

# Stakeholder Process

## Third Meeting - Summary Report

(Approved by stakeholders on September 26, 2008)

Thursday, July 24, 2008, Maine Hospital Association, Augusta, Maine

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# About the Meeting

## **Attendance**

### Stakeholders

Doug Carr, Rite Aid, Perkins Thompson  
Dan Coffey, HealthInfoNet Board  
Bernardo Feliciano, Good Group Decisions  
Vallie Geiger, Maine Primary Care Association  
Peter Gore, Maine State Chamber of Commerce  
Ana Hicks, MaineCare Advisory Committee  
Kala Ladenheim, Maine Center for Public Health  
Tony Marple, MaineCare  
Jim McGregor, Maine Merchants Association  
Sandra Parker, Maine Hospital Association  
Rod Prior, Mainecare  
Gordon Smith, Maine Medical Association

### Interested Parties

Deb Hart, Hannaford  
Don Mingle, M.D., MaineMSO  
Alexandra Serra, PhRMA  
Sharon Young, MEA Benefits Trust

### Staff

Josh Cutler  
Devore Culver  
Craig Freshley, Good Group Decisions

## **Planned Agenda**

9:00           **Opening**  
                  Welcome  
                          Josh Cutler and Devore Culver, co-conveners  
                  Announcements/Reminders  
                          Today's Agenda  
                          Our decision process and ground rules  
                          Website  
                          Future meeting dates  
                          Meeting Notes of June 24, 2008  
                  Introductions

- 9:15           **Technology Investment Fund**  
                  How other funds work  
                  We will hear about similar funds in other states and also explore lessons learned from similar Maine funds.  
                  Draft Guiding Principles  
                  We will discuss ideas regarding the governance, administration and eligibility of the fund. Perhaps some guiding principles will begin to emerge.
- 10:15           **Break**
- 10:35           **Potential Revenue Streams**  
                  Even without quantification of the benefits (a benefit analysis is due September, 2008), there is general agreement that a HealthInfoNet-type system would benefit the public good. Based on this premise alone, we continue our dialogue about there might be public support for the effort.
- For each of the following five topics we will discuss benefits, barriers, and strategies to move forward.
- 1. State funding: general revenue and/or bonding**  
                  **2. Medicaid: leverage and other changes**  
                  **3. Reallocation from existing sources**  
                  **4. New taxes**  
                  **5. Fee for service**
- Perhaps we will work in small groups, depending on our size and composition.
- 11:40           **Next Meeting Agenda**
- 11:50           **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

## Technology Investment Fund

The group heard a presentation on how other technology investment funds work in other states. Devore Culver prepared and distributed a handout. See **Appendix A – Technology Fund State Approaches**.

The group was also presented with a handout prepared by Jim Harnar titled: Questions & Considerations to Help Shape Development of the Technology Investment. See **Appendix B - Technology Questions and Considerations**.

Following these presentations, the group discussed ideas regarding the governance, administration and eligibility of the fund in hopes of drafting Guiding Principles.

### **Other State Approaches**

- **Introduction**
  - The five states referenced are not the only five states doing this work.
- **Louisiana**
  - They have a surplus
  - Used some Katrina relief money (\$10 million)
  - Has a pay for performance system
  - Terrific success with Medicaid compliance
- **Massachusetts**
  - Not yet signed into law
  - 3 years into an ambitious project to make three states full automated
    - Serve as research laboratory
  - Created the E-Health Institute – public/private partnership
    - \$25 million per year from general fund
    - Focused on primary care and high value user served populations
    - Focused on EMR adoption
    - Advisory structure – strictly public
- **Minnesota**
  - Legislature mandate that every citizen must be on an electronic medical record by 2014

- 2% service fee on providers – currently existing – reallocated to help fund EMR grants and loans
- We should consider: “Every citizen will have an EMR.”
  - Puts focus on the individual rather than the provider
- **Tennessee**
  - Governor has been driving this at the national level
  - Has best developed local exchanges in the country
  - Executive order created an office
    - Now devolving into a public/private partnership
  - \$13.6 million investment pool created by legislature
  - Use funds for seed grants
  - Initial focus on rural physicians – asked them to invest in infrastructure and commit to all of the following for a duration of two years in order to receive \$3,500 up front:
    - Do e-prescribing
    - Keep up the Medicaid record
    - Maintain Medicaid immunization record
  - Now some program is being broadened
  - Allowed providers to participate in state telecommunications infrastructure
  - State measured volume of use
- **Vermont**
  - New service fee
    - 1.99% of 1% on all claims extended to self-insured market
    - State Medicaid pays \$500,000 per year
  - \$32 million over 7 years
    - \$10 million > Exchange
    - \$22 million > EMR

## ***Discussion and Comments***

- Establish two funds?
  - One for technology assistance and one for infrastructure?
  - Undecided
- A strategic plan (vision of the future) would help us determine how much effort to put toward HIE (Health Information Exchange) vs. EMR (Electronic Medical Record)
  - There is a wide variety of types of EMR’s and levels of sophistication
- Elements to be considered in prioritization
  - Need

- Readiness (infrastructure)
- Readiness for system change
  - Note – VY and MA require a readiness assessment
  - Certification by CCHIT not adequate
    - This is a federal certification program
- Strategic planning guidance
  - State health plan
  - HealthInfoNet strategic plan
- Provider ROI: 20% - this suggests that most of the funding should go out in grants rather than loans
- Could use the grant and loan funds to incentivize standardization
- To be successful, we must do careful, ongoing evaluation
- Would be helpful for us to define “provider”
- Ideas for initial assistance recipients
  - Primary care practices
    - Could be affiliated with large groups or hospitals
  - Build on the demonstration project
    - 2-year project
    - Connecting hospitals and ambulatory care providers
      - 52% of Maine annual hospital discharges
      - 41% of Maine annual ambulatory visits
    - Seeking to demonstrate
      - We can connect specific records to specific people
      - We can impact the workflow of the provider
      - Meaningful initial impact on key areas
        - Improving our management of medication
        - Emergency room utilization of resources
  - Focus on E-Prescribing
    - Mail order e-prescribing is a super red flag issue among pharmacists
- The primary barriers to using EMR’s is not financial
  - Technical assistance?
  - Lack of standardization?

## ***Technology Fund Conclusions***

### **Questions to Address**

1. Where housed?
2. Priorities?
3. Definition of an EMR
4. Defining “Providers”

### **Technology Fund Work Group Established**

The Technology Fund Work Group, made up of the following individuals, was established by the stakeholder coalition. The group will be convened by Dev Culver.

- Dev Culver
- Kala Ladenheim
- Josh Cutler
- Dan Mingle
- Valli Geiger
- Gordon Smith
- Sandy Parke
- Rod Prior
- Jim McGregor
- Christine Ossenfort (?)
- Sergio Santiago (?)

Dev will send to the Group info about the demonstration project

## **Potential Revenue Streams**

### ***Discussion***

- General
  - To help this be successful
    - Align funding sources with benefits
    - Relate this project to primary care
      - Link to Primary Care Study Group
    - Relate this to the Patient Centered Medical Home
  - Consider how to get Medicare Funding

- State Funding – Appropriation from general fund or bond
  - Benefit – could leverage Medicaid funding
  - Barrier – may result in cuts in other places
  - Strategies
    - Put in a bill for several \$100k
    - Bond for infrastructure investment
    - Bond for the hardware
  
- Medicaid
  - Benefit – could result in large federal contribution
  - Barrier – difficult to measure the impact, especially in one or two fiscal years
  - Potential Strategies
    - Currently a 50% match for administrative services – could be a 90% match
    - Need to show return within the biennium
  
- Reallocation
  - Benefit – could be sustainable over the long run
  - Potential Strategies
    - Look to R.O.I. results to establish reallocations
    - Cost recapture from Emergency Room fee
    - Reallocate from MHDO
      - Need to learn more about this
  
- New taxes
  - Barriers
    - Savings don't go back to private practices
    - Puts the burden on rate payers
    - Free-rider issue
      - People benefiting who have not paid
    - Makes healthcare more expensive
    - Results in health care rationing
    - There will be temperamental opposition to any kind of new tax
    - Perceived similarities to MHDO
  - Strategies
    - Types of taxes identified, including at previous meeting
      - Tax on prescriptions
      - Charges to payers
      - Health insurance claims tax
      - Tax on medical services
    - Recommend all or recommend none
    - General agreement: recommend none
      - Political infeasibility would jeopardize other revenue ideas

- Fee for service
  - Benefits
    - Could be sustainable over long term
    - Access to data
  - Barriers
    - Won't happen right away
    - Lack of sustainable funding
    - Legal and liability issues
    - Measuring impact will be a challenge
  - Questions
    - Need to wait for the R.O.I. results
  - Strategies
    - Offer technical assistance for fee

## ***Revenue Conclusions***

- We assume that electronic medical records serve the public good
- Benefits
  - Will help us address the most complex cases within the system
  - Fewer hospital visits
  - Reduced duplication
  - Fewer medical errors
- Electronic medical records should be focused around the person
  - Rather than around a provider or payer
- First year of funding should include the development of a strategic plan
- Use already existing vehicles to guide our focus
  - State Health Plan
  - Others
- We are considering not recommending any new taxes or increasing any existing taxes

# Appendix A – Technology Fund - State Approaches

Summary Sample of State Approaches to “Public Good” Funding for Electronic Medical Record (EMR) and Health Information Exchange HIE Adoption and Use  
07/23/08

State	Nature of Investment Plan	Core Principles Behind Investment Plan	Eligibility Criteria	Terms and Duration	Application and Fund Management	Post-Implementation Evaluation Criteria
LA	<p><b>Medicaid Incentive Payments</b> Part of \$100 million development funding provided to LA by federal government after Katrina</p> <p>\$10 million of fund devoted to Health Information Technology investment through Medicaid</p> <p>\$7 million directed to EMR/HIE adoption</p> <p>\$3 million to HIE development</p>	HIE adoption is something that needs to be encouraged by the state	<ul style="list-style-type: none"> <li>-Focused on primary care providers serving Medicaid patients agreeing to participate in automated immunization documentation and maintenance</li> <li>-HIE eligibility defined in competitive RFP that is now being finalized (no specific details yet available)</li> </ul>	<ul style="list-style-type: none"> <li>-\$0.25 per Medicaid recipient under 21 utilizing VFC and LDNS (state automated immunization management system) + 75% of recipients aged 24 months up to date with vaccine series</li> <li>-\$0.50 per Medicaid recipient under 21 utilizing VFC and LDNS (state automated immunization management system) 75%-89% of recipients aged 24 months up to date with vaccine series</li> <li>-\$1.00 per Medicaid recipient under 21 utilizing VFC and LDNS (state automated immunization management system) 90% or more of recipients aged 24 months up to date with vaccine series</li> <li>-Payment calculations done monthly and paid quarterly</li> <li>-Provider must manage the enrollment and maintenance of recipients in to the Vaccines for Children (VFC) program</li> <li>-Provider must enroll in and use the LDNS immunization management system</li> <li>-Provider must be enrolled in</li> </ul>	<ul style="list-style-type: none"> <li>-Provider is enrolled as a Medicaid PCP</li> <li>-LA Medicaid manages funds</li> </ul>	<ul style="list-style-type: none"> <li>-Evaluation is ongoing and current to any given month</li> <li>-Evaluation is based on actual usage compared against registered Medicaid members</li> </ul>

State	Nature of Investment Plan	Core Principles Behind Investment Plan	Eligibility Criteria	Terms and Duration	Application and Fund Management	Post-Implementation Evaluation Criteria
MA	<p><b>E-Health Institute Fund (final adoption of bill Pending):</b> General Fund dollars</p> <p>Defined as grants not to exceed \$25 million in any one year.</p>	<p>Transform care delivery and the utilization of care process redesign supported by a statewide, interoperable electronic health records system in order to improve patient safety and quality and to lower costs in the state's health care system</p> <ul style="list-style-type: none"> <li>-Identify regions where compelling opportunities to make strategic investments appear to be present.</li> <li>-Provide development support more generally to organizations to assist in quality improvement activities and the formation and growth of emerging health technology sectors in regions.</li> </ul>	<p>Primary focus of grant program is on "ambulatory care providers with a particular focus on providers" such as community health centers that care for a significant number of persons in underserved populations."</p> <ol style="list-style-type: none"> <li>1. Organizations seeking grants under this program must agree to use the grant to:</li> <li>2. Redesign care processes</li> <li>3. Utilize case management techniques</li> <li>4. Develop and implement an electronic health record system</li> </ol> <p>In selecting grant recipients, the institute shall consider: Existing technology and organizational infrastructure upon which the health information network will be built</p> <p>The extent of stakeholder participation</p> <p>Health care provider participation commitments</p> <p>Capacity to measure quality and efficiency improvements</p> <p>The extent of the opportunity for a plan to improve health care quality and the health outcomes of patients in the region to be served</p>	<p>1.A Medicaid as a Community Care PCP</p> <ul style="list-style-type: none"> <li>-The fund, as proposed, does not have a stated end date either for funding from the general fund or for how long an individual grant awarded will be funded.</li> <li>-Organizations approved for grant funding must begin implementation of their plan no later than the beginning of the second year of receiving the grant</li> </ul>	<ul style="list-style-type: none"> <li>-Fund is organized under a public-private corporation (the e-health institute).</li> <li>-In conjunction with a standing advisory committee to the institute (chaired by the MA secretary of health and human services and includes the secretary of administration and finance, and the director of the health care cost and quality council) the institute develops and submits an annual grant fund plan for projects and objectives that are projected to cost no more than \$25 million per year.</li> <li>-The institute entertains applications from individual organizations seeking grant monies to support EMR and health information exchange (HIE) planning, installation and operating dollars (the application form is not yet defined)</li> </ul>	<p>Based on the grant plan as proposed by individual applicants, annual reporting by the defined objectives for quality and efficiency improvement will be submitted to the institute by the organization(s) receiving grant funds.</p>

State	Nature of Investment Plan	Core Principles Behind Investment Plan	Eligibility Criteria	Terms and Duration	Application and Fund Management	Post-Implementation Evaluation Criteria
MN	<p><b>No Interest Loan Program:</b> Minnesota Health Care Access Fund based on <b>health care provider tax</b>. Tax is applied to all providers (hospitals and physicians) at a rate of 2% of all invoiced services. The main purpose of this Fund is to support MN's Medicaid program.</p> <p>No interest loan program funded at \$3.15 million available for FY 2007-2008 and \$3.15 million available for FY 2008-FY2009</p>	<p>2007 MN Legislature mandated:</p> <ul style="list-style-type: none"> <li>All health care providers and hospitals have an interoperable electronic health record (EHR) system by 2015. All newly acquired electronic health record (EHR) products must be certified by the Certification Commission for Healthcare Information Technology (CCHIT) or its successor. Applies to settings covered by CCHIT certification.</li> <li>A requirement to develop a statewide implementation plan to meet the 2015 interoperable EHR mandate</li> <li>A requirement that all health care providers and payers establish and use an e-prescribing system by January 1, 2011.</li> </ul>	<p>Participation in health information exchange efforts</p> <ul style="list-style-type: none"> <li>Community Clinics as defined in MN Statutes</li> <li>Hospitals eligible for rural hospital capital improvement grants (50 or fewer beds)</li> <li>Physician clinics located in communities with populations less than 50,000</li> <li>Nursing facilities</li> <li>Other providers of health or health care services approved by the Commissioner of Health</li> </ul>	<ul style="list-style-type: none"> <li>First come first serve</li> <li>0% interest rate</li> <li>Six year loan duration</li> <li>Repayment quarterly starting no later than two years from date of loan agreement</li> <li>Maximum loan amount \$1,500,000</li> <li>Pre-Application approval required to submit full application</li> <li>Non-Refundable application fee of \$750</li> <li>No other loan closing costs</li> <li>EHR loan application must address the interoperable exchange of health care information between the applicant and, at a minimum, a hospital system, pharmacy, and a health care clinic or other physician group</li> <li>EHR selected must be certified by the Certification Commission for Healthcare Information Technology (CCHIT)</li> </ul>	<ul style="list-style-type: none"> <li>MN Office of Rural Health and Primary Care Manages the Fund</li> <li>Formal written application form published and available</li> </ul>	<p>Mid-Year report and final report has questions that seek information from loan recipients on what care goals have been accomplished and what changes/improvements have been achieved as a result of implementing the EHR.</p>
MN	<p><b>Grant Program:</b> Minnesota Health Care Access Fund based on <b>health care provider tax</b>. Tax is applied to all providers (hospitals and physicians) at a rate of 2% of</p>	<p>2007 MN Legislature mandated:</p> <ul style="list-style-type: none"> <li>All health care providers and hospitals have an interoperable electronic health record (EHR) system by</li> </ul>	<p>A <b>Community e-Health Collaboratives Eligible organizations.</b> Two or more health care organizations that are</p>	<ul style="list-style-type: none"> <li>Readiness Assessment and \$50,000</li> <li>Implementation: up to \$750,000</li> <li>A one-to-three match is</li> </ul>	<ul style="list-style-type: none"> <li>MN Office of Rural Health and Primary Care Manages the Fund</li> <li>Formal written application form published and</li> </ul>	<p>Mid-Year report and final report has questions that seek information from loan recipients on what care goals have been accomplished and what</p>

State	Nature of Investment Plan	Core Principles Behind Investment Plan	Eligibility Criteria	Terms and Duration	Application and Fund Management	Post-Implementation Evaluation Criteria
	<p>all invoiced services. The main purpose of this Fund is to support MN's Medicaid program.</p> <p>Grant Program: funded at \$3.5 million available for FY 2007-2008 and \$3.5 million available for FY 2008-2009</p>	<p>2015 All newly acquired electronic health record (EHR) products must be certified by the Certification Commission for Healthcare Information Technology (CCHIT) or its successor. Applies to settings covered by CCHIT certification</p> <ul style="list-style-type: none"> <li>A requirement to develop a statewide implementation plan to meet the 2015 interoperable EHR mandate</li> <li>A requirement that all health care providers and payers establish and use an e-prescribing system by January 1, 2011.</li> </ul> <p>The goals of the grant program are to:</p> <ol style="list-style-type: none"> <li>Support expanded adoption and effective use of interoperable electronic health record (EHR) systems and electronic health information exchange, in rural and underserved areas to: <ul style="list-style-type: none"> <li>improve health care outcomes and the provider-patient relationship</li> <li>increase health service delivery efficiencies in rural and underserved areas</li> </ul> </li> <li>Encourage collaboration to leverage resources and</li> </ol>	<p>distinct corporate or governmental entities representing at least two of the following types of health care settings:</p> <ul style="list-style-type: none"> <li>Community clinics as defined in Minnesota Statutes, section 143.0268</li> <li>Hospitals eligible for Rural Hospital Capital Improvement Grants as defined in Minnesota Statutes, section 144.148</li> <li>Physician clinics located in communities with populations of less than 50,000 according to U.S. Census Bureau statistics and outside the seven-county metropolitan area</li> <li>Nursing facilities licensed in Minnesota Statutes, sections 144A.01 to 144A.27</li> <li>Community health boards or boards of health as established in Minnesota Statutes, chapter 145A</li> <li>Nonprofit entities with a purpose to provide health information exchange coordination governed by a representative, multi-stakeholder board of directors</li> <li>Other providers of health or health care services approved by the Commissioner of Health</li> </ul>	<p>required. Applicants must provide one dollar in the form of cash or in-kind services for every three dollars provided by the grant program.</p> <ul style="list-style-type: none"> <li>Meet the minimum requirements of eligible applicants and activities</li> </ul>	<p>available</p>	<p>changes/improvements have been achieved as a result of implementing the EHR.</p>

State	Nature of Investment Plan	Core Principles Behind Investment Plan	Eligibility Criteria	Terms and Duration	Application and Fund Management	Post-Implementation Evaluation Criteria
		<ul style="list-style-type: none"> <li>expand/standardize health information technology</li> <li>3. Support improvements in prevention services and population health.</li> </ul>	<ul style="list-style-type: none"> <li>for which interoperable electronic health records would improve quality of care, patient safety, or community health.</li> <li>B. Community clinics</li> <li>C. Regional or community-based health information organizations including health information exchanges.</li> </ul>			
TN	<p><b>e-Health: Physician Grants and HIE Seed Grants</b></p> <p>Organization created by executive order of the TN governor to staff an e-health advisory board and manage the promotion of e-health and information exchange in TN</p> <p>Governor funded e-Health office with \$10 million from executive budget in FY 2007 with carry over to FY 2008 and FY 2009. Office has issued \$8 million of seed grants to two health information exchanges (one time) to support start up investment. Another two HIE seed grant applications are under consideration.</p> <p>TN Legislature appropriated \$13.6 million to connect rural health providers to statewide e-health "exchange zone" in FY 2007 with carry over to FY 2008 and FY 2009</p>	<ul style="list-style-type: none"> <li>Connect rural providers to broad based Internet services and a statewide electronic health information network</li> <li>Promote the adoption and use of HIE tools in rural, primary care practices</li> <li>Reward providers for active use of key electronic services supporting TN Medicaid members</li> </ul>	<ul style="list-style-type: none"> <li>Initial physician grant offering limited to rural primary care MDs/Dos delivering family practice, internal medicine, pediatric and OB/GYN services</li> <li>Physician grant eligibility now expanded to include mid-level providers who have prescribing authority</li> <li>Physician grant now extended to all rural physician practices regardless of specialty and for urban physicians serving large Medicaid populations</li> <li>HIE seed grants require completion of formal proposal that establishes multi-stakeholder collaborative initiative and clear plan for execution (scope of service) and impact. Specific milestones are defined for measurement and evaluation</li> </ul>	<ul style="list-style-type: none"> <li>Physician grant offers \$5,500 one time per provider (now includes physicians and mid-level providers with prescribing authority)</li> <li>Physician grant money can be used for purchasing and installing e-prescribing solution, and/or EMR, and/or hardware and office network</li> <li>Physician grant participants offered to Internet broadband access through TN state communication network, for \$10 per provider per month (must pay for their connectivity to the network)</li> <li>However, TN pays for the first year of connectivity costs and may extend further</li> <li>Practices participating in grant must commit to minimum of two years e-prescribing for Medicaid patients, validating current state of Medicaid clinical content on statewide</li> </ul>	<ul style="list-style-type: none"> <li>Physician grants requests managed through standard application available on line</li> <li>Physician grant program monies held and managed by e-Health office</li> <li>Application for physician grants managed by sub-contractor groups working under contract to e-Health office</li> <li>HIE seed grants requested through written proposal from HIE. Scope, dollars and duration are awarded specific to what is defined in proposal</li> <li>HIE seed grant dollars are held and managed by e-Health office</li> </ul>	<ul style="list-style-type: none"> <li>SureScripts electronic prescribing volume reporting used to validate usage of e-prescribing by participating practices</li> <li>SharedHealth (Medicaid HIE) validates immunization update and EHR content update by participating practices</li> <li>HIE seed grant progress is measured against defined milestones</li> </ul>

State	Nature of Investment Plan	Core Principles Behind Investment Plan	Eligibility Criteria	Terms and Duration	Application and Fund Management	Post-Implementation Evaluation Criteria
VT	<p><b>Grant Program for EMR Adoption and Health Information Exchange development/operations</b></p> <p>Based on new Service Fee of 1.99% of 1% of all medical claims filed in VT.</p> <p>VT Medicaid pay a flat annual fee of \$500 K</p> <p>Self-insured pay through TPAs.</p> <p>Estimated total funding over seven year commitment \$32 million</p>	<ul style="list-style-type: none"> <li>Expand the rate and scope of EMR adoption within VT's independent primary care delivery system.</li> <li>Support achieving electronic health information interoperability between points of care by focusing on health information exchange and interface development</li> </ul>	<ol style="list-style-type: none"> <li>Must be an independent primary care provider</li> <li>Must have significant underserved patient population in practice (VT still determining percent)</li> <li>Must demonstrate readiness of practice to adopt EMR technology in terms of workflow reengineering, staff education, and commitment to change</li> <li>Participating practices must commit to paying 25% of total cost of investing in EMR</li> </ol>	<p>Medicaid HER, and documenting immunization for children covered by Medicaid</p> <p>HIN seed grants are one time cash commitments based on proposal submitted by HIE</p> <ol style="list-style-type: none"> <li>No more than \$150K, in total grant contribution for a practice per clinical FTE (MD or mid-level) over life of grant</li> <li>Participating practices are paid committed grant funds based on expenses incurred (not prospectively)</li> <li>Must successfully complete Clinical Micro System Primer which is a "boot camp" for training that demonstrates overall readiness of practice for EMR implementation as per #3 under Eligibility Criteria</li> </ol>	<ol style="list-style-type: none"> <li>Grant application form and content is still being developed at this time as funding law was just signed within past few weeks.</li> <li>Funds for grant program are managed within the office of the VT secretary of administration</li> <li>Vermont Information Technology Leaders (VITL) manages the grant application, review, and approval process.</li> <li>VITL makes an overall grant application for funds to the secretary of administration on an annual basis to secure the dollars projected for EMR and health information exchange grant activities</li> </ol>	<ol style="list-style-type: none"> <li>Secretary of Administration will retain independent third party reviewer to assess performance of grant program and the provider organizations participating in the grant.</li> <li>Evaluation criteria are still being defined at this time but will include both quality and efficiency measures</li> </ol>

# Appendix B - Technology Fund - Questions and Considerations

## DRAFT HIN Stakeholder Process

### Questions & Considerations To Help Shape Development of the Technology Investment Fund

#### ***Background***

At least three organizations that are part of the HIN Stakeholder process have substantial experience in establishing and administering statewide funds and/or loan programs in Maine: FAME, the Maine Technology Institute and the Maine Health & Higher Education Facilities Authority. In preparation for the July 24 HIN Stakeholder process, staff spoke with the leaders of each of these organizations to help inform the discussion about Guiding Principles. Although all three individuals (Beth Bordowitz, Betsy Bieman and Bob Lenna are highly interested and engaged in the Stakeholder process, none can be present for the July 24 meeting. They do, however, expect to be available to attend upcoming sessions during which the establishment of a new Health IT fund will be further explored. All organizations agreed to share information and policies that they have in place relating to criteria, eligibility, etc.

#### **Key Questions/Suggestions Relating to the Development of Guiding Principles**

1. It may make sense for the fund to make available both loans and grants
  - Loans might be targeted toward organizations that have the resources to repay them
  - Grants might be targeted at organizations with a greater need or serve as “safety net” providers; or that may not have the financial ability to repay loans
  - Some organizations identified as having a high priority might be eligible for a combination of loans and grants
2. A revolving loan mechanism could be an important strategy for leveraging additional funds over the long term; i.e., over time the fund grows through a combination of investments and interest payments

3. Eligibility for funding should be prioritized based on a larger strategy relating to system implementation:
  - Examples:
    - HIN's vision for long term system implementation
    - State Health Plan
    - Other strategic needs
4. How will the size of the fund be determined? By need? (how will need be established); By limitations of the revenue-producing mechanism? Should it be designed to grow over time?
5. Every effort should be made to focus and prioritize eligibility--- problems will emerge if too many organizations must compete at the same time for a limited pool of funds
6. If existing strategies do not provide sufficient focus and prioritization, eligibility might be shaped in response to these questions:
  - Should the fund be designed to rapidly build the overall volume of providers who use electronic systems; or,
  - Is the fund be designed to target “safety net” providers or rural providers----or certain geographic areas of the state that may have specific needs;
  - Will funding be available to for profit enterprises (example: independent physician practices, for profit nursing homes, etc.) or nonprofit organizations?
7. Eligibility could be phased in over time; example: “high priority” provider organizations might be the only eligible entities for the first few years, followed by other organizations over time based on the overall strategic direction
8. Consideration should be made to “locating” the fund within an organization where it can be protected from being used for other purposes as state revenues ebb and flow. Should the loan-making and grant-making functions be located in the same or in different organizations? Must the fund be located within a public agency or could it be administered by a bank or other private institution?
9. Will there be a need for two distinct “buckets” within the Fund---one designated for HealthInfoNet and another for other eligible organizations?
10. Can organizations use revenue from the fund to leverage other funding or as collateral for borrowing purposes?