Virsys

Automating Provider Directory Data: Avoid Surprise Billing and Non-Compliance through Real-Time Updates

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EXECUTIVE SUMMARY

For years, healthcare administrators have grappled with the issues of incomplete, inaccurate, and outdated provider data in managing health plan directories. Without a single trusted source of provider data, health plans must rely on multiple internal and external sources to ensure the integrity and completeness of their directories. Facilitating this process, administrators have been resigned to the time-consuming and labor-intensive process of contacting providers directly and manually updating listings.

At the point of care, inaccurate directories limit a patient's access to necessary treatments and services. This can result in surprise billings from the provision of out-of-network care, sometimes even at facilities in one's own network.

Since Medicare and Medicaid Centers, as well as several state legislators, have implemented fines for non-compliance, health plan administrators will need to focus more of their human resources on maintaining accurate provider directories. According to the Council for Affordable Quality Healthcare (CAQH), reducing provider outreach alone could save health plans approximately $91 million annually (1).

Increasingly, technological applications and solutions are being developed to reduce the administrative costs and inconvenience of keeping directories up to date, including health plans.

PROVIDER DIRECTORY DATA: A CRITICAL CHALLENGE FOR HEALTH PLANS

Although access to comprehensive and reliable data is quickly becoming the lifeblood of healthcare research, administration, and policymaking, insurers are struggling to navigate data overload. Despite the fact that the data includes straightforward demographic information, such as locations and phone numbers, it has been difficult to standardize, manage, and maintain it. For consumers, provider directories are a critical part of their healthcare journey to access and secure their care needs.

Nevertheless, in many cases maintaining provider directories continues to be performed manually, even by large health plan providers. **In fact, conservative estimates put the industry-wide costs of maintaining provider databases at $2.1 billion annually, according to CAQH (2).** Beyond the administrative burdens, many directories are inaccurate, due to the disparate sources of information relied upon to pay claims. This is compounded by the fact that providers simply cannot keep up with notifying health plans of necessary changes to directories.

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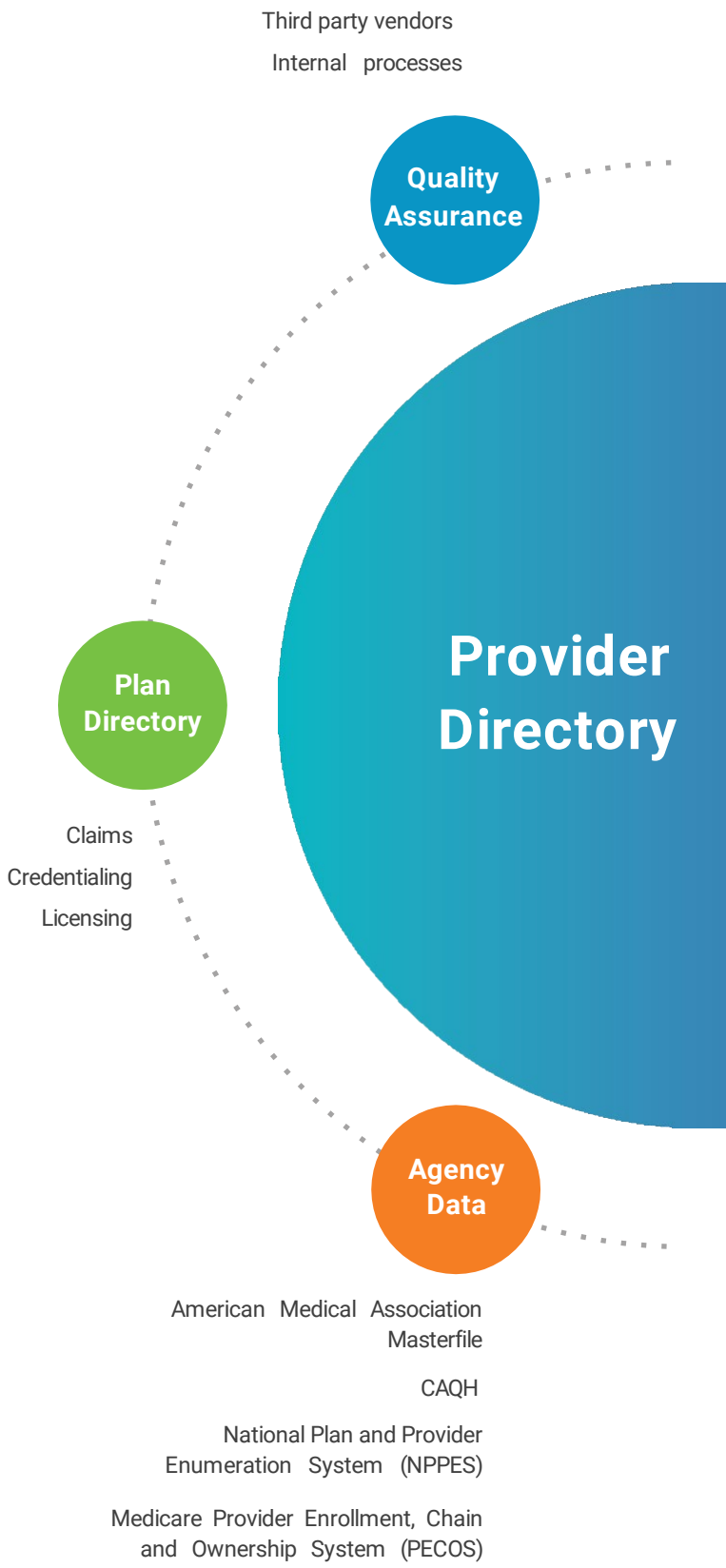


Ultimately, inaccurate provider directories result in disgruntled plan members and surprise billings, not to mention potential penalties for payers. Patients pay the price of inaccurate provider directories when they receive surprise billings for out-of-network care, and from in-network facilities by out-of-network providers (such as radiologists, anesthesiologists, pathologists, and assistant surgeons).

Given its increased visibility in the media and the focus of the current United States' administration, surprise billing will likely be a focal point in the upcoming election cycle. While the No Surprises Act (H.R. 3630) and the Lower Health Care Costs Act (S. 1895) await the House and Senate votes before being signed into law, the ramifications of surprise billing continue to plague payers and patients alike (3,4). Not even providers emerge unscathed since they are often blamed for surprise billing and can end up looking like the villain.

With insurers now facing hefty potential fines for non-compliance – as high as $25,000 per member – health plan providers are experiencing increased pressure to find cost-effective ways to improve the accuracy of their provider directories. Maintaining accurate provider information has been difficult in part because plans have allocated limited resources to adequately execute their directories.

In addition to needing data for provider directories, the critical use cases for health plans include: claims processing, contracting, credentialing, network development, care and use management, quality assurance, and fraud and abuse.

THE TRUE COSTS OF NON-COMPLIANCE

Because provider data changes frequently, directories must be regularly updated. Common demographic data consisting of personal, professional, and practice information is often described as "commodity data" and is typically updated by the provider or their staff. Working with multiple data sources makes manually updating the provider directory challenging, time-consuming, and prone to error.

Issues over the accuracy of provider directories have attracted the scrutiny of both the Centers for Medicare and Medicaid Services (CMS) and state regulatory bodies. For example, Medicare Advantage Plan administrators must now contact providers on a quarterly basis to keep their provider directories up-to- date. As of 2016, CMS began to conduct annual reviews of Medicare Advantage online provider directories for errors and inaccuracies. So far, CMS has determined that up to half of some provider's directory information is inaccurate (5).

In 2018, a CMS audit of provider network directories, published by Medicare Advantage Plans, found that 48 percent of provider locations contained at least 1 inaccurate data entry (6). This prompted the CMS to send 23 notices of non-compliance and 31 warning letters to Medicare Advantage Plan administrators (7). While CMS has yet to impose fines for non-compliance, several state agencies have issued fines – with California leading the way with a $350,000 fine to Blue Shield of California and a $250,000 fine to Anthem Blue Cross (8).

The fines issued by the state Department of Managed Health Care were miniscule compared to the reimbursements paid to patients who were charged out-of-network costs due to inaccurate listings. Blue Shield paid more than $38 million in refunds to affected patients (9). Anthem would later spend more than $4 million in California to make its directories more accurate and user-friendly (10).

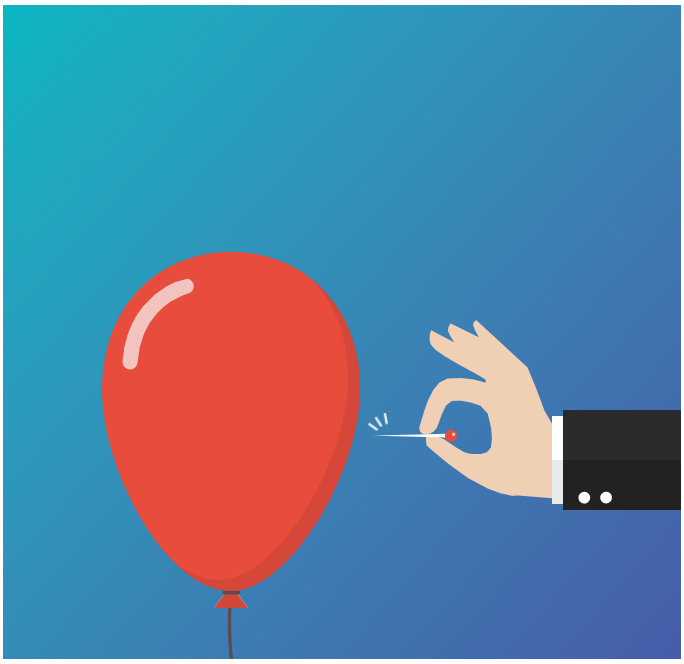
The network adequacy mandate to comply with a certain number of providers in select categories is also a factor for provider directories. A lack of coverage can be perceived as deception and also comes with costly fines. Limited providers can also impact the coverage of the network and the plan's ability to fulfill benefits by failing to provide reasonable access to sufficient numbers of in-network primary care and specialty physicians, not to mention all of the health care services included under contracted terms. State laws have increasingly required provider networks to be of adequate size to guarantee capacity and access to care, with the onus on plans to meet individual state requirements (11).

Another problem of inaccurate directories is that providers must endure unnecessary billing and administrative costs.

MULTIPLIED RISKS

Inaccurate directories come at a cost and multiply the risks of the entire network. In fact, payers face four critical risks from inaccurate provider data and inadequate networks, namely:

1. Regulatory risks
2. Claims payment risks
3. Coverage risks
4. Quality risks



1. REGULATORY RISKS

Regulatory risk often carries the highest potential cost to payers. With federal fines of up to $25,000 per error, per physician, and up to $100 per physician for plans on HealthCare.gov, the cost of non-compliance can add up quickly. As noted above, although CMS has yet to impose fines, they have issued several warning letters for non-compliance and some believe fines will be forthcoming. Further, the restrictions that can be imposed on plan administrators that have inaccurate directories can block members from accessing care.

2. CLAIM PAYMENT RISKS

The risks associated with inaccurate provider data could result in improper payouts, adjustments, and recoupments. Additionally, OIG exclusions can go unchecked, resulting in listings of providers who have been sanctioned and should not be seeing new patients.

3. COVERAGE RISKS

For health plan members, inaccurate directory coverage can be perceived as deception. This coverage risk also comes with a non-compliance ramification that can yield costly fines. That is to say, narrower networks result in higher costs of care since providers are limited based on plan coverage.

4. QUALITY RISKS

Without a quality database, members see disconnected provider data, which impacts their ability to make informed decisions and access care. For instance, if patients can't access accurate data, they are limited to only choosing from plan listings at any given time. Broadly speaking, this limitation can impact the health plan by member attrition. Managing costs further narrows the network and prevents plans from ranking providers. Simply put, the costs related to inefficiency and disconnected provider data add up quickly.

POTENTIAL SOLUTIONS AND THEIR DRAWBACKS

Solutions to resolve the issues of provider data and non-compliance faced by payers range from taking no action to sourcing automated real-time technological applications to keep provider data up-to-date. Indecision or inaction carries costs and ramifications, including significant fines for non-compliance.

One of the biggest hurdles health plan administrators confront is sourcing a proven, feasible process for updating provider directories. Managing the data for thousands of providers with hundreds of contracts and potential network variations has health plan administrators seeking solutions from third-party vendors. Until a centralized repository capable of propagating clean, curated provider data emerges, there will be several disparate sources that providers must aggregate to form a complete provider directory. Even large health plan administrators have been known to employ spreadsheets to update their provider directories.

PROVIDER DIRECTORY SOLUTIONS

Manual Directory Updating	Time-consuming and costly
Multiple Source Monitoring	Time-consuming and conflicting provider information
Vendor Listing Provider	Costly and unreliable provider information
Data Verification Vendors	Costly and complex, duplication of efforts

Real-Time Intelligent Software—*the Preferred Solution*

IS TECHNOLOGY THE ANSWER?

Because of the complexity of managing healthcare data, some insurers choose to outsource this work (in whole or in part). A variety of vendors have emerged, offering diverse provider data solutions around collecting, managing, and distributing provider data. Although these solutions have the potential to alleviate the administrative burden on payers, their results are often dictated by the quality of the data source(s).

Given these considerations, the solution that would offer the most flexibility and responsiveness to meet the administrative needs and demands is a platform that consolidates multiple provider data sources and that has the capacity to self-correct provider profile data from multiple sources (including claims, provider scorecards, and CMS data). The profile could then be used for providers who are both in- and out-of-network for ranking, querying, and network adequacy purposes.

INFORMATION

Hospital price transparency requirements are a moving target. Rules around them are actively being debated, written, and re-written by CMS. While the specifics have yet to be finalized, one thing is certain: the need for up-to-date provider directories will be more vital than ever in order to avoid possible penalties as early as 2021. Based on a previous rule we fully expect that providers will be required to make public their standard charges in a machine-readable format, including CMS-specified 'shoppable' services—meaning a service than can be scheduled in advance. The data must be made accessible to consumers and must be searchable by service description, billing code and payer.

THE BENEFITS OF A PROVIDER DATA ENGINE

To solve both the provider data and compliance problems faced by insurance plans, a real- time connected provider directory delivers the most intelligent and accurate listings.

Virsys12's Salesforce based applications for provider network management (V12 Network) and provider directory management, V12 Provider Data Engine (V12 PDE), can integrate with popular data provider sources, health systems, managed care organizations, integrated physician networks, and accountable care organizations. The V12 applications are scalable, robust, and built on the Salesforce platform which is proven to reduce manual input, improve efficiency, and increase margins with automated workflows. Both applications include bidirectional access from any system including Salesforce Health Cloud, and many more.

With V12 applications, large health plans can scale to new markets and add networks with confidence and success while emerging payers can build and manage a network in weeks.

V12 applications have far-reaching benefits, including:

- Workflow automation to eliminate manual efforts
- Improved financial outcomes
- Paying valid claims only
- Avoiding high-cost fines
- Helping plan administrators stay off the state regulator's 'naughty list'
- Higher member satisfaction
- Better-informed decisions
- Selecting the best providers

CONCLUSION

Because provider data is always changing, directories will remain a source of frustration requiring health plans to commit adequate resources to maintain and keep listings up-to-date. Inaccurate provider directories lead to a succession of problems, beginning with member dissatisfaction as a result of out-of-network care, which later becomes surprise billing. Since manually updating directories by calling providers is especially burdensome, insurers seeking to consolidate the process in order to avoid costly fines by CMS and state agencies now have increasingly more options. Streamlined services and platforms designed to alleviate the administrative burden on both health plans and providers have emerged with Virsys12's V12 Network and V12 PDE "Provider Data Engine" at the top of the list.

NOTES

1. Defining the Provider Data Dilemma, CAQH, September 29, 2016.

2. Defining the Provider Data Dilemma, CAQH, September 29, 2016.

3. "H.R. 3630 — 116th Congress: No Surprises Act." www.GovTrack.us. 2019. November 6, 2019 <https://www.govtrack.us/congress/bills/116/hr3630>

4. "S. 1895 — 116th Congress: Lower Health Care Costs Act." www.GovTrack.us. 2019. November 6, 2019 <https://www.govtrack.us/congress/bills/116/s1895>

5. Provider Directory Review Industry Report Round 3 (CMS), November 28, 2018.

6. Provider Directory Review Industry Report Round 3 (CMS), November 28, 2018.

7. Provider Directory Review Industry Report Round 3 (CMS), November 28, 2018.

8. Blue Shield of California, Anthem Blue Cross fined for inaccurate provider directories, Joanne Finnegan, Fierce Healthcare, Nov 4, 2015.

9. Blue Shield of California, Anthem Blue Cross fined for inaccurate provider directories, Joanne Finnegan, Fierce Healthcare, Nov 4, 2015.

10. 'Health Insurers to Face fines for not correcting doctor directories', The Wall Street Journal, Dec. 28, 2015.

11. Insurance Carrier and Access to Healthcare Providers, Network Adequacy, NCSL, February 1, 2018.

ABOUT THE SPONSOR

Virsys12 is a Salesforce Gold Consulting & AppExchange Partner focused on healthcare innovation nationwide. With success providing transformative technology for mid-market to enterprise, and public and private organizations, the team maintains top customer satisfaction ratings and user adoption. As a recipient of the Salesforce Partner Innovation Award for Healthcare & Life Sciences in 2017, we guarantee our services for implementation, integration, application, and technology strategies.

To see a demo of Virsys12's applications V12 Network and V12 PDE "Provider Data Engine", or to learn more about how you can keep your provider directory up-to-date, please visit our website, call 615-800-6768 or email solutions@virsys12.com.