verato

For payer data, IT, and member experience leaders

Is your member data ready for AI?

A health plan checklist

58% of insured adults experienced a problem with their health insurance in the past 12 months, according to KFF. Not every one of those problems traces back to identity data, but a meaningful share do: a member record that doesn't match across claims, enrollment, and engagement systems, a provider directory nobody has audited, a risk score built on an incomplete history.

Because of these challenges, we've built a checklist that gives payer data, IT, and member experience leaders a fast way to find those gaps before they show up in a Star Ratings score, a payment integrity audit, or an AI model that was supposed to make things better.

Plans that close these gaps early spend less on rework and more on the initiatives the data was supposed to power in the first place.

How to use this checklist

Work through the five sections below in one sitting. Each item pairs a concrete check with the reason it matters. Check off what's already in place, and treat anything unchecked as your starting point.

1. **Member identity foundation**
   Who owns the member record, and whether every system agrees on it.

2. **Provider network and directory accuracy**
   Whether your directory holds up against a 90-day clock.

3. **Quality, Stars, and risk adjustment readiness**
   Whether outreach, quality activity, and chart reviews all trace back to one member record.

4. **Payment integrity and fraud readiness**
   Whether suspicious patterns surface across systems.

5. **AI and analytics governance readiness**
   Whether match decisions are explainable before a model sees them.

58%

of insured adults experienced a problem with their health insurance in the past 12 months.

Source: KFF



1. Member identity foundation

- [ ] Name one owner accountable for member identity across claims, enrollment, and engagement, not one per system. Fragmented ownership produces fragmented records.
- [ ] Confirm your plan recognizes the same member across claims, care management, and the portal. A member who looks like three people to three systems gets consistency from none.
- [ ] Check how many active records exist for a member enrolled in more than one line of business. Medicare Advantage plus a supplemental plan often means two or three separate records that never get reconciled.
- [ ] Ask what share of member outreach is flagged as a possible duplicate before it goes out. Unflagged duplicates waste spend and, worse, make the plan look careless to the member on the other end.



50%

of providers had at least one directory deficiency.

Source: CMS Provider Directory Review, Round 3, 2018

2. Provider network and directory accuracy

- [ ] Check when your provider directory was last validated against a source outside your own system. In CMS's Round 3 Provider Directory Review, 50% of providers had at least one directory deficiency, and 42% of locations had a highest-impact deficiency.
- [ ] Confirm your validation cadence meets the No Surprises Act. The law requires directory verification at least every 90 days, and a manual process that cannot keep pace becomes a compliance exposure.
- [ ] Time how long it takes to validate one provider record. AHIP and Availity put it at about 4.22 minutes by phone to over 16 minutes online, per provider. Multiply by your directory size to see the real cost of a manual process.
- [ ] Check whether your network adequacy report and member-facing directory search use the same data. When they do not, members find providers who are not really in network, and compliance finds out after the complaint, not before.

3. Quality, Stars, and risk adjustment readiness

- [ ] Confirm a member's outreach, utilization, and quality activity connect to one record. Per McKinsey, Medicare Advantage plans rated 4+ Stars added 2.1 times more net members than lower-rated competitors, and a fragmented view makes every Stars-driving intervention harder to target.
- [ ] Check whether a chart review traces back to the correct member with confidence. Risk adjustment and payment accuracy both depend on a clean link between diagnosis, encounter, and member, and a shaky link shows up as a compliance question later.
- [ ] Ask whether your directory validation could pass a secret-shopper review today. The 2024 Medicaid managed care final rule requires annual validation..
- [ ] Review your last two quarters of care-gap outreach for duplicate contacts. Duplicates waste the campaign and lower your measured engagement and conversion rates.

verato

4. Payment integrity and fraud, waste, and abuse readiness

- [ ] Ask whether a suspicious pattern would surface across members, providers, and claims, not just within one system. Fraud losses are conservatively estimated at about 3% of U.S. healthcare spending, per the National Health Care Anti-Fraud Association, and fragmented identity is one reason suspicious activity stays hidden.
- [ ] Check whether the same provider appears under more than one identifier in your claims and network systems. Three identifiers means three risk profiles instead of one.
- [ ] Confirm your team can give a defensible answer for how a payment decision was reached. An unclear link between identity and payment is harder to defend in an audit than a slower process would ever be.
- [ ] Ask what share of flagged claims trace to an identity mismatch rather than coding or coverage. If nobody tracks this, identity is probably a bigger share of your rework than anyone realizes.

5. AI and analytics governance readiness

- [ ] Confirm someone can explain in plain language how your models decide which records match. Poor data quality costs organizations $12.9 million annually on average, per Gartner, and identity is usually the quiet reason a model's data quality looks worse than the vendor promised.
- [ ] Check whether duplicate or fragmented member records are caught before they reach a model, not after. A model trained on duplicates has already learned the wrong lesson.
- [ ] Ask what governance covers access to member-level identity data in analytics. Governance built for healthcare identity workflows lets compliance say yes to a new AI use case instead of stalling it.
- [ ] Revisit this checklist in two quarters. Populations, product lines, and data sources keep changing, and a foundation that was solid last year may not be now.

Why this matters now

None of this is news to the plans already living it. Providers and payers alike say data mismatches directly contribute to lost revenue, and the CMS provider directory numbers are the most consistently cited version of the problem in the industry.

A large health plan needed one trustworthy view of its members across Medicare, Medicaid, and private managed care before it could compile an accurate longitudinal history for each one. Identity matching improved from 85% to 98%.

> **"Verato helps us manage these scenarios so we can compile that true longitudinal view, leverage the data accurately, and have accurate calculations at the end of the day.**
>
> *Senior director of HEDIS, a large health plan*

See where your identity data stands. Get the free assessment. →

Verato®, the identity intelligence company, solves the critical challenge of Knowing Who Is Who™. Proven in healthcare and trusted everywhere, Verato MDM Cloud™ unifies, enriches, and manages identities with unmatched accuracy — powering better experiences, improved outcomes, business growth, and AI-native efficiency across identity-driven business processes.

Verato® is a registered trademark of Verato, Inc. All other product and company names are trademarks (™) or registered trademarks (®) of their respective holders. Use of these marks does not imply any affiliation with or endorsement.

verato®

© 2026 Verato, Inc. All rights reserved.