MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

March 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 $309,385 in February. 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
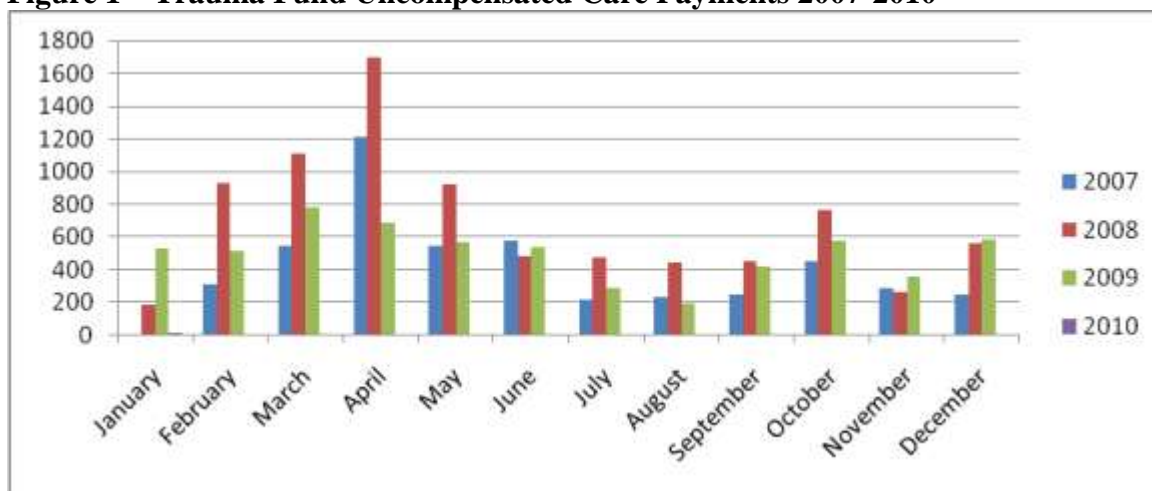
Patient Centered Medical Home Workgroup
Kathleen White, PhD, RN, and Ben Steffen presented an update regarding the activities of the Patient Centered Medical Home Workgroup to the Maryland Health Quality and Cost Council on March 1, 2010.

The Patient Centered Medical Home Workgroup assisted with the bill hearing on HB 929 on March 11th. Twelve members of the Workgroup testified in support of the bill. The medical and

specialty societies testified in support, but offered an amendment that would strike nurse practitioners from the bill. The bill hearing in the Senate will be held Tuesday March 16th.

The MHCC has released an RFP seeking assistance in developing the payment formula for the PCMG program. Responses are due the week of March 15th.

 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.

Data and Software Development

Internet Activities

Total traffic, measured by unique visitors, to the MHCC website was stable with January 2010 even though there were 3 fewer days in the month. Total traffic was up by 12 percent from February 2009. The number of first time visitors held steady at about 42 percent. The length of time a visitor spent on the site was constant with January 2010, although the number of page views decreased by nearly 20 percent.

The largest plurality (43 percent) of visitors to the site arrives directly by entering the MHCC URL (mhcc.maryland.gov) or a subfolder for our URL (mhcc.maryland.gov/hospitalguide for example) 43 percent.   The percent of unique visitors who arrived through search engines, such as Google, decreased stood at 39 percent.   Google alone direct the same percent of visitors to our site as last month, more than 25 percent of all unique visits and nearly 50 percent of all new visits. The most common keyword searches were: "Maryland Health Care Commission;" "mhcc;" "Maryland Healthcare;" and "Maryland Health Care Commission Long Term Care Survey Adult Day Care." The remaining 18 percent of visitors were referred from other state agencies website. The DHMH website was the most common referring site, followed by the Maryland Web Portal (Maryland.gov).

Figure 2 -- Unique Visitors to the MHCC Web Site
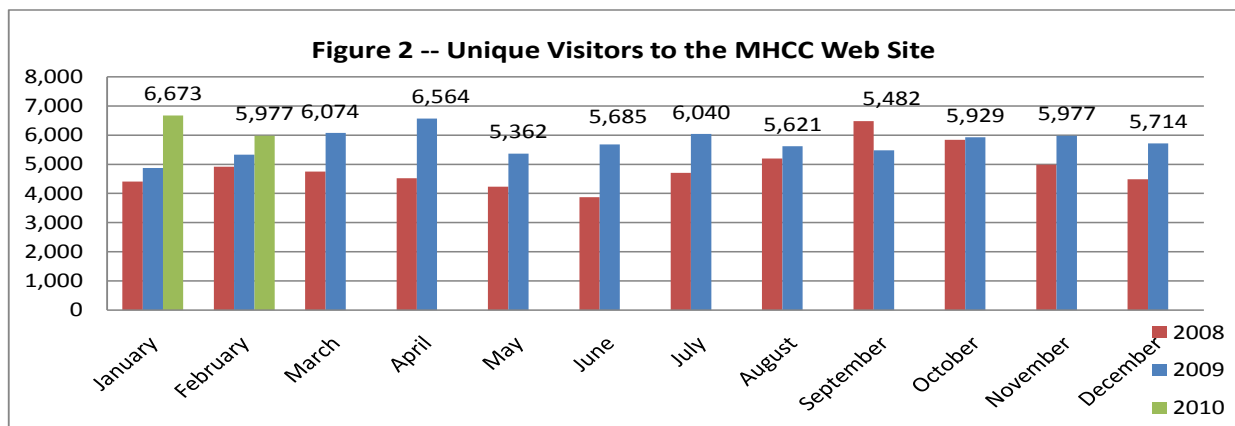
Web Development for Internal Applications
Table 1 presents the status of development for internal applications and for the health occupation boards. In the upcoming months, MHCC staff will add several new capabilities to the website, the first of which will be a listserv capability, which is not available for several projects at the Commission. Planning is underway for several new projects, including a Physician/Health Professional Portal that will integrate information on all projects that are of interest to health professionals in Maryland. The second effort is a redesign of the Hospital Quality website. A combination of internal and contract resources will be used for this effort.

Table 1– Web Applications Under Development

Board	Anticipated Start Development/Renewal	Start of Next Renewal Cycle
MHCC Listserv	Completed	Available as of December 2009
Nursing Home Survey Redesign	Underway	March 2010
MHCC Assessment	Complete	Underway
MRSA Collection Application	Under Development	April 2010
Health Insurance Compare	Proposals being Evaluated	February 2010
Physician Portal	Planning	February 2010
Hospital Quality Redesign	Planning	Spring 2010

Cost and Quality Analysis

Maryland Medical Care Data Base (MCDB) and Data Collection Regulations
The Commissioners will be asked to finalize the proposed replacement regulations for the Maryland Medical Care Data Base (COMAR 10.25.06) at the March 18th meeting. The Commission received no comments on the proposed regulations during the 30-day comment period, which ended on February 5th. The replacement regulations will modify and expand the MCDB reporting requirements for payers operating in Maryland. The replacement regulations will expand the scope of information in the MCDB to include information on institutional services—primarily hospital inpatient and outpatient services—and eligibility information for the enrollees with coverage for medical and pharmacy services, including demographic characteristics of the enrollee and insurance contract information such as date of enrollment and type of coverage. These data, when combined with the information on physician services and prescription drugs currently submitted by the payers, will allow the Commission to provide a more complete picture of health care utilization and spending for insured Maryland residents and will bring Maryland's data collection more in line with similar initiatives now underway in Massachusetts, New Hampshire, Vermont, Maine, Minnesota, and Utah.

Medical Expenditure Panel Survey – Insurance Component, Maryland Sample through 2008
This report has been completed and will be presented at the March Commission meeting. The report describes key characteristics of health insurance coverage through Maryland private-sector employers in 2008, using publically available information from the Medical Expenditure Panel Survey – Insurance/Employer Component. The vast majority of employees in Maryland's private-sector employers—88%—work for an employer that offers health insurance. This *offer rate* is essentially unchanged since 1996 and the same as the national rate in 2008. The offer rate generally increases with

firm size: the smallest firms (less than 10 employees) had an average offer rate of 49% while the largest firms (1000+ employees) had an average rate of 99%.

Unlike the offer rate, the *enrollment rate*—the percent of employees at establishments that offer health insurance who are enrolled—declined in Maryland from 2005 to 2008 (67% to 61%). This decline was due to lower enrollment rates in two industry categories: agriculture, fishing, forestry, and construction (78% to 65%) and all others* (85% to 71%). In these categories, the offer rates did not change, but the number—and likely the occupations—of workers did: construction, etc. grew by 39%, all others shrank by 32%, and their eligibility rates declined significantly. These changes are reflected in an apparent decrease in the overall percentage of private sector workers in Maryland who were enrolled in health insurance plans offered by their employers from 2005 to 2008 (59% to 53). However, most of the workers who did not enroll in their employers' plans obtained coverage from another source (spouse's employer, direct purchase, public coverage), resulting in an 82% insured rate among the state's private sector, nonelderly adult workers in 2007–2008 (Current Population Survey), a rate higher than the national average (79%). (*All Others = utilities; wholesale trade; transportation & warehousing; finance & insurance; real estate, rental & leasing; management of companies)

Health Care Spending in Maryland: How does it differ from other states and why?
This report—the first in the new health care expenditure comparison series—has been completed and will be presented at the March Commission meeting. The report compares per capita personal health care spending in Maryland to other states—both levels of spending and changes over time. Data documenting different aspects of the health care environment—demographic and socio-economic characteristics of residents, supply side and market characteristics, and policy choices—are discussed in order to provide a multidimensional context for examining the variation in spending across states. This type of comparative analysis requires state data that are consistently generated, using identical methods. The only available source is spending estimates created by the Centers for Medicare and Medicaid Services for the years 1991 to 2004. While the data are not as current as desirable, the patterns and forces influencing spending can provide insights into current spending patterns. Regression analyses using these data—with per capita spending as the outcome and demographic, supply, market and policy characteristics as the inputs—are used to identify the factors most strongly associated with health care spending.

Key findings from the report include:
- In 2004, per capita health care spending Maryland averaged $5,590, 6 percent above the national average and 17th highest among the 50 states.
- The average annual growth rate for Maryland was 4.2 percent from 1991 to 1998, increasing to 7.2 percent from 1998 to 2004. For the United States overall, the average annual rate of growth was somewhat higher than Maryland in the earlier period (4.8 percent) and somewhat lower in the later period (6.3 percent). More recent data shows the average annual growth rate in the United States continuing to decline through 2008.
- Underlying geographic variation in health care spending are differences in utilization of services and the prices paid for those services. Utilization is driven by a range of complex and interrelated factors; health status is a major determinant and is in turn influenced by health behaviors, age, income, race/ethnicity, and other sociodemographic characteristics. These interrelationships are difficult to disentangle.
- Together, the 25 factors examined in this report accounted for 90 percent of the per capita variation in health care spending; however only seven factors were found to be significantly associated with per capita spending: 1) proportion of the population in fair or poor health; 2) short-term hospital beds per capita; 3) physicians per capita; 4) SNF beds per capita; 5) Medicaid enrollment generosity; 6) hospital per diem costs; and 7) average insurance premiums.

Health Plan Quality and Performance

The *2009/2010 Comprehensive Performance Report* has been completed by our contractor NCQA and was posted to the MHCC website at the end of February. 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 a few weeks. 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. Unfortunately, negotiations with the franchisee, the Mid-Atlantic Business Group on Health, for the 2010 evaluation period have stalled and we do not anticipating providing eValue8 information in the 2010 reports. Staff met with NCQA's recently appointed VP for Strategy and Quality Solutions to discuss improvements to NCQA's draft proofing protocol and to identify potential opportunities to expand the measurement tools so as to produce a more robust performance report.

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 will be selected by the end of 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 March 9, 2010 enrollment in the Partnership was as follows: 247 businesses; 697 enrolled employees; 1,177 covered lives. The average annual subsidy per enrolled employee is $2,231; the average age of all enrolled employees is 39; the group average wage is approximately $28,000; the average number of employees per policy is 3.9; and the total subsidy amount allocated is more than $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. Several proposed mandates are currently under consideration during the 2010 legislative session.

Long Term Care Policy and Planning

Hospice Data
The FY 2009 Maryland Hospice Survey has been released for online data entry as of February 23, 2010. Programs received notification via certified mail and email when the survey was ready for data entry. Staff will monitor data entry progress with OCS, the contractor for this survey.

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. The most recent conference call to address these issues was held on February 22nd.

Nursing Home Occupancy
On an annual basis, the Commission updates and publishes data on nursing home occupancy and Medical assistance participation rates. This data is used for health planning, data analysis, and Certificate of Need. The tables include occupancy rates by jurisdiction and region and required Medical Assistance participation rates by jurisdiction and region. The tables are scheduled to be published in the March 12th issue of the *Maryland Register.*

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
Data cleaning has been completed for the FY 2008 Home Health Agency Survey. For the FY 2009 survey, for Phase 2 agencies-those agencies with fiscal year ending dates of September 30, and December 31, 2009- data collection began on March 1, 2010. Training is being offered to agency staff during March. The due date for data submission for Phase 2 agencies is May 29, 2010.

Long Term Care Survey
The data cleaning of the FY 2008 Long Term Care survey has been completed. Staff will create the public use data sets and other reports this week, and then data will be available on the Commission's website shortly thereafter. This data is also being used to update the Nursing Home and Assisted Living Guides.

Development of the 2009 Long Term Care Survey is in the final stages; staff continues to test the application and update the specifications where applicable to enhance error resolutions. The survey is scheduled for an early release date two months earlier than previous years.

Long Term Care Quality Initiative

LTC Website Expansion
Staff met with the selected contractor to finalize the project work plan and deliverables schedule. Phase 1 of the expansion consists of extensive review by the contractor of proposed content and technical requirements. Phase 2 will result in a preliminary creative design brief at the end of four-six weeks. The second phase also involves stakeholder feedback to confirm various features of the proposed design. Phase three is the longest phase, building and testing the site over a 6-10 week time period. The final phase includes testing, documentation, installation on MHCC network, training of staff as needed, and project wrap-up. Barring unforeseen delays, the project is expected to be completed by summer 2010.

Nursing Home Surveys
A Request for Proposals (RFP) to secure a contractor to conduct the surveys for calendar years 2010-2014 resulted in receipt of five proposals which will be evaluated by a review team. A contract award will be made before July 1, 2010, when the next survey cycle is scheduled to begin.

Racial and Ethnic Disparities

Dr. Fadia Shaya at University of Maryland School of Pharmacy is applying for a grant entitled "ARRA OS: Recovery Act 2009 Limited Competition: Enhanced State Data for Analysis and Tracking of Comparative Effectiveness Impact: Improved Clinical Content and Race-Ethnicity Data (R01) " One of the objectives of the grant is to provide organizations that collect statewide all-payer, hospital-based encounter-level data (inpatient, emergency department, and ambulatory surgery) the capacity to improve the reliability and validity of information in hospital-based encounter-level data related to race and ethnicity. Dr. Shaya's research proposal has the following three objectives:

Aim 1: Assess the gaps in documentation on race and ethnicity for hospital hospital-based encounter-level data

Aim 2: Build documentation and setup collection methods for race and ethnicity data in hospital hospital-based encounters

Aim 3: Determine methods for establishing the validity and reliability of race and ethnicity for hospital hospital-based encounter-level data

HSCRC will provide data and input for implementing the project and Dr. Şule Çalıkoğlu, Senior Health Policy Analyst, Center for Health Care Financing and Policy will provide analytical support on behalf of the Commission.

CENTER FOR HOSPITAL SERVICES

Hospital Services Planning and Policy

Certificate of Need (CON): February 1, 2010 through February 28, 2010

CONs Issued
A.F. Whitsitt Center (Kent County) – Docket No. 09-12-2305
Addition of 16 intermediate care facility beds at facility

CONs Denied
None

Modified CONs Issued
Lorien LifeCenter- Howard (Howard County) – Docket Nos. 06-13-2185 and 08-13-2246
Change in project design and an increase in cost of the proposed nursing facility
Cost Increase: $1,909,685

Approved CON's Relinquished by Applicant
Southern Maryland Hospital Center (Prince George's County) – Docket No. 06-16-2179
Construction of 2 additional floors to Bed Tower II and renovations to the existing hospital
Cost: $43,516,251

CON Applications Withdrawn
None

CON Applications Dedocketed or Returned by Commission
None

Pre-Licensure/First Use Approval Issued (Completion of CON-Approved Projects)
Shady Grove Adventist Hospital (Montgomery County) – Docket No. 04-15-2138
Construction of a 4-story addition, including six new inpatient nursing units with 144 private rooms, a new surgery department, with an increase from 16 to 18 operating rooms, and an expanded emergency department, and renovations to the existing hospital.
Cost: $98,954,260

CON Letters of Intent
Montgomery General Hospital (Montgomery County)
Addition of 2 operating rooms to the hospitals capacity

CON Applications Filed
Anne Arundel Medical Center (Anne Arundel County) – Matter No. 10-02-2308
Build out of the 6th floor shell space approved in CON 04-02-2153 as a 30 bed medical/surgical unit.
Cost: $5,243,815

Pre-Application Conference
None

Application Review Conference
None

Determinations of Coverage

- **Ambulatory Surgery Centers**
Bay Surgery Centers-Kent Island, LLC (Queen Anne's Co.)
Establish an ambulatory surgery center with1 non-sterile procedure room to be located at120 Sallitt Drive, Suite D, Stevensville, Maryland

Bay Surgery Centers-Glen Burnie, LLC (Anne Arundel Co.)
Establish an ambulatory surgery center with 1 non sterile procedure room to be located at 7671 Quarterfield Road, Suite 301, Glen Burnie, Maryland

Riva Road Surgery Center (Anne Arundel Co.)
Expand center through the leasing and renovation of adjacent space

Arundel Ambulatory Surgery Center (Anne Arundel Co.)
Change in ownership structure of the surgery center

- **Capital Threshold**
None

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

Signature HealthCARE at Mallard Bay (Dorchester County)
Temporary delicensure of 26 CCF beds

  - **Relicensure of Bed Capacity or a Health Care Facility**
None

  - **Relinquishment of Bed Capacity or a Health Care Facility**
None

  - **Miscellaneous**
The Village at Carsins Run (Harford County)
Proposed construction of a new comprehensive care retirement community with 21 independent living cottages, 162 independent living apartments, 10 assisted living beds and 10 comprehensive care facility beds.

- **Waiver Beds**
None

Planning and Policy

A ***Report on the Operations, Utilization, and Financing of Freestanding Medical Facilities*** was prepared as required under the *Freestanding Medical Facilities – Licensing and Pilot Project* law. The *Freestanding Medical Facilities—Licensing and Pilot Project* law requires the Commission, in consultation with the Health Services Cost Review Commission (HSCRC), to conduct a study of the operations, utilization, and financing of freestanding medical facilities, using information collected from the pilot project sites. The findings of this study are to be reported to the Senate Finance Committee and the House Health and Government Operations Committee.

On February 1, 2010, Staff met with Nancy Grimm and other OHCQ staff to talk about issues of mutual interest to both agencies. On February 23, 2010, Staff met with a work group from the Maryland Ambulatory Surgery Association to review proposed revisions to the Survey of Freestanding Ambulatory Surgery Facilities for the 2009 reporting period.

Hospital Quality Initiatives

Hospital Performance Evaluation Guide (HPEG) Advisory Committee

The HPEG Advisory Committee held its monthly meeting on February 22, 2010 and continues to provide guidance on the various activities associated with the maintenance and expansion of the Hospital Performance Evaluation System. Most recent accomplishments are highlighted below:

- *Updates to the Maryland Hospital Performance Evaluation Guide*

Over the past month, the staff has focused on the analysis and reporting of hospital utilization data for high volume cases including Maternity and Newborn cases. The Hospital Guide has been updated to include FY2009 volume and length of stay information for the 50 top Diagnosis Related Groups in Maryland hospitals. The staff has also completed the data analysis to update Maternity and Newborn statistics for FY2009. It is important to note that each hospital was given the opportunity to preview their data before it was displayed on the Guide.

- *Maryland Quality Measures Data Center Project*

The Maryland Quality Measures Data Center (QMDC) was established in 2009 under contract with the Iowa Foundation for Medical Care (IFMC). The QMDC provides a web-based tool for hospitals to upload clinical quality measures and patient experience (HCAHPS) data required to be reported to the Commission. Hospitals have reported the 1st and 2nd quarter 2009 clinical measures and HCAHPS data through this new system and the updated data was released on the Hospital Performance Evaluation Guide in January. The deadline for submission of 3rd quarter 2009 clinical and HCAHPS data was March 8, 2010 and all hospitals met the reporting deadline.

The contract with IFMC also incorporates a data validation component that is currently underway. The validation component includes an on-site review of a sample of patient medical records to ensure that the hospital record supports the quality measures data submitted to the MHCC. The first phase of the validation project focuses on the 1st and 2nd quarter 2009 clinical process measures data reported by 24 hospitals. The results of the data review will be posted to the secure area of the QMDC website for hospital access and review. The staff anticipates the completion of the 1st and 2nd quarter review with a summary report on findings next month.

- *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]

To develop a strategy for collecting PCI data from all Maryland hospitals, the Commission formed a PCI Data Work Group in December 2009. The workgroup met in December and January and developed the following recommendations:

> Recommendation 1. The Work Group recommends that Maryland adopt the NCDR CathPCI Registry® tool.

> Recommendation 2. The Work Group recommends that Maryland adopt the ACTION Registry®-GWTG™ tool.

> Recommendation 3. The Work Group recommends the establishment of an ongoing Cardiac Data Advisory Committee to review data collected, interpret and adjudicate the data, and make recommendations to the Maryland Health Care Commission.

These recommendations were posted on the Commission's website for public comment with comments due by March 5, 2010. In response to this notice, the Commission received comments from 12

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[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.

organizations with the overwhelming majority of comments in support of the proposed data collection approach of the workgroup. Detailed information on the activities and recommendations of the PCI workgroup are available on the MHCC website at:
http://mhcc.maryland.gov/hospital_services/specialservices/cardiovascular/pci_data_workgroup_12210.html The Commission will now take steps to organize the Cardiac Data Advisory Committee and develop an implementation plan.

Healthcare -Associated Infections (HAI) Data
- *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. These additional resources will enable the staff move forward on the implementation of new Surgical Site Infection data collection that is scheduled to become effective July 1, 2010. The additional resources will also enable the staff to establish and coordinate the activities of the committees and sub-committees that are required to fulfill the various components of the grant.

The Healthcare Associated Infections (HAI) Advisory Committee held its monthly meeting on February 24, 2010 to review and discuss a variety of activities related to HAI prevention and control. During the meeting, the group voted to adopt a Mission and Vision Statement that reflects the expanded scope and role of the group as a result of the ARRA Grant activities. The mission and vision statement of the Advisory Committee has been posted to the website and is provided below for your convenience:

MISSION:
The Maryland Healthcare-Associated Infections (HAI) Advisory Committee's mission is to identify specific HAI prevention targets for Maryland consistent with the priorities established by the State of Maryland and U.S. Department of Health and Human Services, identify evidence-based practices needed to achieve and sustain progress in protecting patients in Maryland from the transmission of HAIs that are serious and cause increased morbidity and mortality, and monitor and communicate progress in meeting prevention targets on an on-going basis.

VISION:
The Maryland Healthcare-Associated Infections (HAI) Advisory Committee's vision is for Maryland to become a national leader among the states in the area of preventing and controlling HAIs.

- *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. MHCC staff, in collaboration with the vendor, are preparing the final report of findings for review by the HAI Committee at the March 24th meeting.

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

The results of the 4th quarter 2009 survey collecting data on Active Surveillance Testing (AST) for MRSA in All ICUs have been received from all hospitals. The staff has distributed the results of the 4th quarter surveys to hospitals for preview before display on 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

The Mid-Atlantic Affiliate of the American Heart Association (AHA) invited a broad constituency of health and clinical colleagues from within the Mid-Atlantic Affiliate states to participate on March 3rd in the first in a series of webinars on ST-Elevation Myocardial Infarction (STEMI) systems of care. The Mid-Atlantic Affiliate serves Maryland, the District of Columbia, Virginia, North Carolina, and South Carolina. The webinar focused on Mission: Lifeline from the national perspective, and on the ACTION Registry–GWTG (Get With The Guidelines) and how this registry for acute coronary syndrome patients relates to Mission: Lifeline as the data source for AHA's community-based initiative. Dr. Alice Jacobs, Professor of Medicine at the Boston University School of Medicine, Past President of the American Heart Association, and Chair of the national Mission: Lifeline Advisory Work Group, discussed the national view of Mission: Lifeline and presented a progress report. Dr. Matthew Roe, clinical cardiologist and Associate Professor of Medicine at Duke University and Chair of the ACTION Registry–GWTG Research and Publications Committee, described the premier and limited versions of the ACTION Registry–GWTG and presented national data on trends in the reperfusion of STEMI patients. Commission staff and approximately 35 attendees representing 14 hospitals in Maryland participated in the webinar.

Updated in 2009, the American College of Cardiology (ACC)/American Heart Association Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction, and the ACC/AHA/Society for Cardiovascular Angiography and Interventions (SCAI) Guidelines on Percutaneous Coronary Intervention jointly recommend the following: "Each community should develop a STEMI system of care that follows standards at least as stringent as those developed for the AHA's national initiative, Mission: Lifeline." AHA's Mid-Atlantic Affiliate has allocated funding to support a state-wide Mission Lifeline meeting in Maryland to bring together regional representatives from across the state to work on strengthening STEMI systems of care and improving outcomes for patients in their respective regions. The workshop is scheduled to be held on Saturday, May 22, 2010, at Anne Arundel Medical Center's Conference Center in the Health Sciences Pavilion, 2000 Medical Parkway, Annapolis, Maryland.

Health Information Technology

The Management Service Organizations (MSO) Criteria Development Advisory Panel (Advisory Panel) reconvened in February to review stakeholder comments on the draft criteria for MSOs that seek state designation. The Advisory Panel consists of a broad group of stakeholders that began working last fall to develop a set of criteria that can be used in designating MSOs in Maryland. A requirement under HB 706 is for the MHCC to designate one or more MSOs by October 2012. MSOs are considered a viable alternative to the traditional electronic health records (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. Staff plans to finalize the criteria during the third quarter and anticipates accepting applications from MSOs by the end of the year.

Staff met with representatives from CareFirst and United Healthcare to discuss proposed EHR incentives options. Staff plans to meet with the other large private payers in March. Staff asked payers to provide recommendations for incentives consistent with House Bill 706 (HB 706), *Electronic Health Record – Regulation and Reimbursement*, which was signed into law on May 19, 2009 by Governor Martin O'Malley. Among other things, the law requires state-regulated payers to provide monetary incentives for the adoption and meaningful use of EHRs beginning in 2011. Maryland is the first state to build on the Medicare and Medicaid adoption incentives under the *American Recovery and Reinvestment Act of 2009*, requiring state-regulated payers to provide incentives for the adoption of EHRs. Staff plans to review the proposed incentive recommendations with the other large private payers in March.

Staff incorporated comments from the Maryland Ambulatory Surgical Association (MASA) into the draft *Ambulatory Surgical Center Health Information Technology* report. Last month, the MASA was asked to review and provide comment on the draft. The survey assessed health information technology (HIT) among the freestanding ambulatory surgical centers on their adoption and planning efforts in seven key areas of HIT. These areas include technology such as electronic health records (EHRs), computerized physician order entry, electronic medication administration records, barcode medication administration, electronic infection surveillance, electronic prescribing, and electronic health information exchange. The final report will be released in March. Staff is in the preliminary stages of working with the MASA to make some modification to the survey for next year.

Staff is in the final stages of completing the initial draft of the second annual *Hospital Health Information Technology Survey* (survey) report. The survey assesses the rate of HIT adoption and planning activities in the 47 acute care hospitals. This survey is similar to several surveys administered nationally that assess HIT adoption; however, it's unique in that it includes planning questions in an effort to better understand the future of HIT adoption. The findings are presented in aggregate, based on size, geographic location, and affiliation with other hospitals and health systems and it will compare Maryland's progress in HIT adoption with national activity. In general, hospitals increased their adoption of HIT with EHRs, e-prescribing, and clinical data sharing. Staff is identifying hospital chief information officers to review and provide feedback on the draft report. The report is tentatively scheduled for release in April.

Last month, staff met with independent nursing home administrators to explore opportunities to collaborate on adopting HIT. In general, nursing homes chains are better situated to adopt HIT as compared to independent nursing homes. The independent nursing homes often lack the financial and human capital to implement HIT. As part of the meeting, staff discussed options for independent nursing homes to collaborate on EHR adoption and connecting with the statewide health information exchange (HIE) when it becomes available. EHR adoption by independent nursing homes in Maryland is approximately 24 percent. Over the next couple of months, staff plans to explore the challenges and

opportunities for EHR vendors to integrate with the financial systems that exist in independent nursing homes.

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 roughly 60 physician practices that have not adopted an EHR with web links that contain useful information in performing due diligence on EHR vendors. Staff continued to provide consultative support to physician practices with questions relating to EHR adoption. Participants can earn up to $290,000 over a five year period 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 a number of Technology Committee meetings with the Chesapeake Regional Information System for our Patients (CRISP) relating to the implementation of the statewide HIE. These meetings were aimed at evaluating vendor solutions for the core infrastructure and the Master Patient Index (MPI). In March, CRISP plans to visit several HIEs to view the technology of select bidders that are operating in a production environment. CRISP anticipates completing its evaluation for the core infrastructure and the MPI and present their recommendations to their Board of Directors and the MHCC in April. Last month, staff also participated in the Clinical Excellence and Technology Committee's review of the Use Cases to determine if a reprioritization of the implementation order is required based on changes in the market and provider needs. Throughout the month staff provided consultative support to CRISP in strategizing the implementation approach for the statewide HIE and in developing a provider outreach program.

In February, staff worked with various HIE Policy Board members to identify key policies pertaining to privacy and security that the Policy Board needs to consider over the next several months. The Policy Board consists of about 25 consumer oriented members and has general oversight of the statewide HIE. Over the next month, CRISP will provide the Policy Board with a preliminary list of initial policies that need to be developed to support early Use Cases. A subgroup was formed at the last meeting to provide guidance to the Policy Board in identifying key policies for discussion and in setting the meeting agenda. The subgroup will also deliberate on policy matters at the request of the Policy Board. The subgroup is scheduled to meet in March in preparation for the April 13th Policy Board meeting.

The Electronic Healthcare Network Accreditation Commission (EHNAC) has received ongoing support from staff over the last eighteen months in their effort to develop a national accreditation program for HIEs. Last month, staff reviewed privacy and security policies from about eight existing HIEs to identify key policies to suggest to EHNAC that they include them in the draft HIE accreditation criteria. Roughly 30 stakeholders from around the country are participating on the Advisory Panel that is developing the draft criteria. The EHNAC has published sections of the draft criteria for review by the public, plans to finalize the criteria in the third quarter, and launch the accreditation program toward the end of the year. The Utah Health Information Network, an established HIE, has agreed to test EHNAC's criteria as it is being developed.

The Office of the National Coordinator for Health Information Technology (ONC) requested additional information on various occasions throughout the month on the application staff submitted for the *Health Information Exchange Cooperative Agreement Program*. Most of their requests focused on the budget and the budget narrative and justification. ONC has not said when they plan to announce the awards for the HIE grant. ONC also requested information from CRISP, the lead applicant, on the *Health Information Technology Extension Programs: Regional Centers Cooperative Agreement Program*. Questions from ONC were mostly on the solvency of CRISP as a non-profit organization that was

established in August 2009. ONC is scheduled to make a funding decision on the regional center grant in April.

Staff completed the *HIT Planning Advanced Planning Document* (HIT P-APD) for the Maryland Medical Assistance Program (Medicaid). The application is currently under review by Medicaid. The purpose 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 allocated funding for states to complete the planning activities that will lead to the development of the SMHP. Approval of Medicaid's HIT P-APD application could provide Medicaid with federal financial participation (FFP) funding of about 90 percent for these planning activities, which equates to approximately $1.5M. Medicaid could also use these funds to develop a process that the state will use to oversee the *American Recovery and Reinvestment Act of 2009* incentive payments made to eligible Medicaid providers.

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. Staff is working with EHNAC to develop criteria that would allow administrative networks to validate the transactions of intermediaries. This will enable intermediaries that transmit electronic prescriptions to pharmacies where the transaction passes through an administrative network to meet the certification requirements. Intermediaries that do not route their electronic transactions through an administrative network are required to be accredited by EHNAC before they are certified by the MHCC.

Last month, staff recertified GHN On-Line, AGDATA, and Passport Health. COMAR 10.25.07, *Certification of Electronic Networks and Medical Claims Clearinghouses,* requires payers that are doing business in Maryland to accept electronic transactions from only administrative networks that are MHCC certified. The MHCC certification is valid for two years; roughly 44 administrative networks have been MHCC certified.

National Networking
Staff participated in the *Establishing the Medicaid Presence within the State HIE Governance Structure: a Workshop for Medicaid/CHIP Agencies* webinar. This webinar sponsored by AHRQ provided tools for collaboration within the governance structure for HIEs at the state level. Lessons learned from Medicaid who serves as a significant partners to the state HIE initiatives were discussed.