MARYLAND HEALTH CARE COMMISSION

Accelerating Meaningful Use in Maryland: Strategies Aimed at Eligible Providers

September 2013 – April 2015

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Introduction

Over the next 18 months, the Maryland Health Care Commission (MHCC) will guide the implementation of various strategies developed in collaboration with leading stakeholders to increase participation of eligible providers (EPs) in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs (incentive programs) authorized by the Health Information Technology for Economic and Clinical Health (HITECH) Act. The incentive programs aim to advance the adoption and meaningful use of certified EHRs among EPs. The Centers for Medicare & Medicaid Services (CMS) considers EHR diffusion essential to improve quality, increase population health, and reduce health care costs.[1, 2] EHRs are regarded as a powerful tool for advancing high quality patient centered care and are essential to practice transformation. A fully integrated and appropriately utilized EHR can help improve quality of care, increase productivity, and reduce health care costs.

Approximately 25 percent of Maryland providers who have adopted an EHR have not received an incentive payment under the incentive programs.[3, 4] In the spring of 2013, MHCC assessed the challenges of EP participation in the incentive programs to develop strategies aimed at accelerating participation.[5] As part of this work, MHCC collaborated with the Department of Health and Mental Hygiene (DHMH); Maryland's State-Designated Health Information Exchange (HIE) and Regional Extension Center (REC), the Chesapeake Regional Information System for our Patients (CRISP); MedChi, The State Medical Society; and various State-Designated management services organizations (MSOs).

Meaningful Use and Incentive Payments

EPs must meet certain requirements in their use of an EHR system to demonstrate meaningful use (MU) and receive an incentive payment.[6, 7] MU requirements were developed to become more advanced as EPs progress through three stages.[8, 9] Stage 1 requirements, which began in 2011,

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[1] The Centers for Medicare & Medicaid Services was authorized to create the Medicare and Medicaid EHR Incentive Program under the Health Information Technology for Economic and Clinical Health Act. More information about the incentive program is available at: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms.

[2] EPs for the Medicare program include providers who have at least one Medicare patient and are: doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, optometry, or chiropractors. EPs for the Medicaid program must meet the minimum 30 percent Medicaid patient volume threshold, or 20 percent for pediatricians, and be one of the following: Doctor of Medicine or Doctor of Osteopathic Medicine, dentists, nurse practitioners, certified nurse-midwives, or physician assistants (working for a federally qualified health center only)

[3] CMS June 2013 Payments by Programs by Providers. Available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html.

[4] SK&A Estimated Number of Office-based Providers, provided to Office of the National Coordinator for Health IT (ONC) September 2012. http://dashboard.healthit.gov/data/data/HIT_Publication_Workbook_20121102.xlsx. In Maryland, SK&A has 6,427 offices recorded in its database.

[5] The MHCC competitively engaged a consulting group, Audacious Inquiry, LLC, to assist in the activities.

[6] 42 C.F.R. § 412, 413, 422, et. al. (2010) and 42 C.F.R § 412, 413, and 495. (2012)

[7] Eligible hospitals may also participate in the incentive program.

[8] An overview of Meaningful Use is available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html.

focus on the EP's collection of clinical data electronically in a standard format and use of the information to track and report clinical conditions. Stage 2, which begins in 2014, requires EPs to use technology to share information for care coordination and enable more patient control over their electronic health information.[10] Stage 3 requirements, which begins in 2016, will focus on the EPs increased use of EHR functionality to improve health care outcomes. EPs must formally attest to having achieved the requirements of the Stage in order to receive an incentive payment.[11]

EPs may participate in either the Medicare or Medicaid incentive program.[12] CMS administers the Medicare incentive program, while states can choose to administer the Medicaid incentive program. EPs who participate in the Medicare incentive program and demonstrate MU can earn up to $44,000 over five years. The last payment year for the Medicare incentive program is 2015. DHMH operates the Medicaid incentive program in Maryland, which allows EPs who adopt, implement, or upgrade to a certified EHR system to receive up to $21,250 in the first payment year and a combined amount of up to $63,750 over a six year timeframe.[13, 14] The last payment year for the Medicaid incentive program is 2021.

Meaningful Use Status

EPs must register with CMS and demonstrate MU in order to qualify for an incentive payment. As of June 2013, approximately 14,307 Maryland providers were eligible for the incentive programs; about 57 percent have registered and around 37 percent have received an incentive payment.[15, 16] Nationally, approximately 56 percent of EPs have registered and roughly 45 percent have received incentive payments. Maryland is keeping pace with the nation with its percent of registered EPs; however, the percentage trails slightly for those who have received payments. In general, approximately 1,100 additional Maryland EPs would need to receive an incentive payment in order to reach the nearly 45 percent of EPs paid nationally. Broadly speaking, incentive program registration in Maryland is consistent with states that have a similar population to provider ratio.[17, 18]

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[9] 42 CFR Parts 412,413, 422, et al. Available at: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.
[10] Healthcare IT News, Final rules for Stage 2 meaningful use released, August 2012. Available at: http://www.healthcareitnews.com/news/final-rules-stage-2-meaningful-use-released.
[11] Each Stage of MU includes core measures, which all EPs must achieve, and menu measures that the EPs may select to achieve. Providers must successfully meet a specified threshold on each measure in order to qualify for payment. See Appendix A for a summary of the Stages 1 and 2 MU Measures and threshold requirements.
[12] Some differences in participation requirements exist between the Medicare and Medicaid incentive programs. See Appendix B for more information about program differences.
[13] EPs are allowed to switch participation from one program to the other one time.
[14] See Appendix C for Medicaid and Medicare payments by year.
[15] CMS June 2013 Payments by Programs by Providers. Available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html.
[16] SK&A Estimated Number of Office-based Providers, provided to ONC September 2012. http://dashboard.healthit.gov/data/data/HIT_Publication_Workbook_20121102.xlsx. In Maryland, SK&A has 6,427 offices recorded in its database.
[17] See Appendix D for a detailed comparison of incentive program participation by Maryland and other key states.
[18] See Appendix E for the percent of EPs registered and paid by each state.

Incentive Program EP Registration and Payments *June 30, 2013*							
	Medicare		**Medicaid**		**Totals**		
	Maryland Actual	National Average	Maryland Actual	National Average	Maryland Actual	National Average	National Actual
Registered (#)	5,707	4,648	2,463	2,265	8,170	6,913	400,960
Paid (#)	4,073	4,285	1,217	1,985	5,290	6,270	357,416
Incentive Payment Amounts ($M)	66.3	67.1	25.4	37.9	91.8	105	5,988.5

Meaningful Use Challenges

Achieving MU and qualifying for payment under an incentive program is a multi-step process for EPs. This process typically involves implementing an EHR, determining eligibility for participation in the incentive program, registering for the incentive program, achieving MU requirements, and attesting to completion of the requirements.

Summary of the Processes for EPs to Achieve MU

Preparation	Implementation	Attestation
• Become aware of the program • Determine eligibility • Decide to participate • Evaluate EHR products • Purchase an EHR system	• Register online with CMS • If participating in the Medicaid incentive program, register online with Maryland Medicaid • Implement EHR per MU specification • Redesign practice workflows • Utilize EHR correctly for 90 or 365 days for MU measures	• Produce MU reports from the EHR system • Submit attestation to CMS or Maryland Medicaid • Receive payment after CMS or Maryland approval of MU attestation

Successfully obtaining MU can be difficult for EPs as it requires implementing changes designed to promote a more efficient practice with the goal of controlling costs and improving quality. The following primary challenges were identified by the MHCC through interviews with providers, hospital liaisons, and stakeholders from other states:

- *Lack of clarity regarding calculating Medicaid patient volume*

  The Medicaid incentive program requires EPs to have a minimum Medicaid patient volume of 30 percent, or 20 percent for pediatricians. Patient volume is calculated based on Medicaid encounters over a 90-day period, among other things. Calculating Medicaid patient volume can be a complex process for some providers given the way many billing and practice management systems capture encounter data.[19] DHMH has estimated that approximately 60 percent of registrations/attestations are initially denied due to problems with patient volume calculations.[20]

- *Difficulty with selecting an EHR system*

  EPs who have not adopted an EHR must evaluate certified EHR products and select a system that best meets their practice needs.[21] Selecting an EHR system can be a daunting task. Currently, there are more than 500 EHR vendors and over 3,000 certified products available, making the evaluation process challenging.[22] Further complicating the EHR evaluation process is the need to differentiate systems that are designed for certain physician specialties and specific allied health professionals.

- *Challenges with modifying workflows to appropriately use an EHR system to meet MU measures*

  EPs must use a certified EHR system for the mandated period of 90 days (or 365 days, depending on the year of participation) in order to successfully achieve all MU measures and receive an incentive payment.[23] MU measures require EPs to capture specific clinical data within an EHR system.[24, 25] In addition to implementing an EHR system correctly, EPs must also modify practice workflows to ensure that the system is being appropriately utilized to enable EPs to meet MU requirements.

- *Problems related to utilizing the online CMS and Maryland registration and attestation systems*

  EPs must register on the CMS Registration and Attestation website to begin participation in an incentive program. EPs often experience challenges with registration due to the

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[19] For instance, in a situation where the EP receives a capitated payment for patient care, some encounters recorded in the EP's practice management system may not be eligible for the patient volume calculation because they were not reimbursable.
[20] Based on information provided by DHMH in February 2013. Some of these denials are due to patient volume calculation errors or due to the discrepancies between the volume calculation submitted by the EP and the volume calculated for that EP by DHMH using Medicaid claims data.
[21] EHR products must be certified by an ONC Authorized Certification Body, which certifies that the EHR system is capable of meeting the criteria to support MU.
[22] A list of certified health IT products is available at: http://oncchpl.force.com/ehrcert?q=CHPL.
[23] During the first year of participation, providers must demonstrate compliance for 90 days. Thereafter, providers must demonstrate Meaningful Use for 365 days; except in 2014, when all providers will have a 90-day demonstration period.
[24] For more information about specific MU measures visit: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html.
[25] See Appendix A for a summary of the Stages 1 and 2 MU Measures and threshold requirements.

cumbersome and occasionally time consuming processes involving other Medicare and Medicaid registration systems and provider accounts. Registration with CMS requires EPs to have an individual national provider identifier (NPI) and a National Plan and Provider Enumeration System (NPPES) web user account.[26, 27] If an EP is within a group practice and submits claims under the group's NPI for billing, rather than their individual NPI, the individual NPI is likely to be inactive. EPs must then reactivate or make current their individual NPI before registering for an incentive program.[28] EPs choosing to participate in the Medicaid incentive program must also register with Maryland's electronic Medicaid EHR incentive program (eMIPP) system.[29] In order to participate in Maryland's Medicaid incentive program and register with eMIPP, EPs must be a Maryland Medicaid fee-for-service (FFS) program provider. Some Maryland providers participate only in the Medicaid HealthChoice managed care program and not the FFS program.[30] These providers are required to register for the FFS program prior to participating in the Medicaid EHR incentive program.[31]

- *Finding the right source of information to assist in navigating the registration and MU attestation process*

  The MU registration and attestation process involves a number of federal and State entities. EPs often experience challenges in identifying the appropriate source for obtaining information. At the federal level, EPs can obtain support from CMS regarding the registration process. In Maryland, at least four different organizations routinely provide support to EPs with regard to the incentive program: DHMH, MHCC, CRISP, and MedChi.

Key Strategies to Accelerate Meaningful Use Attestation

The following strategies seek to reduce the most frequently reported challenges experienced by EPs that often inhibit them from completing the MU process.[32] These strategies were developed with the input of EPs who have been paid under an incentive program and with feedback from EPs who plan to seek an incentive payment.

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[26] The CMS Registration and Attestation System website is available at: https://ehrincentives.cms.gov/.
[27] The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 mandated the adoption of a standard unique identifier for health care providers. The NPPES collects identifying information on health care providers and assigns each a unique NPI. The NPPES website is available at: https://nppes.cms.hhs.gov/NPPES/Welcome.do.
[28] EPs whose NPI became inactive due to not using their individual NPI for some time will need to visit the NPPES website and update their information.
[29] The Maryland eMIPP website is Maryland's Medicaid incentive program registration and attestation system and is available at: https://emipp.dhmh.maryland.gov/.
[30] HealthChoice is Maryland's statewide mandatory managed care program for Medicaid beneficiaries and involves about eight managed care organizations.
[31] To register for the FFS program, an EP must register online in the eMedicaid system as a fee-for-service participant and be issued an individual medical assistance number, once all of the EPs data has been verified by DHMH.
[32] See Appendix F for information about the strategies other states have implemented to increase MU attestation.

Strategy 1: Conduct Biannual MU Registration and Attestation Webinars

Biannual webinars that address the complexity of navigating the CMS registration and attestation process and the Maryland eMIPP system are likely to increase the number of EPs who apply for MU incentives. Two registration and attestation webinars will occur twice annually, which will be recorded and made available to EPs. The MHCC received positive feedback from EPs who participated in preliminary registration and attestation webinars held in the first quarter of 2013.[33]

Program Overview

MHCC Activities	• Schedule and host two biannual webinars (Medicare and Medicaid registration/attestation) ○ Webinars will be 60 minutes and provide instructions for utilizing the CMS or eMIPP registration and attestation systems (including the patient volume calculation) • Work with MedChi, the Maryland Hospital Association, and CRISP to advertise the webinars • Using data from CMS ,DHMH, CRISP, and MedChi, perform targeted outreach of the webinars to providers who have registered for an incentive program but have not yet submitted an attestation
Assessing the Value	• Number of individuals participating in the webinars • Post webinar survey to participating individuals • Feedback from MedChi and the Maryland Hospital Association

Strategy 2: Engage Hospitals in Outreach Activities

Guidance from a trusted source in meeting MU requirements should boost participation in the incentive programs. Most hospitals have established relationships with their community providers and routinely provide them with education on various initiatives. Leveraging the hospitals' existing education and awareness initiatives to provide information regarding the incentive programs is likely to increase EP participation.

Program Overview

MHCC Activities	• Provide technical guidance to assist acute care hospitals in their education and awareness outreach activities
Assessing the Value	• The number of EPs attesting to MU in the hospital's service area[34]

[33] See Appendix G for a summary of the topics discussed during the Medicare and Medicaid webinars.
[34] Results will be included as part of MHCC's annual survey, *Health Information Technology: An Assessment of Maryland Hospitals*. The 2012 report is available at: http://mhcc.dhmh.maryland.gov/hit/Documents/2012_hospital_hit_assessment.pdf.

	• Feedback from MedChi and the Maryland Hospital Association

Strategy 3: Develop a Virtual MU Resource Center

A web-based MU resource center is expected to make information about navigating the MU process more readily available to EPs. The virtual MU resource center will include general MU information, Maryland Medicaid incentive program-specific information, and select vendor-specific information. Key information on the virtual MU resource center will include:

- Contact information for relevant entities;
- Overview of MU Stages 1 and 2 requirements;
- CMS MU Stage 1 and Stage 2 Specification Sheets;
- CMS EHR incentive programs' supporting documentation for audits guide;
- EHR vendor documentation on utilizing an EHR system for MU;
- Select EHR system-specific training documents; and
- Information on State-Designated MSOs.[35]

Program Overview

MHCC Activities	• Develop the virtual MU resource center in collaboration with leading stakeholders • Develop and disseminate information regarding the availability of the virtual MU resource center
Assessing the Value	• Number of website visits by unique users • Feedback page posted on the website available to users • Feedback from MedChi and the Maryland Hospital Association

Strategy 4: Establish a Statewide Incentive Program Single Point of Contact

The State-Designated HIE, CRISP, will serve as the single point of contact for Maryland EPs who have questions regarding the MU incentive program.[36] CRISP will triage the inquiry, address applicable questions, and escalate the issue to the appropriate entity as needed for resolution. CRISP will help ensure that EPs' questions are appropriately addressed in an efficient and timely manner.

CRISP Activities	• Develop and promote the availability of an online contact page • Establish a triage plan for questions regarding MU • Develop an organizational escalation plan detailing the routing of inquiries to the appropriate entity for support

[35] MSOs offer hosted EHRs and other services to practices throughout the State and meet specific privacy, security, and technical standards set forth in regulation. See Appendix H for a list of MSOs.
[36] Implementation and on-going operation of this strategy will be contingent on available funds.

	• Determine response time frames for their internal support levels
Assessing the Value	• The number of inquires received by CRISP and appropriately addressed and triaged • Feedback from individuals submitting inquiries • Feedback from MedChi and the Maryland Hospital Association

Remarks

Successful implementation of an EHR is the foundation for practice transformation. EHRs are generally considered to be a tool used to integrate systems and processes to transform practices. Achieving efficiencies in clinical practice and quality requires using EHRs in a meaningful way. Increasing the number of EPs who are attesting to MU is essential to promoting a new model of care delivery, changing existing clinical and business processes and practices, and redesigning the workflows of practices. Over the next 18 months, MU acceleration initiatives are expected to increase the number of EPs who participate in the incentive programs.

Appendix A: Core and Menu Measures for Stages 1 and 2 Meaningful Use

The images below detail the Core and Menu measures for MU Stages 1 and 2. In order to qualify for incentives, EPs must demonstrate that they have met all Core measures and five of the Menu measures, including at least one public health measure. Measures are either demonstrated with a numerator and denominator or Yes/No. The percentages indicated next to some of the measures are threshold requirements that must be achieved. For example, more than 50 percent of all unique patients seen by the EP must have demographics recorded as structured data. The denominator is the number of unique patients seen by the EP during the EHR reporting period, and the numerator is the number of patients in the denominator for whom the EP has recorded all the elements of demographics as structured data.

Stage 1 Core

- Computerized provider order entry - 30%
- Electronic prescribing - 40%
- Record demographics - 50%
- 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%
- Provide clinical summaries for patients for each office visit - 50%
- Provide patients with an electronic copy of their health information, upon request - 50%
- Report ambulatory clinical quality measures to CMS/States
- Implement one clinical decision support rule
- Drug-drug and drug-allergy interaction checks enabled
- Protect electronic health information - perform security assessment

Stage 1 Menu

- Drug-formulary checks enabled
- Incorporate clinical lab test results as structured data - 40%
- Generate one list of patients by specific conditions
- Send reminders to patients per patient preference for preventative/follow up care - 20%
- Provide patients with timely electronic access to their health information - 10%
- 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*

* At least one public health measure must be selected

Stage 2 Core

- Computerized provider order entry (CPOE)
  - 60% medication orders
  - 30% laboratory orders
  - 30% radiology orders
- E-Prescribing (eRx) and drug-formulary check - 50%
- Record demographics - 80%
- Record and chart changes in vital signs - 80%
- Record smoking status for patients 13 years or older - 80%
- Provide clinical summaries for patients for each office visit - 50%
- Provide patients timely online access to health information - 50%
  - Patients view online, download, or transmit health information - 5%
- Incorporate clinical lab test results as structured data - 55%
- Generate one list of patients by specific conditions
- Send reminders to patients per patient preference for preventive/follow up care - 10%
- Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate - 10%
- Medication reconciliation - 50%
- Summary of care during transition of care - 50%
  - Provide summary of care elecronically - 10%
  - Send the summary of care electronically at least once to an unaffiated organization with different EHR vendor.
- Patient sends secure message - 5%
- Electronically report ambulatory clinical quality measures to CMS/States
- Implement five clinical decision support rules and a drug-drug/drug-allergy interaction check
- Protect electronic health information - Perform security assessment

Stage 2 Menu

- Record electronic progress notes - 30%
- Incorporate imaging results (image and notes)- 10%
- Record family health history - 20%
- Ongoing submission of electronic syndromic surveillance data to public health agencies
- Ongoing submission of cancer case information to a cancer registry
- Ongoing submission of specific case information to a specialized registry

Appendix B: Medicare and Medicaid EHR Incentive Programs

Incentives are available to EPs, eligible hospitals, and critical access hospitals under the Medicare and Medicaid incentive programs. Although most hospitals will be able to receive a payment from both programs, EPs must choose to participate in only one of the incentive programs. The table below details similarities and difference between the Medicare and Medicaid incentive programs.

Medicare EHR Incentive Program	Medicaid EHR Incentive Program
Administered by CMS	Administered by the State Medicaid Agency
Maximum incentive amount is $44,000	Maximum incentive amount is $63,750
Payments over five consecutive years	Payments over six years (do not have to be consecutive)
Payment adjustments will begin in 2015 for providers who are eligible but decide not to participate	No Medicaid payment adjustments
Providers must demonstrate meaningful use every year to receive incentive payments.	In the first year, providers can receive an incentive payment for adopting, implementing, or upgrading EHR technology. Providers must demonstrate meaningful use in the remaining years to receive incentive payments.

Appendix C: Medicare and Medicaid Incentive Payments by Year

The tables below details payment amounts available to EPs under the Medicare and Medicaid incentive programs. The columns represent the first payment based on calendar year for an EP who has met MU requirements, and the rows represent the payment amounts EPs receive yearly for continuing to meet MU requirements.

Medicare EP Incentive Payment Schedule					
	CY 2011	CY 2012	CY 2013	CY2014	CY 2015 and later
CY 2011	$18,000				
CY 2012	$12,000	$18,000			
CY 2013	$8,000	$12,000	$15,000		
CY 2014	$4,000	$8,000	$12,000	$12,000	
CY 2015	$2,000	$4,000	$8,000	$8,000	$0
CY 2016		$2,000	$4,000	$4,000	$0
TOTAL	**$44,000**	**$44,000**	**$39,000**	**$24,000**	**$0**

Medicaid EP Incentive Payment Schedule						
	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	$21,250					
CY 2012	$8,500	$21,250				
CY 2013	$8,500	$8,500	$21,250			
CY 2014	$8,500	$8,500	$8,500	$21,250		
CY 2015	$8,500	$8,500	$8,500	$8,500	$21,250	
CY 2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
CY 2017		$8,500	$8,500	$8,500	$8,500	$8,500
CY 2018			$8,500	$8,500	$8,500	$8,500
CY 2019				$8,500	$8,500	$8,500
CY 2020					$8,500	$8,500
CY 2021						$8,500
TOTAL	**$63,750**	**$63,750**	**$63,750**	**$63,750**	**$63,750**	**$63,750**

Appendix D: Key State Comparison to Maryland - Registration and Attestation

As of June 2013, Maryland ranks 22nd among states for the percent of registered EPs and 45th for the percent of attested and paid EPs based on the total number of office-based providers in each state.[37] While the percent of registered Maryland EPs is similar to the national average at 57 percent, Maryland's attestation rate of 37 percent is lower than the national average by at least eight percent. In order to assess Maryland's participation in incentive programs with similar states, an analysis was performed that compared Maryland to states with similar provider to Medicaid and Medicare population sizes and to states with similar numbers of practices and practice sizes.[38, 39, 40] In terms of the number of providers as a percent of the Medicare and Medicaid population, Maryland is similar to Kansas, Virginia, and Montana. North Carolina, Virginia, and Tennessee are similar to Maryland with regard to the number of practices within the State and practice sizes. The findings identified that the gap between the percent of EPs registered and the percent of EPs paid is generally larger in Maryland when compared to similar states.

In comparison to states with similar numbers of providers, Maryland's registration rate of roughly 57 percent is approximately the same or higher.[41] Maryland's attestation rate is lower than these states by at least 11 percent with the exception of Montana, which has an attestation rate similar to Maryland. The following chart provides a comparison of Maryland to states with a similar number of providers.

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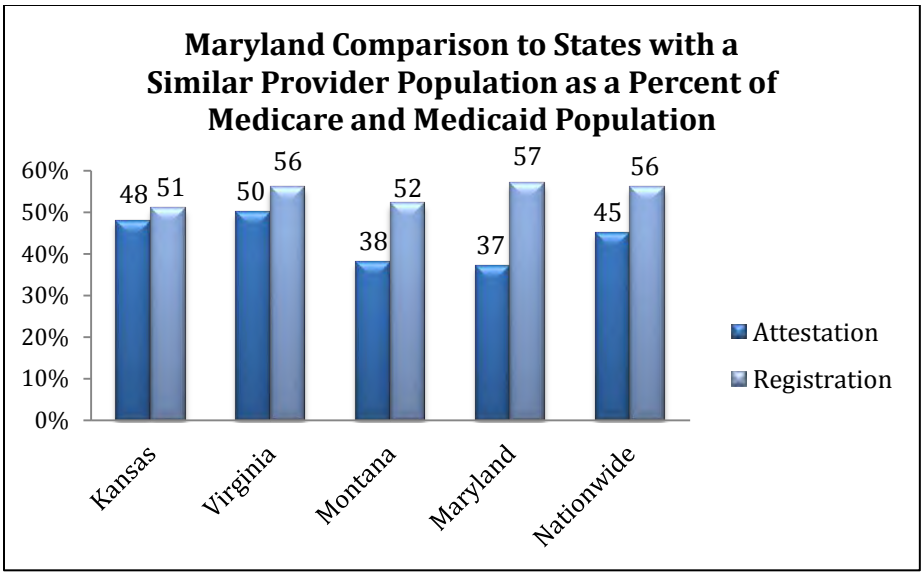
[37] Ranking is based on the SK&A estimated number of health care providers and the June 2013 Payments by Programs by Providers. Available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html.

[38] Provider population size is based on the SK&A estimated number of health care providers, provided to ONC September 2012. http://dashboard.healthit.gov/data/data/HIT_Publication_Workbook_20121102.xlsx.

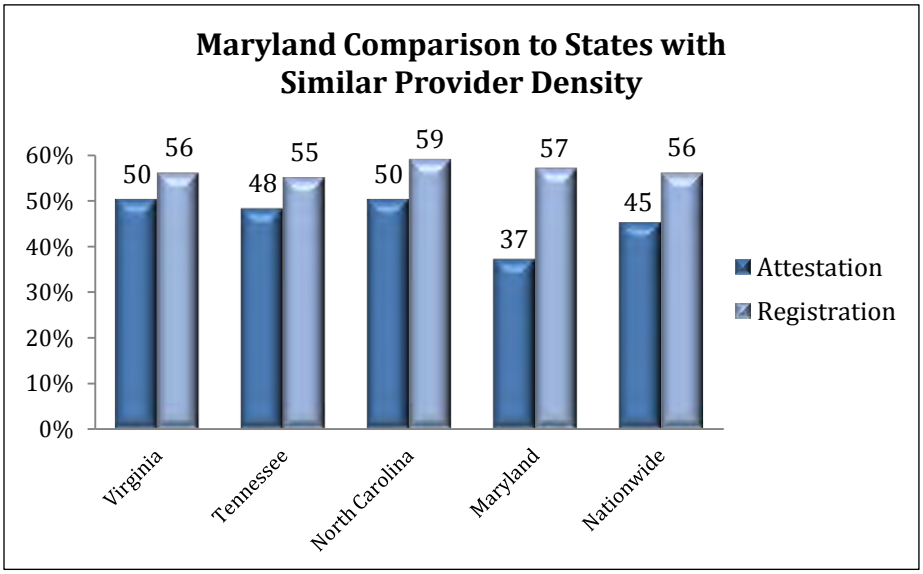
[39] Number of practices and practice size is based on the SK&A U.S. Physician Office Density Report. June 2012: http://www.skainfo.com/health_care_market_reports/physician_office_density.pdf.

[40] Medicare populations as reported by Kaiser Family Foundation: *State Health Facts, Total Number of Medicare Beneficiaries*. Available at: http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/#notes. Medicaid population as reported by Kaiser Family Foundation: *State Health Facts, Total Medicaid Enrollment*. Available at: http://kff.org/medicaid/state-indicator/total-medicaid-enrollment-fy2009/.

[41] Registration and attestation data were taken from the CMS March Registrations by Individual States report and the April 2013 Payments by Programs by Providers report. Available at: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html.



Maryland's participation in the incentive program was compared with other states that are similar in terms of the number of practices within the State and practice size. These states include Virginia, Tennessee, and North Carolina. Surveys show that practices with more than six providers have a higher rate of EHR adoption, which may lead to a higher rate of MU participation.[42] Roughly 10 percent of Maryland practices include six or more physicians.[43] While the percent of Maryland providers registered for the program is similar to Virginia, Tennessee, and North Carolina, the attestation rate is lower by at least 11 percent. The chart below provides a comparison of Maryland to Virginia, Tennessee, and North Carolina.



[42] SK&A Research, *Physician Office Usage of Electronic Health Records Software,* January 2013: http://www.skainfo.com/health_care_market_reports/EMR_Electronic_Medical_Records.pdf.
[43] 2011-2012 Maryland Board of Physicians Licensure File, a database of physician responses to the bi-annual licensure survey.

Appendix E: Percent Registered and Paid for Meaningful Use by State

The table below provides information on each state's estimated number of health care providers and the number and percent of EPs paid and registered for MU through June 2013.[44, 45]

	Estimated Total Number of Health Care Providers	EPs Registered		EPs Paid	
		#	%	#	%
Alabama	9,673	5,716	59	4,787	49
Alaska	1,933	970	50	594	31
Arizona	14,225	8,072	57	6,172	43
Arkansas	5,461	3,101	57	3,097	57
California	76,526	35,675	47	29,284	38
Colorado	12,324	6,269	51	5,351	43
Connecticut	10,542	5,140	49	4,495	43
Delaware	2,298	1,515	66	1,758	77
District of Columbia	2,589	917	35	649	25
Florida	44,863	23,050	51	20,453	46
Georgia	19,411	8,925	46	7,879	41
Hawaii	2,853	1,003	35	905	32
Idaho	3,624	1,663	46	1,322	36
Illinois	27,545	16,978	62	15,417	56
Indiana	14,533	7,601	52	7,103	49
Iowa	6,303	4,736	75	5,004	79
Kansas	6,633	3,405	51	3,197	48
Kentucky	10,124	5,483	54	4,677	46
Louisiana	9,977	5,346	54	4,692	47
Maine	3,995	2,967	74	3,703	93
Maryland	14,307	8,170	57	5,290	37
Massachusetts	20,105	15,379	76	16,352	81
Michigan	23,387	13,705	59	11,187	48
Minnesota	12,992	11,095	85	9,400	72
Mississippi	5,977	3,671	61	3,513	59
Missouri	13,678	8,483	62	8,394	61

[44] Estimated number of health care providers obtained from SK&A, 2012. Available at: http://dashboard.healthit.gov/data/data/HIT_Publication_Workbook_20130408.xlsx.

[45] CMS Medicare and Medicaid EHR Incentive Program, *Combined Medicare and Medicaid Payments by States*, June 2013. Available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html.

	Estimated Total Number of Health Care Providers	EPs Registered		EPs Paid	
		#	%	#	%
Montana	2,495	1,292	52	944	38
Nebraska	4,839	2,582	53	2,162	45
Nevada	5,065	1,998	39	1,567	31
New Hampshire	3,672	2,073	56	2,372	65
New Jersey	21,602	10,227	47	9,689	45
New Mexico	4,324	2,830	65	2,455	57
New York	54,789	24,941	46	21,011	38
North Carolina	22,057	13,009	59	11,108	50
North Dakota	1,787	1,169	65	908	51
Ohio	26,511	16,099	61	16,787	63
Oklahoma	7,355	4,627	63	4,350	59
Oregon	9,339	5,819	62	5,953	64
Pennsylvania	34,769	20,426	59	19,314	56
Rhode Island	3,027	1,242	41	1,246	41
South Carolina	10,031	5,723	57	4,645	46
South Dakota	2,113	1,402	66	1,373	65
Tennessee	16,157	8,860	55	7,834	48
Texas	47,672	26,093	55	22,149	46
Utah	6,229	3,104	50	2,527	41
Vermont	1,884	1,391	74	1,315	70
Virginia	17,658	9,959	56	8,828	50
Washington	16,733	9,849	59	10,135	61
West Virginia	4,621	2,468	53	2,494	54
Wisconsin	14,119	10,779	76	10,182	72
Wyoming	1,263	463	37	383	30

Appendix F: State Assessment of Strategies for Accelerating Meaningful Use

Utilizing data provided by the Office of the National Coordinator for Health IT, MHCC identified states with above average MU attestation rates for a number of states with physician populations similar to Maryland. State Health Information Technology Coordinators, REC representatives, and individuals supporting the Medicaid EHR incentive program were interviewed in each state about the strategies, tools, and resources they have used to support providers as they seek to participate in the MU program.

Key Takeaways from State Assessment

Through discussions with representatives from the states highlighted in this section, the following assistance was identified as being important to their success.

- Provide a single point of contact for the MU program and ensure that all staff, including individuals in the Medicaid agency, RECs, and technical assistance contractors are cross-trained on both the Medicare and Medicaid Incentive Programs.
- Perform targeted outreach to providers who have registered for the MU program, or who have been identified as eligible for the program.
- Provide training events on very specific issues and/or barriers related to the incentive program and, if possible, market these events to a targeted subset of providers.
- Train the payer organizations' provider relations representatives on talking points for MU and utilize those representatives for provider outreach.

Arizona

Arizona Health-e Connection (AzHeC) leads the Arizona REC program. AzHeC has contracted with three sub-recipients for support of the REC priority primary care providers (PPCPs). The sub-recipients include the state's quality improvement organization and two for-profit companies that provide technical assistance to PPCPs. While the sub-recipients are responsible for on-the-ground support, AzHeC coordinates and executes a robust outreach and marketing plan to reach providers and engage them with the REC. One of the REC's very successful efforts involves in-person events or road shows held across the state in order to walk providers through the process of choosing an EHR system, implementing it, and then registering and attesting to AIU (adoption, implementation, or upgrading) and MU. The REC seeks out sponsor for each outreach event to offset costs for food and beverages, since those are not allowable purchases with federal funds. In return, sponsors are given the opportunity to make a brief presentation to attendees regarding its product and have a small exhibit table at the event to speak with providers before or after the event. The REC performs outreach for these events and also utilizes a number of its board member organizations, including State medical associations, to advertise the events to their membership.

In addition to coordinating with its technical assistance partners, Arizona's REC works very closely with the Arizona Health Care Cost Containment System (AHCCCS), which is the state's Medicaid agency. It attributes this statewide collaboration as key to Arizona's success in moving providers through the process of registration, attestation and payment for the AIU and MU. Arizona's REC and

AHCCCS worked together to develop a strategy for reaching Medicaid providers and assembled a comprehensive EP toolkit containing standardized forms for group practices and eligibility worksheets. In addition, the REC and its sub-recipients use the AHCCCS EHR Process Diagram and EHR Incentive Reference Guide/toolkit, which shows a step-by-step process to complete registration and attestation.

Connecticut

eHealth Connecticut is the State of Connecticut's REC. As in Maryland, the REC contracted with Direct Assistance Contractors (DACs) to provide technical support in the field to PPCPs. There are 14 DACs currently operating in the state. Providers register with eHealth Connecticut which in turn assigns them to a specific DAC. eHealth Connecticut has provided educational tools and resources, including educational sessions and CME credits for REC participants. The REC has relied upon all of the major provider stakeholders in Connecticut as channel partners for referrals.

Connecticut's Medicaid IT system vendor, HP, also provides assistance in walking providers through the registration and attestation process for AIU and Stage 1 MU. Connecticut is currently designing an outreach strategy to engage Medicaid providers utilizing its Health Information Technology Implementation Planning Document (IAPD) funding. The State HIT Coordinator works with the Medicaid staff on a weekly basis and has helped develop a method for identifying providers who are most likely to have adequate patient volume to qualify for the Medicaid incentive program. This method utilized claims data from providers who have already attested to identify other providers with similar claims volumes who are likely to be eligible for the program. Connecticut plans to target these providers for outreach and marketing, which it believes will result in higher program participation.

Florida

The Florida Medicaid Incentive Program (program) is administered within the Agency for Health Care Administration (Agency), which also has responsibility for Florida's health information exchange initiatives. The Agency has staffed the program with a full-time processing team consisting of one lead and four team members. Additional staff time is allocated to the program to assist on working with hospitals on calculating hospital incentive payments and statistical staff assists with program metrics. A full-time Outreach Coordinator was contracted to lead all educational and outreach activities. To support program activities, Florida has four RECs that have worked closely with each other and with the Agency. The RECs are spread across the state and have hosted health IT days, vendor fairs, and registration/attestation road shows for EPs.

The Agency uses a combination of activities to identify and educate potential program participants. In addition to targeting Priority Care Providers (PCPs) in Florida's REC program, the Agency has advertised the incentive program more broadly through Medicaid provider alerts, emails, and mailings to all providers. The Agency then performs targeted outreach to these providers, answering their questions or issues and encouraging them to attest for the program. The Agency and the RECs each hold monthly webinars about the incentive programs consisting of sessions that guide providers through the attestation process, including a detailed review of program requirements, MU measures, and application navigation. A series of program workshops are held

twice a year throughout Florida, creating an opportunity for Agency staff to work one-on-one with providers.

To ensure that all provider questions are answered and issues are resolved in a timely manner, the Agency has set up a dedicated email address and call center to answer questions and resolve issues with registration and attestation. An Agency staff member is assigned to monitor the dedicated email inbox and is required to respond to emails within five business days (though most are handled upon receipt). The call center has a toll-free number and is staffed by Florida's attestation system vendor, HP. The call center representatives escalate policy questions they cannot answer to the dedicated email address. There are three full time employees staffing the call center as well as two staff members for the attestation system.

Indiana

Indiana has two RECs, IHITEC (run by Purdue University) and the TriState REC (run by HealthBridge). Both the RECs have focused on PCPs in larger practices. Indiana gives priority to processing Medicaid registrations and attestations from providers working with the RECs. At the state level, rather than focusing on independent providers, the Indiana Family and Social Services Administration (FSSA) has focused its outreach to hospitals and hospital-owned ambulatory practices. FSSA worked with hospital accounting firms to calculate incentive payments for individual hospitals and had the accounting firms assist hospitals with the administrative work of attesting to MU. FSSA works closely with the state's hospital association for marketing and outreach.

Indiana has closely monitored EPs who have attested and targets its marketing to organizations that have not yet attested. FSSA has also focused on outreach to federally qualified health centers (FQHCs) and community health centers. It partnered with a state association that sent faxes and emails to its members and gave presentations on the incentive program. The association and the RECs provided point people to answer the FQHCs' questions and help them with attesting to MU. The FSSA has worked closely with the RECs and the Indiana medical associations and believes that much of its success has been due to a collaborative effort to set goals, increase awareness of the goals, and work towards meeting those objectives through a coordinated effort.

Wisconsin

The Wisconsin Health Information Technology Extension Center (WHITEC), the REC for Wisconsin, is led by MetaStar, a Quality Improvement Organization (QIO). WHITEC has partnered with two sub-recipients, with one focusing on hospitals and the other on ambulatory providers. Many providers in the state practice in large, hospital-owned groups and many small independent providers have worked with hospitals through Stark relaxation to implement Epic, an EHR vendor. Building relationships with health care organizations has been critical to ensuring that EPs participate in the incentive programs. WHITEC partnered with the Wisconsin Primary Health Care Association (WPHCA) for outreach to community health centers (14 in total). WHITEC also performed outreach to independent providers to recruit them for the REC program. Focusing on the measures that tend to be difficult for providers to meet during their 90-day reporting period has helped more providers reach the point of attestation. These measures include the security risk assessment, public health reporting, and the HIE test. WHITEC set up an online tool to help

providers with the security risk assessment and worked directly with EHR vendors and the Wisconsin Immunization Registry to accomplish the public health reporting tests. Additionally, the state has implemented a tax credit for providers who adopt an EHR system.

WHITEC, the Wisconsin Department of Health Services (DHS), and the Wisconsin Statewide Health Information Network (WISHIN) have partnered together on outreach to providers. This outreach, which has included webinars and an in-person presence at various conferences and road shows, has been undertaken using a phased approach. DHS and WHITEC also provided high-level training and materials to Medicaid payers' provider outreach representatives and used them for outreach to providers. Annually, WHITEC, DHS, and WISHIN hold a health IT event that highlights EHR adoption, MU, and HIE.

Appendix G: Medicare and Medicaid Attestation Session Webinar

The items below were presented in March 2013 to assist Maryland providers regarding the MU Medicare and Medicaid attestation process. The webinar was provided in collaboration with DHMH, CRISP, and MedChi.[46, 47]

Medicare

- Overview of the registration process within the Registration and Attestation System (system)[48]
- Attestation process within the system
- Navigating the system
- Providing electronic health record system certification information
- Entering attestation numerators and denominators for core measures
- Entering attestation for yes/no core measures
- Entering clinical quality measures
- Selecting and reporting menu measures
- Selecting and reporting public health measures
- Reviewing the attestation summaries
- Submission process and receipt and resubmission

Medicaid

- Medicaid incentive program overview
- Eligible provider types
- Eligibility requirements
- Patient volume requirements
- Incentive payments available
- Meaningful use requirements
- Medicaid incentive program requirements
- Registration process within eMIPP
- Calculating patient volume
- Medicaid attestation process within eMIPP
- Frequently asked questions

[46] A recording of the Medicare attestation webinar is available at: http://www.crisphealth.org/MedicareEHRIncentiveProgramAttestationWork/tabid/291/Default.aspx.
[47] A recording of the Medicaid attestation webinar is available here: http://www.crisphealth.org/MedicaidAttestationWorkshopVideo/tabid/295/Default.aspx.
[48] The CMS Registration and Attestation System website is available at: https://ehrincentives.cms.gov/.

Appendix H: Management Service Organizations

MSOs have emerged as a way to address the challenges associated with provider adoption of electronic health records. These challenges include the cost and maintenance of the technology and ensuring the privacy and security of data stored electronically. State-Designated MSOs offer health information technology adoption and implementation services to providers. Below is a list of State-Designated MSOs and MSOs in Candidacy Status.[49]

State-Designated MSOs					
Count	**MSO**	**Address**	**City**	**State**	**Zip**
1	Adventist HealthCare ACES Program	1801 Research Blvd. Suite 400	Rockville	MD	20850
2	Anne Arundel Medical Center	2001 Medical Pkwy.	Annapolis	MD	21401
3	Community Health Integrated Partnership	802 Cromwell Park Dr. Suite V	Glen Burnie	MD	21061
4	Children's IQ Network	111 Michigan Ave., NW	Washington	DC	20010
5	D'Souza & Associates	530 Schoolhouse Rd Suite A	Hockessin	DE	19707
6	Darnell Associates Inc.	829 West St.	Annapolis	MD	21401
7	Frederick Memorial Hospital	478 Prospect Blvd.	Frederick	MD	21701
8	Greater Baltimore Medical Center	6701 North Charles St.	Baltimore	MD	21204
9	McFarland & Associates, Inc.	8601 Georgia Ave, Suite 601	Silver Spring	MD	20910
10	MedChi Network Services, LLC	1211 Cathedral St.	Baltimore	MD	21201
11	MedTech Enginuity Corp	12125 Guinevere Place	Glenn Dale	MD	20769
12	MedPlus	4690 Parkway Dr.	Mason	OH	45040
13	Syndicus, Inc.	275 Cape Saint John Rd.	Annapolis	MD	21401
14	Wavelength Information Services, Inc.	504 Franklin Ave. PO Box 739	Berlin	MD	21811
15	Zane Networks, LLC	8070 Georgia Ave. Suite 407	Silver Spring	MD	20910
MSOs in Candidacy Status					
Count	**MSO**	**Address**	**City**	**State**	**Zip**
1	Blue	8070 Georgia Avenue, Suite 306	Silver Spring	MD	20910
2	Doctors' Choice Medical Services, Inc.	2300 Research Blvd. Suite 100	Rockville	MD	20850
3	Innovative Health Solutions, Inc.	8160 Maple Lawn Blvd., 2nd Floor	Columbia	MD	20759

[49] More information about MSOs and State designation is available at: http://mhcc.dhmh.maryland.gov/hit/mso/Pages/mso_main.aspx.

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