Illinois Department of Insurance

JB PRITZKER
Governor

DANA POPISH SEVERINGHAUS
Director

MEMORANDUM

TO: ALL COMPANIES WRITING ACCIDENT AND HEALTH INSURANCE AND MANAGED CARE PLANS IN ILLINOIS

FROM: Dana Popish Severinghaus, Director of Insurance dps

DATE: August 31, 2023

RE: Company Bulletin 2023-10 Provider Directory Audit Filings

---

The Illinois Department of Insurance ("IDOI") is providing guidance to all companies who are required to submit a Network Adequacy Filing related to provider directory audits under 50 Ill. Adm. Code 4540.60. These annual filings, the first of which were due July 1, 2023, and then must be filed by April 1 of every following year, consist of two components. The Department reminds insurers of the importance of the accuracy of their provider directories. The Department is committed to ensuring that consumers can access transparent and up to date information about the providers in the networks they pay for.

First, as described in Section 4540.60(a), the filing must provide information about the insurer's processes for keeping its provider directories up-to-date, accurate, and complete and for conducting self-audits and verifications of all provider directories. This component is a single, annual report giving an overview of the insurer's quality control mechanisms across all of the insurer's provider directories.

Second, the filing must include attachments of all unredacted reports that the insurer generated showing the results of every actual self-audit performed by the insurer on each of its provider directories during the previous calendar year. These are identified in the rule as "self-audit reports." For this second component, each self-audit report generated on or after July 1, 2023 for each provider directory must include a summary with the information described in Section 4540.40(c).

Further details are provided below.

Section 4540.60(a):

- For 2024 onward, the report shall be filed by April 1.
- An insurer shall file with the Department a report applicable to all provider directories of all its network plans that describes the protocols the insurer uses to ensure that it complies with the requirements in 215 ILCS 124/25 to keep each electronic directory up-to-date, accurate, and complete by updating it both at least monthly and within 10 business days of receipt of updated information from preferred providers, as well as to update the print directory and errata quarterly and to ensure that the print directory is accurate as of the date of publication.
- The report shall also describe the insurer's current verification process established pursuant to 42 U.S.C. 300gg-115(a)(2).
- The report shall also describe any changes to these protocols and to the verification process that have occurred since the beginning of the previous calendar year.

- The report shall describe all variances in the protocols and the verification process among the insurer's network plans or between its different provider directories, including any distinctions made among HMO and Preferred Provider Organization (PPO) networks.
- An insurer that demonstrates that, at all times during the audit period, the contents of any print directory are printed from the same data used for the corresponding online directory on the same date of printing is exempt from auditing the print directories separately. Even if an insurer meets this criterion not to perform separate print and electronic self-audits, the insurer must ensure it is clear in the annual report how its protocols and processes above apply to print directories.

Section 4540.60(b):

- An insurer must conduct two self-audits, per provider directory, per year, as required under 215 ILCS 124/25(a)(3).
- If an insurer had not completed a self-audit for a provider directory by the rule's effective date of March 28, 2023, it was required to audit the provider directory for that network plan and generate a report by July 1, 2023. Per the next bullet point, this self-audit report will be one of the attachments to the insurer's next annual filing due April 1, 2024.
- The insurer's unredacted internal self-audit reports generated during the previous calendar year shall be attached to the report required under subsection (a). This applies to **all** self-audits actually conducted during the previous calendar year, whether the insurer met, failed to meet, or exceeded the minimum of two self-audits per provider directory per year.
- If an insurer generated no self-audit reports during 2022, the above provisions mean that the first time the insurer will be required to file any reports of the results of actual self-audits under Section 4540.60(b) will be the 2023 self-audit reports attached to the annual filing due April 1, 2024. For an insurer in that situation, its July 1, 2023 SERFF filing was only required to include the annual report described in Section 4540.60(a).
- If an insurer generated self-audit reports during 2022 for some, but not all, of its provider directories, the insurer was only required to attach to its July 1, 2023 filing the self-audit reports it actually generated during 2022, in addition to submitting the annual report described in Section 4540.60(a). If the insurer complies with the requirement to perform at least two self-audits starting in 2023, then its April 1, 2024 filing would consist of the annual report and attachments of two or more self-audit reports for every provider directory.

Section 4540.60(c):

- In addition to any findings the insurer otherwise identifies in its self-audit reports, each self-audit report generated on or after July 1, 2023, must include a summary specifically identifying each print and electronic directory audited, the marketing name of each network plan using that directory, and the SERFF Tracking Number of the most current filing under 215 ILCS 124/10 that contained the directory.

  The summary must specify, at a minimum:

  4540.60(c)(1)-(5): The information described in the **Audit Summary Template** attached to this Company Bulletin. Insurers may use their own format for the summary in lieu of the template as long as they provide the data required by rule. Insurers that use the template should fill out a separate copy for each provider directory self-audit report they submit. The summary of "combined totals…across all directories provided by the insurer," which is reflected in the "c.5-All" column on the template, should include the combined totals for the calendar year as of the date the self-audit report was generated. Regarding the rule requirement that information be provided "for each specialty type in that directory," the Department recognizes that there are different lists of individual and facility provider specialties provided under Section 4540.40(d) versus Section 4540.40(e). The Audit Summary Template includes

provider specialties from both specialty lists, but the insurer only needs to submit data in the template for the individual and facility specialties that the audited provider directory actually used.

4540.60(c)(6): A high-level evaluation of the effect of known internal or external processes or circumstances and changes to those processes or circumstances on the accuracy of the insurer's directories and the timeliness of updates to directory information under State and federal requirements. One example of an external process or circumstance would be any entity other than the named insurer that provided services related to the insurer's provider directories, including directory updates or audits. These entities and their role should be clearly identified in the high-level evaluation.

Section 4540.60(e):

The Director may request additional information upon receipt of a self-audit report and may at any other time audit the accuracy of any network plan's provider directory.

To assist with the audit and verification of the accuracy of provider directories and the information therein, **the Department requests that insurers submit the following beginning with the filing due April 1, 2024**:

- With each electronic directory self-audit report, inform the Department whether the public directory is accessed through an electronic or online version of the print directory (such as a PDF of the complete provider directory) or a provider search tool. A provider search tool is a searchable online tool that enhances the consumer experience when searching for an In-Network Provider.
- For verification of the accuracy of the self-audit reports, attach the active provider contract or notice of termination for each provider whose directory information was audited.
    - The Department will consider a provider contract submission *adequate and transparent* if it contains the following:
        - The date the contract went into effect.
        - Language stating the contract is currently in effect or notice of termination.
        - Signatures from all parties subject to the contract
- Each self-audit must include:
        - Contacting providers who, within 1 year prior to the audit date, have not submitted claims or communicated an intent to continue participating in the network.
        - Contacting effort results
- For submission of the reports, the Department has had the following TOI/Sub-TOI established within SERFF that should be utilized:
    - TOI: – "NA00 Network Adequacy"
    - Sub-TOI "NA00.002 Network Adequacy Directory Audit."

Questions about this bulletin may be directed to DOI.InfoDesk@illinois.gov.