COLORADO
Department of Regulatory Agencies
Division of Insurance

Bulletin No. B-4.92

STANDARDS AND REPORTING GUIDANCE FOR PROVIDER DIRECTORIES FOR HEALTH BENEFIT PLANS

I. Background and Purpose

The purpose of this bulletin is to provide carriers offering health benefit plans with standards and guidance on the filing requirements for provider directories associated with health benefit plans. Provider directories are required pursuant to Federal law and § 10-16-704(9)(b), C.R.S. The standards and reporting guidelines contained in this bulletin regarding provider directories will help ensure that the Division receives complete network access filings.

Bulletins are the Division's interpretations of existing insurance law or general statements of Division policy. Bulletins themselves establish neither binding norms nor a final determination of issues or rights.

II. Applicability and Scope

This bulletin is intended to inform carriers that offer health benefit plans[1] and consumers of the specific provider directory standards required by current Colorado law[2]. This bulletin does not address any other filings not otherwise required by statute or regulation.

There are two (2) listings of providers and facilities associated with health benefit plan filings. The first listing is the Essential Community Provider (ECP)/Network Adequacy Template, which is submitted with the binder filing for each health benefit plan filing. This template listing will be validated and reviewed to assess compliance with Network Adequacy requirements. That filing is described in more detail in Bulletin 4.90 - Network Adequacy Standards and Reporting Guidance for Health Benefit Plans.

The second listing is the provider directory maintained by the carriers. Screen shots of the provider directories for each carrier must be filed annually with the Network Adequacy binder filings, and reviewed for completeness and compliance with this bulletin. Copies of provider directories will be made available to the Commissioner upon request.

[1] Defined at § 10-16-102(32), C.R.S.
[2] § 10-16-704, C.R.S.

III. Definitions

A. "Covered person" means, for the purposes of this bulletin, a person entitled to receive benefits or services under a health coverage plan.[3]

B. "Emergency services" means, for the purposes of this bulletin:

1. A medical or mental health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical or mental health condition; and

2. Within the capabilities of the staff and facilities available at the hospital, further medical or mental health examination and treatment as required to stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to an emergency medical condition.[4]

C. "Essential community provider" or "ECP" mean, for the purposes of this bulletin, a provider that serves predominantly low-income, medically underserved individuals, such as health care providers defined in the federal law and under part 4 of article 4 of title 25.5, C.R.S.[5]

D. "Network" means a group of participating providers providing services to a managed care plan. Any subdivision or subgrouping of a network is considered a network if covered individuals are restricted to the subdivision or subgrouping for covered benefits under the managed care plan.[6]

E. "Primary care" means health care services for a range of common physical, mental or behavioral health conditions provided by a physician or non-physician primary care professional.

F. "Primary care provider" or "PCP" mean, for the purposes of this bulletin, a participating health care professional designated by the carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person. For the purposes of network adequacy measurements, PCPs for adults and children includes Physicians (Pediatrics, General Practice, Family Medicine, Internal Medicine, Geriatrics, Obstetrician/Gynecologist); and Physician Assistants and Nurse Practitioners supervised by, or collaborating with, a primary care physician.

G. "Specialist" means, for the purposes of this bulletin, a physician or non-physician health care professional who:

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[3] § 10-16-102(15), C.R.S.
[4] § 10-16-704(5.5)(b)(II), C.R.S.
[5] § 10-16-704 (1.5)(a)(II), C.R.S.
[6] Managed Care Plan is defined at § 10-16-102(43), C.R.S.

1. Focuses on a specific area of physical, mental or behavioral health or a group of patients; and

2. Has successfully completed required training and is recognized by the state in which he or she practices to provide specialty care.

"Specialist" includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

H. "Telemedicine" or "telehealth" mean, for the purposes of this bulletin, a mode of delivery of health care services through telecommunications systems, including information, electronic and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a covered person's health care while the covered person is located at an originating site and the provider is located at a distant site. The terms include synchronous interactions and store-and-forward transfers. The terms do not include the delivery of health care services via telephone, facsimile machine or electronic mail systems.[7]

IV. Division Position

A. Provider Directories

Provider directories are comprehensive listings, produced and maintained by the carrier, made available to covered persons and primary care providers, of the plan's participating providers and facilities in each of the carrier's networks.[8]

Provider directories will be maintained by the carriers. Provider directories for each carrier must be filed to the Division annually, and updated no less frequently than monthly. Screen shots of the provider directory will be filed with the Network Adequacy binder filings, and reviewed for completeness and compliance with this bulletin.

Provider directories maintained by the carriers must meet the following requirements:

1. A carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions, as described in Appendix A. In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab without requiring an individual to create or access an account or requiring the entry of a policy or contract number. The carrier shall update each network plan provider electronic directory at least monthly.

2. A carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information described in Appendix A, Section 3 upon request of a covered person or a prospective covered person.

3. For each network plan, a carrier shall include in plain language, in both the electronic and print directory, the following general information:

[7] § 10-16-123(4)(e), C.R.S.
[8] § 10-16-704, C.R.S.

a. A description of the criteria the carrier has used to build its provider network;

b. If applicable, a description of the criteria the carrier has used to tier providers;

c. If applicable, how the carrier designates the different provider tiers or levels in the network and identifies, for each specific provider, hospital or other type of facility in the network, which tier each is placed (e.g., by name, symbols or grouping) in order for a covered person or a prospective covered person to be able to identify the provider tier; and

d. If applicable, note that authorization or referral may be required to access some providers.

4. A carrier shall make it clear, for both its electronic and print directories, which provider directory applies to a particular network plan, such as including the specific name of the network plan as marketed and issued in this state.

The carrier shall include, in both its electronic and print directories, a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the carrier of inaccurate provider directory information.

5. For the pieces of information required in a provider directory pursuant to Appendix A pertaining to a health care professional, a hospital or a facility other than a hospital, the carrier shall make available through the directory the source of the information and any limitations, if applicable.

6. A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

B. Requirements for Provider Directory Updates and Audits

1. The carrier shall include a disclosure in the directory that the information included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website or call the carrier's customer service telephone number to obtain current provider directory information.

2. The carrier shall update each network plan provider directory at least monthly. Current directories shall be made available to the Commissioner at any time, upon request.

3. To help improve the accuracy of the directories, the carrier shall contact providers listed as participating providers who have not submitted claims within the past twelve (12) months to determine whether the provider still intends to participate in the carrier's network, and retain the documentation of such contacts which is to be made available to the Commissioner upon request.

4. No less frequently than quarterly, the carrier shall audit at least 20% of the providers contained in their provider directories for accuracy and update that directory based upon

their findings. Documentation shall be retained of the process and findings of such an audit that shall be made available to the Commissioner upon request.

C. Provider Directory Attestation

The carrier shall attest to the Division for each provider directory included in a binder filing that each of its health benefit plans will maintain a Provider Directory for each network that meets the standards of Colorado Insurance Bulletin 4.90, Network Adequacy Standards and Reporting Guidance for Health Benefit Plans, and is maintained as specified in this bulletin.

This attestation will be included in the "Carrier Network Adequacy Attestations" document submitted in the Binder filing for each health benefit plan.

V. Additional Division Resources

Colorado Insurance Regulation 4-2-39
Colorado Insurance Regulation 4-2-41
Colorado Insurance Bulletin No. B-4.81
Colorado Insurance Bulletin B-4.90

For More Information

Colorado Division of Insurance
Life and Health Rates and Forms Section
1560 Broadway, Suite 850
Denver, CO 80202
Tel. 303-894-7499
Internet: http://www.dora.colorado.gov/insurance

VI. History

- Issued March __, 2016

Appendix A - Provider Directory Contents

1. The carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in a searchable format:

   (a) For health care professionals:
   - (i) Name;
   - (ii) Gender;
   - (iii) Participating office location(s);
   - (iv) Specialty, if applicable;
   - (v) Medical group affiliations, if applicable;
   - (vi) Facility affiliations, if applicable;
   - (vii) Participating facility affiliations, if applicable;
   - (viii) Languages spoken other than English, if applicable; and
   - (ix) Whether accepting new patients.

   (b) For hospitals:
   - (i) Hospital name;
   - (ii) Hospital type (*i.e.* acute, rehabilitation, children's, cancer);
   - (iii) Participating hospital location; and
   - (iv) Hospital accreditation status.

   (c) For facilities, other than hospitals, by type:
   - (i) Facility name;
   - (ii) Facility type;
   - (iii) Types of services performed; and
   - (iv) Participating facility location(s).

2. For the electronic provider directories, for each network plan, a health carrier shall make available the following information in addition to all of the information available under Section 1 above:

   (a) For health care professionals:
   - (i) Contact information;
   - (ii) Board certification(s); and
   - (iii) Languages spoken other than English by clinical staff, if applicable.

   (b) For hospitals and facilities other than hospitals: Telephone number.

3. The carrier shall make available in print, upon request, the following provider directory information for the applicable network plan:

   (a) For health care professionals:
   - (i) Name;
   - (ii) Contact information;
   - (iii) Participating office location(s);
   - (iv) Specialty, if applicable;
   - (v) Languages spoken other than English, if applicable; and
   - (vi) Whether accepting new patients.

(b) For hospitals:
    (i) Hospital name;
    (ii) Hospital type (*i.e.* acute, rehabilitation, children's, cancer); and
    (iii) Participating hospital location and telephone number.

(c) For facilities, other than hospitals, by type:
    (i) Facility name;
    (ii) Facility type;
    (iii) Types of services performed; and
    (iv) Participating facility location(s) and telephone number.