 422.112 and 422.116 at all times. Additionally, per section 110.1.1 of chapter 4 of the MMCM and as specified in 422.116(a)(3), organizations must arrange for medically necessary care outside of the network, at in-network cost sharing, when network providers are unavailable or inadequate to meet an enrollee's medical needs. That is, if an enrollee requires a medically necessary covered service that is not offered by the providers in the network, then the organization must arrange for that service to be provided by a qualified non-contracted provider.

Health Service Delivery Table Uploads in HPMS

1. HPMS is showing a message that both of my tables have been "successfully uploaded" to the system. Does this mean that my submission will automatically be processed in HPMS?

Answer Not necessarily. Successfully uploading your tables is the first step. However, in order to for your tables to be processed, your submission must also pass the "unload" validation edits. The automated HSD validation process may take some time to complete, depending upon the size of your data tables and the number of other organizations submitting data at the same time. Consequently, CMS strongly urges organizations to submit your tables as soon as possible so that there is

sufficient time to complete the unload validation process, retrieve your results, and resubmit your tables if you encounter fatal unload errors.

2. What is the meaning of the "actual time" and "actual distance" fields on the ACC report?

Answer The "actual time" and "actual distance" values reflect the percentage of beneficiaries with access to at least one provider/facility within the required time or distance criteria.

3. Can you explain when a listed provider is included in the Minimum Number of Providers calculation?

Answer A submitted provider is included in the Number of Providers calculation when he/she is located within the prescribed time and/or distance of at least one sample beneficiary listed on the Sample Beneficiary file.

4. How is an address identified as a "duplicate" on the Address Information report?

Answer Providers are considered duplicates, whether they are at the same address or a different address, when they have:

- Same SSA state/county code
- Same provider code
- Same NPI number

***Note: When a different address is listed with the same SSA state/county code,** provider **code and NPI number combination, we will include the address in the calculation for "actual time" and "actual distance," but we will only count the provider once in determining the minimum number of provider's calculation.**

Facilities are considered duplicates when they have the:

- Same SSA state/county code
- Same facility code
- Same NPI number
- Same address**

****Note: A different address for a facility, even with the same SSA state/county code, facility code, and NPI number, is not considered a "duplicate."**

5. Can I list providers or facilities that are part of my network if their office is located outside of the service area?

Answer Yes. If those providers or facilities serve beneficiaries residing within the service area, you may list them in your HSD tables.

6. Is it appropriate to list hospital-based physicians on the Provider HSD Table, or must the provider have his/her own office outside the hospital in order to be listed on the Provider HSD Table?

Answer Hospital-based physicians that can be accessed by a typical Medicare beneficiary in the community may be listed on HSD tables. Hospital-based physicians that only provide care or consultation to inpatients or ER patients should not be included on the Provider HSD Table.

Exceptions

1. Can organizations submit exception requests as "placeholders" when they are in the process of negotiating a contract with a provider?

Answer CMS will not approve a "placeholder" exception request that indicates the organization is in the process of contracting with providers.

2. Is it a valid rationale for an exception if an organization does not contract outside state/county lines based on internal rules/procedures?

Answer No, the organization is still required to comply with current CMS network adequacy criteria, as all organizations are held to the same standards. The time and distance criteria are not limited to the county and/or state where the enrollees reside, and in fact, it is very common practice among the majority of organizations to contract with providers/facilities outside of their respective services areas.

3. If an organization believes an existing state law prohibits contracting with providers over state/county lines, can the organization submit an exception request?

Yes, if an organization believes a state law prohibits MA organizations from contracting with providers over state/county lines, then they need to identify the state and the relevant legislation and submit an exception request. Specifically, evidence in this case will include a reference to the state law that prohibits contracting with providers over state/county lines and documented assurance from a state representative that supports this interpretation. The organization should also provide the name of the state representative so that CMS can contact that person to validate the claim.

4. What is the difference between an exception request for "Original Medicare telehealth providers" and the telehealth "10% credit for Additional Telehealth Benefits"?

Answer **Original Medicare Telehealth Exceptions** - An organization may request an exception to network adequacy standards if they submit substantial and credible evidence that they are furnishing telehealth services that are available under original Medicare (e.g., "Medicare telehealth services" under section 1834(m) of the Act), to fulfill network standards.

Additional Telehealth Benefit Credit- CMS provides MA plans a 10% credit towards the percentage of beneficiaries that must reside within required time and distance standards when the plan makes us aware that they contract with telehealth providers for Dermatology, Psychiatry, Cardiology, Otolaryngology, Neurology, Ophthalmology, Allergy and Immunology, Nephrology, Primary Care, Gynecology/ OB/GYN, Endocrinology, and Infectious Diseases.

5. Will plans be able to submit exception requests during the Consultation period?

Answer Yes, plans are allowed, but not required, to submit exception requests during the Consultation period.

During the Consultation period, applicants and contracts due for their triennial review may upload their HSD tables in the NMM for CMS review. The Consultation period is an **informal** review, and is an opportunity for plans to receive technical assistance related to their network HSD table submissions prior to the formal submission in June. Plans may submit exception requests during this period for feedback from CMS.

Partial Counties

1. Can an organization request to serve a partial county at the plan benefit package (PBP) level?

Answer CMS does not grant partial counties at the plan level. If an organization believes that a partial county is warranted, then they must request and be approved to operate a partial county at the contract level. Please see section 5.1 of the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance for more details.

2. Can I submit a Partial County Justification for a respective county and also submit an ER for that same county?

Answer Yes. An organization may submit a Partial County Justification to request an exception to CMS's county integrity rule defined at 42 CFR 422.2.

If an organization receives an ACC fail for a given specialty type(s) within the zip codes of its existing/active or pending/expanding partial county(ies), at that time the organization may request an exception to CMS's time and distance standards.

3. Is inability to contract an acceptable justification for a partial county?

Answer The inability to establish contracts is not an acceptable justification for approving a partial county service area as it is not consistent with CMS' regulatory definition of MA plan service area at 42 CFR §422.2. See also Chapter 4 of the Medicare Managed Care Manual section 140, and section 4 of the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance.

4. Is it an acceptable justification for a partial county if a provider does not contract with any organizations?

Answer CMS will consider an organization's justification for a partial county if a provider does not contract with any organizations. The organization must provide substantial and credible evidence of this on its Partial County Justification. Please see section 5.1 of the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance for more details.

5. Is it an acceptable justification for a partial county if a provider contracts exclusively with another organization?

Answer CMS will consider an organization's justification for a partial county if a provider contracts exclusively with another organization. The organization must provide substantial and credible evidence of this on its Partial County Justification. Please see section 5.1 of the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance for more details.

Provider-Specific Plan (PSP)

1. Do I need to submit an application to offer a PSP?

Answer No. The PSP is a PBP type as opposed to a contract type. Therefore, CMS does not require organizations to submit an application for a PSP. Rather, organizations request to offer a PSP in June with their bid submissions for the upcoming contract year.

2. Does my PSP have to meet CMS network adequacy requirements?

Answer Yes. At the time of bid submission, organizations must attest that their PSP meets CMS network adequacy requirements.

3. When does CMS review my PSP network?

Answer PSP plans are subject to CMS network adequacy requirements and are reviewed as part of formal network reviews

Regional Preferred Provider Organizations (RPPO)

1. Does an RPPO have to meet the same network adequacy requirements as other MA coordinated care plans?

Answer Situations may arise where an RPPO cannot establish contracts with providers/facilities to meet network adequacy requirements in portions of its defined regional service area. In such cases, RPPOs may meet network adequacy requirements by demonstrating to CMS's satisfaction that there is adequate access to all plan-covered services through methods other than through written agreements (42 CFR 422.112(a)(1)(ii)). Enrollees who receive plan-covered services in non-network areas of an RPPO must be covered at in-network cost sharing levels. As discussed in section 5.2 of the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance, 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.