



# PROVIDER DIRECTORIES: LITIGATION, REGULATORY, AND OPERATIONAL CHALLENGES



**BRG**  
Healthcare



## WHITE PAPER

UPDATE: FEBRUARY 2016

Prepared By:

**BRIAN E. HOYT**

bhojt@thinkbrg.com

202.480.2762

Copyright ©2016 by Berkeley Research Group, LLC. Except as may be expressly provided elsewhere in this publication, permission is hereby granted to produce and distribute copies of individual works from this publication for non-profit educational purposes, provided that the author, source, and copyright notice are included on each copy. This permission is in addition to rights of reproduction granted under Sections 107, 108, and other provisions of the U.S. Copyright Act and its amendments.

Disclaimer: The opinions expressed in this publication are those of the individual author and do not represent the opinions of BRG or its other employees and affiliates. The information provided in the publication is not intended to and does not render legal, accounting, tax, or other professional advice or services, and no client relationship is established with BRG by making any information available in this publication, or from you transmitting an email or other message to us. None of the information contained herein should be used as a substitute for consultation with competent advisors.

# 1 Executive Summary

Since the implementation of the Affordable Care Act (ACA), millions of consumers have signed up for health insurance coverage through the Health Insurance Marketplace.<sup>1</sup> Additionally, employer groups both large and small are increasingly asking health insurers to create health insurance products specific to their employees. As a result, health plans are creating new, contracted network offerings at an unprecedented rate. These range from higher-cost PPO products with broad provider networks to products with narrow or tiered networks that boast lower premiums but provide limited choices of providers.

As the volume and variety of health insurance products increase to accommodate an expanding market, so do concerns about whether the contracted provider networks adequately serve their target patient population. Further, some consumers have complained that the provider network information provided to them by health plans is misleading and inaccurate. As a result, federal and state regulations have added more specificity around what constitutes an adequate provider network and have defined the information that a health plan is required to provide to consumers.

These regulations require health insurers to maintain and provide consumers with an accurate listing of providers—both facilities and physicians—participating in their networks. This includes information about their location, specialty, hospital affiliation, and languages spoken. Consumers are entitled to have access to these provider directories both in hard-copy printed format and via a Web-based provider search portal on a health insurer's website. Although these regulations are intended to ensure that consumers are relying on accurate provider information, recent studies and reports indicate that health plans struggle to maintain accurate provider directories.

The repercussions of inaccurate provider directories can be significant, posing risks to both consumers and health plans. Inaccurate directory information may limit a consumer's ability to verify if a preferred doctor is in-network or to know how many and what types of providers would have to be accessed under a particular product offering. Additionally, the consumer may be at risk of being charged higher out-of-network rates when providers are erroneously listed as being in-network. These inaccuracies also put health plans at greater risk of litigation, government penalties and investigations, and significant administrative costs associated with rectifying inaccurate directories.

The primary purpose of this paper is to provide health plan stakeholders with information on provider directories.<sup>2</sup> These stakeholders include the executives, managers, and analysts within health insurance companies that evaluate provider network contracts, in addition to those directly involved in maintaining the company's provider directories. The first section of the paper includes a critical review of the guidelines and regulations around provider directories. The next section discusses operational challenges that health plans may encounter in maintaining accurate provider directories. This is followed by an assessment of the risks posed by inaccurate provider directories to both consumers and health plans. The paper concludes with a case study and a discussion of the future of provider directories, including recent guidance from the Centers for Medicare and Medicaid Services (CMS).

1 Jenna Levy, "In U.S., Uninsured Rate Sinks to 12.9%," Gallup (January 7, 2015), accessed at: <http://www.gallup.com/poll/180425/uninsured-rate-sinks.aspx>

2 For original paper, see Brian Hoyt, *Provider Directories: Litigation, Regulatory, and Operational Challenges*, Berkeley Research Group (March 2015), accessed at: <http://www.thinkbrg.com/newsroom-publications-hoyt-provider-directories.html>

## 2 Guidelines and Regulations for Provider Directories

Various entities, including the federal government, state governments and departments of insurance, independent accreditation organizations, and trade associations, have provided recommendations and guidelines related to provider directories. Given that regulations around directories are still evolving and vary greatly, it is important to understand the rules in place for maintaining accuracy. The following provides an overview of some rules.

### 2.1 Provider Directory Review during Health Plan Accreditation

The health plan accreditation process typically includes a review of provider directory accuracy and maintenance procedures. Accreditation is a comprehensive evaluation process in which an impartial external organization reviews a health plan's systems, processes, and performance to ensure that it is conducting business in a manner that meets predetermined criteria and is consistent with national standards.<sup>3</sup> The ACA mandates accreditation to ensure quality in the managed healthcare sector,<sup>4</sup> and Qualified Health Plans (QHPs) sold on the Health Insurance Marketplace must go through the accreditation process. Additionally, more than 45 states use accreditation as part of their regular health insurance evaluations.

The National Committee for Quality Assurance (NCQA), the nation's largest accreditation body, has included standards for Physician and Hospital Directories as part of its health plan accreditation guidelines. The scoring is based on several elements, including whether the organization:<sup>5</sup>

- Provides a Web-based physician directory with the following information
  - Name
  - Gender
  - Specialty
  - Hospital affiliations
  - Medical group affiliations
  - Board certification
  - Accepting new patients
  - Languages spoken by the physician or clinical staff
  - Office locations and phone numbers
- Updates the physician directory within 30 days of receiving new information from the physician
- Analyzes the accuracy of physician directories using sampling methodology
- At least annually, identifies opportunities and takes action to improve the accuracy of its provider directories

3 National Conference of State Legislatures, "Accreditation to Approve Health Plans and Providers" (April 2011), 1–2, accessed at: <http://www.ncsl.org/documents/health/HRHealthPlans.pdf>

4 Section 1311(c)1, "Affordable Choices of Health Benefit Plans and Section 1001," as amended by Section 10101 of the Patient Protection and Affordable Care Act (PPACA), Pub. L. 111–148, adds Section 2719 to the Public Health Service Act.

5 NCQA, *HPA 2016 Standards and Guidelines Proposed Updates* (n.d.), 28–34, accessed at: [http://www.ncqa.org/Portals/0/PublicComment/HPA2016/Appendix%201\\_%20Proposed%20Updates%20to%20HPA%202016%20Standards%20and%20Guidelines.pdf](http://www.ncqa.org/Portals/0/PublicComment/HPA2016/Appendix%201_%20Proposed%20Updates%20to%20HPA%202016%20Standards%20and%20Guidelines.pdf)

- For each listing in the directory, provides a source, frequency of validation, and limitations
- Includes search functions within its directory for certain physician information

NCQA also requires that accredited plans validate provider information for directories on at least an annual basis.<sup>6</sup>

## 2.2 Federal Requirements for Provider Directories

The requirements around network adequacy and provider directories for federal health programs are established broadly by federal statutes and/or regulations. The subsequent guidance released periodically by CMS gives additional information on how those regulations are to be implemented. The recent guidance for QHPs, Medicare Advantage Organizations (MAOs), and Medicaid Managed Care Organizations (MCOs) are discussed in the sections that follow.

### 2.2.1 Qualified Health Plans

The Affordable Care Act established the federal requirements around health plan network adequacy and provider directory accuracy. The ACA requires that the Department of Health and Human Services (HHS) establish criteria for the certification of QHPs that:

- Ensure a sufficient choice of providers
- Provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers
- Inclusion of essential community providers serving low-income and medically underserved enrollees<sup>7</sup>

The associated regulations require QHPs to provide online access to provider directory information, provide hard-copy provider directories upon request, and identify when a listed provider is no longer accepting new patients.<sup>8</sup> The guidance issued by CMS specifies additional required information, including “information on which providers are accepting new patients, the provider’s location, contact information, specialty, medical group, and any institution affiliations in a manner that is easily accessible to plan enrollees, prospective enrollees,” among others.<sup>9</sup> A provider directory is considered “easily accessible” when “the general public is able to view all of the current providers for a plan in a provider directory on the issuer’s public website through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number.”<sup>10</sup>

The recent CMS guidance also requires QHP issuers in federally facilitated marketplaces to submit provider directory information in a machine-readable format and update the information at least monthly.<sup>11</sup> CMS announced in late 2015 that it had “access to data from over 90 percent of insurance companies on the Marketplace” and was “piloting a new beta [Doctor Lookup] feature that allows consumers to search plans by their preferred provider or health facility.”<sup>12</sup>

6 NCQA, “Network Adequacy & Exchanges” (2013), 6, accessed at: [http://www.ncqa.org/Portals/0/Public Policy/Exchanges&NetworkAdequacy\\_2.11.13.pdf](http://www.ncqa.org/Portals/0/Public Policy/Exchanges&NetworkAdequacy_2.11.13.pdf)

7 Patient Protection and Affordable Care Act, Section 1311(c).

8 45 CFR 156.230.

9 CMS, “Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces” (December 23, 2015), 54.

10 Ibid.

11 Ibid.

12 CMS, “HealthCare.gov Pilots New Doctor Lookup Feature” (November 3, 2015) available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-11-03-2.html>

### 2.2.2 Medicare Advantage Organizations

The regulations for Medicare Advantage require MAOs to disclose “[t]o each enrollee electing an MA plan ... in clear, accurate and standardized form ... the number, mix, and distribution (addresses) of providers from whom enrollees may reasonably be expected to obtain services.”<sup>13</sup>

Recent guidance from CMS further clarifies that “in order for [CMS] to consider the MAO compliant with [the regulation], MAO must include in their online provider directories all active contracted providers, with specific notations to highlight those providers who are closed or not accepting new patients.”<sup>14</sup> This guidance also requires MAOs to:

- “Establish and maintain a proactive, structured process that enables [MAOs] to assess, on a timely basis, the true availability of contracted providers”
- Perform “as needed, an analysis to verify continued compliance with applicable network access requirements”
- Communicate regularly with providers to “ascertain their availability and, specifically, whether they are accepting new patients”
- Require contracted providers “to inform the plan of any changes...that affect [provider] availability”
- Develop a process to address “inquiries/complaints related to enrollees being denied access to a contracted provider with follow through to make corrections to the online directory”
- Update information in online directories on a “real time” basis<sup>15</sup>

### 2.2.3 Medicaid Managed Care Organizations

The regulation for Medicaid Managed Care Organizations specifies that MCOs “must provide the following information to all enrollees ... Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee’s service area, including the identification of providers that are not accepting new patients.”<sup>16</sup>

A recent proposed rule for MCOs would require MCOs to:

- Add four additional elements to provider directories: a provider’s group/site affiliation, website URL (if available), the provider’s linguistic and cultural capabilities, and the accessibility of the provider’s office to enrollees with physical disabilities
- Update electronic directories within three business days of receiving updated provider information
- Post provider directories on their websites in a machine-readable file and format specified by the HHS Secretary<sup>17</sup>

<sup>13</sup> 42 CFR 422.111(b).

<sup>14</sup> CMS, “Announcement of Calendar Year (CY) 2016 for Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter” (April 6, 2015), 139.

<sup>15</sup> In a memorandum issued on November 13, 2015 (“Provider Directory Requirements – Update”), CMS defined “regular” communications with providers as being “at least quarterly” and “real time” as within 30 days.

<sup>16</sup> 42 CFR 438.10(f)(6).

<sup>17</sup> Federal Register, “CMS-2390-P,” Vol. 80, No. 104 (June 1, 2015), 31162, accessed at: <https://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf>

## 2.3 State-Level Provider Directory Oversight

The National Association of Insurance Commissioners (NAIC) advocates for network adequacy standards to be set at the state level. In a letter to the Center for Consumer Information and Insurance Oversight—the federal agency charged with implementing much of the ACA—the NAIC argued that “federal regulation of network adequacy standards will lead to conflicting standards between state and federal requirements and that network adequacy regulation will be most effective at the state level where the needs of consumers, the cost of care, and the standards of the area, can best be evaluated.”<sup>18</sup> As such, several states have established their own network adequacy rules that include language pertaining to provider directory requirements.

At its fall meeting in November 2015, the NAIC Executive Committee and Plenary adopted the Amendments to the 1996 Managed Care Plan Network Adequacy Model Act (#74). Among other changes, the Amendments added a new section (Section 9) related to Provider Directories. This section specifies that health carriers shall post easily accessible electronic provider directories and update them at least monthly.<sup>19</sup> Similar to NCQA standards, the Model Act also requires periodic auditing of provider directories from a reasonable sample size. Health carriers should also include the following elements in a searchable format:<sup>20</sup>

For healthcare professionals,

- Name
- Gender
- Participating office location(s)
- Specialty
- Medical group affiliations
- Facility affiliations
- Languages spoken other than English
- Whether accepting new patients

The Model Act also requires health carriers to include, in plain language, a description of the criteria the carrier has used to build its network and tier providers.<sup>21</sup>

---

18 Adam Hamm et al., letter to Dr. Mandy Cohen, CMS chief operating officer and chief of staff for Oversight (April 23, 2014). TS.

19 National Association of Insurance Commissioners, “Health Benefit Plan Network Access and Adequacy Model Act,” revisions to Model #74 draft (October 12, 2015), 22, accessed at: [http://www.naic.org/documents/committees\\_b\\_exposure\\_draft\\_proposed\\_revisions\\_mcpnama74.pdf](http://www.naic.org/documents/committees_b_exposure_draft_proposed_revisions_mcpnama74.pdf)

20 Ibid, 23.

21 Ibid, 22.

### 2.3.1 Provider Directory Standards Development: Key Considerations

An element that states define when developing provider directory requirements is the breadth and type of information that health plans are required to include in a provider directory. Beyond what is required by federal law, additional information may be required, such as:<sup>22, 23</sup>

- Provider gender
- Residency information
- Hospital and/or group affiliations
- Languages spoken or interpretation services available
- Telemedicine access
- Quality metrics
- Patient-centered medical home recognition status

Another important point of consideration is the timeliness of the update cycle. Consumers typically use provider directory information to make decisions in real time; however, the frequency with which health plans update their provider directories varies significantly. Many states only require an annual update, which often makes it more difficult for those viewing a provider directory to ensure its information is current. Additionally, states must decide what, if any, penalties should be imposed on health plans when directories have errors, particularly when patients incur out-of-network costs because of it. Regulators may also require health plans to allow consumers to reenroll in a new health plan if their current one has been misrepresented in a provider directory.

### 2.3.2 Variation in State-Level Provider Directory Policies

Since states are allowed to develop their own standards around provider directories, regulations vary widely across states as they attempt to keep pace with new and evolving health plan designs.<sup>24</sup> Appendix A details state-specific regulatory guidelines for plan provider directories; however, states generally fall into one of four categories:

- Tier 1: These states impose the most stringent rules related to provider directories. When a provider leaves a network or its information changes, these states allow up to a month, and frequently less time, for health plans to adjust the provider directory to reflect a change. In some cases, plans must take extra verification steps. For example, New Jersey managed care plans must confirm if a provider is still in-network if the provider has not submitted a claim for 12 months or has stopped communicating with the plan.<sup>25</sup>
- Tier 2: These states allow more leeway in terms of provider directory update cycles. State regulations require updates at least annually, with some states requiring updates on a quarterly or semi-annual basis.

22 L. Blumberg, R. Peters, E. Wengle, and R. Arnesen, *Physician Network Transparency: How Easy Is It for Consumers to Know What They Are Buying?*, ACA Implementation—Monitoring and Tracking, Urban Institute (August 2014), 1–20, accessed at: <http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf415098>

23 Claire McAndrew and Sinsi Hernandez-Cancio, *Network Adequacy and Health Equity: Improving Private Health Insurance Provider Networks for Communities of Color*, Families USA issue brief (August 2014), accessed at: [http://familiesusa.org/sites/default/files/product\\_documents/ACT\\_Network\\_Adequacy\\_Brief\\_final\\_082214\\_web.pdf](http://familiesusa.org/sites/default/files/product_documents/ACT_Network_Adequacy_Brief_final_082214_web.pdf)

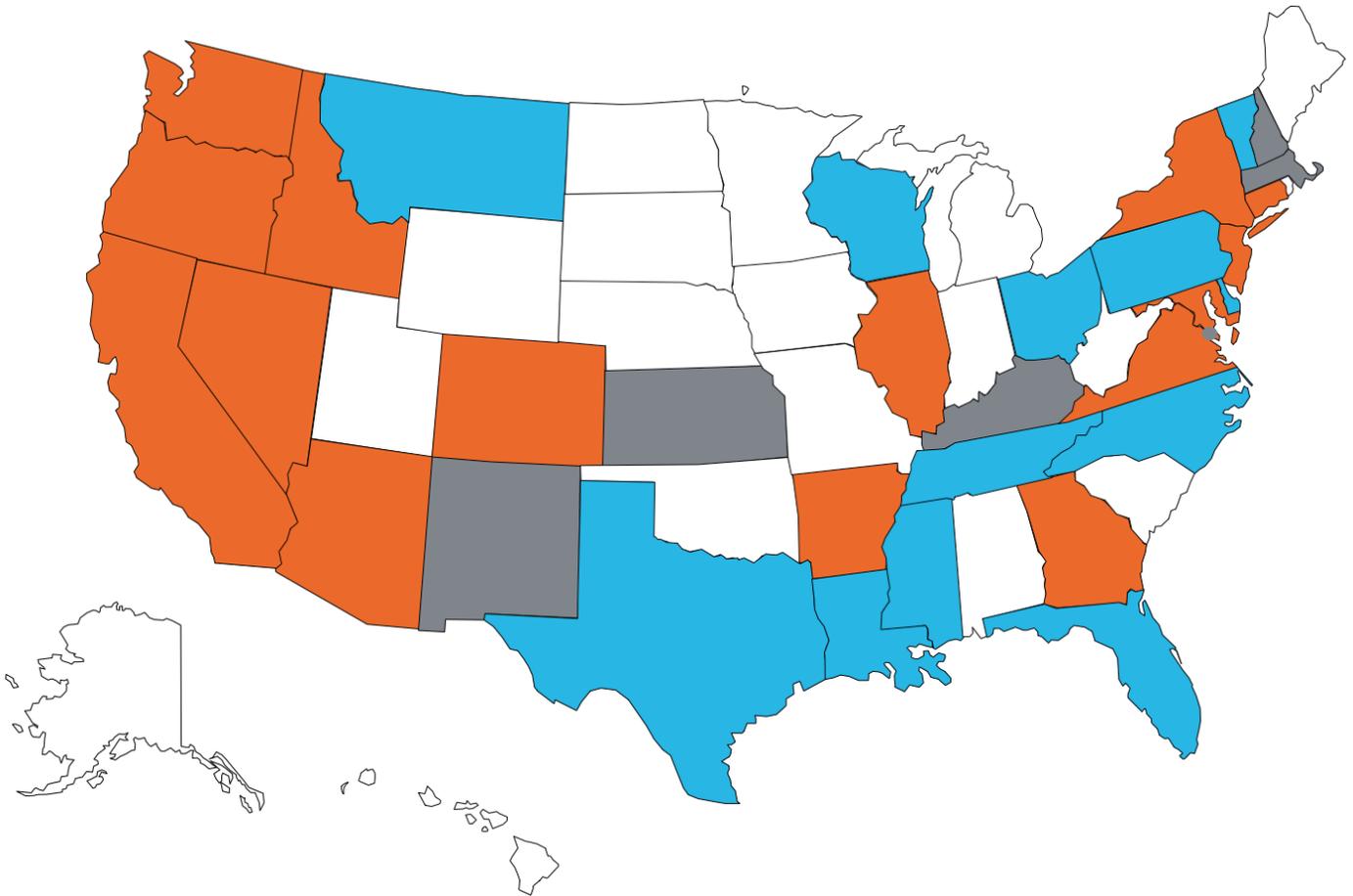
24 C. Barber et al., *Ensuring Consumers' Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market*, Health Management Associates (November 2014), accessed at: [http://www.naic.org/documents/committees\\_conliaison\\_network\\_adequacy\\_report.pdf](http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf)

25 B. Herman, "Insurers draw heat for error-riddled provider directories," *Modern Healthcare* (November 19, 2014), accessed at: <http://www.modernhealthcare.com/article/20141119/NEWS/311199972>

- Tier 3: Regulations in these states are more ambiguous and simply state that directories should be up to date and that any updates should occur in a “timely” or “prompt” manner.
- Tier 4: These states have not yet detailed parameters for provider directories beyond what is required by federal network adequacy regulations or national accreditation entities.

Figure 1 summarizes regulations that apply to health plan products at the broadest level. However, variation also exists across health plan types, with HMOs being the most regulated with respect to network adequacy, followed by PPOs and EPOs.<sup>26</sup>

**FIGURE 1: GROUPINGS OF STATES ACCORDING TO PROVIDER DIRECTORY OVERSIGHT<sup>27</sup>**



Tier	Color	States
1	Orange	Provider directory updates at least on a monthly basis, with potential additional provider validation requirements
2	Blue	Provider directory updates required between a quarterly and an annual basis
3	Grey	Provider directories required to be “up to date” or updated in a timely manner
4	White	No additional state-level guidance found specific to provider directory adequacy and/or that differs from federal regulations

<sup>26</sup> Barber et al. (2014).

<sup>27</sup> See Appendix A.

### 3 Provider Directory Operational Challenges

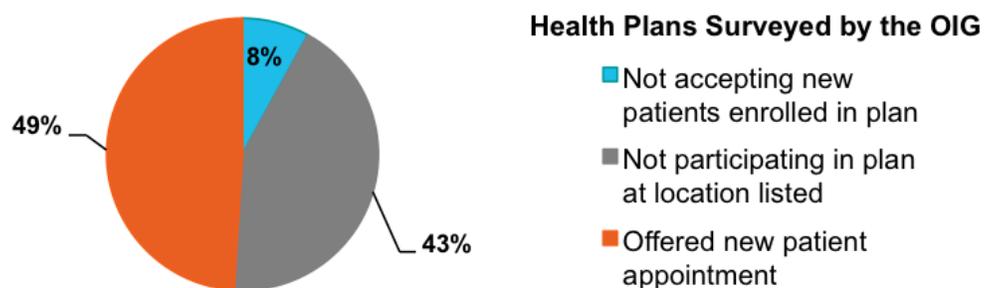
Inaccuracies in health plans' provider directories are garnering greater attention, with several recent reports in the media and professional journals, as well as studies performed by CMS and other regulatory entities. These reports indicate widespread inaccuracies in health plans' provider directories. In a study published by JAMA Dermatology and reported in the Wall Street Journal, "researchers at the University of California, San Francisco, tried contacting [...] 4,754 dermatologists listed in the three largest Medicare Advantage plans in 12 metro areas. Nearly half of the names were duplicates, and only about half the remaining—26% of the total—were at the listed address, accepted the plan and were offering appointments."<sup>28</sup>

The California Department of Managed Health Care (DMHC) performed a non-routine survey of Blue Shield of California showing that "a significant percentage (18.2%) of the physicians listed in the directory were not at the location listed in the Provider Directory and that a significant percentage (8.8%) were not willing to accept patients enrolled in the Plan's Covered California products, despite being listed on the website as doing so."<sup>29</sup> A similar DMHC study of Anthem Blue Cross showed these percentages as 12.5 percent and 12.8 percent.<sup>30</sup> These results may explain the high number of consumer complaints received by the health plan related to provider directories. Anthem customers filed 176 complaints on network issues between January 1 and August 31, 2014, and Blue Shield saw 130 complaints.<sup>31</sup>

A study into the availability of providers in the Medicaid Managed Care program performed by the HHS's Office of Inspector General offers perhaps the most glaring results. The OIG study found the following:

Forty-three percent of providers were not participating in the Medicaid managed care plan at the listed location and could not offer appointments. Notably, 35 percent of providers could not be found at the location listed and were therefore not participating at the location listed by the plan. In these cases, callers were sometimes told that the practice had never heard of the provider or that the provider had practiced at the location in the past but had retired or left the practice. Some providers had left months or even years before the time of the call. Another 8 percent of providers were at the location listed but said that they were not participating in the plan. In some cases, these providers had participated in the plan in the past; in other cases, the providers had never participated in the Medicaid managed care plan.<sup>32</sup>

**FIGURE 2: ACCURACY DISTRIBUTION OF PROVIDER DIRECTORY REPORTING ON AVAILABILITY OF PROVIDERS<sup>33</sup>**



28 M. Beck, "Insurers' Listings of In-Network Doctors Often Out of Date," *The Wall Street Journal* (November 25, 2014), accessed at: <http://www.wsj.com/articles/insurers-listings-of-in-network-doctors-often-out-of-date-1416953787>

29 Department of Managed Health Care, "Final Report: Non-Routine Survey of Blue Shield of California, A Full Service Health Plan" (2014), 1–43, accessed at: [https://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/043\\_nr\\_provider%20directory\\_111814.pdf](https://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/043_nr_provider%20directory_111814.pdf)

30 Department of Managed Health Care, "Final Report: Non-Routine Survey of Anthem Blue Cross, A Full Service Health Plan" (2014), 1–58, accessed at: [https://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303\\_nr\\_provider%20directory\\_111814.pdf](https://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303_nr_provider%20directory_111814.pdf)

31 C. Terhune, S. Poindexter, and D. Smith, "Obamacare doctor networks to stay limited in 2015," *Los Angeles Times* (September 28, 2014), accessed at: <http://www.latimes.com/business/la-fi-0928-obamacare-doctors-20140928-story.html#page=1>

32 HHS, Office of Inspector General, "State Standards for Access to Care in Medicaid Managed Care" Washington DC (2014).

33 Adapted from Figure 1 of HHS OIG (2014).

These reports indicate that health plans have struggled to maintain accurate participating provider information in their provider directories. Health plans find it increasingly difficult to maintain accurate participating provider information in their provider directories for reasons including:

- Inherent and increasing complexity in the insurance products being offered to customers
- The dynamic nature of participating provider information
- Limited resources to adequately execute and maintain provider directories

### 3.1 Complexity of Provider Directory Maintenance

The health insurance business is inherently complex. Some complexity lies in how a health plan contracts with providers—facilities, provider groups, and physicians—to construct its provider networks. Contracting relationships define, among other things, whether providers directly or indirectly contract with the health plan, how providers are divided up among the insurance products offered by the health plan, and whether a provider participates in these products in multiple specialties and/or from multiple locations. Each complexity is discussed in greater detail below.

First, health plans will often contract directly with providers to meet the needs of the members in a service area. This contracting relationship typically places the responsibility on the health plan to ensure that the participating provider information for each directly contracted provider is accurate and up to date. However, for its national PPO products, a health plan will often lease a provider network, since it does not have its own provider network for all service areas in the United States. This arrangement typically places the responsibility of obtaining accurate participating provider information on the rental network company, which will then pass along this verified provider information to the health plan, attesting to its accuracy.

Second, health plans are attempting to lower costs by constructing provider networks that include only certain providers within a health system. A 2014 McKinsey study of products being sold on the ACA health insurance exchanges describes what it refers to as “partial health system participation.” The study found, “Forty-four percent of [ultra-narrow, silver-tier products] exclude at least one hospital from every single participating health system.”<sup>34</sup> The study further suggests that “[a]nother 31 percent of the products exclude at least one hospital from at least one health system” and that the costs for such ultra-narrow networks are 13 percent lower.<sup>35</sup> However, these types of arrangements add complexity to the process of capturing the relevant information in a health plan’s provider system and ensuring that these data are propagated correctly to its provider directories.

Third, a provider practicing multiple specialties or at multiple locations may be participating, or “par,” with a health plan for only one specialty or at one location. This occurs when a provider has completed the credentialing process with the health plan for one specialty or location and not others; the specialties or locations for which the provider has not been credentialed would need to be excluded from the health plan’s provider directories or identified as being out of network. This adds further complexity to the task of obtaining and maintaining accurate participating provider information.

### 3.2 Dynamic Nature of Provider Directories

Consumers rely on provider directories to ensure that the provider they intend to see is participating in the health insurance product that they have purchased from the health plan. As mentioned earlier, provider directories are usually provided in printed form and via a Web-based provider search portal on the health insurer’s website. A difficulty in providing these directories to consumers is that any time one piece of information for a provider listed in a health plan directory changes, that entire directory is technically inaccurate until it is updated with the accurate information.

<sup>34</sup> McKinsey & Co., “Hospital networks: Updated national view of configurations on the exchanges” (June 2014), 3.

<sup>35</sup> Ibid, 13.

Provider directories are typically required to provide, at a minimum, the provider's name (including facilities), address(es), telephone number(s), specialty area(s), hospital affiliation, language(s) spoken, and whether new patients are being accepted. Additionally, provider directories should indicate the provider network(s) (or health insurance products) in which a provider is participating. Some of this information will change frequently, and any change to the participating provider information that is displayed in a directory—either printed or online—should be updated according to the requirements of the relevant state and federal regulations.

Clearly, updated provider information takes longer to reach a consumer in a printed directory than in an online directory, which increases the likelihood that a consumer using a printed directory is relying on inaccurate, outdated information. Presenting directories in either format requires the health plan to aggregate significant amounts of data into its provider system, develop efficient systems and processes for soliciting changes to these data, and ensure that the accurate, current information is propagated correctly to the directories within the timeframes set forth in relevant state and federal regulations.

### 3.3 Resource Limitations

The process required by a health plan to maintain accurate participating provider information in its provider directories is complex and requires substantial resources. At the most basic level, a health plan must implement a system that allows it to store and maintain information related to its provider networks. The health plan is further required to obtain participating provider information from its provider networks, ensure that this information is published correctly in its directories, verify this information on a regular basis, and publish changes in a timely manner. All of this must be performed by health plan resources that are often limited and subject to medical loss ratio (MLR) requirements.

Often, a health plan stores provider information across multiple systems. It may maintain provider contracting and credentialing data in a system apart from the system in which it maintains its participating provider information. The health plan must ensure that information obtained from providers is entered correctly into these systems. The health plan must also ensure that this information is propagated accurately to its provider directories. This involves querying the provider system(s) in a way that maintains the integrity of the data as they flow from the information systems through the process of publishing a printed directory or feeding the underlying data sources for the online search portal.

Once the health plan has implemented these processes, it needs to develop a reliable process to verify its participating provider information on a basis consistent with relevant state and federal regulations, including in some cases obtaining an affirmative response every twelve months from all directly contracted providers in its networks. Health plans with large provider networks often need to perform this outreach and verification on a constant basis throughout the year.

Further, after learning of a change in its participating provider information through either its verification process or direct contact from a provider, the health plan is required to update its provider directories within a timeframe specified by state regulations. For example, the state of New York requires that health plans update provider directories within 15 days of receiving a change in participating provider information.<sup>36</sup>

These processes must be implemented and carried out by health plan resources that are constrained by MLR requirements. The ACA establishes minimum MLRs of 80 percent for small-group (from 1 to 100 workers) and individual markets, and 85 percent for the fully insured large-group market. Most simply, these percentages dictate the percentage of premiums that health plans must spend on non-administrative functions, including the health insurer's incurred claims plus the "insurer's expenditures for activities that improve health care quality."<sup>37</sup> The costs associated with "developing and executing provider contracts and fees associated with establishing and managing a provider network" do not fall under these categories and therefore are considered

<sup>36</sup> State of New York, Senate-Assembly, Bill S6914, A9205 (2014).

<sup>37</sup> 45 CFR 158.221(b).

an administrative expense under MLR rules.<sup>38</sup> As the state and federal regulations impose new requirements around maintaining accurate provider directories, health plans are required to comply with these requirements with increasingly limited resources.

## 4 Risks Associated with Provider Directory Errors

When a health plan's provider directory contains inaccurate participating provider information, it poses risks to both consumers and the health plan itself. First, consumers are at risk because they are making decisions based on faulty or incomplete information. This impacts their decision making when both choosing a health plan and deciding which provider to go to for services. Second, the health plan faces several organizational risks, including additional administrative burden, potential cost of resolving out-of-network charges, an inaccurate picture of potential fraud and abuse, and an increased risk of litigation.

### 4.1 Risks to Consumers

When selecting a health plan, consumers often consult the provider directories provided by the health plans that they are considering. This is often the case in both the individual and employer markets. In either case, a consumer is interested in understanding which providers are considered in-network, especially if the consumer has a prior history with a particular provider that they would like to continue to see. Around 71 percent of enrollees have doctors, hospitals, and other healthcare providers that they would like to see in their health plan network.<sup>39</sup> Additionally, a consumer may want to find a provider that is in close proximity to his workplace. If the provider directory has inaccurate location information and the consumer selects the health plan to have access to this provider, then the consumer is at risk of not having access to that provider at a location that is convenient.

When the provider directory lists the wrong address, this mostly poses an inconvenience to the consumer. However, when the health plan incorrectly lists its in-network providers, this potentially presents a financial risk to the consumer. For example, the health plan may indicate that a provider is part of a particular network when he actually is not. Alternatively, a health plan may list a provider in its provider directories as being par at multiple locations, when in actuality that provider is par at only one location. Regardless of how this error manifests itself in a health plan's provider directory, the impact on the consumer is the same. When the consumer receives services from an out-of-network provider, he will likely be responsible for paying the out-of-network rates, which are often substantially higher than the in-network rates.

Clearly, errors related to in-network participation present to a consumer a different form of risk than an incorrect address. However, consumers are finding that they are able to exert greater influence over health plans by filing complaints with state regulators or by joining class actions against health insurers. As a result, health plans should be aware that, regardless of the nature of the error(s) in its provider directories, these inaccuracies present organizational risks, which are discussed further in the next section.

<sup>38</sup> 45 CFR 158.150(c)(9).

<sup>39</sup> Liazon Corporation, *Medical Plan Preferences in an Environment of Choice* (November 2014), 1–8, accessed at: <http://www.liazon.com/wp-content/uploads/Liazon-White-Paper-Medical-Plan-Preferences-in-an-Environment-of-Choice-November-2014.pdf>

## 4.2 Risks to the Health Plan

In 2010, the Health Bureau Section of the New York Office of Attorney General (OAG) reached a settlement (referred to as an assurance of discontinuance, or AOD) with several health plans in the New York service area. These settlements were a direct result of complaints that the OAG received from health plan consumers alleging that the health plans' provider directories contained inaccurate information related to providers' information and participation status. Per the terms of these public settlements, each health plan had to comply with several requirements, including paying a fine, verifying on an annual basis the participating provider information and participation status for every provider in its networks, offering restitution to members that had been billed out-of-network charges as a result of the inaccuracies, performing internal audits of their provider directories and reporting results to the OAG, and being monitored by an independent auditor. These settlements present a microcosm of the operational risks posed to health plans by inaccurate provider directory information. These risks and their associated burden to the health plan are discussed in greater detail below.

First, there is a financial risk posed to a health plan by having inaccurate participating provider information in its provider directories. The federal regulations pertaining to Medicare Advantage Organizations (MAOs) allow CMS to impose intermediate sanctions and civil monetary penalties for reported provider directory deficiencies. The intermediate sanctions may include suspension of:

- The MA[O]'s enrollment of Medicare beneficiaries
- Payment to the MA[O] for Medicare beneficiaries enrolled after the date CMS notifies the organization of the intermediate sanction
- All marketing activities to Medicare beneficiaries by an MA[O]<sup>40</sup>

The sanctions can continue “until CMS is satisfied that the deficiencies that are the basis for the sanction determination have been corrected and are not likely to recur.”<sup>41</sup>

CMS may also impose civil monetary penalties on MAOs for each deficiency that is identified. The regulations take many factors into account when determining the amount of the penalty, such as the nature of the deficiency, the degree of “culpability” of the MAO, the financial condition of the MAO, and the MAO's history of prior offenses.<sup>42</sup> If a deficiency has “directly adversely affected (or has the substantial likelihood of adversely affecting) one or more MA[O] enrollees,” then CMS may impose a civil monetary penalty of up to \$25,000 for each determination.<sup>43</sup>

CMS may also impose civil monetary penalties on a QHP if it is determined that the QHP has engaged in an activity that has “adversely affected or has a substantial likelihood of adversely affecting one or more enrollees in the QHP offered by the QHP issuer.”<sup>44</sup> These regulations contemplate mitigating factors similar to those for MAOs when determining the amount of the civil monetary penalties. The maximum penalty “for each violation is \$100 for each day for each QHP issuer for each individual adversely affected by the QHP issuer's non-compliance.”<sup>45</sup> Some states have established similar penalties. For example, health plans in New Mexico may be charged a “penalty for any material violation” of the state regulations governing provider directories.<sup>46</sup> Additionally, several states require that plans must make patients whole from extra expenses incurred due to directory inaccuracies.

40 42 CFR 422 Subpart O.

41 42 CFR 422.750(a).

42 42 CFR 422.760(a).

43 42 CFR 422.760(b)(1).

44 45 CFR 156.805(a)(2).

45 45 CFR 156.805(c).

46 N.M. Admin. Code Sections 13.10.22–23.

Second, there is the administrative cost of having to comply with increasingly onerous state and federal regulations. Since 2010, when the ACA was passed, 25 of the 27 states with state-specific provider directory guidelines have created or updated their provider directory-specific regulations.<sup>47</sup> Additionally, many other states are considering changes in provider directory provisions in their forthcoming regulatory agendas. These regulations often dictate specific requirements for how often a health plan must verify the participating provider information for its networks and how that verification is performed. Further, upon learning of a change in its network, a health plan is required to ensure that verified information is propagated to its provider directories within a specific timeframe. Also, several states require health plans to proactively notify members that providers have terminated or left their network. As a result, the health plan needs to develop a robust internal “infrastructure” with sufficient systems and processes to comply with these requirements.

Lastly, a health plan is at an increased risk of litigation when its provider directories have errors. These errors can result in members being charged out-of-network rates, potentially making the health plan responsible for paying the difference between these rates and the in-network rates. If a health plan network actually turns out to be “narrower” than what is indicated in its provider directories, it could be at risk of not meeting network adequacy requirements in its service area. Several class actions have been filed against California health plans, all of which touch on these issues. These actions are demanding the health plans to pay restitution, damages (plus interest), and “such other and further relief as the Court deems just and proper” to the class members.<sup>48</sup>

The organizational risks posed to health plans by inaccuracies in their provider directories are significant, although they are not all to be treated equally. Clearly, penalties and sanctions imposed on a health plan are more easily quantified and, as a result, might appear to be most costly. However, the administrative burden of complying with state and federal regulations and addressing directory inaccuracies gives a truer representation of the “costs” borne by a health plan. Finally, the uncertainties around litigation potentially pose the biggest risk of those discussed above.

## 5 Case Study: Impact of Provider Directory Errors in the State of California

California serves as an excellent example of the scope of complications that can originate from errors within a provider directory. California represents one of the largest health insurance markets in the world, with \$111 billion in revenue in 2011,<sup>49</sup> and is closely regulated by agencies including the California Department of Insurance (DOI) and DMHC plans. However, multiple issues have been identified with provider directories in this state that highlight some of the challenges described above. To wit, the provider directories associated with the Covered California healthcare exchange were fraught with inaccuracies. These inaccuracies were not resolved even as consumer enrollment began, eventually resulting in Covered California removing the directories from the exchange.<sup>50</sup>

Additionally, regulators have seen a significant uptick in consumer complaints related to provider directories. About 50 percent of state complaint-tracking systems have specific complaint codes that relate to provider directory errors and have found that complaints related to network adequacy remain the most common way that regulators uncover provider directories issues.<sup>51</sup> Responding to consumer complaints, California regulators initiated off-cycle network adequacy compliance audits of health

<sup>47</sup> See Appendix A.

<sup>48</sup> *Cowart v. Blue Cross of California*, No. BC549438 (Cal. Super. Ct. Jun. 20, 2014), 12.

<sup>49</sup> California Healthcare Foundation, “California Health Plans and Insurers: A Shifting Landscape” (2013), accessed at: <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CAHealthPlansInsurersAlmanac2013.pdf>

<sup>50</sup> Terhune, Poindexter, and Smith (2014).

<sup>51</sup> Barber et al. (2014).

plan provider directories. The DMHC’s review of Blue Shield of California and Anthem Blue Cross health plans found error rates within provider directories in the double digits.<sup>52</sup> In November 2015, DMHC fined Blue Shield of California \$350,000 and Anthem Blue Cross \$250,000 for inaccurate provider directories.<sup>53</sup> Both plans are required to reimburse enrollees who had been negatively impacted by inaccurate provider directories, and Blue Shield has already reimbursed enrollees more than \$38 million.<sup>54</sup> A class action against Blue Shield is still pending.<sup>55</sup>

This activity led to the DOI commissioner “emergency action” to amend sections of the California Code of Regulations with the intent of strengthening network adequacy requirements, and the passage of Senate Bill 137 in September 2015. The bill sets forth specific requirements for provider directories that will be rolled out in 2016 and 2017. The updates include requiring insurers to:

- Update the directory weekly, when informed of change to provider information
- Develop an online platform for providers to update their information
- Reach out to providers every six months to verify provider information
- Reimburse an enrollee for costs incurred from out-of-network providers because of inaccurate provider directory
- Include National Provider Identifier number, California license number, languages spoken by provider and staff, and other information in provider directory<sup>56</sup>

## 6 The Future of Provider Directory Policies

Provider directories will remain an area of focus for health plans, as well as regulators at the federal and state level, in coming years. CMS has clearly signaled its intentions in its recent guidance by requiring QHPs and MCOs to make their provider directory information available in a machine-readable format. CMS believes that these files will “increase transparency by allowing CMS and other software developers to access provider data and create innovative and informative tools to assist consumer in understanding plans’ provider networks.”<sup>57</sup> CMS has a stated goal to “enhance the transparency of provider networks” in saying that it is considering “instituting a new regulatory requirement for MAOs to provide, and regularly update, network information in a standardized, electronic format for eventual inclusion in a nationwide provider database,” similar to requirements for QHPs.<sup>58</sup> A close reading of the Medicaid Managed Care Proposed Rule indicates that CMS anticipates that the machine-readable files could be used to “allow CMS State Medicaid, or private third parties to ‘plug into’ the provider directories to perform automated accuracy checks.”

State regulators will continue to focus on provider directories as well. Several states are currently defining provider directory requirements, either through state legislatures, departments of insurance, or other working groups. For example, the Massachusetts Division of Insurance regulation on Managed Care Consumer Protections and Accreditation of Carriers indicates that provider

52 A. Brino, “Regulatory probe hits network adequacy,” *Healthcare Payer News* (November 20, 2014), accessed at: <http://www.healthcarepayernews.com/content/regulatory-probe-hits-network-adequacy#.VK1z7CvF-4I>

53 Department of Managed Healthcare, “DMHC Fines Blue Shield and Anthem for Inaccurate Provider Directories,” press release (November 3, 2015), accessed at: <http://www.dmhc.ca.gov/portals/0/abouttheDMHC/newsroom/2015/pr110315.pdf>

54 Ibid.

55 *Harrington et al. v. Blue Shield of California et al.*, San Francisco Superior Court, No. 14-539283 (August 17, 2015), accessed at: <http://static1.squarespace.com/static/54f9fdb2e4b0bec7776174f4/t/5666121ad82d5ed3d739d04d/1449529882442/Consolidated+class+action+suit.pdf>

56 California State Legislature, Senate Bill No. 137 (approved October 8, 2015), accessed at: [https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201520160SB137](https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB137)

57 CMS, “Draft 2017 Letter to Issuers in the Federally-facilitated Marketplace” (December 23, 2015).

58 CMS, “Announcement of 2016 Capitation Rates and Final Call Letter” (April 6, 2015).

directories must contain, among other information, “the effective date, date of issue and [an] expiration date, if applicable.”<sup>59</sup> The penalty for noncompliance with these requirements can be up to \$5,000 per incident per day.<sup>60</sup> Further, the MA-DOI commissioner can suspend the “carrier’s authority to do new business” and/or suspend or revoke the carrier’s accreditation if the carrier is found to be non-compliant.<sup>61</sup> Oregon is very active as well and has formed a Provider Directory Advisory Group charged with developing rules around provider directories. Notes from its December 2015 meeting indicate that the group is reviewing both federal guidelines and the NAIC Health Benefit Plan Network Access and Adequacy Model Act related to provider directories, something that other state departments of insurance will certainly be reviewing in the coming year.<sup>62</sup>

## 7 Conclusion

Provider directory inaccuracies represent a growing and significant risk to both consumers and health plans. Regulators at the state and federal levels continue to review and establish new methods of ensuring network adequacy and protecting consumers’ access to affordable care, and provider directories are factoring more prominently into these efforts. Health plans should seek to be proactive about achieving and ensuring provider directory accuracy, despite the operational challenges involved in doing so. Given an environment that is increasingly regulatory, litigious, investigative, and putative, health plans should deploy organizational resources at a level that is commensurate with the level of risk that these inaccuracies can present.

---

<sup>59</sup> 211 C.M.R. §52.15(4).

<sup>60</sup> 211 C.M.R. §52.17.

<sup>61</sup> Ibid.

<sup>62</sup> Provider Directory Advisory Group, Office of Health Information Technology, draft meeting notes (December 10, 2015), accessed at: <http://www.oregon.gov/oha/OHIT/Meetings/DecPDAGMeetingMaterials.pdf>

## Appendix A: State-Level Regulations Related to Provider Directories

State	Plan Type	Required Update Frequency	Claim Submission Verification Requirement (Y/N)	Year Created or Revised	Source
<b>Tier 1</b>					
Arizona	All Health Plans	Monthly	N	2012	AZ §20-6-1912
Arkansas	All Health Plans	14 Days	N	2014	Arkansas Rule 106
California	All Health Plans	Weekly	N	2014	Emergency Regulation to Title 10 §2240.6
Colorado	QHP	Monthly	N	2014	Colorado PPACA Network Adequacy Filing Procedures for 2015
Connecticut	All Health Plans	Monthly	N	2015	CT Public Act No. 15-146
Georgia	MCO	30 days	N	2010	GA §33-20A-5
Idaho	QHP	Monthly	N	2015	Your Health Idaho 2016 QHP Standard
Illinois	QHP	10 business days	N	2015	IL Public Act 099-0329; Illinois Qualified Health Plans 2015
Maryland	All Health Plans	15 days	N	2010	MD Ins Code §15-112
Nevada	QHP	30 days	N	2014	NV LCB File No. R049-14
New Jersey	MCO	10 days	Y	2014	NJAC 11 24C 4.5 4.6
New York	HMO	15 days	N	2014	NY Emergency Medical Services and Surprise Bills
Oregon	MCO- Workers Comp	Monthly	N	2013	OR 436-015-0030 Applying for Certification
Virginia	All Health Plans	Monthly	N	2006	VA § 38.2-3407.10
Washington	All Health Plans	Monthly	N	2014	WAC 284-43-220(b)
<b>Tier 2</b>					
Delaware	QHP	Quarterly	N	2014	Delaware State-Specific QHP Standards for Plan Year 2016
Florida	EPO	Semi-Annually	N	2012	FL §627.6472
Louisiana	All Health Plans	Annually	N	2013	LA Rev Stat §22:1019.2
Mississippi	HMO	Annually	N	2010	MS Code § 83-41-319
Montana	QHP	Annually	N	2014	Advisory Memorandum - 2015 Health Plan Form Filings
North Carolina	All Health Plans	Annually	N	2014	N.C. §58-3-245
Ohio	All Health Plans	Quarterly	N	2015	OH §3901-8-16
Pennsylvania	All Health Plans	Annually	N	2000	PA 31 §154.16
Tennessee	MCO	Annually	N	2010	Tenn. Code Ann. §56-7-2356
Texas	PPO, EPO, HMO	Quarterly	N	2013	TX §3.3705(i); §843.2015
Vermont	MCO	Semi-Annually	N	2009	VT Reg-H-2009-03
Wisconsin	HMO	Annually	N	2010	Wisconsin Office of the Commissioner of Insurance - Managed Care/Defined Network Plans
<b>Tier 3</b>					
Kansas	QHP	Up-to-date	N	2014	Kansas Qualified Health Plan Submission Attestation Form
Kentucky	MCO	Up-to-date	N	2000	KY Rev Stat §304.17A.590
Massachusetts	MCO	Up-to-date	N	2013	Division of Insurance Filing Guidance Notice 2013-C
New Hampshire	QHP	Up-to-date	N	2014	NH INS-14-025-AB
New Mexico	QHP	Up-to-date	N	2015	NM QHP Submission Guide
Washington, DC	QHP	Up-to-date	N	2014	DC Health Benefit Exchange Authority 2015 Carrier Reference Manual

## About the Author

### *Brian E. Hoyt*

Brian E. Hoyt is a managing director in BRG's Health Analytics Practice in Washington, DC. He combines more than 20 years of healthcare industry expertise with analytical acumen to develop customized solutions to the complex challenges that participants in the healthcare system are facing. He routinely partners with clients—from startups to Fortune 500 companies—to implement a data-driven approach to identify and analyze critical business issues, make informed, strategic decisions, and respond to disputes and investigations. Mr. Hoyt was recently appointed by a state attorney general to serve as the independent monitor of a settlement between the attorney general and a health insurer related to reported inaccuracies in the health insurer's online provider directory. Mr. Hoyt is an expert in health plan provider directories and network adequacy. He is a frequent author and speaker, and has become a regular source for national publications, on these topics.

## About Berkeley Research Group

Berkeley Research Group, LLC ([www.thinkbrg.com](http://www.thinkbrg.com)) is a leading global strategic advisory and expert consulting firm that provides independent advice, data analytics, authoritative studies, expert testimony, investigations, and regulatory and dispute consulting to Fortune 500 corporations, financial institutions, government agencies, major law firms, and regulatory bodies around the world. BRG experts and consultants combine intellectual rigor with practical, real-world experience and an in-depth understanding of industries and markets. Their expertise spans economics and finance, data analytics and statistics, and public policy in many of the major sectors of our economy, including healthcare, banking, information technology, energy, construction, and real estate. BRG is headquartered in Emeryville, California, with offices across the United States and in Asia, Australia, Canada, Latin America, and the United Kingdom.