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June, 2021 Joint Committee on Finance Paper #359

Health Information Exchange (Health Services -- Public Health)

[LFB 2021-23 Budget Summary: Page 283, #10]

CURRENT LAW

Health information exchange makes patient information -- such as a digital electronic health record -- from one healthcare provider or network available to a different healthcare provider. When a patient first sees a specialist or is admitted into a facility, for example, a health information exchange network can quickly provide that patient's new care team with their medical history, prescription information, laboratory and test results, immunization history, and more. Such a network relies on a centralized hub to maintain connections with each individual provider and facility that may contribute information about a patient, thereby enabling providers to make a single query for patient information instead of relying on individual relationships with each other provider or health network in the state.

Federal legislation passed in 2009 provided funding to plan and implement state-based health information exchange networks. 2010 Wisconsin Act 274 established terms and criteria under which DHS would select a nonprofit organization to create and maintain this network. The Wisconsin Hospital Association, Wisconsin Medical Society, Wisconsin Collaborative for Healthcare Quality, and Wisconsin Health Information Organization collaborated to form a nonprofit entity meeting these terms, the Wisconsin Statewide Health Information Network (WISHIN). DHS designated WISHIN to receive the federal grant funds, which supported implementation activities through 2014.

WISHIN currently connects approximately 1,800 healthcare facilities in the state, including hospitals, health systems, clinics, and other providers. Medical professionals at each of these sites can access patient health information generated at any other connected site, while maintaining compliance with HIPAA and other regulations. Since the initial federal implementation grant, WISHIN has been primarily supported by annual subscription fees paid by each connected facility.

DISCUSSION POINTS

1. The Governor's budget bill would provide one-time funding of $655,000 in 2021-22 and 2022-23 only for the Department of Health Services (DHS) to provide as a single grant in each year to support health information exchange activities. DHS would be authorized to transfer moneys provided for this purpose between the two fiscal years (Alternative A1). Although not specified in the bill, the administration indicates that the grantee would use these funds to support the connection of skilled nursing facilities and community health centers to the health information exchange network.

2. Connecting providers in these facilities with more complete patient information can improve the quality of care they deliver. A connection to the exchange network can also facilitate coordination of a patient's care between facilities and reduce unnecessary duplication of procedures or tests. The network also helps integrate other data sources directly into healthcare provider's patient charts, facilitating and increasing use of resources such as the prescription drug monitoring program (PDMP), which helps prevent opioid abuse by monitoring prescriptions.

3. Currently, most skilled nursing facilities (nursing homes) are not connected to WISHIN. Consequently, they cannot import medical information from the network for a newly-admitted patient, and other providers on the network can only access basic information on the date and reason why a patient was admitted into or discharged from a skilled nursing facility, but not detailed information on the care given, tests conducted, and medications prescribed. A small number of skilled nursing facilities that are part of larger health networks do have full connections to WISHIN because their network integrates patient health records with WISHIN.

4. Similarly, many community clinics are not currently connected to WISHIN. This includes federally qualified health centers, free and charitable clinics, and other "safety net" clinics that provide care to underserved communities and people who cannot otherwise afford care. In 2017, the Greater Milwaukee Business Foundation on Health (GMBFH) provided grant funding to connect eight community clinics in the Milwaukee area. GMBFH has maintained funding for the annual costs of these connections, although these funds are not expected to be renewed again.

5. WISHIN charges facilities a one-time fee to cover the costs of creating the connection between the facility's patient records system and the WISHIN network, and an annual membership fee to support the costs to maintain the connection and WISHIN's general operating costs. The one-time implementation costs vary significantly, depending on the size and type of the facility as well as their current health records infrastructure. WISHIN estimates that implementation for a typical facility may cost up to $11,500, although many facilities already use cloud-based health records management tools that make connection to WISHIN significantly less expensive. For example, approximately 40 community clinics in Wisconsin currently manage their patient records using OCHIN, a nationwide nonprofit organization that provides health information technology and services to community health centers and other safety net clinics. WISHIN already has a connection in place to transfer information to and from OCHIN's network, so costs to add facilities that use OCHIN to the WISHIN network are low.

6. Annual membership costs vary depending on facility size and other factors. WISHIN reports that they typically charge small facilities, which would include most community clinics and

small skilled nursing facilities, approximately $3,000 per year.

7. The administration estimates that the proposed funding level of $655,000 per year could support the grantee connecting 50 skilled nursing facilities and 27 community clinics to the exchange network over the biennium (Alternative A1). DHS has not yet determined the specific allocation of funds or terms that would apply to the grant, such as whether the funds would be used to offset the implementation charges in whole or in part, pay the annual membership costs for newly-connected facilities for one or more years, support health information exchange activities in other ways, or some combination of these.

8. If the Committee wished to provide funding for this purpose, it could further specify the intended use of the grant funds in statute. Based on the one-time nature of the proposed funding, the funding could be directed to support only one-time costs, such as implementation charges, rather than recurring membership costs. Alternative A2 would require the grantee to use all grant funds to connect nursing homes and community clinics to the exchange network, and prohibit the grantee from charging these facilities implementation fees. This restricted use of the funding may enable it to serve more than the 77 facilities estimated under the Governor's proposal; based on the typical implementation fees discussed above, $655,000 per year would be sufficient to connect 100 to 125 facilities to the exchange network over the biennium.

9. The Committee could increase or decrease the amount of funding provided, which would increase or decrease the number of facilities that could be connected. Alternatives A3 and A4 provide $300,000 per year, slightly less than half of the Governor's proposal; Alternative A3 otherwise mirrors the Governor's proposal, while Alternative A4 includes the same added restriction as Alternative A2 requiring that the funds be used to cover implementation fees.

10. In addition to the one-time funding to establish new connections to the exchange network, the Committee could also provide ongoing funding to cover the annual membership costs for newly-connected facilities. These fees may pose a particular barrier for community clinics, which typically have limited ability to generate revenue from the patients they serve and rely on charitable contributions and grants that may be restricted to certain eligible uses. Alternative B1 would provide $120,000 per year in ongoing grant funding to cover the annual costs of operating and maintaining community clinics' connections to the exchange network. This funding level could cover annual membership fees for approximately 30 to 40 community clinics.

11. Finally, as a means of increasing the number of facilities that could receive one-time or ongoing assistance, the Committee could establish a match requirement for the facilities that receive assistance from the grantee. If the Committee chose this option, the match percentage could be established at any percentage. Alternatives C1 and C2 would establish the matching percentage at 25% and 50%, respectively.

ALTERNATIVES

A. One-time Funding

1. Provide $655,000 GPR in 2021-22 and 2022-23 as one-time funding for DHS to provide as a grant to support health information exchange activities. Prohibit DHS from encumbering moneys for this purpose after June 30, 2023. Authorize DHS to transfer moneys appropriated for this purpose between the two fiscal years.

ALT A1	Change to Base
GPR	$1,310,000

2. Adopt all of the provisions in Alternative A1, but specify that the grantee must use the funds to connect facilities that are skilled nursing facilities, federally qualified health centers, free and charitable clinics, or other clinics serving underserved communities to the health information exchange network, and that the grantee may not charge implementation fees to facilities connected using funding from this grant.

ALT A2	Change to Base
GPR	$1,310,000

3. Adopt all of the provisions in Alternative A1, but reduce the amount of funding that would be available for the grantee by providing $300,000 GPR in 2021-22 and 2022-23 in one-time funding for DHS to provide as grants to support health information exchange activities.

ALT A3	Change to Base
GPR	$600,000

4. Adopt the funding provisions in Alternative A3. Specify that the grantee must use the funds to connect facilities that are skilled nursing facilities, federally qualified health centers, free and charitable clinics, or other clinics serving underserved communities to the health information exchange network, and that the grantee may not charge implementation fees to facilities connected using funding from this grant.

ALT A4	Change to Base
GPR	$600,000

5. Take no action.

B. Ongoing Funding

1. In addition to any of the Alternatives listed under A, provide $120,000 GPR annually, beginning in 2021-22, to provide as a grant to an entity to support health information exchange activities. Specify that the grantee must use the funds to cover the annual costs of operating and maintaining connections to the exchange network for facilities that are federally qualified health centers, free and charitable clinics, or other clinics serving underserved communities, and that the grantee may not charge annual fees to organizations whose connections are supported by grant funds.

ALT B1	Change to Base
GPR	$240,000

2. Take no action.

C. Match Requirement

1. In addition to any of the Alternatives listed under A or B, specify that the grantee must require all facilities that receive financial assistance under the program to fund 25% of the total one-time or ongoing costs of participating in the health information exchange.

2. In addition to any of the Alternatives listed under A or B, specify that the grantee must require all facilities that receive financial assistance under the program to fund 50% of the total one-time or ongoing costs of participating in the health information exchange.

3. Take no action.

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