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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: June 17, 2020

TO: Medicare Advantage Organizations, Network-based Private Fee-For Service Plans, and Section 1876 Cost Plans

FROM: Kathryn A. Coleman
Director

SUBJECT: Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance

The Centers for Medicare & Medicaid Services (CMS) announces the release of the updated Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance reflecting finalized operational policies supporting the Contract Year 2021 Medicare Advantage and Part D Final Rule (CMS-4190-F1).

The network adequacy standards and methodology, previously outlined in sub-regulatory guidance, are now codified with some modifications at 42 C.F.R. § 422.116. The regulatory text includes:

- Provider and facility specialty types subject to network adequacy reviews: 27 provider specialty types and 13 facility specialty types are currently used in the evaluation of network adequacy in each service area.
- County type designations and ratios: Network adequacy is assessed at the county level, and counties are classified into five county type designations: Large Metro, Metro, Micro, Rural, or CEAC (Counties with Extreme Access Considerations) based on population size and density.
- Minimum number requirements and time and distance standards: MA plans must contract with a specified minimum number of each provider and facility specialty types, MA plan must have a minimum number of in-person providers and facilities in each county for each specialty type. The provider or facility must be within the maximum time and distance of at least one beneficiary in order to count towards the minimum number requirement.
- Exception Requests: An MA plan may submit an Exception Request to provide further information that CMS may consider when evaluating an MA organization's request for an exception to network standards.
- Administrative Practices Related to Network Adequacy: CMS will annually update and make available a Provider Supply file that identifies available providers and facilities with office locations and specialty types, and a HSD Reference File that contain the minimum provider and facility number requirements, minimum provider ratios, and the minimum time and distance standards.

Further, CMS strengthened network adequacy rules for MA plans by finalizing new policies to provide support for the use of telehealth. To encourage and account for telehealth providers in contracted networks, we provide 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. Detailed technical instructions on reporting these telehealth providers 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.**

Finally, we codified that MA organizations may receive a 10% credit towards the percentage of beneficiaries residing within published time and distance standards for affected provider and facility types in states that have Certificate of Need (CON) laws, or other state imposed anticompetitive restrictions, that limit the number of providers or facilities in a county or state. 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. The Automated Criteria Check (ACC) report will reflect the applied credit. Organizations can find the CON Reference File at the following navigation path: **HPMS Home Page>Monitoring>Network Management>Reference Files.**

Note: If an MA organization determines that there are additional county/specialty combinations 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.

The updated Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance is available online under “Downloads”: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index

Questions regarding these updates or content related to network adequacy may be submitted to https://dmao.lmi.org. For technical questions, please contact the HPMS Help Desk at either hpms@cms.hhs.gov or 1- 800-220-2028.