MADENA
BRIDGING HEALTHCARE OPERATIONS

Provider Data Accuracy – why is it important?

Incorrect provider data can have several negative downstream affects.

Provider Directory
The Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage plans to contact their network/contracted providers on a quarterly basis to update the following information in provider directories:

- Closed vs. Open panels (accepting new patients)
- Street address
- Phone number
- Any other changes that affect availability to patients

In a report published by CMS for its third round of MA online provider directory reviews, it found that 48.74% of the provider directory locations listed had at least one inaccuracy. Types of inaccuracies included:

- The provider was not at the location listed.
- The phone number was incorrect.
- The provider was not accepting new patients when the directory indicated they were.

Because members rely on provider directories to locate an in-network provider, these inaccuracies could pose a significant access-to-care barrier. As a result, CMS can, and does, issue compliance actions as a result of directory inaccuracies.

CMS identified several common drivers that may be contributing to provider directory inaccuracies. These include:

- Group practices continue to provide data at the group level rather than at the provider level. Group practices often list a provider at a location because the group has an office there, even if that specific provider rarely or never sees patients at that location. Sometimes this occurs at the direction of the provider group, who may not understand the downstream impacts.
- General lack of internal audit and testing of provider directory accuracy by health plans. MAOs did not create a validation process, and instead relied on credentialing services, vendor support, and provider responses.
- Providers themselves had validated information via fax or email that was subsequently found to be incorrect when CMS directly called the office. CMS believes both the plan and the providers have an active responsibility for ensuring that provider directory data is accurate.

What can be done to ensure these inaccuracies and caught and corrected?

- Work with group practices to ensure that providers are only listed at locations where they accept appointments.
- Remind the provider groups of the CMS requirement to maintain accurate provider directories and that listing all providers at all locations causes plans to be out of compliance with this requirement.

- Validate the accuracy of your provider data stores and data extracts. Implement routine oversight of processes for data validation and self-audits.
- Proactively reach out to providers for updated information on a routine basis using multiple methods: provider web-portals, email, fax, and phone.
- Actively use the data available, such as claims, to identify any provider activity or inactivity that could prompt further investigation.
- Use Call Center and Grievance data to identify provider directory errors and access to care issues being reported.

Network Adequacy

Plans are required to maintain and monitor a network of appropriate providers that is sufficient to offer adequate access to covered services to meet the needs of the population served. Plans must ensure that services are geographically accessible and consistent with local community patterns of care, meaning providers are distributed so that no enrollee residing in the service area must travel an unreasonable distance to obtain covered services.

CMS also monitors an organization's compliance with network adequacy requirements on a triennial basis or upon a triggering event. Triggering events include:

- Initial application – full review
- Service area expansion (SAE) application - partial network review of only the new counties
- Significant Provider/facility contract termination - either a full or partial network review
- Change of ownership transaction - either a full or partial network review
- Network access complaint - either a full or partial network review
- Organization-disclosed network gap - either a full or partial network review

The triennial network adequacy review requires an organization to upload its full contract-level network into the NMM module in HPMS. CMS provides organizations that are due for their triennial review at least 60 days' notice before the deadline to submit their networks.

CMS expects that organizations continuously monitor their contracted networks throughout the respective contract year to ensure compliance with the current network adequacy criteria. If provider data is inaccurate, a plan will not be able to determine if its network is sufficient in number, type, and location of providers.

What happens if a plan fails to meet network adequacy requirements?

- During their triennial review plans may be subject to compliance or enforcement actions.
- Initial applicants may be suppressed from the Medicare Plan Finder for the upcoming Annual Election Period until the initial applicant is determined to have an adequate network in place and is prepared to provide access to services under such network in the new contract.
- Both initial and SAE applicants that fail to meet requirements by January 1 may also be subject to compliance or enforcement actions.
- Plans must ensure access to specialty care by permitting enrollees to see out-of-network specialists at the individual enrollee's in-network cost sharing level for those counties/specialties that fail to have an adequate network.
- Plans may need to make alternate arrangements if the network of primary care providers is not sufficient to ensure access to medically necessary care.

Provider Relations
According to an article published by BenefitsPro[1], providers spend a considerable amount of time and money responding to requests for updated data.

While CMS is working on a centralized repository for provider data, making data collection and verification more efficient and less burdensome for both the plan and providers will result in more accurate and timely data sharing. A centralized database will take time and does not obviate the short-term, immediate need to improve provider directory accuracy. Capitalizing on your Provider Relations and Contracting teams is the best way to obtain the active participation and engagement of providers in improving directory accuracy. Reduce the administrative burden for the health plan and the provider by capitalizing on interactions (authorization requests, peer reviews, claim status calls, etc.) to validate the provider information.

Best practices for a valid and reliable data repository:

Bottom line: actively manage your data and be accountable for the accuracy of the information. Here are some of our best practice recommendations

- Create detailed process/data flow of systems, exports/imports, and data reports that use provider data, linking all areas that "touch" the data.
- When validating provider data, ensure the questions are very clear and concise, and requests include all the necessary provider data.
- Make sure your data repository is capturing the data correctly, at both the group and individual provider level.
    - Do not put the business name in the address line.
    - Do not list an intersection as the address.
    - Enter complete street number and name, do not use abbreviations (unless standard USPS abbreviations).
    - Capture suite number is separate field. This is critical to be able to exclude this information in HSD table submissions.
    - Do not include extra words in the address line (e.g. exclude "Attention: Jane Smith")
    - Make sure all street names are spelled correctly.
    - Make sure street numbers and zip codes are valid.
- Validate that the data is flowing to directory and website vendor(s) correctly and timely.
- Establish routine processes for reaching out to all providers for data updates.
- Audit not only the data repository but the directory and website vendors' use of the data.
- Perform independent data validation audits via reaching out to providers.

Since data integrity continues to be a CMS priority for the compliant operations of your plan, and to prevent any barriers to access-to-care for you members, it is critically important to get provider data correct. Madena can help provide guidance, suggestions, and perform data validation audits to identify data quality issues and mitigate compliance actions. Contact us or learn more at www.madenasolutions.com.

[1] https://www.benefitspro.com/2019/11/20/the-cost-to-keep-provider-directories-up-to-date-2-76-billion-annually/