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# Common Credentialing Advisory Group Meeting

April 6, 2016

The logo for the Oregon Health Authority is centered within a light blue, rounded rectangular background. It features the word "Oregon" in a smaller, orange, serif font positioned above the word "Health", which is in a larger, blue, serif font. A thin blue horizontal line is positioned below "Health", and the word "Authority" is written in a smaller, orange, serif font below the line.

Oregon  
Health  
Authority

# Agenda

- CCAG Membership and Charter
- Procurement Update
- Fee Development
- Programmatic Details
  - Marketing and Outreach
  - Adoption Plan
- Public Testimony

# CCAG Membership

- Oregon Administrative Rule 409-045-0065:
  - Members have three year terms
  - Members must resign if no longer qualify
  - Vacancies must be replaced for unexpired term
- Six membership terms expiring June 30, 2016:
  - Erick Doolen – Health Plan
  - Larlene Dunsmuir - Practitioner
  - Denal Everidge – Hospital
  - Dr. Jene – Practitioner/Oregon Medical Association
  - Becky Jensen – Health System
  - Jennifer Waite – Independent Physician Association
- Reappointments to be approved by OHA Director
- Vacancies may be filled via application process

# Finalized CCAG Charter

- Charter updated to reflect current work, both legislative requirements (Senate Bills 604 and 594) and a high-level implementation timeline
- Reviewed and to be endorsed by the Health Information Technology Oversight Council
- To be posted on the CCAG website

# Procurement Update

# Request for Proposals

- Procurement Process Announcement for Credentialing Vendors released to the Oregon Procurement Information Network website on March 7, 2016:
  - How to sign up with Harris and express interest
  - Minimum qualifications
- Release date pushed to the end of April
- Demonstrations late April 2016, early May 2016
- Site visits to be conducted through May 2016

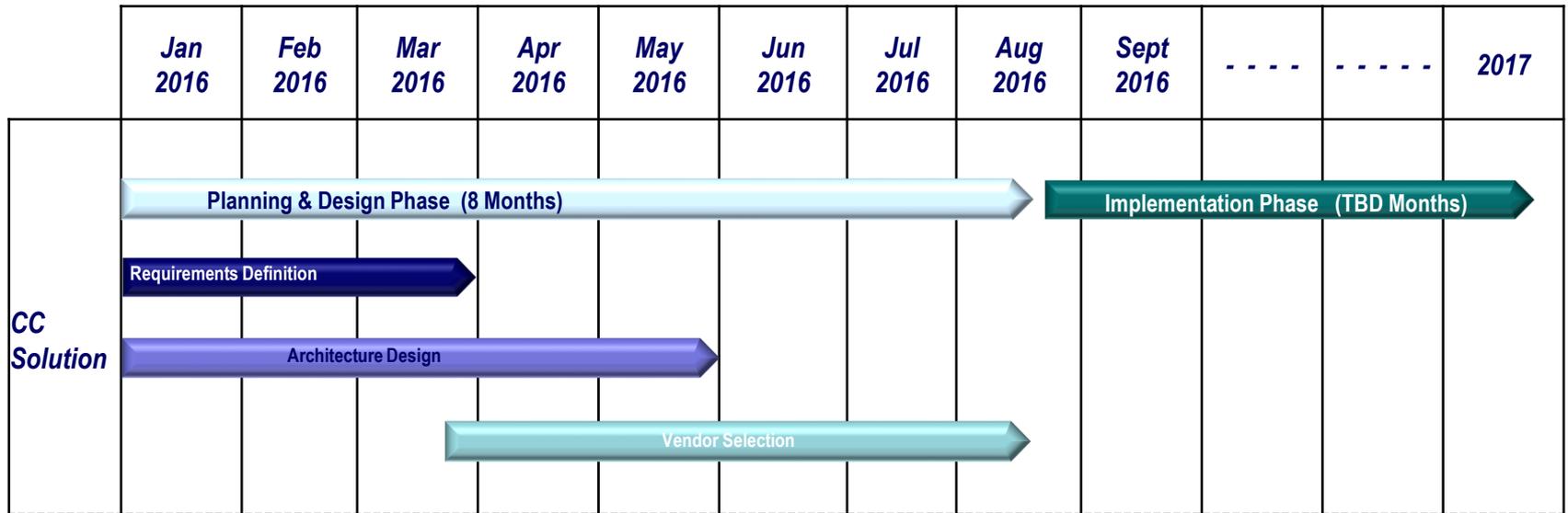
# Minimum Qualifications

- One successful production installation for a period of at least two years and at least one end user's contact information must be supplied.
- Vendor must be able to demonstrate the common credentialing solution if requested.
- Hosted solutions are required to host the solution and production data within the United States, and offshore vendor team members are prohibited from accessing production data and system servers.
- Vendor must be a Credentials Verification Organization or partner with one.

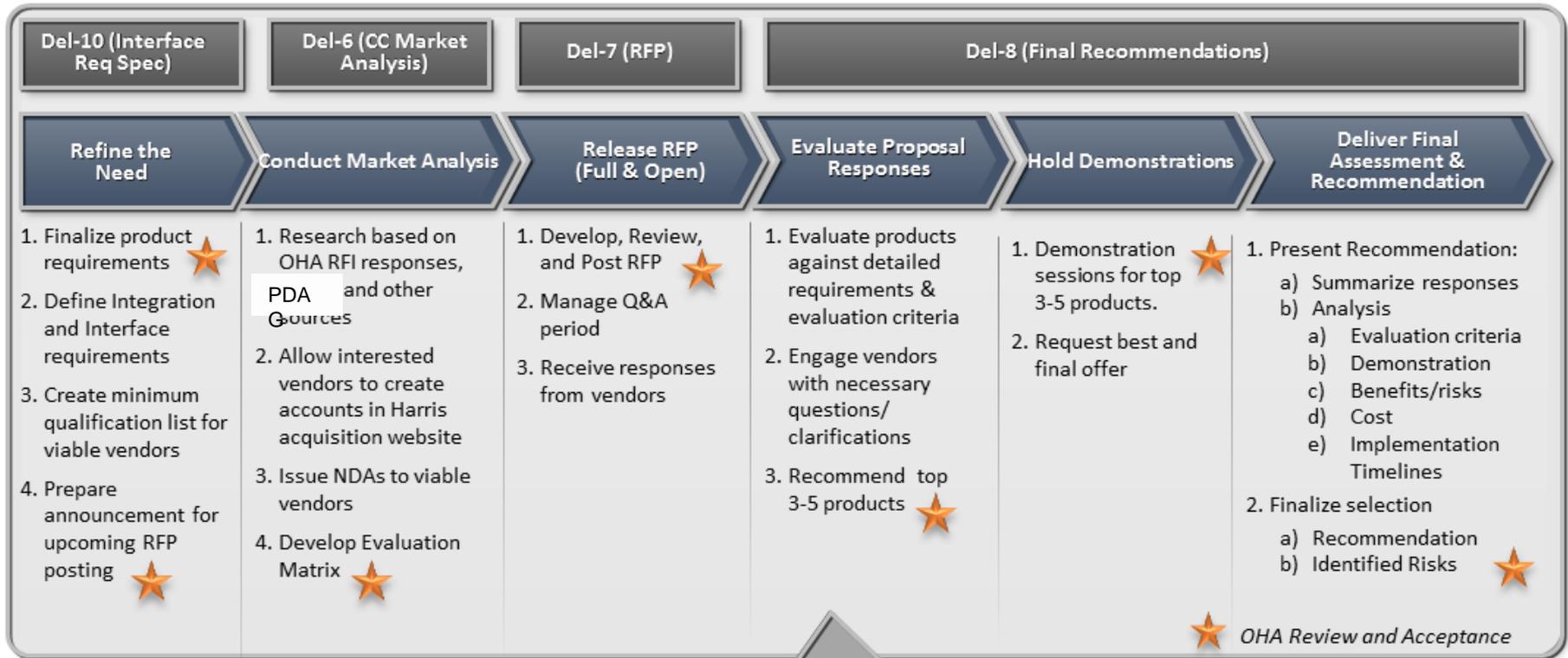
# Evaluation Criteria

- Company information regarding experience, structure, and CVO designation
- Architecture information regarding hosting, scalability, interoperability, complexity
- Security features and protocols
- Product capability and features such as notifications, Primary Source Verification automation
- Support services such as staffing and training
- Cost such as licensing and total cost of ownership

# Evaluation Criteria



# Vendor Product Selection Process



Proposal Evaluation includes:

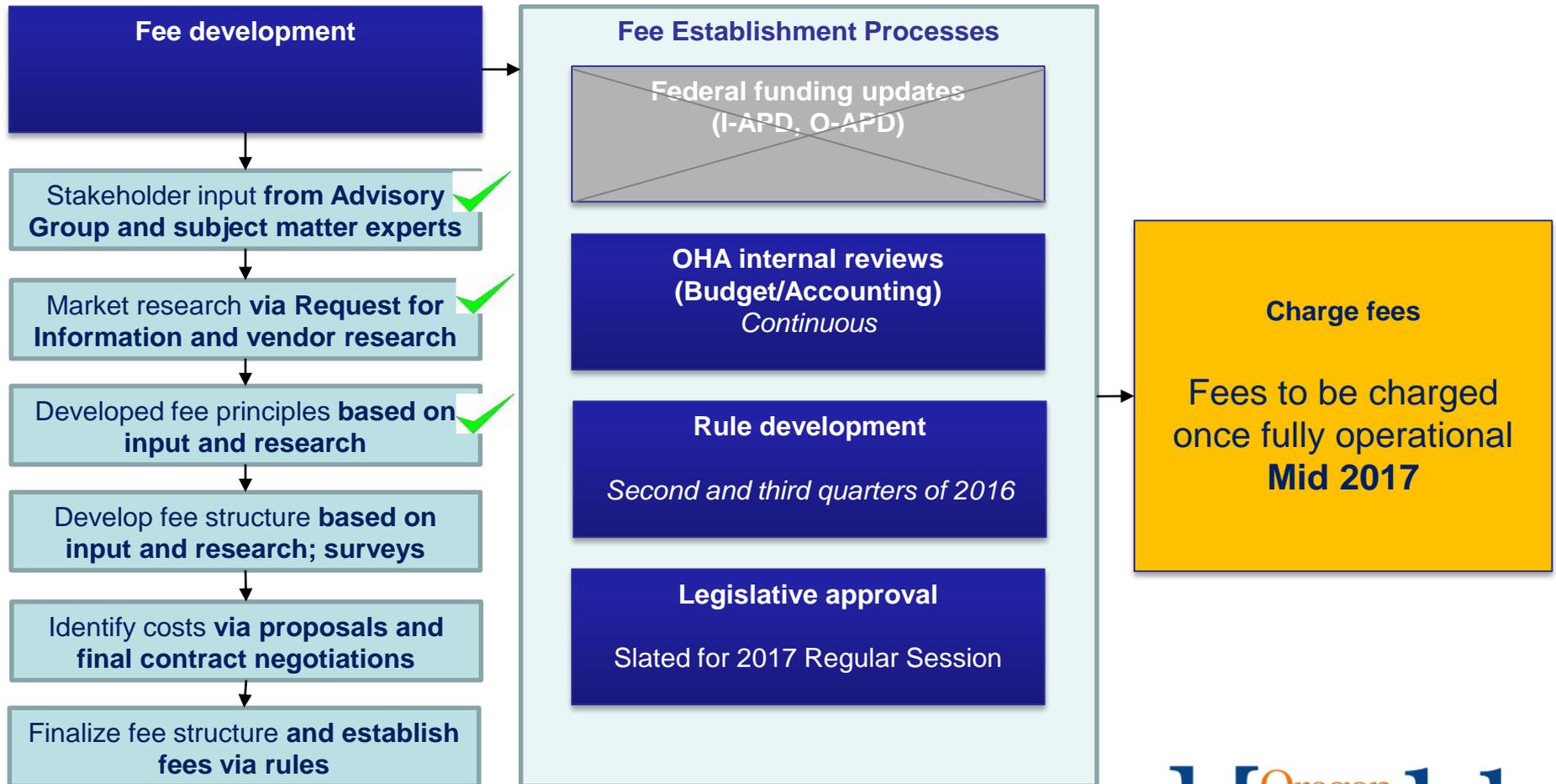
- a) Analysis against Evaluation criteria
- b) Benefits/risks
- c) Cost
- d) Implementation Timelines

# Fee Structure Development

# Current Credentialing Fee Structure

- Credentialing organizations generally cover the costs of credentialing practitioners
- Practitioners generally do not pay for credentialing, BUT:
  - Privileging is supported by fees and includes credentialing
  - Some credentialing costs are built into provider payments
  - Practitioners pay for office staff hours to complete credentialing paperwork and required follow up

# Common Credentialing Program: Fee Establishment Process



# OCCP Fee Structure Principles (at a high level)

Fees should be:

- Balanced considering benefits and resources
- Efficient and economical to administer
- Transparent and justifiable in development
- Stable and produce predictable income to support the costs of operating common credentialing which should include allocations for information technology and operational quality assurance activities and security

*Individually requested processes must be borne by those making requests*

# OCCP Fee Structure Options

FEE OPTIONS	STRUCTURE
<b>Credentialing Organizations</b>	
<b>One-Time Setup Fee</b>	Flat Fee
	Tiered fee
	Flat Fee, + Amortization
<b>Annual Subscription Fee</b>	Tiered fee (hospital revenue/practitioner panel size)
<del><b>Transactional Fee (ongoing operations and maintenance costs)</b></del>	Flat Fee
	<del>Tiered Fee; based on Practitioner Type</del>
<b>Expedited Credentialing Fee</b>	Flat fee per expedite request (each practitioner)
<b>Health Care Practitioners</b>	
<b>Initial Application Fee</b>	Flat fee (one-time)
	<del>Tiered Fee; based on Practitioner Type</del>
<b>Data Users</b>	
<b>Data Use Fee (Provider Directory)</b>	Undetermined

# Fee Structure Tier Development

**OHA is assessing credentialing organizations for information that will inform the development of tiers:**

- Collection of hospital net patient revenue data
- Assessment of Coordinated Care Organization and Dental Care Organization Oregon practitioner data as collected by OHA
- *Surveying* of health plans, health systems, Independent physician organizations, and ambulatory surgical centers for number of credentialed Oregon practitioners

**Outstanding questions:**

1. How can hospital revenue and patient panel tiers be separated?
2. What are the different tiers and how many are appropriate?

# Next Steps for OCCP Fees

- Development of Credentialing Organization fee structure tiers
- Obtaining input on structure from the CCAG and others
- Applying true cost to the fee structure (August 2016)
- Rulemaking Advisory Committee (April 2016 – September 2016)
  - Develop rules (to include fees and other adjustments)
  - Submit Notice of Proposed Rules to Secretary of State
  - Public rules hearing
  - Publish final rules
- Legislative approval process (2017 Regular Session)
- Fees to be charged once legislative session ends and OCCP is fully operational (mid 2017)

# Emergency Department Information Exchange (EDIE) Utility

- EDIE Utility launched in 2015:
  - Collaborative effort led by the Oregon Health Leadership Council with OHA and other partners
  - Connects hospital event data from OR, WA
  - Notifies ED of high utilizers – provides critical information for ED
- Utility governance model
  - Governance committee includes representation of Utility members
    - Hospitals (5)
    - Health plans/CCOs (5)
    - Physicians (3) – one each: OHLC, OCEP, CCO
    - Other (3-4)
      - OAHHS (1)
      - OHA (1)
      - At large (1-2)

# EDIE Utility Finance Model

- EDIE funded by Utility members via annual assessments
  - 50% total costs paid by participating hospitals
    - Tiered based on revenue
  - 50% participating health plans and CCOs
    - Tiered based on membership size
- Annual EDIE Utility budget dictates dues (\$750k/year)
  - Vendor costs
  - Implementation subsidies for critical access hospitals
  - Administrative and contingency costs
- Additional services paid by subscribers:
  - PreManage for CCOs, health plans, providers (PMPM)

# EDIE Financing Principles

- Financing should be as broad as possible
- Simple to administer
- Greater stakeholder investment assures greater adoption
- Federal and state investment should be leveraged
- Need financial commitment through return on investment, which will take several years
- Tiering of financial partners based on current and consistent source data
- Hospitals should pay no more than if purchased directly

# EDIE Financing Methodology

- Data sources should be current and consistently applied
  - Hospital revenue from annual revenue report by Apprise/OAHHS
  - Health plan/CCO membership data from OHA and Division of Business and Finance
  - Self-insured plans will pay a base fixed rate in separate tier
- Health systems:
  - Hospitals within a health system will roll up revenue into one system
    - Hospital systems with owned health plans will receive discount
    - Acquisition/mergers considered if in assessment timeframe
- Invoices sent in 4<sup>th</sup> quarter each year prior to operating year

# EDIE Finance Structure

## Hospital Tiers: Based on Revenue

\$1.5b and above	\$60,000
\$1b to \$1.5b	\$45,000
\$500m to \$1b	\$27,000
\$200m to \$500m	\$12,000
\$100m to \$200m	\$5,900
\$50m to \$100m	\$2,750
\$20 to \$50m	\$1,250
\$0 to \$20m	\$500

*25% discount for hospitals with owned plans*

*2016 Hospital participants include:*

- *All Oregon hospitals including:*
  - *13 health systems with more than one hospital*
  - *12 critical access hospitals that qualify for the subsidy*

## Plan/CCO Tiers: Based on Enrollment

Over 300,000 members	\$55,000
Over 250,000 members	\$43,000
Over 150,000 members	\$31,000
Over 100,000 members	\$19,000
Over 75,000 members	\$14,000
Self-Insured Plans	\$11,000
Over 30,000 members	\$8,250
Over 15,000 members	\$3,000
Under 15,000 members	\$1,000

*2016 Plan/CCO Participants include:*

- *7 Commercial plans*
- *4 Self-insured plans*
- *16 CCOs - OHA funds Medicaid share on behalf of CCOs*

# EDIE Assessments: Adjustments

- Adjustments needed 2<sup>nd</sup> year as revenue and membership changed
  - Kept tier structure, some entities moved tiers – predictability of tier structure was key factor
  - Utility identified impact to budget and applied adjustments proportionally
- Next year
  - Mergers and acquisitions may result in further movement and adjustments
  - Unanticipated members (e.g., urgent care) joining – “pay to play” with data and financially was key factor

More information on the EDIE Business Plan (with financial model) is available at:

<http://www.orhealthleadershipcouncil.org/wp-content/uploads/EDIE-Plus-PreManage-Business-Plan-OHLC-Final-Version.pdf>

OHLC/EDIE website: <http://www.orhealthleadershipcouncil.org/our-current-initiatives/emergency-department-information-exchange-edie>

# Marketing and Outreach

# Communications Goals

- To inform and engage all stakeholders impacted by the OCCP through program implementation and beyond
- To provide transparent and timely communications
- To produce program information that is easy to access and easy to understand
- To ensure health care practitioners and credentialing organizations understand the purpose and benefits of the program

# Key Audiences and Messages

## Key Audiences

- Health Care Practitioners
- Credentialing Organizations
- Policy Makers

## Key Messages

- Mandate to participate
- Value and benefit
- Programmatic requirements (e.g., what to expect, how to use the system, fee structure, what to expect, 120 day attestations)
- Fee structure
- Vendor system

# Marketing and Outreach Roadmap

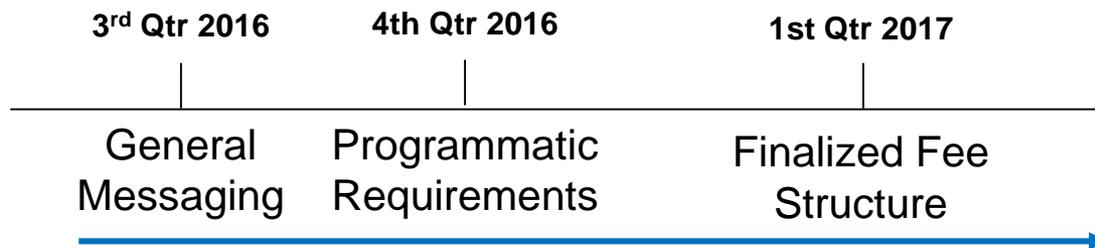
## Communication Methods

- Direct
- Presentations
- Peer to Peer

## Tools/Tactics

- Brochures, facts sheets, etc.
- Informative website
- Webinars
- Toolkit for advocates
- Spokespersons

## Communication Timing



# Adoption Plan

# Adoption Plan Goals

*While system testing and user-acceptance testing will occur, and data from Health Care Regulatory Boards will be imported and tested, there is still a need for a systematic approach to live environment testing and a systematic approach to the rollout of the Common Credentialing Solution...*

## **Goals for the adoption plan:**

- To ensure a systematic approach to system rollout
- To ensure meaningful participation and immediate value
- To manage workload needs for initial go-live

# Adoption Plan Concepts

## Concepts to explore:

1. Recruiting early adopters to populate the system
  - a) Who are the early adopters?
  - b) How will we engage them?
  - c) What is the benefit to them?
2. Using a pilot approach to conduct a soft go-live
  - a) Who are the pilot participants?
  - b) How will we engage them?
  - c) What is the benefit to them?
3. Conducting a targeted marketing to push for strong uptake
  - a) What groups need to most outreach?
  - b) How will we engage them?
  - c) How will we engage them?

*Are there other concepts to explore?*

# Adoption Plan Development

- Exploring and development of adoption plan concepts
- Consultation with Harris and subject matter experts
- Obtaining input from CCAG members
- Plan finalization with the Common Credentialing vendor

# Upcoming Work

- **Procurement activities (demonstrations, site visits)**
- **Continued Fee Structure Development**
- **Marketing and Outreach Roadmap Development**
- **Adoption Plan Development**
- **Convening the Rulemaking Advisory Committee**

# Public Testimony

**Next meeting:**

June 1, 2016

421 SW Oak Street, Suite 775

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**More information can be found at:**

**[www.oregon.gov/oha/OHPR/occp](http://www.oregon.gov/oha/OHPR/occp)**