CAQH Solutions

Under One Roof:
Simplifying Provider Data Management

Background

Provider data drives the most fundamental processes in the healthcare system. The industry uses it to connect patients with healthcare providers, license practitioners, exchange information and pay for services. Though the industry spends more than $2 billion annually to maintain provider data, inaccuracies and inefficiencies persist.[1]

A variety of factors contribute to poor quality provider data, such as the proliferation of proprietary platforms and technologies, complex and inconsistent government requirements, and a lack of consistent provider engagement.

Regardless of the cause, incomplete and inaccurate provider data impacts all stakeholders:

- **Consumers.** Inaccurate provider directories present a barrier to care for patients and, in some cases, result in so-called "surprise billing" and higher out of pocket costs; Poor data can result in delayed or incorrect reimbursements and a variety of administrative hassles.
- **Providers.** Responding to a near continuous stream of inconsistent requests to update and verify provider directories costs physician practices more than $2.7 billion annually;[2] Poor data quality also results in challenges receiving payments for services and other administrative burdens that consume time and resources that could be dedicated to clinical care.
- **Payers.** Health plans spend more than $2 billion annually juggling systems, requirements and vendors and face steep fines and regulatory scrutiny for inaccuracies in the data.

What is provider data?

Simply put, provider data is information about individual providers, groups of providers and institutions — who or what they are, how to access them, the services they provide, the health plan networks or products they participate in and other important attributes. This data is used for everyday business and regulatory transactions, including:

- Credentialing and sanctions monitoring
- Payment integrity/coordination of benefits
- Provider directories
- Payment of claims

Although many of these business functions rely on overlapping data sets, plans often use a variety of solutions to manage them. For example, while maintaining directories and credentialing both utilize data regarding demographics, contact information, sanctions and specialties, many plans use different vendors, in-house departments, portals and platforms to for each. Not only is this costly and inefficient, it can lead to inconsistent information about the same provider across systems managed by a single health plan.

Improving Provider Data is More Important than Ever

Although the industry has grappled with provider data challenges for years, they are becoming increasingly acute for several reasons:

- **Regulatory scrutiny.** In response to inaccurate directories and other provider data challenges, federal and state policymakers have enacted various standards and penalties. What has emerged is a patchwork of requirements on, for example, how frequently plans must reach out to providers to verify directory entries and credentials.
- **New payment models.** With the growing use of alternative payment models, integrated care delivery and narrow networks, the data needed to track health plan-provider contracting is increasingly complex. These new approaches are requiring provider data management systems to flex and adapt.
- **Changing definitions of "provider."** As the healthcare industry changes, the meaning of "provider" is also changing. Today, "provider" extends beyond physicians, hospitals and allied health professionals, such as nurse practitioners, social workers, addiction counselors, community health centers, behavioral health agencies and other community-based organizations. Provider data management has historically focused on traditional clinicians, but it now must work effectively for a larger population. With each new provider type, credentialing and health plan directory requirements are also changing.
- **The member experience.** Health plans are more focused than ever before on improving the member experience. High quality provider information is critical for claims reimbursements to be timely and accurate, and for directories to be up to date — two factors that drive member satisfaction.
- **A continued fragmented approach to collecting data.** Providers today submit directory information in various ways, including by fax (38%); credentialing software (13%); email (13%); provider management and enrollment software (5%); and phone, mail and other methods (14%).[3] Practices likewise submit credentialing and other information over a variety of channels.

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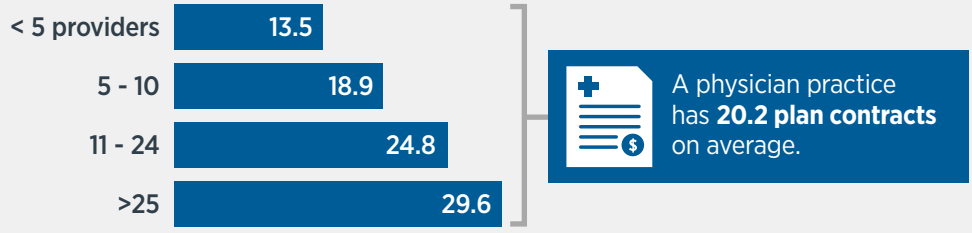
In September 2019, CAQH **surveyed 1,240 physician practices to assess the administrative costs they incur responding to requests from health plans to update and verify directory information**. To gauge the volume and frequency of these requests, the survey also examined the number of plan contracts each practice manages.



Source: CAQH

Defining Data Quality

Just as the term provider has evolved, so too has the definition of data quality, as it relates to provider information. Today, quality provider data has six characteristics:

- **Accuracy.** Has the information been verified?
- **Completeness.** Are there gaps in records?
- **Consistency.** Is the data consistently defined and in common, predictable formats?
- **Timeliness.** Is the information current?
- **Process-ability.** Is it machine readable?
- **Accessibility.** Do those who need it have access to systems and data to make updates?

The problem: Too much of a good thing

Over the past decade, as the industry has awakened to the challenges with provider data, countless approaches and technologies have emerged. Credentialing, for example, may be handled by one of dozens of vendors using a plethora of technology platforms. The function may also be handled by a plan in-house. Verifying primary sources of the credentials may be conducted by another class of vendors and approaches. A similar proliferation of solutions is occurring in directory and claims management and elsewhere.

What has emerged is a "tower of babel" of provider data management: Too many platforms that do not communicate with one another or share common datasets. While the technology may have advanced and plans have more choices for vendors, the problem may not be getting demonstrably better.

In 2016, CMS began studying the online directories of a select group of Medicare Advantage plans to assess their accuracy and found that 52% of the locations listed had at least one error. Since that time, the error rate has remained largely the same.[4]

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The Solution: All Under One Roof

Because provider data management has become so fragmented, more health plans are now seeking to consolidate the management of various provider data-related functions in a single platform or with one partner. This approach not only has the potential to improve data quality and consistency, it also reduces costs and administrative complexity for plans. Because it offers providers one platform to share information with a plan, multiple plans — or, in the best of all worlds, all of the plans it contracts with — this approach can dramatically reduce the burden on physician practices.

Here are some key elements to look for when evaluating a consolidated provider data management solution:

- **Simple, secure and reliable provider data collection.** Does the solution allow providers to enter information one time and into one portal for multiple uses, such as credentialing and directory maintenance? Is the portal web-based and easy to navigate?
- **Standardized maintenance and distribution of delegated roster data for provider groups and health plans.** Managing dozens — or in some cases hundreds — of providers in delegated credentialing arrangements can be complicated, time consuming and prone to errors. Does the solution streamline this painstaking, but important function?
- **Automated and standardized primary source verification of provider information.** Delays in verifying primary sources for credentialing can lead to lags in provider being added to networks. This not only frustrates physicians, it may limit access to care for members. Implementing a way to automate, accelerate and increase control over primary source verification should be a key consideration.
- **Artificial intelligence and automation to improve provider directory accuracy.** Although plans must still rely on the providers themselves for most elements of provider data, machine learning is now being used to identify and correct inaccurate directory information.
- **Continuous and multi-state tracking of healthcare provider licensure disciplinary actions.**
- **Streamlined enrollment for electronic payments and electronic remittance advice.** Electronic payment of claims is faster, more efficient and more accurate than paper checks. Giving providers a simple and secure way to enroll in electronic funds transfer benefits both plans and providers.

Endnotes

1 *Issue Brief: Administrative Provider Data.* CAQH [Analysis completed by Booz & Co., now Strategy&, Inc.] (December 2011).

2 *White Paper: The Hidden Causes of Inaccurate Provider Directories.* CAQH (November 2019)

3 *"What Physicians are Saying About Directories,"* Powerpoint summary, American Medical Association, 2018.

4 "Online Provider Directory Review Report." *CMS, 2017*, www. cms.gov/Medicare/Health-Plans/ManagedCareMarketing/ Downloads/Provider_Directory_Review_Industry_Report_ Final_01-13-17.pdf.

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