Online Provider Directory Review
Jeremy Willard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS
Christine Reinhard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS

Stacey Plizga: I am happy to introduce our next speakers, who will provide information related to the Online Provider Directory Review including methodology, findings, and common issues identified. From the Division of Surveillance, Compliance, and Marketing, please help me welcome Jeremy Willard and Christine Reinhard.

[Applause]

Jeremy Willard: I appreciate you going over what we're covering today; that kind of saves me a couple of breaths. And Christine and I have a lot to share, and we're going to dive right in.

Before I get into the actual content of the presentation, I want everyone, as we go through, to think about the tools you use on a daily basis, how those tools are used. When I was putting this slide together, Google Maps was the very first thing that came to my mind. I rely on it heavily, and I'm sure many of us do when going to airports traveling all around.

And I want you to think to yourself as we're working through this presentation, what would you think if Google Maps got you to the right location 60% of the time? The other 40% might get you close, might get you a couple 100 miles away; it's a little iffy. And you've got to think to

Online Provider Directory Review

Jeremy Willard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS
Christine Reinhard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS

yourself, what would you think of Google as a service, as a brand, as a company? And I want everybody to kind of have that in their mind as we go through today, just to see how critical it is for accurate provider directories.

Now, at its root, provider directories are a simple tool – a tool used to connect beneficiaries and their caregivers to your contracted providers so that they can get the care that they need. The accuracy of that information is paramount for that happening. If any of that information is wrong, they're not able to get to that contracted provider.

I don't think I have to spend a lot of time on our current environment. I was here last year, same time; we talked a lot about the types of things that we're seeing in the media, in previous directory reviews that we've conducted, also beneficiary complaints, Congressional inquiries, so on and so forth. So this continues to drive CMS; this continues to prompt us to look deeper and deeper into online directories to see how accurate they are.

I feel like my dad with the clicker.

So it's important as we go through today's presentation to keep in mind that there are two distinct phases to our directory reviews. And you'll have to forgive me. I'll constantly say directory review; I'm referring to the online directory reviews. Phase I is 99% of what we'll be talking about today. It's the initial review; it's making the phone calls; it's providing analysis to what's on your online provider directories. Phase II is a verification review that comes after Phase I, making sure that any errors that we identify are corrected.

Now, as far as our methodology goes, we have 54 parent organizations that we selected for this year's review; one contract for each parent

organization, 108 providers, evenly split between 4 provider types for each of those 54 parent organizations. And then we reviewed every location for each of those 108 providers. So if you think about it, starting with the 108, it was typical that that would result in 150-200-250 different locations for those 108 providers, resulting in a lot of phone calls, as Christine is going to talk about.

I mentioned that we focused on four different provider types. Those were primary care physicians, oncologists, ophthalmologists and cardiologists. They were selected because they were of the higher utilized provider types for both fee-for-service and Medicare Advantage.

As far as the selection, wondering how we selected the parent organizations, it was a combination. So we looked at enrollment, meaning those organizations with a high enrollment number; and audit, meaning if those organizations were up for audit in that given year, last year; as well as random sample. Each of those together combined to be the 54. We then randomly selected one contract under each parent organization, randomly selected the PBP, as well as randomly selecting the county or zip code.

When we did so, there was a mix of urban versus rural. That came down by each parent organization. So you were either one or the other. We either looked at your rural offerings or your urban offerings.

And then as far as the provider selection, we used a skip-level method where we'd look at the online directory, select the providers by picking one every five or something to that effect, to provide for a random aspect of it.

As far as the elements reviewed go, I've gotten a lot of questions about this; and I think that some folks were really thinking into it maybe a little

Online Provider Directory Review

Jeremy Willard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS
Christine Reinhard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS

too much. Really what we did is we looked at our model provider directory, the various data elements that are required in the model directory; and that's what we called and reviewed based on. Those included the provider name, NPI, provider specialty, practice name, does the provider work at the location, does the provider accept the plan at the location, street address including the suite number, provider accepting or not accepting new patients in general, as well as phone number. Those were the data elements that we reviewed.

Now, some important things to remember when we're talking about this -- CMS was very transparent in how we conducted these reviews. This was not done via secret shopping or anything like that. We didn't pose as beneficiaries. We had a contractor, Booz Allen Hamilton, who conducted all of these phone calls. And when Booz Allen Hamilton called, they explained who they were; who they were calling on behalf of; and they were also at the ready for any kind of documentation should the provider have any questions. So if the provider thought is this really on behalf of CMS, we had faxes, e-mails, letters that were ready on our letterhead that they could share.

And that part is important to note. If you hear any of your contracted providers saying that CMS called and wanted to get beneficiary information, PHI or something like that, you can let them know that that's not us. And we did communicate this with the provider community.

Now, while I say our review was transparent, we did have a beneficiary focus. And I guess boiling it down to its simplest terms, it was making sure that if we were to call that entry, that location for that provider in the directory, would I be able to make an appointment at that location and was that information correct.

The review process itself – and again, this is the Phase I, as I mentioned we had Booz Allen Hamilton -- they made the calls for each provider, so for each organization, the 108 providers. They attempted to check all information by the first call. So if the provider had five locations, they would call the first location in the directory; and they would look to verify all information if that person was feeling equipped to be able to answer that question. And they did check with the person that answered the phone; they didn't just kind of go into their script. They said, "Are you someone that's comfortable answering the questions that we have to ask?"

They would work their way down, hopefully answering all the questions to minimize the number of calls to providers. If they were unable to do so in the first call, they would just work their way down until all locations were resolved, meaning we got the information we needed for all of those locations. As I mentioned, it was a script; so each one was done as close as possible to one another.

That information is then provided back to CMS. It's provided on a very, very big spreadsheet. And if you think of the spreadsheet, line by provider location, column by all of the data elements that we collect. We review that; we identify the deficiencies; and then those deficiencies are shared with the parent organization. They're shared via that same spreadsheet. We make some tweaks to the spreadsheet; but by and large, it's the same.

And it's important to note that if you, again, think of the lines and the columns, any time there's an instance where we find something wrong, we highlight that in yellow; so the errors really pop out to that plan that's receiving that information. In addition, we've dropped additional columns to the right of all of the data, one of which says, "deficiencies, yes or no," so that you can filter just on seeing where are our deficiencies just to give

Online Provider Directory Review

Jeremy Willard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS
Christine Reinhard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS

you an idea of what's wrong and what's right, as well as another column that talks about how many deficiencies for each location. And the importance of that will come into play here in a subsequent slide.

The parent organizations are provided the spreadsheet. We typically have a 15-minute phone call with each parent organization, as well as detailed instructions provided via e-mail and really explaining this is what we're looking for response wise; and they're given two weeks to respond. And as far as what the responses are, for each location, if you think of the spreadsheet again, they're asked to either concur, meaning they agree with the finding or findings; nonconcur, meaning they disagree and they then have a section to provide additional information; or both.

And the both would come into play if you think about those various data elements, there may be three errors identified with a location. They may agree with one and not two. So we agree that the phone number is wrong, but we disagree that the address is wrong.

After the two-week period, CMS receives the spreadsheet back; the plan populates it with their concurs, nonconcurs, and their supporting documentation. And then we review and make a final determination. In an upcoming slide, I'm going to talk about, in a little more depth, as far as what we do to make that final determination. But we make additional phone calls, we review the data, we compare what our contractor found versus what the plan is saying; and we make a final determination.

That final determination is submitted to the parent organization. And then they're given 30 calendar days to make any needed updates. So if a provider shouldn't be in the directory, they remove it from the online directory, remove that provider. If something is wrong, they correct that within 30 days.

Now, in the beginning, I talked a little bit about Phase II being 1% of the presentation; here's our 1% slide. After all of that is done, and no sooner than 30 days, Phase II goes into effect. And that's when we review or validate that the directory has been properly updated. And in addition to the directory, when applicable, we are also looking at HSD tables to see if providers have been removed appropriately.

I'm now going to switch gears just a little bit to talk about some common problems we're seeing with plan responses, and this would be focused on the nonconcurs that I talked about as far as when reviewing the data.

The first is a failure to provide an adequate response or review to the data. And I would sum this up by saying some organizations have what I would call blind faith in their source data. So we would provide an error; and instead of maybe making a phone call or doing additional research, they would look at the source. That may be credentialing; that may be a third party. The phone number is wrong; and they would look at their source data, and they would say, "Nope, that's the phone number we have," and they would nonconcur and cite credentialing said it's correct or our source data said it's correct.

Our expectation is that plans put their best foot forward as far as reviewing the data. We really want you to do what's necessary to hear from the provider themselves, get solid responses as far as if you are disagreeing with us.

The next is a failure to respond to all identified errors. And again, if you think of my example of having multiple errors – and this may be an example of when you would put both, as far as agreeing with some, not agreeing with others. We've seen a number of organizations who will nonconcur or hit both; and they will provide detailed data, but only on one error. And this is where that column of number of errors really comes into

Online Provider Directory Review

Jeremy Willard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS
Christine Reinhard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS

play. If you're in your Compliance Department and you're reviewing this data before it's sent to CMS, you want to just look – filter based on the numbers, compare those numbers to what the responses are, and they should match one another.

The next is failure to actually verify the information. And I would sum this up to kind of a cut-and-paste approach to responding. And you may have 20 errors, and there's the same answer for each of the 20 which, again, by itself doesn't necessarily mean that it's wrong. But what we have found is of those 20, the narrative corresponds to maybe 15 or 12; and then the narrative mismatches with some of the others. So it seems as though it's kind of a rush to response maybe.

We also see some, what I would consider to be like a simple thing to check, such as phone number not working. And so our contractor finds that a phone number is disconnected. The plan nonconcurs and says the phone number is good; and, again, I think this gets back to checking the source data. When that happens, Christine and I pick up the phone and we call; and more times than not, the phone number is disconnected. And it's something that, in my mind, should be an easy thing to double-check.

The last point here – and I think this is the most important in my mind, and I think one that we can easily fix – and that is in our communications with group practices, educating those group practices so that they know we need the data at the provider level, not at the location level. We've seen time and time again with responses where group administrators or folks that are responsible for group practices are really focused on the location, not on the provider.

A great example would be we might have Dr. Smith, and Dr. Smith is listed in your directory five times. And we make phone calls, and two of those the office answers and they say, yeah, Dr. Smith practices here.

The other three – oh, we're sorry, Dr. Smith is in this practice, but they don't practice at this location. We provide that finding to the plan, and then the plan reaches out to their group practice administrator responsible for the provider or that group; and the group, I think, looks at the information and they say, "No, we are there." And then they provide that back to the plan, and the plans gives that to us in the form of a nonconcur.

And I would say at a very high level, we find that what our contractor initially found is what it actually is. And we do that -- again, I'll be talking about it here in a minute – with additional phone calls. And so what's happening is the group practice is really focused on where they are, not who is there. And I think we really need to do a better job as an industry to educate group practices that the expectation of having a doctor listed in a directory at a location is that a beneficiary can call and make an appointment for that doctor at that location. And we saw a very – and I don't want to steal Christine's thunder – but we saw a high number of instances where the provider was not at the location.

Can I have the next slide, please?

Now, getting back to – I alluded to this a little bit – data validation, I want you all to know that we take the response validation very seriously. I don't want anyone in this room or watching online to think that we immediately side with our contractor. When a plan nonconcurs – and we designed this process to allow for that voice, to allow for plans to nonconcur because we know how this data is. And we know that it's not 100%, and we want to make sure that it's 100%. So that's why we have this give and take as far as allowing for nonconcur, concur, and both as far as a response goes.

When we do receive the nonconcurs, then it kind of switches from contractor work to internal CMS work. And for this past year, Christine and I and our team that we work with, we've made probably thousands of phone calls following up on nonconcurs to check our contractor's work. And we don't just blindly accept the answer. We're not trying to quickly get to an answer. It's taken quite a lot of time, but it's really important to us that we get this right. And we make the phone calls and we reach out and we see ourselves almost as a tie breaker. So you have our contractor saying there's a problem; you have the plan saying there's not a problem, and here's why. So we make the phone calls as needed to determine what the final answer is.

And I do not want to dissuade anyone from submitting nonconcurs; but I would say, and this is especially the case for instances where the provider is found to be not practicing at a location, our contractor versus the plan's nonconcur, we have found that through our follow-up phone calls, 90% to 95% of the time, it's showing that the contractor was right versus what the plan is providing. And I think again, some of that is based on the fact that it's source data; it's group practices providing information. But I just would want to keep that in mind. And again, thinking with my compliance hat on, if I worked in a Compliance Department and I was reviewing data before it's being sent to CMS, if you see a high level of nonconcurs, that doesn't mean that that's not possible; but I would look at it with a critical eye, especially given the information that I'm providing today.

Now, switching to the positive, I want to talk about some lessons learned and some helpful suggestions. And the way I kind of think about this – and again, putting on my compliance hat or my plan hat -- when we were writing these slides, it was like, how would I approach this if I were working at a plan? What are some of the things that I would look at?

Online Provider Directory Review

Jeremy Willard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS
Christine Reinhard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS

The first is just the interface of the directory itself. How friendly is it to the beneficiary?

We see instances where plans have a core platform that is kind of pulling multiple products together as far as showing the providers associated with that network. Not a problem – not a problem at all, but you want to make sure that it's clear when you do that. You want to make sure that if you're a Medicare beneficiary, it's very clear what providers you're looking at.

The next is to make sure that providers are only listed one time at each location. And I look at this, again, as another type of low-lying fruit type of thing. And the message or the takeaway is scrub your data. We saw countless instances where a provider was listed, again, five times – five times at the same location, each location spelled slightly differently. So the reality of that is four of those five are wrong, and one is correct. And I don't think it would be too difficult to do a query to pull out similar address and things like that. Providers might have moved next door, or they may have changed a phone number or something like that. And instead of that old entry being removed, we see kind of the snowball effect of things are added, but they're not taken away.

Next slide, please.

The next one, again low-lying fruit wise, is review the number of locations for each provider. And this is another one which was a big takeaway for us. In reviewing the findings, if you have a provider listed six or more times, the chances of one of those listings being incorrect is 80% to 90% based on our reviews. And so, again, it's not impossible that a provider has multiple locations; we saw providers that had 16 locations, and they were all perfectly fine. But if I was at a plan and I was looking for problems and looking to determine how things are going or looking for

Online Provider Directory Review

Jeremy Willard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS
Christine Reinhard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS

just a starting point, I think doing a query of my provider database for instances where a provider is listed six or more times is a great starting point to determine how accurate that information is.

And in the same vein, auditing the data – as I mentioned before, we saw lots of instances where there was this blind faith in source data. And I think it would be very helpful – just like any other operation that takes place within your health plan – to do internal audits, to review the data. And when Christine gets into the content of the actual findings themselves, I think you'll find that it would not take many phone calls to determine how good or bad your data is.

Verify provider locations based on individual versus the group practice – I spent quite a lot of time talking about that, but I would want to reiterate it. We really need to educate group practices as far as how they're providing information to plans.

Claims data is the next point. I'm a big fan of claims data. I've had many conversations with organizations where I've touted claims data as being a good source of information. But I want to make sure I temper that by saying it's not the end-all be-all. Claims data has limitations; sometimes it doesn't give the full picture. And I think that's some of the struggle that we see with this. There is no silver bullet data source that you can look at that's going to give you 100% accuracy, so you kind of have to use a blended approach based on the situation, the provider type you're looking at. And so claims data is great; claims data shouldn't be the only thing.

The next two are just kind of from how the directory is put together. Listing providers once they're active or notating it – we saw lots of instances where we would call a provider; and they would say, Well, the provider is here and everything is right; but the contract is not active until six months from now. And there's nothing wrong with having that provider

listed in the directory ahead of time, but you should notate that effective 1/1/17 or something to that effect because, again, you're setting an expectation for a beneficiary that they can connect with that provider and make an appointment with them. And you're creating kind of a dead end based on that later start date.

And the final point here is notating providers that see only a subset of members. And what I mean by that is you have membership to the plan as being like your initial hurdle to getting access to that network. We see instances where providers have additional hurdles. And I think the greatest – maybe for a little comic relief example that I could think of – is we had a health plan we reviewed, and there was a provider as a PCP, and they worked at a university health center. And so if you were a member of the plan and you were enrolled in that university, you could see that provider as a contracted provider. But unless those two things were met you didn't have access to that provider.

So it's just critical that if there are additional hurdles – and this one was very uncommon; but we do see certain things, Indian Health Service and stuff like that, that there are additional barriers. And our expectation would be that it's fine to list them in the directory, but please note when those barriers exist.

Could we go back one, please?

As far as future policy decisions go, I'll be very high-level on this and very brief because I really know that everybody is looking forward to what Christine has to say. But some of the things we're looking at and trying to get our arms around – and we would be very interested in hearing your feedback – is providers that don't necessarily have a one-to-one relationship with beneficiaries, meaning you can't just look up the provider and call and make an appointment with them; hospitalist is the first thing

that comes to mind. Even though there's not that direct relationship, we did see some of those providers listed for certain specialties. But if you called for that specialty, you were unable to make an appointment with that doctor.

And a great example would be instances where a primary care physician was listed at a location that turned out to be an urgent care. And again, that doctor practicing in that capacity is certainly fine; but when they're in that capacity, they're not in the capacity of a primary care physician in the sense that it's your family doctor and you're calling and making an appointment.

So those are some of the things that we're kind of starting to get our hands around, doing further analysis as far as the directories go. With that, I'm going to turn it over to Christine. She's got a lot of really interesting information to share with us.

Christine Reinhard: Thanks, Jeremy.

Can everyone hear me okay?

Okay, great – Jeremy, at a high-level, went over how many organizations we reviewed. This past year, again, we reviewed 54 parent organizations. We reviewed 108 providers for each parent organization, split as equally as we could among the four specialists: the PCP, the oncologist, ophthalmologist, and cardiologist. It totaled 5,832 providers that were contacted. That was a little under 6,000 calls that our contractor made. That does not include the additional follow-up calls that Jeremy, I, and other members of our team made following initial findings. That accounted for 11,646 locations being reviewed for those 5,800 providers.

Here is our – oh, no – I hope you didn't look. Okay, here is our first little quiz. And we'll have everybody take a look; hopefully you didn't see too much of the data or didn't read too quickly. Out of all of the locations we looked at, I'm curious to know what you think the percentage of locations that had inaccuracies were.

[Pause for responses]

Christine Reinhard: Okay, it looks like we've got some stability here. I think you saw the next slide. Technology works great, but not perfect. So a lot of you guys are saying 45% to 60%, and you are on the mark right there.

Next slide, please.

Okay, so we had 5,257 locations with deficiencies. That accounted for almost 46% of all those locations had one or more items wrong with them. The total number of deficiencies was 5,352 deficiencies. Some locations had more than one deficiency. It may have had the phone number incorrect and the address incorrect. Or it may have had the provider seeing patients when they were, as well as maybe the suite number.

It is important to note, Jeremy mentioned that we did look at practice names. Following the review of the initial findings, we decided to exclude practice names from the final deficiencies. So there were hundreds, if not thousands, of inaccurate practice names we looked at; and there were a variety of reasons that we excluded that. One is that we don't have firm requirements in our directory on exactly what we mean by practice name. The other is that the practice names, there were nuances where you might have three or four names listed; and when we made the call, there may have been only two or three names that the practice name went by. Some organizations had the practice name listed as the contracting entity; whereas when our phone call was made, the practice name was

listed as Willard & Associates. So for various reasons, we did exclude that.

Next slide, please.

Out of the 54 organizations, we have a slide here showing exactly the percentages of inaccuracies that were the final deficiencies for organizations. Taking a look at this, we had two organizations that did quite well; between zero and 10% of their directory was inaccurate. No organization scored between 10.1% and 20%. The majority of our organizations scored between 30.1% and 40% of their online directory; of the 108 providers and the locations, there was at least one inaccuracy if not more.

So we've got a really concentration really between 20% and 60%. We had a couple of outliers. Just to let you know, our lowest inaccurate rate I believe was 1.77%. Our highest inaccuracy rate was almost 87%. So there was a wide range, with the majority of plans falling in that middle section.

Deficiencies – Jeremy mentioned all the items that we looked at. We made follow-up determinations on which of those items were deficient. And we'd like to do a quick polling and would like for you to tell us what you think was the most deficient item.

[Pause for responses]

Christine Reinhard: I love how it just moves back and forth, and it finally stabilizes. It keeps me questioning too; I am on the edge of my seat. Okay, it's looking like we've got a great set of answers there. Okay, I feel like a little bit of David Lettermen, not top 10 but top 5.

Online Provider Directory Review

Jeremy Willard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS
Christine Reinhard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS

Next slide, please.

Okay, No. 5 was address/suite number. It occurred 221 times for about 4% of all deficiencies. Not big – most of these, they were small changes on suite numbers. When we take a look at this for address, important to note, we did separate address from suite number. To CMS, there was a significant difference when the address was 123 Main Street versus 456 West Street. That's a much more egregious and much more problematic issue than when you have suite address and the suite is Suite 101 instead of 102. You can get to the building; you have to go to a different room, versus Google Maps taking you completely to the wrong building. So that was No. 5.

No. 4 – provider is not accepting new patients, 338 times, a little over 6%. We recognize that "provider not accepting new patients" and "provider accepting new patients" can be a fluid item in the directory. When we did look at this, we were pretty lenient on those deficiencies because providers do change, possibly month to month, time to time. So that is one of the areas that is a little bit more difficult to keep up-to-date at the exact time of the phone call.

No. 3 is address. Again, this is a little bit different, as I mentioned, from the suite address. The address is the actual address is incorrect. There had to be corrections made to that 123 Main Street versus 456 West Street 450 times, 8% of the deficiencies.

No. 2, phone number – 521 times, almost 10% of deficiencies. What is really interesting is a lot of these phone number inaccuracies, they were disconnected phone numbers. When you can't get the right phone number, you cannot make an appointment with your provider. We had phone calls that went to providers' personal cellphone numbers; we had emergency rooms; we had other businesses; and I think we had a few

Online Provider Directory Review

Jeremy Willard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS
Christine Reinhard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS

calls that actually went to beneficiaries. I don't know how those numbers got in there and went to individual people; but, please, make sure the phone numbers are correct. The vast majority of them were disconnected or out-of-service phone numbers.

And most people got this right. There's no drum roll because you guys got this all right. The No. 1 deficiency we had was the provider was not at that location; it occurred 3,544 times, 66.2% of all deficiencies. This was not what Jeremy and I expected when we undertook this project from the beginning. We were expecting more items like address, suite number; we were not expecting to find so many providers that weren't even at the location. We had providers that had been retired for years still in the directory. We had providers that had passed away over a year ago or more. We had a number of – a lot of provider practices that said I don't even know who this person is; he or she has never worked here.

So that was a surprise to us. It was either a surprise to you or it wasn't a surprise to you; you may have gotten the data. I'm not sure. Google Maps may have given you a little key that this number was pretty high.

Okay, I'm not very good with this clicker. Can we go back one?

Okay, do you think there's a significant difference in accuracy based on provider specialty? Now remember, we did the cardiologists, oncologists, PCPs and ophthalmologists.

[Pause for responses]

Christine Reinhard: Next slide, please.

We found – and again, statistically, I think you could make some arguments; you can make arguments that aren't statistically significant.

I'm not going to get into that. Ophthalmology was, as you can see, much lower than the other practices. Primary care, oncology and cardiology were all about the same or close. Ophthalmology was lower. We're not saying that the ophthalmology online directories overall were not – what I'm trying to say is if you're going to focus on certain areas, the cardiology/oncology/primary care from our review of 5,800 providers did a little worse than ophthalmology. Clearly, though, accuracy is a problem in ophthalmology too.

What is interesting though is the number of locations that were looked at. When we look at cardiology and ophthalmology, we had relatively close – a difference of 600. We've got a 17%, almost 18%, difference in the percentage of locations that had inaccuracies.

So as Jeremy mentioned, I think it's really important to take a look at the number of locations you have for some of these providers. We had significantly more locations for cardiology.

Next slide, please.

Is there a significant difference based on county density?

Jeremy mentioned we looked at urban plans and rural plans. We then broke out the providers into the five different counties: macro, micro, CEAC, metro and there was one more. Oh, that's on the next slide. And we'll give that just another few seconds. Okay, it looks like that's pretty stable.

Next slide, please.

That breakout, surprisingly, they're all within 10 percentage points of each other, actually a little bit less than that. We were wondering if there were

Online Provider Directory Review

Jeremy Willard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS
Christine Reinhard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS

going to be large differences between the more urban and the more rural settings, and there are not significantly large differences between these. There could be a number of reasons that there are different inaccuracy rates. It's something to consider, something to look at; but at this point, I don't think we're making any real determinations on whether or not they score better or not. We, again, looked at a lot fewer locations for the CEAC and the rural areas -- our concentration, because we looked at a greater percentage of urban plans, and there were a lot more providers in those urban plans, there were a lot more locations. So there's a larger universe to look at.

Going through a few of the CMS concerns is the excessive number of providers not at the locations. That is a big concern looking at the number of those deficiencies that we had. Providers that aren't working there should not be listed in the directory. We also had a big concern with providers not aware they're contracted with a PO. This came into account where the provider worked at the location, but the provider said we don't actually take that plan. In one case, we had an organization that the plan expanded in 2014; and the providers still weren't aware of their contracting status. And these calls were made in mid-2016.

So especially when you expand or add providers to your network, please make sure you educate those providers about the acceptance of your plan.

Implications on network adequacy – when we did this review, we also asked organizations, do you use the same underlying database for your online provider directory as you do for your HSD tables? The majority of plans do. With so many providers not being where they're listed, we are concerned that that's going to have an effect on HSD tables. Now, given that a provider may practice at 5 locations and 4 of them are correct and 1 is incorrect, that's going to have less of an effect versus a provider

Online Provider Directory Review

Jeremy Willard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS
Christine Reinhard, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare, CMS

that's listed at 10 locations and 8 of them are incorrect and the provider is not actually there. So it's something to consider and be aware of.

Next slide, please.

Food for thought – after looking at a review, if a beneficiary of yours picks a provider from the online directory, there's a 46% chance something is going to be wrong with that. There's a 30% chance of the provider not being at that location. So 3 out of 10 providers that they pick, they won't be able to make an appointment with because the provider does not exist at that location.

Next slide, please.

Compliance approach – we are still working on the compliance for this year's provider directory analysis. We intentionally waited until all parent organizations were reviewed. We have and are weighting the deficiencies based on the egregiousness. Provider not even being at the location is certainly more problematic than a suite number being wrong. For this year, if there's more than one deficiency, we're not making a cumulative weighting. We're taking the most egregious deficiency and counting it as the weight of that most egregious and not adding up the other deficiencies.

And as a note, compliance actions can come as a result of Phase I or Phase II; and again, we're still working on that.

Challenges – we know there are challenges. There's no question. We've had many conversations with organizations. We've heard about some of the challenges from these organizations. We've listened to conference calls. We understand. We've read the articles; we understand the challenges. But given the importance of the directory, the accuracy has

got to improve. We understand no provider directory is going to be perfect 100% of the time, every single day. But a 46% inaccuracy rate is just not acceptable at any time.

Next review cycle – we're going to review again about 54 organizations, give or take a few. The review will begin within the next, I'd say, two to four weeks. We're going to look at the same provider types again this year.

Next slide, please.

And I think that was – and we have 17 seconds for questions (laughter).

Stacey Plizga: Actually, we are out of time. So if you do have questions, please hold them until the end of the day during the Open Q&A Session; and we will address them at that time.

Right now, I'd like to thank Jeremy and Christine for sharing with us today.

[Applause]

Stacey Plizga: If you would like to evaluate this session, go ahead and take out your phones and text your response in; or go to the Poll EV link on your iPad, phone, computer or tablet and enter "A" in response to the question, "I would like to evaluate this session." And then go ahead and complete the evaluation.

Also, I have one more announcement; and that is that a black portfolio was found in the women's restroom; so if you are missing your portfolio and you are a woman, you can check with the table outside the door.