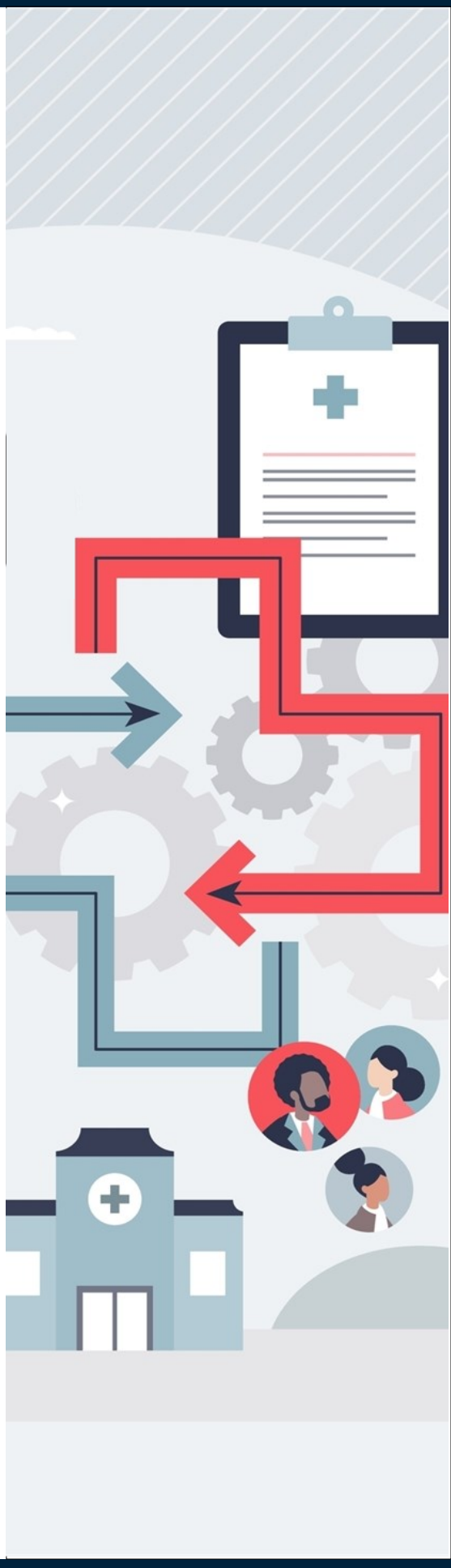
Evaluation Report
October 2023

State Oversight of Idaho's Health Information Exchange



Office of Performance Evaluations
Idaho Legislature

Senator Melissa Wintrow (D) and Representative David M. Cannon (R) cochair the committee.

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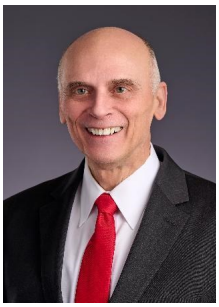
Senators

Melissa Wintrow



C. Scott Grow

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From the director

October 20, 2023

Members
Joint Legislative Oversight Committee
Idaho Legislature

The Idaho Health Data Exchange was intended to ensure that health records are available for Idahoans when needed. Although it has existed since 2008, we found confusion among state officials about the state's role with the exchange.

We found that the state created the exchange as a nonprofit corporation and did not provide the exchange with enough oversight to fulfill its public purpose. Furthermore, the state did not make full use of its system of checks and balances to ensure cost-effective use of public dollars on contracts with the exchange.

This problem became more apparent when a DC-based consulting company took over managing the exchange in 2019. Millions of dollars were spent on noncompetitive contracts without sufficient transparency and accountability. The state received less than what was promised in its most recent contract with the exchange.

We provide several recommendations and policy considerations to improve future public-private partnerships, transparency, and oversight.

Sincerely,

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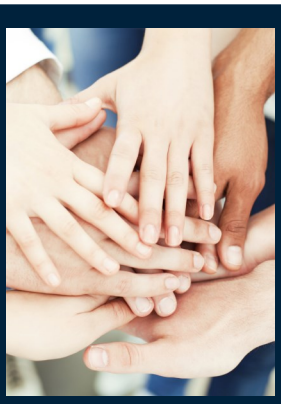
Formal responses from the Governor, the Department of Health and Welfare, and the Department of Administration are in the back of the report.



Sasha O'Connell and Ryan Langrill conducted this evaluation with assistance from Lauren Bailey and Casey Petti.

Leslie Baker copyedited the report.

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Contents

Executive summary

Health information exchanges (HIEs) facilitate the availability of electronic health records for healthcare providers and other users. Idaho's HIE, called the Idaho Health Data Exchange, Inc., filed for bankruptcy in the fall of 2022.

The bankruptcy raised concerns among legislators because the Legislature had recently appropriated funding to improve the exchange. Legislators asked us to evaluate events leading up to the bankruptcy, the state's oversight of the exchange, and how Idaho's experience compared to other states.

During our initial meetings, we found confusion about the state's role with the exchange. Some legislators believed that the exchange was a public-private partnership like the health insurance marketplace, Your Health Idaho. The Department of Health and Welfare described the state as only a customer of the exchange. We found that the reality was more complicated.

The state created the Idaho Health Data Exchange.

We found that the state had significant influence over the design and growth of Idaho's HIE. The Legislature statutorily established the Health Quality Planning Commission in the Department of Health and Welfare. Commissioners were appointed by the Governor and were told to create a plan for the development and oversight of an HIE. The commission created and voted to adopt articles of incorporation and bylaws for the exchange. In 2008, the director of Health and Welfare signed articles of incorporation for a 501(c)(6) nonprofit corporation called Idaho Health Data Exchange, Inc.

The state had a special relationship with the exchange from the beginning. The Governor declared the exchange as the only state designated entity to receive 2009 federal funding for the development of an HIE. Health Quality Planning Commissioners were the exchange's first board members, and a former Health and Welfare employee was the exchange's first executive director. Health and Welfare shared office space with the exchange in a building on State Street in Boise until at least 2017.

Nonprofit corporations have lower transparency standards than government entities.

At least $22 million were spent in contracts to improve the exchange without going out to bid.

The exchange was created as a nonprofit corporation without enough formal state oversight.

The state designed the exchange as a nonprofit corporation without clear statutory guidance about responsibilities and oversight. The state's informal mechanisms of accountability deteriorated over time as turnover left little overlap between the exchange and the state, particularly when consultants from out of state were brought in to manage the exchange.

Accountability to the public also faded because nonprofit corporations have lower standards for transparency than government entities. The exchange does not have to follow Idaho Code related to transparent and ethical government. The Legislature also has far less information about the exchange compared with what is regularly shared or readily available from state agencies.

The Legislature should consider mechanisms to increase transparency of any new public-private partnerships like the exchange. The Legislature should also consider clarifying what authority public officials have to create nonprofit corporations and other corporate entities to carry out public work. The state should be explicit about its oversight role and other expectations of any new public-private partnerships. In chapter 2, we provide examples of sections of Idaho Code that legislators may be interested in referencing to help oversee new public-private partnerships.

The state treated the exchange like a monopoly, even as Health and Welfare paid millions to expand the exchange's capabilities.

Since 2009, Health and Welfare has had an annual $100,000 contract to access data through the exchange for its various responsibilities, such as approving specialized care for Medicaid patients. After Health and Welfare helped create the exchange, it requested that the data access contract be exempt from competitive bid requirements because the exchange was the "sole source" for these services.

In 2015, Health and Welfare began to use its sole source exemption for data access to pay the exchange at least $22 million in other contracts for improvements to the exchange, without going out to bid. Other states have sought competitive

bids for contracts to develop or improve their HIE. The scope creep we found under the exchange's exemption is concerning because other vendors may have been able to build a better exchange or do so more efficiently with public dollars.

Although we found no evidence of impropriety, not going through the procurement process also led Health and Welfare to administer its own multimillion-dollar noncompetitive contracts with an untransparent vendor that was created by a commission in Health and Welfare and for many years had Health and Welfare officials on its board.

We recommend that the Department of Health and Welfare and the Department of Administration take steps to prevent scope creep in procurement exemptions and examine external oversight policies pertaining to conflicts of interest. In chapter 3, we provide detailed suggestions for how the two departments might approach these recommendations.

Health and Welfare officials were on the exchange's board during these noncompetitive contracts.

The state's special relationship with the exchange initially led Health and Welfare to focus on the exchange's financial stability rather than deliverables.

In 2020, the Legislature appropriated $19.5 million in federal SUPPORT Act funding for Health and Welfare's Division of Medicaid to improve the exchange and enroll new providers. We found that Health and Welfare staff tried to use the SUPPORT Act contract to introduce transparency, protect the state, and ensure the public got what it paid for. However, the exchange's special relationship with the state led to loose guidelines in the contract, which Health and Welfare staff later found to be insufficient because of the exchange's new management.

The exchange's special relationship with the state led to loose guidelines in the contract.

We found that Health and Welfare arranged the contract to ensure the exchange received funding up front because it was not financially stable. For example, the exchange was asked to deliver project charters for each part of the contract, which were generally 8-9 page documents that included a cover page, contact information, a short description of the planned work, and key milestones. The exchange's contract included 14 project charters that were typically worth $100,000 each. The contract also included 15 communication plans that were typically worth $100,000 each.

The exchange violated contract provisions several times even before the Legislature approved SUPPORT Act funding.

When Health and Welfare had concerns about the exchange's new management team and tried to require more transparency, the relationship deteriorated.

We found that Health and Welfare staff closely involved with the most recent contract became concerned about the capabilities and trustworthiness of the exchange's new Washington D.C.-based management subcontractors. The exchange quickly began falling behind on work and not meeting other requirements of the federal grant. The exchange violated contract provisions several times even before the Legislature approved SUPPORT Act funding.

We found that the exchange's new management subcontractors were reluctant to accept and sometimes avoided Health and Welfare's attempts to amend the contract with common transparency requirements. Health and Welfare requested but never received financial audits or SOC 2 Type 2 data security audits. The exchange's management team was never approved through the federal vendor database, which is used to ensure vendors are not under investigation or prohibited from working with federal grants. Health and Welfare also was not able to provide us with executed copies of all subcontracts paid for by the SUPPORT Act.

Health and Welfare IT experts spent months reviewing the exchange's protocols but could not confirm that it met federal data security requirements by the end of the contract in September 2020. In October 2021, Health and Welfare determined that a third-party attestation was sufficient evidence that the exchange had met security requirements a year earlier and paid the exchange. We found that experts in Health and Welfare either were not consulted or did not agree that the exchange met federal standards, and that Health and Welfare received pressure from the exchange to close out the contract. We also found signs of a potential conflict of interest with the third party attestor.

We recommend that Health and Welfare require annual validation of the exchange's data security. This issue is discussed further in chapter 4.

The exchange filed for bankruptcy after being sued by a subcontractor for withholding pass-through payments from Health and Welfare.

Health and Welfare prepaid the exchange for several three-year agreements with subcontractors, but the exchange did not pass all that money on to subcontractors. One of the subcontractors sued the exchange in September 2021 for breach of contract, breach of implied good faith and fair dealing, and fraud. In May 2022, the court determined that there was reasonable probability that the subcontractor would prevail on its breach of contract claim. The exchange filed for bankruptcy after the court ordered the Ada County Sheriff to seize $790,000 from the exchange's bank account. The bankruptcy led to dismissal of the civil case.

A subcontractor sued the exchange for breach of contract, breach of implied good faith and fair dealing, and fraud.

In their bankruptcy court filings, the exchange reported that it did not have sufficient assets to fully pay its creditors under liquidation. Instead, the court approved a settlement plan for the exchange to pay about 25 percent of claims to its creditors, including subcontractors that did work under the SUPPORT Act contract with Health and Welfare.

The state did not receive everything promised under the most recent improvement contract but still has a small data access contract with the exchange.

Of the $19.5 million in SUPPORT Act funding appropriated to Health and Welfare, $9 million was paid to the exchange. A large share of funding was withheld because the exchange only connected 2 new users when it was expected to connect 20 new hospitals and 30 new clinics. Health and Welfare renewed its $100,000 annual contract to access data on the exchange in May 2023. Now that the large improvement contracts are over, the state has less leverage over the exchange and the public has little access to information about its business operations.

Now that the large improvement contracts are over, the state has less leverage over the exchange and the public knows little about its business operations.

Officials with the exchange reported operating a growing and successful business now that the exchange has a bankruptcy plan to pay off some of its debt to creditors. We requested documentation to support these statements, but either did not receive or have access to enough documentation to verify them. Stakeholders reported that large providers use the exchange as a backup to other more advanced and expensive systems. Independent and rural providers sometimes make do without the

Idaho Code did not give Health and Welfare clear responsibilities or authority over the exchange.

exchange by calling other providers or relying only on the information they have in front of them.

We found through our interviews that Health and Welfare officials did not trust the exchange's current management. Idaho Code did not give Health and Welfare clear responsibilities or authority over the exchange. Because of turnover, officials often did not know how influential the state was in creating and improving the exchange. Having little influence now, officials with Health and Welfare only felt limited responsibility for the exchange.

Exhibit 1

The state lost its informal mechanisms of oversight before the exchange's most recent improvement contract.

Key events around the creation of the exchange and its later filing for bankruptcy.

Source: Office of Performance Evaluations' analysis of Idaho Code and documents from Idaho Department of Health and Welfare, Idaho Secretary of State, Idaho Department of Administration, Idaho Fourth Judicial District Court, U.S. Bankruptcy Court for the District of Idaho, Internet Archive, and ProPublica.

Federal efforts to standardize and broaden access to private exchange networks leave uncertainty for some HIEs.

States have taken different approaches to developing their HIEs. Many of these HIEs have struggled to be financially independent. Federal funding facilitated the expansion of community HIEs like Idaho's, but since then private software companies have created HIE networks for their customers and led the establishment of other national HIE networks. Today providers can exchange health records through several types of organizations.

The federal government has also been pursuing initiatives to standardize HIEs operated by private companies. For community HIEs to successfully compete, national advocates have recommended that they expand their capabilities and maintain strong relationships with their state, which the Idaho Health Data Exchange currently lacks.

The state has several options moving forward. Health and Welfare could continue its data access contract with the exchange, but explore other options as new HIE solutions continue to increase with support from federal initiatives.

National advocacy groups have been encouraging states to create a health data utility through statute or rule, similar to our recommendation in chapter 2 for new public-private partnerships. The health data utility framework calls for long-term blended local, state, federal, and private funding with increased oversight, accountability, performance measurement, and evaluation. The framework addresses many of the issues we found in our evaluation, but it is unknown whether the exchange would cooperate with such a substantial governance and transparency overhaul. If not, the Legislature would likely need to invest more by developing a new HIE. Although federal funding may be available to offset state costs, the Legislature may not want to pursue this option without full cooperation from the exchange because of the investments already made.

Over the course of this evaluation, we were frequently asked whether the state should run the exchange. States using a similar model to Idaho tended to have more regulation and incentives for their HIE. We did not find evidence that state-run HIEs were more successful than strong public-private partnerships or other models. Health and Welfare also does not have sufficient information to recreate the current HIE. Although the state could create a new HIE, it would take another significant investment by the Legislature.

States using a similar model to Idaho tended to have more regulation and incentives for their HIE.

We did not find evidence that state-run HIEs were more successful than other models.

1 Introduction

Idaho's health information exchange (HIE) facilitates the availability of electronic health records for healthcare providers and other users across the state. See exhibit 2. For example, physicians who participate can

review a patient's blood test or other lab results from another provider,

learn about any current prescriptions that may affect treatment,

look at x-rays from an accident a patient had while out of town, or

review notes from a visit the patient had with a specialist.

Public health officials can use an HIE to monitor infectious diseases or quickly approve the release of special treatments that require federal approval, such as the botulism antitoxin.

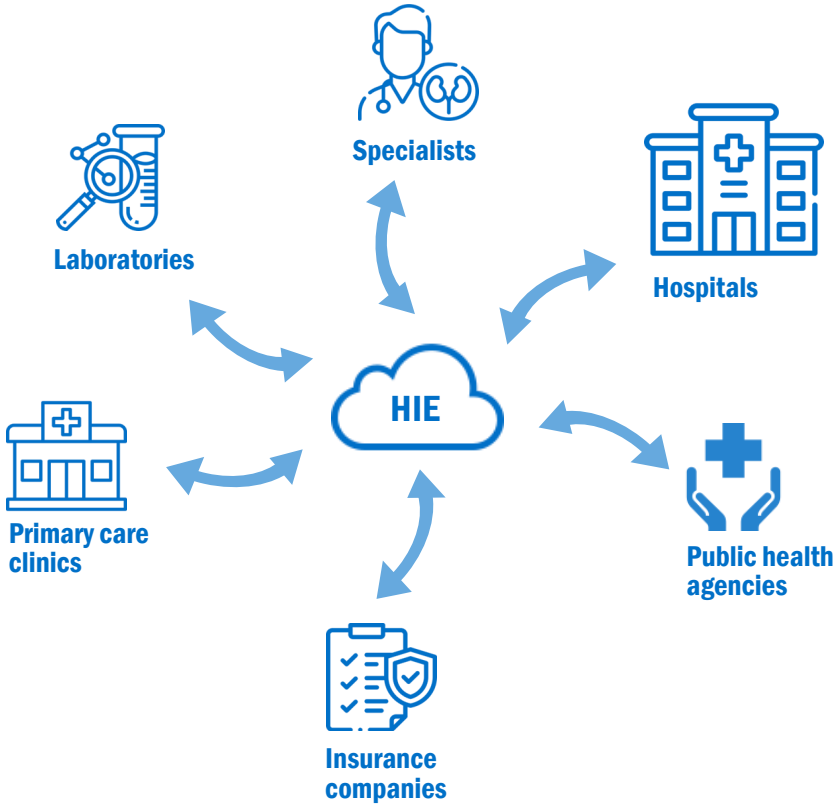
Health care payers, such as private health insurance companies and Medicaid, can use an HIE with the goal of decreasing duplication, verifying when patients need specialized care, and improving quality of care.

Idaho's HIE also stores data, giving it the ability to provide trends and aggregate information.

Exhibit 2

Health information exchanges (HIEs) share electronic health records with health care providers, labs, and other users.

Although HIEs often offer other services, each HIE has the basic functionality of exchanging records.



Source: Office of Performance Evaluations' adaptation based on a literature review.

Legislative interest

Idaho's HIE, called the Idaho Health Data Exchange, filed for bankruptcy in the fall of 2022. The bankruptcy raised concerns among legislators because the Legislature had recently appropriated funding to improve the exchange. Our office received a request to evaluate the events leading up to the exchange's bankruptcy. We were also asked to determine whether the state's level of oversight was appropriate and how our experience compared to other states.

The request for our evaluation is in appendix A.

The bankruptcy raised concerns because the Legislature had recently appropriated funding to improve the exchange.

We focused on the state's oversight of the exchange.

Evaluation approach

The way the state created the exchange prevented us from accessing the records we would need to evaluate the exchange's practices. Officials with the exchange did not respond to our request for documentation commonly made available during evaluations, such as contracts, meeting minutes, and financial statements. Our evaluation focused on the state's oversight of the exchange.

In chapter 2, we describe the beginning of the state's special relationship with the exchange, from creating the exchange to sharing an office and funding its growth. We discuss how the state designed the exchange without mechanisms for ongoing oversight and transparency. We include recommendations related to future public-private partnerships.

In chapter 3, we discuss how the state pursued agreements that allowed the exchange to receive several multimillion-dollar federal grants without competition or external contract oversight. We have recommendations related to technical assistance for contract determinations and external oversight to prevent appearances of a conflict of interest.

In chapter 4, we discuss how the exchange's historically special relationship with the state changed substantially when the exchange outsourced its management to an out-of-state consulting group. We describe major components of contract disputes just before the exchange's bankruptcy. We recommend that the Department of Health and Welfare require proof of data security in its ongoing agreements with the exchange.

In chapter 5, we discuss experiences in other states, the shifting landscape of HIEs, and federal efforts that may affect the exchange. We provide resources to improve governance and oversight should the Legislature decide to invest further in the exchange.

See appendix C for our methods.

Designing a health information exchange

2

The purpose of creating Idaho's health information exchange (HIE) was to facilitate the availability of electronic health records to improve quality of patient care, decrease duplication of tests and services, and monitor population health to guide policy decisions.

Idaho's HIE is run by a nonprofit corporation called the Idaho Health Data Exchange, Inc., which filed for bankruptcy in 2022.[1] During our initial meetings, we found confusion about the state's role with the exchange. Some legislators believed that the exchange was a public-private partnership like the health insurance marketplace, Your Health Idaho. The Department of Health and Welfare described the state as only a customer of the exchange. We found that the reality was more complicated.

We found that the Legislature, the Department of Health and Welfare, and other units of state government had significant influence over the design and growth of Idaho's HIE. The state designed the exchange to be a public-private partnership without clear statutory guidance about responsibilities and oversight. As a result, the state's influence and oversight faded over time. Transparency and accountability to the public also faded.

1. The Idaho Health Data Exchange exited bankruptcy proceedings with a plan to pay a share of debt owed to its creditors in June 2023. As of the release of this report, the exchange was still operating.

The state had significant influence over the design and growth of the exchange.

The Legislature established a commission in Health and Welfare to create a plan for the development and governance of an HIE.

In 2006, the Legislature the created the Health Quality Planning Commission to lead the development of a statewide health information technology (IT) system.[2] The commission was composed of public and private health IT, clinical quality, and patient safety experts appointed by the Governor.

Legislators placed the commission in the Department of Health and Welfare, noting that they intended for the department "to promote improved quality of care and improved health outcomes through investment in health information technology." The enabling legislation explained that widespread use of electronic health records would allow "quick, reliable, and secure" access to promote patient safety and best practices, consistent with the goals of President George W. Bush's new office overseeing health IT.

Commission created a nonprofit corporation

The commission studied the health IT landscape in Idaho with support from staff at the Department of Health and Welfare. We spoke with former commissioners and department staff involved in deciding what the state should do next. The commission determined that Idaho's HIE should be administered by a nonprofit for several reasons including

payers and providers wanted influence over implementation;

the Department of Health and Welfare was being restructured due to management concerns;

the pending economic recession created concern about potential budget shortfalls for the department and other state agencies; and

being outside of government was thought to improve the likelihood of receiving nongovernment funding.

2. H. 738, 58th Leg., 1st Sess. (Idaho 2006) had a fiscal note of $200,000 in state general funds and $300,000 in federal funds. Health insurance companies and hospitals also contributed an unknown amount of funding to support the effort.

The commission voted to formally approve articles of incorporation and bylaws for the Idaho Health Data Exchange. In 2008, the director of the Department of Health and Welfare signed articles of incorporation for a 501(c)(6) nonprofit corporation called Idaho Health Data Exchange, Inc.[3]

The department provided us with several draft reports to the Legislature, some of which mentioned the commission's decision to create a nonprofit corporation. However, the Legislative Services Office did not have a record of legislators receiving them. We did find that members of the commission, including a legislator, discussed the commission's decision with the legislative health care task force in July 2007.

Officials with the exchange described it as a nonprofit corporation during their most recent presentation to a legislative committee in 2009. But the extent to which legislators knew that the exchange was a nonprofit corporation created by the state is unclear. The recent and current legislators we interviewed for our evaluation had little or no information about the state's creation of the exchange as an independent, private corporation.

Health and Welfare provided office space, equipment, and other support to the exchange

We interviewed former legislators and healthcare stakeholders who were involved during the early phases of the exchange. They described being excited about the opportunity to help improve care and reduce costs for Idahoans. Department officials and staff also dedicated substantial efforts to its implementation.

> *The Idaho Health Data Exchange is neither a direct arm of government nor part of any other organization in the state's healthcare environment. It is a true example of a public-private partnership.*
>
> – Health Quality Planning Commission 2009 draft report to the Legislature

We found that the department treated the creation of an HIE like any other large government initiative by sending the Health Quality Planning Commission's plan out for public comment. Then commissioners became the first board members of the

Legislators, Health and Welfare staff, and other stakeholders were excited about the opportunity to improve care and reduce costs.

3. The exchange converted from a 501(c)(6) to a 501(c)(3) in 2019.

Idaho Health Data Exchange. The first executive director of the exchange was a former project manager at the department who helped launch the exchange.

The state also took steps to secure federal funding for the exchange. The Governor wrote a letter to the federal government declaring the Idaho Health Data Exchange as the "qualified State designated authority" to receive grant funding from the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.[4]

3 active directors of Health and Welfare served on the board of the exchange since 2008.

We found that the Department of Health and Welfare also supported the Idaho Health Data Exchange with in-kind support until at least 2017. This included equipment, supplies, and an office in the Health and Welfare building, initially on the 10th floor near the director's office. Three active directors of Health and Welfare sequentially served as board members of the exchange from its inception in 2008 until 2021.

Exhibit 3

The Department of Health and Welfare shared office space with the Idaho Health Data Exchange for nearly a decade.

Idaho Health Data Exchange, Inc. website from 2008 showing the department's address.

Source: Internet Archive.

4. Under the American Recovery and Reinvestment Act of 2009, the HITECH Act provided federal enhanced Medicaid matching funds to support the exchange of electronic health records.

As the exchange became more independent, the state lost its informal mechanisms of accountability.

We found that the Idaho Health Data Exchange's board no longer had the same membership as the Health Quality Planning Commission. The commission wrote in a 2007 draft report to the Legislature that the exchange's board would include representatives from the Department of Health and Welfare and the Legislature. However, those commitments were not in statute or rule, and nonprofit corporations have the ability to change their board representation. The exchange's board no longer had representation from the department or the Legislature in 2023.

The exchange's board has experienced significant turnover, according to its annual reports filed with the Secretary of State. The board changed every year since 2010, with about a quarter of board members not returning in a typical year. Former and current board members also reported that the board intentionally became less involved in operations and chose to take a more advisory role.

> *You've got to remember that none of those people are professional board members. They all have other jobs. It leads to an abdication of responsibility for something that's very important to the state.*
>
> – former Idaho Health Data Exchange board member

Unlike the original director of the exchange, the current director is not a former employee of the Department of Health and Welfare. The exchange's public documents are inconsistent and at times unclear about who was acting as executive director. Using available sources and interviews, we identified at least 6 executive directors since 2010. Since 2019, the exchange's executive directors have not been employees because the exchange has filled this position using out-of-state consulting companies.

> *I don't even recognize the Idaho Health Data Exchange. It looks totally different.*
>
> – director of a neighboring state HIE

The exchange's board no longer had representation from Health and Welfare or the Legislature.

The exchange's board began using out-of-state consultants for its management in 2019.

Idaho Code never included an enforcement mechanism for Health and Welfare or its commission to oversee the exchange.

The Legislature statutorily required detailed regular updates from the commission about the exchange until 2010. After the exchange was operational, legislators removed requirements for regular reporting to the Legislature.[5]

The commission in the Department of Health and Welfare now only has to "monitor the effectiveness" of the exchange.[6] The commission's most recent report was a compilation of minutes from the last three years with a summary statement reading simply: "During this time period HQPC continued to monitor the effectiveness of the Idaho Health Data Exchange (IHDE) and received regular presentations from IHDE representatives about progress and challenges."

We found that the commission continues to meet quarterly but has shifted its focus over time from the exchange to other issues related to quality of care. Officials with the Idaho Health Data Exchange have chosen to present high-level reports to the commission when asked, but they are not required to by Idaho Code. The commission does not have an enforcement mechanism and as a result, we found that it does not offer an effective forum for accountability of the exchange.

5. H. B. 489, 2008 Leg., 59th Sess. (Idaho 2008) and H. B. 494, 2010 Leg., 61st Sess. (Idaho 2010)
6. Idaho Code §56-1054(4) (2023)

Idaho Code treats nonprofit corporations created by government officials like any other nonprofit.

During the scoping process, legislators told us that they wanted to better understand the authority by which the exchange was created. We found that the Legislature statutorily directed the Health Quality Planning Commission in the Department of Health and Welfare to create a plan for the development and governance an HIE.[7] We found that Idaho Code did not prevent or explicitly give the commission or the department authority to create a nonprofit corporation. Idaho Code also did not dictate any additional requirements for nonprofit corporations created by government officials. Our analysis was not as wide reaching as a legal opinion and we encourage the Legislature to discuss this issue with counsel for more information about court findings and constitutionality.

The Idaho Health Data Exchange is fundamentally different from other nonprofit corporations because it was created by public officials for a public purpose with significant public funding. We do not know how many nonprofits have been created by government officials because the state does not track this information. The Secretary of State's Office oversees incorporation and business filings.[8] An official with the office reported that it has no way of knowing whether nonprofit corporations were created by government officials. Current state agency officials may not even know about former involvement in the creation of a corporation because of staff turnover, which is what we found with the exchange.

The exchange is subject to requirements faced by any other nonprofit corporation. These requirements provide very little transparency compared to what state agencies must provide. See exhibit 4. The most detailed information required from nonprofit corporations comes from Form 990s that must be submitted annually to the federal government and become publicly available two years later.[9] Form 990s only provide high-level financial information and list board members and certain employees.

The exchange is fundamentally different from other nonprofits because it was created by public officials for a public purpose with significant public funding.

7. H. 738, 58th Leg., 1st Sess. (Idaho 2006).
8. Idaho Code §67-903 (2023)
9. We found the exchange's Form 990s through 2021 by using ProPublica's Nonprofit Explorer database. The Internal Revenue Service requires nonprofit corporations to provide a copy of their most recent Form 990s within 30 days of a written request from the public. We requested but did not receive 990s from the exchange.

Exhibit 4

Nonprofit corporations have fewer requirements than government entities to be transparent.

Examples of information available to the public upon request.

	State Agency— Department of Health and Welfare	Nonprofit Corporation— Idaho Health Data Exchange, Inc.
Meetings	Idaho's Open Meetings Law states that "it is the policy of this state that the formation of public policy is public business and shall not be conducted in secret." Before a meeting takes place, state agencies and other units of government are required to notify the public and post agendas online and in a prominent place. They must also keep written minutes and make them available to the public, among other requirements.	No requirements.
Contracts	Idaho's Public Records Act states that "every person has the right to examine and take a copy of any public record of this state." Contracts are subject to a public records request, unless they meet one of the exemption standards.	No requirements.
Financials	Revenue sources and expenditures are subject to the Public Records Act. The State Controller's Office has taken steps to ensure quick access to government financials through Transparent Idaho and other publicly accessible resources.	High-level summaries of specific types of financial transactions are on Form 990s. Form 990s do not include individual financial transactions. They do not list who received money from the nonprofit corporation or who paid the nonprofit corporation except in limited circumstances. Form 990s are not available until two years later. Nonprofit corporations are not required to provide more detailed information when requested by the public.
Employees and independent subcontractors	The Public Records Act makes publicly available the names, employment history, pay rates, and other compensation for staff. Information about contractors is similarly available. Transparent Idaho makes this information publicly accessible and searchable.	Employees earning over $100,000 are listed on Form 990s. Employees earning less than $100,000 are not listed. The top 5 highest paid contractors are listed on Form 990s if they received more than $100,000. Contractors earning less than $100,000 are not listed. Contractors earning more than $100,000 are not listed if they are not in the top 5 highest paid. The exchange had more than 5 contractors earning more than $100,000 in 2020 and 2021.

Notes: The state has at various points required more transparency of the exchange in its contracts. To require more transparency, the state must have leverage in contract negotiations. We discuss this further in chapter 3.

Source: Office of Performance Evaluations' analysis of Idaho Code §74-100 and §74-200 as well as information from Form 990s filed with the Internal Revenue Service.

Instead, a potential investigation on the back-end serves as the state's main ongoing mechanisms for accountability with the exchange. The state may be able to access detailed financial information if it pursued an investigation by the Attorney General's Office.[10] The Joint Finance and Appropriations Committee may conduct hearings[11] and the Legislature has subpoena authority.[12] However, the state does not take these actions lightly because they may be costly or involve court proceedings. We found that without transparency up front, the state may not have enough information to determine whether an investigation is warranted.

The Legislature should consider mechanisms to increase transparency of any new public-private partnerships like the exchange.

The state should be explicit about its oversight role and other expectations of any new public-private partnerships like the exchange. Often it may be appropriate to put these expectations in statute.

For example, Alaska's statute holds its health department ultimately responsible for its HIE but allows the department to contract out for services as long as that contractor meets certain requirements, including reporting and board membership.[13]

The Legislature should also consider clarifying what authority public officials have to create nonprofit corporations and other corporate entities to carry out public work. Although Idaho chose to create a nonprofit corporation for this public-private partnership, it may be more appropriate to pursue independent public bodies corporate and politic.[14]

The Legislature should consider clarifying what authority public officials have to create nonprofit corporations to carry out public work.

10. Idaho Code §67-1401(5) (2023)
11. Idaho Code §67-435(b) (2023)
12. Idaho Code §67-407 (2023)
13. Alaska Stat. §18.23.300 (2023)
14. Idaho Code uses the term "independent public body corporate and politic" to refer to public organizations that are independent from other units of government. Requirements for each body are different and stipulated in Idaho Code. Examples other than Your Health Idaho include the Idaho rural development partnership (§67-9004), the Idaho housing and finance association (§67-6202), and the Idaho bond bank authority (§67-8703).

Public-private partnerships like the exchange should be subject to transparency and ethical requirements similar to public entities.

For example, the state's health insurance marketplace, Your Health Idaho, is not a nonprofit corporation or a state agency. Idaho Code dictates that its board include health stakeholders appointed by the Governor and confirmed by the Senate.[15] Code also requires Your Health Idaho to follow open meeting laws, contract for an annual audit, and submit reports to the Legislature.

We recommend that whenever the state or other units of government are involved in creating an entity for a public-private partnership, it should be subject to transparency and ethical requirements that are similar to public entities. The Legislature should consider statutorily requiring new public-private partnerships to be subject to the Public Records Act[16], the Open Meetings Law[17], the Ethics in Government Act[18], and relevant sections concerning bribery and corruption.[19] The Legislature should also consider codifying regular reporting requirements, financial audits, and board membership.

15. Idaho Code §41-6104 (2023)
16. Idaho Code §74-101 through §74-127 (2023)
17. Idaho Code §74-201 through §74-208 (2023)
18. Idaho Code §74-401 through §74-407 (2023)
19. Idaho Code §18-1301 through §18-1362 (2023)

The public invested millions in the exchange, but knows little about the exchange's financials.

The Department of Health and Welfare paid at least $93.3 million to

develop and expand uses for the exchange's systems and software,

create incentives for hospitals, clinics, and other health care providers to develop electronic health records for exchange, and

access data on the exchange for Medicaid quality assurance and public health purposes.

The largest share of funding was $64.9 million in federal grants that went to health care providers to encourage them to develop their systems for electronic health records. See exhibit 5. To be eligible for payment, providers had to demonstrate that they were using the records in a meaningful way, including by exchanging records with other providers.

The exchange itself received $24.4 million in funding through the department. Just over 5 percent of this funding was for the department to access data on the exchange and 95 percent was to develop and expand uses for the exchange. About $1.5 million was from state funding while the rest was from federal grants.

The exchange also received about $480,000 in loans from the Paycheck Protection Program for the COVID-19 pandemic while it was receiving other significant funding from the department in 2020 and 2021. The exchange did not pay back these loans and the federal government subsidized the obligation.

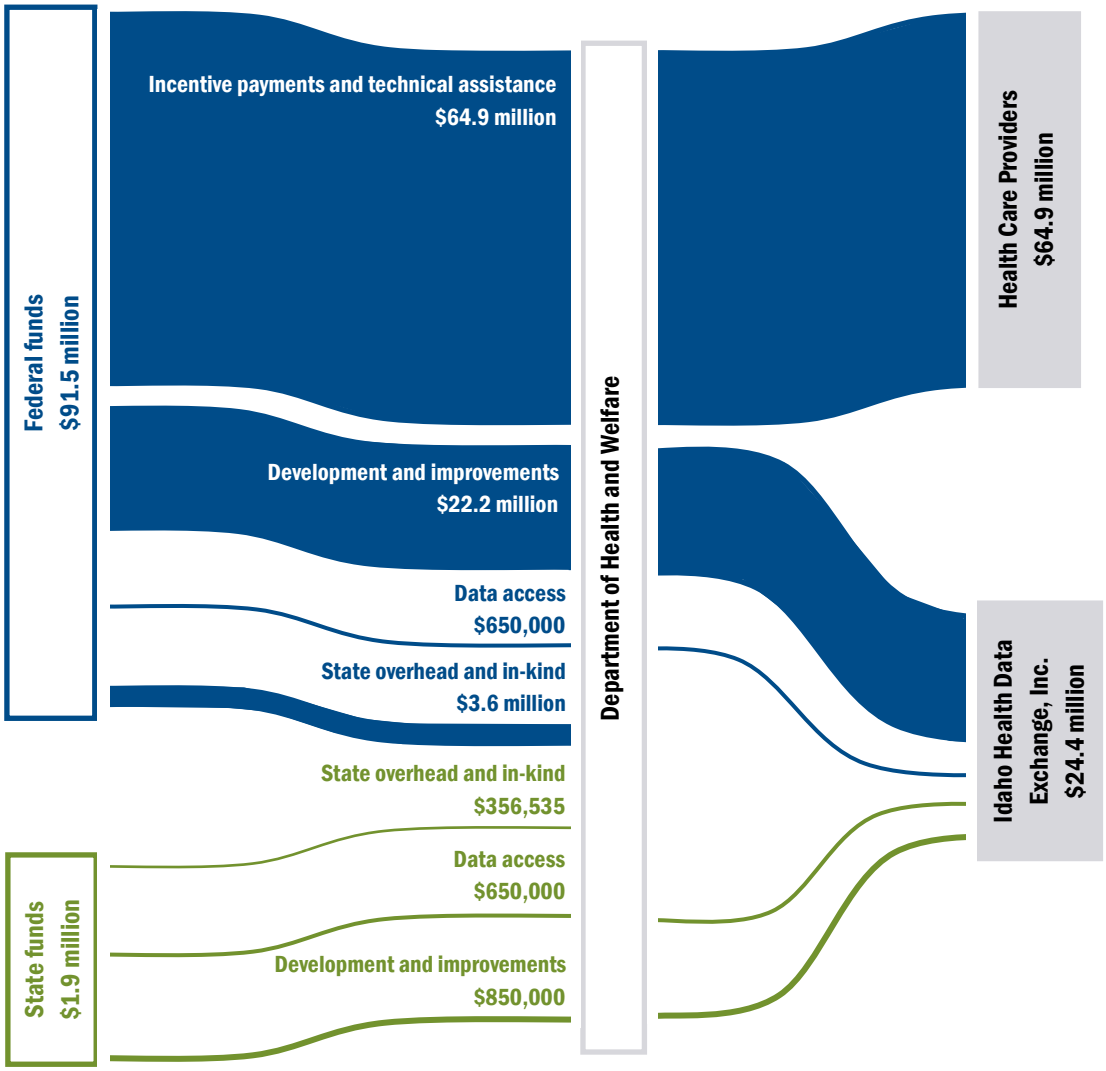
The public has little regular access to the exchange's financials, but the exchange reported in its recent bankruptcy court filings that federal and state funding comprised more than 60 percent of the exchange's revenue since its creation. We did not have access to transaction-level financial data from the exchange like we would for a state agency. As a result, we could not verify statements made on its Form 990s and bankruptcy filings.

Only 5% of funding from Health and Welfare to the exchange was to access data, the rest was to develop and expand uses for the exchange.

Exhibit 5

The Department of Health and Welfare invested $93.3 million for the development, promotion, and use of the exchange.

Federal and state funding from the department related to the exchange from FY 2008 until FY 2022.



Note: Some totals do not add up due to rounding. This exhibit does not include funding for the Health Quality Planning Commission or expenses that may not have been tracked, such as equipment or supplies while the exchange shared an office with the Department of Health and Welfare. This exhibit also excludes funding that did not go through the department, such as Medicare incentive payments and regional extension centers that supported health care providers to develop and exchange electronic health records.

Source: Office of Performance Evaluations' analysis of data from the Department of Health and Welfare.

The exchange collected an annual average of $1.8 million in user fees according to its last three Form 990s, but its recent bankruptcy plan projected more revenue because it plans to increase fees. The exchange reported that it expects $2.7 million in user fee revenue by 2027. It projects spending $2.6 million with about 45 percent going to management, staff, and administration, 43 percent going to IT, and 11 percent to pay off a portion of its debt to creditors. Reports suggest that the exchange has also tried to pursue alternative private funding since the end of its last large improvement contract with Health and Welfare.[20]

Recent bankruptcy filings provided limited additional information about the exchange's financials.

20. According to the Idaho Capitol Sun, the exchange's press release, and court documents, the exchange announced $8 million in grant funding from a private multinational lending company in May 2021. The lending company later made the exchange's management consultant one of the company's executive directors, but funding reportedly never fully materialized for the exchange.

3 Defining and overseeing agreements

Idaho Code gave the state no meaningful oversight mechanisms for the exchange. The state's informal mechanisms of accountability deteriorated over time as turnover left little overlap between the exchange and the state, particularly when consultants from out of state were brought in to manage the exchange. As a result, the state's relationship with the exchange was governed by a series of contracts and subawards. We found that the state struggled to differentiate between two types of fundamentally different agreements to

- access data through the exchange, and
- develop and improve the exchange's database.

Since 2009, the Department of Health and Welfare has had an annual $100,000 contract to access data through the exchange for its various responsibilities, such as approving specialized care for Medicaid patients. We found that the department used a procurement exemption for its data access contracts on much larger agreements to develop and improve the exchange, which other states put out for competitive bid. The department at times also miscategorized these agreements as contracts instead of subawards, which meant federal financial audits were required but not available for our evaluation. The department also did not have external oversight for its contracts with the exchange.

Health and Welfare did not go through a competitive bid process for multimillion-dollar improvement contracts with the exchange.

In many cases, state agencies must seek competitive bids when purchasing goods, services, and other property. The Department of Administration's Division of Purchasing oversees the competitive procurement process for other state agencies.[21] The division administrator may exempt agencies from the procurement process in certain circumstances, including when the needed property is only reasonably available from one supplier.[22]

In 2009, the Department of Health and Welfare requested sole source authorization for a $100,000 annual contract to purchase access to data on the Idaho Health Data Exchange. In their justification, the department cited the Governor's letter about HITECH funding and stated that his designation "establishes the IHDE as the sole provider of these services for the State of Idaho." The Department of Administration approved the exemption request and subsequent renewals.[23]

In February 2020, Health and Welfare requested and received a policy directive so that it would no longer have to regularly request reauthorization of the exemption. The policy directive exempted from competition "specifically the unlimited access to the exchange for the posting and retrieval of medical client electronic health information." Health and Welfare could amend and add funding to its contract with the exchange, as long as work stayed within the scope of the exemption and met other requirements. The policy directive did not have a scheduled date for review or termination.

The Department of Administration usually does not administer agreements when agencies seek an exemption from the

Health and Welfare was exempt from having to seek competitive bids for its smaller contracts to access data on the exchange.

21. Idaho Code § 67-9205 (2023)
22. Idaho Admin. Code r.38.05.01 (2023)
23. Notes show that officials with the Department of Administration raised questions about whether other companies could also provide HIE services. Health and Welfare's data access contracts varied in term length but always amounted to $100,000 annually. Its exemptions from procurement also varied in term length. The sole source authorization was renewed every five years and when the department reported funding was added to the contract, which only occurred once since 2009.

procurement process.[24] Instead, Health and Welfare's own Contract and Procurement Services Unit (CAPS) administered agreements with the exchange while the department's Medicaid program managed most agreements.

Questionable designation as contract instead of subaward

The federal Office of Management and Budget provides guidelines to help states determine whether an entity should receive funding through a subaward or contract:[25]

> a subaward is for the purpose of carrying out a portion of a federal award and creates a federal assistance relationship with the subrecipient[26]
>
> a contract is for the purpose of obtaining goods and services for the state's use and creates a procurement relationship

Agreements to improve and expand uses of the exchange likely should have been subawards, not contracts.

The state should use judgement to make a case-by-case determination based on the scope of work for each agreement with the entity receiving funding. Health and Welfare has a checklist to help programs make this determination, but parts of an agreement may fall under descriptions of both a subaward and contract. When filling out the checklist ourselves, we found that agreements to develop and improve the database more closely met the definition of a subaward and data access agreements more closely met the definition of a contract. Health and Welfare followed this approach until 2015 when it began to use contracts to fund improvements that likely should have been under a subaward.

In 2021, financial auditors with the Legislative Services Office found weaknesses and inconsistencies in Health and Welfare's procedures to identify when an agreement should be a subaward or a contract. These inconsistent procedures may have contributed to Health and Welfare's determination of the exchange as a contractor in several improvement agreements. In 2022, the auditors found that Health and Welfare took steps to improve consistency.

24. Idaho Admin. Code r.38.05.01.113.01 (2023)
25. The Office of Management and Budget provided guidance for all federal agencies to promulgate their own regulations. We primarily cite to US Department of Health and Human Services regulations because it managed federal grants that went to Idaho Department of Health and Welfare related to the exchange.
26. 45 CFR 75.351

Although consistency in using the checklist and documentation improved, we found that programs may need additional help when there is a close determination between a contract and subaward.

Contracts may provide more accountability than subawards in some instances. For example, federal regulations require contracts to adhere to state procurement policies, including a competitive bid process.[27] However, in this case the procurement exemption meant that a standard subaward offered more transparency and accountability. According to federal regulations, subawards require the state to monitor that funds are used for authorized purposes and in compliance with performance goals of the award.[28] Subawards also require the state to ensure the subrecipient submits a financial audit to the federal government for review.[29] Regardless of the state's determination, the federal government decides whether components of an agreement meet the definition of a subaward later in their review process.[30]

The state could add standard subaward requirements to a contract, but it is not required to by federal regulation. The exchange pointed this out during contract negotiations, as we discuss in the next chapter. The exchange argued against adding transparency measures to its contract that would have been standard in a subaward and asserted that Health and Welfare was adding unnecessary requirements.

The exchange later argued against adding transparency requirements that would have been standard in a subaward.

Scope creep from procurement exemption

We also found that Health and Welfare likely exceeded the scope of its exemption from procurement requirements when it pursued improvement contracts with the exchange without going out to bid. Health and Welfare initially requested an exemption from competitive bids for its $100,000 annual data access contracts because there was only one HIE. For several years Health and Welfare appropriately developed and improved the exchange using subawards, which were not contracts and therefore not subject to competitive procurement requirements. Then in 2015, Health and Welfare started to use its sole source exemption to pay the exchange at least $22 million in other contracts for improvements without going out to bid.

Health and Welfare used its data access procurement exemption for much larger improvement contracts.

27. 45 CFR 75.327
28. 45 CFR 75.352
29. 45 CFR 75.352(f)
30. 45 CFR 75.2 "Subaward"

Other states have sought competitive bids for contracts to develop or improve their HIE.[31] The scope creep we found is concerning because other vendors may have been able to build a better HIE or do so more efficiently with public dollars. HIEs in other states may have bid to expand into Idaho.

We recommend that the Department of Administration and the Department of Health and Welfare take steps to prevent scope creep in procurement exemptions.

The Department of Health and Welfare and Department of Administration should implement this recommendation in the manner that works best for them. We will outline several ideas with the goal of being useful, not prescriptive.

Agreements with the Idaho Health Data Exchange illustrate that Health and Welfare should consider providing more technical assistance to its various programs when determining whether to pursue a contract or subaward. Health and Welfare could do so by providing more training to programs, increasing the number of compliance officers, or expanding the role of CAPS to better support programs.

CAPS is already responsible for comparing contract amendments to sole source exemptions to help programs prevent scope creep. We recommend they also help programs prevent scope creep in policy directives. CAPS could also ensure the Department of Administration agrees with their assessment by sending it contract numbers for any new amendments under an exemption. This would allow the Department of Administration to develop a spot check system to review exempted contract amendments in Luma, the state's document management system.

31. For a recent example, see Alaska's 2022 request for proposal for its HIE improvement: https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=204890

Health and Welfare likely would have benefited from external oversight of its contracts with the exchange.

In our 2013 report, *Strengthening Contract Management in Idaho,* we noted that when an agency has issues with a contract that is exempt from procurement, the agency is solely responsible for resolving those issues. We found that by working with the Department of Administration, agencies would have access to experts that may be better equipped to hold the vendor accountable, especially with high-dollar contracts. See exhibit 6. The Department of Health and Welfare likely would have benefitted from external support with disputes in its most recent large contract with the exchange, as we discuss in the next chapter.

Not going through the procurement process also led Health and Welfare to administer its own multimillion-dollar noncompetitive contracts with an untransparent vendor that was created by a commission in Health and Welfare and for many years had Health and Welfare officials on its board. Although we have no reason to believe that anything inappropriate happened with Health and Welfare officials involved with the exchange, any potential misperceptions should have been avoided by having the Department of Administration administer the contract.

The Department of Administration should review policies about administering contracts that are exempt from procurement.

Although it is not common practice, officials with the Department of Administration confirmed that they can and have administered contracts under a procurement exemption when a conflict of interest has been identified. The Department of Administration should reexamine its policies and procedures to address nonprofit corporations.[32] External contract

When an agency has issues with a contract that is exempt from procurement, the agency is usually solely responsible for resolving those issues.

Conflict of interest policies for state contracts should address nonprofit corporations.

32. Ethics guidelines from the Office of Attorney General are available at https://www.ag.idaho.gov/content/uploads/2018/04/EthicsInGovernment.pdf. Although not exempt, this recommendation should be considered for agencies that have delegated purchasing authority under Idaho Administrative Code §38.05.01.021 as well.

administration may have helped the department maintain standardized contract files, which would have been helpful for our evaluation and other reviews.[33] The Department of Administration may consider administering any exempted contracts that are above a certain dollar threshold.

Exhibit 6

The Department of Health and Welfare would have had more support if the Department of Administration had overseen contracts with the exchange.

The Department of Administration's Division of Purchasing typically administers contracts while other agencies manage contracts, but the Department of Health and Welfare oversaw both responsibilities with the exchange because of its purchasing exemption.

Contract Management - State Agency	Contract Administration - Department of Administration's Division of Purchasing
Agency provides the initial specifications, scope of work, and technical input from its subject matter experts for the solicitation, which becomes a substantial part of the contract.	The Division of Purchasing advises the agency regarding solicitation development, issues and administers the solicitation, guides the evaluation process, and awards the contract.
Agency monitors contractor performance for compliance with the terms of the contract through its contract manager or project manager.	The Division of Purchasing is responsible for amendments, renewals, addressing issues of breach, termination, and final closeout, working closely with the agency contract manager or project manager.
Agency receives and pays invoices.	The Division of Purchasing will enforce contract compliance in cases of unresolved disputes, issue cure notices, and assist the agency with enforcing liquidated damages and other remedies.
Agency communicates requests for amendments (e.g., modifications to scope of work, change in funding, etc.) to the Division of Purchasing prior to working directly with the contractor.	
Agency keeps the Division of Purchasing informed of serious issues and unresolved disputes, so that the division can work with the agency to address issues with the contractor.	

Source: Office of Performance Evaluations' adaptation from Department of Administration's Division of Purchasing Contract Administration and Management Guide.

33. Idaho Dept. of Admin. Div. of Purchasing Contract Administration and Management Guide, 7.2 (2014)

Contract management 4

In 2020, the Legislature appropriated $19.5 million[34] in federal SUPPORT Act[35] funding for the Department of Health and Welfare's Division of Medicaid to improve the exchange and enroll new providers. During debates, legislators raised concerns about sending any more public dollars to the exchange, which they had hoped would be operating only on user fees by then. Legislators also had concerns about the department's ability to hold the exchange accountable for its responsibilities in the contract on the tight timeline required by the federal grant. Legislators and department officials we spoke with believed that this was the last time the Legislature would appropriate any significant funding to the exchange.

Since the department stopped pursuing subawards and did not go through the competitive bid process for its recent large improvement contracts, negotiation and management of the contract were essential for accountability. Instead, we found that the state had insufficient leverage because department officials saw the exchange as the only potential source of services. At one point, federal partners at the Centers for Medicare and Medicaid Services (CMS) specifically suggested that the department further investigate their sole source relationship and explore alternative vendors.

We found that department staff tried to use the SUPPORT Act contract to introduce transparency, protect the state, and ensure the public got what it paid for. However, the exchange's special relationship with the state led to insufficiently loose contracts that made it difficult for the department's leadership to follow the advice of its own subject matter experts.

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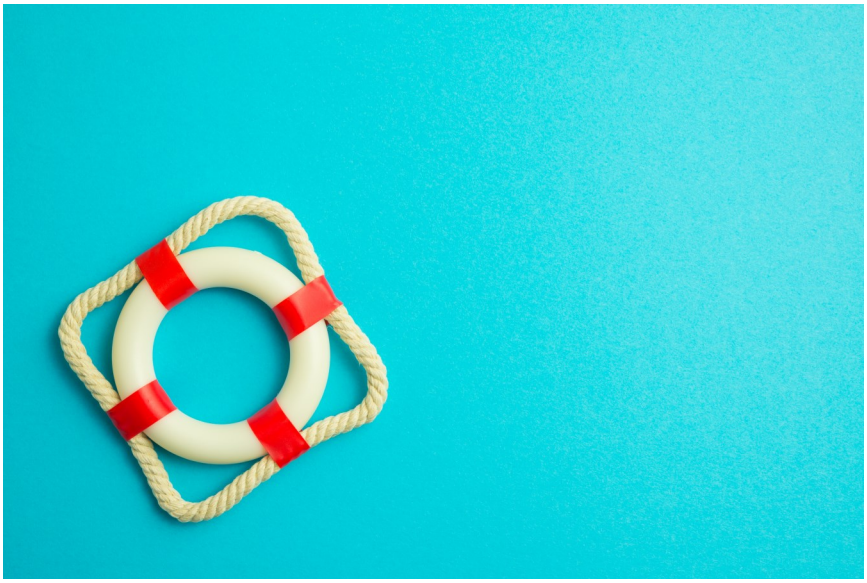
34. S.B. 1393 and S.B. 1418, 2020 Leg., 65th Sess. (Idaho 2020)
35. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, or SUPPORT Act, provided grants for improving access to prescription drug monitoring programs to prevent or decrease the misuse of prescribed controlled substances, including opioids.

The state's special relationship with the exchange led to an initial focus on ensuring the exchange's financial stability rather than deliverables.

Health and Welfare staff referred to this approach as "front-loading" the exchange's contract.

The Department of Health and Welfare initially arranged the contract to ensure that the exchange received funding up front because it was not financially stable. For example, the exchange was asked to deliver project charters for each part of the contract, which were generally 8-9 page documents that included a cover page, contact information, a short description of the planned work, and key milestones. The exchange's contract included 14 project charters that were typically worth $100,000 each. The contract also included 15 communication plans that were typically worth $100,000 each. Department staff referred to this approach as "front-loading" the contract, according to email correspondence.



When Health and Welfare tried to require more transparency, its relationship with the exchange deteriorated.

The exchange's special relationship with the state led to loose guidelines in the contract, which department staff later found to be insufficient because of the exchange's new management. The exchange's board experienced significant turnover with three different board chairs in 2019. At some point during that year, the exchange began contracting for the first time with an out-of-state management team, called Capitol Health Associates. We found that department staff closely involved with the most recent contract under the SUPPORT Act became concerned about the capabilities and trustworthiness of the exchange's new Washington D.C.-based management subcontractors.

Health and Welfare staff quickly became concerned about the exchange's new out-of-state management consultants.

The exchange quickly began falling behind on work and not meeting other requirements of the federal grant, according to email correspondence and performance monitoring citations issued by the department in March 2020. The contract required the exchange to receive approval from the department and, in some cases, CMS, before executing any subcontracts. The exchange violated this provision several times even before the Legislature approved SUPPORT Act funding. The department was also concerned at this time that the consultants acting as executive director were not searching for a permanent replacement.

The department struggled to implement more strict transparency and accountability measures in the contract because work had already started, payments had been made, and the exchange had significant leverage by being seen as the only available source of services. No one wanted to see the exchange fail on their watch after years of public investment.

The exchange's reluctance to adopt transparency measures

We found that the exchange's new management subcontractors were reluctant to accept and sometimes avoided the department's attempts to amend the contract with common transparency requirements.

Health and Welfare removed the new management consultants from the contract, but we found they still received millions from the exchange.

Federal vendor clearance

After the Legislature appropriated SUPPORT Act funding in 2020, staff with the department found that the exchange's new management contractors did not have an active account with the federal System for Award Management (SAM). SAM is used to verify that vendors have not had problems with agreements in other states or the federal government. Staff with the department saw this as a "red flag" because subcontractors without active accounts could be under investigation related to other contracts.

Officials with the exchange initially told the department that their SAM account was unavailable because of a clerical error. Then they asserted that federal regulations did not require their subcontractors, including the management team, to be approved through SAM. The department was never able to verify an account for Capitol Health Associates and several other subcontractors.

Eventually the department formally removed officials with Capitol Health Associates from doing any management or other work related to the federal grant, but they continued to manage the exchange. We found that while receiving funding from the SUPPORT Act, the exchange paid Capitol Health Associates at least $2.2 million for management services according to Form 990s. Substantial payments were also made to other management consulting companies, but we do not know the full amount because of limited information shared on 990s. Form 990s also do not list the names of all subcontractors paid by the exchange.

Access to subcontracts

The exchange relied on subcontracts for most of the SUPPORT Act deliverables. Since the department did not go out for bid on its contract with the exchange and did not have evidence that the exchange went out for bid on its subcontracts, reviewing the subcontracts was an important way for the department to ensure public dollars were being used responsibly. The exchange was required to get approval from the department before entering into any subcontract receiving SUPPORT Act funding. Federal funders at CMS also asked to review any subcontracts over $100,000 after learning about issues leading up to the first performance monitoring citations. However, the exchange entered into several subcontracts for SUPPORT Act work without approval from the department, according to performance monitoring citations.

Initially the exchange also pursued sub-subcontracts, in which the exchange would subcontract with Capitol Health Associates, which would then subcontract with another vendor. After officials with Capitol Health Associates were no longer allowed to work on the contract, the department requested that the exchange contract directly with any subcontractors to limit risk for the state. The exchange did not agree and requested a perspective from CMS. CMS officials agreed with the department that the exchange should contract directly with any subcontractors. We were unable to confirm that the department received all the subcontracts for work under the SUPPORT Act because officials were unable to provide us with them.

We could not confirm that Health and Welfare received all the subcontracts from the exchange that they were supposed to.

Organizational documents and time tracking

The department made multiple requests for organizational charts and contact information of people working on the contract for the exchange, but did not receive them until months later. The number of subcontractors and turnover in the exchange led the department to request policies and procedures for time tracking on the project. The exchange asserted that the department did not have this authority and the department never received time tracking policies.

Financial audits

Department staff raised concerns that sections of work under the SUPPORT Act and previous federal grants would be considered subawards by the federal government and subject to financial audit requirements – regardless of determinations already made by the department.[36] The department also determined that the contract carried risk for several reasons, including the high dollar amount.[37] Department staff requested that the exchange send the department a financial audit required of subawards, called a single audit, for the fiscal year covering the contract. The exchange refused, stating that the department should not have rights to a financial audit and the exchange would only submit to federal audits if required after the contract.

Requiring a financial audit up front, whether or not there is a reason to suspect foul play, may act as a preventative measure.

As stated in chapter 2, without transparency up front, there may be insufficient information for the state or federal government to know whether to pursue a special audit or investigation later on. Requiring a contractor to automatically submit a third-party financial audit, regardless of whether there is a reason to suspect

36. 45 CFR 75.2 "Subaward"
37. 45 CFR 75.352(b)

Although the exchange reported that it submitted ten financial audits to the federal government, we found that it only submitted one in 2015.

foul play, may act as a preventative measure and provide information needed to inform whether a more in-depth investigation or forensic audit is warranted later on.

If federal partners find that part or all of the agreement was a subaward, then the department is required[38] to ensure that the exchange submitted a single audit to the Federal Audit Clearinghouse.[39] Although the exchange reported on its Form 990s that it sent in single audits every year from 2011 through 2020, we only found record of an audit being submitted to the Federal Audit Clearinghouse in 2015.

CMS regularly reviews grants to ensure compliance but has not reviewed Idaho's most recent funding to improve the exchange.[40] If CMS chooses, it has the authority to take back funding upon determining that a state agency did not follow subrecipient monitoring requirements. An official with Legislative Audits informed us that the federal government has several options to recover funds, one of which would be to decrease the amount of future regular grants. The department would then need to decide how to fill that gap.

Data security audits

The department requested that the exchange submit an SOC 2 Type 2 audit. SOC 2 Type 2 audits are not financial audits. They are third party audits to ensure the security, confidentiality, and privacy of systems used to process data. For example, department staff reported that a SOC 2 Type 2 audit would review policies to ensure that staff with the exchange do not violate the Health Insurance Portability and Accountability Act (HIPPA) when accessing the data. Regular SOC 2 Type 2 audits are standard for other IT contractors working with Medicaid according to department staff. The exchange did not agree with the request, stating that it was unnecessary.

38. 45 CFR 75.352(f)
39. 45 CFR 75.2 "Federal Audit Clearinghouse (FAC)"
40. State legislative auditors also sample expenditures to see if agencies meet subrecipient grant monitoring requirements. Auditors reviewed expenditures in this time frame but payments to the exchange were not in their sample.

The exchange filed for bankruptcy after being sued by a subcontractor for withholding pass-through payments from Health and Welfare.

The SUPPORT Act allowed states to prepay for three years' worth of services if the longer contract term would ensure a lower rate. State rules allow prepayment if the state receives an added benefit and the agency ensures that the goods and services are actually received.[41] The department prepaid the exchange for several three-year agreements with subcontractors, but email and formal correspondence suggests that the exchange did not pass all of that money on to subcontractors. Officials with the department were concerned to find out in November 2020 that a subcontractor suspended services because of nonpayment.

According to court documents, one of the subcontractors sued the exchange in September 2021 for breach of contract, breach of implied good faith and fair dealing, and fraud. A contract monitor with the department was deposed in these civil proceedings and provided an affidavit that supported the subcontractor. In May 2022, the court determined that there was reasonable probability that the subcontractor would prevail on its breach of contract claim. Since the $790,000 being sought was not secured by a lien or anything else, the court ordered the Ada County Sheriff to seize assets from the exchange. The sheriff was only able to seize $470,000 from the exchange's bank accounts between May and June 2022.

The exchange filed for bankruptcy in August 2022, which led to dismissal of the civil case. Officials with the exchange reported that its bankruptcy was driven by

> the department's unrealistically high standards, poor contract management, and personal vendettas, and
>
> a disagreement with a subcontractor who was disgruntled about not renewing a contract.

The exchange was sued for breach of contract, breach of implied good faith and fair dealing, and fraud.

41. Idaho Code §67-1024 and Idaho Board of Examiners rules: https://www.sco.idaho.gov/LivePages/fiscal-policies-prepayments.aspx

A bankruptcy court approved the exchange's plan to pay about 25 percent of claims owed to its creditors.

In their bankruptcy court filings, officials with the exchange reported that it did not have sufficient assets to fully pay its creditors under liquidation. Instead, the court approved a five-year settlement plan for the exchange to pay about 25 percent of claims owed to its creditors, including subcontractors that did work under the SUPPORT Act contract with the department.

Health and Welfare IT experts did not believe there was sufficient documentation that the exchange met security requirements.

The SUPPORT Act contract was supposed to end in September 2020, but the exchange was still working on several deliverables when the deadline arrived. The department was particularly concerned about validation of the exchange's data security. Protected health information needs to be shared in a more secure environment due to the significant consequences of any security breach. CMS also required the department to ensure that the work could be recreated by other states or the federal government. Extensive documentation was necessary to meet these federal standards related to protected health information and reuse.

Department officials were unable to confirm that they received sufficient documentation to recreate work done under the contract. Department staff requested documentation to recreate work done with the exchange multiple times, but officials with the exchange asserted that they had already provided sufficient documentation. Department staff and officials with the exchange also disagreed about standards and documentation needed to validate data security measures to protect patient health information.

The department's health IT contractor, chief information officer, and chief information security officer still did not believe the exchange had sufficiently documented meeting data security requirements after the contract ended. Federal CMS officials agreed. The department disconnected the exchange from the state immunization and behavioral health databases in November 2020. After consulting with the department's IT experts, privacy officer, and Deputy Attorney Generals, department officials also filed a complaint about security concerns with the federal Office of Civil Rights to limit the state's liability if there were a data breach.

The department allowed the exchange to receive payments after the contract was over if it could prove that it had met the contract requirements before the termination date of September 30, 2020. Still not coming to an agreement on the data security requirements, the exchange offered to have an independent third party review their security measures in December 2020. After consulting with the project manager and IT experts at the department, the Medicaid administrator determined that an

Health and Welfare made multiple requests for but did not receive sufficient documentation to recreate work done to improve the exchange.

independent assessment may be helpful, but the department would still need to ensure on its own that federal security documentation requirements were met.

The Medicaid administrator left the department for a new position on September 15th, 2021. Five days before he left, the exchange submitted a third-party attestation that it had met the data security requirements before the contract terminated a year prior in 2020. Department leadership requested that IT staff who previously had limited or no involvement review the deliverables with a fresh set of eyes, work through disagreements, and close out the contract. The assessment concluded that the exchange still did not meet federal requirements, according to email correspondence.

In October 2021, the department determined the third-party attestation was sufficient evidence that the exchange met security requirements of the contract in September 2020. The department released $630,000 in payments to the exchange.

We found that a company called HITRUST certified the third party attestor to provide security attestations in August 2021, nearly a year after the exchange was supposed to have met security requirements. We also found that the company providing the third-party attestation was owned by the exchange's own chief information security officer. We did not have access to sufficient information to determine whether the third party attestor was working for the exchange at the time of the attestation. Department officials were not aware of this relationship and reported that they would not have made the final payment if they knew that the attestation was not provided by a third party independent of the exchange.

We recommend that Health and Welfare require regular validation of the exchange's data security.

We do not have evidence that the exchange's database is vulnerable. We also do not believe that the department has sufficient evidence that the exchange is secure given the potential conflict of interest with the 2021 security attestation and the lack of ongoing security requirements in the annual data access contract.[42]

42. The Division of Medicaid has no ongoing requirements for the exchange to prove through external audits that it is meeting federal data security standards. Officials with the Division of Public Health also reported not having data security requirements for the exchange to access the state immunization registry (Idaho Code §39-4803). The Division of Behavioral Health no longer provides the exchange with access to the behavioral health database.

Idaho automatically opts in anyone who has a health record with a provider who participates in the exchange.[43] We believe that this policy, along with the state's historic investments and relationship with the exchange, obligate the state to ensure that the exchange is secure.

The exchange may already be pursuing external assessments of its data security on a regular basis. The department should regularly require a copy of SOC 2 Type 2 audits and other security attestations, such as those provided by assessors certified by HITRUST. A healthcare IT expert we interviewed from a hospital system said that the state should pay for any external audits and attestations to ensure independence. CMS suggested the same according to email correspondence. We recommend that the department at least verify that audits and attestations are conducted by a third party without any relationship with the exchange.

Idaho automatically opts in anyone who has a health record with a provider who participates in the exchange.

Forensic audit

Over the course of our evaluation, several people accused the exchange of having poor management. Several people also accused the exchange's leadership of being deceitful and engaging in fraudulent activity. To rule that out at this point, the state would need to use accountants trained in forensic auditing. Forensic auditors would need access to full financial records from the exchange, which would likely involve court proceedings. Because of the state's decision to operate the exchange through a nonprofit corporation with minimal transparency requirements, our office did not have access to sufficient information to recommend an investigation.

43. Idahoans have the right to opt out of the exchange by filling out a form available on the exchange's website (https://idahohde.org/wp-content/uploads/2022/01/Idaho-Health-Data-Exchange-Opt-Out-Form-2022.pdf). In 2016, researchers contracted by the Office of the National Coordinator for Health IT reviewed state laws, rules, and policies governing HIEs. Idaho was among 21 states that did not have any. For more information, see the report (https://www.healthit.gov/sites/default/files/State%20HIE%20Opt-In%20vs%20Opt-Out%20Policy%20Research_09-30-16_Final.pdf). The same researchers found that 35 "state-sponsored" exchanges, including Idaho's, automatically opt-in residents. See the report (https://www.healthit.gov/sites/default/files/Individual%20State%20HIE%20Organizations%20Consent%20Policy_20160930_FINAL.PDF).

Health and Welfare did not receive everything promised under the most recent improvement contract but still has a small data access contract with the exchange.

Less than half of the appropriated SUPPORT Act funding was paid to the exchange.

Of the $19.5 million in SUPPORT Act funding appropriated to the department, $9 million was paid to the exchange. A large share of funding was withheld because the exchange only connected 2 new users when it was expected to connect 20 new hospitals and 30 new clinics. The department renewed its $100,000 annual contract to access data on the exchange in May 2023. Now that the large improvement contracts are over, the state has less leverage with the exchange and the public has little access to information about its business operations.

Officials with the exchange reported operating a growing and successful business now that the exchange has a bankruptcy plan to pay off some of its debt to creditors. We requested documentation to support these statements, but either did not receive or have access to enough documentation to verify them.[44] Providers we interviewed reported that the exchange is not user-friendly and too expensive. As a result, it does not have enough patient records to be useful. Stakeholders reported that large providers use the exchange as a backup to other more advanced and expensive systems. Independent and rural providers sometimes make do without the exchange by calling other providers or relying only on the information they have in front of them.

We found through our interviews that Department of Health and Welfare officials did not trust the exchange's current management. Idaho Code did not give the department clear authority over the exchange. Because of turnover, officials often did not know how influential the state was in creating and improving the exchange. Having little influence now and restricted management capacity, we found that officials with the department only felt limited responsibility for the exchange.[45]

44. The exchange no longer regularly releases performance reports to the public. We asked the exchange if they would be willing to share any information that state agencies typically make available for our evaluation, such as performance reports, policies and bylaws, contracts, financials, and meeting minutes. Officials did not respond to our request.
45. For more about the department's limited management capacity, see our 2022 report, *Medicaid Rate Setting*, available at https://legislature.idaho.gov/wp-content/uploads/OPE/Reports/r2105.pdf

National landscape and future of the exchange

5

States have taken different approaches to developing their health information exchanges (HIEs). Many of these HIEs any have struggled to be financially independent. Federal funding facilitated the expansion of community HIEs like Idaho's, but since then private software companies have created HIE networks for their customers and led the establishment of other national HIE networks. Today providers can exchange health records through several types of organizations.

The federal government has also been pursuing initiatives to standardize HIEs operated by private companies. For community HIEs to successfully compete, national advocates have recommended they expand their capabilities and maintain strong relationships with their state, which the Idaho Health Data Exchange currently lacks.

The state has several options moving forward. The Department of Health and Welfare could continue its data access contract with the exchange but explore other options as new HIE solutions continue to increase with support from federal initiatives.

National advocacy groups have been encouraging states to create a health data utility through statute or rule, similar to our recommendation in chapter 2 for new public-private partnerships. The health data utility framework addresses many of the issues we found in our evaluation, but it is unknown whether the exchange would cooperate with a substantial governance and transparency overhaul. If not, the Legislature would likely need to invest more by developing a new HIE. Although federal funding may be available to offset state costs, the Legislature may not want to pursue this option without full cooperation from the exchange because of the investments already made.

Over the course of this evaluation, we were frequently asked whether the state should run the exchange. We did not find evidence that state-run HIEs were more successful than other

models. The Department of Health and Welfare also does not have sufficient information to recreate the current HIE. Although the state could create a new HIE, it would take another significant investment by the Legislature.

HIEs are different in each state and dealing with a shifting market.

Although nationwide efforts to develop and exchange electronic health records (EHRs) have existed for over 30 years, significant federal funding began in 2009 with the HITECH Act. At that point some states already had a single private exchange with which the state could collaborate. Other states had several regional organizations with limited coverage. Stakeholders reported that before the Idaho Health Data Exchange, Idaho mainly had large hospitals systems exchanging information with their own members, but little exchange with other providers.

The HITECH Act created incentives for health care providers to share records electronically. States also received grant funding to develop HIEs and "ensure that all eligible providers within every state have at least one option available to them to meet the HIE requirements of Medicare and Medicaid EHR Incentive Programs." States were encouraged to use their existing health IT infrastructure and avoid duplicating work already done in the private market, where it existed.

About 25 percent of states allowed private HIEs to receive federal grant funding directly, according to an evaluation by NORC at the University of Chicago.[46] Another 43 percent of states had a state agency receive the funding and provide exchange services. The remaining states, including Idaho, had a state agency receive funding and then contracted with another party to provide services. We do not know whether other state agencies created nonprofit corporations to run their HIEs.

When major federal funding started in 2009, some states had more private HIE options than Idaho did.

Shifting HIE market still struggling to connect with rural and small providers

Nationwide, more hospitals and office-based physicians have been sharing EHRs with each other. Exchanging health information has not increased as quickly as other forms of health IT though.[47]

46. Prashila Dullabh, Petry Ubri, Sai Loganathan, & Michael Latterner, Evaluation of the State Health Information Exchange Cooperative Agreement Program, NORC at University of Chicago (July 2014).
47. Meghan Gabriel, Emily Jones, Leila Samy, & Jennifer King, *Progress and challenges: implementation and use of health information technology among critical-access hospitals,* Health Affairs (2014).

Academic research and federal reports also showed a wide range in the frequency of record exchange depending on the location and type of health provider. Rural and small health care providers exchanged records less often than larger, more urban providers.[48, 49]

HITECH facilitated the expansion of community HIEs like Idaho's, but since then private software companies have created HIE networks for their customers and led the establishment of other national HIE networks. Today providers can pursue their own individual point-to-point connections or exchange health information through several types of organizations.

Today providers have different options to exchange health information.

Community HIEs, such as the Idaho Health Data Exchange and other local, state, and regional exchanges, facilitate information exchange between different types of health care providers and stakeholders, such as physicians, public health agencies, and hospitals.

EHR vendor networks, such as Epic's Care Everywhere Network, allow providers who use the same health record management software to exchange records with other customers of that software vendor.

National HIE networks, such as the CommonWell Health Alliance, were established with the support of some EHR vendors to connect HIEs and multiple vendor networks.

But the number of community HIEs like Idaho's is declining.

Following federal investments, surveys initially indicated that the number of community HIEs was increasing.[50] However, the trend reversed about a decade ago and the number of community HIEs has since declined by 25 percent, as health care providers started to pursue private exchanges through their EHR software vendor.

48. U.S. Government Accountability Office, Electronic Health Information Exchange Use Has Increased but Is Lower for Small and Rural Providers GAO-23-105540, (April 2023).
49. Jordan Everson, Wesley Barker, & Vaishali Patel, *Electronic health record developer market segmentation contributes to divide in physician interoperable exchange*, Journal of the American Medical Informatics Association (April 2022).
50. Julia Adler-Milstein, Anjali Garg, Wendi Zhao, & Vaishali Patel, *A survey of health information exchange organizations in advance of a nationwide connectivity framework,* Health Affairs (May 2021).

A segmented EHR software market contributes to a gap in exchange use between small and large health care providers. Some developers target larger providers by offering more expensive enterprise solutions connected to national HIE networks. Other developers target small providers by offering less expensive solutions with less connectivity. Stakeholders reported that Idaho now has a patchwork system, without a community HIE covering all Idahoans.

Idaho has a patchwork system, without an HIE that covers all Idahoans.

Academic research indicates that larger and more urban hospitals have addressed this problem by using multiple private exchanges.[51] However, our interviews found that many other providers and public entities cannot afford to pay for access to multiple exchanges. Most Idaho hospitals still did not have the ability to exchange records through their EHR software vendor or a national network, according to a 2021 survey by the American Hospital Association. See exhibit 7.

As providers rely more on other HIE options, some community HIEs like Idaho's may be less able to reach their potential because they do not include enough information about all residents in the state.[52] Fewer records on the exchange decreases the value to providers, which may lead to even less participation or willingness to pay higher costs to access to the exchange. As a result, smaller health care providers and state officials end up needing to rely on old methods of calling and faxing to get medical records. Public health officials and policy makers are not able to use the exchange to track and address population health concerns.

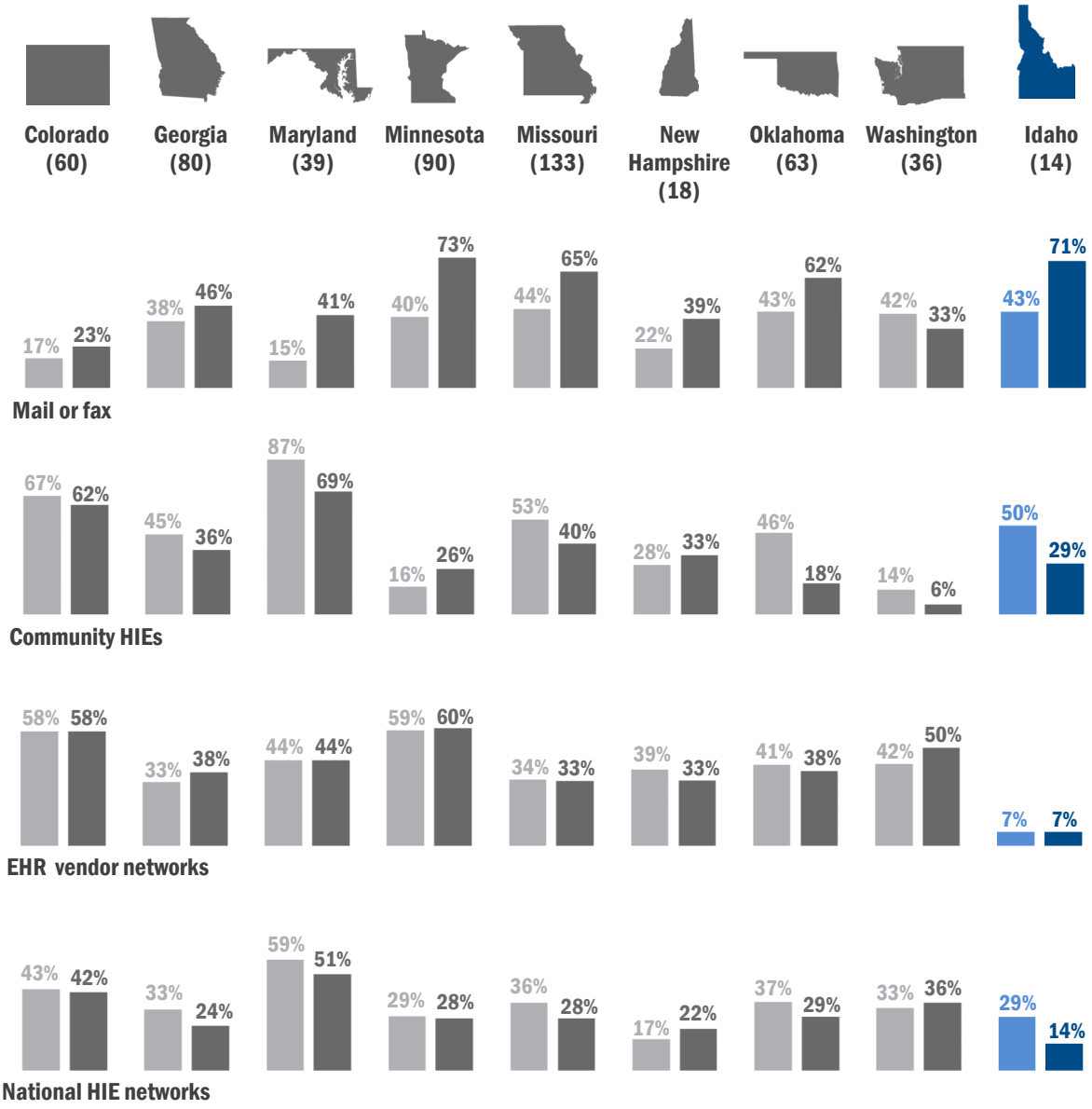
> *My only issue with IHDE being gone tomorrow is that I understand the need for this is with the critical access hospitals. We'll be fine in the Treasure Valley.*
>
> - Physician in the Treasure Valley

51. Jordan Everson & Evan Butler, *Hospital adoption of multiple health information exchange approaches and information accessibility,* Journal of American Medical Informatics Association (February 2020).
52. Some states address this issue with mandatory participation or enhanced Medicaid rates for participating providers.

Exhibit 7

Idaho hospitals relied more on sending and receiving health information through mail and fax, and less on electronic organizations or networks.

Percent of hospitals who reported often sending or often receiving information by each exchange method in selected states in 2021.



Notes: Numbers shown under each state indicate the total number of hospitals in each state that responded to the American Hospital Association Annual Health Information Technology Supplement, 2020. Due to pandemic-related delays, the survey was fielded in 2021 and responses reflect hospitals' experiences in 2021 instead of 2020.

Source: Office of Performance Evaluations' analysis of Idaho hospital responses to the American Hospital Association Annual Survey Information Technology Supplement (2020) and Office of Performance Evaluations' adaptation of exhibit from GAO report 23-105540 *Electronic Health Information Exchange* (Figure 3, page 21).

Evolving state approaches

States evolved over time to have a varying degree of government direction, responsibility, and oversight of their HIEs, according to a recent report by an advocacy group for community HIEs.[53] See exhibit 8. In 2023, 22 states had a single designated community HIE called a public-private utility. Eleven states promoted work in the private sector. Only nine states still operated their own community HIE directly through a state agency. Another seven states had a state agency or nonprofit orchestrate, or coordinate, multiple community HIEs.

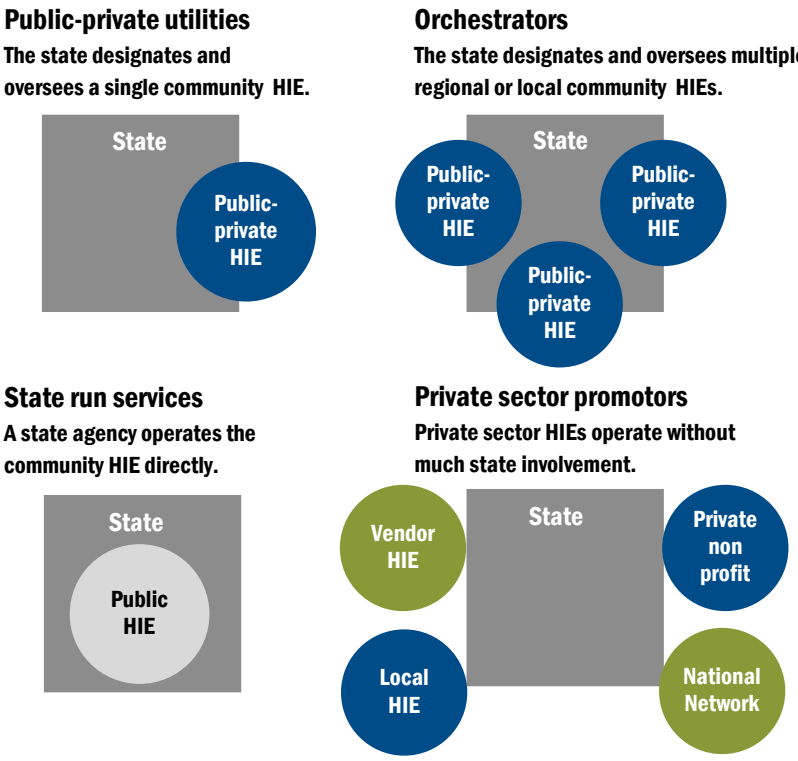
Only 9

states still operated their own HIE in 2023. The most common model is a strong public-private partnership with one community HIE.

Exhibit 8

States take different approaches to governing and supporting HIEs.

State approaches often depend on the availability of private HIEs.



Source: Civitas Networks for Health.

53. Civitas Networks for Health, Methods States Use to Organize and Promote Health Information Exchange (2023).

States using a similar model to Idaho tended to have more regulation and incentives for their HIE.

Idaho was marked as "transitioning" in the report. Idaho initially had a public-private utility model. States using a public-private utility model actively funded their exchange's development, like Idaho did. Many states with a public-private utility model also pursued ongoing incentives and mandates to increase the HIE's reach.

Unlike Idaho, most states with a public-private utility model also placed special restrictions on their HIE through rule promulgation or regulation-like terms in their regular contracts. We reviewed other states' statutes related to HIEs and found several oversight mechanisms that were not used in Idaho. States with often statutorily required government participation in the HIE's board of directors. We also found that several states statutorily required the HIE to report annually to the legislature and submit regular audits.

As the Idaho Health Data Exchange distances itself further from the state, Idaho may be transitioning into a private sector promotor, like California, Illinois, and Washington. Idaho has been behind other states in adopting private HIE options though, likely because of its high number of rural and small providers. We found that states operating as private sector promotors have an average population nearly five times larger than Idaho. Smaller states tend to manage their own HIE through a state agency or operate a public-private utility model with one designated community HIE.

Federal efforts to standardize and broaden access to private exchange networks leave uncertainty for some community HIEs.

HITECH funding stopped in 2021 and the other federal grants through the Department of Health and Welfare were for short term, specific improvements to the exchange. Federal grants were never intended to be the sole or primary source of funding for community HIEs. While some states planned to financially support their HIEs, others, including Idaho, always planned on their HIE being able to support operations with user fees.

Only 24 percent of community HIEs were able to cover their operating expenses with revenue from participants in 2012, according to a nationwide survey.[54] Financial viability has increased, but in 2019 almost half of community HIEs were still unable to cover their operating expenses with revenue from participants. Community HIEs have addressed these challenges by changing their structure or merging with other HIEs. Bankruptcy is not common according to an official with the national advocacy group for community HIEs.

52% of community HIEs like Idaho's were able to cover operating expenses with revenue from participants in 2019.

New federal efforts to standardize national HIE networks

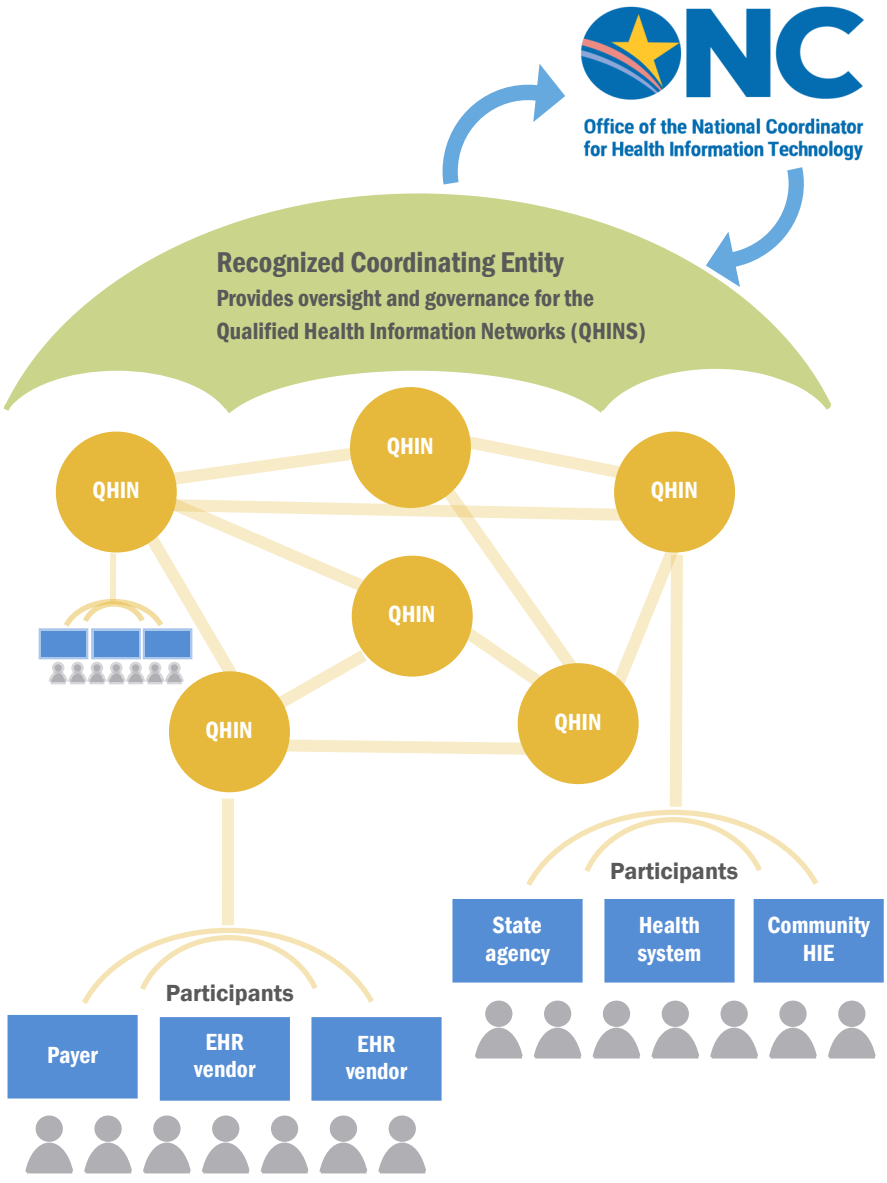
With the expansion of organizations offering HIE services, the federal government has developed optional nationwide standards. The Office of the National Coordinator for Health Information Technology developed the Trusted Exchange Framework and the Common Agreement (TEFCA) to standardize data privacy expectations, simplify connectivity, and increase exchange of EHRs in 2022.[55] The office established standards for organizations that want to become designated as Qualified Health Information Networks (QHINs) under TEFCA. The QHINs will be overseen by a recognized coordinating entity, which will also be responsible for implementing and maintaining the common agreement. See exhibit 9.

54. Julia Adler-Milstein, Anjali Garg, Wendi Zhao, & Vaishali Patel, *A survey of health information exchange organizations in advance of a nationwide connectivity framework*, Health Affairs (May 2021).
55. Pub. L. No. 114-255, § 4003(b), 130 Stat. 1033, 1165 (2016).

Exhibit 9

A new federal initiative attempts to standardize the exchange of health information, including by vendors and other private entities.

Stakeholders reported that federal efforts will strengthen alternatives to the Idaho Health Data Exchange unless the exchange brings value through strong local relationships.



Source: Office of Performance Evaluations' adaptation of exhibits from Office of the National Coordinator for Health Information Technology presentation *The Draft Trusted Exchange Framework Q&A Session* .

TEFCA's impact is unknown because it is still being implemented. In February 2023, the Office of the National Coordinator for Health Information Technology announced that six organizations committed to a yearlong process to become designated as QHINs. Two of the organizations, Epic and CommonWell, were commonly referenced in our interviews as competition for the Idaho Health Data Exchange.

We interviewed HIE stakeholders in all of Idaho's neighboring states and Alaska. Several stakeholders pointed out that the creation of QHINs may lead community HIEs to be less useful unless they can add value through their strong local relationships and advanced technical capabilities. Our interviews with Idaho health care stakeholders found that the Idaho Health Data Exchange may struggle in these areas.

> *HIEs will need to evolve. They won't be able to stand alone. The big question is where is that funding going to come from. I find the HIEs that are successful have a very strong relationship with Medicaid and public health.*
>
> – director of a neighboring state HIE

Community HIEs will succeed if they have strong local relationships and advanced technical capabilities, according to stakeholders.

National community HIE advocates have been encouraging states to designate authority through statute or rule to a health data utility, which would help states integrate health data to support public health and care delivery.[56] The health data utility framework calls for long-term blended local, state, federal, and private funding with increased oversight, performance measurement, and evaluation. The framework addresses many of the issues we found in our evaluation. See appendix D. If legislators would like to invest more in the exchange, we suggest following this framework to improve accountability and transparency.

56. Civitas Networks for Health, Health data utility framework: A guide to implementation (2023).

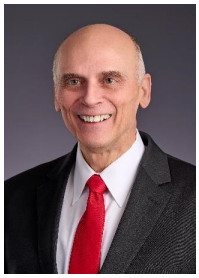
A Request for evaluation

Representative Mike Moyle
Speaker of the House

Representative Ilana Rubel
House Minority Leader

Representative David Cannon

Representative Douglas Pickett



Senator C. Scott Grow

House of Representatives
STATE OF IDAHO
CAPITOL BUILDING
P.O. BOX 83720
BOISE, ID 83720-0038

March 21, 2023

Rep. David M. Cannon, Co-Chair
Sen. Melissa Wintrow, Co-Chair
Joint Legislative Oversight Committee

Dear Co-Chairs,

A recent bankruptcy filing of the Idaho Health Data Exchange has raised concerns among legislators.

In 2006, the Legislature directed the Department of Health and Welfare to create a commission in charge of monitoring the effectiveness of the Idaho's health data exchange and making recommendations for improvement. The Idaho Health Data Exchange was created in 2009 by the commission and funded primarily through federal Health Information Technology for Economic and Clinical Health (HITECH) Act, which had goals to increase coordination of care, ensure privacy, and improve health outcomes. Through 2021, HITECH allowed the federal government to fund 90 percent of the cost of states to administer health information exchanges. The Idaho Health Data Exchange filed bankruptcy in August 2022, reporting that it owes $4 million to creditors.

Given the public funding involved and the state's interest in the health and privacy of Idahoans, we would like the Office of Performance Evaluations to investigate the following:

1. What led to the bankruptcy of Idaho's health data exchange?
2. What responsibility did the state have in setting up the exchange and overseeing implementation, including contract management?
3. Could the state have improved its oversight of the exchange? If so, what barriers existed to oversight?

4. How did Idaho's experience compare to other states?
5. How can the state move forward?

Thank you for your consideration.

Sincerely,

Rep. Mike Moyle
Speaker of the House

Rep. Ilana Rubel
House Minority Leader

Rep. David Cannon

Rep. Douglas Pickett

Sen. C. Scott Grow

mm:jh

cc: Mr. Rakesh Mohan, Office of Performance Evaluations

Evaluation scope

B

1. **What is the purpose of the exchange? What was the process and authority by which the exchange was created?** Addressed in chapter 2.

2. **What led to the bankruptcy of Idaho's health information exchange?** Addressed in chapters 2, 3, and 4.

3. **What responsibility did the state have in setting up the exchange and overseeing its implementation, including contract management?** Addressed in chapters 2, 3, and 4.

4. **Was the state's level of oversight appropriate? Could the state's risk have been reduced with different oversight?** Addressed in chapters 2, 3, and 4.

5. **What kind of performance, financial, and audit oversight does the state in general and the Legislature in particular have over nonprofit corporations that units of government are involved in creating? Should such oversight functions be created or improved? If so, how?** Addressed in chapter 2.

6. **How did Idaho's experience compare with other states?** Addressed in chapter 5.

7. **What options does the state have moving forward?** We have recommendations in chapters 2, 3, and 4. Chapter 5 also discusses potential paths forward.

C Methods

We used a mixed-methods approach for this evaluation. We analyzed data from several independent sources including interviews, national surveys, and state and federal agencies. We also requested and reviewed thousands of pages of meeting minutes, reports, tax forms, emails, court filings, and other documents.

Interviews

We conducted more than 60 interviews with a variety of individuals and groups, including the following

- legislators
- large health systems
- independent health care providers
- critical access hospitals
- emergency medical services
- Idaho Community Health Center Association
- Idaho Hospital Association
- Civitas Networks for Health
- Department of Administration
    - Division of Purchasing
- Department of Health and Welfare
    - Contract and Procurement Services Unit
    - Division of Medicaid
    - Division of Public Health

- Division of Behavioral Health
- Secretary of State's Office
- Idaho Health Data Exchange, Inc.
  - former officials
  - former board members
  - current officials
  - a current board member
  - a current lobbyist
- Alaska Department of Health
- Blue Sky Care Connect in Montana
- HealthieNevada
- Reliance eHealth Collaborative in Oregon
- Utah Health Information Network
- Washington State Department of Health
- One Health Port in Washington
- Wyoming Frontier Information

Literature review

To contextualize our findings and develop recommendations, we reviewed reports about HIEs and public-private partnerships published by federal agencies, advocacy groups, and academic researchers. We also requested and reviewed a memo produced by health policy specialists with the National Conference of State Legislatures. As is typical in our evaluations, we attempted to develop criteria by reviewing expectations of state oversight in

- Idaho Code
- Idaho Administrative Code
- budget requests

We conducted more than 60 interviews.

public debates about budget requests and other proposed legislation

United States Code

Code of Federal Regulations

Research librarians with the Legislative Services Office (LSO) helped us find legislative history related to the exchange, including bills and presentations to legislative committees. Other staff and officials with LSO provided technical assistance as we interpreted oversight requirements in Idaho Code, federal single audit requirements, and budget requests. Our findings do not reflect the views of LSO or individual staff, however we want to acknowledge their expertise and help providing information we used in our evaluation.

In our literature review, we read an article by Cason Schmidt and his colleagues that examined state statutes governing HIEs across the country.[57] Mr. Schmidt was kind enough to provide us with a list of relevant statutes, which we used to supplement other information about best practices in HIE governance.

We requested documentation from the Department of Health and Welfare, including

State Health Information Technology Implementation Advance Planning Document Updates

State Medicaid Health Information Technology Plans

Health Quality Planning Commission meeting minutes

Health Quality Planning Commission reports

contracts with the exchange

contract performance monitoring citations and formal correspondence with the exchange

expenditures by fund source related to the exchange

57. Ari Bronsoler, Joseph Doyle, Cason Schmidt, & John Van Reenen, *The role of state policy in fostering health information exchange in the United States*, NEW ENGLAND JOURNAL OF MEDICINE CATALYST INNOVATIONS IN CARE DELIVERY (January 2023).

Although staff with the Department of Health and Welfare cooperated with our evaluation, they struggled to fulfill our request for historical documentation related to the commission and the exchange. Department staff and officials reported that high turnover posed challenges in maintaining documentation. We found through our interviews that we were still missing documentation of major events leading up to the exchange's bankruptcy.

Although Health and Welfare cooperated with our evaluation, staff struggled to fulfill our requests for historical documentation.

We addressed this by requesting email correspondence from the Department of Health and Welfare to fill in gaps of information and confirm our interview findings. We requested emails using search terms related to the exchange that were sent and received by specific staff from 2019 through 2021. The request for email correspondence was quickly fulfilled.

We requested documentation from the Department of Administration, including

- sole source authorization
- policy directives

We had access to limited information from the exchange because the state designed it as a nonprofit corporation with little transparency. We reviewed publicly available information about the exchange, including

- Form 990s
- Articles of Incorporation and annual reports filed with the Secretary of State
- court documents
- website archives

Officials with the exchange did not respond to our request for documentation commonly made available during evaluations, such as contracts, meeting minutes, and financial statements. However, the exchange's lobbyist provided a copy of some official correspondence between the exchange and the Department of Health and Welfare. The lobbyist also provided a written description of their perspective on events around the most recent improvement contract with the department.

The exchange did not respond to our request for documentation.

Survey analysis

We reviewed a 2023 report about HIE use by the U.S. Government Accountability Office (GAO), which cited data from the American Hospital Association Survey Information Technology Supplement. We obtained and analyzed Idaho-specific data from the American Hospital Association to supplement GAO's national findings and snapshots from other states.

Health data utility framework

D

Component	Health Information Exchange (HIE)	Health Data Utility (HDU)
Scope of technical capabilities and infrastructure	Facilitates access to clinical data for treatment and care coordination across participating health care organizations. May report clinical data for public health uses (e.g., vaccines, syndromic surveillance, notifiable conditions).	Utilizes policy levers to advance data sharing and infrastructure for the aggregation and integration of multiple data sets in ways that expand analytics, quality reporting, data visualization, and other services beyond traditional clinical data exchange. Serves as a designated data source (e.g., public health registries, medications, and social determinants of health data). Expansive network connections directly or through other data networks to payers, providers, and community support services.
Relationship with state and authority policy levers	May have a cooperative partnership with one or more states to align strategy, objectives, and funding. May enter into a state or regional designation agreement, which outlines terms and conditions and is periodically reviewed and updated, as needed. State participation in developing programs and services.	Designated authority defines roles and responsibilities and is formalized via a method of the state's choosing (e.g., legislation, executive order, rulemaking). Uses policy levers to increase efficient and appropriate data exchange and removes restrictions or barriers to electronic health data exchange. Partners with state and local government to align public health goals and secure necessary funding.
Governance	Multi-stakeholder structure for participating organizations and consumers. May prioritize services internally or with a limited group of stakeholders, perhaps with a focus on sustainability.	Establishes expansive multi-stakeholder, cross-sector governance model with state and community partners. Prioritizes services through shared governance ensuring responsiveness to community health initiatives. Ensures a neutral and transparent approach to decision-making.
Stakeholder engagement and community partnerships	Works in parallel with other health data networks. May share data sets with community partners.	Collaborates with data networks and community collaboratives to share and exchange data (e.g., emerging community care hubs, community information exchanges, or all-payer claims databases). Houses or integrates with an existing community directory to offer information on community resources, locations, and services available for individuals, specific populations, or the community.
Financing	Time-limited funding for technical or implementation services; may receive Medicaid funding.	Long-term, braided and blended funding strategy that encompasses local, state, federal, and private investments for value-add technical services, reusable infrastructure, and community engagement and support.
Privacy and security	May codify in statute, regulation, or other agreements required privacy and security policies above the minimum required in federal law.	Continuous learning and implementation of cybersecurity and privacy frameworks and standards to ensure rigorous protections that provide appropriate assurances to federal, state, and regional authorities and build stakeholder confidence. Includes frameworks and standards for health and relevant industries outside of health care.
Accountability and measurement	Reports information to assess performance, quality, and value of services to participating organizations.	Increased accountability through oversight, performance measurement, and evaluation to monitor return on investment and guide strategy for clinical, community, and public health purposes.

Source: Civitas Networks for Health.

Responses to the evaluation

Brad Little,
Governor of Idaho

> I look forward to working with the Idaho Legislature to address issues that can impact future state programs.

Dave Jeppesen, Director
Idaho Department of
Health and Welfare

> DHW greatly appreciates the Legislature's interest in identifying opportunities for improvement to avoid similar outcomes in the future.
>
> ...DHW staff worked diligently and used the tools available to gain contract compliance and to advance Idaho's HIE. However, lacking statutory and regulatory authority to truly hold Idaho's HIE accountable, DHW's efforts proved unfruitful.

Steve Bailey, Director
Idaho Department of
Administration

> Any time the state engages in negotiations with a vendor that has disproportionate bargaining power, the ability to achieve the desired performance is significantly diminished
>
> ...But in many situations, the state backs itself into this comer. If agencies (including Purchasing) want to put themselves in the best position to have an enforceable contract that can be appropriately managed to ensure desired outcomes, there are a few systematic changes they can adopt.

Governor Brad Little
State Capitol :: Boise, Idaho 83720
(208) 334-2100 :: gov.idaho.gov

October 19, 2023

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson St., Ste. 202
Boise, ID 83720

Dear Director Mohan,

I want to thank you and your team at the Office of Performance Evaluations (OPE) for producing a report on Idaho's health data exchange.

I have also reviewed the responses from the Idaho Departments of Administration and Health and Welfare disputing the conclusions of the OPE report, and I agree with the practical considerations raised by the agencies.

I look forward to working with the Idaho Legislature to address issues that can impact future state programs.

Sincerely,

Brad Little
Governor of Idaho

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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October 17, 2023

Sent Via Email to: rmohan@ope.idaho.gov

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson, Suite 202
Boise, ID 83702

RE: Report on State Oversight of Idaho's Health Information Exchange

Dear Mr. Mohan:

Thank you to you and your team for your review of Idaho's Health Information Exchange (HIE, also known as the Idaho Health Data Exchange or IHDE). As it did for legislators, Idaho's HIE bankruptcy filing in the fall of 2022 raised many concerns at the Department of Health and Welfare (DHW), among them the future viability of Idaho's HIE, the safety of Idahoans' information held within Idaho's HIE, and the value that Idahoans received, or failed to receive, for the millions of federal dollars spent to develop Idaho's HIE. DHW greatly appreciates the Legislature's interest in identifying opportunities for improvement to avoid similar outcomes in the future. Most importantly, while DHW disagrees with a few specific findings within the Office of Performance Evaluations' (OPE) report, DHW wholeheartedly concurs with the conclusion that DHW simply did not have statutory or regulatory authority over the HIE and that the HIE should not have been set up as an independent entity. This became particularly apparent as HIE leadership transitioned to Capitol Health Associates and became less compliant or cooperative than previous HIE leadership.

As an agency committed to strengthening the health, safety, and independence of Idahoans, DHW was and is committed to establishing and supporting a viable HIE in Idaho. Recognizing that the efficient electronic exchange of health information is vital to improving health care quality, safety, and patient outcomes, DHW leadership proudly participated along with a unique "cross-section of health care stakeholders sitting collaboratively around the table."[1] Stakeholders included Saint Alphonsus, Idaho Power, St. Luke's, Blue Cross of Idaho, Full Circle Health (formerly Family Medicine Residency of Idaho), Clearwater Valley Hospital and Clinics, Inc./Saint Mary's Hospital, Kootenai Medical Center, Regence BlueShield of Idaho, and Health

[1] Rep. Rusche, minutes from May 8, 2008 HQPC Meeting

West. It was not DHW, but rather this cross-section of committed industry experts, appointed as members to the Health Quality Planning Commission (HQPC) by Gov. Butch Otter, who recommended that Idaho's Legislature set up Idaho's HIE as a nonprofit.

Developing Idaho's HIE as the singular health data exchange in Idaho was the intention of both Gov. Otter and the Legislature. As noted in the report, Gov. Otter "declared the exchange as the only state designated entity to receive 2009 federal funding for the development of an HIE." In addition, in 2010 Idaho's legislature passed House Bill 494, which directed the HQPC to, "Monitor the effectiveness of **the** Idaho health data exchange." [Emphasis added.] Conceptually, these actions by the Governor and Legislature, two separate branches of government, established the foundation that Idaho's HIE, whether used for retrieving client medical health information or the system infrastructure itself that enables such information to be shared, was the only such operation in Idaho. In retrospect, DHW should have informed the Division of Purchasing in writing that the actions of Gov. Otter and the Idaho Legislature established the HIE as the sole source for a health information data exchange in Idaho. Doing so would have documented the authority upon which DHW relied for the sole source designation, which is a different authority than OPE looked to.

Given that Gov. Otter and the Idaho Legislature directed that the HIE was to be Idaho's health information data exchange, DHW could not have legally sought competitive bids to build the exchange and provide the tools to access its data. Notably, in several subsequent years, the Legislature reaffirmed and, in some cases, explicitly directed that DHW distribute funds to the HIE, such as Senate Bill 1171 in 2019, which appropriated money to the department for "…claims payment system improvements and funding connections to the Idaho Health Data Exchange." Had DHW solicited a competitive bid as OPE now suggests, the department would have done so in violation of the legislation.

DHW leadership took action to implement the plan, which HQPC had sent to the Legislature. This included commonplace actions such as sharing supplies and space, and that represented nothing more than acknowledgement that DHW occupied a vast quantity of Boise office space, which, when vacant, was sometimes made available to non-DHW entities or agencies--in this case, a fledgling HIE created at the behest of and with support of Idaho's Governor and Legislature. Previous co-occupants of the same office space included the Northwest Power Planning Council, and currently the Idaho Council on Domestic Violence, the Idaho Division of Human Resources, and the Office of the Attorney General.

On a practical level, DHW worked with the HIE in two capacities. First, DHW was a customer that accessed data through the exchange, such as to approve care for Medicaid patients. This role amounted to $100,000 paid to HIE annually. Second, because the Legislature does not appropriate funds directly to private entities, DHW served as a conduit to steward federal dollars from the Legislature to the exchange. It was in this latter capacity that DHW most carefully evaluated whether a subaward or a contract would be appropriate.

As noted within the report, the decision to enter into a contract with the HIE, versus issue a subaward, is at the discretion of the agency. The Centers for Medicare and Medicaid Services (CMS) reviewed the Department's plan, including the department's use of a contract. CMS could have intervened but did not.

Moreover, using a subaward rather than a contract would not have yielded a different outcome. DHW incorporated subaward compliance requirements into its contracts with the HIE. Specifically, every contract with the HIE required a single audit, and multiple contracts with the HIE required they submit Service Organization Control (SOC) Type 2 reports. DHW purposefully included those contractual requirements to maximize its ability to hold Idaho's HIE accountable.

During the years when Capitol Health Associates served as executive director of Idaho's HIE, DHW staff worked diligently and used the tools available to gain contract compliance and to advance Idaho's HIE. However, lacking statutory and regulatory authority to truly hold Idaho's HIE accountable, DHW's efforts proved unfruitful. Yet DHW remains committed to the vision of improving health care quality, safety, and patient outcomes and reducing the overall cost of medical care to Idahoans that a robust, functioning, secure health data exchange could provide.

Thank you again to you and your staff for the time and effort invested to identify opportunities for improvement as Idaho looks to the future of a health data exchange.

Sincerely,

DAVE JEPPESEN
Director

State of Idaho
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October 11, 2023

Rakesh Mohan, Director
Office of Performance Evaluation (OPE)

Sent via E-mail: rmohan@ope.idaho.gov

Re: Department of Administration Response to Report "State's Oversight of Idaho's Health Information Exchange"

Dear Director Mohan:

Thank you for the opportunity to provide a response to OPE's report titled "State's Oversight of Idaho's Health Information Exchange." Though the Department of Administration ("the Department"), Division of Purchasing ("Purchasing") was not the primary focus of this report, we appreciate the time your team invested in understanding the procurement process and their thoughtful consideration of the complex issued detailed in the report. With that in mind, the Department would like to offer the following response, specific to the procurement and contracting issues in the report.

The Department agrees with many of the recommendations related to procurement and contracting that OPE makes in its report; however, we believe there may be additional context required and some more systematic changes needed to achieve the outcomes OPE is seeking. In its report, OPE identifies several concerns regarding the relationship between the Department of Health and Welfare (DHW) and the Idaho Health Data Exchange (IHDE) including contract administration by DHW as opposed to Purchasing; issuance of contracts as opposed to subgrants; and IHDE's status as a non-profit organization as opposed to a different type of entity. The Department agrees that any of these factors may have contributed to the issues identified by OPE, but that without addressing some underlying challenges, even following OPE's recommendations may not have changed the outcome in this situation.

Balancing Procurement/Contracting Best Practices and Programmatic Needs

As you know, the state executes and administers hundreds of contracts each year, some by and through Purchasing and others directly by agencies and other entities. Careful review of these contracts often occurs only when something "goes wrong" as was the case when IHDE filed for bankruptcy in 2022. Though one can often identify things the state might have done differently, it is important to recognize that decisions related to contracts are often completely reasonable in the moment but may appear insufficient with the benefit of hindsight. Additionally, agencies often make decisions that are not "best practices" in contracting but are necessary to meet a programmatic need.

Any time the state engages in negotiations with a vendor that has disproportionate bargaining power, the ability to achieve the desired performance is significantly diminished. In these situations, negotiating additional requirements, such as audits and other methods of transparency, is extremely difficult. Managing performance through corrective action and cure notices is often ineffective when the agency feels it has no alternative vendor: one of the greatest tools in contract administration is the threat of termination or future disqualification, neither of which is effective if a vendor knows the state has (or believes it has) no alternative.

Based on the information provided in OPE's report, it appears that DHW and Purchasing believed IHDE to be the only vendor that could meet DHW's business needs-- a sole source provider. Understanding that there may be other options available to DHW today, there does not appear to be a suggestion by OPE that DHW was unwilling to engage in a competitive procurement, but rather that DHW staff believed IHDE to be their only choice, perhaps in part because of the significant financial investments made by the legislature over the years. Even if, as OPE recommends, Purchasing had a set dollar limit above which procurements exempted from competition had to be issued and administered by Purchasing, the sole source authorization for DHW likely would not have triggered that requirement. A contract for data access costing $100,000 per year is relatively low dollar and low risk. The additional funding and efforts to improve the IHDE were unknown to Purchasing and therefore could not have influenced Purchasing's decisions. And even if Purchasing had retained the role of contract administrator, the identification of IHDE as a sole source provider, and DHW's programmatic need to contract for the identified services, would have made it difficult to negotiate a contract with the ideal terms or to enforce those terms when performance issues were identified.

There are certainly some situations in which this unequal bargaining power cannot be resolved—in those situations, the state must do its best to foster good contractual relationships and identify creative solutions. But in many situations, the state backs itself into this corner. If agencies (including Purchasing) want to put themselves in the best position to have an enforceable contract that can be appropriately managed to ensure desired outcomes, there are a few systematic changes they can adopt:

- Allowing sufficient time to complete a competitive solicitation – though there's no indication that this happened with IHDE, often agencies seek exemptions because they do not have time to work through a competitive process;
- Engaging purchasing staff early in the process and carefully considering their advice when balancing contracting best practices against programmatic needs; and
- Identifying solutions that can be met by multiple vendors so that they do not become reliant on a sole source provider.

Constraints of Additional Oversight

Finally, the Department agrees with OPE that additional oversight can often help to identify issues (e.g., the "scope creep" identified by OPE) and to ensure that best practices are considered and hopefully implemented. The two primary challenges Purchasing would face in implementing such oversight would be resources and finding solutions when there is uneven bargaining power. Even with the additional visibility available in Luma, and OPE's recommendation for "spot checking," Purchasing would need additional resources to provide meaningful oversight of agencies' exempt contracts or to take increasing responsibility for administering those contracts itself. Additionally, balancing contracting best practices against programmatic needs will always create challenges to effective contract management, regardless of oversight.

Again, the Department appreciates OPE's thorough and thoughtful review. I hope these additional suggestions provide helpful insight.

Sincerely,

Steve Bailey, Director
Department of Administration

Office of Performance Evaluations

ope

Idaho Legislature