



Part 2 - Healthcare Directory: State Examples of Medicaid Managed Care Procurement Activities

Executive Summary

CMS in coordination with the Office of the National Coordinator for Health IT (ONC) has developed guidance to support State Medicaid Agencies as they work towards developing a state strategy for “Provider Directories”.

The Healthcare Directory Guidance is presented in two parts: 1) key questions states should ask themselves as they execute on managed care procurement activities; and 2) examples from states incorporating health IT in the execution of their managed care procurement activities.

This document represents the second part, and presents examples of how Rhode Island (RI), Oregon (OR) and Washington (WA) have addressed the questions introduced in Part 1 of the Guidance.



1. Identifying State-level Healthcare Directory Activities

Question: *What are opportunities within your state regarding implementation of healthcare and/or provider directories?*

Rhode Island leveraged State Innovation Models (SIM) funds to contract with the state designated health information exchange (HIE), the Rhode Island Quality Institute (RIQI), and develop the Statewide Common Provider Directory (SCPD). Currently there are multiple data sources contributing to the SCPD including state government offices such as the Department of Health and the Department of Licensure. RIQI has validated over 15,000 provider records and has begun creating data extracts such as the Medical Home Portal. A public-facing website for consumers is currently in development by the state.

Oregon is currently advancing their coordinated care model to integrate and improve care. Coordinated care organizations (CCOs) are networks of all types of health care providers (physical health care, addictions and mental health care and dental care providers) who have agreed to work together in their local communities under one fixed budget to serve Medicaid. CCOs work on a local level to transform health care delivery to bring better health, better care and lower costs to Oregonians. This requires foundational health information technology (HIT) including implementation of a Statewide Provider Directory, which will be implemented in 2018. Oregon has three concurrent provider data efforts that support provider directories in the state:

1. The Statewide Provider Directory – a resource of aggregated, trusted, authoritative provider data accessible by healthcare entities
2. The Medicaid Managed Care rules (CMS 2390 F) implementation include new updated provider directory elements in the member-facing directories. CCOs will be able to utilize and rely on the data in the Statewide Provider Directory to maintain provider directories as required in rule.
3. The Oregon Common Credentialing Program (OCCP) - a legislatively mandated program that requires centralized collection and verification of health care practitioner information

Washington's opportunities relate to leveraging existing directory efforts (Credentialing, HIE, etc.) to support a single, more comprehensive, global directory solution. To date this has proven elusive. Provider data still sits in a number of uncoordinated databases and the quality of that data is uneven. Washington is currently executing two large Health IT programs: Washington State Medicaid EHR Incentive Payment Program and the statewide Clinical Data Repository (CDR). These two programs support many other aligned innovation and data analytics projects across the states. They have engaged providers in this work that: 1) contract with one or more of the managed care organizations; 2) treat Medicaid clients assigned to managed care; and 3) have a 2014 certified EHR system. The result is a public/private partnership model that offers a state-wide CDR that is hosted by the state's Health Information Exchange (HIE), OneHealthPort.



2. Defining Value Proposition for Electronic Healthcare Directories

Question: What key business drivers do healthcare directory activities address within your state?

Rhode Island's Statewide Common Provider Directory (SCPD) arose out of recognition by the state that data analytics would be critical to supporting value-based payments (VBP). Rhode Island needed one source to identify and manage provider information across the state. Unique provider identifiers within the directory will be used to ensure service encounters attributed to beneficiaries are accurate and thereby providing a foundation to enable value-based payments. In the future as the SCPD continues to be developed, when providers have only one source where they enter their information, enroll in payer programs and update their credentials, it will minimize provider burden, duplicate data entry, and improve data accuracy.

Oregon stakeholders expressed the need for a Statewide Provider Directory to support healthcare transformation efforts. They highlighted current struggles with the lack of accuracy and completeness, new regulations for provider directories (e.g., Medicare Advantage and Medicaid Managed Care) that place requirements for data and how often updates must occur, requirements to have Direct secure messaging addresses to meet meaningful use objectives, and administratively burdensome provider data requests and processes. Two provider data projects, the Statewide Provider Directory and the Oregon Common Credentialing Program (OCCP) will launch in 2018 to address these issues.

The OCCP seeks to reduce practitioner burdens, process redundancies, and third-party verifications by providing more timely and accurate provider data information in the credentialing process. The Statewide Provider Directory will leverage authoritative data from the OCCP and other authoritative sources. Its purpose is to improve efficiencies for operations by having a trusted, single, complete source of information to validate provider data; facilitate care coordination and health information exchange with a complete source of contact information, including Direct secure messaging addresses; and serve as a data resource for health care analysis.

In **Washington**, consumers, payers and providers are experiencing challenges with the emergence of narrow networks and the lack of reliable directories. This has motivated key stakeholders to find and support a state sponsored solution. Another driver motivating key stakeholders to support a state-sponsored solution is the attribution challenge of matching provider identities for performance reporting. Washington learned through stakeholder roundtables that MCOs and state agencies were spending a combined \$52 per beneficiary on records retention associated with documentable events in staff time associated with faxing, storing and document destruction. Access to the provider directory could result in substantial savings for these organizations, even after assessing an annual fee to support the state-wide provider directory solution. (see below "Washington example 2")



3. Identifying level of Health IT adoption by Managed Care Organizations (MCOs)

Questions: How are your participating MCOs leveraging health IT? What activities are you executing to advance MCO adoption of health IT and use of health IT standards?

Rhode Island established a Provider Directory Advisory Committee to serve as a Governance committee for the SCPD. This community includes MCO stakeholders that contribute to discussions regarding use of health IT and implementation of standards.

In **Oregon**, Medicaid CCOs are directed to use health IT to link services and core providers across the continuum of care. CCOs are expected to achieve minimum standards around health IT and to develop goals for the transformational areas of health IT use. CCOs must also have plans for health IT adoption for providers, including creating a pathway to adoption of certified Electronic Health Record (EHR) technology and the ability to exchange data with providers outside their organizational and systems' boundaries. CCOs are required to demonstrate their capacity to use EHRs by reporting and meeting thresholds for clinical quality metrics (CQMs) and other EHR-based measures¹. In general, all 16 CCOs have made an investment in health IT in order to facilitate healthcare transformation in their community. Nearly all CCOs are pursuing and/or implementing both health information exchange/care coordination tools as well as population management/data analytics tools.

CCOs are also required to participate in the Oregon Common Credentialing Program (OCCP) starting in 2018. CCOs participate in both the state's Common Credentialing Advisory Group (CCAG) and Provider Directory Advisory Committee (PDAC). Additional information on the OCCP can be found here:

<http://www.oregon.gov/oha/HPA/OHIT-OCCP/Pages/index.aspx>

In **Washington**, the ability for the state to use managed care procurements to advance a statewide health IT ecosystem required to sustain the state-defined Medicaid program objectives (including a state-wide provider directory strategy) required sustained stakeholder engagement to be successful. Washington engaged in one full year of focused stakeholder engagement to ensure their MCOs would develop a shared health IT resource for gathering standardized clinical documents (using the HL7 C-CDA standard) on Medicaid Managed Care lives. Washington MCOs now provide financial support for the project as well as include messaging and flow down provisions created by the State Agency in communications and provider sub-contracts.

¹ <http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx>



4. Defining the value proposition for MCO participation in state-wide healthcare directory efforts

Question: *What is the value proposition for MCOs to participate in your state-wide healthcare directory efforts?*

Rhode Island's MCOs have been hesitant to submit data to the provider directory, but in order to meet their requirements as an MCO they must now participate in provider directory activities. The hope is that over time as the SCPD becomes more developed, it will demonstrate its ability to provide additional value to MCOs (e.g. to support centralized credentialing, statewide analytics purposes, and coordination of care activities).

Oregon's provider data projects, the OCCP and Statewide Provider Directory, provide a unique opportunity to address issues with current provider directories. The OCCP contains a core set of data that must be entered, verified, and kept up to date. The Statewide Provider Directory leverages the authoritative data from the OCCP and other sources to create one source of truth for the state. Benefits include:

- Improved overall quality of data in an health care entity's own directory
- Reduced burden on providers to provide their current information and remove the duplicate and repetitious requests for their information;
- Improved administrative efficiencies by streamlining current processes to reduce staff time spent on data maintenance activities
- Improved ability to meet regulations related to provider directory accuracy
- Better care coordination for patients
- Improved ability to calculate quality metrics by using detailed provider and practice data

For **Washington**, lack of data, provider burden, and ineffective care coordination are a shared problem between the State and MCOs that cannot easily be solved unilaterally and individual plans were not able to solve the problem by themselves. As such, there is a potential collaborative opportunity. Specific benefits could include: reduction of work for payers reconciling provider identities, reduction in work by provider contributing to multiple directories, greater likelihood that providers would keep one source current, greater consumer satisfaction, fewer questions and complaints if the directories were current, reduction in regulatory burdens from CMS, the State's Office of the Insurance Commissioner (OIC) on directories, and enhanced ability to attribute and report on provider specific performance.



5. Leveraging policy levers for MCO engagement in health IT enabled activities

Question: What contract language have you used in managed care contracts and/or agreements regarding use of health IT and/or healthcare directories?

A recent **Rhode Island** MMCO procurement included language around Statewide Common Provider Directory (SCPD). The language was not specific or directive, it simply encouraged MMCO participation in the SCPD in addition to other healthcare transformation activities (see specific language below).

Contractor is asked to continue to work with the various entities involved with furthering the efforts designed to support the Triple Aim and Health System Transformation Program which includes partnership with the Rhode Island Quality Institute (RIQI) related to the development of a Statewide Common Provider Directory.

This gentle encouragement was viewed as highly successful to ensuring 100% MCO participation in the SCPD.

Oregon - CCO contracts and administrative rules are in the process of being updated for 2018 and are not fully available at this time. Generally, new contract provisions require that CCOs participate in the OCCP to obtain verified credentialing information for health care practitioners and must direct health care practitioners that must be credentialed to the OCCP's electronic system to submit and maintain their credentialing information. In existing contracts, CCOs are directed to use Health IT to link services and core providers across the continuum of care to the greatest extent possible. The CCOs are expected to achieve minimum standards in foundational areas of Health IT and to develop its own goals for the transformational areas of Health IT use. Excerpts from the current CCO model contract language contains the following HIT provisions:

Electronic Health Information

Contractor shall demonstrate how it will achieve minimum standards in foundational areas of health information technology (HIT) such as electronic health records and health information exchange, and shall develop its own goals for transformational elements of HIT such as analytics, quality reporting, and patient engagement.

a. Electronic Health Records Systems (EHRs)

Contractor shall facilitate Providers' adoption and meaningful use of EHRs. In order to facilitate EHR adoption and meaningful use, Contractor shall:

(1) *Identify Provider Network EHR adoption rates; rates may be identified by Provider type or geographic region;*

(2) Develop and implement strategies to increase adoption rates of certified EHR; and

(3) Encourage EHR adoption

b. Health Information Exchange (HIE)

Contractor shall facilitate electronic health information exchange in a way that supports exchange of patient health information among Participating Providers to transform from a volume-based to a value-based delivery system. In order to do so, Contractor shall initially identify current capacity and shall develop and implement a plan for improvement (including benchmarks and evaluation points) in the following areas:

(1) Analytics used in reporting outcomes measures to the Provider Network to assess indicators such as Provider performance, effectiveness and cost-efficiency of treatment;

(2) Quality Reporting to support Quality Improvement within Contractor's Provider panel and to report the data on quality of care necessary for OHA to monitor Contractor's performance;

(3) Patient engagement through HIT, such as using e-mail; and

(4) Other HIT.

Washington (example 1) embedded the following language around provider directories into its managed care contracts:

The Contractor shall maintain an online provider directory that meets the following requirements:

- Maintain a link on the front page of the Contractor's website that immediately links members to the Contractor's online, searchable provider directory.*
- Include a list of all clinical and primary and specialty care providers, including locations and telephone numbers.*
- Include a description of each primary and specialty provider's languages spoken and if appropriate, a brief description of the provider's skills or experiences that would support the cultural or linguistic needs of its members, e.g., "served in Peace Corps, Tanzania, speaks fluent Swahili".*
- Indicates whether each primary and specialty provider, including mental health professionals are accepting new patients.*
- Include a list of hospitals and pharmacies.*



- *Update the provider directory: no less than quarterly; upon completion of quarterly quality assurance reviews; or whenever there is a change in the Contractor's network that would affect adequate capacity in a service area.*
 - *The Contractor shall ensure removal of providers who are no longer in the Contractor's network.*
- *Contractor program staff shall be available to conduct provider searches based on office or facility location, provider discipline, provider capacity, and available languages.*

Washington (example 2): Though not explicitly related to provider directories, Washington State has used its Managed Care Contracting to advance a statewide health IT ecosystem able to achieve and sustain the goals of their Medicaid programs. In Washington, MCOs participate in a multi-year performance improvement project and pay the cost per life per year to maintain an integrated electronic health record for each Medicaid life assigned to Managed Care (1.5 million lives). Embedded in their annual MCO contract is language to require the following:

1. *Multi-year non-clinical statewide prepaid inpatient health plans (PIHP) to establish and maintain a longitudinal patient record for each patient assigned to managed care.*
2. *The integrated patient record will be housed in the Clinical Data Repository using a service provided by the State HIE and set up by the WA ST Health Care Authority.*
3. *The contractor shall pay the annual operational cost to maintain an integrated health record for each enrollee assigned to them at a cost of \$___ per member per year.*
4. *Costs for the MCO to connect to the statewide Health Information Exchanges are the responsibility of the MCO.*
5. *Costs to connect from a MCO network provider's own EHR in their office to the statewide HIE are the responsibility of the providers.*
6. *The MCO will help us facilitate readiness activities intended to prepare office for the secure exchange of high value health information among providers with certified EHR systems. The MCOs will reinforce state expectations that subcontracted providers with certified EHR systems begin submitting CCD-A via automated exports from their EHR into the CDR each time they see a Medicaid enrollee.²*

6. Establishing financing arrangements for MCO healthcare directory participation

Question: What financing arrangement will you employ for engaging MCOs in your statewide healthcare directory activities?

Two states (**OR, WA**) are examining the Medicaid and Medicare EHR Incentive Program's 90/10 match dollars to support HIE as a source of funding for provider directory efforts.

² Washington State requires all data to be classified using HL7 standards of normal (N), restricted (R), and very restricted (V) prior to submission by the contributing entity against which WA contributes administrative data (over a year of adjudicated claims minus the fiscal notes). WA then has a data analytics functionality which classifies these sets of data so that all CCD-A transactions are more easily usable.



Oregon has successfully submitted an Implementation Advanced Planning Document (IAPD) to justify using these funds for provider directory development. In their justification, they stated that the provider directory supports care coordination as well as Meaningful Use objectives, particularly those involving HIE.

Washington has no requirement or financing arrangement for MCO engagement in a Statewide Provider Directory, but the state is looking at potential options to move this forward in the future. However, Washington has entered into a multi-year performance improvement project with the five state MMCOs in which the MMCOs pay the cost to maintain an electronic integrated clinical record for every Medicaid life (N=1.5 million lives).