DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SHO #24-003

RE: Consolidated Appropriations Act, 2023 Amendments to Provider Directory Requirements

July 16, 2024

Dear State Health Official:

On December 29, 2022, the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) was enacted.[1] The Centers for Medicare & Medicaid Services (CMS) is issuing this State Health Official (SHO) letter to provide guidance on requirements and expectations for compliance with Division H, Title V, Section 5123 (hereinafter Section 5123) of the CAA, 2023, entitled "Requiring Accurate, Updated, and Searchable Provider Directories," taking effect on July 1, 2025, which modified sections 1902(a)(83) & (mm), 1932(a)(5), and 2107(e)(1)(G) of the Social Security Act (the Act).[2]

State Medicaid Director Letter # 18-007 previously provided details on how provider directories can support broader efforts to reduce provider burden, improve interoperability, and improve Medicaid beneficiary access to health care services.[3]

This SHO letter specifically addresses:

- Changes to Provider Directory data requirements and features resulting from Section 5123 of the CAA, 2023;
- Availability of enhanced federal financial participation (FFP) for Medicaid fee-for-service Provider Directory development and operations;
- Non-Compliance: Corrective action plan requirements for reapproval of Medicaid Systems; and
- Returning to compliance and requesting reapproval of Medicaid Systems.

[1] https://www.congress.gov/117/plaws/publ328/PLAW-117publ328.pdf.
[2] Hereinafter, all references to the Act refer to the version effective July 1, 2025, unless otherwise noted.
[3] https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/smd18007_27.pdf.

Definitions

***Provider Directory* –** A searchable directory of providers published on a public website.[4]

***Provider Directory Application Programming Interface (API)* –** A publicly accessible, standards-based API that conforms with the technical requirements at 42 CFR 431.60(c), excluding the security protocols related to user authentication and authorization and any other protocols that restrict the availability of this information to particular persons or organizations, and that is accessible via a public-facing digital endpoint.[5]

***Network Provider* –** Any provider, group of providers, or entity who has a Network Provider agreement with a managed care organization (MCO), a prepaid inpatient health plan (PIHP), a prepaid ambulatory health plan (PAHP), or a primary care case management entity (PCCM entity) as defined in 42 CFR 438.2 or a subcontractor of any such entity or plan, and receives Medicaid or Children's Health Insurance Program (CHIP) payment under Title XIX or XXI of the Act directly or indirectly to order, refer, or render covered services as a result of the state's contract with the entity or plan.[6]

Directory Provider – For purposes of fee-for-service (FFS) and primary care case management systems described in section 1915(b)(1) of the Act, providers, and provider types who, as a condition of receiving payment for items and services furnished to individuals eligible to receive medical assistance under the State plan, are enrolled with the agency as of the date on which the directory is published or updated and received payment under the State plan in the 12-month period preceding the published/update date. Directory Provider also includes providers and provider types for whom the state agency does not require such enrollment but who received payment under the state plan (or a waiver of the plan) in the 12-month period preceding the published/update date.[7] This definition includes physicians, hospitals, pharmacies, providers of mental health services, providers of substance use disorder services, providers of long-term services and supports as appropriate, and such other providers as required by the Secretary.

Background

Section 5006 of the 21st Century Cures Act (Cures Act) amended Section 1902(a) of the Act to require each state that provides medical assistance on a FFS basis under a Medicaid state plan or waiver, or through a primary care case management system, to publish a Provider Directory on the public website of the state agency administering the plan no later than January 1, 2017.[8]

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[4] See paragraph (a)(1) of Section 5123 of the CAA, 2023, which added a new subparagraph (E) to Section 1932(a)(5) of the Act. See also paragraph (b)(1) of Section 5123 of the CAA, 2023, which amended 1902(a)(83) of the Act.
[5] 42 CFR 431.70(a), 42 CFR 457.760, 42 CFR 47.1233(d).
[6] Section 1932(a)(5)(E)(ii) of the Act, as added by paragraph (a)(2) of Section 5123 of the CAA, 2023, and section 2103(f)(3) of the Act.
[7] Section 1902(mm) of the Act, as amended by paragraph (b)(2) of Section 5123 of the CAA, 2023. https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf.
[8] See Pub. L. 114-255, Division A, Title V, Section 5006, https://www.govinfo.gov/content/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf.

Section 5006 of the Cures Act also amended Section 1902(a)(83) of the Act to provide descriptions of a Directory Physician or Provider.[9]

In addition to Section 1902(a) of Act, the Interoperability and Patient Access final rule (CMS-9115-F), which appeared in the Federal Register in May 2020 (85 FR 25510), requires CMS-regulated payers, including in the FFS and managed care delivery systems in Medicaid and CHIP, to make Provider Directory information publicly available via a standards-based (HL7 FHIR Release 4.0.1) API by January 1, 2021.[10] As discussed in an August 14, 2020, SHO letter, CMS exercised enforcement discretion concerning this deadline and announced CMS would not expect to enforce the Provider Directory API requirement prior to July 1, 2021.[11] These APIs are important for the accessibility of Provider Directories.

Section 5123 of the CAA, 2023 amended Sections 1902(a), 1932(a)(5), and 2107(e)(1) of the Act, introducing new requirements for Provider Directories that state Medicaid and CHIP FFS programs as well as MCOs, PIHPs, PAHPs, and, when appropriate, PCCM entities must comply with by July 1, 2025, which are described later in this letter.[12]

Inaccurate or out-of-date information in Provider Directories contributes to ongoing access-to-care issues for Medicaid and CHIP enrollees and may lead enrollees to delay or forgo timely care. Provider Directories containing outdated network information can create significant delays and challenges for individuals seeking essential care in areas such as mental health.[13]

Up-to-date Provider Directories can reduce beneficiary and provider burden and enable patients' health information to follow them between providers by providing critical information (such as contact information) that enables providers to coordinate care. In addition to the new requirements under the CAA, 2023, we highly encourage the consideration of additional identity management solutions, including master person indexes or master client indexes to improve coordination of care by enabling the exchange of clinical information.[14]

CAA, 2023 Updates to Medicaid and CHIP Provider Directory Requirements

Section 5123 of the CAA, 2023, amends previously existing statutory Provider Directory requirements and codifies into statute many existing regulatory requirements. In particular, Section 5123:

- Changes the update frequency from an annual to a quarterly basis for FFS programs and primary care case management systems and adds a statutory requirement for managed care programs to update electronic Network Provider directories at least quarterly or more frequently as required by the Secretary. Managed care regulations at 42 CFR 438.10(h) and 42 CFR 457.1207 (by cross-reference to 438.10) already require

[9] Pub. L. 114-255, Division A, Title V, Section 5006, https://www.govinfo.gov/content/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf.
[10] See 42 CFR Sections 431.70, 438.242(b)(6), 457.760, and 457.1233(d).
[11] SHO # 20-003, https://www.medicaid.gov/sites/default/files/2020-08/sho20003_0.pdf.
[12] Section 5123(c) of the CAA, 2023, amended section 2107(e)(1)(G) of the Act to apply section 1902(a)(83) of the Act to States for CHIP.
[13] ONC Provider Directory Task Force *State Strategic Implementation Guide*, https://www.healthit.gov/sites/default/files/statestrategicimplementationguide-providerdirectories-v1-final.pdf.
[14] SMD # 18-007, https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/smd18007_27.pdf.

electronic directories to be updated no later than 30 calendar days after the MCO, PIHP, PAHP, or PCCM entity receives updated provider information and paper provider directories to be updated at least monthly if the MCO, PIHP, PAHP or PCCM entity does not have a mobile-enabled electronic directory or quarterly if the plan has a mobile-enabled, electronic provider directory. This guidance does not change the frequency for updating paper provider directories as specified in 42 CFR 438.10(h)(3).

- Adds to the minimum required information in the Provider Directory[15]:
  - which accommodations the provider's office or facility provides for individuals with physical disabilities, including offices, exam rooms, and equipment (previously required via regulation for managed care programs);
  - the Internet website of such provider, if applicable (previously required at the option of the state for FFS programs and primary care case management systems and required via regulation for managed care programs);
  - whether the provider offers covered services via telehealth;
  - whether the provider is accepting new Medicaid or CHIP patients (previously only required for primary care case management systems and at the option of state for FFS programs, and required via regulation for managed care programs);
- Makes other changes to the required information in the Provider Directory, including
  - adding American Sign Language to the linguistic capabilities about which information must be included for primary care case management systems
  - expanding the underlying requirement to include information on provider cultural and linguistic capabilities from primary care case management systems to also apply to FFS programs, and
  - adding the current managed care program regulatory requirement to include information on provider cultural and linguistic capabilities to Section 1932(a)(5)(E)(i)(V)(aa) of the Act.
- Specifies provider types that must be in the directory, including physicians, hospitals, pharmacies, providers of mental health services, providers of substance use disorder services, providers of long-term services and supports as appropriate, and additional providers as required by the Secretary.
- Revises the description of a Directory Provider under Section 1902(mm) and establishes a definition of a Network Provider under Section 1932(a)(5)(E)(ii) of the Act.

The recent amendments made to sections 1902(a) and 1932(a)(5)(E)(ii) of the Act align provider directory requirements for Medicaid and CHIP FFS and managed care programs.

The established effective date of these changes is July 1, 2025.

Provider Directory Data Requirements

Beginning July 1, 2025, each public, searchable, Provider Directory must include, at a minimum, the following information for each provider:[16]

- The name(s) of the provider;

[15] Section 5123(a)(2)(v) of the CAA, 2023, https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf.
[16] Sections 1902(a)(83), 1932(a)(5)(E)(i), 2103(f)(3), and 2107(e)(1)(G) of the Act.

- The specialty of the provider;
- The address(es) at which the provider provides services;
- The telephone number(s) of the provider;
- Information[17] regarding the following:
    - The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or by a skilled medical interpreter who provides interpretation services at the provider's office;
    - Whether the provider is accepting new Medicaid patients and whether the provider is accepting new CHIP patients;
    - Which accommodations the provider's office or facility has provided for individuals with physical disabilities, including offices, exam rooms, and equipment;
    - The internet website of such Provider, if applicable;
    - Whether the provider offers covered services via telehealth; and
    - Other relevant information, as required by the Secretary.

Managed Care Requirements

Section 5123(a) of the CAA, 2023[18] amends Section 1932(a)(5)(E) of the Act effective July 1, 2025, and requires each MCO, PIHP, PAHP, and, when appropriate, PCCM entity with a contract with a state to enroll individuals who are eligible for medical assistance under the state plan or under a waiver of such plan to publish a Provider Directory that meets certain minimum requirements described in the previous section.[19] The Provider Directory must include all Network Providers, as defined in this letter. Per section 2103(f)(3) of the Act, CHIP managed care programs must comply with several provisions in section 1932 of the Act, including subsection (a)(5).

The current Medicaid and CHIP managed care requirements for a Provider Directory are specified in 42 CFR 438.10(h) and for CHIP, by cross-reference at 42 CFR 457.1207 respectively, and most requirements outlined in section 5123(a) of the CAA, 2023 are already regulatory requirements for managed care programs. The new requirements from section 5123(a) of the CAA require provider directories to be searchable in electronic form and include whether the provider offers covered services via telehealth. On April 22, 2024, CMS released the *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance and Quality* final rule[20] which updates the regulatory requirements at 42 CFR 438.10(h)(1) and (h)(1)(ix) and 42 CFR 457.1207 (by cross-reference) to conform with these new requirements of section 5123(a) of the CAA, 2023.

State Medicaid Agency Requirements

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[17] Meeting these data requirements do not necessarily mean that entities and their facilities and equipment are in compliance with civil rights laws including the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act of 1990, as amended, and the Section 1557 of the Affordable Care Act of 2010, as amended.

[18] https://www.congress.gov/117/plaws/publ328/PLAW-117publ328.pdf.

[19] MCOs, PIHPs, PAHPs, and PCCM entities are defined in 42 CFR 438.2.

[20] https://www.federalregister.gov/public-inspection/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-managed-care-access-finance-and

Section 5123(b) of the CAA, 2023 amends Section 1902(a)(83) of the Act, which requires states with a state plan (or waiver of such plan) that provides medical assistance on a FFS basis or through a primary care case management system to add information to their Provider Directory, as described earlier.

States must include providers and provider types for which the state agency requires the enrollment of the Provider with the State agency and that (1) is enrolled with the agency as of the date on which the directory is published or updated and (2) received payment under the State plan in the 12-month period preceding such date.

States also must include providers and provider types for which the state agency does not require such enrollment but who received payment under the state plan (or a waiver of the plan) in the 12-month period preceding the date on which the directory is published or updated.

States have the option to add other Medicaid or CHIP providers, such as dentists, who may participate in Medicaid or CHIP under a state plan or waiver.[21]

State CHIP Agency Requirements

Section 5123(c) of the CAA, 2023[22] amended Section 2107(e)(1)(G) of the Act making requirements for Provider Directories described in subsection (a)(83) of Section 1902 of the Act applicable to CHIP agencies for CHIP FFS programs.

Provider Directory API

As per the CMS Interoperability and Patient Access final rule requirements (85 FR 25510), CMS-regulated payers, including Medicaid FFS programs,[23] Medicaid managed care plans,[24] CHIP FFS programs and CHIP managed care entities,[25] must also establish and sustain a publicly accessible, standards-based (HL7 FHIR Release 4.0.1) API that publishes complete and accurate Provider Directory information; this requirement is consistent with Section 1902(a)(83) of the Act. The information in the Provider Directory API must be updated within 30 calendar days of the state receiving Provider Directory information or updates to such information.[26] CMS encourages these payers to update the Provider Directory API data and the published Provider Directory on the public website on the same schedule as much as possible, to avoid conflicting information between the published website Provider Directory and the Provider Directory API.

Availability of Enhanced FFP to States for FFS Provider Directory Development and Operations

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[21] Section 1902(mm)(2) of the Act.
[22] https://www.congress.gov/117/plaws/publ328/PLAW-117publ328.pdf.
[23] 42 CFR 431.60.
[24] 42 CFR 438.242(b)(5). The term "managed care plans" here refers to Medicaid MCOs, PIHPs and PAHPs.
[25] 42 CFR 457.1233(d). The term "managed care entities" here refers to CHIP MCOs, PIHPs and PAHPs.
[26] See https://www.cms.gov/files/document/cms-9115-f.pdf, 42 CFR 431.70, and 42 CFR 457.760. See also Sections 438.242(b)(6) and 457.1233(d) for the Provider Directory API requirements for Medicaid and CHIP managed care plans.

Given the new requirements in the CAA, 2023, CMS is reiterating the availability of enhanced FFP for design, development, and implementation (DDI) and operations/maintenance of state Medicaid IT systems. Approval for enhanced FFP requires the submission of an advanced planning document (APD).[27] A state may submit an APD requesting approval for a 90/10 enhanced FFP for the DDI of their Medicaid Enterprise Systems (MES) to support initiatives that contribute to the economical and efficient operation of the Medicaid program. As a reminder, SHO #20-003 provided guidance on utilizing FFP to implement and maintain Provider Directories.[28] For CHIP, states may claim these expenditures at the regular CHIP-enhanced federal medical assistance percentage. Section 2105(c)(2)(A) of the Act and 42 CFR 457.618 limit CHIP administrative expenditures, including systems expenditures, to no more than ten (10) percent of a state's total computable expenditures for a fiscal year.

Additionally, as specified in 42 CFR 433.116,[29] state Medicaid Agencies are eligible for 75 percent FFP for qualifying system operations expenditures (including maintenance) for operating the Provider Directories. States should refer to 45 CFR Part 95 Subpart F – Automatic Data Processing Equipment and Services-Conditions for FFP for the specifics related to APD submission.

MES projects that benefit more than one program require an allocation of costs to each program benefiting from the project. 42 CFR 433.34 provides principles and standards for determining appropriate cost allocation. The basic concept for cost-allocating MES projects is to break the project down into its functional component parts and to charge a share of the cost of each component to only those programs that will directly benefit. If the component only benefits one program, then the total cost of that component will be directly charged to that program.

In considering how to build or modify Provider Directories to comply with the requirements of the Act, CMS emphasizes the importance of reuse in the Medicaid Information Technology Architecture (MITA) framework, which is discussed in detail in SMD # 18-005, "Mechanized Claims Processing and Information Retrieval Systems – Reuse.[30] SMD # 18-005 further advises that states should, as appropriate, leverage or build upon existing MES federal investments.

Non-Compliance: Corrective Action Plan Requirements for State Reapproval of Medicaid Systems

CMS understands that compliance with new requirements can be challenging, and we encourage states to reach out to CMS early to discuss implementation plans to support timely compliance with applicable federal requirements. Pursuant to the CMCS Informational Bulletin (CIB) dated May 24, 2023,[31] if CMS determines a state is non-compliant with the Provider Directory requirement in Section 1902(a)(83) of the Act, by July 1, 2025, CMS will issue a letter requesting that the state submit a corrective action plan within 30 days of the date of the letter.

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[27] 45 CFR 95.610, 42 CFR 433.112(a), and 42 CFR 433.116(a).
[28] https://www.medicaid.gov/sites/default/files/2020-08/sho20003_0.pdf.
[29] FFP is available at 75 percent of expenditures for operation of a mechanized claims processing and information retrieval system approved by CMS, from the first day of the calendar quarter after the date the system met the conditions of initial approval, as established by CMS.
[30] SMD # 18-005, https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18005.pdf
[31] https://www.medicaid.gov/sites/default/files/2023-05/cib052423.pdf.

The state's corrective action plan should identify the issue(s) preventing the state from attaining compliance with the applicable federal requirements, as well as the state's plan and proposed timeline for meeting the requirement.

If the state does not satisfy the conditions listed in the corrective action plan, CMS will determine the state's corrective actions did not enable the system to meet the conditions for reapproval in 42 CFR 433.119[32] and will issue a letter reducing FFP from 75 percent to 50 percent for expenditures for the operations of non-compliant functionality or system components, pursuant to 42 CFR 433.120.[33] If needed, the state can request 90 percent FFP for DDI of system modifications and enhancements via the APD process to align the MES with the conditions for enhanced matching for system operations. The state should provide their MES State Officer with ongoing monthly status updates on the work to resolve outstanding issues to achieve compliance with all applicable federal requirements, allowing the State Officer to monitor project progress against the corrective action plan schedule. The state's progress on implementing the corrective action plan should be tracked in monthly project status reports submitted to the MES State Officer.

Returning to Compliance and Requesting Reapproval of Medicaid Systems

Upon meeting the Provider Directory requirements under Section 1902(a)(83) of the Act and addressing issues identified in CMS' compliance letter, the state can initiate a reapproval request for enhanced federal matching. As addressed in the May 24, 2023, CIB,[34] the State must submit a reapproval request letter to CMS, including:

1) The date the state remediated outstanding issues and the MES once again met the conditions for enhanced federal matching;
2) An operational report and any other applicable data demonstrating compliance with the reapproval conditions for enhanced federal matching required under 42 CFR 433.119,[35] as well as metrics and related evidence demonstrating the achievement of outcomes; and
3) A proposed timeframe for the reapproval review.

The state's reapproval request letter, metrics, underlying data, and explanatory or contextual information should be sent to the CMS State Officer and MES@cms.hhs.gov. The state and CMS State Officer will agree upon a schedule for the review. The reapproval review will focus on metrics, outcomes, and other evidence (such as a system demonstration) establishing the MES meets the conditions for reapproval.

Following the review in which CMS determines the state has resolved previously identified compliance issues and the MES meets the conditions for reapproval, CMS will issue a letter confirming the system complies with the conditions for enhanced federal matching. Pursuant to regulation at 42 CFR 433.122(a), the CMS approval letter will verify the state is eligible for 75 percent FFP for expenditures for system operations beginning with the first day of the calendar

[32] 42 CFR 433.119 Conditions for reapproval; https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-433/subpart-C.
[33] Reduction of enhanced funding only applies to Title XIX Medicaid systems per 42 CFR 433.116. For CHIP compliance requirements, please refer to 42 CFR 457.204.
[34] https://www.medicaid.gov/sites/default/files/2023-05/cib052423.pdf.
[35] 42 CFR 433.119 Conditions for reapproval; https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-433/subpart-C

quarter following the date when CMS determined that the MES again began to meet the conditions of reapproval. The state can then submit an operational APD to request the 75 percent federal match for operations of the MES retroactively from that quarter forward.[36]

Per 42 CFR 433.122(b), CMS may retroactively waive a reduction of FFP for expenditures for system operations if CMS determines that the waiver could improve the administration of the state Medicaid plan. However, CMS cannot waive this reduction for any quarter before the fourth quarter immediately preceding the quarter when CMS issues the determination (as part of the review process) stating that the system is reapproved.

Conclusion

Well-designed care coordination can improve outcomes for patients, providers, and payers,[37] and Provider Directories are an essential component of coordination and access to care. CMS is committed to promoting better data sharing for state Medicaid and CHIP agencies, improving the comprehensiveness and accuracy of Provider Directories for Medicaid and CHIP beneficiaries, and reducing provider burden by requiring accurate and up-to-date information related to coordination of care (e.g., provider contact information). We encourage states to continue to improve public-facing information related to care, and to engage with CMS and stakeholders by providing feedback on relevant policies. States should reach out to their MES State Officers for technical assistance in implementing these requirements, where relevant.

CMS values states as partners in expanding patient access to health information and supporting interoperability within Medicaid.

If states have questions about this SHO letter, please contact Edward L. Dolly, Deputy Director, Data and Systems Group, at Edward.Dolly@cms.hhs.gov.

Sincerely,

/s/

Daniel Tsai
Deputy Administrator and Director

[36] Per 42 CFR 433.116(i), Federal financial participation (FFP) is available at 75 percent of state expenditures for the operation of an MES module if the system meets conditions required at 42 CFR 433.112(b)(10) through (b)(16), including production of transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability pursuant to 42 CFR 433.112(b)(15).

[37] "Care Coordination." Agency for Healthcare Research and Quality (AHRQ), https://www.ahrq.gov/ncepcr/care/coordination.html