Medicaid Managed Care Online Network Directories
Workgroup Recommendations

Introduction

The State of New Jersey, Medicaid Managed Care Organizations (MCO), and health care providers that care for Medicaid eligible individuals recognize that timely and appropriate access to health care is a vital goal of New Jersey's Medicaid system. In order to gain access, Medicaid beneficiaries often rely on the health plans' electronic network directories to find a health care provider, obtain telephone numbers, determine the location, hours, and other relevant information about the provider. In addition, when beneficiaries choose a particular Medicaid health plan they may consult the plans' online directories to determine whether the health care providers they want to see are listed in the plan's network. Therefore, it is important that consumer-facing provider-network information is accessible, complete and accurate.

There are various hurdles to achieving the shared goal of accessible, complete and accurate network directories. These hurdles involve technology, improved communications, and restructuring workflow as various lists of network providers are used for contracting or credentialing but may not be optimal for a consumer-facing directory. Therefore, the Division of Medical Assistance and Health Services saw the need to address the issue in a multi-stakeholder fashion and asked the New Jersey Health Care Quality Institute and the New Jersey Association of Health Plans to co-lead a workgroup to: 1) identify the hurdles and define the scope of the problem; 2) gather best practices and solutions that are under consideration or implementation nationally or in other markets; and, 3) propose recommendations to improve the network directories for New Jersey Medicaid eligible consumers.

The two lead organizations worked together to develop an appropriate list of workgroup participants and engaged those stakeholders to get their support of the project. Then, over the course of several months, the lead organizations convened the workgroup to discuss issues the stakeholders were facing with the provider directories. The Quality Institute and the Association of Health Plans did extensive research to see how other states and markets were being regulated, specifically looking into the Federal Marketplace Final Ruling, the CMS' Final Medicaid Rule, the contract between the State of New Jersey and the Medicaid Managed Care Organizations, the New Jersey Department of Banking and Insurance regulations governing directories in the commercial market, and accreditation standards from NCQA and URAC.[1] The workgroup also took time to consider the work of previous related workgroup meetings convened by the State including the DHS Credentialing Workgroup (on or about early 2015) and the DOBI Credentialing Workgroup (on or about 2008). Lastly, the workgroup invited CAQH, a nonprofit that acts as a clearinghouse for credentialing and network information from providers and plans to streamline communications and workflow, to present its work at one of the workgroup meetings.

[1] See appendix document provided hereto that further details this research and provides links to the data sources.

From the stakeholder meetings and background research, the workgroup was able to articulate some of the most pressing issues when it comes to maintaining network directories and making them meaningful for the consumer. These issues and the workgroup's proposed recommendations to address them are described in more detail below. These recommendations represent the collective ideas of the multi-stakeholder group, but each individual organization may not endorse every suggestion herein.

Workgroup Participants:

Co-Leads: New Jersey Health Care Quality Institute; New Jersey Association of Health Plans

Participating organizations:

- Aetna Better Health of New Jersey
- Amerigroup NJ
- Horizon NJ Health
- Hospital Alliance of New Jersey
- Medical Society of New Jersey
- Mental Health Association in New Jersey
- New Jersey Academy of Family Physicians
- New Jersey Hospital Association
- New Jersey Primary Care Association
- UnitedHealthcare Community Plan
- WellCare

Key Findings Identified by the Workgroup:

Ensuring Data Accuracy

As cited by the workgroup, one of the largest hurdles in providing accessible, complete, and accurate network directories is the communication of data between providers and Medicaid Managed Care Organizations (MCOs). NJ's MCO network directories are populated with provider credentialing data and ongoing provider attestations. MCOs rely on timely, accurate and updated data from provider offices to ensure directory accuracy. This can be a cumbersome process on both ends, as MCOs have to regularly solicit information and attestations from provider offices, and provider offices have to manage their data with multiple MCOs. This process often leads to inaccuracies in network directories, which creates confusion for consumers.

Ensuring Consumer-Friendliness and Usability

One impetus for creating the workgroup was the recognition that online network directories are not as consumer-focused and meaningful as they should be. In part, this is because certain provider credentialing data does not translate well into the consumer-facing directory. While some credentialing data may be meaningful to the consumer (e.g. name, board certification, educational background, etc.), other data can cause confusion. For example, certain providers may be credentialed at several different practice locations to ensure reimbursement at all locations even though they rarely practice there and do not schedule visits at those locations. However, because the network directory is created using the credentialing information, the directory will inaccurately

show that a provider is seeing patients at locations where the provider does not normally practice. This use of credentialing information is misguiding consumers. This is a common issue among FQHCs and hospital-owned practices. In addition, given the directories' current inaccuracies, consumers are often provided misinformation and are forced to reach out several times to receive accurate information. Overall, the directories need to be redesigned through the lens of a consumer, to ensure that they include all the information necessary to make an informed choice of a provider and a health plan.

Key Recommandations Identified by the Workgroup:

Reducing Administrative Burden & Streamlining Data Reporting Processes

- Designate a third party clearinghouse for universal credentialing of providers and maintenance of provider data. This will reduce the burden on providers, allowing single source verification for all Medicaid MCOs. This also creates an incentive for providers to ensure they are providing accurate and updated information.

- Create robust provider attestation processes to ensure data attestation every 120 days, including incentives, penalties, and building the process into daily workflows.

- Ensure that primary care providers attributed to patients are actually primary care providers as defined in the MCO contract and regulations (general pediatrics, family medicine, general Internal Medicine, OB/GYN where appropriate) and not specialists.

- Additional Recommendations:
    - Add a phone number or email address on the directory website for providers to contact if their data is listed incorrectly.
    - Add a phone number or email address on the directory website for consumers to contact if the information they encounter is incorrect.
    - Create a FAQ and guide that shows how providers can update their directory information for each Medicaid MCO and answers questions about the Medicaid managed care program and what it means to be in the network.
    - Create a social awareness campaign around verifying provider directory information.
    - Create tools to help provider staff be more informed of the practice's network status, provider availability, locations etc.

Ensuring Data Accuracy for a Better Consumer Experience

- Add a required data field for providers to designate their primary practicing location(s) (could define "primary practicing locations(s)" by where a provider regularly sees new and existing patients and specifically include the days and hours by location(s)). Providers, for credentialing purposes, may list other locations with the MCO but those locations would not be included in the directory if not marked as "primary practicing locations". For each "primary practicing location" the provider should indicate whether they are taking new patients at that location.

- Add, as a required data field for each practice location, a link for consumers to search for public transit access to the practice location.

- Add a data field(s) that indicates practice recognitions or designations (e.g. PCMH).
- Add a customer service phone number or help line to the directories' webpages that connects to a health plan representative for consumers to use if they are unable to find what they need, including but not limited to, finding a network provider or making an appointment with a network provider

- For larger provider practices, FQHCs, and hospital-owned clinics or practices, include in the directory both the name of the larger provider practice and the ability to search by individual provider and specific location to ensure that the consumer can choose a provider and location that they want and enable the consumer to ensure that the provider is seeing new and/or existing patients covered by a specific MCO

- Include a search page that states the specific parameters that define the search and have the option for consumers to adjust the parameters (e.g. location by zip or county or city, specialty, etc.)