Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance

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1. Introduction

The Centers for Medicare & Medicaid Services (CMS) regulations at 42 CFR 417.414, 42 CFR 417.416, 42 CFR 422.112(a)(1)(i), and 42 CFR 422.114(a)(3)(ii) require that all Medicare Advantage organizations (MAOs) offering coordinated care plans, network-based private fee-for-service (PFFS) plans, and network-based medical savings account (MSA) plans, as well as section 1876 cost organizations, maintain a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served. These organization types must provide enrollees health care 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)(10)). Medicare Advantage (MA) regional preferred provider organizations (RPPOs) are an exception and, under specified conditions and upon CMS pre-approval, can arrange for care in portions of a regional service area on a non-network basis (42 CFR 422.112(a)(1)(ii)).

1.1. Network Adequacy Requirements

Organizations must meet current network adequacy requirements.[1] CMS expects that organizations continuously monitor their contracted networks throughout the respective contract year to ensure compliance with the current network adequacy criteria. CMS also monitors an organization's compliance with network adequacy requirements. Each year, CMS assesses health care industry trends and enrollee health care needs to establish network adequacy criteria. This network adequacy criteria includes 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 and facilities to ensure that organizations contract with a sufficient number of providers and facilities to furnish health care services without placing undue burden on enrollees seeking covered services. CMS programs the network adequacy criteria into the Network Management Module (NMM) in the Health Plan Management System (HPMS) to facilitate an automated review of an organization's network adequacy. See section 2 and section 3 for discussion of the current 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 health care landscape that is not currently reflected in the network adequacy criteria. Organizations should also reference chapter 4 of the Medicare Managed Care Manual (MMCM) for more information on network adequacy requirements.[2]

1.1.1. Triennial Network Adequacy Review

CMS monitors network compliance by reviewing organizations' networks on a triennial basis (i.e., every three years). The triennial network adequacy review requires an organization to upload its full contract-level network into the NMM in HPMS. CMS provides organizations that are due for their triennial review at least 60 days' notice before the deadline to submit their networks. The triennial network adequacy review cycle helps to ensure a consistent process for network oversight and monitoring. For more information, please see the Office of Management

[1] The term "organization" is used throughout this document to refer to both MA organizations and section 1876 cost organizations.
[2] The MMCM is available on CMS's website.

and Budget (OMB)-approved information collection "*Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans*" (OMB 0938-1346, CMS-10636).

1.1.2. Triggering Events

In addition to the triennial network adequacy review, CMS may perform a network review after specific triggering events. Triggering events include:

1. **Initial application:** Any organization seeking to offer a new contract must demonstrate compliance with network adequacy requirements in the proposed service area.
2. **Service area expansion (SAE) application:** Any organization seeking to expand the service area of an existing contract must demonstrate compliance with network adequacy requirements in the proposed service area.
3. **Significant Provider/facility contract termination:** When a contract between an organization and a provider or facility is terminated, and CMS determines it to be significant, then CMS may request to review the network in order to ensure the organization's ongoing compliance with network adequacy requirements. For more information on significant network changes, please refer to chapter 4 of the MMCM.
4. **Change of ownership transaction:** 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 contract(s). Acquiring entities that have not been approved by CMS to operate in the acquired service area may need to demonstrate compliance with network adequacy requirements. If required, CMS will provide acquiring entities with the necessary instructions for submitting their contracted network for CMS review. Existing organizations should reference the change of ownership requirements in chapter 12 of the MMCM for additional information regarding CMS notification requirements.
5. **Network access complaint:** If CMS receives complaints from an enrollee, caregiver, or other source that indicates an organization is not providing sufficient access to covered health care services, CMS may elect to review the organization's contracted network.
6. **Organization-disclosed network gap:** CMS expects that organizations continuously monitor their networks for compliance with the current network adequacy requirements. CMS encourages organizations to notify their CMS Account Managers upon discovery that their network is out of compliance. Once notified, CMS will request that the organization upload its contracted network for CMS review.

The extent of the CMS network adequacy review varies based on the specific circumstances of the triggering event. An initial application always prompts a **full** network review, while an SAE application prompts a **partial** network review of only the new counties. Triggering events 3-6 as detailed above may prompt either a full or partial network review. CMS will provide organizations with specific instructions for submitting their contracted networks and identify a specific submission timeframe. **If an organization experiences a triggering event requiring a full network review, then the timing of that organization's subsequent triennial review may be reset.**

1.1.3. Timing of Network Adequacy Reviews

Prior to the formal network review, CMS provides all organizations the opportunity to upload their networks in the NMM for an informal review. CMS provides technical assistance, guidance, and consultation to organizations that want to take advantage of this opportunity.

However, CMS must give priority to initial and SAE applicants and organizations due for their triennial review before assisting other organizations requesting an informal review.

All organizations submit their bids by the first Monday in June, reflecting their assumed service area for the upcoming coverage year. Initial and SAE applicants and organizations due for their triennial review must upload their health service delivery (HSD) tables into the NMM in mid-June for CMS review.[3] Initial and SAE applicants must upload their tables for the upcoming contract year, while organizations due for their triennial review must upload their tables for the current contract year.

Organizations will not be permitted to resubmit revised Bid Pricing Tools (BPTs) or adjust assumptions in the previously submitted BPTs, but can terminate plan benefit package(s) prior to signing their contract.

1.2. Compliance/Enforcement Actions

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

1.3. Ensuring Access to Care

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

1.4. Document Organization

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

[3] For more information on HSD tables, please see section 4.

Section Number	Section Title	Description
1	**Introduction**	**This section provides an introduction to CMS's network adequacy requirements, network review guidance, information on compliance/enforcement actions, and requirements for ensuring access to care.**
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 Measurements of Network Adequacy**	**This section discusses CMS's methodology for establishing quantitative measurements for each specialty type listed under section 2.**
4	**Health Service Delivery Table Upload Instructions**	**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 measurements outlined under section 2 and section 3.**
5	**Exception Requests for Network Adequacy Criteria**	**This section describes the process by which organizations can request exceptions to CMS's quantitative time and distance standards discussed under section 3.**
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**	**This section defines provider-specific plans (PSPs) and outlines how and when CMS reviews PSP networks.**
8	**Regional Preferred Provider Organizations**	**This section defines regional preferred provider organizations (RPPOs) and the unique opportunity afforded to RPPOs for providing access to care for enrollees.**
9.	**Sub-Networks**	**This section defines sub-networks and enrollee access requirements for sub-networks.**

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.

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.

2.2. Current Specialty Types

Currently, CMS measures 27 provider specialty types[4] and 14 facility specialty types[5] 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 C and Appendix D 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.

[4] Primary care providers (specialty code S03) are measured as a single specialty, but submitted under six codes (001 through 006).

[5] Beginning in 2018, organizations will not be required to include Orthotics & Prosthetics, Home Health, Durable Medical Equipment, Heart Transplant Program, Heart/Lung Transplant Program, Kidney Transplant Program, Liver Transplant Program, Lung Transplant Program, or Pancreas Transplant Program on their HSD tables. Instead, organizations will attest in their applications that they are able to provide adequate beneficiary access to these specialty types.

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 was established to align with the access standards implemented at that time 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^2 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 3-1 are met; etc.).

Table 3-1: Population and Density Parameters

County Type Designation	Population	Density
Large Metro	≥ 1,000,000	**≥ 1,000/mi²**
--	500,000 – 999,999	**≥ 1,500/mi²**
--	Any	**≥ 5,000/mi²**
Metro	≥ 1,000,000	**10 – 999.9/mi²**
--	500,000 – 999,999	**10 – 1,499.9/mi²**
--	200,000 – 499,999	**10 – 4,999.9/mi²**
--	50,000 – 199,999	**100 – 4,999.9/mi²**
--	10,000 – 49,999	**1,000 – 4,999.9/mi²**
Micro	50,000 – 199,999	**10 – 99.9 /mi²**
--	10,000 – 49,999	**50 – 999.9/mi²**
Rural	10,000 – 49,999	**10 – 49.9/mi²**
--	<10,000	**10 – 4,999.9/mi²**
CEAC	**Any**	**<10/mi²**

Each year, CMS applies these parameters to the most recently available U.S. Census Bureau population estimates to determine appropriate county type designations.[6]

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.[7] 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. 95th Percentile of Beneficiaries Served by Organizations[8]

The 95th Percentile Base Population Ratio represents the approximate proportion of total Medicare beneficiaries in a county who may enroll in an MA plan in a given year. It is calculated as the 95th percentile of MA market penetration rates of CCP and network-based PFFS MA

[6] Calendar year 2015 and 2016 population and density estimates are available at this website.
[7] This requirement works in concert with the time and distance criteria to ensure access to covered services.
[8] Note that the 95th 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.

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.[9] Each year, CMS updates the 95th percentile based on current enrollment. The current 95th Percentile Base Population Ratios are presented in Table 3-2.

Table 3-2: 95th Percentile Base Population Ratio

The 95th percentile represents MA market penetration rates based on county type designation

County Type Designation	95th % ile
Large Metro	**0.074**
Metro	**0.127**
Micro	**0.118**
Rural	**0.127**
CEAC	**0.153**

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 95th 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 95th percentile base population ratio

Beneficiaries Required to Cover Sub Component	2018 Reference File Example
County	Baldwin, AL
County Type Designation	Metro
Total Beneficiaries	48,607
95th %-ile for Metro County Designation	0.127
Required to Cover	(48,607 * 0.127)= **6,162 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 C) 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 Required to Cover is multiplied by the Minimum Provider Ratio and rounded up to the nearest

[9] 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%).

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

Minimum Provider Calculation Sub component	2018 Reference File Example
County	Baldwin, AL
County Type Designation	Metro
Beneficiaries Required to Cover	6,162
Specialty Type	Primary Care
Minimum Provider Ratio	1.67/1,000
Minimum Number of Providers	(1.67/1,000) * 6,162 = 10.29 = **11 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 *3.1.2.1. 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.

All facility types on the HSD table 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 along 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.[10] The maximum travel time and distance standards are generally determined by county type and specialty type. CMS determines time and distance standards by county type and specialty type. In setting these time and distance standards CMS

[10] Provider/facilities are not required to be within the county or state boundaries for the service area.

also considers the number and geographical distribution of providers/facilities available in the county to provide services.

3.1.3.2. Provider and Facility Supply File

CMS and its contractor developed a provider and facility supply file. This supply file was developed using traditional Medicare claims data and publicly available sources on the Medicare.gov website to identify, to the extent possible, Medicare providers and facilities available at a national level. To develop the supply file, extracted claims were limited to those with a starting date of service between August 1, 2016 and July 31, 2017 for beneficiaries with both Medicare Part A and B coverage at the time of their claim. 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. MAOs remain responsible for conducting validation of data used to populate HSD tables, including data initially drawn from the supply file. 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 specialty and address were identified though Medicare fee-for-service physician claims from office locations from claims data. The Medicare Specialty Code reported on each claim was used to determine the appropriate assignment of HSD specialty type for each physician. The specific codes used for each HSD specialty are listed in Table 3-5.

Table 3-5: Crosswalk of HSD and Medicare Provider Specialties

HSD Specialty Code	HSD Specialty Name	Medicare Specialty Codes Included
S03	Primary Care	General Practice (01) Family Practice (08), Internal Medicine (11), Geriatric Medicine (38)
007	Allergy and Immunology	Allergy/Immunology (03)
008	Cardiology	Cardiology (06)
010	Chiropractor	Chiropractic (35)
011	Dermatology	Dermatology (07)
012	Endocrinology	Endocrinology (46)
013	ENT/Otolaryngology	Otolaryngology (04)
014	Gastroenterology	Gastroenterology (10)
015	General Surgery	General Surgery (02)
016	Gynecology, OB/GYN	Obstetrics & Gynecology (16)
017	Infectious Diseases	Infectious Disease (44)
018	Nephrology	Nephrology (39)
019	Neurology	Neurology (13)
020	Neurosurgery	Neurosurgery (14)
021	Oncology - Medical, Surgical	Hematology (82), Hematology-Oncology (83), Medical Oncology (90), Surgical Oncology (91), Gynecological Oncology (98)
022	Oncology - Radiation/Radiation Oncology	Radiation Oncology (92)
023	Ophthalmology	Ophthalmology (18)
025	Orthopedic Surgery	Orthopedic Surgery (20), Hand Surgery (40)
026	Physiatry, Rehabilitative Medicine	Physical Medicine and Rehabilitation (25)
027	Plastic Surgery	Plastic and Reconstructive Surgery (24)
028	Podiatry	Podiatry (48)
029	Psychiatry	Psychiatry (26)
030	Pulmonology	Pulmonary Disease (29)
031	Rheumatology	Rheumatology (66)
033	Urology	Urology (34)

034	Vascular Surgery	Vascular Surgery (77)
035	Cardiothoracic Surgery	Thoracic Surgery (33), Cardiac Surgery (78)

3.1.3.2.2. Facility Supply File

Facility specialties were identified from the Medicare claims data for eleven specialties and from the publicly available data for the remaining three (Outpatient Dialysis, Skilled Nursing Facilities, and Inpatient Psychiatric Facility Services), all of which are maintained by CMS.[11] Table 3-6 outlines the source and other details of the data extract for each facility specialty.

Table 3-6: Facility Specialties

HSD Specialty Code	HSD Specialty Name	Primary Data Source	Additional Notes on Approach
040	Acute Inpatient Hospitals	Medicare Claims Data	Identified facilities with inpatient claims then limited to short-term hospitals (CCN between xx0001 – xx0899) and Critical Access Hospitals (CAH) (CCN between xx1300 – xx1399) Excluded children's hospitals (CCN = xx3300 – xx3399) These facilities will still include some specialty hospitals that focus on certain types of care, such as orthopedics and cardiac care
041	Cardiac Surgery Program	Medicare Claims Data	Identified facilities with claims from inpatient hospital services for the most common cardiac surgery MS-DRGs: Valve Replacement (216-221) and Coronary Artery Bypass (231-236) Hospitals providing cardiac surgery services were required to have at least five claims Excluded children's hospitals (CCN = xx3300 – xx3399)
042	Cardiac Catheterization Services	Medicare Claims Data	Cardiac catheterization services are delivered in hospitals and in ambulatory settings Identified facility claims with a revenue code for Cardiac Catheterization Laboratory (0481) • Facilities were required to have at least five claims with the relevant revenue code • Excluded children's hospitals (CCN xx3300 – xx3399) Identified professional claims reported with an office or independent clinic place of service (POS = 11 or 49) that also contained common procedure codes for diagnostic cardiac catheterization (93451 – 93462) where the rendering provider Medicare Specialty in Cardiology (06), Cardiac Surgery (78), or Interventional Cardiology (C3) • Excluded claims with a "26" procedure modifier • Each freestanding facility was required to have five or more claims

[11] 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.

HSD Specialty Code	HSD Specialty Name	Primary Data Source	Additional Notes on Approach
043	Critical Care Services – Intensive Care Units (ICU)	Medicare Claims Data	Critical care services were limited to inpatient claims in acute-care general hospitals (IPPS hospitals and critical access hospitals) Identified inpatient hospital bills with revenue codes for the following ICU categories: ICU (0200), Surgical (0201), Medical (0202), Burn Care (0207), Trauma (0208) Facilities were required to have at least five claims with the relevant revenue codes. Excluded children's hospitals (CCN = xx3300 – xx3399)
044	Outpatient Dialysis	Dialysis Facility Compare (DFC) Downloadable File[12]	All facilities captured in the downloadable file are included in the supply file; no additional filtering was applied.
045	Surgical Services (Outpatient or ASC)	Medicare Claims Data	Surgical services can be delivered in the hospital outpatient (OP) setting and ambulatory surgery centers (ASCs) (inpatient surgical services are included in the inpatient hospital category) Identified outpatient claims in revenue codes for operating room (OR) services: OR Services (0360), Minor Surgery (0361), Other OR Service (0369) • Facilities were required to have at least five claims with the relevant revenue codes. • Excluded children's hospitals (CCN = xx3300 – xx3399) Identified all professional claims with an ASC place of service code (24) and Medicare Specialty code for ASC (49) • Freestanding facilities were required to have at least five claims with the relevant revenue codes.
046	Skilled Nursing Facilities	Nursing Home Compare Downloadable File[13]	Included observations with CMS Certification Numbers (CCNs) that are consistent with Medicare skilled nursing facilities (CCN=xx5000 - xx6499)
047	Diagnostic Radiology	Medicare Claims Data	Diagnostic radiology services are provided in hospitals, in physicians' offices, and by independent diagnostic testing facilities (IDTFs) and mobile x-ray suppliers Identified facility claims in an outpatient setting that had a procedure code related to ultrasound, x-ray, computed tomography (CT), or magnetic resonance imaging (MRI) • Facilities were required to have at least five claims with the relevant revenue codes • Excluded children's hospitals (CCN = xx3300 – xx3399) Identified professional claims that had a procedure code related to ultrasound, x-ray, CT, or MRI from a provider with a Medicare Specialty in Diagnostic Radiology (30) • Freestanding facilities were required to have at least five claims with the relevant revenue codes

[12] The Dialysis Compare database can be downloaded at: https://data.medicare.gov/data/dialysis-facility-compare.
[13] The Nursing Home Compare database can be downloaded at: https://data.medicare.gov/data/nursing-home-compare.

HSD Specialty Code	HSD Specialty Name	Primary Data Source	Additional Notes on Approach
048	Mammography	Medicare Claims Data	Mammograms are provided by hospital outpatient departments, physicians' offices, and IDTFs Identified facility claims from an outpatient setting with procedure codes for Screening and Diagnostic Mammography (G0202, G0204, G0206, 77055, 77056, 77057, 77065, 77066, 77067) • Excluded claims with a "26" procedure modifier • Facilities were required to have at least five claims with the relevant procedure codes • Excluded children's hospitals (CCN = xx3300 – xx3399) Identified professional claims from an office place of service with procedure codes for Screening and Diagnostic Mammography (G0202, G0204, G0206, 77055, 77056, 77057, 77065, 77066, 77067) from a provider with a Medicare Specialty in Diagnostic Radiology (30) • Excluded claims with a "26" procedure modifier • Freestanding facilities were required to have at least five claims with the relevant procedure codes
049	Physical Therapy	Medicare Claims Data	Physical therapy (PT) is available in hospital outpatient departments, in Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs), and in practices of physicians or in the offices of therapists billing independently Identified facility claims with an outpatient setting with revenue codes for Physical Therapy (0420 - 0429); • SNFs (CCN=xx5000 - xx6499) were excluded • Facilities were required to have at least five claims with the relevant revenue codes • Excluded children's hospitals (CCN = xx3300 – xx3399) Identified professional claims from an office place of service with PT evaluation procedure codes (97001, 97161, 97162, 97163) from a provider with a Medicare Specialty in Physical Therapy (65) • Freestanding facilities were required to have at least five claims with the relevant revenue codes
050	Occupational Therapy	Medicare Claims Data	Occupational therapy (OT) is available in hospital outpatient departments, in CORFs and ORFs, and in practices of physicians or in the offices of therapists billing independently Included outpatient facility claims with revenue codes for Occupational Therapy (0430 - 0439) • SNFs (CCN=xx5000 - xx6499) were excluded • Facilities were required to have at least five claims with the relevant revenue codes • Excluded children's hospitals (CCN = xx3300 – xx3399) Identified professional claims from an office place of service with OT evaluation procedure codes (97003, 97165, 97166, 97167) from a provider with a Medicare Specialty in Occupational Therapy (67) • Freestanding facilities were required to have at least five claims with the relevant revenue codes

HSD Specialty Code	HSD Specialty Name	Primary Data Source	Additional Notes on Approach
051	Speech Therapy	Medicare Claims Data	Speech and language pathology (SLP) services are available in hospital outpatient departments, in CORFs and ORFs, and in practices of physicians or in the offices of therapists billing independently Included outpatient facility claims with revenue codes for Speech Language Therapy Pathology (0440 - 0449) • SNFs (CCN=xx5000 - xx6499) were excluded • Facilities were required to have at least five claims with the relevant revenue codes • Excluded children's hospitals (CCN = xx3300 – xx3399) Identified professional claims from an office place of service with SLP evaluation procedure codes (92521, 92522, 92523, 92524) from a provider with a Medicare Specialty in Speech Therapy (15) • Freestanding facilities were required to have at least five claims with the relevant revenue codes
052	Inpatient Psychiatric Facility Services	Inpatient Psychiatric Facility Quality Reporting (IPFQR) Downloadable File[14]	All facilities captured in the downloadable file are included in the supply file; no additional filtering was applied
057	Outpatient Infusion/Chemotherapy	Medicare Claims Data	Chemotherapy infusions are delivered in physicians' offices, hospital outpatient departments, and stand-alone infusion centers. Identified outpatient facility claims reporting the revenue code for Chemotherapy Administration – IV (0335) • Facilities were required to have at least five claims with the relevant revenue code Identified professional claims from an office place of service with chemotherapy infusion procedure codes (96413, 96422, 96425, G0498) and Medicare Specialty in Hematology (82), Hematology/Oncology (83), Medical Oncology (90), or Gynecology/Oncology (98) • Freestanding facilities were required to have at least five claims with the relevant procedure codes

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 organization would not be able to meet the network adequacy criteria. Organizations may submit an Exception Request to CMS's time and distance standards in such instances (see section 5 for additional information).

[14]The Inpatient Psychiatric Facility Quality Reporting (IPFQR) Downloadable File can be found here.

. Health Service Delivery Table Upload Instructions

Note: Detailed technical instructions are outlined in the NMM User Guides in HPMS.

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 in the NMM in HPMS. The NMM is an automated network review tool. **Organizations shall list on the HSD Tables only providers and facilities with which the organization has fully executed contracts.** CMS considers a contract fully executed when both parties have signed the contract. **Please note, RPPOs may list on their HSD Tables those non-contracted providers and facilities for which they have a CMS pre-approved exception to the written agreement (42 CFR 422.112(a)(1)(ii).**

4.1. Populating the HSD Tables

4.1.1. Provider HSD Table

The Provider HSD Table is where an organization lists every **contracted** provider in its network. The Provider HSD Table template (Appendix G) has several fields that must all be populated prior to submission (see Appendix H for the Provider HSD Table fields and associated 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 C for a complete list of provider specialty type codes).

If a provider serves enrollees from multiple counties in the service area, then organizations must list the provider multiple times on the Provider HSD Table in the appropriate state/county code, in order to account for each county. Providers may serve enrollees residing in a different county and/or state than their office locations. However, organizations should not list contracted providers 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 an extraneous listing of a provider affects CMS's 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 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. CMS may request verification of credentialing

documentation 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 results and possible network deficiencies.

In order for the NMM to appropriately process the information, organizations must submit provider 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. See Appendix B for guidance on developing valid addresses. CMS expects all organizations to use the NMM to check their networks and to fully review the results to ensure that their Provider HSD Tables are accurate and complete (see section 4.2 for more information).

4.1.2. Facility HSD Table

The Facility HSD Table is where an organization lists every **contracted, Medicare-certified** facility in its network. The Facility HSD Table template (Appendix I) has several fields that must all be populated prior to submission (see Appendix J for the Facility HSD Table fields and associated definitions). CMS has created specific specialty codes for each facility specialty type. Organizations must use these codes when completing the Facility HSD Table (see Appendix D for a complete list of facility specialty type codes).

If a facility serves enrollees from multiple counties in the service area, then organizations must list the facility multiple times on the Facility HSD Table in the appropriate state/county code, in order to account for each county. Facilities may serve enrollees residing in a different county and/or state than their office locations. However, organizations should not list contracted facilities in state/county codes where enrollees could not reasonably access services and that are outside the pattern of care (e.g., listing a hospital located in California for a county in Massachusetts). Such an extraneous listing of a facility affects CMS's 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 provides services in multiple counties, then the organization should list the facility multiple times with the appropriate state/county code and specialty code for each service.

In order for the NMM to appropriately process the information, organizations must submit 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. See Appendix B for guidance on developing valid addresses. CMS expects all organizations to use the NMM to check their networks and to fully review the results to ensure that their Facility HSD Tables are accurate and complete (see section 4.2 for more information).

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 through 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 NMM in HPMS. To test networks, organizations may use the following navigation path: **HPMS Home Page>Monitoring>Network Management>Submit Network>Select Contract Number>Organization Initiated**. Once an organization initiates its HSD table upload, the

NMM 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 organization-initiated network review will be available through the Automated Criteria Check (ACC) report in HPMS. Organizations may find the ACC reports using the following navigation path: **HPMS Home Page>Monitoring>Network Management>ACC Extracts**.

The ACC report displays the results of the automated network review for each provider and facility. The results are displayed as either "PASS" or "FAIL." Results displayed as "PASS" mean that the specific provider or facility met the CMS network adequacy criteria. Results displayed as "FAIL" mean that the specific provider or facility did not meet the criteria. The NMM also contains the Zip Code Report for Failed Counties that lists the areas where enrollees do not have adequate access. Organizations may find the Zip Code Report for Failed Counties using the following navigation path: **HPMS Home Page>Monitoring>Network Management>ACC Extracts**. Organizations should use the results received during the organization-initiated testing of contracted networks to revise HSD tables and formally submit them by any CMS-designated submission date.

Specific instructions on how to submit HSD tables and access ACC reports are outlined in the NMM Plan User Guide. Organizations may find the Plan User Guide using the following navigation path: **HPMS Home Page>Monitoring>Network Management>Guidance**.

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. Given the variability that occurs in the health care landscape throughout a given year, the providers/facilities available to achieve appropriate network access is constantly changing. The Exception Request process allows organizations to provide evidence to CMS when the health care market landscape has changed or does not reflect the current CMS network adequacy criteria.

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

- The landscape of providers/facilities has changed, and certain providers/facilities are not available such that the organization is not able to meet the CMS network adequacy criteria as currently shown for a given county and specialty type in the HSD Reference File,[15] **and**
- To address the changed provider/facility landscape, the organization has contracted with other providers/facilities that may be located beyond the limits in the time and distance criteria, but who are actually the currently available providers/facilities most accessible to enrollees.

The organization must include conclusive evidence in its Exception Request that the CMS network adequacy criteria cannot be met because of changes to the availability of providers/facilities, resulting in insufficient supply. The organization must then demonstrate that its contracted network (i.e., providers/facilities included on its HSD tables) furnishes 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 that original Medicare beneficiaries primarily use in a specified geographic area in order to receive their Medicare-covered health care services. 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. 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 is 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:
  - 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.

[15] The current HSD Reference File is located online.

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. Organizations must use the current Exception Request Template in the NMM and submit the template in accordance with CMS communications. The current Exception Request template is also located in Appendix E.

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/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. See section 5.4 below for details on pattern of care rationales.

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 providers/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, then CMS expects organizations to meet the criteria without an Exception.

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/facility. 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/facilities. Therefore, CMS will generally not accept an organization’s assertion that it cannot meet current CMS network adequacy criteria because providers/facilities are not willing to contract with it.

If an organization cannot come to a financial contracting agreement with a provider/facility, then 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 Request. 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 may 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. 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. However, the organization may continue to negotiate its contract and add the provider to its HSD table once the contract is fully executed.

5.3.2. Valid Rationales

Generally, organizations use the exception process to identify when the supply of providers/facilities is such that it is not possible for the organization 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, is soon retiring, or has moved to a different office location. Evidence could be in the form of letters or e-mails documenting a retirement, documented calls with the provider/facility office, news articles, or descriptions of sources used to validate provider/facility locations. If the form of documentation is a phone call to the provider/facility office, then CMS recommends that organizations include the date of the call, the name of the provider/facility staff contacted, and the corresponding office number. **CMS may validate statements made on the Exception Request.**

There are instances when CMS will consider an organization's reason for not contracting with a provider/facility 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.[16] **CMS may validate statements made on the Exception Request.**

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

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

[16] 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 consider these 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 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 or 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 may validate statements made on the Exception Request**.

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 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 may validate statements made on the Exception Request**.

5.3.3 Expanded Flexibility for Rural Areas

Beginning in CY 2018, CMS will allow organizations to request an exception if they are using a telehealth or a mobile provider to meet network adequacy requirements. **CMS will consider this type of rationale on an Exception Request only for CEAC, Rural, or Micro county types. CMS may validate statements made on the Exception Request.**

- **Telehealth Providers**: Services furnished by a provider must meet current original Medicare telehealth coverage requirements. The organization may contract with an existing telehealth provider or establish its own telehealth provider to furnish eligible services to its enrollees.
- **Mobile Providers**: Mobile providers must be qualified and furnish services in a scheduled manner.

5.4. Pattern of Care Rationales

In rare instances, an organization may provide a rationale for not contracting with available providers/facilities 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 consider this type of rationale on an Exception Request only 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. Narratives should include why this type of exception is necessary.

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 organization’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 pattern of care rationale on an Exception Request**, CMS may use and compare original Medicare claims data and MA encounter data.

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. CMS will generally approve only full counties in a service area, in order to prevent the establishment of boundaries that could undermine the county-wide MA payment system by excluding an area of the county where beneficiaries with expected higher health care utilization might reside. However, the counties do not need to be contiguous, and under limited circumstances described below, CMS may approve the inclusion of partial counties in a service area.

If an organization offering a local MA plan 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. Specifically, the inclusion of a partial county service area must be determined by CMS to be:

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

All three of these factors must be present in order for CMS to approve an exception to the county integrity rule. CMS may also consider the extent to which the proposed service area mirrors the service area of existing commercial health care plans or MA plans offered by the organization.

6.1. Necessary

For CMS to determine that a partial county is necessary, an organization must be able to demonstrate that it cannot establish a provider network to make health care services available and accessible to beneficiaries residing in the portion of the county to be excluded from the service area.

The following examples illustrate how a local MA plan may have a health care network that is limited to one part of a county and cannot be extended to encompass an entire county.

- A section of a county has an insufficient number of providers or insufficient capacity among existing providers to ensure access and availability to covered services. For example, the organization can submit evidence demonstrating insufficient provider supply (e.g., list of non-contracted provider names/locations and valid reasons for not contracting).
- Geographic features (e.g., mountains, water barriers, large national park) or exceptionally large counties create situations where the local pattern of care in the county justifies less than a complete county because covered services are not available and accessible throughout the entire county. For example, the organization can demonstrate the geographic features or characteristics of the county using a clear, current map showing the barriers creating access issues.

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 may validate 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.

6.2. Nondiscriminatory

For CMS to determine if a partial county is nondiscriminatory, an organization must be able to demonstrate the following:

- The anticipated enrollee health care cost in the portion of the county it proposes to serve is comparable to the excluded portion of the county. For example, the organization can demonstrate its anticipated cost of care (in the partial county area) by using data from the previous year of contracting, comparing the health care costs of its enrollees in the excluded area to those in the area of the county it proposes to serve; **and**
- The racial and economic composition of the population in the portion of the county it proposes to serve is comparable to the excluded portion of the county. For example, the organization can use current U.S. Census data to show the demographic make-up of the included portion of the county as compared to the excluded portion.

Note that the existence of other MA plans operating in the entire county may provide evidence that approving a partial county service area would be discriminatory.

6.3. In the Best Interests of the Beneficiaries

In order for CMS to determine whether a partial county is in the best interests of the beneficiaries, an organization must provide reasonable documentation to support its request. Examples of reasonable documentation include reliable and current enrollee satisfaction surveys, grievance and appeal files, utilization information, or other credible rationale.

6.4. Partial County Justification Submission Instructions

Organizations may request an exception to the county integrity rule at 42 CFR 422.2 by completing and submitting a Partial County Justification. Organizations must submit separate justifications for each county in which the partial county is being requested. **CMS may validate 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 Exception Requests.

6.4.1 Partial County Request in the Application Module

Organizations **requesting** partial county service areas for the first time (initial and SAE applicants) and organizations expanding a current partial county by one or more zip codes (when

the resulting service area will continue to be a partial county) must submit their Partial County Justifications with their applications. For the Application Module, organizations shall use the Partial County Justification Template in HPMS and submit the template in accordance with CMS's application instructions defined in HPMS and available on our website. Please note that organizations expanding from a partial county to a full county do NOT need to submit a Partial County Justification.

6.4.2 Partial County Request for the Network Management Module

Organizations with **current** partial county service areas must resubmit their previously approved Partial County Justifications whenever CMS requests a network upload for those service areas in the NMM. This could occur during the triennial review or during any network reviews prompted by triggering events other than the application. Organizations must complete the Partial County Justification Template in Appendix F and submit the completed template to CMS's website portal.

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.

Organizations request to offer a PSP in June with their bid submissions for the upcoming contract year. CMS expects each PSP-specific network to meet current CMS network adequacy requirements. 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 requirements.

CMS expects that organizations use the Organization Initiated upload function in the NMM to ensure their PSP-specific network's compliance with current CMS network adequacy requirements. Several events may trigger the review of the PSP network, including significant provider/facility contract terminations, network access complaints, and organization-disclosed network gaps. Please reference section 1.1.2 for additional information on these triggering events.

8. Regional Preferred Provider Organizations

Regional Preferred Provider Organizations (RPPOs) offer MA regional plans, which are a type of MA coordinated care plan. Unlike other MA coordinated care plans, 42 CFR 422.2 defines the service area of an MA regional plan 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.

Like other organizations, 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 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 or more failures on the ACC reports, the RPPO may submit an Exception Request for CMS's review. Like all network-based organizations, RPPOs can request an exception to network adequacy criteria. However, unlike other organizations, the MA regulation allows RPPOs to request an exception to written agreements (i.e., operate by non-network means) in those portions of the regional service area 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 organizations, 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 pre-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 must 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 of the MMCM, CMS expects that the RPPO-specific 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 should 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 for 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

submission of the Regional Preferred Provider Organization (RPPO) Upload Template provided in Appendix K. RPPOs must submit the completed template to CMS's website portal

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.

Appendix A: Frequently Asked Questions

A-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.

A-2. Specialty Types

Question 6. **Home health, durable medical equipment, transplant programs, and orthotics & prosthetics have been removed from the Reference File. Am I still obligated to contract for the services of these specialty types?**

Answer. Yes, organizations are obligated to provide Medicare-covered home health, durable medical equipment, transplant programs, and orthotics & prosthetics services. However, these specialty do not need to be included in your HSD table. Instead, in the application you will attest that your organization is able to provide adequate beneficiary access to these specialty types.

A-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.

A-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 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 can I find instructions on how to submit HSD tables and access the ACC reports in the NMM?

Answer Organizations can find the Plan User Guide using the following navigation path: **HPMS Home Page>Monitoring>Network Management>Guidance>Plan User Guide.**

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 organizations 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. 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 5. 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 6. 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 7. 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 8. 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 9. 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 10. 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 11. 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 12. If an MAO submits a service area expansion (SAE) application do they need to upload their entire network along with exceptions or just the proposed

service area and exceptions related to the proposed service area for the network review in June associated with the triggering event?

Answer As stated in section 1 an SAE is a triggering event and CMS will review your proposed service area. Your proposed service area is the new service area you are seeking to expand into to. All networks for the proposed service area and any exceptions related to the proposed service area will be reviewed in June during the formal network upload.

A-5. Exceptions

Question 1. Does CMS allow Exceptions at the plan level?

Answer CMS only reviews and grants exceptions for the contract-level network only.

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 0 for more details.

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

Answer Organizations may only request a pattern of care 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 5.4 for more details.

Question 5. What types of evidence is CMS looking for related to pattern of care on an Exception Request?

Answer CMS will consider internal claims data evidence or detailed narrative supporting the organization's pattern of care rationale. 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 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 a provider does not accept Medicaid patients?

Answer CMS will consider an organization's rationale for an Exception if that organization offers a D-SNP whose enrollee population includes individuals eligible for both Medicare and Medicaid, and a provider refuses to accept Medicaid patients. The organization must provide substantial and credible evidence of this on its Exception Request. Please see section 5.3.2 for more details.

Question 12. 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 3.1.3.2 for more details.

A-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. Please see section 6 for more details.

Question 2. Can I submit a Partial County Justification for a respective county and also submit an Exception Request for that same county?

Answer Yes, but not concurrently. As discussed in section 6, an organization may submit a Partial County Justification 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.

Question 3. 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 4. 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 5. 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.

A-7. Provider-Specific Plan

Question 1. What is a Provider Specific Plan?

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. Organizations request to offer a PSP in June with their bid submissions for the upcoming contract year. Please see section 7 for more details.

Question 2. Do I need to submit an application to offer a PSP?

Answer The PSP is a PBP type as opposed to a contract type. Therefore, CMS does not require organizations to submit an application for a PSP. Rather, organizations request to offer a PSP in June with their bid submissions for the upcoming contract year. Please see section 7 for more details.

Question 3. Does my PSP have to meet CMS network adequacy requirements?

Answer Yes. At the time of bid submission, organizations must attest that their PSP meets CMS network adequacy requirements. Please see section 7 for more details.

Question 4. When does CMS review my PSP network?

Answer Several events may trigger the review of the PSP network, including provider/facility contract terminations, network access complaints, and organization-disclosed network gaps. Please reference section 1.1.2 for additional information on these triggering events.

A-8. Regional Preferred Provider Organizations (RPPO)

Question 1. What is an RPPO?

Answer RPPOs are organizations that offer MA regional plans, which are a type of MA coordinated care plan required to serve in its entirety one or more CMS established regions. As coordinated care organizations, 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 requirements 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 requirements, 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 adequacy requirements as other MA coordinated care plans?

Answer Situations may arise where an RPPO cannot establish contracts with providers/facilities to meet network adequacy requirements in portions of its defined regional service area. In such cases, RPPOs may meet network adequacy requirements by demonstrating to CMS's 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. 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.

A-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 **Error! Reference source not found.** 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.

Appendix B: Guidance on Developing Valid Addresses

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

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

EXAMPLE:

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

2. Do not list an intersection as the address.

EXAMPLE:

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

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

EXAMPLE:

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

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

EXAMPLE:

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

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

EXAMPLE:

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

6. Enter a valid Street Name.

EXAMPLE:

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

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

EXAMPLE:

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

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

EXAMPLE:

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

Appendix C: 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

Appendix D: 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
- 057 – Outpatient Infusion/Chemotherapy

Appendix E: Exception Request Template

This template is provided in this document for informational purposes only. Organizations must use the Exception Request Template available in the NMM when requesting an Exception.

<table>
<tr><td colspan="2">MEDICARE ADVANTAGE AND 1876 COST PLAN
EXCEPTION REQUEST TEMPLATE
(File naming convention: Contract ID_County Code_Specialty Code) – 15 characters</td></tr>
<tr><td colspan="2">Part I: Exception Information</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>Contract ID</td><td></td></tr>
<tr><td>County/SSA Code</td><td></td></tr>
<tr><td>County Name</td><td></td></tr>
<tr><td>State</td><td></td></tr>
<tr><td>Specialty Code</td><td></td></tr>
<tr><td>Specialty Name</td><td></td></tr>
<tr><td colspan="2">Part II: Rationale for Exception</td></tr>
<tr><td colspan="2">Please respond to the questions below by selecting either "Yes" or "No" from the drop-down list for each question.</td></tr>
<tr><td>Question 1: Does the organization attest that it has reviewed publicly available databases and other sources to determine availability of providers/facilities with respect to the exception being requested?</td><td></td></tr>
<tr><td>Question 2: If the organization responded “yes” to Question 1, above, did the organization’s review identify providers/facilities within CMS’s network adequacy criteria, and with which the organization has not contracted?</td><td></td></tr>
<tr><td>Question 3: Did the organization contract with providers/facilities who are outside CMS’s current network adequacy criteria?</td><td></td></tr>
</table>

MEDICARE ADVANTAGE AND 1876 COST PLAN EXCEPTION REQUEST TEMPLATE (File naming convention: Contract ID_County Code_Specialty Code) – 15 characters	
Question 4: Are there other non-contracted providers/facilities outside CMS's current network adequacy criteria who are located closer to plan enrollees?	
Part III: Sources	
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 organizations 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 organizations: 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.***	
Source 1	
Source 2	
Source 3	
Source 4	
Source 5	

MEDICARE ADVANTAGE AND 1876 COST PLAN
EXCEPTION REQUEST TEMPLATE
(File naming convention: Contract ID_County Code_Specialty Code) – 15 characters

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.

Part V: Table of Non-Contracted Providers

Please list below any providers/facilities you have identified within or nearby CMS's network adequacy criteria with whom you have not contracted. Each additional provider/facility should be listed on a separate row. For each additional provider, please complete all columns. Please note, the "Provider State" field and "Additional Notes on Reason for Not Contracting" field have drop-down lists. From the "Reason for Not Contracting" drop-down list, you can select one of the following options:
-Provider is no longer practicing (e.g., deceased, retired),
-Provider does not provide services at the office/facility address listed in database,
-Provider does not provide services in the specialty type listed in the database and for which this exception is being requested,
-Provider has opted out of Medicare,
-Provider does not contract with any organization,
-Sanctioned provider on List of Excluded Individuals and Entities,
-Inability to contract with provider (Note to organizations: This is not a valid rationale for submitting an exception),
-In the process of negotiating a contract with provider (Note to organizations: This is not a valid rationale for submitting an exception,
-Provider is at capacity and is not accepting new patients,
-Other (Note to organizations: Please provide an explanation in the "Additional Notes on Reason for Not Contracting" field
If you need to provide additional notes, the "Additional Notes on Reason for Not Contracting" field is a free-text field without any character limits. If you select "Other" from the "Reason for Not Contracting" drop-down list, please elaborate on this reason in the "Additional Notes on Reason for Not Contracting" field.

Provider/ Facility Name	Provider Street Address	Provider City	Provider State (Drop Down)	Provider ZIP Code (5 Digits)	NPI (10 Digits)	Provider Phone Number (10 Digits)	Reason for Not Contracting (Drop Down)	Additional Notes on Reason for Not Contracting

MEDICARE ADVANTAGE AND 1876 COST PLAN EXCEPTION REQUEST TEMPLATE (File naming convention: Contract ID_County Code_Specialty Code) – 15 characters								

Appendix F: Partial County Justification Template

CY 2018 Partial County Justification Template

Instructions: Organizations requesting service areas that include one or more partial counties must upload a completed Partial County Justification into HPMS.

Complete and upload a Partial County Justification for each partial county in your current and proposed service area. This template is appropriate for organizations (1) offering a current partial county, (2) entering into a new partial county, or (3) expanding a current partial county by one or more zip codes when the resulting service area will continue to be a partial county. This template applies for any organization that has a partial county as part of its service area. Organizations must complete and upload a Partial County Justification for any active/existing partial county or pending/expanding partial county.

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

HPMS will automatically assess the contracted provider and facility networks against the current CMS network adequacy criteria. If the ACC report shows that an organization fails the criteria for a given county/specialty, then the organization must submit an Exception Request using the same process available for full-county service areas.

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 service area.

SECTION II: Partial County Requirements

The *Medicare Advantage Network Adequacy Criteria Guidance* provides guidance on partial county requirements. The following questions pertain to those requirements.

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.

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

2. **Non-discriminatory** – You must be able to demonstrate the following:

   - The anticipated enrollee health care cost in the portion of the county you are proposing to serve is comparable to the excluded portion of the county.

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

- 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.

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

3. **In the Best Interests of the Beneficiaries** – The partial county must be in the best interests 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., mountains, water barriers, large national park), and any other geographic factors that affected your service area designation.

Appendix G: Provider HSD Table

This template is provided in this document for informational purposes only. Organizations must use the Provider HSD Table available in the NMM when submitting their contracted networks.

SSA State/ County Code	Name of Physician or Mid-Level Practitioner	National Provider Identifier (NPI) Number	Specialty	Specialty Code	Contract Type	Provider Street Address	Provider City	Provider State	Provider Zip Code	If PCP, Accepts New Patients? (Y or N)	Name of Medical Group Affiliation or "DC"	Uses CMS MA Contract Amendment (Y or N)

Appendix H: Provider HSD Table Definitions

Column Heading	Definition
SSA State/County Code	Enter the SSA State/County code of the county which the listed physician/provider will serve. The state/county code is a five digit number. Please include any leading zeros (e.g., 01010). The state and county codes on the HSD Criteria Reference Table are the codes you should use. Format the cell as "text" to ensure that codes beginning with a "0" appear as five digits.
Name of Physician or Mid-Level Practitioner	Self-explanatory. Up to 150 characters.
National Provider Identifier (NPI) Number	The provider's assigned NPI number must be included in this column. Enter the provider's individual NPI number whether the provider is part of a medical group or not. The NPI is a ten digit numeric field. Include leading zeros.
Specialty	Name of specialty of listed physician/provider. This should be copied directly off of the HSD Criteria Reference Table.
Specialty Code	Specialty codes are unique codes assigned by CMS to process data. Enter the appropriate specialty code (001 – 034)
Contract Type	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. • A "DC" - direct contract provider, requires the applicant to complete Col. L - Medical Group Affiliation with a "DC". • A "DS" - downstream contract is between the first tier entity and other providers (such as individual physicians). • 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. • Medical Group with downstream contracted physicians complete – Col F Contract Type with a "DS", Col L Medical Group Affiliation – Enter Medical Group Name. • Medical Group with employed providers must complete – Col F Contract Type with a "DS", Col L Medical Group Affiliation – Enter Medical Group Name.
Provider Service Address	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.
Provider City	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. .

Column Heading	Definition
Provider State	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.
Provider Zip Code	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.
If PCP Accepts New Patients?	Indicate if provider is accepting new patients by entering a "Y" for "Yes," or "N" for "No."
Medical Group Affiliation	Provide name of affiliated Medical Group/Individual Practice Association (MG/IPA) or if applicant has direct contract with provider enter "DC."
Model Contract Amendment	Indicate if contract uses CMS Model MA Contract Amendment by entering "Y" for "Yes," or "N" for "No."

Appendix I: Facility HSD Table

This template is provided in this document for informational purposes only. Organizations must use the Facility HSD Table available in the NMM when submitting their contracted networks.

SSA State/County Code	Facility or Service Type	Specialty Code	National Provider Identifier (NPI) Number	# of Staffed, Medicare-Certified Beds	Facility Name	Provider Service Street Address	Provider Service City	Provider Service State	Provider Service Zip Code	Uses CMS MA Contract Amendment (Y or N)

Appendix J: Facility HSD Table Definitions

Column Heading	Definition
SSA State/County Code	Enter the SSA State/County code of the county for which the listed facility will serve. The county code should be a five digit number. Please include any leading zeros (e.g., 01010). The state and county codes on the HSD Criteria Reference Table are the codes that applicants should use. Format the cell as "text" to ensure that codes beginning with a "0" appear as five digits.
Facility or Service Type	Name of facility/service type of listed facility. This should be copied directly off of the HSD Criteria Reference Table.
Specialty Code	Specialty codes are unique 3 digit numeric codes assigned by CMS to process data. Enter the Specialty Code that best describes the services offered by each facility or service. Include leading zeros.
National Provider Identifier (NPI) Number	Enter the provider's assigned NPI number in this column. The NPI is a ten digit numeric field. Include leading zeros.
Number of Staffed, Medicare-Certified Beds	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).
Facility Name	Enter the name of the facility. Field Length is 150 characters.
Provider Service Street Address	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.
Provider Service City	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.
Provider Service State	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.
Provider Service Zip Code	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. For Home Health and Durable Medical Equipment, indicate the business address where one can contact these vendors.

Column Heading	Definition
Model Contract Amendment	Indicate if contract uses CMS Model MA Contract Amendment by entering "Y" for "Yes," or "N" for No.

Appendix K: Regional Preferred Provider Organization (RPPO) Upload Template

The purpose of this upload template is to identify those specialty types for which an RPPO intends to meet CMS's network access requirements through arrangements other than written agreements with providers or facilities pursuant to 42 CFR 422.112(a)(1)(ii). RPPOs shall complete the table below for all specialty types (for each county) in which network access requirements will be met using alternatives to written agreements. RPPOs should add rows to the table, as necessary.

Column Explanations

- **County –** Enter the name of the county that the RPPO will serve.
- **State –** Enter the county's corresponding state that the RPPO will serve.
- **SSA State/County Code –** Enter the SSA state/county code of the county which the listed provider/facility 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 File are the codes you should use. Format the cell as "text" to ensure that codes beginning with a "0" appear as five digits.
- **Specialty –** Enter the name of the specialty of the listed provider/facility. This should be copied directly off of the HSD Criteria Reference Table.
- **Specialty Code –** Enter the appropriate specialty code that corresponds to the specialty in the HSD Criteria Reference File. Specialty codes are unique codes assigned by CMS to process data.

County	State	SSA State/County Code	Specialty	Specialty Code