

Information Exchange Workgroup – Provider Directory Task Force

September 30, 2010

9:00 a.m. to 4:00 p.m./Eastern Time

Holiday Inn Capitol Hill

Washington, DC

Questions for Panelists

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Panel 2:

Business requirements: Health Plans, Public Health and Others

1. Do you currently use external provider directories for health information exchange? What are they and how do you use them?

In defining health information exchange broadly (not just RHIOs), Yes, health plans have functions for collecting provider data either via internal processes or through industry collaborations such as; CAQH.

Health plans use provider data for a wide variety of purposes such as credentialing, claims processing, quality assurance, emergency response, member services (directories and referrals), and more.

Health plans have contractual relationships with intermediaries known as clearinghouses. These clearinghouses generally connect to practice management systems via EDI types of transaction media or via health plan or sponsored portals. They maintain an electronic address. Health plans frequently do not

2. Do you currently maintain an internal provider directory?

- a. If so, how do you validate and maintain it?

Health plans use services via industry collaborations such as CAQH; the Council on Affordable, Quality Health Care. CAQH is supported by America's Health Insurance Plans, the American Academy of Family Physicians, the American College of Physicians, the American Health Information Management Association, the American Medical Association, the Healthcare Administrative Simplification Coalition, the Medical Group Management Association and other provider organizations. Other entities

also are sources of provider data such as informatics companies (IMS Health) and other commercial vendors (Enclarity).

- b. Also if so, would your organization find value in using a third party directory to help maintain/support your internal directory?
Yes as most health plans use a third party today. Accurate provider data has been treated as a cost center and not as a source of meaningful competitive advantage so third party use is an accepted industry norm.

3. What uses would you have for these two types of provider directories? Would you use them? If not, why not?

- a. **Yellow pages:** An authoritative resource listing clinicians and entities that is used to “look up” providers and point to routing directories
Health plan provider directories are generally “yellow pages” as described earlier in this document and we use them as described above
- b. **Routing directory:** routing registrar to provide addressing hierarchy/service to enable machine-to-machine routing in context of health information exchange activities
Health plans **do not necessarily have routing directories although the ability to bi-directionally communicate with physicians** would be a meaningful step forward. Traditionally, we have communicated with the front office (eligibility) or the back office (claims, claim status...). Being able to communicate directly with doctors opens up new doors such as real time messaging for P4P programs, disease management program coordination, automation of medical management programs and many others. These programs would be of interest due to potential administrative cost reductions and/or improvements to medical loss ratio requirements specified in health care reform

4. What set of clinicians and entities need to be included to enable your use cases?

- a. Would it need to include individual clinicians, or is the entity sufficient?
We have entities today. We would prefer individual clinicians; especially for any P4P program, disease management program...

5. What information about clinicians and entities need to go into the provider directory in order to make it useful for you?

- a. For example, provider type, specialties, credentials, demographics and service locations
Demographics, key identifiers including NPI numbers and credentials – about all types of healthcare providers including doctors, dentists, chiropractors, physical therapists, facilities, labs, pharmacies, and others. Ideally we would like a free text section where a provider could enter more specific information of their choosing such as office hours, specific areas of clinical interest, languages spoken or other things they would want a potential patient to know about

6. What data or information about your organization or clinicians could be made available to establish directories?

- a. Issues to be resolved? We have full provider files with substantial amounts of detail in them however they generally are missing any type of electronic address or routing capabilities.

7. If your organization maintains a provider directory, would you allow it to be accessed by outside parties in a federated structure?

Potentially, however we would either want a fee of some type OR we would want credit for providing a service to an HIE and have that be credited as Health IT; therefore not count against the medical loss ratio calculation by NAIC

8. What “trust framework” is needed for populating, maintaining and using provider directories?

- a. Are there specific issues (reliability, trust, privacy, uses of data, others) you would like to make sure are addressed with respect to provider directories

Provider data is not PHI and therefore has not been handled with the same level of protection by the industry. Therefore, a trust framework is not required but an established business relationship linked to the provider and the plan is all that is needed.

9. Can the business interest of existing data suppliers or directory owners be aligned so that they would be willing to help populate, maintain and use an authoritative directory? Is this a desirable goal? Is it feasible? There are already a variety of commercial vendors who maintain up to date provider directories and there are already pooled functions that many in the industry use to create their directory. In some ways, this is less about creating a new directory function and more about how do you leverage what is already available and in use for a new function. The biggest driver of health plan adoption you can create would be to get NAIC to allow health plans to purchase provider directories from HIEs and allow the acquisition of the function to be a HIE Service line item considered Health IT and not an admin cost. That would probably get you almost every health plan in the country to have interest.