INSTRUCTIONS FOR COMPLETING CMS HSD TABLES

Note: Detailed Technical instructions will be outline in the HPMS user guide.

General Instructions for CMS HSD Tables

> *(These tables should be completed by contracted-network MA applicants and are not required for non-network Private Fee For Service PFFS.)*

Applicants will demonstrate network adequacy through an automated review process and revised Health Service Delivery (HSD) Tables. The revised tables and instructions for each HSD table are below. The tables should reflect the applicants' fully executed contracted network providers and facilities that are in place on the date of submission. For CMS purposes, contracts are considered fully executed when both parties have signed.

As part of the application module in the Health Plan Management System (HPMS), CMS will provide applicants with an automated tool for submitting network information via HSD tables prior to the initial application submission deadline. As part of this new process, applicants will have an opportunity to submit HSD tables for automated review, as part of a pre-assessment screening process. During this process, HSD tables will be reviewed automatically against default adequacy measures for each required provider and facility type in each county. Applicants can then use feedback received during the pre-assessment screening to revise HSD tables and formally submit them by the initial submission date. This new process will permit applicants to determine if they have achieved network adequacy prior to submitting their applications. A positive result from the pre-assessment screening process that CMS makes available to applicants does not mean, nor is it meant to imply, that the applicant's application has, or will, be approved.

While the automated pre-assessment process will provide applicants with a better understanding of potential deficiencies prior to the official application review, it is not a substitute for the intensive review conducted by CMS Reviewers that may identify additional deficiencies that require clarification from the applicant.

CMS will make required minimum values known to applicants prior to the opening of the application module and pre-assessment criteria assessment so that applicants can gain a better understanding of the required values (i.e., providers and facilities required for each county, in addition to time and distance standards). This data will help applicants build their networks and contract with providers accordingly. Given the addition of time and distance values, CMS will allow applicants to include providers from surrounding counties as part of a county's proposed network of providers. Thus, county boundaries no longer apply. This will help to address areas where beneficiaries may travel across county lines to seek care.

Network adequacy assessments for Special Needs Plans will continue to be handled on a manual basis as in previous years.

Applicants who have not been able to meet the adequacy requirements and believe that they have a valid reason for not meeting them may seek an Exception at the time of the initial application submission only. In such instances, the applicant will submit required documentation to support the Exception request, as defined by CMS. The HSD tables must still be submitted for assessment, but an additional review of the Exception request will be performed by a CMS reviewer. Exception requests must follow the pre-defined Exception types as defined by CMS. The requesting of an Exception does not guarantee that the request will be approved by CMS which will indicate that the applicant must continue to further develop its network for that particular provider or facility type.

Applicants that submit final HSD tables that meet CMS's adequacy requirements will still be required to submit signed contracts and other documents that demonstrate the accuracy of the HSD table submissions.

CMS will provide training to applicants on the new automated system including the pre-assessment process, exceptions process, the new HSD tables, and the network adequacy requirements (criteria) before the application module opens. CMS expects to annually post the criteria for determining network adequacy in November of each year, prior to the last date for submitting the Notice of Intent to Apply.

Table: HSD-1 – Summary Arrangements with Providers and Specialist

Guidelines:

1. Applicant must indicate the total number of providers for each SSA State/county code in their pending service area. Physicians and specialists should be counted only once per county on this table even if the provider has more than one location in a county.

2. If the applicant uses a sub-network or has multiple delivery systems within the county/service area, the applicant must complete a separate HSD-1 table for each delivery system. Each HSD-1 table should be representative of the aggregate numbers of providers for the delivery system being described.

3. All applicants must include a numeric entry for each provider type. If the number of providers is zero, please enter a zero. Every county in the applicant plan's proposed service area must include an entry for every provider type.

Column Explanations:

A. **SSA State/County Code –**Enter the SSA County code of the county for which the contract network is being submitted on the "SSA State/ County Code" column. The state county code should be a five digit number. Please include the leading zeros (e.g.,01010)

B. **Specialty Type – Self explanatory**

   Note: If there are other specialties that are not listed, list the additional add these specialties to the bottom of the list (below Vascular Surgery") and enter a specialty code of "000" (three zeros).

   Note: Hematology/Oncology should be classified as oncology, medical specialty.

C. **Specialty Code –** Specialty codes are unique codes assigned by CMS to process data.

D. **Medicare Provider Breakdown –** The number of contracted providers by type of contract (direct arrangement or downstream arrangement).

E. **Total # of Providers-** Do not leave blanks- enter zero if the answer is zero.

F. **Total # of PCPs Accepting New Patients –** Do not leave blank. Enter a zero if the answer is zero.

G. **Total # of PCPs Accepting Established Patients Only –** Do not leave blank. Enter a zero if the answer is zero.

Table: HSD-2: Provider of Physicians and Other Practitioners by County

Instructions:

1. If a provider serves in multiple counties, list the provider multiple times with the appropriate state/county to account for each county.

2. All providers that comprise the total counts on HSD-1 must be listed on HSD-2. Providers that have opted out of Medicare must not be included in the applicant's contracted network and on HSD-2.

3. Add additional rows to account for all providers.

Column Explanations:

A. **SSA State/County Code** –Enter the SSA County code of the county for which the contract network is being submitted on the "SSA State/ County Code" column. The state county code should be a five digit number. Please include the leading zeros (e.g.,01010)

B. **Name of Physician or Mid-Level Practitioner –** Self-explanatory.

C. **National Provider Identifier (NPI) Number –** The provider's assigned NPI number must be included in this column. If provider is a part of a Medical group use the provider individual NPI.

D. **Specialty –** Self-explanatory.

E. **Specialty Code –** Specialty codes are unique codes assigned by CMS to process data. Enter the appropriate specialty code. The specialty codes must match the list of codes reported on HSD-1.

F. **Contract Type –** Indicate type of contract with provider. Enter "DC" for direct contract and **a** "DS" for downstream contract.

G-K.
Provider Service Address Columns- Enter the address (i.e., street, city, state, zip code, and county) where the provider serves patients. If a provider has more than one office within a county, list all addresses. P.O. Box addresses, street intersections, and mailing addresses are not acceptable office location addresses.

Note: If a provider has more than one office or suite in one building, only list one of the addresses.

L. **Provider Previously Listed? –** Enter "Y" if the same provider is previously listed in the rows above. Enter "N" if a provider is not previously listed in the rows above.

M. **Contracted Hospital Where Privileged –** Identify the contracted hospital in the service area where the provider has admitting privileges, other than courtesy privileges. If the provider does not have admitting privileges, please leave cell blank. If the provider has admitting privileges at more than one contracted hospital, please insert additional rows as needed and copy all corresponding data in each line for all other contracted hospitals where the provider has admitting privileges. *Note:* The spelling of the contracted hospital(s) must be exactly the same as the spelling of the contracted hospital listed on HSD-3 Detail.

N. **Hospital NPI Number –** Enter the NPI number for the contracted hospital listed where the provider has admitting privileges.

O. **If PCP, Accepts New Patients? –** Indicate if provider accepts new patients by entering a "Y" or "N" response.

P. **If PCP, Accepts Only Established Patients? –** Indicate if provider accepts only established patients by entering a "Y" or "N" response. If "N" was entered in column 11, please leave cell blank.

Q. **Does MCO Delegate Credentialing? –** Enter "Y" if the applicant delegates the credentialing of the physician. Enter "N" if the applicant does not delegate credentialing of the physician. If credentialing is not required, please leave cell blank.

R. **If Credentialing is Delegated, List Entity –** If credentialing is not performed by the applicant, enter the name of the entity that performs the credentialing. The name entered should match one of the entities listed on the "Entity Listing in Preparation for Monitoring Review" document that was previously provided to the RO.

S. **Medical Group Affiliation –** For each provider reflected on the table indicate the name of the medical group/IPA affiliation for that provider. If the applicant has a direct contract with the provider, but is not affiliated with a medical group/IPA, then enter "DC."

- **Notes: Leave this column** b**l**ank if the provider is not affiliated with a medical group/IPA or has a direct contract with applicant (i.e. Hospital employee)
  .

Names MUST be entered exactly the same way each time, including spelling, abbreviations, etc. in order for the automated criteria process to work correctly. Any variances will result in incorrect summaries of data and other errors.

T. **Employment Status –** Indicate whether the provider is an employee of a medical group/IPA or whether a downstream contract is in place. Insert “E” if the provider is an employee. Insert “DS” if a downstream contract is in place for the provider.

Table HSD-2a: PCP/Specialist Contract Signature Page Index

The purpose of this index is to map contracted PCPs and specialty physicians listed in HSD-2 the template contract used to execute the relationship between the applicant and the provider. For SAE MA applicants, the grid will also document whether any of the applicant's current providers will be part of the network available in the expansion area.

Column Explanations:

A. **PCP/Specialist –** Enter the contract name as indicated in HSD-2 for all PCPs and specialist contracts.

B. **Contract Template –** Indicate the specific contract template executed between the applicant and the physician reflected in the PCP/Specialist column.

C. **Existing Network for SAE applicants**– Indicate whether the provider was previously established as a network provider in the applicants existing service area.

Table HSD-3 SUMMARY: Arrangements for Care with Facilities & Services

Instructions:

1. Facilities such as hospitals and clinics that provide more than one service listed on HSD-3 Detail, should be counted once on HSD-3 Summary for each service provided by the facility.

Column Explanations:

1. **SSA State/County Code –**Enter the SSA County code of the county for which the contract network is being submitted on the "SSA State/ County Code" column. The state county code should be a five digit number. Please include the leading zeros (e.g.,01010)

2. **Facility or Service Type –** Provides a list of the services provided by facilities within the applicant plan's network.

G. **Specialty Code –** Specialty codes are unique codes assigned by CMS to process data. Enter the appropriate specialty code.

3. **Total Number of Providers/Services –** Enter the summary number of facilities/providers offering the services to the applicant plan's members.

4. **Number of Staffed, Medicare-Certified Beds –** For the facility types indicated on the table (i.e., Acute Inpatient Hospitals, ICUs, Skilled Nursing Facilities, Inpatient Psychiatric, and Inpatient Substance Abuse) enter the number of Medicare-certified beds for which the plan has contracted to provide access to the plan's members. This number should not include Neo-natal Intensive Care Unit (NICU) beds.

Table HSD-3 DETAIL: List of Facilities & Services

Instructions:

1. Only list the providers who provide the Medicare required services. Please do not list any additional providers or services.

2. All providers that comprise the total counts on HSD-3 Summary must be listed on HSD-3 Detail.

3. If a provider serves in multiple counties the provider should be listed multiple times with the appropriated state/county code to account for each county.

Column Explanations:

A. SSA State/County Code –Enter the SSA County code of the county for which the contract network is being submitted on the "SSA State/ County Code" column. The state county code should be a five digit number. Please include the leading zeros (e.g.,01010)

B.

C. Facility or Service Type – Provides a list of the services provided by facilities within the applicant plan's network.

D. Specialty Code – Enter the Specialty Code that best describes the services offered by each facility or service. The Specialty Code must match one of the Specialty Codes from the list on HSD-3 Summary.

E. Medicare (CMS) Certification Number (CCN) – Enter the facility's Medicare Certification Number in this column.

F. National Provider Identifier (NPI) Number – The provider's assigned NPI number must be included in this column.

G. Number of Staffed, Medicare-Certified Beds – For Acute Inpatient Hospitals, ICUs, Skilled Nursing Facilities, Inpatient Psychiatric, and Inpatient Substance Abuse enter the number of Medicare-certified beds for which the plan has contracted access for the plan's members. This number should not include Neo-natal Intensive Care Unit (NICU) beds.

H. Provider Name – Enter the name of the facility or service provider.

I. Provider Service Address Specify the address (i.e., street, city, state, zip code, and county) where services are provided. P.O. Boxes and street intersections are not appropriate service location addresses. For DME and Home Health, indicate the business address for contacting these vendors.

Table HSD-3a: Ancillary/Hospital Contract Signature Page Index

The purpose of this index is to map contracted ancillary or hospital providers listed in HSD3 to the template contract used to execute the official relationship between the applicant and the provider. The grid will also document whether any of the applicant's current providers will be part of the network available in the expansion area.

Column Explanations:

A. **Ancillary/Hospital HSD3 –** Enter the contract name as indicated in HSD3 Detail for all ancillary and hospital contracts.

B. **Contract Template –** Indicate the template contract executed between the provider and the applicant.

C. **Existing Network –** Indicate whether the provider was previously established as a network provider in the applicant's existing service area. (Not applicable for new MA applicants)

G. Table HSD-4: Arrangements for Additional and Supplemental Benefits

Instructions:

If there are other services that are not listed, add columns to the right of the "Screening-Vision" column to cover these services.

Only list the providers who provide the additional and supplemental benefit services as listed in the "services" columns (columns 7-12). Note: if other services are added to the right of the "Screening-Vision" column (column 12), those providers should also be listed.

If any providers listed on HSD-2 provide the services reviewed on HSD-4, list them as follows:

If all of the providers listed on HSD-2 provide one or more of the services listed in columns 7-12, enter "all providers listed on HSD-2" in the "Name of Provider" column; leave columns 2-6 blank; and place an "X" in column(s) that represent the services provided by all of the providers listed on HSD-2.

If all providers of a certain specialty listed on HSD-2 provide one or more of the services listed in columns 7-12, enter "all providers listed on HSD-2 with specialty (enter specialty) " in the "Name of Provider" column; leave columns 2-6 blank; and place an "X" in column(s) that represent the services provided by the providers of a certain specialty as listed on HSD-2.

If all providers listed on HSD-2 will serve as "PCPs" and provide one or more of the services listed in columns 7-12, enter "all providers listed on HSD-2 who may serve as a PCP " in the "Name of Provider" column; leave columns 2-6 blank; and place an "X" in column(s) that represent the services provided by the providers that may serve as PCPs as listed on HSD-2.

Please list all direct and downstream providers of services.

Arrange benefits alphabetically by county and then numerically by zip code.

Column Explanations:

A. **Name of Provider –** Enter name of the contracted provider, for example – Comfort Dental Group(Dental); Comfort Eyewear Associates (Eyeglasses/Contacts); Comfort Hearing Aids Associates (Hearing Aids); XYZ Pharmacy (Prescription Drugs – outpatient); Comfort Hearing, Inc. (Screening-Hearing); Comfort Vision Specialists (Screening – Vision).

B. **Location –** Enter street address/city/state/zip code, for example – 123 Main Street, Baltimore, MD 11111

C. **County Served by Provider –** List one county the provider serves from this location. (If more than one county is served, repeat information as entered in columns 1-5 and columns 7-12, changing column 6 as applicable.) Examples: Canyon County, Peaks County.

D. **Services (columns 7 though 12) –** Mark an "X" in the box if the provider provides this service. For the providers that are listed in Column 1, please indicate which services this provider provides.

H. Table HSD-5: Signature Authority Grid

The purpose of this grid is to evidence whether physicians of a provider group are employees of the medical practice. The grid will display the medical group, the person authorized to sign contracts on behalf of the group and the roster of employed physicians of that group.

Column Explanations:

A. **Practice Name –** The name of the provider group for which a single signature authority exists on behalf of the group.

B. **Signature Authority –** The representative of the medical practice with authority to execute arrangements on behalf of the group

C. **Physicians –** Reflect all of the physicians in HSD2 for which the signature authority is applicable

I. Requesting Exceptions

Prior to the initial application submission, the applicant plan will have the opportunity to run a pre-submission test of HSD-1, -2, -3 Summary, and -3 Detail tables. This test will identify where the plan may not meet the minimum number of required providers and time and distance standards for each specialty. The applicant plan will then have the opportunity to continue to contract with additional providers and retry the pre-submission criteria assessment.

If the applicant plan still receives deficiency indications from the pre-submission assessment, the plan can continue to contract with providers or submit the HSD tables for consideration as part of the initial application submission and request an Exception. However, even if the plan requests an Exception review, the HSD tables must be submitted to the system for assessment.

If an applicant plan is unable to meet minimum requirements or time and distance requirements, it may request an Exception under these limited circumstances inc

- Insufficient number of providers/beds in service area
- No providers/facilities that meet the specific time and distance standards in service area
- Patterns of care in the service area do not support need for the requested number of and/or provider/facility type
- Services can be provided by an alternate provider type/Medicare-certified facility

The applicant plan will be able to select the reason for the Exception request from a pre-defined drop-down list of options. Once selected, the HPMS system will inform the applicant plan what types of documentation must be submitted for reviewer consideration.