

**Provider Directory Advisory Group (PDAG)
Meeting Summary – February 17, 2016**

Advisory group members in attendance	Advisory group members not in attendance
Gina Bianco Peter Graven (filling in for Stephanie Renfro) Liz Hubert, Co-chair Martin Martinez Jessica Perak (phone) Bob Power, Co-chair	MaryKaye Brady Monica Clark Mary Dallas, MD Kelly Keith Laura McKeane Maggie Mellon Hongcheng Zhao
	OHA staff and consultants Wendy Demers Karen Hale Melissa Isavoran Tyler Lamberts Jason Miranda Rachel Ostroy Elizabeth Linville, HealthTech Solutions (by phone) Kim Norby, HealthTech Solutions (by phone)

Welcome, introductions, and agenda review (slide 1-2)

Karen Hale, Lead Policy Analyst for the Provider Directory (PD) project welcomed everyone to the meeting. She then reviewed the agenda for the meeting.

Presentation: Iowa Lessons Learned (slides 3-10):

Kim Norby, Senior Consultant for HealthTech Solutions was introduced by Karen. Karen explained that he is the former Health IT Coordinator for Iowa and that he has an extensive background in Health IT and Health Information Exchange (HIE). Kim worked on the funding and fee structure that supported the Iowa Health Information Network (IHIN). He began his presentation by discussing how a non-reverting fund was established in Iowa through legislation. This somewhat uncommon type of fund included an Improvement and Development Account as well as a Funded Depreciation Account.

Next Kim highlighted how fees were established in Iowa, including an overview of the fee principles used, the fact that legislation was established to collect fees, the importance of keeping the fee structure simple, benefits of bundling service pricing, and the need for evaluating all of the fee collection method options. He also explained that the Iowa HIE started with a membership model for years one through five, with plans to switch to a usage based model starting in year six. The starting payer mix was the basis of one-third provider, one-third payer, and one-third government. The six year cost (roughly \$28 million) was determined and a financial modeling tool (similar to a pro-forma budget) was developed. Kim also talked about how a unique tiered basis was established for each health care organization type (e.g. hospital net patient revenue, long term care beds, primary care full time equipment of PA) and that the ‘best guess’ adoption was verified with health care organizations. He also shared the projected adoption rates table and the fee structure tables used by the group.

Lastly Kim shared lessons learned from what he experienced in Iowa. He suggested the use of automated payment tools such as ACH and credit cards, the constant work and re-work of the adoption portion of the model, and the use of incentives for specific groups where adoption rates are poor.

The PDAG asked questions about adoption rates in Iowa and the sustainability of the current rates compared with the six year plan that was projected. Kim explained that in some areas adoption has been higher than expected, due to the prevalence of EHR adoption by hospitals related to Meaningful Use. PDAG members were also interested in the pricing differences for users, and Kim explained that smaller hospitals (with a \$5,000 fee starting in 2014) had the most difficult time because they felt they wouldn't necessarily benefit from the services and that they didn't have the money in their budget. However, he also shared that the fee structure was developed by working closely with the hospital association, which proved to be a beneficial route for gaining 'buy in' about the fees.

Fees Discussion (slides 11-27)

Karen shared highlights from the fee discussion at the January PDAG meeting. In general, there was agreement for a simple (as possible) fee structure. The group noted that fee complexity can drive increased costs, could be a barrier to adoption, and that simpler fee structures support transparency. She also noted that there was no consensus concerning discounts for data contributors or early adopters. The favored structures were those based on a package of services received (e.g. bundles and tiers) and those that included paying for what is used versus those based on the size of an organization. Karen also reminded the group that how fees are assessed to different organizations that are comprised of the same users (e.g. CCO and health plans) needs to be determined. Possible ancillary revenue streams and managing user requests requiring additional functionality for the provider directory also needs to be explored further. She then reviewed the fee structure development activities (completed and outstanding) as well as the ongoing fee maintenance and strategies.

Karen then reviewed the current draft of the proposed fee structure principles for the Provider Directory. The group discussed the updated principles, and Rachel Ostroy, Implementation Director, shared a list of assumptions for the Provider Directory software enhancement process with the group. The discussion of the assumptions included a tiered governance strategy as well as the review and prioritization of system enhancements.

Next Karen talked with the group about fee structure components to consider, including membership and special fees ("fee types"), included services, and how services should be classified or tiered. She talked with the group about membership supported by subscriptions (inclusive of an onboarding fee for enrollment and ongoing fees), special fees, and discounts. The Provider Directory services were also discussed, including a web portal, data extracts, a data mart, and an integrated provider directory. Then the group reviewed and discussed samples of fee structures, including a fee structure based on the number of users and services, a fee structure based on organization type and size, and a fee structure based on annual revenue.

The group also began their analysis of fee structure #1 (slide 22)

Benefits	Challenges	Considerations
<ul style="list-style-type: none"> • 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 DataMart • Cost of managing the fee structure is the simplest 	<ul style="list-style-type: none"> • Need to get a better understanding of how many users would actually use the system • Is it the most appropriate way to gauge access? 	<ul style="list-style-type: none"> • Increase the number of users in each tier or define more buckets

Updates (slides 28-33):

HIT Procurement

Rachel Ostroy, Implementation Director, explained to the group that the second contract amendment with Harris is still under review by Centers for Medicare and Medicaid Services (CMS). This amendment will include the market analysis, request for proposal (RFP) and vendor recommendation deliverables for the Provider Directory and Clinical Quality Metrics Registry (CQMR). She also shared that Leslie Clement, Director of the OHA Health Policy and Analytics Division, has a meeting with CMS next week to discuss this contract as well as others from OHA that are currently with CMS for review. She then reviewed the Common Credentialing project schedule that Harris is engaged in currently, highlighting that the RFP will be posted by the end of March and that vendors will have two weeks to submit their proposals to Harris. Rachel noted that a similar timeline and process can be expected for the Provider Directory project. Lastly she shared the vendor product selection process.

Common Credentialing

Melissa Isavoran, Common Credentialing Project Director, shared the current progress with the project. She noted that the Common Credentialing team is currently working with Harris on workflow mapping. Melissa also explained to the group that the vendor is expected to on board in July 2016 with the solution being operational by mid-2017. She then discussed the continued work on the fee structure development and the identification of logistics for tiered set-up fees and annual subscriptions fees. These plans will be solidified by the Common Credentialing Advisory Group (CCAG) at their upcoming April meeting.

She then spoke about upcoming work for the project, including outreach and marketing planning as well as rule revisions via a rulemaking advisory committee made up of subject matter experts (SMEs).

Wrap Up and Next Steps (slide 34)

Karen closed the meeting by sharing that the team has been working on a FAQ document about the Provider Directory project which she would like the PDAG to review. She also reminded members that the next meeting will take place on March 16th in Portland.