Provider Directories Review Update

Kerry Casey

Jim Canavan

Division of Surveillance, Compliance, and Marketing, Medicare Drug & Health Plan Contract Administration Group, CMS

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Agenda

- Background
- Review of Provider Directory Guidance
- Overview of Provider Directory Review Process
- Overview of AHIP's Provider Directory Initiative

Background

- First review cycle ran from February to August 2016
- 54 Parent Organizations reviewed
- Sampled 108 providers from four provider types:
  - PCPs
  - Ophthalmologists
  - Oncologists
  - Cardiologists
- Included 5,832 providers and approximately 11,646 locations
- Review found an average provider location error rate of 41%

Current Status

- Second review cycle began in November 2016.
- Review is looking at the same provider types as previous cycle.
- Plans receive results on a rolling basis.

Provider Directory Guidance

- January 17, 2017 HPMS Memo
  - "Provider Directory Policy Updates"
- Chapter 4 of the Medicare Managed Care Manual
- Medicare Advantage and 1876 Cost Plan Model Provider Directory

Provider Directory Memo Highlights

- Include a notation identifying providers who are accepting new patients OR a notation identifying providers who are NOT accepting new patients
- Make sure the meaning of notation is clear
- Don’t assume specialists are taking new patients

What does this mean if I don’t tell you?

Provider Directory Memo Highlights
Polling Question 1

What notation does your Provider Directory use?

a. Provider IS accepting new patients
b. Provider is NOT accepting new patients
c. We are updating our directory to include this required notation
d. Other

Provider Directory Memo Highlights

- If listing providers prior to the contract effective date, include the date in the directory.
- If a provider has a known contract termination date, include the date in the directory.

Elaine Jones, Oncologist Available as of 1/1/17 456 Howard St Baltimore, MD 21211 410-444-1234	Peter Chang, Cardiologist Not available after 9/30/16 789 Charles St Baltimore, MD 21218 443-555-1234

Provider Directory Memo Highlights
Polling Question 2

When does your plan start listing a new provider in the directory?

a. After the contract is signed, before the effective date
b. On or after the effective date
c. Other
d. I don’t know

Provider Directory Memo Highlights
Polling Question 3

When does your plan remove a provider from the directory?

a. As soon as we know the provider's contract is terminating
b. On or after the termination date
c. Other
d. I don't know

Provider Directory Memo Highlights

- Identify when a provider has significant limitations on patients they see
  - Examples:
    - A provider certified in oncology who practices as a bone marrow transfer specialist and only sees patients referred by their oncologist
    - A provider only accessible to members of a Native American tribe

Provider Directory Memo Highlights
Polling Question 4

Is your plan currently able to identify limitations on what types of patients a provider sees at a location?

a. Yes
b. No
c. We're working on it
d. I don't know

Provider Directory Memo Highlights

- Directories may only include providers at those locations where plan members can schedule appointments.
  - What we've seen:
    - Providers whose duties are administrative only
    - Doctors who oversee clinics where only nurse practitioners/physician assistants see patients
    - Providers who see patients at walk-in/urgent care clinics
    - A provider with admitting privileges at a hospital, but who is unavailable for routine visits

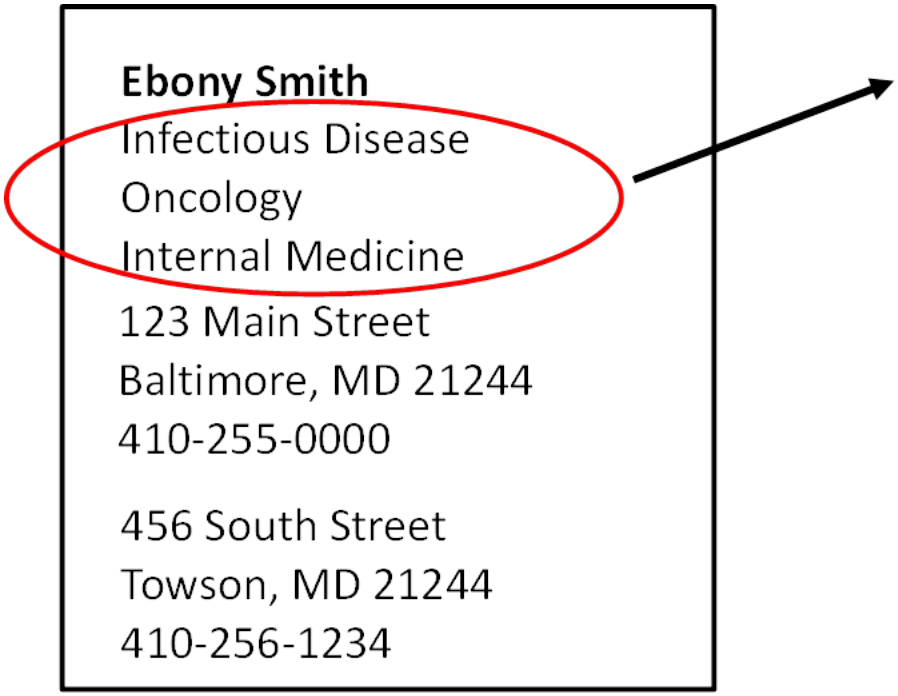
Provider Directory Memo Highlights
Polling Question 5

Is your plan currently able to identify locations where a provider routinely sees patients?

a. Yes
b. No
c. We're working on it
d. I don't know

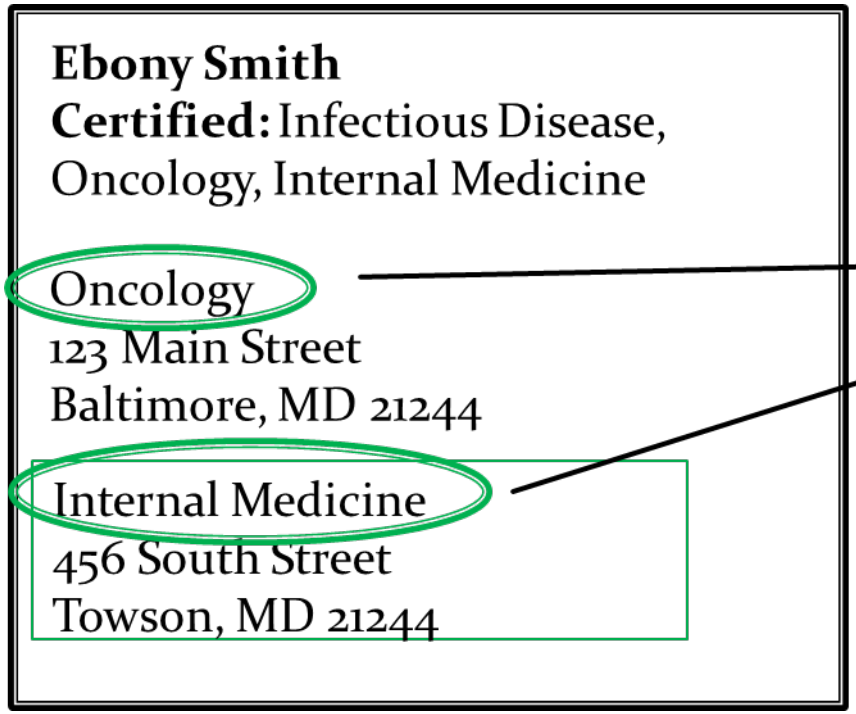
Provider Directory Memo Highlights

- Make clear what type of medicine a provider is practicing.



Does the provider practice all these specialties at both locations?

Provider Directory Memo Highlights



If not, now I know what type of medicine Dr. Smith practices and where she practices it.

Provider Directory Memo Highlights
Polling Question 6

Is your plan currently able to identify the specialty a provider practices at a location?

a. Yes
b. No
c. We're already working on it
d. I don't know

Recapping the Process

- CMS Online Provider Directory Review
  - Operational aspects of the review process
  - Common elements
  - Where to send questions

Review Process

- CMS Contractor
  - Calls locations determined by CMS selection methodology
  - Reports data to CMS on a plan-by-plan basis
- CMS reviews data; makes initial determinations
- Plan reviews data; responds to CMS
- CMS makes final determinations and sends to plan

Common Elements

- Aligned perspective
  - CMS's perspective is as a plan member trying to schedule an appointment
- Use of tools other than credentialing data or provider group reporting
  - Credentialing and provider group data is for purposes other than allowing patients to schedule appointments
- Facilities listed as facilities, providers as providers

Contact Information

Online Provider Directory Review

Kerry Casey, Kerry.Casey@cms.hhs.gov

Jim Canavan, James.Canavan@cms.hhs.gov

Provider Directory Policy

Medicare Part C Policy Mailbox: https://dpap.lmi.org/

America's Health Insurance Plans Provider Directory Initiative: Review and Overview of Results

Jeanette Thornton
Health Plan Operations & Strategy,
America's Health Insurance Plans

May 10, 2017

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Agenda

- Overview of AHIP Initiative
- Overview of AHIP Pilot Evaluation and Findings
- Next Steps

Federal Requirements

- Must be updated on a regular basis and include: network information, provider name, address, phone number, specialty, institutional affiliations, and whether the provider is accepting new patients
- Additional requirements include:
  - **Medicare Advantage**: MA Plans are required to proactively communicate with contracted providers on a quarterly basis and directory updates must be completed within 30 days of receiving the information. CMS conducting ongoing audits.
  - **Exchange**: Federal Marketplace requires “machine-readable” posting that is used for Healthcare.gov provider search tool. Updates required every 30 days.
  - **Medicaid Managed Care**: Directories must list the provider’s cultural and linguistic capabilities and available accommodations for people with disabilities (effective 7/1/17).

State Activity

- NAIC Network Adequacy Model with Provider Directory Standards Approved in December 2015
- AMA proposing Provider Directory Model Bill at NCOIL (Rejected twice)
- Seven states passed provider directory requirements in 2014 - 2016, with others adopting regulations
  - CA, DE, FL, GA, IL, MD, WA with NJ pending
  - CO (permanent regs) and VT amended regs
- At least 9 states poised to debate provider directory standards in 2017:
  - Bills: CT, HI, IL, MA (draft), MO (dental), NY, and RI
  - Regs: Proposed in DE and TX

AHIP Initiative History

• Establish CEO Task Force & Operations Group	Mar 2015
• Determine Overall Approach for Pilots	Jul 2015
• Evaluate and Select Vendors	Oct 2015
• Determine Pilot States	Nov 2015
• Recruit Plans to Participate	Dec 2015
• Launch Pilots	April 2016
• Pilot Wraps	Sept 2016
• Evaluation Complete	Jan 2017

AHIP Pilot Goals

- Improve the accuracy of provider directories to benefit consumers regardless of whether they are covered by private insurance or public programs such as Medicare and/or Medicaid.
- Reduce the number of provider calls and contacts and develop a more efficient approach for providers to update their information for ALL plans.
- Test different approaches to identify the most effective path to a potential solution at a national level.

AHIP Pilot Participants

	Availity	BetterDoctor	
Pilot state	Florida	California	Indiana
# of Plans	5	9	2
Requirements	MA	MA, SB 137	MA
Approach	Leverage existing electronic resources used for eligibility inquiries, claims submissions, portal notifications and other provider-related administrative activities.	Develop outreach methods from scratch and test effectiveness of different media and techniques, i.e., phone calls, faxes, emails based on an aggregation all participating health plan data.	

AHIP Pilot

- Findings and Conclusions

Summary Statistics: Availity

Measures Related to Effectiveness of the Vendor's Process for Achieving Provider Data Validation	Availity Outcome
Estimated providers notified of a request for attestation via Availity portal	51,071
Percentage of practices with a contact attempt	100%
Percentage of practices successfully contacted	35.3%
Percentage of providers who completed the validation process	18.6%
Average number of notifications required to complete the validation process	7.1 notifications

Summary Statistics: Availity (cont.)

Measures Related to Provider Burden and Data Quality	Availity Outcome
Average number of questions asked (for a one-provider, single-location practice)	18.1 questions
Percentage of key data elements edited by providers when they submit data to the vendor	63.9%

Summary Statistics: BetterDoctor

Measures Related to Effectiveness of the Vendor's Process for Achieving Provider Data Validation	BetterDoctor Outcome
Providers contacted by BetterDoctor	109,857
Percentage of providers with a contact attempt	99.8%
Percentage of providers successfully contacted and responded with MA-compliant validation	47.5%
Percentage of providers who completed the validation process	18.4% (CA SB 137)
Relative success of different modes of contact	18.1% (Fax to online form) 39.2% (phone call)
Average number of contacts required to complete the validation process	2.3 contacts (Q2) 1.4 contacts (Q3)

Summary Statistics: BetterDoctor (cont.)

Measures Related to Provider Burden and Data Quality	BetterDoctor Outcome
Average amount of time required by provider to complete validation	16.3 minutes (online form) 4.2 minutes (phone)
Average number of questions asked (for a one-provider practice)	37 questions (online form) 24 questions (phone)
Percentage of key data elements edited by providers when they submit data to the vendor	54.8%

Key Themes from Evaluation

- Provider Engagement
- Provider Accountability
- Technical Standards

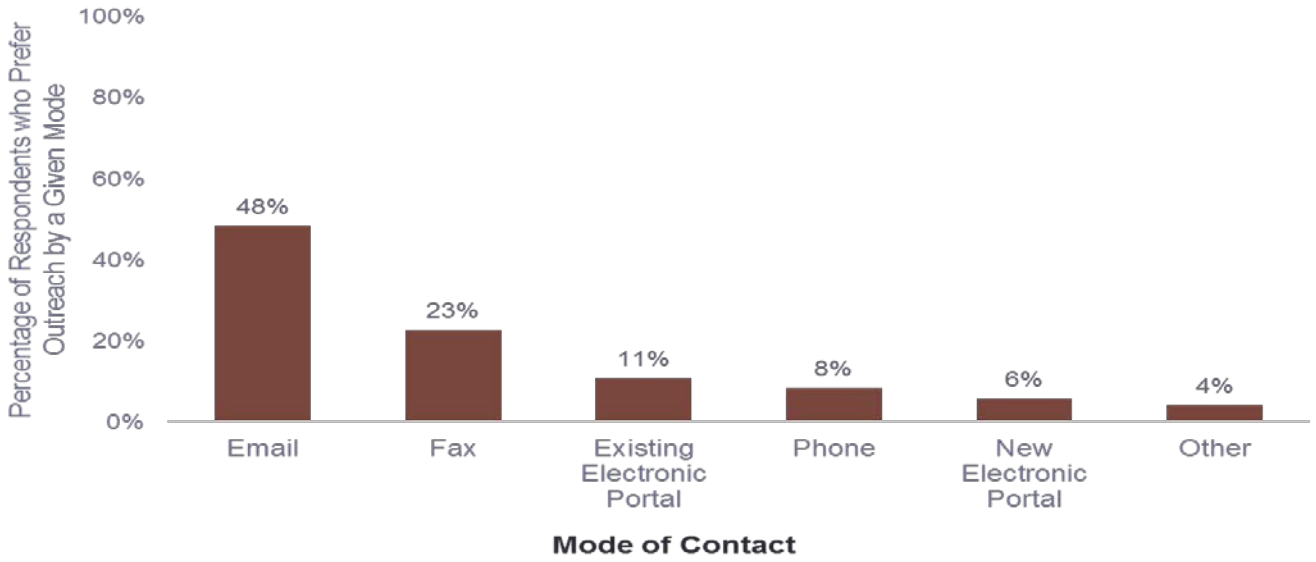
Provider Engagement

- Surveys indicate providers are familiar with provider directory topics

Vendor	Availity	BetterDoctor	
State	Florida (n=85)	California (n=416)	Indiana (n=54)
Aware that insurance plans provide members with search tools to find doctors that are in-network and accepting new patients	96%	98%	100%
Before taking the survey had heard of "provider directory" and knew what it meant	93%	94%	98%

Provider Engagement (cont.)

- Providers Prefer Email Outreach
  - BetterDoctor Provider Preferred Mode of Outreach



Provider Engagement (cont.)

Completed validation is highest via telephone

- BetterDoctor completed validation by mode of contact:
  - Fax to online form: 18.1%
  - Phone call: 39.2%
- Availity completed validation:
  - Online portal: 18.6%

Provider Engagement (cont.)

Conclusion: Providers' preferred method of engagement is not the most effective

- Email and electronic outreach are less burdensome – can be deprioritized or disregarded
- Phone outreach is more burdensome or intrusive – puts pressure on the provider at the time of the outreach
- Plans should consider:
  - How to balance reducing burden while utilizing most effective outreach methods
  - Multiple complementary outreach methods

Provider Engagement (cont.)

Conclusion: Flexibility and Cultivating Trust is Key

- Pursue flexible approach to strategy
  - Hear from plans and providers
  - Allow for iteration
- Ensure providers understand how data will be used and protected
- Consider proactive education prior to vendor outreach
  - Independently
  - Coordinate with provider associations/local stakeholders
- Make it easy for providers to confirm the vendor's role

Provider Accountability

Plans/Providers Indicated Challenges with Managing Provider Contracts

- Lack of consistency in health plan management of provider contracts
- Necessary language is in contracts, but it is not enforced given importance of network participation
- Providers don't realize that they are accountable through contracts

"Providers have no incentive to keep directories up to date unless it is included in the contracts…" – Staff Member from Participating Plan

Provider Accountability (cont.)

Conclusion: Enhance/Enforce Contractual Requirements

- Leverage contractual agreements to promote engagement
- Consider combination of incentives & penalties that mirror those for plans
- Identify contractual provisions that hold providers accountable for non-responsiveness
- Raise provider awareness of existing compliance responsibilities

Provider Accountability (cont.)

Plans and Providers Indicated Uneven Accountability

- Coordinated effort but uneven accountability for ensuring timely data updates
- Providers have priorities that aren't necessarily aligned with plans

"I don't have time to answer individual phone calls or emails in our busy practice, as I do other things…" – Provider participating in pilot

Provider Accountability (cont.)

Conclusion: Increase Shared Responsibility for Providers

- Incentives and penalties for health plans should flow down to providers
- Without carrot or stick, provider directories are lost in the noise
- Communication, guidance and collaboration are essential in instilling a sense of ownership

Technical Standards

Plans Reported Challenges with Coordination of Data Integration

- Plan Survey Responses: What are the most important factors in ensuring timely and accurate directory data?
  - “Actionable data file export”
  - “Data needs to be easily ingested”
  - “Digestible format”
- Loss of time addressing file formats and technical integration issues

Technical Standards (cont.)

Conclusion: Adopt Industry-Wide Standards

- Develop industry-wide (i.e. plans, providers, and other stakeholders) set of standards for provider directory data definitions, file format protocols, and other validation standards
- Focus on more efficient sharing of data between plans and providers

Technical Standards (cont.)

Providers reported one-sided communication

- Providers generally confused about the process for maintaining directory data
- Providers and other consumers have suggestions for how to improve user experience related to provider directories

"Make it easier to ask a question." – Provider participating in pilot

Technical Standards (cont.)

Conclusion: Facilitate Ongoing Provider Input

- Plans should adopt standard processes and channels for allowing providers and other consumers to flag provider directory discrepancies.

Menu of Strategies for Maintaining and Updating Provider Directories

Provider Engagement

- Balance outreach methods burden with effectiveness
- Use complementary outreach methods
- Pursue flexible & iterative approach
- Seek feedback from stakeholders, i.e., providers
- Conduct proactive education about how data will be used & protected prior to & during vendor outreach
- Make it easy for providers to confirm the vendor's role

Provider Accountability

- Leverage contractual agreements to promote engagement
- Consider combination of incentives & penalties that mirror those for plans
- Identify contractual provisions that hold providers accountable for non-responsiveness
- Raise provider awareness of existing compliance responsibilities

Technical Standards

- Develop industry-wide standards for data definitions, file format protocols, & other validation standards
- Focus on more efficient sharing of data between plans & providers
- Acknowledge that establishing mutually acceptable standards requires time & iteration between health plans, third party vendors, & other stakeholders
- Lack of provider awareness & engagement further complicates the process
- Collaborate with stakeholders & set meaningful, long-term goals
- Ensure that validation files clearly identify which data have been updated for audit trail
- Adopt standard processes & channels to allow providers & other consumers to flag provider directory discrepancies

Next Steps

- Education and Outreach
- For more information review AHIP Issue Brief on Key Findings:

https://ahip.org/provider-directory-initiative-key-findings/