Oregon Common Credentialing Advisory Group

AGENDA
Date: Friday May 9, 2014
Time: 1:30pm to 3:30pm

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

#	Time	Item	Materials	Lead
1	1:30 – 1:35	Welcome and Agenda Review	1	Erick Doolen
2	1:35 – 1:45	Explanation of the Attestation Requirement	2	Melissa Isavoran
3	1:45 – 2:30	Draft Credentialing Rules Review	4	Kim Fisher
4	2:30 – 3:00	Request for Proposal Development Process	5	Melissa Isavoran
5	3:00 – 3:15	Outreach Efforts	6	Scott Gallant
6	3:15 – 3:30	Public Comment	NA	Public
7	3:30	Next Steps and Adjournment	NA	Erick Doolen

Materials:

1. Agenda
2. Credentialing Attestation Requirement
3. DRAFT CC Rules Dated 5/7/2014
4. Request for Proposal Summary
5. SB 604 CC Outreach Overview

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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Common Credentialing Attestation Requirement

Purpose
Under Common Credentialing Program requirements, it has been determined that Oregon health care practitioners should be required to attest to their credentialing information through the common credentialing solution every 120 days. This document serves as an explanation of that determination.

Background
Current Oregon health care practitioners must complete an initial credentialing application, complete with initial attestations and required documentation. This is done using the Oregon Practitioner Credentialing Application (OPCA). Credentialing organizations use this application and information for the initial credentialing process and follow requirements set forth by their respective accrediting entities (e.g., the Joint Commission, the National Committee for Quality Assurance, the Utilization Review Accreditation Committee, and DNV Healthcare).

Accrediting entity requirements dictate practitioner types that must be credentialed, how often they are to be credentialed, and what practitioner information must be verified from the primary source. In regards to the information that must be verified from the primary source (known as primary source verification), some accrediting entities identify the timing in which the verification must occur. While verifications of static information such as education and training need only be verified once, verifications of sanctions and claims history must be less than 180 days old. Credentialing organizations use this information to inform their credentialing committees of practitioner qualifications to accurately access a practitioner's ability to be accepted on their provider panel. Credentialing committees generally meet monthly or quarterly.

With a new common credentialing solution as mandated by Senate Bill 604 from the 2013 Regular Legislative Session, health care practitioner applications and primary source verifications will be shared among all credentialing organizations in Oregon. Draft credentialing rules for the OHA Common credentialing program and this solution will be submitted to the Secretary of State in May and will include regulations that allow for the OPCA as the template of information to be gathered through the solution and also 120 day attestations from providers. Frequent health care practitioner attestations will allow for the most current and accurate practitioner information possible. The attestation language is as follows:

"Attestation of credentialing information must occur within 120 days once the complete initial credentialing application information is entered. Re- attestation must occur within 120 days from the date of the initial attestation and every 120 days thereafter. Should credentialing information be updated and attested to by a provider outside of this 120 day re-attestation cycle, the next required re-attestation for the provider shall be due 120 days from the most recent attestation."

Health care practitioners may continuously need to be credentialed or recredentialing by credentialing organizations at different times. It was originally determined that 90 day attestations under Oregon's common credentialing program would be ideal to ensure alignment with the 180 day requirement, monthly credentialing committee meetings, and the 90 day approval or rejection requirement for health insurers (ORS § 743.918). However, a 120 day attestation requirement could also ensure these alignments as it is less than 180 days and the 90 day approval or rejection requirement begin only after an application is completed. Furthermore, other credentialing vendors and the state of Washington use 120 attestations. This timeframe is efficient in ensuring that updated information can be verified during the 30 days gap between the attestation and the 180 day requirement. For these reasons, the OHA has determined the 120 day requirement to be efficient for both the purposes of credentialing practitioners according to accrediting entity standards and for the protection of practitioner time and resources necessary for providing information regularly.

CHAPTER 409
OREGON HEALTH AUTHORITY
OFFICE FOR OREGON HEALTH POLICY AND RESEARCH

DIVISION 45
HEALTH CARE PRACTITIONER ~~PHYSICIAN~~ CREDENTIALING

409-045-0000
Definitions

The following definitions apply to OAR 409-045-0025 to 409-045-0130:

(1) "Accreditation" means a comprehensive evaluation process in which a health care organization's systems, processes and performance are examined by an impartial external organization ("accrediting entity") to ensure that it is conducting business in a manner that meets predetermined criteria and is consistent with national standards.

(2) "Advisory Group" means the Common Credentialing Advisory Group.

(3) "Authority" means the Oregon Health Authority.

(4) "Credentialing" means a standardized process of inquiry undertaken to validate specific information that confirms a health care practitioner's identity, background, education, competency and qualifications related to a specific set of established standards or criteria.

(5) "Credentialing information" means information necessary to credential or recredential a health care practitioner.

(6) "Credentialing organization" means a hospital or other health care facility, physician organization or other health care provider organization, coordinated care organization, business organization, insurer or other organization that credentials health care practitioners. This includes, but is not limited to the following:

(a) Independent Physician Associations
(b) Ambulatory Surgical Centers
(c) Hospitals and Health Systems
(d) Health Plan Issuers
(e) Coordinated Care Organizations
(f) Dental Plan Issuers

(7) "Credentials Verification Organizations" means an organization that gathers data and verifies the credentials of doctors and other health care practitioners and has systems in place to protect the confidentiality and integrity of the information.

(8) "Delegated credentialing agreement" means a written agreement between credentialing organizations that delegates the responsibility to perform specific activities related to the credentialing and recredentialing of health care practitioners. For Telemedicine credentialing, delegated credentialing agreement has the same meaning given that term in ORS 442.015.

(9) "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.

(10) "Health care facility" has the same meaning given that term in ORS 442.015.

(11) "Health care practitioner" means an individual authorized to practice a profession related to the provision of health care services in Oregon for which the individual must be credentialed. This includes, but is not limited to the following:

(g) Doctor of Medicine
(h) Doctor of Osteopathy
(i) Doctor of Podiatric Medicine
(j) Physician Assistants
(k) Oral and Maxillofacial Surgeons
(l) Dentists
(m) Acupuncturists
(n) Audiologists
(o) Licensed Dieticians
(p) Licensed Marriage and Family Therapists
(q) Licensed Professional Counselor
(r) Psychologist Associate
(s) Speech Therapists
(t) Physical Therapists
(u) Occupational Therapists
(v) Registered Nurse First Assistant
(w) Advanced Practice Registered Nurses
(x) Psychologists
(y) Licensed Clinical Social Worker
(z) Optometrist
(aa) Chiropractor
(bb) Naturopathic Physician
(cc) Licensed Massage Therapists

(12) "Health care regulatory board (HCRB) means a board or other agency that authorizes individuals to practice a profession in Oregon related to providing health care services for which the individual must be credentialed.

(13) "Health services" has the same meaning given that term in ORS 442.015.

(14) "Hospital" has the same meaning given that term in ORS 442.015.

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

(16) "Primary source verification" means the verification of an individual practitioner's reported qualifications by the original source.

(17) "Program" means the Oregon Common Credentialing Program.

(18) "Solution" means the Oregon Common Credentialing Program's electronic system through which credentialing information may be submitted to an electronic database and accessed.

(19) "Telemedicine" has the same meaning given that term in ORS 442.015.

Stat. Auth.: Sections X to XX, Ch. 603, OL 2013, ORS 441.056, 442.807
Stats. Implemented: ORS 441.056, 441.223, 442.015, 442.800 to 442.807

Credentialing Requirements for Health Care Practitioners

409-045-0025
Oregon Common Credentialing Program

The Oregon Common Credentialing Program is established within the Authority for the purpose of providing a credentialing organization access to information necessary to credential or recredential a health care practitioner. The Program shall include, but is not limited to the following:

(1) An electronic solution through which health care practitioner credentialing information must be submitted.

(2) A process by which health care practitioners or designees may access the Solution to submit information necessary for credentialing.

(3) A process by which credentialing organizations may input, access, and retrieve health care practitioner credentialing information.

(4) A process by which HCRBs may input and access health care practitioner credentialing information.

(5) Coordination with HCRBs and the process of primary source verification of credentialing information.

Stat. Auth: Sections X to XX, Ch. 603, OL 2013
Stats. Implemented:

409-045-0030~~0000~~
Oregon Practitioner Credentialing Application~~Physician Credentialing, Health Care Service Contractors~~

(1) The Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application, both approved by the Authority based on recommendations from the Advisory Committee on Physician Credentialing Information ~~(ACPCI) on September 28, 2011~~are adopted with respect to ~~hospitals and health care service contractors~~ credentialing organizations ~~as Exhibits 1 and 2 to this rule~~ . The Authority approved applications are available at the on the Committee's website at http://www.oregon.gov/OHA/OHPR/ACPCI/Pages/index.aspx.

(2) Each credentialing organization~~hospital and health care service contractor~~ shall use the application forms adopted in section (1) of this rule for the purpose of credentialing and recredentialing health care practitioners.

(3) The Program shall use the application forms adopted in section (1) of this rule as the template for health care practitioner credentialing information.~~This rule is adopted pursuant to the authority of ORS 441.223 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 441.221 to 441.223 with respect to hospitals and health care service contractors.~~

Stat. Auth.: ORS 441.223
Stats. Implemented: ORS 442.221 – 441.223

409-045-0035
Credentialing Information Verifications

(1) The Program shall accept all HCRB verifications of credentialing information as provided in accordance with OAR 409-045-0050 and shall supplement those verifications, if necessary, to ensure compliance with national accrediting entity standards.

(2) Methods for conducting primary source verification of credentials include direct correspondence, documented telephone verification, secure electronic verification from the original qualification source, or reports from Credentials Verification Organizations or approved agents that meet accrediting entity requirements.

Stat. Auth: Sections X to XX, Ch. 603, OL 2013
Stats. Implemented:

409-045-0040
Health Care Regulatory Board Participation

(1) An HCRB that licenses health care practitioners shall provide practitioner information and documentation to the Solution in a format and frequency as agreed by the HCRB and the Authority beginning January 1, 2016. An HCRB may agree to provide practitioner information and documentation to the Solution beginning July 1, 2015.

(2) A HCRB that provides information to the Solution must also provide an annual attestation to the Authority that clearly identifies the HCRBs specific practices related to the process of primary source verification of health care practitioner information.

(3) HCRBs shall authorize the use of practitioner data through data use agreements established between HCRBs and the Authority.

(4) A HCRB unable to provide information to the Solution by January 1, 2016, may submit a petition to the Authority director for consideration of a waiver from the requirements of this section (1). The Authority shall review the waivers at least every two years for validity. The petition for a waiver must include:

(a) The name of the HCRB;
(b) The phone number and email address for the HCRB contact person;
(c) A description of specific barrier to submitting information and documentation;
(d) Efforts or ideas to address the barrier and the timeframe for doing so; and
(e) The identification of support, including funding, needed to accomplish the efforts or ideas.

Stat. Auth: Sections X to XX, Ch. 603, OL 2013
Stats. Implemented:

409-045-0045
Credentialing Organization Participation

(1) Credentialing Organizations shall obtain health care practitioner credentialing information from the Solution beginning January 1, 2016 if that information is kept and maintained by the Solution.

(2) Credentialing organizations may not request credentialing from a health care practitioner if the credentialing information is available through the Solution. Credentialing organizations may request additional credentialing information from a

health care practitioner for the purpose of completing credentialing procedures as required by the credentialing organization.

(3) A prepaid group practice health plan that serves at least 200,000 members in Oregon and that has been issued a certificate of authority by the Department of Consumer and Business Services may petition the Authority director to be exempt from the requirements of this section. The director may award the petition if the director determines that subjecting the health plan to this section is not cost-effective. If the director grants an exemption, the exemption also applies to any health care facilities and health care provider groups associated with the health plan. Exemptions may be reviewed by the Authority every two-years for validity. The petition for exemption must include:

(a) The name of the prepaid group practice health plan petitioning the Authority;
(b) The phone number and email address for the health plan contact person;
(c) A description of the prepaid group practice health plan;
(d) A brief description of the prepaid group practice health plan's current credentialing practices; and
(e) A justification of why the Solution is not cost-effective.

Stat. Auth: Sections X to XX, Ch. 603, OL 2013
Stats. Implemented:

409-045-0050
Health Care Practitioner Participation

(1) Health care practitioners required to be credentialed by a credentialing organization shall submit information and documentation required pursuant to OAR 409-045-0035 to the Solution beginning on January 1, 2016 to the extent that it is not available to the Solution from the HCRBs. Health care practitioners may agree to provide information and documentation required pursuant to OAR 409-045-0035 to the Solution beginning July 1, 2015. Health care practitioners may use a designee to assist in the submittal process.

(2) Health care practitioners must attest to all credentialing information in the Solution.

(3) Attestation of credentialing information must occur within 120 days once the complete initial credentialing application information is submitted. Re- attestation must occur within 120days from the date of the initial attestation and every 120 days thereafter. Should credentialing information be updated and attested to by a provider outside of this 120 day re-attestation cycle, the next required re-attestation for the provider shall be due 120 days from the most recent attestation.

Stat. Auth: Sections X to XX, Ch. 603, OL 2013

Stats. Implemented:

409-045-0055
Use of Health Care Practitioner Information

(1) A credentialing organization that, in good faith, uses credentialing information provided by the Solution for the purposes of credentialing health care practitioners is immune from civil liability that might otherwise be incurred or imposed with respect to the use of that credentialing information.

(2) All health care practitioner information that is received, kept, and maintained in the Solution, except for general information used for directories, is exempt from public disclosure under ORS 192.410 to 192.505.

Stat. Auth: Sections X to XX, Ch. 603, OL 2013
Stats. Implemented: ORS 192.410 to 192.505, and Sections X to XX, Ch. 603, OL 2013

409-045-0060
Common Credentialing Advisory Group

(1) The Authority establishes the Common Credentialing Advisory Group. Members of the Advisory Group shall be appointed by the Director and shall include members who represent:

(a) Credentialing organizations;
(b) Health care regulatory boards;
(c) Health care practitioners; and
(d) The ACPCI.

(2) All members appointed shall be knowledgeable about national standards relating to health care practitioner credentialing.

(3) The term of appointment for each member is three years. If, during a member's term of appointment, the member no longer qualifies to serve, the member must resign. If there is a vacancy for any reason, the director shall appoint a new member which is effective immediately for the unexpired term.

(4) The Authority and the Advisory Group shall meet at least once per year.

(5) The Advisory Group shall be responsible for advising the Authority on the process of credentialing, including but not limited to the following:

(a) Credentialing industry standards;
(b) Common Credentialing Solution;

(c) Recommended changes to the Oregon practitioner credentialing application pursuant to ORS 442.221 – 441.223; and

(d) Other proposed changes or concerns brought forth by interested parties.

(6) Members of the committee may not receive compensation or reimbursement of expenses.

Stat. Auth: Sections X to XX, Ch. 603, OL 2013
Stats. Implemented:

409-045-0065
Imposition of Fees

Beginning January 1, 2016, the Authority shall impose fees on credentialing organizations that access the Solution and may impose fees on health care practitioners who submit credentialing information to the Solution. Fees shall not exceed the cost of administering the Program.

Stat. Auth: Sections X to XX, Ch. 603, OL 2013
Stats. Implemented:

409-045-0070
Complaints

Complaints regarding the Program and the Program's activities shall be submitted to Authority for evaluation through the Program's website. The Authority shall provide a response to each complaint within two weeks of receiving the complaint.

Stat. Auth: Sections X to XX, Ch. 603, OL 2013
Stats. Implemented:

Credentialing Requirements for Telemedicine Providers

~~**409-045-0105**~~
~~**Purpose**~~

~~These rules, OAR 409-045-0105 to 409-045-0135, establish credentialing requirements for telemedicine health care practitioners providing telemedicine services from distant-site hospitals in Oregon to patients in originating-site hospitals in Oregon.~~

~~Stat. Auth.: ORS 441.056~~
~~Stats. Implemented: ORS 441.056, 441.223, 442.015~~

~~**409-045-0110**~~
~~**Definitions**~~

~~The following definitions apply to OAR 409-045-0105 to 409-045-0135:~~

~~(1) "Authority" means the Oregon Health Authority.~~

~~(2) "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.~~

~~(3) "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.~~

~~(4) "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.~~

~~(5) "Hospital" means 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 provide at least the following health services:~~

~~(a) Medical;~~

~~(b) Nursing;~~

~~(c) Laboratory;~~

~~(d) Pharmacy; and~~

~~(e) Dietary.~~

~~(6) "Originating-site hospital" means a hospital in which a patient is located while receiving telemedicine services.~~

~~(7) "Telemedicine" means the provision of health services to patients by physicians and health care practitioners from a distance using electronic communications.~~

~~Stat. Auth.: ORS 441.056~~
~~Stats. Implemented: ORS 441.056, 441.223, 442.015~~

409-045-~~0115~~0100
General Applicability

(1) These rules apply to all:

(a) Telemedicine health care practitioners who provide telemedicine services from any distant-site hospital in Oregon to patients in originating-site hospitals in Oregon.

(b) Originating-site hospitals located in Oregon that credential telemedicine health care practitioners located at distant-site hospitals in Oregon.

(2) Completion of credentialing requirements does not require a governing body of a hospital to grant privileges to a telemedicine health care practitioner and does not affect the responsibilities of a governing body under ORS 441.055.

Stat. Auth.: ORS 441.056
Stats. Implemented: ORS 441.056, 441.223, 442.015

409-045-~~0120~~0115
Standard List of Credentialing Documents

(1) To become credentialed by an originating-site hospital, a telemedicine healthcare practitioner or the distant-site hospital must provide the following information and documentation to the originating-site hospital:

(a) A completed current (within the past 6 months) Oregon Practitioner Credentialing Application (OPCA) and the following ~~accompanying~~ documents:

(A) A copy of state medical license;

(B) Drug Enforcement Agency certificate;

(C) ~~Educational Commission for Foreign Medical Graduates certificate~~ State approved foreign education equivalency certificate or report, if applicable; and

(D) Certification of professional liability insurance.

(b) Attestation by medical staff at the distant-site hospital that they have conducted primary source verification of all materials of the OPCA except for:

(A) Hospital affiliations other than to the distant-site hospital;

(B) Work history beyond the previous five years~~5 years previous~~.

(2) Originating-site hospitals may request documentation of all the verifications above from the distant-site hospital or the telemedicine health practitioner. Verifications that are not provided may be obtained separately by the originating-site hospital.

(3) Originating-site hospitals may~~must~~ not require either the telemedicine healthcare practitioner or the distant-site hospital to provide the following documentation for the purposes of credentialing or privileging a telemedicine provider:

(a) Proof of Tuberculosis Screening;

(b) Proof of vaccination or immunity to communicable diseases;

(c) HIPAA training verification;

(4) Originating-site hospitals may~~shall~~ not require a telemedicine provider to attend physician and ~~/~~staff meetings at the originating-site hospital.

(5) Originating-site hospitals may~~must~~ not request credentialing information if the credentialing information was made available under OAR 409-045-0115 and is not subject to change**.**

(6) To become recredentialed by an originating-site hospital, every two years a telemedicine healthcare practitioner or the distant-site hospital must~~, every two years,~~ provide a completed current Oregon Practitioner Recredentialing Application and all other information required in OAR 409-045-0115~~0120 (1)~~.

Stat. Auth.: ORS 441.056
Stats. Implemented: ORS 441.056, 441.223, 442.015

409-045-0120~~0125~~
Distant-Site Hospital Agreements

~~In lieuof the requirements in OAR 409-045-0120, h~~Hospitals may use delegated credentialing agreements instead of the requirements in OAR-409-045-0115 ~~to provide that the governing body of a hospital accepts the recommendation of the medical staff at another hospital to credential telemedicine providers~~to stipulate that the medical staff of the originating-site hospital shall 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. If a delegated credentialing agreement is in place the originating-site hospital is not

limited to the information and documents prescribed by the Authority in OAR 409-045-0115~~0120~~.

Stat. Auth.: ORS 441.056
Stats. Implemented: ORS 441.056, 441.223, 442.015

409-045-0125~~0130~~
Hold Harmless Clause

Originating-site hospitals that use credentialing information provided by distant-site hospitals are immune from civil liability that might otherwise be incurred or imposed with respect to the use of that credentialing information.

Stat. Auth.: ORS 441.056
Stats. Implemented: ORS 441.056, 441.223, 442.015

409-045-0130~~0135~~
Information Sharing or Use of Data

(1) Telemedicine healthcare practitioners must provide written, signed permission that explicitly allows the sharing of required documents and necessary evidence by a distant-site hospital with originating-site hospitals, including but not limited to any release required under HIPAA or other applicable laws.

(2) Dissemination of information received under these rules shall only be made to individuals with a demonstrated and legitimate need to know the information.

Stat. Auth.: ORS 441.056
Stats. Implemented: ORS 441.056, 441.223, 442.015

OREGON COMMON CREDENTIALING REQUEST FOR PROPOSAL SUMMARY

Scope of Work Highlights (May 6, 2014)

PURPOSE

On January 17, 2014, the Oregon Health Authority (OHA) released a Request for Information (RFI) to seek vendor input on solutions available to meet Oregon's Common Credentialing Solution (CCS) requirements as set forth in Senate Bill 604 from the 2013 Regular Legislative Session. The OHA used responses to the RFI and stakeholder input to draft a scope of work for a Request for Proposal (RFP) that will result in the procurement of a vendor to carry out common credentialing for all health care practitioners in Oregon. The RFP will be released by July 18, 2014. Below is summary of the RFP scope of work content for review and discussion with the Common Credentialing Advisory Group (CCAG).

SCOPE OF WORK APPROACH

Similar to the RFI, the OHA used key areas of need based on past conversations with the Common Credentialing Advisory Group and other stakeholders to shape the scope of work. These key areas are listed below with high level information on requirements:

- Operational Structure – Focuses on the vendor's operational structure in relation to the scale and needs of the CCS and requirements to operate as a credentialing solution rather than just a repository.
- Functionality, Data Access, and Quality – Identifies vendor solution functionality, data access, and quality requirements in relation to needs identified in the RFP scope.
- Technology and Security – Attempts to identify and understand vendor technological structures, capabilities, and security features that will be used to support the CCS.
- Primary Source Verification – Highlights requirements for the vendor to be able to conduct all primary source verifications (PSVs) as required by national accrediting entities, but work in concert with Health Care Regulatory Boards as possible.
- Fiscal Services – Outlines fee structure principles supported by the OHA and the CCAG and identifies implementation cost and fee structure options that would be feasible and equitable for developing or modifying an off-the-shelf solution for common credentialing and administering the fees necessary to support ongoing operations and maintenance.

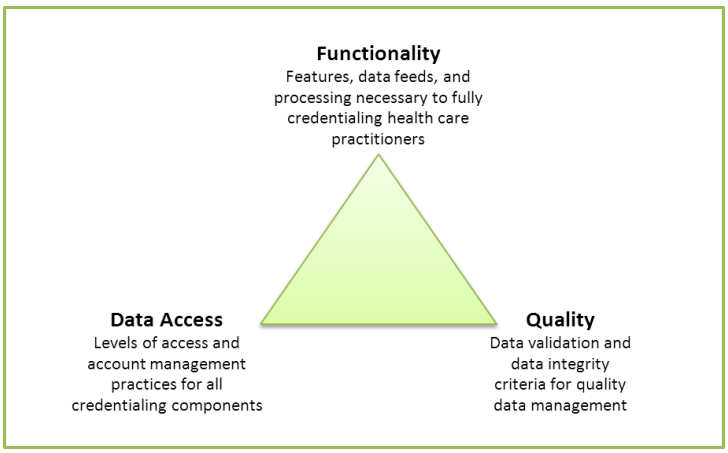
OPERATIONAL STRUCTURE

While development of a new solution is a supported option, the OHA is interested in vendor solutions that can capitalize on existing systems and modify them to meet the needs of Oregon's CCS. Based on RFI responses, almost all of the responding vendors have well-established web-based credentialing solutions that can be hosted by the vendor. This indicates that there are many commercial-off-the-shelf (COTS) solutions that could be used to heighten efficiencies in the implementation process rather than building a costly system from scratch. A COTS solution would include many of the necessary functions for automating the credentialing process and could be modified to meet the specific needs of Oregon's CCS.

Vendors will be required to coordinate with health care regulatory boards (HCRBs) to obtain practitioner information and primary source verifications of that information, but they must also be able to conduct all PSV as necessary to complete credentialing applications. The OHA will be asking vendors to identify their operational capacity and organizational structure that will enable them to meet these requirements with an emphasis on credentialing staff and coordination strategies.

FUNCTIONALITY, DATA ACCESS, AND QUALITY

Through past efforts, focused research, and stakeholder conversations, the OHA has identified many requirements for vendor solution functionality, data access, and quality. These requirements are all interrelated similar to the OHA's triple aim goals of: improving the lifelong health of Oregonians; increasing the quality, reliability, and availability of care for all Oregonians; and lowering or containing the cost of care so it's affordable to everyone.



Required functionality to meet Oregon's CCS needs has been detailed in the RFP Scope of Work with a series of questions related to vendor system functions and how data could be made accessible and managed. Functionality includes web-based access and availability, import and export flexibility, handling of paper documents, data feeds and interfaces, data validation and auditing functions, and notifications. Data access requirements will include levels of access, data validation expectations, concurrent data viewing needs, identification of standard and ad hoc reporting capabilities, and criteria for back-up schedules and business continuity plans.

Data quality and consistency in the CCS will be required to be maintained, to the extent possible, using pre-populated, drop-down menus or pick lists as well as calendar or date-boxes to minimize free text entry by users. Basic data validation will also be required to be supported such as automated system checks for missing or illogical information (e.g., alpha characters in a numeric field). The OHA will clearly identify functionality requirements to ensure clarity of vendor performance expectations. This will include functionality that supports accrediting entity requirements for documentation and timing.

TECHNOLOGY AND SECURITY

Because the OHA is interested in a commercial off-the-shelf solution, detailed technical specifications are not necessary for most of the necessary system components. Most of the vendors that responded to the RFI described solutions that would rely on modular applications accessible through a secured web portal. They further stated that information in the solution would be stored in relational databases and that data field customization would be available to track and report on additional or new types of information. The OHA will be including questions

pertaining to the technical details of the vendors' solutions in an effort to understand programming languages, scalability, system flexibility, and the vendor's overall ability to deliver the functionality required for the operation of the CCS.

While mostly not necessary, there may be a few areas where technical specifications may be encouraged or required. This may be true for special required functions, data security, and data back-up. The OHA has put together a technical review group that will review required functionality for the CCS, study any standard state of Oregon systems requirements, and engage stakeholders with information technology expertise to contribute to necessary technical specifications. CCAG members are encouraged to promptly identify any information technology or credentialing system subject matter experts they would like to recommend to assist the OHA in this area. In addition, the OHA will be required to engage and procure a separate information technology quality assurance contractor to ensure vendor technical capabilities, verify adequate project management, and participate in testing for the CCS.

PRIMARY SOURCE VERIFICATION

Conducting primary source verifications (PSVs) according to accrediting entity requirements is a critical component of the credentialing process. Discussions with the CCAG and other stakeholders have led to the requirement of vendors to be able to conduct all necessary primary source verifications in compliance with accrediting entity standards. However, there will also be a requirement to use HCRBs primary source verifications if available and within the appropriate verification timing requirements as dictated by accrediting entities.

Table #1 below identifies possible coordination with HCRB primary source verifications. These requirements are consistent with legislative intent to use the information already collected and verified by HCRBs. Vendors will be asked to identify their processes for how they verify practitioner information, which should include verification sources, manual processes, and frequency of automated data feeds.

Table #1: Possible Primary Source Verification Coordination with HCRBs

Credentialing Data Element	Comments
Medical/Professional Education	Vendor required to use HCRB verification if available
Foreign Medical Education	Vendor required to use HCRB verification if available
Internship, Residency, Fellowship	Vendor required to use HCRB verification if available
Board Certification/Recertification	Vendor to verify if expires after HCRB verification
State Licensing Information	Vendor to verify differences reported by the practitioner compared to HCRB information of if a license has expired.
Drug Enforcement Administration	Vendor required to use HCRB verification if available
Hospital/Facility Affiliations	Vendor to verify differences reported by the practitioner compared to HCRB information
Practice/Work History	Vendor to verify differences reported by the practitioner compared to HCRB information
Continuing Medical Education	Vendor required to use HCRB verification if available
Professional Liability Insurance	Vendor required to use HCRB verification if available
Sanctions, Discipline, Convictions	Vendor to verify if PSV from HCRB is >6 months
Liability Claims/Lawsuits	Vendor to verify if PSV from HCRB is >6 months

FISCAL SERVICES

While a handful of the vendors decline to respond to the RFP cost inquiry, other vendors responded pertaining to implementation costs and fees for both health care practitioners and credentialing organizations. These responses included not only a large range of costs and fee amounts, but also varied fee structures.

In terms of cost, some vendors claimed they could alter their current systems and absorb the implementation costs with the exception of interfaces needing to be established. Others stated high implementation costs with annual maintenance fees. There were a few middle-ground suggestions that using the vendor's commercial off the shelf product could allow for efficiencies and only initial interfaces and licensing fees would be incurred. Suggested fee structures ranged from enterprise fees based on number of users, annual fees combined with per practitioner fees, and fees based on number of transactions. Due to the range of cost and fee structure suggestions receive in the RFI responses, the OHA must rely on carefully developing the RFP to clearly identify:

- Oregon's common credentialing goal of reducing redundancies and reaping the benefits of producing economies of scale with the mandate of credentialing organization participation
- Expectations that a COTS solution should be used and modified to meet Oregon's CCS needs
- The number and type of credentialing organizations and practitioners expected to utilize the CCS
- Fee structure principles developed through subject matter experts and the CCAG
- Options for feasible fee structures that are in alignment with the fee structure principles
- The need for the vendor to perform all invoicing and fee collection activities for the OHA

Fee structure principles have helped provide guidance in creating feasible fee structure options as they identify the need to ensure that fees are balanced for credentialing organizations and practitioners based on the size of the organization and the type of provider, respectively. For example, fees for credentialing organizations must consider the size and practitioner panel and fees for practitioners must consider practitioner type as physicians generally have more complicated credentialing requirements than practitioners such as massage therapists. **Table #2** below is OHA's attempt to align the fee structure principles in assessing issues associated with fee structure suggestion from the RFI responses. This tool is being used to develop fee structure options that will be identified in the RFP.

Table #2: Fee Structure Issues Assessment

Payee	Type of Fee	Considerations
Credentialing Organizations	Standard fee for participation	• Could disadvantage smaller COs • Disadvantages COs with less complicated practitioner panels
	Fee per practitioner	Provider type complexities would need to be considered
	Combination of annual participation fee and per provider type	Annual participation fee would have to be minimal in order to be equitable considering CO size variances
Practitioners	Small fee	• Practitioners do not currently pay • Fee must be by practitioner type

OHA	Implementation fee	No implementation funding
	Annual licensing/ maintenance fee	Would need to be covered as part of operations and maintenance fees
	Collective per practitioner fee	Would need to be collected as part of operations and maintenance fees
Various	Fees for special changes	This could be fees for COs that ask the vendor to create and additional data field for their purposes.
	Fees for interfaces not covered under implementation	• Fees for COs requiring special interfacing capabilities • Fees for provider directory interfacing

NEXT STEPS

As previously mentioned, this document serves as a summary of content to be detailed in the RFP for release on July 18, 2014. While the CCAG may not view the actual RPF scope of work due to public meeting law and procurement conflicts, the OHA encourages CCAG members to identify any areas of interest or concern to be considered. All past research, RFI responses, and stakeholder discussions will be considered in the RFP development phase to help ensure creation of an efficient common credentialing solution that will reduce costs and administrative burdens for the health care industry in Oregon. All interested parties will be notified once the RFP is released.

Oregon Common Credentialing Outreach Needs Overview

May 2014

Purpose

The Oregon Health Authority (OHA) is in the process of implementing a common credentialing solution as a result of Senate Bill (SB) 604 from the 2013 Regular Legislative Session. While the agency has been working with various stakeholders since October 2013, there is need for outreach to communicate the current progress and expectations more broadly. This is especially important at this time due to draft rules currently in development and a Request for Proposals (RFPs) that is scheduled for release by July 18, 2014.

Overview

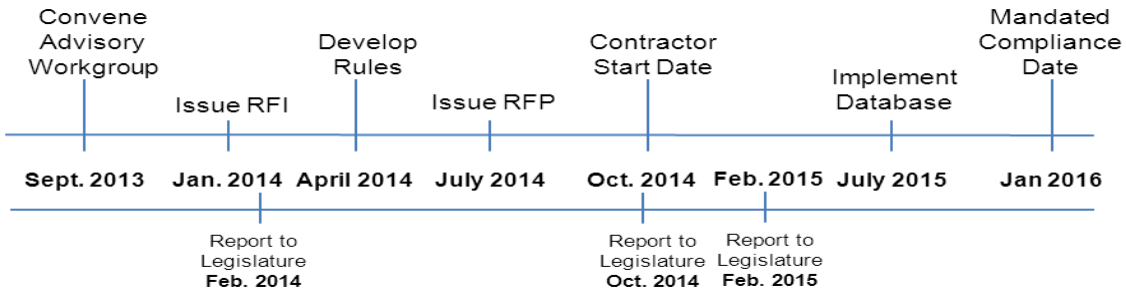
Credentialing organizations currently credential health care practitioners independently, resulting in a duplication of efforts. While Oregon took the first step in minimizing this administratively burdensome process by mandating the use of a common Oregon Practitioner Credentialing Application, this did not limit the number of systems and processes used to capture and verify information reported in the application. The Executive Committee on Administrative Simplification of the Oregon Health Leadership Council also explored a common credentialing solution for Oregon, but was still in need of community support and an adoption plan when SB 604 was signed into law in July 2013. SB 604 requires the OHA to establish a program and database to provide credentialing organizations access to information necessary to credential or re-credential all health care practitioners in the state.

Legislative Requirements and Timeline

Under SB 604, health care practitioners or their designees will submit necessary credentialing information into a common credentialing solution one time and credentialing organizations will be required to use the solution to obtain that information. An efficient common credentialing solution would capture and store credentialing information and documents, perform verifications of select credentialing information, and execute user education. This type of comprehensive solution could significantly reduce redundancy. While compliance for SB 604 is not mandated until January 1, 2016, a considerable amount of work must be done as part of the implementation process. Below is a timeline that identifies the various stages of implementation.

Specific SB 604 (2013) Requirements:

- Establish a credentialing program and database for Oregon health care practitioners and credentialing organizations.
- Convene an advisory group including credentialing organizations, practitioners, and state health care regulatory boards (HCRBs).
- Develop rules on the submittal and verification of practitioner credentialing information, and fees.
- Issue an RFI to seek input from vendors on capabilities and cost.
- Issue an RFP no later than 150 days after the close of the RFI.
- Report to the Legislature periodically on implementation progress.



Work Completed to Date

In September 2013, the OHA convened the Common Credentialing Advisory Group (CCAG) that is responsible for advising the implementation of SB 604. Group membership includes individual practitioners and representatives from urban and rural credentialing organizations, large and small Health Care Regulatory Boards (HCRBs), provider practices, and a large malpractice insurance carrier. Meetings for the CCAG have been conducted monthly since October 2013 and have resulted in the development of a list of health care practitioners who would be expected to participate in a common credentialing solution, the identification of accrediting entity requirements for credentialing, and a Request for Information (RFI) that was released according to plan in January 2014.

Unique to Oregon's common credentialing approach is the inclusion of Health Care Regulatory Boards (HCRB) in the process. HCRBs already collect and verify much of the practitioner information required for credentialing so including them in the solution should create further efficiencies. However, the varying technological capabilities of different HCRBs may also present challenges. To determine the process in which HCRBs would provide practitioner information to the common credentialing solution, OHA staff has been working with HCRBs to obtain information on what practitioner information is collected, how it is verified, differences in timing of licensing versus credentialing, and challenges related to the differences in technological capability for each of the HCRBs. Oregon malpractice insurance carriers have also been engaged in the SB 604 implementation process for similar reasons.

Stakeholder Outreach

Key stakeholders involved in this legislation include all health care practitioners that must be credentialed and all credentialing organizations. Outreach to health care practitioners can be coordinated through professional associations and HCRBs. However, credentialing organizations can be best engaged by identifying robust group forums, such as CCO Medical Director Meetings or forums led by the Oregon Association of Hospitals and Health Systems. Key credentialing organizations include independent physician associations, ambulatory surgical centers, hospitals and health systems, health plan issuers, coordinated care organizations (CCOs), and dental plan issuers.

The OHA encourages interested stakeholder groups to express their interest in receiving more information. This can be done by sending an email to OHPR.Credentialing@dhsoha.state.or.us. Interested stakeholders may also sign up to receive email notifications of updates and meetings by accessing the OHA's Common Credentialing website available at www.oregon.gov/oha/OHPR/Pages/ccag.aspx

Next Steps

In the coming months, the OHA will continue to work with the CCAG on the implementation process. Again, this includes developing rules and drafting a Request for Proposal for release by July 18, 2014. The OHA will also continue to collaborate with other key stakeholders to address specific credentialing needs and challenges, resulting in an efficient common credentialing solution that will reduce costs and administrative burdens for the health care industry in Oregon.

More information on SB 604 and the CCAG can be found at: www.oregon.gov/oha/OHPR/Pages/ccag.aspx.