

Department of Legislative Services
Maryland General Assembly
2009 Session

FISCAL AND POLICY NOTE
Revised

House Bill 706 (Delegate Pena-Melnyk, *et al.*)
Health and Government Operations

Finance

Electronic Health Records - Regulation and Reimbursement

This bill requires the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) to designate a State health information exchange (HIE) by October 1, 2009. By various deadlines, MHCC also must (1) adopt regulations requiring “State-regulated payors” to provide incentives to providers to promote the adoption and meaningful use of electronic health records (EHRs); (2) designate one or more management service organizations (MSOs) to offer EHR services; and (3) submit specified reports.

Beginning the later of January 1, 2015, or the date established for the imposition of penalties under the federal American Recovery and Reinvestment Act of 2009 (ARRA), each provider using an EHR that seeks payment from a State-regulated payor must use EHRs that are certified by a national certification organization designated by MHCC and capable of connecting to and exchanging data with the State HIE. State-regulated payors may reduce payments to health care providers for noncompliance with these requirements.

The bill takes effect July 1, 2009.

Fiscal Summary

State Effect: Potential increase in general fund revenues to be offset by expenditures necessary to adopt use of HER beginning in FY 2012. Potentially significant increase in expenditures for the State Employee and Retiree Health and Welfare Benefits Program (the State plan) for provider incentives beginning in FY 2012. MHCC special fund expenditures increase by \$50,000 in FY 2011 for one-time consulting services and by \$132,000 in FY 2013 for personnel and additional one-time consulting services. Future years reflect inflation.

(in dollars)	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
GF Revenue	\$0	\$0	-	-	-
GF Expenditure	\$0	\$0	-	-	-
SF Expenditure	\$0	\$50,000	-	\$132,000	\$81,800
GF/SF/FF Exp.	\$0	\$0	-	-	-
Net Effect	\$0	(\$50,000)	\$0	(\$132,000)	(\$81,800)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: Potential increase in revenues and expenditures for local health departments due to provider incentives beginning in FY 2012. To the extent health insurance premiums increase under the bill, local jurisdiction expenditures may increase.

Small Business Effect: Meaningful. Small business health care providers receive incentives toward the cost of adopting EHR. Those providers that do not comply with the bill by the required date may receive reduced reimbursement from State-regulated payors.

Analysis

Bill Summary: “Electronic health record” means an electronic record of health-related information that includes patient demographic and clinical health information and has the capacity to provide clinical decision support, support physician order entry, capture and query information relevant to health care quality, and exchange electronic health information with and integrate the information from other sources. “Health care provider” includes both licensed health care practitioners and facilities where health care is provided. “State-regulated payor” means the State plan and carriers issuing or delivering health benefit plans in the State.

Regulations Regarding Incentives for the Adoption and Use of EHRs: By September 1, 2011, MHCC, in consultation with specified stakeholders, has to adopt regulations that require State-regulated payors to provide incentives to health care providers to promote the adoption and meaningful use of EHRs. Any incentives must have monetary value, facilitate the use of EHRs, recognize and be consistent with existing payor incentives regarding EHRs, and take into account incentives under Medicare and Medicaid and available federal grants or loans. Incentives may include increased reimbursement for specific services, lump sum payments, gain-sharing arrangements, rewards for quality and efficiency, in-kind payments, and other items or services to which a specific monetary value can be assigned. The regulations need not require incentives for all health care providers defined under the bill. If federal law is amended to allow the State to regulate payments made by entities that self-insure their health benefit plans, these regulations must be applied equally to those entities.

Designation of Management Service Organizations: By October 1, 2012, MHCC has to designate one or more MSOs to offer EHR services throughout the State. MHCC may use federal grants and loans to help subsidize the use of the designated MSO(s) by health care providers.

Reporting Requirements: By January 1, 2010, MHCC has to report on progress in implementing an HIE and adopting regulations regarding incentives to providers to adopt and use EHRs.

By January 1, 2011, following consultations with stakeholders, MHCC must submit a report on (1) development of a coordinated public-private approach to improve the State's health information infrastructure; (2) any statutory changes necessary to protect the privacy and security of specified health information; (3) any statutory changes necessary to provide for effective operation of an HIE; (4) any actions necessary to align funding opportunities under ARRA with other initiatives related to health information technology; and (5) recommended regulatory language. The Senate Finance Committee and the House Health and Government Operations Committee must be given 60 days for review and comment on this report. The report must be posted on the MHCC web site for public comment.

By October 1, 2012, MHCC must report on progress achieved toward adoption and meaningful use of EHRs by health care providers and recommendations for any statutory changes necessary to achieve optimal adoption and use.

Assurance of Receipt of Payments Provided under ARRA: HSCRC, in consultation with hospitals, payors, and the federal Centers for Medicare and Medicaid Services (CMS), must assure that hospitals receive payments provided under ARRA and implement any changes in hospital rates required by CMS to ensure compliance with ARRA. The Department of Health and Mental Hygiene (DHMH), in consultation with MHCC, has to develop a mechanism to assure that health care providers that participate in Medicaid receive the payments provided for adoption and use of EHR technology under ARRA.

Current Law/Background:

Task Force to Study Electronic Health Records: Chapter 291 of 2005 created a Task Force to Study Electronic Health Records. The task force studied the current use and potential expansion of EHR systems in Maryland. The task force's final report, issued in December 2007, presented 13 recommendations, including balancing the relationship of health information technology (health IT) costs and benefits through a system of payments and subsidies and implementing a statewide health information exchange. The task force found that health IT dissemination has not occurred rapidly in Maryland in part due to the high costs for providers, including initial capital investment, staff training, temporary decrease in productivity while the system is being implemented, and ongoing

maintenance. Absent reimbursement reform, the task force noted that there may be a poor, even negative, incentive for physician investment in health IT. Further, while providers assume the high cost of health IT acquisition and implementation, the majority of cost savings from improved efficiencies are generally realized by payors.

National Findings and Initiatives: The federal Department of Health and Human Services asserts that there are many benefits of EHR, including fewer medical errors and redundant procedures, faster diagnoses and treatment of serious illnesses, timely health screenings, better communication between patients and physicians, and shorter wait times for patients as well as lower operating costs for physicians.

At the national level CMS has a number of initiatives designed to encourage the growth of HIEs. ARRA makes comprehensive health IT reforms, including establishing the Health Information Technology for Economic and Clinical Health (HITECH) Act, a federal program that structurally and economically supports the development of health IT. Monetary incentives are available to Medicaid and Medicare providers to encourage adoption of EHR. Medicare incentives are targeted at physicians and hospitals that demonstrate “meaningful use” of EHR, including the use of interoperable technology and the ability to report data. Incentive payments are phased out over a six-year period followed by penalties imposed on nonadopters. Medicaid incentives provide 100% federal funding to certain providers that serve a high volume of Medicaid patients and to federally qualified health centers and rural health clinics that treat low-income patients. As with the Medicare incentives, the Medicaid incentives are provided on a phased-down basis. ARRA includes a total of \$19.0 billion in funding for health IT, quality, and information privacy activities.

Current Health IT Efforts in Maryland: Maryland is one of four states selected for a five-year CMS demonstration project to help primary care physicians adopt EHR. Beginning June 2009, CMS will provide a modest initial payment and future incentives based on clinical performance for up to 200 physician practices. A solo practice can earn up to \$58,000 and a larger practice approximately \$290,000 over the five-year period.

MHCC’s Center for Health Information Technology is planning a “citizen-centric” statewide health information exchange. Two multi-stakeholder planning groups – Chesapeake Regional Information Systems for Our Patients (CRISP) and the Montgomery County Health Information Exchange Collaborative – reported to MHCC on February 20, 2009 regarding governance, privacy and security policies, access issues, and strategies to assure appropriate patient engagement and control. A request for applications for the exchange is anticipated in April. Development of the exchange should begin in fiscal 2010 and take three to four years before full implementation. To date, these efforts have been funded using money from the hospital all-payor system. Funding for the implementation phase will include \$10.0 million from hospital rate adjustments.

Other States: According to the National Conference of State Legislatures, states have taken significant steps during the past two years to address policy issues associated with health IT. States are working to advance health information exchange by promoting interoperable health IT tools and establishing and sustaining health information exchange organizations and infrastructure.

At least 13 states have established a statewide HIE, including Colorado, Connecticut, Indiana, Kansas, Louisiana, Maine, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Texas, and Vermont. Only two states, Minnesota and Massachusetts, have enacted mandates for the use of health IT tools. Minnesota requires hospitals and health care providers to have interoperable EHR systems by 2015, while Massachusetts tied implementation of EHR to facility licensure standards for hospitals and community health centers. One state, New York, allows providers who meet certain standards to receive supplemental payments for increased costs to use EHR. To receive payment, the provider must have an operational EHR system and a set percentage of patients who are on Medicaid or uninsured.

State Fiscal Effect: MHCC special fund expenditures increase by \$50,000 in fiscal 2011 to hire a consultant to assist with the development of regulations regarding appropriate incentives for health care providers to adopt and use EHRs.

Beginning in fiscal 2012 general fund revenues may increase for State health care facilities from provider incentives. These revenues are expected to be matched with expenditures by those facilities. *For illustrative purposes only*, DHMH estimates that the cost to implement its planned Computerized Health Record Information System (CHRIS) in 15 State-operated inpatient facilities is \$8.4 million, exclusive of operations and maintenance costs. The cost of developing an interface with an HIE for State facilities is estimated at \$500,000 in the first year and \$200,000 annually thereafter.

State plan expenditures (60% general funds, 20% special funds, 20% federal funds) increase by a potentially significant amount to provide incentives to health care providers as required by the regulations MHCC must adopt. The extent of the increase depends on the regulations issued by MHCC and cannot be reliably estimated but could be significant due to the large number of providers.

In fiscal 2013, MHCC special fund expenditures increase by \$132,010. This estimate includes the cost of hiring a one-time consultant to assist with the selection and designation of the MSO(s) and one full-time health policy analyst to administer MSO(s) and assist with HIE. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Position	1
Salary and Fringe Benefits	\$77,420
Contractual Expenses	50,000
Other Operating Expenses	<u>4,590</u>
Total FY 2013 Administrative Costs	\$132,010

Additional expenditures may be required to support HIE, but as such funding is not specified or required in the bill, those costs cannot be reliably estimated. Future year expenditures reflect a full salary with 4.4% annual increases and 3% employee turnover and 1% annual increases in ongoing operating expenses.

Additional Comments: While adoption of EHR and implementation of HIE by Maryland health care providers may require significant initial expenditures, future health care savings are anticipated for the State. A 2005 research study suggests that a fully implemented HIE could save states around \$500 million each year in reduced paperwork, test duplication, and community health status improvements.

Additional Information

Prior Introductions: None.

Cross File: SB 744 (Senator Rosapepe) - Finance.

Information Source(s): *An Overview of Major Health Provisions Contained in the American Recovery and Reinvestment Act of 2009*, S. Rosenbaum, *et al.*, February 18, 2009; Walker, *et al.* "The Value Of Health Care Information Exchange And Interoperability," *Health Affairs*, January 19, 2005; Task Force to Study Electronic Health Records, *Final Report*, December 31, 2007; U.S. Department of Health and Human Services; National Conference of State Legislatures; Department of Budget and Management; Maryland Health Insurance Plan; Department of Health and Mental Hygiene; Maryland Insurance Administration; Department of Legislative Services

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