

**MARYLAND HEALTH CARE COMMISSION**

**UPDATE OF ACTIVITIES**

**March 2008**

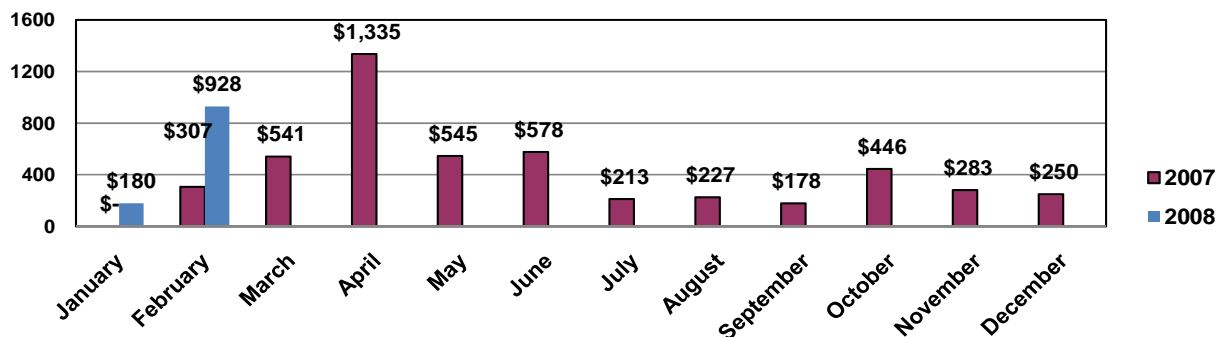
**CENTER FOR INFORMATION SYSTEMS  
AND ANALYSIS**

**Maryland Trauma Physician Services Fund**

**Uncompensated Care Processing**

CoreSource Inc., the third party administrator (TPA) for the Trauma Fund, adjudicated claims with a total paid value of approximately \$927,822 in February. The monthly payments for uncompensated care are shown in Figure 1.

**Figure 1 -- Uncompensated Care Payments 2007 and 2008  
(in 000s)**



**Annual Reconciliation**

Maryland trauma physicians completed their Annual Reconciliation Report. As of March 1, 2008, the Fund has been reimbursed \$162,969. The report was due to the Commission no later than January 31, 2008. Several large institutions have been granted extensions to submit reconciliation reports.

**SB 916 Maryland Trauma Physician Services Fund – Reimbursement and Grants**

The Maryland General Assembly is considering expanding eligibility to the on-call, uncompensated care, and trauma grant funding in the program. The principal goal of the bill is to reconcile expenditures with revenue collected via the automobile registrations and renewals. SB 916 increases spending by:

- Permitting physicians to receive uncompensated care payments for care provided at a rehabilitation hospital;
- Authorizing Level I Trauma Center, Pediatric Trauma Centers, and the 3 specialty referral center to apply for on-call; and,
- Permitting the MHCC to adjust fee levels for uncompensated care to meet specific needs of the Maryland Trauma System.

The Trauma Fund also allows the MHCC to allocate up to 10 percent of the Fund balance from the previous fiscal year to trauma equipment grants. In 2007 the balance in the Fund stood at

about \$20.5 million. If the bill becomes law, MHCC could award up to \$2 million in trauma grants beginning in FY 2009.

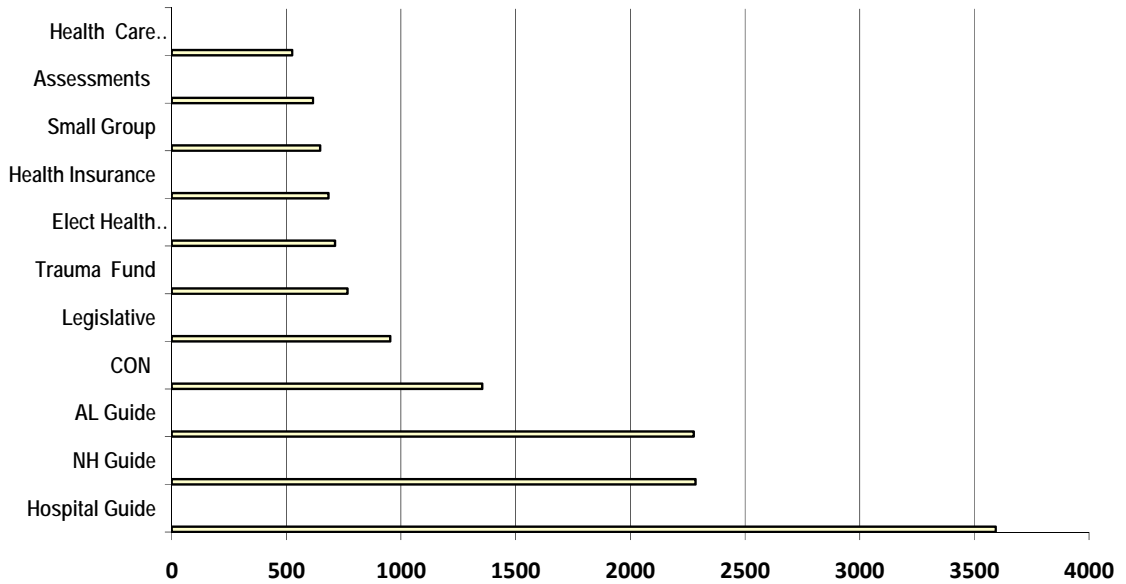
**Data Base and Application Development**

**Internet Activities**

Figure 1 presents results on web utilization for the ten most frequently visited sites in January. About 20,000 unique users visited the site last month. About 9,000 users came directly to the site (typed or pasted a MHCC address in their browser) and GOOGLE referred about 6,000 visitors to the site. The average user spent about 3 minutes on the site.

The Hospital Performance Guide, shown as “Hospital Guide” in the Figure, is the site with the highest utilization. The Assisted Living and Nursing Home Guides had significant traffic. The remaining sites are primarily policy related sites aimed at analysts and policymakers in the respective areas. Fewer visitors would typically be expected.

**Figure 1 Unique Visits to the MHCC Web Site in February  
Initiatives with 500 Visitors or More during the Month**



## Web Development for Internal Applications

A significant number of MHCC web sites are under development or significant redesign. Over the next 6 months the following sites will be launched or redesigned primarily using internal resources.

**Table 1– Health Occupation Boards with Web Applications Under Development**

Board	Anticipated Start Development/Renewal	Launch date
MHCC Assessment	Underway/Not Started	04/01/08
EDI Assessment	Underway/Not Started	06/30/08
LTC Survey	Not Started/ Not Started	08/01/08
Small Business Subsidy Program	Underway/Not started	07/01/08
NH Guide Compliance with ADA Guidelines	Underway/Not Started	Under determined
Redesign of Hospital Guide	External Contractor	Not Specified

## Health Occupation Boards License Renewals

Staff continued to make progress on license renewal applications for occupation boards. Table 2 presents the status on development for health occupation boards.

**Table 2– Health Occupation Boards with Web Applications Under Development**

Board	Anticipated Start Development/Renewal	Start of Next Renewal Cycle
Podiatry	Complete, Complete	11/01/2007
Psychologists	Complete, Underway	12/01/07
Counselors & Therapists	Complete, Underway	2/01/2008
Occupational Therapy	Complete, Underway	04/01/08
Audiologists	Completed, Testing	04/01/08
Acupuncture	Underway, Not started	04/14/08
Morticians	Complete, Testing	03/25/08
Dietetic	06/01/08, Not started	08/11/08
Dental	Underway,	05/01/08
Chiropractic	06/01/08, Not started	09/01/08
Optometry	07/01/08, Not started	06/30/09

## Cost and Quality Analysis

### Health Care Access and Reimbursement Task Force

The General Assembly charged this task force with examining issues affecting access to and reimbursement of physicians that have not been resolved over the past several years. The Task Force is directed to provide recommendations on broad questions affecting:

- patients' access to providers,

- payers' policies on participation on network participation,
- adequacy of current reimbursement levels,
- alternatives to the present system of payment, and approaches for linking reimbursement to quality.

MHCC is staffing this Task Force and arranged for all of the presentations at the February 25<sup>th</sup> Task Force meeting, which included presentations by Ben Steffen, Christopher Hogan, PhD, Direct Research, LLC, and Claudia Schur, PhD, Social and Scientific Systems, Inc. (The presentations are available at <http://www.dhmh.state.md.us/hcar/html/agenda.htm>.) Ben Steffen outlined the results of a meeting held on February 15<sup>th</sup> with representatives of MHA, MedCHI, CareFirst, and MHCC to review the varying perspectives on future physician needs held by the participants. Differences in data sources and methods used to estimate physician supply, both currently and through 2015, were discussed. The participants were able to reach general agreement on several conclusions, although there are technical aspects of these issues which will need to be studied in a Task Force subgroup charged with examining market structure and provider supply issues.

The participants agreed that: 1) Planning for future physician needs is essential, given the time it takes to train physicians; 2) Because the MHA/MedCHI model identifies just one possible future using one set of assumptions, it would be desirable to analyze different scenarios using different assumptions and then investigate the sensitivity of each scenario to small changes in the assumptions; and 3) It may not be possible for the stakeholders to reach agreement on all recommendations, so policymakers should act on a particular recommendation when consensus emerges. The participants were in agreement regarding the following conclusions.

- Access to primary care, emergency medicine, and obstetrics are critical needs for all communities, with access involving not only the number of physicians, but the residents' ability to gain access to willing providers who will provide care they can afford.
- The availability of primary care and specialty care in rural areas of the state, as well as outer suburban areas that are becoming more densely populated warrant special attention.
- Although overall physician supply may be more adequate in the State's highly urbanized areas, populations in these areas with limited access to care continue to need special attention.

Christopher Hogan discussed the impact that the changes in Medicare physician fees had on utilization of care during 1987–2006. Medicare's experience can be useful in understanding physician responses to changes in fee levels because Medicare and private insurance have similar spending trends for physician and clinical services, private payers tend to follow Medicare's lead in physician fee changes, and Medicare's fee changes were (and are) largely driven by a desire to improve rates for evaluation and management (visit) services in the face of a primary care shortage. During this period of large changes in Medicare fee levels, the large fee cuts did not reduce the volume of services provided, patients' access to care remained good, and there was a near-total elimination of balance billing. Physicians' behavior is complex: although most say Medicare rates are a serious concern, nearly all (97%) accept new Medicare patients (a higher acceptance rate than for HMO patients), and almost none (<1%) balance bill. Spending growth is driven mainly by volume growth; in the short run, fee changes matter less than changes in technology and medical practice standards. Volume trends tend to look the same across payers, with the services driving volume growth changing over time: in 1992 it was big ticket items like CABG and TURP; in 2000 it was little ticket items; and today it is imaging and ambulatory procedures.

In spite of the intent of the fee changes, Medicare has had little apparent success in targeting dollars to primary care, due, in part to large volume increases in other types of services. Family practice/general practice physicians have the least opportunity to increase volume through the use of new services and

procedures. From 1994–2004, apparent increases in physician productivity (measured by changes in total RVUs per physician) ranged from just 12 percent for family practice/general practice to 34 percent for diagnostic radiology and 41 percent for orthopedic surgery. Medicare has no uniform payment policy regarding physicians in rural areas, but on average, Medicare pays less in rural areas based on lower prices for inputs. In contrast, private payers tend to pay more in rural areas. Although Medicare does pay more in areas designated as either a Health Professional Shortage Area (10 percent bonus) or a Physician Scarcity Area (5 percent bonus), this is for professional services only, and is perhaps too small to improve physician supply in these areas, especially since Medicare accounts for just 20 percent of physician spending.

Claudia Schur discussed private payer initiatives to refocus systems of payment. The Institute of Medicine report, *Crossing the Quality Chasm*, recommended examining payment methods to remove barriers that impede quality improvement and incorporate stronger incentives for practices that improve patients' health. First generation payment revisions focused on credentialing providers or defining provider tiers based on prices, efficiency (cost per episode of care), and quality. Patients were rewarded for choosing these providers with lower premiums or co-pays, but the insurers did not pay more to these physicians. In the mid-1990s pay-for-performance (P4P) emerged, based on reporting of data related to meeting standards of care. These standards could focus on the process of care (e.g., receipt of preventive screening), service (e.g., patient satisfaction), or outcomes (e.g., lower cholesterol). In this payment system the provider is rewarded with higher payment, such as a percentage increase in the fee schedule or an annual or per member per month bonus. One example of P4P is Medicare's Physician Quality Reporting Initiative (PQRI), which began in mid 2007, is a voluntary quality reporting program that provides financial incentives (up to 1.5 percent of allowed charges) for professionals that meet goals for PQRI measures using information reported on claims. As of July 2006 over half of state Medicaid programs had implemented a P4P program.

In Maryland, the major insurers are at varying stages of implementing their P4P programs. Credentialing or tiered programs have been implemented by both UnitedHealthcare (UHC) and Aetna, but the payers differ in their measures, the payment incentives, and the number of specialties covered by the system. Only CareFirst has incorporated quality into payment, and this is in the early stages of implementation. CareFirst Quality Rewards (P4Q) was introduced in 2008, with new reimbursement effective in 2009, has been endorsed by Bridges to Excellence. It is a voluntary program currently limited to pediatrics, family practice, internal medicine, and some internal medicine specialties, with phase-in for other specialties in coming years. Enrollment in the program is limited to physicians with sufficient claims volume who are participating in specific networks. Assessment will be based on measures of effectiveness (quality) and efficiency (affordability), with the latter assessing the resources used to treat an episode of care. The current measures include 11 quality measures and 5 service-oriented business practices (e.g., use of EMR). Reimbursement is based on points earned, with reimbursements up to 7 percent of the base fee schedule.

### **Disparities in the Quality of Ambulatory Care in Maryland**

MHCC continues to work with Mathematica Policy Research (MPR) on disparities in rates of ambulatory sensitive admissions for the Medicare population in Maryland. MPR submitted its work plan to MHCC in early March. CMS has approved MHCC's release of Medicare claims and related data to MPR. Staff anticipates that the study will be completed by September 2008. MHCC staff hopes to use the results of this study to further the development of a system of ambulatory care performance measures that will provide important feedback to the health care community. The study also serves our goal of strengthening our collaboration with other agencies in DHMH to improve the quality of care received by Maryland residents..

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

**Health Plan Quality and Performance**

**2008 Performance Evaluation: HEDIS Audit and CAHPS Survey**

**HEDIS Audit**

HealthcareData.com (HDC), the audit contractor, has many audit activities in progress including: clinical measure code review, examination of baseline information, onsite interviews, and requisite planning sessions for all plans. Plans are progressing on schedule with completing the automated review portion of their programming code. Additionally, each has completed and submitted to the Commission the behavioral health tool that captures network information. Division staff has worked with audit staff to resolve data discrepancies with the plans.

**Consumer Assessment of Health Plan Study (CAHPS Survey)**

As a check on the survey process, HMO Division staff will be seeded for each of the four scheduled mailings to the representative sample from each plan. The first questionnaire was mailed in early March. In total, W B & A distributed over 13,000 questionnaires to commercial HMO and PPO health plan members. The combined samples include a vendor recommended standard oversample of 10 percent.

**Report Development—2007 Report Series**

HMO Quality & Performance Division staff will finalize text, layout, and data for the eleventh edition of *Maryland Measuring the Quality of Maryland HMOs and POS Plans: 2008/2009 State Employee Guide*—the last report in the three report series. Release of this report will commence in April through a notice in the state employee benefit booklet about the availability of the report on the commission's website.

**Report Development Contract--Procurement**

A request for proposals (RFP) for HMO Report Development work for the next contract period (2008 - 2012, which includes three one-year extension periods) was submitted to and approved by the Department of Budget and Management. The commission released the RFP in February and held a pre-bid conference February 27, 2008 for prospective bidders. Bids are due March 19, 2008.

**Small Group Market**

**Comprehensive Standard Health Benefit Plan (CSHBP)**

At the February public meeting, the Commission approved final regulations on the incorporation of an Exclusive Provider Organization (EPO) as an additional plan type to be offered in the small group market. The regulations will be implemented effective March 24, 2008 and carriers can begin selling this new product on July 1, 2008.

At the February public meeting, Commission staff presented both emergency regulations (for an immediate effective date) and proposed permanent regulations that specify the components of wellness benefits offered under small employer health benefit plans. These regulations are required under SB 6, the "*Working Families and Small Business Health Coverage Act*," enacted during the Special Session of

November 2007. The Commission adopted the regulations as both emergency and proposed permanent. The regulations were submitted to the Department of Business and Economic Development (DBED) and the Administrative, Executive, and Legislative Review Committee (AELR) for approval. Upon approval, the regulatory process will begin, with the posting of these regulations in the Maryland Register for the required comment period. The emergency regulations would be valid for 180 days.

Commission staff is in the process of drafting proposed permanent regulations to implement the Premium Subsidy Program, also required under SB 6. This new Program will be available to certain small employers with 2 to 9 eligible employees as long as they meet the requirements outlined in the law and meet certain salary, wage and other requirements established by the Commission through regulation.

### **Limited Benefit Plan**

As required under Chapter 287 of the Acts of 2004, and through the enactment of HB 800 (2007), the Commission was required to develop a report for the General Assembly on the overall enrollment in the Limited Benefit Plan since its inception on July 1, 2005 through June 30, 2007. The report also included alternative options for individuals enrolled in the Limited Benefit Plan. At the December public meeting, the Commission approved the report and copies were submitted to the General Assembly. The report also is posted on the Commission's website. The requirement that prominent carriers offer the Limited Benefit Plan in the small group market will sunset on June 30, 2008.

### **Racial and Ethnic Disparities**

The Commission has received a request from Delegate Nathan-Pulliam requesting the Commission to invite the health plans, Maryland Insurance Administration, DHMH Office of Minority Health and the universities to meet and confer in an effort to reach consensus agreement on collection and reporting of Maryland specific racial and ethnic data, and development of a project plan to reduce health and health care disparities, but that recognizes the diversity of health plan resources.

It became apparent at a legislative disparity briefing in January that health plans had diverse and frequently episodic projects or programs to address disparities, but an independent entity was needed to bring stakeholders together to achieve the continuity of effort necessary to attain meaningful results.

### **Long Term Care Policy and Planning**

The Fiscal Year 2007 Maryland Hospice Survey was released for online survey completion effective March 5, 2008. This year's survey includes several new additions to the questions to make the survey more compatible with that of the National Hospice and Palliative Care Organization. In addition, updates to the survey process include: forcing totals to be consistent; making sure sections are complete before a person can proceed to the next section; electronic signature to attest to completion; and electronic verification to eliminate the need for several rounds of paper verification and correction.

The public use data files for hospice data have been posted on the Commission's website. This includes the FY 2005 and preliminary FY 2006 public use data sets.

Other long term care reports that were previously published in the *Maryland Register* were recently posted on the Commission's website. They include the following:

- *Required Maryland Medical Assistance Participation Rates for Nursing Homes by Jurisdiction and Region, 2005*

- *Nursing Home Operating Occupancy by Region and Jurisdiction: Maryland, Fiscal Year 2005*
- *Number of Chronic Hospital Beds and Patient Days and Percent Occupancy by Facility: Maryland 2005*
- *Number of Chronic Hospital Beds and Patient Days and Percent Occupancy by Facility: Maryland 2006*

Long Term Care Staff have now completed the Home Health Agency Statistical Profile for FY 2004. The report summarizes data on the utilization and financing of home health agency services in Maryland. The data was obtained from the information collected by the Commission's Home Health Agency Annual Survey for fiscal year 2004, which includes data on overall agency operations and the demographic characteristics, payer types, and services provided to Maryland clients by their jurisdiction of residence. This Statistical Profile, as well as the home health agency public use data tables for FY 2004, 2005, and 2006 have now been posted on the Commission's website. Data tables include an overview of home health agency characteristics, utilization and costs including: volume of admission; referral sources; primary diagnosis on admission; average visits per Medicare client; disposition; revenues by payer types; and home health agency personnel.

Letters were sent to Assisted Living Facilities to inform them of the availability of the Assisted Living Guide and to advise them to update their profile with current rates, services and to submit photograph of the facility. Facilities were given a due date of April 1, 2008 to have their photographs submitted for upload to their profile on the Assisted Living Guide on the Commission's web site.

The Home Health Agency Survey application is now available to the group of home health agencies with a fiscal year end date of December 31, 2007 and a due date of May 31, 2008. Those home health agencies with a due date of February 28, 2008 have been received and reviewed.

### **Long Term Care Quality Initiative**

#### **Long Term Care Web Site Enhancement**

Staff continues to gather formats and content to expand the community services part of the web site to focus on the whole compendium of long term care services, especially community-based services. This effort includes reviewing other local, state, and national web sites for ideas, format, and content and meeting with the LTC Advisory Committee comprised of a diverse stakeholders to provide input.

#### **Nursing Facility Family Survey**

The press release in late January announcing availability of the Nursing Facility Family Survey results produced increased interest both from consumers and the media. In a five week period, over 70 requests were processed by Commission staff for callers without internet access. An increase in traffic on the web site was also noted. Preparations for the next administration of the survey later this year are already in progress.

#### **Other activities**

Providing feedback to the Agency for Healthcare Quality and Research (AHRQ) for the Home and Community Based Services (HCBS) Measure Project. This project is designed to identify existing measures that directly assess HCBS services or can be adapted to do so. Measures in the areas of program performance, client functioning, and client satisfaction are the focus.

Review of the "2009 National Patient Safety Goals for Long Term Care and Home Care" draft for applicability to the MHCC Long Term Care web site. The goals focus on improving the accuracy of

resident identification, medication reconciliation across the continuum of care, and encouraging resident involvement in safety practices for 2009. Additionally, revised healthcare associated infection (HAI) guidelines are due for publication in March 2008. The revised HAI guidelines will also be reviewed for their applicability to LTC settings. Finalizing the Long Term Care Policy and Planning Division Operations Manual.

**CENTER FOR HOSPITAL SERVICES**

**Hospital Services Policy and Planning**

**Certificate of Need (CON)**

**CONs Issued**

Clifton T. Perkins Hospital (Howard County) – Docket No. 07-13-2226  
New construction to the hospital and an increase of 48 special hospital-psychiatric beds  
Cost: \$19,815,968

Devlin Manor Health Care Center (Allegany County) – Docket No. 07-01-2194  
Construction of 30-bed addition and the relocation of 20 comprehensive care beds from the Extended Care Unit at Cumberland’s Braddock Hospital  
Cost: \$5,636,412

Sinai Hospital of Baltimore (Baltimore City) – Docket No. 07-24-2199  
Addition of 4 mixed use operating rooms increasing the number of operating rooms from 21 to 25 and renovation of existing space  
Cost: \$21,907,540

**Modified CONs Issued**

Johns Hopkins Health System (Baltimore County) – Docket No. 03-24-2123  
Increase in capital cost of the project from \$801,926,392 to \$1,054,234,941

**Proposed CON’s Withdrawn by Applicant**

Orthopaedic and Sports Medicine Center ASC (Anne Arundel County) – Docket No. 07-02-2193  
Establishment of an ambulatory surgery center with 3 operating rooms and 2 procedure rooms to be located at 839 Besgate Road, Annapolis.  
Cost: \$5,318,519

**Proposed CON Applications Docketed and Returned by Commission**

Alpha Health Services (Montgomery County) – Docket No. 07-15-2202  
Provide home health services in Montgomery County

BIC Home Health Care (Montgomery County) – Docket No. 07-15-2205  
Provide home health services in Montgomery County

Dynamic Visions Home Health Care (Montgomery County – Docket No. 07-15-2208)  
Provide home health services in Montgomery County

**Pre-Licensure/First Use Approval Issued (Completion of CON-Approved Projects)**

Massachusetts Avenue Surgery Center (Montgomery County) – Docket No. 06-15-2181  
Conversion of an existing non-sterile procedure room to an operating room  
Cost: \$305,785  
Date Pre-Licensed: 2/26/08

Ruxton Surgery Center (Montgomery County) – Docket No. 05-03-2175  
Conversion of an existing non-sterile procedure room to an operating room  
Cost: \$109,650

Union Hospital of Cecil County (Cecil County) – Docket No. 04-07-2141  
Construct a 3-story addition with 48 new med/surg beds and renovations to the existing hospital. The hospital will increase physical capacity from 122 beds to 149 beds, by building 48 new beds and converting 21 semi-private rooms to private rooms through renovation for a net increase of 27 beds.  
Cost: \$22,903,039

**Partial Pre-Licensure/First Use Approval Issued**

Memorial Hospital of Easton (Talbot County) – Docket No. 03-20-2112  
Renovation of the hospital's telemetry unit, relocate and expand the current emergency department, and expansion and reconfiguration of space for outpatient services  
Cost: \$34,649,988  
Partial First Use Approval is for Emergency Department

**CON Letters of Intent**

Levindale Hebrew Geriatric Center & Hospital (Baltimore City) – Addition of 20 special hospital-chronic care beds to the facility and the reduction of 6 special hospital-rehabilitation beds

Levindale Hebrew Geriatric Center & Hospital (Baltimore City) – Renovation and new construction to the existing facility and an increase of 30 CCF beds by relocation from existing facilities in Baltimore City and implementation of waiver beds

Levindale Hebrew Geriatric Center & Hospital (Baltimore City) – Renovation and new construction to the existing facility and an increase of 38 CCF beds by relocation from existing facilities in Baltimore City and implementation of waiver beds

St. Mary's Hospital (St. Mary's County) – Construction of a 3-story addition to the hospital and the addition of 50 med/surg beds

**CON Applications Filed**

Rivermont Nursing & Rehabilitation Center (Montgomery County) –  
Construct a 124 bed comprehensive care facility utilizing 80 temporarily delicensed beds from Mariner Health Care of Circle Manor and 44 existing beds from Springbrook Adventist Nursing & Rehabilitation Center.

Cost: \$21,682,941

Abibank Home Care Services (Baltimore County) – Matter No. 08-03-2229  
Provide home health care in Baltimore County

Allied Alternatives Healthcare Services (Baltimore County) – Matter No. 08-03-2230  
Provide home health care in Baltimore County

American Healthcare Staffing (Baltimore County) – Matter No 08-03-2231  
Provide home health care in Baltimore County

Angels Home Health Services (Baltimore County) – Matter No. 08-03-2232  
Provide home health care in Baltimore County

Carroll Home Care (Baltimore County) – Matter No. 08-03-2233  
Provide home health care in Baltimore County

Celtic Healthcare (Baltimore County) – Matter No. 08-03-2234  
Provide home health care in Baltimore County

FEM Nursing Services (Baltimore County) – Matter No. 08-03-2235  
Provide home health care in Baltimore County

Human Touch Home Health (Baltimore County) – Matter No. 08-03-2236  
Provide home health care in Baltimore County

Madanguit, Gerardo (Baltimore County) – Matter No. 08-03-2237  
Provide home health care in Baltimore County

Maryland Home Health (Baltimore County) – Matter No. 08-03-2238  
Provide home health care in Baltimore County

Mid America Home Health (Baltimore County) – Matter No. 08-03-2239  
Provide home health care in Baltimore County

MISS Health Care Agency (Baltimore County) – Matter No. 08-03-2240  
Provide home health care in Baltimore County

Nurses on Demand (Baltimore County) – Matter NO. 08-03-2241  
Provide home health care in Baltimore County

Nursing & Health Services Training (Baltimore County) – Matter No. 08-03-2242  
Provide home health care in Baltimore County

Premier Health Services (Baltimore County) – Matter No. 08-03-2243  
Provide home health care in Baltimore County

Prime Home Health Care (Baltimore County) – Matter No. 08-03-2244  
Provide home health care in Baltimore County

Spectrum, Inc. (Baltimore County) – Matter No. 08-03-2245

Provide home health care in Baltimore County

**Pre-Application Conference**

Levindale Hebrew Geriatric Center & Hospital (Baltimore City)

St. Mary's Hospital (St. Mary's County)

**Application Review Conference**

Rivermont Nursing & Rehabilitation Center (Montgomery County) – Matter No. 08-15-2228

**Determinations of Coverage**

• **Acquisitions**

Surgery Center of Maryland (Montgomery County) – Change in the ownership structure of the facility

Chester River Health System (Kent County) - Acquisition of Chester River Health System, which owns Chester River Hospital, by the University of Maryland Medical System Corporation

EndoCenter at Quarterfield (Anne Arundel County) - Change of ownership from EndoCenter at Quarterfield Station to Glen Burnie MD Endoscopy ASC, LLC

Riverview Care Center (Baltimore County) - Acquisition of Riverview Care Center by Riverview SNF, Eastern Blvd. Real Estate, LLC

Holly Hill Manor, Inc. (Baltimore County) - Acquisition of Holly Hill Manor by Holly Hill Nursing, LLC and PV Realy-Holly Hill, LLC.

Baltimore Spine Center (Baltimore County)

Change in ownership, NeoSpine Surgery, LLC will be replaced by Neospine Surgery of South Carolina, LLC as one of the owners of Baltimore Spine Center, LLC

Towson Surgical Center (Baltimore County)

Acquisition of an ambulatory surgery center with 1 sterile OR adjacent to Towson Surgical Center – Reviewable CON Required

• **Capital Threshold**

Sinai Hospital of Baltimore (Baltimore City) – Renovation at the hospital to create six replacement operating rooms on the 5300 Unit

Cost: \$9,820,241

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

Alice B. Tawes Nursing Home (Somerset County)

Temporary delicensure of 7 CCF beds

• **Ambulatory Surgery Centers**

Wyman Park ASC Series (Baltimore City)

Establish an ambulatory surgery center with 2 non-sterile procedure rooms to be located at 3100 Wyman park Drive, Suite 326, Baltimore

Summit Ambulatory Surgery Center (Baltimore County)

Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 5051 Greenspring Avenue, Suite 302, Baltimore

Surgery Center of Southern Maryland (Prince George's County)

Establish an ambulatory surgery center with 1 OR and 1 non-sterile procedure room to be located at 9001 Woodyard Road, Clinton

Doctor's of Podiatry (Anne Arundel County)

Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 128 Lubrano Drive, Suite 102, Annapolis

Summit Ambulatory Surgery Center (Baltimore County)

Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 6535 N. Charles Street, Baltimore)

SurgCenter of Glen Burnie (Anne Arundel County)

Establish an ambulatory surgery center with 1 OR and 2 non-sterile procedure rooms to be located at 308 Hospital Drive, Glen Burnie

Bergman Eye Surgery Center (Washington County)

Establish an ambulatory surgery center with 1 OR and 1 non-sterile procedure room to be located at 10210 Governor Lane Boulevard, Suite 1004, Williamsport

EndoCentre of Baltimore (Baltimore County)

Establish an ambulatory surgery center with 4 non-sterile procedure rooms to be located at 1838 Greene Tree Road, Suite 400, Baltimore

Delmarva Surgery Center (Cecil County)

Establish an ambulatory surgery center with 1 OR and 3 non-sterile procedure rooms to be located at 101 Chesapeake Boulevard, Suite C, Elkton

- **Waiver Beds**

Hartley Hall Nursing Home (Wicomico County)

Request to add 3 CCF waiver beds

### **Policy and Planning**

The Task Force on the Plan to Guide the Future Mental Health Service Continuum held its first meeting on Tuesday, February 26, 2008. The purpose of the Task Force is to provide assistance to the Commission in the development of the Plan to Guide the Future Mental Health Service Continuum consistent with the direction from the Joint Chairmen's Report. The Task Force is chaired by Rex W. Cowdry, M.D. Assisting the Commission in providing staff support to the Task Force will be staff from the Mental Hygiene Administration and the Mental Health Transformation project. The Commission has

also obtained consultant services from the University of Maryland, Baltimore (UMAB), School of Medicine, Department of Psychiatry to support the work of the Task Force.

To assist the Task Force in developing the Plan, a series of background White Papers are being prepared. At the first meeting the Task Force discussed a White Paper on *Meeting the Needs for Inpatient Mental Health Services: A Framework for Planning*. The White Paper: (1) identifies factors that should be considered in future capacity planning, including planning principles, geographic regions within Maryland, appropriate age cohorts and clinical subpopulations, and definitions of the service categories for which capacity projections will be developed; and (2) outlines options with respect to the key framing decisions for capacity planning for discussion by the Task Force. It also reviews the relevant research and planning literature around inpatient bed need projections and crisis system development. Articulating the challenges of public processes, the White Paper additionally discusses the complexities and limitations of mental health planning.

The next meeting of the Task Force is scheduled for Thursday, April 10, 2008 at 1:00 p.m. in the Commission offices. Meeting agendas and other materials considered by the Task Force are posted on the Commission's website at [http://mhcc.maryland.gov/mental\\_health\\_services/index.html](http://mhcc.maryland.gov/mental_health_services/index.html)

### **Hospital Quality Initiatives**

The Hospital Performance Evaluation Guide Advisory Committee held its monthly meeting (via conference call) on February 25<sup>th</sup> to discuss various activities associated with the maintenance and expansion of the Hospital Guide. Staff provided an update on the status of legislative proposals that focused on healthcare-associated infections. The staff also reviewed planned updates to the Guide and recent quality data and reporting activities at the federal level. In support of MHCC's hospital quality initiatives, staff continues to reach out to other units within DHMH, federal agencies, professional organizations and other states, to share and gather information and to identify opportunities for collaboration and improvement. These activities are highlighted below:

- The Division of Healthcare Quality Promotion of the CDC manages the National Healthcare Safety Network (NHSN), an internet-based surveillance system that integrates patient and healthcare personnel safety surveillance systems. In accordance with the recommendations of the HAI Technical Advisory Committee, the NHSN system will be the vehicle for collecting data on health care-associated infection data and quality measures from Maryland hospitals. Commission staff continues to review NHSN educational materials to develop an understanding of the technical reporting requirements associated with the surveillance system. Staff also participates in the NHSN State Users monthly teleconferences to stay abreast of issues surrounding HAI hospital performance measures. On March 5<sup>th</sup>, staff participated in the NHSN monthly conference call that included a presentation on a new module designed for multidrug-resistant organism (MDRO) and clostridium difficile-associated disease (CDAD) data collection and surveillance.
- The Healthcare Improvement Partnership (HIP), sponsored by the Delmarva Foundation, the Medicare Quality Improvement Organization (QIO), facilitates the sharing of information relevant to improving the quality of health care in Maryland and the District of Columbia. Commission staff have been invited to participate in the project and attended its quarterly meeting on March 11<sup>th</sup>. The meeting provided valuable information on CMS sponsored quality initiatives including activities related to healthcare-associated infections.

### *Specialized Services Policy and Planning*

Under a contract with the Commission, the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) collects and validates data on patients with ST-segment elevation myocardial infarction (STEMI) who present at hospitals that provide primary percutaneous coronary intervention (PCI) under a waiver granted by the Commission. Data for the fourth quarter (October 1 through December 31) of calendar year 2007 must be complete and in the registry database no later than March 17, 2008. On March 11th, the C-PORT contractors, Commission's staff, and representatives of the 12 hospitals with primary PCI waivers participated in a work session on clinical and data management issues. The session included a summary of preliminary data from the Commission's STEMI/PCI registry, and a review of the 2007 Focused Update of the American College of Cardiology/American Heart Association (ACC/AHA) 2004 Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction. Additionally, John Jerome, Battalion Chief of Howard County Fire and Rescue, and representatives of Howard County General Hospital gave a presentation on Emergency Medical Services (EMS) notification of STEMI and its effect on door-to-balloon time.

The Commission has granted permission to Frederick Memorial Hospital (Docket No. 06-10-0012 WN) to initiate primary PCI services on March 14, 2008.

Upper Chesapeake Medical Center (Docket No. 07-12-0014 WN) has submitted written notification of the hospital's intent to initiate primary PCI services. Upon review of the hospital's notice and any requested supporting documentation, the Commission will advise Upper Chesapeake Medical Center whether the initiation of services on April 4, 2008 is permitted.

The primary PCI waiver application filed by Carroll Hospital Center (Docket No. 08-06-0026 WN) is currently under review to determine whether the hospital meets the requirements in the State Health Plan for Cardiac Surgery and Percutaneous Coronary Intervention Services (COMAR 10.24.17). Carroll Hospital Center is expected to submit information supplementing its application no later than March 21, 2008.

COMAR 10.24.05 Research Waiver Applications: Atlantic C-PORT Study of Nonprimary Percutaneous Coronary Intervention provides for a limited number of qualified hospitals without on-site cardiac surgical services to participate in the Atlantic C-PORT elective angioplasty study. The following hospitals in the Metropolitan Baltimore or Metropolitan Washington regional service area filed applications for a research waiver: Anne Arundel Medical Center, Baltimore Washington Medical Center, Shady Grove Adventist Hospital, Southern Maryland Hospital Center, Johns Hopkins Bayview Medical Center, Holy Cross Hospital, and St. Agnes Hospital. The Commission's staff reviewed each application for completeness and requested additional information to ensure that the application is complete. The staff received responses from the hospitals on March 7, 2008. After a determination that an application is complete, the staff will docket the application for review and publish a dated posting on the Commission's website and in the *Maryland Register*.

### **Health Information Technology**

Staff continued to develop the draft solutions and implementation report that addresses organizational-level business practices related to privacy and security of health information exchange (HIE). A Solutions and Implementation Workgroup (Workgroup) began meeting late last summer to identify solutions and implementation plans for a specific set of barriers pertaining to HIE privacy and security. These barriers were identified by eight Sector Groups in the initial phase of this project, and are documented in the report *An Assessment of Privacy and Security Policies and Business Practices*, which was released in November 2007. The Workgroup identified eight principles for HIE and proposed specific solutions that address key barriers for each principle. Several participants from the Workgroup have volunteered to review the draft, which is scheduled for completion around the end of April.

Staff continued to take part in weekly meetings of the Certification Commission for Health Information Technology's (CCHIT) Network Workgroup (Workgroup) as it continues to develop network test scripts for certification. The Workgroup is reviewing responses from its January survey and plans to address public comments in the second draft of the network certification criteria. In February, a survey was conducted of potential HIE networks to assess interest in CCHIT network certification. CCHIT originally planned to begin certifying the functionality of HIE networks in June; however, last month CCHIT decided to extend the implementation date to October 2008. Similarly, staff is providing consultative support to the Electronic Healthcare Network Accreditation Commission (EHNAC) in their assessment of a HIE privacy and security policy accreditation program. EHNAC is a national accreditation organization for electronic health networks (networks) that exchange administrative transactions.

Staff continued to provide consultative support to the Maryland Hospital Association (MHA) Transaction Workgroup (Workgroup) as they finalized the draft Request for Solution (RFS), which asks vendors and clearinghouses to develop a Maryland Transaction Data Interchange (MTDI). The MTDI intends to support the exchange of eligibility and claim status transactions by Maryland hospitals, and will integrate with hospital IT systems. The RFS expects to be distributed on April 1<sup>st</sup> with responses due by May 1<sup>st</sup>, and a contract awarded by August 1<sup>st</sup>. The MHA's goals in promoting this initiative is to reduce the per transaction costs now paid to networks, increase the availability of electronic claim status and eligibility transactions, and develop a standards-based Maryland Companion Guide to establish standards for HIPAA electronic transactions in the state.

Staff continued in its effort to develop a hospital health information technology (HIT) survey. Last month, staff completed a literature review of existing HIT surveys to identify questions related to technology adoption and utilization. Staff is in the early stages of developing a survey to assess statewide hospital HIT adoption that will at a minimum be able to compare local adoption with national trends and report on hospital utilization. Staff also identified appropriate terms that need to be included in the survey to facilitate consistency in survey responses. Staff plans to seek assistance from hospital CIOs in April to provide feedback on a preliminary set of survey questions. Several CIOs have agreed to pilot the survey this summer. The Commission's Center for Hospital Services is considering including an HIT survey in its 2009 Hospital Quality Survey.

Staff is in the development stage of an electronic health records (EHRs) system adoption initiative that will provide guidance to primary care providers in evaluating and selecting an EHR system. Staff plans to develop various EHR evaluation tools to assist physicians in identifying an appropriate system.

Adoption of EHRs can significantly improve the coordination of care; integrating them into practice workflows improves patient safety and efficiency of care, reduces duplicate tests, and enhances quality of care and health promotions. Staff will identify select CCHIT certified vendors that have strong physician references and are willing to offer physician incentives to implement their system as part of this initiative.

### **Health Information Exchange**

Staff continued to provide consultative support to multi-stakeholder groups interested in submitting a proposal in response to the Request for Applications (RFA) released in January. The RFA is the first step of a two-phased strategic plan to provide funding for designing different parallel projects that layout plans for a statewide HIE, followed by a single implementation project to build the statewide HIE. A number of multi-stakeholder groups have expressed an interest in responding to the RFA. These groups represent community hospitals, and their service area and academic medical institutions. Groups have until March 3<sup>rd</sup> to submit a proposal to the MHCC. The best ideas from the planning phase will be incorporated into a single RFA that builds a statewide HIE capable of sharing patient information across multiple provider settings. Staff invited two representatives from the Task Force to Study Electronic Health Records, a representative from CareFirst and from Oracle, and two nationally renowned individuals in HIE to participate in the RFA review committee.

Last month, Research Triangle Institute, a national consulting organization under contract with the Office of the National Coordinator (ONC), requested that states participating in the Health Information Security & Privacy Collaboration (HISPC) Adoption of Standards Collaborative Workgroup (Workgroup) provide additional documentation to address select deliverables in the Workgroup's proposal. The goal of the HISPC Workgroup is to develop the National Health Bridge (NHB): Basic Policy Requirements for Authentication and Audit that supports cross network HIE for the purpose of treatment for individuals and populations as well as an implementation plan that can be used by participating states to guide the adoption of the NHB. Staff will focus on validating a set of basic policy requirements for authentication and audit developed by several modeling states in the Workgroup. The work of the modeling states will focus on developing a set of basic, minimum policy requirements that MHCC will use to vet emerging service area HIEs (SAHIEs) in Maryland. Staff will also facilitate the development of an implementation strategy used by the Workgroup to guide the state's adoption and use of the NHB. An announcement regarding funding has been delayed until April; MHCC's proposed project budget is approximately \$102,000.

Staff convened several planning meetings with Mosaica Partners, a consultant organization identified to provide support with an initiative to harmonize SAHIE efforts in Maryland. The scope of this project involves identifying current policies and business practices of SAHIEs related to the privacy and security. In May, several CIO workgroups will begin meeting to identify business practices, policies related to privacy and security, and standards that will facilitate the adoption of consistent exchange practices across the state. The harmonization of SAHIE privacy and security practices will provide the foundation for implementation of statewide HIE. The work effort is expected to result in a *SAHIE Planning Guide* that is tentatively scheduled for release in November.

### **Electronic Health Networks & Electronic Data Interchange**

Staff granted initial MHCC certification to MedData, a division of AGDATA, L.P. An application for initial MHCC EHN certification was received during the month from GHN-Online, staff will begin evaluating their application in March. During the month, staff approved recertification for PNC Bank N.A., HDM Corp., and Passport Health Communications. Staff is finalizing the review of recertification documentation for RelayHealth/McKesson. Staff also provided consultative services to Eyefinity to complete its MHCC EHN recertification application, which is due in March, notified Henry Schein Practice Solutions that their recertification application should be submitted by June, and is working with

Gateway EDI, Inc. to complete their recertification documentation requirements. Currently, 33 networks are MHCC certified.

Staff completed the final draft of the *2007 Dental EDI Review* (review) and will ask stakeholders to provide feedback on the review in March. Staff anticipates making any final changes to the review by the end of the month and releasing it in April. The review represents the fourth annual report on dental EDI, and reflects 2006 dental transaction data submitted by 39 private payers, Medicaid, and the seven Medicaid Managed Care Organizations (MCOs). These payers include 14 private payers that offer dental benefits only, and 25 private payers that provide both dental and medical benefits. The review provides an overview of dental electronic data interchange (EDI) in Maryland. Dental payers use the review's information to develop strategies aimed at increasing EDI. In 2006, private payer dental EDI increased about two percentage points to roughly 35%.

Approximately 42 payers were notified in January to submit a *2008 EDI Progress Report* by June 30, 2008, as required by COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks*. Staff has confirmed that all payers have received the EDI notification letter. Staff is in the process of developing a web-based application for payers to submit 2007 transaction data for the 2008 EDI data collection. In March, staff will contact several payers to participate in a pilot of the web-based application; the pilot is scheduled to begin in April.

### **National Networking**

Staff participated in a webcast conducted by the Agency for Healthcare Research and Quality (AHRQ). The webcast provided an overview of the status of the HISPC that analyzed state variations in organization-level business practices, policies, and state laws that affect HIE. Between June 2006 and December 2007, 33 States and one territory (Puerto Rico) participated in the project, which was funded by AHRQ and the ONC. Discussion included the impact of Phase I of the HISPC project, which identified privacy and security barriers to HIE and early progress in Phase II in which multi-state workgroups are developing plans for cross-state collaboration on standards policy adoption; consent options; outcomes and best practices; inter-organizational agreements; provider education; consumer education and engagement; and harmonizing state privacy laws.

Staff also participated in a virtual meeting of the American Health Information Community (AHIC). This federal advisory body makes recommendations to the Secretary of the U.S. Department of Health and Human Services on the development and adoption of HIT. The February meeting included an update on progress to transition AHIC to a public-private partnership and included a presentation of AHIC 2009 priorities and use case development. Two AHIC workgroups, the Personalized Healthcare Workgroup and the Confidentiality, Privacy, & Security Workgroup, provided an update of their activities. The meeting also reported on progress in developing standards and agreements for the National Health Information Network (NHIN) and provided an overview of a survey conducted by the eHealth Initiative Foundation on state, regional and community HIEs.

During the month, staff attended a meeting of the National Governors Associations Center for Best Practices State Alliance for e-Health in Washington, D.C. The State Alliance was formed to improve the nation's health care system by addressing state-level HIT issues and challenges to interoperable HIE. The chairs of the Health Care Practice Taskforce, Health Information Communication and Data Exchange Taskforce, and Health Information Protection Taskforce presented updates of their activities. The meeting also included discussion of modifications to a statement promoting the adoption of e-prescribing, and the designation of two new Taskforces to develop policy on facilitating the secure exchange of electronic health information within and among states.