Improving Provider Data Quality: A Collaborative Initiative

Introduction

As leaders of America's health plans, we acknowledge the paramount importance of enhancing provider data quality to drive operational efficiencies, reduce provider burden, and ultimately, improve patient outcomes across the healthcare ecosystem. With CAQH's leadership, we have undertaken a new, unified effort to address this pressing issue.

This paper explains what we believe to be the root cause of the challenge as it exists today, outlines a set of principles to guide the development of tangible solutions, and articulates the initial steps we are taking to improve provider data quality on a practical scale. We aim to pioneer an approach that can serve as an adaptable, and replicable model across the industry. And we invite the wider healthcare community to actively engage with us in this crucial initiative.

For purposes of this paper, provider data refers to the demographic and administrative information about practitioners, including attributes commonly used in processes like credentialing, network enrollment, directory management, and payment.

Background

Low-quality provider data is an extensive, universally acknowledged, and deeply consequential problem. Basic information about providers—name, specialty, location, etc.—is critical to making many parts of the healthcare system work; yet all too often, this data is riddled with inaccuracies and inconsistencies.

Problems with provider data impact the entire healthcare system. Provider data is an essential ingredient to many parts of the healthcare delivery process, from claims processing to network management. For example, poor data quality can delay a provider's enrollment creating barriers to access and increased costs for members. Poor data quality also hampers claims processing, resulting in slow or inaccurate payments to providers.

Low-quality provider data is perhaps most visible in the context of provider directories. In 2018, CMS conducted a review that revealed that 48% of locations listed in Medicare Advantage provider directories contained at least one inaccuracy.[1] In 2020, the No Surprises Act was enacted, in part, to help engage both health plans and providers to improve the accuracy of certain data elements. However, despite billions of dollars in investment and ongoing attempts to address provider directory data quality by both health plans and providers, progress has been elusive. And patients bear the burden which can include difficulty finding care, or worse, surprise bills from out-of-network providers.

Ultimately, managing low-quality data creates a near-constant re-work and burden for both providers and plans, costing avoidable time, money, and attention—resources that would be far better invested in patient care.

Lastly, these challenges are felt more deeply by small and rural organizations that are already confronting provider shortage issues. These organizations also tend to be resource-constrained, lacking technology solutions and IT support capabilities, resulting in highly manual responses to unique requests and multiple formats.

Exhibit 1

A recent CAQH review of provider data roster templates from 10 health plans highlighted overlap in the data elements collected, but variation in the way the information is requested. The 10 templates included five formats for collecting a practitioner's last name.

Last Name

LAST_NM

Provider Last Name

Practitioner Last Name

Practitioner Last Name (Mandatory)

This kind of structural fragmentation permeates provider-payer data exchange at every level: the type of data that is exchanged, the format in which it is exchanged, and how the data is ingested.

The result:
Redundancy, rework, and errors.

Root Cause Insight

Improving provider data accuracy is a shared responsibility. Providers need an easy way to provide and update accurate information, and health plans need to ingest and maintain data with appropriate quality controls in place. Unfortunately, the system has evolved unintentionally to counter this objective.

The root cause of inaccurate provider data lies in the complex, fragmented, and inconsistent exchange of data between providers and payers across the healthcare ecosystem. Hundreds of health plans nationwide are employing similar but distinct data collection processes; thousands of provider groups are submitting non-standardized data. Collectively, all this imposes a significant administrative burden on providers and health plans alike.

Guiding Principles for Our Initiative

Since structural fragmentation is the crux of the problem, a collaborative and cohesive response must be the solution. Addressing provider data quality necessitates innovative thinking and a collective effort involving health plans of all sizes, providers, government entities, and vendors. We are committed to working collaboratively through CAQH to drive progress at scale—adhering to the following **guiding principles** in our work.

1. **Collaboration:** Engage closely with stakeholders in solving provider data quality issues, and supporting the needs of members, providers, and health plans.

2. **Analysis and Prioritization:** Start with a thorough analysis and prioritization of high-urgency issues affecting many providers and/or members.

3. **Reducing Provider Burden:** Work collaboratively to synchronize requirements impacting providers and members to reduce the burden on providers.

Initial Steps

Aligned with our principle of prioritization, the initial steps of our initiative will focus on improving the exchange of data with large provider groups. We have chosen this first focus area because the complexity of data submissions from large provider groups creates an especially acute challenge when it comes to provider data quality.

- On the provider side, large provider groups submit data to many different insurers, using a variety of different formats, and channels—from standard email to website submission. This complexity makes the data submission burden on these groups extremely heavy.

- Meanwhile, on the insurer side, the accuracy of submissions from larger groups tends to be lower than that from smaller groups or individual providers. One national insurer's monthly, statistically valid audit finds that less than 30% of the provider data it receives from large groups is complete and accurate by CMS's standards.

Only a concerted effort will succeed in streamlining these processes. To begin this effort, we have identified three essential workstreams:

1. **Adopt Common Formats and Processes:** Align around a common format, cadence, and set of processes for collecting data from provider groups.

2. **Improve Data Exchange:** Identify ways to streamline the data submission process and exchange of data transparently between parties.

3. **Implement Solutions:** Launch a pilot program by June 2024 with selected provider groups to test proposed solutions.

In Closing

Low-quality provider data has persisted in American healthcare to this point because it is a complex, multi-factorial, and multi-stakeholder problem.

This statement signifies the beginning of our collective efforts to transform this critical aspect of healthcare impacting the lives of our members, patients, providers, friends, and family. We invite the industry at large to join us in this transformative journey.

For more information, please contact us at **www.caqh.org**.

References:

1. CMS, 11/28/2018, Provider Directory Review Report