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White Paper

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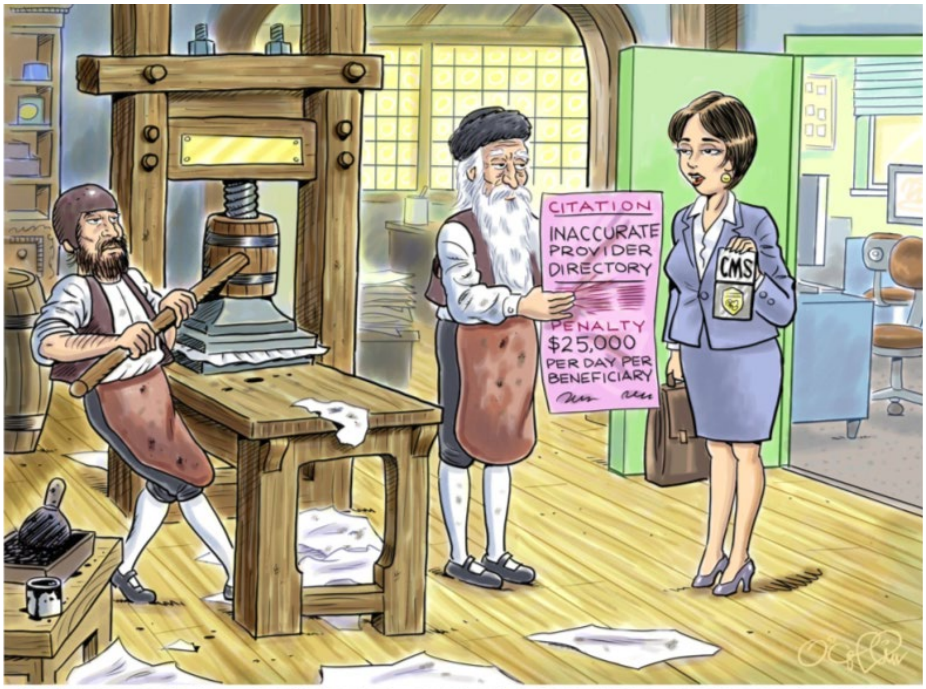
Five Steps Payers Can Take to Make Provider Directories Accurate

Health plans that have been using quick fixes to update provider directories are facing an unwelcome wake-up call: fines that can range up to $25,000 per day per beneficiary. Moreover, payers found in violation of the Centers for Medicare & Medicaid Services (CMS) rules can be banned from new enrollment or marketing.

These penalties are specific to Medicare Advantage programs and policies sold through Healthcare.gov, but they are emblematic of a larger trend. Regulators are responding to consumer frustration by calling attention to those health plans who struggle to manage their provider network databases.

The latest rules from CMS shouldn't come as a surprise. They were announced in draft form last February, and are now in effect as of January 1st. CMS also specified that payers offering federal exchange plans could face penalties per day per affected beneficiary.

It doesn't stop there. State governments, such as New York and California, are penalizing health plans who fail to provide accurate provider information to consumers. Consumers can't make well-informed choices about their plans and providers if the information they get from payers is in error or out of date.



" I'M SORRY MR. GUTENBERG, BUT THE PROVIDER DIRECTORY RULES DON'T OFFER AN EXCLUSION FOR LEGACY TECHNOLOGY. "

The chaos and increasing risk in the system has three causes:

- **Organizational complexity.** Typically, provider enrollment, provider contracting, credentialing, and claims processing are in different departments and systems, often without clear data ownership or consistent processes for updating and correcting directory entries. This problem is often exacerbated

by the lack of a "process owner," someone who is accountable for the governance, business rules and, ultimately, the quality of the provider data used throughout the enterprise.

- **Technological complexity.** Provider data nearly always exists in multiple databases and is often inconsistent between them. The resulting data flows and exception-handling processes foster integrations and manual workarounds that can be so brittle that the slightest change can break them, increasing the inconsistencies and manual work required.

- **Industry complexity.** Physicians who work out of multiple facilities sometimes need to be listed in different networks for each location. Provider data also changes frequently: providers move, renegotiate contracts, gain or lose certifications, retire, and pass away. The net result is a web of interconnected relationships that most systems can't handle without massive manual entries. This forces providers—who are already struggling to adapt to seismic industry changes—to struggle with their health plan systems' inability to support them.

These structural and historical factors explain why provider data can be so problematic. Today's regulators, however, are no longer willing to wait for the industry to clean things up. Provider directory errors have been causing claims problems and frustration for providers and consumers for years—decades, even—as well as headaches for payers themselves.

What was once an annoyance and embarrassment is now being treated with increasing scrutiny and suspicion. Regulators believe the current problems are unacceptable and without excuse. What might have been treated as an administrative problem before is now unacceptable in an era of increasing consumerism and physician incentives.

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In the view of regulators, when a payer tries to manage costs with a narrow network design, the least it can do is tell consumers which providers are in or not in their plan. What the insurer sees as a clerical error, the regulator or State Attorney General may see as a deceptive business practice.

In other words, it's time to fix this problem, and to get it right as an industry. That might mean revising our business processes or rethinking the way we use technology to support our processes.

Unfortunately, the response many payers take is not the most effective strategy. Faced with a crackdown, some payers have hired a small army of staffers or contracted with a service provider that has its own army of staffers. Across the industry, hundreds of people are hard at work, often doing the same job, calling physicians or exchanging faxes to verify data and update records. When a physician is slow to respond, they make more outbound calls and send more faxes.

Often on the other fax machine or waiting on hold, the provider office staff is trying to update their records in the health plan directory, only to find that their repeated efforts fail to have the desired result. All too often, a record is corrected in one database but not another. Or, because of faulty data processes, the newer corrected data record keeps getting overwritten with outdated information.

Whatever the cause, the errors persist, and providers generally hear about them from their patients when their claims are denied. A recent Wall Street Journal article cited one St. Louis dermatologist who has been trying to correct her record with a certain health plan for more than a decade.

The fact that CMS is now imposing penalties for inaccurate provider directories is proof positive that the dermatologist's story might be more common than we think. To help make that story uncommon, here are five steps payers can take to reduce provider abrasion, improve consumer engagement, and restore faith in the system:

Incorporating these five best practices into your business processes will help

ensure your source of provider information can become your provider source of truth.

1. **Create a "single source of truth" for provider records.** This may be axiomatic, but it is too often ignored. There should be *one* authoritative record for every provider, *one* place all other systems go to retrieve provider records, and *one* place to make corrections. In addition, there should be *one* process owner—someone who will define the data management processes, set the business rules, and be accountable to make timely and accurate data available to *all* departments and business functions.

2. **Be prepared to handle data complexity.** If you've decided to create a single source of truth, your data model must be sophisticated enough for the matrix of relationships between providers, facilities, networks, and contracts. That means understanding that the Dr. Smith who (A) practices out of the local university hospital is (B) the same person as the one with an office on Main Street and (C) may only be an in-network provider for services provided at the hospital, depending on the plan. These distinctions aren't trivial and must not be contained only in your source of truth, but also transmitted in a way that they can be accurately represented in your provider directory.

3. **Enforce a workflow for collecting and correcting data.** Once you have the capabilities to manage the complexity of provider data, it's essential to assess the business processes that impact the data. Make sure your software aligns with your business processes and that the software can validate and record data correctly the first time. Also, ensure you have processes in place to check and correct data on a regular basis. Finally, make sure that any personnel who detect data errors are trained and able to initiate the process to fix the error.

4. **Make extensive use of business rules.** The best business processes will use automated business rules with every data entry process to identify and prevent errors. Simple business rules such as validating the National Provider Identifier (NPI) or checking the number of digits can help minimize data entry errors. In addition, some business rules can trigger a task or update a missing or outdated data field. More sophisticated rules might include network participation logic or fee schedule look-ups.

5. **Structure data entry to help minimize errors.** Wherever possible, standardize your data collection routines to ensure quality throughout your organization. For example, provide drop-down lists for physician specialties, hospitals, network and product names, institutions (e.g., medical schools), and so on. Your data entry processes should also contain automated checks throughout the system to look for duplicate or similar data prior to creating a new record. These steps will help guard against data duplication errors, such as multiple listings for the same facility, or enforce specific standards, such as "Street" vs."St." Some data, such as addresses, can be validated against commercially available standardized databases.

With the complexity of today's provider data and the increasing requirements around data accuracy, provider data management has become an industry-wide challenge. Incorporating these five best practices into your business processes will help ensure your source of provider information can become your provider source of truth. With your member and provider relationships on the line, don't risk playing what could end up being a very expensive game of telephone tag.

About McKesson

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