	Benefits	Challenges	Considerations
Option 1 – Usage	• Same concept for all orgs – how you use the provider directory determines which tier you fall into • Keeps separation of users for portal and for data mart • Cost of managing the fee structure is the simplest • Concept is familiar – similar to other fee structures in place now for general systems	• Need to get a better understanding of how many users would actually use the system - hard to predict revenue, users, and uses • Is it the most appropriate way to gauge use? • User Based Pricing models work well for better established products with clear use benefits or companies with enough upfront investment money. They require more up front funding because it takes time for the "Use Benefit" information to spread and bring sufficient customers thereby sufficient income. If operating costs are low enough this could work. Otherwise estimating $500,000 per year to operate and only getting 100 users would require $5,000 per user and that would be very hard for a small organization to want to afford that • There's an inherent risk that people will try to be frugal and pay for/use fewer licenses; they might use a license number for more than one user • May be difficult to reach sustainability – one user per organization would not be sustainable • Unfair to charge entities with large resources the same price as small mom and pop clinics; users are different • Difficult to determine data mart subscription or transactional use	• May need to audit and calculate use based on # logins/# queries per user • Increase the number of users in each tier or define more buckets • Restructure the packages - It doesn't seem like there's enough separation between the plus, premium and enterprise levels. Maybe premium should be listed as 20-50 users and enterprise is above that • Flat access fee may be appropriate • Base subscription for users and special/large uses could be priced separately • Has to be some limit amount on extracts; otherwise it would be a data mart • Include special pricing for disadvantaged or safety-net providers so they can participate at the lowest level • Favorite option for one group

Option 2 – Type of Org	• Larger organizations will get more value out of the provider directory and this structure will be more equitable to smaller organizations and clinics • Removes deterrent for signing up users • Fee tiers are adaptive to different organization types	• By having all of these layers within the fee structure gets messy. For example, if an integrated system has hospitals, clinics, a CCO, health plan, etc., it will get very complex to track and parse out fees with so many elements • May be harder to administer than option 1 but there are likely established processes • Unfair as scaled to have larger organizations take on the cost • Managing and monitoring the system could be administratively complex and burdensome on larger organizations • Concern over if State organizations are being equitably charged vs other participants • Opens up for errors	• Model can include a usage based category or tier of line items that can be used and grow over time • There's the same need for adjusting the number of users for the levels, see comments in fee structure #1 • Trying to make this be available for everyone is going to be difficult • Need to add a safety net category • Maybe a flat fee per use? • Subscription fee based on user may be more accurate • For CCOs, lives change monthly and also number of lives for some cross state organizations – would those counts be for both or just Oregon? • Overall revenue may not be reflective of actual amount of resources consumed by that organization so from a maintaining the solution fee it may not be equitable. • Fee structure type is not possible and should be taken off the table • Favorite option one group
Option 3: Revenue	• This option is the cleanest and will be the easiest for the State to administer • If we are wanting to be inclusive of all option #3 is best • Simple idea – revenue is the proxy for size and seems fair • Guaranteed income	• Need to flesh out how to administer this for an integrated system that has both a health plan and a health system (e.g. Providence or Samaritan Health) • Is revenue really a good proxy for size across all entity types? • Will still have to administer audit protocols for this model and there is a cyclical nature of profit and revenue • Difficult to determine annual revenue (copy of financials?) • Would be more work for the organization to determine	• IPAs don't have gross sales and have 3000 members – what is the right category for them? • Large revenues would share more of the cost burden in this structure • Some providers bring in more revenue than some other providers as well so maybe it's a plus OR a negative that some providers may feel like they are carrying an unfair portion of the fee even though they are only 1 user • How does usage affect the system? Some users may use large amounts of system resources which is not contemplated here

			• Include special pricing for disadvantaged or safety-net providers so they can participate at the lowest level • Dr. Ozanich mentioned some folks only use for DSM addresses. Is the value a combination of revenue and the use? Should use be considered in this as well? • For revenue to work maybe it would work better in concert with special discounts/adjustments that are talked about like contributor discount and federally designated safety net provider discount. • Favorite option for one group

Early adopter comments:

- General comments:
  - Early adopters bring value to the provider directory
  - It will be important to define when the discount begins and ends.
- Parameter considerations
  - Early adopters would "sign up" within the first 6 months, but won't have to complete integration (because it might not be possible if a lot of people sign up) during that time period.
  - Look at example of EDIE and offering subsidy. Maybe if you sign up within the first 6 months you get a discount based on an annual fee. For example, if someone signs up in the middle of the year, they still get the total discount offered based on the annual fee.
  - The discount fee should be substantial enough to get people signed up right away. 30% for the first year sounds reasonable because it will motivate people to sign up early.
  - Any time you're an alpha or beta tester you get a reasonable discount, such as 30% for the first year.
  - The first year is the only time early adoption time. No discount rates should be offered after that.

Fee Discount comments:

- Data is often shared across multiple healthcare entities. When considering discounts, who should get the discount? As far as who should contribute, we should be selective so that the plan with the highest amount of quality data should be sourced. More data sources=more complexity.
- It would be very difficult to define/determine what "good data" is… what's the criteria?
- It would be very challenging to operationalize this…. How do you even define this criteria?
- Why should this be offered? Who benefits from this?
- Are we wanting to encourage contributors?
- How many would we accept?

- If we only want a few golden sources and that ends up to be just a handful, then these are “one-offs” and may not constitute a predefined discount.
- We may only be able to get “accepting new patients data” from multiple sources (plans).
- Maybe a discount is not enough to pay for the cost of gathering and contributing the data.
- Do we want to push for early contributors?
- Early adopter discount should be the only discount offered

Thoughts around whether fees for initial participation which will include onboarding should be higher or lower compared to ongoing fees.

- The business model will need to include how the costs will be spread among all users and be sustainable. We wouldn’t want to see people not participate because of a larger startup costs
- Having two costs could be an impediment to getting people/organizations onboard. It should be a subscription fee without a separate startup fee. Eliminating the initial set up fee again leads back to the fee principle of “Administration of the financing mechanism will be well-defined and as simple as possible”.

Other comments:

- Challenge across the structures: Until there’s a sense of the cost it’s difficult to define the thresholds that people will be willing to pay for. A rough order of magnitude is needed.
- Instituting a new process for getting provider data from the state-level provider directory vs. current processes will need to be assessed by those who work with provider data now
- Functionality and ease of viewing the data is favored over “fancy” graphics in the provider directory solution