Health Record and Payment Integration Program Advisory Committee

DISCUSSION ITEMS/GRIDS

TASK: The Maryland Health Care Commission (MHCC) is tasked with convening an Advisory Committee to conduct a health information technology policy study that assesses the feasibility of creating a health record and payment integration program (or program) that, among other things, could incorporate administrative health care claim transactions into the State–Designated Health Information Exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP).[1] Refer to the Advisory Committee Charter for more information.

DIRECTIONS: Discussion items that follow are in part, specified in law (Chapter 452)[2] to serve as a guide for Advisory Committee deliberations and the development of recommendations. Discussion items have been simplified for the Advisory Committee's assessment and are intended to be thought-provoking and help narrow the focus on specific program components using information gathering grids. In general, terms in the grids have the following meaning:

Benefit: Value derived from producing or consuming a service

Barrier: A circumstance or obstacle (e.g. operational, economic, political, budgetary, etc.) that hinders or prevents progress

Solution: An idea aimed at solving a problem or managing a difficult or complex situation

Note: The discussion items and grids are not an exhaustive list and are a means to spur objective thinking about the feasibility in establishing a health record and payment integration program. Certain bullet points identified in the grids are supported by literature while others are aspirational. Those that are literature-based are noted with an asterisk (*).

[1] Required by Senate Bill 896, *Health Record and Payment Integration Program Advisory Committee*, passed during the 2018 legislative session (Chapter 452). More information is available at: mgaleg.maryland.gov/2018RS/chapters_noln/Ch_452_sb0896E.pdf.

[2] Discussion items one through three are required in law. Discussion items four and five can be classified as other issues in the law appropriate to be included in this policy study.

Discussion Item 1: Feasibility of incorporating administrative health care claim transactions into the State–Designated HIE

Key Components:

A. Requiring MHCC Certified Electronic Health Networks (clearinghouses) to send claims information to CRISP	

BENEFITS *(VALUE ADD/PERCIEVED)*
 	
• Enhance care delivery through provider alerts that include information on patient diagnoses and procedures*
• Fill in missing gaps of information (e.g., from ambulatory encounters) to:
  ○ Ensure continuity pre and post hospitalization
  ○ Improve monitoring and coordination of care, especially for high-risk patients with chronic conditions
  ○ Reduce redundant and unnecessary services and tests
• Identify population health/public health issues*
• Facilitate reporting of quality metrics (e.g., help providers determine if patients have received select services outside their practice)
	BARRIERS & CHALLENGES *(OBSTACLES/POTENTIAL ISSUES)*
	
	• Obtaining legislative authority
	  ○ Compliance and enforcement for providers and clearinghouses
	  ○ Identification of a bill sponsor
	• Funding the additional technology at CRISP required to support X12 transaction receipt and conversion to HL7
	• Development and execution of data sharing agreements and protocols*
	• Addressing consumer consent policies (opt-out)
	• Addressing provider participation options
	• Privacy concerns (e.g., behavioral health)
	• Should paper claims and other claims submitted directly from a provider be included in the requirement
	  ○ Creates workflow challenges (e.g., dual entry)
	  ○ Adds additional administrative costs
	• Identifying an appropriate implementation strategy that does not disrupt the flow of electronic transactions

SOLUTIONS *(FOR INCORPORATING CLAIMS DATA INTO CRISP)* • Provider value and communication strategy • Financial return on investment model • Bill to implement the requirement and enforce compliance • Phased implementation approach • Funding source (model) to implement and sustain the initiative	
PARKING LOT	

B. Enhancing the CRISP infrastructure to support electronic claims transactions

BENEFITS *(VALUE ADD/PERCIEVED)*

- Increased value of the State-Designated HIE*
- The opportunity for expanded use cases aimed at care coordination
- Upgrades to hardware to increase vulnerability protections
- Opportunity to bolster patient matching algorithms
- The ability to support additional standards

BARRIERS & CHALLENGES *(OBSTACLES/POTENTIAL ISSUES)*

- Identifying a funding source(s) for up-front investment and ongoing costs, including additional cost for privacy and security
- Coordination of data transfer procedures from multiple EHNs (37 certified by MHCC as of August 2018) and bandwidth to support a significant volume of claims data
- The ability to accept, process, and store nearly 60M 837s annually
- Absent legislation, the policy requirements needed to manage provider consent and EHN participation are insurmountable
- Planning for implementation
- Identification of appropriate date elements contained in an 837
- Determining a reasonable timeline to complete system enhancements

SOLUTIONS *(FOR ENABLING CRISP TO RECEIVE AND MAKE CLAIMS INFORMATION AVAILABLE TO AUTHORIZED USERS)*

- State mandate to require daily X12 reporting by EHNs operating in Maryland to the State-Designated HIE
- Develop a funding plan that spreads the investment and maintenance cost across stakeholders
- A chartered stakeholder workgroup focused on identifying and policy and technology to support a phased implementation plan

PARKING LOT

- Fee schedule determination
- Timing
- Actual investment and maintenance costs
- AG review on the potential impact (if any) of Gobeille v. Liberty Mutual Insurance Company

Discussion Item 2: Feasibility of establishing a free and secure web–based portal for providers, regardless of payment method being used for health care services to: (a) create and maintain health records and (b) submit claims to third party payors

Key Components:

A. Making available a web-based electronic health record solution (EHR) at no cost to providers	
BENEFITS *(VALUE ADD/PERCIEVED)* • Providers that have not adopted an EHR could be encouraged to use a free web-based solution • Less cost than traditional EHR solutions • Eliminates the need for providers to evaluate, select, or manage EHR technology 1	**BARRIERS & CHALLENGES** *(OBSTACLES/POTENTIAL ISSUES)* • Moving too quickly to develop an alternative solution to the market without fully understanding the issues with the current system • Implementing an EHR that is certified or only select elements of an EHR (buy or build) • EHRs are customized by specialty; a one size fits all approach not likely • Technical support and training for providers by the hosting organization • Design, development, implementation, and ongoing maintenance cost • Ongoing technical maintenance and support by the hosting organization • Technology capabilities of providers (e.g., Internet access, necessary available technology, etc.) • An EHR that is interoperable with other EHR systems • Appropriately assessing need/potential users since physician EHR adoption is nearly 75 percent statewide • Free platform requires technology costs for users • Multiple vendors offer a free EHR/web portal • Determining a funding source 2
SOLUTIONS *(FOR MAKING AN EHR AVAILABLE FOR FREE TO AUTHORIZED USERS)* • Sustainable funding source (model) • An environmental scan to assess providers willingness to use a free web-based EHR solution 3	
PARKING LOT • Funding source(s) • Determining a timeframe for implementing • RFP development process	

B. Developing a web-based portal for submitting claims to third party payers at no cost to providers	
BENEFITS *(VALUE ADD/PERCIEVED)* • May reduce costs associated with claims submission • May eliminate the need for providers to evaluate, select, or manage a billing solution	**BARRIERS & CHALLENGES** *(OBSTACLES/POTENTIAL ISSUES)* • Determining if the State should take on this component of a program or designate responsibility to a vendor • Identifying adequate and sustainable funding sources to support high cost of this work • Time consuming to design, develop, and maintain • Moving too quickly to develop a solution without fully understanding issues with current systems already in place • Completing a cost benefit analysis • Developing a solution that is user friendly and integrated into provider workflows • Identifying the value proposition
SOLUTIONS *(FOR DEVELOPING A FREE WEB-BASED PORTAL FOR SUBMITTING CLAIMS)* • Require users of the system to pay a subscription fee to access the solution • Gauge the value of a free web-based portal on ambulatory providers through an environmental scan • Educate providers on existing payer claims submission portals	
PARKING LOT • Funding model	

Discussion item 3: Approaches for accelerating the adjudication of clean claims

Key Components:

A. Revising prompt payment requirements – Insurance Article, §15-1005(c)	
BENEFITS *(VALUE ADD/PERCIEVED)* • Improved cash flow • More timely information on claims that pend or reject by a payor	**BARRIERS & CHALLENGES** *(OBSTACLES/POTENTIAL ISSUES)* • Assessing impact of current regulatory requirements • Many payors pay clean claims in less than 30 days • Determining if provider concerns are with clean claims or claims where attachments and additional information are sought by the payor • A move to further reduce payor attachment requirements • The impact of retooling payor adjudication systems
SOLUTIONS *(FOR REVISING PROMPT PAYMENT REQUIREMENTS)* • Identify policies to reduce the adjudication cycle on claims where attachments and additional information is required by the payor • Increase provider awareness of claim submission requirements when documentation is required	
PARKING LOT • Timeline for revising prompt payment requirements	

Discussion item 4: Estimated cost to the State to support the program

Key Component:

A. Identifying a funding source	
BENEFITS *(VALUE ADD/PERCIEVED)* • State Designation of an existing provider solution would have less of a financial impact on the State	**BARRIERS & CHALLENGES** *(OBSTACLES/POTENTIAL ISSUES)* • Public funding tends to support start-up but not ongoing operations* • Competitive funding landscape • Sustainability • Addressing participation options • Need buy-in from stakeholders/clear value proposition to payors and other stakeholders* • The years required to obtain a return on the investment
SOLUTIONS *(FOR IDENTIFYING A FUNDING SOURCE)* • Grant funding from public and private sources, if available • User subscription fees • State general funds • Private vendors (State Recognition model)	
PARKING LOT • Development costs for the system could likely range between $3 million and $5 million	

Discussion item 5: Using multiple vendors integrated with the State-Designated HIE

Key Component:

A. Integrating multiple vendors with CRISP	
BENEFITS *(VALUE ADD/PERCIEVED)* • CRISP currently integrates with multiple vendors 1	**BARRIERS & CHALLENGES** *(OBSTACLES/POTENTIAL ISSUES)* • Who pays initial and ongoing vendor integration costs • Vendor contracting • Funding additional technology needed by CRISP to support infrastructure expansion • Expanded privacy challenges • The extended length of time required to integrate a vendor with CRISP 2

SOLUTIONS *(FOR INTEGRATING MULTIPLE VENDORS WITH CRISP)*
 	
• Needs assessment for "direct" (uniquely coded integration) versus "middleware" using commercial interface engines
  ○ "Direct" integration requires more initial effort but results in custom-built solutions
  ○ "Middleware" may have a shorter launch timeframe but result in ongoing vendor contracts
• Consider the long-term value of blockchain technology
3	

PARKING LOT • Costs	

LITERATURE

1. Walker, J., Pan, E., Johnston, D., Adler-Milstein, J., Bates, D. W., & Middleton, B. (2005). The Value Of Health Care Information Exchange And Interoperability: There is a business case to be made for spending money on a fully standardized nationwide system. Health affairs, 24(Suppl1), W5-10.
2. Esmaeilzadeh, P., & Sambasivan, M. (2016). Health Information Exchange (HIE): A literature review, assimilation pattern and a proposed classification for a new policy approach. Journal of biomedical informatics, 64, 74-86.
3. Frisse, M. E., Johnson, K. B., Nian, H., Davison, C. L., Gadd, C. S., Unertl, K. M., ... & Chen, Q. (2011). The financial impact of health information exchange on emergency department care. Journal of the American Medical Informatics Association, 19(3), 328-333.
4. Miller, A. R., & Tucker, C. (2014). Health information exchange, system size and information silos. Journal of health economics, 33, 28-42.
5. Cross, D. A., Lin, S. C., & Adler-Milstein, J. (2015). Assessing payer perspectives on health information exchange. Journal of the American Medical Informatics Association, 23(2), 297-303.
6. Rowley, R. (2010). The sustainability of Health Information Exchanges. Practice fusion blog. Accessed August 10, 2018 from: https://www.practicefusion.com/blog/sustainability-of-health-information/
7. McCarthy, D. B., Propp, K., Cohen, A., Sabharwal, R., Schachter, A. A., & Rein, A. L. (2014). Learning from health information exchange technical architecture and implementation in seven beacon communities. EGEMS, 2(1).