MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

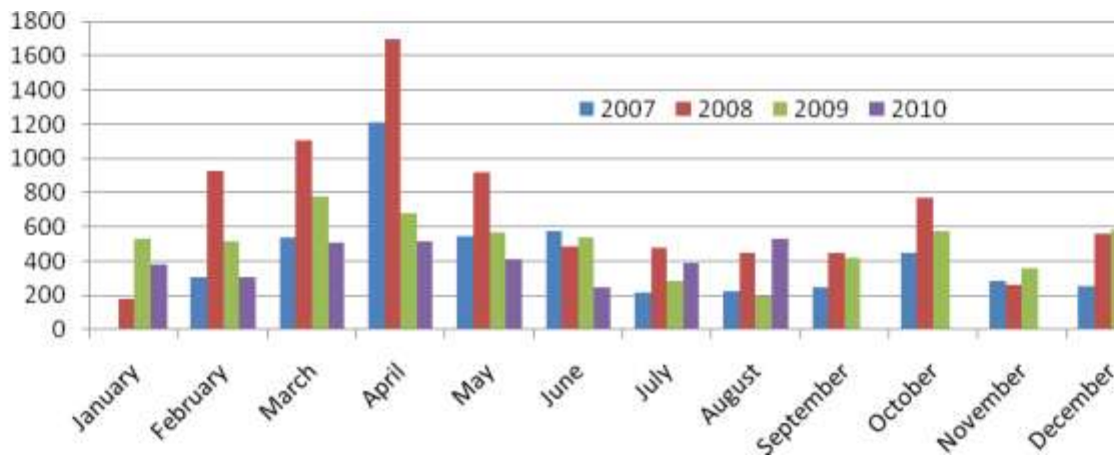
October 2010

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 $532,311 in August. The monthly payments for uncompensated care since February 2007 are shown below in Figure 1.

Figure 1 – Trauma Fund Uncompensated Care Payments 2007-2010



The Report to the General Assembly, Operations from July 1, 2009 through June 30, 2010, due on November 1, 2010, will be finalized, sent to the Governor's office, Secretary of Health and Mental Hygiene, and the General Assembly, and posted to the Commission's website at the end of October.

Patient Centered Medical Home Program

The Maryland Health Care Commission held 7 symposia on the Maryland PCMH Program for primary care practitioners throughout the state from June 22 through August 26th. The State intends to involve 50 practices, with 200 primary care providers—physicians and nurse practitioners—and at least 200,000 patients, in a three-year pilot. To date, more than 100 Maryland primary care practices have submitted applications to participate in the program. The deadline for interested practices to submit an application is October 18, 2010 at 5:00 p.m. For further information, please visit the PCMH Program portal on the Commission's website at: **http://mhcc.maryland.gov/pcmh/** or send an email to Commission staff at: **pcmhpractices@mhcc.state.md.us**.

Dr. Kathi White, Chair of the PCMH Workgroup, updated the Maryland Health Quality and Cost Council on the status of the PCMH Program on September 24, 2010 at its quarterly meeting.

Development and planning of the Program's learning collaborative continues, as well as meetings with employers having self-insured health benefits programs for their employees regarding participation in the program.

Information regarding 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 future Workgroup and subgroup meetings have not yet been scheduled.

Cost and Quality Analysis

Maryland Medical Care Data Base (MCDB)
Most of the payers have met their extended deadlines for submission of calendar year 2009 data to the MHCC. Currently, only two payers have yet to submit their data. The database contractor, Social & Scientific Systems, has begun processing the data files, beginning with a set of programs designed to identify any significant differences in each payer's claims data compared to their 2008 data submission. Payers with significant changes in their data will be asked to confirm that these differences reflect actual changes in utilization and do not result from errors in their data submission processing.

Health Insurance Coverage
In September, the Census Bureau released health insurance coverage data for the nation in 2009 and for each state in 2008-2009, using information from the Current Population Survey, Annual Social and Economic Supplement (CPS-ASEC). The Census Bureau recommends that states average two years of CPS-ASEC data to track changes over time in their uninsured rate and three years of data for cross-state comparisons. The average annual uninsured rate among Maryland's non-elderly (under age 65) residents in 2008–2009 was 14.5%, with an annual average of 720,000 uninsured nonelderly residents. The uninsured rate among all Maryland residents during 2008–2009 was 13.0%, with an average of 720,000 uninsured residents of any age; the all-ages rate is lower than the nonelderly rate because nearly all of the elderly are covered by Medicare. Both the non-elderly uninsured rate and the all-ages uninsured rate are below the national averages for 2008–2009. Compared to other states, Maryland's three-year average, all-ages uninsured rate in 2007–2009 is significantly lower than the average rates in 21 states, similar to the rates in 15 states, and significantly higher than the uninsured rates in 13 states and Washington, DC.

The Commission's bi-annual health insurance coverage report is scheduled for release in January 2011, and staff has begun developing the required data files and analyses. This year's report will differ from previous reports in a couple of ways. Recognizing that policy-makers mainly use the information in this report as a "best guess" for the state's current status with regard to health insurance coverage, this year's report will not make comparisons to the rates and distributions for prior years of survey data, with one exception. The exception will discuss the single year uninsured rates from 2004–2009. The pattern of single year rates—in spite of their relatively high margins of error in the estimates due to small sample size—show that Maryland's uninsured rate has been stable over this time period, with the exception of a statistically significant decline in the uninsured rate in 2008. Maryland's uninsured rate in 2009 is virtually identical to the state's uninsured rate in 2007, due in part to the state's relatively low unemployment rate in 2009. While the U.S. jobless rate jumped by 3.5 percentage points in 2009 to 9.3%, Maryland's rate increased by 2.6 percentage points to 7.0%.

Data and Software Development

Internet Activities
Unique visitors to the MHCC website increased from August 2010 to September 2010 by 3 percentage points. The number of visitors in September 2010 was 25 percentage points higher than those in September 2009 (see Figure 2, below).

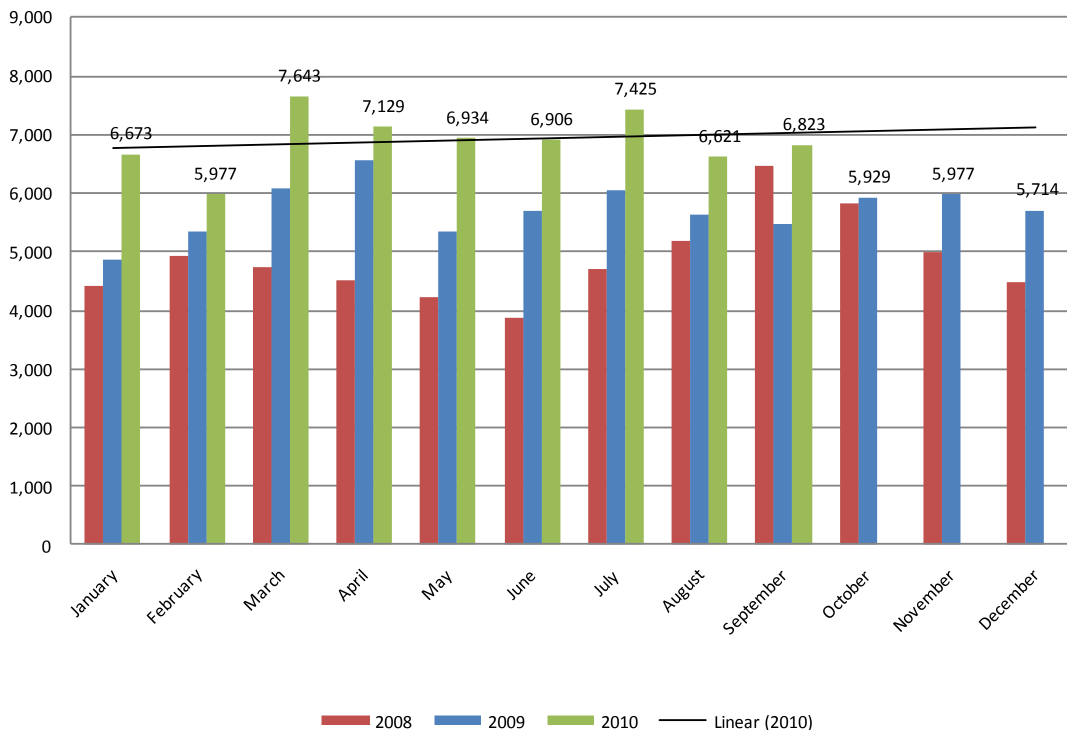
Visitors to the MHCC website typically arrive directly: by entering an MHCC URL or referencing our saved URL, via a search engine such as Google, or from a referral through another State site. Visitors who arrive directly are typically aware of MHCC, but visitors arriving via search engines and referrals are more likely to be new users.

The share of unique visitors who arrived directly accounted for 40 percent of unique visitors. About 38 percent of unique visitors arrived via a search engine. This share fluctuates up and down 3 to 4 percent from month to month. Google remains the dominant search engine directing 28.5 percent of all visitors to the MHCC site. Among the most common search keywords in September:

- "Maryland Health Care Commission"
- "mhcc"
- "assisted living facilities in Maryland"
- "nursing homes in Maryland"
- "health insurance report"
- "health insurance partnership"
- "institutional review board"

The remaining visitors were again referred from sites such as other state agencies. This share also shifts 3 to 4 percent month-to-month with no consistent upward or downward trend. Among top referrers were the DHMH website, the Maryland Web Portal (Maryland.gov), Bing, Yahoo and Crisphealth.org.

Figure 2 -- Unique Visitors to the MHCC Web Site



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 contractual 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	Complete	July 2011
Nursing Home Quality Site	Underway	Start of Project: February 2010
Health Insurance Compare	Underway	Start of Project: July 2010
Physician Portal/PCMH	Complete	Start of Project: April 2010
Hospital Quality Redesign	Planning	Start of Project: Fall 2010
PCMH Employer Outreach	Planning	Start of Project: October 2010

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

Health Plan Quality and Performance

The 2010 Health Plan report series is nearly complete, the *Consumer* Guide will be released in mid-October 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. In conjunction with the Department of Budget and Management we have determined to discontinue producing an independent *State Employee Guide* and have incorporated information targeted toward state employees in the *Consumer Guide*.

We are preparing for the 2011 reports and will host a kick-off meeting with health plans in early November. 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 was 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.

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 this web portal, called VIRTUAL COMPARE. Work on the web portal continues, with January as the operational target date.

To comply with the various reform initiatives under federal health reform (The Patient Protection and Affordable Care Act) that became effective on September 23rd, several changes to the CSHBP regulations

(COMAR 31.11.06) were necessary. Commission staff updated the regulations in cooperation with the MIA and the Commission approved the regulations as both emergency and proposed permanent during the August 19th conference call meeting. The proposed permanent regulations were published in the Maryland Register on October 8th, followed by the required public comment period. Staff will seek final adoption of the regulations at the December 16th public 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 October 13, 2010 enrollment in the Partnership was as follows: 315 businesses; 885 enrolled employees; 1,495 covered lives. The average annual subsidy per enrolled employee is $2,390; the average age of all enrolled employees is 39; the group average wage is approximately $28,400; the average number of employees per policy is 3.9.

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 habilitative services to individuals up to age 25
- Coverage of preventive physical therapy services for patients diagnosed with Multiple Sclerosis
- Spinal Muscular Atrophy – coverage for private duty nursing services
- Coverage for psychological and neuropsychological testing under Mental Health Parity
- Cost sharing equity for cancer chemotherapy
- Prescription drug cost sharing obligations

Two conference calls were held so that Commission and Mercer staff could discuss the proposed mandates with the medical directors and chief pharmacists from each of the major carriers. A draft report will be presented at the December 16th public meeting.

Long Term Care Policy and Planning

Hospice Data
All Maryland hospice programs completed data submission for both Parts I and II of the FY 2009 Maryland Hospice Survey. The FY 2009 public use data set has been posted on the Commission's website. In addition the *Guide to Maryland Hospice Survey Trend Report, FY 2006-2009*, as well as the *Trend Report FY 2006-2009 Hospice Data* have also been posted on the Commission's website.

Minimum Data Set
Staff has completed work 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, has now finalized 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. A meeting of the workgroup was held on September 8, 2010. The group discussed an outline and approach for an educational brochure. Draft materials were circulated for comment. The next step is to send it to the Council on End of Life Care.

Home Health Agency Advisory Group
The first meeting of the Home Health Agency (HHA) Advisory Group was held on September 29, 2010. An overview of HHA utilization trend data from 2002 to 2008, based on data reported to the Commission on its Home Health Agency Annual Survey, was presented at the meeting. Illustration of the statewide trend data showed an overall decline in number of clients and visits from 2002 to 2008, with some fluctuations in alternating years. Average statewide number of visits per client, as well as client use rates per 1,000 population, have declined slightly during the same time period, and vary by age group. An alternative approach to forecasting general HHA need was presented. The Advisory Group conceptually agreed with the notion of moving away from a methodological approach based on referral rates and towards an alternative approach based on utilization rates and trends. Rather than using the number of HHA clients, use the number of HHA visits to determine projected general HHA need, which is based on client use rates and average number of visits. The Advisory Group generally agreed that an alternative approach to projecting need be age-adjusted and jurisdiction-specific. An alternative approach to the existing single capacity threshold of over 400 clients for all jurisdictions was also considered. The Advisory Group agreed that a jurisdiction-specific capacity threshold based on average historical growth in number of HHA visits, and number of HHAs authorized and serving at least seven clients, could be an alternate approach for defining a threshold beyond which a new agency may be needed to meet forecasted additional demand. The next meeting of the Home Health Agency Advisory Group is October 28, 2010.

Home Health Agency Survey
Staff is performing the final stages of data cleaning by updating the data based on the review of frequencies of the data variables and facilities data verification. Staff is also in the planning stages for Fiscal Year 2010 Home Health Agency survey.

Long-Term Care Survey
Staff is in the process of cleaning the 2009 Long Term Care Survey data. All programs necessary for the data cleaning have been updated; staff is testing the programs by creating data runs and checking for errors or warnings. Once errors are diagnosed, staff will be able to create the analysis files as well as other reports including the public use files. Staff continues to work with the programmers from the Center for Information Services and Analysis to document the programs, and create the reports for both the public use files and staff use.

Long Term Care Quality Initiative

LTC Website Expansion
The anticipated launch of the LTC website expansion is delayed because of personnel changes at the contractor and additional time needed to implement the final content and operational components. A launch by the end of October is now planned.

Nursing Home Experience of Care Surveys
Data collection for the family and short stay surveys continues throughout October. Commission staff met with the contractor to discuss issues with the mailing of short stay surveys.

Racial and Ethnic Disparities

The Work Group developed a draft *Blueprint for Action* that outlines the need and diverse approaches to educate employees, employers and carriers on the importance of accurate reporting and sharing of reported information. The *Blueprint* also identifies that the implementation and funding needs to be shared by employers, carriers and state government.

Given uncertainty about how Maryland will approach health reform education and outreach including recent indications that it may incorporate the importance of reporting accurate race, ethnicity and language, coupled with the economic challenges that business and government are currently facing, it was decided that moving on parallel but non- collaborative paths with the Reform Council Work Group was counter-productive. It was the consensus to suspend future meetings until there is more definitive direction from the Council and legislature on the breadth and funding of the Council's education and outreach effort.

CENTER FOR HOSPITAL SERVICES

Hospital Services Planning and Policy

CONs Issued

Waldorf Nursing & Rehabilitation Center (Charles County) – Docket No. 10-08-2309
Construction of a new 67-bed comprehensive care facility ("CCF") to be located at 3735 Leonardtown Road, in Waldorf
Approved Cost: $8,820029

Comprehensive Nursing Services, Inc. – Docket No. 10-03-2310
Provide specialty home health services for pediatric and certain maternal and newborn patients in Baltimore City and Anne Arundel, Baltimore, Carroll, Cecil, Harford and Howard Counties
Approved Cost: $139,000

Approved CON's Relinquished by Applicant

ManorCare Health Services-Bowie, LLC
Construction of a 120-bed CCF in Prince George's County
Approved Cost: $14.897,003

CON Applications Filed

Amedysis MD, LLC d/b/a Home Health Care (Talbot County) – Matter No. 10-20-2312
Expansion of home health services into Talbot County. Branch office to be located in Cambridge
Estimated Cost: $8,450

Peninsula Regional Medical Center (Wicomico County) – Matter No. 10-22-2313
Renovation and expansion of existing operating rooms
Estimated Cost: $17,955,000

Pre-Application Conference

None

Application Review Conference

An application review conference concerning the above-referenced Amedisys application, Matter No. 10-20-2312, was held on September 24, 2010.

Determinations of Coverage

- **Ambulatory Surgery Centers**

Cardiovascular Ambulatory Surgery Center of America, PA (Anne Arundel County)
Establish an ambulatory surgery center with 1 sterile operating room and 1 non-sterile procedure room to be located at 108 Forbes Avenue, Annapolis

Bethesda Chevy Chase Surgery Center, LLC (Montgomery County)
Establish an ambulatory surgery center with 1 sterile operating room and 1 non-sterile procedure room to be located at 6931 Arlington Road, First Floor, Bethesda

Frederick Foot and Ankle Surgery Center, LLC (Frederick County)
Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 3430 Worthington Boulevard, Urbana

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

Montgomery Village Health Care Center (Montgomery County)
Relicensure of 17 temporarily delicensed CCF beds

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

FutureCare-Northpoint (Baltimore County)
Permanent relinquishment of 19 temporarily delicensed CCF beds

- **Miscellaneous**

Gilchrist Hospice (Howard County)
Request to establish a 10 bed inpatient hospice facility to be located at 6334-6336 Cedar Lane, Columbia
CON Review Required

Planning and Policy

Staff have developed an amended regulation to replace COMAR 10.24.11. This current State Health Plan ("SHP") chapter on ambulatory surgical services, COMAR 10.24.11, provides guidance for review of Certificate of Need ("CON") applications involving the development of surgical facilities for the provision of ambulatory surgical services. The amended SHP chapter is broader in scope; it is applicable to both inpatient and outpatient surgical services in hospital and freestanding surgical facilities. The amended SHP chapter also provides guidance regarding the review of proposals to develop outpatient surgical capacity that is not subject to the CON review process (i.e., requests for a Determination of Coverage). Comments on the draft SHP chapter should be forwarded no later than **4:00 p.m. on Friday,**

October 15, 2010 to: Eileen Fleck, Project Manager, Center for Hospital Services, Maryland Health Care Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215

To date, five sets of comments have been received on the draft State Health Plan chapter for Surgical Services: CareFirst BlueCross Blue Shield/Kaiser Permanente; Surgical Center of Greater Annapolis; Maryland Ambulatory Surgery Association; Piney Orchard Surgery Center; and Orthopaedic Associates of Central Maryland Ambulatory Surgery Center, LLC. These "informal" comments will be used to further develop the amended SHP chapter into a proposed regulation for consideration by MHCC.

On September 17, 2010, Center for Hospital Services staff met with consultants to the Mental Health Administration to discuss possible approaches to forecasting the need for residential treatment center beds in Maryland.

On September 28, 2010, Center for Hospital Services staff met with representatives of Anne Arundel Medical Center concerning their proposals for addressing the long-term stabilization and redevelopment of the Dimensions Health System in Prince George's County.

On September 28, 2010, Center for Hospital Services staff participated in a meeting convened by the Health Services Cost Review Commission with hospital and Maryland Hospital Association representatives to develop recommendations on the details of a proposal to modify the way in which capital costs associated with "major" capital projects of hospitals are treated in HSCRC rate setting.

On September 29, 2010, Center for Hospital Services staff participated in a meeting convened by the MHCC Center for Long-Term Care Services with home health agency representatives to discuss new approaches to forecasting the demand for HHA capacity in Maryland and translating such forecasts into a need determination for use in docketing applications for CON review.

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. The Advisory Committee met by conference in both July and August 2010. 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 was posted to the Hospital Guide in July 2010.

The contract with IFMC also incorporates a data validation component that has now been completed for Quarters 1-4 of calendar year 2009 core measure data. 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.

- ***Children's Asthma Care Clinical Process of Care Measures***

The reporting requirement for Children's Asthma Care (CAC 1-Relievers from Inpatient Asthma; CAC-2-Systemetic Corticosteroids for Inpatient Asthma; and, CAC-3 – Home Management Plan of Care Document Given to Patients/Caregiver) became effective January 1, 2010. The first quarter data for January-March 2010 was reported by September 3, 2010 for hospitals required to report this data to the Commission.

- ***Patient Experience Data***

During July 2010, the Commission added service-specific data (medical, surgical, and maternity services) on patient experience to the Hospital Guide to supplement overall patient experience data currently reported. The patient experience data reported on the Hospital Guide is from the HCAHPS *(Hospital Consumer Assessment of Healthcare Providers and Systems)* survey, a standardized, national survey of patients' perspectives of hospital care. Maryland was one of three states that participated in the development and testing of the HCAHPS survey. The survey asks discharged patients 27 questions about their recent hospital stay, including key aspects of their care: communication with nurses and doctors; responsiveness of hospital staff; cleanliness and quietness of the hospital environment; pain management; communication about medications; discharge information; overall rating of the hospital; and, if they would recommend the hospital. The ratings come from surveys completed by approximately 41,000 patients discharged from Maryland's 46 acute care hospitals during calendar year 2009, and for the first time include patients' ratings of the care they received for specific clinical services, including maternity, medical, and surgical services.

Overall, 64% of patients indicate that they would definitely recommend the Maryland hospital where they received care. For maternity services, 68% of patients responded to the patient satisfaction survey by stating that they would definitely recommend the hospital to friends and family. Sixty-two percent (62%) of medical service patients indicate that they would definitely recommend the hospital; 66% of surgical service patients indicate that they would definitely recommend the hospital.

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

The staff has released CLABSI feedback and preview reports to hospitals for the 12- month data period beginning July 1, 2009 through June 10, 2010. 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. The fiscal year 2010 feedback reports will used for the initial public reporting of CLABSI data on the Hospital Guide in October of this year.

- ***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. On August

10-11, 2010, the Commission, with the assistance of Johns Hopkins, held Focus Group meetings with both consumers and health care professionals to obtain feedback on best practices for publicly reporting HAI outcome data.

- ***Health Care Worker Seasonal Influenza Vaccination Survey***

For the first time, data on the number of hospital health care workers who received seasonal influenza vaccinations during last year's seasonal flu season have been publicly reported on the Hospital Guide. The Centers for Disease Control and Prevention have long recommended annual influenza vaccinations for all health care workers. The National Quality Forum includes influenza vaccination of health care workers as one of its 34 safe practices that should be utilized universally to reduce risk to patients. For the 2009-2010 flu season, 78% of Maryland hospital health care workers received the seasonal influenza vaccination.

- ***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.

Specialized Services Policy and Planning

The Commission granted non-primary percutaneous coronary intervention (npPCI) waivers to nine hospitals to participate in a research project conducted by the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT): Anne Arundel Medical Center, Saint Agnes Hospital, Shady Grove Adventist Hospital, Southern Maryland Hospital Center, Frederick Memorial Hospital, Washington County Hospital, Baltimore Washington Medical Center, Holy Cross Hospital, and Johns Hopkins Bayview Medical Center. The C-PORT Elective Angioplasty Study, known as C-PORT E, tests the hypothesis that outcomes of npPCI performed at hospitals without on-site cardiac surgery are not inferior to outcomes of PCI performed at hospitals with cardiac surgery services. The Commission established conditions for a hospital to maintain the two-year research waiver and may take action to extend the waiver term to permit a compliant hospital's continued participation in the C-PORT E study beyond two years. The sample size for the trial is a total of 18,360 patients; as of August 17, 2010, 58 hospitals (including sites that had either withdrawn voluntarily or been asked to withdraw by the C-PORT Data and Safety Monitoring Board) in 10 states had randomized 16,237 patients. According to the C-PORT E case volume guidelines, participating hospitals should be capable of performing a minimum of 200 PCIs per year (the sum of primary and non-primary PCIs). For minimum volumes, the Commission's regulations require a hospital to document that it will meet and maintain a minimum volume of 100 PCIs (primary and non-primary) during the first year of its waiver, and 200 PCIs during the second year of its waiver. On October 4, 2010, Holy Cross Hospital notified the Commission that the hospital was not able to reach the minimum volume of 100 PCIs by the first-year anniversary of the issuance of its npPCI waiver. The Commission's Executive Director has issued a Notice of Relinquishment of the waiver permitting Holy Cross Hospital to participate in the C-PORT E research study; C-PORT has withdrawn the hospital's randomization privileges. Holy Cross Hospital must complete the required follow-up of each study patient at 6 weeks, and at 3, 6 and 9 months after the patient's index procedure.

In the May 21, 2010 edition of the *Maryland Register*, the Maryland Institute for Emergency Medical Services Systems (MIEMSS) published a notice calling for applications from Maryland hospitals that wish to be designated as Cardiac Interventional Centers. MIEMSS will consider applications from hospitals that currently have a Certificate of Need issued by the Commission for a cardiac surgery program or have a current waiver from the Commission to provide primary PCI services. Hospitals

seeking designation prior to December 31, 2010 were required to submit an application to MIEMSS no later than September 30, 2010; hospitals that wish to be designated in 2011 must submit an application no later than December 22, 2010. MIEMSS has received applications for designation in 2010 from the following Maryland hospitals: Peninsula Regional Medical Center, St. Joseph Medical Center, Sinai Hospital of Baltimore, Suburban Hospital, University of Maryland Medical Center, Western Maryland Regional Medical Center, Anne Arundel Medical Center, Baltimore Washington Medical Center, Carroll Hospital Center, Frederick Memorial Hospital, Holy Cross Hospital, Howard County General Hospital, Johns Hopkins Bayview Medical Center, Saint Agnes Hospital, Shady Grove Adventist Hospital, Southern Maryland Hospital Center, and Upper Chesapeake Medical Center.

CENTER FOR HEALTH INFORMATION TECHNOLOGY

Health Information Technology

Staff developed a preliminary draft of the Legislative Report required under House Bill 706 (HB 706), *Electronic Health Records – Regulation and Reimbursement*. This report will be submitted to Governor Martin O'Malley, the Senate Finance Committee, and the House Health and Government Operations Committee by January 1, 2011. This document reports on: 1) the development of a coordinated public-private approach to improve the state's health information infrastructure; 2) any changes in state laws necessary to protect the privacy and security of health information stored in electronic health records (EHRs) or exchanged through a health information exchange (HIE); 3) any changes in state laws necessary to provide for the effective operation of a health information exchange; 4) any actions necessary to align funding for any federal, state, or private sector initiatives; and recommended language for the EHR incentive regulations. HB 706 provides the legislature with 60 days to review and comment on the report.

Staff is reviewing the summary findings from the EHR Demonstration Project (project) Office System Survey administered by the Centers for Medicare and Medicaid Services (CMS). Each year, CMS conducts a survey of project participants. The survey is aimed at collecting data on quality and EHR implementation. Staff plans to use this information to develop programs that ensure meaningful use for practices participating in the project. Currently, about 114 practices participate in the project, with 28 having yet to adopt an EHR. Practices participating in the project must adopt an EHR by May 2011 to remain part of the project. Each month, staff provides project participants with consultative support and educational material related to the adoption and use of EHRs. This is a five year project, with Maryland one of four states participating in this project; the other states include Louisiana, Pennsylvania, and South Dakota.

Staff is in the preliminary stages of drafting a summary brief of the nursing home EHR adoption environmental scan (scan) performed in August. Independent nursing homes and small chains in Maryland were asked to respond to a web-based survey on EHR adoption. Preliminary findings indicate that nearly 30 percent of these nursing homes are using some functionality of an EHR. Staff expects to present key findings of the scan at the annual Lifespan/Health Facilities Association of Maryland's October conference. The association is interested in working with staff to develop strategies aimed at expanding EHR adoption. During the month, staff completed the draft web-based Nursing Home EHR Product Portfolio, similar to the existing Physician EHR Product Portfolio. The portfolio consists of the vendor's PowerPoint presentation of their solution, pricing and five-year projected costs, case studies, and reference reports. Staff has invited representatives from select nursing homes to review the application.

Staff provided guidance to Management Service Organizations (MSO) in Candidacy Status to develop strategies aimed at implementing the first of three milestones required by the Office of the National Coordinator for Health Information Technology (ONC) for meaningful use. MSOs host EHRs and

perform outreach and education to providers. MSOs are considered a viable alternative to the EHR client-server model, which requires providers to assume the maintenance and upkeep of the technology, and the privacy and security of the data. Over the last four months, staff has approved 18 MSOs for Candidacy Status. These organizations must meet specific requirements for Candidacy Status and receive national accreditation within 12 months of Candidacy Status to receive State Designation. Included in the criteria for State Designation are requirements for privacy and confidentiality, technical performance, business practices, resources, security, and operations. HB 706 requires the MHCC to designate one or more MSOs by October 2012.

Staff continues to support activities of the Chesapeake Regional Information System for our Patients (CRISP), the state designated HIE, in developing the Regional Extension Center (REC) program. CRISP received $5.5M in federal funding to establish the Maryland REC. The purpose of this program is to provide EHR education, outreach, and technical assistance to 1,000 priority primary care providers in adopting EHRs and becoming meaningful users. CRISP will use State Designated MSOs to meet the funding requirements of the REC, which includes connecting MSOs to the statewide HIE. MSOs are incentivized by the REC to help providers achieve specific milestones, including: purchasing an EHR, implementing certain functionality of the EHR (i.e., e-prescribing), and meeting meaningful use. Participating MSOs are considered by ONC as sub-recipients of funding under the REC and must submit a strategic plan and budget to ONC. During the month, ONC approved 13 MSOs to participate as a sub-recipient to CRISP. Other MSOs are expected to be approved as sub-recipients by ONC later in the fall.

Staff will provide ongoing support to the Johns Hopkins University (JHU) in their development of the HIT curriculum. The university received funding under the *American Recovery and Reinvestment Act of 2009* (ARRA) in April 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. Support activities under consideration include participating on their HIT Curriculum Advisory Board, presenting on HIT topics at a Grand Rounds, and participating in small focus group discussions. During the month, representatives from the University of Maryland's School of Nursing (UMSN) also met with staff to explore options for participating in HIT related education programs.

Last month, staff provided support to the Electronic Healthcare Network Accreditation Commission's (EHNAC) HIE Advisory Panel (panel) in evaluating the initial privacy and security policy criteria based on additional feedback that EHNAC received during the public comment period. Roughly 30 stakeholders from around the country participated on the panel that is responsible for developing and maintaining EHNAC's HIE accreditation criteria. The panel is also in the preliminary stage of reviewing the standards criteria. EHNAC allows a 30 day public comment period on proposed changes to the criteria before the Commission takes any action on the changes proposed by the panel. EHNAC initiated the HIE accreditation program last summer and recently accredited the Utah Health Information Network.

Health Information Exchange

The statewide HIE Policy Board convened in September to continue deliberating on privacy and security policies for the HIE. The Policy Board discussed policies related to *Participating Organization Access*, *Patient Choice,* and *User Authentication*. During the meeting, a representative from Anakam, a software and services provider of multi-factor authentication, identity proofing, and user verification technologies presented on the risks of HIE participants using single factor authentication (name and password) to gain access to the statewide HIE. The Policy Board also discussed key challenges related to developing a policy on *Sensitive Health Information.* The Policy Board is deliberating on information sharing policies related to sensitive health information and wants to ensure that policy is guided appropriately by existing laws. A representative from the Substance Abuse and Mental Health Services Administration, which works to improve the quality and availability of substance abuse, alcohol and drug additions treatment, and mental health services, participated in the discussion. The Policy Board has assigned primary reviewers to about 17 policies that will need to be developed to guide the HIE. At the November

meeting, the Policy Board expects to take final action on the *Participating Organization Access* policy. Staff plans to convene several policy specific workgroup meetings in October to identify key questions the Policy Board will need to consider during the deliberation process.

Staff continues to provide guidance to the CRISP Advisory Board, which consists of four committees: Finance, Technology, Clinical Excellence, and Small Practice Advisory Committee. During the month, the Finance Committee met to further the discussions on the HIE Sustainability and Service Pricing Plan, which specifies participant cost for connecting to the statewide HIE. A Clinical subcommittee has been established to review the clinical document naming convention issues where hospitals refer to the same data using different names. Two technology subcommittees have been established to advise CRISP on implementation and security related issues. During the month, staff completed its evaluation of the CRISP proposal to use Initiate Systems as the technology for the Master Patient Index (MPI) that is required to do patient matching during queries. Initiate Systems is a robust MPI that will support complex Use Cases. CRISP anticipates completing the integration of the MPI into the core infrastructure by the end of the year. CRISP completed connecting the five hospitals in Montgomery County to the HIE. They also connected Quest Diagnostics Laboratory Corporation of America, RadNet, and American Radiology to the HIE. Staff continues to assess CRISP's website to formulate enhancement recommendations.

Last month, staff continued drafting the *State Medicaid Health Information Technology Plan* (plan). CMS requires each state to have sections of their plan approved before they can develop a program to administer the ARRA EHR adoption and meaningful use incentives for eligible providers and hospitals. In the spring, CMS approved Medical Assistance's *HIT Planning Advanced Planning Documents* (HIT P-APD) that is required to receive funding to develop the plan for implementation of the incentive program. CMS awarded Medical Assistance approximately $1.3M based on the approach defined in the HIT P-APD. The approach to developing the plan includes the initiation of two smaller projects that were approved in September by CMS: a technical feasibility assessment of Medical Assistance and a provider EHR adoption assessment. The technical feasibility assessment will assess the challenges to Medical Assistance implementing an EHR incentive program. The EHR provider adoption assessment will determine Medical Assistance providers' level of readiness to meet meaningful use. These two projects will serve as the foundation for a larger Request for Proposal (RFP) that will identify a vendor who can propose a program to administer the EHR incentives to eligible providers and hospitals. Staff is providing support to Medical Assistance in all phases of the incentive program development.

Electronic Health Networks & Electronic Data Interchange

Staff completed the recertification of MedAssets, Misys/Allscripts, and ProtoMed in September. COMAR 10.25.07 – *Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouses* requires electronic health networks (networks) operating in Maryland to be certified by MHCC. Payers that accept electronic health care transactions that originate in Maryland can only accept transactions from MHCC certified networks. Approximately 45 networks have achieved EHNAC accreditation. During the month, staff participated in a meeting with EHNAC, Surescripts, Emdeon, and Relay Health to discuss the challenges of EHNAC certification of aggregators and the existing Board of Pharmacy requirements that require pharmacies to accept electronic transactions from MHCC certified networks. Networks use aggregators to provide electronic transaction services in support of an electronic application or device used in the delivery of health care.

National Networking

Staff participated in several Axolotl webinars: *Healthcare Image and Information Exchange* that reviewed issues of implementing a next generation information exchange in the Rochester RHIO; *Proven HIE Sustainability* that discussed how leading HIEs are working toward achieving a sustainable business model; and *Franciscan Health System HIE – Connecting to Physicians and Beyond* located in the state of Washington that originally provided EMRs to their physicians and has now evolved to be a full service HIE. Staff also participated in two eHI webinars: *Lessons Learned from around the Globe* that presented

how the development of robust information governance capabilities can help overcome some of the key provider adoption challenges for HIEs; and *Support of Provider-Patient Engagement to Achieve Meaningful Use* that presented the current and future state of provider patient interaction.