Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

CENTER FOR DRUG AND HEALTH PLAN CHOICE

MEMORANDUM

DATE: February 24, 2009

TO: Current and Future Medicare Advantage Organizations

FROM: Louis Polise **/s/**
Acting Director, Medicare Drug and Health Plan Contract Administration Group

SUBJECT: Clarification of Application Guidance

This document is a follow-up to the guidance provided during the two Medicare Advantage (MA) application training teleconferences held on January 7, 2009 and January 14, 2009. It includes responses to frequently asked questions and discusses the Centers for Medicare & Medicaid Services (CMS) updated changes to the HSD-1 Table. Please carefully review this information, which is crucial to your ability to efficiently and accurately complete and submit 2010 application materials.

1. Application Updates

- The 2010 Part C MA application module on the Health Plan Management System (HPMS) website and the online application located at www.cms.hhs.gov has been updated as follows:

  - Initial Application: Section 1.10, Contracts for Administrative & Management Services, "Applicants will have a delegated **accredited** entity that will perform all or a portion of the credentialing functions." The word “accredited” has now been removed.

  - Service Area Expansion (SAE) Application: Section 1.4, Contracts for Administrative & Management Services, "Applicants will have a delegated **accredited** entity that will perform credentialing functions." The word “accredited” has now been removed.

  - Under the Key Management section the word “Contract” has been changed to “Contact”.

2. Documentation of State Licensure

Q: Please clarify what forms/documents are required to be submitted to demonstrate appropriate State Licensure.

A: State License and State Certificate of Authority are the only documents that will satisfy this requirement. The document **must** clearly indicate, on its face or in the text of an accompanying dated issuance letter from the State Department of Insurance or other State Authority issuing the license, that the applicant risk-bearing entity's proposed Medicare Advantage product(s)/offering(s) are within the scope of its licensure or certificate of authority, and can be offered to enrollees residing anywhere in the State or specifies the counties in the State where it can be offered. This is in accordance with 42 CFR 422.400(c), which states that the applicant must "demonstrate to CMS that the scope of its license or authority allows the organization to offer the type of MA plan or plans that it intends to offer in the State and, if applicable, has obtained the State certification required under paragraph (b) of this section." If the State License or State Certificate of Authority (in the case of HMOs so licensed) lacks this specific information, the applicant must submit both the license/certificate of authority document and a completed CMS State Certification Form.

3. Downstream vs. Direct Contracts

Q: On HSD-2, please clarify the definitions of "direct" and "downstream" contract types requested in HSD-2 and how these should be identified. Are all physicians who contract under one medical group contract and bill under the same tax identification number considered to be "direct" or "downstream" by CMS?

A: Downstream providers are those who contract with the applicant's contracted groups or entities other than through employee contracts. We will consider physicians contracting with the applicant through a medical group to be employees of the medical group and not "downstream" contractors, if the medical group legal structure justifies such an assumption.

Applicants should indicate on HSD-2 whether a provider is direct, downstream or employee using the following notations:

D – Direct Contract
W – Downstream Contract
E – Employee

Please see item 5 below for instructions on how to complete corresponding information to be entered into Columns E and F on HSD-1.

4. Letters of Agreement versus Letters of Intent

Q. Will CMS accept letters of agreement to demonstrate a relationship with a provider/supplier or other subcontracted entity?

A. CMS will accept Letters of Agreement that contain all of the required contract language and are properly executed by all parties. CMS will NOT accept Letters of Intent.

5. Guidance on Completing HSD-1

Column Explanations:

- **Column A – County Served (state/county code):** Include the five-digit state and county code. You must include leading zeros (i.e., 01010). These codes are listed at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=descending&itemID=CMS1209528&intNumPerPage=10. Click on the link to the MA 2009 Ratebook, then open the file countyrate2009.csv. The state/county codes are listed in column 1. You must add a leading zero to any of the 4 digit codes. Do NOT add the textual names of the counties to the HSD-1 table.
- **Column B – Specialty Code:** Each specialty/provider is pre-populated with a unique assigned specialty code. Do not change these codes.

  NOTE: If you wish to add other specialties that are not already listed, please add these in the rows following "Pancreas Transplant Facilities" and assign each specialty with the specialty code of "000." Failure to add the "000" to these entries will result in your receipt of an error code upon submission of the table. Please do not change the order of the provider specialty categories or codes as listed on HSD-1.

  NOTE: For radiologists, chiropractors and podiatrists, list only those providers who are contracted directly with the Medicare Advantage Organization (MAO) or downstream entity.
- **Column D – Available Medicare Participating Providers in County:** List the number of Medicare participating providers located in the county. This information is available on Medicare.gov. Applicants that wish to use other sources must identify the data source in their submitted narrative and justify the credibility of the information. CMS will assess both source and the validity of the data as part of its review of the proposed network and the degree to which it assures enrollees access and availability.
- **Columns E & F – Medicare Provider Breakdown:** List the number of contracted specialists/providers by type of contract, either direct or downstream (e.g., if the applicant has contracts with 21 total cardiologists with 10 directly contracted and 11 under downstream arrangements, applicant should put a "10" in Column E and an "11" in Column F). For purposes of completing Table HSD-1, applicants should include in the downstream category those specialists/providers who are employees of subcontractors.

- **Column G – Total Number of Providers:** Enter the total number of network providers per specialty (Column E plus Column F). DO NOT leave blanks – enter a zero ("0") if the answer is none. A provider should be listed only ONCE on this chart.
- **Column H – Total # of PCPs Accepting New Patients:** For providers who may serve as Primary Care Providers (PCPs), indicate the total number of providers who are accepting new patients from this organization's MA enrollees. Do not leave blank – enter "0" if the answer is none. For providers who may not serve as PCPs, please enter NA.
- **Column I – Total # of PCPs Accepting Only Established Patients:** For providers who may serve as PCPs, indicate the total number of providers who are not accepting new patients from this organization's MA enrollees. (Column H plus Column I should equal the total in Column G). Do not leave blank – enter "0" if the answer is zero. For providers who may not serve as PCPs, please enter NA.
- **Column J – Other Counties Served:** You may leave this column blank or, if you wish, you may add the name of the applicable county which corresponds to the state/county code included in Column A.
- **Column K – End of Year Projected Enrollment –** Please enter the end of year projected enrollment for each county. You do not need to repeat the enrollment in each row for all provider types in the county.

  NOTE: The end of year enrollment projection is one of many data points CMS weighs in assessing network adequacy and will not be a principal factor in supporting network approval.

- HSD-1 Technical Instructions

  1. You must use Excel or Access to create HSD-1. (If you do NOT have Office 2007 AND are requesting a **very** large number of counties, you may need to use Access, as pre-2007 versions of Excel will not be able to accommodate a very large number of rows (greater than 65,000) on HSD-1.)
  2. For **each** county in your proposed service area, copy rows 3 – 46 and paste them below, beginning in row 47. Fill in the requested information for each row for each requested county. DO NOT create numerous tabs. Include all counties on one sheet. For example, if you are requesting a service area with 3 counties – A, B and C; copy rows 3-46 and paste the copy in rows 47-90, and again in rows 91-134. For rows 3-46, fill in the requested information regarding the listed provider types for County A. In rows 47-90, fill in the requested information regarding the listed provider types for County B. In rows 91-134, fill in the requested information regarding the listed provider types for County C.
  3. After you have completed HSD-1 (in Excel or Access), you **MUST SAVE THE FILE AS A TAB DELIMITED .txt FILE and name it according to the appropriate naming convention described in the MA readme file.**
  4. Upon upload, you must zip the .txt HSD-1 file and name the zip file according to instructions found in the MA readme file.

6. Completing HSD-1 and HSD-2 for Providers with Multiple Specialties and/or Serving Multiple Counties

Q: How should an applicant communicate to CMS the fact that certain contracted physicians will be available to provide specialty services to Medicare enrollees in two or more specialties or across two or more counties?

A: Physicians who will be listed under multiple specialties/counties in the Organization's Medicare Provider Directory and are credentialed for such specialties in accordance with the organization's credentialing and medical management policies should still be counted only once on HSD-1 and listed once on HSD-2, under the specialty which he or she practices the most with regard to his or her existing Medicare patient panel.

The fact that these physicians practice in multiple counties or in multiple specialties can be cited in the applicant's narrative statement where there is a concern about the number, specialty type, geographic distribution and/or related issues in a given county/service area.