

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
OFFICE OF INSPECTOR GENERAL

**DATA INTEGRITY OF ONLINE
PROVIDER DIRECTORIES**

Inspection on Accuracy of Provider Information



August 23, 2019
OIG Report No. INS-19-001



DATA INTEGRITY OF ONLINE PROVIDER DIRECTORIES:

Inspection on Accuracy of Provider Information

WHY THE OIG CONDUCTED THIS INSPECTION

An inspection was conducted to determine the accuracy of data contained in the managed care organizations' (MCOs') online provider directories.

MCOs maintain online provider directories so clients can easily access the MCO's provider network and schedule health care services. The directories contain provider contact information, including phone numbers and addresses.

The OIG also conducted this inspection to explore the accuracy of data coordinated with MAXIMUS.

WHAT THE OIG RECOMMENDS

The OIG Inspections and Investigations Division recommends:

1. Medicaid and CHIP Services (MCS) should establish consistent requirements for MCOs and Medicaid providers on the number of days required to update provider contact information with HHSC or HHSC's designee.
2. MCS should initiate activities to monitor and ensure provider information is accurate and complete.

View the report online at
<https://oig.hhsc.texas.gov/>

For more information, contact:
IG_Inspections_Division@hhsc.state.tx.us

WHAT THE OIG FOUND

The OIG Inspections and Investigations Division reviewed 177 randomly selected pediatric primary care provider (PCP) entries from the 3 MCOs to determine the accuracy of the provider directory information. The inspection team conducted "secret shopper" calls to the staff of each pediatric PCP to verify the accuracy of contact information, as indicated in the MCO online provider directory. The team also asked the respondent if the provider was accepting Medicaid. The OIG inspection team found that the three MCOs have policies and procedures for updating online provider directories. The team found 55 inaccurate addresses and 57 inaccurate phone numbers in the 177 entries tested. The percentage of inaccurate contact information for the MCOs ranged from 52 to 68 percent. This data was taken at a specific point in time.

The OIG Inspections Division made the following observations:

1. **Regulations governing MCOs and Medicaid providers on the number of days required to update provider contact information with HHSC or HHSC's designee are inconsistent.**

The regulations governing Medicaid providers and MCO online provider directories have inconsistent requirements for submitting updates to addresses or telephone numbers. The Texas Medicaid Provider Procedures Manual requires providers to update information within 10 calendar days. The Texas Administrative Code (TAC) requires providers to report changes, other than ownership, within 90 days. The Medicaid Provider Enrollment Agreement requires the provider to follow TAC and report changes within 90 days. The Code of Federal Regulations and the Texas Government Code require MCOs to update online provider directories at least once a month, while the Uniform Managed Care Contract (UMCC) requires MCOs to update directories at least once a week. Conflicting requirements of standards may cause confusion with providers and hinder enforcement of the requirements.

2. **There is no monitoring function to ensure reconciliation of provider contact information occurs.**

MAXIMUS maintains the MCOs' most current provider network files, which include all providers enrolled with the MCOs. MAXIMUS is only contracted to fulfill a process to match provider contact information. As part of the process, MCOs can submit updates to MAXIMUS daily, if needed, to edit or delete a provider's contact information in the network. Each MCO is responsible for maintaining its own online provider directory.

MAXIMUS reviews the information from the MCOs and checks it against the master provider file and the MAXIMUS network information. MAXIMUS either accepts the information or sends a network error-response file to the MCO to reconcile the information. MAXIMUS does not track whether an MCO reconciles the network error-response file. The UMCC also does not require MCOs to reconcile the errors identified by MAXIMUS. MAXIMUS considers the review and comparison of the error-response file by MCOs as a best practice. This practice verifies the provider's contact information matches the MCO's contact information in the MAXIMUS network file. Reconciliation of provider contact information plays a vital role in determining the MCOs' compliance with the regulations to update online provider directory information.

These concerns led to two OIG recommendations listed to the left. MCS agreed with both recommendations.

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I. PURPOSE AND OBJECTIVES

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Inspections and Investigations Division conducted an inspection to determine the accuracy of managed care organizations' (MCOs') online provider directories.

II. BACKGROUND

Over 93 percent of Texas Medicaid clients receive health care through MCOs. HHSC's Medicaid and Children's Health Insurance Program (CHIP) Services (MCS) provides oversight of MCOs. MCOs maintain online provider directories to enable clients to easily access the provider network and schedule health care services. The directories contain provider contact information, including phone numbers and addresses, which are necessary for clients to schedule medical appointments. HHSC contractually requires MCOs to maintain accurate online provider directories.

HHSC's Uniform Managed Care Contract (UMCC) requires MCOs to routinely update and maintain online provider directories. If online directories are incomplete or inaccurate, Medicaid clients may be unable to find providers in the network.

MAXIMUS maintains the MCOs' most current provider network files, which include all providers enrolled with the MCOs.¹ MCOs can submit updates to MAXIMUS daily, if needed, to edit or delete a provider's contact information in the network. Each MCO is responsible for maintaining its own online provider directory.

A federal study was completed in December 2014 to determine the extent which providers offer appointments to enrollees and the timeliness of the appointments.² The study was based on an assessment of availability of Medicaid managed care providers, which included the accuracy of contact information for providers. The study found that 51 percent of providers could not offer appointments to enrollees, because the providers were either not participating at the listed location or not accepting new Medicaid clients.

The OIG Inspections and Investigations Division conducted this inspection to explore the accuracy of the reported data. The inspection team selected 177 pediatric primary care physician (PCP) entries across 3 MCOs to test based on a statistically valid random sample (SVRS).³

¹ MAXIMUS Inc. is a third-party administrator contracted with HHSC to provide business services for Medicaid and CHIP enrollment.

² December 2014, *Access to Care: Provider Availability in Medicaid Managed Care*, Report OEI-02-13-00670, retrieved from: <https://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf>.

³ See Appendix A: Detailed Methodology - Scope and Sampling for more information.

The Code of Federal Regulations (CFR), the Texas Government Code (TGC), the UMCC, and the Uniform Managed Care Manual (UMCM) each require MCOs to maintain accurate online provider directories. The CFR and TGC require MCOs to update online provider directories at least once a month. However, the UMCC requires MCOs to update directories at least once a week. Table 1 shows the regulations governing online provider directories for MCOs.

Table 1: Regulations Governing Online Provider Directories for MCOs

	Type	Code	Requirement
1	Code of Federal Regulations	42 CFR 438.10(h)(3) Information Requirements	Electronic provider directories must be updated no later than 30 calendar days after the MCO entity receives updated provider information.
2	Texas Government Code	§ 533.0063	Updates to online provider directories are required at least monthly.
3	Uniform Managed Care Contract	Section 8.1.3.3 Monitoring Access	The MCO is required to design, develop, and implement a provider directory verification survey to verify that provider enrollment and other practice information is up to date in its provider directory. The MCO must enforce access and other network standards required by the contract and take appropriate action with noncompliant providers.
		Section 8.1.5.4.2 Provider Network	The MCO must develop and maintain procedures for systematically updating the provider network database, which must include predictable scheduled algorithms. The MCO Online Provider Directory must be updated at least weekly to reflect the most current MCO provider network.
4	Uniform Managed Care Manual	Chapter 3.1 STAR Directories	The MCO’s website must include either a provider directory in text-searchable format, or network provider search functionality. Information must be accurate and the MCO must update it at least twice a month.

Source: CFR, TAC, UMCC, and UMCM

Medicaid providers are required to adhere to the Texas Administrative Code (TAC) and the Texas Medicaid Provider Procedures Manual (TMPPM) when there is any change of contact information. The TMPPM requires providers to report changes in contact information to the Texas Medicaid & Healthcare Partnership (TMHP) within 10 calendar days. However, TAC requires providers to report changes, other than ownership, within 90 days. The Medicaid Provider Enrollment Agreement requires the provider to follow TAC and report changes to HHSC or its designee

within 90 days. Table 2 shows the regulations governing contact information for Medicaid providers.

Table 2: Regulations Governing Contact Information for Medicaid Providers

	Type	Code	Requirement
1	Texas Administrative Code	1 TAC § 352.21 Duty to Report Changes	The provider must report the changes to HHSC or its designee within 90 days of the occurrence.
2	Texas Medicaid Provider Procedures Manual	Section 1.6.2 Maintenance of Provider Information	The provider must within 10 calendar days of occurrence report changes in address, telephone number, name, federal tax ID, and any other information that pertains to the structure of the provider’s organization.
3	HHSC Medicaid Provider Agreement	Section XII Acknowledgements and Certifications 12.1(e)	The written notification must be within 30 calendar days of any changes in the information due to a change of ownership or control interests, and within 90 days of all other changes to the information previously submitted.

Source: TAC, TMPPM, and the HHSC Medicaid Provider Agreement

III. INSPECTION RESULTS

The OIG Inspections and Investigations Division found that the three MCOs reviewed have policies and procedures for updating online provider directories. However, there are inconsistencies in the regulations governing MCOs and Medicaid providers, and there is no monitoring function to ensure reconciliation occurs.

The OIG Inspections and Investigations Division reviewed 177 pediatric PCP entries from the 3 MCOs to determine the accuracy of the provider directory information.⁴ The 177 pediatric PCPs were selected from the MAXIMUS provider network file. Three PCPs were associated with two of the MCOs, resulting in a review of 180 online provider directory entries.

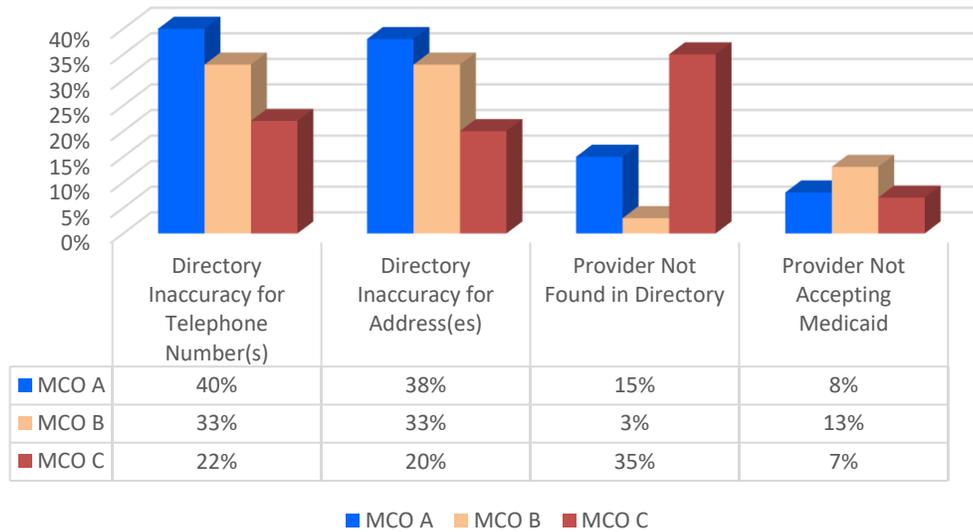
The inspection team conducted “secret shopper” calls⁵ to the staff of each pediatric PCP to verify the accuracy of telephone numbers and physical practice addresses, as indicated in the MCO online provider directory. The inspection team also asked the respondent if the provider was accepting Medicaid. The inspector allowed three attempts per provider telephone number if the number was busy or if no one picked up the line. Each attempt was made on a different day.

⁴ See Appendix A: Detailed Methodology - Scope and Sampling for more information.

⁵ See Appendix A: “Secret Shopper” Methodology for more information.

Table 3 shows the inaccuracies associated with the three MCO online provider directories. The data in Table 3 was taken at a specific point in time and are not reflective of an assessment over a period required for providers to update contact information.

Table 3: Inaccuracies Associated with MCO Online Provider Directories



Source: OIG Inspections and Investigations Division based on data provided by three MCOs on January 15, 2019.

Overall, the “secret shopper” calls found MCO C had inaccurate contact information in 68 percent of the sampled online provider directory.⁶ MCO A had inaccurate contact information in 62 percent of its sampled directory and MCO B had inaccurate contact information in 52 percent of its sampled directory. For the category “provider not accepting Medicaid,” if the inspector was able to reach the provider at the designated phone number, the inspector was able to verify if the provider was accepting Medicaid. These percentages reflect the number of providers with at least one inaccuracy.

The first field tested was the telephone number, which is the gateway for the client to reach a specific provider to make an appointment and obtain services. If a telephone number was incorrect, the client’s next option would be to visit the provider at the listed address. The address was the next field tested. If the address was incorrect, the client may be able to reach the provider with an updated address, if the listed phone number is correct. Instances in which a provider had both an inaccurate telephone and address would make it difficult for a client to reach the provider for services.

⁶ See Appendix A: Percentage of Inaccurate Contact Information for more information.

There were 55 inaccurate addresses and 57 inaccurate phone numbers found in the 177 entries tested. Of the 177 entries tested, 52 had both an inaccurate address and phone number. There were five providers that could not be reached by phone, because the phone number listed was either a fax number, no answer, or not a working number. Provider addresses were identified as inaccurate if the address documented on the online provider directory did not match the verified information from the “secret shopper” call. These inaccuracies included: a) if the provider was not a provider at the location documented on the online provider directory, or b) if there was a distinct inaccuracy in the street number, street name, suite number (if applicable), city, state, or zip code. The inspection team noted one incorrect suite number as an inaccuracy.

Observation 1: Regulations governing MCOs and Medicaid providers on the number of days required to update provider contact information with HHSC or HHSC’s designee are inconsistent.

The regulations governing Medicaid providers have inconsistent requirements for submitting updates to contact information. The TMPPM requires providers to update information within 10 calendar days.⁷ The TAC requires providers to report changes, other than ownership, within 90 days.⁸ The Medicaid Provider Enrollment Agreement requires the provider to follow TAC and report changes within 90 days.

The regulations governing online provider directories for MCOs also have inconsistent requirements. The CFR and TGC require MCOs to update online provider directories at least once a month. However, the UMCC requires MCOs to update directories at least once a week.

The TMPPM specifically states that failing to make changes in the provider group’s contact information may lead to administrative action by HHSC.⁹ However, this is not explicitly stated within the Maintenance of Provider Information section of the TMPPM.¹⁰

Conflicting requirements of standards may cause confusion with providers and hinder enforcement of the TMHP master provider file update requirements. Failure to enforce these requirements could result in providers not updating information and inaccurate information in the master provider file.

Recommendation 1: MCS should establish consistent requirements for MCOs and Medicaid providers on the number of days required to update provider contact information with HHSC or HHSC’s designee.

⁷ TMPPM, Section 1.6.2, Maintenance of Provider Information

⁸ [Title 1, Tex. Admin. Code § 352.21](#)

⁹ TMPPM, Section 1.1.9.16, Group Information Changes

¹⁰ TMPPM, Section 1.6.2, Maintenance of Provider Information

Management Response:

Management agrees with the recommendation.

Implementation Plan:

MCS agrees that consistent communications regarding provider directory updates are important. Regarding provider communications, the Texas Medicaid Provider Procedures Manual will be aligned with the Texas Administrative Code and the Medicaid Provider Enrollment Agreement, to reflect a 90-day requirement for updating provider information.

Regarding MCO requirements for updating provider directory information, MCS believes that it is important for MCOs to update provider directories on a regular basis to ensure directory accuracy and enhance member access to care. Because the Government Code and the Code of Federal Regulations require updates “*at least* once a month,” a weekly requirement does not conflict with that requirement. Requiring weekly updates demonstrates that MCS is exceeding state and federal requirements to ensure member access to care.

Target Implementation Date:

February 1, 2020

Responsible Party:

Katherine Scheib, Deputy Associate Commissioner, Operations

Observation 2: There is no monitoring function to ensure reconciliation of provider contact information occurs.

MAXIMUS is only contracted to fulfill a process to match provider contact information. As part of the process, MCOs submit an electronic file to MAXIMUS daily, if needed, to edit or delete a provider’s contact information in the MCO’s network.¹¹ First, MAXIMUS reviews the information on the electronic file and checks it against the TMHP master provider file. If the information does not match, it is sent back to the MCO. The non-match indicates that the provider did not update new contact information with TMHP. If the information matches, then MAXIMUS compares the provider contact information to the MAXIMUS network information. If the updated provider contact information matches the MAXIMUS network contact information, the file is accepted.

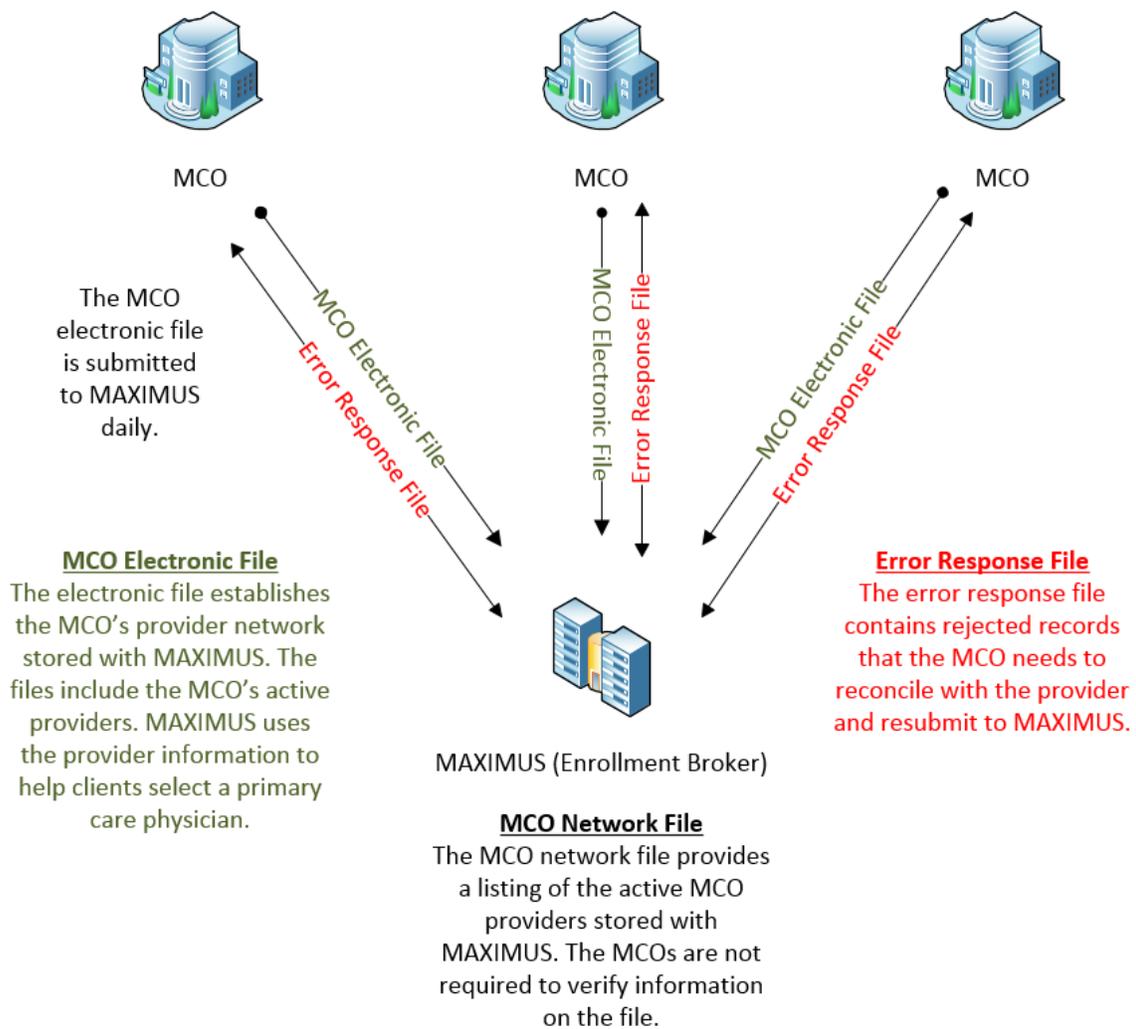
If the information on the electronic file does not match, MAXIMUS sends a network error-response file to the MCO to reconcile the information. The error-response file informs the MCO that the electronic file contains provider contact information, other than the updated information, that does not match the MAXIMUS network file. The MCOs are not currently required to rectify any errors with MAXIMUS.

¹¹ During this process, the regulations governing contact information for Medicaid providers apply (Table 2).

MAXIMUS does not track whether an MCO reconciles the network error response file. The UMCC also does not require MCOs to reconcile the errors identified by MAXIMUS. MAXIMUS considers the review and comparison of the error-response file by MCOs as a best practice. This practice verifies that the provider’s contact information matches the MCO’s contact information in the MAXIMUS network file. See Table 4 for further information on the transfer of data from MCOs to MAXIMUS.

The inspection team obtained a sample of 50 entries from the SVRS to test against the Master Provider File. There were 15 inaccurate addresses and 20 inaccurate phone numbers found in the 50 entries tested. Of the 50 entries tested, 14 had both an inaccurate address and phone number.

Table 4: Provider Information Update Flow from MCOs to MAXIMUS



Source: HHSC Data and Technology, Enrollment Broker Joint Interface Plan

Reconciliation of provider contact information plays a vital role in determining the MCOs' compliance with the regulations to update online provider directory information. The absence of reconciliation may contribute to inaccurate MCO online provider directories. Ensuring a reconciliation process of provider information would ensure the MCO online provider directories are accurate.

Recommendation 2: MCS should initiate activities to monitor and ensure provider information is accurate and complete.

Management Response:

Management agrees with the recommendation.

Implementation Plan:

MCS recognizes the importance of accurate provider directories and their impact on member access to care. While the ability to update the provider directory ultimately depends upon providers updating their information, MCS recently instituted new safeguards to ensure that MCOs are validating their provider directories, including contract changes (effective September 1, 2019) and other new MCO deliverables.

Contract changes that go into effect on September 1, 2019 include:

- 1) Requiring MCOs to have a process in place to ensure that their member-facing provider directories match the master provider file (the system of record), and to contact the provider regarding known discrepancies and work with the provider to update inaccurate information. MCS will evaluate the results of the new process and will continue to explore additional opportunities for process improvements.
- 2) Requiring MCOs to validate a random sample of their provider directory on an annual basis and report that information to MCS in an annual Provider Directory Verification Report.
- 3) Requiring MCOs and all other entities that use provider data (including TMHP and MAXIMUS), to use United States Postal Service (USPS) address standards, which should reduce the number of mismatched files generated in the reconciliation process.

Further, starting January 1, 2019, the MCOs were required to validate provider information or remove from the provider directory those providers who could not be reached during Appointment Availability studies. Two Appointment Availability studies are conducted each year to test whether members have timely access to care. MCS received funding from the 86th Legislature to double the number of Appointment Availability studies in FY 2020.

These monitoring changes resulted from the efforts of a dedicated MCS network adequacy team, focused on improving member access to care. However, these changes are just the first phase of a longer-term project to identify and address the root causes affecting the accuracy of both the master provider file and the MCO provider directory files. Moving forward, the MCS network adequacy team will

continue to work with the MCOs and provider associations to identify holistic solutions that can reduce administrative burden while increasing provider directory accuracy.

Target Implementation Date:

September 1, 2019

Responsible Party:

Dana Jepson, Project Advisor, MCS Network Adequacy Team

IV. CONCLUSION

The OIG Inspections and Investigations Division completed an inspection to determine the accuracy of the MCOs' online provider directories. The OIG found that the three MCOs have policies and procedures for updating online provider directories. However, there are inconsistencies in the regulations governing MCOs and Medicaid providers, and there is no monitoring function to ensure reconciliation occurs. To ensure clients receive accurate information, MCOs should review and update provider information. MCS has implemented a workgroup to review the monitoring of MCOs in respect to reviewing and updating network directories.

The OIG Inspections and Investigations Division made the following observations:

- Regulations governing MCOs and Medicaid providers on the number of days required to update provider contact information with HHSC or HHSC's designee are inconsistent.
- There is no monitoring function to ensure reconciliation of provider contact information occurs.

The OIG Inspections and Investigations Division makes the following recommendations:

- MCS should establish consistent requirements for MCOs and Medicaid providers on the number of days required to update provider contact information with HHSC or HHSC's designee.
- MCS should initiate activities to monitor and ensure provider information is accurate and complete.

The OIG Inspections and Investigations Division thanks HHSC MCS and the managed care organizations for their cooperation and assistance during this inspection.

V. APPENDICES

Appendix A: Detailed Methodology

Scope of Inspection

OIG Data and Technology (DAT) conducted a review of pediatric primary care providers from MAXIMUS' P84 PCP MCO network file, submitted by the MCOs on January 15, 2019. The scope of review only centered on pediatric PCPs enrolled in Medicaid, not the Children's Health Insurance Program or dental providers.

Sampling Information: Pediatric Primary Care Providers

OIG DAT generated a population of pediatric PCPs for the three MCOs from MAXIMUS' P84 PCP Reconcile file based on the primary taxonomy prefix code 2080 for January 15, 2019. The sample unit was based off provider National Provider Identification (NPI). Three statistically valid random samples (SVRS) were generated for each MCO. The sample size included 60 NPIs per MCO, which was selected using the regression analysis of time series statistics random number generator. This generated 177 pediatric PCP providers, 3 of which were included in 2 MCOs.

"Secret Shopper" Methodology

Using the SVRS sample drawn by DAT, the inspection team located the selected provider in each MCO's online provider directory search engine. Once the provider was located on the MCO's online provider directory, the inspection team captured all the contact information for that provider. "Secret shopper" calls were performed January 24-30, 2019. Calls were made based on the provider's contact information captured from each MCO's online provider directory.

First, the inspection team called the provider's telephone number to verify if the number was the business telephone number where the provider practices. If the responder of the call informed the inspector that the provider did not work at the location, or they did not recognize the provider's name, then the telephone number was deemed inaccurate. If the responder of the call informed the inspector that the telephone number was the number for the provider's practice location, then the inspector documented the telephone number as accurate.

Second, the inspector verified the provider's physical practice address with the responder of the call, based on the information displayed in the MCO online provider directory. If the responder of the call informed the inspector that the provider did not work at the location, or they did not recognize the provider's name, then the provider's address was deemed inaccurate. If the responder of the call informed the inspector that the address was the correct address for the provider's practice location, then the inspector documented the address as

accurate.

Third, if the inspector was able to reach the provider at the designated phone number, the inspector was able to verify if the provider was accepting Medicaid. If the responder of the call informed the inspector that the provider was not accepting Medicaid, then it was marked inaccurate. If the responder informed the inspector that the provider accepted Medicaid, then the inspector documented it as accurate.

Finally, if the provider was not found in the MCO's online provider directory, then the inspector documented it as inaccurate.

Percentage of Inaccurate Contact Information

If the MCO directory was inaccurate in any one of the four areas reviewed during the "secret shopper" call, the inaccuracy was notated (per sampled provider) and counted in the percentage of inaccurate contact information.

The inspector allowed three attempts per provider telephone number if the number was busy or if no one picked up the line. Each attempt was made on a different day.

Standards

The OIG Inspections and Investigations Division conducts inspections of the Texas Health and Human Services programs, systems, and functions. Inspections are designed to be expeditious, targeted examinations into specific programmatic areas to identify systemic trends of fraud, waste, or abuse. Inspections typically result in observations and may result in recommendations to strengthen program effectiveness and efficiency. The OIG Inspections and Investigations Division conducted the inspection in accordance with Quality Standards for Inspection and Evaluation issued by the Council of the Inspectors General on Integrity and Efficiency.

Appendix B: Report Team and Report Distribution

Report Team

The OIG staff members who contributed to this report include:

- Lisa Campos Garza, CFE, CGAP, Assistant Deputy IG for Inspections
- Troy Neisen, Director for Inspections
- Xavier Ortiz, Manager for Inspections
- Dennis Barker, Team Lead for Inspections
- Marco Diaz, Inspector
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- Victoria Ford, Chief Policy and Regulatory Officer
- Karen Ray, Chief Counsel
- Wayne Salter, Deputy Executive Commissioner, Access and Eligibility Services
- Stephanie Muth, Deputy Executive Commissioner, Medicaid and CHIP Services
- Nicole Guerrero, Director, Internal Audit

Appendix C: OIG Mission and Contact Information

Inspector General Mission

The mission of the OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, review, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Dirk Johnson, OIG Chief Counsel
- Susan Biles, OIG Chief of Staff
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Olga Rodriguez, Chief of Strategy and Audit
- Quinton Arnold, Chief of Inspections and Investigations
- Steve Johnson, Interim Chief of Medicaid Program Integrity

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