Provider Data Challenges and Opportunities

National Conference of State Legislatures
Insurance Task Force
August 8, 2019
CAQH, a non-profit alliance, is the leader in creating shared initiatives to streamline the business of healthcare. Through collaboration and innovation, CAQH accelerates the transformation of business processes, delivering value to providers, patients and health plans.

Board Members:
CAQH Initiatives Transform Healthcare Business Processes

National operating rules for electronic business transactions.

Shared utilities to collect and manage provider and member data.

Research and collaborative endeavors as a catalyst for industry progress.
Accurate Provider Data is Essential for Administrative Healthcare Functions

- What is provider data?
  - Information about providers, groups of providers, institutions, how to access them, services they provide, health plan networks or products in which they participate.

- Why is it important?
  - Facilitate everyday business transactions: claims processing, credentialing, payments, referrals, directories, contracting and licensing.

- Who uses provider data?
  - Health plans and providers: credentialing, payment processing, fraud and abuse detection, product development, care coordination, information exchange.
  - Regulators: network adequacy oversight, compliance, licensing.
  - Consumers: health plan selection, access to care.

Any solution to administrative pain points in the healthcare industry is dependent on high-quality, accurate provider data.
Directory data accuracy has been a longstanding issue that challenges both providers and health plans.

**Provider Challenges**

1. Similar inquiries from different health plans.
2. Varied data submission requirements.
3. Lack of standardized questions.

**Health Plan Challenges**

1. Incorrect provider contact information.
2. Provider unresponsiveness.
3. Incomplete information provided.
Provider data pain points were mapped across the health plan value chain to determine the breadth of the problem

**Key Messages**

- Accurate provider data is critical to many functional areas across the health plan value chain.
- The acquisition and maintenance of this data is redundant, often manual and highly error-prone.
- Poor quality data can cause significant issues with downstream business processes, which in turn use reactive, resource-intensive approaches for resolution.
Recently published 2018 CMS Audit results indicate that directory accuracy across the industry has not improved over the past two years.

- CMS has completed three audit rounds since 2016, and no significant improvement in accuracy has been identified.

- In all three audit rounds provider location information represented the highest rates of deficiencies.

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Increasing CMS Interest to Identify a Solution

CMS continues to feel MAOs are in the best position to ensure the accuracy of their provider directories. 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.” ¹


“One common struggle expressed by industry is that there is no centralized repository for provider directory data, often referred to as a ‘source of truth’. As a consequence, the current process of verifying the accuracy of provider information can present an undue burden on providers, as multiple plans, in an effort to validate their directory information, ask providers the same validation questions. CMS will continue its focus on and work with stakeholders to improve provider directory accuracy.” ²

² Excerpt from CMS Medicare Advantage 2020 Call Letter Advance Notice – February 2019


- In this report, CMS pointed out that little progress has been made in health plan directories (the industry is still averaging ~50% accuracy), and that a “centralized repository” is “a key component missing.”

- These observations were echoed in the Medicare Advantage 2020 Call Letter Advance Notice, issued in February 2019.
Challenges with Provider Credentialing

Data collection is the most inefficient step of the credentialing process, placing unnecessary burden on providers. Currently, providers complete separate credentialing forms for each payer.

The Manual Credentialing Process

- **Obtaining a complete application**
  - Manual process (e.g., mail, fax, phone, and office visits)
  - Requires long lead time, and is the primary reason why process begins 4-6 months before actual decision is made

- **Primary Source Verification**
  - Performed in accordance with accreditors’ guidelines
  - Involves expensive licensing fees and sharing restrictions
  - Involves third-parties

- **File preparation, committee review, appeals, etc.**
  - Major component of file preparation is ensuring time-sensitive information meets freshness standards when presented to committee
Challenges with Provider Credentialing

- Each provider could potentially receive multiple monthly queries from different health plans for provider directory data.
- Staff resources stretched to address individual queries.
- Limited data quality improvement.
- Continued responsiveness to health plan requests unlikely.
U.S. healthcare administrative spending was $471 billion in 2012 (10% of total healthcare spending) split evenly between providers and payers.

While the healthcare industry continues to look at clinical costs, providers and payers are intensifying efforts at administrative cost reduction.

As organizations improve their internal efficiency, the industry is primed to tackle structural costs that are best addressed collaboratively rather than on an individual basis.


1 Payer costs include both public and private payers.
2 Hospital costs include services in other settings & supplies.
Keys to solving challenges in provider data gathering and validation

1. Standardize the requested content
2. Streamline the number of requests to update or submit information.
3. Simplify the data submission and reconciliation requirements.
CAQH Initiatives

**COMMITTEE ON OPERATING RULES FOR INFORMATION EXCHANGE**
Maximizes business efficiency and savings by developing and implementing national operating rules. More than 140 participating organizations.

**INDEX**
Benchmarks progress and helps optimize operations by tracking industry adoption of electronic administrative transactions.

**COB SMART**
Quickly and accurately directs coordination of benefits processes.

**PROVIEW**
Eases the burden of provider data collection, maintenance and distribution for more than 1.4 million providers 800 participating organizations.

**VERIFIDE**
Streamlines credentialing by consolidating and standardizing primary source verification.

**DIRECTASSURE**
Increases the accuracy of health plan provider directories.

**SANCTIONSTRACK**
Delivers comprehensive, multi-state information on healthcare provider licensure disciplinary actions.

**ENROLLHUB**
Reduces costly paper checks with enrollment for electronic payments and remittance advice for more than 500,000 providers.
A Multi-Stakeholder Collaborative Solution: CAQH ProView

- Initially designed to standardize, centralize and automate paper credentialing and enrollment forms.
- Spearheaded by CAQH member health plans at first, leading to broad industry-wide adoption by nearly 1,000 health plans, hospitals and other organizations participating.
- The CAQH ProView solution has since evolved to help address the directory challenge and serves as a one-stop shop solution for providers to submit both credentialing and demographic data updates.
- Plans implementing ProView to process demographic data updates have seen 25%+ improvements in their directory accuracy.
CAQH CORE Mission and Vision

**MISSION**
Drive the creation and adoption of healthcare operating rules that **support standards**, **accelerate interoperability** and align administrative and clinical activities among providers, payers and consumers.

**VISION**
An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.

**DESIGNATION**
Named by Secretary of HHS to be **national author for operating rules** mandated by Section 1104 of the Affordable Care Act.

**BOARD**
**Multi-stakeholder.** Members include health plans, providers (some of which are appointed by associations such as the AHA, AMA, MGMA), vendors, and government entities. Advisors to the Board include SDOs.

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Over 130 Participating Organizations—spanning multiple stakeholder types—work together to develop and implement the rules of the road and streamline the business of healthcare.

CAQH CORE participation enables healthcare organizations to:

- Lead development of rules that remove unnecessary cost and complexity from the healthcare system.
- Ensure that rules continue to meet evolving business needs and address specific markets.
- Stay up to date on industry developments, upcoming regulations & real-world case studies.
- Develop guidelines for measurement and tracking of ROI across the industry.

Complete list of CAQH CORE Participating Organizations available [here](#).
CAQH CORE Operating Rules

Why They Matter

- Developed to facilitate administrative interoperability and encourage clinical-administrative integration by building upon recognized standards.
- Complement and support healthcare and industry neutral standards – do not repeat or reiterate standards.
- Used by other industries with high volume transactions and multiples parties, e.g. financial services.

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<tr>
<th>INFRASTRUCTURE RULES</th>
<th>CONTENT RULES</th>
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<tr>
<td>Connectivity &amp; Security</td>
<td>Supports use of recognized standards that can deliver valuable structured data or require access to unstructured data.</td>
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<td>Response Time (Batch/Real-time)</td>
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<td>System Availability</td>
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<td>Exception Processing Error Resolution</td>
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<td>Roles &amp; Responsibilities</td>
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**Infrastructure rules** apply across transactions – establish guidelines for the exchange of data; can be used with any version of a standard.

**Data Content rules** support the exchange of data that allow stakeholders to access information needed to manage identified process.
Continued Industry Engagement to Address Prior Authorization

- The National Committee on Vital and Health Statistics (NCVHS), a federal advisory committee to HHS, recommended research and development of additional operating rules to address barriers to improving the prior authorization process.*

- Significant public and private sector interest in addressing challenges throughout the prior authorization continuum.
  
  - July 31, 2018 Senate Health, Education, Labor and Pensions (HELP) Committee hearing on "Reducing Health Care Costs: Decreasing Administrative Spending" was the third in a series of hearings the committee has held on reducing health care costs – prior authorization was a key topic in multiple testimonies.
  
  - Multiple industry statements and guiding principles from multi-stakeholder and provider coalitions.

    ➢ CAQH CORE Board responded with an open letter to the authors of the Consensus Statement on Improving the Prior Authorization Process.

    — Other complementary work efforts include AMA research, WEDI PA Subworkgroup, HL7, HATA, DaVinci Project, state-level work, etc.

*Letter to the Secretary - Findings from Administrative Simplification Hearing, Letter to the Secretary - Recommendations for the Proposed Phase IV Operating Rules, Review Committee Findings and Recommendations on Adopted Standards and Operating Rules.
Draft Phase V Prior Authorization Operating Rules

The Draft Phase V Prior Authorization Rules focus on standardizing key components of the prior authorization process, closing gaps in electronic data exchange to move the industry toward a more fully automated adjudication of a request. These efficiencies enable shorter time to final adjudication and more timely delivery of patient care.

- Consistent patient identification to reduce common errors and associated denials.
- Consistent review of diagnosis, procedure and revenue codes to allow for full health plan adjudication.
- Consistent use of codes to indicate errors/next steps for the provider, including need for additional documentation.
- Detection and display of code descriptions to reduce burden of interpretation.

- Application of standard X12 data field labels to web portals to reduce variation in data elements to ease submission burden and encourage solutions that minimize the need for providers to submit information to multiple portals.
- Confirmation of receipt and acknowledgment of PA submission to reduce manual follow-up for providers.
- System availability requirements for a health plan to receive a PA request, to enable predictability for providers.

In total, more than 100 organizations have substantively contributed to the CAQH CORE prior authorization rule development process through interviews, site visits, subgroup and work group participation, and surveying demonstrating the strong industry commitment to this topic.
Contact and Questions

Randi Chapman
CAQH
Director of State Relations
rchapman@caqh.org