

MINUTES
ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING
Feb 19, 2002

Members Present: Rebecca Burdg, Chair; Allen Johnson, MD; James Kronenberg; Robert Wheeler, MD.

Members Absent: Kelli Fussell; Faye Gilbarg; Barbara Halsey Tom Foster, MD.

Staff Present: Kathy Weaver, MD; Laura Lanssens.

Also Attending: Linda Baker (prospective new member); Mary Park-Lindsey, Providence Health Plans; Debbie McElroy, Coalition for Affordable Quality Healthcare (CAQH); Paul Weaver, GeoAccess.

I. & II. Call to Order and Approval of Minutes

Rebecca Burdg called the meeting to order at 11:09 a.m. in Room 500A in the Public Service Building, 255 Capitol Street NE, Salem, Oregon 97310. The minutes from the last meeting were approved as written.

III. Review New Oregon Rules

The Committee briefly reviewed the new Oregon Rules from Department of Consumer and Business Services (DCBS) and the Oregon Health Division (OHD)

DCBS adopted OAR 836-053-0700, filed October 15, 2001, under Insurance Policies, Physician Credentialing, Health Care Service Contractors, and OHD adopted OAR 333-505-007, filed February 1, 2002, under Hospitals, Physician Credentialing, Health Care Service Contractors. They both state:

“...(1) The Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application, both of which were approved by the Advisory Committee on Physician Credentialing Information (ACPCI) on November 12, 2000, are adopted with respect to health care service contractors. (2) Each health care service contractor shall use the application forms adopted in section (1) of the rule. (3) This rule is adopted pursuant to the authority of ORS 442.807 for the purpose of enabling the collection of uniform information necessary for health care service contractors to credential physicians seeking designation as a participating provider for a health plan, thereby implementing ORS 442.800 to 442.807 with respect to health care service contractors.”

IV. New Member Business –Linda Baker

A. Introduction

Linda Baker, CMSC, CPCS is a Credentialing Services Manager with Health Net of Oregon in Clackamas. Ms Baker comes to the ACPCI highly recommended. She has graciously volunteered to fill the Health Care Service Organization Representative seat that Tiffany Roderick vacated.

B. Appointment of New Member

As a new committee member, Linda Baker was introduced and welcomed by members in attendance. However there was not a quorum to vote Ms. Baker as a member. Laura Lanssens (Staff) stated that she would send out an e-mail to all the members introducing Ms. Baker as the newest member and asking for a vote.

Please note: An e-mail was sent to the members on Thursday March 21st, 2002. The majority of the members responded and voted in favor of Linda Baker taking the vacated seat. Therefore Linda Baker is officially a member of the ACPCI and the Committee is fully seated with nine members.

V. Guest Speakers – Debbie McElroy & Paul Weaver

A. Introductions

Debbie McElroy from Beech Street, a Coalition for Affordable Quality Healthcare (CAQH) member. For this meeting, Ms. McElroy was representing CAQH as an outreach subcommittee member. Paul Weaver represents GeoAccess. Ms McElroy's presentation focused on the credentialing database.

B. CAQH Credentialing Data Initiative Presentation

CAQH is a not-for-profit organization formed in 1999. Right now there are 25 participating members. The goal is not to have just a member organization but to reach out to all constitutes in the health care arena and develop a collaborative application that meets everyone needs and to utilize technology and a shared database to their full advantage which will reduce administrative costs. Also this will free up the physicians and their staff from having to deal with the hassle of multiple credentialing application forms from different organizations and allows them to focus on their practice.

With CAQH membership all 50 states are reached and between all the participating organizations, they have touched collectively 600 thousand physicians. Ms. McElroy stressed that CAQH's primary role was to provide the funding and the momentum for the happening of the participated process, which includes not only the practitioners but also all those who need the same information.

There are three major committee groups within CAQH:

- One is focused on access (to make things easier for consumers)
- Quality and patient safety
- Administration simplification

Administrative simplification is the area, which deals with the credentialing database application. In reality, CAQH is promising one physician, one credentialing application and one storage place, and for all the health care organizations to be able to reach into that source. A meaningful solution was to use technology, thereby bringing in GeoAccess as CAQH's technology partner.

Current data is much more valuable than two year old data. In order to provide access to the most up-to-date data, a technology platform was developed so that the data is in a constant state of readiness and so that the practitioner is reminded every ninety days to verify his/her information so as to keep the information current. In the past year, all the collected data on practitioners is being used to design a credentialing application; and GeoAccess is the repository for the applications.

Ms. McElroy discussed that CAQH has developed a marketing plan whereas they are rolling out different states on a time line. Currently they are in Phase One, which is where the organization is working on outreach, making presentations and finding out and addressing the needs and issues of each state. They take this information back to the appropriate implementation team that will use the mechanisms to put the new information to use.

CAQH wants to make the administration of the whole application process easier on the physicians/ practitioners. Ms. McElroy emphasized that there is no cost to the physicians or practitioners. It is the participants that are paying for the data and the updates to the data. The CAQH members have funded the development of the application of the system and also supply the on-going costs to obtain the information and to provide a warehouse for the data.

All information is confidential. For confidentiality, the physicians/practitioners are the only ones to authorize the release of their data; and only then to the organizations the physicians/practitioners wish to have or receive the data. GeoAccess cannot sell the data outside or use the information for mass mailing. In fact GeoAccess, has mechanisms in place to assure the security and confidentiality over the Internet.

Also CAQH wanted to make sure that the application for retrieving information easy to use. They developed an interview style type format. For receiving credentialing information, the physician is actually walked through the process. For receiving the recredentialing information, the physician is able to go directly to the area that is in need of update and use drop-down boxes to complete the update and changes.

Mr. Weaver further pointed out that an advantage to the interview style format is that they only ask those questions that are relevant to each physician/practitioner

circumstance. By asking approximately four questions, they are able to determine what information is needed, thereby eliminating a completion of a huge form. CAQH and GeoAccess feel that this is a more efficient way of retrieving the needed information. They also recognized that the office staff of the physician/practitioner would probably respond to much of the information. Ms. McElroy stated that the format is “user friendly”.

The question was raised how the system compares with the Oregon mandatory credentialing forms? Ms. McElroy stated that they are aware of differences, however they are willing to find ways of retrieving the necessary information that the Oregon forms request. The goal of Ms. McElroy after today’s meeting is to make a recommendation to CAQH on how to go forward and how to proactively work with the ACPCI and with the existing state mandated forms.

There are future plans for CAQH to look at all the allied health care practitioners and bring them on board. The intent is to address their needs and assimilate them into the system. However for now, they are only working on getting the physicians on board. For further access convenience to the physician, not only is there an Internet base system but also a CD-rom and a paper system is available. However GeoAccess does recommend the use of the Internet connection because the database is already pre-populated prior to completing the information. The prepopulation information comes from many sources from within each state (i.e. CAQH participants). The prepopulation also provides for more security for the physician.

Ms. McElroy and Mr. Weaver confirmed that they are working with the AMA, JCAHO and NCQA to receive endorsements and their support. They are also eager to work with and collaborate with the ACPCI so that they could meet the roll out deadline of October 2002. Ms. McElroy and Mr. Weaver asked for the ACPCI support and recommendation

The presentation was concluded and a brief question and answer session followed. Shortly thereafter, Ms. McElroy and Mr. Weaver were asked to leave the room so that the ACPCI could discuss what previously transpired within the meeting.

Please note: The ACPCI members received handouts with more comprehensive information than these minutes or the presentation provided.

C. Committee Discussion

The Committee discussed and reviewed the presentation information. A comment was made that the attended members would like to hear opinions from the hospital representatives. All three of them were absent from the meeting.

The staff was asked about the formal opinion and what the House Bill 2144 asked the Committee to do. Dr. Weaver read from House Bill 2144, ...”Section 3 (1) The Advisory Committee on Physician Credentialing Information shall develop and submit

recommendations to the Administrator of the Office for Oregon Health Plan Policy and Research for the collection of uniform information necessary for hospitals and health plans to credential physicians seeking membership on a hospital medical staff or designation as a participating provider for a health plan. The recommendations must specify:

- (a) The content and format of a credentialing application form; and
- (b) The content and format of a recredentialing application form.”...

Committee members expressed concerns over the validity, the legal aspects and whether the Oregon applications would maintain their integrity if the ACPI recommends CAQH and GeoAccess.

The Committee wanted more analysis of CAQH’s and GeoAccess’ work with more specific comparison elements relating to the Oregon form. If the Committee is able to receive the information prior to the next meeting, then the members can review it. The request was made and the Staff shall receive the information electronically and then pass on the information to the ACPCI members

VI. Review and Explore any Recent Credentialing Issues

Due to lack of time and due to lack of a quorum, it was suggested that the Committee meet again in two months time so that recent credentialing issues can be explored and discussed.

VII. Adjournment

The Chair adjourned the meeting at 12.47 p.m. The next meeting is scheduled for April 16, 2002.

Rebecca L. Burdug, CPCS, Chair

MINUTES
Advisory Committee on Physician Credentialing Information
April 16, 2002

Members Present: Rebecca Burdg, Chair; Linda Baker; Faye Gilbarg; Barbara Halsey; Allen Johnson, MD; James Kronenberg; Robert Wheeler, MD; Kelli Fussell.

Members Absent: Tom Foster, MD.

Staff Present: Kathy Weaver, MD; Laura Lanssens.

Also Attending: Mary Park Lindsey, Quality Health Plans; Charles Simpson, MD and Juanita Neibert, Complimentary Healthcare Plans.

I., II. Call to Order and Approval of Minutes

Rebecca Burdg called the meeting to order at 11:05 a.m. in Room 500A in the Public Service Building, 255 Capitol Street NE, Salem, Oregon 97310. The approval of February 19, 2002 minutes were approved with a couple grammatical changes.

III. Member Business

A. Introduction of Linda Baker as new member

On March 21, 2002, Staff sent an electronic communication to the ACPCI members requesting a need to fill the vacated seat that was left by Tiffany Roderick. Linda Baker, CMSC, CPCS from Health Net of Oregon in Clackamas was recommended. The members' were asked to return their votes electronically. Once received, the votes were tallied in favor of Linda Baker filling the vacant seat. Therefore Ms. Baker was introduced as the newest member of the ACPCI.

B. Review term limits

Term limits for three of the ACPCI members, Becky Burdg, Chair; G. Faye Gilbarg and Tom Foster, MD had expired. A vote was taken to reinstate them for another three years, pursuant to House Bill 2144. Therefore they will serve in their usual capacity until January 2005.

There was a discussion regarding the next term expiration(s), January 2003. The Committee agreed that it was appropriate to send a notice to Oregon Physician, Hospital and Health Care Service Organizations informing them that there were to be vacancies. This notification would give interested parties, an opportunity to participate. A motion was made, seconded and the vote passed. The ACPCI Staff has been given

the responsibility to provide a reminder to the Committee within two months of term expiration and to notify the various organizations of such vacancies and request recommendations.

IV. Review and Explore any Recent Credentialing Issues

A. Review and Discuss the use/non-use of the Protected Online Applications

Some of the members brought up the subject whether or not the Oregon Credentialing and Recredentialing applications have been used efficiently or effectively. Complaints from various health care offices have been received relating that they cannot transfer their current database to the applications, or that they cannot print the application without the attachments. Apparently the application and the attachments always print out together, creating unnecessary wasted time, toner and paper.

Discussion ensued whether or not to unprotect the documents in order for the process to work easily and effectively, and so that everyone can use the applications. Kelli Fussell stated that she did not feel comfortable with unprotecting the application, since the Committee had put much time and concerted effort into them. She continued to say that the Committee should not be so quick in unlocking or unprotecting the form because that would leave the applications vulnerable to changes being made.

The Committee is in agreement that modifications are not to be made to the application forms. However with the documents protected, there are many who are not able to use the documents electronically due to incompatibility with their computer programs and databases.

There were some members that were averse to unprotecting the documents and others who were not. In fact, there was about an even split of members suggesting to unprotect the documents and members for keeping the documents protected. However the big concern was with the attestation page and the release of information page. All the members in attendance were in favor of keeping the Attestation Questions and the Authorization & Release of Information Form protected from modification.

Linda Baker commented that when the original state credentialing applications forms were released in the 1997, those involved in the development process wanted to prevent any opportunity to modify the text within the applications. Furthermore those applications warned against modifications to the form, yet there were still those who did modify the forms with added text or changing the attestation questions and the release. For those credentialing specialists or office personnel who process the submitted credentialing applications, the focus should be on the information submitted and not on whether the text has been modified.

A suggestion was made whether the attachment could be printed separately from the form. This would reduce the cost of time, toner and paper. The Staff will look into developing an electronic application with the attachments separate.

After much discussion, the Committee suggested keeping the documents protected, at this time, even though the idea may or may not be the correct solution. The members asked the Staff to investigate why the form does not work in its electronic format and provide a resolution on how to protect the text but unlock the document. Also the Committee expressed that the need of technical expertise in web-based application forms be called in to evaluate the electronic documents and evaluate and improve the utilization so that all those who need to credential and/or populate (mail merge) the applications could do so.

Jim Kronenberg mentioned that the Oregon Medical Association (OMA) might be able to provide minimum funds for a technician to assist on working out a solution. Staff will contact Mr. Kronenberg after their investigation has been completed.

Dr. Wheeler will also look into finding answers to some questions that were raised within this meeting regarding electronic documents. He will contact Staff with his findings.

B. Guest Perspective - Mary Park-Lindsey, CMCS, Providence Health Plans

The ACPCI heard testimony from Mary Park-Lindsey from Providence Health Plans. She mentioned that her organization was unable to use the credentialing applications while they were protected, because they could not populate the applications with information from their current database. Mary Park-Lindsey mentioned that there is not only a potential for modification to documents when they are unprotected but also a person can find a way to modify the protected documents if they are computer savvy, creative and or persistent. Even though it may take much time and effort, there are ways around the protected documents. Therefore it leaves the documents open for modification regardless of the protection. Although for the most part, most would respect the warnings "Not to modify".

C. Public Comment

Dr. Charles Simpson, Chief Medical Director and Juanita Neibert, Director of Provider Services for Complementary Healthcare Plans attended this meeting. Introductions were made all around.

They had concerns on mandatory use of the Credentialing and Recredentialing Applications. They raised the question whether or not they had to use the Recredentialing Application to recredential their physicians. The Committee referred to Act 1999, House Bill 2144, Section 4, Item (3) " The uniform credentialing information required pursuant to the administrative rules of the department and the division represent the minimum uniform credentialing information required by the affected

hospitals and health care service contractors. Nothing in sections 1 to 4 of this 1999 Act shall be interpreted to prevent an affected hospital or health care service contractor from requesting additional credentialing information from a licensed physician for the purpose of completing physician credentialing procedures used by the affected hospital or health care service contractor.” Also the OAR 836-053-077 and OAR 333-505-007 state in Section (2) “Each health care service contractor shall use the application forms adopted in section (1) of the rule.” Section (1) refers to the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application, which were approved by the ACPCI, November 14, 2000.

Discussion ensued about the wording of the Oregon Administrative Rules and whether it was clear in its explanation. A suggestion was made to change some of the wording in Section (2) of the OARs, which would read as follows: “Each health care service contractor *must accept* the Credentialing application form and the Recredentialing Application form adopted in section (1) of the rule.” A revision will be forthcoming at the next Legislative Assembly. The Committee reserved the right for further discussion of this topic at a future meeting.

The Committee clearly stated that the initial credentialing application must be accepted. It is the minimum requirement. The use of a physician and/or practitioner profile (application summary) in lieu of the initial credentialing application is not acceptable. However a profile may be used in lieu of the recredentialing application if the health care organization has an initial credentialing application on file for the physician/practitioner.

For clarification, the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application must be accepted if they the physician/practitioner submits one of those applications to the health care organization. The health care organization may request additional information from the practitioner including a profile.

With regards to the Oregon Practitioner Recredentialing Application, Section XVII, Attestation Questions, there was a motion to change the wording from the respective lines from “**In the last two (2) years, ...**” to “**In the last three (3) years, “**. This will comply with national credentialing standards. The motion was seconded and unanimously carried. Staff will change the wording on the electronic document.

V. CAQH Credentialing Data Initiative

A. Review and Discuss the information/documentation

The ACPCI reviewed the handouts that were provided by CAQH. These documents included:

- a letter addressed to Rebecca Burdg, the ACPCI Chair;

- CAQH Application Data Section and Data Element, Paper Replica ver. 1.25, CAQH application vs. the Oregon Application;
- the PowerPoint presentation of the CAQH Universal Credentialing Application and Database;
- a document from CAQH with frequently asked questions;
- and a CAQH provider application.

Dr. Wheeler noted that there are some codes that the Oregon application form requires that are not required or not listed on the CAQH code list.

Dr. Johnson also mentioned that CAQH appears to have some requirements that do not appear on the Oregon application form.

Also it was mentioned that CAQH's application form was huge and daunting. One of the goals for the ACPCI was to keep the application to a minimum when reviewing and updating the 1997 Oregon credentialing application. The members discussed that national electronic credentialing applications are the wave of the future and it is a good thing; however for convenience and efficiency sake, the Oregon credentialing application form needs to be kept as a credentialing form and to a minimum page limit. Some members expressed that CAQH's application form requested information, which may be required by another state but need not be on the Oregon application form.

An issue arose questioning whether we have a role of standing up for Oregon and perhaps the rest of the country when it comes to questionable or limited utility questions on the CAQH application and whether those questions deserve to be required by four hundred thousand providers four times a year.

Dr. Johnson concurred and wondered how many physician organizations were at the table when the CAQH application was designed. It appears the questions resemble questions that any health plan would ever ask to which they would want an answer.

B. Review and Discuss Members Concerns

It was agreed upon that CAQH's application is too lengthy and it is in the phase where Oregon was six years ago. In order for CAQH to work in Oregon, they would have meet Oregon's needs and show first the required Oregon credentialing application. Everything else is optional. The Committee wanted to communicate clearly to CAQH that they could not exclude any participants in Oregon for failure to answer the optional questions. A small addendum is that the ACPCI would review carefully the optional questions (from CAQH's application) at a later date for potential inclusion with regards to merit from a credentialing perspective.

The Committee wants a response from CAQH whether they can make their system work consistent with the Oregon part of the application, which is: our questions, our attestation and our language? If CAQH has proposals for other techniques ACPCI would be happy to meet with them another time for further discussion; but the ACPCI

needs to be assured that those techniques and optional elements that are not required in the Oregon mandated credentialing application are completely separate and are clearly labeled as optional and not required.

Another question was asked if data could be provided to the ACPCI to see how many of the Oregon practitioners answered the optional questions. Perhaps the data could be collected over a calendar year period and then the ACPCI could evaluate the data.

There was concern whether the Oregon application form would be reformatted. The Committee does not want the "look" of the Oregon application form changed because it is a mandated document. Another concern was about quarterly updates, and the notification of whether the change was triggered when a data element was changed so one does not have to look through the many page application for that particular change. Another concern was what the cost for doing business would be? Lastly, the ACPCI would like to know about a timeline (with regards to Oregon's application being available to not only physicians but to practitioners, if an on-line demo would be made available to the ACPCI and what would be the implementation.

A letter needs to be sent to CAQH addressing our concerns and asking for a response from them. The Staff will check to see if CAQH is available and arrange for a teleconference call for the next meeting.

VI. Adjournment

The next ACPCI is Tuesday, May 21, 2002. Barbara Halsey suggested the use of a Salem Hospital conference room for the teleconferencing with CAQH, since the telephone system in Room 500A in the Public Service Building is not conducive to calling an outside number. The Committee Members agreed to hold the next meeting in the basement conference room G of the Salem Hospital, 665 Winter Street SE, Salem, Oregon. Also Ms. Halsey has graciously volunteered Salem Hospital to provide lunch for the Committee. The meeting was adjourned at 12:49 p.m.

Rebecca Burdg, CPCS, Chairman

MINUTES
ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING
May 21, 2002

Members Present: Rebecca Burdg, CMSC, Chair; Barbara Halsey; Allen Johnson, MD; Tom Foster, MD; James Kronenberg; Robert Wheeler, MD; Linda Baker, CMSC.

Members Absent: Kelli Fussell, Faye Gilbarg.

Staff Present: Kathy Weaver, MD; Laura Lanssens.

Also Attending: Mary Park-Lindsey, Providence Health Plans; Melinda Seibert, Valley Community Hospital; Chris Barber, Office of Medical Assistance Programs (OMAP); Carl Hutchinson, Kaiser Permanente.

Attending Via Telephone: Soren Davis, Coalition for Affordable Quality Healthcare (CAQH) Marketing Communications Chair; Judy O'Neal, Stacy Liechty, and Martha Monroe, Price WaterhouseCoopers; Katherine Wade, Cigna.

I. & II. Call to Order and Approval of Minutes

Rebecca Burdg, Chair, called the meeting to order at 11:09 a.m. in Room G of the Salem Hospital. The April 16, 2002 Minutes were approved with some minor corrections.

III. CAQH Credentialing Data Initiative

A. Conference Call

1. Introductions

Becky Burdg gave a brief history about the Advisory Committee on Physician Credentialing Information (ACPCI). Introductions were made all around. Becky also explained that pursuant to the February 2002 meeting, the ACPCI conveyed that the decision was made to retain the Oregon Credentialing and Recredentialing Application forms, exactly as they are when CAQH comes to Oregon, October 2002.

2. Exploration of Oregon Needs and the CAQH Process

Soren Davis said he understood that the Committee has concerns and CAQH does not want to undo the good work that the ACPCI has done. Oregon is not the only state that

has the credentialing process in place. He is very much aware that they [CAQH] have to be able to accommodate and make what they are offering work.

What he wanted to discuss is how they would do this and yet use what the ACPCI developed while merging Oregon's document into their already developed system and still make it work for the Oregon physicians

Mr. Davis gave a background history of CAQH and explained what the Coalition is trying to accomplish. (See Attachment 1 for transcript excerpts)

The jest of the Mr. Davis' presentation was:

- Administrative simplification.
- One physician, one credentialing application and one storage place, and for all the health care organizations to be able to reach into that source.
- Flexibility from state to state.
- On-line interactive system (non-paper approach).
- Confidentiality.
- Providers are the controlling mechanisms.
- Checks and balances.
- Blending Oregon's document with CAQH's database.
- Willing to work with the ACPCI in order to move into Oregon.

3. Review and Discussion of Concerns

Committee members and visitors expressed concerns over the validity, the legal aspects and whether the Oregon applications would maintain their integrity if the ACPI recommends CAQH.

Upon further discussion some other committee concerns were:

- Consistent look of the Oregon form(s).
- Legal assurances needed that the data information not be turned over with a subpoena.
- Not to subvert the Committee's legal mandated guidelines.
- Data should not be used for recruitment.
- Price of functionality and tradeoffs.
- Out-of-state usage and recoverable data
- Amount of data collected vs. the amount of data needed.
- The solidity of limited access.
- Accessibility to mid-level practitioners.
- Feasibility of timeframes.
- Accessibility and leakage of data.
- Customer service, too much vs. too little.
- Need to collect only what is on the Oregon form(s).

The Committee informed Mr. Davis, et.al., that they (the ACPCI) needed to keep in mind all the people they are representing. The simplicity is very compelling. However the Oregon Medical Association legal counsel needs to be consulted and agree to the new system before it is brought into the State.

Before coming to any decisions, the Committee wished to discuss the process and their concerns further at the next meeting.

IV. Staff's Report – Electronic Credentialing Application Issues

The report was deferred until the next meeting.

V. Public Comment

Public comments and concerns were verbalized during the conference call.

VI. Adjournment

The Chair thanked everyone for their participation in the teleconference and also thanked Barbara Halsey and Salem Hospital for providing the lunch, the conference room and the audio equipment. The meeting was adjourned at 12.58 p.m.

Rebecca L. Burdg, CPCS, Chair

ATTACHMENT A

Excerpts from Soren Davis and the conference call:

..."CAQH is a not for profit organization. It's a 511C3, which means that we cannot lobby specifically and we don't exist for that purpose. We exist for the purpose of trying to fix certain problems in the industry through initiatives that we develop and implement.

One of those key initiatives has been administrative simplification and specifically in this initiative the reduction and elimination of the duplication associated with provider applications.... In the context of credentialing because that is how it arose, but clearly as I am sure many of you have seen, it goes well beyond it in terms of data elements captured in fact what would go into directories of what people would put on their websites.

This initiative was strictly in response to a huge complaint from providers. When a provider joins or belongs to a network, which is on an average of 10 to 20 networks, each one of them today requires a different form and a different filing process for re-credentialing. That is a nightmare to the physicians. A state like yours and others have undertaken initiatives to put out a uniform application, which gets to half of the problem. Now you have a uniform process that physicians can follow; yet they still must submit it 10 to 20 times to the different plans in which they participate.

CAQH developed this program, in effect, to create a standard process which would determine application and equally important, arguably more important, to develop a system so that that information can be deposited to one source that the physicians can follow. This is their system. In turn, all of the plans can extract the information they require from that source.

I think what is in front of us in Oregon is how do we take your application, turn it into the front end of the system we've developed so that your form, in effect, becomes web-enabled, so that the physicians can deposit the information electronically and output electronically.

Right now from my understanding you have a form out there. Physicians have to download that, it's either a piece of paper from the web, or they download it into their practice-management systems, and then populate that output of paper and send it to somebody. What I would like to discuss and see how we can take what you have developed and plug it into our system? Our system has already been deployed. It's not something that is about to be built. It has been built, it can obviously be modified and it has been deployed in two (2) states already, our pilot states Colorado and Virginia. We're now in the process of registering doctors and reaching out to them.

I guess that's also one of the important things I don't know if your committee has discussed this, but how you actually get the word communicated to doctors is very important and can be very cumbersome. Part of what we do is, we outreach to the

individual doctors. We create a whole marketing strategy around going out, communicating what's been developed, how it works, what the value proposition is, and ultimately reaching out to the individual providers so that they can go on line and register and begin to use what is available..."

Regarding a question about mandates:

...“What’s interesting about the mandates in different states that we reviewed. Maryland represents probably the most severe application of a mandate. They specify that this is the only thing that can be collected and this is the only information you can ask for. Some other states have mandates where they say this is what the form looks like if you require supplemental information your allowed to ask for it and they leave that variable. Those types of things are all over the map. Maryland will be interesting. Probably it’s the most severe application and we’re able to adapt to it. Now I believe that in Oregon the mandate doesn’t require that it is just the information on the form, that you require that they be the standard application, but if people need additional info they are not restricted from requiring it, correct?”

If, in principal, everybody agrees that there is tremendous value to enabling the application process to electronics, then we are prepared to sit down and work with you to make that happen. I can help it in the discussion right now in terms of some of the key features that are prevalent that might be lost if we do some things versus other things. That’s really I think where the discussion is. The decision will ultimately fall to your folks as to how you want to make this happen. In terms of our requirement, obviously our goal is to create one source for doctors to be able to work through and to have a common system for them to deposit the information, and a back end output that’s logical for the health plans and hospitals that would need the data in the first place.

Regarding the CAQH process...and I think this is part of the issue people have with when they are looking at forms versus what we have developed. CAQH has not developed an application, per se, a paper application. Yes, we’ve created for those scenarios where you need to output the paper, called our form, but the heart of it is really a system.

The providers when they engage in a system to put their data in are not presented with an electronic version of a paper application. What they are presented with are a series of screens that ask for information. Those screens are laid out to be easy to use and to also have logical links and edits because one of the things we found out early on is that a large number of mistakes occur in data quality, e.g. zip code matching into a city or state, or some data elements are just illogical in their presentation. On paper nothing catches that. So, it’s typically caught when its received by the Plan, then a phone call is made, or the application is returned for correction.

The system has a lot of logical edits built in that catch those mistakes as they are happening and alerts the provider that they need to be fixed. In addition, it’s designed

so that certain answers will automatically take them to a section with additional information that's appropriate to the answer they were given. That's something you can't do with a paper application obviously cause its made interactive like that. So, that's the first thing that we need to talk about.

From the perspective of a paper application, we do have the ability to literally front-end our system and present your application to the physician, and then map the responses to the database. The down side of that obviously is that the logical interfaces and these edits aren't going to necessarily be there. Putting them in could be quite cumbersome because arguably you would have to design logic for every variable form out there in order to do that. So, that's what would be lost to some degree. We are not saying wholly, but we would have to analyze to see if we literally mapped the application, if the interpretation had is that the physician must see the physical form layout on the screen, the way you have it on paper, there could be that kind of an issue. We can definitely do it, and we can do the mapping, but we may not be able to have all of the logical connections that arguably make it a much more loser friendly process. And our initial responses from the physicians has been, we want even more of that logic built in, and we're going back now and trying to fine tune some of that in Colorado and Virginia to add even more of this kind of logical editing and connections.

As a quick example, when we asked them for the medical school they went to, they plug in the name and the system will automatically given them the addresses of the schools we have them programmed in there. I don't know if that feature would easily port over given the way its set up. It might, it might not. Right now on a piece of paper they have to put in the name of the school and the address of that school as well. So, that's an example. So that's the first area of discussion. Do you feel that it has to present on the screen to the physician the physical form as it exists or is your concern more around the data elements that you captured? Ok, that sets the discussion up in terms of, I don't think we need to have answers today, unless you've got them that's great, but these are the areas you need to tell us what important. We can give you the pluses and minus' to each one of the decisions.

The other thing that we have as an issue is we know that providers will, without a doubt, have the need to submit paper. Not everyone is going to want to or will be able to use an electronic solution. So, we have made available the paper. Here the application becomes critical because without a doubt, they would be using your application and then the ways its supposed to work is they fax it to us and we would scan it into the system and then populate the system with the electronic data so that the output would still be consistent and the Plans or hospitals would get it from one source. The issue we would have with that in terms of using the state mandated form is just one. We would want to make your form registered for optical scanning. It does not change the fields and it does not change the questions you ask.

What it does do is it has to set up registration marks on the paper and it actually makes the form a little longer because each field becomes bigger because we must need a little box for each letter. When we talk about a scan able form, we are not just talking

about an image, because we will have the ability to just capture images, but we also want to convert the data into data bits that can go right into the system without having to have it re-keyed. The only way to accomplish that successfully is to make the form in such a way that it is machine-readable and can be optically scanned and have the characters optically recognized. We've got that and what it does up front and I think you have seen our form already printed.

If you noted, one of the reasons its so big, is because you see how it played out, the little boxes in the upper left right and lower left right there are little arrows. Those are registration marks. That's what we would need on your form. It could be on your form identical, but if we could have it laid out with that type of boxing then we know that it can be scanned and converted electronically. That's really important to us in the paper process because if we are to enable this electronically it will eliminate a huge amount of the data entry work that would otherwise be required. I think I have lain out from our perspective what we're dealing with in terms of this system itself.

If I could just offer one more example of the interview style logic that is inherent in the front end that we are trying to promote...For example, when we asked a question about additional specialties. If the physician says no I don't have a secondary specialty, then the remaining questions are removed from that session with the physician. If they answer Yes, then we go on to ask what the specialty, Board certification, etc. We are able to interactively or dynamically change the questions that are presented to the physician based on the answers they provide at each step along the way. That logic obviously would not transfer if we just simply front-ended your form.

So this again are the types of tradeoffs that tentatively you folks have to decide because its not our intention to ram our solution down. We know that's not going to work and that's not our purpose here. We really are trying to give people the utility to fix the real problem. There is a lot of potential synergy here and an opportunity and we just need to be able to sit down and see how much flexibility there is in what you've developed and what the pluses and minuses are to what you need relative to the back-end system."

Response, when asked about legal subpoenas:

..."First, this is really the provider's system. It's not the Plan's system, not the Hospital's system. The provider determines who has access to the information and only those entities are allowed to use that information. So, for example, if Multi-Plan does not have a relationship with a provider that Regence has, only Regence will have access to that information. No other party, this is not a system that is open to the public that creates generally accessible and available information.

The controlling mechanism is the provider. Information flows into it in only one direction. The process would typically work as follows: In Virginia, the Plans that participated in Virginia, by the way we had non-CAQH plans participate as well right out of the gate.

It truly is open to everybody because the goal here is to solve a problem in the industry. Each of the plans submits their rosters of providers to the system in CAQH. From those rosters they are pooled together tagging what doctor belongs to what Plan.

Obviously the theory here is that some doctors have belonged to multiple plans, that's where the real power and efficiency comes in. The doctors, based on that, are invited ultimately to a process where they are given a temporary registration number and invited to go into the system. They go into the system using that temporary registration number and set up a secure password-protected area so that they can begin to actually use that system. They are the only ones who have access at that point. The minute they set up their secured process, information flows in one direction, from them out. The Plans cannot go into that system, or anyone else for that matter, and change any of that information. Even if we know it's wrong, it is physician self-reported information. Right or wrong, it goes in that way and they control it. They will see who has identified them on their roster, so any given physician will be given a pick list saying these five Plans or entities, have identified you as having a relationship with them, and are in effect asking for access to the information you are about to put in here. If they accept them, great. If they feel, I don't know who my Plan or I don't know who Regence is, whatever, they can deselect at that point.

What will happen if they deselect is that that entity cannot get the data, even if it's on their Rosters. What will also happen is that the entity that put them on their rosters that got deselected will receive a notice from the system that a provider who was on their initial rosters for submission had deselected them and obviously it's strongly recommended and suggested that they get in touch with them directly to figure out what the disconnect is. But it is the provider that controls that information. Within the context of this system, no one has access to it. When a Plan or hospital extracts the information, in theory the way it works and in practice, the provider completes the application process, authorizes it, attests to it, sends in the documents, the facts that we then scan and attach to the application electronically, e.g. license, etc.

What will then happen is the Plans that have been authorized will be alerted that a record is complete. At that point they will be able to extract that information either electronically or as a paper application completed. They will have 5 electronic formats to download from, or that can opt for paper. Once they have extracted the data, it is no different than what currently exists today in a paper process. The relationship is between that entity, the Plan/Hospital, and that individual provider.

Response to a question about who has access:

"... I need to clarify; the system is not designed to be used for recruiting purposes at either end of the spectrum. So physicians cannot use this system to say "I want to join a network that I don't currently belong" and conversely, Plans cannot use the system to recruit physicians that are not currently in their network. It's not designed for that purpose and, in fact, the blockages toward doing that are very severe in the system. It's triggered by an existing contractual relationship with an entity. That's what triggers the

invitation. So, a physician cannot come say. We are dealing with this issue for new physicians coming out of med school because clearly they have contracts with nobody, and we have requests from medical societies to make some provisions to allow those people to deposit credentials when technically nobody is inviting them to the party. So, we are building a module to accommodate grads, but in theory and what I am trying to get it, is that there is already a governing contract before you can use this system.

In theory, so what your dealing with its not an initial application for a newly contracted physician. There has to be a relationship that's been agreed to between a Plan and a physician. Typically, it's a participation contract that triggers it. Different Plans have different ways of dealing with that because they will do provisional contracts until their credentials are fully accepted into the network. Some will accept them or kick them out later if they don't pass credentialing. There has to be an agreement between the provider and the Plan so that the Plan can then put them on a roster, which then triggers the mechanism, the invitation and the ability to participate.

It may be an initial application with a Plan that's new to the doctor but they may have an existing application or an existing relationship with someone else that has put him into the system. The theory here is that it's a central depository."

Response regarding to the question of peer review:

"Under no circumstance we want to subvert your peer-review process and the legal protection that you've got built into Oregon. So, what I would recommend, we need to look at this from a legal perspective, and create whatever would be deemed a satisfactory document to show you how it works relative to your concerns. I don't think that I would be able to address them here. I can tell you what our intent is. The mechanics of accomplishing that I truly don't know. It is clear, I can assure you, that it's not our intention to subvert or get around provisions that you current have in your law.

What we need to figure out how to translate the current protections that you've got into what we're saying here. I don't know how to do that. Hopefully it is doable, I can't believe it is not. But it clearly will require some lawyers and we've got some lawyers available and we'd be happy to work with you on that. Clearly, it's got to satisfy you. If it doesn't then obviously we can't meet your needs.

Response to a question about data collecting:

"...The second part of the question is a more interesting one. It has to do with the amount of data we are collecting versus the amount of data that you require. This has come up a few times already and I think that the best way to look at this and to understand it, and this is not from the physician perspective I am going to talk because I know its been very hard for physicians, although we have had great success, in actually believing that our industry would attempt to do something that is truly in their best interest. It's a historical adversarial relationship that now all of a sudden is being challenged with we're trying to do something from a physician perspective. It helps

everybody, but it really is focused on the physician and let me talk specifically about the data and the notion of credentialing.

When we looked at what people use the information for, the Plans, which is where the annoyance is cause they are constantly submitting information, you have data that is required for the process of being credentialed, which typically has to meet the specifications of third party accreditation bodies, etc.

Then there is also a wealth of what we call demographic data that every Plan requires and currently required in Oregon I am sure as well. For example, your office hours, those are not a credentialing piece of data; you just need to have them. You are currently reporting office hours to your Plans because they need to put those out on Directories, they need to be able to arm their customer service folks and populate their websites so that when the consumers, the provider's patients, inquire as to what the doctor's office hours are; what the languages are that they speak, a host of other demographic data. That currently captured through some mechanism in your state. Whether it's part of your credentialing application, or part of some other support document."

Response to timeframe:

"We originally scheduled, forgive us in that respect, but part of the plan involved how do we roll out something nationally so we decided to create a schedule. At the time we built it we took into account a variety of factors but primary we looked at load balancing because the ultimate scope would be over 600,000 physicians nationally.

Clearly as we now engage the individual states of discussion, we come up with issues that we didn't anticipate, so to make a long story short, we had October on the timetable. If that's not realistic based on the needs you folks have to work with us to make this happen, we will build a realistic schedule for rolling out in your state.

In terms of how much time we need to work with you to come to that determination, based on the answers to the questions that we've laid out, your willingness to put together a team that will work with us to really get at the root of issues, from that we can very quickly lay out a realistic timetable, and we will marry into what we call a marketing timetable, which is how do we communicate this out to the provider community. It comes from all of us if you will. That's part of what we do here, so that you get the compliance, you get the people coming on to this the way we would all want it to see happen. Technically, Oregon sits on a timetable for October.

If there are any questions, please feel free to forward them on. Is there anything we can do to facilitate this? We are anxious to work with you."

MINUTES
ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING
September 17, 2002

Members Present: Rebecca Burdg, CMSC, Chair; Barbara Halsey; Tom Foster, MD; James Kronenberg; Robert Wheeler, MD; Linda Baker, CMSC.

Members Absent: Kelli Fussell, Faye Gilbarg; Allen Johnson, MD.

Staff Present: Kathy Weaver, MD; Laura Lanssens.

Also Attending: Mary Park-Lindsey, Providence Health Plans; Debra Waln, Mid-Valley IPA; Becky Hawkins, Oregon State Hospital.

I. & II. Call to Order and Approval of Minutes

Rebecca Burdg, Chair, called the meeting to order at 11:10 a.m. in Room 500A of the Public Service Building, 255 Capitol Street NE, 5th floor, Salem, OR 97310. Introductions were made all around for courtesy of the guests and Becky Burdg gave a background history of the ACPCI and what the Committee has accomplished over the past two years.

The Committee briefly reviewed the Minutes and some corrections were made. Due to the length of the Minutes and for the convenience of the Members, it was decided that the approval of the Minutes was deferred. The Minutes would be submitted via e-mail to the Members, and they would respond with approval or corrections.

III. Follow-up Discussion – May 21, 2002 Teleconference Call

Becky led the discussion bringing up two important points, which CAQH had been made during the teleconference. CAQH would like to:

- post the application form in a different order/format so it would make more sense more logically as the applicant is filling out the electronic application.
- Incorporate it as a scannable document

At this time ACPCI have not had any correspondence from CAQH since the last meeting.

Linda Baker reported that CAQH has a revised rollout schedule. All the participating health plans have been waiting for the revised rollout schedule Initial rollout was in

Colorado and Virginia and now in Washington DC and Maryland. Maryland has a mandated application, and CAQH is working through that process. The next rollout will be with New York, New Jersey, Connecticut and Georgia by the end of the year. Because CAQH has made some enhancements to the process and some modifications to the data structure, CAQH made the decision to slow down the rollout process so they can implement the recent data structure changes for a smoother transition across the country. Therefore, Oregon may not rollout until next summer or fall of 2003.

Linda further commented that Georgia would be the first state that requires the Hospital Association, the Health Plan Association, the Medical Society, and Georgia's Medical Association, to participate in the discussion whether or not to endorse the CAQH process. Georgia went through an elaborate rfp process and selected CAQH as the one they would endorse. They are a state to watch particularly because they are the first state that would include hospital participation as well as the health plans. Up until now, it has only been health plans that have registered or wanted their provider panel to go through CAQH process; yet the hospitals have to credential as well.

Originally when CAQH began they were only looking to roll out the health plans and at a later date they were to look at the hospitals. Since Georgia required hospitals to be part of the process, CAQH changed its process to accommodate, which is beneficial to Oregon since CAQH would meet with resistance since Oregon requires all practitioners to credential.

Becky asked if the Committee should respond to CAQH or should the Committee wait. After some discussion, the Committee opted to wait and see what happens with Georgia's rollout.

Barbara Halsey thought it would be very informative to the Committee to see how the other states are doing since they have rolled out. Linda would continue to update the Committee with the CAQH rollout process.

IV. Review & Consider Possible Changes to the Application(s)

There was a concern that the Oregon applications are being modified. Also there is a concern that the most recent application is not being used. Some of the members reported that they are still receiving the 1997 application and some are receiving the November 14, 2000 application. The Committee wished to discuss this subject further at the next meeting.

Becky read from a list of suggestions/recommendations that had been previously sent to Staff.

Becky wanted the Committee to be aware of the impact of the changes to the credentialing and recredentialing applications. It was further mentioned that NCQA and

CMS is on board with the “three years” request versus JCAHO is still on the “two years” request.

There were a couple of recommendations that had been e-mailed previously to the Staff. Staff submitted the recommendations. The Chair read the list aloud and the Committee discussed each recommendation. The Committee decided that at this time the credentialing and recredentialing form would be left as is. The Committee decided the recommendations were more information gathering and billing issues, and they were not part of the credentialing process.

Jim Kronenberg reported that the OMA legal advisors had reviewed the wording of the application along with House Bill 2144. He related that the Oregon Practitioner Credentialing and Recredentialing application forms could not be refused by any health care individual and or health care organization, although additional information and or forms could be used by and asked of the practitioner.

The Committee continued to discuss the wording change from “two years” to “three years” on the Attestation page of the recredentialing application. However there was discussion of whether the hospitals would be accepting of the change even though the some of the health plans have already gone to a “three year” cycle. Dr. Foster informed the Committee that the “three year” cycle is all-inclusive. Some Members would like to take this recommendation back to their office for deliberation. The members were in agreement that any change to the credentialing and recredentialing applications should not be taken lightly. Therefore they agreed that this recommendation needed further exploration.

V. Discuss Term Limits and Solicitation for New Members

With regards to term limits, Jim Kronenberg expressed that there had already been a couple of new members on the Committee that had replaced those members that had left. There is a fair amount of expertise now on the Committee and to keep constancy he suggested that the terms that were expiring at the end of the year should be rolled-over for another term. It was noted that there were also going to be one new vacancy in the near future that would have to be filled. The Chair asked the Committee how to proceed. The Committee was in agreement that this subject needed further discussion and should be put on the agenda for the next meeting.

VI. Explore Other Credentialing & State Website Issues.

Staff reported the condition of the website. Currently the website has the credentialing and recredentialing website in Microsoft Word. There is an on-going struggle of updating the website. OHPR has had difficulty keeping up the website, due to budget cuts and not having a staff member that has the skills for working on the web. The OHPR Office Manager, Mike Wiltfong has been made aware of the problem(s). He

suggested that the Committee solicit for website skilled volunteers because currently the OHPR does not receive nor have the funds to hire someone that is web savvy. The Committee discussed the idea of soliciting volunteers for assistance in update the site and helping to create a document that can be repopulated. Not all the Committee members were comfortable with the idea of soliciting volunteers working on the website. After some discussion, the Commission felt that it was not their responsibility to go shopping for volunteers. However the Committee would like to have an updated website where the credentialing and recredentialing applications can be filled out on line. Also they wanted to be sure that the fields of the applications can be filled in but the content of the application would remain the same, thus the keeping the applications secure.

The Committee asked Staff to request from the OHPR office to provide someone to take care of the website. Also they would like to invite the OHPR Office Manager to the next ACPCI meeting in order to discuss this need. Until then, Staff would do their best to get the website out of “under construction” and at least have the applications available for printing or downloading to a disk, even though a practitioner may not be able to populate them on line.

VI. Adjournment

The chair adjourned the meeting was at 12.48 p.m. The next meeting will be held November 19, 2002, in Room 500A of the Public Service Building.

Rebecca L. Burdug, CPCS, Chair

MINUTES
Advisory Committee on Physician Credentialing Information
November 19, 2002

Members Present: Rebecca Burdg, CMSC, Chair; Faye Gilbarg; Tom Foster, MD; James Kronenberg; Robert Wheeler, MD; Linda Baker, CMSC; Allen Johnson, MD.

Members Absent: Kelli Fussell, Barbara Halsey.

Staff Present: Kathy Weaver, MD; Laura Lanssens.

Also Attending: Mary Park-Lindsey, Providence Health Plans; Mike Wiltfong, Oregon Health Policy & Research (OHPR).

I. Call to Order

Rebecca Burdg, Chair, called the meeting to order at 11:07 a.m. in Room 500A of the Public Service Building, 255 Capitol Street NE, 5th floor, Salem, OR 97310. Introductions were made all around for courtesy of the guests.

II. Approval of Minutes from May 21, 2002

Staff had electronically sent the Minutes from May 21st, 2002 to the Members for their review and their approval. However not everyone had read the minutes. Therefore Becky suggested Staff resend out those minutes along with the minutes from September 17th, 2002.

III Attestation Page Review & Resolution

Becky reported that NCQA and CMS had gone to a 3-year recredentialing cycle. JAHCO was still at a 2-year cycle. She asked the commission how they were handling the changes in their individual offices.

Dr. Alan Johnson said that he thought his office had gone to a 3-year recredentialing cycle and was still using the attestation page with the 2-year wording.

Dr. Foster suggested that the Committee change the wording from two to three because it is all encompassing and the practitioners would be better served.

Dr. Wheeler concurred with Dr. Foster that the 3-year would meet a variety of the entities that are using the form.

Jim Kronenberg and Faye Gilbarg mentioned that the hospitals were still under a 2-year recredentialing. However they did not see a problem in changing the wording.

A motion was made to change the attestation page wording from “In the last two (2) years...” to “In the last three (3) years...”. It was unanimously approved. Staff will send the recommendation to the OHPR Administrator to write a letter to Oregon Health Division and Department of Consumer and Business Services informing them that the Oregon Practitioner Recredentialing Application form had been reviewed, amended and approved as of this date, November 19, 2002 and shall be effective as of January 1, 2003.

Becky asked if there were any other changes that need to be made in order to comply with national standards.

Dr. Foster mentioned that some practitioners in the Corvallis area are reluctant to answer the attestation page questions regarding completion of the credentialing or recredentialing forms because of the feeling that by answering “yes” to any of the questions that that would prove to be negative. Currently some do not complete the form.

Discussion ensued whether there should be further changes to accommodate these practitioners. Various legal councils had reviewed the attestation page and the Committee was averse to going through the process again. The Committee agreed that both attestation pages in the credentialing and recredentialing applications should remain the same except for the recently approved wording change in the recredentialing Attestation page. There were no further recommended changes to the applications. Therefore the Committee had reviewed and approved both application forms.

IV. Update and Discussion regarding application(s) on the-Website - OHPR Office Manager, Mike Wiltfong

Becky led the discussion into the topic of the locked application(s) and the OHPR Website. The Committee was aware that the website was under construction. She pointed out that the Committee had talked about this subject in past meetings but with no resolution.

Becky introduced Mike Wiltfong, the Operations Manager for OHPR. Mike mentioned that the applications were on the website in PDF and Word format. He understood that there had been a problem with some practitioners completing the form online and also some credential specialist had problems merging the document into a database. He related that there is an Adobe PDF Reader on the website that would allow most to view the document and print it out. He further stated that the problems that some may be having may be due to non-current software. He informed the Committee that it is almost impossible for the application to be compatible to everyone’s system.

Dr. Wheeler asked if the PDF version could accommodate a mail merge, which Mike answered yes. Then Dr. Wheeler asked if the PDF Reader would allow one to complete the form online. Mike said no; however one would need to have the Adobe PDF software and further stated that it was advisable to have the software for mail merge as well. Dr. Wheeler remarked that the conceptualization of the problem is excessively narrow. Mike said that might be so however the state is in a budget crisis and not much can be done at this time. He further said that he did not want to pass the expense onto the hospitals and other health care organizations, but the full package for Adobe software costs around \$300 and it one would look at having that program in place to fill out a couple thousand credentialing forms versus paying someone to complete each one, then the investment would be worth while for the hospitals and health care organization. His justification is that knowing what the OHPR budget is and not having the monies or resources to creating a document to fit all users and their systems.

Mary Park-Lindsey from Providence Health Plans reported that she was able to find an unlocked copy. Their credentialing administration populates the forms and then sends in to their practitioners to verify and make any changes. Mike mentioned at one time that there is an Access program that has been used for surveys, but was not met with much success. If the office had the time and the money, then perhaps that program could be used for a database template. But at this time it is not feasible for the OHPR to put forth any more time into the application project. He suggested that those who need the form and is unable to use the form online, they need contact OHPR Staff.

Mike further stated the OHPR office attempted to create a dynamic website where interaction is possible. However there is security issue with the state because the server that is used is not only used by OHPR but by Oregon State Lottery and Revenue. When the OHPR was originally proposing the idea of a dynamic website, the cost was minimal but unfortunately the security checks have made it cost prohibitive and it comes down to OHPR does not have the time and resources.

There was some discussion about unlocking the applications except for the attestation page. Some of the Committee members thought there might be other parts of the applications that should be locked. The idea of sending out a questionnaire asking which parts of the applications should be locked was submitted. After much discussion, the resolution was continue posting the locked applications to the website as they are with the exception that the "under construction" message deleted. The topic of unlocking the documents and sending out a questionnaire will be discussed at a later meeting. In conclusion, if any changes can be made that would benefit and make it easier for the practitioner or user to populate the forms then OHPR Staff will update the website.

V. Term Limits, January 2003 – Discussion & Resolution

After viewing the membership roster, it was found that there were three members that had terms expiring at the beginning of January 2003. The three members were Linda

Baker, Jim Kronenberg and Kelly Fussell. In a previous meeting the Committee had discussed to rollover the members to another 3-year term as their term expired, which was approved unanimously. The OHPR Administrator, Dr. John Santa was informed of this recommendation and agreed to the rollover as a form of having constancy to the ACPCI. Therefore Jim Kronenberg and Linda Baker will continue to sit on the committee until their new term expires, January 2006. However Kelly Fussell will no longer be on the ACPCI. She submitted her resignation because her hospital could no longer commit the time nor the personnel.

Dr. Alan Johnson also submitted his resignation because he is retiring from Kaiser Permanente. His term does not expire until January 2004.

The Committee asked Staff to send out a letter asking for nominees to fill the two vacated seats. The Committee suggested that the current membership roster and the House Bill 2144 accompany the letter that will be signed by Dr. John Santa. Staff will also pass on the Committee's recommendations to Dr. John Santa.

VI. CAQH Update – Linda Baker

Linda Baker gave a CAQH Update. She reported the first rollout occurred last March with Colorado and Virginia. Both of the states use the CAQH application. In September, Maryland was rolled out. Maryland is the first state to have a mandated application. In October they rolled out Connecticut and Washington DC and in November they roll out New York. All three of those states use the CAQH application. New Jersey will be rolled out in December with the CAQH application. Georgia will roll out in January and they have a voluntary application. Also they are the first state to have a roll out team from the state, which includes representatives from the hospital association, the health plan associations, and all of the Georgia associations of medical staff services; so that they are including hospital representation; whereas in the other states that have rolled out, it has been primarily health plan representation pushing for the CAQH applications. Linda suggested that Georgia is the state to watch to see how it unfolds.

Texas, Illinois, and Florida are targeted to roll out in January. Texas and Illinois have mandated applications. Florida will be using the CAQH application. The future state launches that have state specific applications are Ohio, West Virginia, Arkansas, Mississippi, Missouri, Oklahoma, North Carolina and Oregon. They have states slated to rollout through the first quarter in 2003 but have not finalized the rest of the year; although CAQH intending to stay on target in terms of rolling out across the country by the end of 2003. CAQH's expectation of rolling out Oregon is unknown. Linda suspects that it may be late summer or early fall of 2003.

As each state is rolled out, CAQH learns better how to market the product, how to perform their outreaches and they have designed some pretty impressive orientation tools that makes it easier for health plans or office managers. CAQH has completed

an office manual module that assists the managers in completing and updating the applications. This morning CAQH reported that they have had successes with non-CAQH member plans in making the commitment to become a CAQH member or to utilize their repository without becoming a member.

In the last month CAQH sent out to the plans reminders to update their recredentialing information. At this time, the attesting is still every three months. Linda mentioned that no feedback is available yet since they are just beginning the practice.

VII Development of Annual Procedure(s) Time Lines

Becky mentioned that Dr. Wheeler had suggested at the last meeting that the Committee plan out an annual time line, which would include three meetings for the ACPI. Dr. Wheeler further suggested the announcement of the 2003 of these meetings to put up on the website would be Staff's responsibility.

Since the Committee needs to be aware of changes in accrediting standards i.e., HIPAA, NCQA, JAHCO he further recommended that June would be a good month for the first meeting to sound out what changes need to be made. That would give the Staff a chance to solicit input and to petition nominees over the summer. Then the second meeting would be in September, the Committee would review the input of tentative changes that came in, make whatever changes need to be made, and look at who CAQH is rolling off next cycle. The third meeting would be to make any final decisions and prepare and plan for the next year, hence three meetings for the year.

Additionally, issue will come up and when they do, Staff will gather the issues and then e-mail those issues to each Member to receive a response. Any communication will be done electronically. The Committee Members all were in agreement.

VIII. Adjournment

Becky adjourned the ACPCI meeting at 12:47 p.m. The next meeting shall be held in 2003.

Rebecca L. Burdug, CPCS, Chair