

HIEPI Finance Workgroup Meeting (Summit #1)

Meeting Owners	Shanthi Venkatesan Micky Tripathi
Minutes Author	Sean Kelly
Version	1

Date	30-Jun-10
Time	1-4pm EST
Location	Brown Building Rm 232

Pre-work:

Individuals were asked to review the various models from the UT, MD, and NM ONC-approved strategic and operational plans.

Goal of this Summit:

Begin to define the various financing dimensions and the pros and cons of each and bundle them into reasonable options with an associated feasibility ranking for review in our next summit.

AGENDA

Topic	Led By
1. Introduction	Shanthi/Micky
2. Review of Planning Process	Micky
3. Discussion of ONC Approved Financial Plans	Micky
4. Discussion of Funding Alternatives models and Considerations	Micky
5. Next Steps	Micky

ATTENDEES

Name	In Attendance (Y or N)		Name	In Attendance (Y or N)
Shanthi Venkatesan (WG Lead)	Y		Evalie Crosby	Y
Micky Tripathi (Facilitator)	Y		Leslie Randazzo	N
Sean Kelly (Analyst)	Y		Kathy Bizarro	Y
Jeff Watson	Y		Dick LaFleur	N
Tyler Brannen	N		David Briden	Y
Barbara Richardson	Y		Catherine Golas	Y
Alisa Druzba	Y		Mark Belanger	Y

GUESTS

Name	In Attendance (Y or N)
Becky Wadel (Intern with Kathy Bizarro)	Y

* Via telephone

MEETING HANDOUTS

1. HIEPI Financial Model
2. HIEPI Strategic & Operational Planning Presentation
3. Finance Workgroup Agenda for Summit 1 30-Jun-10

MEETING SUMMARY

Introduction & Roll-call

Reviewed Agenda (HIEPI Finance WG Agenda)

Review of Planning process slide deck provided by MAeHC team

- In our assessment of the tasks at hand we began with a review of previously submitted budget provided by Shanthy. While it is preliminary and was submitted prior to the convening of the planning domain workgroups, it contained budgetary placeholders for positions for data analyst, project manager and IT coordinator. However, during the Planning phase of the project, adequate funding is not available to support the Data Analyst position.

Costs to be addressed

- We began to identify some of the costs we should address moving forward including planning & governance costs beyond the ONC deliverables, costs of establishing any governance body with a 501(c)3 designation, Staffing, ongoing Legal service fees, the engagement of Technical Consultants or IT experts, and whether additional costs such as Outreach & Engagement, HIE Education, and Training for use of services/resources such as any provider portals needed to be addressed based on the feedback from the other workgroups. We also identified that there was a total cost of ownership for adoption by users, not just the state where HIT Adoption could mean a provider has to acquire an EHR to use the HIE, or acquire various upgrades.
- To counteract this, we proposed the idea of membership fees and offering reduced membership or transaction fees for early adoption and to spur growth in the user base.
- Additionally we began to identify the parameters of operating expenses, both onetime and ongoing costs, including data management personnel, hosting and the associated services.
- We also identified other costs such as HIE service upgrade and evolutionary costs, such as adding services that are considered in our use case universe but may require legislative modification, such as quality reporting or public health, and the costs for HIE services such as software license fees.

Revenue Alternatives

- Our analysis identified several Revenue Alternatives including Membership Fee models, Subscription fee models, Transaction/volume based pricing models, as well as the possibility to use a hybrid for certain services.
- We identified several candidates for HIE development funding and some for ongoing operations and sustainability.
- This included a discussion of the possibility and amount of state funding, the possibility to develop, expand or maintain certain services via alternative grants, such as the CMS or NHIN.
- We also discussed several options in the private investment/subsidy model as well as connecting payers, hospitals, labs, and practices and charging for services that collectively they could afford, but individually were either too costly to implement or presently were inefficient from a financial perspective (such as costly transactions).
- In order to begin to focus on viable alternatives we also suggested we look at what HIE connected users, when identified, would be willing to pay for and what services do they need, but cannot implement alone.
- This was suggested as a market opportunity for the state to fill a void and draw a sustainable revenue stream by providing access to services, data points or connecting a larger and disparate community.
- While the Business and Operations workgroup will continue to clarify the relevant use cases, the finance workgroup will review this list to identify the costs of the required infrastructure for a NH HIE in terms of acquiring hardware and software, maintain a solution that remains viable, operating or supporting the deployment and continuing to be able to enhance the HIE.

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- This group will also begin to assess the costs associated with these HIE building blocks for connecting edge systems such as EHRs, HISs, Labs, etc as costly implementation with edge systems will only diminish the likelihood that these edge systems will quickly provide revenue through any membership/subscription fees.
 - During our next workgroup we plan to also identify any budgetary constraints and gaps based on the ongoing development of the other workgroups, while in our third summit we will begin to focus on controls and financial oversight required for our financial model.

ONC Approved Funding Models

- As a requisite to the first summit, the 3 ONC-approved Strategic and Operations plans were distributed. Our analysis of these highlighted that subscription fees and the inclusion of financially supportive stakeholders was a central tenet and one we would strive to consider implementing.
- Specifically, we identified New Mexico's (NM) plan which was subscription fee-based, but also had the financial backing for using the HIE with the 5 largest insurance plans in the state, as well as the state Medicaid program. We targeted a similar list for NH to consider reaching out to for future engagement and support.
- We discussed Maryland's (MD) subscription fee model, and how it included payers and hospitals providing financial sustainability through a "Properly developed subscription fee models that incentivize higher utilization of HIE services can provide stability in revenue planning."
- We discussed how Utah (UT) also used subscription fees, as well as had connections and support with state Medicaid, and payers. UT also was the first to identify EHR connectivity grants, the inclusion of a specific population subset, the Indian Health services. UT also listed the decreased membership fees to spur early adoption.
- Our review of these plans suggested that while some payer transactions may not be viable under current NH law, we could seek to model the savings for insurance provider support if the HIE adoption was widespread through savings based on the elimination of redundant tests, as a chief example. Our strategy was to get feedback from payers for insight for prioritized list of services that would encourage financial support.
- We discussed the larger payer plans including Anthem and Harvard Pilgrim. Jeff wants to approach Anthem, and Micky will approach Harvard Pilgrim. We also will approach the Medicaid team, but this may not be possible to engage them prior to completion of this planning stage. We also were seeking support from the VA system, as well as monitoring grants for NHIN, and SSA HIE programs.
- Alternatively, we began to consider funding via outreach to the largest employers in the state, to encourage them to incent their insurance providers to support the HIE for cost savings to the companies in terms of premiums. This list would include UNH, Timberland, LGC, Purchasing group. Jeff was going to begin making inquiries.
- We discussed the possibility of a Bond Issuance with HIE revenue to repay the bond, but this does not address how the revenue would be generated, only how to gain additional start-up capital.
- We also again proposed the concept of contributed time for professionals volunteering on these domain workgroups to count towards the state's matching obligation.
- We began to review the roadmap for payers connectivity and authorization, and specifically how some registries & reporting concepts could be accomplished via secure routing, while some transactions would require push or query models and have implications for what the HIE may have to fund and maintain.
- The maturity of some regional initiatives that are currently deployed was discussed, highlighting that some services such as sending records across a community were already accomplished with existing their networks.

Alternative Funding

- The assessment of alternative funding included a review of existing networks that are at various stages of maturity.

- Some examples included how the NEHIN charges a fee ranging from \$25K-\$100K for small to large hospitals for HIE services.
- The Indiana HIE was a transaction-based system that used a tiered cost for volume discounts.
- We proposed certain policy levers that could be pushed to encourage adoption and charge an associated fee, or receive funding from existing budgets. An example of this was how New York uses its SHIN-NY statewide HIE as the access point for NYS Medicaid data.
- We also began to discuss the possibility of premium revenue taxes, such as an insurance premium revenue tax as subsidy, such as increasing the current 2% premium revenue tax to fund the HIE on an ongoing basis. This highlighted that it would still enable payers to determine how much they would pass along to the consumer if the premium tax concept were employed.

Ongoing vs. Fixed Costs

- We began to frame our need to consider ongoing versus fixed costs, the benefits and limitations of subscription versus transaction models, the likelihood of public or private funding, as well as the likelihood of payer versus provider membership subsidies. We will start to include these in our cost model analysis.

Public Funding

- Under the Public (Payor) alternatives we discussed a Premium tax, but the immediate concern is the constitutionality of such as fee.
- We also discussed a Claims assessment (transaction fee) as VT targets primary care physicians. The concern was that this could lead to a selection bias by users.
- Alternatively, we discussed how a covered life assessment on premiums (such as patient enrollment at \$0.50 tax/year, for every Medicaid enrollee or insurance patient) could be used.
- We also discussed a profit tax on insurers where any profit over a specific amount, such as 4.5% would trigger a tax. The concern was the constitutionality of targeting insurance providers only.
- We were going to collect some calculations/ *parameters from Shanthi, on claims or the number of Medicaid enrollees*

Public Funding (General)

- Under the Public (General) alternative we discussed the possibility of engaging Medicaid and its HIT funds, the bond funding, as well as revenue from licensing providers and entities to perform healthcare-related business in NH.
- For example, we discussed the long list of licensing from the state including physicians, hospitals and their per bed fees, pharmacy boards, LT Care facilities and their per bed fees, ASC, Home Health agencies, Hospice and labs. This model would consider charging fees to these entities to support the HIE. Shanthi will provide some licensing data for review in our next few meetings.

Private Funding

- On the private funding alternative we began to ask whether or not state and local governments would be interested in claims and be willing to pay a fee, as well as whether Medicaid eligibility involvement could be a source of revenue.
- We continued to look at membership fee alternatives as they are used by the NEHIN and UHIN.
- The idea of payor seeding such as with New Mexico was briefly discussed, but not conclusive.
- We considered that the HIE could generate some additional revenues with Advanced Analytics around claims and eligibility.
- We identified that any membership fee needed to be flexible or proportional so we could not have an exorbitant entry fee and expect participation by smaller users.
- We discussed how to charge physicians, specifically by patient panel's size or using a transaction/service fee.

- An example is the HIXNY in upstate NY where physician pays a fee to join if its patient joins the exchange. This model also has the component of a subsidy by the patient's insurance provider to lower the barrier to entry.
- In Cincinnati and Indianapolis, hospitals are paying for the entire HIE.
- Irrespective of whether an entity is a payer or a provider, they will be part of this overall Private-funded model.
- We identified that we should look at some of the ONC value-propositions for a model to show the marketplace, as well as what neighboring states are doing such as VT, Maine, NM, UT, MD.
- Related to this, the annual HIT eHealth initiative survey was just published and will be made available.

Shared Services

- Additional revenue could be provided by offering shared Services. This could include connections to Labs, such as Labcorp or Quest, or HIE necessary services such as a Statewide provider/patient directory, or costly connections to data sources such as Surescripts or state Medicaid.
- Regarding the Fixed versus ongoing costs, we will revisit this once we get the Technical infrastructure feedback. We recognize that this may include different funding sources for particular services.
- Some states also charge different fees based on HIE participation, such as lower fees if you provide data versus a higher cost if you don't share data (view only).

Financial Model

- We will begin to look at building a revenue model and customize based on the other domain's changes to the form of the HIE.
- We will begin by getting information from Tyler to provide some revenue data. We can then conduct a Hospital CIO reach-out via the survey orchestrated with UNH for some data on labs radiology to further our cost and revenue estimates. We will coordinate through Dave for any additional data.
- Tyler Brennan has access to a claims database that captures claims data from throughout the state. There are some patient privacy measures so we can see the same patient go for care between multiple carriers, but cannot identify patient by name or demographics.
- We can also use this to identify the number of labs performed in NH and who did those labs for modification to our model if the HIE were entered into the equation.

Cross-dependencies:

- Tech Infrastructure: include vendor perspectives
- Tech Infrastructure: Claims database (# transactions and claimed dollars, eligibility files)

ACTION ITEMS (FROM PREVIOUS MEETINGS AND NEW)

Item #	Raised By	Action Item Description / Comment	Assigned To	Due Date	Status/ Remarks
1	Barbara, Shanthy	Meet with Tyler Brennan to begin to catalog some data points for HIE financial model from claims database. Start to draft a financial model for reaction.	Sean Kelly, Micky Tripathi	Meet by 7/9	Assignment
2	Shanthy	Number of Medicaid enrollees	Shanthy	Next two summits	Assignment
3	Shanthy	Provide some licensing data for review (who is licensed, fee basis, fee)	Shanthy	Next two summits	Assignment

ISSUES IDENTIFIED

Issue #	Raised By	Issue Description	Assigned To	Due Date	Status/Remarks
1	Micky, Jeff, Shanthi	Which Private sector parties should we engage (e.g. Anthem)? How do we engage Medicaid?	Jeff, Micky	To begin addressing on 7/9	
2	Barbara, Shanthi	Constitutionality of certain tax alternatives	Policy committee	Next two summits	

DECISIONS MADE

Decision #	Sponsor	Decision Description	Approved (Y or N)	Comments
1				