Requirements for Collecting Provider Directory Information

January 28, 2025

mass collaborative
Simplifying Healthcare Administration

Applicability

Health Insurance Plans

The regulation applies to all **fully insured managed care commercial plans issued to individuals or employers in Massachusetts, including Connector Care plans** but may not apply to large employer self funded plans. Government plans such as MassHealth, Medicare Advantage, or out of state plans are not subject to the requirements. Although not specifically subject to the regulation, the Group Insurance Commission (GIC) which insures state and municipal employees will also be following this regulation.

Providers

- Clinicians who contract with health plans and who are listed in traditional commercial health insurance provider directories to help consumers to choose a clinician are subject to the regulation. Examples include primary care physicians, psychologists, clinical social workers, orthopedists, and speech therapists.
- Pediatric dentists may be listed when they participate with a health plan to provide dental services to children.
- Generally, if a consumer does not normally choose to make an appointment with the provider, then the provider does not have to enter their provider directory information. Examples include pathologists, hospitalists, anesthesiologists, radiologists, emergency department physicians, physicians who only see patients at nursing homes, and dentists who are contracted with dental insurance plans.

Who is the Mass Collaborative

- The Mass Collaborative is a voluntary, open organization of more than 35 payers, providers, and trade associations dedicated to reducing complex and cumbersome health care administrative processes in Massachusetts.

- The Collaborative—formerly called the Mass Healthcare Administrative Simplification Collaborative—was developed in 2009 to address the most pressing administrative issues in the Massachusetts health care industry.

- Governed by a Steering Committee comprised of senior leaders from Blue Cross Blue Shield of Massachusetts, the Massachusetts Association of Health Plans, the Massachusetts Health & Hospital Association, the Massachusetts Medical Society, and the Massachusetts Health Data Consortium.

Agenda

- **Welcome & Introductions** Yael Miller, MMS
- **Why are we here today?** Yael Miller, MMS
- **Federal Requirements for Provider Directory Data Submission –** Michael Katzman, BCBSMA
- **Division of Insurance Updates to State Provider Directory Requirements –** Kevin Beagan, DOI
- **What does implementation look like?** Kevin Beagan, DOI and Melissa Speck, CAQH
- **Questions** -- please leave your questions in the chat

Why are we here today?

- **Consumers need accurate, up-to-date information about providers**
  - To find a provider that is in network with their insurance plan
  - To find a provider that serves their specific needs – specialty, affiliation, geographic location

- **Health plans are required to regularly update provider directories**
  - By the federal government – CMS requirements for Medicare, Medicaid, CHIP, ACA requirements, No Surprises Act, CAA, etc.
  - By the state Division of Insurance – state statute (chapter 124 of the Acts of 2019) and the DOI Regulations (211 CMR 52.15)
  - By accreditation organizations – URAC and NCQA set standards carriers must meet in order to receive accreditation
  - By their members – members expect to use their health plan's provider directory to find a provider.

- **Providers are required to regularly submit data to populate provider directories**
  - CMS requires providers and facilities to have business processes in place to provide information every 90 days
  - State regulation now requires health plans to de-list non-responding providers from directories

Without coordination, the process for payers and providers to maintain up-to-date directory information could quickly become overly burdensome.

Federal Requirements for Provider Directory Data

CMS Requirements

- Plans must update directory information **any time they become aware of changes**. All updates to the online provider directories must be completed **within 30 days of receiving information requiring update**.
- **Plans must contact their network/contracted providers on a quarterly basis** to update directory information.
- Medicare Advantage (MA) organizations, Medicaid state agencies, Medicaid managed care plans, Children's Health Insurance Program (CHIP) state agencies and CHIP managed care entities are required to **offer a public facing Provider Directory API** which must include data on a payer's network of contracted providers and **must update within 30 days of receiving new or updated provider directory data.**

CAA Requirements

- Plans must establish a process to verify directory data **at least every 90 days** and providers must have business processes in place to ensure timely provision of data.

NSA Requirements

- Plans must verify directory data every 90 days, process updates within 2 business days of receiving updated information, and remove providers from the directory if their information has not been verified.

Division of Insurance Mission

"The primary mission of the Division of Insurance (DOI) is to monitor the solvency of its licensees [property/casualty, life/annuity and health] in order to promote a healthy, responsive and willing marketplace for consumers who purchase insurance products.

Protection of consumer interests is of prime importance to the Division and is safeguarded by providing accurate and unbiased information so consumers may make informed decisions and by intervening on behalf of consumers who believe they have been victimized by unfair business practices."

Challenges with Provider Directory Data Accuracy

2018 DOI Market Conduct Exam found that between

- 58% and 100% of a carrier's sample behavioral health facility records contained completely accurate information;

- 34% and 68% of a carrier's sample primary care provider records contained completely accurate information; and

- 29% and 64% of a carrier's sample behavioral health provider records contained completely accurate information

The Centers for Medicare & Medicaid Services (CMS) completed its second round of Medicare Advantage (MA) online provider directory reviews between September 2016 and August 2017.

The review found that 52.20% of the provider directory locations listed had at least one inaccuracy. Types of inaccuracies included: accepting new patients, wrong location or phone.

The No Surprises Act requires plans to maintain up-to-date provider directories and reimburse members for costs resulting from any carrier error.

New State Law, New Requirements

An Act Relative to Children's Health and Wellness

Chapter 124 of the Acts of 2019 ("Chapter 124") was enacted, with requirements for improving carriers' provider directories:

<u>Section 2 amends M.G.L c. 176O to add section 28 that establishes standards for carriers' provider directories to present clear, accurate and understandable listings of network providers</u>.

(a) A carrier shall ensure the accuracy of the information concerning each provider listed in the carrier's provider directories for each network plan and shall review and update the entire provider directory for each network plan. A provider directory that is electronically available shall: (i) be in a searchable format; and (ii) make accessible to the general public the current health care providers for a network plan through a clearly identifiable link or tab without requiring the general public to create or access an account, enter a policy or contract number, provide other identifying information or demonstrate coverage or an interest in obtaining coverage with the network plan. Each electronic network plan provider directory shall be updated not less than monthly…

The Call to Action: Provider Directories Task Force Report

“Insurance carriers who provide or arrange for the delivery of health care through a network of providers are expected to provide members with access to clear and comprehensive information about the providers who are part of their networks.

It is essential for patients that carriers and providers establish systems and protocols that will improve the accuracy and quality for provider directory information so that patients will be able to find providers when they need to access care.”*

***from intro to Provider Directory Task Force Report**

What does implementation look like?

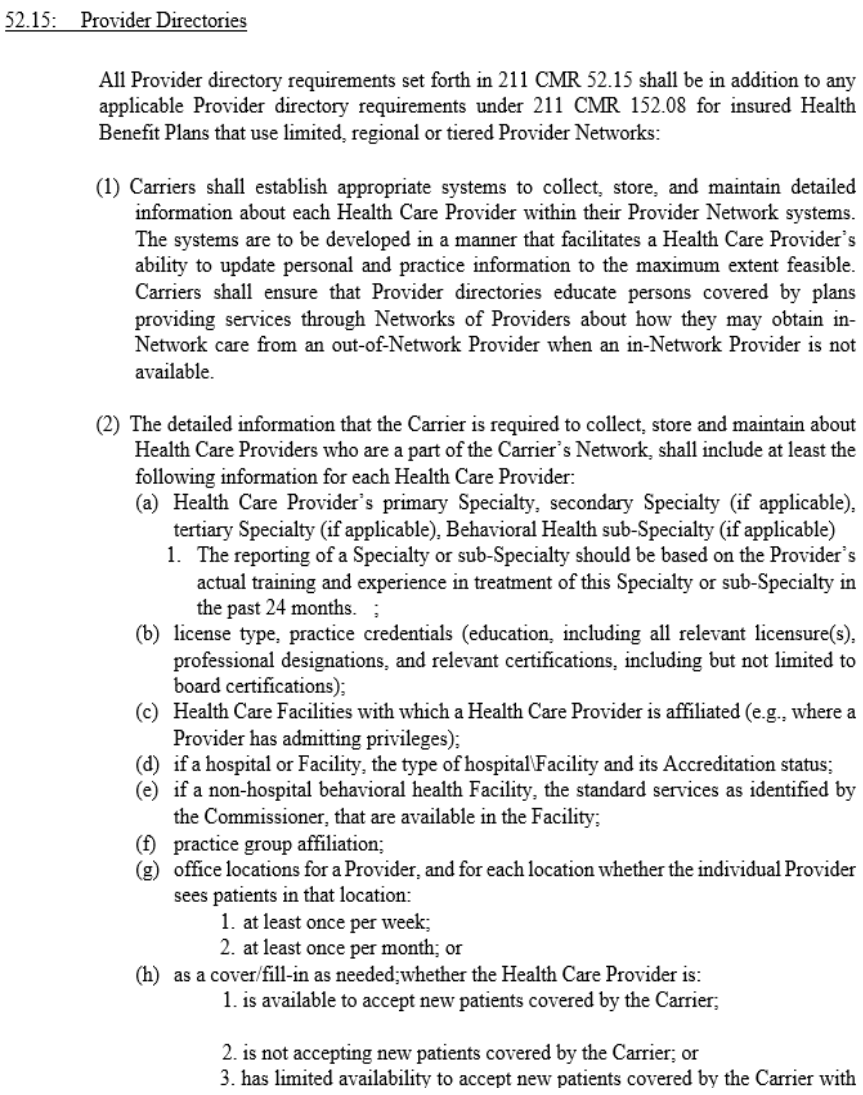
- **Health plans must make changes to both the data fields collected from providers and the data fields displayed in the consumer facing provider directory.**

- **Most health plans in Massachusetts have adopted CAQH's Provider Data Portal * for directory data submission; an overview of the updated questions for providers are on the following slides.**

- **Health plans using an alternative portal are also updating their platforms to accommodate the updated questions.**

- CAQH only collects information on professional providers and NOT facilities. Facility Providers will receive requests for the facility demographics from the health plan or the health plan's vendor they have chosen to work with for facility directory validation. It is important for facilities designate someone who can validate the directory information every 90 days.

Division of Insurance (DOI) Issues Regulations



52.15: Provider Directories

All Provider directory requirements set forth in 211 CMR 52.15 shall be in addition to any applicable Provider directory requirements under 211 CMR 152.08 for insured Health Benefit Plans that use limited, regional or tiered Provider Networks:

(1) Carriers shall establish appropriate systems to collect, store, and maintain detailed information about each Health Care Provider within their Provider Network systems. The systems are to be developed in a manner that facilitates a Health Care Provider's ability to update personal and practice information to the maximum extent feasible. Carriers shall ensure that Provider directories educate persons covered by plans providing services through Networks of Providers about how they may obtain in-Network care from an out-of-Network Provider when an in-Network Provider is not available.

(2) The detailed information that the Carrier is required to collect, store and maintain about Health Care Providers who are a part of the Carrier's Network, shall include at least the following information for each Health Care Provider:

(a) Health Care Provider's primary Specialty, secondary Specialty (if applicable), tertiary Specialty (if applicable), Behavioral Health sub-Specialty (if applicable)
   1. The reporting of a Specialty or sub-Specialty should be based on the Provider's actual training and experience in treatment of this Specialty or sub-Specialty in the past 24 months. ;

(b) license type, practice credentials (education, including all relevant licensure(s), professional designations, and relevant certifications, including but not limited to board certifications);

(c) Health Care Facilities with which a Health Care Provider is affiliated (e.g., where a Provider has admitting privileges);

(d) if a hospital or Facility, the type of hospital\Facility and its Accreditation status;

(e) if a non-hospital behavioral health Facility, the standard services as identified by the Commissioner, that are available in the Facility;

(f) practice group affiliation;

(g) office locations for a Provider, and for each location whether the individual Provider sees patients in that location:
   1. at least once per week;
   2. at least once per month; or

(h) as a cover/fill-in as needed;whether the Health Care Provider is:
   1. is available to accept new patients covered by the Carrier;

   2. is not accepting new patients covered by the Carrier; or
   3. has limited availability to accept new patients covered by the Carrier with

- **211 CMR 52.00, *Managed Care Consumer Protections and Accreditation of Carriers*.**

- **The final regulation includes amendments to 211 CMR 52.00 to establish rules in response to the collection, storage, display, and auditing of network provider directory information**

- **The new Regulation adds a long list of requirements for health plans' provider directories related to:**
  - (1) the information to be displayed;
  - (2) how plans verify, audit and update directory information; and
  - (3) how plans make the directory available to their members.

CAQH Provider Data Portal Changes for Adopted Massachusetts 211 CMR 52.15

January 2025

Full List of 211 CMR 52 (2) Requirements and CAQH Solution Status

Status Reflects Final Filing Guidance Issued June 24, 2024

Provider's primary, secondary, tertiary, and behavioral health specialties	Currently Supported
License Type and Practice Credentials	Currently Supported
Health Care Facility Affiliations	Supported for Hospital Affiliations Only
Facility Accreditation Status	Out of Scope
Facility Behavioral Health Services	Out of Scope
Practice Group Affiliation	Currently Supported
Office Locations and Whether the Provider Sees Patients	Currently Supported
Provider's Availability to Accept New Patients	Interim Solution Addressed in Filing Guidance; CAQH Will Support
Operating Hours for Each Location/ Evening Weekend Availability	Currently Supported

Main Phone Number	Currently Supported
Languages Spoken/Understood by Provider	Currently Supported
ADA Accessibility	Currently Supported
Treatment of Specific Genders	CAQH Will Support
Age Groups Treated	CAQH Will Support
Special Populations- Race/Ethnicity, Sexual Orientation, and Disability	CAQH Will Support
Conditions to Treating a Patient	Concierge Fee Question Under Evaluation; Other Questions Out of Scope
Network Tier Information	Out of Scope for CAQH
Telehealth Availability and Modalities	CAQH Will Support

Not for Distribution

Implementation Schedule

- Languages Spoken by the Provider
- List of Genders and Gender Identities
- Ages
- Special Populations and Cultural Groups
- Telehealth Modalities
- Availability to Accept New Patients

Available for data collection/viewable in PDP
(November/December 2024)

- Health Plan Directory Management Extract

Health plans able to pull data from extract
(~Q1 2025)

Not for Distribution

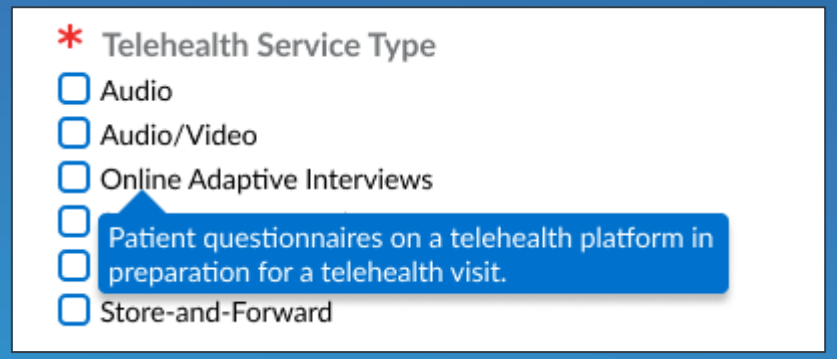
Telehealth Modalities: 52.15 (2)(r)

Requirement

[Identify] which Health Care Providers within a Facility are available for consultation via Telehealth and the modalities of Telehealth the Health Care Provider offers to patients or whether the Health Care Provider is available for consultation only via Telehealth

Current Status: Available in November 2024 Provider Data Portal update.

- Per 211 CMR 52.15 (2)(r) CAQH added “online adaptive interviews as a telehealth modality for providers to select.
- CAQH also added the definition of “online adaptive interviews” adopted in Filing Guidance 2024-H as a hover-over tool tip.



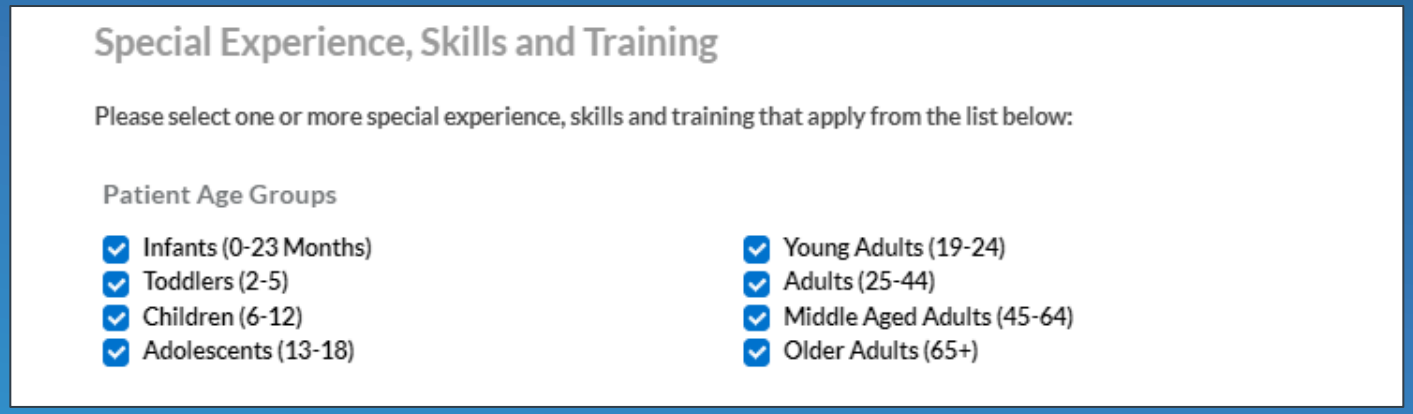
Patient Ages: 52.15 (2)(n)

Requirement

Any specific age groups treated by the Health Care Provider, if the Provider so chooses

Current Status: Available in November 2024 Provider Data Portal update.

- CAQH adopted the Division of Insurance's age list as specified in Filing Guidance Notice 2024-H.



Special Experience, Skills and Training

Please select one or more special experience, skills and training that apply from the list below:

Patient Age Groups

- [x] Infants (0-23 Months)
- [x] Toddlers (2-5)
- [x] Children (6-12)
- [x] Adolescents (13-18)
- [x] Young Adults (19-24)
- [x] Adults (25-44)
- [x] Middle Aged Adults (45-64)
- [x] Older Adults (65+)

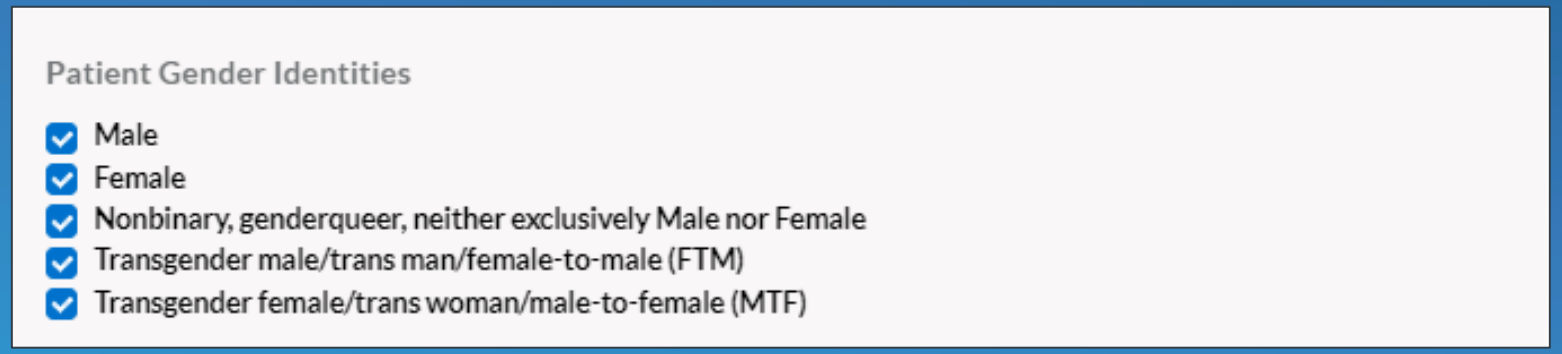
Gender and Gender Identities: 52.15 (2)(m)

Requirement

"Whether the practice specializes in the treatment of specific genders and identification of those specific genders or gender identities based upon the Provider's actual treatment of members of such populations or groups in the last 24 months."

Current Status: Available in November 2024 Provider Data Portal update.

- CAQH adopted the Division of Insurance's gender identity list as specified in Filing Guidance Notice 2024-H.



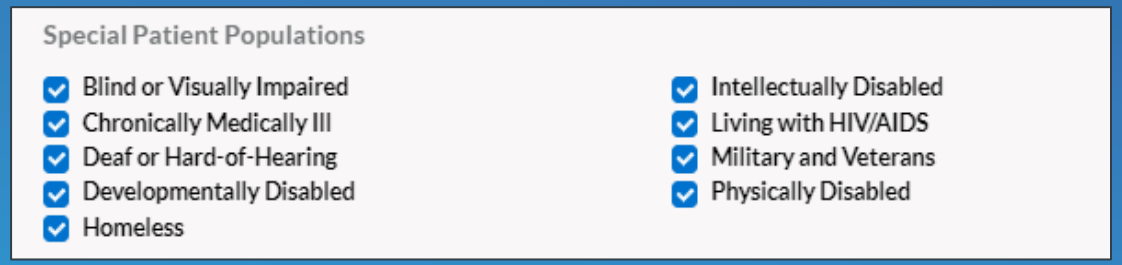
Cultural Groups and Special Populations: 52.15 (2)(o)

Requirement

"Any special populations or cultural groups that the Health Care Provider wishes to highlight that the Health Care Provider serves, as well as the Provider's race and nationality, if the Provider so chooses."

Current Status: Available in November 2024 Provider Data Portal update.

- CAQH adopted the Division of Insurance's special population lists as specified in Filing Guidance Notice 2024-H. The adopted response options are:
  - Patient sexual orientation. (*Below*)
  - Patient disability status. (*Below*)
  - Patient race and ethnicity.(*Next Slide*)



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Current Status: Available in November 2024 Provider Data Portal update.

- CAQH adopted the Division of Insurance's special population lists as specified in Filing Guidance Notice 2024-H.
  - Below is the patient race and ethnicity options listed in Filing Guidance 2024-H.

Availability Options: 52.15 (2)(h)

Requirement

Whether the Health Care Provider:

1. Is available to accept new patients covered by the Carrier
2. Is not accepting new patients covered by the Carrier
3. Has limited availability to accept new patients covered by the Carrier with a waitlist of 4 weeks of [sic] less to schedule an appointment

Current Status: Available in December 2024 Provider Data Portal update

- CAQH currently collects responses #1 and #2.
- The Division of Insurance adopted an interim solution for this requirement in Filing Guidance 2024-H, which CAQH adopted in PDP in December.
- The PDP question currently reads:
  - "Are you accepting new patients?" Yes or No
    - If Yes, "Are you able to contact the new patient to schedule an appointment within 4 weeks?** Yes or No

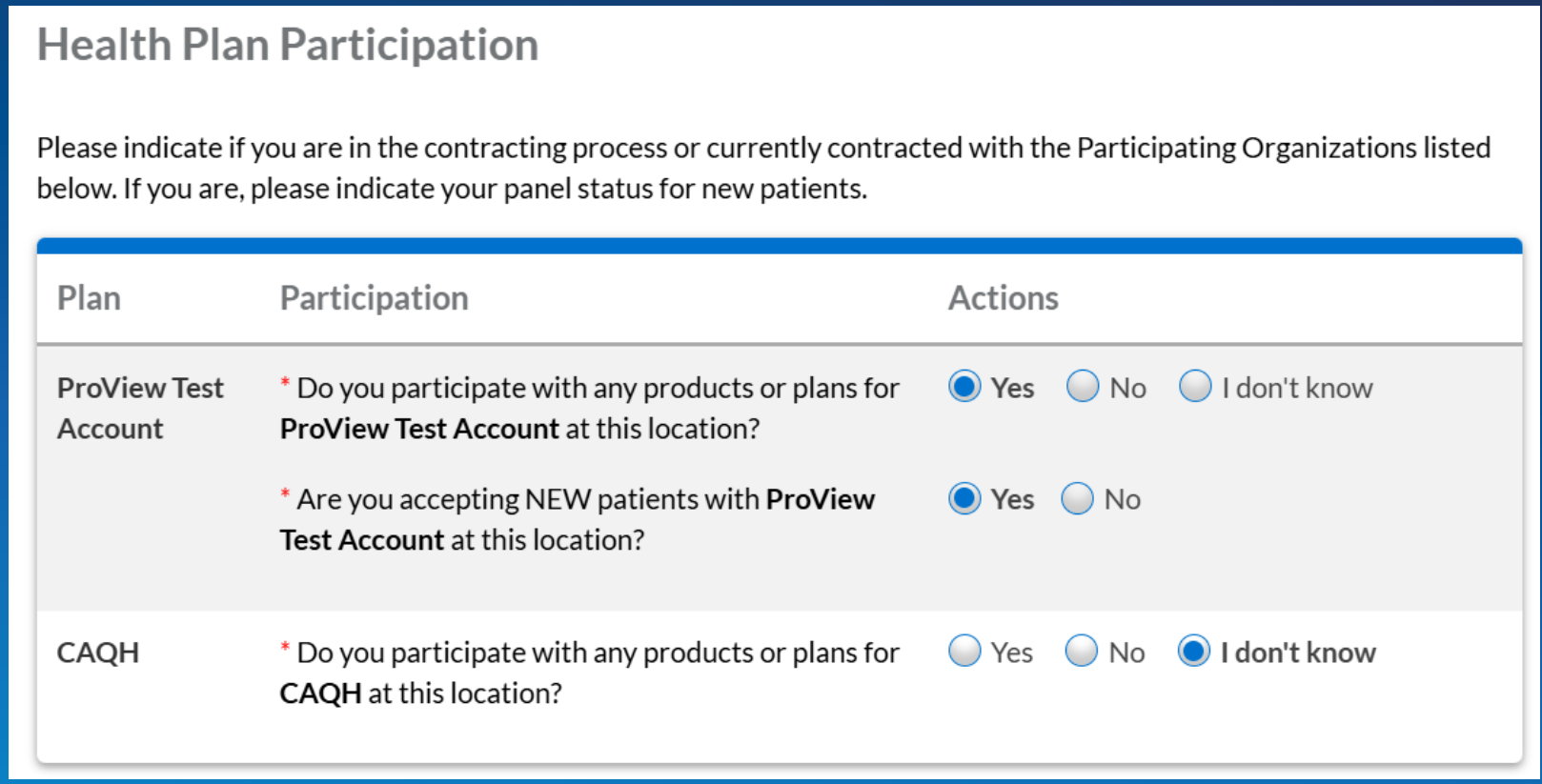
** CAQH will be suppressing (toggling off) the secondary question related to contacting patients within 4 weeks
Targeted release - March 2025

- Until such time as the secondary question has been suppressed providers should reply "NO"

Not for Distribution

Revised View in PDP Effective ~ March 2025

Availability Options: 52.15 (2)(h)



Health Plan Participation

Please indicate if you are in the contracting process or currently contracted with the Participating Organizations listed below. If you are, please indicate your panel status for new patients.

Plan	Participation	Actions
ProView Test Account	* Do you participate with any products or plans for **ProView Test Account** at this location?	(●) **Yes** ( ) No ( ) I don't know
	* Are you accepting NEW patients with **ProView Test Account** at this location?	(●) **Yes** ( ) No
CAQH	* Do you participate with any products or plans for **CAQH** at this location?	( ) Yes ( ) No (●) **I don't know**

To Access Provider Portal Go To:

https://proview.caqh.org/Login

Solution Support

Support for Providers and Practice Managers

Hours of Operation: Monday – Friday 8am-8pm (ET)

Telephone: 1-888-599-1771

Chat Hours of Operation: Monday – Friday 8am-6:30pm (ET)

Chat Automation Hours of Operation: 24/7

Chat URL: https://proview.caqh.org/PR

What to expect in 2025

Late January

- **Providers continue to populate new data fields** and attest to the information quarterly in CAQH Provider Data Portal.
- **WEBINAR** is to provide an overview of changes in CAQH's Provider Data Portal in response to provider directory requirements in MA and importance of completion, etc.
- **Identify and execute additional communications steps** that may be needed.

February

Make Recording of this webinar available.

Mid-Late February (Date TBD)

- **CAQH releases Directory Management Extract** to Health Plans to initiate internal processes for inclusion of new provider directory fields

Q2 2025

- **Providers continue updating/entering new data fields, attesting to the information quarterly, to maximize complete/accurate provider data for use by plans.**

Q3-Q4 2025

- **Expected launch time frame for Health Plan Directories to include display of new requirements**.
- **Carriers may begin delisting providers who do not make updates following necessary notice from carriers**

Questions?

Feel free to contact us after the Webinar

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