Maryland's State-Designated Health Information Exchange

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Technology Components

Health Department Systems of Record

- Immunization Registry
- Vital Statistics (Mortalities)
- Reportable Conditions

Hospital, Medicare, & Medicaid Claims

Hospitals, Clinics, EMS (Participant Data)

National Exchange Networks

Conversion & Normalization

Core Supporting Infrastructure

Master Person Index

Consent Utility

- Secure User Portal
- FHIR APIs
- Push Notifications
- Reports
- Flat Files

HITRUST
Health Information Trust Alliance

EHNAC

Key Pillars of a Health Data Utility

Services

- **Enrich Data**
  - Link disparate data sets
  - Use multiple sources to fill gaps
  - Improve data feeds
  - Surface key insights
- **Distribute Information**
  - Create visualizations
  - Control access levels
  - Push individual clinical records
  - Share analytic files
- **Enable Interventions**
  - Flag patients at the point of care
  - Notify appropriate end users
  - Share relationships between organizations

Value

Enrich Data → All data becomes more useful when it is linked, normalized, deduplicated, and cleansed within a single analytics engine

Distribute Information → User experience is enhanced and usage increases when a single entity is responsible for governance and distribution

Enable Interventions → Alignment between population level reports and actionable individual experiences is more likely to result in positive change

National Trends in Data Exchange

- Multi-regional providers, payers, and the federal government have been pushing for "national networks"
- TEFCA (Trusted Exchange Framework and Common Agreement) is the voluntary national network and legal flow downs created by the Office of the National Coordinator as directed in the 21st Century Cures Act
- Federal solutions enable basic exchange, but do not address certain key issues:
  - Patient matching, identity verification, and consent
  - Compliance with regional laws and regulations
  - Push notifications and bulk data delivery
  - Providers, particularly those serving vulnerable populations, not using optimal EHRs
- Many states, including Pennsylvania (P3N) and Maryland (CRISP), have reciprocal data sharing for each others' residents who cross borders for care

Resources

Training materials, recorded webinars, and patient education flyers can be found at: https://crisphealth.org/

Information about CRISP Shared Services is available at: https://crispsharedservices.org

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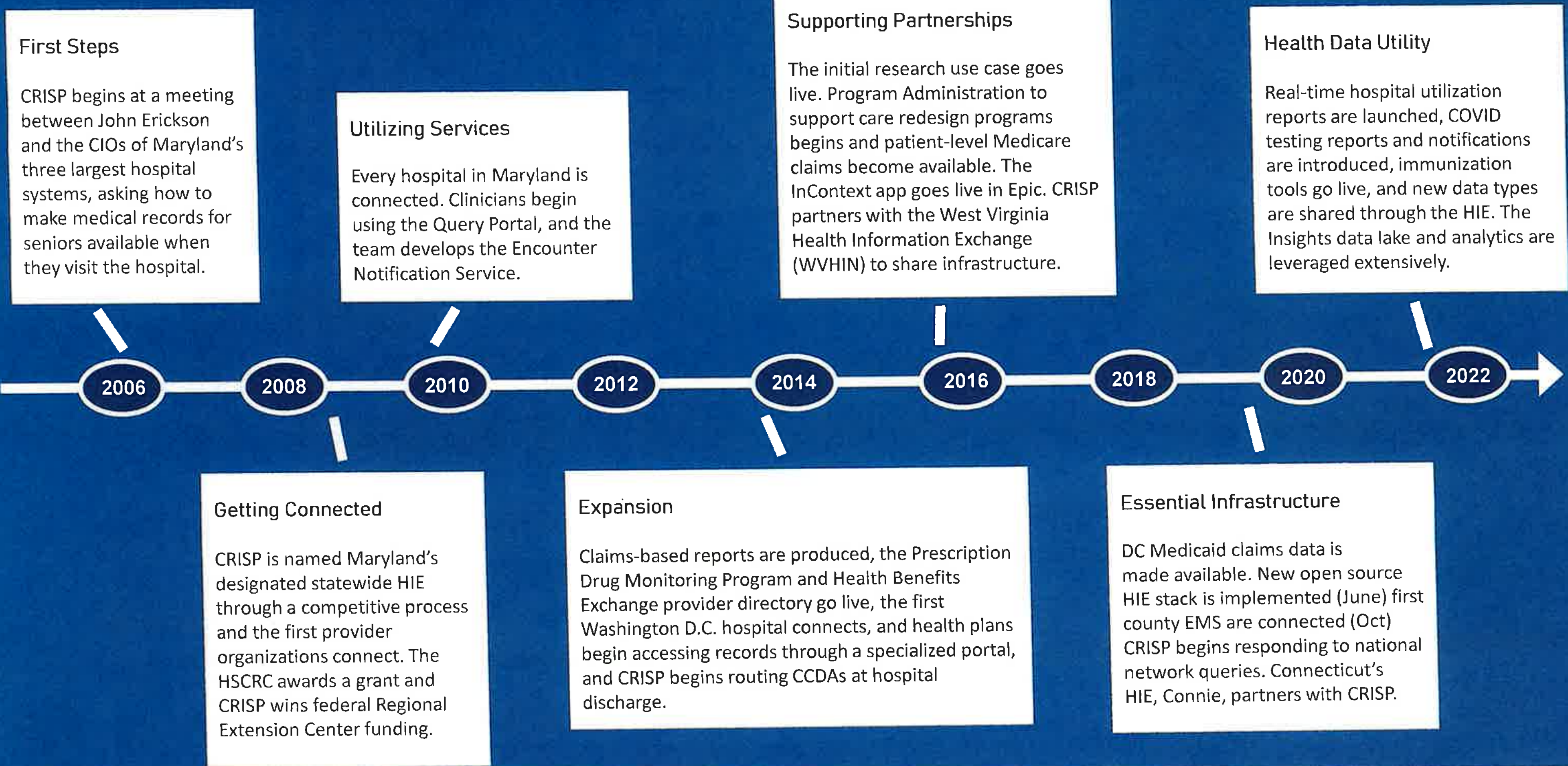

Implementation Timeline
First Steps
CRISP begins at a meeting between John Erickson and the CIOs of Maryland's three largest hospital systems, asking how to make medical records for seniors available when they visit the hospital.
Getting Connected
CRISP is named Maryland's designated statewide HIE through a competitive process and the first provider organizations connect. The HSCRC awards a grant and CRISP wins federal Regional Extension Center funding.
Utilizing Services
Every hospital in Maryland is connected. Clinicians begin using the Query Portal, and the team develops the Encounter Notification Service.
Expansion
Claims-based reports are produced, the Prescription Drug Monitoring Program and Health Benefits Exchange provider directory go live, the first Washington D.C. hospital connects, and health plans begin accessing records through a specialized portal, and CRISP begins routing CCDAs at hospital discharge.
Supporting Partnerships
The initial research use case goes live. Program Administration to support care redesign programs begins and patient-level Medicare claims become available. The InContext app goes live in Epic. CRISP partners with the West Virginia Health Information Exchange (WVHIN) to share infrastructure.
Essential Infrastructure
DC Medicaid claims data is made available. New open source HIE stack is implemented (June) first county EMS are connected (Oct) CRISP begins responding to national network queries. Connecticut's HIE, Connie, partners with CRISP.
Health Data Utility
Real-time hospital utilization reports are launched, COVID testing reports and notifications are introduced, immunization tools go live, and new data types are shared through the HIE. The Insights data lake and analytics are leveraged extensively.
2006
2008
2010
2012
2014
2016
2018
2020
2022

Point of Care: InContext Data Delivery

- View of patient data, pulled from multiple repositories and sources, embedded in the end user's EHR
- Integrations can occur in EHR native app stores or through API queries
- CRISP is FHIR compliant and moving to USCDI+ and TEFCA

HIE InContext

FRODO BAGGINS

Male

Probable

34121 RING LANE, COLUMBIA, MD 21045

Infection Control Alerts VIEW

Next of Kin VIEW

HEALTH RECORDS ENCOUNTERS STRUCTURED DOCUMENT

Health Records

Date	Source	Description
2021-03-04	BAMLANREF	Referral for further care
2020-01-24	MHS	TYPE AND SCREEN
2019-05-10	UMMS_UMMC	Functional Brain MR
2019-02-08	UMMS_UMMC	URINE ANALYSIS
2017-12-19	UMMS_UMMC	Discharge Summary

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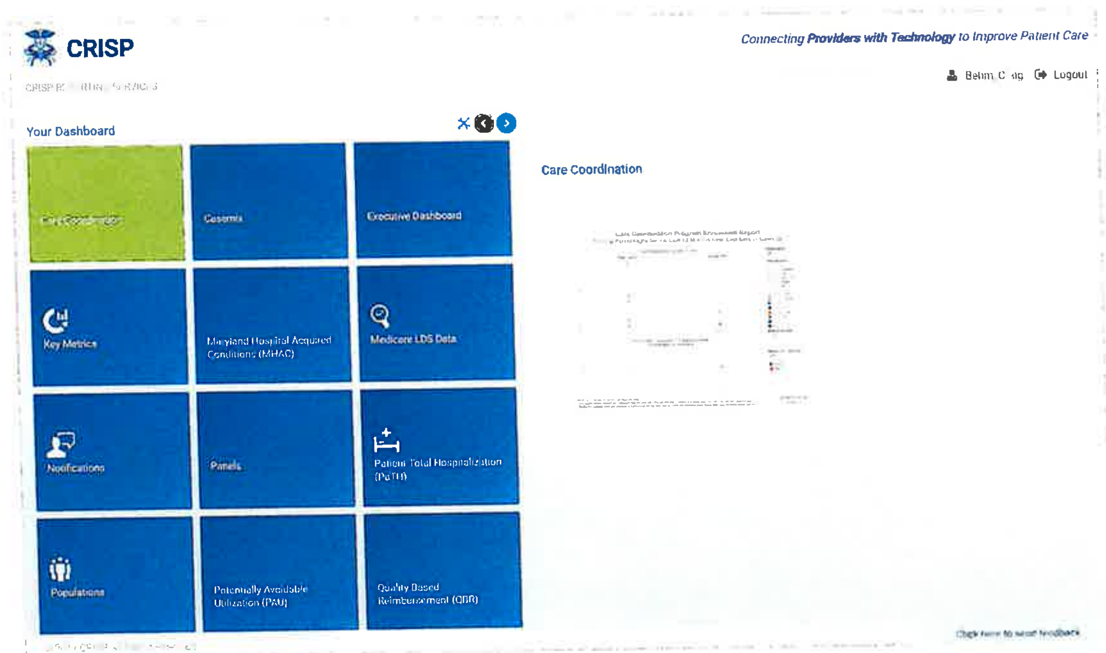
Population Health: CRISP Reporting Services

- Dashboards from administrative data to support high-needs patient identification, care coordination, and progress reporting
- Primary data sets are hospital casemix and Medicare claims and claim line feed (CCLF)
- Different levels of patient data available for hospitals based on HSCRC payment requirements and Total Cost of Care Model participation
- There are over **600 active users** viewing **85 reports** over **2,000 times per month**



Maryland Model Program Participants

Episode Care Improvement Program (ECIP):
15 Hospitals participated in ECIP for CY2023, and the unduplicated count of care partners was **4,764** individual clinicians & **9** facilities.
The total amount of hospital incentives awarded since program inception is **$9,025,347.**

Episode Quality Improvement Program (EQIP):
CRISP supports specialty practice and other provider participation in bundled care arrangements. In CY2023, there were **2,733** care partners participating across **64** EQIP entities

Care Transformation Initiatives (CTIs):
All but 2 MD Hospitals are participating in at least one CTI, and in total, **107** participant elected CTIs cover **263,907** episodes. CRISP Care Transformation Profiler allows hospitals to view all CTIs statewide and to monitor progress.

MD Primary Care Program (MDPCP):
48 practices joined in 2023, and 154 practices graduated to Track 3. Currently there are more than 500 primary care practices participating in the program

Data Quality

In January 2024, we transformed 16.6M inbound ADTs for analytics in Azure with the following completeness by data element:

- Race = 95%
- Ethnicity = 93%
- Gender = 100%
- Address = 99%
- PCP = 70%
- Diagnosis = 38%

Category	1/14/2024	1/7/2024
ADT-based Metrics		
Admit Reason	64 %	62 %
Diagnosis	33 %	34 %
Diagnosis Timeliness	95 %	92 %
Diagnosis Description	34 %	34 %
Discharge Summary Timeliness	68 %	65 %
PCP NPI	52 %	52 %
Next of Kin	60 %	60 %
Address	99 %	99 %

Data Quality Dashboard

Date: 12/1/2023 – 12/31/2023 HIE: All

Source Code	Facility	ADTs	Admit Reason	PCP NPI	Next of Kin	Race	Ethnicity	Language	Address	Phone	Encounters	Dx Codes
MMC	Meritus Medical Center	1,795,474	39 %	84 %	42 %	95 %	98 %	100 %	99 %	99 %	122,090	80 %
JHH	Johns Hopkins Hospital	1,711,482	93 %	59 %	65 %	98 %	95 %	100 %	99 %	99 %	84,902	97 %
CCHS	Christiana Care Health System	1,241,430	80 %	61 %	71 %	95 %	96 %	100 %	99 %	99 %	175,276	57 %
MS_MPP	Medstar Physician Partners	1,058,394	54 %	0 %	50 %	92 %	50 %	100 %	100 %	100 %	453,089	0 %
AAMC	Luminis Health - Anne Arundel Medical Center	888,047	44 %	63 %	62 %	96 %	92 %	100 %	99 %	98 %	106,890	55 %
ENS_PRIVIA	Privia Health	886,440	0 %	3 %	62 %	94 %	94 %	100 %	100 %	100 %	644,705	0 %
JHCPA	Johns Hopkins Home Care Group - RPM	881,903	76 %	74 %	61 %	93 %	88 %	100 %	97 %	97 %	165,645	99 %
MHS	Mercy Medical Center (No Auditable Contacts or Assets)	745,962	36 %	83 %	47 %	99 %	99 %	100 %	99 %	99 %	334,796	38 %
WMHS	UPMC - Western Maryland	622,451	98 %	75 %	98 %	99 %	93 %	100 %	100 %	99 %	26,038	10 %
JHH_BVIEW	Johns Hopkins Bayview Medical Center	584,103	93 %	62 %	68 %	99 %	96 %	100 %	100 %	100 %	31,704	95 %
MEDSTAR_FSH	Medstar Franklin Square Medical Center	408,641	100 %	39 %	91 %	99 %	94 %	100 %	100 %	98 %	33,874	21 %
JHH_HH	Johns Hopkins Home Health	396,081	5 %	57 %	57 %	85 %	77 %	100 %	92 %	92 %	1,990	84 %
HCGH	Johns Hopkins Howard County Medical Center	374,645	91 %	69 %	75 %	96 %	93 %	100 %	99 %	99 %	16,972	95 %
HCH	Holy Cross Health Center - Silver Spring	345,858	86 %	36 %	83 %	83 %	62 %	100 %	96 %	96 %	17,497	85 %
GBMC	Greater Baltimore Medical Center	334,945	70 %	69 %	48 %	83 %	82 %	100 %	97 %	87 %	57,567	26 %
FMH_ID	Frederick Health	334,587	93 %	0 %	89 %	98 %	94 %	99 %	98 %	99 %	26,186	98 %
AGH	Atlantic General Hospital	320,718	97 %	77 %	5 %	98 %	94 %	100 %	100 %	98 %	18,625	0 %

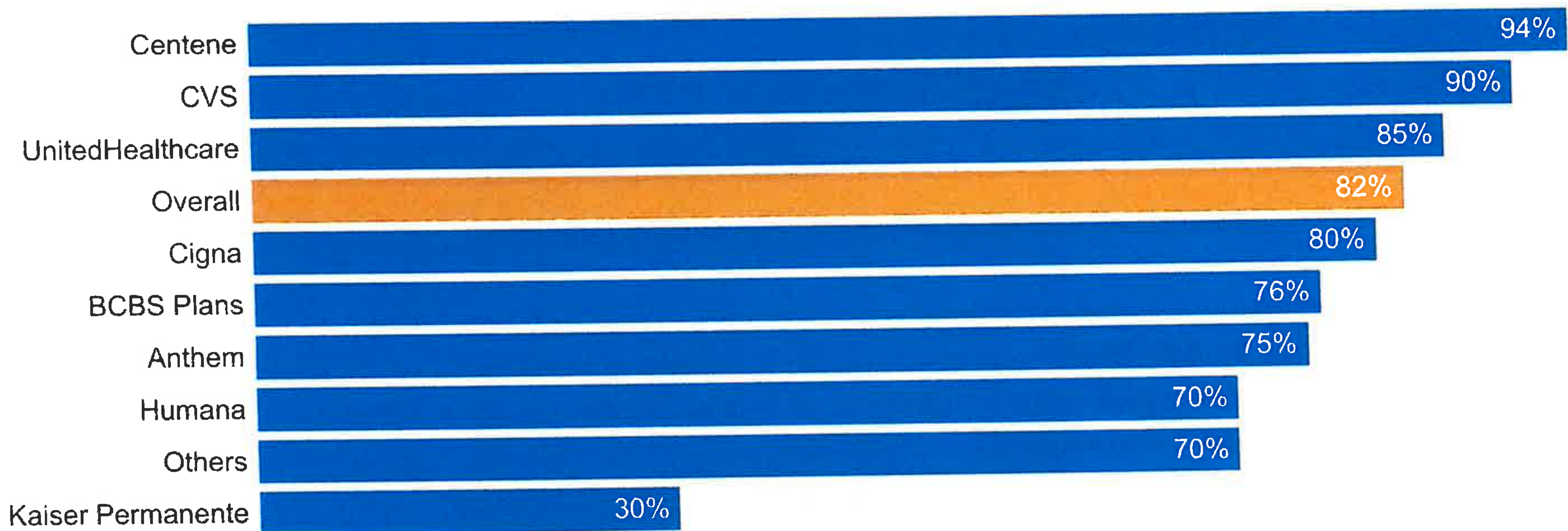
MEDICARE ADVANTAGE

National and Pennsylvania Perspectives

February 28, 2024
Nicole L. Clawson
Vice President Finance/Revenue Cycle
Pennsylvania Mountains Healthcare Alliance
www.pmhalliance.org

Across Most Firms, the Vast Majority of Prior Authorization Request Denials that Were Appealed Were Overturned

Share of reconsiderations that were fully or partially favorable in 2021



NOTE: Includes reconsiderations that were fully or partially favorable. Anthem BCBS plans are not included due to data quality issues.
SOURCE: Technical Specifications Public Use File of Contract Year 2021 Part C and D Reporting Requirements Data

KFF

MGMA Report

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUESTS RESULT IN DANGEROUS DELAYS AND DENIALS IN NECESSARY MEDICAL CARE — REFORM IS CRITICALLY NEEDED. With an increase in utilization of prior authorization across both commercial payers and MA, practices are struggling to ensure patients continue to maintain access to medically necessary care. Prior authorization processes can vary greatly across payers, resulting in a convoluted and overly burdensome process.

97% of medical groups report their **patients experienced delays or denials for medically necessary care (e.g., prescription medicine, diagnostic tests, or medical services) due to prior authorization requirements**

FOR PRIOR AUTHORIZATIONS THAT REQUIRE A PEER-TO-PEER (PRACTICE CLINICIAN TO HEALTH PLAN CLINICIAN) DISCUSSION, IS THE HEALTH PLAN CLINICIAN GENERALLY FROM A RELEVANT SPECIALTY TO THE TREATMENT OR DISEASE IN QUESTION?

72% SAY NO

https://www.mgma.com/getmedia/788a1890-8773-4642-9c22-b224923e4948/05-03-2023_PA-in-MA_FINAL.pdf.aspx?ext=.pdf

Penn. Insurer Prompt Pay Statute

Pennsylvania Statutes Title 40 P.S. Insurance 991.2166.

Prompt payment of claims

(a) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

(b) If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than two ($2) dollars.

Hospitals calling it quits with MA Plans:

- Mayo Clinic (MN)
- Scripps (CA)
- WakeMed (NC)
- Vanderbilt (TN)
- Cameron Regional (MO)
- Baptist Health (KY)
- Stillwater (OK)
- Brookings (SD)
- St. Charles (OR)

(not an exhaustive list)

https://www.beckershospitalreview.com/finance/hospitals-are-dropping-medicare-advantage-left-and-right.html

BECKER'S
Hospital CFO Report

Financial Management

Hospitals take aim at Medicare Advantage

Jakob Emerson - Wednesday, August 16th, 2023

Medicare Advantage may now provide health coverage to more than half of the nation's seniors, but that is not stopping health systems from pushing back against the growing and controversial program.

Hospitals have been dropping Medicare Advantage plans over high claim or prior authorization denial rates since at least 2018, but it was an uncommon move until recently. Some systems have noted that most MA carriers have faced allegations of billing fraud from the federal government and are being probed by lawmakers over high denial rates.

Rochester, Minn.-based Mayo Clinic warned Medicare-eligible patients in Florida and Arizona in October that it does not accept most Medicare Advantage plans, and Vanderbilt University Medical Center in Nashville, Tenn., was preparing to drop Humana and Centene MA plans before reaching contract agreements in March.

Cameron (Mo.) Regional Medical Center stopped accepting Cigna's MA plans in 2023 and plans to drop Aetna and Humana in 2024. It plans to continue Medicare Advantage contracts with UnitedHealthcare and BCBS, the *St. Joseph News-Press* reported in May. Cameron Regional CEO Joe Abrutz previously told the newspaper the decision stemmed from delayed reimbursements.

Stillwater (Okla.) Medical Center ended all in-network contracts with Medicare Advantage plans amid financial challenges at the 117-bed hospital. Humana and BCBS of Oklahoma were notified that their MA members would no longer receive in-network coverage after Jan. 1, 2023. The hospital said it made the decision after facing rising operating costs and a 22 percent prior authorization denial rate for Medicare Advantage plans, compared to a 1 percent denial rate for traditional Medicare.

Brookings (S.D.) Health System will no longer be in network with any Medicare Advantage plans in 2024, the *Brookings Register* reported. The 49-bed, municipally owned hospital said the decision was made to protect the financial sustainability of the organization.

Bend, Ore.-based St. Charles Health System has taken it a step further and is not only considering dropping all Medicare Advantage plans, but is also encouraging its senior patients not to enroll in the private Medicare plans during the next open enrollment period.

The health system's president and CEO, CFO, and chief clinical officer cited higher rates of denials, longer hospital stays and overall administrative burden for clinicians.

"We recognize changing insurance options may create a temporary burden for Central Oregonians who are currently on a Medicare Advantage plan, but we ultimately believe it is the right move for patients and for our health system to be sustainable into the future to encourage patients to move away from Medicare Advantage plans as they currently exist," St. Charles Health CFO Matt Swafford said.