MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

November 2011

CENTER FOR INFORMATION SYSTEMS AND ANALYSIS

Patient Centered Medical Home Program

NCQA Recognition
47 of 52 practice sites submitted their NCQA recognition submissions on or before the October 28, 2011 deadline. Five practices received a deferment of up to one month in order to complete their recognition submissions. Special thanks to the Maryland Learning Collaborative team, headed by Dr. Niharika Khanna, for accomplishing this key program milestone.

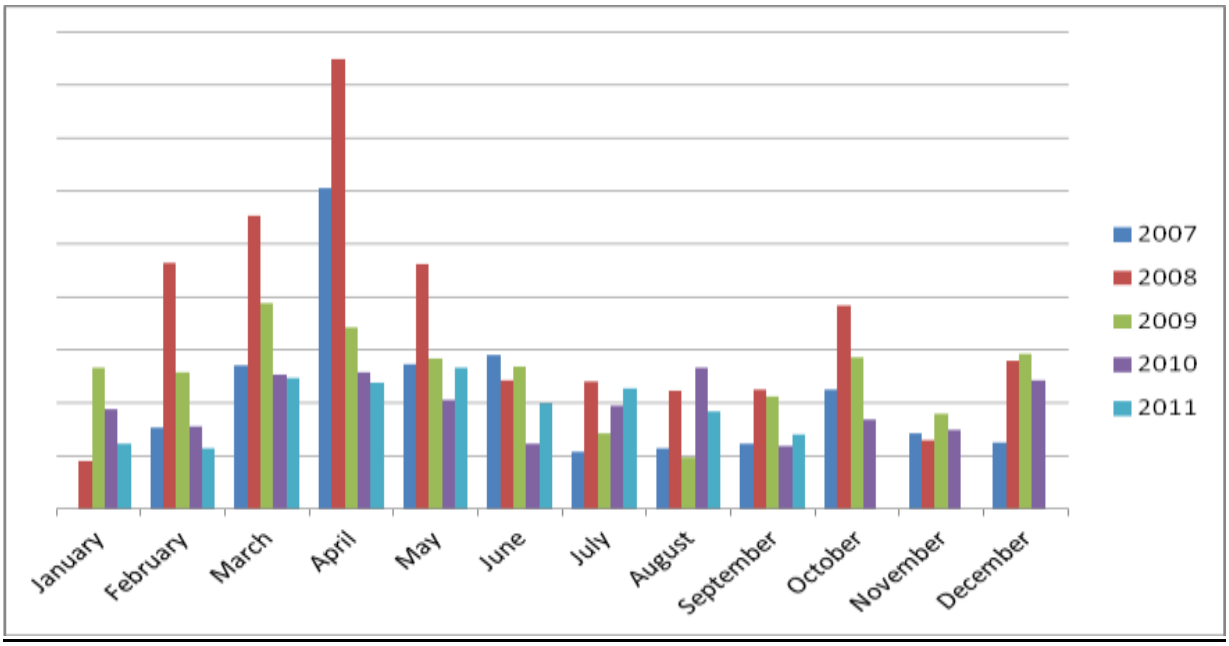
Maryland Learning Collaborative (MLC)
The next meeting of all practices will be November 11-12 with a focus on care management and practice efficiency. Project attendance will be close to 200 participants.

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

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 $278,212 in September 2011. The monthly payments for uncompensated care from March 2007 through September 2011 are shown below in Figure 1.

Figure 1 – Trauma Fund Uncompensated Care Payments 2007-2011



Cost and Quality Analysis

Report on Insurance Coverage through Maryland's Private Sector Employers
Every other year staff produce a report on health insurance coverage through the State's private sector employers, based on results from the Medical Expenditure Panel Survey (MEPS) – Insurance/Employer Component, conducted annually by the Agency for Healthcare Research and Quality. The MEPS Insurance Component sends questionnaires to private and public sector employers to collect data on the number and types of private health insurance plans offered, benefits associated with these plans, premiums, contributions by employers and employees, eligibility requirements, and employer characteristics.

This year's report, ***Medical Expenditure Panel Survey – Insurance Component, Maryland Sample through 2010,*** will examine private-sector establishments in Maryland that offered health insurance and the number of employees in these establishments who were eligible and enrolled in 2010. The report will provide this information by employer and workforce characteristics, such as firm size and industry type. It will include information on trends in health insurance premiums in Maryland through 2010 for single and family coverage, as well the employees' average share of premiums. The report will also present information on the percent of employees in a health plan with a deductible, the average size of the deductible, and the percent of enrollees with a deductible at or above the minimums required by the IRS for a Health Savings Account (HSA). This year's report will include new information comparing plan and enrollment characteristic in firms with fewer than 50 employees to those in firms with 50-99 employees; this information is expected to be of use to Maryland's Health Benefits Exchange Board. Other new information includes plan and enrollment characteristics for employees at firms where the majority of employees are part-time or low-wage workers. Results from this report will be presented at either the December or January Commission meeting.

Prescription Drug Analysis Requested By the Maryland Legislature
The emergence of orally administered drugs that replace intravenous or injected drugs has raised questions about the high patient cost sharing that can result. This issue has been complicated by evolving carrier and employer benefits design plans that require unlimited cost sharing on the pharmacy benefit. These benefit structures largely have not anticipated technology changes that have made very costly drugs that were covered through the medical benefit when they were injected or delivered intravenously available through the pharmacy benefit when delivered orally. Staff recently completed an analysis of prescription claims in the Maryland Medical Care Data Base (MCDB) that had patient cost-sharing of $250 or more to provide legislators with information on the volume and types of prescriptions that have high levels of patient cost-sharing.

The study analyzed privately insured, covered prescription drug claims from the 2009 MCDB; claims for self-insured employers and the federal government were excluded from the study. The study database had 7.8 million claims, representing 11.3 million 30-day-or-less prescriptions. **Less than 1 percent of prescriptions had a patient liability of $250 or more. Of the 11.3 million prescriptions, 10,708 had a patient liability amount of $250 or more. These prescriptions were distributed among 4,917 patients of the more than 1.5 million patients in the prescription drug component of the MCDB.** About half of the patients with liability for an individual prescription of over $250 had total liabilities for high cost prescriptions of less than $500. Antirheumatics, used in the treatment of arthritis and interferons, typically used to treat multiple sclerosis and cancer, were the most common intermediate categories of drugs where high patient liabilities might be applied. These two intermediate drug categories accounted for $3 million of the total $7.7 million in patient spending for high cost-sharing prescriptions. Hormone and hormonal modifiers also accounted for a significant share of patient spending; these drugs are commonly used in oral chemotherapy.

The total liability per patient for high cost sharing prescriptions reflects both the volume of prescriptions received by the patient and the existence of required deductibles. The number of prescriptions per patient ranged from one to 20, with half of the patients receiving just one prescription. The volume of

prescriptions per patient that included a deductible ranged from zero to 10, with at least half of the patients having at least one prescription with a deductible.

The small group market accounts for the largest percentage of patients having at least one prescription with a patient liability of $250 or more (36 percent), followed by patients insured in the large group market (21 percent). Recent changes in the pharmacy benefit allowing coinsurance could have the unintended consequence of significantly increasing patient obligations for very expensive drugs. MHCC will investigate this question when the 2010 MCDB pharmacy claims become available early next year.

Frequency of Patients with a Prescription with Patient Liability of $250 or More By Coverage Type

Coverage Type	Frequency	Percent
Small Group	1777	36
Large Group	1048	21
MHIP	532	11
Individual Market	348	7
Unknown	*1212*	*25*
All	4917	100

Data and Software Development

Internet Activities

The number of unique visitors to the MHCC website increased again in October 2011 (Figure 2). While the number of unique visitors increased in October 2011 by approximately 2.5%, the number of visitors is 10.4% below October 2010, which was an exceptional month.

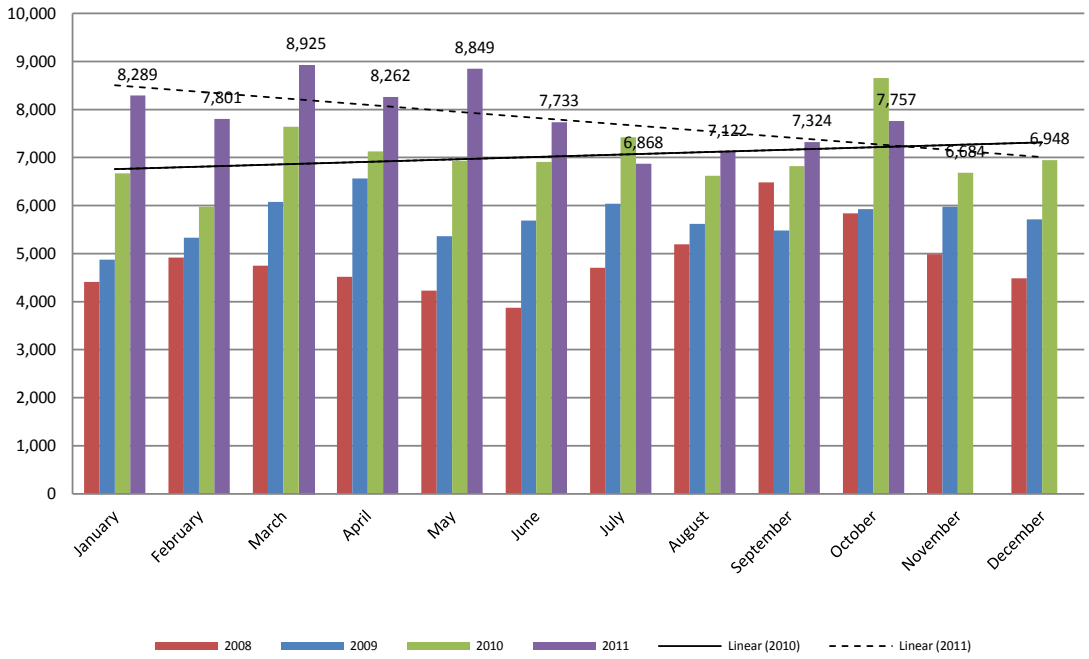
Typically visitors to the MHCC website arrive via a search engine such as Google, directly, by entering an MHCC URL or referencing our saved URL, or from a referral through another State site. Visitors who arrive directly are typically aware of MHCC, but visitors arriving via search engines and referrals are more likely to be new users.

The number of unique visitors increased by 4% in October. The number of visitors arriving via search engine was 47%, directly was 34%, and referred from other sites was 19%. Typically, these shares fluctuate up and down 3 to 4 percent from month to month. Google remains the dominant search engine, with an increase from September 2011 of 2% for a total of 31% of all visitors to the MHCC site, again one of the highest levels in 2011. Among the most common search keywords in October:

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

The 34% of visitors were 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, hscrc.state.md.us, and consumerhealthratings.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 Division of Drug Control web application and changes to all Boards' web applications layout. A combination of internal and contractual resources will be used for these efforts.

Table 1– Web Applications Under Development

Board	Anticipated Start Development/Renewal	Start of Next Renewal Cycle
Board of Physicians – Physician License Renewal	Complete	Start of Project: July 2011
User Fee Assessments	Underway	End of July 2011
Board of Chiropractors – License Renewal	Underway	July 2013
Board of Psychologists	Development	Release December 1, 2011
Partnership	On-going	
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 October 26th. 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) will present 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 December 16th meeting. 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 2011 Health Benefit Plan Performance Report also referred to as the *Consumer Guide* has been prepared and is pending authorization for public release shortly. The annual theme for the *Consumer Guide* this year focuses on maintaining wellness.

The 2011 Comprehensive Performance Report: Commercial HMO, POS, and PPO Health Benefit Plans in Maryland also referred to as the *Comprehensive Report* is in the draft stage and is currently being reviewed by the division for content and design changes. Public release is anticipated in mid-December 2011.

The division has finalized the 2012 Health Benefit Plan Reporting Requirements. A memorandum will soon be released identifying measures to be reported in 2012 as well as health benefit plans that are being required to report. This will be followed by a web-based kick-off meeting in early December for health benefit plans in preparation for the pending 2012 Healthcare Effectiveness Data and Information Set (HEDIS) audit and Consumer Assessment of HealthCare Providers and Systems (CAHPS) survey activities.

The division is preparing a Request for Proposal (RFP) to solicit a contractor for the Report Development component of the division.

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 analytics have remained steady in terms of daily number of visits, average time spent on the site and the number of pages viewed.

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 November 8, 2011 enrollment in the Partnership was as follows: 353 businesses; 1,018 enrolled employees; 1,712 covered lives. The average annual subsidy per enrolled employee is about $2,340; 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. Commission staff will present this report at the December meeting.

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 is in the process of conducting this analysis, which Commission staff will present at the December meeting. The report is due to the General Assembly by January 1, 2012.

Long Term Care Policy and Planning

Hospice Advisory Group
As the first step in updating the Hospice Services section of the State Health Plan, the Commission convened 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.
Two meetings of the Hospice Advisory Group were held. The first meeting, held on October 11, 2011 focused on data trends and policy issues. Presentations were made on hospice issues from the perspectives of CMS, Medicaid, and the Office of Health Care Quality. In addition, data depicting trends in hospice utilization were presented. The second meeting, held on November 1, 20011 began with a review of hospice methodologies used in other states, as well as a discussion about the current Maryland hospice need projection methodology. The meeting then focused on data assumptions and key variables, such as age, use rate, growth rate, and volume threshold.

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 finalized. 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 admissions; 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 began 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. Twenty one (28%) agencies are expected to complete the survey during Phase 1. Phase 2 agencies have a fiscal year end date of December 31, 2011 and will have a survey data collection period beginning in March 2012.
Staff has completed the final steps of cleaning the fiscal year 2010 survey data. Public use data sets and home health agency utilization tables will be produced and made available on the Commission's website by December 2011.

Long Term Care Survey
Staff is currently in the process of cleaning the 2010 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
The RFP to secure a vendor to administer the surveys was released; proposals are due December 1, 2011. Staff is targeting a new award to be made in early 2012 so that survey results can be available by summer.

Seasonal Influenza Vaccination for Staff Working in LTC
Staff is working with both nursing home associations, LifeSpan-Network and Health Facilities Association of Maryland (HFAM), to design the webinar described in the October update that will communicate strategies and resources to enhance influenza vaccination take-up rate among staff employed n nursing homes and assisted living residences.

LTC Web Portal
MHCC LTC quality staff and database and applications development staff have spent a significant amount of time testing changes to the LTC web portal to enhance function, add the capability to display influenza rates for nursing homes and other LTC settings, and enable updating of data for each facility type in real time.

Conferences
Staff continues to monitor developments in the broader quality arena to be informed of the cutting-edge of quality measurement applicable to long term care. The National Quality Forum (NQF) has released Palliative and End-of Life Care Measures for public comment in November. A final decision of endorsement of specific measures is due by the end of February 2012. Following this decision CMS is expected to make announcement of measures CMS may require of providers for report or payment update purposes.

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 the 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 indicate a significant reduction (37%) in the number of CLABSIs in ICUs as compared to FY 2010. The staff is working on additional enhancements to the Guide including the addition of 30-day readmission data and information summarizing hospital performance over time for healthcare associated infections measures. In addition, the staff is preparing for new emergency department measures and global immunization measures that are required for submission on January 1, 2012.

Healthcare Associated Infections (HAI) Data

Maryland 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 on-site audits are underway and should be completed by the end of November. The first year audit will focus on the review of FY2011 central line associated blood stream infections data.

Specialized Services Policy and Planning

Amendments to COMAR 10.24.17

Commission staff released draft proposed amendments to the State Health Plan Chapter for Cardiac Surgery and Percutaneous Coronary Intervention (PCI) Services (COMAR 10.24.17) for informal public comment on November 1, 2011, with comments due on November 8, 2011. The draft was posted on the Commission's website and distributed by e-mail to affected institutions as well as interested persons. The proposed amendments are designed to address the process by which an interventional cardiologist who has not performed the required number of PCI cases during a 12-month period that includes a brief leave of absence from clinical practice may resume performing PCI in a hospital issued a waiver by the Commission. At its public meeting on November 17, 2011, the Commission will review the staff analysis of the informal public comments and consider adoption of the recommended changes as emergency and proposed permanent regulations.

Non-Primary PCI Research Waivers

Pursuant to COMAR 10.24.05.03, the following hospitals submitted applications to continue performing non-primary PCI through participation in the Follow-on C-PORT E Registry: Anne Arundel Medical Center (Docket No. 08-02-0032 NPRW), Saint Agnes Hospital (Docket No. 08-24-0028 NPRW), Shady Grove Adventist Hospital (Docket No. 08-15-0027 NPRW), Southern Maryland Hospital Center (Docket No. 08-16-0031 NPRW), Frederick Memorial Hospital (Docket No. 08-10-0034 NPRW), Meritus Medical Center (Docket No. 08-21-0035 NPRW), Baltimore Washington Medical Center (Docket No.

08-02-0029 NPRW), and Johns Hopkins Bayview Medical Center (Docket No. 08-24-0030 NPRW). On November 17, 2011, the Commission will consider the staff recommendations on these applications.

Primary PCI Waivers

An updated schedule for the submission of primary PCI waiver applications will be published in the *Maryland Register* on November 18, 2011. A hospital that seeks to initiate primary PCI services without on-site cardiac surgery must submit an application for a waiver according to the published schedule. A hospital with a two-year waiver must timely file an application for the renewal of its waiver.

Notice of the docketing of the following primary PCI waiver renewal applications was published in the *Maryland Register* on November 4, 2011: Holy Cross Hospital (Docket No. 11-15-0063 WR), Howard County General Hospital (Docket No. 11-13-0061 WR), Johns Hopkins Bayview Medical Center (Docket No. 11-24-0062 WR), and Saint Agnes Hospital (Docket No. 24-13-0060 WR). The Commission may issue a primary PCI waiver for a two-year period, provided that the applicant hospital meets and continues to meet all requirements for primary PCI programs without on-site cardiac surgery (COMAR 10.24.17, Table A-1). The Commission will consider these applications at its December meeting.

Technical Advisory Group on Oversight of PCI Services

The Technical Advisory Group on Oversight of Percutaneous Coronary Intervention Services held its final meeting on Tuesday, November 8, 2011, from 6:00 p.m. to 8:00 p.m., at 4160 Patterson Avenue, Baltimore, Maryland 21215. Members of the advisory group completed a discussion of suggested statutory changes to provide appropriate oversight of PCI services, and reviewed an outline of its report to the Commission. The report is expected to be completed by November 30, 2011. House Bill 1182 (2011 regular session) requires the Maryland Health Care Commission to report the Commission's recommendations to the Governor and the General Assembly by December 31, 2011.

Solid Organ Transplantation

Updated projections of the need for solid organ transplantation were published in the Maryland Register on October 7, 2011, pursuant to the need projection methodology of COMAR 10.24.15, the State Health Plan Chapter for Organ Transplant Services.

Hospital Services Planning and Policy/Certificate of Need

Certificate of Need ("CON")

CON's Approved

Solomons Nursing Center (Calvert County) – Docket No. 11-04-2317
Addition of 12 comprehensive care facility (CCF) beds to an existing CCF
Cost: $3,504,204

CON Letters of Intent

Massachusetts Avenue Surgery Center, LLC – (Montgomery County)
Add an operating room (OR) through conversion of an existing non-sterile procedure room

Massachusetts Avenue Surgery Center, LLC – (Montgomery County)
Add an OR by leasing adjacent space and renovating that space

Pre-Application Conference

Hospice of the Chesapeake (Anne Arundel County)
Add bed capacity through development of a freestanding inpatient facility
October 7, 2011

Massachusetts Avenue Surgery Center, LLC – (Montgomery County)
Expand OR capacity by leasing adjacent space and renovating that space
October 19, 2011

CON Applications Filed

ManorCare-Fairwood – Matter No. 11-16-2324 – (Prince George's County)
Establishment of a 110 bed CCF on Fairwood Parkway in Bowie. All of the proposed CCF beds would be "relocated" from other ManorCare facilities (HHCC-Adelphi – 65 beds; HHCC-Hyattsville – 30 beds; and ManorCare-Largo – 15 beds)
Estimated cost: $16,042,836

Waldorf Nursing & Rehabilitation Center – Matter No. 11-08-2325 - (Charles County)
Relocation of a previously approved 67-bed CCF (Certificate of Need, Docket No. 10-08-2309 The project, which includes 80 assisted living beds, was authorized for a site at 3735 Leonardtown Road in Waldorf. The new site is Lot 1, Part of Parcel AA, Fairway Village in St. Charles Communities, located off Demarr Road near the intersection with St. Charles Parkway, in Waldorf
Estimated cost:

Modified CON Applications Filed

Lorien-LifeCenter-Harford – Docket No. 08-12-2288 – (Harford County)
Request a change in the approved facility design and a revision to the approved budget, staffing, manpower and operating projections.

Determinations of Coverage

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

Liberty Heights Health & Rehabilitation Center – (Baltimore C0ty)
Temporary delicensure of 23 CCF beds

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

Brighton Gardens – (Montgomery County)
Relinquishment of 2 temporarily delicensed CCF beds leaving a total of 39 CCF beds

FutureCare-Chesapeake – (Anne Arundel County)
Relinquishment of 2 temporarily delicensed CCF beds leaving a total of 152 CCF beds

    - **Miscellaneous**

Seasons Hospice and Palliative Care
Confirmation that the acquisition of VNA Hospice of Maryland, LLC by Seasons Hospice and Palliative Care established legal authority to provide hospice services to residents of Carroll County, as determined by the Maryland courts.

Manokin Manor Nursing & Rehabilitation Center – (Somerset County)
Termination of lease operation agreement between Hermitage Health Care of Manokin Manor, LLC (lessee) and Skipjack, LLC (lessor) with respect to operation of this CCF

Planning and Policy

On October 3, 2011, the *Annual Report on Selected Maryland Acute Care and Special Hospital Services, FY 2012*, was published on the MHCC website. This report provides data on licensed hospital bed inventories and facility and service inventories for acute care hospital emergency, obstetric, and surgical departments.

On October 4, 2011, the Acute Rehabilitation Work Group held its second meeting. This group is assisting MHCC staff in updating COMAR 10.24.09, the State Health Plan chapter for Acute Inpatient Rehabilitation Services. The focus of this meeting was methods for forecasting the need for acute rehabilitation beds and key factors to take into account in forecasting.

CENTER FOR HEALTH INFORMATION TECHNOLOGY

Health Information Technology

Staff participated in the Office of the National Coordinator for Health Information Technology's (ONC) monthly Health Information Technology (HIT) Policy Committee (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. The committee discussed proposed recommendations to the Department of Health and Human Services on issues raised by an Advance Notice of Proposed Rulemaking, entitled *Human Subjects Research Protections*, which was published on July 26, 2011. The recommendations focus on secondary uses of data and consent related to safeguarding electronic health record (EHR) data that is used for research. The committee explored various technology and policy challenges to developing protocols for a model that would query data maintained in EHR systems. The protocols would allow data requestors to pose research questions and enable data holders to decide whether to provide data, which remains under control of the disclosing entity. During the meeting, representatives from the HIT Standards Committee presented on progress in developing standards related to metadata and common vocabularies used in exchanging electronic health information.

Staff released the fourth version of the MHCC EHR Product Portfolio (portfolio), a web-based guide for the evaluation of EHR systems. The portfolio provides product evaluation information on vendors that are nationally certified, including product pricing, privacy and security, functionality capabilities, case studies, and user references. In this release of the portfolio, providers will find more detailed information related how EHR systems manage security around protected health information, the ability to generate consumer reports, and flexibility for a practice to develop customized reporting on unique quality measures. Vendors participating in the portfolio have agreed to offer a discount to Maryland providers. Roughly 29 vendors participate in the portfolio and 20 additional vendors have agreed to participate in this version. Staff updates the portfolio on a bi-annual basis.

Emergency regulation COMAR 10.25.16, *Electronic Health Record Incentives,* was approved during the month by the Joint Committee on Administrative Executive and Legislative Review. The emergency regulation was approved with a September 15, 2011 effective date and is set to expire on March 3, 2012. The proposed permanent regulation was published in the Maryland Register on October 21, 2011. The regulation is a result of the 2011 General Assembly passing House Bill 736, *Electronic Health Records – Incentives for Health Care Providers – Regulations* (HB 736), which was signed into law by Governor Martin O'Malley on May 19th. COMAR 10.25.16 requires certain state regulated payers to provide incentives of monetary value to primary care practices for adopting an EHR. HB 736 requires the incentive be paid in cash unless an alternative incentive is agreed upon by the primary care practice. In coordination with the payers, staff developed a standard application that primary care practices can

complete to request an EHR adoption incentive. Primary care practices can earn up to $15,000 per payer for adopting an EHR and meeting select criteria. In 2012, staff plans to evaluate the EHR adoption incentive program and make recommendations to the Commission about expanding the regulation to include other provider types.

Staff finalized the Management Service Organization (MSO) performance assessment tool (MSOPAT) that will be administered by State Designated MSOs to practices in November. The MSOPAT asks questions related to MSO services in an effort to assess value to the practice. The Regional Extension Center (REC), operated by the state designated HIE, the Chesapeake Regional Information System for our Patients (CRISP), will use the results from the MSOPAT to identify opportunities for program enhancement. To achieve State Designation, MSOs must meet nearly 90 criteria related to privacy, security, business practices, technical performance and operations and undergo accreditation from a nationally recognized accreditation organization. Over the last month, the MSO Criteria Committee finalized changes to the State Designation criteria, which becomes effective on January 1, 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. Approximately 189 nursing homes responded to the scan. Last month, staff completed the data analysis; all combined, nursing home adoption of EHRs is around 56 percent. The report will overview EHR adoption, functionalities in use, and identify leading implementation challenges other than financial. Findings from the scan will be used by staff and the two long term care (LTC) associations, Health Facilities Association of Maryland (HFAM) and LifeSpan Network, to develop strategies aimed at increasing EHR adoption. Staff presented preliminary findings from the scan at the annual HFAM conference. Staff also completed 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, privacy and security policies, and consumer reference reports. Vendors participating in the portfolio agree to offer discounted pricing to LTC facilities in Maryland.

During the summer the General Assembly's Joint Committee on Health Care Delivery and Financing requested the MHCC to develop recommendations around best standards for electronic prior authorizations for pharmacy and medical services. Most payers and pharmacy benefit managers (PBM) require prior authorization to establish medical necessity for certain prescriptions and medical services. The prior authorization process is often manual, nonstandard, and perceived as burdensome to providers. Staff convened two stakeholder meetings to develop recommendations for implementing an electronic prior authorization process. Payers and PBMs are supportive of an electronic system that allows for a single sign-on process to their website or portal that can be used for entering or tracking prior authorization requests. The recommendations under consideration would be phased in over a two-year timeframe and include an electronic form, assignment of a tracking number by payers and PBMs to each prior authorization request, and a notification and determination process on non-urgent prior authorization requests that exceed the existing state requirements of two business days. 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) finalized its recommendations around the standards and technology required to support interoperable telemedicine networks in Maryland. The workgroup proposed recommendations for a technical infrastructure that would support multiple clinical services through a centralized network, which 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. The workgroup is one of three that was formed in response to a 2010 report submitted 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 2010, 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 is providing assistance in facilitating the work. A final report is due to the Maryland Quality and Cost Council in December.

Staff continues to provide 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, JHU is one of five universities that received a Curriculum Development Centers Program grant of about $1.8M from ONC to develop HIT curriculum and instructional materials for community colleges and other educational institutions. During the month, staff provided feedback to JHU on the first component of curriculum materials developed. Curriculum materials developed by these universities are available on the ONC website. In November, staff is scheduled to present on HIT opportunities to Health Informatics and Information Technology Program students at Catonsville Community College.

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 discussion centered on identifying strategies to connect ambulatory practices to the state designated HIE. In general, the cost of EHRs and the challenges around meeting the Federal EHR adoption incentive requirements are barriers to practices connecting to the HIE. The Small Practice Advisory Committee provides recommendations from a clinical perspective to the REC. A requirement of the REC is to assist priority primary care providers (PPCPs) (i.e., internal medicine, family practice, OB/GYN, pediatrics) to meet the meaningful use requirements in the Centers for Medicare & Medicaid Services (CMS), Medicare and Medicaid Programs; Electronic Health Record Incentive Program: Final Rule. To date, approximately 1,311 PPCPs have implemented select functionalities of an EHR required by CMS for the meaningful use incentives. 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). Participation agreements were signed by two out of the three long term care (LTC) facilities participating in the project. Interface development for the electronic exchange of demographic data between LTC facilities and the statewide HIE are underway. The MHCC was awarded approximately $1.6 from the ONC in January 2010 as part of the *State Health Information Exchange Cooperative Agreement Program* to pilot the electronic exchange of clinical documents between pairs of LTC facilities and proximate hospital emergency departments (EDs). The project is aimed at reducing hospital readmission rates for the pilot population. Six large LTC facilities owned by Erickson Retirement Communities, Lorien Health Systems, and Genesis Healthcare are participating in the project. During the month, Erickson Retirement Communities began to complete an online survey for residents that are discharged to the hospital. The survey is designed to capture basic information on the transition of care that will be used to measure performance. As part of the project, the MHCC is tasked with developing a model for electronic advance directives.

Staff continues to provide support to the HIE Policy Board (board) as they develop policy recommendations for the privacy and security of electronic health information exchanged through HIEs operating in Maryland. During the month, staff continued to develop the *Data Use and Disclosure* policy. Roughly 27 policies have been identified for development; to date, the board has developed recommendations for 11 policies. 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. Recommendations supported by the MHCC will become proposed

regulations governing HIEs in Maryland. Staff continues to draft regulations from recommended policies and will seek informal comments before finalizing the proposed regulations. A workgroup consisting of board members is scheduled to meet in November to finalize the *Data Use and Disclosure* policy and discuss the *Consumer Access to Audit* policy.

Data analysis is underway on information collected during the consumer and provider HIE focus group meetings that were held in September. Staff is assessing 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. A common theme expressed by focus group participants is the need for a repetitive and evolving approach to engage consumers in HIE. Focus group participants also noted that providers need to become more familiar with HIE in order to function as an information resource to consumers. Koss on Care, a consultant organization, is providing assistance in facilitating focus groups and in drafting the report. A final report is targeted for release in January 2012 and will include recommendations to address consumer-related HIT challenges.

Electronic Health Networks & Electronic Data Interchange

Staff continues to analyze census level information on administrative health care transactions included in the payer EDI Progress Reports. 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 detailing transaction volume for roughly eight transaction types identified under the *Health Insurance Portability and Accountability Act of 1996, Administrative Simplification Provisions*. A final report is targeted for release in December. During the month, staff recertified three electronic health networks (EHNs): PNC Bank, Post-N-Track Corporation, and QS1. COMAR 10.25.07, *Certification of Electronic Networks and Medical Claims Clearinghouses*, requires the MHCC to certify EHNs that transmit to payers doing business in the state, approximately 41 EHNs are certified. EHNs receive MHCC certification for a two-year period; this certification is based on each network obtaining accreditation from a nationally recognized organization.

National Networking

Last month, staff participated in several HIT webinars. CRISP presented *Medicaid Incentives with Paul Messino* that provided an overview of the Maryland Medicaid EHR adoption incentive program. eHI presented, *Old Data Learns New Tricks: Managing Patient Privacy and Security on a New Data-Sharing Playground*, which discussed common strategies to overcome leading barriers to safeguarding personal information from those who intend to cause harm. NeHC presented, *Florida-based Big Bend RHIO and Ohio-based HealthBridge* where leaders discussed their unique business models.