



Senate Bill 896

Health Record and Payment Integration Program

Advisory Committee



A Report for the Governor and General Assembly

May 2019

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Overview

Senate Bill 896, *Health Record and Payment Integration Program Advisory Committee*, was passed during the 2018 legislative session. The law (Chapter 452)¹ required the Maryland Health Care Commission (MHCC) to establish a Health Record and Payment Integration Program Advisory Committee (Advisory Committee) that consisted of representatives from managed care organizations; health care providers (providers) and facilities; health care suppliers; pharmacies; and health insurers (payors).^{2, 3} The Advisory Committee was tasked with conducting a study to assess the feasibility of creating a health record and payment integration program (or program), including:

1. Feasibility of incorporating administrative health care claim transactions into the State-Designated Health Information Exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP);
2. Feasibility of establishing a free and secure web-based portal (or 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;
3. Feasibility of incorporating the Prescription Drug Monitoring Program (PDMP) data into CRISP so that prescription drug data can be entered and retrieved;
4. Approaches for accelerating the adjudication of clean claims; and
5. Any other issue MHCC considered appropriate to further study health and payment record integration.

The MHCC must report to the Governor and General Assembly detailing findings and recommendations from the study on or before November 1, 2019.⁴ This report includes relevant information about the law, a summary of Advisory Committee deliberations, and recommendations for consideration by the Maryland legislature.⁵

Limitations

Recommendations do not represent unanimous agreement among the Advisory Committee. Gradients of agreement in viewpoints range from endorsement to disagreement. Viewpoints are representative of individuals on the Advisory Committee, and are not necessarily the opinion of the stakeholder group they represent.

¹ Governor Larry Hogan approved Senate Bill 896 on May 8, 2018. See Appendix A for a copy of the law.

² See *Approach* section for more information about workgroup recruitment and meeting frequency.

³ The MHCC engaged the Hilltop Institute to support research activities.

⁴ A study and report was recommended rather than advancing an original version of House Bill 1574 that would have tasked MHCC with the development and implementation of a health record and payment clearinghouse pilot with the State-Designated HIE.

⁵ This report was reviewed by the Advisory Committee. See Appendix J for commentary provided by certain Advisory Committee members.

Approach

The Advisory Committee consisted of 43 members with strong subject matter expertise, representing stakeholder groups with a range of interests and positions as it relates to health record and payment integration.⁶ A Charter⁷ was developed to guide the work and inform the Advisory Committee about study deliverables. Meetings of the Advisory Committee were convened seven times from July 2018 through January 2019.⁸ Meeting information and materials were made available to the public through the Advisory Committee's web page on MHCC's website.^{9, 10}

The MHCC facilitated Advisory Committee meetings. A kick-off meeting provided information about the law and the Advisory Committee's charge. Subsequent meetings included some stakeholder presentations to inform Advisory Committee deliberations on select technology and policy matters.¹¹ Meetings were structured in a roundtable-like approach to foster a collaborative discussion about various topics, such as the benefits and challenges of consolidating clinical and administrative data in a centralized solution; the need to adjudicate (or process) clean claims¹² more timely; the consideration of a unique patient identifier; and technology to support magnetic stripe cards or smart cards.¹³

Information gathering grids (grids) identified benefits, barriers/challenges, and potential solutions and supported an objective approach to the discussions.¹⁴ A Draft Recommendations Subcommittee (subcommittee) convened as a first phase in developing informal draft recommendations. The role of the subcommittee was to discuss key themes from concepts identified in the grids and to formulate draft recommendations for review by the Advisory Committee. All Advisory Committee members were welcome to participate in the subcommittee.

Ongoing State and federal efforts informed Advisory Committee deliberations, and shaped the outlook regarding the value proposition of a health record and payment integration program. These ongoing efforts include key pieces of federal legislation, namely, the Health Insurance Portability and Accountability Act of 1996 (HIPAA)¹⁵ and the Health Information Technology for Economic and Clinical Health (HITECH) Act¹⁶ of 2009. Both HIPAA and HITECH have had a broad impact on health care policy across states as well as providers, insurers, consumers and other third parties.¹⁷

⁶ See Appendix C for a copy of the Advisory Committee Roster.

⁷ See Appendix B for a copy of the Advisory Committee Charter.

⁸ Includes two meetings of the Draft Recommendations Subgroup.

⁹ Advisory Committee web page:

mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_health_record_advisory_comm.aspx

¹⁰ See Appendix D and E for copies of meeting summaries and presentations.

¹¹ *Ibid.*

¹² A clean claim is free of errors when initially submitted and can be processed by a payor without the need for additional information.

¹³ Discussion topics aligned with study requirements in law.

¹⁴ See Appendix F for version 5.

¹⁵ P.L. No. 104-191, 110 Stat. 1938 (1996).

¹⁶ HITECH was enacted as part of the American Recovery and Reinvestment Act of 2009. Pub.L. 111-5.

¹⁷ See Appendix G for relevant background information about HIPAA and HITECH.

Findings and Recommendations

Summary

Health care stakeholders, states, and the federal government have invested substantial financial and human resources in building a health information technology (health IT) infrastructure over the last 10 years. Health IT solutions that have been implemented are compliant with standards adopted by the Office of the National Coordinator for Health Information Technology (ONC).¹⁸ Establishing a health record and payment integration program would diminish previous health IT investments and/or require building additional infrastructure to enable a new program to integrate with existing solutions.

Some Advisory Committee members believe that improvements in care delivery and potential cost savings offset the investment of time, resources, and funding for a program. Others expressed concern about the significant technical and operational challenges that would need to be addressed, and risks of implementing a health IT strategy that does not align with national efforts. The following overarching key themes emerged from Advisory Committee deliberations:

- Policy challenges, funding, and technical complexities to develop and maintain a program requires considerable investment by the State;
- Uncertainty exists regarding payors' and providers' willingness to displace infrastructure from their existing health IT investments, and interest to embrace a program among a smaller portion of providers that have not invested in health IT; and
- Complex issues around program design, governance, and ownership need to be thoroughly evaluated and addressed by stakeholders.

The Advisory Committee concluded that a comprehensive financial analysis of a health record and payment integration program was beyond its capabilities. A financial assessment would require engaging a third-party; and could range from \$300,000 to \$500,000 to complete.¹⁹

Study Requirements

1. Feasibility of incorporating administrative health care claim transactions into the State-Designated HIE, CRISP

Key Themes

- a) Unclear value proposition absent specific use cases to justify investment cost

¹⁸ ONC is organizationally located within the Office of the Secretary for the U.S. Department of Health and Human Services and the principal federal entity charged with coordination of nationwide efforts to implement and use the most advanced health IT and electronic exchange of health information.

¹⁹ Cost estimates arrived at based on anecdotal information from various Advisory Committee members.

- b) Accountability and legal obligations for the data by HIPAA-covered entities and their business associates, including adherence to Confidentiality of Substance Use Disorder Patient Records, 42 Code of Federal Regulations (CFR) Part 2²⁰
- c) Employee Retirement Income Security Act of 1974 (ERISA) restricts access to self-insured data from private health plans
- d) Resistance by payors and the 32 claims clearinghouses operating in Maryland to a mandate that requires claims data to be reported to CRISP
- e) Timeliness and accuracy of claims data as compared to clinical data

Recommendation

Establish a task force to conduct an in-depth feasibility assessment of making claims data available through CRISP, and evaluate other suitable alternatives, such as improving the accuracy and availability of clinical data.

Rationale

In 2016, CRISP funded a small pilot with two claims clearinghouses to assess technical feasibility of reporting claims data to CRISP. This proof of concept demonstrated that it is technically feasible to incorporate claims data into CRISP. While the pilot successfully resolved technical challenges, certain policy questions were identified that, if unresolved, hinder CRISP's ability to scale-up the pilot. This includes policy questions regarding contractual issues between claims clearinghouses and health care organizations that restrict information sharing with CRISP and existing federal privacy laws and regulations that protect patients' personal health information. ERISA requirements pose a complex set of issues that require working directly with privately insured employers to obtain authorization to collect claims data. In addition, federal regulation (42 CFR Part 2) governs how health care professionals, health IT vendors, and payors maintain information security and confidentiality of substance use disorder patient records. An in-depth feasibility assessment is needed to assess strengths and deficits related to legal, economic and resource related matters, among other things.

2. **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) and billing systems

²⁰ 42 CFR Part 2 is a federal law governing confidentiality for people seeking treatment for substance use disorders from federally assisted programs.

- b) Time and resources required to develop and implement technology that meets the needs of various providers
- c) Unknown start-up and ongoing costs

Recommendation

No action at this time.

Rationale

The Advisory Committee noted concerns about the cost to stakeholders to implement a free and secure web-based provider portal. Payors and some EHR vendors already make portals available at no cost to providers. While payors fund their own portals, EHR vendors usually generate revenue from advertisement pop-ups and ribbon messages.²¹ The Advisory Committee questioned whether these solutions could meet ONC certification requirements and noted broad challenges with current revenue generating models for free portals. In 2009, HITECH authorized funding to support EHR adoption, and Maryland law passed by the General Assembly also required State-regulated payors to offer providers EHR adoption incentives.²² EHR adoption is now above 50 percent for every major provider category in the State (acute care hospitals: 100 percent; comprehensive care facilities: 91 percent; dentists: 53 percent; and physicians: 71 percent).²³ Over the last decade, EHRs have become a core component of value-based payment models.

3. Feasibility of incorporating the PDMP data into CRISP so that prescription drug data can be entered and retrieved

Key Themes

- a) The Maryland General Assembly established a PDMP requirement in 2011 and oversight by the Office of Provider Engagement and Regulation at the Maryland Department of Health (MDH), Public Health Services²⁴ 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) During the 2018, legislative session, the General Assembly passed House Bill 115, *Maryland Health Care Commission – Electronic Prescription Records System –*

²¹ An advertising revenue platform is used by many technology services that do not charge its users. For more information, visit: www.nextech.com/blog/you-get-what-you-pay-for-the-cost-of-free-emr.

²² Incentives were made available by State-regulated payors from April 2011 through December 2018. These incentives were separate from the Medicare and Medicaid incentive programs established by HITECH. For more information, visit: mhcc.maryland.gov/mhcc/Pages/hit/hit_ehr/hit_ehr_state_incentive.aspx.

²³ EHR adoption rates are estimates. See Appendix H for more information on EHR adoption in Maryland and the nation.

²⁴ Formerly the MDH, Behavioral Health Administration.

Assessment and Report, that requires MHCC to explore feasibility of developing a repository of non-CDS data.^{25, 26}

Recommendation

No action at this time.

Rationale

PDMP data is already made available through CRISP. Current regulations (COMAR 10.47.07) require dispensers and prescribers to report CDS data to MDH. CRISP supports data collection and access to CDS information by prescribers and dispensers. A separate feasibility study was conducted to assess feasibility of creating a statewide repository for non-CDS data, as required by House Bill 115 passed during the 2018 legislative session. A final report is due to the legislature by January 1, 2020.²⁷

4. 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

Recommendation

No action at this time.

Rationale

In November 2000, the MIA issued regulations (COMAR 31.10.11.14, *Uniform Claim Forms*) establishing standards for claims submission to expedite and simplify claims processing. Bi-annually, private payors report to the MIA information on claims paid within the required 30-day timeframe, and any interest paid for clean claims paid in excess of that requirement. The Advisory Committee concluded that most claims are processed in significantly less time than required by current regulations, and payors and providers are satisfied with the current approach. Many supporting the status quo contend that the current approach provides protections and offers opportunity to further improve claims processing turnaround time.

²⁵ Non-CDS includes medications prescribed to treat medical conditions such as high blood pressure, diabetes, and bacterial infections, not classified as a CDS.

²⁶ See Appendix I for more information on the PDMP and House Bill 115.

²⁷ Ibid.

5. **Any other issue MHCC considers appropriate to study to further health and payment record integration**

The following topic was discussed by the Advisory Committee:

- **A unique patient identifier and technology to support magnetic stripe cards or smart cards**

Key Themes

- a) A unique patient identifier 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
- c) Consolidation of the functions of patient identification, identity management, and access to longitudinal EHRs would necessitate a mandate
- d) Challenges in seeking and delivering care in and out of the State

Recommendation

No action at this time.

Rationale

HIPAA originally included a provision for the adoption of a unique patient identifier. This requirement was later overruled by Congress due to privacy issues. Magnetic stripe cards and smart cards are widely used in the financial industry but have been slow to gain acceptance in health care. The Advisory Committee acknowledged the potential benefits of a unique patient identifier; however, the majority were not supportive given the risk that patient information could be exploited and privacy more difficult to assure. The Advisory Committee expressed concerns about implementing stripe or magnetic card technology that may not be widely embraced and exclusive to Maryland. National efforts around electronic health information exchange are focused on interoperability between systems where patients control the flow of their information.

Conclusion

Over the last decade, the pace of health IT development has quickened and the scope of health IT diffusion has increased in Maryland and the nation. HITECH put the nation on a path to establishing a health IT infrastructure with privacy and security embedded in its framework. Nearly 10 years after the legislation was signed into law, EHR systems have become the cornerstone of most organizations' health IT infrastructure; however, lack of interoperability among systems remains a continuous challenge. Current federal efforts focus on fostering interoperability while breaking down proprietary information silos and enhancing security controls to address evolving cybersecurity vulnerabilities. The concept of a health record and

payment integration program proposed in Senate Bill 896 is laudable; though, it's inconsistent with the evolution of the industry and many stakeholders' vision of the future.

Establishing such a program post-HITECH would compromise stakeholders' current health IT investments and federal and stakeholder interoperability efforts underway. The program would be a misplaced investment, and not align with national initiatives that offer much promise to Maryland providers, payors, and patients. One of the key goals of health record and payment integration is to enable sharing of needed information at the point of care consistent with longtime advocacy efforts in the State. Most Advisory Committee members believe Maryland should continue exploring opportunities to leverage gains from existing health IT investments, which are foundational for value-based care and essential to improving health care quality, safety, and efficiency in the State.

Acknowledgments

The MHCC commends stakeholders that served on the Advisory Committee and contributed to the preparation of this report. Support for this study was provided by the Hilltop Institute at The University of Maryland Baltimore County.

Appendix A: Chapter 452

LAWRENCE J. HOGAN, JR., Governor

Ch. 452

Chapter 452

(Senate Bill 896)

AN ACT concerning

~~Public Health~~ Maryland Health Care Commission – Health Record and Payment Clearinghouse – Pilot Integration Program Advisory Committee

FOR the purpose of requiring the Maryland Health Care Commission, ~~subject to certain limitations, to establish and implement a certain health record and payment clearinghouse pilot program on or before a certain date, requiring the Commission, on or before a certain date, to develop certain standards and determine certain information; authorizing the Commission to contract with an outside entity to establish and maintain the health record and payment clearinghouse; specifying the capabilities the health record and payment clearinghouse must have; requiring the Commission to solicit feedback from certain users of the health record and payment clearinghouse; requiring the Commission to report on the status and implementation of the pilot program to the Senate Education, Health, and Environmental Affairs Committee and the House Health and Government Operations Committee on or before a certain date each year; requiring the Commission, on or before a certain date, to research and evaluate existing public and private health record and payment clearinghouses; requiring the Commission, on or before a certain date, to make certain recommendations for financing the establishment and maintenance of a health record and payment clearinghouse pilot program; a Maryland Health Record and Payment Integration Program Advisory Committee; requiring the Commission to select members of the Advisory Committee from certain persons; requiring the Advisory Committee to study the feasibility of creating a health record and payment integration program, certain approaches, and certain other issues; authorizing the Advisory Committee, to the extent allowed by law, to use certain information in carrying out its duties; requiring the Commission to submit a certain report to the Governor and the General Assembly on or before a certain date; defining a certain term; providing for the termination of this Act; and generally relating to the health record and payment clearinghouse~~ Health Record and Payment Integration Program Advisory Committee.

~~BY adding to~~

~~Article Health – General~~

~~Section 19-150 and 19-151 to be under the new part “Part VI. Health Record and Payment Clearinghouse”~~

~~Annotated Code of Maryland~~

~~(2015 Replacement Volume and 2017 Supplement)~~

Preamble

~~WHEREAS, Maryland has been a leader in health care financing, research, and treatment; and~~

~~WHEREAS, The cost of health care continues to rise, resulting in many individuals not being able to afford health care; and~~

~~WHEREAS, The cost of health care in the United States is among the highest in the world, yet the measures of the effectiveness of our health care system are well below those of other advanced countries; and~~

~~WHEREAS, The high administrative cost of our current health care system is approximately between 3.1% and 31% of every dollar spent on health care expenditures; and~~

~~WHEREAS, Health care billing, and reimbursement, and record-keeping methods are still largely old-fashioned, despite advances in computer technology; and~~

~~WHEREAS, Technologies are available and are already in place in other countries to make a significant impact on health care and the economics of delivering health care services if standards are implemented to allow interoperability and compatibility of systems for immediate online record-keeping, billing, payment, and reporting; and~~

~~WHEREAS, A card with a credit-card-like magnetic strip and password protections can provide secure access to a patient's health insurance and health history information by accessing secure servers over the Internet; and~~

~~WHEREAS, The implementation of such a system in the State, and ultimately in the entire United States, could reduce the cost of health care by up to 15% or more, with an estimated yearly savings for Maryland exceeding \$6,200,000,000 and for the United States exceeding \$350,000,000,000 per year; and~~

~~WHEREAS, Health care is approximately 16% to 18% of the cost of most products and services purchased; and~~

~~WHEREAS, A savings of 10% in the cost of health care could reduce the cost of many products by up to 1.8%, providing benefits well beyond the field of health care; and~~

~~WHEREAS, The benefits of streamlining the administration of health care extend well beyond the field of health care; and~~

~~WHEREAS, The introduction of rapid and secure electronic access to patient records can improve the timeliness of the provision of health care and reduce the cost of health care while improving the quality of and access to health care; and~~

~~WHEREAS, Reductions in the cost of health care will improve access to health care; and~~

~~WHEREAS, Patients can decide individually if they wish to allow their electronic health records, without any personal identifying information, to be used for health care research to help others; and~~

~~WHEREAS, Reporting matters of public health interest can be accomplished rapidly and accurately with electronic systems, leading to improvements in public health; and~~

~~WHEREAS, The many benefits of modern electronic payment and health care records systems will improve the quality of life for Maryland residents; and~~

~~WHEREAS, State government will benefit from an estimated \$70,000,000 reduction in reducing the cost of health care for its employees once implemented as well as from and reduced cost of goods produced in Maryland; and~~

~~WHEREAS, Maryland can serve as a test state for all of the United States and can seek federal grants to assist with the project; and~~

~~WHEREAS, Government must set the standards for an electronic payment and health care records system and lead the way for participation by private industry; and~~

~~WHEREAS, Initial participation by health care providers and payers shall can be voluntary; and~~

~~WHEREAS, The Maryland State Medical Society (MedChi) and the Maryland Psychiatric Society have already passed resolutions endorsing the concept of an electronic payment and health care records system; and~~

~~WHEREAS, It is in the public interest that the State government provide grants and incentives to set up an electronic system for providing health care to State employees and for the benefit of all Marylanders; now, therefore,~~

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

(a) The Maryland Health Care Commission shall establish a Health Record and Payment Integration Program Advisory Committee.

(b) The Commission shall select the members of the Health Record and Payment Integration Program Advisory Committee from:

(1) managed care organizations, as defined in § 15-101 of the Health – General Article;

(2) individuals licensed, certified, or registered under the Health Occupations Article to provide health care;

- (3) facilities that provide health care to individuals; ~~and~~
- (4) persons that provide health care supplies or medications; and
- (5) health insurers and carriers.

(c) The Health Record and Payment Integration Program Advisory Committee shall study:

(1) the feasibility of creating a health record and payment integration program, including:

(i) the feasibility of incorporating administrative health care claim transactions into the State-designated health information exchange established under § 19-143 of the Health – General Article for the purpose of improving health care coordination and encounter notification;

(ii) the 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:

- 1. create and maintain health records; and
- 2. file for payment for health care services provided; and

(iii) the feasibility of incorporating prescription drug monitoring program data into the State-designated health information exchange so that prescription drug data can be entered and retrieved;

(2) approaches for accelerating the adjudication of clean claims; and

(3) any other issue that the Commission considers appropriate to study to further health and payment record integration.

(d) The Health Record and Payment Integration Program Advisory Committee, to the extent allowed under law, may use the information collected by the State-designated health information exchange established under § 19-143(b) of the Health – General Article in carrying out its duties under subsection (c) of this section.

(e) (1) On or before November 1, 2019, the Commission shall submit the findings and recommendations of the Health Record and Payment Integration Program Advisory Committee to report to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.

(2) If the Health Record and Payment Integration Program Advisory Committee recommends the creation of a health record and payment integration program, the report submitted under paragraph (1) of this subsection shall include:

(i) recommendations regarding statutory language to establish and maintain the health record and payment integration program; and

(ii) an estimate of the funding required to support the health record and payment integration program.

~~Article Health General~~

~~PART VI. HEALTH RECORD AND PAYMENT CLEARINGHOUSE.~~

~~19-150.~~

~~IN THIS PART, "HEALTH RECORD AND PAYMENT CLEARINGHOUSE" MEANS A HEALTH RECORD AND PAYMENT CLEARINGHOUSE THAT:~~

~~(1) BUILDS ON THE WORK OF THE CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS;~~

~~(2) ALLOWS AUTHORIZED USERS TO ACCESS PATIENT MEDICAL RECORDS REMOTELY;~~

~~(3) ALLOWS THE EXCHANGE OF DATA BETWEEN SYSTEMS USED BY PROVIDERS AND CARRIERS FOR THE PAYMENT OF HEALTH CARE CLAIMS;~~

~~(4) INTERACTS WITH THE PRESCRIPTION DRUG MONITORING PROGRAM SO THAT PRESCRIPTION DRUG DATA CAN BE RETRIEVED THROUGH THE HEALTH RECORD AND PAYMENT CLEARINGHOUSE;~~

~~(5) MEETS FEDERAL AND STATE REQUIREMENTS REGARDING THE CONFIDENTIALITY OF MEDICAL RECORDS; AND~~

~~(6) IS AVAILABLE SECURELY ONLINE.~~

~~19-151.~~

~~(A) SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET AND ANY OTHER DESIGNATED FUNDING, ON OR BEFORE JULY 1, 2020, THE COMMISSION SHALL ESTABLISH AND IMPLEMENT FOR USE IN A PILOT PROGRAM FOR VOLUNTEER COMPANIES, MUNICIPALITIES, COUNTY EMPLOYEE ORGANIZATIONS, AND EDUCATION EMPLOYEE ORGANIZATIONS AND FOR HEALTH BENEFITS AND SERVICES~~

~~FOR STATE GOVERNMENT EMPLOYEES A HEALTH RECORD AND PAYMENT CLEARINGHOUSE.~~

~~(B) ON OR BEFORE JULY 1, 2010, THE COMMISSION SHALL:~~

~~(1) DEVELOP STANDARDS THAT HEALTH CARE RECORDS AND REQUESTS FOR HEALTH CARE PAYMENTS MUST MEET TO BE ACCESSED OR FILED AND MADE THROUGH THE HEALTH CARE RECORD AND PAYMENT CLEARINGHOUSE;~~

~~(2) DETERMINE WHETHER THE HEALTH RECORD AND PAYMENT CLEARINGHOUSE SHOULD MAINTAIN DATA ABOUT EACH PATIENT, INCLUDING INFORMATION ON THE PATIENT'S:~~

~~(I) DEMOGRAPHICS;~~

~~(II) INSURANCE COVERAGE;~~

~~(III) DIAGNOSES;~~

~~(IV) MEDICATIONS;~~

~~(V) ALLERGIES;~~

~~(VI) ADVERSE REACTIONS;~~

~~(VII) HOSPITALIZATIONS;~~

~~(VIII) TREATMENTS;~~

~~(IX) HEALTH CARE PROVIDERS;~~

~~(X) VACCINATIONS;~~

~~(XI) LABORATORY TESTS AND RESULTS;~~

~~(XII) ELECTROCARDIOGRAPHY TESTS AND RESULTS; AND~~

~~(XIII) RADIOLOGY STUDIES AND REPORTS.~~

~~(C) THE COMMISSION MAY CONTRACT WITH AN OUTSIDE ENTITY, OR CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS, TO ESTABLISH AND MAINTAIN THE HEALTH RECORD AND PAYMENT CLEARINGHOUSE FOR THE PILOT PROGRAM.~~

- ~~(D) THE HEALTH RECORD AND PAYMENT CLEARINGHOUSE SHALL:~~
- ~~(1) CREATE AND MAINTAIN ACCESS SECURITY LOGS;~~
 - ~~(2) INCLUDE SECURITY AND BACKUP SAFEGUARDS;~~
 - ~~(3) INDICATE WHEN A PORTION OF A HEALTH RECORD MAINTAINED ELSEWHERE IS OFFLINE AND PROVIDE MINIMAL DATA, AS DETERMINED BY THE COMMISSION, REGARDING THE RECORD;~~
 - ~~(4) INCLUDE A FREE AND SECURE WEB BASED PORTAL THAT PROVIDERS CAN USE WITHOUT REGARD TO THE METHOD OF PAYMENT BEING USED FOR A HEALTH CARE SERVICE TO:
 - ~~(I) CREATE, MAINTAIN, AND PROVIDE ACCESS BY AUTHORIZED INDIVIDUALS TO HEALTH RECORDS; AND~~
 - ~~(II) FILE FOR PAYMENT FOR HEALTH CARE SERVICES PROVIDED;~~~~
 - ~~(5) PROVIDE FOR THE DETERMINATION AND COLLECTION OF ALL BENEFITS, COPAYS, AND DEDUCTIBLES AT THE POINT OF SERVICE WITH CLAIM ADJUDICATION WITHIN 24 HOURS;~~
 - ~~(6) PROVIDE FOR THE IMMEDIATE ANSWERING OF QUESTIONS REGARDING COVERED SERVICES AND BENEFITS AT THE POINT OF SERVICE;~~
 - ~~(7) PROVIDE FOR THE SUBMISSION OF AN ELECTRONIC RECORD OF HEALTH CARE SERVICES, SUPPLIES, AND MEDICATIONS PROVIDED OR PRESCRIBED IN ORDER FOR PAYMENT TO BE RECEIVED;~~
 - ~~(8) PROVIDE FOR THE FORMAT AND CONTENT OF THE MINIMUM MEDICAL RECORD DATA SET REQUIRED FOR PAYMENT THROUGH THE HEALTH RECORD AND PAYMENT CLEARINGHOUSE;~~
 - ~~(9) INCLUDE THE ABILITY TO PROVIDE REQUIRED DATA SECURELY OVER THE INTERNET WITHOUT REQUIRING PROVIDERS OR SUPPLIERS TO PAY FOR PROPRIETARY SOFTWARE, OTHER THAN PAYING ANY USER FEE TO COVER THE COST OF STARTUP AND OPERATIONS OF THE HEALTH RECORD AND PAYMENT CLEARINGHOUSE;~~
 - ~~(10) ALLOW THE USE OF PROPRIETARY SOFTWARE THAT CAN OFFER EXPANDED FUNCTIONALITY FOR PROVIDERS TO INTERACT WITH THE HEALTH~~

~~RECORD AND PAYMENT CLEARINGHOUSE TO PROVIDE AND OBTAIN ALL INFORMATION AND PAYMENTS NEEDED FOR HEALTH CARE SERVICES;~~

~~(11) ENSURE THAT EACH PATIENT HAS A UNIQUE IDENTIFIER ASSIGNED AND MAINTAINED CENTRALLY BY THE DEPARTMENT;~~

~~(12) DIRECT DATA REQUESTS TO THE CORRECT SERVER OR RECORD HOLDER AND ALLOW FOR MULTIPLE SERVERS OR RECORD HOLDERS TO HOUSE SOME OR ALL OF THE INFORMATION FOR EACH PATIENT;~~

~~(13) ALLOW EACH PATIENT TO INDICATE WHETHER OR NOT THE PATIENT WANTS TO ALLOW RESEARCHERS TO ANONYMOUSLY ACCESS THE PATIENT'S HEALTH CARE RECORDS AND TO WITHDRAW PERMISSION ONCE GIVEN;~~

~~(14) ALLOW FOR SECURE ACCESS THROUGH SPECIFIC TERMINALS BY EMERGENCY ROOM PERSONNEL WHEN A PATIENT IS UNABLE TO PROVIDE INFORMATION THAT WOULD BE REQUIRED TO ACCESS THE PATIENT'S INFORMATION THROUGH THE HEALTH RECORD AND PAYMENT CLEARINGHOUSE;~~

~~(15) INCLUDE THE OPTION AFTER THE FIRST YEAR OF THE PILOT PROGRAM TO USE HEALTH CARDS THAT:~~

~~(i) INCLUDE A COMBINATION OF CREDIT CARDS, DEBIT CARDS, AND HEALTH SAVINGS CARDS; AND~~

~~(ii) PROVIDE INFORMATION, LINKAGES, AND PAYMENTS SO THAT ONLY ONE CARD IS REQUIRED TO COMPLETE ALL ASPECTS OF A HEALTH CARE PAYMENT;~~

~~(16) ALLOW FOR ONLINE AND OFFLINE APPEAL OF DENIED SERVICES, BENEFITS, OR PAYMENTS;~~

~~(17) SUPPORT A HIGH VOLUME OF SIMULTANEOUS USERS, BASED ON THE TOTAL NUMBER OF PROVIDERS IN THE STATE;~~

~~(18) BE COMPATIBLE WITH BOTH THE WINDOWS AND THE MACINTOSH OPERATING SYSTEMS; AND~~

~~(19) MEET ANY OTHER STANDARDS DEVELOPED AND REQUIRED BY THE COMMISSION.~~

~~(E) THE COMMISSION SHALL SOLICIT FEEDBACK ON THE HEALTH RECORD AND PAYMENT CLEARINGHOUSE FROM THE USERS WHO PARTICIPATE IN THE PILOT PROGRAM, INCLUDING:~~

- ~~(1) HEALTH INSURERS AND CARRIERS;~~
- ~~(2) NONPROFIT HEALTH SERVICE PLANS;~~
- ~~(3) HEALTH MAINTENANCE ORGANIZATIONS;~~
- ~~(4) DENTAL PLAN ORGANIZATIONS;~~
- ~~(5) MANAGED CARE ORGANIZATIONS AS DEFINED IN § 15-101 OF THIS ARTICLE;~~
- ~~(6) INDIVIDUALS LICENSED, CERTIFIED, OR REGISTERED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE;~~
- ~~(7) FACILITIES THAT PROVIDE HEALTH CARE TO INDIVIDUALS; AND~~
- ~~(8) PERSONS THAT PROVIDE HEALTH CARE SUPPLIES OR MEDICATIONS.~~

~~(F) ON OR BEFORE DECEMBER 21, 2022, AND DECEMBER 21 EACH YEAR THEREAFTER, THE COMMISSION SHALL SUBMIT A STATUS REPORT ON THE IMPLEMENTATION OF THE PILOT PROGRAM TO THE SENATE EDUCATION, HEALTH, AND ENVIRONMENTAL AFFAIRS COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE IN ACCORDANCE WITH § 2-1246 OF THE STATE GOVERNMENT ARTICLE.~~

~~SECTION 2. AND BE IT FURTHER ENACTED, That:~~

~~(a) On or before December 31, 2018, the Maryland Health Care Commission shall research and evaluate existing public and private health record and payment clearinghouses.~~

~~(b) (1) On or before March 15, 2019, the Commission shall make recommendations for financing the establishment and maintenance of a health record and payment clearinghouse pilot program beginning with fiscal year 2020.~~

~~(2) The recommendations:~~

~~(i) may include provisions, if federal grants may not be available in time to pay for startup costs, for:~~

~~1. nonprofit user fees; and~~
~~2. a state bond to be repaid by nonprofit user fees over the course of up to 20 years;~~

~~(ii) shall include adjustments to the ceiling for user fees to accommodate the health record and payment clearinghouse and any required bonds or other funding; and~~

~~(iii) 1. may include up to \$10,000,000 in grants for up to five health insurance carriers or health insurance providers; and~~

~~2. if the recommendations specify that grants should be provided under item 1 of this item, shall specify that the recipient shall agree to provide health plans with the same benefits as in the immediately preceding year with at least a 5% discount in the cost.~~

~~(3) On or before March 15, 2019, the Commission shall report to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly on its recommendations regarding and funding requests for a health record and payment clearinghouse pilot program.~~

SECTION ~~3~~ 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2018. ~~Section 1 of this~~ This Act shall remain effective for a period of ~~6~~ 2 years and, at the end of June 30, ~~2024~~ 2020, ~~Section 1 of this Act~~, with no further action required by the General Assembly, shall be abrogated and of no further force and effect. ~~Section 2 of this Act shall remain effective for a period of 1 year and 1 month and, at the end of July 31, 2019, Section 2 of this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.~~

Approved by the Governor, May 8, 2018.

Appendix B: Charter



Health Record and Payment Integration Program Advisory Committee

CHARTER

Purpose

During the 2018 legislative session, Senate Bill 896, *Health Record and Payment Integration Program Advisory Committee*, was passed and requires the Maryland Health Care Commission (MHCC) to establish a Health Record and Payment Integration Program Advisory Committee (Advisory Committee). The Advisory Committee will consist of representatives from managed care organizations; health care providers and facilities; health care suppliers; pharmacies; and health insurers and carriers. The Advisory Committee is tasked with conducting a study to assess the feasibility of creating a health record and payment integration program, including:

- Feasibility of incorporating administrative health care claim transactions²⁸ into the State-Designated Health Information Exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP);
- 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;
- Feasibility of incorporating the Prescription Drug Monitoring Program data into CRISP so that prescription drug data can be entered and retrieved;
- Approaches for accelerating the adjudication of clean claims;²⁹ and
- Any other issue that MHCC considers appropriate to study to further health and payment record integration.

The MHCC is required to report on or before November 1, 2019 to the Governor and General Assembly detailing findings and recommendations from the study.³⁰ If the Advisory Committee recommends that a health record and payment integration program be created, the report needs to include proposed statutory language to establish and maintain the program and an estimate of funding required to support the program.

²⁸ A transaction exchanges information electronically between two parties to carry out financial or administrative activities related to health care (e.g., a health care provider sends a claim to a payor for payment of medical services).

²⁹ A clean claim is free of errors when initially submitted and can be processed by a payor without the need for additional information.

³⁰ A study and report was recommended rather than advancing an original version of House Bill 1574 that would have tasked MHCC with the development and implementation of a health record and payment clearinghouse pilot with the State-Designated HIE.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Department of Health and Human Services to adopt standards for the secure exchange of electronic health care transactions among HIPAA-covered entities, including claims, enrollment, eligibility, payment, and coordination of benefits. Use of electronic transactions increases efficiencies in operations, improves quality and accuracy of information, and reduces overall costs to the health care system. The Affordable Care Act in 2010 includes additional provisions that address use of administrative transactions established by HIPAA. These provisions include operating rules for the existing transactions, unique identifiers for health plans, and electronic funds transfer and electronic health care claims attachments.³¹

Rationale

Administrative costs for health care in the United States are considered to be highest in the developed world, and such expenditures do not have an apparent link to better quality care.³² Increasing efficiencies can be accomplished by simplifying procedures, which can, in part, be attributed to optimized use of health information technology.³³ Expanding utility of the infrastructure already in place by the State-Designated HIE could provide a pathway to advance electronic health care record keeping, billing, payment, and reporting.

Approach

The MHCC will convene meetings of the Advisory Committee to discuss specific policy matters related to a health record and payment integration program. The MHCC anticipates that some discussions will potentially require the formation of subgroups, and it is likely that subgroups will have a Chair appointed by MHCC. In addition to presiding at meetings, a subgroup Chair will take an active role in guiding and developing policy recommendations, among other things.

Meetings

All meetings of the Advisory Committee are open to the public.³⁴ A simple majority of Advisory Committee members shall constitute a quorum for convening meetings. The majority of meetings will take place via teleconference. In-person meetings will be held at MHCC offices or another location if circumstances permit; members are strongly encouraged to attend on-site; however, teleconference information will be made available. Members participating via teleconference shall count for quorum purposes, and their position (i.e., support, oppose, abstain) on matters will be recorded. Reasonable notice of all meetings including date, time, teleconference information, and location (if applicable) will be provided by email to all members of the Advisory Committee. Information on meetings is posted on MHCC's website [here](#).

Timeline and Deliverables

³¹ For more information, visit: www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Transactions/TransactionsOverview.html.

³² D. U. Himmelstein, M. Jun, R. Busse et al., "A Comparison of Hospital Administrative Costs in Eight Nations: U.S. Costs Exceed All Others by Far," *Health Affairs*, Sept. 2014 33(9):1586-94.

³³ OECD (2017), *Tackling Wasteful Spending on Health*, OECD Publishing, Paris, dx.doi.org/10.1787/9789264266414-en.

³⁴ As a State agency, MHCC follows the Open Meeting Act.

Meetings are anticipated to be held over the next year starting in July 2018 and take place about every four to six weeks; additional meetings may be needed if a discussion topic warrants continued deliberation about a proposed recommendation. The output from these meetings will be compiled into a final draft report targeted for release in July 2019. The report will include the names of all Advisory Committee members, meeting work papers, and recommendations that could influence future legislation.

Appendix C: Roster

Health Record and Payment Integration Program Advisory Committee Roster (As of December 2018)		
#	Name	Organization
1	Albert Galinn	Johns Hopkins University and Health System
2	Allison Viola, MBA [▲]	Kaiser Permanente
3	Annie Coble	Johns Hopkins University
4	Ashlie T. Bagwell* [▲]	Harris Jones & Malone, LLC
5	Bob Morrow*	Maryland Insurance Administration
6	Brandon Neisweinder* [▲]	CRISP
7	Bruce Taylor, MD [▲]	Private Practice/Taylor Service
8	Carol Emerson, MD	Saint Agnes Healthcare
9	Changrong Ji	CareFirst BlueCross BlueShield
10	Clayton House	CareFirst BlueCross BlueShield
11	Daniel Durand, MD	LifeBridge Health
12	Daniel Schneider*	Cyfluent
13	Dawn Seek* [▲]	Maryland National Capital Homecare Association
14	Deanne Kasim* [▲]	Change Healthcare
15	Deborah Rivkin	CareFirst BlueCross BlueShield
16	Dixie Leikach, RPh, MBA [▲]	Maryland Pharmacists Association
17	Gregory Burkhardt*	Beacon Health Option
18	J. Wayne Brannock	Lorien Health Systems
19	Janet M. Hart [▲]	RiteAid
20	Jennifer Hardesty, PharmD	Remedi
21	Jennifer Witten*	Maryland Hospital Association
22	John Evans*	Change Healthcare
23	John Gutwald [▲]	MedStar Health
24	Kathleen Loughran [▲]	Amerigroup
25	Kathy Ruben, PhD*	Consumer Health First
26	Kenneth Sullivan	CareFirst BlueCross BlueShield
27	Kinekale Tasew	Saint Agnes Healthcare
28	Lauren Simpson, RN, BSN	Potomac Home Health Care
29	Lisa Polinsky, RPh, MBA	LifeBridge Health
30	Mark Kelemen, MD	Independent
31	Matthew Shimoda, PharmD.	SuperValu
32	Mike Denison* [▲]	Change Healthcare
33	Patrick Carlson	Johns Hopkins University and Medicine
34	Patricia Cameron	MedStar Health
35	Pegeen Townsend	MedStar Health
36	Peggy Funk* [▲]	Hospice & Palliative Care Network
37	Rianna Matthews-Brown	Johns Hopkins University
38	Sarah Chaffee, BSN, RN	University of Maryland Medical Center
39	Sean McCarthy	Remedi SeniorCare
40	Tommy Tompsett*	Harris Jones & Malone, LLC
41	Tressa Springmann [▲]	LifeBridge Health
42	Will Price* [▲]	PHIERS
43	Xavier Musenger* [▲]	Cerner

The law requires the Advisory Committee include representation from managed care organizations, health care providers and facilities, health care suppliers, pharmacies, and health insurers. Individuals noted with an asterisk (*) represent other organizations and are thus participating as ex-officio members of the Advisory Committee.

[▲]Participated on the Draft Recommendations Subcommittee.

Appendix D: Meeting Summaries

Health Record and Payment Integration Program Advisory Committee

July 26, 2018

Meeting Summary

Key discussion items include:

- The Maryland Health Care Commission (MHCC) structured the meeting to provide important background context about the law, purpose and role of the Advisory Committee, and information about the State-Designated Health Information Exchange and its previous work with incorporating administrative claims transaction data into the CRISP Query Portal.
- The meeting began with some opening remarks about MHCC's task to convene interested stakeholders to assess the feasibility of creating a health record and payment integration program (program) that expands use of State-Designated Health Information Exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP), for electronic health record keeping and billing.
- Bruce Taylor, M.D. discussed the history and rationale of the Bill, noting the potential to increase administrative efficiencies and improve quality of care through a centralized repository. Dr. Taylor provided guidance to the sponsor of Senate Bill 896, *Health Record and Payment Integration Program Advisory Committee*.
- A representative of CRISP provided an overview of the HIE services they make available to the health care community today and information about a 2017 pilot study which explored how administrative transactions data could be incorporated into CRISP. The pilot demonstrated claims data could be used in care delivery to inform providers about treatment relationships and missing data from the ambulatory setting (e.g., diagnoses, procedures, problem lists, etc.). The pilot encountered challenges since providers use multiple clearinghouses and all clearinghouses were not willing to participate.
- Representatives from payors provided perspective on volume and adjudication processes for paper and electronic claims noting the vast majority of clean claims are typically processed within 24 hours upon receipt; they also mentioned use of a limited number of clearinghouses for purposes of achieving economies of scale, negotiating power, and the benefit of value added services for providers including revenue cycle management. Other members of the Advisory Committee noted that clearinghouses are deeply embedded in optimizing revenue cycle management and provide valuable services, such as analytics. It was suggested there could be value in using CRISP as an ad hoc second destination to capture and disseminate information about claims data.
- *Action Items: Review the draft listing of discussion items and provide suggestions about scope for each that should be considered, including benefits, challenges, limitations, trade-offs, etc. The draft listing is available [here](#); a Word document was e-mailed on July 27, 2018.*
- *Upcoming Meeting: The Advisory Committee will convene again at MHCC offices on Tuesday, August 21st from 2:00pm to 4:00pm EDT. Meeting materials will be posted on the [webpage](#) the day prior.*

Health Record and Payment Integration Program Advisory Committee

August 21, 2018

Meeting Summary

Key discussion items included:

- The meeting included presentations from a payor and an Electronic Health Network (EHN) to provide important context about the claim life cycle (presentation slides available [here](#)).
- Ken Sullivan overviewed claims processing at CareFirst BlueCross BlueShield including claim types (medical, dental, etc.), formats (paper or electronic), volume, and turnaround time. It was noted that CareFirst uses four EHNs (or trading partners) that cannot easily be unplugged and has first pass efficiency rates over 85 percent resulting from business and systemic rules that do not require manual intervention.
- Deanne Kasim, John Evans, and Mike Denison from Change Healthcare provided information about key functions of an EHN, such as connectivity and claims editing for multiple providers, payors, and technology vendors. EHNs play a vital role in transmitting electronic claims and remittances securely through HIPAA compliant infrastructure using administrative transactions standards. Maryland regulations require EHNs operating in the State to be certified by MHCC; 37 EHNs are certified as of August 2018 (more information available [here](#)).
- The Advisory Committee reviewed version 2 of the listing of discussion items, which included thought-provoking categories and grids intended to spur objective thinking about the feasibility in establishing a health record and payment integration program.
- Deliberation of discussion item/grid 1a identified benefits and barriers in a theoretical situation where MHCC certified EHNs were required to report claims information to the State-Designated Health Information Exchange, the Chesapeake Regional Information System for our Patients.
- The discussion highlighted the potential to enhance care delivery through alerts that include patient information on diagnoses and procedures performed, considerations for pre and post-adjudicated claims, and how EHNs do not include claims for some providers that bill directly or submit paper claims.
- *Upcoming meeting: The Advisory Committee will convene again at MHCC offices on Tuesday, September 18th from 2:00 - 4:00pm EDT. Meeting materials will be posted in advance on the Advisory Committee [web page](#).*

Health Record and Payment Integration Program Advisory Committee

September 18, 2018

Meeting Summary

Key discussion items included:

- The meeting included a presentation by Brandon Neiswender of CRISP who provided an overview and lessons learned from a 2016 clearinghouse pilot that made administrative health care claims transactions available through CRISP services (presentation slides available [here](#)). The pilot demonstrated that financial claims data could be incorporated into existing platforms to augment clinical information available through CRISP. Key takeaways include the need for provider education and an assessment of the benefits and challenges of specific use cases (e.g., point of care decision making, notifications, population health) using pre and post-adjudicated claims.
- The Advisory Committee reviewed Version 3 of the discussion items/grids to continue information gathering about potential benefits, barriers/challenges, and solutions for specific components of a health record and payment integration program.
- Discussion of item 1A (i.e., requiring electronic health networks (EHNs) to submit claims information to CRISP) highlighted some key considerations of pre and post-adjudicated claims, including accuracy, completeness, and value in care delivery.
- Discussion of item 1B (i.e., enhancing CRISP to support electronic claims transactions) brought to light how the current Azure cloud structure of CRISP has ample potential for scalability; however, of concern is cost to connect more than 30 EHNs to CRISP.
- Discussion of item 2A (i.e., making available a free electronic health record (EHR) solution to providers) highlighted characteristics of non-EHR adopters, such as age and specialty, which might be more influential than cost for less than 25 percent of physicians in the State that have not adopted an EHR.
- *Upcoming meeting: The Advisory Committee will convene again at MHCC offices on Thursday, October 18th from 1:00pm to 3:00pm EDT. Meeting materials will be posted in advance on the Advisory Committee [web page](#).*

Health Record and Payment Integration Program Advisory Committee

October 18, 2018

Meeting Summary

Key discussion items include:

- The meeting included a presentation by Bob Morrow of the Maryland Insurance Administration who provided an overview of Maryland prompt payment requirements under §15-1005 of the Insurance Article (presentation slides available [here](#)). The presentation highlighted entities subject to comply with the statute and general requirements, including the 30 days processing timeframe after receipt of an undisputed/clean claim. Representation from certain carriers commented how the majority of claims are processed considerably faster, noting that ~88 percent are adjudicated during the “first-pass” and the remaining require manual intervention.
- The Advisory Committee worked on Version 4 of the discussion items/grids, which included discussion about benefits, barriers/challenges, and solutions as it relates to revising prompt payment requirements. There was general consensus that no statutory change is needed to meet the original intent of the law.
- Deliberation of funding sources for a health record and payment integration program was considered highlighting challenges with understanding attributable costs and difficulty in demonstrating return on investment, particularly given significant investments made within the industry. Dr. Bruce Taylor commented that although the law aims to assess feasibility in establishing a free web-based portal for providers to create and maintain health records and submit claims to third party payors, the law still allows for charging reasonable transaction fees on a non-profit basis. Advisory Committee members commented about the opportunity cost of pursuing such a solution given existing investments made within the State to achieve widespread adoption of electronic health records as well ongoing efforts at the federal level.
- Discussion regarding integration of multiple vendors with the State-Designated Health Information Exchange put emphasis again on scope of use cases for pre or post-adjudicated claims and need to evaluate prioritization.
- *Action Items: MHCC plans to form a Draft Recommendations Subcommittee to collaborate virtually over the next month. The subcommittee will develop a preliminary list of informal draft recommendations for discussion by the Advisory Committee. The preliminary list will serve as a working draft to guide deliberations among the Advisory Committee at the next in-person meeting. If you would like to participate on this subcommittee, please email Justine Springer at justine.springer@maryland.gov.*
- *Upcoming meeting: The Advisory Committee will convene again at MHCC offices on Tuesday, December 18, 2018 from 2:00pm to 4:00pm EST. Meeting materials will be posted in advance on the Advisory Committee [web page](#).*

Health Record and Payment Integration Program Advisory Committee

Draft Recommendations Subcommittee

November 27, 2018

Meeting Summary

Key discussion items include:

- The Draft Recommendations Subcommittee (subcommittee) reviewed a preliminary draft of key themes and conceptual ideas as a first phase in framing informal draft recommendations. The discussion took into consideration concepts identified in the discussion items/grids document as it relates to potential benefits, barriers/challenges, and solutions for creating a health record and payment integration (program) as required in law ([Chapter 452](#)).
- There was general consensus among the subcommittee to find ways that maximize the existing infrastructure as opposed to design, development, and implementation of a new infrastructure for a program. Participants acknowledged existing investments made by the industry and federal efforts, such as the 21st Century Cures Act (Cures Act), to increase momentum in maximizing the promise of health information technology.
- Discussion about the feasibility of incorporating administrative health care claims transactions into the State-Designated Health Information Exchange (HIE) noted several technical and policy complexities, including potential legal issues pertaining to ownership of claims data and incomplete data due to lag time in claims processing and exclusions, such as self-insured plans (*Gobeille v. Liberty Mutual Insurance Company*). Participants also noted how the Cures Act aims to improve ownership of health care data for consumers.
- In terms of feasibility of establishing a free and secure web-based portal for providers to create and maintain health records and file for payment, the subcommittee reiterated points about widespread adoption of electronic health records (EHRs) and the potential need for an EHR solution for just less than 15 percent of providers.³⁵ Given State and federal programs over the last ~~ten~~10 years to support EHR adoption and cost associated with making an EHR solution available to providers, participants did not identify a compelling reason why an intervention by the State would be needed.
- The subcommittee agreed there was no need (or force of law required) to accelerate the adjudication of clean claims.
- Exploratory discussions about magnetic stripe cards or smart card technology and unique patient identifiers and matching algorithms noted some privacy concerns, challenges with administrative costs, and downstream issues if implemented.
- *Upcoming Meeting: The subcommittee will convene again virtually on Wednesday, December 19, 2018 from 2:00 to 4:00pm EST. Please contact Justine Springer at justine.springer@maryland.gov if you would like to participate*

³⁵ A large portion of these providers tend to specialize in behavioral health or are nearing retirement.

Health Record and Payment Integration Program Advisory Committee

Draft Recommendations Subcommittee

December 19, 2018

Meeting Summary

Key discussion items include:

- The subcommittee acknowledged that there have been considerable investments made by health care organizations in Maryland and the nation to implement health information technology that aims to increase efficiencies and improve quality of care delivery. Participants noted that there could be potential long-term savings by investing in a health record and payment integration program; however, investment costs (though hard to define) would need to be quantified to begin exploring a potential return on investment (ROI) model.
- The subcommittee generally agreed that uncertainties and trade-offs need to be explored thoroughly to inform the development of policy and potential legislation that balances interests and protects existing investments by all stakeholders. Participants also acknowledged the need to align any new efforts with those at the federal level.
- The subcommittee generally agrees that more evaluation is needed to justify incorporating claims data into the State-Designated Health Information Exchange, particularly as it relates to legal issues, such as governance of the data, as well as identifying the unique value proposition to stakeholders for specific use cases.
- The subcommittee acknowledged federal and State policy that has promoted adoption of electronic health records (EHR) over the last decade, and how there could be some benefit of establishing a free web-based portal for providers to create and maintain health records and file for payment of services rendered. Given existing investments in EHR technology, variation in EHR attributes among different specialties, and that such a solution could potentially be desired by less than 10 percent physicians³⁶, the workgroup decided that there was minimum benefit in developing, implementing, and maintaining an EHR solution at this time.
- There continued to be general consensus that no statutory change is needed to accelerate the adjudication of clean claims or reduce timely filing requirements for providers.
- *Upcoming Meeting: The full Advisory Committee will convene at MHCC offices on Thursday, January 24, 2019 to discuss informal draft recommendations.*

³⁶ Estimated based on electronic health record adoption data collected by the Maryland Board of Physicians.

Health Record and Payment Integration Program Advisory Committee


January 24, 2019

Meeting Summary

Key discussion items include:

- The Advisory Committee reviewed version 3 of the key themes, draft recommendations, and supporting rationale noting that funding is needed to further study complex issues identified in the design and governance of a health record and payment integration program.
- There is general consensus to recommend that a task force assess specific use cases for incorporating claims data into the State-Designated Health Information Exchange. It was noted that evaluation of other suitable alternatives such as improving the accuracy and availability of clinical data should be considered.
- A statutory change to accelerate the adjudication of clean claims cannot be justified at this time. While outside the study's scope, some members acknowledged that providers should be encouraged to improve the timeliness of their claims submissions to benefit consumers.
- Significant challenges were noted around the adoption of a unique patient identifier and technology to support smart cards or magnetic stripe cards. A common viewpoint shared was to rely on existing processes and vendor solutions.
- *There is no upcoming meeting scheduled for February. The MHCC will distribute to the Advisory Committee a revised draft (version 4) for review; members are invited to provide additional written comments. A draft report is expected to be shared with the Advisory Committee in the coming weeks.*

Appendix E: Meeting Presentations



CLAIMS PROCESSING AT CAREFIRST, INC.


High level overview

AUGUST 2018

Proprietary and Confidential

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. which are independent licensees of the Blue Cross and Blue Shield Association.
© Registered trademark of the Blue Cross and Blue Shield Association.

Claims Processing at CareFirst



- **Claims Data and Statistics**
- **Claims Processing and Efficiency**
- **Analytics and Submitted Claims**

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Claim Types

- Medical (institutional and professional)
- COBC (Medicare)
- Dental
- Pharmacy
- Mental Health
- Interplan Teleprocessing System (ITS)
 - Governs how claims are processed & paid throughout the Blue Cross Blue Shield Association

Claim Formats

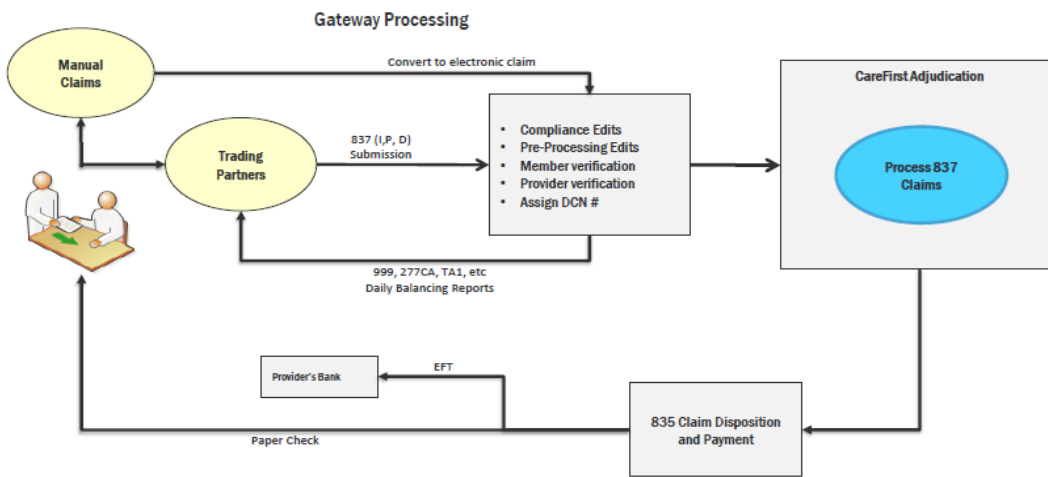
- Paper
- Electronic
 - Electronic Data Interchange (EDI)
 - EDI Transactions -
 - 837 (Claim)
 - 835 (Payment Remittance)
 - 276 (Claim Status Request)
 - 277 (Claim Status Response)
 - 999 (Acknowledgement)
 - Claim versions:
 - Professional - '005010X222A1
 - Institutional - '005010X223A2'
 - Dental- '005010X224A2'

- Claims Volumes:
 - Institutional, Professional, Dental 2017 41.3 M
 - Pharmacy 2017 15 M
- Claims Turnaround Times -
 - 96% within 14 days
 - 100% within 30 days
- Average days of receipt from claim DOS
 - Professional 23.9 days
 - Institutional 34.0 days
 - Dental 16.3 days
- Claim Rejection Rate
 - Electronic 1.6%
 - Paper 4.4%

Claims Processing and Efficiency



Claims arrive throughout the day and are adjudicated on the day they are received. In addition to claims, there are thousands of real time claims status and eligibility *inquiry* transactions (270, 271, 276, 277) received and processed.



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Claims Processing and Efficiency



Two levels of edits are performed upon receipt of the claims: Compliance and Pre-processing (PPE). In both edit types the claims are REJECTED and returned to the Trading Partner:

Compliance Edits is verification and rules surrounding the X12 EDI standard format. Compliance errors relate to EDI uniform data requirements. Examples:

- > Element N401 (D.E. 19) at col. 4 is missing, though marked "Must Be Used"
- > Element NM103 (D.E. 1035) at col. 10 is missing, though marked "Must Be Used"

Pre-Processing (PPE) Edits is the validation of the *contents* on the inbound claim record that CareFirst requires to process according to our business rules. Examples:

- > *NPI not on file*
- > *SubscriberID Not Found*
- > *Invalid NDC[#####] for HCPCS[###] code*
- > *Principal Diagnosis Code [= 'H2001']. Must be entered, must be a valid code for date.*
- > *Procedure Code [= 'NS']. Must be a valid 5 position CPT-4 or HCPCS code.*
- > *Valid Tooth number(s) are not present [= ''] when Procedure Code [= 'D5226'] Level equals T*

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Claims Processing and Efficiency



- Confirm member eligibility
- Confirm provider is in/out of network
- Timely Filing - varies
 - *Account specific*
 - *365 days*
 - *180 days*
 - *NASCO: 365 days, OR end of the following year after the service date (Ex: Service date 08/17/2018, filing limit by 12/31/2019)*
- PENDS
 - *Clinical editing*
 - *Duplicate claims editing/Claims History check*
 - *Utilization Management*
 - *Service Rules (Deductibles, Limits and Penalties)*
- Pricing
- Accumulators

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Claims Processing and Efficiency



- CareFirst Electronic Claims rate equals 99.0% (including conversion of Paper Claims to Electronic Claims)
 - CAQH reports 95.0% based on Industry survey
- First Pass Rates – efficiency measure of our claims processing, along 2 measures
 - Operational - ~85% of claims require no manual intervention due to business rules before automated adjudication
 - System - ~92% claims require no manual intervention stemming from systemic rules before flowing into specific lines of business
- Adjustment Rates –
 - The scope of this metric is limited to adjustments within the claims area (does not include system errors): 2.5-3.5% depending on business unit

8/20/2018

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Claims Processing and Efficiency



➤ Format and Processing

- Claim forms/ claim submission format must adhere to uniform standards set by federal and state law; must have a process to reject claims that do not meet “clean claim” standards (15-1003 through 15-1005)
 - Need to maintain a manual or other document that sets explains claims filing standards (15-1004(d))
 - Need to maintain a phone number where providers can call with questions and concerns related to claims filing (15-1004(d))
 - Claims processing must be compliant with HIPAA standard transactions, privacy, and security rules, as well as complementary state laws

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Claims Processing and Efficiency



➤ Utilization Review:

- Must be certified to do utilization review or contract with a private review agent (15-1001)
 - May need to implement process to handle pre-authorization requests and/or provide advance notice of eligibility/coverage upon request (not sure whether this is applicable?)
- Must ensure that utilization review of mental health and substance abuse claims satisfies state and federal mental health parity laws
- Must have a mechanism to request additional medical records when medical necessity is in question
 - If requesting additional information delays processing of the claim, interest may be due (15-1004)
- Must have an internal process to allow members to appeal adverse benefit determinations, including an emergency process for urgent cases (15-10A-02)
 - This process is strictly regulated and includes requirements related to timing and communication content. In general, emergency cases must be responded to in 24 hours and other cases within 30-45 days
- Must have a process to engage with HEAU/MIA (as applicable) on adverse benefit determination appeals that proceed to external review, including potentially to a formal administrative hearing
- Must be prepared to litigate adverse benefit determinations that advance to formal legal action

8/20/2018

10

Claims Processing and Efficiency



➤ Prompt Pay:

- Must give providers 180 days from date of service to submit a claim (15-1005)
- In general, claims must be processed within 30 days of receipt of a claim (15-1005)
 - Claim must be paid; OR
 - Must transmit notice of what charges are being denied, along with the reason for the denial; if additional documentation is required, the notice must contain this information
- Must give providers a minimum of 90 business days from date of a claims denial to appeal (15-1005)
 - If a claim was denied erroneously, must give providers a minimum of 1 year to notify the payer and request reprocessing (15-1005)
- Payments made by EFT (electronic funds transfer) must meet all relevant federal and state banking laws and other industry standards (i.e., NACHA, etc.)
- Need a process to identify other sources of insurance coverage and coordinate benefits between multiple policies
- Payers serving individual market consumers need to have a process to suspend claims payments and notify providers when consumers receiving federal APTC fall into arrears for late premiums and are in months two and three of their federally-required grace period (15-1005)

8/20/2018

11

Claims Processing and Efficiency



➤ Recoupment:

- Need a process to reconcile and recoup erroneous claims payments
- Maryland allows for recoupments within 6 months of payment—
 - this can be especially challenging when employers do not communicate employee plan terminations on a timely basis.
- Must send the provider a communication explain the recoupment
- Need a compliance program to investigate and report provider billing fraud

➤ Privacy

- We have self funded accounts where we are prohibited by Federal Law from sharing that data
- Consent - who gives consent for the data to go to the intermediary
- Part 2/Mental Health data
 - Is this a legally required submission of data (even then we can't provide ASO groups)? If not, what covered entity is accountable (e.g. who is CRISP a BAA to in this model)?

8/20/2018

12

Claims Processing and Efficiency



➤ Member Communications Related to Claims:

- Insurers must provide consumers with notice of claims processing/claims denials via HIPAA-compliant Explanation of Benefits (EOB) forms (15-1006)
- Insurers must provide consumers with an annual (12 month) summary of all claims submitted by providers and the balance owed by the consumer for each claim filed (15-1007)
- Need a process to handle member-submitted claims and payments owed directly to the member for out of network care
- Need a process to respond to member complaints filed with the MIA
- **Note:** Complaints are different from adverse benefit determination appeals. Complaints can cover a broad range of other issues ranging from poor customer service to major operational/technical problems impacting claims payment.

8/20/2018

13

Analytics and Submitted Claims



- Submitted claims are not generally used in CareFirst clinical processes or administrative reporting
- Claims adjudication may result in the rejection or denial of a submitted claims
- For claims that are accepted, they are often edited based upon CMS rules and CareFirst Medical Policy
 - 74% of Professional Claims are edited, bundled, etc
 - Frequency Validation - Allowed once per date of service, clinically possible/reasonable to perform a given procedure on a single date of service, across all anatomic sites.
 - **Claim Billed:** Appendectomy (44950), DOS 8/1/2018, frequency of 2
Result: 1 unit allowed, second unit denied
 - Frequency Validation - Allowed multiple times per date of service, clinically possible/ reasonable to perform a given procedure on a single date of service, across all anatomic sites.
 - **Claim Billed:** Application of short arm splint (29125), DOS 8/1/2018, frequency of 3
Result: 2 units allowed, third unit denied

8/20/2018

14

Submitted Claims



- **Incidental Procedures** - Certain procedures are commonly performed in conjunction with other procedures as a component of the overall service provided. An incidental procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.
- **Claim Billed:** Laparoscopy abdomen (49320) & Laparoscopy with biopsy (49325), DOS 8/1/2018
Result: 49320 is considered incidental to 49325 and therefore denied, and 49325 is allowed
- Submitted claims may pend and be held for review which may depend upon collection of Medical Records
- Submitted claims can be adjusted based upon appeals
- Submitted and finalized claims are subject to further review for fraud, waste and abuse

8/20/2018

15



OVERVIEW, DISCUSSION

MD SB.896 legislation, Maryland Health Care Commission

08.21.2018

CHANGE
HEALTHCARE

Change Healthcare Team

- △ **Mike Denison**, Senior Director, Regulatory and Standards Compliance
- △ **John Evans**, Director of Content Intelligence, Product Management, Revenue Cycle Management
- △ **Deanne Kasim**, Senior Director, Health Policy Strategy

CHANGE
HEALTHCARE

Questions

- At what point does a clearinghouse insert itself in the claims process?
- What is the value of clearinghouses to providers?
- What type of value add services are offered to providers?
- Other?

Clearinghouse Defined

△ Rule (§ 160.103) public or private entity – can include the following:

- billing service
- repricing company
- community health management information system

△ Value- added services, “switches” for:

- processing information received in nonstandard format (or containing nonstandard data content) into standard data elements (or a standard transaction)
- Receiving standard transaction from another entity and processing information into nonstandard format or nonstandard data content for the receiving entity

Value of Clearinghouse Functions

- Process all HIPAA covered transactions
- Mapping to multiple EHR/PMS systems output (not all transactions are the same)
- Connectivity to multiple payers
- Connectivity to multiple vendors
- Claims editing to increase 1st pass rate
- Certification (EHNAC/Others)
- File Error monitoring
- Claim Rejection monitoring & resubmission
- Remit delivery, timing, follow up, code mapping
- State / Federal Regulatory change updates



The Intelligent Healthcare Network™

- △ Connects providers, payers, and technology partners with the nation's largest health information networks for eligibility and benefits verification, claims submission and processing, remittance, and payments
 - Connects to more than 800,000 providers and 2,100 payers
 - Direct connections to nearly all government and commercial payers



The Intelligent Healthcare Network™

- △ Improves first pass rates with behind-the-scenes edits and customizations
 - Features an extensive repositories of rules and logic to appropriately clean claims before sending
- △ Transmits electronic claims and remittance advice securely through compliance infrastructure – meeting or exceeding industry data standards
 - Includes broadest and widely-accepted accepted standards (ANSI standards, 835/837)
 - Supports nearly all file formats, including .pdf, .jpg,.tif, and .gif

CHANGE
HEALTHCARE

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The Intelligent Healthcare Network™

- △ Provides the platform for transmission of electronic claim attachments - providers can submit via ASC X12 275 transactions or through the secure online portal
- △ Payers can receive batch image and ASC X12 275 index files, and request, receive, and manage using the online portal
- △ FUTURE - Blockchain

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8

Questions, Discussion, Follow-Up

△ Deanne Kasim

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CH~~A~~NGE
HEALTHCARE



CRISP Clearinghouse Pilot: Lessons Learned

September 18, 2018

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Pilot Overview:

- **Goal:** *Determine the feasibility of capturing financial claims data and converting the files into usable clinical data available that can be leveraged by multiple CRISP services (Query Portal / ENS)*
- **Pilot Dates:** February 2016 – June 2017
- **Pilot Practices:** 40
- **Claims Received:** Claims data from 14 practices / 28 Providers / 5100 transactions



Pilot Assessment:

- Financial Claims data can be leveraged to augment clinical data through the query portal (examples below):

The screenshot displays a patient care portal interface. On the left, there is a summary section with the following data:

Encounter Summary		Associated Providers		Source Information	
Visit Date	May 17, 2016 12:00:00 AM	Attending Provider	Polio MD, Lisa E	Source	Southern MD Women's Healthcare
Class	Outpatient			Received On	May 20, 2016 2:14:30 AM
Location	SOUTHERN MARYLAND WOMEN'S HEALTHCARE				

Below this is a 'Conditions' table:

Name	Type	Date	Details
31 weeks gestation of pregnancy	Diagnosis	May 17, 2016 12:00:00 AM	View Condition Details
Encounter for supren of normal pregnancy, third trimester	Diagnosis	May 17, 2016 12:00:00 AM	View Condition Details

At the bottom left is a 'Procedures' table:

Name	Authoring Provider	Details
Prenatal at risk education		View Procedure Details

On the right side of the portal, there are several tabs: Summary, More Patient Information, Patient Groups, Patient Documents, eHT/HE Worklist, Interstate PDMP, and Patient Care Overview. The 'Summary' tab is active, showing various data points:

- Laboratories (17) / Other Orders (0)**: Table with columns Date, Name, Source. Includes entries like TSH+Free T4, GG1h+SCCRP+HPR+, TSH+Free T4, and HCG.
- Imaging (6)**: Table with columns Date, Name, Source. Includes entries like US Pregnancy Limited, US Pregnancy After 1st Tr., US OB LIMITED, CT ABDOMEN/PELVIS W., and MR ANKLE RIGHT/NO D.C.
- Procedures (1)**: Table with columns Date, Name, Source. Includes Prenatal at risk education.
- Medications (2)**: Table with columns Date, Name, Source. Includes OXYCODONE-ACETAMINOL and PHENTERMINE 37.5 MG T.
- Ambulatory Encounters (14) / Inpatient Encounters (0)**: Table with columns Date, Admission Type, Source. Includes entries for Prenatal at risk education, ROUTINE ELECTIVE, and ROUTINE ELECTIVE.
- Social History (0) / Conditions (22)**: Table with columns Title, Reported, Source. Includes entries like 31 weeks gestation of pr., Encounter for supren of..., 29 weeks gestation of pr., Encounter for antenatal, and vaginal bleeding 13 10.

3



Pilot Assessment (Cont.):

- Financial Claims data can be leveraged to generate Event Notifications to care managers and the provider community
 - NOTE: Average data delay was 48 hours.
- Financial claims data can be used similar to an ADT message for auto-subscription of patients (used for Relationship management and privacy features - "break glass")

4



Pilot Assessment (Cont.):

- Financial Claims data is limited when it comes to provider information. Examples:
 - Limited data in claim to identify provider type (PCP, Specialist) and practice location (if multiple locations)
- Multiple EHNs means data from one practice may not be complete.
 - NOTE: collecting only some data from a location / practice could actually create inefficiencies for care managers

5



Opinions on Identified Barriers:

- Addressing consumer consent policies
 - From a CRISP perspective data received for purposes of the pilot was treated the same way clinical data is treated. All consent policies applied.
- Addressing provider participation options
 - CRISP required provider / practice consent to send data through the EHN, but as a BAA of the practice through the participation agreement this was not necessary.
- Privacy concerns
 - The CRISP Participation agreement requires practices to filter sensitive / protected health information.
 - This could be a concern if CRISP is to filter data that should not have been shared.
 - Special agreements are required if sharing data protected under 42 CFR part 2

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Opinions on Identified Barriers:

- **Coordination of data transfers from multiple EHNs:**
 - CRISP already accepts data from over 1500 locations (including large hospital systems and payers). At most this would translate into a large project. Recently we turned on over 40 net new hospitals in WV within 6 months.
- **Ability to accept / process / store 60M new messages**
 - CRISP processed ~6M records between 9/3/18 and 9/9/18. 60M annually equates to a 20% increase. CRISP is already building infrastructures to handle this type of volume.
 - Additional thoughts: Would need to decide how often CRISP purges old claim data (18 months) to ensure system performance and relevancy.

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Questions and Discussion

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Health Record and Payment Integration Program Advisory Committee

2018 Prompt Payment of Claims

Bob Morrow-Associate Commissioner, Life & Health
Maryland Insurance Administration
October 18, 2018

- § 15-1005 of Insurance Article
- Applies to:
 - Individuals
 - Insurers
 - Non-Profit Health Service Plans
 - HMOs
 - MCOs
 - Carriers acting as TPA's for Employer Plan Sponsors
- COMAR 31.10.11 – Uniform Claims Forms
 - Claims filed by providers, hospitals, other institutions (COMAR only)

Requirements Generally

- Pay undisputed/clean claims within 30 days of receipt
- If not paid on time must pay interest on unpaid portion of claim (§15-1005(g))
- If not paid because claim is not “clean,” notice must be sent stating reason for refusal to pay and what specific information is still needed (§15-1005(c)(2))

3

- Claims can be submitted up to a minimum of 180 days from date of service
 - Period can be longer by contract
- Uniform Claim forms must be used by providers
 - Standardized Transactions + Code Sets
 - HCFA Form 1500 (Hospitals/inpatient)
 - HCFA Form UB-92 (individual doctors/practices, etc.)

4

Appendix F: Information Gathering Grids

Draft: Version 5



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 assess 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).³⁷ Refer to the [Advisory Committee Charter](#) for more information.

DIRECTIONS: Discussion items that follow are in part, specified in law (Chapter 452)³⁸ 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/Challenge: 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/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 note with an asterisk (*).

The Advisory Committee discussed quadrants of each grid during the August, September, and October meetings. Subsequently, Bruce Taylor, MD submitted additional suggestions. These suggestions are noted in Track Changes.

³⁷ 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.

³⁸ 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

1A. Requiring MHCC Certified Electronic Health Networks (clearinghouses) to send claims information to CRISP	
<p>BENEFITS (VALUE ADD/PERCIEVED)</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ Quality metrics (e.g., help providers determine if patients have received select services outside their practice) ○ Certain conditions required by law (e.g., flu) 	<p>BARRIERS & CHALLENGES (OBSTACLES/POTENTIAL ISSUES)</p> <ul style="list-style-type: none"> • Obtaining legislative authority <ul style="list-style-type: none"> ○ 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 Use and Reciprocal Support Agreement (DURSA)* • Addressing consumer consent policies (opt-out) • Obtaining practice/provider consent (opt-in) • Determining ownership of data • Addressing provider participation options • Privacy concerns (e.g., behavioral health data filtered by CRISP) • Should paper claims and other claims submitted directly from a provider be included in the requirement <ul style="list-style-type: none"> ○ 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
<p>SOLUTIONS (FOR INCORPORATING CLAIMS DATA INTO CRISP)</p> <ul style="list-style-type: none"> • Provider value and communication strategy • Financial return on investment (ROI) model • Bill to implement the requirement and enforce compliance • Phased implementation approach • Funding source (model) to implement and sustain the initiative • Use of algorithms that pull/use relevant information for a specific use case 	
<p>PARKING LOT</p> <ul style="list-style-type: none"> • Length of time to use/store data • Federal Bill (HR 6082) to align 42 CFR Part 2 with HIPAA • Also capture claims information that do not go through clearinghouses – getting reports from payers on those claims filed directly • To extent that providers promptly upload or make available EMR records, a system to match records and claim transaction data will be needed 	

1B. Enhancing the CRISP infrastructure to support electronic claims transactions

BENEFITS (VALUE ADD/PERCIEVED)

- Increased value of available data from the State-Designated HIE*
- Opportunity for expanded use cases aimed at care coordination
 - Enhance existing use cases
 - Enable broader use cases
- Opportunity to bolster patient matching algorithms
- Potential to build control to ADT data from financial claims information

BARRIERS & CHALLENGES (OBSTACLES/POTENTIAL ISSUES)

- Identifying a funding source(s) for up-front investment and ongoing costs, including additional cost for privacy and security
- Market saturation exists with nearly 32 organizations that exchange electronic transactions in Maryland; competitors will not be enthusiastic about the perception that the State could be shifting business away from them
- Absent legislation, the policy requirements needed to manage provider consent and EHN participation are insurmountable
- Planning an appropriate amount of time for implementation and resources for maintenance
- Identification of appropriate data elements contained in an 837
- Certain data in claims is duplicative from a C-CDA, some of which is already made available by CRISP
- Limited ambulatory connectivity

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
- Phased implementation to mandatory participation
- Brainstorm ways to use claims data long-term
- Develop a funding plan that distributes the investment and maintenance cost across stakeholders
- Convening a workgroup to identify the relevant policy and technology considerations to support a phased implementation plan

PARKING LOT

- AG review on the potential impact (if any) of Gobeille v. Liberty Mutual Insurance Company
- Claims data accuracy
- Drivers and lessons learned from efforts in other states
- Competing priorities/initiatives

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

2A. Making available a web-based electronic health record solution (EHR) at no cost to providers	
1	<p>BENEFITS (VALUE ADD/PERCIEVED)</p> <ul style="list-style-type: none"> • Only ~15 percents of providers (non-EHR adopters) that may be encouraged by the availability of a web-based solution • Track access of patient information (treatment relationships/audit trail)
2	<p>BARRIERS & CHALLENGES (OBSTACLES/POTENTIAL ISSUES)</p> <ul style="list-style-type: none"> • Determining who pays and ensuring cost is not passed to providers • Significant EHR investments already made by health care organizations • Moving too quickly to develop a solution prior to conducting a policy impact assessment • Completing a cost benefit analysis/demonstrating ROI • Saturated EHR market where many low cost and no cost vendor products exist; multiple vendors offer a free EHR/web portal • Implementing an EHR that is certified or only select elements of an EHR (buy or build) • EHRs are customized by specialty; no one size fits all approach • Technical support and training for providers by the hosting organization • Design, development, implementation, and ongoing maintenance cost; sustainability • 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 software requires technology costs for users
3	<p>SOLUTIONS (FOR MAKING AN EHR AVAILABLE TO AUTHORIZED USERS)</p> <ul style="list-style-type: none"> • Grant/bidding to identify existing vendors that provide some free services and charge for value-add services • Funding through state bonds with modest system user fees supporting bond payments • State and federal start-up grants
PARKING LOT	

2B. Developing a web-based portal for submitting claims to third party payors 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)

- Significant investments in billing systems already made by health care organizations, including payors
- 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 and resources required to design, develop, implement and maintain
- Moving too quickly to develop a solution prior to conducting a policy impact assessment
- Completing a cost benefit analysis/demonstrating ROI
- Developing a solution that is user friendly and integrated into provider workflows
- Identifying the value proposition

SOLUTIONS (FOR DEVELOPING A WEB-BASED PORTAL FOR SUBMITTING CLAIMS)

- Require users of the system to pay a subscription/transaction fee
- Educate providers on existing payor claims submission portals
- [Grant/bidding to identify existing vendors that provide some free services and charge for value-add services](#)
- [Funding through state bonds with modest system user fees supporting bond payments](#)
- [Federal grant\(s\) for EMR demonstration project, including possible federal legislation to fund & create the grants if they don't exist now](#)

PARKING LOT

2C. Making secure web-based electronic health record database (EHR) access available at no cost to providers

BENEFITS (VALUE ADD/PERCIEVED)

- Improved patient care with records being promptly available at all points of service
- More timely information on services provided to patient
- Reduced cost of care with less repetition of services
- Facilitates emergency care
- Could include health care powers of attorney
- Could include organ donor status
- Could include willingness to participate in research directly and anonymously
- Expansion of existing CRISP system in use to include more information
- Builds on the 75% of providers now using EMRs

BARRIERS & CHALLENGES (OBSTACLES/POTENTIAL ISSUES)

- Amount of data to be stored
- Security & possible abuse of health data
- Integration of many different systems, softwares & vendors
- Reliance on private parties for detailed data maintenance with associated downtimes and data losses
- Timeliness of data input

SOLUTIONS

- Select one of more universal languages (HL7 for example) and types of files (PDF and JPG files) that can be uploaded or read
- Use two factor identification for all users
- Keep only summary information on state system and develop one click access to more detailed records on private servers
- Accept only registered devices to access the system
- Require a patient generated and maintained password or magnetic card plus password to access the system
- Allow access without magnetic card by user member ID
- Allow access in emergency rooms from specific terminals and providers without passwords or magnetic cards
- Allow patients to opt out of the system, waiving their "rights" to system benefits
- See 2B. and 3A. for additional solutions

PARKING LOT

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

3A. Revising prompt payment requirements – Insurance Article, §15-1005(c)	
<p>BENEFITS (VALUE ADD/PERCIEVED)</p> <ul style="list-style-type: none">• Improved cash flow• More timely information on claims that pend or reject by a payor <p>1</p>	<p>BARRIERS & CHALLENGES (OBSTACLES/POTENTIAL ISSUES)</p> <ul style="list-style-type: none">• Several large private payors report adjudicating claims within 30-days (a high percentage within 24 hours – first pass); unclear benefit of decreasing the adjudication cycle further• Assessing impact of current regulatory requirements (e.g., understanding concern/need, if any, to revise the current 30-day time frame in law)• Effect of a mandate requiring payors to retool their claims adjudication systems <p>2</p>
<p>SOLUTIONS (FOR REVISING PROMPT PAYMENT REQUIREMENTS)</p> <ul style="list-style-type: none">• <u>Implement prompt pay in return for prompt submission of the electronic patient record for the services being charged. Initially this could be something like, make record available online in 4-7 days and get paid in 4-7 days; over time, the time frames could be shortened until eventually as systems are refined, payment could be within 24-48 hours for records uploaded within 24-48 hours.</u> <p>3</p>	
<p>PARKING LOT</p> <ul style="list-style-type: none">• Maryland Insurance Article §15-1005(e) requiring providers to submit claims within 180 days• CMS Adminstrative Simplification Act could reduce EM codes (from five to two)	

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

4A. Identifying a funding source	
BENEFITS (VALUE ADD/PERCIEVED) <ul style="list-style-type: none">Identifying a source; no clear souce identified <p>1</p>	BARRIERS & CHALLENGES (OBSTACLES/POTENTIAL ISSUES) <ul style="list-style-type: none">Accuracy in pricing program components and demonstrating ROIPublic funding tends to support start-up but not ongoing operations*Identifying investors willing to fund the design, development, implementation, and ongoing costSustainabilityNeed buy-in from stakeholders/clear value proposition to payors and other stakeholders*Addressing stakeholder concerns that public funding is a tax to someone <p>2</p>
SOLUTIONS (FOR IDENTIFYING A FUNDING SOURCE) <ul style="list-style-type: none">Explore reasonableness/availability of grant funding (federal and State)User subscription/transaction feesState general fundsPrivate vendors (State Recognition model)BondIndividual physician practices form collaboratives to share costs/leverage resourcesFederal grant(s), possibly with enabling legislation if grants are not available now <p>3</p>	
PARKING LOT <ul style="list-style-type: none">Transaction fees non-profit basis are not prohibited in Chapter 452More specifications of a program are needed to assess actual cost	

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

5A. Integrating multiple vendors with CRISP

BENEFITS (VALUE ADD/PERCEIVED)

- CRISP already integrates with multiple vendors

1

BARRIERS & CHALLENGES (OBSTACLES/POTENTIAL ISSUES)

- Managing integration and maintenance costs
- Determining who pays initial and ongoing vendor integration costs
- Vendor contracting
- Funding additional technology needed by CRISP to support infrastructure expansion
- Expanded privacy challenges
- Extended length of time required to integrate a vendor with CRISP
- Data quality pre/post-adjudicated claims
- Prioritization process

2

SOLUTIONS (FOR INTEGRATING MULTIPLE VENDORS WITH CRISP)

- Explore intelligent APIs

3

PARKING LOT

- Sources of funding – [see 4A.](#)

5B. Integrating access to the statewide EMR system through magnetic stripe cards and unique patient IDs

BENEFITS (VALUE ADD/PERCIEVED)

- CRISP already integrates with multiple vendors
- Ease of access for providers
- Password protections can be incorporated and controlled by the patient
- Patient ID can be linked to record sites to seamlessly pull up available detailed records for use when desired
- Improved security through use of approved terminals and devices
- Real time clinical and financial data for patients, providers, carriers, etc. for expenses as well as treatments

BARRIERS & CHALLENGES (OBSTACLES/POTENTIAL ISSUES)

- Lost cards will need to be deactivated and replaced and might require change of patient unique ID
- Lost password process will need to be developed
- Providers will need to add compatible card readers and card reader software to their systems
- Integration of multiple systems, vendors, payors and software

SOLUTIONS

- Access by patient unique ID or patient demographic data when card is lost or unavailable
- Web based user ID and password replacement functions can be implemented that are widely in use
- The same card reader can be used to access the system and credit card billing

PARKING LOT

- Revise systems online so that with 1-3 card swipes providers can collect all forms of payment: insurance & 3rd party payments, HSA payments, and copays. This would include credit card HSA and out of pocket / cash copays. Eventually the health card electronic access to the system could be merged with credit cards and HSA cards so that one card could serve all three functions. One swipe access to patient data, benefits, insurance and payments.

SUPPORTING LITERATURE

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Appendix G: HIPAA and HITECH – Historical Context

HIPAA Administrative Transactions

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Department of Health and Human Services to adopt national standards for the secure electronic exchange of administrative transactions among HIPAA-covered entities.³⁹ This includes:

- Claims and encounter information
- Payment and remittance advice
- Claim status
- Eligibility
- Enrollment and disenrollment
- Referrals and authorizations
- Coordination of Benefits
- Premium payment

The Patient Protection and Affordable Care Act (PPACA or ACA) enacted in 2010 included additional provisions that address use of HIPAA administrative transactions.⁴⁰ These provisions include operating rules for existing transactions, unique identifiers for health plans, and electronic funds transfer and electronic health care claims attachments.

Electronic transactions aim to increase efficiencies in operations, improve quality and accuracy of information, and reduce overall costs to the health care system through widespread use of electronic data interchange (EDI). EDI is computer-to-computer exchange of information in a standardized format. Electronic health networks (EHN) (also referred to as clearinghouses, networks, or trading partners) play a key role in making sure health care claims conform to standards required by HIPAA to facilitate the electronic exchange of claims-related information, thus reducing the need for mail, fax, and telephone.

HITECH

Recognizing that greater efficiencies could be gained through a more robust health IT infrastructure, Congress passed the American Recovery and Reinvestment Act (ARRA) of 2009.⁴¹ A section of ARRA included the Health Information Technology for Economic and Clinical Health (HITECH) Act designed to modernize health care, with emphasis on promoting adoption of

³⁹ P.L. 104-191 enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information. Collectively these are known as the Administrative Simplification provisions.

⁴⁰ PPACA, 42 U.S.C. § 18001 (2010).

⁴¹ Pub.L. 111-5

electronic health records (EHRs).⁴² The HITECH Act established the Medicare and Medicaid EHR Incentive Programs, now referred to as the Promoting Interoperability Programs (incentive programs). The incentive programs are considered a unique federal policy for driving change among the health care industry through financial incentives for the adoption and Meaningful Use⁴³ of certified electronic health record (EHR) technology.⁴⁴

The HITECH Act also authorized funding of additional programs to guide the health care industry. This included Regional Extension Center Programs to provide support to providers in helping them adopt and meaningfully use certified health IT. Funding was also made available under the State HIE Cooperative Agreement Program through Challenge Grants to states that helped offset cost for encouraging innovations for HIE that could be leveraged nationwide.⁴⁵ These programs have played a key role in guiding development of the necessary foundation of a health IT infrastructure needed to transform the health care industry. Since this funding has been depleted, HIEs have been challenged to find business models for long-term sustainability that include financing mechanisms not reliant on state funding.

⁴² *ONC, 2016 Report to Congress on Health IT Progress: Examining the HITECH Era and the Future of Health IT*, November 2016. Available at: dashboard.healthit.gov/report-to-congress/2016-report-congress-examining-hitech-era-future-health-information-technology.php.

⁴³ Meaningful Use outlines objectives an eligible provider must meet to earn financial incentives.

⁴⁴ A certified EHR meets the technological capability, functionality, and security requirements adopted by the Department of Health and Human Services. The Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program is a voluntary program for the certification of health IT standards, implementation specifications, and certification criteria. This program supports the availability of certified EHRs that is required to participate in MU and most alternative payment models under the purview of federal, state and private entities. For more information, visit: www.healthit.gov/topic/certification-ehrs/about-onc-health-it-certification-program.

⁴⁵ ONC, State Health Information Exchange. Available at: www.healthit.gov/topic/onc-hitech-programs/state-health-information-exchange.

Appendix H: EHR Adoption

The HITECH Act had an unprecedented impact on the health IT landscape in Maryland and the nation. Prior to 2009, most providers captured information on paper and shared this information primarily using fax machines.⁴⁶ Less than a quarter (16 percent) of Maryland hospitals had adopted a basic EHR⁴⁷ as compared to nine percent of hospitals nationally.⁴⁸ Today, certified EHRs have been implemented by all hospitals in Maryland and about 96 percent nationally; all have demonstrated Meaningful Use.⁴⁹ Maryland hospitals have received over \$300 million dollars of more than \$30 billion dollars distributed in federal incentives. Diffusion of EHRs is increasingly becoming more widespread in other care settings (Table 1).

Table 1: Electronic Health Records		
Care Setting	Adoption Rate	
	Maryland	Nation
Acute Care Hospitals	100	96
Comprehensive Care Facilities	91	66
Dentists	53	56
Office-based Physicians	71	80

Note: The MHCC collects data on EHR adoption through surveys and information available from the Maryland Board of Physicians. In general, findings are based on self-reported data that is not audited for accuracy. Interpretation of EHR adoption questions and survey methodologies may vary. The national dental adoption rate also includes use of practice management software. Adoption rate by care setting (Maryland, National): Acute Care Hospitals (2019, 2019), Dentists (2017, 2018), Long term care (2017, 2017), and Office-based physicians (2016, 2017).

⁴⁶ ONC, *2016 Report to Congress on Health IT Progress: Examining the HITECH Era and the Future of Health IT*, November 2016. Available at: dashboard.healthit.gov/report-to-congress/2016-report-congress-examining-hitech-era-future-health-information-technology.php.

⁴⁷ A basic EHR is classified as minimum use of at least 10 core functions: recording patient demographic information; physician notes; nursing assessments; problem lists; medication lists; discharge summaries; ordering medications; and viewing laboratory reports; radiology reports; and diagnostic test results.

⁴⁸ ONC Data Brief 35, *Adoption of Electronic Health Record Systems among U.S. Non-Federal Acute Care Hospitals: 2008-2015*, May 2016. Available at: www.healthit.gov/sites/default/files/briefs/2015_hospital_adoption_db_v17.pdf.

⁴⁹ Hospitals demonstrate Meaningful Use by successfully attesting through either the Centers for Medicare & Medicaid Services Medicare Attestation System or through a state's Medicaid Attestation System.

Appendix I: PDMP and Maryland House Bill 115 (2018)

In 2011, Maryland law⁵⁰ authorized the State to establish a PDMP to monitor the prescribing and dispensing of CDS.⁵¹ The PDMP primarily assists providers and public health and law enforcement agencies in identifying and reducing prescription drug abuse of CDS Schedules II through V.⁵² The law requires dispensers (including practitioners and pharmacies) to report prescription fill information for CDS drugs dispensed to a patient or a patient's agent in Maryland. Approximately 94 percent of pharmacies in Maryland have registered and report to the PDMP.^{53, 54} Effective July 1, 2018, CDS prescribers are required to review a patient's PDMP data before prescribing an opioid or benzodiazepine, and every 90 days during the course of that treatment; pharmacists must consult the PDMP prior to dispensing a CDS drug if they reasonably suspect a patient is seeking the drug for non-medical use.^{55, 56}

The Office of Provider Engagement and Regulation at the Maryland Department of Health, Public Health Services is responsible for oversight of the PDMP. The PDMP utilizes information technology (IT) services provided by CRISP. CRISP recently contracted with NIC, Inc.⁵⁷ to support PDMP-specific IT services that facilitate collection, analysis, and disclosure of prescription information for CDS. Authorized PDMP users are given electronic access to PDMP data through a secure, online portal or within a provider's electronic health record. Originally, dispensers were required to report within three business days after a CDS drug was dispensed. As of October 8, 2018, dispensers must report within 24 hours of dispensing a CDS drug; this new requirement aligns with industry trends nationally.^{58, 59} Reporting is mainly automated, though some processes require manual intervention to ensure data quality and reconcile error reports.⁶⁰

During the 2018 legislative session, House Bill 115, *Maryland Health Care Commission – Electronic Prescription Records System – Assessment and Report* (or bill), was passed. The law (Chapter 435)⁶¹ requires MHCC to convene interested stakeholders for purposes of conducting

⁵⁰ The PDMP is authorized under Health-General Article, Section 21-2A, Annotated Code of Maryland (Chapter 166, 2011). PDMP regulations can be found under Code of Maryland Regulations 10.47.07.

⁵¹ State and federal law define CDS as substances that have abuse potential. This includes drugs listed in Schedules II, III, IV and V that have accepted medical uses, such as opioid pain relievers like oxycodone (OxyContin, Percocet, Percodan, Roxicet), hydrocodone (Vicodin, Lortab), and methadone; anti-anxiety and sedative medications like alprazolam (Xanax) and diazepam (Valium); and stimulants like Adderall and Ritalin.

⁵² The PDMP is a core component of Maryland's comprehensive strategy for reducing prescription drug abuse throughout the State, and a major goal in the Maryland Opioid Overdose Prevention Plan.

⁵³ About 87 pharmacies only dispense non-CDS drugs and are thus not required to register/report to the PDMP.

⁵⁴ Deena Speights-Napata. Executive Director, Maryland Board of Pharmacy. Phone interview with The Hilltop Institute; September 26, 2018.

⁵⁵ Prescribers and pharmacists may delegate PDMP access to staff working in the same practice or facility.

⁵⁶ *Maryland Prescription Drug Monitoring Program*. Available at: bha.health.maryland.gov/pdmp/Pages/Home.aspx.

⁵⁷ CRISP previously contracted with Health Information Designs/Appriss.

⁵⁸ COMAR 10.47.07.03(B) is currently being phased in; enforcement is expected to begin in the spring of 2019, though dispensers are encouraged to report daily before then.

⁵⁹ The majority of states, approximately 42, require dispensers to conduct daily reporting of CDS data. More information is available at: [www.namsdl.org/library/Frequency%20of%20PMP%20Data%20Reporting%20Map%201-2-18%20\(Update\)/](http://www.namsdl.org/library/Frequency%20of%20PMP%20Data%20Reporting%20Map%201-2-18%20(Update)/).

⁶⁰ Presentation by Matthew Shimoda, Pharmacy Director of SuperValu, October 2018.

⁶¹ Governor Larry Hogan approved House Bill 115 on May 8, 2018.

a study that assesses the benefits and feasibility of developing an electronic system (system or statewide repository) of patient prescription medication history. The system would collect and make available to treating health care providers and dispensers information on non-CDS⁶² dispensed in Maryland. Currently, the PDMP makes available to authorized users information on CDS Schedules II through V dispensed in Maryland.

The MHCC convened an Electronic Prescription Records System Workgroup (workgroup) that is tasked with assessing specific aspects of a statewide repository, including:

1. Whether the State-Designated HIE, CRISP, is capable of including a patient's prescription medication history;
2. Enhancements to CRISP required to ensure that the exchange is able to continue to meet other State mandates, including operating an effective PDMP;
3. Resources required for individual health care practitioners, health care facilities, prescription drug dispensers, and pharmacies to provide the information collected in a statewide repository of prescription medication information;
4. Cost to the State to develop and maintain an electronic prescription medication system and the cost to prescribers to access the system;
5. Resources required to ensure that health care practitioners and prescription drug dispensers can maximize the benefit of using the system to improve patient care;
6. Scope of prescription medication information that should be collected in the system, including any specific exemptions; scope of health care providers that would report prescription medication information in the system, including any specific exemptions;
7. Potential for development or use of systems other than CRISP for access to patients' prescription medication history;
8. Privacy protections required for the system, including the ability of consumers to choose not to share prescription data, to ensure the prescription data is used in a manner that is compliant with State and federal privacy requirements, including 42 U.S.C. § 290dd-2 and 42 C.F.R Part 2;
9. Feasibility of ensuring that the data in the system is used only by health care practitioners to coordinate the care and treatment of patients;
10. Standards for prohibiting the use of the data in the system by a person or an entity other than a health care practitioner, including any exceptions for the use of data with identifying information removed for bona fide research; and
11. Any other matters of interest identified by MHCC or stakeholders.

The MHCC is required to report on or before January 1, 2020 to the Governor and General Assembly detailing findings and recommendations from the study.

⁶² See n.25, *Supra*.

Appendix J: Advisory Committee Commentary

Hello Nikki,

Change Healthcare appreciates the opportunity to participate in the Advisory Committee and we support the draft final report findings, recommendations, and conclusions.

We welcome the opportunity to participate and contribute in future Advisory Committee initiatives and specifically the recommendation to establish a task force to conduct an in-depth feasibility assessment of making claims data available through CRISP, and evaluate other suitable alternatives, such as improving the accuracy and availability of clinical data.

We look forward to continuing our support of the Maryland Health Care Commission.

Mike Denison

Senior Director, Regulatory and Standards Compliance



Thanks Nikki. I have read the report and have no comments. Nicely done!

Dawn E. Seek

Executive Director

MNCHA

I am deeply grateful to all the staff of MHCC who have contributed to the Committee and this report as well as to all the Committee members who generously contributed their time and expertise for this effort.

Attached are my comments.

Thanks,

Bruce T. Taylor, M.D.



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April 14, 2019

**Senate Bill 896, Health Record and Payment Integration Program Advisory Committee
Final Report Comments**

History and Problem

It is important to note that the final passed version of Senate Bill 896 was significantly amended from its original intent in order to reach a passable compromise to study a few discrete issues. My original legislative proposal sought to make significant strides in reducing in Maryland the tremendous individual, corporate, government and financial burdens of our current healthcare systems. The United States by all measures spends more per person on healthcare than any other country in the world, yet achieves overall population health results ranking it 25th to 28th among nations. This unbalanced spending makes our country non-competitive in many markets and continually erodes our quality of life, particularly for those with limited resources. The high and continuously rising cost of healthcare, approaching 20% of Gross Domestic Product, and the inequities of access to care as well as the inefficiencies of care (on average 31% of each dollar being spent on administrative costs) remain unsolved by the report of the Advisory Committee. This comes in large part from the narrow focus of the final legislation and the resulting committee as well as a risk averse sentiment to making major changes to part of our social fabric.

Goal

The intent of the original bill was to put in place a system of proven solutions to reduce the cost of healthcare and improve its quality without cutting benefits or services. Other countries have achieved better population health by enacting national coverage and implementing countrywide electronic records solutions. Research has indicated that these systems also improve the quality of care. Even without universal coverage, our nation could save an estimated \$500 Billion a year; Maryland alone could save an estimated \$6.2 billion per year, including \$70 million annually on the cost of state employees' health coverage alone. This would be akin to a 2% boost to the economy.

Limited Results

The Committee by design explored implementing a limited set of solutions. Concerns over legal issues, the cost to implement the solutions and the hidden fears of inherent winners and losers from possible changes has restricted the recommendations of the Committee to financing a study to explore the legal issues and anticipated expenses to implement changes which could benefit all Marylanders and ultimately all U.S. citizens. The attached report acknowledges the challenges of improving our current overly complex system which is deeply engrained in our society. We must seek to cut costs while maintaining services.

Hope for the Future

The hope of the original legislation was that Maryland, so often a leader in healthcare, could be a standard setting model of success for our country; we could achieve significant progress with known technologies that would improve the provision of services while substantially reducing their expense without reducing benefits. This can be accomplished with universal secure online records, online insurance benefits information and payments. These goals remain to be accomplished and are within our reach if we choose to implement them.

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<http://content.healthaffairs.org/content/33/9/1586.abstract>

Nikki

First let me say that although I was not able to attend the meetings, I did follow the email chain and am thankful you kept me in the loop.

As you know Post-Acute (LTC) billing is very different than acute care billing. I had a great discussion with the folks from Hill Top concerning this topic.

I have read the Draft and am in support of the document.

I would like to suggest that if we continue to go forward with this topic that we engage a larger representation of the Post-Acute (LTC) community in future talks since our challenges are very different than our acute care partners.

Feel free to contact me with questions.

Thanks

Wayne

J. Wayne Brannock, Chief Operating Officer

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