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Containing Costs through Provider Data

How higher-quality provider data helps health plans save costs and realize business goals

Provider Data Improvement: From Burden to Opportunity

Provider data is an operational and financial problem for health plans, but it's also an opportunity. Health plans are devoting significant resources to improving the quality of provider data, in order to meet business goals and to fulfill federal mandates. By focusing on improving their provider directories, national and regional health plans are able to effectively scale their networks and compete against rising challenger plans.

Plans that successfully streamline provider data management and elevate the quality of their provider data will achieve three important goals. They'll save costs, fulfill federal mandates, and improve their members' experience finding care.

Rising Cost Pressures

Health plans are pursuing provider data improvement at a time when they are also experiencing unusually high cost pressures, resulting from overall trends in the industry and the impact of the pandemic.

During the pandemic, many individuals with chronic conditions missed out on diagnostic screenings, consistent preventative care, and management of their medical conditions. As a result, healthcare expenses are likely to rise as overall population health worsens. All of these causes are predicted to bring medical costs to levels higher than those of 2016-2020, according to industry analysts PwC.

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These trends will directly affect healthcare costs for employers, unions, and the public sector. Health plan customers will demand more cost-effective health insurance, creating more pressure for health plans to contain internal costs and offer competitive plan options. Health plans' pricing will also face public scrutiny, as CMS begins to enforce Transparency in Coverage Rules in July of 2022 (described below).

The Medical Loss Ratio provision of the Affordable Care Act (ACA) is another source of cost pressure for health plans. The ACA requires that health insurance companies spend 80-85% of their income from premiums on paying claims and improving health quality, with the percentage determined by the markets the health plan serves (individuals and small businesses vs. large group plans). This leaves companies with 15%-20% of remaining income for administration, marketing, and profit.

While experiencing pressures to contain costs, health plans are responding to a series of government mandates requiring rigorous management of provider data, a significant administrative expense. It's estimated that providers and health plans already spend $2.1B annually to maintain provider databases. The process of responding to mandates requires that health plans dedicate additional staff hours to provider directory management. If mandates go unmet, there are also further cost implications for health plans.

Government Mandates Focus on Provider Data

For the past seven years, government mandates have led health plans to dedicate additional time and resources to managing provider data.

A SERIES OF MANDATES

2015

California passes provider directory requirements. The majority of U.S. states follow.

Rules from Center for Medicare and Medicaid Services (CMS) require health plans participating in healthcare.gov to update provider directories every three months.

Inaccurate information can result in penalties of $100 per affected beneficiary.

2016

CMS mandates that health plans participating in Medicare Advantage (MA) must verify provider directory information every three months.

MA plans with inaccurate provider directory information face fines of up to $25,000 per day per beneficiary.

2021

CMS begins to require health plans to make provider directory data available via an API (application programming interface that meets the HL7® FHIR® (Fast Healthcare Interoperability Resources standard.

2022

JANUARY

The federal No Surprises Act requires that health plans and providers take a series of actions to prevent surprise bills for consumers, including maintaining the accuracy of provider directories.

JULY

CMS Transparency in Coverage Rules require that health plans provide consumers with an internet-based comparison tool that shows costs for procedures from specific providers, another requirement that will expose the quality of health plans' provider data.

Health plans are also required to disclose the in-network rates that they negotiate with providers, making this information publicly available through a machine-readable file.

CMS can require corrective action and impose penalties of up to $100 per day for each violation and each individual affected by the violation.

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Responding to the No Surprises Act with Provider Directories

The federal No Surprises Act, part of the Consolidated Appropriations Act (CAA) of 2021, is designed to protect consumers from surprise medical bills. If consumers receive out-of-network care due to inaccurate directory information, the Act protects them financially. Health plans and providers have to bill the consumer as if care was received in-network.

Given the rigorous requirements of the No Surprises Act, it's possible that provider data management costs will grow exponentially for health plans, up from the annual $2.1 billion that the industry has spent in recent years.

The Act specifies that health plans must:

+ Maintain business processes to keep provider directories updated.
+ Verify provider directory information every 90 days.
+ Make updates within two days of receiving information from providers.
+ Remove providers from the directory when network contracts terminate.
+ Remove providers from the directory if the health plan is unable to verify information.
+ Respond promptly to inquiries from members about whether providers are contracted with the health plan.
+ Responses may be sent electronically or in print.
+ Limit a consumer's cost-sharing to in-network amounts (if that individual received out-of-network care because of inaccurate information in a provider directory).
+ Apply the deductible or out-of-pocket maximum as if the care had occurred in-network.

As defined by CMS, provider directories must include:

Name, address, speciality, telephone numbers and digital contact information of individual healthcare providers.

Names, addresses, telephone numbers, and digital contact information of each medical group, clinic, or health care facility contracted to participate in any of the networks of the group health plan or health insurance coverage.

Why It's Hard to Improve Provider Data

The process of verifying provider data is a burden for both health plans and providers. It's estimated that the average practice must respond to provider directory requests from 20 different health plans. The complexity and work involved have directly affected the quality of provider data. A 2018 report from CMS documented that more than half of physician listings in Medicare Advantage (MA) provider directories contained at least one inaccuracy.

The No Surprises Act places significant responsibility on health plans for provider data improvement and management. That's no small feat. Provider data is ever-changing, piecemeal, and disjointed.

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Ever-changing

Affiliations between physician practices, hospitals, and integrated delivery networks change frequently, given that healthcare is one of the top three sectors for mergers and acquisitions. Turnover also keeps provider data in flux. A recent longitudinal study of primary care physicians documented that 30% of physicians weren't working within the same healthcare system within 2-3 years.

Piecemeal

With new federal mandates, health plans are attempting to correct provider data one provider at a time, in a piecemeal manner, and with health plans often shouldering back-end data management. Health plans are dependent on provider office staff responding to requests for help and updating information through provider portals or online forms. Even as companies absorb updated provider data, they face other longer-lasting issues.

The use cases for provider data are also disjointed. Consumers, regulators, and health plan network teams all need and expect a different view of provider data. As a result, health plan employees spend considerable time reconciling information, often through manual and redundant means.

Disjointed

Within many payer organizations, provider data infrastructure is disjointed. Health plan employees know that provider data isn't just limited to the provider directory. Provider data often exists in other siloed and legacy systems, credentialing systems, contract management, marketing tools, and more. In some cases, these systems were built to store data, but weren't designed to mesh with internet-based search. Digital contact information (such as email addresses) may exist only partially, or in a separate system from other contact information.

The rigorous new schedule for provider data updates will support a higher-quality public-facing directory, but there's an organizational challenge to ensure that the data is updated and current across every internal system. For many health plans, there's no single source of truth for provider data.

Questions for health plans to consider:

- How many hours are employees spending on provider data updates and management?
- What is provider data management costing your organization?
- Is your provider data structured to give you flexibility going forward, or locked in a legacy system?
- Are providers responsive to your requests, or are you constantly needing to follow through to obtain up-to-date information?
- Is in-house provider data management cost-effective for your organization?
- Where does provider data reside within your organization? Is your data unified or does it reside in several different systems?
- If you're using a vendor partner, how often do they send you updates?
- Does your vendor partner offer an API for simpler data exchange across your organization?

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A Way Forward

What if health plans could transform provider data from a liability into a strength? Three strategies point the way.

With an approach to provider data that improves, enhances, and innovates, health plans can build a new foundation for provider data, ensure that data is future-ready, make positive changes to member experience, and improve their competitive advantage.

Improve

By elevating the quality of their existing provider data, health plans reduce the time spent correcting and updating data, both by health plan employees and by providers. This enables health plans to free employees for higher-priority tasks, instead of constant provider data correction and management, and guarantees they will pass government audits.

A foundation of current, accurate data supports high-quality provider directories and other initiatives throughout the organization. Rather than being spread across multiple IT systems, provider data is consistent, whole, and trustworthy.

Employer Demand for Better Networks

Highly accurate provider data is becoming even more business-critical as health plans focus on developing high-performance, narrow network plans.

A Willis Towers Watson survey of organizations representing 7.1 million employees found that:

+ 18% of employers are offering a high-performance or narrow network plan in one or more locations.

+ A quarter of employers are using data on provider quality and costs to guide employees' healthcare decisions.

+ 67% of employers are partnering with their health insurance carrier to establish a high-value network.

Enhance

Enhancing provider data delivers an even better experience for plan members and healthplan team members. Consumer-friendly information on providers' specialties, costs, and quality helps members make more informed choices.

Provider data can address health equity issues, such as languages spoken and specialization in LGBTQIA care, making healthcare more accessible for members. More detailed provider data improves the experience of finding care and increases member satisfaction.

Innovate

Accurate provider data becomes the foundation for more innovation by health plans. Health plans can remain competitive and expand to new markets when equipped with the right provider data.

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Network design is simpler, because teams can always access real-time, highly accurate information about every provider. As a result, health plans are better equipped to design and manage high-quality, cost-effective provider networks, and to expand into new service areas. More efficient provider data management and more cost-effective care positively influence health plan costs.

How better provider data improves customer satisfaction

Reduces friction for members when they're searching for care

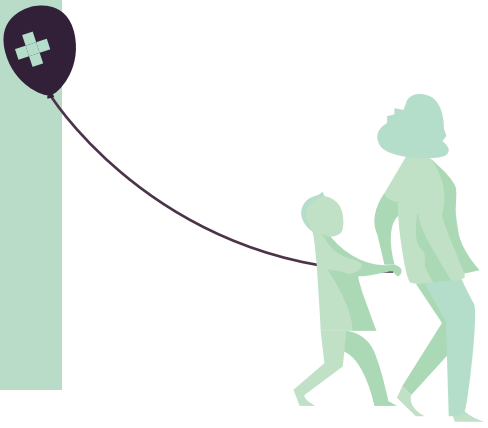
Helps members easily find in-network providers and understand cost responsibilities

Ensures members' care decisions are strengthened with a robust dataset that supports the right care at the right time.

Improves health equity (access to care and cultural competence)

Balances member and customer satisfaction and expectations with the continuing growth of high-quality/narrow network plans

Builds trust in the health plan and brand, including improvements in NPS scores



Why Health Plans Should Partner with Ribbon Health

With Ribbon, health plans can:

+ Create a positive member experience by guiding members to quality, cost-effective care
+ Reduce the costs of updating the provider directory and comply with regulation
+ Build a competitive edge by making informed decisions about network design

Quality Through Data Science

With Ribbon Health, health plan provider data will always be up-to-date through data science, rather than relying on manual provider updates. Ribbon Health's provider data information layer is aggregated from thousands of industry-leading data sources. Because Ribbon's product is an API (application programming interface) layer, data is continually updated from many sources in real-time, allowing health plans to receive immediate ingestion and remove all manual work associated with provider directories.

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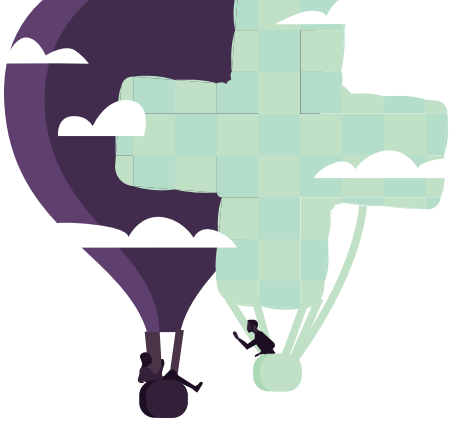

Data quality is maintained through:

+ Automated data cleansing and normalization.
+ Continuous monitoring for accuracy updates.
+ Machine learning for quality, standardization, and completeness.

This provider data infrastructure can be used not only to strengthen public-facing provider directories, but to ensure that provider data is consistent across a health plan's internal systems, such as credentialing and network design.

Built for Easy Search

Ribbon Health's architecture ensures that provider data is structured for fast, intuitive search, delivering a positive experience for health plan members seeking care. The find-a-doctor experience becomes simple and intuitive, based on clear language that explains the conditions providers treat, their patient panel, and the treatments and procedures they perform.

API Compliant

APIs make it possible for organizations to deeply integrate third party products into their own applications. Ribbon data supports provider directory API compliance and seamless integration via API. Health plans can easily integrate provider data across a wide range of technology platforms. With provider data available through API, health plans' digital and data teams are positioned to build new apps that feature provider data, and simplify both internal teams and members' ability to find care.

Partnership and Collaboration

Since Ribbon's founding in 2016, the company has powered care decisions for more than 10 million people across more than 40 customer organizations, using real-time, accurate, and comprehensive data on providers, facilities, insurance plans, cost, and quality of care. Dedicated support engineers help customers realize success across the life of the partnership between the health plan team and Ribbon Health.

Ribbon Health supports health plans in improving provider data quality, supporting their goals of cost containment, greater transparency, and positive member experiences and engagement. We invite you to learn more about how we can collaborate with you on your provider data strategy.

Start a conversation with Ribbon Health

Learn more about how Ribbon Health works with health plans