MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

January 2013

CENTER FOR INFORMATION SYSTEMS AND ANALYSIS

Patient Centered Medical Home Program

Evaluation

IMPAQ International, the evaluation contractor, will initiate its patient satisfaction survey protocol and complete the provider site visits in January 2013. The patient satisfaction survey will be conducted by phone and is based on the CAHPS PCMH survey instrument. A letter from MHCC is being sent to prospective participants to promote patient engagement in the survey.

Payment

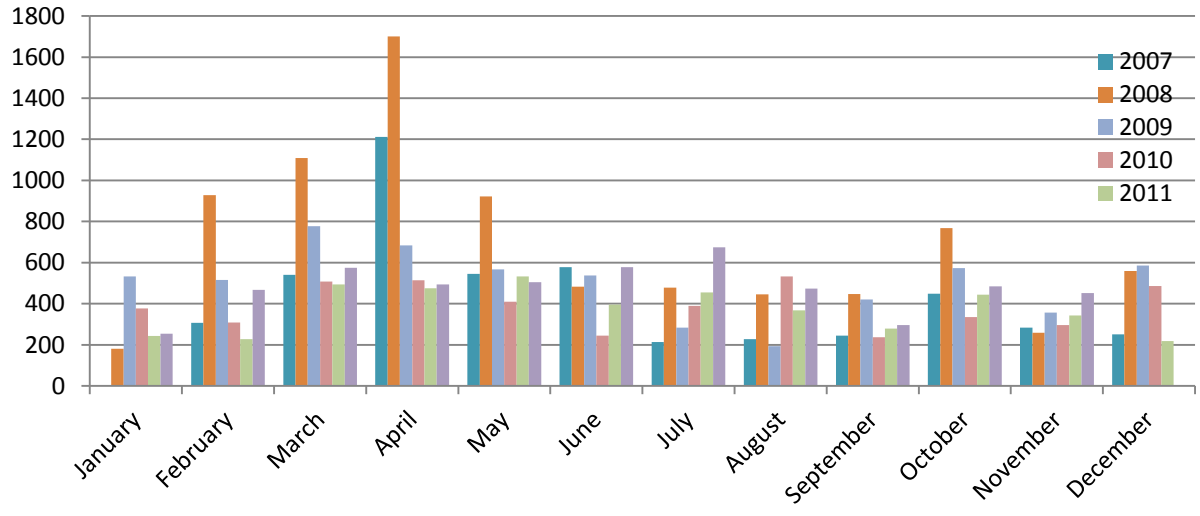
The Hilltop Institute requested that Medicaid MCOs price their encounter data so that baseline expenditures may be established.

Single Carrier Application

Staff received an application from CIGNA to operate a single carrier PCMH program in Maryland with a projected start date of April 1, 2013. This Commission action item is expected to be on the February Commission agenda.

Maryland Trauma Physician Services Fund

Figure 1
Uncompensated Care Payments to Trauma Physicians, 2007-2012



Uncompensated Care Processing

CoreSource, Inc., the third party administrator (TPA) for the Trauma Fund, adjudicated claims with a total paid value of approximately **$451,137** for November of 2012. The monthly payments for uncompensated care from March 2007 through November 2012 are shown above in Figure 1.

On Call and Standby Stipends
Maryland's Trauma Centers' On Call applications for the July through December biannual period will be due to the Commission no later than January 31, 2013.

Audit Contract
In mid-January, Commission staff will request that the Maryland Board of Public Works approve the award of an MHCC agency contract for audit services.

Cost and Quality Analysis

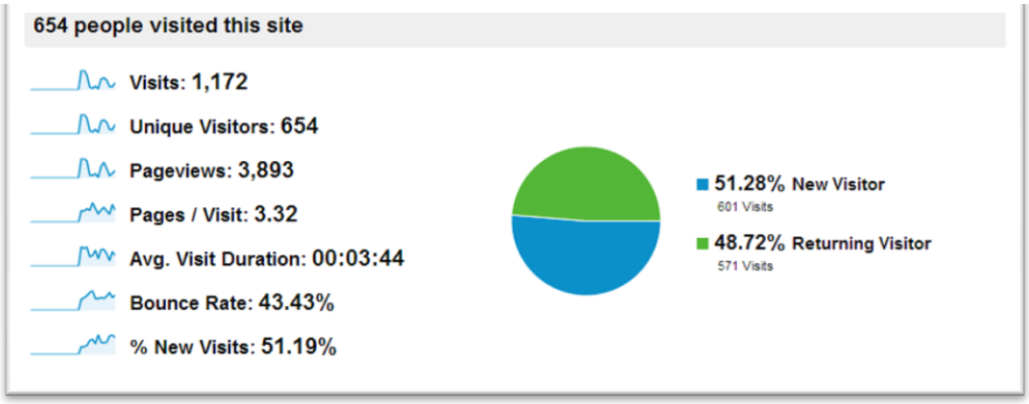
Maryland Multi-Payer Patient Centered Medical Home (PCMH) Program–DUA Update
Staff is arranging a DUA (data use agreement) with the Medicaid Administration so that the MHCC can have access to Medicaid MCO (managed care organization) claims and eligibility information for both PCMH program operations and evaluation of the PCMH program by the evaluation contractor, IMPAQ. The Medicaid Administration is requiring that the MHCC be the requestor of the MCO data and that our request for use go through the DHMH IRB (institutional review board). Program operations require the MCO claims for calculation of MCO shared savings payments to PCMH practices; PCMH program evaluation requires summary of health care utilization and payments at the patient level. MCO data will be transmitted to the MHCC by The Hilltop Institute, and the MHCC will pass along the data to the vendors involved in the shared savings and PCMH program evaluation. Staff within the Center for Analysis and Information Services are collaborating to devise a standard protocol for transmission of confidential data between all parties involved.

Maryland Medical Care Data Base (MCDB) Webinar
A webinar meeting with MCDB payer representatives and staff of the Maryland Health Care Commission (MHCC), Social and Scientific Systems, Inc. (SSS)—our data base contractor—and the Maryland Insurance Administration (MIA) is scheduled to take place on January 23, 2013. The meeting will focus on the MCDB data submission process for the 2012 data and data quality issues that payers need to address. MHCC staff will propose several changes to the information submitted on claims, including an expansion of provider specialty codes to include new specialties that have been recognized since the MCDB was first defined in 1993 and inclusion of a new variable to determine whether a carrier's' payment for an out-of-network physician service was paid directly to the physician (i.e., assignment of benefits) or to the patient. This latter variable is needed for analysis of the impact of the Assignment of Benefits (AOB) legislation.

MCDB Data Expansion Plans
Staff is working on a three-year plan for expansion of the MCDB. The plan will define when and how the MHCC will expand and modify the information in the MCDB and how the new information will be used. The expansion will add Medicaid MCO data, claims from pharmacy benefit managers (PBMs), and claims from small carriers who will sell insurance in the Health Benefit Exchange (HBE) but who currently do not submit data to the MCDB. It will also outline our proposal to increase the frequency of data submissions—which will require a change in our MCDB regulations—and describe our plan to have submitting carriers, the Medicaid Administration, and PBMs submit patient information to CRISP so that CRISP can provide these submitters with a Master Patient Identifier (MPI) for each of their enrollees; the submitters will then include the MPIs for their enrollees with their data submissions to MHCC so that a patient's utilization across submitters can be combined. The plan will be shared with carriers and other interested parties for their comments and suggestions.

Data and Software Development

Figure 2 - Data from Google Analytics for the month of December 2012



- Bounce rate is the percentage of visitors that see only one page during a visit to the site.

Internet Activities

As shown in the chart above, the number of visits to the MHCC website for the month of December 2012 was 1,172 and of these, there were 654 unique visits. The average time on the site was 3:44 minutes. Bounce rate is the percentage of visitors that see only one page during a visit to the website and is included in the percentage rate of both unique and returning visitor categories. Throughout November and early December 2012 we experienced technical difficulties in retrieving the Google Analytic information; in addition, the number of visits to the website were low during December, as they have historically been in the past.

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 highest referral source was from the mhcc.maryland.gov. Other government agencies include dhmh.maryland.gov, Maryland.gov and crisphealth.org. Among the most common search keywords in September were:

- "Maryland health care commission"
- "MHCC"

Table 1 – Website Applications Status

Board	Anticipated Start Development/Renewal	Start of Next Renewal Cycle
PCMH Case Management Monthly Tracking web site	Development	Live January 1, 2013
PCMH Public Site	On-going Maintenance	
PCMH Portal (Maryland Learning Collaborative & MMPP)	On-going Maintenance	
PCMH Practices Site (New)	New User Guide On-going Maintenance	
Boards & Commissions Licensing Sites (13 sites)	On-going Maintenance	
Boards & Commissions: Psych Licensing Site	Ongoing support	Live December 1, 2012
Physician Licensing	Live – On-going Support	July 16, 2012 Providing ongoing support
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	Went Live: February, 2012
Long Term Care 2012 Survey	Annual Maintenance	New questions being added for 2012 survey.
Hospital Quality Redesign	Planning	Start of Project: Fall 2010
MHCC Assessment Database	On-going Maintenance	
IPad/IPhone App for MHCC	Development	Ongoing
npPCI Waiver for the Center for Hospital Services	Configuring site.	New Reporting Quarter begins January 14, 2013

Network Operations & Administrative Systems (NOAS)

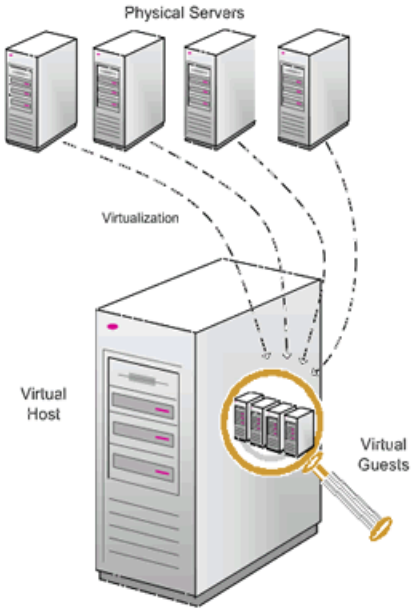
Information Technology Newsletter
The January IT Newsletter containing helpful information about MHCC IT systems and servers has been released.

MHCC Virtualization Project
With the pending implementation of the virtualized environment, following is a brief description and benefits of this exciting technology.

Description
Typically, corporate applications run on super computers located in air conditioned security rooms. Each super computer, called a server, runs 1-3 major applications. In many instances, due to application needs,

storage needs, database needs and communications needs, organizations can run from 10-50 servers in their data centers. In a virtualized environment, special software is installed that allows applications (database, statistical, etc) to run on "virtual machines" instead of physical super computers. In many instances, 1 super computer (server) running this special software can run 3-6 "virtual machines" thus replacing the need for 2-5 physical super computers. Each "virtual machine," or VM acts as it own real physical computer to the applications it supports. The benefits of virtualizing are:

1. Cost savings (server reduction, energy consumption)
2. Implementation of Green technology
3. System administration reduction due to a reduction in the number of physical super computers
4. Better percentage use of hardware (most super computers only use about 20% of their available resources; in a virtualized environment, approximately 80% of a super computer's resources are used)
5. Easier software installation and management



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

Health Plan Quality and Performance

Staff had previously worked with MHCC legal counsel to develop a Memorandum of Understanding (MOU) between MHCC and the Maryland Health Benefit Exchange (MHBE) as it relates to quality and performance reporting of health benefit plans. This MOU remains under consideration by the MHBE.

The 2012 Health Benefit Plan Quality and Performance Report: Measuring the Quality and Performance of Maryland Commercial Health Benefit Plans is anticipated to be released in January. This report presents quality and performance information on health maintenance organization (HMO) plans, point of service (POS) plans, and preferred provider organization (PPO) plans operating in Maryland. In prior years, PPO plans reported on a voluntary basis, but this is the first year that they are mandated to report. The quality and performance information in this report enables Marylanders to compare health benefit

plans on key quality measures regarding health care delivery and member satisfaction. The 2012 report contains information on 59 performance measures and indicators grouped into six categories: Primary Care and Wellness for Children and Adolescents (15 measures and indicators), Child Respiratory Conditions (8 measures and indicators), Women's Health (5 measures and indicators), Primary Care for Adults (20 measures and indicators, Behavioral Health (4 measures and indicators), and Member Experience and Satisfaction (7 measures and indicators). Overall, Maryland plans had strong performance on clinical performance measures and indicators in the categories Primary Care and Wellness for Children and Adolescents as well as Women's Health. Strong performance in these categories means that Maryland's health benefit plans are working effectively to promote prevention and wellness initiatives for their members at the earliest stages, resulting in a healthier Maryland membership.

Currently, Maryland's health benefit plans are in the midst of audit and report preparations for the five quality tools used in 2013 Maryland reporting. The five quality tools include the following: 1) HEDIS-Healthcare Effectiveness Data and Information Set, 2) CAHPS-Consumer Assessment of Healthcare Providers and Systems survey, 3) RELICC-Maryland RELICC [Race/Ethnicity, Language, Interpreters, and Cultural Competency] Assessment, 4) BHA-Maryland Plan Behavioral Health Assessment, and 5) QP-Maryland Plan Quality Profile. It should be noted that the data being reported for the commercial health benefit plans will be used as proxy data for the Maryland Health Benefit Exchange's QHPs in 2013 and 2014 reporting. So although data will continue to be collected by the QHPs themselves, there can be no separate reporting for the QHPs until 2015, when the QHPs have one year of data to report on.

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 May 2011. Over the holiday season, the analytics declined slightly, to an average of approximately 4 Maryland visits per day, with users viewing about 3 pages per visit, and spending an average of about 3 minutes per visit on the site.

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 7, 2013 enrollment in the Partnership was as follows: 416 businesses; 1,158 enrolled employees; 1,898 covered lives. The average annual subsidy per enrolled employee is more than $2,400; the average age of all enrolled employees is 41; the group average wage is about $27,700; the average number of employees per policy is 3.9. The 5th annual report on the implementation of the Partnership will be submitted to the General Assembly and posted on the Commission's website later this month.

Mandated Health Insurance Services
Throughout the legislative session, Commission staff tracked the progress of several bills proposing new mandates or modifications to existing mandates. In 2012, staff received one request for an actuarial analysis requiring carriers to cover orthotics for the management of a diabetic's feet. Mercer, our consulting actuary, prepared the fiscal, medical, and social impact analysis, which staff presented at the November meeting and the Commission approved at the December meeting. The final version of the report was submitted to the Legislature and is posted on the MHCC website. Staff will track similar legislation throughout the 2013 legislative session, which begins later this month.

Long Term Care Policy and Planning

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. Programming for MDS 3.0 was initially done in SQL, and was then updated to SAS. Variables have now been updated into the MDS Manager Program. These programs are now being tested.

Hospice Survey
The Commission collects data annually from all licensed hospice programs in Maryland. All hospice programs have completed both Parts I and II, and the data has been cleaned and checked. The public use data for the FY 2011 survey has now been posted on the Commission's website at: http://mhcc.maryland.gov/public_use_files/index.aspx

Planning is underway for the FY 2012 Hospice Survey.

Hospice Section of State Health Plan
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 continues to undergo 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. The Chapter (COMAR 10.24.13) was released for Informal Public Comment during April. Updates based on revised population projections were posted in May. An analysis of comments received was presented to the Commission in June. Staff met with the Hospice Network about modifying the approach to projecting need for hospice services. The Hospice Work Group was reconvened on August 23, 2012. Also, a meeting was held with interested participants on September 10, 2012. In addition, a briefing was held on September 12, 2012 at the Senate Finance Committee.

Since the Senate Finance Committee briefing in September, staff has been working internally and recently with the Hospice Network to develop an alternative approach to projecting need for hospice services. The Hospice Work Group will be reconvened in January.

Chronic Hospital Occupancy Report
Commission staff has developed the Chronic Hospital Occupancy Report for FY 2011. This report, which is updated annually, is required under COMAR 10.24.08. It reports data on occupancy for both private and state-operated chronic hospitals. The private chronic hospitals in FY 2011 include James Lawrence Kernan Hospital; Johns Hopkins Bayview Medical Center; Levindale Hebrew Geriatric Center and Hospital; University Specialty Hospital; and Laurel Regional Hospital. The state-operated chronic hospitals include Western Maryland Center and Deer's Head Hospital Center. The Chronic Hospital Occupancy Report for FY 2011 was published in the November 16th issue of the Maryland Register and was posted on the Commission's website on December 11, 2012.

Nursing Home Occupancy Report
The annual reports on nursing home occupancy and payment source have been completed. The following tables were submitted to the Maryland Register for publication in the December 28, 2012 issue: "Nursing Home Licensed Beds Occupancy by Region and Jurisdiction: Maryland, Fiscal Year 2011" and "Required Maryland Medical Assistance Participation Rates for Nursing Homes by Region and Jurisdiction: Fiscal Year 2011." These are developed and published annually based on data from the Long Term Care Survey, MHCC bed inventory reports, and Medicaid cost reports. They are used for health planning and Certificate of Need review. These reports have also been posted on the Commission's website at: http://mhcc.dhmh.maryland.gov/ltc/Pages/longtermcare/default.aspx#nh

FY 2011 Home Health Survey
Staff is finalizing the utilization tables and public use data files. When complete, utilization tables and public use files will be posted on the Commission's website. Staff is in the process of updating the Home Health Agency Survey for the 2012 fiscal period.

Long Term Care Survey
Staff is in the process of updating the 2012 Long Term Care Survey.

Long Term Care Quality Initiative

Nursing Home Experience of Care Surveys
Nursing home administrators received notification the last week in November of the timeline for the 2013 survey cycle. Responsible party and recently discharged resident list are due from nursing home administrators in early February, surveys are scheduled to be mailed in March with survey returns received through April, and analysis is scheduled for May.

At a Commissioner suggestion, staff has selected relevant quality indicators to be included in the survey document along with scores specific to the nursing home so prospective respondents will be aware of the nursing home's performance in areas other than experience of care.

Consumer Guide to Long Term Care
No major activity since the last report. Staff continues to work with the Office of Health Care Quality to resolve the assisted living report issue.

Other
Staff attended the special Hospice Open Door Forum hosted by Centers for Medicaid and Medicare in December. The agenda was about the new hospice quality report, specifically how hospices will submit data and details about the data submission process (via a secure web site). Data entry will start in January 2013 for the hospice structural and pain management measures.

CENTER FOR HOSPITAL SERVICES

Hospital Quality Initiatives

Hospital Performance Evaluation Guide (HPEG) Update
In preparation for the January 2013 update to the Hospital Performance Evaluation Guide, preview reports with 2Q2012 clinical and HCAHPS data as well as FY12 data for medical and maternity conditions were sent to hospitals in mid-December. Hospitals were provided the opportunity to review the reports and give feedback or make corrections to their data. To date, MHCC has not received any corrections and will move forward with reporting this data in the January Hospital Guide update. Additionally, the January update will mark the first time that Emergency Department and Immunization data will be publicly reported on the Hospital Guide; these measures include data starting from 1Q2012.

Healthcare Associated Infections (HAI) Data
Maryland hospitals are required to use the CDC National Healthcare Safety Network surveillance system to report data to the Commission on central line associated bloodstream infections (CLABSIs) in any ICU and surgical site infections (SSI) data related to Hip, Knee and coronary artery bypass graft procedures. To ensure the integrity of the data, we have established a five year contract with Advanta Government Services, Inc to provide clinical data quality

review and on-site medical chart audit services. The FY2012 CLABSI and SSI audit and quality review is underway.

The staff finalized the third annual survey of hospital infection prevention and control and sent this survey to the hospitals in December, 2012. The survey is designed to gather information on staffing, operations and activities related to infection prevention and control to inform our statewide public reporting and quality improvement initiatives. The completed surveys will be due in January, 2013.

Specialized Services Policy & Planning

Cardiac Services

Clinical Advisory Group
The fourth meeting of the Clinical Advisory Group (CAG) on Cardiac Surgery and PCI Services was held on December 13, 2012. Co-Chair Loren Hiratzka, MD, presented a proposal for a Maryland oversight structure for cardiac surgery; the proposal included a Cardiac Surgery Subcommittee and quality as well as regulatory reviews based on data from the Society of Thoracic Surgeons Adult Cardiac Surgery Database. At the January 10 (fifth) meeting, the CAG will complete its discussion of recommendations for cardiac surgery. A CAG meeting was added for February 28; this meeting will address revisions of the PCI oversight document discussed in November.

Ongoing Oversight of PCI at Hospitals without Cardiac Surgery Onsite
Commission staff has received and is reviewing applications for renewal of primary PCI (pPCI) waivers from the two pPCI waiver hospitals scheduled to be reviewed by the Commission in February: Frederick Memorial Hospital and Meritus Medical Center.

Amendments to COMAR 10.24.05
The Commission received no comments on the proposed technical amendments to COMAR 10.24.05, which were adopted as proposed permanent regulations by the Commission on September 20, 2012, published for review and comment on November 2, 2012 in the *Maryland Register*, and were open for comments through December 7, 2012. These amendments allow the Commission to continue oversight of non-primary PCI programs at the C-PORT E Registry hospitals, while the Commission is in the process of revising the State Health Plan Chapter on Cardiac Surgery and PCI Services; as such they serve as a bridge during the transition period while the oversight regulations are being updated. They will be considered for permanent adoption at the upcoming January 17, 2013 Commission meeting.

Hospital Services Policy & Planning/Certificate of Need

Certificate of Need ("CON")

CON's Approved

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

College View Center (Frederick County) – Docket No. 12-10-2336

Construction of a replacement comprehensive care facility (CCF) to house the 119 CCF beds at the existing College View Center and relocate 11 temporarily delicensed CCF beds acquired from Frederick Memorial Hospital.
Approved Cost: $19,205,000

Anne Arundel Medical Center (Anne Arundel County) – Docket No. 12-02-2338
Build-out of Third Floor shell space (as approved and modified with CON 04-02-2153) as a 30-bed general medical/surgical unit.
Approved Cost: $8,027,342

Modified CON's Approved

NMS Healthcare of Hagerstown (Washington County) – Docket No. 10-21-2307
Construction of a new 78 CCF bed addition to accommodate 43 CCF beds purchased from Homewood at Williamsport and 35 CCF beds being relocated internally through elimination of all rooms with more than two beds.
Modification: Increase in approved project costs of $1,608,228 bringing the total approved cost to $11,121,461 and a reduction in the scope of approved renovations.

Carroll Hospital Center (Carroll County) – Docket No. 12-06-2330
Construction of a building addition to house an outpatient cancer center and related renovation of the existing Richard N. Dixon Building on the hospital campus.
Modification: Increase in approved project cost of $3,000,000 bring the total approved cost to $30,975,000.

CON Letters of Intent

Asbury Atlantic d/b/a Asbury Methodist Village – (Montgomery County)
Renovation and modernization of the existing 285 bed comprehensive care facility (The Wilson Health Care Center) located at 5301 Russell Avenue in Gaithersburg

Capital Caring – (Prince George's County)
Change the bed capacity of an existing general hospice by establishing a seven-bed general inpatient unit in an assisted living facility, the Residence on Greenbelt, located in Lanham

Pre-Application Conference

Asbury Atlantic d/b/a Asbury Methodist Village – (Montgomery County)
December 19, 2012

Determinations of Coverage

- **Acquisitions/Change of Ownership**

Celtic Healthcare of Maryland, Inc. d/b/a Celtic Healthcare
Transfer of ownership of Celtic Healthcare of Maryland, Inc. which is authorized to provide home health services in Baltimore and Montgomery Counties to PCH, through a Stock Purchase Agreement.

Eastern Shore Endoscopy, LLC (Talbot County)
Change in ownership of Digestive Health Center owned by Shore Health System which is located at 511 Idlewild Avenue, Easton to Eastern Shore Endoscopy

Apex Health of Silver Spring (Montgomery County)

Change in ownership of a comprehensive care facility. The real assets are currently owned by LeeCo, the real assets of Apex are being sold to 2700 Baker Street, LLC.

- **Other**

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

South River Health & Rehabilitation Center – (Anne Arundel County)
Temporary delicensure of four CCF beds

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

Mid-Atlantic of Cumberland – (Allegany County)
Relicensure of nine temporarily delicensed CCF beds

Berlin Nursing Home – (Worcester County)
Relicensure of 36 temporarily delicensed CCF beds

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

Caroline Nursing & Rehabilitation Center (Caroline County)
Permanent relinquishment of eight temporarily delicensed CCF beds

  - **Miscellaneous**

Gentiva Health Services (USA) d/ba Gentiva Health Services
Closure of all non-Medicare-certified home health agency services operated by Gentiva Health Services from its three office locations in Annapolis, Silver Spring and Towson. Gentiva will continue to operate a certified home health agency from its main office in Columbia.

Hospital Services Policy & Planning

On December 6, 2012, Ben Steffen and CHS staff members attended a meeting of the Maryland Hospital Association Legislative and Regulatory Council to provide this group with an update on planning activities related to PCI and cardiac surgery.

On December 17, 2012, CHS staff met with State Senator Richard Colburn to discuss issues related to participation in the review process for a CON application for the relocation of Memorial Hospital at Easton.

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 (health IT) Policy Committee (committee) meeting. The committee is tasked with developing recommendations on a policy framework for a national health information network infrastructure, which includes adopting transmission standards, services, and policies for the exchange of electronic health information. In December, the committee considered best practices for patient identity proofing and authentication to provide patients access to their electronic health information. The committee recommended that providers' processes for identity proofing and

authentication be transparent to patients, flexible enough to meet the needs of their patients, and evolve as technology solutions advance. The committee also discussed barriers to collecting quality data for the meaningful use requirements from various electronic health record (EHR) products; data is coded and captured differently in EHRs. The committee plans to make recommendations on standardizing data elements that underlie the quality measures.

Staff received roughly 63 percent of hospitals' responses to the 2012 Hospital Health Information Technology Survey (survey) from hospital Chief Information Officers that was sent out during the month. The survey has been conducted annually since 2008 and is used to assess the adoption and use of health IT in Maryland's 46 acute care hospitals, including the adoption and use of order entry systems, EHRs, medication administration, infection management, health information exchange (HIE), and telemedicine. This year, staff revised the survey with additional questions related to the meaningful use requirements to assess how hospitals are using health IT to improve patient outcomes. The survey is being administered using an online format, and all survey responses are expected to be completed in early January. The findings will guide staff and hospitals in expanding the adoption and use of health IT to improve patient outcomes. Staff plans to begin analysis of the data early next year and plans to release the findings in the summer of 2013.

Staff reviewed the changes made to the criteria for management service organization (MSO) State designation with the nationally recognized accreditation body, the Electronic Healthcare Network Accreditation Commission (EHNAC). At the recommendation of the MSO Advisory Panel (panel), changes were made to require MSOs to be accountable for all services provided, including services provided by a third party. MSOs provide EHR adoption and optimization services to ambulatory physician practices and must meet nearly 95 criteria related to privacy, security, business practices, technical performance, operations, services, and undergo national accreditation to attain State designation. EHNAC will now require organizations to meet the definition of an MSO as part of the application process. Staff distributed changes made to the criteria and application to the panel for review; staff will convene the panel in January to complete the annual criteria review of the criteria. Once finalized, organizations applying for or renewing their State designation will be required to demonstrate adherence to the new criteria. Currently, 15 MSOs are State Designated and three MSOs are in Candidacy Status.

Staff continued drafting the report to the Governor and General Assembly about the status of State-regulated payer (payer) and pharmacy benefit manager (PBM) implementation of electronic preauthorization of medical and pharmaceutical (health care) services in compliance with Health-General Article §§19-101 and 19-108.2. The law requires payers and PBMs to attain benchmarks for standardizing and automating the preauthorization of health care services through three phases and also requires MHCC to report annually through 2016 on the progress payers and PBMs are making in achieving the benchmarks. Phase 1 required payers to make available on their website a list of health care services that require preauthorization and the criteria for making a preauthorization determination by October 1, 2012; nearly all payers and PBMs met the benchmark. The Phase 2 benchmark requires payers and PBMs to implement an online process to electronically accept prior authorization requests by March 1, 2023. The Phase 3 benchmark requires payers and PBMs to provide real-time approvals when no additional information is required for approving preauthorization requests by July 1, 2013. Staff plans to release the report to the Governor and General Assembly on March 1, 2013. During the month, staff received three formal comment letters to the proposed COMAR 10.25.17, *Benchmarks for Preauthorization of Health Care Service* regulation that was published in the Maryland Registry on November 2nd.

Planning activities continued during the month to conduct an EHR adoption environmental scan (scan) of independent long term care (LTC) facilities throughout the State. Findings from the scan will be used by staff to develop short term strategies for expanding health IT adoption among independent LTC facilities. Staff is exploring the opportunity to include a broader set of questions around health IT as part of the annual Long Term Care Survey (survey). This survey collects information from LTC facilities, assisted

living, adult day care, and chronic hospitals. Staff plans to work with the Health Facilities Association of Maryland and Lifespan Networks, the two LTC trade organizations in Maryland, to finalize the survey questions. Staff plans to distribute the scan to nursing homes in February and expects to release an information brief this summer.

Staff is in the preliminary stage of planning for a health IT consumer advisory group (advisory group). The advisory group will propose ways to increase consumer knowledge of health IT, and suggest strategies aimed at building consumer trust in electronic health information. The establishment of a consumer advisory group was one of the recommendations detailed in the *Health Information Technology Consumer Awareness & Education Brief* (brief) released last September. The brief outlines the findings from several consumer focus groups convened in the fall of 2011 to assess consumer awareness of electronic health information, trust in the electronic exchange of their information, and challenges related to consumer access and control in an environment where multiple HIEs exist. The goal of the advisory group will be to develop a blueprint that will be used to guide the development of a statewide awareness and education program aimed at increasing consumer awareness and trust in HIE. The blueprint will include a guidance document around outreach and education material design and a strategy for implementation of at least one pilot project initiative designed to educate consumers around HIE. Staff plans to convene the first meeting of the advisory group in the winter of 2013.

During the month staff continued to explore the possibility of a statewide telemedicine network. The recommendation to implement a statewide telemedicine network is a result of the 2011 Telemedicine Advisory Council. Staff reviewed several vendor products and participated in a vendor demonstration of a telemedicine network. Over the next couple of months, staff plans to convene an evaluation panel consisting of State Designated MSOs and the statewide HIE to review select telemedicine technology solutions. Activities are also underway to identify secure text messaging networks that would enable providers that use text messaging to securely exchange protected health information (PHI). Staff plans to identify secure texting vendors that provide protections consistent with the Health Insurance Portability and Accountability act of 1996 (HIPAA). Over the next couple of months, in collaboration with MedChi, The State Medical Society, staff plans to develop a secure texting vendor list that among other things, meets the HIPAA requirements.

Staff continued working with stakeholders to identify key recommendations to increase the use of HIE services by ambulatory care practices in Maryland. As of November 2012, around 1.5 percent of physicians had viewed information available from the statewide HIE. The leading recommendations include encouraging ambulatory care practices with an EHR to contribute and consume electronic information from an evolving menu set of options from the statewide HIE; coordinate establishing courses relating to health IT with the Maryland Board of Physicians and allied health care societies; educate employers on the value of EHRs and HIE; encourage human resource groups to inform employees on the benefits of EHRs and HIE; educate the Maryland Association of Health Underwriters and other insurance brokers in Maryland about the benefits of EHRs and HIE; and to enhance the data available to physicians with more clinical content that is available through the statewide HIE. A report is scheduled for release in early 2013.

Health Information Exchange

Staff continues to provide guidance to the Chesapeake Regional Information System for Our Patients (CRISP) in implementing the statewide HIE and to its Advisory Board that consists of four committees: Finance, Exchange Technology, Clinical, and Small Practice Advisory Committees. Last month, staff participated in the Small Practice Advisory Committee meeting. Staff participated in the Exchange Technology and Clinical Advisory Committee meetings in December. The Exchange Technology Advisory Committee provides guidance on infrastructure and other technology related decisions. The Clinical Advisory Committee makes recommendations around exchange service implementations. In both meetings, members discussed opportunities for including additional clinical data, such as reason for

visit and diagnosis, within the electronic admission, discharge, and transfer (ADT) information from hospitals. Including clinical information in the ADT files enhances the amount of information available to ambulatory practices for care coordination. Members of both advisory groups agreed that further exploration by CRISP regarding individual hospitals' capabilities to provide the additional clinical data is warranted. The financial audit of CRISP by CliftonLarsonAllen (CLA) was finalized during the month. Staff met with the CRISP Board of Directors Audit Committee (committee) to review the findings. CLA reported to the committee a deficiency in their internal control identified during a post-audit review of the financial statements. CRISP plans to change internal policies to more accurately estimate expenditure and accruals in their financial statements. Staff plans to begin working with CLA on the security and technology audit of CRISP in February.

Staff is working with ONC to develop a proposal that will allow MHCC to use the nearly $800K remaining from the Challenge Grant (grant) to advance the use of electronic health information in LTC. MHCC received approximately $1.6M from the ONC in 2011 to connect six LTC and post acute care facilities to connect with the statewide HIE. The demonstration concluded with grant funds remaining; staff met with ONC to discuss different options for using the remaining funds. Staff proposed a pilot use case for institutional pharmacies to publish data to the statewide HIE. Medication reconciliation occurs at the time of admission and oftentimes the medication history is incomplete. Staff requested a small amount of funding be used to identify and resolve the challenges associated with implementing this use case. The remaining funding would be used to competitively offer financial support to several independent LTC facilities to implement an interoperable health IT infrastructure. Recipients of the funding will need to demonstrate support for care coordination and efficient transitions through the use of health IT and services of the statewide HIE. Staff is awaiting approval from ONC before continuing with this endeavor.

Staff continues to provide support to the contractor Post and Shell, P.C., a law firm selected to provide assistance in evaluating the draft HIE regulations that, when adopted as final regulations, will govern the privacy and security of electronic health information obtained or released through an HIE. Maryland law (Health-General Article §§4-301 and 4-302) requires MHCC to develop regulations for the privacy and security of protected health information exchanged through an HIE. Staff released HIE draft regulations for an informal public comment period in February 2012 and received comments from about 33 individuals and organizations. The contractor will provide recommendations to modify the draft regulations to ensure they are aligned with current law; mitigate potential privacy and security concerns for consumers; and ensure the regulations are not overly burdensome to implement. During the month, the contractor finalized their initial draft recommendations, which are now being reviewed by staff. Staff expects to release the next version of the informal draft HIE regulations in January 2013 for public comment.

Electronic Health Networks & Electronic Data Interchange

During the month, staff notified approximately 45 payers of the requirement to submit census level information on their electronic administrative transactions in 2013. Payers operating in Maryland whose premium volume exceeds $1 million and select specialty payers, such as dental or vision must complete an Electronic Data Interchange (EDI) Progress Report. Staff plans to distribute the 2013 EDI Progress Report to payers in early March. COMAR 10.25.07 – *Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouses*, requires electronic health networks (EHNs) operating in Maryland to be MHCC certified; payers accepting electronic health care transactions originating in Maryland must accept them from MHCC certified EHNs. During the month, staff completed the recertification of ProtoMed Medical Management Corporate, Ingenix, CareStream Dental and NaviNet. Staff also provided consultative support to HealthFusion, Inc. in completing their recertification.

National Networking

Staff attended several webinars during the month. eHealth Initiative presented, *Meaningful Use Stage 3 Recommendations*, which featured a discussion of the newly released recommendations for Stage 3

meaningful use of the Medicare and Medicaid EHR Incentive Programs. The National eHealth Collaborative presented, *Review of the Health IT Policy Committee's Meaningful Use Request for Comment (RFC)* that detailed the concepts and questions in the RFC and provided additional guidance to the public in submitting informed comments by the January 14, 2013 deadline. The presentation also highlighted the relationship between the RFC and the meaningful use Stage 3 rule making process, the proposed meaningful use measures, objectives, and clinical quality measurement. The American Health Information Management Association presented, *Implementing Health Information Exchange in the LTPAC Community – Perspectives for State and HIE Organizations* that provided a brief overview of industry and government influences shaping the direction and requirements for HIE in the LTPAC setting.