

HSD Instructions for CY 2017 Applications

This document contains information needed to complete the HSD tables required for the online application process (you will not need to complete HSD tables if you are applying for an employer-only SAE). It also contains frequently asked questions (FAQ) regarding HSD submission and processing, guidance on developing valid addresses and field edits for the MA Provider and MA Facility tables. Please note that this document may be revised. Applicants should download the latest version directly from HPMS in the Submit Application Data section of Basic Contract Management. The document is part of the zipped file called MA Download Templates.

Contents

Specialty Codes for the MA Provider Table.....	2
Description of MAProvider Types	3
Specialty Codes for the MA Facility Table	4
Description of MA Facility Types	5
HSD Table Instructions.....	7
MA Provider Table	7
MA Facility Table.....	10
HSD Exceptions Guidance - Requesting Exceptions	12
Appendix A - CY 2017 HSD Submission Frequently Asked Questions.....	13
Appendix B - Guidance on Developing Valid Addresses	22
Appendix C – Field Edits for the MA Provider and Facility Tables	24

SPECIALTY CODES

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

Specialty Codes for the MA Provider Table

- 001 – General Practice
- 002 – Family Practice
- 003 – Internal Medicine
- 004 – Geriatrics
- 005 – Primary Care – Physician Assistants
- 006 – Primary Care – Nurse Practitioners
- 007 – Allergy and Immunology
- 008 – Cardiology
- 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
- 000 – OTHER (Please list the providers actual specialty when including code “000” on the Provider Table).

Description of MA Provider Types

The following section contains information related to MA Provider specialty types in order to assist the applicant with the accurate submission of the MA Provider HSD Table.

MA Provider Table – Select Provider Specialty Types

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

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

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

Primary Care – Physician Assistants (005)- 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 duly certified as a provider of primary care services. In addition, the individuals listed under this specialty code must function as the primary care source for the beneficiary/member, not supplement a physician primary care provider’s care, in accordance with state law and be practicing in or rendering services to enrollees residing in a state and/or federally designated physician manpower shortage area.

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

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

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

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

Specialty Codes for the MA Facility Table

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

- 065 - Liver Transplant Program
- 066 - Lung Transplant Program
- 067 - Pancreas Transplant Program

Description of MA Facility Types

The following section contains information related to MA Facility specialty types in order to assist the applicant with the accurate submission of the MA Facility HSD Table.

MA Facility Table – Select Facility Specialty Types

Contracted facilities/beds must be Medicare-certified.

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

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

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

Home Health (055) – Applicants must list at least one Medicare certified home health agency (HHA) serving each specific county included in the application. While the administration office address for the HHA may be outside of the service area, by listing the HHA on the HSD table,

the applicant is attesting that the provider serves beneficiaries residing throughout that county. Each Medicare certified HHA is licensed for defined service areas and may only serve a portion of a given county; additionally, HHAs vary significantly in the types of home health services provided. Thus, an applicant may be required to contract with more than one HHA in order to ensure adequate coverage of HHA services across the entire county. CMS provides a listing of certified home health facilities at <https://data.medicare.gov/data/home-health-compare> and notes whether each facility provides Nursing Care Services, Physical Therapy Services, Occupational Therapy Services, Speech Pathology Services, Medical Social Services, and Home Health Aide Services.

Durable Medical Equipment (056) – Applicants must list at least one durable medical equipment provider. While the administration office address for the DME provider may be outside of the service area, by listing the DME provider on the HSD table, the applicant is attesting that the provider serves beneficiaries residing throughout that county. A submission under this specialty type can be limited to one provider, so long as that provider covers the full range of Medicare covered durable medical equipment services. Applicants’ submissions for this specialty must provide durable medical equipment services throughout the entire area of the county. MA plans are expected to cover the full range of medically necessary DME supplies that beneficiaries might require. A non-exhaustive list of such supplies can be found at <http://www.medicare.gov/coverage/durable-medical-equipment-coverage.html>.

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

Transplant Programs (061, 062, 064, 065, 066, 067) – Applicants must list at least one contracted program for each of the six transplant program types: Heart, Heart/Lung, Kidney, Liver, Lung and Pancreas.

HSD Table Instructions

The tables should reflect the applicants' **executed contracted** network on the date of submission. CMS considers a contract fully executed when both parties have signed. Applicants should only list providers with whom they have a fully executed updated contract. These contracts should be executed on or prior to application submission deadline. In order for the automated network review tool to appropriately process this information, applicants must submit Provider and Facility names and addresses exactly the same way each time they are entered, including spelling, abbreviations, etc. Any errors will result in problems with processing of submitted data and may result in findings of network deficiencies. CMS expects all applicants to fully utilize the opportunities for pre-checks and to fully review the Automated Criteria Check (ACC) reports to ensure that their HSD tables are accurate and complete.

MA Provider Table

This table captures information on the specific physicians/providers in the applicant's contracted network. If a provider serves beneficiaries residing in multiple counties in the service area, list the provider multiple times with the appropriate state/county code to account for each county served. **Do NOT list contracted providers in state/county codes where the Medicare beneficiary could not reasonably access services and that are outside the pattern of care.** Such extraneous listing of providers affects CMS' ability to quickly and efficiently assess provider networks against network criteria. You must ensure that the MA Provider Table meets the following conditions:

- Providers must not have opted out of Medicare;
- Physicians and specialists must not be pediatric providers, as they do not routinely provide services to the aged Medicare population;
- Psychiatry/Rehabilitation Medicine must only be provided by a licensed physician; Physical Therapists are not qualified to provide the full range of Psychiatry services;
- Psychiatrists must only be licensed physicians and no other type of practitioner;
- Physician Assistant and Nurse Practitioner services are limited to primary care, as they are not able to provide the full range of services independently as a licensed physician.

You are responsible for ensuring contracted providers (physicians and other health care practitioners) meet State and Federal licensing requirements and your credentialing requirements for the specialty type prior to including them on the MA Provider Table.

Verification of credentialing documentation may be requested at any time. Including physicians or other health care practitioners that are not qualified to provide the full range of specialty services listed in the MA Provider Table will result in inaccurate ACC measurements that may result in your application being denied.

Column Explanations

- A. 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.
- B. Name of Physician or Mid-Level Practitioner** – Self-explanatory. Up to 150 characters.
- C. 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.
- D. Specialty** – Name of specialty of listed physician/provider. This should be copied directly off of the HSD Criteria Reference Table. When using specialty code “000” on the Provider Table, list the provider’s ACTUAL specialty in column D; do not list “other.”
- E. Specialty Code** – Specialty codes are unique codes assigned by CMS to process data. Enter the appropriate specialty code (001 – 034). Use Specialty Code “000” on the Provider Table only when requesting an exception.
- F. 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 Columns- Enter the address (i.e., street, city, state and zip code) of the location at which the provider sees patients. **Do not list P.O. Box, house, apartment, building or suite numbers, or street intersections.**

- G. Provider Service Address: Street Address** – up to 250 characters
- H. Provider Service Address: City** – up to 150 characters
- I. Provider Service Address: State** – 2 characters
- J. Provider Service Address: Zip Code** – up to 10 characters
- K. If PCP Accepts New Patients?** – Indicate if provider is accepting new patients by entering a "Y" or "N" response.
- L. Medical Group Affiliation** – Provide name of affiliated Medical Group/Individual Practice Association (MG/IPA) or if applicant has direct contract with provider enter "DC".
- M. Model Contract Amendment** – Indicate if contract uses CMS Model MA Contract Amendment by entering "Y" for yes or "N" for no.

MA Facility Table

Only list the providers that are contracted Medicare-certified providers. Please do not list any additional providers or services except those included in the list of facility specialty codes. Additionally, **do NOT list contracted facilities in state/county codes where the Medicare beneficiary could not reasonably access services and that are outside the pattern of care.** Such extraneous listing of providers affects CMS' ability to quickly and efficiently assess provider networks against network criteria.

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

Column Explanations:

- A. **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.
- B. **Facility or Service Type** – Name of facility/service type of listed facility. This should be copied directly off of the HSD Criteria Reference Table.
- C. **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.
- D. **CMS Certification Number (CCN)** – Enter the facility's CMS Certification Number in this column. The CCN verifies the facility is Medicare certified and for what type of service. The CCN for facilities have 6 digits. The first 2 digits identify the State in which the provider is located. The last 4 digits identify the type of facility. You must obtain the CCN from the provider. The following facilities must have a valid CCN to be listed in the MA Facility Table: 040- Acute Inpatient Hospitals, 044 Outpatient Dialysis, 046-Skilled Nursing Facilities, 052-Inpatient Psychiatric Facility Services, 055-Home Health, 061 – Heart Transplant Program, 062 - Heart/Lung Transplant Program, 064 - Kidney Transplant Program, 065 - Liver Transplant Program, 066 - Lung Transplant Program, and 067 - Pancreas Transplant Program. Do not place the facility's NPI number in this column. The NPI number is the primary identifier for Medicare claims and does not represent Medicare certification. Refer to CMS Manual Publication 100-07 State Operations Provider Certification Section 2779.
- E. **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.

F. **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).

G. **Facility Name** – Enter the name of the facility. Field Length is 150 characters.

Provider Service Address Columns- 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.

H. **Provider Service Address: Street Address** – up to 250 characters

I. **Provider Service Address: City** – up to 150 characters

J. **Provider Service Address: State** – 2 characters

K. **Provider Service Address: Zip Code** – up to 10 characters

L. **Model Contract Amendment** – Indicate if contract uses CMS Model MA Contract Amendment by entering “Y” for yes or “N” for no.

HSD Exceptions Guidance - Requesting Exceptions

If an applicant's HSD Automated Criteria Check report indicates the submitted network does not meet the minimum provider/bed number, time and/or distance requirements for any individual provider/facility type in a particular county, the Applicant may request an Exception for that deficiency under the following circumstances:

- * Other Factors in accordance with 42 CFR 422.112 a(10)(v) that CMS determines are relevant in setting a standard for an acceptable health care delivery network in a particular service area.
- * (Limited to RPPPO applicants) – The RPPPO applicant is relying on Alternative Arrangements to meet access requirements for this provider/facility type in this county. The RPPPO applicant should contact CMS by sending an email to <https://dmao.lmi.org/> and clicking on the MA Applications tab. Please note: this is a webpage, not an email address.

Applicants requesting Exceptions must complete the **CMS Exceptions Template** for each provider/facility type in each county for which an exception is requested and provide the appropriate information requested in the template. Additionally, all Exceptions must be requested and supported with appropriate documentation within the timeframe established by CMS. **All providers listed on the Exception template must be listed in the HSD table in the county for which the exception is being requested.**

NOTE: Applicants requesting partial counties should use the Exceptions Template and Exceptions request process to address deficient providers / facilities when applicable.

Appendix A - CY 2017 HSD Submission Frequently Asked Questions

CMS has developed a series of frequently asked questions (FAQ) regarding the HSD table submission process. These FAQs provide additional technical guidance on the following topics:

- Requirements for participating in the HSD pre-checks
- Understanding the HSD submission statuses
- Reviewing the HSD Status Report and ACC Report
- Informational messages versus errors
- MA Provider and MA Facility table formats and edit checks
- Address Information Report statuses (duplicate address, invalid address)
- Zip –Distributive Process

Please contact Greg Buglio at either gregory.buglio@cms.hhs.gov or 410-786-6562 for technical questions regarding the CY 2017 HSD submission. Please contact the DMAO web portal for questions related to policy: <https://dmao.lmi.org>

1. What is the schedule for HSD pre-checks?

Response: CMS will be providing weekly HSD pre-check processing during the application season. The pre-check process will run on the following dates (all of these dates are Tuesdays): January 19, 2016, January 26, 2016, February 2, 2016, and February 9, 2016. In order for tables to be included in a pre-check, both tables must be uploaded and unloaded successfully prior to the cut off time of 8PM Eastern Time.

2. How can I participate in the HSD pre-check process?

Response: To participate in the HSD pre-check, an applicant must:

- a. Successfully submit (upload and unload) both the Provider Table and Facility Table into HPMS by the weekly pre-check deadline of Tuesday at 8:00 PM Eastern Time. Question 1 lists the dates that pre-checks will occur. See question #4 for information on the automated unload edit process.
- b. As long as both tables upload and unload successfully by Tuesday of a given week, at 8:00 p.m. EST, your files will be included in that week's pre-check process.
- c. If you reupload one or both files in a subsequent week during the pre-check window, again making sure that the files upload and unload successfully, they will automatically be included in the next round of pre-check processing.
- d. NOTE – HPMS will email the Application Contact AND the person who completed the upload when the Unload process has completed. The email will indicate if the Unload was successful or unsuccessful. If unsuccessful, the email

will indicate the errors and will indicate a File Confirmation ID. If you contact the HPMS help desk for assistance in fixing the Unload errors, please reference the File Confirmation ID, located in the email you receive. This will allow the HPMS help desk to quickly reference your files. You will receive a separate email for both the Provider Table and the Facility Table.

3. Where and when can I view my pre-check or final application HSD processing results?

Response: The results of the HSD processing will be available in the HSD Automated Criteria Check (ACC) report. This report should be available between one and three days after the pre-check or final application deadline, depending on how many files are submitted and the size of those files. In prior years, the ACC reports have been available in one to two days. You may access this report at the following link: [HPMS Home Page](#)>Contract Management>Basic Contract Management>Select Contract Number>Submit Application Data>HSD Submission Reports>HSD Automated Criteria Check Report.

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

4. 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 during the next pre-check or final submission processing?

Response: Not necessarily. Successfully uploading your tables is the first step. However, in order to participate in the HSD pre-check process or to final submit your application, your submission must also pass the "unload" validation edits. The automated HSD validation process may take some time to complete, depending upon the size of your data tables and the number of other organizations submitting data at the same time. Consequently, CMS strongly urges applicants to submit your tables as soon as possible so that there is sufficient time to complete the unload validation process, retrieve your results, and resubmit your tables if you encounter fatal unload errors.

5. What other HSD Upload status messages might appear?

Response: The following are the most common Upload messages you will see: "Upload Started," which means the tables are in the process of being uploaded; "Upload Ended," which means the tables are uploaded and waiting to go through the automated Unload edit process. Question #6, #7, #8, #9, #10, and #11 address the automated HSD Unload edit process and the most common Unload messages.

6. Will I be notified when the HSD tables unload successfully or unsuccessfully?

Response: HPMS will email the Application Contact (found on the Contact screen in Contract Management) when the HSD tables have gone through the Unload edit process. The email will indicate if the Unload was successful. If unsuccessful, the email will provide details on the errors encountered and will list a File Confirmation ID. You may contact the HPMS help desk for assistance in resolving Unload errors. Be sure to reference the File Confirmation ID so the HPMS help desk is able to quickly find your files and reports. A separate email will be sent for both the Provider Table and the Facility Table.

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

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

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

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

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

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

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

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

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

Response: An “unsuccessful unload” means that validation errors are present on your file(s) and that until the errors are corrected, your submission will not be included in the next HSD pre-check or final submission process. You must review your error report, make the necessary corrections to your file(s), resubmit the file(s) to HPMS, and pass the “unload” process.

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

Response: Messages marked as “informational” are intended to highlight certain data scenarios. You should review all informational messages to determine if the data being highlighted is correct or if it requires a change. For example, you will receive an informational message if your file does not have a row assigned to a county for a required specialty. If you do have a provider of that specialty serving that county, you would update your file to add the row. If you do not have a provider of that specialty serving the county, and you intend to submit an exception request, then no updates are required to your file. It is important to note that informational messages do NOT prevent a file from passing “unload” validation and moving on to the pre-check.

13. One of the informational messages states that I entered Provider codes of “000”. I thought this was allowed?

Response: You may enter three zeros for provider types of “other” only for alternate providers listed as part of an exception request. Note the use of “000” should be extremely limited and if utilized the provider type should be identified. This message is simply a courtesy which provides you with a quick view of where you entered the three zeros. Note: You may not enter “000” on the MA Facility Table. Entry of “000” on the MA Facility Table is considered an error and will prevent your submission from moving on to either the pre-check or final submission process.

14. Some of the error messages indicate that I am missing data from fields on the table, but when I look at my upload file, those fields are populated. Why am I getting this message?

Response: If your submission contains any formatting errors, you should first correct the formatting errors and then resubmit your file(s) to HPMS. Formatting errors will skew the unload validation of the files and may result in errors reading the files. You may contact the HPMS help desk for assistance with this by emailing them at hpms@cms.hhs.gov.

15. Do I need to include every pending non-employer county on the MA Provider and MA Facility tables?

Response: Yes.

16. Are we required to list at least one of every provider and facility type for each of our pending non-employer only counties?

Response: The requirements are as follows:

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

Note: The HSD Status Report will continue to list every county where a provider or facility code has not been provided. Other than the edits indicated in points a. and b. above, these messages are informational and will not prevent your files from being processed.

17. Can we include placeholder or dummy data on the MA Provider and MA Facility tables for the pre-check?

Response: No. The inclusion of placeholder or dummy data will skew the results you receive in the ACC reports.

18. What format must we use to submit the MA Provider and MA Facility Tables?

Response: You should use the following steps to ensure you are using the correct format:

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

Note: These instructions are also available on the HSD Upload Page.

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

Response: 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.

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

Response: 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.

21. 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?

Response: 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.

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

Response:

Providers are considered duplicates when they have the:

- a. Same state/county code
- b. Same provider code
- c. Same NPI number
- d. 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:

- a. Same state/county code
- b. Same facility code
- c. Same NPI number
- d. 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.”

23. 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?

Response: 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:

- a. 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.
- b. 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.
- c. Duplicate Record – Please see question 16 above for an explanation of Duplicate addresses for Providers and Facilities.
- d. Not Supported by ACC – identifies addresses affiliated with certain situations which are not supported by the automated review process and require a manual review.

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

Response: Please see **Appendix B** for guidance on developing valid addresses for the purposes of the HSD automated review.

25. Can you explain the methodology CMS employs in determining the time and distance check for providers and facilities?

Response: CMS will provide additional information on the methodology for determining time and distance results in a separate communication.

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

Response: Please see **Appendix C** for a listing of the field edits on the MA Provider Table and the MA Facility Table.

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

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

Response: 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.

28. If only one of the files is successfully submitted and unloaded, will that file go through the pre-check or final-submit process?

Response: In order for a submission to go through the pre-check or final-submit process, both the MA Provider and MA Facility tables must be uploaded and unloaded successfully prior to the established deadline.

29. What do the various messages in the HSD Status Report mean and which of these messages will prevent my submission from going through the pre-check process?

Response:

- a. File Processing Error – These are errors in the format of the submitted file. These errors may prevent the system from reading the file correctly. Your HSD submission will not be included in the pre-check process until you correct the errors and successfully resubmit the HSD file(s).
- b. Record Invalid – A record contains a restricted character. Restricted characters are the greater than symbol, the less than symbol and the semi-colon (< > ;). Your HSD submission will not be included in the pre-check process until you correct the errors and successfully resubmit the HSD file(s).
- c. SSA State/County Not in Pending Service Area – The state/county code you provided is not part of your contract’s non-employer only pending Service Area. Your HSD submission will not be included in the pre-check process until you correct the errors and successfully resubmit the HSD file(s).

- d. Invalid/Missing Provider/Specialty Code – You have either entered an invalid specialty code or you have not entered a Primary Care Physician (provider codes 001-006) for every pending non-employer only county in your service area. Your HSD submission will not be included in the pre-check or final application process until you correct the errors and successfully resubmit the HSD file(s).
- e. Invalid/Missing Facility Code – You have either entered an invalid specialty code or you have not entered an Acute Inpatient Hospital (facility code 040) for every pending non-employer only county in your service area. Your HSD submission will not be included in the pre-check or final application process until you correct the errors and successfully resubmit the HSD file(s).
- f. Invalid Data Type – There is a processing error in the record due to incorrect data type (example – alpha character in a numeric-only field). Your HSD submission will not be included in the pre-check process until you correct the errors and successfully resubmit the HSD file(s).
- g. Invalid Length – There is a processing error in the record due to an invalid length in a field. Your HSD submission will not be included in the pre-check process until you correct the errors and successfully resubmit the HSD file(s).
- h. Invalid Data - There is a processing error in the record due to invalid data. Your HSD submission will not be included in the pre-check process until you correct the errors and successfully resubmit the HSD file(s).
- i. Required Field Missing – A required field or fields is missing from the record. Your HSD submission will not be included in the pre-check process until you correct the errors and successfully resubmit the HSD file(s).
- j. Provider/Specialty Code 000 Found – For the Provider Table version of the report – this is an informational message only. It is not an error. You will still be included in the pre-check process. For the Facility Table, you are not permitted to list “000”. If this message appears on the Facility Table version of the report, your HSD submission will not be included in the pre-check process until you correct the errors and successfully resubmit the HSD file(s).
- k. Informational Messages – These messages provide you with information about your submission. If there are missing provider codes or facility codes for a county or counties, they will be listed here. You will still be included in the pre-check process.

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	23502	12 is not a valid street number.

Appendix C – Field Edits for the MA Provider and Facility Tables

The following chart lists the SYSTEM edits for the MA Provider Table and the MA Facility Table. A field marked as “not required” means the system will not reject the file if the field is blank. It does not imply that the field should be blank. Please read the HSD Instructions, located above, to determine which fields are required and which are optional.

MA Provider Table

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

MA Facility Table

Field	Description	Rule
SSA State/County Code	VARCHAR2(5)	Required (not null) and validated against valid values (SSA County Code). Must be pending non-employer county attached to contract.
Facility or Service Type	VARCHAR2(150)	Required (not null)
Facility Specialty Code	VARCHAR2(3)	Required (not null) and validated against valid values

CMS Certification Number (CCN)	VARCHAR2(20)	Optional for 040- Acute Inpatient Hospitals, 044 Outpatient Dialysis, 046-Skilled Nursing Facilities, 052-Inpatient Psychiatric Facility Services, and 055-Home Health and 061-067 All Transplant Facilities. Not Required for all other facility types.
National Provider Identifier (NPI) Number	VARCHAR2(10)	Required (not null) and validated that is 10 digit numeric
# of Staffed, Medicare-Certified Beds	VARCHAR2(10)	Verify that entry is numeric since used in a calculation. Required but only for the following facility types: Acute Inpatient Hospital (040), Critical Care Services - ICU (043), Skilled Nursing Facilities (046), and Inpatient Psychiatric Facility (052).
Facility Name	VARCHAR2(150)	Required (not null)
Provider Street Address	VARCHAR2(250)	Required (not null)
Provider City	VARCHAR(150)	Required (not null)
Provider State Code	VARCHAR2(2)	Required (not null). Validate the state code against the valid list of state abbreviations.
Provider Zip Code	VARCHAR2(10)	Required (not null)
Uses CMS MA Contract Amendment	VARCHAR2(1)	Required (not null); Y for yes, N for no.