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Casey Kline, Attorney for the Commission
Kathy Norris, Fiscal Analyst for the Commission
Al Gossard, Fiscal Analyst for the Commission

Authority: IC 2-5-23

HEALTH FINANCE COMMISSION

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Indianapolis, Indiana 46204-2789
Tel: (317) 233-0696 Fax: (317) 232-2554

MEETING MINUTES[1]

Meeting Date:	**July 22, 2013**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Senate Chambers**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**2**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Ryan Mishler; Sen. Vaneta Becker; Sen. Rodric Bray; Sen. Ed Charbonneau; Sen. Ron Grooms; Sen. Jean Leising; Sen. Pete Miller; Sen. Jean Breaux; Sen. Frank Mrvan; Sen. Mark Stoops; Sen. Greg Taylor; Rep. Ed Clere, Vice-Chairperson; Rep. Steven Davisson; Rep. Ronald Bacon; Rep. Suzanne Crouch; Rep. Donald Lehe; Rep. Eric Turner; Rep. Dennis Zent; Rep. Charlie Brown; Rep. B. Patrick Bauer; Rep. Gregory Porter; Rep. Robin Shackleford.**

Members Absent: **Rep. Robert Behning; Rep. David Frizzell.**

Chairperson Patricia Miller called the meeting to order at 10:05 a.m.

Medicaid Fraud Investigation Procedures

Adrienne Shields, Family and Social Services Administration (FSSA), provided an overview of FSSA's process in investigating recipient Medicaid fraud through the FSSA Benefit Recovery

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[1] These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at http://www.in.gov/legislative Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for hard copies.

Unit and the FSSA Compliance Division. See Exhibit 1. Ms. Shields stated that the evidence drives the time line in the investigation of a fraud complaint, but the goal is to complete the investigation within 120 days. Ms. Shields explained that when a case of suspected fraud is reported to FSSA, the Benefit Recovery Unit reviews the case and gathers information. If the case requires field work, the case is referred to the Compliance Division. Ms. Shields also stated that FSSA monitors social media like Craig's List and Ebay looking for individuals who are selling their benefits online. Ms. Shields elaborated that the problem is occurring in other states, but hasn't yet developed in Indiana. Ms. Shields stated that FSSA is attending an Integrity Plan workshop in August for the Supplemental Nutrition Assistance Program in which other states will share best practices in identifying and stopping fraud. Ms. Shields also discussed types of fraud, case load data, and fraud referral statistics with the Commission. See Exhibit 1.

Free and Reduced School Lunch Program Fraud

Mr. John Barnes, Indiana Department of Education (DOE), testified that the Free and Reduced School Lunch Program (Program) is a federal program that does not require an applicant to provide tax data as verification of income when applying for the Program. Ms. Julie Sutton, DOE, stated that schools are required under federal law to audit exactly three percent of the applications and DOE audits the schools by using a random sample or for cause. Ms. Sutton stated that if it is determined that an application is fraudulent, the family is removed from the program and any future application by the family is subject to verification. Ms. Sutton testified that about 33% of the audited applications are found to be fraudulent. Ms. Sutton stated that the cases are not referred to law enforcement for prosecution. Ms. Sutton informed the Commission that 47% of school students participate in the Program.

Health Insurance Exchange

Mr. Logan Harrison, Indiana Department of Insurance (IDOI), testified that the IDOI actuary has concluded that insurance rates in Indiana will increase an average of 72% and small group insurance rates in Indiana will increase 8% on average for the 2014 plan year as a result of the Affordable Care Act (ACA). Mr. Harrison pointed to several possible reasons for the projected 72% increase, including the implementation of the following under the ACA: (1) an annual fee on health insurance providers; (2) a temporary reinsurance program collection; and (3) an excise tax on high value plans. See Exhibit 2. Mr. Harrison also discussed market issues, including guarantee issuance, morbidity, and the closing of Indiana's high-risk insurance pool. Mr. Harrison stated that 17 companies have withdrawn from Indiana's individual health insurance market.

Mr. Harrison testified that HEA 1328-2013 ensures that IDOI maintains jurisdiction for all Indiana plans, including licensure, rate review, financial solvency, and coordination with the Indiana federally facilitated health insurance exchange (Exchange). Mr. Harrison stated that Indiana has until July 31, 2013 to submit final rate dispositions to the federal government. Mr. Harrison noted that the federal government will review all of the plans to determine what plans will be offered in the Exchange. Mr. Harrison briefly discussed Indiana's decision not to operate a state-based exchange, insurance companies that potentially will participate in the Exchange, the various plan levels to be offered, and the geographic coverage areas. See Exhibit 2. Mr. Harrison said that IDOI has traveled the state to conduct informational sessions for individuals who will be losing coverage in the high-risk insurance pool.

Insurance Coverage

Mr. Jim Zieba, Indiana Optometry, discussed vision coverage under the Healthy Indiana Plan (HIP) and the importance of vision coverage for the total health of a person. Dr. Charles

Poland, DDS, discussed the importance of dental coverage, especially for children, and that savings would be generated by providing dental coverage. Ms. Pat McGuffey, Indiana State Chiropractic Association, discussed the importance of covering a full range of services, including chiropractic services.

Ambulatory Outpatient Surgical Centers

Ms. Nancy Penn, Indiana Federation of Ambulatory Surgical Centers, said that an ambulatory outpatient surgical center is an alternative to hospitals, is more affordable and patient focused, and has a nice atmosphere. Ms. Penn stated that some ambulatory outpatient surgical centers are partially owned by physicians, which helps with the scheduling of surgeries. Ms. Penn commented that ambulatory outpatient surgical centers have contributed to advancement in innovations, including surgical techniques. Ms. Penn indicated to the Commission that: (1) ambulatory outpatient surgical centers are in the preliminary stages of implementing performance measures; and (2) a physician is always present at the ambulatory outpatient surgical center when patients are there, even when the patient is in recovery.

Ms. Libby Cierzniak, Indiana Society of Anesthesiologists (ISA), discussed the differences in the statutory and regulatory requirements in the administration of anesthesia by a Certified Registered Nurse Anesthetist (CRNA) in an ambulatory outpatient surgical center versus a physician's office. See Exhibit 3. Ms. Cierzniak stated that the laws concerning ambulatory outpatient surgical centers require specialized training of the physician supervising the administration of anesthesia whereas a physician's office setting requires a physician to have appropriate education and training to direct or supervise the administration of anesthesia.

Dr. Pat O'Neil, ISA, stated that the rule requiring specialized training is necessary in the ambulatory surgical center setting because of the types of surgeries performed at these facilities. Dr. O'Neil also pointed out the difference in requiring a physician to be "available" versus a physician being "present".

Mr. Mark Scherer, Indiana Association of Nurse Anesthetists (IANA), testified that changes to the ambulatory outpatient surgical center statutes would benefit Indiana citizens and discussed the greater utilization of CRNAs in surrounding states. See Exhibit 4. Mr. Scherer stated that: (1) Indiana has an institutional bias against using CRNAs; (2) Indiana has a restrictive scope of practice for CRNAs; and (3) ambulatory outpatient surgical centers limit the use of CRNAs. Mr. Scherer recommended: (1) amending the ambulatory outpatient surgical center statutes to mirror hospital requirements, which do not require specialized training of a physician supervising a CRNA; and (2) allowing CRNAs to work with podiatrists and in ambulatory outpatient surgical centers in the same manner as allowed in hospitals.

Dr. Jerome Adams, an anesthesiologist, stated that he favors only changing the ambulatory surgical center laws to tighten them. Dr. Adams explained the scope of practice differences between an anesthesiologist and a CRNA. Dr. Adams stated that his priority is patient safety and that there is no back-up system at an ambulatory outpatient surgical center like there is at a hospital.

CRNA Issues

Ms. Cornelia Hammerly, CRNA, told Commission members that she lives in Zionsville, IN, but travels throughout the state to perform her job. Ms. Hammerly stated that there is no difference in outcomes when a anesthesiologist is used versus a CRNA. Ms. Hammerly informed the Commission that the Centers for Medicare and Medicaid Services (CMS) do not require supervising physicians to have specialized training. Ms. Hammerly commented that CRNAs

should be allowed to work for podiatrists and dentists and that 30 other states allow CRNAs to work with podiatrists. In response to a Commission question, Ms. Hammerly responded that she does bill directly and is reimbursed less than an anesthesiologist for the same service.

Mr. Scherer, IANA, noted that Indiana does not recognize a CRNA as an advanced practice nurse while 47 other states do in some fashion. See Exhibit 4. Mr. Scherer stated that designation as an Advanced Practice Nurse would inform patients that a CRNA's training is beyond the Registered Nurse level. Mr. Scherer testified that CRNAs only want the designation as an Advanced Practice Nurse and assured the Commission that they are not seeking prescriptive authority or to be allowed to work under a collaborative agreement.

Ms. Cierzniak, ISA, stated that ISA does not oppose a CRNA being designated as an Advanced Practice Nurse as long as: (1) a CRNA is not given prescriptive authority; (2) a CRNA is not allowed to operate under a collaborative agreement; and (3) the board of nursing is prohibited from increasing the CRNAs' scope of practice to include performing pain management.

Dr. Drew Trobridge, an anesthesiologist speaking on behalf of the Indiana State Medical Association, discussed the differences in education and training received by an anesthesiologist and a CRNA. Dr. Trobridge testified that a CRNA is not trained to practice pain management.

Dr. Adams supported the designation of a CRNA as an Advanced Practice Nurse as long as the CRNA does not have prescriptive authority and there is no increase in the CRNA scope of practice.

Ms. Christina Hamby, a CRNA from Evansville, testified that she travels to Missouri and Kentucky to work as a CRNA because there are no CRNA jobs in Evansville and so that she can specialize in caring for children. Ms. Hamby stated that she provided care in Kentucky to a child who lived in Evansville but could not get the necessary care in Evansville.

Electronic Health Data

Mr. Andrew VanZee, FSSA, described the Indiana Health Information Technology, Inc. (IHIT) and the state Health Information Exchange (HIE) Program. Mr. VanZee stated that the role of HIE is to drive interoperability within the private sector and to integrate data. Mr. VanZee informed the Commission that five health information organizations operate in Indiana: (1) HealthBridge; (2) healthLINC; (3) Indiana Health Information Exchange (IHIE); (4) Michiana Health Information Network; and (5) MedWeb. Mr. VanZee provided statistics concerning electronic health record transactions and the use of electronic health records in Indiana. Mr. VanZee also predicted that the next expansion of the use of electronic medical records will be by consumers who will electronically access their personal health records. Mr. VanZee discussed pilot programs operating in Indiana. See Exhibit 5.

Ms. Chris Mickens, Indiana State Department of Health (Department), provided information concerning the use of electronic medical records by the Department through electronic laboratory reports, surveillance data for state reportable disease conditions, and immunization data. Ms. Mickens briefly discussed the MyVax Indiana Portal, which went active in July, 2012, and allows access to vaccine records. See Exhibit 6. Ms. Mickens stated that the Department is continuing to work on the following: (1) electronic birth and death reporting; (2) public health response and intervention to disease outbreaks; (3) submission of immunization data for children; and (4) integrated data flow with providers and hospitals.

Mr. Vince Caponi, St. Vincent Health, complimented Indiana's electronic health record system. Mr. Caponi stated that providers will be looking for opportunities to standardize and consolidate records to combat the rising costs of healthcare. Mr. Caponi testified that IHIE and the other

exchanges will be looking to coordinate and allow for access to records while maintaining security and protecting personal information.

Mr. John Kansky, IHIE, testified that the state HIE improves healthcare quality, enhances healthcare safety, and reduces healthcare costs. Mr. Kansky showed the Commission a video with background information on IHIE. See Exhibit 7, and see http://www.youtube.com/watch?v=flMqffkrsNI.

Mr. Eric Thieme, IHIE, described how the following words are used in the health information context:

(1) "Privacy"-- whether, when, and how information is collected.
(2) "Confidentiality"-- to whom information may be disclosed.
(3) "Security"-- how information is protected.
(4) "Transparency"-- knowing how information is used.
(5) "Trust"-- built upon privacy, confidentiality, security, and transparency.

Mr. Thieme briefly discussed the federal Health Insurance Portability and Accountability Act (HIPAA) concerning privacy and security rules and the federal Health Information Technology for Economic and Clinical Health (HITECH) for promoting the expansion of health information technology. See Exhibit 7. Mr. Thieme discussed the Indiana Network for Patient Care (INPC) Management Committee, which makes decisions concerning when and for how long electronic health data can be accessed.

Dr. Charlie Miramonti, Indy EMS, testified concerning the benefit of: (1) having a comprehensive profile of a patient that can be used in the provision of care and increase positive outcomes; (2) accessing the Indiana Scheduled Prescription Electronic Collection and Tracking (INSPECT) database to determine the controlled substances that a patient is taking. Dr. Miramonti discussed the affect the database has had on treatment in emergency rooms. Dr. Miramonti stated that it would be beneficial to have information in the database on all prescription drugs being taken by the patient and that this access would assist with medical error reduction.

Mr. Tom Arkins, Indy EMS, discussed the importance of knowing as much medical information about a patient as possible when determining how to treat the patient.

Mr. Randy Hountz, Purdue Healthcare Advisors, discussed Purdue Healthcare Advisors and the grants that it has received to assist providers and hospitals in implementing efforts to become meaningful users of electronic health records (The federal Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs provide financial incentives for "meaningful use" of certified EHR). Mr. Hountz provided statistics concerning state and national progress in the meaningful use of electronic health records. See Exhibit 8. Mr. Hountz stated that providers will incur penalties by the CMS under the Medicare program starting in 2015 if the providers do not maintain continuing meaningful use compliance.

Mr. Tony Gillespie, Indiana Minority Health Coalition, commended the work that has occurred in Indiana on implementing the use of electronic medical records and discussed some challenges that exist in the implementation. See Exhibit 9. Mr. Gillespie stated that electronic medical records are sometimes disconnected information silos that create barriers in achieving a continuum of care. Mr. Gillespie discussed the following: (1) that providers are required to enter information into multiple systems; (2) the need for collecting prescription information in one location; and (3) the privacy rights of patients. Mr. Gillespie also commented on the benefits of electronic health records, including access to accurate and complete health information.

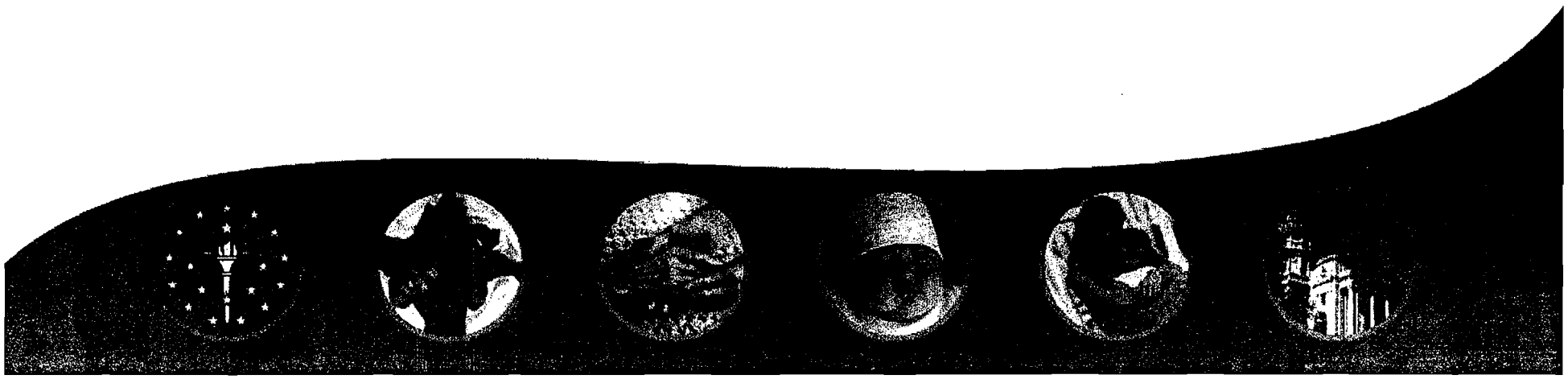
The meeting adjourned at 4:30 p.m.

HFC July 22, 2013 Exhibit 1

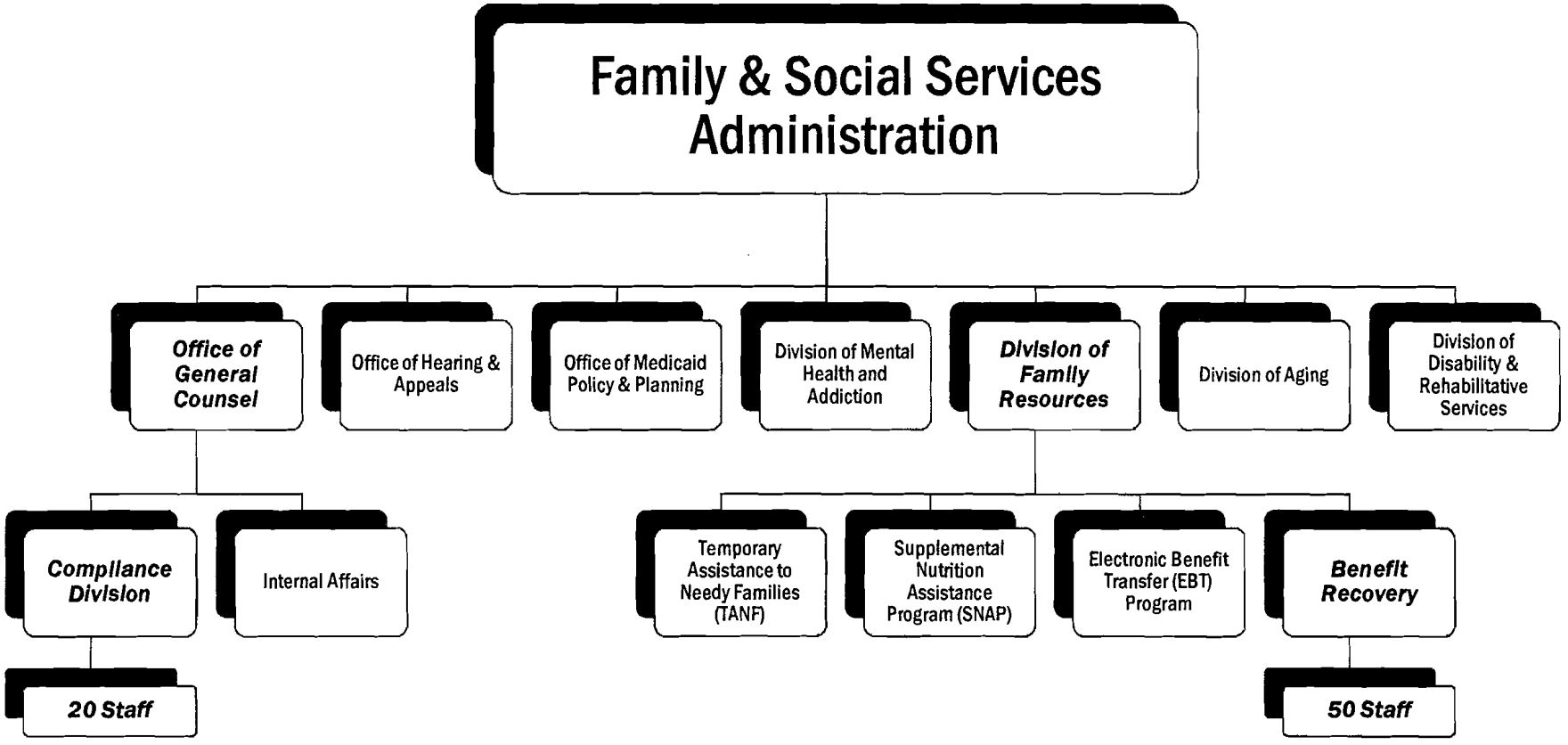
Indiana Family and Social Services Administration

Program Integrity Efforts Health Finance Commission

July 22, 2013



Reporting Structure



FSSA Benefit Recovery Unit

- **Investigation Oversight:**
  - Medicaid
  - Supplemental Nutrition Assistance Program (SNAP)
  - Temporary Assistance for Needy Families (TANF)
- **Investigation:**
  - Front line for Fraud allegations
  - Creates fraud cases in CODY
  - Calculates claims
  - Complete investigations not requiring field work
  - Sends referrals to Compliance Division for further investigation

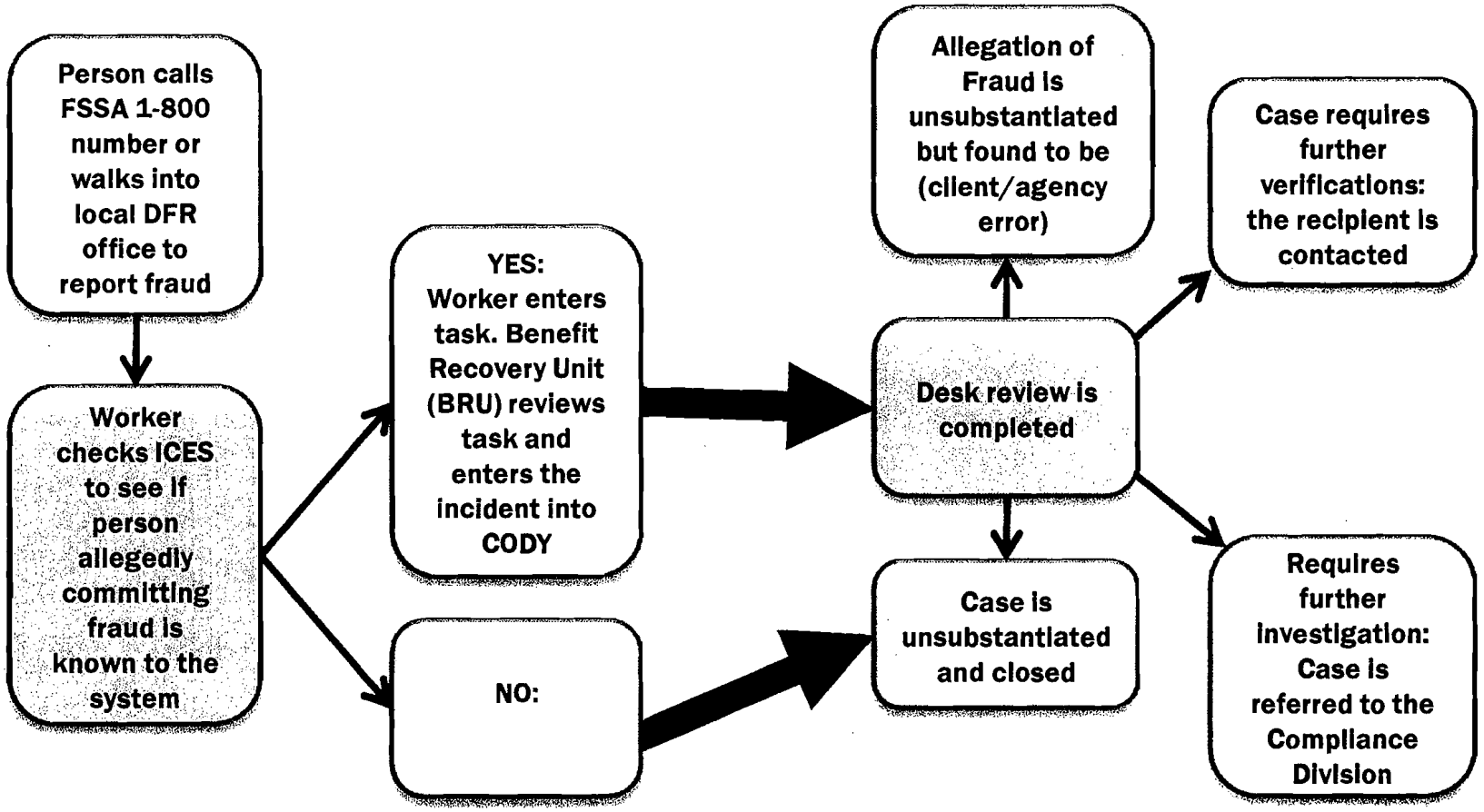
FSSA Compliance Division

- **Investigation Oversight:**
  - Medicaid
  - Supplemental Nutrition Assistance Program (SNAP)
  - Temporary Assistance for Needy Families (TANF)
  - Child Care and Development Fund (CCDF)
- **Investigation Timeline:**
  - Evidence drives the timeline (No set timeframe)
  - 120 days is the goal to clear a case (substantiated, unsubstantiated, refer to prosecutor, refer to Division of Family Resources (DFR)

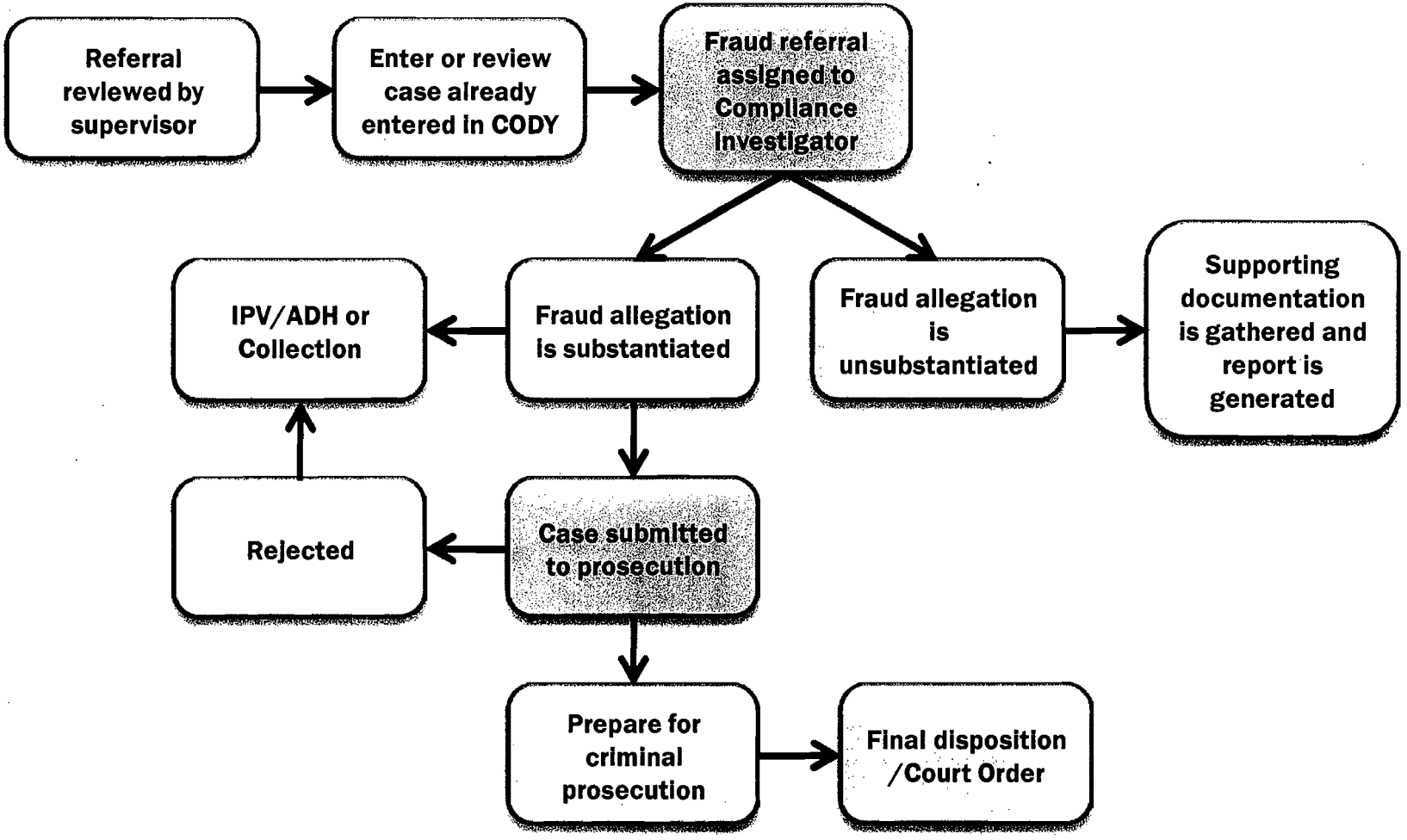
Ways Fraud is Reported to the State of Indiana

Telephone	• DFR's Toll Free Number: **1-800-403-0864**
Local Office	Any person may walk into a DFR local office and report fraud
Email	• **ReportFraud@fssa.IN.gov**
Website	• http://www.IN.gov/FSSA/2385.htm • http://www.IN.gov/FSSA/2404.htm
Internal Investigation	If a fraud investigation is being conducted within FSSA, case will be referred to the FSSA Compliance Division if the person is also receiving public assistance benefits.
Interagency Communication	If a fraud investigation is being conducted within another State agency and the recipient is also receiving public assistance benefits, or if another agency receives allegations of fraud, the allegation is sent to the FSSA Compliance Division.
Postal Mail	*Commonly comes through:* Governor's office, legislator's offices, and FSSA.
Internal Case Review	Caseworker believes there is fraud while working the case. Referral can be made utilizing any of the above methods.
Telephone	JPMorgan Chase EBT Hotline: **1-877-768-5098**

Report of Fraud to 1-800 #; Walk-ins; E-mail



Compliance Division Fraud Process

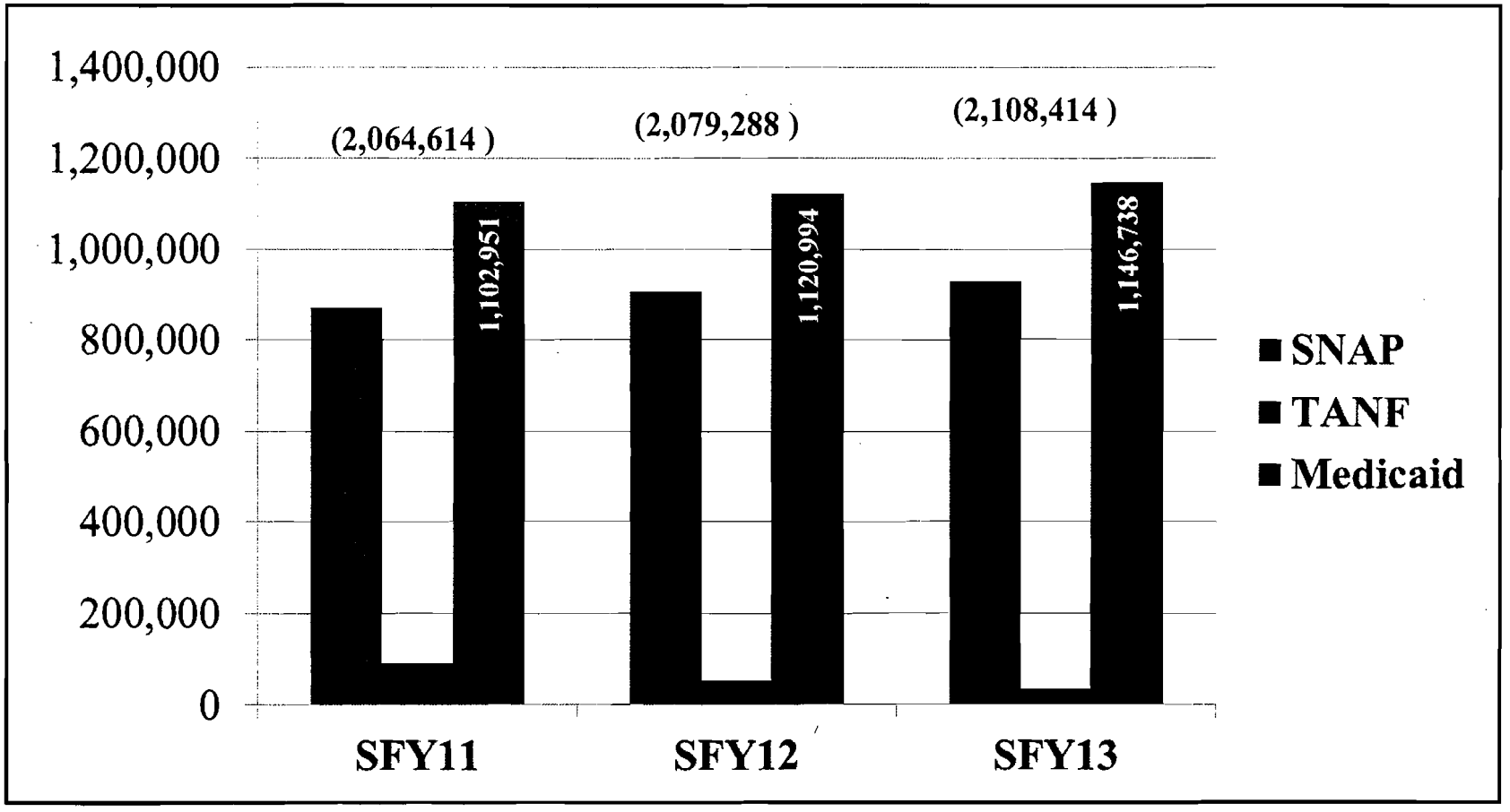


Examples of Types of Fraud

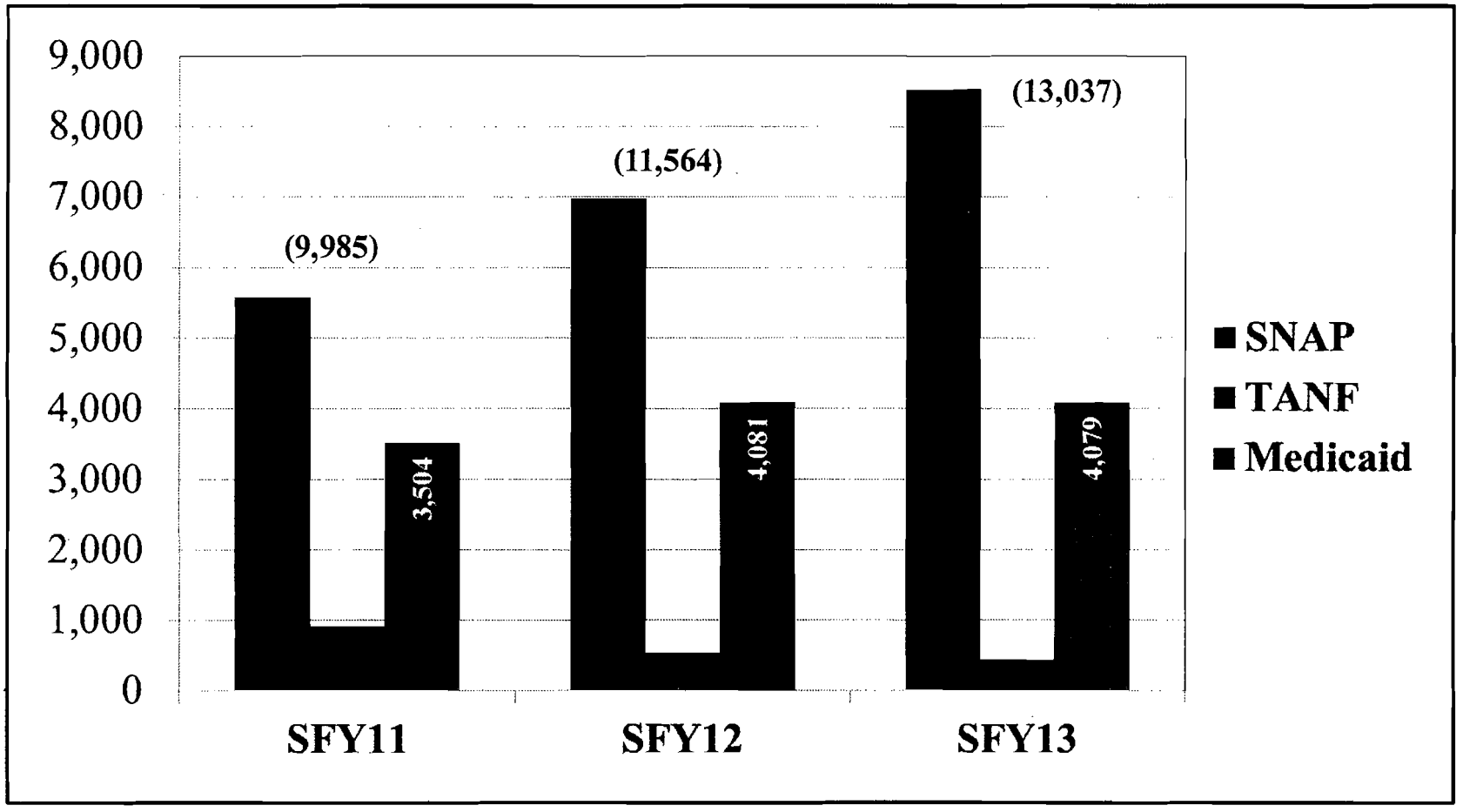
Issue	% of 2013 Annual Total
Undisclosed Income	26.0%
Absent Parent in Household	15.6%
True Residence of Child	15.1%

Issue	% of 2012 Annual Total
Undisclosed Income	27.5%
Absent Parent in Household	17.1%
True Residence of Child	16.8%

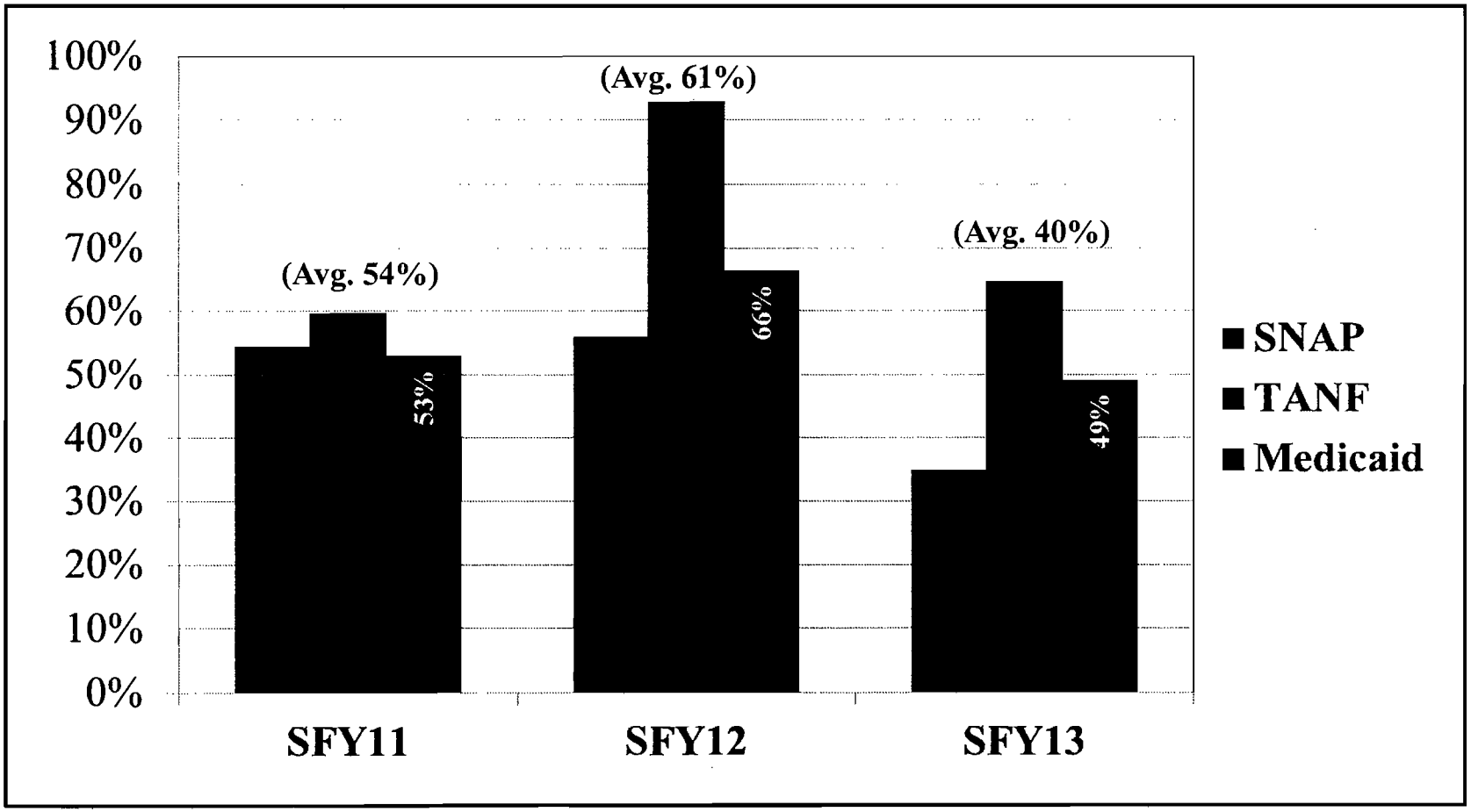
Case Load Data



Fraud Referrals by Program

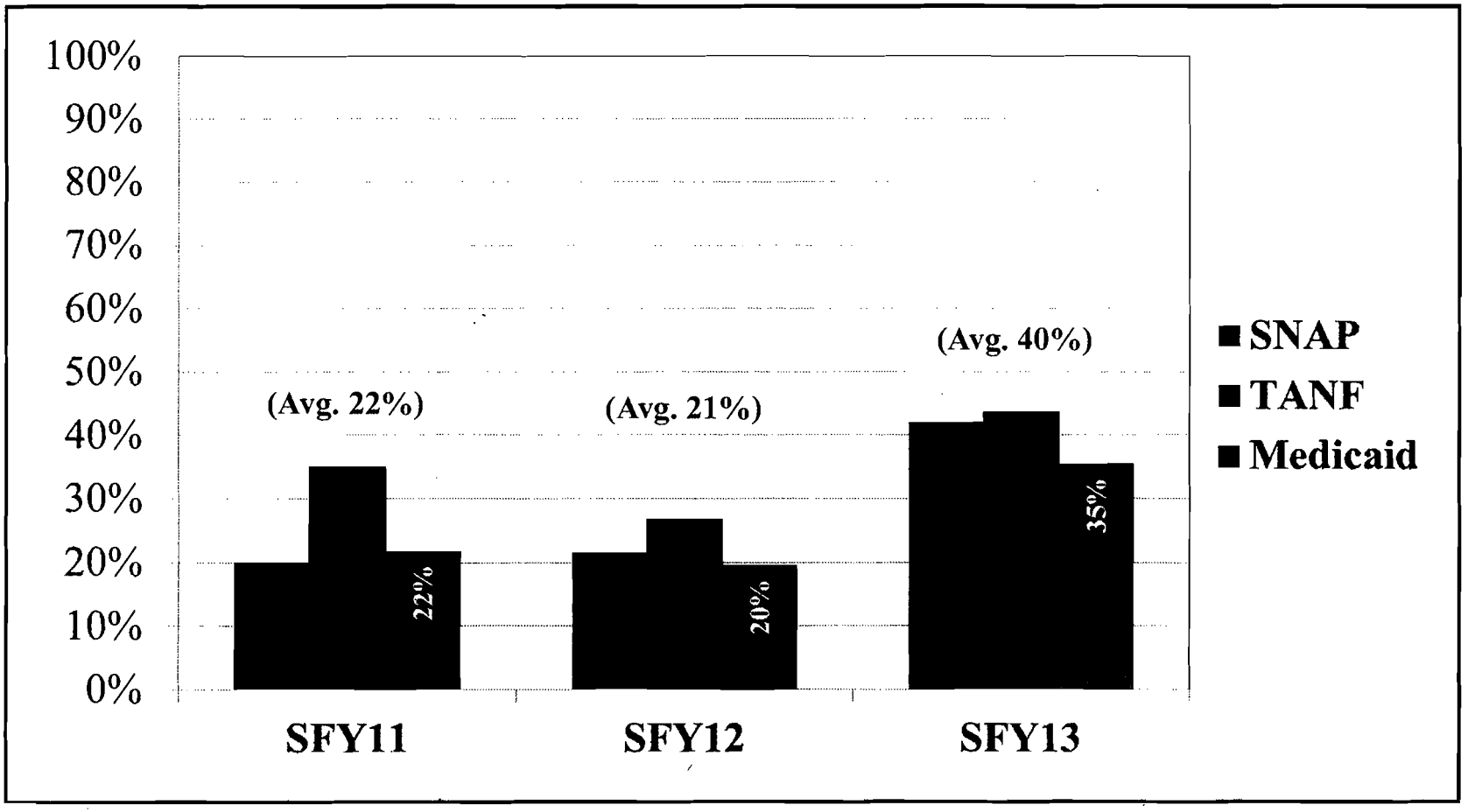


% of Fraud Referrals which become Fraud Cases



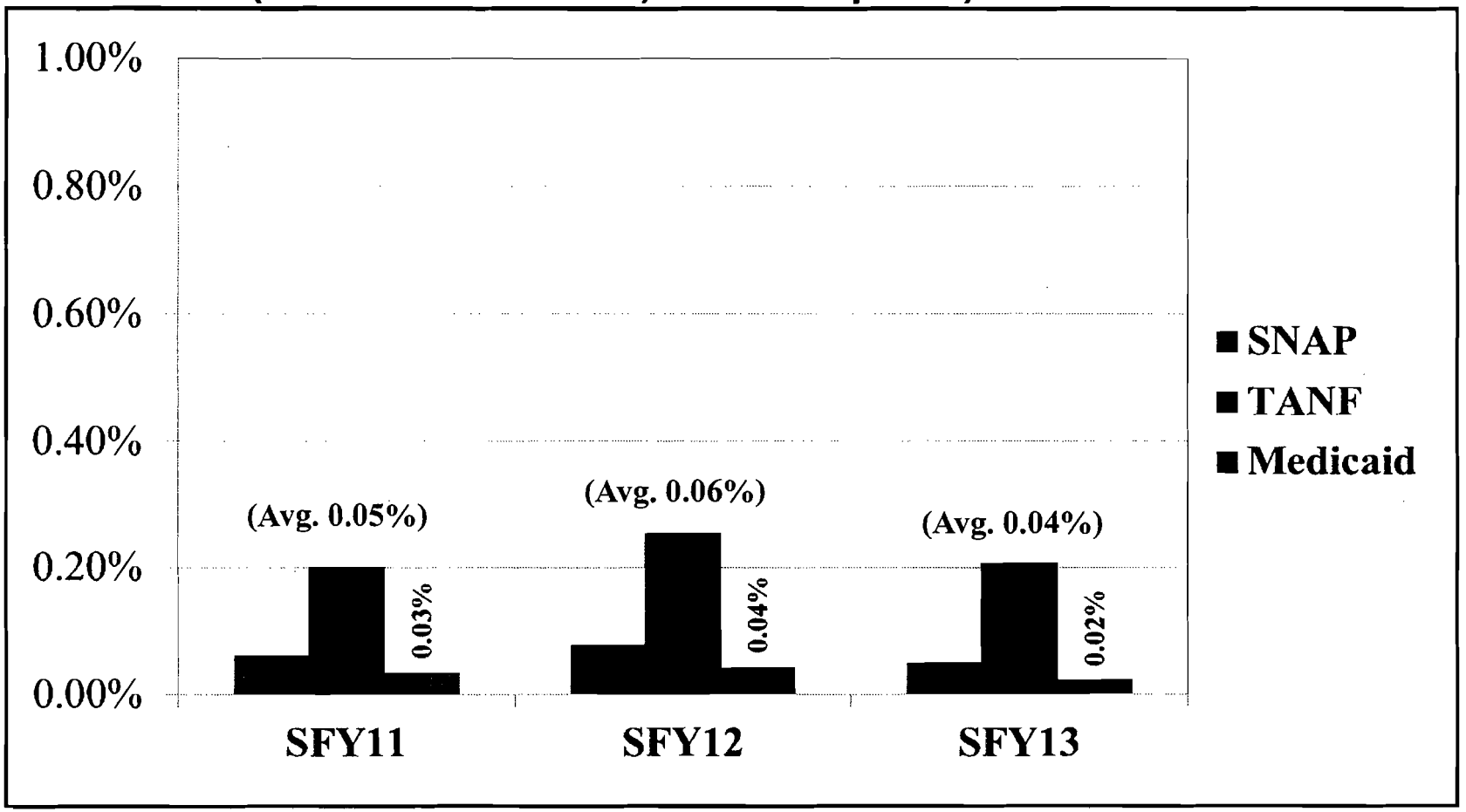
Cost Per Fraud Case Established SFY13: $556

% of Substantiated Cases

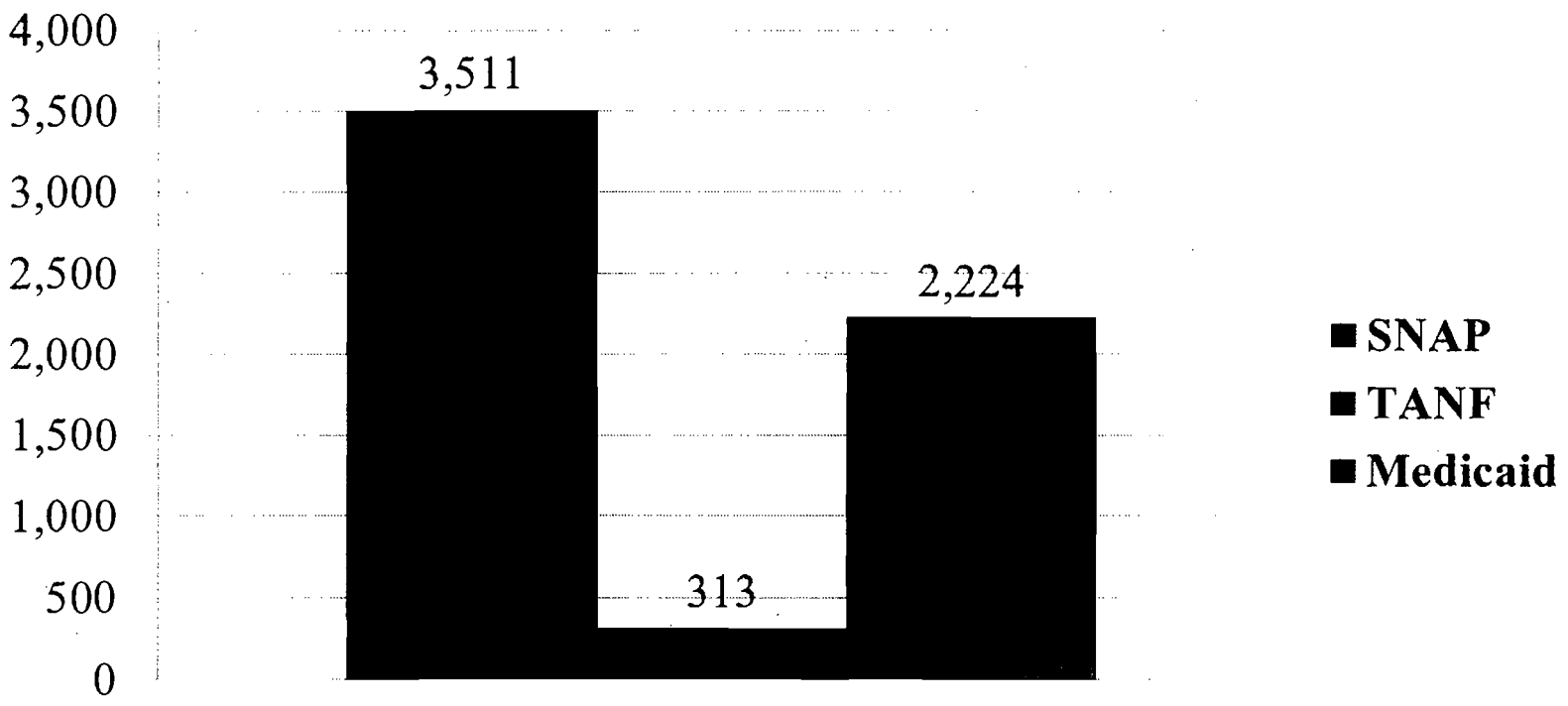


% of Recipient Fraud by Program

(Substantiated Cases / Total Recipients)

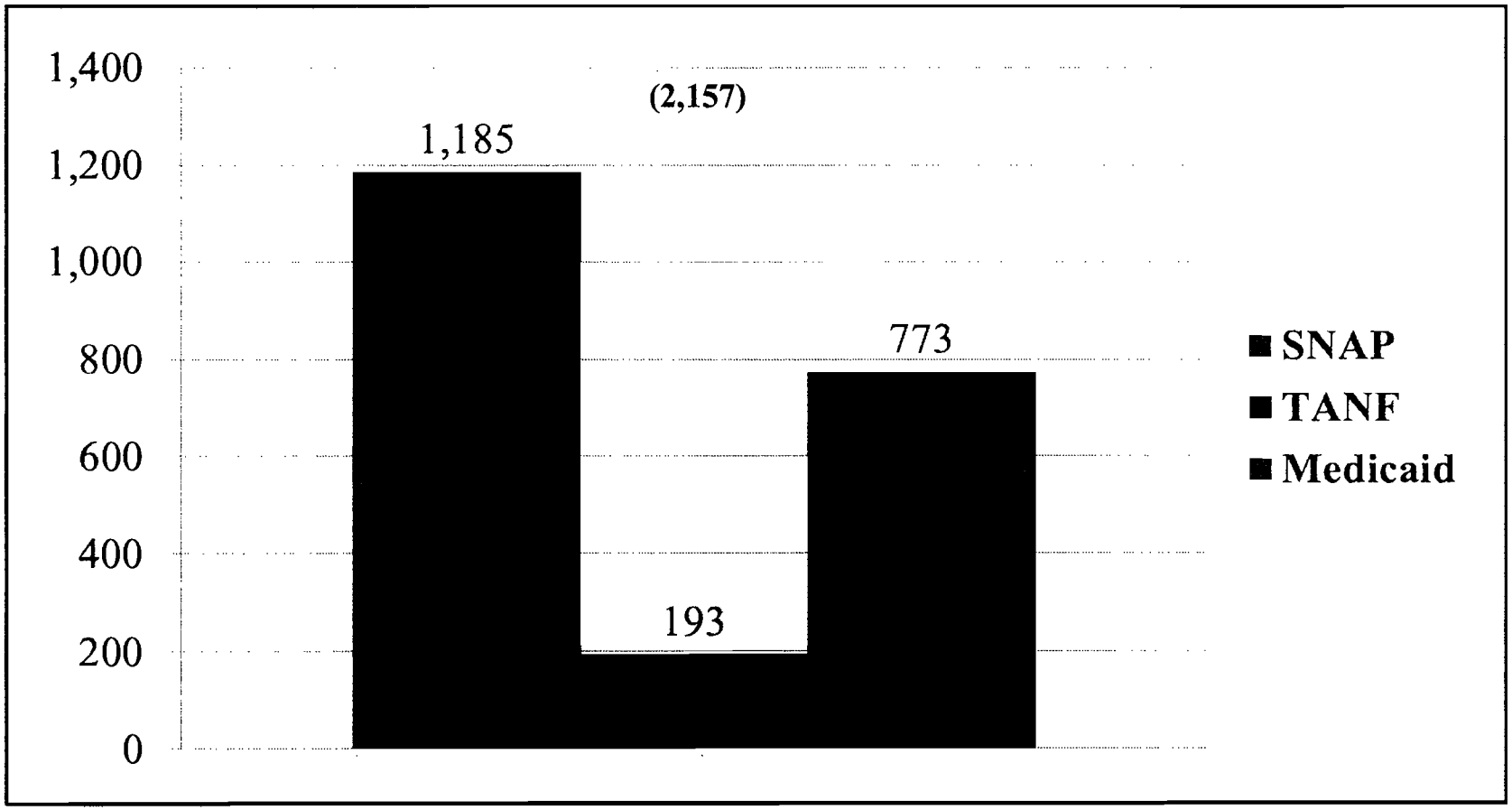


Open Fraud Cases (June 2013)

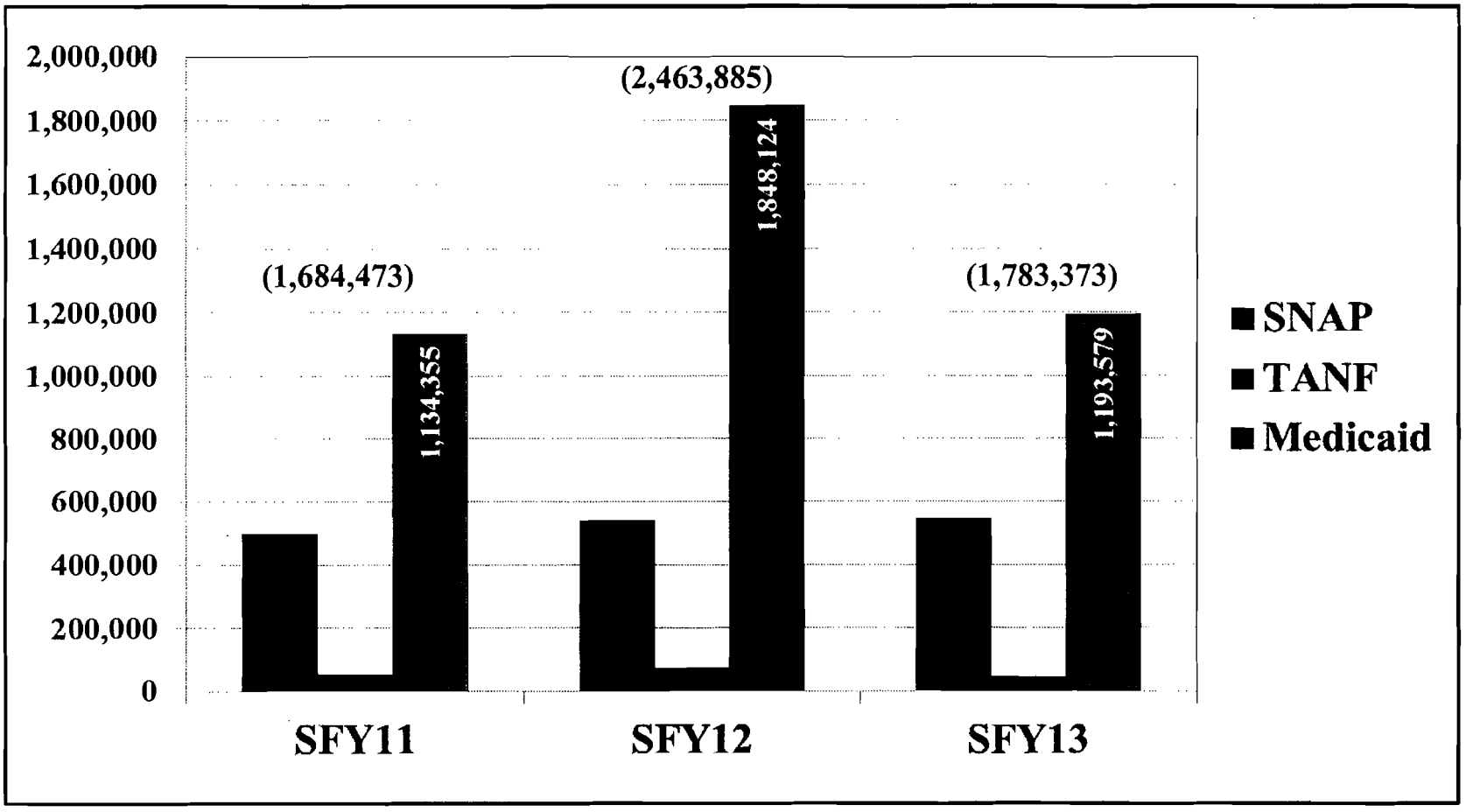


Average Days Open for Fraud Cases: 336

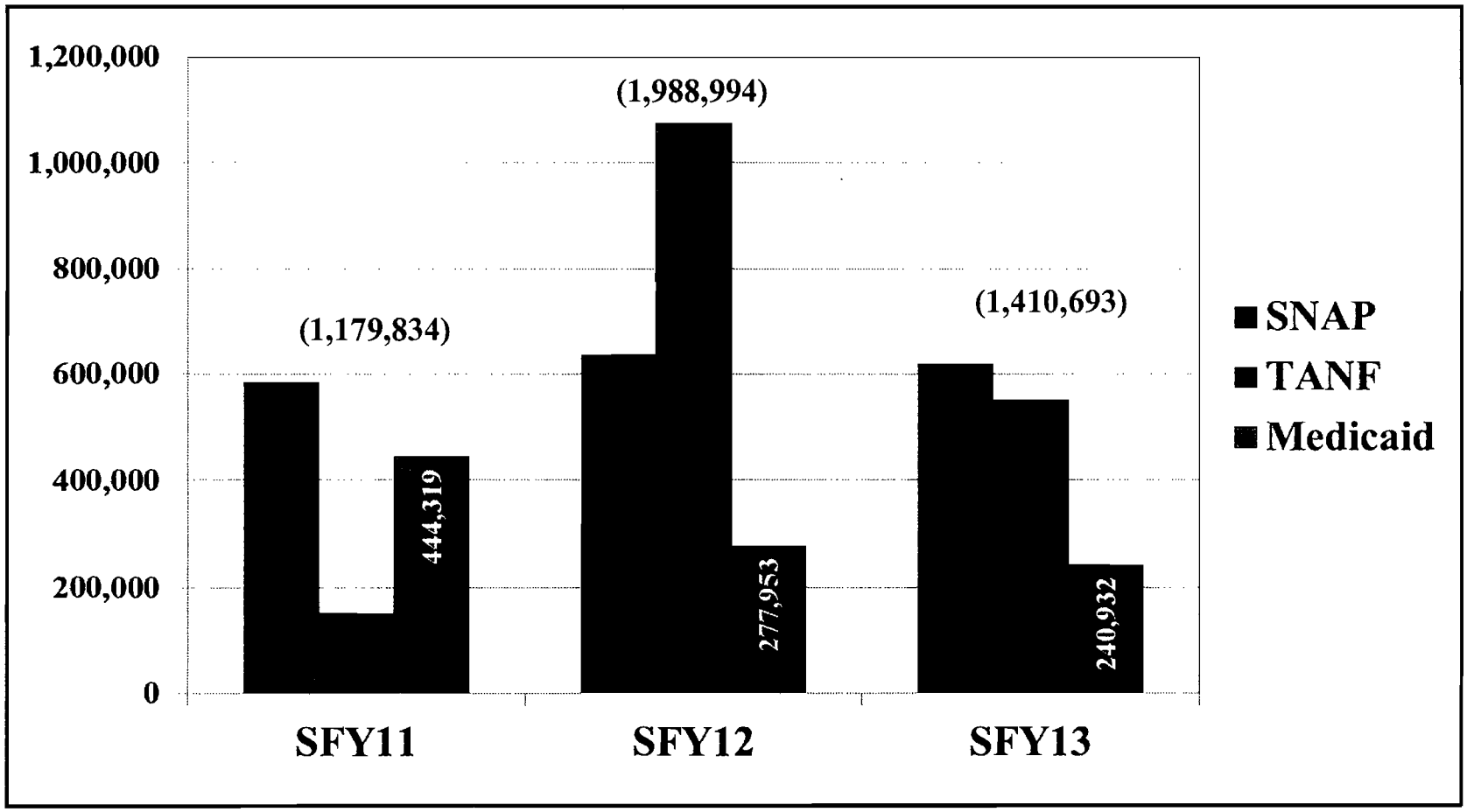
Cases Closed (Last 12 Months)



Claims by Program



Collections by Program



Fraud Case Example

FSSA received a fraud referral (06/2008) stating Jessica was living with her husband Mark and sons in Lafayette, IN while reporting to FSSA that she was living with her parents and children in Thorntown. An investigation revealed Jessica made false and misleading statements to obtain TANF, SNAP and Medicaid benefits for which she was not entitled.

Jessica's mother admitted to investigators she wrote letters to FSSA stating her daughter lived with her in Thorntown when instead Jessica and her sons were living in Lafayette with Mark. Mark stated his signature was forged on several documents given to FSSA by Jessica and he had no idea his wife forged his signature to receive FSSA benefits. Because of a felony drug conviction Mark is not eligible for SNAP, but his income does counted toward the household's income.

Jessica admitted to giving forged and falsified letters to her caseworker and to making false and misleading statements to FSSA to receive benefits. Jessica was convicted of Welfare Fraud (IC.35-43-5-7), a Class C Felony on January 27, 2012 and sentenced to two years at the Indiana DOC.

Restitution ordered: SNAP $12,175.00, TANF $ 5,184.00, Medicaid $26,326.78
Total Overpayment: $43,685.78

Fraud Case Example

In June, 2010, Kenneth reported to DFR he got married and he and his son moved in with his new wife. Kenneth told DFR his wife worked for a gold and rare coin store in Mishawaka, IN. Kenneth used the address of the coin shop in applying for benefits. Kenneth claimed he and his son lived in a rented room in the back of the business. The only income Kenneth disclosed to DFR was Social Security Disability payments. Kenneth's caseworker suspected he was a partner in the business, and was not disclosing possible income to DFR and referred the situation for investigation. Kenneth received SNAP, TANF and Medicaid benefits.

The investigation revealed Kenneth owned a gold and coin store with a second location in Goshen, IN. The business income was proven by examining paid expenses, including vacations, vehicles and gambling winnings and losses. For example, cash transactions reported by an area casino far exceeded the amount of public assistance Kenneth received during this investigation period. From March 2006 to December 2009, Kenneth submitted W-2 showing $242,321.00 in winnings.

A criminal charge alleging Welfare Fraud was filed against in St. Joseph County Superior Court. In January, 2012, the U.S. Attorney filed three counts of tax evasion, one count of Social Security fraud, and one count of bankruptcy fraud, in US District Court.

As a condition of a federal plea agreement, the state was made whole. The Welfare Fraud consisted of SNAP $11,901.61, TANF $1,701.00 and Medicaid $ 50,790.00 (Grand Total $ 64,392.61).

On February 16, 2012 a restitution check for $64,392.61 was sent to FSSA. Kenneth was sentenced to 2 years in federal prison.

Recipient Education and Training

Updated *Rights and Responsibilities*:

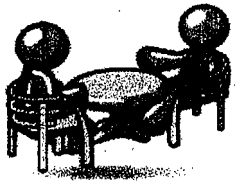
- The State update the *Rights and Responsibilities* document to include information regarding appropriate card usage (i.e. location and new definitions of trafficking), reporting changes (frequency/type).
- The State revised the EBT card flier to help make fraudulent language more understandable.
- Notification of appropriate EBT card usage is included with all new and replacement cards sent to recipients of SNAP and TANF benefits.

EBT Card Mailing Insert

IMPORTANT INFORMATION ABOUT YOUR INDIANA EBT CARD AND BENEFITS

KEEP YOUR CARD

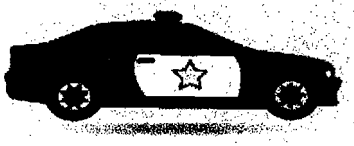
- Your card never expires, even if you are no longer eligible for benefits
- If you order four or more cards in a calendar year, you may be required to complete an interview with FSSA staff to explain why you have had excessive card replacements



ILLEGAL USE OF BENEFITS

Illegal use of your benefits includes:

- Selling, trading or giving away your benefits
- Allowing a retailer to buy your SNAP benefits in exchange for cash or non-food items
- Using or buying someone else's benefits



ILLEGAL TANF WITHDRAWALS

Even if you see the Quest logo, it is a **Class C misdemeanor** to withdraw cash at ATMs in:

- Liquor stores
- Bars, nightclubs
- Private clubs and lodges
- Casinos, horse racing tracks, off-track betting parlors
- Bingo halls
- Gun stores
- Adult entertainment venues

CONSEQUENCES FOR MISUSING YOUR BENEFITS

- Misuse of your benefits can lead to fines and disqualification from the programs
- A person convicted of a Class C misdemeanor for illegal TANF withdrawals can be jailed for up to 60 days and fined up to $500
- The State can forward cardholder information to the county prosecutor for potential prosecution for misuse of SNAP or TANF benefits

INC12166

Right Choices Program (RCP)

- RCP is a medical review and administrative mechanism that identifies members who use IHCP services more extensively than their peers. It is a safeguard against unnecessary or inappropriate use of Medicaid services.
- Restrictions are implemented for those members who would benefit from increased care and coordination. Members are assigned to:
  - One primary medical doctor
  - One pharmacy
  - One hospital
- Actions that may be considered in screening for the RCP program my include: utilization of the ER and/or controlled substances, number of prescribers, number of PMP changes and number of pharmacies, inpatient hospital services, etc.

FSSA Eligibility Process

- **Semi-Annual Redetermination**

  Supplemental Nutrition Assistance Program (SNAP)

- **Annual Eligibility Redetermination:**
  - Medicaid
  - Supplemental Nutrition Assistance Program (SNAP)
  - Temporary Assistance for Needy Families (TANF)

- **Data Matching:**
  - Death
  - Prisoner
  - Social Security
  - Wages (VA, Unemployment)

  Social Media Monitoring

Indiana Family and Social Services Administration

Questions?

July 22, 2013 Health Finance Commission Exhibit 2

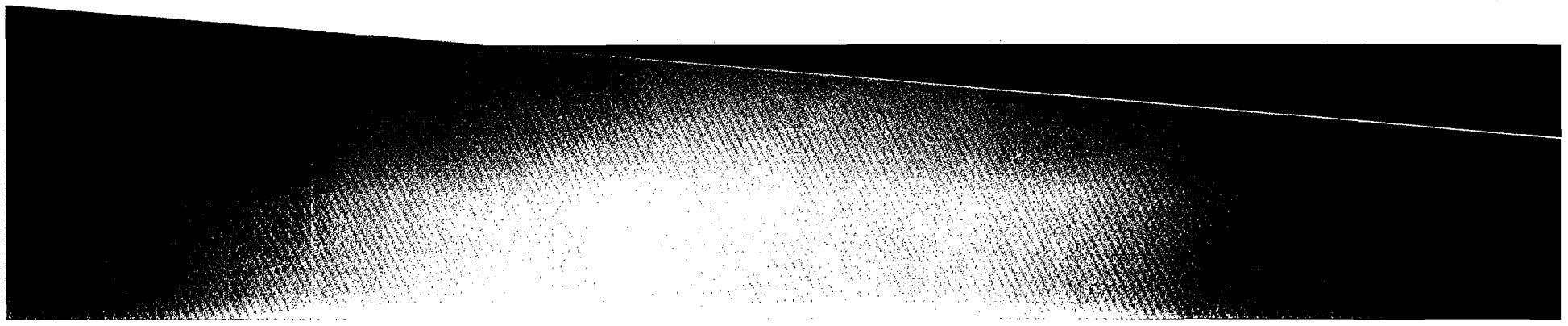
Indiana Department of Insurance

Health Finance Commission Update

July 22, 2013

Logan P. Harrison
Chief Deputy Commissioner of Insurance
lharrison@idoi.IN.gov

Indiana Rate Shock



Department of Insurance Analysis

- The Department of Insurance's chief, in-house actuary has concluded that individual health insurance rates in Indiana will increase ***72% on average*** as a result of Affordable Care Act (ACA) for the 2014 plan year

- For small group insurance rates in Indiana, rates will increase ***8% on average*** as a result of ACA for the 2014 plan year
  - The rate shock was not as dramatic for these products because small group health insurance was guaranteed to be issued to eligible employers who were providing coverage to their employees in Indiana

- By contrast, before 2014 individual health insurance can exclude people who have preexisting health conditions

New Taxes & Fees Leading to Increased Premiums

- Annual Fee on Health Insurance Providers (ACA Section 9010)
  - $8 billion nationwide tax assessment in 2014, increasing to $14.3 billion in 2018
    - Indiana's carriers will bear approximately $220 million
- Temporary Reinsurance Program Collections (ACA Section 1341)
- "Cadillac Tax" Excise tax on high value plans (ACA Section 9001)
- Comparative Effectiveness Research Assessment (ACA Section 6301)
- Limitation on deductibility of remuneration to highly paid individuals (ACA Section 9014)

Source: Milliman Comprehensive Assessment of ACA Factors, April 25, 2013
Source: NAIC HCRAWG
State Rate Review Subgroup;
http://www.naic.org/documents/committees_b_ha_tf_related_docs_aca_fees.pdf

Indiana's Method

- Indiana took the average per member per month (PMPM) base line rate of $251 for 2012 and compared it with the 2014 PMPM of $536, in which the IDOI deems actuarially justified

- This method only accounted for insurers who are ***still writing business*** in this line of insurance and ***will remain*** in 2014

72% Individual Increase Breakdown

- 72% increase does not include any changes due to trend
  - In the future, the primary change will be trend
  - Other smaller changes may occur in the future as reinsurance goes away and assumptions are fine tuned

72% increase primarily in year 1 (2014)	% Increase
Market Issues	52%
Morbidity	17%
Other Cost of Care	5%
Benefit Changes	-4%
Miscellaneous - New Taxes & Fees	2%

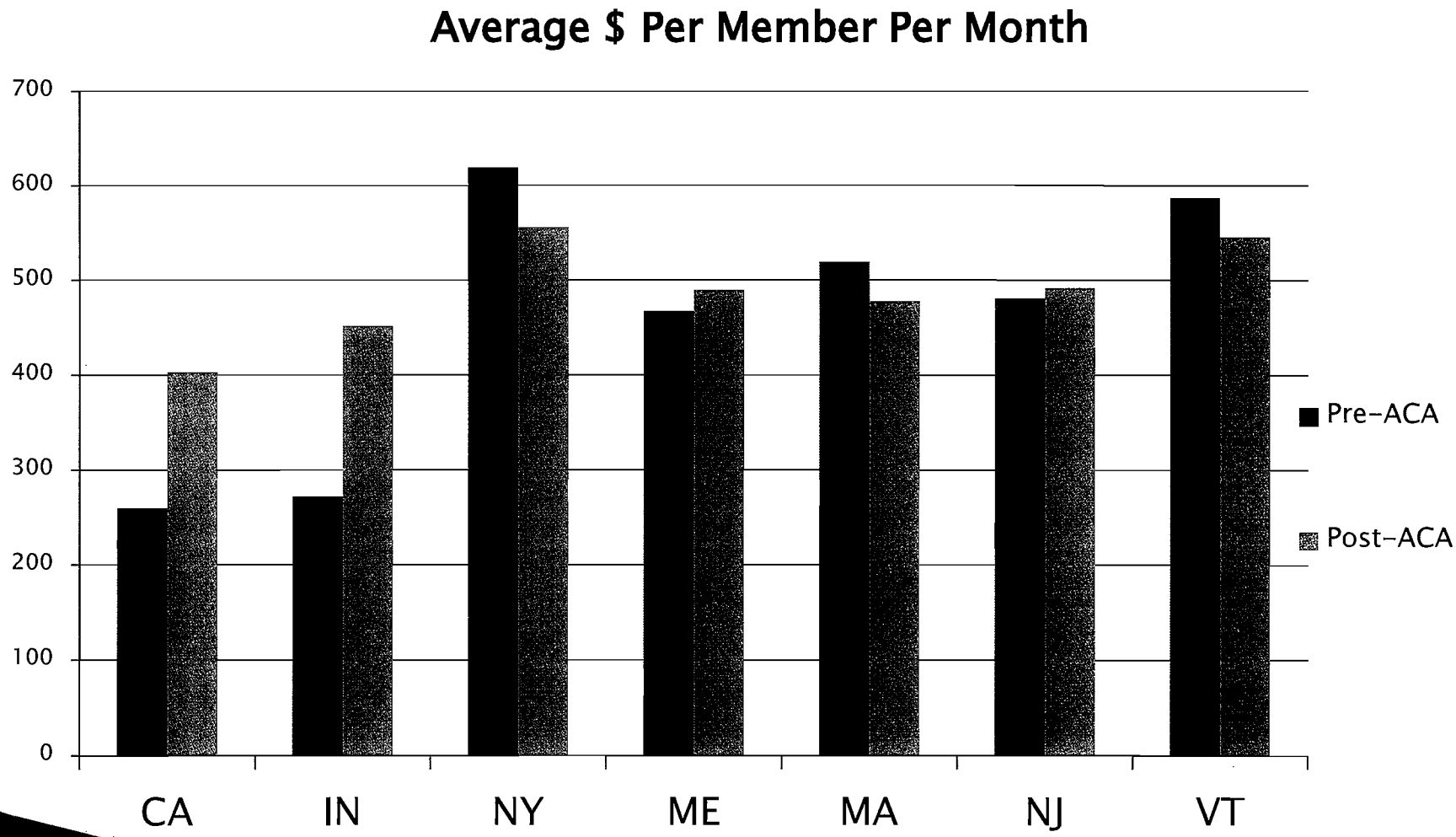
8% Small Group Increase Breakdown

8% increase primarily in year 1 (2014)	% Increase
Morbidity Issues	8%
Network Cost Savings	-2%
Miscellaneous - New Taxes & Fees	2%

Society of Actuaries' (SOA) Method

- By contrast, the SOA did a similar PMPM analysis
  - Analysis included insurers who were writing business in 2012
  - Analysis does not account for insurers who will not be writing business in 2014 due to market withdrawal
    - For example, 17 companies have withdrawn from Indiana's individual health insurance market and 10 have withdrawn from the small group market since ACA became law on March 23, 2010
- Using SOA's method, which is similar to Ohio's projected ACA rate analysis, Indiana's individual health insurance rates will increase 97% on average for 2014
- IDOI's official actuarial projection is 72%

Pre & Post ACA Premiums



Society of Actuaries, Cost of the Future Newly Insured under the Affordable Care Act (ACA) March 2013

Comparing State Rating Practices

State	Individual Market Rating Limit	State High Risk Pool	SOA % Projected Change in Non-Group PMPM
CA	NRS: No Rating Structure	YES	55.2%
IN	NRS: No Rating Structure	YES	66.4%
ME	ACR: Adjusted Community Rating	NO	4.7%
MA	ACR: Adjusted Community Rating	NO	-8.0%
NJ	C: Pure Community Rating	NO	2.2%
NY	C: Pure Community Rating	NO	-10.1%
VT	C: Pure Community Rating	NO	-7.1%

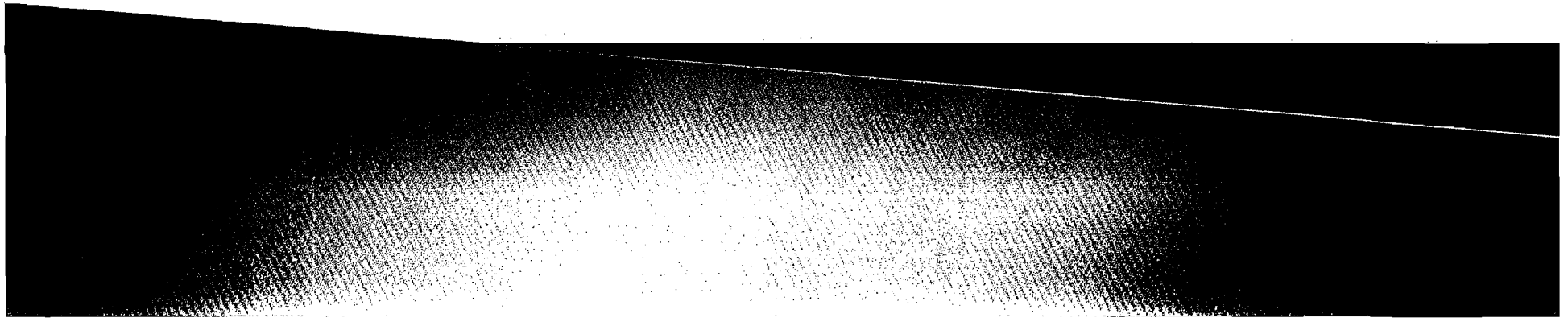
Society of Actuaries, Cost of the Future Newly Insured under the Affordable Care Act (ACA) March 2013

Indiana Index Rates PMPM

MD Wise (HMO)	N/A	$534	N/A	N/A
Coordinated Care (HMO)	N/A	$567	N/A	N/A
Physicians Health Plan of Northern Indiana	$148	$389	$358	$448
Anthem Insurance Companies, Inc.	$255	$541	$349	$494

IDOI Responsibilities

Federally Facilitated Marketplace



IDOI Responsibilities with Federally Facilitated Marketplace

- IDOI maintains jurisdiction for all IN plans:
  - Licensure
  - Rate review
  - Financial solvency
  - Coordination with Federal Marketplace

- Overall responsibility for market
  - Ensure that outside market is not at a disadvantage
  - Review of enrollment requirements
    - Open Enrollment Periods

House Enrolled Act 1328

- Signed by Governor Pence on May 11, 2013
  - Prevents ceding State authority to the federal government

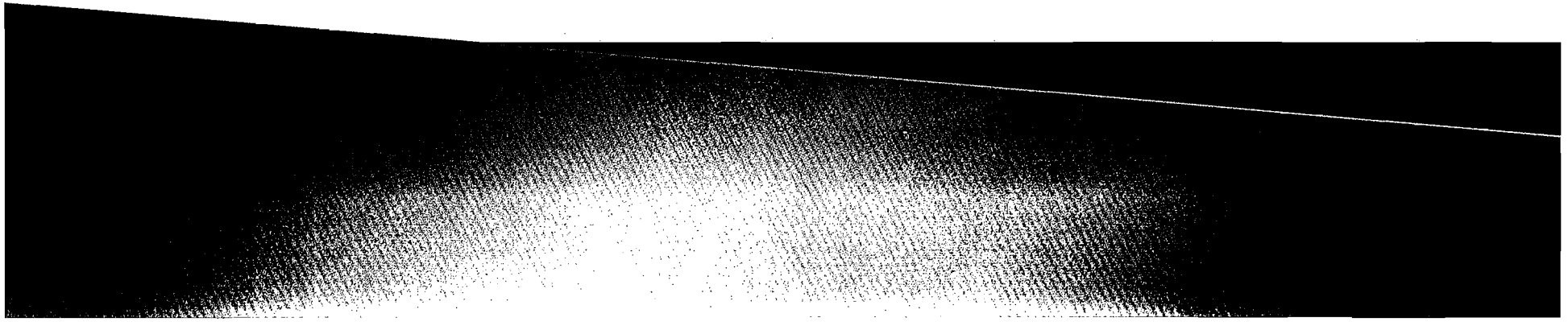
- Key policies of Legislation
  - Level Playing Field Provisions
  - Dissolution of Indiana Comprehensive Health Insurance Association (ICHIA)
  - Federally Facilitated Marketplace (FFM) Provisions
  - Consumer Assistance Program
    - Application Organization
    - Navigator

Rate Review Process Timeline

- Companies have filed with the Indiana Department of Insurance for review as required by State law
  - July 31, 2013 – Deadline for the Department to submit final rate dispositions to the federal government
    - IDOI will submit FFM plans to the federal government authorities before July 31, 2013
- Upon receipt, the federal government will review all plans to determine final marketplace participation

Marketplace

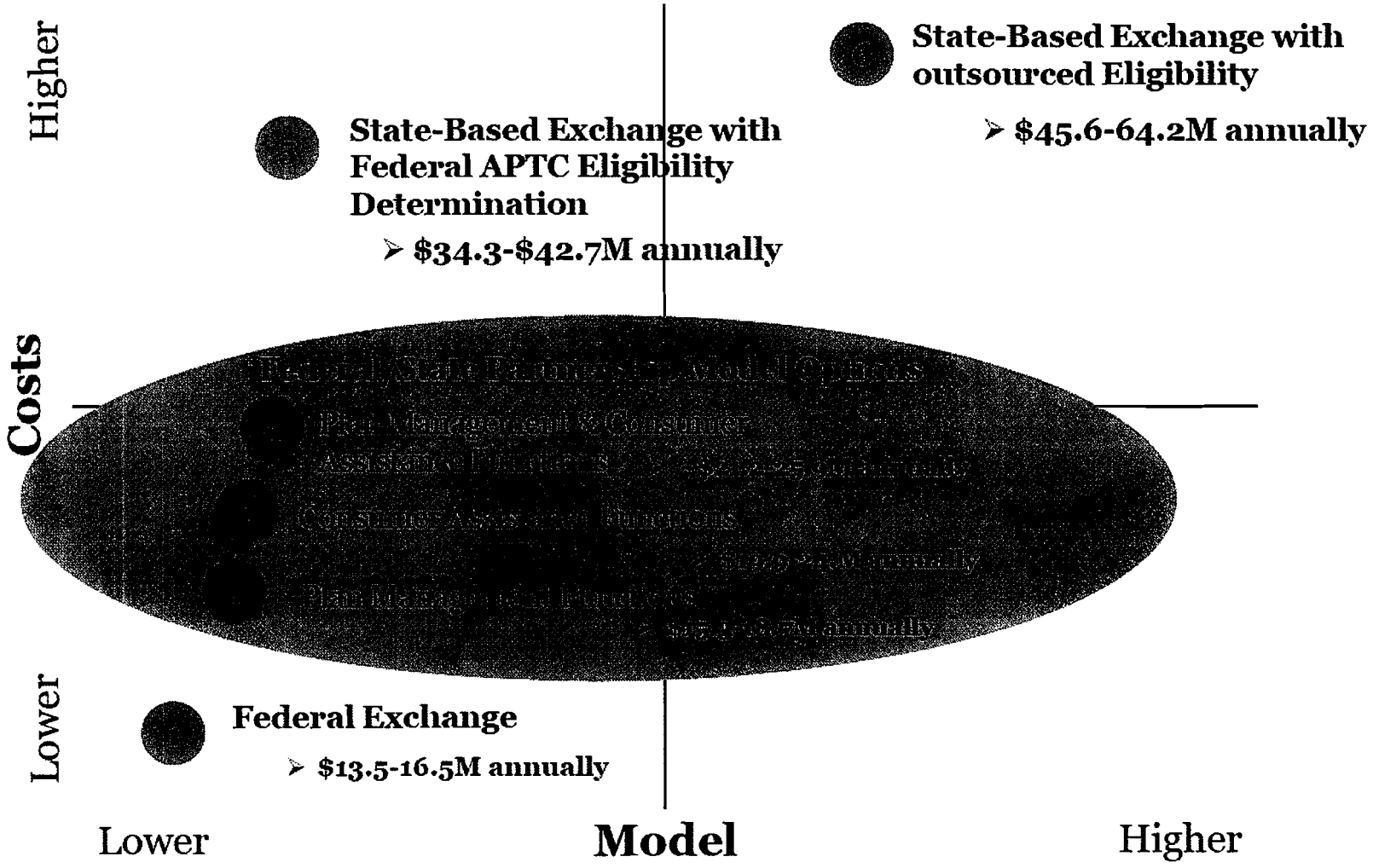
Understanding the Implications for Indiana



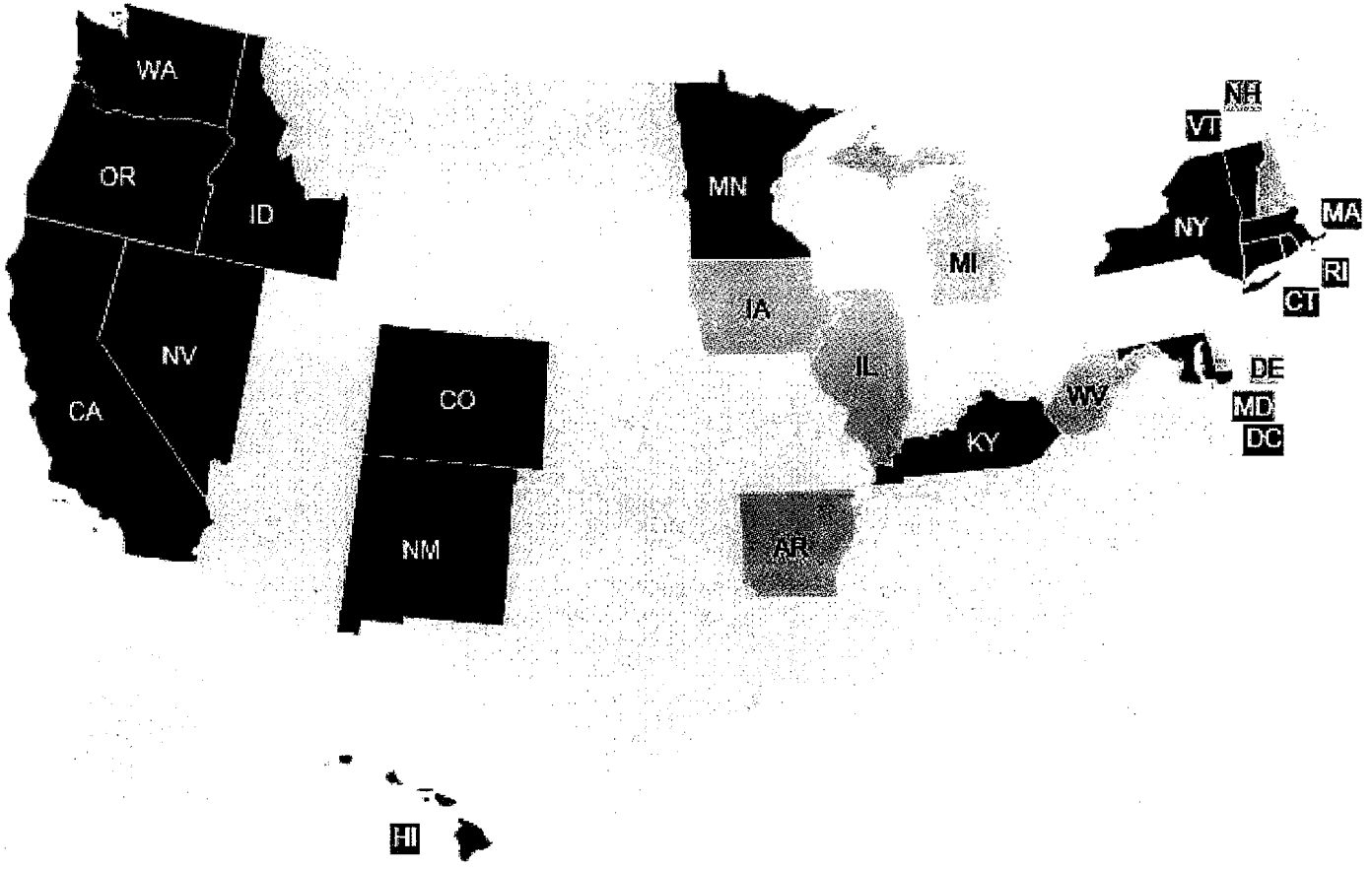
Indiana Decision

- Indiana declined to operate a State Based Marketplace
- $45.6-64.2MM needed annually to operate a state based marketplace
  - No ascertainable metric that Hoosiers would benefit from incurring the cost of operating the Marketplace
    - No evidence it would lower costs or premiums for Hoosiers
    - No policy or operational authority at State-level

Exchange Models- Annual Average Cost 2013 to 2017



State Decisions For Creating Health Insurance Marketplaces

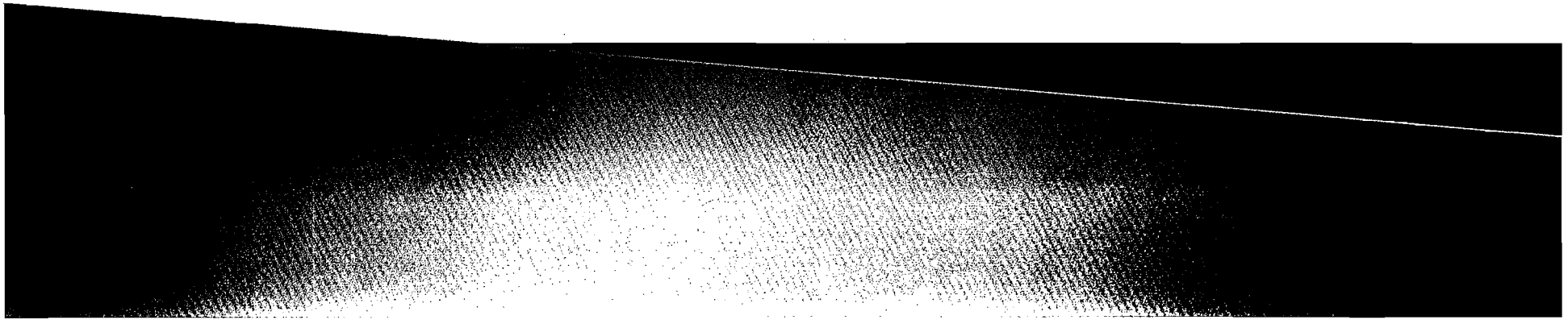


Default to Federal Exchange | Planning for Partnership Exchan | Declared State-based Exchange

As of May 28, 2013: 17 Declared State-based Marketplace; 7 Planning for Partnership Marketplace; 27 Default to Federally Facilitated Marketplace; http://kff.org/health-reform/state-indicator/health-insurance-exchanges/#

Federally Facilitated Marketplace

Understanding the Implications for Indiana



Federally Facilitated Marketplace Responsibilities

- Operate a toll-free call center and website
  - Allow consumers to compare information on all available health plans as well as apply for coverage
- Determine eligibility for premium tax credits and cost-sharing reductions
  - Applies to citizens and legal residents in families with household income between 100% to 400% of the Federal Poverty Level (FPL)
- Determine exemptions from the individual mandate
- Establish a federal navigator program
- Manage Qualified Health Plans (QHPs)
  - Certifying, recertifying, and decertifying QHPs

Potential Marketplace Participants*

MD Wise (HMO)	X	N/A
Coordinated Care (HMO)	X	N/A
Physicians Health Plan of Northern Indiana	X	X
Anthem Insurance Companies, Inc.	X	X

*Pending Federal Marketplace Participation Approval

Plan Levels Offered

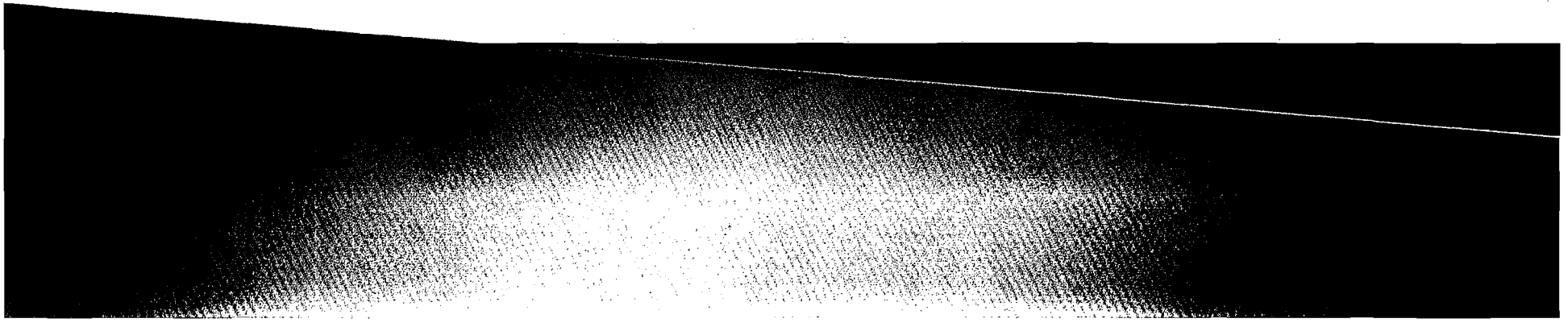
MD Wise (HMO)	**B, S, G**	**N/A**
Coordinated Care (HMO)	**B, S, G**	**N/A**
Physicians Health Plan of Northern Indiana	**C, B, S, G**	**B, S, G**
Anthem Insurance Companies, Inc.	**C, B, S, G**	**B, S, G, P**

C	Catastrophic
B	Bronze
S	Silver
G	Gold
P	Platinum

Geographic Rating & Coverage Areas

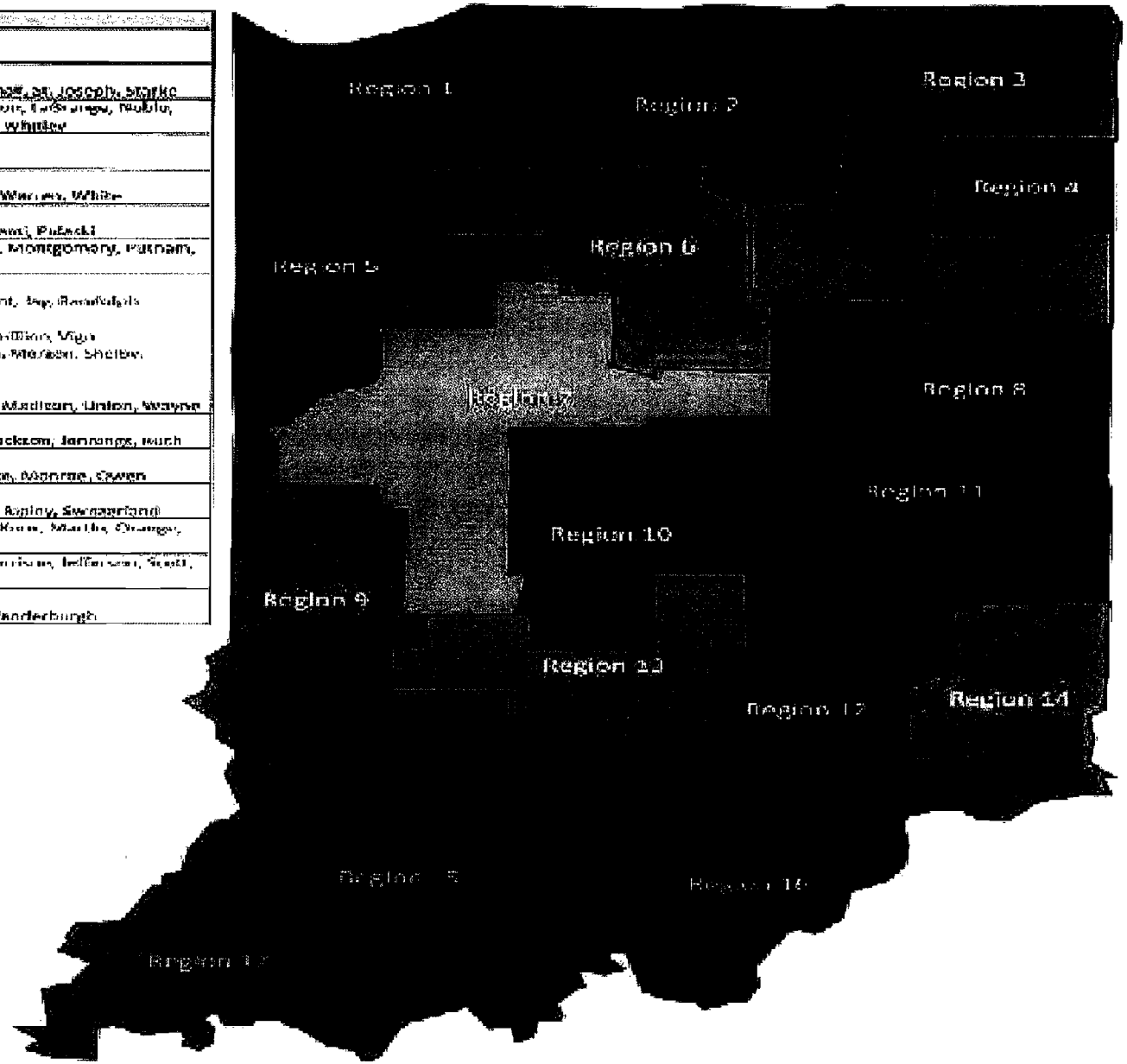
IDOI Bulletin 197

45 CFR §147.102(b)



Geographic Rating Areas in Indiana

Region	Counties
1	Lake, Lagrange, Porter
2	Elkhart, Kosciusko, Marshall, St. Joseph, Starke
3	Adams, DeKalb, Huntington, LaGrange, Noble, Steuben, Wabash, Wells, Whitley
4	Allen
5	Benton, Jasper, Newton, Warren, White
6	Cass, Fulton, Howard, Miami, Pulaski
7	Carroll, Clinton, Fountain, Montgomery, Putnam, Tippecanoe, Tipton
8	Blackford, Delaware, Grant, Jay, Randolph
9	Clay, Parke, Sullivan, Vermillion, Vigo
10	Boone, Hamilton, Marion, Morgan, Shelby, Hendricks
11	Fayette, Hancock, Henry, Madison, Union, Wayne
12	Bartholomew, Decatur, Jackson, Jennings, Rush
13	Brown, Johnson, Lawrence, Monroe, Owen
14	Dearborn, Franklin, Ohio, Ripley, Switzerland
15	Daviess, Dubois, Greene, Knox, Martin, Orange, Perry, Pike, Spencer
16	Clark, Crawford, Floyd, Harrison, Jefferson, Scott, Washington
17	Gibson, Posey, Warrick, Vanderburgh



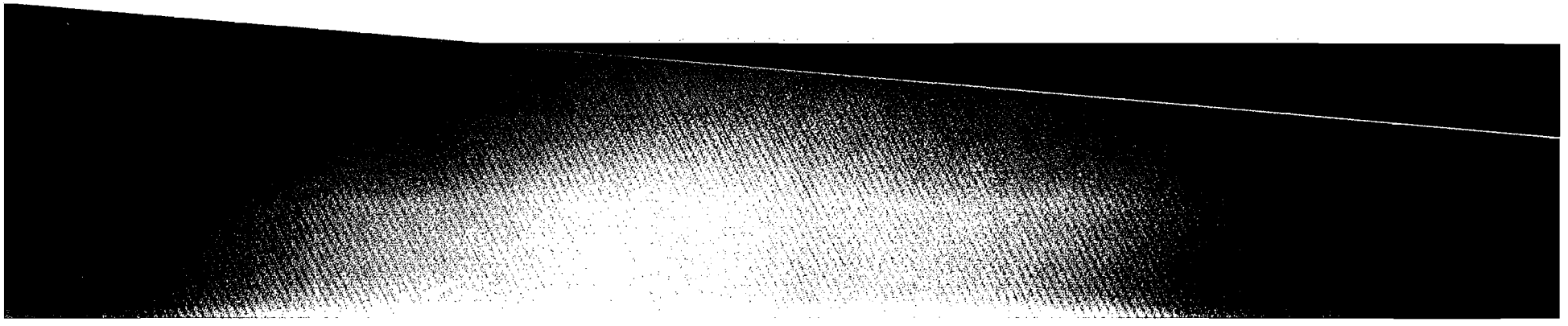
Coverage Areas

- In March 2013, the Department of Insurance issued Bulletin 197 addressing the new geographical rating areas as prescribed by the Affordable Care Act
  - Including a map of Indiana's new 17 regions or geographical rating areas
- Anthem plans will be available statewide*
- PHP will be available in regions 1-8, 10 and 11*
- MD Wise will be available in all regions, *except* for region 14*
- Coordinated Care will be available to regions 2, 3 and 4*

*Pending Federal Marketplace Participation Approval

www.Healthcare.gov

Federally Facilitated Marketplace Website



On Target for Opening the Health Insurance Marketplace

Raising Awareness/ Education

Anticipation – Get Consumers Ready

Enroll Now

June

- Launch HealthCare.gov 2.0 and CuidadoDeSalud.gov with new consumer information and web chat
- HHS Call Center opens for basic consumer questions in English and Spanish
- Consumers can sign up to receive updates and get reminders from HealthCare.gov

July

- Award $150 million to community health centers for outreach and enrollment
- Training for in-person assistance personnel begins
- Consumers can set up a personal login on HealthCare.gov

August

- Award $54 million in grants for Navigators
- Open Call Center for Small Businesses

September

- Consumers can find where to go in their community to get help

October - March

- Open enrollment
- Application and Plan Compare available
- Targeted ads

Ongoing outreach: Digital Media, Public Events, Engaging Partners

Source: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/marketplace-outreach-timeline.pdf

https://www.healthcare.gov/

HealthCare.gov | Learn | Get Insurance | Español

Individuals & Families | Small Businesses | All Topics | Search

Welcome to the new HealthCare.gov!

We've changed to help you get ready for the launch of the Health Insurance Marketplace on October 1. —including where to find some content that used to appear on this site.

The Health Insurance Marketplace is coming soon

A new way to get affordable coverage launches October 1.

Answer a few questions to learn if you qualify for lower costs.

START NOW

GET IMPORTANT NEWS & UPDATES Email Address SIGN UP

What is the Health Insurance Marketplace? | What is the Marketplace in my state? | What if I have job based insurance? | How can I get coverage at lower costs? | What do small businesses need to know?

https://www.healthcare.gov/marketplace/individual?utm_medium=er
US Government Printing... | Health Finance Commission... | SERFF - System for Electr... | Program Integrity Propos... | C-SPAN | Capitol Hill, Th... | Welcome to the Marc...
File Edit View Favorites Tools Help
Convert Select
SERFF 30 DAY CLOCK CALC HIX Home IndianaNet IGA Video Stream Indiana Department of Ins... Indiana General Assembly... LexisNexis SkyDrive SF 2010 Campus Connect Web Slice Gallery Industry News Benefit De...
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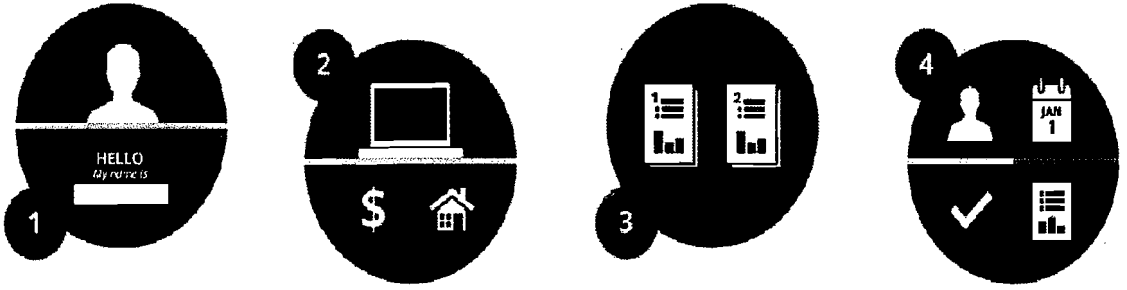
How the Marketplace works



Create an account

First you'll provide some basic information. Sign up for Marketplace emails now and we'll let you know as soon as you can create an account.

Apply

Starting October 1, 2013 you'll enter information about you and your family, including your income, household size, and more.

Use this checklist now to help you gather the information you'll need.

Pick a plan

Next you'll see all the plans and programs you're eligible for and compare them side-by-side.

You'll also find out if you can get lower costs on monthly premiums and out-of-pocket costs.

Enroll

Choose a plan that meets your needs and enroll!

Coverage starts as soon as January 1, 2014.

Learn more about the Marketplace

Questions? Live Chat
10:39 AM
6/25/2013

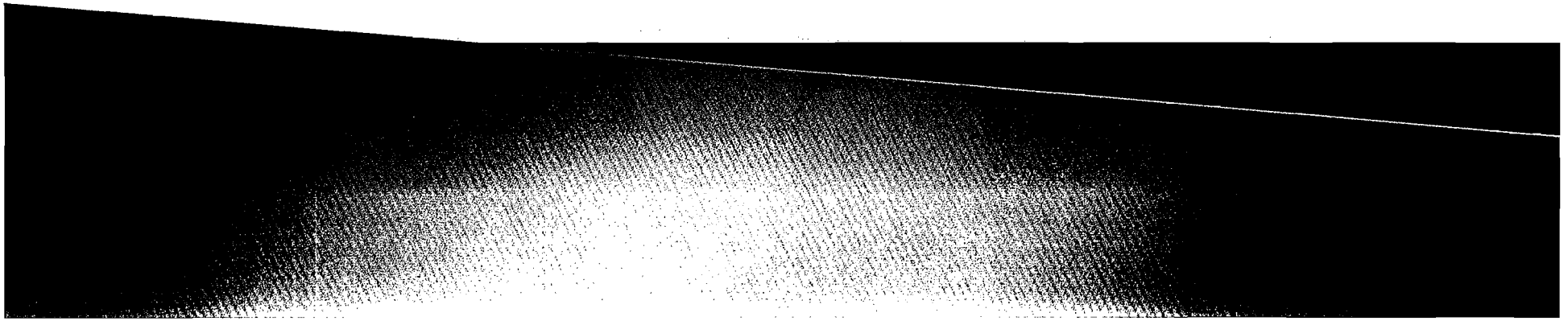
Marketplace Income Verification

- Obama administration has contracted with Equifax Workforce Solutions, a credit reporting agency, to help verify the incomes of people who apply for federal subsidies to buy insurance under the new health care law

- Federal officials will rely on company to verify income and employment
  - Provide information that is more current than what is available on federal income tax returns
  - Provide income information "in real time," usually within a second of receiving a query from the federal government

SHOP Marketplace

Small Business Health Options Program



Employer Mandate Delayed Until 2015

- The Obama administration delayed a key provision of the Affordable Care Act, giving businesses an extra year to comply with a requirement that they provide their workers with insurance but prolonging regulatory uncertainty crucial for business planning
  - Plan to re-vamp and simplify the reporting process
    - Some of this detailed reporting may be unnecessary for businesses that more than meet the minimum standards in the law
  - Allow employers time to test the new reporting systems and make any necessary adaptations to their health benefits

Employer Mandate Requirements

- Employers that averaged at least 50 full time employees during the prior calendar year[1] must offer health insurance or pay a penalty[2]
  - There is a formula for determining full-time equivalents (part-time workers) that could increase the total full-time employees an employer is considered to have at or above the 50 threshold, which would make this mandate applicable
  -
- Mandate specifically requires that employers must offer "affordable,[3]" "minimum value"[4] coverage to all "full-time employees"[5] and their dependents.
  - The penalty is not applicable if the employer offers the coverage, but the employee declines it
- Coverage offer must be made to at least 95% of an employer's full-time employees as defined and referenced
  - Exceptions for "seasonal employees" (i.e., Indiana agricultural community) and "variable hour employees"

[1] 26 USC § 498H(c)(2)(A).
[2] 26 USC § 498H(a).
[3] Affordable means that the employee's contribution to the health plan for their individual cost of coverage cannot exceed 9.5% of the employee's household income
[4] Minimum value means that the health plan has at least a 60% actuarial value
[5] "Full-time employee" is defined as one who works 30 hours per week or 130 hours a month 26 USC §498(H) (c)(4)(A).

Employer Mandate Penalties

- **(1) "No Coverage Penalty"**
  - Employer offers NO COVERAGE to at least 95% of its full-time employees and dependents
  - Penalty is $2,000.00 times ALL of the full-time employees the entity has with the first 30 employees exempted from this calculation divided by the number of months in a calendar year with "no coverage"

- **(2) "Inadequate Coverage Penalty"**
  - Coverage is "unaffordable" (more than 9.5% of one's household income) or
  - Coverage is not the minimum 60% actuarial value coverage
    - Penalty is $3,000.00 times just the number of employees who are receiving subsidized exchange coverage (Advanced Premium Tax Credit or reduced cost-sharing) divided by the number of calendar months with no "adequate coverage"
      - "Inadequate coverage" also requires the employer to pay a $3,000.00 penalty if someone not covered who qualifies for a subsidy receives coverage through the exchange even though they cover the 95% required
      - The "inadequate coverage" penalty cannot exceed the "no coverage" penalty.

Premium Tax Credits Trigger Employer Fines

- Individuals without affordable employer coverage have access to a Premium Tax Credit (PTC) in the Individual Marketplace

- Employer fines are triggered if one employee, who qualifies for a federal advanced premium tax credit or a cost-sharing subsidy, seeks insurance through the exchange
  - In that instance, a fine will be levied against the employer

- If an employee has or qualifies for Medicare, Medicaid, Tricare, VA Plan, Peace Corps plan or other certain Department of Defense plans
  - Considered to have minimum essential coverage
  - Will not be eligible for advanced premium tax credits or cost sharing subsidies on the exchange
    - Any of these employees could not trigger the employer "cost-sharing" penalty.[6]

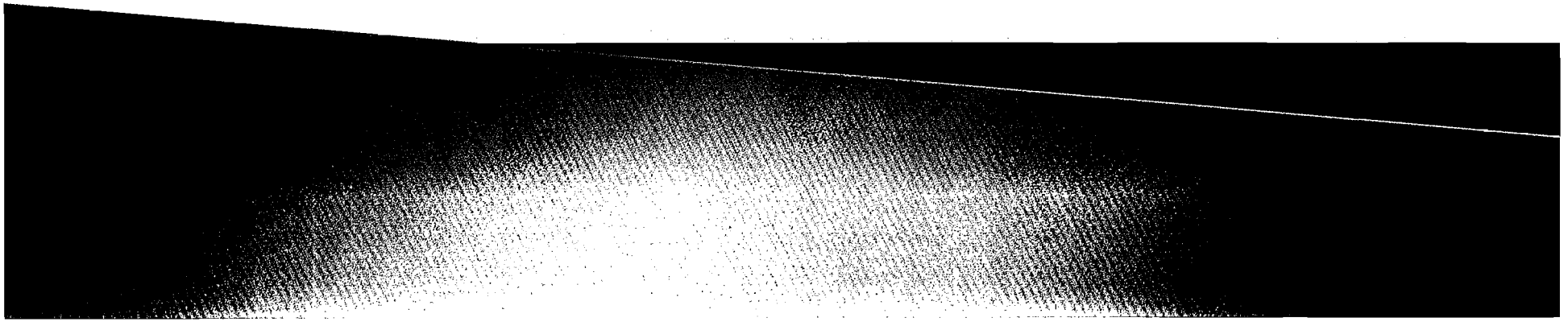
[6] 26 USC § 5000A(f).

SHOP Requirements

- 70% Minimum Participation Rate (MPR) to form a group
  - Open enrollment available throughout the year
  - Employers who do not meet MPR may enroll between November 15th - December 15th each year
- Employer may implement a new-hire waiting period
  - May not exceed 90 days
  - May only change once per year during renewal cycles
- Rates quoted at beginning of a plan year remain in effect for 12 months
  - Applies to newly eligible employees as well

ICHIA
Indiana High Risk Pool

Indiana Comprehensive Health Insurance Association



ICHIA Dissolution

- Effective January 1, 2014, insurance companies **cannot refuse** to sell coverage or renew policies because of an individual's pre-existing conditions
  - Plans cannot impose annual or lifetime dollar limits on the amount of coverage an individual may receive.

- Based on these provisions, ICHIA coverage will no longer be needed in Indiana
  - The Federally Facilitated Marketplace will be a way for all individuals to purchase health insurance

ICHIA Town Hall Schedule

- **Terre Haute**: July 1, 2013 from 6:00 – 7:45 pm at the Vigo County Public Library located at One Library Square (7th & Poplar), Terre Haute, IN 47807 (Room B & C)

- **Rochester:** July 8, 2013 from 6:00 – 7:45 pm at the Fulton County Public Library located at 320 W. 7th Street, Rochester, IN 46975 (Room B)

- **Richmond:** July 10, 2013 from 5:30 – 7:30 pm at the Morrison-Reeves Library located at 80 W. 6th Street, Richmond, IN 47374 (Board Room)

- **Indianapolis:** July 16, 2013 from 6:00 – 8:00 pm at the Indianapolis Central Library located at 40 E. St. Clair Street, Indianapolis, IN 46204 (Riley Room)

- **Salem:** July 24, 2013 from 5:30 – 7:00pm at the Salem-Washington Township Public Library located at 212 N. Main Street, Salem, IN 47167

Contact

Logan P. Harrison

Chief Deputy Commissioner

Indiana Department of Insurance

Lharrison@idoi.in.gov

In both ASCs and physician offices, a CRNA may administer anesthesia if the CRNA acts under the direction of and in the immediate presence of a physician. Following is a comparison of the statutory and regulatory requirements that apply when a physician directs a CRNA in an ASC vs. a physician office.

Ambulatory surgical centers	Physician offices
A physician with specialized training or experience in the administration of an anesthetic must supervise the administration of the anesthetic and remain present in the facility during the surgical procedure.	A physician with appropriate education and training must direct or supervise the administration of an anesthetic and remain physically present during the operative period and be immediately available until the patient is discharged from anesthesia care for diagnosis, treatment, and management of complications or emergencies. A physician who directs the administration of anesthesia must: • Be able to rescue patients who enter a deeper-than-intended state of sedation. "Rescue" means an intervention by a physician proficient in airway management and advanced life support that corrects the adverse physiologic consequences of the deeper-than-intended level of sedation and returns the patient to the originally intended level of sedation. • Be knowledgeable about the risks of regional anesthesia and the interventions required to correct any adverse physiological consequences that may occur. • Maintain current training in advanced resuscitation techniques, such as ACLS or PALS. • Be physically located within the office-based setting and prepared to immediately conduct hands-on intervention if needed. This means that the physician may not be engaged in other activities that could prevent the physician from being able to immediately intervene. • Perform a preanesthetic examination and evaluation or ensure that it has been appropriately performed by a qualified health care provider. • Develop the anesthesia plan or personally review and concur with the anesthesia plan if the plan has been developed by a CRNA • Assure provision of appropriate postanesthesia care. • Ensure that a patient's informed consent for the nature and objectives of the anesthesia is obtained in writing before the procedure is performed.

HFC, 7/22/13 Exhibit 3

PHYSICIAN ANESTHESIOLOGISTS AND NURSE ANESTHETISTS: FOR THE HEALTH AND SAFETY OF PATIENTS, DIFFERENT TRAINING AND EDUCATIONAL BACKGROUNDS SHOULD MEAN DIFFERENT LEVELS OF RESPONSIBILITY

Patients should know the educational and training backgrounds of their health care professionals and the important impact it could have on their health and safety. Consider the vast difference between Physician Anesthesiologists (Physicians) and Nurse Anesthetists (Nurses):

EDUCATION	**PHYSICIAN ANESTHESIOLOGISTS (PHYSICIANS)**	**Nurse Anesthetists (NURSES)**
Initial Education	Bachelor's degree	Associate degree in nursing, a non-degree diploma from an in-hospital nurse training program, or a Bachelor of Science in Nursing[1]
Doctoral or Graduate Degree	**Doctor of Medicine or Osteopathic Medicine; 4 years**	Graduate Nursing Degree: 2-3 years[2]
Post-Doctoral Internship in General Medicine	**1 year**, required[3]	**NONE REQUIRED**
Post-Doctoral Residency in Anesthesiology	**3 years**, required[4]	**NONE REQUIRED**
Total hours of patient care required during training	**12,000 – 16,000 hours**[5], including 3 months pain management training (acute & chronic), 4 months critical care management, and at least 2 months each in: obstetric anesthesia, pediatric anesthesia, cardiothoracic anesthesia, and neuroanesthesia[6]	~1,650 hours[7]

[1] American Medical Association, "Nurse Anesthetists," *Scope of Practice Data Series*, p. 21 (2009).
[2] Id.
[3] American Society of Anesthesiologists President Dr. Mark Warner, letter to Federal Trade Commission Director Susan S. DeSanti, 19 Jan. 2011, p. 4 (Washington, DC).
[4] Id.
[5] American Medical Association, "Do you know your doctor?" p. 1 (2012).
[6] Accreditation Council for Graduate Medical Education, "ACGME Program Requirements for Graduate Medical Education in Anesthesiology," p. 5 (2008).
[7] "The results of an analysis of anesthesia hours reported by 2010 graduates show that nurse anesthesia students receive a median of 1,651 hours of clinical experience." American Association of Nurse Anesthetists,

Clinical experience required in pain management	Anesthesiology residents are required to treat no fewer than 20 patients evaluated for management of acute, chronic, or cancer-related pain disorders during a specified **3-month period**, all while under the direction of faculty physicians with expertise in pain medicine[8]	**NONE REQUIRED**
Subspecialty accreditation available in pediatric anesthesiology, adult cardiothoracic anesthesiology, critical care, obstetric anesthesiology, hospice and palliative medicine, sleep medicine, and pain medicine	These Board-certified subspecialties **each** require **1-2 additional years of training** after an initial 4-year residency in anesthesiology[9],[10]	**NONE REQUIRED**
Subspecialty accreditation in pain medicine	The Board-certified subspecialty of pain medicine requires **1-2 additional years of training** after an initial 4-year residency in anesthesiology[11]	**NONE REQUIRED**

While nurse anesthetists are valuable medical team members, their educational and training backgrounds are significantly different from the comprehensive medical education, training and clinical experience of physicians. In the interest of patient safety and quality of care, the American Society of Anesthesiologists believes that the involvement of a physician anesthesiologist in the perioperative care of every patient is optimal.

"Qualifications and Capabilities of the Certified Registered Nurse Anesthetist," available at http://www.aana.org/ceandeducation , accessed Feb. 21, 2013.

[8] Warner, p. 4.

[9] "Nurse Anesthetists," p. 11.

[10] ACGME website at http://www.acgme.org/acgmeweb/

[11] "Nurse Anesthetists," p. 32.

EXHIBIT 1 HFC, 7/22/13 Exhibit 4

STATE	CRNAs	POPULATION	RATIO
Michigan	1995	9,883,640	1 per 4,954
Kentucky	714	4,339,367	1 per 6,078
Ohio	1837	11,536,504	1 per 6,280
Illinois	1261	12,830,632	1 per 10,174
Indiana	266	6,483,802	1 per 24,375

NATIONALLY

Around 45,000 CRNAs
Around 45,000 Anesthesiologists

INDIANA

Around 266 CRNAs
Around 800 Anesthesiologists

SALARIES

CRNAs earn approximately 40% of the salary of anesthesiologists.

NATIONAL PRACTICE

31 States Permit CRNAs to work with Podiatrists
41 States Permit CRNAs to work with Dentists
47 States Designate CRNAs as Advanced Practice Nurses

DISTRICT	CRNAs	DISTRICT	CRNAs
Clere	14	Pat Miller	1
Davisson	2	Charbonneau	13
Bacon	4	Becker	10
Behning	0	Bray	6
Crouch	6	Grooms	14
Frizzell	2	Leising	8
Lehe	3	Pete Miller	5
Turner	4	Mishler	10
Zent	1	Breaux	1
Brown	2	Mrvan	12
Bauer	1	Stoops	0
Porter	0	Taylor	3
Shackleford	0		

EXHIBIT 2

July 2013

Summary of State Supervisory Requirements for Nurse Anesthetists In Ambulatory Surgical Facilities

No Supervision Requirement

The following **29** states, and the District of Columbia, have **no supervision** requirement concerning nurse anesthetists in nurse practice acts, board of nursing rules/regulations, medical practice acts, board of medicine rules/regulations, ambulatory surgical facility licensing statutes, ambulatory surgical facility licensing rules/regulations, or their generic equivalents:

Alaska
Arizona
California
Colorado
District of Columbia
Georgia
Idaho
Illinois
Iowa
Kansas
Kentucky
Maryland
Massachusetts
Minnesota
Montana
Nebraska
Nevada
New Hampshire
New Mexico
North Carolina
North Dakota
Oregon[1]
Pennsylvania
South Dakota
Tennessee
Texas
Vermont
Washington
Wisconsin
Wyoming

[1] Neither supervision, direction, nor collaboration are required in **Oregon** ambulatory surgical facility licensing statutes, rules, or regulations per se, but pursuant to the nurse practice act, ambulatory surgical facility rules and regulations "may establish requirements for ready availability of an anesthesiologist for medical collaboration consistent with [the nurse practice act] and provide for credentialing, supervision, monitoring, education and professional liability insurance for a certified registered nurse anesthetist consistent with [the nurse practice act] and the scope of practice established by the Oregon State Board of Nursing. . . ."

	Certified Registered Nurse Anesthetist	Nurse Practitioner	Clinical Nurse Specialist	Certified Nurse Midwife
Year Founded	1800s	1965	Over 50 years in Indiana	1920s
Area of Advanced Training	Anesthesia	Primary Care	40 Speciality Areas	Midwifery
Basic Degree	BSN	BSN	BSN	BSN
On The Job Experience	Yes	Yes	Yes	Yes
Advanced Degree	Masters or Doctorate	Masters or Doctorate	Masters or Doctorate	82% Masters
Certification Required by Law	Yes	No	No	Yes
Certification for Reimbursement	Yes	Yes	No	Yes
Drugs	Select, order, & administer	May apply to prescribe	May apply to prescribe	May apply to prescribe
Administer Drugs	Yes	Yes	Yes	Yes
Collaborative Agreements	Not used	Required	Required	Required
Medicare	Yes	Yes	Limited	Yes
Percentage of Physician Rate	100%	85%	85%	100%
Medicaid Reimbursement	Yes	Limited	Limited	Yes
Percentage of Physician Rate	60%			75%
Private Insurance Reimbursement	Yes	Yes	Limited	Yes

EXHIBIT 3

HFC, July 22, 2013 Exhibit 5

Indiana Health Finance Commission

July 22, 2013

What is IHIT?

- Indiana Health Information Technology, Inc.
- State Designated Entity (SDE)
- Received $13.3 million in HITECH funding
- Responsible for furthering HIE activities within the state

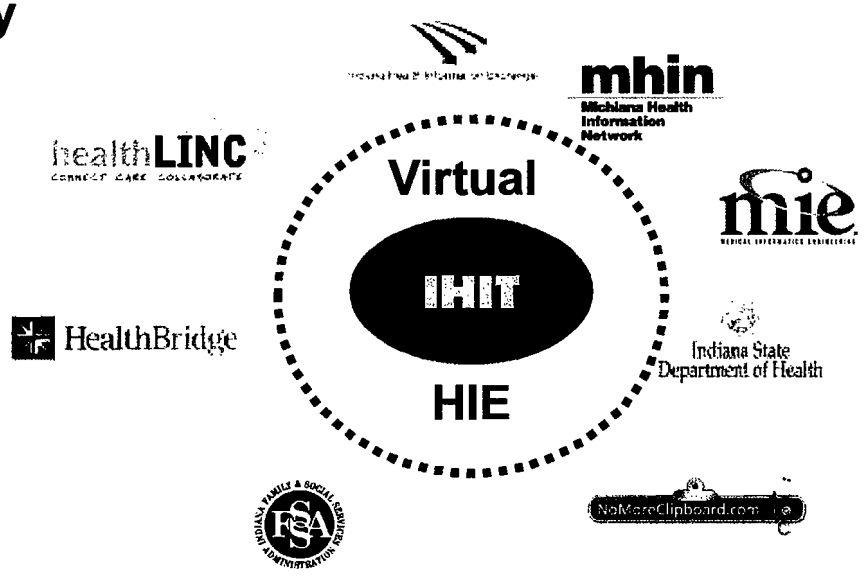
IHIT
INDIANA HEALTH INFORMATION TECHNOLOGY, INC.

State Health Information Exchange (HIE) Program

State HIE Role – Driving Interoperability

Statewide Provider Directory

Nomenclature Normalization



Clinical Message Routing

Patient and Results Discovery/Query

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INDIANA HEALTH INFORMATION TECHNOLOGY, INC.

IHIT Funded Projects, *cont.*

- Long Term Care/Behavioral Facility Integration
  - Transitions of Care Support
- Stage 2 MU White Space
  - CDA Processor
  - Modular Certification
  - ELR integration
  - CCD/Direct support
- Organ Procurement Entity Integration
- Blue Button+ Reference Implementation
  - PHR integration with regional reference lab
- Clinical Data Warehouse Development
  - Improved ACO/MU Analytics
  - ADT Alerts
  - Support Data Queries

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Indiana HIE Metrics

- 56% of Hospitals have access to Care Summaries
- 78% of Hospital Labs Submitting Results
- 48% of Hospitals Submitting Immunizations
- 53% of Hospitals Submitting ELR
- 99% of Hospital ER's submitting Surveillance data
- 42 Million+ Pushed (Directed) Transactions Q1 2013
- 5.2 Million+ Public Health Messages Q1 2013

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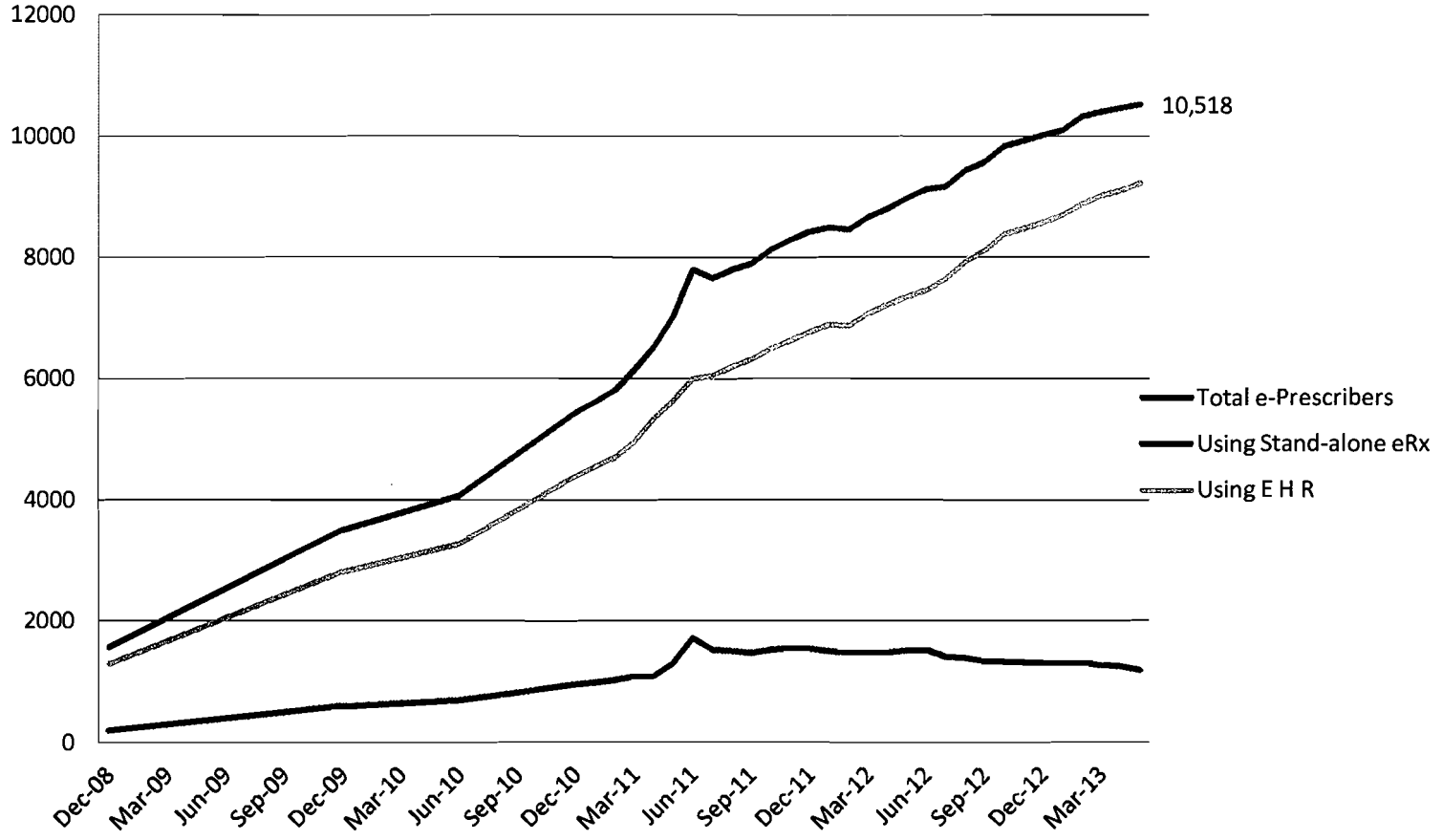
Medicare EHR Payments

Indiana

As of June 30, 2013

Medicare	EP	4,960	$79,999,225
	Hospital	3	$3,856,281
	Dual-Eligible	92	$143,802,533
	Totals	5,055	$227,658,040

E-Prescribing Providers



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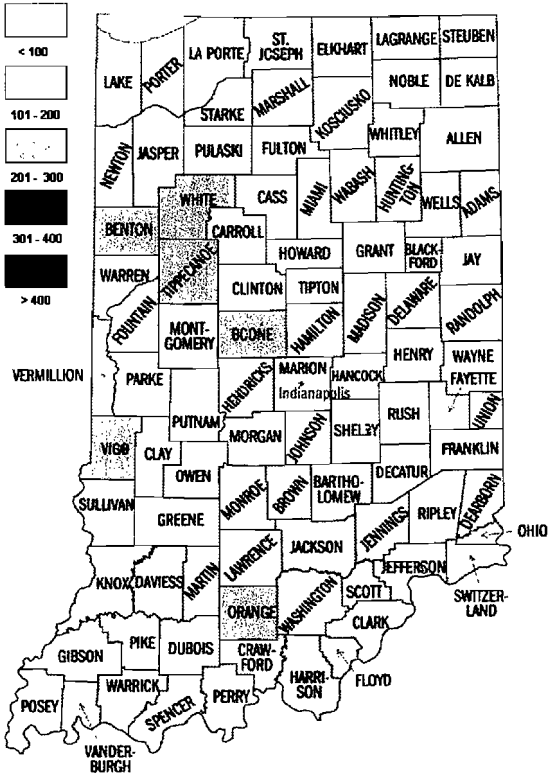
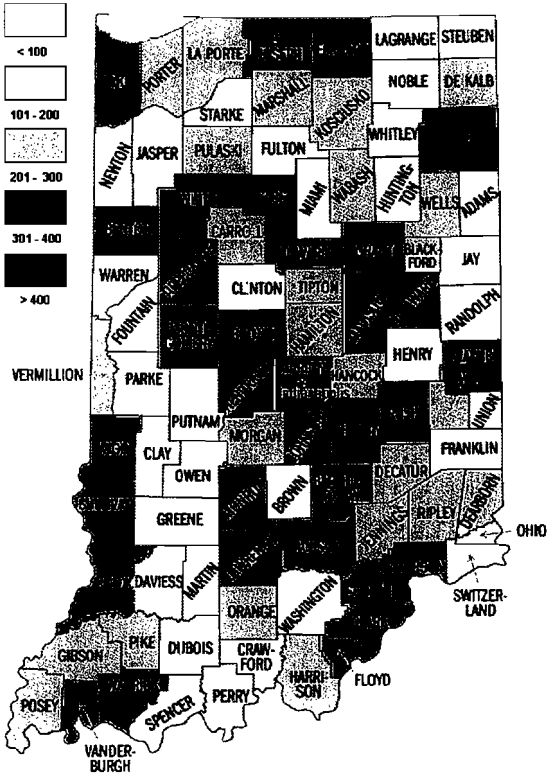
E-prescribing Transactions

June 2010



May 2013



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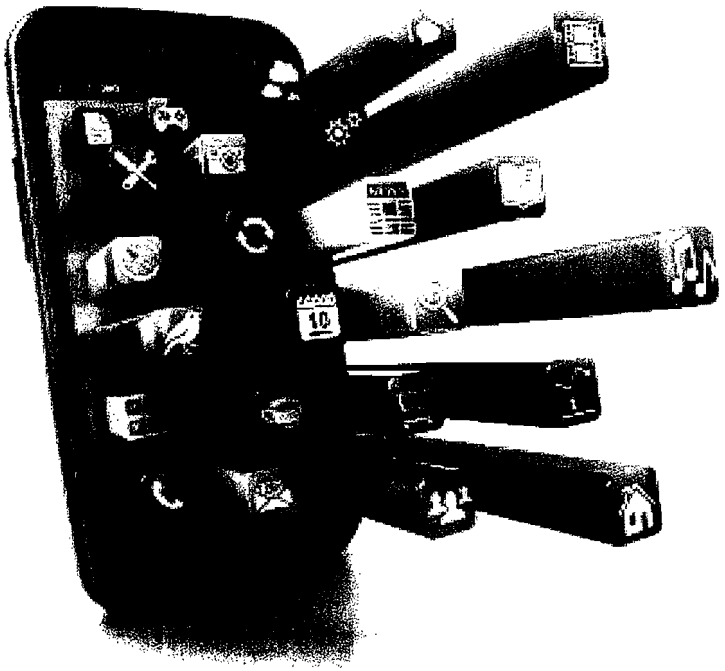
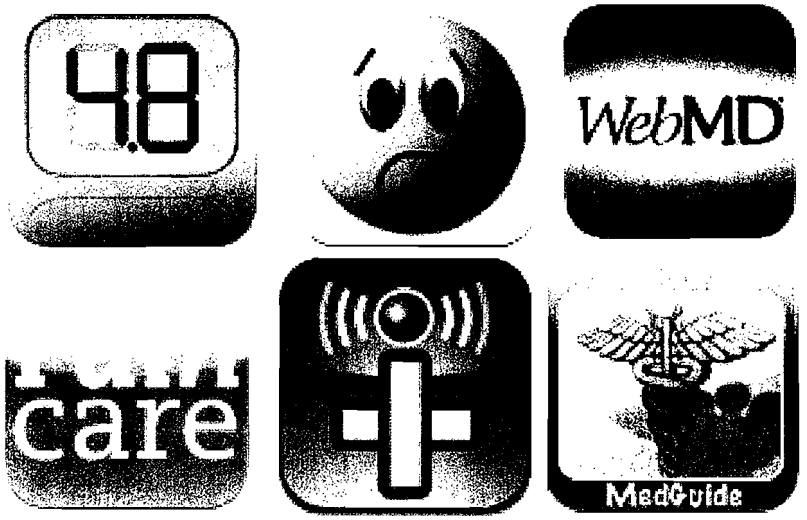
The iPatient





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Personal Health Records (PHR)

NoMoreClipboard.com

Account Summary | Member Summary | Mailbox: 49 | E-Clipboard: 6 | Log Out | Help

Logged in as: **jeffycool** Viewing Member: **Donnell, Jeff S** **Age: 49, Sex: M**

Member Access Center [Edit]

Edit Member Summary Layout
Change what sections appear on this members summary screen.

Member Review
Go through a step by step medical review for Jeff.

Access Privileges
Manage access to your PHR information.

Print Summary
View and print a summary of this member.

Share my PHR information with others
Share your PHR information with your physicians and other providers.

Print NMC911 Card
View and print an NMC911.com card for this member.

Import data from pickup code
Use a pickup code from a provider or other institution to import documents into your profile.

Jeff's Registration Information [Edit]

Jeff S Donnell

Update Photo

Employment:
President
NoMoreClipboard.com
6318 Constitution Drive
Fort Wayne, IN
Work #:(260) 969-4642 x358

Emergency Contact:

cc:Me

Active cc:Me web address:https://www.ccme.com/jeffycool

Active cc:Me secure email address:jeffycool@ccme.com

Print Hey Doc, cc:Me instructions for next appointment

Insurance [Edit]

Microsoft HealthVault [Preferences]

* - Currently, NoMoreClipboard.com syncs the following information between accounts: Basic demographic information, medications, allergies, conditions, procedures, weight, height, blood pressure, blood glucose. .

Create a connection with an MS HealthVault Account

Current Medications [Edit]

- **Dexedrine Spansule** 15mg (Ten times daily)
- **Effexor XR** 150mg (Daily)
- **Percocet** 7.5-325mg (Anguish)
- **Prozac** 40mg (Every ten minutes)
- **Xanax** 2mg (Hourly)
- **Zoloft** 100mg (Stress)

Previously taken medications:

- None Entered

Current Illnesses [Edit] [Conditions Review]

- Asthmatic breathing (09-12-2011)
- Glasses
- Hair Loss
- Hayfever
- High blood pressure (09-14-2011)

Past Illnesses [Edit]

- Chicken Pox
- Difficulty Swallowing
- Pinched nerve

Surgeries/Procedures [Edit]

- Vasectomy for contraception (1987)

Immunizations [Edit]

- Tetanus toxoid (Date: 05-03-1999)

Allergies [Edit]

- Hayfever
- Mold-Yeast-Dust (Difficulty breathing)

MyVaxIndiana Home Page

MY VAX INDIANA

Keeping Hoosiers Connected & Protected

What Is MyVaxIndiana

The Indiana State Department of Health (ISDH) maintains an Immunization Information System known as CHIRP (Children and Hoosier's Immunization Registry Program). The purpose of CHIRP is to collect, forecast, manage, and share vaccine data to registered medical providers in Indiana. A provider may include private medical facilities, local health departments, hospitals, schools, and daycares. The program is run under the Indiana Code 16-38-5 which allows for providers and their designees to access to CHIRP. In addition an individual also may access their personal or their dependents vaccine record from either the registered CHIRP provider or directly from the Indiana State Department of Health.

As an update to the existing program, ISDH has created the MyVaxIndiana Immunization Portal which enables a person to access a vaccine record from any computer. To begin this process a registered CHIRP provider will create a patient ID number (PIN) which will grant a person specific patient access to the record they have requested. A parent or guardian could request a PIN to view their dependents immunization history, or any individual could do the same for their own record. They then have a number of options as to how their data can be viewed and saved. This includes an option to print and save the Official Immunization Record, download the record into a file format that may be compatible with their

FAQs

- How do I use this site?
- How can I find a CHIRP provider?

If you have a question that is not answered here, please feel free to contact us at any time. You can email us here or call toll-free at (888) 227-4439. As a tip, if you wish to download your record, please install Adobe Acrobat Reader.

Increasing Use of PDMP Data

LICENSE TYPE	UNREGISTERED	REGISTERED	TOTAL	% REGISTERED
CLINICAL NURSE SPECIALIST	61	73	[illegible]	54%
CSR-CERTIFIED NURSE MIDWIFE	42	16	[illegible]	28%
CSR-OSTEOPATHIC PHYSICIAN	680	[illegible]	[illegible]	44%
CSR-PHYSICIAN	10885	[illegible]	[illegible]	33%
DENTIST	[illegible]	[illegible]	3179	36%
NURSE PRACTITIONER	[illegible]	[illegible]	2981	46%
PHARMACIST	[illegible]	2903	9905	29%
PHYSICIAN ASSISTA[illegible]	[illegible]	250	612	41%
PODIATRIST	229	101	330	31%
RESIDENT	1204	95	1299	7%
VETERINARIAN	1360	34	1394	2%
TOTALS	25454	11783	37237	32%

1 out of 3 Registered

5,000+ reports/weekday

13,000,00[illegible]
Rxs/annu[illegible]y

PDMP Integration Pilot

- There was a **58% reduction** in either prescriptions written or number of pills prescribed.
- In **72% of cases there was more information** in the report than the physician was aware of.
- **100% reported that integrated report was easier to use.**
- 2 out of 3 accessing report in INPC not registered w/ INSPECT
- Worst offenders are less active (40% drop in 10+ prescribers/60 days)
- PDMP data integration is permanent with INPC as of January 2013.
- Requests increased from 5,000 to 10,000 daily
- *"I have to say that this is probably one of the more genius moves of the 21st century. Having easy access to INSPECT without going to a totally different website and have it pop up instantly has taken a lot of time off of decision making for me. Thanks for spearheading it."*

  Wishard ER Physician

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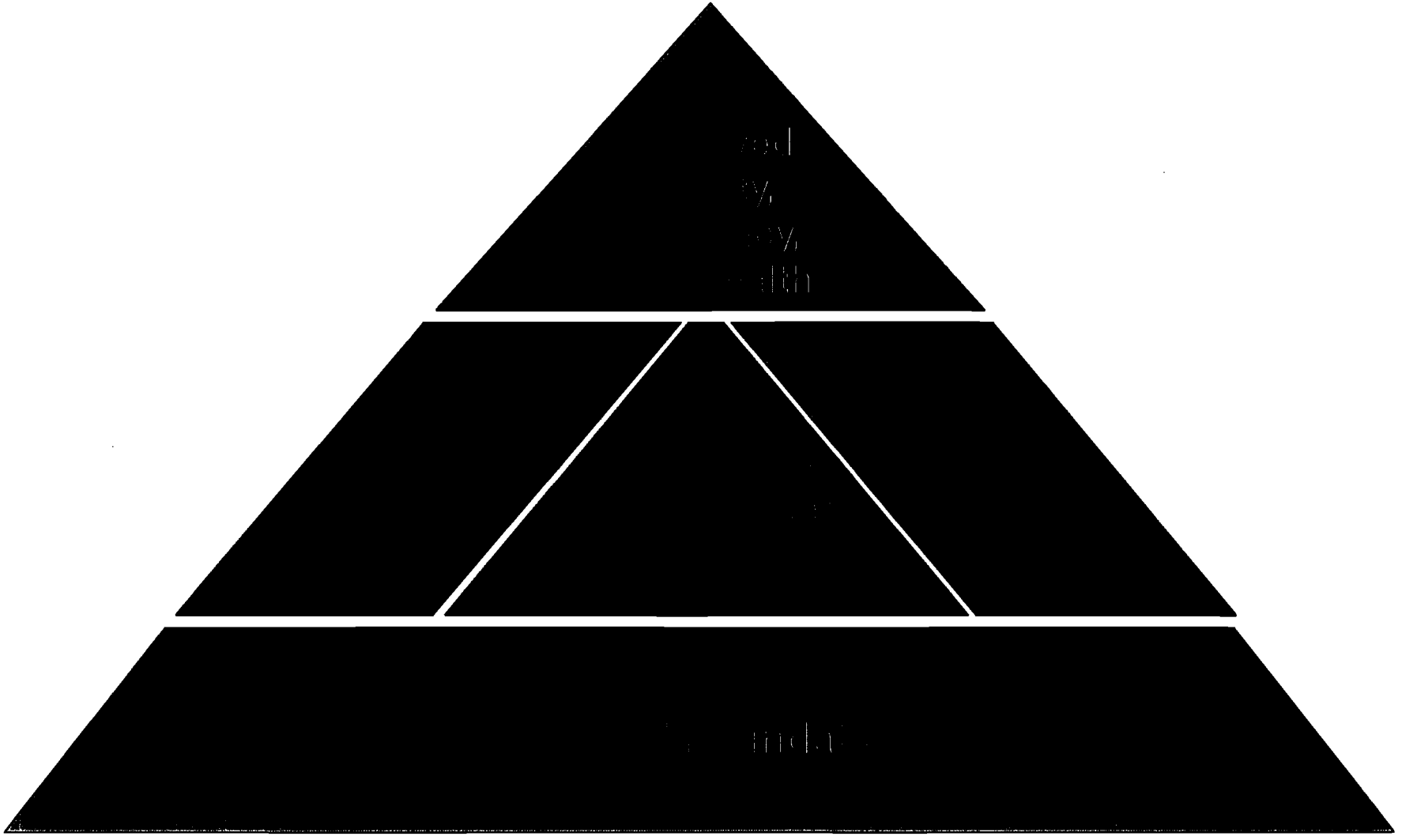
INDIANA HEALTH INFORMATION TECHNOLOGY, INC.

HIT as a Foundation



Contact Information

Andrew VanZee

Statewide Health IT Director

www.indianahealthit.com

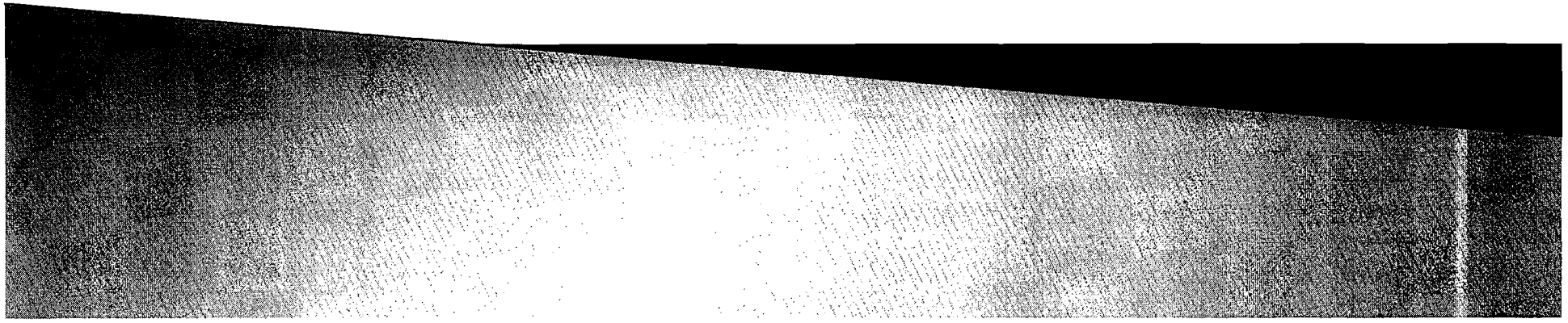
HFC, July 22, 2013 Exhibit 6

Health Finance Committee Report

ISDH use of EMR Data

Chris Mickens

July 22, 2013



The Time Has Arrived

- *Given the significant investments that have been made in EMR adoption and interoperability in recent years, our next step is to integrate EMR data into a variety of health services and systems*

- *EMRs have enabled the health care industry with tremendous potential to provide timely and relevant data in a form that is: usable for quality and safety improvement, population health and public health activities.*

EMR Data

- Today ISDH receives EMR data in three main areas:
  - Electronic Lab Reports
  - Surveillance Data
  - Immunization Data

Electronic Lab Reporting

- Data is received from National Labs, State/County Labs and Hospital Labs
  - An average of 80,000 reports are received monthly
- Data is processed 24/7 and available to our programs for follow-up and EPI team for surveillance of state reportable disease conditions
  - STD, Blood Lead, HIV, TB, and Cancer

Surveillance Data

- Electronic PHESS (Emergency room visits) chief complaint messages are received from hospitals every three hours, over 15,000 reports are received every day
  - To monitor/investigate potential outbreaks

- No longer must we relay upon Emails, Phone calls or Faxes for this reporting.

Immunization Data

- Immunization Data is received 24/7 to our Immunization Registry (CHIRP)
  - Eliminates the need of double data entry (to provider or hospital systems and then entry into CHIRP)
- CHIRP receives on an average of 25,000 HL7 messages per day from over 40 different EHR/EMR systems
- Allows for greater access to Immunization data for providers and individuals

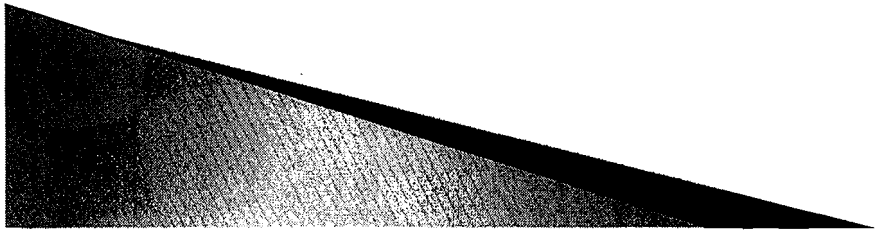
Immunization Data

- Bidirectional data flows allow for vaccine history and vaccine forecasts to be passed back to providers, EMR systems and individuals

MyVaxIndiana Portal

System went live on July 23, 2012, as of Friday July 12, 2013:

- 30,230 Patient ID numbers assigned
- 29,111 Records Viewed
- 37,861 Records Printed



MyVaxIndiana Home Page

MY VAX INDIANA

Keeping Hoosiers Connected & Protected

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FAQs

- [illegible]
- [illegible]

If you have a question that is not answered here please feel free to contact us at any time. You can email us here or call toll-free at (888) 227-4439. As a tip, if you wish to download your record please install Adobe Acrobat Reader.

Step 1: Enter Your Information

Requestor First Name:

Requestor Last Name:

Patient Date of Birth:

Requestor Email Address:

Requestor Confirm Email:

Please keep my email address for future vaccine reminders from the Indiana State Department of Health

Step 2: Enter Security Info & Agree

PIN #:

IQS46

Generate New Image

Type the code from the image

By clicking this box I agree to patient confidentiality and I declare under the penalty of perjury, under the laws of the State of Indiana that the foregoing is true and correct. I understand that the immunization record to be disclosed will be disclosed in accordance with this authorization and within Indiana Code 16-38-5-3. I am authorized to view this record as an individual or as the guardian of the record I am requesting.

Get MyVaxIndiana

Reset

Vaccine View Screen

State of Indiana Official Record of Immunization

All Recorded Vaccinations

Patient Information

IRMS			
Facility Name	PUBLIC HEALTH - ISDH		
Date	6/15/2012	Street Address	
PIN #	3451125	City	
Patient Name	THOMAS TEST	State	IN
Birth Date	1/1/2008	Zip Code	
Gender		Country	United States
Guardian	TIIIA		

Vaccination Information

Vaccine Name	Dose 1	Dose 2	Dose 3	Dose 4
MMR	05/15/2009			
Meningococcal	08/04/2009			
Tdap	07/20/2009	08/04/2009		
Varicella	05/15/2009			

Vaccines marked with a red x indicate the dose given is outside of the ACIP recommended range. If you have any questions about the dose, please call your Medical Provider or the CHIRP help desk at 1-888-227-4439 for an explanation.

CDC ACIP Vaccination Forecast

The Vaccination Forecast for this record is based on the CDC ACIP recommended vaccine schedule. Please consult your Medical Provider if you have any questions about this vaccine forecast or this record.

Vaccine Family	Dose	Recommended Date	Minimum Valid Date	Overdue Date	Status
HEP B 3 DOSE	1	Past Due	1/1/2008	4/1/2008	Past Due
DTaP/DT/Td	1	Past Due	2/12/2008	4/1/2008	Past Due
HIB	1	Past Due	2/12/2008	5/1/2008	Past Due

Meaningful Use

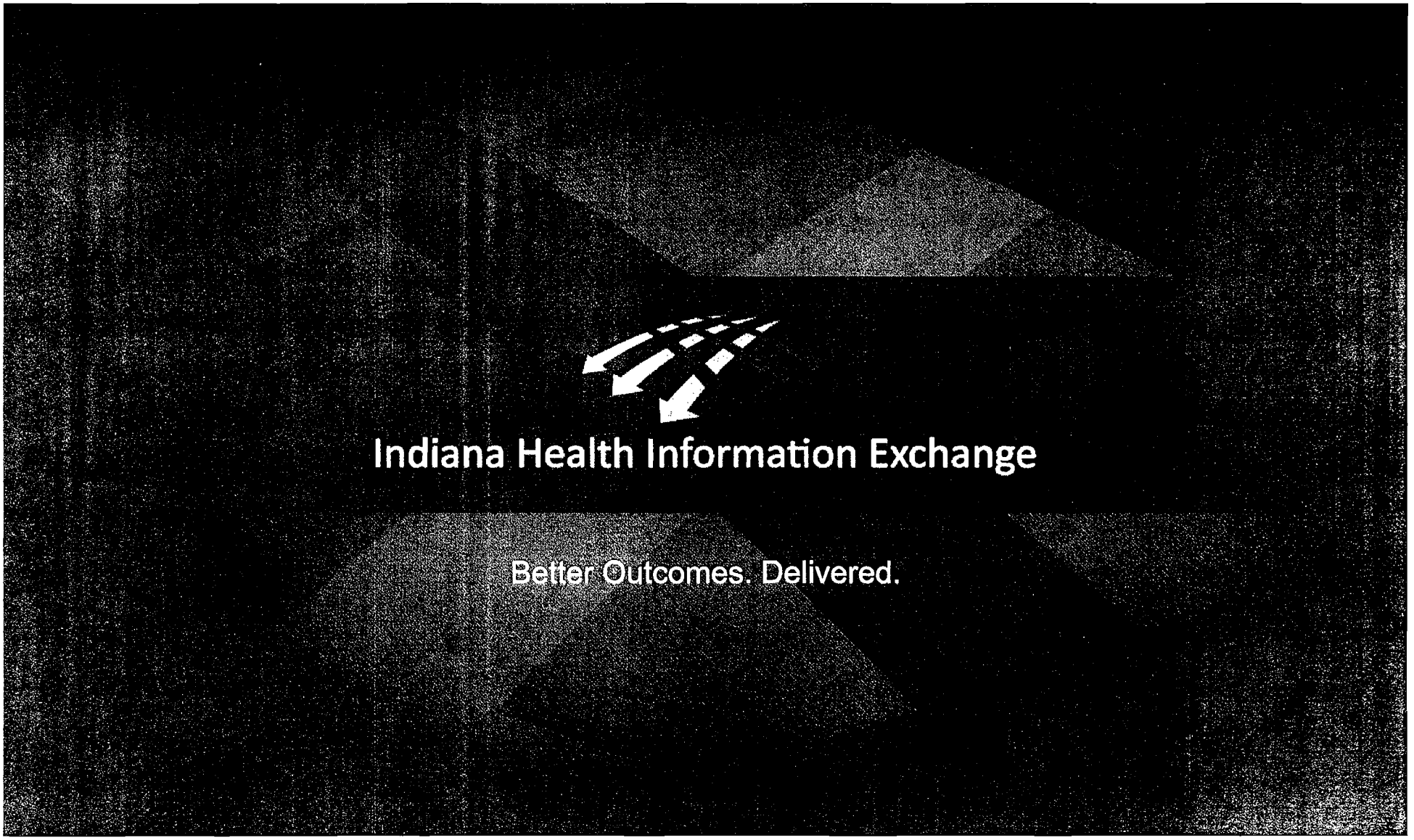
- Providers and hospitals that are submitting Surveillance and Immunization data can also use that submission to attest for Stage 1 of the Public Health requirement

- Federal Meaningful Use incentives dollars have helped hospitals and providers meet this new standard

- Providers and Hospitals in Indiana have received over *342 million dollars* in the CMS Electronic Health Records Incentive Program

Future Improvements

- Public health response, and intervention to disease outbreaks and public health reporting
- Public health policy-making resulting from better availability of truly integrated data
- Reporting timeliness and availability of current data
  - Birth and Death reporting
  - Submission of Trauma data



Health Information Exchange in Indiana

July 2013

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HFC, July 22. Exhibit 7

Health Information Exchange (HIE) in Indiana

Agenda:

- What is Health Information Exchange (HIE)?
- Why is HIE valuable?
- The Indiana Health Information Exchange (IHIE)
  - 7 minute video
  - High level overview of this Indiana asset

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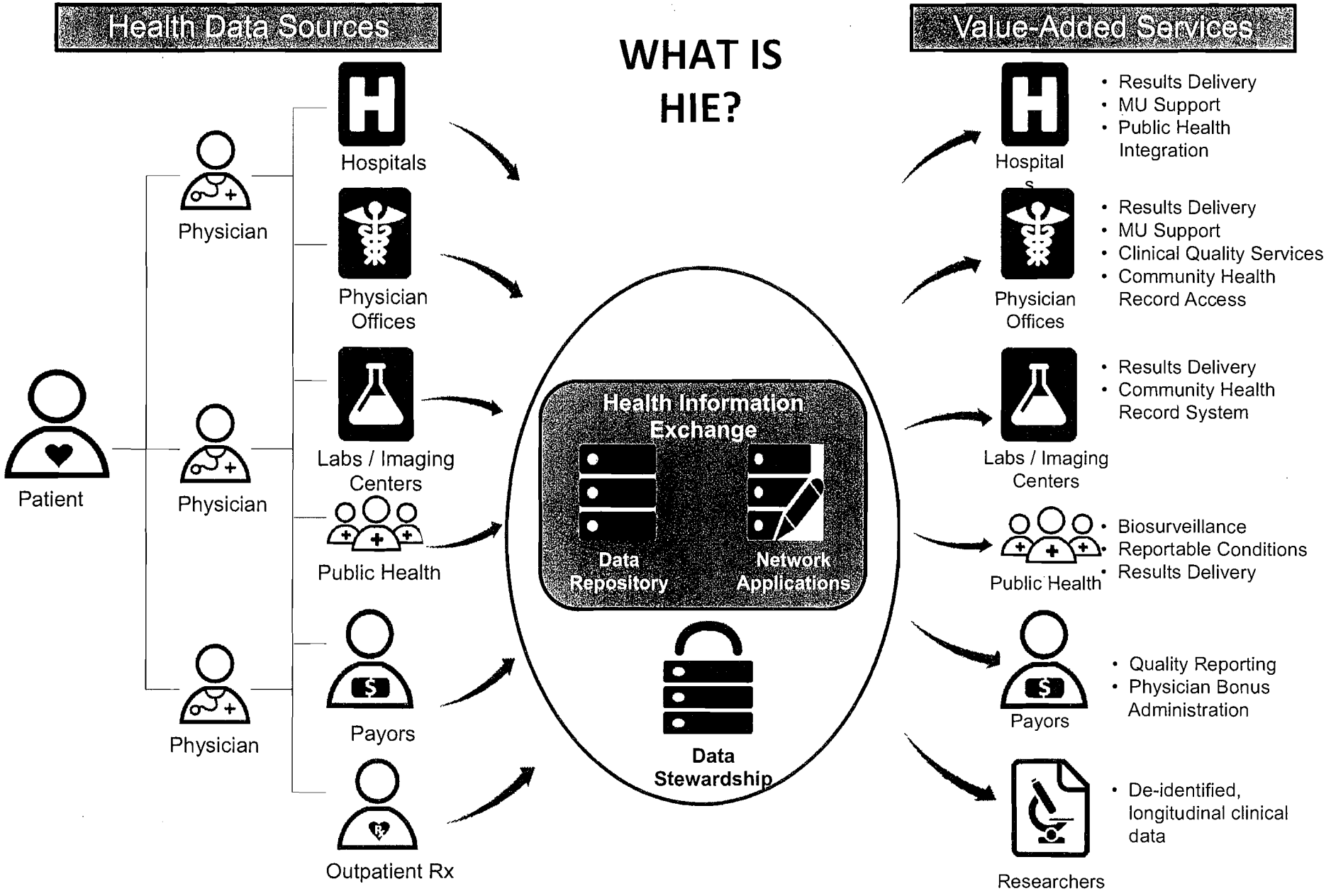
WHAT IS HIE?



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Indiana Health Information Exchange

Examples of HIE value

HIE improves healthcare quality

- Provides clinicians with a patient's clinical data at the point of care to support clinical decision-making
- Tells doctors which of their patients are due for mammograms

HIE enhances healthcare safety

- Informs emergency medical teams of a patient's medication allergies

HIE reduces healthcare cost

- Communicates lab results to doctors securely and electronically at a fraction of the previous cost
- Prevents repeating radiology or lab tests

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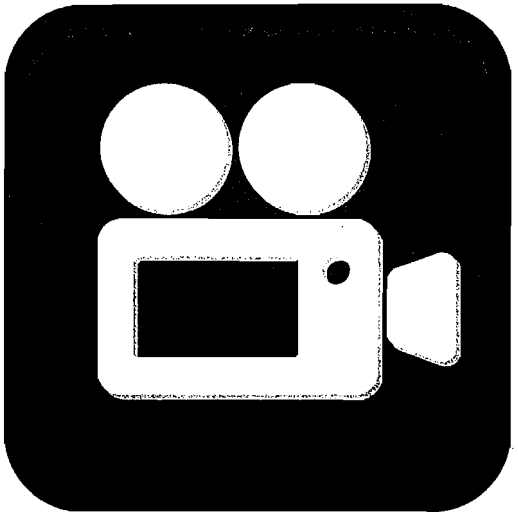
Indiana Health Information Exchange

IHIE Overview: Past, Present & Future



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IHIE MISSION STATEMENT

Our mission is to Improve the quality, safety, and efficiency of healthcare through Health Information Exchange

IHIE is a 501c3 not-for-profit organization.

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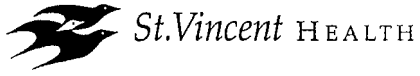
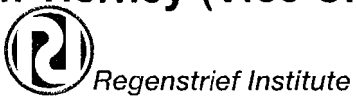
IHIE Board of Directors

Vincent Caponi (Chair)



William Tierney (Vice Chair)



David Johnson (Secretary/Treasurer)

Craig Brater	IU School of Medicine	**Dan Evans**	Indiana University Health
Robert Brody	Franciscan St. Francis	**Matthew Gutwein**	Health and Hospital Corp.
Virginia Caine	Marion County Health Department	**Doug Leonard**	Indiana Hospital Association
William Cast	Community Director	**Ned Lamkin**	Community Director
David Cook	Community Director	**Teresa Lovins**	Indiana State Medical Association
Wayne Deveydt	Community Director	**Bryan Mills**	Community Health Network
John Ellis	Indianapolis Medical Society	**William VanNess**	Indiana State Department of Health

Indiana Health Information Exchange

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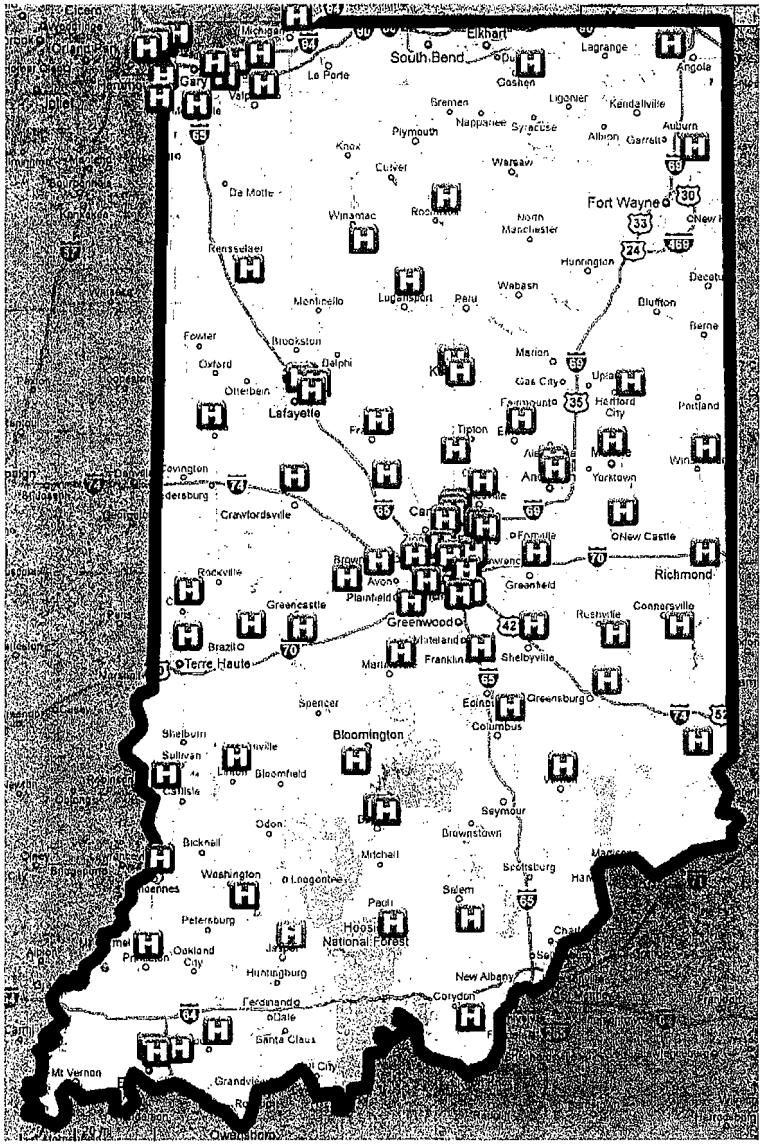

IHIE Background

- Nation's largest HIE
- Founded in February 2004
- Providing services to 94 hospitals, 25,000 clinicians, and 5 payors
- Visionary community partners:
  - Regenstrief Institute
  - BioCrossroads
  - 5 Charter Hospitals
- What we do:
  - Deliver lab and other results to 25,000 doctors…365 days a year
  - Unify patient data from many different sources to make it available to doctors (e.g. Emergency Rooms)
  - Analyze huge volumes of clinical data to answer important questions (e.g. are people with diabetes well cared for?)

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Privacy & Security

Eric Thieme

Vice President

General Counsel & Compliance Officer

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Concepts

Privacy

Whether, when and how information is collected

Confidentiality

To whom information may be disclosed

Security

How information is protected

Transparency

Knowing how information is used

Trust

Built upon privacy, confidentiality, security and transparency

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Concepts Embodied in Law

Health Insurance Portability and Accountability Act (HIPAA)

- Privacy Rule
- Security Rule

Health Information Technology for Economic and Clinical Health (HITECH)

State Laws

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Concepts and Laws in Practice

Privacy
- Sensitive Data Not Exchanged

Confidentiality
- Access Triggers; Role-Based Access

Security
- Encryption, VPNs, Firewalls, Professional Data Centers

Transparency
- Notice of Privacy Practices

Trust
- Shared Data Governance

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INPC Management Committee

Founding Members (each appoint 1 individual)
Community Hospitals of Indiana, Inc.
Franciscan Alliance, Inc.
Indiana University Health, Inc.
IU Medical Group – Primary Care
St. Vincent Health, Inc.
Wishard Health Services
Appointing Organizations (each appoint 1 individual)
Indiana State Department of Health
Indiana Family and Social Services Admin.
Regenstrief Institute (Employee)
Regenstrief Institute (Scientist or IU Faculty)
Indiana Health Information Exchange, Inc.
Affiliation Group (each elect 1 or 2 individuals)
Health Plans or Third-Party Payors (2 elected individuals)
Acute Care Hospitals Not Among the Founding Members (2 elected individuals)
Physicians and Physician Groups (2 elected individuals)
Independent Clinical Laboratories (1 elected individual)
Individual Representing Patients and Consumers (1 elected individual)
Emerging Members (Long-Term Care, EMT, Radiology) (2 elected individuals)

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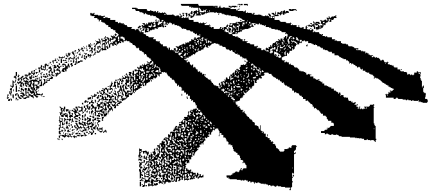

Indiana Health Information Exchange

Thank You

317.644.1750

www.ihie.org

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Indiana Network for Patient Care

Brought to you by: Indiana Health Information Exchange

* Other includes data feeds unique to individual facilities or networks

Participating facilities as of July 2013	Admission/Discharge	Lab	Microbiology	Pathology	Radiology	Transcription	Cardiology	EKG	Other*
Cameron Memorial Community (Angola)	●	●			●				
Centers for Diagnostic Imaging (CDI)	●				●				
CHI - Community Anderson	●	●			●	●			
CHI - Community East	●	●		●	●	●			
CHI - Community North	●	●		●	●	●			
CHI - Community South	●	●		●	●	●			
CHI - Community Westview	●	●			●	●			
CHI - Heart and Vascular	●	●		●	●	●			
CHI - Howard Regional (Kokomo)	●								
Columbus Regional	●	●	●	●	●	●			●
Deaconess (Evansville)	●	●							
Deaconess Gateway (Evansville)	●	●							
Decatur County Memorial (Greensburg)	●	●	●		●	●			
DeKalb Health (Auburn)	●	●	●		●	●			
Dialysis Clinic	●	●							
FA - St. Anthony (Chesterton)	●	●	●	●	●	●			●
FA - St. Anthony (Crown Point)	●	●	●	●	●	●	●	●	●
FA - St. Anthony (Michigan City)	●	●	●	●	●	●	●	●	●
FA - St. Elizabeth (Crawfordsville)	●	●	●	●	●	●	●		
FA - St. Elizabeth (Lafayette Central)	●	●	●	●	●	●	●	●	
FA - St. Elizabeth (Lafayette East)	●	●	●	●	●	●	●		
FA - St. Francis (Carmel)	●	●	●	●	●	●			●
FA - St. Francis (Indianapolis)	●	●	●	●	●	●	●	●	●
FA - St. Francis (Mooresville)	●	●	●	●	●	●	●	●	●
FA - St. Margaret Mercy (Dyer)	●	●	●	●	●	●	●	●	●
FA - St. Margaret Mercy (Hammond)	●	●	●	●	●	●	●	●	●
Fayette Regional (Connersville)	●	●	●		●	●			●
Golden Living Centers	●					●			●
Good Samaritan (Vincennes)	●	●	●	●	●	●	●	●	
Greene County General (Linton)	●	●		●	●	●			

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Indiana Network for Patient Care

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* Other includes data feeds unique to individual facilities or networks

Participating facilities as of July 2013	Admission/Discharge	Lab	Microbiology	Pathology	Radiology	Transcription	Cardiology	EKG	Other*
Hancock Regional (Greenfield)	●								
Hendricks Regional (Danville)	●	●	●	●	●	●	●		
Henry County Memorial (New Castle)	●	●	●	●	●	●	●		
IUH - Arnett (Lafayette)	●	●	●	●		●			
IUH - Ball Memorial (Muncie)	●	●	●	●		●			●
IUH - Bedford	●	●	●			●			
IUH - Blackford (Hartford City)	●	●	●	●		●			
IUH - Bloomington	●	●	●	●		●			
IUH - Goshen	●	●	●		●	●			
IUH - Methodist	●	●	●	●	●	●	●	●	●
IUH - Morgan (Martinsville)	●	●	●	●	●	●			
IUH - North (Carmel)	●	●	●	●	●	●	●	●	●
IUH - Paoli	●	●	●	●	●	●			
IUH - Riley	●	●	●	●	●	●	●	●	●
IUH - Saxony (Fishers)	●	●	●	●	●	●	●	●	●
IUH - Tipton	●	●	●	●	●				
IUH - University	●	●	●	●	●	●	●	●	●
IUH - West (Avon)	●	●	●	●	●	●	●	●	●
Jasper County (Rensselaer)	●	●							
Kindred (Greenwood)	●								
Kindred (Indianapolis)	●								
Logansport Memorial	●	●	●	●	●	●			
Madison County CHC (Anderson)	●								
Major (Shelbyville)	●	●	●	●	●	●			
Northwest Radiology (all locations)	●				●				
PCL Alverno (Hammond)		●	●	●					
Pulaski Memorial (Winamac)	●	●	●		●	●			●
Putnam County (Greencastle)	●	●	●	●	●	●			●
Reid (Richmond)	●	●		●					
Riverview (Noblesville)	●	●	●	●		●			

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Participating facilities as of July 2013	Admission/Discharge	Lab	Microbiology	Pathology	Radiology	Transcription	Cardiology	EKG	Other*
Rush Memorial (Rushville)	●	●			●				
St. Mary's (Evansville)	●	●		●	●	●			
STV - 86th Street	●	●	●	●	●	●		●	
STV - Anderson Regional	●	●		●	●	●			
STV - Carmel	●	●	●	●	●	●		●	
STV - Children's	●	●	●	●	●	●		●	
STV - Fishers	●	●	●	●	●	●		●	
STV - Heart Center	●	●	●	●	●	●		●	
STV - Pediatric Rehabilitation	●	●	●	●	●	●		●	
STV - Seton Specialty (Indianapolis)	●	●	●	●	●	●		●	
STV - Seton Specialty (Lafayette)	●	●	●	●	●	●		●	
STV - Stress Center	●	●		●	●	●		●	
STV - Women's	●	●	●	●	●	●		●	
Sullivan County Community	●	●	●						
Union (Clinton)	●	●	●	●	●	●			
Union (Terre Haute)	●	●	●	●	●	●			
We Care TLC - Fairfield Mfg. (Lafayette)	●	●							●
Wishard	●	●	●	●	●	●	●		●
Witham (Lebanon)	●	●	●		●	●			
Woodlawn (Rochester)	●	●	●						

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Other data available through INPC

Columbus Regional
- Allergies

Fayette Regional
Connersville
- Blood Bank

FA - St. Anthony
Chesterton, Crown Point, Michigan City
- After Visit Summaries (AVS)
- Self-Authored Documents (SAD)

FA - St. Francis
Carmel, Indianapolis, Mooresville
- After Visit Summaries (AVS)
- Self-Authored Documents (SAD)

FA - St. Margaret Mercy
Dyer, Hammond
- After Visit Summaries (AVS)
- Self-Authored Documents (SAD)

Golden Living Centers
- Advance Directives
- Allergies
- Pharmacy
- Problem List

IU Health - Ball Memorial
Muncie
- NeoData

IU Health
Methodist, North, Riley, Saxony, University, Wes
- NeoData
- Pharmacy

Pulaski Memorial
- EFM Scanned Documents

Putnam County
- Blood Bank
- Reference Labs

We Care TLC - Fairfield Mfg.
Lafayette
- Allergies
- Diagnosis (consenting patients)

Wishard
Indianapolis
- Blood Bank
- Coded dx's (ER and IP)
- GI/Endoscopy Reports
- Inpatient Vitals
- MedHub Server
- Newborn Reporting
- Pharmacy
- POC Glucose Results
- Pulmonary Lab Reports w/PDF
- Surgery Scheduling
- Telephone Nurse Triage System
- Vascular Lab Reports w/PDF
- Verified Dictation and Scanned Images
- Viewpoint Ultrasound Reports
- Wishard Advantage Enrollment

For current list, visit: www.ihie.org/indiana-network-for-patient-care

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HFC, July 22, 2013 Exhibit 8

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Transforming healthcare through innovative solutions.™

Mission and Vision

Mission

- Improve Healthcare quality, safety and efficiency by applying the principles of engineering, management and science.

Vision

- Transform healthcare through innovative solutions. We desire to continuously strengthen and broaden our positions as "THE" resource that healthcare providers trust and rely on for expert advice, training and consultation.

PHA Overview

- Established 2005
- Seed funding from Indiana Hospital Association
- Moved from faculty only to dedicated staff model
- 31 dedicated staff, in addition to temporary staff, several subcontractors, utilize faculty as needed
- Three key areas
  - Hospital/provider education & consultation
  - Population/public health
  - Electronic Health Records
- Created Lean Healthcare and Lean Six Sigma Public Health curriculum
- Have worked in all 92 counties
- Over 100 hospitals
- Significant public health work – national and state
- Multiple grants and contracts from State, Federal, and foundation sources

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Purdue Regional Extension Center (REC)

Grant Obligations - $14M award

- Assist 2,200 primary care providers for Stage 1 Meaningful Use
- Assist 30 Critical/Rural Hospitals for Stage 1 Meaningful Use
- Ongoing resource beyond grant

Progress to Date

- Over 2,200 providers and 30 Critical/Rural Hospitals enrolled
- Over 20 additional acute care hospitals engaged with some piece of Meaningful Use
- Helped 1,215 providers achieve Stage 1 Meaningful Use
- Helped 19 Critical Access Hospitals achieve Meaningful Use
- Assisted clients in securing nearly $100M in federal incentives
- Received additional $1 million in other paid services

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Regional Extension Centers

- RECs were created to provide Meaningful Use information, guidance, and technical assistance to healthcare providers to support and accelerate their efforts to become meaningful users
- The Purdue REC is 1 of 62 Regional Extension Centers – grant recipients from the Office of the National Coordinator (DHHS)
- All US locations have an REC
- RECs are helping 147,180 eligible providers throughout the nation
- RECs have assisted 119,489 go live on EHRs, and have assisted nearly 63,000 in meeting meaningful use
- RECs share lessons and have direct access to Federal and State resources to help providers meet MU

Definitions:

Electronic Health Records (EHR) – real-time, patient-centered records that make information available instantly and securely to authorized users including patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory and test results

Eligible providers:

- Medicare – MD's, OD's, Chiropractors and Doctors of Dental Surgery, Dental Medicine, Podiatry, Optometry
- Medicaid - MD's, OD's, NPs, Certified Nurse-Midwives, Dentists, Select PA's who have over 30% Medicaid patient visits (20% for Pediatricians)

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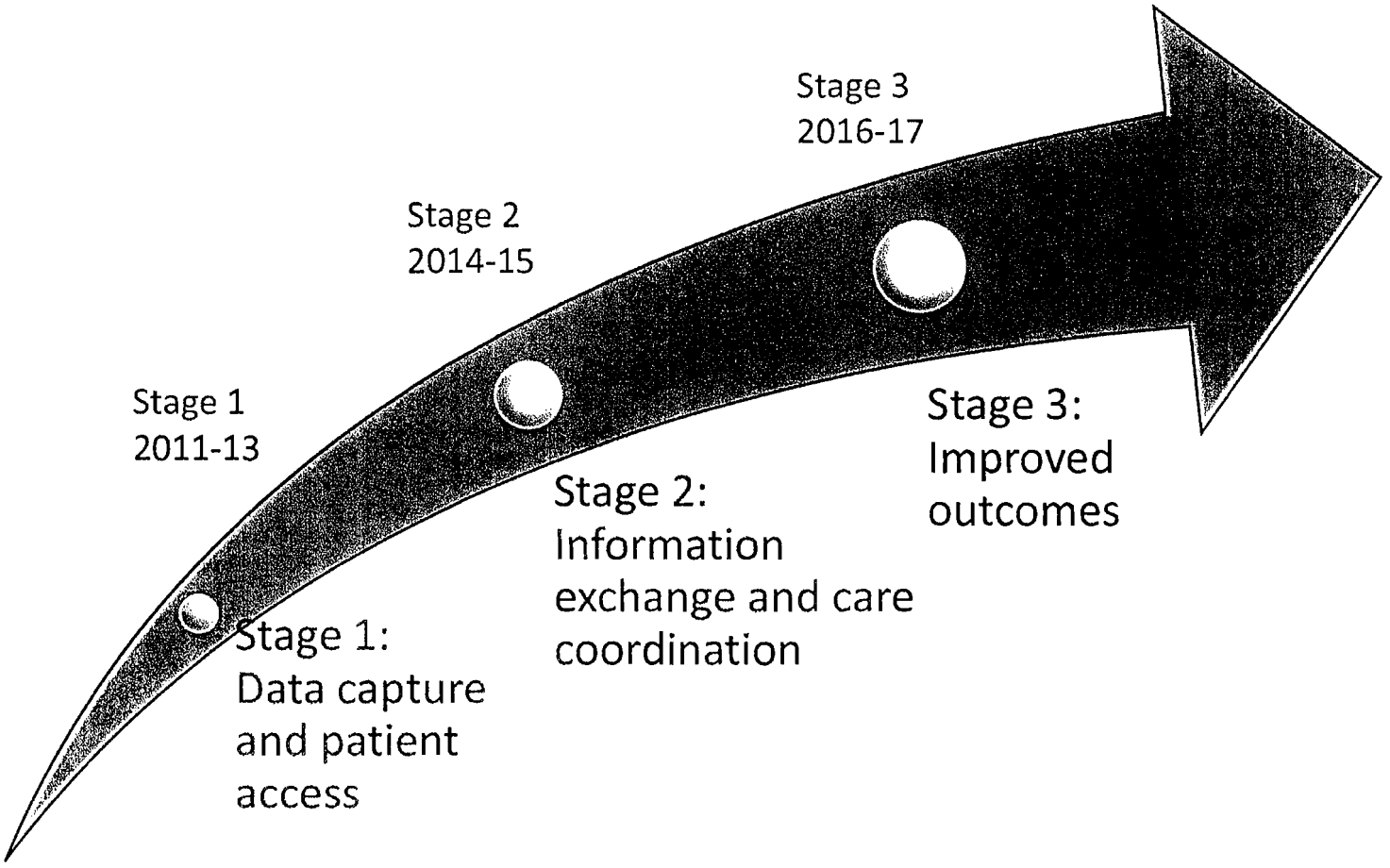
What is Meaningful Use?

- Federal program through the Department of Health and Human Services (HHS) to promote the spread of electronic health records to improve health care
- Financial Impacts: Incentives (and penalties starting in 2015) Federal program
  - Eligible Providers can receive up to $63,750 through Medicare or $44,000 through Medicaid (Medicaid is administered by individual States, FSSA for Indiana)
  - Eligible Hospitals can receive up to several million dollars through both Medicare and Medicaid
  - Penalties: If not a meaningful user by 2014 or meaningful use is not maintained yearly, a 1% penalty is assessed for all Medicare payments in 2015 increasing to 2% in 2016 and 3% in 2017 and each year thereafter
- Requirements:
  - Software – must be certified to be capable of collecting, utilizing, and reporting patient data
  - Providers – must meet 14 core and 5 of 10 menu objectives around the use and security of the EHR
  - Hospitals – must meet 13 core and 5 of 10 menu objectives around the use and security of the EHR
  - Public Health Reporting – includes either Immunization or Syndromic Surveillance submission
  - Quality Measures – additional quality measure reporting
  - Security – reinforcement of the criticality of completing security risk assessments as already required under the Health Insurance Portability and Accountability Act (HIPAA)
  - Progressive – currently in Stage 1, Stage 2 begins for some in 2014, Stage 3 planned for 2016

Meaningful Use Roadmap



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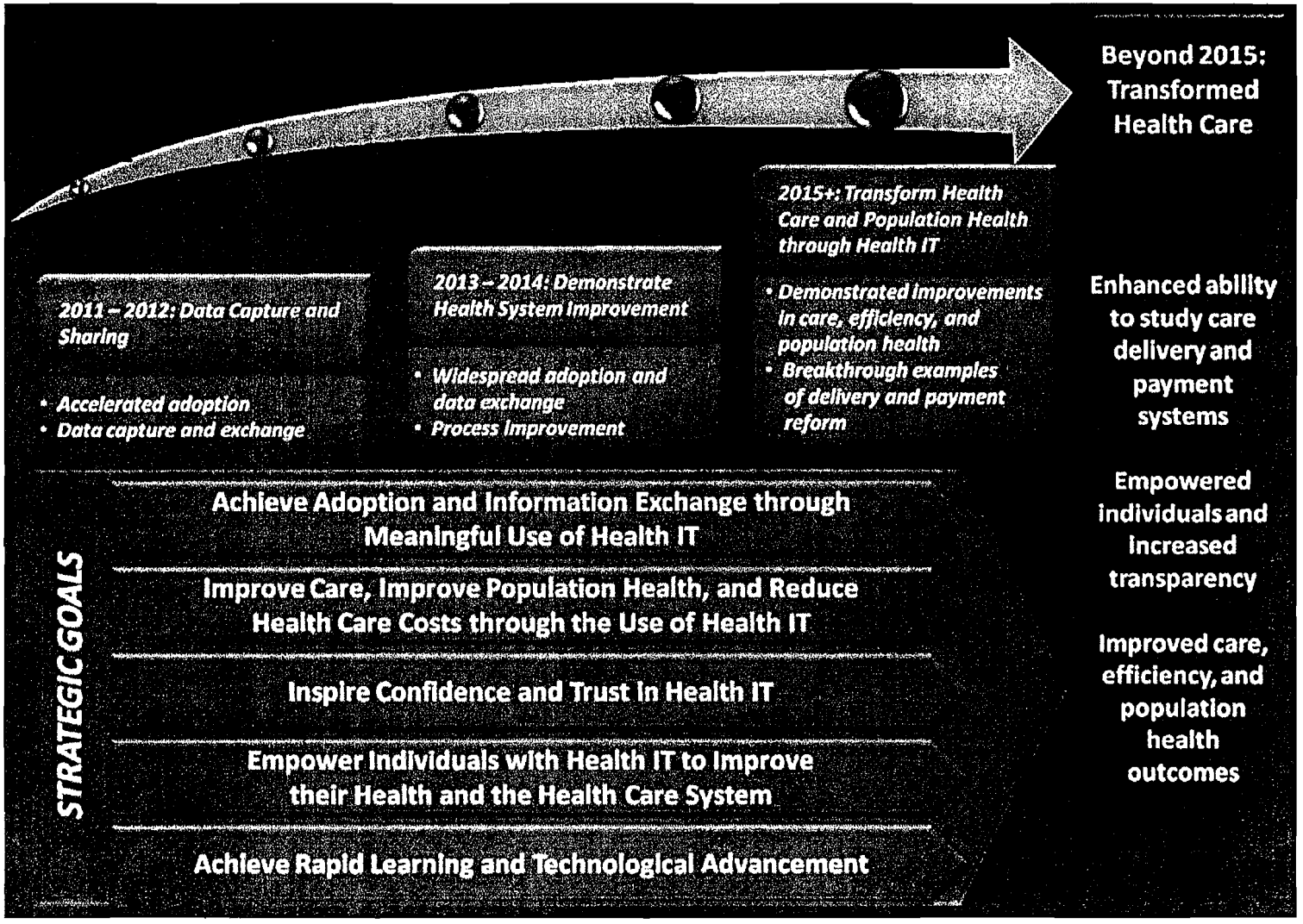
The Health IT Vision



*From the Office of the National Coordinator 2011-2015 Strategic Plan

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National Progress To Date

- Over **40%** (IN at 39%) of Providers had basic systems in 2012 – up from **22%** in 2009
- More than **337,726** Eligible Professionals have received incentive payments from the Medicare and Medicaid EHR Incentive Programs
- More than **3,231** Eligible Hospitals under Medicare, and **4,602** Eligible Hospitals under Medicaid
- More than **$9.3 billion in Medicare** EHR Incentive Program payments have been made
- More than **$5.8 billion in Medicaid** EHR Incentive Program payments have been made

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Indiana Progress to Date

- 39% of providers have basic system
- Most large Health Systems in Indiana are currently deploying their system – comparatively IN is a well-adopted state
- 4,960 Medicare and 444 Medicaid providers have met Meaningful Use
- Nearly 100 hospitals have met Meaningful Use
- $349 million in incentives have been paid
- FSSA has well-run and timely Medicaid attestation process and system

Current Situation

- Adoption and Implementation
  - Adoption at most large health systems in IN is progressing quickly
  - Small practices (rural and urban) are much slower
  - Not readily adopted in Behavioral Health or Long Term Care
- Multiple Initiatives – A Tsunami
  - Accountable Care Organizations (ACO)
  - Patient Centered Medical Home (PCMH)
  - ICD10 (medical procedure billing codes)
  - Hospital quality penalties (readmissions, hospital acquired conditions, etc.)
  - Physician Quality Reporting System

Current Situation (cont.)

- Technology
  - EHRs still being implemented/adopted/designed/upgraded
  - Not everyone is using yet
  - Usability still immature
  - Interoperability is still in infancy
- Patients
  - Not engaged with their personal health records
- Data Security Enforcement Tightened
  - Becomes more important as more records are digitized and shared
- Initial Research Studies Showing Bright Outlook
  - EHRs, ACOs, and PCMHs improve quality and save money to varying degrees

Challenges

- Widespread Usage – time of significant transition for industry
- Immature Technology
  - EHRs are still being implemented/adopted/designed
  - Interoperability between vendor products poor (e.g., AllScripts and Epic)
  - Data is not shared easily
- Patient Engagement
  - Electronic patient portals and heath records required with Stage 2 MU
- Security
  - Healthcare security is less refined

Challenges (cont.)

- Patient-Centric Payment and Quality (Population Health)
  - Entire industry is adjusting – not paid by procedure in the near future, but in overall patient health
  - Population Health quality systems and professionals in short supply
  - Focus shifting from "sick care" to "preventive care"
- Technology Affordability
  - Small independent provider practices
  - Critical Access/Rural Hospitals
- Workforce
  - Data/quality/clinical combined expertise in short supply
  - IT/Security expertise in short supply – especially for smaller or rural organizations

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Recommendations

- Encourage and investigate means for faster implementation of:
  - Meaningful Use
  - Patient Centered Medical Homes
  - Patient Health Records
- Provide ongoing assistance to small provider organizations with Meaningful Use and Patient Centered Medical Home
- Continue to invest in Health Information Exchange (HIE) and interoperability between HIEs
- Invest in HIE/EHR interoperability
- Invest in workforce development

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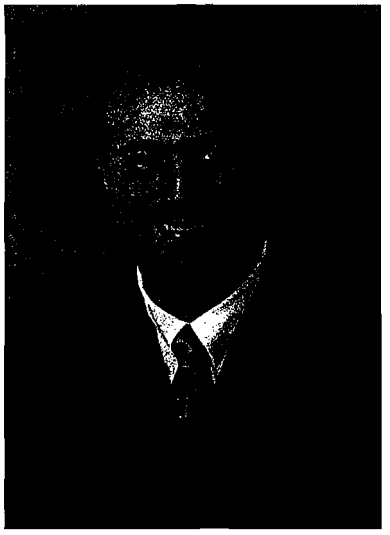

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  - **Electronic Health Records and Quality of Diabetes Care,** Randall D. Cebul, M.D., Thomas E. Love, Ph.D., Anil K. Jain, M.D., and Christopher J. Hebert, M.D., N Engl J Med 2011; 365:825-833September 1, 2011DOI: 10.1056/NEJMsa1102519
  - **Pioneer Accountable Care Organizations succeed in improving care, lowering costs:** http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-16.html
  - **Blue Cross Blue Shield of Michigan saves an estimated $155 million over three years from Patient-Centered Medical Home program:** http://www.bcbsm.com/content/microsites/blue-cross-blue-shield-of-michigan-news/en/index/news-releases/2013/july-2013/bcbsm-saves-155-million-pcmh.html

HFC, July 22, 2013 Exh. 9

TO: Casey Kline, Attorney for the Commission
FROM: Tony Gillespie, Senior Field Consultant, Indiana Minority Health Coalition
RE: 7/22/2013 - Testimony on the collection, maintenance, sharing and use of electronic health data
DATE: July 23, 2013

Introduction

Good afternoon ladies and gentlemen of the committee. Thank you for this opportunity to speak with today. My name is Tony Gillespie, Senior Field Consultant with Indiana Minority Health Coalition. IMHC is a statewide agency with 25 community-based coalitions and affiliates serving 29 Indiana counties. We represent the interest of racial/ethnic minority men, women and families around health disparities, health access and chronic disease conditions.

Testimony

Indiana is to be commended on the work that has been done around implementation of using electronic health records. However there remain major issues facing Indiana's providers, patients and health advocates as they migrate towards Electronic Medical Records and E-prescribing.

- In some instances the functions of the EMR currently are disconnected information silos and thus create major barriers to achieving a true continuum of quality care. We believe an ideal EMR process would create one system that allows the tracking of patients from 1) diagnosis and development treatment plan/options 2) payer approval process 3) utilizing a claims process to track/confirm that a patient has accessed treatment services.
    - Currently, a provider must enter information in their EMR and then repeat the exercise again and again as they have to utilize different systems to complete Prior Authorization forms, INSPECT reports, Vaccine and other Registry forms and the list goes on.
    - Another issue with Prior Authorization is that currently, the top 7 insurers in Indiana have over 661 different PA forms to be completed. In ideal system should be able to easily integrate the PA process into the EMR and electronic prescribing systems to eliminate the duplication of effort when working with EMR entries.
- Another challenge is Medication Reconciliation. This would best be addressed by the development an application that could manage medications for patients, look for drug interactions, and promote adherence with treatments. Currently, medications that are prescribed are not captured anywhere. Information such as:

Indiana Minority Health Coalition, Inc. 3737 NORTH MERIDIAN ST., SUITE 300 INDIANAPOLIS, IN 46208
Phone: 317.926.4011 Fax: 317.926.4012 www.imhc.org

- What is prescribed?
- What is dispensed? (Including over the counter treatments, vitamins, and herbal supplements).

- Additionally privacy rights advocacy groups express concern about:

  - The security of the electronic medical record system is a concern. Can the health system or records be hacked?

  - Medical data may be used against an individual – such as denying employment, health insurance coverage. This is especially true for people living with HIV and other stigmatizing health conditions who are gainfully employed but fearful to seek employer based insurance.

And while many of speakers today have addressed the safety precautions and prevent either of these scenarios do not occur, for our most important and vulnerable partner is this process, the patient, these concern must be appropriately addressed.

Despite the numerous challenges there are clear benefits for both providers and patients:

Electronic health records assist health care providers to:

- Have access to accurate and complete information about an individual's health

- Improve coordination of care with multiple providers.

- Allow provider to share health information with an individual in an electronic format

- Gives provider access to health information that assists in the diagnosis and treatment of an individual, which helps to limit medical errors, improve patient safety, decrease costs

- Improved efficiency and decreased cost due to efficient physician practice, prescribing medication, receiving lab results, and increases confidentiality

Patient benefits from improved efficiencies and service as a result of the EMR include:

- Prescriptions are electronically sent directly to pharmacies and are ready to be picked up after the office visit. (Marked reductions in prescription errors and drug interactions have already been demonstrated in southeastern Michigan from the use of this technology.

- Patients may also be able to request referrals, prescriptions refills, and appointments through the Internet from their physicians' offices.

- Automatic reminders for a variety of preventive health measures can be easily generated. These reminders can improve disease prevention and early diagnosis.

- The integration of laboratory and x-ray reports with other data in the EMR provides a more succinct and exact view of all of a patient's medical information.

- And in the near future, the results can be rapidly passed on to the patient, the end user, through a secure Internet gateway or portal that links a patient to the physician's office. This gives the patient timely access to their own health information thus empowering them to an informed partner in the provision of healthcare services.

- Additionally, the patient will be able to update his/her personal and health insurance information easily and will not be required to complete the same forms each time he/she visits the physician's office.