



REPORT to the GOVERNOR

Fiscal Year 2013

(July 1, 2012 through June 30, 2013)

Martin O'Malley
Governor

Craig Tanio, M.D.
Chair

Ben Steffen
Executive Director

<http://mhcc.maryland.gov/>



This annual report on the operations and activities of the Maryland Health Care Commission for fiscal year 2013 meets the reporting requirement set forth in Health General § 19-109(b)(4) that directs the Maryland Health Care Commission to report annually to the Governor, the Secretary of Health and Mental Hygiene, and the Maryland General Assembly.

This report was written by the chiefs of service for each of the Commission's programs and was completed by the Commission's Administrative Center under the direction Bridget Zombro, Director of Administration. For information on this report, please contact Karen Rezabek at 410-764-3259 or by email at karen.rezabek@maryland.gov.



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Our vision is a state in which informed consumers hold the health care system accountable and have access to affordable and appropriate health care services through programs that serve as models for the nation.

The Maryland Health Care Commission's mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public.



Craig P. Tanio, M.D., Chair
Chief Medical Officer
JenCare Neighborhood Medical Centers

Garret A. Falcone, NHA, Vice Chair
Executive Director
Heron Point of Chestertown

Kathryn L. Montgomery, PhD, RN, NEA-BC
Associate Dean, Strategic Partnerships & Initiatives
University of Maryland School of Nursing

Michael S. Barr, MD, MBA, FACP
Senior Vice President
Division of Medical Practice for the
American College of Physicians

Ligia Peralta, MD, FAAP, FSAHM
Associate Professor of Pediatrics and
Epidemiology
University of Maryland School of Medicine

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

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

John E. Fleig, Jr.
Director
United Healthcare

Frances B. Phillips, RN, MHC
Health Care Consultant

Paul Fronstin, PhD
Director, Health Research and Education
Program
Employee Benefit Research Institute

Glenn E. Schneider, MPH, BS
Chief Program Officer
The Horizon Foundation

Kenny W. Kan, CPA, FSA & CFA
Senior Vice President/Chief Actuary
CareFirst BlueCross BlueShield

Diane Stollenwerk, MA
President
Stollenwerks, Inc.

Barbara Gill McLean, MA
Retired Senior Policy Fellow
University of Maryland School of Medicine

Adam J. Weinstein, MD
Medical Director
Nephrology and Transplant Services
Shore Health System

The Commission is composed of fifteen members appointed by the Governor, with the advice and consent of the Senate, for a term of four years. A brief biography of each Commission member follows.

Craig Tanio., M.D., MBA, the Commission's Chairman, is the Chief Medical Officer at JenCare, a physician owned group that is expanding an innovative global risk care model for moderate to low income seniors that emphasizes preventive and primary care. Previously, he was a partner at McKinsey & Company, a global management consulting firm and the Chief Operating Officer for Baltimore Medical System, a group of federally qualified community health centers serving the Baltimore area. Dr. Tanio received his MD from UC San Francisco, his MBA from the Wharton School and completed internal medicine training at the Hospital of the University of Pennsylvania. He is a part-time Assistant Professor of Medicine at Johns Hopkins School of Medicine and a Senior Fellow in the Department of Health Policy at Jefferson Medical College. Dr. Tanio resides in Baltimore County. (Term Expires 9/30/2016)

Garret A. Falcone, Vice Chair, is the Executive Director of Heron Point of Chestertown, a CCRC on the Eastern Shore. He has over 35 years of experience in acute and long term care. Commissioner Falcone is a graduate in Business Management from Fairleigh Dickinson University in New Jersey and earned his Master's Degree in Health Services Administration from Russell Sage College in Albany, New York. He was awarded the MANPHA Chairmen's Award in 2001 and the Special Chairmen's Award, AEGIS Inc., in 2001. Vice Chair Falcone resides in Kent County. (Term Expires 9/30/2014)

Michael S. Barr, MD, MBA, FACP, is a board-certified internist and Senior Vice President, Division of Medical Practice for the American College of Physicians. He is involved in program and policy development, including advocacy for the patient-centered medical home, medical home neighbor, inter-professional team-based care, and health information technology. Prior to joining the ACP staff, he was the Chief Medical Officer for Baltimore Medical System, Inc., on the faculty of the Division of General Internal Medicine at Vanderbilt University, and served in the United States Air Force. Dr. Barr received his MD from New York University School of Medicine and completed his residency in Internal Medicine at Rush-Presbyterian-St. Luke's Medical Center in Chicago, Illinois. He received a Masters of Business Administration from Vanderbilt Owen Graduate School of Management, and a Bachelor of Science degree in Forest Biology from the State University of New York, College of Environmental Science and Forestry. Dr. Barr holds part-time faculty appointments at Johns Hopkins University and The George Washington University. He currently Chairs the Board of Trustees for Baltimore Medical System, Inc., and is a member of the boards of Integrating the Healthcare Enterprise-USA (IHE-USA), and the National eHealth Collaborative (NeHC). Dr. Barr currently is a member of the IBM Watson Advisory Board and previously served on the Health Information Technology Policy

Committee Meaningful Use Workgroup. Dr. Barr still practices internal medicine part-time in Columbia, Maryland. Commissioner Barr resides in Howard County. (Term Expires 9/30/2016)

Rev. Robert L. Conway is retired from the Calvert County Public School System where he was employed for more than thirty years, serving as an elementary school teacher and principal. He is a graduate of Bowie State, George Washington University, and the Howard University School of Divinity. Commissioner Conway, a member of the Board of Directors of Calvert Memorial Hospital for the past nine years, has also served on Maryland's Hospital Bond Project Review Committee for four years. A resident of Calvert County, Reverend Conway is the pastor of the United Methodist Church and resides in Southern Maryland. Term Expires 9/30/2013)

John E. Fleig is Chief Operating Officer for Mid Atlantic Health Plan for United Healthcare. He is responsible for the overall operations of the health plan and for all aspects of the MAMSI/United integration. Before United Healthcare, he was the Senior Vice President for Mid Atlantic Medical Services, Inc. at MAMSI. Commissioner Fleig earned his undergraduate degree in Psychology from the University of Maryland and his accounting degree from Benjamin Franklin University. He is the former Director of the Maryland Small Group Reinsurance Pool. Commissioner Fleig is a resident of Calvert County. (Term Expires 9/30/2016)

Paul Fronstin is a senior research associate with the Employee Benefit Research Institute, a private, nonprofit, nonpartisan organization committed to original public policy research and education on economic security and employee benefits. He is also Director of the Institute's Health Research and Education Program, and oversees the Center for Research on Health Benefits Innovation. He has been with EBRI since 1993. Dr. Fronstin's research interests include trends in employment-based health benefits, consumer-driven health benefits, the uninsured, retiree health benefits, employee benefits and taxation, and public opinion about health benefits and health care. In 2012, Dr. Fronstin was appointed to the Maryland Health Care Commission. He currently serves on the steering committee for the Emeriti Retirement Health Program and is also the associate editor of Benefits Quarterly. In 2010, he served on the Institute of Medicine (IOM) Committee on Determination of Essential Health Benefits. In 2002 he served on the Maryland State Planning Grant Health Care Coverage Workgroup. In 2001, Dr. Fronstin served on the IOM Subcommittee on the Status of the Uninsured. Dr. Fronstin earned his Bachelor of Science degree from SUNY Binghamton and his Ph.D. in economics from the University of Miami. Commissioner Fronstin resides in Montgomery County. (Term Expires 9/30/2015)

Kenny W. Kan is Senior Vice President and Chief Actuary of CareFirst. He is responsible for the company's healthcare trend and pricing development, claims liability reserving, and actuarial support related to key strategic initiatives. He has more than 20 years of progressively responsible actuarial and health care experience. Commission Kan previously worked at Legg Mason Capital Management where he was a securities analyst. Prior to Legg Mason, he was Staff Vice President, Corporate Actuarial, at WellPoint, Inc. in Thousand Oaks, CA. He is a Fellow in the Society of Actuaries, a member of the American Academy of Actuaries, and a Chartered Financial Analyst. Commissioner Kan holds both a Master's Degree in Professional Accounting and a Bachelor's Degree with high honors in Business Administration/Accounting from the University of Texas at Austin. Commissioner Kan resides in Howard County. (Term Expires 9/30/2016)

Barbara Gill McLean recently retired from the position of Senior Policy Fellow in the Office of Policy and Planning at the University of Maryland School Of Medicine. Prior to joining the School in January 2005, Ms. McLean served as the Executive Director of the Maryland Health Care Commission (MHCC) from 2000-2004 and as Deputy Director of Performance and Benefits at MHCC and one of its predecessor commissions from 1996-2000. Responsibilities included the design and continued development of a standard benefit plan for small employers, implementation of a system to annually evaluate the quality and performance of HMOs, hospitals, and nursing homes for public reporting, and oversight of the Certificate of Need program. Ms. McLean also led a State's initiative for improving patient safety including the creation of the Maryland Patient Safety Center. Ms. McLean received a Masters in Sociology and completed doctoral studies in policy sciences at the University of Maryland. She also served as principal analyst for the Environmental Matters Committee in the Maryland House of Delegates from 1983 to 1991 and as Senior Legislative Analyst for the University of Maryland, Baltimore and the University of Maryland Medical System from 1991 to 1996. Commissioner McLean resides in Baltimore County. (Term Expires 9/30/14)

Kathryn Lothschuetz Montgomery, PhD, RN, NEA-BC is the Associate Dean of Strategic Partnerships & Initiatives and Assistant Professor at the University of Maryland School of Nursing since 2003. She served in prior faculty and administrative roles at the School from 2000 – 2001 after retiring from the United States Public Health Service as Rear Admiral and Assistant Surgeon General within the Department of Health Human Services. While in this capacity, Dr. Montgomery served at the NIH Clinical Center as Chief Nurse. In her academic administrative role, Dr. Montgomery provides leadership in the creation of strategic partnerships, faculty practices, clinics including the Governor's Wellmobile program, and professional education. Dr. Montgomery serves on the leadership team guiding the development of the Maryland Learning Collaborative for the Patient Centered Medical Home initiative. Dr. Montgomery teaches courses in complex healthcare systems, health policy, leadership and teamwork. (Term Expires 9/30/15)

Darren W. Petty is President of the Maryland State United Auto Workers (UAW), and represents over 15,000 active and retired members of the UAW. He also serves as Vice President of the Maryland & DC AFL-CIO, which represents over 400,000 working men and women of Maryland. Darren has been with General Motors Corporation since 1989, and currently works at the Allison Transmission Facility in White Marsh serves as the Human Resources Development and Joint Training Representative for the UAW. Darren is a founding member of the Mack Lewis Foundation, an organization dedicated to enriching the lives of Inner City youths through boxing training and tutoring programs in the spirit of the legendary boxing trainer Mack Lewis. He is an alumna of Essex Community College and Frances Marion University. He and his wife own a restaurant in Canton, Maryland. Commissioner Petty resides in Harford County. (Term Expires 9/30/14)

Ligia Peralta, MD, FAAP, FSAHM, AAHIVM is a clinician and scientist with extensive research expertise in the areas of adolescent health, HIV, sexually transmitted infections and health disparities. Dr. Peralta is President and CEO of Casa Ruben Foundation, Clinical Research Institute, and a fellow in global health care innovation. She is a retired tenured Professor of Pediatrics and Epidemiology and former Chief of the Division of Adolescent and Young Adult Medicine at the University of Maryland School of Medicine. Dr. Peralta is board certified in both Pediatrics and Adolescent Medicine and is internationally known for her work in HIV and for developing health care programs for underserved communities. She holds certification from the American Academy of HIV Medicine and serves as its representative to the National Foundation for Infectious Diseases. She has served as Principal Investigator for over 30 NIH and CDC-funded grants and has published in prestigious scientific journals. Dr. Peralta has worked with the Department of State in Africa and South America and in the development of health care programs for countries in Caribbean and the Far East including the United Arab Emirates. She is an inductee to the Maryland Women's Hall of Fame. Commissioner Peralta resides in Howard County. (Term Expires 9/30/2015)

Frances B. Phillips, RN, MHC, is a consultant focusing on community health improvement and population health innovation after retiring from the Maryland Department of Health and Mental Hygiene where she held the position of Deputy Secretary for Public Health Services from 2008 to 2013. Prior to her appointment as Deputy Secretary, Ms. Phillips was the Health Officer for Anne Arundel County, Maryland from 1993-2008, including a term in 2004 when she served as Interim County Fire Chief. Ms. Phillips holds an undergraduate degree in community health nursing from The Catholic University of America and a master's degree in health care administration from The George Washington University. She is an Adjunct Assistant Professor in the University of Maryland's School of Nursing and an Associate in the Department of Health Policy and Management at Johns Hopkins University Bloomberg School of Public Health. Ms. Phillips is a resident of Anne Arundel County. (Term Expires 9/30/2014)

Glenn Schneider, MPH is the Chief Program Officer for the Horizon Foundation, one of the largest health philanthropies on the East Coast. Prior to joining the Foundation, Commissioner Schneider served as a national consultant, executive director, community organizer, grassroots strategist, and policy director for state/local government and the non-profit sector. His work has resulted in the passage of over twenty-five state and local laws across the nation that protected public health, increased access to health care, raised tobacco prices, created smoke-free public places, and cut youth access to tobacco. In the health care arena, he spearheaded team efforts to launch the Healthy Howard Health Plan, a nationally-acclaimed health care access program for the uninsured, established a rules-based electronic application portal for state health insurance programs and previously served as executive director of the Maryland Health Care for All! Coalition. He has an MPH from the University of Pittsburgh and received his school's highest honor, the Distinguished Graduate Award, in 2002. He lives in Howard County. (Term expires 9/30/15)

Diane Stollenwerk is a member of the Maryland Health Care Commission, and serves as a technical expert appointed by the Centers for Medicare and Medicaid Services to the panel for the National Impact Assessment of CMS Quality Measures. She is the president of StollenWerks Inc, a consulting group providing strategic, policy and planning advice to corporate, nonprofit and government clients. Diane was a vice president at the National Quality Forum, leading the team to engage and support employers, patients and family members, providers, health plans and others at the local, state and national levels regarding practical aspects of measuring and reporting on performance to improve health care. Diane was a founding director of the nationally-recognized Puget Sound Health Alliance, a successful multi-stakeholder coalition that produces the *Community Checkup* report to improve health and health care in the Pacific Northwest. At that time, she was the Robert Wood Johnson Foundation-funded *Aligning Forces for Quality* project director for the region and the *Chartered Value Exchange* liaison to the federal Agency for Healthcare Research and Quality. She provides leadership and expertise in strategic planning, development and sustainability, competitive intelligence, marketing, and service or product line creation. This often involves group facilitation and public affairs work such as messaging and materials, media relations, and grassroots and 'grasstops' organizing. Current and past clients and collaborators come from sectors including health care, software, transportation, manufacturing, corrections, education, utilities, community non-profits and professional associations. Diane earned a masters degree in public policy from Harvard University. She has a bachelor's degree in English from San Diego State University where she earned national recognition in persuasive speaking. Her passion stems from a recognition and deep respect for the dignity of every individual person, and our shared responsibility to improve opportunity and equality for all. Commissioner Stollenwerk resides in Baltimore City. (Term Expires 9/2013)

Adam Weinstein, M.D. is a native of Baltimore County who completed all of his medical education and training to be a kidney specialist at the University of Maryland School of Medicine. He moved to the upper counties of the Eastern Shore in 2006 where he co-founded a private practice, the Kidney Health Center of Maryland. He is the medical director for Nephrology and Transplant Services for the Shore Health System (a University of Maryland Hospital affiliate system) as well as some of the dialysis units on the upper Eastern Shore. He is the President of the Talbot County Medical Society and active in MedChi - the Maryland Medical Society and on the board of directors of the Renal Physicians Association. Dr. Weinstein is board certified in Internal Medicine and Nephrology. (Term Expires 9/30/13)



EXECUTIVE STAFF

Ben Steffen
Executive Director

Linda Bartnyska
Director, Center for Information Services and Analysis

Bruce Kozlowski
Co-Director, Center for Quality Measurement and Reporting

Theresa Lee
Co-Director, Center for Quality Measurement and Reporting

Paul E. Parker
Center for Health Care Facilities Planning & Development

David Sharp
Director, Center for Health Information Technology & Innovative Care Delivery

EXECUTIVE SUMMARY

The Maryland Health Care Commission is an independent state agency located within the Department of Health and Mental Hygiene. Our fifteen Commissioners, appointed by the Governor with the advice and consent of the Senate, come from communities across the Maryland and represent both the State's citizens and a broad range of other stakeholders.

Our mission is simply stated:

To plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public.

We pursue this mission through our information gathering and dissemination, our health planning and regulatory powers, and our health policy analyses.

MHCC STAFF AND THE FIVE CENTERS

During FY 2013, the Commission had an appropriation for 62.7 full time positions. The Commission's staff members represent a broad range of backgrounds and skills, including public policy analysis, data management and analysis, health planning, health facilities construction and financing, Medicaid administration, quality assessment, clinical and health services research, and public performance reporting.

The Commission is organized around the health care systems we seek to evaluate, regulate, or influence, bringing a wide range of tools (data gathering, public reporting, planning and regulation) to bear in order to improve quality, address costs, or increase access. Two of the centers - the Center for Hospital Services and the Center for Long-term Care and Community-based Services - are organized around provider organizations, bringing together under one leadership the expertise and tools to address cost, quality, and access in those sectors of our health care system. Two of the centers include both cross-cutting responsibilities and sector specific efforts: The Center for Healthcare Financing and Policy deals with broad policy issues relating to the organization and financing of health care services and with more narrow issues relating to the regulation of the small group health insurance market. The Center for Information Services and Analysis conducts broad studies using both Maryland databases and national surveys, but also has specific responsibilities relating to physician services. The fifth center, the Center for Health Information Technology, has responsibilities that cut across sectors to facilitate the adoption of electronic health records and to enable the private and secure transfer of personal health information among sectors.

The organizational chart is attached as Appendix 1. A brief description of each of the Centers follows:

The **Center for Information Services and Analysis** has expertise in the creation, maintenance, and mining of large databases, in the management of information technology and networks, and in the analysis and interpretation of population surveys.

- The Center produces key reports to guide health policy, including reports on health expenditures, health insurance, the uninsured, and uncompensated care.
- A special focus of the Center is physician services, including physician reimbursement and reporting on the cost and quality of their services. The Commission staff has served in a consultant role for the General Assembly in this regard.
- The Center oversees the Maryland Trauma Services Fund and has responsibility for development of its procedures and policy options.
- This Center provides analytic and programming services to other divisions of the Commission and is responsible for our intranet and web site. Two individuals serve as liaisons to the Center for Hospital Services and the Center for Long-Term Care and Community-Based Services, participating as appropriate in the discussions of those Centers and assuring that the necessary expertise is brought to bear on the other Centers' data gathering, management, and analysis.

The **Center for Long-term Care and Community-based Services** focuses on improving long-term and community-based care, bringing together planning and public reporting efforts.

- The Center is responsible for health planning regarding long-term and community-based care, including the policies guiding the determination of need in the Certificate of Need process for nursing homes, home health agencies, and hospices.
- The Center is responsible for the Commission's study of long-term care's vision and needs over the coming 25 years, required by legislation during the 2006 session.
- CON applications for nursing homes, home health agencies, and hospices are managed by the CON staff in the Center for Hospital Services, operating according to policies developed by the Center for Long-term and Community-based Care.
- The Center publishes the Nursing Home Guide for Marylanders, providing an easy way to locate and compare nursing homes on quality and outcomes measures. The Center is also pioneering the public reporting of resident and family satisfaction measures.
- The Center has responsibility for policies and information dissemination related to assisted living programs.

The Center for Healthcare Financing and Policy has a specific regulatory responsibility for the small group market for health insurance and a broader responsibility for the analysis of public policy options relating to the organization and financing of health care.

- This Center is responsible for the small group health insurance market, including regulation of the Comprehensive Standard Health Benefit Plan. Specifically, the Commission is responsible for specifying the benefits and covered services included in the core CSHBP offerings and modifying these, when necessary, to meet statutory affordability requirements.
- The Center reports on trends in the small group market, including the costs of plans and the degree of concentration in the market, suggesting regulatory changes that will improve affordability, innovation, and value through improved competition.
- The Center's HMO Consumer Guide reports publicly on the performance of, and satisfaction with, health plans. Traditionally focused on measures of the clinical performance HMOs, the Guide is expanding by requiring PPOs to report beginning in 2012.
- The Center is responsible for the development and analysis of state health policy options affecting the organization and financing of health care. Particular emphasis has been placed on both incremental and non-incremental strategies for expanding health insurance coverage and on strategies to reduce health care expenditures and increase health care value.
- The Commission's commitment to reporting disparities in health and health care is expressed in the Center's Racial and Ethnic Disparities initiative.

The Center for Hospital Services focuses on improving hospital care, bringing together planning, certificate of need, and public reporting of cost and quality.

- Planning for hospital services and the drafting of the acute care chapter of the State Health Plan are the responsibility of the Center for Hospital Services.
- The entire Certificate of Need program remains within the Center for Hospital Services because hospital certificates of need are the most complex and costly of projects requiring CON action. Maryland hospitals are in the midst of a dramatic rebuilding program, replacing an aging hospital infrastructure through renovation, new construction, and in some cases, consolidation or relocation of facilities.
- The Center oversees specialized inpatient services such as cardiac surgery, obstetrics, pediatrics, and psychiatry, including developing the state health plan chapters, managing certificates of need for these services, and granting appropriate waivers to allow hospitals meeting rigorous criteria to perform emergency angioplasty.
- The Center is committed to providing meaningful information to consumers about the quality and outcomes of care provided in all Maryland acute care hospitals. It

publishes the Hospital Guide, containing both general information and specific quality and outcome measures. The Center currently reports on the quality of hospital efforts in surgical infection prevention and is developing strategies to gather and report the rates of key hospital acquired infections. The Center plans to expand public reporting of angioplasty quality and outcomes beyond the current hospitals granted waivers to include all hospitals performing emergency angioplasty and is examining public reporting of risk-adjusted data on the quality and outcomes of cardiac surgery.

- The Center serves as the lead for a report on emergency department crowding.
- As part of the MHCC's Price Transparency Initiative, the Center, working closely with the Health Services Cost Review Commission, publishes each hospital's charges for the most common Diagnosis Related Groups (DRGs).

The Center for Health Information Technology is responsible for the Commission's initiatives in health information technology.

- The Center, in conjunction with the HSCRC, manages the joint MHCC/HSCRC initiative to plan and implement a state-wide health information exchange.
- The Center staffs the Task Force on the Electronic Health Record, established by the General Assembly.
- The Center is conducting a series of privacy and security studies across health care sectors to understand the potential barriers to widespread adoption of electronic health records and health information exchange.
- The Center conducts HIPAA awareness activities, oversees the state certification of electronic data interchange reporting, and conducts provider education on health information and HIPAA issues.

In addition to the five centers, the Executive Director oversees the Executive Direction unit which is responsible for the key functions of budget, user fee assessment, regulations, and procurement; the Government Relations and Special Projects unit, which manages the legislative activity of the Commission, responds to special requests for information by the Maryland legislature, executive departments, and other external groups and serves as an incubator for newly mandated Commission activities; and the Legal Services unit, composed of two Assistant Attorneys General, which provides advice to the Executive Director and the Commission.

BUDGET & FINANCES

In FY 2013, the Commission was appropriated \$31,938,159, which includes an appropriation of \$12.0 million for the traumafund and trauma equipment grant programs, \$2.3 million for the Partnership program, \$3 million for the MD Emergency Medical Systems Operations Fund, \$2.8

million in Federal Fund Income, and \$100.000 as Reimbursable Fund Income. The Commission is funded with special funds through a user fee assessment in order to accomplish its mission and program functions.

ASSESSMENT

The Maryland Health Care Commission's budget is 100% special funds and is funded through a user fee assessment on Hospitals, Nursing Homes, Payers, and through the licensing process of the Health Occupational Boards. Each of these entities contributes to the MHCC budget appropriation according to workload. Currently, the Commission assesses: 1) Payers for an amount not to exceed 29% of the total budget; 2) Hospitals for an amount not to exceed 31% of the total budget; 3) the Health Occupational Boards for an amount not to exceed 18% of the total budget; and 4) Nursing Homes for an amount not to exceed 22% of the total budget. The amount is derived differently for each industry and is set every four years based on Commission work load. The assessment is currently capped at \$12 million.

Surplus

At the close of FY 2013 the Commission's surplus was \$1.8 million.

OVERVIEW OF FY 2013 ACCOMPLISHMENTS

July 2012

Certificate of Need for ManorCare Health Services, LLC was approved.

Certificate of Need for Cosmetic Surgery Center of Maryland d/b/a Bellona Surgery Center was approved.

Certificate of Need for Massachusetts Avenue Surgery Center, LLC was approved.

Certificate of Need for Hospice of Queen Anne's, Inc. was approved.

Certificate of Need for 525 Glenburn Avenue Operations, LLC d/b/a Chesapeake Woods Center was approved.

August 2012

There was no Commission meeting.

September 2012

COMAR 10.24.05 – Continuation of Authority to Provide Non-Primary PCI Through Participating in the Follow-On C-PORT-E Registry was approved.

Certificate of Need – Hospice of the Chesapeake, Inc. was approved.

October 2012

Ben Steffen was appointed as Executive Director of the Maryland Health Care Commission.

COMAR 10.24.11 – FINAL Regulations – State Health Plan for Facilities and Services: General Surgical Services were adopted.

Petition to Amend COMAR 10.24.01 to Grant Interested Party Status to a Jurisdiction without an Acute Care General Hospital in the Review of a Hospital Project in an Adjacent Jurisdiction - Proposed Amendment to Regulations was adopted.

First Shared Savings Results from the Maryland Multi-Payer PCMH Program were released.

Maryland Trauma Physician Services Fund, Report to the Maryland General Assembly, FY 2012, was released.

November 2012

“My Eyes, Your Eyes – How Does the CMS Five-Star Quality Rating System for Nursing Homes Relate to Family Member/Responsible Party Experience of Care?” was presented.

Quarterly Update to the Hospital Performance Evaluation Guide with Focus on Healthcare-Associated Infections was released.

HB 736 – Electronic Health Records – Incentives for Health Providers was presented.

SB 163 – Health Insurance – Diabetes Treatment – Coverage for Orthotics was presented.

Feasibility of Including Reductions in Disparities as a Performance Factor in Maryland’s Multi-payer PCMH Program was released.

December 2012

Determination of Compliance with Non-Primary PCI Research Waiver Requirements: Hospitals Providing Elective PCI Services on January 1, 2012 Through the C-PORT E Registry was presented.

The Commission found that the C-PORT E study produced results that should guide public policy and APPROVED an exception to Anne Arundel Medical Center, Baltimore Washington Medical Center, Frederick Memorial Hospital, Johns Hopkins Bayview Medical Center, MedStar Southern Maryland Hospital Center, Meritus Medical Center, St. Agnes Hospital, and Shady Grove Adventist Hospital to the requirement to obtain a Certificate of Conformance to continue to provide non-primary PCI services.

Certificate of Need – Mercy Medical Center was approved with conditions.

Certificate of Need – College View Center was approved with conditions.

Certificate of Need – Anne Arundel Medical Center was approved.

Certificate of Need Modification – NMS of Hagerstown was approved.

Certificate of Need Modification – Carroll Hospital Center was approved.

SB 163 – Health Insurance – Diabetes Treatment – Coverage for Orthotics was released.

Health Care Practitioner Performance Measurement Project was released.

January 2013

COMAR 10.25.17 – Final Regulations – Benchmarks for Preauthorization of Health Care Services –were adopted.

COMAR 10.24.14 – Final Regulations – State Health Plan – Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services – were adopted.

COMAR 10.25.05 – Final Regulations – Continuation of Authority to Provide Non-Primary PCI Through Participation in the Follow-On C-PORT E Registry – were adopted.

February 2013

Cigna’s Single Carrier PCMH program application was approved.

Certificate of Need – Garrett County Memorial Hospital was approved.

Renewal of Primary PCI Waiver for Frederick Memorial Hospital was approved.

Renewal of Primary PCI Waiver for Meritus Medical Center was approved.

March 2013

Renewal of Primary PCI Waiver for Upper Chesapeake Medical Center was approved.

Draft Regulations Regarding Health Information Exchanges – Privacy and Security of Protected Health Information (COMAR 10.25.18) were released for informal public comment.

Annual Health Care Use Among the Privately Insured was released.

April 2013

Modification of Certificate of Need – St. Agnes Hospital was approved.

Maryland State Health Care Expenditures 2012 was released.

Action Plan for Addressing Legislation Passed in 2013

HB 581 “Establishment of Palliative Care Programs – Required” - Amendments to the bill required the Commission to select five pilot sites, identify core data measures for data collection, develop standards for the reporting requirement, and report the findings of the pilot on or before December 1, 2015.

HB 934/SB 776 “Task Force of the Use of Telehealth to Improve Maryland Health Care” – SB 776, as adopted by the Senate, required the Commission to convene a Task Force to study the

use of Telehealth in Maryland, HB 934, as amended by the House, required the Commission to reconvene the Telemedicine Task Force of 2009 in the form of three advisory groups and required the study to identify opportunities to use Telehealth to improve health status.

HB 1015/SB 746 “Health Insurance – Step Therapy or Fail – First Protocol” –established requirements for therapy or “fail-first” protocols imposed by insurers; required the Commission to study the use of measures similar to step therapy or fail-first protocol by health insurance carriers in their coverage of diagnostic imaging, and medical and surgical procedures and report to the General Assembly by January 1, 2014.

Overview of the Revised Draft Hospice Chapter of the State Health Plan was released for informal public comment.

Update on the Hospital Performance of Central Line-Associated Bloodstream Infections in ICUs was presented.

Maryland Hospital Association Review of Hospital Associated Infections Prevention Initiatives was presented.

May 2013

Renewal of Primary PCI Waiver for Anne Arundel Medical Center was approved.

Renewal of Primary PCI Waiver for MedStar Franklin Square Medical Center was approved with a condition for quarterly reporting on door to balloon time.

Modification of the Certificate of Need for Magnolia Gardens, LLC was approved.

Modification of the Certificate of Need for Mid-Atlantic Waldorf, LLC was approved.

June 2013

Final Regulations – COMAR 10.25.02 User Fee Assessment on Health Care Practitioners and COMAR 10.25.03 – User Fee Assessment on Payors, Hospitals, and Nursing Homes were adopted.

Renewal of Primary PCI Waiver for Shady Grove Adventist Hospital was approved.

COMAR 10.24.13: State Health Plan for Facilities and Services – Hospice Services, were adopted as proposed permanent regulations and the hospice services portion of COMAR 10.24.08 (State Health Plan for Facilities and Services – Nursing Home, Home Health Agency, and Hospice Services) were repealed, contingent on COMAR 10.24.13 becoming effective.

Small Group Market Summary of Carrier Experience as of December 31, 2012 was released.

Report of the Cardiac Advisory Group Report on Regulatory Oversight of PCI and Cardiac Surgery Services was released.

Results of the 2012/2013 Health Care Worker Influenza Vaccination Surveys: Nursing Homes, Assisted Living, and Hospitals were released.



The Center for Analysis and Information Systems

Cost and Quality Analysis Division

Overview

The Division of Cost and Quality Analysis' (Division) primary responsibilities are overseeing construction and maintenance of the Commission's Medical Care Data Base (MCDB)—a data base of health insurance claims for covered services received by privately insured Maryland residents—and preparation of annual reports on health care expenditures in Maryland and the utilization of privately insured professional health care services. Both the MCDB and these annual reports are mandated by Commission statute. The staff also conducts more narrowly focused studies of health care service use and spending, such as examining the impact of Assignment of Benefits and Reimbursement to Non-preferred Providers. The division's staff members examine broader health care issues as well, including the measurement and analysis of insurance coverage in the State.

Accomplishments

During FY 2013, the Division laid out a vision for expansion of the MCDB to enhance the comprehensiveness and timeliness of data collection, improve access to the data, and develop meaningful analytics to support policy, practice, and consumer decision-making. A particular emphasis was placed on providing decision support tools to State partners, such as the Maryland Health Benefit Exchange (MHBE), Maryland Insurance Administration (MIA), Health Services Cost Review Commission (HSCRC), Maryland Medicaid Administration (Medicaid), and the overall Department of Health and Mental Hygiene (DHMH). These enhancements require changes to the existing MCDB Regulations (COMAR 10.25.06) and Submission Manual, which will be promulgated in FY 2014. The Commission continues to engage all stakeholders in development of regulations and in executing its mission overall.

The Division added eligibility data, professional services, institutional services, and prescription drug data for the 2011 calendar year to the MCDB. The Division produced three reports in FY2013. Two reports focused on per capita health care spending. The first report used MCDB data to examine health care utilization and spending among Maryland residents who purchase their insurance from the individual market, Comprehensive Standard Health Benefit Plan (CSHBP) for small employers, and the Maryland Health Insurance Plan (MHIP), as compared to fully-insured large employers. The expected impact of the launch of the MHBE was also assessed. A second report used data from the Centers for Medicare & Medicaid Services' (CMS) national Health Expenditure Accounts to examine per capita personal health expenditure trends in Maryland compared to national trends over the last decade. A third report responded

to a legislative request and used MCDB data to conduct a baseline analysis of the impact of the Assignment of Benefits legislation (Chapter 537, 2010 Laws of Maryland), which became effective July 1, 2011.

MCDB Expansion

With the advent of health care reform, there is an increased need for detailed information on health care utilization, the relationship between health care utilization and health plan benefit design, and quality of care. In response to the need for more information and new reporting requirements placed on the Commission by the Maryland General Assembly and other state agencies, the Division developed a vision for a new MCDB that addresses forthcoming information and data needs by:

- 1) Enhancing the comprehensiveness and timeliness of data collection and leveraging MCDB data by linking it with other sources of health information.
 - Data will be collected from Third Party Administrators, including Pharmacy Benefit Managers and Behavioral Health Administrators to better account for coverage, utilization, and spending in the self-insured market. All payors with plans sold on the MHBE will be required to report. Additional reports and fields focusing on plan benefit design, non-fee-for-service spending, assignment of benefits, race and ethnicity, etc. will also be added to ensure more comprehensive data collection to inform studies.
 - Data submission timelines will be transitioned to quarterly submissions from annual submissions to provide timely data for the MIA's rate review activities, to support an early warning system for the HSCRC's proposed waiver, to provide timeline analysis of the uptake in the MHBE, and to support Medicaid and DHMH in health planning and policy development.
 - In partnership with the Health Insurance Exchange, a Master Patient Index is being developed to link data from MHCC, HSCRC, and the HIE, along with Maryland health care providers. These allow the pairing of cost and utilization data with clinical data to better understand health care in Maryland.
- 2) Improving access to these data with the development of diverse data products, reports, and data release mechanisms.
 - Data products to meet differing needs of policy makers, researchers, and consumers will be developed. These data products will have varying levels of sensitive fields to meet the specific research needs of the data requestor.
 - A revised data release policy will be developed that ensures data security, and a workgroup will be created to provide an opportunity for stakeholders to have input in the development and release of data products.
- 3) Developing meaningful analytics to improve and enhance price transparency, performance measurement, and quality reporting to support policy, practice, and consumer decision-making.

- The Division will work with the MIA and HSCRC to yield meaningful analytics from the MCDB for their respective goals as they relate to price transparency, rate review, utilization, cost, and quality analyses.
- A Practitioner Performance Measurement workgroup will be created to explore reporting quality and performance data for physicians and the use of Medicare claims data to do so.
- Decision support tools will be developed to inform policymakers, practitioners and consumers.

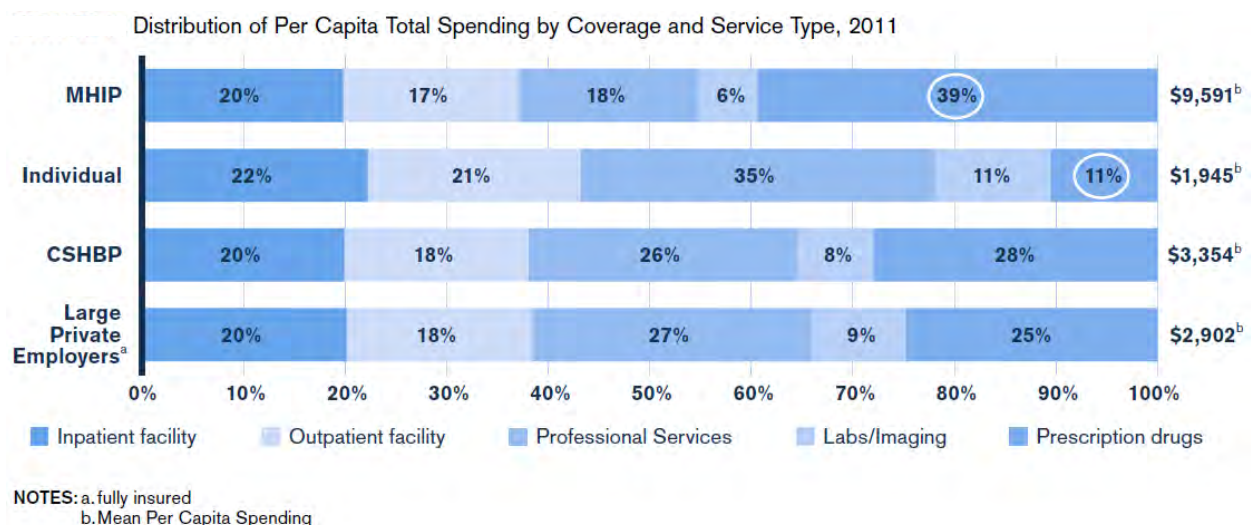
These expansion activities will be done in collaboration with stakeholders, who will have opportunities to participate in workgroups that address key issues in the expansion. The Division, and Commission as a whole, will continue to collaborate with other states, national organizations, and federal policymakers to capitalize on opportunities for standardization with other all payor claims databases (APCDs) and to ensure best practices are being used.

Health Care Spending in Maryland

In advance of the implementation of Maryland's health benefit exchange, the Division released a report examining the health care spending and utilization patterns for Maryland residents insured through the individual, small employer group, and high-risk pool markets. In addition to a comparison with the fully insured large employer group market, the potential impact of the implementation of the Affordable Care Act (ACA) and the MHBE was explored. MCDB data for calendar year 2011 was used for all analyses.

Benefits and expected impacts vary across the different markets. Plans purchased on the individual market tend to have limited coverage and higher cost-sharing (proportion of costs borne by the individual relative to the insurance carrier), but offer lower premiums for younger and healthier enrollees. The impact of the ACA is greatest on the individual market, with minimum coverage requirements (Essential Health Benefits), restrictions on medical underwriting, elimination of exclusion for pre-existing conditions, and changes in carrier pricing practices. In Maryland, the plans sold in the small employer group market have been regulated, with coverage minimums similar to essential health benefits, modified community ratings, prohibitions on exclusion for pre-existing conditions, and limits on premium differences within specified rate bands. As such, the expectation is for limited impact due to the ACA and for the majority of small businesses to continue to purchase plans outside of the Exchange. The Maryland Health Insurance Plan (MHIP) is Maryland's high-risk pool, which serves those who have been denied coverage due to pre-existing conditions, have certain qualifying health conditions, or have exhausted their COBRA coverage. While the program will continue until 2020, enrollees will be transitioned to the Exchange beginning in 2014. In comparison to these markets, there will be little impact from the ACA for plans purchased in the fully-insured large employer market. Most enrollees will retain their current plans, which tend to have broad coverage and lower cost-sharing, with premiums set based on group risk, rather than individual risk.

Mean annual spending for MHIP (\$9,591) was about three times greater than for enrollees covered by fully-insured employers, whether small (\$3,354) or large (\$2,902), and almost five times greater than for enrollees with individually purchased plans (\$1,945). Spending on inpatient, outpatient, and lab or testing services were comparable across the different markets. While total spending was highest for MHIP enrollees, percent of out-of-pocket expenses (18%) was lower than individual (31%) and CSHBP (22%) plans. As seen in the figure below, enrollees in the individual market had the highest percentage of spending on professional services and the lowest on prescription drugs. By contrast, MHIP enrollees had the largest proportion of spending on prescription drugs and the lowest on professional services. Spending and utilization patterns correlate to the coverage and risk pools of the different markets. For example, plans purchased in the individual market often have limited benefits, particularly as it relates to prescription drugs, which is reflected in the lower utilization and spending for this category. Similarly, MHIP's high-risk enrollees are expected to have greater need for utilization of health care services, which is reflected in the greater expenditure. With the many anticipated changes under the ACA, it will be important for policymakers to continue to monitor trends in spending as implementation of the Exchange moves forward.



State Health Care Expenditures

The Division updated previous reports on the growth of total and personal health care spending based on data from CMS's National Health Expenditure accounts. In 2011, Maryland's personal health care expenditures totaled \$47.7 billion, up 4.9% from 2010. While the national rate of growth in total spending grew from 3.7% to 4.9% between 2010 and 2011, Maryland's rate of growth fell to 4.9% from 5.7% in that time. Since 2000, per capita spending in Maryland has been consistently higher than the national average, increasing from 103% in 2000 to 111% in 2011. A 4.2% growth in per capita spending from 2010 to 2011 resulted in \$8,199 in per capita spending in Maryland. This growth was slightly higher than between 2009 and 2010, which some analysts believe indicates that the impact of the recession has leveled off. Maryland residents spent, on average, 16% of their personal income on health care in 2010 and 2011. Approximately 60% of Maryland's total health care spending in 2011 was devoted to inpatient and outpatient care at hospitals (37%) and physician care (23%), which was similar to the

nation, as a whole. The majority (64%) of personal health expenditures in Maryland was for spending reimbursed by private health insurers or paid out-of-pocket and was about 3.5% higher than compared to the nation overall. This is likely driven by the greater private insurance coverage for nonelderly residents in Maryland (70%) compared to the nation (61%). Maryland had a slightly lower proportion of Medicare (21% vs. 23%) and Medicaid (15% vs. 17%) coverage than the country, as a whole. These spending patterns are influenced by economic growth as well as delivery and payment system reforms. As the Exchange, new hospital waiver test, and other reforms are implemented, it will be important to continue to understand the impacts on personal health expenditure of Maryland residents.

Assignment of Benefits – Baseline Analysis

The Assignment of Benefits of Non-preferred Providers (Chapter 537, 2010 Laws of Maryland) became effective on July 1, 2011. The law requires an insurance carrier to recognize an Assignment of Benefits (AOB) and to send the insurance payment directly to the provider who accepts an AOB. Providers are not required to accept AOB, but if they do, the law establishes payment floors for three groups of providers: 1) hospital-based providers, 2) on-call providers, and 3) all other providers. The Commission is required to report on the impact of this law to the House Health and Government Operations Committee and the Senate Finance Committee. The Division released a report that examines the period prior to implementation, which will serve as a baseline for analysis of the impact of the law. MCDB data for calendar year 2010 was used for all analyses.

At baseline, results indicate that participation in private insurance is over 80% for almost all specialties, with the exception of psychiatrists (51%). Hospital-based specialties (75%) received the highest rate of reimbursement for Out-of-Network (OON) services as compared to on-call surgical (46%) or medical (40%) specialties and primary care (28%). Almost one in five patients uses some OON services, and user out-of-pocket spending for copayments, deductibles, and balance billing increased in direct proportion to the percentage of spending on professional services allocated to OON services. For payors, while the share of OON services and ratio of payor reimbursement for OON services to total payor reimbursement did not differ much between hospital and non-hospital location, there were differences in the ratio of reimbursement to billed charges. As the AOB law takes full effect along with delivery system reforms, the Commission will continue to evaluate the impact and report to the House Health and Government Operations Committee and the Senate Finance Committee, as required by the law.

Maryland Trauma Physician Services Fund

The Maryland Trauma Physician Services Fund (“Trauma Fund” or “Fund”) covers the costs of medical care provided by trauma physicians at Maryland’s designated trauma centers for uncompensated care patients, Medicaid enrolled patients, and trauma related on-call expenses. The Fund is financed through a \$5 surcharge on motor vehicle registrations and renewals.

The Maryland General Assembly took steps to increase eligibility and reimbursement levels for trauma fund payments in 2006, 2008, and 2009. House Bill 1164 (Trauma Reimbursement and Grants) passed during the 2006 session of the Maryland General Assembly realigned spending with collections by increasing the physician specialties eligible for uncompensated care and Medicaid under-compensated care and raising the on-call reimbursement formula for trauma centers. Trauma physicians at three specialty referral centers became eligible for uncompensated care reimbursement and elevated Medicaid payments. In addition, Level II and Level III trauma center hospitals were awarded trauma equipment grants beginning in FY 2007. Senate Bill 916 (Maryland Trauma Physician Services Fund – Reimbursements and Grants) passed during the 2008 session expanded eligibility for Trauma Fund on-call payments, made the trauma equipment grant program permanent (subject to funds available), and gave the Commission authority to raise physician reimbursement levels. In 2009, the Maryland General Assembly passed House Bill 521 (Maryland Trauma Physician Services Fund – Rural Trauma Centers – Reimbursement) which expanded on-call stipends for Level III trauma centers for maintaining trauma surgeons, orthopedic surgeons, neurosurgeons, anesthesiologists, plastic, major vascular, oral or maxillofacial, and thoracic surgeons on call; however, the Commission had authority to withhold reimbursement for on-call hours exceeding 35,040 until the remaining costs eligible for reimbursement for Level I, II, III, pediatric and specialty referral centers are fully funded. That component of the law is no longer in effect as of September 30, 2013.

During the 2012 legislative session the Maryland General Assembly removed the restriction that expenditures from the Fund may not exceed the Fund's revenues in a fiscal year, which was effective on October 1, 2012.

The Maryland Health Care Commission approved an 8 percent across the board reduction in payment rates for FY 2010 (with the exception of Medicaid) due to the downturn in automobile registration revenue and an expected increase in uncompensated care claims, which continued through FY 2013. A \$4.3 million surplus existed at the start of FY 2012; however, the law limiting total payments in any fiscal year to revenue collected in that same year remained in effect for FY 2012. Trauma Equipment Grants awarded to the Level II and Level III trauma centers, for a total of \$298,571, were paid from surplus funds.

Payments to eligible providers and the administrative costs associated with making those payments were about \$11,643,380 in FY 2013, a decrease of more than \$500,000 from FY 2012. Comparing FY 2013 to FY 2012, uncompensated care payments and on call trauma payments, combined, increased by approximately \$395,000. Transfers from the Motor Vehicle Administration (MVA) to the Fund decreased by nearly \$80,000 in FY 2013; while administrative costs were similar to those in FY 2012. Reimbursements to the Fund from physicians paid for uncompensated care claims from other sources were nearly \$200,000 less in FY 2013 than in FY 2012.

Data Base and Applications Development Division

Overview

The Data Base and Application Development Division is responsible for data processing and analysis support systems, internet application development, and public reporting of health care information. The Commission has the authority to collect and report on health care professionals, hospitals, and facilities such as nursing homes, assisted living facilities, adult day care centers, home health agencies, and hospices. This division collects and manages internal and external analytic data files used by the Commission, including the Maryland hospital inpatient, outpatient and emergency department discharge data, state and private psychiatric hospital data, ambulatory surgery data, the District of Columbia (DC) hospital inpatient data, hospital CAHPS and clinical quality data, Cath-PCI data, Medicare and private payer insurance claims data, pharmacy claims data, trauma center expenditures and statistics, and several Centers for Medicare & Medicaid Services (CMS) data collections, including quality, deficiency and facility-level data for nursing homes and home health, and MHCC web-based collections of hospice, assisted living and adult day care facilities data.

Accomplishments

Electronic Data Interchange (EDI) Survey

Data staff prepared the EDI Progress Survey launch for 2011, copied the 2010 final EDI survey data to a backup folder, and provided the login table to the HIT staff. Data staff converted the survey tables into Excel for HIT staff use and wrote instructions for them to make edits to the survey claims table.

Long Term Care (LTC) Portal

Data staff developed the portal for reporting.

Patient-Centered Medical Home (PCMH)

The Maryland PCMH program is a model of practice in which a team of health professionals, guided by a primary care provider, provides continuous, comprehensive, and coordinated care in a culturally and linguistically sensitive manner to patients throughout their lives. The PCMH provides for all of a patient's health care needs, or collaborates with other qualified professionals to meet those needs. The Maryland PCMH program is promoted and managed through a series of coordinated online web sites developed and maintained by the Data staff.

Web Development and Support for DHMH Boards and Commissions

The following license renewal sites were developed and are maintained by the Commission and allow practitioners to renew licenses and to provide data to DHMH about the health provider and collect renewal fees:

- Acupuncture
- Audiologists, Hearing Aid Dispensers and Speech Language Pathologists
- Chiropractic and Massage Therapy Examiners
- Dietetic Practice

- Morticians & Funeral Directors
- Optometry
- Physical Therapy Examiners
- Physicians
- Psychology
- Podiatric Medical Examiners
- Professional Counselors and Therapists
- Social Work Examiners

Network and Operating Systems Division

Overview

The division's staff builds, upgrades, and maintains the Commission's local area network (LAN). The LAN encompasses a wide variety of hardware and software products. The MHCC hardware includes database, file, print, mail, intranet and Internet servers, PCs, and peripherals such as tape and disk subsystems, network printers, switches, and other infrastructure equipment. The staff configures and maintains all network equipment and installs and maintains all server and workstation software.

Division staff implement and enforce security conventions to guard against external threats and maintain the data access conventions adopted by the Commission that control staff's access to sensitive information. The division is responsible for network disaster recovery and business continuity planning.

Staff also provide technical assessment, configuration management, and capacity planning functions for the organization and are responsible for assessing new technologies and recommending and implementing changes to keep the Commission's information systems fully responsive to the Commission's needs.

Accomplishments

During FY 2013, the Commission's LAN was available to staff over 98% of the time.

The Commission's LAN continues to be safeguarded by keeping all systems up-to-date with the timely application of software patches and the regular upgrade of an anti-virus database engine. Security is enhanced because the LAN is a private network behind an MHCC firewall, which isolates the MHCC LAN from the DHMH wide area network, which is behind its own firewall. In addition to the standard annual accomplishments listed, the following were also completed in FY 2013:

- 100% transition of MHCC to use of the Google for Government email system;
- Expanded the publically accessible open WiFi Internet service to include 3 access points serving each section of the MHCC office (front, middle, back);

- Upgraded the network infrastructure backup system; conversion from a tape-based system to an optical disc-based environment; the new system creates baseline, then takes “snapshots” of changes every hour; data restore times improved from 2-3 hours to 10-15 minutes;
- Fully implemented a virtualized network server environment; replaced 3 physical network servers with 2 virtual machines; currently using 65% of total storage capacity of the new storage area network supporting the virtual environment (device contains physical drives filling 50% of available bays);
- Upgraded the MHCC database server (SAS system) with a new 4-core, 32GB RAM server, containing 10TB of storage; currently using approximately 35% of total available storage; conversion has reduced large query response time from approximately 8 hours to 10 minutes;
- Upgraded the wiring plant in the MHCC data center for all client workstation connections; changed all workstation cables to new category 6 cables and connected all to a new, manageable network connectivity device (hub);
- Upgraded the audio system in the primary MHCC/HSCRC conference room; installed 14 new wireless microphones with a corresponding transmitter for each individual microphone; added 5 power/signal amplifier devices to boost the audio & wireless signal to all microphones.



The Center for Health Care Facilities Planning and Development

Benefits Analysis Division

Overview

The initial charge to the Health Care Access and Cost Commission (HCACC —one of the predecessors of the MHCC) was to develop a health benefit plan for small employers which includes benefits that are at least equivalent to those benefits required to be offered by a federally qualified HMO with an average premium cap for the basic plan that does not exceed twelve percent of Maryland's average annual wage in any year. Working with this statutory floor and ceiling, the legislation also directed the Commission to adopt regulations (COMAR 31.11.06) specifying a comprehensive standard health benefit plan (CSHBP) to apply under Maryland insurance law (Annotated Code of Maryland, Health-General Article 19-103(c)(6)). The Maryland Insurance Article (Annotated Code of Maryland, Insurance Article, Title 15, Subtitle 12) initially defined the small group market as employers with two to fifty employees. In 1996, the small group market was expanded to include the self-employed. Regulations require the Commission to review the CSHBP annually to assess the adequacy and affordability of coverage (COMAR 31.11.06.12). In 2003, the affordability cap was set not to exceed ten percent of the state's average annual wage (Chapter 93 of the Laws of Maryland, effective July 1, 2003). The General Assembly passed SB 1014 (enacted during the 2005 legislative session, with a sunset provision of September 30, 2008 – subsequently extended through December 31, 2013), that no longer allows the self-employed to enroll in the CSHBP because of their atypically high loss ratio. During the 2009 legislative session, the General Assembly enacted SB 637/HB 674 (Chapter 577 of the Laws of Maryland), which imposed the following modifications to the small group market, with varying effective dates: removal of the statutory floor; elimination of the prohibition on applying pre-existing condition limitations in this market, allowing carriers to impose this exclusion for up to 12 months based on a six-month look-back period on individuals first entering the small group market; the requirement that the Commission establish an information-only web portal to publish small group premium information on its website; adjustment of the rating bands in the small group market to +/-50 percent; and allowance for carriers to rate on entry for new groups entering the small group market, adjusted annually over the first three years of enrollment.

As of July 1, 1994, carriers participating in the small employer market can only offer a policy incorporating the CSHBP on a guaranteed issue, guaranteed renewal basis. Medical underwriting was phased out as of January 1, 1995. Riders can be issued to improve the benefits, but not to diminish them. The insurance reform required community rating adjusted

only for age and geography. Rating bands were established and are currently set at +/-50 percent. Since its inception, this health insurance reform initiative has provided small businesses in Maryland with access to a comprehensive health insurance benefits package on a guaranteed issue, guaranteed renewal basis.

In November 2007, the General Assembly held a special legislative session resulting in the enactment of SB 6, the Working Families and Small Business Health Coverage Act (Chapter 7 of the Laws of Maryland). A major component of this enabling legislation charged the MHCC with creating a Small Employer Health Benefit Plan Premium Subsidy Program, to be made available to certain Maryland small employers with low to moderate wage employees. The purpose of the premium subsidy program is to: (1) provide an incentive for small employers to offer and maintain group insurance for their employees; (2) help low and moderate wage employees of small employers afford the premiums; (3) promote access to health care services, particularly preventive services that might reduce the need for emergency room care and other acute care services; and (4) reduce uncompensated care in hospitals and other health care settings. The Act specifically requires that the premium subsidies be available to small businesses that (1) employ at least 2 but not more than 9 full-time employees where group coverage has not been offered during the most recent 12 months; (2) meet salary and wage requirements established by the Commission; (3) establish a Section 125 payroll deduction plan for the employees; and (4) agree to offer a wellness benefit as part of the group health benefit plan. This Act directed the Commission to adopt regulations (COMAR 10.25.01) to establish both the eligibility requirements and the level of subsidies for small employers under the Program. Finally, on or before January 1, 2009 and annually thereafter, the MHCC is required to report to the Governor and the General Assembly on the implementation of the Small Employer Health Benefit Plan Premium Subsidy Program, branded as the Health Insurance Partnership.

Accomplishments

Comprehensive Standard Health Benefit Plan

With the enactment of the Affordable Care Act in 2010, the Commission enhanced the services provided under the CSHBP to conform to the federally mandated provisions. Through regulations implemented effective September 23, 2010, specific provisions include the following: children can remain covered on a parent's existing policy until the age of 26; certain preventive services recommended by the U.S. Preventive Services Task Force cannot be subject to the deductible nor have any associated cost-sharing requirements if these services are provided in-network; the \$2 million lifetime limit has been removed; the provisions for direct access to gynecologic services are changed from state provisions to federal provisions; and individuals under the age of 19 may not be subject to any pre-existing condition restrictions or limitations. With these additional benefits, and with health care inflation continually exceeding wages, the overall cost of the CSHBP exceeded the affordability cap in FY 2013, at almost 101 percent of the cap as of December 31, 2012. At that time, almost 40,000 Maryland small employers purchased group insurance, covering about 348,000 of their employees and their dependents.

In June 2010, the Commission contracted with Benefitfocus to develop an information-only web portal designed to help small business owners choose a group health benefit plan for their employees. The web portal, known as VIRTUAL COMPARE, became operational on May 3, 2011, and provides information about select health benefit plans available to small employers in Maryland, allowing a side-by-side comparison of benefits, premiums, and out of pocket costs. VIRTUAL COMPARE also includes guidance about choosing health insurance; information about federal tax credits and state subsidies for small, low wage companies; and assistance in finding an insurance broker to apply for coverage. Throughout FY 2013, more than 900 licensed insurance producers in Maryland have registered to be listed on VIRTUAL COMPARE to assist small employers with the group application process. Moreover, the analytics indicate consistent consumer access to VIRTUAL COMPARE, averaging 4 to 7 visits on a daily basis, with the user viewing 2 to 5 pages per visit, and spending between 3 and 6 minutes on the site per visit.

Mandated Health Insurance Services Evaluation

In 1998, the Maryland General Assembly expanded the Commission's duties, requiring the Commission to conduct an initial evaluation of the cost of existing mandated health insurance services and requiring the Commission to assess the medical, social, and financial impact of any legislatively proposed health insurance service, (Insurance Article Title 15, Subtitle 15, Annotated Code of Maryland). The Annual Mandated Health Insurance Services Evaluation report is due to the legislature each December 31st. The mandates do not affect Medicare, Medicaid, self-insured products, or the small group market. It should be noted that the annual mandate evaluation applies only to health services and not to issues of eligibility, continuation of benefits, or reimbursement to certain providers of services, which are also sometimes considered "mandated benefits."

In 1999, the Legislature expanded these requirements to request annual reporting on whether the fiscal impact of existing mandates exceeded a statutory income affordability cap of 2.2 percent of Maryland's average annual wage. If the 2.2 percent affordability cap was exceeded, an analysis of the medical, social, and financial impacts of all current mandates was required. That study was eliminated during the 2003 legislative session and replaced with a new study (now called the "Comparative Evaluation") which was required to be submitted to the General Assembly by January 1, 2004, and every four years thereafter. The Comparative Evaluation must include: (1) an assessment of the full cost of each existing mandated benefit as a percentage of the State's average annual wage and of premiums under a typical group and individual health benefit plan in Maryland, under the State employee plan, and under the Comprehensive Standard Health Benefit Plan (CSHBP) offered to small employers; (2) an assessment of the degree to which existing mandated benefits are covered in self-funded plans; and (3) a comparison of mandated benefits provided in Maryland with those provided in Delaware, the District of Columbia, Pennsylvania, and Virginia based on the number of mandates, the type of mandates, the level and extent of coverage for each mandate, and the financial impact of differences in levels of coverage for each mandate.

In FY 2013, one proposed mandate was evaluated: coverage of foot orthotics for people with diabetes. This analysis, prepared by Mercer/Oliver Wyman, the Commission's consulting actuary, was approved by the Commission in December 2012, submitted to the General Assembly, and posted on the Commission's website. The most recent Comparative Evaluation was approved and published in December 2011, and is due every four years.

With the enactment of the Affordable Care Act in 2010, all health benefit plans offered through the new health benefit exchange must include certain "essential health benefits" beginning January 1, 2014. Federal reform also requires that each state must pay, for every health benefit plan purchased through the exchange, the additional premium associated with any state-mandated benefit beyond the essential health benefits. Any Maryland mandates that apply to the selected benchmark plan will apply to the essential health benefits package in 2014 and 2015. The U.S. Department of Health and Human Services advised in December 2011 that any new mandate enacted during the 2012 legislative session or beyond, or any benefits that do not apply to the benchmark plan, *will not* apply to the essential health benefits package, and thus the State will be liable for the cost of the additional premiums associated with those benefits.

Health Insurance Partnership

COMAR 10.25.01 established the eligibility requirements for employers and employees, as well as the process for calculating the average wage of the business and the group subsidies for the premium subsidy program, the Health Insurance Partnership. Throughout FY 2013, four major carriers (Aetna, CareFirst BlueCross BlueShield, Coventry Health Care, and United HealthCare), together with a number of Third Party Administrators (TPAs) continued enrolling small businesses in the Partnership, with each carrier offering a variety of health benefit plans that qualify for a premium subsidy. Annual funding for the Partnership is \$2 million. On January 1, 2013, the MHCC published the 5th annual report on the implementation of the Partnership indicating that throughout FY 2013, small employers in Maryland continued to renew their subsidized insurance for their employees and several new businesses enrolled as well. By the end of FY 2013, more than 430 businesses enrolled, covering almost 2,000 employees and their dependents. The average annual subsidy per enrolled employee exceeded \$2,400. The annual Health Insurance Partnership report is posted on the Commission's website.

Health Plan Quality and Performance Division

Overview

The Division of Health Benefit Plan Quality and Performance takes action as appropriate to develop, implement, and support public policy to collect and report meaningful, comparative information regarding the quality and performance of commercial health benefit plans authorized to operate in the State of Maryland. The meaningful, comparative information supports employers, as well as individual purchasers, academic and public policymakers, in assessing the relative quality of services provided by health benefit plans that are required under COMAR 10.25.08 to report to the Maryland Health Care Commission (MHCC). Health-General Article, Section 19-134(c), et seq. is the statute that gives MHCC its authority to

establish and implement a system to evaluate and compare, on an objective basis, the quality and performance of care provided by commercial health benefit plans. The statute also permits the MHCC to solicit and publish data collected using standardized health benefit plan quality and performance measurement tools. MHCC currently utilizes the Healthcare Effectiveness Data and Information Set (HEDIS)[®], which focuses on measuring clinical performance; the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which focuses on health benefit plan members' satisfaction with their experience of care; Maryland Race/Ethnicity, Language, Interpreters, and Cultural Competency Assessment (RELICC), which focuses on disparities issues; Maryland Plan Behavioral Health Assessment (BHA), which details the behavioral health care provider network; and Maryland Health Plan Quality Profile (QP), which centers on carrier-specific health care quality improvement initiatives in Maryland. The MHCC is required to annually publish the findings of the evaluation system for dissemination to consumers, purchasers, academics, and policymakers. All information is reported within a framework of the type of delivery system that a health benefit plan is structured as, including categories such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Point of Service (POS) organizations, Exclusive Provider Organizations (EPOs), or any other type of delivery system category that may be introduced in the future.

Using quality and performance information supports informed health care choices, and aids in the selection and purchase of the best quality of care specific to the needs of each consumer, whether the consumer is an employer, individual, or family. Public reporting of standardized quality and performance measures and indicators promotes competition among health insurance carriers and stimulates health benefit plans' efforts toward continuous quality and performance improvement activities that target consumer needs and expectations. In theory, the result of developing and reporting quality information is that quality attains a value in the marketplace. As health benefit plans begin to compete on the basis of quality, they will devote greater attention and resources to quality improvement activities. Ultimately, high performing health benefit plans should be rewarded with greater market share as quality begins to influence consumer choice. We are proud to be driving continuous health care quality improvement in the State of Maryland through publicly reporting meaningful, comparative information on health benefit plan quality and performance.

Accomplishments

Memorandum of Understanding (MOU) between MHCC and MHBE. Division staff successfully negotiated and executed an MOU between MHCC and the MHBE, advancing MHCC's continued collaboration with MHBE. The MOU provides for MHCC to utilize the measurement and reporting experience and the infrastructure it has in place to produce MHBE's federally required reports on the performance of Qualified Health Plans and, prospectively, for Qualified Dental Plans. The MHBE subsequently issued a requirement for qualified health plans (QHPs) that participate in the Exchange to participate in MHCC's Quality and Performance Evaluation System. This collaborative approach has helped MHBE during its time-sensitive and resource-demanding start-up phase. Collaboration with MHCC also provides MHBE with needed services for federal compliance at a reduced financial and human resource cost. MHBE wants to continue this collaborative reporting arrangement for as long as it remains feasible to do so.

Stakeholder input for the 2013 quality and performance reporting requirements and public reporting documents. Each year division staff launches a planning process that identifies presentation approaches and the quality measures that will be used in the next report. Quality measures that are no longer deemed appropriate are retired, promising new measures are added, and sometimes, existing measures are redefined. Employers and health benefit plan representatives play important roles in this planning effort. Employers are helpful in identifying measures that would be most useful to their employees and dependents. Health benefit plan representatives assist the MHCC staff in determining if measures can be accurately collected and provide a perspective on information that would be valuable to their enrollees.

State Health Access Data Assistance Center (SHADAC) and State Network's small group consultation. Division staff, along with other MHCC and MHBE representatives from Maryland, California, Colorado, Massachusetts, Minnesota, New York, Oregon, and other key stakeholder organizations such as the Center for Consumer Information and Insurance Oversight (CCIIO), the Agency for Healthcare Research and Quality (AHRQ), and the Robert Wood Johnson Foundation (RWJF), collaborated on best practices for navigating the various stages of each state's Exchange implementation and explored the varying data needs and reporting requirements related to state-based marketplaces.

Development of the MHBE 5-Star Rating System. Division staff provided extensive consultation and guidance in the development of MHBE's unique 5-Star Rating System. Staff directed MHCC's contractor to develop several potential methodologies (models), and present these methodologies to MHBE staff for review and approval. The methodology selected by the MHBE staff for possible implementation was presented to MHBE's key stakeholders, including Maryland Health Connection development vendors, and subsequently approved by the MHBE Board.

Annual audits of commercial health benefit plans were successfully conducted. Division staff worked closely with MHCC's audit vendor. Quality and performance data integrity issues related to the accuracy and completeness of carrier reporting were identified and were successfully resolved by staff working with the health benefit plans. This audited data provides a higher level of data validation when reporting performance results in the MHCC and MHBE quality and performance reports.

Maryland health benefit plans began mandatory RELICC reporting. In 2013, in order to comply with the Maryland Health Improvement and Disparities Reduction Act of 2012, division staff in collaboration with the MHBE, searched for an affordable, off-the-shelf quality measurement and reporting tool to meet the reporting requirements in the Act. The search pointed to the eValue8 tool, which contained a dedicated section on issues surrounding race/ethnicity, language, interpreter need and cultural competency. In collaboration with the MHBE, MHCC expanded the reporting of quality data to include data related to such issues that address disparities, including issues surrounding race/ethnicity, language, interpreters, and cultural competency. Division staff negotiated and subsequently entered into an agreement with the Mid-Atlantic Business Group on Health and the National Business Coalition on Health to create

a customized, Maryland-specific tool, based on a single section of the proprietary eValue8 tool that focuses exclusively on disparities. This customized measurement tool for use by the State of Maryland goes by the moniker RELICC. This tool was piloted during the 2013 reporting year and meets all the current affordability, measurement, and reporting requirements of the MHCC and the MHBE and will be utilized by the MHCC and MHBE for race and ethnicity reporting in 2014 and beyond. The RELICC quality measurement tool has now been added to MHCC's suite of quality and performance measurement and reporting tools.

A Data Use Agreement with MABGH and NBCH was successfully executed. Division staff successfully executed a between MHCC and the MidAtlantic Business Group on Health (MABGH) as well as the National Coalition on Health (NBCH). This DUA relates specifically to the use of data from the Maryland RELICC (Race/Ethnicity, Language, Interpreters, and Cultural Competency) Assessment.

Carrier-specific Disparities Webinars. Division staff conducted Disparities Webinars with each of the six carriers operating in Maryland. The purpose of the webinars was to share RELICC performance information, discuss the accuracy of reporting and opportunities for improvement that are specific to RELICC. Following established MHCC protocol, first-year results from the use of the RELICC tool will not be publicly released.

An Activities Report was timely prepared for the Cultural Competency Workgroup of the Maryland Health Quality and Cost Council (MHQCC). The MHQCC's Cultural Competency Workgroup had identified its three charges. The chief of this division serves as a co-leader of the Charge 1 Subcommittee. The subcommittee is charged with examining appropriate standards for cultural and linguistic competency for medical and behavioral health treatment, and the feasibility and desirability of incorporating these standards into reporting by health care providers, and tiering of reimbursement rates by payors; Members of the Charge 1 Subcommittee worked together to complete the 7 action steps which were laid out by the Office of Minority Health and Health Disparities. All projects related to the Charge 1 Subcommittee were timely completed and submitted for incorporation with the reports of the other two subcommittees. The summary document will be presented to the Maryland legislature by the Office of Minority Health and Health Disparities.



Long Term Care Policy and Planning

Overview

The Long Term Care Policy and Planning Division is responsible for health planning related to community-based and institutional long term care services. This includes monitoring changes in demographics, medical technology, financing and reimbursement, and their impact on current and projected utilization of long term care services in Maryland; determining where there may be gaps in the continuum of care; promoting the development of needed services in response to identified needs, and assuring access to a full continuum of long term care services. In addition to planning, the Division is also responsible for data collection through three annual surveys, special studies, and quality assessment. The Division coordinates its long term care policy development and planning efforts with other appropriate state agencies and stakeholders, and provides leadership and direction to technical advisory committees and workgroups conducting analyses of a wide range of issues.

Accomplishments

Consultant on Use of the Minimum Data Set (MDS)

On June 23, 2009 the Commission executed a one year contract for support in maximizing the utility of the Centers for Medicare and Medicaid (CMS) Minimum Data Set (MDS) Resident Assessment Instrument to update data sets for planning and policy development; 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. Products developed included: detailed data documentation; data dictionary; software architecture; flow charts; and a glossary. The MDS Manager Program that was developed was used to update MDS data through 2009.

A new contract was awarded to Myers and Stauffer in June 2011 to update the MDS Manager to accommodate federally mandated changes from MDS 2.0 to 3.0 and to update programming languages from Fox Pro (no longer supported) to SAS, the platform used at the Commission. The initial focus was on reviewing and updating variables and programs from MDS 2.0 to 3.0. There has also been testing to assure that the programs developed in SAS produce the output consistent with the previous MDS Manager program. Meetings are held biweekly via conference call to monitor the progress of this contract. The MDS Manager Program has now been updated, work has been done on programming needed to support the Consumer Guide for Long Term Care, and work is underway on programming to support the Long Term Care Survey. In addition, in response to issues raised by providers, staff contacted CMS to update and redefine certain variables collected in Section S (state-specific section) of the MDS. After consultation with CMS staff, the changes were accepted. A letter was sent jointly by MHCC and

the Office of Health Care Quality (OHCQ), which is the repository for the MDS data. This letter informed providers and software vendors of updates that go into effect October, 2013.

Chronic Hospital Occupancy Update

As required under COMAR 10.24.08, a notice was published in the November 16, 2012 *Maryland Register* to update “Chronic Hospital Occupancy for fiscal year 2011.” This report is required to be updated annually. It reports data on occupancy for both private and state-operated chronic hospitals. The private chronic hospitals include James Lawrence Kernan Hospital; Johns Hopkins Bayview Medical Center; Levindale Hebrew Geriatric Center and Hospital; University Specialty Hospital; and Gladys Spellman Specialty Hospital and Nursing Center. The state-operated chronic hospitals include Western Maryland Center and Deer’s Head Hospital Center. The Chronic Hospital Occupancy Report for FY 2011 is posted on the Commission’s website at:

http://mhcc.dhmh.maryland.gov/ltc/Documents/longtermcare/chronic_hospital_occupancy_report_2011_md_register_20121024.pdf

Nursing Home Occupancy Rates and Utilization by Payment Source: Maryland Fiscal Year 2011

Data on nursing home occupancy and Medicaid participation rates is updated periodically and published in the *Maryland Register* to guide health planning and Certificate of Need decisions and other planning functions. The following tables were submitted to the *Maryland Register* for publication in the December 28, 2012 issue: “Nursing Home Licensed Beds Occupancy by Region and Jurisdiction: Maryland, Fiscal Year 2011;” and “Required Maryland Medical Assistance Participation Rates for Nursing Homes by Region and Jurisdiction, Fiscal Year 2011.” These tables are developed and published annually based on data from the MHCC Long Term Care Survey, MHCC bed inventory reports, and Medicaid cost reports. These reports are also posted on the Commission’s website at:

<http://mhcc.dhmh.maryland.gov/ltc/Pages/longtermcare/default.aspx>

State Health Plan Draft Chapter: Hospice Services

During FY 2012, Commission staff began work to update the State Health Plan Chapter on Hospice Services. The Chapter then in statute (COMAR 10.24.08) covers three services: nursing home, home health agency, and hospice services. The draft regulation (COMAR 10.24.13) addresses only hospice services. The current chapter was reviewed, regulations in other states were studied, and a new draft Chapter was prepared. As a major component of this process, a Hospice Advisory Group was formed and held several meetings (see more detail below). Staff presented the draft Chapter at the April 19, 2012 Commission meeting. An Informal Public Comment period was held from April 14- May, 14, 2012. In addition, in response to requests from the industry, a Public Informational Meeting was held on April 27, 2012. Updated population data were received and updated projections were published on the Commission’s website on May 23, 2012.

During the first Informal Public Comment period, 23 comments were received from legislators and 23 comments were received from other individuals and organizations. These comments

were reviewed and analyzed and staff recommendations were made to the Commission in June. Following that meeting, the staff's analyses as well as the full text of comments received, were posted on the Commission's website.

Staff met with the Hospice Network about an alternative approach to projecting the need for hospice services. The Hospice Advisory Group was reconvened on August 23, 2012. In addition, a meeting was held with interested participants on September 10, 2012. On September 12, 2012, a briefing was held at the Senate Finance Committee.

In response to the public comments, as well as issues raised at the Senate Finance Committee meeting, more internal staff work was done on the draft Chapter. Staff worked with the Hospice Network to develop an alternative approach to projecting need for hospice services. The Hospice Work Group was convened on January 16, 2013. At that meeting, consensus was reached on the components of the methodology. Staff returned to brief the Senate Finance Committee on January 24, 2013.

One directive from the Senate Finance Committee was to work on a plan for Educational Initiatives for hospice. In response, staff met via conference call with the Health Officers of both Prince George's County and Baltimore City, areas where need is identified with the revised methodology. More information on this initiative is shown in the section on the Hospice Education Initiative Work Group below.

Commission staff briefed the Commission on this update to the State Health Plan Chapter at its April 18, 2013 meeting. The Hospice Plan Chapter was posted on the Commission's website for a second 30-day Informal Public Comment period, from April 10- May 10, 2013. During this comment period, comments were received from 12 organizations. The Summary and Analysis of Public Comments was presented to the June Commission meeting where the Commission took action to approve COMAR 10.24.13 as proposed permanent regulations. This initiated the formal public comment process. Information on the State Health Plan process for the Hospice Chapter may be found at: <http://mhcc.dhmfh.maryland.gov/shp/Pages/default.aspx>

Home Health Agency Data

Staff compiled data tables on the utilization and financing of home health agency services in Maryland for fiscal year 2011. The data was obtained from the information collected by the Commission's Home Health Agency Survey for fiscal year 2011 using an automated system, which includes data on overall agency operations and demographic characteristics, payer types, and services provided to Maryland clients by their jurisdiction of residence. The data tables for fiscal year 2011 were posted on the Commission's website in April 2013, and can be found at http://mhcc.dhmfh.maryland.gov/data/Pages/public_use_files_/publicuse.aspx

Data tables include an overview of home health agency characteristics, utilization and costs, including: volume of admissions; referral sources; primary diagnosis on admission; average visits per Medicare clients; disposition; revenues by payer types; and home health agency personnel. Staff continued to analyze home health agency utilization trend data based on

information submitted to the Commission in its Home Health Agency Annual Surveys. Data tables are available for fiscal years 2004 - 2011. Public use data sets are also available for fiscal years 2007- 2011.

Home Health Agency Inventory

The home health agency (HHA) inventory is routinely utilized for planning purposes as well as for updating the Commission's long term care website. This inventory was updated monthly to reflect both newly established and acquired home health agencies licensed and operating in Maryland.

Meetings/Collaboration

Nursing Home Liaison Committee

The Committee is chaired by staff of the Medicaid program of the Department of Health and Mental Hygiene (DHMH) and includes representatives of the individual nursing homes, nursing home associations, accounting firms, and consultants. Division staff track changes in Medicaid regulations and receive input from representatives of the long term care industry as members of this liaison committee.

Hospice Advisory Group

As the first step in updating the Hospice Services Section of the State Health Plan, the Commission convened a Hospice Advisory Group in 2011. The charge of the Hospice Advisory Group was to assist Commission staff in analyzing utilization trends, discussing factors contributing to the changes in the utilization of hospice services, identifying potential factors affecting future need for hospice services, and discussing issues for policy development. This Group is composed of: six representatives from Maryland's hospice industry, nominated by the Hospice and Palliative Care Network of Maryland to represent geographic areas as well as the for-profit and non-profit distribution of the members; an administrative representative of the Hospice Network; a representative from the Centers for Medicare and Medicaid Services (CMS) with expertise in planning, evaluation, and financing of hospice services; a representative from the Maryland Medical Care Policy Administration; and a representative of Maryland's Department of Health and Mental Hygiene's Office of Health Care Quality (OHCQ). The charge of the Hospice Advisory Group is to assist Commission staff in analyzing utilization trends, discussing factors contributing to the changes in utilization of hospice services, identifying potential factors affecting future need for hospice services, and discussing issues for policy development.

The first meeting, held in October 2011, focused on data trends and policy issues. Presentations were made on hospice issues from the perspectives of CMS, Medicaid, and the Office of Health Care Quality. In addition, data depicting trends in hospice utilization were presented. The second meeting, held in November 2011, began with a review of hospice methodologies used in other states, as well as a discussion about the current Maryland hospice need projection methodology. The meeting then focused on data assumptions and key variables, such as age, use rate, growth rate, and volume threshold. Based on these discussions, work began on updating the Chapter and developing draft regulations. On August 23, 2012 the

MHCC reconvened the Hospice Advisory Group to review modifications to the methodology, the updated population data, and a step-by-step description of the methodology. Staff then met with the Senate Finance Committee on September 12, 2012. They recommended that staff revise the methodology. Staff then moved towards an “aspirational” approach to projecting hospice need. This was done and the Hospice Work Group was reconvened on January 16, 2013. At that meeting, consensus was reached on the components of the methodology.

Hospice Education Initiative Work Group

One directive from the Senate Finance Committee was to work on a plan for hospice outreach and education. With the revised hospice methodology, need is projected in areas with low hospice utilization and large minority populations. Minorities tend to use hospice at lower rates than the general population. The goal is to improve education and outreach. In response, staff has met via conference call with the Health Officers of both Prince George’s County and Baltimore City, who supported the concept.

The first meeting of the Hospice Education Initiative Workgroup was held on April 29, 2013. Membership included: Hospice and Palliative Care Network of Maryland; Coastal Hospice; Gilchrist Hospice; Hospice of the Chesapeake; Joseph Richey Hospice; Baltimore City Office of Aging; Central Maryland Ecumenical Council; Prince George’s County Dept of Family Services; Prince George’s County Health Dept; Maryland Hospital Association; Med Chi; Office of Health Care Quality; University of Maryland Dept of Social Work; and the DHMH Office of Minority Health and Disparities.

Hospice Regulations Workgroup

The Office of Health Care Quality convened this work group to develop regulations to address the development of residential hospice programs, or “hospice houses.” These currently do not fall under the purview of the licensing regulations. The first meeting was held in November 2011, and a second meeting was held in January, 2012. The group met again in June 2012 and draft regulations were developed. Commission staff participated in this development process.

Data Collection

Hospice Survey

The Commission is charged with collection of hospice data as required by SB 732 (2003). Fiscal Year 2012 hospice data was collected using an online survey and finalized during this time period. The official start of the FY 2012 Maryland Hospice Survey was February 19, 2013 with a due date of 60 days after receipt of the survey for Part I and no later than June 10, 2013 for Part II. Since Part II is based on Medicare cost report data, a longer time period is provided. Staff provided follow up to hospices and 100% reported data for Part I and Part II. Public use data files for FY 2011 hospice data were posted on the Commission’s website in October, 2012. It is posted at: http://mhcc.maryland.gov/public_use_files/index.aspx

Long Term Care Survey

In December 2012, staff finalized the cleaning of the 2011 Long Term Care Survey data which included year by year comparisons, trend analysis and verification by the providers. The data

was used for several purposes, including the 2011 public use data which was made available on the Commission website in December 2012, to update the Consumer Guide, to create the Nursing Home Occupancy report, and to update the State Health Plan.

In an effort to streamline the survey processes and reduce the number of data collections from the nursing home providers, Long Term Care staff worked with the Administration staff to merge the Long Term Care Survey and the User fee Assessment Survey. In past years, two separate surveys were sent to the same provider during the same period. The goal was to reduce the confusion for the providers and improve data quality and efficiency overall. In February 2013, staff sent a notice letter from the Executive Director, to all nursing home providers and stakeholders informing them of the change in the survey process.

The fiscal year 2012 Long Term Care Survey data collection period began on March 11, 2013 for all facility providers and ended on April 9, 2013 for Comprehensive Care facilities to facilitate the timeline of the user fee assessment, and on May 9, 2013 for all other licensure categories including Chronic Care, Assisted Living and Adult Day Care Centers. A total of 737 facilities participated in the survey collection, including Comprehensive Care Facilities (233), Chronic Care Facilities (7), Assisted Living Facilities (376), and Adult Day Care Centers (119), four facilities were exempt due to closure in the current year. Throughout the survey collection period, 30-Day, 15-Day, 7-Day, and final courtesy warning reminders, referencing the ability to issue penalties for noncompliance, were sent to facilities who had not submitted their surveys by the date of each reminder. On April 9th 2013, the due date for the Long Term Care and User Fee Assessment Survey for Comprehensive care facilities, 100% of the surveys were timely submitted and accepted. For the first time, providers were given thirty days to complete the survey. There were no requests for extensions. Numerous comments relating to the length and the combined collection were positive. The survey submission due date for Chronic Care, Assisted Living and Adult Day Care Centers was May 9, 2013. On that date 71% of the chronic care, 64% of the assisted living facilities and 82% of the adult day care centers had their surveys accepted. On May 14, 2013 the Commission sent a *notice of assessment of fine* letter to the thirty-one providers that had not complied by the due date, notifying them of the fine accrued and their right to file an appeal within 10 business days of receipt of that notice. Sixteen facilities appealed the fines and the fines were waived. Thirteen facilities did not appeal the fine, and an invoice was sent out to these facilities. Two facilities were exempt due to closure. As of June 21, 2013, the Commission had a 100% submission rate. Staff provided technical assistance to providers via the message center utility, by telephone, and by emails throughout the data collection period.

Home Health Agency Survey

For the FY 2012 Home Health Agency Survey collection period staff combined the two phases of the survey into one collection period for all agencies. This was in an effort to streamline the data collection process and reduce turnaround time for data auditing and reporting, including distribution of public use data sets. In the past there were two phases to the home health survey collection; but the data was processed only after the second phase was completed. The

goal was to help agencies to have one consistent time period and increase the overall efficiency of survey data collection and processing.

The fiscal year 2012 Home Health Agency Survey data collection period began on April 8, 2013 and ended on June 6, 2013. Sixty agencies participated in the Home Health Agency Survey. Throughout the survey collection period, 30-Day, 15-Day, 7-Day, and final courtesy warning reminders, referencing the ability to issue penalties for noncompliance, were sent to facilities who had not submitted their surveys by the date of each reminder. Eighty-three percent (83%) of the surveys were accepted by the survey due date of June 6, 2013. On June 17, 2013, staff sent a notice of assessment of fine letter from the Executive Director to the provider that had not complied by the due date, notifying that facility of the fine accrued and the right to file an appeal within 10 business days of receipt of that notice. The agency did not appeal the fine within the appeal period, and was fined for non compliance. As of June 28, 2013, the Commission had a 100% submission rate. Staff provided technical assistance to home health agency staff by telephone and emails throughout the data collection period.

Long Term Care Quality Initiative

Overview

Long Term Care Quality and Performance focuses on improving long-term and community-based care through public reporting of long term care (LTC) service provider descriptive information and performance on a variety of metrics. An interactive web-based consumer guide developed and maintained by staff is the platform for presenting a wide range of information about Maryland LTC service providers, including specific performance and quality measures applicable to each service category.

Maryland Annotated Code, Health General 19-134 d requires the Commission to "implement a system to comparatively evaluate the quality of care and performance of nursing facilities on an objective basis...and annually publish summary findings..." The stated purpose is to "improve the quality of care provided... by establishing a common set of performance measurements and annually disseminating the findings...to facilities, consumers and other interested parties".

Description of Key Programs

The Commission in 2001 developed a *Nursing Home Guide* which transformed in 2010 into the comprehensive *Consumer Guide to Long Term Care* <http://mhcc.maryland.gov/consumerinfo/longtermcare/>. The transformation was needed to respond to the trend to "age in place" – a consumer preference for receiving care in the home or in a home-like setting. The interactive Consumer Guide includes services received in one's home, community, or in facilities such as assisted living and nursing homes, with emphasis on in-home and community services. Information categories include living at home, adult day care, assisted living, home-based care such as home health agencies that provide skilled care, nursing homes and rehabilitation facilities, and hospice services.

Key features of the *Consumer Guide*:

Planning for Long Term Care - This feature defines key terms and types of LTC services; offers resources for planning and links to resources for estimating the cost of LTC; discusses ways to finance LTC; and provides Maryland-specific advance directive planning information. It includes:

- Information about home modifications to allow seniors and persons with disabilities to remain in their home;
- Locations of community support services, such as senior centers, meal programs, resources for family caregivers, and transportation;
- A resource section that includes links to federal, state, and local websites to assist in answering questions about prescription drugs, legal resources for seniors and persons with disabilities, a tool that can locate a physician near one's home, and local resources for health care such as county clinics; and
- Guidance on health insurance benefits, Medicare, special transportation for persons with disabilities, and resources for family members or friends who help seniors and persons with disabilities.

Services Search - The *Consumer Guide's* interactive search tool assists users in locating LTC services by facility type and county. Users can view information about facility characteristics such as ownership information; agency accreditation or certification; number of beds or client capacity; clinical and assistance services available; and resident characteristics. Pictures of nursing homes and assisted living facilities, as well as a location map, are displayed to assist Marylanders in narrowing their choice without having to travel.

An analysis of LTC portal user statistics for fiscal year 2012 showed over 125,000 LTC pages viewed and over 58,000 unique pages viewed. Information about assisted living and searches for assisted living residences were the most often viewed, followed by nursing home topics and searches.

Quality and Performance Reporting - Users can view an extensive set of quality and performance measures for nursing homes and Medicare certified home health agencies, as well as several important measures for assisted living. Measures include: the results of the Office of Health Care Quality (OHCQ) annual licensing and complaint surveys; staff influenza vaccination rates; results of the Experience of Care surveys; and outcome and process measures on various clinical aspects of care. Division staff work with federal agencies such as the Centers for Medicare and Medicaid (CMS), the Agency for Healthcare Research and Quality (AHRQ) and other national organizations such as the National Quality Forum (NQF) to ensure that the quality measures reported within the Consumer Guide are reliable, validated, and suitable for public reporting.

Nursing Home Experience of Care Surveys

Staff in the Long Term Care Quality and Performance division design, develop, and provide oversight for the administration of surveys. The Family Experience of Care Survey (Family Survey) measures the experience and satisfaction with the nursing home's staff, care, and living environment from the perspective of a resident's family member or designated responsible party. The Short Stay Resident Experience of Care Survey (Short Stay Survey) contains similar measures and is completed by recently discharged nursing home residents with a short stay for rehabilitation or following an acute illness. The 2013 Family Survey results were released in April 2013. Short Stay Survey results will be available in the late fall of 2013.

Results of the Family Survey for each nursing home are displayed within the Consumer Guide to assist Marylanders when choosing a nursing home. The Family Survey results are also used by the Medicaid Long Term Care Division within the Department of Health & Mental Hygiene as one of four factors in calculating the Medicaid Nursing Home Pay for Performance Program.

Home Health Experience of Care Survey

The Centers for Medicare and Medicaid (CMS) requires all Medicare-certified home health providers to participate in Home Health CAHPS (Consumer Assessment of Healthcare Providers and Systems). The first HHCAHPS survey results were released in April 2012. The Maryland HHCAHPS results are incorporated into the Consumer Guide with an explanation for consumers. Updates occur every six months and as needed.

Future Hospice Experience of Care Survey

CMS has expanded the collection of hospice measures beginning in calendar year 2014. LTC staff is following this process so that the Consumer Guide can be expanded with the new measures. A Hospice Experience of Care survey is planned for 2015.

Staff Influenza Vaccination Survey in LTC Settings

Influenza infection causes considerable morbidity and mortality among older adults. Persons aged 65 years and older account for the majority of the 36,000 deaths that occur from complications of flu each year. The Division staff initiated collection of influenza vaccination data for nursing home staff during the 2009-2010 influenza season. Results are reported for each facility in the Consumer Guide to Long Term Care in order to assist consumers and are used by the DHMH Medicaid Office of Long Term Care and Community Support as one of four measures in the Medicaid Nursing Home Pay for Performance Program. Additional questions also assess:

- Adoption of a mandatory influenza vaccination policy by nursing homes;
- Measures to raise awareness among staff of the importance of influenza vaccination;
- Strategies to ensure compliance with flu policy or to limit the spread of influenza; and
- Methods used to document staff influenza vaccination status

An Influenza Vaccination Survey for staff working in assisted living residences was first mandatory during the 2011-2012 influenza season. Data collection continued for the 2012-2013 season. Individual facility results for two years are reported in the Consumer Guide to Long Term Care.

National Efforts

As noted earlier division staff collaborates with national organizations including CMS, AHRQ, and the National Quality Forum to ensure that quality measures are validated, reliable, and suitable for public reporting. Division staff follow advancements taking place at the national and regional level to maintain Maryland LTC quality efforts at the cutting edge.

Accomplishments

Consumer Guide to Long Term Care - In addition to routine annual and quarterly updates of measures, the web portal was revised in several important ways:

- Transitioned the nursing home quality measures from 2.0 to 3.0;
- Updated nursing home and home health quality measures quarterly;
- Revised explanation of home health quality measures to a more user-friendly format;
- Updated the comparative function for HHCAHPS results;
- Updated staff influenza rates and experience of care.

Production of MDS Quality Measure and Quality Indicator scores were frozen by CMS from October 1, 2010 through September 30, 2011 to accommodate the transition from MDS 2.0 to MDS 3.0. The transition to MDS 3.0 resulted in changes to several nursing home quality measures. Four measures were removed; three new measures were added; and three measures changed significantly in definition. MDS 3.0 measures were not released until July 2012. Results were carefully analyzed by staff to incorporate necessary changes and clarification for users of the LTC Guide. At the same time of the MDS measure transition, CMS changed the format and content of downloadable files containing the measure results. This required both LTC and Data Base & Applications Development staff to revise portions of the Guide to ensure correct display of data and accurate explanation.

Nursing Home Experience of Care Survey Results

2013 Family Survey results show that statewide “overall satisfaction” was rated 8.3 on a scale of 1-10 (10 represents the best rating); additionally, 90% of respondents said they would recommend the nursing home to others.

MHCC staff collaborated with AHRQ by testing the Short Stay Survey in Maryland. This collaboration benefits AHRQ by providing additional field testing of the instrument; MHCC benefits by piloting an experience survey among nursing home short stay residents; and the

participating nursing homes in Maryland benefit by receiving information from short stay residents about their stay. Maryland Statewide results on the 2012 Short Stay Survey show an overall rating of 7.8 on a scale of 1-10. 81% of short stay respondents reported they would recommend the nursing home. The 2013 Short Stay survey results will be reported in the next annual report.

The Maryland Family Survey consistently yields a response rate of nearly 60%, which is well above the national average. AHRQ expects the Short Stay Survey piloted in Maryland to be adopted by CMS for nationwide use.

Influenza Vaccination Survey among Nursing Home Health Care Workers (HCWs)

The average vaccination rate for nursing home HCWs for the 2012-2013 influenza season was 73.6%, an increase of more than 8% above the prior year. Maryland nursing homes report a significantly higher rate than the national estimates reported by CDC for LTC health care workers, which was 58.9% in 2012-2013.

Division staff continued to encourage and assist nursing homes with their efforts to improve their vaccination rates. These efforts consisted of informational emails sent from September to March to all nursing homes with links to written materials, posters and tools that could be readily downloaded from the Centers for Disease Control (CDC) website. Division staff sent targeted emails to facilities with low vaccination rates offering specific suggestions for increasing rates, and corporate rates were sent to corporate officers. The successful webinar arranged and sponsored by the Commission in 2012 entitled, *“Implementing Effective Strategies to Increase Influenza Vaccination Rates and Reduce Staff Resistance to Vaccination”* is available on the Commission website.

Public reporting of nursing home-specific results has been in place since 2011 as an incentive for facilities to improve their HCW vaccination rates. Additionally, HCW influenza vaccination results for nursing homes are part of the DHMH StateStat dashboard. The StateStat Goal is achievement of a 60% or greater HCW vaccination rate for every nursing home. For the 2012-2013 influenza season, 158 (70%) of Maryland nursing homes achieved the StateStat goal compared to the 2011-2012 influenza season when 60% of nursing homes achieved the goal. The Commission also implemented a recognition program for nursing homes. Recognition certificates are sent to nursing homes that achieve a HCW vaccination rate of 95% or better. The number of nursing homes achieving recognition increased from 19 in the 2011-2012 to 37 for 2012-2013 flu season.

Implementation of a mandatory influenza vaccination policy by nursing homes increased slightly in the 2012-2013 collection year: 22.4% of nursing homes reported implementation of a mandatory employee influenza vaccination policy compared to 19% for the prior year; another 15% reported no current mandatory employee influenza vaccination policy, but plan to implement a policy for the 2013-2014 flu season. Two large nursing home chains in Maryland have yet to adopt a mandatory policy; as a result, 62% of nursing homes report no immediate plans to implement a mandatory employee influenza vaccination policy.

Assisted Living Staff Influenza Vaccination Survey

The average assisted living staff vaccination rate for the 2012-2013 influenza season was 50.6% compared to 48% for the 2011-2012 season. Assisted living staff vaccination rates are compared to the general population rather than health care workers. The general population rate for the US reported by CDC was 56.6%; the corresponding rate for Maryland residents was 51.4%.

Additional Performance Measures

Home Health Experience of Care

Medicare-certified Home Health Agencies (HHAs) in Maryland that serve 60 or more patients in a year participate in the HHCAHPS Survey. HHCAHPS reports three composites: how well staff communicated, to what degree staff gave care in a professional way, and to what degree the home health staff discussed medications, pain and home safety, and reports two overall questions: an overall rating on a scale of 1-10 (10 represents the best rating) and “would you recommend the home health agency”.

The average Maryland rating for home health providers show all composites were rated above 80%. The percent of patients giving the HHA an overall rating of 9 or 10 was 83%; the percent of patients reporting that they would definitely recommend the HHA to friends and family was 78%.

Hospice Quality Reporting

During calendar year 2012, the Centers for Medicare and Medicaid Services (CMS) used rulemaking authority to require data submission for the 2014 payment year of two hospice quality measures: a pain management measure and a structural measure requiring hospice programs to report a Quality Assessment and Performance Improvement (QAPI) program addressing at least three indicators related to patient care.

In 2013 CMS made changes to the proposed hospice quality measures. Division staff will follow developments in this area as this report is likely to result in more definitive hospice quality measures for future reporting periods. Division staff has also researched other potential quality measures as part of the update to the Hospice State Health Plan Chapter for Certificate of Need. In the coming year Long Term Care Quality and Performance staff will collaborate with the Maryland Hospice Network to select and pilot hospice quality measures in Maryland.



Center for Hospital Services

Hospital Services Policy & Planning and Specialized Services Policy and Planning

Overview

In FY 2013, these divisions of the Center for Hospital Services led development of policies and standards contained in those components of the State Health Plan for Facilities and Services (“State Health Plan” or “SHP”) that address facilities and services provided in the acute care general hospital setting and ambulatory surgical facilities.

These two divisions were in transition in FY 2013 and, because of a senior staff retirement, other staff turnover, and delays in recruitment related to state personnel policies, staff employed in these divisions had to work across the traditional lines of Divisional responsibility. Maryland’s Certificate of Need (“CON”) program, policies and standards relating to the need for medical surgical inpatient services, pediatric inpatient services, obstetric inpatient services, and general and non-specialized surgery, both inpatient and outpatient, have historically been the responsibility of the Hospital Services Policy and Planning division. The Specialized Services Policy and Planning division covered specialized cardiovascular services, neonatal intensive care services, organ transplantation, medical rehabilitation, and specialized burn treatment. This division also administers the “Waiver” program regulating the provision of percutaneous coronary intervention (PCI) in hospitals that do not provide cardiac surgery services.

These divisions also traditionally took responsibility for most mandated studies, analyses, or reports addressing hospital-based facilities and services. Division personnel have also provided, on an as-needed basis, direct support to the CON Division in analysis of and preparation of reports and recommendations on proposed acute and ambulatory care facility and service projects seeking CON approval.

Accomplishments

State Health Plan

Surgical Services

Development of a comprehensive revision of COMAR 10.24.11, the Ambulatory Surgical Services Chapter of the SHP, was completed in Fiscal Year 2013, after most of the work for this update was accomplished in FY 2012. The new chapter, now configured as a Plan for “General Surgical Services,” is applicable to CON regulation of surgical facilities and services in both the

hospital and freestanding surgical facility setting, addressing both inpatient and outpatient surgery.¹

A proposed repeal and replacement of the chapter was approved by the Commission in May, 2012. The replacement was adopted as final regulations, with two non-substantive amendments, in October, 2012.

Acute Rehabilitation Hospital Services

Development of a revised replacement SHP Chapter of COMAR 10.24.09 began in FY2011 and continued in FY 2012 and FY 2013. A draft Chapter of COMAR 10.24.09 was posted for informal public comments in February of 2013 and proposed regulations were adopted in July, 2013. It is anticipated that the update of these regulations will be finalized in November, 2013.

Cardiac Surgery and PCI Services

As part of implementing HB 1141, a Clinical Advisory Group (CAG) that included both Maryland and out-of-state physician and other clinical experts in heart disease diagnosis and treatment, was convened in September, 2012 to provide expertise and recommendations on standards for cardiac surgery and PCI services. The CAG met eight times, through April, 2013 and discussed key issues regarding the future regulation of cardiac surgery and PCI services. The CAG issued a final report with recommendations in June, 2013. This work provided a foundation for development of a new SHP chapter addressing these services that began in June of 2013 and is expected to be completed in FY 2014.

As part of this effort, staff of MHCC and the Maryland Institute for Emergency Medical Services and Systems also met in FY 2013 to discuss areas of needed coordination between the new regulatory oversight system under development for cardiac services and MIEMSS' program for designation of hospitals as cardiac intervention centers.

Intermediate Care Facilities for Substance Abuse Treatment

In response to a petition from an Intermediate Care Facility for Substance Abuse Treatment (ICF/SA), MHCC was asked to review docketing rules in the applicable SHP chapter, COMAR 10.24.14, which prevented private ICF/SAs from applying for capital projects without provision of charity care equivalent to at least 15% of revenue. The Commission adopted proposed changes to the Plan in September, 2012 and finalized those amendments in January, 2013. This allowed the ICF/SA to file a CON application for review.

Primary PCI Waiver Renewal

In September, 2012, MHCC adopted proposed amendments to regulations governing the waiver program for provision of primary PCI at hospitals without on-site cardiac surgery. These amendments to COMAR 10.24.05 were technical in nature, bringing the rules in line with 2012

¹ This chapter does not address the specialized surgical services performed on the heart (COMAR 10.24.05) or in organ transplantation surgery (COMAR 10.24.13)

legislation addressing regulatory oversight of PCI services, until such time as new regulations are adopted.

Regulatory Activity

Waiver Program for Primary PCI

Thirteen hospitals have a current waiver from the Commission allowing them to provide primary, or emergency, PCI services without having on-site cardiac surgical backup. In FY 2013, the Commission reviewed and approved renewal of primary PCI waivers for eight of these hospitals. All received the maximum two-year renewals, indicating substantial compliance with minimum requirements for primary PCI provision. The staff work for administering PCI waiver renewal in FY 2013 was primarily performed by staff of the Hospital Services and Specialized Services Divisions.

Waiver Program for Non-Primary PCI

There are eight hospitals in Maryland that do not provide cardiac surgery but began providing non-primary, or elective, PCI services under research waivers, participating in the C-PORT Elective Angioplasty study. These programs were allowed to transition to registry programs pending the outcome of the research, published in the Spring of 2012, and further action by MHCC. 2012 legislation (HB 1141) mandated that MHCC review these eight programs by December 2012, to determine whether they continued to meet waiver and registry standards and, thus, under this law, qualified for an exemption to the new Certificate of Conformance requirements of the law. All were exempted by MHCC under the terms of this law and will only be subject to Certificate of On-going Performance reviews in the future to maintain their authorization.

Reports

Annual Acute General Hospital Bed Licensure and Inventory Survey

Each year, the Commission participates in the annual process of updating the licensed acute care bed capacity for Maryland's acute general hospitals. Acute average daily census for the twelve-month period ending in March of each year is calculated from data collected by the Health Services Cost Review Commission. MHCC then reports the total acute care bed capacity for the upcoming fiscal year, equal to 140% of this average daily census. Each hospital then responds with the service mix designation they wish to assign for this licensed bed total, allocating the beds to up to four defined service categories, so long as they have approval for those services. The categories are medical/surgical/gynecological/ addictions, obstetric, pediatric and acute psychiatric.

In May of each year, licensure application forms with the new bed licensure numbers for the coming fiscal year are sent to all hospitals. Along with the allocation of their licensed capacity, hospitals are asked to provide information to the Commission on changes in the capacity of other hospital inpatient services. This annual survey, performed in conjunction with the licensure update process, collects information on the inventory of emergency department treatment spaces, obstetric and perinatal service facilities, surgical facilities, psychiatric facilities, and special hospital facilities and services. In September, 2012, an interim report

summarizing the new acute care hospital bed licensure information for FY 2013 was published on the Commission's web site. In November, 2012, the full *Annual Report on Selected Maryland Acute Care and Special Hospital Services, FY 2013*, was published on the Commission's website.

Ambulatory Surgery Provider Directory

The fifteenth edition of the Commission's *Maryland Ambulatory Surgery Provider Directory* was posted on the Commission's website in February, 2013. The Directory provides CY 2011 information on freestanding and hospital-based ambulatory surgery providers in Maryland, such as inventory and utilization data, surgical specialties, and contact information. The annual survey used to develop this directory had 346 responses in FY 2013.

The Commission's electronic survey of ambulatory surgery providers (the source of the *Directory's* information) is updated annually with input and feedback, as necessary, from representatives of the Maryland Ambulatory Surgery Association and surgical facilities. This survey information also serves as core data for the Commission's web-based *Maryland Ambulatory Surgical Facility Consumer Guide* and can be accessed through the Commission's web-based Public Use Files.

Policy Coordination with Other Agencies and Stakeholders

Throughout FY 2013, Hospital and Specialized Services division staff participated in selected meetings of the following agencies, or groups convened by these agencies to assure appropriate coordination and collaboration on policy and regulatory matters: the Health Services Cost Review Commission, the Office of Health Care Quality of the Department of Health and Mental Hygiene, the Maryland Institute for Emergency Medical Services and Systems, the Maryland Department of Planning, and other units of DHMH. In FY 2013, this included serving on the Maryland Perinatal Advisory Committee, as it worked to review changes in the State's Perinatal Systems Standards in light of a 2012 update of the American Academy of Pediatrics *Guidelines on Perinatal Care*.

Hospital Quality Initiatives

Overview

Chapter 657 (HB 705) of the Acts of 1999 required the Commission to develop a performance evaluation system for hospitals to improve the quality of care and to promote informed decision making among consumers, providers, policymakers, and other interested parties. In fulfillment of this legislative requirement, the Commission released its initial version of the web-based Hospital Performance Evaluation Guide (Guide) on January 31, 2002.

The Guide, which may be accessed on the Commission's website at <http://mhcc.maryland.gov/consumerinfo/hospitalguide/index.htm>, enables Marylanders to review information on various hospital facility characteristics and performance measures. Hospital characteristics include the location of the hospital, number of beds, services provided and accreditation status. Fifty high volume common medical conditions (All Patient Refined Diagnosis-Related Groups or APR-DRGs) are also featured. Marylanders are able to compare the

volume and average length-of-stay by APR-DRG for each hospital. The Guide continues to provide general information, including patients' rights, how hospitals are regulated in Maryland, guidance on what to expect in a hospital setting, and a checklist to help consumers select a hospital. The Guide also includes performance data on twenty-nine process of care measures endorsed by the National Quality Forum (NQF), and adopted by the Centers for Medicare and Medicaid Services (CMS), the Joint Commission, (TJC) and the Hospital Quality Alliance (HQA). These nationally endorsed process measures address hospital compliance with evidence-based standards for the treatment of Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN), Childhood Asthma Care (CAC), surgical patients (SCIP) including the prevention of surgical site infections, Emergency Department throughput, and Patient Immunization.

Patients' perspectives on the care provided by hospitals are an important and valuable indicator of hospital quality and performance. The Commission utilizes the results of a national, standardized survey of hospital patients to obtain and report on measures of hospital performance. The data from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) includes 10 measures for four hospital service categories (maternity services, medical services, surgical services, and all services combined) reflecting key topics, including: communications with doctors and nurses, responsiveness of hospital staff, pain management, communication about medicine, discharge information, cleanliness of the hospital environment, and quietness of the hospital environment. In addition, the Guide includes data on how patients rate the hospital (10 for best, 0 for worst) and whether patients would recommend the hospital to friends and family.

The Guide also includes information on healthcare associated infections (HAIs) in Maryland hospitals. HAIs are infections that patients acquire during the course of receiving medical treatment for other conditions and represent the most common complication affecting hospitalized patients.

Accomplishments

MHCC's quality and performance data collection for Maryland hospitals continues to evolve. In FY 2013, the MHCC and the HSCRC issued a joint policy directive that significantly expands the quality measures data that Maryland hospitals will be required to collect and report. As part of Maryland's exemption from the Centers for Medicare and Medicaid Services (CMS) Value-Based Purchasing Program (VBP) for hospital reimbursement, Maryland must maintain a comparable hospital quality program that meets or exceeds the CMS program in cost and quality outcomes standards. In response to this CMS directive, MHCC intends to expand its hospital quality measures data collection requirements to comply with CMS Inpatient Quality Reporting (IQR), Hospital Outpatient Quality Reporting (OQR) and VBP data collection requirements. The expanded quality data collection requirements are being phased in to ensure full implementation for Maryland hospitals by January 1, 2014. A statewide webinar was held in March 2013 for hospital CFOs, Quality Improvement Staff, Infection Preventionists, and other hospital personnel as part of an ongoing communication strategy to promote compliance with the new data policy.

The HQI staff also focused on two HAI initiatives in FY 2013 that were associated with significant improvement in the performance of hospitals. Central-line associated bloodstream infections in ICUs decreased by over 50% during the three years since the information was first publicly reported on the Hospital Guide. The MHCC worked in collaboration with hospitals, the Maryland Hospital Association (MHA), and a committee of experts in infection prevention and control, to facilitate implementation of evidence based patient safety activities designed to reduce hospital infections. Similarly, public reporting of hospital employee influenza vaccination rates was a major focus in FY 2013. For the past five years, MHCC has conducted an annual survey of hospitals to gather information on employee vaccination rates and hospital policies and practices designed to promote employee flu vaccination. Hospital worker flu vaccination rates have been published in the Hospital Guide for the past four years. Since the release of this information on the Hospital Guide in 2010, Maryland hospitals have achieved an 18% increase in their employee influenza vaccination rates from 78% to 96%. The hospital flu vaccination rate for the 2012-2013 flu season was 96% as compared to 80% during the previous flu season. Information on hospitals with mandatory employee vaccination policies was first added to the Guide in 2012. In FY 2013, the number of hospitals that reported mandatory employee vaccination policies increased to 38 from 25 hospitals the previous year. Again, the HQI staff worked with the Maryland Hospital Association to encourage implementation of mandatory policies.

Hospital Performance Evaluation Guide (HPEG) Advisory Committee

As part of the enabling legislation, MHCC was tasked to work on the design and development of a performance evaluation system in consultation with the Maryland Hospital Association (MHA), the Maryland Ambulatory Surgical Association, and interested parties, including consumers, payers, and employers. The Hospital Performance Evaluation Guide (HPEG) Advisory Committee meets on a quarterly basis and has provided expert advice to the Commission on performance measures and quality improvement strategies since the inception of the Guide. This multi-disciplinary committee includes members representing health care consumers, hospitals, nursing, medical research, and organizations involved in quality and patient safety initiatives.

The Maryland Quality Measures Data Center (QMDC)

The Commission relies heavily on data from a variety of sources to support the HPEG. In FY 2009, the MHCC initiated a consolidated data management strategy which entailed the establishment of a Quality Measures Data Center (QMDC). The QMDC functions as Maryland's repository of hospital performance measures data and includes a secure web portal for hospital submission of quality measures and patient experience data. The QMDC also functions as a centralized communication tool for sharing information with hospitals on upcoming reporting requirements as well as providing a vehicle for review of facility performance data prior to public release. The Commission utilizes the data collected through the QMDC for timely reporting of clinical quality and patient experience measures on the web-based Maryland Hospital Performance Evaluation Guide on a quarterly basis. In FY 2013, the clinical data submitted through the Maryland QMDC was audited to ensure the integrity of the measures used to evaluate hospital performance. Quarterly on-site reviews of hospital medical records

were conducted. The data validation process is intended to enhance the MHCC's understanding of the overall quality of the data as well as to identify areas for targeted performance improvement and educational activities.

Healthcare-Associated Infections Data Collection

Background

In response to the significant impact that Healthcare-Associated Infections (HAIs) have had on both patients and the health care system, mandatory public reporting of HAIs has become a priority for states and the federal government. In the State of Maryland, Senate Bill 135, Hospitals-Comparable Evaluation System-Health Care-Associated Infection Information, became law on July 1, 2006 as Chapter 42 of Maryland law. This law required that the Hospital Performance Evaluation Guide be expanded to include healthcare-associated infection information from hospitals.

To assist in developing a plan for expanding the HAI data on the Hospital Performance Evaluation Guide, the Commission appointed an HAI Technical Advisory Committee (TAC). The purpose of the TAC was to study and develop recommendations to the Commission on the design and content of a system for collecting and publicly reporting HAI data. The Final Report and Recommendations of the HAI Technical Advisory Committee was approved by the Commission in December 2007 and staff was directed by the Commission to proceed with implementation of the recommendations. A copy of the report is available on the Commission's website at

http://mhcc.dhmh.maryland.gov/hai/Pages/healthcare_associated_infections/default.aspx.

Healthcare Associated Infections (HAI) Advisory Committee

The HAI Technical Advisory Committee (TAC) recognized that the implementation and sustainability of the Committee's recommendations would require ongoing involvement of individuals with expertise in infection prevention and control. To facilitate implementation of the recommendations, a permanent HAI Advisory Committee was established to provide ongoing guidance and support to this project. The HAI Advisory Committee meets monthly to review data reporting requirements and other HAI initiatives. As a result, the Commission has made significant progress towards the implementation of the original TAC recommendations. Seven of the eight TAC recommendations for publicly reporting HAI data have been achieved. The 2008 Report and Recommendations for Developing a System for Collecting and Publicly Reporting Data on HAI in Maryland is available on the Commission's website at

http://mhcc.dhmh.maryland.gov/hai/Pages/healthcare_associated_infections/default.aspx

HAI Data Public Reporting

With the focus shifting to align with CMS reporting requirements, several new reporting requirements will be occurring in FY 2014. The National Healthcare Safety Network (NHSN) continues to be the vehicle for collecting these data. The NHSN is an internet-based surveillance system that integrates patient and healthcare personnel safety surveillance systems. It is managed by the Division of Healthcare Quality Promotion of the Centers for Disease Control and Prevention (CDC).

The current reporting requirements are: (1) Central-Line-Associated Bloodstream Infections (CLABSIs) in All Intensive Care Units; (2) Surgical Site Infections (SSIs) for coronary artery bypass graft (CABG), hip (HPRO), and knee (KPRO) surgeries, and (3) Health Care Worker (HCW) Influenza Vaccination. The upcoming expanded reporting requirements for FY 2014 are: (1) *Clostridium difficile* infections (CDI) in all inpatient locations (baby locations are excluded) (effective July 1, 2013), (2) Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia in all inpatient locations (effective January 1, 2014), and (3) the expansion of Surgical Site Infections (SSIs) to include colon (COLO) and abdominal hysterectomy (HYST) surgeries. Of note, the Health Care Worker (HCW) Influenza Vaccination reporting requirement will move from using an in-house survey to the NHSN Health Care Personnel (HCP) Influenza Vaccination module with the 2013/2014 flu season.

In October 2010, the Commission first reported on CLABSIs for the 12-month period from July 1, 2009 through June 30, 2010. During that data period, Maryland acute care hospitals reported 424 CLABSIs in adult ICUs and 48 CLABSIs in Neonatal ICUs (NICUs). In April 2013, the CLABSI data was updated with calendar year 2012 data. The updated data showed a 52% reduction in CLABSIs in Maryland adult/pediatric ICUs, with 155 CLABSIs. Maryland NICUs saw a 24% reduction in CLABSIs with 31 CLABSIs reported for calendar year 2012. Based on a performance measure (the Standardized Infection Ratio or SIR) developed by the CDC, Maryland hospitals in total performed better than the national experience for CLABSIs in ICUs, meaning there were less CLABSIs reported than expected.

The surgical site infections data for Hip, Knee, and CABG procedures was publicly released on the Guide in October 2012. An update to the Guide is scheduled for January 1, 2014.

HAI Data Validation Project

In 2009, the Commission initiated a procurement project to engage the services of a contractor with expertise and experience in the review of healthcare-associated infections data. The project included the on-site review of patient medical records to assess the accuracy of the hospital data submitted through NSHN. The validation project was completed in FY 2010 and the results were used to educate hospital data providers and to facilitate process improvement activities. The final report is available online at

http://mhcc.dhmdh.maryland.gov/hai/Documents/sp.mhcc.maryland.gov/healthcare_associated_infections/hai/clabsi_final_rpt_20100618.pdf.

In FY 2011, the Commission initiated the procurement process to establish a five year contract for ongoing validation of the accuracy of all healthcare associated infections data collected for public reporting on the Hospital Guide. The contract includes the provision of educational webinars and training for hospital infection prevention staff to facilitate accurate and complete data reporting. In FY 2012, an on-site chart review was conducted on CLABSI data. The results were reported to individual hospitals and a statewide educational webinar was conducted in April 2013 to promote data quality. The first on-site chart review of the surgical site infections data is under development.

Certificate of Need (CON) Program

Overview

The Certificate of Need (CON) Program implements the Commission's statutory authority, under the Annotated Code of Maryland, Health-General Article §§ 19-103 and 19-120 through 19-127, to review and approve certain new or expanded health care facilities and services. In its administration of this program, the Commission uses the policies and standards it develops and adopts as regulation in the State Health Plan for Facilities and Services. The procedural regulations that guide CON reviews, at COMAR 10.24.01, establish administrative rules and procedures under which all reviews are conducted, and all decisions are brought to the Commission for action.

The Commission may approve, approve with conditions, or deny applications by health care providers to: (1) establish new facilities or services; (2) relocate facilities; (3) modify existing facilities or previously approved projects; (4) incur capital expenditures for projects that exceed a set dollar threshold, or: (5) close certain facilities or services. In administering the program, the Commission also issues determinations of coverage, providing guidance on the regulatory requirements for health care facility capital projects and validating compliance of persons undertaking health care facility projects that, while not requiring a CON, may be required by law to provide certain information to the Commission in a prescribed form.

All projects requesting CON approval are evaluated for consistency with review standards and need projections in the State Health Plan for Facilities and Services, and are also evaluated against five additional criteria. These are need, viability, impact, the cost and effectiveness of alternatives to the proposed project, and the applicant's track record in complying with conditions and terms of CON approvals placed on project approvals previously issued to the applicant.

Accomplishments

Certificate of Need Applications and Modifications

During FY 2013, the Commission approved ten (10) CON applications. No applications were denied. It also reviewed and approved five (5) modifications to previously approved projects. One issued CON was relinquished by the holders; and one issued CON was voided by the Commission for failure to comply with performance requirements.

The level of project review activity in FY 2013 was very similar, in terms of volume, to that in the previous year, which saw thirteen new project reviews and one review of a change in an approved project. In general, the number of regulated institutional health care facility capital projects proposed by health care facilities regulated under the CON program has declined in the last four years compared to the previous four year period, which saw a heightened level of activity for major hospital projects. On average, less than five hospital project reviews per year were completed during the last five years, FY 2009 through FY 2013. An average of 18 total new project reviews were completed during this same recent period.

Approved CONs

1. **ManorCare Health Care Services, LLC (Prince George's County)**
Establish a 110-bed comprehensive care facility (nursing home) in Bowie.
Approved with a condition - \$16,042,836
2. **Cosmetic Surgical Center of Maryland d/b/a Bellona Surgery Center (Baltimore County)**
Add a single operating room
Approved with a condition - \$104,500
3. **Massachusetts Avenue Surgery Center, LLC (Montgomery County)**
Add a single operating room
Approved - \$710,682
4. **Hospice of Queen Anne's, Inc. (Queen Anne's County)**
Add six beds for general inpatient hospice services
Approved - \$11,400
5. **525 Glenburn Avenue Operations, LLC d/b/a Chesapeake Woods Center (Dorchester County)**
Add 32 beds to an existing comprehensive care facility
Approved with a condition - \$3,492,000
6. **Hospice of the Chesapeake, Inc. (Anne Arundel County)**
Add 14 beds for general inpatient hospice services
Approved - \$5,232,072.
7. **Mercy Medical Center, Inc. (Baltimore City)**
Add four operating rooms and relocate four operating rooms
Approved with a condition - \$23,599,859
8. **700 Toll House Avenue Operations LLC d/b/a College View Center (Frederick County)**
Relocate a comprehensive care facility within Frederick. The replacement facility will have 130 beds
Approved with a condition - \$19,215,000
9. **Anne Arundel Medical Center (Anne Arundel County)**
Add 30 general medical/surgical beds
Approved - \$8,207,342
10. **Garrett County Memorial Hospital (Garrett County)**
Construct a four-story addition to the hospital creating more private patient rooms and modernizing and expanding various departments of the hospital
Approved with a condition - \$23,539,350

Changes in Approved CONs

1. NMS of Hagerstown, LLC (Washington County)

Design changes and an increase in the cost of an approved comprehensive care facility expansion and renovation project.

Approved with a condition - \$11,121,461 (increase of \$1,608,228)

2. Carroll Hospital Center (Carroll County)

Design changes and an increase in the cost of an approved expansion and renovation project.

Approved with conditions - \$30,975,000 (increase of \$3,000,000)

3. St. Agnes Hospital (Baltimore City)

Change in a condition placed on an approved expansion and renovation project. The condition addressed the renovation of existing nursing units and the physical bed capacity resulting from the project. The hospital is revising its renovation plan, necessitating a change in the condition.

Approved with conditions - \$175,935,754 (no change in approved project cost)

4. Magnolia Gardens, LLC (Prince George's County)

Change in financing mechanism and change in ownership of an approved relocation of a comprehensive care facility

Approved with a condition - \$20,326,389 (decrease of \$417,122)

5. Mid-Atlantic Waldorf, LLC (Charles County)

Design changes and an increase in the cost of the approved establishment of a comprehensive care facility

Approved with conditions - \$11,897,178 (increase of \$2,034,331)

Determinations of Coverage and Other Actions

In FY 2013, the Commission issued 133 determinations involving actions proposed by persons or health care facilities requiring a decision with respect to the need for CON review or other Commission authorization. These actions were made in accordance with statutory and regulatory provisions outlining: (1) the scope of CON coverage; (2) the types of projects or actions that, while similar in their general nature to projects that require CON review and approval, can be implemented outside of the CON regulatory process; and (3) the notification requirements and attestations which must be met to obtain the Commission's determination that CON is not required. These determinations are profiled in the following table. Chief among these types of determinations are those involving establishment of outpatient surgical centers with fewer than two sterile operating rooms, acquisitions of health care facilities, temporary delicensure of beds (for up to one year), and small increases in the bed capacity of facilities ("waiver" beds), primarily nursing homes, which are allowed increases of 10% of bed capacity or ten beds, whichever is less, every two years so long as the facility maintains operation of all of its bed capacity without changes during that period of time.

Determinations of Coverage and Other Actions – FY 2013

NATURE OF DETERMINATION/ACTION	
Capital projects with costs below the threshold of reviewability	12
Acquisition of health care facilities	
Comprehensive-care facilities (nursing home): 11	
Ambulatory surgery centers: 4	
Home health agencies: 4	
Hospitals: 2	21
Establishment of new ambulatory surgery centers (no more than one sterile operating room)	
Montgomery (7), Baltimore County (4), Anne Arundel (3), Baltimore City (1), Frederick (1), Harford (1), Howard (1), Prince George's (1), and Wicomico (1)	20
Changes in ambulatory surgery center facilities or operation (e.g., addition of non-sterile procedure rooms, surgical staff, surgical specialties, ownership structure)	18
Relocation of ambulatory surgery centers	6
Voidance of determination of coverage to establish a new ambulatory surgery center	5
Temporary delicensure of CCF beds (355 total beds)	
Relicensure of temporarily delicensed CCF beds (236 total beds)	16
Temporary delicensure of a health care facility (ambulatory surgical facility)	
Temporary delicensure of a health care facility (ambulatory surgical facility)	1
Add "waiver" beds*	
Comprehensive care facilities-3 (27 total beds)	
Acute rehabilitation hospitals-2 (14 total beds)	5
"Exceptional" CCF beds for continuing care retirement communities (19 total beds)**	
"Exceptional" CCF beds for continuing care retirement communities (19 total beds)**	1
Miscellaneous	
Miscellaneous	13
TOTAL COVERAGE DETERMINATIONS	133
Pre-licensure and/or first use approval for completed CON projects (including partial)	
Pre-licensure and/or first use approval for completed CON projects (including partial)	4
Permanent delicensure of beds	
Comprehensive care facilities: for a total of 60 beds	6
Closure of facility (ambulatory surgery center)	1
Closure of a service (hospital inpatient obstetric/perinatal service)	1

*Facilities other than hospitals may add beds in limited increments over time, without obtaining a CON approval, subject to conditions outlined in regulation

**Continuing care retirement communities can be authorized to develop limited numbers of CCF beds without obtaining CON approval. Admission of patients to such beds who are not residents of the CCRC is restricted.

Additionally, the Commission reviewed 4 requests by holders of CONs to implement their projects or parts of their approved projects ("first use review"). The Commission acknowledged six cases in which facilities with temporarily delicensed beds did not take timely action to bring these beds back into operation or to extend temporary delicensure status, thus eliminating these beds from the state's inventory. In FY 2013, all these permanently delicensed beds (60)

were CCF beds. One health care facility, an ambulatory surgical facility, closed in FY 2013 and one regulated hospital service (obstetrics) was closed in this fiscal year.



The Center for Health Information Technology and Innovative Care Delivery

Overview

The Commission's Center for Health Information Technology (Center) is responsible for enhancing the adoption of health information technology (health IT) in the State. The use of health IT enables digital access to clinical information at the point of care, with the goal of improving the quality of health care delivery and reducing health system costs. Key aspects of health IT include electronic health records (EHRs), health information exchange (HIE), and telemedicine. The Center's initiatives focus on balancing the need for information sharing with the need for strong privacy and security policies. The Center has an ambitious plan for advancing health IT that includes:

- Identifying and addressing challenges around health IT implementation and interoperability;
- Promoting standards-based health IT through educational and outreach activities;
- Implementing a statewide HIE and harmonizing local area HIE efforts;
- Designating management service organizations (MSOs) to promote health IT diffusion and optimization;
- Implementing an innovative pilot program for a patient centered medical home model in Maryland; and
- Promoting electronic data interchange between payors and providers, and certifying electronic health networks that accept electronic health care transactions originating in the State.

Health Information Technology Division

The Health Information Technology Division (Health IT Division) works to expand health IT adoption, implementation and optimization in Maryland, working in collaboration with stakeholders. The Health IT Division leads the Center's telemedicine initiatives, oversees the implementation of electronic preauthorization, and manages the Center's long term care activities. Additionally, the Health IT Division is responsible for designating MSOs, monitoring electronic data interchange (EDI), and assessing the implementation of the State-Designated HIE. The Health IT Division works with hospitals and regional HIEs to develop strategies to advance community based HIE. The Health IT Division implements programs for EHR diffusion.

Health Information Exchange Division

The Health Information Exchange Division (HIE Division) is tasked with facilitating the development of an interoperable system for the sharing of electronic health information and is responsible for advancing the State-Designated HIE: the Chesapeake Regional Information

System for our Patients (CRISP). In collaboration with stakeholders, the HIE Division works to develop privacy and security policies for protecting electronic health information and ensuring it is accessible to authorized individuals for permitted uses. The HIE Division facilitates the collection and exchange of health information for quality improvement and public health purposes and certifying electronic health networks (EHNs). The HIE Division oversees the implementation of the State-Regulated Payor EHR adoption incentive program.

Accomplishments

Electronic Data Interchange & Electronic Health Networks

State-regulated payors (payors) who report an annual premium volume of \$1 million or more and select specialty payors are required under COMAR 10.25.09, *Requirements for Payors to Designate Electronic Health Networks*, to report to MHCC their electronic health care claim transaction volumes each year. The health care industry has used electronic data interchange for more than 30 years as a way to exchange medical, billing and other administrative information. Approximately 56 payors completed the progress report this year. Data from these reports are used to develop an annual EDI information brief, which provides an overview of government and private payor EDI activities.

COMAR 10.25.07, *Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouses*, requires EHNs operating in Maryland to be certified by MHCC. To achieve certification, EHNs must provide evidence that they achieve national accreditation and meet standards related to privacy and confidentiality, business practices, physical and human resources, technical performance, and security. Certification is valid for a two-year period from the date MHCC grants the certification. As of June 30, 2013, MHCC has maintained certification of approximately 40 networks operating in Maryland.

EHR Product Portfolio

The EHR Product Portfolio (portfolio) has been revised semiannually in the fall and spring since its first release in 2008. The portfolio serves as a free online resource for health care providers to compare and evaluate EHR products. Vendor participation in the portfolio is voluntary. All vendors included in the portfolio must be nationally certified and offer discounts to Maryland providers. The portfolio includes information on product functionality and pricing, privacy and security policies, and user references. This year, vendors that were at various stages of connecting to the State-Designated HIE were featured. About 32 EHR vendors participated in the fall 2012 update, with an additional eight vendors added in the spring of 2013.

Hospital Health IT Survey

The fifth annual *Health Information Technology Assessment of Maryland Hospitals* (assessment) was conducted to identify health IT adoption trends among all 46 acute care hospitals in the State. The assessment measured adoption and use of the following health information technologies: EHRs, electronic prescribing, computerized physician order entry, clinical decision support, electronic medication administration records, barcode medication administration, infection surveillance software, statewide HIE, and telemedicine. This year's assessment included new questions related to patient portal adoption, participation in the Centers for

Medicare and Medicaid Services EHR Adoption Incentive Program and achievement of meaningful use requirements. Overall, since the survey's inception in 2008, adoption of health IT among Maryland hospitals has increased roughly 25 percent. Generally, health IT adoption among Maryland hospitals continues to exceed national adoption rates; Maryland hospitals exceeded national adoption rates in eight out of ten categories where national comparisons were available. About 89 percent of Maryland hospitals have adopted an EHR.

Management Service Organizations

MSOs are responsible for assisting providers with EHR adoption, implementation, and optimized use. There are a variety of business models of MSOs, such as small businesses, hospital systems, and EHR vendors. MSOs offer centralized administrative and technology services, as well as technical assistance, guidance, and education to support providers as they adopt an EHR. MSOs also provide services for managing the privacy and security of electronic health information among ambulatory practices. Maryland law, Md. Code Ann., Health-Gen. § 19-143 (2009), requires MHCC to designate one or more MSOs that provide hosted EHR solutions. COMAR 10.25.15, *Management Services Organizations—State Designation*, details the requirements for an MSO to obtain voluntary State-Designation. MSOs must meet an initial set of requirements to first receive Candidacy Status; they then have one year to achieve national accreditation through the Electronic Healthcare Network Accreditation Commission (EHNAC) and subsequent State-Designation. To receive national accreditation, MSOs must meet over 94 criteria related to privacy, technical performance, business practices, security, and operations. There are about 15 State-Designated MSOs and three MSOs in Candidacy Status.

During the year, MHCC worked with the MSO Advisory Panel (panel) and EHNAC to identify core criteria for State-Designation. The panel also introduced a criterion to ensure that MSOs are accountable for all services provided, including those provided by a third party. MHCC also conducted an environmental scan to assess the progress MSOs have made in assisting practices with health IT adoption and implementation. Almost all State-designated MSOs participated in the scan; findings indicated these MSOs have provided services to roughly 579 physician practices, and clients reported they were generally extremely satisfied with the MSO services.

State-Regulated Payor Electronic Health Record Incentives

Maryland law, Md. Code Ann., Health-Gen. § 19-143 (2009), aims to expand the adoption of health IT by requiring State-regulated payors (payors) to offer incentives to providers who use certified EHR technology. In November 2012, the State incentive program workgroup (workgroup) was reconvened, as required by law, to study the State incentive program and provide recommendations on whether eligibility for participation should be extended to other specialties beyond primary care physician practices. A report to the Senate Finance Committee and the House Health and Government Operations Committee in January 2013 concluded that additional time was needed to adequately evaluate the impact of the State incentive program and propose enhancements.

In April 2013, leadership from the Maryland House Health & Government Operations Committee requested that MHCC, in coordination with stakeholders, evaluate the State incentive program to determine if changes are necessary to ensure that the intent of the law is met. As of April 2013, approximately four percent of Maryland's eligible primary care physician practices had received payments under the State incentive program. In collaboration with the workgroup, the following State incentive program recommended enhancements were identified: 1) align the State incentive program requirements with the Centers for Medicare & Medicaid Services EHR Incentive program; 2) simplify the administration of the State incentive program application and payment process; 3) clarify the definition of a primary care physician practice eligible for an incentive payment; 4) extend the sunset date by two years to December 31, 2016; and 5) assess the impact of the State incentive program in 2015.

Electronic Health Records – Meaningful Use Acceleration

Eligible providers (EPs) can earn up to \$44K from Medicare or \$63K from Medicaid for the adoption and meaningful use of EHRs through the Centers for Medicare and Medicaid Services EHR incentive program (federal incentive program). As of June 2013, approximately 37 percent of Maryland EPs had achieved meaningful use and received a federal incentive payment. In the spring of 2013, the MHCC collaborated with stakeholders to assess the challenges of EP participation in the incentive programs to develop strategies aimed at accelerating the achievement of meaningful use. Over the next 18 months, MHCC will collaborate with various stakeholders to implement the following strategies to help EPs achieve meaningful use: 1) conduct semiannual meaningful use registration and attestation webinars, 2) engage hospitals in meaningful use outreach and educational activities with community providers, 3) develop a web-based meaningful use resource center to include general meaningful use information and Maryland Medicaid state-specific information, and 4) establish an incentive program single-point-of-contact to triage and address meaningful use inquiries via telephone.

Telemedicine

MHCC reconvened the Telemedicine Technology Solutions and Standards Advisory Group (advisory group) to draft a telemedicine technology-based implementation resource guide (guide). The advisory group collaborated to identify a range of best practices for telemedicine as they relate to infrastructure, clinical devices, video conferencing units, communication hardware, and data exchange standards, which are critical to ensuring that telemedicine networks across the state can easily communicate with each other. Telemedicine networks in Maryland are fairly disparate and not readily capable of interoperating with other networks. Connecting telemedicine networks will increase provider availability to consult on care delivery and better enable the availability of medical services in remote areas of the State. The draft guide will continue to be updated as the advisory group meets through 2014.

Staff conducted a telemedicine environmental scan to assess the Maryland telemedicine landscape to inform the Telemedicine Task Force (task force). The last meetings of the task force were held in 2011, and the telemedicine landscape has since changed as telemedicine adoption has increased. The scan included a literature review of the financial impacts of

telemedicine, an overview of telemedicine initiatives among office-based physicians as well as acute care hospitals, and a review of the current telemedicine technology marketplace.

Health Information Exchange

MHCC continues to work with the State-Designated HIE. In 2009 as required by law, MHCC and the Health Services Cost Review Commission (HSCRC) designated CRISP to build and maintain the technical infrastructure to support establishment of the statewide exchange of electronic health information. Initial funding for the State-Designated HIE is from the HSCRC through the all payor rate setting system and from the Office of the National Coordinator for Health Information Technology. The State-Designated HIE facilitates the secure exchange of health information among Maryland's health care organizations, providers, and public health agencies in accordance with industry recognized best practice standards. Each year, a financial audit and a security audit of the State-Designated HIE are conducted by a competitively selected third party. The financial audit is conducted in accordance with auditing standards generally accepted in the U.S. The security audit aims to determine the risks to patient data that is processed, transmitted and stored by CRISP, and to evaluate the potential for unauthorized disclosure or breach.

CRISP has made continuous progress toward the goal of building a robust statewide HIE. All 46 acute care hospitals in Maryland submit encounter data to CRISP regarding hospital admissions, discharges, and transfers (ADTs). Roughly 40 hospitals also submit laboratory results, radiology reports, and clinical documents to CRISP. Information made available to the State-Designated HIE is accessible for query through an Internet-based portal. As of June 2013, there were about 136 health care organizations using the portal and the average number of portal queries in 2013 was roughly 13,000 per month. The State-Designated HIE also offers real-time notification alerts to providers when one of their patients has an encounter at a Maryland hospital. As of June 2013, there are about 38 organizations receiving these alerts, which are generally used to coordinate care and facilitate post acute care follow up. The State-Designated HIE also reports hospital readmissions, which contain patient intra-hospital and inter-hospital readmissions for roughly 32 hospitals. These reports are generally used to inform population health initiatives aimed at reducing readmissions.

Regional Hospital Meetings

The MHCC convened the four regional meetings with hospital Chief Information Officers (CIOs) and Chief Medical Informatics Officers (CMIOs). The purpose of the regional meetings was to discuss the technical challenges of expanding hospital clinical data submission to the State-Designated HIE through patient ADT data. During the meetings, the potential for expanding hospital encounter data submitted to CRISP and the timeline and technical challenges of implementation were discussed. All 46 acute care hospitals currently send ADT data to CRISP, but most do not include clinical information, such as chief complaint, discharge diagnosis, or death indicator. This additional clinical information would be useful to include in alerts that are sent to ambulatory practices for care coordination enhancements.

MHCC staff conducted technology site visits at community-based hospitals around the State that operate local HIEs. Staff met with hospital CIOs to discuss health IT adoption strategies

and activities around developing local HIE platforms to enable ambulatory providers in their service area to exchange clinical information. Technical standards and data integration activities with the hospital's EHR system and ambulatory practices were discussed. The site visits were aimed at harmonizing HIE efforts among community-based hospitals to ensure interoperability with the State-Designated HIE.

Challenge Grant

In 2011, MHCC received approximately \$1.6M from ONC through the Challenge Grant Program, which requires the development of innovative and scalable solutions. The Maryland Challenge Grant aims to enable long term and post acute care facilities to exchange clinical documents with hospitals by establishing direct interfaces to the statewide HIE. Mid-way through the grant, the implementations were found to be highly complex and resource-intensive, and the planned approach to interface development was not scalable. As such, the demonstration concluded with approximately \$600K in grant funds remaining. In February 2013, MHCC received approval from ONC to use the remaining funds to competitively award independent long term care (LTC) facilities with grants to improve transitions of care between the facilities and hospitals. Three LTC facilities were awarded a total of approximately \$440K. The LTC facilities are working with MSOs to implement health information technologies and use CRISP's services in an effort to reduce hospital readmissions.

Broad use of EHRs and health information exchange can lead to innovative ways to coordinate and manage the needs of LTC residents. MHCC conducted an environmental scan among 24 independent LTC facilities across five regions of the State: Baltimore City, Central, Eastern, Southern, and Western Maryland. The scan assessed the status of EHR adoption among the facilities as well as implementation challenges. About 58 percent of LTC facilities surveyed had adopted an EHR, an increase of about 33 percent since 2009. This is the third year the scan was conducted; it was previously administered in 2009 and 2010. The findings are used to develop strategies to advance EHR diffusion and in building awareness of how electronic HIE can benefit LTC facilities in the State.

HIE Policy Board

Maryland law requires MHCC to adopt regulations for the privacy and security of protected health information obtained or released through an HIE. The MHCC convened the HIE Policy Board (Board), a staff advisory group, to develop recommendations of policies for the private and secure exchange of health information through HIEs. Staff considers the Board recommendations in drafting the regulations. MHCC developed informal draft regulations, which were released for informal public comment in February 2012. Comments were received from over 33 organizations and individuals; the comments were used by MHCC staff to modify the first draft. The modifications aimed to ensure that the requirements were not overly burdensome to implement, were financially responsible, and maintained the privacy and security of health information electronically exchanged among providers. In March 2013, second informal draft HIE regulations were released; staff received 17 comments during the informal comment period.

Regional Extension Center Program

In 2010, CRISP received approximately \$6.8M from ONC to implement Maryland's Regional Extension Center (REC). The REC partners with State-Designated MSOs to provide direct assistance to primary care physicians in selecting, successfully implementing and meaningfully using EHRs. The REC is tasked with enrolling at least 1,000 primary care providers into the program and achieving performance milestones regarding EHR adoption and meaningful use. As of June 2013, the REC enrolled about 1,884 physicians, and approximately 608 had achieved meaningful use.

Consumer Engagement in Health IT

New technologies, legislative changes, rising costs and growing consumer expectations mean that the health care industry needs to think differently about how to build relationships with consumers. The adoption and use of health IT by consumers may empower patients to manage their health status and health care services by increasing their access to their health information. Placing the consumer at the center of health care delivery has the potential to improve the overall well-being of individuals. National consumer health IT awareness and education efforts have been slow to materialize. Maryland, and many other states are now beginning to explore opportunities to educate the public on health IT. In September 2012, MHCC released *Health Information Technology: Consumer Awareness & Education Brief* (brief). To develop the brief, the MHCC convened several consumer focus groups in the fall of 2011 to assess consumer awareness of electronic health information, trust in the electronic exchange of their information, and challenges related to consumer access and control of health information. The focus groups provided an opportunity to engage consumers, providers, and community-based organizations in identifying an approach to build consumer confidence in electronic health information. Consistent themes that emerged from the focus group discussions included: consumers prefer to control who has access to their electronic health information; CBOs are concerned about the risk of electronic health information being lost or stolen; and concern regarding the lack of health IT awareness and education activities in the state. The focus group discussions provided the framework to formulate a strategy to advance consumer awareness and trust of electronic health information in Maryland.

Preauthorization

The submission of preauthorization requests has typically been manually, requiring the use of fax, phone, or mail. Automating the preauthorization process for the submission of medical and pharmaceutical service (health care services) preauthorization requests is intended to streamline the request and approval process and minimize administrative burdens on providers. In 2012, Maryland law (Md. Code Ann., Health-Gen. 19-108.2) required the MHCC to work with payors and pharmacy benefit managers (PBMs) to execute a phased-implementation approach to standardize and automate the preauthorization process. Phase 1 required payors and PBMs to provide online the list of health care services that need a preauthorization and the key criteria for making a determination by October 1, 2012. Phase 2 required payors and PBMs to accept preauthorization requests electronically and assign a unique identification number to each request by March 1, 2013. Phase 3 established time frames for approval and notification of electronic preauthorization requests that needed to be in place by July 1, 2013.

MHCC is required to report to the Governor and General Assembly annually through 2016 on the progress made payors and PBMs in implementing electronic preauthorization. This year, payors and PBMs reported to MHCC on their attainment of the phases, and MHCC audited implementation of their electronic preauthorization systems. In March 2013, MHCC submitted to the Governor and General Assembly a legislative report detailing payor and PBM progress in establishing online preauthorization systems. All payors and PBMs are in compliance with the law.

Maryland Multi-Payer Patient Centered Medical Home Program

Overview

The Patient Protection and Affordable Care Act (PPACA) aims to reform the health care system. One of the means to institute reform outlined in the PPACA is the establishment of patient centered medical home (PCMH) pilot programs. The PCMH program provides a framework of care delivery where a team of health professionals, guided by a primary care provider, provides continuous, comprehensive, and coordinated care. Over 50 pilot programs have been completed or are underway throughout the country. Maryland law, (Maryland Annotated Code, Section 19-1A) required MHCC to establish a PCMH pilot program (PCMH pilot) and requires five payors of fully insured health benefit products (Aetna, CareFirst, Cigna, Coventry, and UnitedHealthcare) to participate in the PCMH pilot. The Federal Employee Health Benefit Plan, Maryland State employee health benefits plan, TRICARE, and other private employers have voluntarily elected to offer the program to their employees.

The three goals of the PCMH pilot are to improve provider and patient experience and satisfaction, reduce costs, and increase quality of care. Participating practices provide patient centered care through: evidence-based medicine; expanded access and communication; care coordination and integration; and increased care quality and safety. The PCMH pilot program was initiated in 2011 with 52 practices and over 300 practitioners from urban, suburban, and rural settings with practices ranging from primary care to geriatric and pediatric groups. The PCMH pilot is entering the third year of the program. To successfully implement the PCMH pilot, ambulatory practices must transform the way they deliver care to a comprehensive model of care coordination. Practice transformation includes elements of team-based care, attention to preventive care and chronic disease management, empowering clinical staff to carry out protocol driven services, open access, and the optimized use of health IT.

The Maryland Learning Collaborative

To implement the PCMH pilot, MHCC partnered with the University of Maryland School of Medicine, Department of Family and Community Medicine to operate the Maryland Learning Collaborative (MLC). The MLC facilitates practice transformation by creating a collaborative environment for practice staff to work together to redesign their practices. It is anticipated that the learning collaborative environment will contribute to the success of the PCMH pilot. The MLC partnership uses resources from education and research communities at both the

University of Maryland and Johns Hopkins Medicine to help facilitate the use of PCMH processes and components in practice transformation.

PCMH Pilot

The PCMH pilot incorporates a number of methods to assess success of the program, including practice quality and utilization measures. The MHCC developed a practice quality measure tool to compare PCMH pilot practices' performance to other similar primary care practices in the State and throughout the nation. The PCMH pilot assesses practice performance in reducing costs. Practices that generate savings receive shared savings incentive payments, which are a percentage of the savings generated through improved care and better patient outcomes. This year, approximately 19 practices qualified for shared saving incentive payments that totaled about \$1.9M.

The PCMH pilot requires practices to demonstrate successful practice transformation through the achievement of recognition from the National Committee for Quality Assurance (NCQA). During the year, roughly 27 participating practices achieved level three NCQA recognition. The NCQA is a private, not-for-profit organization that has developed specific benchmarks for practices to work toward in their effort to provide better, safer, and more coordinated care. The NCQA developed nine areas that are used to achieve one of three levels of recognition. The NCQA provides educational programs, support and guidance for practices transforming to a patient centered model. In addition to shared savings incentive payments, PCMH pilot practices receive fixed transformation payments semi-annually. These payments are disbursed based upon the practices' NCQA recognition level achieved and are intended to be invested in care coordination.

The MHCC continues to provide guidance to IMPAQ International as they conduct an ongoing evaluation of the PCMH pilot. The evaluation will include an assessment of: costs, utilization and quality measures; and patient and family (for pediatric patients) satisfaction. The evaluation will also include qualitative interviews with providers via site visits and an on-line survey.

MARYLAND HEALTH CARE COMMISSION

