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Don't You (Forget About Me)—Recent Requirements for Provider Directories in an Era of Consumer-Directed Health Care

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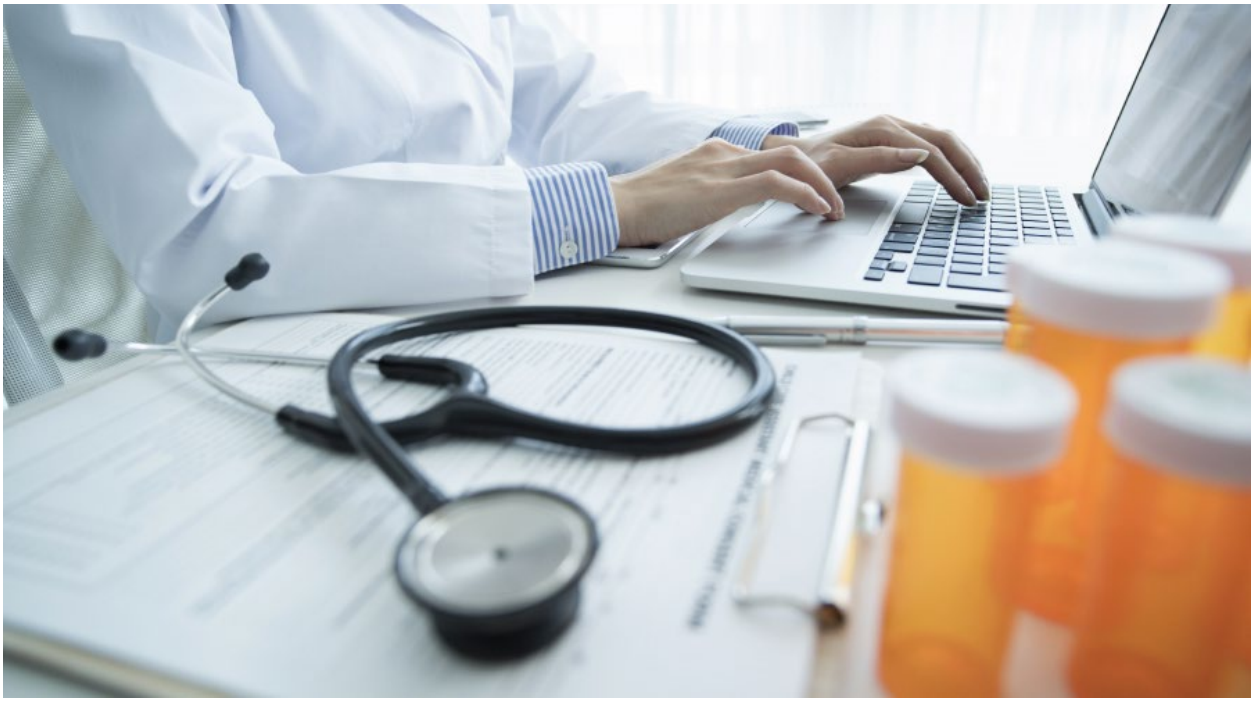

> "Provider directories make key information about health care professionals and organizations available to help consumers identify a provider when they enroll in an insurance plan or as new health needs arise."[1]

The era of increased health care transparency and consumer-directed health care is upon us. In the dawn of this new era, and the complex regulatory environment for health plans and insurance issuers (Health Plans), provider directories remain an overlooked, yet critical, tool for consumers. With Health Plans facing many competing, overlapping, and complex new regulatory requirements, it is understandable why the implementation of the No Surprises Act provider directory requirements may have been overlooked. While

provider directory requirements are nothing new for managed care plans in the commercial, Medicare, and Medicaid markets, the new requirements provide additional consumer protections and place obligations on providers to be responsible for timely responses to Health Plans. Health Plans must also comply with provider directory requirements stemming from the Centers for Medicare & Medicaid Services' (CMS') 2020 Interoperability final rule.[2] Further, Health Plans must meet additional requirements under the *Transparency in Coverage* final rule, many of which rely on the same underlying provider data as directories.[3]

The consistent theme through these overlapping, and in some cases duplicative requirements, is that a plan's provider network cannot be fully accessible without up-to-date information for enrollees. The movement towards greater transparency in health care relies on accurate and up to date electronic health information in order to encourage innovation as well as increase consumer literacy. For those who seek a more market-oriented, consumer-driven health care, or the continued expansion in Medicaid managed care and Medicare Advantage, up to date and accurate information about available providers and facilities is critical. In turn, inaccurate provider directory information can call into question the sufficiency of a health plan's network and result in surprise bills for patients.

This article briefly describes provider directory requirements from the No Surprises Act and the two final rules and the commonalities between them.

Patient Access and Provider Directory APIs from the CMS Interoperability Rule

The 2020 Interoperability final rule required Health Plans to develop a public facing provider directory Application Programming Interface (API). CMS already required hard copies and online access to a Health Plan's provider directory in Medicare Advantage, Medicaid managed care, the Children's Health Insurance Program (CHIP), and for qualified health plans (QHP).[4] An API "is a way for two computers or services to exchange data."[5] In the final rule, CMS states their belief that the creation of these APIs will permit third-party apps to make the information more widely available and permit innovation to assist in comparing plan provider networks when shopping for coverage.[6]

The requirement is applicable to Health Plans offered in Medicare Advantage,[7] Medicaid,[8] CHIP,[9] and QHPs.[10] The preamble text in the final rule succinctly states the requirements across the various programs: "[s]pecifically, the Provider Directory API must include provider directory data on a payer's network of contracted providers, including names, addresses, phone numbers, and specialties, updated no later than 30 calendar days after a payer receives provider directory information or updates to provider directory information."[11] When provider directory information

changes, it must be updated within 30 business days. While CMS used its enforcement discretion to delay enforcement until July 1, 2021, that requirement is now in effect.

No Surprises Act

Section 116 of division BB of the Consolidated Appropriations Act, 2021, entitled "Protecting Patients and Improving the Accuracy of Provider Directory Information," established requirements for provider directories to assist in protecting consumers from surprise medical bills.[12] This section requires each group health plan and health insurance issuer offering group or individual health insurance coverage to update and verify provider directory information no less than every 90 days.[13] The health plan must establish a procedure for the removal of providers or facilities from directories where unable to verify the provider or facility data.[14] The process must also provide for updates to the provider directory database within two business days.[15] The provider directory information must include, for each provider or facility with which the Health Plan has a contractual relationship, the name, address, specialty, telephone number, and digital contact information.[16]

In addition to placing requirements on Health Plans to maintain accurate provider directories, the law adds protections against surprise bills where an enrollee relies on inaccurate data. First, when an enrollee requests information about whether a provider or facility is in-network via telephone or the internet, the Health Plans must (1) respond no later than one business day after the request; (2) provide a written electronic or print response; and (3) maintain a copy of the communication for at least two years.[17] Where an individual relies on inaccurate provider directory information and receives items or services from an out-of-network provider, the individual will not be responsible for cost sharing greater than in-network cost sharing and the amount paid by the individual will count towards in-network deductibles and out-of-pocket maximums.[18]

Notably, Section 116 also adds obligations on health care providers and facilities to facilitate the provision of accurate provider and facility information with Health Plans. First, providers and facilities are required to have in place processes to timely share information to update provider directory information with Health Plans.[19] Providers and facilities must share provider directory information with Health Plans when: (1) entering a network agreement; (2) terminating a network agreement; (3) when there are material changes to provider directory information; and (4) the provider, facility, or Secretary of HHS determine appropriate.[20] Should an enrollee receive a surprise bill exceeding in-network cost-sharing amounts because they improperly relied on inaccurate provider directory information, and the enrollee pays the bill, the provider or facility must issue a refund for the excess amount plus interest.[21]

While the statute implements this requirement as of January 1, 2022, the Departments of Health and Human Services, Treasury, and Labor released guidance on August 20, 2021,

providing that notice and comment rulemaking would not be issued by January 1, 2022. In the meantime, Health Plans "are expected to implement these provisions using a good faith, reasonable interpretation of the statute."[22] In turn, a health plan will not be deemed to be out of compliance where an individual that relies on inaccurate provider directory information is only responsible for the in-network cost-sharing amount and it is applied towards any deductible or out-of-pocket maximum.[23]

Transparency in Coverage

The *Transparency in Coverage* final rule requires Health Plans "to disclose cost-sharing information upon request to a participant, beneficiary, or enrollee […] for covered items or services furnished by a particular provider."[24] Additionally, Health Plans are required "to disclose in-network provider negotiated rates, historical out-of-network allowed amounts, and drug pricing information through three machine-readable files posted on an internet website."[25]

While not containing explicit provider directory requirements, the rule requires the sharing and disclosure of much of the same underlying data relied upon for accurate provider directories. Health Plans must make cost-sharing information available "through a self-service tool" on their websites, and in paper form, upon request.[26] The online tool is required to consider many of the same data elements that Health Plans are required to include in their provider directories (e.g., provider names, locations, and network tiers) when calculating an enrollee's cost-sharing amounts. Similarly, the machine-readable file containing negotiated in-network rates relies on many of the same directory data elements. However, the rule diverges from directory requirements by requiring Health Plans to maintain and disclose information related to out-of-network providers, both cost-share and allowed amounts.[27]

The cost-sharing requirements are to be phased in, with cost-sharing for "500 items and services" to be made available on or after January 1, 2023, and for "all items and services" on or after January 1, 2024.[28] The machine-readable files were to be made available on January 1 of this year. The rule specifies that these machine-readable files are to be updated monthly.[29]

Conclusion

The era of health care transparency is well underway. Maintaining up-to-date provider directories is an underappreciated piece of empowering enrollees, and potential enrollees, to utilize high quality and cost-efficient providers in their plan networks and to protect them from surprise bills. Provider directory and related regulatory requirements provide additional consumer protections while also creating compliance risks for Health Plans.

About the Authors

Jeff J. Wurzburg is a Senior Counsel at Locke Lord LLP. His practice focuses on regulatory, compliance, reimbursement, and policy issues facing health plans and providers, with vast experience in Medicare, Medicaid, and the Affordable Care Act. He regularly advises clients on federal health care program reimbursement, compliance, state and federal fraud and abuse laws, and government investigations. Jeff previously served as an attorney in the U.S. Department of Health and Human Services (HHS) Office of the General Counsel in Washington, D.C., where he advised the Centers for Medicare & Medicaid Services and the Center for Medicare & Medicaid Innovation. Jeff serves as a Vice Chair of Educational Programming for the American Health Law Association Payers, Plans, and Managed Care Practice Group.

Brian E. Hoyt is a Managing Director in BRG's Heath Analytics Practice in Washington, DC and is an expert in network adequacy and health plan provider directories. Mr. Hoyt has been selected as an independent monitor of enforcement decrees pursuant to both state and federal investigations in these areas. He also routinely works with health plans to proactively navigate the risks and complexities that these areas present, as well as to respond in the event of disputes and investigations. His expertise extends not only to the data and technology used in these areas, but also to the state and federal regulatory landscape in which plans operate.

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[1] *Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers*, 85 Fed. Reg. 25510, 25559 (June 30, 2020).

[2] *Id*.

[3] *Transparency in Coverage*, 85 Fed. Reg. 72158 (Nov. 12, 2020).

[4] *See* 42 C.F.R, § 422.111, 42 C.F.R. § 438.10(e)(2)(vi) and (h), 42 C.F.R. § 457.1207, and 45 C.F.R. § 156.230(b).

[5] Ben Rooney, *APIs: The Power Transforming the Web*, Wall St. J., Oct. 3, 2012.

[6] 85 Fed. Reg. at 25559.

[7] 42 C.F.R. § 422.120

[8] 42 C.F.R. § 438.242(b)(6).

[9] 42 C.F.R. § 457.1233(d)(3).

[10] Notably, qualified health plans are not required to develop an API because of the existing requirement to make provider directories available in a machine-readable format. 45 C.F.R. § 156.230(c).

[11] 85 Fed. Reg. at 25560; Medicaid MCOs are required to provide additional information such as website, whether the provider accepts new enrollees, cultural and linguistic capabilities, and whether the office or facility has accommodated for individuals with physical disabilities. *See* 42 C.F.R. § 438.10(h)(1). Medicare Advantage and Part D plans are required to include pharmacy directory data. *See* 42 C.F.R. § 422.119(b)(2).

[12] Pub. L. No. 116-260, 134 Stat. 1182, Division BB, (2020), https://www.congress.gov/bill/116th-congress/house-bill/133/text; adding 42 U.S.C. 300gg, 29 U.S.C. § 1185i, and 26 U.S.C. § 9820.

[13] 42 U.S.C. § 300gg-115(a)(2)(A).

[14] 42 U.S.C. § 300gg-115(a)(2)(B).

[15] 42 U.S.C. § 300gg-115(a)(2)(C).

[16] 42 U.S.C. § 300gg-115(a)(6).

[17] 42 U.S.C. § 300gg-115(a)(3)(A) and (B).

[18] 42 U.S.C. § 300gg-115(b)(1)(A) and (B).

[19] 42 U.S.C. § 300gg-139(a).

[20] 42 U.S.C. § 300gg-139(a)(1)-(3).

[21] 42 U.S.C. § 300gg-139(b).

[22] *FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49*, Aug. 20, 2021, https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf.

[23] *Id*. at Question 8.

[24] 85 Fed. Reg. at 72158.

[25] *Id.*

[26] 85 Fed. Reg. at 72176.

[27] 85 Fed. Reg. at 72205.

[28] *Id*. at 72303.

[29] *Id*.