Request for Application – Bidder Question and Answers

A Consumer-Centric Health Information Exchange for Maryland

May 5, 2009

1. Can additional detail be provided regarding the funding mechanism and disbursement? What legal entity will hold the contract with the winning applicant?

   Funding for the RFA is through the HSCRC all-payer rate setting system. The HSCRC will issue a Rate Order Letter, and not a contract to participating hospitals. It will be up to the hospitals identified by the multi-stakeholder group to disburse the funds. Ongoing adjustments in rates are contingent on performance identified in the RFA and in the Rate Order Letter.

2. Please clarify the RFA requirements for the multi-stakeholder group's role to resolve many modeling and governance matters. Please describe how the responsibilities of the Policy Board and the Governance will complement one another.

   The Exchange proper will be incorporated as a 501(c)(3) non-profit and will be governed by the Board proposed in the response to the RFA. This governance will be responsible for the planning and operation of the exchange. The Governance of the Exchange and the Policy Board have some limited joint membership and will be expected to collaborate in crafting policies that are appropriate, technically feasible, and acceptable to both the public and providers.

   The importance of a multi-stakeholder group cannot be overestimated. If a statewide exchange is to succeed, it must be broadly representative and widely trusted. The breadth of participation in the group receives a greater weight than any other evaluation factor. The Policy Board will be established by the Commissions. By its very nature, the Exchange itself will predominantly involve providers. The Policy Board, in contrast, will predominantly involve non-providers and will focus on broad policy issues, particularly those related to privacy and security provisions essential to building public trust, not specific solutions. The intent is not to micromanage but rather to set policy parameters within which the exchange operates. For example, policy regarding authorizations required for different types of access to health information and policy regarding the number and type of factors required for authentication in different circumstances are issues that the Policy Board set

3. Is it the MHCC's intent for respondents to choose a technology solution prior to response to be able to provide the details requested, or can we respond with less detail in order to keep multiple vendor solutions open?

   RFA responders could specify the vendor solution or the process by which a solution will be chosen. If the responder decides to specify the process by which the solution will be chosen, the responder should expect a provision in the rate order letter regarding approval of the technical solution by the commissions since we were not able to review the solution as part of the RFA response.

4. Please outline the consumer consent and participation model expected for the implementation and future of the HIE.

   We believe this has been set forth in sections A and C of the Privacy and Security section of the RFA. Let me review the key points:

   Privacy and Security Section of RFA, (A. - Access), p.12

   The HIE is required to implement a process that assigns access constraints and allowances to those roles that access the HIE to perform a particular function or task. The HIE will use the registry to control provider access. Responders are required to discuss how role-based access will be implemented in the HIE to allow for participating entities to control access levels for various resources within their organization. Responders need to describe how the HIE will locate, transport, and block consumer information. Consumers must be able to grant access to their information through a permissions table.

   Privacy and Security Section of RFA, (C. - Authorization), p.13

   Responders are required to detail an approach to authorization that strikes a balance between the complexity, usability and administrative overhead. Responders must discuss how consumers may grant providers authorization to view information; and the viewing rights will be controlled by the consumer and can be modified at any time.

5. Will providers be allowed to augment the consumer's HIE data? Or, will they be limited to strictly "read-only" access?

   Based on our understanding of the question, it is not clear and requires clarification by the submitter. The HIE fundamentally exchanges provider data, since health record banks and PHRs develop, consumers could conceivably control user rights to the information.

6. Does the solution need to provide a process to disable access to data initially granted for use in analytical reporting purposes? Do tiered access rights need to be supported in which specific components of the database are available based on an individual's role?

   The general answer would be that authorizations in place at the time of information release/ exchange would govern the use of the data. No "claw back" of data is envisioned, if the release was appropriate. Future release/use of the data would be governed by authorizations in place at the time the subsequent release occurs, although we are not clear about the specific circumstances envisioned in the first question.

   We believe the second question is answered in section A of the Privacy and Security section of the RFA. In brief, the system as a whole must be capable of role-based access. The more challenging question relates to consumer control over release of specific types of health information from specific providers, to specific sources (the issue of granular control). The RFA states only that the system must be capable of implementing a "permissions table."

7. Please clarify what is meant by "early functionality."

   The phrase "early functionality" is used in the Introduction of the RFA where it states "this RFA seeks proposals to develop the infrastructure and early functionality of a statewide HIE. Responders should refer back to the Exchange Functionality on pages 17 and 18 of the RFA where for the criteria for selecting the uses cases are discussed. The key point follows:

   Exchange Functionality of RFA, Pp.17-18

   Appropriately managing the implementation of the HIE's functionality is critical to gaining acceptance by consumers and providers and to ensuring financial sustainability. Implementing the least complex use cases initially and focusing on data that are of greatest importance to the provider will demonstrate success and lead to adoption as new use cases are accepted.

8. Do the Commissions see public health and human services agencies as service providers? If so, do the Commissions agree that these agencies must be included into the HIE?

   In the case of these agencies publishing health information to the Exchange: if the agency is acting as a provider of clinical services, it may be expected to make the data (such as lab results) available to the Exchange, unless otherwise restricted by state law.

   In the case of these agencies requesting information from the exchange, access by an agency would be a joint determination of the Board of the Exchange and the Policy Board and would depend in part on the planned uses and whether the data were de-identified or anonymous.

9. Could the Commissions provide estimates of annual volumes of information-request transactions subject to the HIE? For example, how many requests for information are made by various health care providers of family physicians? What sources of such information is recommended for responders to prepare revenue projections and to estimate operating costs for the anticipated volume of activity (in subscribers, transactions, volumes of collected and disseminated data, etc.)?

    We are not able to provide estimates of annual volumes. Determining estimates depends on the schedule of implementation of the uses cases. Ideally, because of the likely utility of the information, the exchange would make available a CCR like document for all transfers between providers and for most clinical encounters.

10. What are the performance metrics, such as system availability and system response time for key application functions?

    We expect this will be part of the vendor selection criteria used by the exchange. The larger problem will be posing a solution to ensure availability of data from non-24/7 providers.

11. Have minimum return on investment (ROI) or net present value (NPV) targets been established that the respondents must meet?

    We assume these calculations will be part of the financial feasibility model for achieving sustainability based on the initial investment of the State.

12. Would you elaborate on the Application Evaluation process?

    The staff of the MHCC will evaluate the applications received, drawing as necessary on additional expertise from individuals unconnected with the applicant multi-stakeholder groups. At least three raters will independently score the applications and then meet to resolve differences. If any of the applications are found to be satisfactory, MHCC staff will meet with those applicant groups to resolve any issues not addressed in the initial applications and to identify best and final proposals. One or more of these will be recommended to the members Maryland Health Care Commission for action.

    If the MHCC commissioners approve one or more of the applications, their recommendation will be sent to the HSCRC, together will recommendations regarding any provisions the MHCC believes should be incorporated into the Rate Order Letter. The HSCRC will consider the recommendations, select a multi-stakeholder group to fund, and develop the appropriate Rate Order Letter to provide funding and performance expectations.