

Health Service Delivery (HSD) Instructions for Medicare-Medicaid Plans (MMPs) and Minnesota Dual Special Needs Plans (MN D-SNPs) Annual Medicare Network Submission

This document contains information needed to complete the HSD tables required for the MMP and MN Senior Health Options D-SNP annual Medicare network submission. It also contains frequently asked questions (FAQ) regarding HSD submission and processing, guidance on developing valid addresses and field edits for the MMP Provider and MMP Facility tables.

Contents

Specialty Codes for the MMP Provider Table	2
Specialty Codes for the MMP Facility Table	5
HSD Table Instructions.....	7
MMP Provider Table Template	7
MMP Facility Table Template.....	8
Exception Requests:.....	8
Appendix A - HSD Submission Frequently Asked Questions	15
Appendix B - Guidance on Developing Valid Addresses	22
Appendix C – MMP Provider Table Column Explanations	24
Appendix D – MMP Facility Table Column Explanations	26
Appendix E – Field Edits for the MMP Provider and Facility Tables.....	27
Appendix F – CMS Public Data Source for HSD Exception Request	29

General Instructions and Guidance

MMPs and the MN Senior Health Options D-SNPs should include all contracted providers within and outside of the service area that will be available to serve the county's beneficiaries (even if those providers/facilities may be outside of the time and distance standards). After your organization submits the required MMP health service delivery (HSD) tables, CMS-generated Automated Criteria Check (ACC) reports will be created showing the provider and facility types that are meeting or failing to meet the MMP access standards. CMS will invoke rounding for the MMP and MN Senior Health Options D-SNPs Medicare network submission for any results of 89.5% or higher. Based on those results, your organization may submit exception requests based on the process described below.

MMPs and MN Senior Health Options D-SNPs must submit HSD tables for the service area reflected in the CMS Health Plan Management System (HPMS). This requires MMPs with counties that they have not been deemed ready to market and enroll beneficiaries but that still appear in HPMS to upload the MMP network for those pending counties. As articulated in the Exceptions section below, this will allow MMPs to request exceptions in those pending counties. CMS will not take any compliance action on MMPs where a pending county does not meet network adequacy at the conclusion of the annual MMP network review. **All submissions must utilize the 2019 templates.**

SPECIALTY CODES

CMS has created specific specialty codes for each of the physician/provider and facility types. MMPs and MN Senior Health Options D-SNPs must use the codes when completing HSD tables (MMP Provider and MMP Facility tables).

Specialty Codes for the MMP Provider Table

- 001 – General Practice
- 002 – Family Practice
- 003 – Internal Medicine
- 004 – Geriatrics
- 005 – Primary Care – Physician Assistants
- 006 – Primary Care – Nurse Practitioners
- 007 – Allergy and Immunology
- 008 – Cardiology
- 010 - Chiropractor
- 011 – Dermatology
- 012 – Endocrinology
- 013 – ENT/Otolaryngology

- 014 – Gastroenterology
- 015 – General Surgery
- 016 – Gynecology, OB/GYN
- 017 – Infectious Diseases
- 018 - Nephrology
- 019 - Neurology
- 020 - Neurosurgery
- 021 - Oncology - Medical, Surgical
- 022 - Oncology - Radiation/Radiation Oncology
- 023 – Ophthalmology
- 025 - Orthopedic Surgery
- 026 - Physiatry, Rehabilitative Medicine
- 027 - Plastic Surgery
- 028 - Podiatry
- 029 - Psychiatry
- 030 - Pulmonology
- 031 - Rheumatology
- 033 - Urology
- 034 - Vascular Surgery
- 035 – Cardiothoracic Surgery

Description of MMP Provider Types

The following section contains information related to MMP and MN Senior Health Options D-SNP Medicare Provider specialty types in order to assist the MMP and MN Senior Health Options D-SNPs with the accurate submission of the MMP Provider HSD Table.

MMP Provider Table – Select Provider Specialty Types

Primary Care Providers – The following six specialties are reported separately on the MMP Provider Table, and the criteria, as discussed below, are published and reported under “Primary Care Providers (S03)”:

- General Practice (001)
- Family Practice (002)
- Internal Medicine (003)
- Geriatrics (004)
- Primary Care – Physician Assistants (005)
- Primary Care – Nurse Practitioners (006)

MMPs and MN Senior Health Options D-SNPs submit contracted providers using the appropriate individual specialty codes (001 – 006). CMS sums these providers, maps them as a single group, and evaluates the results of those submissions whose office locations are within the prescribed time and distance standards for

the specialty type: Primary Care Providers. These six specialties are also summed and evaluated as a single group against the Minimum Number of Primary Care Providers criteria (note that in order to apply toward the minimum number, a provider must be within the prescribed time and distance standards, as discussed below). States may require MMPs to include pediatric providers in their tables, However, CMS does not review pediatric providers for purposes of network adequacy determinations. Therefore, physicians and specialists must not be pediatric providers; as they do not routinely provide services to the Medicare-population. There are HSD network criteria for the specialty type: Primary Care Providers, and not for the individual specialties. The criteria and the results of the Automated Criteria Check (ACC) are reported under the specialty type: S03.

Primary Care – Physician Assistants (005) -- MMPs and MN Senior Health Options D-SNPs include submissions under this specialty code **only if** the contracted individual meets the applicable state requirements governing the qualifications for assistants to primary care physicians and is duly certified as a provider of primary care services. In addition, the individuals listed under this specialty code must function as the primary care source for the beneficiary/member, not supplement a physician primary care provider's care, in accordance with state law and be practicing in or rendering services to enrollees residing in a state and/or federally designated physician manpower shortage area.

Primary Care – Nurse Practitioners (006) -- MMPs and MN Senior Health Options D-SNPs include submissions under this specialty code **only if** the contracted registered professional nurse is currently licensed in the state, meets the state's requirements governing the qualifications of nurse practitioners, and is duly certified as a provider of primary care services. In addition, the individuals listed under this specialty code must function as the primary care source for the beneficiary/member, not supplement a physician primary care provider's care, in accordance with state law and be practicing in or rendering services to enrollees residing in a state and/or federally designated physician manpower shortage area.

Geriatrics (004) – Submissions appropriate for this specialty code are internal medicine, family practice, and general practice physicians who have a special knowledge of the aging process and special skills and who focus upon the diagnosis, treatment, and prevention of illnesses pertinent to the elderly.

Physiatry, Rehabilitative Medicine (026) – A physiatrist, or physical medicine and rehabilitation specialist, is a medical doctor trained in the diagnosis and treatment of patients with physical, functionally limiting, and/or painful conditions. These specialists focus upon the maximal restoration of physical function through comprehensive rehabilitation and pain management therapies. Physical Therapists are NOT Physiatry/Rehabilitative Medicine physicians and are not to be included on the MA Provider tables under this specialty type.

Psychiatry (029) -- Psychiatrists must only be licensed physicians and no other type of practitioner.

Cardiothoracic Surgery (035) – Cardiothoracic surgeons provide operative, perioperative, and surgical critical care to patients with acquired and congenital pathologic conditions within the chest. This includes

the surgical repair of congenital and acquired conditions of the heart, including the pericardium, coronary arteries, valves, great vessels and myocardium. Cardiologists, including interventional cardiologists, are not cardiothoracic surgeons, and may not be included under this specialty type.

Specialty Codes for the MMP Facility Table

- 040 – Acute Inpatient Hospitals
- 041 - Cardiac Surgery Program
- 042 - Cardiac Catheterization Services
- 043 - Critical Care Services – Intensive Care Units (ICU)
- 044 - Outpatient Dialysis
- 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

Description of MMP Medicare Facility Types

The following section contains information related to MMP and MN Senior Health Options D-SNPs Medicare Facility specialty types in order to assist the MMPs and MN Senior Health Options D-SNPs with the accurate submission of the MMP Facility HSD Table.

MMP Facility Table – Select Facility Specialty Types

Contracted facilities/beds must be Medicare-certified.

Acute Inpatient Hospital (040) – MMPs and MN Senior Health Options D-SNPs must submit at least one contracted acute inpatient hospital. MMPs may need to submit more than one acute inpatient hospital in order to satisfy the time/distance criteria. There are Minimum Number criteria for the acute inpatient hospital specialty. MMPs and MN Senior Health Options D-SNPs must demonstrate that their contracted acute inpatient hospitals have at least the minimum number of Medicare-certified hospital beds. The minimum number of Medicare-certified acute inpatient hospital beds, by county of application, can be found on the “Minimum Facility #s” tab of the HSD Reference Table.

Cardiac Surgery Program (041) – A hospital with a cardiac surgery program provides for the surgical repair of problems with the heart, traditionally called open-heart surgeries. Procedures performed in a cardiac surgery hospital program include, but are not limited to: coronary artery bypass graft (CABG), cardiac valve repair and replacement, repair of thoracic aneurysms and heart replacement, and may additionally include minimal access cardiothoracic surgeries. (Please note – not all cardiac surgery programs include heart transplant services. Medicare-approved heart transplant facilities are listed under facility table category 061 (heart transplant) and 062 (heart/lung transplant), as appropriate.)

Inpatient Psychiatric Facility Services (052) – Inpatient Psychiatric Facility Services may include inpatient hospital services furnished to a patient of an inpatient psychiatric facility (IPF). IPFs are certified under Medicare as inpatient psychiatric hospitals and distinct psychiatric units of acute care hospitals and critical access hospitals. The regulations at 42 CFR § 412.402 define an IPF as a hospital that meets the requirements specified in 42 CFR § 412.22 and 42 CFR § 412.23(a), 42 CFR § 482.60, 42 CFR § 482.61, and 42 CFR § 482.62, and units that meet the requirements specified in 42 CFR § 412.22, 42 CFR § 412.25, and 42 CFR § 412.27.

Outpatient Infusion/Chemotherapy (057) – Appropriate submissions for this specialty include freestanding infusion / cancer clinics and hospital outpatient infusion departments. While some physician practices are equipped to provide this type of service within the practice office, MMPs and MN Senior Health Options D-SNPs should only list a contracted office-based infusion service if access is made available to all members and is not limited only to those who are patients of the physician practice.

HSD Table Instructions

The tables should reflect the contracted MMP or MN Senior Health Options D-SNP executed contracted network on the date of submission. CMS considers a contract fully executed when both parties have signed. MMPs or MN Senior Health Options D-SNPs should only list providers with whom they have a fully executed updated contract. These contracts should be executed on or prior to the submission deadline. In order for the automated network review tool to appropriately process this information, your organization must submit Provider and Facility names and addresses exactly the same way each time they are entered, including spelling, abbreviations, etc. Any errors will result in problems with processing of submitted data and may result in findings of network deficiencies. CMS expects all organizations to fully utilize the functionality in the CMS HPMS Network Management Module (NMM) to conduct organization-initiated checks prior to the September due date to ensure that their HSD tables are accurate and complete. For instructions on the organization-initiated NMM uploads, please refer to HPMS>Monitoring>Network Management>Documentation>Guidance>Plan User Guide.

MMP Provider Table Template

The MMP Provider Table Template can be found in HPMS using the following path: HPMS>Monitoring>Network Management> Documentation>Templates. This table captures information on the specific physicians/providers in the MMP's and MN Senior Health Options D-SNP's contracted network. If a provider serves beneficiaries residing in multiple counties in the service area, list the provider multiple times with the appropriate state/county code to account for each county served. Do NOT list contracted providers in the state/county codes where the beneficiary could not reasonably access services and that are outside the pattern of care. Such extraneous listing of providers affects CMS' ability to quickly and efficiently assess provider networks against network criteria. You must ensure that the providers listed must not have opted out of Medicare.

The MMP and MN Senior Health Options D-SNP is responsible for ensuring contracted providers (physicians and other health care practitioners) meet state and Federal licensing requirements and your credentialing requirements for the specialty type prior to including them on the MMP Provider Table. Verification of credentialing documentation may be requested at any time. Including physicians or other health care practitioners that are not qualified to provide the full range of specialty services listed in the MMP Provider Table will result in inaccurate ACC measurements that may result in your MMP and MN Senior Health Options D-SNP Medicare network submission being found deficient. Explanations for each of the columns in the MMP Provider Table can be found in Appendix C, and HPMS system edits for the MMP Provider Table can be found in Appendix D.

MMP Facility Table Template

The MMP Facility Table Template can be found in HPMS using the following path: HPMS>Monitoring>Network Management> Documentation>Templates. Only list the providers that are Medicare certified providers. Please do not list any additional providers or services except those included in the list of facility specialty codes. Additionally, do not list contracted facilities in state/county codes where the Medicare-Medicaid beneficiary could not reasonably access services and that are outside the pattern of care. Such extraneous listing of facilities affects CMS' ability to quickly and efficiently assess facility networks against network criteria.

If a facility offers more than one of the defined services and/or provides services in multiple counties, the facility should be listed multiple times with the appropriate "SSA State/County Code" and "Specialty Code" for each service.

Exception Requests:

As MMPs and the MN Senior Health Options D-SNPs will submit networks annually, any approved exceptions will be in place until the next annual MMP and MN Senior Health Options D-SNP Medicare network submission. CMS, in collaboration with each respective state, will consider requests for exceptions to the required minimum number of providers and/or maximum time/distance criteria under limited circumstances. Each exception request must be supported by information and documentation as specified in the exception request template attached to these instructions. If your organization believes that it will not meet the time/distance or minimum number MMP standards based on your contracted network, wants to request an exception(s), and already has additional contracted providers outside of the time and distance to serve beneficiaries, then you must include those other contracted providers on the MMP HSD tables in the annual MMP and MN Senior Health Options D-SNP Medicare network submission.

Exception Justifications

The exception request template has been revised and converted into a fillable form to ease in completion and allow for greater accuracy in the submission of information. The form also allows for the inclusion of in-home delivery of services, the use of mobile health clinic, and the use of telehealth.

Telehealth: A telehealth provider is a board-certified physician or advanced practitioner that provides virtual medical advice, treatment options and referrals to a provider if needed for non-life-threatening medical conditions from a distant site¹. These electronic services must include an interactive 2-way telecommunications system (with at a minimum real-time audio and video equipment) which is used by

¹ Distant site – site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

both the provider and the enrollee receiving the service. Such telehealth providers must be contracted to provide services to the entire enrollee population within the specified service area.

Mobile Health Clinics: Any mobile health clinics that are contracted to provide services to the entire enrollee population within the specified service area. A mobile health clinic may be a specially outfitted truck or van that provides examination rooms, laboratory services, and special medical tests to those who may be in remote areas or who have little to no access to medical facilities, and to patients who do not have the resources to travel for care.

In-Home Medical Services: MMPs and MN Senior Health Options D-SNPs can receive consideration in the exceptions process where contracted providers deliver medical services in the beneficiary's home in lieu of an office where the office location may be outside of the established time and or distance standards.

CMS reserves the right to follow up for any additional information that may be need as a result of the exception request review which could include an attestation from the provider outlining their service area/counties, and may also include the number of enrollees served by each provider type (telehealth, mobile health clinics and in-home service providers) within the designated service areas/counties. CMS will also work with your state of operation to verify laws pertaining to telehealth and mobile health clinics.

Exception Process Timing

Following the first submission for the annual MMP and MN Senior Health Options D-SNP Medicare network review, organizations must review the ACC report. This report identifies the providers and/or facilities passing and failing to meet the MMP Medicare network standards. For those providers and/or facilities that are not meeting the MMP Medicare network standards, your organization may submit an exception request.

Exceptions are only permitted to be requested and uploaded between specific timeframes identified in the HPMS Cover Memo and may only be submitted using the required template attached to these instructions.

MMPs and MN Senior Health Options D-SNPs submitting exception requests will be notified by an automated HPMS email when the exception reviews are complete. All MMPs and MN Senior Health Options D-SNPs will be notified by an automated HPMS email of the second and final HSD table submission window (submit updated tables from the original submission, and/or correct HSD tables from the original submission).

Completing the Exception Request Template

The MMP and MN Senior Health Options D-SNPs Annual Network Submission HSD Exception Request template provides the basis for any MMP exception request. MMPs and MN Senior Health Options D-SNPs must submit distinct exception requests per contract ID, county, and specialty code. Each request should be tailored to the provider/facility type and the specific county **using the 2019 MMP exception template**. CMS will not accept exception request submissions using the Medicare Advantage application

template or the MMP template from prior years' annual MMP network submissions. The exception request template is segmented into the following seven parts:

- I. Exception Information
- II. Justification for Exception
- III. Rationale for why Exception is Necessary
- IV. Sources
- V. Narrative Text (Optional)
- VI. Non-Contracted Providers/Facilities
- VII. Telehealth Providers, Mobile Health Clinics, and In-Home Medical Services
- VIII. Low Utilization

Exception Information: This section of the template requires the plan to enter the Contract ID and select from the drop-down list the County name and code and the Specialty name and code for the exception request your organization is seeking.

Justification for Exception: When submitting an exception request in HPMS, the NMM only provides one basis – patterns of care; however, the MMP exception request template requires MMPs and MN Senior Health Options D-SNPs to choose from a selection of reasons for the exception. Your organization must select the applicable justification.

Note: CMS will only consider low utilization exception requests for existing counties. MMPs cannot demonstrate low utilization of a provider type for a county where the MMP has not been deemed ready to enroll beneficiaries. If the basis for the exception request is based on low utilization of the provider/facility type for the demonstration population, your organization must skip to and complete only the table included in Part VIII: Low Utilization.

Rationale for why Exception is Necessary:

- Questions 1-5 must be answered Yes or No
- If the response is Yes for Question 3, then Part IV must be completed.
- If the response is Yes for Question 4, then the table included in Part VI: Non-Contracted Providers/Facilities section must be completed.
- If the response is Yes for Question 5, then the table included in Part VII: Telehealth Providers, Mobile Health Clinics, and In-Home Medical Services section must be completed

Sources:

Please enter any sources (up to six) you used to identify providers/facilities within or nearby CMS' network adequacy criteria. To enter a source, select an option from the drop-down list, which is comprised of sources commonly used by organizations and CMS. If you have more than six sources, or a source not included on the drop-down list, please describe the additional sources in the Part V: Narrative Text section. The drop-down options for the sources are as follows:

- Physician Compare
- Hospital Compare
- Nursing Home Compare
- Dialysis Compare
- NPI file/NPPES
- Other (Please describe the other source(s) in the “Part V: Narrative Text” section)
- Provider of Services (POS) file
- Direct outreach to provider
- Provider website
- State licensing data
- Online mapping tool

Narrative Text (Optional):

Please use the free text format box in this section to enter any additional text to justify your exception request. This section may also be used to explain “Other” and additional sources from the Part IV: Sources section.

Non-Contracted Providers/Facilities:

Complete the table in this section if your organization answered "Yes" to question 4 in the Part III: Rationale for why Exception is Necessary section. Please include all non-contracted providers/facilities in the table. If the sources of information used (and listed in the table) are proprietary or otherwise not publically available, the MMP/MN Senior Health Options D-SNP must describe how the information supports the reason for not contracting with a provider/facility and provide evidence of the data source information (e.g., screenshots).

The table is designed to capture most of the non-contracted provider/facility information in a free text format; however, there are drop-down lists to capture the provider state and the reason for the provider not contracting with your organization. The drop-down options to capture the reason for not contracting are as follows:

Reasons for not contracting:

- Provider is no longer practicing (e.g., deceased, retired, etc.)
- Provider does not provide services at the office/facility address listed in database
- Provider does not provide services in the specialty type listed in the database and for which this exception is being requested
- Provider does not contract with Medicare-Medicaid Plans

Reasons for not contracting:

- Provider/Facility type better than prevailing Original Medicare pattern of care
- Contract offered to provider/facility but declined/rejected
- Geographic limitations, explain below
- Provider is at capacity and is not accepting new patients

Reasons for not contracting:

- Sanctioned provider on List of Excluded Individuals and Entities
- Provider has opted out of Medicare

Reasons for not contracting:

- Other (please enter explanation on the last column of the table)

Telehealth Providers, Mobile Health Clinics, and In-Home Medical Services:

Complete the table in this section if your organization answered "Yes" to question 5 in the Part III: Rationale for why Exception is Necessary section. Please include all telehealth providers, mobile health clinics, and in-home medical services in the table.

The table is designed to capture most of the provider/facility information in a free text format; however, there are drop-down lists to capture the provider state and the provider type. The drop-down options to capture the provider type are as follows:

- Telehealth Provider
- Mobile Health Clinic
- In Home Medical Service

In addition to completing the table in this section, your organization must provide justification for utilizing telehealth providers, mobile health clinics, and in-home medical services. This justification must be provided in a free text format to address the following questions for each provider type:

JUSTIFICATION FOR TELEHEALTH PROVIDERS	JUSTIFICATION FOR MOBILE HEALTH CLINICS	JUSTIFICATION FOR IN-HOME MEDICAL SERVICES
a. How does the telehealth provider provide services for the entire population in the service area?	a. Explain the medical services provided by the mobile health clinic(s).	a. Explain the medical services provided in the beneficiaries' home?
b. What are the requirements for beneficiaries to be eligible to participate in telehealth?	b. How do beneficiaries access mobile health clinic services?	b. How do beneficiaries access the in-home medical services? Are there any specific requirements for beneficiaries to be able to qualify for in-home visits?

JUSTIFICATION FOR TELEHEALTH PROVIDERS	JUSTIFICATION FOR MOBILE HEALTH CLINICS	JUSTIFICATION FOR IN-HOME MEDICAL SERVICES
c. How do beneficiaries access telehealth services?	c. Is the mobile health clinic contracted directly with your organization or is the mobile health clinic associated with facility or provider group contracted with your organization?	c. Explain the timeframe for when beneficiaries requests the in-home medical services to when the in-home medical service is provided.
d. How does your organization provide access to a provider when an in-person visit is deemed necessary following a telehealth visit?	d. Provide the mobile health clinic’s fixed schedule that specifies the date(s) and location(s) for services.	d. How does your organization provide access to a provider when an in person visit is deemed necessary following an in-home visit?
e. Provide additional details or considerations to support your organization’s option to utilize these types of providers over providers in a physical location.	e. Provide any additional details for consideration that supports your organization’s option to utilize these types of providers over providers in a standard physical building location.	e. Provide any additional details for consideration that support your organization’s option to utilize these types of providers over providers in a standard physical building location.

Low Utilization

If the basis for the exception request is due to low utilization of the provider/facility type for the demonstration population, your organization must only complete the table in this section.

Note: CMS will only consider low utilization exception requests for existing counties. MMPs cannot demonstrate low utilization of a provider type for a county where the MMP has not been deemed ready to enroll beneficiaries.

The table is designed to capture the justification for an exception request due to low utilization. The following questions must be answered in a free text format:

Low Utilization Justification
a. Provide the volume of enrollees who access the specialty type within the specific county over the last year.
b. Provide the volume of enrollees who accessed the specialty type under the MMP's/MN Senior Health Options D-SNP'S overall Service Area over the past year.
c. Provide the rationale for why enrollees do/do not utilize provider/facility services in the area, which might contribute to the low utilization.
d. How will the MMP/MN Senior Health Options D-SNP provide the existing provider/facility service to current enrollees?
e. How will the MMP/MN Senior Health Options D-SNP provide the provider/facility services should utilization increase?
f. How will the MMP/MN Senior Health Options D-SNP provide ongoing monitoring of provider/facility type utilization?
g. Provide additional information to support low utilization reason.

HPMS Path

MMPs and MN Senior Health Options D-SNPs can locate the NMM in HPMS by using the following path: Monitoring>Network Management. To access the appropriate HSD templates click Templates from the right-side drop down menu>Select Contract Number>Click Search>Click the event name identified in the HPMS cover memo. The HPMS User Manual can be located using the following path: Monitoring>Network Management>Documentation>Guidance>Plan User Guide, and will detail how to download, complete, and upload the correct HSD templates for your organization.

Appendix A - HSD Submission Frequently Asked Questions

CMS has developed a series of frequently asked questions (FAQ) regarding the HSD table submission process. These FAQs provide additional technical guidance on the following topics:

- Understanding the HSD submission statuses
- Reviewing the HSD Status Report and ACC Report
- Informational messages versus errors
- MMP Provider and MMP Facility table formats and edit checks
- Address Information Report statuses (duplicate address, invalid address)
- Zip –Distributive Process

Please contact Greg Buglio at either gregory.buglio@cms.hhs.gov or 410-786-6562 for technical questions regarding the MMP and MN Senior Health Options D-SNP annual Medicare network submission.

- a. How can I check my network prior to the submission deadline?

Response: All organizations may utilize the Network Management Module -- Organization Initiated Upload process to check networks against current CMS criteria. The NMM Organization Initiated Upload functionality may be accessed at this path: HPMS Home Page>Monitoring>Network Management. The Quick Reference User Guide, under the Documentation link, explains how to perform an Organization Initiated Upload and how to check the ACC results (see section 2 and section 7 of the NMM Quick Reference User Guide). NOTE: CMS may not access the uploaded tables or the ACC results affiliated with an Organization Initiated Upload.

- b. Will I be notified when the HSD tables unload successfully or unsuccessfully?

Response: HPMS will email the person identified as the Medicare Compliance Officer in HPMS (found on the Contact screen in Contract Management) and the person who completed the upload when the HSD tables have gone through the Unload process. The email will indicate if the Unload was successful. If unsuccessful, the email will provide details on the errors encountered and will list a File Confirmation ID. You may contact the HPMS help desk for assistance in resolving Unload errors. Be sure to reference the File Confirmation ID so the HPMS help desk is able to quickly find your files and reports. A separate email will be sent for both the Provider Table and the Facility Table.

- c. How can I verify if my submission passed the “unload” validation edits successfully?

Response: Validation edits are provided in Appendix E of this document. You must look at the HSD Status Report in the NMM. MMPs must use the following navigation path to access this report: Monitoring >Network Management> Status Report> Enter or Select Contract Number > Click Search>Select the Event ID identified in the automated emails to access the current Status Reports (in the Select a Record Column)>Click the hyperlink in the Error Report column. If no errors existed, “No Error” will be displayed in the Error Report column. Note: A unique Error Report is generated for both the Provider table upload and the Facility table upload.

- d. The HSD Status Report indicates that my MMP Provider and MMP Facility submissions have been “Unloaded Successfully.” What does that mean?

Response: Achieving the “Unloaded Successfully” status indicates that your submission has passed all of the validation edits. If both the MMP Provider and MMP Facility Tables unload successfully, your submission will be processed in the submission process.

- e. The HSD Status Report indicates that one or both of the HSD tables has an “Unload Failed” status. What does that mean?

Response: An “unsuccessful unload” means that validation errors are present on your file(s) and until the errors are corrected, your submission will not be included in the final submission process. You must review your error report, make the necessary corrections to your file(s), resubmit the file(s) to HPMS, and pass the “unload” process.

- f. In the HSD Status Report, some messages are marked as informational. What does that mean?

Response: Messages marked as “informational” are intended to highlight certain data scenarios. You should review all informational messages to determine if the data being highlighted is correct or if it requires a change. For example, you will receive an informational message if your file does not have a row assigned to a county for a required specialty. If you do have a provider of that specialty serving that county, you would update your file to add the row. If you do not have a provider of that specialty serving the county, and you intend to submit an exception request, then no updates are required to your file. It is important to note that informational messages do NOT prevent a file from passing “unload” validation and moving on to the pre-check.

- g. Some of the error messages indicate that I am missing data from fields on the table, but when I look at my upload file, those fields are populated. Why am I getting this message?

Response: If your submission contains any formatting errors, you should first correct the formatting errors and then resubmit your file(s) to HPMS. Formatting errors will skew the unload validation of the

files and may result in errors reading the files. Please contact the HPMS Help Desk for assistance with formatting errors at hpms@cms.hhs.gov. In the email, include the module (NMM), contract number, table or tables with errors, and the reference number from the Unload Error automated email (optional).

- h.** Do I need to include every pending county on the MMP Provider and MMP Facility tables?

Response: Yes. The submission must include all counties listed in the Service Area section of HPMS.

- i.** Are we required to list at least one of every provider and facility type for each of our pending counties?

Response: Your organization must submit network information for all counties reflected in the HPMS Service Area for the applicable contract ID. Within each county, the requirements are as follows:

- a. On the MMP Provider Table, you must include at least one type of Primary Care Physician (provider codes 001-006) for every county identified in your HPMS Service Area.
- b. On the MMP Facility Table, you must include at least one Acute Inpatient Hospital (facility code 040) for every county identified in your HPMS Service Area.
- c. You must complete **all** required fields on both of the tables.
- d. You must adhere to the edit rules for both of the tables.
- e. Please read the NMM Instructions, located above, to determine which fields are required and which are optional.

Note: The HSD Status Report will continue to list every county where a provider or facility code has not been provided. Other than the edits indicated in points a. and b. above, these messages are informational and will not prevent your files from being processed.

- j.** What format must we use to submit the MMP Provider and MMP Facility Tables?

Response: You should use the following steps to ensure you are using the correct format:

- a. Download the templates for the MMP Provider and MMP Facility Tables in the MMP download section in the NMM.
- b. Complete your files in Excel.
- c. Save the files as tab-delimited text files (.txt).
- d. Zip the .txt files.
- e. Upload each file on the HSD Upload page.

- k.** Can we use the MA Provider and MA Facility Tables for the MMP HSD Upload?

Response: No. You must use the MMP Provider and Facility Tables for the MMP annual Medicare network submission. The tables contain different fields and the MA Provider and Facility Tables will fail to upload for the MMP HSD submission.

- l.** Can you explain what the meaning of the “actual time” and “actual distance” fields on the ACC report?

Response: The “actual time” and “actual distance” values reflect the percentage of dual-eligible beneficiaries with access to at least one provider/facility within the required time or distance criteria.

- m.** Can you explain when a listed provider is included in the Minimum Number of Providers calculation?

Response: A submitted provider is included in the Number of Providers calculation when he/she is located within the prescribed time and/or distance of at least one sample beneficiary listed on the Sample Beneficiary file.

- n.** I have listed twenty different providers for a specific county/specialty combination, and I meet the Minimum Number of Providers check. How is it possible that I failed the Time and/or Distance check?

Response: When performing the Minimum Number of Providers check for a specific county/specialty combination, HPMS starts with the Provider addresses and ensures that at least one sample beneficiary is within the time and/or distance indicated in the criteria. The Time and/or Distance checks start with each of the sample beneficiaries in the county and determine that at least 90% of them have at least one of the measured providers within the prescribed Time and/or Distance criteria (CMS will invoke rounding from 89.5% for purposes of meeting the 90% threshold).

NOTE: If your network consists of five specialists who all practice from the same building, and one sample beneficiary lives across the street from the practice, within the Time and/or Distance criteria, then all five will be included in the Minimum Number of Providers check. However, at least 90% of all beneficiaries must have at least one of these provider types within the time and/or distance of their specific location to pass the time and/or distance checks.

- o.** How is an address identified as a “duplicate” on the Address Information report?

Response:

Providers are considered duplicates when they have the:

- a. Same state/county code
- b. Same provider code
- c. Same NPI number
- d. Same address or different address (i.e., a different address is still considered a duplicate for the provider).

Note: When a different address is listed with the same state/county code, provider code and NPI number combination, we will include the address in the calculation for “actual time” and “actual distance,” but we will only count the provider once in determining the minimum number of provider’s calculation.

Facilities are considered duplicates when they have the:

- a. Same state/county code
- b. Same facility code
- c. Same NPI number
- d. Same address

Note: A different address for a **facility**, even with the same state/county code, facility code, and NPI number, is **not** considered a “duplicate.”

- p.** If a provider or facility appears on the Address Information Report, are they still used in the automated calculations for the minimum number of providers, time, and distance?

Response: There are four reasons why an address may be listed on the Address Information Report, and depending on the status, the address may or may not be included in the automated processing. The four statuses are:

- a. Zip-Distributive – when an address is listed on this report with a reason of Zip-Distributive, it means that it was not located in our mapping software. As long as the zip code is valid, the software will include it in the ACC process by providing a randomly generated geo-code within the zip code based on population density. The randomly generated geo-code will be the same for the address every time the ACC process is invoked.
- b. Invalid Address – an address is considered invalid if it is not contained in the mapping software and the zip code is not valid. The address is not included in any automated processing.
- c. Duplicate Record – Please see question 16 above for an explanation of Duplicate addresses for Providers and Facilities.
- d. Not Supported by ACC – identifies addresses affiliated with certain situations which are not supported by the automated review process and require a manual review.

- q.** How can I avoid having addresses listed as “Invalid” or “Zip-Distributive” on the Address Information Report?

Response: Please see **Appendix B** for guidance on developing valid addresses for the purposes of the HSD automated review.

- r. What are all of the edit checks applied to the MMP Provider Table and MMP Facility Table?

Response: Please see **Appendix E** for a listing of the field edits on the MMP Provider Table and the MMP Facility Table.

- s. Can I list providers or facilities that are part of my network as serving a county other than where their office is located?

Response: Yes. You should associate providers or facilities within a given county on your table(s) based on whether they serve beneficiaries residing within the county, not whether they are physically located in the county itself. There is no requirement that the provider/facility be in the same county as the beneficiaries who would utilize those services. The COUNTY column on the Provider and Facility upload files should be populated with the county where the beneficiaries reside who will receive services from that specialty, NOT the county where the provider or facility is physically located.

Example: If a provider has an office location in Howard County, and it is reasonable to assume that beneficiaries residing in Baltimore County will utilize that provider, on the Provider Upload table, populate the County column with Baltimore County. If the provider will provide services to beneficiaries in both Howard County and Baltimore County, enter the provider information twice on the Provider upload table. In the first instance, list Baltimore County in the COUNTY column, in the second, list Howard County in the COUNTY column.

- t. If only one of the files is successfully submitted and unloaded, will that file go through the process?

Response: In order for a submission to go through processing, both the MMP Provider and MMP Facility tables must be uploaded and unloaded successfully prior to the established deadline. **NOTE:** In order to trigger an Org. Initiated Upload, BOTH the Provider and Facility upload tables must be submitted and they must both unload successfully. The ACC process will not be invoked until both tables are uploaded successfully with no fatal errors.

- u. What do the various messages in the NMM Status Report mean?

Response:

- a. File Processing Error – These are errors in the format of the submitted file. These errors may prevent the system from reading the file correctly.
- b. Record Invalid – A record contains a restricted character. Restricted characters are the greater than symbol, the less than symbol and the semi-colon (< > ;). SSA State/County Not

in Service Area – The state/county code you provided is not part of your contract’s Service Area.

- c. Invalid/Missing Provider/Specialty Code – You have either entered an invalid specialty code or you have not entered a Primary Care Physician (provider codes 001-006) for every county in your service area. Invalid/Missing Facility Code – You have either entered an invalid specialty code or you have not entered an Acute Inpatient Hospital (facility code 040) for every county in your service area.
- d. Invalid Data Type – There is a processing error in the record due to incorrect data type (example – alpha character in a numeric-only field).
- e. Invalid Length – There is a processing error in the record due to an invalid length in a field.
- f. Invalid Data - There is a processing error in the record due to invalid data.
- g. Required Field Missing – A required field or fields is missing from the record.
- h. Informational Messages – These messages provide you with information about your submission. If there are missing provider codes or facility codes for a county or counties, they will be listed here. You will still be included in the pre-check process.

Appendix B - Guidance on Developing Valid Addresses

The following list the most common errors encountered with listing addresses in the HSD files.

1. Do not put the Business Name in the address line.

Example:

Address	City	State	Zip	Reason
Dupage Obstetrics and Gynecology	Amf Ohare	IL	60666	Address listed as Office Name

2. Do not list an intersection as the address.

Example:

Address	City	State	Zip	Reason
E 65th St at Lake Michigan	Chicago	IL	60649	Intersection

3. Do not include a house, apartment, building or suite number in the address.

Example:

Address	City	State	Zip	Reason
306 US ROUTE ONE, BLDG C-1	Scarborough	ME	04074	Should remove "BLDG C-1"
5900 B LK WRIGHT DR	Norfolk	VA	23502	Should remove "B"

4. Enter the complete Street Number and Street Name in the address line.

Example:

Address	City	State	Zip	Reason
21 Cir Dr	Barrington	IL	60010	Should enter "21 Circle Dr."
LK WRIGHT DR	Norfolk	VA	23502	Missing house number

5. Do not enter extra words in the address line.

Example:

Address	City	State	Zip	Reason
450 W Hwy 22 Medical	Barrington	IL	60010	Should remove "Medical"
449 FOREST AVE PLZ	Portland	ME	04101	Should remove "PLZ"

6. Enter a valid Street Name.

Example:

Address	City	State	Zip	Reason
5900 LK Right DR	Norfolk	VA	23502	Correct name should be "LK WRIGHT DR"

7. Enter correct Street Address and Zip Code combination in the address line.

Example:

Address	City	State	Zip	Reason
5900 LK WRIGHT DR	Norfolk	VA	21043	Should correct zip code to be 23502

8. Enter the correct Street Number in the address line.

Example:

Address	City	State	Zip	Reason
12 LK WRIGHT DR	Norfolk	VA	23502	12 is not a valid street number.

Appendix C – MMP Provider Table Column Explanations

- A. SSA State/County Code** – Enter the SSA State/County code of the county which the listed physician/provider will serve. The state/county code is a five digit number. Please include any leading zeros (e.g., 01010). The state and county codes on the HSD Criteria Reference Table are the codes you should use. Format the cell as “text” to ensure that codes beginning with a “0” appear as five digits.
- B. Name of Physician or Mid-Level Practitioner** – Self-explanatory. Up to 150 characters.
- C. National Provider Identifier (NPI) Number** – The provider’s assigned NPI number must be included in this column. Enter the provider’s individual NPI number whether the provider is part of a medical group or not. The NPI is a ten digit numeric field. Include leading zeros.
- D. Specialty** – Name of specialty of listed physician/provider. This should be copied directly off of the HSD Criteria Reference Table.
- E. Specialty Code** – Specialty codes are unique codes assigned by CMS to process data. Enter the appropriate specialty code (001-034).
- F. Contract Type** – Enter the type of contract the MMP holds with listed provider. Use “DC” for direct contract between the MMP and the provider and “DS” for downstream (define DS) contract.
- A “DC” – direct contract provider requires the MMP to complete Column K – Medical Group Affiliation with a “DC” and Column L – Employment Status should be marked as “N/A”.
 - A “DS” – downstream contract is between the first tier entity and other providers (such as individual physicians).
 - Where the MMP has a contract with an Independent Practice Association (IPA) with downstream contracts with physicians, MMP must complete Column F – Contract Type with a “DS”, Column K – Medical Group Affiliation must be completed by entering the IPA Name and Column L – Employment Status should be marked as “N/A”.
 - Where the MMP has a contract with a Medical Group with downstream contracted physicians, the MMP must complete Column F – Contract Type with a “DS”, Column K – Medical Group Affiliation must be completed by entering the name of the Medical Group, and Column L – Employment Status should be marked as “N/A”.
 - Where the MMP has a contract with a Medical Group with employed providers, the MMP must complete Column F – Contract Type with a “DS”, Column K – Medical Group Affiliation must be completed by entering the name of the Medical Group, and Column L – Employment Status should be marked as “E”.

Provider Service Address Columns- Enter the address (i.e., street, city, state and zip code) of the location at which the provider sees patients. **Do not list P.O. Box, house, apartment, building or suite numbers, or street intersections.**

G. **Provider Service Address: Street Address** – up to 250 characters

H. **Provider Service Address: City** – up to 150 characters

I. **Provider Service Address: State** – 2 characters

J. **Provider Service Address: Zip Code** – up to 10 characters

K. **Medical Group Affiliation** – Provide name of affiliated Medical Group/Individual Practice Association (MG/IPA) or if MMP has direct contract with provider enter “DC”.

Appendix D – MMP Facility Table Column Explanations

- A. **SSA State/County Code** – Enter the SSA State/County code of the county for which the listed facility will serve. The county code should be a five digit number. Please include any leading zeros (e.g., 01010). The state and county codes on the HSD Criteria Reference Table are the codes that MMP should use. Format the cell as “text” to ensure that codes beginning with a “0” appear as five digits.
- B. **Facility or Service Type** – Name of facility/service type of listed facility. This should be copied directly off of the HSD Criteria Reference Table.
- C. **Specialty Code** – Specialty codes are unique 3 digit numeric codes assigned by CMS to process data. Enter the Specialty Code that best describes the services offered by each facility or service. Include leading zeros.
- D. **National Provider Identifier (NPI) Number** – Enter the provider’s assigned NPI number in this column. The NPI is a ten digit numeric field. Include leading zeros.
- E. **Number of Staffed, Medicare Certified Beds** – For Acute Inpatient Hospitals (040), Critical Care Services – Intensive Care Units (ICUs) (043), Skilled Nursing Facilities (046), and Inpatient Psychiatric Facility Services (052), your organization must enter the number of Medicare certified beds for which it has contracted access for enrollees. This number should not include Neo-Natal Intensive Care Unit (NICU) beds.
- F. **Facility Name** – Enter the name of the facility. Field Length is 150 characters.

Provider Service Address Columns- Enter the address (i.e., street, city, state and zip code) from which the provider serves patients. **Do not list P.O. Box, house, apartment, building or suite numbers, or street intersections.** For Home Health and Durable Medical Equipment, indicate the business address where one can contact these vendors.

- G. **Provider Service Address: Street Address** – up to 250 characters
- H. **Provider Service Address: City** – up to 150 characters
- I. **Provider Service Address: State** – 2 characters
- J. **Provider Service Address: Zip Code** – up to 10 characters

Appendix E – Field Edits for the MMP Provider and Facility Tables

The following chart lists the SYSTEM edits for the MMP Provider Table and the MMP Facility Table. A field marked as “not required” means the system will not reject the file if the field is blank. It does not imply that the field should be blank. Please read the HSD Instructions, located above, to determine which fields are required and which are optional.

MMP Provider Table

Field	Description	Rule
SSA State/County Code	VARCHAR2(5)	Required (not null) and validated against valid values (SSA County Code). Must be pending county attached to contract.
Name of Physician or Mid-Level Practitioner	VARCHAR2(150)	Required (not null)
National Provider Identifier (NPI) Number	VARCHAR2(10)	Required (not null) and validated that it is 10 digit numeric
Specialty	VARCHAR2(150)	Required (not null)
Provider Specialty Code	VARCHAR2(3)	Required (not null) and validated against valid values
Contract Type	VARCHAR2(150)	Required (not null)
Provider Street Address	VARCHAR2(250)	Required (not null)
Provider City	VARCHAR2(150)	Required (not null)
Provider State Code	VARCHAR2(2)	Required (not null). Validate the state code against the valid list of state abbreviations
Provider Zip Code	VARCHAR2(10)	Required (not null)
Medical Group Affiliation	VARCHAR2(150)	Not Required
Employment Status	VARCHAR2(150)	Required (not null)

MMP Facility Table

Field	Description	Rule
SSA State/County Code	VARCHAR2(5)	Required (not null) and validated against valid values (SSA County Code). Must be pending non-employer county attached to contract.
Facility or Service Type	VARCHAR2(150)	Required (not null)
Facility Specialty Code	VARCHAR2(3)	Required (not null) and validated against valid values
National Provider Identifier (NPI) Number	VARCHAR2(10)	Required (not null) and validated that is 10 digit numeric
# of Staffed, Medicare-Certified Beds	VARCHAR2(10)	Verify that entry is numeric since used in a calculation. Required but only for the following facility types: Acute Inpatient Hospital (040), Critical Care Services - ICU (043), Skilled Nursing Facilities (046), and Inpatient Psychiatric Facility (052).
Facility Name	VARCHAR2(150)	Required (not null)
Provider Street Address	VARCHAR2(250)	Required (not null)
Provider City	VARCHAR(150)	Required (not null)
Provider State Code	VARCHAR2(2)	Required (not null). Validate the state code against the valid list of state abbreviations.
Provider Zip Code	VARCHAR2(10)	Required (not null)

Appendix F – CMS Public Data Source for HSD Exception Request

The following table listed below provides a list of acceptable CMS data sources used for review of HSD Exception Request. **Note:** The Medicare Advantage Provider Supply File is not used as a data source for purposes of the MMP and MN Senior Health Options D-SNP Medicare Network Review.

HSD Specialty Type	Data Source
Allergy and Immunology Cardiology Chiropractor Dermatology Endocrinology ENT/Otolaryngology Gastroenterology General Surgery Gynecology, OB/GYN Infectious Diseases Nephrology Neurology Neurosurgery Oncology – Medical, Surgical Oncology – Radiation/Radiation Oncology Ophthalmology Orthopedic Surgery Physiatry, Rehabilitative Medicine Plastic Surgery Podiatry Primary Care Providers Psychiatry Pulmonology Rheumatology Urology	Physician Compare – Data available at: https://data.medicare.gov/data/physician-compare
HSD Specialty Type	Data Source
Vascular Surgery Cardiothoracic Surgery	
Acute Inpatient Hospitals Cardiac Surgery Program Cardiac Catheterization Services Critical Care Services – Intensive Care Units (ICU) Surgical Services (Outpatient or ASC) Inpatient Psychiatric Facility Services	Provider of Services – Data available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/
Outpatient Dialysis	Dialysis Facility Compare – Data available at: https://data.medicare.gov/data/dialysis-facility-compare
Physical Therapy Speech Therapy Occupational Therapy	Physician Compare – Data available at: https://data.medicare.gov/data/physician-compare and National Plan & Provider Enumeration System (NPPES) – Data available at: http://download.cms.gov/nppes/NPI_Files.html

HSD Specialty Type	Data Source
Skilled Nursing Facilities	Nursing Home Compare – Data available at: https://data.medicare.gov/data/nursing-home-compare
HSD Specialty Type	Data Source
Mammography	Hospital Compare – Data available at: https://data.medicare.gov/data/hospital-compare and National Plan & Provider Enumeration System (NPPES) – Data available at: http://download.cms.gov/nppes/NPI_Files.html
Diagnostic Radiology Outpatient Infusion/Chemotherapy	National Plan & Provider Enumeration System (NPPES) – Data available at: http://download.cms.gov/nppes/NPI_Files.html
HSD Specialty Type	Data Source
	and Provider of Services – Data available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/