SB 744

Department of Legislative Services

Maryland General Assembly
2009 Session

FISCAL AND POLICY NOTE

Senate Bill 744 (Senator Rosapepe)
Finance

Electronic Health Records - Regulation and Reimbursement

This bill requires the Maryland Health Care Commission (MHCC) to adopt regulations by specified dates regarding adoption and certification of electronic health records (EHR) and reimbursement of providers by "State-regulated payors" for costs associated with adopting EHR. MHCC must also designate a State health information exchange and a management service organization to host EHR.

Beginning October 1, 2014, all providers, including health care facilities, must use EHR in order to receive reimbursement. State-regulated payors are prohibited from reimbursing a health care provider that does not meet this requirement.

Fiscal Summary

State Effect: Potential increase in general fund revenues to be offset by expenditures necessary to adopt use of EHR. Potentially significant increase in expenditures for Medicaid, the State Employee and Retiree Health and Welfare Benefits Program, the Maryland Health Insurance Plan (MHIP), and the Department of Health and Mental Hygiene (DHMH) for enhanced provider reimbursement beginning in FY 2011. 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	-	-	-	-
GF Expenditure	$0	-	-	-	-
SF Expenditure	$0	$50,000	-	$132,000	$81,800
GF/SF/FF Exp.	$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 enhanced provider reimbursement beginning in FY 2011. 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 additional reimbursement toward the cost of adopting EHR. Those providers that do not comply with the bill by the required date are ineligible for 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 Maryland Medical Assistance Program (Medicaid), the State Employee and Retiree Health and Welfare Benefits Program (the State plan), and carriers (any person or entity that provides health benefits plans in the State).

By October 1, 2010, MHCC must adopt regulations that (1) require State-regulated payors to reimburse health care providers for the cost of the adoption of EHR; and (2) designate a health information exchange for the State. MHCC must determine the appropriate level of health care provider reimbursement, taking into account available federal funds. MHCC may not require additional reimbursement for hospitals regulated by the Health Services Cost Review Commission (HSCRC). To the extent allowed under federal law, these regulations apply to reimbursement by self-insured entities and Medicare.

By October 1, 2012, MHCC must adopt regulations that specify certification requirements for EHR. MHCC must also designate a management service organization to host EHR and provide other management services throughout the State. MHCC may use available federal funds to subsidize the use of the management service organization by health care providers.

Beginning October 1, 2014, every health care provider must use EHR that (1) are certified in accordance with standards adopted by MHCC; and (2) have interoperability with, are connected to, and are exchanging data with the health information exchange designated by MHCC. State-regulated payors are prohibited from reimbursing a health

care provider that does not use EHR as required under the bill. Hospitals regulated by the Health Services Cost Review Commission that do not use EHR may not be reimbursed by any payor for health care services. To the extent allowed under federal law, these requirements apply to reimbursement by self-insured entities and Medicare.

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, the Centers for Medicare and Medicaid Services (CMS) has a number of initiatives designed to encourage the growth of health information exchanges. The American Recovery and Reinvestment Act of 2009 (ARRA), makes comprehensive health IT reforms. ARRA establishes 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 health information exchange, 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 determination of appropriate reimbursement levels for health care providers for the cost of the adoption of EHR.

From fiscal 2011 through the first quarter of fiscal 2015, general fund revenues increase for services provided at State health care facilities from enhanced provider reimbursement. 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 a health information exchange for State facilities is estimated at $500,000 in the first year and $200,000 annually thereafter.

Expenditures for health care provider reimbursement increase by a potentially significant amount. Enhanced reimbursement is to be paid by Medicaid, the State plan, MHIP, and multiple administrations within the Department of Health and Mental Hygiene. The extent of the increase depends on the regulations issued by MHCC and cannot be reliably estimated but is expected to be significant due to the large number of providers. To the extent that federal funds are available for this purpose, general fund expenditures are reduced.

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 management service organization and one full-time health policy analyst to administer the management service organization and assist with the health information exchange. 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	4,590
Total FY 2013 Administrative Costs	**$132,010**

Additional expenditures may be required to support the health information exchange, 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 a health information exchange 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 health information exchange 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: HB 706 (Delegate Pena-Melnyk) - Health and Government Operations.

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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Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510