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).[1] Refer to the Advisory Committee Charter for more information.

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

Benefit: Value derived from producing or consuming a service

Barrier/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 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 (*).

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

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

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

Key Components:

1A. Requiring MHCC Certified Electronic Health Networks (clearinghouses) to send claims information to CRISP

BENEFITS *(VALUE ADD/PERCIEVED)*

- Enhance care delivery through provider alerts that include information on patient diagnoses and procedures*
- Fill in missing gaps of information (e.g., from ambulatory encounters) to:
  - Ensure continuity pre and post hospitalization
  - Improve monitoring and coordination of care, especially for high-risk patients with chronic conditions
  - Reduce redundant and unnecessary services and tests
- Identify population health/public health issues*
- Facilitate reporting of:
  - Quality metrics (e.g., help providers determine if patients have received select services outside their practice)
  - Certain conditions required by law (e.g., flu)

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BARRIERS & CHALLENGES *(OBSTACLES/POTENTIAL ISSUES)*

- Obtaining legislative authority
  - Compliance and enforcement for providers and clearinghouses
  - Identification of a bill sponsor
- Funding the additional technology at CRISP required to support X12 transaction receipt and conversion to HL7
- Development and execution of Data 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
  - 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

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SOLUTIONS *(FOR INCORPORATING CLAIMS DATA INTO CRISP*

- 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

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- 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 date 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

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- 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

Key Components:

2A. Making available a web-based electronic health record solution (EHR) at no cost to providers	
BENEFITS *(VALUE ADD/PERCIEVED)* • Only ~15 percents of providers (non-EHR adopters) that may be encouraged by the availabilty of a web-based solution • Track access of patient information (treatment relationships/audit trail) 1	**BARRIERS & CHALLENGES** *(OBSTACLES/POTENTIAL ISSUES)* • 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 2
SOLUTIONS *(FOR MAKING AN EHR AVAILABLE TO AUTHORIZED USERS)* • 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 3	
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)*

Determining who pays and ensuring cost is not passed on to providers

- 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 repitition of services
- Facilitates emergency care
- Could include heatlh care powers of attorney
- Could include organ donor status
- Could include willingness to participate in research directly and annonymously
- 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

Key Component:

3A. Revising prompt payment requirements – Insurance Article, §15-1005(c)	
BENEFITS *(VALUE ADD/PERCIEVED)* • Improved cash flow • More timely information on claims that pend or reject by a payor 1	**BARRIERS & CHALLENGES** *(OBSTACLES/POTENTIAL ISSUES)* • 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 2
SOLUTIONS *(FOR REVISING PROMPT PAYMENT REQUIREMENTS)* ~~None~~ • 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 dyas 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. 3	
PARKING LOT • 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

Key Component:

4A. Identifying a funding source	
BENEFITS *(VALUE ADD/PERCIEVED)* • Identifying a source; no clear souce identified 1	**BARRIERS & CHALLENGES** *(OBSTACLES/POTENTIAL ISSUES)* • Accuracy in pricing program components and demonstrating ROI • Public funding tends to support start-up but not ongoing operations* • Identifying investors willing to fund the design, development, implementation, and ongoing cost • Sustainability • Need buy-in from stakeholders/clear value proposition to payors and other stakeholders* • Addressing stakeholder concerns that public funding is a tax to someone 2
SOLUTIONS *(FOR IDENTIFYING A FUNDING SOURCE)* • Explore reasonableness/availability of grant funding (federal and State) • User subscription/transaction fees • State general funds • Private vendors (State Recognition model) • Bond • Individual physician practices form collaboratives to share costs/leverage resources • Federal grant(s), possibly with enabling legislation if grants are not available now 3	
PARKING LOT • Transaction fees non-profit basis are not prohibited in Chapter 452 • More specifications of a program needed to assess actual cost	

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

Key Component:

5A. Integrating multiple vendors with CRISP	
BENEFITS *(VALUE ADD/PERCIEVED)* • CRISP already integrates with multiple vendors 1	**BARRIERS & CHALLENGES** *(OBSTACLES/POTENTIAL ISSUES)* • Managing integration and maintenance costs • Who pays initial and ongoing vendor integration costs • Vendor contracting • Funding additional technology needed by CRISP to support infrastructure expansion • Expanded privacy challenges • The extended length of time required to integrate a vendor with CRISP • 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 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 ccompatible card readers and card reader software to their systems
- Integration of multiple systems, vendors, payors and softwares

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.

LITERATURE

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