

AGENCY/ORGANIZATION	PROVIDER DIRECTORY PROCESSES/DATA	FREQUENCY OF UPDATES
Utilization Review Accreditation Commission (URAC)¹	<p>Credentialing and contracting processes are completed and a provider initially approved for network participation is</p> <ol style="list-style-type: none"> 1) Displayed in online provider directories 2) Flagged for inclusion in subsequent hard copy versions of the provider directory <p>Determination is made that provider is not re-credentialed for any reason/no longer meets the credentialing requirements and is removed from the online directory</p> <p>Determination that provider is no longer participating in the network and is removed from:</p> <ol style="list-style-type: none"> 1) Electronic versions of the provider directory 2) Flagged for removal in subsequent hard copy versions of the provider directory 	<p>45 calendar days</p> <p>5 business days</p> <p>45 calendar days</p>
CMS Medicare Advantage^{2,3}	<p>Information is captured regarding:</p> <ol style="list-style-type: none"> 1) Accepting new patients/availability in network 2) Provider's location and contact information 3) Specialty, medical group, and any institutional affiliations 	<p>Quarterly</p> <p>(Updates from providers will be made within 30 days)</p>
CMS Medicaid Managed Care⁴ <i>Information taken from a proposed rule and will be reevaluated when the final rule is published.</i>	<p>Information is captured regarding:</p> <ol style="list-style-type: none"> (i) The provider's name as well as any group affiliation. (ii) Street address(es). (iii) Telephone number(s). (iv) Web site URL as appropriate. (v) Specialty, if appropriate. (vi) Whether the provider will accept new enrollees. (vii) The provider's cultural and linguistic capabilities (viii) Whether the provider's office/facility is accessible for people with physical disabilities, including offices, exam room(s) and equipment. <p>Standardized network information provided in electronic format for eventual inclusion in a nationwide provider database</p>	<p>At least monthly - updates to the directory within 3 days</p> <p><i>CMS is considering - on or after Calendar Year 2017</i></p>
CMS Healthcare.gov insurers (ACA)⁵	<p>Credentialing and contracting processes are completed and a provider initially approved for network participation is</p> <ol style="list-style-type: none"> 1) Displayed in online provider directories 2) Flagged for inclusion in subsequent hard copy versions of the provider directory <p>Determination is made that provider is not re-credentialed for any reason/no longer meets the credentialing requirements and is removed from the online directory</p> <p>Determination that provider is no longer participating in the network and is removed from:</p> <ol style="list-style-type: none"> 1) Electronic versions of the provider directory 2) Flagged for removal in subsequent hard copy versions of the provider directory 	<p>At least monthly</p> <p>At least monthly</p> <p>At least monthly</p>

¹ <https://www.urac.org/>

² *Advanced Notice of Methodological Changes for Calendar Year 2016 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter.* Centers for Medicare & Medicaid Services. 20 Feb 2015. <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2016.pdf>

³ *Provider Directory Requirements – Update.* Centers for Medicare & Medicaid Services. Medicare Drug & Health Plan Contract Administration Group. 12 Nov 2015. <http://www.caqh.org/sites/default/files/solutions/cms-hpms-provider-directory-memo-11132015.pdf?token=XuA5pnDs>

⁴ *Medicaid Managed Care (CMS-2390-P).* Centers for Medicare & Medicaid Services. 1 June 2015. <https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>

⁵ *Final 2016 Letter to Issuers in the Federally-facilitated Marketplace.* Centers for Medicare & Medicaid Services. Center for Consumer Information and Insurance Oversight. 20 Feb 2015. <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf>

Oregon Network Adequacy⁶

The health carrier must make the following data elements available through an electronic provider directory for each network plan in a searchable format:

At least monthly

For health care professionals: name, gender, participating office location(s), specialty (if applicable), medical group affiliations (if applicable), facility affiliations (if applicable), participating facility affiliations (if applicable), languages spoken other than English (if applicable), and whether accepting new patients

For hospitals: hospital name, hospital type (e.g. acute, rehabilitations, children’s, cancer), participating hospital locations, and hospital accreditation status

For facilities, other than hospitals, by type: facility name, facility type, type of service performed, and participating facility location(s)

Additionally, the health carrier must make the following data elements available through an electronic provider directory for each network plan:

For health care professionals: contact information, board certification(s), and languages spoken other than English by clinical staff (if applicable)

At least monthly

For hospitals: telephone number

For facilities, other than hospitals, by type: telephone number

Law goes into effect on 1/1/2017

Agencies/organizations that do not have applicable Provider Directory Process/Data information include:

- *Accreditation Association for Ambulatory Health Care (AAAHC)*
- *America’s Health Insurance Plan (AHIP)*
- *Det Norske Veritas (DNV)*
- *National Committee for Quality Assurance (NCQA)*
- *The Joint Commission (TJC)*

⁶ *Health Benefit Plan Network Access and Adequacy Model Act.* National Association of Insurance Commissioners. 4th Quarter 2015. <http://www.naic.org/store/free/MDL-74.pdf>

Fee Structure Principles

Below are draft fee structure principles developed by the OHA based on Common Credentialing (CC) and the Emergency Department Information Exchange (EDIE) Utility Model principles:

Principle Description
Fee development for health care organizations and providers must be delicately balanced considering the benefits they may experience and their respective resources (CC)
Ensure that costs are not a barrier to participation (CC)
Fees should be equitably balanced between different organization types considering their required level of participation (CC) Fees for health care organizations should be equitably balanced consider the size and types of its health care organization (CC) Sources for revenue size should be as current as possible and consistently applied. (EDIE)
Tiering of financing partners (should be) based on revenue. (EDIE)
Be efficient and economical to administer, ensuring a simplified billing approach (CC) Administration of financing mechanism should be as simple as possible. (EDIE)
Fees should be transparent and justifiable in how they are developed (CC)
Fees should be stable (not vary considerably year to year) and predictable with changes based only on scope adjustments, CPI increases, and increases in participants (CC)
Fees should produce a predictable income to support the costs of operating common credentialing which should include allocations for information technology and operational quality assurance activities and security. (CC)
Ensure that costs of specific, individually requested processes that are not of general application should be borne by those making such requests (CC)
Investment by as many stakeholders as possible assures greater adoption. (EDIE)
Federal and State investment to stimulate implementation of statewide technology should be leveraged. (EDIE)