

**CAQH Testimony Submission to the
HIT Policy Committee NHIN Workgroup on Directory Services and Certificates
December 16, 2009**

Introduction

Dr. Mostashari, Dr. Lansky, Mr. Weitzner and members of The HIT Policy Committee's NHIN Workgroup, thank you for the opportunity to discuss the important topic of Directory Services and Certificates.

I would like to begin by providing an overview of CAQH. CAQH is a nonprofit alliance of health plans and trade associations that serves as a catalyst for industry collaboration on initiatives to simplify healthcare administration. CAQH solutions promote quality interactions between plans, providers and other stakeholders; reduce costs and frustrations associated with healthcare administration; facilitate administrative healthcare information exchange and encourage administrative and clinical data integration.

Currently CAQH is engaged in two major initiatives: the Committee on Operating Rules for Information Exchange (CORE), and the Universal Provider Datasource (UPD). CORE is a transparent, multi-stakeholder, and consensus-based initiative to adopt a set of operating rules for electronic administrative transactions among providers, vendors and health plans by supporting existing standards and thoroughly vetted policies. The UPD is a well-established and trusted registry of comprehensive provider information. Both initiatives have provided CAQH excellent experience on how to successfully build industry utilities.

The Health Information Technology for Economic and Clinical Health Act (HITECH) directed the National Coordinator for Health Information Technology to undertake activities that are "consistent with the development of a nationwide health information technology infrastructure that allows for the electronic use and exchange of information." Among the benefits that Congress envisioned for this infrastructure is "reducing costs resulting from inefficiency, errors, inappropriate or duplicative care, and incomplete information." In regard to this important opportunity, NHIN and CAQH share similar goals and I am pleased to offer our commitment to assist NHIN rapidly achieve these important objectives.

Q1: What is the scope of service, content, structure and business model of your directory services?

We understand that a directory is loosely referred to as one or more "lists" that can be accessed under certain conditions to identify organizations and how to reach them – and eventually to identify individuals within organizations.

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In early 2002, CAQH responded to requests from numerous provider stakeholders interested in reducing the redundancy, inefficiency and costs associated with what they referred to as the “provider credentialing process” by developing and implementing the UPD: a comprehensive, non-proprietary provider directory that invites licensed practitioners to submit and maintain their individual data, thereby enabling secure web-based use by authorized health plans, hospitals, and other managed care organizations for credentialing, directory maintenance, claims administration and quality assurance.

Currently the system supports data collection for a wide range of licensed practitioners: MD, DO, DC, DPM, DMD, DDS, and some 30 allied/ancillary practitioner types in all 50 states. All are identified as providers in the UPD.

The UPD is a real-time system that includes a central database with on-line tools to support provider input of information and tools for authorized organizations to view and electronically extract the information. The UPD also supports, through provider-selected communications channels, a mechanism to remind providers to periodically update and attest to their information, as well as authorize release of their information to organizations participating in the UPD.

Providers input their data directly into the UPD after they have registered, selected a unique security credential and identified a preferred method of contact – e-mail or fax. Once the provider has taken possession of their UPD record, the system uses an interview style interface that steps them through a series of logical questions designed to collect the needed data – data that includes demographics, licenses, certificates, other Identifiers (including NPI), education, training , specialties, practice details, billing information, hospital privileges, malpractice liability insurance, work history and references, disclosure questions and images of supporting documents. The system supports some 700 data fields for each provider.

Upon completing data entry and passing all system edits, a provider is presented with a list of organizations that have contractually represented to CAQH that they have a relationship with the provider. If the provider agrees, he or she then authorizes the release of their data and attests to the accuracy of the information submitted. In addition to on-line tutorials, providers also have access to toll-free telephone-based support to assist with specific questions regarding use of the UPD.

Once provider data has been submitted with attestation, participating organizations are notified that provider information is ready to be accessed. Organizations can view the data on-line or set-up custom data extracts that can run as often as daily and can show all provider data, or just recent changes. The data is available in ASCII, XML or replica image (.pdf) files.

A key pillar of the UPD philosophy, and arguably the most critical factor for its success, is that providers control their data and are responsible for managing and maintaining it. Transparency, trust and a clear chain of custody within the UPD are integral features. It is due to these features that the UPD has been able to reach critical mass and begin to broaden service offerings.

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Today, throughout the United States nearly 800,000 providers are using the UPD, with an additional 8,000 joining every month. More than 550 health plans, hospitals and healthcare organizations electronically access UPD data to receive timely provider information and are eliminating costly, cumbersome and often inaccurate paper application gathering and processing.

The UPD also enjoys strong support from numerous national provider stakeholder organizations such as AAFP, ACP, AHIMA, AMA and MGMA as well as the support of many local medical societies and other industry stakeholders such as AHIP and HASC.

CAQH has created a solution that significantly advances its objectives to reduce the redundancy, inefficiency and costs associated with the provider data collection process.

Every health plan, hospital, ambulatory surgery facility or other healthcare organization in which a physician participates or practices must verify a physician's credentials before allowing them into the network or permitting them to practice, and then those organizations must re-verify the accuracy of the information periodically - every two years for hospitals and every three years for health plans.

A 2005 MGMA study found that physician practices, on average submit 17.86 credentialing applications per physician each year. MGMA calculated that each application required an average of 69 minutes of support staff time and 11.27 minutes of physician time; resulting in yearly cost for a 10 physician group of \$7,618. Using MGMA data, CAQH estimates that the UPD has saved providers time and money by eliminating nearly 2.3 million legacy paper applications, and reducing provider administrative costs by an estimated \$90 million, or more than 3 million man hours per year. Moreover, environmentally, the system is saving nearly 10 thousand trees per year. The UPD business model is simple and transparent; providers have free access to the system, and there are no hidden fees or special system or software investments required. Participating organizations pay a nominal annual fee per provider for unlimited access.

The widespread adoption of the UPD by providers, along with the nonprofit status of CAQH and its transparent and trusted public/private collaborative development model, has led thirteen states to adopt the UPD application as their mandated or designated provider credentialing form. Other states are now considering similar actions.

In addition, through CAQH's work with the Medicaid Information Technology Architecture (MITA), several state Medicaid Agencies have adopted the UPD as a tool to support with their provider enrollment data collection efforts.

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Q2: Based on your experience, how should directory services be governed and operated?

CAQH believes directory services should be governed and operated in line with a set of open, guiding principles, including:

- Delivered by not-for-profit “public utility” that replaces fragmented and disparate systems.
- Where possible, deliver immediate “critical mass” (e. g. user penetration).
- Avoid “reinventing the wheel”, but rather leverage existing best practices that align with NHIN goals, objectives and HIE framework.
- Scale easily and rapidly.
- Offer a minimal learning curve for directory users.
- Require no or minimal organizational investment in new technology.
- Provide for data quality monitoring and ongoing data quality improvement.
- Integrate multi-state, independent information (e.g., for provider data, continuous licensing board actions and sanctions monitoring).
- Comply with existing standards for user data (e.g., credentialing standards for state Insurance Departments).
- Have strong support of industry stakeholders (e.g., for provider directory, support from health plans, networks, hospitals, other care delivery organizations and key provider associations such as AAFP, MGMA, AMA, ACP, etc.).
- Provide for input from all stakeholders in a transparent and consistent fashion.
- Offer mechanisms for defining and developing shared strategic goals.
- Demonstrate the ability to support future enhancements.
- Serve as a trusted source for all participating stakeholders.
- Enables phased adoption and incorporates sufficient controls to engender trust.

Q3: If your directories are not currently used to facilitate information exchange, what challenges to you see in making them available for this purpose?

CAQH understands that directories for NHIN need to include all types of organizations, including providers, health plans, public health, emergency responders, labs, etc.

As a provider directory, the UPD is currently used to facilitate information exchange nearly 800,000 providers and more than 550 healthcare organizations. We have established clear rules and processes for organizations to connect to the UPD and obtain provider data.

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Due to HITECH, specific Health Information Exchange (HIE) requirements may require expansion of the UPD data set with respect to both the type of information collected and the variety of providers from which that information is collected. To support the provider directories needed by HIEs, CAQH is prepared to help facilitate multi-stakeholder agreements on provider data use and implementation rules and policies. CAQH has confidence that HIE needs can be supported based on our experience in the evolution of the UPD, and as demonstrated by the widespread support from the provider community.

Beyond provider directory considerations and based on CAQH's experience facilitating CORE – which has over 110 multi-stakeholders developing and then adopting data exchange rules for entities that exchange and hold data for over 180 million Americans – some of the key challenges in facilitating nationwide health information exchange using the NHIN include:

- **Unique Identifiers:** To reliably discover organizations and to exchange information, a universally accepted scheme is needed for uniquely identifying all organizations in the network including providers, health-plans, public health, emergency responders, labs, health information exchanges.
- **Data Sharing Policies:** Before organizations can exchange information, a business relationship and a data sharing agreement are needed. As done with UPD and CORE, milestone approaches to such data sharing could be appropriate due to market maturity and need to take the appropriate time to develop such policies. The Data Use and Reciprocal Services Agreement (DURSA) concept developed by NHIN could be refined to help facilitate business and data sharing relationships among all entities involved in this national network.
- **Digital Authentication:** Electronic transactions need to honor the business trust relationships using mechanisms like digital certificates. Standards and technologies for certificates exist already, but the widespread and nationwide use of certificates for establishing secure data interchanges requires policies and regulations. Through efforts with CORE Connectivity, which requires digital certificates and is aligned with HITSP efforts, CAQH is currently conducting a pilot with VeriSign and other interested certificate authorities to study the administration of certificates.
- **Use of Standards:** For interoperability, all directories must support widely used industry standards for discovering and retrieving information from them efficiently and securely using public networks like the Internet. e.g., CORE Connectivity.

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Q4: If your directories are currently used to facilitate information exchange as part of a proprietary network, could you imagine making your directory available as a service to other organizations? Could you imagine using a public directory instead of your internal one?

The UPD is not part of a proprietary network. As an example, CAQH has shared the UPD data schema with the MITA team at CMS, as well as with a broad range of industry organizations. Furthermore, provider associations have collaborated with CAQH to approach CMS about using UPD for Medicare provider data needs. Overall CAQH has a commitment to open, transparent and consensus based adoption of open standards for real-world implementations, to facilitate interoperability and efficiency.

CAQH is prepared to work with NHIN and state HIEs to make access to the UPD data widely available, and to offer the CORE open standards based connectivity work-products and significant experience in this area.

Q5: Is it feasible to aim for universal authoritative directories, or should we accept the reality of multiple, fragmented and overlapping directories?

Based on our experience over the past seven years in building UPD, we believe it is feasible to have a universal authoritative provider directory.

While some may suggest that multiple, fragmented and overlapping provider directories are an unfortunate reality, the UPD, with an existing, accurate and actively used directory of nearly 800,000 providers, is clear evidence that a universal approach *should* be the aim. However, strong support at the Federal level is necessary if there is to be a truly universal authoritative provider directory.

CAQH understands that directories for NHIN need to include all types of organizations, including providers, pharmacies, labs, health plans, public health, emergency responders, etc. A federated approach for directory governance and management should be considered given the significant progress by multi-stakeholder efforts; i.e., each sub-sector (e.g., provider, public health, health plans) maintain an authoritative directory that is independently governed and maintained as per the policies and regulations of that sub-sector, with each directory implementing standards such that any organization on the NHIN can find and use their information. Such collaboration will enable HITECH to jump-start deployment and focus on efforts to fill key gaps, such as identifiers.

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Q6: If there were authoritative directories of providers, would other institutions (including vendors, health plans and other organizations) integrate such directory services into their current or future business relationships?

Yes. UPD has already demonstrated that more than 550 healthcare organizations have integrated UPD data into their business processes. These organizations include health plans, hospitals, clinics, provider groups and now Medicaid and other public organizations that require provider data. The range of supporters for UPD – including organizations such as the American Academy of Family Practice, the American Medical Association and the Medical Group Management Association – speak to the ability of the industry to work collaboratively towards a shared goal.

Q7: What institutions could support these directory lists?

As noted in our response to Question #2, we believe that there are critical characteristics required to be successful as this type of endeavor, such as:

- The ability to facilitate complex multi-stakeholder collaborative processes.
- Proper governance.
- Adherence to open standards for interoperability.
- Non-profit status.
- Untiring commitment to transparency and inclusiveness.

Q7a: What will be required for these institutions to be trusted with the policy, technical and administrative tasks? What are your views on the broader “trust fabric”?

For an institution to be trusted with policy, technical and administrative tasks that are involved in managing a directory for NHIN, it must have:

- A proven track record in running such a directory – and thus the trust of the community.
- Be a market-leader in the information that it provides.
- Well established process in creating and managing the information and services that it provides.
- Adherence to open standards for interoperability.
- Consideration of market readiness, e.g., within CORE, a key consideration on the selection of open standards is market readiness of the industry for adopting and implementing those standards.

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For provider directories, the success of UPD has been dependent on the trust of the provider community in CAQH to act as a reliable curator and honest gatekeeper of their information. In order to do that, CAQH developed a transparent business model that places control of the data with the provider, including responsibility for supplying and maintaining data, as well providing assurance that a provider will always know who has accessed his or her data based on provider-controlled release from UPD.

CAQH has also worked closely with provider stakeholder organizations, providing access to policies and procedures and encouraging feedback and involvement as the system has evolved. Today, providers view the UPD as their most trusted data source and often encourage organizations that need their data to contact CAQH and retrieve it from there.

Optional Issues

1. How might forms of credentialing and identity management be managed through directory services?

At a basic level, identity management involves identity and contact information about the users or organizations. At a more advanced levels, it may involve security related information such as roles and authorizations. Similarly, credentialing may be professional credentials (e.g., practice licenses), or may be digital ones (e.g., digital certificates).

The UPD is a directory service managing a critical portion of the data collection process for providers today. It is already a trusted, secure source of provider data, thus one could imagine enhancements to include actual electronic credentials such as digital certificates and information such as network privileges. Basic identity management is already part of the UPD and could be extended further due to the extensive data on providers already maintained and the operating procedures in place.

We have conducted discussions with organizations involved in identity management including digital certificate management that would extend the capabilities of the UPD to include full identity management and authentication. These discussions complement the policies and process that we are considering through the CORE Connectivity efforts.

2. What standards issues must be addressed to achieve more effective use of directory services?

Technical standards, particularly web services definitions, should be created to enable development of interoperable directory services. Strong Federal support for these standards would spur adoption and use of these standards. Universal and unique organization identifiers must be established for effective use of directories. For digital trust, Federal policies and regulations are needed for widespread acceptance and adoption of digital certificates.

Beyond standards, policies and regulations, operating rules among stakeholder organizations must be established to enable use of the standards in practical production systems.

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Concluding Statement

In closing, I would again like to thank each of you for the opportunity to discuss the important topic of Directory Services and Certificates. I hope that the committee will seriously consider and act on the opportunity to leverage existing industry initiatives that are widely used and trusted by all stakeholders - initiatives that have demonstrated meaningful reductions in redundant and unnecessary administrative costs and processes.