MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

February 2010

CENTER FOR INFORMATION SYSTEMS AND ANALYSIS

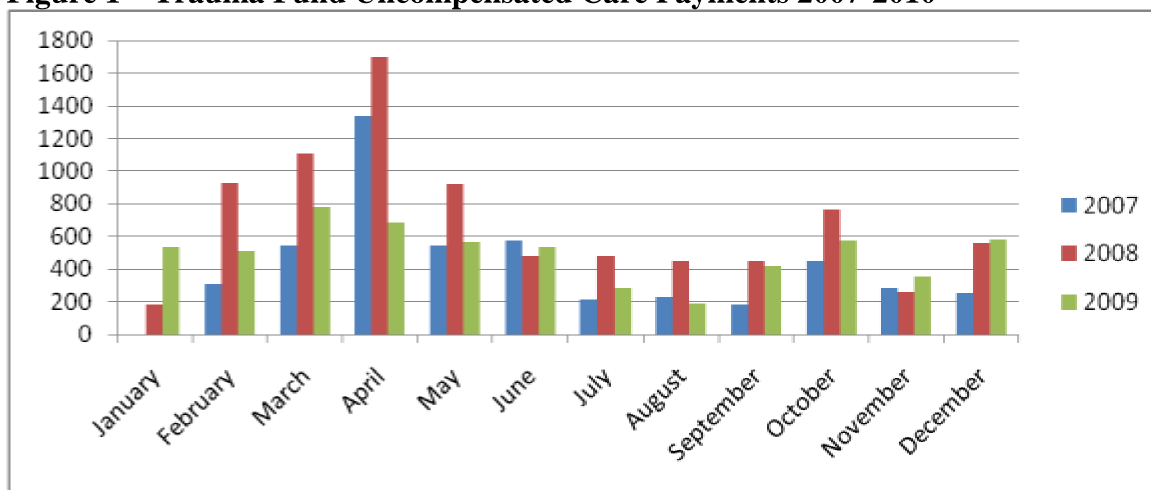
Maryland Trauma Physician Services Fund

Uncompensated Care Processing

CoreSource, Inc., the third party administrator (TPA) for the Trauma Fund, adjudicated claims with a total paid value of approximately $377,400 in January. The monthly payments for uncompensated care since February 2007 are shown below in Figure 1. Although the level of uncompensated care payments had been falling significantly since the start of the 2010 fiscal year in July, claims payments over the past two months have been greater than those in November and December of 2008.

Electronic submission of Trauma Fund claims is now available. Physician practices' staff may contact Maureen Abbott, the Trauma Fund's customer service representative at CoreSource, at 1-800-624-7130, extension 55512, or direct dial at 410-933-5512 for further information.

Figure 1 – Trauma Fund Uncompensated Care Payments 2007-2010

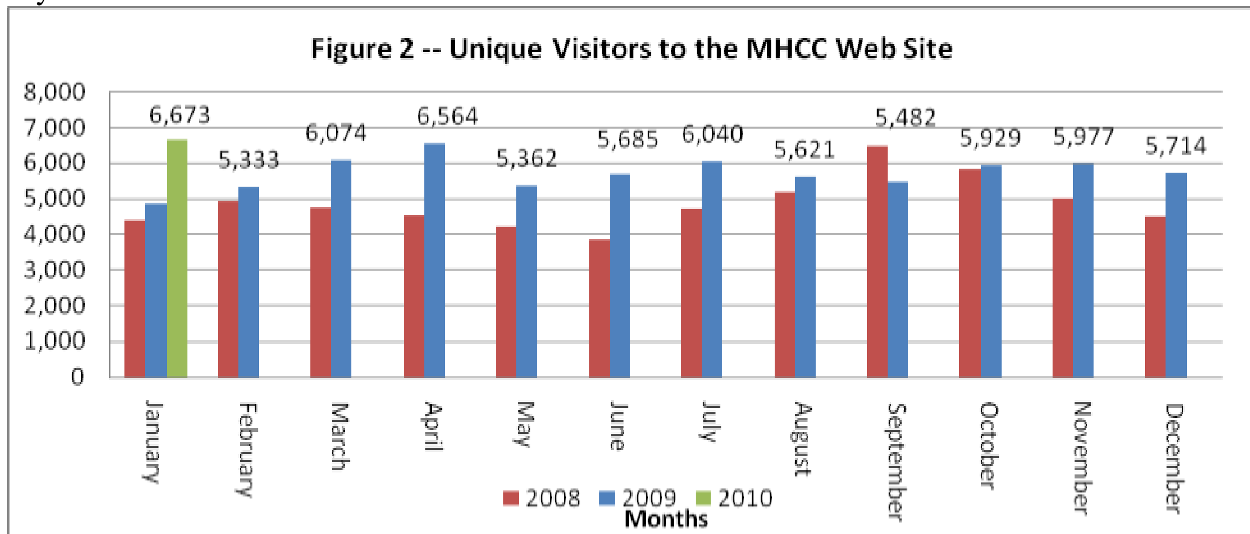


Patient Centered Medical Home Workgroup

The Patient Centered Medical Home Workgroup meet by teleconference call on February 11, 2010. Information regarding the work of each of the subgroups and the Workgroup, as well as the schedule of upcoming meetings, is available on the Council's website at: http://dhmh.state.md.us/mhqcc/pcmh.html. PCMH Workgroup meetings are regularly held at the Commission's offices in Room 100, though conference call attendance is also available. Persons interested in participating in the Workgroup should send an e-mail to: pcmhpractices@mhcc.state.md.us.

Internet Activities

Unique visitors to the MHCC website increased 16.8 Percent from December 2009 and by 37 percent from January 2009. The number of unique visitors was higher than at any time overtime since 2004. The number of first time visitors as a share of all visitors dropped about 2 percentage points to just below 41 percent. Duration on the site remained constant with the previous month, but the number of pages viewed increased by 43 percent from December 2009, higher than for any month since 2008.



The percent of unique visitors who arrived by directly entering the MHCC URL (mhcc.maryland.gov) or subfolders for our URL (mhcc.maryland.gov/hospitalguide for example) remained consistent with the previous month, at about 41 percent. The percent of unique visitors who arrived via Google or another search engine, increased by nearly 2 percent to 41 percent. However, Google alone accounts for 25 percent of all unique visits. The remaining 19 percent of visitors originated other state agencies. The DHMH website was the most common referring site, followed by the Maryland Web Portal (Maryland.gov).

Most visits to appear to be brief. The average user time at the site was 2.46 minutes per visitor. The average time on the site has never averaged less than 2 minutes or more than 3 minutes since MHCC began collecting data.

Cost and Quality Analysis

Health Care Expenditures Comparison Report

The design of the first report in the new *Health Care Expenditures Comparison Report (HCEC)* series has been determined, and the work on the report is nearing completion. ***Health Care Spending in Maryland: How does it differ from other states and why?*** compares spending in Maryland to spending in 10 other states, as well as the national average. The report begins with a review of what is known about geographic variation in health spending, with a focus on some of the most noted and recent research exploring the underlying factors that influence observed variation. Key features of Maryland's health care environment are identified and discussed to provide context for the discussion of spending, and an overview of available statistics on state-

level spending highlight how Maryland stands relative to other states and the nation overall. Chapter 2 presents data on a variety of demographic and socio-economic factors that may affect health care use and spending—both across states and over time. Chapter 3 focuses on supply side forces, including characteristics of the health care marketplace and Chapter 4 presents aspects of policy that could influence spending. In Chapter 5, the relationship between health care spending, the demand and supply of health care services, and policy initiatives is examined. (A description of the data sources is provided in the Appendix to this report.) Results from this report will be presented at the March Commission meeting.

Report on Insurance Coverage through Maryland's Private Sector Employers
Every other year staff produce a report on health insurance coverage through the State's private sector employers, based on results from the Medical Expenditure Panel Survey – Insurance/Employer Component, conducted annually by the Agency for Healthcare Research and Quality. The MEPS Insurance Component sends questionnaires to private and public sector employers to collect data on the number and types of private health insurance plans offered, benefits associated with these plans, premiums, contributions by employers and employees, eligibility requirements, and employer characteristics. This year's report, ***Medical Expenditure Panel Survey – Insurance Component, Maryland Sample through 2008,*** examines private-sector establishments in Maryland that offered health insurance and the number of employees in these establishments who were eligible and enrolled in 2008. The report provides detailed information by employer and workforce characteristics, such as firm size and industry type, and on premiums and employee contributions for single and family coverage. The report will present information on trends in health premiums in Maryland through 2008, and will include new information on the percent of employees in health plan with a deductible and the average size of the deductible. The report will also include information on the percent of employees enrolled in self-insured plans in 2008. Results from this report will be presented at the March Commission meeting.

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

Health Plan Quality and Performance

The 2009/2010 Comprehensive Performance Report has been completed by our contractor NCQA and will be posted to the MHCC website shortly. This year the Comprehensive Report has been streamlined, reducing text by merging introductory information for each measure into four major topical categories. This also resulted in a negotiated reduction in the cost to produce the report in current and future years.

Currently staff are working with NCQA to produce the State Employee Guide to Maryland Managed Care Plans which will be released in early March. The State has transitioned from offering HMO plans to offering exclusive provider organization (EPO) plans. EPOs are somewhere between HMOs and PPOs. This has complicated health plan reporting in the State Employee Guide.

We have piloted a proprietary product for the last two years called eValue8 which complements the HEDIS measures and creates a much more robust performance measurement program and subsequently results in a report with greater utility for employers and employees choosing a health plan. We are still in negotiations with the franchisee, the Mid-Atlantic Business Group on Health for the 2010 evaluation period.

Small Group Market

Comprehensive Standard Health Benefit Plan (CSHBP)
The enactment of SB 637/HB 674 requires the Commission to post on the MHCC website and update quarterly, premium comparisons of health benefit plans issued in the small group market. The RFP for development of this web portal (referred to as VIRTUAL COMPARE©) was issued and 5 proposals were received. A vendor could be selected by early March with the web portal operational within 6 months or less of vendor selection.

Health Insurance Partnership
The "Partnership" premium subsidy program has been available to certain small employers with 2 to 9 full time employees since October 1, 2008. As of February 9, 2010 enrollment in the Partnership was as follows: 238 businesses; 673 enrolled employees; 1,123 covered lives. The average annual subsidy per enrolled employee is $2,161; the average age of all enrolled employees is 39; the group average wage is approximately $28,000; the average number of employees per policy is 4; and the total subsidy amount allocated is almost $1.5 million.

Mandated Health Insurance Services
Insurance Article § 15-1501, Annotated Code of Maryland, requires the Commission to submit an annual report to the General Assembly on: (1) any proposed mandated health insurance service that failed during the preceding legislative session; and (2) any request for analysis on a proposed mandated benefit that was submitted by a Legislator to the Commission by July 1st of that year. Each evaluation must include an assessment on the medical, financial, and social impact of the proposed mandate. At the December 2009 meeting, the Commission approved the annual report (prepared by Mercer) that evaluated two proposed mandates: coverage for autism spectrum disorder without age and monetary limits; and cost of changing the eligibility requirement in the current mandate covering in vitro fertilization (IVF) from two years of infertility to one year of infertility. The approved report was submitted to the General Assembly in early January and is posted on the MHCC website.

Long Term Care Policy and Planning

Hospice Data
The FY 2008 hospice data collection is complete and the data has been posted on the Commission's website. The FY 2009 survey has been tested and updated. The FY 2009 survey is due to be available for online survey completion by February 23rd. Programs will receive notification via certified mail and email when the survey is ready for data entry.

Hospice Day in Annapolis
Long Term Care Staff made a presentation at the annual Hospice Day in Annapolis on January 28, 2010. The presentation included data on the "typical" hospice patient, selected hospice trends from FY 2004-2008, and new data items in the FY 2008 survey. There was also a discussion of the status of the annual hospice survey, the availability of public use data sets from FY 2003-2008, a satisfaction survey comparable to the one for LTC, and planned LTC website expansions.

Minimum Data Set
Staff is currently working with the minimum data set (MDS) Resident Assessment Instrument to update data sets for planning and policy development. The focus is on: update current programs and address programming issues; construct variables for research projects; develop a methodology to impute missing data; create data sets that permit tracking of variables over time; and link data sets.

Nursing Home Liaison Meeting

The discussion at the January 27, meeting included the following topics: issues with KeyPro claims processing; Hilltop Institute's Long Term Care Chartbook; Nursing Facility Quality Assessment; Pay for Performance; and legislative updates.

Home Health Agency Data Analysis
Commission staff continues to review and analyze utilization trend data of HHA services. Staff is looking at age-specific use rates, as well as jurisdiction-specific utilization patterns in order to determine possible changes to the methodology for forecasting home health agency need. Preliminary analysis of Medicare and Medicaid home health utilization by zip code has also been part of the home health agency data analysis.

Home Health Agency Survey
There are 21 home health agencies with fiscal year ending dates of March 31, May 31, or June 30 which are in Phase I of data collection. To date, 100 % of the home health agency surveys have been submitted and accepted. Phase 2 agencies- Agencies with fiscal year ending dates of September 30, and December 31, 2009, data collection will begin on March 1, 2010. The due date for Phase 2 agencies is May 29, 2010.

Long Term Care Survey
Development of the 2009 long term care survey is in progress; staff continues to test the application and update the specifications where applicable to enhance error resolutions. Staff anticipates beta testing to begin later this month. The data cleaning of the 2008 long term care survey is in progress, staff anticipates the data cleaning will be completed by the beginning of March.

Long Term Care Quality Initiative

LTC Website Expansion
A contractor has been selected to design and build the new website. Staff is preparing the many files and datasets to be forwarded to the contractor. Managing the development work will be a collaborative effort between LTC Quality Initiative and Data Base and Applications development staff.

Nursing Home Surveys
The results of the 2009 Maryland Nursing Home Family Survey were received from the contractor, the third year for the survey administration. Maryland is one of only a few states that conduct an annual nursing home survey. Overall, survey respondents continue to give high marks to the nursing homes. Statewide 90% of respondents said they would recommend the nursing home and the rating for overall care was 8.3 on a scale of 1-10 with 10 representing the best care. Last year 89% would recommend the nursing home and 8.2 was the overall rating of care. Staff is preparing information for the release of individual facility results to the public and will brief the Commission prior to the release.

The Short Stay Resident Survey results are still being analyzed by the Agency for HealthCare Research and Quality (AHRQ) on a pro bono basis. The short stay results will be shared with the nursing facilities but because this was a pilot year, only aggregate results will be published.

A Request for Proposals (RFP) to secure a contractor to conduct the surveys for calendar years 2010-2014 has been released; response are due back in March.

Other
Staff has again been invited to present at the CAHPS User Group Meeting, sponsored by the Agency for Healthcare Research and Quality (AHRQ). The presentation will be part of a panel discussion of experience with the short stay resident survey. The meeting is scheduled for April 19-21, 2010 in Baltimore.

Staff is participating in the "Home Health Process of Care and Outcome Measures Workgroup" which has been formed to assist CMS in incorporating new Home Health Process and Outcome Measures into the Home Health Compare (HHC) Website. The first meeting reviewed the results of consumer testing of the proposed public report of the measures. The information gained by participation in the effort can be used to improve the LTC information displayed on the MHCC LTC portal.

CENTER FOR HOSPITAL SERVICES

Hospital Services Planning and Policy

Certificate of Need (CON): January 1, 2010 through January 31, 2010

CONs Issued

Montgomery General Hospital (Montgomery County) – Docket No. 09-15-2293

Extend a building addition currently under construction by "fitting out" a shell third floor as a general medical/surgical unit and constructing 3 additional floors as shell space. Renovate space on three existing nursing units to convert patient rooms to other uses.
Cost $15,857,986

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

Maryland Home Health, LLC (Montgomery County) – Docket No. 07-15-2215
Provide general home health services to Montgomery County
Cost: $250,000

CON Letters of Intent

Mid Atlantic Health Care, LLC - (Charles County)
Establish a new 67-bed comprehensive care facility ("CCF") to be located at Industrial Park Drive, Tract 9B

Mid Atlantic Health Care, LLC – (Charles County)
Establish a new 67- bed CCF to be located at 5650 Washington Avenue

Mid Atlantic Health Care, LLC – (Charles County)
Establish a new 67-bed CCF to be located at 69 Crane Highway

Mid Atlantic Health Care, LLC – (Charles County)
Establish a new 67-bed CCF to be located at Doolittle Drive, Tract 21F

Mid Atlantic Health Care, LLC – (Charles County)
Establish a new 67-bed CCF to be located at 7450 Hawthorne Road

FutureCare-Old Court – (Baltimore County)
Add 30 CCF beds at FutureCare-Old Court in Randallstown, replacing and relocating 30 temporarily delicensed CCF beds at FutureCare-Northpoint in Baltimore

CON Applications Filed

Kaiser Permanente Baltimore Surgical Center (Baltimore County) – Matter No. 10-03-2306
Establish a free-standing ambulatory surgical facility with 2 operating rooms to be located at 1601 Odensos Lane, Baltimore
Estimated Cost: $9,091,490

NMS Healthcare of Hagerstown (Washington County) – Matter No. 10-21-2307
Add 43 CCF beds replacing and relocating beds from Homewood of Williamsport and replace 35 CCF beds
Estimated Cost: $15,084,498

Pre-Application Conference

FutureCare-Old Court (Baltimore County)
January 20, 2010

Mid Atlantic Health Care, LLC (Charles County)
January 20, 2010

Anne Arundel Medical Center (Anne Arundel County)
January 22, 2010

Comprehensive Nursing Services (Central Maryland)
January 26, 2010

Determinations of Coverage

- Ambulatory Surgery Centers

Coastal Cosmetic Surgery Center, LLC (Calvert County)
Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 70 Sherry Lane, Prince Frederick, Maryland

Lockwood Ambulatory Surgery Center, LLC (Montgomery County)
Establish an ambulatory surgery center with 2 non-sterile procedure rooms to be located at 10801 Lockwood Drive, Suite 260, Silver Spring, Maryland

- Capital Threshold

Shady Grove Adventist Hospital (Montgomery County)
Renovation of existing operating room (OR) space to create two cardiac catheterization laboratories and replacement of two ORs
Estimated Cost: $6,025,658

- Other

    - Delicensure of Bed Capacity or a Health Care Facility

LaPlata Center (Charles County)
Temporary delicensure of 10 CCF beds

Woodside Center (Montgomery County)

Temporary delicensure of 5 CCF beds

Knollwood Manor (Anne Arundel County)
Temporary delicensure of 19 CCF beds

Loch Raven Center (Baltimore County)
Temporary delicensure of 3 CCF beds

The Pines (Talbot County)
Temporary delicensure of 5 CCF beds

Laurelwood Care Center at Elkton (Cecil County)
Temporary delicensure of 26 CCF beds

Chesapeake Shores (St. Mary's County)
Temporary delicensure of 5 CCF beds

- <u>Relicensure of Bed Capacity or a Health Care Facility</u>

Manokin Manor Nursing & Rehabilitation Center (Somerset County)
Relicensure of 9 temporarily delicensed CCF beds

Allegany Nursing Home (Allegany County)
Relicensure of 2 of 15 temporarily delicensed CCF beds

Caton Manor (Baltimore City)
Relicense of 2 temporarily delicensed CCF beds

Perring Parkway Center (Baltimore County)
Relicensure of 1 temporarily delicensed CCF bed

Cromwell Center (Baltimore County)
Relicensure of 1 temporarily delicensed CCF bed

- <u>Relinquishment of Bed Capacity or a Health Care Facility</u>

Caton Manor
Relinquishment of 10 temporarily delicensed CCF beds

Perry Parkway Center (Baltimore County)
Relinquishment of 8 temporarily delicensed CCF beds

Cromwell Center (Baltimore County)
Relinquishment of 9 temporarily delicensed CCF beds

- <u>Miscellaneous</u>

Mercy Medical Center (Baltimore City)
Fit-out of shell space to add beds

Washington County Hospital (Washington County)
Fit-out of shell space to add beds

Upper Chore Community Mental Health Center (Kent County)
Closure of inpatient hospital services

Potomac Valley Nursing Facilities (Montgomery County)
Corporate reorganization

Jewish Social Services Agency
Provide hospice care to 1 terminally ill patient in Howard County (outside of approved jurisdiction)

- Waiver Beds

Rock Glen Nursing & Rehabilitation Center
Addition of 5 CCF waiver beds for a total of 120 CCF beds at the facility

Planning and Policy

On January 8, 2010, the Maryland Ambulatory Surgery Provider Directory, displaying data for CY 2008, was published on the MHCC web site. This annual publication contains survey data on ambulatory surgery in the general hospital and freestanding ambulatory surgical facility setting. This latest update includes information on 325 freestanding facilities and 47 general hospitals.

Hospital Quality Initiatives

Hospital Performance Evaluation Guide (HPEG) Advisory Committee

The HPEG Advisory Committee held its monthly meeting in January and continues to provide guidance on the various activities associated with the maintenance and expansion of the Hospital Performance Evaluation Guide (HPEG). Over the past month, the HPEG Committee has focused on issues surrounding the implementation of the new Quality Measures Data Center (QMDC), considered and approved proposed measures for inclusion in the Guide and reviewed the progress on HAI data collection, reporting and validation activities. Most recent accomplishments are highlighted below:

- *Collection of Data on Specialized Cardiac Care Services*

MHCC defines specialized cardiac care to include three major services: (1) emergency angioplasty referred to as primary percutaneous coronary intervention (pPCI) services, for certain types of heart attacks or ST elevation myocardial infarctions (STEMIs); (2) elective or non-primary PCI; and, (3) cardiac surgery. There are currently ten Maryland hospitals that offer all three specialized cardiac care services. In addition, thirteen Maryland hospitals without cardiac surgery on-site provide emergency angioplasty services under a waiver program established by the Commission.[1]

MHCC currently collects data on patients receiving specialized cardiac care services and is interested in adopting a new standard data set for each category of specialized cardiac care service that will provide high quality and timely data measuring the process and outcomes of care. To that end, the Commission distributed a request for public comment and stakeholder input on alternative approaches to the collection of data on specialized cardiac care services, including primary and non-primary PCI and cardiac surgery services. The Commission received numerous detailed comments from hospitals and interested parties and established a work group to develop recommendations for collection of performance data to monitor and assess the quality of specialized cardiac services in Maryland hospitals. The workgroup met in December and January and agreed upon an alternative strategy for a data collection and reporting system

[1] Nine of these hospitals have been approved by the Commission to participate in a research study of non-primary PCI in hospitals without cardiac surgery on-site.

for cardiac care services. The recommendations of the PCI workgroup have been posted for public comment. Comments are due by March 5, 2010.

- *Maryland Quality Measures Data Center Project*

The Quality Measures Data Center (QMDC) provides a web-based tool for hospitals to upload clinical quality measures and patient experience (HCAHPS) data required to be reported to the Commission. This initiative will not only accelerate the timely receipt of data directly from hospitals, but it will enable the Commission to validate the accuracy and completeness of the data as well. Hospitals have reported the 1st and 2nd quarter 2009 clinical measures and HCAHPS data to the QMDC and the data has been recently released on the Hospital Performance Evaluation Guide.

Healthcare-Associated Infections (HAI) Data

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

Since July 1, 2008, Maryland hospitals have been required to use the National Healthcare Safety Network (NHSN) surveillance system to report data to the Commission on Central Line-Associated Blood Stream Infections (CLABSI) in any ICU. Hospitals are required by NHSN to report data in the system within 30 days following the end of the month. The Commission has collected several months of CLABSI data and initiated an independent quality review of the data prior to public release of the information on the Hospital Guide. The Commission has engaged the services of a contractor with expertise and experience in auditing healthcare infections data. The contractor, APIC Consulting Services, Inc., has completed the on-site reviews and is now preparing the preliminary summary of findings for staff review.

- *American Recovery and Reinvestment Act (ARRA) Grant Funding*

On September 4, 2009, the Centers for Disease Control and Prevention (CDC) announced the award of a $1.2 million grant to Maryland under the American Recovery and Reinvestment Act (ARRA) to enhance the prevention of healthcare-associated infections (HAI). The grant is a collaborative effort involving the Department of Health and Mental Hygiene, Maryland Health Quality and Cost Council, and the Maryland Health Care Commission. The funds available under this program will build on the Commission's HAI initiatives and enable Maryland to strengthen its data collection, reporting, and analysis infrastructure to meet the challenge of preventing HAI. The grant will support two Health Policy Analyst positions. The staff has completed the recruitment process and has hired two employees to support this project.

- *Active Surveillance Testing (AST) for MRSA in All ICUs Survey*

The results of the 3rd quarterly survey for collecting data on Active Surveillance Testing (AST) for MRSA in All ICUs have been submitted by hospitals. It is important to note that this is a process measure that evaluates the rate of hospital screening (AST) for MRSA in all ICUs. It is not an outcome measure that evaluates the rate of MRSA colonization or infection in the hospital. The survey results have been included, for the first time, in the January 2010 update of the Hospital Guide.

Other Activities

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

Specialized Services Policy and Planning

Since January 2006, the Commission's STEMI Registry has provided audited data on STEMI patients presenting at hospitals that have a waiver to provide primary percutaneous coronary intervention (pPCI) services without on-site cardiac surgery. The pPCI waiver hospitals must enter their final STEMI Registry data into the database no later than February 25, 2010.

In the State Health Plan for Cardiac Surgery and Percutaneous Coronary Intervention Services (COMAR 10.24.17), the Commission established the following policies concerning the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and hospitals that provide pPCI, including balloon angioplasty: MIEMSS should develop and implement a protocol that will triage appropriate acute myocardial infarction patients to a primary angioplasty center; and, in consultation with the Maryland Hospital Association, the Department of Health and Mental Hygiene, and the Commission, MIEMSS should develop regulations for the designation of primary angioplasty centers. MIEMSS is governed by the State Emergency Medical Services Board; the EMS Board has approved a proposal to adopt new regulations that will provide standards under which MIEMSS may designate a hospital as a Cardiac Interventional Center. Under the proposed regulations, designation by MIEMSS will be voluntary for a hospital. Notice of the proposed action was published in the *Maryland Register* on January 29, 2010.

CENTER FOR HEALTH INFORMATION TECHNOLOGY

Health Information Technology

Staff reviewed the draft *Ambulatory Surgical Center Health Information Technology* report with representatives from the Maryland Ambulatory Surgical Association (MASA). Staff plans on incorporating MASA's comments into the final version of the report. MASA participated in the survey design and provided support in drafting the questions. The survey assessed the freestanding ambulatory surgical centers (FASCs) in Maryland on health information technology (HIT) adoption and planning activities as it relates to the seven key areas discussed in the report, such as electronic health records (EHRs) and computerized physician order entry (CPOE). Among the unique findings is that FASCs in the Baltimore metropolitan area lead the other regions in the state in HIT adoption, and that single specialty FASCs are more advanced in their HIT adoption than the multi-specialty FASCs. The MHCC will release the final report in March.

Staff is in the process of drafting the *Hospital Health Information Technology Survey* (survey) report. This is the second year that the MHCC collected data on HIT from acute care hospitals in Maryland. The survey assessed the rate of HIT adoption and planning efforts underway in the 47 acute care hospitals. The report includes aggregate findings based on size, geographic location, and affiliation with other hospitals and health systems. The report will also include HIT adoption trends, implementation, and utilization at the state and national levels. This survey is unique in that it assesses hospital planning efforts that national surveys do not take into account. A key finding from the survey is that CPOE adoption increased by nearly nine percent from the prior year. Staff is currently working with several hospital chief information officers to review and provide input on the draft. Staff anticipates releasing a final report in May.

A requirement under HB706, *Electronic Health Record – Regulation and Reimbursement,* is for the MHCC to designate one or more management service organizations (MSOs) by October 2012. Staff invited approximately 30 stakeholders to take part on an Advisory Panel to discuss MSO designation

criteria. MSOs are considered a viable alternative to the traditional EHR client-server model where the technology is maintained at the provider site. These organizations are capable of supporting multiple EHR products at reduced costs through economies of scale and bulk purchasing. The Advisory Panel is planning to meet again in February to continue its criteria development discussion. Staff plans to finalize the criteria during the third quarter of 2010 and begin accepting applications prior to the end of the year.

In January staff released the *Electronic Health Record Assessment of Maryland Nursing Homes* environmental scan brief (brief). This brief assessed the adoption of EHRs among approximately 51 independent nursing homes in Maryland. Nursing homes with an affiliation to an organization were excluded from the assessment as they tend to be more technologically advanced and have greater access to funding for technology adoption. The brief focused on four areas: computerized functions, EHR implementation, adoption barriers, and importance. Staff has invited nursing home administrators for independent nursing homes to participate in a discussion that explores opportunities to collaborate on potential EHR adoption solutions. Key areas for collaboration include bulk purchasing of standalone client server-based EHRs and the potential for utilizing an MSO. Approximately 39 nursing home administrators will take part in this discussion at the MHCC on February 16th.

Staff continues to provide support to the Centers for Medicare and Medicaid Services (CMS) on their EHR Demonstration Project (project), which has been underway since June for nearly 120 physician practices in Maryland. Last month, staff provided several links to EHR adoption assessment tools that can assist the approximately 60 physician practices that have not adopted an EHR in the evaluation and selection process. Participants can earn up to $290,000 over five years by demonstrating the adoption of EHRs and reporting select quality measures to CMS. Physician practices must implement an EHR system by May 2011 to remain in the project. CMS has limited this project to four states: Maryland, Louisiana, PA, and South Dakota.

Health Information Exchange

Staff participated in several Chesapeake Regional Information System for our Patients (CRISP) Advisory Board Committee meetings relating to the implementation of the statewide health information exchange (HIE). In January, the Technology Committee reviewed the responses to CRISP's Request for Proposal to identify technology vendors for the Master Patient Index, Medication History, and Core Infrastructure. The Technology Committee will invite the top three vendors to present on their technology solution in February. CRISP is on target with their established timeline for recommending key vendors to the MHCC in April. The Technology Committee is also assessing the viability of the Medication History Use Case (services). CRISP is exploring the viability of this Use Case now that SureScripts has made it commercially available. The Technology Committee plans to make a recommendation in January on the viability of this Use case.

The HIE Policy Board, which consists of about 25 members, met for the second time in January. The Policy Board has general oversight of the statewide HIE. At the January meeting, CRISP reviewed the architecture of the HIE and addressed questions among the members relating to the design of the infrastructure. Staff also reviewed a list of key policies that the Policy Board plans to begin deliberating on during the March meeting. Key policies for consideration at the next meeting include access, authentication, authorization, and audit. CRISP also expects to identify additional policies for the Policy Board that need development to support the implementation of the initial Use Cases. The Policy Board is scheduled to meet eight times in 2010 and will focus their efforts primarily on developing policies regarding consumer authorization and consent, user authentication, role-based authorization, security requirements, and audit trail requirements.

The Office of the National Coordinator for Health Information Technology (ONC) provided feedback on the state's response to the *Health Information Exchange Cooperative Agreement*. ONC requested additional information, which staff provided in January. ONC also provided feedback on the *Health Information Technology Extension Programs: Regional Centers Cooperative Agreement Program*

submitted by CRISP, the lead applicant. Staff provided support to CRISP in responding to ONC's request for additional information prior to the end of the month. A funding decision by ONC on both grant applications is scheduled for early 2010.

Staff provided support to the Howard County consortium responding to ONC's *Beacon Community Cooperative Agreement* grant application released in January. The consortium consists of nearly 20 provider organizations in Howard County that will serve as a community for the grant application; Johns Hopkins Health System is the lead organization. This grant will provide funding to approximately 15 communities that already have an HIT infrastructure in place to build and strengthen their HIT infrastructure; demonstrate where providers and patients are meaningful users of HIT; and to achieve measurable improvements in health care quality, safety, efficiency, and population health. The average funding amount is approximately $15M and the grant is for approximately 36 months. Applications are due by February 1st; ONC anticipates making an award announcement in March.

Staff continued drafting the *HIT Planning Advanced Planning Document* (HIT P-APD) for the Maryland Medical Assistance Program (Medicaid). The objective of the HIT P-APD is to describe how the state will develop a high-level management statement of the state's vision, needs, purposes/objectives, plans, and estimated costs, which will result in the development of the *State Medicaid HIT Plan* (SMHP). CMS has funding available for planning activities that will lead to the development of the SMHP. CMS's approval of Medicaid's HIT P-APD application could secure 90 percent of federal financial participation (FFP) funds for these planning activities, or roughly $1.5M. These funds can also be used to develop a process that the state will use to oversee the *American Recovery and Reinvestment Act of 2009* (ARRA) incentive payments made to eligible Medicaid providers. Staff anticipates completing the application in February.

Staff continues to provide support to the Electronic Healthcare Network Accreditation Commission (EHNAC) in their effort to develop a national accreditation program for HIEs. EHNAC has more than 30 national stakeholders participating on an Advisory Panel to assist in the development of the accreditation criteria. EHNAC has retained a consultant to assist in vetting the proposed criteria to subject matter experts from around the country. The Advisory Panel will use the feedback obtained from the consultant to modify the draft criteria. EHNAC expects completing modifications to the criteria in March before publishing the proposed criteria for public comment. The Utah Health Information Network (UHIN) is currently beta testing the current version of the proposed criteria. The UHIN is a value-added network for administrative transactions that several years ago began exchanging limited clinical data.

Electronic Health Networks & Electronic Data Interchange

The Maryland Board of Pharmacy recently modified existing regulation COMAR 10.34.20 – *Format of Prescription Transmission* to require intermediaries who transmit prescriptions electronically to pharmacies to be certified by the MHCC. Last month, staff convened a virtual meeting with roughly 25 pharmacy e-prescribing software vendors that are also intermediaries to discuss the change in the regulations. Intermediaries that route transactions through a certified administrative network are not affected by these regulations. Staff plans to work with EHNAC to explore developing criteria for the certification of intermediaries that send transactions directly to a pharmacy. Staff has initiated the certification process for five administrative networks that will need recertification in February: RealMed, Relay Health, GHN On-Line, Herae, and Passport Health.

National Networking

Staff attended the eHealth Initiative's Annual Conference on *Delivering the Promise of eHealth*. This conference discussed the rapidly changing world of HIT and highlighted specific examples of how HIT is being implemented across the country, as well as raised questions about the ability of the country to move towards universal, meaningful use of HIT. Staff participated in two webinars hosted by the eHealth Initiative: the first, *Dissecting the Meaningful Use Proposed Rule*, which provided an overview of

meaningful use, policy vision, and goals; and the second, *E-Prescribing 2.0 Meaningful Use and Care Coordination*, discussed the challenges and barriers of the Federal e-prescribing program.

Staff also participated in two HIMSS webinars: *Understanding the Meaningful Use Proposed Rule and the Certification Criteria Interim Final Rule, What You Need to Know Now*, which provided an overview of all aspects of the meaningful use proposed rule; and *Translating from Theory to Practice Certification Criteria and Standards for Obtaining Meaningful Use,* which provided an overview on meaningful use and certification of EHR technology. Modern Healthcare also hosted a webinar entitled *The Search for Meaning--and Money--in 'Meaningful Use' Regulations,* which provided an overview on the key sections of the regulations that have an impact on hospitals, health systems, and physicians.