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Provider Enrollment and the Patient Protection and Affordable Care Act

Testimony Provided to the Subcommittee on Standards National Committee on Vital and Health Statistics

Gwendolyn Lohse
CAQH Deputy Director/CORE Managing Director
glohse@caqh.org

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Testimony Overview

- Introduction.
- Looking at Enrollment: An Integrated View.
- Sharing of CAQH Valuable Experience.
- Moving Forward: Recommendations.

Appendix: NCVHS Enrollment Questions.

Attachments: 1. UPD Participating Entities.

2. UPD Overview.

3. Provider Data Summit Agenda.

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Introduction

- This testimony is presented on behalf of CAQH, an unprecedented nonprofit alliance of health plans and trade associations serving as a catalyst for industry collaboration on initiatives that simplify healthcare administration. Of particular relevance to this hearing is:
  - The CAQH Universal Provider Datasource (UPD), an industry utility that replaces multiple paper processes with a single, electronic and uniform data collection process.
  - The CAQH Committee on Operating Rules for Information Exchange (CORE), the only national effort solely engaged in the development of operating rules for the facilitation of administrative healthcare transactions as outlined in previous testimony.
- The comments today are based on CAQH's extensive, collaborative industry experience in healthcare enrollment through:
  - The development, maintenance and enhancement of the UPD.
  - Authoring operating rules that address HIPAA transaction provider enrollment.
  - Collaboration with Standards Development Organizations (SDOs).

Looking at Enrollment: An Integrated View

- For the healthcare industry, provider enrollment efforts are inter-related when considering process improvements that can be made under the Patient Protection and Affordable Care Act (ACA) to achieve *administrative simplification through electronic and standardized enrollment.*
- The ACA has several provisions that touch upon enrollment, as do many industry efforts. An integrated view is needed when considering the scope of Section 10109 and how the application process, including enrollment, could have greater uniformity.

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Looking at Enrollment: An Integrated View (cont'd)

- We believe it is important for the industry to work collaboratively to address critical questions that will develop a scope that achieves administrative simplification:
  - What ***common definitions*** are needed for the required uniform list of data elements/data sets?
    - There are very broad definitions in Section 10109, which can be interpreted in many ways, e.g., what is meant by a standard with regard to applications and enrollment given the number of elements included in such items?
  - What **front-end processes** exist for enrolling providers for EDI, whether using HIPAA transactions or non-HIPAA interactions, e.g., use of a defined database(s)?
  - What are considered ***best practices, standards and operating rules?***
    - Are there ***existing standards to query, access and verify*** provider enrollment data? What is considered a standard, e.g., are ubiquitous file formats used to access data, and are these considered standards?
  - What efforts exist with regard to the ***electronic data collection, ongoing maintenance and distribution of the data,*** given the goal of administrative simplification?

Sharing of CAQH Valuable Experience

New approaches must be pursued to address the increasing demand, and need, for collaboration and leveraging existing solutions.

- What industry efforts exist? How can they be leveraged?
- What is the expectation for public-private collaboration? How is this working today with regard to uniformity of provider enrollment and applications?

<u>CAQH CORE enrollment operating rule experience with HIPAA transactions.</u>

- Based upon priority setting by the industry, different stakeholders working together determined that the CAQH CORE EFT and ERA Operating Rules would address provider enrollment in a health plan for both of these transactions.
- Both ASC X12 and NCPDP participated in the CAQH CORE rule writing; the draft CAQH CORE EFT and ERA Enrollment Rules address both medical and pharmacy needs.

<u>CAQH experience with enrollment using non-HIPAA transactions.</u>

- With over 700 data elements, the UPD has simplified the front-end provider data collection, maintenance and enrollment processes for almost one million providers and over 650 organizations needing provider data.
- UPD uses a number of ubiquitous, industry-neutral formats to transfer data from the registered providers to participating entities.

UPD Facts

See Attachment 1 (UPD Participating Entities) and Attachment 2 (UPD Overview)

- Launched in 2002 to support the provider credentialing process – the first step in enrolling a provider in a health plan network, or on a hospital medical staff.
- Used by physicians, allied health, behavioral, optical and dental providers.
- Over 650 participating organizations.
  - Includes national and regional health plans, hospitals, state and federal government agencies, including state Medicaid agencies and the US Army National Guard, to improve the collection of needed enrollment data.
- Over 970,000 providers have registered and are using the UPD to transmit their data.
  - Nearly 8,000 new providers are registering each month.
  - Nearly three in five *practicing* physicians (MDs and DOs) are using UPD.
  - A study of UPD transactions over a 20-month period confirmed that providers utilize the UPD routinely and update information frequently.
- Available in all 50 states and the District of Columbia.
  - 12 states and the District of Columbia have adopted the UPD application form as their mandated/recommended state form for credentialing.
  - 13 states have unique credentialing application forms supported by UPD.
  - Remaining states have no specific requirements; UPD application is voluntarily used.
- Compliant with NCQA, URAC and The Joint Commission data collection requirements for accreditation.

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UPD: Uniform Application and Provider Ownership

- Replace multiple organization-specific paper processes with a single, uniform data collection process. Key features include:
  - Access.
    - Web based system available 24/7.
    - Completely **free** for providers, with no system investment requirements.
    - Complete application online or via fax.
    - Providers can update system at any time and updates are immediately available electronically to authorized organizations.
    - Toll-free help desk to assist providers.
  - Accountability.
    - Providers are responsible for supplying and maintaining their data in the system.
    - UPD does **not** use the system to advertise to providers or to independently resell their data.
    - Providers are required to attest to their data and then are reminded to re-attest every 120 days, using electronic signature.
    - Supporting documents are imaged and attached to electronic record.
  - Trust.
    - Providers see organizations requesting data and control who can receive it.
    - Only providers can change their data in the system.
  - Transparency.
    - Data chain of custody is clear – from provider control of data entry and attestation, through visibility and authorization of data users.
- Designed to address requirements identified by providers.

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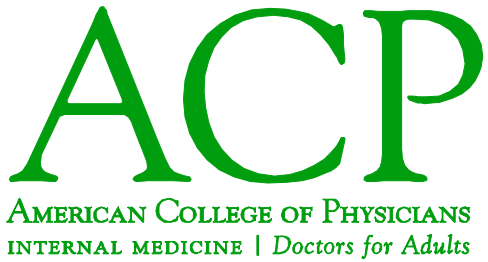
UPD: Provider Data Elements

- The UPD collects broad and robust data about providers once to accommodate multiple administrative needs for multiple healthcare organizations, e.g.,
  - Demographics, Licenses and Other Identifiers (including NPI).
  - Education, Training and Specialties.
  - Practice Details – Sites of Service, Days and Hours, Contact Information.
  - Billing Contact Information.
  - Hospital Affiliations.
  - Malpractice Liability Insurance.
  - Work History and References.
  - Disclosure Questions.
  - Images of Supporting Documents.
- Includes SanctionsTrack offering – NCQA approved primary source service that monitors and reports provider license revocations and disciplinary actions from over 480 different state licensing boards, OIG/OPM reports, and Medicare/Medicaid sources.

UPD: Stakeholder Association Support



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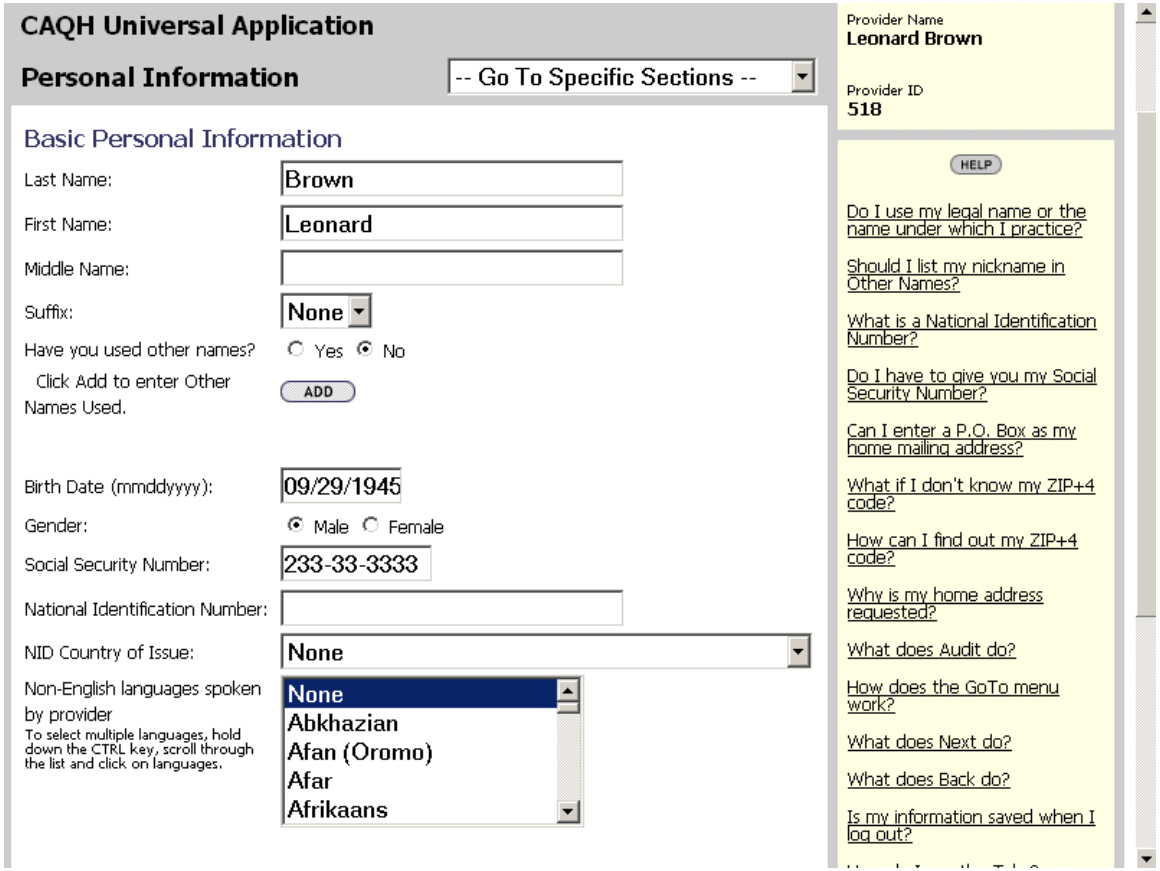
UPD: Completing the Application

The uniform online application is completed much like tax preparation software; providers can use this data to pre-populate UPD and non-mandated state applications. Alternatively, a paper application can be requested from the toll-free help desk.



Interview-style questions help practitioners navigate the application one section at a time. Drop-down menus are used where appropriate to save time and prevent data entry errors.

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UPD: Provider Application/Enrollment Efforts

- UPD data is flexible. UPD collects more than *700 data elements* and makes them available in XML, ASCII formats or replica PDF images. Users may elect to map only those data elements relevant to the specific function.
  - The average health plan enrollment forms contain the same elements, e.g., Name, Provider Type, Specialty, Contact Info, Medicare/Medicaid IDs, License Numbers and other Identifiers.
  - Many health plans have eliminated their legacy paper enrollment forms. Entities are researching how UPD data can help maintain other provider enrollment needs.
- Given the success of the UPD, CAQH has efforts underway to enhance this utility, e.g.,
  - Accuracy: An independent review of UPD data accuracy indicated that there is over 95% accuracy; expected to reach 97% in 2012 due to targeted enhancements (detailed report available).
  - Support for Large Group Practices: System enhancements underway to expand options for data input and supporting functionality for large group practices and delegated provider organizations.
  - Reducing Redundancy Across Systems: Through an independent research organization, examining ROI of expanding UPD data use for other provider data dependent functions within health plans.
  - Use by Pubic Entities: Increase number of state Medicaid agencies using UPD for Medicaid provider enrollment and, at the request of provider stakeholder organizations, continuing dialogue with CMS to explore use of UPD as a resource for evolving PECOS System.

UPD: Provider Application/Enrollment Efforts (cont'd)

(See Attachment 3 for December 6th Provider Data Summit Agenda)

- CAQH is using collaborative efforts to identify additional uses for UPD that address some of the challenges of enrollment.
  - Health Information Exchange (HIE) Provider Directories: Conducted survey with eHealth Initiative regarding HIE provider directory needs; many of the identified data elements are in the UPD; direct provider involvement in data updates was viewed as essential *(report available).*
  - Basic Provider Enrollment in Health EDI Services: Sponsored and conducted research for multi-stakeholder meeting to identify provider EFT enrollment requirements for providers and health plans. Outlined detailed options and requirements *(report available).*
  - Partnership for Identity Proofing and Primary Source Verification: Held several healthcare industry meetings on primary source verification, which is a required function for health plans and hospitals. Also discussing with the financial services industry (operating rule authoring entity NACHA, ACH industry entity The Clearing House) and others, e.g., The Federal Bridge Certification Authority - Entrust, approaches for identity goals given market maturity and cost to healthcare.
  - Additional Elements Key to Addressing and Routing: Based upon involvement in ONC efforts, outlined opportunities and benefits for administrative simplification using UPD to collect addressing and routing information.
  - Administrative Simplification Priorities: On December 6th, hosting a conference for the industry to discuss the challenges and opportunities of assuring quality, timely and accurate provider data. White Paper to be issued.

Operating Rules for Provider Enrollment

- Operating rules can be used to identify and outline the rules of engagement for specific enrollment processes.
  - What data or data sets are needed?
  - What standards and/or well-recognized best practices exist?
  - Are there health plan offerings for electronic access?
  - What players are essential to address for roles and responsibilities?
  - What is the interaction between enrollment requirements and data?
  - What are the key definitions, and how do we harmonize definitions across industries when addressing transactions or processes that depend on healthcare working with other industries, e.g., EFT and financial services industry?
  - What system availability is needed?
  - How should Connectivity and Security operating rules come into play?

CAQH CORE Draft EFT/ERA Enrollment Operating Rules: Why Are They Needed?

- Problems addressed by these two operating rules:
  - Separate, non-standard provider enrollment forms and data sets are required by health plans.
    - Variations in data elements collected, e.g., TIN vs. NPI provider preference for payment, needed for EDI.
  - Key elements are excluded from many enrollment forms that would ensure these transactions could be processed electronically.
    - Operating rules require collection of data during enrollment that is necessary for populating applicable standards, e.g., ACH CCD+ Standard and ASC X12 835.
- CAQH CORE rules to date are based on extensive research regarding existing market challenges.
  - Work has been done by organizations such as WEDI and AMA over many years to identify process issues.
  - Collection and evaluation of over 100 enrollment forms from a range of public-private health plans, e.g., nomenclature and data element use comparisons.
  - Input from more than 120 stakeholders participating on CAQH CORE Rules Work Group via straw polls of documented findings and discussions.

NOTE: *Detailed research, Work Group straw polls and discussions informed the development of draft rules and is documented.*

CAQH CORE Draft EFT/ERA Enrollment Operating Rules: Scope and Requirements

- Scope of the operating rules:
  - Applies to entities that enroll providers in EFT and/or ERA.
  - Outlines what is out of scope for the rule, e.g., the collection of data for other business purposes and how health plans may use or populate the enrollment data.
- High-level requirements for the operating rules, e.g.,
  - Identifies a maximum set of approximately 70 standard data elements for EFT enrollment, with related data elements grouped into 8 Data Element Groups.
  - Outlines a strawman template for paper and electronic collection of the data elements.
  - Should a health plan decide to have a combined EFT/ERA enrollment form, the CAQH CORE required data elements for EFT/ERA enrollment, including terminology, must be included in the combined form.
  - Requires health plans to offer electronic EFT and ERA enrollment.
    - A specific electronic method is not required.
  - Identifies that a process will be used to review the maximum data set on an annual or semi-annual basis to meet emerging or new industry needs.

NOTE: *Detailed research, Work Group straw polls and discussions informed the development of draft rules and is documented.*

Draft CAQH CORE EFT/ERA Enrollment Operating Rules: Examples of Market Impact

- Simplifies provider enrollment by having health plans collect consistent data.
  - Requires that provider preference regarding how to deliver information is collected.
  - Mitigates hassle factor for providers when working with health plans that previously were not collecting data elements needed for streamlined EDI workflow.
  - Ensures data elements have consistent nomenclature.
  - Enables health plans to collect standardized data for complex organizational structures and relationships, e.g., retail pharmacy chains.
- Coordinates trading partners by including rules for when providers outsource functions, e.g., vendors/banks.
  - Ensures all entities involved in provider enrollment have defined roles and responsibilities, e.g., collection of trading partner name and ID numbers.

Moving Forward: Recommendations

- It is hoped that the CAQH experiences can help inform the Subcommittee as it moves forward with the industry to further refine scope of provider enrollment efforts.
  - Not all aspects of provider enrollment should be addressed by standards and operating rules, and not all can be addressed within the given timeframes.
- Standards and operating rules should support/enhance existing solutions that are widely utilized and enjoy strong provider and industry support.
  - CMS, as the largest payer, can demonstrate further public-private collaboration by considering how to work with existing solutions like UPD to ensure administrative simplification for the industry.
- Given the short timeframes in the ACA, NCVHS should consider identifying:
  - Additional information needed to define the scope.
  - Operating rule author as early as possible to ensure sufficient time for that author to prioritize industry enrollment needs.
  - Gaps in existing enrollment standards and requesting the rationale for introduction of new standards.

Moving Forward: Recommendations (cont'd)

- Based on our extensive experience, CAQH is available as a resource for the industry and NCVHS and would be pleased to provide the Subcommittee with more detailed information.
- When the time is appropriate, CAQH CORE intends to pursue designation as an operating rule author for enrollment, per the requirements of the ACA.

Appendix

CAQH Experience:
NCVHS Enrollment Questions

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CAQH Experience: NCVHS Enrollment Questions

- Beyond detailing its efforts in the main part of this testimony, CAQH is pleased to address the questions posed by the Subcommittee.
  - Responses are based on CAQH's extensive experience with various forms of provider enrollment. CAQH would be pleased to share additional detail given the current time limitations.
- Question: Differentiate between enrollment for EDI and other electronic transactions such as EFT and the credentialing process.
  - The provider enrollment process serves the purpose of identifying the provider to the health plan so that claims and other transactions can occur and payments can be made; requirements for identification vary by transaction. There may or may not be a direct contract involved. Providers out of the normal service area may be handled in a different way than the routine processing. In most cases, health plans would "credential" the provider as being licensed to perform the services being claimed, as well as other qualifications that may be required by the health plan for reimbursement. EDI enrollment enables the provider to submit claims and other EDI transactions to the health plan, and may enable the health plan to send EDI transactions to the provider. In addition to the basic provider enrollment information, EDI addressing and routing information, etc., are required.

CAQH Experience: NCVHS Enrollment Questions (cont'd)

- Question. How many provider enrollment forms and processes exist today? Discuss the issues this creates for providers and their business associates. Would it be onerous to consolidate an enrollment data set? How different is the data that is compiled by each health plan?
  - For both UPD and CAQH CORE, there was – and continues to be – a review of numerous applications, from both the public sector and private industry, e.g.,
    - For EFT, CAQH CORE reviewed over 100 enrollment applications and presented findings to the CAQH CORE participants regarding data elements as well as processes regarding common needs such as providing access and conducting authentication.
    - UPD initially reviewed many applications in use at that time. Since then, UPD continues to review state mandated, state Medicaid and all applicable CMS forms. Public and private needs must be aligned in order to bring providers administrative simplification.
  - Depending upon the focus of enrollment, there are expensive, frustrating and burdensome processes for both health plans and providers. Variations in format and content result in redundancies, gaps and inaccuracies, which are burdensome and expensive to address.
  - The expertise and resources needed to conduct such analysis to ensure it is done with consideration of the larger picture in which enrollment exists should not be underestimated. Also, other components required to successfully support such analysis, e.g., industry leadership and trust, also should not be underestimated.

CAQH Experience: NCVHS Enrollment Questions (cont'd)

- Question. Is anyone sharing an enrollment system for providers to allow for one gateway that serves several entities? Are there systems that could be leveraged to be a shared enrollment system for providers with all health plans?
  - The CAQH UPD is a prime example of an industry utility that replaces multiple paper processes for collecting provider data with a single, electronic, uniform data-collection system.
    - As noted in earlier slides, over 970,000 providers self-report their information to UPD and over 650 health plans, hospitals and other organizations access the system. They include a range of public and private entities, e.g., state Medicaid agencies.
    - Guiding principles have driven the widespread adoption and acceptance of UPD as a trusted source, not-for-profit, free to providers, no advertising or reselling, public/private usage, provider preferences, addressing over 700 elements versus a specific transaction function.
  - Other common gateways do exist in the market, e.g., Surescripts, NaviNet, Availity.

CAQH Experience: NCVHS Enrollment Questions (cont'd)

- Question. Are paper enrollment forms still used extensively across health plans? Are "wet" signatures required on enrollment forms by most plans?
  - The healthcare system still heavily and extensively relies on paper enrollment forms; many providers request such forms. "Wet" signature requirements are typical.
    - For example, as outlined at a CAQH co-sponsored conference in March of this year, EFT enrollment health plan authorization requirements vary in terms of number of signatures required, supporting documentation and level/role of signatory.
  - Use of digital and electronic signatures is growing in the industry.
    - CAQH CORE Connectivity Operating Rule supports use of digital certificates for transport-level security (SSL/TLS), in sync with NHIN.
    - The UPD uses a combination of electronic and "wet" signature. When a provider first engages with the UPD, a "wet" signature is required on the authorization, attestation and release form which is then submitted, imaged and appended to the provider's electronic records. Subsequent re-attestations are entirely electronic.
  - As we move forward beyond "wet" signatures, administrative-clinical alignment will be critical, but emphasis must be placed on administrative simplification, ROI and market maturity in this arena.

CAQH Experience: NCVHS Enrollment Questions (cont'd)

- Question: ASC X12 has a potential standard for provider enrollment. What is the industry's perception of that transaction?
  - The ASC X12 274 standard is one of several standards available to the healthcare industry for purposes of provider enrollment. Others do exist, e.g., IHE.
  - CAQH is unaware of any applications using this standard so we cannot comment on its impact. When participating for several months on an early 2011 ONC panel under the HIT Technical Committee regarding provider directories, the use of the ASC X12 274 did not emerge.
  - Based on the recent ONC S&I framework discussion, it is CAQH's understanding that the Provider Directory Committee is reviewing the ASC X12 274 as it considers pilot opportunities. CAQH concurs with ONC's strategy for pursuing pilots, including within the context of ACA's provider enrollment requirements.

Thank You!

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Attachment 1

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CAQH Universal Provider Datasource
Participating Organizations
(as of November 2, 2011)

Health Plans and PPO Networks

1st Medical Network
1199 SEIU National Benefit Fund
Absolute Total Care
ActivHealthCare
Advantage Health Plan
Advantica Eyecare*
Aetna, Inc.*
Affiliated Healthcare, Inc. (AHI)
Affinity Health Plan
Always Care Benefits
America's Health Medical Services
American Care, Inc.
American Specialty Health Network
AmeriChoice
Amerigroup Corporation*
AmeriHealth Mercy*
AmeriHealth New Jersey
Anthem Blue Cross of California
Anthem Blue Cross of Colorado
Anthem Blue Cross of Connecticut
Anthem Blue Cross of Kentucky
Anthem Blue Cross of Maine
Anthem Blue Cross of Missouri
Anthem Blue Cross of Ohio
Anthem Blue Cross of Virginia
Anthem Blue Cross of Wisconsin
Arcadian Health Plans
Arizona Health Advantage/ Arizona Priority Care Plus
Atlantis Health Plan
AultCare
Avalon Healthcare
Averde Health
AvMed Health Plans
Beacon Health Network
Block Vision
Blue Care Network*
Blue Cross and Blue Shield of Alabama*
Blue Cross and Blue Shield of Arizona
Blue Cross and Blue Shield of Florida
Blue Cross and Blue Shield of Georgia
Blue Cross and Blue Shield of Illinois
Blue Cross and Blue Shield of Kansas
Blue Cross and Blue Shield of Kansas City
Blue Cross and Blue Shield of Massachusetts
Blue Cross and Blue Shield of Michigan*
Blue Cross and Blue Shield of Missouri
Blue Cross and Blue Shield of Nebraska
Blue Cross and Blue Shield of New Mexico
Blue Cross and Blue Shield of North Carolina*
Blue Cross and Blue Shield of Oklahoma
Blue Cross and Blue Shield of Rhode Island
Blue Cross and Blue Shield of Texas
Blue Cross and Blue Shield of Western New York
Blue Cross and Blue Shield of Vermont
Blue Cross of Northeastern Pennsylvania
Bluegrass Family Health
Boston Medical Center HealthNet Plan
Bravo Healthcare
Bridgeway of Arizona
Buckeye Community Health Plan*
Capital District Physicians' Health Plan (CDPHP)*
Care1st of Arizona
Care Access Health Plans
CareFirst BlueCross BlueShield
Care Improvement Plus
Caremore
CareSource Indiana
CareSource Ohio
Care to Care
Carolina Care Plan
Carolina Crescent Health Plan
Cenpatico Behavioral Health
Centene Corporation
Center Care Health Benefit Programs
CentMass
Ceridian Corporation*
Children's Mercy Family Health Partners
CHS America
CIGNA HealthCare*
CIGNA Behavioral Health*
Colorado Access
Commonwealth Family Health Plan*
Community Eye Care
Community Health Network of Connecticut
Comprehensive Care Management
ComPsych
Concordia Behavioral Health
Connecticare
Continuum Health
Coventry Health Care
Creoks Behavioral Health Services, Inc.
Davis Vision*
Deaconess Health Plans

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Health Plans and PPO Networks *(continued)*

Delta Health Systems
Dentaquest
Devon Healthcare
Driscoll Childrens Health Plan*
DC Chartered Health Plan, Inc.*
Educators Mutual/EMI Health
Elderplan, Inc.
Empire Blue Cross and Blue Shield
EyeMed Vision Care
Excellus Health Plans*
Fairpay Select Health*
Fallon Community Health Plan
Family Health Network
FEI Behavioral Health
Fidelis Care New York*
Fidelis Secure Care
The First Health Network
First Care
Florida Healthcare Plus/Gold Coast Health Plan*
Freedom Healthcare
FrontPath Health Coalition*
Geisinger Health Plan
General Vision Services (GVS)
Gold Coast Health Plan of Ventura
Great Lakes Health Plan
Great-West Healthcare*
Group Health Insurance of New York (GHI)
Guardian Healthcare, Inc.
Harvard Pilgrim Health Plan
Health Alliance Plan*
Health Alliance Medical Plan
Health Care Service Corporation (HCSC)
Health First, Inc.
HealthLink, Inc.
HealthNet, Inc.*
HealthNet Federal Services, LLC*
Health New England
HealthNow New York, Inc.
Health One Alliance / Alliant Health
Health Options, Inc.
Health Partners
The Health Plan, Inc.
HealthPlan of Michigan*
HealthPlus of Michigan
Health Plus PHSP
HealthSmart Preferred Care (Parker Group)
HealthSpan
Highmark Blue Cross Blue Shield
Hillcrest Family Health Services
HIP Health Plan of New York*
Horizon Blue Cross Blue Shield of New Jersey*
HSC Health Plan *
Hudson Health Plan, Inc.
Humana / ChoiceCare Network
Humana Vision
Illini Care Health Plan Incorporated*
Independence Blue Cross
Independent Health
Informed, LLC
Integrated Health Plan
Integrated Solutions Health Network
Inspiris
Interplan Health (Parker Group)
Johns Hopkins Healthcare
Kaiser Foundation Health Plan of the Mid-Atlantic States
Kaiser Health Foundation of Georgia*
Kaiser Foundation Health Plan of Ohio*
Kentucky Division of Medicaid Services*
Kentucky Spirit Health Plan*
Keystone Mercy Health Plan*
Logistics Healthcare
Louisiana Health Care Connections Inc*
Louisiana Office of Group Benefits
Lovelace Health Plan
MAMSI Health Plans
Magellan Health Care, Inc.
MagnaCare Health Plan
Magnolia Health Care
Managed Health Network*
Managed Health Service
Martin's Point Health Care
MDI
Mclaren Health Plans
MedCost
Medical Care at Home
Medical Mutual of Ohio*
Medigold/Mt Carmel Health Plan
Mercy Care Plan
Mercy Health Plans
Meridian Health Plan
MHN Specialty Services, Inc.
Mississippi Physicians Care
Molina Healthcare of California
Molina Healthcare of Florida
Molina Healthcare of New Mexico
Molina Healthcare of Ohio
Molina Healthcare of Utah
Molina Healthcare of Washington
Mountain State Health Alliance
Multicultural Primary Care Medical Group
Multiplan
MVP Health Plan, Inc.*
National Capital Preferred Provider Org. (NCPPO)
National Vision
Neighborhood Health Plan
Network Health Plan

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Health Plans and PPO Networks *(continued)*

New Avenues, Inc
New Directions Behavioral Health
New Jersey Manufacturers Insurance Company
New York State Department of Health
Opticare Eye Health Network
Optum Physical Health*
OrthoNet
Oxford Health Plans, Inc
Paragon Health Network
Parkview Health Plan Services*
PartnerCare Health Plan, Inc.*
Passport Health Plan
Peach State Health Plan*
People's Health
Physicians Health Plan of Mid Michigan
Physicians Health Plan of Northern Indiana, Inc.
Physician Staffing, Inc.
Physicians United Plan, Inc.
Piedmont Community Health Plan
Planned Parenthood of Metropolitan Washington DC, Inc.
Preferred Care Partners (Florida)
Preferred Health Plan*
Preferred Health Professionals
Premier Eye Care
Prestige Health Choice
Principal Financial Group*
Priority Health
Prism Health
Psychcare
Qualcare
Rocky Mountain Health Plans*
Royal Healthcare
Salubris, Inc.
SCAN Health Plan*
Scion Dental
Secure Health Plans of Georgia*
Select Health
Sendero Health Plan
Sentara Healthcare*
Schaller Anderson*
Senior Whole Health, LLC*
SIHO Insurance Services
Simply Healthcare
State of Connecticut Judicial Branch*
State of Pennsylvania Department of Public Welfare
Sterling Life Insurance
SummaCare
Sunshine State Health Plan
The Superior Plan*
TennCare, State of Tennessee Medicaid*
Total Health Care Online
TRIAD Healthcare, Inc.
Tufts Health Plan
UniCare
Unified Physician Network
Unison Health Plan
UnitedHealthcare
United Behavioral Health
United Physicians
United States Army National Guard
Universal Health Care
University Health Plans
Univera
Universal American
US Family Healthplan/St Vincent Catholic Medical Centers
Valley Baptist Health Plan
Virginia Premier
Visiting Nurse Service of New York/VNS Choice
Vohra Health Services
WellCare
Wellmed
WellChoice
WellPoint, Inc.
Windsor Health Plan
Wisconsin Physicians Service

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Hospitals

Adventist HealthCare (Maryland) (3)
Baptist Health South Florida
Brattleboro Memorial Hospital
Central Vermont Medical Center
Childrens Hospital Medical Center (Cincinnati)
Childrens National Medical Center
Copley Hospital
Detroit Medical Centers (7)
Fletcher Allen Healthcare
Genesis Healthcare*
Georgetown University Hospital*
Gifford Medical Center
Henry Ford Health System (6)
Hospital For Sick Children/HSC Medical Center*
Inova Health System* (5)
Kingman Regional Medical Center
Mt Ascutney Hospital
Mt Carmel Health System (4)
National Rehabilitation Hospital
Nationwide Childrens Hospital *
North Country Health System
Northwestern Medical Center
OhioHealth Group, Ltd. (8)
Ohio State University Health System (5)
OSS Orthopedic Hospital*
Otis Health Care Center/Grace Cottage
Porter Hospital
Rutland Regional Medical Center
Southwestern Vermont Medical Center
Springfield Hospital Vermont
Tenet Healthsystem DBA St Louis Univ Hospital
University Hospitals (8)
University of Missouri - University Health (3)

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Provider Groups

Affiliated Chiropractic Network
Adventist Health Network
AGMCA (Akron General PHO)
Alliance Health Partners
Alliance Health, Incorporated
Alpha Care Medical Group
American Health Network of Indiana
Angeles IPA
Bakersfield Family Medical Center
Beacon Health Strategies
Beth Israel Deaconess Provider Organization*
CAP Management
Care Ohio/Cardinal Health Partners
Center Care (Commonwealth Health Corp)
CentMass
Century PHO
Childrens Mercy Health Network
Clarian Health Partners
Cleveland Clinic Community Physician Partnership
Clinical Practice Organization
Coalition of Athens Area Physicians
Community Care Physicians
Community Family Care Medical Group
Community Health Center Network
Compass IPA
Comprehensive Care Management Corp
Continuum Health
Corinthian Medical IPA
Cornerstone Alliance Inc. A PHO
Culpeper PHO
Dental Partners of Georgia, LLC
DuPage Valley Physicians
East Georgia Physician Group
Employee Health Systems
First Choice PHO
Freedom HealthCare
Gateway Health Alliance, Virginia
George Washington University Medical Faculty Practice
Gordon PHO
Goshen Health*
GRIPA
HCA Shared Services
Health Alliance of the South
Health One Alliance / Alliant Health
HealthCare Partners IPA
HealthSpring, Inc.
Hollywood Presbyterian Medical Group
HS1 Medical Management Inc
Huron Valley Health Care
Imagine Health
Industry Buying Group
IPA of Georgia (EHS)
Innovative Health Network
Kent County Health Services
Kentucky Independent Physical Therapy Network
Kentucky Medical Services Foundation, Inc
KnightMD
KORT
Lakewood IPA
LaSalle Medical Associates
Lewis Gale Clinic
Linked IPA
MDwise Care Select
Mercy Health System PHO (Ohio)
Meridan Wallingford IPA
Micron Health Partners Network
Mid-County IPA
MindGent Healthcare Clinics, LLC
Mount Kisco Medical Group
Multicultural Primary Care Medical Group
New England Physician Alliance
North Texas Specialty Physicians
Northwest Georgia Physicians Association
Owensboro Community Health Network*
Parkview Health Plan Services*
Physician Associates of Middle Georgia
Physician Organized Healthcare System*
Physicians of Coastal Georgia
Pinehurst Medical Clinic
Pinnacle Health
Planned Parenthood of Metro Washington
Platinum Physician Services
Primary Care of California
Primary Care of Northern Ohio
RCIPA
Redlands IPA
River Valley Health Alliance
Saint Barnabas - Metrowest IPA
South Georgia Physicians Association, LLC
Southern California Children's Health Network
Space Center IPA
St Francis PHO
St Francis PHO Connecticut

**Sanctions Track user*

Provider Groups *(continued)*

St Francis Health Network
St John Mercy PHO
Stark Regional PHO
Texas Professional Healthcare Alliance
TriState Health Partners
Unified Physicians Network
United Physicians
Unity Healthcare
University of Toledo Physicians, LLC
University Physicians Associates Louisville
University Physicians Network (NYU Langone Medical Center)
Valley Health Network
Wise Provider Networks
Women and Infants PHO

**Sanctions Track user*

Attachment 2

Universal Provider Datasource®
A CAQH Initiative

Overview

The CAQH® Universal Provider Datasource® (UPD®) is the trusted national standard for the effective and transparent collection and distribution of accurate, timely and relevant data for the healthcare industry. UPD is reducing paperwork and saving millions of dollars in annual administrative costs for more than 970,000 providers – representing 3 in 5 licensed and practicing physicians – and over 600 participating organizations across the U.S. Approximately 7,000 new providers begin using the service each month.

Launched in 2002, UPD enables physicians and other health professionals in all 50 states and the District of Columbia to enter and maintain their credentialing and demographic information in a single, uniform online application that meets the credentialing data needs of health plans, hospitals and other healthcare organizations. Once authorized by a provider, participating organizations gain real-time access to self-reported provider information that can also be used for claims administration, quality assurance and member services such as directories and referrals.

Five key UPD principles have resulted in broad adoption by the provider community:

- Access – Available to providers at no charge.
- Accountability – Providers are responsible for entering, managing and updating their data.
- Trust – Providers control their data in UPD and control release to participating organizations.
- Transparency – All data users must be identifiable to the provider.
- Not-for-Profit – UPD was established to eliminate redundant provider data collection.

Data Quality

The application meets the data collection requirements of URAC, the NCQA and the Joint Commission standards. Providers are prompted by system reminders to update and attest to their information every 120 days. An independent data quality study in 2010 showed that the sampled data was 93.9% accurate. Planned system refinements will improve data quality, and are expected to increase UPD data accuracy to 97% by year end 2011.

State Support

Twelve states and the District of Columbia have adopted the CAQH Standard Provider Credentialing Application as their mandated or designated provider credentialing form. In addition, several state Medicaid agencies are already using UPD to assist with provider enrollment and data maintenance.

Industry Support

UPD is supported by America's Health Insurance Plans, the American Academy of Family Physicians, the American College of Physicians, the American Health Information Management Association, the American Medical Association, the Medical Group Management Association (MGMA) and other provider organizations. The Vermont Hospital Association has adopted UPD as its recommended process for provider data collection.

Measures of Success

Based on figures from an MGMA analysis of administrative costs, CAQH estimates that today UPD is effectively reducing provider administrative costs by approximately $112 million per year, and has eliminated approximately 2.8 million credentialing applications to date.

Participating health plans have reported efficiencies through the use of UPD, including a substantive decrease in the average processing turnaround time, near elimination of new provider initial credentialing packet mailings, and real-time updating of provider directories.

Future Directions

Going forward, CAQH is planning enhancements to broaden the industry use of UPD in support of the growing need for timely and accurate provider data, and all-payer solutions. Opportunities being considered include automated uploads and data feeds to eliminate data entry and document imaging; opt-in modules to enable interested providers to participate in different initiatives and programs, such as emergency responder registries; enrollment functions; and additional data fields to support new users and uses.

Attachment 3

SUMMIT ON THE FUTURE OF PROVIDER DATA
hosted by CAQH

Preliminary Agenda

December 6, 2011
7:30 a.m. – 4:30 p.m.
The Madison Hotel, Washington, DC

An interactive one-day, event for thought-leaders from across the healthcare industry who are interested in improving the current state of administrative provider data.

Objectives

Through interactive, collaborative discussions among the broad spectrum of healthcare industry stakeholders:

- Understand what administrative provider data needs organizations have in common and how they differ, as well as the way data is currently collected, maintained, and managed.
- Explore the future of provider data in light of health reform, the emergence of new delivery systems, and health information exchange, among other trends and drivers.
- Discuss the pros and cons to administrative provider data management approaches aimed at improving efficiencies, increasing accuracy, and potentially lowering costs.
- Share opinions, ideas, and feedback from industry leaders to provide a framework for cross-stakeholder discussions about ways to improve administrative provider data accuracy and efficiency.

Agenda

7:30 – 9:00	**Registration, Networking Breakfast**
9:00 – 9:15	**Welcome and Introductions** **Robin Thomashauer**, *Executive Director,* CAQH
9:15 – 9:45	**Opening Remarks: *The Dollars and Sense of Administrative Simplification*** **Rachel Block**, *Deputy Commissioner for Health Information Technology Transformation*, New York State Department of Health **Topic:** Examine the importance of accurate and timely administrative provider data, including an overview of regulatory and marketplace trends.
9:45 – 10:00	**Break**
10:00 – 11:15	**Panel Discussion: *Administrative Provider Data - Defining the Problems and the Barriers to Change*** This session will be facilitated by a Washington-based healthcare journalist and establish background for interactive stakeholder sessions following the panel discussion. **Topic:** Identify major issues healthcare organizations face in collecting, maintaining, and managing administrative provider data, including areas that need improvement and barriers to change. **Panelists:** • **Paul Williams**, *Sr. Director, Provider Network Operations,* CIGNA • **Robert Tennant**, *Sr. Policy Adviser*, Medical Group Management Association (MGMA) • **Dennis Elliott**, *Director, Provider Services,* TennCare • **Yohannes Birre**, *Center for Program Integrity, Medicaid Integrity Group, Division of Fraud and Detection,* CMS

11:15 – 11:30	**Break**
11:30 – 12:15	**Stakeholder Voices: *Breakout Session #1*** Attendees will be prompted with questions that enable stakeholders to discuss their experiences, opinions, and ideas in a live, interactive, collaborative setting. Results of the discussion will be reported out and inform the next set of discussions. **Topic:** Pinpoint challenges in collecting, maintaining, and managing administrative provider data.
12:15 – 1:00	**Networking Lunch**
1:00 – 1:30	**Report Out: *Breakout Session #1*** Brief summaries of the most important insights from the morning breakout sessions will be presented by each stakeholder table.
1:30 – 2:30	**Panel Discussion: *The Future of Provider Data*** This session will be facilitated by a Washington-based healthcare journalist and establish background for interactive stakeholder sessions following the panel discussion. **Topic:** Visualize the future of administrative provider data, including trends and drivers shaping the management of provider data, the impact of new demands for data, and creative approaches that organizations are using or considering to address inefficiencies and redundancies in provider data management. **Panelists:** • **Tim Kaja***, SVP- Physician & Hospital Service Operations,* UnitedHealth Group • **Linda Syth**, *COO*, Wisconsin Medical Society • **Ellen Pryga**, *Director, Policy*, American Hospital Association • HIE Representative,TBD
2:30 – 2:45	**Break**
2:45 – 3:30	**Stakeholder Voices: *Breakout Session #2*** Attendees will be prompted with questions that enable stakeholders to discuss their experiences, opinions, and ideas in a live, interactive, collaborative setting. Results of the discussion will be reported out and inform next steps. **Topic:** Identify commonalities, trends and new demands for provider data among different stakeholder organizations. Consider potential approaches to improve the collection and maintenance of timely and accurate administrative provider data in the near and long-term future.
3:30 – 4:15	**Report Out: *Breakout Session #2*** Brief summaries of the most important insights from the afternoon breakout sessions will be presented by each stakeholder table.
4:15 – 4:30	**Summary and Thoughts on Next Steps** **Robin Thomashauer***, Executive Director,* CAQH
4:30	**Adjourn**