DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: January 10, 2018

TO: Medicare Advantage Organizations and Section 1876 Cost Plans

FROM: Kathryn A. Coleman, Director

SUBJECT: Contract Year 2018 Changes to Network Review Process for Medicare Advantage Organizations and Section 1876 Cost Plans

CMS announces changes to the network review process for Medicare Advantage (MA) organizations and Section 1876 cost plans, effective for contract year (CY) 2018.

On December 22, 2017, the Office of Management and Budget (OMB) approved CMS's information collection "*Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans*" (CMS-10636, OMB 0938-1346). CMS will now review organizations' networks on a three-year cycle, unless there is a triggering event that resets the timing of the organization's triennial review.[1] For the first triennial review cycle, CMS will pull a sample of active contracts, including contracts that have not undergone a full network review since contract initiation[2]. CMS will provide selected organizations at least 60 days' notice before the June deadline to submit their networks.

While network reviews have been removed from the application process, all applicants must attest to their ability to provide an adequate network during the entire contract year. Because network reviews are no longer a part of the application process, initial and service area expansion (SAE) applicants will have until June to formally submit their networks to CMS. Please note: CMS will conduct a complete network compliance review of initial applicants but will review only the new counties of SAE applicants for CY 2019.

In February 2018, CMS will provide all organizations the opportunity to upload their networks in the HPMS Network Management Module for an informal review. CMS will provide technical assistance, guidance, and consultation to organizations that want to take advantage of this opportunity. However, CMS must give priority to initial and SAE applicants and organizations that have been selected for triennial review before assisting other organizations requesting an informal review.

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[1] Triggering events requiring a full network review include, but are not limited to, initial applications, certain provider/facility contract terminations, certain change of ownership transactions, certain network access complaints, and certain organization-disclosed network deficiencies. When CMS requires a network review based on a triggering event, CMS will identify a specific submission timeframe.

[2] CMS will review all contracts that have not undergone a full network review since contract initiation within the first two years of this initiative by ensuring that they are included in the random sample of active contracts.

Organizations that fail to meet network adequacy requirements during their triennial review may be subject to compliance or enforcement actions. Initial applicants that fail to meet network adequacy requirements may be suppressed from Medicare Plan Finder for the upcoming Annual Election Period until the initial applicant is determined to have an adequate network in place and is prepared to provide access to services under such network in the new contract. Both initial and SAE applicants that fail to meet the network adequacy requirements by January 1, 2019 (when services must be provided under the new contract or service area) may also be subject to compliance or enforcement actions.

Organizations that fail to meet network adequacy requirements must ensure access to **specialty care** by permitting enrollees to see out-of-network specialists at the individual enrollee's in-network cost sharing level for those counties/specialties that fail to have an adequate network (42 C.F.R. § 422.112(a)(3)) and may need to make alternate arrangements if the network of **primary care** providers is not sufficient to ensure access to medically necessary care (42 C.F.R. § 422.112(a)(2)). Organizations must also notify **affected enrollees** at least 30 days in advance of the effective date of applicable changes in rules to address the inadequate network (42 C.F.R. § 422.111(d)(3)).

CMS will release updated network adequacy criteria and partial county policy and operational guidance in the near future. CMS has also posted the updated Health Service Delivery Reference File at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html. If you have questions, please submit them to the DMAO mailbox portal located at: https://dmao.lmi.org.