CALIFORNIA
HEALTHCARE
FOUNDATION

manatt

Directory Assistance:
Maintaining Reliable Provider
Directories for Health Plan Shoppers

SEPTEMBER 2015

Contents

About the Author

Manatt Health is the interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips. Manatt Health provides expertise in health care coverage and access, health information technology, health care financing and reimbursement, and health care restructuring. For more information, visit www.manatt.com.

About the Foundation

The California HealthCare Foundation (CHCF) is leading the way to better health care for all Californians, particularly those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

Introduction

In this post-Affordable Care Act (ACA) era, many consumers are making health coverage decisions for the first time and in new ways; some are struggling to choose between health insurance products with varying provider network configurations and cost structures. To understand their choices and inform their decisions, many consumers turn to provider directories — electronic or printed lists of physicians, hospitals, and other health care providers in each health insurance carrier's products.

Inaccurate provider directories can lead to consumer frustration and confusion, and result in substantial out-of-pocket costs for consumers who may unintentionally seek and receive out-of-network care. Yet it has proven challenging for organizations to maintain accurate and up-to-date provider directories given the lack of data and communication standards used to transmit changes between providers and carriers, the frequency with which networks change (e.g., opening of new practices and locations; providers entering, leaving, and closing practices; changes to contracts), and the dearth of strong incentives and enforcement mechanisms requiring regular updates.

This report examines policy, operational, business, and technical challenges and solutions for maintaining well-functioning, integrated provider directories in four states: Colorado, Maryland, New York, and Washington. It details the perspectives and experiences of consumer advocates, carriers, providers, state-based marketplaces (SBMs), and state Medicaid agencies in these four states, as well as in California, with the goal of informing California policymakers and stakeholders as they seek to improve access to provider network information.

The considerations in this report are generally applicable to stakeholders across all sectors of the market — including, but not limited to, commercial carriers, Medicaid, and Medicare. And while the information on provider networks that is contained in provider directories may be used for many purposes, including review of carriers' compliance with network adequacy requirements, this report's focus is on provider directories as tools to help consumers make informed decisions when selecting and using health coverage. The findings shed light on opportunities to make directories more accessible to California's diverse population of consumers and more accurate through better regulation and standards.

Background

Since implementation of the ACA, more Californians are shopping for health insurance through the individual commercial market. Many of these consumers are obtaining insurance for the first time. While California has taken steps to simplify and standardize health plan benefit designs, these consumers and the millions of Californians who get health benefits through their employers must navigate a complex coverage market and make important decisions for themselves and for their families based on available information. Simultaneously, as carriers seek to control costs and keep premiums from skyrocketing, some provider networks are becoming increasingly selective, making consumer access to accurate information about provider network participation even more important.

In 2013, consumers who were likely to purchase marketplace-based coverage were surveyed. More than half of survey participants identified choice of providers as a very important factor influencing their selection of a product.[1] In addition, with the creation of marketplaces in response to the ACA's focus on simplifying health plan shopping and enrollment, as well as the continued proliferation of web-based shopping and comparison tools for health care and other products, it is safe to assume that consumers will have high expectations when it comes to the accuracy and availability of provider network information.

Some carriers, state Medicaid agencies, and SBMs publish provider directories to inform consumers as they select, enroll in, and use carriers' products. Organizations that offer multiple products across multiple carriers, such as SBMs, may publish integrated provider directories — online databases of carrier and product data, which consumers may search or filter based on a set of criteria, such as provider name, address, and location. Some state Medicaid agencies and SBMs do not publish provider directories, and instead point consumers to online provider directories published and maintained by carriers.

Definitions

Application programming interface (API). A software-to-software interface that contains a set of computer programming instructions and standards for a software application or tool.[2] APIs allow software developers to design other products to interact with the original company's product. For example, Amazon.com releases an API so that a third-party website can directly post links to Amazon products with updated prices and allow customers to purchase the items.[3]

Delegated model. A health care delivery model in which health plans contract with and delegate to medical groups some health plan functions, such as claims payment, utilization review, and care management, in return for a fixed, per-person monthly fee (capitation payment) for the subset of the health plan's enrollees assigned to the group. This model has been in wide use among California HMOs since the mid-1980s.

Federally Facilitated Marketplace (FFM). A health insurance exchange model under the ACA in which the US Department of Health and Human Services (HHS) performs all or most of the exchange functions. Consumers in states with a FFM apply for and enroll in coverage through www.healthcare.gov.

Health insurance product ("product"). A health coverage plan or insurance policy that specifies the enrollees' covered benefits, the provider network and coverage model, and the consumer share of the costs. Product types include, but are not limited to, HMOs, PPOs, EPOs, and high-deductible health plans.

Integrated provider directory. A searchable database bringing together provider network data from multiple carriers' health insurance products. An integrated provider directory may include contracted physicians, clinics, and medical groups by carrier, or product, or both, and may also provide information about participating hospitals or other contracted facilities, such as pharmacies. Integrated directories may include advanced search functionality allowing consumers to search by location, specialty, open or closed panel, languages, or other characteristics.

Leased networks. A provider network organized and contracted with a third party that carriers may lease from the third party. Carriers may opt to lease provider networks in areas where they do not have a sufficient number of contracted providers to meet regulatory requirements (such as network adequacy) or to support ancillary or supplemental products, such as behavioral health or dental products. Carriers may also lease their networks to other payers, such as self-insured plans.

Machine-readable. Data formatted to be understood and consumed automatically by a computer system or web browser without human intervention. Machine-readable data allows third parties to access data and potentially reuse it to create new search solutions, tools, and services for other purposes.

Marketplace. The umbrella term used by the Centers for Medicare & Medicaid Services (CMS) for ACA health insurance exchanges through which eligible individuals, families, and small businesses can purchase coverage. An ACA marketplace is the only venue where consumers can apply for and receive federal assistance in the form of premium tax credits to help pay for coverage. It also offers a website where consumers can shop for and compare available health insurance products.

Network adequacy. A carrier's ability to deliver necessary health benefits and services contractually or legally required by providing access to a sufficient number of in-network (contracted) providers, including primary care physicians, specialists, hospitals, and other facilities.

Provider directory. A list of participating providers such as physicians, hospitals, and other facilities included in the network of a carrier's insurance product.

Provider network. The providers (physicians, hospitals, and other health care providers) available to consumers enrolled in a specific health insurance product. Network providers agree by contract to accept negotiated rates from the carrier for services. Depending on the health insurance product type, consumers may be limited to the contracted (network) providers for nonemergency care and will generally pay lower out-of-pocket costs for network providers compared to those out-of-network.

State-based marketplace (SBM). A health insurance exchange under the ACA where the state assumes responsibility for performing most marketplace functions. Consumers in these states apply for and enroll in coverage through marketplaces established and maintained by the states.

Qualified health plan (QHP). A health insurance plan certified by ACA state-based or federal marketplaces as meeting specific federal and state requirements, including that the plan's product covers required ACA benefits (essential health benefits). Only certified QHPs may be offered in ACA marketplaces, but carriers may also offer QHPs outside of the marketplaces subject to relevant federal and state laws. (California requires carriers to offer products that mirror their QHPs outside the marketplace.)

Consumers use provider directories to:

➤ Evaluate coverage options to determine whether a primary care physician, specialist, hospital, clinic, or other health care provider they would like to use is considered in-network and covered under a product

➤ Select products based on cost, network size, and care options

➤ Identify and locate providers and services when seeking care

A March 2015 survey by Consumer Reports National Research Center found that 78% of privately insured Americans used their carrier's online provider directory in the past two years to find doctors, facilities, or both.[4]

Despite the availability of provider directories, it is widely acknowledged throughout the industry that directories often contain inaccuracies. Directory errors may lead a consumer to seek care at the wrong address, or worse, a consumer may learn that the health insurance product they purchased does not cover a specific provider they want to see or are already seeing, despite being listed in the directory. This is troublesome because consumers may be required to pay significant fees to cover their visits to out-of-network providers. In fact, more than half of consumers surveyed were unsure if they would be responsible for extra costs associated with seeing an out-of-network provider if it was due to an error in the carrier's provider directory.[5]

Methodology

To identify target states, Manatt conducted research in February 2015 to identify SBMs with functioning, integrated provider directories that were accessible from the marketplace's website and that returned search results. Researchers assessed and documented the capabilities of each marketplace's provider directory, eliminating those that did not return search results. Manatt could not confirm the accuracy of the data returned by directory searches and, at the time of the research, there was very limited public information available on the accuracy of SBM provider directories.[6]

This review yielded functioning, integrated provider directories operated by Connect for Health Colorado

(connectforhealthco.com), Maryland Health Connection (www.marylandhealthconnection.gov), New York State of Health (www.nystateofhealth.ny.gov), and Washington Healthplanfinder (www.wahealthplanfinder.org). The search capabilities of each SBM's provider directory are documented in Appendix A. While California's SBM, Covered California, does not have an operational provider directory at time of publication, California served to provide context for the findings from other states.

Manatt conducted additional research on carriers and state Medicaid agencies in the target states, as well as a literature review and stakeholder interviews. This research focused on relevant state laws and regulations; carrier, SBM, and provider business policies, practices, and requirements; and technical considerations related to creating and maintaining integrated provider directories. Manatt conducted 32 interviews with stakeholders representing consumer advocates, SBMs, state Medicaid agencies and regulators, carriers, and providers.

Finally, Manatt and the California HealthCare Foundation convened a small advisory group of California stakeholders and subject matter experts to guide the project's approach and to review and provide feedback on key findings. A list of advisory group members can be found in Appendix B.

Policy Landscape

Marketplace Directories

The passage of the ACA, which sought not only to broadly expand health coverage but also to modernize the enrollment process for consumers receiving public financial assistance for health care, shed light on many of the longstanding challenges associated with providing timely, accurate provider network information.

Federal regulators began to address provider directories in the early stages of marketplace planning and implementation, seeking to resolve challenges while at the same time allowing states flexibility. (Please refer to Appendix C for additional detail on the national policy landscape.) In March 2012, the Department of Health and Human Services (HHS) issued the final rule for the establishment of marketplaces and qualified health plans (QHPs), and included expectations for marketplace

and QHP provider directories.[7] The rule states that HHS expects Federally Facilitated Marketplace (FFM) and SBM QHP issuers' provider directories to be "consistent with current industry practice" and to include provider licensure, specialty, and contact information at a minimum, allowing individual SBMs to establish additional data requirements. The rule also requires QHP issuers to identify providers that are not accepting new patients but does not specify frequency of updates to provider directories, suggesting that timelines should strike a balance between supporting consumer choice and carriers' administrative burdens.[8]

States preparing to go live with SBMs in time for the first open enrollment period in 2013 were not required to produce or host provider directories. A few states, including California, went beyond SBM requirements in an effort to support consumer decisionmaking and enrollment, and published integrated provider directories as part of their initial implementation on October 1, 2013.

In 2014, reports of inaccuracies in SBM provider directories began to surface and gain national attention. California's provider directory was removed indefinitely in February 2014 after consumers and providers grew frustrated with its errors. Covered California did not reinstate the provider directory for the 2015 open enrollment period and instead directed consumers to each carrier's website and provider directory. The marketplace's 2016 QHP application removed former references to a centralized provider directory.[9] In the summer of 2014, the Mental Health Association of Maryland performed a secret shopper study to verify the accuracy of the Maryland Health Connection's provider directory and

"I . . . strongly urge New York consumers not to rely solely on provider lists offered by insurance companies. Call the insurance company you are considering, as well as your providers, to confirm that they are in the plan's network. Do this before you sign up. It's a quick and easy way to protect your family's health and your wallet."

— New York State Attorney General
Eric T. Schneiderman

found only 14% of psychiatrists listed in the directory were accepting new patients, and 57% were unreachable.[10] Finally, in advance of the 2015 open enrollment period, the New York Attorney General advised consumers not to rely only on carriers' provider directories, encouraging consumers to call carriers and providers directly to confirm network participation.[11]

A recent report by the Commonwealth Fund found that several SBMs, including those in California, New York, and Washington, increased their provider directory requirements for participating QHPs between the first and second years of coverage, demonstrating an increasingly active role for marketplaces with respect to provider directories.[12]

Figure 1. Required Data Updates, by SBM

SBM	FREQUENCY OF UPDATES
California*	Quarterly
Colorado	Every other week
Maryland	Every other week
New York	Quarterly
Washington	Monthly

*California's SBM does not currently maintain an integrated directory but contractually requires that carriers submit provider information to Covered California on a quarterly basis.

Recent HHS guidance for the FFM is more specific than its previous guidance. HHS guidance released in February 2015 requires FFM QHPs to provide a hyperlink to their provider directory and to include the following information for each provider: location, contact information, specialty, medical group, any institutional affiliations, and whether the provider is accepting new patients.[13] QHPs must update this information at least monthly and make their provider directories publicly available in a machine-readable file format specified by HHS to allow third parties to create aggregated provider directories.[14]

According to the HHS final rule: "The general public should be able to easily discern which providers participate in which plan(s) and provider network(s) if the health plan issuer maintains multiple provider networks, and the plan(s) and provider network(s) associated with each providers…" The Center for Consumer Information and Insurance Oversight and CMS indicated in 2016

guidance that HHS may impose civil monetary penalties up to $25,000 should a QHP provide incorrect information to a marketplace, or $100 per day for each person adversely affected by a QHP's noncompliance.[15] Notably, this guidance did not address SBMs, which continue to set their own requirements for participating QHPs, nor did it mandate the use of standards or a common data template for QHPs participating in the Federally Facilitated Marketplace.

Recent Developments for Medicare and Medicaid Directories

Federal regulations regarding Medicare, Medicaid, and Children's Health Insurance Program (CHIP) provider directories have also become increasingly prescriptive in response to concerns and reports of pervasive errors. In December 2014, HHS's Office of the Inspector General found that over half of the providers in Medicaid managed care products could not offer timely appointments to enrollees because the providers could not be reached at their listed location, were not accepting new Medicaid patients, or were not participating in the Medicaid managed care product.[16]

In February 2015, CMS released guidance for Medicare Advantage Organizations (MAOs) establishing new and more detailed expectations for MAO provider directories.[17] The new guidance requires MAOs to create structured processes to assess provider availability and to update online directories in real-time, and notes than an effective process will include at least quarterly communication between the MAO and providers to ensure that provider information is up-to-date and to confirm whether providers are accepting new patients.

CMS plans to monitor MAO provider directory compliance by engaging a contractor to verify directory accuracy, audit directories, and take action against MAOs that fail to comply. MAOs that "fail to maintain complete and accurate directories may be subject to compliance and/or enforcement actions, including civil money penalties or enrollment sanctions."[18] CMS is also considering requiring MAOs to report network information in a standardized electronic format beginning in or after 2017 for eventual inclusion in a nationwide provider database.

In May 2015, CMS released new proposed regulations for Medicaid and CHIP managed care carriers requiring that their directories include information on physicians, hospitals, pharmacies, behavioral health providers, and long-term supports and services (LTSS) providers.[19] The regulations propose that electronic directories should be updated within three business days of receipt of information and be posted in a machine-readable file format. In addition, the proposed regulations state that CMS believes provider directories would be more accurate and useful in a standardized format and exposed through open and standardized application programming interfaces (APIs); as such, CMS is considering requiring carriers to use the "best available provider directory standard" as defined by the Office of the National Coordinator for Health Information Technology (ONC) in the 2015 Interoperability Standards Advisory.[20]

National Association of Insurance Commissioners

In November 2014, the National Association of Insurance Commissioners (NAIC), an association of the chief insurance regulators from the 50 states, released revised draft model legislation on health plan network access and adequacy.[21] NAIC model legislation can be highly influential, as it is a reflection of best practices and often leads to the passage of legislation or creation of administrative rules in states. Carriers also look to the NAIC as a guidepost and may adopt recommended practices independent of state regulations.

The model legislation would require carriers to update provider directories at least monthly and include information for physicians, hospitals, and other health care providers. The NAIC also suggested that states consider requiring carriers to contact providers who have not submitted claims in the past six months, conduct internal audits, and initiate more robust monitoring of consumer complaints. The NAIC updated a draft of the model legislation in September 2015.[22]

Findings

Policies, Regulations, and Enforcement

Lack of enforcement of regulatory and contractual requirements creates an environment that does not foster shared accountability.

Shared Accountability

The development and maintenance of a provider directory involves many actors, including carriers and marketplaces, physician practices and clinics, IPAs, hospitals, and other facilities and institutions. Each actor is dependent on the others for specifying and meeting directory requirements, delivering and receiving directory information, and publishing and making information available to consumers. Over time, these individual actors have developed their own processes, systems, and requirements to create and update information used to populate and maintain directories.

The authors found that all carriers, marketplaces, and state Medicaid agencies have contractual language requiring accurate and timely provision of provider directory data. These contracts and their requirements for provider directory data are passed through carriers to medical groups, individual providers, and institutions.

In addition to specifying data requirements, contracts between state Medicaid agencies, SBMs, carriers, physicians and other health care providers, such as hospitals, also describe penalties or remediation measures should a party fall out of compliance. According to interviewed stakeholders, carriers and SBMs may impose such penalties as de-delegation or suspension of assignment or enrollment of new enrollees to providers and carriers. SBMs and state Medicaid agencies also use corrective action plans to work with carriers to amend and improve their practices rather than imposing more severe penalties. While these contractual provisions appear prevalent, stakeholders reported that penalties are generally not enforced, primarily out of concern for compromising robust provider networks and the mutual interests of state Medicaid agencies, SBMs, and carriers to minimize disruption of member services.

Figure 2. Who Is Accountable for Provider Directory Information? A Cascade of Contracts and Data.
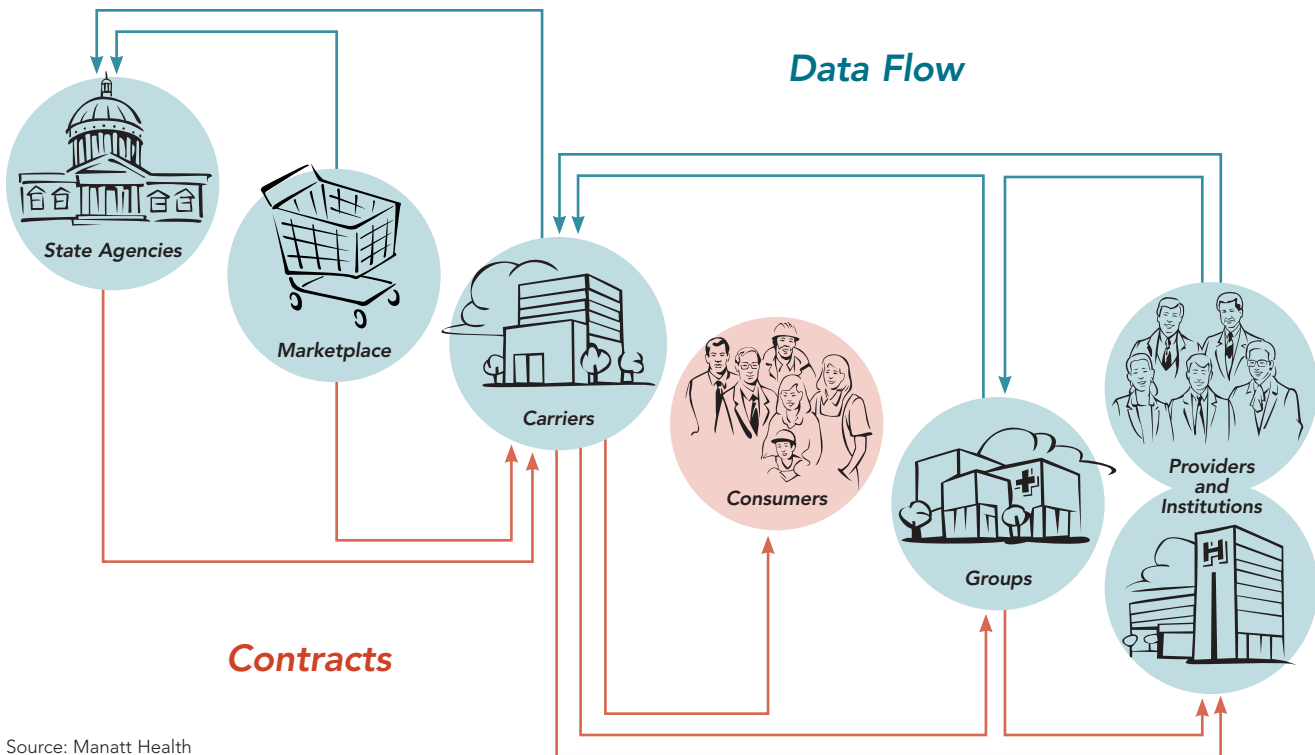
Source: Manatt Health

> *"Insurers are placed in a difficult position when establishing requirements for providers to update their information. When providers don't update their information in accordance with contractual requirements, it is difficult for insurers to simply end the contractual relationship, as they must maintain an adequate network."*
>
> — Vice president, government affairs, carrier

Many states have taken actions to set baseline requirements and expectations for provider directories, and all of the target states examined for this project and California have passed laws or regulations requiring carriers to maintain accurate provider directories. In most states, however, there has been limited to no regulatory enforcement or penalties issued to carriers for failure to maintain accurate directories. As a result, there are few incentives for institutions to invest significant resources to maintain directories or to penalize contracted network entities for failing to meet contractual obligations to provide them with necessary information.

New York's Aggressive Regulatory Action

New York stakeholders were the only interviewees to report enforcement of penalties by the state for failure to maintain accurate directories. The New York State Attorney General has reached settlements with more than a dozen carriers related to their provider directories since 2010. In a 2012 settlement, the attorney general required eight carriers to "ensure the accuracy of provider directories . . . implement new business practices for updating their online provider directories in a timely manner . . . and to pay restitution to consumers who paid more than they should have because they saw providers erroneously listed as in-network."[23] A similar settlement in 2010 required five carriers to correct issues with their online provider directories and improve their business practices.[24]

The New York State Attorney General's actions created an environment that motivated carriers to take steps to ensure that their provider directories are up-to-date and accurate. In response to the attorney general's actions, carriers reformed their business practices and made investments in infrastructure and processes to support the collection, audit, and review of provider directory data. Following the settlements and recognizing the

Figure 3. New York Carrier Contracting and Accountability
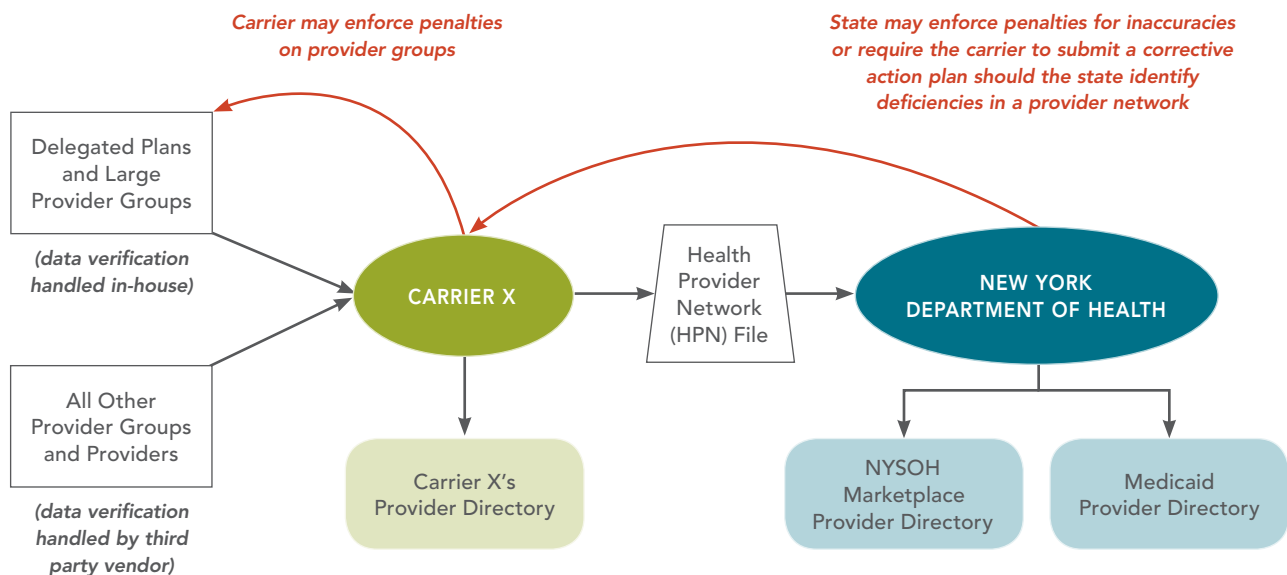
Source: Manatt Health

potential for the state's Department of Health to enforce additional penalties, one carrier overhauled its processes relative to review and audits of provider data. The carrier's revamped processes initially reduced the carrier's unique record count by approximately 25% as it deleted inaccurate and duplicative records; the carrier continues to eliminate 10% to 12% of records annually due to provider turnover.

In other states where policies have not been coupled with aggressive regulatory action, research and interviews found that carriers have not been as motivated to improve their provider directories.

Data Standards

"Garbage in, garbage out" — A lack of uniform data standards and accompanying guidance results in unusable data, especially when data come from disparate sources.

Lack of Standards and Standardized Processes

Provider directories that exist at the state Medicaid agency, SBM, and carrier levels have largely been homegrown — built by the organization — rather than developed according to industry standards. As a result, provider directories, and the standards and processes used to maintain them, are largely unique to each organization. This poses significant challenges for marketplaces, state Medicaid agencies, and other organizations that collect, aggregate, and reconcile provider data across multiple carriers and insurance products to create a single, integrated provider directory. It also poses challenges for providers and carriers that must submit data in multiple formats and according to disparate standards to satisfy contractual obligations.

Research and stakeholder interviews suggested that in most states, there is minimal coordination or collaboration to standardize and streamline processes that could make directory updates easier and more efficient. Most carriers interviewed for this project ask providers to notify them of changes by phone, fax, and mail; some carriers have established secure online portals through which providers may submit updates. In cases where medical groups, IPAs, and third-party leased networks contract directly with carriers on behalf of a provider or group of providers, these groups serve as an intermediary and assume responsibility for transmitting updated provider

information to carriers, adding an additional layer to the cascade of contracts and data flows (Figure 2, page 8).

Provider Directory Data Submission Templates

Some state Medicaid agencies and SBMs require the use of standards or a common template for carrier submission of provider data. For example, in California, the Department of Managed Health Care (DMHC), which enforces network adequacy and timely access standards, requires plans to use a standard template when submitting data. Plans submit an annual timely access report to confirm the status of their network and enrollment on a county-by-county basis.[25] DMHC and Covered California have partnered to enable health plans to use the DMHC template for both the required DMHC timely access filing and their Covered California quarterly network report.[26] Covered California may also use carriers' submissions to populate a provider directory in the future. This approach minimizes the burden on carriers and streamlines reporting of provider information.

In New York, carriers submit quarterly provider data to the Department of Health for all state-sponsored plans (Medicaid and CHIP) and the marketplace, and submit data annually for commercial managed care products via the Provider Network Database System (PNDS).[27] The state provides carriers with over 370 pages of data submission guidelines, underscoring the complexity of the data submission process, the resources the state has devoted to standardizing the process, and the resources carriers devote to submitting the necessary information.[28] The New York State Department of Health uses information submitted via the PNDS to complete regular network adequacy reviews, and the New York State of Health (NYSOH), the SBM for New York, uses the information to populate its provider directory.

While California and New York are examples of states and health insurance marketplaces working together to streamline carrier reporting of provider information, carriers that operate nationally or in multiple states must maintain separate reporting processes for their respective markets in the absence of national or widely accepted industry standards. Several carriers noted that complying with disparate requirements and submission guidelines is burdensome and requires significant resources. To minimize the burden, some carriers look for common data elements across requesting parties to develop baseline data submission forms and processes.

Data Integrity

Efforts to audit, perform quality assurance, and verify the accuracy of provider directory data vary widely, with many organizations performing little to no quality review.

Lack of Robust Quality Assurance Processes

Ensuring the integrity of provider directories via quality assurance processes is a critical function when aggregating disparate carrier and provider data or passing data between parties. Data integrity is especially relevant in the context of SBMs and state Medicaid agencies that consume data from multiple sources to create a single integrated provider directory. Despite the significant need for deliberate and ongoing efforts to ensure data integrity, few carriers, marketplaces, or state Medicaid agencies reported conducting robust data review or quality assurance activities.

Each step in the cascade of contracts and data (see Figure 2, page 8) introduces opportunities for errors and a breakdown in the flow of information. Errors can occur anywhere in the cascade as data are received in a variety of formats and standards, and issues can persist as compromised data are passed up the chain from providers and carriers to marketplaces and state Medicaid agencies.

The cascade also has implications for the timeliness of data updates; one vendor that operates a marketplace's provider directory reported a two-week lag between when an error is identified and when it is corrected in the provider directory. Other organizations reported similar lags of 15 business days to a few weeks between error notification and correction. These lags were attributed to data processing and the need for data to often pass through multiple departments and personnel before they can be published. Finally, marketplaces and provider representatives noted that even when providers submit updated information to a carrier, the information is not always carried through and reflected in the latest version of the carrier's or marketplace's provider directory.

Almost all marketplaces and some carriers report provider information as they receive it and perform little to no quality assurance or data reconciliation. (Some seek to verify data using existing databases, but typically do not change data found to be incorrect.) This approach may result in multiple entries for the same provider due to

"Even if provider information is updated, it may never make it to the directory."

—Director, consumer health advocacy organization

differences in carrier naming conventions (e.g., Dr. John Smith, Dr. J. Smith, and Dr. John H. Smith). A few SBMs and carriers attempt to clean the data, using identifying information such as the provider's national provider identifier (NPI), address, date of birth, or a state licensing number to reconcile the disparate information submitted by carriers and to create a single record for each provider. Even when data are cleaned or reconciled, however, significant limitations remain because organizations do not have access to a single source of provider information and may not be able to successfully resolve all provider records. Unique data elements such as an NPI may assist organizations attempting to create a master provider or institution index against which to match information submitted by carriers or providers.

Verification Efforts

In addition to data reconciliation, some marketplaces, state Medicaid agencies, and carriers make an effort to verify provider information through routine or ad hoc audits. For example, when an issue is reported to a marketplace or state Medicaid agency, the New York and Maryland SBMs and California and Washington state Medicaid agencies reported that they or their vendors may reach out to the provider directly to confirm information and contract status. If the marketplace or agency identifies an inaccuracy with the provider's information,

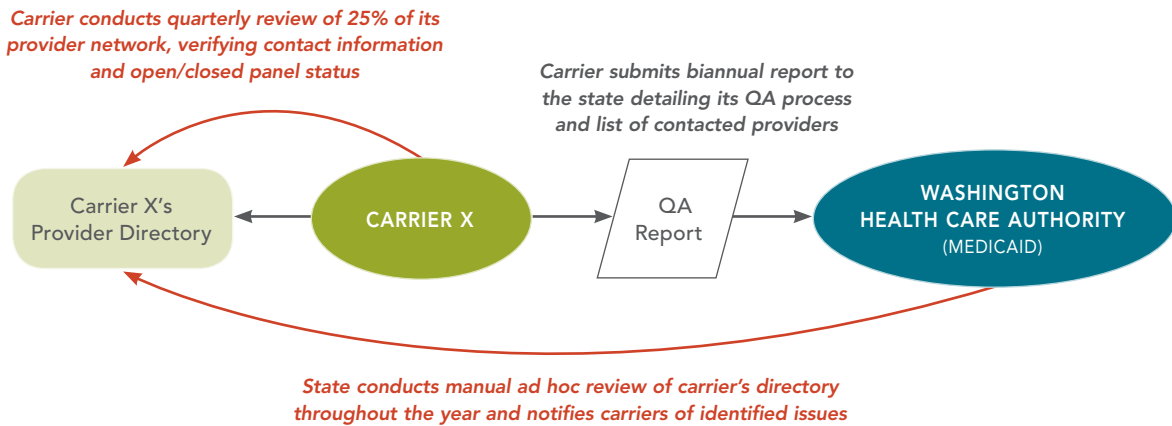*"When you sit down with states and health plans, the discussion is always about what [data] each can and cannot change. Plans think they own the data and have it right. States want plans to own the data and get it right. We need to make it clear who owns the data and how best to get the data updated throughout the process — this piece is really important."*

— Health information technology director, vendor

## Washington Medicaid and New York State Data Integrity Processes

The **Washington Health Care Authority,** which operates the state's Medicaid program, does not produce a provider directory for its managed care plans but does actively monitor carriers' directories and confirms their accuracy. Under its contract with the Health Care Authority, a Medicaid managed care plan must verify provider information for 25% of its network every quarter, completing a review of 100% of its providers annually (see below). Carriers then submit reports to the state detailing their processes and the providers they contacted, specifying any changes that were made to the providers' information as a result of the review process. The Health Care Authority then conducts ad hoc manual reviews of participating Medicaid managed care carriers' directories throughout the year. When an issue is identified, the Health Care Authority contacts the carrier to correct the information and, depending on the extent of the issue, may conduct a full review of the carrier's provider network and place the carrier on a corrective action plan.

Carrier conducts quarterly review of 25% of its provider network, verifying contact information and open/closed panel status

Carrier submits biannual report to the state detailing its QA process and list of contacted providers

State conducts manual ad hoc review of carrier's directory throughout the year and notifies carriers of identified issues

In **New York, the New York State Department of Health (DOH)** is the hub for data collection and analysis for state and marketplace products once carriers submit data using the Health Provider Network file and Provider Network Data System (PNDS). Carriers submit data using the PNDS and submit provider network files to DOH each quarter and, upon receipt, DOH verifies that the submissions are complete and removes sanctioned providers from carriers' networks (see below).

DOH also sends the data to two third-party vendors. One cleans the data, attempts to reconcile inconsistencies among carrier submissions, and posts the provider networks to the NY State of Health (NYSOH) website to assist consumers in selecting a health plan. A second vendor reviews and analyzes each product at the county and service-area levels to ensure carriers are compliant with network adequacy requirements.
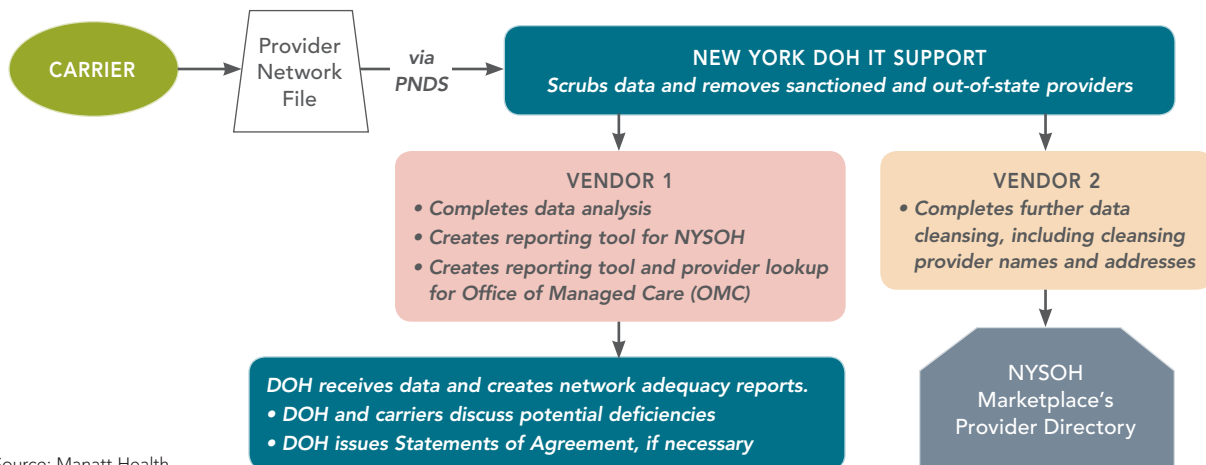
Source: Manatt Health

they typically work with the carrier to correct the information for the carrier's next data submission rather than correct the information in their system to reflect a real-time update. The Maryland Health Connection and Covered California ask carriers to correct inaccuracies in provider data rather than making the change directly in their own systems. Marketplace staff reported that their reliance on carriers is due to concerns over data ownership and liability, and the desire that carriers themselves update underlying data.

The Maryland Health Connection identified an additional challenge with leased provider networks: Carriers that lease provider networks often do not have the ability to alter data reported by the leased networks.

Time and Resource Requirements

Organizations typically rely on time- and labor-intensive manual processes to develop and support provider directories.

All of the carrier, marketplace, and state Medicaid agency stakeholders interviewed for this project reported investing time and resources in creating and maintaining provider directories. To a large extent, processes and systems rely heavily on manual efforts to verify and update provider data. Many use a combination of manual and electronic processes to collect and publish data. All marketplaces and carriers that were interviewed reported contracting with third-party vendors to augment their internal provider directory resources and perform functions that the organizations do not have the capabilities to accomplish in-house.

"Sometimes it's quicker to just handle it manually than to put in new standards and processes."

— Project specialist, carrier

Stakeholders acknowledged that resource limitations constrain their abilities to improve processes and systems devoted to maintaining provider directories. This was most apparent among marketplaces and states that rely on federal or public funding sources, and it is a growing concern as marketplaces transition to become self-sustaining in 2016 and beyond. States like New York rely on older computer systems that were not designed to receive and process the large amounts of data required

to drive a Medicaid or marketplace provider directory and to ensure its accuracy. New York is currently seeking to procure and implement a new system.

Carriers reported significantly different levels of resources dedicated to provider directories, and also struggled to uncouple their directory efforts from provider contracting, as many resources span the two functions. Carriers' resources also varied relative to their size and the number of markets in which they offer products, with some dedicating two full-time equivalents (FTEs) to provider directories and others upward of 20 FTEs. For example, a carrier operating in multiple states and offering QHPs, as well as commercial and Medicaid plans, had significantly more resources to ensure compliance with state and federal requirements than a local carrier offering only QHPs and Medicaid plans in a single state. Those with smaller teams suggested that to properly perform quality assurance, they would need significantly more personnel. The Washington Health Care Authority, which oversees six managed care plans, expressed a desire to triple their team from one to three FTEs.

"It takes a village to make the end product as effective and useful as possible. So many different departments must touch the information to get it in the system correctly and then extract it in an effective way."

— Senior director, carrier

Consumer Decisionmaking

Provider directories do not currently serve to effectively engage and inform consumers as they enroll in coverage and seek care.

Early State-Based Marketplace Efforts
Even though SBMs were not required to implement provider directories under the ACA, several took the initiative to do so to help consumers as they purchase and enroll in coverage. While stakeholders have been broadly supportive of marketplaces' provider directory efforts, issues with data quality and usability have marred these efforts to support consumer decisionmaking.

Consumer advocates noted the importance of provider directories in the marketplace enrollment process, but

also pointed out that they are relying on the carriers' directories when helping individuals enroll in coverage rather than on the marketplace's aggregated directory due to concerns over quality and accuracy. Some marketplaces suggest that consumers call the carrier or provider to ensure the provider is in-network.[29] Connect for Health Colorado will create a special enrollment period for consumers who purchased products that listed providers incorrectly and will work with consumers and carriers to resolve out-of-network claims that may have incurred as a result of inaccurate listings.

Critical Data Elements

While there was not consensus regarding the data elements required to create a directory with an adequate level of information to support consumer decisionmaking, stakeholders agreed that the following data elements would be valuable:

- ➤ Name
- ➤ Address
- ➤ Phone number
- ➤ Open/closed panel (specific to product)
- ➤ Gender

- ➤ Languages spoken by provider and office staff
- ➤ Specialties
- ➤ Accessibility
- ➤ Hours of operation
- ➤ Admitting privileges / affiliations

Some stakeholders also felt that facility information, including names, locations, and other demographic information, would be important, especially to Medicaid populations who may be used to seeking care at a specific clinic rather than with a particular provider. However, clinic data can pose an additional challenge for a provider directory. For example, a clinic with multiple locations that only reports or bills under their main location's address would only have that one location appear in a directory, unless significant work is done by directory administrators to identify all associated locations of that clinic. To date, most SBMs, including New York and Maryland, have not endeavored to list facilities like clinics due to challenges with reconciling data or their systems' technical limitations, all of which were too significant to overcome in the early stages of marketplace development.

Stakeholders also recognized that increasing the amount of data in a provider directory may lead to more opportunities for error and increased costs for maintaining that information. Recognizing this trade-off, stakeholders noted the importance of balancing the quantity and quality of information made available to consumers.

Provider Contracting

Confusion exists among providers about contracting and participating in specific carrier products and the requirements and processes needed to update provider data.

Stakeholders reported a general lack of awareness among providers with respect to certain carrier contracting practices, which can result in confusion between providers and members seeking their services. The most common instance stakeholders pointed to are all-product clauses, in which carriers include provisions in provider contracts requiring the provider to participate in all of a carrier's products. Carriers may rely on such clauses to ease the administrative burden that would be placed both on the plan and their entire contracted network of providers associated with issuing new contracts and amendments for every new product launch and change. While all-product clauses have been banned in at least six states, they remain common in California and New York.[30]

To address these concerns, the New York State Department of Public Health and Department of Financial Services plan to implement provider education guidelines for 2016 to reduce provider confusion about marketplace contracts. Both carriers and providers share responsibility for understanding and communicating the implications of all-product and other contractual obligations specified in contracts that they mutually sign.

Interviewees also pointed to the need to educate providers and their staff about the importance of updating their information and communicating changes to carriers in a timely manner. Carriers reported using the contracting process, existing network management relationships, newsletters, and other marketing opportunities to educate and remind providers about their obligations to update and communicate changes to their information under their contracts. Marketplaces expressed interest in implementing provider-facing portals where providers, after proving their identity, could verify and correct their information. The Maryland Health Connection is currently developing and testing such a portal before making it available to providers. One national carrier that operates a secure portal where providers can update

their information reported slow uptake among providers; when providers submit updates via the portal, changes are published on the carrier's online provider directory via weekly system updates.

Considerations for California

The increasing prevalence of narrow networks, coupled with the evolving health care market and shifting consumer expectations toward technology-enabled health care tools, are reinforcing the importance of establishing and maintaining accurate and integrated provider directories.[31]

Research revealed several opportunities for policymakers, carriers, providers, and advocates to improve provider directories to help inform and support consumer decisionmaking.

1. **Policy and regulatory alignment.** Policy and regulation without enforcement action appears to have failed to motivate marketplaces and carriers to ensure the accuracy and availability of provider directories. States, marketplaces, and carriers have generally not imposed sanctions or terminated carriers or providers for noncompliance with provider directory contractual provisions, policies, and regulations. The exception is the actions by New York's attorney general against noncompliant carriers, which have been imposed with monetary penalties and requirements to uphold obligations to publish accurate provider directories supported by robust quality assurance and data integrity processes.

   California's carriers are subject to oversight and guidance by two regulators — DMHC and California Department of Insurance (CDI). In addition, carriers offering QHPs are subject to Covered California's oversight as an active purchaser, with the power to set standards through contracting standards, which include standards around provider directory data integrity;[32] Medi-Cal managed care plans are also subject to contracting requirements of the Department of Health Care Services (DHCS). Regulators and public and private policymakers should consider how they convey consistent guidance and policy coupled with

enforcement to set clear expectations for carriers. This is especially relevant in California, where misaligned or conflicting policies across regulators, major purchasers, and agencies could result in confusion and inefficiencies for carriers. Rather, if California's regulators, Covered California, and DHCS were to issue consistent guidance and require the same practices of carriers serving the commercial, marketplace, and Medicaid markets, carriers would have significant motivation to comply and could issue clearer and more consistent guidance to their contracted provider networks.

2. **Standards and accompanying guidance for provider directories.** The New York State Department of Health has achieved economies of scale by standardizing carriers' submission of provider data for state, marketplace, and commercial managed care products. Carriers across the state are accustomed to collecting and submitting data in the state-prescribed template, and the template collects sufficient data to support its provider directories and network adequacy review. This approach also minimizes the burden on carriers as they submit data using a single template across multiple products.

   California has taken steps in this direction by enabling health plans to use the DMHC template for both the required DMHC timely access filing and the plans' Covered California quarterly network reporting. Also, state legislation under consideration in 2015 would require DMHC and CDI to establish provider directory standards, as well as set additional requirements for provider directories.[33] The state could be well-served through continued development of a single template coupled with detailed guidance, agreed-upon standards and nomenclature of required data fields (e.g., provider and facility name, provider identifiers, practice/facility locations), and robust data submission and verification processes. The agreement among stakeholders on a single template to be used to meet both state and marketplace needs will not be easily achieved and will require clear guidance and education to help carriers successfully transition to its use.

   A separate but related issue California may consider is whether there is sufficient demand to develop a reliable, centralized resource of provider information. Today, carriers, Covered California, and Medi-Cal rely

on self-reported provider data and disparate sources against which they check provider information for accuracy and to identify if providers are sanctioned. To the extent each organization collects provider data in a unique format, aggregating and reporting these data at the marketplace or state level is increasingly difficult, and organizations would benefit from access to single, authoritative sources with up-to-date provider information.

Increased Attention in California

November 2014. DMHC audits identify significant inaccuracies in two large carriers' directories.

January 2015. State Senator Ed Hernandez introduces SB 137 to improve provider directories. Specifies time frames and processes for directory updates and directs the state to develop standard provider directory standards.

CDI issues emergency regulations to update network adequacy requirements for CDI-regulated plans. Provider directories of CDI-regulated plans must include demographic information, status of practice, and other elements.

June 2015. A California state auditor report examining DHCS's oversight of Medi-Cal managed care plans finds three carriers had significant inaccuracies in their directories and DHCS's provider directory review tool and process insufficient.

3. **Health care resources and diversity.** California's health care landscape is large and diverse. The state boasts nearly 49,000 primary care providers and over 53,000 specialists, many of whom practice in 280 delegated medical groups, IPAs, foundations, clinics, and other organizations, and provide care to over 38 million Californians.[34] The sheer size of California and the diversity of its health care institutions also have significant implications for the resources required to adequately establish and maintain accurate provider directories, especially any centralized efforts by the state or marketplace.

The size and significance of California's health care landscape should not be underestimated by policymakers and others working to develop and maintain

provider directories. If individual carriers are expected to dramatically improve the quality and timeliness of their provider directories, they will need to enhance investments in their staff and systems and have the commitment of their contracted provider partners to invest in efforts to deliver timely updates. These investments could result in some of the costs being passed along to consumers in the form of increased premiums and higher cost sharing. Similarly, at the state and marketplace levels, it will be a significant task to create and maintain more accurate provider directories, requiring an investment in resources and a commitment from leadership to prioritize provider directory efforts.

4. **Improving consumer decisionmaking and protections.** To be successful in informing consumers as they enroll in coverage and seek health care services, directories must:

   ► Be accessible to consumers with various levels of health literacy

   ► Take into account and address California's cultural and language diversity

   ► Provide protections for consumers against inaccurate information

First, provider directories must be developed with the consumer in mind and consider the way consumers think about and experience the health care market. Stakeholders designing and implementing directories should consider how to best serve consumers with low levels of health literacy to meaningfully inform their decisionmaking. For example, a provider directory could include definitions at appropriate reading levels that explain important aspects of the health care system, insurance coverage, and the products consumers are considering, as well as point consumers to both electronic and in-person resources to assist with coverage decisions.

Second, directories should take into account and be responsive to the heterogeneous needs of California's diverse population. Primary language, cultural norms, and the specific needs of people with disabilities all factor into consumer decisionmaking in the health care arena. Directories can provide information related to provider and staff language capabilities,

ethnicity, and gender, which can be important factors for some consumers, and whether a provider's office or clinic is accessible according to the Americans with Disabilities Act guidelines.

Finally, when consumers buy an insurance product based on a provider directory network listing that may have inaccuracies, adequate financial protections and a clear process for recourse for consumers can be put into place. Policymakers, providers, and carriers can work together to ensure that special enrollment periods, coverage for out-of-network care, and other safeguards are afforded to consumers should they encounter and make decisions based on incorrect provider directories. For example, a misrepresentation or error in the provider directory can trigger a special enrollment period for consumers purchasing coverage through Covered California.[35] More can be done to make certain that assisters, brokers, and health plan personnel understand that provider directory errors trigger specific recourse for effected consumers and encourage them to take action so that consumers receive the health care services they need.

Appendix A: Target State-Based Marketplace Functionality

	NUMBER OF HEALTH PLANS (2015)	TOTAL ENROLLEES (2015)	PROVIDER DIRECTORY SEARCH FUNCTIONS									
			Provider Name	Provider Specialty	Hospital Name	Facility Name (e.g., labs)	Location	Carrier Name	Plan Name	Metal Level	Plan Quality Rating	Rx Drugs
CO	10	140,000	✓ Searchable by first or last name		✓	✓	✓					✓
MD	5	119,000	✓	✓			✓ Provider state, county, and/or zip	✓	✓			
NY	16	2.1 million	✓ Must search by last name and county	✓ Only with provider name			✓ Only for providers and with provider name and by county	✓		✓	✓	
WA	9	170,000	✓ Searchable by first or last name		✓		✓					

Note: SBM functionality data was verified as of February 2015.

Appendix B: List of Advisory Group Members

Ahmed Al-Dulaimi
   Senior network specialist
   Covered California

Bill Barcellona, MHA
   Senior vice president, government affairs
   California Association of Physician Groups

Beth Capell, PhD
   Policy advocate
   Health Access

Athena Chapman, MA
   Director of state programs
   California Association of Health Plans

Elizabeth Gallagher
   Director, provider services operations,
   provider network management
   Health Net of California

Betsy Imholz, JD
   Director, special projects
   Consumers Union

Tam Ma, JD
   Policy counsel
   Health Access

Craig Paxton, PhD
   Principal
   Cattaneo & Stroud

Julie Silas, JD
   Senior attorney
   Consumers Union

Appendix C: Federal Guidance and Action on Provider Directories

AGENCY/ ORG	REGULATION/ACTION/PROPOSAL	DATA REQUIREMENTS	FREQUENCY OF UPDATES
CMS	Advance Notice of Methodological Changes for Calendar Year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter	**Providers:** whether accepting new patients; demographic information, including address, phone number, and hours Carriers must contact providers at least quarterly to verify network participation and demographic information.	In real-time for online directories
CMS	Medicaid and Children's Health Insurance Program (CHIP) Programs: Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions related to Third Party Liability (proposed 5/26, published 6/1)	**Physicians, hospitals, pharmacies, behavioral health providers, and LTSS providers:** provider name and affiliation; street address; phone number; website, as appropriate; specialty; open/closed panel; languages spoken by provider or skilled medical interpreter; and accessibility for those with physical disabilities	At least monthly for paper directories and within three business days of receipt of updated information for electronic directories
HHS	Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (final rule and interim final rule, 2012)	**Providers:** licensure; specialty; contact information, including institutional affiliation; whether accepting new patients; accommodations for individuals with disabilities and/or limited English proficiency	None provided — suggested that timelines should strike a balance between consumer choice and the burden that updates place on carriers
HHS	Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 (final rule)	**Providers:** whether accepting new patients, location, contact information, specialty, medical group, and any institutional affiliations	At least monthly
NAIC	Draft Health Benefit Plan Network Access and Adequacy Model Act (draft)	**Providers:** name, gender, contact information, specialty, whether accepting new patients, hospital affiliation(s), medical group affiliation(s), board certification(s), language(s) spoken by provider or staff, and office location(s) **Hospitals and facilities:** name, location, type (facilities only), and procedures performed (facilities only)	At least monthly

Endnotes

1. Linda J. Blumberg, Sharon K. Long, Genevieve M. Kenney, and Dana Goin, *Factors Influencing Health Plan Choice Among the Marketplace Target Population on the Eve of Health Reform,* The Urban Institute, December 2013, hrms.urban.org.

2. Dave Roos, "How to Leverage an API for Conferencing," How Stuff Works, money.howstuffworks.com.

3. Ibid.

4. *Surprise Medical Bills Survey: 2015 Nationally-Representative Online Survey,* Consumer Reports National Research Center, May 5, 2015, consumersunion.org.

5. Ibid.

6. Capabilities were assessed in February 2015, and a directory's ability to return search results and its search features may have changed since then.

7. "Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule," 45 CFR 155-157 (2012), www.gpo.gov (PDF).

8. Ibid.

9. *Draft Covered California Qualified Health Plan New Entrant Certification Application for Plan Year 2016,* Covered California, December 22,2014, hbex.coveredca.com (PDF).

10. *Access to Psychiatrists in 2014 Qualified Health Plans,* Mental Health Association of Maryland, January 26, 2015, mhamd.org (PDF).

11. "A.G. Schneiderman Offers Tips to Help Consumers Compare Health Care Plans in Advance of NYS Marketplace Open Enrollment," New York State Office of the Attorney General, November 10, 2014, www.ag.ny.gov.

12. Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, *Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks,* The Commonwealth Fund, May 2015, www.commonwealthfund.org (PDF).

13. *2015 Letter to Issuers in the Federally-Facilitated Marketplaces,* Centers for Medicare & Medicaid Services, March 14, 2014, www.cms.gov (PDF).

14. "HHS Notice of Benefit and Payment Parameters for 2016; Final Rule," 45 CFR 144, 147, 153, et al. (2015), www.gpo.gov (PDF).

15. *Final 2016 Letter to Issuers in the Federally-Facilitated Marketplaces,* Centers for Medicare & Medicaid Services, February 20, 2015, www.cms.gov (PDF).

16. Daniel R. Levinson, *Access to Care: Provider Availability in Medicaid Managed Care,* Department of Health & Human Services Office of Inspector General, December 2014, oig.hhs.gov (PDF).

17. *Advance Notice of Methodological Changes for Calendar Year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter,* Centers for Medicare & Medicaid Services, February 20, 2015, www.cms.gov (PDF).

18. Ibid.

19. "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability," 42 CFR 431, 433, 438, 440, 457, and 495 (2015), federalregister.gov.

20. Ibid; "2015 Interoperability Standards Advisory," Office of the National Coordinator for Health IT, 2015, www.healthit.gov.

21. *Health Benefit Plan Network Access & Adequacy Model Act (draft),* National Association of Insurance Commissioners, November 12, 2014, www.naic.org (PDF).

22. More information available at www.naic.org.

23. "A.G. Schneiderman Announces Settlements Requiring Health Insurers to Publish Accurate Provider Directories," New York State Office of the Attorney General, January 19, 2012, www.ag.ny.gov.

24. *Assurance of Discontinuance Pursuant to Executive Law Section 63, Subdivision 15,* Attorney General of the State of New York, December 6, 2010, www.ag.ny.gov (PDF).

25. *Timely Access Network Reporting General Instructions,* California Department of Managed Health Care, January 1, 2015, www.dmhc.ca.gov (PDF).

26. Ibid.

27. The PNDS is a web-based system "implemented by the New York State Department of Health in December of 1996 to gather information about the provider and service networks contracted to (carriers) operating in New York State." *Data Dictionary: Provider Network Data Systems Version 6.8,* New York Department of Health, January 2015, www.health.ny.gov (PDF).

28. Ibid.

29. *Shopping for Health Insurance: Helpful Tips for Open Enrollment,* New York State Office of the Attorney General, 2014, www.ag.ny.gov (PDF).

30. "Managed Care State Laws and Regulations, Including Consumer & Provider Protections," National Conference of State Legislatures, September 2011, www.ncsl.org.

31. Dan Polsky and Janet Weiner, *The Skinny on Narrow Networks in Health Insurance Marketplace Plans,* University of Pennsylvania's Leonard Davis Institute of Health Economics, June 2015, www.rwjf.org (PDF).

32. *Qualified Health Plan Model Contract, Section 2.15, Attachment 14,* Covered California, January 23, 2015, hbex.coveredca.com (PDF).

33. "SB-137 Health Care Coverage: Provider Directories," August 2015, leginfo.legislature.ca.gov.

34. "Total Professionally Active Physicians," Kaiser Family Foundation, kff.org; *California Physician Facts and Figures,* California HealthCare Foundation, July 2010, www.chcf.org; US Census Bureau.

35. "Covered California Regulations," 10 CCR § 6504(a)(4), govt.westlaw.com. The regulations are also accessible from Covered California's website: hbex.coveredca.com/regulations.