Contract Year (CY) 2017 Medicare Advantage Health Service Delivery (HSD) Provider and Facility Specialties and Network Adequacy Criteria Guidance and Methodology

Table of Contents

HSD Provider and Facility Criteria

Medicare Advantage Organizations (MAOs)[1] must demonstrate that they are able to provide adequate access to current and potential beneficiaries through a contracted network of providers and facilities for all counties within the service area of the contract ID. Beginning with Contract Year (CY) 2017, Medicare Advantage (MA) service area expansion (SAE) applications will require Health Service Delivery (HSD) tables for the entire contract ID and not just those counties that the MAO is proposing to expand into. Additional details on this requirement will be forthcoming through Health Plan Management System (HPMS) memos.

Access to a given provider/facility is considered "adequate" when the three criteria presented in Table 1 are met (described in detail throughout this document).

Table 1: Description of Three Provider and Facility Criteria

Criteria	Description
1. Minimum number of providers/facilities	MAOs must demonstrate that their networks have sufficient numbers of providers/facilities to meet minimum number requirements[2] and allow adequate access for beneficiaries/potential enrollees. Specialized, long-term care, and pediatric/children's hospitals as well as providers/facilities contracted with the MAO only for its commercial, Medicaid, or other products do not count toward meeting HSD criteria and should not be included on the HSD tables.
2. Maximum travel time ***3. Maximum travel distance***	MAOs must demonstrate that their networks do not unduly burden beneficiaries in terms of travel time and distance to network providers/facilities. 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. MAOs must demonstrate that 90 percent of beneficiaries (or more) have access to at least one provider/facility, for each specialty type, within established time and distance requirements for that county.

[1] "MAO" is used throughout this document to refer to entities currently approved to operate as an MAO as well as those applying to operate as an MAO. This guidance does not apply to Medicare-Medicaid Plans. MMPs should refer to the following link and scroll to the section titled "Network Adequacy Standards for Medicare-Medicaid Plans": https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/MedicareMedicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html [2] Although the minimum number requirement for each facility specialty is one (with the exception of Acute Inpatient Hospital beds), MAOs may need to submit more than one of each facility in order to meet time and distance requirements. Similarly, MAOs may need to exceed the minimum number requirements for providers and Acute Inpatient Hospital beds to meet the HSD time and distance requirements.

The specific criteria for each county are published annually in the HSD Criteria Reference Table, which can be found on the CMS website at http://www.cms.hhs.gov/MedicareAdvantageApps/. For CY2017, the HSD Criteria Reference Table Excel file includes the following tabs:

- **Master Tab** – Provides an overview of the HSD criteria by provider and facility specialty type and county designation.
- **Minimum Provider #s** – Lists the minimum number of providers required for each provider specialty type in each county.
- **Minimum Facility #s** – Lists the minimum number of facilities required for each facility specialty type in each county.
- **Provider Time and Distance** – Lists the maximum travel time and distance to contracted providers for each provider specialty type in each county.
- **Facility Time and Distance** – Lists the maximum travel time and distance to contracted facilities for each facility specialty type in each county. Note: Some facility types do not have maximum time and distance standards (e.g., durable medical equipment).
- **Notes** – Provides notes for several specialty types, including definitions and what is appropriate for inclusion on the HSD table submissions.

Calculating the Network Adequacy Criteria

Minimum Number of Providers/Facilities

With the exception of Acute Inpatient Hospital beds, all facilities have a minimum number requirement of one facility.[2] The minimum number criterion for Acute Inpatient Hospital beds and for the HSD provider specialties follows the three calculations discussed below.

1. ***95th Percentile of Beneficiaries Served by MA Organizations***
   The "95th Percentile Base Population Ratio" represents the 95th percentile of MA market penetration rates of CCP and network-based PFFS MAO contracts by county for each county type[2] (Large Metro, Metro, Micro, Rural and CEAC); i.e., 95% of CCP and network-based PFFS contracts have county penetration rates equal to or less than the calculated rates.[3] Each year CMS updates the 95th percentile based on current enrollment. CY2017 percentiles are presented in Table 2.

Table 2: 95th Percentile by County Type

County Type	95th %-ile
Large Metro	0.072
Metro	0.131
Micro	0.115
County Type	95th %-ile

[2] County type designations are discussed in detail in Appendix A of this document.

[3] Penetration 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 of 100/1,000, or 0.10 (10%).

Rural	0.121
CEAC	0.129

2. ***Beneficiaries Required to Cover***

   To determine the base population that an MAO is required to cover, "Beneficiaries Required to Cover," the number of Medicare beneficiaries in a specific county is multiplied by the applicable 95th percentile, as shown in Table 3.

Table 3: Example of Beneficiaries Required to Cover Calculation

County:	*Muscogee, GA*
County Type:	*Metro*
Total Beneficiaries:	*31,705*
95th %-ile:	*0.131*
Beneficiaries Required to Cover:	*(31,705 * 0.131) =* ***4,164***

3. ***Minimum Provider Ratios***

   CMS has established ratios of providers that reflect the utilization patterns and clinical needs of the Medicare population. Specifically, the HSD criteria include a ratio of providers required per 1,000 beneficiaries for the specialty types in the MA Provider Table and also for the Facility specialty "Acute Inpatient Hospital" (# of required beds). These ratios vary by county type and are published for the applicable specialty types in the HSD Reference Tables. To calculate the minimum number of each specialty type in each county, the number of Beneficiaries Required to Cover is multiplied by the Minimum Provider Ratio and rounded up to the nearest whole number.

Table 4: Example of Minimum Provider Calculation

County:	*Muscogee, GA*
County Type:	*Metro*
Beneficiaries Required to Cover:	*4,164*
Specialty:	*Primary Care*
Minimum Provider Ratio:	*1.67 /1,000*
Minimum Number of Providers:	*(1.67/1,000) *4,164 =* ***7***

Maximum Time and Distance

The maximum time and distance criteria were developed using a process of mapping beneficiary locations juxtaposed with provider practice locations. MAOs must ensure that at least 90% of the beneficiaries residing in a given county have access to at least one provider/facility of each type within the published time and distance criteria. The maximum travel time and distance criteria are generally determined by county type and specialty type.

Summary of Changes to the CY2017 MA Provider and MA Facility Criteria

CMS continues to evaluate the process, guidance, and assumptions governing its oversight of the adequacy of MAO provider networks. As with previous years, CMS updated total beneficiaries and

county type values (see HSD Reference Files) to reflect the most recently published number of Medicare beneficiaries in each county, as well as the county population and density, for CY 2017.

Applying Network Adequacy Criteria to MAOs

CMS uses a mapping software program to evaluate MAOs' submitted networks. The software evaluates contracted networks against beneficiary locations across an entire county, which allows CMS to determine whether an MAO's proposed network meets HSD adequacy standards (i.e., minimum number, maximum time, and maximum distance). If an MAO believes that HSD criteria cannot be met, the MAO can request consideration for an exception through the HSD Exception Request process.

MAOs are only permitted to include in their submitted HSD tables providers and facilities that are *under contract at the time of their submission* to CMS. In achieving the network adequacy criteria, contracted providers do not need to be located within the physical boundaries of the county being assessed, but the providers must be within the time and distance requirements of at least one beneficiary in that county (see below).

Minimum Number of Providers/Facilities

Through the automated HPMS process, CMS assesses whether an MAO meets the minimum provider/facility numbers based on the providers/facilities listed on the submitted HSD tables as serving the county being assessed. A listed provider/facility must be within the maximum travel time and distance of at least one beneficiary residing in the county being assessed in order for the provider/facility to count towards the minimum number requirements. For example, a cardiologist located in Shelby County, Tennessee will not count toward the minimum provider number requirement for beneficiaries residing in Miami-Dade County, Florida, even if the MAO has listed that provider for Miami-Dade County.

MAOs must have at least one of each HSD facility type. At this time, CMS has not established additional criteria for the minimum number of required providers for most of the specialty types on the CMS MA Facility Table. The one exception is for the requirements concerning acute inpatient hospital beds. CMS has established a requirement for the minimum number of acute inpatient beds (12.2 inpatient hospital beds per 1,000 beneficiaries required to cover for that county). This criterion was calculated using the same type of determinants as those described above.

Maximum Travel Time and Distance

In addition to meeting the minimum number of providers criteria, MAOs must demonstrate that, taking into consideration the geographic distribution of beneficiary locations within the county being assessed, at least 90% of the Medicare beneficiaries residing in that given county have access to at least one provider/facility, for a given specialty, *within the time and distance requirements*.
In order to meet the time and distance requirements, the number of providers/facilities that an MAO must submit may need to exceed the minimum number requirements, depending upon the practice locations of the providers/ facilities. MAOs may include contracted providers/facilities located outside of the MAO's requested service area/counties if those providers are within the time and distance requirements of the county being assessed.

HSD Provider and Facility Specialty Details

Specialty Codes

CMS has created specific specialty codes for each of the provider and facility types. MAOs must use the codes when completing MA Provider and Facility HSD tables.

Table 5: List of specialty codes for provider table

Specialty Codes for the MA Provider Table

001 – General Practice
002 – Family Practice
003 – Internal Medicine
004 – Geriatrics
005 – Primary Care – Physician Assistants
006 – Primary Care – Nurse Practitioners
007 – Allergy and Immunology
008 – Cardiology
009 – NOT IN USE
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
024 – NOT IN USE
025 – Orthopedic Surgery
026 – Physiatry, Rehabilitative Medicine
027 – Plastic Surgery
028 – Podiatry
029 – Psychiatry
030 – Pulmonology
031 – Rheumatology
032 – NOT IN USE
033 – Urology
034 – Vascular Surgery

035 – Cardiothoracic Surgery

Table 6: List of specialty codes for facility table

Specialty Codes for the MA Facility Table
040 – Acute Inpatient Hospitals 041
– Cardiac Surgery Program
042 – Cardiac Catheterization Services
043 – Critical Care Services – Intensive Care Units (ICU)
044 – Outpatient Dialysis
045 – Surgical Services (Outpatient or ASC)
046 – Skilled Nursing Facilities
047 – Diagnostic Radiology
048 – Mammography
049 – Physical Therapy
050 – Occupational Therapy
051 – Speech Therapy
052 – Inpatient Psychiatric Facility Services
053 – NOT IN USE
054 – Orthotics and Prosthetics
055 – Home Health
056 – Durable Medical Equipment
057 – Outpatient Infusion/Chemotherapy
058 – NOT IN USE
059 – NOT IN USE
060 – NOT IN USE
061 – Heart Transplant Program
062 – Heart/Lung Transplant Program
063 – NOT IN USE
064 – Kidney Transplant Program
065 – Liver Transplant Program
066 – Lung Transplant Program
067 – Pancreas Transplant Program

Specialty Guidance

To assist MAOs further, this section contains additional information on the appropriate submissions for a number of the MA HSD Provider and MA HSD Facility Table specialty types, about which CMS periodically receives questions.

MA Provider Table – Select Provider Specialty Types

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

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

MAOs submit contracted providers using the appropriate individual specialty codes (001 – 006). CMS sums these providers, maps them as a single group, and evaluates the results of those submissions whose office locations are within the prescribed time and distance standards for the specialty type: Primary Care Providers. These six specialties are also summed and evaluated as a single group against the Minimum Number of Primary Care Providers criteria (note that in order to apply toward the minimum number, a provider must be within the prescribed time and distance standards.. There are HSD network criteria for the specialty type: Primary Care Providers and not for the individual specialty types that are summed into this category. The criteria and the results of the Automated Criteria Check (ACC) are reported under the specialty type: S03.

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

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

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

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

Cardiothoracic Surgery (035) – Cardiothoracic surgeons provide operative, perioperative, and surgical critical care to patients with acquired and congenital pathologic conditions within the chest. This includes the surgical repair of congenital and acquired conditions of the heart, including the pericardium, coronary arteries, valves, great vessels and myocardium. Cardiologists, including interventional cardiologists, are not cardiothoracic surgeons, and may not be included under this specialty type.

MA Facility Table – Select Facility Specialty Types

Contracted facilities/beds must be Medicare-certified.

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

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

Physical Therapy (049) – Physical Therapists should never be listed under the "Physiatry, Rehabilitative Medicine" specialty type (specialty code = 026). Physical therapists (PTs) are not Doctors of Medicine or Doctors of Osteopathic Medicine. PTs assess and treat mobility and pain problems that result from disease, aging, or injury through physical methods such as exercises,

massage, and hot/cold applications. PTs must hold licensure or certification specific to the rendering of physical therapy services in each state or territory in which they practice. PTs, for purposes of the HSD Table inputs, may provide care for people in free-standing office settings or clinics, or outpatient hospital clinics. It is not appropriate to include PTs who render services in the home or in skilled nursing facility settings only.

Occupational Therapy (050) – Occupational Therapists render care to people requiring specialized assistance to lead independent and productive lives otherwise impaired due to physical, developmental, social, or emotional problems. Occupational therapists use the "occupations" of selfcare, work, and play/leisure activities to increase independence, enhance development, and/or prevent disability. Occupational therapists (OTs) are not Doctors of Medicine or Doctors of Osteopathic Medicine. OTs must hold licensure or certification specific to the rendering of occupational therapy services in each state or territory in which they practice. OTs, for purposes of the HSD Table inputs, may provide care for people in free-standing office settings or clinics, or outpatient hospital clinics. It is not appropriate to include PTs who render services in the home or in skilled nursing facility settings only.

Speech Therapy (051) – Speech Therapists, also called speech-language pathologists, assess and treat speech and language problems that result from a number of disorders, including stroke, amyotrophic lateral sclerosis, and Huntington's disease. Audiologists should not be included under this specialty type. Speech therapists (STs) are not Doctors of Medicine or Doctors of Osteopathic Medicine. STs must hold licensure or certification specific to the rendering of speech therapy services in each state or territory in which they practice. STs, for purposes of the HSD Table inputs, may provide care for people in free-standing office settings or clinics, or outpatient hospital clinics. It is not appropriate to include STs who render services in the home or in skilled nursing facility settings only.

Orthotics and Prosthetics (054) – A prosthetist is a healthcare professional trained to measure, design, fit, and adjust prostheses/prosthetic devices as prescribed by a physician. Prosthetic devices replace all or part of an internal body organ or all or part of the function of a permanently inoperative or malfunctioning internal body organ. An orthotist is a healthcare professional trained to plan, design, fit and adjust orthotic devices as prescribed by a physician. Orthotic devices are rigid/semirigid devices applied to the outside of the body to support a weak or deformed body part, or to restrict motion in an area of the body. MAOs' contracts for orthotics and prosthetics must ensure access for beneficiaries/members to the fitting and modification and services to the devices (orthotics and prosthetics) and to the healthcare professionals (orthotists and prosthetists).

Home Health (055) – MAOs must list at least one Medicare certified home health agency (HHA) serving each specific county included in the MAO's current and proposed service area. Each Medicare certified HHA is licensed for defined service areas and may only serve a portion of a given county; additionally, HHAs vary significantly in the types of home health services provided. Thus, an MAO may be required to contract with more than one HHA in order to ensure adequate coverage of HHA services across the entire county. CMS provides a listing of certified home health facilities at https://data.medicare.gov/data/home-health-compare and notes whether each facility provides

Nursing Care Services, Physical Therapy Services, Occupational Therapy Services, Speech Pathology Services, Medical Social Services, and Home Health Aide Services.

Durable Medical Equipment (056) – MAOs must list at least one durable medical equipment provider. A submission under this specialty type can be limited to one provider, so long as that provider covers the full range of Medicare covered durable medical equipment services. MAOs' submissions for this specialty must provide durable medical equipment services throughout the entire area of the county. MA plans are expected to cover the full range of medically necessary DME supplies that beneficiaries might require. A non-exhaustive list of such supplies can be found at http://www.medicare.gov/coverage/durable-medical-equipment-coverage.html.

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

Transplant Programs (061, 062, 064, 065, 066, 067) – MAOs must list at least one contracted program for each of the six transplant program types: Heart, Heart/Lung, Kidney, Liver, Lung and Pancreas. A list of Medicare-approved transplant programs can be found at https://www.cms.gov/medicare/provider-enrollment-andcertification/certificationandcomplianc/downloads/approvedtransplantprograms.pdf.

Appendix A: Designating County Types

The county type, Large Metro, Metro, Micro, Rural, or CEAC, is a significant component of the network access criteria. CMS uses a county type designation method that is based upon the population size and density parameters of individual counties.

Table 7 lists the population and density parameters applied to determine county type designations. These parameters are foundationally based on approaches taken by the Census Bureau in its delineation of "urbanized areas" and "urban clusters," and the OMB in its delineation of "metropolitan" and "micropolitan." A county must meet both the population and density thresholds for inclusion in a given designation. For example, a county with a population greater than one million *and* a density greater than or equal to 1,000/mi^2 is designated Large Metro. Any of the populationdensity combinations listed for a given county type may be met for inclusion within that county type (i.e., a county would be designated Large Metro if *any* of the three Large Metro population-density combinations listed in Table 7 are met; a county is designated as Metro if any of the five Metro population-density combinations listed in Table 7 are met; etc.).

Table 7: Population and Density Parameters

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

CMS applies these parameters to US Census Bureau population estimates to determine, annually, appropriate county type designations. Current population and density estimates (calendar year 2014) are available at http://quickfacts.census.gov/qfd/download_data.html.