EXORCIZING GHOST NETWORKS:

Tools and Strategies for Compliance Professionals

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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

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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.

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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

NEW TERM, SAME PROBLEM

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

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Compliance and Business Risks

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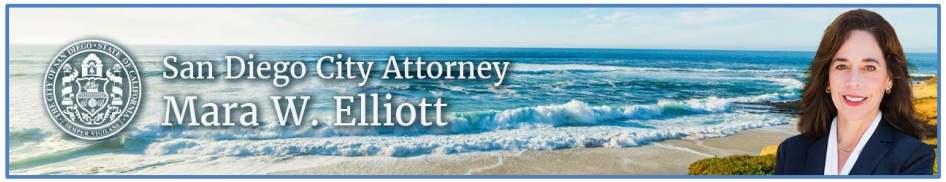
Reputation of the Organization



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

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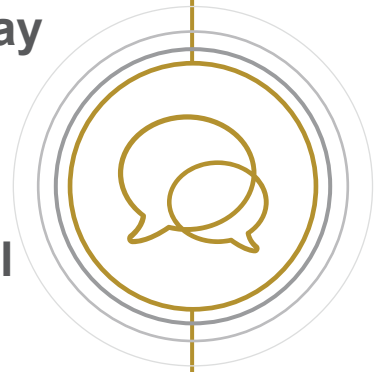
Regulatory Compliance

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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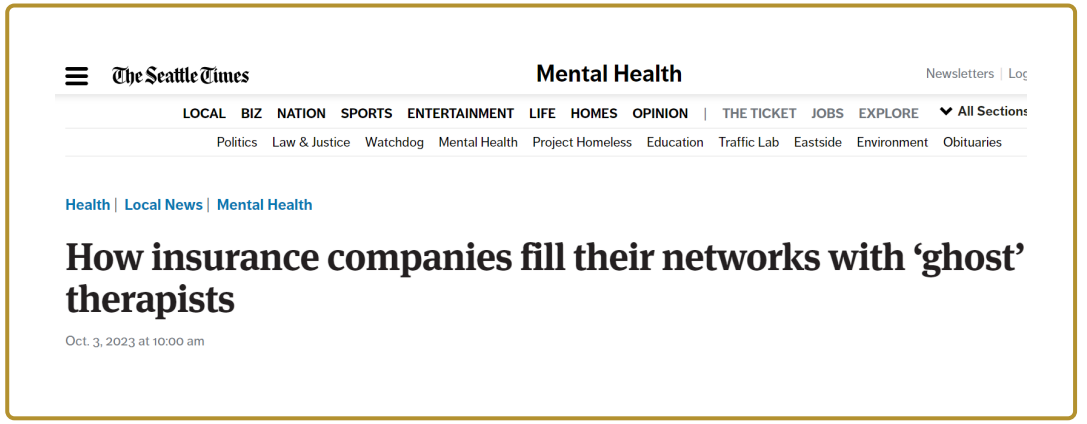
Reputation of the Organization

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

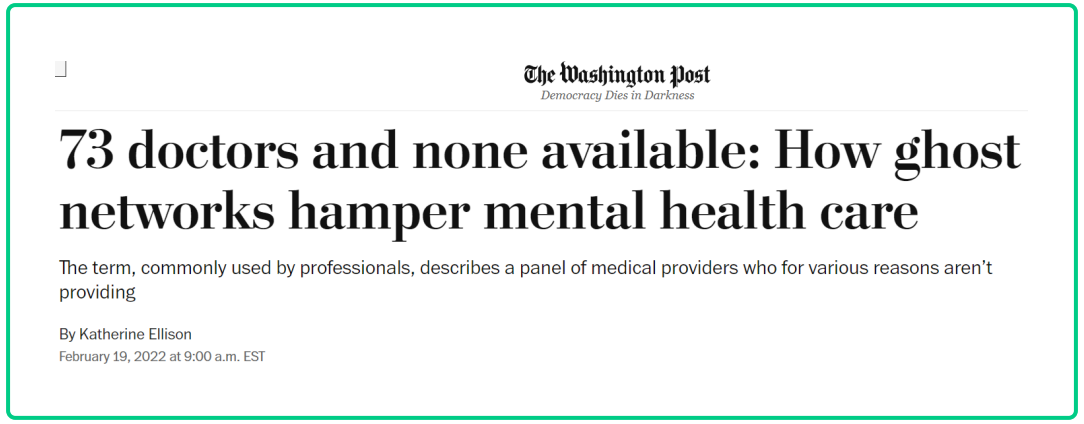
LOCAL BIZ NATION SPORTS ENTERTAINMENT LIFE HOMES OPINION | THE TICKET JOBS EXPLORE All Sections

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

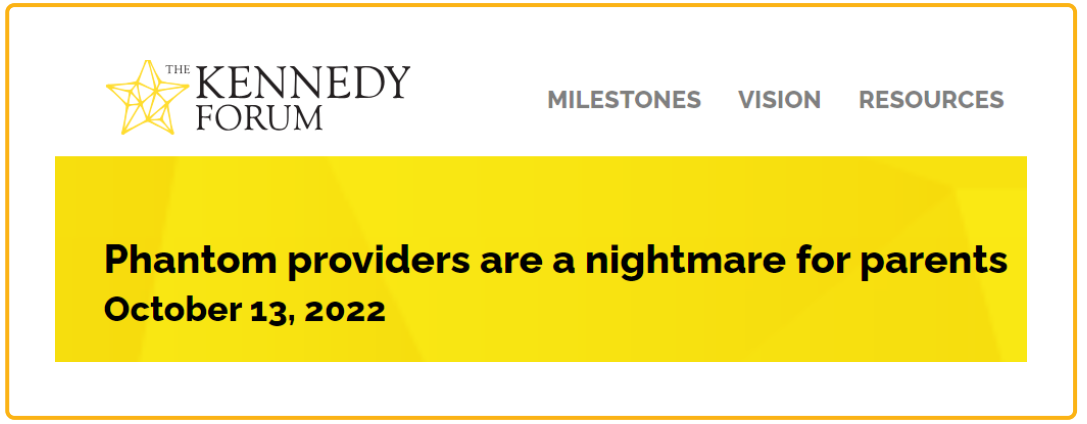
Democracy Dies in Darkness

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

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TM

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.

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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)

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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

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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

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PROACTIVE PROVIDER OUTREACH AND ATTESTATION

Two Outreach Approaches

Both methods require attestations every 90 days in most LOBs.

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.

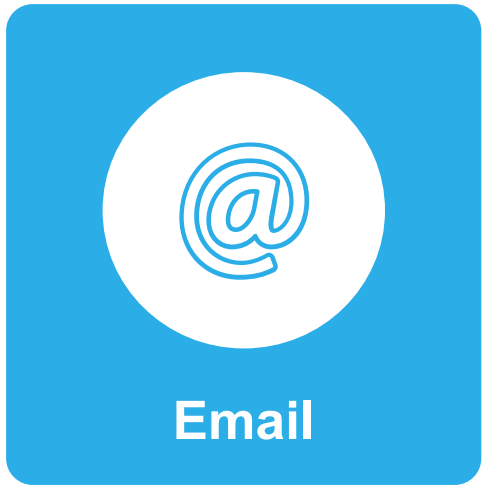
SMALLER PRACTICES
(Standard)

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

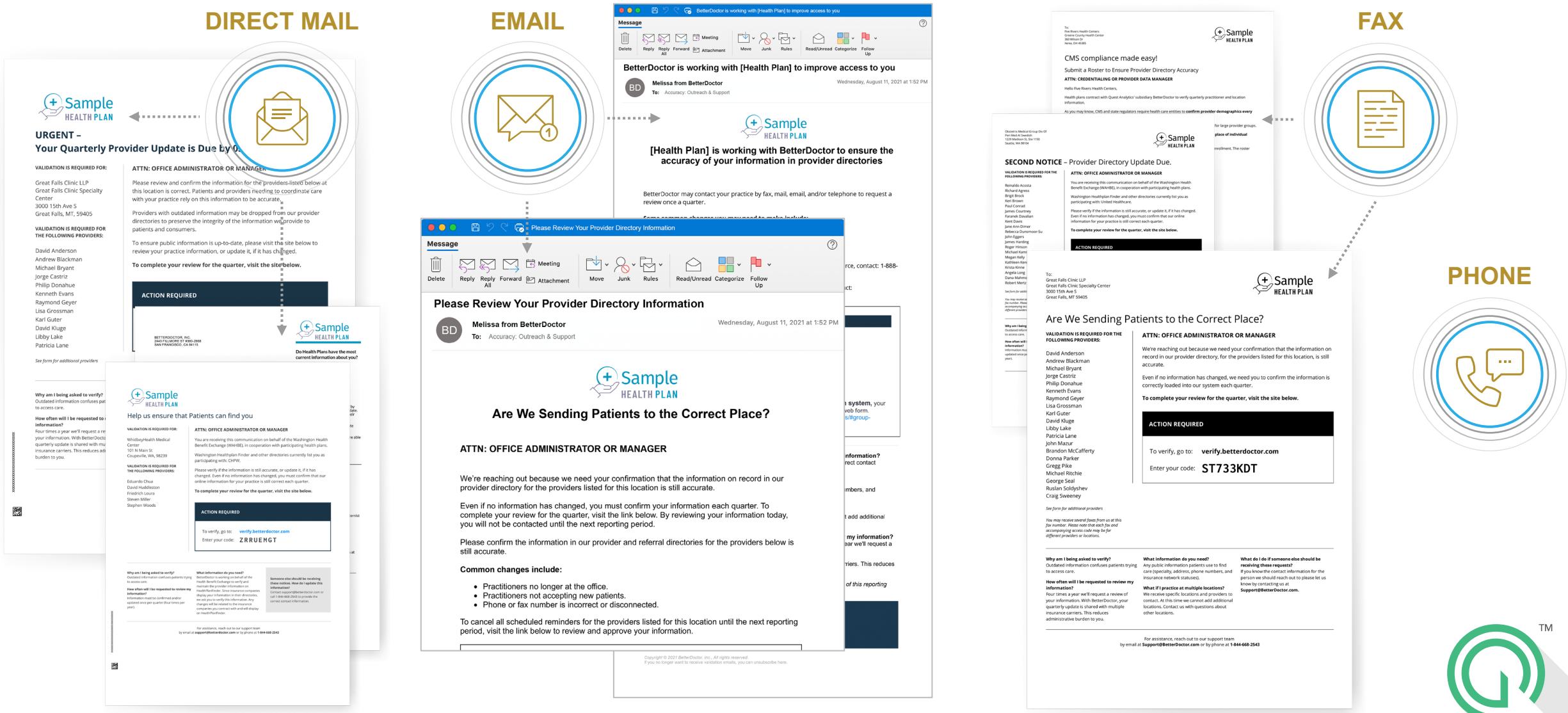
Total: 175,463
2.26% of total
Q/Avg: 43,866

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.

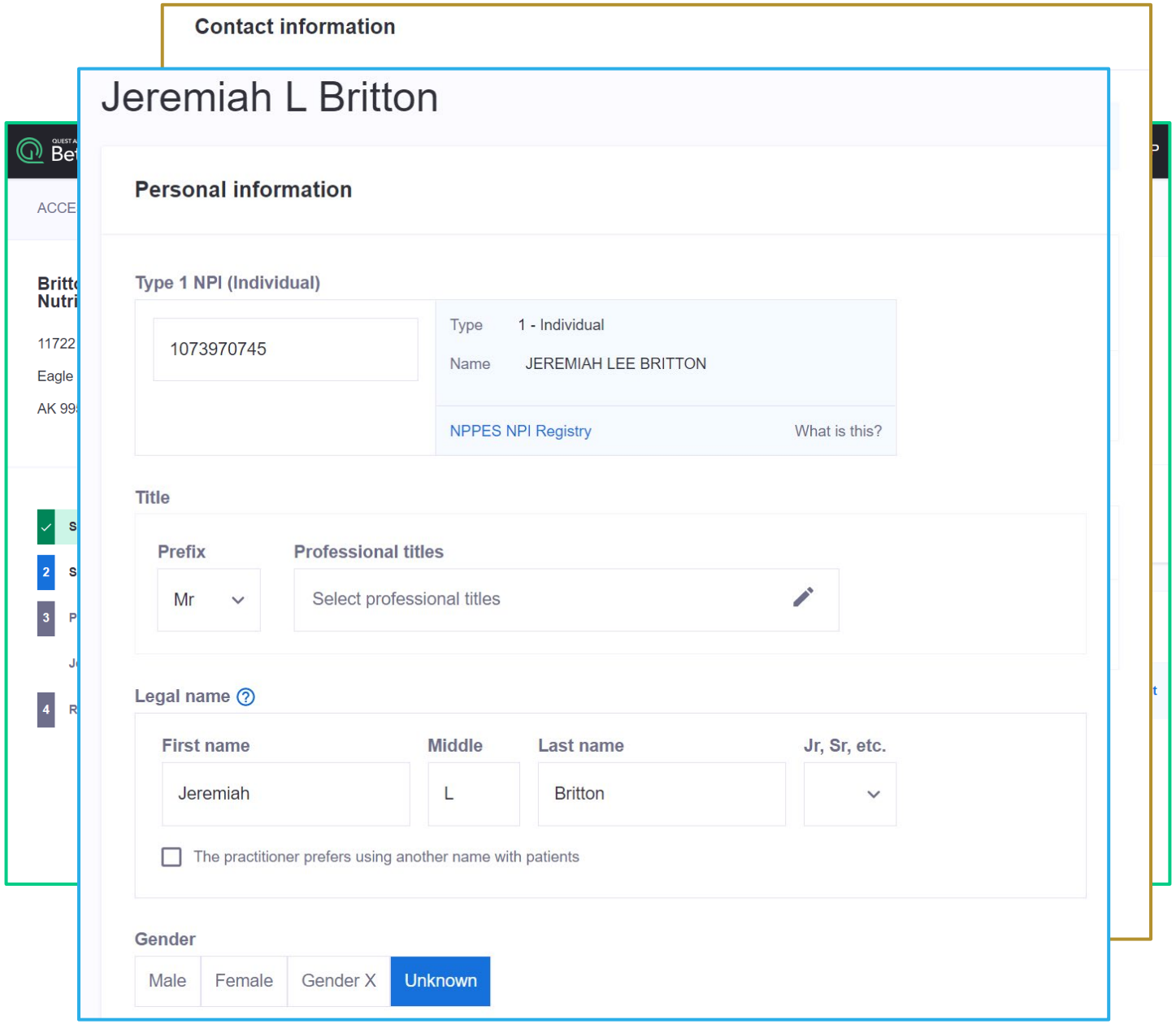
* From 2022

Standard Outreach



Online Portal

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



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

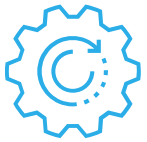
Excess Address Providers

# 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

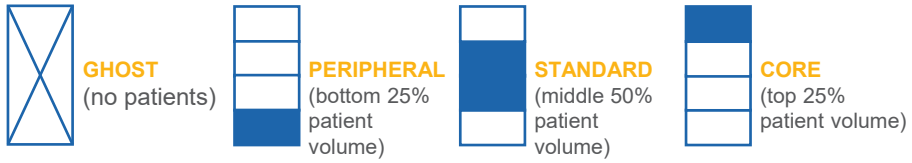
PROVIDER CLAIMS INSIGHTS

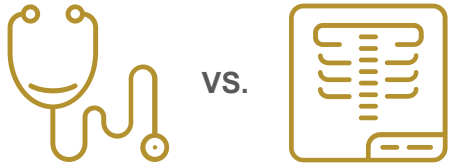
Provider Claims Data Elements

CLAIM ACTIVITY (PCA)

By LOB

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



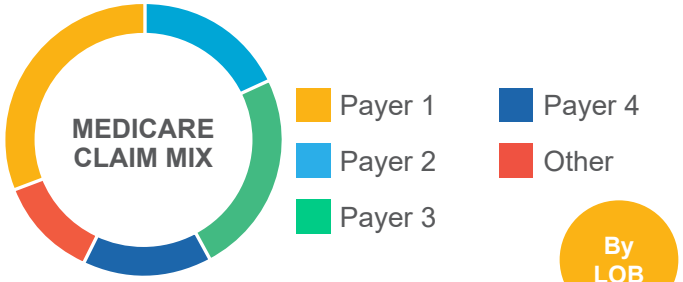


TOP CONDITIONS & PROCEDURES

- Determine area of clinical focus

PAYER MIX

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



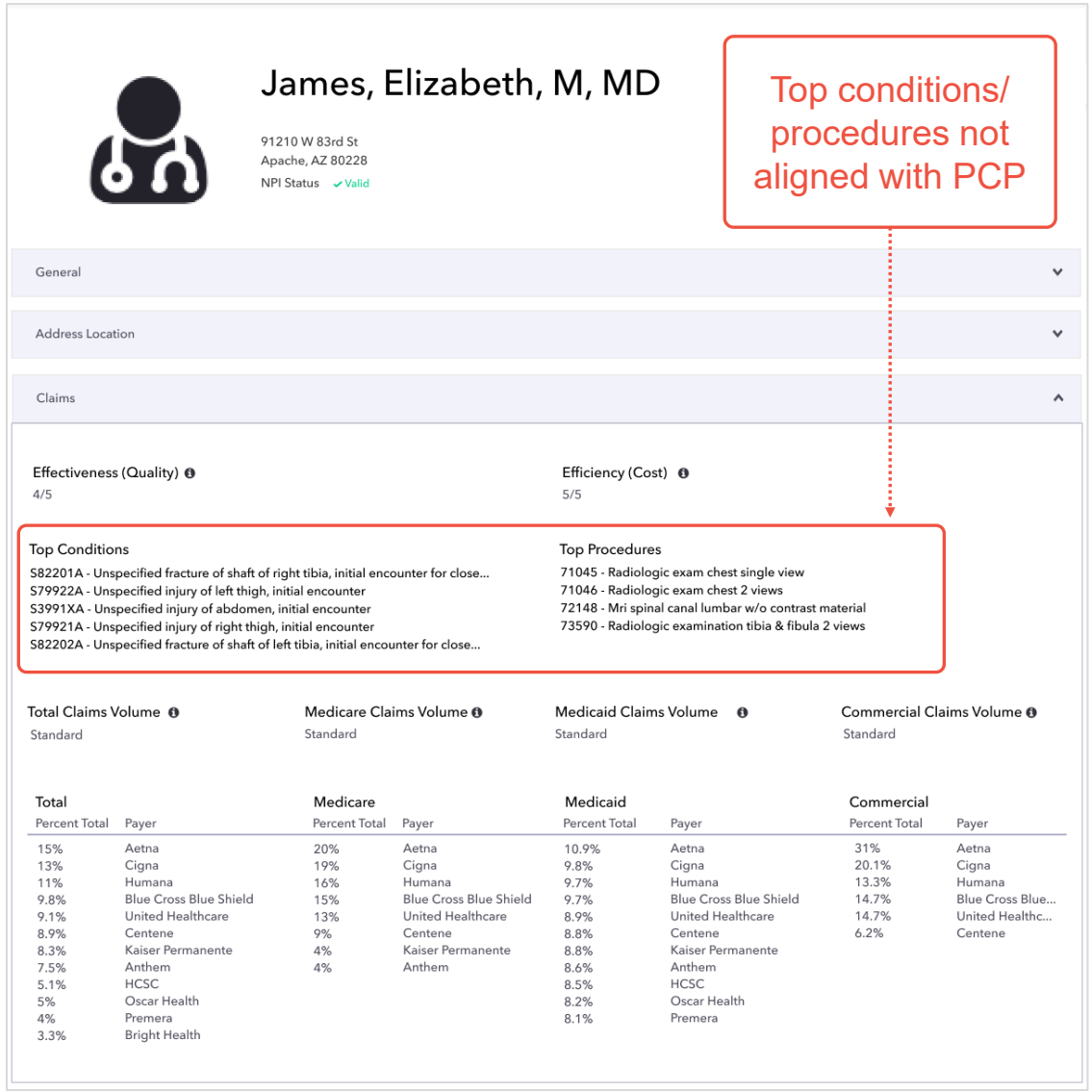
By LOB

PRACTITIONER AT LOCATION CONFIDENCE

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

Powered by Machine Learning

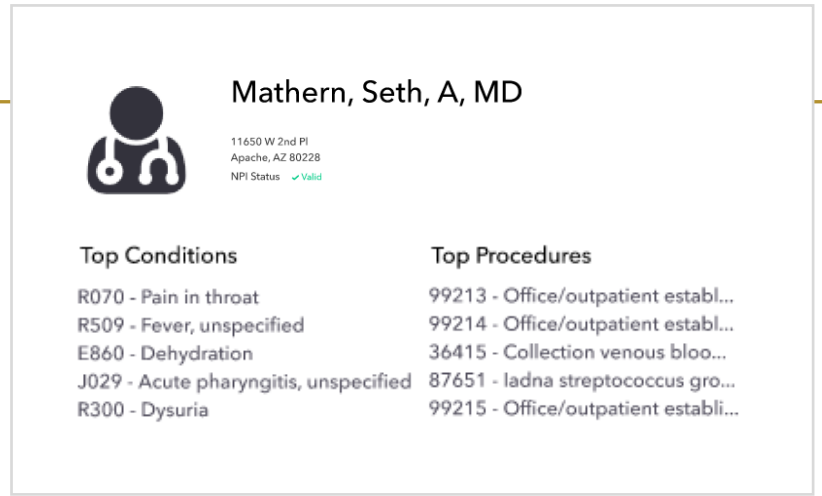
Top Conditions & Procedures — Area of Clinical Focus



Two providers warrant further investigation

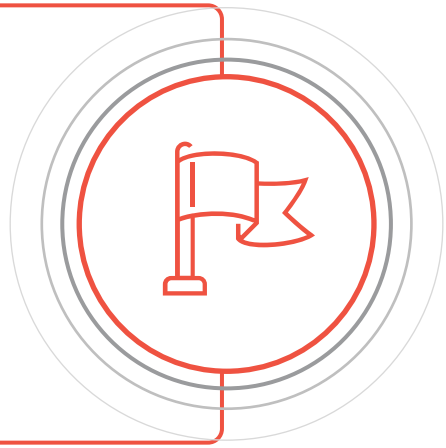
Looking at top conditions/procedures Elizabeth James, MD does not appear to be practicing as a PCP

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



Time and Distance Analysis

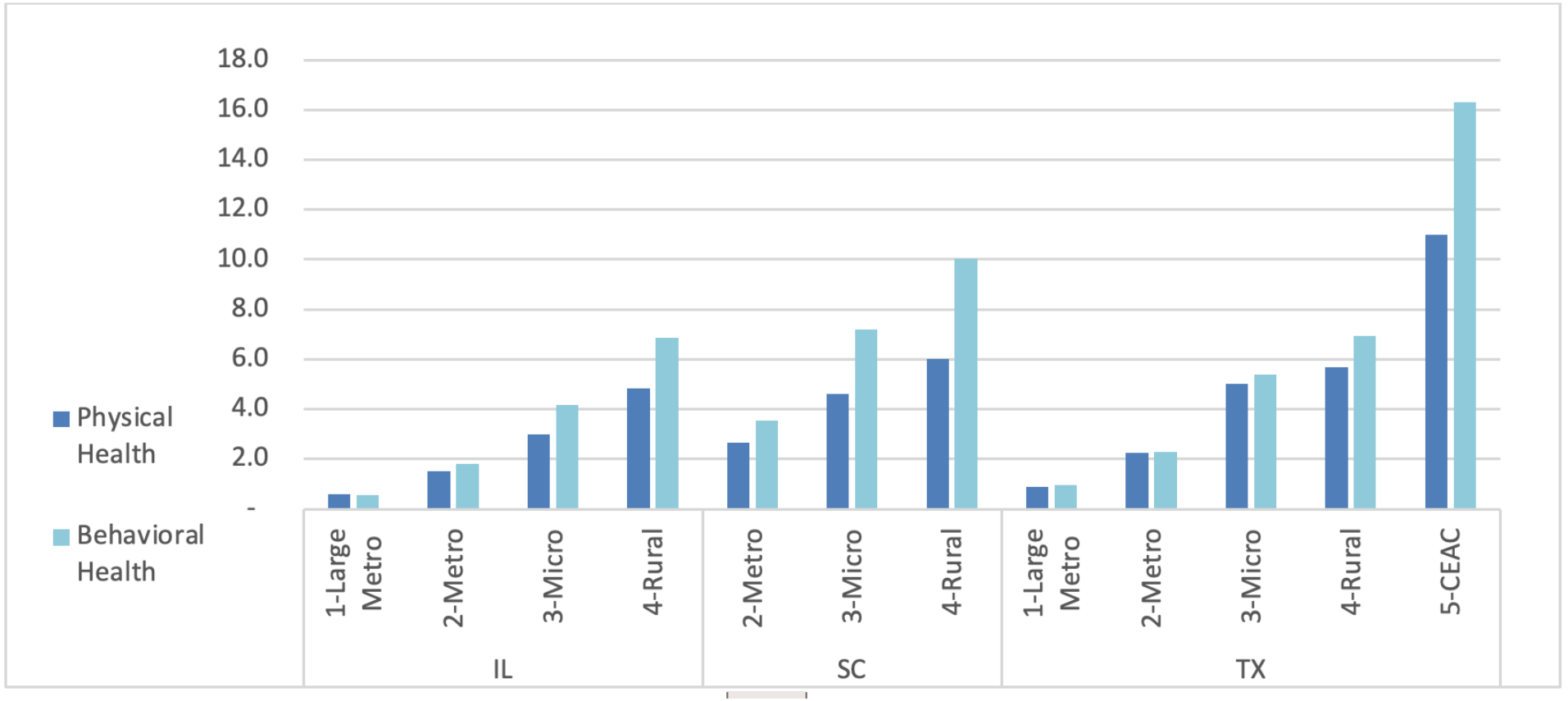
Interest in behavioral health parity is increasing, as is regulatory activity. For example, the Depts of HHS, Labor and Treasury warned **"a network that includes far fewer MH/SUD providers than medical/surgical providers—[is] a [MHPAEA] red flag."**
FAQ 7, Set 39



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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Provider Network Management