Health Service Delivery (HSD) Instructions for Medicare-Medicaid Plans (MMPs) Annual Medicare Network Submission

This document contains information needed to complete the HSD tables required for the MMP annual Medicare network submission. It also contains frequently asked questions (FAQ) regarding HSD submission and processing, guidance on developing valid addresses and field edits for the MMP Provider and MMP Facility tables.

Contents

General Instructions and Guidance

In June 2020, CMS codified network adequacy rules at 42 CFR § 422 on maximum time and distance standards in rural areas, telehealth, and Need (CON) laws. The standards identified at 422.116 define how CMS quantifies prevailing community patterns of health care delivery for each provider and facility specialty type in a service area. MMCO has used the waiver authority provided under Section 1115A to apply these regulatory provisions to develop network adequacy standards based on the dually eligible beneficiary population. These standards are used to assess network adequacy for Medicare- Medicaid Plans (MMPs).

In April 2023, CMS finalized revisions at 42 CFR § 422.116 (b)(1) to include Clinical Psychology and Clinical Social Work under the specialty types applicable to network adequacy evaluation. CMS also amended §422.116(d)(5) to include Clinical Psychology and Clinical Social Work to the list of specialties for the 10-percentage point credit towards the percentage of beneficiaries residing in published time and distance standards when a plan includes one or more telehealth providers that provide additional telehealth benefits in its contracted networks. MMPs will be required to include these new provider specialty types in their network submissions for formal network adequacy review beginning in calendar year 2024. If indicated, the telehealth credit will be automatically applied in the CMS Health Plan Management System (HPMS). MMPs should include all contracted providers within and outside of the service area that will be available to serve the county's beneficiaries (even if those providers/facilities may be outside of the time and distance standards). After your organization submits the required MMP health service delivery (HSD) tables, CMS-generated Automated Criteria Check (ACC) reports will be created showing the provider and facility types that are meeting or failing to meet the MMP access standards. CMS will invoke rounding for the MMP Medicare network submission for any results of 89.5% or higher. Based on those results, your organization may submit exception requests based on the process described below.

MMPs must submit HSD tables for the service area reflected in HPMS. This requires MMPs with counties that they have not been deemed ready to market and enroll beneficiaries but that still appear in HPMS to upload the MMP network for those pending counties. As articulated in the Exceptions section below, this will allow MMPs to request exceptions in those pending counties. CMS will not take any compliance action on MMPs where a pended county does not meet network adequacy at the conclusion of the annual MMP network review. **All submissions must utilize the current provider, facility and exception templates located in HPMS.**

Specialty Codes

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

Specialty Codes for the MMP 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
- 036- Clinical Psychology
- 037- Clinical Social Work

Description of MMP Provider Types
The following section contains information related to MMP Medicare Provider specialty types to assist the MMP with the accurate submission of the MMP Provider HSD Table.

MMP Provider Table – Select Provider Specialty Types

Primary Care Providers – The following six specialties are reported separately on the MMP 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)

MMPs 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). States may require MMPs to include pediatric providers in their tables, However, CMS does not review pediatric providers for purposes of network adequacy determinations. Therefore, physicians and specialists must not be pediatric providers; as they do not routinely provide services to the Medicare- population. 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) -- MMPs 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) -- MMPs 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.

Psychiatry (029) -- Psychiatrists must only be licensed physicians and no other type of practitioner.

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 MMP Facility Table

- 040 – Acute Inpatient Hospitals
- 041 - Cardiac Surgery Program
- 042 - Cardiac Catheterization Services
- 043 - Critical Care Services – Intensive Care Units (ICU)
- 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

Description of MMP Medicare Facility Types
The following section contains information related to MMP Medicare Facility specialty types to assist the MMPs with the accurate submission of the MMP Facility HSD Table.

MMP Facility Table – Select Facility Specialty Types
Contracted facilities/beds must be Medicare-certified.

Acute Inpatient Hospital (040) – MMPs must submit at least one contracted acute inpatient hospital. MMPs 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. MMPs 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.)

Inpatient Psychiatric Facility Services (052) – Inpatient Psychiatric Facility Services may include inpatient hospital services furnished to a patient of an inpatient psychiatric facility (IPF). IPFs are certified under Medicare as inpatient psychiatric hospitals and distinct psychiatric units of acute care hospitals and critical access hospitals. The regulations at 42 CFR § 412.402 define an IPF as a hospital that meets the requirements specified in 42 CFR § 412.22 and 42 CFR § 412.23(a), 42 CFR § 482.60, 42 CFR § 482.61, and 42 CFR § 482.62, and units that meet the requirements specified in 42 CFR § 412.22, 42 CFR § 412.25, and 42 CFR § 412.27.

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, MMPs 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.

Certificate of Need Credit

CMS' network adequacy requirements also account for Certificate of Need (CON) laws, or other anticompetitive restrictions, as described at 42 CFR § 422.116(d)(6). In a state with CON laws, or other state imposed anti-competitive restrictions that limit the number of providers or facilities in the state or a county in the state, CMS will either award the organization a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distances standards for affected providers and facilities or, when necessary due to utilization or supply patterns, customize the base time and distance standards. CMS conducted extensive analyses to identify all counties and specialties where the CON credit is applicable and created a CON reference file. Networks submitted to the NMM will automatically be reviewed for the CON criteria and receive the credit as applicable. Please note, in accordance with 42 CFR § 422.116(d)(6), the 10% credit will not be applied if the county maximum time and distance standards are customized.

If an organization determines there are additional county/specialty combinations that are not reflected in the CON reference file, they may request an exception related to the CON criteria and provide substantial and credible evidence that a provider or facility type is adversely affected by a CON law. Organizations need to use the current exception request template. Organization should select "other" as the reason for not contracting on the exception request template and include supplemental documentation at the end of the PDF. Organizations can find the MMP Exception template at the following navigation path: HPMS Home Page>Monitoring>Network Management>Templates

Telehealth Credit

Organizations will receive a 10% credit towards the percentage of beneficiaries that reside within required time and distance standards when they contract with telehealth providers in the following specialties:

- Primary Care (S03)
- Allergy and Immunology (007)

- Cardiology (008)
- Dermatology (011)
- Endocrinology (012)
- ENT/Otolaryngology (013)
- Gynecology, OB/GYN (016)
- Infectious Diseases (017)
- Nephrology (018)
- Neurology (019)
- Ophthalmology (023)
- Psychiatry (029)
- Clinical Psychology (036)
- Clinical Social Work (037)

Detailed technical instructions on reporting telehealth providers during a MMP's network submission are outlined in the HPMS NMM Plan User Guide. Organizations can find the Plan User Guide at the following navigation path: HPMS Home Page>Monitoring>Network Management>Guidance.

MMP Supply File

The MMP 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 is segmented by state to facilitate development of networks by service area. Contracts with service areas 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. The current supply file is published in HPMS>Monitoring>Network Management>Documentation>Reference Files.

Given the dynamic nature of the market, the file is a resource and may not be a complete depiction of the provider and facility supply available in real-time. MMPs remain responsible for conducting validation of data used to populate HSD tables, including data initially drawn from the supply file. MMPs should not rely solely on the MMP supply file when establishing networks, as additional providers and facilities may be available. CMS uses the MMP supply file when validating information submitted on exception requests. Therefore, CMS may update the MMP supply file periodically to reflect updated provider and facility information and to capture information associated with exception requests.

HSD Table Instructions

The tables should reflect the contracted MMP executed contracted network on the date of submission. CMS considers a contract fully executed when both parties have signed. MMPs should only list providers with whom they have a fully executed updated contract. These contracts should be executed on or prior to the submission deadline. In order for the automated network review tool to appropriately process this information, your organization 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

organizations to fully utilize the functionality in the CMS HPMS Network Management Module (NMM) to conduct organization-initiated checks prior to the September due date to ensure that their HSD tables are accurate and complete. For instructions on the organization initiated NMM uploads, please refer to HPMS>Monitoring>Network Management>Documentation>Guidance>Plan User Guide.

MMP Provider Table Template

The MMP Provider Table Template can be found in HPMS using the following path: HPMS>Monitoring>Network Management> Documentation>Templates. This table captures information on the specific physicians/providers in the MMP'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 the state/county codes where the 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 providers listed must not have opted out of Medicare.

The MMP is 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 MMP 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 MMP Provider Table will result in inaccurate ACC measurements that may result in your MMP Medicare network submission being found deficient. Explanations for each of the columns in the MMP Provider Table can be found in Appendix C, and HPMS system edits for the MMP Provider Table can be found in Appendix D.

MMP Facility Table Template

The MMP Facility Table Template can be found in HPMS using the following path: HPMS>Monitoring>Network Management> Documentation>Templates. Only list the providers that are 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-Medicaid beneficiary could not reasonably access services and that are outside the pattern of care. Such extraneous listing of facilities affects CMS' ability to quickly and efficiently assess facility 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.

Exception Requests

As MMPs will submit networks annually, any approved exceptions will be in place until the next annual MMP Medicare network submission. CMS, in collaboration with each respective state, will consider requests for exceptions to the required minimum number of providers and/or maximum time/distance criteria under limited circumstances. Each exception request must be

supported by information and documentation as specified in the exception request template attached to these instructions. If your organization believes that it will not meet the time/distance or minimum number MMP standards based on your contracted network, wants to request an exception(s), and already has additional contracted providers outside of the time and distance to serve beneficiaries, then you must include those other contracted providers on the MMP HSD tables in the annual MMP Medicare network submission.

Exception Justifications
The exception request template has been revised and converted into a fillable form to ease in completion and allow for greater accuracy in the submission of information. The form also allows for the inclusion of in-home delivery of services and the use of mobile health clinic.

Mobile Health Clinics: Any mobile health clinics that are contracted to provide services to the entire enrollee population within the specified service area. A mobile health clinic may be a specially outfitted truck or van that provides examination rooms, laboratory services, and special medical tests to those who may be in remote areas or who have little to no access to medical facilities, and to patients who do not have the resources to travel for care.

In-Home Medical Services: MMPs can receive consideration in the exceptions process where contracted providers deliver medical services in the beneficiary's home in lieu of an office where the office location may be outside of the established time and or distance standards.

CMS reserves the right to follow up for any additional information that may be need as a result of the exception request review which could include an attestation from the provider outlining their service area/counties and may also include the number of enrollees served by each provider type (mobile health clinics and in-home service providers) within the designated service areas/counties. CMS will also work with your state of operation to verify laws pertaining to mobile health clinics.

Exception Process Timing
Following the first submission for the annual MMP Medicare network review, organizations must review the ACC report. This report identifies the providers and/or facilities passing and failing to meet the MMP Medicare network standards. For those providers and/or facilities that are not meeting the MMP Medicare network standards, your organization may submit an exception request.

Exceptions are only permitted to be requested and uploaded between specific timeframes identified in the HPMS Cover Memo and may only be submitted using the required template attached to these instructions.

MMPs submitting exception requests will be notified by an automated HPMS email when the exception reviews are complete. All MMPs will be notified by an automated HPMS email of the second and final HSD table submission window (submit updated tables from the original submission, and/or correct HSD tables from the original submission).

Completing the Exception Request Template
The MMP Annual Network Submission HSD Exception Request template provides the basis for

any MMP exception request. MMPs must submit distinct exception requests per contract ID, county, and specialty code. Each request should be tailored to the provider/facility type and the specific county **using the current MMP exception template** found in HPMS using the following path: HPMS>Monitoring>Network Management> Documentation>Templates. CMS will not accept exception request submissions using the Medicare Advantage application template or the MMP template from prior years' annual MMP network submissions. The exception request template is segmented into the following eight parts:

I. Exception Information
II. Justification for Exception
III. Rationale for why Exception is Necessary
IV. Sources
V. Narrative Text (Optional)
VI. Non-Contracted Providers/Facilities
VII. Mobile Health Clinics and In-Home Medical Services
VIII. Low Utilization

Exception Information: This section of the template requires the plan to enter the Contract ID and select from the drop-down list the County name and code and the Specialty name and code for the exception request your organization is seeking.

Justification for Exception: When submitting an exception request in HPMS, the NMM only provides one basis – patterns of care; however, the MMP exception request template requires MMPs to choose from a selection of reasons for the exception. Your organization must select the applicable justification.

Note: CMS will only consider low utilization exception requests for existing counties. MMPs cannot demonstrate low utilization of a provider type for a county where the MMP has not been deemed ready to enroll beneficiaries. If the basis for the exception request is based on low utilization of the provider/facility type for the demonstration population, your organization must skip to and complete only the table included in Part VIII: Low Utilization.

Rationale for why Exception is Necessary:

- Questions 1-5 must be answered Yes or No
- If the response is Yes for Question 3, then Part IV must be completed.
- If the response is Yes for Question 4, then the table included in Part VI: Non-Contracted Providers/Facilities section must be completed.
- If the response is Yes for Question 5, then the table included in Part VII: Telehealth Providers, Mobile Health Clinics, and In-Home Medical Services section must be completed.

Sources:

Please enter any sources (up to six) you used to identify providers/facilities within or nearby CMS' 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 six sources, or a source not included on the drop-down list, please describe the additional sources in the Part V: Narrative Text section. The drop-down options for the sources are as follows:

- Physician Compare
- Hospital Compare
- Nursing Home Compare
- Dialysis Compare
- NPI file/NPPES
- MMP Provider Supply File
- Provider of Services (POS) file
- Direct outreach to provider
- Provider website
- State licensing data
- Online mapping tool

Other (Please describe the other source(s) in the "Part V: Narrative Text" section Narrative Text (Optional): Please use the free text format box in this section 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 IV: Sources section.

Non-Contracted Providers/Facilities:
Complete the table in this section if your organization answered "Yes" to question 4 in the Part III: Rationale for why Exception is Necessary section. Please include all non-contracted providers/facilities in the table. If the sources of information used (and listed in the table) are proprietary or otherwise not publicly available, the MMP must describe how the information supports the reason for not contracting with a provider/facility and provide evidence of the data source information (e.g., screenshots).

The table is designed to capture most of the non-contracted provider/facility information in a free text format; however, there are drop-down lists to capture the provider state and the reason for the provider not contracting with your organization. The drop-down options to capture the reason for not contracting are as follows:

Reasons for not contracting:
- Provider is no longer practicing (e.g., deceased, retired, etc.)
- 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

Reasons for not contracting:
- Provider/Facility type better than prevailing Original Medicare pattern of care
- Contract offered to provider/facility but declined/rejected
- Geographic limitations, explain below

- Provider does not contract with Medicare-Medicaid Plans
- Sanctioned provider on List of Excluded Individuals and Entities
- Provider has opted out of Medicare
- Provider is at capacity and is not accepting new patients
- Other (please enter explanation on the last column of the table)

Low Utilization

If the basis for the exception request is due to low utilization of the provider/facility type for the demonstration population, your organization must only complete the table in this section.

Note: CMS will only consider low utilization exception requests for existing counties. MMPs cannot demonstrate low utilization of a provider type for a county where the MMP has not been deemed ready to enroll beneficiaries.

If the plan has low utilization across the overall service area. Plans still need to take every effort to execute a contract for the required provider or facility type.

The table is designed to capture the justification for an exception request due to low utilization. The following questions must be answered in a free text format:

Low Utilization Justification
a. Provide the volume of enrollees who access the specialty type within the specific county over the last year.
b. Provide the volume of enrollees who accessed the specialty type under the MMP's overall Service Area over the past year.
c. Provide the rationale for why enrollees do/do not utilize provider/facility services in the area, which might contribute to the low utilization.
d. How will the MMP provide the existing provider/facility service to current enrollees?
e. How will the MMP provide the provider/facility services should utilization increase?
f. How will the MMP provide ongoing monitoring of provider/facility type utilization?
g. Provide additional information to support low utilization reason.

HPMS Path

MMPs can locate the NMM in HPMS by using the following path: Monitoring>Network Management. To access the appropriate HSD templates, click Documentation>Templates from

the left-side drop down menu. The HPMS User Manual can be located using the following path:
Monitoring>Network Management>Documentation>Guidance>Plan User Guide, and will detail how to download, complete, and upload the correct HSD templates for your organization, frequently asked questions and guidance on developing valid addresses.

Appendix A – MMP Provider Table 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. **Specialty Code** – Specialty codes are unique codes assigned by CMS to process data. Enter the appropriate specialty code (001-037).

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.

D. **Name of Physician or Mid-Level Practitioner –** Self-explanatory. Up to 150 characters.

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.**

E. **Street Address** – up to 250 characters

F. **City** – up to 150 characters

G. **State** – 2 characters

H. **ZIP Code** – up to 10 characters

Appendix B – MMP Facility Table 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 MMP should use. Format the cell as "text" to ensure that codes beginning with a "0" appear as five digits.

B. **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.

C. **National Provider Identifier (NPI) Number –** Enter the provider's assigned NPI number in this column. The NPI is a ten-digit numeric field.

D. **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.**

E. **Street Address** – up to 250 characters

F. **City** – up to 150 characters

G. **State** – 2 characters

H. **ZIP Code** – up to 10 characters

I. **Number of Staffed, Medicare Certified Beds** – For Acute Inpatient Hospitals (040), Critical Care Services – Intensive Care Units (ICUs) (043), Skilled Nursing Facilities (046), and Inpatient Psychiatric Facility Services (052), your organization must enter the number of Medicare certified beds for which it has contracted access for enrollees. This number should not include Neo-Natal Intensive Care Unit (NICU) beds.

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

The following chart lists the SYSTEM edits for the MMP Provider Table and the MMP 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.

MMP 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 county attached to contract.
Specialty Code	VARCHAR2(3)	Required (not null) and validated against valid values
National Provider Identifier (NPI) Number	NUMBER	Required (not null) and validated that it is 10 digits numeric
Name of Physician or Mid-Level Practitioner	VARCHAR2(150)	Required (not null)
Street Address	VARCHAR2(250)	Required (not null)
City	VARCHAR2(150)	Required (not null)
State	VARCHAR2(2)	Required (not null). Validate the state code against the valid list of state abbreviations
ZIP Code	VARCHAR2(10)	Required (not null)

MMP 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.
Specialty Code	VARCHAR2(3)	Required (not null) and validated against valid values
National Provider Identifier (NPI) Number	NUMBER	Required (not null) and validated that is 10 digits 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)
Street Address	VARCHAR2(250)	Required (not null)
City	VARCHAR(150)	Required (not null)
State	VARCHAR2(2)	Required (not null). Validate the state code against the valid list of state abbreviations.
ZIP Code	VARCHAR2(10)	Required (not null)

Appendix D - CMS Public Data Source for HSD Exception Request

The following table listed below provides a list of acceptable CMS data sources used for review of HSD Exception Request. **Note:** The Medicare Advantage Provider Supply File is not used as a data source for purposes of the MMP Medicare Network Review.

HSD Specialty Type	Data Source
Allergy and Immunology Cardiology Chiropractor Dermatology Endocrinology ENT/Otolaryngology Gastroenterology General Surgery Gynecology, OB/GYN Infectious Diseases Nephrology Neurology Neurosurgery Oncology – Medical, Surgical Oncology – Radiation/Radiation Oncology Ophthalmology Orthopedic Surgery Physiatry, Rehabilitative Medicine Plastic Surgery Podiatry Primary Care Providers Psychiatry Pulmonology Rheumatology Urology	Physician Compare – Data available at: https://www.medicare.gov/care-compare/ MMP Supply File – Data available at: HPMS>Monitoring>Network Management>Documentation>Reference Files
HSD Specialty Type	**Data Source**
Vascular Surgery Cardiothoracic Surgery	MMP Supply File – Data available at: HPMS>Monitoring>Network Management>Documentation>Reference Files
Acute Inpatient Hospitals Cardiac Surgery Program Cardiac Catheterization Services Critical Care Services – Intensive Care Units (ICU) Surgical Services (Outpatient or ASC) Inpatient Psychiatric Facility Services	Provider of Services – Data available at: https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/provider-of-services-file-hospital-non-hospital-facilities MMP Supply File – Data available at: HPMS>Monitoring>Network Management>Documentation>Reference Files
Outpatient Dialysis	Dialysis Facility Compare -- https://www.medicare.gov/care-compare/
Physical Therapy Speech Therapy Occupational Therapy	Physician Compare – Data available at: https://www.medicare.gov/care-compare/ National Plan & Provider Enumeration System (NPPES) – Data available at: https://nppes.cms.hhs.gov/#/ MMP Supply File – Data available at: HPMS>Monitoring>Network Management>Documentation>Reference Files

HSD Specialty Type	Data Source
Skilled Nursing Facilities	Nursing Home Compare – Data available at: https://www.medicare.gov/care-compare/ MMP Supply File – Data available at: HPMS>Monitoring>Network Management>Documentation>Reference Files
HSD Specialty Type	Data Source
Mammography	Hospital Compare – Data available at: https://www.medicare.gov/care-compare/ and National Plan & Provider Enumeration System (NPPES) – Data available at: https://nppes.cms.hhs.gov/#/
Diagnostic Radiology Outpatient Infusion/Chemotherapy	National Plan & Provider Enumeration System (NPPES) – Data available at: https://nppes.cms.hhs.gov/#/ MMP Supply File – Data available at: HPMS>Monitoring>Network Management>Documentation>Reference Files Provider of Services – Data available at: https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/provider-of-services-file-hospital-non-hospital-facilities