MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

January 2012

CENTER FOR INFORMATION SYSTEMS AND ANALYSIS

Patient Centered Medical Home Program

Since September of 2011 and as of January 9, 2012, the following practices have been notified that they had achieved NCQA Level III recognition: Potomac Physicians (3 sites) , University of Maryland Family Medicine, Johns Hopkins Community Physicians (2 sites), MedStar, Union Primary Care, Stone Run Family Medicine, Calvert Internal Medicine (2 sites), Ulmer Family Medicine, and Dobin and Hoeck. NCQA is still processing the applications from the balance of the sites and so this is a partial report of level III practices.

Quality Measure reporting in the aggregate, and without benchmarks, is due February 29, 2012. A web portal was established by MHCC and is being tested by several volunteer practice sites with the final version to be released to all practice sites on or about January 29, 2012.

A mini-collaborative meeting for the Maryland Learning Collaborative is planned for February 4, 2012.

Care Management reporting of time and patient contacts will begin July 2012.

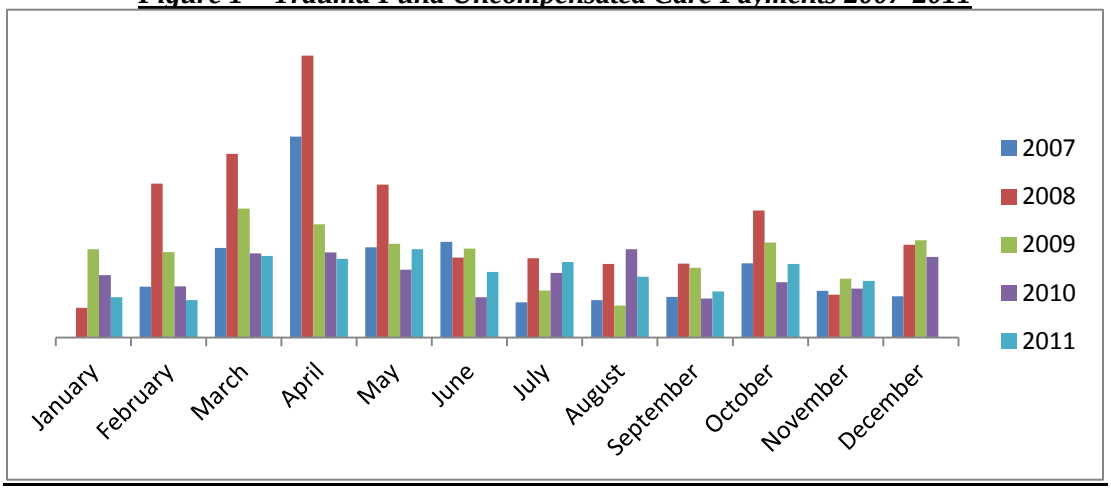
Information regarding the PCMH program is available on the Commission's website at: http://mhcc.maryland.gov/pcmh/.

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 $ 343,212 in November 2011. The monthly payments for uncompensated care from March 2007 through November 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 – Insurance/Employer Component, conducted annually by the Agency for Healthcare Research and Quality. A presentation on this year's report, ***Medical Expenditure Panel Survey – Insurance Component, Maryland Sample through 2010,*** will be made at the January Commission meeting. The report provides information on availability of, and enrollment in, employer-offered health insurance by employer and workforce characteristics, such as firm size and industry type. It includes information on trends in health insurance premiums in Maryland through 2010 for single and family coverage, as well the employees' average share of premiums. It reports the percent of employees in a health plan with a deductible, the average size of the deductible, and—new this year—the percent of enrollees with a deductible at or above the minimums required by the IRS for a Health Savings Account (HSA). Also new this year, are comparisons for firms with fewer than 50 employees to those in firms with 50-99 employees and information for employees at establishments where the majority of workers are part-time or low-wage (earning no more than $11.50 per hour).

Submission of 2010 Data for the Maryland Medical Care Data Base (MCDB)
The submission of data by CareFirst is not yet complete. The very late submission of data by CareFirst has significantly delayed the construction of the complete 2010 MCDB. Consequently, the annual report on utilization of professional services will be delayed by a couple of months.

Reports in Development – State Health Expenditures
This year the Commission will be producing a report on annual health care spending in Maryland. The report—a collaboration of staff from the MHCC and the data base vendor, Social & Scientific Systems—will use a new methodology for estimating annual health care spending developed by the state of Florida. The Florida methodology is based on the methods used by the Centers for Medicare & Medicaid Services (CMS) to estimate state-level spending for all states, which CMS does every five years.

The Maryland spending report is in development, but will likely contain the following information:

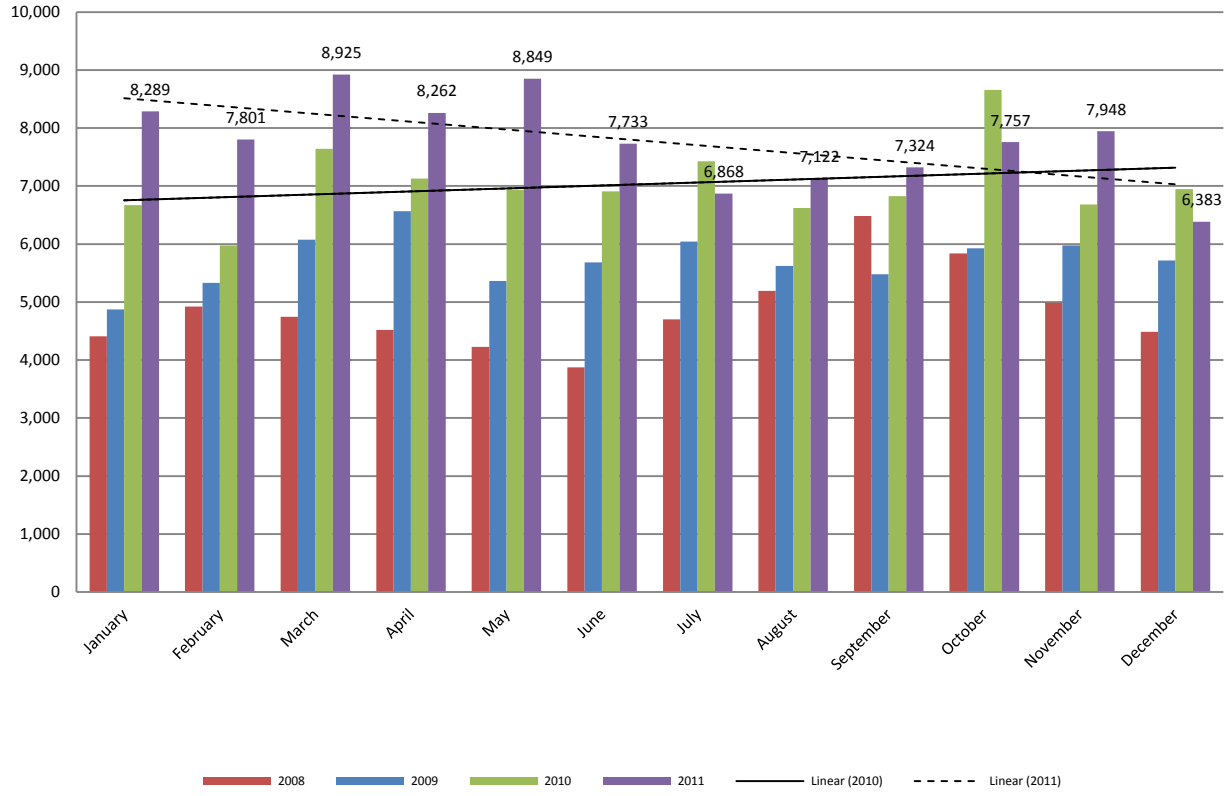
- Total and per capita spending, 2010
- Trends in total and per capita spending
- Spending by type of service, 2010
- Trends in spending by type of service
- Comparisons to other states—using CMS data—through 2009.

Data and Software Development

Internet Activities
The number of unique visitors to the MHCC website decreased in December 2011 (Figure 2) by approximately 20 percent, to the lowest number of visitors since March 2010. December 2011 was 8% below December 2010. The number of new visitors was 22 % lower than last month as well.

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.

Figure 2 -- Unique Visitors to the MHCC Web Site



The number of visitors from all traffic sources to the MHCC websites decreased in December 2011 by 18% to the lowest it has been since December, 2009 when we started using this software package for web statistics. Of note is that while the number of visitors decreased by a significant amount, the proportion of traffic sources continued to be within 15 of the proportions in November 2011. Traffic arriving by search engines increased by 1% to 47%. This was offset by the slight decreases in traffic for users arriving directly, to 33% and the users from site referrals, to 21%. 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 December 2011 of 18% for a total of 49% of all visitors to the MHCC site, the highest level since starting to use this software package. Among the most common search keywords in December:

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

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, crisphealth.org, and consumerhealthratings.com.

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 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
PCMH Quality Measure website	Under Development	
PCMH Public Site	On-going Maintenance	Project goes live: end of January, 2012
PCMH Portal (Learning Center & MMPP)	On-going Maintenance	
Boards & Commissions Licensing Sites (13 sites)	On-going Maintenance	
Boards & Commissions Licensing Sites (13 sites)	Modifying for Ethnicity	
Health Insurance Partnership Public Site	On-going Maintenance	
Health Insurance Partnership Registry Site	Monthly Subsidy Processing	
Health Insurance Partnership Registry Site	Monthly Registration	
Health Insurance Partnership Registry Site	On-going Maintenance	
Hospice Survey Update	Redesign in progress	Project goes live: February, 2012
Long Term Care 2011 Survey	Annual Maintenance	Start of Project: January 2012
Hospital Quality Redesign	Planning	Start of Project: Fall 2010

Maryland Telemedicine Task Force Financial and Business Model Advisory Group

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 December 19th 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 Comprehensive Performance Report: Commercial HMO, POS, and PPO Health Benefit Plans in Maryland, also referred to as the Comprehensive Report, is in the final draft stage and currently being reviewed by the division for minor content and design changes. The 2011 Comprehensive Report will, for the first time, contain an Executive Summary that aims to paint a picture of Maryland's commercial health benefit plans' overall performance on various quality measures. Public release of the report will follow and overview of the report at the January Commission meeting.

As a result of health benefit plan feedback following the December 8th kick-off meeting to discuss Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of HealthCare Providers and Systems (CAHPS) survey tools, as well as the 2012 Quality and Performance Reporting Requirements (QPRR), resulted in release of a Revised and Final 2012 QPRR for Maryland's commercial health benefit plans on December 14th. The Revised and Final 2012 QPRR identified required measures to be reported in 2012, measures that are encouraged for quality improvement initiatives by health benefit plans, as well as health benefit plans that are known to be required to report.

Taking a collaborative approach to the expanded regulation of Maryland health benefit plans, an additional teleconference with health benefit plan representatives has been scheduled for January 18th to discuss 2013 QPRR as well as other policy matters including potential reintroduction of eValu8 as a complementary measurement tool. It had been piloted and discontinued due to lack of voluntary plan participation. It is a labor intensive measurement tool and we are carefully evaluating whether the "juice is worth the squeeze."

The division has forwarded to the Department of Budget and Management (DBM) for review and approval a Request for Proposals (RFP), to solicit a contractor to provide continued support with the development of the HMO/POS/PPO quality and performance reports.

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 3, 2011. 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 January 10, 2012 enrollment in the Partnership was as follows: 359 businesses; 1,014 enrolled employees; 1,713 covered lives. The average annual subsidy per enrolled employee is about $2,375; the average age of all enrolled employees is 40; the group average wage is about $28,000; the average number of employees per policy is 4.0. The 4th annual report on the implementation of the Partnership was submitted to the General Assembly on January 1st and is posted on the Commission's website.

Mandated Health Insurance Services
Insurance Article § 15-1501, Annotated Code of Maryland, requires the Commission to submit an annual report to the General Assembly on: (1) any proposed mandated health insurance service that failed during

the preceding legislative session; and (2) any request for analysis on a proposed mandated benefit that was submitted by a Legislator to the Commission by July 1st of that year. The 2011 report, an evaluation on coverage for the treatment of bleeding disorders was prepared by Mercer, approved by the Commission at the December meeting, and submitted to the General Assembly. The report is also posted on the Commission's website.

As required under Insurance Article § 15-1502, Annotated Code of Maryland, every four years, the Commission is required to conduct an analysis on the full cost of each existing mandated health insurance service in Maryland as a percentage of premium and as a percentage of wages, as well as a comparison of Maryland's mandates to those in Delaware, Pennsylvania, Virginia, and the District of Columbia. Mercer conducted this analysis, which the Commission approved at the December meeting. The report was submitted to the General Assembly and is posted on the Commission's website.

Long Term Care Policy and Planning

Section S of MDS
The Centers for Medicare and Medicaid Services (CMS) requires that all nursing homes complete the federal minimum data set (MDS) for all residents. In review of the data, MHCC noticed that Section S (state-specific items) was not fully completed. Many of these demographic items had been part of MDS 2.0, but were removed from MDS 3.0. The Office of Health Care Quality (OHCQ) is the data repository for MDS data. Staff consulted with Deb Horton, State MDS Coordinator, and Bryon Dedmond, Director of Information Technology for OHCQ. Staff then developed a joint letter from OHCQ and MHCC, urging nursing homes to provide complete and accurate data. This letter was also sent to the nursing home associations for their information and to ask them to encourage their members to complete the data as required.

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. Variables have now been updated into the MDS Manager Program.

Hospice Regulations Workgroup
The Office of Health Care Quality has convened a work group to develop regulations to address the development of residential hospice programs, or "hospice houses." These currently do not fall under the purview of the licensing regulations. Commission staff is participating in this development process. The first meeting was held on November 29th. The second meeting is scheduled for January 10, 2012.

Home Health Agency Survey Data
Commission staff is reviewing and analyzing home health agency utilization trend data, based on submission of information reported by every home health agency in Maryland on the Commission's Annual Home Health Agency Surveys.

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. All agencies complied with the deadline, and all surveys have been accepted. Planning for Phase 2 of the FY2011 HHA survey, expected to be sent out in March, has commenced.

Long Term Care Survey
Staff is currently in the process of cleaning the FY 2010 Long Term Care Survey Data. Staff is following with nursing homes to resolve discrepancies with the data. Once data cleaning is complete, public use data sets and staff reports will be produced. Planning for the FY2011Long Term Care Survey, expected to be sent out in March, has commenced.

Long Term Care Quality Initiative

Nursing Home Experience of Care Surveys
Three organizations responded to the RFP with a significant range in price. A vendor has been selected and we are scheduled to go before the Board of Public Works in late January for final approval. Staff has begun internal preparations and is gathering needed materials so that work can begin as soon as BPW approval is obtained.

Seasonal Influenza Vaccination for Staff Working in LTC
Being vaccinated for influenza is voluntary unless the employer chooses to make it a condition of employment. 40% of nursing home employees are currently opting out for medical, religious or other reasons. This is consistent with the national experience.

In an effort to improve the vaccination rate, staff in collaboration with the nursing home associations, is planning a webinar for the end of January/early February with an exciting and knowledgeable speaker, Hilary Babcock, MD, MPH who will discuss: "effective strategies to increase rates and reduce worker resistance to vaccination". Dr. Babcock is author of an article describing implementation of an influenza vaccination policy in a large health system that includes hospitals, community settings and LTC. She is also a member of the National Vaccine Advisory Committee, sub-group that wrote the recommendations for achieving Health People 2020 goals for influenza vaccination of HCW.

We will also provide resources that can be used to increase awareness of the benefits of vaccination among full time nursing home staff.

CENTER FOR HOSPITAL SERVICES

Hospital Quality Initiatives

Hospital Performance Evaluation Guide (HPEG) Update
The HQI staff has been in the process of preparing for the January update to the Hospital Performance Evaluation Guide which will include updates to the 27 "process of care" measures for heart attack, heart failure, pneumonia, surgical care and childhood asthma for the 12-month period ending June 2011. Patient experience measures are also updated for 12-month period ending June 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 Guide will also include 30-day readmission measures for AMI, Heart Failure, and Pneumonia in the January update.

Data Collection Initiative for Specialized Cardiac Care
All Maryland acute general hospitals with a waiver from the MHCC to provide primary percutaneous coronary intervention (PCI) services or with a certificate of need for a cardiac surgery and PCI program are required to report quarterly data to the Commission through use of the American College of Cardiology Foundation's (ACCF) National Cardiovascular Data Registry (NCDR®) ACTION Registry®-

GWTG™ and ACCF's NCDR CathPCI Registry®. These reporting requirements apply to eligible patients discharged on or after July 1, 2010. A copy of the Register notices and related information is available on the Commission's Cardiac Data webpage located at http://mhcc.maryland.gov/cardiac_advisory/index.html.

In addition, as a condition of designation as a Cardiac Interventional Center, the Maryland Institute for Emergency Medical Services Systems (MIEMSS) requires hospital participation in the NCDR ACTION Registry to fulfill its data reporting requirements under COMAR 30.08.16.02 D (9). These reporting requirements also apply to three out of state hospitals operating under Memoranda of Understanding with MIEMSS as Cardiac Interventional Centers.

The staff has been working on the development of a process, format and schedule for the transfer of the ACTION and CathPCI registry data to the MHCC. We have been working collaboratively with MIEMSS to create a single data transfer process to accommodate the data requirements of both agencies and to minimize the burden on hospitals.

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 central line associated bloodstream infections (CLABSIs) in any ICU and surgical site infections related to Hip, Knee and CABG surgeries. MHCC has established a five 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 have been completed and the final report is under development. The staff is working with the vendor to develop enhanced internal data quality checks and recommendations for improvements to our established auditing process. The staff in collaboration with the contractor are also preparing for a webinar to update hospital Infection Preventionists on our findings and to review current NHSN definitions and requirements. Finally, the staff are working with the contractor to develop a strategy for the review and auditing of surgical site infections data.

Specialized Services Policy and Planning

Amendments to COMAR 10.24.17

Notice of the Commission's proposed action to amend the State Health Plan Chapter for Cardiac Surgery and Percutaneous Coronary Intervention (PCI) Services (COMAR 10.24.17) was published in the *Maryland Register* on December 30, 2011. 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 percutaneous coronary intervention (PCI) in a hospital issued a waiver by the Commission. The Commission will accept public comments on the proposal through January 31, 2012.

Primary PCI Waivers

On December 15, 2011, the Commission approved the renewal of two-year waivers to provide primary percutaneous coronary intervention (PCI) services without on-site cardiac surgery services for the following hospitals: Holy Cross Hospital; Howard County General Hospital; Johns Hopkins Bayview Medical Center; and Saint Agnes Hospital.

Statutory Recommendations on PCI Oversight

House Bill 1182, *Certificates of Need – Percutaneous Coronary Interventions Services,* required that the Commission develop recommendations for statutory changes needed to provide appropriate oversight of PCI services and report its recommendations to the Governor and the General Assembly by December 31, 2011. The Technical Advisory Group (TAG) on Oversight of PCI provided input to the MHCC over its four meetings in July, September, October, and November of 2011. A summary report of the TAG's

activities and consensus recommendations was presented to the Commission at the public meeting on December 15, 2011. Public comment regarding the TAG report was invited, and thirteen entities submitted written comments. A full report including statutory recommendations was approved by the Commission on December 22, 2011, and sent to the General Assembly and the Governor on December 28, 2011. Here is a summary of the recommendations:

1. Percutaneous coronary intervention should be identified in the statute as a service regulated by MHCC, in the same manner that the law now specifically identifies cardiac surgery, organ transplant surgery, and other services as categorically regulated.
2. Oversight of the establishment and continuing performance of PCI services can be accomplished through the Certificate of Need (CON) exemption process, which may not be as lengthy and resource-intensive as the regular CON process.
3. The Commission believes that it is appropriate to "grandfather" existing primary PCI programs that met and continue to meet requirements established or to be established in the State Health Plan.
4. MHCC should be given statutory authority to oversee PCI and cardiac surgery, including existing cardiac surgery hospitals, on an ongoing basis after issuance of a CON or an exemption from CON. This ongoing regulatory authority will require that PCI and cardiac surgery programs meet minimum performance standards as a condition of continuing to provide PCI and cardiac surgery services.
5. MHCC should be identified in Health-General §19-218 and Health Occupations §14-411 as a State agency that can receive and share information for the purpose of investigating quality or utilization of care in regulated facilities.

Hospital Services Policy & Planning/Certificate of Need

Certificate of Need ("CON")

CON's Approved

Knollwood Manor – (Anne Arundel County) Docket No. 11-02-2316
Construction of a replacement comprehensive care facility (CCF) at a new site. The existing 87-bed CCF will be replaced by a 110-bed CCF through "relocation" of the existing 87 beds and 23 CCF beds from other Anne Arundel County CCFs operated by the applicant.
Approved cost: $20,403,760

Modified CON's Approved

Lorien LifeCenter Harford – (Harford County) – Docket No. 08-12-2288
Design changes and cost increase ($169,895) in an approved new 78-bed CCF to be located near Blenheim Road and Pulaski Highway, in Havre de Grace.
New approved cost: $9,485,458

CON Letters of Intent

Carroll Hospital Center – (Carroll County)
Construction of an Outpatient Cancer Center and renovation to the existing Dixon Building on the hospital campus.

Chesapeake Woods Center – (Dorchester County)
Addition of 23 CCF beds.

Mercy Medical Center – (Baltimore City)
Addition of six operating rooms.

Pre-Application Conference
Hospice of Queen Anne's – (Queen Anne's County)
Change inpatient hospice bed capacity through conversion of a non-licensed residential program to a licensed inpatient facility
December 12, 2011

Carroll Hospital Center – (Carroll County)
Construction of an Outpatient Cancer Center and renovation to the existing Dixon Building on the hospital campus.
December 14, 2011

Chesapeake Woods Center – (Dorchester County)
Addition of 23 comprehensive care facility beds allocated to Caroline County to the facility located in Dorchester County, per COMAR 10.24.08.07.(1)
December 21, 2011

First Use Approval
Holly Hill Nursing & Rehabilitation Center – (Baltimore County) – Docket No. 08-03-2285
Addition of 20 CCF beds and related renovations
Cost: $3,657,475

(Partial First Use) Williamsport Nursing Home – (Washington County) – Docket No. 07-21-2195
Addition of 22 CCF beds. Renovation phase of project in progress.
Estimated cost: $10,513,100

Determinations of Coverage

- **Ambulatory Surgery Centers**

Ambulatory Surgery Center Development Company, LLC – (Prince George's County)
Establish an ambulatory surgery center with two non-sterile procedure rooms to be located at 8824 Cunningham Drive, Suite D, Berwyn Heights, Maryland.

Center for Pain Management, LLC – (Baltimore County)
Establish an ambulatory surgery center with two non-sterile procedure rooms to be located at 1838 Greenetree Road, Suite 150, Pikesville, Maryland

- **Acquisitions/Change of Ownership**

Holly Hill Nursing & Rehabilitation Center – (Baltimore County)
Acquisition of the ownership interests of PV Realty-Holly Hill MD, LLC by OHI Asset HUD, WO, LLC

- **Waiver Beds**

Goodwill Mennonite Home, Inc. (Garrett County)
Addition of 9 CCF beds yielding a new total of 107 CCF beds

St. Catherine's Nursing Home (Frederick County)
Addition of 7 CCF beds yielding a total of 83 CCF beds

Hospital Services Policy & Planning

On December 2, 2011, Hospital Policy & Planning (HPP) staff, along with other MHCCH staff, visited Union Memorial Hospital (UMH) for a presentation on the UMH PCI program and an opportunity to observe the PCI facilities and program in operation.

On December 7, 2011, HPP staff and other MHCC staff met with representatives of American Hospice Management to discuss work on amending COMAR 10.24.08 with respect CON regulation of hospice services and AHM's proposals for obtaining docketing of CON applications to establish new hospice programs in Maryland.

On December 9, 2011, HPP staff and other MHCC staff met with the Maryland Hospital Association's Legislative and Regulatory Council to discuss MHCC's work on developing a report to the General Assembly on regulatory oversight of PCI at Maryland hospitals.

On December 13, 2011, HPP staff participated in a meeting of the Health Services Cost Review Commission's Capital Work Group.

On December 14, 2011, HPP staff attended a presentation by representatives of the American College of Cardiology on the 2011 updates to the ACCF/AHA/SCAI Guideline for PCI.

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 progress of the Centers for Medicare and Medicaid Services Electronic Health Record Incentive (EHR) Programs. The committee considered challenges related to the implementation and management of disclosure policies from the perspective of the patient, law enforcement, or an organization. During the meeting, key recommendations regarding a framework of security protections for EHRs were identified and include the following: security policies should be responsive to innovation and changes in the marketplace; security policies should be flexible and scalable; providers need education and guidance on how to comply with security policy requirements; and the Department of Health and Human Services should have a consistent and dynamic process for updating security policies and rapid dissemination of new rules and guidance to all impacted.

Last month staff provided support to the Statewide HIE Coalition (Coalition) in developing comments to the Office of the National Coordinator for Health Information Technology (ONC) on the impact of implementing ONC's defined transport protocols known as Direct. States are working towards multiple forms of health information exchange (HIE) that include query based exchange and secure point-to-point messaging otherwise known as Direct. Query based HIE offers long term sustainability and requires significant time and financial commitments, as well as the participation by a large number of data contributors to generate value to users. Direct has potential for moving beyond the current, rudimentary forms of electronic health information exchange but has limitations relative to the longer term need for solutions that can easily and cost-effectively address the increasingly diverse and intensifying demands for data exchange. The Coalition noted the importance of Direct and emphasized the significance of building a sustainable infrastructure that supports multiple forms of HIEs.

Staff provided guidance to the state-regulated payers implementing the revised regulations, COMAR 10.25.16, Electronic Health Record Incentives adopted by the Commission at the December 15th Commission meeting. The regulation requires certain state-regulated payers to pay cash as the incentive for adopting and meaningfully using an EHR unless a provider and payer agree on an incentive of equivalent value. Previously, incentive categories were determined by the payer and administered through increased reimbursement for specific services, lump sum payments, gain-sharing, and in-kind payments. The regulations were modified as a result of House Bill 736, *Electronic Health Records – Incentives for Health Care Providers – Regulations* (HB 736), that was passed by the General Assembly during the 2011 legislative session. As part of the regulation, certain state-regulated payers are required to report annually on their activities under the incentive program. The incentives are currently aimed at primary care practices. Staff plans to convene payers and providers in July 2012 to discuss the potential of expanding the regulations to include other provider types.

Staff awarded management service organization (MSO) *State Designation Candidacy Status* to Verushealth, LLC; eight MSOs are currently *State Designated* and about nine MSOs are in *Candidacy Status*. MSOs have one year to complete almost 90 criteria related to privacy, technical performance, business practices, resources, and security required for *State Designation*. MSOs provide centralized administrative and technology services that allow providers to adopt a hosted EHR through a monthly subscription fee, and are considered a viable alternative to the EHR client-server model where the technology is hosted by the provider. These organizations assume the maintenance of the technology and the privacy and security of the data. During the month, MSOs asked providers to respond to the MSO Performance Assessment Tool (MSOPAT). The MSOPAT assesses provider satisfaction and the results are used to enhance MSO performance and identify opportunities for additional program development by the Regional Extension Center (REC), which is operated by the state designated HIE, the Chesapeake Regional Information System for our Patients (CRISP).

Staff continues to provide support to acute care hospitals in completing their *2011 Hospital Health Information Technology Survey* (survey). The survey assesses the rate of HIT adoption among hospitals and evaluates the extent of adoption within the hospital's patient care areas, as well as assesses the planning efforts related to HIT. Staff has received about 80 percent of the surveys and anticipates collecting the remaining surveys in January. Responses to nearly 21 questions are reported in aggregate, based on size, geographic location, and affiliation with other hospitals and health systems, and benchmarks Maryland's HIT adoption progress with national activity. Results from the survey are used by hospitals to compare performance with other hospitals and assess technology adoption trends. The findings are also used by staff in developing strategies aimed at advancing HIT in the state. Although this survey is similar to several administered nationally, it is unique in that it includes planning questions in an effort to better understand the future of HIT adoption. The survey is scheduled for release in the spring of 2012 and will be the fourth year the MHCC has assessed hospital HIT adoption.

Staff presented the findings from the *Recommendations for Implementing Electronic Prior Authorization* to the Joint Committee on Health Care Delivery and Financing. In general, the recommendations include a phased approach that focus on short-term solutions to incrementally reduce the burden on providers, state-regulated payers, and third party administrators (TPAs) by taking advantage of payer portals for identifying prescription medication and medical services that require prior authorization, including the required information on the portal for completing the request, enabling online tracking of the request, and processing prior authorization requests in real time when no additional information is required. Prior authorization is required by payers and TPAs to establish medical necessity for certain prescriptions and medical services. The MHCC developed recommendations based on feedback from stakeholders. Stakeholders agree that there is room to improve the prior authorization process, and preferred voluntary adoption as opposed to legislation. Over the next year, the MHCC intends to monitor payer and TPA progress with implementing the recommendations.

The *Telemedicine Task Force Report* was presented to the Maryland Health Cost and Quality Council (Council) in December. The recommendations focus on state regulated payer voluntary reimbursement of telemedicine services; a centralized telemedicine network; and changes in licensure, credentialing, and privileging of providers to facilitate the adoption of telemedicine. Over a six-month timeframe, three committees were convened by the MHCC and the Maryland Institute of Emergency Medicine Services Systems (MIEMSS) to formulate the recommendations: Clinical Advisory Group, Technical Solutions and Standards Advisory Group, and Financial and Business Model Advisory Group. In November of 2010, former Secretary of the Department of Health and Mental Hygiene (DHMH), John Colmers, requested the MHCC and MIEMSS develop specific recommendations to advance telemedicine in Maryland.

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. During the month, staff participated in the Small Practice Advisory Committee meeting. This committee is responsible for providing guidance to CRISP in advancing HIE connectivity in ambulatory practices. Discussion centered on identifying early use cases and in developing two pilot programs for Direct. CRISP anticipates initially enrolling roughly 50 practices in a pilot program to assess the value of Direct. Staff also provided support to CRISP in developing the technical specifications for a Request for Quote (RFQ) to identify a technology company that can supply software to support multi-domain hosting, direct address provisioning, certificate management, mailboxes, role-based security, and integration with a provider directory. The RFQ was released on December 23rd with responses due on January 6th. Staff worked with Clifton Gunderson, LLP to finalize the financial audit. In January of 2012, the auditors and the MHCC are scheduled to review the findings with CRISP.

Implementation activities continued in November as it relates to the Challenge Grant as part of the *State Health Information Exchange Cooperative Agreement Program* (project). Maryland will receive approximately $1.6M from the Office of the National Coordinator (ONC) over three years to develop innovative and scalable solutions that improve long term care and post acute care transitions by leveraging the HIE. Maryland is one of ten states to receive a Challenge Grant award from the ONC. The state designated HIE will exchange select clinical summaries and medication histories among six long term care facilities and acute care hospitals. The electronic exchange of clinical information is expected to result in a reduction of hospital readmission rates for the pilot population. The state designated HIE will also develop the required framework for storing and exchanging advance directives in Maryland and includes advance directives as a component of the electronic summary of care record. During the month, Lorien Health Systems continued to enter data into an online survey for residents that are discharged to the hospital. The survey is designed to capture basic information on the transition of care used to measure performance. Contract negotiations are currently underway with Genesis for participation in the project. Developing a model for electronic advance directives is also included in the scope of work. An Advance Directives Focus Group (focus group) has been meeting to propose recommendations around establishing a repository for signed Medical Orders for Life-Sustaining Treatment (MOLST) forms, and potentially creating an electronic version of MOLST. A strategy document that includes broad recommendations is being developed by the focus group; the recommendations are targeted for release in January of 2012.

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. In December, the workgroup convened to consider principles and policies related to *Data Use and Disclosure.* Key principles identified by the workgroup include: limiting the data provided by an HIE for the specific patient records requested; an HIE shall provide access to patient information available at the time of the request; an HIE shall maintain the security and integrity of the information exchanges; and an HIE shall work with the custodian of the record to address compulsory legal processes and protect patient privacy. The workgroup will meet in January to continue developing

principles for *Data Use and Disclosure.* The workgroup uses the principles to develop policies for consideration by the board. During the month, staff circulated a draft of the proposed privacy and security regulations for review by select individuals at the DHMH. In January of 2012, Staff plans to seek informal comments on the draft regulations from the public.

Staff continued to assess data collected from various consumer focus groups pertaining to provider and community-based organization awareness of electronic health information, trust in the electronic exchange of this information, and challenges related to consumer access and control in an environment where multiple HIEs exist. Over the last six months, focus group meetings were convened to collect data that can be used to formulate policies around implementing consumer access to their electronic health information; determining the level of consumer awareness and trust of electronic health information exchange in Maryland across socioeconomic status, race, ethnicity, age, gender, health status, and literacy level; and to develop consumer outreach and education recommendations for health information exchange (HIE). Koss on Care, a consultant organization, is providing assistance in analyzing the data and drafting the report that is targeted for release in January of 2012.

Electronic Health Networks & Electronic Data Interchange

COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks* requires payers with premiums of $1M or more to complete an electronic data interchange (EDI) progress report by June 30th of each year. This information is used by health care associations and payers to develop strategies to increase the use of technology. Payers submit their information through a web-based application (application). During the month, staff notified roughly 37 payers about the reporting requirement for 2012. COMAR 10.25.07 – *Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouses* requires payers to contract with MHCC certified electronic health networks (EHNs or networks) for the exchange of electronic health care transactions that originate in Maryland. Approximately 41 networks have been certified by the MHCC; during the month staff worked with roughly five networks to complete the re-certification process. Staff also continued updating the *EHN Policy and Procedure Manual.*

National Networking

Staff participated in several webinars during the month. eHI presented two webinars: *Private Health Information Exchange: Enterprise and Proprietary Data Exchange* that explored the challenges encountered by HIEs; and *Top Health Industry Issues in 2012: Connecting in Uncertainty*, which presented methods to contain health care costs, new state health insurance exchanges, increasing drug shortages and new reporting requirements. CRISP presented a webinar entitled, *Long Term and Post Acute Care Adoption of HIE* that provided information on improving long-term and post-acute care transitions. Health IT presented *Managing Risk and Enforcing Compliance in Healthcare with Identity Analytics*, which centered on issues around patient privacy and unauthorized access to sensitive health information that may deter adoption of electronic health care initiatives.