

contract with the organization for CYs 2016 and 2017 absent circumstances warranting special consideration. An organization can, however, apply to contract with CMS in 2017 to operate in CY 2018. CMS understands that there are a variety of reasons that an organization may decide to terminate or to non-renew a contract, and subsequently want to re-enter the program. CMS will consider when circumstances warrant special consideration on a case-by-case basis.

CMS encourages organizations with questions about the applicability of the two-year prohibition to submit them to CMS's Non-Renew/Terminations mailbox located at: <https://dmao.lmi.org>.

Guidance to Verify that Networks are Adequate and Provider Directories are Current

42 CFR § 422.111 requires MAOs to disclose the provider directory; § 422.112 requires MAOs maintain and monitor the network of providers and to provide adequate access to covered services. Providers whose practices are closed or who are otherwise unavailable cannot be used to successfully meet our network adequacy standards. CMS has become aware of a range of issues with online provider directories. Recent provider and beneficiary complaints have highlighted problems with the accuracy of some MAO online provider directory information. For example, there have been complaints of directories including providers who are no longer contracting with the MAO, have retired from practice, have moved locations, or are deceased. Additionally, some provider directories contain the names of providers who, while still in the MAO's network, are not open and available to new patients, but are not identified as such. Therefore, CMS may view inaccurate provider directories as an indication that the MAO may be failing established CMS access standards.

In the draft Call Letter, we proposed new guidance on our regulatory requirements to ameliorate these issues. We received a number of comments from beneficiary advocacy organizations, professional associations and from the industry on these proposals, which are discussed below.

Beneficiary advocacy and some provider professional organizations were highly supportive of CMS efforts to redress problems with online provider directories and network adequacy standards. Overall, most commenters supported CMS's three-pronged approach to monitor compliance, and intent to consider instituting a requirement for MAOs to submit, and regularly update, network information to CMS in a standardized, electronic format for eventual inclusion in a nationwide provider database.

Most industry stakeholders who commented objected to the proposed guidance regarding online provider directories, stating that the requirements were unnecessary because they believe clear guidance currently exists in the Medicare Marketing Guidelines and there is no need to expand the guidance. These commenters stated that these requirements would result in undue added burden and administrative costs. A few commenters suggested that requirements for online directory updates should conform to those established for the Qualified Health Plans (QHPs) in the Marketplace. Additionally, they suggested that CMS take action to compel providers to notify MAOs of their status.

We firmly believe the provision of accurate provider information and verifying adequate access to covered services are essential protections for enrollees and help enrollees make educated decisions about their MA plan choices. We have carefully considered the comments and are finalizing the provisions as proposed with clarifications.

Over time, CMS will harmonize these policies with the requirements for QHPs to provide health plans with consistent rules across programs. As indicated in the preamble to the recent QHP final rule (80 FR 10830), QHPs in the Marketplace are required to update provider directories monthly. Consistent with those requirements, we clarify that MAOs are expected to update their online provider directories in real-time, which means MAOs are to make updates when they are notified of changes in a provider's status, or when the MAO itself makes contracting changes to its network of providers. Additionally, MAOs are expected to communicate with providers monthly regarding their network status.

CMS does not have the authority to require providers to notify MAOs of their current status. However, we strongly encourage providers to be responsive to MAO inquiries and to notify MAOs of changes in their status in a timely manner.

Consistent with the requirement of § 422.1(b) to maintain and monitor an adequate network, MAOs are expected to establish and maintain a proactive, structured process that enables them to assess, on a timely basis, the true availability of contracted providers which includes, as needed, an analysis to verify that the provider network is sufficient to provide adequate access to covered services for all enrollees. An effective process would include:

- Regular, ongoing communications/contacts (at least monthly) with providers to ascertain their availability and, specifically, whether they are accepting new patients, in addition to requiring contracted providers to inform the plan of any changes to street address, phone number, and office hours or other changes that affect availability; and
- Developing and implementing a protocol to effectively address inquiries/complaints related to enrollees being denied access to a contracted provider with follow through to make corrections to the online directory.

We are reinforcing that, in order for us to consider the MAO compliant with §§ 422.111 and 422.112, MAOs must include in their online provider directories all active contracted providers, with specific notations to highlight those providers who are closed or not accepting new patients.

We will initiate a three-pronged approach to monitor compliance with the regulations, including:

- 1) Direct monitoring. We have secured additional contractor funding to verify the accuracy of MAOs' online provider directories.
- 2) Development of a new audit protocol. A new audit protocol will be tested in CY 2015 to further enhance our oversight of the validity and accuracy of MAOs' online directories as well as the availability and accessibility of network providers and whether the lack of

availability and accessibility may impact a plan's ability to meet provider network adequacy standards.

- 3) Compliance and/or enforcement actions. MAOs that fail to maintain complete and accurate directories may be subject to compliance and/or enforcement actions, including civil money penalties or enrollment sanctions. MAOs whose network adequacy is not met because of failure to have a sufficient number of providers open and accepting new patients may also be subject to such actions.

In addition, CMS is considering, beginning on or after CY 2017, instituting a new regulatory requirement for MAOs to provide, and regularly update, network information in a standardized, electronic format for eventual inclusion in a nationwide provider database. This approach would build upon other Departmental efforts, including pursuit of similar requirements for QHPs in the Health Insurance Marketplace. CMS's goal in this effort would be to make provider network data readily available to beneficiaries, stakeholders, and the public in a uniform format, based on the best available consensus-based standards that would be required by CMS. CMS anticipates that a common format and standard would enable greater interoperability across provider directories and more up-to-date information in provider directories maintained by health plans, at a state level, and in national databases such as the National Plan and Provider Enumeration System. Standardized provider directories would serve as a useful tool to search for individual providers and determine, on a readily-accessible, provider-specific basis, every MA plan for which a specific provider is currently contracted. We believe this approach could also be leveraged by application developers to create user-friendly search applications that will be more accessible, up-to-date, and useful for consumers than the current, non-standardized websites or printed provider directories. This approach would enhance the transparency of provider networks, and enable beneficiaries to make informed decisions about their health care coverage.

Guidance for Off-cycle Submission of Summaries of MOC Changes

CMS continues to emphasize the importance of the SNP MOC as a fundamental component of the SNP quality improvement framework. See §§ 422.101 and 422.152(g). In order to more effectively address the specific needs of its enrollees, a SNP may need to modify its processes and strategies for providing care during the course of its MOC approval timeframe. CMS indicated in the CY 2015 Call Letter that it would establish a mechanism by which SNPs could notify CMS when they make revisions to their approved MOC.

Based on our experience, we expect that such submissions will be relatively rare. During each of the past few years, very few SNPs have contacted CMS about the need to make MOC changes during an approval cycle and we do not anticipate this new process will result in a higher incidence of such MOC changes. Only relatively unusual circumstances require SNPs to make changes to their MOCs that are so significant that notification of CMS is warranted.