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JEREMIAH W. (JAY) NIXON, GOVERNOR • RONALD J. LEVY, DIRECTOR

P.O. BOX 1527 • BROADWAY STATE OFFICE BUILDING • JEFFERSON CITY, MO 65102-1527  
WWW.DSS.MO.GOV • 573-751-4815 • 573-751-3203 FAX

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To: Micky Tripathi and David Lansky, Co-Chairs  
Health IT Policy Committee's Information Exchange Workgroup

From: George L. Oestreich, PharmD, MPA  
Project Director, MO HITECH  
Deputy Division Director-Clinical Services  
MO HealthNet Division, Dept. of Social Services

Subject: Testimony on patient directories and health information exchange

Thank you for the opportunity to provide testimony for provider registry creation and sustainability. I am providing this information from the perspective of the state's single state Medicaid agency and from the perspective of the state's HITECH initiative. I have the honor of serving both of those agencies. I will briefly describe our initial activity and then provide responses to those areas set out the ONC blog for potential comment. I am happy to provide additional information and answer questions to the best of my current knowledge and ability.

When CMS announced the National Level Registry initiative to support the Medicaid Incentive Grant Program, Missouri began preparing for the opportunity. At essentially the same time we had begun a provider census to support the incentive grant program. This effort was done in conjunction with the state of Kansas and the contracting efforts they had undertaken for the same purpose.

During this developmental process it was clear that the many Missouri stakeholders needed essentially the same provider information and also found the duplicating efforts were still falling short in maintaining access to authoritative and complete provider information. At that point we decided to establish an initial meeting of all state stakeholders and their advocacy groups that may be directly impacted by the effort.

At an initial meeting attended by the Department of Health and Senior Services (DHSS), the Missouri HIT Assistance Center (ONC grantee), advocacy groups, Office of Social and Economic Data Analysis (OSEDA), MO Health Net (MHD), Department of Social Services (DSS), and the MO Office of Health Information Technology (MOHITECH). The group discussed the problems encountered in securing and maintaining actionable provider information and quickly came to the consensus that a single collective effort would be more effective. The group agreed to continue to come together to support the formation of the provider registry. Absent from the initial meeting was the Department of Insurance in which the licensure boards exist. The group agreed that DOI should be contacted to gauge their interest and support. The group also suggested the newly formed governance body of the

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state Health Information Organization be contacted to discuss the possibility of housing and managing a state-wide provider registry. The group acknowledged the funding mechanisms were best leveraged in the HIO.

The group suggested: a single effort would be most effective; the data elements common to all parties could be housed and maintained within the registry; updating for the common elements would be supported by the HIO; access policies with data use agreements would be established by the HIO; necessary costs would be supported and pro-rata cost levied to each using agency; and the ad hoc group would continue to support the effort as required. Since that meeting DOI has been contacted and is considering the common registry concept. The group acknowledged the funding mechanisms were best leveraged in the HIO.

The remaining comments will be targeted at the questions set out in the ONC Blog and in the context of the building the state-wide vision previously discussed.

**What use cases do you or your stakeholders have for provider directories? Who would use them and for what?**

- Medicaid provider enrollment core provider data points for billing and data exchange
- DHSS workforce reporting demographics: syndromic surveillance, disease reporting, prescription monitoring, epidemiological reporting, and chronic disease monitoring
- DOI/profession regulation: licensing and discipline reporting to appropriate agencies
- HITECH secure messaging: support meaningful use, secure exchange
- NLR: exchange of all provider incentive status information

**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?**

**b. Does it need to be authoritative and complete, for instance containing all licensed physicians in a state?**

- Hospitals
- Physicians
- Medical practices
- Nurses
- Pharmacists
- Pharmacies
- Dentists

**The following may be added after discussion with DOI**

- OT, PT
- Behavioral health therapists
- Optometrists
- Nursing homes, all levels

Possible other DOI licensed entities and practitioners

The registry should be complete with all members of cohort both members and entities. It should be authoritative. The registry could begin with all prescribers and hospitals and add additional providers in phases.

### **How will provider directories support providers in meeting MU requirements?**

- Secure messaging for communication and referrals and exchange of clinical data bundles
- Practice location(s) for targeted push-pull transactions

### **Which type of provider directory are you focusing on and why?**

- a. Yellow pages: An authoritative resource listing clinicians and entities that is used to “look up” providers and point to the routing directory**
- b. Routing directory: routing registrar to provide addressing hierarchy/service to enable machine-to-machine routing in context of health information exchange activities**

- We would focus on both, please see discussion below.

### **What information about clinicians and entities needs 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.**
- b. What level of data accuracy is needed for your purposes?**

- The following would be the targeted information in the registry: provider type specialties, credentials, demographics, service locations, licensure status, and numeric identifiers to assure identity
- Data accuracy needs to be authoritative and complete.

### **Given your use cases how would you recommend a directory be structured? At what level should the directory be established (e.g. state, regional or national)? What concerns do you have?**

- The structure should be federated, national preferable but believe it to be unlikely, therefore initially state with a phase in approach to contiguous states or limited regional registry.

### **What standards do you recommend using for provider directories (data standards, exchange standards)?**

- Please consider the following discussion from our technical consultant.

For both Routing Directories and Yellow Pages there is a choice between a federated approach where directory information remains local and centralized models where directory information is consolidated in a repository. This latter approach is the most common today, mostly due to the limited size and scope of current efforts. The DNS used by many Internet services is the only significant federated directory in large scale production today that we are aware of. However, the Routing Directory is solving a very similar problem and at state or national scale there is reason to believe a federated approach is more appropriate. We believe this is probably the only

practical approach given the number of routing directories in use today in Hospitals, Hospital Networks, Community HIEs, Medicaid, Public Health, etc. Further, MO and most states are interested in standing up both Routing Directories and Yellow Pages to support statewide HIE, and MO Health Net along with other states is implementing both directories to support the CMS NLR program. The timing of these deployments is too close for any coordinated effort to be used in place of local efforts. Therefore the most productive approach would be a federated architecture based on standard interfaces and data formats. In this manner local programs already in existence can be leveraged and programs with near term development and deployment requirements can proceed while working to develop national standards so that existing and newly deployed implementations can interoperate.

A similar argument can be made regarding Yellow Pages; there are local, state, regional and national Yellow Pages already in use and consolidating them seems challenging at best. Thus a federated architecture seems the best approach in this case as well, and would require an analogous effort to develop standard interfaces and data formats. In the ideal case a national Yellow Pages (even a global version) seems logical to take advantage of economies of scale in deployment and maintenance. Use of a federated architecture with standard interfaces could eventually be consolidated if stakeholders and governments can agree on an approach.

There are no widely deployed standards in Healthcare regarding either directory type today. Standards should be established and could draw from existing standards for services such as DNS and email that deal with similar issues. HL7 and IHE standards efforts in this area should also be taken into consideration.

**What is your approach to building or enabling provider directories?**

- a. How will your approach support information exchange for stage one meaningful use?**
- b. What data sources are you considering to populate a provider directory?**
- c. What are the key challenges you are facing?**

- We would start with a single data mart using provider census (currently in process) and licensure as base.
- Completeness and accuracy of data in addition to cost and maintenance of accuracy after go live

**How can ONC and states work to ensure interoperability and access across provider directories being created under the State HIE Cooperative Agreement Program? What steps could be taken to encourage regional collaboration in establishing provider directories?**

- This could be a combined condition of ONC and CMS in the joint management and a requirement in funding approval. It could also be stipulated that the NLR must be complete and authoritative.
- ONC and CMS could require the use of standardized interfaces.

**Would you consider working with other States and federal partners to establish a consistent set of business and technical requirements? If so, would you consider a joint procurement process and/or establishing a service that others (States, public or private organizations, etc.) could use? If so, what can ONC, CMS and states do to support this process?**

- Most definitely, cooperation in all areas. We actively discussing collaborating intra-state and interstate would be more preferable yet unlikely without ONC/CMS support. The three entities (including state programs) could support through NLR. Joint use could be supported through the review and approval of the state plans (as an encouraged or required criterion) at both levels.

**What are the opportunities and challenges to creating provider directories that are openly available and usable by multiple information exchange entities and participants? Who should be permitted to participate in such a model? How would this work at a technical level?**

- Privacy and security, authoritative and complete, timely, cost and sustainability as well as maintain discrete data fields from broad based general access. Defined collaborators with ownership by HIO so a MOU can dictate data elements shared as well as terms and conditions of use.

**What policy levers can state governments or the federal government use to assist in the establishment of provider directories and maintaining data accuracy and quality?**

- Funding, requirements with NLR, coordination of standards, require coordination between ONC and CMS grantees; minimize regulations of program regarding funding that may occur for CMS providers versus all providers would support build out.

**What trust framework is required for establishing, accessing and information sharing among 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**
  - The trust framework could be set through an agreement for data use and policy by the owner (HIO) for the broad user base. Could use the same trust framework as adopted by HIO for HIE.

**What are the resource requirements to create and maintain directories and what are the funding options (up-front and ongoing)?**

We have not determined total cost of the provider registry. The suggestion would be to jointly fund by Medicaid and the HIO with Medicaid supporting for use in its provider enrollment process, certification for prior authorization of Medicaid services and need in the EHR incentive program administration. Sustainability could be accomplished by prorating ongoing cost and depreciation by all users through the HIO based on use parameters. User fees on transaction and intensity of use perhaps linked to relative value scale