

Network Adequacy and Provider Directory Accuracy Methods of Review — A Comparative Analysis

Deborah Schreiber, Network Compliance Officer, UnitedHealthcare
Michael S. Adelberg, Principal, Faegre Baker Daniels Consulting
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Polling Questions

1. Do you feel confident that your plan directories are totally accurate? Yes or No
2. Do you feel confident that your regulator(s) will concur the next time you need to make mid-year network changes? Yes or No

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Presentation Overview

1. Background & Methodology
2. Results of analysis of regulator reviews and research studies
3. Effectiveness of methods to identify issues and drive improvement
4. Best practices that can be applied by managed care plans
5. Emerging trends

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Background & Methodology

Background: Reliability of Network Adequacy Methods of Review

- Impacted by industry-wide provider data accuracy challenges
- Impacted by frequent changes in supply of physicians and other providers
- May also be impacted by political environment and media bias

Methodology for Comparative Analysis

- Reviewed multiple methods of assessment (2015 to present)
- Applied concepts of compliance program effectiveness and organizational effectiveness to evaluate methods of review
- Identified potential issues and recommended best practices

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Background & Methodology

Compliance Program Effectiveness (2018 U.S. Sentencing Commission)

1. Standards and procedures for prevention and detection of issues
2. High-level and knowledgeable governance (authority, resources and structure)
3. Reasonable efforts to exclude individuals who have engaged in misconduct from positions of authority
4. Effective communication and training on compliance expectations
5. Reasonable detection of misconduct (auditing, monitoring, reporting, non-retaliation, and periodic evaluation of effectiveness)
6. Incentives and disciplinary measures to consistently promote and enforce compliance
7. Reasonable response to detected misconduct including steps to prevent similar misconduct in the future
8. Periodic risk assessment and plan to address key risks

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Background & Methodology

5 Competencies of Organizational Effectiveness

(Robbins and Judge, 2013, Organizational Behavior)

1. Leadership (clear vision, priorities and cohesiveness)
2. Decision-Making and Structure
3. People (attracting, developing and retaining talent)
4. Process and Systems
5. Culture

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Background & Methodology

Regulator Reviews

1. CMS Triennial Network Adequacy Reviews (MA)
2. CMS Online Provider Directory Reviews (MA)
3. Louisiana Medicaid Directory Reviews
4. New Hampshire Network Adequacy Assessment (Commercial / Exchange / Medicaid)

Research Studies

1. Improving Provider Directory Accuracy: Can Machine-Readable Directories Help? (Adelberg, et al.)
2. Primary Care Physician Networks in Medicare Advantage (Feyman, et al.)

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Compliance Program Effectiveness – Potential Issues

1. Ineffective Communication:
 - Some methods of review do not include a meaningful process for disputing accuracy of data or reasonableness of standards
 - Some agencies do not share methodology or summarize results
2. Ineffective Response to Identified Issues:
 - Some methods of review do not include a process to validate the identified issues were corrected
3. Ineffective Risk Assessment:
 - There may be a false assumption of the prevalence of network adequacy issues based on unreliable data, methodologies that result in invalid findings, potentially biased media coverage and political pressure

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Compliance Program Effectiveness - Recommended Best Practices

1. Include a meaningful process for disputing the accuracy of data used
 - CMS Network Adequacy “Exception” process allows MAOs to dispute CMS provider supply file data. Even more effective / efficient if CMS allowed verbal discussion with MAOs seeking clarification
2. Include a meaningful process for disputing network adequacy criteria
 - CMS uses approved exceptions to adjust network adequacy criteria. Even more effective / efficient if CMS adjusted criteria more consistently and timely
3. Publish methodology and summarize common findings and recommendations so all plans can benefit from learning opportunities
 - CMS Online Provider Directory Review includes annual report (transparent methodology, facilitates industry-wide learning opportunities)

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Compliance Program Effectiveness - Recommended Best Practices

4. Goal of reviews should include understanding the problem, identifying issues and best practices, and driving improvement (e.g., CMS Online Directory Reviews, Louisiana Medicaid Directory Reviews, etc.)
5. Focus reviews on critical specialties (e.g., Medicaid agencies focused on behavioral / mental health provider shortages, CMS focused on Medicare high utilization specialties) or new specialties (e.g., new dental benefit, or non-emergency medical transportation benefit, etc.)
6. Conduct reviews in a way that is close to actual member experience (e.g., call the same phone number published in directories for members to call)

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Compliance Program Effectiveness - Recommended Best Practices

7. Review all locations listed for a specific physician / provider (e.g., is physician regularly seeing patients at 10+ office locations?)
8. Review whether plan / provider recently “validated” data accuracy (e.g., is the root cause of an issue at the plan or provider office level?)
9. Include a process to validate that appropriate action was taken to correct identified issues, and prevent future similar issues
 - CMS Online Provider Directory Review process included a step to validate undisputed data issues were corrected within 30 days

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Compliance Program Effectiveness - Recommended Best Practices

10. Clearly define the issues or problems we are trying to solve
 - Is there a shortage of providers available to contract with plans, or are plans not contracting with enough of the available providers? Or both?
 - Are plans struggling to update provider directory data when they receive changes from contracted provider groups, or are provider groups struggling to keep plans updated on their changes? Or both?
11. Evaluate information sources for potential bias

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Organizational Effectiveness - Potential Issues

1. Leadership (clear vision, priorities and cohesiveness)
 - Many stakeholders (consumers, payers, providers, regulators)
 - Lack of cohesiveness on what is causing the problems
 - Lack of clear vision on how to measure and drive improvement
2. Decision-Making and Structure
 - Lack of clear accountability and roles for provider data
 - Lack of source of truth for provider data
 - Lack of consistent data dictionary and regulatory standards
 - Lack of structure to enable effective coordination across industry

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Organizational Effectiveness - Potential Issues

3. People (attracting, developing and retaining talent)
 - Inconsistent quality of talent assigned to provider data maintenance duties at some provider entities (or not assigned to anyone)
4. Process and Systems
 - Lack of consistent processes and systems results in significant inefficiency for both plan and provider entities
5. Culture
 - U.S. healthcare industry is highly fragmented and historically dysfunctional (blame game, defending status quo, etc.)

Good News: Most plans and provider entities agree that collaboration and coordination is needed to resolve these issues

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Organizational Effectiveness - Best Practices

1. Forum needed for collaboration across all stakeholders (consumers, payers, providers, regulators, etc.) to help enable and support:
 - aligning on a shared vision for how to measure and drive improvement
 - understanding different perspectives on problems and their root causes
 - understanding different perspectives on a provider data source of truth (including accountability, roles related to data management, etc.)
 - developing recommendations for a consistent data dictionary
 - developing recommendations for provider data staff qualifications
 - assessing and making recommendations for industry solutions
 - setting a positive example of health care industry collaboration and coordination (build on examples from CAQH, ICE, Synaptic Alliance, etc.)

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Organizational Effectiveness - Best Practices

2. Automated processes / systems for Network Adequacy reviews
 - CMS Network Management Module (NMM) Automated Criteria Check
 - Even more effective: dialogue related to exceptions to automated criteria
3. Efficient process for 'triggering events' and 'triennial' reviews
 - Allows focused reviews (e.g., specific county / specialty) when needed
 - Ensures periodic full contract review (at least once every 3 years)
4. Use Claims Data to assess network adequacy / directory accuracy
 - New Hampshire Comprehensive Healthcare Information System (CHIS) using All-Payer Claims Database for new network adequacy review methodology
 - Suppress providers with no recent claims (e.g., 12 months) from directory and target those providers for data validation and potential permanent removal

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Network Adequacy and Accuracy

Emerging Trends and Items to Watch

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Emerging Trends: Medicaid Network Adequacy

Medicaid Network Adequacy

- 2018 CMS Proposed Medicaid Managed Care Rule
 - Eliminates requirement for States to establish travel time and distance standards
 - Allows States to establish any quantitative network adequacy standard
 - Potential alternatives to times/distance include:
 - Numerator/denominator (network breadth)
 - Appointment times
- Rule will be finalized in 2020, Implications:
 - More opportunity for MCOs to work with states on approach
 - Harder for multi-state MCOs to efficiently comply w/ diverse standards
 - Quantitative standards should allow for an exception process
 - Example: State standards related to appointment wait times

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Emerging Trend: MA Network Adequacy & Accuracy

The Trump Administration has been friendly to the MA program, and provider networks are prominent in the mix of pro-MA policies

- Delayed submission of HSD for new applications
 - HSD “lock-down” moved from early February to June
 - Application denials replaced with plan finder suppression
- Implemented new triennial network audits
 - No warning letters or enforcement actions
- Directory accuracy review continue
 - No enforcement actions for three years; CMS backs away from fines
- High Value provider flexibility added
- Telehealth added to Network Adequacy via VBID (going to national?)

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Items to Watch: Interoperability Reg

CMS Interoperability Regulation (pending finalization)

- Would require Medicare Advantage and Medicaid provider directories be posted electronically in a common API
- Similar to the “machine readable” requirement for Health Insurance Exchange provider directories
- Implications: “Democratization” of directory information
 - 3rd parties establish “doc finder” tools
 - “Thicker” networks actively marketed
 - Inter-market network comparison
 - Network adequacy, breadth, and accuracy measured by more than regulators

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Items to Watch: Surprise Bill Legislation

Surprise Bill legislation will likely contain provider directory provisions

- Senate Bill: Lower Health Care Costs Acts
- Sec. 204 titled “Protecting patients and improving the accuracy of provider directory information”
- Requires commercial health plans to have up-to-date directories available online, or provide one **within one business day** of an inquiry
- Providers who refuse to keep directory information current can be suppressed from directory
- If a patient receives incorrect information from an insurer about a provider’s network status prior to a visit, the patient is only responsible for the in-network cost-sharing
- Similar provision in House bill

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Items to Watch: State Actions on Provider Networks

Quietly, more states are taking an interest in provider networks; sampling of actions in 2019

- Washington and Massachusetts impose CMPs for network problems
- Pennsylvania and Georgia intervene in disputes between major hospital systems and major insurers
- Louisiana Medicaid establishes directory accuracy incentive
- New Hampshire experiments with All-Claims Payer Database as a tool to measure network adequacy
- California launches a non-profit as the “source of truth” to achieve directory accuracy

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Items to Watch: Provider Agitation on Networks

The AMA and state Medical Societies are increasingly organized in identifying and lobbying on provider network issues

- AMA letter on Medicare Advantage networks
- CT and IL Medical Societies register concerns with State and Congress
- Behavioral health and dermatologist groups sponsor studies of provider networks
- Provider groups advocate for...
 - “Any willing provider” network rules
 - Simplified directory accuracy/verification processes
 - Network stability measurement

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Items to Watch: Provider Networks Evolve

Steerage Innovations

- Tiered networks
- Benefits tied to High Value providers

Access Innovations

- Telehealth providers
- In-home visits
- Transportation to appointments

Professional Evolutions

- Greater use of NPs and PAs
- Ever-growing list of outpatient medical procedures

Do today's network adequacy and accuracy tests ask the right questions?

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Questions...



Deb Schreiber

Network Compliance Officer, UnitedHealthcare

Phone: 952-931-4367

Deborah.A.Schreiber@uhc.com



Mike Adelberg

Principal, Faegre Baker Daniels Consulting

Phone: 202-312-7464

Michael.Adelberg@faegrebd.com

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