AN AVAILITY WHITE PAPER

THE PROVIDER DIRECTORY DILEMMA

Why fixing bad provider data is more difficult and more important than ever
Bad provider data has plagued the healthcare industry for years, and over time health plans have learned to live with it. However, the passage of Affordable Care Act (ACA) saw millions of people gain healthcare coverage for the first time, and the influx of new members has turned bad provider data from an annoyance into a significant—and potentially costly—problem for plans. Members regularly use health plan directories to select participating physicians, but bad provider data has led to frustration and, in some cases, higher healthcare costs. In response, federal and state regulators have recently updated their guidance and increased penalties for health plans with data inaccuracies, while some consumer groups have even filed lawsuits. The increased focus and potential costs are forcing health plans to rethink how they manage provider directories.
Imagine you recently signed up for health insurance coverage and are trying to make an appointment with a nearby provider, only to find that none are accepting your insurance. Or imagine that you saw a physician who you thought was in network, until an out-of-network bill tells you otherwise. Many members find themselves in this situation as they try to make informed decisions about their healthcare. At issue is the accuracy—or lack thereof—of health plan provider directories.

Health plans create directories to help members decide which insurance product to sign up for during open enrollment periods, and to help the same members find physicians when care is needed. For years, directories were only available in hard copy, but with the advent of the internet, health plans moved their directories online so members could more easily access the information. However, the underlying processes didn’t change much: the directories were usually updated each year for enrollment season, and the information quickly became stale.

So while the quality of provider directory data has been a known issue for a long time, it has gained attention in recent years because more people have been negatively affected by it. Since 2013, 2.3 million adults gained healthcare coverage under the Affordable Care Act (ACA)1 and many have looked to these directories for help choosing a physician. Frustration with inaccuracies has led many consumers to contact federal and state regulators, who in turn are issuing more detailed guidance on what constitutes adequacy in a provider directory. Some members are also lodging class-action lawsuits in an effort to recover monetary damages. What was once an inconvenience for health plans has become a significant problem that needs an immediate solution.

But the root cause of the problem isn’t the directories themselves; it’s the underlying data. Capturing, storing, and retrieving provider data has always been a complex process, and health plans have struggled with it for years. Fixing the problem is important, not just because of the directories, but because of the broader issue of provider and health plan engagement. The transition from fee-for-service to value-based payment models creates a need for better communication and coordination between health plans and their provider networks, particularly around the areas of risk sharing and quality measures. To achieve this, plans and providers need a way to improve data quality and it starts with provider data.

THIS WHITE PAPER COVERS:

- What’s driving the increased focus on provider directories
- The existing guidelines for provider communications and directory updates
- Why health plans struggle to capture and maintain accurate provider data
- What improvements health plans can make to internal processes
- How technology can address health plan limitations

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When selecting a healthcare provider, consumers use provider directories to find physicians in their area who are in-network and accepting new patients, as well as to find correct address and contact information. When the directories have bad data, it’s not only frustrating for members who are trying to find someone to treat them, but it could end up costing them more than they expected when they are charged out-of-network fees for a physician they thought was in-network. The result is thousands of angry consumers who are now raising the issue with providers, health plans, and regulators.

Federal and state regulators have heard these complaints and are responding. New regulations went into effect in 2016 that enable the Centers for Medicare and Medicaid Services (CMS) to fine health plans up to $25,000 per Medicare beneficiary for errors in Medicare Advantage plan directories and up to $100 per beneficiary for mistakes in plans sold on HealthCare.gov. Individual states are also holding health plans accountable with their own rules for provider directories. In November, two large health plans were fined a total of half a million dollars for errors in their state directories.

But regulatory fines are just one potential cost to health plans. Consumer watchdogs are increasingly targeting health plans with lawsuits, seeking to recover both compensatory and punitive damages caused by incorrect provider directories. In California, a consumer group filed lawsuits against insurers, alleging “significant misrepresentations” in their provider networks resulted in costly out-of-network bills for patients. Health plans are realizing the financial risks of not addressing provider data accuracy are becoming too big to ignore.

\[\text{UP TO} \ $25,000 \ \text{PER BENEFICIARY FOR ERRORS IN MEDICARE ADVANTAGE PLAN DIRECTORIES}\]

\[\text{UP TO} \ $100 \ \text{PER BENEFICIARY FOR PLANS SOLD ON HEALTHCARE.GOV}\]

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3 Ibid.
INCREASED FOCUS ON PROVIDER DIRECTORIES

Provider Communication Guidelines

CMS increasingly sees communications between providers and health plans as a two-way flow of information. Not only are providers sending demographic information to the plans, but there’s a requirement for health plans to conduct outreach to providers. CMS has also made a distinction between outreach to providers and updates to the directories.

FEDERAL 2016 GUIDANCE

The following is the CMS’s guidance on proactive outreach to providers and required timeframe for making edits to provider directories.⁴

<table>
<thead>
<tr>
<th>Communications Requirements</th>
<th>Qualified Health Plan (QHP)</th>
<th>Medicare Advantage (MAO)</th>
<th>Medicaid Managed Care (MCO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update Requirements</td>
<td>Silent on communications</td>
<td>Quarterly communications</td>
<td>Silent on communications</td>
</tr>
<tr>
<td></td>
<td>Updated monthly</td>
<td>Updated within 30 days</td>
<td>Updated within 30 calendar days</td>
</tr>
</tbody>
</table>

STATE REGULATIONS AND ACTIONS

State regulations are often more strict than the federal guidelines, and can affect commercial, as well as government-funded, insurance plans. Add to that the 50 individual state departments of insurance, with concomitant variations in language, and health plans with multi-state networks quickly find themselves struggling to keep up with the laws, in addition to maintaining current data.

The following are the regulations in place at the state level:⁵

<table>
<thead>
<tr>
<th>TIER</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider directory updates at least on a monthly basis with potential additional provider validation requirements</td>
</tr>
<tr>
<td>2</td>
<td>Provider directory updates required between a quarterly to an annual basis</td>
</tr>
<tr>
<td>3</td>
<td>Provider directories are required to be “up-to-date” or updated in a timely manner</td>
</tr>
<tr>
<td>4</td>
<td>No additional state-level guidance or requirements specific to the provider directories</td>
</tr>
</tbody>
</table>

⁵ Ibid.
As more attention is given to provider directories, some people question why it's difficult to keep them accurate. There's an assumption that provider data is largely stagnant and should be relatively easy to keep updated. In fact, the opposite is true. The following sections cover some of the challenges health plans face in collecting and maintaining accurate provider data.

### COMPLEX AND DYNAMIC DATA

Health plans often update provider data annually as part of the contract and credentialing process, using this information to populate provider directories. For providers, documenting this information takes time, as a detailed record can track up to 380 distinct line items, including service locations, billing locations, and payment locations. There are also specialties, certifications, affiliations, office hours, and languages spoken, along with whether or not the provider is accepting new patients. Additionally, health plans and providers typically have multiple complex contractual relationships that must be reflected.

Federal regulations governing provider directories generally restrict required information to the most essential elements: locations, contact information, specialties and certifications, and whether or not new patients are being accepted. However, many states add additional requirements, such as practitioner gender, languages spoken (by the practitioner or staff at each location), accommodation for special needs or language barriers, and so on.

Sometimes the provider’s information doesn’t conform to the data structure required by the health plan. Take, for example, whether a provider is accepting new patients. Most health plans capture this data as a binary—yes or no—field, but the reality can be more nuanced. A provider specializing in a certain branch of medicine may be willing to accept patients that meet certain criteria, but not the general population. Or the specialist may be able to accommodate new patients at one service location, but not at another. How does the provider communicate this to the health plan in a way that helps patients make informed decisions?

Ultimately, the challenge for health plans is that information gathered during contracting or credentialing reflects a snapshot of that provider. Even events that should automatically generate updates to directory information, such as a new physician joining a practice, may not be reflected.
PROVIDER DATA CHALLENGES

CUMBERSOME PROCESSES
Health plans lack an effective way to capture provider changes as they happen, relying instead on updates from the provider. But providers contract with an average of 15-20 health plans, and each plan has its own way of collecting demographic data. Complicating this is the fact that health plans haven’t standardized provider data structures, so one plan might want to receive a name as “First Name, Last Name,” while another wants “Last Name, First Name.” The more difficult this process is for the providers, the less likely they are to complete it.

An additional complication is that state and federal insurance regulators have very little authority over practitioners when it comes to directories. The CMS mandates require the health plans to do the outreach, and CMS explicitly states that it has no authority to compel providers to comply. Texas and California—two of the states most focused on providers directories—also put the onus for accuracy on the health plans.

LEGACY SYSTEMS
Many health plans still rely on legacy systems where provider data is stored in multiple, disconnected databases. As business requirements have evolved, organizations have implemented incremental stop-gap measures to address data limitations, but these don’t address the core challenge: the lack of a single source of truth. Therefore, to create directories, provider data must be cross-referenced against multiple systems, which means it’s more likely to contain redundancies and incomplete or incorrect data.

DIRECT VS. DELEGATED NETWORK CONTRACTS
Health plans sometimes rent provider networks from managed care companies, rather than contract directly with providers. Here, the third party owns the relationship with the provider and is responsible for communicating provider changes to the health plan. But if the company fails to do so, the health plan is still liable in the eyes of CMS.

RESOURCE LIMITATIONS
While health plans recognize the limitations of legacy technology, implementing large-scale initiatives to modernize them requires a significant capital investment, which may not be feasible given the ACA’s Medical Loss Ratio (MLR) requirement. This is the national minimum standard that must be met by insurers selling major medical insurance policies, and it requires individual, small group, and large group health plans to report how much of a healthcare premium is being spent on medical and medical-related expenses and how much is being spent on administration, fees, and profits.

For individual and small group insurance plans, an annual minimum of 80 percent MLR is required by the ACA, while large group insurance plans are required to have an 85 percent MLR. The requirements made by the ACA differ from many individual state MLR laws that generally just compare medical claims to earned premium. Health plans that fail to comply with MLR face fines, and may be required to provide rebates to consumers to compensate for their excessive spending. This funding constraint makes it difficult to budget for data quality improvement initiatives.
OPPORTUNITY: IMPROVE INTERNAL PROCESSES

Along with populating directories, provider data is used for many critical functions across health plans, including claims processing, credentialing, network management, member service, case management, risk adjustment, etc. But without a central source of provider data, the departments responsible for these functions create their own unique processes for capturing and storing the information they need.

These organizational silos have a direct impact on providers, who are often asked to provide the same information to multiple people within a health plan—a process sometimes referred to as “chart chase.” Fulfilling these multiple requests is frustrating and time-consuming for providers, and if they are not mandated to provide the information they are less likely to provide it voluntarily.

The following are some of the ways health plans can improve their internal processes for collecting provider data.

MANAGE DATA REQUIREMENTS ACROSS DEPARTMENTS

By understanding how data is captured and used throughout the organization, health plans may be able to streamline processes simply by sharing data that already exists. For example, the claims and network management departments both rely on service and payment addresses. If one becomes aware of a new address, there should be a mechanism that alerts the other of that change.

IDENTIFY KEY STAFF MEMBERS AT PROVIDER FACILITIES

Different staff members within a provider facility handle different types of information. For example, the person who answers information about claims may not be the same person who handles risk management inquiries. But more often than not, the person answering the main line at the provider office doesn’t know how to route these calls. Health plans can reduce some of this churn by having the name and contact information for key staff members who can handle their request.

RECONSIDER HOW—AND HOW MUCH—DATA IS COLLECTED

Is it more important to get all the data, or is it more important to get clean data? The answer is both. In the short term it can be tempting to capture the minimum number of data elements required to meet the federal and state mandates because it’s easier for the data management team and less irritating to the providers. However, health plans should also consider long-term requirements and opportunities for future improvements when building their data schema. One solution may be to use data capture tools that allow providers to complete “chunks” of information, allowing for incremental saves.

INCENTIVIZE PROVIDERS

While it might change in the future, health plans right now bear full responsibility for the accuracy of provider directories. Contracts may require providers to keep the health plan apprised of material changes to their businesses, but apart from de-certification or contract non-renewal, there is little incentive for providers to keep their data up to date. Health plans may want to consider ways to incentivize providers for providing timely updates. It’s also important for health plans to educate providers on how bad data affects their businesses, including lost referrals, increased administrative loads, and patient dissatisfaction.
SOLUTION: LEVERAGE AN INTELLIGENT, MULTI-PAYER TECHNOLOGY PLATFORM

Although there are many provider data management solutions on the market, many lack the functionality needed to address health plans’ core challenges, which include provider engagement, issues with data structure, and the ability to capture updates as quickly as possible. One technology solution that does address this combines a multi-payer platform with real-time data exchange.

MULTI-PAYER PLATFORM

Health plans have built a variety of online portals and other online tools in an effort to improve communications with providers, but in doing so they’ve lost sight of the fact that providers contract with 15 or more health plans, and may submit claims to many more over the course of a year. For providers and their staff, having to use multiple portals—each with its own design and navigation—can make the process of conducting business and communicating with health plans more complicated.

Multi-payer platforms provide a better option because they leverage the strength and market participation of many health plans, giving providers a single point of entry and streamlined navigation. Rather than moving between completely different interfaces, providers and their staff have to learn to navigate just one, which then enables multiple workflows. This compares to the interface of the Microsoft® Office suite of productivity software, for example. Menus and commands are shared across workflows – and across plans. The goal is to deliver a consistent look and feel, while still giving participating health plans the opportunity to communicate payer-specific information to their networks.

Along with a consistent workflow, the multi-payer platform allows providers to update demographic information just once and have the data sent to participating health plans, in much the same way that real estate listings are shared among realtors and others who are interested in the information. Providers don’t have to manually complete forms and figure out how to submit them, and they don’t have to manipulate their data to accommodate the health plan’s preferred data structure. The benefits are similar on the health plan side, as each health plan receives up-to-date, accurate information in formats that their systems can consume and use. The plans don’t need to analyze submissions to verify that similar but unique specialty names, addresses, or certifications are consistently used.
SOLUTION: LEVERAGE AN INTELLIGENT, MULTI-PAYER TECHNOLOGY PLATFORM

DATA INTELLIGENCE
Health plans don’t want more data; they want more intelligent data. To achieve this, they need a platform that monitors billions of healthcare transactions in search of data anomalies. As more data flows through the network, the accuracy of the network is honed, delivering more accurate information more quickly. Analytics similar to those used by retail and financial companies can be leveraged by health plans to spot trends, identify errors, and drive improvements across the enterprise, which would not otherwise be possible.

PROCESSES THAT ARE PART OF THE PROVIDER WORKFLOW
Health plans can greatly improve their chances of getting up-to-date data from providers by making it part of the existing workflow. Here’s an example of how it works: A staff person in a provider office is submitting a claim to a health plan or checking benefits when the system identifies a potential address mismatch. The system flags the record, and when a practice administrator with responsibility for updating records logs into the system, that individual receives a message with a prompt to validate or update the information. Because this all happens within the existing administrative workflow and because the updated information is automatically sent to all participating health plans, provider offices are more inclined to complete the task. After all, it’s much easier than manually completing a dozen or more forms.
CONCLUSION

In many ways, provider directories should be viewed as the canary in the coalmine, signaling to health plans that it’s time to do something about the accuracy of their provider data. With regulatory bodies stepping up their efforts to ensure compliance and consumer groups promising lawsuits if they don’t, health plans can no longer afford to ignore the issue.

But simply improving the quality of provider directories shouldn’t be the goal. Instead, as health plans address the underlying problems of organizational silos, legacy systems, and manual processes, they should be taking critical steps toward creating better engagement among health plans and providers. They can do this by:

- Making it easier for providers and health plans to share quality and risk information, helping reduce costs and improve patient care.
- Reducing the number of requests to providers by asking the right person for the right information at the right time.
- Fostering better relationships with providers, helping improve HEDIS and STARS ratings.
- Improving adoption of data management systems by allowing providers to quickly and easily update their demographic information and send it to all participating health plans.

With access to timely and accurate data, health plans are better able to manage costs, improve engagement with providers, and ensure members have the information they need to make healthcare decisions.

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