The #HCBiz Show! Episode 13
PD04 - Are We Asking Providers the Wrong Questions? | Ron Urwongse | CAQH

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Don Lee: You're listening to the HCBiz show. The podcast dedicated to unraveling the mind-numbingly complex business of healthcare. I'm your host, Don Lee. Welcome to part 4 in our ongoing Provider Directory series. As we've seen so far this is a problem with many layers and "sneaky" complexity. I call it "sneaky" because the issue sounds simple at first but as you peel back the layers of the onion, you quickly see why so many people are working on this and why they are not finding any easy answers. On this episode, we talk to Ron Urwongse. Ron is a product manager at the CAQH. He's going to share insights he's gathered over the years guiding their per-view product. That's the platform that allows providers across the country to self report changes to their demographics and then to make those changes available to payers. Ron will help us to better understand why this issue exists in the first place. We'll also talk about some interesting initiatives that CAQH is leading to drive industry-wide collaboration to fix it. Just a quick note before we jump in. Head on over to thehcbiz.com where you'll find all of our blog post, podcast, videos and more. There you can also signup to get a weekly update right from me. All we need is your email address. And now, Ron Urwongse. Thank you for joining us and welcome to the show.

Ron Urwongse: Thanks, Don. Thanks for having me.

Don Lee: As you know, we are in the midst of a Provider Directory or Provider Data series here on the HCBiz show. Obviously, CAQH and the products that you put out in a work that you do there you operate right in the middle of all of this. In particular, you've put out a white paper called "defining the provider data dilemma."

Ron Urwongse: That's right.

Don Lee: On today's episode, we're going to spend most of the time talking about some of the wise around this issue. Why do we still have this problem? For anybody who's jumping in on this episode, I'd like to start out and talk a little bit about what is this problem? What is provider data? Just frame up the issue for the listeners. Let's start there, to you, what is provider data?

Ron Urwongse: Great. Thanks, Don for the questions. Provider Data is any information about healthcare providers. That maybe be individual practitioners, groups of practitioners, health systems or other institutions. Information that is

necessary to perform different business functions. Who they are? What are their names? What are their identifiers? What do they do? What kind of services do they provide? Where do they practice? How to access them? Are they in the network or out of network? This information is being used by a multitude of different organizations so that the health systems themselves, the regulators and payers as well. Patients, of course, as they need to look for practitioners to provide them with the care that they need. Some of the business functions are credentialing, claims management and ajudication and then imparticular provider directory that's a big hot topic that's getting a lot of attention nowadays. As the information changes and becomes out-of-date, we know that around 2 to 2,5% of all provider demographic data changes on the monthly basis so there is some degradation of the data over time. Becomes less reliable and becomes very costly to perform these business functions as the data becomes less reliable. There's a lot of effort, a lot of cost in terms of keeping the data up-to-date. There are a lot of stakeholders involved. You can't put the responsibility on either the payers, the regulators or the providers. It's a multi [00:03:41] problem and it requires a lot of collaboration to solve.

Don Lee: Sure. When you think about this problem, as you said, a lot of attention goes to it from a provider directory side. While that's usually important, it almost down plays the issue a little bit. We're not just talking about phonebook data if you will. I think that's what a lot of times people hear, how does an insurance company not have the proper phone numbers and contact information? How do they not know where a provider works? It doesn't stop there, it's not just about that. Your white paper frames it up and classified three types of data there. That's the demographic and that make sense. To some extent that's the facility and organizational data too, but we're also talking about here as industry-wide, and we'll get into this little more detail, is the quality of the performance data that is required to run some of these complex healthcare programs that we're working on today.

Ron Urwongse: That's right. As we're moving towards the world where we value base care is more prevalent than the quality data about the providers becomes a much more important. One of the goals of the Affordable Care Act was to allow patients or consumers to be able to shop for the right coverage or the right health plan products that would be meeting their needs. A big part of that is to provide more transparency into the performance for that quality of particular provider groups and networks of that patients can make the best decision possible.

Don Lee: Got it. That's one group that's directly impacted by this. Again, the obvious one, the patients can't find the provider they're looking for. Can't get in contact with them. Maybe they're presented with one that's not really on their network but it still showed up on the website. Who else is

affected by this? How are provider groups or health plans themselves and who else is impacted by it?

Ron Urwongse: Health plans are definitely impacted by it and I know that health plans as we're moving into a more market-centric world and patients have more choices. They're looking to provide a more consumer-friendly experience to these patients. Directories have become that much more important because as patients are looking to make decisions on what plan product they want to adopt. They want to know if their preferred providers are in the network or not. For those who are gaining health insurance for the first time, the ACA did result in influx. I believe the numbers are around the 20 million at a high-end of newly insured. That's a large volume of new consumers of healthcare that haven't been in the system before. They may be looking for healthcare providers for the first time. It's important to be able to find a healthcare provider at a location you want, who provides a care that you want, who is practicing within the specialty that they have said that they are within the directory. Those are all important aspects of it. Health Plans want to have the most accurate data possible for that consumer experience. That being said, there is also a regulatory aspect of it as well. As this large influx of new beneficiaries that came into the market and are shopping for the health insurance for the first time, they found a lot of errors and discrepancies in health plan provider directories. It came to light, not just among the patients but also to regulators, that this was their problem. In 2014, there was a dramatology study that was a little bit of a watershed study that highlighted the problem of directories showed that within 12 US metropolitan areas that some directories were as much as 50% inaccurate. That was the first time a lot of people realized the magnitude of the problem. Soon after that, you got regulatory actions from CMS, from states and some accreditation bodies as well and that increased the focus of health plans on this problem.

Don Lee: Yes, right on. That also led to similar studies from health affairs out in California, they've found very similar results and they, same kind of setup like a secrets shopper, almost kind of mode. Similar results too from CMS going out and they've released their report earlier this year assessing the quality of provider directories out there too and to your point, 50% inaccurate across the board some of these numbers are just really surprisingly bad. I guess is the simplest way to put it. To that end, one other thing that stood out to me from reading that white paper that you've put out is the investment around this. We just set up as a pretty clear problem here, we've got really inaccurate data and you've found that just commercial plans and the providers are investing about 2,1 billion dollars per year in addressing these directory issues. By their own estimation, we've talked to these folks, they will admit it. They're doing a really poor job of it. The output that they're generating is just not [00:08:38] and these reports are burying it out. Let's jump into it from health plan standpoint in

particular. They're taking all of this heat down the issue. Why did they have such bad provider data in the first place?

Ron Urwongse: It's tempting to point the finger at one particular party. When a lot of this regs first came out there was a little bit of that going around. The health plan industry was putting the finger at providers saying "if providers just omitted accurate data this wouldn't be a problem". There are some provider groups and associations who pointed the finger at the health plan saying "we're giving you the accurate data, you're just not updating it in a timely fashion". It's neither one or the other exclusively. It's a combination of issues on both sides of the equation. I've mentioned that the data degrades on a pretty frequent basis or on pre-rapid pace. That's one aspect of the problem. In a credentialing world, you submit your data and it's good for three years because that's the credentialing cycle. Now, with directory and demographic data that changes a lot more frequently. For example, the hours in which you're practicing might change. Whether or not you're accepting new patients might change. If you're practicing within the large group you may be switching locations at some point in the course of the year. All of those types of data are changing on a pretty regular basis so it's important to keep that up-to-date. Some of the contributing factors around that are that providers may not have a clear incentive to keep the information up-to-date with their health plans. While there is emerging, and increasing regulatory burden on the health plans there is a very little legal responsibility upon the providers keep their information up-to-date. Some health plans have some contractual requirements for providers to keep the information up-to-date but today, that hasn't been enforced a lot. The plans are looking at contractual levers they can use to motivate providers to keep their information up-to-date but it hasn't been used a ton.

Don Lee: Sure. That's a tricky issue too when you think about it because there tends to be a little bit of tension on that relationship already and with the ever increasing demands on the providers I got to assume it's just from that standpoint it's difficult for the health plans to put too much pressure on them.

Ron Urwongse: Yes, I guess related to that, the administrative burden is exacerbated because of the number of relationships providers have with the health plan. On average a physician practice has 12 different health plan relationships while keeping the information up-to-date for particular health plan whether it's faxing them the information or submitting it through their provider portal or contacting their network [00:11:33] is difficult. Multiplying that across 12 different health plans and with this new regulatory burden, Medicare Advantage is requiring quarterly outreach. It's a huge, huge administrative burden on the providers to keep this information up-to-date.

Don Lee: Right on. The Medicare Advantage, the penalties that they've been talking about are pretty significant too. I don't remember the numbers of hands but it was like a large per...

Ron Urwongse: Yes. It's 25000$ per day per beneficiary for Medicare Advantage.

Don Lee: Yes. That's just enormous. Have they started to enforce that or come down on anybody? Has anybody paid that amount for being out of whack at this point?

Ron Urwongse: Not within the Medicare Advantage rules, they haven't. CMS has been monitoring Health Plans providing pretty detailed reports on some of the sample analysis they've done on the directory. There haven't been a secret shopping, per se, when they do call up locations and perform these monitoring events. They're identifying themselves as CMS but they're making clear it's for the purpose of keeping directories up-to-date. They haven't yet but there have been, I don't have the numbers off the top of my head, but I know there have been cases of fines in California, New York state. I think even before a lot of the formal regulations came out there. The Attorney General's office instituted some penalties on health plans doing business within their state, too. There are examples of that and I'm sure CMS will be moving towards that over time.

Don Lee: Got it. I want to talk a little bit more about the provider's side of this equation, but one last thing on the health plans before we move on. Do the health plans do a good job of sharing this information amongst themselves internally? The reason I ask this is I had a reporter reach out to me recently and she was coming at this from a consumer side of things and her question was simply "If I go to the doctor and I get serviced on and they submit the claim to the insurance company, that insurance company will know right away that they don't have to pay that claim because that doctor is not the part of their plan. How do they not know, at the time of putting these networks up on the websites for instance, so that when I as a consumer look at them, I can find out whether they're in or out?" She was looking, basically, her question was "where is that disconnect? how the two groups within the insurance company do not know the same truth?"

Ron Urwongse: That's a good question. I think one that we're getting some more insight into as we're peeling back the layers. It's interesting when we talk to health plans about solving the provider directory problem. As it relates to other functions within their organization that requires provider data. The fact of the matter is some of these functions have performed pretty independently in the past. I don't like to use the word "Silo" but big organizations will have silos sometimes. Most health plans that we're talking to are making

efforts to break through those. Increase the level of data sharing among the claims group with the [00:14:35] provider data functions and with the credentialing and other areas of the business that require good provider data. That is also a theme in solving the problem is when you got a good provider data in one part of the organization and it really needs to be shared across the way and there really needs to be an enterprise approach around solving the problem. It can't just be a point solution if you will.

Don Lee: Yes, I agree with you 100%. It's got to be dealt with internally and externally if you will. Otherwise, one doesn't matter. From the provider's side then, that's the simple question is, and it's usually what I get on this, simple questions. Why aren't the doctors updating this data? Why can't a health plan go to NPPS database where the providers are all supposed to be registered and keeping things in there? Why can't they just go there and get the information they need for these provider directories? I know in the white paper, you guys cited a lack of accountability as a driver here. I wanted to get into that a little bit. What do you mean a lack of accountability drives us towards this problem?

Ron Urwongse: I think that a part of the problem, the lack of accountability and that goes back to the incentives and penalties into the provider. There just aren't a whole lot right now and we know that there are some health plans who are experimenting with models for their incentivizing providers to submit accurate information and potentially imposing some level of penalty, whether it's removing from a directory or something more claims related. There's some experimentation going on there and I think that's part of it. As providers or any party who's doing business within the healthcare system, they're going to be motivated by incentives and disincentives. That being said, I do believe that providers and health plans wanted to do the right thing. CAQH did some surveying of providers who are using our system to keep provider data information up-to-date. We're asking them why are you doing it? This was all the providers who are regularly updating their information and then testing to it, on multiple times a year. A majority of them are saying because they want to keep directory information up-to-date, they want the patients to be able to find them and they want the health plan directories to be up-to-date. I do believe they want to do the right thing. I think the health plans want to do the right thing too. I think of a big aspect of it is when providers are submitting information to a health plan or to any other organization they're trying to accomplish their job. When it's credentialing, it can't be for one reason. If it's group rosters to health plans, it can't be for another reason. We've done some interviews and surveying of providers [00:17:16]. Why are you submitting so many locations to health plan directories? That is really the bulk of errors that the regulators are seeing. CMSs said that 66% of directory deficiencies are provider data location. We ask providers why are you submitting all these locations? They're saying "well, as a provider

I may practice there at some point in the future. I may cover for a colleague. If I submit a claim from that location, I don't want it to be denied." Ask any group that's submitting [00:17:51] number of locations, do they have past experiences for when that's happened and they all say yes. It's not a universal rule, I've talked to a health plan on Friday last week and they said "we don't have any business rules around claims now based on location" but many health plans do, at least some of the time and providers are seeing that behavior and saying "I'm going to [00:18:15] cover my basis in all those locations". The job that they're trying to accomplish by submitting this data is they're playing defense if you will. They're trying to prevent claims denials. If you foot the question around it and ask which of these should be published in the directory or how often are you practicing here or are you just covering for colleagues here? Providers are answering the question in the right way. I believe health plans can use those answers to keep their directories accurate, much more accurate than they had before. You're meeting a provider where they are. You're understanding the job that they're trying to accomplish. The multiple jobs they're trying to accomplish. Giving them the right tools to be able to communicate the information the right way. I think the accountability and incentives and disincentives as an aspect of it, but I think giving the right tools and the right channels for providers communicate the right information is an even bigger part of it.

Don Lee: Yes, absolutely. I've never heard that angle from you before. That's really interesting about them playing defense on the claims denial side. That sounds like, basically grounds for an education issue here. It's not necessarily accountability because as you said, that when they asked the question in the for the proper framing, at least the proper framing for them, they answered correctly. When that framing is taken away, they play a little bit of defense. They're trying to go above and beyond almost in anticipation of an issue. To me, that's a big education issue to make sure that the providers know what this data that I'm asking from them... What is it going to be used for? How is it going to be used and how is it going to impact them? That's a really interesting one.

Ron Urwongse: Yes. I think that bidirectional aspect of it is super important too because a lot of times when providers are submitting information to health funds they say "It's like working on all this information, filling out all of these forms, it might be like falling into a black hole." I've heard that quote at least once. Providing feedback to the providers, letting you know that the information is actually being looked at. What we've seen, as well, is that if you find errors or discrepancies in the data that providers submit and you call them out on that. If you let them know that you're looking at it and you've noticed there's an issue with the data, they are incredibly responsive. We've done some experiments around this where we call out very specifically. You've mentioned that you're practicing at this location,

we did some sample phone calling and noticed that you are not actually or this phone number is out of date. Could you please fix it? Over 80% of those providers are coming into the system within two weeks to update their information. It's a great response rate, I think engagement is important. Letting providers know how their information is being used and that you're actually paying attention to it, I think it goes a long way.

Don Lee: Yes. Absolutely. If I've been getting all these requests and I don't think you're going to used it for something useful, then I'm not going to be inclined to get back to you. Certainly, within two weeks, that's a pretty reasonable turnaround. Would that at least fit within these, some of the regulations that we've seen? Two other issues that I think play into this that I'd like to touch on. One is you gave an example, again going back [00:21:26] on the white paper, you said in a typical practice. Take five providers, they're having unaverage 12 contracts. Each of those 12 contracts are looking for about a 140 data points. You're looking at 8400 data points. Now that this one, relatively small five provider practice is providing. If there's any amount of, maybe they don't understand what the data is being used for or the data is being requested at all different times and in different ways from different people, that's got to be contributing to this confusion too, is it not?

Ron Urwongse: Yes. I think that just the scope of data that's being requested is resulting in the complexity and the effort and cost required to maintain this information. Some information changes more frequently than others. [00:22:14] information about how the provider practices at a location if they're accepting new patients. That can change fairly frequently. Their specialty and education may not change as much or not at all. Of the 140 data elements, there's some breakdown of information that changes a little bit more frequently than others are. Your point is right that the scope of data that is necessary it's an increasing scope. It's making it more complicated for the providers to keep that information up-to-date. I'll just say it that some of the regulatory requirements that are being implemented around health plan provider directories from the state's specific perspective and for different CMS rules, they're increasing the scope of the data that is being required. It's not just irregular like what addresses is this provider practicing at? What phone number can I make an appointment at? Has cultural confidence training been taken by this practitioner? What languages do they speak? What languages do the staff speak? Accessibility of requirements around in a wheelchair access, restrooms. It's all important but it's just an increasing scope of data that the providers have to keep up-to-date which is contributing to the complexity.

Don Lee: That happens way to much with regulation and what industry standards in general is we look at the problem here that we're already doing a poor job at saying "Let's fix this up and while we're at it let's ask for a whole bunch

more stuff on top of it." It would just make so much more sense if we could sit back and agree on "What are the minimal things that we definitely need to get done? Let's get those right and then start to expand on all of those other things." I think that would take a lot of heat off of everybody involved.

Ron Urwongse: To be fair, CMS has done a pretty good job of prioritizing deficiencies to be solved. It's part of their monitoring methodology. They've waited for different deficiencies at different levels. I think that shows that while they've made a lot of requirements for health plans they are prioritizing some over others. I think that's important not just from the regulatory perspective but from the health plan and provider perspective as well. If we're going to solve this very complicated problem we should at the beginning be laser-focused on the biggest problem and then move on from there. I think that's what we're seeing with a lot of the health plans that we're working with. Perhaps, at the very beginning when the regs first came out, there was a temptation to boil the ocean and to solve all of them at once. From a compliance perspective to be as conservative as possible, you want to solve for as many of the requirements as possible. But in the attempt to do that, you may not be doing justice to the top priority area. We've seen an evolution in the industry where there is a prioritization of those deficiencies that are both most prevalent and the most highly waited. I think that's the right way to go. Kudos to CMS for prioritizing in conveying these priorities to the industry as well.

Don Lee: Yes, I hear you. That definitely does show through in their report that they put out early in the year. Like you said, the waiting of the different issues and trying to penalize most [00:25:20] for the things that impacted access most directly for the patients. That's a really good point. I'm glad you circled back to that. One other item here that I wanted to pull back to that ties in with the location issue, how does the fact that we contract at the group or the tin level play into all of this? What I'm getting out here and it's early, you were talking about the provider, reporting that they work at a particular place, just in case. Another way that I saw that issue be explained is that all of the information that is getting reported back to CMS and back to the health plans is getting done at the group level. I've got the group and it might not be the case for these small five doc practices. But If I've got a group that's got 100 docs and we've got 25 different locations across town the contracts get done at the group level and the provider directory information then also get submitted at the group level. So, I have a doc that works at a location X getting reported as also working at a whole bunch of other places that they don't work at.

Ron Urwongse: I see what you're saying. That's something that CMS identified it as well in their first round of [00:26:28] and they said that one of the biggest drivers of this provider not at location issue is group submitting all

locations for all providers within their group and I think that goes back to this defensive mode that the groups are playing. They want to prevent claims denials. I guess legitimately within a group a practitioner can't cover for a colleague at some point in time but if they're not practicing there on a regular basis this location shouldn't be published within the directory. That's a big driver of it, these groups were submitting either group rosters or even through portals in on-a-provider/by-a-provider basis. There's a temptation in we've observed some practice by these groups of submitting all these locations. In particular, with group rosters is groups are uploading those to plans. Those files may not have appropriate flags for a location that needs to be on-record for claims purposes only versus directories. There's some aspect of it which is defensive and there is another which is there's just no good way to communicate where the groups need to communicate.

Don Lee: Got it. Okay, that makes sense. Are there any security issues at play here? One of the reasons I asked that is a lot of times in healthcare inner op and healthcare data there's a reluctance to share because of these security concerns and privacy concerns. Obviously, we're not talking about any patient data directly here, but curious. Did you see any of that at that where the providers are concerned about their information being out there?

Ron Urwongse: As it relates to the directory, maybe not as much because most of this information is publicly available, that's the purpose of the information is to be published within directories for consumers and the general public to be able to access. In fact, some regulators are requiring that directories are not behind a log-in wall that any consumer who is interested in looking would be able to find it. I guess there may be some reluctances as the directory requirements expand, as quality plays a larger role in it there may be some sensitivity around that. Thinking maybe of identifiers that might be sensitive from the provider perspective of, you've mentioned that your groups are submitting things at the tin level. Your tax identifiers are sensitive value so there needs to be a proper security control at some place for that. That may be some concern but I don't see it as an over-arching concern.

Don Lee: I think that's where I was going with this. Once you start getting anywhere near the competitive space around this data. I think that might be where you could have people climb up a little bit. That sounds like you're not seeing too much of that. Last question here and the "why area" is, I think you touched on this already, but I want to give you a chance to expand if you want to. Why did it take so long for anybody to start caring about this problem? Why is it all of a sudden that now the states and the feds and everybody is getting on board and saying "This got to be fixed, it's got to be fixed now"? Why did it take until basically this past year for that to start to heat up?

Ron Urwongse: The wave of the regulatory requirements started in the spring of 2015. If you work your way back there the drama dramatology study came out in 2014 and then the Affordable Care Act was sometime before that, I forgot the exact date but the ACA resulted in that influx of 20 million or so, new consumers of healthcare so this larger volume of patients looking for care who perhaps hadn't had it before or hadn't had irregular relationships with healthcare providers so that was new. I also say another contributing factor to that it's just the time and age we're living in. By 2015 if you just take a look at the overall US workforce. Millennials' by 2015 made up a plurality of the US workforce. There is just really high expectations from consumers in a rapidly digitizing world. In this day and age where we can pull out our smartphone and get an Uber car or a lift car or order a pizza and know exactly when the pizza is going to arrive at your house. There are some very high expectations from a consumer perspective on the reliability of information and being able to get services on demand. 15% of records within the directory are potentially inaccurate and there is in narrow network situations becomes increasingly difficult whether our provider is in or out of network. All of those factors converged and resulted in a situation we're in right now and the regulations had have emerged after that and increased focus from the industry on this problem since then.

Don Lee: Yes, that makes good sense. I think the increased scope of the data too that you've mentioned plays into it just at the more complex are programs, the more data we need to know about the providers. As everything that's going on that you just said, I'm shining the light on it, it's also getting more difficult. One other thing too is the expansion of care team. The provider is not just a doctor anymore. There's a lot more people that need to be kept track of in this regard. How does that plan do? Do they have on the health plans with the provider directories is that an issue to keep track of all the nurse practitioners and physical therapists and all of the other people that are starting to take a more active role in this care model?

Ron Urwongse: That exactly right. As we see more care being handled by non-mddo practitioners and health plans want to be able to publish those types of practitioners within their directories. You've mentioned MPs also PAs.You're increasingly able to make appointments with nurse practitioners and physician's assistants. Especially in the behavioral space as well. There are the increasing number of non-MD practitioners who need to be published within their directories often times by regulatory mandate. We're seeing a lot of that within our CAQH Proview platform, that is a source of the highest growth of provider adoption is among non-MD, non-DO practitioners. We're seeing a lot of them.

Don Lee: Very good. So really a perfect storm of scenarios all coming together here

right at the time we've got the influx of 20 million patients. You've got the plans getting more complicated and you've got studies coming out that are shining light on. All of that together that makes perfect sense that we've been hearing as much as we have about it.

Ron Urwongse: And we've seen a lot of activity on the solution side as well. CAQH has its initiatives but health plans are experimenting with their own efforts. We've seen some other associations do some work. I think that's what regulators wanted. The exchanged requirements required the publishing of machine readable files. They were hoping that was going to motivate more innovation within the industry. We've seen a lot of that. I think experimenting with a lot of these different methods is going to eventually produce the right solution, but there's no silver bullet here. It requires collaboration. It requires continuous improvement. It requires data and measurement of data. I can't stress that enough that any health plan hoping to solve this problem for themselves needs to have a really great understanding of their own accuracy baseline and measure that over time.

Don Lee: I think that collaboration is huge and let me ask a little bit about that. How do the health plans and providers, in particular, those that are in competition with one another? How are they coming to the table together and collaborating on this issue while they're also still in a competitive mode?

Ron Urwongse: As we interact with health plans on this topic, what we've heard from them is that they view this as a non-competitive function and non-strategic function. One where collaboration is also not harmful in terms of trying to solve the problem but perhaps even necessary to solve the problem. I've mentioned that the 12 different health plan relationships that the average physician practice has. If we could reduce that and we're not reducing the number of relationships if you could reduce the number of channels in which the providers are being requested to submit information, that's a win on a both sides of the table. On the health plan and the provider side.

Don Lee: Absolutely. You guys actually recommended that one of the keys to the solution here is to reduce that provider burden while simultaneously increasing their accountability. I love that. You can't just ratchet up the accountability before we've given them the means to actually deal with this problem.

Ron Urwongse: That's right.

Don Lee: A couple of other items that stood out to me I'm getting that concept of building, what is that smallest data set? That minimum data set that's going to be needed for this? The paper laid out if I counted it correctly

there were 18 elements in there. To my point earlier, I love that approach as well. How do we solve the barebones problem first? I think that's a really smart way to do it as by limiting that data that you're going after. One other item that I wanted to point out is that you called for regulations to stay at the high level and to really focus on the primary goal. Again, I think that's the key because a lot of times you'll see regulation creep if you will, that can be harmful to the things like this.

Ron Urwongse: I think that's right, keeping it at the outcomes level and not necessarily at the approach with the methodology level would be ideal. It's tricky because regulators have got a really great view on the entire problem because they are looking at things at the industry level. Health plans, in particular, are interested in the perspective that the regulators have as they're performing monitoring efforts and how they see the relative prioritization of different types of the components of the problem. There's an interest to see how are they viewing the problem? What kind of guidance may want to present? In terms of being prescriptive on the approach, that's something that may limit the innovation. I think we're at an okay place where it's mostly focused on the outcomes and the industry has a lot of room to be able to innovate and experiment with new approaches.

Don Lee: Got it. CAQH has the Proview platform, which obviously lets the providers come in and update their information with the idea that would be disseminated out to many health plans, thus reducing that number of touchpoints for sharing their data. What are you guys doing right now to take that platform, expand on it and head down this path of industry collaboration? What steps is CAQH taking towards this problem?

Ron Urwongse: You've mentioned CAQH Proview platform, it's been around for a long time, 15 years. Even before the regulations came out in 2015, we were making strides towards making it a channel for provider data beyond credentialing. Credentialing was the initially used case. The directories being able to submit data for claims purposes as well. We've been building on top of the platform, we've got really great adoption by providers. 1,4 million healthcare providers and they're coming in on a very regular basis to keep their information up-to-date. What we've done is to help solve the directory problem is to make it absolutely clear for those providers coming into the system and reviewing their information. This information is being used for directory purposes. We're listing out the health plans who have express interest in consuming those provider's data for directory purposes and for updating those particular records. In addition to that, we're asking better questions within the system. We are asking those more detailed questions about the nature by which providers are practicing at specific locations. How often are they practicing there? Are they actually able to take appointments from patients at specific locations? In addition to that,

we're performing a lot of outreach. The Medicare Advantage rules require quarterly outreach to providers were trying to collapse the amount of outreach that providers have to receive from health plans to just one a quarter from their health plans. As more and more health plans are adopting CAQH solution, the number of communications that providers have to receive from those health plans will decrease. Ideally, they'll only get one a quarter from all the health plans over time. We're taking steps towards that goal.

Don Lee: One a quarter, I think that would be welcome to many providers listed out there, so good luck to you on that front. In closing here, where can people find out more about you, CAQH, the platform? Whatever else you want to share?

Ron Urwongse: You can find more information about us as an organization at CAQH.org. If folks are interested in learning about the provider data action lines you can go to CAQHproviderdata.org. There are information specifically about our solutions about our provider data management. You can go to www.providerdatamanagement.org

Don Lee: Awesome. The white paper, last I've found it, it was linked up right on your homepage. Is it still pretty front and center there?

Ron Urwongse: It's still there.

Don Lee: As I've mentioned, I highly recommend anybody who is interested in learning more about this problem, start there. It's one of the best breakdowns, I'd say, of the problem that I've seen. From defining what the issue is and that it's way more than just a health plan problem. A walking through all of the data elements and some of the used cases in the problems that are behind it. And again, some of the ideas around solutions. All around, a great read, highly recommended. I'll link all of those things up including the white paper in the show notes here. That would do it for today. I just want to say thank you, Ron, for coming on and sharing with us. It's been very informative. I greatly appreciate it.

Ron Urwongse: Thanks, Don for having me.

Don Lee: Awesome. Have a great day.

Ron Urwongse: You too. Bye.

