PROVIDERTRUST

# Smarter Provider Network Monitoring for Blues

Healthcare in the US faces numerous challenges as it shifts to care models that are more value-based, more digital, and more equitable. Adapting to meet these challenges requires innovation within payer and provider organizations that embrace automation, meaningful data, and interoperability.

**The Problem:** The old, interval model of provider network oversight is poorly equipped for the future of healthcare. An interval model for provider verification, screening, and re-credentialing leaves payers with an expensive and inefficient pay-and-chase approach to ineligible claims. This approach creates barriers to interoperability and generates a lot of work for poor-quality results – all while allowing bad actors to fly under the radar for years at a time.

In this solution guide, we define how a proactive approach to provider network eligibility can help payers create greater efficiency and profitability within their government programs, reduce the risk of ineligible claims, and improve interoperability and collaboration across functional teams.

# Defining Provider Eligibility

Some provider eligibility components, like education credentials, do not change over time, and therefore should be excluded from an ongoing oversight strategy. However, many other components are subject to change over time. The topic of eligibility in government programs most frequently turns to patients, but applying a similar lens to provider networks can have powerful implications for the financial health of government programs and downstream effects on patient safety.

Patient eligibility asks the questions: **"Does this member meet the agreed upon requirements to participate in this plan?"** And **"Does this care fall within the benefits of this plan?"**

In the same vein, provider eligibility asks, **"Does this provider meet program integrity standards to participate in this network and submit this claim?"** And, **"Has this provider done anything to prevent Medicare or Medicaid reimbursement?"**

Because of how quickly the answers can change, best practice asks these questions early and often.

The topic of provider eligibility carries the most saliency within Medicare Advantage and Medicaid plans. Oversight and payments from CMS and Medicaid agencies, as well as departments of insurance, create pressure on payers to align payment and participation standards with the requirements of these governing bodies. Defining provider eligibility for your plans and networks is the first crucial step to improving provider oversight and simplifying cross-functional processes.

Eligibility standards for individual plans, states, or lines of business often vary, but the main components of a holistic approach to provider eligibility monitoring includes:

### Provider Eligibility-Affecting Sources

- **Sources Confirming Provider Identity**
  - National Plan & Provider Enumeration System (NPPES)
  - Social Security Administration's Death Master List (SSA DMF)
  - Office of Foreign Assets Control (OFAC)
- **Federal and State Exclusion Sources**
  - OIG LEIE
  - SAM.gov
  - State Medicaid Excluded or Terminated Provider Lists (43 total)
- **CMS Status and Authority**
  - CMS Ordering & Referring List
  - Medicare Opt-Out
  - CMS Preclusion List
  - FDA Debarment
  - DEA Sanctions List
- **Licenses and Certifications**
  - State medical license and professional boards

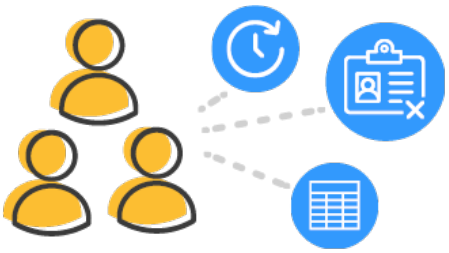
**Download our template to build a provider eligibility monitoring matrix for your plan.**

**Download the Template**

## Upstream Provider Insights

The traditional processes for provider lifecycle management serve as periodic stop-gaps to identify license or other eligibility issues, often after the fact and resulting in costly and ineffective recoupment efforts.

This fragmented approach to provider data creates these challenges:

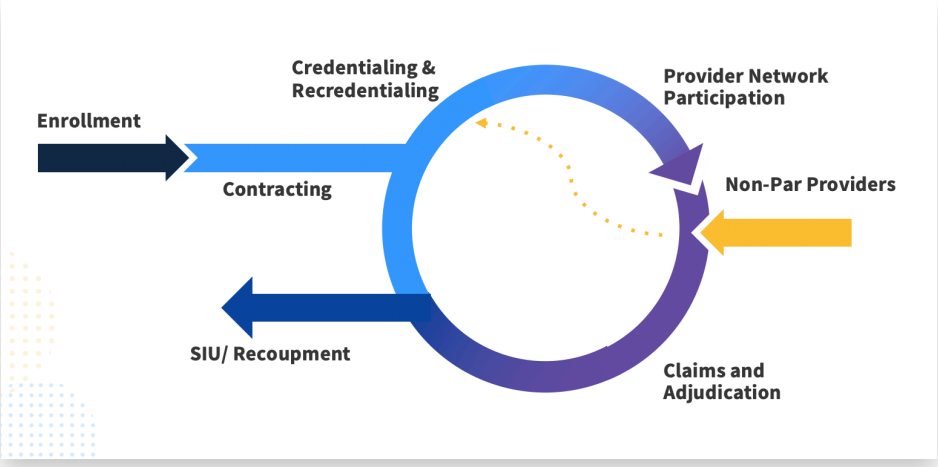


- **Duplicated efforts** occur when people across teams check the same provider profile data
- **Poor data hygiene:** spreadsheets are outdated as soon as they exist
- **License and eligibility issues** fly under the radar for years at a time

**Payers can solve all of these challenges by flipping the model and swimming upstream, which enables a continual source of truth through direct data connection and real-time monitoring.**

# The Provider Eligibility Lifecycle

The provider lifecycle describes the flow of provider profile data through a payer organization over time. From NPI and license information to practice addresses and endorsements, this data may cross back and forth between various systems and functional departments over time.




In reality, this lifecycle can be much more complex than this graphic, with numerous back-and-forth interactions due to the needs of audits, oversight, and interdependent processes. Regardless of the flow, various functional teams each ask their own questions of the same provider network data set:

- **Compliance asks:** Are we meeting the **internal and external standards** for oversight and protecting ourselves from penalties and damages? Do we have the **readily available documentation** to prove this?
- **Credentialing asks:** Is this provider who they say they are and **do they meet network participation standards**?
- **Payment Integrity asks:** What **evidence** can corroborate this lead I'm investigating?

Holistic and ongoing provider eligibility monitoring can help answer these questions and more through real-time data analytics and on-demand reporting. Centralizing and streamlining provider eligibility data and insights across functional departments promotes internal alignment and creates operational efficiency.

# Fraud, Waste, and Abuse (FWA) in Government Programs

The tremendous costs of **healthcare fraud**, waste, and abuse (FWA) is an evergreen topic for US healthcare. Identifying, investigating, and ending fraudulent and abusive schemes within provider networks demand significant resources. The success of these efforts depend on data speed and transparency, and cross-functional collaboration.

Since provider-committed fraud typically manifests as ongoing cycles of false or upcoded claims and kickbacks, speed to action protects revenue. **Data transparency and collaboration are the twin hallmarks of effective action. High-quality provider eligibility monitoring ensures data insights exist where stakeholders need it and empowers efficient communication across teams.**

## Provider Eligibility Monitoring and Fraud

Continual insight into a provider's eligibility through license statuses, OIG, and state Medicaid exclusions, NPI validation, and various other data sources can help improve SIU teams' efficiency on two fronts. First, ongoing monitoring insights enable quick lead triage and investigation. Second, the eligibility monitoring serves as a lead source in itself, triggering a stop on ineligible payments and saving on **claims recoupment** efforts later.

The ability to instantly query a holistic list of eligibility-affecting sources improves lead triage efficiency, saving time, and effort for SIU teams.

## Did you know?

**43%**

**of all reported OIG exclusions relate to licensure actions.**

**But on average, it takes**

**173 days**

**for a state action to reach the OIG.**

**If a provider isn't up for re-credentialing during that time, will your process catch the first red flag?**

**Learn more about why non-par providers present outsized risk for claims leakage.**

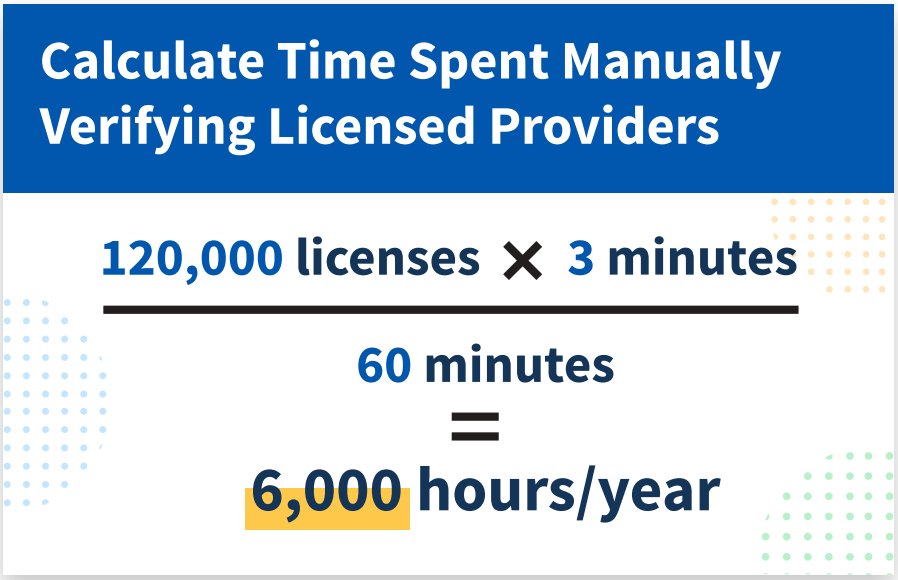
Learn More

## Provider Eligibility Monitoring and Waste

While fraud often garners the most attention, waste due to administrative complexity is by far the largest driver of cost.

A 2019 study published in JAMA found **waste accounted for a quarter** of all US healthcare spending. The price tag for healthcare waste due to administrative complexity: $265.6 billion. While much of this waste occurs both in and around the delivery of care, the reports' recommendations for curbing waste through data interoperability and value-based payment arrangements have obvious implications and opportunities for payers.

In terms of administrative waste, what exactly can you save through a continuous eligibility model? Let's look at the area of primary source license verification, which is one element of continuous eligibility. Most payers verify provider licenses at credentialing and every 1-3 years after that (unless a triggering event prompts an ad hoc verification). For a plan that conducts yearly primary source verifications on a provider network of 120,000, the total operational expense looks like this:




An interval approach leaves your plan relying on always outdated records and presents a significant drain on resources. For health plans conducting less frequent verifications, the operational expense may be less, but the risk of missing license revocations or surrenders becomes much higher. The obvious answer to decreasing wasteful administrative complexity is fully automated continuous insight into provider licenses and other eligibility requirements.

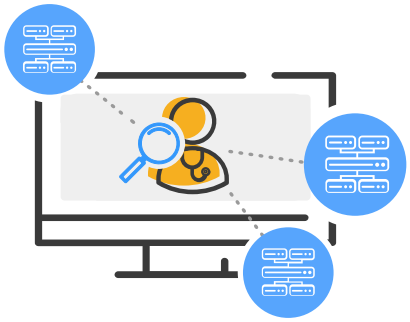
Measuring eligibility throughout the provider lifecycle empowers payers to make faster and smarter decisions about network participation and claims payment at every juncture. No longer will enrollment, credentialing, compliance provider operations, and SIU teams all end up wasting time and effort querying the same sources for different reasons at different times.

**Download our free Guide to Selecting a License Monitoring Solution.**

**Download the Guide**

# Primary Source Data Challenges to Eligibility Verification

Achieving continuous verification of a provider's network and billing eligibility requires more than simply aggregating publicly available data sources. Any successful solution must also fill in the gaps of publicly available data and constantly evolve to avoid creating continual drain on operational and investigative resources.



The world of primary source healthcare data largely lacks consistency and interoperability. For example, the standards for what data fields must be published around state Medicaid exclusions are minimal. Leading some states to publish so little information that confirming a provider's identity can require multiple phone calls and emails. Similarly, state licensing boards are frequently evolving to heighten security through captchas, presenting challenges to automation. The gaps in primary source data make verification of a possible FWA issue nearly impossible without a corresponding data enrichment strategy.

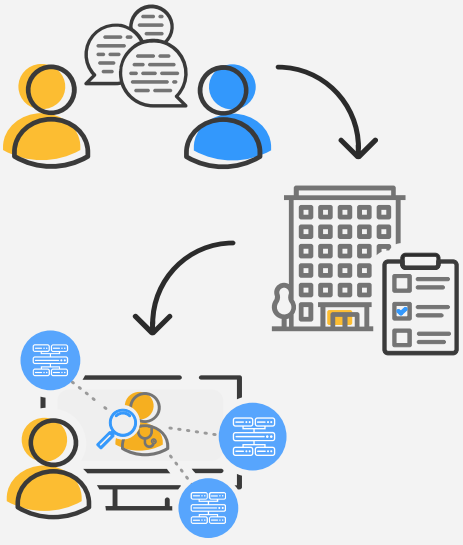
Our Smarter Monitoring technology enriches primary source provider data with unique identifiers, enabling healthcare organizations to identify and verify fraud and inaccuracies that they otherwise would miss. These capabilities prevent our clients from inadvertently processing ineligible claims or hiring ineligible providers.

**30 - 40%**

**of the eligibility issues we find in provider networks are identified only because of our enhanced data capabilities.**

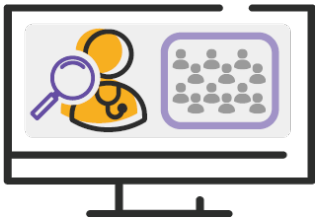
### Three Steps to Achieving Continuous Provider Eligibility

- Define ownership among constituents across the business.
- Establish or update eligibility standard operating procedures (scope, criteria, frequency) for your organization.
  - **Scope:** For which provider populations do we need continuous eligibility monitoring? Which LOBs and networks?
  - **Criteria:** What sources must be a "green light" for a provider participating in your Medicare Advantage network?
  - **Frequency:** How often do you need eligibility verification of each primary source?
- Integrate provider eligibility insights into your existing workflows (API / SFTP). Ensure every stakeholder team has the data they need where they need it to discontinue wasteful manual work.



# Dash: The Provider Eligibility Engine for Health Plans

Since provider eligibility alerts inform decision making across your health plan, you need a powerful and flexible tool to house eligibility data and deliver it back into the relevant teams.
We created Dash to meet the evolving needs of health plans for smarter data about provider oversight.



## Network Insights

View provider data health and eligibility issues at a high level. Segment providers by contract, location, or LOB. Identify high risk segments of your network at a glance and quickly see how many providers are likely ineligible at any moment.

## Individual Provider Insights

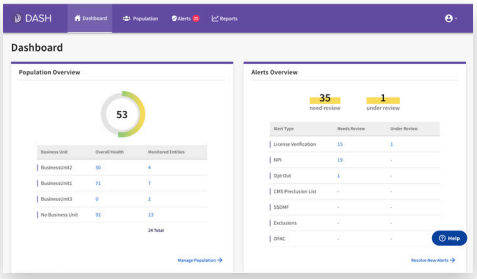
Get faster insight into compliance issues that affect a provider's billing eligibility. Save time investigating with alert details and primary source screenshots. See all of the information that you currently have regarding the provider as well as the current status of each license you are monitoring.

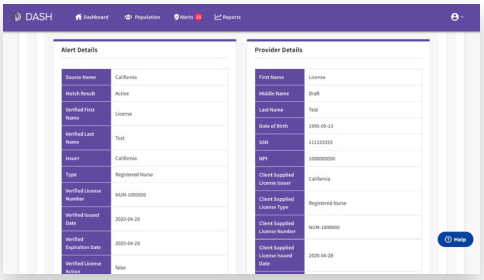
## Audit-Ready Reporting

Meet audit requirements for provider oversight with pre-configured and custom reports. View a provider's status with each of your eligibility criteria on any given day.

## Flexible APIs

Dash seamlessly integrates with your existing workflows and applications via industry-standard APIs to create cross-functional efficiencies. Rather than ripping and replacing existing systems, Dash complements current tools and allows you to route eligibility alerts to the teams that need them.




**Interested how Dash can empower smarter provider network oversight for your Health Plan?**

**Learn More**