



WEDI MEMBER POSITION ADVISORY REPORT:

CMS QHP DIRECTORY PILOT

OCTOBER 2026

Workgroup for Electronic Data Interchange • 3503 Connecticut Ave, NW, Suite 205
Washington, DC 20008 • www.wedi.org

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ABOUT WEDI

The Workgroup for Electronic Data Interchange (WEDI) was formed in 1991 by Secretary of HHS, Dr. Louis Sullivan in an effort to identify opportunities to improve the efficiency of health data exchange. WEDI was named in Section 1172(c) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislation as an advisor to the Secretary. Since that time, WEDI has closely interacted with every subsequent U.S. Administration, including the current one. With its close working relationships with the Centers for Medicare & Medicaid Services (CMS), Office for Civil Rights (OCR), and Office of the National Coordinator for Health Information Technology (ONC), WEDI has the ability to influence all facets of health IT policy.

Today, WEDI drives strong, unified public-private partnerships to improve health information exchange by bringing together organizations from across the health care spectrum including providers, payers, vendors and government. By convening health care leaders and driving consensus-based solutions, WEDI has been successful in resolving current data exchange-related roadblocks and continuously motivates the industry towards administrative automation.



Mission

Provide multi-stakeholder leadership and guidance to the nation's health care system on how to use and leverage the industry's collective technology, knowledge, expertise and information resources to improve the administrative efficiency, quality and cost effectiveness of health care information.

Vision

Better health care at lower cost through collective action.

EXECUTIVE SUMMARY

This report documents the WEDI Member Position Advisory (MPA) on the CMS Qualified Health Plan (QHP) Directory Pilot, convened at the request of the CMS Center for Consumer Information and Insurance Oversight (CCIIO). The purpose of the MPA was to gather broad, industry-wide input on the functionality of provider directories, specifically data accuracy, data exchange, consumer value, user experience, provider burden, and scalability. The MPA was designed for WEDI members to voice their perspectives on the QHP Directory Pilot currently underway in Oklahoma and share their experiences with provider directories for future CMS provider directory initiatives. This report is intended to communicate what WEDI heard from stakeholders and is made publicly available alongside supporting appendices.

WEDI created the MPA process to collect feedback from its members for the purpose of submitting comments on regulatory actions, requests for information, and other relevant governmental actions that accomplish WEDI's objectives in its advisory role to HHS. The MPA provides WEDI members with the opportunity to voice their perspectives, opinions, and positions on critical topics shaping health data standards, interoperability, privacy and security, and other issues of importance. Information gathered and conclusions made through the MPA process are compiled into a letter or report that is finalized and approved by the WEDI Board of Directors.

For this MPA, CMS provided WEDI with seven topics on which it was seeking feedback. WEDI held a virtual event where CMS and contractor representatives presented an overview of the Oklahoma QHP Directory Pilot, demonstrated the directory portal, and answered questions. An in-depth discussion of the CMS-provided topics followed and was facilitated by industry experts.

Overarching themes for future provider directories discussed across the topics included:

- The importance of including the right data for the right purposes, supporting interoperability and reuse

of that data, and establishing strong data quality and transparency, allowing provider directories to evolve from a basic listing into trusted infrastructure supporting consumers, providers, health plans, and broader health care interoperability.

- The need to develop a standardized approach for future provider directory solutions but strategically transitioning through a phased-in approach that supports the needs of organizations with varying technical and resource capabilities.
- The need for provider directories to move beyond simply providing “demographic” information to supporting patient care journey needs through more dynamic information.
- The importance of measuring the success of a provider directory by how it supports the ability of patients to make informed decisions and efficiently and effectively access care.
- The importance of provider participation in any future provider directory to be easier, more useful, and less burdensome than the current fragmented process.
- The need to reduce repetitive reporting by providers by leveraging trusted sources, automation, and interoperable infrastructure that allows verified provider information to flow across programs and systems.
- The need to replace fragmented reporting rather than adding another layer of burden, while creating a flexible, interoperable framework that can accommodate state requirements and evolve through future rulemaking.

The remainder of this document provides the detailed record supporting this summary, including an outline of the MPA process, summaries of the CMS presentation, demonstration, and topic discussions during the virtual event, and the edited open-discussion transcript. The appendices compile key artifacts used during the MPA (WEDI's MPA procedure, MPA agenda, and transcripts). Together, these materials are intended to give CMS, other policymakers, and industry stakeholders a transparent view into WEDI member input and the range of perspectives on the CMS QHP Directory Pilot and future work on provider directories.

OVERVIEW OF WEDI'S MEMBER POSITION ADVISORY PROCESS

WEDI, as a named advisor to the Secretary of HHS in HIPAA, has long maintained a process through which it obtains feedback from its members for the purpose of submitting comments to HHS and its agencies to fulfill this advisory role. Multiple methods can be employed by WEDI to gather feedback, including the MPA process, an ad hoc task group, a relevant WEDI workgroup or subworkgroup, or other individuals designated by the Chair.

The purpose of the MPA process is to ensure that members provide input and data on relevant topics that assist WEDI's Vice Chair of Policy, Policy Committee, and Board of Directors in developing recommendations, comments, and positions that reflect the views held by WEDI's diverse membership. This process may include requests for written statements, surveys, virtual meetings, in-person meetings, interviews, electronic polling tools, and other means to gather the necessary input.

The MPA process may be initiated for a variety of reasons including, but not limited to, responding to a Notice of Proposed Rulemaking, Interim Final Rule

with Comments, Request for Information, Listening Session, other request for formal industry feedback, invitation to speak to or communicate in an official capacity with a government entity, and other documents for which industry feedback is sought. The MPA process supports obtaining input and data to inform such recommendations, comments, or positions, which are finalized by the WEDI Board of Directors.

The goal of the MPA process is to offer the opportunity for WEDI members to advise the organization on topics and issues of importance. Member participation gives WEDI greater insights into the perspectives and concerns of a broader range of stakeholders. Additionally, the MPA format provides for expedited means to collect the input and data.

The MPA process is designed for members to advise the WEDI Board of Directors on the topics and issues in which it has knowledge, background, experience, and perspectives. The Board of Directors' responsibility is to review and finalize recommendations, comments, and positions that reflect the input and advice of the members while aligning them with WEDI's mission.

OVERVIEW OF CMS QHP DIRECTORY PILOT MPA PROCESS

In July 2026, CMS contacted WEDI leadership regarding its QHP Directory Pilot project underway in Oklahoma. CMS requested WEDI's assistance in obtaining industry-wide feedback on the functionality of the directory pilot, specifically its usability by providers and health plans and improvements for patients seeking providers. The intent of the MPA was to gather WEDI members' perspectives on this pilot and its potential to shape future CMS provider directory initiatives. The CMS QHP Directory Pilot MPA followed the following process:

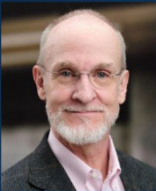
- CMS provided a list of topics it wanted to have explored in the MPA.
- Facilitators for the MPA were selected to represent a balance of stakeholder types and subject matter expertise from the WEDI Board of Directors, WEDI Workgroups and Subworkgroups, and other WEDI members.
- Frequent messaging through various WEDI communication channels was completed to provide members with the details of the MPA and encourage participation.
- The 3-hour MPA event was held virtually and included the following:
 - Welcome and MPA Overview
 - Facilitator Introductions
 - CMS-led QHP Directory Pilot Overview, Demonstration, and Q&A
 - Discussion of CMS Provided Topics and Questions

MPA Report

Following the MPA, WEDI staff drafted this report, which was then reviewed by the WEDI Board of Directors. Once finalized and approved by the Board, the final report was sent to CMS and released publicly.

**MEMBER POSITION
ADVISORY EVENT**

**MEET OUR
FACILITATORS**

 MERRI-LEE STINE AETNA WEDI CHAIR	 DENNY BRENNAN MHDC WEDI CHAIR ELECT	 JULIE BROWN-GEORGI AMA	 TERRY CUNNINGHAM AHA	 CORRIE HEARN GEISINGER	 TREVOR HOBAN AVAILITY	 ANNA HYDE ARTHRITIS FOUNDATION
 STEVEN JOHNSON HCSC	 GAIL KOCHER BCBSA	 DANIELLE LLOYD AHIP	 SAM MEHLIR MGMA	 KAY WARD LANYARD HEALTH	 ROBERT TENNANT WEDI EXECUTIVE DIRECTOR	 NANCY SPECTOR WEDI SENIOR DIRECTOR OF FEDERAL AFFAIRS & MODERATOR

SUMMARY OF CMS QHP DIRECTORY PILOT MPA

Structure of CMS QHP Directory Pilot MPA

The structure of the CMS QHP Directory Pilot MPA was set in a manner that would provide as much industry-wide input as possible from WEDI members, including:

- An overview given by CMS staff and LMI contractors of the CMS QHP Directory Pilot
- A demonstration given by CMS and LMI of the QHP Directory Pilot portal
- A Q&A session led by CMS and LMI on the QHP Directory Pilot and portal
- An interactive discussion facilitated by representatives of a broad range of industry stakeholders of the CMS provided topics and questions, including participation by approximately 100 attendees.

See Appendix B for the detailed CMS QHP Directory Pilot MPA agenda.

CMS QHP Directory Pilot, Demonstration, and Q&A

Presenters

- Erika Melman, Director, Division of Issuer Management & Operations, CMS CCIIO
- Cassie Thompson, Management Analyst, CMS CCIIO
- Ivan Kuo, LMI Solutions
- David McGinnis, LMI Solutions

Introduction

Erika Melman, CMS, provided an overview of the agency's interest in this topic and receiving broad industry feedback on their work with the QHP Directory Pilot in Oklahoma. Accurate provider directories are a critical priority because providers are essential to Medicare, Medicaid, and Marketplace programs and are a key factor in consumers' health plan decisions. Despite significant efforts by CMS, health plans, and providers to collect and maintain provider information, directory inaccuracies remain a persistent issue that can

negatively affect consumers. It is anticipated that CMS will pursue broader agency-wide initiatives to improve provider information and broad stakeholder input will be essential as effective solutions are developed. The Oklahoma Provider Directory Pilot, while limited in scope, has already generated valuable lessons that CMS is expected to apply to larger efforts.

Pilot Summary

Cassie Thompson, CMS, described the QHP Provider Directory Pilot. The pilot is a partnership with the state of Oklahoma, and it is designed to create a centralized, automated provider directory that streamlines how providers submit, verify, and maintain information and how health plans access that data. The pilot uses information from multiple sources, including the National Plan and Provider Enumeration System (NPPES), CMS-submitted machine-readable data, and network adequacy data, to create an initial dataset that providers, administrators, or assigned delegates can review and update through a secure portal. QHP issuers then access verified provider information through a Fast Healthcare Interoperability Resource® (FHIR®) application programming interface (API) to update their own public-facing directories, with the goal of improving data accuracy, standardizing the data, and reducing the administrative burden associated with maintaining multiple directories.

Provider directories are currently inconsistent, costly to maintain, and often inaccurate, which can negatively affect patients making decisions about where to receive care. In particular, inaccurate provider directory information can result in patient protections requiring health plans to apply in-network cost-sharing when patients rely on incorrect information and receive care from an out-of-network provider. A centralized approach could reduce duplicative data collection and help providers and health plans meet federal provider directory requirements, including requirements under the No Surprises Act.

SUMMARY OF CMS QHP DIRECTORY PILOT MPA continued

Oklahoma is requiring Marketplace Health Plans to participate by directing their providers to use a centralized portal and then incorporate the verified information into their own directories. The pilot is also assisting CMS better understand operational challenges and identify opportunities to support compliance with existing and future federal requirements. Lessons learned from the Oklahoma pilot are expected to inform broader CMS efforts and potential future national approaches to improving provider directory accuracy and interoperability.

Demonstration

Ivan Kuo, LMI, a designer and researcher on the QHP Directory Pilot team, played a video demonstrating the QHP Provider Portal. The demonstration showed the CMS QHP Directory Pilot portal and how providers and health care organizations can review, update, and verify provider directory information, while enabling QHP issuers to retrieve verified data through standardized data exchange. In the production environment, users authenticate using NPPES credentials and multi-factor authentication, with access and permissions based on their role. The portal provides reminders to update information within 30 days of a change and verify information every 90 days.

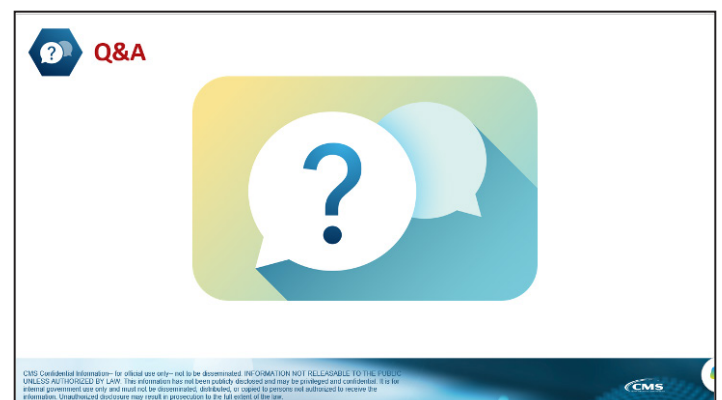
As outlined in the demonstration, the portal guides provider users through a series of sections, including professional contact information, demographics, professional profile, practice locations, and health plan participation. Much of the information is pre-populated from existing data sources, with some fields designated as read-only. Providers can edit permitted fields, such as specialties, practice details, care delivery modalities, and whether they are accepting new patients for specific health plans. Providers then review their information, attest to its accuracy, and submit the updates through the portal.

The demonstration also highlighted different access levels for organizational administrators and provider delegates, allowing users to manage information based on their assigned permissions. In response to previous stakeholder feedback, CMS enhanced the portal to

support bulk verification, recognizing that organizations may oversee numerous providers and practice locations. The bulk verification functionality allows administrators to review and make multiple updates across providers and locations from a single screen.

Following the video, Mr. Kuo provided an overview of the Bulk Verify functionality. It was designed to help organizational users efficiently review multiple provider directory records through a dedicated scope-selection page and consolidated worksheet. Users can select up to 10 records per verification session, with organization records and their associated practice locations displayed together to clarify relationships and required information. The worksheet distinguishes read-only and required fields and provides integrated validation, identifying errors that must be corrected before submission and warnings that prompt users to review potentially problematic information.

Presentation Slides



SUMMARY OF CMS QHP DIRECTORY PILOT MPA continued

Presentation Slides continued



Resources

QHP Directory Pilot Website:
Includes a user guide to the portal, FAQs, and an introductory webinar:
<https://www.cms.gov/qhpdirectorypilot>



Help Desk: For more information, including dates of upcoming Office Hours, or for any other questions, please email:
QHPDirectorypilot@cms.hhs.gov

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Overview (cont'd)

Why It Matters

- Reduces administrative burden
- Improves provider directory accuracy
- Supports better patient access to accurate information
- Reduces the risk of provider financial liability



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Agenda

- Overview
- How It Works
- Provider Responsibilities
- Why Accurate Directory Information Matters
- Key Takeaways
- Next Steps
- Demonstration of Portal Interface
- Q&A
- Resources

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How It Works

1 DATA AGGREGATION

CMS combines provider and facility information from existing systems into one directory.

2 PROVIDER VERIFICATION

Providers log into a secure portal to review, correct, and verify their pre-populated information – avg. 4 minutes per profile.

3 HEALTH PLAN UPDATES

Verified data is shared with health plans via FHIR API, ensuring up-to-date directories.

4 FEEDBACK & IMPROVEMENT

CMS collects performance data and provider feedback throughout the pilot to shape future directory standards.

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Overview

What Is The Pilot?

- On September 17, 2024, CMS announced a partnership with the state of Oklahoma on a pilot program aimed at improving provider directory accuracy.
- The pilot creates one centralized directory for participating providers and Qualified Health Plans (QHPs) in Oklahoma.
- CMS combines provider data from existing systems into one unified source.
- Providers can review and verify their information through a secure portal.
- The pilot will help inform a future National Provider Directory.
- The portal is live as of June 9, 2025, and the pilot runs through the end of the calendar year.



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Provider Responsibilities

Providers Should:

- ✓ Review, update, and verify pre-populated information as soon as possible.
- ✓ Update directory information within 30 days of changes, including:
 - Contact Information
 - Practice Locations
 - Specialties/Services
 - Network Participation
- ✓ Reverify information every 90 days.
- ✓ Share feedback on portal usability and data accuracy.

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SUMMARY OF CMS QHP DIRECTORY PILOT MPA continued

Presentation Slides continued



Key Takeaways

What Providers Need to Remember

- The portal is live as of June 9, 2025, and the pilot runs through the end of the calendar year.
- Review and maintain accurate directory information.
- Update information promptly when changes occur.
- Verify directory information regularly.
- Accurate provider data supports patients, health plans, and compliance efforts.
- Provider feedback will help improve future directory standards.

Provider feedback is critical!

Resources





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CMS



Next Steps

- CMS will provide portal access and guidance materials.
- Providers should identify internal staff responsible for directory updates.
- Questions and feedback are encouraged throughout the pilot.



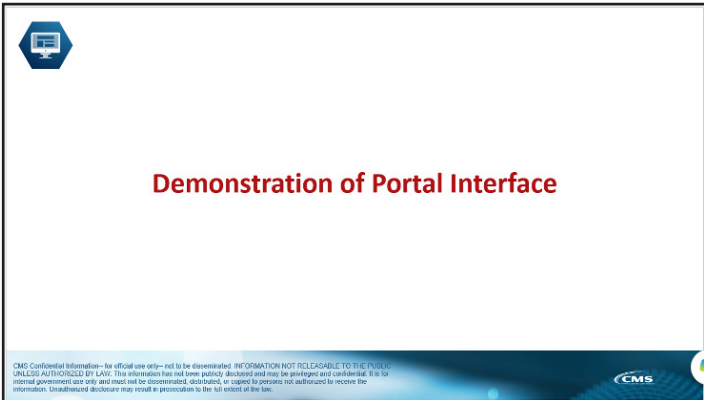


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CMS



Demonstration of Portal Interface



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CMS

Summary of CMS Q&A Session

The following is a summary of each question and response:

1. *How can a practice designate a surrogate to review and approve information?*

Practices can designate surrogates through the CMS Identity & Access (I&A) system. Surrogacy is assigned through the NPPES business function, allowing the designated individual to access the QHP Directory Pilot portal and manage the provider's information.

2. *What happens if provider records are not updated within the required timeframe?*

CMS sends reminders to users when information needs to be updated or verified. The portal uses color coding to indicate whether records are current, approaching their update deadline, or past due, helping users identify records requiring attention.

3. *Can consumers see whether provider information has been verified or is out of date?*

The pilot portal is not currently public facing, so consumers cannot see verification status directly. Participating QHP issuers, however, can see when provider information was last verified or attested to and can use that information when managing their own directories.

4. *How is the pilot addressing inaccurate or conflicting data sources and No Surprises Act requirements?*

CMS encouraged Oklahoma providers to review the information being incorporated into the pilot because the system draws from multiple sources, including NPPES and commercial health insurer data, which can contain conflicting or inaccurate information. CMS recognizes that inaccurate provider directory data can create compliance and financial risks under the No Surprises Act and hopes future efforts will give providers a practical, centralized way to validate information and maintain compliance.

5. *Does the pilot capture provider EHR FHIR endpoints?*

Not currently. The pilot does not pull provider electronic health record (EHR) FHIR endpoints. It primarily uses data sources internal to CMS, although

the project team indicated that incorporating EHR endpoints could be considered for future development.

6. *How is provider participation in a health plan network validated?*

Network participation is currently provider-reported. Providers identify the networks in which they participate, and that information determines which issuers receive the provider's directory data.

7. *Can large practices submit a single spreadsheet with all their providers' information?*

The portal does not currently have a spreadsheet or roster upload capability. However, CMS has developed the Bulk Verify functionality to allow organizations managing multiple providers and locations to review and update multiple records more efficiently.

8. *What adoption rate is the pilot currently seeing?*

CMS is targeting approximately 50% participation among QHP-associated providers in Oklahoma. At the time of the discussion, approximately 32% of the targeted provider population had participated, with CMS continuing to work toward its 50% goal.

9. *Will providers be held accountable for keeping their information complete and accurate?*

The portal is designed to clarify which information is administrative and which information is shared with issuers and potentially made public. CMS is also using required fields, verification processes, and reminders to encourage providers to maintain accurate information, while recognizing that some existing data, such as NPPES contact information, can be confusing or difficult to interpret.

10. *What FHIR Implementation Guide is being used?*

The pilot is primarily based on the Provider Data Exchange (PDex) Plan-Net Implementation Guide (IG), while incorporating selected elements of the National Directory of Healthcare (NDH) IG. When the pilot began, the NDH IG was still in preview, so the team selected Plan-Net as its primary foundation while continuing to monitor and incorporate useful elements from NDH.

11. What are the next steps for expanding the pilot beyond Oklahoma and Marketplace plans?

The Oklahoma pilot is expected to sunset at the end of 2026, but CMS has broader efforts underway to improve provider directory information nationally. Verified data and lessons learned from the Oklahoma pilot will feed into those efforts, with potential future expansion to other CMS programs and lines of business, including Medicare and Medicaid.

Summary of Facilitated Discussion of CMS Topics and Questions

Note: Wording in italics on the slides was added by WEDI.

Topic 1: Data Trust and Accuracy

#1: Data Trust and Accuracy

- What data elements are most critical for provider matching, directory updates, and network validation?

Data elements for individuals:

- Practitioner information, e.g., name, provider type, credentials, NPI, specialty, license number, etc.
- Practice and affiliation information, e.g., practice or group name; group, hospital, or facility affiliations; etc.
- Practice location, e.g., address, phone number, hours, etc.
- Services and clinical information, e.g., specialty, services provided, populations served, etc.
- Network and participation information
- Languages spoken
- Accepting new patients
- Others?

Data elements for organizations and groups:

- Organization name, e.g., legal business name, NPI, tax ID, accreditation status, license number, etc.
- Organization type and services, e.g., facility or group, specialty, website URL, services provided, clinical programs, populations served, etc.
- Locations, e.g., physical address, mailing address, phone number, hours, etc.
- Network and participation information
- Affiliations, e.g., other groups or facilities, parent organization, etc.
- Others?

15 mins (1:45 – 2:00)

#1: Data Trust and Accuracy

- What data elements are most critical for provider matching, directory updates, and network validation?

Data elements for individuals:

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- Network and participation information
- Languages spoken
- Accepting new patients
- Others?

Data elements for organizations and groups:

- Organization name, e.g., legal business name, NPI, tax ID, accreditation status, license number, etc.
- Organization type and services, e.g., facility or group, specialty, website URL, services provided, clinical programs, populations served, etc.
- Locations, e.g., physical address, mailing address, phone number, hours, etc.
- Network and participation information
- Affiliations, e.g., other groups or facilities, parent organization, etc.
- Others?

15 mins (1:45 – 2:00)

- Develop purpose-driven data elements. The data needed for provider matching, directory updates, and network validation are not necessarily the same.

Health plans may maintain significantly more provider attributes than those currently included in the pilot, based on the use of the data. Any future provider directory efforts should identify and prioritize data elements based on specific use cases rather than creating one broad list of data elements.

- Focus on consumer relevant information. Accurate information in a provider directory, such as accepting new patients, specialties and expertise, practice locations, contact information, network participation, and services offered, can directly affect patients’ ability to access care and make informed decisions. Additional relevant information for a provider directory is appointment wait times and provider affiliations and relationships within health systems, particularly for patients managing complex or chronic conditions.
- Support broader interoperability through provider directories. Incorporating FHIR API endpoints and interoperability-related data in provider directories will support larger interoperability efforts by allowing directories to serve not only as a patient resource but also as infrastructure for broader health information exchange, prior authorization, and other electronic transactions.
- Design provider directories to support multiple uses. Provider directories have the potential to transform from a single source of provider information to support multiple health plans, states, and lines of business. Ideally, rather than requiring providers to update separate systems, updates would be made once and flow across other relevant sources, with appropriate security guardrails and safeguards in place.
- Establish trust through data provenance and validation. Problems with data, such as PO boxes, personal email addresses, National Provider Identifier (NPI) mismatches, and inaccurate read-only information, can occur. Clear validation rules, timely escalation processes, and mechanisms to connect back to authoritative source systems are necessary so errors can be corrected at the source. A two-way process would assist in preventing multiple conflicting versions of provider information and create a more reliable source of truth.

- Increase consumer confidence through transparency. Providing verification dates, attestation history, and timestamps would identify how current the provider information is. Increased transparency regarding when information was last verified would increase trust in provider directory data.
- Consider phased implementation of data elements. Organizing data elements into manageable categories, such as provider identity, qualifications, and organization location, and phasing implementation of the data elements may be an appropriate way to manage the various uses of provider directories.
- Solicit additional public input through formal rulemaking. The formal rulemaking process would provide CMS with a more in-depth evaluation, more specific use cases, and well-rounded feedback to direct, establish, and refine the data elements necessary for any future provider directory effort.

Topic 2: Interoperability and Data Exchange

#2: Interoperability and Data Exchange

- What is the preferred method for receiving QHP Directory Pilot data (FHIR, bulk file, change notifications, etc.)?
 - How frequently should updates be delivered?
 - Should the exchange include full provider files, change-only files, or both?
- Which existing standards or exchange processes should the QHP Directory Pilot align with to support increased adoption?
 - What workflow changes would be needed to incorporate QHP Directory Pilot data?
 - Are there existing contracts, vendor processes, or internal review requirements that could limit integration?

15 mins (2:10 – 2:25) ¹⁵

- Establish FHIR APIs as the preferred long-term approach. FHIR-based APIs would be the preferred primary method for exchanging provider directory information, consistent with the broader industry shift toward API-driven interoperability.
- Support both API and bulk exchange methods. Due to organizations' different levels of technical maturity, optimally, any solution should support real-time and API-based exchange, as well as bulk or batch FHIR, allowing organizations that are not yet ready for FHIR APIs to participate.
- Use change notifications plus periodic file down-

loads. A combination of change-only updates or notifications for high-value changes supplemented by periodic file downloads to support reconciliation, validation, and data integrity can minimize operational burden. An appropriate cadence must be established for uploading data changes to meet organizations' expectations, data uses, and system requirements. Inconsistent updates and delivery schedules across organizations could create timing problems and undermine the reliability of any national provider directory. A standardized approach to the update frequency will be important as adoption expands.

- Consider subscription-based notifications. FHIR subscriptions could notify health plans when provider information changes, reducing the need for continuous downloading and helping health plans maintain more current directories.
- Align with existing FHIR and provider directory standards. Greater alignment with existing FHIR provider directory standards and data exchange processes would make adoption easier by allowing organizations to incorporate the solution into existing workflows rather than creating entirely new processes.
- Account for workflow and contractual impacts. Transitioning from multiple health plan-specific directories to a centralized source of information could require changes to existing vendor arrangements, contracts, internal review processes, and downstream systems. CMS should consider these operational impacts as the model evolves.

Topic 3: Data Architecture and Matching

#3: Data Architecture and Matching

- How do issuers and provider groups currently organize provider data across individual practitioners, organizations, practice locations, and networks?
 - Which identifiers (NPI, EIN, taxonomy, issuer-assigned IDs, etc.) are needed for reliable matching across systems?
- How should the QHP Directory Pilot Portal represent practitioners who work at multiple locations or participate in multiple networks?
 - Are there data relationships in existing systems that would support successful integration?

15 mins (2:25 – 2:40) ¹⁶

- Use multiple identifiers and data elements. NPI Type 1 and Type 2 identifiers can support matching providers across multiple locations, but identifiers alone may not be sufficient. Additional information, such as group affiliations, taxonomy, contracting relationships, and location data, is needed to accurately establish provider relationships.
- Support complex provider relationships. Directory architecture needs to accommodate providers who practice at multiple facilities, maintain their own practices, or have affiliations with multiple organizations and networks. There is also a need to clearly identify who has verified information and establish a process for correcting erroneous matches.
- Leverage existing provider roster structures. Existing provider group rosters commonly organize information around the individual provider, organization or clinic affiliation, associated address, and network or health plan participation. This existing structure could provide a useful foundation for future provider directory architecture and matching approaches.
- Improve the provider verification experience. Highlighting information that has changed since a provider's previous verification rather than requiring users to review every data element repeatedly will streamline provider efforts to verify their data. Better visual cues and education could reduce administrative burden and help prevent inaccurate information.
- Consider referral relationships and care pathways. Future provider directories should provide greater visibility into referral networks, provider affiliations, and care pathways, particularly to help patients with complex or chronic conditions identify appropriate specialists and coordinate care.
- Address privacy and downstream data use. Matching is only one part of the provider directory architecture. There is also a need to consider how sensitive information, including tax identifiers and personally identifiable information (PII), is protected, tokenized where appropriate, and made available to authorized downstream users.
- Design for different levels of technical maturity. The directory architecture must work for provider

organizations and health plans of different sizes, resources, health IT capabilities, specialties, affiliations, and patient populations. It is important to make the system accessible to organizations with varying levels of technical sophistication.

- Obtain stakeholder input through formal rulemaking. Given the complexity of provider relationships, identifiers, matching scenarios, and potential discrepancies, a robust rulemaking and stakeholder engagement process is necessary to establish how these issues should be addressed nationally.

Topic 4: Consumer Value and Directory Completeness

#4: Consumer Value and Directory Completeness

- What provider directory information is currently hardest for patients to find or most frequently inaccurate?
 - Which details beyond network participation and specialty (e.g., appointment availability, telehealth) are most important to care decisions?
- Are there data elements missing from the QHP Directory Pilot Portal that would drive adoption?
 - Could demonstrating a clear consumer benefit motivate providers to keep their QHP Directory Pilot information current?

20 mins (2:45 – 3:05) ¹⁸

- Focus on consumer utility to measure provider directory value. A provider directory should not be judged solely on data completeness or successful data exchange. Its value ultimately depends on whether it enables patients and caregivers to efficiently and effectively find, access, and navigate care.
- Prioritize accurate provider directory information. Consumers need confidence that the data in a provider directory is accurate. Incorrect and outdated information can significantly undermine a directory's usefulness. Dynamic and relational data, while more difficult to keep current, may have greater value for consumers. Data to be considered includes:
 - Whether a provider is accepting new patients
 - Appointment availability and average wait times
 - Services offered at a specific location

- Telehealth, hybrid, and in-person availability
- Whether referrals are required
- Appointment scheduling methods
- Accessibility and accommodation information
- Languages spoken
- Caregiver support options
- Provider's network relationships
- Provider's affiliations with other providers and organizations
- Phase in consumer-facing improvements. While additional data elements could increase a provider directory's value, the foundational data and existing pilot processes need to be completed before adding more complexity. Future enhancements should be phased in based on consumer value.
- Build on existing regulatory requirements to support updated data. Requirements under the No Surprises components of the Consolidated Appropriations Act and existing health plan processes provide a foundation for keeping provider directory information current, although continued improvement is needed.
- Establish usability of directories through consumer-centered measures. CMS is encouraged to evaluate provider directory improvements using measurable outcomes such as:
 - Reduced time to find an appropriate provider
 - Reduced errors in directory information
 - Improved consumer confidence in provider directory information
 - Reduced barriers to accessing care
 - Improved connections to an appropriate provider
- Build a national approach to provider directories. Rather than maintaining multiple disconnected directories across states and health plans, a national approach could improve consistency, reduce duplicative reporting, and make provider information more useful to consumers across the health care system. The Oklahoma QHP Directory Pilot can help inform this broader effort.
- Focus on provider directory value, not just completeness. The ultimate measure should be whether the information is accurate, updated in a timely manner, actionable, and meaningful enough to help

consumers, patients, and caregivers make decisions and successfully access care.

Topic 5: Provider Participation and User Experience

#5: Provider Participation and User Experience wedi

- What barriers make it difficult for providers or their delegates to keep directory information up to date?
 - What incentives would encourage providers to keep their information current in the QHP Directory Pilot Portal (e.g., bulk verification, task delegation, clearer value communication)?
- What Portal improvements would reduce burden for users, especially those responsible for verifying a large volume of records?
 - Which data elements could be verified in bulk without requiring users to review every record individually?
- Individual practitioners appear less likely to log in than delegates or organizational administrators. Are there additions that would make the Portal more useful or worthwhile for individual practitioners to use directly or specific tasks they would prefer to complete themselves rather than delegate?

20 mins (3:05 – 3:25) ¹⁹

- Address the variability of provider directory burden. Large health systems may have dedicated staff managing provider directory information across hundreds or thousands of providers and multiple health plans. Small, rural, and under-resourced practices typically will have clinicians or general administrative staff manage the process themselves. A one-size-fits-all approach to populating directory information could create disproportionate burden on smaller, rural, and under-resourced providers.
- Reduce the number of provider directories. Stakeholders emphasized that future provider directory efforts should replace or consolidate existing processes rather than create another standalone portal or add another reporting requirement. Providers and organizations are already responding to multiple health plan requests and other initiatives.
- Prioritize provider education and outreach. Some delegated practice staff may not be aware of provider directory requirements or fully understand their responsibilities. Provider education, especially targeted at smaller, rural, and under-resourced providers, should be an ongoing component of any national effort.
- Design provider outreach to alleviate burden. Health plans currently use email, phone, mail,

newsletters, proprietary portal, and other approaches to obtain directory updates from the providers in their network. While multiple methods can improve response rates, inconsistent outreach processes across health plans can also create delays and duplicate requests.

- Design provider directories to highlight required maintenance actions. A valuable enhancement would be to clearly indicate what information has changed since the last verification, so users do not have to re-review every record when most information remains unchanged.
- Simplify authority and access requirements as appropriate. Current challenges exist involving Type 1 and Type 2 NPIs, NPPES access, security credentials, and previously affiliated locations. Clear roles and authority for who can update different types of provider information in the directory are needed.
- Establish the value proposition for providers maintaining their information. Demonstrating how supplying accurate provider directory information supports other administrative and clinical workflows, reduces reporting burden, and enhances patient care, could encourage timely updates from providers and their delegates.
- Identify meaningful incentives or regulatory requirements for maintaining data. Education alone may not achieve broad participation. Some form of regulatory requirement or meaningful incentive may be needed, without being overly punitive.
- Support providers with limited technical resources. A phased approach could help small, rural, under-resourced, and technology-deficient practices transition to a new model without creating disproportionately burdensome administrative or technology requirements.
- Promote successful provider directory experiences. A successful national model should minimize duplicate reporting, provide intuitive workflows, and bulk capabilities, clearly identify changes requiring attention, educate providers and delegates, and create sufficient incentives or requirements to achieve sustained participation.

Topic 6: Issuer Adoption and Provider Burden

#6: Issuer Adoption and Provider Burden wedi

- How could issuers use QHP Directory Pilot data to reduce duplicate verification requests to providers?
 - Which updates could be applied automatically vs. requiring manual review, and where could QHP Directory Pilot data fit into existing workflows without creating a separate process?
 - What barriers (e.g., operational, technical, policy) might prevent issuers or providers from fully utilizing QHP Directory Pilot data?
- How could issuers help communicate the value of the QHP Directory Pilot to providers?
- As a provider or practice leader, when updating directory information (locations, panel status, telehealth availability), how many different systems do you typically have to touch, and how often are you asked to submit the same information to multiple directories or portals?
 - Which steps feel the most duplicative, and how does this affect your day-to-day work?

20 mins (3:25 – 3:45)²⁰

- Seek to reduce duplicate data requests across health plans and programs. Once a provider or authorized organization verifies information, issuers should avoid repeatedly requesting unchanged data unless there is a regulatory, credentialing, or data-quality reason to do so.
- Leverage trusted data sources and automation to reduce administrative burden. Future provider directory initiatives require authoritative, high-confidence sources that can support automatic updates, while retaining manual review for data elements or discrepancies that require additional validation. Tracking data provenance and discrepancies would also help build trust.
- Design a broader interoperable provider directory ecosystem. Bi-directional APIs connecting CMS, health plans, credentialing organizations, licensing entities, and other authoritative sources will be critical. Updates flowing automatically, rather than requiring providers to update multiple systems independently, will support broader interoperability needs.
- Quantify current provider reporting burden and design future initiatives to reduce it. Measuring the time providers spend updating Medicaid, state licensing systems, NPPES, credentialing organizations, EHRs, QHPs, and commercial health plan portals could establish a baseline and demonstrate the value of a future provider directory initiative. A FHIR-based data asset could ultimately support

multiple CMS compliance, provider-access, and consumer-facing uses rather than functioning as another standalone provider directory.

Topic 7: Policy and Scalability

#7: Policy and Scalability

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- The QHP Directory Pilot is currently focused on Oklahoma. What regulatory, operational, or consumer expectation differences would affect what data is collected or how the Pilot operates in other states?
- Are there existing state-level data sharing agreements that could support keeping provider information updated for beneficiaries?
 - What challenges do state health and insurance stakeholders face with provider directory data today?
- *Additional perspectives on a national solution?*

10 mins (3:45 – 3:55) 21

- Establish a common core while allowing for state-specific requirements. Differences in state laws, mandated data elements, enrollment rules, required update frequencies, audit requirements, patient protections, and other state specific requirements will need to be accommodated without creating a separate process for every state.
- Replace existing provider directory requirements. Any future solution must consolidate and replace, not add to, multiple health plan and state reporting requirements in order to drive increased provider participation by improving the return on investment and significantly reducing administrative burden.
- Design any national provider directory solution as a governed, interoperable ecosystem. An ideal provider directory ecosystem will incorporate a network of authoritative data sources, supported by secure bi-directional APIs, including health plan data and FHIR endpoints, while addressing privacy, credentials, delegated access, and other stakeholder requirements.
- Conduct rulemaking to allow further exploration of these topics. The topics and questions discussed at the MPA were generally narrow in scope and limited to the CMS QHP Directory Pilot in Oklahoma. Further consideration for any national solution needs to be outlined in rulemaking, giving stakeholders the opportunity to provide feedback and recommendations to the agency.

CMS QHP DIRECTORY PILOT MPA

FINDINGS AND RECOMMENDATIONS

The following are the findings and recommendations from the CMS QHP Directory Pilot MPA.

Overarching Recommendation:

Throughout the MPA discussion, repeated requests were made for CMS to use formal rulemaking to solicit broader and more in-depth stakeholder feedback on topics critical to the development, implementation, and maintenance of any national provider directory. CMS should use future rulemaking and continued stakeholder engagement, possibly through a Request for Information, to further explore the governance, technical, operational, state-specific, and policy issues necessary to establish future provider directory strategies.

Topic 1: Data Trust and Accuracy

1. Establish a purpose-driven, consumer-focused core data set

Finding: Any future provider directory solution should not attempt to collect every provider attribute currently maintained by health plans. The appropriate data elements will vary depending on the use case, such as provider matching, network validation, provider directory maintenance, or patient decision-making. At the same time, the provider directory must prioritize information that consumers need to find and select appropriate care, including specialties, locations, network participation, services, accepting new patients, and potentially appointment wait times and provider affiliations.

Recommendation: CMS should develop a core, purpose-driven provider directory data set, organized around specific use cases and patient needs, phasing in additional data elements and using formal rulemaking to solicit broader stakeholder input.

2. Build the provider directory as interoperable infrastructure

Finding: Provider directories have the potential to become much more than a source of information for

consumers. Incorporating FHIR APIs and other interoperability capabilities could allow provider directory information to more effectively support health information exchange, prior authorization, provider matching, and other electronic transactions. A future approach could also reduce the burden of maintaining separate provider directories across health plans, states, and lines of business.

Recommendation: CMS should design any future provider directory solution as interoperable infrastructure that supports multiple use cases and stakeholders, incorporating FHIR-based access and enabling an “update once, use many times” approach.

3. Strengthen data quality, provenance, and transparency

Finding: The usefulness and credibility of any future provider directory solution depend on the accuracy and currency of its information. Issues, such as NPI mismatches, incorrect contact information, and outdated data, demonstrate the need for stronger validation and correction processes. Users also need visibility into when information is verified and how current it is. **Recommendation:** CMS should consider establishing clear data validation, provenance, and governance requirements, including mechanisms to improve transparency and consumer confidence.

Topic 2: Interoperability and Data Exchange

1. Establish FHIR APIs as the long-term direction while supporting multiple exchange methods during the transition

Finding: FHIR-based APIs are viewed as the preferred long-term approach for provider directory data exchange and align with the broader movement toward API-driven interoperability. Organizations, however, are at different levels of technical maturity, so requiring API-based exchange immediately could create barriers to participation.

CMS QHP DIRECTORY PILOT MPA FINDINGS AND RECOMMENDATIONS continued

Recommendation: CMS should consider establishing FHIR APIs as the long-term standard for provider directory data exchange, while supporting bulk and batch methods and other practical exchanges during an appropriate transition period.

2. Develop a standardized, predictable approach for updates and notifications

Finding: A combination of change-based notifications and periodic bulk files could provide an effective balance between timely information and data reconciliation. Subscription-based notifications may further reduce the burden on health plans by alerting them only when relevant provider information changes. Without consistent update schedules and processes, any future provider directory solution could still contain outdated or conflicting information.

Recommendation: CMS should consider establishing standardized requirements for update frequency, change notifications, and reconciliation processes with a predictable update cadence as adoption expands.

3. Align with existing standards and account for operational transition

Finding: Adoption will be easier if the provider directory leverages existing FHIR and data standards rather than creating new technical requirements. At the same time, transitioning from multiple health plan-specific provider directories to a centralized or national model could have significant operational implications, including changes to contracts, vendors, internal workflows, and downstream systems.

Recommendation: CMS should maximize alignment with existing industry standards and workflows before establishing new requirements while supporting an appropriate transition period.

Topic 3: Data Architecture and Matching

1. Build a relationship-based provider identity and matching architecture

Finding: The NPI is an important foundation for provider matching, but it is not sufficient to accurately

represent the complex relationships among individual providers, organizations, practice locations, facilities, and networks. Providers may work across multiple organizations and locations, maintain independent practices, or participate in multiple networks. Existing provider roster structures could provide a useful foundation for developing this relationship model.

Recommendation: CMS should consider developing a relationship-based provider identity and matching framework that uses multiple identifiers and attributes and establish clear processes for verification, resolving errors, and maintaining relationship data over time.

2. Design a provider directory solution around usability, verification, privacy, and diverse organizational needs

Finding: The success of any future provider directory solution will depend not only on the accuracy of matching but also on how easily providers and organizations can maintain and verify their information. Requiring providers to repeatedly review unchanged information can increase administrative burden, while unclear relationships or insufficient privacy protections could reduce trust and participation. The system also needs to accommodate organizations with very different technical capabilities and resources.

Recommendation: CMS should consider in the design of any future provider directory solution minimizing provider administrative burden, protecting sensitive information, and accommodating organizations' varying levels of technical maturity.

3. Ensure that any future provider directory solution supports care relationships and establishes national standards through stakeholder engagement

Finding: Any future provider directory solution should provide value beyond basic provider identification by capturing relationships that help explain how providers deliver care, including affiliations, referral networks, and care pathways. Determining how these complex relationships should be represented nationally will require significant stakeholder input and agreement.

CMS QHP DIRECTORY PILOT MPA FINDINGS AND RECOMMENDATIONS continued

Recommendation: CMS should explore how provider directories can represent referral relationships, affiliations, and care pathways to further support patients' needs.

Topic 4: Consumer Value and Directory Completeness

1. Measure provider directory success by patient outcomes, not data completeness

Finding: The ultimate value of a provider directory is whether it effectively allows consumers, patients, and caregivers find, select, and successfully access appropriate care. A provider directory can be technically complete but still be limited in value if information is inaccurate, outdated, or not actionable. Dynamic information, such as whether a provider is accepting new patients, appointment availability, services offered, telehealth options, referral requirements, accessibility, languages, and network relationships, may be particularly valuable to patients and consumers.

Recommendation: CMS should consider establishing patient and consumer-centered measures of provider directory effectiveness and prioritize accurate, timely, and actionable information rather than completeness alone.

2. Take a phased approach to expanding directory information

Finding: Additional data elements to a directory can significantly improve its usefulness but adding too much complexity before foundational processes are established could create unnecessary administrative and operational burdens for reporting. Existing regulatory requirements and health plan processes establish a foundation for maintaining current information that can be built upon.

Recommendation: CMS should prioritize and phase in additional patient and consumer-facing data elements based on their demonstrated value and feasibility.

3. Use the pilot to advance future provider directory solutions

Finding: The long-term opportunity is to move away

from fragmented provider directories maintained independently toward a consistent national approach. A future provider directory solution could reduce duplication, improve consistency, and support information that can be reused across the health care system. The Oklahoma QHP Directory Pilot provides an opportunity to identify practical lessons before broader implementation.

Recommendation: CMS should use the pilot to inform the development of a future provider directory solution while continuing to engage stakeholders to establish a scalable approach that can support consumers, providers, health plans, and other users.

Topic 5: Provider Participation and User Experience

1. Design a future provider directory solution to reduce burden for providers of all sizes

Finding: Any new provider directory solution should be less burdensome and more accurate than the processes it replaces. Providers need clear information about what they are responsible for updating, who will have authority to make changes, and how provider directory information will be used. New processes for updating provider information are necessary and need to address existing issues with data workflows, verification, and change management.

Recommendation: CMS should consider designing a future provider directory solution to replace and consolidate existing reporting processes with efficient workflows, bulk capabilities, and simplified verification process that meets the needs of the broad spectrum of providers.

2. Establish appropriate participation incentives while avoiding disproportionate impacts

Finding: Education alone may not achieve consistent participation across the industry. Some combination of meaningful incentives and regulatory requirements may be necessary to encourage sustained participation. However, overly punitive approaches could disproportionately affect smaller providers and potentially create a downstream negative impact on consumer access to accurate data.

CMS QHP DIRECTORY PILOT MPA FINDINGS AND RECOMMENDATIONS continued

Recommendation: CMS should consider establishing meaningful incentives with reasonable requirements to encourage provider participation.

Topic 6: Issuer Adoption and Provider Burden

1. Make reduction of provider reporting burden a central objective of any future provider directory solution

Finding: Any future provider directory solution should reduce, rather than add to, the administrative burden providers experience today. Once information has been verified, providers should not have to repeatedly confirm unchanged information unless there is a valid regulatory, credentialing, or data-quality reason.

Recommendation: CMS should consider establishing provider reporting burden reduction as a core measure of a provider directory's success and use measurable reductions in provider reporting as a key performance indicator.

2. Leverage authoritative sources and automation to create a trusted, continuously updated data ecosystem

Finding: Significant opportunities exist to reduce manual data maintenance by identifying authoritative, high-confidence sources and automating provider updates. A future provider directory solution should not operate as an isolated repository. Instead, information should flow bi-directionally among CMS, health plans, credentialing organizations, licensing entities, and other authoritative sources. Data provenance and discrepancy tracking will be important for establishing trust.

Recommendation: CMS should consider prioritizing automated, bi-directional data exchange using FHIR APIs and establish clear rules for identifying authoritative sources, validating information, and resolving discrepancies.

3. Design any future provider directory solution as reusable infrastructure rather than another standalone database

Finding: The most significant long-term value of any

future provider directory solution may come from its ability to support multiple CMS, regulatory, provider, patient, and health plan use cases. An interoperable data asset could allow verified information to be reused across programs rather than requiring separate data collection and maintenance processes.

Recommendation: CMS should consider developing any future provider directory solution as shared, interoperable infrastructure that supports multiple use cases, enabling appropriate stakeholders to access and contribute verified information while maintaining data governance, privacy, security, and quality controls.

Topic 7: Policy and Scalability

1. Develop a framework that reduces burden while accommodating state-specific needs

Finding: Any future provider directory solution should establish a common core set of data elements while allowing flexibility for state-specific requirements, including differences in laws, data elements, enrollment processes, update frequencies, audits, and patient protections. The benefit for providers will come from replacing and consolidating existing reporting requirements, rather than creating another system that providers must maintain.

Recommendation: When developing any future provider directory solution, CMS should consider establishing a standardized core set of data requirements while allowing appropriate flexibility to include state requirements. CMS should also consider prioritizing opportunities to consolidate or replace duplicative health plan and state reporting processes.

2. Build a governed, interoperable ecosystem and use rulemaking when developing any future provider directory solution

Finding: CMS should consider developing an interoperable ecosystem of authoritative data sources, rather than a single centralized database. Secure, bi-directional APIs, health plan data, FHIR endpoints, and appropriate governance can allow information to flow

CMS QHP DIRECTORY PILOT MPA FINDINGS AND RECOMMENDATIONS continued

among stakeholders while addressing privacy, credentials, delegated access, and data quality needs.

Recommendation: CMS should explore a governed, interoperable provider directory solution that connects authoritative data sources through secure, standards-based exchange. In addition, the federal rulemaking process should be deployed to ensure stakeholders have the opportunity to comment on any proposal.



APPENDICES

Appendix A: WEDI MPA Procedure

Appendix B: CMS QHP Directory Pilot MPA Agenda

Appendix C: MPA CMS Presentation and (Edited) Discussion Transcript

Appendix D: MPA Chat (Edited) Transcript

Appendix A: WEDI MPA Procedure

The following is the WEDI MPA Procedure as included in the WEDI Policy & Procedure Manual, effective May 14, 2026.

3.6 Member Position Advisory Process

3.6.1 Policy

The purpose of the Member Position Advisory (MPA) process is to ensure that Members provide input and data on relevant topics that assist the Vice Chair of Policy, Policy Committee, and Board of Directors in developing recommendations, comments, and positions that reflect the views held by WEDI's diverse Members. This process may include requests for written statements, surveys, virtual meetings, in-person meetings, interviews, electronic polling tools, and other means to gather the necessary input.

The goal of the MPA process is to offer more options for data collection through which Members can advise WEDI on topics and issues of importance. The flexibility has the potential for more Members to participate thereby giving WEDI greater insights into the perspectives and concerns of a broader range of Members. Additionally, the formats provide for expedited means to collect the input and data.

The MPA process is designed for Members to advise the Board of Directors on the topics and issues in which it has knowledge, background, experience, and perspectives. The Board of Directors' responsibility is to develop recommendations, comments, and positions that reflect the input and advice of the Members while aligning them with WEDI's mission.

3.6.2 Initiating the MPA Process

The MPA process may be initiated for a variety of reasons including, but not limited to, any invitation to speak to or communicate in an official capacity with a government entity, such as CMS, ONC, OCR, NCVHS, HITAC, or other federal, state, or local agency or through an NPRM, IFC, RFI, requests for testimony, and other documents for which industry feedback is sought.

Additionally, as noted in 3.7 Communications with Government Entities, if it is anticipated that WEDI will be expected to present specific formal recommendations, comments, or positions during a meeting with a government entity, those recommendations, comments, or positions must be vetted and approved by the Board of Directors, or Executive Committee. The MPA

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process may be used to obtain input and data to inform such recommendations, comments, or positions.

3.6.3 MPA Process

1. If the MPA process is invoked in 3.5 Comment Development Process, the Vice Chair of Policy works with the Policy Committee on establishing the format to be used.
2. The Policy Committee may delegate the activity of the MPA process to a task group of volunteers, existing workgroup or subworkgroup, or other relevant group as deemed appropriate. The Policy Committee will continue to oversee and remain responsible for the MPA process.
3. The MPA process used may depend on:
 - a. the response being developed, e.g., letter, testimony, or other response
 - b. deadline for submitting letter or testimony
4. The MPA process will include an interactive component of the MPA participants, such as an in-person or virtual meeting. During the meetings, participants will engage in guided discussion and draft and vote on recommendations, comments, and positions. MPAs will be open only to members to attend. Should a vote take place, member attendees are permitted only one vote per member organization.
5. The MPA process may also include any one or more of the following as means to receive input:
 - a. Request to submit written position statements
 - b. Survey to solicit input on specific questions
 - c. Interviews with specific Members
 - d. Electronic voting tool to obtain feedback on support
 - e. Other tools for obtaining input
6. The Senior Director of Federal Affairs will provide the Policy Committee, or delegated group, with a summary of recommendations, comments, and positions made by WEDI in previous letters and testimony relevant to the current request. The Policy Committee, or delegated group, will use this information to develop the MPA request materials, survey questions, meeting materials, interview questions, etc.
7. After the MPA format is decided, the Policy Committee, or delegated group, will determine the rules or guidelines to be used.
8. The MPA format will be conducted.
9. The Policy Committee, or delegated group, will collect and analyze the information and data received from the MPA participants. The analysis will include identifying any gaps in input from any stakeholder groups and if that gap is relevant for the final recommendations, comments, and positions being developed.

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10. The Policy Committee, or delegated group, with the assistance of the Senior Director of Federal Affairs, will draft an analysis with preliminary recommendations, comments, and positions that will be sent to the Policy Committee (if drafted by a delegated group) and Board of Directors for review. If timing is an issue, the Executive Committee may complete the review of the analysis and recommendations, comments, and positions.
11. If there are conflicting views on one or more recommendations, comments, or positions from the Members, the Policy Committee, or delegated group, may conduct a poll using an electronic polling tool to attempt to gain consensus on the topic.
12. Based on feedback from the Board of Directors or Executive Committee, the Senior Director of Federal Affairs will draft the letter or testimony incorporating the recommendations, comments, and positions and send it to the Board of Directors or Executive Committee for review and final approval.
13. Following submission of the letter or testimony, it is published on the WEDI website.

3.6.4 Evaluation of MPA Process

The Policy Committee, with the assistance of the Senior Director of Federal Affairs, will track the use of the MPA process including dates, request or document for which comments were sought, MPA format used, comments and impressions by the Policy Committee at the time the MPA process was conducted, etc. The Policy Committee will periodically conduct an evaluation of the MPA process and report its findings to the Board of Directors.

3.6.5 Example

The following is a hypothetical example showing how the MPA process can be used for a 60-day comment period. The range of days are estimates and not meant to establish requirements.

Day 1 – 4: A significant NPRM is published with a 60-day public comment review period. Per the Comment Development Decision Process, the Officers agree that WEDI will comment on the NPRM and the Board of Directors is notified. The Chair, Chair-Elect, Immediate Past Chair, Vice Chair of Policy, and Executive Director discuss the comment development process to be used. The decision is to use the MPA process.

Day 5 – 7: The Senior Director of Federal Affairs is notified and provides summaries of the NPRM and previous recommendations, comments, and positions made by WEDI on the topic of the NPRM.

Day 8 – 10: The Policy Committee reviews the summaries and decides the format of the MPA will be a virtual meeting preceded by participants submitting written statements answering specific questions.

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Day 11 – 15: The Policy Committee develops a list of questions for the MPA participants to submit prior to the virtual meeting. The WEDI staff schedule the virtual meeting to be held on Day 30.

Day 16: The plans for the virtual meeting and questionnaire are released for Members to register and complete.

Day 17 – 29: The Policy Committee completes planning for the virtual meeting, which includes:

- Planning a webinar on Day 28 by the Senior Director of Federal Affairs who walks through the topics of the NPRM relevant to WEDI.
- Deciding on the rules for the MPA participants to follow during the virtual meeting.
- Compiling the results of the submitted questionnaires and developing slides with the content and draft recommendations or comments to be reviewed during the meeting.
- Developing voting questions to be used during the virtual meeting.
- Sending participants materials for the virtual meeting.

Day 28: The webinar is held.

Day 30: The virtual meeting is held. The meeting begins with 3 hours of discussion on prepared recommendations, comments, and positions on the topics the Policy Committee determined needed Member input. Each participant is limited to 3 minutes to speak and is required to wait until all others speak before speaking again. The meeting includes a 2-hour break that allows the facilitators time to reconcile the information heard, develop additional voting questions, and wordsmith language. The virtual meeting concludes with 1 hour of voting on final language and discussion of next steps.

Day 31 – 40 : The Policy Committee analyzes the input received and results of the voting during the virtual meeting. During the analysis, the Policy Committee identifies a specific topic that was not covered during the virtual meeting and they want to gather specific input on it. They developed a brief survey of specific questions and send it to the Members with a deadline to complete in 5 days.

Day 41 – 45: The Policy Committee with the assistance of the Senior Director of Federal Affairs, begin writing an analysis with preliminary recommendations, comments, and positions.

Day 45: The Policy Committee reviews the survey results of the follow up survey to the Members and incorporates the findings into the overall analysis. The analysis is finalized and sent to the Board of Directors for review.

Day 45 – 50: The Board of Directors or Executive Committee reviews the analysis and provides feedback via email to the Policy Committee and Senior Director of Federal Affairs.

Day 51 – 54: The Senior Director of Federal Affairs drafts the letter of recommendations and sends it to the Board of Directors for review.

Day 55 – 59: The Board of Directors meets on one of these days and the letter is approved.

Day 60: The letter is submitted per the NPRM submission instructions. The letter is also posted on the WEDI website.

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Appendix B: CMS QHP Directory Pilot MPA Agenda

CMS QHP Directory Pilot Member Position Advisory

Wednesday, August 26, 2026

1:00 – 4:00 PM ET

Agenda

Time (ET)	Topic	Speaker
1:00 pm	Welcome and MPA Overview	Merri-Lee Stine, WEDI Chair Robert Tennant, WEDI Executive Director
1:10 pm	Facilitator Introductions	Nancy Spector, WEDI Senior Director of Federal Affairs
1:15 pm	CMS QHP Directory Pilot, Demo, and Q&A	CMS and QHP Pilot Representatives
1:45 pm	Topics and Discussion • Data Trust and Accuracy • Interoperability and Data Exchange • Data Architecture and Matching	Moderator: Nancy Spector
2:40 pm	Break	
2:45 pm	Topics and Discussion (cont.) • Consumer Value and Directory Completeness • Provider Participation and User Experience • Issuer Adoption and Provider Burden • Policy and Scalability	Moderator: Nancy Spector
3:55 pm	Wrap Up and Next Steps	Nancy Spector

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Facilitators

- Merri-Lee Stine, WEDI Board Chair
- Denny Brennan, Massachusetts Health Data Consortium and WEDI Board Chair-Elect
- Julie Brown-Georgi, American Medical Association and WEDI Provider Information Subworkgroup Co-Chair, and WEDI Board Director
- Terrence Cunningham, American Hospital Association and WEDI Board Director
- Corrie Hearn, Geisinger and WEDI Board Director
- Trevor Hoban, Availity
- Anna Hyde, Arthritis Foundation and WEDI Patient Experience Workgroup Co-Chair
- Steven Johnson, Health Care Services Corporation and WEDI Board Director
- Gail Kocher, Blue Cross Blue Shield Association and WEDI Board Director
- Kay Lanyard, Lanyard Health and WEDI Provider Information Subworkgroup Co-Chair
- Danielle Lloyd, AHIP and WEDI Board Director
- Samantha Meklir, Medical Group Management Association and WEDI Board Director
- Contributor: Rich Brennan, ALS Association
- Robert Tennant, WEDI Executive Director
- Moderator: Nancy Spector, WEDI Senior Director of Federal Affairs

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Appendix C: MPA CMS Presentation and (Edited) Discussion Transcript

The following transcript has been edited to remove identifying names, except for the presenters and facilitators. The grammar and formatting have also been edited to allow for easier readability of the content.

CMS Presentation and Demonstration of QHP Directory

[Erika Melman (CMS/CCIIO)] 13:12:08

Thank you all so much for having us on today. We really appreciate getting everyone's perspective. We can sit in CMS, and we sometimes draft regulations and guidance around provider direct accuracy, but as we build and architect things and get into the operations of it, it's really important for us to have that stakeholder feedback and really broad stakeholder feedback.

Provider directory accuracy is really important to CMS. I know it's important to a lot of stakeholders, providers are the engine of CMS main programs. You can't have a Medicare plan or a Medicaid plan or a marketplace plan without providers. And we also know that providers are one of the big decision points about how consumers decide to select a plan.

Across the agency, we spend a ton of time and effort collecting provider information. We know the issuers spend a lot of time collecting provider information and providers spend a lot of time giving provider information to issuers and plans. But despite all this effort, as we know, provider directories, unfortunately, are not as accurate as we want them to be, and that really hurts consumers. For an agency built on serving consumers, this is a huge problem.

We do have some agency-wide efforts. The earlier speaker focused on that a little bit. We are working across CMS on some sort of broader-scope efforts to improve provider information. Our project is a lot smaller in scale. It's only in Oklahoma. It's only marketplace plans. But already by just starting this pilot over the last year, we've learned so much that we plan to share with those who are working on larger efforts and we look forward to getting your feedback during this presentation.

[Cassie Thompson] 13:14:35

Thanks, Erica. Hi, everyone. My name is Cassie Thompson. I'm with CMS. A part of this QHP directory pilot project, along with a number of others on the call today. Thank you so much for taking your time and time out of your busy day to be with us and providing us with this feedback because it is really important.

So, a little about the pilot. I know Erica shared a little bit already, but again, as a reminder, CMS in partnership with the state of Oklahoma, launched this automated statewide centralized provider directory focused in Oklahoma and designed to streamline how providers submit and maintain that directory data, and then how plans and issuers access that data.

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This pilot is focused on qualified health plans offered through the health insurance marketplace. Through a secure portal, providers can access pre-populated data. They can make updates, verify their information, and issuers access that information. There is a lot of interest in directory efforts across CMS data and lessons learned from this pilot will inform future national provider directory. So that's why feedback like yours is so important and we really appreciate you taking time with us today.

We can't emphasize this enough that provider directories today are poorly standardized. They're often inaccurate. They're costly to maintain. CMS is looking to help improve this ecosystem by reducing administrative burden with this centralized place to update directory information across multiple payers.

That's what we're testing. Which also should help improve data standardization and data accuracy. Creating a system that helps support payer and provider compliance with federal provider directory requirements as well, will ultimately help both payers and providers reduce risk of financial liability.

CMS started out by pulling directory data for Oklahoma providers and facilities from a number of data sources, including NPPES, machine-readable information submitted to CMS, and network adequacy data, among others and applied data matching and cleansing effort to build out an initial data set to pre-populate the QHP directory pilot portal.

Providers, organizational administrators, or their assigned delegates can then log into the portal directly via the website, review the information associated with the profile, and update and verify accordingly. This takes about four minutes on average per profile.

Then QHP issuers can access this verified data via a FHIR API. They cannot log into the portal directly, but instead they pull that data via a FHIR API and use that data to update their own directories.

Feedback in this process is really important to us and really crucial to the process of improving the system. We want to emphasize the importance of accurate directory information and helping patients make informed care decisions, which is, again, part of why these efforts are so important across CMS.

Oklahoma is also requiring all the marketplace health plans in the state to participate by directing their providers to use the portal to update their directory information and then pulling that information from the portal to use to update their own public-facing directories.

There are also federal directory requirements, including under the No Surprises Act for both payers and providers that require them to regularly update and submit information to help. For instance, if a health plan or issuer's provider directory is inaccurate and the consumer receives care from an out of network provider or facility, the patient can't be charged more than the in-network cost sharing amount, and the plan must count cost sharing amounts towards any in-network deductible or out-of-pocket maximum. Additionally, the patient is entitled to a full refund from the provider of any money paid over the in-network cost-sharing amount plus interest if that patient paid out-of-network costs to a provider due to reliance on inaccurate provider directory information.

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CMS anticipates upcoming rulemaking on this subject and participation in projects like this help support compliance with federal requirements to keep that directory information up to date and accurate.

I'm going to turn it over to my colleagues to provide a demonstration of the portal so you can see it in action. Thank you all.

[Ivan Kuo, LMI - QHP Directory Pilot] 13:20:30

This is a video demonstrating the portal.

Hello, my name is Kathy and I am a nurse practitioner supporting the team on the Qualified Health Plan Directory Pilot and I'm honored to present to you this recording of a demonstration of the portal site.

But before we begin the actual walkthrough, I want to briefly frame the experience we will show you. The QHP Directory Pilot is testing whether a centralized portal can make it easier for providers and health care organizations to review, update, and verify directory information in one place while allowing participating QHP issuers to retrieve verified information through standardized data exchange.

For today's WEDI discussion, we will show the same core user workflows and also highlight how CMS is extending the portal to better support users who manage directory information at higher volumes.

Next, I am going to pull up the actual testing site of the portal. Let me preface this demonstration. We're using fictitious data and there is no actual personally identifiable information or protected health information in this demonstration.

As a user, if you were in the live production environment, you would log in to the portal using your NPPES credentials that were granted to you through the CMS Identity and Access, or I&A system, and you would also complete a multi-factor authentication process, which I'm not demonstrating today. Once logging in with your NPPES credentials, I would check here that I understand that the QHP directory will store personally identifiable information and log in. After, it's going to take me to the home page where you're seeing us now. And I want to point out key elements on this page to familiarize yourself with it. Firstly, if you look toward the left-hand side of the page, you see that blue highlighted rectangle with check marks. This is reminding the user of how often information should be updated within the portal. For instance, if there's been a change in the directory, it should be updated at least within 30 days of the change. And a user should verify the accuracy of the data in the portal every 90 days. So that's a reminder there. Also, I want to point out that you are assigned role permissions and access to the portal based on your NPPES credentials. For instance, if you are an individual provider, you're going to see your provider name, your NPI number and that will appear as you're seeing here in the middle of the screen on the card there before you, as well as the provider's name appearing on the right upper hand side.

Our fictitious provider for today's demonstration is Dr. Dustin O. Hayes. If I were Dr. Hayes, I would see my name listed here, as well as in the right upper hand side, and I would go here to the Verify button. That will be how I begin the process of verification. Now, some quick key

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elements here that I want to point out. As you can see, underneath Dr. Hayes' NPI number, you see the date of last verified, as well as to the right of it, when the date is for the verification to be conducted again. This helps with ensuring that you can see the ballpark of when you're to verify the information again within the portal.

If I were Dr. Dustin Hayes, I would go ahead and start here by verifying. The individual provider will first see their contact information, and it will not be displayed on public facing provider portals. This is not public facing. But look through here and ensure if you are a provider, your professional contact information is correct. So, I would go ahead and verify the information. For instance, if I were Dr. Hayes and I changed my professional email address. I can simply go to the right-hand side of that section in that role and click on edit and make those changes in real time and then save. And then once everything else looks good, I would go to the bottom of the section and press next. And you notice each time I hover over a button, it highlights yellow. That means that I have permission to make those changes.

It takes me to the demographics page. Next, I check that information, make any edits as needed, go to the bottom of that section, press next. Then it takes me to the professional profile of the individual provider. Most of the information within the portal is pre-populated from other professional sources that it draws that information in and some of it is in a read-only status. You will see most of the information pre-populated. If you see read-only, obviously you still want to ensure that that information is correct.

It has the provider's primary specialty. They can also add secondary specialties if they wish. Their credentials, as well as their state licensing information. At the bottom of that section, there's always that next button that highlights to yellow, takes you to the practice locations. For this particular demonstration, Dr. Hayes is only practicing at one location. The physical address and phone number in this particular section is read-only, but I still want to verify that that information is correct. I can scroll down here, look at my asterisk fields. You can see the asterisk is here for the specialty of the provider, but I can also see that there's other fields that I may want to go ahead and fill in or edit. For instance, the days of the week that the provider is at that location, what care delivery modality or method is utilized at that location. For instance, is it in-person care or telehealth or both?

I could even edit here for this individual provider whether I accept out-of-network and self-pay acceptance plans or in networks acceptance of certain health care plans. Going through each insurance network on the left-hand side. I can identify whether I'm accepting any new patients as an individual provider for each selected health plan. I can mark, let's say I'm going to accept new patients here for Dr. Hayes for Blue Advantage PPO, and then I would click a check mark here that I am accepting those new patients.

Then go to the next page, and this final page is the review and submit section. I scroll through it to make sure one more time that everything is correct. If it is, I click the statement of verification stating that I verify to the best of my knowledge that it is accurate and then submit. Once submitted, it will take me back to the home page.

So that's the individual provider section. If I am an organizational administrator for a health care site, I may only see this section of organizations. I may only have that access, or I may also have

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access as a provider delegate or surrogate, meaning that I have access to the provider's data, and I can make any adjustments as needed.

I'll draw your attention back here to the organizational section. Usually, most individuals that are organizational administrators would have this access.

Based on a lot of our user feedback, we have found that many facilities, organizations have multi-practice locations, as well as many providers that practice at those locations. Listening to user feedback, we found that there was a need for bulk verification for those users that were accountable and responsible for making updates or verifying data in the directory for multiple locations and for multiple providers. We made an enhancement for our users to make the portal more efficient and more user-friendly. We added this bulk verification button here on the side. If you're an administrator that's responsible for many practice locations and providers, you can click on that bulk verification. That'll take you to a page where on one screen you can do multiple edits, have different locations, and different providers in one screen glimpse.

My name is Ivan Kuo, and I'm a designer and researcher on the QHP Directory Pilot team. I'm excited to talk to you a little bit about the Bulk Verify experience. Bulk Verify begins with a dedicated scope selection page. Here, the user selects the eligible organizations they want to include in the bulk verification session and then continues to the worksheet.

At this time, users can select up to 10 records in a single bulk verification. This keeps each batch manageable, supports reliable loading and submission, and reduces the risk of lost work while the experience continues to evolve.

The selected organizations now appear together in the Bulk Verify worksheet. Organization roles are followed by the related practice location rows, so the user can review multiple records while seeing how the information is structured and related in the directory. Instructional text at the top of the worksheet explains how the page is organized and identifies when an action needs to be completed through the individual record workflow.

Organization and practice location labels help distinguish the type of record being reviewed. Read-only fields are marked with a lock icon, and the required fields are identified based on whether the requirement applies to the organization, the practice location, or both.

For this demonstration, I'll make a supported update in the worksheet and then show how Bulk Verify handles validation in the worksheet. Because users are working across multiple records, validation is displayed directly within the worksheet, errors such as a missing required field or an invalid format are clearly identified and must be resolved before the affected record can be submitted. Warnings can also call attention to information the user may want to review, including a potential PII warning. Warnings do not necessarily prevent submission, but they prompt the user to double-check the information before proceeding.

Hovering over an error or warning icon provides additional guidance, such as the expected format for a field. The status column gives the user another way to see which rows.

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[Cassie Thompson] 13:34:36

Thank you, Ivan. And team and Kathy who recorded that demo for us. We mentioned we could take a few minutes for Q&A on our overview and demo, but please keep us honest on time.

CMS Q&A Session

[Nancy Spector] 13:34:56

We still have time.

[Cassie Thompson] 13:35:08

We're happy to take any general questions about the pilot or the demo, if anyone has any.

[Nancy Spector] 13:35:16

This is open to all attendees.

I see a question posted in the chat. We will start with that, and then we'll let the facilitators ask questions, and then we'll open it up to the attendees at large.

QUESTION: What is the process for a practice to designate a surrogate to review and approve the required information?

[Cassie Thompson] 13:35:53

This can be done through the CMS I&A, which is the system we use to log in to the portal. There is a process within I&A specifically to assign surrogacy to individuals. They would assign surrogacy through the NPPES business function and then whomever would have those rights would be able to log into the system.

[Allison Crowley, LMI - QHP Directory Pilot] 13:36:30

Good afternoon. I'm Allison Crowley from LMI. I've been working with CMS on the pilot. Cassie, you hit it perfectly. Thank you.

[Nancy Spector] 13:36:54

Another question in the chat.

QUESTION: What happens when or if a provider's records aren't updated within the expected timeframes?

[Cassie Thompson] 13:37:04

You get reminders from us. We do and maybe the team can remind me of the cadence of when those reminders go out. But as you're seeing in the portal there's some different color coding to show when records are in good standing, when they're going to be due to be updated soon, or when they're past due to be updated, and there will be reminders that go out to those users to update the information.

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[Facilitator] 13:37:35

QUESTION: If they're not updated in time, are there any indicators on the other end of things that would say this information hasn't been verified in a certain period of time, for someone who would be consuming the information?

[Cassie Thompson] 13:37:56

Again, this isn't public facing right now. This pilot is not designed to have this interface be set up publicly to be public facing. But the issuers who are the plans who are accessing the data can see when that data has been verified or attested to and then can better organize the data so that we make sure it is accurate and we're getting it right.

Feedback like that, that you can use on our system or systems to come is really helpful, because we understand that a lot of times that it's the way systems are set up now that people maybe not understand exactly what's being asked for, or they may not like all the data isn't in the right place. It's sort of fragmented across the system, and so that just leads to a lot of inaccuracy. We understand it's a complicated system.

[Camille Kirsch, CMS] 13:41:42

If I could just speak a little bit specifically to the No Surprises Act point. We would really encourage you and any members of the provider group work group who may practice in Oklahoma to come in and take a look at the data that we're pulling in, because it pulls in not just from NPPES, but from commercial health insurers data. We know that there is inaccurate and conflicting data across these different data sources.

We also know that the No Surprises Act creates these penalties for conflicting and inaccurate data. And as we look towards future rulemaking, we want to move towards a state that does not set up providers to fail. A state that has a way for providers to realistically validate and verify data centrally and ensure that they can be in compliance realistically. So, we really appreciate provider feedback.

[Nancy Spector] 13:42:50

Thank you. We do have quite a number of comments and questions here in the chat. So, I'll hit on a couple more. If we're not able to get to all of them, hopefully, CMS and the LMI team can answer them in the chat.

QUESTION: Does the process capture provider EHR FHIR endpoints?

[David McGinnis, LMI - QHP Directory Pilot] 13:43:30

I'm David McGinnis. I'm the solution architect for the project and have also been heavily involved with the FHIR implementation for this. We are currently not pulling in provider EHR FHIR endpoints. That is not a bad idea. We can certainly take that back, but at this point, we're pulling in a lot of different data sources, but almost all of them are internal to CMS. That's been the scope of the pilot from the beginning.

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[Nancy Spector] 13:44:05

QUESTION: What is the process for validating a provider's participation within a given network? Or is that self-reported? Provider-reported?

[Cassie Thompson] 13:44:17

Provider reported. Right now, providers can list the networks that they are a part of and then that influences which issuers receive that data about that provider would be based on the networks they've identified, they're part of.

[Nancy Spector] 13:44:34

QUESTION: Is there a process for a large practice to submit a single spreadsheet with all their information?

[Cassie Thompson] 13:44:46

We do not currently have an upload roster feature like available in other systems, but we do have that bulk verify feature that we've been working on that was provided in the demo.

[Nancy Spector] 13:45:00

QUESTION: What kind of adoption rate are you seeing within the pilot?

[Cassie Thompson] 13:45:06

Right now, we have a goal set of 50% of our targeted group of providers in Oklahoma. We've been targeting QHP-associated providers. We're at about 32%. We're aiming for 50%.

[Nancy Spector] 13:45:32

QUESTION: Around poor data or poor quality of data, is there going to be any data validation and will providers be held accountable at all for keeping their records complete and up to date?

[Cassie Thompson] 13:45:53

We've tried to set up the portal in such a way so that there are different sections that are clarifying. In terms of acknowledging that NPPES contact information can be a little confusing at times, the information that we make visible or make accessible to issuers is the contact information associated with the practice. And there is a section for a provider to include personal contact information. We're trying to make that clear. What's for administrative purposes but not meant to be shared. It's not shared with the issuers, not to be shared with the issuer to be publicly available. So, we're trying to bridge that gap there.

[Nancy Spector] 13:46:58

I'm going to do two last questions, and one question is going to be a combination of two of the questions in the chat.

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QUESTION: What FHIR IG is being used for this directory?

[David McGinnis, LMI - QHP Directory Pilot] 13:47:22

We are basing our work on the PDEX Plan Net implementation guide, but we are pulling in pieces of the NDH spec. When we started this, it was still in preview, so we decided to go with Plan Net, but we are keeping our eye on the NDH IG and using useful bits out of it where we can.

[Nancy Spector] 13:47:46

QUESTION: What's the next steps in terms of potentially going beyond just the pilot state and then other lines of business, like beyond the ACA marketplace plans?

[Erika Melman (CMS/CCIIO)] 13:48:02

This is a pilot. It will sunset most likely at the end of this calendar year. But there are broader efforts within CMS and so all the work that Oklahoma providers and plans have done will be incorporated into that. All the verified data will feed into those efforts. I think any scaling effort will happen as part of the broader work across CMS and that will also touch on the other lines of business, like Medicare and Medicaid.

[Nancy Spector] 13:48:44

We really appreciate all of you from CMS and LMI being able to join us today and go through an overview and demo of the QHP Directory Pilot. This has been very helpful, so we appreciate all your effort and time in doing all this.

Facilitated Discussion of CMS Topics and Questions

[Nancy Spector] 13:48:44

We are going to move onto the facilitated discussion on the topics and questions that CMS provided to us. They are looking for feedback on these particular topics and questions. When we're done with talking about a topic, if we've got extra time left, we'll open up for attendees to be able to come off mute and also participate.

Topic #1: Data Trust and Accuracy

This question is about the data elements that are most critical for provider matching, directory updates, and network validation.

My understanding of provider directories when it comes to data elements is that they're really dependent on whether it's the health plan's provider directory or the provider's. directory, and then organizations themselves, in terms of what are considered critical data elements.

We are focusing specifically on the health plan directory aspect of this and what would be most critical for these particular uses.

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On the slide, what's in italics here is what we've added, which is a sample of known data elements that are used for these particular purposes.

The question really is around are these data elements that you believe to be critical and are there ones not included on this list or in what you're seeing with health plan directories.

[Facilitator] 13:51:50

From our [members], as we understand it, there's something roughly around 30 attributes CMS does. The health plans can sometimes have upwards of 150 attributes. These are good, but if we're looking at this not as a pilot, but how we're going forward in the future, there probably needs to be many additional elements that we probably can't litigate here.

I think just to step back, a broader point I want to make here is that this is why a full rulemaking process is necessary here. They're probably going to be some pretty long comment letters back to CMS with really detailed information, like exactly what elements would be necessary.

[Facilitator] 13:53:10

One of the things that I think is difficult is that there's a whole bunch of things and the data that's needed to do provider matching is not synonymous 100% with what is needed for directory updates, nor for network validation.

Even when we looked at this as the moderators before this event, I do struggle with having this master list because there are things in the list that I will never use to match a provider, but I may want to put in a directory. I think one of the first things is it's really important to know what you're using the data elements for versus just this massive list of data that may or may not be used for one thing versus another.

[Nancy Spector] 13:54:06

Good point. I wanted to also interject here that when we were doing introductions to the facilitators, [Invited Facilitator] from the [patient association] had wanted to participate today, but unfortunately, he couldn't be available at this time. He did send some comments ahead of time, and those comments have been shared with the facilitators. I wanted to share a comment from him about data accuracy:

Accuracy is especially important for the information patients use when making healthcare decisions, including whether providers are accepting new patients, specialty expertise, practice location, contact information, and network participation. Errors in these data elements can lead to delayed appointments, unnecessary travel, and frustration for patients. CMS should prioritize ongoing verification of high-value consumer information that directly affects healthcare decision-making.

I wanted to raise that, because it provides the rationale for why this information is critical, related to updates and network affiliation.

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[Facilitator] 13:55:45

Building off of [Invited Facilitator's] comment and the patient perspective, there are some of the data elements that I think are really important to patients, and I'm coming from the lens of chronic disease. A typical rheumatoid arthritis patient may need two to up to 9-plus providers just to manage that condition. So that's a lot of care coordination. From a patient perspective, what would also be really important to know, that may or may not be able to be built into this, is as you're looking for a new rheumatologist, to understand the other providers that you need within your regular care journey that are also affiliated within the same health system or what the kind of affiliation or relationship there is. To the extent that you want to have as many of your providers in the same system as possible.

Accepting new patients is really important, but also the average wait times for a first appointment. This may be really difficult to build in but from the patient perspective, especially in rural areas, a lot of the rheumatologists have a first appointment of 6-plus months. If you are in an active flare and really need to have an emergency visit to a rheumatologist, that information would be helpful.

Another piece is the services and clinical information, like specialty services provided. The patient might want to know does this rheumatologist offer in-office infusions. That's really important in terms of decision-making about what type of treatment to choose and method of delivery. Or imaging or labs or things like that. Things that would be important for patients with chronic diseases to know.

[Facilitator] 13:58:03

My question is related to the use of the provider directory as essentially the skeleton, if you will, the guidelines for reaching providers for everything from real-time prior authorization to collecting and exchanging clinical information with health plans to providing access to patients and consumers. We often hear when we talk about provider directories one user's perspective, when in reality there are probably five or six different primary users, but at the heart of this is in order for patients to be able to access information that is correct and reliable, we need the provider directory to include the kind of information, endpoints, etc., that allow for reaching the physicians of record in a predictable, accurate, and reliable manner. Are there plans for incorporating endpoint data and interoperability-related data into your provider directory infrastructure. I know that HL7 is working on this. I know that others are working on it. I just wanted to get a sense of where you are with regards to that, to that aspect of the provider directory.

[Cassie Thompson] 14:00:09

Could you repeat that question? I wasn't entirely sure if you were directing that towards actual health plans.

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[Facilitator] 14:00:19

No, I was directing it to the Oklahoma folks, predominantly around how a provider directory is a multifaceted, multi-dimensional thing. It's not only what's necessary for credentialing, enrollment, and patients getting accurate information through a network. It's also the telephone book, if you will, of the network itself. It really tells endpoint information and FHIR API endpoints to every provider in the network, which is going to be a huge and essential element of achieving interoperability at scale. So, I was wondering, as Oklahoma looks at this project, is that one of your goals or are your goals different from that? And if so, what are they and how and why did you choose those?

[Cassie Thompson] 14:01:22

I think that's a really good question. And I think that's something when this project was being conceived, we were really trying to think about, we were trying to think about how to balance what data we were collecting, and also it was starting out as a starting point, which is why we started with what we started with. But getting feedback from you all is really helpful, especially as you mentioned in thinking about all these use cases that this applies to.

Now, this directory that we've created is a little different because it's not public facing. We're collecting the information through the portal, and then the plans are pulling that data to use in their own sites and the way they've developed and built out their public-facing directories, right? I think that moving forward as the national provider director, which is being worked on, which is another team separate from our team, so we can't really speak to that here. As that builds out and this builds, this builds on and up. Again, whatever recommendations folks with the WEDI members have for us and how to think about that is really helpful.

[Nancy Spector] 14:02:58

I have been seeing comments in the chat. Someone asked if all these elements were included in the Oklahoma pilot. I don't know if you are able to share with us a list of the data elements in the pilot directory. It might be helpful as we look at and debate whether there are any big gaps. We can't debate each one individually, but maybe just to look at whether there's any noticeable gap.

[Cassie Thompson] 14:03:59

Sure, that is something we should be able to maybe get in the chat. Or provide to you in the future.

[Nancy Spector] 14:04:19

[Facilitator] posted a comment: There are many directions this could go in and perhaps categories around provider identity, qualifications, organization location, and prioritization of integration of data elements and attestation would be a more amenable way to phase in all these elements in an approachable, verifiable, manageable way. Also exploring through rulemaking how discrepancies are resolved.

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Another comment that just got posted: Are there some prompts that can be used to help providers supply exactly what is needed? For example, a provider participates as a PCP for an HMO plan but as a specialist for other networks. Or the provider is showing they practice at one location two days a week, but they participate in value-based care contract, managed care. I think what I'm reading from this comment is that there's quite a lot of complexities, such as the provider's availability, their network, their affiliations, their network status, and whether a provider directory can accommodate all of that.

The next slide is a continuation of data trust and accuracy. This question is very specific about what information about QHP Directory Pilot attestations would make the data trustworthy enough to share publicly. They had examples of submitter timestamp and change history. Would submitter contact information or other data elements make the data more trustworthy? The other two questions ask when QHP Directory pilot attested data differs from an issuer's existing data, how should this discrepancy be reviewed and resolved and should issuers be able to send discrepancy information back to the QHP directory pilot.

[Facilitator] 14:07:40

Our [members] have reported that they have encountered some data accuracy issues around, as an example, provider attestations for PO boxes, or using personal emails, or mismatches between type 1 and Type 2 NPIs, etc. They have gone through the process of communicating with CMS to work with the providers on understanding what needs to be included for the educational aspect, but also corrections. I think it does underscore making sure that there's clear validation expectations and timely ways to escalate if something's detected that's not believed to be correct. You mentioned as part of the presentation that the read-only aspect for some things is sometimes incorrect and that requires the provider to go back to the source system, which may make it more difficult to make sure that it's updated. The ability to somehow facilitate source validation and updating the underlying sources would also be helpful.

[Facilitator] 14:09:52

I want to upvote what was just stated there in terms of making it simple to go ahead and have a connection to those sources so that the things can get updated, because otherwise we're going to continue to have multiple versions of the truth.

The other thing about discrepancy resolution is, this shouldn't be a one-way workflow. If a payer, provider, organization, or other participant identifies a discrepancy, there should be a mechanism, or can there be a mechanism, to send that information back in for review and reconciliation?

[Facilitator] 14:10:56

I'm reading the questions and then forgetting to step back like I did last time. I think of our perspective more broadly than this question is really that the directory concepts moving forward should really be a public-private partnership, and that the CMS list is the one list to rule

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them all. One that really allows payers and delegated vendors and others with credentials and protections to go in and make changes. That provenance types of things, validation processes, etc. But if private payers, and particularly if this were to go to an all-payer basis, which we think is really key to achieving the efficiencies, you don't want to have one portal per state and different portals per lines of business. The way we achieve efficiencies is getting to a point where there's a mechanism to access this across different payers and different states. As part of that process and ability to make changes if the private payers learn something perhaps faster than CMS does, of course with protections and guardrails.

[Facilitator] 14:12:43

Adding on to that just a little bit and maybe just diverging just a moment, while this is just for the QHP directories, this pilot, we maintain a single provider record for all our networks across all our lines of business. As CMS is considering this information that they're going to feed into this national directory, it's going to be really important that all the updates that are made are reflected across all the various programs within CMS. That's what's going to be helpful for us, because obviously most of us are in more than just QHP, from a health plan perspective, are on various lines of business, so having that single provider ability is going to be really helpful from a plan perspective. Thank you.

[Nancy Spector] 14:13:37

Thank you. That gets to the concern about having to do this multiple times for different uses, whether it's the health plan or different lines of business. Being able to do it once and have it populate for all would be an ideal state.

I want to also pull in again the patient perspective in this. So, another comment that [Invited Facilitator] had was that patients should be able to easily determine how up-to-date directory information is and when it was most recently verified. I think this is what we want to see on all sides of this particular provider directory issue. Having that information, such as the verification dates, attestation history, update, timestamps, would really increase consumer confidence and improve trust in the directory data. From our own perspectives on anything that's got a date on it, we're going to look for something that's the most current. [Invited Facilitator] is saying transparency is particularly important as CMS evaluates centralized models that may serve as sources of truth for provider information.

Other thoughts on any of the other parts of the questions here?

Okay, let's move on to the next slide.

Topic #2: Interoperability and Data Exchange

[Nancy Spector] 14:15:00

This topic is on interoperability and data exchange.

What is the preferred method for receiving QHP directory pilot data?

How frequently should updates be delivered?

Should the exchange include full provider files, change-only files, or both?

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Which existing standards or exchange processes should the pilot directory align with to support increased adoption?

What workflow changes would be needed?

Are there existing contracts, vendor processes, or internal review requirements that could limit integration?

Thoughts on these questions.

[Facilitator] 14:16:43

I think ideally both real time and batch options should be in play here, if FHIR-based exchanges are where things are headed, but there are many organizations that still rely on bulk file processing. So, it should probably support both.

In terms of the update frequency, change notifications for high value updates and then maybe periodic full files as a reconciliation mechanism.

In terms of full files or change files, I think both because the change-only files are going to reduce operational overhead, but the periodic files would support the validation and reconciliation.

[Facilitator] 14:17:54

Those were great questions and great comments to make. I couldn't agree more.

We're moving into a FHIR-first world. The idea of moving data from one place to another is being replaced by API connectivity that enables me to see the data I need and minimize the security risks and data risks associated with moving data around. I think batch or bulk file distribution is important to accommodate organizations that have not reached the level of maturity with respect to FHIR.

With FHIR, you can basically attest or test the accuracy of information across a panel of providers, across a subset of providers by using a hosted service that has the hosted provider directory that ideally would be one that was used nationally and one that would provide multiple benefits for the credentialing for enrollment for interoperability and data transport. For updates, the provider directory is not a real-time database, in the sense that we have to have everything updated in real time, but the frequency of updates should be pretty quick or daily, if not closer to real time.

Should the exchange include full provider files? Again, I think the exchange is where we're moving data around, and ideally, if we are in an API economy, this FHIR, this interoperability directory, this provider directory exists hosted by CMS or an organization that has awarded a contract by CMS and is made available to all providers and health plans and patients in the country. Access to the data is less important than access to its use.

I would say you would be notified through a FHIR subscription that changes happened in the provider directory that had providers that were in your networks. That would be an important thing to address.

And workflow changes, this is going to change everything because this is replacing multiple different use cases that have their own separate directories with a single directory and ideally

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support organizations in a number of aspects. I'm sure there are contracts that rely on provider data that may be changed or vendor processes that rely on access to a directory that is hosted by the health plan, for example, rather than elsewhere.

There are certainly going to be internal reviews undertaken by almost any organization, but I think the thing that I see in this is moving away from directory data all over to having a place where it resides and it's managed, and making that data available to payers, providers, and consumers through APIs and interoperable FHIR technology.

[Facilitator] 14:21:13

I think we need to recognize this is a pilot in one area and as we move to broader potential rollout and adoption that we do need to meet people where they are, which might be different across the country, but generally speaking, FHIR-based for sure. And bulk and subscription are also much appreciated.

[Facilitator] 14:21:59

We actually are excited for the FHIR APIs in general, and we've been putting a lot of resources and work into all the FHIR APIs across the board. We think utilizing an API would be one of the best mechanisms and ways to deliver this data. I think also it goes along with the administration's priorities. I think [Facilitator] said it and summarized it well in a lot of ways there is this move towards using FHIR as the means of creating this rural interoperable network. I think going along with what's already been the manner in which we've already been accustomed to or things we've been building towards will be really important to continue to do so through using those APIs.

[Facilitator] 14:22:56

In terms of the workflow issue in particular, a couple of plans raised that they appreciated the change that doesn't require a new token every 30 minutes. That's really helped from the workflow perspective, so that's something we'd want to see carried on.

[Facilitator] 14:23:34

In order to make the data viable for its use, everyone in the ecosystem that's using it is going to have to work on the same kind of approach. You can't have half of the entities providing data full files once a week and others doing a full file and then incremental files daily or even more than daily, because then you're going to run into huge issues with data timing. Especially if there's downstream uses of that data. I recognize that not everyone might be ready and prepared to do FHIR but to assume that you can constantly have different time frames on which data is submitted, that's going to set your whole data set out of whack in terms of the timing that you need and that folks that are going to use it are looking at. You may have to roll into a more delta-like approach that you may not be able to go there right away if not all the entities can handle that in the beginning.

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[Facilitator] 14:25:01

I'll make a clarification just on my point because I totally agree. When I was saying that, I meant to download, not upload. If some payers may want to download in different ways and at different times.

[Nancy Spector] 14:25:43

There are a few comments in the chat.

The closer that this aligns to existing FHIR directory standards, existing provider data exchange, these are the adoption that will happen. Organizations are more likely to adopt something that fits within their existing workflow.

I'm not technical as I'm on the business side, but I agree with FHIR as that is where the industry is headed.

I think bulk FHIR has to be a capability due to sheer size of changes and updates taking place daily.

Definitely would like to see the central server provide subscription support for easier communication of changes to all health. FHIR and bulk are not mutually exclusive. I would rather see an approach supporting both real-time API as well as bulk FHIR support.

Consider whether the directory is queriable in real time or intended for more constrained downloads.

Topic #3: Data Architecture and Matching

[Nancy Spector] 14:27:00

Let's move on to the next topic, which is data architecture and matching.

The questions are about how issuers and provider groups currently organize provider data across individual practitioners, organizations, practice locations, and networks.

Which identifiers are needed for reliable matching across systems?

How should QHP directory pilot portal represent practitioners who work at multiple locations, participate in multiple networks?

Are there data relationships in existing systems that would support successful integration?

[Facilitator] 14:28:12

I think this would apply to all of these, but this is a lot. Not every practice has folks who are steeped in this. Education and socialization and quick response to user feedback are essential.

Perhaps the key is to focus on that providers aren't intending to perpetuate bad data, but there's a real brass tacks of the already existing administrative burden and having to get through an approval process or to face some sort of penalty.

I had mentioned categories in response to the first topic, and I think when there has been no change in the data from what has previously been approved, some sort of highlighting in what is presented to the provider to say you had previously approved this. If any of this has changed, let us know. But here's what's new or here's what's changed. That sort of visual cue can help get through what seems to be a growing number of data elements.

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Also, are there any lessons to be learned in how other programs have navigated having Type 2 and Type 1 NPIs and a whole host of different presentations, relationships, or groupings? What I'm thinking of is a provider who works at 3 different facilities that may or may not be affiliated. If they have their own practice, then they also work at a surgery center, and then they also have an inpatient affiliation. How would they know when someone else has verified their data on their behalf and how would they be able to validate whatever someone else matched? How does that relationship get identified in the event that for any reason, an erroneous match was approved, and the provider unearths it and would like to rectify it? I just think that there's an opportunity to look at how others have approached this, but also again seconding [Facilitator's] robust rulemaking notice response process would be a really helpful way to underscore all these different permutations.

[Nancy Spector] 14:31:35

I did want to circle back to, I think [Facilitator] was making this point earlier, and this was again another comment that [Invited Facilitator] had made, which was that CMS should explore opportunities to improve visibility into referral networks and care pathways within provider directories. For patients experiencing complex conditions, timely referral to the appropriate specialist can significantly impact diagnosis, treatment planning, and outcomes. So better information about referral relationships and coordinated care networks could help patients navigate the health care system more efficiently.

[Facilitator] 14:32:14

From our perspective, using the NPI Types 1 and 2, we're able to successfully match the individuals and even when they are at multiple locations. We do believe in some ways this could be a best practice that could be standardized if it would be something that'd be helpful for all plans.

[Facilitator] 14:32:45

When I think about this topic, I think about things being organized around relationships. Obviously, NPI is an important starting point, but provider directories are really relationship driven. The challenge is sometimes not identifying the provider, it's accurately representing the provider's relationships to different locations, organizations, and networks. When we think about the data architecture and how to do matching, it's really centered around all those different relationships.

[Facilitator] 14:33:34

One of the things that the [organization] does is collect data from [members], and we do a national directory. We use identifiers, but we can't rely on the identifiers by themselves. For some of the things that were already mentioned, such as how providers enumerate and which NPIs they actually are contracted under may vary, especially if you have plans that both have the capability to contract with a provider. Their taxonomy code may be different. We actually

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use special data elements to say that practitioner A is part of group B and they might also be part of group C over here. And then on the flip side of that, when you use that data, obviously you're not going to issue the tax identifiers, or if there is a business reason to share those with someone using the data, it requires additional tokenization, especially in the FHIR world because this is PII and very sensitive PII. That has to be thought about, not just how you match the data, but how the data is then used and who has access to the data downstream.

[Attendee] 14:35:47

The only thing I was going to add is that if you look at provider group rosters, which are fairly like provider groups, they are typically sending that one roster to many of us. They're not customizing them. They may have certain fields that may apply to certain payers, and then others that aren't required across all of us. But if you look across the fields there, I think that really lends itself to a structure that we've all kind of adopted. You think about that architecture and matching and the level in which they're giving us that data. Typically, it is what kind of individual provider are they, what clinic affiliation or organization affiliation they have, the bill address that address is associated to, and the accepting of new patients at Medicare level, commercial level, Medicaid level, state exchange levels, etc. To me, if you look at that structure, it is kind of how we've built our infrastructure around, and the matching. As we look at that capability, especially as you're talking groups and as we expand nationally with the concept, they'll have the ability to bring all of that data into one central repository, rather than looking one by one by one by one across hundreds, if not thousands of records.

[Nancy Spector] 14:37:12

I see [Facilitator] put a comment in the chat:

Data architecture should be accessible across groups of varying sizes, resources, health IT maturity levels.

That makes this complex on so many different levels, but one of them is around this idea that you've got varying sizes, resources, and tech maturity levels within those provider groups and health plans. It also varies by affiliations, specialties, and patient populations.

Next, we will take a short break and start again at 2:45.

Topic #4: Consumer Value and Directory Completeness

[Nancy Spector] 14:45:10

The next topic that we have is on consumer value and directory completeness. There are questions about what provider directory information is currently hardest for patients to find or most frequently inaccurate.

Which details beyond network participation and specialty are most important to care decisions?

Are there data elements missing from the QHP pilot portal that would drive adoption?

Could demonstrating a clear consumer benefit motivate providers to keep their QHP directory pilot information current?

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With this being consumer focused, I want to share comments from [Invited Facilitator], which are:

Provider directories should be viewed as more than just a data management and interoperability initiative for patients and caregivers. They are a critical access to care tool that influences how quickly individuals can find the right provider, obtain an accurate diagnosis, understand their coverage and costs, and access recommended treatments. As CMS evaluates the QHP directory pilot considers future, he encourages the discussion to focus on how directories can improve patient access, care navigation, affordability, and health outcomes. A directory that is technically accurate but difficult to use will not achieve its intended purpose. CMS should ensure that directory tools are accessible, consumer friendly, and designed with input from patients and caregivers, including individuals with disabilities, information such as telehealth availability, accessible accommodations, language services, and caregiver support options can make directories far more valuable to consumers.

[Facilitator] 14:47:45

I think the examples here of appointment availability and telehealth are huge. I would definitely double down on that. What I said earlier about average wait time for the first appointment for new patients.

In terms of most frequently inaccurate, I feel there's been a lot of improvement over time in provider directories here. At one time, we heard a lot about lag times and providers accepting new patients, but I haven't heard so much from patients in recent times. I don't know if that's reflective or not, I just would make that point that I think there's been a lot of improvement in this over time in general provider directories.

I think these things listed here and then again, some of that more granular information that maybe more specific to people with chronic diseases. Where you're looking for a regular source of care and that care coordination piece. I know that [Invited Facilitator] talked about that as well. Ultimately, I think being able to access this data is part of that general umbrella of the need for patients to be able to coordinate the administration of their care.

[Facilitator] 14:49:25

I'm not sure. Hopefully, this is relevant here. As we're thinking about this, I'm thinking about things like accessibility, accommodations, appointment scheduling methods, things like that may be focus areas. I'm not sure if that's the same as specialty and not sure if it'll always be valid whether it could be indicated whether referrals are required. But these are just some things that come to mind as we're talking through this. Language spoken, I think might have been mentioned earlier, but those are just some of the things that come to mind when I think through this.

[Facilitator] 14:50:25

I fully appreciate the idea of thinking ahead, but I do want to emphasize that I think we need to get what we have now right before we add too much more. It's already pretty complex, and

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there's a lot of things to fix in the meantime. The patients don't directly draw down from the pilot directory itself, but certainly the payers are looking to take some of this information and create downstream consumer value, which we already do. The notion of putting additional information in here is welcome. It's just a matter of phasing things along.

[Nancy Spector] 14:51:31

Well, and I think one of the aspects here is that it's not necessarily all about what's going on in the pilot. There's an aspect to what CMS is asking, which is about what do we need to think about for future efforts.

But I definitely agree or understand the point that you made that we've got a lot already, and we also need to make sure we're getting that right.

I want to back up in the chat. [Facilitator] put in the comment that practices with multiple locations often list all their providers as practicing at each for potential billing purposes. Many only practice in select locations. Again, this is an aspect of how you might be using this information for administrative purposes within the practice as well as for your patients' access abilities.

[Attendee] made the comment about beyond specialty, what do they specialize in could help with care navigation.

[Facilitator] commented that provider language spoken is not always captured in present directories.

[Facilitator] made the comment that area of focus is not necessarily equal to a specialty. Areas of focus are often very narrowed within their specialty. A great example is an orthopedic surgeon who focuses on hand, or hip, or ankle and foot, so that would be the focus area, and not necessarily being the same as their specialty.

Many practices' websites give more information about the areas of focus and directories don't always capture that. That was in our list of data elements we were looking at earlier with a URL to the providers' website. I because. Presumably, the provider website is kept more up to date, although they should be equally up to date.

[Attendee] made the comment about additions are often easier than removals. A new provider on the network is more likely to be included than a provider leaving the network and having to remove that.

[Facilitator] commented that there are requirements under the Consolidated Appropriations Act to keep the data current. There are processes in place at payers to address this more timely.

[Facilitator] made the comment that telehealth, hybrid, and in-person should be designated in the directory.

Going back to comments that [Invited Facilitator] submitted. He brought up the idea of a way to evaluate provider directories. Measures of success on whether they helped patients successfully find and access care, not simply whether the data is exchanged accurately between systems.

CMS should consider patient-centered measures, such as reduced time to finding appropriate providers. Fewer failed appointment attempts and improved confidence in directory information. So ultimately the value of directory should be determined by its ability to improve

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access to care and reduce barriers for patients and caregivers and strengthen their connections to relevant health care providers. Measures like this would be quantifiable data, such as start and stop times, to provide measurable data.

[Facilitator] 14:57:11

The completeness of the provider directory is less important than the utility of the information that's in it. We tend to think about completeness. We tend to think about capturing all the information that we need. But we sometimes fail the consumer if we can't say, when the consumer asks, can I actually get the care I need from a provider at this location under my insurance? That's kind of the core problem. I think highest value problems tend to be dynamic relationship data rather than basic provider data. We often find that CMS historical audits have found the same. That the most consequential errors in provider directories tend to be that the provider did not practice where stated. They had incorrect or disconnected phone numbers, providers shown as accepting new patients when their panels were closed, and some of these errors were attributed to group-level information being populated down to individual providers. For consumers, I think network participation is really important, and the actual practice location is really important. Accepting new patients, appointment availability, services at the location, things like that are really, really important. And I think when that utility happens, that enables the network to gain more power, because the more the information is of utility to patients and the more patients find out that this information is not up to date, the more there will be considerable push for providers and health plans to fix this. How we go about fixing that. Right now, we have multiple provider directories scattered across the country. Ideally, we'll have a national provider directory, which the Oklahoma pilot will inform. This is becoming a challenge on multiple dimensions and in many respects, as I started saying, the completeness of the data is really important, but it's not as important as, does this data help patients? Does it actually answer their questions in a way that's meaningful for them?

Topic #5: Provider Participation and User Experience

[Nancy Spector] 15:00:11

Topic number 5 has to do with provider participation and user experience from the provider perspective.

What barriers make it difficult for providers or their delegates to keep directory information up to date?

What incentives would encourage providers to keep their information current?

What portal improvements would reduce burden for users, especially those responsible for verifying a large volume of records?

Which data elements could be verified in bulk without requiring users to review every record individually?

That's the last one. So individual practitioners appear less likely to log in, then delegates or administrators, are there additions that would make the portal more useful or worthwhile.

For specific tasks they would prefer to complete themselves rather than delegate.

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[Facilitator] 15:01:38

Comments I had for previous questions carry over here. And then there's just the sort of brass tacks that we've provided in other areas, like another portal that we have to log into and do some activity in.

These are really great questions to go through rulemaking, because it varies based on practice size, it varies based on geography, it varies based on contracts and how many places you work at, etc.

It's not intended to block advancement. The position is meant to emphasize that there's a real-world burden. That the workflows run into authority over type 1 and type 2 NPIs may be unclear, or like NPPES access may be inconsistent or unreliable based on passwords and security validation, or previously affiliated locations that you weren't aware of, or other components that can just make it very burdensome and difficult to reconcile.

One of the comments that I made previously was a way to know when you've already validated something, and now you have to go in and revalidate if any information is new, or if everything is the same as before, that simple interface enhancement could be very beneficial.

Some of the other items that we don't yet know is the availability for the next appointment.

Where will that data be sourced from? Is that something that we will have to insert? Are they going to create a connection to practice management systems? It's just quite a large unknown. We'd like to work together to explore how to improve the data quality. But there's already a lot on folks' plates. And if you're at a large health system, that maintenance has been delegated to other staff. Or if you are in a small practice that's in a rural area, you're trying to do it all. And you went to med school, not necessarily to manage the provider directory. So, I would just offer that it gets conflated and becomes messier in different ways based on practice size, location, specialties, etc.

[Facilitator] 15:05:14

In general, what do we do to get providers more interested, or why has provider participation not been to the level they had expected? I think there's a couple of factors that aren't necessarily specific to the particular program but rather external. The fact that this is a pilot. You were asking providers who are already dealing with a lot of other pilots that have been proposed. Institutions were already dealing with these other pilots and don't have the bandwidth or the resources to take up another pilot. They decide to wait until rulemaking to make the necessary changes. That might have been part of the lack of enthusiasm for participating in the pilot.

One of the other things when you're talking about resource constraints, it really comes down to bang for your buck. When you've got a small subset of plans that are participating in a limited amount of time, the amount of operational changes that might be required as part of this process without necessarily the insurance that it is going to lead to a more broadly applied, broader scope of health plans, as well as at a larger scale weren't there. I think if you get to the

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point of rulemaking and the establishment of something that is national, you might see more provider uptake.

That being said, I recognize the pilot requires providers, but it at least requires providers to get to that stage, I think there was a lot of someone else will do it because I don't have the bandwidth right now, and so I think the resource constraints in this space are real. I think that's been a lot of concerns.

The process can be burdensome from a hospital perspective. You have your hospital, but you have all these employed providers and providers who you would also have to keep up the provider directory information on, and I think it was overwhelming at that point, and so to the extent that we can cut down on kind of the breadth of what this would entail, that would be helpful, but I'm encouraged to see when this does move to a broader, more national standpoint. I think providers are interested and excited. But again, I think what we want to make sure is that it replaces rather than adds to current processes and this is not just another portal.

[Facilitator] 15:08:06

Provider education has been a priority for the plans throughout the pilot and certainly provider engagement has been a real challenge. The CMS representative shared, I think it was 32% of provider participation with a goal of 50%. So, it's still pretty low. You know, I think to [Facilitator's] point, you know, this is a pilot, it's not national, it's not all lines of business.

There's lots of things that would be part of a big national program that would help. But it's not going to get us to 100%. This is certainly a challenge absent any sort of regulatory compulsion or some sort of meaningful incentives. The plans themselves don't have a lot of tools. We certainly don't want to drop providers from the network for not getting their information updated and validated. That's going to backfire for all of us, most importantly for the consumers. So, we do think there needs to be some sort of hook to help. I will note, and I think a lot of people are not going to like to hear this, but the most effective way in a previous pilot that [organization] did with our members around provider directories to get providers to update their data was withholding payments, and that was super effective. I don't necessarily want to go there, recognizing that's pretty draconian, but I do think we need to really think about ways in which to make sure that there is provider participation. And again, with all those caveats of it needs to be a reasonable, efficient system that's intuitive, etc.

Limited provider engagement really creates a barrier for the plans because they can't fully rely on the pilot information. I think the worst scenario is having one of these systems, whether pilot or national, and still having each individual payer coming to the providers up to every 90 days trying to get stuff validated. That's just going to make things worse.

[Nancy Spector] 15:10:43

I see quite a number of comments.

[Facilitator] had mentioned education. Lots of delegates at offices have no idea whether some of these requirements exist.

[Facilitator] commented that education has been a priority with the pilot.

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[Facilitator] made the comment that inconsistent methods of reaching out to the provider can cause delays if you're doing phone, mail, or email.

And [Facilitator] responded that a lot of times plans use those multiple methods when they've been unsuccessful in getting a response, so they move on to a different method.

[Facilitator] commented that having data submitted and propagated showing how time involving directory reporting and updates can add value and other work streams to burdened administrators would be a probably be a way to make it more useful for getting the information updated.

And then [Attendee] asked, how were individual providers in Oklahoma contacted about the pilot? Maybe the CMS or LMI people can respond to that.

[Facilitator] 15:12:58

It wasn't just the CMS folks, the payers also reached out with direct emails, newsletter, lots of multimedia, multimodal, omnichannel, etc.

[Nancy Spector] 15:13:34

A comment that came in prior to this event from someone who wanted to attend but wasn't going to be able to. She did provide a comment via email, and I think the comments fit within this particular topic. She said:

With only about 20% of Oklahoma QHP providers participating so far, actually we just heard it's 32%, it is important to understand whether early success reflects selection bias towards providers who are already equipped to respond. It's also worth considering whether a state-run model, rather than a CMS-wide platform could still leave providers managing multiple portals. Provider directory accuracy continues to face systemic challenges, including inconsistent verification processes, duplicative requests, and uneven adoption across diverse practice settings. A national standards-based approach that reduces burden, clarifies authoritative sources, and supports practical workflows with a phased-in model for small rural and low-tech providers would make future enhancements, such as price or quality transparency more achievable.

CMS put some information in the chat about the contact work done in Oklahoma.

Topic #6: Issuer Adoption and Provider Burden

[Nancy Spector] 15:16:00

The next one is on issuer adoption and provider burden.

How could issuers use QHP Directory Pilot data to reduce duplicate verification requests to providers?

Which updates could be applied automatically versus requiring manual review?

What barriers might prevent issuers or providers from fully utilizing the directory pilot data?

How could issuers help communicate the value of the directory pilot to providers?

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As a provider practice leader, when updating directory information, how many different systems do you typically have to touch, and how often are you asked to submit the same information to multiple directories or portals?

Which steps do you feel are the most duplicative and how does this affect your day-to-day work?

Thoughts on these questions.

[Facilitator] 15:17:04

Broadly, I will say I've sat down with numerous members where they will show me their Excel spreadsheets. Thinking more across business lines as opposed to just the Oklahoma pilot. These providers are participating under multiple lines of business for each of these payers oftentimes. So, we have to look at this more holistically than just what we're getting as part of this QHP pilot only in Oklahoma. Providers will have an Excel spreadsheet that shows what CMS's information says, what their internal information says, what our vendor says, and what Google says. They have seven or eight fields, sometimes layering on artificial intelligence techniques to try to kind of piece all of this together and understand the accuracy. So, it is really complex. We have to look at it in a bigger piece. I guess anything being automatic worries me a little bit because it seems like there has to be some extra review of things kind of broadly.

[Nancy Spector] 15:19:08

[Facilitator] made the comment that one simple issue is ensuring that the practice contact point is accurate and consistent.

[Facilitator] 15:19:42

To add to that, the QHPs have been reaching out and communicating extensively with the providers. I think that's a must, no matter how this is scaled. Having multiple communication channels because you never quite know who's going to read what. But we do also have to be careful not to get to the level of spamming everybody or create confusion if messaging is worded differently. The biggest barrier is whether there's sufficient participation and usage and timely updates from the providers. I don't think it's technical problems or anything. It's just really kind of critical mass.

[Facilitator] 15:21:03

Building on [Facilitator's] comments, just through a different lens, because I do think these are mutually beneficial, but once either provider authorized organization verifies an element through whether it's the Oklahoma pilot or any sort of national pilot, then do we really need to continue querying or requesting that unchanged element again during a verification process. Unless there's some documented regulatory or credentialing or data quality exception, stop requesting the same unchanged information. Ingesting trusted validated changes that cannot be validated but just confirmed through an authoritative source.

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Other efficiencies where we would both have trust in the validity of the data, even when it comes to discrepancies. Having those tracked back to the data source, or even something as simple as confirming receipt.

Small actions like that can go a long way and hopefully can avoid alert fatigue.

The other main branch for us would be what's automatic versus manual processing? Where can we have some items automatically updated? Where have we already verified it? Again, I know if we have deeply rooted data inaccuracies that we may be reticent to trust, but perhaps through rulemaking, we can identify some sources that we do have high trust and validation processes that are applicable. So that way we don't have to go through revalidating those.

There could be an opportunity for CMS to measure in minutes and hours instead of looking to the industry to provide research and publications on that but trying to collect that burden of evidence is a real opportunity here. Like, how often are practices going in and updating Medicaid and also their state medical board and PECOS and NPPES and DataSpring and updates in their EHR and QHP and commercial insurer portals. So, I think there's an opportunity here for CMS to collect data and get some refined estimates on that real experienced burden.

[Facilitator] 15:24:37

I think to [Facilitator's] point of all these different organizations, like licensure, credentialing, etc. And that's part of why we were thinking of this in the blue-sky territory. Creating more of an ecosystem where there's bi-directional APIs between lots of different kinds of organizations, particularly the source organizations where some of these feeds could automatically update the CMS system and could be picked up from the payers.

That's why we think this needs to be a bigger conversation. A broader public-private partnership, and a broader interoperability play where there's bi-directional APIs as part of the bigger, longer-term vision.

[Facilitator] 15:26:08

As we've been going through this, I've been thinking about that all along. I think we need to drive with that first, because I think that's the biggest benefit to adopting this and probably one of the best what's in it for me drivers is the long-term plan and how the intent is to reduce burden, because I really think that's going to be important.

[Nancy Spector] 15:26:56

[Facilitator] commented about perhaps reaching out to CAQH to determine how they ensure they receive timely and accurate updates from providers within the purview of their credentialing process.

[Attendee] added a couple of examples on reducing duplication verifications or barriers, including delegated roster, providers submit provider additions and terminations, and I believe the current portal would need to be enhanced to give the necessary details to allow those transactions to be processed without separate outreach to providers.

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[Attendee] commented that there are repositories that can help modernize your provider directory by bringing provider data into a centralized FHIR native platform. That data can be made searchable and accessible through standards-based APIs while also leveraging it across CMS compliance prioritization, provider access, member-facing applications, turning the provider directory from a point solution into an enterprise data asset.

Topic #7: Policy and Scalability

[Nancy Spector] 15:29:00

Let's move on to the final topic, which is related to overall policy and scalability of the pilot. Currently, this pilot is focused on Oklahoma. What regulatory, operational, or consumer expectation differences would affect what data is collected, or how the pilot operates in other states?

Are there existing state-level data sharing agreements that could support keeping provider information updated for beneficiaries?

What challenges do state health and insurance stakeholders face with provider directory?

[Facilitator] 15:30:40

In terms of the first question, factors might be different at different states and that could impact participation, such as how many plans there are in these various states.

I think the pilot from a provider perspective has the opportunity to replace a whole bunch of different provider directory processes for constantly updating and receiving outreach on them. The more plans you're replacing with this single directory, the more attractive it probably is for providers to participate. I don't know what Oklahoma's specific health insurance landscape looks like, but different states obviously might have more insurers. So, I think that's a key for at least provider participation because it's going to improve the return on investment.

[Nancy Spector] 15:31:51

Good points. When you start looking outside of just CMS, some states have more health plans than other states, along with different mixes of large and mid-sized health plans.

[Facilitator] 15:33:03

Sometimes there are different requirements by the states themselves in terms of what we're collecting and making available to patients. So that's an important part.

It worries me a little bit that there was a question about state level data sharing agreements because particularly for national plans, doing this state by state by state is really challenging.

To restate a couple of the things from the other questions based on this last question, we appreciate this pilot, which we greatly appreciate CMS's efforts on, as well as the contractor, providers, plans, and everybody who participated in. But to be frank, we should be thinking about this very holistically as a public-private partnership across all lines of business to really achieve greater efficiencies and reduce burden significantly for providers, which we think will greatly improve the chances that the information we get is accurate.

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There need to be some additional tools where not just the clinicians themselves are making changes but also access by some of their delegated vendors and such to be able to push and pull information through bi-directional APIs for a really robust ecosystem that's also secure and maintains privacy of the information for everybody involved.

We need to look into the future and bring in a broader group of stakeholders, as we mentioned, to get at credentials and other things that are important.

All of this is really what additional rulemaking should be for. Where we can all really dig into the details. I think we've only been able to scratch the surface here today but certainly appreciate the effort and opportunity to do so.

[Nancy Spector] 15:35:53

[Attendee] commented that some states require them to use their state repository data. North Carolina and Ohio are examples. States have varying enrollment rules and how mid-levels versus PCPs are accounted for. I think regulatory variances and processes need to be accounted for.

[Facilitator] commented that the challenges are in identifying a common national core while allowing flexibility for state-specific requirements.

[Attendee] commented supporting [Attendee's] comments. This is part of the public-facing information provided by [health plan].

[Facilitator] commented that variations occur across update frequencies, mandated elements, audit accuracy, consumer complaint, etc. These would need to be taken into consideration. A national solution should be a governed network of authoritative sources, not just one large database.

[Attendee] commented we should consider the individual Departments of Insurance, which do have specific provider data requirements like Massachusetts, California, and Colorado to mention just a few.

Other comments on this? We do have some time if any attendees want to come off of mute. We can also circle back to the other topics if anyone has more to say on one of them.

[Attendee] posted a comment here about not hearing a feature that entices a provider to visit the directory other than uploading their data, fixing errors that may exist, or other administrivia. Consider a feature that creates a structured package of each provider's data that can be downloaded by that provider for use in a standardized enrollment data set, which a provider can simply upload to a payer organization to fully comply with enrollment data requirements. Consider making these features and attractions to each newly enrolling provider so that they or their admin support can quickly and easily grab a package that can be reused multiple times for each of their own enrollments with payers to whom they wish to submit claims.

[Attendee] asks how we go about submitting our feedback?

At this point, WEDI is gathering feedback from our members. That is what we're doing right in this MPA responding to the questions from CMS. Other commenting to CMS could be done in future rulemaking, a request for information, or something more official that would come out through CMS where they would be looking for industry feedback.

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[Attendee] commented that we also need to ensure our payer data and FHIR endpoints are part of the national solution.
Other questions or comments? None

Appendix D: MPA Chat (Edited) Transcript

The following chat entries have been edited to remove identifying names.

- <https://www.cms.gov/qhpdirectorypilot>
- What is the process for a practice to designate a surrogate to review/approve the required information?
- What happens when/if a provider's records aren't updated within the expected timeframes?
- does the process capture Provider EHR FHIR endpoints?
- What is the process for validating a providers participation within a given network?
- Reacted to "does the process capture Provider EHR FHIR endpoints?" with 🙏
- Is there a process for a large practice to submit a single spreadsheet with all of their provider data at once?
- What kind of adoption rate have you seen with the pilot? % of providers, types of users, etc.
- One of the major problems with NPPES has been poor data quality and outdated information. For example, I have seen provider records where a HL7 FHIR web service endpoint value is set as the doctor's personal @yahoo.com email address. Will there be any data validation? Will providers be held accountable for keeping their records complete and up to date?
- Reacted to "does the process capture Provider EHR FHIR endpoints?" with 💡
- Are there some prompts that can be used to help providers supply exactly what is needed: For example, Provider participates as PCP for HMO plan (HPBP) but as a Specialist for other networks. Or the provider is showing they practice as 1 location 2 days a week but they participate in a Value-based care contract and the Managed Care Office of the health system wants them to appear available for selection at All locations without limitations.
- What are the next steps for this pilot, in terms of potential rollout dates beyond just the OK pilot state?
- what FHIR IG is being used for this directory?
- Reacted to "What is the proces..." with 👍
- Are there any plans to extend this pilot to other lines of business beyond ACA marketplace plans?
- Reacted to "One of the major problems with NPPES ..." with 💡

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- Excellent point
- Were all of these elements included in the Oklahoma pilot?
- Building on [commenters'] comments - there are many directions this could go and perhaps categories (e.g., provider identity and qualifications, organization and location, provider-location relationships, plan/product/network participation) and prioritization of integration of data elements and attestation would be a more amenable way to phase-in all of these elements in an approachable/verifiable/manageable way.
- Does Network and Participation Information implies Insurance Plan information?
- Also exploring through rulemaking how discrepancies are resolved.
- Replying to "Does Network and Participation Information ..."
Da Vinci plan-net IG models the network as an organization. An InsurancePlan can reference a network, but network doesn't reference a plan
- Replying to "Does Network and Participation Information ..."
It does look like plan-net servers are required to implement insurancePlan
- second that ask
- Replying to "Are there some promp..."
The current design allows individual providers to add practice locations, and for each location indicate care delivery method (e.g., telehealth, in-person, or both), network participation, specialty, and availability. This allows the provider's information to vary by location, so a provider can participate in different networks, practice different specialties, or have different availability depending on the location being verified. Please let me know if that does not answer your question!
- Did CMS track accuracy based on provider edits made to get a sense of data attributes that are more frequently needing updates?
- Confirming we'll follow up after the call with a full list of data elements!
- Reacted to "Confirming we'll follow up after the call ..." with 🙌
- Replying to "Does Network and Participation Information ..."
in Plan Net, the network(s) a provider is in is referenced out to from Practitioner Role or Provider Organization Affiliation. Their participation dates are also within Pract Role or Prov Org Affil.
The payer that the network belongs to is identified in Insurance Plan, which references to the Network (organization) resource and payer (organization) resource
- Replying to "Did CMS track accuracy based on provider ... "
We are still collecting information during the duration of the pilot!
- Agree -- we need a mechanism to exchange data with the provider to avoid all payers then going to the provider and increasing abrasion and duplication of work.
- Reacted to "Confirming we'll follow up after the call ..." with ✅
- Reacted to "in Plan Net, the network(s) a provider ..." with ✅
- Agree with [comment] on the transparency issue around verification.. A critical element if orgs and patients are expected to trust and consume the data.

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- How has workflow integration and administrative burden reduction been assessed/evaluated as part of the demo (perhaps from select sites if not at large evaluation).
- FHIR and Bulk are not mutually exclusive. I would rather see a pure FHIR approach supporting both real-time API as well as BULK FHIR support.
- Reacted to "How has workflow integration and administrative ... " with 👍
- Replying to "Does Network and Participation Information ... "
In our implementation, we are representing Issuers and Networks, based on the PDEX Plan-Net specification. These networks are then what is associated with PractitionerRoles via the accepting new patients information. Our implementation does not store any data about insurance plans themselves, only the networks and issuers.
- The closer this aligns to existing FHIR directory standards and existing provider data exchange processes, the easier adoption becomes. Organizations are more likely to adopt something that fits into existing workflows than one requiring a separate operating model.
- Reacted to "The closer this aligns to existing FHIR directory standards ... " with 👍
- I am not technical as I am on the business ops side but agree with FHIR as that is where the industry is headed. I think bulk FHIR has to be a capability due to sheer size of changes/updates taking place daily. The ability to understand what has been validated and/or changed in a given day or date span is ideal.
- Definitely would like to see the central server provide Subscription support for easier communication of changes to all the HealthPlans
- The FHIR API we make available to the issuers does have bulk download support in both JSON and CSV formats. The bulk download API matches the standard FHIR spec for bulk export.
Thank you for your feedback!
- Reacted to "The current design..." with 👍
- One additional dimension to consider is whether the directory is queryable in real-time or intended for more constrained downloads (e.g., bulk download 1x per period, potentially supplemented with pub/sub for changes)
- Reacted to "Definitely would I..." with 👍
- Data architecture should be accessible across groups of varying sizes/resource/health IT maturity levels.
- Reacted to "Definitely would like to see the central server provide ... " with ✅
- Reacted to "FHIR and Bulk are not mutually exclusive. I would ... " with ✅
- Practices with multiple locations often list all of their providers as practicing at each (for potential billing purposes). Many only practice in select locations.
- Beyond specialty capturing areas of expertise will help a consumer..... do they specialize in ADHD, hip replacement, or various specific conditions could help care navigation.

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- To what [commenter] just stated, address affiliation is critical so we don't get every address which is what providers are worried about for claim payment (so do they accept appointments 1/week, 1/month, cover/call at a location, group location only, read records at location, etc.)
- Provider language spoken is important, but not always captured and presented in a directory
- Those are good examples!
- area of focus is not necessarily equal to specialty - areas of focus are often very narrowed area within their specialty
- I think additions are often easier than removals. For example, new provider on the network is more likely to be included than a provider leaving a network is to be removed. Not sure what a solution might be...
- Reacted to "area of focus is n..." with ¹⁰⁰
- Replying to "area of focus is not necessarily equal to specialty ... "
Good example is Orthopedics which often have specialist within the same location (e.g., Shoulder, neck, elbow, etc)
- To [commenter's] point, many practice websites give more information regarding the providers area of focus (ie, geriatric medicine, sports medicine). But directories do not always capture these nuances
- Replying to "I think additions are often easier than removals... "
payers have requirements under CAA to keep the data current so there are processes in place at payers to address this more timely
- Telehealth, hybrid (clearly defined), in person should be designated in the directory.
- Reacted to "Telehealth, hybrid (clearly defined), in person ... " with 👍
- Education, education, education; lots of delegates at offices have no ideas some of these requirements exist
- inconsistent method of reaching out to the provider can cause delays (i.e., phone, mail, email)
- Reacted to "Education, education, education; lots of delegates ..." with ¹⁰⁰
- Clinicians often delegate provider directory updates to their office staff and those personnel often lack the technical knowledge on how to set certain fields, or what those fields even mean. Unless there are some real consequences for providers who fail to keep their directory entries up to date I am concerned that gaps and data quality problems will persist.
- Replying to "inconsistent method of reaching out to the provider ... "
a lot of times Plans use multiple methods when one method has been unsuccessful in getting a response
- Having data submitted and propagated - showing how time involving directory for reporting/updating can add value in other workstreams to burdened administrators.
- How were individual providers in Oklahoma contacted about the pilot?

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- Reacted to "Clinicians often delegate provider directory updates ... " with 👍
- Reacted to "Clinicians often d..." with 👍
- Replying to "How were individual providers in Oklahoma contacted about the pilot?"
CMS has been attempting to reach individual providers and facilities through a number of venues including directly through email, member associations, etc. CMS welcomes any suggestions about best ways to reach providers directly to engage in the pilot.
- One simple issue-ensuring that the practice contact point is accurate and consistent
- Perhaps reaching out to CAQH to determine how they ensure they receive timely and accurate updates from providers to their ProView credentialing process
- Reacted to "Perhaps reaching out to CAQH to determine ... " with 💡
- Just a couple of examples on reducing dup verifications or barriers..... Delegated rostered providers submit provider adds and terminations and I believe current portal would need to be enhanced to give the necessary details to allow those transactions to be processed without separate outreach to providers. When we do an add (or even a change), the associated billing information is required in the process.
- There are repositories that can help modernize your provider directory by bringing provider data into a centralized, FHIR-native platform. We can make that data searchable and accessible through standards-based APIs, while also leveraging it across CMS compliance, prior authorization, provider access, and member-facing applications—turning the provider directory from a point solution into an enterprise data asset.
- Yes, this would be extremely helpful in the management to ensure the data is accurate and useable.
- When collecting the data you can build in your own business rules and policies.
- Will national solution support NDH and not Plan.Net?
- I have to drop, but I would say Medicaid state regulatory requirements vary greatly by state and would need to be considered. Additionally, some states require us to use their state repository data (NC and OH are examples). States have varying enrollment rules and how mid-levels vs PCPs are accounted for. I think regulatory variances and processes need to be accounted for.
- The challenge is identifying a common national core while allowing flexibility for state-specific requirements.
- Supporting [commenter's] comments above, this is part of the public facing information provided by Ohio Medicaid, "Professional liability insurance that covers the provider or provider group (minimums based on state – example, Ohio providers require 1 million occurrence and 3 million aggregate and Indiana providers require 250,000 occurrence, 750,000 aggregate)."
- State variations occur across:
 - directory update frequencies
 - state-mandated data elements
 - audit and accuracy requirements

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- consumer complaint and correction procedures
- accessibility and language requirements
- Medicaid program structure
- state-based vs. federally facilitated marketplace ops
- network adequacy standards
- provider licensure and facility regulations
- delegated credentialing arrangements
- data privacy and sharing restrictions
- rurality and provider shortages
- telehealth laws and interstate practice
- state-specific identifiers/terminology
- A national solution should be a governed network of authoritative sources not just one larger database. Perhaps it could include:
 - a nationally defined core dataset
 - state extensions where legally required
 - common FHIR implementation specs
 - clear field-level accountability
 - provider and issuer write-back capes
 - stable practitioner, org, location, product, and network identifiers
 - event-driven change
 - transparent dispute resolution
 - strong privacy and data-minimization controls
 - support for enterprise and independent practices
 - reuse across QHP, Medicare, Medicaid, and commercial programs
- Hi everyone! Also, we should consider the individual Department of Insurance which do have specific provider data requirements like MA, CA, and CO to mention just a few.
- Reacted to "A national solution should be a governed ..." with 🍌
- Reacted to "A national solutio..." with 🍌
- The thought occurs to me that I am not hearing a feature that entices a provider to visit the directory, other than uploading their data, fixing errors that may exist, or other "administrivia" (even if not trivial). Consider a feature that creates a structured package of each provider's data that can be downloaded by that provider, for use in a standardized enrollment dataset which that provider can simply upload to a payer organization, to fully comply with the enrollment data requirements of any payer? Regardless of adoption of a standard national directory, we are facing a mid-term (4 to 7 years?) when individual provider enrollment in each payer's system will likely be the norm. Consider making this feature an attraction to each newly enrolling provider, so that they or their admin support can quickly and easily grab a package that can be re-used multiple times for each of their enrollment with payer to whom they wish to submit claims?

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- Reacted to "The thought occurs to me that I am not hearing ... " with 👍
- Reacted to "The thought occurs to me that I am not hearing ... " with 🙌
- How do we go about sending our feedback
- We also need to ensure Payer data (FHIR end points) be part of national solution
- Reacted to "The thought occurs to me that I am not hearing ... " with ❤️
- Reacted to "The thought occurs to me that I am not hearing ... " with 👍
- Reacted to "We also need to ensure Payer data ..." with 👍
- Reacted to "Hi everyone! Also, we should consider the individual ... " with 👍

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