MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

October 2011

CENTER FOR INFORMATION SYSTEMS AND ANALYSIS

Patient Centered Medical Home Program

Attribution of Patients
The MMPP program began the second round of patient attribution. The next Fixed Transformation Payments will be due to participating practices on January 1, 2012.

Maryland Learning Collaborative (MLC)
Practice transformation activities continue with intensive effort devoted to NCQA recognition. The next major meeting of all practices will be November 11-12. The learning collaborative and Commission staff are identifying quality measure specifications and developing a reporting guide as well as considering technical issues related to data sharing for care management.

Program Evaluation
The Maryland Board of Public Works approved the award of a contract to IMPAQ to conduct evaluation of the program. Commission staff met with IMPAQ staff to plan the evaluation.

Ben Steffen was joined by Drs. Howard Haft, Kimberly Johnston, and Richard Fornadel to present their perspectives on the program to the Maryland Quality and Cost Council on September 26, 2011.

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

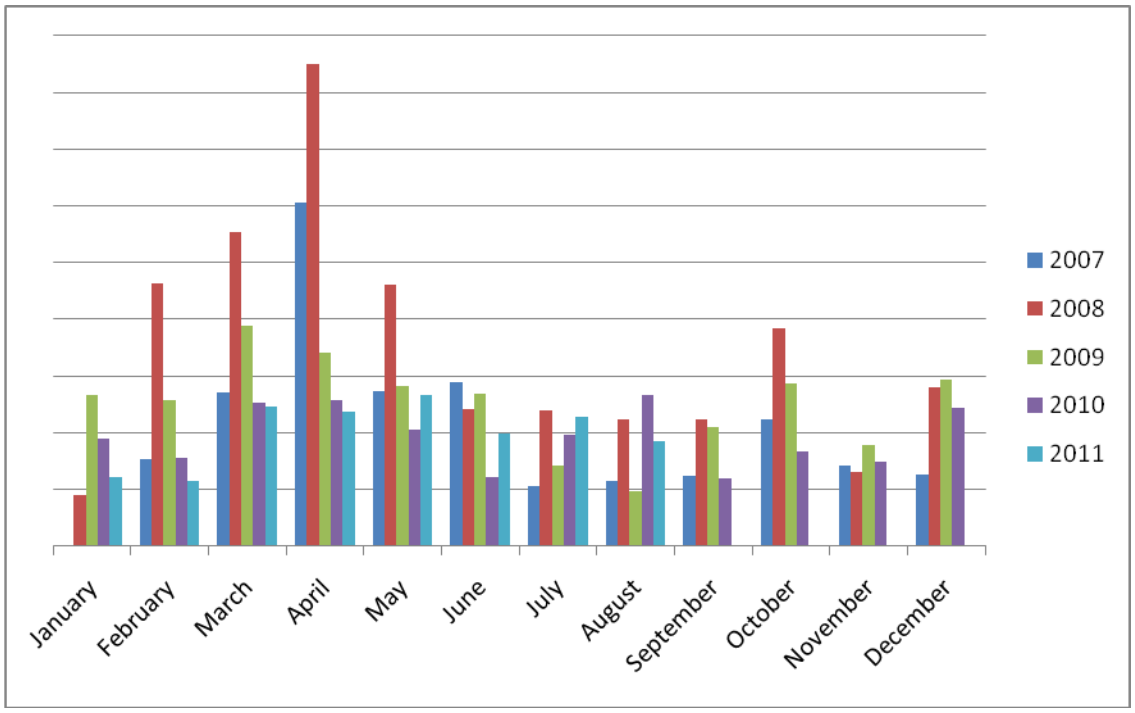
Maryland Trauma Physician Services Fund

Annual Report to the Maryland General Assembly
This year's Annual Report is complete and will be sent to the Maryland General Assembly by the end of October.

On-Call Applications
Payments were requested for Maryland Trauma Centers' on-call stipends reimbursement of on-call expenses for January 1 through June 30, 2011.

Uncompensated Care Processing
CoreSource, Inc., the third party administrator (TPA) for the Trauma Fund, adjudicated claims with a total paid value of approximately $366,971 in August 2011. The monthly payments for uncompensated care from March 2007 through July 2011 are shown below in Figure 1.

Figure 1 – Trauma Fund Uncompensated Care Payments 2007-2011



Cost and Quality Analysis

Report on Utilization of Privately Insured Services by the Nonelderly in Maryland
This report, *Healthcare Spending in Maryland's Individual and Small Group Markets,* has been completed. A summary of the report findings will be presented at the October Commission meeting by Dr. Claudia Schur, Vice President, Center for Health Research & Policy, Social & Scientific Systems. The report compares annual spending for professional, institutional, and prescription drug services by privately insured Maryland residents with health insurance obtained in three different health insurance markets: the individual market, the small employer market—the Comprehensive Standard Health Benefit Plan (CSHBP), and the state's high-risk health insurance program—the Maryland Health Insurance Plan (MHIP). The purpose of this report is to provide information from Maryland's Medical Care Database (MCDB) that may be useful to policymakers in implementing Maryland's Health Benefit Exchange.

The results show that utilization of health care services and spending are higher for persons covered through the small group market as compared to those who purchased coverage in the individual market. Not surprisingly, spending is highest for persons covered through the high-risk pool. Median spending among high-risk pool enrollees is almost three times that of persons covered in the small group market, and over five times that of those covered under individually-purchased policies. Regional variation in spending is slightly greater in the individual market than the small employer market but relatively limited overall.
The age and income distribution in each of the markets differs considerably. These differences in the age distribution of people covered in the markets partially explain the differences in health care spending. Almost one-quarter of users in the individual and small group markets are children less than 18 years of age, a group that tends to use relatively few health care services. In contrast, just 10 percent of users in the high-risk pool are children. People in the 60 to 64 year-old age group are highly likely to use health care

services; while fewer than ten percent of users with coverage through the individual or small group markets are 60 to 64 years of age, this age cohort accounts for almost one-quarter of those enrolled in MHIP. Spending by people in the MHIP, not surprisingly, is heavily influenced by greater disease burden. The expenditure risk score indicates substantially greater evidence of health conditions that are associated with higher spending. The typical (median) risk score for those in MHIP is over twice that of those in the small group market, and over three times that of individual purchasers.

In general, the relationship between income and use of health care services is not straightforward. People living in low-income zip codes tend to be in somewhat worse health (suggesting greater spending) but they also have fewer resources available to purchase services (which may lead to lower spending). Within each market, persons living in the lower-income zip codes are more likely to use both inpatient and outpatient hospital services. Risk scores are somewhat higher among users in lower-income zip codes, indicating more health conditions and helping to explain the higher use of both inpatient and outpatient hospital services. Median spending is higher within low-income areas for MHIP enrollees only; however, mean spending is higher for those within low-income areas across all three markets, suggesting that there may be a subset within the low-income group with particularly high spending.

In addition to the likely spending of those currently insured through the three markets discussed above, premiums for policies offered by the exchange will be influenced by new entrants who will come primarily from the pool of those currently uninsured. The largest group of currently uninsured adults can be represented by a male, 25 to 34 years of age, with an income just above the maximum for Medicaid eligibility (approximately $60k-$75k), and living in either the Baltimore or DC metro areas. Average spending for a person with these characteristics in the individual and small employer markets is substantially lower than the typical spending in each of these markets, suggesting that these types of entrants will tend to have a favorable impact on premiums in the Exchange.

Healthcare Workforce Measurement and Planning Activities

Staff has been involved in healthcare workforce measurement and planning activities during recent months. In June, Linda Bartnyska attended a conference on Monitoring Health Reform at the State Level: Access Measures Related to Workforce at George Mason University; it was funded by the Robert Wood Johnson Foundation under the auspices of the SHARE project (State Health Access Reform Evaluation). She was one of two presenters giving a state perspective on healthcare workforce access measures. In August, Linda participated in Maryland's Future of Nursing Regional Action Coalition subcommittee 8. The subcommittee is charged with addressing recommendation #8 from the Institution of Medicine's report, "The Future of Nursing: Leading Change, Advancing Health." The report focuses on the need for nurses' roles, responsibilities and education to change significantly in order to meet the increased demand for care that will be created by healthcare reform; recommendation 8 addresses the need to build an infrastructure for the collection and analysis of interprofessional healthcare workforce data. In September, Linda and Ben Steffen made presentations at the Governor's Workforce Investment Board's Summit meeting: Preparing for Health Reform: Health Care 2020. Linda made a presentation on the Commission's collection and analysis of physician data, and Ben made a presentation on Maryland's Patient Centered Medical Home Program.

Data and Software Development

Internet Activities

The number of unique visitors to the MHCC website increased again in September 2011 (Figure 2). While the number of unique visitors increased in September 2011 by approximately 2.8%, the number of visitors is still 5.3% below the June, 2011 number. However, when
September 2011 is compared to September 2010, the number of visitors increased approximately 7.3%.

Typically, visitors to the MHCC website arrive directly, by entering an MHCC URL or referencing our saved URL, via a search engine such as Google, or from a referral through another State site. Visitors

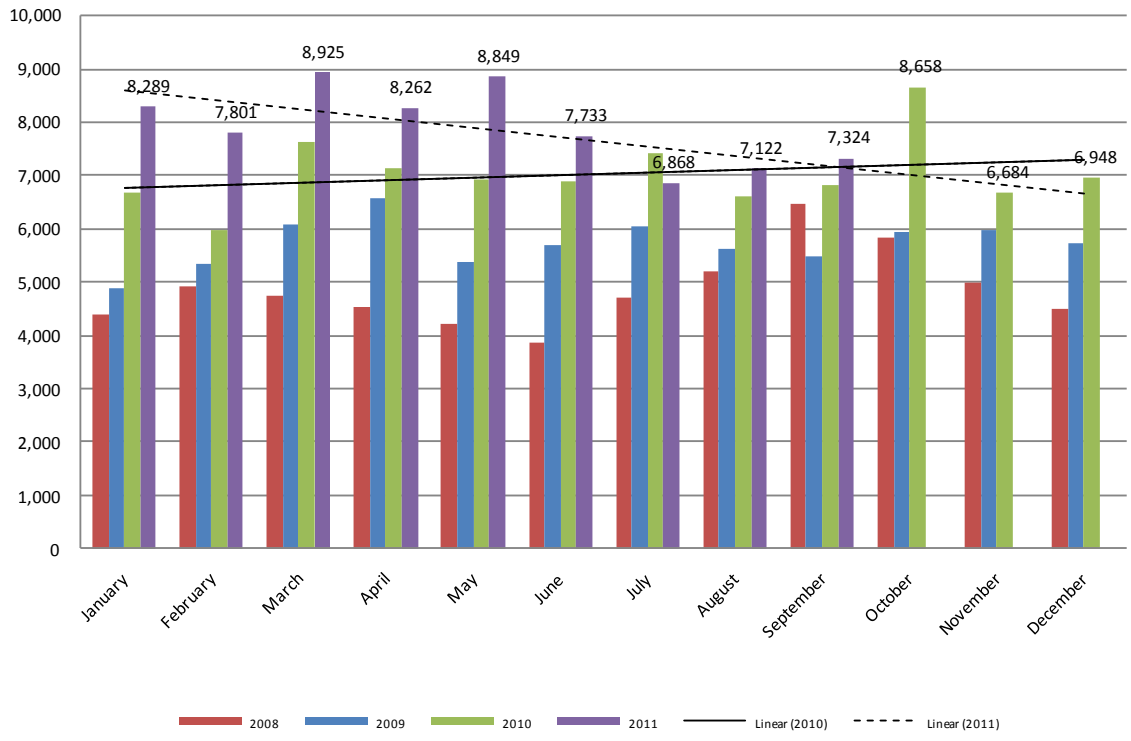
who arrive directly are typically aware of MHCC, but visitors arriving via search engines and referrals are more likely to be new users.

The number of visitors from all traffic sources to the MHCC websites also increased in September 2011, but again did not return to the level of June, 2011. The percentages by traffic sources for overall unique visitors decreased by approximately 2.7%, with 44.6% arriving via search engines, 35.2% directly, and 20.17% by referring sites, which is less than 1 percent variance over the past couple of months. Typically, these shares fluctuate up and down 3 to 4 percent from month to month. Google remains the dominant search engine, with a decrease from August 2011 of 1.8 % for a total of 28.9% of all visitors to the MHCC site, one of the highest levels in 2011. Among the most common search keywords in September:

- "maryland health care commission"
- "mhcc"
- "maryland healthcare"
- "hippa"
- "public comment"

The remaining visitors were again referred from sites such as other state agencies. This share also shifts 3 to 4 percent month-to-month with no consistent upward or downward trend. Among top referrers were the DHMH website, the Maryland Web Portal (Maryland.gov), dhmh.maryland.gov, consumerhealthratings.com, and pediatric.com.

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. Planning is underway for several new projects. The three projects are of equal importance – the Physician Portal for Patient Centered Medical Home, User Fee Assessment, and the Physicians License Renewal. A combination of internal and contractual resources will be used for this effort.

Table 1– Web Applications Under Development

Board	Anticipated Start Development/Renewal	Start of Next Renewal Cycle
Board of Physicians – Physician License Renewal	Development Underway	Start of Project: July 2011
Nursing Home Quality Site	Underway	Start of Project: February 2010
Health Insurance Compare	Underway	Start of Project: July 2010
Physician Portal/PCMH	On-going	Start of Project: April 2010
Hospital Quality Redesign	Planning	Start of Project: Fall 2010
User Fee Assessments	Completed	End of July 2011
Board of Chiropractors – License Renewal	Underway	Start of Project: July 2013
Partnership	On-going	
Hospice survey – Data Update	Completed	Start of Project: January 2012
Division of Drug Control Web Application	Planning	
Changes to all Boards web app Layout	On-going	

Maryland Telemedicine Task Force Financial and Business Model Advisory Group

The Maryland Telemedicine Task Force, Financial and Business Model Advisory Group, met on September 27th. The Advisory Group is considering recommendations to be made to the Maryland Quality and Cost Council regarding reimbursement of these services. Ben Steffen and David Sharp of the Commission staff and Robert Bass M.D., Executive Director of the Maryland Institute for Emergency Medical Services Systems (MIEMSS) presented a report on the status of the Maryland Telemedicine Task Force and its advisory groups' work to the Maryland Quality and Cost Council at its September 26th meeting. The next meeting of the Financial and Business Model Advisory Group will be held on October 26, 2011 from 1:00 to 3:00 p.m. in Room 100 at the offices of the Maryland Health Care Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215. Additional information on the Advisory Groups' work is available on the Commission's website at this link: http://mhcc.maryland.gov/electronichealth/telemedicine/index.html and on the Quality and Cost Council's website at this link: http://www.dhmh.state.md.us/mhqcc/telemedicine.html.

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

Health Plan Quality and Performance

The interview process for a Center Chief for Health Plan Quality and Performance was concluded in September. The selected applicant will be introduced at the Commission meeting.

The October 19, 2011 Board of Public Works meeting agenda includes review of the recommended vendors to provide services for the HEDIS Audit of Commercial Health Benefit Plans and the Survey of Commercially Insured Health Benefit Plan Members. A third RFP to secure the services for report development is at the Department of Budget Management for pre-release review.

The Health Benefit Plan Performance Report for Consumers will be released later this month. A press release is being prepared by staff. The companion Comprehensive Health Benefit Report which includes all HEDIS and CAHPS measures and related statistics is expected to be released in November. The Comprehensive report is used primarily by the health benefit plans and state policy makers.

Regulations COMAR 10.25.08, Evaluation of Quality and Performance of Health Benefit Plans were approved by the Commission for final action at the September meeting. The regulations are effective October 17, 2011. The regulations move preferred provider organization (PPO) plans from voluntary participation to mandatory participation in performance measurement and reporting. Staff are working with carrier representatives regarding PPO plans that will participate for reporting year 2012. Staff is also in the process of finalizing measures to be reported in 2012.

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. Over the past 30 days, the daily number of visits has almost doubled. The average time spent on the site and the number of pages viewed have also increased.

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 October 11, 2011 enrollment in the Partnership was as follows: 352 businesses; 1,027 enrolled employees; 1,739 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.

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. For the 2011 report, due by December 31st, Mercer will evaluate coverage for the treatment of bleeding disorders.

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
The official start of the FY 2010 Maryland Hospice Survey was May 23, 2011 with a due date of July 25, 2011. All 30 Maryland hospice programs have now completed the survey. Staff has reviewed and edited the data as needed with follow-up calls to the agencies as needed for data corrections. Data review has been completed and the public use data set is now posted on the Commission's website.

Hospice Advisory Group
As the first step in updating the Hospice Services section of the State Health Plan, the Commission is convening a Hospice Advisory Group. The Hospice Advisory Group is composed of: six representatives from Maryland's hospice industry, nominated by the Hospice and Palliative Care Network of Maryland to represent geographic areas as well as the for-profit and non-profit distribution of the members; an administrative representative of the Hospice Network; a representative from the Centers for Medicare and Medicaid Services (CMS) with expertise in planning, evaluation, and financing of hospice services; a representative from the Maryland Medical Care Policy Administration; and a representative of Maryland's Department of Health and Mental Hygiene's Office of Health Care Quality (OHCQ). The charge of the Hospice Advisory Group is to assist Commission staff in analyzing utilization trends, discussing factors contributing to the changes in utilization of hospice services, identifying potential factors affecting future need for hospice services, and discussing issues for policy development. The first meeting is scheduled for Tuesday, October 11, 2011.

Chronic Hospital Occupancy Report
Commission staff is currently reviewing the draft Chronic Hospital Occupancy Report for FY 2010, which is updated annually, as required under COMAR 10.24.08. It reports data on occupancy for both private and state-operated chronic hospitals. The private chronic hospitals in FY 2010 include James Lawrence Kernan Hospital; Johns Hopkins Bayview Medical Center; Levindale Hebrew Geriatric Center and Hospital; University Specialty Hospital; and Gladys Spellman Specialty Hospital and Nursing Center. The state-operated chronic hospitals include Western Maryland Center and Deer's Head Hospital Center. Following internal staff review, the Chronic Hospital Occupancy Report for FY 2010 will be published in the *Maryland Register*.

Minimum Data Set Project
Commission staff are working with Myers and Stauffer (contractor) via bi-weekly phone conference calls to make the transition from the federal minimum data set (MDS 2.0) to MDS 3.0 as well as to convert the program from FoxPro to SAS programming language so that it is supported by and consistent with other programs at the Commission. The initial focus has been on reviewing and updating variables and programs from MDS 2.0 to 3.0.

Home Health Agency Survey Data
The Home Health Agency (HHA) Utilization Tables for FY 2010 are currently being reviewed and edited. The data provided in these tables were obtained from the information collected by the Commission's Annual Home Health Agency Survey. The tables summarize agency and jurisdiction-specific data on the utilization and financing of home health agency services. An overview of HHAs in Maryland include: volume of admission; referral sources; primary diagnosis on admission; length of care; average visits per Medicare client; dispositions; average cost per visit; revenues by payer type; and home health agency personnel. Data provided on Maryland resident use of home health agency care include: age group; unduplicated clients by payer type; and visits by payer type. Upon final review, the HHA Utilization Tables for FY 2010 will be made available on the Commission's website.

Home Health Agency Survey
Phase 1 of the FY2011 Home Health Agency Survey collection period will commence on October 11, 2011 with a submission due date of January 10, 2012. Phase 1 agencies are home health agencies with a fiscal year end date on or before June 30, 2011. Survey notice letters were sent on October 3, 2011, notifying agencies that the survey is available for data entry. Phase 2 Agencies, which are agencies with a fiscal year end date of December 31, 2011, will have a survey data collection period that will begin March 2012. Staff is currently in the final steps of cleaning the fiscal year 2010 survey data. Once data cleaning is complete, public use data sets and staff reports will be produced.

Long Term Care Survey
Staff is currently in the process of cleaning the2010 Long Term Care Survey Data. Once data cleaning is complete, public use data sets and staff reports will be produced.

Long Term Care Quality Initiative

Nursing Home Experience of Care Surveys
A new RFP to secure a vendor to administer the surveys is still under review by Department of Budget and Management.

Seasonal Influenza Vaccination for Staff Working in LTC
In an effort to ensure that all employees paid by a nursing home receive the influenza vaccine, StateStat will report on the percentage of nursing homes with an influenza vaccination rate of 60% or higher in 2012. Both nursing home associations, LifeSpan and HFAM are working with MHCC staff to improve vaccination rates in nursing homes. To that end MHCC staff have produced a series of communications to encourage nursing homes and assisted living facilities to either provide the vaccine or direct staff to low cost or no cost alternatives. MHCC, LifeSpan and HFAM are also collaborating on a webinar for nursing homes to communicate strategies and resources to in enhance vaccination rate. HFAM has one currently scheduled for their members. Staff has also provided each association the participation rate for each of their member facilities in 2011.

Factors that increase the vaccination rate among HCW (healthcare workers in settings such as hospitals and ambulatory care) include:

- Requiring the vaccine as a condition of employment
- Offer vaccine on-site
- Offer vaccine for multiple days on-site
- Offer a token incentive (such as a drawing for a gift card or a day off)
- A personal reminder from the employer to acquire the vaccination

Conferences
MHCC staff attended the Agency for Healthcare Research and Quality's (AHRQ's) annual Conference held September 19-21, 2011. There were several presentations on long term care quality initiatives. Staff brought back information that will be used to enhance the public report of quality in LTC. Staff viewed a podcast titled “How Social Media Can Draw Visitors to a Quality Report” which described how the Massachusetts Health Quality Partners uses social media to promote awareness and use of its comparative quality reports.

CENTER FOR HOSPITAL SERVICES

Hospital Quality Initiatives

Hospital Performance Evaluation Guide (HPEG) Update
The Hospital Performance Evaluation Guide was updated on October 11th to include 27 "process of care" measures for heart attack, heart failure, pneumonia, surgical care and childhood asthma for the 12-month period ending March 2011. Patient experience measures were updated for 12-month period ending March 2011. These measures of the patient's perspective on the care provided by hospitals are important and valuable indicators of hospital quality and performance. The updated Hospital Guide also includes updated central line associated bloodstream infection (CLABSI) data for the 12-month period ending June 30, 2011. The new data shows a significant decrease (37%) in the number of CLABSIs in ICUs as compared to FY 2010. The staff will review the Hospital Guide updates during the October Commission Meeting, focusing specifically on the metrics that point to the progress hospitals have made in reducing preventable infections in intensive care units. For your convenience, a link to the hospital Guide is provided below:

http://mhcc.maryland.gov/consumerinfo/hospitalguide/index.htm

Healthcare Associated Infections (HAI) Data
Maryland acute care hospitals are required to use the CDC National Healthcare Safety Network (NHSN) surveillance system to report data to the Commission on CLABSIs in any ICU and surgical site infections related to Hip, Knee and CABG surgeries. On July 6th, the Board of Public Works approved MHCC's request to enter into a 5-year contract with Advanta Government Services, Inc to provide HAI data quality review and on-site medical chart audits to verify the accuracy and completeness of the HAI data submitted by hospitals. The contract officially began on August 1, 2011 and we anticipate the on-site chart audits to begin during the week of October 17th. This first year audit will focus on the review of FY2011 central line associated blood stream infections data.

Specialized Services Policy and Planning

Non-Primary Research Waivers for Percutaneous Coronary Intervention (PCI)
On September 15, 2011, the Commission took final action to amend COMAR 10.24.05, Continuation of Non-Primary Research Waivers Through Participation in the Follow-On C-PORT E Registry, by changing the requirement for patient follow-up from six weeks post-procedure to the time of hospital discharge. A notice of the final action on the amendments was published in the *Maryland Register* on October 7, 2011.

Each of the following hospitals has filed an application requesting renewal of the hospital's two-year waiver to provide primary PCI services without on-site cardiac surgery services: Holy Cross Hospital, Howard County General Hospital, Johns Hopkins Bayview Medical Center, and Saint Agnes Hospital. The staff has requested that each hospital provide additional information needed to determine whether the hospital meets the requirements in the State Health Plan for Cardiac Surgery and Percutaneous Coronary Intervention Services (COMAR 10.24.17, Table A-1).

Technical Advisory Group on Oversight of PCI Services
The Technical Advisory Group on Oversight of PCI Services held its third meeting on Tuesday, October 11, 2011 at the MHCC offices. Representatives of the Maryland Chapter of the American College of Cardiology, the Society for Cardiovascular Angiography and Interventions, and the Maryland Hospital Association's Necessary Care Work Group gave presentations on the role of internal and external peer

review in the oversight of PCI services; members of the advisory group discussed suggestions for statutory changes needed to provide appropriate oversight of PCI services. The final meeting of the Technical Advisory Group will be held on Tuesday, November 8, 2011, from 6:00 p.m. to 8:00 p.m., at the same location.

Hospital Services Planning and Policy/Certificate of Need

Certificate of Need ("CON")

CON Letters of Intent

Hospice of the Chesapeake – (Anne Arundel County)
A change in bed capacity through the establishment of a 14-bed inpatient hospice facility at 90-92 Ritchie Highway in Pasadena.

Hospice of Queen Anne's – (Queen Anne's County)
A change in bed capacity through the establishment of a six-bed inpatient facility at an existing hospice "residential center" located at 255 Comet Drive in Centreville.

Evidentiary Hearing

Washington Adventist Hospital – Docket No. 09-15-2295 (Montgomery County)
Replacement and relocation of a general acute care hospital contested by three interested parties.
A hearing convened from August 8 to August 12, 2011 was reconvened and concluded on September 8, 2011.

CON Applications Filed

Genesis Bayview SNF – Matter No. 11-24-2323 - (Baltimore City)
Construction of a 132-bed comprehensive care facility (CCF) on the campus of Johns Hopkins Bayview Medical Center (JHBMC). The proposed facility's beds will be acquired from and replace beds licensed and temporarily delicensed at JHBMC.
Estimated cost: $26,150,769

Determinations of Coverage

- **Ambulatory Surgery Centers**

Surgery Center of Annapolis, LLC – (Anne Arundel County)
Establish an ambulatory surgery center with one sterile operating room to be located at 130 Admiral Cochrane Drive, Suite 302, in Annapolis

- **Acquisition/Change of Ownership**

Northwest Nursing and Rehabilitation Center (Baltimore City)
Acquisition of PV Realty-Northwest, LLC, owner of the real assets of Northwest Nursing and Rehabilitation Center (Northwest) by White Pines Holdings III, LLC and acquisition of the assets and liabilities of Northwest Nursing, LLC, operator and licensee of Northwest by Northwest SNF, LLC d/b/a Northwest Nursing & Rehabilitation Center.

Manokin Manor Nursing and Rehabilitation Center – (Somerset County)
Acquisition of the real and personal property of Manokin Manor Nursing and Rehabilitation Center by Sabra Health Care Northeast, LLC.

Nine Physician Outpatient Surgical Centers

New determinations of coverage were issued for the acquisition of nine outpatient surgical centers originally established through determinations of coverage. Ownership of the facilities was split between two corporations, Ambulatory Surgery Center Development Company, LLC and Center for Pain Management ASC, LLC, both of which were owned by physicians practicing at the facilities. The facilities are:

Ambulatory Surgery Center Development Company, LLC

Center for Pain Management ASC – (Charles County)
3460 Old Washington Road, Suite 300
Waldorf, Maryland 20602

Center for Pain Management ASC – (Frederick County)
75 Thomas Jefferson Drive, Suite C
Frederick, Maryland 21702

Center for Pain Management ASC – (Harford County)
510 Upper Chesapeake Drive, Suite 415
Bel Air, Maryland 21014

Center for Pain Management ASC – (Howard County)
7120 Minstrel Way, Suite 106
Columbia, Maryland 21045

Center for Pain Management ASC – (Prince George's County)
16900 Science Drive, Suite 100
Bowie, Maryland 20715

Center for Pain Management ASC, LLC

Center for Pain Management ASC – (Anne Arundel County)
1600 Crain Highway, Suite 300
Glen Burnie, Maryland 21061

Center for Pain Management ASC – (Baltimore City)
3901 Greenspring Avenue, Suite 304
Baltimore, Maryland 21211

Center for Pain Management ASC – (Montgomery County)
11921 Rockville Pike, Suite 505
Rockville, Maryland 20852

Center for Pain Management ASC – (Washington County)
1150 Professional Court, Suite P
Hagerstown, Maryland 21740

In this transaction, physician practitioners owning the facilities, through the two ownership entities listed above, are transferring their ownership interest to National Spine and Pain Centers ASC Corp (NSPC ASC) [0.1%] and National Spine and Pain Centers, LLC (NSPC LLC) [99.9%]. NSPC ASC is wholly-owned by NSPC LLC, which is wholly-owned by National Spine and Pain Centers Holdings, LLC, which is owned by Sentinel NSPC Investments, LLC (Sentinel) [66.7%] and investment fund(s) managed by

Sentinel and physician practitioners (33.3%), who will continue to manage the daily operation of the facilities.

- **Other**

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

Moran Manor Health Care Center – (Allegany County)
Temporary delicensure of 10 CCF beds.

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

FutureCare – Old Court (Baltimore County)
Relicensure of 12 temporarily delicensed CCF beds for an authorized capacity of 144 CCF beds.

Corsica Hills Center (Queen Anne's County)
Relicensure of five temporarily delicensed CCF beds for an authorized capacity of 115 licensed CCF beds. The facility still retains five temporarily delicensed CCF beds.

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

Moran Manor Health Care Center – (Allegany County)
Relinquishment of 10 temporarily delicensed CCF beds leaving a total of 120 CCF beds.

Bethesda Health and Rehabilitation Center – (Montgomery County)
Relinquishment of seven temporarily delicensed CCF beds, leaving a total of 185 CCF beds.

  - **Miscellaneous**

Berkeley and Eleanor Mann Residential Treatment Center (RTC) at Sheppard and Enoch Pratt Hospital – (Baltimore County)
A change in RTC bed capacity, reducing the licensed bed capacity by three, leaving a total of 65 RTC beds, configured as 48 general beds and 17 beds dedicated to use by youth referred by the Multi-Agency Review Team, also known as "Lisa L" beds.

Brightwood Center – (Baltimore County)
Change in trade name from Brightwood Center to PowerBack Rehabilitation, Brightwood Campus.

- **Waiver Beds**

Charlotte Hall Veterans Homes (St. Mary's County)
Addition of six CCF beds. This request was denied based on non-compliance with applicable regulations.

General German People's Home of Baltimore d/b/a Edenwald (Baltimore County
Addition of seven CCF beds.

Planning and Policy

On September 26, 2011, Hospital Planning and Policy staff and staff from the Center for Long-Term Care Services met with staff of the Office of Health Care Quality of the Department of Health and Mental Hygiene to review planning and regulatory issues related to the emergence of "residential homes" by

general hospice programs, which are unlicensed venues for housing terminally ill hospice clients. Problems associated with the operation of these venues were discussed and options for addressing these problems were reviewed.

CENTER FOR HEALTH INFORMATION TECHNOLOGY

Health Information Technology

During the month, staff participated in the Office of the National Coordinator for Health Information Technology's (ONC) Health Information Technology (HIT) Policy Committee meeting. The HIT Policy Committee is tasked with developing recommendations on a policy framework for a national health information infrastructure, which includes standards for the exchange of electronic health information. During the month, the HIT Policy Committee discussed ONCs HIT strategic plan, the challenges of engaging consumers in e-health, the privacy and security of electronic health records (EHRs), and the potential for using a national HIT infrastructure to support select use cases for public health. Recommendations finalized by the HIT Policy Committee are considered for adoption by the National Coordinator and the Secretary of the Department of Health and Human Services. ONC also met with staff to discuss the need for revisions to strategies states have deployed to implement a statewide health information exchange (HIE). The MHCC is scheduled to present its HIT strategic plan to ONC in October.

Staff assessed about 26 EHR systems used by primary care practices participating in the Patient Center Medical Home pilot (PCMH). The assessment focused primarily on the technological capabilities around generating reports on the nearly 21 quality measures that practices participating in the PCMH pilot are required to track. As part of the evaluation, staff reviewed the privacy and security features and conducted a user satisfaction evaluation of the technology. In general, almost all EHRs used by practices participating in the PCMH pilot are able to report on the specified quality measures. EHR systems used by practices participating in the PCMH pilot are also included in the MHCC EHR Product Portfolio (portfolio). The portfolio contains product evaluation information on vendors that are nationally certified; information in the portfolio relates to product pricing, privacy and security, functionality capabilities, case studies, and user references. Participants in the portfolio have agreed to provide a discount to Maryland providers. The portfolio is updated bi-annually; the October release will include additional vendors, specialty vendors, and more detailed product functionality information.

The Management Service Organization (MSO) Advisory Panel subcommittees convened during the month. The Evaluation/Provider Satisfaction Committee met on two occasions to develop an MSO performance assessment tool (MSOPAT); the MSOPAT will assess provider satisfaction and was finalized with the assistance of nearly nine State Designated MSOs. State Designated MSOs plan to ask providers to respond to the MSOPAT in November. Results from the MSOPAT will be used to enhance MSO performance and identify opportunities for additional program development by the Regional Extension Center (REC) operated by the state designated HIE, the Chesapeake Regional Information System for our Patients (CRISP). The Criteria Committee also met twice during the month to review the existing MSO State Designation criteria to identify potential changes to the criteria. In general, MSOs must meet nearly 90 criteria related to privacy, technical performance, business practices, security, and operations to achieve State Designation. Revisions proposed by the Criteria Committee and approved by the MHCC will become effective in the next version of the criteria, which is targeted for release in January 2012.

In July, staff invited nearly 233 nursing homes to take part in an EHR adoption environmental scan (scan). This year, the distribution of the scan included all nursing homes as opposed to last year where the focus was on independent nursing homes. The report will overview EHR adoption, functionalities in use, and identify leading implementation challenges other than financial. During the month, staff

completed data entering of the responses and conducted a preliminary review of the data for the nearly 189 nursing homes that responded to the scan. Findings from the scan will be used by staff and the two long term care (LTC) associations, Health Facilities Association of Maryland and LifeSpan Network, to develop strategies aimed at increasing EHR adoption. Staff also began updating the Nursing Home EHR Product Portfolio (portfolio). The web-based portfolio is updated bi-annually and includes information to assist nursing homes in evaluating EHRs. The portfolio includes vendor presentation, line item pricing, pricing projections, policies for privacy and security, and consumer reference reports. Vendors participating in the portfolio agree to offer discounted pricing to LTC facilities in Maryland. Staff expects to finalize updates to the portfolio in October.

In July 2011, the General Assembly's Joint Committee on Health Care Delivery and Financing requested the MHCC to develop recommendations around best standards for prior authorization of prescription medications and medical services. Prior authorization establishes in advance the medical necessity of certain care and services covered by the payer. The prior authorization process is often manual, nonstandard, and perceived as burdensome to providers. Providers currently must complete different prior authorization forms for each payer, which are usually completed by hand and submitted via fax. Frequent follow-ups with payers via faxes, telephone calls, and messaging have been reported in the past resulting in a process that can take an extended amount of time to complete. Over the last month, staff convened several stakeholder meetings to discuss modifications to the prior authorization process. Discussions have centered on the use of web-based technology, turnaround times, and best practices on workflow requirements. Additional stakeholder meetings are scheduled in October to continue developing the recommendations. Audacious Inquiry, a consultant organization, is providing assistance in facilitating the work. A final report is targeted for release in December.

The Telemedicine Technology Solutions and Standards Advisory Group (workgroup) continued to evaluate the standards around technology required to support interoperable telemedicine networks in Maryland. The workgroup developed draft recommendations around a technical infrastructure that would support multiple clinical services through a centralized network that includes a provider directory. The network would allow for various organizations to connect through a secure Internet connection to a centralized telemedicine hub. Participants in the workgroup include hospital chief information officers, CRISP, physicians, local health departments, a representative from the American Telemedicine Association, and technology vendors. In 2010, the Telemedicine Task Force submitted a report to the Maryland Quality and Cost Council with recommendations related to expanding telemedicine for the treatment of stroke and other key clinical conditions. In November, former Secretary John Colmers requested that an Advisory Committee replace the Telemedicine Task Force and established three subcommittees to focus on making recommendations regarding use cases, technology, and the financial and business model. Audacious Inquiry, a consultant organization, is providing assistance in facilitating the work. A final report is due to the Maryland Quality and Cost Council in December.

Last month, staff provided input on several HIT workforce training programs for Johns Hopkins University (JHU) School of Nursing Curriculum Development Centers Program. As part of the American Recovery and Reinvestment Act of 2009 (ARRA), JHU received a grant of about $1.8M from ONC to develop HIT curriculum and instructional materials for community colleges and other educational institutions. Over the last year, staff has provided input on an ad hoc basis to JHU on proposed curriculum that would be used by community colleges in workforce training programs. Participants in these programs receive training on EHRs and HIT and are awarded a certificate at the completion of the course. HIT workforce training is aimed at educating practice managers and displaced workers to assist providers in implementing EHRs. JHU is one of five universities to receive funding under this program that is entering its second year.

Health Information Exchange

Staff continues to provide guidance to CRISP in implementing the statewide HIE and to its Advisory Board that consists of four committees: Finance, Technology, Clinical Excellence, and Small Practice

Advisory Committee. Last month, staff participated in the Small Practice Advisory Committee meeting. The Small Practice Advisory Committee provides recommendations from a clinical perspective to the CRISP REC program. Members discussed REC milestone accomplishments around assisting 1,000 priority primary care providers (PPCPs) (i.e., internal medicine, family practice, OB/GYN, pediatrics) to achieve meaningful use. To date, about 1,253 PPCPs have signed an agreement with an MSO, and roughly 206 PPCPs have demonstrated they have implemented certain functionality of their EHR (i.e., electronic prescribing) required for the Centers for Medicare and Medicaid Services meaningful use incentives. As of the end of September, all 46 acute care hospitals in Maryland are connected and about half are exchanging limited electronic health information through CRISP. During the month, staff participated in a CRISP Board of Directors strategic planning session that centered on developing strategies for connecting ambulatory providers to the statewide HIE. Activities related to the financial audit are ongoing; last month Clifton Gunderson, LLP continued to review CRISP's FY2012 financials.

Implementation activities continued in September as it relates to the Challenge Grant project, which is aimed at piloting the electronic exchange of clinical documents between pairs of LTC facilities and proximate hospital emergency departments (EDs). The pilot centers on six large LTC facilities across Maryland owned by Erickson Retirement Communities, Lorien Health Systems, and Genesis Healthcare. The ONC released a funding opportunity announcement in December of 2010 to encourage breakthrough innovations in HIE that can be scaled and replicated across the country. It sought applications in five "challenge areas", with one aimed at transitions of care in LTC. The ONC made ten 10 awards between $1-2M, and in January of 2011 the MHCC was awarded $1.6M to improve LTC and post acute care transitions through HIE; the Challenge Grant award duration is for 36 months. Participating LTC facilities are paired with a hospital in its immediate medical service area and the statewide HIE will be used for the exchange of electronic care summaries. As part of the Challenge Grant project, the MHCC is tasked with developing a model for electronic advance directives. In September, staff convened a focus group to discuss advance directives and other documents and processes relating to end-of-life care that could be improved through the use of the statewide HIE.

The HIE Policy Board (board) consists of roughly 30 members representing broad stakeholders and strong consumer orientation. The board is responsible for the development and recommendation of policies for the privacy and security of protected health information exchanged through HIEs operating in Maryland. Roughly 27 policies have been identified for development; all combined, the board has recommended 11 to staff which were adopted. Two workgroups were convened during the month that focused on finalizing the *Secondary Data Use* policy. During the month, the board met to consider recommending to the MHCC the adoption of the *Secondary Data Use* policy and the *Audit of Access, Use and Disclosure* policy; the board voted to approve recommending adoption of these policies to the MHCC. Policies recommended by the board and adopted by the MHCC will become proposed regulations governing HIEs in Maryland. House Bill 784, *Medical Records – Health Information Exchange* requires the MHCC to develop regulations for privacy and security of protected health information obtained or released through an HIE. Staff continues to draft proposed regulations and intends to seek informal public comments on them in November.

Several focus groups were convened during the month to assess provider and community-based organization awareness of electronic health information, trust in the electronic exchange of their information, and challenges related to consumer access and control in an environment where multiple HIEs exist. In general, providers who have adopted an EHR believe that consumers trust these providers will protect the privacy and security of their electronic health information. For the most part, community-based organizations are somewhat concerned over the risk of electronic health information being lost or stolen. Participants expressed a desire to control who has access to their electronic health information and trust their physician with using this information electronically. Koss on Care, a consultant organization, is providing assistance in facilitating focus groups and in drafting the final report. As part of the work, the consultant will conduct an in-depth interview with HIEs, providers, and community-based organizations throughout the state, as well as assess the consumer outreach and education efforts

underway. A report on the findings is targeted for release in January 2012 and will include recommendations for strategies to address consumer-related HIT challenges.

Electronic Health Networks & Electronic Data Interchange
COMAR 10.25.09 – *Requirements for Payers to Designate Electronic Health Networks* requires payers with a premium volume of $1 million or more to submit an annual EDI Progress Report (report) by June 30th. Approximately 51 payers submitted a report, which includes census level information on administrative health care transactions for roughly eight transaction types identified under the *Health Insurance Portability and Accountability Act of 1996, Administrative Simplification Provisions*. Staff continues to evaluate the data and work with payers to resolve reporting discrepancies. The final report is targeted for release in December.

National Networking
Last month, staff participated in several HIT webinars. NeHC presented, *HIT Orientation,* which introduced HIT to stakeholders new to the HIT. eHI presented, *Utilizing Existing Data Exchanges to Create ACOs* that explored the exchange requirements in the accountable care organization (ACO) program, and provided real-life examples of how an ACO can coordinate with existing HIEs to meet the requirements. Government Health IT presented, "*Proactive Security and Privacy Monitoring for Modern Health Care Networks*" that discussed emerging security, privacy, and compliance challenges health care institutions must manage as a result of the ARRA.