

ISSUEBRIEF:

ADMINISTRATIVE PROVIDER DATA

SUMMIT ON THE
FUTURE OF PROVIDER DATA

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■ INTRODUCTION

This issue brief was developed as a common reference point for Summit on the Future of Provider Data attendees. CAQH would like to thank those organizations that shared their expertise and insight.

Healthcare, perhaps more than any other industry, is dependent on data. While clinical data usually gets the most attention, administrative provider data is essential to keeping the country's \$2.7 billion healthcare system going, from paying bills to improving patient care. As several health care executives suggested, provider data is like an underground river that flows beneath the landscape of all healthcare. The problem, they said, is that it flows without control and creates administrative waste.

Millions of dollars in operating costs for physician offices, hospitals, payers, government agencies, and others are the result of redundancy, inefficiencies, and inaccuracies associated with the collection, maintenance, and distribution of provider data. Information about providers – from basic personal and demographic data to the more complex data about practice and business relationships – is required by many different organizations. Compounding this problem are the needs for this information at different times and for different purposes, even within the same organization – needs related to hospital privileges, payer credentialing, directory maintenance, and claims administration to name a few. In addition, healthcare reform initiatives will increase demand for more accurate, timely, and complete data.

Many healthcare industry leaders agree that these fragmented and uncoordinated processes contribute to waste, fraud, and strained relations among providers, hospitals, health plans, and government agencies.

The purpose of this issue brief is to be a catalyst for discussions on administrative provider data. It is not intended as a comprehensive analysis. The brief offers the perspectives of healthcare industry stakeholders regarding the current issues they face with provider data, the major drivers that will be making even greater demands on data in the future and ongoing improvement efforts.

The information was gathered from interviews with numerous provider data experts from around the country who work with health plans, physician organizations, hospitals, healthcare industry associations, and government. A literature review of key articles, reports, and issue papers was also conducted.

■ DEFINING ADMINISTRATIVE PROVIDER DATA

There is limited consensus on standard definitions for administrative provider data. This is due to the diversity of organizations that need this data and the many different functions and purposes for which it is used.

Providers are typically required to supply data to health plans, preferred provider organizations (PPOs), hospitals, third party administrators, the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, state medical boards, and many other organizations. Organizations need this data for a variety of reasons, such as credentialing, hospital privileging, directories, network management, provider relations, claims processing, compliance, fraud detection, and numerous other administrative functions. As a result, they often collect and maintain that data through separate and disconnected processes.

Despite the seemingly impossible task of defining administrative provider data in a way that meets everyone's needs, industry leaders agree there is a need to develop a consensus on how to get beyond the status quo. Most stakeholders agree that there are two categories of administrative provider data:

Common Demographic Information

This information typically consists of personal, professional, and practice information. Such data is described by some experts as “commodity data,” meaning that its availability and accuracy should not be considered a competitive advantage. “Everybody needs it; it’s expensive to collect, but collecting it does not add value,” a healthcare association representative said.

Personal information includes name, gender, age, languages spoken, and race/ethnicity. Professional information includes medical education, medical licenses, National Provider Identifier (NPI), certificates, and specialties.

Practice information identifies a provider’s professional practice settings and locations, hospital affiliations and privileges, phone numbers, Taxpayer Identification Numbers (TINs), billing information, and network affiliations.

The most important characteristic of this data is that the information is usually the same regardless of the organization seeking/receiving it. While there are many sources for the data, much of it originates with and must be supplied and updated by the provider and/or the provider’s office staff.

Organization-Specific Information

This refers to provider information that is specifically relevant to an organization with which a provider is affiliated. Such information may include contractual or financial terms that are vital to an organization's relationship with a provider and is not typically shared with other organizations. As one health plan representative described it, "This data is the secret sauce: how we organize networks, who is in them, and exactly how they are getting paid. It is all very organization-specific."

■ USES OF ADMINISTRATIVE PROVIDER DATA

If providers were only individuals, managing administrative provider data might not be so difficult. However, a provider is much more than an individual. He or she is also – in data terms – a physical location, a billing entity, a contractual relationship, a practice environment, etc.

As the industry grapples with the demands to bend the cost curve, it is widely agreed that the current state of provider data collection, maintenance, and distribution is in need of improvement, and that the inefficiencies and costs associated with current processes can be significantly reduced and the quality improved. The need to make provider data more easily available, less costly, and more accurate will only become more urgent under healthcare reform as the government promotes adoption of health information technology to improve care delivery and reduce costs. The following are examples of processes dependent on provider data:

Credentialing

Traditionally, credentialing is the starting point for the collection of provider data. All of the nation's hospitals and health plans must credential physicians and other providersⁱ with whom they contract, grant privileges, or, increasingly, employ. State medical licensing boards must verify that providers meet the requirements for licensure, and state Medicaid agencies and Medicare must credential providers as part of program enrollment.

Organizations have differing views of this process, but all would agree that credentialing is designed to protect patients. For example, licensing boards must confirm education and appropriate qualifications before granting a medical license. Health plans must verify the qualifications of providers prior to enabling network participation. Hospitals place great emphasis on credentialing and privileging to ensure provider competency for hospital-based procedures and technologies. CMS and state Medicaid regulators have focused their efforts on fraud and abuse preventionⁱⁱ.

Operations

Health plans use provider data to contract, manage networks, create directories, adjudicate claims, and for quality initiatives. Most use a variety of systems and processes to correlate these activities to providers' various practice settings – offices, clinics, hospitals, or other specialty situations, each of which may have unique NPIs and TINs. Claims adjudication, in particular, depends on accurate provider data. Claims processing errors alone account for approximately \$17 billion in unnecessary administrative costs, according to the National Health Insurer Report Card,ⁱⁱⁱ and often the processing errors are related to provider data.

As hospitals and provider groups organize new models of care supported by the Affordable Care Act (ACA) – such as Accountable Care Organizations (ACO) or Patient Centered Medical Homes (PCMH) – managing provider relationships and maintaining accurate demographic data is increasingly important. According to *Becker's Hospital Review*, “While great patient care is important, a major factor that can affect the success of an ACO is the quality of a hospital's relationships with physicians' healthcare organizations outside the hospital walls.” Bad data can quickly sour effective communication and coordination with associated physicians.^{iv}

Government Agencies and HIEs

State Medicaid agencies are increasingly focused on collecting and maintaining accurate provider data. CMS has published regulations for implementing ACA provisions that establish procedures for screening providers of medical or other services and suppliers in Medicare, Medicaid programs, and the Children's Health Insurance Program. Included in these regulations are requirements that providers and suppliers submit enrollment information and update and recertify to the accuracy of their enrollment information every five years.^v Administrative provider data is also required to populate provider directories, which are part of the backbone for health information exchange (HIE) in support of federal requirements for Meaningful Use of electronic health records and to enable the Nationwide Health Information Network. Exchanging messages securely among providers requires an authoritative yellow pages that enables providers to identify and connect with referral partners.

■ CURRENT ADMINISTRATIVE PROVIDER DATA CHALLENGES

Multiple Data Sources

No single organization or company currently captures, maintains, or integrates all of the data that providers are asked to continuously supply, and that health plans, third-party administrators, hospitals, labs, pharmacies, and others use on a daily basis. While administrative provider data drives many essential processes, stakeholders lament that there are too many intake valves. Industry experts say there is no single source of truth.

Provider demographic information flows from multiple channels – providers responding to requests for information, licensing boards, credentialing services, physician offices, hospitals, and health information exchanges, to name just a few. Judging which data are the most accurate and current is difficult at best. Conflicting information must be reconciled either by staff or outsourced to vendors that specialize in data review and cleansing. “It is a Sisyphean task,” said a hospital association executive.

Accuracy, Timeliness & Completeness

Regardless of the source, provider data must be accurate, timely, and complete. But where does responsibility rest? While primary-sourced information is usually accurate and timely, it represents only a small portion of the information required by organizations. As a result, much of the additional data required must be obtained directly from providers or from intermediaries that collect and compile information from various sources.

Several issues compound the problem – the frequency with which provider data changes and the current processes for managing updates that are fragmented, uncoordinated, and primarily rely on the providers to decide what is needed by whom, for what purpose, and when. Physician organizations point out that this puts an enormous burden on doctors and their staff, taking time away from patient care. According to one estimate, 2 to 2.5 percent of provider demographic data changes each month. Other data attributes, such as practice affiliations, privileging status, and sanctions, also change frequently.^{vi}

Processes like credentialing have established specific timeframes for periodic review – every two years for hospitals and every three years for health plans. While this works well for periodically assessing provider qualifications, it is insufficient to address the data needs of other processes that require more current and complete demographic data.

The complexity of keeping data accurate and complete increases when providers practice in different locations using different NPIs and TINs. If the number is wrong for a payer, it can be wrong for other entities, including hospitals, pharmacies, and labs.

“To do an even passable job, an organization must find and continually monitor all of the current industry sources, accurately match records across those sources, and select the correct value of each data attribute across those records. Then, it must do it all again; however, this time the organization must match the external information to the records in many internal systems and databases and then again select the correct value or values for each attribute. It typically must make correct, current information available on demand to people who need it, and distribute it to many systems.”^{vii}

To illustrate the magnitude of the problem, an analysis of provider files from dozens of payers, PPOs, and third-party administrators concluded that 40 percent of the records examined had errors or were missing data; 22 percent of the providers had inaccurate or missing NPI numbers; and 15 percent of the phone numbers were missing or wrong.^{viii}

Redundant Processes

In addition to the challenges of obtaining accurate data, the healthcare industry is fraught with redundant, inefficient data gathering processes. “Different organizations believe they have unique needs and different requirements and uses for provider data,” a health plan executive said. “But in the end we all have the same needs.” The belief that needs are unique has led to the current state where many organizations have specific data collection applications and processes. Within the same organization, there are often data silos that are protected by internal ‘owners’ and not shared with other operational functions.

Unlike the consumer credit reporting industry, for example, where three companies compile standardized credit reports on 220 million Americans, there are hundreds of organizations that perform data collection and credentialing services for hospitals, health plans, and providers.

A recent Booz & Company analysis for CAQH estimates that payers alone spend \$2.1 to \$2.3 billion annually to maintain provider databases. It further estimated that 75 percent of those costs could be offset by directly integrating to an external ‘single source of truth’, if such a source existed.

■ THE ROLE OF VENDORS

Health information management vendors help organizations resolve administrative provider data issues and enable them to efficiently perform essential administrative functions. Many are expanding their ability to address the data for managing provider performance reporting, development of new care delivery models and relationships (e.g., ACOs), adoption of electronic health records (EHRs), and creation of HIEs.

Vendors offer a variety of provider data solutions, and while there is substantial crossover and interrelatedness between the types of services they provide, there are three distinct service groupings for collecting, managing, and distributing provider data:

[Data warehousing](#) involves the collection and maintenance of detailed demographic and practice information on large numbers of providers. One example is the CAQH Universal Provider Datasource (UPD), which collects data directly from providers. Data warehousing companies such as Enclarity, SK&A, and LexisNexis typically collect data from primary sources, such as licensing boards, public databases, and their clients' internal data sources, and then conduct large-scale analysis and aggregation to verify provider information.

[Data management and analytics firms](#) provide a wide range of services designed to help organizations manage, cleanse, integrate, and use demographic and/or quality data. The focus of these services is usually to reduce data management costs and increase the reliability of the organization's own internal provider data for existing operations. Increasingly, data must be managed to meet the requirements of EHR adoption, health information exchange, new delivery models, incentive programs, and payment methodologies. Companies including Vistar Technologies, Portico Systems, OptumInsight, Enclarity, MedeAnalytics, MethodCare, and Trizetto provide services in this area.

[Data processing and connection services](#) are provided by vendors that develop sophisticated clearinghouses or portals to support electronic data exchange. These portals enable paperless transactions and bridge the barriers between IT systems. They facilitate eligibility and benefits determination, claims submission, and electronic funds transfers through a single portal rather than having providers and organizations deal with multiple systems. Provider data is vital to making these services work effectively. Emdeon, Availity, and NaviNet are some of the vendors offering such solutions.

IMPACT OF CURRENT STATE

Credentialing

The Medical Group Management Association (MGMA)^{ix} estimates that, on average, practices submit 17.86 credentialing applications per physician each year, with each application requiring an average of 69 minutes of support staff time and 11.27 minutes of physician time. This translates to an annual cost of \$762 per physician per year. With more than 800,000 licensed and practicing physicians in the United States^x, over \$609 million is spent to compile and supply data for credentialing. But that is not the end of the process: CAQH conservatively estimates that health plans alone spend between \$110 to \$145 million annually on the primary source verification component of the credentialing process for physicians (MDs and DOs) and many millions more for other providers.^{xi}

Claims

It is estimated that one percent of all claims do not auto-adjudicate as a result of inaccurate and/or incomplete provider demographic data. For health plans, that results in hundreds of thousands of dollars in operational costs associated with the manual processes needed to find the right identifier data and manually adjudicate claims. In addition, approximately 10 percent of adjustment requests are due to bad administrative provider data, with an annual cost of more than \$240,000 for the typical mid-sized health plan. Fifteen percent of claims appeals are driven by inaccuracies in provider data with annual costs of over \$300,000 for a mid-sized health plan.^{xii}

Consumer Relations

Consumer-directed healthcare has placed more responsibility on consumers for all aspects of their care. With that comes the expectation that health plans will provide detailed, real-time access to coverage and provider information. Patients need information about physicians to make informed decisions about access, costs, and quality. Poor information about any of these factors not only creates substantial dissatisfaction, but can result in fines from state insurance departments or increase a health plan's liability. For example, the NCQA guidelines include accuracy of the online provider database in the criteria for health plan accreditation.

NEW PRESSURES ON ADMINISTRATIVE PROVIDER DATA

New Models of Care

Development of ACOs, PCMHs, and trends in wellness and health promotion, as well as new approaches to value-based contracting and purchasing, are altering traditional relationships between provider organizations, purchasers, employers, and patients. These trends are creating increased demands for better provider data.

ACA Medical Loss Ratio Requirements

Medical loss ratio (MLR) regulations under the ACA will require that at least 80 to 85 cents of every premium dollar be spent on medical care for activities that improve healthcare quality. This is leading many health plans to re-examine existing administrative processes, including provider data collection and management to reduce costs.

Emergency Response

Following September 11, 2001, federal legislation was enacted that requires states to develop provider registries to avoid credentialing bottlenecks during emergencies. Hurricane Katrina confirmed this need.^{xiii} Currently, the US Department of Health and Human Services Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) is funding state efforts to address these needs. Most states have launched programs and are now focused on provider outreach and data collection, a costly challenge for both the agencies collecting the data and the providers who must supply their data.

Health Information Technology

The national push to adopt health information technology and EHRs brings with it new requirements and data collection needs. The Office of the National Coordinator (ONC) has identified accurate provider directories as an essential component to establish who is sending and who is receiving electronic patient information. A CAQH and eHealth Initiative survey among eHI member organizations sought to understand specific data required to fully support HIE directories. Respondents said “granular” provider data is required or strongly desired. Survey respondents ranked health plans, followed by state Medicaid agencies, as the most authoritative sources for administrative provider data for directories. Daily, weekly, or monthly updates were preferred. Direct provider involvement in updates was considered very or somewhat important by 93.2 percent of respondents.

APPROACHES TO IMPROVEMENT

Experts agree that nirvana is a single trusted source – or a handful of trusted sources – for the key data elements and relationships that comprise provider data. Some experts believe that a national database that everyone could access is a logical step, while others believe that states and/or local registries should form the nucleus of such efforts.

Nirvana may not be around the corner, but a variety of state-mandated and private sector ideas and efforts to improve the current situation already are underway. While differing in approaches, these efforts share common traits – they focus on relieving the cost and time burden on providers and organizations to collect and maintain data, improving data quality, establishing common sources of information, facilitating more frequent updating, and providing transparency.

Examples include:

- Medicare instituted the Provider-Supplier Enrollment, Chain and Ownership (PECOS) enrollment system in 2010.
- Twelve states and the District of Columbia have adopted the CAQH UPD as a standard application form for health plans. Also, the American Association of Family Physicians^{xiv}, MGMA, and numerous individual health plans have endorsed the UPD. Initiated as a voluntary collaboration among health plans in 2002, the UPD currently includes data on nearly one million providers.
- The Federation of State Medical Boards sponsors the Federation Credentials Verification Service, which provides a single source of verified data for more than 127,000 providers seeking licensure, saving duplicate efforts by state medical boards.^{xv}
- OneHealthPort in Washington State is a coalition of health plans, physicians, and hospitals “applying collaborative information technology” to simplify business and clinical transactions by enabling secure access to the participating organizations’ websites with the goal of avoiding “time-consuming phone calls or logging into several different websites.” The program is in response to Washington State Senate Bill 5346, which requires a uniform, statewide data collection process for electronic provider credentialing.
- Sponsored by local health plans, physician organizations, the state hospital association and state medical society, the Massachusetts Physician Credentialing Initiative has established a standardized process for physician credentialing. The effort “features a uniform application for physicians to submit to each health plan and hospital with which they seek affiliation.”^{xvi} This initiative leverages the CAQH UPD for data collection and OptumInsight for primary source verification of the data.
- Other states, such as the Utah Health Information Network’s UHINSpeedi™ have initiated streamlined electronic approaches to credentialing as well. UHINSpeedi is an Internet-based tool that gives providers a single site to manage their credentialing information with payers. Healthcare providers are looking for meaningful solutions that will allow them to reduce the burden of administrative services and focus on the delivery of quality patient care.^{xvii}



■ WHAT IT WILL TAKE

While nearly all stakeholders acknowledge the need to improve the collection, maintenance and distribution of provider data, streamlining and improving these processes will not be easy. Moving forward will require industry leadership, collaboration, trust, and an appreciation of all perspectives.

Since stakeholders see provider data through the lens of their own responsibilities and interaction with the healthcare system, several key questions must be asked: What are these different views and how much commonality is there among them? What are the differences – are they meaningful? Is there sufficient consensus on common needs to build a foundation for collaborative action?

Solutions may involve additional data standards, a central and/or regional data repositories, support for technology integration, compelling reasons for providers to update information, and a sustainable cost model. Data standards, rules, and procedures will also be essential.

There is a consensus on the issues. Developing consensus on the solutions is the next step.

END NOTES

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