



MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

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TO: Medicare Advantage Organizations and Section 1876 Cost Organizations

FROM: Kathryn A. Coleman
Director

SUBJECT: Provider Directory Policy Updates

The Centers for Medicare and Medicaid Services (CMS) is issuing this memorandum in conjunction with the recent findings and posting of the Online Provider Directory Review Report. In this memorandum, we reiterate existing CMS policy and provide additional guidance related to provider directory requirements for Medicare Advantage organizations (MAOs) and section 1876 cost plans. CMS will incorporate this updated guidance into the next revisions of both chapter 4 of the Medicare Managed Care Manual (MMCM) and the Medicare Advantage and 1876 Cost Plan Model Provider Directory. The guidance contained herein is effective immediately. In addition to this guidance, CMS reminds organizations to also reference the provider directory best practices in the contract year (CY) 2017 Final Call Letter.¹

Regulatory Requirements

CMS regulations at 42 C.F.R. §422.111(b)(3)(i) require organizations to provide the number, mix, and distribution (addresses) of providers from whom enrollees may reasonably be expected to obtain services. This information must be provided to each enrollee in a clear, accurate, and standardized form (42 C.F.R. §422.111(a)(2)). Regulations at 42 C.F.R. §422.504(a) and §422.504(a)(4) require organizations to adhere to all regulations and general instructions and to disclose information to beneficiaries in the manner and the form prescribed by CMS as required under §422.111. In accordance with 42 C.F.R. §422.111(h)(2)(ii) and guidance in section 100.2.2 of the Medicare Marketing Guidelines, each organization must post an online provider directory on its website. Section 1876 cost plan regulations at 42 C.F.R. §417.427 require cost plans to adhere to the MA regulations at §422.111. In addition, section 1876 cost plans are required to comply with CMS's general instructions related to cost plan requirements (42 C.F.R. §417.472).

CMS has provided general instructions regarding the elements and the format of the provider directory through chapter 4 of the MMCM as well as the Medicare Advantage and 1876 Cost Plan Model Provider Directory. Specifically, CMS permits organizations to meet the online provider directory requirements by either posting an electronic version of the hardcopy provider

¹ <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/downloads/Announcement2017.pdf>

directory or providing a search engine/database to look up network providers and locations. Organizations must also provide the option on their websites for users to request a hardcopy provider directory. Organizations are expected to mail the requested hardcopy directory within three business days of the request.

Existing Provider Directory Requirements

CMS's core focus remains making sure provider directories are accurate for enrollees and their caregivers who rely on them to make informed decisions regarding their health care and health plan choices. The provision of accurate provider information and ensuring adequate access to covered services are essential protections for enrollees. Effective compliance by organizations includes the following:

- Organizations are required to provide accurate information at all times, and this requirement extends to providers that an enrollee may access. Therefore, both hardcopy and online provider directories must be up to date. Organizations may determine the best method to ensure up-to-date directories. CMS believes regular outreach to individual providers (e.g., quarterly) is one way to assist organizations in ensuring data is accurate. Note that facilities' (e.g., hospitals') information must be accurate but may not require as frequent outreach as individual providers. Whether updates are obtained by an organization's regular outreach or obtained through other sources (e.g., enrollee notification), CMS recognizes that there may be a delay between receipt of information from providers and the organization's ability to update its directory. Therefore, CMS is allowing organizations up to 30 calendar days to update hardcopy and online directories. Organizations may use addenda to update hard copies. CMS's measure of success is an accurate provider directory.
- Organizations must include a notation that identifies providers who are accepting new patients or a notation that identifies providers who are not accepting new patients so that enrollees may identify those providers from whom they may reasonably expect to obtain services.
- All providers listed in hardcopy or online directories must have current contracts with the organization to participate in the plan network. Directories provided during the Annual Enrollment Period for the upcoming plan year must accurately and fairly represent the network for the upcoming plan year. If a provider is listed in a directory prior to the effective date of the contract, then the directory must notate the effective date. Similarly, if a provider is expected to leave the network, then the directory must notate the termination effective date. This is in addition to the organization's responsibilities to provide individual, written notice under 42 C.F.R. §422.111(e) to patients when a provider is terminated from the network.

Additional Provider Directory Guidance

As mentioned previously, directories must provide enrollees with a list of providers from whom the enrollee may reasonably be expected to obtain services. CMS's recent online provider

directory review identified numerous instances in which providers participated in the network but had significant limitations on the enrollees who could make an appointment, or the provider listed did not see patients, or the enrollee was unable to make appointments. In these cases, the enrollee cannot reasonably expect to make an appointment with the provider. Therefore, per §422.111, these providers should not be listed as available to all enrollees. Depending on the issue, additional steps or information are necessary to ensure that the provider directory accurately identifies the providers from whom enrollees may reasonably be expected to obtain services:

- Notations identifying any substantive restrictions on access to a provider must be made next to providers who have such restrictions, as follows:
 - Providers who are only available to a subset of enrollees. For example, only Native American enrollees may access a provider associated with a Native American tribe, or only enrollees who are students may access a provider at the college's student health service.
 - Providers who practice concierge medicine and are available only to patients who pay an annual fee or retainer.
 - Providers who only offer home visits and do not see patients at a physical office location.
- Directories may only list providers who enrollees can go to for appointments. For example:
 - Directories may not list providers who work only at a hospital location and are not available for office visits to provide or in connection with covered services (i.e., if the enrollee cannot call the phone number listed and make an appointment with that provider at the address listed).
 - Directories may not list on-call and substitute providers who are not regularly available to provide covered services at an office or practice location. Only providers who regularly practice at the specified location may be listed.
- CMS realizes that providers may be credentialed in more than one specialty or that other specialties can be considered offshoots of the more general term of internal medicine. To guard against enrollee confusion when selecting a specialist or a primary care physician (PCP), organizations must ensure that the directory makes it clear the capacity the provider is practicing. For example, in searching for a PCP, an internal medicine/oncologist who does not practice as a PCP should not be displayed. Another example is a provider who has two specialties, A and B, but only practices Specialty A. When an enrollee searches for Specialty B, the provider in this example should not be displayed.
- If a non-physician practitioner (e.g., nurse practitioner, physician's assistant) is listed, enrollees must be able to call and make an appointment with that provider, and the directory must clearly notate that the provider is a non-physician practitioner and not a primary care physician.

- For group practices, directories must only list individual providers at locations where they routinely see patients, as opposed to every location of the group practice.
- Organizations must make a reasonable attempt to ensure provider practice names are up-to-date and reflect the name stated when an enrollee calls to make an appointment.

Best Practice

CMS strongly believes that organizations should institute other steps to ensure that provider directories are accurate and provide the most useful information. Therefore, CMS strongly encourages organizations to provide a hotline number that puts enrollees in direct contact with the organization if they discover an error in the directory information, including if a provider is no longer accepting new patients. The organization could then use this information to correct the discovered error, and, if necessary, assist the enrollee in setting up an appointment with a provider. Use of a specific contact number and specific staff to track and implement the necessary changes when there is a report of inaccurate directory information greatly decreases the chance that information or the need for changes will be overlooked.

For example, in the circumstance where an enrollee calls a provider that is not accepting new patients, the enrollee would call the hotline number. The organization would then make, or coordinate making, the changes to the directory necessary to address the inaccurate information. In addition, the organization would help the enrollee schedule an appointment with a different in-network provider who is accepting new patients.

CMS is reminding organizations that changes in provider contracting/directories may affect access. Therefore, organizations must periodically reassess whether additional providers need to be added to the network to ensure that current CMS network adequacy standards are met. CMS expects that organizations complete the necessary steps to ensure that, when applicable, updates to provider directories are synced with updates to Health Service Delivery (HSD) tables. For example, if an organization finds that a provider has retired and then updates its provider directory, then the organization should also update its HSD tables and run the updated network through the Network Management Module in HPMS to see if the network still meets current standards.

Failure to ensure access and failure to provide accurate information to enrollees may result in compliance notice and/or enforcement action.

If you have questions about this memorandum, please submit an inquiry to the Medicare Part C Policy Mailbox, located at: <https://dpap.lmi.org>.