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Achieving Provider Data Quality in Your Directory

Members utilize online provider directories to select participating providers, however data inaccuracies inherent in provider data has led to increased consumer frustration. As a result, state and federal regulators have recently updated their guidance and introduced penalties for non-compliant directories, thereby forcing health plans to rethink how they manage provider data.

Core xRM offers provider data verification as a BPO service to health plans and payers

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What is a Provider Directory?

A provider directory is a listing of healthcare professionals (providers) who have contracted with a health plan to provide care to its customers. Directories are generally available to members on a health plan's website, and they allow members to interactively search for providers that meet their criteria. In addition to just listing the providers, most directories will also give additional information to help their members select the proper provider and seek care from them.

Examples of provider data displayed in the directory includes:

What is Provider Data?

Defining provider data is difficult as standard definitions for data elements within the industry are lacking, and there are many stakeholders who define data elements differently based on their specific use of the data. A simple definition would be that **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 in which they participate, and other important attributes (currently more than 200 unique data elements.)

As the healthcare industry changes, the meaning of "provider" is also changing. Today, "provider" extends beyond physicians, hospitals, and allied health professionals to other practitioners and institutions who deliver or coordinate healthcare services, such as nurse practitioners, social workers, addiction counselors, community health centers, behavioral health agencies, and other community-based organizations. The extended complement of "providers" often addresses patients' underlying social determinants of health, such as housing, transportation, access to healthy food, and employment. Provider data has historically focused on traditional clinicians, but, given the industry's migration toward value-based care and its increasing reliance on other provider types, addressing today's provider data challenges must include a more expansive definition of "provider."

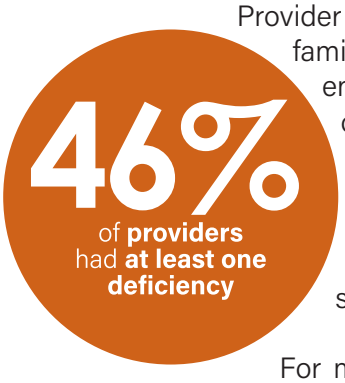
Provider data currently includes

— more than 200 —

unique data elements

Even when there are standards in place, there is a lack of overall adoption within the industry. For example, the National Uniform Claim Committee (NUCC) developed and maintains a taxonomy for provider specialties and sub-specialties. However, rather than relying solely on it, many organizations have modified the NUCC taxonomy or developed proprietary taxonomies that work well to facilitate internal operations but are not transferable to other provider data users without translation efforts.

Impact of Inaccurate Directory Data



Provider directories can help answer key questions before individuals and their families choose health plans in which to enroll or providers to see once enrolled. For example, provider directories can help answer the question of whether an individual's primary care physician or specialist, or a nearby hospital or pharmacy, is in the health plan's network. However, when the provider data in the directory is inaccurate, it can negatively impact many different constituents, including members, providers, health plans, regulatory agencies, etc. Below are some of the more significant impacts that inaccurate provider data can have.

For members, the impacts can range from inconvenience and frustration to significant, unexpected financial liability. Take, for example, members who find specialists listed in the directory as in-network and accepting new patients, only to learn that, when they call to schedule appointments, the doctors are either not in-network or are not accepting new patients. This results in the members spending additional time trying to find other providers to schedule appointments. While this is frustrating for members, the impact is relatively minor compared to that affecting a member who finds a specialist in the directory—indicated as in-network and taking new patients—makes an appointment, sees the provider, and later has the health plan deny the claim because the provider is, in fact, not in-network. In this case, the member could be responsible for paying the full, non-contracted provider fees, which could be significant, and, adding insult to injury, these payments would not count toward annual health plan deductible amounts.

For providers, the impact can be anything from additional administrative overhead, such as having to submit claims multiple times, to a loss of income and revenue, which drives up the overall cost of the services they provide. Since health plans are accountable for the accuracy of their provider directories, inaccurate data mostly impacts them in the form of unsatisfied members, potential regulatory fines, or downgrading of their quality scores (which impacts future sales).

Why Directory Accuracy is a Hot Topic

The passage of the 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 health 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.

In the past two years, over 25 states and the District of Columbia, as well as Medicare, Medicaid, the Federally Facilitated Marketplace, and the National Committee for Quality Assurance, have released requirements for the provider data displayed in health plan directories. In addition to guidance and requirements, regulators are responding with new regulations that carry financial penalties. In 2016, such regulations went into effect, enabling 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.

CMS is in the process of auditing all Medicare Advantage Organizations' (MAOs) provider directories, and, to date, it has completed two full cycles of audits.

In the most recent audit of 54 MAOs' directories, CMS issued 52 compliance actions:

31 were notices of non-compliance
18 were warning letters
3 were warning letters with a request for business plans.

These results represent a deficiency rate of over 96%!

What are the Quality Issues with Directory Provider Data?

The first question that must be asked is: "What does quality provider data look like?" Unfortunately, today there is no standard way to define or measure the quality of provider data. In fact, different consumers of provider data may define quality in completely different ways. **When thinking about provider data quality, users should consider:**

- The accuracy of the data elements
- The completeness of the data
- The consistency of the data (i.e., definitions and comparability)
- Timeliness
- Processability (machine readability)
- Accessibility

Generally, inaccurate data in a directory falls into one of four categories:

Practice information such as phone numbers for making appointments or the addresses of practices, is incorrect

Lists of providers actively practicing at a service location are out of date—either listing providers who no longer practice at that service location or missing providers who do work there.

Provider participation information such as whether a provider participates in a certain health plan network or whether the provider is accepting new patients, is incorrect.

The providers' demographic information such as specialties, genders, or names, are incorrect.

While the accuracies of this data are important to a positive member experience as a whole, not every piece of this data has the same potential impact on that experience. As part of the audit of MAOs' directories, CMS has weighted the importance of these inaccuracies, with the attributes pertaining to making an appointment with an available provider being the most important—i.e., the provider listed at the service location actually practices there; the provider is accepting new patients; and the phone number for making appointments is accurate. Other attributes, such as specialty or provider name inaccuracies, are weighted as less important, since they do not necessarily impact a member's ability to get care.

According to the CMS audit results, the biggest category of inaccuracies is providers being listed as practicing at a service location when they do not, in fact, regularly practice or see patients there. In smaller locations, this happens when a provider retires or sells a practice, and the change is never communicated to the health plan to be updated in the directory. In large practice groups, with many providers and multiple service locations, the practice will typically tell a health plan that all providers actively practice at all service locations, even when some of those providers never see patients at certain service locations.

Why do Provider Data Quality Issues Happen?

Unfortunately, there is no simple answer as to why provider data inaccuracies occur. In studying the various inaccuracies, as well as the business processes associated with displaying provider data in a directory, several areas that have a high potential for introducing errors into the data can be identified. Below we look at some of these areas to gain more insight into why they are likely to introduce errors into the data.

Provider data is ever changing. While some attributes change less than others, in aggregate, up to 20-30% of a provider's data changes annually. The more the data changes, the more frequently updates should be sent to provider directories. The more frequently the data is sent, the more likely it is to introduce errors (see below).

Health plans receive provider data from a number of different types of entities—directly from the providers; through a delegated provider organization, such as Pharmacy Benefit Manager, which offers its list of participating pharmacies; or through affiliated provider groups, such as an integrated care network that contracts to provide both professionals and facilities. In cases where data is received from a delegated or affiliated entity, the data will likely be processed multiple times, increasing the likelihood of an error being introduced along the way.

Currently, there is no unified process for updating directory information. With each health plan, medical group, or independent physician association (IPA) requesting updates on its own, and each medical practice, hospital, and pharmacy working separately with Medicare Advantage Plans, Medicaid Plans, and private health plans, this process is time consuming, costly, and error prone for health plans and providers alike.

Provider Engagement

While providers indicate that they are familiar with provider directories and are aware that directories help consumers find clinicians who are in-network and accepting new patients, they and their staff:

- Are not necessarily aware of state and federal regulations requiring health plans to have accurate, up-to-date, provider directory information.
- Express a general lack of awareness regarding the need to proactively alert plans of changes to their information.
- Do not understand the purpose of, or need for, responding to plan requests to validate or update their information.
- Feel overwhelmed with responsibility and, therefore, prioritize activities that are required of them by regulation or that secure payment for the provider.

State regulations are often stricter than 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.

Strategies for Improving Provider Directory Accuracy

Today, there are a number of technology groups, industry groups, and standards organizations working on solutions, such as: 1) block chain, 2) national provider directories, and 3) standards for defining and exchanging provider data, as well as ways to measure provider data accuracy. When looking at similar, historical healthcare initiatives, such as EMR adoption or ICD10 implementation, we know that such initiatives take years before they achieve any significant traction in the industry. Take ICD 10 for example. It was originally published in 1996, but it was not until 2015, when its use was mandated, that it gained any significant traction.

With the current focus and regulatory landscape around provider data, what can a health plan do now to begin improving quality? It can:

- Educate providers on the value of accurate provider data, as well as the regulatory requirements for keeping the data current in a timely manner
- Build an ongoing provider data validation and auditing process to perform quarterly validations with each provider office—verifying and auditing the results.
- Consolidate multiple legacy provider databases into a single 'source of truth' for all provider data and build a multi-disciplined data governance program to oversee how provider data is managed.
- Leverage data intelligence that utilizes machine learning on both internal and external provider data sources to identify and prioritize potential data inaccuracies.

Core xRM's Provider Data Quality Business Process Outsourcing Solution

Core xRM is a software development and consulting company that specializes in healthcare solutions. Core xRM's provider data quality (PDQ) platform was specifically designed to help health plans manage the provider data verification and audit process. The platform offers the following capabilities:

- Coordinating and tracking the outreach to all provider offices.
- A multi-channel provider select method for performing data validation and providing updates, with no portals or provider logins required.
- Verification and auditing of provider-supplied data updates.
- Education for providers on the value and requirements of participating in the validation process.
- Intelligent machine learning analysis of millions of internal and external provider data elements to initiate and prioritize provider validations.
- Robust reporting and provider feedback.

The PDQ platform can be licensed and operated by a health plan, or it can be utilized as a business process outsourcing (BPO) model in which Core xRM and their specially-trained provider representatives will perform the process on behalf of the health plan.

References

1. Health Data Management - 7 Reasons why provider data is often inaccurate – June 5, 2018
2. AHIP – Provider Directory Initiative Key Findings – March 2017
3. Centers for Medicare & Medicaid Services – Online Provider Directory Review Report – January 13, 2017
4. Availity – The Provider Directory Dilemma, why fixing bad provider data is more difficult and more important than ever
5. Rosin, Tamara – Health insurers now face steep fines for outdated physician directories – 12/29/15
6. CMS – Online Provider Directory Review Report – August 2016
7. CAQH – Defining the Provider Data Dilemma – 2016
8. Dan P. Ly, MD. And Sherry A. Glied, PhD. – The Impact of Managed Care Contracting on Physicians – 9/2013