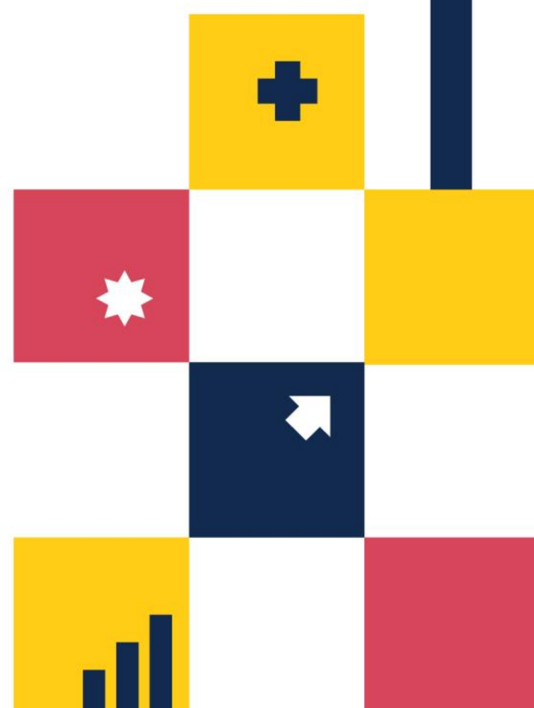
Public Health – State Designated Exchange – Clinical Information



Briefing Paper

December 2021

MARYLAND Health Care Commission

MARYLAND
Health Care
Commission

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Summary

The Maryland General Assembly passed legislation in 2021 (Chapters 790 and 791, *Public Health - State Designated Exchange - Clinical Information*)[1] that requires nursing homes[2] to submit electronic clinical information to the State Designated health information exchange (HIE), CRISP.[3] The law also requires electronic health networks (EHNs) certified by the Maryland Health Care Commission (MHCC)[4, 5] to submit administrative health care transactions (administrative transactions)[6] to CRISP.[7] The MHCC is required to update the Governor and General Assembly on the availability of funding and technical infrastructure sustainability to support the law on or before January 1, 2022.

Funding to support the nursing home requirements is available under an existing financial agreement (agreement) between CRISP, the Health Services Cost Review Commission (HSCRC), and the Maryland Department of Health (MDH). The agreement leverages Medicaid Enterprise System certified technology funding. Systems operated and maintained by CRISP on behalf of MDH are eligible for a federal match of up to 90 percent; the remaining amount is provided by HSCRC through hospital assessments and MDH grants.

The CRISP technical infrastructure can support the requirements in law. In 2022, CRISP will integrate with two electronic health record (EHR) systems (PointClickCare and MatrixCare) that together support about 90 percent of nursing homes operating in Maryland.[8] The estimated cost to integrate with these EHR systems is about $330,000 annually. CRISP also plans to integrate administrative transactions from six EHNs over the next year. These EHNs account for nearly all (99.6 percent) administrative transactions statewide.[9] The estimated cost for CRISP to integrate administrative transactions from these EHNs is approximately $180,000 annually.

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[1] Enacted under Article II, § 17(c) of the Maryland Constitution, May 30, 2021. See Appendix A for a copy of the law.
[2] Referred to as comprehensive care facilities under Maryland law.
[3] The Chesapeake Regional Information System for our Patients is a 501(c)(3) independent non-stock Maryland membership corporation. Refer to the *About CRISP* section on pages 9-10 for more information.
[4] EHNs (or clearinghouses) are entities involved in the exchange of administrative transactions between a payor, health care provider, vendor, and any other entity. To operate in Maryland, EHNs must be certified by MHCC every two years. More information is available at: mhcc.maryland.gov/mhcc/pages/hit/hit_ehn/hit_ehn.aspx.
[5] See Appendix D for a listing of all EHNs certified by MHCC.
[6] See Appendix B for more background information on federal rules as it relates to administrative transactions.
[7] The law prohibits an EHN from charging a fee to a health care provider, payor, or the State Designated HIE.
[8] See Appendix E for more information on EHR vendor share.
[9] See Appendix F for more information of EHN transaction volume and share.

Discussion

The MHCC is responsible for advancing diffusion of health information technology (health IT) statewide. The value of health IT rests in the promise that electronic health information can improve care delivery while reducing health care costs.[10, 11] Chapters 790 and 791 (the law) authorizes CRISP to provide health information to health care providers, HIE users, and State and federal officials to facilitate a state health improvement program, mitigate a public health emergency, and improve patient safety. The law provides for the protection of health information by limiting redisclosure of financial information, restricting information from individuals who have opted-out of information sharing, and restricting data from health care providers that possess sensitive health care information.[12]

The value of data increases when datasets from different sources are linked.[13] The law represents a significant step towards improving data analytics required to achieve better quality and health outcomes. CRISP will combine datasets from multiple sources to inform decision making at the point of care. Combined datasets provide more intelligence and opportunity to better estimate the magnitude of problems, identify groups at higher risk of having poorer outcomes, examine relationships between risk factors and outcomes, develop interventions, and better monitor the effectiveness of those interventions overtime.[14] Most states require providers to report information to public health agencies, and often leverage functions of an HIE.[15] States with a designated HIE or equivalent frequently serve as the utility for public health reporting.

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[10] The Office of the National Coordinator (ONC) for Health Information Technology, *Connecting Health and Care for the Nation – A Shared Nationwide Interoperability Roadmap*. Available at: www.healthit.gov/sites/default/files/nationwide-interoperability-roadmap-draft-version-1.0.pdf.

[11] University of Illinois Chicago, *Applying Technology To Improve Healthcare: What Is Healthcare IT?*, July 2020. Available at: healthinformatics.uic.edu/blog/applying-technology-to-improve-healthcare-what-is-healthcare-it/.

[12] Federal regulations outlined in 42 CFR Part 2 (Confidentiality of Substance Use Disorder Patient Records) limits the use and disclosure of sensitive health information.

[13] EY, *How we can place a value on health care data*, July 2019. Available at: www.ey.com/en_us/life-sciences/how-we-can-place-a-value-on-health-care-data .

[14] Soucie JM. Public health surveillance and data collection: general principles and impact on hemophilia care. Hematology. 2012;17 Suppl 1(0 1):S144-S146. doi:10.1179/102453312X13336169156537.

[15] ONC, *Health IT Playbook - Section 10 Population & Public Health*. Available at: www.healthit.gov/playbook/population-public-health/.

Data Supports Health Care Reform – Key Federal Drivers

Data can catalyze improvements in health care by addressing challenges in current delivery systems.[16] Value-based care requires the compilation and exchange of health information across the continuum to achieve transformation.[17, 18] Data-driven approaches using health IT are essential to help ensure there is greater opportunity for individuals to achieve their full health potential across all populations and communities in the State.[19] Federal legislation has been integral to promoting health IT adoption through incentives, penalties, and mandates. Several federal laws are credited with driving health care reform through the use and expansion of health IT; these laws are helping turn data into actionable information.[20]

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of American Recovery and Reinvestment Act of 2009,[21] provided the framework to advance health IT by incentivizing EHR adoption, funding HIE development, and establishing EHR standards that enable health information to be interoperable, a central tenet of health care reform.[22, 23, 24] Prior to HITECH, HIEs did not exist and EHR adoption nationally was low – generally under 10 percent for hospitals,

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[16] The Commonwealth Fund, *Moving Toward High-Value Health Care: Integrating Delivery System Reform into 2020 Policy Proposals*, November 2018. Available at: www.commonwealthfund.org/publications/issue-briefs/2018/nov/high-value-care-delivery-system-reform-2020.
[17] American Hospital Association, *Leveraging Data for Health Care Innovation*, 2021. Available at: www.aha.org/system/files/media/file/2021/01/MI_Leveraging_Data_Report.pdf.
[18] Factors driving health care transformation include fragmentation, access problems, unsustainable costs, suboptimal outcomes, and disparities.
[19] Health Catalyst, *Health Equity: Why it Matters and How to Achieve it*, March 2018. Available at: www.healthcatalyst.com/insights/health-equity-why-it-matters-how-to-achieve-it/.
[20] Nelson-Brantley, Heather V. PhD, RN, CCRN-K; Jenkins, Peggy PhD, RN; Chipps, Esther PhD, RN, NEA-BC Turning Health Systems Data Into Actionable Information, JONA: The Journal of Nursing Administration: April 2019 - Volume 49 - Issue 4 - p 176-178 doi: 10.1097/NNA.0000000000000734.
[21] HIPAA Journal, *What is the HITECH Act?* Available at: www.hipaajournal.com/what-is-the-hitech-act/.
[22] Gold M, McLaughlin C. *Assessing HITECH Implementation and Lessons*: 5 Years Later. Milbank Q. 2016;94(3):654-687. doi:10.1111/1468-0009.12214.
[23] Health Affairs, *Health Information Exchange After 10 Years: Time For A More Assertive, National Approach*, August 2019. Available at: www.healthaffairs.org/do/10.1377/hblog20190807.475758/full/.
[24] See Appendix C for more information on key HITECH provisions.

ambulatory practices (practices), and nursing homes. By 2017, EHR adoption was at nearly 96 percent among hospitals, 80 percent for practices, and 66 percent for nursing homes. [25, 26, 27, 28]

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)[29] represents a significant step in advancing practice transformation and includes the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (AAPMs). Both MIPS and AAPMs incentivize providers for delivering high quality, cost-effective care where clinical decision-making, analytics, and reporting is supported by advanced use of health IT.[30]

The 21st Century Cures Act was signed into law in 2016 and further promotes the availability of electronic health information, among other things. Provisions focus on advancing interoperability and supporting access, exchange, and use of electronic health information.[31] This includes ensuring that consumers have different pathways to access their electronic health information.[32]

Nursing Home EHR HIE Integration – A Pressing Need

Inaccessible, incomplete, and ill-timed information impedes the delivery of high-quality care and necessary care coordination when older adults transfer between nursing homes and hospitals.[33] The recognized benefits of HIE to patients and providers has not generated momentum to eliminate longstanding information gaps. The consequence for patients is prolonged hospital stay or unneeded readmission after the initial hospital discharge. The availability of electronic health information

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[25] ONC, Non-federal Acute Care Hospital Electronic Health Record Adoption, Health IT Quick-Stat #47. www.healthit.gov/data/quickstats/non-federal-acute-care-hospital-electronic-health-record-adoption. September 2017.

[26] ONC, Office-based Physician Electronic Health Record Adoption, Health IT Quick-Stat #50. www.healthit.gov/data/quickstats/office-based-physician-electronic-health-record-adoption. January 2019.

[27] ONC, Electronic Health Record Adoption and Interoperability among U.S. Skilled Nursing Facilities and Home Health Agencies in 2017, Data Brief # 41. www.healthit.gov/sites/default/files/page/2018-11/Electronic-Health-Record-Adoption-and-Interoperability-among-U.S.-Skilled-Nursing-Facilities-and-Home-Health-Agencies-in-2017.pdf.

[28] Nursing home EHR adoption in Maryland was around 91 percent in 2017. More information is available at: mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_Nursing_Home_Brf_20190826.pdf.

[29] MACRA was signed into law on April 16, 2015. Available at: cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.

[30] Elation, *MIPS v. APMS*, July 17, 2007: Available at: www.elationhealth.com/blog/mips-v-apms/.

[31] American College of Surgeons Bulletin, September 2021: Available at: bulletin.facs.org/2021/09/the-21st-century-cures-act-final-rule/.

[32] Federal Register, 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program Final Rule. Available at: www.federalregister.gov/documents/2020/05/01/2020-07419/21st-century-cures-act-interoperability-information-blocking-and-the-onc-health-it-certification.

[33] EHR Intelligence, *Health Information Exchange Tools Needed in Nursing Homes*, June 2015. Available at: ehrintelligence.com/news/health-information-exchange-tools-needed-in-nursing-homes.

during treatment improves all aspects of care delivery, including safety, effectiveness, patient-centeredness, and quality of care.[34] Nursing home EHR system integration with CRISP is essential to ensure that a treating provider can access a patient's health information when a transfer or discharge occurs.

Two EHR systems predominantly used by nursing homes in Maryland (i.e., PointClickCare or "PCC" and MatrixCare)[35] have different HIE integration strategies. PCC enables HIE connectivity at the vendor level where HIE integration is activated simultaneously across all nursing homes. PCC requires HIEs to fund connectivity; a monthly fee is determined based on total EHR system installations. MatrixCare integrates with HIEs at the nursing home level. Each facility is assessed a connection fee and billed monthly based on total bed days. Integrating nearly 170 nursing homes using PCC with CRISP will occur during the first six months of 2022. Integrating roughly 29 nursing homes using MartixCare requires more time since implementation depends on nursing home and vendor technical resource availability.

EHN Administrative Transactions – Support for Population Health Programs

EHNs route administrative transactions electronically between providers and payors,[36] which historically had been performed by paper using the postal system. EHNs are a value-add to providers and payors by validating administrative transactions for completeness and accuracy, monitoring the status of each transaction, and retaining transaction backup files.[37] EHNs reduce administrative overhead as the payor cost to process electronic claims is around seven percent of the paper cost, and the provider cost to generate an electronic claim is about 47 percent of the paper cost.[38, 39]

Existing regulations, COMAR 10.25.07, *Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouses*, requires payors operating in the State to only accept administrative

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[34] ONC, *Health Information Exchange*, October 2019. Available at: www.healthit.gov/topic/health-it-and-health-information-exchange-basics/health-information-exchange.
[35] See Appendix E for more information on EHR vendor share.
[36] EDI Basics. Available at: www.edibasics.com/edi-resources/document-standards/hipaa/. https://www.edibasics.com/edi-resources/document-standards/hipaa/.
[37] The Centers for Medicare & Medicaid Services, *Remittance Advise and FAQs*. Available at: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ICN905367TextOnly.pdf.
[38] Payor claim submission cost per transaction is $1.18 for manual and $0.08 for electronic. Provider claim submission cost per transaction is $2.52 for manual and $1.19 for electronic.
[39] 2020 CAQH, Closing the Gap: *The Industry Continues to Improve, But Opportunities for Automation Remain*. Available at: www.caqh.org/sites/default/files/explorations/index/2020-caqh-index.pdf.

transactions from MHCC certified EHNs.[40] To receive MHCC certification, EHNs must be accredited or certified by a nationally recognized organization.[41] Accreditation and certification ensures that EHNs meet standards related to privacy and confidentiality, business practices, physical and human resources, technical performance, and security. Approximately 30 MHCC certified EHNs operate in Maryland.[42]

HIE EHN Administrative Transaction Integration

Standards adopted by EHNs are different than standards used by HIEs. In 2015, MHCC funded CRISP and two EHNs to complete a standard conversion demonstration (demonstration) to determine whether standards used by EHNs could be converted to HIE standards. The demonstration was successful and included around 32 practices, 68 providers, and 16,000 administrative transactions. Several challenges were identified, such as scaling to meet high volumes of administrative transactions, extracting select data elements from a transaction type, identification of specific use cases, and data timeliness.

The MHCC convened several EHNs in September 2021 to explore technical and policy matters to be considered when implementing the law. Discussions focused on policy requirements and short-term challenges. The MHCC concluded that broader EHN participation was needed. The MHCC engaged The Cooperative Exchange, The National Clearinghouse Association[43] to gain deeper insight into the challenges to ensure policies are thoughtfully crafted to meet the aims in law.

About CRISP

Health-General §19-143, Annotated Code of Maryland (2009) charged MHCC and the HSCRC with the designation of a statewide HIE. The MHCC and HSCRC competitively selected CRISP in August 2009 to build and maintain the technical infrastructure to support the secure exchange of electronic health information. Since then, MHCC has developed and executed a *State Designated HIE Designation Agreement* (SDA) every three years that sets conditions for CRISP as Maryland's State Designated HIE.

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[40] Health General Article § 19-134 requires MHCC to establish standards for the operation of medical care electronic claims clearinghouses in Maryland and license clearinghouses meeting those standards.

[41] Organizations include the Electronic Healthcare Network Accreditation Commission (EHNAC) and the Health Information Trust Alliance (HITRUST).

[42] See Appendix D for a listing of all EHNs certified by MHCC.

[43] The Cooperative Exchange is the recognized resource and representative of the health care transaction clearinghouse industry. More information is available at: www.cooperativeexchange.org.

Re-designation builds on CRISP's accomplishments and supports MHCC in advancing a strong, flexible health IT ecosystem in the State.[44]

CRISP services enable authorized users to access clinical information at the point of care, receive electronic notifications when patients have a hospital encounter, obtain information on dispensed drugs that contain controlled dangerous substances, and utilize care management reports and analytics tools to improve care delivery and care coordination.[45] During the COVID-19 public health emergency, CRISP provided key support aligning services with response needs and identifying care delivery gaps across the State. CRISP is well-positioned to support public health efforts by combining clinical information from nursing home EHR systems and EHN administrative transactions with other data to inform public health interventions.[46]

Legislative Update – Funding and Sustainability

The law requires MDH to identify appropriate funding to support implementation. The MHCC is tasked in law to report on funding requirements and sustainability of the technical infrastructure in accordance with § 2–1257 of the State Government Article and the General Assembly.

CRISP's technical infrastructure is certified Medicaid Enterprise System technology.[47] The Centers for Medicare & Medicaid Services (CMS) validates and certifies this technology to ensure efficient and effective management of the program and satisfy regulatory requirements and CMS directives for funding.[48] Certified technology is eligible for a federal match of up to 90 percent.

Federal Medicaid matching funds (FMMFs) will cover technology costs required to meet the aims in law. Matching funds will be provided through HSCRC hospital assessments and MDH grants. Ongoing costs will be included in future FMMFs, MDH grant requests, and HSCRC hospital assessments.

Integrating nursing home EHR systems with CRISP will cost approximately $330,000 annually. The cost for CRISP to integrate PCC is around $250,000 and MatrixCare is about $80,000. Funding also

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[44] SDAs previously executed with CRISP in 2009, 2013, and 2016.
[45] More information about CRISP is available at: crisphealth.org/.
[46] HIMSS, *HIEs Are Vital to Public Health, But Need Reshaping*. Available at: himss.org/resources/hies-are-vital-public-health-need-reshaping.
[47] Certification ensures that vendors meet the Centers for Medicare & Medicaid Services guidelines that aligns with Medicaid Information Technology and Architecture, and the standards and conditions for Medicaid information technology.
[48] E-Bulletin, *The Medicaid Management Information System Snapshot*, April 2016. Available at: www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ebulletins-medicaidmanage-infosystem.pdf.

supports use case development, compensation to EHR technology channel partners, data quality audits, and data storage and security.

Integrating EHN administrative transactions with CRISP will cost about $180,000 annually. Actual costs will be lower or higher depending on EHN transaction volumes and number of use cases. The MHCC has begun working with stakeholders to identify clinically relevant use cases where EHN administrative transactions combined with other data can improve care delivery. The MHCC believes the EHN industry sees value in sharing administrative transactions for public health purposes, but identifying a long-term funding source will be critical to engaging the industry.

Chapter 790 (Cross-filed with Chapter 791)

(House Bill 1022) (Cross-filed with SB0748)

AN ACT concerning

Public Health – State Designated Exchange – Clinical Information

FOR the purpose of requiring a nursing home, on request of the Maryland Department of Health, to electronically submit clinical information to the State designated exchange for a certain purpose; authorizing the State designated exchange to provide certain information to certain individuals and entities in a certain manner; providing that information submitted under a certain provision of this Act may be combined with other data maintained by the State designated exchange for a certain purpose under certain circumstances; providing that certain information submitted by a nursing home may only be used for a certain purpose and may not be used for any other purpose; requiring an electronic health network to provide certain transactions to the State designated exchange for certain purposes; prohibiting an electronic health network from charging a certain fee to a health care provider, health care payor, ~~of~~ or the State designated exchange; requiring the State designated exchange to develop and implement certain policies and procedures; authorizing the Maryland Health Care Commission to adopt certain regulations; altering the purposes to which certain regulations adopted by the Commission are required to limit the scope of certain information; ~~providing~~ requiring that certain regulations adopted by the Commission ~~may~~ limit redisclosure of certain information and restrict certain data in relation to the exchange of certain information; requiring the Department to identify and seek certain funding; requiring the Commission to report to the Governor and the General Assembly on or before a certain date; defining certain terms; making stylistic changes; and generally relating to the State designated exchange and the sharing of clinical information.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 4–302.3
Annotated Code of Maryland
(2019 Replacement Volume and 2020 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

4–302.3.

(a) (1) In this section the following words have the meanings indicated.

(2) " ELECTRONIC HEALTH CARE TRANSACTIONS" MEANS HEALTH CARE TRANSACTIONS THAT HAVE BEEN APPROVED BY A NATIONALLY RECOGNIZED HEALTH CARE STANDARDS DEVELOPMENT ORGANIZATION TO SUPPORT HEALTH CARE INFORMATICS, INFORMATION EXCHANGE, SYSTEMS INTEGRATION, AND OTHER HEALTH CARE APPLICATIONS.

~~(2)~~ (3) "ELECTRONIC HEALTH NETWORK" MEANS AN ENTITY ~~INVOLVED~~:

(I) INVOLVED IN THE EXCHANGE OF ELECTRONIC HEALTH CARE TRANSACTIONS BETWEEN A PAYOR, HEALTH CARE PROVIDER, VENDOR, AND ANY OTHER ENTITY; AND

(II) CERTIFIED BY THE MARYLAND HEALTH CARE COMMISSION.

~~(3)~~ (4) "NURSING HOME" HAS THE MEANING STATED IN § 19–1401 OF THIS ARTICLE.

[(2)**]** **~~(4)~~ (5)** "Standard request" means a request for clinical information from a health information exchange that conforms to the major standards version specified by the Office of the National Coordinator for Health Information Technology.

[(3)**]** **~~(5)~~ (6)** "State designated exchange" means the health information exchange designated by the Maryland Health Care Commission and the Health Services Cost Review Commission under § 19–143 of this article.

(b) This section applies to:

(1) Except for the State designated exchange, a health information exchange operating in the State; and

(2) A payor that:

(i) Holds a valid certificate of authority issued by the Maryland Insurance Commissioner; and

(ii) Acts as, operates, or owns a health information exchange.

(c) An entity to which this section applies shall connect to the State designated exchange in a manner consistent with applicable federal and State privacy laws.

(d) When a standard request for clinical information is received through the State designated exchange, an entity to which this section applies shall respond to the request to the extent authorized under federal and State privacy laws.

(e) A consent from a patient to release clinical information to a provider obtained by an entity to which this section applies shall apply to information transmitted through the State designated exchange or by other means.

(F) (1) ON REQUEST OF THE DEPARTMENT, A NURSING HOME SHALL SUBMIT ELECTRONICALLY CLINICAL INFORMATION TO THE STATE DESIGNATED EXCHANGE TO FACILITATE THE OBJECTIVES STATED IN PARAGRAPH (3) OF THIS SUBSECTION.

(2) IN ACCORDANCE WITH STATE AND FEDERAL LAW AND TO FACILITATE THE OBJECTIVES STATED IN PARAGRAPH (3) OF THIS SUBSECTION, THE STATE DESIGNATED EXCHANGE MAY PROVIDE THE INFORMATION SUBMITTED UNDER PARAGRAPH (1) OF THIS SUBSECTION TO:

(I) A HEALTH CARE PROVIDER;

(II) AN AUTHORIZED HEALTH INFORMATION EXCHANGE USER; (III)

A HEALTH INFORMATION EXCHANGE AUTHORIZED BY THE MARYLAND HEALTH CARE COMMISSION;

(IV) A FEDERAL OFFICIAL; AND

(V) A STATE OFFICIAL.

(3) (I) IF APPROVED BY THE MARYLAND HEALTH CARE COMMISSION, THE INFORMATION SUBMITTED UNDER PARAGRAPH (1) OF THIS SUBSECTION MAY BE COMBINED WITH OTHER DATA MAINTAINED BY THE STATE DESIGNATED EXCHANGE TO FACILITATE:

~~(I)~~ 1. A STATE HEALTH IMPROVEMENT PROGRAM;

~~(II)~~ 2. MITIGATION OF A PUBLIC HEALTH EMERGENCY; AND

~~(III)~~ 3. IMPROVEMENT OF PATIENT SAFETY.

(II) THE INFORMATION SUBMITTED BY A NURSING HOME UNDER PARAGRAPH (1) OF THIS SUBSECTION MAY BE USED ONLY TO FACILITATE THE OBJECTIVES STATED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH AND MAY NOT BE USED FOR ANY OTHER PURPOSE, INCLUDING LICENSING AND CERTIFICATION.

(G) (1) AN ELECTRONIC HEALTH NETWORK SHALL PROVIDE ~~ADMINISTRATIVE~~ ELECTRONIC HEALTH CARE TRANSACTIONS TO THE STATE

DESIGNATED EXCHANGE FOR THE FOLLOWING **PUBLIC HEALTH AND CLINICAL PURPOSES:**

(I) A STATE HEALTH IMPROVEMENT PROGRAM;

(II) MITIGATION OF A PUBLIC HEALTH EMERGENCY; AND

(III) IMPROVEMENT OF PATIENT SAFETY.

(2) AN ELECTRONIC HEALTH NETWORK MAY NOT CHARGE A FEE TO A HEALTH CARE PROVIDER, HEALTH CARE PAYOR, **OR TO THE STATE DESIGNATED EXCHANGE FOR PROVIDING THE INFORMATION AS REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION.**

(3) THE STATE DESIGNATED EXCHANGE SHALL DEVELOP AND IMPLEMENT POLICIES AND PROCEDURES TO IMPLEMENT PARAGRAPH (1) OF THIS SUBSECTION THAT ARE CONSISTENT WITH REGULATIONS ADOPTED BY THE MARYLAND HEALTH CARE COMMISSION.

[(f)**] (H)** The Maryland Health Care Commission:

(1) May adopt regulations for implementing the connectivity to the State designated exchange required under this section; and

(2) Shall seek, through any regulations adopted under item (1) of this subsection, to promote technology standards and formats that conform to those specified by the Office of the National Coordinator for Health Information Technology.

[(g)**] (I)** (1) The Maryland Health Care Commission may adopt regulations **[**specifying**] THAT:**

(I) SPECIFY the scope of clinical information to be exchanged under this section**; AND**

(II) PROVIDE FOR A UNIFORM, GRADUAL IMPLEMENTATION OF THE EXCHANGE OF CLINICAL INFORMATION UNDER THIS SECTION.

(2) Any regulations adopted under paragraph (1) of this subsection shall limit the scope of the clinical information to purposes that **[**promote**]**:

(i) **[**Improved**] IMPROVE** access to clinical records by treating clinicians; or

(ii) [Uses] **PROMOTE USES** of the State designated exchange important to public health agencies.

(3) REGULATIONS ADOPTED UNDER PARAGRAPH (1) OF THIS SUBSECTION ~~MAY~~ SHALL:

(I) LIMIT REDISCLOSURE OF FINANCIAL INFORMATION, INCLUDING BILLED OR PAID AMOUNTS AVAILABLE IN ELECTRONIC CLAIMS TRANSACTIONS;

(II) RESTRICT DATA OF PATIENTS WHO HAVE OPTED OUT OF RECORDS SHARING THROUGH THE STATE DESIGNATED EXCHANGE OR A HEALTH INFORMATION EXCHANGE AUTHORIZED BY THE MARYLAND HEALTH CARE COMMISSION; AND

(III) RESTRICT DATA FROM HEALTH CARE PROVIDERS THAT POSSESS SENSITIVE HEALTH CARE INFORMATION.

[(h)] **(J)** This section does not:

(1) Require an entity to which this section applies to collect clinical information or obtain any authorizations, not otherwise required by federal or State law, relating to information to be sent or received through the State designated exchange;

(2) Prohibit an entity to which this section applies from directly receiving or sending information to providers or subscribers outside of the State designated exchange; or

(3) Prohibit an entity to which this section applies from connecting and interoperating with the State designated exchange in a manner and scope beyond that required under this section.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Department of Health shall identify and seek appropriate funding to implement Section 1 of this Act.

(b) On or before January 1, 2022, the Maryland Health Care Commission shall report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on:

(1) the availability of funding to implement Section 1 of this Act; and

(2) the sustainability of the technical infrastructure required to implement Section 1 of this Act.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2021.

Enacted under Article II, § 17(c) of the Maryland Constitution, May 30, 2021.

Appendix B – HIPAA Administrative Transactions

One aim of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was to improve the efficiency and effectiveness of the nation's health care system. The Administrative Simplification provisions required the Department of Health and Human Services (HHS) to adopt national standards for electronic administrative transactions. Administrative transactions are the electronic exchange of information between two parties to carry out financial or administrative health care related activities. HHS issued its Final Standards for Electronic Transactions Rule (Rule) on August 17, 2000.[49, 50] The rule consists of eight electronic administrative transactions:

- Payment and remittance advice;
- Claims status;
- Eligibility;
- Coordination of benefits;
- Claims and encounter information;
- Enrollment and disenrollment;
- Referrals and authorizations; and
- Premium payment.[51]

Health care providers and health plans are required to use the standards; they may comply directly or may use a health care clearinghouse (or EHN).

[49] 65 Fed. Reg. 50312 (Aug. 17, 2000)
[50] The deadline for compliance with the Rule was October 16, 2003.
[51] CMS, *Transactions Overview*. Available at: www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Transactions/TransactionsOverview.

Appendix C – HITECH Provisions

The HITECH Act launched reforms to promote adoption and use of health IT. Key provisions:

- Established the Office of the National Coordinator for Health Information Technology and committees that provide standards and specifications for health IT quality;
- Required federal agencies to use health IT and provide for its voluntary use by private providers;
- Provided for testing, research, grants, and loans for implementation and demonstrations for health IT education, including financial assistance to states and tribes;
- Applied privacy and security requirements and penalties to health IT and required audits and enforcement; and
- Secured incentive payments through CMS for professionals and hospitals that are deemed eligible based on their "meaningful use" of certified EHR technologies.[52]

[52] Centers for Disease Control and Prevention, *Federal Public Health Laws Supporting Data Use and Sharing*, March 2015. Available at: www.cdc.gov/phlp/docs/datasharing-laws.pdf.

Appendix D – EHNs Registered and Certified to Operate in Maryland

Electronic Health Networks *as of December 2021*	
1	Ability Network Inc.
2	ACS EDI Gateway, Inc., a Xerox Company
3	Allscripts Healthcare, LLC
4	athenaEDI™
5	Availity, LLC
6	Carestream Dental, LLC
7	Cerner Corporation
8	Change Healthcare
9	Cyfluent, Inc.
10	EDI Health Group, Inc.
11	Experian Health
12	Eyefinity, Inc.
13	Inmediata Corp.
14	InstaMed Communications, LLC
15	NantHealth, Inc.
16	nThrive, Inc.
17	Office Ally, LLC
18	Optum
19	Optum 360 Formerly CareMedic
20	PNC Bank, NA
21	PNT Data Corp.
22	QS/1 Data Systems
23	RelayHealth
24	Smart Data Solutions, LLC
25	The SSI Group, LLC
26	Surescripts
27	Tesia Clearinghouse, LLC
28	TransUnion Healthcare, LLC
29	TriZetto Provider Solutions, LLC
30	Waystar

Appendix E – Nursing Home EHR Vendor Market Share for Maryland

Vendor Name	Share (%)
MatrixCare	13
PointClickCare	77
Other[53]	10

Source: MHCC Annual Long Term Care Survey, 2020

[53] Includes 9 EHR vendors.

Appendix F – EHN (Top 6 in Maryland) Administrative Transaction Volume and Share

EHN Name	Administrative Transaction Volume (Medical)	Total (%)[54]	Cumulative (%)[55]
Change Healthcare	7,847,960	43.8	43.8
Availity, LLC	5,294,276	29.6	73.4
RelayHealth	1,591,636	8.9	82.3
Allscripts Healthcare LLC	1,253,103	7.0	89.3
Optum	924,721	5.2	94.5
PNT Data Corp	910,016	5.1	99.6
Total (Top 6)	17,821,712	99.6	
Other[56]	76,855	0.4	100
Total	17,898,567	100	100

Source: MHCC Electronic Data Interchange Payer Progress Reports, 2020[57]

[54] Administrative transaction volume by EHN divided by total administrative transaction volume.
[55] Sum of total percentages.
[56] Includes 4 EHNs. Data for all EHNs registered in Maryland unavailable.
[57] COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks*, requires payers operating in Maryland with an annual premium volume exceeding $1 million to report census information to the Maryland Health Care Commission (MHCC). Each year MHCC examines administrative transaction data from payers. More information available at: mhcc.maryland.gov/mhcc/Pages/hit/hit_edi/hit_edi.aspx.

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