Provider Directory Advisory Committee Meeting

May 17, 2017

Oregon Health Authority

Welcome!

- Meeting agenda/objectives review (5 min)
- Introduce Health Information Technology (HIT) Commons (20 min)
- PDAC work buckets and charter discussion (20 min)
- Review Provider Directory value, functions, timelines, and funding (50 min)
- Break (10 min)
- Discuss Adoption/Communications plan (50 min)
- Common Credentialing update (15 min)
- Close (10 min)

Objectives for today's meeting

- Awareness and understanding of:
  - HIT Commons and it's potential linkages to the Provider Directory
  - Common Credentialing fees and updates
  - Value, functions, timelines, phases, regulations, and outlining where the Provider Directory and Common Credentialing align/differ
- List of:
  - Roles for Provider Directory champions
  - Provider Directory adoption gaps, barriers, and risks and how to address them
  - Key stakeholders and influencers and the best way to connect
- Input and recommendations on user phasing approach, funding, and roadmap
- Consensus on charter, work buckets, and new PDAC success metrics
- Definitions for key performance indicators in the roadmap

HIT Commons

Sean Carey

Lead Policy Analyst

Background for Collaboration

- Oregon HIT strategy development in 2013
  - IT infrastructure support for healthcare transformation
  - Patient and family
  - Providers
  - Coordinated Care stakeholders
  - Policy makers
- Envisioned "Commons" approach to community wide access to essential information
  - "Democratization" of essential information
  - Governance structure to reflect interests of common good

Early Successes

- OneHealthPort single sign on: voluntary, informal, standardize
- EDIE / PreManage: formal state/private "co-sponsorship" with common governance structure
  - State financial support for Medicaid share of infrastructure, and support for high priority Medicaid users of PreManage (CCOs, behavioral health teams)
  - Private financial support/sponsorship for primary care clinics
  - Standard vendor contracts, data use agreements, research and analytic support, and decision making policies
- Prescription Drug Monitoring Program – HIT Gateway
  - Coordinated legislative strategy
  - Coordinated technology solutions (e.g., Gateway)
  - Potential for shared funding for infrastructure and operations that leverages federal, state and private funding

Potential Principles for an Oregon HIT Commons

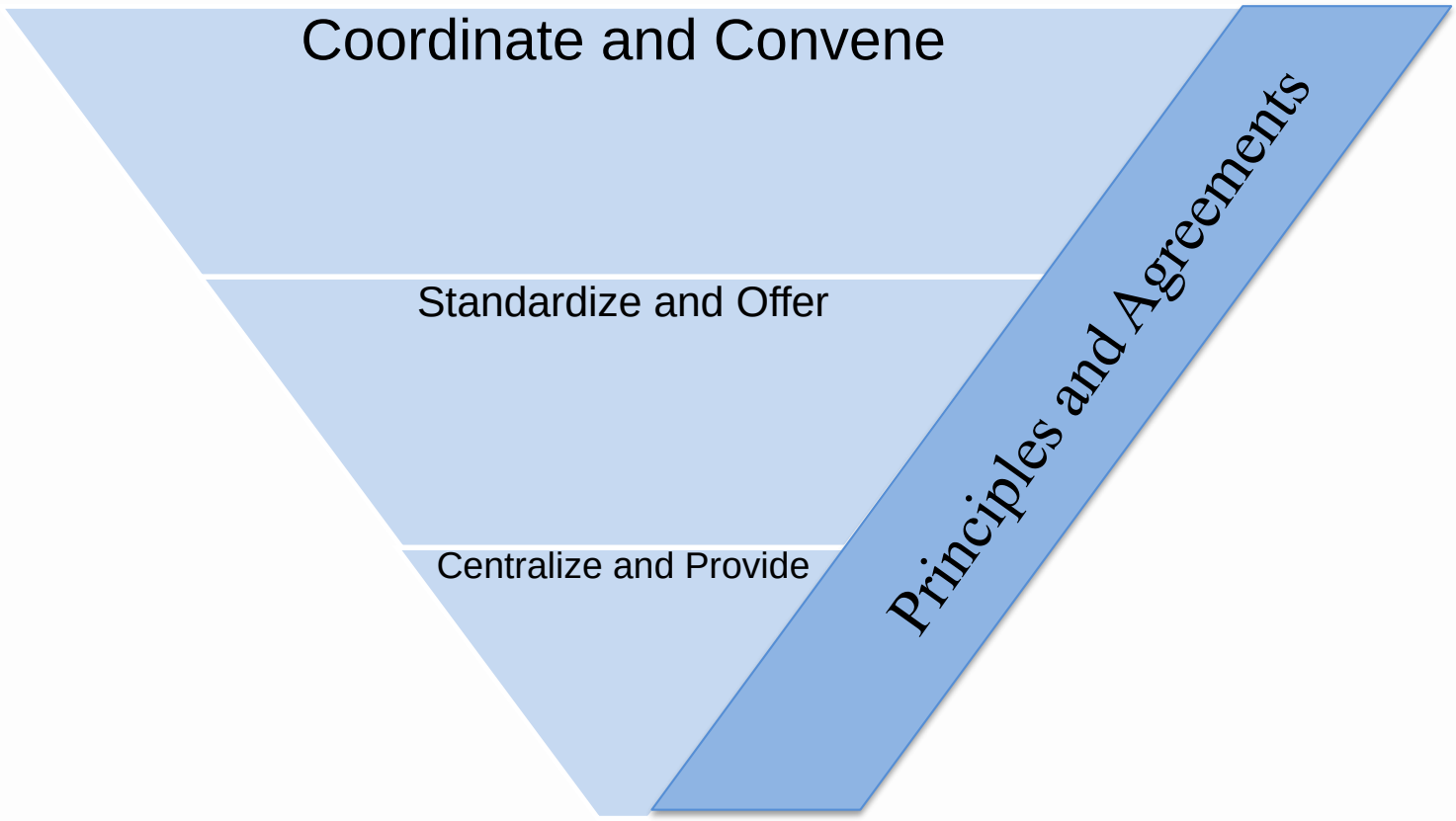
- Everyone "in" with commitment of proportionate resources (financial or other)
- Clear scope in service to the critical few, common good initiatives
- Clear economies of scale
- Clear performance expectations
- Clear stakeholder /sponsor governance inclusion & selection
- Clear dispute resolution, adherence to decisions
- Regulatory and legislative support for decisions
- Clear exit plan / consequences
- Clear roles / RACI defined

Funding Available to Support Activities

- OHA is able to leverage federal funds for certain health IT projects and program costs related to the Medicaid program
- Funding depends on availability of state matching funds and the specific nature of activities
- 90/10 funds are available for development and implementation of programs through 2021
- 75/25 funds are available for certain ongoing IT costs
- 50/50 funds are available for many other administrative and program costs

- Note: Funding is limited to Medicaid-portion of costs; non-Medicaid portion is cost-allocated

Layers of HIT Commons Roles



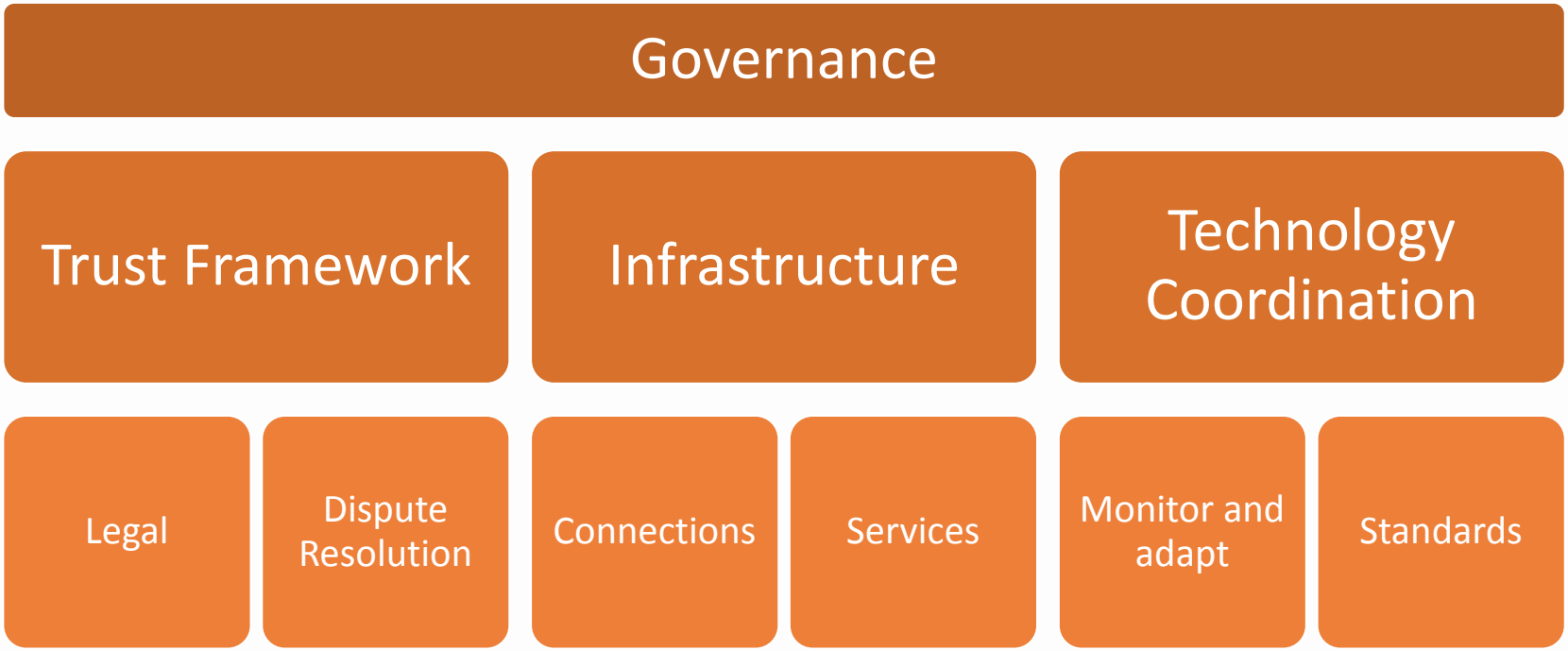
Possible HIT Commons Roles

	Light ⟷	
Agreements and Principles	Principles of participation; Data use agreements	Data governance
Coordinate	Promote initiatives (e.g. Open Notes); Communication/education; Reporting on data showing ROI/value of Commons	Learning collaboratives; Supporting pilots (e.g., funding); Significant evaluation
Standardize	Implementation guides; Value add tools/services (e.g., PreManage)	Technical assistance; Endorse/certify technology solutions
Centralize	Provide funding and subsidies (e.g., HIE Onboarding); Provide light-weight services (e.g., PDMP Gateway)	Vendor management/ procurement; Provide significant centralized services
Organization formality	Sponsors with external fiscal agent	Stand-alone legal entity (e.g., non-profit); Formal public/private partnership

Example Problem to Solve
Statewide HIE Network of Networks

- Goal to have minimum core data available wherever Oregonians receive care or services across the state
- Basic movement of health information is improving but
  - Significant gaps remain
  - Barriers to HIE: technology, organizational culture, trust
  - Ensuring HIE is meaningful is complex
- "Raising all boats" to connect providers across the state can best be accomplished together
  - Statewide efforts and shared governance can play a significant role

Network of Networks



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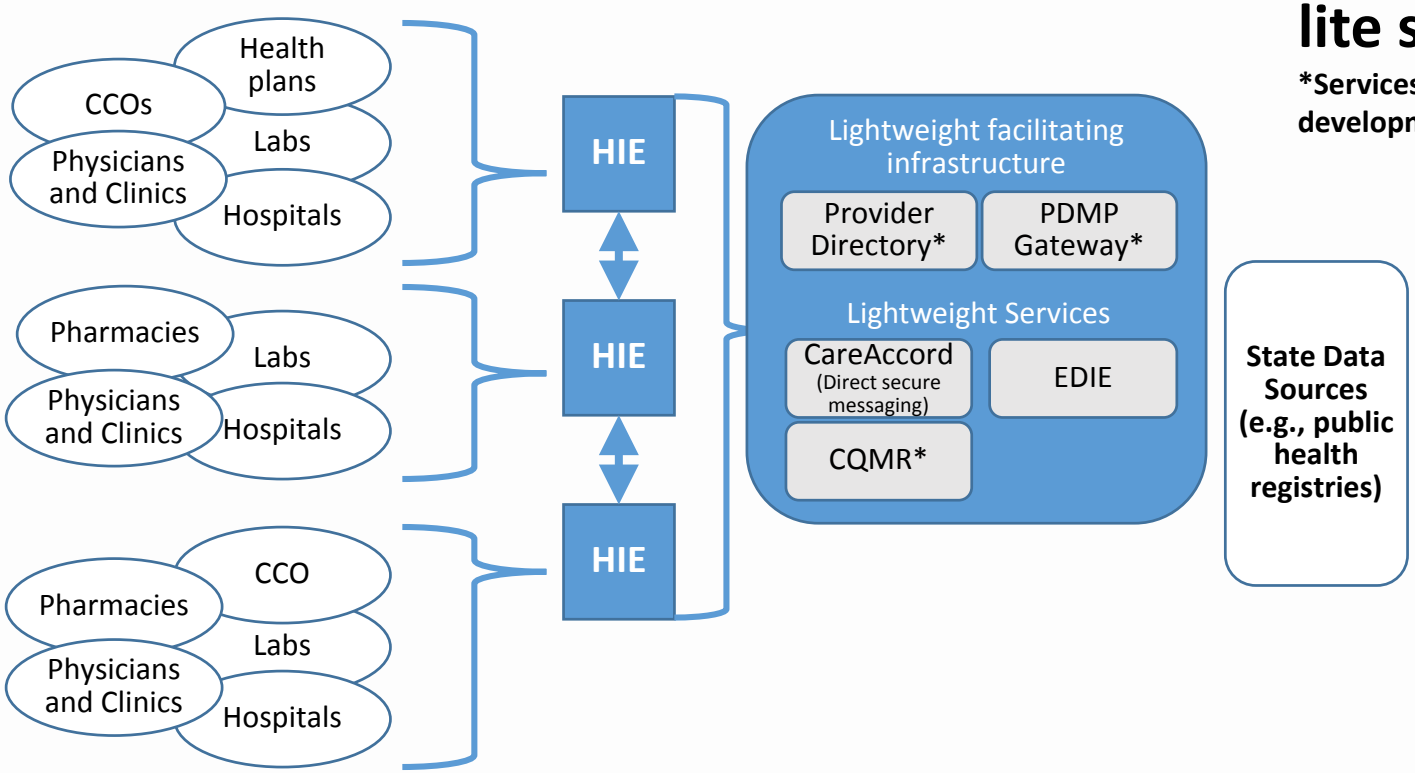
Robust HIE Model with lite services

***Services/ programs in development**



** Not shown: connections between organizations/ national frameworks for exchange

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Timeline

- January – March: Initial Input and Research
  - February 16 sensing session
  - February 23 HIT Advisory Group meeting for CCO input
  - Individual 1:1 sensing sessions with additional stakeholders
  - Research and reflection on other states' models, successes, and challenges
- Starting in May: Interim advisory group meets to help formulate business plan
- May - July: Draft business plan input
  - OHLC, OHPB, HITOC, HITAG
- Late Summer 2017: Final business plan released

Questions?

PDAC Charter and Work Plan

Karen Hale

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Priority buckets of work for the PDAC

Input areas	Process	Deliverables

• Communications strategies
  • Marketing and Outreach
• Adoption and uptake strategies
• Fee structures and options
• Governance
  • Data
  • Program
	• Meetings
	• Discussions
	• Mid-meeting surveys and collaboration tools
		• Participation
		• Meeting summaries and documentation
		• Recommendations and input

Review work plan

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Updates to Charter – PDAC Success Metrics

- Written recommendations to HITOC on program, policy, and technical areas addressed by the PDAC including:
  - Adoption and rollout strategy
  - Fee models
  - Benefits and Value Proposition to Stakeholders
  - Communications, Marketing, and Outreach
  - Change management processes
- Documentation posted for original and updated:
  - Risks and risk mitigation strategies
  - Gaps and barriers accompanied by recommended approaches to bridge gaps and remove barriers
- ≥75% average attendance rate at PDAC meetings
- ≥50% average participation in non-meeting requests and activities
- ≥50% PDAC members participate as Provider Directory spokespeople and champions
- >25% PDAC participation in UAT (including delegation)
- PDAC participation in initial adoption based on TBD adoption targets

Provider Directory adoption risks, barriers, and gaps

1. When implementing the Provider Directory,

⚠What are some of the risks that may impact success

⚠What are some of the barriers?

⚠What about gaps?

2. What are ways to mitigate risks, remove barriers, or bridge gaps?

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Examples of what we will be tracking (starting today)

Risk	Mitigation
Poor data quality	✓ Use skilled data stewards ✓ Test, test, test ✓ Ensure data quality meets established standards ✓ Use stakeholders in UAT and as early adopters

Gaps	Countermeasures
Accepting new patients is not in phase 1	Clear communication on what will be available and when Analyze work arounds

Barrier	Countermeasures
Timing for the provider directory to become live and contractor onboard due to state and federal contract processes	Research methods to potentially speed up the approval process

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Provider Directory Spokespeople and Champions

- What are the right roles and activities for a champion?
- What would it take for you to be a Provider Directory champion?
- What do you need to make a decision? What tools do you need to be effective?
- What champion activities should be tracked? How?

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Provider Directory value, functions, timelines, and funding

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Top Five Provider Directory Benefits/Value

Improved administrative efficiencies and quality of provider directory data

- Reduce staff time spent on data maintenance activities and burden on providers
- Remove duplicate and repetitious requests

Improved ability to meet regulations related to provider directory accuracy

- Provide one complete, accurate source for Medicare Advantage Organizations and Medicaid and Medicaid Managed Care entities

Better care coordination for patients and increased health information exchange

- Find contact information, including electronic servicing information, for specific providers or for those who meet certain criteria
- Use of Direct secure messaging improves security and privacy of patient data and reduces use of fax/paper resources

Improved ability to meet Advancing Care Information and Meaningful Use objectives

- Find providers and their electronic contact information, essential to meeting the Health Information Exchange measures for care summary exchange and incorporation

Support research, reporting, measurement, and other health analytics needs with accurate, historical, and complete datasets

- Calculate outcomes that require detailed provider and practice data characteristics

Proposed Phasing Approach

	Functionality	Phase
Solution	Stand –up, security, access controls	1
Data Elements*	Basic Provider and Organization	1
	Additional (e.g., accepting new patients, hours)	2
Data Sources	Common Credentialing,, MMIS, CareAccordFFD, *Lexis Nexis (optional)*	1
	EHR Incentive Programs, PCPCH, CCO network, Public Health, NPPES, PECOS, APAC, HIEs, Other	2
Quality and matching	Clean, score and match data	1
	Golden record	1
	Data flagging	1
	Data stewardship	1
Data entry	By users	2
Access	Portal; static extract	1
	Custom extract; Interfaces (APIs/web services)	2
	Other functionality (optional) (GIS)	2

***Basic provider and organization data;**
Demographics and identifiers
Addresses
Contact info
Affiliations: clinics and practices, payers, CCOs, PCPCHs, Medicaid
Credentials
Licensing
HIE Addresses
EHR Info

Additional;
Accepting new patients
Office hours/hours worked/FTE, website, Other

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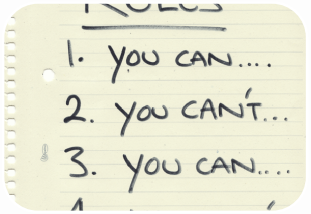
Delineating details for use cases

- The Provider Directory Subject Matter Expert Workgroup (PD-SME) will ensure the Provider Directory meets the needs of users
- Discussing and analyzing 25 use cases
- Documentation of the prioritized use cases will contain:

Description and Scope

Actors

Functional processes



Rules and facts

Data requirements

Providers in the PD

Questions for the group

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25 Use Cases

Analytics use cases

- Analytics extract
- Practice location/Program
- Performance analytics
- Outcomes and intervention
- Privileging
- GIS mapping

Availability use cases

- Office hours
- Accessibility (disability, language, cultural competency)
- "In-network" search (referrals)
- Accepting new patients

Data affiliations use cases

- Payer to provider affiliation
- Hospital to provider affiliation (privileging)
- CCO affiliations

Data entry use cases

- Data error flagging
- Entering data into the Provider Directory

Health Information Exchange (HIE) use cases

- Find a provider and their Electronic Servicing Info (ESI) if you know something specific about them or need to do a general search
- PD to meet care coordination needs
- HIE data – upgrading from the CareAccord Flat File directory

Operations use cases

- Pulling data for own PD validation
- Find contact information on a provider or person who is part of the care team

Regulations use cases

- Medicare Advantage requirements
- Network adequacy reporting
- Network adequacy PD requirements
- Meaningful use objectives
- Medicaid Managed Care PD requirements

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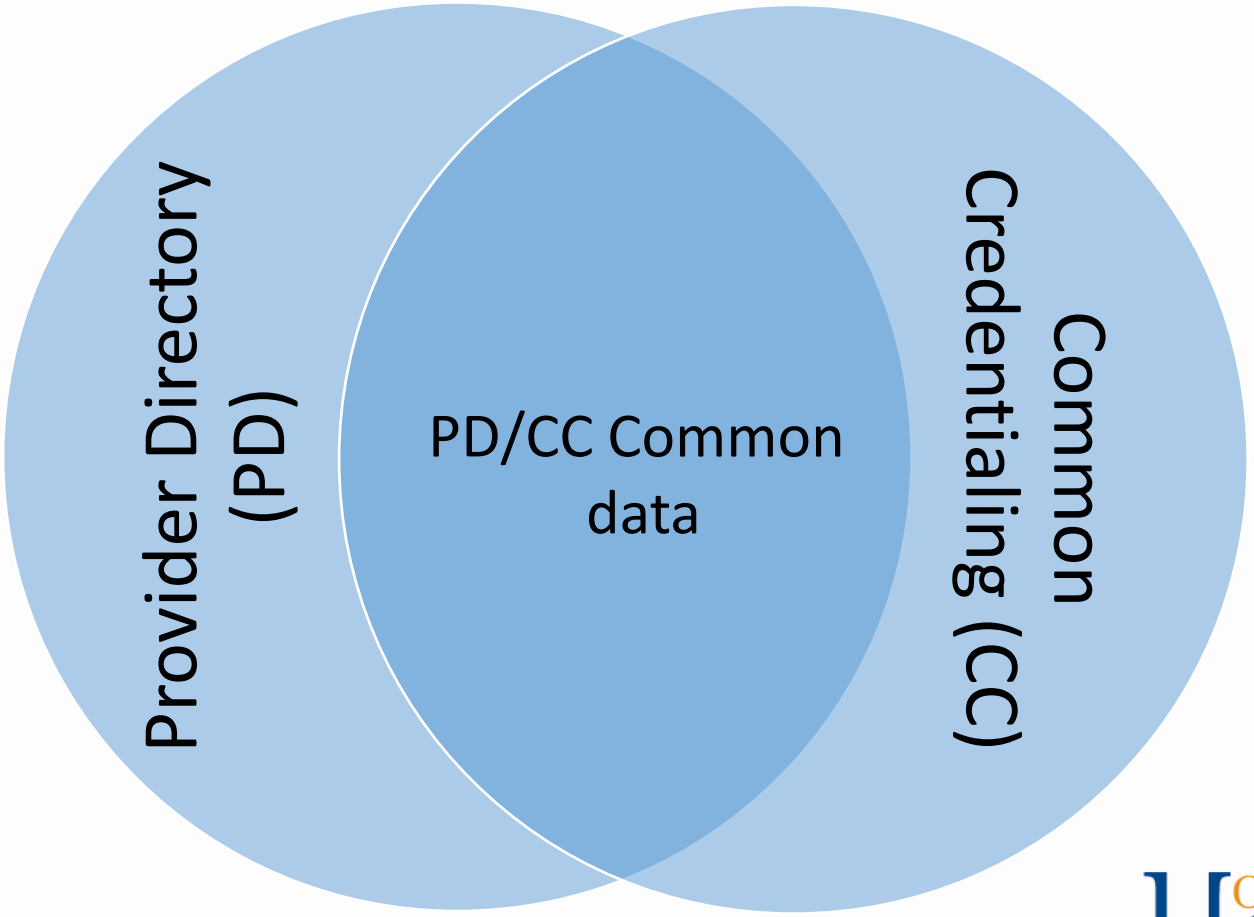
Provider Directory Data Comparison

Data	Medicare Advantage	Medicaid Managed Care	Network Adequacy	PD Phase	Common Credentialing
Name	X	X	X	1	X
Location	X	X	X	1	X
Telephone number	X	X	X	1	X
Specialty	X	X	X	1	X
Gender			X	1	X
Board Certifications			X	1	X
Provider Language	X	X	X	1/2	
Cultural Competency		X		2	
Practice and Facility affiliations	X	X		1/2	X
Accepting New Patients	X	X	X	2	
Website URL		X	X	2	
Network affiliations and tier level			X		
Office hours	X			2	
ADA Accessibility/accommodations		X		2	
Facility type			X	1	
Hospital Accreditation status			X		

Provider Directory vs. Common Credentialing



CC and PD common data

Data type	Data
Demographics	Provider name and other names used, specialty, primary care practitioner designation, age, gender
Affiliations	Primary/Secondary Practice info: Name of clinic, work hours (Full time/part time), addresses (street, mailing, billing), effective date, contact information, practice call coverage Hospital and facility affiliations**:** Organization name, address, effective dates (some privileging information)
Identifiers	Oregon license #, type, dates; Drug Enforcement Agency(DEA)/Controlled Substance Registration (CSR) #; National Provider Identifier (NPI); Medicare #; Medicaid #; other state licenses, registrations, and certificates

Common Credentialing Provider Types

- Acupuncturists
- Audiologists
- Certified Registered Nurse Anesthetist
- Chiropractor
- Clinical Nurse Specialist
- Doctor of Dental Medicine
- Doctor of Dental Surgery
- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Licensed Clinical Social Worker
- Licensed Dieticians
- Licensed Marriage/Family Therapists
- Licensed Massage Therapists
- Licensed Professional Counselor
- Naturopathic Physician
- Nurse Practitioner
- Occupational Therapists
- Optometrist
- Oral and Maxillofacial Surgeons
- Psychologists
- Physical Therapists
- Physician Assistants
- Psychologist Associate
- Registered Nurse First Assistant
- Speech Therapists

CC only data (not shared with PD)

Data type	Data
Personal Demographics	Home Street Address, phone, email, social security number (SSN), date of birth
Identifiers	Tax Identifier (ID) (can be Federal Tax ID or SSN)
Peer references	Peer name, specialty, relationship, phone, fax, email, address
Education	Undergraduate; Graduate; Medical/Professional; Post-graduate year 1/internship; Residencies; Fellowships, Preceptorships, or other clinical training programs; Continuing Medical Education
Professional Liability	Current and prior carrier information and action detail
Attestation	Attestation questions

Access to a provider file is only granted to credentialing organizations selected by the provider.

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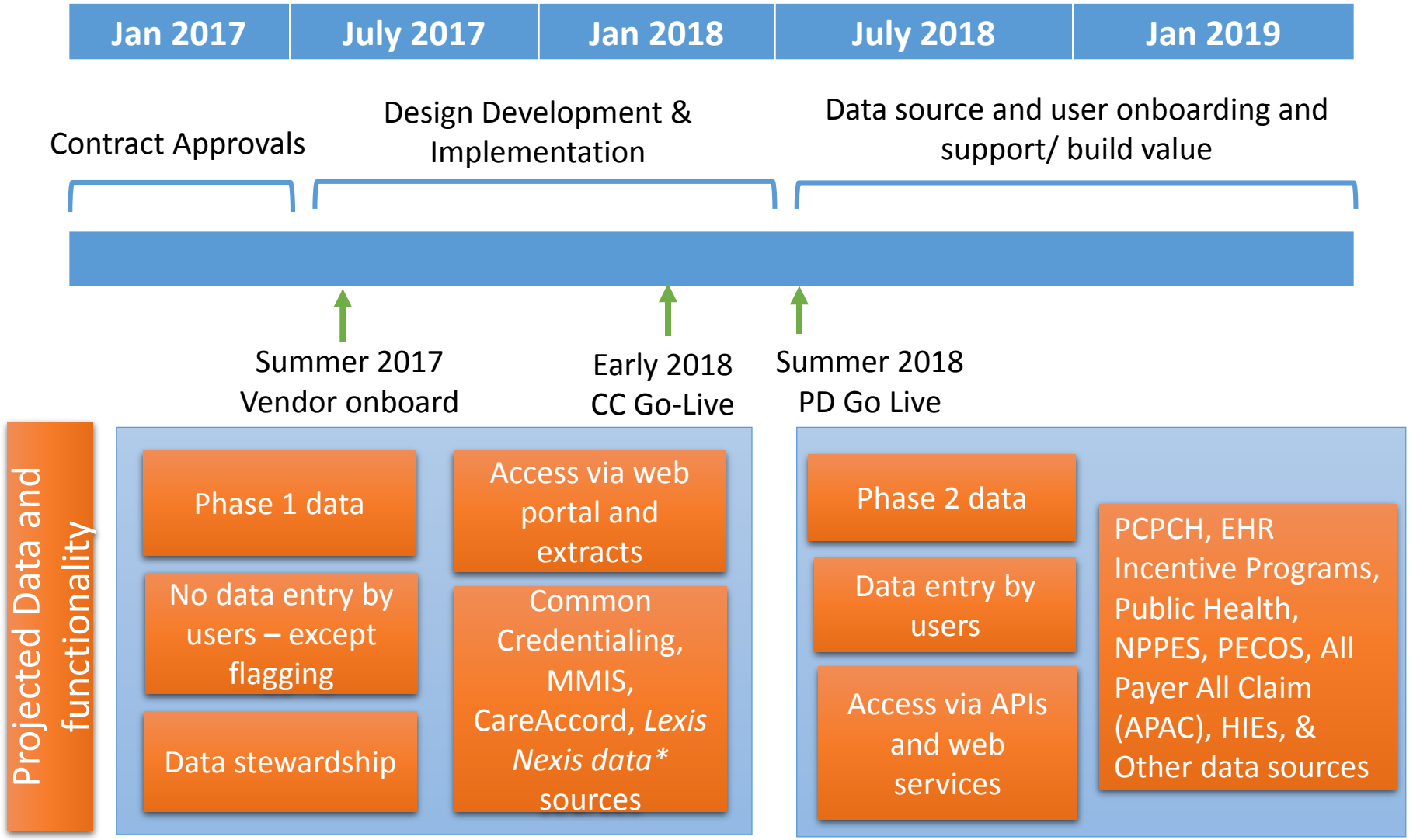
PD only data

Data type	Data
Demographics	Ethnicity, languages/linguistic capabilities*
Affiliations	Affiliations to programs and payers (e.g., EHR Incentive Programs, Patient Centered Primary Care Home (PCPCH) program and tier, CCO/DCO, Medicaid, Health Information Exchange, All Payer All Claim (APAC) information, Medicare)
Training	Cultural competency*
Accessibility	Accepting new patients, website, disability access to locations, office hours
Electronic Servicing Information	Direct secure messaging address and other information needed to exchange protected health information (PHI)
Other	Electronic Health Record (EHR) name and version, stage of meaningful use, EHR program participation, philosophy of care

- Access to all provider records in the Provider Directory
- Providers in the Provider Directory can be individuals with or without an NPI (e.g., care coordinators) or organizations (e.g., facilities, hospitals)
- Data not coming from CC are validated by data stewards

*data element under evaluation

Timeline



Review Roadmap with Success Factors

**under consideration*

Medicaid and non-Medicaid share

- In 2014, to support Meaningful use, OHA secured 90-10 Medicaid funding for the design, development, and implementation (DDI) of the Provider Directory
- In 2015, HB 2294 was passed which allows the OHA to expand Health IT beyond the Medicaid program and charge fees
- Use of the Provider Directory beyond Medicaid users must be cost allocated (fees)
- The cost allocation share is based on a calculation that is based on a ratio of Medicaid to non-Medicaid (e.g., Medicaid providers/Non-Medicaid providers).
- We are working on the share % and who would be considered a Medicaid user vs. non-Medicaid user.
- The share % that is attributed to Medicaid is covered by CMS at 90%. State general fund (GF) covers 10%. The non-Medicaid share can be covered by other sources including fees and state GF.
- The calculation and plan requires CMS approval and will be requested when fees can support the non-Medicaid costs.

User phasing approach

Now – Plan	Go Live – "Early Access"	After Go Live – Expanded access
Engage Medicaid and non-Medicaid stakeholders	Limit PD to support Medicaid uses; establish value and stabilize the directory	Full set of data to support use cases
Develop adoption plan, including tiers	Minimum Viable Product: limited data or functionality, data quality may be lower	Support non-Medicaid share with fees
Develop fee models, timelines, sustainability plan, and cost allocation	Work to expand access: Approve sustainability plan and cost allocation	Onboard non-Medicaid and Medicaid users
Develop and execute communications plan with milestones; monitor/adjust	Continue to build functionality and add data that support all uses	

PDAC feedback

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Break

Adoption/Communications Planning

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Communication Plan Objectives (2016)

- Create awareness and garner support from health care entities
- Define ways the provider directory functionality matches stakeholder needs and creates value
- Delineate how the provider directory fits in with the bigger picture
- Promote use and uptake of the provider directory
- Encourage collaboration and transparency

Next Output:
PDAC informed and recommended adoption and outreach plan

Components to address in the Adoption Plan

- Goals
  - E.g., Ensure systematic approach to system rollout, maximize participation, etc.
- Strategies
  - E.g., Deploy targeted outreach by user type and use (tiers), coordinate early access, set adoption targets and track them, ensure data are meaningful, etc.
- Approach
  - E.g., Involve external stakeholders in design consultations and UAT, develop simple messages by user tiers, etc.
- Timeline
- Action plan
  - For each strategy/approach, document who is involved, how it will happen, and timeframe

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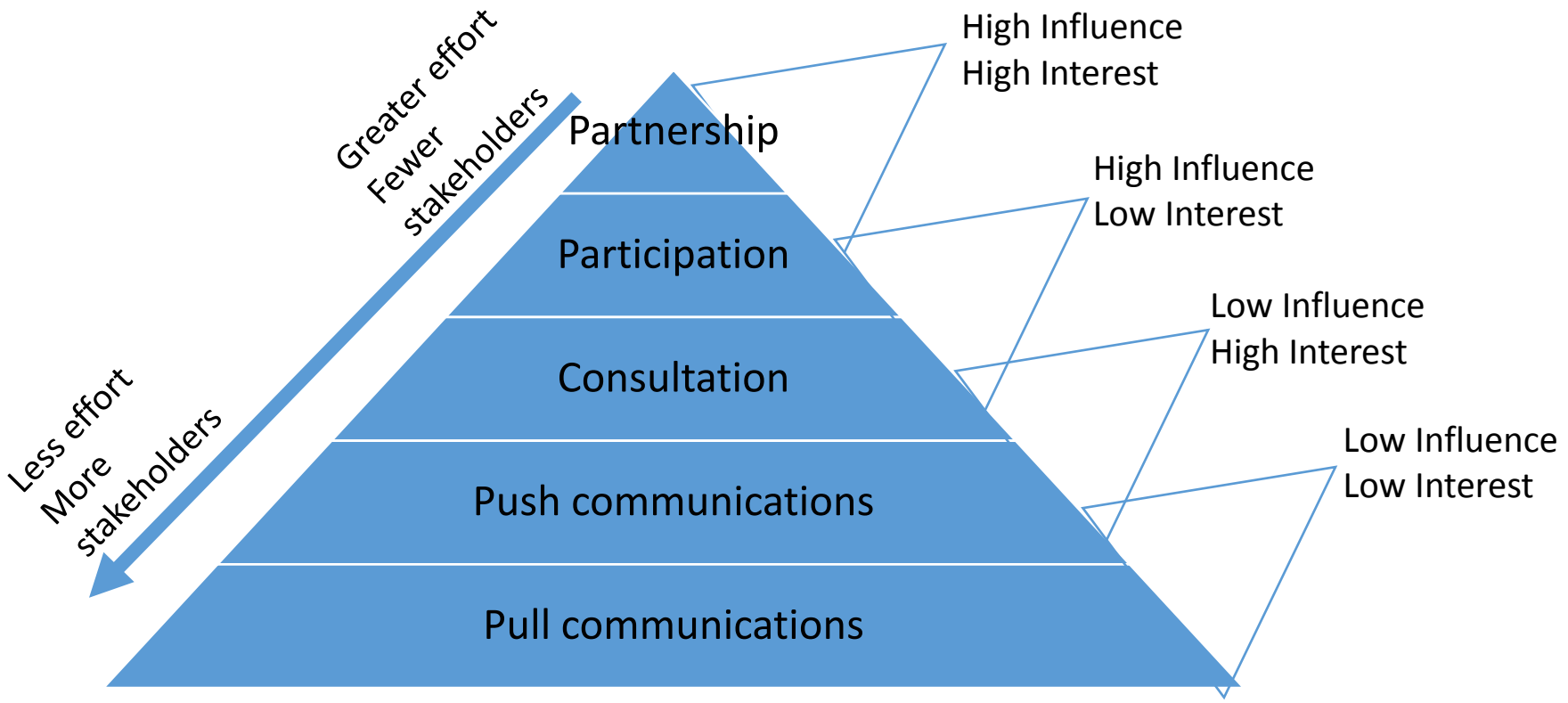
Step 1: Who are our key audiences and users?

- Consider classification and levels of engagement:



Channels and tools

Channels

- OHA websites
  - Office of Health IT, including common credentialing
  - OHA Home page
  - Provider services homepage
- OHIT newsletter and e-blasts
- OHA Health System Transformation newsletter
- Media stories – when and where appropriate
- OHA social media outlets
- Through partner organizations
  - Websites and newsletter stories
- Through champions and spokespeople

Tools

- Fact sheets and FAQs
- Presentations
- Association newsletter articles and e-bulletins
- Direct mailers
- Partner organization's websites and social media outlets
- Industry publications (news articles, advertising)
- Webinars
- Facebook/Twitter
- Youtube videos

Key users discussion

For each user grouping

- Who are the key audiences within the group?
- What is their interest? Influence?
- Are they currently engaged?
- What is the best way to connect?

Users

- Health Plans
- CCOs
- Dental Care Organizations (DCOs)
- Health Information Exchanges (HIE)
- Independent Physician Association (IPA)
- Providers and Clinics (includes dental and behavioral)
- Health Systems/Hospitals
- Long term care
- Tribal
- Research organizations (not marketing)
- Other

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The Oregon Common Credentialing Program

May 17, 2017

Melissa Isavoran, Program Manager

Health Policy & Analytics
Office of Health Information Technology

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Progress Update

- OHA executed contract with Harris on March 23, 2017
  - Finalizing subcontracts with Conduent (Xerox) and Medversant
- Exact OCCP go-live date to be determined in next month
- Other programmatic work continuing:
  - Detailed policy discussions, program outreach materials development, and change management planning still underway
  - Rule changes drafted for the 1st Rules Advisory Committee on May 3, 2017. Two additional meetings are being scheduled through June
  - Resourcing needs, implementation and ongoing, are being assessed and discussed internally

CC Implementation Team and Introductions

- Call Center Help Desk Support (Tier 1,2,3)
- Harris subcontractor; responsible for all Medversant (2nd tier subcontractor) deliverables

- CVO Services and Common Credentialing Portal
- Software development efforts to enhance credentialing software to meet OHA's requirements
- Conduent subcontractor

- Prime Contractor
- Program Management
- System Integration Analysis & Implementation
- Testing Services

- Single Sign On and enrollment solution for CC Implementation
- OHP currently supports 9,945 Organizations and 42,345 subscribers in Oregon (OCCS overlap unknown)
- Harris subcontractor

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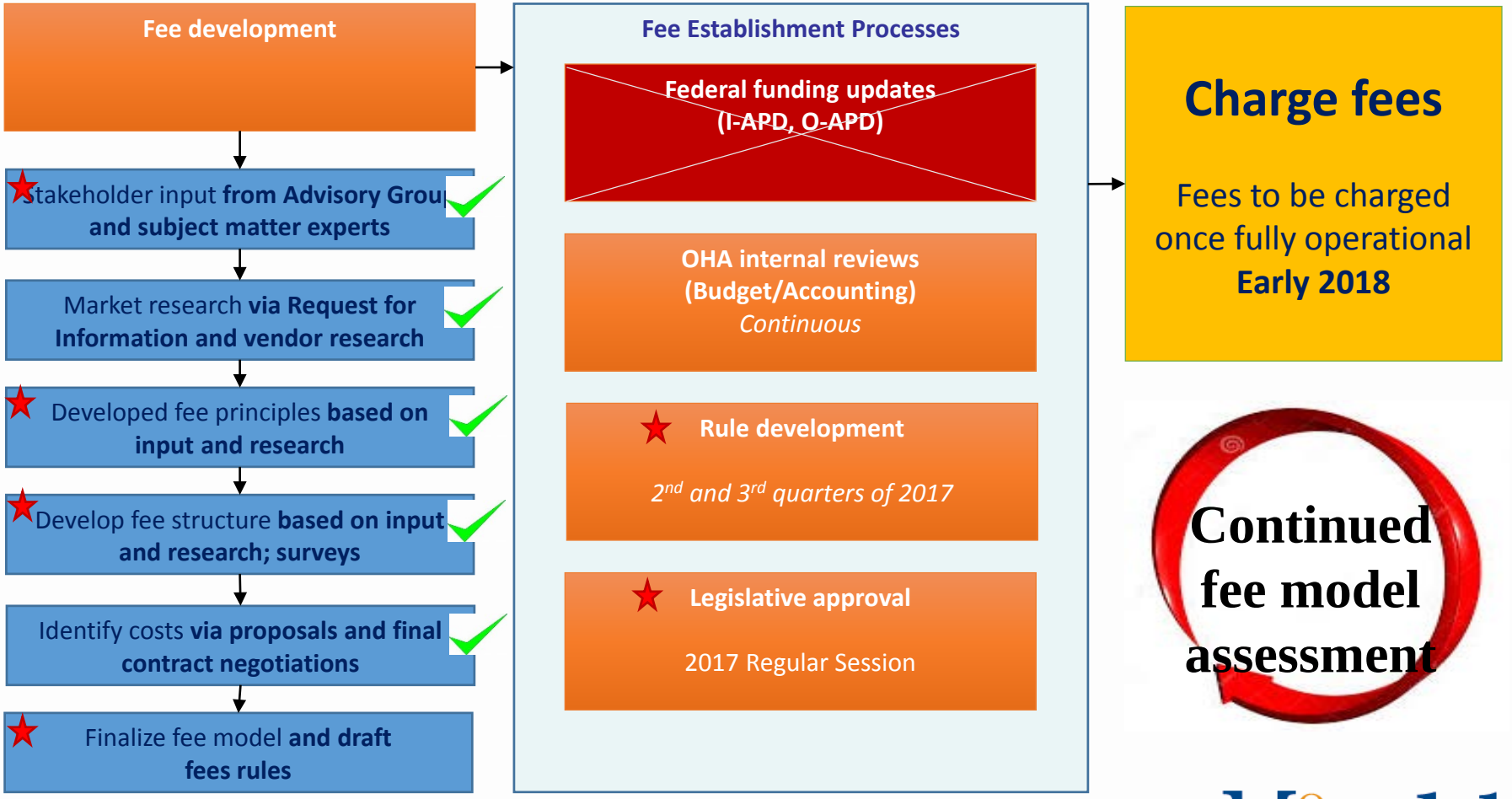
Fee Process



★ ***Indicates opportunity for stakeholder input***

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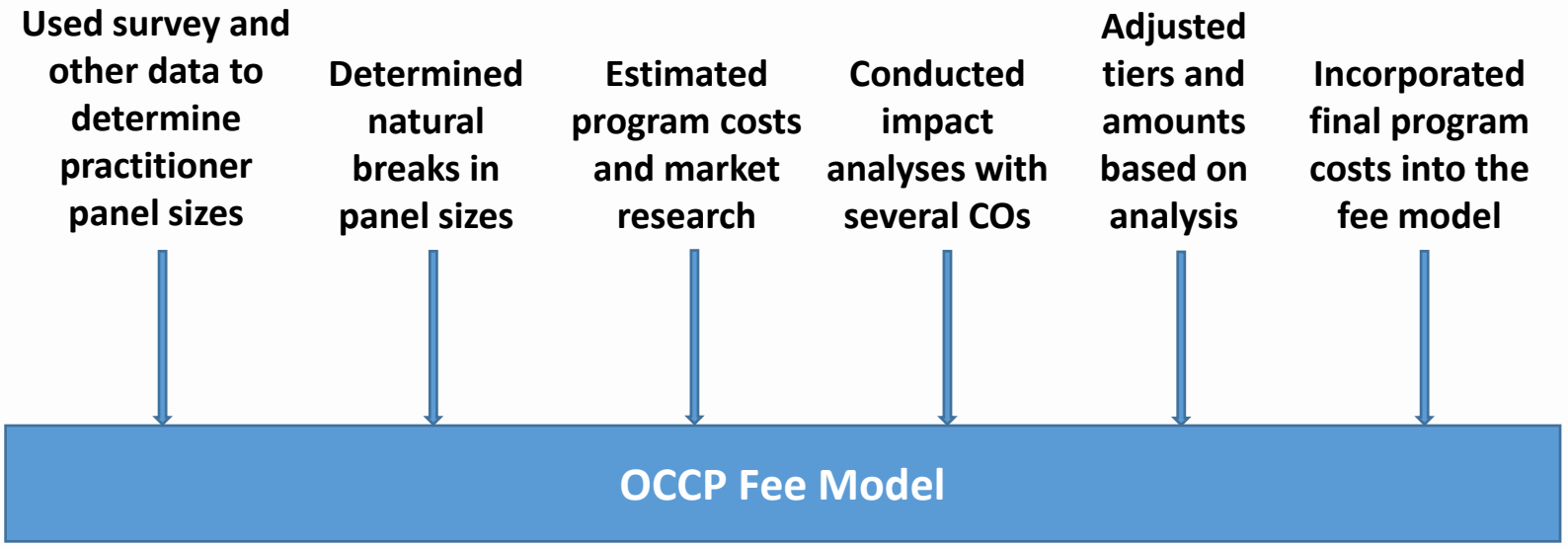
Fee Model Development

OHA Worked with stakeholders on a fee structure whereby:

- Practitioners pay a one-time application fee
- COs pay a one-time set up fee and annual subscription fees
- Tiered fees for COs would be used and based on practitioner panel size as a proxy for anticipated use of the system



OCCP Fee Model

Practitioner Fee: One-time initial application fee of **$150** per practitioner

Credentialing Organization Fees:

		Set-up Fee	Annual Fee	Total Initial Fee
Tier	**Practitioner Panel Size**	**Fee Per CO**	**Fee Per CO**	**Per CO**
Tier 1	**1-100**	*$10/practitioner*	*$90/practitioner*	*varies*
Tier 2	**101-150**	$1,010	$9,090	$10,100
Tier 3	**151-250**	$1,500	$13,500	$15,000
Tier 4	**251-500**	$2,500	$22,500	$25,000
Tier 5	**501-750**	$5,000	$40,000	$47,000
Tier 6	**751-1,500**	$7,200	$60,000	$67,200
Tier 7	**1,501-2,500**	$11,500	$85,000	$96,500
Tier 8	**2,501-5,000**	$14,500	$110,000	$124,500
Tier 9	**5,001-7,500**	$17,000	$125,000	$142,000
Tier 10	**7,501-10,000**	$19,500	$140,000	$159,500
Tier 11	**10,001-15,000**	$22,500	$165,000	$187,500
Tier 12	**>15,000**	$26,000	$195,000	$221,000

Expedited Credentialing Fee: Up to $100/practitioner assessed to COs that optionally request an initial credentialing application be expedited.

Health Care Practitioner Services

Health care practitioner contribution via a one-time application fee at initial set up

- 24/7 web-based access to OCCP system to submit credentialing information
- Ability to manage changes to credentialing information via centralized location
- Ability to centrally adjust CO assignment as needed
- Designee access to assist in maintaining practitioner information

Health Care Practitioner Workflow Changes

Credentialing process	HCP current workflow	HCP post OCCP workflow
Submitting initial applications	**Submittal to each new CO**	**One time initial submittal**
Submitting supporting documentation	**Submittal to each CO**	**Submittal to OCCP**
Submitting CO specific documentation	**Submittal to each requesting CO**	**Submittal to each requesting CO**
Ensure application completeness	**Coordination with each CO**	**Coordination with OCCP**
Submitting recredentialing applications	**Submittal to each CO**	**Attest every 120 days**

Notes:

- The recredentialing application will no longer be necessary as COs must access the OCCP system to retrieve a current application with updated attestations/verifications
- Practitioners credentialed with one or fewer COs will be excluded from 120 day attestations

Credentialing Organization Services

CO pay a one-time setup fee and annual subscription fee at initial setup based on self-reported practitioner panel size

- Covers initial setup and account maintenance
- Allows 24/7 access to practitioner credentialing information
- Provides primary source verification and documentation
- Monitoring of practitioner sanctions and expireables
- Ad hoc reporting and flat files
- Standardized Application Programming Interface

Credentialing Organization Workflow Changes

Credentialing services	CO current	OCCP workflow	CO post OCCP
Providing and managing a credentialing database	X	X	X
Sending/generating applications	X	X	-
Reviewing applications for completeness	X	X	-
Practitioner follow up for additional/missing info	X	X	-
Verifying licenses	X	X	-
Verifying board certifications	X	X	-
Verify all education and training	X	X	-
Requesting and reviewing residency letters	X	-	X
Verifying all hospital affiliations	X	X	-
Verifying work history up to ten years	X	X	-
Collecting three peer references	X	X	-
Verifying three peer references	X	-	X
Reviewing of Medicare Opt-Out List	X	X	-
Querying OIG for exclusion	X	X	-
Collecting liability coverage face sheet	X	X	-
Running NPDB/HIPDB queries	X	-	X
Tracking returned verifications	X	X	-
Managing status update inquiries and rosters	X	-	X

Workflow Considerations

COs should consider the following workflow impacts:

- Extracting information from the system may be desired
- Initial participation may require additional resources
- CO credentialing policies may need adjustment
- Delegation agreements may need to be altered
- Auditing activities may need to be altered
- Practitioners may need new workflow guidance
- There may be opportunities to redistribute staff work

OHA will be working with stakeholders representing different participants (practitioners, health plans, ambulatory surgical centers, etc.) to develop change management plans that can maximize value of the Program.

Questions?

Send questions, comments, or volunteer interests to:
credentialing@state.or.us

More information can be found at:
www.oregon.gov/oha/OHIT/occp

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Close

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Q & A/Close

- For this meeting, what worked well?
- What could we do better next time?
- What questions do you have?

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