Provider Directories Review Update

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Stacey Plizga: Up next we have some speakers from CMS who will provide an update on the Online Directory Review and share the most current information on the project. America's Health Insurance Plans, or AHIP, who conducted a Provider Directory Initiative, will provide an overview of the initiative and lessons learned for the health plan industry.

It is my pleasure to introduce to you from CMS Kerry Casey and Jim Canavan; and from AHIP, Jeanette Thornton.

[Applause]

Kerry Casey: Hi, good afternoon. I'm Kerry Casey from the Division of Surveillance, Compliance and Marketing. Today I'm going to be giving you some background about CMS's Provider Directory Review, as well as some reminders about our current Provider Directory guidance. My colleague, Jim Canavan, will be discussing CMS's Provider Directory Review process. Finally, Jeanette Thornton, a Senior Vice President from AHIP, will be discussing AHIP's Provider Directory initiative.

As some background, our first review of Provider Directory accuracy ran from February to August of 2016. We reviewed 54 parent organizations and sampled 108 providers from a Provider Directory of each of those

parent organizations. The providers were divided among PCPs, ophthalmologists, oncologists, and cardiologists. The review included 5,832 providers and approximately 11,646 locations. We found an average provider location error rate of 41%.

Our current status is that we began the second cycles of reviews in November 2016. Our review this year is looking at the same provider types as last year, and plans are receiving their results on a rolling basis.

Just as a reminder, the Provider Directory guidance is located in a few different spots. January 17, 2017, we released an HPMS memo, "Provider Directory Policy Updates." We also have information in Chapter 4 of the Medicare Managed Care Manual, and the Provider Directory model itself has instructions.

So what I'm going to be going over today are the highlights of the Provider Directory memo. We chose different topics based on common errors that we're finding in the Provider Directory that we review.

First off is a reminder that plans must include a notation identifying providers who are accepting new patients or a notation identifying providers that are *not* accepting new patients. One thing that we ask is please make sure the meaning of that notation is clear. I've got a green checkmark there, but you don't know what that means if I don't tell you; and that's something that we've found in provider directories…that those notations are difficult to interpret. Again, we ask don't assume that specialists are accepting new patients. There are times where specialists are *not* accepting new patients, and that needs to be noted in the directory.

Today, we're going to do some polling questions to get an idea of where the industry is at. We're not asking for the compliant answer; we're asking

what you all are doing today. So what notation does your Provider Directory use?

It looks like so far we've got 100% "provider is accepting new patients." Our other options: provider is not accepting new patients; we are updating our directory to include this notation; and "Other" is our final option.

[Pause for audience response]

I'm going to wait a few seconds while people keep answering.

Okay, well, thank you very much for this information. We can see overwhelmingly "provider is accepting new patients" is the most commonly used one. If you're working to update your directory to add this information, that's great; we look forward to that.

Another thing that we encounter in the directories is providers that are listed before their contract is effective and also providers that are listed who are soon to terminate…there's a known termination date. We want to remind you that if you're listing a provider prior to the contract effective date, that date should be included in the directory. Similarly, if a provider has a known termination date, include that in the directory; and you can see below an example of how that might be done.

To better understand where the industry is at here, when does your plan start listing a new provider in the directory? A, after the contract is signed before the effective date; B, on or after the effective date; C, Other; or D, I don't know.

[Pause for audience response]

Great, I appreciate the honesty of people who don't know. As long as the people in your organization who need to know know, that's what counts.

All right, so "on or after the effective date" looks like it has the most results.

Similarly, when does your plan remove a provider from the directory? A, as soon as we know the provider's contract is terminating; B, on or after the termination date; C, Other; and D, I don't know.

[Pause for audience response]

All right, so similarly, most responses are "on or after the termination date." Thank you for that information.

Another thing that we want to highlight is plans must identify when a provider has significant limitations on the patients that they see. One example we encountered was someone certified in oncology who practiced as a bone marrow specialists and only saw patients who were referred by their oncologists. Obviously, that's a significant limitation on who they see.

Another example is providers who are only accessible to members of a Native American tribe. Along those lines, we're wondering: "Is your plan currently able to identify limitations on what types of patients a provider sees?" A, yes; B, no; C, we're working on it; and D, I don't know.

[Pause for audience responses]

Well, it's very hopeful to see there that a lot of people are struggling with that; that's useful information for us. Again, if you don't know, please make sure the people at your organization who need to know do.

This next requirement addresses a very common problem that we've encountered in the directories. Directories may only include providers at

those locations where plan members can schedule appointments. Here are some examples of what we've seen: providers whose duties are administrative only; doctors who oversee clinics where only nurse practitioners and physician assistants see patients; providers that walk in our urgent care clinics, where appointments aren't scheduled with them directly; as well as doctors who have admitting privileges to a hospital but don't schedule appointments at that hospital.

So something we're really curious about…is your plan currently able to identify locations where a provider routinely sees patients? A, yes; B, no; C, we're working on it; D, I don't know.

[Pause for audience response]

It's great to see how many people are working on it; that's what we really want to hear. This is very important to beneficiaries.

Lastly, one thing we want to remind you all is that you must make clear what type of medicine a provider is practicing at a location. This example is something we've commonly seen: Dr. Smith has some sort of background in infectious disease, oncology, and internal medicine; and she practices at two locations. But I don't know for what conditions I would schedule an appointment to see this provider.

So here's an example of something that gives you a much clearer idea of what the provider does: She's certified in infectious disease, oncology, and internal medicine; but if I need an oncologist, I go to Main Street and if I need an internist, I can go to South Street.

So our last polling question: Is your plan currently able to identify the specialty a provider practices at a location?

[Pause for audience response]

Again, it's good to see how many people feel confident of that. I'd just ask you if the people who do this type of in-the-weeds work aren't here today, make sure that those people are aware of these things.

Now I'm going to turn things over to my colleague, Jim Canavan, to discuss the Provider Directory Review process itself.

Jim Canavan: Thank you, Kerry.

Many of you have probably already gone through the process; some of you may not have yet. We're going to go over a little bit of what happens during that process. Then we're going to discuss some common elements that pop up during this that we see…best practices, things like that. Then finally we'll discuss if you have any questions about this where you can send them.

The process starts with our CMS contractor. What they do is they work with us to generate a list of what plans we're going to be reviewing; and then they generate a list of providers, using our methodology that we've created, for each of those plans. Kerry mentioned earlier how that breaks down…the 108 providers across the four different categories.

Then the contractor calls each of the locations for those providers. So while there will be 108 providers in the sample, there will be more "lines of data" is the best way to put it because some providers have multiple locations. They give each of these reports to us based on their calls on a plan-by-plan basis. So when we see the data, we see it for one plan at a time. What we do is we look it over, just make some general observations, and then we pass it on to your Medicare Compliance Officer.

Then we schedule a call with that person and with anybody else they want to bring to the call. The calls are very short. We schedule them for 15 minutes; they usually don't take more than 5-6 minutes. We basically just explain what we're doing, what our expectations are, give some best tips, things like that. Then we give you two weeks to review the file. So what you'll do is you'll review the file and make notes on it in the appropriate places. We send a set of instructions along with the file to explain that. Then you'll return the file to us.

We then go over the file and look at your responses. Sometimes they require additional calls that we can pass on to our contractors; sometimes we'll make the calls ourselves; sometimes it requires some other types of research. But eventually, we make a final determination. Some of the findings are weighted more heavily than others; and we return that as your final results.

Now, one thing we ask you to keep in mind as you're getting ready for this review is that when we ask our contractor to review the Provider Directory, they're looking at your online Provider Directory and using only the data that's in that Provider Directory. So that's their perspective. They're using the perspective of a member who only has your online Provider Directory information available because that's what we're evaluating. So they're calling these providers. They identify themselves as a CMS contractor, but they're calling with the perspective of a member trying to schedule a routine appointment.

So when you're reviewing the data, we ask that if you're going to use things like provider group reports or some type of credentialing report, we ask that you do so with a grain of salt. You can look at it and have that help you to determine what your response is going to be; but keep in mind that those are for other purposes. Those are not just for the purpose of determining whether or not one of your members, as a patient, could schedule a routine appointment.

Finally, one of the things we've noticed is that certain providers, like surgeons for example, will be listed at the facility where they perform surgeries. That's not where they're going to have – I mean, that's where the member will go for the surgery; but for the purpose of scheduling routine appointments, they actually usually have an office or a clinic somewhere else and that facility is often listed as a surgical center, something like that. Basically, you want to list facilities as facilities; and you want to list providers as providers.

If you have any questions during all of this, whether you have questions on a report that's already been done or if yours is coming up and you want to make sure you're ready for it, please e-mail us. You can e-mail Kerry and me; you want to get both of us on the e-mail address. You also want to put the Medicare Part C Policy Mailbox on there, which is listed on the screen there.

That is it for me, so I think we're going to turn it over to Jeanette.

Jeanette Thornton: All right, thank you.

Hi, everyone. Thanks for having me here. With all of the focus from the CMS compliance perspective on health plan provider directories, we at America's Health Insurance Plans took a step back and tried to look at what potential industry solutions and what we could learn about how we could improve the accuracy and the timeliness of the information in our member health plan directories. I'm going to talk to you about a project we wrapped up earlier this year and share some insights, best practices. I think this will help you as you're looking at complying with the Medicare guidance related to your Medicare Advantage plans.

I'm going to talk about the initiative, talk about some of our pilot work in evaluation, and sort of where we're looking to take this going forward. I

think many of you, in addition to participating in the Medicare Advantage space, also have other lines of business whether it be commercial, Medicaid, exchange/marketplace, et cetera. I'm sure you're aware that the providers that you contract with for Medicare also participate in your other networks. So we really wanted to look at this holistically and not just based on Medicare requirements but more broadly.

There is sort of a growing convergence around the Federal requirements for a common set of data elements across different lines of business that have to be included in plan provider directories, and we've included a subset of them here. Medicare Advantage is unique with a new requirement – or not new now, probably about a year or so – that you have to do outreach to your contracted providers on a quarterly – it was originally monthly – basis and the audits that are ongoing that Jim and Kerry talked about.

There are also very specific requirements for those of you that participate in the Federal marketplace…these machine-readable files, which I'm sure you've heard of…as well as new requirements related to Medicaid Managed Care that kick in this summer that really get at some more unique aspects of the Medicaid population looking at a provider's cultural and linguistic capabilities. Those are some new requirements and new things that plans are having to look at in terms of building out their online and paper directories.

In addition to the Feds, I think we've seen a growing amount of State focus on this. While these State activities may not address Medicare specifically, they do address your other lines of business; so I thought it was important to include here. We do have an NAIC Network Adequacy Model that does have provider directory requirements. The AMA has been pushing very specific requirements related to what has to be in a plan directory, but these have not yet been adopted. We've seen a

number of states, either through legislation or regulation, adopt new requirements.

I think the most significant of those are California's SB 137, which came into effect while we were doing our work, which has a lot of requirements for the plans, as well as a stick and a requirement that providers respond in a certain time frame. Then we've got additional activity that should be on the horizon for the remainder of 2017…so just wanting to make sure we don't think of this as just a Medicare issue, definitely much more broad.

So in looking at this, as I mentioned at the outset, we really wanted to think about this holistically and worked with a group of our CEOs who are very interested in this issue and providing industry leadership to go through a competitive process where we selected two vendors that we could test different solutions to update plan directory data. We launched pilots, which I'll talk about; and we've just wrapped up our evaluation earlier this year.

We wanted to think about how we could improve the quality and accuracy of plan directories with the Medicare requirements at the time that health plans had to call or e-mail or fax providers on a monthly basis. We didn't think it made sense for every plan to have to call every provider's office; that would be a lot of incoming calls every month and wanted to think about if we could work together as an industry. We wanted to reduce the number of calls and contact and really think about if we were ready and at a point where this could be adopted on a national level.

We decided to go into three states: Florida, California, and Indiana. Florida and Indiana, we were specifically focused on the baseline requirements in the Medicare Program. California, as I mentioned, had the new law SB 137. We took different approaches; we wanted to see where providers and their staff, who are most typically answering these

requests, would be receptive to responding and getting back information to the plans who were contacting them on a regular basis.

So in Florida, we tried to get at the administrative staff where they're already working with you…where they're submitting eligibility requests, submitting claims, and using one of the portals that's out there, Avality, where staff are already working with you on a regular basis. So we wanted to see if those kinds of things were the best way to get at this.

BetterDoctor, a startup company out of California, took a different approach; and they used phone, fax, and a mobile tool that providers were basically given a link and able to log on. They saw their information as already presented by the health plans…were able to say yes/no, yes/no, and make those updates as appropriate. So we took different methods, and I think it presented some interesting results that we'll talk about.

I'm going to talk about them a little bit differently, just because there were different regulatory requirements that came into play. We contacted in Florida 51,000 providers. This wasn't a small pilot. I think it is very interesting, if you look at the very bottom, it took us to contact each provider's office seven times to get them to respond. So what does that tell us?

Well, providers are very busy people. But it took a lot to get their attention, where they're trying to basically get the claims paid or check the status of a claim. So I thought that was very interesting. The vehicle, at least in our pilot – and certainly this will be improved based on the lessons learned – presented them some challenges; and providers, maybe due to a lack of awareness, sort of deprioritized this over other administrative things.

We did end up contacting about 35% of the providers in the pilot, and we had about 18% finish. Some even started this process and stopped midway.

We asked them about 18 questions, and this gets to all of the different regulatory requirements and wanting to make sure we're really, for the first time, going through this and updating all of their information.

Also very much of interest, they had a *lot* of data changes; 63.9% of the data elements were edited by the staff during this process. I think that aligns with some of the things that Jim and Kerry and their team have found in some of the audits as they've been looking at the data out there. So certainly we have improvements to make.

I'll talk a little bit about BetterDoctor --you can see the comparison – and then sort of roll this up. We contacted 109,000 providers across California and Indiana; it's a bigger market. We got about 47.5% to respond, and this is because we called in addition to faxing and e-mailing. Of course, you kind of have to answer the phone; so it was easier to get ahold of them by phone. But one of the things we've learned is that providers don't necessarily like getting all those phone calls.

We had 18.4% of the providers complete the validation request. We started out this process using old fashioned faxes; and I think you all know that providers are the last industry to love the fax machine. We hope that dies soon. But throughout this process, we switched to phone calls and then they'd get a one-page fax that would drive them to a Web page where they could complete the information. So not like faxing the information back; but that's just how we contact them because we know that plans have fax numbers for their providers and are slowly building out e-mail addresses for the providers and their network.

In California, it took less number of contacts…starting with just over 2.0 and dropping that to 1.4; and that's just because of the phone calls to sort of wrap up the outcome. Phone calls also take a long time; we had to actually break them up into chunks to get through all of the required data elements. California's state law has more data elements required than Medicare Advantage, but it still took quite a long time; and we were able to end up walking through that in about 37 to 24 questions, depending on if you do it online or on the phone. Then again, similar to Florida, just a lot of data had to be updated. We were looking at almost a 55% update rate for what was in the plan's directory.

Let me talk about some themes and what this can mean for all of your work as you're looking at your Medicare compliance obligations. It was very clear to us that providers know what health plan provider directories are…very high awareness rates. We did do a survey of all of the providers that participated in the project, an online survey after the fact. So they've heard of this; so that's not the problem. The general awareness is not the issue here.

We also, as I mentioned before, learned that they really want an electronic way to respond to plans' requests to update information. They want to have an e-mail. Some still, like I said, love the fax machine; I don't know why. But phone, which has been a way that plans have done these updates, is much lower on the scale. It's something to think about. We'll talk a little bit about this…the importance of a multi-channel approach, where you start with one method and move to another. I think it's important to think about as you're looking at how to update your data on your network.

So we got the biggest response, as I mentioned, via telephone…phone call, 40%; fax seemed to work well; and again, if you've ever looked at a fax machine submission, you don't want to be having somebody

transcribe that information you get back. You really need to drive them to an online capability.

Again, the portal, while it did get some responses, it wasn't – at least in our pilot, and this can certainly change as vendors get better and this process evolves – finding a provider where they're doing other things with you didn't get the most response. That may very well be because they're busy, and they want to get those claims paid and other sorts of things.

One of our conclusions…their preferred method may not be the most effective. We want to move to e-mail/electronic outreach, but some of this can be deprioritized or disregarded. Phone outreach can also be very burdensome, especially if a provider contracts with a number of different health plans and they have each one of those contacting them on a regular basis.

So one of the things that we're asking plans to think about is how to balance that burden with the most effective outreach method, and you may have to use more than one outreach method to reach providers in the best way and the most cost-effective manner.

We also thought that it was very important to cultivate that trust with your provider, and that starts with building awareness and wanting to pursue a flexible approach. So it's really important to talk to the providers in your network and see how they want to be contacted to get these updates, wanting to let them know how their data will be used and protected. They may get contacts from a vendor that they don't know that you're working with that vendor, and how do you clearly delineate that Vendor X is working with Health Plan Y?

We also had very good success working with provider organizations and specialty societies. They want to be helpful here on behalf of their membership. We also learned that it's really important when you do

newsletters or e-mails or other sorts of regular contact with your network that you tell them…this vendor is going to be contacting you to update your information; this is what we're going to be doing; here's where your data is going to be used. We heard a lot about that from our providers. They would fax back some of these pages and say, "Who is this? Who are you working with," and really wanting to make sure that that data was to secure. So make it easy for providers to confirm the vendor's role.

We definitely learned through this process that we have different approaches used at different plans…whether you store the data differently, you manage the data differently. That posed some challenges when working with a unified -- a vendor that worked with multiple health plans.

We also talked a lot about provider contracts. I don't know if you all know this, but we learned through this process that many health plans already have language in their contracts that whenever they change information -- they move across town, they move suites, they update some other information --they have to contact you. But we didn't necessarily think that was actually always happening in practice or that was uniformly enforced, and I think this puts plans in a very difficult situation. You do not want to remove this provider from your network for something like this; on the other hand, you want to ensure that the beneficiary and the consumer are getting accurate information. So it does create some challenges there.

We didn't think that many of the providers really understood that they *did* have this in their contract. I don't know…before bed, you probably don't sit and read your contracts; but we definitely know that providers didn't realize this was in there. I think this goes back to what I was saying about the carrot and the stick; all of the burden and the compliance right now is on the plan. There's no kind of corresponding incentive for the provider to respond in a timely way.

The leverage that you have, whether that's delisting the provider from the directory or removing them from the network, is not always practical or it is not always the best thing for consumers…so definitely learned about some of the challenges there. But we definitely still think this is one tool that plans do have in looking at the contractual requirement and figure out ways that you could hold providers accountable if they aren't responding to those requests.

I talked a little bit about this already in terms of that uneven or unbalanced accountability, so I won't belabor the point. I think everyone knows we're busy. Providers are busy; they get a lot of calls from various entities out there, and we have to think about the best way to engage them on this issue or we'll continue to have challenges where plans are sending data requests and we're just not getting the responses.

We've thought a lot about this; and I think needing to start with those carrots, those positive incentives…increasing education, not just the fact that plans have directories and it's important for them to be accurate, but how can we instill a greater sense of collaboration with our providers to ensure that they are responding and you're the first one they call when they make a change to their information that could impact consumers being able to find them.

Finally, this isn't the most sexy topic to talk about but it's important…technical standards. There's still some work to be done in this space when you're talking about collecting data, taking data from a vendor and then sharing that back to you. So you can take that data and then quickly turn that around and put in your provider directory as soon as you get it presents some challenges for plans…a lot of problems with export of files, imports of files, and being able not to have somebody look at spreadsheets and manually update your provider directory – we don't want that.

There are a lot of other groups working on standards. I know X12, CAQH has done a lot of great work in this area and others. California is also investing a lot of resources in standards development, so I think we'll get to some solutions on this piece soon; and it will definitely be necessary as we have more cross-plan collaboration and vendors in this space.

I think it's also just important to answer the question: Do your providers know what to do if they have a change in information? Is it your portal? Do they call? Do they fax? What is the process that providers need to do so you can get those data requests proactively before you're doing your quarterly outreach?

I think it's also important to have a channel for how consumers can report changes or issues with a directory, and those can be investigated by teams and then result in updates to the provider directory to make it easier to ask a question.

The last thing I'll say is that there needs to be greater standardization in the process and channels for providers and consumers to flag issues. I think this is really important. Consumers are using mobile tools – iPhone directories, things like that – to be able to find a provider; and if they find something wrong, there should be an easy way to flag that for you.

Very small words, but we did collapse sort of all of the lessons learned together in one slide. We have issue briefs on this that has all of this for you and your teams if it's something that you're interested in learning more. We have also done some detailed webinars that your team can download and listen to if your network people want to learn more about what we learned and strategies to work on provider directories. All that's available on our website; you just have to search for "Provider Directory." I encourage you to take a look at that if it's something that you're interested in.

I will say that we'll continue to work on this; we know how important it is for consumers to get good information on plan directories, and we definitely think it is an important initiative for the health insurance industry to be focusing on in both the near and long term.

I appreciate you having me today; I hope I was informative and look forward to your questions.

[Pause]

Stacey Plizga: Do we have any questions from our in-house audience? Please introduce yourself and let us know where you're from.

Tom Hennessy: Good afternoon. My name is Tom Hennessy from Johns Hopkins. As Jeanette aptly noted, the burden is on the plan to make sure that these issues are resolved. I have a question to the CMS members on the stage. Has CMS given any thought to working with the plans to help bring awareness to this on the provider side so that we're not out there just knocking on a door by ourselves to try and get them to give us the information that we need? Providers change information on a whim; and oftentimes, we don't find out about it until a member shows up at the office or calls and has a question. So just wondering if CMS would do something in its role as a national overseer of healthcare in this country to help us to work with the providers?

Kerry Casey I would say that we have received that feedback, and we appreciate it. If there are specific suggestions about things that we might do, we're always interested in hearing them. For us, the contractual relationship involved is between the plan and the provider; and so we have to keep that in mind…that the relationship is between the plan and the provider, not between CMS and the provider in this particular instance. But we are always open to suggestions about what we might do.

Jim Canavan: Just to add to that, we have received interest from other parties as well in assisting with that sort of a project.

Jeanette Thornton: We would love it.

Tom Hennessey: Thank you.

Michael Sneckenberger: Hi, Mike Sceckenberger, Anthem -- He took my questions almost exactly, verbatim; but I wanted to just mention it here also as kind of the push behind it too, I would say. Thank you.

Thank you.

Elizabeth Lippincott Hi, Elizabeth Lippincott, Strategic Health Law -- I have a question for the CMS panelists. Do you anticipate expanding these specialties or types of providers that you'll be reviewing in future years; and if so, do you have any plans to look at behavioral health?

Kerry Casey: We haven't finalized our plans for the next cycle of review. I would say that we have been happy that our first- and second-cycle reviews are comparable, so we know that the data is similar; and we can better identify improvements because we haven't made changes like that. If you all have feedback that that would be an important step to take, certainly send it in to us; and we'd be happy to consider it.

Stacey Plizga: We have a question up at the front mic.

Linda Howard: Linda Howard from Alternative – I have a question in terms of the effective outreach to providers. We know we're not getting 100%. So are there any benchmarks in terms of us making a determination as to what is an effective method? For instance, there were some data in terms of this got 47% response; this may have gotten a 20% response. What should

be we be using as a benchmark to help us determine what's effective and what's not effective?

Kerry Casey: CMS doesn't have a benchmark. I can tell you that during our process, what we do is we call providers; and that is the best – we get a decent response. Our contractors tell us when providers refuse to participate, and it's very rare. I can say that we use phone calls. I think AHIP and other organizations that are doing their own research may have some feedback for you also, something to look at; but CMS doesn't have a benchmark.

Linda Howard: Okay, thank you.

Andrew Finkelstein: Andrew Finkelstein, Health Partners Plans in Philadelphia – Referring back to the first question, if CMS could provide some more information to the extent that CMS might have other provider demographic information through, for example, provider enrollment…notwithstanding the contractual argument from CMS,…is there any intention on the part of CMS to use *that* information that the plans could rely on?

Sub question to that is whether or not there's any future plans on the part of CMS to use the data that it's acquired through this pilot and make that publically available, to the extent that there may be accurate demographic information that CMS has collected through this program?

Kerry Casey: Your second question…we hadn't considered that. We would have to think about it. I'm not sure how appropriate it will be, given that it was plan-specific…although we could remove the plan data, obviously. But it was drawn from specific plans, and so we would have to think carefully about whether or not that was a really appropriate thing to do.

In terms of CMS data around providers, some of that is available online already. It's not handled on the Medicare Advantage side, but there is

some; and it's information for us to think about in terms of what we could do there…and appreciate the feedback.

Jeanette Thornton: Yeah, I'll add from our pilot and what we saw, one of our vendors actually took all of the plans – we had nine plans in California participate – and aggregated their information and sent reports back to the plans. You could see both issues with how plans normalize the data – like first, middle names, nicknames. All of that information was not standardized across the plan, so even *that* work is very difficult to clean up and important. If the provider goes by (inaudible), you want to have that correct. So there's certainly an emerging vendor segment out that will gladly take your money, I guess, and do this; but I think it isn't important to be able to leverage all of those sources of data that are out there because there is a lot of data that's out there.

Michael Adelberg: Hi, Mike Adelberg, Faegre Baker Daniels – To the degree that Jeanette was talking about moving toward carrots and sticks to greater incent providers to take keeping the directories updated seriously, at least the sticks part of that could result in provider complaints, terminations of certain providers that might conceivably result temporarily in dropping below on the network adequacy spec. I'm just wondering the degree to which CMS has thought about the push/pull of different requirements and whether it's possible for the plans. If they *do* choose to step up the pressure on providers, the balloon might get squeezed; and the balloon might pop somewhere else.

Jim Canavan: Well, I mean, again, mostly what we're discussing here is the contract between the provider and the health plan. We don't really have a lot of sway over that. But from our perspective, certainly we've considered all sorts of aspects of how this could play out; and we are always keeping in mind our goal that we want accurate data in the provider directory so that your members, Medicare beneficiaries, will be able to get the care they need where they need it. So certainly, yes, we do consider all those; and

that would be a definite consequence. But at the same time, providers do want to get paid; so they are going to continue working with insurance companies where they can. And that matches my own experience with clinics, I guess is the best way – a clinical environment.

Jeanette Thornton: Yeah, Mike, I think that's a really good question. One of the things that was very unique about the law in California is it gives plans the ability to withhold claims payments after certain timelines aren't met in terms of the updates and the responses to provider directories…both the D listing, as well as the actual withholding of payments for 30 days until they actually respond. I'm not aware if there's any data out there yet about how many plans have actually use that, but it certainly has increased the participation by the various specialty societies and other provider groups to work with the providers and the State to up their game and respond to these requests…so just something to think about.

Michael Adelberg: Thank you.

Stacey Plizga: Okay, thank you for those questions. At this time, I would like to thank our panel for the discussion on provider directories.

[Applause]

Stacey Plizga: If you would like to evaluate this session, go ahead and take out your phones, or on your computers select "A," and follow the link.

It is time for a quick 15-minute break, so please return promptly at 2:30 p.m. for our next session. Remember for our viewing audience, if you have questions, go ahead and send those in via the SurveyMonkey link. Thank you.