SANATOR
PROVIDER REGISTRY

SB137 Implications for Health Plans and Provider Organizations

Green Paper

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"Green Paper" is a term used by European and Commonwealth countries to describe a tentative legislative report and consultation document of policy proposals for debate and discussion. A Green Paper often precedes a more definitive White Paper once the content is finalized. California Senate Bill 137 is still in its infancy and subject to interpretation in many areas, for this reason we publish this "Green Paper" to guide debate on this topic.

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Contents

Introduction

Commencing July 1, 2016, a health care service plan shall publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrolees, including those that accept new patients. A provider directory shall not list or include information on a provider that is not currently under contract with the plan.

California Senate Bill No. 137

California senate bill No. 137 (SB137) was passed into law on 8th October 2015 and comes into effect on 1st July, 2016.

Gaine has been working with provider organizations, trade associations, regulators and health plans since the bill was passed to create a state-wide provider registry. Our focus has been on defining processes that result in an overall reduction in administration for all stakeholders. This paper explores the key terms of the statute as they apply to the relationship between plans and their contracted provider organizations.

The opinions expressed in this document were formed in (quite literally) hundreds of conversations with stakeholders from all corners of the California health care market. However, no matter how well informed the content of this paper, we must include the following statement:

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We welcome your feedback or questions at *www.providerregistry.com/contact-us/*

Key Terms for Health Plans and Provider Organizations

We have extracted and summarized the key terms from SB137 as they apply to the relationship between health plans and their provider organizations. The reference to the statute is included when quoting from the bill. For a full reading of the bill refer to *https://legiscan.com/CA/bill/SB137/2015*

SB137 governs health plans directly; Individual providers (IPs) and provider organizations (POs) are impacted indirectly via amendments to health plan contracts required to enable health plans to comply with the new legislation. Health plans were required to file their proposed contract amendments with the Department of Managed Health (DMHC) care by May 6th, 2016. Gaine has copies of many of these amendments however, at the time of writing, these amendments have not yet been ratified by the DMHC and are still subject to change.

Summary of Key Terms

The key terms of SB137 as they apply to the relationship between plans and POs are summarized below:

- Plans must update provider directories weekly.
- Plans have an obligation to confirm changes communicated to them before publication in a directory.
- POs must communicate changes to panel status to their contracted plans within 5 days of identifying a change.
- Plans must provide POs with an electronic interface to submit changes to provider details. The act does not stipulate the nature of this “online interface”.
- Plans can define the process and format of how changes are submitted by POs. These processes and formats are subject to review and acceptance of DMHC.
- Plans do not control how POs verify their provider information.
- In order to validate a plan directory, the plan must provide POs with the current directory information and the network and product information.
- POs must validate their provider information at least every 12 months.
- IPs must validate their provider information at least every 6 months.

Weekly Updates by the Provider

(j).(1) The contract between the plan and a provider shall include a requirement that the provider inform the plan within five business days when either of the following occur:

A. *The provider is not accepting new patients.*

B. *If the provider had previously not accepted new patients, the provider is currently accepting new patients.*

This clause is very specific in defining the changes that POs or IPs must communicate to a contracted plan, but this paragraph does not specifically limit the information a plan may request. POs are looking carefully at plan amendments to consider the practicality of communicating additional changes requested by plans within the 5 business day window.

Plans should expect resistance to overreaching requests for data if these additional requests will place a material burden on the POs. We have already seen "cease and desist" notices filed by POs and their advocacy partners in reaction to overreaching plan amendments.

Online Interface

(m).(2) Every health care service plan shall ensure processes are in place to allow providers to promptly verify or submit changes to the information required to be in the directory or directories pursuant to this section. Those processes shall, at a minimum, include an online interface for providers to submit verification or changes electronically and shall generate an acknowledgment of receipt from the health care service plan…

The act contains no definition of "online interface" and this should not be construed as a provider portal to be accessed by POs or IPs. Plan amendments suggest that this requirement is satisfied by the facility to accept an Excel spreadsheet or the provision of an email inbox. However, the clause does invalidate any requirement for POs to report changes via telephone, fax or written notification.

(m).(2) continued …Providers shall verify or submit changes to information required to be in the directory or directories pursuant to this section using the process required by the health care service plan.

Plans should expect that POs will look very closely at the plan contract amendments to determine whether the process required by a plan is reasonable and does not place an undue burden on their business.

To the maximum extent possible, plans should ensure that their process for notifications is flexible and can be automated by the POs. Inflexible reporting mechanisms that require manual input are likely to be challenged by the POs.

Reporting Inconsistencies

(5.m.3) The plan shall establish and maintain a process for enrollees, potential enrolees, other providers, and the public to identify and report possible inaccurate, incomplete, or misleading information currently listed in the plan's provider directory or directories.

When a consumer complaint is registered with the plan it may be necessary to involve the contracted PO or IP to resolve the grievance. Plans should establish a mechanism to report grievances to the contracted PO or IP that enables both parties to track progress and to analyze the root cause of the problem.

Verification of Provider Details

(l).(1) A plan shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the plan's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire provider directory or directories for each product offered.

This paragraph places the responsibility on the plan to review and update the provider directory for each product offered at least annually – this does not mean that this validation is limited to once per calendar year. Individual providers must be notified at least every 6 months, POs must be notified at least every 12 months. There is no limitation stipulated in the act as to the maximum number of times an IP or PO can be notified by the plan.

(l).(2) The notification shall include all of the following:

(A) The information the plan has in its directory or directories regarding the provider or provider group, including a list of networks and plan products that include the contracted provider or provider group.

The act stipulates that the plan must provide POs with the directory information they hold, and a list of networks and plan products.

(C) Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface developed pursuant to subdivision (m).

The notification to the POs must also include instructions on how the POs can update their directory information. This process must support some form of electronic transmission of data changes.

(l).(3) The plan shall require an affirmative response from the provider or provider group acknowledging that the notification was received. The provider or provider group shall confirm that the information in the provider directory or directories is current and accurate or update the information required to be in the directory or directories pursuant to this section, including whether or not the provider or provider group is accepting new patients for each plan product.

This paragraph stipulates that POs must confirm that the data is correct and accurate but it does not stipulate how the POs should accomplish this validation.

(n).(1) This section does not prohibit a plan from requiring its provider groups or contracting specialized health care service plans to provide information to the plan that is required by the plan to satisfy the requirements of this section for each of the providers that contract with the provider group or contracting specialized health care service plan. This responsibility shall be specifically documented in a written contract between the plan and the provider group or contracting specialized health care service plan.

This paragraph confirms that the plan may require an IP or PO to provide the provider information required to maintain the plan directories by including specific wording in the plan contract. If this responsibility requires a plan contract amendment, these amendments are subject to review and acceptance by the DMHC.

(n).(2) If a plan requires its contracting provider groups or contracting specialized health care service plans to provide the plan with information described in paragraph (1), the plan shall continue to retain responsibility for ensuring that the requirements of this section are satisfied.

This paragraph can be roughly translated as, if the PO has performed regular roster reconciliations for a plan, then these will continue under the new law.

Payment Delays

(p).(1) Notwithstanding Sections 1371 and 1371.35, a plan may delay payment or reimbursement owed to a provider or provider group as specified in subparagraph (A) or (B), if the provider or provider group fails to respond to the plan's attempts to verify the provider's or provider group's information as required under subdivision (l). …

Payment delays are only allowed under the terms of subsection p if the IP or PO fails to respond to an attempt by a plan to verify the provider information. This clause does not grant plans control over how this verification is performed. In fact, the clause only requires that the IP or PO responds to the plans' attempts to verify the IP or PO information.

(n).(4) A provider group is not subject to the payment delay described in subdivision (p) if all of the following occurs:

A. A provider does not respond to the provider group's attempt to verify the provider's information. As used in this paragraph, "verify" means to contact the provider in writing, electronically, and by telephone to confirm whether the provider's information is correct or requires updates.

B. The provider group documents its efforts to verify the provider's information.

C. The provider group reports to the plan that the provider should be deleted from the provider group in the plan directory or directories.

This clause has given rise to some confusion regarding the method required by POs to "verify" provider information. The verification process prescribed in this clause (by phone, electronically and in writing) is only pertinent to POs establishing a defensive position against potential payment delays if the POs expects to be breach the (much less onerous) terms of (p).(1).

We see no reason why POs would need to resort to a hugely expensive outreach program (n).(4).(A) if the same defense can be achieved by responding to a plans attempts to verify provider information (p).(1).

Common Misconceptions

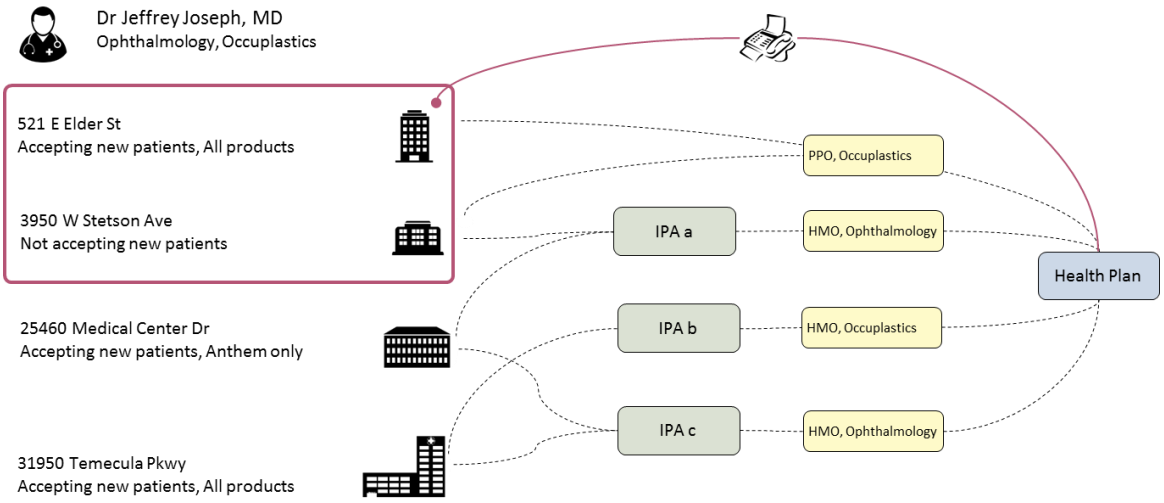
This section outlines some of the more common misconceptions we encounter as we speak with POs, associations, plans and regulators.

Plans Are Confirming Provider Data for Provider Organizations

Some POs are under the misconception that they are compliant with SB137 if their plan has undertaken some direct outreach program.

This is incorrect for several reasons and will create risks for POs if plans do not clarify this misunderstanding with their contracted POs.

Firstly, certain plans are contacting IPs for only certain products and networks. If a plan is not taking responsibility for validating provider information for its contracted POs, then it should inform the POs to clarify this situation. Consider this example:



If the health plan reaches out to Dr. Jeffrey Joseph (at either E Elder St or W Stetson Ave) to verify the PPO contract, none of the three IPA contracts are verified by this process.

Secondly, the periodic outreach to IPs by the plan does not meet the requirements to report changes to the plans within 5 business days.

Lastly, the periodic outreach does not relive the PO of roster reconciliation.

Plans Can Define the Verification Process at a PO

There is a misconception within POs that health plans can require POs to follow a prescribed process for verification (such as calling the doctors), or that the plans may reject provider data from a PO unless the PO is using a "plan approved" process.

Plan amendments, once ratified by the regulator, control the frequency of verification and method of submission of the data from the contracted entity to the plan. The statute does not impose upon health plans the right or responsibility to determine the method a contracted entity uses to verify its provider information.

There is no facility within the statute that would prevent a PO or IP using the Sanator Provider Registry for its verification process or preparing the files for submission to the plan. In fact, using Sanator when both the plan and PO are subscribers essentially removes the need for periodic verifications as provider data is synchronized on a daily basis.

Only Individual Provider Must Notify Plans of Changes

This is a misconception that the responsibility to report changes to the plans within 5 business days only applies to individual providers.

The statute and plan amendments require that all contracted providers, IPs, and POs, report changes within 5 business days. If a PO is aware of a change to panel status for one of its IPs then the PO must also communicate this change to all contracted plans within 5 business days.

POs Must Verify Information by Phone, Fax or Written Letter

The misconception around the method of verification arises from the definition of "verify" within the defensive provisions of subsection n, paragraph 4, sub paragraph A.

The method of verification for the purposes of defending an otherwise non-compliant process is defined in the statute (see Payment Delays in the previous section of this document).

The process of verification of provider data to meet the requirements of subsection l, paragraph 3 or subsection n, paragraph 1, is not specified in the statute or any plan amendments that we have reviewed at the time of writing.

POs are free to adopt a process of validation that is most efficient within their normal course of business as long as the level of data quality meets the accepted standard at any point in time.

Best Practices

We have compiled a set of best practices from the more than fifty provider organizations, health plans and trade associations that are currently using the Sanator Provider Registry.

Leverage Each Contact

In the normal course of business, plans and POs are in contact with their individual providers for a variety of reasons. Each one of these encounters presents a "free" opportunity to validate some or all of the provider's data. Many organizations are already doing this type of validation on an ad hoc basis, but most only capture changes when they are required and have no record of when the current data is validated as correct.

Plans and POs should use the Sanator Provider Portal or equivalent tool to mark certain data elements of the provider's portal as validated during these interactions.

During the course of normal business, and with multiple points of contact for each individual provider, each provider's profile is regularly validated. By tracking these validations, when periodic validations are due, it is only necessary to verify "stale" data that has not been recently validated. This process enables the "crowd sourcing" of provider validations between Sanator subscribers— thus reducing the administrative burden for all participants.

Tracking Distributions from POs and IPs

Subsection q makes provision for plan enrolees to be compensated for any charges they incur as a result of incorrect directory data. We assume that if the health plan is able to track this loss to bad data provided by a PO or IP, then the PO or IP would be expected to incur the loss.

Plans should use the Sanator Registry or equivalent process to ensure that they can recreate the provider data provided to them at any point in history. Plans that are able to show that the error occurred because bad data was sent to them by an IP or PO are much better positioned to pursue claims arising from directory inaccuracies.

Adopt a Robust Data Integration Method

SB137 is going to increase the volume and frequency of provider data reported to plans. More data more frequently does not always translate into better data quality; indeed, the addition of

data directly from physicians' offices and data from POs are likely to result in lesser data quality unless the plans have an extremely robust integration capability.

Plans that adopt the Sanator Provider Registry process have the benefit of aggregating and comparing provider data from multiple parties prior to publication. Sanator identifies conflicts, tracks confirmations, and tracks verifications wherever they arise in the Sanator network. In combination with confirming provider data at each encounter, Sanator will greatly reduce the number of providers that any plan must contact for the purposes of additional validation.

Another benefit of the Sanator process is that a large number of POs and plans have adopted this method of data validation— which means if data is incorrect, then it is incorrect for everyone in the network providing some degree of "safety in numbers" when under scrutiny from regulators.

Automate Roster Reconciliation

Roster reconciliation is still required for POs that are required to perform this arduous task on a periodic basis. Some plan amendments request more frequent roster reconciliation to increase the quality of provider directory data.

Plans and POs should get away from the time consuming, and error prone manual reconciliation of rosters to reduce administrative costs and potential penalties. The Sanator Registry enables complete roster reconciliation in an automated process within 24 hours of receiving the standard roster format from a contracted health plan.

Process Improvement

Good data quality results from good data management processes. Plans and POs should be able to trace data errors in directories to the process failure that created the error. Only by tracking the root cause of data quality problems can processes be improved.

Sanator Provider Registry provides complete auditability of all data changes which enables any Sanator participant to investigate precisely where any data error originated.

Manage Your Workflow

The new SB137 legislation will undoubtedly create better provider directory information over time, but we have years of "process debt" to deal with before we reach the levels of data quality desired by the regulator and the public. In the first year of SB137 we can expect a large amount of "churn" with regards provider data maintenance. Plans and POs may be overwhelmed by the

number of data deficiencies and conflicts that exist across the all organizations participating in the process. Plans and POs should establish an internal process to sort and prioritize their data gaps. Not all data gaps are of equal importance; for instance, conflicts in the spelling of a provider name or date of birth could be considered less important than the provider's panel status at a particular location.

Sanator creates a centralized work queue of data errors and warnings along with the ability for each Sanator subscriber to sort and prioritize these notifications. In addition, Sanator provides various analysis on notifications raised by the system including: the type of notifications raised, how the notifications are resolved, who responded to the notification, and how long it takes to respond to a notification.

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