Oregon Common Credentialing Advisory Group

AGENDA
Date: Thursday, January 9, 2014
Time: 2:00pm to 4:00pm

LOCATION:
Oregon Health Authority, Lincoln Building
421 SW Oak Street, 7th Floor Conference Room, Portland, Oregon 97204

#	Time	Item	Materials	Lead
1	2:00 – 2:10	Welcome and Agenda Review	1	Erick Doolen
2	2:10 – 2:20	Telemedicine Credentialing (Senate Bill 569)	2	Scott Gallant
3	2:20 – 2:40	Rulemaking Advisory Committee Process • RAC Participation • Rules Process Timeline	3,4	Melissa Isavoran
4	2:40 – 3:20	Primary Source Verification Discussion	5	Melissa Isavoran/ Scott Gallant
5	3:20 – 3:45	Review of Final Request for Information and Review Plan	6	Melissa Isavoran
6	3:45 – 4:00	Public Comment	N/A	Public
7	4:00	Next Steps and Adjournment	N/A	Erick Doolen

Materials:

1. Agenda
2. Senate Bill 569 (2013)
3. Rulemaking Process Timeline
4. Current Credentialing Rule - ACPCI
5. Primary Source Verification Requirements
6. Final Draft Request for Information

Public Comment: Common Credentialing Advisory Group meetings are open for the public to attend. However, public comment or testimony will be limited to 15 minutes at the end of each meeting. Due to the time limitations, individuals can submit public comment or testimony by visiting the Common Credentialing website at www.oregon.gov/OHA/OHPR/CCAG/index.shtml.

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Enrolled
Senate Bill 569

Sponsored by Senators STEINER HAYWARD, KRUSE, Representative HARKER; Senators BAERTSCHIGER JR, BATES, BEYER, BOQUIST, BURDICK, CLOSE, COURTNEY, DEVLIN, DINGFELDER, EDWARDS, FERRIOLI, GEORGE, GIROD, HANSELL, HASS, JOHNSON, KNOPP, MONNES ANDERSON, MONROE, OLSEN, PROZANSKI, ROBLAN, ROSENBAUM, SHIELDS, STARR, THOMSEN, WHITSETT, WINTERS, Representatives BAILEY, BARKER, BARNHART, BENTZ, BERGER, BOONE, CONGER, DAVIS, DEMBROW, DOHERTY, ESQUIVEL, FREDERICK, FREEMAN, GARRETT, GILLIAM, GORSEK, GREENLICK, HICKS, HOLVEY, HUFFMAN, JOHNSON, KENNEMER, KENY-GUYER, KOMP, KRIEGER, LIVELY, MATTHEWS, OLSON, PARRISH, READ, SMITH, SPRENGER, THATCHER, THOMPSON, VEGA PEDERSON, WEIDNER, WHITSETT, WITT

CHAPTER .....

AN ACT

Relating to telemedicine; creating new provisions; amending ORS 442.015 and 442.807; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this 2013 Act is added to and made a part of ORS chapter 441.

SECTION 2. (1) The Oregon Health Authority shall prescribe by rule the information and documents that a governing body of an originating-site hospital may request for credentialing a telemedicine provider located at a distant-site hospital.

(2) The rules adopted by the authority under subsection (1) of this section must:

(a) Prescribe a standard list of information and documents that shall be provided by a distant-site hospital;

(b) Prescribe a list of information and documents that may be requested by an originating-site hospital in addition to the standard list of information and documents;

(c) Prescribe a list of information and documents that may not be requested by an originating-site hospital; and

(d) Be consistent with all applicable legal and accreditation requirements of an originating-site hospital and the health plans with which the originating-site hospital contracts.

(3) Except as provided in subsection (4) of this section, an originating-site hospital in this state must comply with the rules adopted under this section if the telemedicine provider is located at a distant-site hospital that is located in this state. This section does not prevent hospitals located outside of this state from using or require such hospitals to use the prescribed list of information and documents in credentialing a telemedicine provider.

(4) An originating-site hospital is not limited to the information and documents prescribed by the authority if the originating-site hospital has a delegated credentialing agreement with the distant-site hospital where the telemedicine provider is located and the

governing body of the originating-site hospital accepts the recommendation of the medical staff to credential the telemedicine provider.

(5) In the adoption of the rules described in subsections (1) and (2) of this section, the authority shall consult with representatives of distant-site hospitals and originating-site hospitals in this state. Once adopted, the authority may not amend the rules to alter the prescribed lists without first consulting representatives of distant-site hospitals and originating-site hospitals in this state.

(6) This section does not affect the responsibilities of a governing body under ORS 441.055 and does not require a governing body of a hospital to grant privileges to a telemedicine provider.

SECTION 3. ORS 442.015 is amended to read:

442.015. As used in ORS chapter 441 and this chapter, unless the context requires otherwise:

(1) "Acquire" or "acquisition" means obtaining equipment, supplies, components or facilities by any means, including purchase, capital or operating lease, rental or donation, [*with intention*] **for the purpose** of using such equipment, supplies, components or facilities to provide health services in Oregon. When equipment or other materials are obtained outside of this state, acquisition is considered to occur when the equipment or other materials begin to be used in Oregon for the provision of health services or when such services are offered for use in Oregon.

(2) "Affected persons" has the same meaning as given to "party" in ORS 183.310.

(3)(a) "Ambulatory surgical center" means a facility or portion of a facility that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.

(b) "Ambulatory surgical center" does not mean:

(A) Individual or group practice offices of private physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a physician's or dentist's office using local anesthesia or conscious sedation; or

(B) A portion of a licensed hospital designated for outpatient surgical treatment.

[*(4) "Budget" means the projections by the hospital for a specified future time period of expenditures and revenues with supporting statistical indicators.*]

(4) "Delegated credentialing agreement" means a written agreement between an originating-site hospital and a distant-site hospital that provides that the medical staff of the originating-site hospital will rely upon the credentialing and privileging decisions of the distant-site hospital in making recommendations to the governing body of the originating-site hospital as to whether to credential a telemedicine provider, practicing at the distant-site hospital either as an employee or under contract, to provide telemedicine services to patients in the originating-site hospital.

(5) "Develop" means to undertake those activities that on their completion will result in the offer of a new institutional health service or the incurring of a financial obligation, as defined under applicable state law, in relation to the offering of such a health service.

(6) "Distant-site hospital" means the hospital where a telemedicine provider, at the time the telemedicine provider is providing telemedicine services, is practicing as an employee or under contract.

[*(6)*] **(7)** "Expenditure" or "capital expenditure" means the actual expenditure, an obligation to an expenditure, lease or similar arrangement in lieu of an expenditure, and the reasonable value of a donation or grant in lieu of an expenditure but not including any interest thereon.

[*(7)*] **(8)** "Freestanding birthing center" means a facility licensed for the primary purpose of performing low risk deliveries.

[*(8)*] **(9)** "Governmental unit" means the state, or any county, municipality or other political subdivision, or any related department, division, board or other agency.

[*(9)*] **(10)** "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges and other operating revenue. "Gross revenue" does not include contributions, donations, legacies or bequests made to a hospital without restriction by the donors.

[*(10)(a)*] **(11)(a)** "Health care facility" means:

(A) A hospital;

(B) A long term care facility;

(C) An ambulatory surgical center;

(D) A freestanding birthing center; or

(E) An outpatient renal dialysis center.

(b) "Health care facility" does not mean:

(A) A residential facility licensed by the Department of Human Services or the Oregon Health Authority under ORS 443.415;

(B) An establishment furnishing primarily domiciliary care as described in ORS 443.205;

(C) A residential facility licensed or approved under the rules of the Department of Corrections;

(D) Facilities established by ORS 430.335 for treatment of substance abuse disorders; or

(E) Community mental health programs or community developmental disabilities programs established under ORS 430.620.

[*(11)*] **(12)** "Health maintenance organization" or "HMO" means a public organization or a private organization organized under the laws of any state that:

(a) Is a qualified HMO under section 1310 (d) of the U.S. Public Health Services Act; or

(b)(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services:

(i) Usual physician services;

(ii) Hospitalization;

(iii) Laboratory;

(iv) X-ray;

(v) Emergency and preventive services; and

(vi) Out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of the basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis; and

(C) Provides physicians' services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

[*(12)*] **(13)** "Health services" means clinically related diagnostic, treatment or rehabilitative services, and includes alcohol, drug or controlled substance abuse and mental health services that may be provided either directly or indirectly on an inpatient or ambulatory patient basis.

[*(13)*] **(14)** "Hospital" means:

(a) A facility with an organized medical staff and a permanent building that is capable of providing 24-hour inpatient care to two or more individuals who have an illness or injury and that provides at least the following health services:

(A) Medical;

(B) Nursing;

(C) Laboratory;

(D) Pharmacy; and

(E) Dietary; or

(b) A special inpatient care facility as that term is defined by the Oregon Health Authority by rule.

[*(14)*] **(15)** "Institutional health services" means health services provided in or through health care facilities and includes the entities in or through which such services are provided.

[*(15)*] **(16)** "Intermediate care facility" means a facility that provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment

that a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services above the level of room and board that can be made available to them only through institutional facilities.

[*(16)*] **(17)(a)** "Long term care facility" means a **permanent** facility with [*permanent facilities that include*] inpatient beds, providing**:**

(A) Medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the Director of Human Services[*, to provide*]**; and**

(B) Treatment for two or more unrelated patients.

(b) "Long term care facility" includes skilled nursing facilities and intermediate care facilities but [*may not be construed to*] **does not** include facilities licensed and operated pursuant to ORS 443.400 to 443.455.

[*(17)*] **(18)** "New hospital" means**:**

(a) A facility that did not offer hospital services on a regular basis within its service area within the prior 12-month period and is initiating or proposing to initiate such services[*. "New hospital" also includes*]**; or**

(b) Any replacement of an existing hospital that involves a substantial increase or change in the services offered.

[*(18)*] **(19)** "New skilled nursing or intermediate care service or facility" means a service or facility that did not offer long term care services on a regular basis by or through the facility within the prior 12-month period and is initiating or proposing to initiate such services. "New skilled nursing or intermediate care service or facility" also includes the rebuilding of a long term care facility, the relocation of buildings that are a part of a long term care facility, the relocation of long term care beds from one facility to another or an increase in the number of beds of more than 10 or 10 percent of the bed capacity, whichever is the lesser, within a two-year period.

[*(19)*] **(20)** "Offer" means that the health care facility holds itself out as capable of providing, or as having the means for the provision of, specified health services.

(21) "Originating-site hospital" means a hospital in which a patient is located while receiving telemedicine services.

[*(20)*] **(22)** "Outpatient renal dialysis facility" means a facility that provides renal dialysis services directly to outpatients.

[*(21)*] **(23)** "Person" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation, of a state.

[*(22)*] **(24)** "Skilled nursing facility" means a facility or a distinct part of a facility, that is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or an institution that provides rehabilitation services for the rehabilitation of individuals who are injured or sick or who have disabilities.

(25) "Telemedicine" means the provision of health services to patients by physicians and health care practitioners from a distance using electronic communications.

SECTION 4. ORS 442.807 is amended to read:

442.807. (1) Within 30 days of receiving the recommendations of the Advisory Committee on Physician Credentialing Information, the Administrator of the Office for Oregon Health Policy and Research shall forward the recommendations to the Director of the Oregon Health Authority. The administrator shall request that the Oregon Health Authority adopt rules to carry out the efficient implementation and enforcement of the recommendations of the committee.

(2) The Oregon Health Authority shall:

(a) Adopt administrative rules in a timely manner, as required by the Administrative Procedures Act, for the purpose of effectuating the provisions of ORS 442.800 to 442.807; and

(b) Consult with each other and with the administrator to ensure that the rules adopted by the Oregon Health Authority are identical and are consistent with the recommendations developed pursuant to ORS 442.805 for affected hospitals and health care service contractors.

(3) The uniform credentialing information required pursuant to the administrative rules of the Oregon Health Authority represent the minimum uniform credentialing information required by the affected hospitals and health care service contractors. [*Nothing in ORS 442.800 to 442.807 shall be interpreted to prevent an affected hospital or health care service contractor from requesting*] **Except as provided in subsection (4) of this section, a hospital or health care service contractor may request** 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.

(4) In credentialing a telemedicine provider, a hospital is subject to the requirements prescribed by rule by the authority under section 2 of this 2013 Act.

SECTION 5. (1) Section 2 of this 2013 Act and the amendments to ORS 442.015 and 442.807 by sections 3 and 4 of this 2013 Act become operative October 1, 2013.

(2) The Director of the Oregon Health Authority may take any actions necessary before October 1, 2013, in order to implement section 2 of this 2013 Act and the amendments to ORS 442.015 and 442.807 by sections 3 and 4 of this 2013 Act on and after October 1, 2013.

SECTION 6. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.

Passed by Senate April 18, 2013

Repassed by Senate June 5, 2013

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Robert Taylor, Secretary of Senate

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Peter Courtney, President of Senate

Passed by House May 30, 2013

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Tina Kotek, Speaker of House

Received by Governor:

.....M.,....., 2013

Approved:

.....M.,....., 2013

.....
John Kitzhaber, Governor

Filed in Office of Secretary of State:

.....M.,....., 2013

.....
Kate Brown, Secretary of State

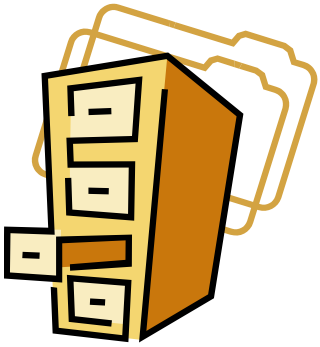
Department of Human Services

Permanent Administrative Rule Time Line

Rule Title: Credentialing (SB 604 & SB 569 Merged, current ACPCI amended)

Rule Number(s): 409-045-0000 and #s to TBD

Action: Permanent Rule(s) - Adopt



Proposed Effective Date:
6/1/14

4/10	☐	Program provides rule coordinator (RC) with draft rule text, filing documents, and list of interested parties
4/11	☐	RC notifies legislators
4/11	☐	RC files documents with Secretary of State (SOS)*
5/1	☐	RC notifies interested parties
5/1	☐	Notice posted in SOS bulletin*
week of 5/19	☐	Hearing date (RC and program attend)*
5/30	☐	RC files final documents with SOS and legislative counsel
6/1/14	☐	Rule effective date

***not** applicable to temporary rules

OREGON HEALTH AUTHORITY

OFFICE FOR OREGON HEALTH POLICY AND RESEARCH

DIVISION 45

PHYSICIAN CREDENTIALING

409-045-0000

Physician Credentialing, Health Care Service Contractors

(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 September 28, 2011, and both of which carry that date, are adopted with respect to hospitals and health care service contractors as Exhibits 1 and 2 to this rule.

(2) Each hospital and health care service contractor shall use the application forms adopted in section (1) of this 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 hospitals and health care service contractors to credential physicians seeking designation as a participating practitioner for a health plan, thereby implementing ORS 442.800 to 442.807 with respect to hospitals and health care service contractors.

Stat. Auth.: ORS 442.807
Stats. Implemented: ORS 442.800 - 442.807
Hist.: OHP 1-2012(Temp), f. & cert. ef. 1-11-12 thru 6-30-12; OHP 3-2012, f. & cert. ef. 5-1-12

DRAFT Common Credentialing Solution Primary Source Verification Requirements

For Discussion with the Common Credentialing Advisory Group

Oregon's common credentialing solution will collect information from health care practitioners. It will also collect practitioner information collected by the state's Health Care Regulatory Boards (HCRBs) that is verified through the primary source in the same manner as that required by credentialing organizations in their credentialing process. It is important to identify which information will be verified by the HCRB and which information will need to be verified or reverified by the solution. It is the OHA's intention to create efficiencies in the credentialing process and minimizing today's duplicative efforts involving numerous primary source verifications on the same information. The table below identifies credentialing information required to be verified, what the HCRBs will verify and provide to the solution, and what verifications the solution would be expected to perform.

Credentialing Data Element	Regulatory Board	Vendor	Comments
Medical/Professional Education	PSV (State Licensing Boards or Board cert. can be used)	-	
Foreign Medical Education Equivalent Evaluation	PSV	-	
Internship, Residency, Fellowship	PSV (AMA,AOAP)	-	
Board Certification/Recertification	PSV	PSV	Vendor to verify only if certification expired after HCRB verification
State Licensing Information	-	PSV	
Drug Enforcement Administration (DEA) Registration Number	-	x (copy of DEA)	
Controlled Substance Registration (CSR) Number	-	x (copy of CSR)	
Hospital/Health Care Facility Affiliations	PSV	PSV (if not already verified by HCRB)	Vendor to verify only differences reported by the practitioner compared to those provided by the HCRB
Practice/Work History	x	x (5 yrs min.)	Vendor to verify only differences reported by the practitioner compared to those provided by the HCRB
Continuing Medical Education (CME)	x	-	
Professional Liability Insurance Information	-	x (certificate of insurance)	
Disclosure of Sanctions, Discipline, Convictions	PSV	PSV	Vendor to verify only if PSV from HCRB is greater than 6 months old
Liability Claims/Lawsuits	x	PSV (5-year hist. - NPDB or carrier)	Vendor to verify only if PSV from HCRB is greater than 6 months old

Oregon Health Authority

The State of Oregon
Oregon Health Authority
Issues the Following

DRAFT
Request for Information (RFI)

for

Oregon Common Credentialing Solution

Date of Issuance: January 17, 2014

Responses Due: February 17, 2014
3:00 P.M., Pacific Time, at the Issuing Office

1. INTRODUCTION

On behalf of the Oregon Health Authority (OHA), Office of Health Policy and Research, the Office of Contracts and Procurement issues this Request for Information (RFI) on a common credentialing solution for Oregon. The solution should collect and verify Oregon health care practitioners' information for the purpose of credentialing that satisfies the requirements of Senate Bill 604 from the 2013 Regular Legislative Session and the requirements of credentialing organization accrediting entities. The OHA is looking for a low-cost, Commercial Off-the-Shelf (COTS) or Modified Off-the-Shelf (MOTS) solution for an integrated information system.

This RFI also allows respondents the option of addressing OHA's related state-level provider directory requirements, as the provider directory and common credentialing requirements overlap and may best be served by one vendor. Responses to the provider directory elements are considered optional, and are marked as such throughout the RFI.

This RFI will not in itself result in any kind of contract, nor will it obligate OHA to procure goods or services of any kind. The responses will be used to evaluate the state of the market and to identify functional requirements and system capabilities from vendors, or combinations of vendors, into a project scope; however, these responses will not result in specifications targeted to a specific vendor. Each vendor or vendor team who would like to submit a response and participate must complete and submit the attached Vendor Profile Questionnaire, Appendix 1; "Component List", Appendix 2; "Component Response Sheet", Appendix 3; and "Cost Matrix", Appendix 4.

2. BACKGROUND

Health care delivery systems and insurance carriers in Oregon independently credential health care practitioners resulting in duplication of efforts. Oregon took the first step in tackling this administratively burdensome process by developing the Oregon Practitioner Credentialing Application (OPCA) that all health plans and hospitals are required (OAR 409-045-0000) to use, but this did not limit the number of systems used to capture the information. The OHLC's Executive Committee on Administrative Simplification has also done a great deal of work exploring a common credentialing solution, but was still in need of full community support and a provider adoption plan. Senate Bill 604 was passed in July 2013 mandating a common credentialing solution that will allow providers' key information to be provided once and then accessed by multiple credentialing entities. The solution must be operational with credentialing organizations using the solution to obtain credentialing information by January 1, 2016.

SB 604 requires the Oregon Health Authority (OHA) to establish a program and database for the purpose of providing credentialing organizations access to information necessary to credential or recredential all health care practitioners in the state. Health care practitioners or their designees will be required to submit information for credentialing purposes and credentialing organizations (e.g., plans and hospitals) will be required to go through the credentialing database to look up credentialing information. SB 604 specifically requires the OHA to:

- **Establish a credentialing program and database** for Oregon health care practitioners.

- **Convene an advisory group** that includes credentialing organizations, practitioners and state health care regulatory boards (HCRBs).
- **Develop rules** on submittal requirements, the primary source verification (PSV) of credentialing information, and fees.
- **Issue an RFI** to seek input from vendors on capabilities and cost structures.
- **Issue an RFP** no later than 150 days after the close of the RFI.
- **Report to the Legislature** periodically on implementation progress.

Efficient common credentialing solutions include the functionality to: capture credentialing information and documents; perform primary source verification of select credentialing information; and execute marketing and education campaigns. This comprehensive solution, as mandated in SB 604, will significantly reduce redundancy but will also present some challenges:

- **Change management** for credentialing organizations that have been using their own systems;
- **Risk and liability** concerns regarding an external entity conducting credentialing verifications;
- **Interfacing capabilities** allowing data to be imported or exported into a new system will be needed; and
- **Fee development** for credentialing organizations and providers must be delicately balanced.
- **Funding for implementation** has not yet been identified and will need to be secured timely.

Concurrently, the OHA is working on a state-level provider directory that will be a resource for provider information including demographics, addresses, affiliations to clinics, etc. This state-level provider directory is intended to achieve administrative efficiencies and facilitate efforts by OHA and health systems, health plans, and other organizations to serve operational, analytic, and health information exchange needs. The OHA is seeking information on provider directory solutions for both the technology as well as the related operations. A state-level provider directory would:

- Be a primary source of provider's general data such as name, address, phone, National Provider Identifier (NPI), specialty, etc.;
- Identify relationships between individual practitioners and their affiliated organizations, such as clinics, hospitals and health systems, health plans, etc.;
- Identify provider information needed to facilitate exchange of patient health information, including Direct secure messaging addresses and other information to facilitate exchange;
- Provide access to other important information for operational and analytic purposes such as vital records, business registration, HCRBs, common credentialing, etc.;
- Store some provider information as well as federate to other, external provider directories; and
- Operate provider directory services including activities to ensure the provider directory data are updated and maintained, so that the directory provides reliable, validated provider information and is not outdated.

Other legislation in the 2013 regular legislative session focused on the process of credentialing mental health organizations (HB 2020) and providers of telemedicine (SB 569). Health care transformation in Oregon has also led to interest in a centralized registry for traditional health care workers (THWs) and a centralized way to track prerequisites for health professions students doing clinical placements. The OHA is cognizant of the connections between these projects and the work to create a common credentialing solution and is interested in aligning efforts where possible.

In summary, the OHA is collaborating with key stakeholders that are helping to address specific credentialing needs and challenges, resulting in an efficient solution that will reduce costs and administrative burdens for the health care industry in Oregon. The OHA will also work to ensure that

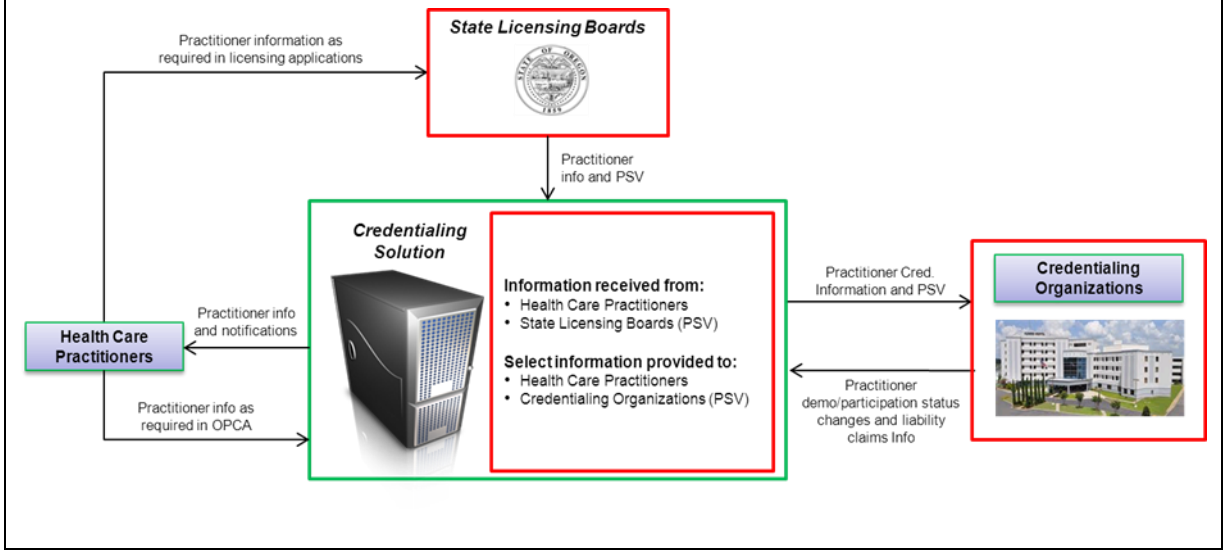
related opportunities are considered in the process of implementing a comprehensive common credentialing solution and will build from past efforts. This RFI seeks information on potential options for a low-cost common credentialing solution, a possible provider directory solution, and estimated costs.

3. SCOPE OF REQUEST

OHA is seeking input from vendors on available solutions that could support implementing a centralized, web-accessible database to collect and maintain health care practitioner credentialing information for use by credentialing organizations. This request also gives respondents the option to provide input from vendors and organizations on state-level provider directory solutions and to describe how a solution could achieve efficiencies in addressing both common credentialing and provider directory requirements.

While SB 604, in its most basic interpretation, requires a system that will capture credentialing information and documents that will be accessible by health care practitioners and credentialing organizations (as illustrated in ***Diagram #1*** below as the Baseline Common Credentialing Solution), the OHA is interested in exploring the possibility of a comprehensive solution that will be more efficient and effective for numerous entities. However, the OHA also realizes that a more robust solution may be overly complex for initial implementation. OHA is requesting that vendors provide information on at least a baseline common credentialing solution to meet the legislative requirements. Vendors may additionally provide information on a more comprehensive solution and/or a sequential approach beginning with a baseline solution and phasing in additional functionality. Optionally, vendors may provide information on the additional need for a provider directory solution.

Diagram #1: Baseline Common Credentialing Solution Design as required under SB 604



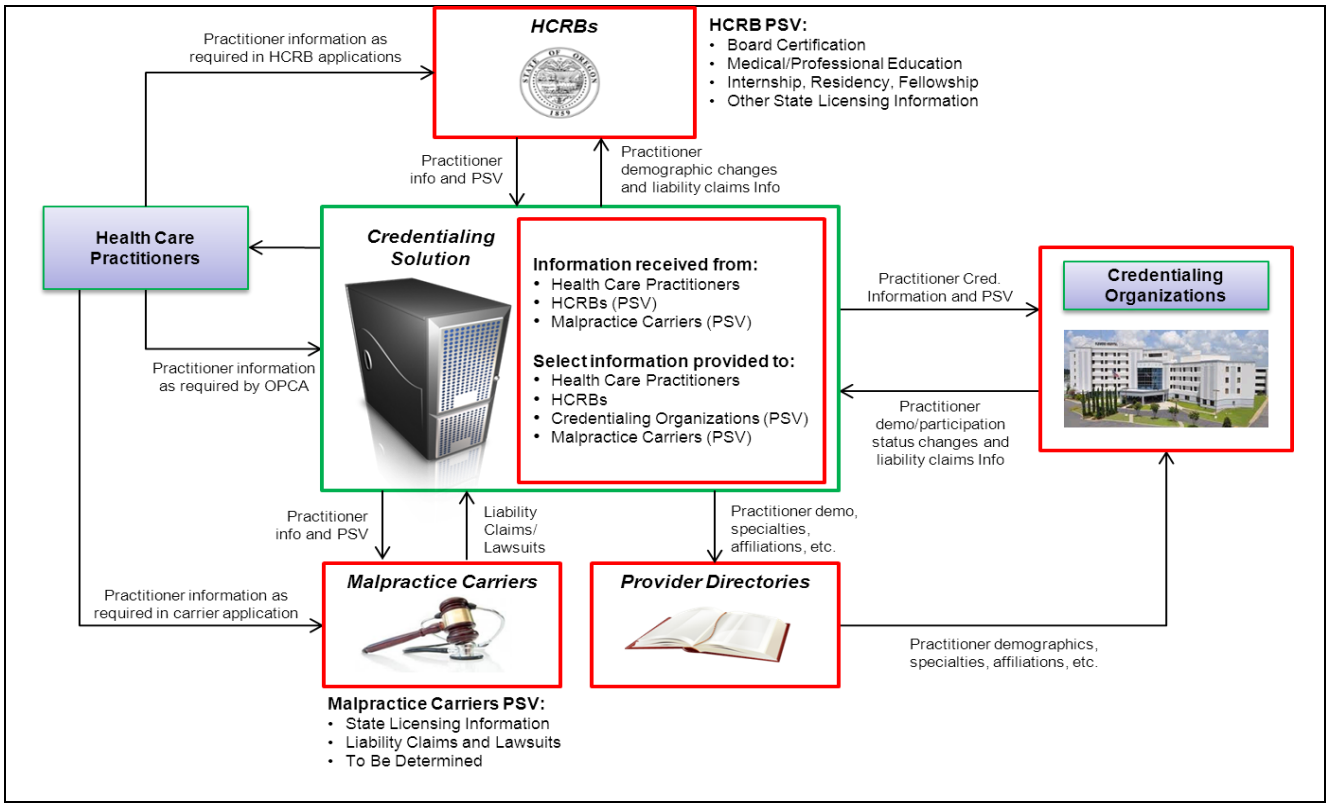
Requirements for the Baseline Solution, which would support initial credentialing, reattesting, and recredentialing of healthcare practitioners in the state of Oregon, include:

- A web-based portal for individual health care practitioners to create individual credentials records, provide updates, and view their information on a real-time basis.
- A process for primary source verification for non-static information required to be verified by national accrediting entities (i.e., the Joint Commission, NCQA, URAC, and DNV).

- A web-based portal and/or data interface functionality for HCRBs to supply credentialing elements, as outlined in the OPCA (see Attachment), and documents as required by national accrediting entities or the Oregon Health Authority for specific credentialing data elements;
- A web-based portal or data interface functionality for credentialing organizations to retrieve practitioner credentialing and primary source verification information;
- An automatic notification system for health care practitioners and credentialing organizations to provide alerts about board certification expirations, license expirations, malpractice claims actions, HCRB discipline, recredentialing periods, address changes, etc.;
- Ad hoc query and reporting capabilities for credentialing organizations;
- The ability to accept scanned documents as necessary to collect and gather health care practitioner credentialing information from the various stakeholders;
- Full accessibility for health care practitioners, credentialing organizations, and HCRBs 24 hours a day, 7 days a week;
- Robust safeguards for personal data and protected health information;
- Processes to protect data integrity (e.g., protections against creating duplicate records, data validation, records retention, offsite back-ups, etc.);
- The capability to add additional system components or requirements or to easily change business processes or rules as influenced by new policy directives or other means; and
- The ability to reduce data input by retaining and relating relevant information already captured (e.g., clinic information for a health care practitioner).

The more comprehensive common credentialing solution (as illustrated in ***Diagram #2*** below) would, in its most efficient and effective form, include a process for not only state HCRBs, but also malpractice carriers, to feed specified information into the database. It will also provide interoperability, allowing these entities to query appropriate information through reporting mechanisms and include automated notifications of record changes. There is also interest in the feasibility of having the system produce provider directory information with specified functional requirements. Below are more detailed requirements for the more comprehensive solution.

Diagram #2: Comprehensive Common Credentialing Solution Design



In addition to the basic requirements, the comprehensive common credentialing solution should allow for interoperability with HCRB, credentialing organization, and malpractice carrier systems. Optionally, it could also include a provider directory solution using the data collected for credentialing health care practitioners. Some of the more detailed requirements for the comprehensive common credentialing solution include the ability of the system to:

- Allow interfacing with HCRBs and malpractice carriers of varying levels of technological sophistication that will enable electronic communication with the solution on a real-time basis pertaining to health care practitioner record changes (e.g., address changes, new liability claim information, sanctions, etc.);
- Have an automatic notification system for health care practitioners, credentialing organizations, HCRBs, and malpractice carriers on board certification expirations, license expirations, claims actions, sanctions, recredentialing periods, address changes, etc.
- Provide ad hoc query and reporting capabilities for credentialing organizations, HCRBs, and malpractice carriers
- Include the capability to link to provider directory data or be a source of data for provider directories (see below).

OPTIONAL: State-level Provider Directory Solution Design and Operations

Short list of design requirements and diagram to be inserted here.

Beyond the technical aspects, OHA is also interested in options for a fee structure that could support such a solution. Credentialing organizations and health care practitioners share a stake in the benefit of such a common credentialing solution and legislation has allowed for a fee structure to be put in place to support the ongoing operations and maintenance of the solution. Potential financing options should

distribute costs equitably across the credentialing organizations and health care practitioners, which must be delicately balanced with consideration to benefits they may experience and their respective resources.

4. GENERAL TERMS, CONDITIONS AND PROCEDURES

- Ownership of all data, material and documentation originated and prepared for OHA pursuant to this RFI response will belong exclusively to OHA.
- OHA is not responsible for any expenses and/or costs incurred by Respondent in submitting their response to this RFI. Each Respondent does so solely at that Respondent's own cost and expense.
- OHA retains the right to hold onsite demonstrations by vendors that demonstrate in their written response that they can supply the goods and services, and that they are a viable contractor for these products and services.
- OHA encourages respondents to provide a budgetary cost estimate for five (5) and ten (10) years of product licensing, maintenance and implementation.
- All Respondents understand and agree that OHA is not obligated to include any Respondent in any future solicitation process by distributing an RFI to them, nor is OHA obligated to contract with any Respondent.
- News releases pertaining to this RFI or the services, or project to which it relates shall not be made without prior OHA approval.

5. HOW TO RESPOND

Response must arrive by hard copy by courier (USPS, FedEx, UPS, etc.) or hand delivery. Delivery and cost of delivery is the sole responsibility of Respondent.

FAX (facsimile) or electronic responses will not be accepted.

Respondent should identify the title of the Response, date of Response, name of Respondent, address, telephone number, fax number, E-mail address and name of primary contact. You are required to submit two (2) hard copies and one (1) electronic copy on CD-ROM.

Your response must be received by February 17, 2014 3:00 P.M., Pacific Time. Responses should be delivered to:

Jose Perfecto, Contract Manager???
800 NE Oregon St., Suite 640
Portland, OR 97232

6. CONFIDENTIAL OR TRADE SECRET INFORMATION

Respondents are advised that most documents in the possession of OHA are considered public records and subject to disclosure under the State Public Records Law (ORS 192.410 to 192.505). An exemption from disclosure is provided for trade secrets. If any part of the information given is considered a trade secret, the vendor must clearly designate that portion as confidential in order to protect it from disclosure. Simply marking a section "confidential" will not ensure protection. Vendor must be prepared to advance the reasons why the material is a trade secret; OHA agrees to maintain information deemed a trade secret confidential to the extent permitted by law.

7. CONTACT INFORMATION

For any questions regarding the content of this RFI, vendors may send their questions by email (only) to the single point of contact for this RFI. All questions regarding this RFI must be emailed no later than 5:00 PM Pacific Time, January 31, 2014, to:

Jose.c.Perfecto@dhsoha.state.or.us

Please note that email attachments cannot exceed 4MB.

This RFI #### documentation is also listed on the ORPIN web site: http://orpin.oregon.gov/open.dll/welcome and view RFI number ####.

VENDORS ARE RESPONSIBLE FOR ENSURING THAT THEIR CONTRACTOR INFORMATION IS CURRENT AND CORRECT: OHA IS NOT RESPONSIBLE FOR INCORRECT OR INCOMPLETE CONTRACTOR INFORMATION ON ORPIN.

NOTE: VENDORS SHOULD CONSULT THE ORPIN SYSTEM REGULARLY, UP TO AND INCLUDING THE CLOSING DATE AND TIME, TO ASSURE THAT YOU HAVE NOT MISSED ANY RFI ANNOUNCEMENTS

8. DISCLAIMER

This RFI is issued solely for information and planning purposes; it does not constitute a solicitation. There will not be an evaluation or scoring of the material submitted. Information received in response to this RFI will not be returned. Responses to this notice are not considered an offer and cannot be accepted by the State of Oregon to form a binding contract. All costs submitted with the RFI are for OHA budget purposes only and are not considered to be a bid. Responders are solely responsible for all expenses associated with responding to this RFI. Respondents will not be notified as a result of this RFI or interviews. Participating in this RFI and presentations is not a requirement for responding to the RFP and does not affect the ability to participate in the RFP process.

9. PRESENTATIONS

Formal demonstrations are not planned at this time. However, OHA reserves the right to schedule demonstrations among potential vendors. Vendors who, at the sole assessment of the State, respond in a manner indicating they possess the knowledge, skills, and capabilities may be invited to make a presentation or be provided an opportunity to demonstrate their system capabilities in an open public forum.

NOTE: It is at OHA's sole discretion to schedule demonstrations among vendors submitting a response to this RFI.

10. ESTIMATED PROJECT DATES AND MILESTONES

1. RFI posted on January 17, 2014
2. RFI Questions concerning the RFI due on January 31, 2014 by 5:00 PM
3. RFI responses due on February 17, 2014 by 3:00 PM

4. RFI demonstrations – if necessary, March or April 2014
5. RFP post date: No later than 150 days after the close of the RFI

NOTE: *These dates represent a tentative RFI Time Line. The State reserves the right to modify these dates at any time.*

PROPOSERS SHOULD CONSULT THE ORPIN SYSTEM REGULARLY, INCLUDING UP TO AND INCLUDING THE CLOSING DATE AND TIME, TO ASSURE THAT THEY HAVE NOT MISSED ANY RFI ANNOUNCEMENTS.

APPENDIX 1

Vendor Profile Questionnaire

General Vendor Information

Vendor Name: _____ **Date:** _____

Contact Name: _____

Contact Address: _____

Contact Email: _____

Contact Telephone: _____

Year Company was Founded: _____

Number and Location of Employees: _____

Vendor Experience

1. Indicate whether you are an accredited Credentials Verification Organization (CVO) and list your accreditations (e.g. URAC, NCQA, TJC and/or others).
2. Describe your credentialing solution and include whether it is operated and maintained by your firm or if it is hosted or managed elsewhere by another company.
3. Describe your experience working with multiple accrediting entities and how your organization remains current with and manages changes in national standards.
4. Explain what, if any, experience you have with Oregon credentialing organizations or HCRBs and whether you currently have any Oregon provider information.
5. Describe your experience providing a system with multiple interfaces and multiple end-users of varying levels of technological sophistication
6. Indicate whether your organization has any return on investment (ROI) information pertaining to the scope of the common credentialing solution described in this RFI.
7. List any related applications or services that you offer that you feel should be considered in this section.
8. OPTIONAL: Describe your experience providing provider directory services.

APPENDIX 2

Component List

Please check the relevant column and include a brief description of whether the desired component could be supported in your solution, or comment on any components currently under development or that would need to be developed.

Desired Component	LIVE	PLANNED	NO	Description/Comments
A web-based portal for individual health care practitioners to create individual credentials records, provide updates, and view their information on a real-time basis, ensuring the gathering of all information on the OCPA				
A web-based portal and data interface functionality for credentialing organizations to query and/or retrieve practitioner credentialing and Primary Source Verification information				
A web-based portal and/or data interface functionality for HCRBs, of varying levels of technological sophistication, to allow input of healthcare practitioner license information				
Automatic notification system for health care practitioners and credentialing organizations on board certification expirations, license expirations, malpractice claims actions, HCRB discipline, re-credentialing periods, address changes, etc.				
Ad hoc query and reporting capabilities				
Ability to support paper and scanned document processing as necessary to collect and gather health practitioner credentialing information from the various stakeholders				
Accessible by health care practitioners, credentialing organizations, and HCRBs 24 hours a day, 7 days a week				
HIPPA compliant – security safeguards for personal data and protected health information				
Capability to add additional system components or requirements or easily change business processes or rules as influenced by new legislation or policy directives				
Ability to reduce data input by retaining and relating relevant information already captured, for example clinic information for a provider				

Desired Component	LIVE	PLANNED	NO	Description/Comments
Interface with state malpractice carriers, of varying levels of technological sophistication, to allow input of healthcare practitioner insurance information				
Interface with HCRBs and malpractice carriers of varying levels of technological sophistication to allow real time access to query or export appropriate practitioner information including health care practitioner record changes (e.g., address changes, new liability claim information, sanctions, etc.)				
Automatic notification system malpractice carriers on board certification expirations, license expirations, malpractice claims actions, HCRB discipline, recredentialing periods, address changes, etc.				
Automatic notification system for HCRBs about malpractice claims actions and employer sanctions.				
Account and Access Management Functionality				
Support various technical levels of interface for data import and export, real-time, ad hoc, and batch.				
Audit trail capabilities				
Storage and retrieval of source documentation				
Use of business rules and data standards to protect data integrity				
OPTIONAL COMPONENTS FOR PROVIDER DIRECTORY				
Ability to capture Health Information Exchange (HIE) addresses such as direct secure messaging and other routing information for providers				
Ability to affiliate providers to their clinics, organizations, or groups				

APPENDIX 3

Product Questionnaire

1. **Proposed Solution:** Provide the name of your solution and a brief description of it.

2. **Summary of Features of Functionality:** Provide a description of how your product addresses each of the components of information management listed in Appendix 2, component list.

3. **Summary of Solution:** Provide a description of how your product could address the needs stated in Section 3, "Scope of Request." Include information regarding timing and any sequential or "phase-in" approach, if any, your solution would follow beginning with a baseline solution and phasing in additional functionality.

4. Summary description of operations: Describe how your organization could operate as a credentialing solution, rather than just operating a repository. Include information regarding the following:

    a) How your organization could work with HCRBs to ensure the collection of health care practitioner information regardless of the board's level of technological sophistication;
    b) How your organization could primary source verify specified credentialing information in a manner that will meet national accrediting standards and remain in compliance with current credentialing requirements;
    c) How the collection of primary source verifications as required by national accrediting entities could be conducted;
    d) The process of working with health care practitioners to ensure the completion of the credentialing data gathering and that all documentation is provided;
    e) Whether your organization has a Quality Assurance Plan and how it is audited for performance;
    f) Whether and how your organization would engage end-users to provide input on the solution;
    g) What business continuity plans your organization has in place;
    h) What approach could your organization use to achieve successful implementation and quick adoption of the service and its concomitant workflow changes for health care practitioners, credentialing organizations, HCRBs, and malpractice carriers (include any past lessons learned in this area);
    i) A high-level timeline to achieve a successful implementation by January 1, 2016;
    j) Types and frequency of training, communications, and support your organization could provide for end-users: health care practitioners, delegated administrators, credentialing organizations, HCRBs, and/or malpractice carriers; and
    k) How your organization could ensure a partnership with the OHA and conduct regular policy research in order to identify changing needs in credentialing and the new projects that could benefit from the credentialing solution.

5. **Summary description of functionality and system architecture:** Describe the extent to which the system meets modularity and interoperability requirements for functions, services and architecture and that the content is locally configurable by a user who has administrator rights. Include information regarding the following:

a) The technology your solution is built upon including programming languages and database management system, etc.);
b) Whether your solution could include credentialing form elements required in the Oregon Practitioner Credentialing Application;
c) Describe the scalability of your system and database including the number of providers that could be serviced with the system and the number of simultaneous users the system could support;
d) How you could work with HCRBs and malpractice carriers with different levels of electronic data capability to not only receive data from them, but also share data provided by credentialing organizations with the HCRBs and malpractice carrier;
e) Describe the technology and data formats available with your systems to enable data consuming site to integrate the information into their systems;
f) Whether your organization could provide web portal services available for data consuming sites to integrate with their systems;
g) Various ways your solution could allow providers to interface and provide data to your solution and how your solution could accommodate providers that do not have an electronic interface capability;
h) What process your solution could use to allow health care practitioner's delegates to enter data on the practitioner's behalf and the process for which information could be re-attested to for accuracy;
i) Data Change Management functionality including any date/time stamp capabilities that could prevent further changes or audit changes to data that was already attested to and how changed or new information could be transmitted to credentialing organizations or HCRBs that have already consumed the initial data;
j) Whether all online submitted entries could send updates to all interfaced systems where a data element is stored at the same time; identifying any timing delays or requirements for duplicate data entry exceptions);
k) How transmission interruptions (e.g., transmission failure, partial data updates, etc.) between your solution and data consuming sites are managed and resolved;
l) Reporting capabilities (standard and ad hoc) of the solution for various audiences: credentialing organizations, HCRBs, malpractice carriers, and health care practitioners;
m) System capability to interface to and utilize Oregon's single sign-on solution;
n) Ability of the system to be modified, enhanced, and adapted going forward to meet changing needs and the possibility of merging of systems;
o) How your common credentialing solution could interface with or incorporate a state-level or local/organizational provider directory;
p) OPTIONAL FOR PROVIDER DIRECTORY: How providers and their specialties, which may vary are affiliated to and credentialed at multiple clinics, groups, organizations, hospitals and other organizations, including how those data are structured and kept current; and
q) OPTIONAL FOR PROVIDER DIRECTORY: How your solution could manage direct secure messaging addresses, affiliations, and preferences for health information exchange.

6. **Summary description of data access and quality, and available support:** Describe connectivity and data access options for credential organizations, HCRBs, malpractice carriers and health care practitioners accessing the service for data sharing. Include information regarding the following:
    a) Interfacing capabilities of your solution and how you could create new ones with entities of varying technological sophistication, including the sharing of provider demographics

across multiple groups/databases and whether the same record be viewed concurrently by multiple locations/users;

b) How your solution could protect against simultaneous updates of the same data field(s) by more than one user;
c) How the solution could track that a provider did not complete the application and how it could retain incomplete application data and flag the application as incomplete;
d) Whether the authenticity of your data has ever been challenged, (e.g., non-repudiation of changes/information);
e) Whether your solution has a data cleansing process;
f) Any processes for edit checks on data fields and consistency checks between data fields to reduce data entry errors and duplicate records;
g) Your company's approach to support and maintenance for various users, to include: types of support, including normal support hours, where support staff is located, response time, etc.; and
h) What kind of user help functionality the solution supports.

7. **Information Security:** Provide a description of how your product's security functions. Include information regarding the following:
    a) Your organization's approach to data/information security, especially with regards to internet security and what industry approaches for encryption and authentication are utilized;
    b) Standard account management capabilities of your solution (e.g., accommodating multiple users on a common workstation, imposing different access limitations on different types of users, etc.);
    c) Audit capabilities of your solution that may log activity to provide a complete audit trail of the specific user or practitioner record, describing the data elements that may be logged and how reports of activity could be available to system administrators;
    d) Data authentication or the ability to corroborate that data has not been altered or destroyed.
    e) How your solution protects, detects and cleans computer viruses;
    f) Whether your solution supports electronic signatures;
    g) Strategies that could be used to maintain adequate bandwidth during peak use hours.
    h) Strategies that could be used to backup data (including frequency) to minimize any loss during unplanned events that interrupt service;
    i) How significantly the end-user performance must deviate before an alert is generated.
    j) What tools exist for validating or disputing the presence of a problem When degradation is reported;
    k) What tools exist for isolating exactly what part of the system (application server, database server, network, workstation, etc.) is responsible for degraded performance;
    l) What monitoring and measurement reports would be available to validate your last six months of system up-time and consistent performance of the service; and
    m) Whether the system supports role-based security or some other method to enable segregating provider data so that access can be granted on specific data elements (i.e., sanction information may not be available to all users of the system).

APPENDIX 4

Cost Sheet

Describe the licensing, maintenance and implementation, and any other related costs estimated for both a 5 and 10 year period. Cost should be described by functionality and/or component or by phase as applicable (e.g., baseline Solution, the inclusion of PSV and interoperability, the comprehensive solution, and the option of a provider directory solution). Include financing sustainability options for ongoing operations and maintenance that distributes costs equitably across credentialing organizations and health care practitioners considering the benefits they may experience and their respective resources. Options might include volume-based or participation fees, a membership structure, or others.

END OF RFI