MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

July 2010

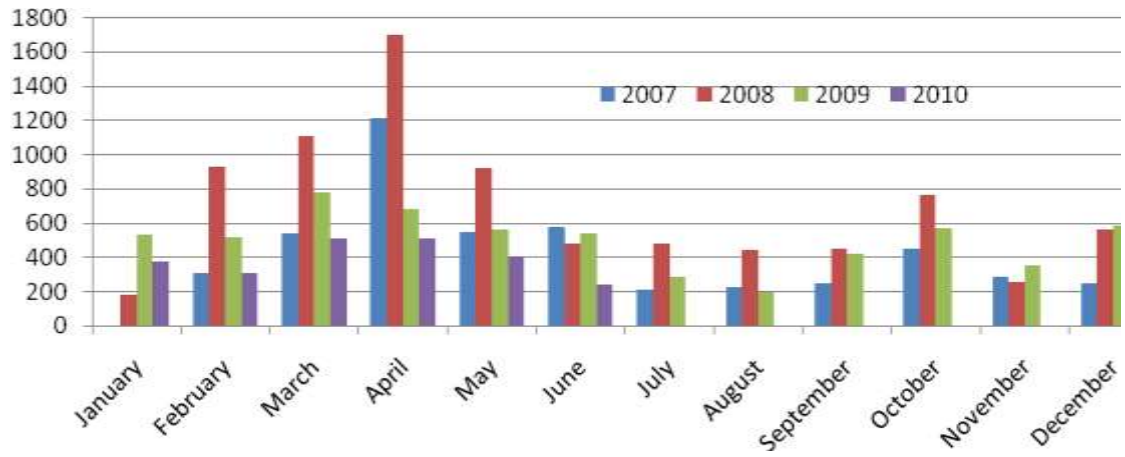
CENTER FOR INFORMATION SYSTEMS AND ANALYSIS

Maryland Trauma Physician Services Fund

Uncompensated Care Processing

CoreSource, Inc., the third party administrator (TPA) for the Trauma Fund, adjudicated claims with a total paid value of approximately $244,040 in June. The monthly payments for uncompensated care since February 2007 are shown below in Figure 1.

Figure 1 – Trauma Fund Uncompensated Care Payments 2007-2010



Patient Centered Medical Home Workgroup

The Maryland Health Care Commission began holding symposia on the Maryland PCMH Program for primary care practitioners throughout the state from June 22 through the first week of August. The State aims to involve 50 practices, with 200 primary care providers—physicians and nurse practitioners—and at least 200,000 patients in this initiative. For further information regarding the Commission's symposia, please send an email to Commission staff at: pcmhpractices@mhcc.state.md.us.

Information regarding the work of each of the subgroups and the PCMH Workgroup, as well as the schedule of upcoming meetings, is available on the Maryland Health Quality and Cost Council's website at: http://dhmh.state.md.us/mhqcc/pcmh.html. Please note that the next meeting of the Workgroup has not yet been scheduled.

Cost and Quality Analysis

Maryland Medical Care Data Base (MCDB)
The MHCC will host a webinar/in-person meeting with payers who submit data to the MCDB to address any outstanding issues regarding the submission of 2009 claims data on Tuesday, July 20th. The meeting will address required changes in the 2009 data submission due to the replacement regulations for the Maryland Medical Care Data Base (COMAR 10.25.06) that became effective in March. The 2009 data submission will include information on institutional services—primarily hospital inpatient and outpatient services. These data, when combined with the information on physician services and prescription drugs currently submitted by the payers, will allow the Commission to provide a more complete picture of health care utilization and spending for privately insured Maryland residents. The expanded MCDB will be used in a new report on health care utilization by the state's nonelderly privately insured to be released in 2010.

Payers may request a waiver for submission of selected data elements through August 16th; all 2009 data files are to be submitted by August 31st. As with the 2008 data, payers have the opportunity to submit their data to MHCC by uploading it to a secure FTP (file transfer protocol) server—provided the payer has a secure FTP client—eliminating the need to physically transfer data on electronic media such CDs. Last year, about half of the records submitted to MCDB were submitted via the FTP server.

Maryland Board of Physicians License Renewal Survey
The Board of Physician's Renewal Questionnaire was revised by MHCC staff in 2009 to obtain more detailed information on the number of hours worked by physicians practicing in Maryland—including how these hours are allocated across patient care, administration, teaching, and research—and practice size, including the numbers of physician and non-physician providers of medical care. About half of all physicians licensed in Maryland renew their two-year license each year, so that two years of survey data are needed to study all physicians in the state. The 2010 renewal survey begins in July, and when it is combined with the 2009 data in the fall of 2010, staff will initiate a study of the work patterns of physicians licensed to practice in Maryland.

Report on Use of Professional Services by the Nonelderly, Privately Insured in Maryland
This legislatively mandated annual study has been completed, and a summary of the findings will be presented at the July Commission meeting; printed copies of the report will be available in August. An important change in this year's analysis is the imputation of payments for services in the MCDB that lack payment information (due to capitation or contracting arrangements). This imputation significantly improves the accuracy of the reported professional service utilization among users with some capitated services, increasing the average expenditure per user in this group by about 20%. Among those using professional services, the average expenditure was $1,186 in 2008, 5 percent higher than in 2007. This growth is principally due to a 3 percent increase in the total number of professional services per user, but a 1 percent increase in average service complexity also contributed to the increase in spending. The average payment rate—as measured by the average payment per relative value unit (RVU)—was unchanged from 2007

User risk status, as determined by an expenditure risk score, is an important determinant of per-user expenditures for professional services. The annual expenditure for a user with "medium" risk is about twice that of a "low-risk" user, and the annual expenditure for a "high-risk" user is about five times that of a low-risk user. Annual growth in the average expenditure per user did not vary by patient risk status, coverage type, or region. However, growth in average per user spending was lower in HMO plans (3%) compared to non-HMO plans (5%); about 60 percent of the users in the MCDB are reported to be in non-HMO plans.

Although the overall payment rate was unchanged from 2007, there were changes in the payment rate when examined by payer market share. In the services insured by the largest payers, the average payment per RVU increased by 1 percent between 2007 and 2008, while the average payment rate among the other

payers decreased by 1percent. The average payment rate among the largest payers, $34.30 per RVU, continues to be below the average rate paid by other payer, $39.80. Differences in the average payment rate for large and other payers are due to three related factors. First, the largest payers compete more aggressively on price because they can deliver larger patient volumes to a practice. Second, the largest payers pay greater shares of services to in-network providers in contrast to other carriers that cannot offer large numbers of enrollees as an inducement to join the network. Third, many other payers reimburse non-participating practices at or near billed charges. Consequently, practices have less incentive to join these carriers' networks. The relationship among these three factors will be explored further in a future study.

Data and Software Development

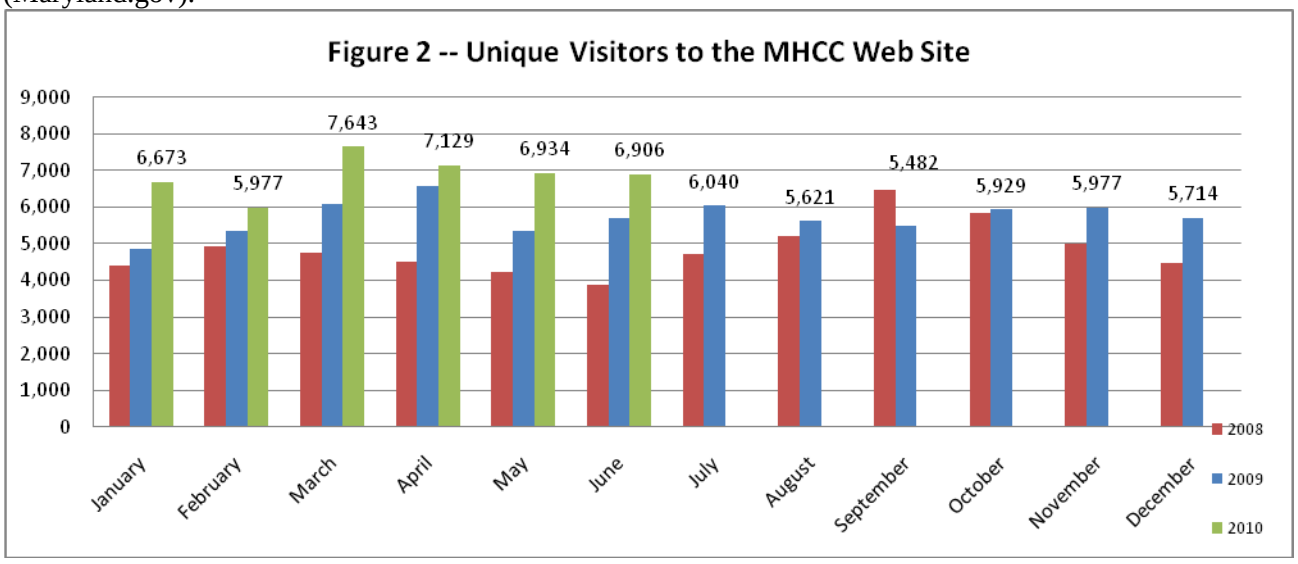
Data and Software Development

Unique visitors to the MHCC website decreased from May 2010 by 3 percentage points, but increased 21 percentage points from May 2009. The share of first time visitors as a percent of all visitors remained nearly the same, at 38 percent from the previous month. The amount spent on the site by new visitors and all visitors was unchanged from May 2010.

Visitors who arrived by directly entering the MHCC URL (mhcc.maryland.gov), or subfolders for our URL (mhcc.maryland.gov/hospitalguide for example), decreased by 5 percentage points from May 2010 to 44 percent New visitors who came directly to our site held nearly the same at 24 percent. Visitors who arrived via a search engine, such as Google, increased by 4 percentage points, to 40 percent Google specifically was responsible for directing 28 percent of visitors to our site in May, an increase of 4 percentage points from May. Four of the five most common keywords used in the search were the same as May:

- "Maryland Health Care Commission;"
- "mhcc;"
- "maryland health information exchange;" and
- "help paying for prescription drugs."
-

The remaining 17 percent of visitors were referred from sites such as other state agencies. The DHMH website was again the most common referring site, followed by the Maryland Web Portal (Maryland.gov).



Web Development for Internal Applications
Table 1 presents the status of development for internal applications and for the health occupation boards. Planning is underway for several new projects, including a Physician/Health Professional Portal that will integrate information on all projects that are of interest to health professionals in Maryland. The second effort is a redesign of the Hospital Quality website. A combination of internal and contract resources will be used for this effort.

Table 1– Web Applications Under Development

Board	Anticipated Start Development/Renewal	Start of Next Renewal Cycle
Board of Physicians – Physician Renewal	Planning	July 2010
Nursing Home Quality Site	Proposals Under Review	Start of Project: February 2010
Health Insurance Compare	Underway	July 2010
Physician Portal/PCMH	Complete	June 2010
Hospital Quality Redesign	Planning	Fall 2010

CENTERS FOR HEALTH CARE FINANCING AND LONG-TERM CARE AND COMMUNITY BASED SERVICES

Health Plan Quality and Performance

Currently we are in the planning stages for the 2010 Health Plan report series. As in past years we anticipate releasing the *Consumer* Guide in September 2010 and the *Comprehensive Guide* in November 2010. Due to the State transition from offering HMO plans to offering exclusive provider organization (EPO) plans (EPOs are a hybrid somewhere between HMOs and PPOs) health plan reporting in the *State Employee Guide* has become complicated. We are planning to meet with the Department of Budget and Management later this month to determine what health plan quality information would be useful to distribute to state employees at the time of open enrollment.

We have piloted a proprietary product for the last two years called eValue8 which complements the HEDIS measures and creates a much more robust performance measurement program and subsequently results in a report with greater utility for employers and employees choosing a health plan. While eValue8 data will not be represented in the 2010 reports we have been working with the Mid-Atlantic Business Group to ensure this information will be provided in the 2011 reports.

Staff are working with NCQA to determine how to expand measurement in a way that will better address quality measurement topics. Additionally, staff are reaching out to Maryland employers to get feedback on the content and utility of the *Consumer Guide*.

Small Group Market

Comprehensive Standard Health Benefit Plan (CSHBP)
The enactment of SB 637/HB 674 requires the Commission to post on the MHCC website and update quarterly, premium comparisons of health benefit plans issued in the small group market. The Commission contracted with Benefitfocus to design, develop and host the web portal called VIRTUAL COMPARE. Work on the web portal continues, with October as the operational target date.

Because of the incremental effective dates of the various reform initiatives under federal health reform (The Patient Protection and Affordable Care Act), various changes to the CSHBP regulations (COMAR 31.11.06) will be necessary. Commission staff is in the process of modifying the CSHBP regulations in cooperation with the MIA so as to comply with changes under federal reform that are effective on September 23, 2010. The goal is to seek approval of the emergency and proposed permanent regulations at the September meeting.

Health Insurance Partnership
The "Partnership" premium subsidy program has been available to certain small employers with 2 to 9 full time employees since October 1, 2008. As of July 7, 2010 enrollment in the Partnership was as follows: 282 businesses; 778 enrolled employees; 1,321 covered lives. The average annual subsidy per enrolled employee is $2,357; the average age of all enrolled employees is 39; the group average wage is approximately $28,000; the average number of employees per policy is 3.9; and the total subsidy amount allocated exceeds $1.8 million.

Mandated Health Insurance Services
Insurance Article § 15-1501, Annotated Code of Maryland, requires the Commission to submit an annual report to the General Assembly on: (1) any proposed mandated health insurance service that failed during the preceding legislative session; and (2) any request for analysis on a proposed mandated benefit that was submitted by a Legislator to the Commission by July 1st of that year. Each evaluation must include an assessment on the medical, financial, and social impact of the proposed mandate. The 2010 annual mandated benefits report will include evaluations of the following issues:

- Coverage for the treatment of bleeding disorders
- Coverage for routine HIV screening
- Coverage for habilitative services to individuals up to age 25
- Spinal Muscular Atrophy – coverage for private duty nursing services
- Cost sharing equity for cancer chemotherapy
- Prescription drug cost sharing obligations
- Mental Health Parity – analysis of amendments proposed by the Mental Health Association that were rejected
- Coverage of physical therapy services for patients diagnosed with Multiple Sclerosis

Long Term Care Policy and Planning

Hospice Data
The FY 2009 Maryland Hospice Survey was released for online data entry as of February 23, 2010. All Maryland hospice programs have now completed data submission for both Parts I and II of the survey. Staff is working with OCS, the contractor for the survey, to clean and finalize the data. Once the data cleaning is complete, the public use data set will be posted on the Commission's website.

Minimum Data Set
Staff is currently working with the minimum data set (MDS) Resident Assessment Instrument to update data sets for planning and policy development. The focus is on: update current programs and address programming issues; construct variables for research projects; develop a methodology to impute missing data; create data sets that permit tracking of variables over time; and link data sets. Myers and Stauffer, the contractor for this project, is finalizing several items for this contract. These include: detailed project documentation; a data dictionary; scenarios; software architecture; flow charts; and a glossary. The MDS Manager Program has been used to update MDS data through 2009.

End of Life Bill of Rights
Following the 2009 legislative session a workgroup met to discuss end of life care options and the development of an End of Life Care Bill of Rights. One of the recommendations of the workgroup was to distribute the End of Life Care Bill of Rights and to develop accompanying educational materials. A follow-up meeting was held on June 3, 2010 to discuss plans for an educational process. The purpose of the meeting was: 1) for agencies to affirm the Bill of Rights; 2) to convene a subgroup to develop a "how to" booklet to accompany the Bill of Rights; 3) to determine where to distribute it; and 4) to seek funding. The Bill of Rights was discussed and a small subgroup was appointed to work on educational materials. The larger group will reconvene on July 15th to review the work of the subgroup.

Home Health Agency Inventory
Staff is currently conducting a verification and update of its home health agency (HHA) inventory. As part of this process, staff sent out letters to all home health agencies on May 5, 2010, requesting each agency to advise the Commission staff whether the agency agreed with their authorized service area. Should the agency disagree with the listed authority in the letter, then the agency was to provide documentation to the Commission of other jurisdictions where the HHA believed it has such authorization by June 7, 2010. Staff plans to finalize the HHA inventory by the end of July 2010. This will be used for planning purposes as well as for updating the Commission's long term care website.

Home Health Agency Survey
At this time, 100% of the home health agency surveys have been submitted and accepted. Staff will proceed with data cleaning within the next few weeks.

Long-Term Care Survey
The survey notice was sent out on April 1, 2010 and it was available for online data entry as of April 8, 2010. Several reminder notices were sent out during the 60-day survey period. Completed surveys were due June 7, 2010. At the conclusion of the survey, the Commission received completed surveys by 100% of the nursing homes, 99% of the assisted living providers, 100% of the adult day care providers and 100% of chronic hospitals. Fining letters were sent to four assisted living providers who did not complete the survey on time. One of those has paid the fine and one has completed the survey.
Staff has begun working on the process for cleaning the data.

Long Term Care Quality Initiative

LTC Website Expansion
The new expanded long-term care website continues to be a work in progress with development right on schedule. The website design and functionality testing will be done using Staff and a diverse representation of external stakeholders. The website launch will coincide with the September Commission meeting and include a site demonstration to the Commissioners followed by a media event.

Nursing Home Surveys
The nursing home family experience of care survey cycle begins July 1, 2010 with a new contractor and a 33% reduction in cost from the current contract. There are strict performance requirements in the contract to ensure maintenance of Maryland's high response rate.

The *Seasonal Influenza Vaccination Survey* for nursing homes has been completed and data tabulation is in progress. 85% of nursing homes participated in this pilot survey. Commission staff will meet with the nursing home associations to review the data and formulate a plan to publish the results of the 2010-2011 survey on the LTC web site. Participation in the survey will be mandatory in 2011.

As part of the current LTC survey process staff expanded efforts to enforce the mandate for submitting a facility photo. At the end of an extended survey submission period, all but one nursing home and 98% of assisted living facilities submitted a facility photo.

Racial and Ethnic Disparities

Four new members were introduced to the Workgroup, including Dr. Wayne S. Rawlins, National Medical Director, Racial and Ethnic Equality Initiatives, AETNA; Ms. Michele Toscano, Head, Business Management Planning and Reporting, Office of the Chief Medical Officer, AETNA; Dr. Cynthia Reeves Tuttle, Vice President, Center for Prevention and Health Services, National Business Group of Health; Wendy Frisby, Account Manager, Pfizer; and Dr. Pamela Smith, Medical Outcomes Specialist, Pfizer.

Dr. Tuttle, NBGH, presented a PowerPoint entitled Racial and Ethnic Health Disparities in the Workplace: Achieving Equity Among the Insured, which highlighted recent efforts of the NBGH Center for Prevention and Health Services, in partnership with the Department of Health & Human Services Office of Minority Health, in addressing issues of racial and ethnic (R/E) health disparities, particularly within the insured population. In particular, the Employer Guide entitled: Addressing Racial and Ethnic Health Disparities: Getting Started and Things to Consider (September 10, 2000), which contains guidelines for the collection and analysis of R/E data, was discussed in terms of developing a consumer education program.

Mr. Kozlowski, MHCC, provided the Workgroup with an overview of the June 10, 2010 Maryland Health Care Reform Coordinating Council, summarizing the challenges involved in providing simple, reliable information to consumers, educating consumers and engaging them in their health care decisions.

Dr. Hussein and Dr. Mann, DHMH, highlighted the principles applied during the recent H1N1 vaccination campaign in Maryland, as well as lessons learned related to R/E data collection efforts.

Ms. Villalta, Kaiser Permanente, presented a synopsis of the Qualified Bilingual Staff (QBS) Train the Trainer Program and Kaiser's recent data collection efforts.

The next meeting of the Disparities Workgroup is Wednesday, July 21, 2010 from 9-11 am. Development of a consumer education program will be discussed, with input from the academic community, as well as a presentation by Dr. Rawlins and Ms. Toscano, AETNA, on current education efforts.

CENTER FOR HOSPITAL SERVICES

Hospital Services Planning and Policy

Certificate of Need (CON): June 1, 2010 through June 30, 2010

CONs Issued

Fredericktown Ambulatory Surgery Facility (Frederick County) – Docket No. 09-10-2302
Relocation/Establishment of a freestanding ambulatory surgical facility ("FASF"), through the addition of a second operating room ("OR") at Physicians Surgery Center of Frederick, located at 81 Thomas Johnson Drive, in Frederick, and the closure of Fredericktown Ambulatory Surgical Center, a two-OR FASF located at 198 Thomas Johnson Drive, also in Frederick
Cost: $102,636

Kaiser Permanente Baltimore Surgical Center (Baltimore County) – Docket No. 10-03-2306
Establishment of an FASF with two operating rooms to be located at 1601 Odensos Lane, in Baltimore County
Cost: $9,091,490

Anne Arundel Medical Center (Anne Arundel County) – Docket No. 10-02-2308
Addition of 30 medical/surgical/gynecological/addictions ("MSGA") beds in space currently under construction and originally approved as shell space (CON Docket No. 04-02-2153)
Cost: $5,243,815

Modified CONs Issued

Holly Hill Nursing and Rehabilitation Center (Baltimore County) – Docket No. 08-03-2285
Significant change in the physical plant design and a 63.8% increase in the cost of an expansion and renovation project, adding 20 comprehensive care facility ("CCF") beds, at this existing facility
New Approved Cost: $5,992,358

Approved CON Relinquished by Applicant

Kennedy Krieger Institute (Baltimore City) – Docket No. 08-24-2282
Relocation of two inpatient special hospital pediatric programs (the Neurobehavioral Unit and the Pediatric Feeding Disorder Unit) from 707 North Broadway to 1750 East Fairmount Avenue, on the Johns Hopkins Hospital/Kennedy Krieger Institute campus in Baltimore
Cost: $5,500,000

CON Applications Filed

Bethesda Eye Surgery (Montgomery County) – Matter No. 10-15-2311
Establish an FASF with 8 operating rooms to be located at 5001 Wilson Lane, in Bethesda.
Estimated Cost: $50,000

Determinations of Coverage

- **Ambulatory Surgery Centers**

Deer Point Surgical Center, LLC (Wicomico County)
Establish an ambulatory surgery center with one sterile operating room and two non-sterile procedure rooms to be located at 6503 Deer Point Drive, in Salisbury

Clinical Associates ASC (Baltimore County)
Relocation of an ambulatory surgery center, which has two non-sterile procedure rooms, from 515 Fairmount Avenue, Suite 500, in Towson, to Suite 101A at the same address

- **Capital Threshold**

Anne Arundel Medical Center/Pathways Drug & Alcohol Abuse Treatment Center (Anne Arundel County)
A capital expenditure of $600,000 to upgrade electrical and lighting systems, repair fire dampers, install a call system, upgrade the emergency power generator, and renovate the main nursing station and reception area of this intermediate care facility for alcohol and substance abuse treatment. MHA Bond Program funding will be sought for this project.

Mercy Medical Center (Baltimore City)
A capital expenditure of $3 million for the replacement and relocation of obstetric and pediatric facilities in the new hospital tower currently under construction. (It was determined that expenditure is within the scope of an approved CON – Docket No. 05-24-2174.) MHA Bond Program funding will be sought for this project.

Maryland General Hospital (Baltimore City)
A capital expenditure of $10.8 million to expand and renovate the emergency department. (It was determined that this expenditure did not require CON approval subject to documentation of the expenditure ultimately obligated.) MHA Bond Program funding will be sought for this project.

Sinai Hospital of Baltimore (Baltimore City)
A capital expenditure of $10,191,875 to finish shell space to replace and relocate medical rehabilitation beds and add critical care beds. (It was determined that this expenditure did not require CON approval subject to documentation of the expenditure ultimately obligated and bringing licensed medical rehabilitation bed capacity into conformance with physical medical rehabilitation bed capacity.) MHA Bond Program funding will be sought for this project.

Dorchester General Hospital (Dorchester County)
A capital expenditure of $2,516,443 for the renovation and expansion of the behavioral health unit, including a reallocation of MSGA bed capacity to acute psychiatric bed capacity. MHA Bond Program funding will be sought for this project.

- **Other**

    - **Delicensure of Bed Capacity or a Health Care Facility**

Fayette Health & Rehabilitation Center (Baltimore City)
Delicensure of 14 CCF beds

Liberty Heights Health & Rehabilitation Center (Baltimore City)

Delicensure of 3 CCF beds

Manokin Manor Nursing & Rehabilitation Center (Somerset County)
Delicensure of 9 CCF beds

Oakland Nursing & Rehabilitation Center (Garrett County)
Delicensure of 10 CCF beds

Policy and Planning

Data collection related to this year's hospital bed and service inventory surveys was completed by Center for Hospital Services staff in June. This survey establishes the allocation of acute care hospital beds among four services for the coming fiscal year and, in addition to gathering data on all types of hospital bed capacity, also includes surveys of emergency department treatment capacity, surgical facilities capacity, obstetric and perinatal services capacity, psychiatric facilities capacity, and medical rehabilitation and other special hospital bed services capacity. The survey was expanded last year to include information on surgical cases and surgical case times, in order to more accurately gauge operating room activity. This addition to the survey was viewed as largely successful and, with some minor changes, has continued as part of this year's survey.

The total number of acute care hospital beds that will be licensed for Maryland's 46 general acute care hospitals in Fiscal Year 2011, which began on July 1, 2010, will be 10,729 beds. This is 151 fewer acute care beds than the licensed acute care bed total of 10,880 beds for FY 2010, a decline of 1.4%, and represents the first decline in licensed acute care hospital beds since the current formula-driven hospital beds licensure program was initiated in Maryland in 2000. Twenty-seven hospitals saw a decline in acute care patient census in the twelve-month period that ended on March 31, 2010, when compared with the twelve-month period that ended March 31, 2009 and, thus, have experienced a drop in their licensed bed capacity. Thirteen hospitals saw an increase in average daily census from 2009 to 2010, and, thus, an increase in licensed beds and six hospitals saw no change in census or licensed beds. An interim report profiling the new hospital bed licensure data for FY 2011 will be posted on the MHCC web site later this month and the full standard annual report covering bed licensure and the other hospital service inventory data collected in the annual survey will be posted by September 1, 2010.

Hospital Quality Initiatives

Hospital Performance Evaluation Guide (HPEG) Advisory Committee

The HPEG Advisory Committee provides guidance and expertise on the various activities associated with the maintenance and expansion of the Hospital Performance Evaluation System. Most recent accomplishments are highlighted below:

- *Maryland Quality Measures Data Center Project*

The Maryland Quality Measures Data Center (QMDC) was established in 2009 under contract with the Iowa Foundation for Medical Care (IFMC). The QMDC provides a web-based tool for hospitals to upload clinical quality measures and patient experience (HCAHPS) data required to be reported to the Commission. Hospitals have recently submitted 4th quarter 2009 clinical and HCAHPS data which represents a major milestone for this project as a full calendar year of data has been collected through the Commission's new web-based system. The calendar year data will be posted to the Hospital Guide this month.

The contract with IFMC also incorporates a data validation component that is currently underway. The validation component includes an on-site review of a sample of patient medical records to ensure that the

hospital record supports the quality measures data submitted to the MHCC. The contractor has completed the on-site review process for 36 hospitals, with 10 recorded being audited per hospital. The results of the audit have been positive. The 4th quarter on-site data audit is underway.

- *New Surgical Care Improvement Project Clinical Process of Care Measures*

The staff is completing the process for adopting two new measures. The 30-day informal comment period ended on June 14, 2010. No comments were received. A formal notice of the new measure requirements will appear in the July 16, 2010 issue of the *Maryland Register*. The two NQF endorsed process measures will be required for the Hospital Performance Evaluation System effective January 1, 2011. CMS includes these measures in the RHQDAPU initiative as of January 1, 2010. The measures are briefly summarized below:

SCIP-Inf-9: **Urinary catheter removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with the day of surgery being 0**

Description: Surgical Patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with day of surgery being day 0

S**CIP-Inf-10**: **Surgery Patients with Perioperative Temperature Management**

Description: Surgery patients for whom either active warming was used intraoperatively for the purpose of maintaining normothermia or who had at least one body temperature equal to or greater than 96.8°F/36°C recorded within the 30 minutes immediately prior to or the 15 minutes immediately after Anesthesia End Time.

- *Collection of Data on Specialized Cardiac Care Services*

All Maryland acute general hospitals with a waiver from the Commission to provide primary percutaneous coronary intervention (PCI) services or with a certificate of need issued by the Commission for a cardiac surgery and PCI program are required to enroll in and report quarterly data to the Commission from the: American College of Cardiology (ACC) Foundation's National Cardiovascular Data Registry (NCDR) ACTION Registry-GWTG; and, ACC Foundation's NCDR CathPCI Registry. These reporting requirements apply to eligible patients discharged on or after July 1, 2010. For the ACTION Registry-GWTG, hospitals may submit either ACTION Registry-GWTG Limited or Premier. The Commission published formal notice regarding these reporting requirements in the *Maryland Register* on April 23, 2010.

On June 29, 2010, the Commission held an ACTION Registry-GWTG Training Session to assist hospitals in preparing for the new requirements. Representatives from the NCDR provided an in depth review of the system data requirements, reporting features and quality metrics. Over thirty participants representing eighteen hospitals participated in the workshop.

The Commission is in the process of organizing a standing Maryland State Cardiac Data Advisory Committee to assist in implementing the percutaneous coronary intervention (PCI) data reporting requirements. All meetings of the Advisory Committee will be open to the public. A webpage has been added to the Commission's website to post materials related to the Maryland State Cardiac Data Advisory Committee and may be accessed at: http://mhcc.maryland.gov/cardiac_advisory/index.html

Healthcare-Associated Infections (HAI) Data

The Healthcare-Associated Infections (HAI) Advisory Committee held its monthly meeting in June to review and discuss a variety of activities related to HAI prevention and control. Current and ongoing activities are highlighted below:

- *Validation of Data on Central Line-Associated Blood Stream Infections (CLABSI) in the ICU*

Since July 1, 2008, Maryland hospitals have been required to use the National Healthcare Safety Network (NHSN) surveillance system to report data to the Commission on Central Line-Associated Blood Stream Infections (CLABSI) in any ICU. Hospitals are required by NHSN to report data in the system within 30 days following the end of the month. The Commission has collected several months of CLABSI data and initiated an independent quality review of the data prior to public release of the information on the Hospital Guide. The Commission engaged the services of a contractor with expertise and experience in auditing health care infections data. The contractor, APIC Consulting Services, Inc., completed the on-site reviews and facility specific results were shared with hospitals for review and comment. *The Maryland CLABSI: Data Quality Review and Chart Audit Report* summarizes the chart review process and findings and has been posted on the MHCC HAI webpage.

- *Release of Revised Central Line-Associated Bloodstream Infections (CLABSI) Feedback Reports to Hospitals*

The staff has released revised CLABSI feedback reports to hospitals for the 6 month data period beginning July 1, 2009 through December 30, 2009. These reports enable hospitals to compare their individual CLABSI rates to statewide performance by ICU type. The reports also compare individual hospital performance to national performance using a Standardized Infection Ratio (SIR), a metric used by the CDC to compare hospital and state performance. These reports were released for hospital review as part of the on-going validation and data quality review process necessary to ensure accurate and meaningful public reporting. The feedback reports incorporate updates and corrections identified as a result of the CLABSI data quality review and audit process.

- *Public Reporting of Central Line-Associated Bloodstream Infections (CLABSI) on the Hospital Guide*

To ensure that the CLABSI data is presented in a meaningful and useful way, the Commission has engaged the services of the Center for Innovation in Quality Patient Care at Johns Hopkins to assist in developing alternative presentations of the data for public reporting. The contractor will perform a review the literature and environmental scan, solicit input through focus groups and develop recommendations at the HAI Advisory Committee for public reporting the CLABSI data on the Hospital Guide.

- *Health Care Worker Seasonal Influenza Vaccination Survey*

The 2009-2010 Health Care Worker Seasonal Influenza Vaccination Survey has been completed and preliminary results show some improvement in the rate of HCW vaccination over last year. The staff is preparing the survey results for display on the Hospital Guide in July.

- *Surgical Site Infection Data Reporting*

Effective July 1, 2010, hospitals are required to collect data on Surgical Site Infections (SSI) for surgeries involving hip replacements, knee replacements, and CABG, using the CDCs National Healthcare Safety Network System (NHSN). To facilitate communication regarding this new initiative, the staff will work with the HAI Advisory Committee to develop supporting materials, including a Frequently Asked Questions (FAQ) document for posting to the Commission's HAI webpage.

Other Activities

In support of MHCC's hospital quality initiatives, the staff continues to reach out to other units within DHMH, federal agencies, professional organizations and other states, to share and gather information and to identify opportunities for collaboration and improvement.

Specialized Services Policy and Planning

On May 21, 2010, the Commission docketed an application for a waiver to initiate a primary percutaneous coronary intervention (pPCI) program at Doctors Community Hospital (Docket No. 10-16-0050 WN). The Commission's staff is awaiting a response to its request for additional information from the hospital.

The staff is updating the forms used to apply for a waiver to provide pPCI services in a hospital without on-site cardiac surgery. The revised application forms will be available in August. The pPCI waiver application schedule is available at: http://mhcc.maryland.gov/hospital_services/specialservices/cardiovascular/ppci.html.

CENTER FOR HEALTH INFORMATION TECHNOLOGY

Health Information Technology

During the month, staff reviewed the proposed electronic health record (EHR) incentives regulations with select stakeholders. COMAR 10.25.16; *Electronic Health Record Incentives* will require state-regulated payers to provide primary care practices with an incentive for adopting an EHR. The Commission approved the release of the proposed regulations for public comment at the June meeting. These regulations were developed as a result of House Bill 706 (HB 706), *Electronic Health Records – Regulation and Reimbursement*, which passed during the 2009 legislative session. The public comment period begins on July 30th; the Commission will accept comments on the proposed regulations through August 30th. Staff worked with the six largest payers over a six month timeframe to reach consensus on an EHR incentive program. The payers include: Aetna, CareFirst, CIGNA, Coventry Health Care, Kaiser Permanente, and United HealthCare. These six payers represent more than 90 percent of the total premium volume in the state. The proposed regulations were vetted at various provider meetings throughout the spring. Currently, Maryland is the only state that requires state-regulated payers to offer incentives to providers for the adoption of EHRs.

HB 706 also requires the MHCC to designate one or more MSOs that offer hosted EHRs by October 2012. Staff worked with an Advisory Panel consisting of nearly 40 stakeholders to develop the criteria for State Designation over a four month period. MHCC began accepting applications for State Designation on May 17th. Eleven organizations have applied for State Designation; these organizations include hospitals, EHR vendors, and small technology companies. MSOs that are approved for Candidacy Status are required to submit documentation regarding their policies related to the privacy and security of health information along with their application. MSOs have 12 months to complete a self-assessment manuscript and undergo an evaluation by a national accrediting organization. The MHCC will award State Designation to MSOs that have obtained national accreditation.

Staff continues to provide EHR education to independent nursing homes. Over the last six months, staff convened two meetings with nursing home administrators to discuss the benefits, barriers, and risks associated with adopting EHRs. Staff is in the planning stages of convening a meeting that will be held in November where a panel consisting of an EHR vendor, nursing homes that have adopted EHRs, and the statewide health information exchange (HIE) will discuss EHR adoption and connectivity to the HIE. Staff submitted an application to present on EHR adoption and the statewide HIE at the annual Lifespan/HFAM conference in September. Staff is in the preliminary stage of developing the second environmental scan survey *An Assessment of Maryland Nursing Homes,* which is targeted for release at the end of summer. This environmental scan is aimed at determining the current level of EHR adoption among nursing homes. The questions focus on four areas: computerized functions, EHR implementation, adoption barriers, and the importance of adopting an EHR.

Modifications to the draft *Hospital Health Information Technology Survey* (survey) report continued in June. This survey is similar to several surveys administered nationally that assess health information technology (HIT) adoption; however, it is unique in that it includes planning questions in an effort to better understand the future of HIT adoption in hospitals. The findings are presented in aggregate, based on size, geographic location, and affiliation with other hospitals and health systems. The survey assesses the rate of HIT adoption among the state's 47 acute care hospitals, and evaluates the extent of adoption within the hospital's patient care areas, as well as the hospital's planning efforts related to HIT adoption. Overall, the rate of HIT adoption increased from the previous year across all areas of HIT assessed in the survey. Staff anticipates releasing the final report by the end of July.

Staff continues to work with the Centers for Medicare and Medicaid Services (CMS) on their EHR Demonstration Project (project). About 120 physician 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. In June, staff provided education on EHR adoption to the 60 practices that have yet to adopt an EHR. These practices have until 2011 to implement an EHR to remain part of the project. Staff sent practices a brief questionnaire aimed at understanding their progress in adopting EHRs, with responses due back in July. CMS has administered the first annual office system survey to practices with an EHR. These responses will be used to determine their initial incentive payment, which CMS will distribute during the fourth quarter of 2010. Maryland is one of four states participating in this project; the other states are Louisiana, Pennsylvania, and South Dakota.

Staff continues to provide feedback to the Johns Hopkins University (JHU) and the Community College of Baltimore County (CCBC), recipients of funding under the *American Recovery and Reinvestment Act of 2009* (ARRA) in April of this year for the development of HIT-related graduate and certificate education programs. JHU received approximately $1.8M for the *Curriculum Development Centers Program* to develop graduate level programs for HIT, and about $3.7M for the *University-Based Training Programs* to train professionals for vital, highly specialized HIT roles. CCBC will provide continuing education and training for the completion of non-degree programs within a six month timeframe. MHCC is providing input to JHU and CCBC on the challenges related to HIT for possible inclusion in their curriculum development.

Staff provided support to the Howard County consortium in their response to the Office of the National Coordinator's (ONC) *Beacon Community Cooperative Agreement* grant application released in May. The consortium consists of nearly 20 provider organizations in Howard County that will serve as a community for the grant application; the Johns Hopkins Health System is the lead organization. This grant will be awarded to approximately two communities to build and strengthen their existing HIT infrastructure; demonstrate where providers and patients are meaningful users of HIT; and achieve measurable improvements in health care quality, safety, efficiency, and population health. The average funding amount is approximately $15M and the award is for approximately 31 months. Applications were due by June 28th; ONC anticipates making an award announcement in August.

Health Information Exchange

Staff continues to provide guidance to committees of the Advisory Board for the Chesapeake Regional Information System for our Patients (CRISP), the statewide health information exchange (HIE). The Advisory Board consists of three committees: Finance, Technology, and Clinical Excellence. During the month, the Technology Committee discussed the current roll-out strategy for the core infrastructure and the Clinical Excellence Committee reviewed the initial HIE services. CRISP completed the initial configuration of the core infrastructure technology. HIE activity in Montgomery County continues to progress with technical connectivity and interfacing work underway with Holy Cross Hospital. CRISP is in conversations with a number of hospitals around the state and other early participants (i.e., laboratories and radiology centers). Staff worked with the Secretary of Health and Mental Hygiene to develop a list of recommendations for the Governor to consider in helping to expand HIE connectivity with the acute care hospitals. Staff also participated in a minority business enterprise meeting that CRISP convened; presenters included the Lt. Governor and Special Secretary Lawanda Jenkins from the Governor's Office of Minority Affairs.

Staff continues to provide support to the Maryland Medical Assistance (Medicaid) program in meeting the requirements under the *HIT Planning Advanced Planning Document* (HIT P-APD). Medicaid received an award of around $1.3M from CMS in April to provide a document that describes how the state will develop a high-level management statement of the state's vision, needs, purposes/objectives, plans, and estimated costs, which will result in the development of the *State Medicaid HIT Plan* (SMHP). Staff attended two CMS hosted technical assistance calls related to the implementation of the Health Information Technology for Economic and Clinical Health (HITECH) Act and developing the SMHP. Staff reviewed vendor responses for two small procurements: The first identified a vendor that can complete a feasibility assessment of Medicaid's alignment with existing health IT initiatives. The second procurement is to assess the Medicaid providers' level of readiness to meet the meaningful use requirements and to identify what information providers will be need from Medicaid to participate in the ARRA incentive program. Staff also completed a draft of a Request for Proposal to identify a vendor that can develop and maintain a program to administer the Medicaid ARRA incentives to eligible providers and hospitals for the adoption and meaningful use of EHRs.

The statewide HIE Policy Board subgroup convened in June to discuss key policies for consideration by the Policy Board at their July 13th meeting. In general, policies have been categorized into three areas: general, participation, and technical configuration. Members of the subgroup discussed the prioritization of the ten policies identified for review and continued to discuss the expectations around the primary reviewer concept. Policy Board members have volunteered to serve as a primary reviewer for policy development. Their primary role is to review a specific policy and to make recommendations for consideration by the Policy Board. Policy Board members were asked to provide preliminary feedback on Provider Access and Patient Choice policies in advance of the July meeting. Primary reviewers will consider feedback from the preliminary review in developing their recommendations.

Staff continues to provide support to the Electronic Healthcare Network Accreditation Commission (EHNAC) in the development of their national HIE accreditation program. During the month, staff participated in several virtual meetings with EHNAC and provided feedback on the privacy and security criteria. The Utah Health Information Network concluded testing of the criteria and provided EHNAC with comments. The public comment period ended in June, EHNAC expects to complete revisions to the criteria in July. The EHNAC Commission anticipates a final version of the criteria will be available around the end of the summer. EHNAC intends to begin accepting applications from HIEs around the end of the year. Staff also provided consultative support to EHNAC's Executive Director in developing a program launch strategy.

Electronic Health Networks & Electronic Data Interchange

Staff completed the recertification of Quadax and granted certification to Caremedic in June. COMAR 10.25.07 – *Certification of Electronic Health Networks and Medical Care Electronic Claims*

Clearinghouses requires the certification of electronic health networks that operate in Maryland. Payers that accept electronic health care transactions originating in Maryland must accept transactions from an MHCC certified electronic health network. The MHCC has certified approximately 45 electronic health networks.

During the month, staff provided consultative support to the 48 payers that are required to submit an EDI Progress Report. COMAR 10.25.09 – *Requirements for Payers to Designate Electronic Health Networks* requires payers with a premium volume of $1 million or more to complete an annual EDI Progress Report (report). The regulations require payers to submit a report to the MHCC by June 30th. The report includes census level information on administrative health care transactions for roughly eight transaction types identified under the Health Insurance Portability and Accountability Act of 1996, Administrative Simplification Provisions. The report is used by the MHCC, payers, and health care associations to develop strategies that expand the use of technology in Maryland.

National Networking

Staff participated in two Axolotl HIE Webinars: *Hospital Health Information Exchange ROI and Benefits Derived in Improving Patient Care*, which compared hospitals referring physicians workflow, pre and post HIE, ROI derived and how they got the HIE to pay for itself, and their plans for connecting into exchanges where they exist. The second webinar, *EMR Adoption – Helping Small Practices Achieve Meaningful Use* presented EHR adoption for clinics and small physician practices through web-based SaaS applications, the importance of affordability and simple implementation, as well as interoperability as a critical component to achieving meaningful use.

Staff participated in two CMS webinars: *Health Information Exchange and Tribal Affairs*, which presented current activities between Medicaid and the Indian Health Services related to provider adoption of EHRs and meeting meaningful use. The second webinar, *Promoting Electronic Records Adoption/Communications/Outreach*, detailed ONC's support of providers that implement EHRs.