Contract Year 2024 Medicare Advantage and Section 1876 Cost Plan Provider Directory Model and Instructions

*Issued: May 24, 2023*

**Introduction**

This guidance applies to Medicare Advantage (MA) organizations for all network-based MA plans and to organizations offering cost plans under section 1876 of the Social Security Act (the Act).[[1]](#footnote-2) We refer to these entities generally as “plans” throughout this document.

**Content requirements.** Through a provider directory, plans must provide the number, mix, and distribution (addresses) of providers from whom enrollees may reasonably be expected to obtain Medicare-covered items and services.[[2]](#footnote-3) Beginning with contract year 2024, plans must also include in their provider directory each provider’s cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider’s office.[[3]](#footnote-4) Plans must furnish provider directory information to each enrollee in a clear, accurate, and standardized form.[[4]](#footnote-5) Plans must also have and follow written policies and procedures for the evaluation and credentialing of providers who participate in the network, both initially and at regular intervals.[[5]](#footnote-6) In developing their provider directory (a model communications material), plans must adhere to the general requirements for communications, comply with the standards for required materials and content, and may deviate from the provider directory model so long as they accurately convey the required information and follow the order of content specified by CMS.[[6]](#footnote-7) Plans must include a Standardized Material Identification (SMID) in their provider directory.[[7]](#footnote-8)

**Delivery requirements.** Plans must deliver their provider directory to *current* enrollees by October 15 prior to the beginning of the plan year and upon request, within three business days of the request. Plans must deliver their provider directory to *new* enrollees within the ten calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever is later.[[8]](#footnote-9)

Plans must adhere to the requirements for permitted electronic delivery of their provider directory, and must post both printable and searchable versions of their provider directory on their website (the printable version by October 15 prior to the beginning of the plan year).[[9]](#footnote-10) The online provider directory must be searchable by every element required in the provider directory model, including name, location, specialty, phone number, and the cultural and linguistic capabilities of the provider. When applicable (that is, for MA-PD plans), plans must post a searchable pharmacy directory combined with a provider directory.[[10]](#footnote-11)

**Update requirements.** Plans must update their provider directory any time they become aware of changes, and updates must be completed within 30 days of receiving information requiring update. Also, plans must complete updates to hardcopy provider directories within 30 days, but hard copy directories that include separate updates via addenda are considered up-to-date.[[11]](#footnote-12)

**API requirements.** Plans must also implement and maintain a publicly accessible, standards-based Application Programming Interface (API) for their provider directory, which must conform with the applicable technical requirements and documentation requirements, be accessible on the plan website, and be updated no later than 30 calendar days after receiving information or updates.[[12]](#footnote-13) A plan’s API must include all of the information that this Provider Directory Model describes as required for the provider directory.[[13]](#footnote-14) For more information, please see <https://www.cms.gov/regulations-and-guidance/guidance/interoperability/index#P_Directory>.

**Accessibility & Translation requirements.**[[14]](#footnote-15) Plans must furnish their provider directory in an accessible format where necessary to individuals with disabilities to ensure an equal opportunity. Plans must also translate their provider directory into any non-English language that is the primary language of at least 5 percent of the individuals in a service area; fully integrated dual eligible (FIDE) special needs plans (SNPs), highly integrated dual eligible (HIDE) SNPs, and applicable integrated plans must also translate their provider directory into the language(s) required by the Medicaid translation standard as specified through their capitated Medicaid managed care contract. Plans must also furnish their provider directory in an accessible format or non-English language on a standing basis.[[15]](#footnote-16)

**Instructions**

The following instructions, guidance, and the Provider Directory Model template apply to all **hardcopy and online** provider directories produced by all network-based MA plans[[16]](#footnote-17) and section 1876 cost plans. **The model template is provided in this document beginning on page 1**. All variable fields to be populated with plan-specific information on current network providers are denoted by gray highlighted text and brackets. Any instructions containing the word “must” (here and in the model template) indicate required information. Plans should refer to these instructions, and the regulations cited above as necessary, in completing the provider directory.

**Provider Listings.**

***To ensure that the required information about providers is provided in a clear, accurate, and standardized form, plans must:***

* List only currently contracted and credentialed providers.
* 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. Clearly explain this information in the directory.
* Identify the providers and/or services for which an enrollee must obtain a referral, or explain where this information can be found.
* Indicate each provider’s cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider’s office.
* List only the office or practice location(s) where the provider regularly practices and is regularly available to provide covered services.
* List non-physician practitioners (e.g., nurse practitioners, physician’s assistants) as “Primary Care Providers (PCPs)” (see page 7) only if an enrollee can make an appointment with that practitioner for covered primary care services. Clearly identify that the provider is a non-physician practitioner.
* 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. Plans may identify providers who are/are not accepting new patients in any manner (i.e., “Accepting New Patients? Yes/No” or an “\*” with a footnote), so long as beneficiaries can determine those providers from whom they may reasonably expect to obtain services.
* Clearly identify the capacity in which the provider is serving for that particular network (i.e., specialty and/or sub-specialty), 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. List the provider only under the category of the services they will be furnishing to enrollees as an in-network provider.
* Make reasonable attempts 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.
* Indicate providers who may have restrictions on access by including 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 only offer home visits and do not see patients at a physical office location (Note: Plans should also exclude a specific street address from the provider’s listing but still list the provider underneath the appropriate provider type, state, county, city, and neighborhood/zip code per the model document below);
  + Providers (or provider practices) that offer services exclusively via telehealth (those accessible through a downstream contracted telehealth company or similar downstream entity should be listed as such);
  + Providers and/or locations that are not accessible for people with physical disabilities (e.g., lack of availability of ramps, elevators, and accessible medical equipment);
  + Providers who will be available in-network only for a certain period (e.g., as of a future date) or who will leave the network as of a specified date, and provide a clear indication of the time limitation (such as “beginning XX, X, 20XX” or “until XX, X, 20XX”).

***Plans may not:***

* List a provider prior to the provider being credentialed by the plan.
* List a provider if the enrollee cannot call the phone number listed and request an appointment with that provider at the address listed (e.g., urgent care, on-call, fill-in/substitute providers).
* List locations where a provider may practice only occasionally (e.g., filling in for other providers who are sick or on vacation).

**Appointment Wait Time Standards.**[[17]](#footnote-18) MA plans are required to maintain written standards for timeliness of access to care (i.e., appointment wait times) that meet or exceed CMS’s standards. The MA plan’s written standards for appointment wait times for primary care and behavioral health services must meet or exceed the minimum standards as follows:

* Urgently needed services or emergency—immediately;
* Services that are not emergency or urgently needed, but the enrollee requires medical attention—within 7 business days; and
* Routine and preventive care—within 30 business days.

Plans must indicate their appointment wait time standards for primary care and behavioral health services in their provider directory. Plans may include this information as a general rule applicable to primary care and behavioral health provider types in the Introduction section (see page 3).

**Sub-Networks.** Plans offering sub-networks may develop a separate provider directory for each sub-network or note which providers are part of a sub-network in the provider directory. The sub-network directory must clearly state that enrollees are not limited to the providers listed in the sub-network directory and must provide instructions on how to access the plan’s entire provider network (including a link for the larger online directory). The sub-network directory must also describe how enrolleesmay request access to providers outside of the sub-network. For more information on sub-networks, please refer to the Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance, located at: <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html>.

**Plans with Limited or Specific Networks/Provider-Specific Plans.** Organizations may use one directory for multiple plans so long as the information in the directory is accurate for all plans for which the directory is used. Plans that use a different or limited network, such as a subset of the network used for other plans offered by the organization, must develop and issue a separate directory that clearly identifies available providers.Examples of plans of this type are provider-specific plans (PSPs), which must develop and issue separate directories for 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, eliminate, or tier cost sharing of medical benefits 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 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. See the Medicare Managed Care Manual, chapter 4, section 50.1 for additional guidance on tiered cost sharing of medical benefits.

**Typical Alterations.** The following are typical alterations that plans make to the model:

* Making minor edits as necessary (e.g., grammatical or punctuation changes, correcting references).
* Changing the formatting/style (e.g., font, margins) to meet regulatory requirements and other guidance.
* Adding additional data elements.
* Adding plan logos.
* 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 of those terms is already used in the model.
* Changing references to other plan materials (e.g., Evidence of Coverage) to the terms typically used by the plan.
* Deleting instructions to plans when populating the model.

**Best Practices.** CMS strongly 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” to a provider’s office line when enrollees requesting help in finding a provider that is accepting new patients.

CMS also encourages plans to incorporate the following information about providers into the provider directory, as practicable:

* Provider’s website and e-mail address
* Provider’s ability to support electronic prescribing
* Provider’s medical group and/or institutional affiliation
* Provider’s telehealth capabilities
* Provider’s expertise in treating patients with opioid use disorder (OUD) (e.g., prescribers of medications for OUD, addiction specialists, Opioid Treatment Programs (OTPs))

**[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 for [provide a description of the plan’s service area or geographic sub-set of service area that the directory covers.]

[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 [toll-free number], [days and hours of operation]. [TTY/TDD] users should call [TTY or TDD number].

[For online directories, as a best practice, insert: To request a hard copy of [Plan Name]’s provider directory, please call our [Customer/Member] Service Department at [toll-free number], [days and hours of operation]. [Plan Name] will mail a hard copy of the provider directory to you within three (3) business days of your request. [Plan Name] may ask whether your request for a hard copy is a one-time request or if you are requesting to receive the provider directory in hard copy permanently.

If you request it, your request for hard copies of the provider directory remains until you leave [Plan Name] or request that hard copies be discontinued.]

You can get this information for free in other formats, such as large print, braille, or audio. Call our toll-free number at [toll-free number]*.*

[For plans that meet the 5% non-English language threshold, the plan should include: This document is available for free in [insert languages that meet the 5% threshold].]

[For FIDE SNPs, HIDE SNPs, and applicable integrated plans that meet the language threshold required by the Medicaid translation standard as specified through their capitated Medicaid managed care contract, the plan should include: This document is available for free in [insert languages that meet the applicable threshold].]

[As a best practice and as applicable, plans should include: Your request for the provider directory in an accessible format or language will be applied on a standing basis unless you request otherwise.]

[SMID]

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## Section 1 – Introduction

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

[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 iii 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 the 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.] [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.]

[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 [toll-free 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 should 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.).]

[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 benefits (e.g., vision, dental) must furnish a provider directory for those benefits but may choose to either include these network providers in a directory combined with PCPs, etc. or in a separate provider directory.]

[Note for Dual Eligible Special Needs Plans (D-SNPs) only: To assist dual eligible enrollees in obtaining access to providers and covered services, D-SNPs must 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 model global statement is: “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 should 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]

[*Required:* cultural and linguistic capabilities (e.g., languages spoken, languages offered, interpreter/translation services offered, sensitivity to cultural health beliefs/practices)]

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

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

[*Optional:* medical group and/or institutional affiliation]

[*Optional:* telehealth capabilities]

[*Optional:* expertise in treating patients with OUD]

### [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]

[*Required:* cultural and linguistic capabilities (e.g., languages spoken, languages offered, interpreter/translation services offered, sensitivity to cultural health beliefs/practices)]

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

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

[*Optional:* medical group and/or institutional affiliation]

[*Optional:* telehealth capabilities]

[*Optional:* expertise in treating patients with OUD]

### [Hospitals]

[State]

[County]

[City]

[Zip Code]

[Hospital Name]

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

[Phone number]

[*Required:* cultural and linguistic capabilities (e.g., languages spoken, languages offered, interpreter/translation services offered, sensitivity to cultural health beliefs/practices)]

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

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

[*Optional:* medical group and/or institutional affiliation]

[*Optional:* telehealth capabilities]

[*Optional:* expertise in treating patients with OUD]

### [Skilled Nursing Facilities (SNFs)]

[State]

[County]

[City]

[Zip Code]

[SNF Name]

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

[Phone number]

[*Required:* cultural and linguistic capabilities (e.g., languages spoken, languages offered, interpreter/translation services offered, sensitivity to cultural health beliefs/practices)]

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

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

[*Optional:* medical group and/or institutional affiliation]

[*Optional:* telehealth capabilities]

[*Optional:* expertise in treating patients with OUD]

### [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]

[*Required:* cultural and linguistic capabilities (e.g., languages spoken, languages offered, interpreter/translation services offered, sensitivity to cultural health beliefs/practices)]

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

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

[*Optional:* medical group and/or institutional affiliation]

[*Optional:* telehealth capabilities]

[*Optional:* expertise in treating patients with OUD]

### [Pharmacies]

[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 (available at <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Materials>) for Part D requirements for pharmacy directories.]

[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 address]

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

1. Unless otherwise noted, all regulation cites are to title 42 of the Code of Federal Regulations (CFR). Per 42 CFR §§ 417.427 and 417.428, the disclosure (§ 422.111) and marketing and communications (Part 422, subpart V, §§ 422.2260 through 422.2276) apply to cost plans offered pursuant to contracts under section 1876 of the Act. [↑](#footnote-ref-2)
2. See § 422.111(b)(3)(i); plans must also provide information on the conditions and limitations on benefits coverage, such as prior authorization (§ 422.111(b)(7)) and access to out-of-network providers (§ 422.111(b)(3)). [↑](#footnote-ref-3)
3. § 422.111(b)(3)(i); Medicare Program; 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 Final Rule ([88 FR 22120](https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program) [Apr. 12, 2023]). [↑](#footnote-ref-4)
4. §§ 422.111(a)(2) and 422.2267(e)(11) [↑](#footnote-ref-5)
5. §§ 422.202 and 422.204. Plans should review §§ 422.200 through 422.224 for additional requirements as to the type of provider that may be paid by the plan to furnish covered benefits. [↑](#footnote-ref-6)
6. §§ 422.2262 and 422.2267(a) and (c) [↑](#footnote-ref-7)
7. § 422.2262(d) [↑](#footnote-ref-8)
8. § 422.2267(e)(11)(i)-(iii) [↑](#footnote-ref-9)
9. §§ 422.2267(d); 422.111(h)(2)(i)-(ii); 422.2265(b)(3)-(4); 422.2265(c)(1)(iv)-(v) [↑](#footnote-ref-10)
10. § 422.2265(b)(4)-(5) [↑](#footnote-ref-11)
11. § 422.2267(e)(11)(iv) [↑](#footnote-ref-12)
12. §§ 422.120 and 422.119(c) and (d) [↑](#footnote-ref-13)
13. §§ 422.111(b)(3)(i) and 422.2267(e)(11); [85 FR 25536](https://www.govinfo.gov/content/pkg/FR-2020-05-01/pdf/2020-05050.pdf) [↑](#footnote-ref-14)
14. MA organizations and Part D sponsors must comply with Section 504 of the Rehabilitation Act of 1973 and section 1557 of the Affordable Care Act, and the Department of Health and Human Services implementing regulations at 45 CFR parts 84 and 92. As recipients of federal financial assistance, MA organizations and Part D sponsors must provide appropriate auxiliary aids and services, including interpreters and information in alternate formats, to individuals with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from the service in question. Auxiliary aids and services can include braille, large print, data/audio files, relay services, and TTY communications. These instructions are not a full description of plans’ obligations under these laws, and plans should review the regulations at 45 CFR parts 84 and 92 as well. See also § 422.2260 defining “alternate format.” [↑](#footnote-ref-15)
15. § 422.2267(a)(3)-(4) [↑](#footnote-ref-16)
16. The term “network-based plan” is currently defined in § 422.114(a)(3)(ii). CMS proposed to add the definition of the term “network-based plan” to § 422.2 in the December 2022 notice of proposed rulemaking, “Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specification” ([87 FR 79452](https://www.govinfo.gov/content/pkg/FR-2022-12-27/pdf/2022-26956.pdf) [Dec. 27, 2022]). However, that proposal has not been finalized as of the date of this guidance. [↑](#footnote-ref-17)
17. § 422.112(a)(6) [↑](#footnote-ref-18)