



Date: December 15, 2016

Subject: New Provider Directory Requirements

Dear Health Care Provider:



The Centers for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) have enacted requirements that health plans engage providers in reviewing and maintaining provider directory information. The regulations are designed to ensure health care consumers have current and accurate provider demographic information.

As a result, all health plans will ask each individual provider to verify their information every 90 days. Some health plans already have started this outreach to providers and their office staffs to validate information, and will continue to do so on an ongoing basis. Providers will be asked to review the following information*, including, but not limited to:

1. Provider office locations and addresses
2. Phone number
3. Specialty
4. Panel status
5. Product participation

CMS and other organizations will audit health plan directory information to validate its accuracy, and will report incorrect findings back to health plans for correction.

HCAS and our participating health plans appreciate your compliance with these regulations that will help to ensure your providers are accurately listed and consumers have the most up-to-date provider directory information.

We wanted to make you aware that participating HCAS health plans will be reaching out to you with instructions for complying with the new requirements.

HealthCare Administrative Solutions, Inc. (HCAS) is a non-profit entity founded by several Massachusetts health plans to collaborate on administrative simplification initiatives.

**The list includes examples of data elements and may not reflect all elements required by CMS and NCQA.*