**WHITE PAPER**

# Optimizing Provider Data to Boost Efficiency, Patient Experience and Compliance

Provider information supports payers' requirements for claims, network adequacy and directory accuracy.

## Overview

Those feeling frustrated and looking for better solutions for achieving provider data quality and efficient ongoing healthcare data management are far from alone—and their frustration is not unfounded, according to a Centers for Medicare and Medicaid Services report released in 2018, which showed that despite a focus on directory accuracy, more than 45% of all provider directory locations had at least one inaccuracy.[1]

*Despite a focus on directory accuracy, more than 45% of all provider directory locations had at least one inaccuracy.[1]*

The report summarized audit results of 52 Medicare Advantage organizations, with a total of 5,602 providers across 10,504 locations. Common deficiencies included:[1]

| | |
|---|---|
| Providers listed at the wrong location | 39.6% |
| Providers who should not be listed at any location | 26.4% |
| Wrong phone numbers | 13.1% |
| Wrong addresses | 6.9% |
| Wrong suites | 4.5% |
| Providers listed as accepting new patients when they actually are not | 4.5% |
| Providers listed as not accepting new patients when they actually are | 4.2% |

These results underscore the daunting challenges health plans face when trying to reconcile, manage and maintain quality provider data. To efficiently and effectively leverage data, health plans need to address and improve data quality. They also need to manage information flow across their enterprise and deploy a systematic approach to maintaining that cascade of data.

## Pain points and best practices

Poorly managed, inaccurate data directly impacts patient satisfaction. Individuals may have to make a nerve-racking number of calls to obtain an appointment, show up at the wrong location, visit a doctor they mistakenly think is in their health insurance network, or even worse, enroll in a plan because they believe their existing providers participate in the network only to discover they are not in the network.

For these reasons, health plans that do not adequately maintain accurate provider data can lose Medicare Advantage contracts or contracts with employer groups.

Health plans are one of the only entities with a complete, longitudinal view of a given patient's or provider's interactions across the continuum of care. This perspective gives them a competitive advantage, but it also shows how important it is for health plans to serve as stewards of data. Faulty data has ripple effects that expand outward until it compromises patient care, which can lead to a lost plan member.

Duplicate or inaccurate data can lead to increased costs, delays and frustration on the part of the payer, the provider and the patient. **Nearly 30% of provider data changes every year, through provider changes in practice patterns, employment and affiliations, so ensuring directory data quality and accuracy requires constant attention.**[2] The pace of business leads to additional inaccuracies:

- Human errors in data entry
- Data integration challenges across data sources
- Errors and omissions in multi-method delivery of incoming transactions and updates

When the wrong information is shared externally, such as on a directory, it can critically impact a member's ability to access care.

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Rich Morino, senior director of health care strategy, LexisNexis Risk Solutions

To properly store, update and disseminate data, health plans and provider organizations need an approach that manages master data and serves as an internal, foundational data store. This should include data points such as provider credentials, demographics, locations and contact information. Different applications within this environment should be able to consistently access data.

Health plans currently get snippets of provider data from claims, provider group rosters, and the contracting and credentialing processes. Often, the data captured from each of these does not align and has some degree of inaccuracy. "You have to consider each data source, determine what is valuable in the data provided, then incorporate that into what you already know," said Rich Morino, senior director of health care strategy at LexisNexis Risk Solutions.

To address these data weaknesses, health plans should corroborate information across different data sources. This presents the critical need to adopt a multi-faceted approach that utilizes claims analytics, machine learning and additional industry touchpoints to provide context and validation for those data sources. "It's important to understand if the information coming from different sources is backing up other information in your systems, or if it is in conflict," said John Markloff, senior director of health care strategy at LexisNexis Risk Solutions. "A source might indicate that a provider is actively practicing and part of a relevant payer or insurance company universe, but if they haven't submitted any claims in over 18 months, are they really?"

*"Organizations who optimize data management and view data as an asset will be more insightful. Putting a focus on a dependable data feed will make them better, faster and stronger."*

John Markloff, senior director of health care strategy, LexisNexis Risk Solutions

Inefficient, fragmented and uncoordinated processes used to manage this information contribute to waste. Data science is becoming central to healthcare organizations' efficiency and ability to provide quality care. "Organizations who optimize data management and view data as an asset will be more insightful," said Markloff. "Putting a focus on a dependable data feed will make them better, faster and stronger."

Bottom line, healthcare organizations need a single source of truth that all processes can depend upon. Both providers and health plans must adopt a clear plan for data accountability and ownership.

## Provider data is the foundation of our healthcare system. Payers rely upon provider information at different times to support many critical processes:

**Designing the network and targeting providers**
- Identifying providers for plan participation
- Recruiting providers based on network needs

**Verifying and enrolling the providers**
- Contracting and credentialing
- Validating providers' information
- Onboarding them with portal access

**Managing the provider data network and risks**
- Building and managing the provider directory
- Managing network adequacy and provider relations
- Screening for bad actors

**Receiving and processing claims**
- Adjudicating and validating
- Setting up a fraud screen
- Allocating funds for recovery
- Remitting claims
- Providing adequate customer service

**Reporting, analytics and compliance**

### The workflow journey

Health plans lay the groundwork for the workflow journey by designing the network and then recruiting and enrolling providers and provider groups. As the workflow journey proceeds, they need to have processes in place to continually check for accuracy, timeliness and completeness of the myriad of data points related to each provider.

At the outset, health plans need to ensure that the information on the provider roster sent by a given group practice is appropriately incorporated to support claims processes. However, not all the locations included in a roster may be applicable to a directory, because along with a provider's regular practice locations, the rosters often include locations where a provider only sees patients occasionally.

Health plans should collaborate with doctors and provider groups to make sure the appropriate information is available to deliver the best care possible. Rather than operate inefficiently in silos, an exchange of data across health plans and providers can enable the highest quality.

In addition, health plans who apply upfront quality checks to validate data immediately can avoid potential problems caused by proliferating inaccurate data throughout the workflow.

Checking data on the front end helps ensure that the payer's single source of truth is correct and complete at the outset. There are a lot of reasons for poor data quality. People may not look closely at the information supplied to them; they may not actually confirm it's right or wrong. It's it just "Trust us, we clicked the OK."

## *Basic provider information changes at a rate of 2.4% per month.[3]*

Beyond the issues with the initial input, basic provider information changes at a rate of 2.4% per month because providers relocate, change affiliations, stop practicing and make other changes. To keep up with managing the changing data, LexisNexis Risk Solutions recommends at least monthly or even weekly data checks to ensure that the changes don't become so overwhelming that they impede good decisions throughout the workflow.

Adopting an internal culture in which data is shared, rather than reflexively siloed, could also enable healthcare organizations to disseminate data in a faster, more robust and more granular way.

Once the right processes are in place, it becomes easier to digest updates downstream, which is important to ensure timely updates, especially in California, for example, which enacted legislation giving health plans only seven days to apply updates supplied by providers.

## The healthcare industry-wide source of truth

To ensure accurate data, the payer industry needs to expand from company-specific single sources of truth to an industry-wide data ecosystem. LexisNexis Risk Solutions believes its solutions are the right platform to accomplish this ambitious undertaking.

Most provider groups share their information with more than 10 health plans. Large payer groups can receive updates from a network of up to thousands of provider groups. "It's madness to be doing all that point-to-point communication," Markloff said. "If you streamline that data flow, and have common intake and distribution mechanisms, you can eliminate those redundant activities."

It's time for the healthcare industry to have a single hub that leverages all of the cross-industry touchpoints with providers across the continuum of care to help identify anomalies in the data and drive greater accuracy. The Centers for Medicare and Medicaid Services (CMS) agrees. In its most recent round of Medicare Advantage Organization (MAO) directory reviews, the CMS said (emphasis added): "Through the insight gained from our reviews, it has become clear that a **centralized repository for provider data is a key component missing from the accurate provider directory equation.** CMS is currently looking at the provider data the agency collects to determine how it may be used to foster a collaborative industry approach to achieving a centralized location for provider data."[4]

Moving to a single hub would lower costs by eliminating duplication and overlaps, ensure distribution of updates, and reduce lag time. Providers would have a sense of accountability with and confidence in a single source rather than fragmented processes.

The cross-industry vision of LexisNexis Risk Solutions ties together pharmacies, life sciences, providers and health plans. "We have a pretty solid foundation already," Morino said. "Part of it is creating that trust, so that people buy into a single-hub concept—because if participants don't buy in to it, you don't have an effective single source of truth for the industry."

LexisNexis Risk Solutions has created a complete, comprehensive, accurate view of provider data over the past twelve years, boosting its "horsepower" over time and developing best practices around the resolution of relationships and differences in data. The scope of LexisNexis Risk Solutions spans the entire U.S. and territories, all top 10 pharmacy retailers, eight of the top 10 life science companies, 90% of U.S. commercial health plans and more than 3,000 provider organizations.

To continually keep data up-to-date, LexisNexis Risk Solutions is using machine-learning processes by scanning thousands of existing data sources for updates and adding new sources. The more sources we add, including contributions by clients, the more comprehensive and accurate the resulting data gets.

# IDC's Eye on LexisNexis Risk Solutions

Industry analyst IDC views LexisNexis Risk Solutions as a major player for provider data management for health plans, with the expertise to provide an "end-to-end solution for a system of truth," according to a vendor assessment released in 2018.[5]

Multiple stakeholders—across payers, providers, pharmacies and life science organizations—have a need for high-quality information and already maintain information about providers. They require a sustainable model to keep up with changes and make better use of their existing data. A provider data exchange hub makes this possible.

The data exchange hub facilitates the exchange of provider information, monitoring for changes in near real-time and providing those updates to the stakeholders that need them. This reduces the exchange of redundant data, as well as the dependency on the myriad data collection and distribution methods.

It also leverages other industry activity to help payers identify anomalies. For example, a provider may appear in a directory listing; however, the hub can show they are no longer submitting claims from the group, have moved to another state, or even that they have an inactive medical license.

**These issues can then be corrected, and the directory improved.**

As value-based care and consumerism continue to bring changes to the healthcare sector, tools like a data exchange hub can help payers tap the full potential of available data. With full access to data, they are well equipped to provide the right care and the best experience for their members.

## A centralized repository road map starts with business processes such as:

1. Agreeing on common definitions
   - For example, identify what a provider location is:
     › Is it the billing address?
     › Is it a regular practice location?
     › Is it an irregular practice location?

2. Applying the right technology

3. Measuring and monitoring quality results

4. Adjusting the plan based on the actual observed results and applying continuous improvement

## The future of provider data management

- **Higher provider data quality**
- **More valuable insights leveraging cross-industry analytics**
- **Real-time decisions via workflow integration, monitoring and alerts**
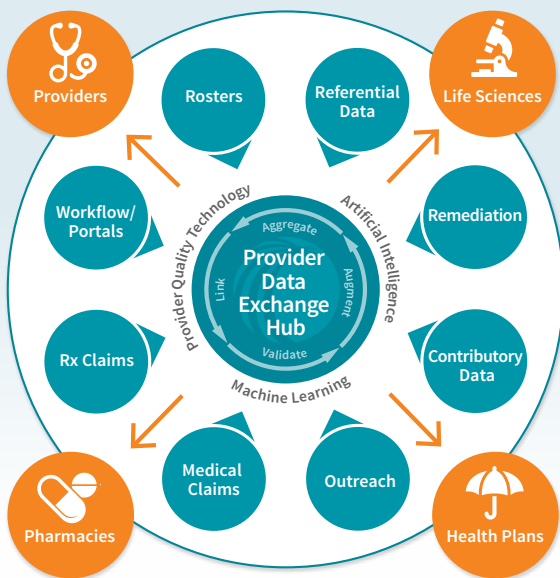


LexisNexis Risk Solutions maintains current information on more than 8.5 million healthcare practitioners and handles 1.64 billion claims annually, according to IDC's report. LexisNexis has a suite of five complementary products often bought together:[6]

- **Provider Data MasterFile™**
  a subscription service for provider data

- **Provider Data Enhancements**
  a data-cleansing service

- **Provider Data Validation**
  a web-based provider-information search service

- **VerifyHCP®**
  which combines data enhancements with claims analytics and multichannel outreach to validate directory information

- **Provider Integrity Scan**
  which screens providers' professional and personal attributes

**LexisNexis MarketView™** was historically not available to health plans but has recently been introduced and provides insights into referral patterns, physician-alignment strategies, network quality, patient volumes and reimbursement patterns. LexisNexis Risk Solutions also offers data enrichment capabilities; which, respectively, provide reliable, verified physician business email addresses.

*"LexisNexis Risk Solutions' commitment to cleansed, quality provider data is outstanding and evident. Its presence in dozens of health plans, including the vast majority of the top 10, shows its scalability and range."*

International Data Corporation (IDC)

IDC recommends that buyers consider LexisNexis Risk Solutions "when very, very serious about provider data quality" and notes that, "as nontraditional (non-NPI) providers enter the payer spectrum through the expansion of provider types (home health, holistic, deeper specialties, social determinants, etc.), horizontal big data services like LexisNexis Risk Solutions become more relevant and attractive."[7]

## Sources:

[1] Online Provider Directory Review Report, Centers for Medicare and Medicaid Services, https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf

[2] LexisNexis Risk Solutions research

[3] Ibid.

[4] Online Provider Directory Review Report, Centers for Medicare and Medicaid Services, https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf

[5] IDC MarketScape: U.S. Provider Data Management 2018 Vendor Assessment, December 2018, https://www.idc.com/getdoc.jsp?containerId=US44514018

[6] Ibid.

[7] IDC MarketScape Names LexisNexis Risk Solutions as Major Player in Provider Data Management 2018 Vendor Assessment, February 26, 2019, https://risk.lexisnexis.com/about-us/press-room/press-release/20190226-idc-marketscape

**For more information, call 866.396.7703 or visit risk.lexisnexis.com/healthcare**

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**About LexisNexis® Risk Solutions**

LexisNexis Risk Solutions harnesses the power of data and advanced analytics to provide insights that help businesses and governmental entities reduce risk and improve decisions to benefit people around the globe. We provide data and technology solutions for a wide range of industries including insurance, financial services, healthcare and government. Headquartered in metro Atlanta, Georgia, we have offices throughout the world and are part of RELX (LSE: REL/NYSE: RELX), a global provider of information-based analytics and decision tools for professional and business customers. For more information, please visit www.risk.lexisnexis.com and www.relx.com.

Our healthcare solutions combine proprietary analytics, data science and technology with the industry's leading sources of provider, member, claims and public records information to deliver insights that improve cost savings, health outcomes, data quality and compliance.