

---

# Provider Directory Advisory Group Meeting

December 16, 2015



# Welcome!

- Introductions
  - Welcome Healthtech solutions!
- Agenda review
- Updates on standards matrix, HIT procurement, and Common Credentialing
- Fees discussion
- Break
- Fees discussion
- Premanage presentation
- Wrap up and next steps

---

# Standards Matrix Update

Tyler Lamberts  
Business Analyst



---

# HIT Procurement Updates

Rachel Ostroy  
Implementation Director



# HIT Portfolio Upcoming Milestones

- QA Vendor (CSG) onboard
- System integrator (Harris) contract
- Stage Gate 3 submission
- Harris begins planning phase

Fall 2015 (Q4)

- Provider Directory RFP
- CC vendor selection

Winter 2016 (Q1)

Spring 2016 (Q2)

Summer 2016 (Q3)

- Provider Directory (PD) Market Analysis
- Common Credentialing (CC) RFP

- CC Implementation
- PD vendor selection

---

# Common Credentialing Updates

Melissa Isavoran  
Credentialing Project Director



# Current Progress

- Stakeholder discussions continuing on whether to track delegation agreements and the credentialing decision
- Provider data alignment discussions with stakeholders continues with a deeper dive on determining value vs. complexity
- Fee structure development work continues with identifying logistics for tiered set-up fees
- Requirements updates to be completed by end of January
- Reporting to the HITOC
- Advisory group RFA ends December 18, 2015

---

# Provider Directory Fees



# Fee structure development

What do we know about fees and costs now:

- 2014 Request for Information on provider directory costs were inconsistent:
  - Out of the 10 RFI responses received, 6 contained costs but were significantly varied in amounts and time periods for the costs
- 2013 Request for Information responses for Common Credentialing regarding fee structure questions:
  - Not a lot of consistency in responses
  - Total cost ranges varied greatly
  - Some structures conflicted with principles due to inequities (e.g., annual Maintenance fees)
  - Some structures (e.g., enterprise fees) not feasible as they considered number of credentialing organization users, which would actually be small

# Fee development so far (2014) – Fee definitions

- **Membership Fees**

- **Onboarding fee (enrollment)** – an initial fee that is assessed when access to the provider directory is initially granted
  - Supports account set-up and authorization
  - Allows access to the provider directory
- **Ongoing fee** – a fee assessed at a specified timeframe, such as annually that continues access to the provider directory.

- **Service Fees**

- **One-time fee** - a fee assessed for additional or specific services or for a one time use
- Supports authorization to access data for a specified timeframe
- **Contractor services** - negotiated between the contractor and the user (TBD)

# Fee development so far (2014) – Access level definitions

- **Web portal** - Users who need to access information via the web portal and export results
- **Integrated provider directory** - Users who access the provider directory within their own Health IT system, such as an Electronic Health Record (EHR) or a regional Health Information Exchange (HIE)
- **Data extracts** - Users who need large extracts of data

# The work ahead (starting today)

- Understand current state of provider directory fees and costs
- Develop fee principles and incorporate best practices
- Continue fee structure development
  - Discuss and refine fee definitions developed so far
  - Develop additional fee definitions and approaches within the structure
  - Consider what would be included within certain fee categories or fee bundles
- Develop fee structure options and considerations
  - Benefits
  - Challenges
  - Considerations

# Group discussion - Current state of provider directory costs

1. How many staff FTE are spent on maintaining provider directories in your organization?
  - What are the types of staff that are involved in this work (e.g., IT, administrative, etc.)
  - What are the types of activities involved in maintaining a provider directory?
2. Do you use contracted services for data that is used in your directories?
3. What financial penalties can be levied due to incorrect data being relied upon for care?
  - What is the legal risk?
4. What are some of the additional costs that are also realized due to not having an authoritative complete source of provider data?

# Group discussion - Current state of provider directory costs

What costs would change with the use of the statewide PD for the top identified uses?

8: Validation data sets

6: Provider searches for DSM addresses

15/16: Provider Searches

24 - Provider data sets for analytics

---

# Provider Directory Fee Principles Discussion



# Common Credentialing Fee Structure Principles (at a high level)

- Fees should be balanced considering benefits and resources
- Ensure that costs are not a barrier to participation
- Fees should be equitably balanced between provider types and credentialing organization types and sizes
- Fees must be efficient and economical to administer
- Fees should be transparent and justifiable in development
- Fees should be stable and produce predictable income to support the costs of operating common credentialing which should include allocations for information technology and operational quality assurance activities and security
- Individually requested processes must be borne by those making such requests

# Provider directory fee structure principles

Review Common Credentialing and applicable Emergency Department Information Exchange (EDIE) principles

Consider and discuss: Which ones can be leveraged for Provider Directory? Which ones need to be modified? Do any need to be added?

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

Common Credentialing principles:

<http://www.oregon.gov/oha/OHPR/occp/CCAGMeetingDocs/3.3.2014%20Materials.pdf>

---

**Break**

The logo for the Oregon Health Authority is centered within a light blue, curved banner. The word "Oregon" is written in a smaller, orange, serif font above the "Health" portion of the logo. The word "Health" is written in a large, dark blue, serif font. Below "Health", the word "Authority" is written in a smaller, orange, serif font. A thin orange horizontal line is located at the bottom of the slide.

**Oregon**  
**Health**  
**Authority**

---

# Fee structure options



# Common Credentialing Fee Structure Options

FEE OPTIONS	STRUCTURE
<b>Credentialing Organizations</b>	
One-Time Setup Fee	Flat Fee
	Tiered Fee
	Flat Fee, + Amortization
Transactional Fee (ongoing operations and maintenance costs)	Flat Fee
	Tiered Fee; based on Practitioner Type
Expedited Credentialing Fee	Flat Fee
<b>Health Care Practitioners</b>	
Initial Application Fee	Flat Fee
	Tiered Fee; based on Practitioner Type
<b>Delegation Agreements</b>	
Capitated Fee?	Annual Capitated Fee?
<b>Data Users</b>	
Data Use Fee	Undetermined

# Provider directory fee structure components to consider

1. Membership and service fees (“fee types”)

2. How the provider directory is accessed (“access types”)

3. Different sizes and types of organizations and appropriate tier levels within (“participant/size types”) and other options

4. How provider directory services should be classified or bundled (e.g., web portal access for all?)

# Provider Directory fee types

- **Membership Fees**
  - **Onboarding fee (enrollment)** – an initial fee that is assessed when access to the provider directory is initially granted
    - Supports account set-up and authorization
    - Allows access to the provider directory
  - **Ongoing fee** – a fee assessed at a specified timeframe, such as annually that continues access to the provider directory.
- **Service Fees**
  - **One-time fee** - a fee assessed for additional or specific services or for a one time use
  - Supports authorization to access data for a specified timeframe
  - **Contractor services** - negotiated between the contractor and the user (TBD)

Do the fee types make sense?

Are there other options the group wants to explore?

What questions do you have?

# Provider Directory Fee types

Membership – Service fees vs. other?

Option	Benefits	Challenges	Considerations
Fee types			
Other			

# Provider Directory Access Categories

- **Web portal** - Users who need to access information via the web portal and export results
- **Integrated provider directory** - Users who access the provider directory within their own Health IT system, such as an Electronic Health Record (EHR) or a regional Health Information Exchange (HIE)
- **Data extracts** - Users who need large extracts of data

Do the access categories make sense?

Are there other options the group wants to explore?

What questions do you have?

# Provider Directory Access Options

Access types (web portal, HIT integration, extract) vs. flat charge for all access levels

Option	Benefits	Challenges	Considerations
Access types			
Flat			
Other			

# Provider directory – fees by size and/or participant types options

Participant types/size

Annual revenue

Participant type/annual revenue (shortened)

Flat charge per seat

Other

# Fees by Participant types/size

- Provider practice
  - Tiered based on # providers (1-5, 6-10, up to 90+ providers)
- Hospital
  - Tiered based on # beds
- Provider organization
  - Tiered based on # beds (LTC, nursing)
- Government agencies
  - Flat amount
- Payers
  - Tiered based on covered lives
- EHR vendors, IPAs, Regional HIEs, hosted solutions
  - Based on # active users?



# Fees by participant types/size– annual revenue

Organization Level	Annual Organization Revenue	2013 Annual Subscription fee
Entry	\$0 - \$10 Million	\$600
Small	\$10 Million - \$100 Million	\$6,000
Mid-size	\$100 Million - \$500 Million	\$12,000
Large	\$500 Million - \$1 Billion	\$24,000
Leadership	\$1 Billion plus	\$48,000

<http://www.onehealthport.com/sites/default/files/hie/HIE%20Collateral.pdf>

# Sample fee structure by Participant types/size – annual revenue

	Set-up (Onboarding) fee			Ongoing fee			One time fee
	Web portal	HIT Integration	Extracts	Web portal	HIT Integration	Extracts	Extracts
<b>Entry</b>	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x
<b>Small</b>	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x
<b>Mid-size</b>	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x
<b>Large</b>	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x
<b>Leadership</b>	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x

# User types by participant type/size - (shortened)

## Membership Type *(select one)*

All Members may participate in Committees and Workgroups and suggest topics for or present at the Knowledge Network, are included on CAHIE's exclusive member mailing list and receive invitations to CAHIE activities, may use the CAHIE logo on their marketing material, and are included as a CAHIE Member on our web site.

- Large HIE Organization**      HIOs with greater than \$50M in annual revenue  
*\$5,000 annually*
- Small HIE Organization**      HIOs with less than \$50M in annual revenue  
*\$2,500 annually*
- Junior HIE Organization**      HIOs in the first two years of incorporation that do not yet have the  
*No cost*      budget for full membership
- Affiliate Member**      Clinic, hospital, or other participant of a Member HIO (Large or Small  
*\$500 annually*      HIE Organization)
- Non-HIE Association**      Not-for-profit associations of health IT stakeholders interested in  
*\$1,000 annually*      HIE
- Government Organization**      Any federal, state, or local government agency  
*No cost*

[http://www.ca-hie.org/site-content/2014/08/CAHIE-Membership-Application\\_20150402.pdf](http://www.ca-hie.org/site-content/2014/08/CAHIE-Membership-Application_20150402.pdf)

# Sample fee structure by Participant types/size - (shortened)

	Set-up (Onboarding) fee			Ongoing fee			One time fee
	Web portal	HIT Integration	Extracts	Web portal	HIT Integration	Extracts	Extracts
Large HIE	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x
Small HIE	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x
Junior HIE	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x
Affiliate Member	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x
Non-HIE	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x
Government	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x	\$ x

# Provider directory tiered fee options based on participant types/size

Option	Benefits	Challenges	Considerations
Participant types			
Annual revenue			
Participant size/type (shortened)			
Flat charge per seat			
Other			

# Provider Directory additional charges based on certain uses

- Are there certain use cases that require a more advanced or specific data elements that are not part of the basic provider search query?
  - Those that require high level of accuracy and validation?
  - Those that require historical data?
  - A use that hasn't been prioritized and/or identified?
- Would it be equitable to provide reduced costs to users who front the cost for additional interfaces, functionality, and/or access methods?
- Would it be equitable to provide reduced costs to data contributors or charge more to organizations that do not contribute?

# Ongoing fee maintenance and strategies

- Annual review of participation fees
- Development of monthly, quarterly and annual financial statements that report participation rates, revenue and expenses and whether projections are being met.
- If projections are not on target, OHA will develop and submit to the Provider Directory governance body action steps to implement changes to meet targets and projections (e.g., increase marketing, offer additional services).
- The provider directory operating entity must cultivate business relationships with other potential participants, and implement new services to meet future business needs of stakeholders.
- The provider directory operating entity will establish a Funded Depreciation Account for the planned replacement of current equipment assets, and an Improvement and Development Account to dedicate revenue to the future enhancement of the PD (e.g., additional functionality and services)

---

# **EDIE/PreManage**

## **Statewide Hospital Notifications**

Justin Keller

Lead Policy Analyst

Office of Health Information Technology



# Rationale for EDIE

- Statewide hospital notifications were identified as a service that would enable a base infrastructure for health information exchange
- Emergency department visits are a main driver of health care costs
- More providers and plans are entering into risk-sharing arrangements—critical to identify populations with a high risk for ED utilization (such as individuals with severe mental illness)
- Helps to improve coordination during the transition from hospital to primary care setting

# Overview of EDIE

- EDIE provides real-time alerts to hospitals when a registered patient is a high utilizer of ED services
- Centralized source of data for all 59 hospitals in Oregon and Washington
- Alerts are limited to actionable information in order to prevent alert fatigue:
  - Date and location of ED visit
  - Diagnosis
  - Known medications and/or care providers
  - Care guidelines and other supplemental information that can be uploaded by EDIE users like care managers/social workers

# How EDIE Works

- Patient Presents in ED
- Admission Record Auto Interfaced to CMT
- CMT Identifies Patient, Sends Notice Based on Pre-Defined Criteria:
  - 5 or more visits in last 12 months
  - 3 different ED's in last 60 days
  - Other criteria as desired by facility
- Notification by EMR Integration, Fax, Phone, Email or Report
- EMR Integration – EDIE Alert on ED Tracking Board at the Point of Care –or- Single Sign-on Web
- Care Guidelines or Care Plans can be quickly entered and Shared Outside of Authoring Facility

# PreManage

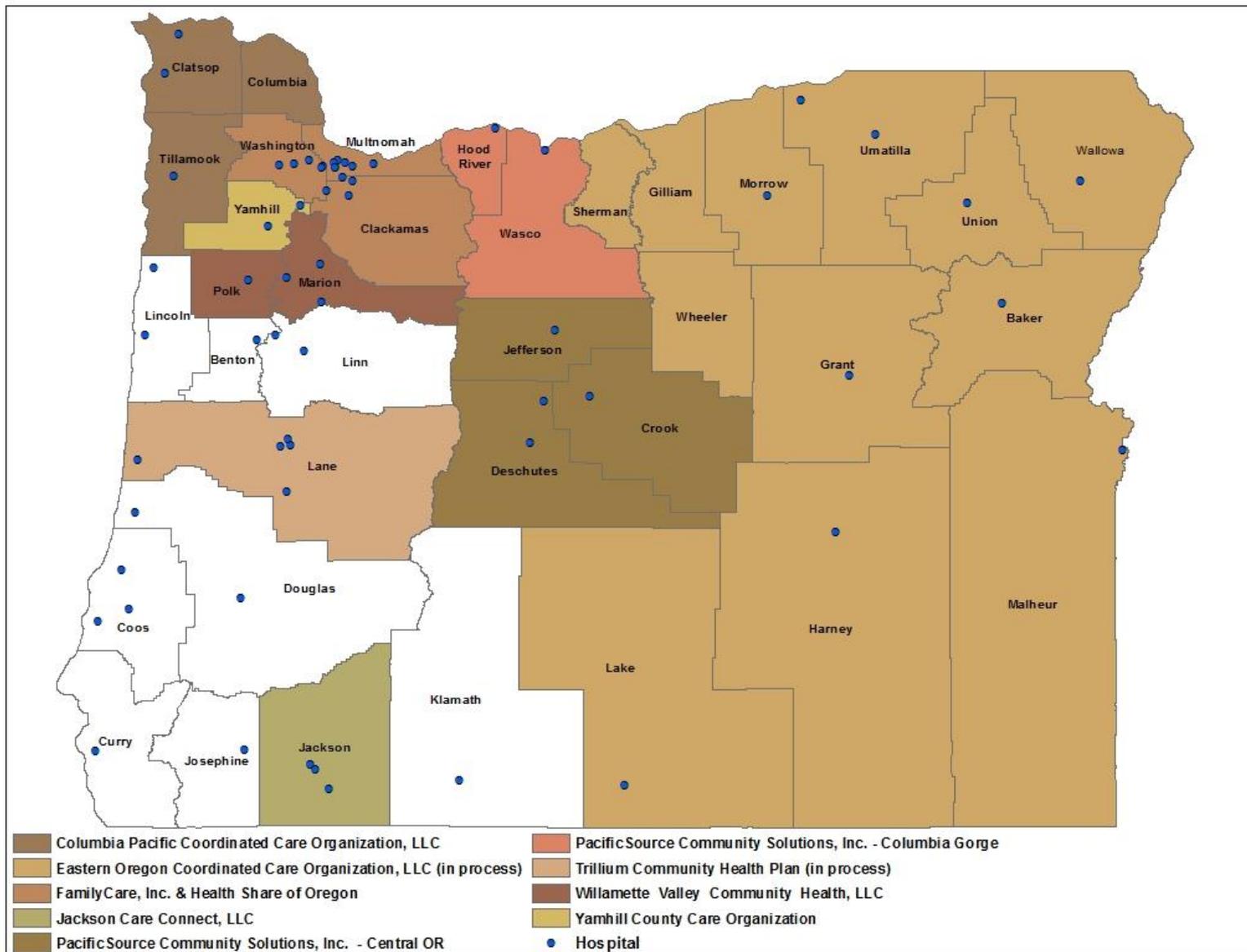
- Complementary product for health plans, CCOs, clinics, care managers, etc. to access EDIE data to better manage their patients
- Subscription-based product—PreManage users define their own member/patient population
- PreManage dashboard allows users to manage cohorts and track populations
- Access to the same ED and inpatient ADT data in EDIE

# PreManage Highlights

- About 75% of CCOs have engaged with CMT on PreManage (7 CCOs live; 2 in process; 2 in discussion)
- Clinics and key practices going online
  - OPCA Webinar for FQHCs
- ACT Pilot – 8 teams live
- OHA Statewide Medicaid Subscription

# Statewide Hospital Notifications in Oregon

## CCOs (PreManage), Hospitals (EDIE)



# Impact of EDIE/PreManage Thus Far

- Very positive response from ED physicians and hospital staff
- Real-time interventions are resulting from these tools and are making a significant impact on the lives of high-risk patients
- Care guidelines are ramping up in hospitals and are being added by PreManage users
- Coordination improving between hospitals and primary care (one provider group's readmission rate was cut in half!)
- Users want EDIE to provide additional information (e.g. Prescription Drug Monitoring Program—PDMP—data)

# EDIE Data: Psychiatric Boarding Use Case

- Concerns about individuals with psychiatric crises “boarded” in EDs
- OHA Budget Note: study the extent of this issue
- Office of Health Analytics working with OSU to review data from 2 sources: EDIE and the Apprise ED Discharge Dataset (Hospital Association)
- EDIE could be a potential useful source of this data
  - EDIE collects time stamps for ED admission and discharge, as well as admitting diagnoses

# EDIE/PreManage Data Limitations

- Purpose of EDIE/PreManage: providing critical utilization and treatment information to ED physicians at the point of care
- CMT (vendor for EDIE/PreManage) collects ADT feeds from throughout the state. ADT messages are inconsistent in how they are filled out by hospitals
- There have been concerns raised about the accuracy and timeliness of provider information contained in EDIE/PreManage
  - Data coming from ADT, member/patient list upload by users, manual entry, etc.
- “Broad but narrow” – just high level demographics and utilization information

---

# Updates and next meeting

Karen Hale

