Massachusetts Division of Insurance

SUMMARY REPORT
Market Conduct Exam
Reviewing Health Insurance Carriers' Provider Directory Information

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Commissioner of Insurance

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Acknowledgements

The following report was prepared by the Health Care Access Bureau ("HCAB") within the Massachusetts Division of Insurance ("Division") to summarize the results of the market conduct examination of health carriers' provider directory information and the processes used to collect, store and monitor provider directory information as reviewed by BerryDunn/Quest Analytics and Gorman Actuarial/ RLCarey Consulting. The report is based on the aggregate results of 14 health insurance carrier groups offering insured managed care products within Massachusetts at the end of 2016.

EXECUTIVE SUMMARY

In response to complaints about the accuracy of provider network information, the Massachusetts Division of Insurance (DOI) called a special examination of 14 health insurance carrier groups (carriers) with managed care networks to look at the accuracy of provider network information and the processes the carriers use to collect, store and monitor such information. The DOI examined provider network information for primary care providers, seven (7) types of behavioral health inpatient/intermediate care facilities, and ten (10) types of behavioral health practitioners.

Providers are contractually responsible to notify health carriers with up-to-date information about their continued participation in networks, contact information – including addresses, hours, phone numbers, willingness to provide certain services, and availability for appointments. Certain providers, including behavioral health providers, change locations/circumstances somewhat frequently, and due to staffing or other constraints may not regularly update each of the plans with which they contract when their circumstances change.

Health carriers have an important responsibility to provide accurate information to their members so that they are able to contact network providers who can provide needed health care. In addition, prospective members rely on the accuracy of provider network information when choosing/selecting a plan. Despite the fact that many providers have not routinely and regularly provided appropriate notification as required, carriers are nonetheless obligated to take appropriate steps to collect accurate provider network information and enable covered persons to arrange for needed care.

Systems to Collect, Store and Report Information

Carriers each collect provider information separately through initial and renewal credentialing, as well as update information as forwarded by providers to the carriers. The consultants found the following:

- There is no centralized database of provider information for carriers to use. Providers send information separately to each carrier.
- Each carrier sends providers regular reminders to update contact, availability, and service information through periodic newsletters and electronic requests.
- Carriers contracting with management companies for behavioral health care (often referred to as "carve-outs") may delegate certain provider network information to the management companies.
- Not all carriers regularly remove providers from network information when they do not respond to carriers' requests for updated information.

Telephone Surveys

Over 2,000 "secret shopper" calls were made to a limited or targeted sample of providers drawn from each carrier's 2017 provider directory information. (The samples were drawn from each carrier based on those primary care and behavioral health care providers without a record of submitting a claim for payment to that carrier in 2015.) After making calls to verify the accuracy of each provider's phone number, address, specialty, in-network status, age groups treated, and whether the provider was accepting new patients, the consultants found the following:

- A limited number of providers remain listed in carrier directory information even though the provider

no longer has an active practitioner identification number.

- "Secret shopper" callers highlighted how difficult it was to reach a provider on the phone during regular business hours, as over half of all calls went to voice mail. That being said, some small providers may reasonably rely on patients' use of voice mail as a communication tool.
- When "secret shopper" callers did reach a person within provider offices, depending on the carrier and type of provider, the "secret shoppers" found on the calls that the provider network information was not completely accurate for up to 70% of the providers contacted.
- While 58-100% of behavioral health facility information was accurate, depending on the carrier, 32% - 66% of primary care and 36% -71% of behavioral health care providers' information was not completely accurate.
- Carrier information did not provide adequate detail about the provider's willingness to treat patients of differing age groups (e.g., child, adolescent, adult, senior).

Actions to Improve Provider Network Information

Each carrier acknowledged that much needs to be done to improve the quality of provider information but highlighted that it is necessary that providers recognize the importance of accurate provider network information and that they be involved in a collaborative effort to improve its accuracy. The carriers reported the following initiatives:

- All the carriers have indicated their commitment to improve their efforts to contact providers and make it easier for providers to update their information.
- Many carriers are devoting resources to developing a centralized database to facilitate a provider's ability to use one portal to update information for use by many or all carriers.
- A few carriers are hiring additional staff to regularly call network providers to verify information.
- A few carriers are contracting with audit firms that will either regularly call providers or will check provider network information with other sources of information.
- A few carriers with carve-outs are considering better methods for overseeing the updating of provider network information.
- One carrier acknowledged employing staff to act as "navigators" to assist members directly to find providers who are taking patients and treating the type of care requested.

Additional Observations

Although carriers may be devoting resources to improve what is in their systems, the information will continue to be flawed if carriers are not obtaining correct information from providers. Efforts to develop statewide databases are planned for 1-2 years from now and thus will not address members' current need for clear and accurate information. The DOI is considering the following regulatory solutions to address ongoing problems with the quality of provider information:

- Carriers should have dedicated resources to regularly audit the quality of information, especially provider contact information and availability of taking appointments.
- Carriers should have information available about which providers regularly treat children, adolescents, adults, and seniors based on all available updates and past claims-filing patterns.
- Carriers should have information available about which providers regularly treat certain behavioral health conditions, based on all available updates and past claims-filing patterns.
- Carriers should have dedicated staff who are available to help members find the appropriate type of providers to treat conditions based on age and type of treatment. Such staff should be available at dedicated phone lines to contact providers, where necessary, to help schedule appointments for certain difficult-to-treat ages or behavioral health conditions.
- Carriers should establish systems and processes that make updating information as easy as possible.

Introduction

The Massachusetts Division of Insurance (DOI) called market conduct examinations of 14 groups of health insurance carriers (carriers)[1] under the provisions of M.G.L. c. 175, §4; M.G.L. c. 176B, §9; and/or M.G.L. c. 176G, §10, and contracted with BerryDunn/Quest Analytics and Gorman Actuarial/RLCarey Consulting to conduct an assessment of provider directory information, including a review of provider directory processes and the accuracy of information within the provider directories. The DOI called the examination in order to determine: (1) how information is collected and kept up-to-date; (2) the manner by which information is provided to consumers; and (3) how carriers ensure that information about providers' ability to treat health conditions is accurate. Each assessment focused on the following:

- Information systems and business processes;
- The manner by which carriers obtain and validate information submitted by providers;
- The types of provider-specific information made available to consumers;
- The means by which carriers provide consumers with information on network providers;
- How each carrier maintains and updates its provider directory information; and
- Whether, and to what extent, carriers routinely audit or verify information in the provider directory to ensure it is accurate and up-to-date.

[1] Aetna Health Insurance Company
Blue Cross and Blue Shield of Massachusetts, Inc. and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Boston Medical Center Health Plan, Inc.
CeltiCare Health Plan of Massachusetts, Inc.
CIGNA Health and Life Insurance Company
ConnectiCare of Massachusetts, Inc.
Fallon Community Health Plan, Inc. and Fallon Health and Life Assurance Company, Inc.
Harvard Pilgrim Health Care, Inc. and HPHC Insurance Company, Inc.
Health New England, Inc.
Minuteman Health Plan, Inc.
Neighborhood Health Plan, Inc.
Tufts Associated Health Maintenance Organization, Inc. and Tufts Insurance Company, Inc.
Tufts Health Public Plans, Inc.
United HealthCare Insurance Company

I. Background / Scope of the Project

This market conduct examination comes at a time of increasing scrutiny of health carriers' provider directory information. A 2016 evaluation of 54 Medicare Advantage Organizations' (MAO) provider directories by the federal Centers for Medicare and Medicaid Services (CMS) found that 45% of provider directory listings surveyed were inaccurate.[2] The most common inaccuracies were:

- Provider was not at the location listed;
- Provider's phone number was incorrect; and
- Provider was not accepting new patients when the directory indicated that the provider was accepting new patients.

In the Commonwealth, consumers and consumer advocates have brought to the attention of DOI and other interested parties that provider directory information is frequently inaccurate. Common points include: providers listed in the directory are no longer participating in the network; providers are not accepting new patients though the directory shows that they are; provider phone numbers listed in the directory are incorrect; and the provider does not treat the condition or provide the service listed in the directory.

[2] "Online Provider Directory Review," Centers for Medicare and Medicaid Services, Washington, January 2017. Available at: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.html.

II. Review of Administrative Processes

To complete this market conduct examination, Gorman Actuarial/RLCarey Consulting utilized questionnaires, conducted on-site interviews with carrier group staff, which included a demonstration of each carrier group's provider directory system, and held an on-site follow-up meeting with each carrier group's representatives. The questionnaire sent to each carrier group, a copy of which is attached as Appendix A, sought information in the following areas:

1. Administrative and information systems used for the provider directory information;
2. Key staff responsible for maintaining the provider directory information;
3. Provider directory formats available to consumers (e.g., online, print, PDF);
4. Provider-specific data elements included in the provider directory information;
5. Frequency of updates to the provider directory information;
6. Online search capabilities;
7. Internal audit practices;
8. Identification of network providers not accepting new patients;
9. Identification of "concierge" physicians;
10. Processes used to verify / validate services reported by providers, including services and treatment specialties for which board certification is not applicable;
11. Processes used to update provider directory information; and
12. Provider information made available to consumers by customer service representatives (CSR).

Gorman Actuarial/RLCarey Consulting reviewed each carrier's responses to the questionnaire and sought clarification, as necessary. A follow-up meeting was held in February 2018 to discuss more recent actions that each carrier had taken with regard to its provider directory information and to review industry-wide opportunities to improve the accuracy of provider directories.

Each carrier-specific report includes details about the following areas:

- Contracting, Credentialing, Verifying – an overview of the initial onboarding process that each carrier uses for new network providers;
- Provider Directory Updates – a review of the ways in which each carrier updates its provider directory;
- Consumer Information – a discussion of the various provider directory formats available to consumers, as well as an overview of the provider-specific information included in each carrier's provider directory;

- Federal Standards Applicable to Provider Directories – a review of CMS regulations and guidance applicable to provider directories and an assessment of each carrier's compliance with these standards;
- Accessing Information on the Web – an assessment of each carrier's online provider directory, including accessibility, ease of use, and search functionality;
- Customer Service / Call Center – an overview of the role of each carrier's CSRs and the tools used to assist members in locating providers;
- Outreach to Providers – a review of the ways in which each carrier engages providers to maintain an accurate provider directory;
- Monitoring Panel Status – a discussion of each carrier's monitoring of network providers' panel status (i.e., accepting new patients);
- Provider Availability Standards – a review of each carrier's standards pertaining to wait times for members to schedule an appointment with providers, and the extent to which each carrier monitors these standards and holds providers accountable;
- Senior Leadership Follow-Up Meeting – an update on provider directory initiatives undertaken by each carrier and insights on industry-wide efforts to improve the accuracy of provider directories; and
- Observations – key observations from each market conduct examination.

III. Calling Providers about Information in Carrier Network Directories

Telephone Surveys

As part of this market conduct examination, BerryDunn/Quest Analytics drew a sample from each of the carrier group's files and contacted providers as "secret shoppers" new to the area who were looking for an appointment for a specific type of behavioral health or primary care. The "secret shoppers" were asked to verify the accuracy of provider information regarding the provider's phone number, address, specialty, in-network status, age groups treated, and whether the provider was accepting new patients.

Limitations of the Study of Provider Information

Samples were drawn from primary care and behavioral health providers, including inpatient/intermediate care facilities, without a record of submitting a claim for payment in 2015. Given that this sample focuses on provider records more likely to be out-of-date and/or incorrect, it therefore may not reflect the quality of the overall provider directory information.

The Consultants were directed to speak directly with provider offices to verify information. In many cases, the "secret shopper" was asked by the provider office to leave a message to get a call back. Since the "secret shopper" was unable to leave a message, the "secret shopper" was directed to make three attempts during normal business hours to talk with someone in the provider's office to verify information. When calling the providers in the sample, the "secret shopper" was not able to talk with someone for over half of the calls. The majority of calls were not connected, as the "secret shopper" reached voice mail each of three times called. In addition, a significant number of calls rang without response each of three times called; were sent to a facsimile machine; or were disconnected phone numbers.

Unanswered calls are not necessarily unexpected due to the number of primary care and behavioral health providers who practice in multiple offices on different days of the week, as well as small providers' limited administrative staff. Restricting the ability for providers to return calls may skew the results because the Consultants were only able to draw information from providers who did answer phones when the Consultants called.

Results of Calls

For the sample calls where the "secret shopper" was able to talk to someone, the Consultants recorded the number of provider records containing accurate information about the provider's name, phone number, address, specialty, and willingness to take new patients. They found from this limited sample that results by carrier varied with between:

- **58% and-100%** of a carrier's sample behavioral health facility records contained completely accurate information;
- **34% and 68%** of a carrier's sample primary care provider records contained completely accurate information; and
- **29% and 64%** of a carrier's sample behavioral health provider records contained completely accurate information.

IV. Industry Efforts

Each carrier acknowledged that much needs to be done to improve the quality of provider information but highlighted that it is necessary that providers recognize the importance of accurate provider network information and that they be involved in a collaborative effort to improve its accuracy.

A number of the carriers indicated that they were actively participating in a provider directory project being coordinated by a local organization, HealthCare Administrative Solutions, Inc. (HCAS), which recently issued a request for proposals (RFP) on behalf of the participating carriers to determine if a centralized system exists that would allow providers to submit updates to their provider directory information in one location and have the update distributed to all carriers with whom the provider contracts. The intent is to streamline the process for updating provider directory information. A centralized system could be used to replace the current process, whereby providers must notify each carrier separately whenever there is a change in their provider directory information (e.g., change in phone number, address, group affiliation, panel status). Responses to the RFP are due later in the spring of 2018, and HCAS plans to make a recommendation before the end of the year.

With regard to the type of data made available in the provider directory, some carriers noted that, as more data is required to be included in the directory, more resources are necessary to ensure the data is accurate. Panel status (i.e., whether the provider is accepting new patients) can change frequently for some providers, particularly behavioral health care clinicians, which makes it challenging for carriers to keep the directory up to date.

The carriers reported the following other initiatives:

- A few carriers are hiring additional staff to regularly call network providers to verify information.
- A few carriers are contracting with audit firms that will either regularly call providers or will check provider network information with other sources of information.
- A few carriers with carve-outs are considering better methods for overseeing the updating of provider network information.
- One carrier acknowledged employing staff to act as “navigators” to assist members directly to find providers who are taking patients and treating the type of care requested.

V. Observations

Throughout the course of the review of the business processes, staffing, and information systems utilized by carriers to manage provider directory information, the review team identified the following issues and challenges faced by carriers in maintaining up-to-date and accurate provider directory information:

- Most carriers' provider networks include tens of thousands of physician and non-physician providers. The large number of providers impacts the ability of carriers to manage and maintain the accuracy of their provider directory information.
- Provider networks are in a frequent state of flux as new clinicians are added, physicians retire, doctors move from one practice to another, physicians change phone numbers, providers move to a new address, providers' panels open and close.
- Carriers have relied primarily on providers to notify them when the provider's status changes and the listing in the provider directory information needs updating. Carriers noted that many providers do not notify carriers when phone numbers, locations, or other information changes.
- Many carriers have recently initiated new and comprehensive surveys to verify the information contained in directories.
- Provider directory information maintenance is currently a largely manual process, and providers typically notify carriers of changes in their practice via email or phone. Although many carriers request that providers use standard change forms, providers are not required to use these forms. Depending on the carrier and the method by which the provider submits the change information, it can take up to thirty (30) days to process changes to provider directories.
- Most behavioral health care clinicians' subspecialties are self-reported and cannot be regularly and independently verified by the carriers, in light of the licensing designations through professional clinical boards. The majority of behavioral health subspecialties are not subject to licensure or certification that would enable a carrier to use a state or national licensing board to validate a clinician's ability to render the services.

VI. Improving Information

Although carriers may be devoting resources to improve what is in their systems, information will continue to be flawed if carriers are not obtaining correct information from providers. Efforts to develop statewide databases are planned for 1-2 years from now and thus will not address members' current need for clear and accurate information. The DOI is considering the following regulatory solutions to address ongoing problems with the quality of provider information:

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VII. Appendices

Appendix A. Questionnaire forwarded to Carriers

General

1. a) Describe the administrative and information systems used to ensure the information contained in the provider directory is accurate and up-to-date.

   b) Identify the manager and department with overall responsibility for the information in the provider directory material and the titles of staff who regularly monitor and update the provider directory material as it becomes available. If certain categories of providers (e.g., behavioral health providers) are delegated to a separate manager (or separate entity, such as a BH "carve-out"), please identify the manager and department responsible for that category of provider information and how the manager and department with overall responsibility for the information monitor the work of the manager to which the work is delegated.

2. In which formats is the provider directory available to consumers (web, print, PDF, other)? If "other", please specify.

3. For each format type (column), please indicate if the data element falls into one of the following 3 categories:

   1) The data element is not collected (N)
   2) The data element is collected, but not included in the provider directory (CN)
   3) The data element is collected and is included in the provider directory (Y)

   Please mark "N", "CN" or "Y" for each element. Indicate "N/A" for the column if you do not make available the provider directory in a particular format.

Provider name	Web	Print Copy	PDF	Other (please specify)
Office location (s)				
Phone number (s)				
Web address (provider's URL)				
Hours of operation				
Gender				
Professional Degree (MD, DO, etc.)				
Board Certification				
For Primary Care Providers: PCP Type (Family Practice, Internal Medicine, OBGYN, etc.)				
For Specialists: Specialty Type				

Hospital / institutional affiliations (in network facilities)				
Open / Closed panel (i.e., accepting new patients)				
Languages accommodated				
Handicap accessible				
Quality of care designation				
Network name that provider is in				
Network tier (for tiered network plans)				
Designation of "concierge" (i.e., patients are charged an annual fee or retainer to see the provider)				
Other (please specify and add rows if necessary)				

4. How frequently is the provider directory updated? [Monthly, Weekly, Daily, Other?]

   Web:_____

   Print:_____

   PDF:_____

   Other:_____

5. With regard to the online provider directory, in what ways are consumers able to search the directory for providers that meet one or more variable (e.g., pediatricians with an open panel located in Worcester)? Please describe the search / filtering functionality.

6. Describe the internal audits that are conducted to ensure the provider directory is correct. How often is an audit performed? Do you compare the data provided via the web to other formats? Also, identify any differences in the internal audits between the web provider directory, and other formats (paper, pdf, etc.).

7. With regard to whether a provider is accepting new patients, how is this information obtained, documented and updated (e.g., reported by provider's office, survey initiated by insurer)?

8. With regard to providers that charge members an annual fee or retainer (i.e., "concierge" providers), how is this information obtained, documented and updated (e.g., reported by provider's office, survey initiated by insurer)? Is this information included in the provider directory?

9. How do you ensure that the provider credentials are accurately reflected in the provider directory? Specifically, for services that do not have a board certification, how do you verify that the provider is qualified to render the services listed in the provider directory?

10. How do you ensure that the provider correctly identifies for which service the provider intends to take patients, especially if the provider indicates the ability to practice in multiple specialty areas?

Providers

11. If a provider's office wishes to report a change in their listing (e.g., office location, specialty, panel closed to new patients), describe the process to accommodate this type of request.

12. Is there a form or web-based tool available on your provider portal that allows the provider to update their information? If yes, how often is each provider contacted to remind them to use the form or web-based tool to update information about the provider's practice?

13. From the time you are notified of a change to the provider listing by the provider's office, how long does it typically take for the corrected information to be incorporated into the provider directory and made available to consumers? Also, identify any differences in the time it takes to update the paper provider directory versus the website versus pdf, etc.?

Consumers

14. If a consumer notices a discrepancy between the information available in the provider directory and what the provider's office reports, what's the process for resolving the discrepancy?

15. From the time you are notified of a discrepancy in the provider listing by a consumer, how long does it typically take for the corrected information to be incorporated into the provider directory and made available to consumers? Also, identify any differences in the time it takes to correct information on the paper provider directory versus the website versus the pdf, etc.?

16. When a consumer calls looking for a certain type of provider near his / her home, what information is provided to the caller?