Electronic Health Records:

Incentives and Program Progress

August 2015

MARYLAND HEALTH CARE COMMISSION

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Introduction

The Maryland General Assembly passed a law in 2009[1] that requires certain State-regulated payors (payors) to offer incentives for providers to adopt electronic health records (EHRs). Similar efforts to promote the adoption and use of EHRs were also occurring at the federal level. The American Recovery and Reinvestment Act of 2009 authorizes the Centers for Medicare & Medicaid Services (CMS) to provide incentive payments to eligible professionals (EPs) and hospitals who adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. [2]

In 2009, 19 percent of Maryland office-based physicians had adopted an EHR, which trailed national adoption by approximately three percent. The Maryland Health Care Commission (MHCC) worked with the six largest payors and provider representatives in the State to establish an incentive program. The State incentive program requires payors to provide incentives to primary care practices (family, general, geriatric, internal medicine, pediatric, or gynecologic practices), including nurse practitioner-led practices.[3] Primary care practices are eligible to qualify for an incentive of up to $15,000 per payor, calculated at $25 per member. The current State incentive program enables primary care physician practices that meet select criteria to receive a financial incentive. In order to qualify, the practice must demonstrate that it has either: 1) attested to the current meaningful use requirements under the Medicare or Medicaid EHR Incentive Program (federal incentive programs); or 2) participates in any MHCC-approved patient centered medical home (PCMH) program, and has achieved recognition from the National Committee for Quality Assurance (NCQA) for meeting NCQA's 2011 or later standards for at least level two PCMH recognition.[4] The State incentive program was implemented in October of 2011.

Adoption among office-based physicians in Maryland is approximately 64 percent and leads the nation by roughly 10 percent (Figure 1). Widespread adoption and meaningful use of EHRs is necessary to transform health care. EHRs have the potential to make information available at the point of care; enable patients to have access to their electronic health information; and allow for more efficient exchange of a patient's health information. This information brief provides an update on the impact of the State incentive program and the initiatives aimed at encouraging program participation among eligible practices.

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[1] See Appendix A for Md. Code Ann., Health-Gen. § 19-143.

[2] The federal incentive program as detailed within 42 C.F.R. § 142, 143, 422, et. al. (2010). More information is available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html.

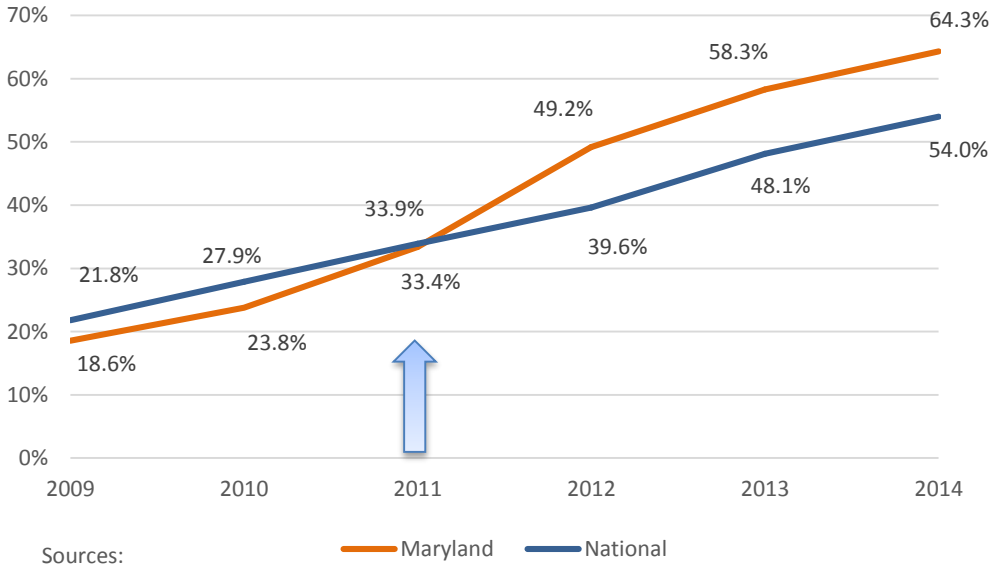
[3] Payors required to comply with the State incentive program include: Aetna, Inc.; CareFirst BlueCross BlueShield; Cigna HealthCare Mid-Atlantic; Coventry Health Care; Kaiser Permanente; and UnitedHealthcare, Mid-Atlantic Region.

[4] NCQA defines a PCMH as "a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner." http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx.

Incentive Program Alignment

In the summer of 2013, MHCC assessed the progress of the State incentive program and developed recommendations to ensure its continued progress in advancing the adoption and use of EHRs.[5] While the State incentive program had been impactful, the performance trailed when compared to practice participation in the federal incentive programs. About four percent of eligible primary care physician practices had received a State incentive, as compared to 29 percent that had received a payment under the federal incentive program, which went into effect in January 2011. The MHCC believes that the relatively low participation rate among eligible practices in the State incentive program was somewhat attributed to its misalignment with the requirements under the federal incentive programs. In an effort to drive value in using technology to improve care delivery and outcomes, MHCC, in coordination with stakeholders developed recommendations to align the State incentive program with the federal incentive programs. The most significant program change required at least one physician within the practices to attest to meaningful use under either federal incentive programs in order for the practice to qualify for a State incentive. Changes to the State incentive program were implemented on October 7, 2014.[6]

Figure 1: EHR Adoption Among Office-Based Physicians



Sources:

- Maryland Data – Maryland Board of Physicians
- National Data – 2009-2013 National Center for Health Statistics
- National Data – Centers for Medicare and Medicaid Services EHR Incentive Program data, December 2014

Raising awareness regarding the availability of the State incentives was also necessary to ensure practices take advantage of the opportunity. About the same time, MHCC in collaboration with MedChi, The Maryland State Medical Society; the Department of Health and Mental Hygiene (DHMH); the Chesapeake Regional Information System for our Patients (CRISP); and the Maryland Nurses Association targeted providers, via fax blasts, emails, newsletters, and website posts to raise awareness of the program. Efforts

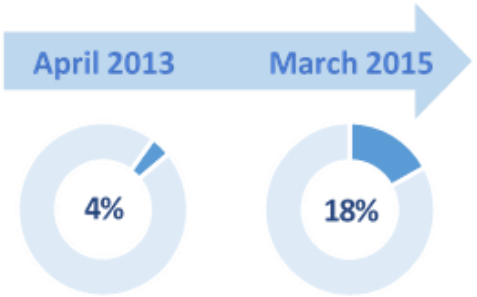
[5] The MHCC released a report entitled, Electronic Health Records: State Incentives and Usability Across Hospital Settings, available at: http://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_EHR_State_Incentives_Usability_20131101.pdf.

[6] Amended regulations went into effect on June 9, 2014 and allowed for a 120 day implementation period. See Appendix B for COMAR 10.25.16, Electronic Health Record Incentives.

focused on: 1) primary care providers that had either registered or attested under the federal incentive programs, 2) individuals who contacted the meaningful use help desk (operated by CRISP); and 3) management service organizations (MSOs) who work with providers to achieve meaningful use.

State Incentive Program and EHR Adoption Progress

Figure 2: State Incentive Program Participation



The State incentive program has been impactful in advancing EHR adoption statewide. EHR adoption among Maryland office-based physician has increased from 33 percent in 2011 to 64 percent in 2014 (Figure 1). Aligning the State incentive program with the federal incentive programs has resulted in an increase in the number of payments made to eligible practices.[7] Under the previous program, the number of applications that resulted in payments averaged 33 payments per month, while under the existing program, approximately 43 applications result in payment per month. Generally speaking, more practices are taking advantage of the State incentives, including those who have attested to meaningful use. As of March 2015, about 18 percent of the 2,025 eligible primary care practices have received a State Incentive, an increase of about 14 percent since April 2013 (Figure 2).[8, 9] Also, roughly 38 percent of the eligible primary care practices who have received a federal incentive have also received a State incentive; an increase of about 27 percent since April 2013.[10]

Remarks

Meaningful use of EHRs is an essential component of health care reform and can improve the quality of care, increase efficiencies, and reduce health care costs. The State incentive program has offset the investment costs of implementing an EHR for approximately 17 percent of primary care practices. Given the current rate of participation in the federal incentive programs, MHCC anticipates that nearly 1,289 (80 percent) practices eligible for a State incentive to attest to meaningful use by 2018. The MHCC plans to explore extending the State incentive program through 2018 to ensure all eligible practices are given adequate time to participate in the State incentive program.

[7] As reported by payors required to comply with the State incentive program for period October 2014 - March 2015.
[8] See Appendix C for more details regarding State incentive program payments and progress.
[9] State incentive estimates based on data reported by payors required to comply with the State incentive program for period October 2011-March 2015 and federal incentive participation as of March 2015 from the Maryland Department of Health and Mental Hygiene.
[10] See Appendix D for more details regarding EHR incentive program participation.

Appendix A: Md. Code Ann., Health-Gen. § 19-143

Md. HEALTH-GENERAL Code Ann. § 19-143

Annotated Code of Maryland

*** Current through all Chapters Effective October 1, 2012, of the 2012 General Assembly Regular Session, First Special Session, and Second Special Session. ***

HEALTH - GENERAL

TITLE 19. HEALTH CARE FACILITIES

SUBTITLE 1. HEALTH CARE PLANNING AND SYSTEMS REGULATION

PART IV. ELECTRONIC HEALTH RECORDS -- REGULATION AND REIMBURSEMENT

Md. HEALTH-GENERAL Code Ann. § 19-143 (2012)

§ 19-143. Electronic health records

(a) Designation of health information exchange. -- On or before October 1, 2009, the Commission and the Health Services Cost Review Commission shall designate a health information exchange for the State.

(b) Progress report. -- On or before January 1, 2010, the Commission shall:

(1) Report, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee on progress in implementing the requirements of subsections (a) and (d) of this section; and

(2) Include in the report recommendations for legislation specifying how incentives required for State-regulated payors that are national carriers shall take into account existing carrier activities that promote the adoption and meaningful use of electronic health records.

(c) Subsequent report for review and comment. –

(1) On or before January 1, 2011, following consultations with appropriate stakeholders, the Commission shall post on its website for public comment and submit to the Governor and, in accordance with § 2-1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee a report on:

(i) The development of a coordinated public-private approach to improve the State's health information infrastructure;

(ii) Any changes in State laws that are necessary to protect the privacy and security of health information stored in electronic health records or exchanged through a health information exchange in the State;

(iii) Any changes in State laws that are necessary to provide for the effective operation of a health information exchange;

(iv) Any actions that are necessary to align funding opportunities under the federal American Recovery and Reinvestment Act of 2009 with other State and private sector initiatives related to health information technology, including:

1. The patient-centered medical home;

2. The electronic health record demonstration project supported by the federal Centers for Medicare and Medicaid Services;

3. The health information exchange; and

4. The Medicaid Information Technology Architecture Initiative; and

(v) Recommended language for the regulations required under subsection (d) of this section.

(2) The Senate Finance Committee and the House Health and Government Operations Committee shall have 60 days from receipt of the report for review and comment.

(d) Regulations; legislative intent. –

(1) On or before September 1, 2011, the Commission, in consultation with the Department, payors, and health care providers, shall adopt regulations that require State-regulated payors to provide incentives to health care providers to promote the adoption and meaningful use of electronic health records.

(2) Incentives required under the regulations:

(i) Shall have monetary value;

(ii) Shall facilitate the use of electronic health records by health care providers in the State;

(iii) To the extent feasible, shall recognize and be consistent with existing payor incentives that promote the adoption and meaningful use of electronic health records;

(iv) Shall take into account:

1. Incentives provided to health care providers under Medicare and Medicaid; and

2. Any grants or loans that are available to health care providers from the federal government;

(v) May include:

1. Increased reimbursement for specific services;

2. Lump sum payments;

3. Gain-sharing arrangements;

4. Rewards for quality and efficiency;

5. In-kind payments; and

6. Other items or services to which a specific monetary value can be assigned; and

(vi) Shall be paid in cash, unless the State-regulated payor and the health care provider agree on an incentive of equivalent value.

(3) The regulations need not require incentives for the adoption and meaningful use of electronic health records, for each type of health care provider listed in § 19-142(e) of this subtitle.

(4) If federal law is amended to allow the State to regulate payments made by entities that self-insure their health benefit plans, regulations adopted under this section shall apply to those entities to the same extent to which they apply to State-regulated payors.

(5) Regulations adopted under this subsection:

(i) May not require a group model health maintenance organization, as defined in § 19-713.6 of this title, to provide an incentive to a health care provider who is employed by the multispecialty group of physicians under contract with the group model health maintenance organization; and

(ii) Shall allow a State-regulated payor to:

1. Request information from a health care provider to validate the health care provider's incentive claim; and

2. If the State-regulated payor determines that a duplicate incentive payment or an overpayment has been made, reduce the incentive amount.

(6) The Commission may:

(i) Audit the State-regulated payor or the health care provider for compliance with the regulations adopted under this subsection; and

(ii) If it finds noncompliance, request corrective action.

(7) It is the intent of the General Assembly that the State Employee and Retiree Health and Welfare Benefits Program support the incentives provided under this subsection through contracts between the Program and the third party administrators arranging for the delivery of health care services to members covered under the Program.

(e) Actions to ensure compliance with federal law. -- The Health Services Cost Review Commission, in consultation with hospitals, payors, and the federal Centers for Medicare and Medicaid Services, shall take the actions necessary to:

(1) Assure that hospitals in the State receive the payments provided under § 4102 of the federal American Recovery and Reinvestment Act of 2009 and any subsequent federal rules and regulations; and

(2) Implement any changes in hospital rates required by the federal Centers for Medicare and Medicaid Services to ensure compliance with § 4102 of the federal American Recovery and Reinvestment Act of 2009 and any subsequent federal rules and regulations.

(f) Mechanism for receipt of payments for participants in State medical assistance program. -- The Department, in consultation with the Commission, shall develop a mechanism to assure that health care providers that participate in the Maryland Medical Assistance Program receive the payments provided for adoption and use of electronic health records technology under § 4201 of the federal American Recovery and Reinvestment Act of 2009 and any subsequent federal rules and regulations.

(g) Report to Governor and General Assembly. -- On or before October 1, 2012, the Commission shall report to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly on progress achieved toward adoption and meaningful use of electronic health records by health care providers in the State and recommendations for any changes in State laws that may be necessary to achieve optimal adoption and use.

(h) Designation of management service organization. –

(1) On or before October 1, 2012, the Commission shall designate one or more management service organizations to offer services throughout the State.

(2) The Commission may use federal grants and loans to help subsidize the use of the designated management service organizations by health care providers.

(i) Requirements of electronic health records. -- On and after the later of January 1, 2015, or the date established for the imposition of penalties under § 4102 of the federal American Recovery and Reinvestment Act of 2009:

(1) Each health care provider using an electronic health record that seeks payment from a State-regulated payor shall use electronic health records that are:

(i) Certified by a national certification organization designated by the Commission; and

(ii) Capable of connecting to and exchanging data with the health information exchange designated by the Commission under subsection (a) of this section; and

(2) The incentives required under subsection (d) of this section may include reductions in payments to a health care provider that does not use electronic health records that meet the requirements of paragraph (1) of this subsection.

HISTORY: 2009, ch. 689; 2011, chs. 380, 532, 533.

Appendix B: COMAR 10.25.16, Electronic Health Record Incentives

Title 10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 25 MARYLAND HEALTH CARE COMMISSION

Chapter 16 Electronic Health Record Incentives

Authority: Health-General Article, §§19-103(c)(2)(i) and (ii), 19-109(a)(1), and

19-143(d)(1), (2), (3), and (4) and (i), Annotated Code of Maryland

10.25.15.01

.01 Scope.

A. This chapter applies to each payor that is required to provide an incentive payment to each primary care practice, including a practice owned by a hospital, that adopts and reaches an approved level of use of electronic health records.

B. Only a primary care practice that meets the requirements established in this chapter may receive an adoption incentive for electronic health record adoption under this program.

C. Adoption incentives under this chapter are available through December 31, 2016.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Achieved NCQA level two recognition" means a primary care practice has received recognition from NCQA for meeting NCQA's 2011 or later standards for a level two patient centered medical home.

(2) "Attested to meaningful use" means a physician or nurse practitioner within a primary care practice has achieved the meaningful use requirements under either the Medicaid or Medicare EHR Incentive Program and has received confirmation of the attestation from:

(a) The Center for Medicare and Medicaid Services; or

(b) The Maryland Medical Assistance Program (Medicaid).

(3) "Electronic health record" or "EHR" means a complete electronic record system that is certified by an authorized testing and certification body designated by the Office of the National Coordinator for Health Information Technology and that contains health-related information on an individual.

(4) "EHR adoption incentive" means a payment that an eligible primary care practice can receive from a payor to assist the primary care practice in adopting an electronic health record and attaining a required use level that:

(a) Consists of a one-time cash payment not to exceed $15,000 or an incentive of equivalent value agreed upon by the primary care practice and payor; and

(b) Is based on a $25 per-patient payment applied to the total number of patients on the practice panel who are Maryland residents.

(5) Fully insured health benefit plan.

(a) "Fully insured health benefit plan" means a medical policy, contract, or certificate for which an:

(i) Employer pays a per-employee premium to a payor and the payor assumes the risk of providing health coverage for insured events and incurred administrative costs; or

(ii) Individual pays a premium to a payor.

(b) "Fully insured health benefit plan" does not include a self-insured health plan or a health plan for which a payor is acting only as a third party administrator.

(6) Health care provider.

(a) “Health care provider” means a person who is licensed, certified, or otherwise authorized under Health Occupations Article, Annotated Code of Maryland, to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program.

(b) “Health care provider” includes a facility where health care is provided to patients or recipients, including:

(i) A facility, as defined in Health-General Article, §10-101(e), Annotated Code of Maryland;

(ii) A hospital, as defined in Health-General Article, §19-301, Annotated Code of Maryland;

(iii) A related institution, as defined in Health-General Article, §19-301, Annotated Code of Maryland;

(iv) An outpatient clinic;

(v) A freestanding medical facility, as defined in Health-General Article, §19-3A-01, Annotated Code of Maryland;

(vi) An ambulatory surgical facility, as defined in Health-General Article, §19-3B-01, Annotated Code of Maryland; and

(vii) A nursing home, as defined in Health-General Article, §19-1401, Annotated Code of Maryland.

(c) For purposes of this chapter, “health care provider” does not include a health maintenance organization as defined in Health-General Article, §19-701, Annotated Code of Maryland.

(7) “Incentive of equivalent value” means:

(a) Specific services;

(b) A gain-sharing arrangement;

(c) Rewards for quality and efficiency;

(d) In-kind payment; or

(e) Other items or services that can be assigned a specific monetary value.

(8) “Implementation period” means the first 120 days after the effective date of this chapter.

(9) “Meaningful Use” means the criteria and requirements established by the Centers for Medicare and Medicaid Services as detailed under 42 C.F.R. § 142, 143, 422, et. al. (2010) and subsequent regulations.

(10) “Medicare and Medicaid EHR Incentive Programs” means the programs described at 42 C.F.R. pt. 412, 413, 422, and 495 (2010) and 42 C.F.R pt. 412, 413, and 495 (2012), adopted by the Centers for Medicare & Medicaid Services (CMS) to implement provisions of the American Recovery and Reinvestment Act of 2009, the Medicare EHR Incentive program as administered by CMS, and the Medicaid EHR Incentive program as administered by Medicaid.

(11) "MHCC” or “Commission" means the Maryland Health Care Commission.

(12) “NCQA” means the National Committee for Quality Assurance, a health care quality accreditation, certification, and recognition body.

(13) “NPI” or “national provider identifier” means the unique individual identification number issued by the National Provider System to a health care provider typically used in administrative and financial transactions.

(14) Payor.

(a) “Payor” means a State-regulated carrier that issues or delivers health benefit plans in the State and includes:

(i) Aetna, Inc;

(ii) CareFirst BlueCross BlueShield;

(iii) CIGNA HealthCare Mid-Atlantic;

(iv) Coventry Health Care;

(v) Kaiser Permanente; and

(vi) United Healthcare, Mid-Atlantic Region.

(b) “Payor” does not include a managed care organization as defined in Health-General Article, Title 15, Subtitle 1, Annotated Code of Maryland.

(15) “Practice panel” means:

(a) The patients who are Maryland residents and enrolled in a fully insured health benefit plan assigned by a payor to a provider within a primary care practice at the time the primary care practice requests an EHR incentive payment; or

(b) When a payor does not assign patients enrolled in a fully insured health benefit plan to a provider within a primary care practice, the patients who are Maryland residents and enrolled with that payor in a fully insured health benefit plan who have been treated by the primary care practice within the 24 months preceding a primary care practice's request for an EHR adoption incentive payment.

(16) "Primary care practice" means a medical practice located in the State that is composed of:

(a) One or more physicians who provide health care in family practice, general practice, geriatric, internal medicine, pediatric medicine, or gynecologic practice and that uses one of the following CMS specialty codes in claims submissions:

(i) Family practice (08);

(ii) General practice (01);

(iii) Geriatric medicine (38);

(iv) Internal medicine (11);

(v) Pediatric medicine (37); or

(vi) Obstetrics & Gynecology (16); or

(b) One or more nurse practitioners who provide health care in family practice, general practice, geriatric, internal medicine, pediatric medicine, or gynecologic practice and that uses CMS taxonomy code in claims submissions:

(i) Adult Health (363LA2100X);

(ii) Family (363LF0000X);

(iii) Gerontology (363LG0600X);

(iv) Obstetrics & Gynecology (363LX0001X);

(v) Pediatric (363LP0200X);

(vi) Primary Care (363LP2300X); or

(vii) Women's Health (363LW0102X).

(17) "State" means the State of Maryland.

(18) "Third party administrator" means a person that is registered as an administrator under Title 8, Subtitle 3 of the Insurance Article, Annotated Code of Maryland.

.03 Program Description.

A. An EHR adoption incentive shall be available to a primary care practice that meets the requirements set forth in Regulation .04 of this chapter.

B. A payor may exclude from a primary care practice's EHR adoption incentive calculation the payor's patient members who were previously included in another primary care practice's EHR adoption incentive calculation.

C. A payor may, upon notification to a primary care practice:

(1) Request additional information from a primary care practice to validate the primary care practice's EHR adoption incentive request; and

(2) Reduce a remaining EHR adoption incentive to a primary care practice if the payor determines that a duplicate payment or an overpayment has been made under this chapter.

D. The MHCC may conduct audits to determine compliance with this chapter as follows:

(1) A payor shall cooperate with the MHCC's audit process and file information required by the MHCC in a timely manner;

(2) A primary care practice shall cooperate with the MHCC's audit process and report requested information in a timely manner; and

(3) If an audit reveals noncompliance with this chapter, the MHCC may require corrective action.

E. This chapter shall also apply to an entity that self-insures its health benefit plans, if federal law is amended to allow state regulation of such EHR payments.

.04 Participation Requirements.

A. To be eligible for an EHR adoption incentive under this chapter, a primary care practice shall:

(1) Adopt a certified EHR;

(2) Complete and submit an EHR adoption incentive request to each appropriate payor from which the practice desires an incentive award; and

(3) Demonstrate that the primary care practice has either:

(a) Attested to the current Meaningful Use requirements under the Medicare or Medicaid EHR Incentive Program; or

(b) Participates in any MHCC approved patient centered medical home program and has achieved NCQA level two recognition.

B. An EHR adoption incentive request shall include the following:

(1) Practice specific information:

(a) Name;

(b) Address;

(c) Specialty;

(d) Organizational national provider identifier number; and

(e) Tax identification number;

(2) The individual NPIs of each provider within the primary care practice.

(3) The estimated total number of patients on the practice panel, if available;

(4) The name and version of the certified EHR system implemented by the primary care practice;

(5) Documentation that the primary care practice meets the criteria for the EHR adoption incentive including:

(a) A copy of the confirmation received from CMS or Medicaid of acceptance of attestation to meaningful use by at least one physician or nurse practitioner within the practice; or

(b) A copy of the NCQA level two recognition letter; and

(6) An attestation signed by an authorized member of the primary care practice that:

(a) The information contained in the request is accurate; and

(b) If the practice is led by a physician, that all the physicians within the primary care practice are using the certified EHR system; or

(c) If the practice is led by a nurse practitioner, that all the nurse practitioners within the primary care practice are using the certified EHR system

C. A payor shall issue an EHR adoption incentive request acknowledgement letter as soon as is reasonably possible and no later than 45 days after receipt of an EHR adoption incentive request.

D. The meaningful use attestation of a physician or nurse practitioner may only be included in a single EHR adoption incentive request to a payor.

E. A payor may request additional information as necessary to determine the validity of an EHR adoption incentive request.

F. A payor shall process and pay in full the adoption incentive within 75 days of receiving a complete EHR adoption incentive request.

G. A payor shall provide each primary care practice requesting an EHR adoption incentive with a written notification regarding:

(1) The amount of the EHR adoption incentive awarded to the primary care practice;

(2) The method of distribution of the EHR adoption incentive; and

(3) The time period over which the incentive will be distributed.

H. A primary care practice that provided an attestation to meaningful use must give written notice within 90 days to each payor that awarded an EHR adoption incentive to the practice under the following circumstances in the event that the CMS, Medicaid, or its designated entity:

(1) Conducted a prepayment or post-payment audit of compliance with the participation requirements of the Medicare or Medicaid EHR Incentive Program regarding the physician or nurse practitioner identified by the primary care practice as part of its EHR adoption incentive request; and

(2) Determined that the physician or nurse practitioner had not met the requirements under the Medicare or Medicaid EHR Incentive Program.

I. Payors may request reimbursement of the incentive payments made under this chapter to the primary care practice in the event of notice provided by the primary care practice under sections .04H(1)-(2) of this regulation.

J. Nothing in this chapter shall require a group model health maintenance organization to provide an incentive to a health care provider who is employed by a multispecialty group of physicians or nurse practitioners under contract with the group model health maintenance organization.

.05 Incentive Payment Calculation by Payor.

A. An EHR adoption incentive is calculated at $25 per member, up to a maximum of $15,000 and limited to the payor's patient members on the practice panel.

B. Upon request by a primary care practice, a payor shall provide the practice, in a timely manner, with an accounting of its EHR adoption incentive including the names of each patient included in the EHR adoption incentive calculation.

.06 Reporting.

A. A payor shall submit:

(1) An annual report to the MHCC for calendar years 2011 through 2016 no later than 90 days after the end of each calendar year, and

(2) At the request of the MHCC, a payor shall submit an interim report within 30 days of the Commission's request.

B. The annual and interim reports shall include:

(1) The number of EHR adoption incentive requests received by the payor for the requested calendar year or time period;

(2) The number of EHR adoption incentive payment requests processed by the payor for the requested calendar year or time period;

(3) The total value of incentives distributed for the calendar year or time period; and

(4) Other information available to the payor and requested by the MHCC to determine the effectiveness of EHR adoption incentives programs.

C. A payor shall submit a final report to the MHCC no later than May 31, 2017 that includes all information required in an annual report under this regulation.

.07 Incentive Program Transition

A. A payor has until the end of the implementation period to implement this chapter's requirements.

B. Except as provided in section .07E of this regulation, a primary care practice that received an incentive under earlier incentive program requirements is not eligible to receive an incentive under the requirements of this replacement chapter.

C. A primary care practice may be eligible to receive an incentive provided under the requirements of an earlier EHR adoption incentive regulation if the practice, under an earlier EHR adoption incentive regulation:

(1) Did not receive an incentive payment; and

(2) Prior to the effective date of this chapter:

(a) Submitted an incentive application and payment request; or

(b) Submitted an incentive application but not an incentive payment request.

D. A primary care practice in section .07C (1)(2)(b) of this regulation shall have 60 days after the effective date of this replacement chapter to submit a payment request to the payor for a base and additional incentive, as provided in earlier regulations.

E. Within 90 days after the effective date of this replacement chapter, a primary care practice that received an additional incentive that was less than or equal to the base incentive under earlier incentive program requirements may request that the payor award the difference between the previously received incentive payment and the incentive payment calculated under this replacement chapter based on the practice's eligible patient enrollment with the payor at the time of the original payment.

F. A payor shall process a payment request within 75 days of receiving a complete EHR incentive request from a primary care practice submitted under sections.07C, .07D, and .07E of this regulation.

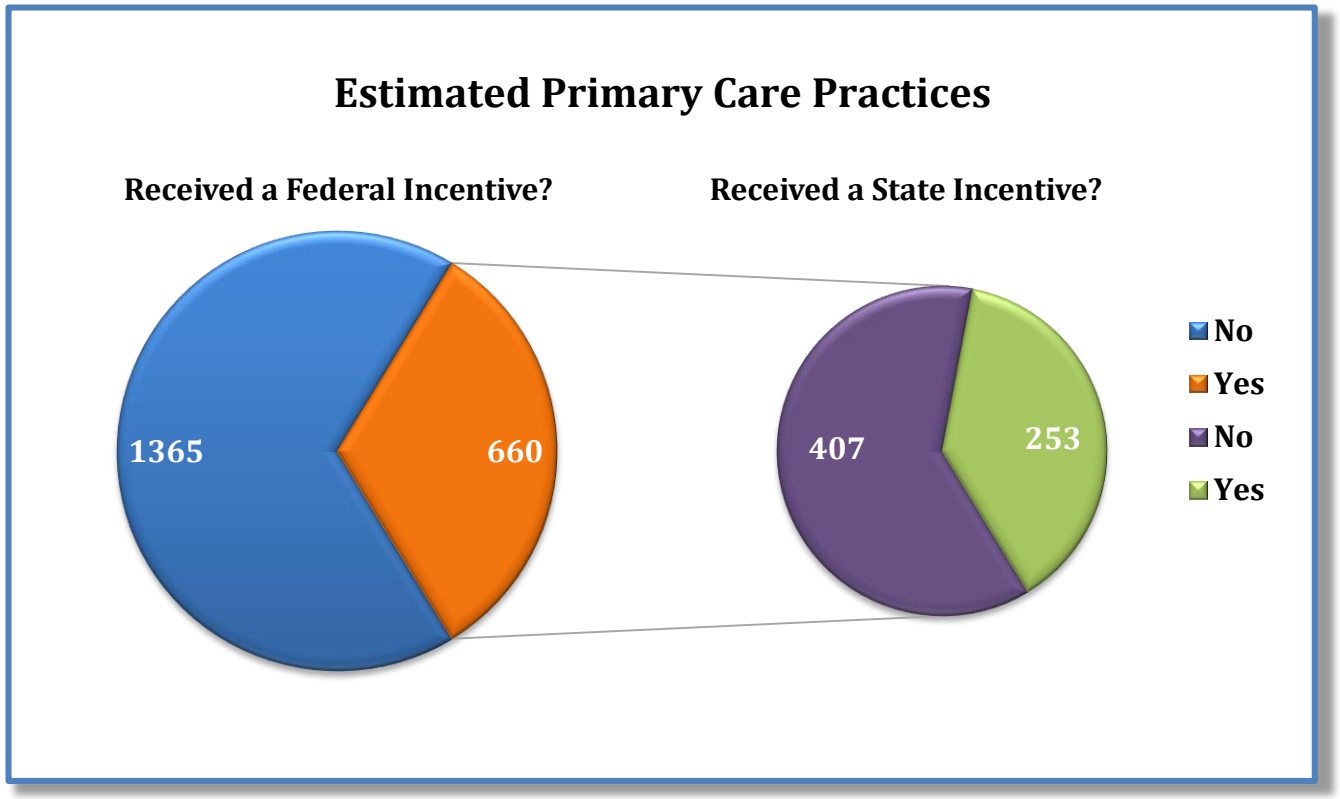
Appendix C: State Incentive Program Payments Summary

In accordance with Maryland law, payors required to comply with the State incentive program must report to MHCC annually and on an ad hoc basis regarding the status of their implementation of the State incentive program. The table below provides summary information for each payor regarding the number of payments made and total amount paid as reported by payors.

Payor	October 2011 - April 2013		May 2013 - December 2013		January 2014 - September 2014		October 2014 - March 2015		October 2011 - March 2015	
	18 months		8 months		9 months		6 months		40 months	
	Payments Made (#)	Total Amount Paid ($)	Payments Made (#)	Total Amount Paid ($)	Payments Made (#)	Total Amount Paid ($)	Payments Made (#)	Total Amount Paid ($)	Payments Made (#)	Total Amount Paid ($)
Aetna, Inc.	84	848,842	47	426,941	106	974,098	52	211,190	289	2,461,071
CareFirst BlueCross BlueShield	86	932,736	84	920,040	98	1,036,976	48	345,425	316	3,235,177
CIGNA Health Care Mid-Atlantic Region	80	31,412	94	63,235	71	52,902	61	77,301	306	224,850
Coventry Health Care	70	551,592	39	326,796	57	452,172	30	29,775	196	1,360,335
Kaiser Permanente	5	39,228	12	47,248	15	108,704	9	32,229	41	227,409
UnitedHealthcare, MidAtlantic Region	85	247,584	75	271,648	46	145,176	57	178,667	263	843,075
Total	**410**	**2,651,394**	**351**	**2,055,908**	**393**	**2,770,028**	**257**	**874,587**	**1,411**	**8,351,917**
Total Unique Practices	**107**		**124**		**169**		**100**		**370**	

Appendix D: EHR Incentive Program Participation Status

The following chart provides an overview of the participation in the State and federal incentive programs among eligible Maryland primary care physician practices. About 38 percent of the eligible primary care practices who have received a federal incentive have also received a State incentive; an increase of about 27 percent since April 2013.[11]



[11] State incentive estimates based on data reported by payors required to comply with the State incentive program for period October 2011-March 2015 and federal incentive participation as of March 2015 from the Maryland Department of Health and Mental Hygiene.

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