

# **Medicare Advantage Network Adequacy Criteria Guidance**

*(Last updated: January 10, 2017)*

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## 1. Introduction

All organizations, including Medicare Advantage organizations (MAOs) offering coordinated care plans (CCPs), network-based private fee-for-service (PFFS) plans, and network-based medical savings account (MSA) plans, as well as section 1876 cost organizations, must ensure access to essential services, in accordance with 42 CFR 417.414, 42 CFR 417.416, 42 CFR 422.112(a)(1)(i) and 42 CFR 422.114(a)(3)(ii). Therefore, these organization types must provide enrollees healthcare services through a contracted network of providers that is consistent with the pattern of care in the network service area (see 42 CFR 422.112(a)). Regional plans are an exception and under specified conditions can arrange for care in portions of a region it serves on a non-network basis (see [section 8](#) for additional information on regional plans).

### 1.1. CMS Responsibility

CMS monitors an organization's compliance with network access requirements. Each year, CMS, with the support of the network adequacy criteria development contractor<sup>1</sup>, assesses healthcare industry trends and Medicare Advantage (MA) enrollee healthcare needs to establish network adequacy criteria. This network adequacy criteria include provider and facility specialty types that must be available consistent with CMS number, time, and distance standards. Access to each specialty type is assessed using quantitative standards based on the local availability of providers to ensure that organizations contract with a sufficient number of providers and facilities in order to provide healthcare services without placing undue burden on enrollees trying to obtain covered services. CMS programs the network adequacy criteria into the Health Plan Management System (HPMS) to facilitate an automated review of an organization's network adequacy. See [section 2](#) and [section 3](#) for a discussion of the established network adequacy criteria. CMS also provides organizations an opportunity to request exception(s) to the network adequacy criteria and reviews those requests manually. As discussed in [section 5](#), valid exceptions to the network adequacy criteria occur where there has been a change to the healthcare landscape that is not currently reflected in the network adequacy criteria. Organizations should also reference section 110 of chapter 4 of the Medicare Managed Care Manual (MMCM) for more information on network access requirements, which is available on CMS's website at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html>.

#### 1.1.1. Events Triggering CMS Network Reviews

Several events trigger CMS's review of organizations' contracted networks.

1. **Application.** Any organization seeking to offer a new contract or to expand the service area of an existing contract must demonstrate compliance with CMS's network adequacy criteria in its application. Applications are submitted to CMS in February of each calendar year.
2. **Provider-Specific Plan.** A provider-specific plan (PSP) is an MA plan designed to offer enrollees benefits through a subset of the overall contracted network in a given service area. An organization requests to offer a PSP with their bid submission on the first Monday in June of each calendar year.

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<sup>1</sup> CMS is currently contracted with The Lewin Group, Inc. to support the development of network adequacy criteria.

3. **Provider/Facility Contract Termination.** When a contract between an MAO and a provider or facility is terminated, CMS may request to review the remaining contracted network in order to ensure the organization's ongoing compliance with network adequacy criteria. For more information on significant network changes, please refer to section 110.1.2 of chapter 4 of the MMCM.
4. **Change of Ownership.** As defined in 42 CFR 422 Subpart L, a change of ownership is the transfer of title, assets, and property to the new owner or acquiring entity that becomes the successor in interest to the current owner's MA contract. Acquiring entities that have not been approved by CMS to operate in the acquired service area may need to demonstrate compliance with network adequacy criteria through the application process. If required, CMS will provide acquiring entities with the necessary instructions for submitting their contracted network for CMS review. Existing MAOs should reference the change of ownership requirements in chapter 12 of the MMCM for additional information regarding CMS notification requirements.
5. **Network Access Complaints.** If CMS receives a complaint from an enrollee, caregiver, or other source that indicates an organization is not providing sufficient access to covered healthcare services, CMS may elect to review the organization's contracted network.
6. **Organization-Disclosed Network Deficiency.** CMS expects that organizations continuously monitor their networks for compliance with the current network adequacy criteria. CMS encourages organizations to notify CMS upon discovery that their network is out of compliance with network adequacy criteria. Once notified, CMS will request that the organization upload its contracted network for CMS review.

The extent of the CMS network review varies based on the specific circumstances of the triggering event. CMS will provide organizations with specific instructions for submitting their contracted networks.

### 1.1.2. CMS-Identified Deficiencies

When CMS identifies deficiencies in an organization's contracted network, there are impacts on the application, bid, and/or operational contract.

- **Application:** CMS will deny any application that has one or more unresolved network deficiencies.
- **Bid:** CMS will not approve a PSP when the plan-specific network has one or more unresolved network deficiencies.
- **Operational Contract:** CMS may take compliance action when an existing, contracted network has one or more CMS-identified deficiencies.

Communications about network deficiencies found in the application are part of the application process. Communications related to bid submissions for PSPs occur during CMS's bid review process in June through August. Any communications related to an operating contract's network deficiencies will be facilitated through the organization's Account Manager and other CMS staff.

## 1.2. Organization Responsibility

Organizations that have existing contracts with CMS and organizations seeking a new contract with CMS must meet current CMS network access requirements for a respective contract year. This includes compliance with CMS's county integrity rule and network access requirements at

42 CFR 422.2, 42 CFR 422.112(a)(1)(i), and 42 CFR 422.114(a)(3)(ii). CMS expects that organizations continuously monitor their contracted networks throughout the respective contract year to ensure compliance with the current network adequacy criteria.

### 1.3. Document Organization

The remaining sections of this document provide guidance related to CMS’s network adequacy requirements. This document is organized as follows.

Section Number	Section Title	Description
1	Introduction	This section provides an introduction to CMS’s network adequacy requirements and the roles of the organization and CMS for ensuring adequate access to care for enrollees.
2	Specialty Types	This section identifies CMS methodology for establishing the specialty types CMS will assess in order to determine that an organization’s contracted network provides sufficient access to covered services.
3	Quantitative Measures of Network Adequacy	This section discusses CMS’s methodology for establishing quantitative measures for each specialty type listed under <a href="#">section 2</a> of this document.
4	Health Service Delivery (HSD) Table Submission	This section describes how organizations submit contracted networks for review against CMS’s network adequacy criteria, which is the combination of the specialty types and quantitative measures outlined under <a href="#">section 2</a> and <a href="#">section 3</a> .
5	Exception Requests for Time and Distance Standards	This section describes the process by which organizations can request exceptions to CMS’s quantitative time and distance standards discussed under <a href="#">section 4</a> .
6	Partial Counties	This section describes CMS’s requirement that organizations serve full counties and describes the process by which organizations may request an exception to the CMS’s full county policy (also known as the “county integrity rule”).
7	Provider-Specific Plans (PSPs)	This section defines PSPs and outlines how CMS reviews networks when a PSP is requested for a prospective contract year.
8	Regional Preferred Provider Organizations (RPPOs)	This section defines RPPOs and the unique opportunity afforded to RPPOs for providing access to care for enrollees.

In addition to the sections above, there are several appendices that provide additional guidance

and templates to organizations. Questions concerning this document should be directed to CMS's website portal at: <https://dmao.lmi.org>.

**Please note that the guidance contained in this document does not apply to the following product types: Medicare/Medicaid Plans (MMPs), section 1833 cost plans, and non-network PFFS/MSA plans.**

## 2. Specialty Types

### 2.1. Selection of Provider and Facility Specialty Types

Through the development of the network adequacy criteria, CMS establishes national standards that would ensure access to covered healthcare services. CMS identifies provider and facility specialty types critical to providing services through a consideration of:

- Medicare Fee-for-service (FFS) utilization patterns,
- Utilization of provider/facility specialty types in Medicare FFS and managed care programs,
- Clinical needs of Medicare beneficiaries, and
- Specialty types measured to assess the adequacy of other managed care products (e.g., Tricare, Medicaid, and commercial products).

CMS publishes any changes to the specialty types each year on our website at:

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

### 2.2. Current Specialty Types

Currently, CMS measures 27 provider specialty types<sup>2</sup> and 23 facility specialty types to assess the adequacy of the network for each service area. CMS has created specific codes for each of the provider and facility specialty types which may be found in [Appendix D](#) and [Appendix E](#) of this document. Organizations must use the codes when completing Provider and Facility HSD Tables. Additional information on specialty types and codes is available in the current HSD Reference File posted on CMS's website at: <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/>.

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<sup>2</sup> Primary care providers (specialty code S03) are measured as a single specialty, but submitted under six codes (001 through 006).

### 3. Quantitative Measurements of Network Adequacy

The sections below describe CMS's methodology for measuring access to covered services through the establishment of quantitative standards for the specialty types described in [section 2](#). These quantitative standards are collectively referred to as the MA network adequacy criteria.

#### 3.1. Methodology for Measuring Access to Covered Services

CMS requires that organizations contract with a sufficient number of providers and facilities to ensure that at least 90 percent of enrollees within a county can access care within specific travel time and distance maximums. The 90 percent coverage requirement aligns with access standards implemented by other federal programs, such as TRICARE's standard for convenient access and Medicare Part D's standard for retail pharmacy networks.

The quantitative criteria take into account differences in utilization across provider/facility types and patterns of care in urban and rural areas. Utilization was calculated and informed using Medicare fee-for-service (FFS) claims data and published literature on utilization for both FFS and managed care populations. The resulting criteria thus reflect the expected use of providers and facilities (by specialty type) for MA enrollees. The sections below describe the components of the quantitative network adequacy criteria and how they are calculated.

##### 3.1.1. County Type Designations

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). CMS uses a county type designation method that is based upon the population size and density parameters of individual counties. These parameters are foundationally based on approaches used by the Census Bureau in its classification of "urbanized areas" and "urban clusters," and by the Office of Management and Budget (OMB) in its classification of "metropolitan" and "micropolitan."

Table 3-1 lists the population and density parameters applied to determine county type designations. **A county must meet both the population and density thresholds for inclusion in a given county type designation.** For example, a county with a population greater than one million and a density greater than or equal to 1,000/mi<sup>2</sup> is designated as Large Metro. Any of the population density combinations listed for a given county type designation may be met for inclusion within that county type designation (i.e., a county would be designated Large Metro if any of the three Large Metro population-density combinations listed in Table 3-1 are met; a county is designated as Metro if any of the five Metro population-density combinations listed in Table 1 are met; etc.).

**Table 3-1: Population and Density Parameters**

County Type Designation	Population	Density
<b>Large Metro</b>	≥ 1,000,000	> 1,000/mi <sup>2</sup>
--	500,000 – 999,999	≥ 1,500/mi <sup>2</sup>
--	Any	≥ 5,000/mi <sup>2</sup>
<b>Metro</b>	≥ 1,000,000	10 – 999.9/mi <sup>2</sup>
--	500,000 – 999,999	10 – 1,499.9/mi <sup>2</sup>
--	200,000 – 499,999	10 – 4,999.9/mi <sup>2</sup>
--	50,000 – 199,999	100 – 4,999.9/mi <sup>2</sup>
--	10,000 – 49,999	1,000 – 4,999.9/mi <sup>2</sup>
<b>Micro</b>	50,000 – 199,999	10 – 99.9 /mi <sup>2</sup>
--	10,000 – 49,999	50 – 999.9/mi <sup>2</sup>
<b>Rural</b>	10,000 – 49,999	10 – 49.9/mi <sup>2</sup>
--	<10,000	10 – 4,999.9/mi <sup>2</sup>
<b>CEAC</b>	Any	<10/mi <sup>2</sup>

Each year, CMS applies these parameters to the most recently available U.S. Census Bureau population estimates to determine appropriate county type designations.<sup>3</sup>

### 3.1.2. Minimum Number Requirement

Organizations must demonstrate that their networks have sufficient numbers of providers and facilities to meet minimum number requirements to allow adequate access for beneficiaries. The minimum number requirement ensures that organizations have a contracted network that is broad enough to provide beneficiaries residing in a county access to covered services.<sup>4</sup> Specialized, long-term care, and pediatric/children’s hospitals, as well as providers/facilities contracted with the organization only for its commercial, Medicaid, or other products, do not count toward meeting the MA network adequacy criteria.

#### 3.1.2.1. Minimum Number of Providers

Organizations must contract with a specified minimum number of each provider specialty type; each contracted provider must be within the maximum time and distance of at least one beneficiary in order to count toward the minimum number. The following section describes the subcomponents of the minimum number of providers requirement.

##### 3.1.2.1.1. 95<sup>th</sup> Percentile of Beneficiaries Served by Organizations<sup>5</sup>

The 95<sup>th</sup> Percentile Base Population Ratio represents the approximate proportion of total

<sup>3</sup> Calendar year 2015 population and density estimates are available at: <http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>.

<sup>4</sup> This requirement works in concert with the time and distance criteria to ensure access to covered services.

<sup>5</sup> Note that the 95<sup>th</sup> percentile base population ratio is a metric used to determine the minimum number requirement prior to HSD table submission. It is conceptually unrelated to the 90% requirement, which is used to evaluate reasonable access of networks submitted by organizations, demonstrating that at least 90% of beneficiaries in the county are within the maximum time and distance for a given specialty.

Medicare beneficiaries in a county who may enroll in an MA plan in a given year. It is calculated as the 95<sup>th</sup> percentile of MA market penetration rates of CCP and network-based PFFS MA contracts by county for each county type designation; i.e., 95 percent of CCP and network-based PFFS contracts have county penetration rates equal to or less than the calculated rates.<sup>6</sup> Each year, CMS updates the 95<sup>th</sup> percentile based on current enrollment. The current 95<sup>th</sup> Percentile Base Population Ratios are presented in Table 3-2.

**Table 3-2: 95th Percentile Base Population Ratio**

*The 95<sup>th</sup> percentile represents MA market penetration rates based on county type designation*

County Type Designation	95 <sup>th</sup> %-ile
Large Metro	0.070
Metro	0.126
Micro	0.112
Rural	0.119
CEAC	0.134

**3.1.2.1.2. Beneficiaries Required to Cover**

Beneficiaries Required to Cover is the base population that an organization’s network should be able to serve (i.e., provide adequate access to covered services). It is an estimate of the potential number of beneficiaries an organization may serve within a county service area based on the penetration of MA products. To calculate this metric, the number of Medicare beneficiaries in a specific county is multiplied by the applicable 95<sup>th</sup> percentile, as shown in Table 3-3 below. Note that the number of beneficiaries required to cover is determined at the county level, and it is independent of specialty type.

**Table 3-3: Beneficiaries Required to Cover, Example Calculation**

*The beneficiaries required to cover is the product of the total Medicare beneficiaries and 95<sup>th</sup> percentile base population ratio*

County	Baldwin, AL
County Type Designation	Metro
Total Beneficiaries	46,542
95 <sup>th</sup> %-ile for Metro County Designation	0.126
Required to Cover	$(46,542 * 0.126) = \mathbf{5,857 \text{ Beneficiaries}}$

**3.1.2.1.3. Minimum Provider Ratios**

The Minimum Provider Ratio is the number of providers required per 1,000 beneficiaries for provider specialty types. CMS has established ratios of providers that reflect the utilization patterns based on the Medicare population. Specifically, the network adequacy criteria includes a ratio of providers required per 1,000 beneficiaries for the provider specialty types (see [Appendix D](#)) identified as required to meet network adequacy criteria. These ratios vary by county type and are published for the applicable specialty types in the HSD Reference File. To calculate the minimum number required for each specialty type in each county, the number of Beneficiaries

<sup>6</sup> Penetration rate is calculated by dividing the number of Medicare beneficiaries enrolled in an MA contract by the number of eligible Medicare beneficiaries in that county. For example, in a county with 1,000 eligible Medicare beneficiaries, an MA CCP contract with 100 members would have a penetration rate of 100/1,000, or 0.10 (10%).

Required to Cover is multiplied by the Minimum Provider Ratio and rounded up to the nearest whole number. Please note that organizations may need to submit more than the minimum number required in order to ensure that 90 percent of beneficiaries have access to at least one provider (per specialty type) within time and distance standards to meet all components of the network adequacy criteria.

**Table 3-4: Example of Minimum Provider Calculation**

*The minimum number of providers is the product of the beneficiaries required to cover and the minimum provider ratio*

County	Baldwin, AL
County Type Designation	Metro
Beneficiaries Required to Cover	5,857
Specialty Type	Primary Care
Minimum Provider Ratio	1.67/1,000
Minimum Number of Providers	$(1.67/1,000) * 5,857 = 9.78 = \mathbf{10 \text{ Providers}}$ (rounded up)

**3.1.2.2. Minimum Number of Facilities**

Organizations must demonstrate that their contracted inpatient hospitals have at least the minimum number of Medicare-certified hospital beds per 1,000 beneficiaries, calculated using the same methodology as described for provider specialties in Minimum Number of Providers above based on beneficiaries expected to cover and utilization ratios. The minimum number criteria for acute inpatient hospitals is calculated based on the number of beds rather than the number of facilities to reflect the varying capacity of acute inpatient hospitals.

With the exception of home health, durable medical equipment (DME), and transplant specialties, all other facility types and transplant programs have a minimum number requirement of one facility. To count towards the minimum number requirement, the contracted facility must be within time and distance parameter, and thus organizations may need to submit more than one of each facility in order to ensure that at least 90 percent of beneficiaries are within time and distance standards to meet the network adequacy criteria. This may be the case if there is a facility located in the far corner of a county, beyond the maximum distance threshold for more than 10 percent of the beneficiaries in the county.

**3.1.3. Maximum Time and Distance Standard**

Organizations must demonstrate that their networks do not unduly burden beneficiaries in terms of travel time and distance to network providers/facilities. Time standards complement distance standards by ensuring access in an appropriate timeframe. These time and distance metrics speak to the access requirements pertinent to the approximate locations of beneficiaries, relative to the locations of the network provider/facilities. The maximum time and distance criteria were developed using a process of mapping beneficiary locations juxtaposed with provider/facility practice locations. Organizations must ensure that at least 90 percent of the beneficiaries residing in a given county have access to at least one provider/facility of each specialty type within the published time and distance standards.<sup>7</sup> The maximum travel time and distance standards are generally determined by county type and specialty type.

<sup>7</sup> Provider/facilities are not required to be within the county or state boundaries for the service area.

### ***3.1.3.1. Specialty Types not Subject to Time and Distance Standards***

The following facility types are not subject to maximum time and distance parameters.

- Home Health
- Durable Medical Equipment
- Heart Transplant Program
- Heart/Lung Transplant
- Kidney Transplant Program
- Liver Transplant Program
- Lung Transplant Program
- Pancreas Transplant Program

For these select facility specialty types, organizations are required to submit at least one facility, supplier, or transplant program that will provide access to beneficiaries across the entire county of application and provide the full range of covered services for the specific specialty type.

### ***3.1.3.2. Provider and Facility Supply***

Beginning in contract year (CY) 2017, network adequacy criteria for a limited selection of counties and specialties have been customized to reflect the current availability of providers and facilities, and potentially reduce the burden associated with the preparation and review of Exception Requests. The customization specifically addresses instances where moderate increases to the distance standard would likely enable organizations to provide coverage to at least 90 percent of beneficiaries residing in the county.

CMS and its contractor have developed a provider and facility supply file. This supply file was developed using multiple data sources to identify, to the extent possible, Medicare providers and facilities available at a national level. The supply file is a cross-sectional database that includes information on provider and facility name, address, national provider identifier, and specialty type and is posted by state and specialty type.

The supply file published in HPMS has been segmented by state to facilitate development of networks by service area. Organizations whose service area is near a state border may need to review the supply file for multiple states, as the network adequacy criteria are not restricted by state or county boundaries but are driven by the time and distance criteria (i.e., organizations may have to contract with providers and facilities in a neighboring state or county to meet the network adequacy criteria).

**Given the dynamic nature of the market, the database may not be a complete depiction of the provider and facility supply available in real-time. Additionally, the supply file is limited to CMS data sources – organizations may have additional data sources that identify providers/facilities not included in the supply file used as the basis of CMS’s network adequacy criteria. As a result, organizations should not rely solely on the supply file when establishing networks, as additional providers and facilities may be available.**

CMS uses the supply file when validating information submitted on exception requests. Therefore, CMS and its contractor may update the supply file periodically to reflect updated

provider and facility information and to capture information associated with Exception Request submissions.

#### *3.1.3.2.1. Provider Supply File*

Provider information was obtained from the Physician Compare downloadable database. Physician Compare is a database maintained by CMS, which documents physicians and other healthcare professionals that are currently enrolled in Medicare.<sup>8</sup> Once downloaded, providers are grouped to align with HSD specialty types based on the following:

- Providers who have “Pediatric Medicine” listed as a primary or secondary specialty are removed from the database.
- For providers whose primary specialty is listed as “Internal Medicine,”
  - If their secondary specialty was listed as “Emergency Medicine,” they were removed from the supply file.
  - If their secondary specialty was associated with an HSD specialty code, they were matched to the respective code (e.g., if a provider’s primary specialty was listed as “Internal Medicine” and their secondary specialty was listed as “Cardiovascular Disease,” then their specialty code would be listed as “008 - Cardiology” in the supply file).
  - If their secondary specialty was not associated with another HSD provider specialty type, then the provider was assigned an HSD specialty code of “S03 - Primary Care Providers.”
- The remaining providers were then matched to an HSD specialty code, as appropriate, based on their primary specialty (e.g., a provider whose primary specialty was listed as “Cardiac Electrophysiology” would be assigned a specialty code of “008 – Cardiology”).

#### *3.1.3.2.2. Facility Supply File*

Facility information was gathered from various publically available data sources, including the Provider of Services (POS) file, Nursing Home Compare, Home Health Compare, and Dialysis Compare, all of which are maintained by CMS.<sup>9</sup> Facilities were then assessed to determine whether they would serve a Medicare population and assigned to the appropriate HSD specialty type:

- Facilities that were identified as only serving the Medicaid population were removed from the supply file.
- Facilities listed in Nursing Home Compare<sup>10</sup> were assigned a specialty code of “046 – Skilled Nursing Facilities.”

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<sup>8</sup> Physician Compare has a time lag between when data is received and when it is made publically available, and it may not be reflective of the current supply in real-time; the Physician Compare database can be downloaded at: <https://data.medicare.gov/data/physician-compare>.

<sup>9</sup> These data sources have a time lag between when data is received and when it is made publically available; as a result, data from these public data sources may not be reflective of the current supply in real-time.

<sup>10</sup> The Nursing Home Compare database can be downloaded at: <https://data.medicare.gov/data/nursing-home-compare>.

- Facilities listed in Home Health Compare<sup>11</sup> were assigned a specialty code of “055 – Home Health.”
- Facilities listed in Dialysis Compare<sup>12</sup> were assigned a specialty code of “044 – Outpatient Dialysis.”
- For facility specialty types identified using the POS file,<sup>13</sup> a series of inclusion and exclusion criteria were applied to identify facilities that were eligible and likely to serve the Medicare population.

Data from public files was supplemented by Medicare claims data to confirm the services offered for select facility specialty types.

### ***3.1.3.3. Exceptions to Network Adequacy Criteria***

Although the time and distance standards vary by degree of urbanization and specialty type and are generally attainable across the country, there are unique instances where a given county’s supply of providers/facilities is such that an applicant would not be able to meet the network adequacy criteria. Organizations may use submit and Exception Request to CMS’s time and distance standards in such instances (see [section 5](#) for additional information). **NOTE: CMS does not permit exception requests for the specialty types defined under section 3.1.3.1 as these specialties are not assessed against time and distance standards.**

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<sup>11</sup> The Home Health Compare database can be downloaded at: <https://data.medicare.gov/data/home-health-compare>.

<sup>12</sup> The Dialysis Compare database can be downloaded at: <https://data.medicare.gov/data/dialysis-facility-compare>.

<sup>13</sup> The POS file can be downloaded at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/>.

## 4. Health Service Delivery Table Upload Instructions

*Note: Detailed Technical instructions are outlined in the HPMS User Guides*

Organizations must demonstrate that they have an adequate contracted provider network that is sufficient to provide access to covered services, as required by 42 CFR 417.414, 42 CFR 417.416, 42 CFR 422.112(a)(1)(i) and 42 CFR 422.114(a)(3)(ii). Organizations are able to demonstrate network adequacy through the submission of Provider and Facility Health Service Delivery (HSD) Tables. **Organizations shall only list providers and facilities with which the organization has fully executed contracts on the HSD Tables.** CMS considers a contract fully executed when both parties have signed and should be executed on or prior to the HSD submission deadline. The HSD Tables templates are available in [Appendix H](#) and [Appendix J](#) and in the MA Download file in HPMS.

### 4.1. Populating the HSD Tables

#### 4.1.1. Provider HSD Table

The Provider HSD Table is where you will list every **contracted** provider in your network. The Provider HSD Table template has several fields to record the state/county code for the county that the provider will be serving, the provider's name, National Provider Identifier Number (NPI), specialty, specialty code, contract type, provider service address, if accepts new patients, medical group affiliation and if uses CMS MA contract amendment (see [Appendix I](#) for the Provider HSD Table field definitions). CMS has created specific specialty codes for each provider specialty type. Organizations must use these codes when completing the Provider HSD Table (see [Appendix D](#) for a complete list of Provider Type specialty codes). If a provider serves beneficiaries from multiple counties in the service area, list the provider multiple times on the Provider HSD Table in the appropriate state/county code to account for each county. Providers may serve enrollees residing in a different county/or state than their office locations. However, organizations should not list contracted provider in state/county codes where enrollees could not reasonably access services and that are outside the pattern of care (e.g. listing a primary care provider practicing in California for a county in Massachusetts). Such extraneous listing of provider affects CMS' ability to quickly and efficiently assess provider networks against the network adequacy criteria.

Organizations must ensure that the Provider HSD Table meets the conditions described below.

- Providers must not have opted out of Medicare.
- Providers are not currently sanctioned by a federal program or relevant state licensing boards.
- Physicians and specialists must not be pediatric providers, as they do not routinely provide services to the aged Medicare population.
- Mid-level practitioners, such as physician assistants and nurse practitioners, must not be used to satisfy the network adequacy criteria for specialties other than the Primary Care Providers (see the HSD Reference File for additional conditions related to physician assistants and nurse practitioners).

Organizations are responsible for ensuring contracted providers meet state and federal licensing requirements as well as the organization's credentialing requirements for the specialty type prior to including them on the Provider HSD Table. Verification of credentialing documentation may be requested at any time. Including providers that are not qualified to provide the full range of specialty services listed in the Provider HSD Table will result in inaccurate ACC results and possible network deficiencies.

In order for the automated network review tool to appropriately process this information, MAOs 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 NMM to check their networks and to fully review the ACC reports to ensure that their HSD tables are accurate and complete.

#### **4.1.2. Facility HSD Table**

The Facility HSD Table is where you will list every **contracted** facility in your network. Only list the facilities that are contracted and Medicare-certified. Please do not list any additional facilities or services except those included in the list of facility specialty codes (see [Appendix E](#) for a complete list of Facility Type specialty codes). The Facility HSD Table template has several fields to record the state/county code for the county that the facility will be serving, facility or service type, NPI number, number of staffed/Medicare-certified beds, facility name, provider service address, and if uses CMS MA contract amendment (see [Appendix K](#) for the Facility HSD Table field definitions).

Facilities may serve enrollees residing in a different county and/or state than their office location. However, organizations should NOT list contracted facilities in state/county codes where the enrollee 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 the network adequacy criteria.

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

#### **4.2. Organization-Initiated Testing of Contracted Networks**

Organizations that received a contract ID number from CMS, either through the Notice of Intent to Apply process or receipt of a signed contract, have the opportunity to test their contracted networks' compliance with network adequacy criteria at any time throughout the year via the Network Management Module (NMM) in HPMS. To test networks, organizations may access the following navigation path: **HPMS Home Page>Monitoring>Network Management>Organization Initiated Upload**. Once an organization uploads their HSD tables through the Organization Initiated Upload, HPMS will automatically review the contracted network against CMS network adequacy criteria for each required provider and facility type in each county.

The results of the HSD tables review will be available through the HSD Automated Criteria Check (ACC) report in HPMS. The ACC reports may be accessed at the following navigation

path: **HPMS Home Page>Monitoring>Network Management>ACC Extracts.**

The ACC report displays the results of the automated network assessment for each provider and facility. The results are displayed as either “PASS” or “FAIL”. Results displayed as “PASS” means that the specific provider or facility met the CMS network adequacy criteria. Results displayed as “FAIL” means that the specific provider or facility did not meet the criteria. In addition, HPMS has available the HSD Zip Code Report that indicates the areas in which enrollees do not have adequate access. The ACC reports may be accessed at the following navigation path: **HPMS Home Page>Monitoring>Network Management>ACC Extracts.** Organizations should use the feedback received during the network self-checks to revise HSD tables and formally submit them by the application initial submission date.

Specific instructions on how to submit each table and access the ACC reports will be outlined in the NMM Organization Quick Reference Guide. The NMM Reference Guide may be accessed at the following navigation path: **HPMS Home Page>Monitoring>Network Management>User Guide>NMM Org Quick Reference User Guide.**

### 4.3. CMS Network Adequacy Reviews

As discussed in [section 1](#), several events trigger CMS’s review of an organization’s contracted network. The type of triggering event dictates where CMS requires an organization to upload their HSD tables, as shown in Table 4-1 below.

**Table 4-1: HPMS Module for CMS Network Adequacy Reviews**

Triggering Event	Application Module	Network Management Module
Application	X	
Provider-Specific Plan		X
Provider/Facility Contract Termination		X
Change of Ownership	X	
Network Access Complaint		X
Organization-Disclosed Network Deficiency		X

As reflected in Table 4-1, the NMM supports network reviews of existing, operational contracts only. The Application Module supports networks reviewed as part of the application review process that qualifies an entity to offer Medicare Advantage plans in a service area pursuant to 42 CFR 422 Subpart K. The sections below provide instructions for uploading HSD tables in the HPMS.

#### 4.3.1. HPMS Application Module

By the application initial submission date, organizations will formally submit HSD tables via the HPMS Online Application module. The Online Application upload requirements are completed in the following navigation path: **HPMS Home Page> Contract Management>Basic Contract Management>Select Contract Number>Contract Management Start Page>Online Application>Upload Files>HSD Tables.** Organizations applying for a Service Area Expansion

(SAE) must upload HSD tables for the entire network not just the counties targeted in the SAE application.

HSD tables will be automatically reviewed against CMS network adequacy criteria for each required provider and facility type in each county. After each submission, the results of the HSD tables review will be available through the HSD Automated Criteria Check (ACC) Report in HPMS. The ACC reports may be accessed at the following navigation path: **HPMS Home Page > Contract Management > Basic Contract Management > Select Contract Number > Submit Application Data > HSD Submission Reports.**

#### **4.3.2. HPMS Network Management Module**

The NMM, Org-Initiated Functionality, may be used to check Networks against the current criteria. To Utilize the Org-Initiated Functionality, please reference the User Guide located at: **HPMS Home Page>Monitoring>Network Management>User Guide.**

## 5. Exception Requests for Network Adequacy Criteria

CMS updates the network adequacy criteria each year based on the most current data available, as described in [section 2](#) and [section 3](#) above. Given the high volume of change that occurs in the healthcare landscape throughout a given year, the providers/facilities available to achieve appropriate network access is in a constant state of flux. The Exception Request process allows organizations the opportunity to provide evidence to CMS when the healthcare market landscape has changed or does not reflect the current CMS network adequacy criteria (e.g., provider retirement or facility closure).

An organization may request an Exception to the current CMS network adequacy criteria if:

- The existing landscape of providers/facilities does not enable the organization to meet the current CMS network adequacy criteria for a given county and specialty type, as reflected in the HSD Reference File<sup>14</sup>, **and**
- The organization has contracted with other providers/facilities that, although, may be located beyond the limits set in CMS’s criteria for time and distance, do provide access that is consistent with or better than the original Medicare pattern of care for a given county and specialty type. Generally, these will be those qualified providers/facilities who are most accessible to beneficiaries in terms of time and distance.

Once an organization provides conclusive evidence in its Exception Request that the CMS network adequacy criteria cannot be met because of insufficient supply, the organization must then demonstrate that its contracted network (i.e., providers/facilities included on its HSD tables) provides at least 90 percent of enrollees in the county with adequate access to covered services and is consistent with or better than the original Medicare pattern of care for a given county and specialty type.

CMS defines the “original Medicare pattern of care” as those providers/facilities original Medicare beneficiaries primarily utilize in a specified geographic area in order to receive their Medicare covered healthcare services. An enrollee who resides in the same geographic area must have access to providers/facilities furnishing Medicare-covered services that is consistent with or better than an original Medicare beneficiary’s access to providers/facilities, in terms of time and distance. However, while it is a necessary condition that MA networks are consistent with the original Medicare pattern of care, it is not always a sufficient condition to meet network adequacy criteria; CMS always prioritizes the best interests of beneficiaries. Organizations should ensure adequate access without placing undue burden on enrollees.

In evaluating an organization’s Exception Request, CMS will consider:

- Whether the current access to providers/facilities are different from the present reflection in the HSD Reference File, **and**
- Whether there are “other factors” present, in accordance with 42 CFR 422.112(a)(10)(v), including:

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<sup>14</sup> The current HSD Reference File is located at: <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/>

- The proposed Exception reflects access that is consistent with or better than the original Medicare pattern of care, **and**
- The proposed Exception is in the best interests of beneficiaries.

**Please note that organizations may need to contract with providers/facilities located outside CMS network adequacy criteria to ensure adequate access.**

### **5.1. Exception Request Upload Instructions**

Organizations must resubmit all previously approved Exception Requests whenever CMS requests an organization to upload its HSD tables.<sup>15</sup>

- **Application Module:** For network reviews that occur using the Application Module, organizations shall use the Exception Request Template in HPMS and submit the template in accordance with CMS’s application instructions defined in HPMS and available on our website at: <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/>.
- **Network Management Module:** For network reviews that occur using the NMM, organizations shall complete the Exception Request Template in HPMS. Organizations will submit the completed template in accordance with CMS communications.

### **5.2. County Type Considerations**

If an organization is offering a plan in an urban area (i.e., Large Metro or Metro county type designations), then CMS does not expect that the network adequacy criteria will warrant an Exception. The abundance of available providers/facilities in densely populated counties will usually ensure that organizations can establish a network that is consistent with if not better than the prevailing original Medicare pattern of care. Specifically, the high population density of Large Metro and Metro counties is accompanied by a significant number and array of available providers and facilities, including most specialists, allowing for reasonable travel times/distances for enrollees to obtain covered services – as opposed to more extended patterns of care, as might be expected in rural areas. Consequently, for CEAC, Rural, and Micro county types, organizations may need to request an Exception if the current landscape of providers/facilities does not enable the organization to meet the CMS network adequacy criteria for a given county and specialty type.

### **5.3. Rationales for Not Contracting**

The Exception Request template allows organizations the opportunity to provide a valid rationale for not contracting with providers/facilities that are within or close to the time and distance limits of the CMS network adequacy criteria. Organizations are to follow the instructions on the most current Exception Request template to provide a reason for not contracting with certain provider/facilities. Typically, organizations use the Exception Request to identify when a provider has retired or moved to a different office location, effectively changing the available supply and ability to meet the CMS network adequacy criteria. If a sufficient number of providers/facilities are available to meet CMS network adequacy criteria, CMS expects organizations to meet the criteria without an Exception.

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<sup>15</sup> See [Appendix F](#) for the current Exception Request template.

### **5.3.1. Invalid Rationales**

CMS defines “inability to contract” as the organization’s inability to successfully negotiate and establish a contract with a provider. In general, CMS does not consider “inability to contract” as a valid rationale for an Exception to the network adequacy criteria. The basis for this is that CMS cannot assume the role of arbitrating or judging the bona fides of contract negotiations between an organization and available providers. Therefore, CMS will generally not accept an organization’s assertion that it cannot meet current CMS network adequacy criteria because providers are not willing to contract with it.

If an organization cannot come to a financial contracting agreement with a provider, this is not a valid reason for an Exception Request. For example, an organization selects “Inability to contract with provider” as a “Reason for Not Contracting” on the Exception Template. The organization then states that the provider was not willing to accept the organization’s proposed payment rates, and therefore refused to contract with the organization. CMS would consider the organization’s inability to contract rationale to be invalid.

CMS expects organizations to only submit an Exception Request when the current CMS network adequacy criteria cannot be met based on provider/facility supply. Organizations shall not submit a “placeholder” Exception Request that indicates the organization is in the process of contracting with providers/facilities. CMS will only consider providers/facilities on the HSD tables as in-network that have been credentialed and contracted, and CMS will not accept claims of interim contracting efforts on an Exception Request. For example, an organization selects “In the process of negotiating a contract with provider” as a “Reason for Not Contracting” on the exception request template. The organization then states that contracting negotiations are still underway with a provider, and the provider will be in-network as soon as the contract is signed and executed. CMS would consider the rationale to be invalid because the organization does not currently have an established, effective contract with that provider and, therefore, cannot list the provider on its HSD table.

There are rare instances when CMS will consider an organization’s reason for not contracting with a provider that is available. Please see the section 5.3.2 below for more details.

### **5.3.2. Valid Rationales**

Generally, organizations use the Exception Request process to identify when the supply of providers/facilities is such that it is not possible for the MAO to obtain contracts that satisfy CMS’s network adequacy criteria. Valid rationales include recent changes in an area, such as when a provider has retired or moved to a different office location. There are rare instances when CMS will consider an organization’s reason for not contracting with a provider that is available. For example, based on public sources, an organization might claim that an available provider may cause beneficiary harm. CMS will consider beneficiary harm rationale if the organization provides substantial and credible evidence. On the Exception Request, from the “Reason for Not Contracting” drop-down list, the organization must select “Other,” and then provide evidence in the “Additional Notes on Reason for Not Contracting” field. Evidence of beneficiary harm could be a public news article about a provider’s gross negligence in providing care to beneficiaries.<sup>16</sup>

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<sup>16</sup> CMS will generally not accept an organization’s unwillingness to contract with an otherwise qualified provider/facility due to the organization’s own internal standards.

**CMS will validate all statements made on the Exception Request.**

CMS will also consider an organization’s rationale for an Exception if a provider/facility either:

- Does not contract with **any** organizations, or
- Contracts **exclusively** with another organization.

CMS will consider these two different rationales if the organization provides substantial and credible evidence. More detailed information and evidence in the Exception Request will give CMS more confidence in the request when validating the organization’s claims. On the Exception Request, from the “Reason for Not Contracting” drop-down list, an organization could select either “Provider does not contract with any Medicare Advantage Organization” or “Other” if the provider/facility contracts exclusively with another organization. The organization must then provide evidence in the “Additional Notes on Reason for Not Contracting” field. Evidence could be in the form of a letter or e-mail from the provider’s/facility’s office stating the policy and refusal to contract. Where this evidence is present, CMS would consider this information when reviewing the exception request. **CMS will validate all statements made on the Exception Request.**

Another instance is an organization might claim that an available provider is inappropriately credentialed under MA regulations. CMS expects organizations to adhere to the credentialing requirements described in 42 CFR 422.204 and in section 60.3 of chapter 6 of the MMCM. CMS will consider inappropriate credentialing rationale if the organization provides substantial and credible evidence. On the Exception Request, from the “Reason for Not Contracting” drop-down list, the organization must select “Other” or “Provider does not provide services in the specialty type listed in the database and for which this exception is being requested,” as appropriate. The organization must then provide evidence in the “Additional Notes on Reason for Not Contracting” field. Evidence of inappropriate credentialing could be an official document stating the provider’s current credentialing status in accordance with MA regulations, and demonstration that this status conflicts with what is reflected in the relevant provider database. **CMS will validate all statements made on the Exception Request.**

**Please note, if an organization believes that another organization has a monopoly on the MA market in a given area, reducing both competition and beneficiary choice, then the organization should notify CMS about this circumstance on its Exception Request, which may warrant a referral to the Office of the Inspector General for further investigation.**

**5.4. Pattern of Care Rationales**

In rare instances, an organization may provide a rationale for not contracting with available providers because the pattern of care in that area is exceptionally unique and the organization believes their contracted network is consistent with or better than the original Medicare pattern of care. CMS will only consider this type of rationale on an Exception Request for CEAC, Rural, or Micro county types.

As with all Exception Requests, the organization must first demonstrate that the CMS network adequacy criteria cannot be met based on an insufficient supply of providers/facilities. On the

Exception Request, an organization would then identify non-contracted providers/facilities that may be closer to enrollees in terms of time and distance in comparison to the organization's contracted network of providers/facilities that may be located farther away. From the "Reason for Not Contracting" drop-down list, an organization could select "Other" and then provide evidence in the "Additional Notes on Reason for Not Contracting" field that demonstrates that the organization did not contract with the available provider/facility because the organization's current network is consistent with or better than the original Medicare pattern of care. For this pattern of care rationale, CMS would expect an organization to provide in the "Additional Notes on Reason for Not Contracting" field:

- Internal claims data evidence and detailed explanation that demonstrates the current pattern of care for enrollees in the given county for the given specialty type, or
- Detailed narrative that supports their rationale that their contracted network provides access that is consistent with or better than the original Medicare pattern of care.

Although CMS considers information provided on an organization's Exception Request, CMS does not solely rely on an organization's claims data or supporting narrative to make a decision. An MAO's claims data typically represents the pattern of care for the organization's current enrollees who would presumably travel to providers and facilities within the organization's network. This would not necessarily show the true pattern of care for original Medicare beneficiaries. Therefore, **when validating a pattern of care rationale on an Exception Request**, CMS may use and compare original Medicare claims data and Medicare Advantage encounter data through the Integrated Data Repository (IDR).

## 6. Partial Counties

Organizations submitting networks for CMS review against the current network adequacy criteria might have full county service areas or partial county service areas. If an organization has a partial county service area, it is an exception to the CMS county integrity rule as outlined at 42 CFR 422.2, which states that, in defining the service area of its plans, organizations should serve whole counties and not portions of or zip codes within a county. CMS regulations do allow for an exception to the county integrity rule under the conditions outlined at 42 CFR 422.2 and in section 140.3 of chapter 4 in the MMCM. Specifically, the inclusion of a partial county service area must be determined by CMS to be:

- 1) Necessary,
- 2) Nondiscriminatory, **and**
- 3) In the best interests of the beneficiaries.

The inability to establish economically viable contracts is not an acceptable justification for approving a partial county service area, as it is not consistent with CMS regulations. **CMS will validate all statements made on the Partial County Justification.** However, CMS will consider an organization's justification for a partial county if a provider/facility either:

- Does not contract with **any** organizations, or
- Contracts **exclusively** with another organization.

CMS will consider these two justifications if the organization provides substantial and credible evidence. For example, an organization could submit letters or e-mails to and from the providers' offices demonstrating that the providers were declining to contract with any MAO; thus no MAOs could be offered in the area in question. Where this evidence is present, CMS would consider this information when reviewing the partial county request. Please note, if an organization believes that another organization has a monopoly on the MA market in a given area, reducing both competition and beneficiary choice, then the organization should notify CMS about this circumstance on its Partial County Justification, which may warrant a referral to the Office of the Inspector General for further investigation. For more examples of Partial County Justifications that CMS would consider, please see section 140.3 of chapter 4 of the MMCM.

Both organizations with **current** partial county service areas and organizations **requesting** partial county service areas must submit a Partial County Justification document whenever CMS requests a network upload.<sup>17</sup> **CMS will validate all statements made on the Partial County Justification.**

If an organization with partial counties fails the network adequacy criteria in a certain area, then the organization may submit an Exception Request. Please see [section 5](#) for information on how to submit Exception Requests.

### 6.1. HPMS Partial County Justification Upload Instructions

Organizations may request an exception to the county integrity rule at 42 CFR 422.2 by

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<sup>17</sup> See [Appendix G](#) for the current Partial County Justification template.

completing and submitting a Partial County Justification Template. Organizations must submit separate Templates for each county in which the exception is being requested.

- **Application Module:** For network reviews that occur using the Application Module, organizations shall use the Partial County Justification Template in HPMS<sup>18</sup> and submit the template in accordance with CMS's application instructions defined in HPMS and available on our website at: <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/>.
- **Network Management Module:** For network reviews that occur using the NMM, organizations shall complete the Partial County Justification Template in [Appendix G](#). Organizations will submit the completed template in accordance with other CMS communications.

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<sup>18</sup> The Partial County Justification Template that is part of the download file in HPMS is the same template available under [Appendix G](#).

## 7. Provider-Specific Plans

A provider-specific plan (PSP) is an MA plan benefit package (PBP) that limits plan enrollees to a subset of contracted providers/facilities in a county or counties that are within the larger contract-level network approved by CMS. For example, a PSP has a network that is comprised of fewer providers/facilities than what CMS approved for that county during the organization's contract-level network review. However, the limited PSP-specific network also is reviewed and approved by CMS before the organization may offer a PSP (see 42 CFR 422.112). Organizations request to offer a PSP in June with their bid submissions for the upcoming contract year.

### 7.1. Network Adequacy Reviews – Contract-Level Network

As discussed in [section 1](#), CMS considers an organization's request to offer a PSP an event that triggers a review of the associated contract-level network. CMS announces the timeframes for uploading contract-level networks prior to the June bid submission deadline in HPMS. As discussed in [section 4](#), organizations have the ability to test their networks using the NMM in advance of the CMS-requested contract-level network upload.

Organizations shall upload final HSD provider and facility tables for their entire contract-level network in the NMM in accordance with CMS's required deadlines. Following a successful upload, organizations will have the opportunity to see their ACC results and request Exceptions in accordance with [section 4](#) above. CMS will provide organizations with any network deficiencies, offer organizations an opportunity to seek clarification on any identified deficiencies, and provide an opportunity to submit additional information for CMS's consideration. CMS will provide organizations with final determinations on the contract-level network prior to the June submission deadline. Any deficiencies noted at this time may result in compliance actions.

**IMPORTANT NOTE: CMS reviews and approves Exception Requests for the contract-level network only.**

### 7.2. Network Adequacy Reviews – Plan-Level Network

As part of the bid submission process that begins in June, an organization offering a PSP must confirm and attest that the PSP's network meets current CMS network adequacy criteria under 42 CFR 422.112. To support this attestation, organizations upload their PSP-specific network for CMS review in the NMM. Organizations should receive the results of their PSP-specific network upload within three to five days of their network submission.

As discussed in [section 4](#), CMS expects organizations to use the Organization-Initiated Upload function in the NMM to test the adequacy of their PSP-specific network prior to formal submission of the PSP HSD tables to CMS. CMS fully expects each PSP-specific network to meet CMS network adequacy criteria when the organization formally submits the PSP-specific HSD provider and facility tables in June for CMS's review. CMS will deny any PSP that fails to meet network adequacy criteria.

Organizations will not be permitted to resubmit revised Bid Pricing Tools (BPTs) or adjust assumptions in the previously submitted BPTs that included the PSPs. Therefore, an organization has two options for moving forward when the PSP fails network adequacy criteria.

1. **The organization can remove the PSP indicator from the bid.** This would require organizations to change their response to the PSP question (change from Yes to No) in the bid submission module after the bid gates have been opened for the plan to make changes. Organizations may not re-upload the bid.
2. **The organization can terminate the plan.** This option may have other consequences with Contract and Special Needs Plan service areas if the county(ies) in the PSP service area are not included in any other PBPs.

Given the consequences of a PSP that fails network adequacy criteria, it is important that organizations use the Organization-Initiated Upload function in the NMM to test their PSP-specific network's compliance with network adequacy prior to the bid submission deadline.

**NOTE: Organizations could face potential compliance actions for submitting inaccurate bids.**

## 8. Regional Preferred Provider Organizations

Regional Preferred Provider Organizations (RPPOs) are a type of MA coordinated care plan. Unlike other coordinated care plans, 42 CFR 422.2 defines the service area of an RPPO as one or more entire regions. Regions consist of one or more states as opposed to counties. The list of current RPPO regions is available on CMS's website at: <https://www.cms.gov/Medicare/Health-Plans/RPPO/index.html>.

Like other coordinated care plans, existing RPPOs or organizations seeking to qualify as an RPPO must submit their contracted networks to CMS for review as discussed in [section 1](#). The remainder of this section uses the term RPPO to cover both existing RPPOs and organizations seeking to qualify as an RPPO through the application process.

Following successful HSD provider and facility table uploads, RPPOs will receive the automated results of their review as discussed in [section 4](#). In the event that an RPPO's contracted network receives one (1) or more failures on the ACC reports, the RPPO has the ability to submit an exception for CMS's review. Like all network-based MA plans, RPPOs can request an exception to network adequacy criteria. However, unlike other MA plans, the MA regulation allows RPPOs to request a network exception (i.e., operate by non-network means) in those portions of the region it is serving where it is not possible to build a network that meets CMS network adequacy criteria.

### 8.1. Requesting an Exception to Network Adequacy Criteria

As discussed in [section 5](#), an RPPO, like other network-based MA plans, may seek an exception to CMS's network adequacy criteria for a given county and specialty type.

### 8.2. RPPO-Specific Exception to Written Agreements

RPPOs have the flexibility under 42 CFR 422.112(a)(1)(ii), subject to CMS approval, to operate by methods other than written agreements in those areas of a region where they are unable to establish contracts with sufficient providers/facilities to meet CMS network adequacy criteria. RPPOs that use this RPPO-specific exception shall agree to establish and maintain a process through which they disclose to their enrollees in non-network areas how the enrollees can access plan-covered medically necessary health care services at in-network cost sharing rates (see 42 CFR 422.111(b)(3)(ii) and 42 CFR 422.112(a)(1)(ii)). As discussed in Chapter 1, section 20.2.2 of the MMCM, CMS expects that the exception to written agreements will be limited to rural areas.

**Please note that, while this flexibility exists, CMS expects that RPPOs will establish networks in those areas of the region when there are a sufficient number of providers/facilities within time and distance criteria available to contract with the RPPO.**

#### 8.2.1. RPPO-Specific Exception Request in the Application Module

RPPOs shall reference the MA application for specific instructions related to the submission of RPPO-specific exceptions in the Application Module.

#### 8.2.2. RPPO-Specific Exception Request in the Network Management Module

RPPOs that undergo a CMS network review in the NMM have the opportunity to request CMS review and approval of the network exception at 42 CFR 422.112(a)(1)(ii) through the upload of the Regional Preferred Provider Organization (RPPO) Upload Template provided in [Appendix L](#).

RPPOs should submit this template in accordance with timeframes and instructions established by CMS in separate communications.

## 9. Sub-Networks

A sub-network occurs when enrollee access to providers/facilities is guided by the network provider group they join. Each provider group furnishes primary care and may also furnish specialty and institutional care. For example, a plan with sub-networks has more than one provider group, and referrals by an enrollee's primary care provider (PCP) are typically made to providers/facilities in the same group.

A plan with sub-networks must allow enrollees to access all providers/facilities in the CMS-approved network for the plan's service area; that is, **the enrollees may not be locked in to the sub-network**.

If an enrollee wants to see a specialist within their plan's overall network but that is outside of the referral pattern of their current PCP in a sub-network, then the plan can require the enrollee to select a PCP that can refer the enrollee to their preferred specialist. However, each plan must ensure that it has a network that meets current CMS network adequacy criteria.

## 10. Appendix A: Frequently Asked Questions

### 10.1. General Network Adequacy

**Question 1. Can we count a provider in network for adequacy purposes if they are not open daily but rather are only available once/week or a few times a month?**

**Answer.** CMS does not currently consider provider availability status when reviewing an organization's network adequacy. We do not have a check in place for the number of days that a provider is available. Therefore, you may count a "part-time" provider as in-network by listing this provider on your HSD tables.

**Question 2. Does an organization have to credential a provider before they enter into a contract agreement?**

**Answer.** CMS expects organizations to follow the credentialing process described in 42 CFR 422.204 and in Chapter 6 section 60.3 of the MMCM. Credentialing is the review of provider/supplier qualifications, including eligibility to furnish services to Medicare beneficiaries and other relevant information pertaining to a health care professional who seeks appointment (in the case of an MA organization directly employing health care professionals) or who seeks a contract or participation agreement with the MA organization. Section 60.3 of the MMCM provides the procedures that an organization follows when initialing credentialing providers and determining that providers are eligible for a contract to provide health care services. Given that an organization can only list contracted providers on their tables, it also stands that those providers must also be credentialed as a pre-requisite to the existence of that contract.

**Question 3. Does an organization have to have an executed contract with a provider/facility to list them on the HSD table?**

**Answer.** Yes. As discussed in [section 4](#), organizations shall only list providers and facilities with which the organization has fully executed contracts on the HSD Tables.

**Question 4. If I am currently conducting negotiations and expect to have a contract with the provider/facility after a CMS requested HSD table upload, can I list that provider/facility on my HSD table?**

**Answer.** No. As discussed in [section 4](#), organizations shall only list providers and facilities with which the organization has fully executed contracts on the HSD Tables. CMS considers a contract fully executed when both parties have signed and should be executed on or prior to the HSD submission deadline.

**Question 5. For purposes of the Primary Care Provider specialty type, can an organization contract with Mid-Level Practitioners, such as Nurse Practitioners and Physician Assistants to meet the CMS network adequacy criteria?**

**Answer.** As discussed in the Health Service Delivery Reference File, the purpose of the inclusion of 005 - Primary Care - Physician Assistants, and 006 - Primary Care - Nurse Practitioners is to inform CMS of the rare contracting with non-MD primary care providers in underserved counties to serve as the major source of primary care for enrollees. Applicants 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 fully credentialed by the applicant 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.

## 10.2. Specialty Types

**Question 1. Is an organization obligated to provide Medicare-covered transplant services through a Medicare-approved transplant center?**

**Answer.** Yes, organizations are obligated to provide Medicare-covered transplant services through a Medicare-approved transplant center. The contracted transplant program(s) that an organization lists on its HSD tables must be Medicare-approved. Please see the current HSD Reference File, which can be found as a download on the following webpage: <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html>. For more information on transplant services, please see chapter 4, section 10.11, of the MMCM.

### 10.3. Quantitative Standards

**Question 1. Are there circumstances where an organization will need to contract with more than the minimum number of providers/facilities?**

**Answer.** Yes, depending upon the locations of the contracted providers/facilities, organizations may need to have more than the minimum number in order to also meet the time and distance requirements in a given county. Please see [section 3](#) for additional information.

**Question 2. If a provider/facility is outside of the time and distance criteria is the provider/facility counted towards the minimum number requirement?**

**Answer.** No, a provider/facility must be located within the time and distance criteria to be counted towards the minimum number requirement. Please note, however, that there are no time and distance requirements for home health, durable medical equipment, and transplant specialty types.

## 10.4. Health Service Delivery Table Uploads in HPMS

### Question 1. Can I test my network before the CMS-requested HSD upload deadline?

**Answer.** Organizations may utilize the NMM – Organization Initiated Upload process to check networks against current CMS criteria as discussed in [section 4](#) of this document. 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). Organizations, including applicants, may check their networks via the NMM – Organization Initiated Upload at any time throughout the year. **NOTE: CMS may not access the uploaded tables or the ACC results affiliated with an Organization Initiated Upload.**

### Question 2. Where and when can I view my application HSD processing results?

**Answer.** The results of the online application HSD processing will be available in the HSD Automated Criteria Check (ACC) report. An automated email will be sent when the ACC results are available (typically three to five days after the submission window closes). Organizations may access their ACC reports in HPMS using the paths below, as appropriate. You may access this report at the following link: **HPMS Home Page>Contract Management>Basic Contract Management>Select Contract Number>Submit Application Data>HSD Submission Reports>HSD Automated Criteria Check Report.\***

**\*NOTE: More information about using the ACC report, and all HSD reports, is available in the Online Application User’s Manual, located under “Documentation” on the Basic Contract Management screen. An email notification will be emailed to the Part C Application Contact and to the email affiliated with the user ID of the person who uploaded the HSD tables when the ACC reports are available.**

### Question 3. HPMS is showing a message that both of my tables have been “successfully uploaded” to the system. Does this mean that my submission will automatically be processed in HPMS?

**Answer.** Not necessarily. Successfully uploading your tables is the first step. However, in order to for your tables to be processed, your submission must also pass the “unload” validation edits. The automated HSD validation process may take some time to complete, depending upon the size of your data tables and the number of other organizations submitting data at the same time. Consequently, CMS strongly urges applicants to submit your tables as soon as possible so that there is sufficient time to

complete the unload validation process, retrieve your results, and resubmit your tables if you encounter fatal unload errors.

**Question 4. What other HSD Upload status messages might appear?**

**Answer.** The following are the most common Upload messages you will see: “Upload Started,” which means the tables are in the process of being uploaded; “Upload Ended,” which means the tables are uploaded and waiting to go through the automated Unload edit process.

**Question 5. Will I be notified when the HSD tables unload successfully or unsuccessfully?**

**Answer.** HPMS will email the Organization’s contact (e.g., the Organization’s “Application Contact” found on the Contact screen in Contract Management) when the HSD tables have gone through the Unload edit 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.

**Question 6. How can I verify if my submission passed the “unload” validation edits successfully?**

**Answer.** You must look at the HSD Status Report on the Online Application page. Applicants must use the following navigation path to access this report: **Contract Management > Basic Contract Management > Select Contract Number > Submit Application Data > HSD Status Report**. The Part C application contact and the email address affiliated with the user ID performing the HSD table uploads will also receive an email when the unload process has completed; that email will indicate if the unload was successful or if errors exist.

**Question 7. When I access the HSD Status Report, the report provides the following message: “Currently, there is no HSD Status Report for this contract.” What does this mean?**

**Answer.** This message means that your HSD submission is still in the “unload” validation process. If you encounter this message, CMS strongly recommends that you check the report at a later time. Once your submission completes the “unload” validation process, you will see a link for each of the files (MA Provider File and MA Facility File). Also, the Application Contact will be emailed when the Unload Process has completed.

**Question 8. The HSD Status Report indicates that my MA Provider and/or MA Facility submissions have a status of “Unload Started.” What does that mean?**

**Answer.** The status of “Unload Started” means that your table or tables are in the process of going through the edit routine. Once they have completed Unload edit process, the status will be updated to “Unloaded Successfully” or “Unload Failed,” and an email will be sent to the Part C Application Contact and the person who completed the upload.

**Question 9. The HSD Status Report indicates that my MA Provider and MA Facility submissions have been “Unloaded Successfully.” What does that mean?**

**Answer.** Achieving the “Unloaded Successfully” status indicates that your submission has passed all of the validation edits. If both the MA Provider and MA Facility Tables unload successfully, your submission will be processed in the HSD pre-check or the final submission process.

**Question 10. The HSD Status Report indicates that one or both of the HSD tables has an “Unload Failed” status. What does that mean?**

**Answer.** An “unsuccessful unload” means that validation errors are present on your file(s) and that until the errors are corrected, your submission will not be included in the next HSD pre-check or 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.

**Question 11. In the HSD Status Report, some messages are marked as informational. What does that mean?**

**Answer.** 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 new 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 testing process.

**Question 12. 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?**

**Answer.** 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. You may contact the HPMS help desk for assistance with this by emailing them at

[hpms@cms.hhs.gov](mailto:hpms@cms.hhs.gov).

**Question 13. Do I need to include every ACTIVE and PENDING non-employer county on the MA Provider and MA Facility tables?**

**Answer.** Existing MAOs must upload both their active/existing and pending/expanding counties in response to a CMS-requested upload. Please reference [section 4](#) for additional information.

**Question 14. Are we required to list at least one of every provider and facility type for each of our ACTIVE and PENDING non-employer only counties in order to pass the basic HPMS Upload Edits?**

**Answer.** The requirements are as follows:

- On the MA Provider Table, you must include at least one type of Primary Care Physician (provider codes 001-006) for every ACTIVE and PENDING non-employer county in your application. **If you do not do this, you will receive a fatal error for the upload.**
- On the MA Facility Table, you must include at least one Acute Inpatient Hospital (facility code 040) for every ACTIVE and PENDING non-employer county in your application. **If you do not do this, you will receive a fatal error for the upload.**
- You must complete **all** required fields on both of the tables as discussed in [Appendix C](#).
- You must adhere to the edit rules for both of the tables as discussed in [Appendix C](#).
- Please read the HSD Instructions, located above, to determine which fields are required and which are optional to pass the HPMS Upload Edit rules as discussed in [Appendix C](#).
- Please note that the edit rules in [Appendix C](#) apply ONLY to data edits which determine if an applicant may hit Final Submit. A field marked as “optional” may be required (see the field descriptions above), but the absence of the field will not be a fatal error. You will still be found deficient if you don’t submit all required data. Why do we do this? We do this to permit applicants to hit Final Submit. If these were “fatal” errors, you would not be permitted to final submit the application. To reiterate, these edit rules (in [Appendix C](#)) indicate which errors are fatal and which are informational. Actual required fields are noted above.

**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 above for primary care and acute inpatient hospitals, these messages are informational and will not prevent your files from being processed.**

**Question 15. Can we include placeholder or dummy data on the MA Provider and MA Facility tables when testing our contracted networks prior to a CMS requested upload?**

**Answer.** The inclusion of placeholder or dummy data will skew the results you receive in the ACC reports.

**Question 16. What format must we use to submit the MA Provider and MA Facility Tables?**

**Answer.** You should use the following steps to ensure you are using the correct format:

- Download the templates for the MA Provider and MA Facility Tables in the MA download section on the Application Start Page.
- Complete your files in Excel.
- Save the files as tab-delimited text files (.txt).
- Zip the .txt files.
- Upload each file on the HSD Upload page.\*

**\*Note: These instructions are also available on the HSD Upload Page in HPMS.**

**Question 17. Can you explain what the meaning of the “actual time” and “actual distance” fields on the ACC report?**

**Answer.** The “actual time” and “actual distance” values reflect the percentage of beneficiaries with access to at least one provider/facility within the required time or distance criteria.

**Question 18. Can you explain when a listed provider is included in the Minimum Number of Providers calculation?**

**Answer.** 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.

**Question 19. 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?**

**Answer.** 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.\*

**\*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.**

**Question 20. How is an address identified as a “duplicate” on the Address Information report?**

**Answer.** Providers are considered duplicates when they have:

- Same state/county code
- Same provider code
- Same NPI number
- 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:

- Same state/county code
- Same facility code
- Same NPI number
- 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.”**

**Question 21. 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?**

**Answer.** 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:

- 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.

- 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.
- Duplicate Record – Please see questions and responses above for an explanation of Duplicate addresses for Providers and Facilities.
- Not Supported by ACC – Identifies addresses affiliated with certain situations which are not supported by the automated review process and require a manual review.

**Question 22. How can I avoid having addresses listed as “Invalid” or “Zip-Distributive” on the Address Information Report?**

**Answer.** Please see [Appendix B](#) for guidance on developing valid addresses for the purposes of the HSD automated review.

**Question 23. What are all of the edit checks applied to the MA Provider Table and MA Facility Table?**

**Answer.** Please see [Appendix C](#) for a listing of the field edits on the MA Provider Table and the MA Facility Table. Please note that the edit rules in [Appendix C](#) apply ONLY to data edits which determine if an applicant may hit Final Submit. A field marked as “optional” may be required (see the field descriptions above), but the absence of the field will not be a fatal error. You will still be found deficient if you don’t submit all required data. Why do we do this? We do this to permit applicants to hit Final Submit. If these were “fatal” errors, you would not be permitted to final submit the application. To reiterate, these edit rules (in [Appendix C](#)) indicate which errors are fatal and which are informational. Actual required fields are noted above.

**Question 24. Can I list providers or facilities that are part of my network as serving a county other than where their office is located?**

**Answer.** 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.

**Question 25. If only one of the files is successfully submitted and unloaded, will that file go through the HPMS automated review process?**

**Answer.** In order for a submission to go through the HPMS automated review process, both the MA Provider and MA Facility tables must be uploaded and unloaded successfully prior to the established deadline.

**Question 26. What do the various messages in the HSD Status Report mean and which of these messages will prevent my submission from being processed?**

**Answer.** The list below describes the various HSD Status Report messages and they impact on the HSD table submission through organization-initiated testing.

- File Processing Error – These are errors in the format of the submitted file. These errors may prevent the system from reading the file correctly. Your HSD submission will not be processed until you correct the errors and successfully resubmit the HSD file(s).
- Record Invalid – A record contains a restricted character. Restricted characters are the greater than symbol, the less than symbol and the semi-colon ( < > ;). Your HSD submission will not be processed until you correct the errors and successfully resubmit the HSD file(s).
- SSA State/County Not in ACTIVE or PENDING Service Area – The state/county code you provided is not part of your contract’s non-employer only ACTIVE or PENDING Service Area. Your HSD submission will not be processed until you correct the errors and successfully resubmit the HSD file(s).
- 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 ACTIVE and PENDING non-employer only county in your service area. Your HSD submission will not be processed until you correct the errors and successfully resubmit the HSD file(s).
- 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 ACTIVE and PENDING non-employer only county in your service area. Your HSD submission will not be processed until you correct the errors and successfully resubmit the HSD file(s).
- Invalid Data Type – There is a processing error in the record due to incorrect data type (example – alpha character in a numeric-only field). Your HSD submission will not be processed until you correct the errors and successfully resubmit the HSD file(s).
- Invalid Length – There is a processing error in the record due to an invalid length in a field. Your HSD submission will not be processed until you correct the errors and successfully resubmit the HSD file(s).
- Invalid Data - There is a processing error in the record due to invalid data. Your HSD submission will not be processed until you correct the errors and successfully resubmit the HSD file(s).
- Required Field Missing – A required field or fields is missing from the record. Your HSD submission will not be processed until you correct the errors and successfully resubmit the HSD file(s).
- 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. Your submission will be processed,

though you may need to address these Informational Messages in subsequent HSD submissions.

**Question 27. For service area expansion (SAE) applications, is an existing MAO required to submit exception requests for the active/existing portions of the service area?**

**Answer.** In accordance with section 2.9 of the application, applicants who have conclusive evidence that there is an insufficient supply of a provider or facility type for a given county within CMS's time and distance standards may seek an exception. When there is a corresponding HSD fail result, the applicant has the opportunity to provide evidence that supply is not available through a request and subsequent upload of an Exception Request template.

As stated under section 2.7 of the application, MAOs seeking a service area expansion must submit HSD tables for their entire network under the respective contract, which includes both active/existing and pending/expansion counties. Applicants will receive HSD fail results for both the active and pending portions of a county. When an MAO believes an exception is warranted, the MAO should submit exception requests for both the active and pending portions of the applicant's service area using the most recent version of the exception request template in HPMS.

**Question 28. If an existing MAO received approval of their exception request in a prior year, is the MAO required to resubmit that exception request?**

**Answer.** Since both provider availability and patterns of care are continuously evolving, an Exception Request that was approved by CMS in the past may need to be modified or may no longer be necessary. Therefore and as discussed in the January 15, 2016 HPMS memo, Exception Requests and Partial Counties Policy Clarifications, Medicare Advantage organizations (MAOs) must resubmit all previously approved exception requests whenever CMS requests an MAO to upload its HSD tables for a given contract or contracts. This includes exceptions related to HSD tables submitted with an application.

**Question 29. For service area expansion (SAE) applications, is the existing MAO required to submit partial county justifications for the active/existing portions of the service area?**

**Answer.** As discussed in [section 6](#), both organizations with **current** partial county service areas and organizations *requesting* partial county service areas must submit a Partial County Justification document whenever CMS requests a network upload. Therefore, SAE applicants must upload a Partial County Justification template for both any existing/active and pending/expanding partial counties.

**Question 30. When will I receive the results exception requests submitted on a pending application?**

**Answer.** Applicants will be notified of Exception Results after CMS completes the Exception review process later in the application cycle. When the exception results are released, organizations will see each exception status on both the ACC Reports and the Exception reports. When an Exception is approved, applicant will note that the overall county/specialty status changes from Fail to Pass.

**Question 31. How long does an applicant have to fix their Health Service Delivery (HSD) failures if CMS denies the Exception Request?**

**Answer.** Pursuant to 42 CFR 422.502(c)(2), if CMS finds any deficiencies on an application, which would include HSD failures, CMS will notify the applicant of these deficiencies in the Notice of Intent to Deny, or NOID. The applicant has ten (10) days from receipt of the NOID to respond to any deficiencies cited in the NOID.

**Question 32. In what way are applicants able to modify their service area after the MA application is submitted?**

**Answer.** For full county requests, applicants are permitted to remove full counties from a pending service area until the denial/conditional approval letter is sent to applicants. Applicants are not permitted to remove individual ZIP codes from a pending county after an application has been submitted. In other words, an applicant cannot move from a full county to a partial county following the initial application submission.

For partial county requests, the applicant's initial service area submission cannot be modified following the application submission. Therefore, after the application submission, applicants are not permitted to add or remove individual ZIP codes from a pending partial county. Applicants are also not permitted to move from a partial county to a full county following the initial application submission. However, the applicant may choose to drop the entire pending partial county.

**Question 33. Following the submission of an application, are applicants able to convert counties from full to partial or vice versa, or reduce or add ZIP codes to a partial county application during that same application cycle?**

**Answer.** Applicants are not permitted to drop ZIP codes from pending partial or full counties after they hit final submit. Applicants are permitted to request that CMS remove pending counties (partial or full) from an application after submission, but not ZIP codes.

## 10.5. Exceptions

**Question 1. If an organization fails to meet network adequacy criteria for the service area of its PSP, does the organization have the opportunity to request an Exception?**

**Answer.** CMS only reviews and grants exceptions for the contract-level network only. CMS does not permit organizations to request exceptions to network adequacy criteria when narrowing their network at the plan level. Please reference [section 7](#) for additional information.

**Question 2. What does CMS mean by “consistent with or better than the original Medicare pattern of care”?**

**Answer.** CMS defines the “original Medicare pattern of care” as those providers/facilities original Medicare beneficiaries more regularly utilize in a specified geographic area in order to receive their Medicare covered healthcare services. At a minimum, an MA enrollee who resides in the same geographic area must have access to providers/facilities furnishing Medicare-covered services that is consistent with or better than an original Medicare beneficiary’s access to providers/facilities, in terms of time and distance. Please see [section 5](#) for more details.

**Question 3. Does CMS consider Exception Requests for Large Metro and Metro county types?**

**Answer.** CMS will consider any Exception Request; however, Exceptions for these urban county types will typically not need to be approved because of the abundance of available providers/facilities in such high population density areas. Please see section 5.1 for more details.

**Question 4. In which county types might organizations need to request a pattern of care Exception?**

**Answer.** Organizations may need to request an Exception in CEAC, Rural, and Micro county types if the current landscape of providers/facilities does not enable the organization to meet the CMS network adequacy criteria. Please see section 5.1 for more details.

**Question 5. What types of evidence is CMS looking for related to pattern of care on an Exception Request and what data source/repository does CMS use for validation?**

**Answer.** CMS will consider internal claims data evidence or detailed narrative supporting the MAO’s pattern of care rationale. CMS uses the Integrated Data Repository (IDR) to validate pattern of care rationale on an Exception Request. Please see section 5.4 for more details.

**Question 6. Is inability to contract a valid rationale for an Exception?**

**Answer.** No, in general, CMS does not consider “inability to contract” as a valid rationale for an Exception to the network adequacy criteria. The basis for this is that CMS cannot assume the role of arbitrating or judging the bona fides of contract negotiations between an organization and available providers. Please see section 5.3.1 for more details.

**Question 7. Is it a valid rationale for an Exception if a provider does not meet CMS’s quality/credentialing standards?**

**Answer.** There are rare instances when CMS will consider an organization’s reason for not contracting with a provider. For example, an organization might claim that an available provider may cause beneficiary harm or is inappropriately credentialed under MA regulations. CMS expects organizations to adhere to the credentialing requirements described in 42 CFR 422.204 and in section 60.3 of chapter 6 of the Medicare Managed Care Manual. CMS will consider beneficiary harm rationale and/or inappropriate credentialing rationale if the organization provides substantial and credible evidence. Please see section 5.3.2 for more details.

**Question 8. Can organizations submit Exception Requests as “placeholders” when they are in the process of negotiating a contract with a provider?**

**Answer.** In the majority of cases, organizations should only submit an Exception Request when the current CMS network adequacy criteria cannot be met based on provider supply. Organizations cannot submit a “placeholder” Exception Request that indicates the organization is in the process of contracting with providers. CMS will only consider providers on the HSD tables as in-network that have been credentialed and contracted, and CMS will not accept claims of interim contracting efforts on an Exception Request. Please see section 5.3.1 for more details.

**Question 9. Is it a valid rationale for an Exception if a provider does not contract with *any* organizations?**

**Answer.** CMS will consider an organization’s rationale for an Exception if a provider does not contract with *any* organizations. The organization must provide substantial and credible evidence of this on its Exception Request. Please see section 5.3.2 for more details.

**Question 10. Is it a valid rationale for an Exception if a provider contracts *exclusively* with another organization?**

**Answer.** CMS will consider an organization’s rationale for an Exception if a provider contracts exclusively with another organization. The organization must provide substantial and credible evidence of this on its Exception Request. Please see section 5.3.2 for more details.

**Question 11. Is it a valid rationale for an Exception if an organization does not contract outside state/county lines based on internal rules/procedures?**

**Answer.** No, the organization is still required to comply with current CMS network adequacy criteria, as all organizations are held to the same standards. The time and distance criteria are not limited to the county and/or state where the enrollees reside, and in fact, it is very common practice among the majority of organizations to contract with providers/facilities outside of their respective services areas. If an organization believes a state has a law that prohibits this, then they need to identify the state and the relevant legislation in their Exception Request. Specifically, evidence in this case will include a reference to the state law that prohibits contracting with providers over state/county lines and documented assurance from a state representative that supports this interpretation. The organization should also provide the name of the state representative so that CMS can contact that person to validate the claim. Please see section 3.1.3 for more details.

## 10.6. Partial Counties

### **Question 1. Can a Medicare Advantage Organization (MAO) request to serve a partial county at the plan benefit package (PBP) level?**

**Answer.** Pursuant to 42 CFR 422.2, each MA plan must be available to all MA-eligible individuals within the plan's service area. A service area is generally defined as one or more counties in which an MAO will provide healthcare services to enrollees. Pursuant to 42 CFR 422 Subpart K, CMS qualifies an MAO's service area at the contract level through the application process. If an MAO believes that a partial county is warranted, then that MAO must request and be approved to operate a partial county at the contract level. CMS does not grant partial counties at the plan level.

### **Question 2. What is CMS's policy related to partial counties?**

**Answer.** Pursuant to 42 CFR 422.2, local Medicare Advantage (MA) plans must meet the county integrity rule whereby a local MA plan's service area generally consists of a full county or full counties. This county integrity rule exists because counties are MA payment areas and CMS expects that MA plans will be made available to the demographic range of beneficiaries in a given county. 42 CFR 422.2 provides CMS with the authority to approve a service area that includes only a portion of a county if CMS determines that the "partial county" area is:

- Necessary,
- Nondiscriminatory, and
- In the best interests of the beneficiaries.

Organizations have the ability to demonstrate that these three elements are present through the submission of a partial county justification template. CMS provides additional guidance to plans in section 140.3 of chapter 4 of the MMCM to further define CMS's policy and assist organizations with providing supporting information in their partial county justification request.

While CMS may grant a partial county request at a specific point in time, organizations are required to be in compliance with current network adequacy criteria and access requirements. The Medicare health care needs evolve from year-to-year, necessitating changes to our network adequacy criteria to meet those needs, and any organization has to demonstrate their ability to meet current network access requirements pursuant to 42 CFR 422.112 and Subpart K. Therefore, CMS expects that existing MAOs monitor the evolving health care access trends and reassess their networks to determine whether or not a previously approved partial county is still warranted based on CMS's policy. When an MAO determines that a partial county is no longer warranted, the MAO has the opportunity to submit a service area

expansion application in the upcoming year to cover the county in full (subject to CMS's review and approval).

CMS assesses an organization's overall compliance with network access requirements, inclusive of compliance with our partial county policy, whenever there is a contracted network submitted to CMS for a network adequacy review. For example, in the application cycle, CMS requires that existing MAOs seeking to expand their service area upload their contract-level network (both existing/active and expanding/pending counties) for CMS review. This contract-level upload also includes the completion and upload of a partial county justification template for both previously approved and new partial counties as discussed in [section 6](#).

**Question 3. Can I submit a Partial County Justification template for a respective county and also submit an exception request in that same county?**

**Answer.** Yes. As discussed in [section 6](#), an organization may submit a Partial County Justification template to request an exception to CMS's county integrity rule defined at 42 CFR 422.2. If an organization receives an ACC fail for a given specialty type(s) within the zip codes of its existing/active or pending/expanding partial county(ies), then the organization may request an exception to CMS's time and distance standards as discussed in [section 5](#) above.

**Question 4. Is inability to contract an acceptable justification for a partial county?**

**Answer.** The inability to establish economically viable contracts is not an acceptable justification for approving a partial county service area, as it is not consistent with CMS regulations. Please see [section 6](#) for more details.

**Question 5. Is it an acceptable justification for a partial county if a provider does not contract with any organizations?**

**Answer.** CMS will consider an organization's justification for a partial county if a provider does not contract with any organizations. The organization must provide substantial and credible evidence of this on its Partial County Justification. Please see [section 6](#) for more details.

**Question 6. Is it an acceptable justification for a partial county if a provider contracts exclusively with another organization?**

**Answer.** CMS will consider an organization's justification for a partial county if a provider contracts exclusively with another organization. The organization must provide substantial and credible evidence of this on its Partial County Justification. Please see [section 6](#) for more details.

## 10.7. Provider-Specific Plan

### Question 1. What is a PSP?

**Answer.** A PSP is an MA plan benefit package (PBP) that limits plan enrollees to a subset of contracted providers/facilities in a county or counties that are within the larger contract-level network approved by CMS. For example, a PSP has a network that is comprised of fewer providers/facilities than what CMS approved for that county during the organization's contract-level network review. However, the limited PSP-specific network also is reviewed and approved by CMS before the organization may offer a PSP (see 42 CFR 422.112). Organizations request to offer a PSP in June with their bid submissions for the upcoming contract year. Please see [section 7](#) for more details.

## 10.8. Regional Preferred Provider Organizations (RPPO)

### Question 1. What is an RPPO?

**Answer.** RPPOs are coordinated care plans that are required to serve in its entirety one or more CMS established regions. As coordinated care plans RPPOs must offer a uniform benefit package across the service area, must establish a ‘catastrophic’ maximum enrollee out-of-pocket cost sharing limit, and must establish a provider network approved by CMS.

**Network Access Exception** - In those portions of its regional service area where it is possible, RPPOs must meet network adequacy criteria for original Medicare services by having written agreements (i.e., contracts) with a full network of providers/facilities. However, in more rural areas of a region, where it is not possible to establish a network consistent with CMS network adequacy criteria, RPPOs may request an exception to CMS’s access requirement that the RPPO have written agreements in order to meet network adequacy criteria (see 42 CFR 422.112(a)(1)(ii)).

**Essential Hospital Provision** - 42 CFR §422.112(c) describes the requirements for an RPPO to apply to CMS to designate a non-contracting hospital as an essential hospital. If CMS approves the application and the hospital annually meets the requirements at §422.112(c) then the essential hospital is “deemed” to be a network hospital of the RPPO and normal in-network inpatient hospital cost-sharing levels (including the catastrophic limit described in 42 CFR §422.101(d)(2)) apply to all enrollees accessing covered inpatient hospital services in that hospital.

### Question 2. Does an RPPO have to meet the same network access requirements as other coordinated care plans?

**Answer.** Situations may arise where an MA plan cannot establish contracts with providers that meet Medicare access requirements in portions of an RPPO’s defined service area. In such cases, RPPOs may meet Medicare access requirements by demonstrating to CMS’ satisfaction that there is adequate access to all plan-covered services through methods other than through written agreements (42 CFR §422.112(a)(1)(ii)). Enrollees who receive plan-covered services in non-network areas of an RPPO must be covered at in-network cost-sharing levels for the enrollee. As discussed in [section 8](#), while this flexibility exists, CMS expects that RPPOs will establish networks in those areas of the region when there are a sufficient number of providers/facilities within time and distance criteria available to contract with the RPPO.

## 10.9. Sub-Networks

### Question 1. What is a sub-network?

**Answer.** A sub-network occurs when enrollee access to providers is guided by the network provider group they join. Each provider group furnishes primary care and may also furnish specialty and institutional care. For example, a plan with sub-networks has more than one provider group, and referrals by an enrollee's PCP are typically made to providers in the same group. A plan with sub-networks must allow enrollees to access all providers in the CMS-approved network for the plan's service area; that is, **the enrollees may not be locked in to the sub-network**. Please see [section 9](#) for more details.

### Question 2. The guidance states that, "A plan with sub-networks must allow enrollees to access all providers in the CMS-approved network for the plan's service area." Is CMS's definition of "the plan's service area" the coverage area of each PBP or the overall network provided by the entire plan or contract?

**Answer.** In this statement, we are referring to the network that the organization has used to meet the CMS network adequacy criteria for the PBP. In other words, the CMS-approved network for a particular PBP includes the providers listed on the organization's contract-level HSD tables for the county or counties that comprise the PBP's service area (i.e., coverage area). In some cases, a PBP may be a PSP and have a provider-specific network, where the network associated with the PBP has been separately reviewed in the NMM in HPMS and confirmed to meet at least the minimum CMS network adequacy criteria. In other cases, an organization may allow its enrollees access to a wider network of providers approved at the contract level that exceeds the minimum CMS network adequacy criteria. For example, some of the providers may be located outside of the service area of the enrollees' plan. For more details on service area, please see section 140 of chapter 4 of the MMCM. For more details on HSD tables and PSPs, please see sections [4](#) and [7](#) (of this document) respectively.

### Question 3. Are enrollees permitted to select a provider outside of their PBP's coverage area but still within the plan/contract's overall coverage area? For example, can an enrollee who lives and enrolled with a plan in Los Angeles choose a provider in San Diego and still be considered part of the plan's service area?

**Answer.** Each plan must ensure that it has a network that meets current CMS network adequacy criteria. Some plans may allow their enrollees a wider choice of providers in the overall contract-level network. In the situation where an enrollee has a wider choice of providers, the enrollee can select a provider that is outside of their plan's

service area if that is their preference. Please see section 1.2 for more details on organizational responsibility to maintain an adequate network.

**Question 4. The guidance states that “the enrollees may not be locked in to the sub-network.” What happens if an enrollee selects two providers that are not contracted with the same provider group/sub-network (a PCP and a specialist, for example)? Is the plan obligated to allow the enrollee access to both providers simultaneously even if the providers are not contracted with the same sub-network, or is the plan permitted to assign the enrollee a new provider (while keeping the other) so that they are all under the same sub-network?**

**Answer.** If an enrollee wants to see a specialist within their plan's overall network but that is outside of the referral pattern of their current PCP in a sub-network, then the can require the enrollee to select a PCP that can refer the enrollee to their preferred specialist. Please see [section 9](#) for more details.

**Question 5. If a plan has two PBPs that cover the same coverage area but contracted with different providers/sub-networks, and an enrollee requests a provider that is part of the sub-network not assigned to the PBP they are enrolled in, is the plan obligated to allow this assignment?**

**Answer.** Network-based plans are only required to furnish enrollees access to those plan providers that were listed on the organization's HSD tables to establish network adequacy for the plan or the contract as the case may be. Please see [section 4](#) for more details.

## 11. 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:

<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Reason</b>
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:

<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Reason</b>
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:

<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Reason</b>
12 LK WRIGHT DR	Norfolk	VA	21043	12 is not a valid street number.

## 12. Appendix C: Field Edits for the Provider and Facility Health Service Delivery (HSD) Tables

The following charts lists the SYSTEM edits for the Provider HSD Table and the Facility HSD Table. Please note that the edit rules apply ONLY to data edits which determine if an applicant may hit Final Submit. A field marked as “optional” may be required (see FAQs on Unload Errors in the [Appendix A](#)) but the absence of the field will not be a fatal error. You will still be found deficient if you don’t submit all required data. Why do we do this? We do this to permit applicants to hit Final Submit. If these were “fatal” errors, you would not be permitted to final submit the application. To reiterate, these edit rules indicate which errors are fatal and which are informational. Actual required fields are noted above.

### Provider Table

Field	Description	Rule
<b>SSA State/County Code</b>	VARCHAR2(5)	Required (not null) and validated against valid values (SSA County Code). Must be ACTIVE or PENDING non-employer county attached to contract.
<b>Name of Physician or Mid-Level Practitioner</b>	VARCHAR2(150)	Required (not null)
<b>National Provider Identifier (NPI) Number</b>	VARCHAR2(10)	Required (not null) and validated that it is 10 digit numeric; May not be All Zeros.
<b>Specialty</b>	VARCHAR2(150)	Required (not null)
<b>Provider Specialty Code</b>	VARCHAR2(3)	Required (not null) and validated against valid values
<b>Contract Type</b>	VARCHAR2(150)	Required (not null)
<b>Provider Street Address</b>	VARCHAR2(250)	Required (not null)
<b>Provider City</b>	VARCHAR2(150)	Required (not null)
<b>Provider State Code</b>	VARCHAR2(2)	Required (not null). Validate the state code against the valid list of state abbreviations
<b>Provider Zip Code</b>	VARCHAR2(10)	Required (not null)
<b>If PCP, Accepts New Patients</b>	VARCHAR2(1)	Required only for provider types 001-006; otherwise not required.
<b>Medical Group Affiliation</b>	VARCHAR2(150)	Not Required
<b>Uses CMS MA Contract Amendment</b>	VARCHAR2(1)	Required (not null); Y for yes, N for no.

## Facility Table

<b>Field</b>	<b>Description</b>	<b>Rule</b>
<b>SSA State/County Code</b>	VARCHAR2(5)	Required (not null) and validated against valid values (SSA County Code). Must be ACTIVE or PENDING non-employer county attached to contract.
<b>Facility or Service Type</b>	VARCHAR2(150)	Required (not null)
<b>Facility Specialty Code</b>	VARCHAR2(3)	Required (not null) and validated against valid values
<b>National Provider Identifier (NPI) Number</b>	VARCHAR2(10)	Required (not null) and validated that is 10 digit numeric; May not be All Zeros.
<b># of Staffed, Medicare-Certified Beds</b>	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).
<b>Facility Name</b>	VARCHAR2(150)	Required (not null)
<b>Provider Street Address</b>	VARCHAR2(250)	Required (not null)
<b>Provider City</b>	VARCHAR(150)	Required (not null)
<b>Provider State Code</b>	VARCHAR2(2)	Required (not null). Validate the state code against the valid list of state abbreviations.
<b>Provider Zip Code</b>	VARCHAR2(10)	Required (not null)
<b>Uses CMS MA Contract Amendment</b>	VARCHAR2(1)	Required (not null); Y for yes, N for no.

### 13. Appendix D: Provider Specialty Type Codes

- 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

## 14. Appendix E: Facility Specialty Type Codes

- 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
- 054 – Orthotics and Prosthetics
- 055 – Home Health
- 056 – Durable Medical Equipment
- 057 – Outpatient Infusion/Chemotherapy
- 061 – Heart Transplant Program
- 062 – Heart/Lung Transplant Program
- 064 – Kidney Transplant Program
- 065 – Liver Transplant Program
- 066 – Lung Transplant Program
- 067 – Pancreas Transplant Program

**15. Appendix F: Exception Request Template**

This template is provided in this document for informational purposes only. Organizations shall use the Provider HSD Table Upload Template available in HPMS when submitted their contracted networks.

<p><b>CY 2018 MEDICARE ADVANTAGE HEALTH SERVICE DELIVERY EXCEPTION                  REQUEST TEMPLATE</b></p> <p>(File naming convention: Contract ID_ County Code_ Specialty Code) – 15 characters</p>	
<p><b>Part I: Exception Information</b></p>	
<p><i>Please enter the Contract ID, County/SSA Code, and Specialty Code, for which you are requesting an exception. The County Name, State, and Specialty Name fields will auto-populate based on your responses. If you need to make changes to the fields, please delete the County/SSA Code and the Specialty Code fields.</i></p>	
<p><b>Part II: Rationale for Exception</b></p>	
<p><i>Please respond to the questions below by selecting either "Yes" or "No" from the drop-down list for each question.</i></p>	

**CY 2018 MEDICARE ADVANTAGE HEALTH SERVICE DELIVERY EXCEPTION  
REQUEST TEMPLATE**

(File naming convention: Contract ID\_ County Code\_ Specialty Code) – 15 characters


**Part III: Sources**

**CY 2018 MEDICARE ADVANTAGE HEALTH SERVICE DELIVERY EXCEPTION  
 REQUEST TEMPLATE**

(File naming convention: Contract ID\_ County Code\_ Specialty Code) – 15 characters

*In the rows below, please enter any sources (up to five) you used to identify provider/facilities within or nearby CMS’s network adequacy criteria. To enter a source, select an option from the drop-down list, which is comprised of sources commonly used by MAOs and CMS. If you have more than five sources, or a source not included on the drop-down list, please describe the additional sources in the Part IV: Narrative Text section below. The drop-down options for the sources are:*

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

*Additionally, if you select “Other,” please describe the other sources in the Part IV: Narrative Text section below.*


**Part IV: Narrative Text (Optional)**

*Please use the below box 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 III: Sources section.*





## 16. Appendix G: Partial County Justification Template<sup>19</sup>

Instructions: MA applicants requesting service areas that include one or more partial counties must upload a completed Partial County Justification with the MA Application.

Complete and upload a Partial County Justification form for each partial county in your proposed service area. This form is appropriate for organizations (1) entering into a new partial county or (2) expanding a current partial county by one or more zip codes when the resulting service area will continue to be a partial county. In this scenario, the Justification pertains to the proposed zip codes versus the zip codes already approved by CMS.

MA applicants expanding from a partial county to a full county do NOT need to submit a Partial County Justification.

Beginning with the CY2016 applications, HPMS will automatically assess the contracted provider and facility networks against the CMS criteria. If the ACC report shows that a provider or facility fails the network criteria, the applicant must submit an Exception Request using the same process available to full-county applicants.

CMS has revised its partial county guidance to eliminate the use of the inability to establish economically viable contracts as a partial county justification.

**NOTE: CMS requests that you limit this document to 20 pages.**

### SECTION I: Partial County Explanation

Using just a few sentences, briefly describe why you are proposing a partial county.

### SECTION II: Partial County Requirements

The Medicare Managed Care Manual Chapter 4, Section 140.3 provides guidance on partial county requirements. The following questions pertain to those requirements; refer to Section 140.3 when responding to them.

Explain how and submit documentation to show that the partial county meets all three of the following criteria:

1. Necessary – It is not possible to establish a network of providers to serve the entire county.

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<sup>19</sup> NOTE: This template reflects the Partial County Justification template organizations reviewed through the Paperwork Reduction Act process for the CY 2018 MA and Cost Plan application. CMS is providing a clarification to this template for the following paragraph:

*Complete and upload a Partial County Justification form for each partial county in your proposed service area.*

*This form is appropriate for organizations (1) entering into a new partial county or (2) expanding a current partial county by one or more zip codes when the resulting service area will continue to be a partial county. In this scenario, the Justification pertains to the proposed zip codes versus the zip codes already approved by CMS.*

This template applies for any organization that has a partial county as part of its service area. Consistent with [section 6](#) of this document, organizations must complete an upload a partial county template for any active/existing partial county or pending/expanding partial county.

Describe the evidence that you are providing to substantiate the above statement that it is not possible to establish a network to serve the entire county and (if applicable) attach it to this form:

2. Non-discriminatory – You must be able to substantiate both of the following statements:

- The racial and economic composition of the population in the portion of the county you are proposing is comparable to the excluded portion of the county.

Using U.S. census data (or data from another comparable source), compare the racial and economic composition of the included and excluded portions of the proposed county service area.

- The anticipated health care costs of the portion of the county you are proposing to serve is similar to the area of the county that will be excluded from the service area.

Describe the evidence that you are providing to substantiate the above statement and (if applicable) attach it to this form.

3. In the best interest of beneficiaries – The partial county must be in the best interest of the beneficiaries who are in the pending service area.

Describe the evidence that you are providing to substantiate the above statement and (if applicable) attach it to this form.

### **SECTION III: Geography**

Describe the geographic areas for the county, both inside and outside the proposed service area, including the major population centers, transportation arteries, significant topographic features (e.g., lakes, mountain ranges, etc.), and any other geographic factors that affected your service area designation.



## 18. Appendix I: MA Provider Health Service Delivery (HSD) Table Template Definitions

<b>Column Heading</b>	<b>Definition</b>
<b>SSA State/County Code</b>	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</b>	Self-explanatory. Up to 150 characters.
<b>National Provider Identifier (NPI) Number</b>	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.
<b>Specialty</b>	Name of specialty of listed physician/provider. This should be copied directly off of the HSD Criteria Reference Table.
<b>Specialty Code</b>	Specialty codes are unique codes assigned by CMS to process data. Enter the appropriate specialty code (001 – 034)
<b>Contract Type</b>	<p>Enter the type of contract the Applicant holds with listed provider by using a “DC” - Direct Contract or “DS” - Downstream Contract. Use “DC” for direct contract between the applicant and provider.</p> <ul style="list-style-type: none"> <li>• A "DC" - direct contract provider, requires the applicant to complete Col. L - Medical Group Affiliation with a "DC".</li> <li>• A "DS" - downstream contract is between the first tier entity and other providers (such as individual physicians).</li> <li>• An Independent Practice Association (IPA) with downstream contracts with physicians must complete – Col F Contract Type with a “DS”, Col L Medical Group Affiliation – Enter IPA Name.</li> <li>• Medical Group with downstream contracted physicians complete – Col F Contract Type with a “DS”, Col L Medical Group Affiliation – Enter Medical Group Name.</li> <li>• Medical Group with employed providers must complete – Col F Contract Type with a “DS”, Col L Medical Group Affiliation – Enter Medical Group Name.</li> </ul>
<b>Provider Service Address</b>	Up to 250 characters. 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.
<b>Provider City</b>	Up to 150 characters. Enter the address (i.e., street, city, state and zip code) from which the provider serves patients. Do not list P.O.

<b>Column Heading</b>	<b>Definition</b>
	Box, house, apartment, building or suite numbers, or street intersections. .
<b>Provider State</b>	2 characters. 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.
<b>Provider Zip Code</b>	Up to 10 characters. 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.
<b>If PCP Accepts New Patients?</b>	Indicate if provider is accepting new patients by entering a “Y” for “Yes,” or “N” for “No.”
<b>Medical Group Affiliation</b>	Provide name of affiliated Medical Group/Individual Practice Association (MG/IPA) or if applicant has direct contract with provider enter “DC.”
<b>Model Contract Amendment</b>	Indicate if contract uses CMS Model MA Contract Amendment by entering “Y” for “Yes,” or “N” for “No.”



## 20. Appendix K: MA Facility Health Service Delivery (HSD) Table Template Definitions

<b>Column Heading</b>	<b>Definition</b>
<b>SSA State/County Code</b>	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 applicants should use. Format the cell as “text” to ensure that codes beginning with a “0” appear as five digits.
<b>Facility or Service Type</b>	Name of facility/service type of listed facility. This should be copied directly off of the HSD Criteria Reference Table.
<b>Specialty Code</b>	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.
<b>National Provider Identifier (NPI) Number</b>	Enter the provider’s assigned NPI number in this column. The NPI is a ten digit numeric field. Include leading zeros.
<b>Number of Staffed, Medicare-Certified Beds</b>	For Acute Inpatient Hospitals, Critical Care Services – Intensive Care Units (ICU)s, Skilled Nursing Facilities, and Inpatient Psychiatric Facility Services, enter the number of Medicare-certified beds for which the Applicant has contracted access for Medicare Advantage enrollees. This number should not include Neo-Natal Intensive Care Unit (NICU) beds. The following facilities must include this field on the submitted Facility Table: Acute Inpatient Hospital (040), Critical Care Services - ICU (043), Skilled Nursing Facilities (046), and Inpatient Psychiatric Facility (052).
<b>Facility Name</b>	Enter the name of the facility. Field Length is 150 characters.
<b>Provider Service Street Address</b>	Up to 250 characters. 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.
<b>Provider Service City</b>	Up to 150 characters. 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.
<b>Provider Service State</b>	2 characters. 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.
<b>Provider Service Zip Code</b>	Up to 10 characters. 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.

<b>Column Heading</b>	<b>Definition</b>
	For Home Health and Durable Medical Equipment, indicate the business address where one can contact these vendors.
<b>Model Contract Amendment</b>	Indicate if contract uses CMS Model MA Contract Amendment by entering “Y” for “Yes,” or “N” for No.

