
Provider Directory Advisory Group Meeting

May 18, 2016



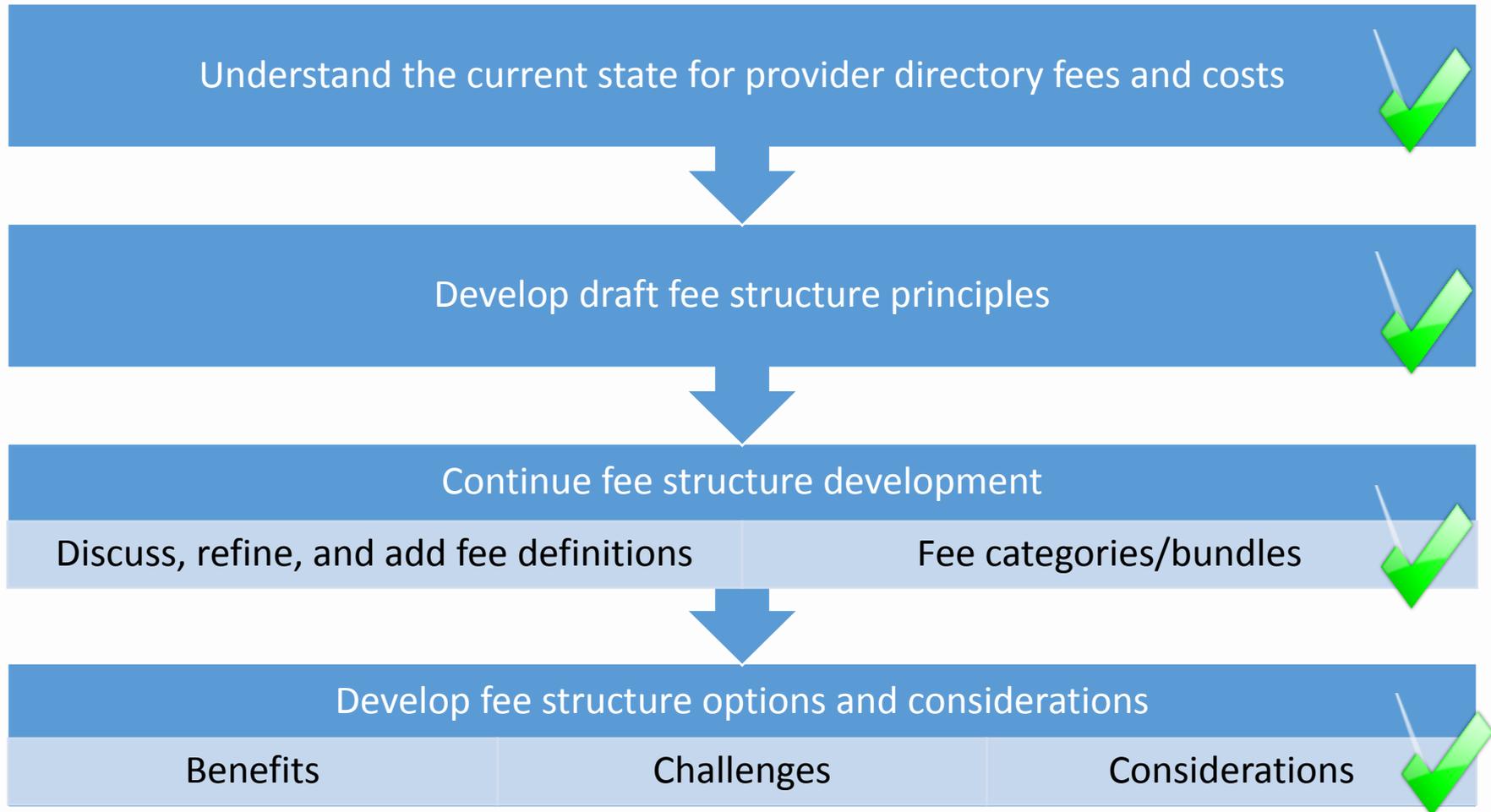
Welcome!

- Introductions, announcements, and agenda review
 - Welcome Luke Glowasky, Dan Pasch, and Stacey Weight
- Provider Directory Workshop summary
- Fee structure recap discussion and review
- Communication strategy
- Harris presentation
- Updates on HIT procurement and Common Credentialing
- Wrap up and next steps

Provider Directory Workshop

- The Office of Health IT was one of several public and private stakeholders asked to present at the Federal Health Architecture (FHA) and Office of the National Coordinator for Health IT (ONC)
 - Current challenges
 - Successes
 - Data standards
 - Solutions
- Other states: Rhode Island, Michigan, and California
- Federal organizations: CMS, FHA, ONC, SSA
- Outputs
 - Difficult to develop common list of provider directory use cases
 - IHE-HPD standard vs. FHIR
- Next steps:
 - Continue to coordinate with other provider directory efforts and emerging standards

Fee structure development activities



Fees...Next steps

- Today
 - Review comments from March meeting
 - Gather feedback on a new model
 - Questions for the group based on what we heard
- Next
 - Wait.....for the RFP to get a better sense of fees

Recap

Three sample Provider Directory structures:

- 1) Fees based on # users and services
- 2) Fees based on types and size of organization and services
- 3) Fees based on annual revenue and services



Findings:

- Consensus on:
 - Having early adopter discounts
 - Not having data contributor discounts
 - Maintaining similar fees for initial participation and ongoing fees
- No consensus on any single structure
- Difficult to determine structure without having a general sense of costs or rough order of magnitude
- Most comments reinforced our principles – simple to administer, fair

1. Fee structure based on # users and services (Sample)

Services	Basic	Plus	Premium	Enterprise
Web-Based Query Access	<10	<20	<30	30-50*
Extract(s) Per Month**	1	2	5	Unlimited
Data Mart ***	--	--	--	Unlimited

Different fees may apply for initial (onboarding) vs. ongoing participation

Special fees and discounts:

* \$X.XX for each additional license

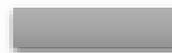
** Additional extracts can be purchased for \$X.XX per extract

*** Data Mart can be added to any subscription for \$X.XX annually

10% annual data contribution discount/early adopter?

HIT Integration (may have no charge, additional charge, or a discount)

1. Fee structure based on # users and services discussion



- Cost of managing the fee structure is the simplest
- Concept is familiar
- Difficult to reach sustainability with a new service
- Difficult to estimate use
- Doesn't account for actual usage
- Unfair to smaller entities

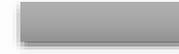
Summary statement: This makes sense but it may be a better model after Provider Directory is an established service.

2. Fee structure based on organization type/size (Sample)

Each subscription level includes web portal access	Basic	Plus	Premium	Enterprise
Provider Practice and facilities				
Tiered based on # providers	<10	<20	<30	30-50
Hospitals (and Integrated Delivery Networks)				
Tiered based on annual revenue	\$0-50 MM	\$50-200MM	\$200-1 BB	>\$1 BB
Provider organizations (Long term care, nursing facilities)				
Tiered based on # beds	<50	<100	<200	>400
Payers				
Tiered based on # of covered lives	<30K	<100K	<250K	>250K
State Agencies				
Medicaid share	\$ x	\$ x	\$ x	\$ x
Other state agencies	\$ x	\$ x	\$ x	\$ x
HIEs, EHR vendors/hosted solutions, IPAs				
Active users?	<10	<20	<30	30-50
Gross sales?	\$0-10 M	\$10-100M	\$100-500M	\$501 M +
Other?	\$ x	\$ x	\$ x	\$ x

Extracts included: Basic – 1 Plus – 2 Premium – 5 Enterprise – unlimited plus data mart	Different fees may apply for initial (onboarding) vs. ongoing participation	Special fees and discounts: 10% annual data contribution discount Additional extracts Data mart HIT Integration
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2. Fee structure based on organization type/size



- Equitable to smaller organizations and clinics
- Removes deterrent for signing up users
- Fee tiers are adaptive to different types of organizations
- Complicated
- Managing and monitoring the system could be administratively complex and burdensome on larger organizations
- Concern if State organizations are being equitably charged vs other participants

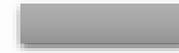
Summary statement: Too complex...but there is value in distinguishing tiers based on organization size and type.

3. Fee structure based on annual revenue (Sample)

Annual revenue	Standard	Data mart
\$0-10 M	\$	\$
\$10-100M	\$\$	\$\$
\$100-500M	\$\$\$	\$\$\$
\$501 M +	\$\$\$\$	\$\$\$\$

<p>Standard includes: Web based query access 5 data extracts</p>	<p>Different fees may apply for initial (onboarding) vs. ongoing participation</p>	<p>Special fees and discounts: 10% annual data contribution discount Additional extracts Data mart HIT Integration</p>
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3. Fee structure based on annual revenue



- Simple idea
- Revenue is a fair proxy for size
- Guaranteed income
- Easier to administer
- Is revenue a fair proxy?
- Difficult to determine annual revenue (copy of financials?)
- Some users don't have gross sales, like Independent physician associations (IPA)

Summary statement: This is an easier model to follow but may not be applicable to certain types of users of the provider directory

A fourth potential fee structure?

- Fees are tiered based on organization size and type – assumption larger organizations consume more data and pay a higher rate
- Fees are fixed regardless of access volume, # users in an organization, or number of underlying organizations
- PDAG will discuss subscriber tiers and distinctions between the tiers
- Fee basis are based on the type organization (revenue, beds, etc.)
- Actual costs are still TBD

Subscriber Tier	Provider Directory Access cost	Data mart cost
1	\$	\$
2	\$\$	\$\$
3	\$\$\$	\$\$\$
4	\$\$\$\$	\$\$\$\$
5	\$\$\$\$\$	\$\$\$\$\$

Special fees and discounts:
Early adoption discount
Additional extracts (after 5)
HIT Integration

Reference Massachusetts Health Information Hiway
<http://www.masshiway.net/HPP/HowtoJoin/Rates/index.htm>

Tiers Discussion

- Thoughts on tiers
- For the entities that have tiers, how often would a re-evaluation be needed?
- Is it correct to have a small, medium, and large category for
 - Health plans?
 - Hospitals?
 - CCOs?
 - Others?
- When distinctions between tiers are needed for the following types of groups, is the basis for that distinction the best option?

Hospitals	# beds or annual revenue?
Health Plan	# members or annual revenue?
HIE	# users or annual revenue?
Ambulatory practices	# providers or annual revenue?

Communications Plan



Communications Plan

Objectives

Key messages

Key audiences

Strategies and Tactics

Spokesperson

Channels

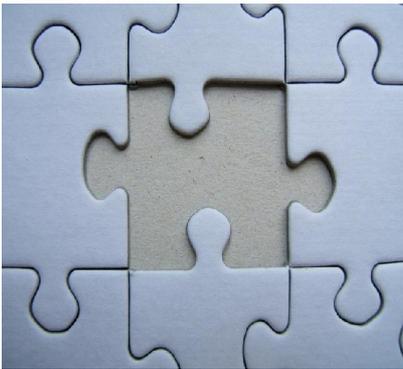
Tools

Challenges

Timeline

Communication Plan Objectives

- Create awareness and garner support from healthcare entities
- Ensure provider directory functionality matches stakeholder needs and has a strong value proposition
- Promote use and uptake of the provider directory
- Encourage collaboration and transparency



Are there other objectives to add?

Key messages

1. What problems the provider directory is solving
2. What the benefits are to having an authoritative complete source of provider data that:
 - a) Promotes efficiencies for operations
 - b) Enables care coordination and health information exchange
 - c) Serves as a resource for health care analysis
3. When the provider directory will be operational
4. What data source information including which provider data will be in the directory, what data sources are contributing, and how the data will be scrubbed, matched, and scored
5. Who can use the provider directory
6. Who will pay for the provider directory and how much

Problems, Solution, Impact

- These will be used to populate communications tools but will be converted into friendlier formats
- Are there other problems, solutions, or impacts to add?
- Do these speak to your organization?



Key Audiences

Who we are talking to today:

- Provider Directory Advisory Group (PDAG)
- CCO Health IT Advisory Group (HITAG)
- Health IT Oversight Council (HITOC)
- Oregon Health Authority and Department of Human Services
- Oregon Health Leadership Council – Administrative Simplification Workgroup

Who else should we be talking to (today or future)?

What is the best way to engage?

Harris Intro



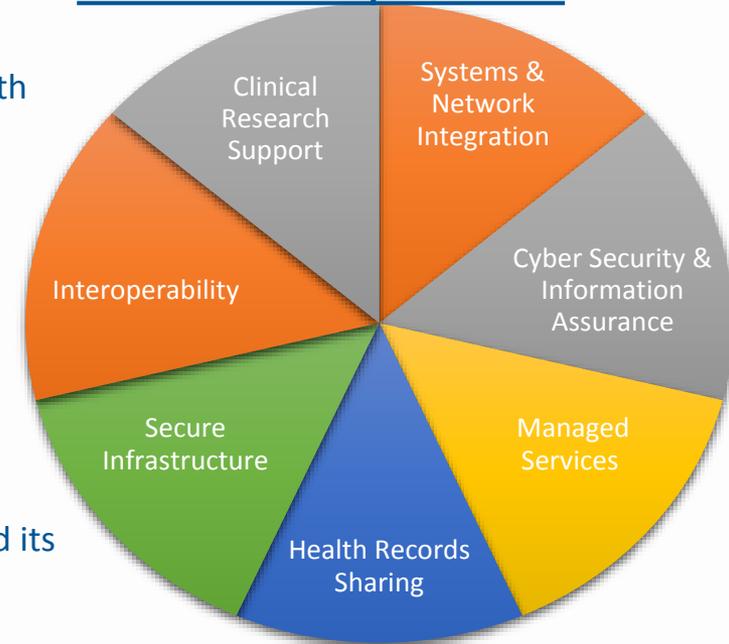
Harris Overview

- Leading technology innovator, solving mission-critical challenges through advanced, technology-based solutions for government & commercial customers
- Founded in 1895
- More than 22,000 employees, including 9,000 scientists and engineers

Harris in Healthcare

- Entered domain in 2006 with vision of bringing data processing technologies used in defense areas to help solve challenges of health care, including:
 - Increasing interoperability
 - Making clinical and administrative workflow more efficient
 - Strengthening collaboration across the continuum of care
- Harris became the prime contractor for the Oregon HIE (Health Information Exchange), branded as CareAccord
 - CareAccord went live in May 2012
 - Offers statewide portal accounts for Direct Secure Messaging and its Provider Directory

Areas of Expertise:



HIT Procurement Updates

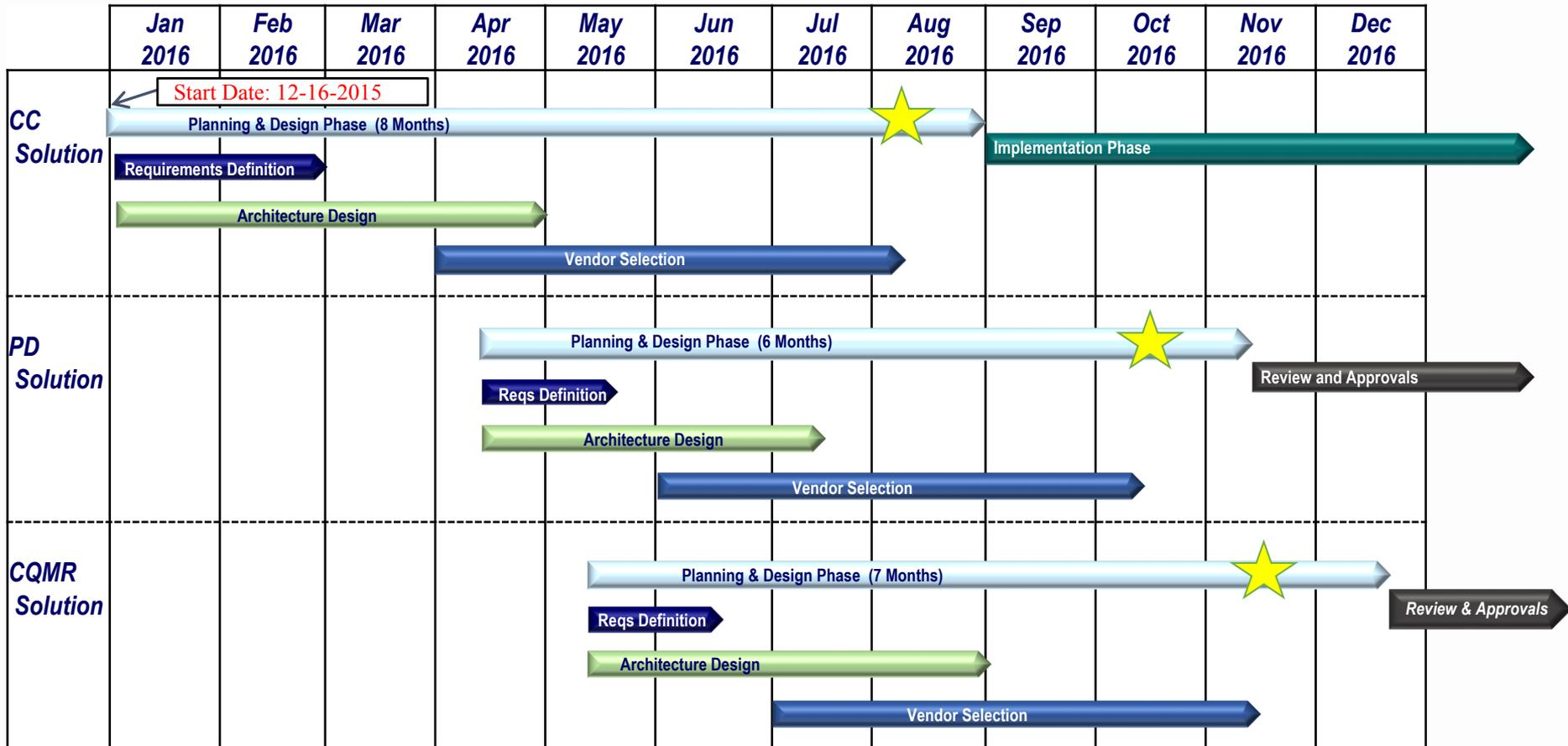


New Scope (Amendment 10)

Executing Amendment 10 on the existing Oregon HIE Solution Contract:

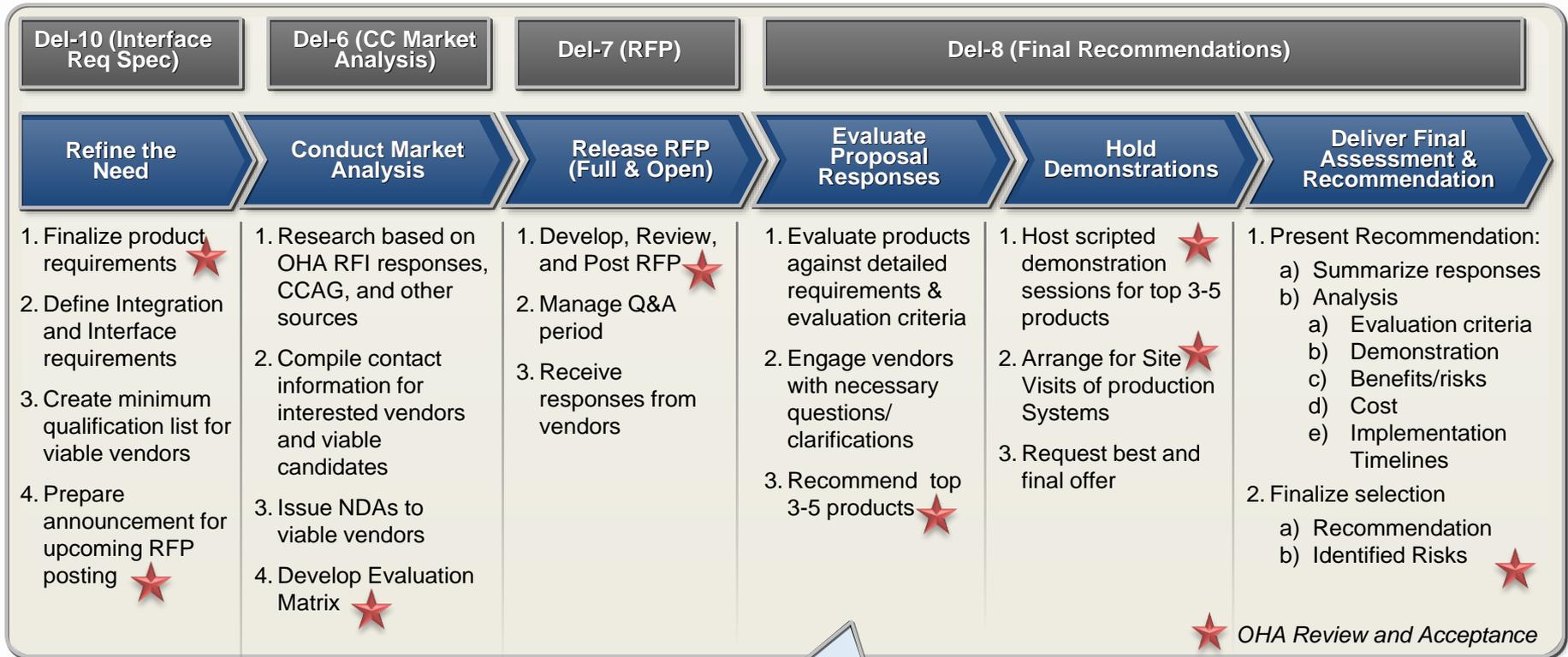
- Scope includes conducting the planning and design phase for Provider Directory, CQMR and SI requirements stated in the HIT portfolio SOW
- Tasks include product evaluations, securing a product subcontractor for the PD and CQMR solutions, procurement, contracting, interface and integration solutions, common access solutions, data management, and project management service
- Contract type is Firm Fixed Price (FFP), completion-based; completion milestones are the deliverables in SOW

Overall HIT Project Summary



★ = indicates vendor selection

Vendor Product Selection Process



Proposal Evaluation includes:

- a) Analysis against Evaluation criteria
- b) Benefits/risks
- c) Cost
- d) Implementation Timelines

Upcoming Provider Directory Procurement Timeline

- Timeline displayed in ORPIN Announcement:
 - RFP Release Date: July 2016
 - Q & A Period: 1 week after RFP Release
 - RFP Response Due Date: 4 weeks after RFP Release
 - Demonstrations and Site Visits: August – September 2016
 - Vendor Selection: October 2016
- Interested vendors can contact the Harris team at:
OregonProcurement@harris.com

Common Credentialing Updates

Melissa Isavoran
Credentialing Project Director



Current Progress

- Procurement Update:
 - Harris released RFP April 29, 2016!!!
 - Vendor selection to be in July/August 2016
- Fee structure development work continues:
 - Ambulatory surgical centers, Independent physicians associations, health plans, Coordinated Care Organizations, and Dental Care Organizations to be surveyed
 - Hospital tiers may be based on provider panel rather than revenue
- Other upcoming work:
 - Outreach and marketing planning
 - Adoption plan development
 - Rule revisions via a rulemaking advisory committee (SMEs)

Updates and next meeting

Karen Hale

