NEW JERSEY HEALTH CARE QUALITY INSTITUTE Quality powered.

New Jersey AHP Association of Health Plans

Medicaid Managed Care Network Directories Workgroup Backgrounder

I. Introduction to the issue

a. **OIG Report** (http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf) In 2014, OIG assessed the availability of Medicaid managed care providers and timeliness of appointments for enrollees by calling a stratified random sample of 1,800 primary care providers and specialists. The study found that 35 percent of providers could not be found at the location listed by the plan, and another 8 percent were at the location but said that they were not participating in the plan.

II. Current Oversight and Regulations

a. **Federal (CMS/HHS) Requirements**

i. **Marketplace Final Ruling[1]:** Re. Marketplace plans, CMS requires that "a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the FFM, HHS, and OPM. A provider directory will be considered up-to-date if it is updated at least monthly and easily accessible when the general public is able to view all of the current providers for a plan in the provider directory on the issuer's public website through a clearly identifiable link or tab without having to create or access an account or enter a policy number. The general public should be able to easily discern which providers participate in which plan(s) and provider network(s). Further, if the health plan issuer maintains multiple provider networks, the plan(s) and provider network(s) associated with each provider, including the tier in which the provider is included, should be clearly identified on the website and in the provider directory. CMS is also requiring issuers to make this information publicly available on their websites in a machine-readable file and format specified by HHS, to allow the creation of user-friendly aggregated information sources."

http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf

This section applies to all QHP issuers in the FFMs, including in States performing plan management functions in the FFM.

ii. **Medicaid Final Rule** http://www.ecfr.gov/cgi-bin/text-idx?SID=b3ed782c598bf05c77dfeed46d200aa3&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_110

42 CFR 438.10(h) *Information for all enrollees of MCOs, PIHPs, PAHPs, and PCCM entities—Provider Directory.* (1) Each MCO, PIHP, PAHP, and when appropriate, the PCCM entity, must make available in paper form upon request and electronic form, the following information about its network providers: (i) The provider's name as well as any group affiliation. (ii) Street address(es). (iii) Telephone number(s). (iv) Web site URL, as

[1] Although the scope of the workgroup's charge is the Medicaid Managed Care network directories, we included information on the marketplace as well to provide resources and examples of network directory oversight and improvement strategies.

appropriate. (v) Specialty, as appropriate. (vi) Whether the provider will accept new enrollees. (vii) The 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, and whether the provider has completed cultural competence training. (viii) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment. (2) The provider directory must include the information in paragraph (h)(1) of this section for each of the following provider types covered under the contract: (i) Physicians, including specialists; (ii) Hospitals; (iii) Pharmacies; (iv) Behavioral health providers; and (v) LTSS providers, as appropriate. (3) Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the MCO, PIHP, PAHP or PCCM entity receives updated provider information. (4) Provider directories must be made available on the MCO's, PIHP's, PAHP's, or, if applicable, PCCM entity's Web site in a machine readable file and format as specified by the Secretary.

b. State

i. **MCO Contract** http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf

4.8.4 PROVIDER DIRECTORY REQUIREMENTS A. The Contractor shall prepare a provider directory which shall be presented in the following manner. Fifty (50) hard copies of the Contractor's up-to-date provider directory shall be provided to the HBC and two (2) hard copies and one (1) CD format shall be provided to DMAHS at least every six months or within 30 days of an update, whichever is earlier. Up-to-date, web-based provider directories shall also be maintained with updates made no later than every 30 days. Primary care providers who will serve enrollees listed by: County, by city, by specialty; Provider name and degree; specialty board eligibility/certification status; office address(es) (actual street address); telephone number; fax number if available; office hours at each location; indicate if a provider serves enrollees with disabilities and how to receive additional information such as type of disability; hospital affiliations; transportation availability; special appointment instructions if any; languages spoken; disability access; and any other pertinent information that would assist the enrollee in choosing a PCP. This shall include a separate listing of dental providers who can provide dental diagnostic, preventive and treatment services to children under the age of 6 and updated annually. B. Contracted specialists and ancillary services providers who will serve enrollees; Listed by county, by city, by physician specialty, by non-physician specialty, and by adult specialist and by pediatric specialist for those specialties indicated in Article 4.8.8.C. (i.e. specialties that cover all benefits referenced in Article 4.1 Covered Services); MLTSS providers listed by county, by city, by specialty/MLTSS offered; with name, office address(es), telephone number and fax number if available and information on service area and services offered. C. Subcontractors: Provide, at a minimum, a list of all other health care providers by county, by service specialty, and by name. The Contractor shall demonstrate its ability to provide all of the services included under this contract.

B.4.14 NJ QAPI Standards, Standard IX: Credentialing and Re-credentialing, A. Written policies and procedures - The managed care organization has, at a minimum, written policies and procedures, consistent with NCQA standards and State requirements, to address the following: 12. Process for ensuring that listings in provider directories and other materials for Members are consistent with (re)credentialing data, including, education, training, board certification and specialty.

ii. **DOBI Regulations** (does not apply to contract entered into between a carrier and Medicaid to provide Medicaid Only coverage or NJ FamilyCare coverage)

§ 11:24C-4.5 Content and availability of provider network directories

(a) Carriers shall maintain accurate and current information on all providers, and make that information available to members and prospective members through network directories, as described in this section.

(b) Directories shall include, at a minimum, the following information on all participating providers: name, gender, office locations, phone numbers, professional designation, specialty, acceptance of new patients, practice limitations, and languages spoken other than English.

(c) Directories shall contain a listing of the carrier's in-network hospital outpatient facilities by the types of services the facilities provide. Where applicable, directories shall also prominently display a statement advising members that not all outpatient service providers located at in-network hospitals are in-network providers, and urging members to confirm whether an outpatient service provider is or is not a member of the network before obtaining services from such provider.

(d) A carrier's electronic directory shall include functions designed to facilitate the ability of members to customize their search for providers. Search functions shall include, but not be limited to, specialty and geographic area.

(e) Upon request, carriers shall provide their current printed directory to members and prospective members of the health benefits plans offered by the carrier. The requirement to supply printed directories upon request may be complied with by printing and mailing the most current version of the on-line directory applicable to a particular member's plan in lieu of periodic publication and stocking of hard copy directories. The carrier shall mail a copy of the printed directory to a member or prospective member within five business days of the request measured from the date of the carrier's receipt of the request.

(f) If a carrier publishes a hard copy of the directory, the information shall accurately reflect the content of the carrier's electronic directory as of the date the printed directory was submitted for publication. The following information shall be included in or accompany the printed directory:

1. The date of publication of the printed directory;
2. A statement that the directory is accurate as of the date on which the printed directory was submitted for publication;
3. A statement that more current directory information is available on the carrier's electronic directory available on the carrier's website;
4. The anticipated date on which the next printed edition will be published; and
5. The carrier's website address where the electronic directory can be accessed.

(g) Carriers shall maintain a history of their electronic directories for three years. This requirement may be met by establishing a capability of reconstructing a directory as of any date within the prior three years.

(h) Carriers publishing hard copy directories shall retain as business records copies of each version of its printed provider directory for at least three years from the publication date.

§ 11:24C-4.6 Standards for accuracy of provider directory information

(a) Carriers shall implement a system for maintaining accurate and current information on all providers listed in a network directory.

(b) Carriers shall ensure the information in the provider directory is based on the most recently submitted information from the provider or the Council for Affordable Quality

Healthcare (CAQH).
(c) Carriers shall update electronic directories within 20 days of the carrier's receipt of confirmation from a provider or CAQH that current information is inaccurate or has changed. When a carrier disputes a notice that information on a provider is inaccurate, the carrier shall, within 15 days of receipt of a notice from a provider or consumer asserting that the information is inaccurate, respond to the notice in writing and include in its response the reason(s) supporting its position that the challenged information is accurate.
(d) Carriers shall confirm the participation of any provider who has not submitted a claim for a period of 12 months or otherwise communicated with the carrier in a manner evidencing the provider's intention to continue to participate in the carrier's network and for whom no change in provider status has been reported by CAQH. The process for confirming participation shall be as follows:
1. The carrier shall contact the provider and request that the provider confirm his or her intention to continue to participate in the carrier's provider network. Based on the provider's response, the carrier shall update its directories as necessary.
2. If the provider fails to respond to a communication by the carrier, the carrier shall mail a follow-up request to the provider by certified mail, return receipt requested. If the provider fails to respond to such request within 30 days, the carrier shall remove the provider from its network and update its directories as necessary.

III. Example of Current Practices in New Jersey

a. **Horizon NJ Health:** currently uses a document entitled, "How to Update Your Information with Horizon NJ Health" which outlines what providers are required to submit when updating various practice information. Depending on the type of request, the required documentation can vary substantially. All such communication must be performed via email or fax. See Appendix A.

IV. Other Resources

a. **NAIC recommendations**
(http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf) NAIC recently revised its model law for states to require that plans update their provider directories at least monthly.

V. Work group discussion topics to consider:

a. Where we are now: scope of the issue and whether it differs by region, payer, specialty, facility type.
b. Identify causes of the problem (again by varying type)
c. Ways to address the problem
    i. How we can de-couple consumer facing information from information used for other purposes such as contracting and credentialing
    ii. How to create more efficient processes for both plans and providers
    iii. How technology can help
    iv. Lessons learned from other groups focused on creating consumer-driven tools, e.g. RWJF pilot

VI. Working group goals and next steps: TBD

Horizon
Horizon NJ Health

How to Update Your Information with Horizon NJ Health

Requests to update demographic information with Horizon NJ Health can be emailed or faxed to us. Please provide a letter outlining your request along with the following documentation **30 days prior** to the effective date of the requested change(s):

Type of Request	Documentation Required	Comments
Relocation or Add New Location	1) Communication from provider 2) List of providers 3) W-9 4) Americans with Disabilities Act (ADA) survey and site visit for PCPs and OB/GYNs	Specify whether you are closing an existing office and/or adding an additional location
Add Provider to New Location/Group	1) Communication from provider 2) List of location(s) 3) W-9 4) ADA survey for new location 5) Site visit* for OB/GYNs and PCPs for new location	
Close or Open Panel	1) Communication from provider	There is a 90 day waiting period, per policy. Provider must have at least 50 members. We do not close panels for specialists.
Update Other Demographics (hours, phone, fax, suite, languages, age limits, panel limit)	1) Communication from provider	If updating a suite, verify if site visit is needed (required for new locations for PCPs and OB/GYNs).
TIN Change or Purchase of Another Entity	1) Communication from provider 2) W-9 4) List of providers	Note whether you are assuming liability of prior TIN.
Billing and Remittance Change	1) Communication from provider 2) W-9	Be sure the billing address is not a PO box; must be a physical location.
Term from Location/Group	1) Communication from provider	Advise where paneled members should be moved/transferred, if applicable (for PCPs only).

*Site visit is conducted by the Horizon NJ Health Provider Relations Representative.

Your request and supporting documentation can be faxed to 1-973-274-4126 or emailed to ProviderFileOps2@horizonblue.com.

Please include the following on your request:

- Submitter's name
- Submitter's email address
- Submitter's telephone number