AAPAN AMERICAN ASSOCIATION OF PAYERS, ADMINISTRATORS AND NETWORKS

Federal Provider Directory Requirements

Both Congress and federal agencies have acted to improve the accuracy of provider directories. This document outlines those efforts and requirements that are in place for Medicare Advantage (MA) plans, Medicaid managed care plans, the Children's Health Insurance Plan (CHIP) managed care entities, exchange plans, and group and individual plans.

Medicare Advantage

Section 4001 of the Balanced Budget Act of 1997 (BBA) (P.L. 105–33) established a new Medicare Part C (Medicare Advantage) program.

Section 1852(c)(1)(C) of the Social Security Act required Medicare Advantage organizations (MAOs) to annually disclose in a clear, accurate, and standardized form to each MA plan enrollee, the number, mix, and distribution of plan providers, among other information.

CMS has issued updated guidance over several years regarding the responsibilities of MA organizations to have accurate provider directories, with guidance appearing in the Medicare Marketing Guidelines and Medicare Communications and Marketing Guidelines and section 110 of Chapter 4 of the Medicare Managed Care Manual.

The February 2022 Medicare Communications and Marketing Guidelines outline the requirements on the timing of provider directory communications:

- Provided to current plan enrollees by October 15 of the year prior to the applicable year.
- Provided to new plan enrollees within 10 calendar days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.
- Must be provided to current enrollees upon request, within three (3) business days of the request.
- Plans must update directory information any time they become aware of changes. All updates to the online provider directories must be completed within 30 days of receiving information requiring update. Updates to hardcopy provider directories must be completed within 30 days, however, hardcopy directories that include separate updates via addenda are considered up-to-date.

The April 2016 Medicare Managed Care Manual outlines provider directory requirements for MAO. According to the manual, MAOs are expected to update directory information any time they become aware of changes. All updates to the online provider directories are expected to be completed within 30 days of receiving information. Updates to hardcopy provider directories must be completed within 30 days, however, hardcopy directories that include separate

updates via addenda are considered up-to-date.

MAOs should contact their network/contracted providers on a quarterly basis to update the following information in provider directories:

- Ability to accept new patients
- Street address
- Phone number
- Any other changes that affect availability to patients

In May 2020, CMS published a final rule, ‘‘Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Healthcare Providers’’ (CMS Interoperability and Patient Access final rule), that required MA organizations to make standardized information about their provider networks available through a Provider Directory Application Programming Interface (API) that is conformant with technical standards finalized by HHS Office of the National Coordinator for Health IT (ONC) by January 1, 2021. Those Provider Directory APIs are required to be accessible via a public-facing digital endpoint on the payer’s website to ensure public discovery and access. Payers must make all directory information available to current and prospective enrollees and the public through the Provider Directory API within 30 calendar days of receiving new or updated provider directory data.

In April 2022, CMS released the final Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly rule that would modify provider directory requirements. CMS is requiring a provider directory to be searchable by every element, such as name, location, and specialty. CMS is also requiring directories to include providers’ cultural and linguistic capabilities.

Medicaid and CHIP

In section 4701 of the BBA, Congress added section 1932(a)(5)(B)(i) of the Act, which requires that the Medicaid managed care organizations that are specified in the statute make available, upon request, the identity, locations, qualifications, and availability of providers that participate with that entity.

These same requirements were applied to Children’s Health Insurance Program (CHIP) managed care entities via section 403 of the Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111–3), at section 2103(f)(3).

Section 5006 of the 21st Century Cures Act (Cures Act) (P.L. 114–255) requires Medicaid agencies to publish online a directory of certain physicians who participate in the state's fee-for-service (FFS) program. Medicaid agencies must update these directories at least annually and include providers' names, specialties, addresses, and telephone numbers. For physicians participating in a primary care case-management system, the directory must also indicate whether they are accepting Medicaid beneficiaries as new patients and the physician's cultural and linguistic capabilities. Other providers may be included at the state's option, as may certain additional information such as the physician's or provider's internet website.

In the May 2020 CMS Interoperability and Patient Access final rule (referenced above), CMS also required Medicaid and CHIP fee-for-service programs, Medicaid managed care plans, and CHIP managed care entities to make standardized information about their provider networks available through a Provider Directory API that is conformant with technical standards finalized by ONC by January 1, 2021. Those Provider Directory APIs are required to be accessible via a public-facing digital endpoint on the payer's website to ensure public discovery and access. Payers must make all directory information available to current and prospective enrollees and the public through the Provider Directory API within 30 calendar days of receiving new or updated provider directory data.

Exchange Plans

In 2015, in the ''Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016'' final rule, CMS established requirements for Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges. QHPs must publish online an easily-accessible, up-to-date, accurate, and complete provider directory and make this information publicly available on their own websites in a machine-readable file and format to allow third parties to create resources that aggregate information on different plans.

Those directories must include information on:

- Which providers are accepting new patients
- Provider's location
- Provider's contact information
- Specialty
- Medical group
- Any institutional affiliations

Group and Individual Plans

AAPAN AMERICAN ASSOCIATION OF PAYERS, ADMINISTRATORS AND NETWORKS

In 2020, the Consolidated Appropriations Act, 2021 (CAA) (P.L. 116–260), Division BB, section 116 added a new section 2799A–5 to the PHSA, section 720 to the Employee Retirement Income Security Act of 1974 (ERISA), and section 9820 to the Internal Revenue Code of 1986 which address provider directories. The administration has said that further rulemaking is forthcoming for the provider directory requirements of that law.

The law requires group health plans and health insurance issuers offering group or individual health insurance coverage to:

- Publish a provider directory
- Establish a process to verify data in the directory at least every 90 days, beginning with plan years that start on or after January 1, 2022

Those directories must include:

- Names
- Addresses
- Specialty
- Telephone numbers
- Digital contact information for health care providers and healthcare facilities

The CAA (section 2799B–9 to the PHSA) also requires each provider and facility to have in place business processes to ensure the timely provision of provider directory information to those payers.

CMS Oversight

Annual Audits of Exchange Plans

CMS conducts annual reviews to assess the accuracy of QHP issuers' machine-readable provider data files, comparing the data files to the issuers' online provider directories and other data sources, such as the National Plan and Provider Enumeration System (NPPES) and the United States Postal Service (USPS) address verification database.

In March 2022, CMS released a report on its findings. Over five plan years beginning in plan year (PY) 2017 through PY2021, CMS found that no more than 47 percent of the provider entries reviewed from the machine-readable provider data files included a complete set of accurate telephone numbers, addresses, specialties, plan affiliations, and whether the provider is accepting new patients. Furthermore, only 73 percent of the providers reviewed could be fully matched to the published directories on the payer's website. Finally, when CMS compared provider information from the machine-readable data files to the NPPES National Provider

Identifier (NPI) registry, only 28 percent of the provider names, addresses, and specialties matched.

CMS Monitoring of MA Plans

In the Contract Year 2016 Call Letter for Part C (Medicare Advantage) and Part D plans, CMS announced it was initiating a monitoring effort of the accuracy of online provider directories for plans offered by MA organizations. Beginning in February 2016, CMS studied the accuracy of information in MA organizations' online directories. In July 2018, CMS released its findings from three rounds of reviews which identified at least one deficiency in 45 percent, 55 percent, and 49 percent of listed locations. The significant types of identified inaccuracies included providers who did not practice at the listed location, providers who did not accept the plan at the listed location, incorrect phone numbers or addresses, and mistaken "accepting new patients" flags.

On January 3, 2020, as a follow-up to the MA provider directory monitoring study conducted from 2016 to 2018, CMS issued a Health Plan Management System (HPMS) memo encouraging MA organizations to work with their contracted providers and to urge those providers to review and update their NPPES data. CMS announced that it would exercise enforcement discretion with regard to potential violations of §422.111(b)(3) should CMS uncover errors in an MA organization's provider directory where the errors are consistent with NPPES data that were updated or certified between January 1 and April 30, 2020, provided the MA organization corrected any identified errors within 30 days.

National Directory of Healthcare Providers and Services RFI

In October 2022, CMS released a request for information (RFI) seeking public input on the concept of CMS creating a directory with information on health care providers and services or a "National Directory of Healthcare Providers and Services" (NDH). CMS said health care directories can serve as an important resource for patients, helping them locate providers who meet their individual needs and preferences and allowing them to compare health plan networks. Directories can also facilitate care coordination, health information exchange, and public health data reporting. The agency said the current health care directory landscape is fragmented, resulting in patients sometimes struggling to find current information about providers in their network and providers facing redundant and burdensome reporting requirements to multiple databases. Directories often contain inaccurate information, rarely support interoperable data exchange or public health reporting, and are costly to the health care industry.

CMS sought public input on a directory that could serve as a "centralized data hub" for all health care directories and digital contact information with accurate, up-to-date, and validated data in a publicly accessible index developed through streamlined information submission from providers. CMS also wanted comments on whether consolidating those data could help improve access to care and patient choice by making it easier for patients to identify, compare, and locate providers

who meet their specific needs and preferences, such as those related to office accessibility, languages spoken, or other data. The comment period closed December 6, 2022.

AAPAN submitted comments in response to the RFI raising several questions that the agency should consider before moving forward. The NDH holds promise but AAPAN pointed out the RFI did not consider the cost to issuers. AAPAN raised concerns with the public-facing aspect of a NDH. The comments encouraged CMS to take a measured and thoughtful approach before moving forward with such a concept.