HIE Sustainability
Reflections from State Hospital Associations
February 2012

QUESTION

CONNECTICUT - We are struggling with questions around the business model and funding.

We are working with the quasi-public agency that was named as the SDE here in Connecticut and are trying to help them define a business model that makes sense for hospitals. What services is your state HIE offering or planning to offer? Is there a ramp-up schedule in terms of functionality?

On the funding side, we have serious concerns about the proposed pricing model for hospitals. The state HIE is proposing a subscription model, tiered by hospital size, with start-up fees ranging between $70,000 - $250,000, and annual participation fees between $50,000 - $150,000 per hospital. Is this consistent with the pricing you're seeing in your states?

ANSWERS

COLORADO - In Colorado we have two HIEs. One is called the Quality Health Network (QHN). It is based in Grand Junction and connects providers in the western part of the state. It has been around for close to 10 years, is well established, and providers have become somewhat reliant on it. Providers in that region decided to take steps to integrate care several years ago, primarily to try and keep health care costs in check, given the sometimes challenging nature of their economy. They tend to be in the fore in that respect.

The other HIE is called the Colorado Regional Health Information Exchange Organization (or CORHIO). It is based in Denver and is set up to provide services to providers in the eastern part of the state (where the majority of the population resides). It is also the officially designated HIE for Colorado. It is up and running, primarily because of significant grant funding. One of our large systems, and a handful of other larger hospitals have joined. That said, similar to other HIEs, their largest challenge is sustainability. They have developed a tiered pricing model, much like the model you describe John, only about half the size in magnitude. That said, our small and rural members have told us there is no chance that they will be participating given the current pricing structure. CORHIO has agreed to revisit their model, but have been very slow in doing so.

KANSAS - Kansas has chosen the "orchestrator" model where the state entity does not operate the HIE. Rather they manage our Opt Out process, set policy and approve and regulate HIO's to operate in Kansas and actually who do the work of exchange. The Kansas Health Information Exchange (KHIN) is a partnership between the medical society and the KHA and was created as a provider driven exchange and is recognized as the only statewide exchange. Their pricing is tiered and includes only providers currently with Insurance, pharmacy and lab who will also pay for participation as soon as the exchange is actually moving data (waiting on state approval.) Current pricing ranges

from $15k to $30K for Implementation/start up then from $10k to $120K/yr for annual fees. There are also reduced rates for systems or datacenters that connect 3 or more facilities. Docs and other EPs are really cheap.

NEBRASKA - I think a lot of HIEs are working on their sustainability plans. The Nebraska Health Information Initiative (NeHII) has been in operation sense 2009. BCBS has been on board from day 1. UHC and Coventry have been playing the waiting game.

Our biggest issue is the state itself. Neither the public health side nor Medicaid have provided support. Yet, there are many demands from immunizations, syndromic surveillance, etc.

That pricing is very consistent with our urban/referral hospitals. The CAHs are at $21,000 and balking. BCBS pays to participate also.

NEW HAMPSHIRE - New Hampshire is exactly at the same point that you are at. Through legislation we created a public/private organization called the NH Health Information Organization that started in September 2011. Their last board meeting was centered on the discussion of pricing and they continue to lean toward tiering based on hospital size. The initial prices are not as high as you quoted because they plan to use some of the federal money to give directly to the early adopters to offset the first two year of costs (so they are planning a ramp up in pricing). I can't really say where the pricing will ultimately end up, but I haven't heard those kinds of prices you mentioned being discussed. It's more around the $50,000-$75,000 range on the upper end of the tiering. But we also have a lot more smaller hospitals. We have 13 CAHs and 13 PPS hospitals. Outreach is also being done to other healthcare providers (nursing homes, home care, independent labs) so there is hope that those entities will also join on in time.

They are also planning a ramp up in services. Because of some limitations in current state law, the HIE can provide limited services for sharing health information for treatment purposes only right now. For example, eventually, there is hope that public health data can flow through the HIE. Other services, such as MPI, are under consideration.

NEW JERSEY - In New Jersey we have 4 ONC funded HIEs and two that we not funded by the ONC. Each HIO has a different HIE vendor and vary in the number of hospitals participating. The dollar ranges listed below seem to mirror the ranges of hospital costs here in NJ. We've found that legal fees (DURSA) and IT resources for hospitals to connect to the HIEs have also been a significant financial drain on hospitals. We expect more legal costs once a state-wide patient consent model is settled on.

The state is planning to connect the HIEs through a state wide HIN (public-private partnership) and tie into state information resources like immunization information and NJ Medicaid medication history. We're also hoping at some point down the road to centralize patient discovery through the NJHIN rather than point to point between HIEs using the IHE XCPD Standard, which is what we have now. So far the state has not talked about requiring a fee for HIEs to connect to the state (NJHIN), but that could potentially add more cost to the HIEs and the hospitals that have contributed the lion share in supporting clinical information exchange.

At this year's A2IRNet Conference in NYC (April 22-25 2012) there is a half day dedicated to EHR & HIEs (three state HIT Coordinators are scheduled to attend). This should be a great opportunity to learn how hospitals in various states are dealing with these costly issues.

NEW MEXICO - This is a looming problem in NM. We have a fairly strong SDE that has received upwards of $7M of federal funding over the last several years.
Now that is being phased out and the sustainability scramble is on. I sit on the SDE board and have facilitated their sustainability taskforce. In 2011, the fed grant required 10% in-kind community contribution. Dept. of Health committed $235,000 for surveillance efforts. The Medicaid agency allowed their MCOs to use funding of the SDE in the administrative cost portion of the MLR. That yielded $274,000. Our only teaching hospital kicked in $120k. That left a gap of $155,000 which we attempted to ask non-Medicaid MCOs, the 10 largest hospitals and the 10 largest medical groups to cover using various allocation formulas. (For hospitals, we used the same Medicare cost report expenses that we use for our dues calculations to pro-rate the hospital share - 48% of the gap.) It would have been $27,000 for the largest hospital but quickly dwindled to $3-7K further down the list.

This was simply a good faith effort to get a wide selection of stakeholders feet wet in dealing with the 10% in-kind need. Aside from the amounts committed by Medicaid MCOs and the university hospital, the rest of it fell flat. (BCBS did step up with $20k.) The need grows in the coming years and we've not found a business model that will stick but the main thrust is to aggressively market a service that can show a real ROI.

NORTH CAROLINA - North Carolina has followed the same path, has implemented the technology, and is now recruiting providers to connect. The sustainability model is based on subscription fees which hospitals complain are too high: $1 per $10,000 in NPR for hospitals and $100 per physician per year; for independent physicians, it is also $100/yr. We helped pass a law that enables more sensitive information to flow through the NC HIE and providers are immune from liability when basing care using data gathered through the exchange and some argue these protections are worth the cost.

We have a "qualified organization" approach in which RHIOs like the one we are creating in partnership with our state medical society are connected to one another through the NC HIE (the so-called 'network of networks' approach). Providers cannot connect directly to the NC HIE. This can be thought of as a "channel strategy" and the benefit is that it drives providers to affinity organizations such as hospital associations to connect and look out for their interests, but the downside is that providers see two levels of fees: one for the QO and one for the NC HIE. The NC HIE will offer core services and optional value-added services, as do many of the QOs (again, duplication of effort? duplication of fees?).

I had one of my hospital CIOs approach me a few minutes ago and say there's no way in hell he's connecting to the NC HIE until there is a mandate because the cost is too high. Perhaps my QO will allow providers to connect to us without connecting to the NC HIE? Too soon to tell, but I believe we'll all be connected in the next 3-5 years and I believe the role of our hospital associations is to advise our members, connect them when they want to be connected, and advocate on their behalf at the state and federal level regarding HIE (hint: be on the lookout for external stakeholders wanting to 'liberate' your members' data and sell it to fund the SDE that your members don't want).

OHIO - In Ohio we are a non-profit that is the SDE as well as the state REC, the hospital association if a founding member with the state, medical association and osteopathic association. We were originally able to find matching funds from the state from some non GRF sources and that was moved over to the Partnership for both programs as our matching funds. I have been leased out to run the Partnership until both the hospital association board and Partnership board feel the need to go in a different direction.

The HIE model relies on fees from hospitals, payers, SNFs and physicians. We spent a lot of time looking at use cases for all the stakeholders and they developed the business model. Interestingly enough almost every hospital and other stakeholders have varying business problems they are trying to solve. The fees are based on previous years acute care discharges for the hospitals and it is $0.50/month (for the annual discharge #) with a minimum fee of $1500/mo for CAH and $2000 for non CAHs. There are also some caps/maximums. The grant funding is paying for all the up-front costs and implementation costs.

The model is also phased, result delivery, referrals and alerts, this will build the MPI and RLS as well as create some more simple exchange in the beginning. Phase two is query and retrieval with a community health record that will be rolled out as a community becomes saturated with participants.

OREGON - Overview of Oregon Health Information Exchange plan

* Relies on local communities to create their own HIOs; uses Direct Project to cover areas w/ no HIOs
* An incremental, phased approach to implementation
* A federated model with light central services
* Role of state: Standards, certification, coordination

In Oregon the phase 1 plan is to stand up a Direct Project web portal starting March 22 and offer it free of charge to providers and hospitals. This will enable a secure e-mail connection to send lab results, discharge summaries, continuity of care documents, ect. This strategy will cover the substantial "gray space" in our state where no HIOs have organically arisen, and enable eligible providers and hospitals to meet the HIE requirements for Meaningful Use.

In terms of a phase 2 strategy to build a more comprehensive HIE, the state is exploring using a pilot area (Salem, Oregon) to demonstrate a fuller set of offering which may include:

* Registries: Provider registry and practice registry
* Trust services: Verify identity of parties in exchange, security of the transmission & data integrity
* Push services that allow health info to be transmitted
* Community data repository