MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

March 2012

CENTER FOR INFORMATION SYSTEMS AND ANALYSIS

Patient Centered Medical Home Program

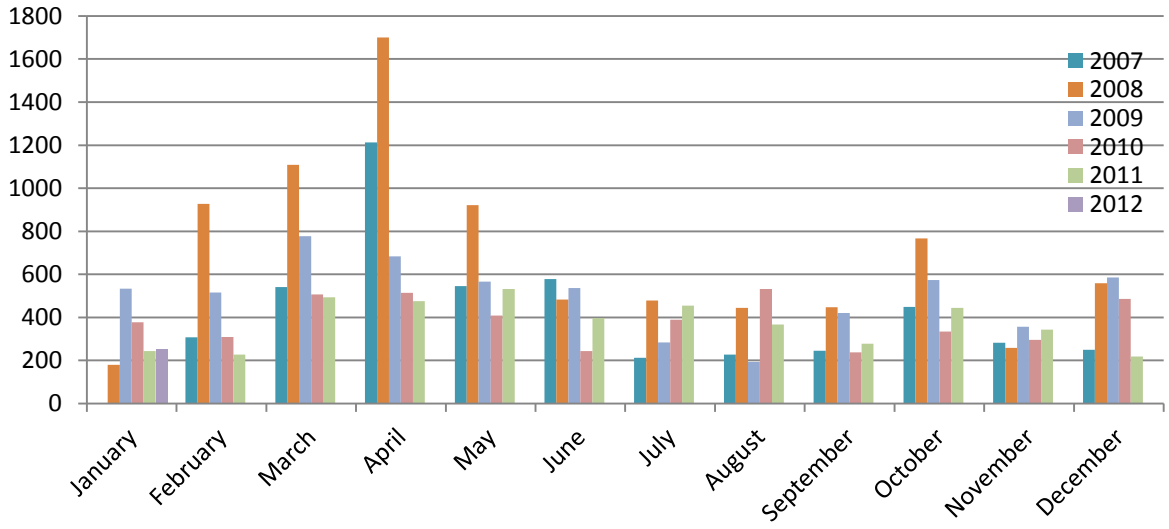
MMPP Advisory Panel
A quarterly MMPP Advisory Panel meeting was conducted on Tuesday, March 6th. Discern Consulting presented on shared savings methodology. The panel also discussed data sharing.

Quality Measure Reporting
Quality Measure reporting was successfully implemented with all but one practice submitting information by the deadline of February 29, 2012. These data are now being reviewed by the Commission's contractor.

Maryland Learning Collaborative (MLC)
The MLC conducted an intense half day interdisciplinary session on care plans on Thursday, March 8th. Approximately 45 care team members were in attendance.

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 $253,569 for January 2012. The monthly payments for uncompensated care from March 2007 through January 2012 are shown above in Figure 1.

On Call Payments
Payments to the trauma centers for on call stipends for the July through December 2011 six month period were requested on February 22, 2012.

2012 Trauma Equipment Grants
MHCC has developed a grant program that is equitable and streamlined for all trauma centers, but ensures appropriate oversight of the grants. Each center will be eligible for up to $42,857 for equipment used in trauma care this year. Maryland's Level II and Level III trauma centers are in the process of completing Equipment Grant applications, which are due to Commission staff no later than March 31, 2012.

Cost and Quality Analysis

Submission of 2010 Data for the Maryland Medical Care Data Base (MCDB)
The submission of data is complete and the preliminary 2010 data files created by the data base vendor, Social & Scientific Systems (SSS), have been transferred to MHCC. While SSS prepares the data for the professional services report, MHCC staff will begin to examine the new eligibility file, which will provide a count of residents enrolled in private insurance. In the past, MHCC has only been able to determine the number of privately insured who obtained care during the year, but not the total number of enrollees. The new file of eligibility will provide valuable information needed by the Maryland Insurance Administration and the Health Benefits Exchange regarding the average expenditure per enrollee.

State Health Expenditures Report
After meeting with staff at the Centers for Medicare & Medicaid Services (CMS) responsible for producing CMS's estimates for health expenditures in each state–which happens every five years—staff from SSS recommended a revision to the methodology that MHCC is using to estimate Maryland health care spending in 2010. Although the report content is not yet finalized, findings from the report will be presented to the Commissioners at the March Commission meeting. The findings to be presented include:

- Total and per capita health care spending, 2010;
- The trend in the rate of increase in per capita spending over the last decade for Maryland versus the U.S.;
- Distribution of spending across the types of service in 2010;
- Trends the distribution of spending by type of service over the last decade for Maryland versus the U.S.;
- Comparisons of per capita spending in Maryland to other states—using CMS data—through 2009, the most recent year available for all states.

Analyses Requested By Maryland Legislators
Staff has conducted several analyses using the MCDB at the request of State legislators. In the most recent instance, a legislator who is proposing to expand the mandate regarding coverage of habilitative services—physical therapy (PT), occupational therapy (OT), speech/language therapy (S/LT)—wanted to determine if any private insurers in Maryland were already covering habilitative services for persons under age 22 who had diagnoses of delays in development. These diagnoses include reading disorder, mathematics disorder, developmental speech or language disorder, and developmental coordination disorder.

An examination of the 2009 MCDB found nearly 12,600 claims for habilitative services, with S/LT accounting for 57% of the claims and PT accounting for 42%. There were claims for 1,149 patients; the patients included just four persons of age 20 and one person of age 21. Patients with a coordination diagnosis averaged 25.3 claims each, almost exclusively for PT; patients with a speech diagnosis averaged 10.8 claims each, almost exclusively for S/LT. More than half (62%) of the patients had a speech/language diagnosis and they accounted for 61% of all the claims, most notably, 92% of the S/LT claims and 19% of the PT claims. Just 16% of the patients had a coordination diagnosis, but they accounted for 36% of the claims, most notably 77% of the PT claims.

Data and Software Development

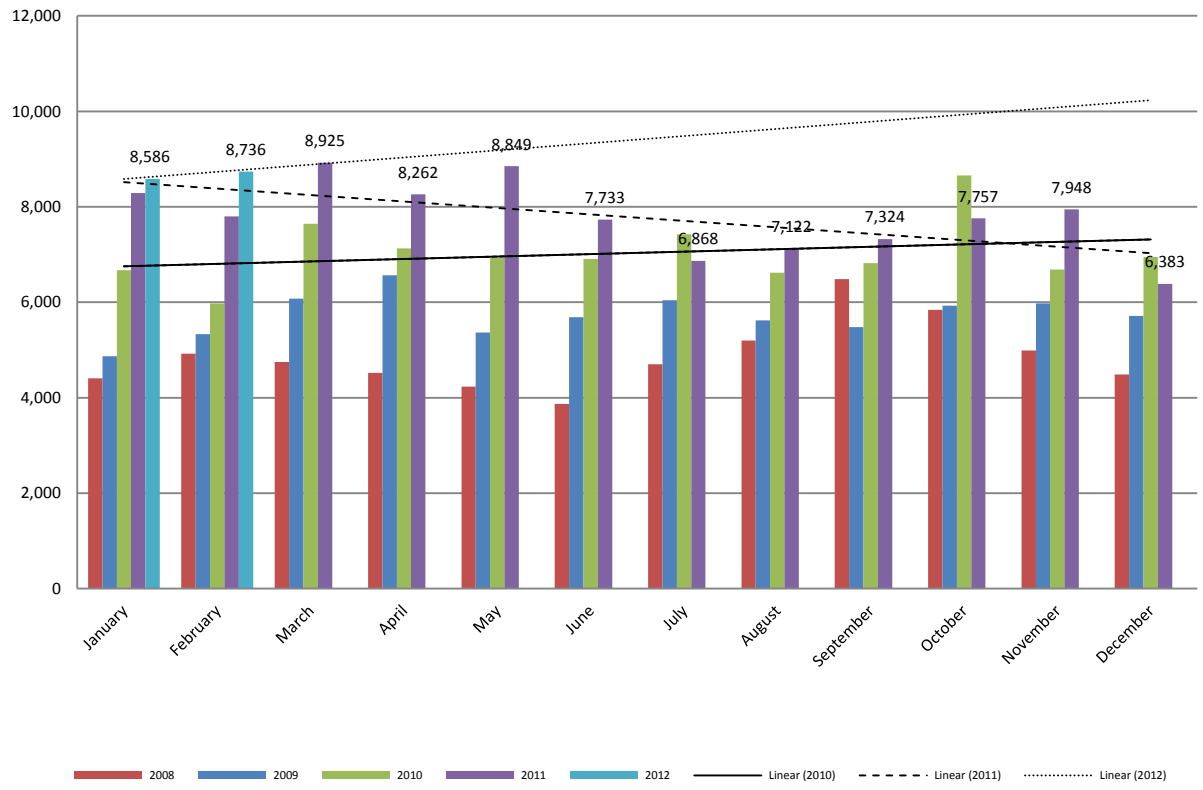
Internet Activities

The number of unique visitors to the MHCC website increased again in February 2012 (as shown in Figure 2, below) by slightly less than 9%. February 2012 was 12% above February 2011 and the number of new visitors also increased slightly, 1.6%, above last month.

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 traffic sources' proportions change within 2-3% from month to month

The number of visitors from all traffic sources to the MHCC websites decreased slightly in February 2012, by less than 0.5%. The variations within the traffic sources changed very slightly – less than 1% in all types. Traffic arriving by search engines increased by roughly 0.7% to 49%. This was offset by the slight decrease in traffic for users arriving directly, to 30%. The users from site referrals continued at 21%.

Figure 2 -- Unique Visitors to the MHCC Web Site



Google remains the dominant search engine, with a decrease from January 2012 of less than 0.5% for a total of 51% of all visitors to the MHCC site. Among the most common search keywords in February were:

- "maryland health care commission"
- "maryland healthcare commission"
- "mhcc"
- "legislative reports"
- "christine daw 'maryland health care commission' "

The remaining visitors were referred from sites such as other state agencies. Among top referrers were the DHMH website, the Maryland Web Portal (Maryland.gov), dhmh.state.md.us, consumerhealthratings.com, and carefirst.benefitnation.net.

Web Development for Applications
Table 1 presents the status of development for internal applications and for the health occupation boards. A combination of internal and contractual resources are used for these efforts.

Table 1– Web Applications Under Development

Board	Anticipated Start of Development/Renewal	Start of Next Renewal Cycle
PCMH Quality Measures website	Underway	Project went live Jan 26, 2012
PCMH Public Site	On-going Maintenance	Project went 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	Underway	Survey went live February, 2012
Long Term Care 2011 Survey	Annual Maintenance	Start of Project was January 2012

Network Operations & Administrative Systems (NOAS)

DHMH Active Directory Migration
All MHCC network user accounts have been created and activated in the new consolidated DHMH network infrastructure. The new accounts will enable all MHCC users to have access to Gmail for Government accounts and website services on the consolidated SharePoint platform.

SharePoint Website Migration
All static pages have been migrated from the existing MHCC website to the consolidated SharePoint site hosted at DHMH HQ. MHCC staff are now testing and cleaning up all pages and links. This process is estimated to be completed by March 30, 2012.

Virtualization Project (Redesign MHCC Data Center Infrastructure)
A Request for Proposal (RFP) was released and proposals received. A vendor will be selected by Friday, March 9, 2012 and the appropriate documentation will be submitted for approval to the State of Maryland Department of Information Technology (DoIT) shortly thereafter.

Workstation Upgrades
NOAS staff are completing the final workstation inventory "refresh" for FY 2012. The current workstation refresh cycle is set on a 3-year retirement cycle. Staff ordered and received 20 workstations and monitors. 15 users are slated for 3-year workstation retirement upgrades. The remaining 5 systems will stay in inventory for emergency replacements. To date, two of the 15 retirement upgrades have been completed.

Notebook Upgrades
With the dependence on remote connectivity for MHCC staff, the NOAS staff has ordered and received 10 new notebook computers. Each user that currently has remote access to MHCC systems and has a MHCC notebook computer will have their remote system upgraded.

External Meetings
NOAS staff joined a workgroup and attended a meeting for State of Maryland web managers and joined a workgroup for establishing standards for State of Maryland use of social networking resources. NOAS staff will meet with the Health Benefits CIO and respective staff to assist with technology infrastructure changes. NOAS staff will also meet with the DHMH Chief Information Officer (CIO) and respective staff to discuss MHCC options for a pending DHMH Active Directory project, which will also include a meeting with HSCRC staff to discuss options for that project.

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

Health Plan Quality and Performance

The last in a series of teleconference was held February 27th and provided an opportunity for plan representatives to collaborate on the design, layout and theme of the 2012 performance report series. Plan representatives provided valuable feedback regarding efforts to track and reduce disparities and provide culturally appropriate educational materials to members. Costs associated with various methods of data collection and the impact of measure rotation was also discussed. Finally, preliminary discussion began in an effort to identify 2013 performance goals for targeted measures identified in the quality and Performance Reporting Requirements as well as the National Quality Forum measures related to the Million Hearts Campaign. A major outcome of the February teleconference was agreement that although challenging, health benefit plans will begin taking steps toward collaboratively establishing 2013 quality improvement goals for NQF and MHCC's QPRR measures.

A follow-up teleconference with health benefit plan representatives is scheduled for mid-March to continue work on 2013 QPRR, with emphasis on meeting the requirements of Senate Bill 234 by including the additional required performance reporting on Race, Ethnicity, Language, and Cultural Competency (RELCC).

Division staff is participating in on-site performance audit exit conferences held at the corporate office of each health benefit plan scheduled to occur throughout the month of March.

The division had previously presented to the Department of Budget and Management (DBM) for review and consideration, a revised Request for Proposals (RFP), to solicit a contractor for the Report

Development activities of the division. A pre-bid conference related to this RFP is pending a second response addressing recommendations from the DBM.

Small Group Market

Comprehensive Standard Health Benefit Plan (CSHBP)
VIRTUAL COMPARE, the information-only web portal developed for use by small businesses has been operational since last May. Over the past 30 days, the analytics have remained steady, averaging approximately 7 Maryland visits per day, 4 pages per visit, and 4 minutes per visit, the majority being new users of VIRTUAL COMPARE.

Health Insurance Partnership
The "Partnership" premium subsidy program has been available to certain small employers with 2 to 9 full time employees since October 1, 2008. As of March 5, 2012 enrollment in the Partnership was as follows: 384 businesses; 1,079 enrolled employees; 1,790 covered lives. The average annual subsidy per enrolled employee is about $2,300; the average age of all enrolled employees is 40; the group average wage is about $27,000; the average number of employees per policy is 4.1. 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
Commission staff is awaiting direction from the Legislature related to MHCC's role in evaluating the existing mandates so that Maryland remains in compliance with the essential health benefits (yet to be defined) under the ACA. Staff is also tracking the progress of several bills proposing new mandates or modifications to existing mandates.

Long Term Care Policy and Planning

Minimum Data Set Project
Commission staff continue 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. Work is underway to update the program into SAS.

Hospice Survey (FY 2011)
The Commission collects data annually from all licensed hospice programs in Maryland. Letters regarding the release of the FY 2011 Maryland Hospice Survey were sent out on February 13, 2012. The official launch date for the online survey was February 14th. The survey is completed in two parts. Part I is due 60 days after receipt of the survey notice. This year that is April 16, 2012. Part II (which is based on Medicare cost report data) is due no later than June 7, 2012.

Draft Hospice Section
The State Health Plan for Facilities and Services addresses health services that are regulated under the Certificate of Need (CON) program. One chapter, COMAR 10.24.08 covers nursing homes, home health agencies, and hospice programs. This chapter is currently undergoing review and update. In lieu of a single chapter covering the three types of health services noted above, there will now be a separate COMAR chapter for each. The first chapter for update will be hospice services. A brief update was presented at the January Commission meeting. The goal is to release this chapter for informal public comment the third week of March.

Hospice Regulations Workgroup
The Office of Health Care Quality within DHMH 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 was held on January 10, 2012. A draft of proposed regulations is currently under review. The next meeting is scheduled for March 13, 2012.

Home Health Agency Survey Data
Commission staff is analyzing home health agency utilization trend data, including authorized jurisdictions actually served, based on submission of information reported the on the Annual Home Health Agency Surveys.

FY 2011 Home Health Agency Survey
Phase 1 of the FY2011 Home Health Agency Survey collection period ran from October 11, 2011 to January 10, 2012. The Commission received 100% submission rate on the due date of January 10, 2011. Phase 1 agencies are home health agencies with a fiscal year end date on or before June 30, 2011. Data collection for Phase 2 Home Health Agencies began on March 1, 2012 with a due date of May 29, 2012. Survey notification was sent by mail and email. Staff will provide technical assistance to users during the 90 day collection period.

Long Term Care Survey
The FY 2010 Long Term Care Survey data has been cleaned for all facility types including Comprehensive Care, Assisted Living, Adult Day Care, and Chronic Hospitals with minimal changes to survey data for 6% of the facilities. These changes have been implemented, and staff is in the process of creating public use data sets and the Nursing Home Occupancy report.
Staff is preparing for the data collection of the 2011 Long Term Care Survey scheduled for release in March 2012. Staff is conducting final testing of the web survey application and verifying inventory in preparation for the mailing.

Long Term Care Quality Initiative

Nursing Home Experience of Care Surveys
Maryland nursing homes are in the process of submitting lists of responsible parties and recently discharged residents in preparation for the survey mailing.

Seasonal Influenza Vaccination for Staff Working in LTC
The power point and audio recording of the webinar "Implementing Effective Strategies to Increase Flu Vaccination Rates & Reduce Worker Resistance" was posted on the MHCC web site; providers were notified how to access the files.

Staff is preparing materials to launch the survey to collect immunizations rates in nursing homes and assisted living. The survey is open for data entry from April 5-May 15, 2012.

Consumer Guide to Long Term Care
Staff performed a review of assisted living residences data for completeness and found a number of residences missing information or photos and a number of assisted living facilities listed on the most recent Office of Health Care Quality licensee directory, but missing from the MHCC dataset. Staff is in the process of contacting these facilities to request the information needed to add the facility to the consumer guide.

Hospital Quality Initiatives

Hospital Performance Evaluation Guide (HPEG) Update

The HQI staff successfully implemented the January update to the Hospital Performance Evaluation Guide on schedule. The January update includes clinical quality measures data for heart attack, heart failure, pneumonia, surgical care and childhood asthma for the 12-month period ending June 2011. Patient experience measures were also updated for 12-month period ending June 2011. For the first time, the Guide also includes 30-day readmission measures for AMI, Heart Failure, and Pneumonia.

On February 7, 2012 the HQI staff held a webinar for hospital quality and performance improvement staff to review new quality measures data requirements and related changes to the Hospital Performance Evaluation System. Over 50 hospital representatives participated in the webinar.

On February 27, 2012, the HPEG Advisory Committee met via conference call to consider new quality measures data requirements to support the Hospital Guide enhancements for 2013.

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 developed a process for the transfer of the ACTION and CathPCI registry data to the MHCC. We continue to work collaboratively with MIEMSS to maintain a single data transfer process to accommodate the requirements of both agencies and to minimize the burden on hospitals. The HQI and IT staff are working with individual hospitals to address outstanding technical issues.

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 procedures. MHCC has established a five year contract with Advanta Government Services, Inc (AGS) to provide HAI data quality review and on-site medical chart audit services. The audit of the FY2011 data has been completed and hospitals have been provided a summary of their results. At the January 25th meeting of the HAI Advisory Committee, AGS presented preliminary audit findings to the group. The staff is now working with the vendor and individual hospitals to address outstanding issues and discrepant cases. MHCC will host an educational webinar to update hospital Infection Preventionists on our findings and to review current NHSN definitions and requirements.

Specialized Services Policy and Planning

State Health Plan
At the February 16, 2012 public meeting, the Commission took final action to approve State Health Plan amendments related to PCI physician volume standards. The amendments address the specific situation when a cardiac interventionalist at a PCI waiver hospital does not perform the minimum of 75 PCI cases during a 12 month period that includes a leave of absence; they allow such a physician to resume performing PCI alone in the cardiac catheterization lab of the PCI waiver hospital after completion of 10 proctored PCI cases, provided that the physician performed at or above minimum volume in the year prior to the leave of absence, and that he or she continues to satisfy the hospital's credentialing requirements. The final action will be published in the *Maryland Register* on March 9 with the amendments becoming effective on March 19.

Primary PCI
Staff requested interim compliance reports, covering the first four quarters of their current primary PCI waivers, of five primary PCI waiver hospitals. Four of these hospitals (Anne Arundel Medical Center, Baltimore Washington Medical Center, MedStar Franklin Square Medical Center, and Shady Grove Adventist Hospital) submitted their interim reports, which include data on total volume of PCI procedures, door-to-balloon times on primary PCI, and interventionalist cardiology volumes. These four hospitals are currently compliant with the performance standards in their primary PCI waivers. Staff is awaiting an interim compliance report from Southern Maryland Hospital Center.

Elective PCI
Staff is reviewing C-PORT E and elective PCI Registry adverse event reports submitted by npPCI waiver hospitals. According to C-PORT E Study Principal Investigator Thomas Aversano, results of the C-PORT E research will be presented on March 26, 2012 at a meeting of the American College of Cardiology, and journal publication is expected shortly thereafter.

Legislation
Staff has attended legislative committee hearings in the House of Delegates and the Senate on:

- HB1140 / SB749, which establishes data sharing arrangements between MHCC, BOP, HSCRC, and OHCQ for purposes of investigating quality and utilization issues; and
- HB1141 / SB750, which identifies PCI as a a specialized service regulated by the MHCC and decouples oversight of PCI from cardiac surgery; makes oversight of PCI and cardiac surgery consistent across all hospitals; transfers oversight of PCI from a waiver process to a certificate process; and provides for consistent oversight of cardiac surgery across all hospitals.

Hospital Services Policy and Planning

Certificate of Need ("CON")

CON's Approved

Johns Hopkins Bayview Medical Center – (Baltimore City) Docket No. 11-24-2321
Capital project for the expansion of the emergency department
Cost: $40,098,889

Johns Hopkins Bayview Medical Center – (Baltimore City) Docket No. 11-24-2322
Capital project to create a comprehensive cancer program at the hospital
Cost: $26,057,437

CON Letters of Intent

Fort Washington Medical Center – (Prince George's County)
Construct a new two-story addition featuring 15 new private patient rooms, and 18 new treatment bays and 6 new holding beds in the emergency department, an addition of an operating room and construction and renovation to the existing hospital.

Fort Washington Medical Center – (Prince George's County)
Construct a new one-story addition featuring 14 new treatment bays and 6 new holding beds in the emergency department, construction of a new critical care unit, and construction and renovation to the existing hospital.

Maryland General Hospital – (Baltimore City)
Relocation of 33 temporarily delicensed inpatient rehabilitation beds from Maryland General Hospital to Harford Memorial Hospital

Pre-Application Conference

Fort Washington Medical Center – (Prince George's County)
Construct a new two-story addition featuring 15 new private patient rooms, and 18 new treatment bays and 6 new holding beds in the emergency department, an addition of an operating room and construction and renovation to the existing hospital.
February 15, 2012

Fort Washington Medical Center – (Prince George's County)
Construct a new one-story addition featuring 14 new treatment bays and 6 new holding beds in the emergency department, construction of a new critical care unit, and construction and renovation to the existing hospital.
February 15, 2012

CON Applications Filed

Carroll Hospital Center – (Carroll County) – Matter No. 12-06-2330
Construction of an Outpatient Cancer Center and renovation of the existing Richard N. Dixon Building on the hospital campus.
Cost: $27,975,000

Chesapeake Woods Center – (Dorchester County) – Matter No. 12-09-2331
New construction and expansion of the facility by the addition of 23 comprehensive care beds allocated to Caroline County which can be located in Dorchester County under COMAR 10.24.01.07(1)
Cost: $3,475,000

Mercy Medical Center – (Baltimore City) – Matter No. 12-24-2332
Fit-out of shell space in the Bunting Building to relocate 4 existing operating rooms and the addition of 4 new operating rooms.
Cost: $24,599,859

Determinations of Coverage

- **Ambulatory Surgery Centers**

SurgCenter of Silver Spring, LLC – (Montgomery County)

Establish an ambulatory surgery center with 1 sterile operating room and 1 non-sterile procedure room to be located at 8710 Cameron Street, Suite 100, Silver Spring

Massachusetts Avenue Surgery Center – (Montgomery County)
Construction of shell space at the ambulatory surgery center located at 6400 Goldsboro Road, Bethesda

Shore Health System Surgery Center – (Talbot County)
Renovation of existing space and the addition of a non-sterile procedure room at the facility located at 6 Caulk Lane, Easton

Maryland Podiatry Surgical Center, LLC – (Howard County)
Establish am ambulatory surgery center with 1 non-sterile procedure room to be located at 3460 Ellicott Center Drive, Suite 103, Ellicott City

- **Capital Projects**

University of Maryland Medical Center – (Baltimore City)
Replacement and relocation of the neonatal intensive care unit to the 4th floor of the North Building and an increase from 40 to 52 bassinets. Capital Cost: $25,150,000

- **Other**

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

Chester River Manor Nursing & Rehabilitation Center – (Kent County)
Temporary delicensure of 10 CCF beds

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

Randallstown Center – (Baltimore County)
Relicensure of 12 temporarily delicensed CCF beds

- **Waiver Beds**

Fairland Nursing Center – Anne Arundel County
Addition of 8 CCF waiver beds for a total of 96 CCF beds

Villa Rosa Nursing Home – (Prince George's County)
Addition of 8 CCF waiver beds for a total of 109 CCF beds

Planning and Policy

Surgical Services
On February 7, 2012, a meeting of the Surgical Services Advisory Group was convened to discuss issues raised by the Commission in its consideration of a proposed rule repealing and replacing COMAR 10.24.11.

Hospital Capital Planning
On February 17, 2012, the Chief for Hospital Services Policy and Planning/CON presented at the Health Care Financial Management Association-Maryland Chapter Seminar on Capital Planning. The presentation focused on the current status of CON regulation, changes underway, and the future of CON regulation under health care reform.

Consultation
On February 27, 2012, CHS staff participated in a conference call with New York State staff for Health Systems Management and CON to discuss features of CON regulation in Maryland and answer questions related to regulatory reform efforts underway in New York.

Health Care Facility Licensure
On February 27, 2012, CHS staff participated in a conference call with the Office of Health Care Quality of DHMH concerning the status of health care facility licenses that have not been used by their holders to provide licensed services and regulatory changes needed to address this issue. The conference was prompted by a request made to MHCC on this matter by a hospital.

CENTER FOR HEALTH INFORMATION TECHNOLOGY

Health Information Technology
Staff participated in the Office of the National Coordinator for Health Information Technology's (ONC) Health Information Technology (HIT) Policy Committee (committee) meeting. The committee discussed the progress and adoption challenges of health information exchange (HIE) that included deliberations on key challenges for HIEs around infrastructure development and in identifying funding opportunities. During the meeting, the committee discussed its plan to identify quality measures for consideration in Stage 3 meaningful use. The committee also discussed the challenges of achieving interoperable health information systems, which include building interfaces to electronic health records (EHRs) and how to transfer data in a safe and effective way due to a lack of standards around data transport. The committee plans to work with the Health Information Technology Standards Committee to address standard vocabularies and syntax used to support quality measures. 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.

Staff continues to evaluate the responses from the *2011 Hospital HIT Survey* (survey), which collected responses for the fourth year from all 46 acute care hospitals in Maryland. Included in the survey are questions regarding the adoption of seven technologies: computerized physician order entry (CPOE), EHRs, electronic medication administration records (eMARs), infection surveillance software (ISS), electronic prescribing (e-prescribing), electronic data interchange, and telemedicine. The survey is similar to nationally administered surveys; however, it is unique in that it includes questions related to HIT planning and inquirers on the number of primary care units that have implemented different HIT functionalities. This is the first year the staff collected information regarding the use of telemedicine and requested that hospitals report on the number of units using each technology and the functionality to gauge HIT use within hospitals. Included in the report are HIT adoption trends by hospital size, geography, and affiliation. The report is scheduled for release this spring.

During the month, staff completed the draft annual HIT assessment of Freestanding Ambulatory Surgical Centers (Centers) in Maryland. This is the third year of the assessment that evaluated the Centers progress in adopting key HIT functionalities including: CPOE; EHRs; eMARs; BCMA; ISS; e-prescribing; and electronic HIE with laboratories, diagnostic centers, and outpatient physicians. All 335 Centers in Maryland responded to the annual HIT survey, which is administered as part of the *Maryland Freestanding Ambulatory Surgical Center Survey*. Most notably, around 84 percent of Centers reported adopting an EHR and about 54 percent reported e-prescribing. In general, health IT adoption increased in all nine HIT categories, with the highest increase in the adoption of CPOE at around 63 percent, and e-prescribing, which increased by roughly 58 percent. Over the next month, staff plans to seek feedback from the Maryland Ambulatory Surgical Association on the draft report. The report is targeted for release in April.

Staff worked with state designated management service organizations (MSOs) and EHR vendors to advance interface development with the statewide HIE. Interfaces are required to connect EHRs to the HIE infrastructure. Last month, staff convened meetings with about five EHR vendors. The MSOs assist physicians in addressing the challenges associated with EHR adoption including cost, maintaining the technology, and ensuring that data is stored securely. MSOs are well-positioned to serve as the technology hub to connect EHRs to the HIE. Currently nine MSOs have received *State Designation* and approximately seven MSOs are in *Candidacy Status*. As part of MSO State Designation, MSOs are required to meet roughly 94 criteria regarding privacy and confidentiality, technical performance, business practices, resources, security, and services. Over the next month, staff plans to continue meeting with EHR vendors and to develop timelines and affordable pricing models for HIE connectivity.

Staff is working with select payers and pharmacy benefit managers to implement a single sign-on option to a payer's prior authorization website or portal. A single sign-on option is the first step to implementing the three phased approaches recommended in the December 2011 *Recommendations for Implementing Electronic Prior Authorizations* report. In general, over the next two years, certain payers and pharmacy benefit managers must include key criteria used to make a final determination of a prior authorization request on their website; develop an online process to electronically accept prior authorizations and issue a tracking number, and process electronic prior authorizations in real time. A multi-stakeholder workgroup developed these recommendations last fall. The recommendations were adopted on a voluntary basis; however, a current bill under consideration by the legislature, House Bill 470, *Maryland Health Care Commission – Preauthorization of Medical Services and Pharmaceuticals – Standards* requires the adoption of these recommendations.

Staff continues to modify the web-based EHR Product Portfolio (portfolio). In addition to the existing 45 EHR vendors that currently participate in the portfolio, staff has a preliminary commitment from an additional 20 vendors. First released in 2008, the portfolio offers evaluative and comparative information about EHR products and is frequently used by the state designated HIE and by MedChi, The State Medical Society, in promoting EHR adoption. Participating vendors must have national certification, provide EHR product screen prints; user references; product pricing and implementation cost projections; privacy and security policies; and case relevant studies. New to the portfolio is information from vendors regarding their plans to implement direct protocols and the estimated costs for this functionality. Direct protocols specify a secure, scalable, standards-based way for participants to send authenticated, encrypted health information directly to known, trusted recipients over the Internet. The updated portfolio is expected to be released in March.

Staff is in the preliminary stages of working with the Maryland-National Capital Homecare Association to explore opportunities to advance HIT with home health care agencies. The home health care industry has emerged as a way for patients to remain within their homes and provide needed services to patients who are unable to receive care outside the home. Staff collaborated with the University of Maryland – Baltimore County, Department of Information Systems to assess the current HIT implementation activities among home health care providers and identify opportunities to improve care delivery and coordination, reduce costs, and improve access to care using technology. Over the next three months, staff plans to convene focus groups, conduct interviews, and evaluate existing literature to identify a framework for advancing HIT in home health.

Staff evaluated strategies for assessing the progress achieved toward the adoption and meaningful use of EHRs in the state, and to identify recommendations for any changes in state law that may be necessary to achieve optimal adoption and use as required by House Bill 706 (HB 706) *Electronic Health Records – Regulation and Reimbursement*. HB 706 was passed during the 2009 legislative session and requires the MHCC to designate MSOs and to develop regulations that require state-regulated payers provide incentives for EHR adoption. A report is due to the Governor and the General Assembly in October 2012. Staff competitively identified Audacious Inquiry, LLC (AI) to provide assistance in completing the work and in developing the report.

Health Information Exchange

Staff provided support to the Chesapeake Regional Information System for Our Patient (CRISP), the statewide HIE, in evaluating responses to a Request For Quote to identify a vendor to implement a Direct pilot. A Maryland-based vendor, Secure Exchange Solutions, was selected to complete the work. Implementing Direct protocols will enhance services offered by the statewide HIE; however, query-based HIE is generally considered a viable long-term option for the electronic exchange of health information, and requires participation by a large number of data contributors to generate value to users. Staff continued to support the technology security audit of the HIE; CliftonLarsonAllen, LLP (CLA) is in the preliminary stages of implementing parameters for the technology security audit. CLA expects to review nearly 150 information security controls as part of the audit. This is the second year the MHCC has completed an information technology audit to evaluate the privacy and security controls of the statewide HIE infrastructure. A report is scheduled to be released in May.

Staff continues to provide guidance in implementing the statewide HIE to CRISP and its Advisory Board that consists of four committees: Finance, Technology, Clinical Excellence, and Small Practice Committee. Last month, staff participated in three Advisory Committee meetings. The Small Practice Advisory Committee met to discuss recommendations for education programs for the Medicaid EHR Incentive program, and pricing models for ambulatory providers to connect to the HIE. The Finance Committee discussed HIE connectivity pricing models for ambulatory providers; it is expected to make recommendations regarding pricing for ambulatory practice connectivity in the next few months. The Technology Committee discussed implementing a small demonstration project for diagnostic image exchange.

Staff provided support to CRISP in implementing the Regional Extension Center (REC) program. CRISP received $6.4M in federal funding to administer a program to assist 1,000 priority primary care providers (PPCPs) with adopting and becoming meaningful users of EHRs. This program utilizes MSOs for expanding EHR adoption and connecting to the HIE. To date, about 1,492 PPCPs have signed an agreement with an MSO, roughly 619 PPCPs have demonstrated implementing certain functionality of their EHR (i.e., electronic prescribing) required for the Centers for Medicare and Medicaid Services (CMS) meaningful use incentives, and approximately 53 PPCPs have demonstrated meeting the Stage 1 meaningful use requirements for Medicare EHR adoption incentives. During the month, the ONC completed a bi-annual review of the REC program; the ONC will use the results from the review evaluating additional funding that might be available to RECs.

Staff launched with CRISP and the Abell Foundation an Innovative Ideas Contest, a program conceived by the Secretary of the Department of Health and Mental Hygiene (DHMH). The contest seeks to leverage the statewide HIE and identify innovative and practical ideas for using clinical information on a patient population to drive advances in public health. The contest intends to stimulate innovations around the use of potential data sources, both within and outside the health care domain, to achieve new insights, solutions, or interventions to address public health challenges. The contest is open to the public for submission. Applications will be submitted online through a leading social media platform that allows for voting and includes a rating mechanism. Applicants will go through multiple rounds of evaluation, including a review by an expert panel. The contest includes a winner and two honorable mentions, along with a people's choice award. The total award amount for the contest is $5,000 with the largest amount going to the first place winner; finalists will receive public recognition from the Secretary of DHMH. During the month, activities continued around customizing a social media website to support this initiative, and to develop the communication plan and evaluation form; the Innovative Ideas Contest is tentatively set to begin in March with winning applications selected in May 2012.

Implementation activities of the Challenge Grant, a part of the *State Health Information Exchange Cooperative Agreement Program* (project), continued during the month. Maryland received an award of approximately $1.6M from ONC. This Challenge Grant is centered around developing solutions to

exchange electronic clinical documents between long term care and post acute care facilities and proximate hospitals by leveraging the HIE. The goal of the Challenge Grant is to integrate six long-term care facilities with the HIE; implement the HIE portal with almost 50 long term care facilities; and develop recommendations regarding advanced directives. In February, staff convened a focus group to discuss recommendations regarding the implementation of a phased approach that enables advance directives to be electronic and accessible via a web portal, along with implementing an online registry for Medical Orders for Life Sustaining Treatment forms. An information brief regarding the recommendations of the focus group is targeted for release in the spring. Staff also worked with the University of Maryland Center for Health Information and Decision Systems to finalize the nursing home admission survey analysis methodology.

Staff collaborated with the state designated HIE to develop strategies that encourage ambulatory practices to connect with the HIE. This initiative aims at identifying technology challenges and workflow changes required to increase ambulatory practice connectivity to the HIE. Last month, staff developed a practice questionnaire that focuses on key questions around connecting ambulatory practices to the HIE. Over the next month, staff plans to meet with nearly 50 ambulatory practices to identify barriers to HIE connectivity. The decision by CMS not to include a requirement for ambulatory practices to connect to a state designated HIE for EHR adoption incentive payments has caused states to retool strategies to engage ambulatory practices with the HIE. Through a competitive process staff has selected AI to assist in completing the work. The ambulatory care connectivity report is scheduled for release this summer.

During the month, staff released draft HIE regulations for informal public comment; March 19th closes this public comment period. The draft HIE regulations are a result of nearly 18 months of work by the HIE Policy Board (board), which consists of roughly 30 members with a strong consumer orientation. Roughly 26 policies have been identified for development; the draft HIE regulations include recommendations for 11 policies. The board is responsible for recommending policies for the privacy and security of protected health information exchanged through HIEs operating in Maryland. House Bill 784, *Medical Records – Health Information Exchange* (HB 784), which was signed into law on May 19, 2011 requires the MHCC to develop regulations around privacy and security for HIEs operating in Maryland. During the month, staff convened a workgroup to finalize the *Primary Data Use and Disclosure* and *Consumer Access to Audit* policies. These policies and an update to the *Resolution for Increased Patient Control* are scheduled to be presented at the March 20th board meeting.

Staff is in the drafting stage of an HIE consumer engagement, awareness, and access to HIE report. The report reflects the work of consumer focus groups convened around the state in the fall of 2011 to determine the level of 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. The report will help formulate policies around implementing consumer access to their electronic health information; determine the level of consumer awareness and trust of information exchanged electronically in Maryland across socioeconomic status, race, ethnicity, age, gender, health status, and literacy level; and develop consumer outreach and education recommendations for HIE. Koss on Care was competitively selected to provide assistance in completing the work. The report is targeted for release in the spring.

Electronic Health Networks & Electronic Data Interchange

Staff completed the recertification of two electronic health networks (EHNs): Passport Health Communications, Inc. and MedData. COMAR 10.25.07 – *Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouses* requires third party payers to contract with MHCC certified EHNs. Certification is awarded to networks that have achieved accreditation by a nationally recognized organization by the MHCC. Staff is modifying the application process to enable EHNs to submit information online.

Staff is in the preliminary stages of updating the web-based application for payers to submit their 2011 electronic administrative transaction census data. COMAR 10.25.09 – *Requirements for Payers to Designate Electronic Health Networks* requires payers operating in the state who report a premium volume that exceeds $1 million to annually report their electronic health care transaction volumes.

National Networking

Staff participated in a series of webinars during the month: *Guiding CIOs through a Changing Healthcare System with Health Information Exchange* that presented an overview of guidelines to assist Chief Information Officers in making decisions required to develop HIEs; *The Use of Telemedicine within an HIE for Chronic Disease Management* that provided insight on how telemedicine could be used with an HIE; *Solving Urgent Enterprise-wide Integration Challenges While Focusing on the Future* that summarized the vendor evaluation and selection process; *Update of Direct Trust*, an overview of Direct exchange; and *Trends in HIT Innovation Health Indicators Warehouse & Network of Care for Healthy Communities* that provided innovative online data tools allowing stakeholders to access population health data easily and quickly.