House Bill 706

Electronic Health Records – Regulation and Reimbursement

Legislative Report

December 2010

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MHCC | MARYLAND HEALTH CARE COMMISSION

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Introduction

The Maryland General Assembly passed House Bill 706 (HB 706), *Electronic Health Records – Regulation and Reimbursement* (Appendix A) during the 2009 legislative session. The purpose of this legislation is to expand electronic health record (EHR) adoption and establish a statewide health information exchange (HIE). The Maryland Health Care Commission (MHCC or Commission) and the Health Services Cost Review Commission (HSCRC or Commission) are the two state agencies named in the law; each are tasked with completing specific activities related to the requirements of HB 706.

HB 706 requires the Commissions to designate a statewide HIE for the private and secure exchange of electronic health information among health care providers. The Commissions designated the Chesapeake Regional information System for our Patients (CRISP) as the statewide HIE in 2009. Part of the law states that the MHCC must designate one or more Management Service Organizations (MSOs) to offer services throughout the state. MSOs offer hosted EHRs as an alternative to the traditional model where the technology is located at the provider site. The MHCC must also adopt regulations that require state-regulated payers to provide incentives of monetary value to providers for implementing EHRs. Working with an MSO Advisory Panel, the MHCC established a program for MSOs to receive State Designation.

The MHCC is required to report annually through 2012 to Governor Martin O'Malley, the Senate Finance Committee, and the House Health and Government Operations Committee on the status of expanding health information technology (health IT), which includes EHR adoption and HIE implementation. Each reporting year requires the MHCC to address specific items identified in HB 706; the 2010 update includes the following information:

- *The development of a coordinated public-private approach that improves the state's health information infrastructure;*
- *The recommended language for the EHR adoption incentive regulations;*
- *Any actions that are necessary to align funding opportunities under the American Recovery and Reinvestment Act of 2009 (ARRA) with other state and private sector initiatives related to health IT; and*
- *Proposed legislation for any changes in state laws that are necessary to:*
    - *Protect the privacy and security of health information stored in EHRs or exchanged through the HIE; and*
    - *Provide for the effective operation of an HIE in the state.*

HB 706 required the MHCC to post the report on its website for public comment (see Appendix I) and includes a provision that enables the Senate Finance Committee and the House Health and Government Operations Committee to review and comment on the proposed EHR incentive regulations. The committees have 60 days from receipt of the report to provide the MHCC with feedback on the regulations.

Health Information Technology
A Coordinated Public-Private Approach

Health Information Exchange Planning

Four years ago, the MHCC began the process of planning for a statewide HIE by engaging numerous stakeholders to address fundamental health IT issues and determine a course of action. The MHCC brought together a series of multi-stakeholder groups to assess the current health IT landscape and discuss various policy strategies. A number of major assessment and policy reports (Appendix B) were produced based on these consensus-building deliberations. The work of these groups established the foundation for planning and implementing a statewide HIE.

Two independent multi-stakeholder groups were competitively selected in 2008 to propose strategies for the governance, technical architecture, privacy and security, and financially sustainable business model for the statewide HIE. After a comprehensive review of the two planning reports that were submitted in February 2009 and a thorough study of HIEs nationally, the MHCC developed the *Design Specifications for the Maryland HIE*. The MHCC used the design specifications to develop a Request for Applications (RFA) to build *A Consumer-Centric Health Information Exchange for Maryland*.

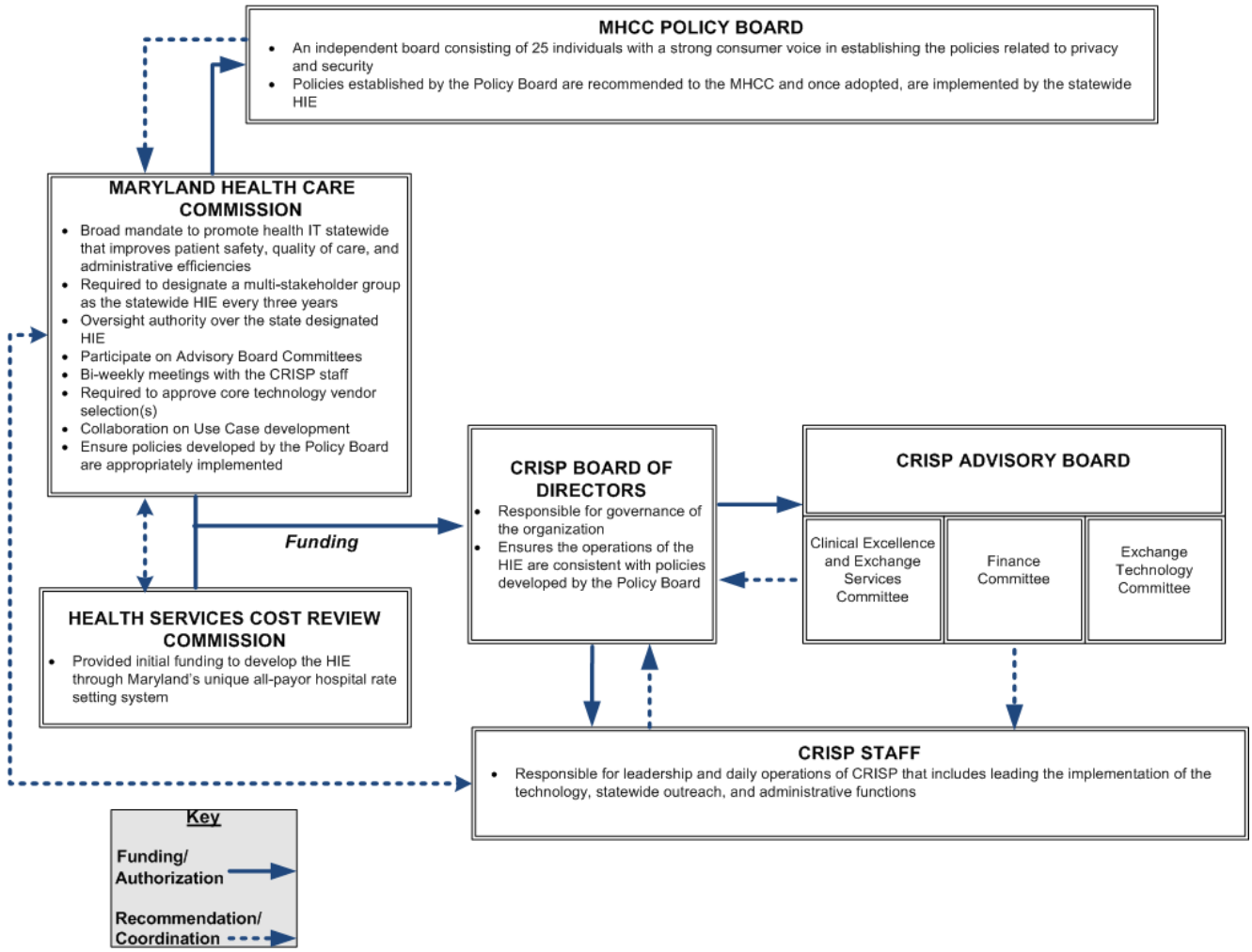
Health Information Exchange Implementation

In August 2009, the Commissions designated CRISP, a multi-stakeholder and non-profit organization, to build the statewide HIE. CRISP is a collaborative effort among Johns Hopkins Health System, MedStar Health, University of Maryland Medical System, Erickson Retirement Communities, and more than two dozen other stakeholder groups. The HSCRC awarded initial funding of up to $10 million through Maryland's unique all-payer hospital rate setting system. In March 2010, the MHCC received a federal award of $9.3 million to develop a statewide HIE through the federally funded *State Health Information Exchange Cooperative Agreement Program*—a program funded through the *Health Information Technology for Economic and Clinical Health* (HITECH) *Act* and administered by the Office of the National Coordinator for Health Information Technology (ONC). The goal is to establish a private, secure, and consumer-centric statewide HIE that enables appropriately authorized providers to exchange electronic health information. Maryland's approach ensures high quality, safe, and effective health care; makes certain that data is exchanged privately and securely; ensures transparency and stakeholder inclusion; supports connectivity regionally and nationally; achieves and maintains financial sustainability; and serves as the foundation for transforming health care statewide.

HIE Governance

The HIE governance structure consists of the CRISP Board of Directors, the Advisory Board, and an independent Policy Board convened by the MHCC. The Board of Directors is comprised of members appointed by the respective founding member organizations. The Advisory Board is divided into four committees. While a strong provider representation on the Advisory Board guides the CRISP Board of Directors on the development and operation of the statewide HIE, a consumer focused Policy Board establishes the policies governing data sharing. This separation of responsibilities assures that policies that govern the exchange of electronic health information are consumer oriented (see Figure 1 for an illustration of the Maryland HIE Governance Structure).

Figure 1 – Maryland HIE Governance Structure



Board of Directors

The statewide HIE Board of Directors is the authoritative entity overseeing the operations of the statewide HIE. The Board of Directors considers the recommendations of the Advisory Board and ensures that the policies developed by the Policy Board are implemented. The governance structure of the statewide HIE is fairly consistent with those implemented by other HIEs nationally. The statewide HIE bylaws provide a mechanism to support changing the composition of the Board of Directors as long as these revisions do not have a significant impact on governance, best practices, or legal considerations, such as those for tax-exempt organizations.

Advisory Board

The statewide HIE operates under the guidance of an Advisory Board. The statewide HIE Advisory Board is organized into the following four committees - technology, finance, clinical excellence and exchange services, and small practice; each committee is comprised of approximately 10 to 15 members. Members are identified through a nomination process and appointed by the Board of Directors. Most of the work done by the Advisory Board is accomplished at the committee level. The Advisory Board is tasked with making recommendations on matters such as the technology to support the core infrastructure, early Use Case implementation, and sustainability models.

The Policy Board

The Policy Board is comprised of approximately 25 members selected based upon their expertise, the breadth of stakeholder representation, and a strong consumer voice, which is essential to building trust among stakeholders. Ex-officio members of the Policy Board consist of representatives from CRISP and state government including Medicaid, the MHCC, and the HSCRC. The responsibilities of this Policy Board primarily include the development of policies for privacy and security (see Appendix E for the Policy Board Operating Guidelines). The MHCC will consider the policies developed by the Policy Board; the statewide HIE is required to implement policies adopted by the MHCC.

The Policy Board is convened on a six-week schedule (Appendix D) and over the past year has made notable progress in drafting key policies that will govern the statewide HIE. Approximately 17 policies (Appendix F) have been identified for development. The Policy Board establishes the prioritization of policy development with advisement from the statewide HIE and the MHCC.

HIE Operations

In the first year of operations, the statewide HIE secured the organization's business site, developed a Request for Proposal (RFP) for the Master Patient Index (MPI) technology, developed the RFP for the Core Infrastructure, and completed the response evaluations for both RFPs. A team of industry experts evaluated the RFPs and took part in vendor demonstrations. Following a thorough evaluation process, Axolotl was selected as the vendor for the Core Infrastructure, and Initiate Systems was selected as the vendor for the patient matching technology, or MPI. The Axolotl and Initiate products will support connectivity to 46 acute care hospitals and nearly 8,000 physician practices throughout Maryland. The statewide HIE also developed a universal provider agreement that all stakeholders are required to sign for participation in the HIE. The Maryland Motor Vehicle Administration (MVA) database is currently being assessed to determine the possibility of using select data elements to populate the MPI database.

The statewide HIE will enable critical information to be shared among providers of different organizations and different regions in real-time; support the use of evidence-based medicine; contribute to public health initiatives in biosurveillance and disease tracking; and prepare for emergency preparedness efforts that will positively impact health care outcomes by providing greater access to secure and accurate health information. The architecture of the statewide HIE is a distributed model where data remains at the source and the statewide HIE acts as the conduit for the secure transmission of this data from one provider or organization to another.

HIE Connectivity

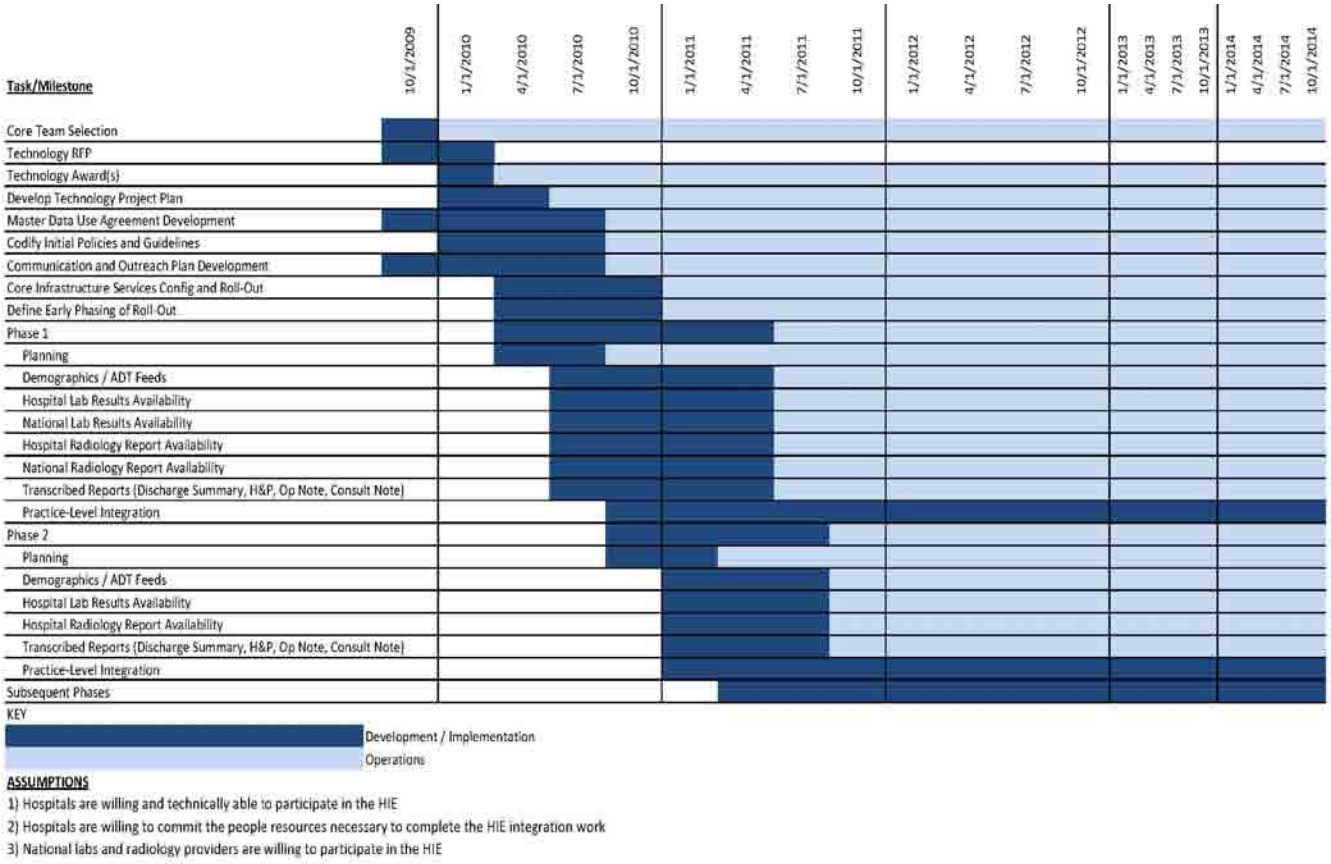
In July, Governor Martin O'Malley, Lieutenant Governor Anthony Brown, and Secretary of the Department of Health and Mental Hygiene John Colmers, along with the MHCC convened a *Health Information Technology Forum* (Forum) at Sinai Hospital in Baltimore with the hospital Chief Executive Officers (CEOs) and other senior level executives from Maryland's acute care hospitals. In attendance at the Forum were elected officials, media, and more than 200 hospital representatives. State leaders stressed the value of the HIE and the significance of sharing information between places of care and coordinating efforts across different providers. They also mentioned that electronic health information will become even more important in an era of personalized medicine and accountable care. The Governor, Lieutenant Governor, and Secretary encouraged the CEOs to sign a Letter of Intent (LOI) conveying their hospital's intent in connecting to the statewide HIE. The statewide HIE received a signed LOI from each of the acute care hospitals in September. Hospitals selected one of four timeframes for connecting (see Table 1 for the *Timeframes Specified by Hospitals for Connecting to the HIE*).

Table 1 – Timeframes Specified by Hospitals for Connecting to the HIE

Timeframe for HIE Connectivity	Percent of Hospitals
Early (6 months)	38
Mainstream (6-12 months)	23
Deferred (12-18 months)	22
Late (18-24 months)	17

Efforts to connect providers to the statewide HIE have centered on hospitals, since they are considered large suppliers of data, and will then proceed to connect ambulatory care practices. The Montgomery County hospitals were the first to begin connecting to the statewide HIE; most of these hospitals as well as Quest Diagnostics, LabCorp, RadNet, and American Radiology are connected to the exchange. The statewide HIE anticipates connecting ambulatory care providers beginning in 2011 and expects to have all hospitals connected within two years. Providers connecting to the statewide HIE will be able to exchange data as specific services are made available through the exchange. The statewide HIE has an ambitious schedule to implement services over the next six months (see Figure 2 for an illustration of the *HIE Services Implementation Timeline*).

Figure 2 – HIE Services Implementation Timeline



The State Health Information Technology Plan

The MHCC developed a comprehensive *State Health Information Technology Plan* (plan; Appendix J) for advancing health IT in the state that is updated annually. The approach balances the need for information sharing with the need for strong privacy and security policies, while maintaining a judicious approach to funding the statewide HIE. The plan describes a strategic and operational approach for establishing an HIE with sound technology and robust policies to ensure that all electronic health information is securely

delivered in real-time to individuals and their providers when needed, and that this information is available to analyze for continuous improvement in the delivery of care and research. The MHCC's plan is one of the first three in the nation to receive ONC approval, which was essential in securing federal funding for the HIE. While the detailed implementation of the statewide HIE is entrusted to the knowledgeable experts and informed by a broad range of stakeholder input, the governance, policy, and technical infrastructure outlined in the plan makes certain that the general public has a strong role in the development of fundamental policies governing the statewide HIE.

EHR Adoption Activities

Provider adoption and meaningful use of EHRs is an essential component in transforming care delivery. An EHR that has achieved national certification is a requirement for providers to connect to the statewide HIE. The MHCC has provided support on a number of provider initiatives aimed at increasing EHR adoption across the state. These initiatives include the EHR Product Portfolio, the Centers for Medicare & Medicaid Services' (CMS) EHR Demonstration Project, Long Term Care (LTC) EHR Adoption initiative, the Regional Extension Center (REC) Program, Management Service Organization (MSO) State Designation, and the EHR Incentives program.

EHR Product Portfolio

In September 2008, the MHCC released the first version of the EHR Product Portfolio (portfolio). The portfolio is revised annually and updated semi-annually, and is in its third release with approximately 30 vendors participating in the portfolio. The portfolio contains side-by-side comparison information regarding EHR products, pricing, consumer reviews, and privacy and security policies. Included in the portfolio is a number of literature resources that can help providers assess, select, and implement an EHR.

CMS EHR Demonstration Project

Maryland is one of four states participating in the CMS EHR Demonstration Project (CMS project); the other states include Louisiana, Pennsylvania, and South Dakota. In Maryland, the CMS project is studying EHR adoption in 255 small to medium-sized primary care physician practices. The MHCC provides physician practices with support in the evaluation of EHRs and educational material related to the adoption and meaningful use of EHRs. The CMS project began in June 2009 and continues through May 2014.

LTC EHR Adoption Initiative

The MHCC is working with the Health Facilities Association of Maryland and LifeSpan Network, the two long term care (LTC) associations in Maryland, to advance EHR adoption among independent LTC organizations. LTC administrators participated in several meetings to explore options for implementing EHRs. The MHCC completed an EHR adoption environmental scan and found that EHR adoption by independent LTC organizations increased by 4 percent over the last year to around 28 percent. These findings will be used by the MHCC to develop EHR adoption programs in collaboration with the two LTC associations.

REC Program

The statewide HIE received $5.5M in funding from the ONC under the HITECH Act to establish a regional extension center (REC) in Maryland. The goal of the REC is to help 1,000 priority primary care providers, as defined by the ONC, in Maryland with adopting EHRs and achieving the meaningful use requirements. The statewide HIE worked with the MHCC to develop a sustainable business model that utilizes State Designated MSOs to enable the REC to meet the ONC requirements, expand EHR adoption, and provide

other EHR-related services to all providers. The MHCC State Designation is a core component for an MSO to participate with the REC. The statewide HIE has partnered with roughly 13 MSOs that are currently in Candidacy Status for State Designation. These MSOs are expected to offer assistance to all providers in Maryland and will receive subsidies under the ARRA for assisting priority primary care providers in meeting established milestones, which include: provider enrollment, EHR implementation and utilization, and meeting meaningful use.

COMAR 10.25.15, Management Service Organization State Designation

Overview

MSOs have emerged as a way to address the financial and technical challenges associated with the adoption of EHRs by providers. Unlike the traditional EHR client-server model where the data and technology is hosted locally at the provider site, MSOs offer EHRs hosted in a centralized, secure data center. The data is safeguarded through a network operating center that, by design, ensures high quality and uninterrupted service. MSOs enable physicians to access a patient's medical record wherever access to a high speed Internet connection exists. MSOs eliminate the costs associated with technology maintenance and the responsibilities assumed by the provider that accompany the private and secure storage of electronic health information. Remotely hosted EHRs enable providers to focus on practicing medicine rather than expending time and resources to support the software application and hardware.

Background

HB 706 requires the MHCC to designate one or more MSOs that offer services throughout the state. The MHCC convened an Advisory Panel (Panel) consisting of nearly 40 stakeholder organizations to develop the *MSO State Designation Criteria* (Appendix G). The Panel established standards for privacy and confidentiality, technical performance, business practices, resources, security, and operations for MSOs seeking State Designation. Approximately 18 MSOs have applied for State Designation (Appendix H). The proposed regulations for MSO State Designation were published in the August 27th issue of the *Maryland Register* and are outlined below.

> Title 10
>
> DEPARTMENT OF HEALTH AND MENTAL HYGIENE
>
> Subtitle 25 MARYLAND HEALTH CARE COMMISSION
>
> Chapter 15 Management Service Organization State Designation
>
> Authority: Health-General Article, §§4-302, 19-103(c)(2)(i) and (ii), 19-109(a)(1), 19-135(a), (b), and (d), and 19-143(h), Annotated Code of Maryland
>
> ***.01 Scope.***
>
> This chapter applies to the State Designation of Management Service Organizations. Only those Management Service Organizations that complete the State Designation process pursuant to this chapter may utilize the Management Service Organization State Designation status title.
>
> ***.02 Definitions.***
>
> A. In this chapter, the following terms have the meanings indicated.
>
> B. Terms Defined.

(1) "Candidacy Status" means the preliminary status granted by the MHCC to an MSO after the MSO submits an approved application and prior to the MSO successfully completing the MSO State Designation Criteria.

(2) "Commission" or "MHCC" means the Maryland Health Care Commission.

(3) "Electronic Health Record (EHR)" means technology that maintains a longitudinal record of health information in an electronic format.

(4) "Executive Director" means the Executive Director of the MHCC.

(5) "Formal Disposition Letter" means a letter issued by the Executive Director or the Executive Director's designee that acknowledges whether an MSO has met the initial documentation requirements for application.

(6) "Health Information Exchange (HIE)" means a statewide infrastructure that provides organizational and technical capabilities to enable the electronic exchange of health information between health care providers and other health service organizations authorized by the Commission.

(7) "Management Service Organization (MSO)" means an organization that offers one or more hosted electronic health record solutions and other management services to multiple health care providers.

(8) "National Accrediting Organization" means an independent accrediting organization that is recognized by the MHCC to administer the State Designation Criteria.

(9) "Network Operating Center (NOC)" means a secure data center where the MSO maintains the data and technology.

(10) "State Designation" or "State Designated" means the status granted by the Commission to an MSO that has met the criteria requirements for State Designation under this chapter.

(11) "MSO State Designation Criteria" means the standards that an MSO must meet to obtain State Designation, as determined by the Commission.

.03 Designation Time Lines.

A new or existing MSO that desires State Designation shall:

A. Provide evidence that it has been granted full accreditation status by a national accrediting organization; and

B. Comply with the requirements of this chapter.

.04 Duration of State Designation.

State Designation is valid for two years, unless suspended or revoked by the Commission.

.05 Procedure to Obtain State Designation.

A. Application for State Designation.

(1) An MSO must submit a completed application with the MHCC on a form prescribed by the Commission.

(2) An application on behalf of a corporation or association shall be made by an authorized officer of the corporation or association, or their designee.

(3) The MHCC will evaluate the application based on initial documentation requirements determined by the Commission and issue a formal disposition letter to the applicant.

(4) An MSO will be considered in Candidacy Status immediately after the Commission issues a formal disposition letter that acknowledges that the MSO has met the Commission’s initial documentation requirements for application.

(5) MSOs in Candidacy Status are considered to be State Designated by the Commission.

(6) An MSO in Candidacy Status has one year from the date of the issuance of its formal disposition letter to obtain accreditation from a nationally recognized accrediting organization, or the MSOs Candidacy Status may be revoked by the Commission.

(7) The applicant for a State Designated MSO is the holder of the MSO State Designation certificate issued by the Commission and responsibility for conformance with the standards and regulations of this chapter rests on the holder.

B. The Executive Director or the Executive Director's designee shall review each application for State Designation to determine whether the applicant meets all State Designation standards.

C. The Executive Director or the Executive Director's designee shall award State Designation when an applicant meets the requirements of this chapter.

.06 Standards for Designation.

In order to obtain State Designation, an applicant shall:

A. Be State Designated by the Commission as having complied with the MSO State Designation Criteria in effect on the date the applicant applies for or renews State Designation; and

B. Agree to become a State Designated MSO.

.07 Nontransferability of Designation.

State Designation issued pursuant to these regulations may not be sold, assigned, leased, or transferred in any way to a person or entity that is not the certified entity.

.08 Transfer of State Designated MSO.

A. At least 60 days before the closure, sale, lease, assignment, or transfer of a State Designated MSO to any other person or entity, the State Designated MSO shall notify the Commission of the impending closure, sale, lease, assignment, or transfer of the State Designated MSO.

B. If a State Designated MSO is closed, sold, leased, assigned, or transferred in any way to a person or entity that is not the State Designated entity, the Executive Director shall or the Executive Director's designee shall review current State Designation status pursuant to the renewal requirements set forth in Regulation .09 of this chapter.

.09 Renewal of State Designation.

A. Application for renewal of State Designation shall be made at least 90 days before the expiration of the State Designation in a manner prescribed by the Commission.

B. The applicant shall submit the self-assessment manuscript and undergo a site review by a representative of a nationally recognized accrediting body no later than 90 days from the expiration of the State Designation.

C. The Executive Director or the Executive Director's designee shall renew the State Designation of each renewal applicant and determine whether the applicant meets the requirements set forth in this chapter.

D. If the Executive Director or the Executive Director's designee determines that a renewal application should be denied, the Executive Director or the Executive Director's designee shall notify in writing of the decision, supported by reasons, within 45 days of a receipt of an application for renewal.

.10 Grounds for Denial or Other Penalties.

The following are grounds for denial of State Designation, denial of State Designation renewal, suspension, revocation of State Designation, or imposition of conditions on a State Designated MSO:

A. Failure to meet any requirements and standards set forth in this chapter, as determined by the Commission;

B. A principal, owner, or operator of the State Designated MSO or the corporation itself pleading guilty to or being convicted of or receiving probation before judgment for a crime related to the operation of the MSO; or

C. A principal, owner, or operator of the State Designated MSO or the corporation itself being found in violation of State or federal laws or regulations governing the operation of the MSO.

.11 Commission Review.

A. The Commission may, on its own motion or in response to a grievance or complaint filed with the Commission by a member of the public, investigate any State Designated MSO or applicant for State Designation and, following an investigation, the Executive Director or the Executive Director's designee may take remedial action, including any of the following sanctions:

(1) Suspension for a definite period of time, depending upon the circumstances of the case, after which an MSO may petition for reinstatement of its State Designation;

(2) Imposition of conditions necessary to remedy any deficiencies revealed during the Commission's investigation; or

(3) Revocation.

B. At the Commission's discretion, a State Designated MSO may be allowed the opportunity to correct the deficiencies identified by the Commission before the imposition of any sanction.

C. The Commission, at its discretion, may provide an opportunity for an applicant or State Designated MSO under consideration for sanctions to present its position to the Commission, either in person or in writing.

Formal Public Comments Received

The MHCC received comments from MedChi, The Maryland State Medical Society, on the proposed regulations. MedChi encouraged the MHCC to require MSOs to carry liability insurance and have a Maryland workforce. MedChi suggested that MSO be required to provide a letter of credit or performance bond with their State Designation application. MedChi also recommended the MHCC designate an MSO of last resort to ensure the market includes at least one MSO.

MHCC Recommendations

The MHCC took final action on the proposed regulations at the October 21st Commission meeting. The comments the MHCC received during the comment period were considered by the Commission. The regulations were adopted by the Commission without any modification. The following is a summary of the comments received in response to the proposed *Management Service Organization State Designation* regulations.

Summary of Proposed Changes and MHCC Recommendations

1) Require MSOs to provide proof of workers compensation and general liability insurance.

   The MHCC does not support including a requirement in the regulations for MSOs to submit proof of workers compensation and general liability insurance. The regulations require that an MSO seeking State Designation must submit an application to the MHCC. MSOs are required to submit this information as part of the application process.

2) Require MSOs to submit a letter of credit or performance bond with their application.

   The MHCC does not support including a letter of credit or a performance bond as a requirement in the regulations. MSOs in candidacy status have expressed concern about the financial burden of

this requirement and said they would exit the Maryland market if this becomes a requirement. MHCC has determined that EHR solutions hosted by the MSOs already include various provider financial safeguards in the event the vendor discontinues support of the solution.

3) Establish an MSO of last resort.

The MHCC does not support establishing an MSO of last resort in the regulations. Approximately 18 MSOs have met the requirements for candidacy status. MSOs must offer nationally certified products, achieve national accreditation, and have in place a Business Continuity Plan to ensure that providers will be able to transition to another MSO in the event that their current MSO decides to exit the market.

COMAR 10.25.16, Electronic Health Record Incentives

Overview

Maryland is the first state to require certain state-regulated payers to provide incentives of monetary value to select health care providers to promote the adoption and use of EHRs. At present, only Medicare and Medicaid offer incentives to providers for the adoption and meaningful use of EHRs. These incentives are made available to select providers under certain circumstances through the HITECH Act. The MHCC developed EHR incentive regulations as a result of HB 706.

Background

In September 2009, the MHCC convened a public meeting where approximately 22 stakeholder organizations, including payers and providers, gathered to discuss ideas related to developing the EHR incentive regulations. Feedback from the public meeting and additional input from various stakeholders over a six-month timeframe were used in drafting the regulations. COMAR 10.25.16, *Electronic Health Record Incentives,* was published in the July 30th issue of the *Maryland Register* and is outlined below.

> 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), 19–143(d)(1)(2)(3)(4) and (i), Annotated Code of Maryland
>
> **.01 Scope.**
>
> A. This chapter applies to the state-regulated payors who provide incentive payments to providers that adopt and use electronic health records.
>
> B. Only providers who meet the requirements pursuant to this chapter will receive incentive payments for electronic health record adoption.
>
> **.02 Definitions.**
>
> A. In this chapter, the following terms have the meanings indicated.
>
> B. Terms Defined.
>
> (1) "MHCC or Commission" means the Maryland Health Care Commission.
>
> (2) "Additional Incentive" means a monetary amount above the Base Incentive for a practice that meets additional criteria in the use and adoption of electronic health records including

adoption of electronic health records through a Management Service Organization and/or a practice that can demonstrate advanced use of electronic health records.

(3) "Base Incentive" means a monetary amount that an eligible practice can receive as calculated by the number of payor members treated by the practice on a per member bases.

(4) "Electronic health record (EHR)" means an electronic record of health-related information on an individual that:

(a) Includes patient demographic and clinical health information; and

(b) Has the capacity to:

(i.) Provide clinical decision support;

(ii.) Support physician order entry;

(iii.) Capture and query information relevant to health care quality; and

(iv.) Exchange electronic health information with and integrate the information from other sources.

(5) "EHR Monetary Incentive Application" means an application submitted by a practice to a payor that will seek an incentive payment for EHR adoption.

(6) "EHR Monetary Incentive Application acknowledgement letter" means a letter sent by the payor to the practice accepting the practice's EHR Monetary Incentive Application.

(7) "EHR Monetary Incentive Voucher" means an application sent by the practice to the payor requesting the incentive payment.

(8) "Health information exchange (HIE)" means a statewide infrastructure that provides organizational and technical capabilities to enable the electronic exchange of health information between health care providers and other health services organizations authorized by the Commission.

(9) "Management service organization (MSO)" means an organization that offers one or more hosted electronic health record solutions and other management services to health care providers.

(10) "Non-hospital owned practices" means a family, general, geriatric, internal medicine, pediatric, or gynecologic practice designated by the payor for the EHR adoption incentive that is not owned by a hospital.

(11) "Payor" means state-regulated payor.

(12) "Practice" means a primary care practice consisting of a single or group of physicians that provide patient care services in family, general, geriatric, internal medicine, pediatric or gynecologic practice.

(13) "Practice panel" means the patients who have been assigned to a primary care provider by the payor or the patients treated by the practice within the last 24 months when the payor does not assign a primary care provider.

(14) "State Designated MSO" means an MSO that has received state designation by the MHCC.

(15) "State-regulated payor" includes:

(a) Aetna, Inc.; CareFirst BlueCross BlueShield; CIGNA HealthCare Mid-Atlantic; Coventry Health Care; Kaiser Permanente; and United Healthcare, Mid Atlantic Region;

(b) The state employee and retiree health and welfare benefits program; and

(c) Does not include a managed care organization as defined in Title 15, Subtitle 1 of this article.

.03 Program Description.

A. The EHR adoption incentive is a one-time incentive that can be administered through reimbursement for specific services; lump sum payments; gain-sharing arrangements; rewards for quality and efficiency; in-kind payments; or other items or services that can be assigned a specific monetary value.

B. The EHR adoption incentive is available to non-hospital owned practices.

C. A payor must provide a written description of the incentive of monetary value and timeframe for distribution to a practice.

D. A payor may exclude plan participants from the incentive calculation for a practice that was previously included in another practice's incentive calculation.

E. A practice that has received a payor EHR adoption incentive before January 1, 2011 is only eligible to receive the difference between the payor's initial monetary incentive value and the maximum value of the incentive under these regulations.

F. A payor must provide a practice with the total value of any EHR adoption incentive they provided prior to January 1, 2011 upon written request by a practice.

G. Payors have the authority to request additional information from a practice to validate their incentive claim and to reduce payments to a practice where a payor determines that duplicate and /or overpayments have been made.

H. The MHCC has the authority to audit both the payor and the practice for compliance with these regulations and can request corrective action in areas of non-compliance.

.04 Participation Requirements.

A. To be considered for an EHR adoption incentive, a practice must complete an EHR Monetary Incentive Application; the practice will submit the completed application to the appropriate payor(s). The application will include:

(1) Practice specific information:

(a) Name;

(b) Address;

(c) Specialty;

(d) Organizational National Provider Identifier number; and

(e) Tax Identification Number.

(2) The total number of members on the practice panel. In situations where the payor does not assign a primary care provider, the total number of members treated by the practice in the last 24 months;

(3) The name and version of the nationally certified EHR system implemented by the practice;

(4) A description of the EHR functions that have been implemented by the practice;

(5) A plan outlining when the practice expects to implement the available EHR system functionality; and

(6) A signed attestation regarding the accuracy of the information contained in the application.

B. A practice must submit an EHR Monetary Incentive Application nine months in advance of requesting an EHR adoption incentive.

C. Payors must issue an EHR Monetary Incentive Application acknowledgement letter within 90 days of receiving an application.

D. A practice can request an incentive of monetary value approximately nine months after receiving an EHR Monetary Incentive Application acknowledgement letter, and not later than 15 months from the time they are eligible to submit their incentive payment request.

E. A practice must complete an EHR Monetary Incentive Voucher and submit it to the appropriate payor to receive an EHR incentive.

F. A practice will be required to include in the EHR Monetary Incentive Voucher the following:

(1) A copy of the EHR Monetary Incentive Application acknowledgement letter; and

(2) A report that includes the identification information of the members on the practice panel at the time of the request. In situations where the payor does not assign members to a

practice, the practice must provide a list of the payors' members treated by the practice within the last 24 months.

G. A payor may request additional information to validate an incentive payment request.

H. Member eligibility used in the incentive calculation is based on enrollment with the payor at the time a practice makes a request for the incentive payment.

I. Payors must adjudicate EHR Monetary Incentive Vouchers within 60 days of receipt.

J. Payors are required to notify practices in writing of the monetary incentive value, how it will be distributed to the practice, and over what time period.

.05 Incentive Components.

A. A practice that meets the requirements for participation will receive an incentive of monetary value from the payor based on the payor's share of members treated by the practice. Incentives are calculated on a per member basis.

B. An Additional Incentive of monetary value is available to a practice that adopts EHRs through a State Designated MSO.

(1) A practice that adopts an EHR through a State Designated MSO is required to submit a copy of the MSO's state designation certificate with their EHR Monetary Incentive Voucher.

C. An Additional Incentive of monetary value is available to a practice for demonstrating advanced use of EHRs during the immediate 90 days prior to submitting an EHR Monetary Incentive Voucher to a payor. The following advanced uses of an EHR will be considered:

(1) As defined in Definitions .02(4);

(2) Participates in a payors' quality improvement outcomes initiative, and has achieved the established performance goals; and

(3) A signed attestation is required by the practice to substantiate advanced use of an EHR system, and that the practice is a participant in the state designated HIE.

.06 Incentive Payment Calculation by Payor.

A. The eligibility time period for a practice to apply for an EHR adoption incentive is January 1, 2011 through December 31, 2014.

B. Payors have the flexibility to disburse incentives over a 12-month timeframe.

C. EHR adoption incentives of monetary value are calculated at $8 per member and limited to Maryland residents.

D. The EHR adoption incentive has a maximum monetary value of $15,000 per practice per payor (combined Base Incentive and Additional Incentives).

E. The monetary value of the Base Incentive must account for approximately 50 percent of the combined Base Incentive and Additional Incentives in .05 D.

F. EHR adoption incentives for hardware and/or software may be declined by a practice in which case a payor is required to offer an alternative adoption incentive of equal monetary value.

.07 Reporting.

A. Payors are required to submit an annual report to the MHCC no later than March 31st of the following year for calendar years 2011 through 2014 that includes the following information:

(1) Number of incentive applications received and paid for that year;

(2) Total value of distributed Base Incentives for that year; and

(3) Total value of Additional Incentives for that year.

Formal Public Comments Received

The MHCC received comments from 18 organizations (Appendix I), which included responses from: 1) Anne Arundel Health System; 2) Atlantic General Hospital; 3) CareFirst; 4) Eastern Shore Psychological Services; 5) Kaiser Permanente; 6) Maryland Academy of Audiology; 7) Maryland Chapter of the American College of Physicians; 8) Maryland Department of Budget and Management; 9) Maryland Health Care Commission; 10) Maryland Hospital Association; 11) Maryland Podiatric Medical Association; 12) MedChi,

The Maryland State Medical Society, along with the American Academy of Pediatrics, the Maryland Academy of Family Physicians, the American College of Physicians – Maryland Section, the Mid-Atlantic Association of Community Health Centers, and the Maryland Hospital Association; 13) MedChi, The Maryland State Medical Society; 14) MedStar Health; 15) Mosaic Community Services; 16) J. William Pitcher, Esq., representing the Nurse Practitioner Association of Maryland, the Maryland Academy of Audiologists, the Maryland Psychological Association, the Maryland Athletic Trainers Association, and the Maryland Ambulatory Surgical Association; 17) St. Luke's House; and 18) United Healthcare.

MHCC Recommendations

The MHCC has not taken final action on the regulations. As previously mentioned, HB 706 requires the Senate Finance Committee and the House Health and Government Operations Committee to review and provide comments on the regulations within 60 days of receipt of this report. In general, providers that commented on the regulations requested the MHCC to modify the definition of an eligible practice, limited to primary care practices in the proposed regulations, to include them. The Commission specifically decided to focus the incentive on primary care practices where the need for incentivizing EHR adoption is the greatest and a limited amount of subsidy funding would have the greatest impact. Most providers are eligible for substantial federal subsidies for EHR adoption: incentives available for Medicare providers can reach $18,000 per eligible professional in year one and $44,000 in total, and incentives available to Medicaid providers can reach $21,000 in year one and $63,750 overall. The federal incentives will help offset the investment in EHR adoption for a wide range of providers including hospitals. State funding comes directly from carriers and thus from premium dollars; because of this, the Commission has kept the incentive program carefully focused to produce the greatest benefit at a reasonable cost. Most other commenters proposed clarifying language to select items within the regulations. The following is a summary of the comments received in response to the proposed *Electronic Health Record Incentives* regulations.

Summary of Proposed Changes and MHCC Recommendations

1) Allow providers to select incentive type.

   The MHCC does not support allowing providers to select the incentive type. The MHCC concludes that state-regulated payers should have some degree of flexibility to offer a combination of incentives of monetary value.

2) Decrease the payment period for eligible practices to receive an incentive.

   The MHCC supports adjusting the payment period down from nine (9) months, as outlined in the regulations, to six (6) months. Section .04 Participation Requirements E.

3) Expand the definition of practice beyond primary care to include other specialties.

   The MHCC does not support expanding the definition of an eligible provider for the reasons stated above.

4) Exempt the State of Maryland as a payer under the regulations.

   The MHCC does not have the authority to exempt the State of Maryland through the regulatory process. In contrast to the definition of eligible provider, in which the Commission is given substantial regulatory authority, the definition of a state-regulated payer is set forth in statute and explicitly includes the State of Maryland . Statutory change would be necessary to exempt the state employee health benefit program, based on its status as a self-insured health benefit plan

5) Include physicians practicing in hospital-owned practices in the definition of primary care provider.

The MHCC does not support expanding the incentives to hospital-owned physician practices. The current definition is largely consistent with the federal EHR incentive program. Hospital-owned practices generally receive substantial EHR support from the hospital system.

6) Require the MHCC to develop the EHR Monetary Incentive Application.

The MHCC supports developing a standard application using the criteria in the proposed regulations. The application will be made available on the MHCC website.

Proposed Clarifying Language and MHCC Recommendations

1) Include national certification as a requirement of the EHR in the definition of an EHR. *Section .02 Definitions B(4).*

The MHCC supports this change.

2) Change the definition of a Management Service Organization to Management Service Organization (MSO) means an organization that has received recognition by the Maryland Health Care Commission (MHCC) as a State Designated MSO or has received MHCC MSO Candidacy Status in accordance with HB 706, *Electronic Health Records- Regulation and Reimbursement*. *Section .02 Definitions B(9).*

The MHCC supports this change.

3) Scope should be clarified to include only a fully insured business, not self-funded plans by referencing the title under which payors are regulated. *Section .01 Scope A.*

The MHCC does not support this change.

4) Modify the definition of practice to include "…located in the State of Maryland." *Section .02 Definitions B(12).*

The MHCC supports this change.

5) Include *member* in the definitions as an individual covered by a state-regulated insurance plan or the State of Maryland plan and a resident of the state. *Section .02 Definitions.*

The MHCC does not support this change.

6) Insert the words *evidence of* before the "total value of any EHR…" *Section .03 Program Description F.*

The MHCC supports this change.

7) Change the definition of the EHR monetary incentive voucher to mean documentation sent by a practice to the payer supporting validation of an incentive payment request. *Section .02 Definitions B(7).*

The MHCC supports this change.

8) Program Description should change to a payer's prior monetary incentive. *Section .03 Program Description E.*

The MHCC supports this change.

Funding Alignment Opportunities

HB 706 requires the MHCC to identify any actions that are necessary to align funding opportunities under the ARRA with other state and private sector initiatives related to health IT. The law focuses on the patient centered medical home, CMS's EHR demonstration project, the HIE, and the Medicaid information technology architecture initiative (MITA). An essential component for the success of these programs is the need to exchange patient information electronically, and increase adoption and meaningful use of EHRs.

Patient Centered Medical Home

The patient centered medical home (PCMH) is a model of practice where a team of health professionals, guided by a primary care provider, provides continuous, comprehensive, and coordinated care in a culturally and linguistically sensitive manner to consumers. On April 13th Governor Martin O'Malley signed a law entitled the *Patient Centered Medical Home Program* (HB 929, 2010 legislative session). This law requires the MHCC to establish a PCMH program that will provide care to nearly 200,000 consumers in Maryland. Under this program, reimbursement includes a care coordination payment plus opportunities for shared savings in addition to existing fee for service or capitation models. Adoption and meaningful use of an EHR and sharing electronic health information is vital to support a PCMH. Funding for the PCMH program supports the notion that additional funding is needed for primary care providers. At this time, no additional action on the part of the legislature is required to align funding with the ARRA.

EHR Demonstration Project

Maryland is one of four states participating in the CMS five-year demonstration project to encourage small to medium sized primary care physician practices to use EHRs. About 127 practices in Maryland are eligible to earn up to $290,000 over a five-year period for adopting EHRs and reporting to CMS on select quality measures. Participating practices must complete an annual Office System Survey (OSS) that CMS will use to determine the amount of incentive payments paid to practices. Around the same number of practices participating in the demonstration project, though not selected for the study group, will receive an annual payment for completing the OSS. CMS and the MHCC use the findings from the annual OSS to develop programs aimed at helping these practices become meaningful users of EHRs. CMS has excluded practices that participate in the EHR Demonstration Project from receiving Medicare incentives under the ARRA. These practices are able to participate in the incentive program under Medicaid. At this time, no additional action on the part of the legislature is required to align funding with the ARRA.

Statewide HIE

The successful development and implementation of the statewide HIE will be defined by how beneficial health information is in improving quality, reducing health care costs, and improving health outcomes. The infrastructure of the statewide HIE ensures flexibility so that the organization can respond to market changes and eventually connect providers throughout the state. The technological design of the statewide HIE is based on federally-endorsed standards and integration protocols that bridge proprietary boundaries. The incremental approach to building the statewide HIE ensures sustainability for a core set of services within about five years. Should additional services beyond the core services be identified by the stakeholder community or the legislature, the need for additional funding to support the development of these services would be required. At this time, no additional action on the part of the legislature is required to align funding with the ARRA.

Medicaid Information Technology Architecture Initiative

The MHCC in collaboration with Medicaid is developing a program for Medicaid to administer the EHR adoption and meaningful use incentives under the ARRA. Medicaid has received around $1.3 million from CMS to develop the *State Medicaid Health IT Plan* that will detail the technology design of an incentive program that can be managed by a third party organization and interfaces with the existing legacy Medicaid Management Information System (MMIS). The technical specifications will also include interfacing requirements with a new MMIS system based on Medicaid Information Technology Architecture Initiative (MITA) principles. The implementation of a new MMIS is expected to be in place by September 2013 and is not expected to impact on the administration of the ARRA. Medicaid will provide oversight to a third party vendor in administering the incentive payments, tracking meaningful use by providers, and pursuing initiatives to encourage the adoption of certified EHR technology. Medicaid will receive 100 percent reimbursement on EHR adoption and meaningful use incentive payments and 90 percent of the cost to administer the program. A funding source for the 10 percent administrative match will need to be identified.

Proposed Legislation

HB 706 requires the MHCC to propose changes in state laws that are necessary to protect the privacy and security of health information stored in EHRs or exchanged through the statewide HIE. Existing state and federal laws related to privacy and security are generally insufficient to protect the medical record when shared electronically. In the early phase of implementation, the statewide HIE is limiting data sharing to results delivery, discharge summaries, and select clinical information where current laws are adequate to protect the data. Over the next year, the Policy Board empanelled by the MHCC to develop policies related to privacy and security of the exchange, will be considering additional changes in state laws. The MHCC expects to include these recommendations in the *2011 Health IT Update* to the legislature.

The law also requires the MHCC to suggest any changes in state laws that are necessary to provide for the effective operation of an HIE. In collaboration with stakeholders, the MHCC has identified changes in law that are necessary to facilitate HIE in Maryland. These revisions include: define an HIE and qualified HIE; establish liability protections for the exchange and providers that participate in the HIE; and require HIEs that are non-commonly owned, such as a hospital or health system, to adhere to the exchange policies adopted by the MHCC.

The Policy Board is planning to deliberate on policies related to disclosure in 2011. The MHCC anticipates that changes in law will be required to support policies pertaining to the disclosure of protected health information (PHI). These changes will be necessary to ensure the release of PHI, such as a provider to an edge server accessible to the HIE, or to the HIE for identification purposes is not considered a disclosure. The following describes the proposed changes in state law in more detail.

Health General

4-301 (Definitions)

- "Health information exchange" means an infrastructure that provides organizational and technical capabilities to enable the electronic exchange of health information among health care providers and which offers participation in the health information exchange to willing and qualified health

care providers regardless of the health care provider's employment or other affiliation with, or membership in, a specific health care facility or other organization, health care system, or medical staff of a health care facility.

- "Qualified health information exchange" means a health information exchange which is organized and operates in accordance with health information exchange regulations issued by the Maryland Health Care Commission and which has adopted the health information exchange policies and procedures promulgated by the Maryland Health Care Commission and which operates in accordance with the requirements for a business associate, as specified in regulations issued pursuant to the *Health Insurance Portability and Accountability Act of 1996*, with respect to the health care providers that exchange health information through the health information exchange's infrastructure.

New Section 4-30X (Health Information Exchanges)

- §4-30X (a)[1] Neither a qualified health information exchange nor health care provider as to the health care provider's participation in a qualified health information exchange shall be liable in any action for damages or costs of any nature, in law or equity, which results solely from the qualified health information exchange's provision or failure to provide or from the participating health care provider's request or failure to request or from the participating health care provider's use or failure to use the medical records available from, or provided by, the qualified health information exchange.
- (a)(1) Neither a qualified health information exchange nor a health care provider as to the health care provider's participation in the qualified health information exchange shall be liable for damages in any civil action for the release of medical records to or through the qualified health information exchange, so long as the release was done in the ordinary course of operations of the qualified health information exchange[2] and so long as the release was consistent with federal and state law and with policies established by the MHCC and the governing body of the HIE, and was not caused by gross negligence or willful misconduct by the releasing party.
- (a) (2) References in §4-30X (a) (1) and (a) (2) to a qualified health information exchange shall refer to the legal entity which operates the qualified health information exchange, any parent organization of the legal entity which operates the qualified health information exchange, and the officers, directors, members, or shareholders of the qualified health information exchange, and any employees, agents, or other individuals or entities for whose actions the qualified health care exchange is legally responsible.
- 4-30X (b) A non-commonly owned qualified health information exchange and its business associates must adopt policies promulgated by the Maryland Health Care Commission, with respect to the health care providers that exchange health information through the health information exchange's infrastructure.

[1] This is adapted from Delaware Code § 9923 (b).
[2] This is intended to exclude breaches that are subject to reporting by federal or state law.

Remarks

The MHCC is actively involved in promoting the wide-spread adoption of EHRs and implementing a statewide HIE. EHRs support a variety of health care-related activities and have the capability of being shared across different health care settings. A statewide HIE facilitates the private and secure sharing of electronic health information. Moving away from a largely paper-based silo system for managing health information to a digital system of record keeping where the information is capable of being shared electronically is essential. Health IT will transform health care to a system where technology can be appropriately used to streamline provider workflows and increase safety though evidence-based decision support, quality management, and outcomes reporting. Increased use of health IT continues to receive national attention and is a factor in the health care reform dialogue nationally. Many of the provisions in the comprehensive health reform legislation recently passed by the U.S. Congress are supported by health IT.

The MHCC has an ambitious plan for advancing health IT that balances the need for information sharing with the need for strong privacy and security policies. Maryland is one of several states that are connecting providers to an exchange; most states are still in the planning phase for implementing a statewide HIE. In September, hospitals that requested to be early adopters began establishing a connection to the exchange. At the same time, the leading national laboratory and radiology vendors in Maryland connected to the HIE. Over the next year, the MHCC anticipates that nearly half of the acute care hospitals will connect to the statewide HIE; large ambulatory practices will begin accessing hospital data through the exchange; State Designated MSOs will increase EHR adoption considerably; and the Policy Board will recommend to the MHCC many of the key policies for adoption related to the privacy and security of electronic health information.

Appendix A
House Bill 706
Electronic Health Records
Regulation and Reimbursement

J1, C3 9lr2923
CF SB 744

By: ~~Delegate Pena-Melnyk~~ Delegates Pena-Melnyk, Hammen, Benson, Costa, Elliott, Hubbard, Kipke, Kullen, McDonough, Montgomery, Morhaim, Nathan-Pulliam, Oaks, Pendergrass, Reznik, Riley, Tarrant, V. Turner, and Weldon
Introduced and read first time: February 9, 2009
Assigned to: Health and Government Operations

Committee Report: Favorable with amendments
House action: Adopted with floor amendments
Read second time: April 4, 2009

CHAPTER _____

AN ACT concerning

Electronic Health Records – Regulation and Reimbursement

FOR the purpose of requiring the Maryland Medical Assistance Program to reimburse certain health care providers in accordance with certain provisions of this Act; ~~requiring the Maryland Health Care Commission, in consultation with the Department of Health and Mental Hygiene and the Maryland Insurance Administration, to adopt certain regulations on or before a certain date requiring certain payors to include certain costs in a certain reimbursement structure; requiring the Commission to designate a certain health information exchange on or before a certain date; requiring the Commission to determine the appropriate level of additional reimbursement in a certain manner; providing that certain regulations shall apply to certain entities under certain circumstances; requiring the Commission, in consultation with the Department and the Administration, to adopt certain regulations that specify certain certification requirements on or before a certain date;~~ requiring the Maryland Health Care Commission and the Health Services Cost Review Commission to designate a health information exchange for the State on or before a certain date; requiring the Maryland Health Care Commission, on or before a certain date, to report on progress in implementing certain provisions of this Act; requiring, on or before a certain date, the Maryland Health Care Commission, following consultation with certain stakeholders, to post on its website for a public comment and submit to the Governor and certain legislative committees, a report on certain aspects of health information technology; requiring the

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

committees to have a certain period of time for review and comment; requiring, on or before a certain date, the Maryland Health Care Commission, in consultation with the Department of Health and Mental Hygiene and others, to adopt regulations that require certain payors to provide incentives to health care providers to promote the adoption and certain use of electronic health records; establishing certain requirements for the incentives; providing that the incentives may include certain items and services; specifying that the regulations need not require incentives for certain types of health care providers; requiring the regulations to apply to certain entities under certain circumstances; requiring the Health Services Cost Review Commission and the Department, in consultation with certain other entities, to take certain actions that relate to the American Recovery and Reinvestment Act of 2009 and certain rules and regulations; requiring the Maryland Health Care Commission, on or before a certain date, to report to the Governor and the General Assembly on certain progress achieved and recommendations for changes that may be necessary for certain adoption and use of electronic health records; requiring the Maryland Health Care Commission to designate ~~a~~ certain management service ~~organization~~ organizations on or before a certain date; authorizing the Maryland Health Care Commission to use certain grants and loans in a certain manner; requiring certain health care providers to use certain electronic health records on ~~or~~ and after a certain date; ~~prohibiting certain payors from reimbursing certain health care providers on or after a certain date under certain circumstances; providing that certain provisions of this Act shall apply to certain entities under certain circumstances;~~ providing that certain provisions of this Act apply to health maintenance organizations; requiring ~~certain carriers~~ State–regulated payors to ~~reimburse~~ provide incentives to certain health care providers in accordance with certain provisions of this Act; requiring the Secretary of Budget and Management to ensure that the State Employee and Retiree Health and Welfare Benefits Program complies with certain provisions of this Act; defining certain terms; and generally relating to the regulation of and reimbursement for the use of electronic health records.

BY repealing and reenacting, without amendments,
Article – Health – General
Section 1–101(a) and (c), 15–101(a) and (h), and 19–101
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

BY adding to
Article – Health – General
Section 15–105.2; 19–142 ~~through 19–145~~ and 19–143 to be under the new part "Part IV. Electronic Health Records – Regulation and Reimbursement"; and 19–706(ttt)
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

BY adding to
Article – Insurance

Section 15–132
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

BY repealing and reenacting, without amendments,
Article – State Personnel and Pensions
Section 2–501(a) and (b)
Annotated Code of Maryland
(2004 Replacement Volume and 2008 Supplement)

BY repealing and reenacting, with amendments,
Article – State Personnel and Pensions
Section 2–503(a)
Annotated Code of Maryland
(2004 Replacement Volume and 2008 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

1–101.

(a) In this article the following words have the meanings indicated.

(c) "Department" means the Department of Health and Mental Hygiene.

15–101.

(a) In this title the following words have the meanings indicated.

(h) "Program" means the Maryland Medical Assistance Program.

15–105.2.

THE PROGRAM SHALL REIMBURSE HEALTH CARE PROVIDERS IN ACCORDANCE WITH THE REQUIREMENTS OF TITLE 19, SUBTITLE 1, PART IV OF THIS ARTICLE.

19–101.

In this subtitle, "Commission" means the Maryland Health Care Commission.

PART IV. ELECTRONIC HEALTH RECORDS – REGULATION AND REIMBURSEMENT.

19–142.

(A) IN THIS PART IV OF THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "CARRIER" MEANS:

(1) AN INSURER;

(2) A NONPROFIT HEALTH SERVICE PLAN;

(3) A HEALTH MAINTENANCE ORGANIZATION; OR

~~(4) A DENTAL PLAN ORGANIZATION; OR~~

~~(5)~~ ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO REGULATION BY THE STATE.

(C) "ELECTRONIC HEALTH RECORD" MEANS AN ELECTRONIC RECORD OF HEALTH–RELATED INFORMATION ON AN INDIVIDUAL THAT:

(1) INCLUDES PATIENT DEMOGRAPHIC AND CLINICAL HEALTH INFORMATION; AND

(2) HAS THE CAPACITY TO:

(I) PROVIDE CLINICAL DECISION SUPPORT;

(II) SUPPORT PHYSICIAN ORDER ENTRY;

(III) CAPTURE AND QUERY INFORMATION RELEVANT TO HEALTH CARE QUALITY; AND

(IV) EXCHANGE ELECTRONIC HEALTH INFORMATION WITH AND INTEGRATE THE INFORMATION FROM OTHER SOURCES.

(D) (1) "HEALTH BENEFIT PLAN" MEANS A HOSPITAL OR MEDICAL POLICY, CONTRACT, OR CERTIFICATE ISSUED BY A CARRIER.

(2) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE:

(I) COVERAGE FOR ACCIDENT OR DISABILITY INCOME INSURANCE;

(II) COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE;

(III) LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY INSURANCE AND AUTOMOBILE LIABILITY INSURANCE;

(IV) WORKERS' COMPENSATION OR SIMILAR INSURANCE;

(V) AUTOMOBILE OR PROPERTY MEDICAL PAYMENT INSURANCE;

(VI) CREDIT–ONLY INSURANCE;

(VII) COVERAGE FOR ON–SITE MEDICAL CLINICS;

(VIII) DENTAL OR VISION INSURANCE;

(IX) LONG–TERM CARE INSURANCE OR BENEFITS FOR NURSING HOME CARE, HOME HEALTH CARE, COMMUNITY–BASED CARE, OR ANY COMBINATION OF THESE;

(X) COVERAGE ONLY FOR A SPECIFIED DISEASE OR ILLNESS;

(XI) HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE; OR

(XII) THE FOLLOWING BENEFITS IF OFFERED AS A SEPARATE INSURANCE POLICY:

1. MEDICARE SUPPLEMENTAL HEALTH INSURANCE, AS DEFINED IN § 1882(G)(1) OF THE SOCIAL SECURITY ACT;

2. COVERAGE SUPPLEMENTAL TO THE COVERAGE PROVIDED UNDER CHAPTER 55 OF TITLE 10, U.S.C.; OR

3. SIMILAR SUPPLEMENTAL COVERAGE PROVIDED TO COVERAGE UNDER AN EMPLOYER–SPONSORED PLAN.

~~(D)~~ (E) (1) "HEALTH CARE PROVIDER" MEANS:

(I) A PERSON WHO IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION OR IN AN APPROVED EDUCATION OR TRAINING PROGRAM; OR

(II) A FACILITY WHERE HEALTH CARE IS PROVIDED TO PATIENTS OR RECIPIENTS, INCLUDING:

1. A FACILITY, AS DEFINED IN § 10–101(E) OF THIS ARTICLE;

2. A HOSPITAL, AS DEFINED IN § 19–301 OF THIS TITLE;

3. A RELATED INSTITUTION, AS DEFINED IN § 19–301 OF THIS TITLE;

4. AN OUTPATIENT CLINIC;

5. A FREESTANDING MEDICAL FACILITY, AS DEFINED IN § 19–3A–01 OF THIS TITLE;

6. AN AMBULATORY SURGICAL FACILITY, AS DEFINED IN § 19–3B–01 OF THIS TITLE; AND

7. A NURSING HOME, AS DEFINED IN § 19–1401 OF THIS TITLE.

(2) "HEALTH CARE PROVIDER" DOES NOT INCLUDE A HEALTH MAINTENANCE ORGANIZATION AS DEFINED IN § 19–701 OF THIS TITLE.

~~(E)~~ (F) "HEALTH INFORMATION EXCHANGE" MEANS A STATEWIDE INFRASTRUCTURE THAT PROVIDES ORGANIZATIONAL AND TECHNICAL CAPABILITIES TO ENABLE THE ELECTRONIC EXCHANGE OF HEALTH INFORMATION BETWEEN HEALTH CARE PROVIDERS AND OTHER HEALTH SERVICES ORGANIZATIONS AUTHORIZED BY THE COMMISSION.

~~(F)~~ (G) "MANAGEMENT SERVICE ORGANIZATION" MEANS AN ORGANIZATION THAT OFFERS ~~MULTIPLE~~ ONE OR MORE HOSTED ELECTRONIC HEALTH RECORD SOLUTIONS AND OTHER MANAGEMENT SERVICES TO MULTIPLE HEALTH CARE PROVIDERS.

~~**(G) "MEDICARE" MEANS THE HEALTH INSURANCE FOR THE AGED ACT, TITLE XVIII OF THE SOCIAL SECURITY AMENDMENTS OF 1965, AS AMENDED.**~~

(H) (1) "STATE–REGULATED PAYOR" MEANS:

~~**(1) THE MARYLAND MEDICAL ASSISTANCE PROGRAM;**~~

~~(2)~~ (I) THE STATE EMPLOYEE AND RETIREE HEALTH AND WELFARE BENEFITS PROGRAM; AND

~~(3)~~ (II) A CARRIER ISSUING OR DELIVERING HEALTH BENEFIT PLANS IN THE STATE.

(2) "STATE–REGULATED PAYOR" DOES NOT INCLUDE A MANAGED CARE ORGANIZATION AS DEFINED IN TITLE 15, SUBTITLE 1 OF THIS ARTICLE.

19–143.

~~(A) ON OR BEFORE OCTOBER 1, 2010, THE COMMISSION, IN CONSULTATION WITH THE DEPARTMENT AND THE MARYLAND INSURANCE ADMINISTRATION, SHALL:~~

~~(1) ADOPT REGULATIONS THAT REQUIRE STATE–REGULATED PAYORS TO INCLUDE IN THEIR REIMBURSEMENT STRUCTURE FOR HEALTH CARE PROVIDERS THE COST OF THE ADOPTION OF ELECTRONIC HEALTH RECORDS BY HEALTH CARE PROVIDERS; AND~~

~~(2) DESIGNATE A HEALTH INFORMATION EXCHANGE FOR THE STATE THAT:~~

~~(I) INCORPORATES PRIVACY RULES THAT ARE CONSISTENT WITH EXISTING FEDERAL AND STATE LAWS AND REGULATIONS; AND~~

~~(II) MAKES ITS SERVICES AVAILABLE TO HEALTH CARE PROVIDERS, STATE–REGULATED PAYORS AND OTHER HEALTH CARE SERVICES ORGANIZATIONS AS AUTHORIZED BY THE COMMISSION.~~

~~(B) (1) THE COMMISSION SHALL DETERMINE THE APPROPRIATE LEVEL OF ADDITIONAL REIMBURSEMENT TO BE REQUIRED UNDER THIS SECTION, TAKING INTO ACCOUNT ANY GRANTS OR LOANS THAT ARE AVAILABLE TO HEALTH CARE PROVIDERS FROM THE FEDERAL GOVERNMENT.~~

~~(2) THE COMMISSION MAY NOT REQUIRE ADDITIONAL REIMBURSEMENT UNDER THIS SECTION FOR A HOSPITAL THAT IS REGULATED BY THE HEALTH SERVICES COST REVIEW COMMISSION.~~

~~(C) IF FEDERAL LAW IS AMENDED TO ALLOW THE STATE TO REGULATE SELF–INSURED ENTITIES AND MEDICARE, REGULATIONS ADOPTED UNDER THIS SECTION SHALL APPLY TO REIMBURSEMENT BY SELF–INSURED ENTITIES AND MEDICARE.~~

~~**19–144.**~~

~~(A) (1) ON OR BEFORE OCTOBER 1, 2012, THE COMMISSION, IN CONSULTATION WITH THE DEPARTMENT AND THE MARYLAND INSURANCE ADMINISTRATION, SHALL ADOPT REGULATIONS THAT SPECIFY CERTIFICATION REQUIREMENTS FOR ELECTRONIC HEALTH RECORDS.~~

~~(2) THE COMMISSION SHALL INCLUDE IN REGULATIONS ADOPTED UNDER THIS SUBSECTION A REQUIREMENT THAT ELECTRONIC HEALTH RECORDS MUST MEET ANY STANDARDS FOR ELECTRONIC HEALTH RECORDS THAT ARE PROVIDED FOR IN FEDERAL LAW.~~

~~(B) (1) ON OR BEFORE OCTOBER 1, 2012, THE COMMISSION SHALL DESIGNATE A MANAGEMENT SERVICE ORGANIZATION TO OFFER HOSTED ELECTRONIC HEALTH RECORDS AND OTHER MANAGEMENT SERVICES THROUGHOUT THE STATE.~~

~~(2) THE COMMISSION MAY USE AVAILABLE GRANTS AND LOANS FROM THE FEDERAL GOVERNMENT TO HELP SUBSIDIZE THE USE OF THE MANAGEMENT SERVICE ORGANIZATION BY HEALTH CARE PROVIDERS.~~

~~19–145.~~

~~(A) ON OR AFTER OCTOBER 1, 2014, EVERY HEALTH CARE PROVIDER IN THE STATE SHALL USE ELECTRONIC HEALTH RECORDS THAT ARE:~~

~~(1) CERTIFIED IN ACCORDANCE WITH STANDARDS ADOPTED BY THE COMMISSION; AND~~

~~(2) HAVE INTEROPERABILITY WITH, ARE CONNECTED TO, AND EXCHANGING DATA WITH THE HEALTH INFORMATION EXCHANGE DESIGNATED BY THE COMMISSION UNDER § 19–143 OF THIS SUBTITLE.~~

~~(B) (1) ON OR AFTER OCTOBER 1, 2014, A STATE–REGULATED PAYOR MAY NOT REIMBURSE A HEALTH CARE PROVIDER THAT DOES NOT MEET THE REQUIREMENTS OF SUBSECTION (A) OF THIS SECTION FOR HEALTH CARE SERVICES.~~

~~(2) IF FEDERAL LAW IS AMENDED TO ALLOW THE STATE TO REGULATE SELF–INSURED ENTITIES AND MEDICARE, THIS SUBSECTION SHALL APPLY TO REIMBURSEMENT BY SELF–INSURED ENTITIES AND MEDICARE.~~

~~(C) ON OR AFTER OCTOBER 1, 2014, A HOSPITAL THAT IS REGULATED BY THE HEALTH SERVICES COST REVIEW COMMISSION THAT DOES NOT MEET THE REQUIREMENTS OF SUBSECTION (A) OF THIS SECTION MAY NOT BE REIMBURSED BY ANY PAYOR FOR HEALTH CARE SERVICES.~~

(A) 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) 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) (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) (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; AND

(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.

(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.

(E) 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) 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) 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) (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) 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–DESIGNATED~~ 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 ~~(C)~~ (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.

19–706.

(TTT) THE PROVISIONS OF § 15–132 OF THE INSURANCE ARTICLE APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

Article – Insurance

15–132.

~~(A) IN THIS SECTION, "CARRIER" MEANS:~~

~~(1) AN INSURER;~~

~~(2) A NONPROFIT HEALTH SERVICE PLAN;~~

~~(3) A HEALTH MAINTENANCE ORGANIZATION;~~

~~(4) A DENTAL PLAN ORGANIZATION; OR~~

~~(5) ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO REGULATION BY THE STATE.~~

~~(B) A CARRIER SHALL REIMBURSE HEALTH CARE PROVIDERS IN ACCORDANCE WITH THE REQUIREMENTS OF TITLE 19, SUBTITLE 1, PART IV OF THE HEALTH – GENERAL ARTICLE.~~

(A) IN THIS SECTION, "CARRIER" HAS THE MEANING STATED IN § 19–142 OF THE HEALTH – GENERAL ARTICLE.

(B) A CARRIER SHALL PROVIDE INCENTIVES TO HEALTH CARE PROVIDERS IN ACCORDANCE WITH THE REQUIREMENTS OF TITLE 19, SUBTITLE 1, PART IV OF THE HEALTH – GENERAL ARTICLE.

Article – State Personnel and Pensions

2–501.

(a) In this subtitle the following terms have the meanings indicated.

(b) "Program" means the State Employee and Retiree Health and Welfare Benefits Program.

2–503.

(a) The Secretary shall:

(1) adopt regulations for the administration of the Program;

(2) ensure that the Program complies with all federal and State laws governing employee benefit plans; [and]

(3) each year, recommend to the Governor the State share of the costs of the Program; **AND**

(4) ENSURE THAT THE PROGRAM COMPLIES WITH TITLE 19, SUBTITLE 1, PART IV OF THE HEALTH – GENERAL ARTICLE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect ~~October~~ July 1, 2009.

Approved:

_____

Governor.

_____

Speaker of the House of Delegates.

_____

President of the Senate.

Appendix B
Health IT Policy Reports

Report Title	Web Link (URL)
Task Force to Study Electronic Health Records: Final Report	http://mhcc.maryland.gov/electronichealth/presentations/ehr_finalrpt0308.pdf
Review of the Task Force to Study Electronic Health Records 2007 Final Report Recommendations	http://mhcc.maryland.gov/electronichealth/EHRTaskForceSummaryFinal061909.pdf
Assessment of Privacy and Security Policies and Business Practices	http://mhcc.maryland.gov/electronichealth/assess_privacy_security.pdf
Privacy and Security Solutions and Implementation Report	http://mhcc.maryland.gov/electronichealth/solutions_implement_rpt0908.pdf
Service Area Health Information Exchange: A Hospital Data Sharing Community Resource Guide	http://mhcc.maryland.gov/electronichealth/SAHIE_03-06-09-WEBFinal.pdf
2009 Health Information Technology: An Assessment of Maryland Hospitals	http://mhcc.maryland.gov/electronichealth/HospitalHITSurveyReportFINAL.pdf
2010 Health Information Technology: An Assessment of Maryland Hospitals	http://mhcc.maryland.gov/electronichealth/2010_hospital_hit_report.pdf
Management Services Organizations: A Vision of State Designated Organizations for Physician Practices	http://mhcc.maryland.gov/electronichealth/MSOPRINT.pdf
CRISP Planning Report	http://mhcc.maryland.gov/electronichealth/CRISP_FinalReport.pdf
MCHIE Planning Report	http://mhcc.maryland.gov/electronichealth/MCHIE_Final_Report.pdf
CRISP Response to the Request for Application for a Consumer-Centric Health Information Exchange for Maryland	http://mhcc.maryland.gov/electronichealth/CRISP.pdf
Health Information Technology State Plan FY 2009-2013	https://mhcc.maryland.gov/electronichealth/hiestateplan/hit_state_plan_060910.pdf
2010 HIT: An Assessment of Freestanding Ambulatory Surgical Centers in Maryland	http://mhcc.maryland.gov/electronichealth/ambulatory_surgery/amsurg_hit_report.pdf

Appendix C
Policy Board 2010 and 2011 Schedules

2010

Date	Location	Time
January 19, 2010	Community Health Integrated Partnership	2:00 p.m. to 4:00 p.m.
March 1, 2010	Anne Arundel Medical Center	2:00 p.m. to 4:00 p.m.
April 13, 2010	Maryland Health Care Commission	2:00 p.m. to 4:00 p.m.
May 25, 2010	Community Health Integrated Partnership	2:00 p.m. to 4:00 p.m.
July 13, 2010	Anne Arundel Medical Center	2:00 p.m. to 4:00 p.m.
August 17, 2010	Maryland Health Care Commission	1:00 p.m. to 4:00 p.m.
September 28, 2010	Community Health Integrated Partnership	1:00 p.m. to 4:00 p.m.
November 9, 2010	Anne Arundel Medical Center	1:00 p.m. to 4:00 p.m.

2011

Date	Location	Time
January 11, 2011	Maryland Health Care Commission	1:00 p.m. to 4:00 p.m.
March 1, 2011	Frederick Memorial Hospital	1:00 p.m. to 4:00 p.m.
April 12, 2011	Community Health Integrated Partnership	1:00 p.m. to 4:00 p.m.
May 24, 2011	Anne Arundel Medical Center	1:00 p.m. to 4:00 p.m.
July 12, 2011	Maryland Health Care Commission	1:00 p.m. to 4:00 p.m.
August 16, 2011	Frederick Memorial Hospital	1:00 p.m. to 4:00 p.m.
September 27, 2011	Community Health Integrated Partnership	1:00 p.m. to 4:00 p.m.
November 8, 2011	Anne Arundel Medical Center	1:00 p.m. to 4:00 p.m.

Appendix D
Policy Board Operating Guidelines

Purpose

The Maryland Health Care Commission (MHCC) has assembled a Policy Board with responsibility for general oversight of the state's health information exchange, including the authority to evaluate and recommend to the MHCC the policies that will govern the statewide health information exchange. The MHCC selected the members based upon their expertise, with a strong emphasis on achieving both broad stakeholder representation and a strong consumer orientation. The existence of a Policy Board that is separate from the administration of CRISP assures participation by the public in both policy development and operational oversight.

The purpose of these Operating Guidelines is to set forth succinctly how the Policy Board will function. The Operating Guidelines are effective when adopted by the Policy Board and may be changed by a vote of the majority of the Policy Board.

Responsibilities of the Policy Board

The responsibilities of this Policy Board include, although are not limited to, the development of policies for privacy and security, which the MHCC will adopt and the health information exchange will implement. In particular, the Policy Board will establish policies regarding consumer authorization and consent, user authentication, role-based authorization, security requirements, and audit trail requirements. In addition, further policies may include the architecture of the exchange, use case priorities and implementation, consumer access and control, provider access, financing, and secondary uses of data. The Policy Board will develop policies that ensure a high level of protections for the statewide health information exchange.

Although the Policy Board is formally an advisory body reporting to the MHCC, the expectation is that the MHCC, through its control of the federal and Maryland all-payer funding of the exchange, will assure that the policies developed and recommended by the Policy Board are implemented by CRISP. In the unlikely event that the MHCC reaches a preliminary decision not to implement a recommendation of the Policy Board, the Commission's concerns will be brought to the Policy Board for further discussion before any final decision is reached.

Chair

The Executive Director of the MHCC or his designee will chair the Policy Board. The Chair, with the consent of the Policy Board, may establish special committees and appoint members to serve on the committees.

Frequency and Location of Meetings

The Policy Board will meet approximately eight times per year. The meeting schedule detailing the location and time of the meetings are available on the Policy Board webpage located on the MHCC website at: http://mhcc.maryland.gov/electronichealth/hie_policy_board/index.html.

Policy Board members will also receive meeting notification via e-mail approximately one week prior to the meeting date. The notification will include a reminder about the date, time, and location of the meeting, and instructions regarding any meeting materials posted on the Policy Board webpage. Policy Board members are encouraged to print out meeting materials and bring them to the meeting.

Members are requested to confirm their participation in meetings upon receipt of the meeting notification e-mail. Members are encouraged to schedule the designated days for Policy Board meetings on their calendars in advance for the entire 2010 year.

Committees will meet as determined by the Chair of the committee, commonly by conference call using numbers provided by the MHCC.

Communication

Communication with the Policy Board and among its members will be mostly through the listserv, hie@mhcc.state.md.us, and by posting of information on the webpage previously mentioned. Information related to Committee activities and recommendations will also be posted to the Policy Board webpage.

Agenda

The MHCC will develop an agenda for each meeting and post it on the Policy Board webpage approximately one week prior to the meeting. The agenda and any supplemental information to the meeting will be provided to the Policy Board members for discussion during the meeting. The agenda will also note the issues to be presented for decision, for discussion, or for information.

Minutes

The MHCC will electronically record each meeting of the Policy Board and may use the recording to identify key discussion items to include in the minutes when available. The MHCC will post the minutes on the Policy Board webpage approximately ten days following each meeting. Policy Board members may suggest revisions to the minutes at the beginning of each Policy Board meeting.

Decision Making Process

The Policy Board will use Roberts Rules of Order to guide decision making; however, a more informal process of discussion and deliberation may also be used if no objection is raised by a member of the Board, and decisions made by a more informal process will have the same force and effect. A quorum shall consist of the majority of Policy Board members in attendance. All formal policy actions must be proposed by a member of the Policy Board in the form of a motion and seconded by another Policy Board member. The motion will be discussed and a vote taken with a majority rule. Any motion not adopted unanimously will have the exact vote recorded in the minutes.

Policy Board members can nominate decision items as warranting greater consensus among board members due to their high sensitivity and impact to consumers. If a majority of members agree to the designation decision-making will require a super majority vote, or approximately 75 percent agreement by the Policy Board.

Non-Agenda Items

Policy Board members may discuss matters and make recommendations on issues not on the agenda. Policy Board members introducing an issue may request that a decision on it be made during the meeting in which it is introduced. If any member requests time for further consideration, no action will occur until the item has been placed on the agenda for a subsequent meeting as a decision item.

Open Meetings

All meetings of the Policy Board are open to the public. The Policy Board may invite the public to present on specific topics, either on its own initiative or in response to a request from a member of the public. The time permitted for presentations from the public or members shall be decided by the Chair with the advice

of the Policy Board, and such limits shall be reasonable and related to the agenda and the importance of the topic.

Tenure

The Policy Board assures a strong role for the public in both policy development and operational oversight of the statewide health information exchange. Policy Board members shall serve for a term of three years, and may be reappointed to serve one additional term. Continuity of the membership is essential to developing policies that will foster authorized, private, and secure information sharing within the state and eventually across state borders.

Appendix E
Proposed Policy Development Prioritization

The table below depicts the prioritization of proposed policies for the statewide health information exchange. The status of the policy development, the Policy Board member that volunteered to act as the Primary Reviewer(s) for each policy, and their respective organizations are listed.

Policy	Status	Primary Reviewer	Organization
Participating Organization Access	v1.3	Sarah Posner	ACLU of Maryland
Consumer Choice	v1.3	Tom Lewis	Primary Care Coalition of Montgomery Co.
User Authentication	v1.3	Beverly Collins	CareFirst
Sensitive Health Information	v1.2	Sarah Tucker	National Network to End Domestic Violence
User Authorization	v1.1	Gene Gary-Williams	The National Society of Allied Health
Emergency Access for Participating Organizations	v1.1	Sarah Tucker	National Network to End Domestic Violence
Suspension and Termination of User Access	v1.1	Doug Abel	Anne Arundel Medical Center
Data Use and Disclosure	v1.1	Chris Shea	OSI - Baltimore
Consumer Access	v1.0	Steve Daviss Salliann Alborn	Baltimore Washington Medical Center Community Health Integrated Partnership
Audit	v1.0	Shannah Koss	Koss on Care
Consumer Access to Audit	v1.1	Liza Solomon	Consumer Member
Complaints	v1.1	Ellen Maltz	M&T Bank
Notification of Breach	v1.1	Damien Doyle	Hebrew Home of Greater Washington
Public Health Reporting	v1.0	Frances Phillips Liza Solomon	DHMH Consumer Member
Suspension and Termination of Consumer Access	v1.0	Lee Cotton	Higher Ground, Inc.
Consumer Outreach & Education	v1.0	Shannah Koss	Koss on Care
Enforcement	v1.0	TBD	TBD
Policy Review & Revisions	v1.0	TBD	TBD
Liability	v1.0	TBD	TBD

Policy Status Key	
v1.0	First Draft
v1.1	First Draft with Primary Reviewer Comments
v1.2	Draft Iterations *(i.e., 1.2.1, 1.2.2, 1.2.3, 1.2.4, etc.)*
v1.3	Final Draft
v2.0	Approved by Policy Board

Appendix F
MSO State Designation Criteria

Maryland Health Care Commission

Management Service Organizations
State Designation Criteria

Table of Contents

OVERVIEW

Utilizing health information technology (health IT) in an optimal manner can help improve health care quality, prevent medical errors, and reduce costs by delivering essential information at the point of care. Successful health IT requires two crucial components – widespread use of electronic health records (EHRs) and the ability to exchange health information privately and securely. While both are challenging projects conceptually, technologically, and economically, the implementation of EHRs poses special challenges. These challenges mostly relate to the cost of the software and maintaining systems that support the application. The integration of EHRs into a physician practice takes time and is influenced by technological constraints, costs, and different perceptions and expectations. Management service organizations (MSOs) have emerged as a way to address these challenges.

MSOs offer centralized administrative and hosted technology services and are considered a viable alternative to the traditional EHR client-server model where the technology is maintained locally at the provider site. MSOs enable physicians to access patient records wherever access to the Internet exists. These organizations are capable of supporting multiple EHR products at reduced costs through economies of scale and bulk purchasing. Technical support usually extends beyond the standard business hours and in some instances is available on a 24/7 basis. Data is safeguarded through a network operating center that, by design, ensures high quality and uninterrupted service. Remotely hosted EHRs enable providers to focus on practicing medicine rather than dedicating staff to support the application and technology.

On May 19, 2009, Governor Martin O'Malley signed into law House Bill 706, *Electronic Health Records – Regulation and Reimbursement*. This law requires the Maryland Health Care Commission (MHCC) to designate one or more MSOs that offer EHRs throughout the state by October 2012. The MHCC convened an MSO Advisory Panel that developed the criteria for *State Designation*. The criteria outline the requirements for *MSO State Designation* and assess privacy and confidentiality, technical performance, business practices, resources, security, and operations of MSOs.

STATE DESIGNATION I: QUALIFYING EVENTS

MSOs will need to conform to select requirements in order to be considered for State Designation. The requirements and the Criteria are subject to change and existing State Designated MSOs that seek to renew their State Designation must meet the requirements in existence at the time of application.

- The MSO must offer a hosted EHR solution that is certified by a nationally recognized certifying organization.
- The MSO must complete an application and self-assessment manuscript using the Criteria recognized by the MHCC.
- The MSO and any subcontractor must provide services (i.e., education, technology, support, etc.) using a workforce where at least 50 percent of the resources originate in Maryland.
- The MSO must establish and maintain an active connection to the state designated health information exchange.
- The MSO must agree to a bi-annual site visit.
- The MSO must re-apply every two years and meet the requirements outlined in the MSO State Designation Criteria.
- The MSO must support state efforts and the efforts of the state designated health information exchange in advancing health information technology consistent with the goals of the Office of the National Coordinator for Health Information Technology.

STATE DESIGNATION II: PRIVACY AND CONFIDENTIALITY

State Designated MSOs must have appropriate policies and procedures in place that comply with the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) requirements to ensure the integrity and confidentiality of protected health information (PHI). These policies and procedures must protect against any anticipated threats or hazards to the security or integrity of electronic information. The policies and procedures must also protect an individual's interests by managing who has access to PHI. The measures stated below reference specific information that should be discussed in the self-assessment manuscript.

MEASURES TO ENSURE DATA PRIVACY AND CONFIDENTIALITY

- The MSO must have policies to protect against inappropriate disclosure of PHI.
- The MSO must have policies and procedures in place to ensure continuing compliance with data security standards, including secure methods of access to and transmission of data.
- The MSO must refrain from selling, marketing or otherwise using PHI in any way that violates privacy or confidentiality.
- The MSO must utilize strong encryption, user authentication, message integrity, and support for non-repudiation as security measures in compliance with any federal or state legislation.
- The MSO must use effective controls and implement procedures for guarding against, detecting, and reporting malicious software and/or intrusion events.
- The MSO must maintain a list of all individuals, contractors, and business associates with access to electronic PHI maintained by the MSO.
- The MSO must demonstrate that configuration standards are in place and include patch management for systems that store, transmit, or access electronic PHI, including workstations within the MSO.
- The MSO must implement policies and procedures to ensure compliance with any applicable federal and state privacy and security requirements.
- The MSO must notify their customer(s) in writing within 60 calendar days of discovering a breach or disclosure of PHI.
- The MSO must have policies and procedures to ensure that PHI is not stored nor transported in an insecure manner as established by federal and state security requirements.

STATE DESIGNATION III: TECHNICAL PERFORMANCE

State Designated MSOs must provide assurances and have policies in place to ensure that authorized users are able to access patient health records in a timely manner. Areas of technical performance include:

- Customer service inquiries
- System availability
- Compliance with industry standards
- Capacity monitoring and management
- Auditing
- Storage and retrieval
- Internet access

CUSTOMER SERVICE INQUIRIES

- The MSO must have a service inquiry management and a tracking system that documents date and time of initial contact through resolution.
- The MSO must have the capability to acknowledge inquiries within three business hours.
- The MSO must respond to open inquiries within one business day with either a resolution or plan of action for issues requiring escalation.
- The MSO must have documented escalation procedures based on severity to follow the inquiry to completion.

SYSTEM AVAILABILITY

- The MSO must have minimum system availability and appropriate redundancy that assures system access for 98 percent of contracted and/or advertised hours. This requirement shall not preclude acts of nature.
- The MSO must support extended hours of support, if required by clients.
- The MSO must provide practices with a notice of all scheduled downtime at least one business week prior to the actual downtime.
- The MSO must notify all practices within two hours in the event of unscheduled downtime.

COMPLIANCE WITH INDUSTRY STANDARDS

- The MSO must maintain a current analysis of any federal and state privacy or security laws that the MSO reasonably believes apply to information stored or transmitted by the MSO (e.g., security breach notification laws), and the MSO must have a plan to comply with any such laws.

CAPACITY MONITORING

- The MSO must have the ability to measure system capacity and have an ongoing monitoring capability in place for measuring that system and managing capacity.

- The MSO must have a formal system capacity plan for handling load and expansion including a demonstration of 99.5 percent availability on communication exchange components per the advertised service level agreements. This requirement does not preclude acts of nature.

AUDITING

- The MSO must implement an accurate and transparent auditing mechanism.

STORAGE AND RETRIEVAL

- The MSO must have an off-site location that has a six-month minimum backup archive, storage and retrieval of all data, and adheres to all applicable federal and state regulations.

- The MSO must annually test the backup restoration process for all practice data.

- The MSO must have, or show progress towards having, a seven-year back-up archive, storage and regeneration capabilities at minimum, and a process for providing extended back-ups at the request of the practice.

- The MSO must have the ability to partition data into separate files that can either be aggregated for a multi-provider practice or separated for extraction by a single provider of that multi-provider practice.

- The MSO must have a process in place to have operations restored in a timely manner.

INTERNET

- The MSO must have a firewall configured to protect the system integrity.

- The MSO must ensure that internal databases cannot be modified directly through an external website, unless made securely, by authenticated users and contain integrity checks.

- The MSO must ensure that integrity checks are made on all modifications to external systems (e.g., those kept on the web server) prior to synchronization with any internal database.

- The MSO must provide capacity and bandwidth adequate for business needs. The MSO must have a process in place to daily monitor Internet bandwidth and communication server performance.

- The MSO must have processes and procedures in place to monitor and/or block intrusion attempts or attacks from the Internet and provide alarms to appropriate personnel.

- The MSO must have documented procedures to respond to a successful intrusion or attack from the Internet within a timely manner of when an alarm is generated or notification received.

- The MSO must have an established plan to conduct an annual threat and vulnerability assessment through an independent third party. The MSO must develop an improvement process based on the results of those assessments.

- The MSO must have documented web server security configurations to protect the web server from attack or intrusion.

STATE DESIGNATION IV: BUSINESS PRACTICES

State Designated MSOs must have sound business practices that support the goals of the organization. These business practices center on procedures for measuring customer satisfaction; provide non-restricted access to the system based on assigned level of access; adequately provide for customer education and training; and have standard contracts and service agreements.

TRUTH-IN-ADVERTISING

- The MSO must demonstrate compliance with their published service levels.

ACCESS

- The MSO must offer at least one nationally certified hosted EHR solution.

AGREEMENTS

- The MSO must have service level agreements that take into consideration the needs of the MSO and practice, and have reasonable termination provisions for both parties.

STATE DESIGNATION V: RESOURCES

State Designated MSOs must possess the physical, human, and administrative resources necessary to maintain a high level of technical performance and business practices. These resources must include facilities adequate to conduct the MSOs current and anticipated business volume and maintain qualified staff.

PHYSICAL RESOURCES

- The MSO must have physical resources adequate for accomplishing the stated mission.
- The MSO must regularly monitor capacity to support its defined services.
- The MSO must have a formal expansion plan in place when strategic plans project organizational growth of more than 10 percent annually.

PERSONNEL

- The MSO must have sufficient, qualified personnel to perform all tasks associated with accomplishing the stated mission.
- The MSO must ensure that employees receive effective, relevant job training to remain current in knowledge and skills.
- The MSO must provide, at a minimum, annual job training that includes training applicable with the HIPAA provisions for all employees and ensure contractors have received similar training.
- The MSO must maintain a record of employee and contractor compliance with the routine training. A copy of the curriculum, and any versioning, must also be kept on file.
- The MSO must demonstrate a thorough due diligence process in their hiring practices.

STATE DESIGNATION VI: SECURITY

State Designated MSOs must have appropriate administrative, technical, and physical safeguard policies and procedures to ensure the integrity and confidentiality of PHI. These policies and procedures must protect against any anticipated threats or hazards to the security or integrity of the data. MSOs must comply with all the HIPAA requirements. MSOs should uniquely describe their policies in the self-assessment manuscript relating to the following:

ADMINISTRATIVE SAFEGUARDS

- The MSO must comply with all federal and state security rules.
- The MSO must conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of PHI held by the MSO.
- The MSO must implement an enforcement policy that will authorize the MSO to apply appropriate sanctions against workforce members (i.e., employees, contractors, and vendors) who are not in compliance with the MSO's security policies and procedures.
- The MSO must implement procedures to regularly review records of information system activity such as audit logs, access reports, and security incident tracking reports.
- The MSO must maintain a record of any discrepancies noted from the record review and report these discrepancies to the security officer for review.
- The MSO must implement policies and procedures to ensure that all members of the MSO's workforce have access to the minimum necessary PHI to perform work assignments and to prevent access to workforce members who do not need access electronic PHI.
- The MSO must implement termination procedures for withdrawing access to PHI when the employment of a workforce member ends.
- The MSO must implement and document a security awareness and training program for all members of the MSO's workforce.
- The MSO must implement and document procedures for creating, changing, and safeguarding passwords and/or other login procedures.
- The MSO must have a process in place to identify and respond to suspected or known security incidents and mitigate harmful effects of security incidents that are known to the MSO.
- The MSO must establish written policies and procedures for responding to an emergency or other occurrence such as fire, vandalism, system failure, or natural disasters that impact systems that contain PHI.

- The MSO must include in their disaster recovery/business continuity plan the following: annual testing of the plan, what constitutes a disaster, a communication plan notifying providers of the disaster and escalation process, and identification of critical personnel who are responsible for conducting the damage assessment and mitigation process.

- The MSO must implement and document procedures for periodic testing, assessment, and review and revision of contingency plans. Testing and all appropriate revisions must occur no less than annually.

PHYSICAL SAFEGUARDS

- The MSO must implement and document policies and procedures to limit physical access to its information systems and the facility or facilities in which they are housed, while also providing that all properly authorized persons have adequate access.

- The MSO must establish procedures that allow secure facility access in support of restoration of lost data under the disaster recovery plan and emergency mode operations plan in the event of an emergency.

- The MSO must implement policies and procedures to safeguard the facility and the equipment therein from unauthorized physical access, tampering, and theft.

- The MSO must implement procedures to control and validate a person's access to data based on their role or function.

- The MSO must implement policies and procedures, including a log, governing the receipt and removal of hardware and electronic media that contain PHI into and out of a facility, and the movement of these items within the facility.

- The MSO must implement policies and procedures to address the final disposition of PHI and the hardware or electronic media on which it is stored.

- The MSO must implement procedures for removal of PHI from electronic media before the media are discarded or made available for re-use.

TECHNICAL SAFEGUARDS

- The MSO must implement technical policies and procedures for electronic information systems that maintain electronic PHI to allow access only to those persons or software programs that have been granted access rights.

- The MSO must assign a unique name and/or number for identifying and tracking all system user identities.

- The MSO must establish procedures for accessing necessary PHI during an emergency.

- The MSO must implement electronic procedures that terminate an electronic session after a predetermined time of inactivity.

- The MSO must implement hardware, software, and/or procedural mechanisms that record and examine activity in information systems that contain or use PHI.

ORGANIZATIONAL REQUIREMENTS FOR BUSINESS ASSOCIATE CONTRACTS

- The MSO must require Business Associates to implement administrative, physical, and technical policies and procedures that are reasonable, appropriate, and required by federal and state regulations to protect the confidentiality, integrity, and availability of the PHI it creates, receives, maintains, or transmits on behalf of the MSO.

- The MSO must require Business Associates to report to the MSO any security incident of which it becomes aware.

POLICIES AND PROCEDURES AND DOCUMENTATION REQUIREMENTS

- The MSO must record and maintain the policies and procedures implemented to comply with applicable federal and state regulations; policies and procedures should be available to those that need access to them.

- The MSO must review documentation annually, and update as needed, in response to environmental or operational changes affecting the security of the PHI.

STATE DESIGNATION VII: OPERATIONS

State Designated MSOs are required to support the activities of the Regional Extension Center. The leading areas of support center on EHR implementation support, technical assistance, and ongoing assistance to the provider to meet the *meaningful use* requirements established by the Centers for Medicare & Medicaid Services.

- The MSO must have an EHR adoption education plan for providers without an EHR system.
- The MSO must have a plan for maximizing EHR functionality of providers with an EHR system.
- The MSO must have a plan in place to furnish technical assistance to the providers participating with the MSO.
- The MSO must conduct an annual provider satisfaction survey under the guidance of the Regional Extension Center and in consultation with the MHCC and report on the findings.

APPENDIX

Acknowledgements

The Maryland Health Care Commission greatly appreciates the contribution made by everyone that participated in the Advisory Panel and the ongoing support in developing the criteria for state designation. Special thanks go to the following individuals for giving of their time to complete the designation criteria. The information provided by these individuals has led to this groundbreaking initiative.

Doug Abel
Anne Arundel Medical Center

Ray Adkins
Peninsula Regional Medical Center

Scott Afzal
Audacious Inquiry

Salliann Alborn
Community Health Integrated Partnership

Jama Allers
The Maryland State Medical Society

Karen Barker
LifeBridge Health

Lee Barrett
EHNAC

Shelby Boggs
NextGen Healthcare

Gary Broadwater
Antietam Health Services

Jeffrey Cheng
GURU Consulting

Chuck Dorin
e-MDs

Kathryn Feldmann
CGI System Integrators

Mike Fierro
Dynamed

Marty Frygier
Perficient

Beverly Gazmen
Chesapeake Ortho & Sports

Ed Grogan
Calvert Memorial

Chuck Henck
University Physicians, Inc

Michael Hill
SysInformation

David Horrocks
CRISP

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CareFirst

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Mary Jane Kamps
Union Hospital of Cecil County

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Ron Moser
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Sandlot

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Denise Reeser
New Heights Consulting

Ewart Russell
Children's Pediatric Associates

Telly Shackleford
Sandlot

Michael Snyder
Planned Systems International

Matthew Tan
Knowledge Advantage

Kevin Tyler
Mid-Atlantic Systems

Tina Whims
Frederick Health Services

Gary White
Practice Works Systems

Appendix G
State Designated MSOs

State Designated Management Service Organizations									
MSO	Contact Name	Address	Address 2	City	State	Zip	Phone	Email	Status*
Advanced Data Systems	Marc Klar	15 Prospect Street		Paramus	NJ	07652	(800) 899-4237	marc.klar@adsc.com	CS
Agastha	William Simpson	3520 Toringdon Way	Suite 103	Charlotte	NC	28277	(704) 544-6504	william@agastha.com	CS
Anne Arundel Medical Center	Doug Abel	2001 Medical Parkway		Annapolis	MD	21401	(443) 481-5215	dabel@aahs.org	CS
AVS Medical	Lloyd Morris	877 Balto. Annapolis Blvd.	Suite 111	Severna Park	MD	21146	(410) 975-9160	lloyd@avsmedical.com	CS
CHIP	Salliann Alborn	802 Cromwell Park Drive	Suite V	Glen Burnie	MD	21061	(410) 761-8100	salborn@chipmd.org	CS
Children's IQ Network	Brian Jacobs	111 Michigan Avenue, NW		Washington	DC	20010	(202) 476-3969	bjacobs@cnmc.org	CS
D'Souza & Associates	Rohit D'Souza	530 Schoolhouse Road	Suite A	Hockessin	DE	19707	(302) 239-9671	rohit@dsouzainc.com	CS
Erickson IT	Scott Erickson	12864 Macbeth Farm Lane		Clarksville	MD	21029	(410) 929-5570	scott@ericksonit.com	CS
Frederick Memorial Hospital	Tina Whims	478 Prospect Boulevard		Frederick	MD	21701	(240) 379-6061	twhims@fmh.org	CS
GBMC	Tressa Springmann	6701 North Charles Street		Baltimore	MD	21204	(443) 849-3749	tspringm@gbmc.org	CS
MedPlus	Dawn Johnson	4690 Parkway Drive		Mason	OH	45040	(410) 419-6324	djohnson@medplus.com	CS
Mosaic Technologies	Jason Bach	15720 Crabbs Branch Way	Suite 2B	Rockville	MD	20855	(240) 399-3900	jbach@mosaictechnologies.com	CS
Networking Technology RxNT	Karen Childs	1106 West Street		Annapolis	MD	21401	(800) 943-7968	kchilds@rxnt.com	CS
SuiteMed, LLC	Danielle Taimuty	333 Hegenberger Road	Suite 800	Oakland	CA	94621	(877) 682-7482	dtaimuty@mbssi.net	CS
Sydian Solutions, Inc.	Chuck Dorin	9505 Hull Street Road	Suite C	Richmond	VA	23236	(804) 276-6456	cdorin@sydian.com	CS
Wavelength	Murray Oltman	504 Franklin Avenue	PO Box 739	Berlin	MD	21811	(410) 629-0913	murray@wavelengthIS.com	CS
Zane Networks, LLC	Luigi Leblanc	8070 Georgia Avenue	Suite 407	Silver Spring	MD	20910	(301) 560-0500	leblancl@zanenetworks.com	CS

Status Key: SD = State Designated; CS = Candidacy Status

Rev. 8/20/2010

Appendix H
COMAR 10.25.16 EHR Incentives
Public Comments

Anne Arundel Medical Center

2001 Medical Parkway
Annapolis, MD 21401
443-481-1000
TDD: 443-481-1235
www.aahs.org

August 30, 2010

Mr. David Sharp, Director
Center for Health Information Technology
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

RE: Proposed Regulations-10.25.16 *Electronic Health Record Incentives*

Dear Mr. Sharp:

I would like to thank you and the Maryland Health Care Comission for your continued leadership promoting the adoption of electronic health records (EHRs) in Maryland. The widespread use and adoption of EHRs have the potential to significantly improve the quality of care provided to Marylanders. Anne Arundel Health System (AAHS) has implemented an EHR in the acute setting and is offering its EHR to the physician community.

AAHS does not support the provision in the proposed rule (.03 B.) that specificially excludes hosptial-owned physicians from participating in the program. The exclusion is not consistent with the statute or with the underlying policy objectives. HB 706, passed in 2009, permits the Commission to promulgate rules that design incentives for specific Health Care Providers, as defined in the Health Facilities and Health Occupations sections of the Code (§19-142 (E) and §14-101). The Health Occupations definition of Physician is not distinguished by ownership type. As a result, the exclusion of a Physician based on ownership type was not the intent of the General Assembly. Further, the underlying purpose of the statute is to promote EHR adoption in such a manner that supports existing federal and state programs. The existing federal and state programs do not exclude physicians based on practice ownership structure. Much of the focus has been on primary care and related specialties regardless of ownership. Hospital-owned physicians are eligible to receive ARRA and Medicare funds as complimentary incentives.

Hospital-owned physicians should not be excluded from the incentives because these physicians are key to encouraging widespread EHR adoption and they confront the same obstacles as other physicians when implementing an EHR solution. An increasing number of primary care physicians are practicing in hosptial-owned practices due to the challenging reimbursement environment. Physicians in hosptial-owned practices face the same challenges training for and implementing an EHR as all physicians do, including declines in short term productivity and increased costs. EHR adoption by hosptial-owned practices is critical to our shared vision of a robust Health Information Exchange based on universal adoption.

I appreciate the opportunity to comment on the proposed rule. I look forward to continuing to work with the Commission on innovative programs that encourage EHR adoption and building our statewide Health Information Exchange.

Sincerely,

Victoria W. Bayless
President
Anne Arundel Health System

Douglas Abel
Chief Information Officer
Anne Arundel Health System

From: Murray Oltman [mailto:moltman@atlanticgeneral.org]
Sent: Monday, August 30, 2010 3:06 PM
To: David Sharp
Subject: Proposed Regulations - 10.25.16 Electronic Health Record Incentives

David Sharp
Director, Center for Health Information Technology
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

RE: Proposed Regulations – 10.25.16 Electronic Health Record Incentives

Dear David,

I wanted to thank you and the Commission for your continued assistance to physician practices as we jointly work towards increased EHR adoption within the State of Maryland.

In reviewing the proposed regulations, I noted the following comments:

.02.B.1 states: Additional incentive means a monetary amount above the base incentive for a practice that meets additional criteria in the use and adoption of electronic health records including adoption of electronic health records through a management service organization and/or a practice that can demonstrate advanced use of electronic health records.

You may consider changing "managed service organization" to "MHCC recognized Management Service Organization (MSO)"

The last sentence uses "and/or" . Do I read this correctly that the "additional Incentive" is available to the provider if they either use a MSO **or** if they demonstrate advanced use of an EHR? Or was the intent for the "additional incentive" that the provide use a MSO **and** demonstrate advanced use?

.02.B.3 states: Electronic health record (EHR) means an electronic record of health-related information on an individual that.....

Should ARRA certification be noted as an EHR requirement? Or is there a minimum recent certification date?

.02.B.8 states: Management service organization (MSO) means an organization that offers one or more hosted electronic health record solutions and other management services to health care providers.

You may consider changing this definition to read "Management Service Organization (MSO) means an organization which has received recognition by the Maryland Health Care Commission ("MHCC") as a Designated MSO or has received MHCC MSO Candidacy Status in accordance with House Bill 706, Electronic Health Records-Regulation and Reimbursement.

.03.B. states: The EHR adoption incentive is available to non-hospital owned practices.

Hospital-owned and independent physician practices incur similar costs when implementing EHRs. All physician practices, hospital owned or non-hospital owned, must bear the expense of EHR implementation.

In the case of AGH, excluding hospital-employed physician practices which operate within our community in an ambulatory setting, from this private payor EHR incentive could limit the benefit of EHR adoption. If I am not mistaken, Worcester County in its entirety (where the community based AGH-employed ambulatory physicians practice) is designated as both a Primary Care Medically Underserved Area/Population (MUA/P) and Primary Care Health Professional Shortage Areas (HPSA). We have ~10 different ambulatory care offices throughout Worcester County.

We would ask that the Commission reconsider their position on this eligibility requirement.

.04.E states: E. A practice may request an incentive of monetary value approximately 9 months after receiving an EHR Monetary Incentive Application acknowledgement letter, and not later than 15 months from the time they are eligible to submit their incentive payment request.

We would ask that the Commission allow providers to request an incentive of monetary value within three (3) months after receiving an EHR Monetary Incentive Application acknowledgement letter (assuming they meet all other criteria). There are significant initial or upfront costs associated with EHR adoption and allowing providers to request the incentive earlier will greatly assist the physicians.

.05.B States: An additional incentive of monetary value is available to a practice that adopts EHRs through a State designated MSO.

You may consider changing "EHRs through a State designated MSO" to "EHRs through a MSO (as defined in .02.B.8)."

.05. D states: An additional incentive of monetary valve is available to a practice for demonstrating advanced use of EHRs during the immediate 90 days prior to submitting an EHR monetary incentive voucher to a payor.

Same question as above, does the incentive require both participation with a MSO **and** demonstrating advanced use?

I'll be glad to follow-up with you on any of the comments above.

Thanks,

Murray W. Oltman, CHCIO
CIO, Director of Information Services
Atlantic General Hospital
410-629-0913

Chet Burrell
President and Chief Executive Officer

CareFirst BlueCross BlueShield
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
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E-mail: chet.burrell@carefirst.com

CareFirst BlueCross BlueShield

August 26, 2010

Rex W. Cowdry, M.D.
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Cowdry:

The State of Maryland took a major step forward in encouraging the adoption of health information technology among the state's medical care providers with the enactment last year of House Bill 706. As you know, we are supportive of the intent of the legislation. Attached, you will find CareFirst's complete comments on the draft regulations (Subtitle 25 Maryland Health Care Commission, *10.25.16 Electronic Health Record Incentives)* for the Commission's consideration.

I would like to particularly encourage the Maryland Health Care Commission (MHCC) to ensure that the final regulations maximize the benefit of this program to Maryland's primary care physician (PCP) community.

There is wide acknowledgment that PCPs can play a central role in improving health care quality and constraining rising health care costs. Given the limited available funds for the program and the critical importance of Electronic Health Records in both the State's Patient Centered Medical Home (PCMH) pilot and in single carrier PCMH programs, it is logical and essential that funding generated by HB 706 be focused on PCPs.

We appreciate the opportunity to work with MHCC on development of the guidelines. Should you have any questions or require clarification of our comments, you or your staff should feel free to contact me.

Thank you in advance for consideration of CareFirst's input on these important regulations.

Sincerely,

Chet Burrell
President and Chief Executive Officer

Attachment

Subtitle 25 MARYLAND HEALTH CARE COMMISSION

10.25.16 Electronic Health Record Incentives

Authority: Health–General Article, §§ 19-103(c)(2)(i) and (ii), 19-109(a)(1), 19–143(d)(1),(2),(3),(4), and (i) Annotated Code of Maryland

.01 Scope.

A. This chapter applies to the State-regulated payors who provide incentive payments to providers that adopt and use electronic health records.

- We suggest that the scope clarify that the chapter relates only to fully-insured business, not self-funded plans. "State-regulated payors" are referenced throughout. However, this term could be made clearer by referencing a title under which those payors are regulated. For example, the definition at .02B(15) could add "means a payor regulated under subtitle 19 of this title or Title 31.

B. Only providers who meet the requirements pursuant to this chapter will receive incentive payments for electronic health
record adoption.

.02 Definitions.

- We suggest that the term "member" be defined as a patient covered by a state regulated insurance plan, or the State of Maryland plan, who is a resident of Maryland.
- We suggest that the term "Incentive of Monetary Value" as used in Sections .04E, .05A and .06F be defined.

A. In this chapter, the following terms have the meanings indicated.
B. Terms Defined.
(1) "Additional incentive" means a monetary amount above the base incentive for a practice that meets additional criteria
in the use and adoption of electronic health records including adoption of electronic health records through a management
service organization and/or a practice that can demonstrate advanced use of electronic health records.
(2) "Base incentive" means a monetary amount that an eligible practice can receive as calculated by the number of payor
members treated by the practice on a per member basis.
(3) "Electronic health record (EHR)" means an electronic record of health-related information on an individual that:
(a) Includes patient demographic and clinical health information; and
(b) Has the capacity to:
(i) Provide clinical decision support;
(ii) Support physician order entry;
(iii) Capture and query information relevant to health care quality; and
(iv) Exchange electronic health information with and integrate the information from other sources.
(4) "EHR monetary incentive application" means an application submitted by a practice to a payor that will seek an incentive payment for EHR adoption.

- Further clarification should be made as to the differences between monetary incentive application and monetary incentive voucher.
- .02B(4) and .04 list requirements for the EHR incentive application. The MHCC should clarify the form of that application. For example, with the MHCC adopt a uniform application to be used by all payors, or will each payor adopt its own application.

(5) "EHR monetary incentive application acknowledgement letter" means a letter sent by the payor to the practice accepting the practice's EHR monetary incentive application.
(6) "EHR monetary incentive voucher" means an application sent by the practice to the payor requesting the incentive payment.
(7) "Health information exchange (HIE)" means a Statewide infrastructure that provides organizational and technical capabilities to enable the electronic exchange of health information between health care providers and other health services
organizations authorized by the Commission.
(8) "Management service organization (MSO)" means an organization that offers one or more hosted electronic health
record solutions and other management services to health care providers.
(9) "MHCC or Commission" means the Maryland Health Care Commission.
(10) "Non-hospital owned practices" means a family, general, geriatric, internal medicine, pediatric, or gynecologic practice designated by the payor for the EHR adoption incentive that is not owned by a hospital.

- MHCC should define hospital ownership. For example, percentage of ownership or majority? If a hospital has an affiliation with a group and provides the group resources and/or access to electronic records, the payor should not have to incentivize the group to use electronic records. Should such groups be considered non-hospital owned?

(11) "Payor" means State-regulated payor.
(12) "Practice" means a primary care practice consisting of a single physician or group of physicians that provide patientcare services in family, general, geriatric, internal medicine, pediatric, or gynecologic practice.

- CareFirst supports the definition of "practice" to include primary care practices only.
- The definition of "practice" should indicate that the practice is located in the State of Maryland.

(13) "Practice panel" means the patients who have been assigned to a primary care provider by the payor or the patients
treated by the practice within the last 24 months when the payor does not assign a primary care provider.
(14) "State Designated MSO" means an MSO that has received State designation by the MHCC.
(15) State Regulated Payor.
(a) "State-regulated payor" includes:
(i) Aetna, Inc.;
(ii) CareFirst BlueCross BlueShield;
(iii) CIGNA HealthCare Mid-Atlantic;
(iv) Coventry Health Care;
(v) Kaiser Permanente;
(vi) United Healthcare, Mid Atlantic Region; and
(vii) The State employee and retiree health and welfare benefits program.
(b) "State regulated payor" does not include a managed care organization as defined in Title 15, Subtitle 1, Annotated Code of Maryland.

- We suggest that the definition clarify that a "state regulated payor" does not mean self-funded plans. "State-regulated payors" are referenced throughout. However, this term could be made clearer by referencing a title under which those payors are regulated. For example, the definition at .02B(15) could add "means a payor regulated under subtitle 19 of this title or Title 31."

and over what time period.

.05 Incentive Components.

A. A practice that meets the requirements for participation shall receive an incentive of monetary value from the payor based on the payor's share of members treated by the practice. Incentives are calculated on a per member basis.

B. An additional incentive of monetary value is available to a practice that adopts EHRs through a State designated MSO.

C. A practice that adopts an EHR through a State designated MSO is required to submit a copy of the MSO's State designation certificate with their EHR monetary incentive voucher.

D. An additional incentive of monetary valve is available to a practice for demonstrating advanced use of EHRs during the immediate 90 days prior to submitting an EHR monetary incentive voucher to a payor. The following advanced uses of an EHR shall be considered:

(1) As defined in Regulation .02B of this chapter;

(2) Participates in a payors' quality improvement outcomes initiative, and has achieved the established performance goals;

and

(3) A signed attestation is required by the practice to substantiate advanced use of an EHR system, and that the practice is a participant in the State designated HIE.

.06 Incentive Payment Calculation by Payor.

A. The eligibility time period for a practice to apply for an EHR adoption incentive is January 1, 2011 through December 31, 2014.

B. Payors have the flexibility to disburse incentives over a 12-month timeframe.

C. EHR adoption incentives of monetary value are calculated at $8 per member and limited to Maryland residents.

D. The EHR adoption incentive has a maximum monetary value of $15,000 per practice per payor (combined base incentive and additional incentives).

E. The monetary value of the base incentive shall account for approximately 50 percent of the combined base incentive and additional incentives as defined in Regulation .06D of this chapter.

F. EHR adoption incentives for hardware or software, or both, may be declined by a practice in which case a payor is required to offer an alternative adoption incentive of equal monetary value.

.07 Reporting.

Payors are required to submit an annual report to the MHCC not later than March 31st of the following year for calendar years 2011 through 2014 that includes the following information:

A. Number of incentive applications received and paid for that year;

B Total value of distributed base incentives for that year; and

C. Total value of additional incentives for that year.

From: Kathy Seifert [mailto:k.seifert@espsmd.com]
Sent: Tuesday, August 03, 2010 9:39 PM
To: David Sharp
Subject: EHR reimbursement

In proposed regulation 10.25.16.02B(12) add 'behavioral health' to the definition of 'practice.' Mental health and addiction services are integral to overall health and must be included in all such initiatives

Dr. Kathy Seifert

Get my free email newsletter at: http://drkathyseifert.com
Get the CARE2 online at: http://care2systems.com

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Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

AUG 16 2010 AM11:38

David Sharp
Director, Center for Health Information Technology
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Kathleen B. Francis
Chief, Health Information Exchange
Center for Health Information Technology
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

August 3, 2010

Re: Support for COMAR 10.25.16 *Electronic Health Record Incentives*

Dear Mr. Sharp and Ms. Francis:

On behalf of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., I would like to offer our full support for COMAR 10.25.16 *Electronic Health Record Incentives*. As required by the enactment of House Bill 706 *Electronic Health Records – Regulation and Reimbursement,* the purpose of the proposed regulations is to require state-regulated payers to provide incentives to providers to promote the adoption of electronic health records (EHRs). As you are aware, Kaiser Permanente members have long had the advantage of receiving their health care from an integrated delivery system that relies heavily on the use of electronic records. EHRs have the potential to improve health care quality, patient safety, care coordination and continuity, while reducing the overall cost of health care.

COMAR 10.25.16 establishes requirements for provider incentives, indicates which items and services may be provided as incentives, specifies that incentives are not required for certain types of health care providers and, specifies which entities and under what circumstances the regulations are applicable. The proposed regulations are the result of a thorough development process that was undertaken by the Maryland Health Care Commission (MHCC) over the past 8 months. MHCC staff engaged state-regulated payers, providers and other stakeholders in the discussion including a representative from the Mid-Atlantic Permanente Medical Group. As a result, the proposed regulations are thorough, well-vetted and reflect the intent of the original legislation.

Thank-you for the opportunity to offer Kaiser Permanente's support for C*OMAR 10.25.16 Electronic Health Record Incentives.* If you have any questions or require additional information, please feel free to contact me at 301.816.6440 or Kendall.Hunter@KP.org.

Kendall D. Hunter
Chief Operating Officer

2101 E. Jefferson Street
Rockville, Maryland 20852

Maryland Academy of Audiology
P.O. Box 6481, Ellicott City, MD 21042

AUG 23 2010 PM 3:57

August 19, 2010

David Sharp, Director
Center for Health Information Technology
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Sharp:

Health care providers and consumers should applaud the Maryland Health Care Commission's Electronic Health Records (EHR) incentive program. This incentive to bring about change in practices to include EHR will truly enhance the quality of patient care and reduce the cost related to the care. The Maryland Academy of Audiology (MAA), representing more than 300 practitioners across the state, supports this program.

We have reviewed the proposed regulations and would like to comment on the use of provider neutral language. Under Definitions, in .02(B)(3)(b)(ii), "support physician entry" could be construed as omitting non-physician providers, such as Audiologists, Optometrists, Physical Therapists, and other non-physician clinical providers. Likewise, #12 of that section defines "practice" as consisting of only physicians. It would follow then, in #13 to pertain only the patients of physicians.

Audiologists, by virtue of Maryland state licensure, diagnose and treat hearing loss and balance disorders, as well as tinnitus and auditory processing disorders. The profession of Audiology provides doctorate level patient treatment and care. Audiologists have provided independent care since its inception in the late 1940s. In fact, in a recent peer review publication comparing physician care to audiologists found no difference in diagnosis, treatment and management recommendations (Zapala et al., 2010).[1]

We hope that you will take these concerns regarding provider neutral language into consideration and strongly recommend that this language be modified accordingly, before final publication of the regulations. Please feel free to contact me if you would like to discuss this further.

Sincerely,

Alicia D.D. Spoor, Au.D.

Alicia D.D. Spoor, Au.D.
Doctor of Audiology
President, Maryland Academy of Audiology
P.O. Box 6481
Ellicott City, Maryland 21042
410-313-9100
aspoor@cavtel.net

[1] Zapala, D. A., Stamper, G. C., Shelfer, J. S., Walker, D. A., Karatayli-Ozgursoy, S., Ozgursoy, O. B., & Hawkins, D. B. (2010). Safety of Audiology Direct Access for Medicare Patients Complaining of Impaired Hearing. Journal of the American Academy of Audiology, 21, 365-379.

ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

R. Dobbin Chow, MD, FACP
Governor, ACP, Maryland Chapter
STAFF – MARYELLEN WOODWARD
MEW4WORK@AOL.COM
920 TRINITY STREET
BALTIMORE, MD 21202
410-332-8444

July 1, 2010

Cindy S. Friend, RN, MSN, MBA/HCA
Chief of Health Information Technology
Maryland HealthCare Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: House Bill 706

Dear Ms. Friend,

I am pleased to write on behalf of the Maryland Chapter of the American College of Physicians. We whole-heartedly support House Bill 706, *Electronic Medical Records - Regulation and Reimbursement*. General internal medicine physicians in Maryland have been challenged to adopt electronic medical records. This relates to cost as well as the need for technical expertise and training. The proposed regulation will help primary care physicians address these needs. Primary care physicians play a central role in providing healthcare for Maryland citizens and for delivery of high quality of care for patients in our state. Primary care physicians typically have lower reimbursement schedules then other specialty providers, and are least able to afford adoption of electronic medical records in their offices. We fully support the passage of this regulation and would be glad to serve as a resource should you require further information or assistance regarding our specialty or the practice of internal medicine.

Sincerely yours,

R. Dobbin Chow, M.D., FACP
Governor, Maryland Chapter of ACP

MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

MARTIN O'MALLEY
Governor
ANTHONY BROWN
Lieutenant Governor

T. ELOISE FOSTER
Secretary
DAVID C. ROMANS
Deputy Secretary

August 9, 2010

Rex W. Cowdry, M.D.
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2222

Dear Dr. Cowdry:

I have just received a copy of the proposed regulations that you have submitted to the Division of State Documents amending COMAR Title 10, Subtitle 25, Chapter 16. These regulations are being proposed as a result of legislation passed by the General Assembly during the 2009 session (HB 706) to promote the adoption and use of electronic health records.

Certain provisions contained in that legislation authorized the Maryland Health Care Commission to require certain "State-regulated payors" to provide monetary incentives to providers to employ the use of electronic health records. Further, in that legislation "State-regulated payors" was defined to include health insurance carriers and the State Employee and Retiree Health and Welfare Program (Program). In order to clarify the intent of this legislation, members of my staff met with you and a number of your staff members in your offices last summer. In that meeting it was agreed that it was neither your intent nor that of the Maryland Health Care Commission to require the Program to provide monetary incentives to providers, but rather to encourage the advancement of the use of electronic health records through our contractual relationships with the health insurance carriers. It was unanimously recognized that it certainly would be impractical to use State employee and retiree premium dollars to provide direct monetary incentives to providers with whom the State has no contractual arrangement.

In our review of the proposed regulations, I am concerned that this ambiguity still exists, and I would like to request a simple wording change that I believe will provide the necessary clarification.

.01 Scope.
A. This chapter applies to the state-regulated payors who CONTRACT DIRECTLY WITH PROVIDERS FOR HEALTH CARE SERVICES TO BE PROVIDED TO ITS MEMBERS AND provide incentive payments to providers that adopt and use electronic health records.
B. Only providers who meet the requirements pursuant to this chapter will receive incentive payments for electronic health record adoption.

~Effective Resource Management~
45 Calvert Street • Annapolis, MD 21401-1907
Tel: (410) 260-7041 • Fax: (410) 974-2585 • Toll Free: 1 (800) 705-3493 • TTY Users: call via Maryland Relay
http://www.dbm.maryland.gov

I am sorry that, as a potential stakeholder in these regulations, my agency was not provided an opportunity for review and feedback prior to submission to the Division of State Documents as promised. I am hopeful that these regulations can be corrected. If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

T. Eloise Foster

T. Eloise Foster
Secretary

cc: David Sharp

August 17, 2010

David Sharp
Director, Center for Health Information Technology
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215

RE: Proposed Regulations – 10.25.16 *Electronic Health Record Incentives*

Dear Mr. Sharp:

The Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatrics, the Maryland Academy of Family Physicians, the American College of Physicians - Maryland Section, the Mid-Atlantic Association of Community Health Centers and the Maryland Hospital Association jointly submit these comments on the above referenced regulations regarding the creation of an incentive program that will require specific State-regulated payors to provide incentives to certain health care providers to promote the adoption and use of electronic health records(EHR).

While each of the respective undersigned organizations may have additional comments on these proposed regulations that reflect interests, the comments reflected in this letter represent the collective voice of the primary care physicians in the State. The financial and operational challenges that face primary care physicians are multifaceted. For many primary care physicians, the adoption of an EHR is beyond their capability absent a meaningful financial contribution from an external source or sources. The passage of House Bill 706 in 2008 and the regulatory framework that these regulations propose provides an excellent framework to begin to assist primary care practices in the acquisition and implementation of EHRs. While we are excited about the possibility of a meaningful incentive program and encouraged by the State's commitment to attempt to ensure that the program is able to achieve the stated objectives, we nonetheless have several questions and comments that we would like the Commission to consider.

First and foremost is a concern that a payor retains the authority to determine in what form the incentive will be provided. Section 10.25.16.03A., provides a list of possible incentives that a payor may utilize. Any one of these incentives may or may not be of benefit to a primary care physician. For instance, "In-kind payments," "rewards for quality and efficiency," and other such incentives may not provide sufficient direct cash flow to a practice in a manner that will enable the practice to make the financial investment in an EHR - the intended objective of the program. Our organizations would ask the practice have the right to determine the form of the incentive payment.

Given that the regulations specify the total value of the incentives a payor is required to provide - $8 per member, Maryland residents only - with a maximum of $15,000 per practice (Section 10.25.15.06C.-D.) the financial exposure of the payor is limited and the form of the incentive should be at the discretion of the physician not the payor. The only discretion held by the physician is a right to decline hardware and software as the form of incentive. For the incentives to be meaningful, they must match with the needs of the practice. A "one size fits all" decision by a payor with respect to the form of its incentives could render them meaningless to a substantial segment of the marketplace.

Our organizations would also like to request that the Commission consider shortening the time frame of payment of the incentives. From the date of application for an incentive to the possible receipt of any meaningful funds can be as long as 1 year and may extend well beyond that time frame. Again, the only way this incentive program can be successful in achieving its objectives is if the monetary contributions are both timely and sufficient so that they match with the planning and purchase needs of the practice. A shorter, more flexible time frame for application and payment will enhance the effectiveness of the program.

Finally, our organizations would like to request that the Commission ensure that the standards for recognizing a "management service organization" (MSO) are rigorous and include such requirements as demonstration of general insurance liability coverage and other threshold parameters that ensure they are legitimate. Because the regulations enable the payment of additional incentives for adoption of EHRs through an MSO, we want to be sure that if our members chose to adopt HER through one of these MSO's that they will not find their investments has been made in a company that cannot ultimately deliver the necessary technology and services.

We look forward to continuing to work with the Commission on the implementation of this program and believe our requested changes, if adopted will yield a more meaningful and successful program.

Sincerely,

Gene M Ransom III

Gene Ransom, Chief Executive Officer
MedChi, The Maryland State Medical Society

Eric Levey MD

Eric Levey, M.D., President
Maryland Chapter of the American Academy of Pediatrics

Eugene J. Newmier, D.O., President
Maryland Academy of Family Physicians

R. Dobbin Chow, M.D., Governor
Maryland Chapter of the American College of Physicians

8/17/10

Miguel McInnis, Chief Executive Officer
Mid-Atlantic Association of Community Health Centers

Valerie Shearer Overton
Senior Vice President, Legislative Policy
Maryland Hospital Association

From: Richard Bloch [mailto:Richard@sbhpa.com]
Sent: Friday, August 13, 2010 12:35 PM
To: Kathy Francis
Cc: David Sharp; William Chan
Subject: RE: Fall Meeting

Hi Kathy,

As you know we always welcome MHCC at our meetings. October already has a speaker and a pretty full agenda. However, I would like to know how long a presentation you want to make, and the specifics of the topics. Let's see if we can fit you in, even for as brief presentation.

I am copying David Sharp, as I also want to raise the concerns of MPMA regarding the proposed EHR regulations recently published. The definition of "practice" excludes non-physician providers from the program. This is not the intent of the federal program, which includes podiatrists, and the stated "purpose" language of the regulations which refers to "health care providers". MPMA wants to be sure that all providers, and especially podiatrists, are included in the EHR incentive program. Without full participation of the healthcare community, the program is too limited and does not fulfill its purpose.

Thank you,

Richard

Richard Bloch
Executive Director
Maryland Podiatric Medical Association
600 Baltimore Avenue, Suite 301
Towson, MD 21204-4022
Phone (410) 332-0736
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MedChi
The Maryland State Medical Society

1211 Cathedral Street
Baltimore, MD 21201-5516
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www.medchi.org

August 19, 2010

David Sharp
Director, Center for Health Information Technology
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215

RE: Proposed Regulations – 10.25.16 *Electronic Health Record Incentives*

Dear Mr. Sharp:

I submit these comments on the above referenced regulations on behalf of MedChi, The Maryland State Medical Society. First and foremost, I want to thank you for the time and deliberative attention you have given a number of concerns that I have already raised with you regarding these regulations, particularly as it relates to the State requirements for "management service organizations" (MSOs). Your agreement to require that certificates for workers compensation and general liability insurance be filed with an application for certification will help ensure that designated MSOs have a Maryland presence and are properly insured should they fail to fulfill their obligations.

We would also ask that the Commission consider including a requirement for a performance bond or letter of credit with their application. Maryland physicians will be investing thousands of dollars in EHR technology and Med Chi wants to be sure that their reliance on State designated MSOs does not create financial and legal havoc for physicians should an MSO fail. To that end, MedChi would also suggest the Commission create an "MSO of last resort" to ensure that there is always an alternative should a designated MSO fail.

MedChi is excited about the potential benefit of a meaningful EHR incentive program for primary care physicians in the State. It has been well recognized that for many primary care physicians, the adoption of an EHR is beyond their financial capability without contribution from an third party. The regulatory framework established with these regulations provides an excellent starting point to begin to assist primary care practices in the acquisition and implementation of EHRs. MedChi is encouraged by the perceived commitment of the Commission to ensure that the program is able to achieve the objectives encompassed in Senate Bill 706 passed in 2008. The regulatory framework presented in the regulations is a tremendous start in that right direction; however we have several questions and comments that we would like the Commission to consider.

As you are aware, MedChi was a signatory on a letter submitted by six organizations that represent the primary care community in Maryland. That letter is attached for reference purposes. We would again like to reiterate the importance of the issues raised including the right of physicians to determine the form of the incentive payment and a shorter timeframe for payment of those incentives. We hope the

MedChi
The Maryland State Medical Society

Commission will incorporate those comments and suggestions in its final regulations. In addition to the issues raised in that letter, we would offer a few additional suggestions that we believe will strengthen the program and are in accordance with the intent of the legislation.

The entire incentive program is based on the number and proportion of enrollees of a particular insurer in a given practice. To assist in obtaining consistent data across all insurers, the "EHR monetary incentive application" should be standardized across all payers and approved by the MHCC. This not only will ensure consistent data collection but will facilitate the physician's application process and reduce administrative burden. It is analogous to the "uniform credentialing form" that is utilized by physicians when seeking to participate on carrier provider panels.

The regulations provide a right for an insurer to exclude "plan participants" from a practices "incentive calculation." The regulations should define a standardized notification and justification process that an insurer must use when making an exclusion from the calculation and the practice should have an appeal and adjudication process to challenge that exclusion. These incentives payments will be critical to a practice's ability to invest in EHR and an insurer should not be able to arbitrarily decide to exclude patients from the calculation.

Finally, this incentive program, as structured, is only available to primary care physicians. MedChi recognizes the myriad of challenges facing primary care physicians and acknowledge their financial status makes EHR adoption as or more challenging than many other specialties. However, the challenges of EHR adoption are not limited to primary care physicians and we would urge the Commission to create a mechanism whereby other specialties, particularly those specialties that primarily bill E & M codes and/or have been identified as a specialty for which there is a shortage, also have a mechanism to request participation in the program.

MedChi thanks the Commission for its consideration of these comments and suggestions. We believe the adoption of our suggestions will enhance the success of the program and the attainment of its objectives. We look forward to continuing to work with you as you move forward toward implementation of this critical program.

Sincerely,

Gene M Ransom III

Gene M. Ransom, III
Chief Executive Officer
MedChi, The Maryland State Medical Society

From: Peter.Basch@Medstar.net [mailto:Peter.Basch@Medstar.net]
Sent: Wednesday, August 04, 2010 3:18 PM
To: David Sharp
Subject: comment on EHR incentive bill

Good afternoon David - hope you are well...

I have just reviewed this bill and believe that the exclusion of hospital-employed physicians is a mistake. Just as with the Meaningful Use program, the need to get physicians in outpatient practice adopting and optimally using EHR technology is critical regardless of employment status - and of similar cost, particularly when physician time is considered. And from a policy perspective, we have learned that getting our docs to use an EHR is one thing; getting them to use it for advanced functionality / enhancing quality is another story. Thus, even if the appetite for paying initial incentives was not present, I would urge consideration of paying the additional incentives for demonstration of advanced use *regardless* of employment status.

tnx, and have a great day

Peter

Peter Basch, MD, FACP
Medical Director, Ambulatory EHR and Health IT Policy
MedStar Health
5565 Sterrett Place, 3rd Floor
Columbia, MD 21044
Tel 410-772-6710
peter.basch@medstar.net

Maryland
Hospital Association

MHA
6820 Deerpath Road
Elkridge, Maryland 21075-6234
Tel: 410-379-6200
Fax: 410-379-8239

August 30, 2010

David Sharp
Director, Center for Health Information Technology
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

RE: Proposed Regulations – 10.25.16 *Electronic Health Record Incentives*

Dear Mr. Sharp:

We applaud the Maryland Health Care Commission (MHCC) for supporting physician practices in adopting electronic health records (EHRs). The incentive program authorized by the 2009 Maryland General Assembly in the form of HB 706, complements the federal incentives under the American Recovery and Reinvestment Act (ARRA), which provide incentive payments to health care providers who use certified EHRs in a meaningful way and eventually penalizes providers who fail to do so. However, the MHCC regulations narrow the scope of the state EHR incentive statute by excluding two important segments of the physician population--practices owned by hospitals and specialty physician practices.

Hospital-owned physician specialty practices provide services to patients in both the inpatient and the ambulatory care settings. Physicians in those practices often utilize two different EHR systems when accessing inpatient records and records in the ambulatory care setting. While inpatient hospitals, in the aggregate, have implemented EHRs more widely compared to other provider types, EHRs used in ambulatory care settings are very different from inpatient EHRs because of the inherent differences between the types of care provided. Implementing an EHR in an ambulatory setting requires a significant cost above and beyond the cost of implementing the inpatient EHR.

Hospital-owned and independent physician practices incur similar costs when implementing EHRs. All physician practices must bear the expense of EHR implementation while operating in a financially responsible and sustainable manner. The benefit to being a practice owned by a hospital lies in access to support structure and administration. This administrative support takes the burden of practice management away from the physicians, while at the same time providing the tools and an incentive to operate efficiently.

Excluding hospital-owned physician practices--many of which provide services in ambulatory-care settings--from eligibility for the HIT incentive payments would limit the benefit of EHR adoption in all communities, and especially in urban and rural settings. These urban and rural practice sites, which utilize an ambulatory EHR that is comparable or equivalent to the EHR platform used in traditional private practice settings, provide anchors to community-based

services in their markets. In many cases, they are, in fact, the only available source of ambulatory care to thousands of people.

Specialists and hospital-owned physician practices are eligible for ARRA incentives. CMS only excluded professionals providing substantially all of his/her services in the hospital, e.g., anesthesiologists and pathologists from ARRA incentive eligibility with the rationale that the professional would also use the facility and equipment of the hospital, including any EHR. Hospital owned and independent primary care and specialist physicians practicing at the hospital and in the community are eligible for ARRA incentives.

As the Chesapeake Regional Information System for our Patients (CRISP), Maryland's statewide health information exchange, begins operations it is particularly important that nearly all community primary care and specialist physicians and other providers utilize EHRs that allow them to provide data to and receive data from CRISP in an automated manner. To ensure the broadest participation possible in CRISP, we believe it is important to include all physician providers in the state incentive program. We recommend MHCC modify its proposed regulations to allow specialist and hospital-owned physician practices to be eligible for the state EHR incentive program.

We appreciate the opportunity to comment on proposed regulations. If you have any questions, please contact me.

Sincerely,

Valerie Shearer Overton
Senior Vice President, Legislative Policy

Traci Lynn La Valle

Traci La Valle
Assistant Vice President, Financial Policy

From: Kathy Francis
Sent: Tuesday, August 24, 2010 8:22 AM
To: Amelia Rutlledge
Subject: COMAR 10.25.16

Hi Cookie

We spotted two problems with the Maryland Register publication for COMAR 10.25.16 from July 30, 2010.

Item .05.D should say an additional incentive of monetary value (it says valve)

Item .06.E should reference Regulation .05D of this chapter, not .06D

How does this get corrected?

Kathy

From: Spencer Gear [mailto:Spencer.Gear@mosaicinc.org]
Sent: Friday, August 13, 2010 2:32 PM
To: David Sharp
Subject: Proposed Implementation Regulations for Incentives

David:

I am extremely concerned that the proposed implantation for incentives in Maryland does not include behavioral health programs. There seems to be little appreciation of the scale of these programs, their penetration in the public health arena, and the acuity of their patients. Overall patient care of severely ill individuals is managed to a far greater degree by their behavioral health providers than by their PCP's. In addition, behavioral health centers are involved in a significant portion of hospital admissions and discharges, and will clearly benefit greatly from enhanced EMR capability.

Thanks

Spencer L. Gear ACSW, LCSW-C

Chief Systems Officer

Mosaic Community Services, Inc.

Tel 410-453-9553 x 1181

On July 1, 2010, the North Baltimore Center became a part of Mosaic. The merger of these two comprehensive community-based mental health service providers will expand the geographic reach of Mosaic services into Baltimore City, and will promote an integrated service delivery system that includes Baltimore City, Baltimore County, Carroll County and a portion of Howard County.
Join Mosaic Community Services in celebrating 25 years of Excellence.

LAW OFFICE OF
J. WILLIAM PITCHER

27 Maryland Avenue
Annapolis, Maryland 21401
bpitcher@marylandlobbying.com

JULIA P. WORCESTER
Legislative Consultant
julia@marylandlobbying.com

August 19, 2010

David Sharp, Director
Center for Health Information Technology
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Proposed Regulations – Maryland Register – July 30, 2010

Dear Mr. Sharp,

On behalf of the many non-physician specialist associations that our firm represents, we are eagerly anticipating the implementation of the Electronic Health Records (EHRs) Incentive Program for Maryland's many health care providers.

Our firm is honored to have contracts with the Nurse Practitioner Association of Maryland (NPAM), the Maryland Academy of Audiologists (MAA), the Maryland Psychological Association (MPA), the Maryland Athletic Trainers Association (MATA), and the Maryland Ambulatory Surgical Association (MASA), all of whom are anticipating the implementation of the EHR program for their various practice groups.

It has come to our attention that while we applaud the efforts of the proposed regulations in the *Maryland Register (July 30, 2010) - Title 10 Department of Health and Mental Hygiene - Subtitle 25 Maryland Health Care Commission - 10.25.16 Electronic Health Record Incentives,* we are concerned that the current language would have the unintended consequences of excluding highly qualified non-physician specialists, such as those mentioned above, from participating in the incentive program thus precluding any reason for those providers to streamline their professional practice groups by implementing EHRs.

Specifically, we are concerned about the definitions under .02(B)(3)(b)(ii), "support physician entry" which could be interpreted to exclude non-physician providers such as Audiologists, Nurse Practitioners, and others.

It follows that (12) of that section defines "practice" as consisting of only physicians which is not representative of the many Nurse Practitioner, Psychologist, and Audiologist owned practices in the State of Maryland.

Likewise, (13) of that section defines "practice panel" as though it would pertain only to the patients of physicians. And within that very definition, the verbiage "primary care provider" is used, yet not defined in that regulation although the providers mentioned in the previous paragraph all are considered "primary care providers" under Maryland Statute.

We hope that you will take these concerns regarding provider neutral language into consideration and strongly recommend that this language be modified accordingly, before final publication of the regulations. If you should have any questions please contact me at your convenience.

Thank you for your time and consideration.

Sincerely,

Julia P. Worcester
Legislative Consultant

From: Susan Wilkoff [mailto:Wilkoffs@stlukeshouse.com]
Sent: Monday, August 16, 2010 3:25 PM
To: David Sharp
Subject: please add behavioral health!

In proposed regulation 10.25.16.02B(12) add 'behavioral health' to the definition of 'practice.' Mental health and addiction services are integral to overall health and must be included in all such initiatives.

Thank you,

Susan Wilkoff
Utilization Management Director
St. Luke's House, Inc.
301-493-4200 Ext 251
Fax 301-493-6209

From: Aleta Barnes [mailto:barnesa@stlukeshouse.com]
Sent: Monday, August 16, 2010 3:31 PM
To: David Sharp
Subject: Behavorial Health Supporter

Good afternoon Mr. Sharp,

I'm emailing my support on behalf of St. Luke's House Inc.

In proposed regulation 10.25.16.02B(12) add 'behavioral health' to the definition of 'practice.' Mental health and addiction services are integral to overall health and must be included in all such initiatives.

Sincerely,

Aleta Barnes

From: Sarah Moore [mailto:moores@stlukeshouse.com]
Sent: Monday, August 16, 2010 3:40 PM
To: David Sharp
Subject: Proposed Regulation-10.25.16.02B(12)

To the Director of the Center for Health Information Technology:

Dear Mr. Sharp,

As an employee of St. Luke's House, Inc., which serves individuals with severe and persistent mental illness, I would like to submit the following suggestion:

"In proposed regulation 10.25.16.02B(12) add 'behavioral health' to the definition of 'practice.' Mental health and addiction services are integral to overall health and must be included in all such initiatives."

Sincerely,

Sarah

Sarah Moore, M.A.
Clinic Specialist
St. Luke's House, Inc.
301-493-4200, ext. 309

From: Murray Claytor [mailto:ClaytorM@stlukeshouse.com]
Sent: Monday, August 16, 2010 4:55 PM
To: David Sharp
Cc: Susan Wilkoff
Subject: 10.25.16.02B(12)

Dear Mr. Sharp,

Electronic Health Records incentives are currently targeted at primary care practices only. Why not include us? I am a behavioral health provider, who works at an OMHC in Montgomery County, Maryland. Why not incentivize us? Our medical care is very important to our community, and is an integral part of health care services. Best practice initiatives include providing embedded services for health care and addiction/mental health care. This is an important opportunity for Maryland medical practices, including ours.

I am asking that you add *Behavioral Health* to the definition of "practice" in proposed reg. 10.25.16.02B(12).

Thank you,

Frances Murray Claytor, M.D.

From: Jackie Shipp [mailto:shippj@stlukeshouse.com]
Sent: Monday, August 16, 2010 4:52 PM
To: David Sharp
Subject:

David Sharp
Director
Center for Health Information Technology

Dear Mr. Sharp:

In proposed regulation 10.25.16.02B(12) add 'behavioral health' to the definition of 'practice.' Mental health and addiction services are integral to overall health and must be included in all such initiatives.

Jacqueline S. Shipp
Executive Assistant/Manager of Administration
St. Luke's House, Inc.
6040 Southport Drive
N. Bethesda, MD 20814

From: Benjamin Cramer [mailto:cramerb@stlukeshouse.com]
Sent: Monday, August 16, 2010 4:46 PM
To: David Sharp
Subject: Include mental health and addiction services in online medical records

Hello Mr. Sharp,
Please consider, in proposed regulation 10.25.16.02B(12) adding 'behavioral health' to the definition of 'practice.' Mental health and addiction services are integral to overall health and must be included in all such initiatives.
I appreciate your efforts!
Thanks,

Ben

Benjamin Cramer
Career Transition Specialist
Career Transition Program
St. Luke's House
6040 Southport Dr.
N. Bethesda, MD 20814
(C) 240-429-9302
(F) 301-493-6209

From: Cindy Ostrowski [mailto:CindyO@stlukeshouse.com]
Sent: Monday, August 16, 2010 4:16 PM
To: David Sharp
Subject: Health Care Providers and Electronic Health Records

Dear Mr. Sharp,

I am writing as leader of a community mental health agency, including an outpatient clinic. We have implemented an electronic health record, and I would like to request that we and other similar agencies be included in health IT provisions.

In proposed regulation 10.25.16.02B(12) please add 'behavioral health' to the definition of 'practice.' Mental health and addiction services are integral to overall health and must be included in all such initiatives. We are part of the complete continuum of holistic care and most of our clients have high needs in both physical and mental health care, so collaboration and exchange of information is critical.

Thank you for your consideration.

Cindy

Cindy E. Ostrowski, APRN, BC
President/CEO
St. Luke's House, Inc.
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Fax 301-493-5129
www.stlukeshouse.org

From: Kathleen Napoda [mailto:napodak@stlukeshouse.com]
Sent: Monday, August 16, 2010 4:11 PM
To: David Sharp
Subject: Regulation 10.25.16.02B(12)

Dear Mr. Sharp,

In proposed regulation 10.25.16.02B(12) please add 'behavioral health' to the definition of 'practice.' Mental health and addiction services are integral to overall health and must be included in all such initiatives.

Thank you,

Kathleen Napoda
Residential Counselor
St. Luke's House, Inc.

From: Naioma Muse [mailto:musen@stlukeshouse.com]
Sent: Monday, August 16, 2010 4:06 PM
To: David Sharp
Subject: Regulation 10.25.16.02B(12)

David Sharp,

Director, Center for Health Information Technology

Dear Director Sharp,

In proposed regulation 10.25.16.02B(12) add 'behavioral health' to the definition of 'practice.' Mental health and addiction services are integral to overall health and must be included in all such initiatives.

~ Naioma Muse
St. Luke's House, Inc
301-493-4200 ext. 435

From: Nicole Graner [mailto:GranerN@stlukeshouse.com]
Sent: Monday, August 16, 2010 4:06 PM
To: David Sharp
Subject: Proposed regulation 10.25.16.02B(12)

Mr. Sharp,

I am writing with regard to proposed regulation 10.25.16.02B(12) and urging you to add 'behavioral health' to the definition of 'practice.' Mental health and addiction services are integral to overall health and must be included in all such initiatives.

Thank you for your consideration.

Nicole Graner
Residential Program Manager

St. Luke's House, Inc.
6040 Southport Drive
Bethesda, MD 20814
301-896-4225
301-493-4200 (fax)

From: Larry Abramson [mailto:Abramson@stlukeshouse.com]
Sent: Monday, August 16, 2010 5:16 PM
To: David Sharp
Subject: Include Mental Health programs in the Electronic records incentive program

Mr. Sharp,

As you know electronic health records area a key component to quality care. There is a critical need for Mental Health Programs to have electronic records. I can think of no good reason to exclude these programs.

Larry Abramson
Vocational Director

From: Kristen Wright [mailto:wrightk@stlukeshouse.com]
Sent: Tuesday, August 17, 2010 9:01 AM
To: David Sharp
Subject: proposed regulation 10.25.16.02B(12)

Dear Mr. Sharp,

As a supervisor in a Mental Health Agency that has converted to an electronic health records system, I cannot begin to describe the importance of access to records as a part of our practice. Despite the incredible expense and cumbersome amount of work the conversion required, having secure access to client information whenever it is needed has proven instrumental in maintaining and improving client outcomes in all aspects of their mental and physical health and their ability to function effectively in their communities. ***In proposed regulation 10.25.16.02B(12) add 'behavioral health' to the definition of 'practice.' Mental health and addiction services are integral to overall health and must be included in all such initiatives.***

Sincerely,
Kristen Wright

Kristen M. Wright, M.S.
EFC3 Team Leader
St. Luke's House
8555 16th St. Ste 601
Silver Spring, MD 20910
301-493-4200 x458
Fax: 301-565-0527

From: Dominique Keuper [mailto:keuperd@stlukeshouse.com]
Sent: Tuesday, August 17, 2010 11:12 AM
To: David Sharp
Subject: Regulation 10.25.16.02B(12)

David Sharp,

In proposed regulation 10.25.16.02B(12) add 'behavioral health' to the definition of 'practice.' Mental health and addiction services are integral to overall health and must be included in all such initiatives

Thank You,

Dominique Keuper
Supported Employment Specialist
St. Luke's House, Inc.
(301) 493-4200 ext. 459
keuperd@stlukeshouse.com

UnitedHealthcare®
A UnitedHealth Group Company

August 27, 2010

Mr. David Sharp
Director
Center for Health Information Technology
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Proposed Regulation for Electronic Health Records Issued July 30, 2010

Dear Mr. Sharp:

UnitedHealthcare (UHC) wants to thank you for the opportunity to submit comments to the proposed regulation for Electronic Health Records (EHR) issued by the Maryland Health Care Commission (Commission) on July 30, 2010. We appreciate the fact that the regulations are still subject to amendment. Because we have previously submitted comments while House Bill 706 was under legislative consideration and because the Commission has adopted some of those previous suggestions, our comments concerning the proposed regulation will not be extensive.

Several previous discussions with the MHCC have emphasized the need for this initiative to be limited to primary care practices. Specifically, the identified practices would include: internal medicine; family practice; pediatricians, and OB/GYN. We believe that the Commission has appropriately focused its proposed regulations on primary care. As addressed in HR 929, the legislation authorizing the state's pilot initiative for Patient Centered Medical Home, the primary care setting provides the appropriate comprehensive care coordination for the care of a patient. Therefore, it is also appropriate that it is on the primary care setting that the MHCC focus its efforts to ensure adoption of power analytic tools that will support comprehensive patient care – specifically the electronic health record. By finalizing the proposed regulation with its current focus on primary care, the state correctly reinforces policies reflected in health care reform and oversight priorities, as well as sound research. See, e.g. Ferrante, J. MD, et al., *Principles of a Patient Centered Medical Home and Preventive Services Delivery*, Annals of Family Medicine, 8: 108-116 (2010); Friedberg, M., et al., *Primary Care: A Critical Review Of The Evidence On Quality And Costs Of Health Care*, Health Affairs, 29, no. 5 (2010): 766-772; Goodson, J. MD, *Patient Protection and Affordable Care Act: Promise and Peril for Primary Care*, Ann Intern Med 152:742-744 (June 1, 2010)

Moreover, the policy underpinning the proposed regulation's focus on primary care is to improve the quality of care without increasing the overall cost of care, and hopefully, while lowering costs over time. Given these overall goals, UnitedHealthcare agrees with the state

that the proposed regulation properly focuses carriers' limited resources on a limited number of primary care practices where incentives to reward the adoption of EHRs may be most needed. In contrast, an unlimited or unfocused incentive program could dramatically increase the cost of care while diluting the potential impact of EHR adoption to improve primary and preventive care. Note that specialty practices are not without subsidies and support: federal incentives available for Medicare practitioners can reach $15,000 per eligible professional in year one and $41,000 in total, and incentives available to Medicaid practitioners can reach $25,000 in year one and $65,000 overall. It seems that these sums are adequate, if not generous, for specialty practices that have substantially higher reimbursement rates than primary care.

UHC would like to take this opportunity to request clarification on certain provisions addressed in the proposed regulation. For instance, HB 706 speaks to the importance of collaboration with other legislative initiatives that are currently under development with the Commission. The proposed rule on EHR adoption incentives is philosophically aligned with Maryland's desire to ensure more of its residents have "medical homes", as addressed in the Patient Centered Medical Home Pilot (PCMH)– HB 929. All are in agreement that primary care providers play a critical role in both initiatives. HB 706 speaks to the need to align ARRA and other state and private sector funding opportunities that focus on health related technologies. Similarly, part of HB 929's implementation is proposed to include "prospective bundled payments to cover PCMH related practice expenses not covered by fee for service", item 9, prospective regulations implementing HB 929. It also is proposed to include a "performance based component based on achieving defined quality and efficiency goals" (id, item 10).

The regulation does not reiterate the suggestion in HB 706 about collaboration nor does it take into consideration the substantive and technological overlaps the initiatives. As a result, great potential exists for physician practices to be in receipt of two items of monetary value (quoting the proposed regulations) for single technological and program supports utilized to implement both initiatives.

Additionally, UHC believes that where a primary care practice, as identified in the proposed EHR regulation, **also** participates in the medical home pilot described in HB 929 and its implementing regulations, the payor's financial obligations under HB 929 should **also** count towards the financial obligations under the proposed EHR regulation. Similarly, fulfillment of those obligations as permitted by the EHR regulations, including with in-kind services of appropriate market value, should count towards fulfillment of the carrier's obligations under HB 929. For example, if a payor provides a financial incentive to assist a Medical Home practice in workflow redesign including the use of a registry (id. appendix A, item 2, proposed HB 929 regulations) or e-prescribing *technology (id, item 9; see also CMS Final Rule on Meaningful Use Incentives, 75 Fed Reg 44313-44588 (July 28, 2010),* then that assistance should also count towards the payors obligations under the EHR regulation.

Moreover, to ensure that no additional burden is placed on the physicians' practices, payors participating in both the EHR incentive program and the PCMH program can undertake the necessary accounting and documentation to obtain credit under both programs.

Second, UHC is requesting that the Commission provide clarification to the provisions that describe how the incentive elements work together. The regulation is unclear as to whether Additional Incentives are available when a practice obtains the EHR it from a MSO and demonstrates advance use, *or* if Additional Incentives are available when the practice obtains the EHR from a MSO or demonstrates advanced use. Similarly, are conditions of Section .05(B) and (C) cumulative (both must be met) or alternative (either B or C must be met) to make Additional Incentives payable.

Third, the definitions of incentives as contained in the proposed regulation could be clarified to ensure that payors and physician practices correctly understand the financial structure the regulation seeks to establish. For example, the regulation uses such terms as "Base Incentive", "Additional Incentive" and "incentive of monetary value", yet the regulation does not specify how it intends for these terms to work together. Specifically, the definitions of "Base Incentive" and "Additional Incentive" do not specify if they can be paid in kind as described in section .3 with a monetary value as specified in section .6. We believe that if the definitions were more clear, then section .5(A) would also be more clear in that payors and physicians would better understand measures that will be used to determine the incentives.

Finally, the regulation uses the term "adoption incentive" but this term is undefined. UHC recommends that a reasonable interpretation of all these terms might be shown in a formula that might look like this:

> "Adoption Incentives" = "Base Incentives" + "Additional Incentives"; and
>
> "Base Incentives" and "Additional Incentives" can both be comprised of cash or "items of monetary value".
>
> Adoption Incentives must not exceed $15,000.

Again, we appreciate the opportunity to provide comment. Please do not hesitate to contact me at 240-632-8087.

Sincerely,

Carol Mandel
Director, Regulatory Affairs

Appendix I
Public Comments for
House Bill 706
Electronic Health Records
Regulation and Reimbursement
2010 Legislative Report

MedStar Health

DEC 9 2010 PM 2:19

Pegeen A. Townsend
Corporate Vice President
Government Affairs

December 7, 2010

Ms. Sarah Orth
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: HB 706 – Electronic Health Records – Regulation and Reimbursement – 2010 Legislative Report

Dear Ms. Orth:

On behalf of the MedStar Health, I am writing regarding the Maryland Health Care Commission's 2010 Legislative Report required under HB 706 – Electronic Health Records – Regulation and Reimbursement enacted in the 2009 Session of the Maryland General Assembly.

At the outset, I want to commend the Maryland Health Care Commission for the significant work undertaken to support physician practices in adopting electronic health care records. The effective use of electronic health records across the health care system will not only improve the quality of care provided in the state of Maryland but also will help contribute to controlling the rise in health care costs. The incentive program enacted under HB 706 in the 2009 Session of the General Assembly will enable the State of Maryland to take a leadership role in the adoption of EHRs by complementing and building upon the federal incentive payments the American Recovery and Reinvestment Act (ARRA).

One of the recommendations contained in the report and the proposed regulations to implement that recommendation, however, is problematic because two important segments of the physician community in Maryland would be excluded from the incentive payments – practices owned by hospitals and specialty physician practices.

Hospital-owned physician specialty practices provide services in both the inpatient and outpatient settings. Physicians in those practices typically utilize two different EHR systems when accessing inpatient records and records in the ambulatory setting. EHRs used in the ambulatory setting are very different from inpatient EHRs because of the inherent differences between the types of care provided. For these physicians, implementing an EHR in an ambulatory setting requires a significant cost above and beyond the cost of implementing the inpatient EHR.

5565 Sterrett Place - 5th Floor, Columbia, Maryland 21044
phone: 410 772 6688 • *fax:* 410 740 0818 • *e mail:* pegeen.a.townsend@medstar.net

Hospital-owned and independent physician practices incur similar costs when implementing EHRs in the ambulatory setting. Excluding these practices from eligibility for the incentives will limit the benefit of EHR adoption in all communities throughout Maryland.

We would note that specialists and hospital-owned physician practices are eligible for the federal ARRA incentives for adoption of EHRs. The only exclusion under the federal program is for physicians who provide substantially all of their services in the hospital because those physicians would use the facility and equipment of the hospital. HB 706 did not make a distinction in the types of practices that would be eligible for the EHR incentives. The state law was intended to compliment and build upon the federal law.

Further, as the Chesapeake Regional Information System for our Patients (CRISP) moves forward it will be particularly important to have as many physician practices as possible utilizing EHRs to allow them to provide data to and receive data from CRISP in an automated manner. To facilitate the broadest participation in CRISP we believe it is essential to include all physician providers in the state incentive program.

For the above stated reasons, I am requesting the MHCC modify the recommendations and regulations to allow specialist and hospital-owned practices to participate in the state EHR incentive programs.

Sincerely,

Pegeen A. Townsend

Pegeen A. Townsend

Cc Members, Senate Finance Committee
Members, House Health and Government Operations Committee
The Honorable John Colmers

Appendix J
Health Information Technology State Plan

(Integrity of page numbers from original State Plan intact)

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MARYLAND

Health Information Technology State Plan

FY 2010 – FY 2013

MHCC MARYLAND HEALTH CARE COMMISSION

Commissioners

Marilyn Moon, Ph.D., Chair

Vice President and Director, Health Program
American Institutes for Research

Garret A. Falcone, Vice Chair
Executive Director
Charlestown Retirement Community

Reverend Robert L. Conway
Retired Principal and Teacher
Calvert County Public School System

John E. Fleig, Jr.
Director
United Healthcare

Tekedra McGee Jefferson, Esquire
Assistant General Counsel
AOL, LLC

Kenny W. Kan
Senior Vice President, Chief Actuary
CareFirst BlueCross BlueShield

Sharon Krumm, R.N., Ph.D.
Administrator & Director of Nursing
The Sidney Kimmel Cancer Center
Johns Hopkins Hospital

Robert Lyles, Jr., M.D.
Medical Director
LifeStream Health Center

Barbara Gill McLean, M.A.
Retired, Senior Policy Fellow
University of Maryland School of Medicine

Roscoe M. Moore, Jr., D.V.M., Ph.D., D.Sc.
Retired, U.S. Department of Health
and Human Services

Kurt B. Olsen, Esquire
Klafter and Olsen LLP

Sylvia Ontaneda-Bernales, Esquire
Ober, Kaler, Grimes & Shriver

Darren W. Petty
Vice President
Maryland State and DC AFL-CIO
General Motors/United Auto Workers

Nevins W. Todd, Jr., M.D.
Cardiothoracic and General Surgery
Peninsula Regional Medical Center

Randall P. Worthington, Sr.
President/Owner
York Insurance Services, Inc.

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Introduction

The Maryland Health Care Commission (MHCC) is pleased to submit its State Plan for review by the Office of the National Coordinator for Health Information Technology (ONC) under the *State Grants to Promote Health Information Technology Planning and Implementation Projects*. MHCC believes that its State Plan accurately reflects a strategic and operational plan that is consistent with the planning guidance. Efforts are currently underway to implement a private and secure statewide health information exchange (HIE) in Maryland. This ambitious plan for advancing health information technology (HIT) balances the need for information sharing with the need for strong privacy and security policies, while maintaining a judicious approach to funding the HIE. Establishing an HIE with sound interoperability will ensure that all health information is securely delivered electronically in real-time to individuals and their providers (an individual licensed in the State of Maryland to practice medicine) when needed, and that this information is available for analysis for continuous improvement in the delivery of care and research. The statewide HIE will also allow providers to maximize incentive funding under the *American Recovery and Reinvestment Act of 2009* (ARRA).

Maryland has moved into the implementation phase for the statewide HIE after several years of planning. The strategic approach consisted of the following key activities:

- ***Building trust and consensus.*** Maryland believes that broad agreement on key policy issues – particularly privacy, security, and data use – should precede the development of an HIE. MHCC brought together a series of multi-stakeholder groups to discuss a range of policy issues and published a number of major policy reports based on these consensus-building deliberations. These deliberations formed the foundation for subsequent actions directed towards planning and implementing a statewide HIE.
- ***Planning the statewide HIE***. MHCC funded two independent multi-stakeholder groups in 2008 to develop two competing approaches for the governance, architecture, privacy and security, access and authentication, financing, and establishment of a sustainable business model. These reports were evaluated and the best ideas from the two groups, and from a study of HIEs in various stages of development nationwide, were consolidated into a Request for Applications (RFA) released on April 15th of this year.
- ***Designating and funding Maryland's statewide HIE.*** The MHCC received four responses to the RFA. A technical panel consisting of internal and external reviewers recommended that the Chesapeake Regional Information System for our Patients (CRISP) receive up to $10 million in funding from Maryland's all-payor rate setting system to implement a statewide HIE. The Maryland Health Services Cost Review Commission approved the funding on August 5th. CRISP is a particularly strong not-for-profit collaborative effort among the Johns Hopkins Health System, MedStar Health, University of Maryland Medical System, Erickson Retirement Communities, and Erickson Foundation, with notable support from two dozen major stakeholders across the state, including minority and safety net provider interests.
- ***Establishing a Policy Board with Strong Representation from the General Public.*** While a collaborative with strong provider representation will develop and operate the HIE, the Policy Board associated with the MHCC will establish the policies governing the exchange. This separation of

responsibilities assures a strong role for the public in both policy development and operational oversight. Members of the Policy Board have been selected to assure expertise, breadth of stakeholder representation, and a strong consumer voice in establishing the policies essential to building trust.

The statewide HIE is designed to deliver essential patient information to authorized providers at the time and place of care to help assure appropriate, safe, and cost-effective care; store and transmit sensitive health information privately and securely; provide patient access to important elements of an individual's clinical record to help engage patients in their own care; provide a means for the patient to exercise appropriate control over the flow of private health information, both as a matter of right and as a means of assuring trust; provide a secure method of transmitting administrative health care transactions; and gather information from the health care system to research efficiency and cost-effectiveness of care, to measure quality and outcomes of care, and to conduct biosurveillance and post-marketing surveillance of drugs and devices.

The State Plan appropriately reflects the high priority that Maryland places on advancing HIE and expanding the adoption of electronic health records (EHRs) while ensuring that the interest of consumers and the general public are protected. Maryland's planning efforts led to the development of a comprehensive design to facilitate and expand the secure, electronic movement and use of health information among providers according to nationally recognized standards. While the detailed implementation of the statewide HIE is entrusted to the knowledgeable experts and informed by a broad range of stakeholder input, the governance, policy, and technical infrastructure outlined in the State Plan make certain that the general public and the federal government have strong roles in the development of fundamental policies governing the information exchange. ARRA funding and collaboration with the ONC will accelerate and enhance the state's implementation of the statewide HIE, assuring more rapid dissemination of a broader range of Use Cases.

Strategic Plan for a Statewide HIE

General Topic Guidance

Environmental Scan

Maryland has a strong foundation and a number of special advantages above and beyond its convenient location for implementing a statewide HIE in collaboration with ONC. In 2008, the U.S. Census Bureau reported Maryland's population at roughly 5.6 million. The state's diverse population and size have made it relatively easy for stakeholders from around the state to meet regularly to plan a single statewide HIE. Maryland is rich in geographic and cultural diversity that includes rural and inner city areas and diverse minority populations. The state has a long tradition of hospital-hospital and hospital-government collaboration on projects, including the award-winning Maryland Patient Safety Center. Located in the state are three prominent regional medical systems (Johns Hopkins, MedStar, and the University of Maryland), several local hospitals belonging to national hospital systems, and a number of independent community hospitals.

Hospital reimbursement is through the all-payor rate setting system that effectively shares the financial burden of uncompensated care across all hospitals. This system funds projects that are in the financial interest of the overall health care system, including the initial development of an HIE. Maryland has an extensive record of participation in numerous pilot projects; the most recent and relevant is that Maryland was selected as one of four states to participate in the Centers for Medicare and Medicaid Services' (CMS) Demonstration Project for EHR adoption in priority primary care provider practices. The state has renowned academic programs in clinical, public health, and health services research, and has state health care leaders with experience at the national level in health care foundations, federal agencies (including NIH, AHRQ, CMS, CEA, CBO, and NEC), and more specifically in national groups involved with health information technology (HIT), including ONC and the Markle Foundation's Connecting for Health Steering Group.

Market Readiness Assessment

Maryland has approximately 47 acute care hospitals. EHR adoption is reported in around 80 percent of the hospitals. Nearly 60 percent have computerized physician order entry (CPOE). About 17 percent are actively implementing technology to enable some electronic data sharing with appropriate authorized users outside the hospital. Maryland has roughly 13,795 physicians in active practice. These physicians treat patients in approximately 7,907 practices. The number of primary care physicians is nearly 5,035 and the number of primary care practices is around 2,325. Physician EHR adoption parallels the nation, at approximately 20 percent. However, many of these EHRs do not have clinical decision support, CPOE, e-prescribing, or results receipt and delivery functionalities.

The number of service area health information exchanges (SAHIEs), or community data exchanges where a hospital acts as the technology hub, are increasing in numbers throughout the state. Last year, the MHCC convened stakeholders to develop standard policies that will enable the exchange of data among SAHIEs. SAHIEs have the ability to expand data sharing to providers within their service area. Under the Stark Law revisions, hospitals statewide are closely exploring options that enable them to provide technology to

providers in their service area. Many SAHIEs utilize these guidelines to establish policies with community providers located in bordering states.

Management Services Organizations (MSOs) provide an alternative to expanding EHR adoption. The software is accessed via the Internet and data is hosted offsite in secure network operating centers (NOCs). For the most part, providers need access to a high speed Internet connection. Maryland has taken steps to promote the MSO arrangement as an alternative to the traditional stand-alone model where the client-server is maintained in the physician's office. Under recent legislation, the MHCC is required to designate one or more MSOs by the fall of 2012. The MHCC envisions that these MSOs will offer a variety of certified EHR products for physicians to choose from, assist with the integration to the statewide HIE, and ensure that the technology is compliant with the standards for meaningful use.

Technology adoption is widespread throughout nursing homes, although their readiness for EHR adoption is variable. Most nursing homes in Maryland use computers to support billing and other related administrative functions that tie to reimbursement and certification requirements. Approximately one-half of nursing homes use limited technology for clinical applications (e.g., resident assessments, progress notes, and care planning), and about one-quarter use EHRs for clinical charting. This is fairly consistent with other states that have assessed clinical charting in nursing homes. Medication administration is reported nationally at roughly 38 percent, and around 12 percent of nursing homes in Maryland use this technology.

The MHCC has assessed community readiness for HIE based on market structure, project leadership, and provider readiness to adopt. The MHCC used the eHealth Initiative's Market Readiness Assessment Tool and determined that Maryland's market readiness index was about 56 percent. Generally speaking, conditions in Maryland are relatively favorable for building a statewide HIE where significant interest from participants exists.

The environmental scan also revealed the importance of ensuring perceived fairness in the prices that providers are asked to pay for participation in the HIE. An HIE based on subscription fees that are appropriately priced by stakeholder value was a more appealing alternative than a one-size-fits-all pricing model. A transaction-fee based HIE was determined not to be a favorable option as it places the most burden on those who use the system frequently. The transaction fee approach encourages participants to carefully monitor and perhaps budget their use of the HIE, and such self-restriction contradicts the larger objectives of the HIE.

Statewide Readiness

After several years of planning and building stakeholder trust, Maryland has moved into the implementation phase for a statewide HIE. Through a competitive process, the MHCC selected CRISP to implement the statewide HIE in August 2009. The following table provides an organizational overview of the MHCC Policy Board, which has oversight of the statewide HIE, the CRISP organization, and those involved in the development of the HIE.

Maryland HIE Stakeholder Participants

Maryland Health Information Exchange Policy Board

ACLU of Maryland
AIDS Legislative Council
Anne Arundel Medical Center
British American Auto Care
CareFirst Blue Cross Blue Shield of Maryland
Community Health Integrated Partnership
Genesis Healthcare
Hebrew Home of Greater Washington
Higher Ground, Inc.
Koss on Care
M&T Bank
Planned Parenthood of Maryland
Primary Care Coalition of Montgomery County
Sinai Hospital of Baltimore
Washington County Health System
Maryland Health Care Commission (*ex-officio*)
CRISP (*ex-officio*)

Chesapeake Regional Information System for Our Patients (CRISP)

Founding Board Members:

Erickson Retirement Communities, LLC
Johns Hopkins Health System Corporation
MedStar Health, Inc.
University of Maryland Medical System, Inc.
Erickson Health Information Exchange

Advisory Board Members:

To Be Named

Institutional Affiliations of Additional Participants in the Maryland Planning Process

APPTIS
AARP of Maryland
Access Carroll
Advanced Radiology
Adventist HealthCare
Advocates for Children and Youth
Aetna
AIDS Legislative Council
American Cancer Society
American Heart Association of Maryland
American Medical Informatics Association
American Society of Consultant Pharmacists
Anne Arundel Medical Center
Atlantic General Hospital
Audacious Inquiry
Baltimore City Medical Society
Baltimore Medical System
Baltimore Washington Medical Center
Bon Secours Hospital
Braddock Hospital
Bravo Health
British American Auto Care, Inc.
Calvert Memorial Hospital
CareFirst Blue Cross Blue Shield of Maryland
Carroll Hospital Center
Catonsville Diagnostic Imaging
Center for Health Information and Decision Support, University of Maryland
Chesapeake Eye Center
Chester River Hospital Center
Civista Medical Center
Clinical Information Systems
CMS - State Programs
Columbia Medical Practice
Community Health Integrated Partnership
Constellation Energy Group
CVS
Darnell Associates, Inc.
Delmarva Foundation
Delta Dental Plans Association
Dimensions Health System
Doctors Community Hospital
Dorchester General Hospital
Edward W. McCready Memorial Hospital
Emdeon Business Services
EPIC Pharmacies and EPIC Pharmacy Network, Inc.
The Erickson Foundation
Erickson Retirement Communities
Former Senator of Maryland & Privacy Advocate
Franklin Square Hospital
Frederick County Public Schools
Frederick Memorial Healthcare System
Garrett County Memorial Hospital
Genesis HealthCare
Ginger Cove Retirement Community
Good Samaritan Hospital of Maryland
Greater Baltimore Medical Center
Harbor Hospital
Harford County Medical Society
Harford Memorial Hospital
Health Care Information Consultants
Health Improvement Network
Healthcare for All
Healthcare for the Homeless
Hebrew Home of Greater Washington
Holy Cross Hospital
Howard County General Hospital
HR Anew, Inc.
James Lawrence Kernan Hospital
Johns Hopkins Bayview Medical Center
Johns Hopkins Community Physicians
The Johns Hopkins HIPAA Office
Johns Hopkins Medical Institutions
Johns Hopkins University & School of Medicine
Johns Hopkins Urban Health Institute
Kelly and Associates
Kennedy Krieger Institute
Kodak Dental Systems
Laboratory Corporation of America
Laurel Regional Hospital
Legal Aid Bureau
LifeBridge Health
Maryland Community Health Resources Commission
Maryland General Hospital
Maryland Hospital Association
Maryland Medicaid
Maryland State Board of Pharmacy
Maryland State Delegate
Matria Health Care
MedChi, The Maryland State Medical Society
MedStar Health
MedStar Health VNA
Memorial Hospital & Medical Center of Cumberland
Memorial Hospital at Easton
Mercy Medical Center
Mid-Atlantic LifeSpan
Montgomery County Medical Society
Montgomery Family Practice
Montgomery General Hospital
Montgomery Internal Medicine Association
Mount Vernon Pharmacy
Nachimson Advisors, LLC
NAMI of Maryland
National Institutes of Health
Neighborcare/NHS
Network Health Services
Northwest Hospital Center
Ober|Kaler
Office of the Attorney General of Maryland
Payerpath, Inc.
Peninsula Regional Medical Center
Personal Touch Home Care
Practicing Psychiatrist
Primary Care Coalition of Montgomery County
Prince George's Health Department
Prince George's Hospital Center
Provider Synergies
Quest Diagnostics
RxNT
Shady Grove Adventist Hospital
Shepherd's Clinic
Shepherd Pratt Health System
Sinai Hospital of Baltimore
Southern Maryland Hospital Center
Spiro Consulting, Inc.
St. Agnes Healthcare
St. Agnes Hospital
St. Agnes OB/GYN Associates
St. Joseph Medical Center
St. Mary's Hospital
Suburban Hospital
Summerville at Westminster
Summit Health Institute for Research and Education, Inc.
The Neurology Center
Union Hospital of Cecil County
Union Memorial Hospital
United Healthcare Mid-Atlantic
University of Maryland Medical System
University Physicians, Inc.
Upper Chesapeake Medical Center
VA Maryland Health Care System
Vermont Information Technology Leaders
Vindobona Nursing Home
Vulcan Enterprises, LLC
Walter Reed Army Medical Center
Washington Adventist Hospital
Washington County Health System
William Hill Manor
Xavier Health Care Service

HIE Development and Adoption

Vision, Goals, and Objectives

Three years ago the MHCC began the process of planning the implementation of a statewide HIE by engaging numerous stakeholders to address the fundamental policy issues and plan a course of action. State legislation passed in 2009 required the MHCC to designate a multi-stakeholder group to implement the statewide HIE; CRISP was selected based upon the breadth of stakeholders and their response to the state's RFA. The statewide HIE makes possible the appropriate and secure exchange of data, facilitates and integrates care, creates efficiencies, and improves outcomes. MHCC's efforts are targeted towards developing a widespread and sustainable HIE that supports the meaningful use definition that qualifies providers for CMS incentive payments. This strategy also supports state public health programs to ensure that public health stakeholders prepare for HIE and mobilize clinical data needed for consumer engagement and health reform in Maryland.

The statewide HIE will support high quality, safe, and effective health care; make certain that data is exchanged privately and securely; ensure transparency and stakeholder inclusion; support connectivity regionally and nationally; achieve financial sustainability; and serve as the foundation for transforming health care in Maryland. The HIE architecture will be capable of connecting approximately 47 acute care hospitals and 7,914 physician practices throughout Maryland. The infrastructure will support the meaningful use requirements and eventually connect with other HIEs regionally and nationally. The governance of the statewide HIE will guide the development of the five domains that support the grant program, establish the policies governing the exchange, and determine Use Case implementation. The statewide HIE will provide a mechanism for authorized individuals to perform sophisticated analytics and reporting for public health, biosurveillance, and other appropriate secondary uses of data.

Statewide HIE Design Characteristics

The statewide HIE will utilize a hybrid technology approach, maintaining confidential health care data at the participating facilities and providers, with consumers having an option to request that their information be held in a Health Record Bank (HRB) or Personal Health Record (PHR) account that they control. The HIE will perform as a secure and trusted conduit rather than a centralized repository.

The statewide HIE will consist of a hybrid approach that combines a federated or distributed model, keeps the data at its source facilities or with providers, and uses the HIE as the conduit for sharing. In the proposed model for development in Maryland, a hybrid system is conceived of one that consists of a single core infrastructure vendor that serves as a platform for expanding functionality of the utility by adding different vendor applications to the core system. For instance, the core infrastructure selected may consist of an exchange utility with a master patient index (MPI). The MPI in most solutions lacks the robust features necessary to support advanced matching of consumer's to their health information. Available on the market are vendor solutions specific to MPIs that would serve as an alternative to MPI in a core infrastructure solution (i.e., Initiate). In general, the HIE provides a roadmap for properly routing information to the appropriate location. The HIE will maintain a central master patient index (MPI) and a separate registry (Registry) of the record's location within the system. The design also includes the use of a HRB/PHR that is controlled by the consumer, which does not use MPI or Registry. The hybrid model also allows the centralization of records when directed by consumers. This does not constitute a centralized record,

but rather directory information that allows records to be identified and located throughout the distributed system. The hybrid model used in Maryland is less threatening to participants and individual consumers because it is less disruptive to existing, trusted relationships between individuals and their care providers, and raises fewer regulatory issues in today's privacy and security focused regulatory environment. A disadvantage of a hybrid approach is the absence of a single database that can be queried for a variety of health services research, public health reporting, and post marketing surveillance purposes. This disadvantage can be minimized by efficient queries to the statewide HIE, long retention times on edge servers, and special purpose databases with privacy protections suspect to the statewide HIEs controls and data sharing policies. A single HRB associated with the statewide HIE can also deliver robust resource to monitoring capability together with consumer control.

The statewide HIE will allow consumers to have access to and control over their health information through an HRB/PHR application.

The statewide HIE will integrate with HRB/PHR applications that meet appropriate technology standards. Information in a PHR may be generated directly from the records of health care providers or entered by the patient. While records from a PHR may not be assigned the same value by providers as either a hospital or physician-generated record since consumers may add information to the record, PHRs allow individuals virtually complete control over their own information and how to share it. For many consumers, this will likely be an attractive option.

The statewide HIE will allow individuals the freedom to participate or not participate in the HIE.

The statewide HIE will enable individuals to have the right to be informed of their provider's access to and use of the HIE to access their data. Consumers will have the capability to opt-out of participation entirely. If a consumer elects to opt-out, providers will not have the ability to exchange that consumer's information. The HIE will inform individuals of their right not to participate through an intensive public awareness campaign and the consumer's rights related to it. A simple and visible opt-out process will be included at each point of care within the HIE.

The statewide HIE will use standards consistent with emerging national technology standards.

The statewide HIE will use federally-endorsed standards and integration protocols that bridge proprietary boundaries. Making this a core HIE principle will not only ensure that the HIE is not vulnerable to vendor selection issues and risks, but also compatible with HIEs developed by other states and the federal initiative.

The statewide HIE will act now but build incrementally.

Growth of the statewide HIE will be based on an incremental strategy, building from individual Use Cases, with individual HIE services that have a demonstrated need and evident clinical value to consumers and care providers. The alternative, which is the implementation of an HIE that immediately seeks to provide widespread exchange of all health information to care providers, imposes significant challenges. The leading challenge is setting such high initial technological and user acceptance thresholds that the HIE misses the current window of opportunity. The HIEs incremental approach is already underway with the first Use Case, the provision of medication information to the emergency departments of participating facilities.

The statewide HIE will ensure focus on the medically underserved.

Amid the inherent challenges of HIE, underserved populations must not be overlooked. The MHCC will ensure that resources and focus remain directed to this particular component of the overall HIE effort, as it represents an important part of the solution and a key part of the quality, access, and cost challenges in health care. The success of the HIE will ultimately require that all constituents using the exchange engage in its development.

HIE Policy Development

MHCC completed a series of policy reports that relate to implementing a statewide HIE. These policy reports provided the foundation for the multi-stakeholder group to implement an HIE in Maryland. The policy reports focused in part on formulating solutions and developing implementation plans that address organizational-level business practices affecting privacy and security policies, planning and implementing a statewide HIE, and developing community data sharing policies.

An Assessment of Privacy and Security Policies and Business Practices: Their Impact on Electronic Health Information Exchange

A workgroup that consisted of eight health care sector groups was convened to assess business policies and practices in general, and security policies and practices in particular that could impede the development of an effective statewide HIE. This assessment included an examination of each sector group's perception of HIE; concerns regarding the benefits, risks, and challenges impacting each group; and various alternatives to address these issues. The report is located at: http://mhcc.maryland.gov/electronichealth/assess_privacy_security.pdf.

Privacy and Security Solutions and Implementation Activities for a Statewide Health Information Exchange

The MHCC assembled a multi-stakeholder workgroup to develop solutions and recommend activities to develop guiding principles and evaluate the privacy and security barriers for HIE implementation. The workgroup proposed a number of solutions that would guide efforts to establish a statewide HIE. They also assembled a list of implementation activities that they believed would guide HIE to a desired future state in Maryland. This report is located at: http://mhcc.maryland.gov/electronichealth/solutions_implement_rpt0908.pdf.

Planning for a Statewide Health Information Exchange

Building a successful HIE requires considerable planning in order to implement a business model that creates incentives for use, and recognizes the need for funding from those stakeholders that derive value and benefits for using technology to share health information. The MHCC brought together two distinct groups of diverse stakeholders to address complex policy and technology issues from somewhat different perspectives. The two multi-stakeholder groups selected to participate in the planning phase were: the *CRISP* and the *Montgomery County Health Information Exchange Collaborative (MCHIE)*. These teams focused specifically on addressing issues related to governance; privacy and security; role-based access; user authentication and trust hierarchies; architecture of the exchange; hardware and software solutions; costs of implementation; alternative sustainable business models; and strategies to assure appropriate consumer engagement, access, and control over the information exchange. Final reports, submitted by each group on February 20, 2009, are located at: http://mhcc.maryland.gov/electronichealth/statehie.html.

Service Area Health Information Exchange

Providers throughout the state are beginning to exchange limited amounts of electronic patient information. SAHIEs are emerging and are typically made up of providers in a select geographic area that share the same patients across practices and settings. These providers must address challenges related to privacy and security, business practices, and technology. The MHCC convened a workgroup of chief information officers, privacy officers, and various other health care stakeholders to develop a resource guide that includes the policies relating to patient rights to their health information and control of this information; range of business practices for access, authentication, authorization, and audit; technical requirements for standards and process workflows; communication mechanisms and outreach initiatives; key community-level financial, organizational, and policy challenges; and alternate community data uses. The *Service Area Health Information Exchange: A Hospital Data Sharing Community Resource Guide* is located at: http://mhcc.maryland.gov/electronichealth/SAHIE_03-06-09-WEBFinal.pdf.

HIT Adoption

MHCC has implemented a number of strategic initiatives to bolster the adoption of EHRs in Maryland. MHCC's strategy has been to accelerate the adoption of EHRs in the state. These efforts focused on increasing the provider's use of this technology. Among other things, the strategy has focused on increasing adoption through education and awareness activities. For the last several years, the MHCC has conducted presentations on HIT at annual practice administrator meetings, professional society conferences, and has engaged providers on a one to one basis. Effective data sharing depends largely on the ability of providers to access and maintain patient information electronically. MHCC expects to modify its HIT adoption activities based on the future release of meaningful use standards by ONC. Key HIT adoption initiatives include the following.

Task Force to Study Electronic Health Records

The legislatively established Task Force to Study Electronic Health Records (Task Force) consisted of 26 members, including 20 appointees of the Governor. The Task Force was formed in 2005 and charged with studying EHRs; the current and potential expansion of their utilization in Maryland, including electronic transfer, e-prescribing, computerized provider order entry CPOE; and the cost of implementing these functions. The Task Force also studied the impact of the current and potential expansion on school health records and patient safety and privacy. The Task Force presented 13 recommendations to facilitate EHR adoption among providers. The Final Report was released in 2007 and is located at: http://mhcc.maryland.gov/electronichealth/presentations/ehr_finalrpt0308.pdf.

The Task Force reconvened in April of 2009 to review the impact of The American Recovery and Reinvestment Act (ARRA) of 2009 on the original recommendations. The Task Force proposed modest updates to the original recommendations. The report of the proposed modifications is located at: http://mhcc.maryland.gov/electronichealth/EHRTaskForceSummaryFinal061909.pdf.

EHR Product Portfolio

MHCC developed an EHR Product Portfolio (Portfolio) to provide physicians with evaluation and comparison information on EHRs. The Portfolio contains a core set of product information to assist physicians in assessing EHRs and includes only those vendors that have met the most stringent and recent certification standards from the Certification Commission for Health Information Technology (CCHIT)

relating to functionality, interoperability, and security. Vendors that have offered discounts to Maryland providers are included in the Portfolio and have provided details regarding product information, pricing, privacy and security policies, and user references that were developed into a consumer reference report. The Portfolio is located at: http://mhcc.maryland.gov/electronichealth/ehr/cchitehrvendors.html.

The MHCC expects to develop additional Portfolios for other health care sectors, such as long term care. The Portfolios are updated semi-annually to ensure that providers have state-of-the-market information available. Future enhancements will include information related to navigation and usability. MHCC plans to work with the statewide HIE to develop a more robust Portfolio, if awarded a *Health Information Technology Extension Program: Regional Centers Cooperative Agreement Program* grant.

Centers for Medicare & Medicaid Services EHR Demonstration Project

Maryland is one of four states participating in the CMS five year demonstration project to encourage small to medium sized primary care physician practices to use EHRs. The project aims to improve the quality of patient care by improving the way health care information is managed. The Maryland/DC Physician EHR Demonstration Collaborative (EHR Collaborative) was formed to assist CMS in its efforts to increase EHR adoption. The EHR Collaborative is comprised of MedChi (The Maryland State Medical Society), the MHCC, the Medical Society of the District of Columbia, and other stakeholders. Over 250 physician practices in the Maryland/DC area were selected to participate in either a control or treatment group. The EHR Collaborative promotes EHR adoption and will educate providers in becoming meaningful users of EHRs. Details of this initiative can be found at: http://mhcc.maryland.gov/electronichealth/cmsdemo/index.html.

Electronic Health Records – Regulation and Reimbursement

The Maryland General Assembly passed (HB 706) legislation titled *Electronic Health Records – Regulation and Reimbursement*, which was signed into law on May 19th of this year by Governor Martin O'Malley. The law aims at expanding the adoption of EHRs through incentives from state-regulated payers to providers who use certified EHRs that are capable of connecting to an HIE. The law requires the MHCC to complete a number of support activities specifically aimed at fostering the adoption of HIT, including the development of the reimbursement regulations. Developing these regulations will require the involvement of stakeholders in the discussions. MHCC will use the feedback from these discussions to develop the regulations.

Management Services Organizations

MSOs are considered a viable alternative to the traditional stand-alone EHR client-server model, which requires practices to individually negotiate pricing and maintain the technology required to support the software. MSOs are capable of supporting multiple EHR products at reduced costs through economies of scale and bulk purchasing. The MSO approach uses the Application Service Provider (ASP) model to host one or more EHR systems through the Internet. MSOs often provide (24/7/365) product support through a Network Operation Center (NOC).

In accordance with legislation, the MHCC is required to designate one or more MSOs. The MHCC's vision of designated MSOs is one that offers choices of EHR products, meets national certification requirements, and uses an NOC that, at a minimum, complies with the *Health Insurance Portability and Accountability Act of 1996* (HIPAA), Administrative Simplification Provisions. The MHCC will designate these MSOs by October 2012.

School Health Records

The Task Force included school health records in its study of EHRs and recommended the encouragement of EHR adoption in school-based health centers. The MHCC is acting upon this recommendation and has completed a market scan on the use of EHRs in public schools, and has identified EHR vendors in the industry that may be helpful in the adoption of EHRs in public schools. The Task Force noted that the laws governing protect health information and the laws governing education records are not always consistent and need further attention. The MHCC intends to convene a workgroup of stakeholders, such as school officials and vendors, to develop an outreach and education program to help increase the adoption of EHRs in Maryland's public schools. MHCC will engage these stakeholders to assist in the development of a Portfolio that assists schools in the assessment and selection of EHRs.

Medicaid Coordination

The Maryland Department of Health & Mental Hygiene, Office of Systems, Operations, and Pharmacy (DHMH OSOP) assessed the current State of the Maryland Medicaid Management Information System (MMIS) along with the current Medicaid processes used by the State of Maryland and developed a transition plan to align with the federally mandated Medicaid Information Technology Architecture (MITA) requirements and state HIT and HIE initiatives. The new system will modernize existing system functions and significantly enhance the goals of the MMIS ensuring that eligible individuals receive the health care benefits to which they are entitled, and that providers are reimbursed promptly and efficiently. Coordination between DHMH and the MHCC is in place to ensure that opportunities for data sharing and the HIE are maximized.

DHMH intends to replace its legacy MMIS claims processing system with a new MMIS system based on MITA 2.0 principles that will include imaging and workflow management, and a robust business rules engine to aide in creating and managing flexible benefit plans. The new MMIS will process all Medicaid claims and eliminate the duplicative adjudication of the Mental Hygiene Administration (MHA), Developmental Disabilities Administration (DDA), and dental claims. The new MMIS system will also support coordination of benefits, surveillance and utilization review, federal and management reporting, case management, and the statewide HIE. In conjunction with the MMIS replacement, DHMH intends to add a Decision Support System (DSS); implement a Service Oriented Architecture (SOA) Integration Framework to provide a platform for the system that will enable better interoperability with existing legacy applications; and develop a Member and Care Management portal. These enhancements will help eliminate manual processes and will improve general population health by targeting individuals by cultural, diagnostic, or other demographic indicators to ensure that appropriate and cost-effective medical or medically-related social and behavioral health services are identified, planned, obtained, and monitored for individuals identified as eligible for care management services under programs such as:

- Medicaid Waiver Program Case Management;
- Home and Community-Based Services;
- Employed Individuals with Disabilities (EID);
- Primary Adult Care (PAC);
- Breast and Cervical Cancer;
- Rare and Expensive Case Management (REM);
- Traumatic Brain Injury (TBI);

- Disease Management;
- Catastrophic Cases; and
- Healthy Start Program.

The SOA Integration Framework will enable a bi-directional real-time interface with the State's Client Automated Resources Eligibility System (CARES) and the statewide HIE to facilitate better access to the complete eligibility record, resolve data integrity issues across systems, improve claims payment accuracy by capturing the most current eligibility information, and support inter-agency coordination to provide appropriate and cost effective medically necessary care management services. The SOA Integration framework will eventually support an evolutionary approach to information sharing and integration for the Medicaid enterprise and the statewide HIE to allow the creation of a single source of a recipient's demographic, financial, socio-economic, and health status information.

The desired system will have the ability to support EHR initiatives and provide enough flexibility to respond to the changing needs of these initiatives. The system will also allow for required system modifications made by the HIE and to access and utilize data from other state HIEs, EHRs, and PHRs, as permissible. The desired system will also have an indicator mechanism on the electronic claim to measure provider participation in the statewide HIE.

Medicaid HIT P-APD Project

The Maryland Medical Assistance Program in consultation with the MHCC will collaborate in the development of the *Health Information Technology Planning-Advanced Planning Document* (HIT P-APD), which initially will be used to request Federal Financial Participation (FFP) from CMS for administrative costs to support planning activities authorized by the ARRA to promote the use of HIT and EHRs among Medicaid providers. Under the ARRA HIT incentive program, providers can qualify for 100 percent of Federal incentive funding for adoption and meaningful use of certified EHR technology and support services, such as maintenance and training. The program also authorizes a 90 percent FFP for reasonable administrative expenditures to support state efforts to administer this program. The purpose of the HIT P-APD is to create the State Medicaid HIT Plan (SMHP) that will outline the strategic HIT vision for the Maryland Medical Assistance Program. The SMHP will lay the groundwork for achieving this vision by describing the current "As-Is" HIT landscape, the desired "To-Be" HIT landscape, and a comprehensive five year plan for expanding HIT using MITA principles and approaches as a foundation. The HIT P-APD activities will also include planning to support the incentive payments for EHR systems authorized in Section 4201 of the ARRA. Section 4201 of the ARRA provides funding support for certified EHRs through Medicaid adoption and implementation payments. CMS and the Maryland Medical Assistance Program will provide oversight, as directed in the ARRA. The MHCC and the Maryland Medical Assistance Program have held monthly meetings since August 2009 to work through the challenges in coordinating the development of the HIT P-APD. As of April 2010 a preliminary HIT P-APD exists.

Included in this HIT P-APD will be a description of a series of planning tasks pertaining to: provider education and awareness activities; development of the SMHP comprised of an "As-Is" HIT landscape assessment of the current status of HIT, particularly among Medicaid providers; a "To-Be" vision and Roadmap Plan; development of the HIT Implementation Planning Advance Planning Document (HIT I-APD) to implement activities identified in the Roadmap Plan necessary to support the "To-Be" vision and the

SMHP; and the development of an Request for Proposal (RFP) for a vendor to provide operational support and program audit services.

Coordination of Medicare and Federally Funded, State Based Programs

The successful development and implementation of the statewide HIE will be defined by how beneficial health information is in improving quality, reducing health care costs, and improving health outcomes. Achieving these benefits is dependent on much more than just technology. The statewide HIE will work collaboratively with DHMH to develop reporting capabilities that will allow DHMH to report required data to the Centers for Disease Control. Discussions with DHMH are already underway to develop a Use Case for testing in 2010. Data from the Medicaid long term care population will be made available through the HIE as part of the collaboration with DHMH on the MITA initiative. Demonstrated improvements in public health require access to clinical information from the Medicaid program. The statewide HIE will utilize many of the resources and tools developed by the Agency for Healthcare Research and Quality to assist Medicaid and the Children's Health Insurance Program in improving the delivery and coordination of care through exchanging electronic patient information. Maryland's goal is to maximize coordination efforts with Medicaid and Medicare on relevant federally-funded state programs to advance robust interoperable HIE as quickly and strategically as possible.

The Advisory Board of the statewide HIE will work with CMS to identify the challenges in exchanging electronic health information. The Advisory Board is responsibility for providing oversight into the development of the technology to support data sharing with federal programs. Current funding from the unique-all-payor hospital rate setting system in Maryland includes the development of Use Cases to support exchanging data with Medicare and other federally-funded programs. The Technical Infrastructure Committee, a subgroup of the Advisory Board, is in the preliminary stages of identifying the architecture, hardware, and software along with network configuration to connect with all publically funded programs. The Technical Infrastructure Committee will also evaluate process design, functionality, and system maintenance requirements necessary to support the electronic exchange of health information. Policies essential to exchange data with publically funded programs will be developed by the Policy Board, which is an independent policy making committee under the direction of the MHCC.

Participation with Federal Care Delivery Organizations

The Veterans Affairs (VA) Maryland Health Care System is a dynamic and progressive health care organization dedicated to providing quality, compassionate, and accessible care and service to Maryland's veterans. The Baltimore and Perry Point VA Medical Centers, the Baltimore VA Rehabilitation & Extended Care Center, and five community-based outpatient clinics all work together to form this comprehensive health care delivery system. The VA has successfully implemented a system-wide EHR in a health care system that serves nearly 6 million patients in more than 1,400 hospitals, clinics, and nursing homes (Department of Veterans Affairs, 2008). Connecting the statewide HIE with the VA is of high importance to the MHCC. The statewide HIE will explore data sharing with the VA in 2010. Implementation is expected to occur on a Use Case basis.

Most of the physicians who work for the VA hold dual appointments at the University of Maryland, School of Medicine. The University of Maryland, School of Medicine is part of the University of Maryland Medical System, which is an active participant in the planning and implementation of the statewide HIE. The MHCC plans to reach out to the VA in Maryland for guidance in implementing EHRs.

Coordination with the Nationwide Health Information Network

The proposed infrastructure of the statewide HIE will be designed to ensure flexibility so that the organization can respond to market changes and eventually support data sharing with the Nationwide Health Information Network (NHIN). The technological design of the statewide HIE is based on federally endorsed standards and integration protocols that bridge proprietary boundaries. Building the statewide HIE consistent with national standards mitigates a wide range of technology challenges for providers in Maryland and establishes the framework for eventual connectivity to the NHIN. Stakeholders agreed that a statewide HIE must build upon approved standards to not only avoid vulnerability to vendor selection issues and risks, but to ensure compatibility with other HIEs and federal initiatives. Participants of the statewide HIE, along with the MHCC, have been engaged in conversations with staff of the Federal Health Architecture (FHA) under the ONC. The MHCC and the statewide HIE anticipate beta testing of select use cases with the NHIN architecture in 2010. Previous discussions with Mr. Vish Sankaran, Program Director of the FHA, have resulted in his support of preliminary testing in late 2010.

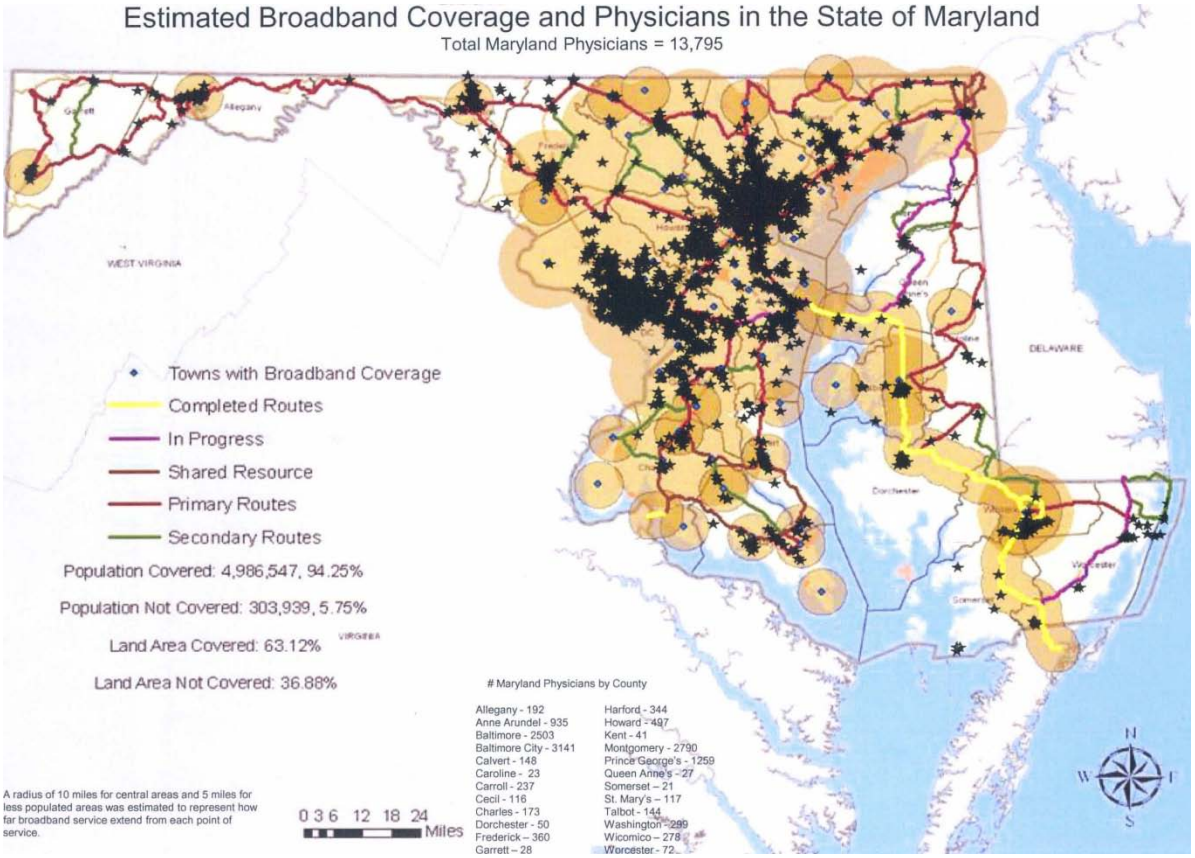
Coordination of Other ARRA Programs

The statewide HIE has submitted a preliminary application for approval as it relates to funding for the *Health Information Technology Extension Program: Regional Centers Cooperative Agreement Program.* The application submitted depicts a Regional Center for the State of Maryland. Many of the required activities of this program are aimed at assisting providers in becoming meaningful users of certified EHR technology, which is consistent with MHCC's existing outreach and education strategy to facilitate EHR adoption by physician offices and the development of an MSO model program to install and support EHRs in Federally Qualified Health Centers (FHQCs) in Maryland. MHCC will provide strategic guidance to the statewide HIE in executing the deliverables of the grant, if it is awarded. The statewide HIE will function as the primary contact and engage a number of non-profit organizations to participate as subcontractors to complete the work. Subcontractors assisting in the work effort will be required to use physician champions and professionals from workforce development programs under ARRA.

The approach will vary based upon geographic location, provider type, and current users of EHRs. The focus is on expanding EHR adoption and meaningful use to ensure that providers take advantage of the Medicare and Medicaid incentives under ARRA, and qualify for incentives under the new legislation in Maryland that also incentivizes for adoption and meaningful use. Initially, the broadband service areas will be targeted for education, awareness, and technical assistance. Emphasis will be placed upon expanding the adoption and meaningful use for priority primary care providers within a 5 to 10 mile radius of towns with broadband coverage. A more customized approach is required for providers in remote areas of the state. The following state maps depict the broadband coverage and the physician practice locations that will be used in fully developing the Regional Center strategy. The Regional Center will coordinate with the Maryland Department of Natural Resources, Office for a Sustainable Future, which is the state entity that will facilitate the *National Telecommunications and Information Administration State Broadband Data and Development Grant* under ARRA.

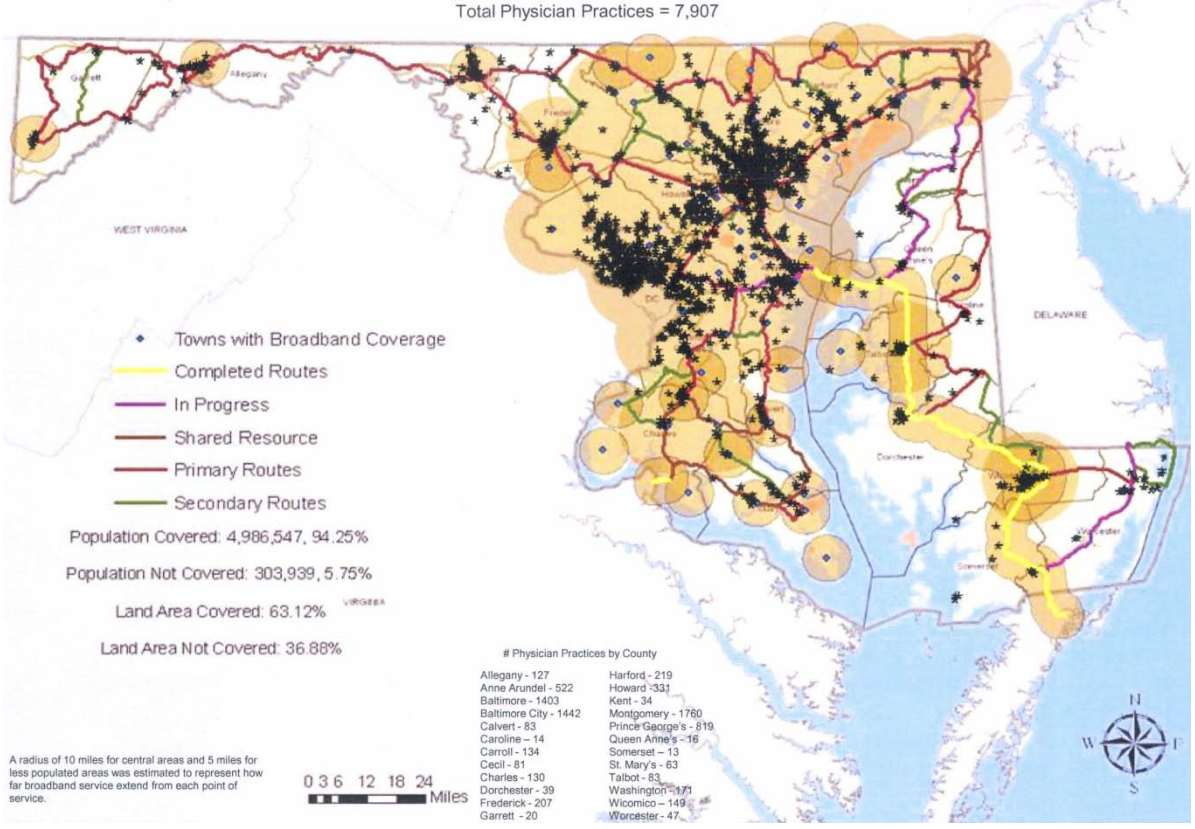
Estimated Broadband Coverage and Physicians in the State of Maryland

Total Maryland Physicians = 13,795



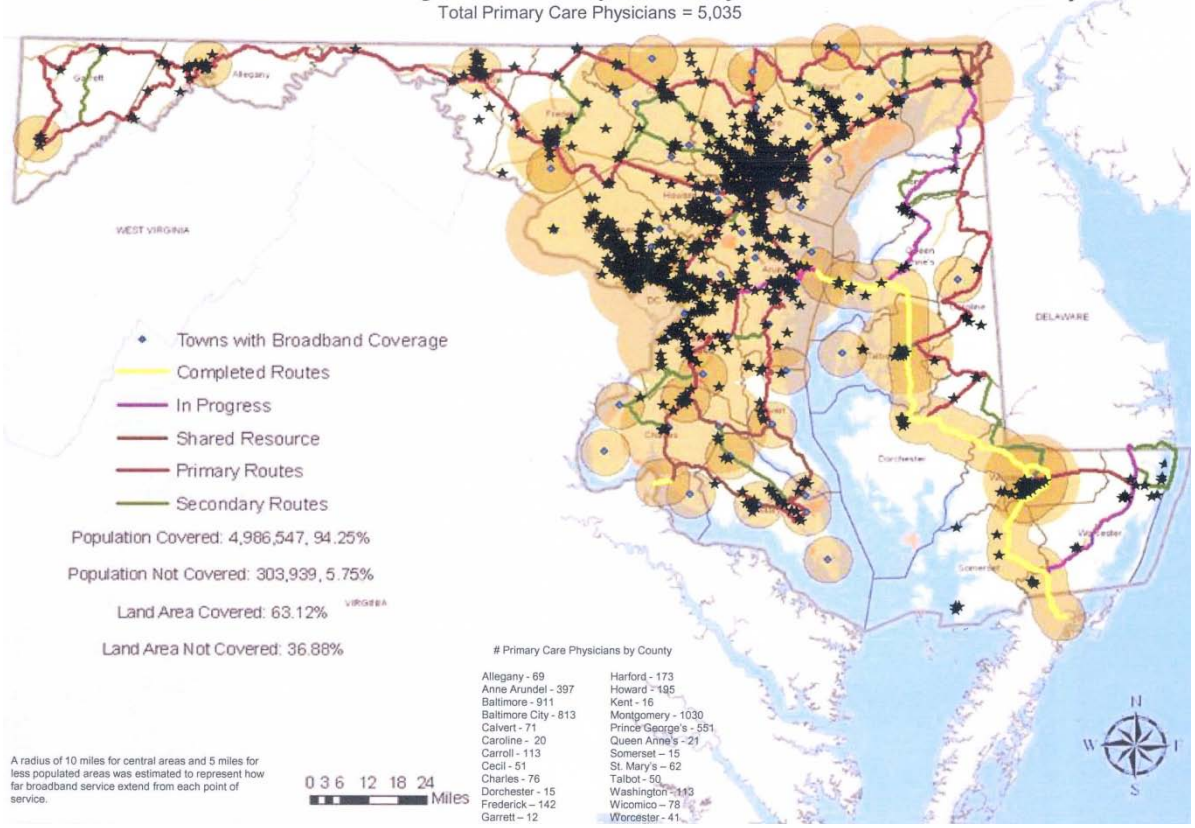
Estimated Broadband Coverage and Physician Practices in the State of Maryland

Total Physician Practices = 7,907



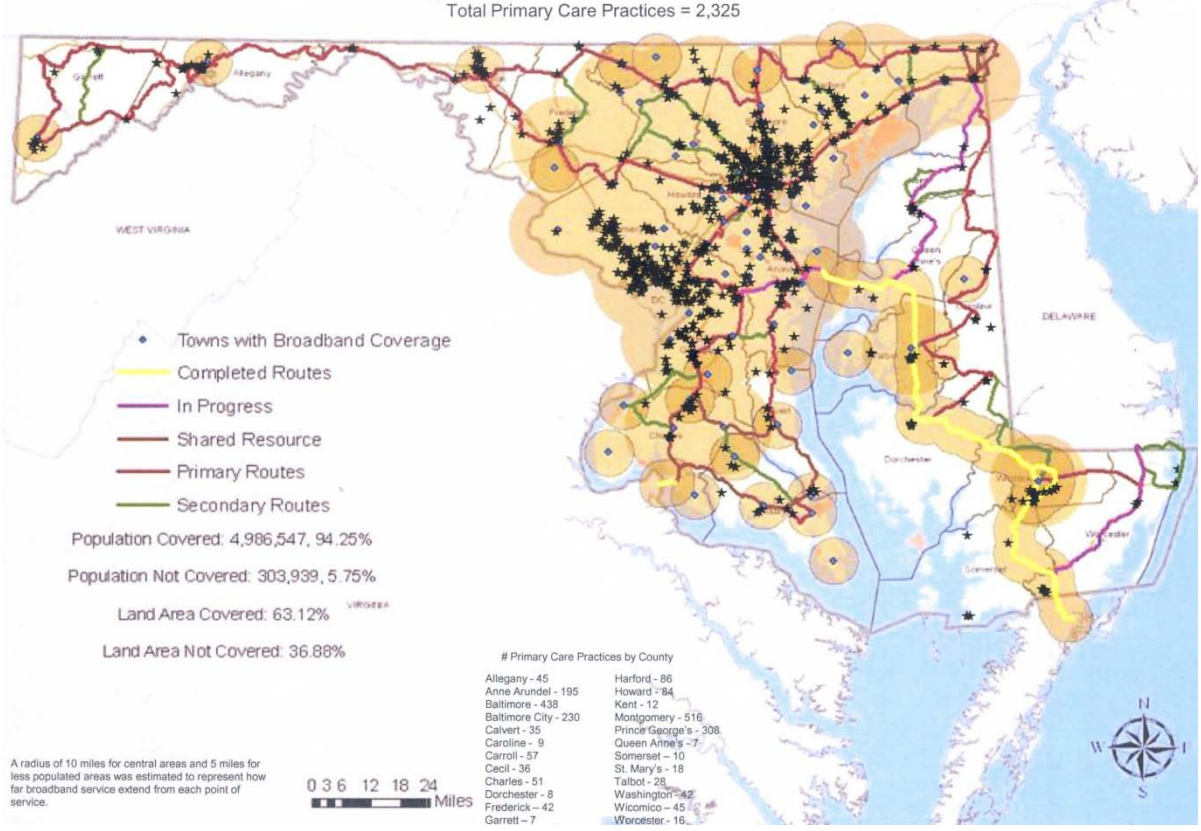
Estimated Broadband Coverage and Primary Care Physicians in the State of Maryland

Total Primary Care Physicians = 5,035



Estimated Broadband Coverage and Primary Care Practices in the State of Maryland

Total Primary Care Practices = 2,325



Domain Requirements

Governance

Collaborative Governance Model

The MHCC is responsible for implementing a statewide HIE in Maryland. The MHCC has oversight authority for the work of the state designated HIE and is an active participant in all phases of the work effort. In August 2009, the MHCC identified a multi-stakeholder consortium known as CRISP, the Chesapeake Regional Information System for our Patients, to implement the Health Information Technology State Plan (state plan). While the state plan intentionally refers to CRISP as the statewide HIE, the responsibility for implementing a statewide HIE rests with the MHCC. The MHCC's commitment to the state designated HIE is limited to three years. At the end of the three year period, the MHCC will evaluate the performance of CRISP and determine if an additional three year continuance is appropriate. The HIE consists of a diverse governance structure that promotes transparency and addresses the needs of various stakeholders. The governance is comprised of the MHCC Policy Board, Board of Directors, and the Advisory Board.

The Board of Directors is the authoritative entity overseeing the operations of the statewide HIE and consists of representatives from Johns Hopkins Health System, University of Maryland Medical System, MedStar Health, and Erickson Retirement Communities. The Board of Directors consists of 9 individuals with overall management and governance responsibilities. The Board of Directors will ensure that the policies developed by the Policy Board are implemented and will take the recommendations from the Advisory Board under consideration. The governance model is designed to be flexible to ensure the organization can respond to market changes and eventually support data sharing with the NHIN.

The Policy Board consists of approximately 25 diverse members selected based upon their expertise, with a strong emphasis on achieving both broad stakeholder representation and a strong consumer orientation. The Policy Board will provide oversight to the HIE, develop the policies related to privacy and security, and represent the public's interests. Medicaid holds an ex-officio seat on the Policy Board and will have active involvement with the development of the policies that govern the statewide HIE. The existence of a Policy Board that is separate from the administration of statewide HIE assures participation by the public in both policy development and operational oversight. The responsibilities of this Policy Board include, although are not limited to, the development of policies for the enforcement of privacy and security, auditing protocols, and other policies consistent with current laws. Moreover, the Policy Board will be charged with proposing additional requirements under the *Maryland Confidentiality of Medical Records Act* (MCMRA).

The Advisory Board will routinely consult with Medicaid on policy and technology issues. The Advisory Board is comprised of approximately 30 members who are divided into three committees: the Exchange Technology Committee, the Clinical Excellence and Exchange Services Committee, and the Finance Committee.

Oversight by the MHCC Convened Policy Board and the Commissions

The decisions of the Policy Board, when adopted by the MHCC, will be enacted and augmented by the governance structure of the HIE. Bi-directional communication between the Policy Board and the statewide HIE governance structure is important and will help ensure no disconnect between policy creation and that which is technically feasible or practical. Cross-membership between the Advisory Board and the Policy

Board is an appropriate mechanism to facilitate that communication. Included on the Policy Board is a senior level representative from the Maryland Medical Assistance Program (Medicaid). This individual actively participates on the Policy Board and is tasked with making recommendations that will impact the Medicaid program, in consultation with Medicaid's senior leadership. The statewide HIE and the executive leadership at Medicaid meet routinely to discuss the needs of Medicaid in the statewide HIE. The leadership of the statewide HIE meets with the leadership of state-based payers in Maryland, as well.

Enforcement

The statewide HIE Board of Directors are ultimately accountable for the accomplishments of the work effort. The Board of Directors, which consists of a number of stakeholders, have been actively involved in implementing data sharing projects within their communities, across their organizations, and at a state level. These individuals that constitute the Board of Directors are charged with ensuring that all aspects of the state plan have been implemented to the satisfaction of the MHCC. They have the authority to make any necessary changes within the CRISP organization to ensure that these goals are met. The Board of Directors also has enforcement of privacy and security and other policy issues. The Board of Directors has the authority to convene administrative hearings related to all aspects of the organization's activities in an effort to resolve issues. The MHCC has the authority to request action to be taken from the statewide HIE Board of Directors as deemed necessary by the event.

State Government HIT Coordinator

The MHCC's Center for Health Information Technology (Center) Director, David Sharp, will serve as the Maryland Government HIT Coordinator. The Center Director is actively involved in HIT and HIE in Maryland and previously participated on the national Health Information Security and Privacy Collaboration, Adoption of Standard Policies Collaborative. The Center Director is currently working with Medicaid to explore data sharing opportunities under the MITA transformation project and is actively involved with CMS as part of its EHR Demonstration Project.

As the HIT Coordinator for Maryland, the Center Director also sits on the Steering Committee for the Community Health Integrated Partnership's (CHIP) Electronic Patient Record System Implementation project. CHIP provides roughly nine community health centers with the business expertise to achieve the shared goal of quality improvement in the care they deliver, and is a recipient of HIT funding from the Health Resources and Services Administration. The Center Director is an ex-officio member on the CRISP Advisory Board, a participant on the state Policy Board, and is actively involved with the state's medical society and hospital association.

Accountability and Transparency

The basic framework for building consumer trust, collaboration with stakeholders, and transparency necessary to achieve HIE sustainability is attributed to the vast policy discussions that have occurred over the last several years. The MHCC required the statewide HIE to have a diverse governance structure. A group of core members representing the major stakeholders, consisting of hospitals, health systems, government entities, and large ancillary service providers, with rotating membership among other ancillary stakeholders and the public, are important components of the statewide HIE. The statewide HIE formulated bylaws that avoid domination or coercive pressure by any one stakeholder. All members have real input and influence over policy formation. All Advisory Board and Policy Board meetings are open to the public. The statewide HIE will maintain a website where essential information will be posted. The MHCC will post

the monthly progress reports submitted from the statewide HIE on its website. The $10 million in funding through Maryland's all-payor rate setting system is based on the statewide HIE meeting specific deliverables identified in MHCC's specifications for a statewide HIE and also in the Memorandum of Understanding. MHCC has entered into a three year agreement with CRISP to implement the statewide HIE.

Privacy and security policies and practices provide the virtual locks and enforcement tools made possible by technology, and can make it more difficult for violators to access electronic health information and help ensure that when there is a breach that the perpetrators will be detected and punished. Enacted in 1990, the MCMRA long predated the HIPAA Privacy Rule and is generally not preempted by it. This law applies to any medical record, a term that includes any oral, written, or other transmission in any form or medium of information that identifies a patient, is entered in a patient's record, and relates to the health care of the patient [HG §4-301(h)]. Although medical records in electronic form may have been uncommon when the Act became law, the definition's comprehensive phrasing ("any form or medium of information") means that the Act encompasses paper records themselves, the electronic embodiment of paper records after scanning or some other imaging process, and records initially created in electronic form. A recent opinion letter from the State's Attorney General indicated that electronic health information is governed by the MCMRA. Individuals who violate the MCMRA are subject to criminal penalties, private right of action, and civil penalties.

Finance

Potential funding from the ARRA is expected to speed implementation of the statewide HIE. These funds will be used in conjunction with the funding approved through Maryland's all-payor rate setting system to expand the number of Use Cases implemented over the four year performance period. Initial funding by the state is limited and is not expected to enable full deployment of the statewide HIE. The incremental approach to building the statewide HIE ensures sustainability within about five years. Key to the development of this cost model are a series of assumptions about the fees that various participants would be willing to pay for services offered through the statewide HIE, and how fast those services could be deployed and subsequently adopted by the user community. The following table depicts those assumptions:

Model Assumptions	Adoption Rates					
Use Cases	Subscription/ Month	Assessment Unit	2010	2011	2012	2013
National Laboratory Results Delivery	$10	Per doc	30%	50%	70%	90%
Hospital Laboratory Results Delivery	$2	Per doc	10%	30%	50%	70%
Local Laboratory Results Delivery	$3	Per doc	10%	30%	50%	70%
ED/Hospital Discharge Summaries to Physicians/Clinics	$10	Per doc	10%	30%	50%	70%
ED/Hospital Discharge Summaries to ED/Hospital	$2,000	Per facility	10%	30%	50%	70%
Clinical Summary to EDs	$2,000	Per facility	0%	0%	30%	50%
Clinical Summary to Physicians/Clinics	$10	Per doc	0%	0%	10%	30%
National Radiology Results Delivery	$5	Per doc	0%	30%	50%	70%
National Radiology Results History	$1,000	Per facility	0%	30%	50%	70%
Hospital Radiology Results Delivery	$1	Per doc	0%	0%	10%	30%
Hospital Radiology Results History	$350	Per facility	0%	0%	10%	30%
Local Radiology Results Delivery	$2	Per doc	0%	0%	10%	30%
Local Radiology Results History	$650	Per facility	0%	0%	10%	30%
Max Subscription – All Services	$43	Per doc				
Max Subscription – All Services	$6,000	Per facility				

The strategy for identifying revenue sources was formed by considering a number of factors, including:

- State monies should be leveraged to achieve a sustainable business model;
- The participants in the statewide HIE will be willing to pay fees relative to the value they gain from using the exchange;
- The value of EHR adoption and HIE participation by physicians has been markedly increased by the Medicare and Medicaid payment incentives for meaningful use;
- The financial model should not rely on grant funding, even though grants may be available for future projects and expansions;
- Revenue should not be sought disproportionately from any one stakeholder or group of stakeholders; and
- Properly developed subscription fee models that incentivize higher utilization of HIE services can provide stability in revenue planning.

To arrive at reasonable revenue estimates that meet all of these criteria, the statewide HIE followed a model established by eHealth Initiative (eHI) entitled *Health Information Exchange: From Startup to Sustainability* and the accompanying toolset released by the U.S. Department of Health and Human Services and Health Resources and Services Administration on May 22, 2007. These materials, developed under a grant from the Office for the Advancement of Telehealth, provide a template for planning and implementing HIEs that includes sustainability over the long-term. The eHI report draws on the experience of several organizations and projects, including:

- Health Bridge of Cincinnati, Ohio, which implemented an HIE for order entry, eligibility verification, portal services, and clinical messaging;
- IHIE of Indiana, which implemented an HIE for clinical messaging; and
- THINC of the Hudson Valley in New York, which implemented an HIE for hosted EHRs.

Technical Infrastructure

The statewide HIE was designed for sufficient flexibility and the capability of growing and adapting over time. Attracting and retaining both private and public stakeholders, creating a level playing field, and caring for the needs of those with limited resources are critical elements to a statewide HIE. The architecture was specifically developed using national standards. Implementation of a standards -based solution will offer immediate value that supports connectivity to the NHIN. As part of the technology evaluation and procurement process, the statewide HIE will complete an assessment of the technology for compliance with the standards endorsed by the Secretary of the Department of Health and Human Services (HHS), and will only integrate technology that meets these requirements. The statewide HIE will monitor the work of ONC's Health IT Policy Committee and the Health IT Standards Committee to ensure that the technical infrastructure includes those standards endorsed by HHS. The statewide HIE anticipates using CONNECT to interface with the NHIN in early 2011. The MHCC is expected to annually engage an independent audit team that will audit the financial, operational, and technical components of the statewide HIE. As part of the audit process the audit team will be required to validate that HHS published standards are in place by the

statewide HIE. The accountability for addressing concerns identified by the audit team rests with the statewide HIE Board of Directors. The statewide HIE anticipates that eventually meaningful use will require providers to exchange information among each other and work cooperatively with providers across state borders to coordinate patient care. The statewide HIE anticipates communicating the lessons learned regarding the technical infrastructure and other aspects of data sharing directly with ONC and through collaboration with the designated Regional Center.

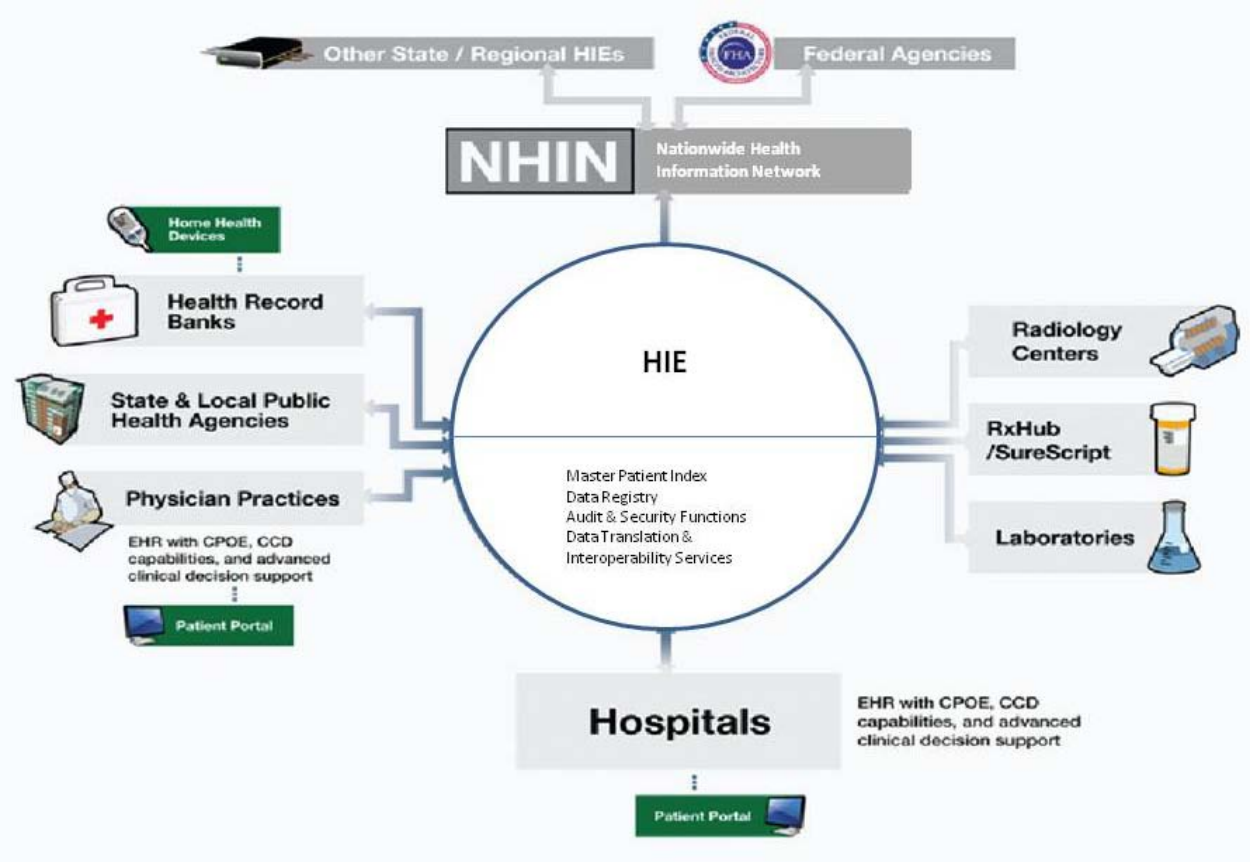
The statewide HIE will be a hybrid, standards-based model. In the proposed model for development in Maryland, a hybrid system is conceived of one that consists of a single core infrastructure vendor that serves as a platform for expanding functionality of the utility by adding different vendor applications to the core system. For instance, the core infrastructure selected may consist of an exchange utility with a master patient index (MPI). The MPI in most solutions lacks the robust features necessary to support advanced matching of consumer's to their health information. Available on the market are vendor solutions specific to MPIs that would serve as an alternative to MPI in a core infrastructure solution (i.e., Initiate). The exchange will operate using Healthcare Information Technology Standards Panel (HITSP)-endorsed XDS (cross-enterprise document sharing) infrastructure that is appropriate for supporting both distributed data and HRB. This flexible approach will accommodate the planned distributed data model, such as envisioned by the Markle Foundation, with an MPI and Registry. The distributed model ensures that data will be held where it is created, which avoids the negative perceptions and potential privacy and security consequences of storing all patient information in a centralized health information repository. The implications of a decentralized model include capacity monitoring, system availability, storage and retrieval, and security response time. Technology performance goals and standards will be established for providers connecting to the statewide HIE. For research and public health reporting the Policy Board is expected to conclude on data repositories as part of the statewide HIE or whether the statewide HIE can connect to independent repositories.

The flexible, standards-based, hybrid infrastructure will allow for the secure transfer of a defined set of clinical information between participating entities. The core infrastructure will leverage a distributed model developed in adherence to generally accepted specifications and standards. The design will ultimately drive towards the technical capability that allows providers to access distributed repositories, also known as HRBs, of consumer-controlled health information where it is deemed appropriate or in the interest of the consumer. The HRB serves the same functions as a PHR in this model. While clearly there are distinctions in the industry about HRBs and PHRs, in the model conceived of for Maryland there is considerable overlap in functionality. Primarily, both allow for consumer control and in this model the HRB also acts as a permissions portal for sharing patient information. The statewide HIE will support health records to ensure that consumers have the ability to create an HRB account where they will have control over the flow of their health information within the HIE. The statewide HIE will enable consumers to grant their health care provider(s) access to specific information in their HRB/PHR. Access to the HRB/PHR through the statewide HIE will be for viewing purposes only and the data will not be integrated into the clinical record of the provider. MHCC anticipates that the HRB/PHR vendors that are selected by the consumer will have established authentication procedures for consumers when accessing their data.

A fiscally sound incremental approach to implementing the statewide HIE represents the vision for what the exchange will aim to achieve. In the near-term, clinical data sharing will leverage portions of the functionality that will be deployed in the full-scale HIE. The following conceptual diagram illustrates

foresight by positioning Maryland's HIE infrastructure to account for market development in either a distributed or HRB driven model.

Maryland Health Information Exchange Fundamental Design



Public Program Connectivity

The statewide HIE expects to work closely with public agencies to establish connectivity for the exchange of electronic health information. Collaboration with Medicaid has already begun and discussions with the Department of Veterans Affairs (VA), Department of Defense, and other state and federal agencies will ensue near the end of 2010. The statewide HIE will connect to the existing MMIS as a first step in connecting with public programs and will work with Medicaid to implement technology to support the MITA transformation. Efforts to connect with the VA are expected to overlap with activity related to connecting Medicaid to the statewide HIE. The Baltimore and Perry Point VA Medical Centers, in addition to the Baltimore VA Rehabilitation & Extended Care Center, and five community-based outpatient clinics all work together to form a comprehensive health care delivery system for Maryland veterans. Connecting public programs to the statewide HIE is an essential part of demonstrating the vision and future of meaningful use to achieve measureable improvements in health care quality, safety, and efficiency. Discussions of public program connectivity have evolved and have produced a strategy to integrate data exchange capability between the statewide HIE and publically funded programs. Specific details regarding an implementation plan are expected to be developed in the 3rd quarter of 2010. The strategy that will be deployed consists of utilizing the statewide HIE's system architecture and equivalent individuals connected with these public programs to

perform a detailed evaluation of the technology that is in place and required to support data sharing. These recommendations will be presented to the Advisory Board for decision-making that is required to support connectivity with these public programs.

Integrating the Healthcare Enterprise Overview

Integrating the Healthcare Enterprise (IHE) represents an approach to developing a statewide HIE that is standards-based, which will allow Maryland to achieve cross-organizational interoperability. IHE has defined specific profiles aimed at constraining existing standards to define implementation guides. IHE profiles organize and leverage the integration capabilities achieved by coordinated deployment of communication and security standards. They provide precise definitions of how standards can be implemented to meet specific clinical needs. HITSP has endorsed a number of the IHE profiles that will enable broad HIE implementation. In addition, many EHR vendors have begun to build functionality into their products that can enable interoperability from the native EHR system, in some cases negating the requirement for the installation of an edge device that would allow a participant to trade data with the HIE.

Master Patient Indexing

For an HIE to function, providers need a reliable way of matching their patients with available records in the network. This is no trivial task, and even within a single enterprise, matching a person with his or her past records is not always easy. The statewide HIE will follow the IHE Patient Identity Cross-Reference (PIX) approach to patient matching. At a high level, the PIX manager is a layer on an MPI that is operated within the exchange. Each record in the PIX contains cross-references to medical record numbers (MRN) located at participating institutions. In essence, the PIX can translate the MRN of one provider to the MRN of another provider. The initial link of an MRN to an existing PIX record is initiated through statistical matching. That matching will be tuned to avoid errors and final linking can be resolved through either probabilistic or deterministic matching.

The statewide HIE Use Cases will not require providers who are consuming/receiving data to write PIX feeds to the exchange MPI. Instead, receiving providers will send demographic data to the exchange that is matched probabilistically to the MPIs of data suppliers/senders (e.g., RxHub's Initiate Systems MPI) to obtain available data. It is only when an institution becomes a supplier/sender of data to the HIE that their MPI will need to be linked to the PIX.

MPI Discussion

The objective of the MPI strategy is to maximize the positive identification of subject patients while minimizing both false positives and false negatives. The recommended approach will use the IHE PIX Manager integration profile accounting for demographic data variation (i.e., first name John vs. Jonathan) and human data entry error (e.g., zip code or birthday number transposition) with weighted scoring assignments to each data element based on those variations. The MPI will run algorithms against the existing demographic information to preprocess the database to determine the frequency of every attribute and score the match according to the discriminating ability of the specific attributes of that database. The limits of acceptance and rejection will be tailored to the size of the population and the risk tolerance of both false negatives and false positives.

Comparing Probabilistic and Deterministic PIX Record Linking

Significant challenges and risks are inherent in maintaining an accurate MPI rooted in statistical matching techniques. Effectively mitigating those risks is possible. An understanding of the difference between probabilistic and deterministic record linking within a PIX/MPI is critical in evaluating the overall risk of false-positive and false-negative linking. Relying on a completely automated probabilistic record matching and linking approach requires an extremely high threshold for accuracy to limit the potential for false-positives, thereby increasing false-negative outcomes.

An effective PIX/MPI solution will require some degree of manual intervention and ongoing attention to linking. Deterministic matching includes manual intervention by escalating MPI matching events that do not meet the threshold requirements set by the exchange operators. A resource in the HIE support center would then look at the records and try to determine whether or not they in fact refer to the same person. They will use a combination of intelligence, common sense, and investigation to make this determination. The support resource will determine that the records match and that the numbers were likely transposed. The resource will then manually merge the records. If the matching issue is not as straightforward as a transposition, the resource may need to do some more investigation by perhaps calling the organization where the record originated to see if it has more information on the patient that could help them make a determination. The statewide HIE will implement a deterministic matching approach in an effort to build trust in the accuracy and effectiveness of the exchange MPI.

Storage of Clinical Information

Each node on the statewide HIE will store data locally in either their own, or shared, edge devices that are in turn made available to the requestor via the statewide HIE if an allowable request is received. Since the current level of EHR adoption is around 20 percent, the statewide HIE will offer a provider portal to allow for early access to the HIE. HRBs will connect to the statewide HIE in a manner similar to any other provider, enabling consumers the ability to control data in consumer oriented edge devices separate from the central exchange infrastructure.

Registering Clinical Information with the Exchange

The central Registry will capture the metadata of any information being stored locally on an edge device. The intent of the document Registry is to maintain information about the location and type of documents that exist on the network. When a participant saves a document to the statewide HIE edge device, a standard transaction is initiated to register the document and sends the necessary document identification information to the centralized Registry.

Data Request, Exchange, and Publishing

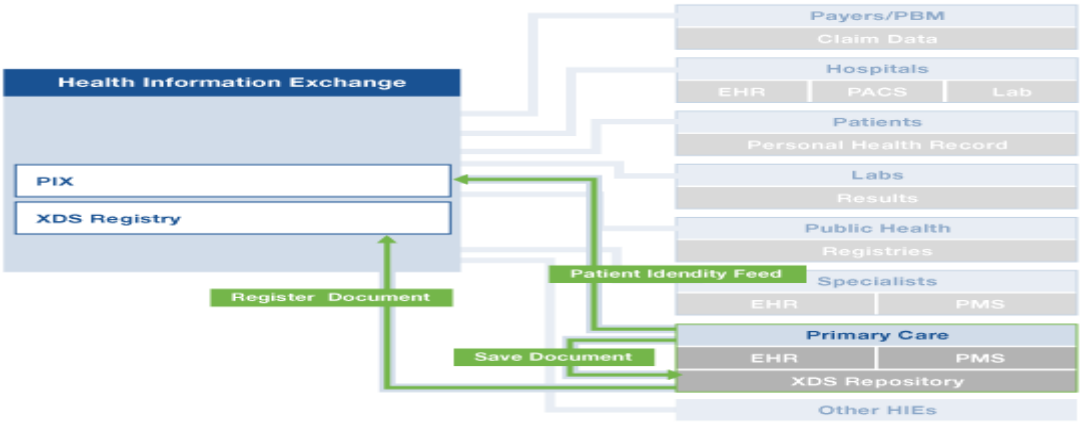
The statewide HIE operates with an agreement, amounting to the consent, of the consumer whose information is being exchanged. As a baseline process, consumers will be notified about the existence of the statewide HIE and will have a choice to opt-out of all exchange participation, whereby they will be able to choose to disallow any of their health information from flowing through the statewide HIE. The consumer notification describes the statewide HIE, its purpose, and its functions. In effect, opting-out is the equivalent of being placed on a do-not-call or global suppression list. Depending upon the Use Case and associated data, additional opt-in patient consent protocols are employed over and above the opportunity to opt-out completely. In practice this means all patients will be included in the statewide HIE by default, unless they ask not to be. For those consumers that participate, the statewide HIE is available for a variety of purposes,

some of which will require additional consumer consent or authorization under HIPAA and Maryland law, and some of which will operate without explicit consumer approvals.

Persistence of information in edge devices highlights the concept of control over health information and the ability for the information to be updated or deleted. Information in edge servers does not necessarily need an expiration/auto-delete date. If data were to be deleted from an edge device, the data in the originating system will still exist, and all logs of access to the previous data will persist in the statewide HIE audit log.

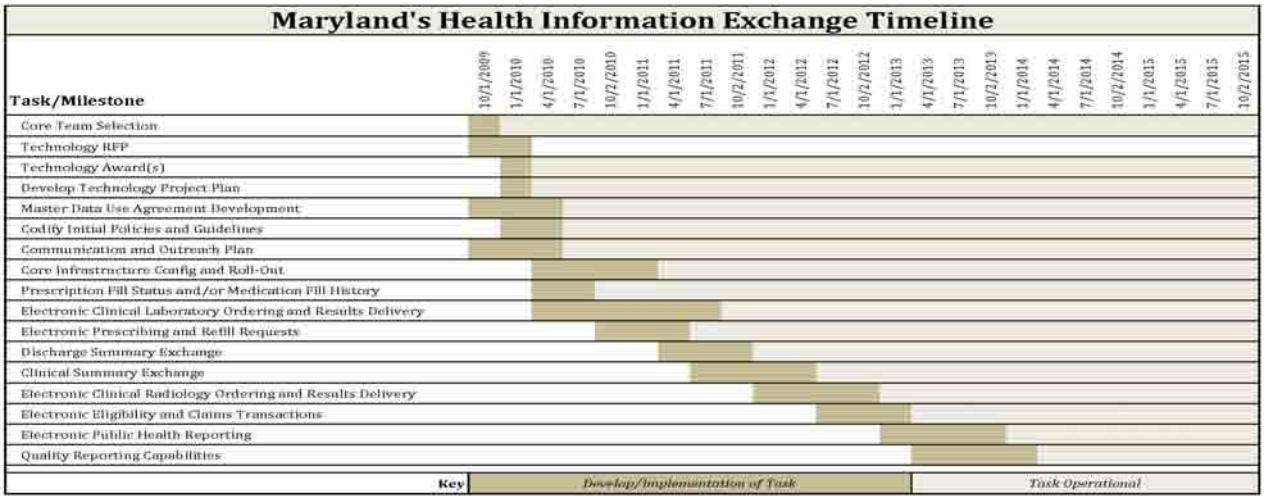
For primary clinical uses of the information, ancillary data will be routed from the processing facility (i.e., laboratory or imaging center) through the statewide HIE to the ordering physician. The statewide HIE will initially leverage SureScripts/RxHub as a source of medication information derived from both pharmacy data (SureScripts) and claims data (RxHub). This data will be accessed by routing provider requests through the HIE to SureScripts/RxHub and locating the patient using that company's MPI service. As the statewide HIE evolves, the ability for consumers to maintain medication history information in their own PHR/HRB will be possible.

The figure below illustrates the high-level process by which the statewide HIE participant will submit, store, and register patient health information privately and securely with the HIE.



HIE Services Implementation Timeline

The table below provides the HIE services that will be offered, the timing, and priority of the Use Cases:



HIE Services

When fully implemented, the statewide HIE architecture will enable connections between Maryland's approximately 47 acute care hospitals and 7,907 physician practices. The statewide HIE will provide a mechanism that enables appropriately authorized individuals to perform select analytical reporting. The statewide HIE will also allow secondary uses of data for public health, biosurveillance, and other appropriate secondary uses of data. Below is a brief discussion regarding the statewide HIE's implementation schedule for the required Use Cases.

Electronic Eligibility and Claims Transactions

Administrative health networks (networks) are required to be certified by the MHCC to operate in Maryland. Select networks are expected to collaborate with the statewide HIE to implement this Use Case. Preliminary discussions are underway between the statewide HIE and a network that is used by one of the state's largest payers, CareFirst. The statewide HIE intends to engage in further discussions with a number of networks and to involve CareFirst in developing this Use Case. Though electronic eligibility and claims transactions was not an initial Use Case, the statewide HIE will use any potential funds from the grant opportunity to fully develop this Use Case.

Electronic Prescribing and Refill Requests

In Maryland, provider usage of e-prescribing is slightly more than five percent and around 75 percent of the 1,628 pharmacies are capable of accepting some form of electronic prescription. This Use Case will improve the adoption of e-prescribing among the more than 3,102 priority primary care practices in Maryland. This Use Case will be aligned with the incentives available under the *American Recovery and Reinvestment Act of 2009* (ARRA) and will be implemented accordingly.

Electronic Clinical Laboratory Ordering and Results Delivery

Maryland exceeds the national rate of computerized physician order entry (CPOE) adoption by roughly seven percent. The implementation of this Use Case is expected to take more than a year to implement as negotiating connectivity with national, local, and hospital laboratories is expected to be somewhat of a lengthy process.

Electronic Public Health Reporting

Maryland has specific regulations governing public health reporting for a number of infectious or communicable diseases, such as meningitis, measles, mumps, and smallpox, to name a few. Currently, providers are required to submit information to public health officials for monitoring and reporting purposes with variable requirements on the reporting timeframe. Initial discussions regarding the implementation process for this Use Case are underway.

Quality Reporting Capabilities

Quality reporting is essential to inform and educate stakeholders, and it is an important component for achieving meaningful use. Interest in quality reporting continues to grow; however, a consistent mechanism for reporting does not exist. The statewide HIE is expected to make available quality reporting, as deemed appropriate, for use by authorized stakeholders.

Prescription Fill Status and/or Medication Fill History

The Medication History Use Case was piloted during the HIE planning project and continues to function within three hospital emergency departments. Today, this Use Case is returning results for approximately 70 percent of patients who consent to participate in the pilot program.

Clinical Summary Exchange

The Clinical Summary Exchange Use Case allows for the sharing of summary clinical data, such as a discharge summary, Continuity of Care Document (CCD), or Continuity of Care Record (CCR), to assure that health information is shared among authorized providers. The information contained in this Use Case is constrained by EHR system capabilities. This Use Case will ensure that data or an appropriate image is available to participating providers. Portions of this Use Case will be operational in 2011.

Support for HIE Services

The statewide HIE will provide technical support to providers for each Use Case through the establishment of a technical vendor managed help desk. The help desk is responsible for resolving technical and operational issues, including connectivity and performance. The help desk will resolve the majority of provider inquiries within one business day, or escalate the more complex issues to the statewide HIE for resolution. The statewide HIE will be responsible for tracking and monitoring performance of the help desk.

Safeguarding Data

The statewide HIE will maintain the confidentiality of patient information by establishing policies related to securing the integrity and ensuring the availability of electronic patient information. The statewide HIE will comply with the 18 broad standards under the HIPAA Security Rule. The Advisory Board will define the security requirements that must be implemented. Vendor technology partners will be required to demonstrate that their solutions meet or exceed the security requirements. Participation agreements will stipulate that users comply with the HIPAA requirements. The statewide HIE will maintain a log of activity for auditing purposes.

The statewide HIE will document the security policies, procedures, and decisions, which the Board of Directors will review. The statewide HIE will mitigate risk through a routine systematic and analytical approach that identifies and assesses these problems. The risk analysis will develop appropriate and reasonable protections, and anticipate risks and implement security measures. The statewide HIE is well positioned to verify the accuracy of information through audit logs and conduct annual penetration testing to identify vulnerabilities and determine the adequacy of the security protections. The statewide HIE will comply with all aspects of the Security Rule on an ongoing basis.

The statewide HIE will provide security of PHI through a number of leverages. The physical locations, networks, platform, and application technologies that will support data sharing are expected to provide ample security on all levels. The statewide HIE will deploy the following hosting and network practices for any systems related to PHI. First, there is physical machine security and servers operating in Tier 4 data centers that can pass the internationally recognized SAS 70-II standard requirements. This includes physical precautions such as HVAC units, fire retardant measures, strict host and guest authentication/sign in policies, and more. Next, network security must be addressed. Servers will be installed behind multiple firewalls configured for high availability and minimal vulnerability. All servers will be installed with the latest versions of Windows 2003 Server and Symantec AntiVrius Corporate Edition. OS security and virus

definition updates will be performed regularly. Finally, network transfer security will be established. For web services, secure network transport will be provided using components such as SAML, the X.509 token profile, XML encryption, and XML digital signature.

Credentialing

The first step for provider participation in the statewide HIE is the authentication of that individual as a health care provider. The statewide HIE will query the existing Maryland Board of Physician Licensure Database to authenticate the existence and status of state licensure. The statewide HIE will develop a participation agreement that will codify the relationship with various participants. Providers interested in participating in the statewide HIE will have the ability to review the terms and conditions of the participation agreement on the statewide HIE's website. The logic behind arriving at a consistent participation agreement that is entered into by each participant without substantial or material modification is to ensure that "transitive trust" can be maintained across the entire exchange. Transitive trust is the mutual trust between HIE participants rooted in the knowledge that each participant has entered into a consistent participation agreement that defines appropriate usage and requirements for participation, thereby avoiding the participant-to-participant need to know every individual provider and employee accessing the exchange. This approach acknowledges understanding on the terms and conditions in a participation agreement for a future state, establishment of a robust electronic exchange (including any potential data types), and gaining community-wide agreement by each participant. The statewide HIE is expected to complete the credentialing process for providers participating in the statewide HIE. Consumer credentialing will occur directly with the provider at the point of care.

Business and Technical Operations

The statewide HIE will require that EHRs connecting to the utility meet the technical requirements for certification. Among other things, EHR systems will need to be able to report on quality measures, and providers will need to demonstrate that they are fully utilizing the functionality of the system. Providers connected to the statewide HIE will need to complete an attestation to use the system in a manner that is consistent with the meaningful use standards. Compliance with the meaningful use standards serves the public interest by transforming a largely paper-based system into a private and secure electronic, interconnected system that is transparent, earns public trust, and helps address health challenges facing Maryland, including preventable medical errors, disparities in the quality of care, high costs, administrative inefficiencies, and the lack of care coordination among providers.

Maryland's ambitious plan for advancing HIE balances the need for information sharing with the need for strong privacy and security policies, and includes a judicious approach to funding. Today, Maryland is home to approximately 5,035 primary care providers that provide care in about 2,325 practices. The statewide HIE will eventually be capable of computable semantic interoperability; thus ensuring that all health information is securely delivered electronically in real-time to individuals and their providers when needed, and that this information is available for analysis for continuous improvement in care delivery and research. The strategy to implement HIE in physician practices will initially target priority primary care practices located in central Maryland. These practices are in established broadband service areas and provide care to the majority of the state's residents.

Statewide, approximately 17 percent of acute care hospitals have initiatives in place to share some data electronically with providers in their service area. These hospitals typically host the technology that

enables a one-way transfer of a limited amount of data with a high speed Internet connection. Last year, MHCC convened a meeting of hospital chief information officers and various other stakeholders to reach consensus on a range of standards and policies to ensure that hospitals that embark on data sharing initiatives implement similar policies. Acute care hospitals are also well positioned to operate as MSOs and host one or more EHR solutions. They are appropriately situated to provide a consistent way of managing privacy and security and ensuring the existence of robust physical and technical safeguards of electronic health information. MSOs are of particular interest to priority primary care providers related to the benefits of bulk purchasing and dedicated technical support.

The statewide HIE will work closely with the Maryland Hospital Association (MHA) to target hospitals in urban and suburban areas of the state for HIT awareness and education initiatives aimed at increasing EHR adoption among providers in their service area and conveying the advantages of implementing data sharing technology. Hospitals in urban and suburban areas are typically smaller in scale and with the least amount of dollars to invest in HIT. The statewide HIE expects to be compatible with the standards deployed in the NHIN and capable of connection once the infrastructure for the NHIN is in place.

During the first two years of implementation, the statewide HIE anticipates hiring only several regular employees. Systems integrators and management agreements will provide the bulk of statewide HIE's capacity in this startup phase. In years three and beyond, the statewide HIE expects to transition towards regular employees to support the ongoing operations of the exchange. This strategy will allow the statewide HIE to engage higher-caliber talent during the critical implementation period, without incurring the long-term expense of those resources when we reach sustainability.

Project Plan Risk Assessment and Mitigation

Approach

Implementing a statewide HIE is a complex project consisting of integrating multiple systems that need to work together to ensure the success of the HIE. Many different types of evaluation tools exist and were considered for tracking the performance of the statewide HIE implementation activities. The majority of methods, techniques, and tools place particular emphasis on quantification. In an effort to accurately assess the impact of systems on systems, the statewide HIE will evaluate performance through a technique known as systems thinking. Ample evidence exists that suggests complex initiatives are better managed by the application of systems thinking. This will enable the statewide HIE to seek out new and diverse perspectives when solving problems in a manner that considers complexity, environmental influences, policy, change, and uncertainty.

The statewide HIE will use systems thinking to self-evaluate and determine the appropriate measurement of success with regard to implementation and interdependencies. As a strategic simulation tool, systems thinking evolved from a variety of tools aimed at mapping and modeling the global interaction of processes, information feedback, and policies across sectors. Viewing the statewide HIE from a very broad perspective that includes structures, patterns, and events, rather than limiting the assessment to just the events, allows for rapid detection and identification on the true cause of any issue and helps in determining specific areas that need attention to address these issues. The evaluation process will focus on input, processes, outputs, and outcomes pertaining to the implementation and interdependencies of the statewide HIE. The data will be used to balance the processes that control change and help maintain stability.

Tools

The statewide HIE will use a number of systems thinking design tools in conducting ongoing evaluations of the implementation and interdependencies of the HIE. These tools will increase the understanding and analyses of the statewide HIE and the conditions that create or affect the interdependencies. Key assessment tools include:

- Causal loop diagrams;
- Behavior-over-time graphs;
- Systems archetypes; and
- Flow diagrams.

A combination of these tools will accurately depict a particular system or core system to the infrastructure of the statewide HIE. Systems thinking will encourage the statewide HIE to look at issues through a broad range of evaluation tools that provide a realistic measurement of performance, and to identify changes necessary to deliver sustainable and comprehensive process improvements.

Techniques

The statewide HIE will evaluate each Use Case prior to deployment and then monitor and assess the progress of implementation and interdependencies from a technical and operational perspective. Systems thinking will be applied to each Use Case during the implementation phase and as appropriate on an ongoing basis. The Advisory Board will develop any process modifications that are identified from the analysis. The statewide HIE will maintain all systems thinking evaluations as a permanent record, and is subject to annual audits by an independent reviewer.

Vendor Risk Management

The statewide HIE will rely on vendors to provide services necessary to implement the exchange of electronic patient information, which can be a risky proposition. This approach can expose the statewide HIE to greater risk relating to delivery disruption or vendors' inability to deliver services for which they are contracted. The statewide HIE will develop a vendor management plan to identify and mitigate any potential risks. The statewide HIE will also develop a contingency plan to support and avert disruptions in business operations should the worst happen and the vendor supporting the exchange fails to provide contracted services. The statewide HIE will develop a vendor risk management plan that includes an assessment of the organizational risk, financial risk, support risk, and strategy risk.

Disaster Recovery

The MHCC has a comprehensive Disaster Recovery Plan on file, which is tested during an annual audit. This information is proprietary in nature and is not available for publishing.

Legal/Policy

Privacy and Security

Maryland's ambitious plan for implementing a statewide HIE balances the need for information sharing with the need for strong privacy and security policies. The HIE is designed to deliver essential patient

information to authorized providers at the time and place of care to help assure appropriate, safe, and cost-effective care; store and transmit sensitive health information privately and securely; provide patient access to important elements of an individual's clinical record to help engage patients in their own care; provide a means for the patient to exercise appropriate control over the flow of private health information, both as a matter of right and as a means of assuring trust; provide a secure method of transmitting administrative health care transactions; and gather information from the health care system to research efficiency and cost-effectiveness of care, to measure quality and outcomes of care, and to conduct biosurveillance and post-marketing surveillance of drugs and devices.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was used as a guide for the design of the statewide HIE. It is clear that HIPAA does not require any patient consent or authorization for the exchange of an individual patient's health information among health care providers for treatment purposes. A patient's consent to such exchanges is viewed as implicit in the patient's consent to receive medical care. Certain other exchanges are also permitted without either consent or authorization under both HIPAA and the MCMRA, generally for payment purposes and for certain health care operations constituting quality assurance, reviewing provider qualifications, and fraud and abuse monitoring or response. HIPAA does permit disclosures to government agencies for a number of lawful purposes, including public health surveillance without patient consent or authorization. The consensus among the legal community is that other disclosures, as further Use Cases are adopted, will require patient specific authorization, which the patient can withhold, in a form that meets the requirements of HIPAA.

In December of 2008, the Office of Civil Rights under the HHS and HHS' HIPAA civil enforcement arm, issued a series of related papers on the HIPAA Privacy Rule and Health Information Technology (the Guidance). The Guidance constitutes an overview of HHS positions on the application of the HIPAA Privacy Rule to HIEs. In general the Guidance is consistent with, and supportive of, the type of HIE under construction in Maryland. The Guidance deals with a model of HIE that is, in operational terms, the same as the Maryland model for the statewide HIE. While recognizing that patients' consent to the exchange of their information among health care providers for treatment purposes is implied in the general consent to be treated and does not require specific affirmation by the patient, the Guidance favors allowing individuals the opportunity to opt-in or to opt-out of having their information flow through the HIE. The Guidance refers in this regard to the option providers are given in the HIPAA Privacy Rule to seek patient consent for treatment uses and disclosures, even in the absence of a requirement that providers do so. The Guidance affirms that an HIE, as a business associate, can maintain a MPI and a Registry for patients of participating providers, in advance of any actual treatment communications for those patients.

State Laws

The MCMRA is substantively consistent with HIPAA with regards to implicit consent and the other HIPAA issues discussed in the preceding section. Under the Act, an individual's health information may be exchanged among healthcare providers with only implicit consent for treatment purposes. In 2007, the Maryland Attorney General issued an opinion related to the MCMRA which addressed the requirement of a patient opt-in versus opt-out policy in an electronic health records system. According to the opinion, a patient does not have a right under the Act to opt-out of an HIE, to receive services from a health care provider while insisting that the medical records related to that service be excluded from the HIE. The Attorney General went on to conclude that the disclosure of medical record information solely for purposes

of clinical care and payment and to the technical personnel needed to keep the system operational, as discussed above, is permitted without the authorization of the patient. The MCMRA does not prohibit an HIE from operating on the basis that participating health care providers must make all of a patient's medical records available through the HIE. However, because the law does not dictate appropriate policy, an important caveat to the interpreted allowance is that making a patient's medical records available does not imply those records are stored within the exchange.

In the opinion, the Attorney General concluded that the MCMRA would permit an HIE in which medical records are held by certain providers and referenced in the MPI facilitating other providers' access to the records as needed without the authorization of the patient. This indexing function is a critical element of the approach in Maryland. Provider workflow considerations and management of a patient's right to participate or to not participate are also of considerable concern in creating a consent policy. If patient participation rights were managed on a provider-by-provider, encounter-by-encounter basis, then providers would bear a significant, and potentially prohibitive, technical and workflow burden establishing processes for obtaining and tracking consent of their patients.

Policies and Procedures

The policies governing the exchange will be established by the Policy Board associated with the MHCC. This separation of responsibilities assures a strong role for the public in both policy development and operational oversight. Members of the Policy Board have been selected to assure expertise, breadth of stakeholder representation, and a strong consumer voice in establishing the policies essential to building trust. Policies developed by the Policy Board will enable and foster information sharing with the state and eventually across state boarders.

Service delivery of the statewide HIE will operate under the guidance of the Advisory Board. In general, services are rendered with the agreement, amounting to the consent of the patient whose information is being exchanged. As a baseline process, consumers will be notified about the existence of the HIE and their ability to opt-out of all exchange participation, meaning they will have a choice to disallow their health information from being transmitted to an authorized recipient. The notice will describe the HIE, its purpose, and its functions. In effect, opting out will be the equivalent of being placed on a do not call or global suppression list. For certain other Use Cases and associated data, opt-in patient consent protocols will be required in addition to the consent implied by not opting out.

In practice, this means all patients will be in the exchange by default, unless they request not to be included. For those consumers that participate, the exchange will be available for a variety of purposes, some of which will require additional patient consent or authorization under HIPAA and the MCMRA, and some of which will operate without explicit patient approvals. By way of example, specific consent would be required to provide identifiable patient information to a longitudinal research study of the natural cause for an illness in the community and the effects of treatment. On the other hand, a laboratory will not seek any additional patient consent before transmitting lab results across the HIE to an ordering physician.

Opt-Out as the Baseline Consent Process

The statewide HIE will function on an opt-out principle. By default, demographic information from any patient treated at a participating provider organization could be included in a MPI hosted by the exchange. Basic personal information such as name, gender, address, and birth date would be transmitted, captured, and stored in secure computers owned or contracted for use by the statewide HIE. A separate Registry

database, which is core component of the HIE technology, will house information or metadata for what type of health information about a particular patient is in the exchange and where that information can be found. Both technical and privacy justifications drive the need for separate MPI and Registry databases, which is the preferable method, instead of keeping all patient identifying and record locating information in one database. This decision is a result of the work completed by the stakeholder workgroups during the *HIE Planning Phase*. A consumer's health information will not be captured and stored by the statewide HIE, and will remain with the participating entities. The statewide HIE will only serve as the roadmap and transport mechanism to find and retrieve records.

Hospitals and other providers will allow consumers greater control of those records published to the statewide HIE. The statewide HIE will allow consumers the right to opt-out of the HIE and to be informed of a provider's access to and use of their health information at the point of care or through a web-based portal connected to the statewide HIE. If a consumer elects to opt-out, the statewide HIE will not have the ability to access that consumer's health information. However, some demographic data will likely be transmitted and stored in the MPI hosted by the HIE. Storing limited demographic data in the MPI is necessary in the event that the consumer decides to opt-in at another time. The statewide HIE will inform consumers of their participation rights through an intensive outreach campaign. The statewide HIE will implement a simple and transparent opt-out process at each point of care within the HIE.

Trust Agreements

Any health information exchange will require the development of a participation agreement that will codify the relationship between the HIE organization and the various participants. The statewide HIE will enter into a Data Use and Reciprocal Support Agreement (DURSA) with the participants of the statewide HIE. The statewide HIE DURSA will be developed using the work from HITSP and will be used for harmonizing data sharing efforts with bordering states and the NHIN. One of the challenges in creating such an agreement is that multiple participants, each of whom may have its own in-house legal counsel, will have to agree on the components and structure of the document. The logic behind arriving at a consistent participation agreement that is entered into by each participant without substantial or material modification is to ensure that transitive trust can be achieved and maintained across the statewide HIE.

Oversight of Information Exchange and Enforcement

The appropriate use policy is a document that will be included in the participation agreement defining specific appropriate and inappropriate uses of the statewide HIE by individuals who have been granted access. The participation agreement will also articulate the consequence of misuse. It is impossible to completely eliminate the possibility of breaches and misuse of information. Though the statewide HIE itself is not necessarily a HIPAA-covered entity, any related business associate agreements would render the business associate responsible for adequately safeguarding PHI. The Policy Board and the governance of the statewide HIE will mitigate the probability of breaches and misuse through appropriate policies, systems monitoring, and established security, training, and reporting procedures.

Pre-emptive measures must be taken to reduce the likelihood that health information is used for purposes other than those for which it was intended. Establishing policies and procedures and training personnel are two important actions that should be taken. All policies and procedures should be clearly written to enforce privacy standards and communicated to staff accordingly. As part of the anticipated work to be performed under the Regional Center grant by CRISP, physician practices will receive information related to best

practices for workforce members with access to PHI. The education material will focus on education to better understand privacy and security standards.

In the event that a breach does occur, appropriate sanctions will be in place and enforced against any workforce member who violated proper procedures. Additionally, attempts must be made to rectify the extent of harm caused. For example, the individual whose data was compromised will be informed of the breach so that he or she can take necessary protective precautions. However, excellent design coupled with breach reporting is not sufficient protections for personal health information. The statewide HIE will also employee penetration testing to assure that the robust security features function as designed and that other potential vulnerabilities are actively tested. Penetration testing will be performed by the core infrastructure vendor on a quarterly basis and an annual penetration test to be conducted by an independent third party.

Operational Plan for a Statewide HIE

General Topic Requirements

Coordinate with ARRA Programs

The MHCC will use funds from the *State Health Information Exchange Cooperative Agreement Program* to advance Use Case implementation throughout the statewide HIE. The statewide HIE will explore opportunities to collaborate with the recipients of ARRA funding related to workforce development initiatives, wellness and prevention programs, comparative effectiveness research, and grants to community health centers. Under the current operational plan, the statewide HIE will also be the recipient of the potential Regional Center grant.

Regional Center

The statewide HIE will implement outreach, education, and technical assistance programs within Maryland's 23 Counties and Baltimore City consistent with the meaningful use criteria. The Baltimore metropolitan area is initially targeted for program development based upon the high volume of priority primary care providers and the availability of the Internet. Program development efforts initially will focus on priority primary care providers, although all providers are expected to receive some guidance from the Regional Center. MHCC maintains a physician licensure database that contains practice level information that is updated annually through the state's physician licensure process. The data includes information related to HIT adoption, among other things, that will be used in developing specific initiatives for the Regional Center. Although the statewide HIE will be involved broadly in education and support, the ARRA funded activities will focus specifically on improving and expanding HIE services to reach all health care providers in an effort to improve the quality and efficiency of health care.

Education and Outreach to Providers

The statewide HIE will contract with a faith-based organization, a safety net organization, the state medical society, and the hospital association to complete the work of the Regional Center. Specific outreach, education, and technical assistance initiatives will be developed using the physician database should the statewide HIE receive a formal request from ONC to submit a full application for Maryland. The statewide HIE will provide select assistance to providers in conducting an appropriate needs assessment, selecting and negotiating with system vendors or resellers, implementing project management, and instituting workflow changes to ultimately improve clinical performance and outcomes. More granular activities will be identified as the supporting organizations begin their field work.

The statewide HIE will coordinate with the Health Information Technology Research Center (HITRC) to participate in regional and national activities. Representatives of the statewide HIE will evaluate information from the HITRC and incorporate selected information into the Regional Center's outreach, education, and technical assistance plan. Maryland plans to host regional meetings, as appropriate.

EHR Implementation

The statewide HIE will assist providers in assessing their HIT needs, and in the selection and negotiation of EHR systems, hardware, and software contracts with vendors or resellers. The MHCC currently has

negotiated EHR system pricing with roughly 27 EHR vendors that have received 2008 certification from the CCHIT. This program was developed in an effort to leverage volume discounts and assure a high level of service for all providers. The statewide HIE will build upon the MHCC bulk purchasing program, which offers discount pricing of EHR software, to include technical support services. The use of MSOs that offer hosted EHRs through the Internet will provide a suitable alternative to providers. Maryland is taking steps to designate MSOs that meet certain performance standards related to technology and policy.

The statewide HIE will provide project management support for EHR implementations, including on-site coaching, consultation, troubleshooting, and other-related activities. These activities will assure that providers are able to assess and enhance organizational readiness for HIT, configure the software to meet practice needs and enable meaningful use, ensure adequate software training for all staff, and track and adhere to implementation timelines. The statewide HIE will also provide consultative support for workflow redesign necessary to achieve meaningful use and assist providers in connecting to the statewide HIE, and NHIN as available.

Privacy and Security Best Practices

While a collaborative with strong provider representation will develop and operate the HIE, the MHCC Policy Board will be established as part of the governance to develop the policies governing the exchange of patient information. The policies will focus on consumer authorization and consent, minimum criteria for user authentication, minimum requirements for role-based authorization, security requirements, and audit trail requirements. The Policy Board will also review and comment on standard Business Associate trust agreements used by the statewide HIE.

Progress towards Meaningful Use

The statewide HIE will participate in program training offered by the HITRC and make available to providers effective assistance in attaining meaningful use. Through collaboration with other states and the HITRC, the statewide HIE will implement programs that are not duplicative of other meaningful use efforts. Information related to HIT adoption will be used from the physician licensure database each year to assess the level of adoption and use of clinical support features essential for meaningful use.

Workforce Development

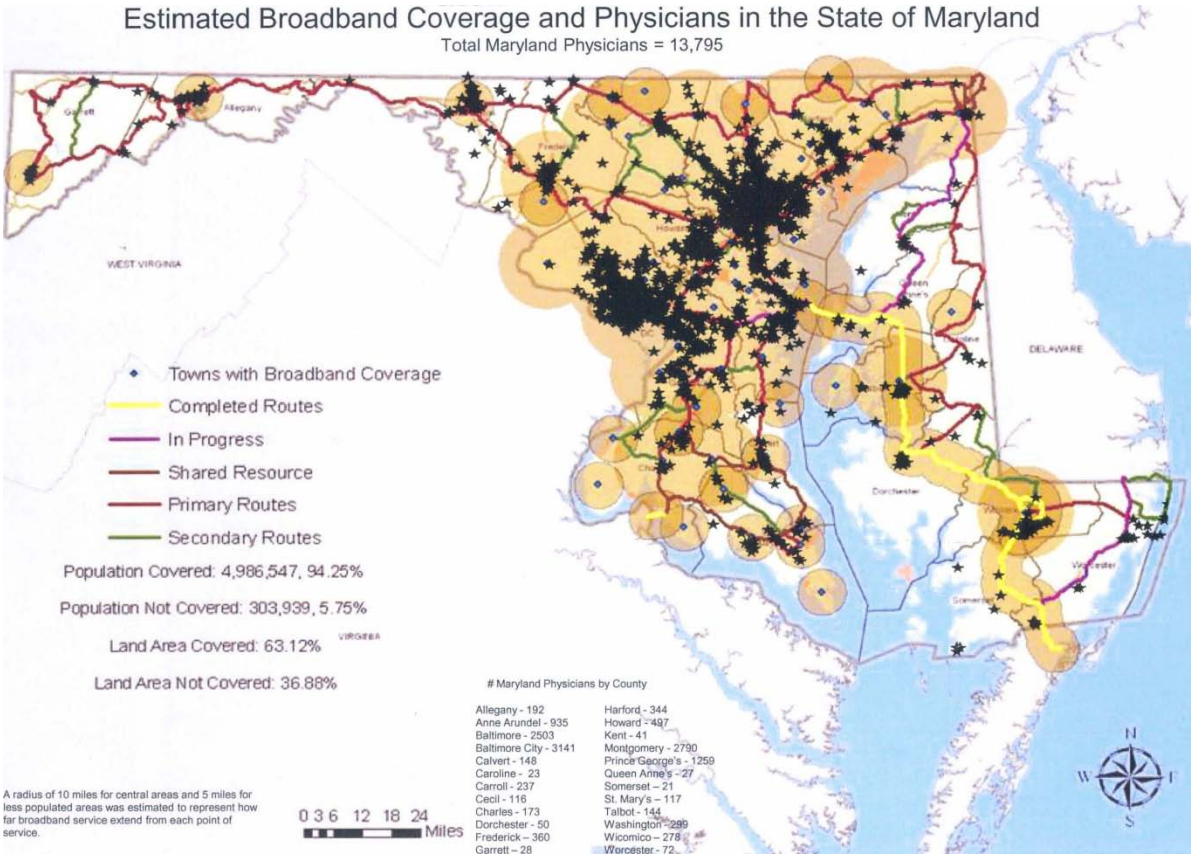
The statewide HIE will work with academic institutions to promote integration of HIT into the training of health professionals and support staff. MHCC has already entered into discussions with The Johns Hopkins Bloomberg School of Public Health. The Maryland Association of Community Colleges (MACC) will be contacted to discuss the state's practical needs with regard to implementing an HIE. Each year, nearly 500,000 individuals attend one of Maryland's 16 community colleges, in both credit programs and in continuing education and workforce development courses. The statewide HIE will seek to employ trained professionals from workforce development programs under ARRA when available.

Broadband Mapping and Access

The statewide HIE will use broadband mapping data that includes physician and practice level locations in determining target areas for connecting providers to the HIE. Maryland is home to approximately 5,035 primary care providers in about 2,325 practices that provide care. The statewide HIE will be implemented across the state on an incremental basis. Eventually, data sharing will be on the level of computable semantic interoperability, which will ensure that all health information is securely delivered electronically

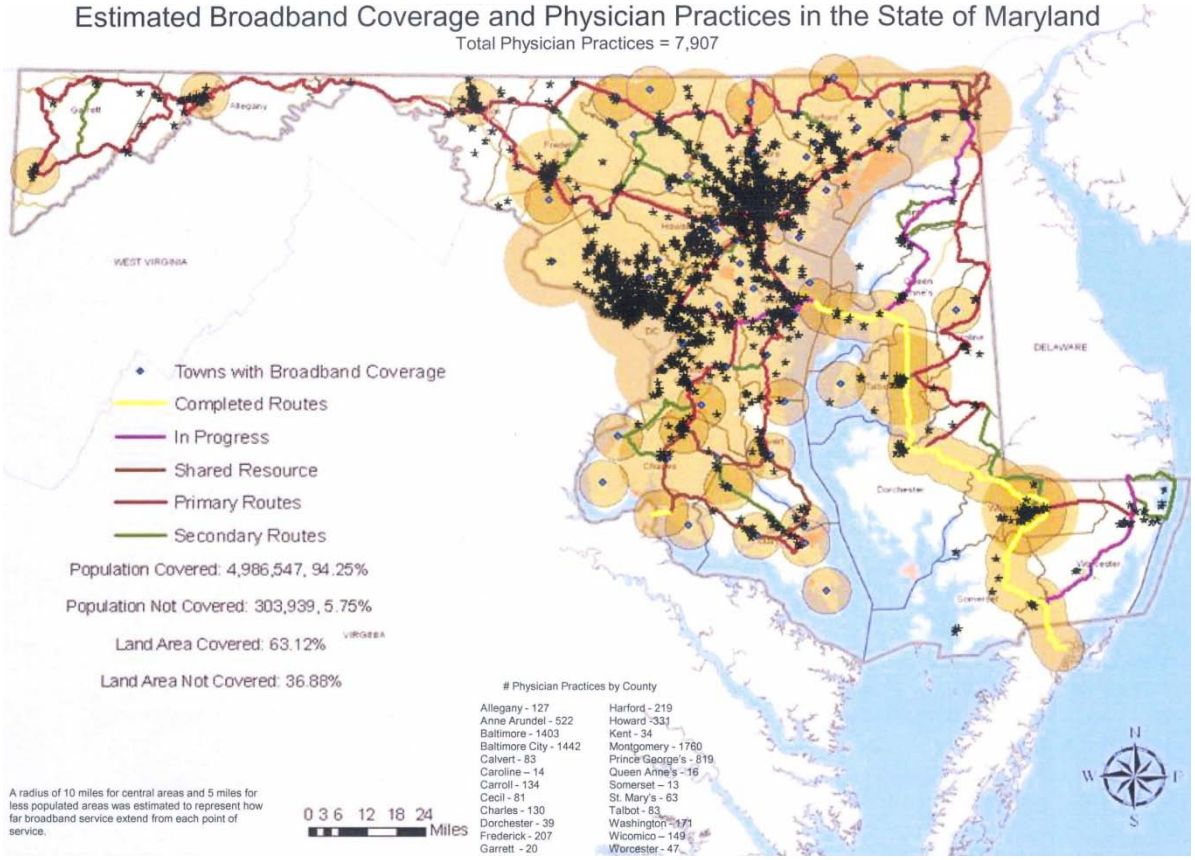
in real-time to individuals and their providers when needed. All 47 acute care hospitals in Maryland have access to a high speed Internet connection. Statewide, approximately 17 percent of hospitals have implemented electronic data sharing initiatives with providers in their service area. These hospitals typically host the technology that enables a one-way transfer of a limited amount of data with a high speed Internet connection.

The statewide HIE will initially connect and offer some form of technical assistance to priority primary care providers located in Central Maryland, which has broadband coverage. This part of the state accounts for approximately 85 percent of the providers in Maryland. By the end of the second year, all providers will be familiar with where they can find resource information regarding the HIE and additional information related to HIT. Connection will occur incrementally with roughly 25 percent targeted for the first year, and similar increments in subsequent years. The statewide HIE will work with the Maryland Department of Natural Resources, Office of a Sustainable Future to facilitate provider connections to statewide HIE in Western Maryland, Southern Maryland, and the Eastern Shore. It is anticipated that connections in these areas will begin in 2011.



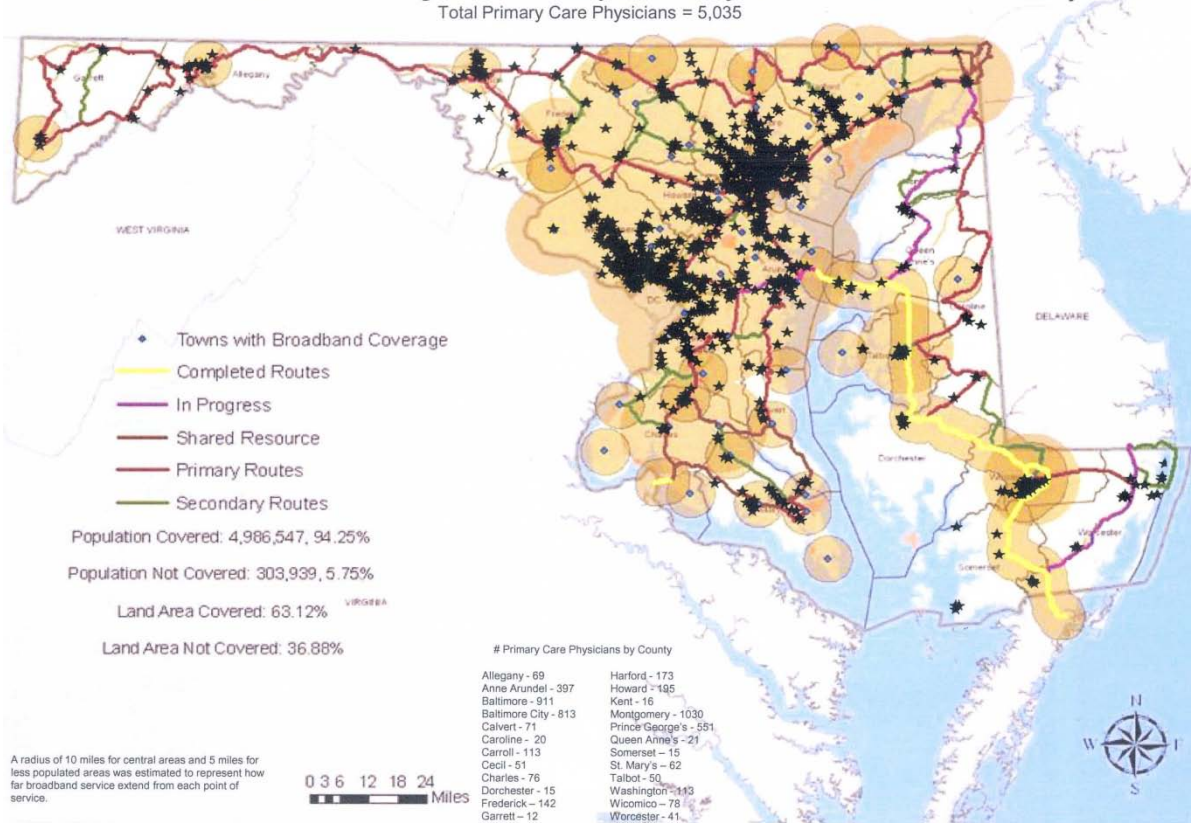
Estimated Broadband Coverage and Physician Practices in the State of Maryland

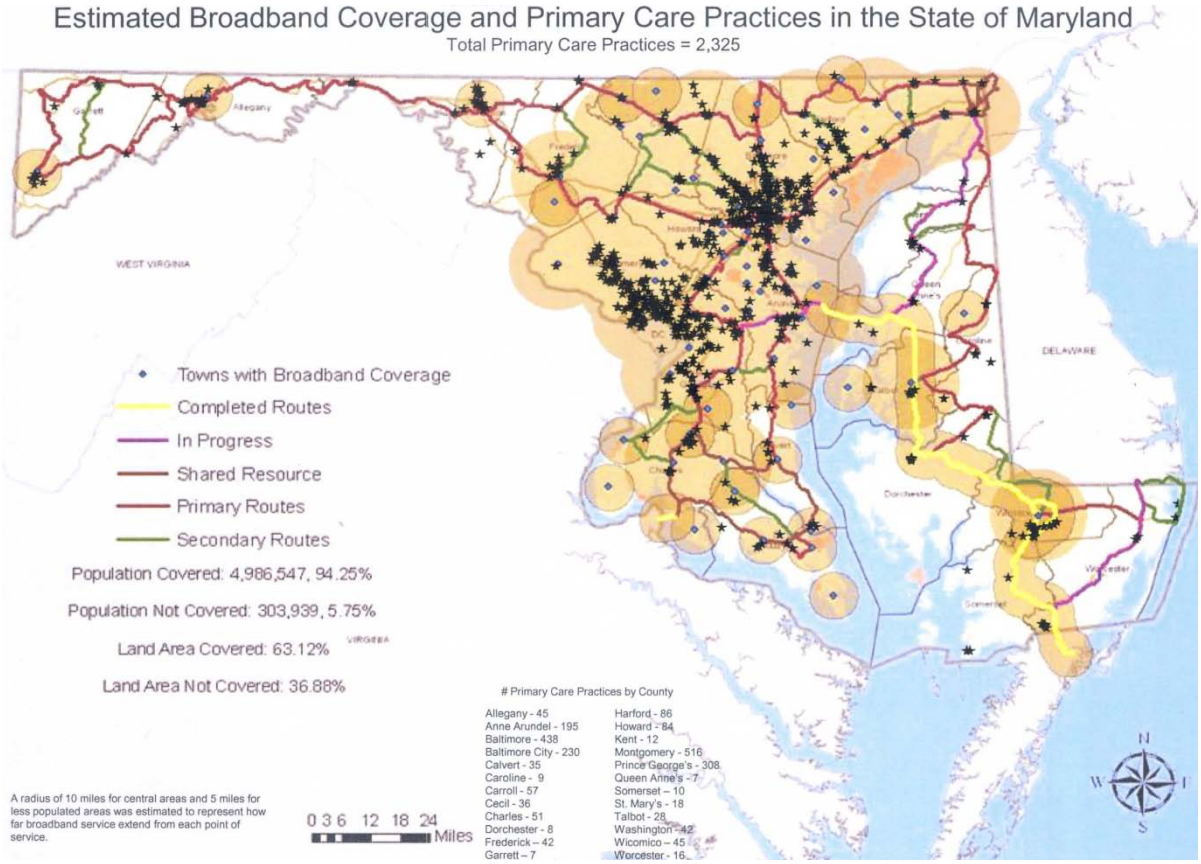
Total Physician Practices = 7,907



Estimated Broadband Coverage and Primary Care Physicians in the State of Maryland

Total Primary Care Physicians = 5,035





Coordinate with Other States

MHCC has been in communication with the District of Columbia, Virginia, Delaware, Pennsylvania, and West Virginia to discuss the strategies they have used for implementing their HIEs. This collaboration has provided a mechanism for Maryland to share lessons learned, identify the challenges, and discuss various unique policy-related issues. Discussions around technology evaluation, selection, and implementation have also occurred. Most recently, MHCC participated in the National Governors Association Center for Best Practices State Alliance for e-Health Regional IT Consultation meeting. Participating states explored challenges related to implementing HIE and established information sharing networks with other states. MHCC expects to continue building communications with other states over the next year and exploring opportunities to share lessons learned as it moves forward with implementing the statewide HIE. Beginning in 2010, MHCC will participate in quarterly meetings with representatives from bordering states to discuss interstate HIE connectivity.

Medicaid Coordination

The Maryland Department of Health & Mental Hygiene, Office of Systems, Operations, and Pharmacy (DHMH OSOP) assessed the current State of the Maryland Medicaid Management Information System (MMIS) along with the current Medicaid processes serves as the framework in the transition plan to align with the federally mandated Medicaid Information Technology Architecture (MITA) requirements. Existing DHMH OSOP plans outline the replacement of its legacy MMIS claims processing system. The replacement MMIS system is base on MITA 2.0 principles that will include imaging and workflow management, and a robust

business rules engine to aide in creating and managing flexible benefit plans. The new MMIS will process all Medicaid claims and eliminate the duplicative adjudication of the Mental Hygiene Administration (MHA), Developmental Disabilities Administration (DDA), and dental claims. The new MMIS system will also support coordination of benefits, surveillance and utilization review, federal and management reporting, case management, and the statewide HIE. In conjunction with the MMIS replacement, DHMH intends to add a Decision Support System (DSS); implement a Service Oriented Architecture (SOA) Integration Framework to provide a platform for the system that will enable better interoperability with existing legacy applications; and develop a Member and Care Management portal. These enhancements will help eliminate manual processes under programs such as:

- Medicaid Waiver Program Case Management;
- Home and Community-Based Services;
- Employed Individuals with Disabilities (EID);
- Primary Adult Care (PAC);
- Breast and Cervical Cancer;
- Rare and Expensive Case Management (REM);
- Traumatic Brain Injury (TBI);
- Disease Management;
- Catastrophic Cases; and
- Healthy Start Program.

The SOA Integration Framework enables a bi-directional real-time interface with the State's Client Automated Resources Eligibility System (CARES) and the statewide HIE to facilitate better access to the complete eligibility record, resolve data integrity issues across systems, improve claims payment accuracy by capturing the most current eligibility information, and support inter-agency coordination to provide appropriate and cost effective medically necessary care management services. The SOA Integration framework will eventually support an evolutionary approach to information sharing and integration for the Medicaid enterprise and the statewide HIE to allow the creation of a single source of a recipient's demographic, financial, socio-economic, and health status information.

Medicaid HIT P-APD Project

The HIT P-APD will serve as the framework to create the SMHP that outlines the strategic HIT vision for the Maryland Medical Assistance Program. The SMHP will lay the groundwork for achieving this vision by describing the current "As-Is" HIT landscape, the desired "To-Be" HIT landscape, and a comprehensive five year plan for expanding HIT using Medicaid Information Technology Architecture (MITA) principles and approaches as a foundation. The HIT P-APD activities also include planning to support the incentive payments for EHR systems authorized in Section 4201 of the ARRA. The Maryland Medical Assistance Program will use existing data included in the analysis for the HIT State Plan as the basis for assessing the "As-Is" landscape for Medicaid providers. The Medicaid Information Technology Architecture State Self-Assessment (MITA S-SA) will also provide critical information in determining the "As-Is" landscape of the Medicaid systems and HIT adoption and readiness of Medicaid providers. Objectives associated with this assessment include: determining the field of eligible providers, identifying barriers to acceptance of HIT by

providers, identifying barriers to acceptance of HIT by Medicaid beneficiaries, providing a foundation for identifying future goals and available resources by assessing the status of the current program and HIT environment; determining the interrelationships between Medicaid, Medicare and other populations as they relate to the adoption of HIT; and identification of policy issues where additional guidance from CMS may be required.

The Maryland Medical Assistance Program expects to develop a "To-Be" vision using HIT to improve health care quality and patient safety, promote care coordination and continuity, and assist in clinical decision making and the use of evidence-based guidelines. Consumer control over their health information and the development of sound policy related to access, authorization, authentication, and audit are essential components of the vision. The Maryland Medical Assistance Program will develop a Roadmap Plan with milestones and objectives that meets the meaningful use criteria in the proposed Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule. The Roadmap Plan will include overseeing the Medicaid incentive payment to eligible providers and readying nearly 5,901 Medicaid physicians to participate in the ARRA EHR incentives.

The SMHP will consist of a five year strategy to implement a Roadmap Plan that will address the administration of provider incentive payments, including provider eligibility determination, issuance and tracking of incentive payments, and auditing of financials and meaningful use. Objectives associated with these activities include: identification of short-term and long-term goals for the project; development of recommendations to ensure cost-effective strategies to be realized as part of the "To-Be" vision; establishing measurable benchmarks, milestones, tasks, and timelines to guide project progress; and establishment of the framework for the development of I-APD tasks and activities. The Maryland Medical Assistance Program will bring together various stakeholder workgroups to address particular components of the Roadmap Plan and to identify appropriate measurable benchmarks.

The five year strategy will be aligned with the MITA transition. The "To-Be" vision and Roadmap Plan will provide direction in the development of the transition plan with the MITA requirements. The Maryland Medical Assistance Program assessed the current Medicaid Management Information System (MMIS) along with the current Medicaid processes. This information will be used to develop a transition plan as part of the SMHP to align with the federally mandated MITA requirements. MITA is expected to modernize existing system functions and significantly enhance the goals of the MMIS. Replacing the existing legacy MMIS claims processing system with a new MMIS system based on MITA is part of the "To-Be" vision and Roadmap Plan.

The Maryland Medical Assistance Program will develop a HIT Implementation Advanced Planning Document (HIT I-APD) with the guidance of CMS, establishing specific implementation activities necessary to support the SMHP. Stakeholder involvement is a critical component in developing the HIT I-APD. The Maryland Medical Assistance Program plans to assemble stakeholder workgroups to fully address the objectives associated with this activity, and to develop a detailed approach to the implementation of the plan and obtain supporting FFP. The HIT I-APD development will be an iterative process; development of the document is expected to occur throughout the planning phase of the project.

The SMHP is a component of the state's HIT State Plan and reflects the high priority that Maryland places on advancing HIT in the state Medicaid program. Maryland's planning efforts have led to a comprehensive design to expand the use of certified EHRs and to facilitate and expand the secure, electronic movement and use of health information among providers according to nationally recognized standards. The state has taken an ambitious approach to advancing HIT that balances the need for information sharing with the need

for strong privacy and security policies, while maintaining a judicious approach to funding the initial development of a statewide HIE. The SMHP will serve as Maryland's five year strategic plan to expand EHR adoption among Medicaid providers and to ensure connectivity with the statewide HIE in a manner consistent with the existing HIT State Plan. Developing a SMHP that will become part of the HIT State Plan is an appropriate and timely next step to ensure that the state has a complete strategic and operational plan for a comprehensive HIT initiative in Maryland.

Coordination of Medicare and Federally Funded, State Based Programs

The statewide HIE is working with DHMH to develop reporting capabilities to allow DHMH to report required data to the Centers for Disease Control. Discussions with DHMH are already underway to develop a Use Case for testing in 2010. Data from the Medicaid long term care population will be made available through the HIE as part of the collaboration with DHMH on the MITA initiative. The statewide HIE will utilize many of the resources and tools developed by the Agency for Healthcare Research and Quality to assist Medicaid and the Children's Health Insurance Program in improving the delivery and coordination of care through exchanging electronic patient information. The statewide HIE will rely upon the Advisory Board to provide guidance to the work effort to implement data sharing with publically funded programs. The Advisory Board will provide monthly updates to the Board of Directors for the statewide HIE on the progress from implementing Use Cases with publically funded programs. The statewide HIE is expected to connect with the Veterans Affairs (VA) as an early Use Case in 2010. The Technology Infrastructure Committee, a subgroup of the Advisory Board, are currently considering the challenges related to an early Use Case with the VA. This includes mapping out the requirements for the technology and network configuration to support this Use Case. The Policy Board has begun deliberating on policies related to access and authorization as a general policy for a number of Use Cases, including the VA.

Participation with Federal Care Delivery Organizations

The statewide HIE will explore data sharing with the VA in 2010 and implementation will occur on a Use Case basis. The VA Maryland Health Care System is a dynamic and progressive health care organization dedicated to providing quality, compassionate, and accessible care and service to Maryland's veterans. The VA has successfully implemented a system-wide EHR in a health care system that serves nearly 6 million patients in more than 1,400 hospitals, clinics, and nursing homes. The Baltimore and Perry Point VA Medical Centers, the Baltimore VA Rehabilitation & Extended Care Center, and five community-based outpatient clinics all work together to form this comprehensive health care delivery system. Most of the physicians who work for the VA hold dual appointments at the University of Maryland, School of Medicine. The University of Maryland, School of Medicine is part of the University of Maryland Medical System, which is an active participant in the planning and implementation of the statewide HIE. The MHCC and the statewide HIE have had preliminary discussions around implementing a data sharing on select Use Cases in 2010. The Baltimore VA Medical Center given its close proximity to the University of Maryland School of Medicine will serve as a beta site for implementation of an early Use Case.

Coordination with the Nationwide Health Information Network

The technology specifications for the statewide HIE is based on federally endorsed standards and integration protocols that bridge proprietary boundaries. Using approved standards mitigates vulnerability to vendor selection issues and risks, and ensures compatibility with other HIEs and federal initiatives. The infrastructure of the statewide HIE is designed to enable flexibility while ensuring that the organization can

respond to market changes and eventually support data sharing with the NHIN. The core infrastructure technology vendor that was selected by the statewide HIE and the MHCC is Axolotl. The President and Chief Executive Officer of Axolotl, Ray Scott, has committed verbally and contractually to supporting only those standards approved by HHS. While the system currently includes some proprietary standards, a full migration to those standards supported by HHS is planned for the 3rd quarter of 2010. These modifications to the Axolotl system are expected to make it fully compatible with the Nationwide Health Information Network. Preliminary data sharing testing is scheduled to occur later in 2010.

Domain Requirements

Governance

The statewide HIE has established a governance structure that is inclusive of all stakeholders. The governance structure consists of the MHCC Policy Board, Board of Directors, and an Advisory Board with three committees: the Exchange Technology Committee, the Clinical Excellence and Exchange Services Committee, and the Finance Committee. Each committee has a specific set of objectives that they are charged with accomplishing. Policy recommendations that emerge from the Advisory Board will be forwarded to the Policy Board for deliberation. The Policy Board is convened by the MHCC and acts as an oversight body to ensure that public interests remain at the forefront in all decision-making. Policies developed by the Policy Board are forwarded to the Board of Directors for implementation. The Board of Directors provides oversight to the implementation of policies and operational activities. The Board of Directors is accountable for all aspects of the statewide HIE. The Advisory Board, Policy Board, and Board of Directors meet regularly.

The statewide HIE will operate under the oversight of an Advisory Board, which is accountable to the Board of Directors. The Advisory Board includes a diverse group of approximately 30 stakeholders to ensure that a breadth of interested organizations can make certain that the interests and perspectives of their respective constituencies are heard with respect to the HIE services. The statewide HIE's Board of Directors affirms their intentions and commitment to implement Maryland's HIE through their mission statement:

> *[CRISP's] mission is to advance the health and wellness of Marylanders by deploying health information technology solutions adopted through cooperation and collaboration. We will enable the Maryland healthcare community to appropriately and securely share data, facilitate and integrate care, create efficiencies, and improve outcomes.*

Enforcement

The statewide HIE Board of Directors are ultimately accountable for the accomplishments of the work effort. The Board of Directors, which consists of a number of stakeholders, have been actively involved in implementing data sharing projects within their communities, across their organizations, and at a state level. These individuals that constitute the Board of Directors are charged with ensuring that all aspects of the state plan have been implemented to the satisfaction of the MHCC. They have the authority to make any necessary changes within the CRISP organization to ensure that these goals are met. The Board of Directors also has enforcement of privacy and security and other policy issues. The Board of Directors has the authority to convene administrative hearings related to all aspects of the organization's activities in an effort to resolve issues. The MHCC has the authority to request action to be taken from the statewide HIE Board of Directors as deemed necessary by the event.

The MHCC Policy Board

The Policy Board represents roughly 25 stakeholders, with the majority of members representing consumers and broad public interest, as opposed to individuals representing health care interests, and includes ex-officio members from state government, including Medicaid, MHCC, and the Health Services Cost Review Commission. The statewide HIE is required to implement the Policy Board decisions, which has primary responsibility for developing policies pertaining to privacy and security, among other things. The MHCC has ex-officio representation on the Policy Board and the Advisory Board. The responsibilities of this Policy Board include, although are not limited to, the development of policies for enforcement of privacy and security and other policies consistent with the MCMRA as well as propose additional requirements under the MCMRA. The Policy Board has eight meetings scheduled in 2010 and will develop privacy and security policies, audit procedures, and identify additional legislation to bolster the MCMRA. Participants of the statewide HIE that violate the DURSA will be subject to penalties that range from an initial warning to expulsion of privileges to the statewide HIE. These actions will also be defined by the Policy Board in 2010.

Board of Directors

The statewide HIE Board of Directors consists of nine members and is critical to the strategic and operational effectiveness of the statewide HIE. The Governance bylaws provide a mechanism for the addition of member organizations to the statewide HIE; and with agreement of the members of the Board of Directors, its composition can change as long as these revisions do not have an untoward impact on common governance best practices and legal considerations, including those for tax-exempt organizations.

Advisory Board

The statewide HIE operates under the oversight of an Advisory Board. This Advisory Board is broad based to ensure that a breadth of interested organizations can make certain that the interests and perspectives of their respective constituencies are heard with respect to the statewide HIE's services. The mission statement affirms that the HIE will serve the entire Maryland health care community. The Advisory Board assists the Board of Directors and the Policy Board of the statewide HIE to ensure that this mission is fulfilled. Certain members of the Advisory Board sit on multiple committees, but most individuals are only in one. A single committee is comprised of approximately 10 people. Individuals selected by the Board of Directors by a nomination process were chosen on the basis of deep subject matter expertise. The Advisory Board's responsibilities include, though are not limited to:

- Provide strategic guidance on the adoption of evolving technology standards;
- Make recommendations for procurement and management of technology solutions, through RFP response scoring and performance evaluation;
- Evaluate the development of implementation project plans and methodologies;
- Recommend prioritization for clinical Use Case deployment;
- Provide input for the evaluation of clinical effectiveness of HIE services;
- Build community trust through effective implementation of policies established by the Policy Board;
- Expand provider awareness and participation in the HIE;
- Aid in the development of patient education and outreach materials;

- Help balance the interests of the many stakeholders in the state;
- Evaluate business plans, and particularly the impact of service fees;
- Assist in the pursuit of funding to further the aims of the HIE;
- Ensure that the plans for specific Use Cases will preserve the financial health of the HIE; and
- Promote transparency in the operation of the HIE, ensuring that the general public has ready access to the operational policies and information about the HIE.

Committees

The statewide HIE Advisory Board is organized into three standing committees. Each committee has a chair, and most of the work done by the Advisory Board will be accomplished at the committee level. Certain members of the Advisory Board, such as the representatives of the MHCC, will sit on multiple committees, but most individuals will sit on just one. Any individuals beyond those positions listed in the RFA would be selected on the basis of deep subject matter expertise. The committees include:

1. Exchange Technology
2. Clinical Excellence and Use Cases
3. Finance and Community

Oversight by the MHCC Convened Policy Board and the Commissions

The decisions of the Policy Board will be enacted and augmented by the governance structure of the HIE. Bi-directional communication between the Policy Board and the statewide HIE governance structure is important and will help ensure no disconnect between policy creation and that which is technically feasible or practical. Cross-membership between the Advisory Board and the Policy Board is an appropriate mechanism to facilitate that communication. Included on the Policy Board is a senior level representative from the Maryland Medical Assistance Program (Medicaid). This individual actively participates on the Policy Board and is tasked with making recommendations that will impact the Medicaid program, in consultation with Medicaid's senior leadership. The statewide HIE and the executive leadership at Medicaid meet routinely to discuss the needs of Medicaid in the statewide HIE. The leadership of the statewide HIE meets with the leadership of state-based payers in Maryland, as well.

Policy Board Members

HIE Policy Board					
	Name		Title	Organization	e-Mail
1	Doug	Abel*	Vice President, Chief Information Officer	Anne Arundel Medical Center	dabel@aahs.org
2	Salliann	Alborn*	Chief Executive Officer	Community Health Integrated Partnership	salborn@mdhealth.net
3	Barbara	Blount Armstrong	Consultant	Armstrong Enterprises	BArmstro5@aol.com
4	Cindy	Boersma	Legislative Director	ACLU of Maryland	boersma@aclu-md.org
5	Marilyn	Burnett	Executive Director	Older Women Embracing Life	marilyn606@comcast.net
6	Peter	Chow	Administrative Supervisor	CCACC	ccaccadhc@gmail.com
7	Beverly	Collins	Physician, Medical Director	CareFirst	Beverly.Collins@CareFirst.com
8	Lee	Cotton	President	Higher Ground, Inc	lcotton@highergroundmd.com
9	Damien	Doyle	Physician, Medical Director	Hebrew Home of Greater Washington	doyle@hebrew-home.org
10	Brian	England	Owner	British American Auto Care	beengland@comcast.net
11	Gene	Gary-Williams	Executive Director	The National Society of Allied Health	ggarywilliams@gmail.com
12	Shannah	Koss*	Consultant	Koss on Care	kossoncare@starpower.net
13	Peggy	Leonard*	Senior Director, Inpatient Systems	Genesis Healthcare	margaret.leonard@genesishcc.com
14	Carey	Leverett	Vice President, Information Systems	Washington County Health Systems	leverett@wchsys.org
15	Tom	Lewis*	Physician, Chief Information Officer	Primary Care Coalition of Montgomery Co.	tom_lewis@primarycarecoalition.org
16	Ellen	Maltz	Business Medical Relationship Manager	M&T Bank	EMaltz@mtb.com
17	John	Nugent*	President, Chief Executive Officer	Planned Parenthood of Maryland	John.Nugent@ppmaryland.org
18	Kurt	Olsen	Attorney	Klafter and Olsen	ko@klafterolsen.com
19	Marcos	Pesquera	Executive Director	Center on Health Disparities	mpesquera@ahm.com
20	Frances	Phillips	Deputy Secretary for Public Health Services	DHMH	fphillips@dhmh.state.md.us
21	William	Prescott	Physician	Brook Lane Health Services, Inc.	oregon@aol.com
22	Chris	Shea	Clinical Director	Father Martin's Ashley	chrismd104@gmail.com
23	Liza	Solomon	Consumer Member	Consumer Member	Liza_Solomon@Abtassoc.com
24	Sarah	Tucker	Technology Safety Specialist	National Network to End Domestic Violence	st@nnedv.org
Ex-Officio Members					
25	Scott	Afzal*	Director	Audacious Inquiry	scott@audaciousinquiry.com
26	Rex	Cowdry*	Physician, Executive Director	MHCC	rcowdry@mhcc.state.md.us
27	Cindy	Friend*	Division Chief, HIT and Special Projects	MHCC	cfriend@mhcc.state.md.us
28	David	Horrocks*	President	CRISP	david.horrocks@crisphealth.org
29	Steve	Ports*	Principal Deputy Director	HSCRC	Sports@hscrc.state.md.us
30	Tricia	Roddy*	Director of Planning	DHMH	RoddyT@dhmh.state.md.us
31	David	Sharp*	Center Director	MHCC	dsharp@mhcc.state.md.us

** Denotes participation on the Policy Board Subgroup*

Policy Board Meeting Schedule

Date	Location	Time
January 19, 2010	Community Health Integrated Partnership	2:00 p.m. to 4:00 p.m.
March 1, 2010	Anne Arundel Medical Center	2:00 p.m. to 4:00 p.m.
April 13, 2010	Maryland Health Care Commission	2:00 p.m. to 4:00 p.m.
May 25, 2010	Community Health Integrated Partnership	2:00 p.m. to 4:00 p.m.
July 13, 2010	Anne Arundel Medical Center	2:00 p.m. to 4:00 p.m.
August 17, 2010	Maryland Health Care Commission	2:00 p.m. to 4:00 p.m.
September 28, 2010	Community Health Integrated Partnership	2:00 p.m. to 4:00 p.m.
November 9, 2010	Anne Arundel Medical Center	2:00 p.m. to 4:00 p.m.
January 11, 2011	Maryland Health Care Commission	2:00 p.m. to 4:00 p.m.

Statewide Health Information Exchange

Policy Board Operating Guidelines

Purpose

The Maryland Health Care Commission (MHCC) has assembled a Policy Board with responsibility for general oversight of the state's health information exchange, including the authority to evaluate and recommend to the MHCC the policies that will govern the statewide health information exchange. The MHCC selected the members based upon their expertise, with a strong emphasis on achieving both broad stakeholder representation and a strong consumer orientation. The existence of a Policy Board that is separate from the administration of CRISP assures participation by the public in both policy development and operational oversight.

The purpose of these Operating Guidelines is to set forth succinctly how the Policy Board will function. The Operating Guidelines are effective when adopted by the Policy Board and may be changed by a vote of the majority of the Policy Board.

Responsibilities of the Policy Board

The responsibilities of this Policy Board include, although are not limited to, the development of policies for privacy and security, which the MHCC will adopt and the health information exchange will implement. In particular, the Policy Board will establish policies regarding consumer authorization and consent, user authentication, role-based authorization, security requirements, and audit trail requirements. In addition, further policies may include the architecture of the exchange, use case priorities and implementation, consumer access and control, provider access, financing, and secondary uses of data. The Policy Board will develop policies that ensure a high level of protections for the statewide health information exchange.

Although the Policy Board is formally an advisory body reporting to the MHCC, the expectation is that the MHCC, through its control of the federal and Maryland all-payer funding of the exchange, will assure that the policies developed and recommended by the Policy Board are implemented by CRISP. In the unlikely event that the MHCC reaches a preliminary decision not to implement a recommendation of the Policy Board, the Commission's concerns will be brought to the Policy Board for further discussion before any final decision is reached.

Chair

The Executive Director of the MHCC or his designee will chair the Policy Board. The Chair, with the consent of the Policy Board, may establish special committees and appoint members to serve on the committees.

Frequency and Location of Meetings

The Policy Board will meet approximately eight times per year. The meeting schedule detailing the location and time of the meetings are available on the Policy Board webpage located on the MHCC website at: http://mhcc.maryland.gov/electronichealth/hie_policy_board/index.html.

Policy Board members will also receive meeting notification via e-mail approximately one week prior to the meeting date. The notification will include a reminder about the date, time, and location of the meeting, and instructions regarding any meeting materials posted on the Policy Board webpage. Policy Board members are encouraged to print out meeting materials and bring them to the meeting.

Members are requested to confirm their participation in meetings upon receipt of the meeting notification e-mail. Members are encouraged to schedule the designated days for Policy Board meetings on their calendars in advance for the entire 2010 year.

Committees will meet as determined by the Chair of the committee, commonly by conference call using numbers provided by the MHCC.

Communication

Communication with the Policy Board and among its members will be mostly through the listserv, hie@mhcc.state.md.us, and by posting of information on the webpage previously mentioned. Information related to Committee activities and recommendations will also be posted to the Policy Board webpage.

Agenda

The MHCC will develop an agenda for each meeting and post it on the Policy Board webpage approximately one week prior to the meeting. The agenda and any supplemental information to the meeting will be provided to the Policy Board members for discussion during the meeting. The agenda will also note the issues to be presented for decision, for discussion, or for information.

Minutes

The MHCC will electronically record each meeting of the Policy Board and may use the recording to identify key discussion items to include in the minutes when available. The MHCC will post the minutes on the Policy Board webpage approximately ten days following each meeting. Policy Board members may suggest revisions to the minutes at the beginning of each Policy Board meeting.

Decision Making Process

The Policy Board will use Roberts Rules of Order to guide decision making; however, a more informal process of discussion and deliberation may also be used if no objection is raised by a member of the Board, and decisions made by a more informal process will have the same force and effect. A quorum shall consist of the majority of Policy Board members in attendance. All formal policy actions must be proposed by a member of the Policy Board in the form of a motion and seconded by another Policy Board member. The motion will be discussed and a vote taken with a majority rule. Any motion not adopted unanimously will have the exact vote recorded in the minutes.

Policy Board members can nominate decision items as warranting greater consensus among board members due to their high sensitivity and impact to consumers. If a majority of members agree to the designation, decision-making will require a super majority vote, or approximately 75 percent agreement by the Policy Board.

Non-Agenda Items

Policy Board members may discuss matters and make recommendations on issues not on the agenda. Policy Board members introducing an issue may request that a decision on it be made during the meeting in which it is introduced. If any member requests time for further consideration, no action will occur until the item has been placed on the agenda for a subsequent meeting as a decision item.

Open Meetings

All meetings of the Policy Board are open to the public. The Policy Board may invite the public to present on specific topics, either on its own initiative or in response to a request from a member of the public. The time permitted for presentations from the public or members shall be decided by the Chair with the advice of the Policy Board, and such limits shall be reasonable and related to the agenda and the importance of the topic.

Tenure

The Policy Board assures a strong role for the public in both policy development and operational oversight of the statewide health information exchange. Policy Board members shall serve for a term of three years, and may be reappointed to serve one additional term. Continuity of the membership is essential to developing policies that will foster authorized, private, and secure information sharing within the state and eventually across state borders.

Statewide HIE Bylaws *(as provided by CRISP)*

BYLAWS
of

CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS, INC.

ARTICLE I
NAME

1.1. Name. The name of the Corporation is Chesapeake Regional Information System For Our Patients, Inc. (hereinafter "Corporation").

ARTICLE II
REGISTERED OFFICE AND AGENT

2.1. Registered Office and Agent. The registered office of the Corporation is at 701 Maiden Choice Lane, Baltimore, Maryland 21228. The registered agent in charge thereof is Gerald Doherty.

ARTICLE III
PURPOSES AND POWERS

3.1. Nonstock Corporation. The Corporation shall be a Nonstock Corporation under the laws of the State of Maryland.

3.2 Purposes and Powers. The Corporation is organized and will be operated exclusively for charitable and educational purposes, specifically to promote health through the development, ownership and operation of a health information exchange.

The affairs and activities of the Corporation shall be carried out at all times for the purposes and in accordance with the terms set forth in its Articles of Incorporation and these Bylaws, and in conformity with all applicable provisions of the Internal Revenue Code of 1986, as amended, (the "Code") affecting nonprofit organizations qualified for tax-exempt status as described in section 501 (c)(3) of the Code.

ARTICLE IV
MEMBERS

4.1. Members. The corporation shall have three (3) classes of members, Class A Members, Class B Members and Class C Members (collectively, the “Members”).

4.2 Qualifications of Members.

4.2.1 Class A Members The Class A Members shall be the entities identified as Class A Members on Schedule A of these Bylaws, which schedule shall be updated as necessary by the Secretary of the Corporation.

4.2.2 Class B Members The Class B Members shall be the entities identified as Class B Members on Schedule A of these Bylaws, which schedule shall be updated as necessary by the Secretary of the Corporation.

4.2.3 Class C Members The Class C Members shall be the entities identified as Class C Members on Schedule A of these Bylaws, which schedule shall be updated as necessary by the Secretary of the Corporation.

4.2.4 Member Representatives The institutions comprising the Members shall have the authority and sole discretion to select the individuals who will represent such Members in attending meetings, taking action, or otherwise participating in the affairs of the Corporation. Each Member represents and warrants

that any such individual duly selected by them shall have the requisite corporate authority to act on their behalf.

4.3 Member Rights.

4.3.1 Class A and Class B Member Rights In addition to those rights granted by law, the Articles of Incorporation, and the provisions of these Bylaws, each Class A and B Member shall have the following rights with regard to the Corporation:

(a) To vote on any matters before the Members;

(b) To appoint and remove two (2) Directors as provided in Section 6.3;

(c) To select one or more representatives who may attend and speak at meetings of the Members and receive a copy of any materials made available to the Members but who shall not have the right to vote as a Member.

4.3.2 Class C Member Rights In addition to those rights granted by law, the Articles of Incorporation, and the provisions of these Bylaws, each Class C Member shall have the following rights with regard to the Corporation:

(a) To vote on any matters before the Members;

(b) To appoint and remove one (1) Director;

(c) To select one or more representatives who may attend and speak at meetings of the Members and receive a copy of any materials made available to the Members but who shall not have the right to vote as a Member.

4.4 Member Financial Support. The Members have contributed or will contribute to the capital of the Corporation in such amounts as described in Schedule B of these Bylaws. The Members shall not be required to contribute any additional capital to the Corporation, except as provided in Section 6.16 of these Bylaws.

ARTICLE V
MEETINGS OF MEMBERS

5.1. Annual Meeting. The annual meeting of the Members shall be held during the month determined by the Board by resolution for the transaction of any business that comes before the Members.

5.2. Special Meetings. Special meetings of the Members may be called by the Chair, the Board of Directors, or a majority of the Members.

5.3. Place of Meetings. Meetings may be held at any place specified by the Board of Directors or the Members. If no designation is made for any meeting, the place of meeting shall be the principal office of the Corporation.

5.4. Notice of Meetings. Written notice, or electronic notice to the extent permitted by law, stating the place, date, and hour of any meeting of the Members shall be given to each of the Members no fewer than ten (10) days before the date of the meeting, either personally or by mail (or e-mail if electronic), at the direction of the Board Chair or the Secretary. In the case of a special meeting, the notice shall state the purpose or purposes for which the meeting is called.

5.5. Waiver of Notice. The Members may waive any notice requirement by signing a written waiver of notice and delivering it to the Secretary of the Corporation for inclusion in the minutes or filing with the corporate records. Attendance at a meeting shall constitute waiver of notice unless the Member, at the beginning of the meeting, objects to holding the meeting or transacting business at the meeting. Attendance at a meeting also waives objection to consideration of a particular matter at a meeting that is not within the purposes described in the notice, unless the Member objects to considering the matter when it is presented.

5.6. Quorum. The presence of a majority of the Members in person or represented by proxy shall constitute a quorum at a meeting of the Members. If a quorum is not present at any meeting, the Members at the meeting shall have the power to adjourn the meeting to another time or place without further notice. 5.7.

Vote Required. When a quorum is present at any meeting, the affirmative vote of a majority of Members who are present at the meeting or represented by proxy and entitled to vote on the matter shall be the act of the Members, unless by express provision of any applicable statute, the Articles of Incorporation, or these Bylaws, a different vote is required, in which case that express provision shall govern and control the vote. The Board shall adopt procedures for the use of proxy voting which may include electronic proxies if permitted by applicable law.

5.8. Informal Action by Members. Any action required by law or which otherwise may be taken at a meeting of the Members may be taken without a meeting and without prior notice if all of the Members entitled to vote on the matter consent in writing to the action. The Secretary shall file the written consent with the records of the meetings of the Members. Such consent shall be treated for all purposes as a vote at a meeting of the Members at which a quorum was present and voting.

ARTICLE VI
BOARD OF DIRECTORS

6.1. Powers. The Board of Directors shall exercise all corporate powers and manage the business and affairs of the Corporation, except as otherwise provided by law, the Corporation's Articles of Incorporation, or these Bylaws.

6.2. Initial Director. Upon the adoption of these Bylaws by the initial Director designated in the Articles of Incorporation at the organizational meeting of the Corporation, the initial Director shall resign as the initial Director and the members shall appoint new Directors as provided in Section 6.3 (which may include, if appointed, the initial Director).

6.3. Appointment and Removal of Directors. Each Class A and Class B Member shall appoint two (2) Directors and each Class C Member shall appoint one (1) Director. Each Member shall provide notice to the Corporation of any removal or appointment of Directors. The Member appointing a Director shall have the exclusive right to remove such Director unless such removal is required by applicable law. Directors shall serve without regard to term limits.

6.4 Qualifications. The Board of Directors shall be representative of the Corporation's Members and have the requisite knowledge, skill and experience to further the Corporation's mission and purposes.

6.5. Number. The number of Directors of the Corporation shall be nine (9) not including the president of the Corporation who shall serve as an ex-officio Director, without vote, or such other number approved by the Members.

6.6. Resignation. Any Director may resign at any time by giving written notice to the Board of Directors, the Chair, or the Secretary of the Corporation. A resignation shall be effective when the notice is given unless the notice specifies a future date. in which case the future date shall be the effective date of resignation. The pending vacancy may be filled before the effective date in accordance with Section 6.3 and 6.7. but the successor shall not take office until the effective date.

6.7. Vacancies. Any vacancy occurring in the Board of Directors may be filled by a replacement appointed by the Member who appointed the departed Director.

6.8. Regular Meetings. An annual meeting of the Board of Directors shall be held, without other notice than these Bylaws, at the same place as the annual meeting of the members shall be held. The Board of Directors may provide by resolution the time and place for the holding of additional regular meetings of the Board of Directors without notice other than the resolution.

6.9. Special Meetings. Special meetings of the Board of Directors may be called by or at the request of either of the Chair or any two (2) Directors. The person or persons authorized to call special meetings of the Board of Directors may designate the meeting's location.

6.10. Notice of Special Meetings. Three (3) days notice of any special meeting of the Board of Directors shall be given. If mailed, the notice will be deemed to be delivered when deposited in the United States mail in a sealed envelope, with postage thereon prepaid, addressed to the Director at his or her address as shown by the records of the Corporation. If notice is given by facsimile or electronically (if permitted by applicable law), the notice will be deemed to be delivered upon an effective transmission of the facsimile or electronic notice. Neither the business to be transacted at, nor the purpose 04 any special meeting of the Board of Directors need be specified in the notice of the meeting.

6.11. Waiver of Notice. A Director may waive any notice requirement by signing a written waiver of the notice and delivering it to the Secretary of the Corporation for filing with the minutes or the corporate records. Attendance of a Director at any meeting shall constitute a waiver of notice of the meeting except when a Director attends the meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened, and does not thereafter vote for or assent to action taken at the meeting.

6.12. Manner of Voting. A majority of the votes of the Directors who are present in person at a meeting at which a quorum is present shall be necessary for the adoption of any matter voted upon by the Board of Directors, unless the vote of a larger number is required by law, by the Articles of Incorporation, or by these Bylaws.

6.13. Quorum. A majority of the entire Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors. If less than a majority of the Directors are present, a majority of those present may adjourn the meeting to another time.

6.14. Informal Action. Any action required by law to be taken at a meeting of the Directors, or any action that may be taken at a meeting of the Directors, may be taken without a meeting, if consents in writing, setting forth the action so taken, are signed by all of the Directors and the written consents are included in the minutes of the proceedings of the Board of Directors or filed with the corporate records. The consents shall have the same effect as a unanimous vote of the Board of Directors for all purposes.

6.15. Participation By Means of Communication Equipment. A member of the Board of Directors may

participate in a meeting by conference telephone or similar communication equipment by means of which all persons can hear and speak to each other. Participating in a meeting by such means constitutes presence in person at the meeting.

6.16. Major Decisions. Notwithstanding anything to the contrary in these Bylaws, the following actions of the Corporation shall require the affirmative vote of at least one Director appointed by each Class A Member and at least one Director appointed by either the Class B or the Class C Member: (i) Admission of new Members; (ii) an amendment to the Articles of Incorporation of the Company or these Bylaws that affects the rights of any Member or the mission or purpose of the Corporation; (iii) the sale of all or substantially all of the Corporation's assets; (iv) the merger, consolidation or dissolution of the Corporation; (v) the license to a third party (including an affiliate of a member) of any material intellectual property owned by the Corporation; or (vi) the making of capital calls.

ARTICLE VII
OFFICERS

7.1. Officers. The elected officers of the Corporation shall consist of the Chair, Vice Chair, Secretary, Treasurer, President, and Vice President. The Board may also appoint such other officers as, in its judgment, are necessary to conduct the affairs of the Corporation.

7.2. Duties of Chair. The Chair shall be designated from among the Directors. The Chair shall be the chief elected officer of the Corporation. He or she shall preside at all meetings of the Board of Directors and the Executive Committee. The Chair will determine the regular agenda of all meetings of the Board of Directors and the Executive Committee. The Chair shall present a report at the Annual Meeting, appoint the chairs and members of committees (unless otherwise specified herein) authorized by the Board of Directors, act as liaison between the Corporation's staff and the Board, and perform such other duties as are inherent in the office of Chair or as authorized by the Board of Directors.

7.3 Duties of Vice Chair. The Vice Chair shall act in place of the Chair in the event of the absence of the Chair and shall exercise such other duties as may be delegated to the office by the Board. The Vice Chair shall serve as the Board's parliamentarian.

7.4 Duties of Secretary. The Secretary shall:

(a) certify and keep at the principal office of the Corporation the original or a copy of the Articles of Incorporation and these Bylaws, as amended, to date;

(b) keep, or cause to be kept, at the principal office of the Corporation or at such other place as the Board of Directors may order, a book of minutes of all meetings of the Members and the Board of Directors, and any committees having any of the authority of the Board of Directors, recording therein the time and place of holding, whether annual, regular, or special, how notice of the meeting was given, the names of those present at the meetings, and the proceedings thereof;

(c) be custodian of the records of the Corporation and see that all documents of the Corporation, the execution of which on behalf of the Corporation is authorized by law or by these Bylaws, are properly and duly executed;

(d) exhibit at all reasonable times to the Members, a Director, or proper designee, upon request, the Bylaws, and the minutes of the proceedings of the Members, Board of Directors and the committees of the Corporation; and

(e) perform any and all other duties incident to the office of Secretary and other duties as may be prescribed by law, the Articles of Incorporation, these Bylaws, or the Board of Directors.

7.5 Duties of Treasurer. The Treasurer shall:

(a) keep, or cause to be kept, adequate and correct accounts of all the properties and financial transactions of the Corporation;

(b) deposit, or cause to be deposited, all monies and other valuables in the name of and to the credit of the Corporation, with such depositories as may be designated by the Board of Directors;

(c) cause all the funds of the Corporation to be disbursed as ordered by the Board of Directors;

(d) render to the Board of Directors, upon request, an accounting of all financial transactions of the Corporation and a statement of the financial condition of the Corporation, and, after consultation with the Corporation, cause an annual audit of the Corporation's financial affairs to be conducted; and

(e) perform any and all other duties incident to the office of Treasurer and other duties as may be prescribed by law, the Certificate of Incorporation, these Bylaws, or the Board of Directors.

7.6 Duties of President. The President shall have the necessary authority and responsibility to operate the Corporation in all its activities subject only to the policies and directions of the Board of Directors or

any of its committees. The President shall act as the duly authorized representative of the Corporation in all matters in which the Board of Directors has not formally designated some other person to so act. The President shall report periodically to the Board of Directors. The President is charged with continuous responsibility for the management of the Corporation, commensurate with the authority conferred on him or her by the Board of Directors and consistent with the expressed aims and policies of the Board of Directors. The President is responsible for the application and implementation of established policies in the operation of the Corporation. The President shall be an ex-officio member of the Board of Directors without vote. The President shall keep appropriate records, and prepare or cause to be prepared all necessary reports, returns, and filings, and shall prepare an operating budget and financial statements. Expenditures shall be made in accordance with policies approved by the Board of Directors. The Board of Directors shall authorize reasonable compensation for the President. The Board may contract with a qualified firm to provide the services of a President; however, the choice of individual to provide such services shall be subject to the approval of the Board.

7.7. Vice President. The Vice President shall act in place of the President in the event of the absence of the President and shall exercise such other duties as may be delegated to the office by the Board.

7.8. Election of Officers. All of the elected officers of the Corporation shall be ejected by the Board of Directors every year at the Annual Meeting, provided, however, that the initial Chair shall serve a term of one (1) year and each subsequent Chair shall serve a term of two (2) years. An officer may be elected to serve more than one term in any office. Each officer shall hold his or her office until his or her successor shall be elected and qualified, unless he or she shall sooner resign or be removed or otherwise become disqualified to serve. Elections of all officers shall be by an affirmative vote of the majority of the votes of the entire Board of Directors.

7.9. Resignation. Removal. and Disqualification. Any officer may resign at any time by giving written notice of his or her resignation to the Board of Directors of the Corporation. Any resignation shall take effect upon receipt of the notice or upon any later time specified in the notice. The Board of Directors may remove any officer whenever *in* its judgment the best interests of the Corporation will be served thereby. Such removal shall be without prejudice to the contract rights, if any, of the persons so removed, but election or appointment of an officer or agent shall not of itself create contract rights. Vacancies among the officers shall be filled by the Board of Directors.

ARTICLE VIII
COMMITTEES

8.1. Committees. The Board of Directors may designate from among its members one or more committees, each committee to consist of two or more Directors. The Board may also from time-to-time appoint one or more persons as consulting members of a Board committee to serve at the pleasure of the Board and such persons need not be Directors. The Board of Directors shall establish procedures for meetings, action without meetings, notice and waiver of notice, and quorum and voting requirements for each committee.

Each committee shall exercise the authority of the Board of Directors to the extent authorized by resolution or other express delegation of authority by the Board of Directors. However, a committee may not:

(a) approved action that requires member approval;
(b) fill vacancies on the Board of Directors or any of its committees; or
(c) approve major Decisions set forth in Section 6.16 of these Bylaws.

There shall at all times be, at a minimum, an Audit Committee.

8.2. Audit Committee. The Audit Committee shall be directly responsible for the appointment, compensation, and oversight of the work of any accountant or accounting firm employed by the Corporation for the purpose of preparing or issuing an audit report or related work, and each such accountant or accounting firm shall report directly to the Committee. The Committee shall establish procedures for: (a) the receipt, retention, and treatment of complaints received by the Corporation regarding accounting, internal accounting controls, or auditing matters; and (b) the confidential, anonymous submission by employees of the Corporation of concerns regarding questionable accounting, auditing or other financial matters.

ARTICLE IX
CONTRACTS, CHECKS, AND DEPOSITS

9.1. Contracts. The Board of Directors may authorize any officer or officers, agent or agents of the Corporation, in addition to the officers so authorized by these Bylaws, to enter into any contract or execute and deliver any instrument in the name of and on behalf of the Corporation. Such authority may be general or confined

to specific instances.

9.2. Checks, Drafts, and Notes. All checks, drafts, or other orders for the payment of money, notes, or other evidences of indebtedness issued in the name of the Corporation shall be signed by the officer or officers, agent or agents of the Corporation and in the manner determined by resolution of the Board of Directors. In the absence of a determination by the Board of Directors, those instruments shall be signed by the President of the Corporation.

9.3. Deposits. All funds of the Corporation shall be deposited from time to time to the credit of the Corporation in those banks, trust companies, or other depositories selected by the Board of Directors.

ARTICLE X
BOOKS AND RECORDS

10.1. Books and Records. The Corporation shall keep correct and complete books and records of account and shall also keep minutes of the proceedings of the Members, Board of Directors, and all committees, and shall keep at the principal office of the Corporation a record of the names and addresses of the Directors of the Member. All books and records of the Corporation may be inspected by the Members at any reasonable time.

ARTICLE XI
INDEMNIFICATION

11.1. Indemnification. The Corporation shall indemnify Directors, officers, employees, or other agents of the Corporation to the extent prescribed in the Articles of Incorporation and to the fullest extent permitted by applicable law, provided, however, that the person being indemnified acted in good faith and in a manner the person reasonably believed to be in or not opposed to the best interest of the Corporation, and with respect to any criminal action or proceeding, had no reasonable cause to believe the person's conduct was unlawful.

ARTICLE XII
CONFLICTS OF INTEREST

12.1. Loans. No loans shall be made by the Corporation to its Directors or officers. Any Director or officer who assents to or participates in the making of any such loan shall be liable to the Corporation for the amount of such loan until the repayment thereof.

12.2. Conflicts of Interest Policy. The Corporation shall adopt and abide by a conflicts of interest policy to protect the Corporation's interest when it is contemplating entering into a transaction or arrangement that might benefit the private interest of a Director, officer or other person with the ability to substantially influence the Corporation. The conflicts of interest policy is intended to supplement, but not replace, any applicable state and federal laws governing conflicts of interest applicable to nonprofit and tax-exempt organizations.

ARTICLE XIII
VOLUNTARY WITHDRAWAL OF MEMBERS

Any Member, except the sole remaining Member of the Corporation, may voluntarily withdraw from the Corporation (the "Withdrawing Member") by providing written notice to the Corporation and each other Member at least thirty (30) days prior to the proposed effective date of the withdrawal. The Company shall refund the Withdrawing Member's capital contributions to the Withdrawing Member (less all amounts owed to the Company by the Withdrawing Member and remaining unpaid as of the effective date of the withdrawal) no later than one hundred eighty (180) days after the effective date of the withdrawal. Upon the effective date of such withdrawal, the directors appointed by the Withdrawing Member shall be deemed to have resigned. Any Member withdrawal pursuant to this Article XIII shall not affect any other agreements between the Withdrawing Member and the Company and/or any other Member including, but not limited to, any agreement licensing intellectual property.

ARTICLE XIV
AMENDMENTS

14.1. Adoption of Amendments. The power to alter, amend, or repeal the Bylaws of the Corporation, or to adopt new bylaws, is vested in the Board of Directors, subject always to repeal or change by action of the Members. Such action shall be effectuated by the Board of Directors in accordance with Section 6.16.

14.2. Record of Amendments. Whenever an amendment or new bylaw is adopted, or the Bylaws are

repealed and new Bylaws adopted, a record of the change shall be maintained in the records of the Corporation.

Schedule B

Capital Contributions

Name of Member	Capital Contribution	Contribution Date
Johns Hopkins Health System Corporation	$0.00	6/1/08
MedStar Health, Inc.	$0.00	6/1/08
University of Maryland Medical System, Inc	$0.00	6/1/08
Erickson health information Exchange, LLC	$250,000.00	6/1/08
Erickson Retirement Communities, LLC	$0.00	6/1/08

Financial Model and Sustainability

Cost Estimates and Staffing Plans

Revenue Sources

The state has committed $10 million in funding through its all-payor rate setting system for the implementation of a statewide HIE. These funds will be disbursed annually based upon a budget that reflects findings from an independent review and a defined set of deliverables. An incremental approach to Use Case implementation and provider connectivity balances the use of state funding along with revenue generated by the statewide HIE. Potential funding from the *State Health Information Exchange Cooperative Agreement Program* will not be used to supplant state funding. Instead, these funds will be used to expand Use Case implementation and accelerate connectivity of priority primary care providers. The $10 million in all-payor funding will provide the matching funds required by ARRA.

The development of a secure HIE poses special challenges. Trusted HIE requires the involvement of a broad range of stakeholders – patients, providers, payers, purchasers, and health agencies – and the consideration of a broad range of policies, principles, and designs. Identifying solutions to the following specific series of issues is essential: governance; privacy and security; role-based access; user authentication and trust hierarchies; architecture of the exchange; hardware and software solutions; cost of implementation; alternative sustainable business models; and strategies to assure appropriate patient engagement, access, and control over information exchange. Establishing an appropriate funding mechanism to support the development costs of the exchange and the daily operations until it becomes sustainable is a key issue related to the deliverable. States that have implemented an exchange continue to grapple with funding issues.

Budget

The budget is comprised of core infrastructure costs that include hardware and software costs that are not unique to a specific function but are required to support the statewide HIE as a whole, such as the cost of the data sharing platform and portal license, and the Enterprise Master Patient Index. The budget also includes the cost of human resources to implement and maintain the statewide HIE. The Board of Directors provides oversight to the budget and will resolve issues related to the budget and determine appropriate financial risks. A combination of implementation resources and maintenance staff will be utilized in years one and two with three full-time employees as permanent staff. Implementation resources in expected to incrementally decrease as full-time staff assumes the maintenance responsibilities for the statewide HIE.

The total for the core infrastructure and Use Case costs are approximately $8.2 million for the first and second years of operation, with a slight increase to around $9.0 million in the third year and decrease to roughly $7.0 million in year four. In the first couple of years the core costs are higher than Use Case costs related to the implementation of the statewide HIE. In years three and four, the cost of Use Cases exceeds core costs related to the increase in the implementation of the Use Cases. Revenue increases as Use Case deployment expands and net income becomes sustainable in year four.

Core Infrastructure	Number	Unit Cost	2010	2011	2012	2013
Exchange Platform and Portal License	1	($2,500,000)	($1,500,000)	($1,000,000)	($600,000)	($621,000)
EMPI	1	($350,000)	($350,000)	($140,000)	($140,000)	($140,000)
Hardware/Supporting Software	1	($500,000)	($500,000)	($166,667)	($172,500)	($178,538)
Implementation Resources	16	($230,000)	($3,680,000)	($3,680,000)	($1,840,000)	($1,840,000)
Permanent Resources (incl. Benefits)	3	($142,000)	($425,000)	($439,875)	($455,271)	($471,205)
Overhead (10% of resources)			($410,957)	($425,341)	($229,527)	($237,560)
Total Core Costs			($6,865,957)	($5,851,883)	($3,437,298)	($3,488,303)
Total Use Case Costs			($1,344,000)	($2,418,000)	($5,584,050)	($3,610,732)
Total HIE Costs			($8,209,957)	($8,269,883)	($9,021,348)	($7,099,035)
Maryland State Funding			$5,000,000	$2,000,000	$2,000,000	$1,000,000
ONC Funding			$3,350,000	$3,313,924	$2,000,000	$750,000
Total Use Case Revenues			$1,018,800	$2,487,600	$4,362,000	$5,937,200
Net Income			$1,158,843	($468,359)	($659,348)	$588,165

Software purchase and maintenance

Software licenses are calculated at $1,500,000 in the first year; $1,000,000 for licenses in the second year; and $600,000 for the third year, with an anticipated increase of 3.5 percent in each successive year. The budget will be adjusted if open source software, such as that provided by the ONC's Federal Health Architecture group, is incorporated into the technology infrastructure.

Hardware purchase and maintenance

In the event that the statewide HIE must acquire computer hardware and incur installation and maintenance costs, a Maryland organization will be contracted for these services. Hardware will likely be leased through an agreement with the service provider. Approximately $500,000 has been budgeted in the first year for the contract to provide all hardware and supporting software for the exchange. The hardware and supporting software projected for the second year is $166,700, with an anticipated increase of 3.5 percent for each successive year.

Key to the development of this cost model is a series of assumptions about the fees that various participants are willing to pay for services offered through the statewide HIE, and how fast those services could be deployed and subsequently adopted by the user community. The following table depicts those assumptions:

Model Assumptions	Adoption Rates					
Use Cases	Subscription/ Month	Assessment Unit	2010	2011	2012	2013
National Laboratory Results Delivery	$10	Per doc	30%	50%	70%	90%
Hospital Laboratory Results Delivery	$2	Per doc	10%	30%	50%	70%
Local Laboratory Results Delivery	$3	Per doc	10%	30%	50%	70%
ED/Hospital Discharge Summaries to Physicians/Clinics	$10	Per doc	10%	30%	50%	70%
ED/Hospital Discharge Summaries to ED/Hospital	$2,000	Per facility	10%	30%	50%	70%
Clinical Summary to EDs	$2,000	Per facility	0%	0%	30%	50%
Clinical Summary to Physicians/Clinics	$10	Per doc	0%	0%	10%	30%
National Radiology Results Delivery	$5	Per doc	0%	30%	50%	70%
National Radiology Results History	$1,000	Per facility	0%	30%	50%	70%
Hospital Radiology Results Delivery	$1	Per doc	0%	0%	10%	30%
Hospital Radiology Results History	$350	Per facility	0%	0%	10%	30%
Local Radiology Results Delivery	$2	Per doc	0%	0%	10%	30%
Local Radiology Results History	$650	Per facility	0%	0%	10%	30%
Max Subscription – All Services	$43	Per doc				
Max Subscription – All Services	$6,000	Per facility				

Operating Costs Statement

Salaries

The statewide HIE will staff three positions with permanent/non-contractor resources at the outset of the implementation project: the President, the Director of Outreach, and an Administrative Assistant. The Board of Directors will negotiate with the candidate for the President's position. Compensation for the other positions will be negotiated by the President in consultation with the Board of Directors. It is anticipated that the average salary of permanent resources will be approximately $113,000 in the first year; with an increase of 3.5 percent assumed for successive years. The implementation and integration resources will be procured from Maryland-based businesses and contracted at an average billable rate of approximately $115 per hour.

Benefits & Taxes

Benefits for permanent resources will include family medical insurance coverage. Benefits and taxes for permanent resources will amount to 25 percent of payroll or roughly $28,000 per resource in the first year, with an anticipated increase of 3.5 percent in each successive year. Payroll taxes borne by the HIE are estimated at approximately 9 percent of payroll. The statewide HIE expects to receive not-for-profit status by August 2011. As a not-for-profit organization, the statewide HIE does not expect to have any obligation for income taxes. Contract positions are not eligible for benefits and taxes will be the responsibility of the individual contractor.

Overhead

Rent, Utilities, Office Expenses, and General Overhead

The budget for office expenses, rent, utilities, and other overhead expenses amounts to approximately 10 percent of human capital costs. The overhead budget is further broken down as follows:

Overhead Items	2010	2011	2012	2013
Rent	$36,000	$37,260	$38,564	$39,914
Utilities	$24,000	$24,840	$25,709	$26,609
Outreach and Communication	$60,000	$60,000	$7,500	$7,763
Legal Services	$85,000	$85,000	$8,000	$8,280
Liability Insurance	$12,000	$12,420	$12,855	$13,305
Office Expenses/Other SG&A*	$193,957	$192,940	$137,388	$135,757
Total Overhead	$410,957	$412,460	$230,016	$231,628
*SG&A = Selling, General, and Administrative Expenses				

Outreach and Communication Activities

Absent funding from the *State Health Information Exchange Cooperative Agreement Program,* the approximate budget for outreach, education, and technical services is anticipated at $60,000 for years one and two, and roughly $7,500 in year three, with a projected increase of 3.5 percent per year forecasted for subsequent years. This amount could significantly increase with grant funding under the ARRA. The statewide HIE outreach, education, and technical assistance plan will:

- Position Maryland as a leader nationally with regard to state HIE efforts;
- Coordinate effectively with the constituents' marketing and communication departments to maximize exposure and streamline outbound messaging;
- Articulate the mission, vision, and value proposition to providers and consumers in simple, compelling terms through a range of channels;
- Provide transparency into the organization;
- Build public and constituent trust;
- Leverage grassroots support of champions among target providers and the consumer population; and
- Coordinate public-facing and provider outreach strategies.

Legal Fees

Legal counsel has been retained by the statewide HIE to provide support to the policy development framework, privacy and security requirements for system development and use, data sharing agreements, evaluation of existing laws and regulations, and assistance in multi-state policy harmonization activities. Approximately $85,000 has been budgeted per year in years one and two for legal services and $8,000 in year three, with an anticipated increase of 3.5 percent per year for subsequent years.

Liability insurance

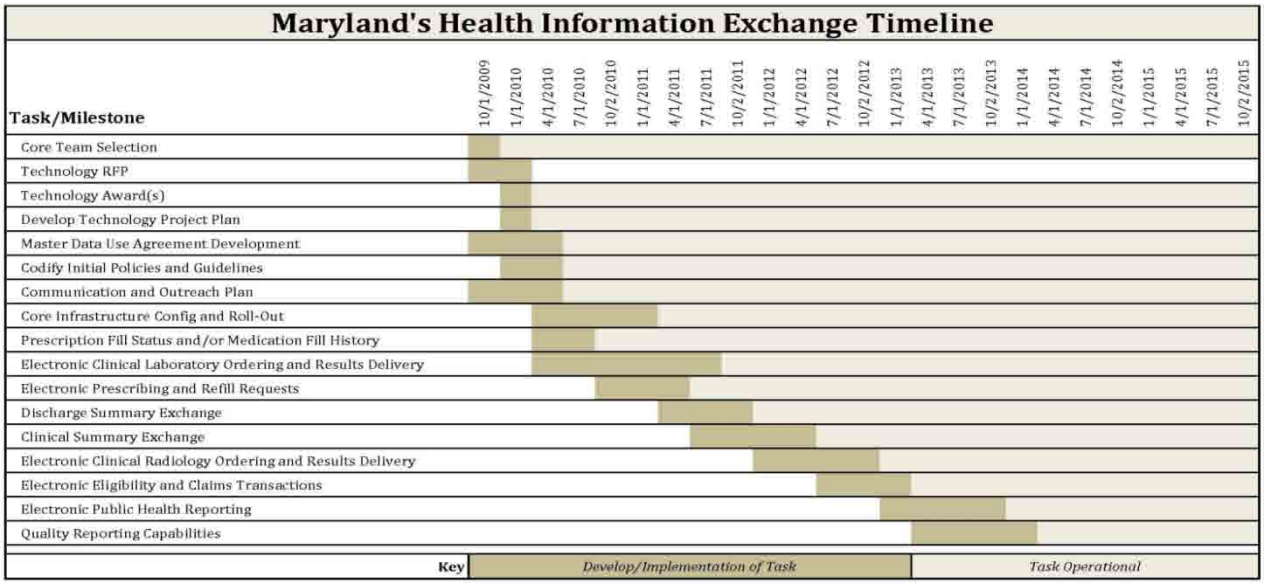
The statewide HIE has procured directors, officers, general liability, and workers compensation insurance. A budget of $12,000 per year for insurance is estimated for the first year of operation with an anticipated increase of 3.5 percent per year in successive years.

Statement of Cash Flows

The model assumes that all of the services and infrastructure required to build the exchange are not acquired as assets, but rather leased or sourced as a service. The statewide HIE will consider lines of credit to fund certain aspects of the operations. This is not anticipated but, should it occur, there will be minor impact to this cash flow statement.

Cash Flow from Operations	2010	2011	2012	2013
Beginning Cash	$0	$1,058,843	$590,484	($68,864)
Additions to Cash				
Maryland State Funding	$5,000,000	$2,000,000	$2,000,000	$1,000,000
ONC Grant	$3,250,000	$3,313,924	$2,000,000	$750,000
Total Use Case Revenues	$1,018,800	$2,487,600	$4,362,000	$5,937,200
Subtractions from Cash				
Total HIE Costs	($8,209,957)	($8,269,883)	($9,021,348)	($7,099,035)
Cash Flow Per Year	$1,058,843	$590,484	($68,864)	$519,301

Project Timeline



HIE Services

The statewide HIE architecture enables connections between Maryland's approximately 47 acute care hospitals and 7,907 physician practices. The statewide HIE provides a mechanism that enables appropriately authorized individuals to perform select analytical reporting. The statewide HIE also allows secondary uses of data for public health, biosurveillance, and other appropriate secondary uses of data. Below is a brief discussion regarding the statewide HIE's implementation schedule for the required Use Cases.

Electronic Eligibility and Claims Transactions

Administrative health networks (networks) are required to be certified by the MHCC to operate in Maryland. Select networks are in discussions with the statewide HIE to implement this Use Case. Preliminary discussions are underway between the statewide HIE and a network that is used by one of the state's largest payers, CareFirst.

Electronic Prescribing and Refill Requests

In Maryland, provider usage of e-prescribing is slightly more than five percent and around 75 percent of the 1,628 pharmacies are capable of accepting some form of electronic prescription. This Use Case will improve the adoption of e-prescribing among the more than 3,102 priority primary care practices in Maryland.

Electronic Clinical Laboratory Ordering and Results Delivery

Maryland exceeds the national rate of computerized physician order entry (CPOE) adoption by roughly seven percent. The implementation of this Use Case is expected to take more than a year to implement as negotiating connectivity with national, local, and hospital laboratories is expected to be somewhat of a lengthy process.

Electronic Public Health Reporting

Maryland has specific regulations governing public health reporting for a number of infectious or communicable diseases, such as meningitis, measles, mumps, and smallpox, to name a few. Currently, providers are required to submit information to public health officials for monitoring and reporting purposes with variable requirements on the reporting timeframe. Initial discussions regarding the implementation process for this Use Case have occurred.

Quality Reporting Capabilities

Quality reporting is essential to inform and educate stakeholders, and it is an important component for achieving meaningful use. Interest in quality reporting continues to grow; however, a consistent mechanism for reporting does not exist. The statewide HIE is expected to make available quality reporting, as deemed appropriate, for use by authorized stakeholders.

Prescription Fill Status and/or Medication Fill History

The Medication History Use Case was piloted during the HIE planning project and continues to function within three hospital emergency departments. Today, this Use Case is returning results for approximately 70 percent of patients who consent to participate in the pilot program.

Clinical Summary Exchange

The Clinical Summary Exchange Use Case allows for the sharing of summary clinical data, such as a discharge summary, Continuity of Care Document (CCD), or Continuity of Care Record (CCR), to assure that health information is shared among authorized providers. This Use Case will ensure that data or an appropriate image is available to participating providers.

Support of HIE Services

The statewide HIE will provide technical support to providers for each Use Case through the establishment of a technical vendor managed help desk. The technical vendor managed help desk will be procured through a competitive bid process by the statewide HIE. The vendor will resolve issues related to connectivity and performance. The statewide HIE will provide oversight to the help desk.

Controls and Reporting

The statewide HIE will use generally accepted accounting principles to prepare, present, and report financial statements. Each month the statewide HIE will provide the Board of Directors and the MHCC a report on its financial status and provide information related to the activities of the Advisory Board and the progress of implementation based on the established timeline. The statewide HIE will undergo an independent audit performed by a state designated auditor. The audit Letter of Recommendation will be issued to the MHCC and Board of Directors. The statewide HIE will respond to the audit letter within 45 days.

The Board of Directors is responsible for ensuring that appropriate financial controls are in place and that all relevant Office of Management and Budget circulars are addressed pertaining to potential funding under the *State Health Information Exchange Cooperative Agreement Program*. The Board of Directors will also provide oversight in the completion of reports due to ONC as it relates to the progress of the statewide HIE and use of any funding.

Project Manager

ID	Task Name	Duration	Start	Finish
1	**Planning for HIE**	779 days	Tue 9/5/06	Fri 8/28/09
2	**Assess Privacy and Security Policies and Business Processes**	**325 days**	**Mon 9/4/06**	**Fri 11/30/07**
3	Determine team members	325 days	Mon 9/4/06	Fri 11/30/07
4	Determine date for kick off meeting	325 days	Mon 9/4/06	Fri 11/30/07
5	Contact team members about meeting	325 days	Mon 9/4/06	Fri 11/30/07
6	Prepare agenda and purpose of meeting	325 days	Mon 9/4/06	Fri 11/30/07
7	Hold kickoff meeting	325 days	Mon 9/4/06	Fri 11/30/07
8	Determine workgroups	325 days	Mon 9/4/06	Fri 11/30/07
9	**Workgroup 1**	**325 days**	**Mon 9/4/06**	**Fri 11/30/07**
10	Hold meetings to discuss deliverables	325 days	Mon 9/4/06	Fri 11/30/07
11	Determine best practices	325 days	Mon 9/4/06	Fri 11/30/07
12	Write section report	325 days	Mon 9/4/06	Fri 11/30/07
13	**Workgroup 2**	**325 days**	**Mon 9/4/06**	**Fri 11/30/07**
14	Hold meetings of team members	325 days	Mon 9/4/06	Fri 11/30/07
15	Determine best practices	325 days	Mon 9/4/06	Fri 11/30/07
16	Write section report	325 days	Mon 9/4/06	Fri 11/30/07
17	**Workgroup 3**	**325 days**	**Mon 9/4/06**	**Fri 11/30/07**
18	Hold meetings of team members	325 days	Mon 9/4/06	Fri 11/30/07
19	Determine best practices	325 days	Mon 9/4/06	Fri 11/30/07
20	Write section report	325 days	Mon 9/4/06	Fri 11/30/07
21	**Workgroup 4**	**325 days**	**Mon 9/4/06**	**Fri 11/30/07**
22	Hold meetings of team members	325 days	Mon 9/4/06	Fri 11/30/07
23	Determine best practices	325 days	Mon 9/4/06	Fri 11/30/07
24	Write section report	325 days	Mon 9/4/06	Fri 11/30/07
25	**Workgroup 5**	**325 days**	**Mon 9/4/06**	**Fri 11/30/07**
26	Hold meetings of team members	325 days	Mon 9/4/06	Fri 11/30/07
27	Determine best practices	325 days	Mon 9/4/06	Fri 11/30/07
28	Write section report	325 days	Mon 9/4/06	Fri 11/30/07
29	**Workgroup 6**	**325 days**	**Mon 9/4/06**	**Fri 11/30/07**
30	Hold meetings of team members	325 days	Mon 9/4/06	Fri 11/30/07
31	Determine best practices	325 days	Mon 9/4/06	Fri 11/30/07
32	Write section report	325 days	Mon 9/4/06	Fri 11/30/07
33	**Workgroup 7**	**325 days**	**Mon 9/4/06**	**Fri 11/30/07**
34	Hold meetings of team members	325 days	Mon 9/4/06	Fri 11/30/07
35	Determine best practices	325 days	Mon 9/4/06	Fri 11/30/07
36	Write section report	325 days	Mon 9/4/06	Fri 11/30/07
37	**Workgroup 8**	**325 days**	**Mon 9/4/06**	**Fri 11/30/07**
38	Hold meetings of team members	325 days	Mon 9/4/06	Fri 11/30/07

39	✓	Determine best practices	325 days	Mon 9/4/06	Fri 11/30/07
40	✓	Write section report	325 days	Mon 9/4/06	Fri 11/30/07
41	✓	Call entire group back together	325 days	Mon 9/4/06	Fri 11/30/07
42	✓	Combine reports	325 days	Mon 9/4/06	Fri 11/30/07
43	✓	Review combined report	325 days	Mon 9/4/06	Fri 11/30/07
44	✓	Release report	325 days	Mon 9/4/06	Fri 11/30/07
45	✓	**Privacy and Security Solutions and Implementation Activities for HIE**	**217 days**	**Sat 12/1/07**	**Tue 9/30/08**
46	✓	Determine team members	217 days	Sat 12/1/07	Tue 9/30/08
47	✓	Determine date for kick off meeting	217 days	Sat 12/1/07	Tue 9/30/08
48	✓	Contact team members about meeting	217 days	Sat 12/1/07	Tue 9/30/08
49	✓	Prepare agenda and purpose of meeting	217 days	Sat 12/1/07	Tue 9/30/08
50	✓	Hold kickoff meeting	217 days	Sat 12/1/07	Tue 9/30/08
51	✓	Determine barriers for focus of group	217 days	Sat 12/1/07	Tue 9/30/08
52	✓	**Barrier 1 - access to data**	**217 days**	**Sat 12/1/07**	**Tue 9/30/08**
53	✓	Meetings to discuss types of barriers	217 days	Sat 12/1/07	Tue 9/30/08
54	✓	Meetings to discuss solutions to each type	217 days	Sat 12/1/07	Tue 9/30/08
55	✓	Draft section of report for barrier	217 days	Sat 12/1/07	Tue 9/30/08
56	✓	**Barrier 2 - common patient identifier**	**217 days**	**Sat 12/1/07**	**Tue 9/30/08**
57	✓	Meetings to discuss types of barriers	217 days	Sat 12/1/07	Tue 9/30/08
58	✓	Meetings to discuss solutions to each type	217 days	Sat 12/1/07	Tue 9/30/08
59	✓	Draft section of report for barrier	217 days	Sat 12/1/07	Tue 9/30/08
60	✓	**Barrier 3 - concerns regarding the use of data**	**217 days**	**Sat 12/1/07**	**Tue 9/30/08**
61	✓	Meetings to discuss types of barriers	217 days	Sat 12/1/07	Tue 9/30/08
62	✓	Meetings to discuss solutions to each type	217 days	Sat 12/1/07	Tue 9/30/08
63	✓	Draft section of report for barrier	217 days	Sat 12/1/07	Tue 9/30/08
64	✓	**Barrier 4 - funding**	**217 days**	**Sat 12/1/07**	**Tue 9/30/08**
65	✓	Meetings to discuss types of barriers	217 days	Sat 12/1/07	Tue 9/30/08
66	✓	Meetings to discuss solutions to each type	217 days	Sat 12/1/07	Tue 9/30/08
67	✓	Draft section of report for barrier	217 days	Sat 12/1/07	Tue 9/30/08
68	✓	**Barrier 5 - interoperability**	**217 days**	**Sat 12/1/07**	**Tue 9/30/08**
69	✓	Meetings to discuss types of barriers	217 days	Sat 12/1/07	Tue 9/30/08
70	✓	Meetings to discuss solutions to each type	217 days	Sat 12/1/07	Tue 9/30/08
71	✓	Draft section of report for barrier	217 days	Sat 12/1/07	Tue 9/30/08
72	✓	**Barrier 6 - liability**	**217 days**	**Sat 12/1/07**	**Tue 9/30/08**
73	✓	Meetings to discuss types of barriers	217 days	Sat 12/1/07	Tue 9/30/08

74	✓	Meetings to discuss solutions to each type	217 days	Sat 12/1/07	Tue 9/30/08
75	✓	Draft section of report for barrier	217 days	Sat 12/1/07	Tue 9/30/08
76	✓	**Barrier 7 - stakeholder trust**	**217 days**	**Sat 12/1/07**	**Tue 9/30/08**
77	✓	Meetings to discuss types of barriers	217 days	Sat 12/1/07	Tue 9/30/08
78	✓	Meetings to discuss solutions to each type	217 days	Sat 12/1/07	Tue 9/30/08
79	✓	Draft section of report for barrier	217 days	Sat 12/1/07	Tue 9/30/08
80	✓	**Barrier 8 - technical and process infrastructure**	**217 days**	**Sat 12/1/07**	**Tue 9/30/08**
81	✓	Meetings to discuss types of barriers	217 days	Sat 12/1/07	Tue 9/30/08
82	✓	Meetings to discuss solutions to each type	217 days	Sat 12/1/07	Tue 9/30/08
83	✓	Draft section of report for barrier	217 days	Sat 12/1/07	Tue 9/30/08
84	✓	Convene entire team	217 days	Sat 12/1/07	Tue 9/30/08
85	✓	Consolidate reports	217 days	Sat 12/1/07	Tue 9/30/08
86	✓	Review consolidated report	217 days	Sat 12/1/07	Tue 9/30/08
87	✓	Final report released	217 days	Sat 12/1/07	Tue 9/30/08
88	✓	**Service Area Health Information Exchange**	**108 days**	**Wed 10/1/08**	**Fri 2/27/09**
89	✓	Determine team members	108 days	Wed 10/1/08	Fri 2/27/09
90	✓	Determine date for kick off meeting	108 days	Wed 10/1/08	Fri 2/27/09
91	✓	Contact team members about meeting	108 days	Wed 10/1/08	Fri 2/27/09
92	✓	Prepare agenda and purpose of meeting	108 days	Wed 10/1/08	Fri 2/27/09
93	✓	Hold kickoff meeting	108 days	Wed 10/1/08	Fri 2/27/09
94	✓	Determine areas to address	108 days	Wed 10/1/08	Fri 2/27/09
95	✓	**Patient rights to electronic health information**	**108 days**	**Wed 10/1/08**	**Fri 2/27/09**
96	✓	Hold sub group meetings	108 days	Wed 10/1/08	Fri 2/27/09
97	✓	Draft report	108 days	Wed 10/1/08	Fri 2/27/09
98	✓	**Range of business practices**	**108 days**	**Wed 10/1/08**	**Fri 2/27/09**
99	✓	Hold sub group meetings	108 days	Wed 10/1/08	Fri 2/27/09
100	✓	Draft report	108 days	Wed 10/1/08	Fri 2/27/09
101	✓	**Technical requirements**	**108 days**	**Wed 10/1/08**	**Fri 2/27/09**
102	✓	Hold sub group meetings	108 days	Wed 10/1/08	Fri 2/27/09
103	✓	Draft report	108 days	Wed 10/1/08	Fri 2/27/09
104	✓	**Communication mechnisms**	**108 days**	**Wed 10/1/08**	**Fri 2/27/09**
105	✓	Hold sub group meetings	108 days	Wed 10/1/08	Fri 2/27/09
106	✓	Draft report	108 days	Wed 10/1/08	Fri 2/27/09
107	✓	**Key community-level financial, organizational, and policy challenges**	**108 days**	**Wed 10/1/08**	**Fri 2/27/09**
108	✓	Hold sub group meetings	108 days	Wed 10/1/08	Fri 2/27/09
109	✓	Draft report	108 days	Wed 10/1/08	Fri 2/27/09
110	✓	**Alternate community data uses**	**108 days**	**Wed 10/1/08**	**Fri 2/27/09**

111	✓	Hold sub group meetings	108 days	Wed 10/1/08	Fri 2/27/09
112	✓	Draft report	108 days	Wed 10/1/08	Fri 2/27/09
113	✓	Reconvene members	108 days	Wed 10/1/08	Fri 2/27/09
114	✓	Review each section of reports	108 days	Wed 10/1/08	Fri 2/27/09
115	✓	Draft report	108 days	Wed 10/1/08	Fri 2/27/09
116	✓	Review consolidated report	108 days	Wed 10/1/08	Fri 2/27/09
117	✓	Finalize report	108 days	Wed 10/1/08	Fri 2/27/09
118	✓	**Multi-stakeholder worgroups**	**276 days**	**Fri 2/1/08**	**Fri 2/20/09**
119	✓	Obtain financing from HSCRC	53 days	Fri 2/1/08	Tue 4/15/08
120	✓	Develop RFP for responses to apply for planning	53 days	Fri 2/1/08	Tue 4/15/08
121	✓	Release RFP	53 days	Fri 2/1/08	Tue 4/15/08
122	✓	Review RFPs	53 days	Fri 2/1/08	Tue 4/15/08
123	✓	Select two planning groups	53 days	Fri 2/1/08	Tue 4/15/08
124	✓	Kick off meeting with planning groups to discuss goals and	1 day	Tue 4/15/08	Tue 4/15/08
125	✓	**Planning group 1 - CRISP**	**212 days**	**Thu 5/1/08**	**Fri 2/20/09**
126	✓	Develop structure of teams and areas to focus	212 days	Thu 5/1/08	Fri 2/20/09
127	✓	**Legal and regulatory**	**212 days**	**Thu 5/1/08**	**Fri 2/20/09**
128	✓	Hold meetings of team members	212 days	Thu 5/1/08	Fri 2/20/09
129	✓	Determine best practices	212 days	Thu 5/1/08	Fri 2/20/09
130	✓	Draft report	212 days	Thu 5/1/08	Fri 2/20/09
131	✓	**Policy formation**	**212 days**	**Thu 5/1/08**	**Fri 2/20/09**
132	✓	Hold meetings of team members	212 days	Thu 5/1/08	Fri 2/20/09
133	✓	Determine best practices	212 days	Thu 5/1/08	Fri 2/20/09
134	✓	Draft report	212 days	Thu 5/1/08	Fri 2/20/09
135	✓	**Clinical workflows**	**212 days**	**Thu 5/1/08**	**Fri 2/20/09**
136	✓	Hold meetings of team members	212 days	Thu 5/1/08	Fri 2/20/09
137	✓	Determine best practices	212 days	Thu 5/1/08	Fri 2/20/09
138	✓	Draft report	212 days	Thu 5/1/08	Fri 2/20/09
139	✓	**Communication and education**	**212 days**	**Thu 5/1/08**	**Fri 2/20/09**
140	✓	Hold meetings of team members	212 days	Thu 5/1/08	Fri 2/20/09
141	✓	Determine best practices	212 days	Thu 5/1/08	Fri 2/20/09
142	✓	Draft report	212 days	Thu 5/1/08	Fri 2/20/09
143	✓	**Governance**	**212 days**	**Thu 5/1/08**	**Fri 2/20/09**
144	✓	Hold meetings of team members	212 days	Thu 5/1/08	Fri 2/20/09
145	✓	Determine best practices	212 days	Thu 5/1/08	Fri 2/20/09
146	✓	Draft report	212 days	Thu 5/1/08	Fri 2/20/09
147	✓	**Infrastructure and data management**	**212 days**	**Thu 5/1/08**	**Fri 2/20/09**
148	✓	Hold meetings of team members	212 days	Thu 5/1/08	Fri 2/20/09
149	✓	Determine best practices	212 days	Thu 5/1/08	Fri 2/20/09

150	✓	Draft report	212 days	Thu 5/1/08	Fri 2/20/09
151	✓	**Finance and sustainability**	**212 days**	**Thu 5/1/08**	**Fri 2/20/09**
152	✓	Hold meetings of team members	212 days	Thu 5/1/08	Fri 2/20/09
153	✓	Determine best practices	212 days	Thu 5/1/08	Fri 2/20/09
154	✓	Draft report	212 days	Thu 5/1/08	Fri 2/20/09
155	✓	Reconvene entire team and review each section report	212 days	Thu 5/1/08	Fri 2/20/09
156	✓	Draft combine reports into consolidated report	212 days	Thu 5/1/08	Fri 2/20/09
157	✓	Finalize report	212 days	Thu 5/1/08	Fri 2/20/09
158	✓	Submit report to MHCC	212 days	Thu 5/1/08	Fri 2/20/09
159	✓	**Planning group 2 - MCHIE**	**212 days**	**Thu 5/1/08**	**Fri 2/20/09**
160	✓	Develop structure of teams and areas to focus	212 days	Thu 5/1/08	Fri 2/20/09
161	✓	**Governance**	**212 days**	**Thu 5/1/08**	**Fri 2/20/09**
162	✓	Hold meetings of team members	212 days	Thu 5/1/08	Fri 2/20/09
163	✓	Determine best practices	212 days	Thu 5/1/08	Fri 2/20/09
164	✓	Draft report	212 days	Thu 5/1/08	Fri 2/20/09
165	✓	**Community perspectives**	**212 days**	**Thu 5/1/08**	**Fri 2/20/09**
166	✓	Hold meetings of team members	212 days	Thu 5/1/08	Fri 2/20/09
167	✓	Determine best practices	212 days	Thu 5/1/08	Fri 2/20/09
168	✓	Draft report	212 days	Thu 5/1/08	Fri 2/20/09
169	✓	**Privacy and security**	**212 days**	**Thu 5/1/08**	**Fri 2/20/09**
170	✓	Hold meetings of team members	212 days	Thu 5/1/08	Fri 2/20/09
171	✓	Determine best practices	212 days	Thu 5/1/08	Fri 2/20/09
172	✓	Draft report	212 days	Thu 5/1/08	Fri 2/20/09
173	✓	**Technical infrastructure**	**212 days**	**Thu 5/1/08**	**Fri 2/20/09**
174	✓	Hold meetings of team members	212 days	Thu 5/1/08	Fri 2/20/09
175	✓	Determine best practices	212 days	Thu 5/1/08	Fri 2/20/09
176	✓	Draft report	212 days	Thu 5/1/08	Fri 2/20/09
177	✓	**Finance and sustainability**	**212 days**	**Thu 5/1/08**	**Fri 2/20/09**
178	✓	Hold meetings of team members	212 days	Thu 5/1/08	Fri 2/20/09
179	✓	Determine best practices	212 days	Thu 5/1/08	Fri 2/20/09
180	✓	Draft report	212 days	Thu 5/1/08	Fri 2/20/09
181	✓	Reconvene entire team and review each sectiion report	212 days	Thu 5/1/08	Fri 2/20/09
182	✓	Draft combine reports into consolidated report	212 days	Thu 5/1/08	Fri 2/20/09
183	✓	Finalize report	212 days	Thu 5/1/08	Fri 2/20/09
184	✓	Submit report to MHCC	212 days	Thu 5/1/08	Fri 2/20/09
185	✓	**MHCC Design Specifications**	**23 days**	**Sat 2/21/09**	**Wed 3/25/09**
186	✓	Develop bid board notice	23 days	Sat 2/21/09	Wed 3/25/09
187	✓	Post bid board notice	23 days	Sat 2/21/09	Wed 3/25/09
188	✓	Review vendor responses	23 days	Sat 2/21/09	Wed 3/25/09

189	✓	Select contractor	23 days	Sat 2/21/09	Wed 3/25/09
190	✓	Kick-off meeting to discuss work to be completed	23 days	Sat 2/21/09	Wed 3/25/09
191	✓	Contractor performs work	23 days	Sat 2/21/09	Wed 3/25/09
192	✓	Bi-weekly status meetings	23 days	Sat 2/21/09	Wed 3/25/09
193	✓	Draft of final report	23 days	Sat 2/21/09	Wed 3/25/09
194	✓	Final report submitted to MHCC	23 days	Sat 2/21/09	Wed 3/25/09
195	✓	**MHCC HIE Implementation Plan**	**44 days?**	**Sun 3/1/09**	**Thu 4/30/09**
196	✓	Develop bid board notice	44 days?	Sun 3/1/09	Thu 4/30/09
197	✓	Post bid board notice	44 days	Sun 3/1/09	Thu 4/30/09
198	✓	Review vendor responses	44 days	Sun 3/1/09	Thu 4/30/09
199	✓	Select contractor	44 days	Sun 3/1/09	Thu 4/30/09
200	✓	Kick-off meeting to discuss work to be completed	44 days	Sun 3/1/09	Thu 4/30/09
201	✓	Contractor performs work	44 days	Sun 3/1/09	Thu 4/30/09
202	✓	Bi-weekly status meetings	44 days	Sun 3/1/09	Thu 4/30/09
203	✓	Draft of final report	44 days	Sun 3/1/09	Thu 4/30/09
204	✓	Final report submitted to MHCC	44 days	Sun 3/1/09	Thu 4/30/09
205	✓	**HIE RFA**	**109 days?**	**Wed 4/1/09**	**Mon 8/31/09**
206	✓	Draft HIE Implementation RFA	91 days?	Wed 4/1/09	Wed 8/5/09
207	✓	Finalize HIE implementation RFA	91 days?	Wed 4/1/09	Wed 8/5/09
208	✓	Post RFA on MHCc website	91 days	Wed 4/1/09	Wed 8/5/09
209	✓	Hold bidders conference	91 days	Wed 4/1/09	Wed 8/5/09
210	✓	Gathere RFA responses	91 days?	Wed 4/1/09	Wed 8/5/09
211	✓	Determine scoring criteria	91 days	Wed 4/1/09	Wed 8/5/09
212	✓	Determine who will score the applications	91 days	Wed 4/1/09	Wed 8/5/09
213	✓	Submit applications to scorers	91 days	Wed 4/1/09	Wed 8/5/09
214	✓	Scorers grade each application	91 days	Wed 4/1/09	Wed 8/5/09
215	✓	Determine top 2 contenders	91 days	Wed 4/1/09	Wed 8/5/09
216	✓	Perform due diligence and review of top 2 contenders	91 days	Wed 4/1/09	Wed 8/5/09
217	✓	Determine best candidate	91 days?	Wed 4/1/09	Wed 8/5/09
218	✓	Submit candidate to Commissioners for approval	91 days	Wed 4/1/09	Wed 8/5/09
219	✓	Submit approved candidate to HSCRC commission	91 days	Wed 4/1/09	Wed 8/5/09
220	✓	Obtain HSCRC approval for candidate	91 days	Wed 4/1/09	Wed 8/5/09
221	✓	Announce award to candidate	91 days	Wed 4/1/09	Wed 8/5/09
222	✓	Secure financing letters from hospitals	1 day	Mon 8/31/09	Mon 8/31/09
223		**ONC HIE Cooperative Agreement Grant**	804 days	Wed 8/5/09	Mon 9/3/12
224		**ONC HIE grant submission**	**804 days**	**Sat 8/1/09**	**Thu 8/30/12**
225	✓	Review HIE ONC grant opportunity	804 days	Sat 8/1/09	Thu 8/30/12
226	✓	Draft letter of intent	804 days	Sat 8/1/09	Thu 8/30/12
227	✓	Review letter of intent	804 days	Sat 8/1/09	Thu 8/30/12
228	✓	Finalize letter of intent	44 days	Sat 8/1/09	Thu 10/1/09

229	✓	Devlop grant documents	44 days	Sat 8/1/09	Thu 10/1/09
230	✓	Strategic and operatuional plan	44 days	Sat 8/1/09	Thu 10/1/09
231	✓	Draft strategic and operational plan	44 days	Sat 8/1/09	Thu 10/1/09
232	✓	Review strategic and operational plan	44 days	Sat 8/1/09	Thu 10/1/09
233	✓	Finalize strategic and operational plan	44 days	Sat 8/1/09	Thu 10/1/09
234	✓	Project abstract	44 days	Sat 8/1/09	Thu 10/1/09
235	✓	Draft project abstract	44 days	Sat 8/1/09	Thu 10/1/09
236	✓	Review project abstract	44 days	Sat 8/1/09	Thu 10/1/09
237	✓	Finalize project abstract	44 days	Sat 8/1/09	Thu 10/1/09
238	✓	Current state	44 days	Sat 8/1/09	Thu 10/1/09
239	✓	Draft current state	44 days	Sat 8/1/09	Thu 10/1/09
240	✓	Review current state	44 days	Sat 8/1/09	Thu 10/1/09
241	✓	Finalize current state	44 days	Sat 8/1/09	Thu 10/1/09
242	✓	Project summary	44 days	Sat 8/1/09	Thu 10/1/09
243	✓	Draft project summary	44 days	Sat 8/1/09	Thu 10/1/09
244	✓	Review project summary	44 days	Sat 8/1/09	Thu 10/1/09
245	✓	Finalize project summary	44 days	Sat 8/1/09	Thu 10/1/09
246	✓	Performance measures and reporting	44 days	Sat 8/1/09	Thu 10/1/09
247	✓	Draft performance measures	44 days	Sat 8/1/09	Thu 10/1/09
248	✓	Review performance measures	44 days	Sat 8/1/09	Thu 10/1/09
249	✓	Finalize performance measures	44 days	Sat 8/1/09	Thu 10/1/09
250	✓	Project management	44 days	Sat 8/1/09	Thu 10/1/09
251	✓	Draft project management	44 days	Sat 8/1/09	Thu 10/1/09
252	✓	Review porject management	44 days	Sat 8/1/09	Thu 10/1/09
253	✓	Finalize project management	44 days	Sat 8/1/09	Thu 10/1/09
254	✓	Evaluation	44 days	Sat 8/1/09	Thu 10/1/09
255	✓	Draft eveluation	44 days	Sat 8/1/09	Thu 10/1/09
256	✓	Review evaluation	44 days	Sat 8/1/09	Thu 10/1/09
257	✓	Finalize evaluation	44 days	Sat 8/1/09	Thu 10/1/09
258	✓	Organizational capabilities	44 days	Sat 8/1/09	Thu 10/1/09
259	✓	Draft organizational capabilities	44 days	Sat 8/1/09	Thu 10/1/09
260	✓	Review organizational capabilties	44 days	Sat 8/1/09	Thu 10/1/09
261	✓	Finalize organizational capabiltiies	44 days	Sat 8/1/09	Thu 10/1/09
262	✓	Budget narrative	44 days	Sat 8/1/09	Thu 10/1/09
263	✓	Draft budget narrative	44 days	Sat 8/1/09	Thu 10/1/09
264	✓	Review budget narrative	44 days	Sat 8/1/09	Thu 10/1/09
265	✓	Finalize budget narrative	44 days	Sat 8/1/09	Thu 10/1/09
266	✓	Budget detail	44 days	Sat 8/1/09	Thu 10/1/09
267	✓	Draft budget detail	44 days	Sat 8/1/09	Thu 10/1/09
268	✓	Review budget detail	44 days	Sat 8/1/09	Thu 10/1/09
269	✓	Finalize budget detail	44 days	Sat 8/1/09	Thu 10/1/09

270	✓	Colate all sections of grant application	10 days	Fri 10/2/09	Thu 10/15/09
271	✓	Review consolidated grant application	10 days	Fri 10/2/09	Thu 10/15/09
272	✓	Finalize consolidate grant appliation	10 days	Fri 10/2/09	Thu 10/15/09
273	✓	Submit grant application	1 day	Thu 10/15/09	Thu 10/15/09
274	✓	Feedback from ONC on application	41 days	Fri 1/1/10	Fri 2/26/10
275	✓	Perform modifications to application	41 days	Fri 1/1/10	Fri 2/26/10
276	✓	Feedback from ONC on application	41 days	Fri 1/1/10	Fri 2/26/10
277	✓	Perform modifications on application	41 days	Fri 1/1/10	Fri 2/26/10
278	✓	Feedback from ONC on application	41 days	Fri 1/1/10	Fri 2/26/10
279	✓	Perform modifications to application	41 days	Fri 1/1/10	Fri 2/26/10
280	✓	Feedback from ONC on application	41 days	Fri 1/1/10	Fri 2/26/10
281	✓	Perform modifications on application	41 days	Fri 1/1/10	Fri 2/26/10
282	✓	Grant awarded to MHCC	1 day	Mon 3/15/10	Mon 3/15/10
283		Update strategic and operational plan	30 days	Mon 4/5/10	Fri 5/14/10
284		Update governance requirments	30 days	Mon 4/5/10	Fri 5/14/10
285		Update finance requirements	30 days	Mon 4/5/10	Fri 5/14/10
286		Update technical infrastructure requirements	30 days	Mon 4/5/10	Fri 5/14/10
287		Update business and technical operations requirements	30 days	Mon 4/5/10	Fri 5/14/10
288		Update legal/policy requirements	30 days	Mon 4/5/10	Fri 5/14/10
289		Submit changes to ONC for review and approval	1 day	Fri 5/14/10	Fri 5/14/10
290	✓	Receive feedback from ONC on changes to strategic and operational	1 day	Thu 4/15/10	Thu 4/15/10
291		Make modifications to strategic and operational plan	22 days	Thu 4/15/10	Fri 5/14/10
292		Receive feedback from ONC on changes to strategic and operational	22 days	Thu 4/15/10	Fri 5/14/10
293		Make modifications to strategic and operational plan	22 days	Thu 4/15/10	Fri 5/14/10
294		Receive feedback from ONC on changes to strategic and operational	22 days	Thu 4/15/10	Fri 5/14/10
295		Make modifications to strategic and operational plan	22 days	Thu 4/15/10	Fri 5/14/10
296		Finalize strategic and oprational plan	22 days	Thu 4/15/10	Fri 5/14/10
297		Align strategic and operation plan with State Mediciad HIT plan	12 days	Fri 5/14/10	Mon 5/31/10
298		Submit final strategic plan to MHCC Commission	1 day	Tue 6/15/10	Tue 6/15/10
299		Approval by Commission for strategic and operational plan	1 day	Tue 6/15/10	Tue 6/15/10
300		Provide Governor et al final strategic and operational plan	1 day	Thu 6/17/10	Thu 6/17/10
301		Post final strategic and operational plan on web site	1 day	Fri 6/18/10	Fri 6/18/10
302		**State HIE Program reporting**	**1051 days**	**Thu 4/1/10**	**Thu 4/10/14**

303	✓	Submit ARRA quarterly reports at federalreporting.gov	7 days	Thu 4/1/10	Fri 4/9/10
304		Submit ARRA quarterly reports at federalreporting.gov	7 days	Thu 7/1/10	Fri 7/9/10
305		Submit ARRA quarterly reports at federalreporting.gov	6 days	Fri 10/1/10	Fri 10/8/10
306		Submit ARRA quarterly reports at federalreporting.gov	6 days	Mon 1/3/11	Mon 1/10/11
307		Submit ARRA quarterly reports at federalreporting.gov	6 days	Fri 4/1/11	Fri 4/8/11
308		Submit ARRA quarterly reports at federalreporting.gov	6 days	Fri 7/1/11	Fri 7/8/11
309		Submit ARRA quarterly reports at federalreporting.gov	6 days	Mon 10/3/11	Mon 10/10/11
310		Submit ARRA quarterly reports at federalreporting.gov	7 days	Mon 1/2/12	Tue 1/10/12
311		Submit ARRA quarterly reports at federalreporting.gov	8 days	Mon 4/2/12	Wed 4/11/12
312		Submit ARRA quarterly reports at federalreporting.gov	7 days	Mon 7/2/12	Tue 7/10/12
313		Submit ARRA quarterly reports at federalreporting.gov	8 days	Mon 10/1/12	Wed 10/10/12
314		Submit ARRA quarterly reports at federalreporting.gov	8 days	Tue 1/1/13	Thu 1/10/13
315		Submit ARRA quarterly reports at federalreporting.gov	8 days	Mon 4/1/13	Wed 4/10/13
316		Submit ARRA quarterly reports at federalreporting.gov	8 days	Mon 7/1/13	Wed 7/10/13
317		Submit ARRA quarterly reports at federalreporting.gov	8 days	Tue 10/1/13	Thu 10/10/13
318		Submit ARRA quarterly reports at federalreporting.gov	8 days	Wed 1/1/14	Fri 1/10/14
319		Submit ARRA quarterly reports at federalreporting.gov	8 days	Tue 4/1/14	Thu 4/10/14
320		**COHORT 3 State HIE Grant general Requirements**	**1233 days**	**Mon 4/12/10**	**Wed 12/31/14**
321		**Governance**	**121 days**	**Mon 4/12/10**	**Mon 9/27/10**
322	✓	MHCC must submit appraoch to revising strategic and	1 day	Mon 4/12/10	Mon 4/12/10
323	✓	Identify to ONC designated state HIT coordinator who	1 day	Sat 5/1/10	Mon 5/3/10
324		Submit approach to governance structure and make up of	1 day	Mon 9/27/10	Mon 9/27/10
325		Submit content that outlines oversight and accountability	1 day	Mon 9/27/10	Mon 9/27/10
326		Submit framework for MHCC to align with emerging natiionwide	1 day	Mon 9/27/10	Mon 9/27/10
327		**Finance**	**906 days**	**Mon 9/27/10**	**Mon 3/17/14**
328		Submit analysis of how state may use purchasing power to	1 day	Mon 9/27/10	Mon 9/27/10
329		Update strategic and operational plan	1 day	Tue 3/15/11	Tue 3/15/11
330		Update strategic and operational plan	1 day	Thu 3/15/12	Thu 3/15/12
331		Update strategic and operational plan	1 day	Fri 3/15/13	Fri 3/15/13
332		Update strategic and operational plan	1 day	Mon 3/17/14	Mon 3/17/14
333		**Technical infrastructure**	**1 day**	**Mon 9/27/10**	**Mon 9/27/10**
334		Submit approach to how existing reguional and state	1 day	Mon 9/27/10	Mon 9/27/10

335		Submit statewide technical architecture	1 day	Mon 9/27/10	Mon 9/27/10
336		Submit content to show planned technical architecture leverages	1 day	Mon 9/27/10	Mon 9/27/10
337		Submit content to show planned technical architecture aligns	1 day	Mon 9/27/10	Mon 9/27/10
338		Submit content show planned technical architecture	1 day	Mon 9/27/10	Mon 9/27/10
339		Submit content show state has considered provider and patient	1 day	Mon 9/27/10	Mon 9/27/10
340		**Business and technical operations**	**1 day**	**Mon 9/27/10**	**Mon 9/27/10**
341		Submit approach to provide technical assistance as needed	1 day	Mon 9/27/10	Mon 9/27/10
342		Submit plan that indicates how recipients will align with State	1 day	Mon 9/27/10	Mon 9/27/10
343		Submit approach for monitoring and plan for remdeiation of	1 day	Mon 9/27/10	Mon 9/27/10
344		Submit staffing plan to show how staff will be established	1 day	Mon 9/27/10	Mon 9/27/10
345		Submit communications plan to outline MHCC strategy to	1 day	Mon 9/27/10	Mon 9/27/10
346		**Legal/Policy**	**926 days**	**Mon 8/30/10**	**Mon 3/17/14**
347		Submit outline of legal framework to facilitate HIE	1 day	Mon 9/27/10	Mon 9/27/10
348		Submit plan to establish statewide policy framework for	1 day	Mon 9/27/10	Mon 9/27/10
349		Submit process to ensure appropriate safeguards are in	1 day	Mon 9/27/10	Mon 9/27/10
350		Update strategic and operational plan to address	1 day	Tue 3/15/11	Tue 3/15/11
351		Update strategic and operational plan to address	1 day	Mon 3/12/12	Mon 3/12/12
352		Update strategic and operational plan to address	1 day	Fri 3/15/13	Fri 3/15/13
353		Update strategic and operational plan to address	1 day	Mon 3/17/14	Mon 3/17/14
354		Submit analysis of barriers, resources and ooprtunities ofr	1 day	Mon 9/27/10	Mon 9/27/10
355		Within 3 months pf plan approval, begin executing plan	1 day	Mon 8/30/10	Mon 8/30/10
356		**Outcomes and performance measures**	**1118 days**	**Mon 9/20/10**	**Wed 12/31/14**
357		Submit plan to monitor and maitain targeted degree of	1 day	Mon 9/20/10	Mon 9/20/10
358		Update strategic and operational plan to address statewide HIE alignment with other federal programs	1 day	Tue 3/15/11	Tue 3/15/11
359		Update strategic and operational plan to address statewide HIE alignment with other federal programs	1 day	Thu 3/15/12	Thu 3/15/12
360		Update strategic and operational plan to address statewide HIE alignment with other federal programs	1 day	Fri 3/15/13	Fri 3/15/13
361		Update strategic and operational plan to address statewide HIE alignment with other federal programs	1 day	Mon 3/17/14	Mon 3/17/14
362		Participate in HIE program evaluation	1 day	Fri 12/31/10	Fri 12/31/10

363		Participate in HIE program evaluation	1 day	Mon 1/2/12	Mon 1/2/12
364		Participate in HIE program evaluation	1 day	Mon 12/31/12	Mon 12/31/12
365		Participate in HIE program evaluation	1 day	Tue 12/31/13	Tue 12/31/13
366		Participate in HIE program evaluation	1 day	Wed 12/31/14	Wed 12/31/14
367		**Planning**	**19 days**	**Wed 9/1/10**	**Mon 9/27/10**
368		Submit strategic and operational plan to ONC	1 day	Mon 9/27/10	Mon 9/27/10
369		Submit evidence of stakeholder endorsement of strategic and	1 day	Mon 9/27/10	Mon 9/27/10
370		Training and technical assistance	1 day	Wed 9/1/10	Wed 9/1/10
371		Particpate in NHIN Governance Training	1 day	Wed 9/1/10	Wed 9/1/10
372		Review updates to statewide HIE toolkit	1 day	Wed 9/1/10	Wed 9/1/10
373		**Master Data Use Agreement**	**152 days?**	**Thu 10/1/09**	**Fri 4/30/10**
374		Examine federal and state laws	152 days?	Thu 10/1/09	Fri 4/30/10
375		Draft data use agreement	152 days	Thu 10/1/09	Fri 4/30/10
376		Review data use agreement	152 days	Thu 10/1/09	Fri 4/30/10
377		Input from multi-stakeholders	152 days	Thu 10/1/09	Fri 4/30/10
378		Revise data use agreement	152 days	Thu 10/1/09	Fri 4/30/10
379		Review data use agreement	152 days	Thu 10/1/09	Fri 4/30/10
380		Finalize data use agreement	1 day	Fri 4/30/10	Fri 4/30/10
381		**Contracts**	**32 days**	**Mon 5/3/10**	**Tue 6/15/10**
382		Develop terms and conditions for participants	30 days	Mon 5/3/10	Fri 6/11/10
383		Examine industry for available contracts	30 days	Mon 5/3/10	Fri 6/11/10
384		Develop service level agreements with responsibilities	30 days	Mon 5/3/10	Fri 6/11/10
385		Determine pricing schema for participants	30 days	Mon 5/3/10	Fri 6/11/10
386		Develop contracts for particpants	32 days	Mon 5/3/10	Tue 6/15/10
387		Execute contracts	30 days	Mon 5/3/10	Fri 6/11/10
388		**Communication and Outreach plan**	**383 days**	**Sat 8/1/09**	**Wed 1/19/11**
389	✓	Hire consumer outreach coordinator	1 day	Sat 8/1/09	Mon 8/3/09
390		**Develop outreach plan for hospitals**	**340 days**	**Thu 10/1/09**	**Wed 1/19/11**
391		Determine list of applicable members	210 days	Thu 10/1/09	Wed 7/21/10
392		Develop educational tools for target audience	210 days	Thu 10/1/09	Wed 7/21/10
393		Review educational tools for target audience	210 days	Thu 10/1/09	Wed 7/21/10
394		Sample test educational tools with 3 targets	210 days	Thu 10/1/09	Wed 7/21/10
395		Adjust educational tools as needed	210 days	Thu 10/1/09	Wed 7/21/10
396		Develop schedule of on site visits	210 days	Thu 10/1/09	Wed 7/21/10

397		Begin on site visits to promote HIE	210 days	Thu 4/1/10	Wed 1/19/11
398		Obtain consents	210 days	Thu 4/1/10	Wed 1/19/11
399		**Develop outreach plan for physicians and practices**	**340 days**	**Thu 10/1/09**	**Wed 1/19/11**
400		Determine list of applicable members	210 days	Thu 10/1/09	Wed 7/21/10
401		Develop educational tools for target audience	210 days	Thu 10/1/09	Wed 7/21/10
402		Review educational tools for target audience	210 days	Thu 10/1/09	Wed 7/21/10
403		Sample test educational tools with 3 targets	210 days	Thu 10/1/09	Wed 7/21/10
404		Adjust educational tools as needed	210 days	Thu 10/1/09	Wed 7/21/10
405		Develop schedule of on site visits	210 days	Thu 10/1/09	Wed 7/21/10
406		Begin on site visits to promote HIE	210 days	Thu 4/1/10	Wed 1/19/11
407		Obtain consents	210 days	Thu 10/1/09	Wed 7/21/10
408		**Develop outreach plan for consumers**	**340 days**	**Thu 10/1/09**	**Wed 1/19/11**
409		Determine list of applicable members	210 days	Thu 10/1/09	Wed 7/21/10
410		Develop educational tools for target audience	210 days	Thu 10/1/09	Wed 7/21/10
411		Review educational tools for target audience	210 days	Thu 10/1/09	Wed 7/21/10
412		Sample test educational tools with 3 targets	210 days	Thu 10/1/09	Wed 7/21/10
413		Adjust educational tools as needed	210 days	Thu 10/1/09	Wed 7/21/10
414		Develop schedule of on site visits	210 days	Thu 10/1/09	Wed 7/21/10
415		Begin on site visits to promote HIE	210 days	Thu 4/1/10	Wed 1/19/11
416		Obtain consents	210 days	Thu 4/1/10	Wed 1/19/11
417		**Develop outreach plan for vendors**	**340 days**	**Thu 10/1/09**	**Wed 1/19/11**
418		Determine list of applicable members	210 days	Thu 10/1/09	Wed 7/21/10
419		Develop educational tools for target audience	210 days	Thu 10/1/09	Wed 7/21/10
420		Review educational tools for target audience	210 days	Thu 10/1/09	Wed 7/21/10
421		Sample test educational tools with 3 targets	210 days	Thu 10/1/09	Wed 7/21/10
422		Adjust educational tools as needed	210 days	Thu 10/1/09	Wed 7/21/10
423		Develop schedule of on site visits	210 days	Thu 10/1/09	Wed 7/21/10
424		Begin on site visits to promote HIE	210 days	Thu 4/1/10	Wed 1/19/11
425		Obtain consents	210 days	Thu 4/1/10	Wed 1/19/11
426		**MHCC Policy Board**	**356 days**	**Tue 9/1/09**	**Tue 1/11/11**
427	✓	Determine membership of MHCC Policy	22 days	Tue 9/1/09	Wed 9/30/09
428	✓	Develop mission and goals of policy board	22 days	Tue 9/1/09	Wed 9/30/09
429	✓	Develop agenda for kick-off meeting	22 days	Tue 9/1/09	Wed 9/30/09

430	✓	Post informaiton on web site	1 day	Wed 9/30/09	Wed 9/30/09
431	✓	Hold PB initial kickoff meeting	1 day	Tue 12/8/09	Tue 12/8/09
432	✓	Develop PB operating guidelines	30 days	Tue 12/8/09	Mon 1/18/10
433	✓	Obtain PB approval	1 day	Tue 1/19/10	Tue 1/19/10
434	✓	Prepare meeting materials	29 days	Wed 12/9/09	Mon 1/18/10
435	✓	Develop agenda	29 days	Wed 12/9/09	Mon 1/18/10
436	✓	Post on website	1 day	Mon 1/18/10	Mon 1/18/10
437	✓	Send reminders to PB members	1 day	Fri 1/15/10	Fri 1/15/10
438	✓	Hold PB meeting	1 day	Thu 1/7/10	Thu 1/7/10
439	✓	Prepare meeting materials	28 days	Wed 1/20/10	Sun 2/28/10
440	✓	Develop agenda	28 days	Wed 1/20/10	Sun 2/28/10
441	✓	Post on website	1 day	Sun 2/28/10	Mon 3/1/10
442	✓	Send reminders to PB members	1 day	Wed 2/24/10	Wed 2/24/10
443	✓	Hold PB meeting	1 day	Tue 1/19/10	Tue 1/19/10
444	✓	Prepare meeting materials	30 days	Tue 3/2/10	Mon 4/12/10
445	✓	Develop agenda	30 days	Tue 3/2/10	Mon 4/12/10
446	✓	Post on website	1 day	Mon 4/12/10	Mon 4/12/10
447	✓	Send reminders to PB members	1 day	Wed 4/7/10	Wed 4/7/10
448	✓	Hold PB meeting	1 day	Mon 3/1/10	Mon 3/1/10
449	✓	Prepare meeting materials	30 days	Tue 3/2/10	Mon 4/12/10
450	✓	Develop agenda	30 days	Tue 3/2/10	Mon 4/12/10
451	✓	Post on website	1 day	Mon 4/12/10	Mon 4/12/10
452	✓	Send reminders to PB members	1 day	Wed 4/7/10	Wed 4/7/10
453	✓	Hold PB meeting	1 day	Tue 4/13/10	Tue 4/13/10
454		Prepare meeting materials	22 days	Wed 4/14/10	Thu 5/13/10
455		Develop agenda	22 days	Wed 4/14/10	Thu 5/13/10
456		Post on website	1 day	Thu 5/20/10	Thu 5/20/10
457		Send reminders to PB members	1 day	Tue 5/18/10	Tue 5/18/10
458		Hold PB meeting	1 day	Tue 5/25/10	Tue 5/25/10
459		Develop policies	1 day	Tue 5/25/10	Tue 5/25/10
460		Prepare meeting materials	22 days	Wed 5/26/10	Thu 6/24/10
461		Develop agenda	22 days	Wed 5/26/10	Thu 6/24/10
462		Post on website	22 days	Wed 5/26/10	Thu 6/24/10
463		Send reminders to PB members	1 day	Thu 7/1/10	Thu 7/1/10
464		Hold PB meeting	1 day	Tue 7/13/10	Tue 7/13/10
465		Develop policies	1 day	Tue 7/13/10	Tue 7/13/10
466		Prepare meeting materials	28 days	Wed 7/14/10	Fri 8/20/10
467		Develop agenda	28 days	Wed 7/14/10	Fri 8/20/10
468		Post on website	1 day	Tue 8/10/10	Tue 8/10/10
469		Send reminders to PB members	1 day	Mon 8/2/10	Mon 8/2/10
470		Hold PB meeting	1 day	Tue 8/17/10	Tue 8/17/10
471		Develop policies	1 day	Tue 8/17/10	Tue 8/17/10
472		Prepare meeting materials	28 days	Wed 8/18/10	Fri 9/24/10

473		Develop agenda	28 days	Wed 8/18/10	Fri 9/24/10
474		Post on website	1 day	Fri 9/10/10	Fri 9/10/10
475		Send reminders to PB members	1 day	Fri 9/10/10	Fri 9/10/10
476		Hold PB meeting	1 day	Tue 9/28/10	Tue 9/28/10
477		Develop policies	28 days	Wed 9/29/10	Fri 11/5/10
478		Prepare meeting materials	28 days	Wed 9/29/10	Fri 11/5/10
479		Develop agenda	28 days	Wed 9/29/10	Fri 11/5/10
480		Post on website	1 day	Mon 11/1/10	Mon 11/1/10
481		Send reminders to PB members	1 day	Mon 11/1/10	Mon 11/1/10
482		Hold PB meeting	1 day	Tue 11/9/10	Tue 11/9/10
483		Develop policies	1 day	Thu 9/9/10	Thu 9/9/10
484		Prepare meeting materials	28 days	Fri 9/10/10	Tue 10/19/10
485		Develop agenda	28 days	Fri 9/10/10	Tue 10/19/10
486		Post on website	1 day	Mon 1/3/11	Mon 1/3/11
487		Send reminders to PB members	1 day	Mon 1/3/11	Mon 1/3/11
488		Hold PB meeting	1 day	Tue 1/11/11	Tue 1/11/11
489		Develop policies	1 day	Tue 1/11/11	Tue 1/11/11
490		Incorporate Polices into HIE	286 days	Tue 12/8/09	Tue 1/11/11
491		**CRISP HIE Implementation**	**1412 days**	**Tue 8/4/09**	**Wed 12/31/14**
492	✓	**Pick core selection team**	**19 days**	**Tue 8/4/09**	**Fri 8/28/09**
493	✓	Direct hires	19 days	Tue 8/4/09	Fri 8/28/09
494	✓	Consultants	1 day	Tue 8/4/09	Tue 8/4/09
495		**Develop technical RFP for MPI**	**955 days**	**Thu 10/1/09**	**Wed 5/29/13**
496	✓	Draft document	152 days	Thu 10/1/09	Fri 4/30/10
497	✓	Review document	955 days	Thu 10/1/09	Wed 5/29/13
498	✓	Finalize document	955 days	Thu 10/1/09	Wed 5/29/13
499	✓	Post document on web	955 days	Thu 10/1/09	Wed 5/29/13
500	✓	Receive and answer bidder questions	955 days	Thu 10/1/09	Wed 5/29/13
501	✓	Responses received	955 days	Thu 10/1/09	Wed 5/29/13
502	✓	Review vendor responses	955 days	Thu 10/1/09	Wed 5/29/13
503	✓	Narrow to top 5 vendors	955 days	Thu 10/1/09	Wed 5/29/13
504	✓	Top 5 vendor presentations	955 days	Thu 10/1/09	Wed 5/29/13
505	✓	Narrow to top 2 vendors	955 days	Thu 10/1/09	Wed 5/29/13
506	✓	Perform site visits	955 days	Thu 10/1/09	Wed 5/29/13
507	✓	Perform due diligence on top 2 vendors	955 days	Thu 10/1/09	Wed 5/29/13
508	✓	Choose 1 vendor	955 days	Thu 10/1/09	Wed 5/29/13
509	✓	Obtain technical teacm approval	955 days	Thu 10/1/09	Wed 5/29/13
510	✓	Obtain board approval	955 days	Thu 10/1/09	Wed 5/29/13
511	✓	Obtain MHCC approval	955 days	Thu 10/1/09	Wed 5/29/13
512	✓	Contract negotiations	955 days	Thu 10/1/09	Wed 5/29/13
513		Contract signed	955 days	Thu 10/1/09	Wed 5/29/13
514		**Develop RFP for core infrastructur**	**1370 days**	**Thu 10/1/09**	**Wed 12/31/14**

515	✓	Draft document	955 days	Thu 10/1/09	Wed 5/29/13
516	✓	Review document	955 days	Thu 10/1/09	Wed 5/29/13
517	✓	Finalize document	955 days	Thu 10/1/09	Wed 5/29/13
518	✓	Post document on web	955 days	Thu 10/1/09	Wed 5/29/13
519	✓	Receive and answer bidder questions	955 days	Thu 10/1/09	Wed 5/29/13
520	✓	Responses received	955 days	Thu 10/1/09	Wed 5/29/13
521	✓	Review vendor responses	955 days	Thu 10/1/09	Wed 5/29/13
522	✓	Narrow to top 5 vendors	955 days	Thu 10/1/09	Wed 5/29/13
523	✓	Top 5 vendor presentations	955 days	Thu 10/1/09	Wed 5/29/13
524	✓	Narrow to top 2 vendors	955 days	Thu 10/1/09	Wed 5/29/13
525	✓	Perform site visits	955 days	Thu 10/1/09	Wed 5/29/13
526	✓	Perform due diligence on top 2 vendors	955 days	Thu 10/1/09	Wed 5/29/13
527	✓	Choose 1 vendor	955 days	Thu 10/1/09	Wed 5/29/13
528	✓	Obtain technical teacm approval	955 days	Thu 10/1/09	Wed 5/29/13
529	✓	Obtain board approval	955 days	Thu 10/1/09	Wed 5/29/13
530	✓	Obtain MHCC approval	955 days	Thu 10/1/09	Wed 5/29/13
531	✓	Contract negotiations	955 days	Thu 10/1/09	Wed 5/29/13
532		Contract signed	955 days	Thu 10/1/09	Wed 5/29/13
533		Develop technology project plan	210 days	Mon 5/3/10	Fri 2/18/11
534		Begin implementation of technology	210 days	Mon 5/3/10	Fri 2/18/11
535		Hire necessary staff to maintain system	210 days	Mon 5/3/10	Fri 2/18/11
536		Purchase necessary sw and hw	210 days	Mon 5/3/10	Fri 2/18/11
537		Implement necessary sw and hw	210 days	Mon 5/3/10	Fri 2/18/11
538		System tralning	210 days	Mon 5/3/10	Fri 2/18/11
539		Configure sw and hw	210 days	Mon 5/3/10	Fri 2/18/11
540		Test sw and hw	210 days	Mon 5/3/10	Fri 2/18/11
541		Reconfigure as needed	210 days	Mon 5/3/10	Fri 2/18/11
542		Perform load testing	210 days	Mon 5/3/10	Fri 2/18/11
543		Perform penetration testing	210 days	Mon 5/3/10	Fri 2/18/11
544		Test contingency plan	210 days	Mon 5/3/10	Fri 2/18/11
545		Test disaster plan	210 days	Mon 5/3/10	Fri 2/18/11
546		Complete technology implementation	210 days	Mon 5/3/10	Fri 2/18/11
547		Hire deployment staff	210 days	Mon 5/3/10	Fri 2/18/11
548		Train deployment staff	210 days	Mon 5/3/10	Fri 2/18/11
549		Begin pre-production pilot	210 days	Mon 5/3/10	Fri 2/18/11
550		Make system adjustments	210 days	Mon 5/3/10	Fri 2/18/11
551		Ensure all policeis are current and distributed	210 days	Mon 5/3/10	Fri 2/18/11
552		Ensure proper licensing in place	210 days	Mon 5/3/10	Fri 2/18/11
553		Comply with standards to supoort meaningful use	210 days	Mon 5/3/10	Fri 2/18/11

554		Develop process to capture and report metrics and HIE status	210 days	Mon 5/3/10	Fri 2/18/11
555		Begin production pilot	210 days	Mon 5/3/10	Fri 2/18/11
556		Make system adjustments as needed	210 days	Mon 5/3/10	Fri 2/18/11
557		Set up end users on portal	210 days	Mon 5/3/10	Fri 2/18/11
558		Train users on portal	210 days	Mon 5/3/10	Fri 2/18/11
559		Provide privacy and security training to end users	210 days	Mon 5/3/10	Fri 2/18/11
560		Production environment live	210 days	Mon 5/3/10	Fri 2/18/11
561		Determine production services deployment schedule (assume	210 days	Mon 5/3/10	Fri 2/18/11
562		Determine production deployment schedule (includes	210 days	Mon 5/3/10	Fri 2/18/11
563		System maintenance as needed	1218 days	Mon 5/3/10	Wed 12/31/14
564		**Service group 1 development (includes prescription fill. Lab orders and results, discharge summary, clinical summary, e-prescribing, rad orders and results)**	**90 days**	**Tue 6/1/10**	**Mon 10/4/10**
565		For each service - total of 6	90 days	Tue 6/1/10	Mon 10/4/10
566		Identify vendor solution options	90 days	Tue 6/1/10	Mon 10/4/10
567		If applicable, negotiate vendor solution contracts	90 days	Tue 6/1/10	Mon 10/4/10
568		**Requirement gathering**	**90 days**	**Tue 6/1/10**	**Mon 10/4/10**
569		Outbound ADT triggers	90 days	Tue 6/1/10	Mon 10/4/10
570		Inbound report	90 days	Tue 6/1/10	Mon 10/4/10
571		Consent process	90 days	Tue 6/1/10	Mon 10/4/10
572		Provider workflow	90 days	Tue 6/1/10	Mon 10/4/10
573		Reporting and quality measures	90 days	Tue 6/1/10	Mon 10/4/10
574		Establish acceptance criteria	90 days	Tue 6/1/10	Mon 10/4/10
575		**Design**	**90 days**	**Tue 6/1/10**	**Mon 10/4/10**
576		Outbound ADT triggers	90 days	Tue 6/1/10	Mon 10/4/10
577		Inbound report	90 days	Tue 6/1/10	Mon 10/4/10
578		Consent process	90 days	Tue 6/1/10	Mon 10/4/10
579		Provider workflow	90 days	Tue 6/1/10	Mon 10/4/10
580		Reporting and quality measures	90 days	Tue 6/1/10	Mon 10/4/10
581		**Build**	**90 days**	**Tue 6/1/10**	**Mon 10/4/10**
582		Outbound ADT triggers	90 days	Tue 6/1/10	Mon 10/4/10
583		Inbound report	90 days	Tue 6/1/10	Mon 10/4/10
584		Consent process	90 days	Tue 6/1/10	Mon 10/4/10
585		Provider workflow	90 days	Tue 6/1/10	Mon 10/4/10
586		Reporting and quality measures	90 days	Tue 6/1/10	Mon 10/4/10
587		**Training and education**	**90 days**	**Tue 6/1/10**	**Mon 10/4/10**
588		Develop training materials	90 days	Tue 6/1/10	Mon 10/4/10
589		Develop patient education materials	90 days	Tue 6/1/10	Mon 10/4/10

590		**Service group 2 development (includes eligibility claims, public health reporting and quality reporting)**	**90 days**	**Fri 6/1/12**	**Thu 10/4/12**
591		For each service - total of 6	90 days	Fri 6/1/12	Thu 10/4/12
592		Identify vendor solution options	90 days	Fri 6/1/12	Thu 10/4/12
593		If applicable, negotiate vendor solution contracts	90 days	Fri 6/1/12	Thu 10/4/12
594		**Requirement gathering**	**90 days**	**Fri 6/1/12**	**Thu 10/4/12**
595		Outbound ADT triggers	90 days	Fri 6/1/12	Thu 10/4/12
596		Inbound report	90 days	Fri 6/1/12	Thu 10/4/12
597		Consent process	90 days	Fri 6/1/12	Thu 10/4/12
598		Provider workflow	90 days	Fri 6/1/12	Thu 10/4/12
599		Reporting and quality measures	90 days	Fri 6/1/12	Thu 10/4/12
600		Establish acceptance criteria	90 days	Fri 6/1/12	Thu 10/4/12
601		**Design**	**90 days**	**Fri 6/1/12**	**Thu 10/4/12**
602		Outbound ADT triggers	90 days	Fri 6/1/12	Thu 10/4/12
603		Inbound report	90 days	Fri 6/1/12	Thu 10/4/12
604		Consent process	90 days	Fri 6/1/12	Thu 10/4/12
605		Provider workflow	90 days	Fri 6/1/12	Thu 10/4/12
606		Reporting and quality measures	90 days	Fri 6/1/12	Thu 10/4/12
607		**Build**	**90 days**	**Fri 6/1/12**	**Thu 10/4/12**
608		Outbound ADT triggers	90 days	Fri 6/1/12	Thu 10/4/12
609		Inbound report	90 days	Fri 6/1/12	Thu 10/4/12
610		Consent process	90 days	Fri 6/1/12	Thu 10/4/12
611		Provider workflow	90 days	Fri 6/1/12	Thu 10/4/12
612		Reporting and quality measures	90 days	Fri 6/1/12	Thu 10/4/12
613		**Training and education**	**90 days**	**Fri 6/1/12**	**Thu 10/4/12**
614		Develop training materials	90 days	Fri 6/1/12	Thu 10/4/12
615		Develop patient education materials	90 days	Fri 6/1/12	Thu 10/4/12
616		**Production deployment for service group 1 (includes prescription fill status, lab orders and results, e-prescribing and refills, discharge summary, clincal summary, radiology orders and results)**	**805 days?**	**Fri 10/1/10**	**Thu 10/31/13**
617		**Site 1**	**805 days?**	**Fri 10/1/10**	**Thu 10/31/13**
618		Obtain network subscription agreement	805 days?	Fri 10/1/10	Thu 10/31/13
619		Interface requirements obtained	805 days?	Fri 10/1/10	Thu 10/31/13
620		Interface developed (includes build, configuration, installation)	805 days?	Fri 10/1/10	Thu 10/31/13
621		Install necessary hw/sw (edge servers)	805 days?	Fri 10/1/10	Thu 10/31/13

622		Interface implementation (includes testing, validation, go-live)	805 days?	Fri 10/1/10	Thu 10/31/13
623		Set up users on portal	805 days?	Fri 10/1/10	Thu 10/31/13
624		Train users on portal	805 days?	Fri 10/1/10	Thu 10/31/13
625		Privacy and security training	805 days?	Fri 10/1/10	Thu 10/31/13
626		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
627		**Site 2**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
628		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
629		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
630		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
631		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
632		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
633		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
634		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
635		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
636		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
637		**Site 3**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
638		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
639		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
640		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
641		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
642		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
643		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
644		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
645		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
646		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
647		**Site 4**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
648		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
649		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
650		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
651		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
652		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
653		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
654		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13

655		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
656		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
657		**Site 5**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
658		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
659		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
660		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
661		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
662		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
663		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
664		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
665		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
666		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
667		**Site 6**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
668		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
669		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
670		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
671		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
672		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
673		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
674		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
675		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
676		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
677		**Site 7**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
678		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
679		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
680		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
681		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
682		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
683		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
684		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
685		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
686		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
687		**Site 8**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**

688		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
689		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
690		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
691		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
692		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
693		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
694		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
695		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
696		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
697		**Site 9**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
698		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
699		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
700		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
701		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
702		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
703		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
704		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
705		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
706		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
707		**Site 10**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
708		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
709		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
710		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
711		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
712		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
713		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
714		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
715		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
716		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
717		**Site 11**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
718		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
719		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13

720		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
721		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
722		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
723		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
724		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
725		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
726		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
727		**Site 12**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
728		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
729		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
730		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
731		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
732		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
733		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
734		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
735		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
736		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
737		**Site 13**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
738		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
739		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
740		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
741		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
742		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
743		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
744		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
745		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
746		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
747		**Site 14**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
748		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
749		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
750		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
751		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13

752		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
753		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
754		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
755		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
756		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
757		**Site 15**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
758		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
759		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
760		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
761		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
762		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
763		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
764		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
765		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
766		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
767		**Site 16**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
768		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
769		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
770		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
771		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
772		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
773		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
774		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
775		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
776		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
777		**Site 17**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
778		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
779		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
780		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
781		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
782		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
783		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
784		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13

785		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
786		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
787		**Site 18**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
788		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
789		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
790		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
791		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
792		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
793		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
794		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
795		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
796		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
797		**Site 19**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
798		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
799		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
800		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
801		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
802		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
803		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
804		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
805		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
806		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
807		**Site 20**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
808		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
809		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
810		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
811		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
812		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
813		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
814		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
815		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
816		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
817		**Site 21**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**

818		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
819		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
820		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
821		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
822		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
823		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
824		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
825		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
826		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
827		**Site 22**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
828		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
829		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
830		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
831		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
832		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
833		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
834		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
835		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
836		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
837		**Site 23**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
838		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
839		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
840		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
841		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
842		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
843		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
844		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
845		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
846		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
847		**Site 24**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
848		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
849		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13

850		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
851		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
852		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
853		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
854		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
855		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
856		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
857		**Site 25**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
858		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
859		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
860		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
861		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
862		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
863		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
864		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
865		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
866		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
867		**Site 26**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
868		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
869		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
870		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
871		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
872		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
873		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
874		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
875		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
876		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
877		**Site 27**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
878		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
879		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
880		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
881		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13

882		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
883		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
884		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
885		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
886		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
887		**Site 28**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
888		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
889		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
890		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
891		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
892		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
893		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
894		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
895		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
896		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
897		**Site 29**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
898		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
899		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
900		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
901		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
902		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
903		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
904		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
905		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
906		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
907		**Site 30**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
908		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
909		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
910		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
911		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
912		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
913		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
914		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13

915		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
916		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
917		**Site 31**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
918		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
919		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
920		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
921		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
922		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
923		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
924		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
925		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
926		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
927		**Site 32**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
928		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
929		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
930		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
931		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
932		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
933		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
934		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
935		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
936		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
937		**Site 33**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
938		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
939		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
940		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
941		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
942		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
943		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
944		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
945		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
946		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
947		**Site 34**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**

948		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
949		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
950		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
951		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
952		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
953		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
954		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
955		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
956		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
957		**Site 35**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
958		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
959		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
960		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
961		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
962		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
963		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
964		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
965		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
966		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
967		**Site 36**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
968		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
969		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
970		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
971		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
972		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
973		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
974		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
975		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
976		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
977		**Site 37**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
978		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
979		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13

980		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
981		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
982		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
983		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
984		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
985		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
986		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
987		**Site 38**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
988		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
989		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
990		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
991		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
992		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
993		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
994		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
995		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
996		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
997		**Site 39**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
998		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
999		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
1000		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
1001		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
1002		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
1003		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1004		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1005		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
1006		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
1007		**Site 40**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
1008		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
1009		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
1010		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
1011		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13

1012		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
1013		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1014		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1015		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
1016		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
1017		**Site 41**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
1018		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
1019		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
1020		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
1021		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
1022		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
1023		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1024		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1025		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
1026		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
1027		**Site 42**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
1028		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
1029		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
1030		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
1031		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
1032		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
1033		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1034		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1035		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
1036		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
1037		**Site 43**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
1038		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
1039		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
1040		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
1041		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
1042		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
1043		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1044		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13

1045		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
1046		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
1047		**Site 44**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
1048		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
1049		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
1050		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
1051		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
1052		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
1053		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1054		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1055		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
1056		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
1057		**Site 45**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
1058		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
1059		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
1060		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
1061		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
1062		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
1063		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1064		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1065		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
1066		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
1067		**Site 46**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
1068		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
1069		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
1070		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
1071		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
1072		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
1073		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1074		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1075		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
1076		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
1077		**Site 47**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**

1078		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
1079		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
1080		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
1081		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
1082		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
1083		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1084		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1085		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
1086		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
1087		**Physican practice 1 - 2325**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
1088		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
1089		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
1090		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
1091		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
1092		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
1093		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1094		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1095		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
1096		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
1097		**vendor deployment (ie outside Lab/Rad)**	**805 days**	**Fri 10/1/10**	**Thu 10/31/13**
1098		Obtain network subscription agreement	805 days	Fri 10/1/10	Thu 10/31/13
1099		Interface requirements obtained	805 days	Fri 10/1/10	Thu 10/31/13
1100		Interface developed (includes build, configuration, installation)	805 days	Fri 10/1/10	Thu 10/31/13
1101		Install necessary hw/sw (edge servers)	805 days	Fri 10/1/10	Thu 10/31/13
1102		Interface implementation (includes testing, validation, go-live)	805 days	Fri 10/1/10	Thu 10/31/13
1103		Set up users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1104		Train users on portal	805 days	Fri 10/1/10	Thu 10/31/13
1105		Privacy and security training	805 days	Fri 10/1/10	Thu 10/31/13
1106		Go-live	805 days	Fri 10/1/10	Thu 10/31/13
1107		**Production deployment for service group 2 (includes eligibility and claims transactions, public health reporting, quality reporting)**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1108		**Site 1**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**

1109		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1110		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1111		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1112		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1113		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1114		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1115		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1116		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1117		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1118		**Site 2**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1119		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1120		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1121		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1122		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1123		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1124		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1125		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1126		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1127		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1128		**Site 3**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1129		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1130		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1131		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1132		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1133		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1134		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1135		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1136		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1137		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1138		**Site 4**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1139		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1140		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14

1141		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1142		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1143		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1144		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1145		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1146		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1147		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1148		**Site 5**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1149		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1150		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1151		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1152		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1153		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1154		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1155		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1156		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1157		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1158		**Site 6**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1159		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1160		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1161		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1162		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1163		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1164		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1165		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1166		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1167		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1168		**Site 7**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1169		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1170		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1171		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1172		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14

1173		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1174		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1175		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1176		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1177		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1178		**Site 8**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1179		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1180		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1181		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1182		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1183		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1184		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1185		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1186		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1187		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1188		**Site 9**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1189		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1190		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1191		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1192		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1193		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1194		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1195		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1196		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1197		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1198		**Site 10**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1199		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1200		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1201		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1202		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1203		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1204		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1205		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14

1206		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1207		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1208		**Site 11**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1209		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1210		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1211		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1212		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1213		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1214		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1215		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1216		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1217		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1218		**Site 12**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1219		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1220		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1221		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1222		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1223		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1224		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1225		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1226		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1227		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1228		**Site 13**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1229		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1230		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1231		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1232		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1233		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1234		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1235		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1236		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1237		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1238		**Site 14**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**

1239		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1240		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1241		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1242		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1243		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1244		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1245		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1246		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1247		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1248		**Site 15**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1249		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1250		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1251		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1252		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1253		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1254		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1255		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1256		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1257		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1258		**Site 16**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1259		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1260		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1261		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1262		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1263		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1264		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1265		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1266		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1267		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1268		**Site 17**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1269		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1270		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14

1271		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1272		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1273		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1274		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1275		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1276		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1277		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1278		**Site 18**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1279		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1280		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1281		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1282		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1283		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1284		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1285		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1286		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1287		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1288		**Site 19**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1289		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1290		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1291		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1292		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1293		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1294		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1295		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1296		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1297		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1298		**Site 20**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1299		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1300		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1301		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1302		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14

1303		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1304		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1305		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1306		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1307		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1308		**Site 21**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1309		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1310		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1311		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1312		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1313		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1314		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1315		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1316		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1317		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1318		**Site 22**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1319		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1320		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1321		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1322		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1323		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1324		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1325		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1326		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1327		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1328		**Site 23**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1329		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1330		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1331		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1332		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1333		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1334		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1335		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14

1336		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1337		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1338		**Site 24**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1339		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1340		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1341		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1342		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1343		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1344		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1345		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1346		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1347		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1348		**Site 25**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1349		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1350		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1351		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1352		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1353		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1354		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1355		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1356		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1357		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1358		**Site 26**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1359		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1360		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1361		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1362		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1363		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1364		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1365		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1366		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1367		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1368		**Site 27**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**

1369		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1370		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1371		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1372		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1373		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1374		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1375		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1376		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1377		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1378		**Site 28**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1379		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1380		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1381		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1382		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1383		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1384		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1385		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1386		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1387		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1388		**Site 29**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1389		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1390		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1391		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1392		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1393		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1394		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1395		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1396		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1397		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1398		**Site 30**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1399		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1400		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14

1401		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1402		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1403		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1404		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1405		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1406		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1407		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1408		**Site 31**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1409		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1410		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1411		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1412		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1413		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1414		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1415		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1416		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1417		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1418		**Site 32**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1419		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1420		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1421		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1422		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1423		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1424		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1425		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1426		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1427		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1428		**Site 33**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1429		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1430		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1431		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1432		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14

1433		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1434		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1435		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1436		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1437		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1438		**Site 34**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1439		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1440		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1441		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1442		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1443		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1444		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1445		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1446		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1447		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1448		**Site 35**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1449		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1450		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1451		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1452		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1453		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1454		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1455		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1456		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1457		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1458		**Site 36**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1459		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1460		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1461		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1462		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1463		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1464		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1465		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14

1466		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1467		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1468		**Site 37**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1469		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1470		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1471		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1472		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1473		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1474		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1475		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1476		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1477		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1478		**Site 38**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1479		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1480		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1481		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1482		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1483		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1484		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1485		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1486		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1487		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1488		**Site 39**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1489		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1490		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1491		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1492		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1493		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1494		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1495		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1496		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1497		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1498		**Site 40**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**

1499		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1500		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1501		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1502		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1503		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1504		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1505		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1506		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1507		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1508		**Site 41**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1509		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1510		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1511		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1512		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1513		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1514		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1515		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1516		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1517		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1518		**Site 42**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1519		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1520		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1521		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1522		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1523		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1524		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1525		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1526		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1527		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1528		**Site 43**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1529		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1530		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14

1531		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1532		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1533		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1534		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1535		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1536		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1537		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1538		**Site 44**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1539		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1540		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1541		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1542		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1543		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1544		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1545		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1546		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1547		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1548		**Site 45**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1549		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1550		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1551		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1552		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1553		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1554		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1555		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1556		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1557		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1558		**Site 46**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1559		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1560		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1561		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1562		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14

1563		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1564		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1565		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1566		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1567		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1568		**Site 47**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1569		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1570		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1571		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1572		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1573		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1574		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1575		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1576		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1577		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1578		**Physican practice 1 - 2325**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1579		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1580		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1581		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1582		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1583		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1584		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1585		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1586		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1587		Go-live	545 days	Mon 1/2/12	Fri 1/31/14
1588		**vendor deployment (ie outside Lab**	**545 days**	**Mon 1/2/12**	**Fri 1/31/14**
1589		Obtain network subscription agreement	545 days	Mon 1/2/12	Fri 1/31/14
1590		Interface requirements obtained	545 days	Mon 1/2/12	Fri 1/31/14
1591		Interface developed (includes build, configuration, installation)	545 days	Mon 1/2/12	Fri 1/31/14
1592		Install necessary hw/sw (edge servers)	545 days	Mon 1/2/12	Fri 1/31/14
1593		Interface implementation (includes testing, validation, go-live)	545 days	Mon 1/2/12	Fri 1/31/14
1594		Set up users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1595		Train users on portal	545 days	Mon 1/2/12	Fri 1/31/14
1596		Privacy and security training	545 days	Mon 1/2/12	Fri 1/31/14
1597		Go-live	545 days	Mon 1/2/12	Fri 1/31/14

Technical Infrastructure

Standards and Certifications

The Advisory Board serves as the multi-stakeholder group for the purpose of identifying a widely accepted and useful set of standards for the statewide HIE. All standards deployed by the statewide HIE have already been accepted by HHS and will support widespread interoperability among providers in Maryland and with the NHIN. The statewide HIE anticipates using CONNECT to interface with the NHIN in early 2011. As part of the technology evaluation and procurement process, the statewide HIE has completed an assessment of the technology for compliance with HHS standards and will only integrate technology that meets these requirements. The MHCC has engaged Clifton Gunderson to perform an independent audit of the statewide HIE. Clifton Gunderson is ranked as one of the nation's largest certified public accounting and consulting firms and provides a wide range of assurance, accounting, tax, and consulting services to clients in a variety of industries. The audit is scheduled to begin in August 2010 and will focus on the financial, operational, and technical standards (HHS published standards compared to HIE implemented standards). The accountability for addressing concerns identified by the audit team rests with the statewide HIE Board of Directors.

Standards used by the statewide HIE infrastructure include: Health Level 7 (HL7), Digital Imaging and Communications in Medicine (DICOM), IHE, Electronic Data Interchange X12 (EDI X12), National Council on Prescription Drug Plans (NCPDP), Standard Object Access Protocol (SOAP), electronic business Extensible Mark-up Language (ebXML), Secure Socket Layer (SSL), and Transport Layer Security (TLS). DICOM and NCPDP provide for messaging standards around imaging and medication information, respectively. The statewide HIE has defined two Use Cases that will leverage these standards for the delivery of image and drug information. The American National Standards Institute Accredited Standards Committee X12 (ANSI ASC X12) is a standard that will be used in the exchange of administrative health care transactions.

The statewide HIE plans to use the Continuity of Care (CCD) C32 as a document standard with the recognition that further definition and constraints within that document will need to be applied. The use of the CCD standard is built upon and reinforced by the CCHIT identifying the CCD as a document standard in its 2008 certification criteria. The Advisory Board views some standards as having more relevance to the early phases of the HIE implementation than others.

A condition of connectivity for providers is that they use an EHR that meets national certification standards and other meaningful use requirements. Technology deployed by the statewide HIE will use existing standards recognized by the Secretary of HHS. The approach leverages a number of HITSP-endorsed IHE profiles, as well as ensuring emerging standards and interoperability specifications that have been endorsed by the appropriate oversight committee.

The statewide HIE is monitoring the work of ONC's Health IT Policy and Standards Committees to ensure that the technical infrastructure includes only those standards endorsed by the Secretary of HHS. Lessons learned regarding the technical infrastructure and other aspects of data sharing will be communicated directly with ONC and through collaboration with the designated Regional Center.

Safeguarding Data

In the first year of operation, the Advisory Board will define what security rules need to be implemented for the exchange of electronic patient information. Complying with the HIPAA Security Rule is expected to

require significant time and effort on the part of the statewide HIE. Adherence to the 18 broad standards is viewed as a critical step to ensuring the protection of electronic patient information. The statewide HIE's Board of Directors consists mainly of provider organizations that view the security of the data as paramount. These individuals will help guide the statewide HIE as it develops a compliance process. Vendor technology partners are required to demonstrate that their solutions meet or exceed the security requirements. Participation agreements stipulate that users comply with the HIPAA requirements. The statewide HIE will maintain an inventory of electronic patient information. The flow of electronic patient information will be easily tracked throughout the statewide HIE.

The statewide HIE will mitigate risk through a systematic and analytical approach that identifies and assesses these problems. The risk analysis will be used to develop appropriate and reasonable protections, and to anticipate risks and implement security measures. Security policies, procedures, and decisions will be documented by the statewide HIE and reviewed by the Board of Directors. The statewide HIE is well positioned to verify the accuracy of information through audit logs and conduct annual penetration testing to identify the vulnerabilities and determine the adequacy of the security protections. Penetration testing will be performed by the core infrastructure vendor on a quarterly basis and an annual penetration test to be conducted by an independent third party.

Disaster Recovery

The MHCC has a comprehensive Disaster Recovery Plan on file, which is tested during an annual audit. This information is proprietary in nature and is not available for publishing.

Technical Architecture

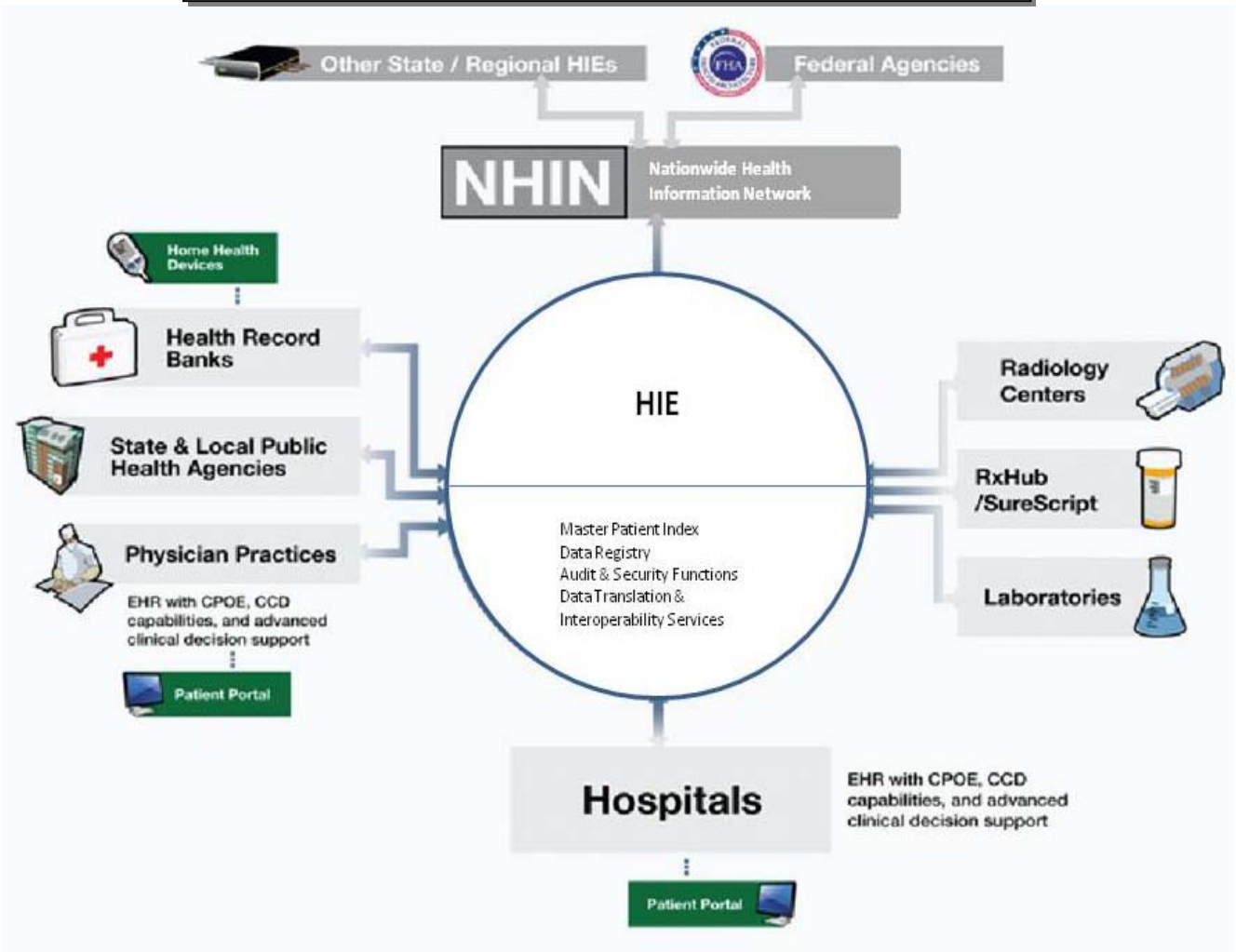
The statewide HIE is a standards-based, decentralized, hybrid model that supports both distributed data and PHRs and HRBs that will allow statewide availability for the secure transfer of a defined set of clinical information between appropriate participating entities. In the proposed model for development in Maryland, a hybrid system is conceived of one that consists of a single core infrastructure vendor that serves as a platform for expanding functionality of the utility by adding different vendor applications to the core system. For instance, the core infrastructure selected may consist of an exchange utility with a master patient index (MPI). The MPI in most solutions lacks the robust features necessary to support advanced matching of consumer's to their health information. Available on the market are vendor solutions specific to MPIs that would serve as an alternative to MPI in a core infrastructure solution (i.e., Initiate). The HRB serves the same functions as a PHR in this model. While clearly there are distinctions in the industry about HRBs and PHRs, in the model conceived of for Maryland there is considerable overlap in functionality. Primarily, both allow for consumer control and in this model the HRB also acts as a permissions portal for sharing patient information.

The statewide HIE Advisory Board will establish the technical performance requirements for providers connecting to the statewide HIE in 2010. The infrastructure is flexible to allow for market development in either a distributed or HRB driven model and will accommodate a MPI and Registry to locate records within the HIE. The distributed model ensures that data is held where it is created, therefore avoiding the negative perceptions and potential privacy and security consequences of storing all patient information in a large centralized HIE repository. In some cases such as laboratory results, radiology reports, pathology reports, and medication histories, clinical data will not be held in edge servers, but rather routed from the laboratory or imaging center to the ordering provider. The statewide HIE fosters a market in which consumers utilize

PHRs/HRBs, which function as a node in the statewide HIE. Access to the HRB/PHR selected by the consumer through the statewide HIE will be for viewing purposes only, and the data will not be integrated into the clinical record of the provider. Data from the statewide HIE will be available for public health and other approved secondary uses. The Policy Board will deliberate on data repositories for research and public health reporting in 2010. The architecture of the statewide HIE is compatible with NHIN core services.

The State of Maryland currently owns and operates the existing MMIS. The system is a direct descendant of the original MMIS applications based upon the Federal Blue Book specifications and technical architecture of the 1970's. Maryland has opted to proceed in pursuing a replacement MMIS with fiscal agent services and program operations through the MITA. Coordination with Medicaid is underway to ensure integration of the statewide HIE with MITA.

Maryland Health Information Exchange Fundamental Design



Selected Core Infrastructure: Axolotl

General Privacy and Security Strategy

Restricted Access to PHI

A main principle of the Privacy Rule is to prevent the availability of patient data to anyone other than healthcare providers designated by the patient. In addition to security measures to block intruders from accessing the network or system (please see Network Security below), privacy from unauthorized users is provided by the Elysium User Directory, nested within the Lotus Domino Directory. The directory provides user role and user workgroup creation, configuration, and administration tools. When users access the system, configured roles and workgroups are cross checked against database Access Control Lists (ACLs). ACLs define the users that can access a database, the data that can be accessed by those users, and the actions that they can perform on that data. Through these tools, Elysium Exchange restricts users, such that they may only access, edit, and manage clinical data according to their clinical workgroup and/or staff position.

Precise Patient Search

Protected health information (PHI) is further protected by Elysium Exchange's precise patient search technology. Elysium Exchange's patient index can find and return patients based on many items of patient information. Furthermore, patient index search engine restrictions are highly configurable. By configuring strict search parameters that require multiple items of patient information for the return of results, health systems greatly reduce the chance of physicians accessing PHI for patients they aren't treating.

Comprehensive User Audit

Elysium provides robust auditing capability for all access obtained to PHI. There will always be some cases where users may misappropriate clinical data, despite hardware security and configurations in the Elysium User Directory. In the case of such misappropriation, Elysium Exchange components provide the ability to audit users for the clinical information they have accessed, and when and from where they accessed it (please see Framework Components – EUA). Accordingly, an HIE may inform patients of all PHI that was compromised.

Physical and Network Security

Axolotl provides security of PHI in an Elysium Exchange through a number of leverages. The physical locations, networks, platform, and application technologies that support Elysium Exchange provide ample security on all levels.

Axolotl will deploy the following hosting and network practices for any systems related to PHI. First, there is physical machine security. Axolotl only hosts production Elysium Exchange servers in Tier 4 data centers that can pass the internationally recognized SAS 70-II standard requirements. This includes physical precautions such as HVAC units, fire retardant measures, strict host and guest authentication/sign in policies, and more.

Next, network security must be addressed. All Axolotl hosted Elysium servers are installed behind multiple firewalls configured for high availability and minimal vulnerability. All servers are installed with the latest versions of Windows 2003 Server and Symantec AntiVrius Corporate Edition. OS security and virus definition updates are performed regularly. Finally, network transfer security should be established. Secure

network connections and protocols are responsible for the transfer of PHI outside the network. Web standards such as VPN tunnels, WANs, HTTPs, and sFTP greatly reduce the threat of third party interception of sensitive data. For web services, secure network transport is provided by WSsecurity components such as SAML, the X.509 token profile, XML encryption, and XML digital signature. To verify that these location and network security measures are effective, Axolotl regularly performs internal security audits and penetration testing, in addition to bringing in outside firms to perform full audits of the system.

Platform Security

Beneath network security lays platform and application security measures. IBM Domino is responsible for most of the secure data transfer across Elysium servers. Domino provides greater security by using NRPC key encryption on all data that passes through Domino's Notes Transfer Port. This encryption makes intercepted data useless to offenders for lack of an appropriate decryption key. Further platform security is provided by the Domino Directory. The directory provides administrators with user role and user workgroup creation, configuration, and administration tools. When users access the system, configured roles and workgroups are cross checked against database Access Control Lists (ACLs). ACLs define the users that can access a database, the data that can be accessed by those users, and the actions that they can perform on that data. Through these tools, IBM Domino governs that users may only access, edit, and manage clinical data appropriately, according to their clinical workgroup and staff position.

Application Security and Privacy

Components of Elysium Exchange serve as the bottom level of security in the system. The Elysium User Directory was designed to build on the strengths of the IBM Domino Directory. Accordingly, user authentication is still largely powered by the Domino engine; however there are more specific user role and access definitions that may be configured. These specific role configurations allow Elysium Exchange to provide a greater range of access levels to the system. The Elysium Exchange has also been designed to effectively utilize Domino's flexible document formats. Beyond ACLs, Elysium databases are configured such that each user may only see certain views, forms, fields, and documents based on user type. If necessary items are not defined on a user document, the system will compute not to display certain information or options in the U/I. This strengthens Elysium's ability to prevent unauthorized access to PHI by disabling the display of it. In the case of users who may require access to data without prior patient authorization (e.g. emergency users), customizable consent forms may be configured and presented to users. Although it may be easy to "click through" these forms, the confidentiality and legality warnings displayed should serve as a serious deterrent. By using these challenge forms, users are forced to question whether they are legitimately accessing PHI. If not, they are subject to audit and legal scrutiny.

Authentication and Authorization

Elysium Directory manages an exchange's user and workgroup registration, access rights, and security. Elysium Directories are nested within IBM Domino directories. IBM clients provide an interface for the administration of user accounts and access rights. Domino directories are LDAP compliant, so some Elysium Directory management is available via LDAP.

Elysium provides industry recognized standards for authentication and security. Because the application is web based, authentication must be established through the browser interface. Elysium utilizes the available authentication tools from the Domino platform, web browsers, and more, including session based

authentication and SSL encryption. For web service authentication and security, WS-security policies are employed such as SAML, the X.509 token profile, XML encryption, and XML digital signature.

Elysium Directory provides an exchange with all the necessary tools to add and manage system users. System administrators can easily add users with a host of configuration options at their finger tips. These options determine what may be accessed, viewed, and modified by users, in addition to establishing some basic user preferences and demographic details. The various configuration options allow a great level of detail for user access roles and privileges. Beyond demographics, configuration options include system user type, available system add-ons (e.g., eRx, lab ordering), user's workgroup, job category, prescription DEA and license numbers, user specialties, provider ID configurations, and more. With this diverse set of fields to define each user, administrators can grant a wide variety of access levels to the system according to each user's clinical role.

Within each configuration, users are assigned to a specific workgroup. For a typical end user, this workgroup consists of all users in a particular practice. As such, each user shares a practice specific database, allowing providers and staff to manage patient workflow easily and efficiently. It is important to note that practice workgroup information is cross referenced before patient summary data is displayed. In other words, patient summary data that is displayed may be practice specific unless consent has been otherwise set by the patient. This system prevents out-of-practice users from viewing clinical data to which they have no right. For web services, authentication and authorization security is provided by WS-security components such as SAML, the X.509 token profile, XML encryption, and XML digital signature.

The Elysium Exchange platform supports single sign on (SSO), and Axolotl has done some limited integration of external systems with Elysium Exchange through this technology. However, SSO integration has not been frequently requested by Axolotl clients, as the Elysium Exchange suite effectively allows users to access data without the need of multiple applications. This tends to eliminate the need for SSO integration. Should portal integration be required, users may be able to access Elysium EMR and other systems through an SSO based portal, without the requirement of multiple authentication entries. Elysium EMR is agnostic with regard to portal technology; it may be integrated with any portal that supports SSO.

Data Ownership

There are generally two methods for systems integration with Elysium Exchange. The first is through the Elysium Framework based SOA Platform Gateways (e.g., Elysium I Hub, Elysium PHR Gateway), which enable heterogeneous integration of third party applications and services. The second is through Elysium Distributed Gateway EdgeServers, which allow participant entities to interface with the exchange while maintaining ownership and stewardship of entity specific data.

As described above, the heart of the Elysium Exchange system is the Elysium SOA platform. This platform has been designed for heterogeneous application integration, and is built using industry leading middleware technologies. The platform offers a rich, standards based set of web services for application integration. The integrated applications, either custom developed or provided by third party vendors, can interoperate seamlessly with Elysium applications and modules such as Elysium EMR, VHR, patient index and clinical summary. The web services offered by the Elysium SOA platform are highly secure and designed to support high transaction loads. The web services are built using Java EE. They use an enterprise service bus for event-driven communication, and use SAML and WS-Security for authentication and authorization.

Alternatively, for major CDOs or large participant entities that require some level of federation and maintenance of data control, Elysium EdgeServers may be provided. Elysium EdgeServer manages the transformation and distribution of data from systems such as legacy hospitals, lab systems, radiology systems, payers, and other regional information exchanges to Elysium. Elysium EdgeServers reside between source systems and an exchange on logically separated servers. Key EdgeServer databases include a site and feed configuration database, an administration database, a log database, and a routing database.

Logging and Audit

Auditing services will be provided at a number of levels. Elysium Exchange is IHE ATNA profile compliant; all authentication, interface use, and data import/export is logged to Elysium internal logs or to Web service audit repositories. All audit data is easily exported for analysis and reporting. Audit logging is configurable, all events are auditable (login/logout, lockouts, records viewed, data accessed, web services use, etc.) and reporting tools are configurable to easily track event trails. Some of these audit services may be provided by tools internal to Elysium Exchange, such as the Elysium Usage Analyzer, described in detail below. For Web service audit, Elysium Exchange provides services to populate and query ARRs. Elysium may also provide ARRs for population and query from any authorized users.

Elysium Exchange can route de-identified/pseudo-anonymized data to interfaced systems, such as public health population surveillance systems. If necessary, the pseudo-anonymization can include identifiers that will enable appropriate users to link back to identified patient records.

Additionally, Elysium Usage Analyzer (EUA) provides usage, performance, access, and security reporting for activity within an exchange. Elysium Usage Analyzer exists as a Domino database. This database references server log files of all web activity on the server. The EUA pulls data for a configurable time range, sorts it, and displays it in a number of views for reporting and analysis. Because the EUA produces a comprehensive view of web server activity, it proves itself ideal for system performance analysis. The EUA retrieves all data related to user web requests. As such, administrators may easily break down user activities, the time it takes the system to receive web requests, and the time it takes the system to respond. This kind of data allows for detailed analysis of overall system performance, specific component performance, specific user performance, most common user activities, and more.

Beyond system performance, the EUA provides views and tools for user audit and investigation into the misuse of PHI. Administrators with appropriately configured security roles may access restricted views, configure and run security audits, and view audit reports to determine what information was accessed by which user. This information can then be relayed for HIE staff to address appropriately.

The audit tools provide the ability for users to both proactively and reactively report against audit information. If desired, audit reports may be run for up to the minute access of the system or specific data. As such, audit report data may be used to identify users who have consumed PHI.

There is some flexibility with regard to logging options for CRISP. Various system components support a variety of log levels, and system audit tools (e.g. Elysium Usage Analyzer) may be configured to only reference and pull specific log information.

Custom audit rules may easily be generated, as the reporting module for generating EUA audit reports is highly flexible.

The EUA does not currently include automated alerting for audit exceptions; however, the product may be enhanced to provide automated alerts to security administrators if required.

Consent Management

The Elysium Exchange platform provides a highly flexible and configurable patient consent module. The module supports the ability for users to request "break the glass" one time access, for patients to set consent to share data, and for patients to give consent to disclose records. The consent to share data component is flexible, it can be configured to accommodate community wide sharing, or practice/user specific sharing. The consent to disclose records component enables patients to specify which records they want to submit to the HIE, and which they do not.

The way the system behaves based on known consent conditions is configurable. For example, if patients opt in, they may be opting in to share with the entire community, or they may have to specify practices and entities to share data with. The consent modules flexibility is also highlighted by the ability to configure the system to react differently based on unknown consent conditions. For example, if a patients consent is unknown, the system may automatically treat the consent as opt-in to automatically share with the community, opt-out to deny community access, or emergency only to allow community access if an emergency situation is declared. Flexibility may also be applied with regard to minor consent to share models. First, HIE administrators have to define the age range for "minors." Once a consumer reaches the configured "minor" range, the system will automatically reset the minor's consent to a configured setting for that age range (in this case, opt-out / do not share). HIE administrators may also define whether these consent settings may be edited for the minors, and by whom they may be edited.

These are just a few examples of how the Elysium Exchange consent module may be configured and deployed. The module is designed to be highly flexible to meet a very wide variety of regional, state, and federal consent requirements.

Existing consent status may be imported to the Elysium consent module through standard or proprietary interfaces, based on the capability of the system providing the consent status. Axolotl has had extensive experience deploying the consent management module at all Elysium Exchange deployment. The most in depth experience has been gained through work in the state of New York, where Axolotl provides a variety of consent management services to four separate regions of the state. Some of these regions, and NY state specifically, are known for employing some of the most complex consent models in the country. As New York and other clients propose new consent models required for patient privacy assurance, the Elysium Exchange consent module and HIE platform is modified accordingly.

Consumer Personal Health Record Authentication and Identity Management

Axolotl does not provide its own patient portal product, however, as with other health information systems, Elysium Exchange may interface with any standards based PHR system. Axolotl's philosophy is that with the emergence of PHRs supplied by health plans and employers, not to mention Google and Microsoft, it is highly unlikely a single vendor PHR solution will succeed. As such, similar to integration with any CCHIT or standards-based EMR, Axolotl is prepared to integrate with any suitable PHR.

It is imperative that some level of identity management and authentication services are built into the PHR or the portal that connects them so as to ensure any exchange of health data is assured to be by and for the patient purportedly using the PHR. Axolotl has partners that can be utilized to provide strong and/or two-

factor authentication services at very reasonable prices. Axolotl has a current customer that is establishing third party PHR integration into an Elysium with two PHRs initially with plans to expand. This same customer has put up a Patient Portal website that enables the patients to submit their participation consents for data sharing as well as register a PHR if they are using it. Axolotl has also been involved in discussion with Google Health for deployment of Elysium-Google Health integration in existing Elysium HIEs, and we anticipate a pilot HIE to begin exchanging data with Google Health in the first half of 2010.

Elysium PHR Gateway is still under construction, but Axolotl imagines a wide range of data will be exchanged via this gateway. Information type being considered for PHR exchange include patient demographics, appointment information, consent details, patient results, patient medication information and refill requests, self reported data, uploaded data from home healthcare devices, and more.

Policy

Axolotl's solution allows for deep granularity in defining user access roles and privileges

The various configuration options of the Elysium Directory allow for a detailed level of definition for user access roles and privileges. Beyond demographics, configuration options include system user type, available system add-ons (ex: eRx, lab ordering), user's workgroup, job category, prescription DEA and license numbers, user specialties, provider ID configurations, and more. With this diverse set of fields to define each user, administrators can grant a wide variety of access levels to the system according to each user's clinical role.

Axolotl's solution provides a highly flexible and configurable patient consent module

The module supports the ability for users to request "break the glass" one time access, for patients to set consent to share data, and for patients to give consent to disclose records. The consent to share data component is flexible; it can be configured to accommodate community wide sharing, or practice/user specific sharing. The consent to disclose records component enables patients to specify which records they want to submit to the HIE, and which they do not.

Axolotl's solution includes comprehensive user audit for all access to the HIE

Elysium provides robust auditing capability for all access and use of the exchange across all types of users, both administrative and clinical. Inevitably, cases will exist where users may inappropriately access the HIE, despite hardware security and configurations in the Elysium User Directory. In these cases, the Elysium Usage Analyzer provides views and tools for user audit and investigation into misuse of PHI. Administrators with appropriately configured security roles may access restricted views, configure and run security audits, and view audit reports to determine what information was accessed by which user. This information can then be relayed for HIE staff to address appropriately.

Axolotl provides strict physical and network security for all exchange of data

Axolotl provides security of data in an exchange through a number of avenues. The physical locations, networks, platform, and application technologies that support Elysium Exchange provide ample security on all levels. First, there is physical machine security. Axolotl only hosts production Elysium Exchange servers in Tier 4 data centers that can pass the internationally recognized SAS 70-II standard requirements. This includes physical precautions such as HVAC units, fire retardant measures, strict host and guest authentication/sign in policies, and more.

All Axolotl hosted Elysium servers are installed behind multiple firewalls configured for high availability and minimal vulnerability. All servers are installed with the latest versions of Windows 2003 Server and Symantec Antivirus Corporate Edition. Operating system security and virus definition updates are performed regularly. Beyond internal network protection, network transfer security is established. Secure network connections and protocols are responsible for the transfer of data outside the network. Web standards such as VPN tunnels, WANs, HTTPs, and SFTP greatly reduce the threat of third party interception of sensitive data. For web services, secure network transport is provided by WSsecurity components such as SAML, the X.509 token profile, XML encryption, and XML digital signature. To verify that these location and network security measures are effective, Axolotl regularly performs internal security audits and penetration testing, in addition to bringing in outside firms to perform full audits of the system.

Axolotl's solution ensures restricted access to data

In addition to security measures to block intruders from accessing the network or system, privacy from unauthorized users is provided by the Elysium User Directory, nested within the Lotus Domino Directory. The directory provides user role and user workgroup creation, configuration, and administration tools. When users access the system, configured roles and workgroups are cross checked against database Access Control Lists (ACLs). ACLs define the users that can access a database, the data that can be accessed by those users, and the actions that they can perform on that data. Through these tools, Elysium Exchange restricts users, such that they may only access, edit, and manage clinical data according to their clinical workgroup and / or staff position.

Axolotl offers an HIE Access Tool that allows clinicians to design workflows and policies based on the need of that particular clinician

The Elysium HIE Access Tool is a product that allows clinicians to design workflows and policies based on the needs of that particular clinician. Databases and functionality include clinical inboxes and disease reporting and rules engines. Add-ons include Elysium Ordering, Elysium Encounter Data Store, and Elysium Health Alerts. Off the shelf functionality includes components such as inbox management, clinical messaging, workflow management, referrals and consults, e-signature of documents, auto print and processing, patient summaries, and e-prescription writing.

Axolotl provides several levels of access solutions to ensure that providers have access to the exchange regardless of their current level of technology adoption

Axolotl has been in the HIE industry for many years and recognizes that to have a successful exchange with widespread use, an HIE must account for varying levels of participant technology. Axolotl offers access solutions for the full spectrum of users. Providers with EMRs may obtain information directly within their EMRs. For providers who would like to access the exchange electronically but have not yet implemented an EMR, Axolotl offers a cost-efficient HIE Access Tool product with customizable workflows and eRx. For providers who do not want an electronic system, Axolotl can configure the exchange to print or fax information to designated office spaces.

Axolotl has strong speed to value for deployment

Axolotl has brought over twenty successful HIEs live, and from these experiences they have developed an understanding of how to bring speed to value for an HIE. In the deployment plan presented to CRISP, Axolotl demonstrated a deep understanding of factors that will both increase speed to value and factors that are common barriers to implementation. Their methodology was proven, for example, in Nebraska, where

Axolotl recently enabled NeHII to ribbon cut the HIE for Omaha, their capital region medical trading area (MTA), within a matter of three months.

Axolotl has a service oriented architecture (SOA) platform that is proven in live deployments across the country

Axolotl's SOA approach enables third party development and customization of applications. Axolotl is deploying a strategy of making documented APIs available to all customers. This will help the statewide HIE ensure that we will not be restricted by a single vendor's product map or product vision. For example, the Rochester RHIO leveraged Axolotl's SOA platform to integrate information from the Monroe County Office for the Aging with the exchange.

Axolotl has strong standards support and compliance

Federally recognized groups such as IHE, HITSP, and CCHIT have created a number of profiles and standards that will be relied on to drive interoperability across domains. Axolotl has followed these committees and workgroups closely, and has made significant effort to adhere to standards while still meeting client and provider needs. As such, Axolotl has passed several IHE certifications key to interoperability and data exchange (PIX, PDQ, XDS.b, XCA, ATNA, ARR etc.), and has adapted traditional Elysium technology to be able to employ these profiles. Axolotl has demonstrated this technology at IHE Connectathons, HIMSS Interoperability Showcases, in the deployment of the SHIN-NY, and in the NHIN demonstrations. Axolotl participates yearly in IHE Connectathons, and has been consistently invited to take part in the HIMSS Interoperability Showcase that demonstrates this IHE technology.

Axolotl's technology has been proven in a good number of installations, including several statewide HIEs

In a recent KLAS report, Axolotl was a top vendor for number of installations. Axolotl is also the underlying technology for three statewide HIEs, which is more than any other vendor. The statewide HIE performed additional technical and financial due diligence both through internal company exploration and existing customer interaction.

Axolotl's technology has integrated tools for syndromic surveillance and public health reporting

Axolotl took a further step to enhance Elysium technology by integrating tools for syndromic surveillance and public health reporting. Through Elysium Registry and Reporter, authorized users can create and run reports across databases to detect clinical conditions and trends throughout the community (e.g. a diabetes report may be generated for all patients with relevant A1C results). Not only can the system scan and report on these conditions, but it may be configured to automatically alert appropriate community members in the event of any public health emergency.

The Health Record Bank and Personal Health Record Exception

Consumers have the option of exclusion from the statewide HIE for all other data transfer, while still allowing information to flow from an HRB to a health care provider. This feature of the statewide HIE is designed for consumers desiring more granularity than an all-out option. As consumer access applications become more available, user controls within those applications allow consumers to manage the flow of their personal health information within the statewide HIE, as long as those applications adhere to the technical and privacy standards established by the statewide HIE. When a query is initiated, the transaction process flow includes a reference to consumer-defined configurations for access to health information. The patient

has the ability to change those controls in real-time or near real-time to modify which providers have access to his or her information, what information they have access to, and the duration of access for a given provider. By creating an HRB account, consumers can opt-out of the full treatment, payment, and health care operations (TPO) exchange of their data and exercise greater control over what elements of their health records are shared through the statewide HIE.

The statewide HIE will allow PHRs, HRBs, and other consumer access applications to act as nodes on the statewide HIE, similar to any other provider participant. Consumer access will not be enabled in the early phases of the statewide HIE, but rather after early phase functionality has been deployed and is in use. In practice, this implies that PHRs/HRBs will adhere to similar IHE integration standards supporting the standardized transactions. The statewide HIE includes minimum integration standards that HRB vendors can build against and then engage the exchange to implement the product. These standards may leverage the IHE profiles, but may also look to deploy the XPRH IHE integration profile, the purpose of which is to support interoperability between PHR systems used by patients and the information systems used by healthcare providers. The statewide HIE will publish minimum authentication standards and will determine patient authentication to ensure the accurate delivery of patient records in HRB accounts in 2010.

The statewide HIE will provide a consumer access portal into the HIE, similar to the provider portal, which will allow consumers to view their health information and exert control over how it flows through the system. Encouraging consumer engagement by offering a standardized consumer portal solution will act as a catalyst for broader adoption of consumer health management tools.

Electronic Health Records

The statewide HIE includes a provider portal solution that can act as a mechanism to drive the adoption of robust EHR solutions as the statewide HIE grows and its value is realized. The concept is that less intrusive HIT solutions, such as portal access to the exchange, can allow providers to participate and use external health information during patient treatment without having to deploy intensive EHR solutions locally or significantly to modify clinical workflows.

Underserved Populations

The statewide HIE will include communities facing health, and health care, disparities. The statewide HIE will engage safety net clinics, federally qualified health centers, and underserved advocacy groups. A number of safety net clinics, federally qualified health centers, and underserved advocacy groups are already involved in the statewide HIE efforts. The statewide HIE is currently working with the Summit Health Institute for Research and Education, Baltimore Medical System, Community Health Integrated Partners, and the Shepherd's Clinic.

Public Program Connectivity

The statewide HIE is working with Medicaid to connect the existing Medicaid Management Information System. It will also assist Medicaid in selecting technology compatible with the statewide HIE for the Medicaid Information Technology Architecture transformation. Assessment activity related to connecting with the VA, Department of Defense, and other state and federal agencies will take place around the end of 2010. Among other things, this includes having the Advisory Board perform an in-depth evaluation of potential Use Case opportunities with these public agencies and to make recommendations to the Board of

Directors on the prioritization. Efforts to connect Medicaid and the VA are expected to overlap. Public program connectivity to the statewide HIE is vital to improving health care quality, safety, and efficiency.

Discussions of public program connectivity have evolved and have produced a strategy to integrate data exchange capability between the statewide HIE and publically funded programs. Specific details regarding an implementation plan are expected to be developed in the 3rd quarter of 2010. System architectures from the core infrastructure vendor selected by the statewide HIE are expected to meet with representatives from public programs within the next six months to complete a system integration design that will support connectivity of these programs to the statewide HIE.

Credentialing

The first step for provider participation in the statewide HIE is the authentication of that individual as a health care provider. This process is easily accomplished through a license number verification process. The statewide HIE will query the existing Maryland Board of Physician Licensure Database to authenticate the existence and status of state licensure. The Maryland Board of Physician Database is updated annually. Providers not appearing in the MBP Database will be manually authenticated with the Maryland Board of Physicians as they could be new to the Maryland market.

The Director of Outreach for the statewide HIE will complete the credentialing process for providers participating in the exchange. The statewide HIE with the assistance of legal counsel has developed a participation agreement that codifies the relationship with various participants. Providers interested in participating in the statewide HIE will have the ability to review the terms and conditions of the participation agreement on the statewide HIE's website. The participation agreement provides a mechanism for participants to acknowledge their understanding of the terms and conditions for participating in the statewide HIE. Providers interested in connecting to the statewide HIE are required to have a participation agreement on record with the statewide HIE before access to the HIE will be granted. A valid participation agreement requires the signature of an officer at the provider organization and the President of the statewide HIE. All participation agreements are maintained on-site by the statewide HIE and are included in the annual operational audit. It is the responsibility of each participating provider to ensure that employees of their organization with access to the statewide HIE have been appropriately credentialed. This approach avoids the statewide HIE from having to credential every individual provider and employee accessing the statewide HIE. Consumers are credentialed directly by the care provider at the point of care.

Analytics/Reporting

Public Health, Care Management, and Quality Improvement

The public health opportunities associated with the statewide HIE are immense. Databases of anonymized health information can create powerful quality improvement initiatives aimed at identifying best practices, defining evidence-based practices, and developing care management plans. The concerns related to privacy are of comparable significance. Some public health needs also do not require immediate or any reference of having to trace back to a particular individual.

Many providers in Maryland are already required to submit multiple files for secondary uses by public health officials for monitoring and reporting purposes. The statewide HIE will serve as a conduit to facilitate this existing reporting requirement, easing the burden on the provider community. However, the standards

for identified, de-identified, or anonymized data will be clearly defined by the Policy Board, communicated accurately, and understood widely when health information is used for these purposes.

The MHCC and the statewide HIE have had a series of discussions with DHMH over the last eight months regarding integrating Maryland's Immunization Registry, known as ImmunNet, into the statewide HIE. DHMH is considering utilizing the statewide HIE as a utility for maintaining the immunization registry. A decision regarding an immunization Use Case is expected later in 2010. The MHCC and the statewide HIE are expecting to be an active participant in the Maryland Medical Assistance Program's MITA redesign effort. While the statewide HIE will not serve as a data repository for the Medicaid program, it will serve as the utility by which the data will flow. During the 2010 legislative session a bill failed to pass that would require the statewide HIE to establish a prescription drug monitoring program that would rely on the statewide HIE as a repository for prescription drug information. The legislature has requested that the MHCC, in consultation with the statewide HIE and DHMH, evaluate the ability of the statewide HIE to serve as an efficient repository for prescription drug data and make recommendations back to the legislature in the 2011 session.

Other Secondary Use Opportunities

The statewide HIE will use secondary data, as approved by the Policy Board, to provide clear societal benefits and benefits to various local, state, and national public health agencies for the purposes of early identification of communicable diseases and acute or long-term population health threats. The communications between the appropriate parties during such public health events, as well as on-going and real-time monitoring of public health threats, are vital functions of a mature statewide HIE. The mechanism that will be implemented for collecting and analyzing health data from the HIE will enable public-health professionals to analyze and respond in real-time, which will significantly improve the responsiveness and efficacy of public-health risk remediation and response.

Technology Deployment

The deployment of the statewide HIE is planned incrementally to ensure that the HIE meets the requirements of meaningful use. This incremental strategy is rooted in the knowledge that moving too quickly in an environment as nascent as the HIE field could lead to unintended consequences for the statewide HIE and the HIE participants. However, incrementalism does not negate the statewide HIE's ability to be progressive, forward thinking, and to produce results at a faster rate than previously observed in other efforts. Efforts to align functionality of the statewide HIE will closely parallel the planned activity of the NHIN. The statewide HIE expects to begin sharing select electronic patient information with HIEs in the region within two years and will be ready to connect with the NHIN for select data as services become available. The statewide HIE will test against the implementation specification on a Use Case basis to assure compliance with the meaningful use requirements.

The statewide HIE is currently developing a preliminary set of questions for technology vendors. The questions are related to infrastructure capabilities, data and security standards, use of IHE Integration Profiles, and ability to support specific Use Cases. These questions will be posted on the statewide HIE website and sent by email directly to a group of approximately 30 vendors chosen based on their role in the market. These vendors represent a spectrum of HIT companies, ranging from off-the-shelf product vendors, component vendors, to systems integrators that can meet the challenges of data sharing in the private and public sectors and enable appropriate secondary uses of data.

Service Oriented Architecture

The statewide HIE embraces a SOA approach, which is necessary for the long-term viability of the HIE. The statewide HIE infrastructure is comprised of numerous services that will run on an enterprise service layer and enable the core functions of the HIE. By incorporating an SOA approach into the design, the statewide HIE will ensure that the exchange takes advantage of developing and advancing services and not rely upon a single service provider for all services. They include:

- Master Patient Indexing;
- Provider Identity Management Services;
- Registry Services;
- Repository Services;
- Authentication Services;
- Audit Services;
- Nomenclature Normalization Services;
- Consent/Authorization Management Services; and
- Network Monitoring Services.

Locating and Retrieving Records

Reading the Master Patient Index

When a participant in the statewide HIE is attempting to locate a patient in the HIE, that participant will send a request to the MPI PIX manager by submitting a standardized PIX Query. The PIX Query transaction carries the local medical record number (MRN) and locates that MRN within the PIX manager. Once found, the PIX Manager, as the name suggests, cross-references the submitted MRN with the other record numbers that have been associated with that MRN when the original PIX feeds were submitted to the exchange. Providers also have the ability to query the statewide HIE using demographic information for those patient encounters for which no MRN has previously been established or communicated with the PIX manager for cross-referencing. The Patient Demographic Query transaction will allow basic patient demographic information to be submitted to the MPI for patient location by leveraging statistical matching.

Locating Clinical Information

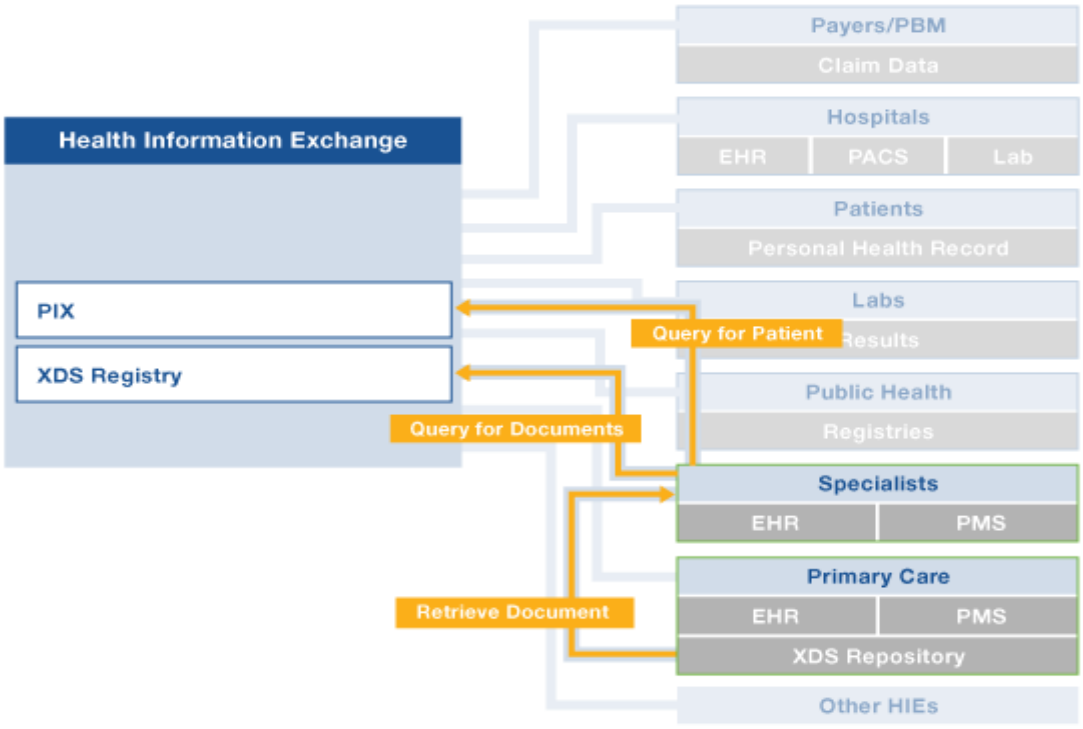
After successfully locating the patient, a transaction will be executed to locate records for that patient within the centralized Registry. Data housed in the Registry is not clinical data and is only metadata about the location and type of information available on edge devices and other repositories connected to the statewide HIE. Information in the Registry will then be presented to the provider as a list of clinical documents available in the statewide HIE, or normalized and compiled into a single clinical summary. The list of documents presented to the provider is dependent upon the access rights defined for that provider within the statewide HIE. Data will be presented to the provider as a list, but other data delivery options exist.

Retrieving Clinical Information from the Exchange

Following the initial PIX Query and the subsequent query and response of the statewide HIE Registry, the provider will have the option to select a document from the Registry that they wish to exchange, again

dependent upon their access rights to view that document. When a provider selects a document from the Registry list, a Retrieve Document transaction will be initiated that will send a request to the edge device storing the clinical information. When the request is accepted, that clinical document will be presented to the requesting provider.

This process for the retrieval of clinical information implies a pause in the location of patient records at the exchange Registry level for review of available documents. However, scenarios exist whereby a provider may prefer to receive core clinical data about a patient without the additional workflow of selecting clinical documents from a list of all available documents. In this scenario, the statewide HIE will identify, locate, and deliver a core document, defined by the document type, to be delivered to the requesting provider.



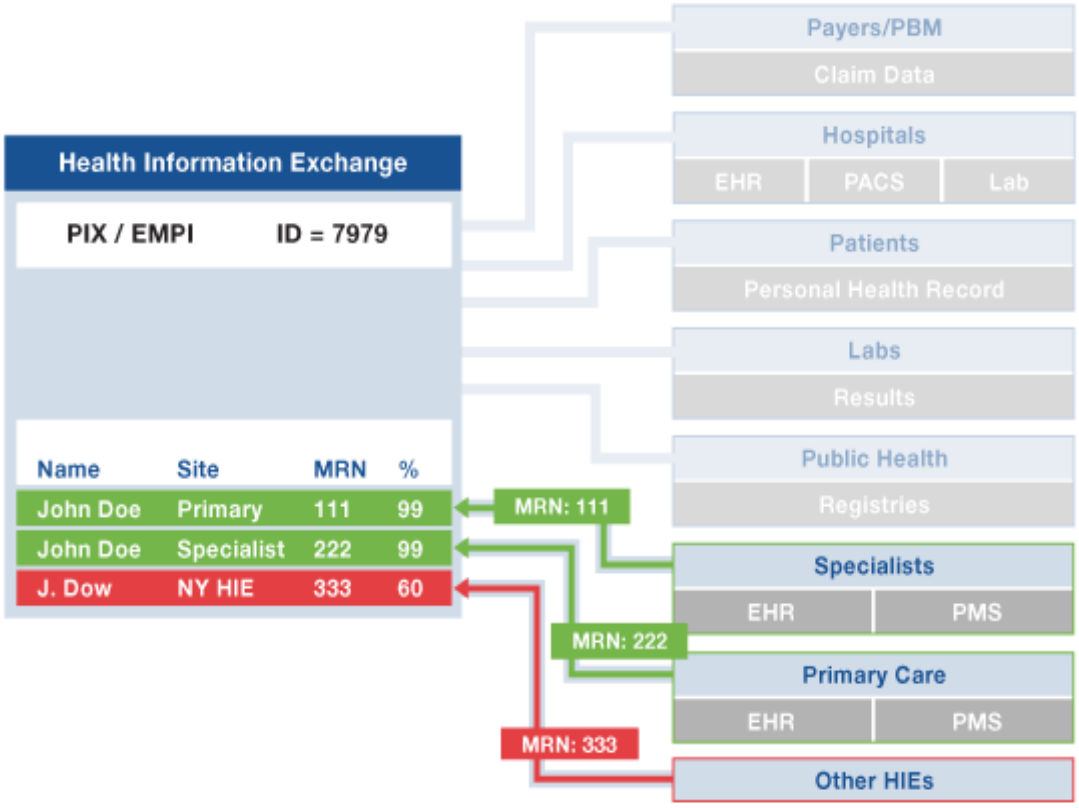
Master Patient Indexing

The statewide HIE will deploy the IHE PIX approach to patient matching to minimize both false positives and false negatives. The PIX manager is a layer on an MPI that is operated within the exchange and each record in the PIX contains cross references to the MRN located at participating institutions, which translates the MRN of one provider to the MRN of another provider. The initial link between a provider MRN and an existing PIX record is accomplished through statistical matching. Errors are mitigated through probabilistic or deterministic matching. This approach is similar to deploying a record locator service; however, it leverages an independent MPI and independent Registry to separate the functions in pursuit of an SOA approach.

The early statewide HIE Use Cases require that a supplier/sender will need to feed their MPI into the PIX, and receiving/consuming providers can send demographic data to the statewide HIE to be matched probabilistically to the MPIs of data suppliers/senders to obtain available data. The MPI will run algorithms against the existing demographic information to preprocess the database to determine the frequency of every attribute and will score the match according to the discriminating ability of the specific attributes of

that database. The limits of acceptance and rejection will be tailored to the size of the population and the risk tolerance of both false negative and false positives.

The diagram below illustrates an HIE participant submitting a standardized patient identity feed to populate the centralized MPI. Based on a centrally defined set of non-clinical patient information, a standard message will be sent to the central exchange MPI. If the subject patient already exists, the inbound transaction will be cross-referenced with the new record.



Business and Technical Operations

Current HIE Capacities

Approximately 17 percent of Maryland's acute care hospitals have initiatives underway to share limited patient information electronically with providers outside the hospital. In an effort to increase efficiency and quality of care, hospitals are implementing data sharing initiatives unique to their geographic area although consistent with existing standards and statewide policy. These hospitals will function as a single node on the statewide HIE and will manage connectivity with providers in their service area. The statewide HIE intends to make available to acute care hospitals connectivity to the HIE on a Use Case basis beginning in 2010. Connectivity depends largely on the readiness of each hospital. The statewide HIE is particularly interested in connecting the nearly seven percent of acute care hospitals that have an affiliation to a hospital in another state. Connecting these hospitals to the statewide HIE will allow for the identification and harmonization of technology and policy beyond those identified during the planning phase for the statewide HIE. The statewide HIE will assess hospital readiness for connecting to the HIE and, based on Use Cases,

establish connectivity with one hospital at a time. Connectivity with acute care hospitals that have an affiliation with an out of state hospital is anticipated around the fourth quarter of 2010.

State-Level Shared Services and Repositories

The statewide HIE's Advisory Board will explore opportunities for shared services and repositories with acute care hospitals that exchange some limited electronic patient information in their service area. These services include, but are not limited to: Patient Locator Service, Data/Document Locator Service, and Terminology Service. Over time, other services may be developed that comply with the standards and certification criteria adopted by HHS in an effort to expand participation in HIE. Currently, data sharing initiatives of acute hospitals is fairly limited. The Advisory Board's Exchange Technology Committee will work with acute care hospitals to identify opportunities for leveraging services from the statewide HIE. The Exchange Technology Committee is also expected to work with Medicaid as they move forward with implementing MITA. Coordination with Medicaid will eliminate redundancies in technology implementation and ensure that technology implemented by the statewide HIE is appropriately deployed. The MHCC is currently in discussion with Medicaid as they continue to plan for MITA implementation.

Standard Operating Procedures for Statewide HIE

HIE services are defined by Use Cases, which are services that provide benefits to patients, providers, and other stakeholders. Ultimately, the selection and prioritization of Use Cases is largely market driven. Market assessment by the Advisory Board's Clinical Excellence and Exchange Services Committee is ongoing. The statewide HIE website is one source for stakeholders to recommend Use Cases. The Board of Directors has the final decision on the implementation of new Use Cases. The Board of Directors will consider the Use Case recommendations from the Advisory Board's Clinical Excellence and Exchange Services Committee. Those approved will be forwarded to the staff of the statewide HIE to operationalize the Use Case. Prioritization will be based on existing workflows, resources, and potential revenue. At startup, in the absence of market feedback, the statewide HIE developed a list of Use Cases based on results from the two statewide HIE multi-stakeholder groups nine month planning project.

Human Capital

The statewide HIE has retained three full-time employees to manage the operations and implementation of the exchange. Systems integrators and management agreements are being used to provide the bulk of the statewide HIE's capacity in the first two years. In the following years, the statewide HIE will transition towards full-time employees based upon business needs. This approach will enable the statewide HIE to assess human capital needs within the organization to ensure appropriate resources to meet business requirements.

The statewide HIE expects to transition from a contractual labor model to a permanent staffing model based upon the work requirements and available revenue. Today, the implementation process is occurring based on a model that includes specific scope of work activities. Consultants are deployed based upon the work requirements in the existing scope of work. The decision to use contractual labor has been one that centers around work volume and costs. To hire FTEs to complete the current work effort would cost considerably more money than using consultants on a discretionary basis. The core infrastructure vendor selected for the HIE will provide input to determine the appropriate time when to retain FTEs in the PMO. The statewide HIE will only transition to an FTE when the scope of work demand meets or exceeds at least 173 hours per month, which is the work time required for an FTE. This work demand will be assessed on a

monthly basis and the position transition will occur when this need is sustained for a minimum of 90 days. The MHCC and the statewide HIE have evaluated the risks and trade-offs associated with using contractual labor as opposed to hiring FTEs. This approach ensures that the statewide HIE will not unnecessarily hire individuals where the work efforts do not support this decision.

Project Plan Risk Assessment and Mitigation

Approach

The majority of methods, techniques, and tools place particular emphasis on quantification for assessing the implementation and interdependencies. In an effort to accurately assess the impact of systems on systems, the statewide HIE will evaluate performance through a technique known as systems thinking. Data suggests that complex initiatives are better managed by the application of systems thinking. This will enable the statewide HIE to seek out new and diverse perspectives when solving problems in a manner that considers complexity, environmental influences, policy, change, and uncertainty.

Systems thinking will be used to self-evaluate the statewide HIE to determine an appropriate measurement of success with regard to implementation. As a strategic simulation tool, systems thinking evolved from a variety of tools aimed at mapping and modeling the global interaction of processes, information feedback, and policies across sectors. Viewing the statewide HIE from a very broad perspective that includes structures, patterns, and events, rather than limiting the assessment to just the events, allows for rapid detection and identification on the true cause of any issue and helps in determining specific areas that need attention to address these issues. The evaluation process will focus on input, processes, outputs, and outcomes pertaining to the implementation of the statewide HIE, and analyze select activities relating to the implementation and interdependencies of the statewide HIE. Data collected will be used to balance the processes that control change and help maintain stability.

Tools

The statewide HIE will use a number of systems thinking design tools in conducting ongoing evaluations of the HIE. These tools will increase the understanding and analyses of the statewide HIE and the conditions that create or affect the interdependencies. A combination of these tools will accurately depict a particular system or core system to the infrastructure of the statewide HIE. Key assessment tools include:

- Causal loop diagrams;
- Behavior-over-time graphs;
- Systems archetypes; and
- Flow diagrams.

Techniques

Systems thinking will be applied to each Use Case during the implementation phase and as appropriate on an ongoing basis. The statewide HIE will evaluate each Use Case prior to deployment and then monitor and assess the progress of implementation from a technical and operational perspective. The Advisory Board develops any process modifications that are identified from the analysis. The statewide HIE will maintain all

systems thinking evaluations as a permanent record, and is subject to annual audits by an independent reviewer. The statewide HIE is required to report on its self-evaluation activity to the MHCC.

Risk Management

The statewide HIE is responsible for developing risk management and contingency plans. The committees of the Advisory Board are active participants in identify risks and ways to mitigate the risks. The Board of Directors is ultimately accountable for the integrity and success of the risk mitigation plans.

Vendor Risk Management

Business Operations

Risk: The use of contractors poses challenges related to meeting the milestones of the State Plan.

Mitigation: The statewide HIE has three FTE positions and relies upon contractors to meet its deliverables. The contractors are required to provide the statewide HIE with a Scope of Work document that identifies the deliverables due from the contractor and are required to meet with the President of the statewide HIE on a weekly basis to ensure completion of the work. The contractor providing human capital support is a Maryland-based minority business and located within the same county as the offices of the statewide HIE. The organization supporting the statewide HIE continues to express their eagerness to be a part of this process and contracting organization has a stable workforce with minimal turnover.

Contingency Planning

Risk: Disruption in the statewide HIE's ability to meet its deliverables in the event of a severed relationship with the supporting contractor(s).

Mitigation: The statewide HIE has identified a working relationship with a competing human capital consulting organization local to the Maryland market. Representatives from this organization participate on voluntary basis on a number of planning and implementation activities. This consulting organization currently has the technical and policy development staff that could easily resume the business operations of the statewide HIE should any disruption occur in the existing relationships.

Vendor Oversight

Risk: Improper oversight of contractors could negatively impact the workflow and build out of the statewide HIE.

Mitigation: The Project Management Office (PMO) Director of the statewide HIE will manage vendor relations. The PMO Director reports to the President and is responsible for implementing the HIE technology and leading various project teams to ensure effective and efficient roll out of Use Cases. The PMO Director is responsible for monitoring the projects and preparing reports that track the performance of the statewide HIE.

Participant Risk Management

Participation

Risk: Unpredictable demand for services from the statewide HIE.

Mitigation: Services of the statewide HIE will be regionally deployed and clustered by location around the state. The work of the Regional Extension Center is structured to target high concentration medical trading areas. The statewide HIE has established a plan to work with The Maryland State Medical Society to leverage their support in getting providers to participate in the statewide HIE. In addition, Maryland passed House Bill 706, *Electronic Health Records – Regulation and Reimbursement*, during the 2009 legislative session that will incent providers to adopt EHRs and participate in the statewide HIE.

Health System Implementation

Risk: Uncertainty as to the period of time that the health systems will connect to the statewide HIE.

Mitigation: The effective exchange of electronic health information largely depends on the three academic health systems participating in the statewide HIE. These health systems constitute approximately 30 percent of all hospitals in Maryland and are associated with roughly 50 percent of the physicians that would be participating in the HIE. The statewide HIE has been working with the CIOs and the leadership of the leading health systems to encourage early adoption of the HIE services.

Payers Participation

Risk: Payers may delay implementation due to concerns over value and services.

Mitigation: Approximately two payers in the state have about 90 percent of the privately insured market. The statewide HIE, in consultation with the MHCC, has met on several occasions with the leadership of these two payers to keep them informed of the work activity and encourage participation in the statewide HIE. Presently, both payers are represented on the Advisory Board of the statewide HIE.

Technical Risk Management

Technology Deployment

Risk: Staggered implementation of component technology may impact the overall functionality of the statewide HIE.

Mitigation: Identifying technology partners and resolving issues related to functionality and contracting are critical in keeping with the established timeline. As a hybrid model health information exchange, the system is build using components from different vendors. Adhering closely to the timeline is critical to ensuring that services are deployed as scheduled. The statewide HIE is monitoring vendor activities and limits the time potential vendor solutions have to overview products, address questions, and complete contract negotiations.

Policy Implementation

Risk: The ability of the technology to support policies developed by the MHCC Policy Board.

Mitigation: Policies developed by the Policy Board will impact on the technology capabilities of the statewide HIE. The statewide health information exchange is required to implement policies from the Policy Board. The statewide HIE will complete a technology impact assessment that evaluates the implications that policies will have on the technology prior to making any changes to the system. Modifications to the system will be scheduled based on the impact of the change and the significance of the policy.

Sustaining the Functionality of the Core infrastructure

Risk: Disruption in services due to a hybrid model, resources, and increased utilization.

Mitigation: Maintaining the functionality of the system as additional components are added to the system and as new providers begin to participate with the statewide HIE can have an impact on the ability to adequately maintain network availability and reliability, and recover quickly from any unforeseen disruption to the system. The operational plan anticipates growth in services and in capacity. The statewide health information exchange will monitor capacity on a monthly basis to determine if additional technology and human resources are needed to sustain the core infrastructure. The technical staff of the core infrastructure that is being deployed will also monitor capacity and assist in capacity planning and evaluation.

User Education

Risk: Improperly trained users can create system disruptions and breaches to best practices.

Mitigation: Every new user that participates with the statewide HIE will require authorization, authentication, education, and technical support. The statewide HIE's Outreach Coordinator is responsible for ensuring that large provider groups with more than ten providers follow specific training guidelines for instructing users of the system on best practices. For practices with less than ten providers, the Outreach Coordinator will conduct an on-site visit to train users how to access the system.

Integrating Community Data Sharing Initiatives

Risk: Community data sharing initiatives may not see the benefit in participating with the statewide HIE.

Mitigation: Leadership from the statewide HIE and the MHCC routinely meet with hospital CIOs to discuss the value of participating in the statewide HIE and technology requirements to connect to the exchange. Providing CIOs with critical information regarding connectivity and their participation prior to implementing the statewide HIE helps the hospitals align their technology deployment plans with the State Plan.

Financial Risk Management

Sustainability

Risk: Improperly setting user participation fees at a threshold where providers are willing to pay for value.

Mitigation: The statewide HIE's Finance Committee of the Advisory Board is charged with identifying the appropriate costs of HIE services. The work of this group includes provider surveys and the review of national efforts to determine price points for services provided by the statewide HIE. Initial funding received through the unique all-payor-rate-setting system will help offset participant costs during the first couple of years of operation. This is in an effort to ensure pricing stability in the early years of the statewide HIE.

Cost Containment

Risk: Improper pricing of services in comparison of value and the cost of the services could negatively impact participation, thus increasing costs to those that are participating.

Mitigation: The Finance Committee of the statewide HIE's Advisory Board is tasked with developing unit costs for each service provided by the statewide HIE. The evaluation includes assessing CPU usage, human capital, and potential support from technology partners. Each service will have the base amount as well as a fee required by the provider type to manage cost in the most appropriate manner. The outcome of this process is used in determining a standard user fee for participation in the statewide HIE.

Legal Risk Management

Participant Agreement

Risk: Developing a participant agreement that is enormously complex or too simplistic to appropriately address participant requirements.

Mitigation: The statewide HIE has engaged an outside legal resource to modify the DURSA. The legal counsel will seek feedback from the provider community in the modifications proposed to the DURSA. The Advisory Board, the Board of Directors, and the MHCC Policy Board will review and approve the final document for use by the statewide HIE. Providers will not be permitted to modify the document once it has been finalized.

Liability Insurance

Risk: Insufficient insurance to cover risks associated with potential civil suits that could emerge as a result of sharing electronic health information.

Mitigation: The statewide HIE recognizes the risks associated with exchanging electronic health information. The statewide HIE has retained liability insurance to counter any litigation that could materialize. Feedback from the Board of Directors and outside legal counsel will routinely be sought to ensure adequate liability coverage of the organization and its' officers.

Competitive Risk Management

Community Data Sharing Initiatives

Risk: Acute care hospitals may choose to implement community sharing initiatives in their service area and bypass the statewide HIE.

Mitigation: The statewide HIE is working with all of the hospitals to ensure that they will participate with the statewide HIE. Engaging the hospitals early in their technology planning processes will help ensure that independent efforts to connect physicians to hospitals will not affect the community from participating in the statewide HIE. Existing state legislation offers incentives of monetary value to physicians who adopt certified EHRs that meet meaningful use requirements and participate in the statewide HIE.

Payers establishing their own HIE

Risk: Payers may choose to implement data sharing initiatives for their provider network.

Mitigation: The statewide HIE continues to engage Maryland payers in the design and service deployment of the statewide HIE. The goal is to identify the value for payers by participating in the exchange and implementing select services (i.e., electronic claims, eligibility verification, etc.) in the early stages to keep payers engaged in developing a statewide HIE.

Legal/Policy

Establish Requirements

The statewide HIE has retained Ober|Kaler, a Baltimore-based legal firm, with expertise in health care law and specializing in HIT and HIE matters. Legal counsel has been retained to ensure compliance with all applicable federal and state legal and policy requirements. Thus far, legal counsel has assisted in the development of participation agreements for the statewide HIE and has been instrumental in the Privacy and Community Interaction workgroup for one of the multi-stakeholder groups' HIE planning projects. Expert legal counsel has also provided substantial services to the Board of Directors of the statewide HIE. The Chair and the Secretary of the statewide HIE Board of Directors both bring a health care oriented legal background to the leadership team. Ober|Kaler reviewed the statewide HIE's work and provided guidance to the Board of Directors as it relates to compliance with HIPAA and MCMRA.

The input of legal counsel shapes the evolving policy regarding secure HIE consistent with existing laws. The statewide HIE recognizes that the regulatory environment in which the HIE operates will be significantly changed as the various HIPAA amendments and new requirements of the HITECH Act section of ARRA become effective. The statewide HIE's legal counsel has reviewed those requirements and assessed them on a high level basis and is confident that, directly and through appropriate vendor selection, the statewide HIE will be in compliance. Other requirements, such as the need to support accounting for disclosures on behalf of TPOs for a rolling three year period, will not be required for several years and the statewide HIE will ensure that selected vendors can support these requirements.

Legal counsel views HIPAA and the MCMRA as consistent with, and in fact supportive of, the type of HIE that Maryland intends to implement. Both Acts support the transfer of more data earlier in the life of the exchange, for treatment purposes at least, which could lead to greater adoption of both EHRs and in entity

participation in the HIE due to the fact that one measure of the value of the statewide HIE will be the amount of data available. The growth rate will accelerate as more data becomes available, and an opt-out policy fosters use of the HIE.

Opt-Out as the Baseline Consent Process

The statewide HIE will function on an opt-out principle only. Basic demographic information such as name, gender, address, and birth date will be transmitted, captured, and stored in secure computers owned or contracted for use by the statewide HIE. A separate Registry database, which is a core component of the HIE technology, will house the information or metadata that identifies what type of health information about a particular patient exists in the exchange and where that information can be found. Technical and privacy justifications require separate MPI and Registry databases as compared to keeping all patient identifying and record locating information in one database. A consumer's health information will remain with the participating entities and the statewide HIE will only serve as the roadmap and transport mechanism to find and retrieve records.

Providers will enable patients greater control over which of their records are published to the statewide HIE. The statewide HIE will allow consumers the right to opt-out of the HIE at the point of care or through a web-based portal connected to the statewide HIE. When the consumer opts out at the point of care they will complete a consent form which allows them to indicate their preference on whether to allow their information to be exchanged through the statewide HIE, or not. The form will also include a global check box that allows the consumer to completely opt out of the exchange. A consumer that chooses to opt out through the web-based portal will be required to appropriately identify themselves and then complete patient permissions table that enables electronic patient information to be shared with the select providers used in break-the-glass situations or opt out entirely. The statewide HIE will implement a policy to authenticate consumers prior to opting them out of the statewide HIE. This process includes a combination of confirmations through cell phones, snail mail, and call backs.

Providers will not have the ability to access patient information if the consumer elects to opt-out. However, as mentioned above, some demographic data will be transmitted and stored in the MPI hosted by the HIE, which is necessary in the event that the consumer elects to opt-in to the statewide HIE at a later date. The statewide HIE will inform consumers of their right to participate through an intensive public awareness campaign.

Privacy and Security Harmonization

Working with legal counsel, the statewide HIE will harmonize privacy and security requirements and compliance across Maryland and its bordering states relative to access, audit, authentication, and authorization. Harmonization of privacy and security requirements will be addressed through convening meetings with bordering states. These policies specify how participants in the statewide HIE are defined as individual users of the system; how the usage of the system is governed; how users are accurately and appropriately identified; and how records of that usage are captured, stored, and used for various audit purposes. Statewide policy development will initially focus on the four A's of HIPAA (access, audit, authentication, and authorization).

Access

The statewide HIE will use role-based access to allow participating entities to control access levels for the various resources within their organizations. Providers who currently utilize health information systems will likely have experience with assigning roles that dictate access level. In considering how role-based identity management is controlled, the statewide HIE must determine what entity defines those roles. Varying levels of identity management complexities exist, dependent upon whether participants access the statewide HIE through local integrated systems or through a specific client or web-based application.

The inclusion of an additional application, usernames, and passwords into a participating entity's operations imposes a number of challenges; however, the statewide HIE intends to pursue this approach because it is more realistic for near term clinical data exchange. Role types will be established and assigned because the statewide HIE will offer a physician portal to access the HIE. Administrators of the statewide HIE will have privileges to the appropriate user within participating entities who will then have the ability to assign usernames and passwords to individuals within that entity.

Participants will enter into participation agreements that are developed by the governance, approved by legal counsel, with a consistent approach to role assignment in order for the exchange to be successful. The Advisory Board will define the assignment of roles and access protocols in a common statewide HIE policy guide and codify that definition in a contractual agreement allowing for the trust that is a prerequisite for clinical data exchange.

Audit

Audit logs will be stored centrally at the statewide HIE level and will include detailed information about the type of data accessed, by whom, and when, but will not store the actual health information in the audit log. The statewide HIE includes providers that vary in size and have different audit and logging capabilities, the statewide HIE will avoid specific or complex audit requirements at the participant level and account for transactions flowing through the HIE in a centralized auditing log. The statewide HIE will conduct random auditing of logs based on specific rules that trigger audit events, including:

- Audits of all VIP records;
- Procedures for follow-ups on suspicious activity, such as indications of possible privacy or security breaches;
- Review of network intrusion detection system activity logs;
- Review of system administrator authorizations and activities;
- Review of physical access to data centers; and
- Review of other technical, physical, and administrative safeguards as established by the policies of the HIE.

Audit policies will include system event and mechanisms to disseminate incident reports and breach notifications. The Policy Board will define accountability actions to handle breaches, investigate complaints, and provide resolution or enforcement activities when such incidents occur. The Board of Directors will develop sanctions for any participant violating appropriate use of data.

The statewide HIE will at a minimum conduct annual penetration testing to exploit the vulnerabilities to determine whether unauthorized access or other malicious activity is possible. Penetration testing will include all applications, controls, and processes within the statewide HIE. Penetration testing will occur from both outside and inside the statewide HIE.

Authorization

The granularity that the Policy Board deems appropriate is a balance between complexity, usability, and administrative overhead of the exchange and will be arrived at in consultation with the statewide HIE participants. The statewide HIE will enable providers to view and save data for the purposes of treatment. The statewide HIE will verify which functions a user is authorized to perform. Authorization can range from the ability to view, contribute, and save data. These functions could be as simple as distinguishing between the ability to view data or view and contribute data, or they may involve more complex functions such as defining to the ability to see specific types of data and filtering various health data elements.

Authentication

A username and strong password will be the basis of authentication for access to the statewide HIE. When accessing the statewide HIE through a web-based application, participants will be required to have additional security measures deployed. The Policy Board will determine an appropriate balance between usability, security, and cost.

Federal Requirements

The statewide HIE anticipates exchanging health information with federal care delivery organizations. Discussions with the VA Maryland Health Care System are scheduled to occur during the fourth quarter of 2010. Planning meetings with representatives with the Maryland VA are essential to identify barriers and discuss challenges that relate to data sharing. Actual data sharing is not expected until late 2011.

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