

EXORCIZING GHOST NETWORKS:

Tools and Strategies for Compliance Professionals

Presented by:

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What We'll Be Covering Today

- What is a “Ghost Network” or “Ghost Provider” and what are their risks?
- Current and Emerging Standards for Provider Directories
- Tools and Strategies to Uncover Ghost Providers and Mitigate Compliance Risks



About Faegre Drinker

Faegre Drinker is a top 50 law firm. We opened our doors on February 1, 2020, uniting Faegre Baker Daniels and Drinker Biddle & Reath, two firms known for exceptional legal and consulting capabilities. We have more than 1,200 experienced attorneys, consultants and professionals in 21 locations across the United States, United Kingdom and China.

We have broad legal and consulting teams focused on Health Care, Insurance, Government Affairs and Lobbying.

Note: The content of this webinar and corresponding materials is intended for information only and is not to be considered legal advice.





Who is Quest Analytics?

Quest Analytics serves both health plans and regulators, including the **Centers for Medicare & Medicaid Services (CMS)**, by providing technology that enables the ability to **measure, monitor, and manage** health plan network **adequacy and provider data accuracy** while complying with federal and state regulations.



What is a Ghost Provider or Ghost Network?

A **Ghost Provider** is a provider that is listed in the directory but is not available due to various reasons, such as:

- Not In-network
- Not Accepting New Patients
- Not Seeing Patients At The Location Listed
- Left The Practice
- Incorrect Specialty or Contact Information Listed

A **Ghost Network** occurs when a health plan's provider directory contains inaccurate provider listings or unavailable providers.

- *U.S. Senate Committee on Finance, Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks*

NEW TERM,
SAME
PROBLEM

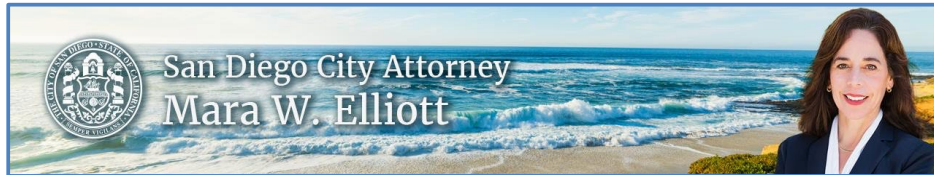
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Compliance and Business Risks



Reputation of the Organization



FOR IMMEDIATE RELEASE: June 25, 2021

Contact: Leslie Wolf Branscomb at lawolf@sandiego.gov or (619) 533-5896

Elliott Challenges Health Insurers for Deceiving Consumers

Inaccurate Provider Directories Unlawfully Dupe Consumers

San Diego City Attorney Mara W. Elliott today filed lawsuits against three major California health insurers for misleading consumers with inaccurate provider directories that include doctors who are not affiliated with the providers and whose work is not covered by their plans.

Provider directories are a prime advertising and recruitment tool for health insurance providers that new enrollees use in deciding which provider to trust with their family's health care. A consumer's decision may be determined by which doctors are in-network under which plan, as well as the number of specialists available in their geographic area. Some consumers rely on provider directories exclusively in making decisions.

The lawsuits allege that the provider directories of health insurers Kaiser and HealthNet have error rates of at least 35 percent, and in Molina's case, as high as 80 percent, despite California law requiring that they provide up-to-date, complete, and accurate provider directories. The false, out-of-date, or incomplete information found in these "ghost networks" impede attempts by enrollees to find needed care from in-network providers.

"Consumers should be able to trust their health insurers when seeking medical attention," San Diego City Attorney Mara W. Elliott said. **"Error-filled directories create dangerous barriers to healthcare services, with patients struggling to find a directory-listed doctor who will accept their insurance. These misleading ghost networks not only violate state law but undermine the health of San Diegans and Californians."**

The three complaints filed in San Diego Superior Court on behalf of the People of the State of California against health insurers Molina, Kaiser, and HealthNet allege that such practices are unlawful business practices under both state and federal law. The complaints also allege that the directories constitute false advertising.

Despite the clear requirements of both state and federal law, health insurers Molina, Kaiser, and HealthNet -- which together have more than a million individuals enrolled in their health plans statewide -- are among the worst actors in California when it comes to the inaccuracy of their provider networks.

**3 California
Health Insurers
Sued For Deceiving
Consumers With
Inaccurate Provider
Directories**

ALLEGATIONS:

**Violation of Unfair Competition Law
(Cal. Bus. & Prof. Code § 17200, et seq.)**

**Violation of False Advertising Law
(Cal. Bus. & Prof. Code § 17500, et seq.)**

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Quality of Care and Member Experience

2020 Health Affairs Study on Mental Health Provider Directories

Directory Use and Mental Health Psychological Distress

- **44%** of participants had used a mental health directory in the past 12 months.
- Participants who used a directory were **more likely** to have serious psychological distress, as compared to non-users.
 - **41% versus 32%**

Directory Inaccuracies and Out-of-Network Providers

- Experiencing directory inaccuracies was **significantly associated** with the use of out-of-network providers.

Among participants who encountered any of the studied directory inaccuracies:

- **40%** were treated by an out-of-network provider in the past year.
- In comparison, **20%** among those who did not encounter directory inaccuracies.

Reporting Complaints Or Grievances

- Participants who encountered directory inaccuracies filed complaints at higher rates compared to those who did not.

Complaint Rates:

- Among those with inaccuracies: **28%**
- Among those without inaccuracies: **4%**

[busch-kyanko-2020-incorrect-provider-directories-associated-with-out-of-network-mental-health-care-and-outpatient.pdf \(healthaffairs.org\)](#) – Cited in MHPAEA Proposed Rule

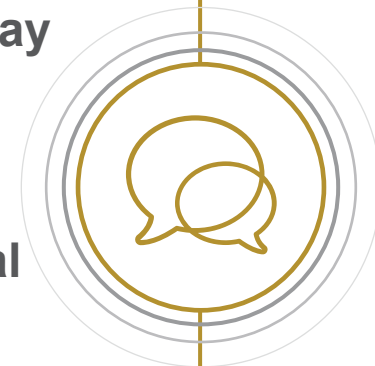
Regulatory Compliance

Market Conduct Examinations found provider directory inaccuracies resulted in the following:

- \$5 million fine for one insurer in Georgia – this is the largest ever levied by the state.
- \$1.25 million fine for one insurer in Illinois.
- Other states have also levied fines in the hundreds of thousands.

“This examination uncovered a number of serious issues, including improper claims settlement practices, violations of the Prompt Pay Act, failure to reply to consumer complaints in a timely manner, inaccurate provider directories, and significant delays in loading provider contracts,” continued King. **“As a result, our office has issued the largest fine in Agency history, with potential additional penalties if certain benchmarks are not reached.”**

– Commissioner John F. King, March 29, 2022



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Reputation of the Organization

The New York Times

Medicare Advantage Plans Offer Few Psychiatrists

A new study finds that people have a very difficult time finding doctors in their networks under the private-sector policies.

The Seattle Times

Mental Health

Newsletters | Log

LOCAL BIZ NATION SPORTS ENTERTAINMENT LIFE HOMES OPINION | THE TICKET JOBS EXPLORE All Sections

Politics Law & Justice Watchdog Mental Health Project Homeless Education Traffic Lab Eastside Environment Obituaries

Health | Local News | Mental Health

How insurance companies fill their networks with 'ghost' therapists

Oct. 3, 2023 at 10:00 am

The Washington Post
Democracy Dies in Darkness

73 doctors and none available: How ghost networks hamper mental health care

The term, commonly used by professionals, describes a panel of medical providers who for various reasons aren't providing

By Katherine Ellison
February 19, 2022 at 9:00 a.m. EST

THE KENNEDY FORUM

MILESTONES VISION RESOURCES

Phantom providers are a nightmare for parents
October 13, 2022

Medicare Advantage Provider Directory Accuracy Standards

Regulations

Updates to online directories must be completed within 30 days of receiving information requiring update; updates to hardcopy versions must be completed within 30 days and can include separate updates via addenda.

- 42 CFR 422.111(b)(3) and 42 CFR 422.2267(e)(11)

Provider Directory Application Programming Interface (API) with all contracted providers must also be publicly available.

- 42 CFR 422.120

Guidance and Enforcement

CMS guidance suggests MA plans contact providers quarterly to update directory information.

- Sec. 110.2.1, Ch. 4, MMC

All plans undergo a network adequacy review at least once every three years, or more frequently if compliance issues arise. This is called a “triennial review.”

- 1/10/18 HPMS memo

CMS stopped publishing its provider directory accuracy audits after Nov. 2018

Pending: REAL Health Providers Act (S. 3059)

Included in a larger package that passed Senate Finance Committee with wide bipartisan support (26-0) in November 2023

More Frequent Outreach, Verification, and Updates: MA plans would be required to **verify provider directory information at least every 90 days**. Aligns with the No Surprises Act which emphasizes ongoing outreach instead of quarterly updates.

Indication of Unverified Providers in the Directory: MA plans must clearly note in their directories which providers have **unverified** information.

Prompt Removal of Providers: When the MA plan determines a provider is no longer part of the network, they must remove that provider from the online and printed directory listings within 5 business days.

Cost-Sharing Protection for Enrollees: If an enrollee received care from an out-of-network provider that was listed when the appointment was made as an in-network provider in the plan's directory, the MAO would be required to cover that out of network care, as long as it was a covered item or service and ensure that the enrollee was only responsible for in-network cost sharing.

Annual Provider Directory Accuracy Reports: MAOs would conduct and submit to CMS **annual reports** of their provider directory accuracy, including provider specialties with high inaccuracy rates, such as providers specializing in mental health.



Medicaid

Current Federal

Update paper directories quarterly if plan has mobile-enabled electronic directory (otherwise monthly).

- 42 CFR 438.10(h)(3)(i)

Update **electronic directories every 30 days** after receipt of updates.

- 42 CFR 438.10(h)(3)(ii)

Post machine readable file

- 42 CFR 438.10(h)(4)

Post Provider Directory API

- 42 CFR 438.242(b)(6)

Proposed Federal

States must perform **secret shopper surveys** via independent entities for electronic provider directory accuracy of 4 discrete data points for certain specialties (PCP, OB/GYN, outpatient MH/SUD providers):

- Network status
- Address
- Telephone
- Accepting new patients
 - New 42 CFR 438.68(f)

Note: appointment wait times also proposed

State Standards

Can exceed federal standards

Many states have **provider ratios, appointment wait time and timely access standards** or additional plan auditing requirements through regulation or state MCO contracts

- See: [MCO ProviderNetwork CompanionGuide 5.17.21.pdf \(la.gov\)](#) (Louisiana)

Commercial: Qualified Health Plans (QHPs)

Current Federal Exchange

Publish **online directory** and make hard copy available on request.

Post Machine **Readable File** And Update at Least Monthly

– 45 CFR 156.230(b)

Section 116 of the **No Surprises Act** (next slide)

Proposed & Pending Federal Exchange

Appointment Wait Times (CY 2025)

– 45 CFR 156.230(a)(2)(i)(B)

State Exchanges

Section 116 of the **No Surprises Act** (next slide)

Additional Exchange or State-specific Standards Vary

Commercial: Market wide

Section 116 of the No Surprises Act Applicable January 1, 2022

Group health plans and health insurance issuers in the group and individual market are required to:

- Establish a process to **update and verify** provider directory information at least once every 90 days.
- Establish a protocol to **respond to enrollee requests** about a provider's network participation status within one business day from the date of the request
- Update the provider directory within two business days upon **receiving a provider notification** that their information has changed.
- Establish a process and timeline to **remove providers** from the directory who have not verified their information.
- Apply “**good faith, reasonable interpretation**” of the provider directory verification requirements until regulations are issued.
 - This includes honoring in-network cost-sharing if provider directory or plan-supplied information about participation status is inaccurate. [FAQ 8, Set 49](#)

Commercial: Market wide MHPAEA

Current Guidance

QHPs: References back to 45 CFR 156.230(b)

ERISA-covered plans: If a plan uses a network, the plan must furnish a list of providers that is up-to-date, accurate, and complete (using reasonable efforts).

– [Q10, Set 39](#)

Network composition is a non-quantitative treatment limitation (NQTL) for which parity must be demonstrated

Pending Regulations

If the proposed rules are finalized, the Departments are considering specifying that plans and issuers would be required to collect and evaluate for NQTLs related to network composition which would include:

- the percentage of in-network providers who submitted no in-network claims
- the percentage of in-network providers who submitted claims for fewer than five unique enrollees during a specified period

Depts may specify the MH/SUD and Med/Surg provider categories for such evaluations

– [Technical Release 2023-01P](#)

Develop a Compliance Strategy



**PROACTIVE
PROVIDER OUTREACH
AND ATTESTATION**

**DATA INSPECTORS
AND ANALYSIS**



**CLAIMS
BASED INSIGHTS**

**TIME AND
DISTANCE ANALYSIS**



PROACTIVE PROVIDER OUTREACH AND ATTESTATION

Two Outreach Approaches



LARGER PRACTICES
Large Group Health System - LGHS

1. Groups **submit rosters directly** to health plan or health plan vendor
2. Data is **audited** for completeness and correctness
3. Rosters that meet requirements are then **ingested** into a larger database
4. Work directly with the groups to **resubmit** updated Rosters after requirements have been fully met.

Both methods require attestations every 90 days in most LOBs.



SMALLER PRACTICES
(Standard)

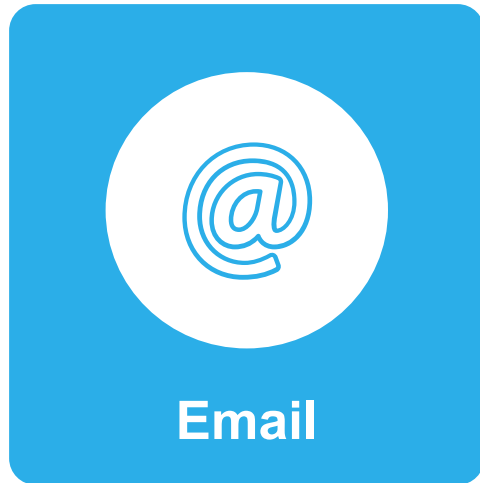
Rolling 90-day Verification Outreach to attest and verify provider information

Focus on practitioner-at-location.



Provider Outreach

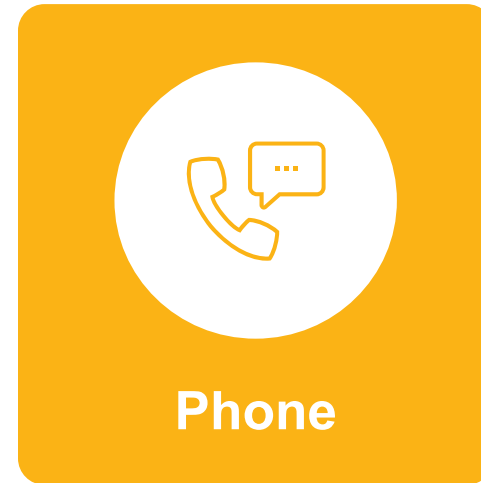
A multi-channel outreach strategy is necessary to ensure maximum network coverage and attestation rate.



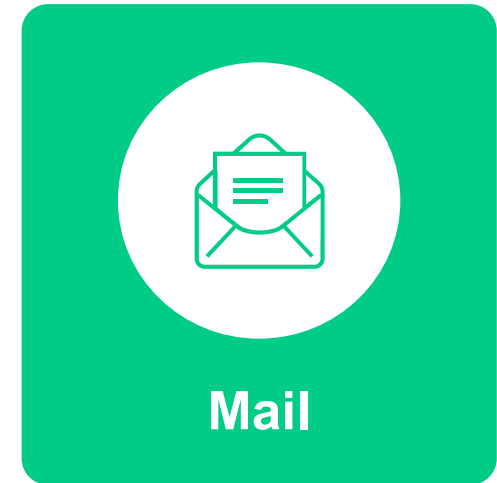
Total: 2,633,810
33.9% of total
Q/Avg: 658,453



Total: 4,701,774
60.52% of total
Q/Avg: 1,175,444



Total: 175,463
2.26% of total
Q/Avg: 43,866



Total: 258,264
3.32% of total
Q/Avg: 64,566

The outreach method is determined by contacts we receive either from client data files, previously attested data and/or previous attester details.



Standard Outreach

DIRECT MAIL

EMAIL

FAX

PHONE

URGENT - Your Quarterly Provider Update is Due by 08/11/21

VALIDATION IS REQUIRED FOR THE FOLLOWING PROVIDERS:

Great Falls Clinic LLP
Great Falls Clinic Specialty Center
3000 15th Ave S
Great Falls, MT, 59405

VALIDATION IS REQUIRED FOR THE FOLLOWING PROVIDERS:

David Anderson
Andrew Blackman
Michael Bryant
Jorge Castriz
Philip Donahue
Kenneth Evans
Raymond Geyer
Lisa Grossman
Karl Guter
David Kluge
Libby Lake
Patricia Lane

See form for additional providers

Why am I being asked to verify?
Outdated information confuses patients to access care.

How often will I be requested to review my information?
Four times a year we'll request a review of your information. With BetterDoctor, quarterly updates are shared with multiple insurance carriers. This reduces administrative burden to you.

What information do you need?
BetterDoctor is working on behalf of the Washington Health Benefit Exchange (WHBE), in cooperation with participating health plans. Please review and confirm the information for the providers listed below at this location is correct. Patients and providers needing to coordinate care with your practice rely on this information to be accurate.

Providers with outdated information may be dropped from our provider directories to preserve the integrity of the information we provide to patients and consumers.

To ensure public information is up-to-date, please visit the site below to review your practice information, or update it, if it has changed.

To complete your review for the quarter, visit the site below.

ACTION REQUIRED

To verify, go to: verify.betterdoctor.com
Enter your code: **ZRRUEMGT**

Why am I being asked to verify?
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To complete your review for the quarter, visit the site below.

ACTION REQUIRED

To verify, go to: verify.betterdoctor.com
Enter your code: **ZRRUEMGT**

BetterDoctor is working with [Health Plan] to improve access to your

Message

BD Melissa from BetterDoctor
To: Accuracy, Outreach & Support
Wednesday, August 11, 2021 at 1:52 PM

[Health Plan] is working with BetterDoctor to ensure the accuracy of your information in provider directories

BetterDoctor may contact your practice by fax, mail, email, and/or telephone to request a review once a quarter.

Please Review Your Provider Directory Information

Message

BD Melissa from BetterDoctor
To: Accuracy, Outreach & Support
Wednesday, August 11, 2021 at 1:52 PM

Are We Sending Patients to the Correct Place?

ATTN: OFFICE ADMINISTRATOR OR MANAGER

We're reaching out because we need your confirmation that the information on record in our provider directory for the providers listed for this location is still accurate.

Even if no information has changed, you must confirm your information each quarter. To complete your review for the quarter, visit the link below. By reviewing your information today, you will not be contacted until the next reporting period.

Please confirm the information in our provider and referral directories for the providers below is still accurate.

Common changes include:

- Practitioners no longer at the office.
- Practitioners not accepting new patients.
- Phone or fax number is incorrect or disconnected.

To cancel all scheduled reminders for the providers listed for this location until the next reporting period, visit the link below to review and approve your information.

BetterDoctor is working with [Health Plan] to improve access to your

Message

BD Melissa from BetterDoctor
To: Accuracy, Outreach & Support
Wednesday, August 11, 2021 at 1:52 PM

[Health Plan] is working with BetterDoctor to ensure the accuracy of your information in provider directories

BetterDoctor may contact your practice by fax, mail, email, and/or telephone to request a review once a quarter.

CMS compliance made easy!

Submit a Roster to Ensure Provider Directory Accuracy

ATTN: CREDENTIALING OR PROVIDER DATA MANAGER

Hells Five Rivers Health Center,
Health plans contract with Quest Analytics' subsidiary BetterDoctor to verify quarterly practitioner and location information.

As you may know, CMS and state regulators require health care entities to confirm provider demographics every quarter.

For larger provider groups, place of individual involvement. The roster.

SECOND NOTICE - Provider Directory Update Due.

VALIDATION IS REQUIRED FOR THE FOLLOWING PROVIDERS:

Remonda Morales
Richard Agness
Bridg Brink
Karl Brink
Paul Conzel
James Courtney
Farahna Dhanraj
Karl Davis
Janae Ann Driver
Rebecca Davenport-Sa
John Egger
James Harding
Roger Johnson
Michael Kane
Maggie Kelly
Kathleen Kim
Arnell Lott
Angela Long
Carmel Maloney
Robert Mertz

Who is being contacted?
Outreach staff in your area.

How often will I be requested to review my information?
Four times a year we'll request a review of your information. With BetterDoctor, quarterly updates are shared with multiple insurance carriers. This reduces administrative burden to you.

Why am I being asked to verify?
Outdated information confuses patients trying to access care.

How often will I be requested to review my information?
Four times a year we'll request a review of your information. With BetterDoctor, quarterly updates are shared with multiple insurance carriers. This reduces administrative burden to you.

What information do you need?
BetterDoctor is working on behalf of the Washington Health Benefit Exchange (WHBE), in cooperation with participating health plans. Please review and confirm the information for the providers listed below at this location is correct. Patients and providers needing to coordinate care with your practice rely on this information to be accurate.

Providers with outdated information may be dropped from our provider directories to preserve the integrity of the information we provide to patients and consumers.

To ensure public information is up-to-date, please visit the site below to review your practice information, or update it, if it has changed.

To complete your review for the quarter, visit the site below.

ACTION REQUIRED

Are We Sending Patients to the Correct Place?

ATTN: OFFICE ADMINISTRATOR OR MANAGER

We're reaching out because we need your confirmation that the information on record in our provider directory, for the providers listed for this location, is still accurate.

Even if no information has changed, we need you to confirm the information is correctly loaded into our system each quarter.

To complete your review for the quarter, visit the site below.

ACTION REQUIRED

To verify, go to: verify.betterdoctor.com
Enter your code: **ST733KDT**

Why am I being asked to verify?
Outdated information confuses patients trying to access care.

How often will I be requested to review my information?
Four times a year we'll request a review of your information. With BetterDoctor, quarterly updates are shared with multiple insurance carriers. This reduces administrative burden to you.

What information do you need?
Any public information patients use to find care (specialty, address, phone numbers, and insurance network statuses).

What do I do if someone else should be receiving these requests?
If you know the contact information for the person we should reach out to please let us know by contacting us at Support@BetterDoctor.com.

What if I practice at multiple locations?
We're using specific locations and providers to contact. At this time we cannot add additional locations. Contact us with questions about other locations.

For assistance, reach out to our support team by email at Support@BetterDoctor.com or by phone at 1-844-668-2543



Online Portal

A portal guides providers to confirm demographics for the service location, practitioner and practitioner at location.

Contact information


Jeremiah L Britton

Personal information

Type 1 NPI (Individual)

1073970745	Type 1 - Individual
	Name JEREMIAH LEE BRITTON
NPPES NPI Registry What is this?	

Title

Prefix	Professional titles
Mr	Select professional titles 

Legal name [?](#)

First name	Middle	Last name	Jr, Sr, etc.
Jeremiah	L	Britton	

The practitioner prefers using another name with patients

Gender

Male	Female	Gender X	Unknown
------	--------	----------	----------------

DATA INSPECTORS AND ANALYSIS

Analysis & Inspection

Analyze and compare to verified data in a larger database

- **Attested information from providers**
 - Health plan or health plan vendor Portal
 - Large Group/Health System Rosters
- **Authoritative 3rd-party sources**
 - National Plan and Provider Enumeration System (NPPES)
 - Office of Inspector General (OIG)
 - Medicare Preclusion/Opt-Out (CMS)
 - American Board Medical Specialties (ABMS)
 - Federation of State Medical Boards (FSMB®)

Excess Specialty Providers

# of Valid Specialti...	Netw...
2	1,436
1	43,527

Deactivated, Deceased,

Status	Netw...
Valid	173,558
Deactivated	319
Invalid	2
Missing	407
Medicare Opt Out	94
OIG Exclusion	0
OIG Exclusion Wai...	0
Medicare Precluded	0

Excess Address Providers

# of Addresses	Netw...
144	1
134	1
133	1
121	1
116	1
104	1
101	1



Actionable Insights



SUPPRESS

There is a reason I should remove this record from my directory



INVESTIGATE

There is something I should examine further



UPDATE

There is something incorrect in my data that I should change (Validity Inspectors Only)



SUPPLEMENT

There is something missing in my data that I should add (Validity Inspectors Only)



ENRICH

There is something that potentially could be added to my data (Enrichment Inspectors Only)



STANDARDIZE

The data has been put into a standard format



RETAIN

There is nothing I need to do with this record



PROVIDER CLAIMS INSIGHTS

Provider Claims Data Elements

CLAIM ACTIVITY (PCA)

- Relative patient volume vs. peers
- Identify “ghost” providers



GHOST
(no patients)



PERIPHERAL
(bottom 25% patient volume)



STANDARD
(middle 50% patient volume)



CORE
(top 25% patient volume)



vs.



TOP CONDITIONS & PROCEDURES

- Determine area of clinical focus



PAYER MIX

- Breakdown of provider claim volume by payer
- Understand provider relationship with competitors



■ Payer 1
■ Payer 2
■ Payer 3

■ Payer 4
■ Other



PRACTITIONER AT LOCATION CONFIDENCE

- Gain confidence that a practitioner is active at a specific location



Powered by Machine Learning



Top Conditions & Procedures — Area of Clinical Focus

James, Elizabeth, M, MD

91210 W 83rd St
Apache, AZ 80228
NPI Status ✔ Valid

Top conditions/
procedures not
aligned with PCP

General ▼

Address Location ▼

Claims ▲

Effectiveness (Quality) ⓘ

4/5

Efficiency (Cost) ⓘ

5/5

Top Conditions

S82201A - Unspecified fracture of shaft of right tibia, initial encounter for close...

S79922A - Unspecified injury of left thigh, initial encounter

S3991XA - Unspecified injury of abdomen, initial encounter

S79921A - Unspecified injury of right thigh, initial encounter

S82202A - Unspecified fracture of shaft of left tibia, initial encounter for close...

Top Procedures

71045 - Radiologic exam chest single view

71046 - Radiologic exam chest 2 views

72148 - Mri spinal canal lumbar w/o contrast material

73590 - Radiologic examination tibia & fibula 2 views

Total Claims Volume ⓘ

Standard

Medicare Claims Volume ⓘ

Standard

Medicaid Claims Volume ⓘ

Standard

Commercial Claims Volume ⓘ

Standard

Total		Medicare		Medicaid		Commercial	
Percent Total	Payer	Percent Total	Payer	Percent Total	Payer	Percent Total	Payer
15%	Aetna	20%	Aetna	10.9%	Aetna	31%	Aetna
13%	Cigna	19%	Cigna	9.8%	Cigna	20.1%	Cigna
11%	Humana	16%	Humana	9.7%	Humana	13.3%	Humana
9.8%	Blue Cross Blue Shield	15%	Blue Cross Blue Shield	9.7%	Blue Cross Blue Shield	14.7%	Blue Cross Blue...
9.1%	United Healthcare	13%	United Healthcare	8.9%	United Healthcare	14.7%	United Healthc...
8.9%	Centene	9%	Centene	8.8%	Centene	6.2%	Centene
8.3%	Kaiser Permanente	4%	Kaiser Permanente	8.8%	Kaiser Permanente		
7.5%	Anthem	4%	Anthem	8.6%	Anthem		
5.1%	HCSC			8.6%	HCSC		
5%	Oscar Health			8.2%	Oscar Health		
4%	Premera			8.1%	Premera		
3.3%	Bright Health						

Two providers warrant further investigation

Looking at top conditions/procedures Elizabeth James, MD does not appear to be practicing as a PCP

Dr. Seth Mathern is high in efficiency and effectiveness, sees Medicare patients and appears to be practicing as a PCP- based on this info he may be prioritized for contracting

Mathern, Seth, A, MD

11650 W 2nd Pl
Apache, AZ 80228
NPI Status ✔ Valid

Top Conditions

R070 - Pain in throat

R509 - Fever, unspecified

E860 - Dehydration

J029 - Acute pharyngitis, unspecified

R300 - Dysuria

Top Procedures

99213 - Office/outpatient establ...

99214 - Office/outpatient establ...

36415 - Collection venous bloo...

87651 - ladna streptococcus gro...

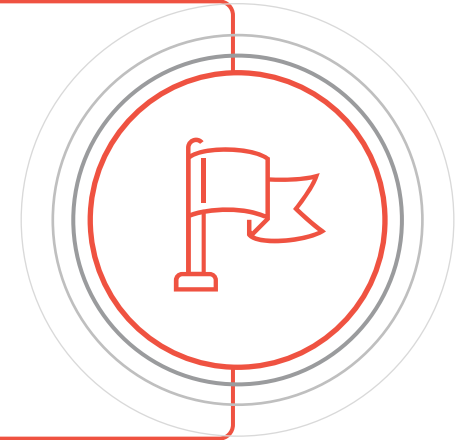
99215 - Office/outpatient establ...



Time and Distance Analysis

Interest in behavioral health parity is increasing, as is regulatory activity. For example, the Depts of HHS, Labor and Treasury warned “**a network that includes far fewer MH/SUD providers than medical/surgical providers—[is] a [MHPAEA] red flag.**”

FAQ 7, Set 39

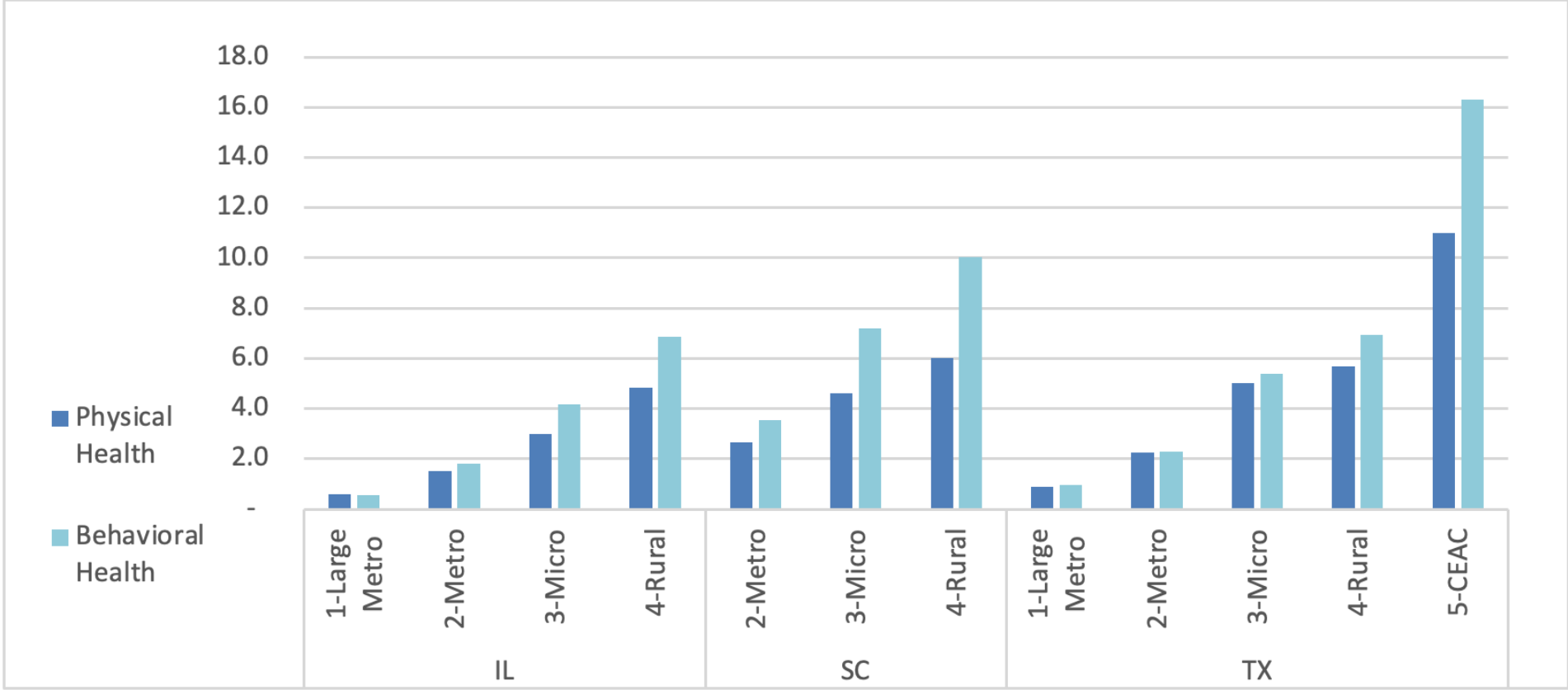


To understand whether there might be an imbalance between access to physical and behavioral health providers, Quest Analytics researchers examined average driving distances to the **closest physical and behavioral health providers** in Qualified Health Plans (QHPs) networks.



Time and Distance Analysis

FIGURE 1. Average Distance to Closest Provider by State and County Classification



THANK YOU!

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