FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

May 29, 2015

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-10558
Submitted electronically on http://www.regulations.gov

Families USA is a national nonprofit, nonpartisan organization dedicated to achieving high-quality, affordable health coverage and care for all. We appreciate the opportunity to provide comments on the Proposed Information Collection for Machine Readable Data for Provider Network and Prescription Formulary Content for FFM QHPs. Overall, we support this information collection, which we hope will lead to a wider proliferation of user-friendly, accurate, and meaningful information about in-network providers and formulary drugs in FFM QHPs for consumers.

Families USA has long been concerned with the accuracy and accessibility of health plans' provider directories. Provider directories are often outdated or inaccurate, erroneously including providers who are no longer in a plan's network or including many dead phone numbers that make it impossible for consumers to even ascertain whether a given provider is available to him or her. These issues create barriers to care for consumers and make it challenging to assess whether health plans' networks are adequate for their enrollee populations. By opening up provider directory data to additional entities for examination and use, we are hoping that the availability of machine readable data will engage more parties in identifying and ultimately correcting provider directory inaccuracies.

However, we also believe it is important to ensure that third parties that use machine readable data are concerned with the integrity of these data. **Specifically, we believe that safeguards must be in place to ensure that third parties will use the most up-to-date versions of provider directories and formularies to populate their tools, and be held accountable for doing so, such as through user agreements they sign.** At no point should third parties be using data that is less up to date than the data that issuers use to populate their provider directories and formularies, and issuers should be required to update their publicly available machine-readable files every 30 days.

Integrated Provider Directories

Another key reason for our support of the information collection for machine readable data is that it should simplify the process of creating an integrated provider directory and formulary for healthcare.gov. Having these tools available in integrated formats would be very beneficial for consumers, particularly if they allowed consumers to search for a provider or drug and then find out which of all of the marketplace plans available to them gave them access to that provider or drug.

Additionally, integrated, searchable provider directories could potentially be more accurate than existing directories if they allowed integrated updates. For example, if a provider retired, the provider could inform the marketplace or its directory manager that he or she was no longer practicing, and the provider could be removed from all plans' directories simultaneously, instead of having to communicate with multiple issuers and wait for each issuer to remove the information from their directory.

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We urge CMS to look into creating integrated provider directory and formulary capabilities for heatlthcare.gov as soon as possible.

Due to the benefits of integrated provider directories and formularies, we also believe that it should be as easy as possible for state-based marketplaces to create these tools. We also believe that consumers in all states, not just those in FFM states, should benefit from other uses of machine readable provider directory and formulary data. Therefore, **we urge CMS to expand the requirements to make machine readable formats available such that they apply to all QHPs and not just those in the FFM.**

Comments on Specific Content in the Machine Readable Files

Families USA supports that the PRA recognizes that specific features about provider networks and formularies must be specified to consumers in order to make network and formulary information meaningful. For example, for drug formularies, we strongly support the inclusion of factors such as: drug tier, mail order, pharmacy type, cost-sharing sub-type, prior authorization, step therapy, quantity limit, and other parameters of a plan's drug coverage that consumers must know to understand how much and what type of coverage a plan provides for their specific pharmaceutical needs. Higher level, more generalized information about a plan's formulary would be significantly less useful for consumers.

For provider network information, we strongly support including "network tier," but would recommend adding in example values of "tier 1, tier 2, tier 3," to reflect common structures of network tiers. We also recommend including the following additional factors, both in provider directories generally and in the machine readable files:

- Which languages other than English, if any, providers speak
- Provider gender
- Any interpreter services or communication and language assistance services that are available at the provider's facilities
- Physical accessibility of the provider's facilities
- Specific descriptions of any available telemedicine services

Additional Improvements

Given that most plans update their provider directories frequently based on the information they receive from providers, yet very severe provider directory inaccuracies persist, Families USA strongly believes that additional measures must be in place to address provider directory accuracy problems going forward. Inaccurate directories mask issues of inadequate networks and make it impossible for consumers to identify plans that meet their needs when shopping and find providers when it is time for them to obtain care. While standards that require plans to conduct timely directory updates, such as every 30 days, are important for directory accuracy, they simply are not sufficient. If providers retire, move away, or die and never intend or are unable to notify a carrier of their network status change, such standards will not lead to accurate directories. It is therefore essential that additional standards be put in place to ensure that consumer rights to accurate directories are fulfilled.

As such, in addition to standards that require carriers to update their directories every 30 days, Families USA recommends CMS adopt the following additional provider directory accuracy standards for QHP issuers:

1. **A requirement that all plans prominently list on their directories an email address or phone number for members of the public to directly notify the plan when provider directory information is inaccurate, and a requirement that plans be accountable for investigating these reports and modifying directories accordingly in response.** This email address or other channel for submission should be used for no other purpose but collecting inaccurate provider directory information. Plans should be required to investigate reports of inaccuracies from the public and modify directories (such as by removing providers no longer in network) in accordance with the findings of the investigations within 7 business days of receiving the reports. Plans should be required to report annually to HHS on the number of reports received, the timeliness of the plans' response, and the corrective actions taken, and these data should be publicly available.

2. **A requirement that plans internally audit their directories and modify directories accordingly based on audit findings:** Plans should be required to call at least 30 percent of providers in each specialty in their directory twice a year (or for specialties in which 30 or fewer providers or facilities are listed, to call all providers and facilities in the specialty) to assess: 1) whether their contact information is correct, 2) whether they are really in the plan's network 3) whether they are taking new patients. If any of the information listed in the directory is found to be inaccurate based on the findings of the audit, the directory must be updated within one month of the date in which the specific inaccuracy is noted.

3. **A requirement that plans contact providers listed as in network who have not submitted claims within the past six months to determine whether the provider still intends to be in network.** Based on the provider's response, the plan must update the directory accordingly. If the provider does not respond within 30 days, the plan must attempt contact again, and if the provider does not respond within another 30 days, the plan must remove the provider's information from the directory. (This recommendation is based on a similar requirement under NJ regulation, N.J.A.C. 11:24C–4.6.)

4. **A requirement that plans honor provider directory information** such that if a consumer relies on materially inaccurate information from a directory indicating that a provider is in-network and receives care from that provider, the consumer is held harmless and the plan must pay the provider an in-network rate and charge the consumer only in-network cost-sharing for the care.

Implementing these standards will more directly address provider directory inaccuracies than simply waiting for updates from providers that may never come. These recommended standards will also serve to catch and eliminate inaccurate information that has lingered in directories for years because providers failed to submit changes or because plans failed to make updates based on reported changes.

In terms of how to populate and update provider directories generally, we are interested in whether CMS could discuss with issuers whether their claims payment systems or databases, as well as data they already have in house about which providers have current contracts with them, could be used to obtain accurate and timely information about which providers are in network that could be used for provider directories. Utilizing these existing technological resources seems like it could provide a more efficient and effective solution for creating accurate provider directories than relying solely on repeated and burdensome communication between issuers and providers.

We appreciate your consideration of our comments. Should you have any questions, please contact Claire McAndrew, Private Insurance Program Director, at cmcandrew@familiesusa.org or at 202-628-3030.