White Paper

A Business Case for Fixing Provider Data Issues

Save money, reduce waste and improve member services.
Proactive provider data management

LexisNexis® | Health Care

The health care industry is plagued by low quality provider information, although most payers don't realize the prevalence of low quality information in their own databases. The following pages will discuss what deficient provider information quality is, why it matters, how it affects health care payer organizations, its financial impact and ways it can easily be improved.

Why does provider information quality matter?
Provider information fuels many functions of a payer's everyday business, including provider directories, claims processing, network management, compliance and fraud detection. These are functions that get noticed only when they are wrong and are rarely acknowledged when they are correct. When these functions don't work properly, the impact and pain of errors and missing attributes can be felt throughout the organization.

The collection, management and maintenance of provider information itself is a specialized area, and the consumers of the information are spread throughout an organization. Therefore, the impact of bad provider information is not felt immediately and often falls to the back of the priority queue behind traditional strategic initiatives and major IT projects. Often basic yet important questions are left unanswered, including:

- How bad is our data?
- Is it worth fixing?
- Can it even be fixed in a material way?
- Can we keep it clean for the long haul?

The reality is that without proactive management, extreme diligence and supporting technology, the quality of an organization's provider information degrades over time, resulting in operating inefficiencies such as low auto-adjudication rates, extra calls to member services, duplicate provider records, wasted mailing costs, extra staff for file remediation projects, and sub-optimal networks that cost health care payers hundreds of thousands, and even millions, of dollars each year.

Provider information, especially demographic data, changes continually. Our research shows that 2 - 2.5 percent of provider demographic data changes each month. Other data attributes, such as affiliations, status and sanctions, also change frequently.

As a result, the quality of an organization's provider information degrades over time, resulting in ongoing operating inefficiencies. What's good today is not good in two months, twelve months, etc.

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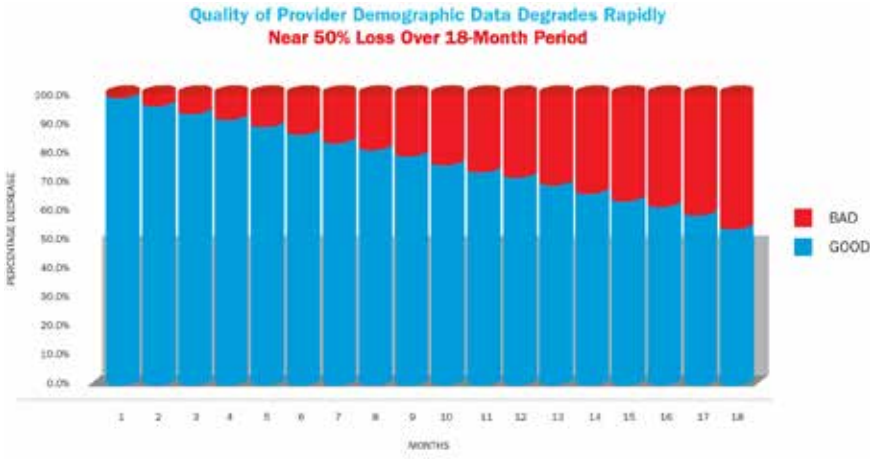

It is very difficult for an organization focused on its core business to keep up with all of those changes on its own. To do an even reasonable job, an organization must find and continually monitor all of the correct industry sources, accurately match records across those sources, and select the correct value for each data attribute across those records. Then, it must match the external information to the records in many internal systems and databases, and again select the correct value or values for each attribute. Adding to the pressure to choose the correct values, typically the correct and current information is expected to be available on demand for those who need it, and be distributed to many systems across the organization.

How bad are average provider files?

How successful is the typical organization at keeping up with ever-changing provider information? LexisNexis® has gathered some statistics by analyzing provider files from dozens of leading payers, PPOs, TPAs, property and casualty insurers, and others over the past few years.

In a Typical Provider File	Average
Records containing errors or missing information	35%
Records that are duplicates	28%
Providers with inaccurate or missing National Provider Identifier (NPI) Numbers	12%
Phone numbers that are wrong or missing	15%
Addresses that are wrong or missing	12%
Providers with sanctions	1.3%
Deceased providers	0.2%

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Provider information, especially demographic data, changes continually. Some highlights from our research include:

- The range of provider records with issues has been consistently between 30 and 40 percent.
- Non-purposeful duplicates are those that were not created to indicate a contract or product arrangement or new location. Most records are added over time because of name and address variations or because it's quicker to add a record than find the correct one. These records clog up the provider file, confuse staff, make directory reconciliation difficult and cause financial accuracy errors. In an extreme case, LexisNexis found 71 percent of the records were duplicates.
- Even today, 12 percent or more of provider records have inaccurate or missing NPI numbers. Sadly, this is a current statistic, and shows the difficulty in determining Type 2 NPI and identification of providers who have yet to obtain an NPI.
- Practice telephone numbers are the most important part of the directory and a big driver of member dissatisfaction with access to care. In a severe example, we found 36 percent of the phone numbers were wrong or missing.
- The wrong address listing on a directory is also a problem. What happens if a member uses an online mapping service and is directed to the incorrect address? In the worst case scenario, 23 percent of the addresses were wrong or missing.
- Not keeping up with sanctions causes compliance risk, member risk and financial risk.
- From a fraud perspective, validating that claims are submitted by legitimate, licensed, active, non-sanctioned and living providers is the payers' responsibility.
- A recent study of a Blue plan's Provider Data Quality Index (PDQI) found that if provider information had been managed proactively, 76 percent of errors could have been avoided and 20 percent appealed.

What are the real costs and savings opportunities of provider file problems and the functional issues?

A midsize payer with one million members will have about 250,000 providers on file and average 10 million claims a year. The average costs for dealing with bad provider data quality will range from $6-24 million per year, depending on how inaccurate the data quality is and how much manual work is required to fix the bad data. On average, the potential reduction of those costs ranges between 21-46 percent when the data in the provider file is accurate and up-to-date.

Additionally, we know that unlike a budget for a functional area or an advertising budget, the true cost and impact of poor provider information

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does not appear neatly summarized on a single line of a typical organization's budget. Instead, the costs are often spread across the organization, appearing in areas such as IT, provider relations, claims, customer service, compliance and accounting. Because the costs are embedded in operational budgets, it's not obvious how much bad data costs the organization and is often underestimated and thought of as "a normal cost of doing business."

When we think of an operating budget for claims processing, it is not broken down by 10 full-time equivalents (FTEs) allocated to bad provider data, 20 for enrollment issues and five for contract validations. It's a budget for 35 FTEs to handle the totality of the claims fallout processing. Therefore, the portion related to bad provider data doesn't get acknowledged or focused on for reduction or improvement.

The problem is when costs and impacts are dispersed, it's hard to get acknowledgement, budget and approval to do something about it. Many executives will ask: Why spend extra money in the provider operations area on provider data? Isn't that what they have a budget for already? Further, just as the costs are spread across the organization, so are any savings and benefits. As a result, addressing the underlying issue of bad provider data stands in the queue behind other problems that executives who manage those areas have more experience solving and can address in a typical planning and budget cycle.

- **On average, 20-30 percent of claims fall out of the auto-adjudication process, with an estimated 25 percent due to provider data quality problems.** At 1,000,000 total claims, that adds up to 250,000 just to work bad provider data fallout.
- **9-14 percent of all mail sent to providers is returned. Every 100,000 pieces of mail returned, costs $400,000 (estimated based on research, envelope and postage).** Add in void and reissues, adjustment costs and outreach calls, and the costs grow substantially.
- **Researching and updating provider information typically takes 20-40 minutes per provider.** The cost averages $8-15 per provider. Updating and maintaining 100,000 providers annually costs between $800,000 and $1.5 million.

Bad provider information specifically impacts an organization in three major categories:

1. Provider file costs
2. Downstream operational impacts
3. Soft costs

Possibly more close to home for health and wellness concerns is the concept of personal data gathering through user input.

Provider file costs include the costs related to establishing and maintaining a provider information file or files. For example:

- One-time and ongoing IT costs related to: Finding and updating data sources; loading source files; developing and maintaining matching algorithms; developing and/or licensing software for standardization, parsing, etc.; and storage, hardware, etc.
- The costs of ongoing integration of the data into your systems, including: Verification of duplicates and potential changes, and the associated downstream processes associated with those changes.
- The labor costs for additions of and corrections to provider records, including: Verification costs and the costs to support claims and customer service issues. In addition, there are ongoing costs associated with responding to changes in regulations and compliance.
- The labor costs to support claims fallout and customer service.
- Project costs when your data quality degrades badly.
- Ongoing costs of preparing your directory files.

In this example, a payer with three million members and a 450,000 record provider file will spend an estimated $4.5 million chasing, fixing, remediating, de-duping and feeding information across an organization. These are costs related to data degradation, reactive and inefficient processes, reliance on claims submissions and phone calls for information. Those costs are split between manual corrections, claims/service support, data cleanup projects, IT support for file cleanup and transfers, and directory preparation. In addition, there are costs related to maintaining credentialing and contracting databases.

Downstream operating costs caused by bad provider information include:

- Customer service costs of handling inquiries about provider directories.
- Manual rework of claims that did not auto-adjudicate.
- Calling research and documentation costs required to deal with disputed claims.
- Missed discounts when providers are paid at a higher rate.
- Normal and late payment interest associated with sub-optimal claims cycles.
- Returned mail costs.
- Missed opportunities for mail aggregation.
- Administrative costs for re-cut checks and reworked 1099s.
- The costs associated with all types of provider research.
- Underperforming fraud detection and other models due to duplicate records and an inability to match provider records in a data warehouse.

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- The costs of compliance with many types of regulation, from state laws that require NPIs on claims to national laws related to improper payments to sanctioned providers.
- Underperforming fraud detection.
- Inefficient and under performing networks due to unfilled gaps.
- The costs of re-printing directories.
- Hard and soft costs associated with lower National Committee for Quality Assurance (NCQA) and PDQI scores.
- Payment of performance guarantees.
- Late payment interest.
- The hard and soft costs related to member and provider satisfaction, including the potential for lost accounts and practices that quit the network.

Midsize and large payer organizations can expect to recover hundreds of thousands, and even millions, of dollars per year by improving provider information quality. LexisNexis has, in its work with very large organizations, identified eight-figure annual savings.

For example, the downstream costs for a payer with three million members and a 450,000 record provider file translated to an estimated $9.5 million to resolve fallout claims, answer calls, re-mail claim information, re-mail marketing materials, reissue checks, handle adjustments and mail extra items missed in the mailing aggregation process. In addition, late payment interest and performance guarantees are also impacted when timeliness and accuracy measures are missed. The biggest downstream impact is related to lost clients and ultimately EPS valuations.

Soft costs caused by bad provider information include: increased claims backlogs, member and provider dissatisfaction, group retention issues, poor NCQA results and regulatory compliance issues. The negative impact of poor provider data quality could include: weakened brand, unhappy providers, provider defections from your network, accreditation loss, and inefficient use of one of your most important resources — your staff.

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Questions to ask a potential vendor.

The costs and impacts are high and everyone wants a higher quality, more efficient and accurate process. But what can be done to stop organizations from a "business as usual" process that doesn't solve the real problem? You start by figuring out just how good or bad your provider information is and how it's impacting your organization. There are two ways:

1. Ask the internal organization responsible for your provider data to report on its quality. But, because that organization would fix errors in the data if it could, that question is unlikely to yield an accurate, unbiased answer. There is no accurate comparison to your peers. The symptoms of bad provider data can be perceived as exceptions to the norm, such as complaints about directory quality, rejected and disputed claims, returned mail, re-cut checks, missed discounts, network gaps, performance guarantees you have to pay, late payment interest, etc.

2. Third-party review and analysis of your data. Ask if the vendor offers a proof-of- value trial to allow you to evaluate the quality of their results. A proof-of-value also gives you a critical benchmark to measure and quantify the quality of your provider data, and give you a road map for improvements. It also gives you a holistic view of all providers and attributes. It frees you from having to do this yourself.

If you go the route of an independent assessment, there are some important things to consider:

- **Whether it's just different from the vendor's**. A vendor should have a comprehensive industry database to compare against, be able to clearly explain what they do to make sure their database is accurate, and be able to tell you their level of confidence in the quality of each data attribute in their file and yours.

- **The vendor's ability to match your records with the data attributes you need**. Vendors, especially vendors whose roots are in providing marketing lists, often quote impressive sounding numbers about their sources of information and their provider counts. Both of those things can be, but aren't necessarily, good. More sources or records might result in improved quality, or they might not. It depends on the sources and the vendor's ability to select the right data for each attribute from them, and whether the sources contain the data attributes you need.

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High counts might lead to more matches, or they might not. Again it depends on whether the counts include duplicates, inactive providers, deceased providers, etc., and even more importantly, the quality of the data attributes you need in each of the vendor's records. In the end, in order to audit your data quality, a vendor must be able to accurately match to the provider records in your file, and be able to render an accurate opinion as to whether each data attribute in each record has a correct and current value, or if it is incorrect and out-of-date.

- **The vendor's ability to express your data quality in a way that can be used to compare status over time, across systems and even as a benchmark versus other organizations.** Detailed data quality statistics are important basic measures required to manage day-to-day data operations. However, because managements' needs are better served by a single indicator that rises above the detail to effectively summarize status, a vendor should offer a relevant summary measure as well as the detail.

- **The vendor's ability to go beyond an audit of data quality to quantify the expected return you'll receive from using that vendor to improve your information quality.** Projected and realized improvements in information quality can and should be translated in terms of dollars for business executives. From business case to project review, insist that your vendor provides summaries of value using your data and your operating costs.

A before-and-after measurement of information quality and associated return on investment will help you determine if a provider data vendor is right for your organization. LexisNexis' approach is to perform a benchmark and ROI assessment, including:

- A Proof of Value that uses your data, metrics and costs
  - *It summarizes the current state of your provider information quality*
- A Proof of Value trial gives you an essential benchmark that lets you plot the potential improvement in information quality over time
  - *It quantifies the economic value of that improvement*
- A clear description of the proposed solution and the associated return on investment
  - *It should only take about six weeks with a minimum of your staff's time*
- Ongoing monitoring and reporting

Because the quality of an organization's provider information degrades over time, focusing on maintaining your provider data quality is critically important.

If you never thought that health care provider information mattered or thought that "business as usual" was good enough, now you can see how deep its impact is on your organization. Provider data is at the heart of provider directories, claims processing, network management, compliance, fraud detection and other key areas.

Because the quality of an organization's provider information degrades over time, focusing on maintaining your provider data quality is critically important. The good news is that it's possible.

By making a commitment to proactively maintaining the quality of your provider data, you can improve your auto-adjudication rates, improve member services, reduce mailing costs, focus your staff resources on other areas that really need their attention, make your network more competitive, and perhaps most important, save hundreds of thousands, and even millions, of dollars each year.

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For More Information:

Call 800.869.0751 or visit
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