Preparing for the Era of Provider Directory Transparency

February 2, 2021

faegre drinker

QUEST ANALYTICS

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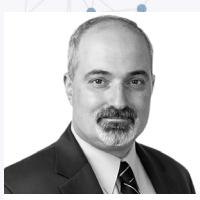

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Agenda

1. The Provider Directory Regulatory Landscape
2. Ensuring Compliance
3. Preparing for the New Era of Transparency

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The Regulatory Landscape

Mike Adelberg

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Why We Should Care about Provider Networks

- On most days, for most of health plan members, the provider network IS the health plan
- 80% or more health plan dollars are paid to network providers
- Besides members, network providers are the health plan's most important constituency
- Network providers are more responsible for plan quality and quality scores than any other part of the health plan
- Network providers and access to them is a large driver of member retention and instability draws member complaints, unflattering media, and regulatory attention

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Regulator Fines in the Last Five Years

Government attorneys won $5M and $15M settlements against health plans for network misrepresentation

CA: Fines Medicaid plan $600,000 for provider directory inaccuracies

WA: Fines Exchange plan $500,000 for inadequate network

MA: Fines Commercial plan $80,000 for inadequate behavioral health access

CMS audits Medicare Advantage provider directories over three years

- Medicare Advantage provider directory error rate based on report
- 45%
- Warning letters issued to 21 of 54 survey MA plans

CMS fines national MA plan $1M for pharmacy directory errors

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What are Provider Associations Saying?

In 2019 American Medical Association writes five-page letter to CMS calling for more vigorous provider network oversight.

Other provider trades have launched secret shopping projects to document network gaps.

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Where are Provider Networks Today?

Mike Adelberg

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What do we know about provider networks today?

Central findings from three recent studies.

FRAKT, ET AL, *HEALTH AFFAIRS*

- MA plan broad networks increased from 80.1 percent in 2011 to 82.5 percent in 2015.
- Enrollment in broad-network plans grew from 54.1 percent to 64.9 percent.
- HMOs networks are narrower than PPO and HMO-POS networks.

HAEDER, ET AL, *HEALTH SERVICES RESEARCH AND MANAGERIAL EPIDEMIOLOGY*

- Looking at CA, MA networks have 25-35% of Medicare physicians in metro areas, and higher percentages in more rural areas;
- MA networks are less likely to include the highest quality physicians in rural areas.

ADELBERG, ET AL, *AMERICAN JOURNAL OF MANAGED CARE*

- Provider directories are widely inaccurate.
- PDF MA directories are slightly more accurate than machine-readable (MR) Exchange directories, but …
- Google addresses are more accurate than both.

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Medicare Advantage Directory Oversight

For three years, CMS conducted provider directory accuracy reviews

- Outbound calling to provider offices to confirm directory information
- Each of the three years, roughly half of the offices had incorrect information in the directory
- Tremendous diversity in results (less than 10% error rates for top MAOs; 90% error rates for lowest MAOs)
- Call Letters threaten enforcement actions for repeated high error rates
- Majority of MAOs receive warning letters

In Call Letter for 2020, CMS stepped away from threatening language and discussed need to collaborate with MAOs on "source of truth"

- January 2020 - NPPES memo offers a collaborative path to accuracy

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Medicaid Provider Directory Requirements

State Medicaid programs use multiple methods to monitor MCOs Provider Directories

1. All State's review MCO supplied data and require MCOs to verify their data
2. Majority of State's audit directories as part of an external quality review process
3. Most State's require paper directories to be updated at least monthly
4. Some State's require payers to update their online directories weekly and conduct directory audits
5. Many States are adding additional data element requirements like ADA accessibility, cultural competency training, and telehealth indicators

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Machine Readable Directories

- Machine Readable Directories have been required in the ACA exchanges for four years (more in some states)
- Federal exchanges use machine readable directories to:
  - Power a national "doc finder" tool on healthcare.gov
  - Power a network breadth consumer tool
- Data posted in a common format; easily downloaded at any time
  - Can be used by regulators for oversight
  - Can be used by competitors for comparisons and network analysis
  - Can be used by researchers for trending
- CMS implementing the Interoperability regulation
  - National API standard for Medicaid and Medicare Advantage directories
  - Forms the basis for a national "source of truth" on provider information
  - CMS recently announced that enforcement will begin July 1

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The Interoperability Regulation: API Provider Directories

CMS Interoperability regulation finalized and delayed to July 2021

- Requires MA and Medicaid FFS provider directories be posted electronically in a common API
- Similar to the "machine readable" requirement for Health Insurance Exchange provider directories
- Proposed Medicaid managed care rule – expands provider directory APIs to Medicaid Managed care plans

Implications for transparent directory information

- 3rd parties will establish "doc finder" tools and log inaccuracies
- "Thicker" networks will be measured and actively marketed by competitors
- Network adequacy and accuracy are today's measures; network stability is tomorrow's measure

The Recently Passed - NO SURPRISES ACT

Applies to self-funded plans and fully insured individual and group plans who are not subject to state-specific provider directory laws.

JANUARY 1, 2022

Plans must establish a provider directory verification process & establish a procedure for removing providers or facilities with unverifiable information

90 DAYS

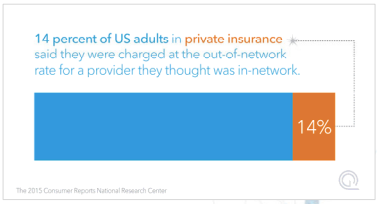
Not less than once every 90 days, plans must verify and update their provider directory database

2 BUSINESS DAYS

Plans will be required to update their directory database within 2 business days of receiving a provider update

1 BUSINESS DAY

Plans must respond to consumer provider directory telephone calls within one business day of receiving a request



New York Times Article: *Surprise Medical Bills Cost Americans Millions. Congress Finally Banned Most of Them.*

Ensuring Compliance

John Weis

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Directory Compliance Challenges

DIFFICULTY OBTAINING PROVIDER UPDATES

Infrequent provider updates and outreach

MULTIPLE COMPLIANCE REQUIREMENTS

Varying compliance requirements across lines of business and states

INACCURATE DATA

Difficulty identifying what's right, wrong, and missing in the data

ORGANIZATIONAL SILOS

Multiple departments managing directories for different lines of business

INFLATED NETWORKS

Network adequacy and accuracy are not measured together

MEMBER DISATISFACTION

Members use outdated directory to choose a plan and determine if their providers are in network

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Creating a Verification Process

Health plans must develop am process to remove providers who have NOT verified their information.

- Conduct outreach at least quarterly (required for MA and now private insurance lines)
- Include the ability to audit provider outreach and results
- Use primary sourced data whenever possible
- Ensure each provider last verification date is included in your directory data
- Incorporate an accuracy score into each network (the same way CMS does)

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Managing Regulatory Compliance Across All Lines

- Follow the most stringent requirements and incorporate them across all lines of business
- Partner with vendors who have established relationships with state and federal regulators
- Use flexible systems that allow for adoption of new regulatory requirements

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Ingesting Accurate Verified Data

PROMOTE

Promote what is right so the good data surfaces

DEMOTE

Demote what is unknown so less confident data points do not surface on a search

FIX AND NOTE

Fix what is wrong and note the impact

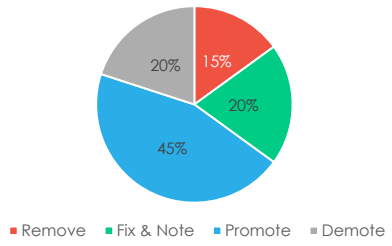
Removing Organizational Silos

- Align provider management staff across lines of business – (Medicaid, MA, Exchange, Pharmacy, and Commercial plans)
- Use the same system to measure, manage, and monitor directories in each line in the same way (interoperability provider directory APIs will expose companies who do not do this)
- Dedicate consistent resources to measure, manage, and monitor directories at the enterprise level

Eliminating Inflated Networks

Because you can't have Accuracy without impacting Adequacy

Typical Provider Network



A typical provider network includes anywhere from 10-30% of providers that are no longer practicing. Remove these providers and what happens to your network?

Accuracy & Adequacy

Remove and identify providers

Inactive

Remove deceased, retired and OIG excluded providers

Excessive Addresses

Flag providers who are listed at more than five addresses and verify they are seeing patients at each location

Suspect Specialties

Take note and verify providers are listed as having multiple unrelated specialties

Increasing Membership Satisfaction

- Ensure the directory is accurate reflection of the network to avoid unfair marketing consumer complaints
- Reduce the risk of members scheduling appointments with out of network providers (reduces costly arbitration billing disputes)
- Decrease consumer scheduling and access frustrations to increase Star ratings (consumer experience will make up 1/3 of the MA Star rating metric in 2023)
- Consumer knowledge will improve due to interoperability - errors will be easily exposed and could reduce consumer confidence in your plan

Preparing for the New Era of Transparency

John Weis

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New Era of Transparency

Regulators are interested in measuring the following

Aligning with new compliance factors
Social Determinants of Health (SDoH)
Telemedicine
Surprise Billing & Narrow Networks
Network Cost & Quality
Provider Utilization

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Ensuring Audit Readiness & Access to Care

Q&A

Are you ready?	
	How are you currently verifying your provider data? With what frequency? What attributes do you verify?
	How do you ingest updates into your provider directories? With what frequency? Do you leverage updates across all lines of business?
	Do you know the age of your data? Do you know the percentage of providers who have not verified in the past 6 months? Do you have a process for eliminating non-verifying providers?
	Can you measure, manage and monitor your accuracy score? Do you know the impact your accuracy has on your network adequacy?

Are you measuring Accuracy + Adequacy Together?

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"Transparent networks create risks for health plans but will also enable greater understanding of common and leading plan practices."

The Era of Provider Directory Transparency

Compliance Today | August 2020

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