# Why identity is the missing piece of your successful data and analytics strategy

## Introduction

Payers manage a massive volume of data that is created and stored in wide variety of fragmented systems such as enrollment, quality, risk, and reimbursement. Bringing relevant data together is almost impossible across separate business functions, unconnected systems, and distinct users who are all interacting with the data every day.

**Interoperability** challenges **cost the healthcare system** over **$30B annually.**[1]

In fact, almost **60% of payers that have invested in interoperability have not realized positive ROI** due to low data utility.[2]

The **missing piece** that is often overlooked or solved piece meal through a mixture of point solutions, is **identity.**

Without a single source of truth for identity, your organization will continue with the current abysmal results. However, with the right identity data management investment in place, you can unlock a successful data and analytics strategy to help you improve retention and lower costs.

[1] HIMSS, Technology and cost care convergence.
[2] Gartner, Gartner's Payer Interoperability Benchmarking survey 2023

**30% of the world's data volume is generated by the healthcare industry.**[1]

**Healthcare data is growing 47% per year.**[2]

**1 petabyte of pricing data per month is generated by insurance companies.**[3]

[1] IDC, The Digitization of the world.
[2] Healthtech Magazine, Structured vs. unstructured data in healthcare.
[3] Turquoise Health, A petabyte of health insurance rates a month.

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# Understanding identity data management

With identity data management you need to be able to identify, manage, and push that data out to your business systems.

The first step is identify and link information between person and organization data with the highest confidence. This ensures the full and accurate information for a member is used across the organization such as for risk assessment or potential care management program enrollment. Or for example, ensuring the correct demographics, licensing, insurance, and specialty are accurately used for clinician reimbursement.

People and organization data can change and does change in some cases quite frequently. For example, **20-30% of physicians change affiliations each year.**[1] Therefore, your organization requires the ability to update records based on new information. The ability to change these records to maintain accuracy over time is foundational for identity data management.

Lastly, synchronizing all data to ensure every user within any business function regardless of system is able to use the best information about that person or organization to complete their workflow is essential. An identity data management solution ensures a centralized mechanism to continually propagate the most accurate and complete information to all systems.

A strong identity data management solution will support payers and their need to reliably exchange healthcare information between different clinical and administrative systems, within and between organizations, both retroactively and in real time.

[1] LexisNexis, A business case for fixing provider data issues .

## Impact of identity data management on retention

As the healthcare industry continues to tackle rising costs of care, new competitive pressures from Amazon, Walgreens, and Walmart are focused on personalized care and driving a consumer grade experience. Consumer engagement is a priority for Payers in achieving their member retention goals. Retention is an important quality metric for Medicare plans and revenue driver across risk adjusted members.

Despite the extensive investments, Payers have not achieved the financial gains as expected and haven't cracked the formula from the retail industry to develop consumer grade experiences for members. Effective digital engagement strategies all begin with identity – requiring a single source of truth to integrate into member touchpoints.

## Personalized member experiences

Member tenure depends on maintaining trust and loyalty by providing good experiences, particularly at crucial points. Providing the right experience to the right member at the right time depends on truly knowing your member.

Convenient and tailored interactions based on a member's healthcare needs, known communication preferences, and demographics increases their engagement while building trust.

Other industries like retail, works with large swaths of consumer grade detail to enhance segmentation, optimize for outreach, and better anticipate consumer needs and interests, such as:

- Personalized and relevant health tools along their care journey
- Easier online tools
- Flexible, inclusive networks with virtual care (leveraging digital and wellness offerings rather than narrowing the network to payer owned providers)
- Improved care coordination (prior authorizations, etc)

One of the biggest challenges associated with total experience is having an accurate and complete single source of truth for a member and provider.

**49% of members say that experience factors made them leave a payer, including inaccurate or inconsistent information, unanswered questions, poor experiences using digital tools, poor customer service and discomfort with how payers used their personal data.[1]**

[1] Accenture, The difference between loyalty and leaving.

## Ensuring seamless continuity of care

Improving engagement and providing a better member experience not only improves retention, but also improves care effectiveness.

Many members, particularly those with chronic diseases, require the integrated functioning of a distributed care team. Patient needs change over time, while clinicians on the team may move elsewhere, or change focus. A strong identity data management solution enables improved care coordination over time with accurate and complete member and provider data.

Payers are making investments in patient-centered care coordination across the healthcare system. These programs typically integrate preventive care approaches to reduce medical services and costs while improving member outcomes. Care management involves any payer-driven efforts to engage with targeted members and their care ecosystems to encourage and enable high-value decisions.

**Payers enable their members to access quality care they need.**

**Members want their health plan to make it easy to:**

- Get needed healthcare services
- Find the information needed for a new physician
- Select the preferred treatment option

**Payers' effectiveness across these factors has a significant impact on people's perception of their health experiences, and as such, on their retention.[1]**

[1] Accenture, The difference between loyalty and leaving.

## Increasing member trust and loyalty

A crucial period is during new member onboarding and registration. What happens in the first 90 days of a health plan membership colors a member's total experience. If a new member has trouble seeing if their chosen healthcare provider is at a facility convenient to them, notes missing or incorrect medications on their record, or has to answer a lot of questions the plan should already know, they will lose trust.

Efficiency and relevance in online interactions improves member experience. Members, particularly younger members, value customized digital tools such as directories to find care. **34% of people regard coverage and cost as the top factor in selecting a new provider.**[1] Access to accurate provider data saves members a lot of time and effort. They can shop around for a clinician, use an online tool to estimate their out of pocket expenses without having to spend time on the phone.

**Members who trust their providers are 4X more likely to stay with their current payer than distrusters.**[1]

Gain trust with your members who:

Provide consistent information across channels

Help them understand their coverage

Minimize hassles to get care

> **"It's important to resist the muscle memory of siloed improvement efforts that lack the scope and scale needed for real change."**[1]

[1] Accenture, The difference between loyalty and leaving.

# Impact of identity data management on total cost of care

Medical cost management is the driver of a payer's cost structure and market competitiveness; therefore, payers are constantly focused on improving their visibility into cost drivers and investing in strategies to tackle the highest drivers of cost.

Payers can reduce costs by integrating high-quality data sets from a wide range of sources while ensuring all data is linked to the appropriate individual and synchronized to ensure completeness.

## Preventing duplicate records and billing errors

Duplicate member records can lead to significant risk resulting in inaccurate billing, denied claims, and even legal liability. Correcting the resulting errors increases administrative costs. Providers feel the impact of these errors as well since these errors serve as an additional stress point between them and payers, particularly when a payer denies reimbursement for what they see as an unnecessary repeated diagnostic test resulting from a duplicate record.

**For a plan with 4 million annual claims, costs to manually resolve claims errors could exceed $20M.**

HealthScape, Provider Data Management: A longstanding problem

**Using identity to reduce provider data quality issues can reduce the number of claims that fail to auto-adjudicate and must be manually handled by around 25%.**[1]

Accurate and complete provider contracting information is critical for adjudicating claims. Organizations will have more denied claims and lower rates of auto-adjudication, which gets expensive quickly.

[1] LexisNexis, A business case for fixing provider data issues.

**Estimates show that anywhere from 9-14 percent of mail sent to providers is returned – every 100,000 pieces of mail returned costs $400,000.**[1]

**Updating and maintaining 100,000 providers annually costs between $800,000 and $1.5 million.**[1]

## Quality matters

Quality is a critical factor in the payer's bottom line and additionally in how the payer evaluates plan and provider performance. Payers define quality in a specific way that not only dictates their contractual requirements for their provider networks but gives us insight into how the payer and provider collaboration needs to work for success.

Payers define quality in two ways. One, by the healthcare effectiveness data and information set (HEDIS) and two, the CMS' five-star rating program if they have a Medicare Advantage plan.

Prevention is key to healthcare cost reduction with primary preventive services estimated to save nearly **$7B compared with costs associated with secondary and more specialized services.**[2] HEDIS has been adopted by 90% of US health plans which is no surprise since these measures incorporate a strong preventive care perspective.[3] Providers contractually will take on financial risk for their compliance in completing the clinical documentation required for HEDIS to payers. The star rating impacts how much a payer will receive in bonus payment with CMS.[4]

**A decline in even 1 star on a single plan can be responsible for billions of dollars in market value losses to a payer.**

Accurate identity is critical to appropriately capture all care gap closures across multiple member populations to optimize reimbursements.

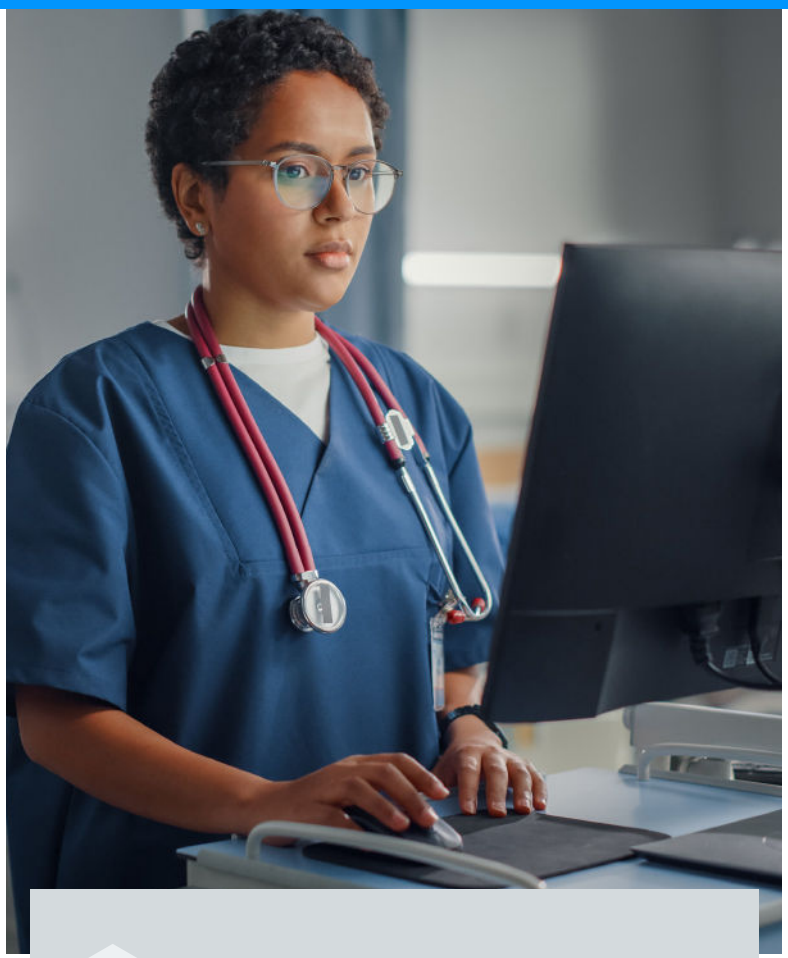
**For example, a 20% increase in lab results matched to membership profiles can represent millions in additional revenue for a payer.**

[1] LexisNexis, A business case for fixing provider data issues.

[2] NIH, Missed Prevention Opportunities.

[3] Health.gov, Healthcare effectiveness data and information set

[4] Reuters, CVS Health, Centene lead health insurers lower after 2023 Medicare ratings



## Reducing administrative costs

**The No Surprises Act requires provider directory accuracy and timeliness. Violations can incur financial penalties. But researching and updating provider data can cost a plan $8-$15 per provider annually.[1]**

**And poor provider information is another cause of member dissatisfaction, and churn.**

[1] LexisNexis, A business case for fixing provider data issues.

Payers waste a large amount of time and money simply because of poor provider identity. Between 2 and 14 percent of mail sent to providers is returned undeliverable, indicating provider data quality problems.[1]

Identity data management helps improve the quality and relevance of member communication, but it also saves significant costs simply through reducing mail waste. It reduces mail that is undeliverable because of obsolete, incomplete, or missing member names and addresses.

## Focusing on care management

Medical cost management aims to identify key cost drivers and focus on reducing them.

Identity data management helps in several different aspects of care management. Knowing each patient, their history, and their propensity for response allows for targeting members either when they would be most receptive to a care management message, or when a significant cost savings could be realized.

Predictive analytics can identify potential high-risk patients and arrange for early intervention before their condition becomes more serious.

Communications around care management can come via whatever channel, whether text, voice, video, or longer communications, has been found to be most appropriate to that patient. These messages can be personalized, mentioning specifics of their care. A call from a nurse can come at the time of day they are most likely to respond.

A communications strategy based on identity data management allows for customized interventions, in the right medium, at the right time to maximize response, with full confidence that they are based on the best possible and most complete data on that member.

With full knowledge of provider identities, payers can use advanced analytics to analyze referral patterns and identify places where there is revenue to identify:

- revenue leakage through noncontracted specialists.
- physicians who do not refer to the most effective specialists in network.
- physicians who overuse certain diagnostic tests or in-office procedures.

Value-based care requires being able to get visibility and insight into individual members in the payer's network. With care for the provider's key role in the patient relationship, payers can collaborate to customize care for each individual patient.

## Making risk adjustment more accurate

Risk is directly tied to the payer's bottom line and a cornerstone in managing overall medical costs. Payers measure risk to optimize for reimbursement by a risk adjustment process. Payers depend on the provider documentation to power their risk management workflows.

Payment models based on risk adjustment depend on predictive algorithms to determine risk coding and risk stratification. No matter what risk model is used, it will depend on the accuracy and timeliness of clinical data.

**Identity data management clarifies this data, and makes it easier to reconcile and verify risk-related documentation in case of a risk adjustment audit.**

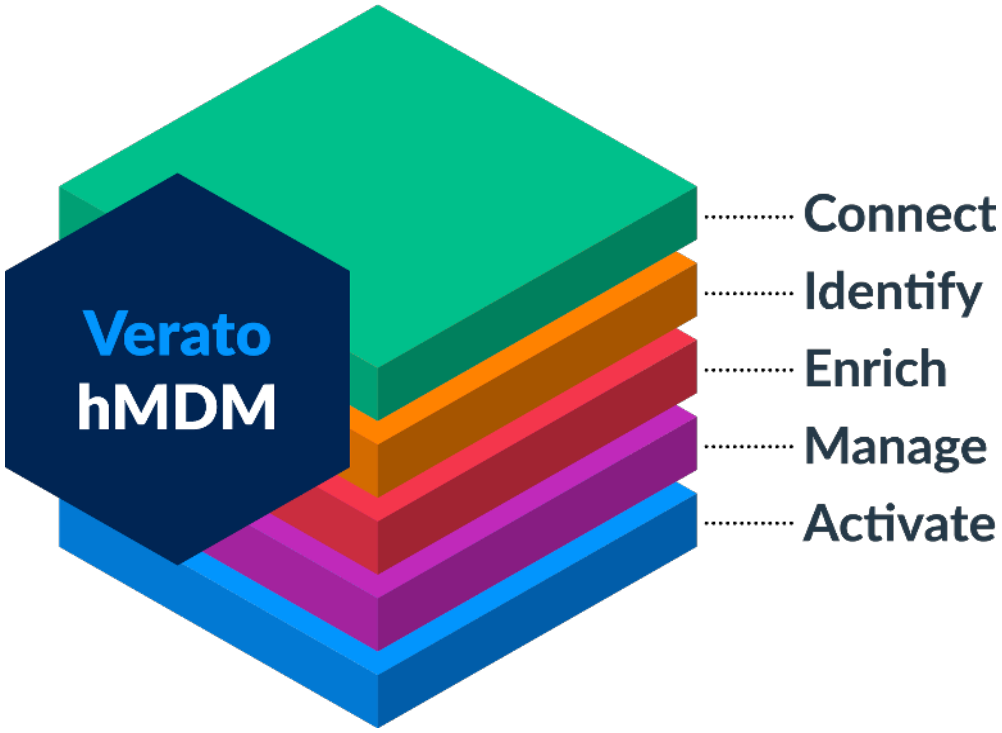
A payer's quality and risk teams both share challenges with provider generated documentation. Some of these issues will always be there, but **clear patient and provider identities** that **remove all duplication and ambiguity** make it **easier to request and process provider documentation.**

# What to look for in an identity data management solution

Faced with a proliferation of data and systems, some Payers may have invested in multiple technology solutions designed to organize and stitch together critical data about their members and providers. Unfortunately, in many healthcare these systems have been launched in a way that is siloed and disconnected.

The point of identity data management is establish a reliable identity and use that single point of truth for identity as the foundation for aggregating and integrating healthcare and other data to create a whole-person view of members and providers so everyone across the business has the most trusted and complete data.

## A strong identity data management solution should do these five things:




## 1. Connect

Seamlessly and securely integrate all sources of identity data, clinical and non clinical, internal and external

Identity data management solutions should offer multiple ways to connect to your ecosystem of data systems regardless of data type or method of interaction, and propagate data upstream and downstream.

Solutions that understand organizations require flexibility to scale to expand current capabilities while allowing organizations to reuse existing technology and lower resource costs.

## 2. Identify

Accurately resolve and verify identity for people and organizations. A trusted solution will have highly accurate capabilities across all data from sources with varying levels of integrity such as clinical grade, marketing grade, and analytics grade data.

A solution's ability to identify without compromising quality is an important detail that can often be overlooked but is crucial operationally. When evaluating a solution's ability to identify, preferred approaches leverage advanced data science and an unparalleled set of algorithms to determine identity which far out paces typical probabilistic approaches.

Additionally, innovative solutions understand the importance in digital experiences and offer capabilities to verify a member or provider identity enabling a secure and frictionless experience.

## 3. Enrich

Integrate social determinants of health (SDOH), lifestyle, and demographic data for a more complete view of members, and providers. The best identity data management solutions offer capabilities to enrich underlying member and provider data to optimize completeness without compromising on quality.

For member data, capturing better contact information can make all the difference in your educational or care management program outreach. Or gaining a better picture of thier lifestyle such as transportation and food risks that could help inform eligibility for additional benefits.

With provider data, gain the ability to verify and fill in missing information, such as contact information, credentials, specialties, and affiliations directly ensuring the validity, utility, and precision of that information.

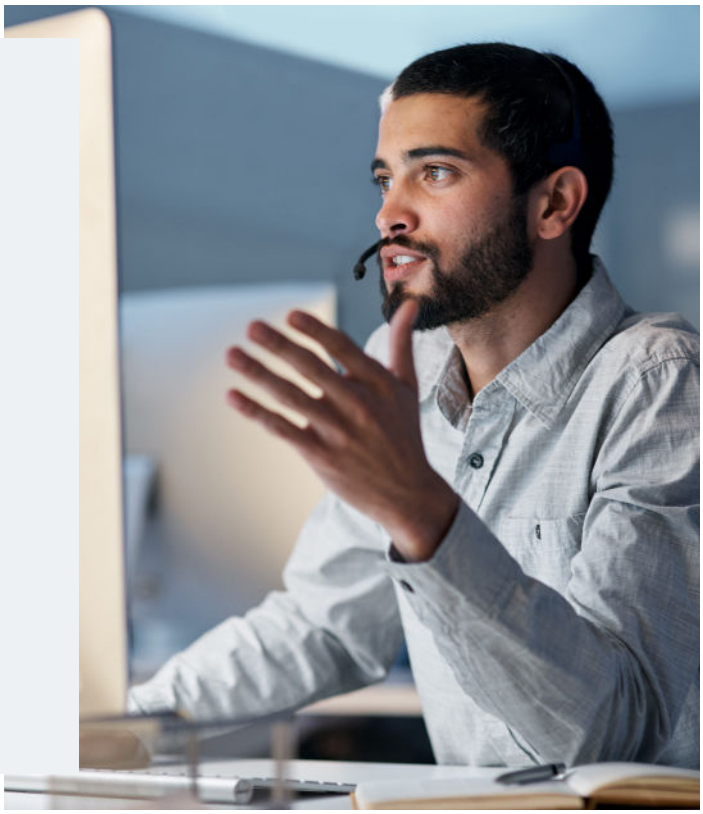
Your organization from care management to your analytics requires complete information --- you can't rely on the source of origin for completeness. However, your strategy should account and solve for incomplete data quality through data enrichment capabilities.

## 4. Manage

Support data mastering, management of multiple data domains and entity relationships, and intuitive data stewardship.

Many data management solutions offer "golden record" capabilities to ensure a single cohesive data set containing accurate and up to date information about a person or organization.

However, to meet the strategic initiatives at a payer organization, **better solutions will offer multiple, configurable, composite views of a person or organization** for different business needs. This ensures appropriate data governance while gaining the right data at the right time for the right workflow.




## 5. Activate

Provide a cloud-first solution that integrates with all healthcare applications and supports enterprise analytics across all domains

With an identity data management solution, look for capabilities that unlock the data so you have access to harness this data easily and gain insights for your organization.

**Look for solutions with built in capabilities to measure data quality metrics and generate reports – ensuring your data is fully activated throughout your entire organization.**

# Learn from other health plans that have trusted Verato as their identity data management solution

## Improved quality tracking

Large health plan struggled to match supplemental clinical data to its membership data for its quality measurement process (HEDIS). This incomplete matching obstructed HEDIS measures for over 25% of its membership. By leveraging Verato within its existing HEDIS process to dramatically improve the matching success rate despite the errors and omissions in the supplemental data. **Verato matched 3.1M more lab results** to membership profiles. **98% of members with newly matched labs saw improvement** in HEDIS measures, leading to **$10M incremental incentive revenue.**

## Reduce member duplicates

A regional health plan leveraged Verato to reduce their member duplicates in their EDW and operational system, FACETs (automates claims processing, billing, care management, and network management workflows). **Verato helped reduce duplicates in their EDW by nearly 470K and 78K in their FACETS systems. Verato was also able to reduce the potential false positives by over 650.**

## Improved analytics

Verato helps this medicare focused health plan and care delivery organization to create an integrated reporting system for clinical hospital data, increase analytic efficiencies, improve new member acquisition, and drive better risk management across their membership. Verato helps them achieve a single, longitudinal view of a member across multiple sources, their Health Plan Eligibility, Membership, and Capitation files as well as their EHR and Salesforce CRM. Verato provides names and mailing addresses for members who meet their prospecting criteria as this organization expands into new markets to improve their marketing analytics.

## Consent management

A regional health plan, after having some challenges with consent management across their membership with CMS, this health plan leveraged Verato to augment their **membership matching process to identify members across multiple enrollment sources and their member management system, FACETS.**

## Longitudinal member record

An organization that works with regional health plans and hospital systems to grow or to launch new Medicare Advantage Dual-Eligible Special Needs Plan insurance offerings and ACOs needed to rationalize all information about a person to develop care plans, close gaps, analyze outcomes, and coordinate care. This organization receives claims and eligibility info for members of multiple health plans. For a single health plan, they can receive data on eligibility for different health products and within a given product a member may have changing/inconsistent demographics, and across products they may have different member IDs, so **Verato helps better determine the collection of records that all pertain to the same individual.**

# Take the next step

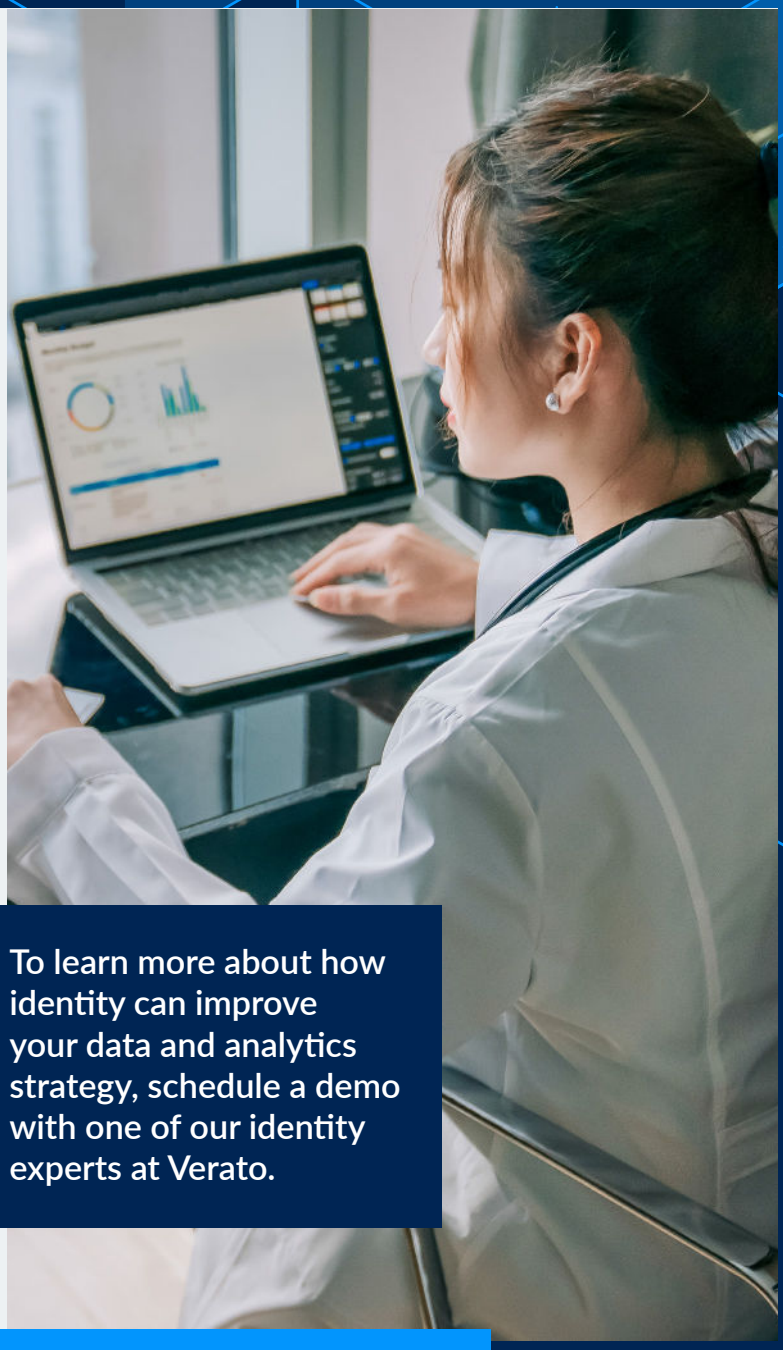
Without understanding who is who across all person and organization data, your interoperability and digital engagement strategy won't work — risking member churn and revenue.

Across every aspect of data exchange, whether you are trying to share data across internal silos or receiving clinical data from your provider partners --- it all starts with accurate identity.

Without a strong identity solution your data will continue to be disjointed, inaccurate, incomplete, and inaccessible.

Now is the time to adjust your strategy for success --- increase your data's utility and double down on identity data management that can effectively power your entire business.

With reliable data activated throughout your business, achieve your goals for retention and total costs of care across all of your strategic initiatives.



To learn more about how identity can improve your data and analytics strategy, schedule a demo with one of our identity experts at Verato.

Verato enables digital engagement, clinical interoperability, cloud migration, and provider data integrity by solving the problem that drives everything else—knowing who is who. The Verato hMDM platform, the industry's first purpose-built healthcare master data management solution, enables a complete and trusted 360-degree view of patients, consumers, members, providers, and communities. With a secure enterprisewide single source of truth for identity, Verato ensures that you get identity right from the start.

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