Health Record and Payment Integration Program Advisory Committee

KEY THEMES, DRAFT RECOMMENDATIONS, & SUPPORTING RATIONALE

BACKGROUND

Senate Bill 896, *Health Record and Payment Integration Program Advisory Committee,* was passed during the 2018 legislative session. The law (Chapter 452) required the Maryland Health Care Commission (MHCC) to convene interested stakeholders (Advisory Committee) to conduct a feasibility study as it relates to creating a health record and payment integration program (or program) and report on or before November 1, 2019 to the Governor and General Assembly detailing findings and recommendations from the study.

APPROACH

Reflecting on Advisory Committee deliberations, including information gathered in the discussion items/grids document, the Draft Recommendations Subcommittee (Subcommittee) identified emerging key themes during meetings in November and December 2018. Key themes were used to help formulate informal draft recommendations for consideration by the Advisory Committee, for each study component required in the law. This document is an evolving draft and is subject to change; items in the draft should not be viewed as representing consensus among the Advisory Committee or Subcommittee.

STUDY COMPONENTS

1. Feasibility of creating a health record and payment integration program

Key themes

A. Policy challenges, funding, and technical complexities to develop a program requires a considerable investment by the State

B. Uncertainty exists around whether payors and providers are willing to move away from existing health IT investments, and the willingness of providers that have not invested in health information technology (health IT) to adopt the program

C. Complex issues around program design, governance, and ownership need to be addressed by stakeholders

Draft Recommendation

No action at this time.

Rationale

The health care industry has made considerable investments in health IT over the past decade. The amount invested varies from millions of dollars by large organizations to thousands of dollars by small organizations. The Advisory Committee noted numerous health IT solutions that exist and have been implemented are compliant with regulatory requirements, standards, implementation specifications, and certification criteria adopted by the Office of the National Coordinator for Health

Information Technology (ONC). Augmenting what is already in place by establishing a health record and payment integration program requires human resources, time, and cost to be absorbed by the State, providers, and entities operating in Maryland, including payors and clearinghouses. The Advisory Committee noted that a comprehensive financial and technical analysis of the program was beyond its capabilities. Program ownership and governance was not addressed in detail by the Advisory Committee. Funding approved by the legislature would be needed to engage a third party to conduct a more in depth assessment of a program, which is estimated to cost upwards of $500,000.

2. Feasibility of incorporating administrative health care claims transaction into Chesapeake Regional Information System for our Patients (CRISP)

Key themes

A. Unclear value proposition absent specific use cases to justify investment cost

B. Provider contracting issues pertaining to data ownership

C. Employee Retirement Income Security Act of 1974 (ERISA) restricts access to self-insured data from private health plans

D. Resistance is likely by payors and the 32 clearinghouses that operate in Maryland of a mandate to report claims data to CRISP

Draft Recommendation

Establish a task force to conduct a more in-depth study.

Rationale

In 2016, CRISP funded a small pilot with two clearinghouses to assess technical feasibility of reporting claims data to CRISP. This proof of concept demonstrated that it is technically feasible to incorporate administrative health care claims transactions (transactions) into CRISP. The pilot successfully resolved technical challenges and identified policy matters that, if unresolved, hinder CRISP's ability to scale-up the pilot. This includes contractual issues between clearinghouses and health care organizations that restrict information sharing with CRISP. ERISA requirements also pose a complex set of issues that require working directly with privately insured plans to obtain authorization to collect claims data. In addition, some payors and clearinghouses have expressed concern about a mandate that necessitates sharing data with CRISP. Broad agreement exists among the Advisory Committee to establish a task force to conduct a more in-depth study about these issues.

3. Feasibility of establishing a free and secure web–based portal that providers can use, regardless of the method of payment being used for health care services to create and maintain health records and file for payment for health care services provided

Key themes

A. Provider buy-in due to widespread adoption of electronic health record (EHR) technology and billing systems

B. Time and resources required to develop and implement the technology to meet the needs of various providers

C. Unknown start-up and ongoing costs

Draft Recommendation

No action at this time.

Rationale

Various federal and State policies have promoted EHR adoption since enactment of the American Recovery and Reinvestment Act (ARRA) of 2009, which included the Health Information Technology for Economic and Clinical Health (HITECH) Act designed to modernize health care. EHR diffusion statewide is noteworthy as all hospitals, about 50 percent of comprehensive care facilities, nearly 70 percent of dentists, and roughly 75 percent of physicians have implemented an EHR. The Advisory Committee acknowledged there is some cost that would inevitably be spread across stakeholders in order to make available a free web-based portal to providers statewide. Free web-based provider portals already exist and rely on advertising pop-ups and ribbon messages for funding. The ability for these solutions to meet the rigors of ONC certification requirements are questionable. The Advisory Committee noted broad challenges that need to be addressed in order to include a reimbursement component within a portal. The general viewpoint among the Advisory Committee was to rely on existing processes and vendor solutions.

4. Feasibility of incorporating the Prescription Drug Monitoring Program (PDMP) data into CRISP so that prescription drug data can be entered and retrieved

Key themes

A. The PDMP mandate was established in 2011 and the Maryland Department of Health (MDH) Behavior Health Administration competitively selected CRISP to support the technical infrastructure

B. Requirements exist for prescribers and dispensers of Controlled Dangerous Substances (CDS) Schedule II-V drugs to report to the PDMP, and consult the PDMP (COMAR 10.47.07, *Prescription Drug Monitoring Program*)

C. In 2018, the General Assembly passed House Bill 115, *Maryland Health Care Commission – Electronic Prescription Records System – Assessment and Report,* during the 2018 legislative session that requires MHCC to explore feasibility of developing a repository of non-CDS data

Draft Recommendation

No action at this time.

Rationale

Current regulations (COMAR 10.47.07) require that CDS data be made available to MDH's Behavior Health Administration, which contracts with CRISP to support the collection of data from prescribers and dispensers, and to make the information available to providers. The MHCC convened an Electronic Prescription Records System Workgroup in the summer of 2018 to explore the feasibility of collecting non-CDS data, and use of CRISP and other technology vendors to make this information

available to treating providers. A final report is due to the legislature by January 1, 2020.[1] The Advisory Committee agreed that no action is required.

5. Approaches for accelerating the adjudication of clean claims

Key themes

A. The Maryland Insurance Administration (MIA) has not identified concerns regarding non-compliance with Insurance Article Annotated Code of Maryland (Insurance Article) §15-1003(d), which requires payment of undisputed claims within 30-days of receipt of a claim

B. Private payors report that most electronic claims are processed in near real-time

C. Provider concerns exist around changing the statute that allows a provider 180-days from the date of service to submit a claim

Draft Recommendation

No action at this time.

Rationale

In November 2000, the MIA issued regulations required by the Insurance Article that govern how private payors adjudicate health care claims. COMAR 31.10.11.14, *Uniform Claim Forms,* established standards for claims submission to expedite and simplify claims processing. Bi-annually, private payors report to the MIA on claims that were paid within the established timeframe, and on claims paid where interest was included for exceeding the 30-day requirement. The Advisory Committee concluded that payor initiatives enable most claims to be processed in significantly less time than required by the regulations. Concerns were expressed by the Advisory Committee regarding the potential negative consequences to providers in changing the 180-day timely filing requirement. The Advisory Committee agreed that no statutory change is needed at this time to accelerate the adjudication of clean claims or reduce timely filing requirements by providers.

6. Any other issue that MHCC considers appropriate to study to further health and payment record integration

The following topic was discussed by the Advisory Committee:

- **A single health care consumer identification card for Marylanders that is accepted by payors**

Key themes

A. A single patient identification number is viewed as controversial due to privacy concerns

B. Magnetic stripe cards (or smart cards) pose challenges as reading devices currently support financial management systems and the full impact of a conversion is unknown

Draft Recommendation

No action at this time.

[1] For more information, visit: mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_hit_electronic_prescription.aspx.

Rationale

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) originally included a provision for the adoption of a unique patient identifier. This requirement was later overruled by Congress due to privacy issues.[2] The Advisory Committee acknowledges the many benefits of a unique patient identifier, as compared to the current system, for identifying patients. Most Advisory Committee participants were not in support of a unique patient identifier given the risk that patient information could be easily exploited and that privacy may be more difficult to assure than what exists today. Magnetic stripe cards and smart cards are widely used in the financial industry. They have been slow to gain acceptance in health care. The Advisory Committee has concerns about implementing technology that may not be widely embraced and exclusive to Maryland. National efforts around electronic health information exchange focus on portability between systems where patients control the flow of their information.

[2] PUBLIC LAW 105–277 Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999.