The Voice of Accountable Physician Groups

August 3, 2016
Bill Barcellona
Sr. VP Government Affairs

Provider Directories – Driving Accurate Lists for Consumers

CAPG is an association of more than 180 capitated-delegated physician groups across California that serve 18 million Californians. Our membership also spans 43 other states. CAPG member "Groups" construct multi-specialty networks of physicians and other providers to enable coordinated patient care across the primary, specialty, inpatient and post-discharge spectrum. Often, these groups are comprised of hundreds and sometimes thousands of individual providers. The individual providers may be employed, contracted, exclusive to the network, or not. Our members contract with several different health plans and insurers. Overall, CAPG physician groups serve over half the population of California and contain over 50,000 active practice physicians and other health care providers. This market reality creates significant challenges for compliance with the new provider directory laws and regulations. This paper summarizes these issues.

The Knox Keene Act defines "Provider Group" as either a "medical group, independent practice association, or any other similar organization" under Section 1373.65. Health plans and insurers frequently contract directly with provider groups to obtain access on behalf of their members to an entire multi-specialty network of physicians and affiliated providers.

What is a Provider Directory? A directory should be a living document that changes daily to reflect the evolution of a health plan's provider network. It should inform a prospective patient about the various types of providers available, their qualifications and capabilities, and provide a little background to personalize each listed individual. The directory should also reflect the market reality of provider organizations, so that consumers can begin to learn more about the availability of organized providers that coordinate care across a spectrum of services. At a broader level, CAPG advocates for a single, multiplan directory for Californians that will allow consumers and purchasers to compare each plan's network to the other's.

The Technical Compliance Requirements:

SB 137 includes specific requirements for provider groups to comply with the statute:

- The provider group shall provide an affirmative response to the notice provided by the plan (at least annually) and 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 – 1367.27(l)(3).

- Comply with the plan contract requirements of this section for each of the providers that contract with the provider group or contracting specialized health care service plan – 1367.27(n)(1). This includes both statutory and negotiated contractual obligations on the part of network providers and provider groups. Many of the distinct requirements are set forth in the next section covering health plan compliance under SB 137.
- Terminate a contract with a network provider for a pattern or repeated failure of the provider to update the information required to be in the directory or directories pursuant to this section – 1367(n)(3).
- 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 – 1367.27(n)(4)(A)-(C).

SB 137 also contains specific requirements for plans concerning provider groups:

- Enrollees, potential enrollees, providers and the public must be able to search by "provider group" within the plan's public internet web site - §1367.27(c)(2)
- Update its online provider directory at least weekly when informed that an individual provider within a provider group is no longer accepting new patients - §1367.27(1)(A)
- Remove an individual provider listing from its directory when informed by the provider group that the individual is no longer associated with the group - §1367.27(e)(2)(C)
- List the provider group currently under contract with the plan through with which the individual provider sees enrollees - §1367.27(h)(7)
- For physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with the plan - §1367.27(8)(A)
- Notify a provider group at least once annually with the following information:
  (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.

(B) A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subdivision (p).
(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) - §1367.27(l)(1)(B)(2)(A)-(C)

- The plan shall require an affirmative response from the provider group acknowledging that the notification was received - 1367.27(l)(3) and non-responsive provider groups shall be removed from the directory listing at the next required update - 1367.27(l)(4).
- Establish a process to allow provider groups to promptly verify or submit changes to the information required in the directory or directories, which shall include an online interface the verification or changes electronically and generate an acknowledgment of receipt – 1367.27(m)(2).
- A plan may require its provider group 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 – 1367.27(n)(1).
- Abide by the provisions of the Health Care Provider's Bill of Rights with respect to any material change in the provider contract – 1367.27(N)(5).
- Delay payment to a provider group that has not responded to the notice under Section 1367(l) – 1367.27(p)(1). The payment delay is subject to a process set forth under 1367.27(p)(2).
- Terminate a provider group contract for a pattern or repeated failure to alert the plan to a change in information – 1367.27(p)(3).
- Document each instance that a payment was delayed and report it to the Department – 1367.27(p)(4).

How do Provider Groups Comply with SB 137?

Health Plans provide "rosters" to a contracted provider group that contain all of the required information fields for each individual provider in the provider group's network. Plans are required to inform the provider group of each product and network in which the provider group is listed. Separate rosters may be required to satisfy this provision. The rosters are typically formatted under Microsoft Excel and must be modified through time-consuming key strokes. Some plans provide Excel rosters but then require provider groups to go online and make manual edits to individual provider listings.

It is typical for a provider group to hold a dozen to two dozen separate plan contracts. An example is provided as Attachment A to this paper. A provider group is therefore required to comply with each plan's distinct procedure for roster verification and updates. Each plan utilizes a different format and exchange procedure. Some require

special color codes in the Excel workbook fields. Others require submittal through one and only one email address. Beyond the workload imposed by the varying formatting and protocols for exchange, timing is also an important factor. Health plans use monthly, quarterly, semi-annual and annual exchange cycles with their contracted provider groups. The 30-day review periods triggered by a roster notification could foreseeably overlap between several plans – leading to significant increases in the provider group's staffing workload to comply with plan directory submittal requirements.

Because the roster verification process utilized by each plan is unique, highly manual in nature, prone to human error and time consuming – CAPG will review each plan's submitted SB 137 policy and procedure to determine whether it meets the standard required under the Act for prompt and timely verification (§1367.27(m)(2)). Particular areas of focus include:

- The time it takes for provider group staff to make changes to the plan's directory via the plans' online portal – which could be so cumbersome that the process is not "prompt."
- Whether a receipt of the change is generated by the plan's portal
- Whether the plan's procedures typically result in the processing of changes submitted by a provider group (Groups frequently complain that their submitted changes are not processed by the plans).
- Whether a plan's process intentionally bypasses the contracted group and directly contacts the individual providers within the group network. If so, whether the plan has a process in place to promptly notify the group of any changes to the information concerning the individual providers that it contacted directly. A group cannot adequately verify an individual provider's information if it never receives notice of the update that the plan obtained directly from the individual. Such procedures create endless disputes over the validation of information in the directory.
- Whether the plan's format for roster review and verification clearly identifies variations in products and networks for individual providers within a group's network
- Whether the plan's rosters contain all of the required data fields for each provider type and individual provider required to be listed in the directory. Some plans are distributing blank provider rosters. Blank or incomplete rosters do not contain information that can be "verified" under SB 137 and are not compliant.
- Does a plan's submitted process tend to produce a high percentage of validated information about its providers, or does it reveal a lack of administrative capacity to comply with the requirements of the statute?
- Whether a plan can accept automated, validated information from a provider groups' third party vendor.

How Can Roster Review and Submittal Be Improved?

Health plans must recognize that provider groups have multiple contracts and that the tremendous variation is the roster review process creates unnecessary inefficiency. Provider groups often contract with individual providers rather than employ them. Individual providers that are not exclusive to one group are also subject to a barrage of phone calls, faxes and varying submittal procedures as well. Not just from the plans that they contract with directly, but the three or four IPAs and the local FQHC as well. These individual providers will receive dozens of contacts to verify their information. Plans must realize that they cannot ensure accuracy concerning the contractual obligations of providers unless all parties to the agreement are part of the directory and review process.

For example, it is typical for individual providers to function at several office locations – and some of these locations may be unique to certain provider group networks, certain plan contracts, and not others. It is also common for individual providers within an independent practice association network to be subject to contractual requirements that are too complex for them to report directly to a provider directory vendor retained by a health plan. In that instance, input from the provider group is also necessary to resolve specific contract issues – such as whether an individual provider can close their practice without the prior approval of the IPA. Health plans that are bypassing contracted provider groups to verify information directly with downstream individual providers will cause greater inaccuracy through this process. When it comes time to reconcile their roster with the contracted medical group or IPAs that incorporate the doctor into each of their networks, errors and disagreements will result. For example, one plan that selected individual providers to serve in its Covered California 2014 PPO network ended up listing several dozen IPAs in that network. The individual providers were part of such IPA networks – but IPAs do not participate in PPO networks due to FTC antitrust rules. Consumers referring to the directory saw that a 1200-doctor group in Fresno was part of the PPO network, when in fact the plan had only selected 7 directly contracted physicians that happened to be part of that group. The plan's directory was not only inaccurate and misleading, it raised antitrust exposure issues for those groups mistakenly named in the directory with federal regulators.

Processes that rely on static "snapshots" of provider information submitted from multiple sources create conflicting data that can never be reconciled. This is why one plan had a provider directory with over 10,000 distinct provider group names – while only about 200 such groups exist in California. A single group was identified by 20 different names. Excel spreadsheets aren't capable of automation to reconcile varying names for the same group. CAPG created and submitted a provider group naming convention system in 2014 to the DMHC, which we understand has been adopted by the Department for use by plans in the annual submission of timely access network

adequacy filings. We urge the immediate adoption of this system for all provider directory compliance under SB 137 by the plans and their delegated provider groups.

In the directory model that CAPG has sponsored, such situations are avoided because multiple sources of information about a single provider are aggregated, and a picture is built up of the varying and complex relationships for that doctor. Because the process is externalized at a registry level, a clearer picture can be obtained that is more likely to be accurate. If inaccuracies exist, they can be flagged, reported and changed quickly. Internalized, siloed directory processes within each plan cannot and will never be able to provide this level of timeliness, accuracy and efficiency.

Health plans can work with CAPG and its members to accept automated, validated information from a single source rather than imposing outdated, manual, error-prone Excel spreadsheet-based information or imposing manual updates to electronic portals that are just as time-consuming and error prone.

CAPG has proposed and sponsored a solution that allows provider groups to maintain accurate, timely information about the individual providers in their network that can be shared with all affiliated contracting health plans. When provider groups can enter updates to an individual provider's information once, it is more likely that this information will be correct and reported timely to each health plan rather than making dozens of the same entries manually within each plan's unique portal.[1] We strongly recommend the following capabilities from provider directory vendors:

- Once and done capability – a provider group administrator makes a change which can be promptly reported out to each contracting health plan via an automated system.
- A registry style structure that permits several groups, plans and individual providers to contribute information on the same topic that is processed, reconciled and updated in a systematic, accurate manner, and which allows each party to independently review, accept or reject updated information provided through the registry.
- Pre-population of roster information from several data sources to simplify and speed up the process of roster creation and maintenance.
- The automated portal records and preserves the date, time and content of all transactions so that an auditable trial of compliance is available to the group and the plan.
- Full recognition of the contract-level reporting obligations of each party subscribing to the registry.
- Capability to meet varying formatting requirements utilized by each health plan

[1] See Gaine Healthcare, www.providerregistry.com.

- Capability to allow individual network providers to update their information within a provider group's network listings, subject to review/approval by the provider group administrator.

Building a Single, Uniform Online Multiplan Directory for California:

CAPG wrote to the Director of the Department of Managed Healthcare in September, 2015 urging that she require health plans involved in mergers to adopt "undertakings" that required the development and funding of a single online multiplan directory for consumers in California.[2] We did this because such a system will be far easier, cheaper, more accurate and more useful than the dozens of individual, siloed health plan directories currently in use. We were pleased to see the adoption of this policy in the first two orders of undertaking issued by the Department concerning the Blue Shield-Care First and Centene-Health Net mergers. We believe that the architecture of the registry solution developed by Gaine Healthcare will enable such a solution to be deployed within California.

For further information about CAPG's policies related to provider directory development and compliance, see www.capg.org/advocacy/california legislative and regulatory policy/SB 137 Provider Directory Implementation or link here.

Contact:

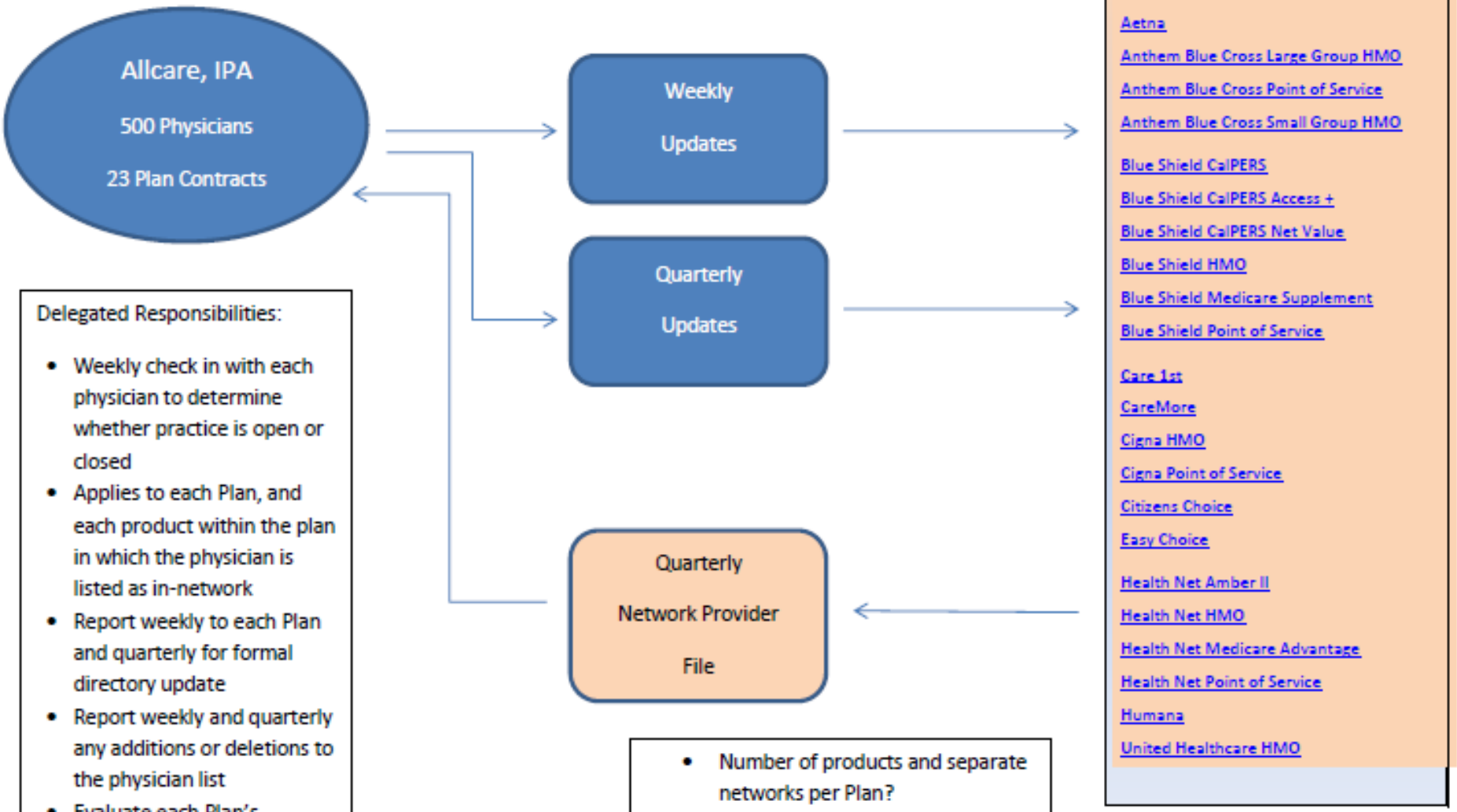
Bill Barcellona
Senior Vice President for Government Affairs
CAPG – the Voice of Accountable Physician Groups
1215 K Street, Suite 1915
Sacramento, CA 95814
(916) 443-4152
wbarcellona@capg.org

Attachment A: Example provider group roster exchange graphic

[2] Follow this link: http://www.capg.org/index.aspx?page=303.

ATTACHMENT A: PROVIDER GROUP EXAMPLE

Operational diagram of how SB 137 provider directory process would work for a mid-level medical group



Delegated Responsibilities:

- Weekly check in with each physician to determine whether practice is open or closed
- Applies to each Plan, and each product within the plan in which the physician is listed as in-network
- Report weekly to each Plan and quarterly for formal directory update
- Report weekly and quarterly any additions or deletions to the physician list
- Evaluate each Plan's network listing file, which is provided quarterly by each Plan to Allcare

- Number of products and separate networks per Plan?
- How often do Plans change their products and networks, requiring updates to the directory?

California Provider Directory Summit
Draft Agenda

Location: Sterling Hotel

Time	Topic	Summary
10-10:30 am	**Purpose of the Summit**	BSCA and Summit co-sponsors tee up the Summit's purpose before introducing Manatt facilitators.
10:30-11:30 am	**Legislative and Regulatory Environment**	Panel Discussion (Joel Ario to facilitate): • DMHC (SB 137) • CDI (SB 137) • DHCS • Joel Ario or CMS (federal requirements, Medicare, Medi-caid, QHP)
11:30 am-12:30 pm	**Current Initiatives**	Panel Discussion (Jonah Frohlich to facilitate): • Covered California • CAPG • BSC • ONC/Richard/CA HIE
12:30-1:00 pm	**Lunch**	
1:00-3:00 pm	**Working Session**	Manatt to facilitate: 30 mins: Determining use cases and prioritize 60 mins: breakout sessions by use case to evaluate current challenge & barriers, path forward, opportunities for collaboration 30 mins: Presentations by group
3:00-4:00pm	**Vendor Panel**	Vendors to present (10 mins each) on: • Solution Process/Work flow • Data Sources and Validation • How you evaluate accuracy
4:00-4:30pm	**Close and Next Steps**	Summit co- sponsors and Manatt will sum up major takeaways from the day and outline next steps, including concrete mechanisms (i.e., Work Groups) for ongoing stakeholder participation.
4:40-6:00 pm	**Vendor Fair (optional)**	

California Provider Directory Summit
Attendee List

First Name	Last Name	Organization
Andrea	Leeb	Cal INDEX
Eric	Cherney	Coastel eHealth Connection
Lyman	Dennis	Connect Healthcare
Timothy	Tyndall	RAIN
Ayami	Tyndall	RAIN
Will	Ross	Redwood MedNet
Mark	Elson	San Joaquin HIE
Bill	Beighe	Santa Cruz HIE
Dena	Mendelson	Consumers Union
Tam	Ma	Health Access
Linda	Nguy	Western Center on Law & Poverty
Dan	Smiley	Emergency Medical Services Authority
Leslie	Witten-Rood	Emergency Medical Services Authority
Janice	Rocco	Department of Insurance
Elaine	Scordakis	Health and Human Services Agency
Marko	Mijic	Health and Human Services Agency
Ahmed	Al-Dulaimi	Covered California
James	DeBenedetti	Covered California
Raul	Ramirez	Department of Health Care Services
Linette	Scott, MD	Department of Health Care Services
Larry	Dickey, MD	Department of Health Care Services
Cynthia	Guest	Department of Health Care Services
Mary	Wattanabe	Department of Managed Health Care
Havi	Jogani	Department of Managed Health Care
Marta	Green	Department of Managed Health Care
Scott	Christman	Office of Statewide Health Planning and Development
Michael	Valle	Office of Systems Integration
Mike	Hogarth	UC Davis
Michael	Marchant	UC Davis
Ryan	Stewart	Dignity Health
Doug	Angove	Sutter Health
Liz	Ames	Sutter Health
Paul	Matthews	OCHIN
Doug	Jenkins	OCHIN
Ben	Pierson	OCHIN
Rim	Cothren	CAHIE
David	Minch	CAHIE
Karen	Boruff	CAHIE
Angela	Boruff	CAHIE
David	Ford	CalHIPSO

Craig	Paxton	Catane & Stroud
Jeff	Rideout	IHA
Sarah	Summer	Blue Shield of California
Mike	Bassett	Blue Shield of California
Tom	Manning	Blue Shield of California
Kathleen	Lynaugh	Blue Shield of California
Linda	Brown	Health Net
Phil	Katz	Humana
Mike	Stansberry	Humana
Michelle	Espinoza	Molina
Robert	O'Reiley	Molina
Aaron	Sanchez	Molina
Delena	Penner	Scan Health Plan
Syed	Hamdani	Western Health Advantage
Matthew	Eyles	AHIP
John	Wenger	AHIP
Wendy	Soe	CAHP
Athena	Chapman	CAHP
Debby	Rogers	California Hospital Association
Deepa	Prasad	California Hospital Association
Jodi	Black	California Medical Association
Stacey	Wittorff	California Medical Association
Meaghan	McCamman	California Primary Care Association
Dean	Burrill	Hill Physicians Medical Group
Eric	Aquino	Hill Physicians Medical Group
Julee	Gould	Hill Physicians Medical Group
Amy	Adams	California Health Care Foundation
Kier	Wallis	Manatt Health
Jonah	Frohlich	Manatt Health
Joel	Ario	Manatt Health
Reece	Rayford	Beacon Health
Laura	Grossman	Beacon Health
Rich	Gold	Kaiser Permanente
Caroline	Sanders	California Pan-Ethnic Health Network
Komsan	Sem	Health Net
Rick	Krum	Anthem
Terry	German	Anthem
Anthony	Mader	Anthem
Anne	Eowan	ACLHIC
Bill	Barcellona	CAPG
Dave	Briere	Valley Health Plan - Santa Clara County
Ryan	Stanfield	Cal EMSA
Anita	Sankaran	Manatt Health

Vendors

Ari	Tulla	BetterDoctor
Andrew	Kobylinski	BetterDoctor
Scott	Everline	CAQH
Atul	Pathiyal	CAQH
Mark	Bradley	LexisNexis
Michael	Yeganeh	Sales Force
Rajan	Shah	Gaine Solutions
Chris	Westerman	Availity
Mark	Martin	Availity