

Stakeholder Process

Second Meeting - Summary Report

(Approved by stakeholders on July 24, 2008)

Tuesday, June 24, 2008, Dirigo Health Agency and Maine Quality Forum,
211 Water Street, Augusta, Maine

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About the Meeting

Attendance

Stakeholders

Doug Carr, Rite Aid, Perkins Thompson
Dan Coffey, HealthInfoNet Board
Rick Erb, Maine Health Care Association
Katie Fullam Harris, Anthem Blue Cross
Ana Hicks, MaineCare Advisory Committee
Nancy Kelleher, AARP
Kala Ladenheim, Maine Center for Public Health
Kevin Lewis, Maine Primary Care Association
Jim McGregor, Maine Merchants Association
Cathy McGuire, Muskie School of Public Service
Sergio Santiviago, PhRMA
Kristine Ossenfort, Maine Chamber of Commerce
Rod Prior, Mainecare
Gordon Smith, Maine Medical Association
David Winslow, Maine Hospital Association

Observers

Deb Hart, Hannaford
Rep. Lisa Miller, HHS Committee
Will Kilbreth, Dirigo Health Agency
Alexandra Serra, Preti Flaherty
Shaun Alfreds, University of Massachusetts Medical School

Staff

Josh Cutler
Devore Culver
Jim Harnar
Craig Freshley

Planned Agenda

9:00 **Opening**
 Welcome
 Josh Cutler and Devore Culver, co-conveners
 House Keeping
 Reminder about our decision process and ground rules
 Meeting Notes of May 30, 2008

Meeting Calendar
Website Reminder
Today's Agenda
Introductions

- 9:15 **Valuation Models and Other State Experiences**
1. We will begin with an overview of the results of the June 20 conference call regarding valuation and return on investment models. What are the pros and cons of various methods? Are there one or two methods that seem to make the most sense for Maine?
2. We will also hear about other state approaches to Health Information Exchanges and which approaches potentially make the most sense for Maine.
- 10:00 **Potential Revenue Streams (and Information Needs)**
1. Even though there may be unanswered questions about value, we will begin to brainstorm potential ways in which to pay for a Maine Health Information Exchange AND pay for a Technology Investment Account. We will begin by getting all the ideas out on the table and then try to organize into specific categories.
2. As we have our discussion, we will also identify specific needs for more information required to help us make decisions. Before completing the discussion, we will make a plan for how to gather need information – perhaps establish study groups.
- 11:25 **Deciding our Process**
Based on the draft provided at the May meeting, we will discuss and hopefully agree on our decision making process and operational details regarding our meetings and communications.
- 11:40 **Next Meeting Agenda**
- 11:45 **Closing Comments**
Stakeholder and observers will have a chance to make brief closing comments.
- 12:00 **Adjourn**

Ground Rules

- All stakeholder perspectives considered
- Observers welcome – participation at appropriate times

- Phone listeners welcome
- Recognized before speaking
- Minimize distractions
- Neutral facilitation and summary report

Valuation Models and Other State Experiences

Valuation Models Conference Call

The group heard an overview of the results of the June 20 conference call regarding valuation and return on investment models. Six people participated in the conference call but few, if any, had read the advance materials.

The following reflect comments made by those who participated in the call:

- Several good resources at the website
- Objective
 - Use an existing model as a point of departure
- Next week or two
 - Settle on a few preferred models
 - Runs some numbers through the preferred models
- End goal: We want to come to consensus on a basis for attributing value to this project
- The papers that we were asked to review were macro-level analysis, not specific business models
 - They estimated savings in a general way
- Challenge: Who are our customers?
 - Answer: The Legislature
- Helpful to realize we are not trying to develop a set of “sellable” products
- It was valuable to focus in on the most relevant research
 - Focused on Oregon study
- Realized that many other similar projects are still in their infancy
- Concluded that we are not going to be able to show a benefits realization in the near term
 - This is because we need to build an infrastructure before we can leverage value
- Need to make sure we don’t over-promise and under-deliver in terms of benefits

Other State Experiences Presentation Highlights

The group heard about other state approaches to Health Information Exchanges (HIE) and which approaches potentially make the most sense for Maine. Shaun Alfreds of the University of Massachusetts Medical School made a presentation using PowerPoint. **See Appendix A for the slides presented.**

The following comments were made by Mr. Alfreds in conjunction with this slide presentation and/or by stakeholders during the presentation.

HIE Stages of Development

- **Survey**
 - 130 Organizations responded to the survey
 - Responses clarified that the definition of HIE is very broad
- **HealthInfoNet's Stage of Development**
 - HealthInfoNet is at Stage 4 (see Appendix A for detail)

HIE Organization and Governance

- **Stakeholder Importance**
 - Stakeholders need to be bought in
- **Challenges**
 - How to involve consumers?
- **Four Basic Models**
 - Nonprofits
 - Public utility models
 - Physician/payer collaborations
 - For-profit HIE's

Examples of Services

- **Varieties**
 - There is a wide variety of services being offered
- **Products to Offer**
 - HealthInfoNet plans to offer three products initially (those with 'x' marks on the chart)

- Services with ‘?’ marks are represent additional services that are expected to contribute to return on investment
 - Suggestions (from group)
 - All cells for HealthInfoNet should have ‘?’ marks
- **Clarifications**
 - Indiana gets revenue from clinical messaging (among other services) – could be expanded to include two-way communications and clinical decision support

Sustainability

- **Determinant of Sustainability**
 - Primary determinant of sustainability is the service mix, not the architecture
- **Fees for Service**
 - Mature HIE’s are providing services that stakeholders are willing to pay for:
 - Transaction fees
 - Membership/subscription fees
 - Charging for administrative data exchange
 - Value-added service fees
- **Public Support**
 - Claims tax (.02% in Vermont)
 - State authority charges
- **Clarifications**
 - 8% of doctors today are using interoperable EMR’s

Discussion

- **Projected Cost**
 - The projected cost of HealthInfoNet is \$6 million
 - \$4 million for operations from fee for service
- **Prioritization of Service**
 - Sharing clinical data at time and point of care
 - Medication history
 - Public health surveillance/reporting

- **Clarifications**
 - HealthInfoNet doesn't plan to get into claims management

Potential Revenue Streams

Brainstorming Discussion

The group brainstormed potential ways in which to pay for a Maine Health Information Exchange AND pay for a Technology Investment Account. The group got all ideas up on the wall and then Craig organized them into categories as follows:

System

1. Fee for Service

- a. Value-added service fees
- b. Charging for administrative data exchange
- c. Membership/subscription fees
- d. Transaction fees
- e. Clinical messaging
- f. Training and technical assistance

2. Public Support

- a. New Taxes
 - i. Tax on prescriptions
 - ii. Charges to payers
 - iii. Claims tax
 - iv. Tax on medical services
- b. State Funding
 - i. General Fund (state budget)
 - ii. Revenue bonds
 - iii. Appropriation with private sector match
 - iv. Hit funds established by legislation
- c. Medicaid
 - i. Medicaid leverage
 1. Build off claims management system
 2. Transformation grants
 3. MMIS match

- d. Reallocation
 - i. Federal money for OMS needs
 - ii. All payer claims data-base
 - iii. State money reallocated from other contracts
 - iv. OSA monitoring program
- e. Other
 - i. Donations and grants
 - ii. State authority charges for services

3. Incentives

- a. CON (Certification of Need) certification incentive

Provider Access

1. Tax credits for providers

Conclusions

What Would Be Worth Paying For?

Craig reflected earlier comments about the value of something like HealthInfoNet and the experience of other states that in order to succeed, stakeholders need to perceive and experience value.

He challenged stakeholders to identify what they might be willing to pay for if they believe that it has value.

The following reflects comments made:

- Payers
 - Lab test results
 - Real time information for emergency room visits
 - Reduction of duplication of testing – reduces work
 - Need to explore why physicians are ordering duplicative tests
 - Care coordination
 - Medication management
- Consumers
 - Personal health record

- Care coordination
- Clinical Providers
 - Ability to access information outside existing structure
 - Awareness of info that you wouldn't otherwise even know exists
 - Real time information for emergency room visits
 - Reduction of duplication of testing – reduces work
 - Care coordination
 - Medication management
- Pharmaceutical Providers
 - Medication management
 - Management of unused medications
 - Potential improvements to access
 - Emergency response – access to medicines
 - Capture public data

Ability to Pay is Questionable

In spite of the identifications of many valuable aspects of HealthInfoNet, actual ability to pay for it is another matter.

It was noted that “Ability to Pay” is questionable for

- Community Health Centers
- Nursing home providers
- Payers
 - We're already paying for a lot of this
 - Proprietary
 - Competitive environment
- Consumers

Areas of Consideration

In conclusion, it was generally agreed that there are five types of potential revenue streams worthy of consideration, as follows:

- State funding
 - General Revenue
 - Bonding
- Medicaid
 - Leverage and other changes
- Reallocation
- New taxes
- Fee for service

Stakeholder Process Guidelines

The group discussed the proposed stakeholder process guidelines and agreed to some revisions. In particular, the group agreed that a draft report should be presented and discussed at the fifth meeting and that it should be written by an independent third party such as Craig Freshley, the facilitator.

See Appendix B for the Stakeholder Process Guidelines as revised and agreed to by the group.

Next Steps

It was confirmed that the group will meet next on Thursday, July 24 from 9:00am to 12:00am at the Maine Hospital Association in Augusta. Perhaps we will break up into five study groups at the meeting to explore the five “areas of consideration.”

How States are Supporting/Funding HIT and HIE

- Executive orders and legislative action establishing workgroups to convene stakeholders/develop Roadmaps (often are associated with funding)
 - AL, CA, CO, IA, MA, ME, MO, ND, NJ, UT
- Establish HIT funds for development and support
 - AK, ID, LA, MO, VT
- Authorize entities to collect or receive funds
 - Vermont H 229 (2007) "VITL ... may accept any and all donations, gifts, and grants of money, equipment, supplies, materials, and services from the federal or any local government, or any agency thereof, and from any person, firm, or corporation..."

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How States are Supporting/Funding HIT and HIE (Cont.)

- Grants: States often target groups otherwise not able to afford HIT such as CHCs, small practices and rural providers
 - Minnesota HE 1078 (2007) gives preference to projects benefiting providers located in rural and underserved areas of Minnesota which have an unmet need for the development and funding of electronic health records. Grant funds awarded on a three-to-one match basis with maximum grant of \$300,000.
- Tax Incentives: Credits and Deductions
 - Wisconsin enacted a tax credit for providers who purchase electronic medical records. Providers can claim up to 50% of the cost of the system with a maximum of \$10 million a year.
- Purchasing Power: Driving HIT and HIE adoption and support through existing programs
 - Targeted reimbursement (e.g. Medicaid reimbursement for home and community services delivered via telemedicine (CO, ME))
 - Requirement for HIT standards purchased with state funds (CT, IA, VA, IN, MN, UT)

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Sources of State Support/Funding

- States are looking at various means to fund HIT – States primarily look at HIT as a means to generate savings
- Medicaid and federal transfers dominate
 - 37 States have eHealth activities in Medicaid (many of which focus on sharing claims based data)
 - DRA Transformation Grants have been a primary driver
 - MITA offers potential opportunities for enhanced match funding
 - Quality improvement / programmatic match funds available
- State employee health plans have recently increased activity
 - MN SEHP requires eRx by 2015; grants and incentives available
 - CalPERS partnership with CALRHIO; \$25/ED visit charge for participating plans
- Other funding sources include: dues, bonds, loan guarantees, insurer assessments, and user fees

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What Does this Mean for HealthInfoNet?

- Currently there is no competitive pressure from other HIEs in the state
- HealthInfoNet has significant provider participation in the pilot
- Additional support from other stakeholders will be necessary for pilot completion and moving toward a state-wide HIE
 - The State has shown interest but must be cautious in any IT / IIT investments due to recent Medicaid MMIS challenges
 - HealthInfoNet and the State may wish to consider "public utility" funding, but should recognize the accountability requirements associated
- A sustainable business plan will require careful formulation of the specific service set that stakeholders (public and private) see value in and will pay for

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Thank You!

For Further Information:

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UMass Medical School Center for Health Policy and Research
<http://www.umassmed.edu/healthpolicy/HIT/Policy/Development.aspx>

Also See:
National Governors Association State Alliance for eHealth at:
www.nga.org/center/ehealth/

National Conference of State Legislatures: Searchable database of state health IT bills is at:
http://www.ncsl.org/programs/health/forum/Hitch/HIT_database.cfm

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Appendix B – Process Guidelines

HealthInfoNet

Stakeholder Process Guidelines

Approved: June 24, 2008

A. Decision Making

1. Stakeholders will try to reach consensus on all issues
 - a. All perspectives will be heard and considered
 - b. The group will attempt to accommodate all concerns
 - c. Consensus will be formally affirmed when no one objects to a written proposal (although some stakeholders may “stand aside”)
2. When consensus cannot be reached, stakeholders will decide by majority vote of those present
 - a. The facilitator will determine if/when consensus cannot be reached
 - b. There must be a written proposal under consideration
 - c. When possible, a vote will be announced in advance

B. Information Gathering

1. Stakeholders are invited to share information and research findings with the group as a whole
 - a. All research findings will be properly cited
 - b. It is helpful if information and research findings are provided electronically to the facilitator
2. At times, committees may be established to gather information and develop options
 - a. Committees will have specific charges
 - b. Committees may include people other than stakeholders

C. Information Sharing (including meeting minutes)

1. Minutes
 - a. Minutes will include attendance and a summary of key points of discussion and decision. They will not include all comments
 - b. Draft minutes of each meeting will be circulated by e-mail among those who attended for editing and approval
 - c. Once approved by e-mail, minutes will be:
 - i. Circulated by e-mail to all stakeholders and observers
 - ii. Posted at the HealthInfoNet Stakeholder Process Website
2. Minutes will include presentations
3. Agendas
 - a. Agendas will be
 - i. Circulated in advance by e-mail to all stakeholders and observers

- ii. Posted in advance at the HealthInfoNet Stakeholder Process Website
 - b. Agendas will include major points of business and also details about the meeting location including how to get there
- 4. Other Information
 - a. Information and research findings that any stakeholder wants shared with the group will be
 - i. Circulated by e-mail to all stakeholders and observers
 - ii. Posted at the HealthInfoNet Stakeholder Process Website

D. Membership

- 1. Stakeholders
 - a. Stakeholders have been initially invited by the co-conveners, Josh Cutler and Devore Culver, in accordance with the enabling resolve.
 - b. Additional stakeholders will be invited by the co-conveners upon recommendation of existing stakeholders.
 - c. Stakeholders are committed to participating fully throughout the process and honoring these guidelines.
- 2. Proxies

Proxies are welcome with the understanding that they are:

 - a. Properly informed about past activities of the group
 - b. Empowered to make decisions on behalf of the organization they represent
- 3. Observers
 - a. Anyone may request to be an observer by providing their contact information to the facilitator.
 - b. All such requests will be honored.

E. Meetings

- 1. Schedule and locations
 - a. The schedule and locations of meetings will be determined by the group upon recommendation of the co-conveners.
 - b. The schedule and locations will be circulated and posted as far in advance as possible
- 2. Agenda setting
 - a. Agendas for meeting will be established by the facilitator and co-conveners based on
 - i. Decisions and discussion of the previous meeting
 - ii. Need to achieve outcomes in a timely manner
 - iii. Specific requests for agenda items
 - b. Stakeholders are welcome to suggest agenda items by submitting them in writing to the facilitator at least two weeks in advance of any meeting.
- 3. Facilitation and ground rules

- a. Meetings will be facilitated by a third-party, independent facilitator selected by the co-conveners
 - b. The following ground rules will be used for meetings
 - i. All stakeholder perspectives considered
 - ii. Observers welcome – participation at appropriate times
 - iii. Phone listeners welcome
 - iv. Recognized before speaking
 - v. Minimize distractions
 - vi. Neutral facilitation and summary report
4. Participation
- a. All meetings are public and anyone is welcome to attend
 - b. Discussion is limited to stakeholders except at specific times when observers are invited to contribute
 - i. There will be time near the end of every meeting to hear comments from observers
 - ii. There may be times during meetings when the facilitator or a stakeholder may ask and observer for comment
 - c. Phone participation
 - i. Phone participation in meetings is accommodated but in-person participation is encouraged
 - ii. Phone participants are expected to listen and should not be expected to participate in the same way as in-person participants
 - iii. If you want to participate by phone, please notify the facilitator at least three days in advance of the meeting.
5. Preparation
- a. Meeting participants are expected to be prepared for meetings by having read advance materials
 - b. Presentations will be provided in handout form at meetings when possible

F. Final Report

- 1. Draft to be provided prior to the fifth meeting
 - a. Report to be drafted by the facilitator (if possible)
(Perhaps with the help of Shaun Alfreds, Muskie and/or other resources)
- 2. If consensus is not reached on the final report and it is approved by majority vote, minority comments will be included