The #HCBiz Show! Episode 10

PD01 - Provider Directories: How Hard Can This Really Be? | Don Lee and Shahid Shah

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Don Lee: Good day. You are listening to the HC Biz Show. This is the podcast dedicated to complex, convoluted, sometimes seemingly irrational, but not really irrational business of health care. And I am your host, Don Lee. Very excited to have back on the show today, my co-host, Shahid Shah. Welcome sir.

Shahid Shah: Hi there. Thanks for having me on again and I'm looking forward to our conversation.

Don Lee: So, this is all ready, episode number 10 for our audio side of the show. Probably about 45 if you count all the videos and everything. That's my first lesson here out of the gates, is like everything else. Like power of just getting started on something. It's crazy that a month ago we had none and now we have 10.
I just wanted to start by acknowledging that once again, a lesson I keep learning in life, just **get started**.

Shahid Shah: Great lesson. Definitely you see that in health care all the time, as people are trying to build the big solution or the big vision instead of just getting started with something small and helping one patient at the time.

Don Lee: You got it. That's awesome. I just wanted to touch base to the infection prevention and control series that we just did. We've done nine episodes on that front and really aid up [00:01:14] to that infection prevention and control. Really interesting stuff that came out of there and one thing in particular that fit the modern model of the show is when it comes to the infection prevention and control in that world, we're dealing with the problem that nobody debates exist. Everybody sees it, everybody knows it. Everybody knows that it's costing us a ton of money. It's harming patients and it's hurting families. We have a lot ideas, lot of very good ideas about how to fix it or at least how to make great improvements on it and it's still really difficult to get those things done. The problems that we saw over and over again. We're talking with everyone from academic experts in that space, to people that are running startups and trying to roll the new solutions out, to establish companies

that were trying to roll the solutions out. They all had the same issue. They were struggling to isolate the value that they were bringing to the market.
I think that's really important. It's a clear problem, everyone sees it as a real problem. Everyone understands the value behind it, but how do you isolate the problem, that your solutions bringing to a particular problem? How do you prove that it's working? How do you tie that to a very clear and repeatable, unsustainable revenue model that is going to sustain at going forward?

This is the problem that, again we are talking about, specifically iPad companies here. That's kind of a problem if you're trying to roll an innovation in health care. How do you isolate the value? How do you prove it and how do you sustain it? What are your thoughts on that?

Shahid Shah: I think one of the things that we neglect as we're building some of our startups and building some of these solutions, is going back to first principles and that is who's the actual person who's accountable for something versus responsible for something. In this case for example, infection control, you see a lot of people are responsible for making sure that they are doing the right thing. Something as simple as one person needing to make sure that they wash their hands. Another one needing to make sure that they track where are certain antibiotics being given that might actually lead to higher levels of resistance off an bacteria. There are people that are doing these jobs, but it's unclear when something bad happens, who is held accountable? For example, if a plane crashes, the pilots are accountable and there is no question where the investigation is going to start. It may lead to other places and other things, but what we see here is, literally, when you see errors and infection control and other areas where it's very clear that there are jobs that the people doing. Which is what we often see from a startup perspective or from an innovation perspective and say: "Look, if I just automated that guy's job, he would buy something from me. If I just automated a little bit more of that problem, than maybe someone would purchase my solution." But what we neglect here to recognize is, are people just responsible for these things or is there a person that's accountable as well? If you find somebody that's accountable, that's the guy that's going to be able to say [. . .] All right, when I say accountable I mean really accountable. He can go to jail or get in trouble or be fined or he or she has a line item in their performance reviews. I was just at the FDA earlier this week at the FDA Cyber Security event and people were asking why is Cyber Security so hard to maintain and manage and it's very similar to infection control where there's a bunch of people doing a bunch of things? When something goes wrong, you can't focus on a group or person, but you can say "all right, we're going to start there. There's somebody accountable for that particular activity." That's what you see here in infection and control. There are lot of people. Lots of people that are interested in and talking about the problem, lots of solutions

et cetera. There isn't a person you can point to and say "that's the guy who I'm going to talk to." And as I gave the example earlier this week to a lot of the FDA representatives and I said: "If you have guidance for anything, whether it's infection control, cyber security or anything like that and there is nobody at the company whose job points to your guidance and in their performance review, is there a line item that says that at the end of this year you will be accountable for the X, Y and Z? If there's not, this is an interesting conversation, but nobody really is going to actually make anything happen.

Whenever we wonder why something in health care doesn't happen, don't worry as much about who's doing the job and what the problem is. Worry a lot more about when something goes wrong or when something goes right. If infection controls are properly maintained, who gets a bonus? If that's nobody, that means nobody is accountable. If infection control goes bad, who gets fired? If the answer is nobody, then we haven't figured out what that looks like."
When we are looking as innovators, and this is Don more for you and I. As we talk to startups, as we talk to innovators, this is what I try to make sure that the people separate the idea behind responsibility versus accountability and that would tie things properly I think.

Don Lee: Yes, that's huge. What a lot of people do is they go on and think that if I convince the money man, if I can get to the CFO or the control or where the people are spending the money, that's where I got to start off. If I can convince those top-level decision makers, that's where I start and I work my way down, but as you said, you got to find out actually who's accountable for, because everybody in health care is too busy and if they aren't actively trying to solve their problem, then it's going to be hard to get their attention, whether it's going to save the money or not. So, yes. Dig in and find out who is the person who is losing sleep at night over this particular issue we're trying to solve and that's where you got to get your foot in the door.

Shahid Shah: Yes.

Don Lee: Really good advice there, Shah.

Shahid Shah: Just when you tie that in, just think about this one simple thing. If a person doesn't have a bonus attached to it at the end of the year or they don't have it under performance review, those are two good

ways to know. If somebody is in charge of in particular task that you are helping to automate and that person gets a bonus because it's been automated, that's what you want to focus on. Or if that person can be fired because of it, or if that person has the ability to get [00:07:14] on their performance appraisal, those are always good things if you're just looking for a few tips that's what you should focus on.

Don Lee: There's something else I hope the show does for people. You and I get the benefit of working with a lot of different stakeholders from a lot of different angles on this business, so we get to see some patterns that might not be so intuitive, if you're only looking at it from one perspective all the time. I think that's what a listener of this show can get. Even if you are not interested, per se, in infection prevention and control or the sub coming provider directory series that we're kicking off today, you can still look and listen to the lessons that are in there about how do you identify that person. How do you get your foot in the door so you can start having that conversation? The work outside of this subject matter we're talking about and that was the key reason I wanted to bring that one up.

Shahid Shah: Yes, great point.

Don Lee: With that, I want to start changing gears here. As a show, we're doing these deep dives where [00:08:13] we've done nothing but talk about infection prevention and control. We are going to switch gears and for the next six, eight, ten weeks, however works out, we haven't quite nailed down all of the shows yet. We're going to be digging into provider directories. This is the problem that I like to call the ultimate death by paper-cut in health care and it's this little thing that's been nagging at us, annoying at us and hurting us. A lot of unexpected, not so obvious ways over the years that's just now finally starting to get looked at. It's getting looked at by CMS. We've got big penalties potentially coming down from them. We've got states like California putting out bills with lot of teeth through them to really move people towards dealing with this issue. Again, I think a very interesting one, because it's hard to pin down. It's a bit [00:09:01] in terms of what it actually is. I want to start right at the very top, Shah. What, from your perspective, what the heck are we talking about here? Provider directories? What is a provider directory? What is this provider data and why is it all wrong?

Shahid Shah: Yes, I know. It's such a good question because this is one of those areas where when you think about it, it's a little unobvious and that is how hard could it possibly be to know what physicians are being of service by a particular network and a particular health plan, right? The general problem is, as a patient, if I wanted to go and get a new primary care provider. I've got the new disease that I need to take care of so, I need a new specialist. One of the first things that I do is, I find a good provider or the best provider that I can find in that particular area. Then I check the one main thing and that is, are they covered by my insurance. Let's think about the business angle here for a minute. The reason why the affordable care act a few years ago and then the CMS by the end of 2015. started to indicate that they will by fining, creating penalties for health plans that do not have accurate provider directories. It is principally because of a one key business reason and that is the old "bait and switch". Supposed when I purchased insurance you told me on your insurance plan that you've covered a 1000 different providers and a 150 of them were primary care providers. Very cool. They are all in my area and I got a 150 providers, so I sign up for your plan. I loved the plan. A month later, I now need a primary care physician. Then I go into your directory and everybody I call up, they are telling me: "Yes, we took this insurance last year but we don't take it this year" or "Hey, I got the insurance. I do take it, but I'm not accepting new patients." And then when you ask: "What do you mean? I signed this up in January and everybody said that you are on the plan". Now, all of a sudden you are telling me that you are not going to be covering any services that I want, so I can't find the doctors that I need. Fundamentally, from a patient's perspective, I have now been baited. Meaning, I've got the insurance company and now I've been switched. I can't get the doctors that were supposedly on the plan list and instead I have others. Extend this out to specialist. Extend this out to diagnostics, imaging, et cetera. These are all common problems where you have a set of services that an insurance company promises to provide in any particular time period and these are what we now refer to as "narrow networks". Unless you're on your own plan and on a plan that's very opening, you can pick your own provider anywhere you want. In most, I help maintenance type of organizations you have narrow networks. And when you have narrow network you have to know the accuracy. That's what it's called, network accuracy, so how accurate it is the network that we have. And network adequacy? How adequate is the network so do I have enough primary care, do I have enough specialists, et cetera. Fundamentally, it's a very simple problem and that is, health plans should be regularly contacting their contracting providers on a quarterly basis. This is what CMS expects. Preferably, on

a monthly or weekly basis, which almost never happens, but you got to do it on at least a quarterly basis and you have to synchronize all the individual physician information updates by those contracted providers in this network. It basically includes things like demographics, do you accept new patients? If you're accepting [00:12:25], united health or [00:12:27] or whatever. Which particular products and plans do you do? What is your phone number? What facilities do you operate under? It all seems like really simple stuff, but it's very, very hard because the health insurance group where I go and find out whether or not someone is covered versus the provider, which are basically contractors for the health plan, are two completely different institutions. They are two completely different networks and basically the insurance companies have to verify and validate, or otherwise be penalized, that the contracted physicians in their network are actually the part of their network and that when me, as a patient or a member of a health insurance company, goes and asks for an new primary care physician or a new oncologist or a new cardiologist. That when I call them up they will say "Of course I take this because I'm on the list and of course I'm accepting new patients." This is a fundamental problem in health care today. When you look at an affordable care organization, a value base network, the accuracy of the network, who are the contracted physicians and health systems and facilities. The adequacy of that - are there enough of them to actually help me when I need help - fundamentally flawed. Because we're expecting the health insurance company to manage its contractors and the assumption that the contractors, like physicians and hospitals et cetera, that they would be very open to giving back updates and whenever things change on their side, they'll update the health insurance plans and that almost never happens. You're looking at upwards at 30%, so as low as 5-10%. Upwards at 40-50% of all data in network provider directories at health insurance plans may have one or more inaccuracies.
Why this matters even more is that Centers for Medicare and Medicaid Services have established penalties. 25.000$ per inaccuracy. It's not clear what that exactly means and I've not actually heard of anybody being fined for large number of dollars there yet. That's only a year old, but we will see this year, though, is that CMS put out a report earlier this year indicating their study now, after a year and it would've turned out that if they were actually applying penalties and sending out the fines, easily half of all health insurance plans would have been fined in the tens of thousands, if not in hundreds of thousands of dollars and that's a fundamental problem in the industry, for sure.

Don Lee: Well, there you go. Back to our earlier problem. I'll find you a person who's going to be promoted or penalized by this internally, and there is probably someone who's in charge of all of this health plans. Now, given this problem and that's what we're starting to see and work on it. Problem one than is, this is an issue for the consumers. This is an issue of [00:15:15]. You put it a bait and switch or false advertising. I have an interesting flip scenario from a consumer perspective, from my own personal experience on this front with a specialist. We were switching health plans and, of course, moving to the super high deductible. Like we do these days. We wanted to find out if a particular specialist, that my family uses on a regular basis, was on the plan. We picked the plan, narrowed it down to what we wanted and just wanted to confirm this one specialist. Should be easy-peasy, right? We called this big national health plan. Called them up first and we tell them that we see part of this practice, not this particular provider. Can they tell us whether he's in or out. They, of course, could not. They directed us to the practice, which makes sense. We called the practice, asked them and we said to them: "Hey, one of your doctors is on there, but not all the rest." This is a large group, this is north of a hundred physicians in this overall, multispecialty group and they said: "That doesn't make any sense. If one of our providers is on, they should all be on there. Tell me, what's your insurance code? What's the code on the front of your card?" Because, if it starts with an "A" then I know we'll be covered because that's what I bill out on. "We don't have our card yet." And they said: "Well, when you have your card, call us back and then we'll confirm for you." As a consumer, I'm in a sport where I'm trying to pick a plan and the payer, who I'm trying to buy the plan from, can't tell me whether or not I'm going to be covered for this particular physician and the physicians themselves can't even tell me until after I choose and then I have the information I need to tell them what plan I'm actually on. It's just a slight flip on the issue that you talked about there. I'm looking at a list trying to pick one and I pick one and they are not on there. I already have picked. We've been using him for years and we want to make sure we can continue to, but I actually cannot safely pick a plan and know ahead of time whether or not I'm going to be able to stick with that doctor.

Shahid Shah: It's such a great example, because you know what you're doing. You know this market and all this stuff.

Don Lee: Yes, that was exactly my thought. If I can't figure this out and I understand how all of this works, how's my grandma going to do this?

How is my cousin, who's completely outside of this industry, going to do anything about it?

Shahid Shah: Yes. That's why you have to think of this as a "bait and switch" model because if someone at the plan told you and you signed up, they told you affirmative. In this case, they didn't tell you bad data, they just left it blank, basically. This is the one things people don't understand. This is not an issue of data management. It's not a data cleansing issue. First and foremost, it is a business issue that says that you are offering me a product, whether it's false advertising... We don't want to go to that extreme that somebody is purposely doing false advertising because in this case it could be that 99 out of a 100 of your records might be correct but one of them is incorrect. That's that 25.000$ fine that, in theory, based on what the guidance says from late 2015. "You could be fined". To me, the struggle is in our crazy intermediated system. You have a patient who needs that data. The payer, who absolutely wants to do the right thing, nobody is sitting there saying that they want to do the wrong thing, are being held to account for information that only the providers actually know. The payer knows their contract basis. They are contracting with an institution and a certain number of providers. The providers, they are not being paid or not paid by the accuracy of their data back to the health plans. In this basic scenario, nobody is responsible, nobody is accountable. But for sure, if the payer gets this wrong, the patient is going to suffer because now they are telling them [00:18:55] the patient doesn't need. Doesn't have.
And then, the provider… if they took the patient and they were wrong and it turned out they were on a wrong plan, they would not be reimbursed for services that they thought that they would be reimbursed for. It's a fundamental problem. It's so massive. We're only talking about maybe 18 to 20 pieces of information for any particular provider. At one, you would think "My goodness, how hard could it be to get these 20 pieces of information?" I want to give you just one example. Let's think about why is this so hard. On a normal basis and you could have one physician who could work for three different organizations simultaneously. Monday and Tuesday, they round in a hospital. Tuesday afternoon and Wednesday and Thursday morning, they happen to be in their private practice. Friday afternoon and Saturday, they board for a local tenams that happens to staff and emergency room that is outside of the health system that they round on, on the first couple of days. This is not out of the ordinary. It's not very, very common, but fairly, it's common enough. Now think about that person. You have to know for each facility. Each day that they're working on. Which facilities do they go to, which they're not going to.

Are they accepting new patients. Of course, they wouldn't accept new patients at the E.R. but think about the two… One in a private practice and one in the health system. The data seems so simple. There's a guy, he happens to be an MD. He has a specialty. He has these demographics, but just because the facility is, whether they're working on any particular day or are they permanent or are they part-time. It's a fairly significant problem. Imagine, outside of the health care world, we call this "the supply chain management problem". That means, based on the supplies that I have in the services that I perform, who are all my providers of services, the contractors. There are entire companies. They go in and manage the supply. The supply chain for other companies. That level of expertise is what we need here. Think about how hard it is and that's just one example that I gave you. Now, add-on the ability that one physician and this isn't about where he works, but about what value networks he belongs to. The accountable care organization or other places. You start to see this gets very, very complicated very quickly. It's not a technology problem, per se, because we know how to connect data. What is the minimal amount of information that I need? What open source packages could we put into place, where we can get the national provider identifier to gather the facility information and so on. Unfortunately, part of this network management is proprietary. If you have a really good, solid network you don't want everyone to know about that network because you built that narrow network that's got the best physicians in there. You've done a lot of work and it's not that easy to just say: "Okay, let's open this up and go share this around as well". It's a foundation of mental health.

Don Lee: Yes. That's interesting.

Shahid Shah: It is very difficult to solve.

Don Lee: Yes, basically they are being mandated to share something that they don't want to share because it is their competitive advantage. That goes back to this whole… We have a half national - half private health care system, if you will. This constant struggle between, are we a free market or are we not? There's flavors of both and they are jamming together all the time like that.

Shahid Shah: That's right. I don't believe we are free market because we are intermediated system. That's a whole another ten conversations.

Don Lee: Yes. We like to pretend, though. We are exactly. We look at this from the consumer's stand point and the problems that this causes from the consumer's stand point. You touched down a little bit there about why it's a difficult problem to solve. Some of the other areas that we are going to dig into here is that, while this is the national conversation going on right now, this bad data is the problem inside the organizations, too. If you look inside of a health plan, especially if you take one of these large national plans that's grown over time and there's been merges and acquisitions, you've got all kinds of different systems that grew up at different times in there. Even within a health plan, this information is not consistent from department to department. The claims, department for instance might know, that the provider is in or out, because they have to know. Either they're going to pay or they're not going to pay. The group that's put provider directories up on a website, is not the same group, not the same system and not the same data and they are not necessarily sharing all the time. Without getting to deep into it here, because this is going to be a part of what we explore throughout the series, let's just touch on this a little bit Shah. What is going on inside of a health plan and how are they internally and operationally being harmed by this bad data themselves?

Shahid Shah: I think you hit the nail on the head when you said there is a number of different departments and they use this data for different purposes. For example, one department uses this data for credentialing. Did a provider commit any crimes? Do they have any fines? Have they had any lawsuits? So, credentialing is one area. Then, we have another area where they're using it for payments. If I'm going to send a payment out for doctor Lee, am I sending it to when he was a E.R. physician at one health system or was it for the rounding that he did in another health system? That's a second kind. A third kind is, now I need to be able to package all this up putting into my marketing sheets and I need to be able to put them under my plans and my networks, so when I'm using it for selling on the affordable care exchanges themselves, I need to present those to patients. A fourth one where they use, is that I need to put these networks together and package them up so I can sell them to employers. As we know, many health plans are directly selling to employers as a third-party administrator. They have to go in and convince somebody very big like Dell or Intel or Ford.
"Hey, you should use my health insurance company because I have all of these network providers. They have these quality scores and this is why they're very good". Just in those four examples, and there's

another half a dozen we can talk about, they're not always using a single source. Not because they don't know how, but because they are for completely different purposes. A number of years ago, when CMS laid out the initial versions of MP [00:25:01] that's the MPI master data base and there is one system called PECOS which basically allows physicians to log in and update their data. Initially, we thought that that's how physicians would go ahead and update their data, manage it. But remember, [00:25:18] and MPIs and PECOS are really for CMS. If you are a Medicare doctor taking Medicare patients at Medicare as well, then you have to be a [00:25:27]. If you're completely commercial, you're not going to be in any master directory anywhere. The purposes are different. The sources of data happen to be different. We really haven't reimagined, that's what we really need to do if we talk about this over the next series, is what does a reimagined approach look like in a crowd sourced way? Where we are going to go ahead and pull this data together inside of a health system, but doing so in a way in which we're a part of the network? I always like to give the example of the domain name system on the internet. There's no one group that would benefit from everyone knowing where every website is, but all of us do in general. We created back in the 70's, this idea of a domain naming system. Whenever I want to know information about you, I'm going to call you directly and you are just going to give me that and then I got a whole bunch of technics for cashing it and pushing it all up and down. The data about your domain and where you happen to, if you go to "http google.com", "google.com" owns that record and there's a standard way they expose that record to any groups that they want to. Then, there are domains named "packaging people" who grab out all of those packages, make them cash, make them available and all kinds of stuff like that. There are the fundamental uses of the data that are different which makes the lists of data different. Then, because we don't actually have a good, sound strategy for the fact that who is responsible for a physician's data. Is a physician responsible or is the health plan responsible? The answer from CMS is "the health plan is responsible", because they are their contractor and because they are selling something to their patients. In long term, does that makes sense? I don't think so. I think that there has to be some kind of combination of the two, where physician owns part of that information. The payer owns part of it. Portions of it are shared or kept private, because of network requirements and for keeping proprietary data, proprietary.

Don Lee: Even from the provider stand point as well, that's another area where the ultimate source of this information because they are the

information. Likewise, with the health plans is because they too struggle internally because of this. The example is the same. You've got these large health systems, they've grown up over time, they've acquired clinics, they've acquired different practices and everything is pulled in and under this one roof. As you described earlier, you've got the 15 health plans that they're contracting with. You've got ACO, you've got Health home, you've got a Medicare Redesigned Program growing and all these different groups and factions within the health system who all need this information as well and now they're struggling with the same thing. The information all resides within the health system but the [00:28:10] don't have it all or don't have most up-to-date information. Maybe there is a call center in the hospital that's managing referrals for the network and they don't have the proper information. Some of the things that aren't front and center on this national discussion about the provider directories but all of that stuff at the end of the day, cost us money. It slows down the delivery of health care. It probably inserts errors in delivery of health care. It's almost just as if we're working a bit sloppier than we need to, right out of the gates when it comes to this information.

Shahid Shah: Nobody is taking control of it, right? Who here is accountable as it goes to a same question. No, you're never going to walk into a scenario where somebody says: "Oh, yeah, provider directories have been solved, they're working great." Like when you were talking about infection and control, everyone agrees that this is the problem. The issue is that health insurance companies might be waiting for CMS. Health care providers might be waiting for their insurance companies. What you really need is somebody in the middle. A lot of bought a AHIP that's America's health insurance plan associations. Innovations lab has done as to say "Okay, let's assume this is our problem. Between all the health insurers. What would we do? What would we do from the architecture perspective? From a business architecture and technical architecture perspective? What would we do from the monetization perspective? Do we start paying people to keep their data up-to-date? What would we do with the data sharing perspective? How much of our network participation in one plan or another should be made public versus private?" When you start to look at this, unless we as a group, somebody comes up and says: "We are going to take responsibility to go ahead and put all of this stuff into place." Then, there are people that are accountable. That have to make these phone calls, which currently happen to be the insurers by the way. They are accountable at least in principle because of the memo from the late 2015. that says "25.000$ per inaccurate data". We know that there are some folks,

for sure when their health plans being payed to do this job. What they lack is a really good, crowd sourcing, multi institution, multi stakeholder, multisite model which is an open system. Everybody is expecting that the government is going to do this but that's not about to happen any time soon.

Don Lee: The accountability that we're talking about here needs to be applied to appropriate place, because the other issue and it's what we'll see as we dig through this and we start talking about why does this issue exist and in particular, why does it exist within an organization. As if that accountability has placed at a point too far down or it doesn't solve the global problem. That's where you'll end up with the bunch of different people who are solving their problem. That's when marketing will be focusing on their data, making sure their data is really good and maybe being willing to share with other people but not necessarily being willing to trust the import from other departments. That's what I've seen in my travels. The best example would be sitting in a large health system and we had the health system folks there that were managed in provider directories or the provider data at the top level. We also had an ACO that was affiliated with the hospital and a Medicaid redesign team all affiliated with the hospital. We sat in the room and looking at provider records we pulled one up and it was literally the first one we pulled up that we could find that was part of all of those groups. All three of them had different information. Then we hit Google. Google had a fourth version of this provider's address. As it turns out, this provider had recently moved their office and there is good reason why there would be this information disparity across the groups, but it was the very first example we pulled up was that bad. Are you kidding me? That's the level of the problem that we're dealing with here.

Shahid Shah: Yes, and then the Google example that you gave is a good one. So, this problem exists outside of health care as well. That's why whenever we're looking at this, always look to outside of health care about how this has been resolved. Google does this, Bing does it, DNS domain services do this. In Google, if you were to put in your address and it was incorrect there's a button there that says "Claim this address for Google and centralize." So, claim it, update it and then, over time, that'll get updated. Now, in the case of a DNS system, for example, you don't have to claim anything. It's your data. You provide it and there is no benefit to anyone else other than you to keep that information up-to-date. If a practice or a health system or a hospital owns a website they would

never let some other group manage their domain. Let's call it "Shahid's clinic.com". That's my business. I want people to come to my business, so I own that domain and as part of Shahid's domain .com I have subdomains, I have email address information. I have an IP address or server information. This is very similar to what networks do I belong to. What facility am I at. If we got together and partnered with system vendors and others like EHR's and revenue cycle management and others to say how is this being solved from much more complex kinds of things outside of health care and how do we apply that. Could we then make that open source with open API's? In a way that the broad data that was necessary, is made available for free and used by everybody. But then portions of it. Like the network that we talked about. That would be the one to keep proprietary, make the money on it. Then you can actually build people. There are people who manage your domain name services for you. You can hire people to say "Okay, you manage my local directory. When you'd managed my local directory for me it's all in my location, it's in my system and anybody who wants it can come look". This is different than if I work with five different health plans and five different, any particular health system will actually deal with dozens of health plans, dozens of partners. They are now responsible for making sure all of those people have the updates. What if we just created a shared system or everybody just manage their own data and through a federated capability from us to connect back and forth, we were able to pull that together. That seems like magical thinking, but that's how trillions of dollars of work is done on the internet, literally all day long. Because we got together in the past, engineers got together and said "It's really important for me to know who you are and who I am. What materials I have at my places where my facilities are? Where my addresses records are? What's my contact for this? What's my admin?" It's actually quite similar about the 20 pieces of information that I'm saying. Instead of saying that there's a huge problem, it's unsolvable et cetera, let's say "How is it being solved elsewhere?" and we'll find it's not as unsolvable as we think it is if we make inroads toward this with the proper, accountable people at the associations or at others that are looking outside of government for this help.

Don Lee: Yes. I'm with you on it 100%. I see that the only way to solve this problem at any kind of global scale or national scale is that somebody does have to produce the solution that ultimately becomes the easiest way to get the best data. That's when folks are going to come to [00:35:14]. Good question is, in this market we eluded

to it earlier, there's still plenty of competition. How does the market come together? Treat this as a problem that's not of competitive nature. It's almost like dial tone type service for the industry. Can we do that? Can we get enough people onboard at this stage in a game that they'll put that stuff aside and they'll say "We just need to solve this problem because it's impacting our business down the line. Let's do it together."

Shahid Shah: Yes, I think the answer is yes. Just because of the work that we're doing where with the AHIP innovation lab, we know that's true. There are very nice, big payers who wants to solve this once and for all. Let's just do it for the industry. You have some very progressive thinkers in that particular way. I'm not worried about that. The question basically boils down to… I think if we can get the agreement that if you are accountable for an inaccuracy in your data, let's imagine in my fantasy world, where everybody who has a domain name system or has an email address as part of their DNS record they now add this basic information about their facility, what their demographics look like et cetera in this fantasy. Once we do that, if there is ever an inaccuracy, you can always blame the person who manages that record. Not the 500 people that have been pulling from that record, but the person who created that record. That's how it works in the real world with domain name systems and others where if I have a problem with getting to a server because you told me that your server address was "1.2.3.4" but in fact it was "2.3.4.5" when somebody doesn't get there I don't blame the browser. I don't blame the person trying to get there. I blame the person who created that record. That's the real accountability. That's what I mean by the first part. I think the people will get together. If we went to 10 large health plans to each one of them and we told them to put in 100.000$, we'd have enough money to start this. I think that's actually not the hard part. The hard part is, can we agree that the federation is the right approach? Can we agree that decentralization is the only way that this is going to work? Can we push accountability to the only people who'd ever actually know that information? The patients are never going to know it. The health system can't possibly know it without checking and when they do check, they have to ask somebody at the facility. Who is it at the facility that would know what different addresses that they use. We got to figure out where that accountability lies. Once we can figure that out and get some common understanding that the accountability is at the plan or at the provider, or the health system or the institution. Once we do that, then I think that the "go forward" plan is actually much easier than it looks like. What we're really looking for is a high accuracy,

least disruptive, as much regulatory compliances possible. We do this kind of work in other industries, it does work. We just have to say that our old style centralized approach isn't going to work and that unless we say that the person who is providing the data is responsible for that accuracy of the data, how can we ever solve this problem.

Don Lee: Yes. From the government's perspective, the CMS has put out there and they look out to California is the odds on favor right now for that accountability is to be square on the health plans. I think the only question to be answered at this point is, are they're going to keep it there or are they going to distribute that out across the providers and come up with different ways for there to be financial incentive on the providers as well. I think that's what the industry is still sorting out as well. Would you agree?

Shahid Shah: I think so and I don't actually mind that the health plans are accountable for because it is the health plan that I have as a member, just like in your example, my contractual relationship is with the health plan. They are effectively telling me something about the service that they're offering and the subcontractors that they are authorized to work with me. So, it is their problem. There is no question about that. The real question is, are these health plans willing to say "Hey, whenever you send me a claim, you also have to send me your updated information about the provider directory and if you don't I'm not going to pay your claim." That one piece… Again, this is in my fantasy world where you could say "let's put in… it could be incentives. It could be carrots sometimes. Sometimes it's a stick." The health plans, what they are basically saying is "We don't know, so we're just going to call you up once every three months." Then, you have hundreds of health plans calling tens of thousands health systems all the time and their data doesn't work. I actually don't mind if the accountable party is the health plan. The question is who is accountable for the accuracy of that data and will health systems, who also have the same problem, be the ones that somehow get incentivize or somehow get penalized as a flow-through. Because I don't actually have a deal with the health system until I go see them. I think that just like the California is doing, just like CMS is doing. The fines are probably pointed in the right direction. They're just incomplete, thus far as the flow-through toward those fines should be going.

Don Lee: My perspective at this point too, is it's unreasonable to point the blame, just yet, at the providers. Whether or not they are the source of some, we know they are the source of some of this bad information, but we have not given them, the industry has not given them a reasonable set of tools or a reasonable workflow to be able to solve this problem. You've eluded to it a couple of times here. If you take one provider that's got a pretty busy club, they might have 12 different health plans that they're contracted with. They might be part of the ACO. They might be part of a Health home. They might be participating in Medicaid redesign and all of those parties are all coming at them for this information now on a quarterly basis. Those are all phone calls going to their staff. Those are all disruptions to their own workflow. They're being asked that, in different intervals, to deliver the information in different ways. For my stand point right now, it's no wonder they're getting the bad information out of this providers in some of these cases, because we're going about it in a very, very sloppy and inefficient way that's prone to error. I think for today's conversation the fines and the pressure has been applied at the appropriate place and bottom line is, it's going to have to be a industry solution. All of these parties and all of these stakeholders are going to have to participate. So, that's what we'll be breaking down now over the course of the next six or so weeks, six or so episodes. We are going to take the typical approach that we do on the HC Biz Show to this problem. Which is the **what**, **why** and **how**. "What is this problem" and we're going to get a little bit deeper into each of this different levels and we're going to talk to providers. We're going to talk to health plans. We're going to talk to consumer groups and potentially, even talk to some government folks to find out what is the perspective. How are they suffering or how are they feeling with the pain of this issue, just to make sure that we really understand all of the different perspectives here. Because it's such a global issue I don't think you can hope to solve it, unless you truly do understand all of those perspectives. We'll start there, then we'll dig into our "why". Why does this problem exist within each of those verticals and why is it become such a hot button issue today, when it's been around for quite some time? And then finally, of course, our favorite part is we're going to start talking about how to fix it. We do see groups across the country coalescing to put solutions out there. We've got private market companies putting solutions together and aggregating data and cleaning it up and putting it out. We've got industry groups trying, we've got innovation groups trying. There's a lot of interesting people that we're going to get to talk to. Along that solutions front. Then, of course, at the very end of the series, Shahid, you and I will come back together and we'll put all of this together and put our spin on

everything that we've learned across the course of this show and talk about what we see as somebody's solutions and some of the things that we're actually working on.

Shahid Shah: That sounds terrific. As an example, if we conclude that a centralized model is an insane model, let's stop anybody working on central should stop working on that, right? And if we agree that the federator decentralizes, we got to get out this idea that there is one solution to everything and there is one database in the sky that's going to manage all of this. That's what I think what we will find over the next few parts of this series. It's unworkable in the same way that there is no way there can be one holder of all data across the internet. There can't be no single holder and that's what we need to work towards.

Don Lee: You look across the internet, another industries and worthy solutions are going and that's what you're looking at with blockchains and things like that. All these new technologies are coming out to decentralize, decontrol and to decentralize the potential for error and the wrongdoing. The potential for error and mistakes in causing problems and for lock another people out. I would definitely make sense that that's a good way to look at this problem. I look forward to digging in with all of these folks. We got some really interesting interviews lined up. We've actually already completed a few of them, so we're going to start cutting those up and getting them out to you.

Shahid Shah: Yes, sounds exciting.

Don Lee: Awesome. So, thanks Shahid. Always a pleasure and we'll wrap up here and closing. I just want to remind everybody you can check us out. You'll see all of our shows, blog posts et cetera, at the *hcbiz.com*. We've recently started a newsletter there which you can sign up with just your email address. Really simple, plain text, weekly email. We'll tell you about new shows that are coming out. Coming up, new topics and just share some information about the things that we're working on and coming across in the industry as we travel about. Check that out, the *hcbiz.com.* Thank you everyone for joining us and we'll see you next week.

Shahid Shah: All right. Bye guys.

