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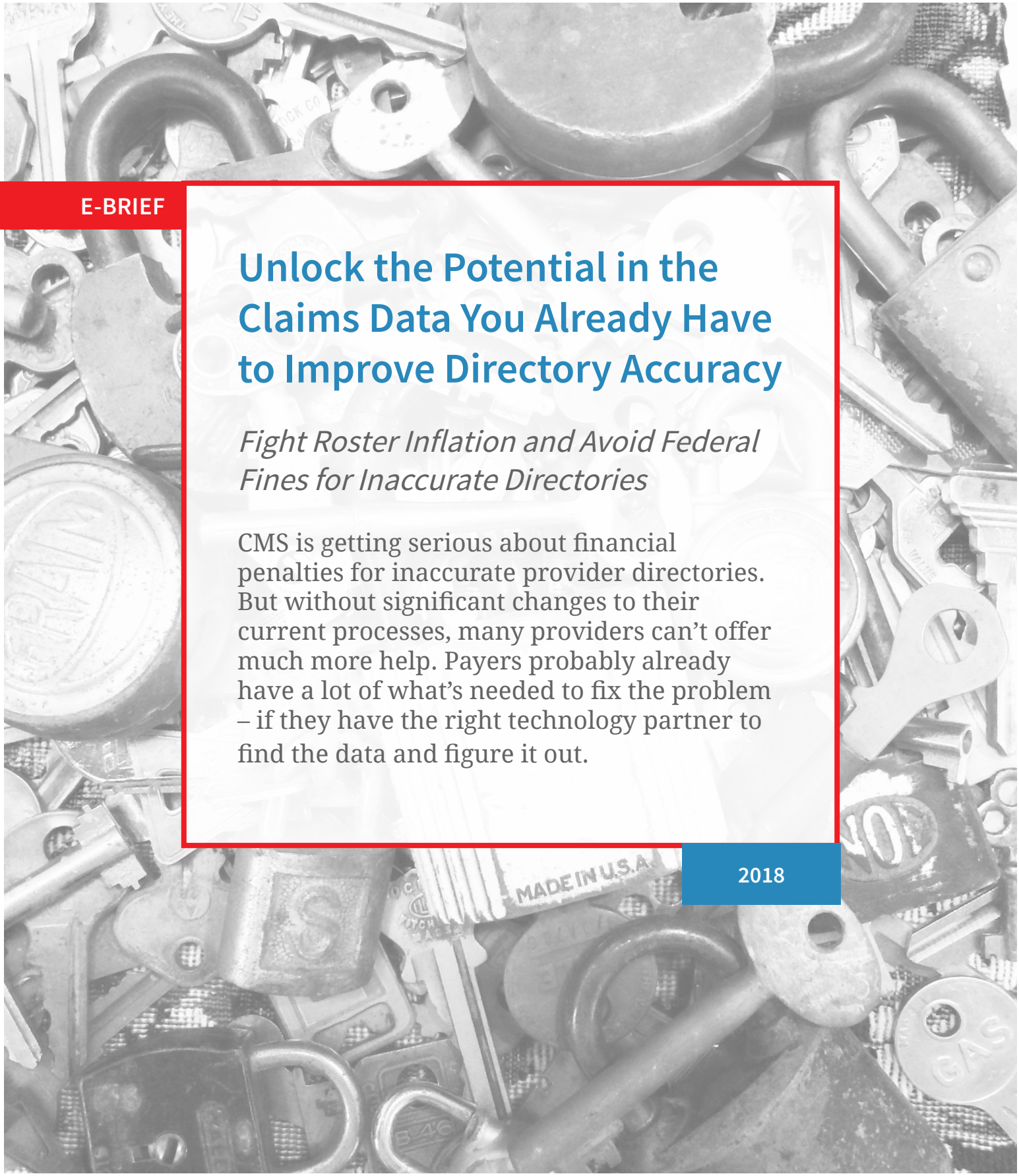

E-BRIEF

Unlock the Potential in the Claims Data You Already Have to Improve Directory Accuracy

Fight Roster Inflation and Avoid Federal Fines for Inaccurate Directories

CMS is getting serious about financial penalties for inaccurate provider directories. But without significant changes to their current processes, many providers can't offer much more help. Payers probably already have a lot of what's needed to fix the problem – if they have the right technology partner to find the data and figure it out.

2018

Introduction

For health plans, the mandate to better manage provider directory data has grown teeth. A chronic administrative challenge, ensuring the accuracy of information about which providers practice at which locations now comes with significant financial penalties. Medicare Advantage Organizations' online directories, according to the Centers for Medicare and Medicaid Services, must be accurate – and payers bear the lion's share of responsibility for making sure the information is correct. If they don't, they'll face fines from federal regulators.

Data management frustration is common, though:

- Leveraging vast systems and sources of provider information to populate directories, for benefits design and for strategic planning is a challenge for most health plans.
- Frontline healthcare practices often just don't have the administrative bandwidth to comply with multiple payers' data gathering needs, or to adopt the new technology needed to upgrade their reporting capabilities.

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A key complication, says CMS, is provider location listings in online directories. Too often, the directories list every provider who could practice in an office as being on staff at that site – so they can end up inaccurately including hundreds of provider location combinations for a given large group, with individual doctors appearing to travel, in some cases, to more than three dozen offices to provide services. That can't be, and CMS won't put up with it anymore. There's a way to sort out the truth: Start with those large and delegated groups and comb existing claims data to detect the practice activity and patterns that reveal who's really providing services at which locations.

Regulators are Cracking Down on Inaccurate Directories

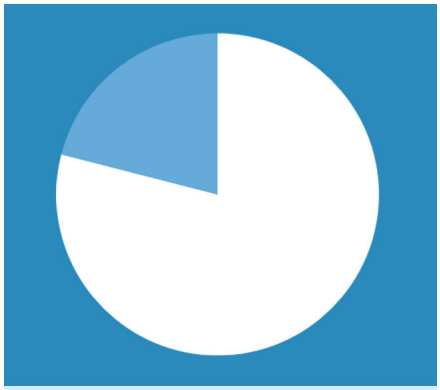
The feds are fed up, and payers are going to pay the price.

CMS and nearly every state now have in place regulations and requirements for directory elements and accuracy. All are pretty similar, but CMS has so far gone the farthest in measuring and publishing results, and has provided the most insight as to causes and recommendations as to cures; technically, CMS only audits MAOs, but what it finds generally applies across most types of provider directories. CMS has also been at it for a while, publishing the first call letter highlighting concerns about directory accuracy in 2015.

In 2016, CMS audited one-third of MAOs and, in 2017, another one-third. By early this year, results from both were publicly available. They weren't very good results.

- Despite all the focus, time and effort health plans have invested in better managing provider data, the second CMS review results were actually worse than the first – even though fundamentally the same audit process was used – and "87.43% of locations with deficiencies had the most egregious" kind.
- All in all, a disappointing 79% of deficiencies involved basic provider location and phone information.
- CMS commented that "MAOs are not adequately maintaining the accuracy of their provider directories" and added that "very few organizations performed well."

CMS also said that by mid-2019, MAOs will have had "ample time" to address directory accuracy, considering that the first call letter came in 2015. And the feds backed up that ominous assertion with just-released advance guidance describing proposed formulas for civil money penalties for violations.



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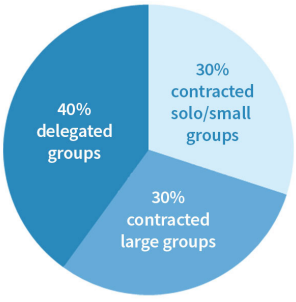
Roster Inflation Impacts Directory Accuracy

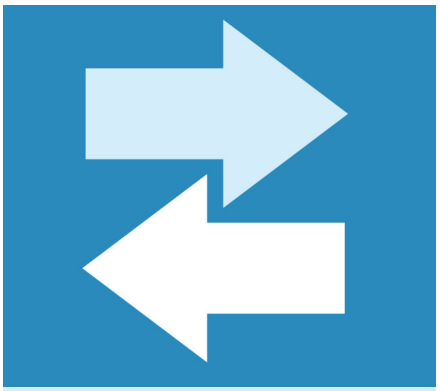
One of the key deficiency drivers that plague plans, according to CMS, is some provider groups' bad habit of listing individual doctors at a location because the practice has offices there – even if a given provider rarely or never sees patients at that site. Representing providers at locations where they can provide coverage, but that they don't go to regularly – LexisNexis Risk Solutions calls it "roster inflation" – is especially problematic with large practices, groups and delegated groups that submit location information via roster. And they can make up 70% of a provider panel. In a typical directory:



- About 30% of provider listings are directly contracted solo practitioners and groups with 10 or fewer provider location combinations.
- Another 30% are directly contracted large groups.
- The other 40% are delegated groups or providers.

*Based on payer provider directories seen by LexisNexis

While direct contract solo and small group providers are relatively easy to keep track of – most outreach channels are effective – the remaining 70% can be a challenge. Here's why:



Providers are mobile, exhibiting up to 2.5% movement a month

- For one thing, providers are mobile, exhibiting up to 2.5% movement a month.
- For another, delegated providers can be extremely hard to reach out to – because the delegate holds the contract and may only update location information during credentialing.
- As well, large groups – delegated or not -- can be difficult to fax or call for updates, and sometimes they reasonably expect payers to refer to the rosters they submit.
- Those rosters aren't always accurate, though, and may not include all the information health plans need, such as languages spoken and office hours.
- And formatting may not be compatible with payers' existing internal systems, slowing efforts to compare the rosters to underlying databases.

Compounding the technical and demographic challenges that updating directory information poses is the bottom line fact that nobody wants to make changes that will negatively impact the timely processing and payment of claims.

Internal Analysis Reveals Scope of Directory Inaccuracies

But is the problem really as bad as CMS says it is?

In fact, it is.

To determine the potential extent of the roster inflation that can result, LexisNexis Risk Solutions examined more than 4,000 large provider groups and found that 17% or more of the roster data is very probably inflated – showing each provider at five or more locations; 15% may also be inflated, showing each provider at three or four. The other 68% appears reasonable – meaning about one-third of group data is the type CMS plans to levy fines for.

17% or more of the roster data is very probably inflated.

If you do the math to calculate the location-to-provider ratio for the MAOs that CMS examined, each provider averages 2.2 locations, well below the 5.0-plus locations shown on 17% of the large provider group directory data.

LexisNexis Risk Solutions took a closer look at an actual large group that shows up on a payer directory to see how claims and referential data could be applied. The group under study included 52 providers and 41 service locations in the Southwest.

- Of the 2,132 possible provider location combinations – that's simple math: 52 providers X 41 locations = 2,132 combos – there were 2,052 directory listings for the group, implying that each provider treats patients regularly at 39.5 different locations.
- That can't be right. Each doctor would have to provide services at two locations a day, every day, and only return to each one once a month.

LexisNexis Risk Solutions study of a large group in the Southwest found that 94% of the provider directory listings would fail a CMS audit.

So LexisNexis® applied its proprietary analytics – leveraging existing claims and encounter data and other details from public and private sources – to cut through the data density to see what the directory should look like.

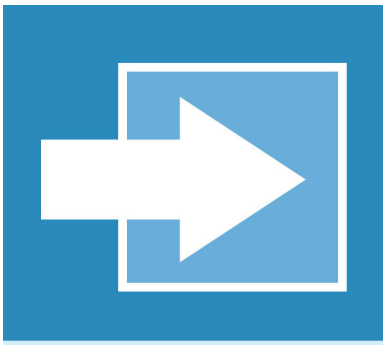
- Providers who have moved on can be identified from a combination of response and reference data and transactional activity – if they're not practicing, they won't have any activity at that location.
- Based on their documented activity in the last 18 months, the providers in the group examined actually average 3.6 locations each.
- Of the 2,052 directory listings, just 188 – 6% – are actually appropriate. 94% of the listings would fail a CMS audit.

That's useful information for supplementing outreach activity in general, such as paring down the outreach list or better managing providers' lack of response to information requests. It's also the kind of information that can help plans avoid financial penalties.

Data and Tools Exist to Achieve Total Directory Accuracy

Even though CMS notes that "both MAOs and their contracted providers are responsible for ensuring that provider directory data is accurate," it also emphasizes that "MAOs are in the best position to ensure the accuracy of their plan provider directories" and that "MAOs must proactively reach out to providers for updated information." Plans can't assume providers will provide accurate information, so battling roster inflation is largely up to them, regardless of where the information is coming from and the process the providers use.

Realistically, payers have three basic options for addressing the situation.



Improve inbound roster handling.

Conduct full-scale outreach to every listing

Apply analytics with an experienced technology partner

- Fine-tune and improve inbound roster handling.
- Conduct full-scale outreach to every listing, asking for updates to existing data.
- Apply analytics – with an experienced technology partner – to existing data and carefully selected supplemental data from trusted sources.

The first option accepts responsibility for directory accuracy, but it requires trusting providers to provide up-to-date information – and CMS says that isn't adequate to get you off the hook for mistakes. The second option requires health plans to send groups the data they have and request the providers to review and return it. But the costs can be exorbitant, and some groups will simply resend or refer you to previously submitted rosters. Indeed, providers in general are becoming less and less responsive to any type of outreach.

Plans "should actively use the data available to them, such as claims," the feds said, "to identify any provider inactivity that could prompt further investigation."

The third option holds untapped potential: Work with a technology partner that knows what to look for in existing data and in targeted additional information; that partner should also be able to make updates internally where possible, so you only expend resources on targeted, strategic outreach to the rest. That's a platinum example of what CMS advised: Plans "should actively use the data available to them, such as claims," the feds said, "to identify any provider inactivity that could prompt further investigation."

The technology partner you work with must offer a suite of data management, analytics and support tools to gather and read the files you have – and offer you ways to use the information your files contain. LexisNexis® ProviderPoint®, for example, is the industry standard for provider file cleansing, augmentation and integration, and LexisNexis® VerifyHCP, brought to market along with the American Medical Association, is a robust solution addressing provider directory accuracy that leverages the industry's leading source of provider information and more than a decade of data management and stewardship experience. It's also responsive to federal and state regulatory mandates and changes.

Better Use of Existing Data Can Avoid Penalties – and Serve Patients' Needs

Health plans can reduce their administrative burden – and their network providers' administrative burden – through smarter use of the data they already have coupled with more precise outreach efforts for directory data. Providers are the very heart of the healthcare ecosystem, and matching them with patients is the essence of a payer's existence; to do so, plans need access to current, comprehensive and accurate information about the people who take care of their members. Moving that information into accurate directories and maintaining its accuracy over time is, at the end of the day, only one of the many new data management mandates health plans face – but it's an especially poignant one because when it doesn't work properly, patients suffer.

For more information, call 866.396.7703 or visit risk.lexisnexis.com/healthcare

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