Tell Your Boss Takeaways from **"Provider Data Quality: How Rosters Drive Business Outcomes"**

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Thesis: Provider data is critical to a myriad of healthcare processes, yet it's often inaccurate, incomplete, and inconsistent. Improving provider data accuracy must be 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. In this session, we'll explore the root causes of low-quality provider data, in particular roster data, and discuss practical solutions for improving data quality and the positive downstream impacts it can have on the healthcare ecosystem.

Learning Objective#1: Explore the drivers that are creating low-quality provider data, from non-standard information collection to inconsistencies in data exchange.

Key points:

1. The role of delegated rosters has evolved tremendously over the last decade. **2.** Data quality is a systemic issue touching all stakeholders within the healthcare ecosystem. **3.** Provider organizations have to coordinate across various functions within their organization, while reconciling multiple in-house data sources all while communicating with practitioners and managing staffing and technical resources.	**4.** Health plans have to solve for data quality when managing for variance in structure of rosters and format of data received, all while applying data for various use cases. **5.** This evolving complexity results in frequent back and forth communication between provider and health plan teams amounting to significant administrative burden and cost.

Learning Objective#2: Gain insight on the key levers available for driving meaningful change to improve provider data accuracy with delegated rosters

Key points:

1. Collaborating with your health plans to align around a single roster format that can solve for variance in data requests across all contracts can drive efficiency and reduce the need for customization. **2.** Understanding the business validation logic enforced by your contracted health plans can help you design upstream processes to resolve data quality issues at the source and avoid the churn of	back and forth with your health plans. **3.** Ensuring that your provider data management systems are as integrated as possible will help keep your in-house data consistent and avoid the need for internal reconciliation. **4.** Advocating for preferred exchange processes across all health plans can reduce manual effort and customization, ultimately reducing the volume of data quality failure points.

Learning Objective#3: Learn the steps required to improve processes and reduce administrative burden associated with provider data management.

Key points:

1. Ensuring that your organization has a streamlined operational process to bring together various in-house sources (contracting, credentialing, enrollment) is crucial to drive the quality of your rosters. Getting this right will best equip you to respond to inquiries from your contracted health plans. **2.** Taking time to document the various use cases that your roster supports for the health plan's operations will ensure that you are working from the correct context when creating rosters. Understanding that this may not be the same across all contracted health plans is crucial.	**3.** Aligning your provider data management platforms and process to industry standards like NUCC taxonomy and/or AHA hospital names/IDs will improve the interoperability of your data, resulting in more potential for automation on the health plan side and quicker turnaround times for enrollment and directory updates. **4.** If you are reconciling multiple in-house data sources to construct your rosters, ensure that the timing for how these sources are updated and collated is setup for success, driving towards the most accurate representation of your organization and providers today.|

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