

**MINUTES OF THE JANUARY 5, 2012, MEETING
OF THE BUDGET & FINANCE COMMITTEE
OF THE GOVERNING BOARD OF THE
ILLINOIS HEALTH INFORMATION EXCHANGE AUTHORITY**

The Budget and Finance Committee (“Committee”) of the Board of Directors (the “Board”) of the Illinois Health Information Exchange Authority (“Authority”), pursuant to notice duly given, held a meeting at 10:30 a.m. on January 5, 2012, at the offices of the Office of Health Information Technology (“OHIT”), State of Illinois James R. Thompson Center, 100 W. Randolph, Suite 2-201, 100 W. Randolph St., Chicago, IL 60601.

<u>Committee Members Present:</u> 1. Dr. Bruce Wellman (by telephone) 2. Dr. Cheryl Whitaker 3. HFS – Director Julie Hamos (by telephone)	<u>OHIT Staff Present:</u> Laura Zaremba; Mark Chudzinski; David Fagus
<u>Committee Members Absent:</u> 1. Mr. Mark Neaman	

Call to Order and Roll Call

Mr. Chudzinski, Secretary of the Board, confirmed the presence of the Members of the Committee noted above. A majority of the members of the Committee were in attendance; the ability of Dr. Wellman and Director Hamos to clearly participate by telephone was confirmed, and no objection was expressed to their participation in this manner.

Approval of Minutes

The minutes of the meeting of the Committee of November 16, 2011 were approved with corrections.

Discussion of Finance Policy Questions

Mr. David Fagus presented for the Committee’s consideration the following financial policy questions, the answers to which would have a significant impact upon the development of the Authority’s business plan.

Policy Question 1: When should ILHIE begin charging for services?

The Illinois Health Information Exchange will offer two services initially: ILHIE Direct Secure Messaging and the ILHIE Core Services. The following options pertain only to the ILHIE Core Services and any additional services developed in the future. (Under the federal HHS/ONC grant for the development and implementation of the ILHIE, ILHIE Direct Secure Messaging will be provided at no cost to users at least through 2012.)

Option 1: ILHIE can establish and charge fees for all providers from the point of inception, planned for late 2012.

Rationale: ILHIE needs to establish a revenue stream as soon as possible. Providing free service establishes an expectation that it will always be free. Alpha testers and beta testers will reap a distinct advantage in the marketplace by being one of the earliest adopters in Illinois to have completed the process of building and establishing access to the Illinois HIE which will empower patients of their operation to have the best medical record access in the state.

Option 2: ILHIE can begin charging fees for service beginning in 2013

Rationale: It is anticipated that the Alpha and Beta testing will be complete by the end of calendar year 2012. At that time the ILHIE core services will be available to the marketplace. It is the intent that the ILHIE will be funded by the participants. Providing free service beyond this point creates an environment where participants do not become acclimated to user charges which cannot exist indefinitely. Grant dollars utilized to subsidize basic service (Option 3), will constrict the flexibility and the ingenuity of the Board and its staff to further develop the ILHIE solutions and to invest in preparing the underserved/underfunded communities to be targeted for special assistance. Grant dollars utilized to provide subsidy to organizations and enterprises that would otherwise join at a small reduction in cost (Option 1), for many will result in less participation and less information being available.

Option 3: ILHIE can offer services at no cost until January 2014 (end of federal grant)

Rationale: The development of a customer base is essential to the growth of the ILHIE. In order for the ILHIE to have value and be useful to the participant it must have a large amount of patients participating. Encouraging participation through a program incentive of no cost will generate the highest level of participation.

In the Committee's discussion it was noted that there was not much practical difference between the first two options.

Policy Question 2: Should ILHIE pricing structures provide for discounted or subsidized rates for "Safety Net" and disadvantaged providers and hospitals? What should the criteria be to qualify for such a discount?

"Safety Net" (high-volume Medicaid/uninsured) and rural providers are essential participants in HIE. It is a basic expectation of the ILHIE enabling statute and the federal HHS/ONC grant that this State-level HIE program will be one that is available to all patients and providers. Some providers and their organizations operate in an environment whereby the expense of HIE costs are simply unaffordable. Without subsidy they will not be able to participate in the HIE.

Option 1: No subsidy will be granted.

Rationale: The provision of a subsidy beyond the grant period will impact all participants' ability to participate unless a source for funding a subsidy is identified. No source has been identified. Relying on obtaining the funds needed to provide a subsidy for a particular group or set of groups will result in the funding will have to be generated by overcharging unsubsidized members.

Option 2: “Safety Net” providers should be granted a subsidy in an amount to be determined by the Board once the base pricing for all participants has been determined.

Rationale: Establishing a subsidy for “Safety Net” providers will provide a path to meet the goals of the program to provide all patients with the opportunity to participate in the HIE regardless of the ability to pay. Additionally, for the payer community and the public health community, the availability of additional patient information allows for the opportunity to monitor various diseases, treatment plans and other factors in providing care that will eventually lead to better outcomes and healthier patients.

Option 3: Rural providers should be granted a subsidy to be determined by the Board once the base pricing for all participants has been determined.

Rationale: Rural providers, isolated providers, and telemedicine providers offer services in communities and settings that are often economically challenging and are often underserved communities. Providing a path for these providers and institutions to participate in the HIE will be beneficial to their practice, but most importantly will highly benefit the patient. Having immediate access to recent data related to the patients’ health will have an unprecedented impact.

In the Committee’s discussion it was noted that there was not much practical difference between the second and third options, which could be combined into a single policy option.

Policy Question 3: Should sub-State HIEs (local, enterprise, etc.) be charged to connect to the ILHIE? Should the Board create a committee to review this and related decisions or address in the Budget and Finance Committee?

In order to ensure appropriate security and privacy requirements for the ILHIE network, every user of the ILHIE is going to be required to be a member of ILHIE, regardless of how they connect to the network (i.e. directly or through a sub-State HIE). This policy is predicated on the idea that charges will not be implemented until such a time that we are charging for services.

Option 1: Charge enterprise/private HIEs at the usual and customary rate.

Rationale: Enterprise and other private HIEs that consist of primarily or exclusively of hospitals and doctors are simply large organizations that provide service to patients. Due to their size they are structured technologically in a way that they are already functioning as a closed HIE for their institutions and partners. Charges for their service, therefore, should be calculated as a collection of individual provider charges.

Option 2: Each sub-State HIE can provide HIE service and not be charged to connect to ILHIE. The members of any sub-State HIE will need to be members of the ILHIE in order to conduct any business on the ILHIE network and therefore ILHIE will generate revenue from these memberships, not the sub-State HIE.

Rationale: Sub-State HIEs that are open to any entity in a given geographic region are conduits to the local providers and institutions that ILHIE wants to encourage to participate in HIE. The benefit to the patient is in their records being available in an electronic format, and not that their records are in the hands

of a sub-State or a state-level HIE. Any avenue that increases the likelihood of patient participation should be utilized to its fullest advantage.

Option 3: Each sub-State HIE will be required to provide ILHIE memberships to any and all of its customers and will forward such payments to the ILHIE.

Rationale: Local HIEs can provide services to the local service area and as the service provider and collect fees on behalf of the ILHIE. The rate that the local determines it will charge is a local issue determined by each individual HIE.

Option 4: The ILHIE should proceed with a business plan that does not charge the local HIEs, with the intention of becoming the sole provider of HIE services in Illinois.

Rationale: The ILHIE will be offering core services to the entire State. The local HIEs will be offering duplicative core services to a sub-section of the State. In order to survive, the local HIEs and ILHIE will compete for customers and this competition will inhibit the growth and the value of the HIE by creating multiple pools of information that will fragment patient information. Additionally, as potential HIE participants continue to sit on the sidelines and wait to determine which service will survive and provide the best value to their organization, those entities that deliver value to customers and can be sustained will become apparent.

Option 5: ILHIE can enter into a contractual relationship with the sub-State HIEs whereby the sub-State HIE functions as an ILHIE-designated HIE service provider and ILHIE markets services through the sub-State HIE whenever possible. ILHIE serves as the provider for areas that do not offer sub-State HIE services or for those who have service needs that cannot be met by the sub-State HIE.

In the Committee's discussion it was suggested that in order to facilitate the policy discussion, consideration be given to distinguishing between enterprise HIEs (private, closed) (Option 1) and the emerging "local" sub-State HIE initiatives (public, open, membership driven). Consideration should also be given to the method to be used for collection of ILHIE fees, and the prospect of according volume discounts. It was noted that Options 2 and 4 both propose that the ILHIE and sub-State HIEs will co-exist separately, and in effect are the same, though it is unclear whether Option 4 proposes any connectivity between ILHIE and the sub-State HIEs. It was noted that Options 3 and 5 both propose that the sub-State HIEs serve as the "local retail agents" of the ILHIE, but with the sub-State HIEs under Option 5 being granted some degree of exclusive "franchise" for operation in a designated geographic area. The prospect of the Authority being able to legally grant and enforce exclusive geographic franchise territories for HIEs was seriously questioned. Options that envision an ongoing role for sub-State HIEs should also consider the fiscal sustainability of such entities, and whether they separately collect fees from users in addition to any ILHIE fees (collected directly by ILHIE or indirectly through the sub-State entity).

The prospect of providers being connected only to sub-State HIEs without connectivity to the State-level HIE would appear to be inconsistent with the State's eventual need to have all records of Medicaid patients accessible through the State-level ILHIE.

In proposing an eventual organizational structure for the delivery of HIE services in Illinois, specifically the relationship to be established between a State-level ILHIE and sub-State HIE initiatives, it was suggested that OHIT staff should carefully distinguish between the actual capabilities of emerging sub-State entities and their aspirations.

In the Committee's discussion it was suggested that the potential formation of additional Board committees was more appropriately a consideration of the Governance and Nominating Committee.

Policy Question 4: Should physicians and hospitals who participate in the ILHIE be required to share patient records (with appropriate consent) in order to access patient records?

In the future, patients will expect to control their own health data. Data sharing is essential to the short and long-term success of all HIEs. If ILHIE participating members are allowed to view data without providing data it will provide incomplete patient records and will deny the patient the fundamental right to participate in the HIE. Data sharing requirements for participation in the ILHIE can be adopted in administrative rule. Recommendations regarding consent policy that clarifies or modifies existing law will require adoption of resolution of the Board to seek legislation to be acted upon by the General Assembly.

Option 1: All participants must provide data from any patient that wishes to participate in an HIE service.

Option 2: Providers may have View Only privileges for a 90 day trial. At the end of that period the customer will have the option of continuing services as a fully sharing member or services will be terminated.

Option 3: ILHIE will offer a "View Only" option. Having information available to the providers, regardless of the providers willingness to share data, is a benefit to the patient.

In the Committee's discussion it was noted that the OHIT staff strongly favors the first policy option, but that the second option might be feasible depending on the challenges of practical implementation.

The Committee directed the OHIT staff to refine these finance policy questions to reflect the Committee's guidance, and to refer these questions for consideration by the remaining members of the Board at the next meeting of the Committee of the Whole.

Public Comment

There were no comments offered from the general public.

Adjournment

The meeting was adjourned at 12:23 p.m.

Minutes submitted by: Mark Chudzinski, Secretary