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

MAOP Annual Meeting

October 12, 2014
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
- Telehealth Initiatives
- Questions
• The Maryland Health Care Commission (MHCC or Commission) is an independent regulatory agency whose mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public.

• The Commission's vision for Maryland is to ensure that informed consumers have access to affordable and appropriate health care services through programs that serve as models for the nation.
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
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
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
Expanding EHR Adoption and Use

“I can’t decide which smartphone to buy. Which one will solve all my problems and make my life perfect?”
Maryland Data – Maryland Board of Physicians
National Data – National Center for Health Statistics
Dash lines – Preliminary Data

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 physician 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.
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)
## Eligibility

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
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</thead>
<tbody>
<tr>
<td><em>Doctors of medicine or osteopathy</em></td>
<td><em>Doctors of medicine or osteopathy</em></td>
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<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><em>Doctors of dental surgery or dental medicine</em></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
- Must begin by 2014 to receive incentive payments
- Last payment year is 2016
# Medicare Incentives Timeline

<table>
<thead>
<tr>
<th>Payment Schedule</th>
<th>First Payment Received in 2011</th>
<th>First Payment Received in 2012</th>
<th>First Payment Received in 2013</th>
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<td>Reduction ($40)</td>
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<td>$43,720</td>
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Reduction: Incentive payments made through the Medicare EHR Incentive Program are subject to the mandatory reductions in federal spending known as sequestration, required by the Budget Control Act of 2011. Under these mandatory reductions, incentive payments are reduced by 2%.
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
  - Must begin by 2016 to receive incentive payments
- Incentives available through 2021
# Medicaid Incentives Timeline

<table>
<thead>
<tr>
<th>Payment Schedule</th>
<th>1st Payment Received in 2012</th>
<th>1st Payment Received in 2013</th>
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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 current 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 https://pecos.cms.hhs.gov/pecos/login.do
What You Need to Participate

• Registration: Medicaid Specific Details
• Maryland eMIPP system
  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
• Contact Provider Enrollment at (410) 767-5340
• EPs must be also have an active eMedicaid account at:
  https://encrypt.emdhealthchoice.org/emedicaid/
### Stages of Meaningful Use

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For 2014 only: All providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a three-month EHR reporting period.
New 2014 CEHRT Rule

- On August 29, 2014 CMS and ONC released a final rule that allows providers to use the 2011 Edition of certified electronic health record technology (CEHRT) for calendar and fiscal year 2014.

- The rule grants flexibility to providers unable to fully implement 2014 Edition CEHRT for an EHR reporting period in 2014 due to delays in 2014 CEHRT availability.

New Maryland MU Resource Center

The Medicare and Medicaid EHR Incentive Programs were created under the American Recovery and Reinvestment Act (ARRA) to provide financial incentives to Eligible Providers and Eligible Hospitals who adopt and demonstrate meaningful use of electronic health records (EHRs). Achieving Meaningful Use can be a confusing and challenging endeavor for providers and their staff. The Meaningful Use Resource Center was created to provide a single, comprehensive informational tool for Eligible Professionals and their staff as they work towards meeting the Meaningful Use requirements.

If you have additional Meaningful Use questions, please call or email CRISP at:
1-877-852-7477
support@crisphealth.org

Meaningful Use Updates

September 16, 2014 - CRISP and the Maryland Department of Health and Mental Hygiene held Meaningful Use Update Webinars on Wednesday, September 24th and Thursday, September 25th. Click here to view the presentation.

August 29, 2014 - CMS has announced a final rule on 2014 Certified EHR Technology. Read the CMS Quick Guide here and check out an interactive tool to help understand your options here.

Acknowledgements

The Maryland Meaningful Use Resource Center was developed by the Chesapeake Regional Information System for our Patients (CRISP), with documentation and support from the Maryland Department of Health and Mental Hygiene (DHMH), EHR vendors, the Office of the National Coordinator for Health Information Technology (ONC), and the Centers for Medicare & Medicaid Services (CMS).
Payment Adjustments and Hardship Exemptions

Medicare Only
Medicare Payment Adjustments

• Attestation deadline to avoid payment adjustment for Medicare eligible professionals is Oct 1st 2014.

• Must demonstrate Meaningful Use by Oct 1st 2014

• Medicare payment adjustments of 1% per

  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

- To be considered for an exception, an EP must complete a Hardship Exception application along with proof of the hardship
  - 2015 Eligible Professional Hardship application deadline was July 1, 2014
  - 2016 Eligible Professional Hardship application will be available soon
- If approved, the hardship exception is valid for 1 payment year only
- A new application must be submitted if the hardship continues for the following payment year.
- In no case may a provider be granted an exception for more than 5 years

Automatic Hardship Exceptions

- Some providers will automatically be granted an exception for 2015; CMS will use Medicare data to determine their exception

- The following providers do not need to submit a hardship application:
  - New providers in their first year
  - EPs who are hospital-based
  - Eligible professionals in which 90% of their claims include POS 21, POS 23 and certain observation services using POS 22
  - EPs with certain PECOS specialties (05-Anesthesiology, 22-Pathology, 30-Diagnostic Radiology, 36-Nuclear Medicine, 94-

- EPs should verify that their PECOS specialty is up to date
Maryland State-Regulated Payor EHR Incentive Program
State EHR Incentive

- Eligibility – Primary care practices, including Family, General, Internal Medicine, Pediatrics, Geriatrics, and Gynecology; including those lead by a Nurse Practitioner
- 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
How Do Practice Qualify

- An EHR must be certified by an Authorized Testing and Certification Body designated by the Office of the National Coordinator for Health Information Technology.

- In order to qualify, the practice must:
  
  - Demonstrate that a Physician or Nurse Practitioner within the practice has attested to the current Meaningful Use requirements under the Medicaid or Medicare EHR Incentive Program; or

  - Participates in a Maryland Health Care Commission (MHCC) approved patient-centered medical home (PCMH) program and has achieved the National Committee for Quality Assurance's (NCQA) 2011 or later standards for at least level two PCMH recognition.
Available State EHR Incentive

- One time payment per payer
- An incentive from each payor is based on the payor’s share of members treated by the practice
- Calculated at $25 per member and limited to Maryland residents
  - Based on each fully-insured patient assigned to a provider within the practice; or
  - In cases where the payor does not assign patients, the fully-insured patients enrolled with that payor who have been treated by the practice in the last 24 months

The payment is per practice, not per provider.
Requesting an Incentive

• Practices can complete and submit the EHR Adoption Incentive Payment Request to each payor

• The revised EHR adoption incentive program begins on October 7, 2014 and ends December 31, 2016

• Payors must process and pay in full each payment request within 45 days of receipt of a complete 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
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 Maryland acute care hospitals and two specialty hospitals are connected and provide admission, discharge, and transfer information

- Around 45 Maryland 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**
   Search for your patients’ prior hospital and medication records

2. **Maryland Prescription Drug Monitoring Program (PDMP)**
   Monitor the prescribing and dispensing of drugs that contain controlled dangerous substances

3. **Advance Directives**
   Find patient submitted advance directives

4. **Encounter Notification Service (ENS)**
   Be notified in real time about patient visits to the hospital
While Maryland was one of the last states to enact PDMP legislation, we were in a position to pursue a unique / powerful approach.

The program requires all pharmacies licensed to dispense controlled dangerous substances in Maryland to report dispense records for Schedule II through V drugs.

Maryland approach to PMDP took public health and intervention orientation to the program and placed integration with CRISP as a priority.

We are currently working on establishing additional medication data through the SureScripts network.
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<th>Name</th>
<th>Source</th>
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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**: 28
- **Method of Payment**: Commercial Insurance
Advance Directives Query
Directive View

Summary for Physicians

ROGER RIENMAN MCBEE

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Final Preferences

Final Days:
- At home. I want hospice care at home if possible.

Organ Donation:
- I want to donate Heart, Kidneys, Eyes to help save someone else’s life.

Autopsy:
- I want an autopsy if my doctor thinks it will help others.

My Thoughts

My likes / joys:
- Like Bach, especially the cantatas. St. Martin in the Fields.

How to care for me:
- I don’t like being treated like an object. I would like to be greeted like a person before working on me.

My religion:
- Not Religious

My unfinished business:
- I am awaiting a message from the...
How Does CRISP Receive Hospital Encounter Information?

A patient goes to the hospital

At registration the hospital asks the patient for basic information (name, DOB, etc.) and the reason for the visit.

The registrar enters that information into an Electronic Medical Record.

When the registrar is completed entering that information, and pushes ‘save’, a copy of that information is immediately sent to CRISP.
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How Do Facilities Enroll in ENS?

- When enrolling in CRISP ENS, the doctor’s office or SNF must supply CRISP with a list of patients they wish to be alerted on.

- CRISP works with providers to help them generate an excel spreadsheet or automatic feed of the patients they wish to ‘subscribe’ to.

- A provider can subscribe to any patient they have a treatment or care coordination relationship with.

For more information visit: http://crisphealth.org/CRISP-HIE-SERVICES/Encounter-Notification-System-ENS
Telehealth
Telehealth

- The delivery of health education and services using telecommunications and related technologies in coordination with health care practitioners

- Wide-range of benefits:
  - Helps increase access to health care and reduce health disparities
  - Improves time-to-diagnosis by eliminating distance and time barriers
  - Creates efficiencies in health care delivery
Telehealth Landscape

• Where is adoption today?
  • Fragmented adoption - acute care hospitals ~ 46 percent; physicians ~ 12 percent; pharmacies and supermarkets beginning to develop programs
  • Minimal use - about 50 providers submitted roughly 78 telemedicine claims to State-regulated payors from October 1, 2012 through June 30, 2013

• Why is adoption so low?
  • Despite the potential of telehealth to enhance care delivery, adoption is not expected to increase significantly absent widespread adoption of value-based care
  • Existing fee-for-service models incentivize episodic care, limiting incentives for providers to invest in new models of care delivery
Telemedicine Task Force

- 2010 – established by the Maryland Health Quality and Cost Council (Council) to explore telehealth expansion in Maryland

- 2011 – reconvened with the establishment of three advisory groups to develop recommendations for increasing telehealth adoption

- 2013 – State law required MHCC and the Council to study the use of telehealth by reconvening the task force

  - Comprised of public and private stakeholders and

Convened approximately 28 times between July 2013 and July 2014; roughly 149 individuals participated.
Legislative Activity

• Senate Bill 781 (2012)
  • Requires State-regulated payors to provide coverage for health care services delivered through telemedicine

• Senate Bill 798 (2013)
  • Enables hospitals to rely on credentialing and privileging decisions made by distant site

• Senate Bill 496 (2013)
  • Requires the Maryland Medical Assistance Program to provide reimbursement for certain services delivered through telemedicine under certain circumstances

• Senate Bill 776 (2013)
  • Requires MHCC, in conjunction with the Maryland Health Quality and Cost Council, to reconvene the 2010 task force
2014 Task Force

Charge: Identify opportunities for telemedicine to improve health status and care delivery

- Clinical Advisory Group
  
  Recommend Innovative Telehealth Use Case Categories

- Finance and Business Model Advisory Group
  
  Identified telehealth financial and business model challenges
Thank You!

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