Electronic Health Records and Health Information Exchange: Updates from the Maryland Health Care Commission

MAOP Annual Meeting

December 6, 2013
Discussion Topics

• Role of the Maryland Health Care Commission (MHCC) and the Center for Health Information Technology & Innovative Care Delivery

• Health Information Technology (Health IT)

• Electronic Health Record (EHR) Incentive Programs

• Health Information Exchange (HIE) Services

• Questions
MHCC Center for Health IT & Innovative Care Delivery

• Responsible for advancing health IT Statewide by:

  • Promoting and facilitating the adoption and optimal use of health IT for the purposes of improving quality and safety of health care, while decreasing overall health care costs

  • Increasing availability and utilization of standards-based health IT through consultative, educational and outreach activities

• Support new models of care delivery and payment
Health IT Components

- Electronic Health Records
- Health Information Exchange
- Telemedicine
Benefits of Health IT Adoption and Use

- Ensure providers have the right information available at the time and place of care, which can improve treatment, prevent errors, and reduce health care costs through:
  - Increased access to patient health information
  - Streamlined and enhanced provider workflows
  - Minimized fragmentation

- Facilitate collection of information to improve disease surveillance, increase health care knowledge, and shape best practice guidelines

- Improve quality of health care delivery with valid, timely, and comprehensive data
Electronic Health Records
Electronic Health Records

- Digitally record a patient’s longitudinal health record beyond oral health, and may include information such as:
  - Patient demographics
  - Summary or progress notes
  - Medications and allergy lists
  - Vital signs
  - Immunization records
  - Laboratory or pathology reports
Physician EHR Adoption

<table>
<thead>
<tr>
<th>Year</th>
<th>Maryland</th>
<th>National</th>
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<tbody>
<tr>
<td>2007</td>
<td>11.8%</td>
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<tr>
<td>2008</td>
<td>16.9%</td>
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<tr>
<td>2012</td>
<td>49.2%</td>
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Note: National survey data permits benchmarking Maryland’s progress. The small national sample size (~15,000) does not allow for more detailed analysis. Maryland calculates EHR adoption based on census data obtained from ~15,600 active physicians through the annual Maryland Board of Physicians licensure process. In 2009 the methodology for measuring EHR adoption among active, office-based physicians was modified to align with the national methodology.
EHR Adoption by Setting in Maryland

Notes
• Primary Care includes: family practice, general practice, internal medicine, pediatrics, and obstetrics and gynecology.
• Physician data are from the 2012 Maryland Board of Physicians licensure data.
• Hospital Based settings include acute general, psychiatric, rehabilitation, chronic, and pediatric hospitals; hospital laboratories.
• Office Based settings include freestanding physician offices, certain clinic/outpatient-departments, and penitentiary settings.
• Other Settings, such as community health centers, rehabilitation and extended care facilities, etc.
Medicare & Medicaid EHR Incentive Programs
EHR Incentive Programs Overview

• Created under the American Recovery & Reinvestment Act of 2009 (ARRA)

• Incentive programs for Medicare and Medicaid
  
  • Medicare incentive program is federally run by CMS
  
  • Medicaid incentive program is run by states and is voluntary

• Available to hospitals and eligible professionals (EPs)

• Must use certified EHR technology AND demonstrate adoption, implementation, upgrading or meaningful use
## Eligibility

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<td><strong>Doctors of medicine or osteopathy</strong></td>
<td><strong>Doctors of medicine or osteopathy</strong></td>
</tr>
<tr>
<td>Doctors of podiatric medicine</td>
<td>Nurse practitioners</td>
</tr>
<tr>
<td>Doctors of optometry</td>
<td>Certified nurse-midwives</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>Dentists</td>
</tr>
<tr>
<td>Doctors of dental surgery or dental medicine</td>
<td>Physicians assistants working in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is so led by a physicians assistant</td>
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</table>

Hospital-based EPs are NOT eligible for incentives
90% or more of their covered professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital

* Receives 2/3 of a Physician’s incentive amount
Medicare Incentive Payments Overview

- Incentive amounts based on fee-for-service allowable charges
- Only one incentive payment per year
  - Incentives decrease if participating after 2012
  - Maximum incentives are $44,000 over five years
- Extra bonus amount available for practicing predominantly in a Health Professional Shortage Area
- Must begin by 2014 to receive incentive payments
- Last payment year is 2016
# Medicare Incentives Timeline

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- **Columns** = calendar year EP qualifies to receive first payment
- **Rows** = payment amount yearly if meeting requirements

- **TOTAL** = $44,000 for CY 2011, $44,000 for CY 2012, $39,000 for CY 2013, $24,000 for CY 2014, $0 for CY 2015 and later.
Medicaid Incentive Payments Overview

- Only one incentive payment per year
  - Incentives are same regardless of start year
  - First year payment is $21,250
  - Maximum incentives are $63,750 over six years
- No extra bonus available for health professional shortage areas
- Must begin by 2016 to receive incentive payments
- Incentives available through 2021
# Medicaid Incentives Timeline

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</table>

- **Columns** = calendar year EP qualifies to receive first payment
- **Rows** = payment amount yearly if meeting requirements
How to Participate

• All providers must:
  
  • Register via the EHR Incentive Program website
  
  • Be enrolled in Medicare FFS, MA, or Medicaid (FFS or managed care)
  
  • Have a National Provider Identifier (NPI)
  
  • Use certified EHR technology

  • Medicaid providers may adopt, implement, or upgrade in their first year

  • List of certified EHRs available here http://oncchpl.force.com/ehrcert

• All Medicare providers and Medicaid eligible hospitals must be enrolled in PECOS http://www.cms.gov/EHRIncentivePrograms
What You Need to Participate (Continued)

• Registration: Medicaid Specific Details

• Maryland eMIPP system [https://emipp.dhmh.maryland.gov/](https://emipp.dhmh.maryland.gov/) will interface with the CMS EHR Incentive Program registration website

• EPs must be enrolled with Medicaid FFS
  • Includes MCO-based providers
  • Special process for enrolling eligible PAs and certain unique provider types
  • Eligible rendering providers can participate, but payments will go to NPIs unless they change provider status

• EPs must be also have an active eMedicaid account at:
  [https://encrypt.emdhealthchoice.org/emedicaid/](https://encrypt.emdhealthchoice.org/emedicaid/)
Meaningful Use Requirements and Clinical Quality Measures
Meaningful Use

- Use of certified EHR technology to improve health care and population health and engage patients, while maintaining privacy and security


Phase 1: Data capture and sharing

Phase 2: Advanced clinical processes

Phase 3: Improved outcomes
Meaningful Use Requirements

• Reporting period is 90 days for the first year and then one year subsequently

• Must report core and menu objectives and Clinical Quality Measures (CQM)
  • 15 core objectives
  • 5 of 10 menu objectives (at least 1 public health objective)
  • 6 CQMs (3 core or alternate core, and 3 out of 38 from menu set)
  • Reporting may be yes/no or numerator/denominator attestation for first year and then CQM submitted electronically in 2014

• To meet certain objectives/measures, 80% of patients must have records in the certified EHR technology
Meaningful Use Requirements (continued)

- EPs – 15 Core Stage 1 Objectives
  - Computerized physician order entry (CPOE) – 30%
  - E-Prescribing (eRx) – 40%
  - Report ambulatory clinical quality measures to CMS/States
  - Implement one clinical decision support rule
  - Provide patients with an electronic copy of their health information, upon request – 50%
  - Provide clinical summaries for patients for each office visit – 50%
  - Drug-drug and drug-allergy interaction checks
  - Record demographics – 50%
EPs – 15 Core Stage 1 Objectives (continued)

- Maintain an up-to-date problem list of current and active diagnoses – 80%
- Maintain active medication list – 80%
- Maintain active medication allergy list – 80%
- Record and chart changes in vital signs – 50%
- Record smoking status for patients 13 years or older – 50%
- Capability to exchange key clinical information among providers of care and patient-authorized entities electronically (removed starting in 2013)
- Protect electronic health information
Meaningful Use Requirements (continued)

• Menu objectives - must complete five of 10

• At least one public health objective must be selected (noted by an asterisk *)

• EPs – 10 Stage 1 Menu Objectives
  ▪ Drug-formulary checks
  ▪ Incorporate clinical lab test results as structured data – 80%
  ▪ Generate lists of patients by specific conditions
  ▪ Send reminders to patients per patient preference for preventive/follow up care – 20%
  ▪ Provide patients with timely electronic access to their health information – 10%
Meaningful Use Requirements (continued)

- EPs – 10 Stage 1 Menu Objectives (continued)
  - Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate – 10%
  - Medication reconciliation – 50%
  - Summary of care record for each transition of care/referrals – 50%
  - Capability to submit electronic data to immunization registries/systems*
  - Capability to provide electronic syndromic surveillance data to public health agencies*
CQM Reporting in 2013

- CQM reporting will remain the same through 2013
  - 44 EP CQMs
    - Three core or alternate core (if reporting zeroes in the core) plus three additional CQMs
    - Report minimum of 6 CQMs (up to 9 CQMs if any core CQMs were zeroes)
  - 15 Eligible Hospital and CAH CQMs
    - Report all 15 CQMs
- In 2012 and continued in 2013, two methods are available for reporting-Stage 1 measures
  - Attestation
  - eReporting pilots
    - Physician Quality Reporting System EHR Incentive Program Pilot for EPs
- Medicaid providers submit CQMs according to their state-based submission requirements
CQM Specifications in 2013

- CQMs are no longer a core objective of the EHR Incentive Programs beginning in 2014, but all providers are required to report on CQMs in order to demonstrate meaningful use.

- Electronic specifications for the CQMs for reporting in 2013 will not be updated.

- Flexibility in implementing EHRs in the 2014 edition certification criteria in 2013.
  - Providers could report via attestation CQMs finalized in both Stage 1 and Stage 2 final rules.
  - For EPs, this includes 41 of the 44 CQMs finalized in the Stage 1 final rule.
Electronic Submission of CQMs
Beginning in 2014

• Beginning in 2014, all Medicare-eligible providers in their second year and beyond of demonstrating meaningful use must electronically report their CQM data to CMS

• Medicaid providers will report their CQM data to their State, which may include electronic reporting
CQMs Beginning in 2014

• A complete list of CQMs required for reporting beginning in 2014 and their associated National Quality Strategy domains will be posted on the CMS EHR Incentive Programs website (www.cms.gov/EHRIncentivePrograms)

• CMS will include a recommended core set of CQMs for EPs that focus on high-priority health conditions and best-practices for care delivery
  • Nine for adult populations
  • Nine for pediatric populations
Payment Reduction and Hardship Exemptions

Medicare Only
A Medicare EP who does NOT demonstrate meaningful use by 2015 will be subject to payment reductions in their Medicare reimbursement schedule.

The HITECH Act stipulates that for Medicare EPs, a payment decrease of about 1% applies yearly if they are not a meaningful EHR user.

Adopt, implement and upgrade ≠ meaningful use

A provider receiving a Medicaid incentive for AIU would still be subject to the Medicare payment adjustment.
Hardship Exceptions

• Infrastructure
  • EPs must demonstrate that they are in an area without sufficient Internet access or face insurmountable barriers to obtaining the necessary health IT infrastructure (e.g., lack of broadband)

• New EPs
  • Newly practicing EPs who would not have had time to become meaningful users can apply for a two-year limited exception to payment adjustments

• Unforeseen Circumstances
  • Examples may include a natural disaster or another unforeseeable barrier
Hardship Exceptions (continued)

• Patient Interaction:
  • Lack of face-to-face or telemedicine interaction with patients
  • Lack of follow-up needed with patients

• Practice at multiple locations
  • Lack of control over availability of CEHRT for more than 50% of patient encounters
Leading Resources to Learn More

• Get information, tip sheets and more at CMS’ official website for the EHR incentive programs:
  
  http://www.cms.gov/EHRIncentivePrograms

• Learn about certification and certified EHRs, as well as other ONC programs designed to support providers as they make the transition:
  
  http://healthit.hhs.gov
Maryland State-Regulated Payor EHR Incentive Program
State EHR Incentive

- Eligibility – Primary care practices, including Family, General, Internal Medicine, Pediatrics, Geriatrics, and Gynecology

- Primary care practices must adopt a certified EHR in order to qualify

- The six largest private payors required to provide incentives include:
  - Aetna
  - CareFirst
  - Cigna
  - Coventry
  - Kaiser Permanente
  - United Healthcare
Available State EHR Incentive

- One time payment per payer

- Base Incentive of up to $7,500 – based on the practice’s panel members, calculated at $8 per member

- Additional Incentive of up to $7,500 – based on advanced EHR use and may include:
  - Contracts with a State Designated Management Service Organization (MSO) or an MSO in Candidacy status for EHR adoption or implementation services
  - Demonstrates advanced use of EHRs as determined by each payor
  - Participates in the payor’s quality improvement outcomes initiative and achieves the per maximum value of $15,000 per practice per payor
  - Performance goals established by the payor
Applying for the Incentive

• Practices can complete and submit the EHR Adoption Incentive Application (application) to each payor

• The EHR adoption incentive program ends January 1, 2015, and applications must be submitted prior to June 30, 2014

• Six months following the application, practices should submit a payment request to each payor

• Payors must process and pay in full each payment request within 90 days of receipt

• Practices have the option to request the Base Incentive and the Additional Incentive at the same time or request the Additional Incentive in a subsequent payment request

• More information is available at:
  http://mhcc.dhmh.maryland.gov(hit/ehr/Pages/stateincentive/stateehrincentive.aspx)
Health Information Exchange
HIE Overview

• HIE is the secure electronic sharing of clinical and administrative information among disparate health information systems for clinical care, process improvement and simplification, research, and reporting

• Providers can join networks to securely access and exchange patient health information electronically

• HIEs have the potential to create efficiencies in health care delivery by reducing duplicate medical tests and improving care coordination among health care providers, leading to better health outcomes for patients
HIE - The Vision

• Advance the health and wellness of Marylanders by deploying health information technology solutions adopted through cooperation and collaboration

• Enable and support the Maryland health care community to appropriately and securely share data in order to:

  • Create efficiencies in the health care delivery system

  • Reduce duplicate medical tests and improve care coordination among health providers

  • Enable providers to view a patient’s full record electronically, which could include other physician visits, lab work, medications, etc.
Development of the Statewide HIE

- Planning and legislative authority
  
  - Two multi-stakeholder groups worked independently to identify the best implementation strategy (May 2008 - Feb. 2009)
  
  - Legislative authority to designate a statewide HIE in May 2009 - House Bill 706, *Electronic Health Records – Regulation and Reimbursement*
  
- The Chesapeake Regional Information Systems for our Patients (CRISP) was competitively selected in August 2009 as the State-Designated HIE
  
  - CRISP is a not-for-profit collaborative effort among the Johns Hopkins Health System, MedStar Health, University of Maryland Medical System, Erickson Retirement Communities, and Erickson Foundation, and more than two dozen major stakeholders across the state
Maryland’s State-Designated HIE

- Went live with encounter data in the five Montgomery County hospitals in September 2010
- All 46 acute care hospitals and two specialty hospitals are connected and provide admission, discharge, and transfer information
- Around 40 hospitals send clinical data (e.g., labs, radiology, clinical documents) to the HIE
- Two national laboratory and three radiology centers are connected and provide laboratory and radiology reports
CRISP’s Services

1. **Query Portal**

   Gives providers access to obtain clinical information about their patients, such as prior hospital and medication records.

2. **Encounter Notification Service (ENS)**

   Notifies providers in real-time about their patients' encounters with any Maryland hospital.

3. **Direct Secure Messaging**

   Enables referrals and other care coordination efforts to be conducted through secure e-mail.
CRISP Portal
CRISP Portal

- Providers can query the HIE portal for information about their patients.

- Information obtained can be downloaded or printed and incorporated into patient health records.

- Single sign on integration can be enabled (with some effort) allowing providers to click a CRISP button in their EHR to see external data available in the HIE.

Types of data available:

- Patient demographics
- Lab results
- Radiology reports
- Medication fill history
- Discharge summaries
- History and physicals
- Operative notes
- Consults
### Portal Lab Results

#### Order Info
- **Order Type:** Laboratory
- **Observation Date:** Mar 30, 2013 5:00:00 AM
- **Status:** Final results; Can only be changed with a corrected result.
- **Placer Order Id:** 005148754001
- **Filler Order Id:** 2000103309

#### Providers On Order
- **Ordering Provider:** Council, Joseph

#### Source Information
- **Source:** CRISP General Hospital
- **Received On:** Jul 25, 2013 12:35:03 PM

#### Encounter
- **Admission Type:** Emergency
- **Source:** CRISP General Hospital
- **Class:** Inpatient
- **Attending Provider:** Lopez, Eugene
- **Admission Date:** Mar 28, 2013 3:28:00 PM

#### CBC W/ AUTO DIFF
- **Status:** Final results; Can only be changed with a corrected result.
- **Placer Field 1:** 04212
- **Placer Field 2:** CRAG
- **Filler Field 1:** RESULT
- **Reported Date:** Mar 30, 2013 6:27:04 AM

#### Observations
- **Observed:**
**Portal Radiology Reports**

**Imaging**

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**Encounter**

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**CHEST, SINGLE VW (A/P-P/A)**

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**Notes**

EXAM: portable chest. 1252 hours
## Portal Clinical Documentation

### Documentation

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- **Order Type**: Clinical Documentation
- **Observation Date**: Apr 1, 2013 2:22:26 PM
- **Status**: Final results; Can only be changed with a corrected result.
- **Filler Order Id**: 130357817

#### Providers On Order

#### Source Information
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- **Received On**: Jul 25, 2013 12:35:01 PM

### Encounter

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### OPERATIVE REPORT

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#### Notes
- Operative Report

**DATE OF SURGERY: 03/29/2013**
### Portal Prescription Drug Monitoring

**Medications**

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**Medication**

- **Name**: OXYCODONE HCL 10 MG TABLET
- **Start Date**: Apr 24, 2013 12:00:00 AM

**More Information**

- **Prescribing Provider**: Caruso, Thomas D
- **Refills Remaining**: 0 of 0
- **Total Refills**: 0

**Pharmacy Information**

- **Name**: NEW MARKET PHARMACY LLC, FN2757485
- **Address**: 29015 THREE NOTCH ROAD UNIT 7, MECHANICSVILLE, MD 20659 US

**Source Information**

- **Source**: Maryland Prescription Drug Monitoring Program
- **Received On**: Sep 19, 2013 5:20:50 PM

**Notes / Comments**

- **Days Supply**: 29
- **Method of Payment**: Commercial Insurance
CRISP Portal

- ENS enables participants to receive real-time notifications when one of their patients or members is hospitalized.
- The alerts are generated from the “ADT” messages CRISP receives from participating hospitals.
- Participants can only subscribe to “active patient or members”.
- If an individual has opted out of the HIE, an alert will not be triggered.
- In Maryland, there are currently over 3,000,000 patients subscribed, resulting in over 2,000 notifications per day.
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Thank You!

Angela Evatt
Chief, Health Information Exchange
410-764-3574
Angela.Evatt@maryland.gov
mhcc.dhmh.maryland.gov