MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

June 2011

CENTER FOR INFORMATION SYSTEMS AND ANALYSIS

Patient Centered Medical Home Program

The Maryland Learning Collaborative has engaged more than 180 primary care providers and their key staff members over the past month. The primary focus at this time is in creating t Practice Transformation Plans.

Attribution of patients for the participating practices with the Program's participating health insurance carriers, self-insured employers, and staff from Social and Scientific Systems (the Commission's claims data base contractor) continues. The carriers will make the first Fixed Transformation Payments to the participating practices in July.

Center for Information Systems and Analysis staff created a secure log-on website for Maryland Learning Collaborative faculty and participating practice representatives.

MHCC has released a revised RFP for PCMH Program Evaluation services and will hold a pre-bid conference on June 22, 2011 at 10:00-11:30 am in Room 100 at the offices of the Maryland Health Care Commission. For further information, please contact the Commission's Procurement Officer, Sharon M. Wiggins at swiggins@mhcc.state.md.us.

Ben Steffen will update the Maryland Quality and Cost Council on the Maryland Multi-payer PCMH Program on Friday, June 10, 2011. Mr. Steffen will also present information on the program to the Baltimore Area Health Underwriters on June 15, 2011.

Information regarding the PCMH program is available on the Commission's website at: http://mhcc.maryland.gov/pcmh/.

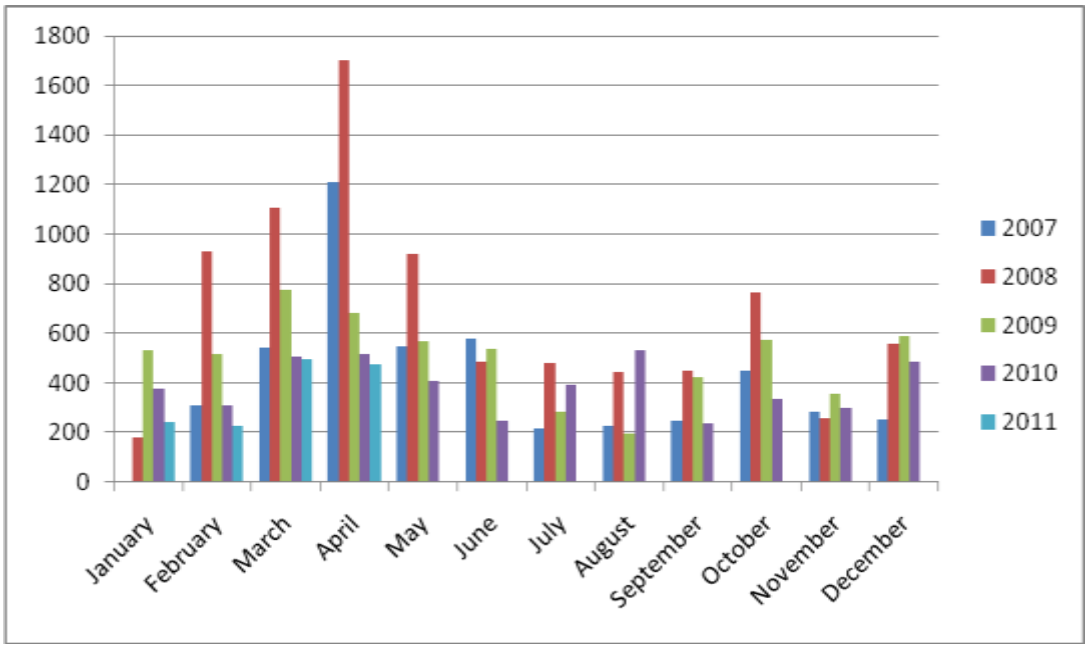
Maryland Trauma Physician Services Fund

On-Call Applications
Maryland Trauma Centers 'Applications for on-call stipends will be due on July 29, 2011 for reimbursement of on-call expenses for January 1 through June 30, 2011.

Trauma Equipment Grants
Commission staff will release the 2011-12 Trauma Equipment Grant applications to the coordinators for each of Maryland's eligible Trauma Centers in July.

Uncompensated Care Processing
CoreSource, Inc., the third party administrator (TPA) for the Trauma Fund, adjudicated claims with a total paid value of approximately $475,241 in April 2011. The monthly claims report for May claims has not yet been received. The monthly payments for uncompensated care from March 2007 through April 2011 are shown below in Figure 1.

Figure 1 – Trauma Fund Uncompensated Care Payments 2007-2011



Cost and Quality Analysis

Submission of 2010 Data to the Maryland Medical Care Data Base (MCDB) from payers are due June 30, 2011, and, as in previous years, staff are receiving and processing requests from submitting payers for data element waivers. As always, the staff assesses each payer's request(s) based on that payer's particular circumstances, including specific claims information provided to or retained by the payer and changes in staffing or claims processing and storage systems that may impact either the information the payer can submit or when the submission can be completed. Between mid-May and early June, staff received waiver requests from 22 of the 24 payers that are required to submit 2010 claims data. As of June 9th, all but one of these waiver requests has been processed and responses have been sent to the payers. The outstanding waiver request is pending due to a need for additional information from that payer. The rapid turn-around of waiver requests is a result of both staff efforts to streamline waiver processing and staff commitment to assisting the payers with providing quality data and meeting submission deadlines.

Report on the *Use of Professional Services by the Nonelderly, Privately Insured in Maryland.*
This legislatively-mandated annual study is nearing completion and will be available on the Commission's website at the end of June. A summary of the findings will be presented at the July Commission meeting, and we are working to have printed copies of the report available at the July meeting. Completion of the report was delayed due to having to develop a methodology to handle problems with the 2009 data submitted by Aetna, as discussed in last month's update.
Among Maryland residents under age 65 who both used privately insured professional services and were covered by the same insurance plan throughout 2009, the average expenditure for privately insured professional services was $1,238 in 2009, 2% higher than in 2008. The spending figure includes both reimbursements by payers and patient's payment obligations (co-payments and deductibles). This growth was principally due to a 2% increase in the average payment rate for the mix of services obtained by the users—as measured by the average payment per relative value unit (RVU). A 1% increase in average number of professional services per user also contributed to the growth in average spending. Service complexity (number of RVUs per service) was unchanged from 2008. The increase in per user spending

was concentrated almost exclusively among users enrolled in HMO plans (4%), while users in non-HMO plans exhibited no increase in per user spending.

This increase in average expenditure per user differed from the 2007–2008 expenditure increase in two notable ways. The increase in per user spending from 2008 to 2009 is lower than in the 2007–2008 period (5%). And the primary driver of the 2007–2008 increase was an increase in the average volume of professional services per user, which grew by 3%. The average payment rate did not change in the 2007–2008 period, but service complexity increased by 1%, contributing to the increase in per user expenditures in that time period.

User risk status, as determined by an expenditure risk score, is an important determinant of per-user expenditures for professional services. The annual expenditure for a user with "medium" risk is about twice that of a "low-risk" user, and the annual expenditure for a "high-risk" user is about five times that of a low-risk user. Annual growth in the average expenditure per user from 2008 to 2009 varied by coverage type and was especially large in the individual market, where the per-user expenditure for professional services grew by 8%.

The increase in the average payment rate from 2008 to 2009 was mainly due to a 2% increase among the largest payers; the payment rate increase among the other payers was lower, at 1%. Among the largest payers, the average for services from participating providers grew by 2%, while the average rate for services from non-participating providers grew considerably more, by 9%. Among the other payers, the average rates for services from participating and non-participating providers grew by 1% each. Overall, the average rate for participating provider services grew by 2% and the average rate for non-participating provider services grew by 7%.

Data Base & Applications Development

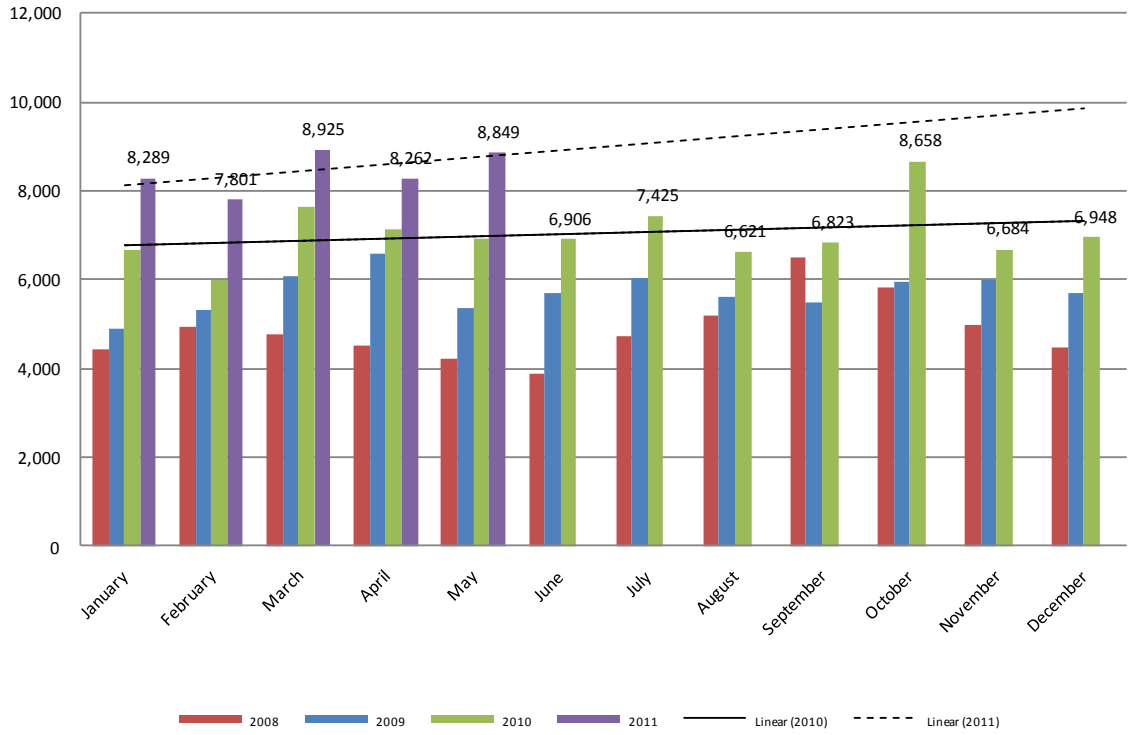
Internet Activities

After a decrease in unique visitors to the MHCC website during April (see Figure 2, below) the number of unique visitors increased in May by approximately 2 percent. The number of visitors was nearly 22 percent than May 2010. Visitors to the MHCC website arrive directly by direct reference to an MHCC URL (39 percent), via a search engine such as Google (43 percent), or by referral from another State site (18 percent). Visitors who arrive directly are typically aware of MHCC, but visitors arriving via search engines and referrals are more likely to be new users. The shares for any particular point of origination fluctuate up and down 3 to 4 percent from month to month. Google remains the dominant search engine. Among the most common search keywords were:

- "maryland health care commission"
- "mhcc"
- "nursing homes in maryland"
- "maryland healthcare commission"
- "health care cost maryland"

The top state referring sites were the DHMH website, the Maryland Web Portal (Maryland.gov), dhmh.maryland.gov, crisphealth.org, and marylandaccesspoint.info.

Figure 2 -- Unique Visitors to the MHCC Web Site



Web Development for Internal Applications

Table 1, below, presents the status of development for internal applications and for the health occupation boards. Planning is underway for several new projects, including a Physician/Health Professional Portal that will integrate information on all projects that are of interest to health professionals in Maryland. The second effort is a redesign of the Hospital Quality website. A combination of internal and contractual resources will be used for this effort.

Table 1– Web Applications Under Development

Board/Project	Anticipated Start Development/Renewal	Start of Next Renewal Cycle
Board of Physicians – Physician Renewal	Complete	July 2011
Nursing Home Quality Site	Complete	February 2011
Health Insurance Compare	Complete	May 2011
Physician Portal/PCMH MLC	Complete	May 2011
Hospital Quality Redesign	Planning	Start of Project: Fall 2011

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

Health Plan Quality and Performance

The Consumer Assessment of HealthCare Providers and Systems (CAHPS) survey responses for health plans participating in the survey were finalized and sent to NCQA. The overall response rate was 34%. The report contractor is progressing in design and content of the 2011 reports.

Proposed changes to regulation COMAR 10.25.08 "Evaluation of Quality and Performance of Health Benefit Plans" were released for informal public comment through June 3, 2011. Staff received two sets of timely comments that suggested clarification of terminology or expanded definition within the regulations and proposed changes in dates for certain activities in the evaluation system. Other comments were related to audit requirements. At the June meeting, staff will request Commission approval to submit proposed permanent regulations to AELR for approval and publication in the Maryland Register which will include a formal 30-day public comment period.

Two RFPs were issued the first to secure a vendor to provide an independent Healthcare Effectiveness Data and Information Set (HEDIS) compliance audit of the commercial health plans required to participate in the Evaluation of Quality and Performance of Health Benefit Plans. The second RFP seeks a vendor to provide survey administration for the CAHPS 4.0H Adult survey for the health plans participating in the quality and performance evaluation system. CAHPS serves as the tool for assessing consumer satisfaction with a health plan. Pre-bid conferences were held for each solicitation, responses are due in early July.

Small Group Market

Comprehensive Standard Health Benefit Plan (CSHBP)
VIRTUAL COMPARE, the information-only web portal developed for use by small businesses, was released on May 3rd. Commission staff prepared a press release and both the DHMH public relations personnel and the Commission's public relations contractor distributed it amongst the 170 print, radio, and television media outlets throughout Maryland. Staff also prepared announcements so that participating carriers and the Maryland Chamber of Commerce could notify the broker and small business communities about the availability of this new web portal. A press release was also sent to 44 minority business associations and incubator organizations. Staff also prepared an article on VIRTUAL COMPARE which appeared in the March print issue of the Insurance & Financial Advisor and also has been posted on their website and also published in the Baltimore Business Journal. BenefitFocus, the contractor that developed the web portal, is tracking the number of hits to the site and provides daily updates to staff via Google Analytics. To date, several hundred brokers have registered to be listed on VIRTUAL COMPARE. Later in the meeting, staff will present a brief overview of VIRTUAL COMPARE.

Each year, carriers participating in the small group market are required to submit to the Commission completed survey forms that include enrollment and premium information in the CSHBP for the preceding calendar year. This year's analysis is based on data for the calendar year ending December 31, 2010. Commission staff is in the process of analyzing these data and will present the findings of these surveys at the June public meeting.

Health Insurance Partnership
The "Partnership" premium subsidy program has been available to certain small employers with 2 to 9 full time employees since October 1, 2008. As of May 10, 2011 enrollment in the Partnership was as

follows: 341 businesses; 1,000 enrolled employees; 1,671 covered lives. The average annual subsidy per enrolled employee is about $2,400; the average age of all enrolled employees is 39; the group average wage is about $28,000; the average number of employees per policy is 4.1. The 3rd annual report on the implementation of the Partnership was submitted to the Governor and the General Assembly in late December for the January 1, 2011 due date and is posted on the Commission's website.

Mandated Health Insurance Services
Insurance Article § 15-1501, Annotated Code of Maryland, requires the Commission to submit an annual report to the General Assembly on: (1) any proposed mandated health insurance service that failed during the preceding legislative session; and (2) any request for analysis on a proposed mandated benefit that was submitted by a Legislator to the Commission by July 1st of that year. Each evaluation must include an assessment on the medical, financial, and social impact of the proposed mandate. The 2010 annual mandated benefits report was approved by the Commission at the January 2011 public meeting and subsequently submitted to the General Assembly. The report also is posted on the Commission's website.

Commission staff tracked a number of proposed mandate bills during the 2011 legislative session, most of which were evaluated by Mercer in the 2010 annual mandate report. Each proposed mandate either received an unfavorable report or was withdrawn by the sponsor.

As required under Insurance Article § 15-1502, Annotated Code of Maryland, every four years, the Commission is required to conduct an analysis on each existing mandated health insurance service in Maryland, including a comparison of Maryland's mandates to those in Delaware, Pennsylvania, Virginia, and the District of Columbia. Mercer will be conducting this analysis later in the year. The report is due to the General Assembly by January 1, 2012.

Long Term Care Policy and Planning

Hospice Survey
Notice was sent to all Maryland hospice programs on May 20th that the survey was available for data entry. The official start of the FY 2010 Maryland Hospice Survey was May 23, 2011 with a due date of July 25, 2011. Staff will be providing assistance to providers as needed.

Nursing Home Occupancy and Payment Reports
The annual reports on nursing home occupancy and payment source have been completed. The following tables have been published in the April 22nd issue of the *Maryland Register:* "Nursing Home Licensed Beds Occupancy by Region and Jurisdiction: Maryland, Fiscal Year 2009" and "Required Maryland Medical Assistance Participation Rates for Nursing Homes by Region and Jurisdiction: Fiscal Year 2009." These are developed and published based on data from the Long Term Care Survey, MHCC bed inventory reports, and Medicaid cost reports. They are used for health planning and Certificate of Need review. These tables will also be posted on the Commission's website.

Home Health Agency Data
Staff is updating the Home Health Agency (HHA) inventory, and is monitoring utilization trends in jurisdictions authorized to provide HHA services based on data reported in the Commission's Annual Home Health Agency Surveys.

Home Health Agency Survey
The Home Health Agency Survey due date was May 26, 2011. Since there was a server error, the due date was extended to June 13, 2011. There are 39 Home Health Agencies (HHAs) completing the survey. As of June 6, 2011, 82% have been completed, 16% are in progress, and 2% have not started. Staff continues to provide technical assistance as well as user support on survey content during the survey collection period.

Long Term Care Survey
The 2010 Long Term Care Survey data collection period began on March 28, 2011 with a due date of May 26, 2011. There are a total of 691 facilities completing the Long Term Care Survey. These include: nursing homes, assisted living facilities with 10 beds or more, adult day care centers, and chronic hospitals. As of June 6, 2011, 97% have been accepted, 2% are in progress, and 1% have not started. On June 1, 2011, the "Notice of Imposition of Fines for Failure to Complete 2010 Maryland Long Term Care Survey" was sent by email and FedEx to 25 facilities with a status of "Not Started" or "In Progress". This notice informed the facilities that as a courtesy, the Commission would grant them a ten business day grace period extending the due date to June 13, 2011. However, since the Survey due date was May 26, 2011, facilities that do not comply in having a completed and accepted survey by June 14, 2011 will be fined by the Commission at $100 per day retroactive to May 27, 2011. Notice of fines to be imposed was also shared with the Health Facilities Association of Maryland as well as Lifespan, so that they could encourage compliance by their members. As was explained, the goal is to assure accurate and timely survey completion rather than the collection of fines. Staff continues to provide technical assistance as well as user support on the survey content during the survey collection period.

Long Term Care Quality Initiative

Long Term Care Staff Influenza Vaccination Rate Survey
The Nursing Home Health Care Worker Influenza Vaccination Survey and the pilot survey for Assisted Living staff are finalized; a presentation will be made to the Commission during the June meeting.

Consumer Guide to Long Term Care
The contractor is finishing enhancements to the site to display Home Health Agency quality measures and facility-specific nursing home vaccination rates.

CENTER FOR HOSPITAL SERVICES

Hospital Services Planning and Policy

Certificate of Need ("CON")

CON Applications Filed

Solomons Nursing Center (Calvert County) – Matter No. 11-04-2317
Addition of 12 comprehensive care facility ("CCF") beds

Determinations of Coverage

- **Ambulatory Surgery Centers**

Maryland Ambulatory Surgical Center (Howard County)
Establish an ambulatory surgery center with one sterile operating room and one non-sterile procedure room to be located at 92 Old Annapolis Road, Suite 200, Ellicott City

Center for Pain Management, LLC (Prince George's County)
Establish an ambulatory surgery center with two non-sterile procedure rooms to be located at 8824 Cunningham Drive, Suite D, Berwyn Heights

Hagerstown Surgery Center (Washington County)
Establish an ambulatory surgery center with one sterile operating room and two non-sterile procedure rooms to be located at 11236 Robinwood Drive, Hagerstown

- **Acquisitions/Change of Ownership**

Capital Area Surgery Center, LLC (Charles County)
Change in the ownership of the ambulatory surgical center from 50% ownership interest by Mruthyunjaya Gonchigar, M.D. and 50% ownership interest by Sandeep Sherlekar, M.D. to 100% ownership by Dr. Gonchigar and a name change to Newbridge Surgery Center at Waldorf, LLC

Collington Episcopal Life Care Community, Inc. (Prince George's County)
Change in the ownership of the CCF from 100% ownership interest by Collington Care Services, Inc to no ownership interest by this entity. The facility will operate without an owner member after affiliating with The Kendal Corporation. Collington Episcopal Life Care Community, Inc. will continue to own and operate the facility.

Reisterstown Ambulatory Surgical Center, LLC (Baltimore County)
Change in the ownership structure of the ambulatory surgical center by the addition of Keith J. O'Reilly, M.D. as an owner.

- **Capital Projects**

Chester River Hospital Center (Kent County)
Renovate and physically expand the Emergency Department, renovate the main hospital lobby, relocate the main hospital entrance and triage area, create a new central registration space and add elevators. MHA Bond Program identified as a funding source.
Estimated cost: $7,700,000

Holy Cross Hospital (Montgomery County)
Establish a primary care health center for uninsured patient in the Wheaton/Aspen Hill area. MHA Bond Program identified as a funding source.
Estimated cost: $1,399,497

Adventist Behavioral Health-Rockville (Montgomery County)
Renovation of the Seneca Unit. MHA Bond Program identified as a funding source.
Estimated cost: $642,000

Northwest Hospital Center (Baltimore County)
Expansion of the emergency department. MHA Bond Program identified as a funding source.
$3,504,783

- **Other**

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

Gladys Spellman Specialty Hospital and Nursing Center (Prince George's County)
Temporary delicensure of the 61-bed

    - **Miscellaneous**

Gladys Spellman Specialty Hospital and Nursing Center (Prince George's County)

Relocation of the 46-bed specialty hospital/chronic from 2900 Mercy Lane, in Cheverly to existing facilities at Laurel Regional Hospital, located at 7300 Van Dusen Road, in Laurel

Chesapeake Treatment Center, Inc. d/b/a New Directions RTC (Baltimore County)
Change in designation to accept referrals of adjudicated youth offenders, aged 18-21 years, who are not sex offenders. (Determined to require CON approval as a non-dedicated Residential Treatment Center).

Policy and Planning

On May 4, 2011, a Surgical Services Planning Work Group had it first meeting. This group, with ambulatory surgical facility, hospital, and payor representatives was formed to provide Center for Hospital Services staff with input on proposed amendments to COMAR 10.24.11, the State Health Plan chapter for surgical facilities and services. The Group's work is led by Eileen Fleck, Program Manager.

Hospital Quality Initiatives

Hospital Performance Evaluation Guide (HPEG) Advisory Committee
The HPEG Advisory Committee held its regular monthly meeting 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, staff has worked with the HPEG Committee on ideas for a comprehensive annual report of hospital performance. The HPEG Committee also approved staff recommendations for the collection of Emergency Department data and reviewed the progress on HAI data collection and reporting activities. Most recent accomplishments are highlighted below:

Maryland State Cardiac Care Data Advisory Committee
The Advisory Committee met in May and had a guest presenter, Edward Hannan, M.D., talk about the experiences in developing cardiac data bases for the State of New York.

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. In 2009, the Commission engaged the services of an independent auditor to perform an on-site chart review of CLABSI cases prior to public release of the information on the Hospital Guide. The staff is again in the process of seeking the services of a qualified contractor to review the HAI data, to include CLABSI, surgical site infections data, and other data planned for collection over the next five years. The procurement process has been initiated, an evaluation panel has been established, and we held our first proposal review meeting on Monday, May 9th. It is anticipated that the procurement process will be completed by next month..

- *2010-2011 Health Care Workers (HCW) Influenza Vaccination in Hospitals Survey*

Staff distributed the 3rd annual Survey on Health Care Workers (HCW) Influenza Vaccination to Maryland hospitals. This survey will provide useful information on individual hospital vaccination rates as well as hospital performance in comparison to peer facilities and to the State as a whole. The survey has been enhanced as a result of lessons learned from the pilot survey conducted last year. The online survey was distributed to hospitals in April for completion within 30 days following the end of the flu season (May 15, 2011). Staff is in the process of working the hospitals to complete data collection and prepare preview reports.

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

The staff is processing the results of the 1st quarter 2011 survey for collecting data on Active Surveillance Testing (AST) for MRSA in All ICUs. 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 results of the survey are under staff review for completeness and will be distributed to hospitals for review prior to public reporting.

- *Presentation to College of State and Territorial Epidemiologists (CSTE)*

In June, the Commission will present a poster on the CLABSI Audit at the annual meeting of the CSTE in Pittsburg, Pa. In addition, the Commission will participate in a breakout session on public presentations of CLABSI data.

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. The staff continues to collaborate with the HSCRC staff on data issues to support the Quality Based Reimbursement project and broader rate setting issues.

Specialized Services Policy and Planning

Shady Grove Adventist Hospital (Docket No. 11-15-0058 WR) and Southern Maryland Hospital Center (Docket No. 11-16-0057 WR) each timely filed an application requesting renewal of the hospital's two-year waiver to provide primary percutaneous coronary intervention (pPCI) services without on-site cardiac surgery services. On June 16, 2011, the Commission will consider the staff recommendation on each application.

To continue providing pPCI services without on-site cardiac surgery services, Carroll Hospital Center must file an application seeking renewal of its two-year waiver by June 15, 2011. The hospital's current waiver was issued on September 17, 2009; commenced on October 13, 2009; and will end on October 13, 2011.

In February 2011, the Commission adopted proposed permanent and emergency regulations to extend the term of an existing research waiver held by a hospital that maintains good standing under the Commission's requirements while the hospital participates in the C-PORT E Registry of Non-Primary (elective) PCI that follows-on the C-PORT E Study of Non-Primary PCI. The C-PORT E study is a randomized clinical research trial conducted in multiple states by the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) to determine whether non-primary PCI (npPCI) performed in hospitals without on-site cardiac surgery services is as safe and effective as npPCI performed in hospitals with on-site cardiac surgery services. A hospital with a non-primary PCI research waiver in good standing must file an application to enter the Registry and demonstrate that it meets the applicable review criteria. The hospital is permitted to continue to perform npPCI under the limitations and for the Registry term provided in the regulations until such time as the Commission has the information from the research study that is needed to guide State policy about the regulation of non-primary PCI. The emergency regulations became effective on March 23, 2011. At the public meeting on June 16th, the staff will seek approval of a proposed amendment to COMAR 10.24.05 that will change the requirement for patient follow-up from 6 weeks post-procedure to the time of hospital discharge (either index or transfer hospital discharge). The proposed change will make the regulation consistent with the requirements in the Manual of Operations for the C-PORT elective angioplasty registry of patients undergoing npPCI at hospitals without surgery on-site that participated in the C-PORT E study. Additionally, the proposed amendment will make Maryland consistent with the other states participating in the follow-on C-PORT E Registry.

CENTER FOR HEALTH INFORMATION TECHNOLOGY

Health Information Technology

Staff participated in the Markle Connecting for Health HIE Advisory Committee (Markle) meeting that centered on identifying best practices for health information exchange (HIE) implementation and developing resources for implementing a private and secure HIE. As part of the meeting, states were asked to identify the policies currently under development for testing by their state designated HIE. Over the last six months, staff has provided input to Markle in developing policies regarding how electronic health information is protected and exchanged. Markle strives to realize the full potential of information and information technology that addresses critical public needs, particularly in the areas of health and national security. In 2006, through collaboration with the public and private sectors, Markle published a Roadmap that sketched a vision of nationwide health information exchange through a decentralized system of networks united by a common framework of shared policies and technical standards. The statewide HIE under development in Maryland incorporates many of the policies from the Roadmap. During the month, staff also participated on a health information technology (HIT) panel at the annual Maryland Addiction Directors Council Behavioral Health Conference.

Staff completed a preliminary draft of the third annual *Hospital HIT Survey* (survey) report and plans to seek feedback on the draft from hospital Chief Information Officers in June. The survey assesses the rate of HIT adoption among the state's 46 acute care hospitals and evaluates the extent of adoption within the hospital's patient care areas, as well as the planning efforts anticipated for the particular HIT in question. This year, the hospital's responses to the survey identifies the type of HIT implemented over the last three years, addresses questions related to connectivity with the state designated HIE, assesses the ability to meet meaningful use criteria, and reports on plans to participate in the Centers for Medicare and Medicaid Services (CMS) EHR adoption incentive program. Overall, the level of hospital HIT adoption in Maryland exceeds the national adoption rate. This survey is similar to several others administered nationally that assess HIT adoption; however, it is unique in that it includes planning questions in an effort to better understand the hospital's future designs regarding HIT adoption. Staff anticipates releasing the report around the end of June.

The second annual *2010 HIT Assessment of Freestanding Ambulatory Surgical Centers in Maryland* report (report) was released at the end of May. During the month, staff incorporated feedback on the draft report from the Maryland Ambulatory Surgery Association. The report assesses the current HIT adoption among the 333 Freestanding Ambulatory Surgical Centers (Centers) in Maryland related to: computerized physician order entry; EHR adoption; electronic medication administration records; barcode medication administration; infection surveillance software; electronic prescribing; and electronic health information exchange. Overall, around 23 percent of Centers reported having an EHR; and about 13 percent use electronic prescribing technology.

Last month staff awarded management service organization (MSO) *State Designation* to the Community Health Integrated Partnership and D'Souza & Associates, and approved MedTech Enginuity Corporation for *Candidacy Status*; nearly 19 MSOs are in *Candidacy Status*. MSOs have one year to complete almost 90 criteria related to privacy, technical performance, business practices, resources, and security required for *State Designation*. MSOs provide centralized administrative and technology services that allow providers to adopt a hosted EHR through a monthly subscription fee, and considered a viable alternative to the EHR client-server model where the technology is hosted by the provider. These organizations assume the maintenance of the technology and the privacy and security of the data. Staff continues to work with the MSOs to develop an *MSO Product Portfolio* that will help physicians evaluate their products and services. Staff is in the preliminary stages of evaluating the MSO accreditation criteria for

state designation and plans to seek input from MSOs on the proposed criteria in July. Over the last year, MSOs have signed up roughly 1,000 priority primary care practices.

During the month, staff finalized the *Nursing Home EHR Product Portfolio* (portfolio). The web-based portfolio lists EHR products specifically designed to assist nursing homes in the evaluation of EHRs. Approximately six vendors have agreed to participate in the portfolio; staff extended invitations to approximately 20 vendors that met the reporting criteria. In May, staff invited independent nursing homes in Western Maryland to an HIT meeting where the challenges to adopting EHRs were discussed. Participants provided staff with proposed solutions to key challenges that included establishing an MSO for nursing homes, bulk purchasing of client-server model EHRs, and the eventual increase of Medicaid rates for EHR adoption. Staff plans to incorporate the technology recommendations into the upcoming EHR adoption environmental scan (scan) for distribution to the nearly 235 nursing homes. The scan is targeted for release in July.

Last month, staff asked payers to comment on the draft *EHR Monetary Incentive Application* (application) for primary care practices to use when they apply to participate in the payer's EHR adoption incentive program under COMAR 10.25.16, *Electronic Health Record Incentives*. The regulation requires state-regulated payers to offer a monetary incentive to primary care practices for the adoption and use of EHRs. The draft of the application includes information related to the EHR in use by the primary care practice, demographic information, and a patient listing with payer member identification numbers. Payers were also asked to comment on the draft *EHR Monetary Incentive Voucher* (voucher) for practices to use when seeking an incentive payment. The voucher requires a primary care practice to submit a copy of the payer acknowledgement letter, which shows their acceptance into the payer's EHR adoption incentive program. The voucher also requires a primary care practice to outline their current EHR functionality to receive consideration for an additional incentive under the regulation. Staff will use the feedback it receives from the payers in the final version of the application and voucher documents. Staff also completed modifications to the regulations to reflect cash as the EHR adoption incentive and decreased the waiting period for providers to submit a request for an incentive from nine to six months. The changes are a result of House Bill 736, *Electronic Health Records – Incentives for Health Care Providers Regulations* that was signed into law on May 19th. The modifications to the regulations will be presented at the June Commission meeting.

Health Information Exchange

Staff continues to provide guidance to CRISP's Advisory Board that consists of four committees: Finance, Technology, Clinical Excellence, and Small Practice Advisory. Last month, staff participated in the meetings for the Small Practice Advisory Committee, which considered the marketing, press, and educational activities of the REC and the Clinical Excellence Advisory Committee, which assessed the impact of HIE querying on hospital workflows and the process for identifying and adding new data types to the HIE portal. Staff met with the CRISP Board of Directors Finance Subcommittee to review the findings of the final *Information Technology Security and Finance Audit Report* performed by Clifton Gunderson, LLP (CG). Key recommendations from CG related to the adoption of expanded controls to safeguard the HIE and around tracking expenditures related to the federal grant. Staff is in the preliminary stages of working with CG to determine the audit requirements for the fiscal year 2012 audit that will begin later this summer.

Staff reviewed the deliverable of the ONC awarded Challenge Grant with the state designated HIE. In January the MHCC was awarded approximately $1.6M from the ONC as part of the *State Health Information Exchange Cooperative Agreement Program* to address challenges and share innovative solutions nationwide specific to HIE. The project will pilot the electronic exchange of clinical documents between pairs of nursing homes and proximate hospital emergency departments. Six nursing homes and four hospitals have committed to the project. Working in partnership with CRISP, the MHCC expects this project will reduce hospital readmission rates for the pilot population. The project will also ensure that advance directives are a component of the electronic summary of care by developing the required

framework for storing and exchanging advance directives electronically in Maryland. The ONC is expected to release the grant funding in June for this 36-month project.

Staff continues to provide support to the Policy Board in the development of policies that, once adopted by the MHCC, will become regulations that govern the statewide HIE in Maryland. The Policy Board identified roughly 27 policies for development; nine have been recommended and adopted by the MHCC. Workgroups met on three occasions to continue drafting policies related to *Consumer Access* and *Consumer Outreach, Education and Engagement*. The Policy Board voted to approve these two policies at the May meeting. Staff also organized a webinar demonstration of a consumer portal product to inform Policy Board members on consumer access solutions available. Preliminary development activities are underway for the *Data Use and Disclosure* and *Audit* policies. The workgroup is scheduled to meet twice in June in an effort to finalize these policies for consideration at the July Policy Board meeting.

Staff engaged the assistance of a contractor to assist in accurately identifying consumer interest in electronic health information, the challenges related to implementing consumer access to and control over an individual's electronic health information, and to propose practical solutions for implementation in a state where multiple HIEs exist. The contractor will also propose strategies for consumer outreach and education regarding the electronic collection, storage, and exchange of health information; consumers' rights relative to the collection, storage, and exchange of electronic health information; and participation in HIEs. The contractor is expected to conduct focus group meetings throughout the state. A report on the findings, that is due in January 2012, will include recommendations that will be used to help guide policy development.

Staff continues to collaborate with the Centers for Medicare and Medicaid Services (CMS) on the CMS EHR Demonstration Project (project). Maryland is one of four states participating in the project along with Louisiana, South Dakota and Pennsylvania. During the month, staff provided practices with resource information on EHR adoption, implementation, and meeting the meaningful use criteria. The project provides financial incentives up to $290,000 over a five-year period for small to medium-sized primary care practices to incentivize EHR adoption and meet established quality reporting measures. Approximately 114 practices in the treatment group are eligible for these incentives. Roughly 70 percent of the practices in the treatment group have adopted an EHR. Approximately 127 practices are in the control group and can receive a small payment for completing an *Office System Survey* in years two and five. Nearly 68 percent of the practices in the control group have adopted an EHR.

Planning activities continued during the month regarding convening a Technical Solutions and Standards Advisory Group (group) that will evaluate technology required to support the expanded use of telemedicine in Maryland. The group will consist of hospital Chief Information Officers, representatives from the Maryland HIE, MedChi, and the HIE Policy Board. At the end of 2010, the Telemedicine Task Force submitted a report to the Quality and Cost Council with recommendations related to expanding telemedicine for the treatment of stroke and other key clinical conditions. Last November, former Secretary John Colmers requested an Advisory Committee, to replace the Telemedicine Task Force, establish three subcommittees to create specific recommendations about use cases, technology, and the financial and business model. The group is scheduled to convene at the end of June and complete its recommendations this fall.

Electronic Health Networks & Electronic Data Interchange

Staff provided consultative services to payers completing the annual EDI Progress Report (report). Roughly 66 payers are required to complete the report; thus far, about 24 payers have begun to complete the online web-based application and five have submitted their reports. COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks* requires payers with premiums of $1M or more to complete the report by June 30th of each year. During the month, staff completed the recertification of two electronic health networks (networks): MD Online and Mercury Data Exchange. COMAR 10.25.07;

Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouses requires networks operating in Maryland to be MHCC certified.

National Networking

Staff participated in two webinars during the month. *A Workshop on Choosing an EHR Product for your Practice*, which gave a presentation on how to evaluate and select an EHR; and *The CMS Electronic Prescribing Incentive: Get the Benefit and Avoid the Penalty* that explained how physician practices can avoid penalties by meeting certain requirements on a timely basis in the CMS e-prescribing incentive program.