PAYER-PROVIDER COLLABORATION

The Directory Dilemma: Challenges and Solutions for Accurate Provider Directories

Most consumers looking for a primary care physician or specialist use their health insurance plan's online directory to find conveniently located, available in-network providers. Federal policymakers remain increasingly concerned about the accuracy of provider directory information. Without up-to-date and accurate provider directories, patients struggle to find the right providers and subsequently face delays in care and unexpected costs.

Despite dedicating significant resources toward collecting and validating provider information, maintaining provider directories remains a major challenge. This is due to the:

- varying quality of information health plans receive from providers,
- lack of provider accountability to ensure updated provider information and
- absence of reporting standards for payers or provider.

ACHP member companies found that direct outreach with providers and office staff has been the most effective way to improve directory accuracy. Despite these close relationships, this outreach does not overcome all barriers.

ACHP identified policy solutions for systemic and long-term improvement to reduce provider burden and ensure directories are accurate and useful for consumers. These recommendations include a national provider directory to create a "single source of truth" and single reporting location for provider information. Until a national provider directory is established, however, ACHP recommends standardizing format requirements.

Background

Health plans must comply with both federal and state laws that attempt to maximize the usefulness and accuracy of provider directories. Health plan provider directories are required to have current information about practice location, ability to accept new patients, office hours and contact information.

On the federal level, CMS requires Medicare Advantage (MA) organizations, Medicaid state agencies, Medicaid managed care plans, Children's Health Insurance Program (CHIP) state agencies and CHIP managed care[1] entities to offer a public facing Provider Directory Application Programming Interface. Additionally, in the Consolidated Appropriations Act of 2021, Congress passed the No Surprises Act that included several provisions related to maintaining provider directories and protecting patients from out-of-network expenses when inaccurate directories resulted in patients receiving out-of-network care.

State requirements for provider directories vary, particularly on reporting frequency. As of May 2024, 19 states required plans to update their provider directory at least monthly; 12 states require updates between quarterly and annually; and seven states generally require directories to be "up-to-date" or updated in a timely manner.

Despite these requirements and major investments by plans in updating provider directories, significant challenges remain. Federal policymakers are increasingly concerned about the level of accuracy of provider directory data and how it impacts beneficiaries' ability to navigate the health system.

Why Maintaining Provider Directories is So Challenging

ACHP member companies dedicate significant financial and human resources to maintaining and verifying the information in provider directories, but still face challenges in obtaining timely and fully accurate data. Through years of experience, our member companies have identified three key barriers.

Barrier 1: Health plan provider directories are only as good as the information they receive from providers.

Most health plans receive provider information by issuing queries or receiving updates from in-network providers. If providers do not complete these requests in a timely fashion, health plans have dedicated staff conduct direct outreach to provider offices. The quality of the data provided from a physician's office or group depends on who provides a written response to an inquiry or picks up the phone when directly contacted. One ACHP member noted that it can receive different information depending on whether they speak with a general administrative staffer or the credentialing department or the billing department. Depending on who responds, knowledge of the practice or their interpretation of health plans' data requests varies. This variation in responses makes it exceedingly difficult to verify information and correct inaccurate data.

Other experiences reported by ACHP member companies that exemplify the challenges when getting information from providers:

- Credentialing offices do not update or keep track of information about which providers are accepting new patients or where their appointment locations are.
- Billing departments will often either provide information for central headquarters or will alternatively list every last phone number or location a provider *might* offer services (rather than the specific location(s) they actually do) out of concerns a health plan may deny claims if the locations are not captured in the provider directory.

The ramification of providing this excessive information is that patients will call attempting to schedule appointments and be told that provider doesn't work at that location, making the information technically inaccurate. However, the information is correct from the perspective of the provider office. While some health plans leverage additional vendor datasets to help fill gaps and flag discrepancies, this is a costly workaround and does not address underlying misunderstandings or help plans reach full accuracy of the data.

Barrier 2: There are no enforcement mechanisms to ensure providers update health plans when they change their information, even when required or contractually obligated to do so.

Providers are required, according to the No Surprises Act and/or their contractual agreements with payers, to update their information in a timely manner. There is little oversight or enforcement, however, for either of these. While the No Surprises Act does contain some surprise billing protections relating to provider directories and require providers and health care facilities to submit data to health plans in a timely manner, there is no enforcement mechanism outside of the health plan removing the provider from the directory.

Despite the various requirements to do so, ACHP members find it uncommon for providers to update information for changes to staff, practice name, address, phone or terminations. This is particularly challenging for contracted specialists, who move locations often.

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Attempts to leverage contract requirements to hold providers responsible also tend to yield minimal improvements to provider directory data accuracy. In network constrained areas where providers hold significant market leverage, providers know that health

plans need their contract to meet network adequacy requirements. This dynamic can put health plans in a limited position to negotiate contract terms with financial penalties for delayed or inaccurate information. ACHP member companies that offer financial rewards for submitting timely information report that it yields minimal improvements in provider directory accuracy.

Barrier 3: There is no standard across public and private payers about how providers report a change in their information.

Providers receive provider directory update requests from each health plan they contract with and these requests can come in various formats. It is a time-intensive and burdensome task for an already overburdened workforce. This lack of standardization can lead to misunderstandings. Some ACHP member companies found that provider offices will give different answers to requests based on how certain questions were phrased. For example: "where does this provider see patients?" versus "where does this provider schedule patients on a regular basis?" would often yield different results according to one ACHP member. This process is burdensome for health plans implementing mostly manual processes to maintain provider directories relying on multiple full-time employees, trial and error and occasionally costly vendor solutions.

Processes That Successfully Helped ACHP Member Companies Improve Provider Director Accuracy

ACHP member companies achieved the most success improving provider directory accuracy through varying multi-layered processes. The improvement methods ACHP members use include a combination of some or all of the following:

- Person-to-person outreach;
- Standard spreadsheets queries;
- Partnering with vendors;
- Self-audits;
- Claims review and comparison; and
- Contract incentives.

Direct outreach that leverages longstanding relationships with providers and office staff has proven to be the most impactful process to improve provider directory accuracy. Despite being a

labor-intensive process, and not fully accounting for the barriers outlined above, it ensures health plans are consistently asking the right questions to the correct individual in the provider's organization.

Many ACHP member companies also rely on partnerships with vendors such as the CAQH, Veda, LexisNexis or others. These solutions are costly and have mixed results on collecting provider directory information and improving accuracy. Depending on the vendor model, these companies leverage existing data sources to cross check health plan data and either fill in gaps or flag data that has a low, medium or high likelihood of being inaccurate. While these vendors help to an extent, health plans often find similar issues with provider data, resulting in limited provider directory data accuracy improvements.

Comparing provider information between the directories and claims data can offer health plans some insights into the accuracy of the provider's information. However, ACHP member companies have often found that providers will put a headquarters address in the claims for reimbursement purposes, as opposed to where services took place. Additionally, claim comparisons offer mixed value when it comes to whether a provider is accepting new patients or if a provider has retired or is deceased. An abundance of claims or lack thereof is not sufficient information for a health plan to change a provider's information or status, but it may indicate the need for follow-up processes.

ACHP's Policy Positions to Improve Provider Directories

As regional health plans with close relationships with provider partners and systems, ACHP member companies offer unique insight into the best practices for improving provider directory accuracy. Despite these close relationships, they face immense challenges keeping directories up-to-date—demonstrating how difficult and complex this process is. Meaningful reforms to provider directories are necessary to reduce payer and provider burden and administrative spending in health care.

ACHP makes the following recommendations to overcome the significant challenges to maintain accurate and up-to-date provider directories:

Establish a CMS National Provider Directory

To drastically reduce provider burden and ensure directories are useful for consumers, CMS should create a "single source of truth" and reporting for provider information in the form of a national provider directory, as proposed in CMS' RFI about the National Directory of Healthcare Providers & Services. This would eliminate the multiple requests providers receive from contracted health plans and clarify the purpose and intent of the information to submit. Payers and providers would then share accountability -- with providers being held responsible for the accuracy of their own information and health plans being held responsible for pulling that information into their systems in a timely manner. Of course, under this proposal, health plans would still be

responsible for collecting and verifying information for the small portion of their network providers that are not contracted with CMS.[2]

Until a National Provider Directory is established:

1. Standardize reporting format and information for providers.

To reduce the burden of navigating multiple different forms and formats, there should be a standardized reporting format with standardized questions. These standards should include sufficient clarity for providers to ensure only relevant information is being shared for the purposes of improving a patient's ability to schedule appointments with in-network providers. These standards should also be consistent across payer program requirements.

2. Hold health plans harmless for directory inaccuracies if they can verify use of a multi-layered provider directory accuracy and verification process.

When health plans dedicate significant resources to create a multi-layered process to verify provider directory information, it demonstrates their dedication to improving this resource for consumers. Health plans with these multiple processes should be held harmless for any remaining inaccuracies that are due to inaccurate information submitted by providers.

3. Do not penalize health plans for inaccurate provider directories and do not implement requirements to remove providers from directories.

Financial penalties for health plans with inaccurate provider directories will do little to improve the information. A penalty would only add administrative dollars to health plan efforts. Additionally, forcing health plans to remove providers from their directories altogether can be burdensome if a provider later submits correct information or renegotiates the contract with the plan. ACHP prefers policy recommendations that allow plans to suppress that provider's information until it can be updated.

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1. Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs) are already required to make provider directory information available in a specified, machine-readable format and are not included in the API requirement.

2. CMS only has the authority to issue requirements on Medicare and Medicaid contracted physicians and providers through Conditions of Participation.

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