Integrated Provider Directories

Lessons from Other States & Implications for California

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Introduction

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Agenda

- Project Overview
- Provider Directory Landscape
- Integrated Provider Directory Ecosystem
- Key Findings
- Considerations for California
- Q&A

Note: The assertions made in the following slides are limited to Manatt's research and interviews in California, Colorado, Maryland, New York, and Washington.

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Housekeeping

- Attendees are in “listen only” mode
- This session will be recorded
- Slides and recording will be posted on CHCF website within a week – www.chcf.org
- To ask a question:

  Logistical Questions: Use CHAT to Host

  Questions for Speakers: Use CHAT to Host and Panelist

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Integrated Provider Directory Definition

Integrated Provider Directories *– online databases that bring together data from multiple carriers and their products which consumers may search or filter based on a set of criteria, such as provider name, address, and location*

Consumers utilize provider directories to:

- Evaluate coverage options to determine whether a primary care provider, specialist, or hospital they would like to see is considered "in-network" and covered under their current product
- Select products based on cost, network size, and care options
- Identify and locate providers and services when seeking care

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Project Overview

Purpose: *Examine the technical, policy and operational challenges and solutions that stakeholders confront when implementing and maintaining integrated provider directories to inform California's efforts.*

Research Provider Directories

- Integrated provider directory research
- Convene Advisory Group

Interview Stakeholders

30+ Stakeholder interviews in target states (CO, MD, NY, WA) and California

Publish Results

- Review findings and considerations with Advisory Group
- Develop issue brief

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The Consumer Perspective

	amazon.com	HealthCare.gov
Seller	Manufacturer	Carrier
Product	Widget	Health Insurance Policy
Rating System	5-star rating system and customer reviews	Star quality rating system
Product Guarantee	"If you received a damaged or defective item, we'll ship you a replacement of the exact item."	If you don't agree with a decision made by the Health Insurance Marketplace, you may be able to file an appeal.
Return Policy	"You may return most new, unopened items sold and fulfilled by Amazon.com within 30 days of delivery for a full refund."	If you have a 2015 plan through the Health Insurance Marketplace, you have limited opportunities to make changes outside the Open Enrollment Period. The deadline for changing or enrolling in a 2015 plan was February 15, 2015.

National Provider Directory Landscape

Federal guidance for carriers sets a floor for required data elements and includes penalties

Qualified Health Plans (QHPs)

- State & Federal Marketplaces must include provider licensure, specialty, contact information, institutional affiliation and panel status
- Federal Marketplace data must be submitted at least monthly, and include whether a provider is accepting new patients
- HHS may impose civil monetary penalties should a QHP provide incorrect information to the Federal Marketplace

Medicare Advantage Organizations (MAOs)

- Must contact providers at least quarterly to confirm information and make "real-time" updates
- Inaccurate or incomplete directories may result in monetary penalties, enrollment sanctions

Medicaid and CHIP managed care carriers' directories must include information on: physicians, hospitals, pharmacies, behavioral health providers, and long-term supports and services (LTSS) providers

National Association of Insurance Commissioners proposed draft model legislation addressing provider directories

California Provider Directory Recent Developments

November 2014

Chapter 2 of the CA Health and Safety Code (Knox Keene) requires carriers to update directories quarterly and include certain elements. **DMHC audits identify significant inaccuracies in two large carriers' directories**

January 2015

CA Department of Insurance issues emergency regulations to strengthen network adequacy. Provider directories of CDI-regulated plans must include: demographic information, status of practice and other elements

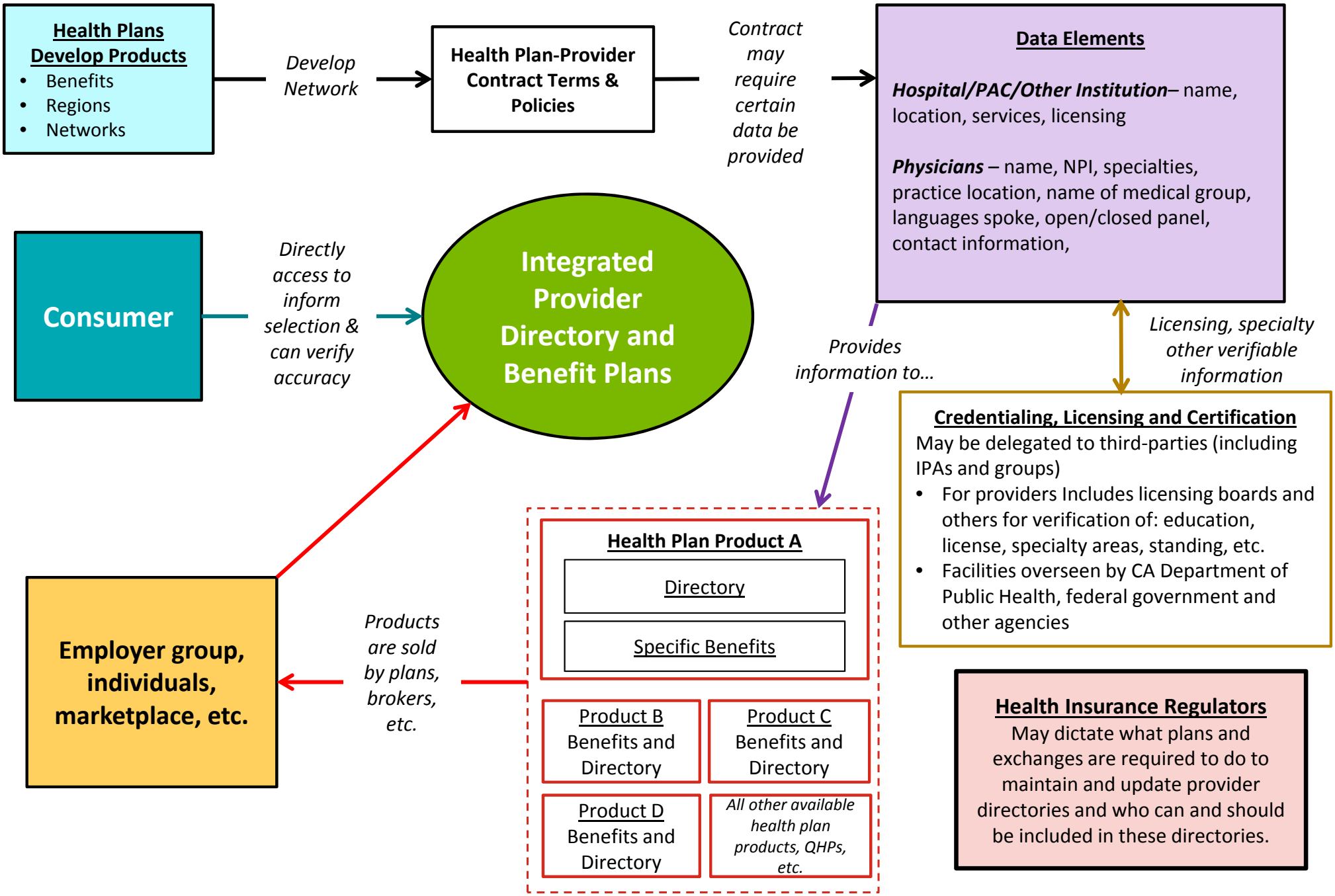
Senator Hernandez introduces SB 137 to improve provider directories. Requires weekly updates, and directs the State to develop standard provider directory template

June 2015

California State Auditor Report examine DHCS's oversight of Medi-Cal managed care plans, finding:

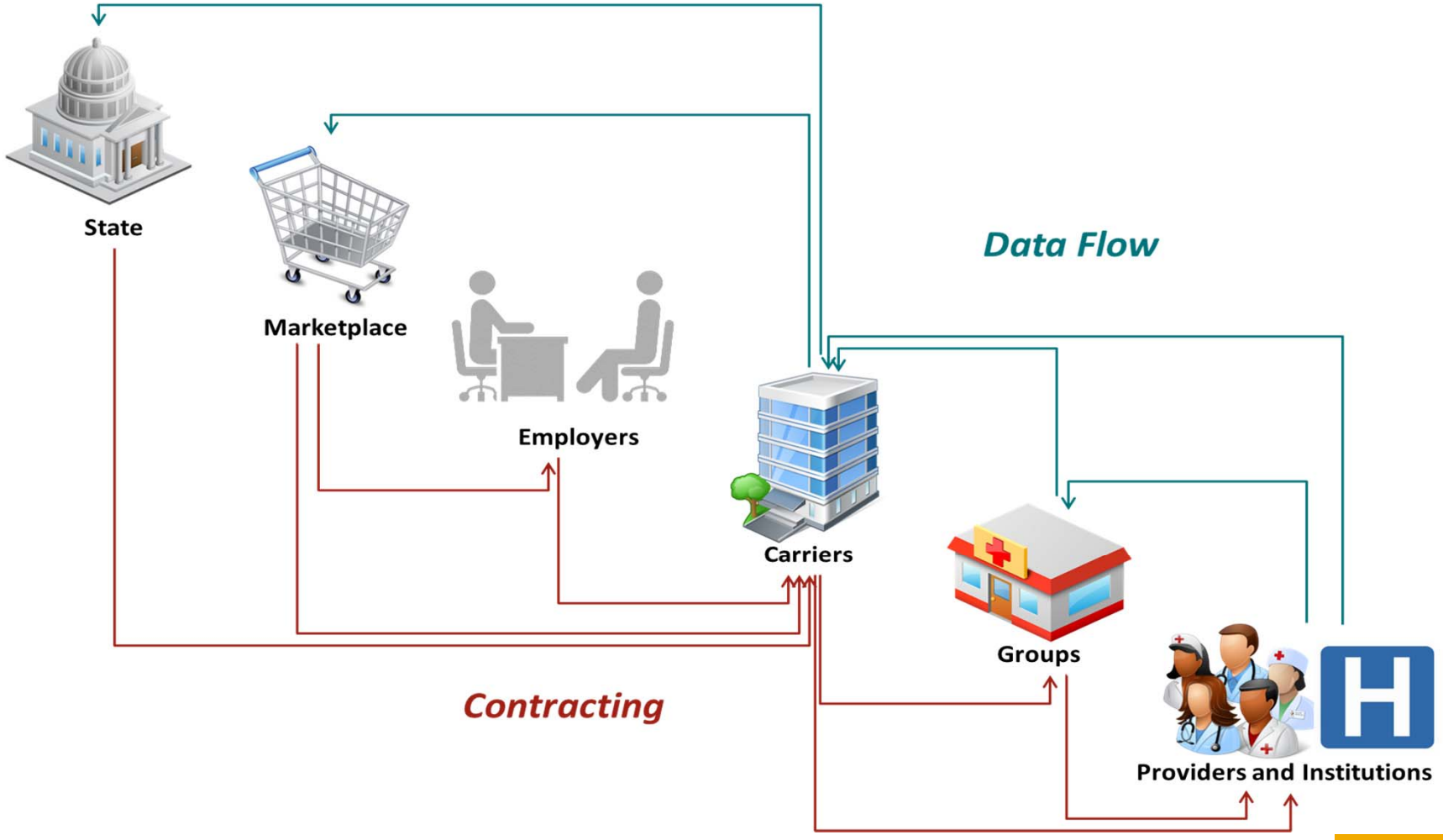
- Three carriers had significant inaccuracies in their directories
- DHCS's provider directory review tool and process is insufficient

Integrated Provider Directory Ecosystem



The Ecosystem's Cascade of Contracts and Data

Many actors are involved, many having their own contractual language and data systems and requirements, creating opportunities for errors



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Key Findings

- Shared Accountability
- Policies and Regulations
- Data Standards & Data Integrity
- Time and Resource Requirements
- Consumer Decision-Making
- Health Plan & Provider Contracting

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Key Findings - Shared Accountability

Lack of enforcement of regulatory and contractual requirements creates an environment that does not foster shared accountability

- Actors have unique processes, systems, and requirements
- Contracts typically require accurate and timely provision of data and outline penalties or remediation measures
  - Only one carrier reported enforcing penalties on providers
  - Marketplaces and State Medicaid Agencies largely did not report enforcing penalties on carriers
- Marketplaces are reluctant to alter data due to data ownership/liability concerns

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Key Findings - Policies and Regulations

Aggressive regulatory actions in New York are creating incentives for industry stakeholders to monitor and update provider directories

- New York State Attorney General actions in 2010 and 2012 spurred carriers to take steps to increase accuracy of their provider directories
- As a result of its new provider directory auditing and updating processes, one carrier found 25% of its provider records were inaccurate or duplicative
- In states where policies have not been coupled with aggressive regulatory action, carriers were not as motivated to improve their directories or processes

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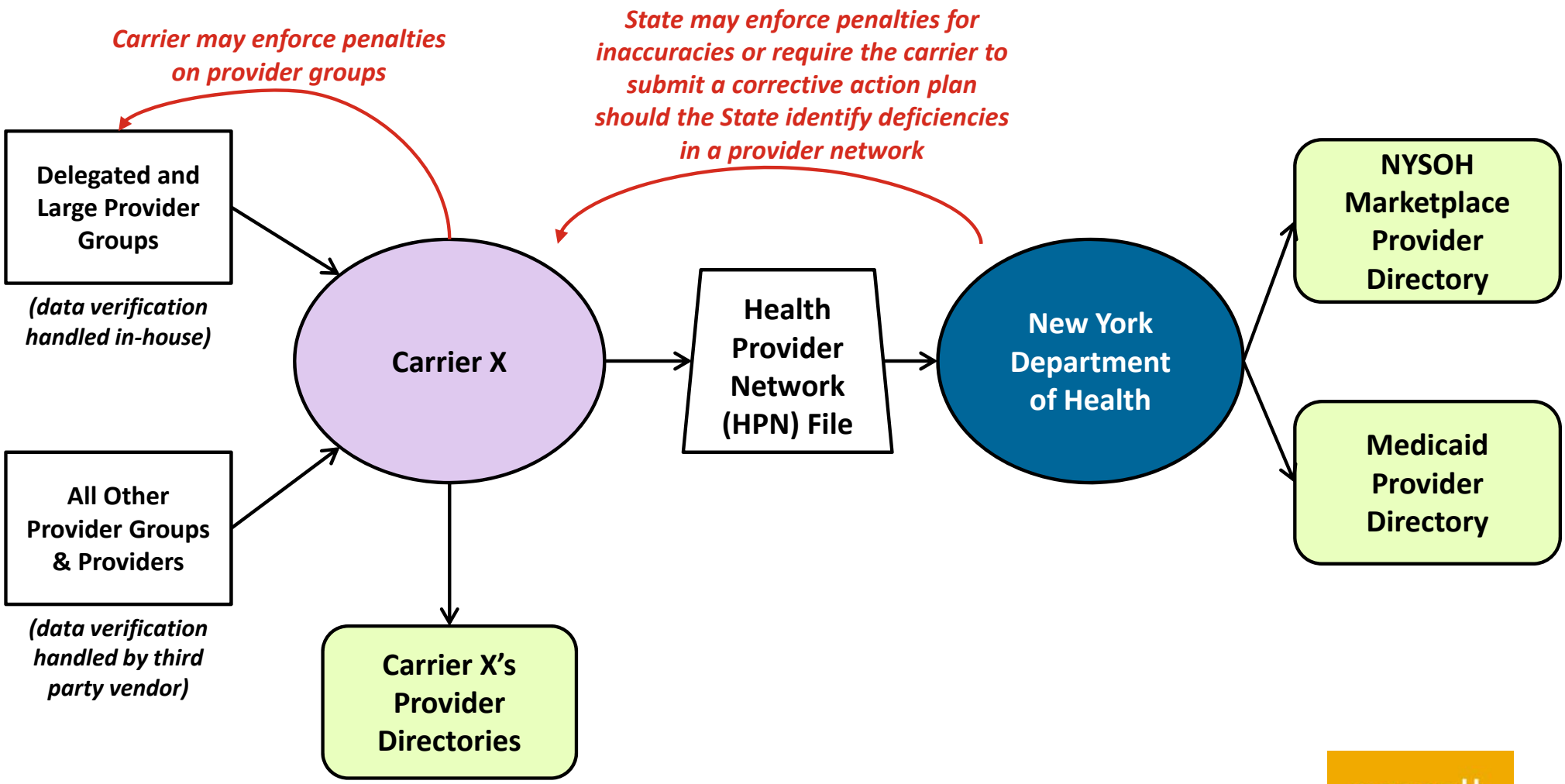
New York State and Carrier Processes

New York stakeholders reported enforcement of penalties by the State spurred carrier action to improve provider directory processes



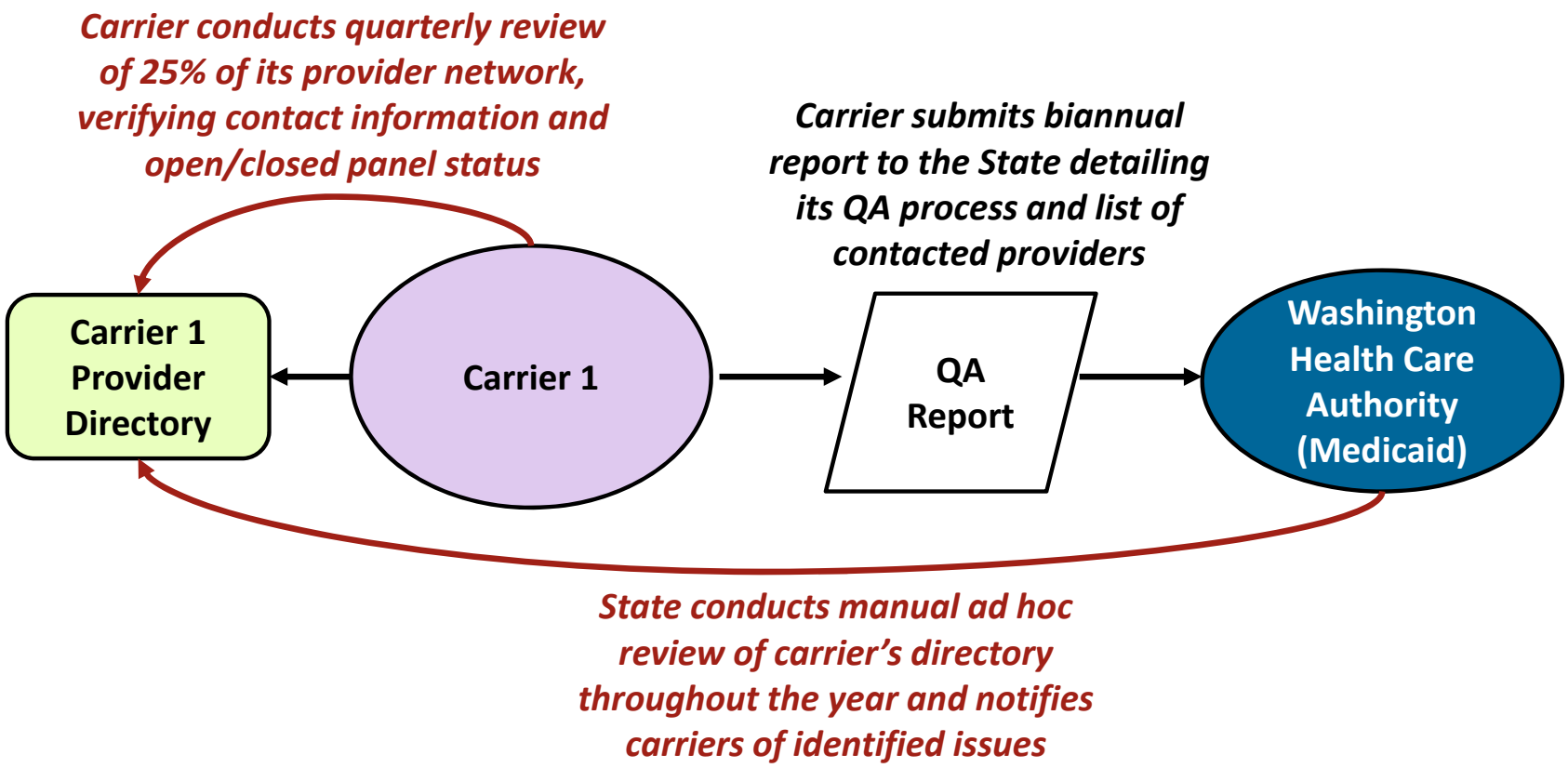
Key Findings - Data Standards & Data Integrity

The lack of both uniform data standards and robust quality assurance processes results in poor data quality and multiple errors

"Garbage in, garbage out"

- There are no federally mandated or industry accepted provider directory standards
- Carriers and providers are confronted with varying Marketplace and State Medicaid Agency requirements and templates; the CA, CO, and NY Marketplaces have re-purposed State templates
- Most organizations publish provider data with little verification or quality review
- Some Marketplaces and carriers run provider data against licensing databases and sanctioned provider lists, but no single source of provider information exists
- Facility, ancillary, and leased network data present additional challenges

Data Integrity: Washington Health Care Authority



Key Findings - Time and Resource Requirements

Organizations typically rely on time and labor-intensive manual processes to develop and support provider directories

- Resources dedicated to provider directories vary widely
- Organizations rely on some manual processes to verify and update provider data
- There may be lags of up to two weeks or more between data submission, review, cleanup, and publishing
- Marketplaces that update data electronically contract with third party vendors
- Budget and resource constraints impact the extent of quality review that each organization conducts and the functionality of directories

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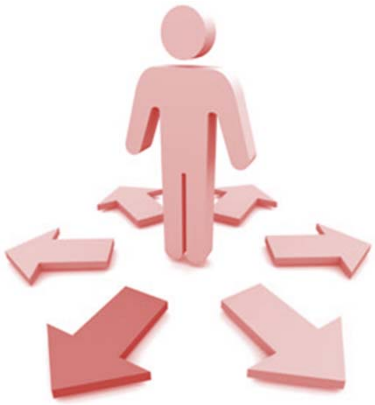
Key Findings - Consumer Decision-Making

Provider directories do not adequately and effectively engage and inform consumers as they enroll in coverage and seek care



- Marketplaces that undertook development of provider directories went above and beyond ACA requirements
- Navigators and advocates assisting consumers with QHP enrollment reported sending consumers directly to carriers' directories due to inaccuracies in the Marketplace's directory
- Marketplace consumers in CO and CA are eligible for a special enrollment period if they enroll in plans based on inaccurate provider directory
- There is no consensus among stakeholders regarding the necessary data elements required to create a directory with an adequate level of information

Key Findings - Health Plan & Provider Contracting

Confusion persists among providers with respect to:
1. Contracting & participation in specific carrier products; and,
2. Requirements & processes available to update provider data

- Provider awareness of carrier contracting practices varies
- Many carriers offer multiple ways for providers to update information and some are creating secure web portals. Some providers reported challenges and delays when updating their information with carriers.
- Provider education is key to ensuring relevant information is updated and changes are properly communicated

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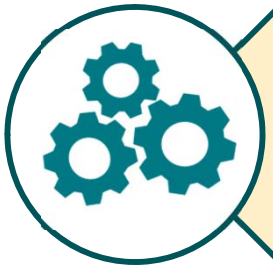
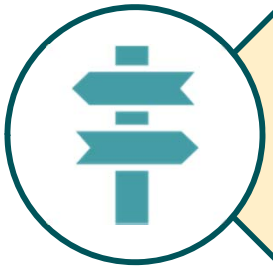
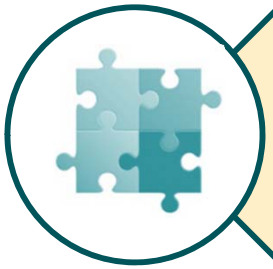
Considerations for California



Policy and Regulatory Alignment – Consistent guidance and requirements across all markets could motivate carriers to comply and issue clearer guidance to their provider networks.



Standards and Accompanying Guidance – Development of a single template and data standards could prove very useful, but must be coupled with detailed guidance, standards, and robust data submission and verification processes.



Health Care Resources and Diversity – The size, diversity, and complexity of California's health care landscape and institutions require significant resources to centralize and maintain accurate directories.

Improving Consumer Decision-Making and Protections – Directories should play a role in educating and increasing consumers' understandings of health coverage and should reflect California's language and cultural diversity.

Questions?

(The issue brief is forthcoming)

Appendix

State Marketplace Directory Overview

Preliminary Research Process and Approach

- Review available research on states with functional integrated provider directories on their Marketplace websites.
- Tested functionality of all states with directories.

Only four states had fully functional directories at the time our research was conducted: Colorado, Maryland, New York, and Washington

Research and document specific functionality of each of the four selected states' directories as well as any state legislation, regulations, business policies and technical/operational issues and their respective solutions.

State Marketplace Directory Overview (February 2015)

			Provider Directory Search Functions									
	Number of Health Plans (2015)	**Total Enrollees (2015)**	**Provider Name**	**Provider Specialty**	**Hospital Name**	**Facility Name (e.g., labs)**	**Location**	**Carrier Name**	**Plan Name**	**Metal Level**	**Plan Quality Rating**	**Prescription Drugs**
CO	10	~140,000	✓* Searchable by first or last name		✓	✓	✓					✓
MD	5	~119,000	✓	✓			✓* Provider State, County, and/or ZIP	✓	✓			
NY	16	2.1 Million	✓* Must search by last name & county	✓* Only with provider name			✓* Only for providers and with provider name & by county	✓		✓	✓	
WA	9	160,000 paid enrollees	✓* Searchable by first or last name		✓		✓					

Key Terms

Application programming interfaces (API) – A software-to-software interface that contains a set of computer programming instructions and standards for a software application or tool. APIs are released to the public to allow software developers to design other products to interact with the original company's product. For example, Amazon.com released an API so that a third-party website can directly post links to Amazon products with updated prices and allow customers to purchase the item.

Delegated Model – A health care delivery model where health plans contract with medical groups and "delegate" to the contracted groups some health plan functions, such as claims payment, utilization review, and care management, in return for a fixed, per person monthly fee (capitation payment) for a subset of the health plan's enrollees assigned to the group. The delegated model has been in wide-use among California HMOs since the mid-1980s.

Federally-facilitated Marketplace (FFM) – A health insurance exchange model under the ACA in which the US Department of Health and Human Services (HHS) performs all or most of the exchange functions. Consumers in states with a Federally-facilitated Marketplace apply for and enroll in coverage through HealthCare.gov.

Health Insurance Product (Product) – A specific health coverage plan or policy which specifies the enrollees' covered benefits, the provider network and coverage model, and the consumer share of the costs. Product types include, but are not limited to HMOs, PPOs, EPOs , and high-deductible health plans, among others.

Provider Network – The providers and facilities available to consumers enrolled in a specific health insurance product. Network providers agree by contract to accept negotiated rates from the carrier for services. Depending on the health insurance product type, consumers may be limited to the contracted (network) providers for non-emergency care and will generally pay lower out-of-pocket costs for network providers compared to out of network providers.

Integrated Provider Directory – A searchable database bringing together provider network data from multiple carriers' health insurance products. An integrated provider directory may include contracted physicians, clinics and medical groups by carrier/product, and may also provide information about participating hospitals or other contracted facilities, such as pharmacies. Integrated directories may include advanced search functionality allowing consumers to search by location, specialty, open or closed panel, languages, or other characteristics.

Key Terms

Leased Networks – A provider network organized and contracted with a third-party that carriers may lease from the third-party. Carriers may choose to lease provider networks in areas where they do not have a sufficient number of contracted providers to meet regulatory requirements (such as network adequacy) or to support ancillary or supplemental products, such as behavioral health or dental products. Carriers may also lease their networks to other payers, such as self-insured plans.

Machine-readable – Data that is displayed or reported in a format understood and can be consumed automatically by a computer system or web browser without human intervention. Machine-readable data allows third-parties to access data and potentially reuse it to create new search solutions , tools and services for other purposes.

Marketplace – The umbrella-term used by the Centers for Medicare and Medicaid Services for ACA health insurance exchanges under the ACA which offer health insurance coverage to eligible individuals, families, and small businesses. ACA marketplaces offer a website where consumers can shop for and compare available health insurance products and are the only venue where consumers can apply for and receive federal assistance in the form of premium tax credits to help pay for coverage.

Network Adequacy – A carrier's ability to deliver necessary health benefits and services contractually or legally required by providing access to a sufficient number of in-network (contracted) providers, including primary care physicians, specialists, hospitals, and other facilities.

Provider Directory – A list that includes the participating providers, hospitals, and facilities included in a carrier's insurance product.

State-based Marketplace (SBM) – A health insurance exchange under the ACA where the state assumes responsibility for performing most Marketplace functions. Consumers in these states apply for and enroll in coverage through Marketplaces established and maintained by the states.

Qualified Health Plan (QHP) – A health insurance plan certified by ACA State-based or federal Marketplaces as meeting specific federal (and state) requirements, including that the plan's product covers required ACA benefits (essential health benefits). Only certified QHPs may be offered in ACA Marketplaces but carriers may also offer QHPs outside of the marketplaces subject to relevant federal and state laws.

Key Federal Guidance

Agency/ Org	Regulation/Action/Proposal	Data Requirements	Frequency of Updates
CMS	Advance Notice of Methodological Changes for Calendar Year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter	Accepting new patients and demographic information, including: address; phone number; and, hours. Carriers must contact providers at least quarterly to verify network participation and demographic information	In real-time for online directories.
CMS	Medicaid and Children's Health Insurance Program (CHIP) Programs: Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions related to Third Party Liability (Proposed 5/26, Published 6/1)	Include the following information on physicians, hospitals, pharmacies, behavioral health providers, and LTSS providers: • Provider name and affiliation • Street address • Phone number • Website, as appropriate • Specialty • Open/closed panel • Languages spoken by provider or skilled medical interpreter • Accessibility for those with physical disabilities	At least monthly for paper directories and within three business days of receipt of updated information for electronic directories.
HHS	Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule (2012)	Licensure; specialty; contact information including institutional affiliation; accepting new patients; accommodations for individuals with disabilities and/or limited English proficiency	None provided – suggested that timelines should strike a balance between consumer choice and the burden updates place on carriers
HHS	Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule	If provider is accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations	At least monthly
CCIO	Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces	HHS may impose civil monetary penalties of up to $25,000 on QHP issuers in the FFM that provide incorrect information to a Marketplace, or $100 per day for each person adversely affected by the QHP's non-compliance	N/a
NAIC	Draft Health Benefit Plan Network Access and Adequacy Model Act	Providers: name; gender; contact information; specialty; whether accepting new patients; hospital affiliation(s); medical group affiliation(s); board certification(s); language(s) spoken by provider or staff; and, office location(s) Hospitals and Facilities: name; location; type (facilities only); and, procedures performed (facilities only)	At least monthly