

Long before the American Recovery and Reinvestment Act (ARRA) of 2009 made stimulus funding potentially available for hospitals and other eligible providers, Minnesota began coordinated efforts to plan for the adoption and interoperability of electronic health records (EHRs). As a cornerstone of this effort, in 2004 the Minnesota Department of Health (MDH) established its multi-stakeholder E-Health Advisory Committee.

State mandates

The work of the E-Health Advisory Committee led to state legislation that will require all providers to have the ability to do electronic prescribing by 2011 and then to have interoperable EHRs by 2015.

Health Information Exchange (HIE) in Minnesota

Within the last few months, MDH successfully applied for and received \$9.6 million to establish a statewide infrastructure for health information exchange (HIE). These funds were made available through the ARRA.

MDH utilized the E-Health Advisory Committee and its work groups to craft a workable statewide HIE plan. Minnesota's HIE plan defines the governance, finance and regulatory requirements for entities to qualify as health information organizations (HIOs) and registered health data intermediaries (HDIs).

- An HIO must be a non-profit company and be able to exchange clinical information with all participating providers, as well as other HIOs and HDIs. HIOs may be thought of as providing the full range of services needed to exchange clinical information. There may be one or several organizations that will qualify to serve as HIOs.

- HDIs must be able to exchange information with HIOs. Organizations that primarily provide the service of exchanging prescription information are a possible example of an HDI.

Regional extension center

Minnesota had another successful application for funds from the ARRA that will establish a regional extension center to assist small clinics

and critical access hospitals adopt EHRs and become meaningful users of health information technology. The Key Health Alliance — comprised of Stratis Health (Minnesota's quality improvement organization), the Rural Health Resource Center, and the College of St. Scholastica — was named the regional extension center for both Minnesota and North Dakota and will receive \$19 million over four years to help providers achieve meaningful use.

This is not free assistance for the providers. During the first two years of the program, participating providers pay 10 percent of the fee with a 90 percent federal subsidy. In the last two years, this ratio is flipped — the providers pay 90 percent of the cost with a 10 percent federal subsidy. This way, at the end of the four years, the total funding will be 50 percent from provider and 50 percent from federal subsidy.

Meaningful use of EHRs

In order for hospitals and eligible providers to access ARRA funds, they must be meaningful users of EHRs. Failure to achieve meaningful use by 2015 will result in Medicare payment penalties to providers. A definition of meaningful

FEDERAL ACTION REQUESTED:

Please ensure that hospitals and physicians can access ARRA funding as Congress intended.

use was put forward in a Centers for Medicare and Medicaid Services (CMS) proposed rule earlier this year. The Minnesota Hospital Association (MHA) submitted comments on the proposed rule, which are summarized below. MHA is concerned that the bar for meaningful use was set so high that none or very few hospitals will be able to meet it.

Definition of eligible provider

The intent of Congress was to exclude physicians, such as pathologists and anesthesiologists,

who work nearly exclusively at the hospital from receiving additional payments. The proposed rule expanded the definition of hospital-based provider to include any physician using the same billing company. This makes physicians who work in a clinic that is part of a health system ineligible for incentives, and if this definition were allowed to stand, would cost Minnesota in excess of \$100 million in incentives because of the way health care is organized in Minnesota.

All or nothing

The proposed rule would require hospitals to meet all 23 criteria

in order to qualify for any incentive funds. MHA's recommended alternative approach would define four or five required criteria a provider would have to meet as well as 25 percent of any of the remaining criteria in order to qualify for incentives.

For example, one of the criteria in the proposed rule is having 10 percent of all orders done through Computerized Prescriber Order Entry (CPOE). Only three in ten hospitals with an EHR have implemented CPOE, so more than 70 percent of our hospitals would be ineligible for incentives without even looking at the other 22 criteria.

Timelines

MHA believes the 2015 deadline for meaningful use is overly aggressive.

There are problems with backlogs with the EHR vendors and shortages of qualified staff. The penalties should start no earlier than 2017. The MHA approach would set a threshold of 75 percent compliance with the criteria in 2015, with 100 percent being expected by 2017.

Administrative functions and quality reporting

The proposed rule would require EHRs to perform insurance eligibility checks and claims processing. The

Health Insurance Portability and Accountability Act (HIPAA) already addressed the standardization of these electronic transactions. Consequently, this requirement in the proposed rule would be duplicative and potentially confusing. Also, the proposed rule requires EHRs to submit quality measures electronically. CMS has stated that it cannot accept the required quality measures until at least 2012. Also, the EHR vendors have not been tested for quality measures in their certification efforts. In other words, none of the vendors can prove they have the ability to produce quality measures.