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T O P L I N E

Directory Accuracy and Network Adequacy as a Strategic Initiative for Healthcare Payers

Streamlining provider operations can prevent fines, increase member loyalty, and position payers for telemedicine.

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Introduction

More than the internal systems backbone for network definition and demographic capture, the provider data asset differentiates the payer's tangible image for the consumer. Thus the ability for a member to understand and easily consume the provider service options within the network via searchable directories is paramount.

For years, consumers have complained that payer directories were inaccurate, out of date, and generally hard to use. At first, payers responded by putting their paper directories online; members could digitally see their provider options, but often the online directory data was incorrect. As a result, members experienced out-of-network charges, new patients couldn't find open providers, and overall consumer satisfaction continued to decline. Inaccurate and inadequate provider data is no longer acceptable in a payer environment that is increasingly litigious, regulated, consumer focused, competitive, and transparency oriented. Directory accuracy and network adequacy is on the table because of:

- Increasing pressure to prove network adequacy
- Necessary compliance with the Affordable Care Act (ACA)
- Emergence of the individual health marketplace and required access to "provider search"
- Consumer outcry about poor data quality after executing a search
- State and federal regulations about how often directories need to be updated and how networks must be "adequate"
- Recent Centers for Medicare & Medicaid Services (CMS) regulations, aligned with America's Health Insurance Plans (AHIP), National Association of Insurance Commissioners (NAIC), and Council for Affordable Quality Healthcare (CAQH) recommendations about what fields are required, how audits will be conducted, and what fines will be levied

How Bad Is the Problem?

Payers, providers, and vendors generally agree that provider data is changing all the time. Estimates abound that:

- 2% of provider demographics change each month.
- 20–30% of doctors change affiliations each year.
- 5% of polled doctors change "status" each year (lose license, die, retire, sanctioned).
- If payers had 100% accuracy in their database, in 18–24 months, around 50% of the records would have errors/omissions.

One vendor claims that in its survey of 200 health plans, payers in the United States are 55–70% accurate on critical directory fields.

Why Is There a Problem?

This industry problem has been present for decades. Payers generally have one initiative a year to "fix" the provider data problem, the results of which are expected to last for many years. These initiatives are usually microfocused on issues such as claims pass rate or credentialing workflow. They ignore macroconditions such as the following:

- Regulations are pointed to payers to get them to comply, but the source of the data is the providers.
- Payers execute human errors in entering the data coming into claims or provider relations.
- There is no single point of data entry; all entry points have their own edit and error criteria.
- Data integration challenges exist across data sources and organizational silos; an enforced "system of record" rarely exists in payer organizations.
- Providers are resistant.

Who Is Affected Inside the Payer Organization?

As payers consolidate and/or rethink their provider subject area, they would be well-served to consider a holistic, decoupled approach to restructuring their Provider 360 data architecture and optimizing the process workflow that produces and maintains it through digital transformation. Provider operations (recruitment, onboarding, credentialing, contracting, pricing, directory) is rife with manual, paper-intensive, cross-departmental, and fragmented processes.

In the future, we will see increasing cross-pollination and integration between payers and providers. Payer core systems (claims, payment, and enrollment) and provider-hosted systems (revenue cycle management, care coordination, provider scheduling, and telemedicine enablement) will converge both within and outside the portal concept. Payer-enabled scheduling, payer-facilitated care plans, and payer-encouraged steerage to laddered virtual medicine protocols will become the norm.

Why Is Directory Accuracy and Network Adequacy Important for Payers?

In 2016, new federal regulations allowed the CMS to fine payers up to $25,000 per beneficiary for errors in Medicare Advantage plan directories and up to $100 per beneficiary for errors in plans (medical or standalone dental) offered on the federal insurance exchange Healthcare.gov in 37 states. Payers found in violation of the CMS rules could also be banned from new enrollment and marketing.

States are also focusing on this consumer problem, recognizing that consumers are upset about incurring out-of-network costs because of inaccurate or outdated provider directories. A five-month investigation by the Department of Managed Health Care in California in 2014 found that more than 18% of doctors listed in Blue Shield of California's directory were not at the location listed and nearly 9% were unwilling to take patients enrolled in the Covered California exchange, "despite being listed on the website as doing so." Also in California, some 12.5% of physicians in Anthem's directory were not at their listed locations and nearly 13% were not accepting state exchange patients. The investigation resulted in a November 2015 ruling against Anthem and Blue Shield and subsequent rebates by Blue Shield of $38 million.

States have begun to take a variety of regulatory actions. For example:

- Over half of the state Medicaid agencies mandate outreach and frequency of update on a monthly, quarterly, or annual basis.
- California, Maryland, New Jersey, the District of Columbia, and Vermont require proactive verification of provider data elements.
- All but 12 states have provider directory requirements for some types of state health plans.
- In California, SB 137, implemented in July 2016, requires:
  - A standardized provider directory template for California insurers
  - That payers make their directory viewable online to the public
  - Updating directories at least weekly
  - Updating the printed provider directory at least quarterly
  - A plan to reimburse an enrollee or insured for any amount beyond what the enrollee or insured would have paid for in-network services, if the enrollee or insured reasonably relied on the provider directory

Payers need to pay attention to this seismic shift in the regulatory environment.

Be Ready for Increased Network Adequacy and Directory Quality Audits

CMS is cracking down on Medicare Advantage plans that have skimpy provider networks and inaccurate provider directories. CMS officials talk specifically about these enforcement efforts in the 2017 advance notice and 2017 draft call letter for the Medicare Part C Medicare Advantage plan program and the Medicare Part D prescription drug plan program. In a section on Medicare Advantage and Medicare Part D audits, officials say they are conducting wide-scale efforts to monitor network adequacy and provider directory accuracy that are separate from the normal audit process. Enforcement group officials will use the monitoring results to audit and validate correction of any problems found. According to CMS officials, "Those organizations [that] fail to correct and come into compliance with these requirements may be subject to possible enforcement action, including civil penalties or enrollment sanctions."

Officials say they have received many questions about how CMS calculates "civil money penalties" or fines. CMS plans to post a memo on how it interprets the penalty calculation rules at some point in 2017.

Set the Table for Telemedicine/Virtual Care Network Design Alternatives and Changes to Network Adequacy Variables

Two facts jump out to anyone looking at directories and networks. First, network design is changing to incorporate virtual and retail care. Second, because network design is changing, the in-network, primary physician, time-and-distance network adequacy measurement model simply does not apply in the future; more variables are present, and these variables are relevant. A legitimate directory ecosystem establishes the environment to allow these disruptive and transformational network trends to be accommodated.

Using Digital Transformation to Find a Solution

Consider the following two fundamental tactics for how to address directory accuracy and network adequacy:

- Establish a virtual or physical *system of record*, a canonical *data access mart* with accompanying *integrated workflow* and SOA *services*
  - Buy or build an independent flexible system of record that holds authoritative structured provider data, or meld data from multiple sources using transformative business process management (BPM) software to give the seamless appearance of one system of record
  - Set up a corresponding/linked unstructured data store to be referenced by document automation and those wishing to view "attachments" to the structured data, or meld that data using transformative BPM software to virtually connect the data
  - Deploy a ubiquitous workflow to enable the many departments listed in the directory to coordinate in an automated, paperless, streamlined fashion using BPM software
  - Create a universal (canonical) data mart for all access, with real-time data integrity from the system of record
    - Allows vendor change-out of the system of record
    - Standardizes and homogenizes data terms across the enterprise
    - Enables SOA services from the data mart for internal and external information access
- Enable business capabilities incrementally in a decoupled way using digital transformation software
  - Consider cross-functional needs among departments when automating to improve capabilities within any single department
  - Build a *universal workflow* across the landscape to continuously validate and disseminate the data from the system of record downstream in a one-way flow
  - Choose vendors based on flexibility and API richness; *avoid highly coupled applications*
  - Enjoy better first-pass rates, better match rates, less claims adjudication effort, and improved customer service and member directory satisfaction