Applicants and contracts due for their triennial review will be prompted to upload their health service delivery (HSD) tables into the NMM in mid-June 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.

Contracts that fail to meet network adequacy requirements during the contract year may be subject to compliance or enforcement actions. Applicants that fail to meet network adequacy requirements may be suppressed from Medicare Plan Finder for the upcoming Annual Election Period.

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 are unable to request Exceptions with the Evaluate My Network function.

Organizations can refer to *Evaluate My Network* section in the NMM User Guide for detailed instructions on how to test their contracted networks, 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 ~ Reports ~ 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).

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.

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 listed in the Provider Supply file, resulting in insufficient supply. The organization must then demonstrate that its contracted network (i.e., providers/facilities included on its HSD tables) furnishes at least the minimum requirement of enrollees in the county 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.

Organizations must ensure that exception requests include accurate and complete information, including, contract ID, county name/SSA code and state, and specialty name and code.

If a provider/facility serves enrollees from multiple counties in a service area, then organizations must list the provider multiple times on the HSD Table in the appropriate state/county code, in order to account for each county. If the provider/facility is not listed for every applicable county, CMS may identify those providers on an exception request denial.

Providers may serve enrollees residing in a different county and/or state than their office locations. However, organizations should not list contracted providers in state/county codes where enrollees could not reasonably access services and that are outside the 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. [5]

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, theorganization 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.

An organization could provide substantial and credible evidence that they use Original Medicare telehealth 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

[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.

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 and the Non-Contracted Providers Overflow template are located in *HPMS ~ Monitoring ~ Network Management ~ Documentation ~ Templates.*

The exception upload should contain one exception request (PDF) for each exception requested. For exception requests with more than the allotted providers in *Part V:Table of Non-Contracted Providers* on the exception request template, organizations should add all overflow entries in the MA Exception Template Non-Contracted Providers Overflow template, and submit the file as a continuation of the main exception form. This document should follow the following naming convention: "ContractID_CountyCode_SpecialtyCode_cont"
For example: Hxxxx_12345_001_cont.pdf

Organizations should submit supplemental documentation (e.g., maps, screenshots, letters) in a separate document with the exception upload zip file. Supporting document filenames must use the following naming convention: "ContractID_CountyCode_SpecialtyCode_Supporting Document"

For example: Hxxxx_12345_001_supporting document.pdf

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

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 ~ Documentation ~ Guidance*

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 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 ~ Documentation ~ Guidance

- *HPMS NMM Reference Files:* MA Reference File and MA Supply File
  https://hpms.cms.gov ~ Monitoring ~ Network Management ~ Documentation ~ Reference Files

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