Contract Year 2021 Medicare Advantage and Section 1876 Cost Plan Provider Directory Model

Regulatory Requirements

CMS regulations at 42 CFR 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 CFR 422.111(a)(2)). Regulations at 42 CFR 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 42 CFR 422.111. In accordance with 42 CFR 422.111(h)(2)(ii), each organization must post an online provider directory on its website. Section 1876 cost plan regulations at 42 CFR 417.427 require cost plans to adhere to the MA regulations at 42 CFR 422.111. In addition, section 1876 cost plans are required to comply with the applicable requirements and conditions set forth in this subpart and in general instructions issued by CMS (42 CFR 417.472(b)).

Instructions

The following instructions and Provider Directory Model template apply to all **hardcopy and online** provider directories produced by all network-based Medicare Advantage (MA) plans and Section 1876 Cost Plans (as defined in 42 CFR 422.114(a)(3)(ii)). These instructions and model template serve as CMS's requirements for provider directories and supplement guidance in the Medicare Communications and Marketing Guidelines (MCMG). **The model template is provided beginning on page 1**. Please note: If the organization uses the Provider Directory Model, it must use the Provider Directory Model as provided, unless otherwise indicated in these instructions (see "Use of Non-Models" below). All variable fields are denoted by gray highlighted text and brackets and must be populated with plan-specific information on current network providers.

Provider Listings. Plans must list only currently contracted and credentialed providers in their directory. Plans may not list a provider in their directory prior to being credentialed.

Provider directories must clearly explain all plan-specific rules regarding enrollee access to providers. For example, a health maintenance organization (HMO) plan may have an open panel of providers or it may only offer a closed panel. A closed panel may require that enrollees obtain a referral from a Primary Care Provider (PCP) in order to access specialists. The plan must clearly explain this information in the directory. In addition, the directory must identify the providers and/or services for which an enrollee must obtain a referral, or the directory must explain to enrollees where they can find this information.

Plans may not list a provider in their directory if the enrollee cannot call the phone number listed and request an appointment with that provider at the address listed (e.g., when the provider works only at a hospital/urgent care center and is not available for routine office visits).

Plans may not include providers in their directory that serve as on-call and substitute providers and who are not regularly available to provide covered services at an office or practice location. Plans may only list providers who regularly practice at the specified location.

Plans must clearly state in the directory the capacity in which the provider is serving for that particular network even if the provider is credentialed in more than one specialty. For example, an internal medicine physician/oncologist that does not practice as a PCP should not be displayed as a PCP in the directory. The plan may only list the provider under the category of the services he/she will be furnishing to enrollees.

Plans may list non-physician practitioners (e.g., nurse practitioners, physician's assistants) as "Primary Care Providers (PCPs)" (see page 7) if an enrollee can make an appointment with that practitioner. The plan must clearly identify that the provider is a non-physician practitioner.

If a provider practices at multiple locations, the plan may only list the location(s) at which the provider regularly sees patients, and not every location where the provider may practice only occasionally.

Plans must either clearly identify whether or not a provider is accepting new patients or provide a notice directing beneficiaries to contact a provider to determine if he or she is accepting new patients. If listing the status for each individual provider, plans are not limited in the manner by which they identify providers who are/are not accepting new patients (i.e., "Accepting New Patients? Yes/No"), so long as beneficiaries can determine those providers from whom they may reasonably expect to obtain services (e.g., a special character next to the provider's name and an accompanying footnote for all providers who are not accepting new patients).

Plans must make a reasonable attempt to ensure provider practice names are up-to-date and reflect the name of the practice used when an enrollee calls to make an appointment.

Plans whose providers may have restrictions on access must include a notation next to the provider's listing indicating such restrictions. Examples include, **but are not limited to**, the following:

- Providers who are only available to a subset of enrollees (e.g., only Native American enrollees may access a provider associated with a Native American tribe, only enrollees who are students may access 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;
- Providers who regularly alternate between two or more different office locations;
- Providers who offer services exclusively via telehealth;
- Providers who will be available in-network as of a future, specified contract effective date (Plans must list this date next to the provider's name); and
- Providers who will leave the network as of a specified contract termination date (Plans must list this date next to the provider's name if the termination date is known/final).

Sub-Networks. If a plan offers sub-networks, it may develop a separate provider directory for each sub-network. Enrollees in a sub-network may be provided a directory reflecting their sub-network, but the directory also must clearly state that enrollees are not limited to the providers listed in the sub-network directory. The plan must provide a link where the enrollee can obtain a directory that includes the plan's entire provider network. This larger directory may be made available online or furnished in hard copy upon request by the enrollee. In addition, the plan

must describe how enrollees may request access to providers outside of the sub-network. For more information on sub-networks, please refer to the network adequacy guidance, located at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html.

Provider-Specific Plans. A provider-specific plan (PSP) must develop a separate directory which clearly identifies available providers in the PSP network. A contract-level provider directory cannot be used for the purpose of communicating a PSP network to potential beneficiaries or enrollees. For example, a plan cannot simply add symbols or information to the broader network's directory to show which providers are in the more limited PSP network.

Different Cost Sharing Arrangements/Tiering. Plans that reduce or eliminate cost sharing for enrollees that use certain providers (e.g., through the use of MA uniformity flexibilities), must identify these providers with special characters and/or footnotes.

Plans that tier cost sharing of medical benefits for certain providers must use special characters and/or footnotes indicating there are different cost sharing amounts for those providers. Plans must include language referring enrollees to the Evidence of Coverage (EOC) for more information. Plans are not required to use the word "tier" if they use different terminology to describe these cost sharing arrangements.

Use of Non-Models. MA organizations and Section 1876 Cost Plans may also develop non-model online or hardcopy provider directories. Non-model directories, for instance, may contain additional data elements or follow a different format than this model. However, non-model directories must follow all instructions and include all standardized language, as specified herein.

Permissible Alterations. The following are permissible alterations to the model:

- Minor edits as necessary (e.g., grammatical or punctuation changes, correcting references).
- Formatting/style (e.g., font, margins) that meets the MCMG and other guidance.
- Adding plan logos.
- Reordering Section 2 - List of Network Providers.
- Inserting MAO name or "we," "our," "us," "the plan," "our plan," or "your plan" where the document indicates "[Plan Name]." In addition, "we," "our," "us," "the plan," "our plan," or "your plan" may be used interchangeably even when one is already used in the model.

Modifications or Deletions. The following are modifications or deletions that CMS expects from plans:

- When populating the model, delete instructions to plans.
- References to other plan materials (e.g., Evidence of Coverage) may be changed to the terms typically used by the plan.

Best Practices. CMS encourages plans to institute procedures that support the ongoing accuracy of their provider directory. For example, plans can provide enrollees a hotline number to contact the plan for help in making appointments or to report directory errors. CMS also suggests as a best practice that plans incorporate a "warm transfer" for enrollees requesting help in finding a provider that is accepting new patients.

Also as a best practice, CMS encourages plans to incorporate the following elements into their directories, as practicable:

- Machine readable content
- Provider medical group
- Provider institutional affiliation
- Non-English languages spoken by provider
- Provider website address
- Accessibility for people with physical disabilities

[Plan Name]
[HMO / PPO / RPPO / Cost / PFFS / MSA] Plan
Provider Directory

This directory is current as of [Month DD, YYYY].

This directory provides a list of [Plan Name]'s current network providers.

This directory is for [provide a description of the plan's service area or geographic sub-set of service area that the directory is for.]

[For hardcopy directories, insert: To access [Plan Name]'s online provider directory, you can visit [Web address].] For any questions about the information contained in this directory, please call our [Customer/Member] Service Department at [phone number], [days and hours of operation]. [TTY/TDD] users should call [TTY or TDD number].

[Insert availability of alternate formats, in accordance with section 504 of the Rehabilitation Act of 1973 (45 CFR Part 84)]

Table of Contents

Section 1 – Introduction

This directory provides a list of [Plan Name]'s network providers. To get detailed information about your health care coverage, please see your Evidence of Coverage (EOC).

[Use this introduction section to describe how enrollees should use this directory (e.g., how to select a PCP if your plan uses PCPs, explain sub-networks or certain providers used in MA uniformity flexibilities, if applicable, and describe which types of providers require a referral). Please refer to the instructions beginning on page i for more information. Use, delete, or modify the following based on your plan type.]

[Insert this paragraph if applicable: You will have to choose one of our network providers listed in this directory to be your **P**rimary **C**are **P**rovider (PCP). Generally, you must get your health care services from your PCP.] [Explain PCP in the context of your plan type.]

[Full-network PFFS plans insert: We have network providers for all services covered under original Medicare [indicate if network providers are available for any non-Medicare covered services]. You may still receive covered services from out-of-network providers who do not have a signed contract with our plan, as long as those providers agree to accept our plan's terms and conditions of payment. You may visit our website at: [insert link to PFFS terms and conditions of payment] for more information about PFFS plan payments.] [Indicate whether this PFFS plan has established higher cost sharing requirements for enrollees who obtain covered services from out-of-network providers.]

[Partial-network PFFS plans insert: We have network providers for [indicate what category(ies) of services for which network providers are available]. You may still receive covered services from out-of-network providers who do not have a signed contract with our plan, as long as those providers agree to accept our plan's terms and conditions of payment. You may visit our website at: [insert link to PFFS terms and conditions of payment] for more information about PFFS plan payments.] [Indicate whether this PFFS plan has established higher cost sharing requirements for enrollees who obtain covered services from out-of-network providers.] [Note that in order to charge higher cost sharing when a PFFS enrollee obtains services from an out-of-network provider, the PFFS plan must meet current CMS network adequacy criteria for that specialty type.]

[Section 1876 Cost Plans must clearly explain that enrollees may use in-network and out-of-network providers and explain the benefit/cost sharing differentials between the use of in-network and out-of-network providers.]

The network providers listed in this directory have agreed to provide you with your [insert appropriate term(s): health care/vision/dental] services. You may go to any of our network providers listed in this directory [;/.] [Insert if applicable: however, some services may require a referral.] [Insert applicable details on referrals, per instructions beginning on page i.] [Insert, if applicable: Other providers are available in our network.] [Note: Modify the discussion in this section to reflect the access to services rules that apply to your plan type (e.g., HMO, PPO, etc.), such as closed panels, sub-networks, etc. If you do not require referrals, adjust the language appropriately. Please refer to the instructions beginning on page i for more information.]

[PFFS plans insert: [Plan Name] does not require enrollees or their providers to obtain a referral or authorization from our plan as a condition for covering medically necessary services that are covered by our plan. If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get the service or care.]

[PPO plans insert: Out-of-network providers are under no obligation to treat [Plan Name] enrollees, except in emergencies. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our [Customer/Member] Service Department at [phone number], [days and hours of operation]. [TTY/TDD] users should call [TTY or TDD number]. You may also refer to your Evidence of Coverage (EOC) for more information, including the cost sharing that applies to out-of-network services.]

[Include any out-of-network or point-of-service (POS) options as appropriate.]

[Include instructions to enrollees that, in cases where out-of-network providers submit a bill directly to the enrollee, the enrollee should **not** pay the bill but should submit it to the plan for processing and determination of enrollee liability, if any.]

[Include instructions informing enrollees that they may obtain emergency services from the closest available provider, and they may obtain urgently needed services from any qualified provider when out of the plan's service area or when network providers are unavailable.]

[HMO plans insert: You must use network providers except in emergency or urgent care situations [or for out-of-area renal dialysis or other services]. If you obtain routine care from out-of-network providers, neither Medicare nor [Plan Name] will be responsible for the costs.]

[PPO and POS plans must include information that, with the exception of emergencies, it may cost more to get care from out-of-network providers.]

What is the service area for [Plan Name]?

The ["county" or "counties"] [for Regional Preferred Provider Organizations (RPPOs) only: "state" or "states"] [for plans with a partial county service area only: parts of counties/zip codes] in our service area ["is" or "are"] listed below. [Optional: You may include a map of the area (in addition to listing the service area), and modify the prior sentence to refer readers to the map.]

[Insert plan service area listing. If approved for the entire county, use county name only. For approved partial counties, use county name and zip code (e.g., "county name, the following zip codes only: XXXXX…")].

How do you find [Plan Name] providers that serve your area?

[Plans should describe how an enrollee can find a network provider nearest his or her home relative to the organizational format used in the provider directory.] [Note: RPPO plans must fully describe how enrollees residing in any non-network areas of their plan can access covered services at in-network cost sharing.]

If you have questions about [Plan Name] [or require assistance in selecting a PCP], please call our [Customer/Member] Service Department at [phone number], [days and hours of operation]. [TTY/TDD] users should call [TTY or TDD number]. You can also visit [Web address].

Section 2 – List of Network Providers

[Show all current contracted network providers for each type of provider (e.g., PCP, specialist, hospital, etc.). Optional: You may include other provider types in addition to the required types on pages 7-12.]

[Recommended organization:

Type of Provider (PCPs, Specialists (types), Hospitals, Skilled Nursing Facilities, Outpatient Mental Health Providers, and Pharmacies (types) where outpatient prescription drugs are offered by the plan.)

State (Include only if directory includes multiple states)

County (Listed alphabetically)

City (Listed alphabetically)

Neighborhood/Zip Code (Optional: For larger cities, providers may be further subdivided by zip code or neighborhood)

Provider Name (Listed alphabetically)

Provider Details]

[Note: Plans that offer supplemental services (e.g., vision, dental) must choose to either include these network providers in a directory combined with PCPs, etc. or in a separate provider directory.]

[For Dual Eligible Special Needs Plans (D-SNPs) only: To assist dual eligible enrollees in obtaining access to providers and covered services, identify Medicare providers that accept Medicaid. Plans have the option to include a global statement at the beginning of the network provider listing section or to provide a Medicaid indicator next to each provider. The global statement should state: "All providers in this provider directory accept both Medicare and Medicaid." Inclusion of the global statement signifies a model directory without modification. Those plans that choose not to use a global statement need to place a Medicaid indicator next to each provider (e.g., an asterisk and an accompanying footnote for all Medicare providers that participate in Medicaid also.) Inclusion of a Medicaid indicator next to each provider signifies a non-model directory with modification.

[Full and partial network PFFS plans must indicate, for each type of provider, whether the plan has established higher cost sharing requirements for enrollees who obtain covered services from out-of-network providers.]

[Primary Care Providers (PCPs)]

[State]

[County]

[City]

[Zip Code]

[PCP Name]

[*If applicable:* Accepting New Patients? Yes/No]

[PCP Street Address, City, State, Zip Code]

[Phone number]

[*Optional:* website and e-mail addresses]

[*Optional:* Indicator for PCP(s) that support electronic prescribing]

[Specialists]
[Specialty Type]

[State]

[County]

[City]

[Zip Code]

[Specialist Name]

[*If applicable:* Accepting New Patients? Yes/No]

[Specialist Street Address, City, State, Zip Code]

[Phone number]

[*Optional:* website and e-mail addresses]

[*Optional:* Indicator for specialist(s) that support electronic prescribing]

[Hospitals]

[State]

[County]

[City]

[Zip Code]

[Hospital Name]

[Hospital Street Address, City, State, Zip Code]

[Phone number]

[*Optional:* website and e-mail addresses]

[*Optional:* Indicator for hospital(s) that support electronic prescribing]

[Skilled Nursing Facilities (SNFs)]

[State]

[County]

[City]

[Zip Code]

[SNF Name]

[SNF Street Address, City, State, Zip Code]

[Phone number]

[*Optional:* website and e-mail addresses]

[*Optional:* Indicator for SNF(s) that support electronic prescribing]

[Outpatient Mental Health Providers]

[State]

[County]

[City]

[Zip Code]

[Provider Name]

[*If applicable:* Accepting New Patients? Yes/No]

[Provider Street Address, City, State, Zip Code]

[Phone number]

[*Optional:* website and e-mail addresses]

[*Optional:* Indicator for provider(s) that support electronic prescribing]

[All plans have the choice to either (1) list information on both providers and pharmacies in one combined document; or (2) provide two separate documents: a provider directory and a pharmacy directory.

In the list of pharmacies (whether appearing in a combined or single document), plans must identify or include those pharmacies that provide Part B drugs, if applicable.

Note: Plans offering a Part D benefit, please refer to the Part D Model Pharmacy Directory for Part D requirements.]

[Pharmacies]

[Type of pharmacy as applicable: Retail, Mail Order, Home Infusion, Long Term Care (LTC), Indian Health Service/Tribal/Urban Indian Health (I/T/U)]

[State]

[County]

[City]

[Zip Code]

[Pharmacy Name]

[Pharmacy Street Address, City, State, Zip Code]

[Phone number]

[*Optional:* website and e-mail addresses]

[*Optional:* Indicator for pharmacy(ies) that support electronic prescribing]