



Network Adequacy Review Roundtable Discussion

“A Day in the Life of a Network Review at CMS”

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Polling Question #1

How familiar are you with CMS's network adequacy review activities?

- a) Not at all familiar – Beginner
- b) Familiar – Intermediate
- c) Very familiar – Expert



What is a Network?

- **Organization perspective:**
 - All providers & facilities with contracts
- **Enrollee perspective:**
 - Providers & facilities I can choose from to get health care
- **Network-based plans:** CCPs, 1876 Cost, PFFS, MSA
 - Must maintain a network sufficient to provide adequate access to covered services to meet the needs of the population served (42 CFR 422.112(a)(1)(i))



Network Adequacy Criteria

- CMS updates **annually**
- Elements:
 - Minimum Number of Providers
 - Maximum Travel Distance
 - Maximum Travel Time
 - Beneficiary Coverage Ratio
 - County Type Designations
 - Provider & Facility Specialty Types

<https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html>



Network Reviews

- ***New for 2018*** – CMS reviews contract-level networks on a triennial basis (every three years)
- **Triggering events** for a network review:
 - Initial application (very first review)
 - Service Area Expansion (SAE) application (only new counties reviewed)
 - Significant provider/facility contract termination
 - Change of ownership transaction
 - Network access complaints
 - Organization-disclosed network gap



Timeline

June:

- Deadline to remove counties
- Service area verification
- Bid submission

September:

- Contracts signed

January

- HSD
Reference File
released

February-June

- Informal
Network
Consultation

June-
September

- Formal
Network
Review

September-
January

- Compliance
assessment



Starting Point...

- CMS releases the Health Service Delivery (HSD) Reference File
- Development of Supply File:
 - By CMS and the network adequacy contractor
 - Using Medicare claims data and publicly available sources on Medicare.gov website
- Location of Supply File:
 - HPMS



Consultation

- Regional Office Account Managers and Central Office staff lead consultation efforts
- Ongoing communication with organizations
- Consultation process
- HSD feedback



Consultation (continued)

- Organizations submit their HSD tables in the Network Management Module (NMM) in HPMS
- Organizations receive their Automated Criteria Check (ACC) report
- Organizations may submit Exception Requests



Exception Review Team

Network reviews are conducted by the Exception Review Team, comprised of dedicated staff from:

- CMS Central Office;
- CMS Regional Office; and
- Network adequacy contractor



The Role of Exceptions

- Point-in-time determination
- Real-time update to provider/facility supply
- Network adequacy criteria updated
- Submitted every time CMS requests network upload
 - Previously approved Exception Request does not guarantee that the exception will be approved the following year



Polling Question #2

True or False?

Only CMS Central Office staff review Exception Requests.

- a) True
- b) False



Valid Reasons for Exception Requests

- Provider(s) moved/retired or facility(ies) closed
- Provider(s)/facility(ies) may cause enrollee harm
- Provider(s)/facility(ies) are inappropriately credentialed under MA regulations
- Provider(s)/facility(ies) do not contract with **any** organization
- Provider(s)/facility(ies) contract **exclusively** with another organization



Valid Reasons for Exception Requests (continued)

Micro, Rural, and Counties with Extreme Access Considerations (CEAC) counties:

- Pattern of Care
- Telehealth
- Mobile Providers



Invalid Reasons for Exception Requests

- Inability to successfully negotiate and establish a contract with a provider/facility
- Inability to come to a financial contracting agreement with a provider/facility
- Being in the process of negotiating a contract with a provider
- Failure to cross state or county lines to contract with a provider/facility
- Pattern of care, telehealth, and mobile providers in Large Metro and Metro county types



Important Events to Remember

- Deadline to remove counties from service area
- Service Area Verification
- Bid Submission



Polling Question #3

If your organization wants to remove an active county from your service area, what action do you take?

- a) Remove county from application
- b) Service area reduction module
- c) Send an e-mail to CMS



Polling Question #4

Is your organization scheduled for your formal network review this June?

- a) Yes, I am an initial applicant.
- b) Yes, I am an SAE applicant.
- c) Yes, I was selected for my triennial review.
- d) No.
- e) Not sure.



Formal Network Review

- In June, CMS conducts the formal network review to include:
 - All CY 2019 **Initial** applicants,
 - All CY 2019 **SAE** applicants (new counties only), and
 - Organizations identified for their **triennial** review.



What Happens Next – Initial Applications

- Initial applications that fail to meet CMS's network requirements may be suppressed from Medicare Plan Finder in two cases:
 - No CMS history with managing a network
 - Prior compliance issues with networks
- Once an applicant demonstrates compliance, the organization will be added to Medicare Plan Finder.



Initial and SAE Compliance

- Compliance actions that may be taken
 - Notice of Non-Compliance
 - Warning Letter
 - Warning Letter with Business Plan
 - Corrective Action Plan
- Organizations have until **January 1** to meet network adequacy requirements



Triennial Review Compliance

- Failure to meet standards will result in compliance action
 - Notice of Non-Compliance
 - Warning Letter
 - Warning Letter with Business Plan
 - Corrective Action Plan



Compliance Methodology

- Review of final data, after Exceptions
- Formula for determining level of compliance
- Consistent
- Data-driven



Factors in Non-Compliance

- Failure to have sufficient number of providers
- Failure to meet the 90% threshold



Resources

- For questions, go to:
 - Division of Medicare Advantage Operations (DMAO) Portal: <https://dmao.lmi.org>
- MA Applications website: <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html>
 - HSD Reference File
 - Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance
- Health Plan Management System (HPMS):
<https://hpms.cms.gov/app/login.aspx?ReturnUrl=%2fapp%2fhome.aspx>
 - Network Management Module (NMM)