

(ii)(A) *Number of beneficiaries required to cover.* (1) The number of beneficiaries required to cover is calculated by multiplying the 95th percentile base population ratio by the total number of Medicare beneficiaries residing in a county.

(2) CMS uses its MA State/County Penetration data to calculate the total number of beneficiaries residing in a county.

(B) *95th percentile base population ratio.* (1) The 95th percentile base population ratio is:

(i) Calculated annually for each county type and varies over time as MA market penetration and plan enrollment change across markets; and

(ii) Represents the proportion of Medicare beneficiaries enrolled in the 95th percentile MA plan (that is, 95 percent of plans have enrollment lower than this level).

(2) CMS calculates the 95th percentile base population ratio as follows:

(i) Uses its most recent List of PFFS Network Counties to exclude any private-fee-for-service (PFFS) plans in non-networked counties from the calculation at the county-type level.

(ii) Uses its most recent MA State/County Penetration data to determine the number of eligible Medicare beneficiaries in each county.

(iii) Uses its Monthly MA Enrollment By State/County/Contract data to determine enrollment at the contract ID and county level, including only enrollment in regional preferred provider organization (RPPO), local preferred provider organization (LPPO), HMO, HMO/provider sponsored organization (POS), healthcare prepayment plans under section 1833 of the Act, and network PFFS plan types.

(iv) Calculates penetration at the contract ID and county level by dividing the number of enrollees for a given contract ID and county by the number of eligible beneficiaries in that county.

(v) Groups counties by county designation to determine the 95th percentile of penetration among MA plans for each county type.

(f) *Exception requests.* (1) An MA plan may request an exception to network adequacy criteria in paragraphs (b) through (e) of this section when either

paragraph (f)(1)(i) or (ii) of this section is met:

(i)(A) Certain providers or facilities are not available for the MA plan to meet the network adequacy criteria as shown in the Provider Supply file for the year for a given county and specialty type; and

(B) The MA plan has contracted with other providers and facilities that may be located beyond the limits in the time and distance criteria, but are currently available and accessible to most enrollees, consistent with the local pattern of care.

(ii)(A) A facility-based Institutional-Special Needs Plan (I-SNP) is unable to contract with certain specialty types required under §422.116(b) because of the way enrollees in facility-based I-SNPs receive care; or

(B) A facility-based I-SNP provides sufficient and adequate access to basic benefits through additional telehealth benefits (in compliance with §422.135) when using telehealth providers of the specialties listed in paragraph (d)(5) of this section in place of in-person providers to fulfill network adequacy standards in paragraphs (b) through (e) of this section.

(2) In evaluating exception requests, CMS considers whether—

(i) The current access to providers and facilities is different from the HSD reference and Provider Supply files for the year;

(ii) There are other factors present, in accordance with §422.112(a)(10)(v), that demonstrate that network access is consistent with or better than the original Medicare pattern of care; and

(iii) Approval of the exception is in the best interests of beneficiaries.

(iv) As applicable, the facility-based I-SNP submits:

(A) Evidence of the inability to contract with certain specialty types required under this section due to the way enrollees in facility-based I-SNPs receive care; or

(B) Substantial and credible evidence that sufficient and adequate access to basic benefits is provided to enrollees using additional telehealth benefits (in compliance with §422.135) furnished by providers of the specialties listed in paragraph (d)(5) of this section and the