DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMD # 18-007

RE: 21st Century Cures Act Section 5006 Compliance – Provider Directories

July 17, 2018

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is issuing this State Medicaid Director (SMD) letter to provide sub-regulatory guidance on compliance with Section 5006 of the 21st Century Cures Act (Cures Act), entitled "Requiring Publication of Fee-for-Service Provider Directory," and on states' receiving enhanced federal financial participation (FFP) for such systems per existing guidance.

Section 5006 of the Cures Act amended § 1902(a) of the Social Security Act (the Act) to add a new subparagraph (a)(83), requiring each state that provides medical assistance under a state plan or waiver on a fee-for-service basis or through a primary care case-management system to publish a provider directory on the public website of the state agency administering the plan not later than January 1, 2017, and to update this directory at least annually. The requirements of Section 5006 of the Cures Act do not apply to states where all individuals enrolled in Medicaid under a state plan or a waiver, with some exceptions, are enrolled in Medicaid managed care plans for all of their services. States should reach out to their CMS regional office to discuss compliance with Section 5006 of the Cures Act.

As states assess how to implement provider directories that comply with the requirements of Section 5006 of the Cures Act, states can also consider how those provider directories can support broader efforts to reduce provider burden, improve interoperability, and promote the objectives of the MyHealthEData Initiative,[1] which provides patients greater flexibility to access and share their health data. States can also consider issues that are prevalent among Medicaid patients, including the issue of Medicaid patients moving often between multiple care settings.

Provider directories published by State Medicaid agencies can help some Medicaid beneficiaries find out if a provider is accepting new patients, which can help improve access to care. And, with thoughtful implementation, such provider directories could help reduce provider burden and improve interoperability. As Medicaid patients often move between multiple care settings, a more dynamic provider directory that has functionalities beyond a list of providers might also work with a master person index or master client index to coordinate care by exchanging clinical information in a manner which supports the objectives of the MyHealthEData Initiative.. Further, linking identity proofing and care coordination technologies to rules engines that allow a Medicaid patient to direct how his or her data is shared further advances the objectives of MyHealthEData.

[1] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-03-06.html

In considering how to build or modify provider directories to comply with the requirements of Section 5006 of the Cures Act, CMS emphasizes the importance of reuse in the Medicaid Information Technology Architecture (MITA) as discussed in detail in SMD # 18-005, "Mechanized Claims Processing and Information Retrieval Systems – Reuse. SMD # 18-005 advises that states should, as appropriate, leverage or build upon existing federal investments supported by the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009. Provider directories have historically been considered a credentialing source of truth for payers in verifying a provider's licensure, board certification, sanctions, etc. In recent years, as states have invested more in systems capable of coordinating care across providers, provider directories are, in many cases, also supporting connections between providers by allowing providers to exchange structured data supporting transitions of care, including summaries of care, discharge summaries, problem lists, medication histories, bi-directional connections to public health for reporting and alerting, etc. Provider directories that are part of health information exchanges outside of state government may provide the data to support this section and should be considered by states as they consider their efforts to meet the requirements of Section 5006 of the Cures Act, so long as the provider directory is also published on the public website of the state agency, particularly if such health information exchanges have previously been supported by HITECH funds.

States may have made investments in provider directories that are also exchanging clinical data or helping coordination of care or public health reporting in a number of ways, which might help states align with MITA business processes in support of Medicaid patients and providers, and advance Medicaid enterprise systems development in accordance with the MITA maturity model, including systems interoperability via an Application Program Interface (API) or enterprise service bus-enabled integration hub. Provider directories exchanging clinical data are potentially aligned with case management business processes.[2] MITA supported Case Management[3]is eligible for FFP at enhanced levels when submitted as part of an Advanced Planning Document defining the scope of the business processes that benefit Medicaid, i.e. activities that support the efficient and cost-effective administration of the Medicaid program. Additionally, for enhanced Medicaid Management Information System (MMIS), Eligibility and Enrollment (E&E), and HITECH funding, cost allocation with other entities accruing benefit is still required.

To facilitate compliance with the requirements of section 5006 of the Cures Act, a sample Medicaid State plan amendment preprint that states can reference is included as Enclosure A. States, particularly those that are planning to come into compliance with the requirements of section 5006 of the Cures Act or may need state legislation to be enacted in order to come into compliance with the requirements of Section 5006 of the Cures Act, should reach out to their CMS regional offices to discuss compliance. Enclosure B discusses optional and required pieces of information to be included in such a provider directory, which CMS refers to as data elements.

[2] Guidance regarding the "Case Management" business process are located in .zip files located at https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html. See page 18 of the file named, "MITA 3.0 Part 1" for the details on "Establish Case."

We remind states that Title II of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act require states as covered entities to ensure that their programs and activities provided through electronic and information technology, such as state websites, be accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the program or activity. States should consider following the widely accepted industry standard for web accessibility in the Web Content Accessibility Guidelines (WCAG) 2.0.

Interoperability

This SMD letter is issued to be consistent with the objectives described in the Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10) final rule (80 FR 75817). States should also consider aligning any resulting efforts with Section 4003 of the Cures Act, entitled "Interoperability."

Provider directories have the ability to support the MyHealthEData Initiative by creating a system by which a patient's health information may follow him or her from provider to provider. Provider directories as described in Section 5006 of the Cures Act and components of the state enterprise such as case management systems, registries, or care coordination platforms, are increasingly likely to support health information exchange and interoperability, often serving as a hub where Medicaid providers coordinate care. States are reminded that 42 CFR § 433.112(b)(16) was amended in the Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10) final rule (80 FR 75817), to state that "[t]he system supports seamless coordination and integration with the Marketplace, the Federal Data Services Hub, and allows interoperability with health information exchanges, public health agencies, human services programs, and community organizations, providing outreach and enrollment assistance services as applicable."

States have the support of CMS to use enhanced FFP to integrate provider directories, fee-for-service or otherwise, and master person indexes in a manner that supports the MyHealthEData Initiative goals that encourage self-directed data exchange in a manner consistent with 42 CFR Part 433. A state may consider leveraging such support to create a consent registry layer supporting the goals of the MyHealthEData Initiative, as well as data segmentation concerns related to the regulations at 42 CFR Part 2 regarding the confidentiality of substance use disorder records, or the consent components of Section 4003 of the Cures Act. These efforts can be aligned with business process described in MITA, specifically, "Advocating for the member," as a function of, "Manage Case Information[4]." States should consider whether the provider directories constructed for Section 5006 of the Cures Act, or any other components of the Medicaid enterprise (e.g., record locator services connecting human services and public health, disease management platforms, data tools for identifying special populations or special needs, etc.), might help a state support Case Management business processes described within the Case Management business area of MITA 3.0[5]. The Case Management business processes require

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[4] Guidance regarding the "Manage Case Information" business process are located in .zip files located at https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html. In the MITA 3.0 Part 1 .zip file, see page 21 of the "Part I – Business Architecture – Appendix C – Business Process Model Details" .pdf document for the details on "Manage Case Information."

[5] https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html

integrating many data sources to facilitate care coordination, as well as interoperability with human services and appropriate public health registries. As states look to add new systems in order to comply with the requirements of Section 5006 of the Cures Act, or to meet the Case Management requirements in MITA 3.0, states are reminded of SMD # 18-005 and the emphasis on reusability of state systems, including systems originally supported by HITECH funds, described in SMDL# 16-003[6] and the reuse of those systems as described in SMDL# 18-005[7]. As states move closer to quality based reimbursement or states exercise greater flexibility in program design, CMS expects that more states will invest in Case Management business processes, including for provider directories made in order to comply with the requirements of Section 5006 of the Cures Act that connect to the state via an API or other means.

In supporting care coordination via provider directories and MyHealthEData, a state may also leverage the enhanced match in building and operationally supporting interoperability networks as described in MITA as "Establish Business Relationship," which states:

"The Establish Business Relationship business process encompasses activities undertaken by the State Medicaid Agency (SMA) to enter into business partner relationships. Agreements are between state agency and its partners, including collaboration amongst intrastate agencies, the interstate and federal agencies. It contains functionality for interoperability, establishment of inter-agency service agreements, identification of the types of information exchanged, and security and privacy requirements. These include Trading Partner Agreements (TPA), Service Level Agreements (SLA), and Memoranda of Understanding (MOU) with other agencies; Electronic Data Interchange (EDI) agreements with providers, Managed Care Organizations (MCOs), and others; and Centers for Medicare & Medicaid Services (CMS), other federal agencies, and Regional Health Information Organizations (RHIO)[8]," which could include any state investments in supporting Section 4003 of the Cures Act, both in terms of the design, development and implementation of such connections as well as the maintenance and operations of such connections.

States are also reminded of the importance of complying with industry standards as a condition of receiving FFP under MITA. 42 CFR § 433.112(b) lists the conditions that need to be met for CMS to approve the E&E or claim system. Specifically, CMS reminds states that "[t]he agency ensures alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator [ONC] for Health IT in accordance with 45 CFR part 170, subpart B . . ."

States are also encouraged to consider ongoing efforts at multi-payer alignment on provider directory architecture and business rules, as stewarded by the ONC. States are encouraged to review this ongoing work and participate here[9]. Provider directories are increasingly needed to support advanced patient and provider attribution models for state innovations in delivery system reform. Other use cases to consider with provider directory design or procurement might include

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[6] https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16003.pdf

[7] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18005.pdf

[8] Guidance regarding the "Establish Business Relationship" business process are located in .zip files located at https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html. In the MITA 3.0 Part 1 .zip file, see page 21 of the "Part I – Business Architecture – Appendix C – Business Process Model Details" .pdf document for the details on "Establish Business Relationship."

[9] https://oncprojectracking.healthit.gov/wiki/display/TechLabSC/HealthCare+Directory

network adequacy review, bidirectional connections to public health, or revenue cycle management initiatives. The diversity of use cases captured by this workgroup participation is encouraged. Similarly, states considering provider directories, for fee for service and otherwise that link to patient-facing systems should consider leveraging the BlueButton 2.0 API[10] to facilitate greater interoperability.

As key components of identity management solutions and shared services, provider directories can have wide application across the state Medicaid enterprise, and should advance the integration of key Medicaid systems including the MMIS, E&E system, and solutions promoting health information exchange. Provider directories and other identity management solutions (including master person indexes) are critical to ensuring the effective and secure exchange of patient health and other sensitive information across the Medicaid enterprise and other human services organizations. In coordination with other MITA-aligned modules, shared services, and technical architecture components, provider directories facilitate an enterprise approach, where individual processes, modules, systems, and sub-systems are interoperable and work together seamlessly and transparently to support a unified Medicaid enterprise.

Consistent with the modularity standard described in SMD # 16-110[11], as well as the final rule cited previously and subsequent CMS sub-regulatory guidance promoting modularity in development and operations of Medicaid systems, provider directories and associated enterprise identity management solutions should harmonize with state efforts to implement discrete, independent, interoperable modules and other components to support the state Medicaid "system of systems" environment. Finally, provider directories can have a role in emerging state efforts to integrate clinical and administrative data, thereby enhancing visibility into the connection between services provided across health and human service agencies, and beneficiary health outcomes.

Provider Training

States are reminded that Appendix A of SMDL# 16-004 describes the 90 percent FFP for planning mechanized claims processing and information retrieval systems under section 1903(a)(3) of the Act, as well as several instances of 75 percent FFP for provider support, which might help in reducing provider burden with thoughtful training and outreach to help Medicaid providers with new system operation. As Medicaid providers are being introduced to new systems, including but not limited to a provider directory required by Section 5006 of the Cures Act, workflow analysis, business process modeling, and other sorts of thorough training might be required for meaningful on-boarding. As states attempt to align various quality reporting programs, CMS notes that this training support could prove helpful in easing provider burden by helping Medicaid providers in their on-boarding to quality reporting systems, as well as provider directories or other systems performing the Case Management business processes in MITA 3.0.

As Medicaid technology continues to evolve into more nimble and efficient modular systems, considerations for state approaches supporting the same are critical to meeting the needs of Medicaid patients and providers. As states consider their compliance with Section 5006 of the

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[10] https://bluebutton.cms.gov/
[11] https://www.medicaid.gov/federal-policy-guidance/downloads/smd16010.pdf

Cures Act, a careful review of what options might leverage or reuse existing federal investments is encouraged.

Sincerely,

Timothy Hill
Acting Director

cc:
National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State Territorial Health Officials
Council of State Governments
National Conference of State Legislatures
Academy Health

Enclosure A

State: ____________________________

Date: ____________________________

21ST CENTURY CURES ACT – Section 5006:

“Requiring Publication of Fee-for-Service Provider Directory”

☐ State is in compliance with the requirements of Section 5006 of the 21st Century Cures Act.

☐ State will be in compliance with Section 5006 of the 21st Century Cures Act by ________.

☐ State Plan’s managed care coverage exempts this state from the requirements of Section 5006 of the 21st Century Cures Act.

☐ State would potentially need to enact legislation to comply with Section 5006 of the 21st Century Cures Act and will discuss compliance with CMS.

Enclosure B - Data Elements

Section 5006(a) of the 21st Century Cures Act (Cures Act), by adding a new Section 1902(a)(83) to the Social Security Act (the Act), requires "in the case of a State plan (or waiver of the plan) that provides medical assistance on a fee-for-service basis or through a primary care case-management system described in section 1915(b)(1) (other than a primary care case management entity (as defined by the Secretary)), the State shall publish (and update on at least an annual basis) on the public website of the State agency administering the State Plan, a directory of the physicians described in section 1902(mm) of the Act and, at State option, other providers described in such subsection."

Section 5006(a) of the Cures Act lists certain pieces of information, which CMS refers to below as "data elements," that such provider directories are either required to include or may be included at State option. Section 5006(b) of the Cures Act adds a new Section 1902(mm) of the Act, which sets forth who are "directory physicians or providers."

Data Element	**Fee For Service Physician**	**Fee for Service Other Provider**	**Primary Care Case Management System Physician**	**Primary Care Case Management System Other Provider**
The name of the physician or provider	Required	At State Option, CMS Recommends	Required	At State Option, CMS Recommends
The specialty of the physician or provider	Required	At State Option, CMS Recommends	Required	At State Option, CMS Recommends
The address at which the physician or provider provides services	Required	At State Option, CMS Recommends	Required	At State Option, CMS Recommends
The telephone number of the physician or provider	Required	At State Option, CMS Recommends	Required	At State Option, CMS Recommends
Whether the physician or provider is accepting as new patients individuals who receive medical assistance under this title	At State Option, CMS Recommends	At State Option, CMS Recommends	Required	At State Option, CMS Recommends
The physician's or provider's cultural and linguistic capabilities, including the languages spoken by the physician or provider or by the skilled medical interpreter providing interpretation	Not Specified, CMS Recommends	Not Specified, CMS Recommends	Required	At State Option, CMS Recommends

Data Element	Fee For Service Physician	Fee for Service Other Provider	Primary Care Case Management System Physician	Primary Care Case Management System Other Provider
services at the physician's or provider's office[1]				
The Internet website of such physician or provider	At State Option, CMS Recommends	At State Option, CMS Recommends	At State Option, CMS Recommends	At State Option, CMS Recommends

[1]This is not specified in the statute but whether the physician or provider offers accessibility features to patients with disabilities and/or limited mobility, including ADA compliant facilities, and/or accessible examination and/or medical diagnostic equipment should be consistent with Section 510 of the Rehabilitation Act as appropriate (https://www.access-board.gov/). States should also consider including whether a provider provides effective communication to individuals with disabilities and auxiliary aids and services, including sign language interpreters, when necessary for effective communication,