Provider Directory Initiative Key Findings

ISSUE BRIEF

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KEY TAKEAWAYS

Collaboration is important to finding a solution

Health plans are committed to making accurate and up-to-date provider directory information available to consumers. Collaboration amongst plans, and the industry more broadly, is important in finding a solution.

contacted over 160,000 providers

Between April and September 2016, AHIP worked with two vendors to contact over 160,000 providers, testing different ways to coordinate with them to update key directory data.

information updated quickly and accurately

Maintaining accurate provider directories is a shared responsibility that requires a joint commitment from health plans and providers to ensure consumers and patients have the information they need and the information is updated in a timely and accurate fashion.

Background

Provider directories are comprehensive listings of the physicians and other clinicians, facilities (e.g., hospitals), and pharmacies that are contracted with a health plan to provide services to their enrollees. These directories, which are usually posted online and in a searchable format, are a valuable resource for individuals and their families. Information such as provider address, phone number, and specialty are typically included in the directory.

Provider directories can help answer key questions before individuals and their families decide which health plan to enroll in or which providers to see once enrolled. For example, provider directories can help answer the question of whether an individual's primary care physician or specialist is in the health plan's network. They can also help an individual determine whether a nearby hospital or pharmacy is part of the health plan's network. As a result, it is essential that provider directories reflect the most current and accurate information about participating providers and facilities so that individuals can maximize the value of their coverage.

Overview of Current Regulation of Provider Directories

Health plans use a variety of approaches to maintain and update provider directory information, including regular phone calls, follow-up faxes, emails, online reminders, and in-person visits. This multi-faceted outreach effort is reinforced by contractual requirements between health plans and providers to ensure provider directory information is accurate and up to date.

In addition to these efforts, there are federal, and often state, requirements related to provider directories. In general, federal requirements specify that provider directories must be updated on a regular basis and include network information, provider name, address, phone number, specialty, institutional affiliations, and whether the provider is accepting new patients. Additional requirements apply to Medicare Advantage plans, plans offered in the federal Exchange marketplace, and Medicaid managed care plans. For example:

- Medicare Advantage plans are required to proactively communicate with contracted providers on a quarterly basis to ensure provider directory information is accurate. Directory updates must be completed within 30 days of receiving the information, and the Centers for Medicare & Medicaid Services (CMS) conducts ongoing audits.

- Plans offered in the federal Exchange marketplace are required to post directory information in "machine readable" format to be used for Healthcare.gov provider search capabilities and must be updated every 30 days.

- Medicaid managed care plans are required to list the provider's cultural and linguistic capabilities and available accommodations for people with disabilities in their provider directories.

In addition to these federal requirements, a number of states have enacted laws or established regulation addressing requirements for health plan provider directories. These laws may address the format of provider directories (online versus paper), the content of provider directories, timeframes for updating provider directories, and/or the process used to ensure the accuracy of provider directory information.

Challenges to Maintaining Accurate, Up-To-Date Provider Directories

A critical issue for both health plans and consumers is the accuracy and completeness of provider directories. Given the breadth and diversity of providers in health plans' networks and the frequency of changes, information can quickly become out of date. For example, information on office hours and whether providers are accepting new patients can quickly change based on the number of patients in the practice. Moreover, not all providers rely on the same method of communicating information to health plans. This often leads to delays in updating pertinent provider information.

The challenges of obtaining and maintaining updates to directory information are further complicated by the fact that physicians contract with multiple health plans and may be part of multiple medical groups or independent physician associations (IPAs). Currently, there is no unified process for updating directory information. With each health plan or medical group/IPA requesting updates on its own and each medical practice, hospital, and pharmacy working separately with Medicare Advantage plans, Medicaid plans, and private health plans, this process is time consuming and costly for health plans and providers alike.

Unique challenges exist for large group practices who often rely on a practice administrator to maintain provider data. Such practices often assume the duty of gathering clinic level information (physicians at that site, address, phone numbers, etc.) and sending this information to health plans on behalf of the practice. However, inaccuracies have been found in the clinic level data when audited by the health plans or regulators.

For example, a review of Medicare Advantage online provider directories found that a key driver of inaccuracies is that group practices often provide data at the group level rather than at the provider level. This results in a group practice listing a provider at a location because the group has an office there, even if that individual provider does not see patients at that location.[1]

AHIP Pilot Overview

To address the challenges related to developing and maintaining accurate, up-to-date provider directories, AHIP launched a pilot project in 2016. The pilot built on health plans' ongoing efforts to provide the information consumers need to make informed health care choices. The pilot took place in three states (California, Florida, and Indiana) with the participation of 13 AHIP member health plans. The goals of the pilot were as follows:

- To improve the accuracy of provider directories to benefit consumers regardless of whether they are covered by private insurance or public programs such as Medicare and Medicaid.
- To reduce the number of provider calls and

- contacts and develop a more efficient approach for providers to update their information for all plans

- To test different approaches to identify the most effective path to a potential solution at a national level

AHIP partnered with two vendors – Availity for the Florida pilot and BetterDoctor for the California and Indiana pilots to test different approaches for providers to validate and update their information. Availity's requests for directory information were consistent with the information required under Medicare Advantage, while BetterDoctor's requests were consistent with the information required by both California SB 137 and Medicare Advantage.[2] More than 160,000 providers were contacted to validate and/or update their directory information as part of the pilot. Each vendor used slightly different approaches for reaching out to providers and obtaining validated directory information. The approaches included contacting providers and their staffs through phone calls, faxes, emails, and/or alerts within existing online portals and asking them to update important information such as address, phone number, specialty, and type of insurance accepted. This information was then shared with the participating health plans so that they could update their online and hard copy directories. The pilot was conducted from April 2016 to September 2016.

Plans Participating in Pilot

Anthem, AvMed, Blue Shield of CA, CareMore, Cigna, Florida Blue, HealthNet, Humana, L.A. Care Health Plan, Molina Healthcare of CA, SCAN Health Plan, Wellcare, Western Health Advantage

Availity

Founded in 2001 as a collaboration between Florida Blue and Humana, Availity is a health care information technology firm that works with ambulatory providers, hospital systems, health plans, and patients, providing data connections between them to improve information- sharing, billing, and claims workflows.

BetterDoctor

Founded in 2011 in San Francisco, BetterDoctor has a focus on improving consumers' ability to find providers in their coverage network by working with health plans, provider groups, and health systems to create and deliver high quality, accurate provider directory data.

Findings of Independent Evaluation of Pilot

AHIP asked NORC at the University of Chicago to conduct an independent evaluation of the pilot. In conducting the evaluation, NORC looked at the information obtained from the two participating vendors in addition to conducting surveys and interviews with the providers and plans participating in the pilot to get additional feedback. The evaluation was completed in January 2017. NORC's findings fall within three key themes – provider engagement, provider accountability, and technical standards.

Key Statistics: Availity

Estimated providers contacted for validation via Availity portal	51,071
Percentage of practices with a contact attempt	100%
Percentage of practices successfully contacted	35.3%
Percentage of providers who completed the validation process	18.6%
Average number of notifications to complete the validation process	7.1
Average number of questions asked (for a one-provider, single-location practice)	18.1
Percentage of key data elements edited by providers when they submit data to the vendor	63.9%

Key Statistics: BetterDoctor

Estimated providers contacted for validation via phone/fax	109,857
Percentage of practices with a contact attempt	99.8%
Percentage of providers who completed the validation process	18.4% (CA SB 137) 47.5% (MA)
Success of different modes of contact	18.1% (fax to online form) 39.2% (phone)
Average number of notifications to complete the validation process	1.4 – 2.3 contacts
Average amount of time required by provider to complete validation	16.35 minutes (online form) 4.22 minutes (phone)
Average number of questions asked (for a one-provider, single-location practice)	37 questions (online form) 24 questions (phone)
Percentage of key data elements edited by providers when they submit data to the vendor	54.8%

Provider Directory Initiative Key Findings

Provider Engagement: While providers indicated that they were familiar with provider directories and were aware that directories are used to help consumers find clinicians who are in- network, and accepting new patients, they and/or their staff:

- Expressed a general lack of awareness regarding the need to proactively alert plans of changes to their information
- Did not understand the purpose of, or need for, responding to plan requests to validate or update their information;
- Felt overwhelmed with responsibility and therefore prioritized activities that were required of them by regulation or to secure payment for the provider

Additionally, while providers reported preferring to be contacted via email, this was not the most effective way of getting updated information from them – phone calls resulted in the highest levels of information validation. In particular:

- While 48 percent of providers reported to BetterDoctor that their preferred mode of communication was email, validation by phone call resulted in the highest level of validation at 39.2 percent.
- In addition, response rates increased over time after modifications to the validation process were made, such as implementing additional methods of outreach and providing urgent deadlines to respond.

Provider Accountability: Providers were not necessarily aware of state and federal regulations requiring health plans to have accurate, up-to-date provider directory information and both health plans and providers indicated numerous challenges with managing provider contracts, such as:

- Providers were not aware that they were accountable through their contracts, despite having language in contracts between health plans and providers requiring providers to submit updates to directory information in the event of a change.
- Health plans reported that though there typically was contractual language requiring timely updates to directory information, that language did not always extend to requiring providers to respond to plans' outreach or validation attempts.

In addition, the pilot highlighted the uneven accountability for ensuring timely updates to directory information. The response rates of the individual vendors underscored the difficulty in getting providers' offices to respond to requests to validate or update provider directory information. For example:

- Only 18.6 percent of the providers contacted by Availity completed the validation process and it took an average of 7.1 notifications or contacts to complete the validation process.
- Only 18.4 percent of the providers contacted by BetterDoctor completed the validation process related to information required by California SB 137, though a higher percentage – 47.5 percent – completed the validation process for information required by Medicare Advantage. It took between 1.4-2.3 contacts to complete the validation process.

The higher completion percentage for validation of Medicare Advantage requirements can be explained by the fact that the Medicare Advantage requirements are a subset of those in California SB 137. Moreover, the standard for validation completion is more lenient under Medicare Advantage in that contact with a practice and confirmation of any data element is sufficient to comply with the Medicare Advantage standards while California SB 137 requires a response to every data element to be considered compliant.

It should be noted as well that the California SB 137 requirements allow health plans to withhold payment to a non-responding provider for 30 days, and may have increased the engagement and awareness of providers in the state. Mutual accountability measures, such as contractual or regulatory requirements, improved awareness from the providers due to the potential consequences of non-compliance.

Technical Standards: Through their work both with the pilot vendors and outside of the pilot, health plans reported challenges with coordination of data integration, citing easily ingested data formats as one of the most important factors in ensuring timely and accurate directory information and noted that data audits were not the most effective way of managing provider data. Other findings include:

- Lack of provider understanding of the technical process for maintaining directory information
- Different plan approaches to provider data management including data stored across multiple systems
- Challenges with relying on manual provider data audits to validate health plan data
- Frequency in data updates from provider offices including receiving conflicting information from a provider's office versus data received from the provider's affiliated provider group (or groups)

Implications for Policymakers and the Industry

AHIP's provider directory pilot highlights the complexity of and challenges to maintaining accurate and up-to-date provider directories. The findings of the independent evaluation of the pilot clearly identify three main areas where there are opportunities for more work to be done to identify a national solution to this issue. Selected strategies that health plans should consider in future efforts to improve the accuracy and timeliness of provider directories are listed below.

Improving Provider Engagement: Because providers' preferred method of engagement (email) is not the most effective (phone calls), health plans should consider:

- How to balance reducing provider burden while utilizing the most effective outreach methods
- Using multiple and complementary outreach methods rather than relying on a single approach
- Assessing their outreach efforts periodically and modifying as necessary to reduce provider burden and maximize response rates

Additionally, because providers are not necessarily aware of or understand the need to proactively alert plans of changes to their information or respond to plan requests to validate or update their information, health plans should consider:

- Educating providers and their staff on the purpose of provider directories and the need for responding to requests from plans to validate or update information

- Making sure that providers and their staff understand how the information will be used and protected during the validation process

Increasing Provider Accountability: Due to the uneven accountability for ensuring timely directory information updates, as well as the lack of consistency of language in and enforcement of provider contracts related to provider directory information, health plans should consider:

- Enhancing and enforcing contractual requirements to update/validate directory information

- Using regulation and/or payment as an instrument for shared provider accountability by raising provider awareness of existing compliance responsibilities, and increasing provider accountability for compliance[3]

- Promoting a sense of ownership in the directory information through communication, guidance, and collaboration with providers

Improving and Harmonizing Technical Integration and Standards: Because of the importance of easily ingested data formats and the significant amount of time it took to address file formats and technical integration issues during the pilot, health plans should consider:

- Developing an industry-wide (i.e., plans, providers, and other stakeholders) set of standards for provider directory data definitions, file format protocols, and other validation standards

- Exploring approaches to manage provider data received from provider groups

In addition, while providers generally did not understand the technical process for maintaining directory information, they can provide valuable feedback and input for how to improve the process for validating and updating information. Therefore, health plans should consider adopting standard processes and channels for allowing providers and consumers to flag provider directory discrepancies.

Menu of Strategies for Maintaining and Updating Provider Directories

Provider Engagement

- Balance the administrative burden of outreach with effectiveness
- Use complementary outreach methods
- Pursue flexible & iterative approach
- Seek feedback from stakeholders, i.e., providers
- Conduct proactive education about how data will be used & protected prior to and during vendor outreach
- Make it easy for providers to confirm the vendor's role

Provider Accountability

- Leverage contractual agreements to promote engagement
- Consider combination of incentives and penalties that mirror those for plans
- Identify contractual provisions that hold providers accountable for non-responsiveness
- Raise provider awareness of existing compliance responsibilities

Technical Standards

- Develop industry-wide standards for data definitions, file format protocols, and other validation standards
- Focus on more efficient sharing of data between plans and providers
- Acknowledge that establishing mutually acceptable standards requires time & iteration between health plans, third party vendors, and other stakeholders
- Collaborate with stakeholders and set meaningful, long-term goals
- Ensure that validation files clearly identify which data have been updated for audit trail
- Adopt standard processes and channels to allow providers and other consumers to flag provider directory discrepancies

Conclusion

Health plans are committed to making accurate and up-to-date provider directory information available to consumers and believe that a strong partnership and active participation with physician practices is essential to achieving this goal. AHIP's Provider Directory Initiative identified several opportunities for improving the process of developing and maintaining accurate and timely provider directory information. These opportunities underscore the need for increased awareness on the part of providers of the importance of timely communication with health plans to validate and update their information.

In addition, enhancing provider responsibility for ensuring accurate directory information will lead to a more collaborative process and a more useful tool for consumers, avoiding the inconvenience of inaccurate office locations, incorrect phone numbers, and non-acceptance of new patients. Lastly, greater standardization and harmonization in the technical aspects of the information validation process will reduce provider and plan burden and make it easier to update directory information.

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Related Topic

Endnotes

1 Centers for Medicare & Medicaid Services. Online Provider Directory Review Report. January 13, 2017. Available at https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Final_01-13-17.pdf

2 The requirements for Medicare Advantage are a subset of the requirements in SB 137, with SB 137 including several additional information requirements, such as product, network tier, languages spoken, hospital admitting privileges, and affiliated provider groups.

3 For example, California's SB 137 expressly permits health plans to delay payment if a provider fails to respond to attempts to validate directory information. Evaluation of the pilot found that provider office staff in California were more aware than their counterparts in Florida or Indiana that health plans may be required by the state or federal government to keep their provider directories up-to-date and accurate.