DEPARTMENT OF HEALTH

Minnesota Provider Directory Feasibility Study Report

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Introduction

Provider directories are an essential administrative component of the health care system but managing them is very time and resource intensive. Currently, each health plan and health system maintains its own consumer-facing provider directory, and multiple state agencies maintain provider directories for various administrative and/or research needs. Information from health systems and other provider organizations is the primary data source for health plan provider directories.

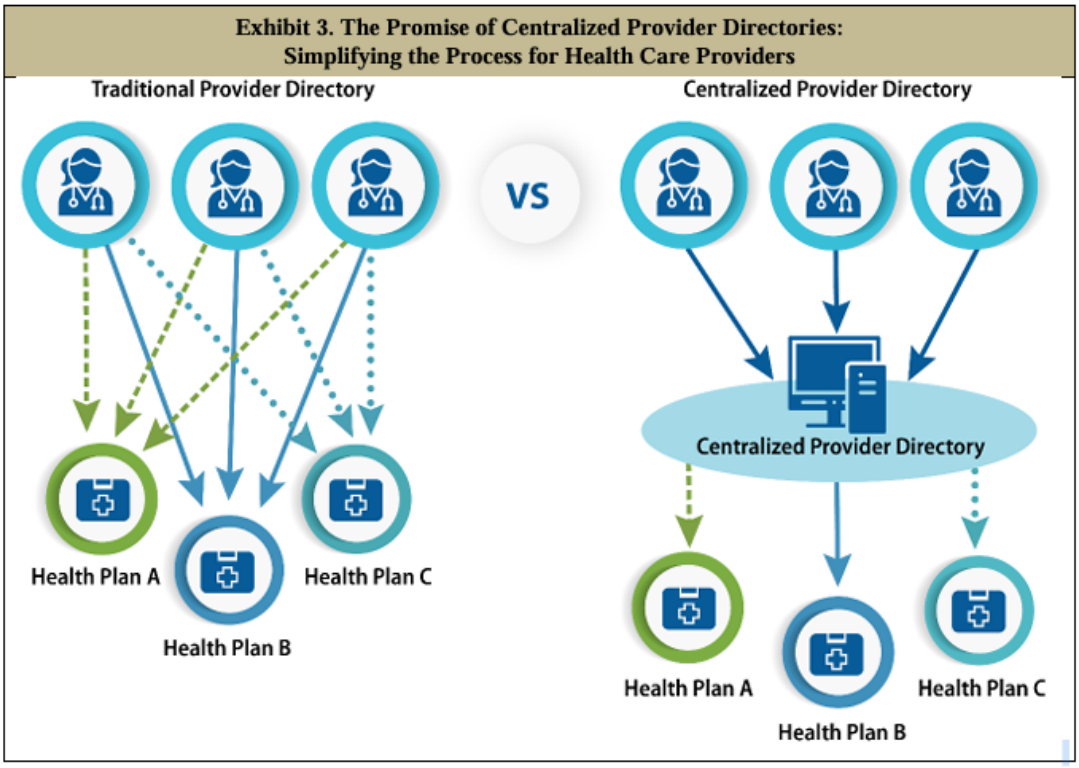
There are both primary and secondary uses for provider directory information:

- Health plans use consumer-facing provider directories to provide information to their plan members about providers in various contracted networks (information the health plan maintains) as well as information on individual providers and clinics that is supplied by health systems and others (e.g., provider specialties, clinic locations and hours, accepting new patients, etc.) This includes health plans that are contracted with Minnesota Medical Assistance (Minnesota Medicaid) and MNsure.
- Health systems and other provider organizations use their own consumer-facing provider directories to display individual provider and clinic specifics and contact information which is very similar to what is supplied to health plans for their directories.
- Some state agencies develop and use internal provider directories to connect and coordinate individuals to programs and providers using source data from health plans, health systems or providers.

Information in health plan provider directories changes frequently and the information requirements keep expanding and presenting challenges (CAQH and American Medical Association, 2022). The layering of information in a directory creates significant complexity due to the need to manage multiple relationships. For example, the core data may be individual provider details (credentials, specialties, education). Practice location(s) by contract then get added, as well the schedule for that location (days provider is there) and whether the provider is accepting new patients. The location details (e.g., clinic address, phone, accessibility, languages spoken, etc.) are then added for each provider. The complexity is multiplied by the frequency of changes to this information (changes in provider's clinic days, whether patients are being accepted, etc.).

Given these challenges keeping provider directories up to date, health plans and insurers struggle to maintain accurate directories. Inaccurate directories can make it difficult for individuals to locate and access care and may result in unexpected out-of-network fees or surprise bills (Busch, 2020). "Provider directory accuracy has been a longstanding problem and despite significant efforts, minimal improvement has been observed" (CAQH and American Medical Association, 2022).

Centralized or shared provider directories are considered a way to streamline information sharing among provider organizations, health plans, other payers and regulators and potentially help support more accurate provider directories. “A centralized provider directory can become the single source of provider information that is distributed to multiple participating health plans, which reduces the administrative burden on health care providers who receive requests from each health plan or health plan vendor to update and verify data elements like location, hours, and whether or not they are taking new patients.” (Office of the Assistant Secretary for Planning and Evaluation, 2023).



Source: Office of the Assistant Secretary for Planning and Evaluation, 2023

Study purpose and process

The Minnesota Department of Health (MDH) was directed by the Minnesota legislature to conduct a study that would assess the feasibility of a statewide provider directory:

> *The commissioner shall assess the feasibility and stakeholder commitment to develop, manage, and maintain a statewide electronic directory of health care providers. The assessment must take into consideration: consumer information needs, state agency applications, stakeholder needs, technical requirements, alignment with national standards, governance, operations, legal and policy considerations, and existing directories. The commissioner shall conduct this assessment in consultation with stakeholders, including but not limited to consumers, group purchasers, health care providers, community health boards, and state agencies.*

See Appendix A for full legislative language with definitions.

In response, the Center for Health Information Policy and Transformation (CHIPT) team at MDH contracted with Management Analysis and Development (MAD) to conduct the study, using the following working definition for "statewide shared provider directory":

> *A centralized "platform" for provider data management that would serve as a single source of truth to support accurate provider information. A statewide shared provider directory would help health plans and providers streamline the complex data exchange processes to help improve efficiency, quality, and ease of use.*

The study sought to identify and define the uses of and needs for a statewide shared health care provider directory and answer the following questions:

- What do stakeholders need from a statewide shared health care provider directory?
- What level of interest and commitment is there for a statewide solution, and by whom?
- What are considerations for governance, funding, policy, legal issues and sustainability?

The feasibility study included the following four data collection efforts:

- An environmental scan of State of Minnesota agency provider directories
- A request for information (RFI) for interested parties to respond
- Conversations with other states about their provider directory efforts
- Conversations with participants and administrators of the Minnesota Credentialling Collaborative

The summary findings are shared in this report. A research report completed by MAD is available upon request.

Minnesota provider directory landscape

State government agencies

The study team coordinated a survey and conducted interviews with the state agencies most likely to use and house provider directories. Agencies included the Minnesota Department of Health, the Minnesota Department of Human Services, and MNsure. Each of these agencies has directories that serve one or more purposes and a corresponding infrastructure that has been developed based on business needs and available technology. The directories may include information at a facility or individual provider level. They may be populated at a point-in-time, in real time, or have archival needs for recording historical changes.

Minnesota Department of Health

Within the agency, MDH has over 17 directories across various programs that collect and store provider, facility and other data. A large number track and store provider information at the facility or organization level in addition to individual provider level. Those directories are used to connect individuals to providers for specific diseases or conditions or for monitoring and regulatory purposes. While the majority of the MDH directories are for internal use only, a few are public or consumer-facing.

Minnesota Department of Human Services

The Minnesota Department of Human Services (DHS) maintains a search tool of health plans that participate in Minnesota Health Care Programs, Medical Assistance (Medicaid), and MinnesotaCare Directories for fee-for-service participants. Managed care organization (MCO) directories are hosted and maintained by the MCO and submitted to DHS on an ongoing basis. Directories can be found online or can be printed. Of note, 85% of Medical Assistance enrollees participate with an MCO.

MNsure

MNsure has devoted significant time and effort to developing and maintaining an accurate consumer-facing directory of the providers in the qualified health plans that participate in Minnesota's health insurance exchange. MNsure requires not only point-in-time data on providers but also historical provider data that was previously displayed for audit purposes. Data accuracy will always be a challenge as qualified health plans need to ensure the data is up to date, which includes verification with providers and health systems.

Minnesota health care ecosystem

MDH issued a Request for Information (RFI) in September 2024 to receive input on the impact, costs, and considerations for a statewide shared health care provider directory. A brief outline of the RFI questions is shared below and the complete list of questions is in Appendix B.

Respondents were asked to provide information in two parts on the following.

1. Organization and current provider directory information, such as:
    - Organization type, annual budget, patient encounters or plan members
    - Provider directory purposes and processes to update and verify information
    - Staff and financial resources support required to maintain directories
    - General rating/ranking of identified provider directory administrative burdens
    - Readiness for technology changes
2. Concept, features and governance of a shared provider directory including:
    - Benefits and potential drawbacks
    - How it might improve health care access in underserved communities
    - Programs or policies that would encourage participation
    - What would be needed for their organization to support the shared/centralized provider directory?

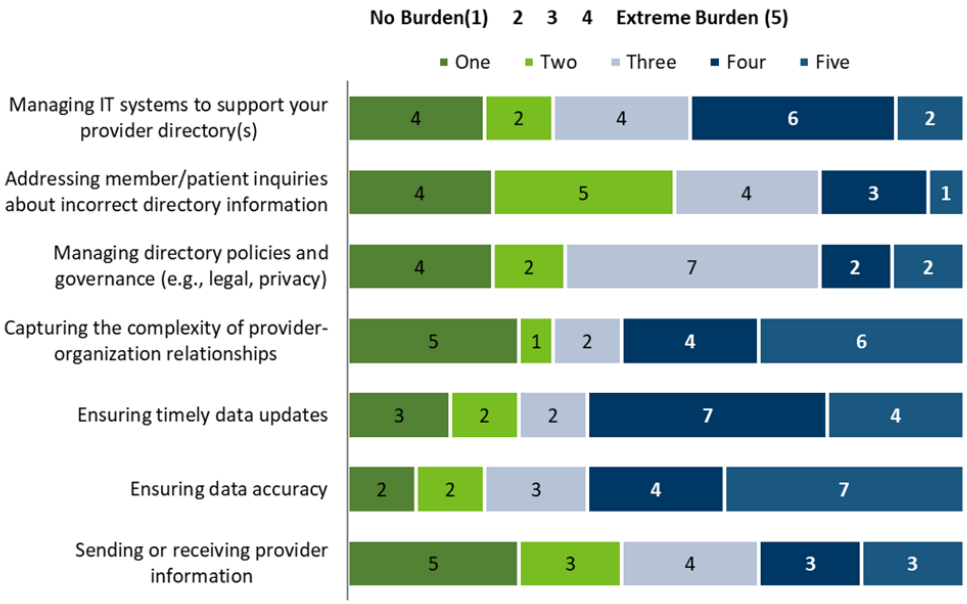
MDH received 25 responses from across the health care and health plan continuum.

The two most burdensome tasks identified were keeping directories accurate and current. The administrative burden is the result of several factors. Firstly, most plans and systems maintain multiple provider directories for specific purposes (e.g., credentialing, consumer-facing) and different data are needed for each type of directory. Secondly, the directory updating

frequency varies from “real-time” to quarterly to as needed and most updates are largely manual. Thirdly, the lack of alignment in directory requirements (state, federal rules, intra and inter-health plan, data elements) is a large burden for both providers who must submit information to multiple directories and for the health plans who must maintain them.

Respondents were asked to rate seven potential administrative burdens from one (no burden) to five (extreme burden). Exhibit 1 shows that ensuring data accuracy and timely data updates were identified as most burdensome. Items with the least burden include addressing member/patient inquiries about incorrect directory information and sending or receiving provider information.

Exhibit 1. Provider directory administrative burdens



Source: MAD Research Report, 2025

While only a small number of responses received, internal annual costs (e.g., staffing, IT systems) ranged from $73,000 to more than $2 million per year and between one and 34 staff to manage the directories. Those with smaller directories noted that costs were minimal. Provider directories engage multiple areas of the organization and are embedded in data infrastructure (MAD research report, 2025).

Regulatory efforts to improve provider directories

Federal and state legislation and regulatory requirements have been enacted to increase provider directory accuracy but have not explicitly addressed administrative burden or lack of alignment of requirements and the resulting duplication of effort (CAQH and American Medical Association, 2022).

The No Surprises Act has requirements for both health systems and providers and health plans/health insurers to submit information at specified times to health plans and insurers. Health plans and health insurers must create a process to verify and update their provider directories’ information at least once every 90 days. They must also establish a procedure for

the removal of a provider or facility whose information could not be verified and must update their database within two business days of receiving information from a provider or facility.

Several states also have additional requirements in legislation. For example, 30 states have laws for provider directory requirements: 22 for electronic directories and nine for paper directories. State laws include requirements for directory content, timeframes for directory updates, processes for ensuring accuracy, and provider obligations (America's Health Insurance Plans, 2019).

Centralized provider directories

In addition to federal and state requirements to improve accuracy and reduce burden, the Centers for Medicare and Medicaid Services (CMS) and several states are trying to implement or have implemented a centralized provider directory like the statewide shared provider directory that is the subject of this feasibility study.

"A centralized provider directory accepts provider information once and distributes that information to multiple health care plans, in hopes of reducing administrative burden and staff time costs for both parties. This reduction in administrative burden can happen for providers in two ways. First, if the centralized provider directory has a robust process of reconciling provider information data from multiple sources (provider organizations, health plans, and other publicly available reference sources), it may make the baseline provider information more accurate even before providers are asked to verify or update information. Then, by streamlining the frequency and the number of requests they receive to attest to or update information, health care providers may be more likely to: (1) respond to requests for updates or attestation that existing information is correct; and therefore, (2) offer more accurate information that is used to populate participating health plans' provider directories that consumers see"(Office of the Assistant Secretary for Planning and Evaluation, 2023).

Federal efforts

The CMS issued a Request for Information (RFI) entitled National Directory of Healthcare Providers & Services (NDH) in October 2022 seeking public comments on establishing an NDH that could serve as a ''centralized data hub'' for health care provider, facility, and entity directory information nationwide. CMS received 647 responses; CHIPT staff reviewed responses from Minnesota-based organizations, vendors doing business in Minnesota, and regional and national health information exchange providers and related associations. While the responses showed "qualified" support for the overall goal and concept of the NDH, many identified reservations about a national/federal endeavor and articulated recommendations for modifications or structure. Importantly, there was mixed support for a centralized "source of truth" database. A preference for a federated rather than centralized approach was also a common response.

Most recently, on June 3, 2025, CMS announced its commitment to move forward on a number of initiatives including "…building a dynamic, interoperable national provider directory."

Oklahoma Pilot - Directory for Qualified Health Plans (Insurance Marketplace)

CMS announced on June 30, that the pilot provider directory for Oklahoma's insurance marketplace is live. As noted in the CMS frequently asked questions, "One goal of this pilot is to develop an automated, single, statewide centralized directory for Qualified Health Plans (QHPs) to improve data accuracy and lessen burden on Oklahoma providers and payers, lower administrative costs, support interoperable data exchange, and ultimately improve patient and provider experiences." (Centers for Medicare and Medicaid Services Qualified Health Plan Directory Pilot, 2024). CMS also believes that this pilot may also help inform future National Directory of Health developments. This project did not yet have evidence to support the goals of this study.

Other states' efforts

Several other states have attempted, completed, or are still in process of implementing a statewide shared provider directory or "source of truth" directory. The study team looked at six state directory efforts whose primary purpose ranged from a directory optimized for a specific use (e.g., exchanging information, look-up tool for comparing contracted health plan providers or credentialing) to a directory with comprehensive individual and contract information. In this group of six, two were not successful, three had narrow, specific uses, and only one with a comprehensive vision to improve accuracy and decrease administrative burden is still operating. Experiences in these states indicate that implementation of a statewide shared provider directory is challenging and requires both substantial funding and stakeholder commitment for long-term sustainability.

California

California's Symphony provider directory is likely the best example of a robust and comprehensive centralized provider directory. A 2016 report highlighted provider directory inaccuracies that prompted a push for a potential solution using an independent entity to host and develop a centralized provider directory (California Department of Managed Healthcare, 2016). A pilot was led by the Integrated Healthcare Association (IHA) which developed the Symphony provider directory. Initial pilot testing phases helped to define use cases, data validation, and member needs. Since 2019, IHA has continued to recruit directory participants and has developed tools for assisting practices of different sizes. There are now over 100 large provider organizations, nearly 120,000 smaller provider entities, and 18 health plans and purchasers participating/providing data to the directory. The Symphony goal was to have 80% by 2023; the study team was not able to confirm the current percentage participating. The Symphony directory, collects, validates and verifies information from health plans, purchasers, and providers to generate a "golden record" for individual providers. Health plans and others can use these "golden records" for their consumer-facing directories. A single source for accurate provider information is the main use currently. Expansion to other uses, for example, credentialing, HIE are not currently in scope.

Oregon

Oregon planned and partially implemented a provider directory from 2015-2021 with credentialing as a priority use case. There was substantial stakeholder involvement in planning prior to launching the directory. Mostly federal and some state funds ($12 million) were used. When the additional state funds needed for a federal match were not secured the project was stopped (Oregon Health Authority, 2025).

Rhode Island

Rhode Island's Department of Public Health launched planning work in 2013 on a statewide provider directory that would be a single, authoritative source of provider information. A pilot directory, funded by federal and state sources, was built but never fully implemented due to lack of sustainability and widespread support.

Michigan

Michigan has a centralized directory used to help facilitate exchange of health information between providers. Building upon the already existing state health information exchange infrastructure, the Michigan Health Information Network Shared Services (MiHIN) implemented a health provider directory with provider electronic endpoints as a key data element. An electronic endpoint is a digital address that allows healthcare providers to send and receive health information securely—kind of like an email address, but for protected medical data. These are crucial in provider directories because they enable seamless and secure communication and data exchange between health care providers, system and health plan entities. Though this is an important use for a provider directory, this directory does not include more detailed individual provider information that is common in other provider directories. (Michigan Health Information Network Shared Services, Health Directory Use Case, 2023) (Office of the Assistant Secretary for Planning and Evaluation, 2023).

New York

New York has a statewide directory that is a consumer-facing look-up tool of providers by insurance carrier or health plan. The tool was developed by the New York State Department of Health as an additional use for network adequacy information (New York State, 2025).

Washington

Washington State has had a uniform electronic process since 2009 for collecting and transmitting credentialing data using the state's health information exchange to develop and maintain this process. As of January 2025, the Foundation for Health Care Quality is the state's Lead Organization for Administrative Simplification and is responsible for credentialing activities required by Washington state law (Foundation for Health Care Quality, 2025).

Provider credentialling as a possible use case

The provider credentialing process can be time-consuming for health systems and health plans and may result in development of separate databases or directories (as was noted in the RFI). Disparate databases/directories may result in siloed information which can be difficult to reconcile and make it challenging to keep all databases/directories up to date.

As noted earlier in this report, other states have implemented statewide shared services for credentialing. Correspondingly, several RFI respondents mentioned the Minnesota Credentialing Collaborative (MCC) as a statewide resource for consideration. The study team explored the MCC as a potential model for a provider directory in Minnesota.

The MCC is a collaboration among the Minnesota Council of Health Plans, the Minnesota Hospital Association, and the Minnesota Medical Association with support from the Minnesota Medical Group Management Association. Launched in 2008, the MCC converted the traditional paper-based Minnesota Uniform Credentialing Application into a secure, centralized, web-based system. While the MCC has been accepted by most health plans, there is relatively little uptake by health systems and providers. The reasons include: some health systems are allowed to credential their own providers (delegated credentialing), staff are still needed to credential for national and other plans, and the participation cost is too much for some organizations.

The study team explored the MCC as an example of collaboration and governance and as a potential use case for a centralized provider directory, but lack of participation by provider organizations indicates there is not adequate engagement to build upon this model.

Key findings

Below are the key findings from MDH's assessment of provider directories in Minnesota, other states, and related national initiatives.

- While national and other states' surveys have identified provider directory inaccuracies as a significant issue, it is unclear whether Minnesota has significant inaccuracies in health plan provider directories.
- A major source of provider directory inaccuracies is due to inconsistent or infrequent verification and validation of provider information by providers or their proxies. Regulatory requirements, health plan contractual obligations, and improving processes for updating and validating information more easily through third-party vendors are strategies that have been tried with limited widespread effect on provider directory accuracy.
- The promise of increased accuracy using a shared or centralized directory is yet to be realized or verified, and the "human-based" factor remains a challenge. For example, in one study, two vendors tested approaches for centralizing provider outreach and data validation. Results suggested that even when centralized, few providers completed a validation process, which is a key factor in any directory's accuracy. Provider response rates were similar whether contacted by phone, email, fax, or online portal alerts. Phone validation took less time than the online portal (AHIP, 2017).

- Though there have been several efforts to implement a centralized "source of truth" directory, there is limited to no evidence showing that these directories have achieved improved accuracy or reduced administrative burden as they were either stopped before completion or are not fully implemented (Urwongse, 2024).
- Even with the promise of improved accuracy or slight reductions in administrative burden, centralized provider directory implementation drawbacks include:
- Shared directories are challenging to develop, manage, and maintain.
- Significant financial and staff resources are required to plan, implement and maintain shared provider directories. Multiple states noted costs and estimates in the millions of dollars for development, as well as annual ongoing operating costs in the millions.
- There is not a single recommended way, or even a consistent set of suggested approaches, to implement a centralized shared directory.
- Lack of alignment in provider directory requirements among federal, state, and national entities, in addition to individual health plans, will be a continued obstacle.
- While there may be considerable administrative burden with the current provider directory processes, a centralized or shared directory may not reduce that burden and could even increase the burden.

Considerations

A critical success factor for any statewide shared directory is trust in directory information accuracy and strong commitment to moving forward among all participants. For example, the federal Office of the Assistant Secretary for Planning and Evaluation study found that, "State-based efforts may be more successful when initiated with broad, local stakeholder interest in trying to improve the accuracy of health plans' provider directories." (Office of the Assistant Secretary for Planning and Evaluation, 2023).

Specific conditions or policies if a shared provider directory were pursued in Minnesota include:

- Participation incentives or mandates with enforcement mechanisms would likely be needed to ensure full participation.
- Broad participation by organizations to develop governance and oversight processes.
- A long-term sustainability roadmap including financing plans for the start-up and ongoing costs (e.g., state government, health systems, and health plan funding) as well as in-kind staff resources, would be required.
- One or more compelling use cases should be the primary driver for broad adoption of a statewide shared directory.

Conclusions and potential next steps

Based on the information gathered for Minnesota and other states, the study team concludes that developing a statewide shared provider directory may not be feasible at this time. Although the Minnesota health plans and health provider respondents to the RFI expressed support in concept for a statewide shared provider directory, it is unclear whether that support would translate into long-term commitment by interested parties, which the study team considered a critical success factor.

The study team recommends continued monitoring as a potential next step. This could include:

- Monitoring research or other resources to understand the status of provider directory accuracy in Minnesota.
- Monitoring the national, federal, and state activities and landscape, in particular:
  - No Surprises Act compliance, including Minnesota statutory requirements to report summary data on No Surprises Act claims and complaints (Minnesota Department of Health Managed Care Systems, 2025).
  - CMS provider directory Oklahoma pilot to understand CMS next steps and impact on Minnesota.
  - California's IHA Symphony directory to assess continued progress and metrics of success and lessons learned.
  - WEDI Provider Information Workgroup. WEDI is the preeminent national membership association for health IT guidance and collaboration. The workgroup is charged to identify business issues impacting the transmission and receipt of provider directory data. Commit to understanding the nuances of the data along with industry successes and best practices for obtaining the information in a timely and accurate fashion (WEDI Provider Information Workgroup, 2025).
- If monitoring reveals best practices that may be applicable to Minnesota, consider engaging the Minnesota e-Health Initiative to review and make recommendations about distributing such best practices and considering additional action.
- If monitoring identifies opportunities for further action (e.g., federal pilot expansion, other RFIs), consider convening interested parties of the Minnesota e-Health Initiative to respond to new information or opportunities.

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Appendix A: Legislative Language

Minnesota Session Laws - 2023, Regular Session, Chapter 70, Article 2, Section 42, (Statewide Health Care Provider Directory) (www.revisor.mn.gov/laws/2023/0/Session+Law/Chapter/70/?keyword_type=exact&keyword=STATEWIDE+HEALTH+CARE+PROVIDER+DIRECTORY.#laws.2.42.0)

STATEWIDE HEALTH CARE PROVIDER DIRECTORY

Subdivision 1.

Definitions.

(a) For purposes of this section, the following terms have the meanings given.

(b) "Health care provider" means a practicing provider that accepts reimbursement from a group purchaser.

(c) "Health care provider directory" means an electronic catalog and index that supports the management of health care provider information, both individual and organizational, in a directory structure for public use to find available providers and networks and support state agency responsibilities.

(d) "Group purchaser" has the meaning given in Minnesota Statutes, section 62J.03, subdivision 6.

Subd. 2.

Health care provider directory.

The commissioner shall assess the feasibility and stakeholder commitment to develop, manage, and maintain a statewide electronic directory of health care providers. The assessment must take into consideration consumer information needs, state agency applications, stakeholder needs, technical requirements, alignment with national standards, governance, operations, legal and policy considerations, and existing directories. The commissioner shall conduct this assessment in consultation with stakeholders, including but not limited to consumers, group purchasers, health care providers, community health boards, and state agencies.

Appendix B: Request for Information Questions

Released: September 16

Responses due: October 16

For questions, please email MN.eHealth@state.mn.us

Profile

1. Indicate the perspective you are responding on behalf of:
    a. Health system, health care provider or provider organization (including mental/behavioral health)
    b. Health plan, payer, or purchaser
    c. Local or state government program, department, or agency
    d. Non-clinical community-based or social service organization
    e. Individual, consumer, and/or patient advocacy group
    f. Vendor
    g. Other (please specify)
2. What is your organization's approximate annual operating budget?
3. Health systems/providers: What is your organization's approximate annual number of patient encounters?
4. Health plans/payers: What is your organization's approximate annual number of plan members?

Provider directory data and operations

5. Briefly describe the purposes of your provider directory(s) and how they are supported and managed. (e.g., do you have one combined directory or several directories, what vendor or in-house systems are used, etc.).
6. Health plans/payers: Do you use an external vendor to manage all or part of your provider network(s)?
7. Briefly describe your process for updating, verifying and/or validating directory information (e.g., how frequently, how many staff involved, number of directories updated, automated or manual, reference data sources, use of AI tools, etc.).
8. To what extent are the following items an administrative burden for your organization. (1= no burden; 5 = extreme burden; not sure)
    a. Sending or receiving provider information
    b. Ensuring data accuracy
    c. Ensuring timely data updates
    d. Capturing the complexity of provider-organization relationships (e.g., provider working at multiple sites, organizations and/or networks)

e. Managing directory policies and governance (e.g., legal, privacy)
f. Addressing member/patient inquiries about incorrect directory information
g. Managing IT systems to support your provider directory(s)

Describe any other burdens not captured above.

9. What is your organization's readiness to support the technical architecture for provider information data exchange (e.g., application programming interfaces (APIs), cloud-based service, or other mechanisms)?
    a. We are currently ready
    b. We expect to be ready within 5 years
    c. Expect to be ready after 5 years
    d. Not sure
10. What is your organization's estimated annual cost of maintaining your provider directory(s), including:
    a. Internal costs (e.g., staffing, IT systems)
    b. External costs (e.g., contracted vendors, consultants)

    (If an estimate can't be calculated, please describe number of employees, IT systems, contracted vendors, etc.)
11. Please describe any additional challenges or costs associated with managing your provider directory(s).

Provider directory features and governance

12. What features of a statewide shared provider directory could improve health care access in underserved communities?
13. Based on personal experiences and/or experiences of your patients or members, what health care access problems could a statewide shared provider directory help solve?
14. What purposes would be most beneficial for statewide shared provider directory?
15. What drawbacks or potential unintended consequences should be considered?
16. If Minnesota stakeholders were to establish a statewide shared provider directory, what programs or policies might help support full participation (e.g., incentives) or limit full participation (e.g., market competition, proprietary information, user agreements, privacy)?
17. What would your organization need to consider supporting a statewide shared provider directory (e.g., sharing data into it, pulling data from it, helping think through the build, paying for it)?
18. Share any other comments on this topic that have not been addressed.