MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

February 2013

CENTER FOR INFORMATION SYSTEMS AND ANALYSIS

Patient Centered Medical Home Program

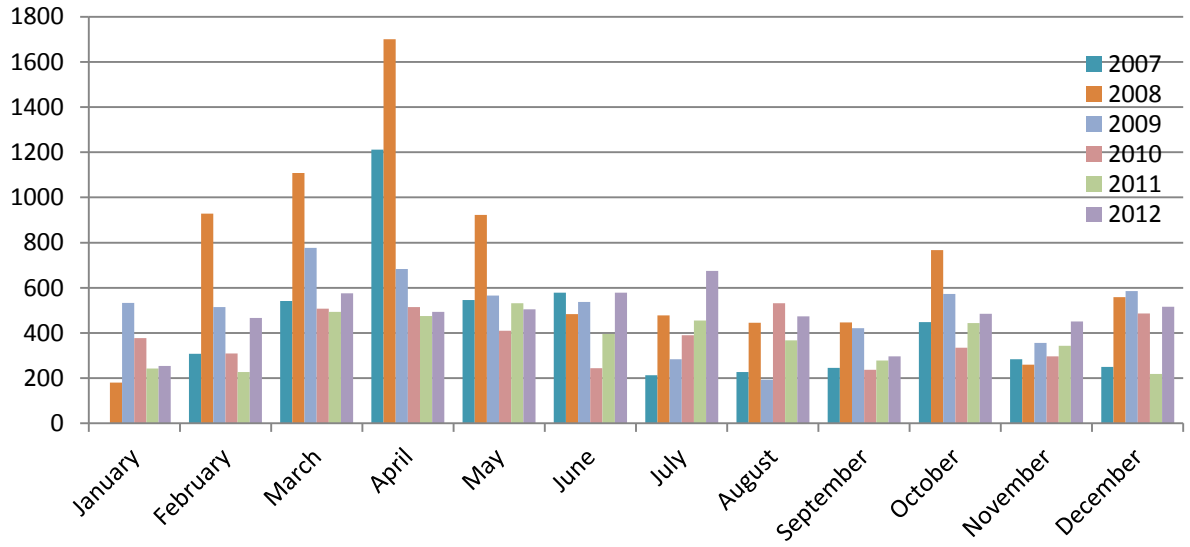
Cigna
The Commission will consider and take action at the February 21, 2013 meeting on Cigna's single carrier program application.

TRICARE
The TRICARE demonstration project was published in the Federal Register on Thursday February 14, 2013. The program will become effective in 30 days and will operate for two years. The negotiations and preparation of supporting documents for this key federal partner to join the program took place over a two year period.

Staff and key contractors are providing some support to another TRICARE PCMH demo (with CMS) by virtue of allowing the TRICARE CMS demo team to participate on current MMPP TRICARE project planning calls and through arranging a few special briefing calls.

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 and **$518,503** for December of 2012. The monthly payments for uncompensated care from March 2007 through December 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 were due to the Commission no later than January 31, 2013.

Audit Contract
The Maryland Board of Public Works approved the award of an MHCC agency contract for audit services to Myers and Stauffer, LC on January 23, 2013.

Cost and Quality Analysis

Practitioner Performance Measurement Project Update
Staff has initiated the process of applying to CMS for certification as a Qualified Entity (QE) so that the MHCC can use Medicare claims data aggregated with claims from our private insurance claims data (MCDB) for practitioner performance measurement. We have confirmed that the claims data MHCC currently receives from CMS under our research DUA (data use agreement) is the same as the claims data provided to QEs. However, we have also learned that CMS expects QEs to make measurement results available to the public within 12 months after achieving QE certification. This timeline is too short for the development and testing of alternative performance measures (resource use/cost, efficiency), which require approval from CMS. We have scheduled a conference call with relevant CMS staff (including Niall Brennan) to discuss this short timeline, when CMS will permit the MHCC to convert our research DUA to a State Agency DUA (which will permit the MHCC to share Medicare claims data with other state agencies in Maryland), and whether CMS has plans to form a learning collaborative for QEs.

Staff has also awarded a bid board contract to Discern Consulting for:

- Advice to MHCC on preparing evidence for its application to CMS;
- Research on quality and cost measures for practitioners and recommendations for their use in MHCC's performance reports; and
- Technical assistance to plan and manage a stakeholder workgroup.

Discern's relevant credentials include: training as an executive reviewer on the Qualified Entity standards; in-depth understanding of performance measurement; and experience in the development of the QE certification process.

Maryland Medical Care Data Base (MCDB) Webinar #2
A webinar meeting with MCDB payer representatives and staff of 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 February 20, 2013. During the meeting, staff will review this year's Data Submission Manual, focusing on a few changes to last year's submission manual and information required by the manual that payers either omitted or interpreted incorrectly in last year's submission. MHCC staff has decided to delay any major changes to the information submitted on claims until next year's submission, but carriers are required to report to MHCC on their ability to report the additional information that will be included in next year's submission. Because practitioner performance measurement will rely on the National Provider Identifier (NPI) to identify the same practitioner across payers' claims data, staff has decided to rely on the specialty taxonomy code the practitioner submitted to CMS when applying for an NPI. This will provide a common specialty code

regardless of how the carriers designate a practitioner's specialty. Although there is a requirement for a servicing practitioner NPI on every claim, there are a few carriers who have been unable to meet this requirement. Staff will set up individual meetings with these carriers to discuss the problem.

National IMPaCT Conference
NASHP is convening a conference in Oklahoma City on February 21-22 to discuss strategies for building and sustaining a primary care quality improvement infrastructure. Sixteen states have been invited to attend the conference, including Maryland. Maryland's attendees will include: Linda Bartnyska from MHCC; Dr. Niharika Khanna of the University of Maryland, School of Medicine, head of the Maryland Learning Collaborative, which provides practice transformation services to the PCMH practices; Donald Nichols, PhD of IMPAQ International, head of the PCMH Evaluation Contract team; and Russ Montgomery, who works at DHMH with Dr. Laura Herrera. The states will explore ways to strengthen their primary care medical home initiatives, increase consistency across states (to the extent that this is possible and desirable), identify challenges and opportunities, and generate new ideas and promising approaches to address them. NASHP hopes the information shared by the participants will lead to the conceptualization a national toolkit for primary care extension programs.

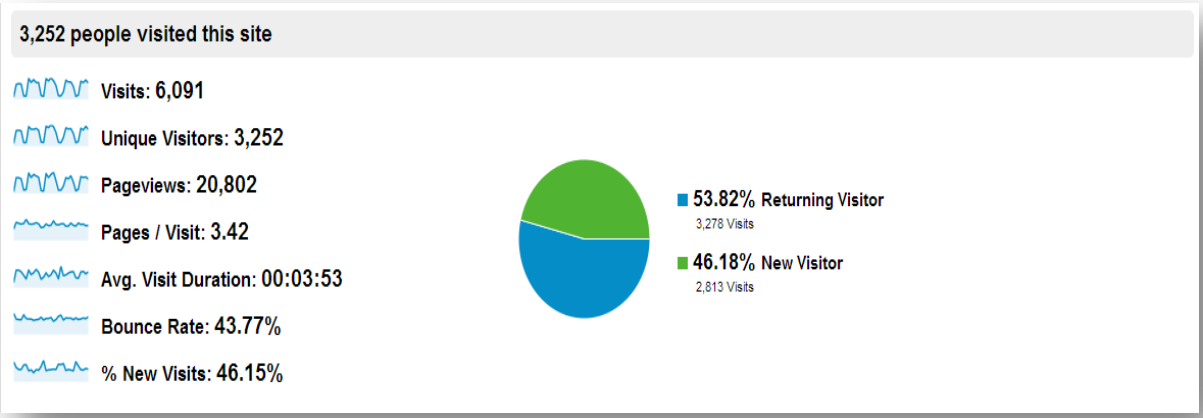
Data and Software Development

Internet Activities
As shown in the Figure 2 below, the number of visits to the MHCC website for the month of January 2013 was 6,091 and of these, there were 3,252 unique visits. The average time on the site was 3:53 minutes. Bounce rate of 43.77 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.

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 mhcc.maryland.gov. Other government agencies include dhmh.maryland.gov, Maryland.gov and crisphealth.org. Among the most common search keywords in January were:

- "Maryland health care commission"
- "MHCC"

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.

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

Table 1 – Website Applications Under Development

Board	Anticipated Start Development/Renewal	Start of Next Renewal Cycle
PCMH Quality Measures website	Completed	Time Tracking submission for 2012-Period 2 (July-December) completed
PCMH Public Site	On-going Maintenance	Ongoing
PCMH Portal (Learning Center & MMPP)	On-going Maintenance	Ongoing
PCMH Practices Site (New)	New User guide Ongoing maintenance	Ongoing
Boards & Commissions Licensing Sites (13 sites)	On-going Maintenance	Various cycles as determined by the boards
Boards & Commissions Licensing Sites (13 sites)	Modifying for Ethnicity (10 sites updated to date) Psych Board site updated to add 50 new fields	Ethnicity modifications completed for all boards
Physician Licensing	Live—Ongoing support	July 16 Providing ongoing support Physicians July of each year A-L and M-Z alternate every other year
Health Insurance Partnership Public Site	On-going Maintenance	Ongoing
Health Insurance Partnership Registry Site	Monthly Subsidy Processing	Ongoing registrations and user updates Legislative Reports produced monthly
Health Insurance Partnership Registry Site	Monthly Registration	Monthly subsidy payments and reports processed on the first of each month
Hospice Survey Update	Updates completed and tested	Live February 19, 2012
Long Term Care 2011 Survey	Annual Maintenance	Start of Project: January 2012 Survey Finished. Database results uploaded.
Long Term Care Survey	Completing updates Live in April	Moving Annual Nursing Home Assessment
Hospital Quality Redesign	Planning	Start of Project: Fall 2010
MHCC Assessment Database	Development	Moving Annual Nursing Home Assessment to Nursing Home Survey
IPad/IPhone App for MHCC	Development	Ongoing
npPCI Waiver	Live-completed	For MHCC's Center for Hospital Services

Network Operations & Administrative Systems (NOAS)

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

MHCC Virtualization Project
Due to pending changes in the amount and type of data to be stored internally, the Commission is procuring a more robust backup environment. The current tape based system will be allocated to "fallback" status, and a new disc-based system is being purchased. This new process will permit faster backup and restore times. The new backup system will be replicated at an off-site location for the purposes of business continuity.

Information Technology Business Continuity Plan
Staff is in the process of updating the current Commission Information Technology Business Continuity Plan. The new plan will have updated information, including contacts, software licensing, hardware configuration, usage and maintenance of all technology systems in the data center and in use as workstations, printers, scanners, etc. This plan will be kept in hard and soft copy, and will be stored in our off-site backup facility.

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. The MOU was recently updated to include several new provisions which reflect changes that have occurred since the original MOU was issued to the MHBE. The updated MOU was re-issued to the MHBE on February 12, 2013. This MOU remains under review by the MHBE.

As requested by the MHBE, staff had directed its report development contractor to develop several methodologies for a MHBE-specific 5-star rating system. These methodologies were presented to MHBE staff on January 25, 2013. On January 30, the contractor made a presentation to the MHBE's key stakeholder group consisting of qualified health, dental and vision plan representatives. The proposed methodology for the MHBE-specific 5-star rating system is currently in its public comment period and is anticipated to be finalized by the MHBE in February 2013.

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 past 30 days, the analytics increased to an average of more than 6 Maryland visits per day, with users viewing about 4 pages per visit. Both statistics are higher than the national average.

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 February 13, 2013 enrollment in the Partnership was as follows: 421 businesses; 1,153 enrolled employees; 1,884 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 was submitted to the General Assembly in January and posted on the Commission's website.

Mandated Health Insurance Services
Throughout the legislative session, Commission staff will track bills proposing new mandates or modifications to existing mandates, if any, in order to meet the Commission's statutory requirement to report on the fiscal, medical, and social impact of the proposed legislation. Staff will also track bills relevant to the small group insurance market and its conformity with the ACA, and other health reform legislation.

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.

In addition, in response to issues raised by providers, staff contacted CMS to update certain variables collected in Section S (state-specific section) of the MDS. Staff worked with representatives of CMS and the changes have been accepted.

Hospice Survey
The FY 2012 Maryland Hospice Survey will be starting effective February 19, 2013. Notices were sent out to providers on Monday, February 11th. Part I of the survey will be due 60 days after the survey commences. Part II will be due no later than June 10, 2013. The public use data set for the FY 2011 Hospice Survey has been posted on the Commission's website.

Hospice Section of the 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 Draft 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 with the Hospice Network to develop an alternative approach to projecting need for hospice services. The Hospice

Work Group was reconvened on January 16th. At that meeting, consensus was reached on the components of the methodology. Staff returned to brief the Senate Finance Committee on January 24th. To prepare for our next appearance before Senate Finance we are scheduling meetings with the Health Officers in Baltimore City and Prince George's County and the staff at the respective Department of Aging.

FY 2012 Home Health Survey
Staff is in the process of updating the Home Health Agency Survey for the 2012 fiscal year period. For the FY 2012 Home Health Agency Survey, there will be only one survey collection period for all agencies. This is in an effort to streamline the data collection process and reduce turnaround time for data auditing and reporting, including distribution of public use data sets. In the past there were two phases to the home health survey collection; but the data was only processed only after the second phase was complete. The goal is to help agencies to have one consistent period and increase the overall efficiency of survey data collection and processing.

Long Term Care Survey
Staff is in the process of updating the FY 2012 Long Term Care Survey to incorporate the collection of the User Fee Assessment Survey for nursing homes. In an effort to streamline the survey processes and reduce the number of data collections from the nursing home providers, Long Term Care staff worked with the Administration staff to merge the two surveys. This will help reduce the confusion for the providers and improve data quality and efficiency overall. This week staff will mail a notice letter from the executive director, to all nursing home providers and stakeholders informing them of the change in the survey process.

Staff expects to have the Long Term Survey available for online data entry in March 2013. The survey notice letter will be mailed by the end of February.

Long Term Care Quality Initiative

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. The MOU was recently updated to include several new provisions which reflect changes that have occurred since the original MOU was issued to the MHBE. The updated MOU was re-issued to the MHBE on February 12, 2013. This MOU remains under review by the MHBE.

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CENTER FOR HOSPITAL SERVICES

Hospital Quality Initiatives

Hospital Performance Evaluation Guide (HPEG) Update
The Hospital Performance Evaluation Guide was updated in January 2013 with FY2012 core measures and HCAHPS data as well as FY2012 data for common medical conditions and maternity and newborn utilization data. Additionally, the January update to the Hospital Guide represents the first release of two

measures that address the time patients remain in the emergency department and two measures that focus on patient immunization (pneumonia and influenza).

In January, MHCC issued a joint letter from MHCC/HSCRC regarding our new policy to expand hospital quality measures data collection. The expanded data collection effort not only supports MHCC's public reporting initiatives, but also strengthens the Maryland hospital quality based reimbursement system. Our new data policy will establish comparability with the CMS Inpatient Quality Reporting (IQR), Outpatient Quality Reporting (OQR), and Value Based Purchasing program data reporting requirements. Our expanded data collection requirements will be phased in over time, with full implementation for Maryland hospitals beginning January 1, 2014. Hospital contacts were sent a follow-up email outlining the schedule for new measures. To prepare for the collection of outpatient measures, MHCC is requiring hospitals to complete the Hospital OQR Program Online Notice of Participation by February 28, 2013; this notice will allow MHCC and HSCRC to access claims-based outpatient data. The staff is planning to hold a webinar on March 5, 2013 to facilitate communication on the new data policy and to address hospitals' questions and concerns.

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 (SSI) data related to Hip, Knee and CABG procedures. To ensure the integrity of the data, we have established a five year contract with Advanta Government Services, Inc (AGS) 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 has finalized the third annual survey of hospital infection prevention and control programs. The survey was sent to 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 were due in January 2013 and staff members are currently summarizing the information received from the hospitals.

Beginning in July 2013, Maryland hospitals will be required to utilize CDCs National Healthcare Safety Net (NHSN) surveillance system for collection of Clostridium difficile infections data (CDI LabID events). CDILabID events that occur in all inpatient locations must be reported (Neonatal ICUs, Well Baby Nurseries, and Well Baby Clinics are excluded) through the CDC surveillance system. The staff is preparing for this new reporting initiative.

Specialized Services Policy & Planning

Cardiac Services
Clinical Advisory Group
The fifth meeting of the Clinical Advisory Group (CAG) on Cardiac Surgery and PCI Services was held on January 10, 2013. Led by Co-Chair Loren Hiratzka, MD, the group completed its discussion of recommendations for cardiac surgery including proposals for a Maryland oversight structure for cardiac surgery initiated at the December meeting. 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.

Ongoing Oversight of PCI at Hospitals without Cardiac Surgery Onsite
On January 17, 2012, the Commission adopted as final regulations, amendments to COMAR 10.24.05 that will bring these rules, that are currently used for renewal of primary PCI (pPCI) waiver programs at hospitals without cardiac surgery backup, in line with 2012 legislation addressing regulatory oversight of PCI services, until such time as new regulations are adopted.

Hospital Services Planning and Policy/Certificate of Need

January 1, 2013 through January 31, 2012

Certificate of Need ("CON")

Pre-Application Conference

On January 18, 2013, a pre-application conference was held with Capital Caring Hospice concerning its Letter of Intent to change its bed capacity by developing a general inpatient hospice unit within space leased from an assisted living facility in Prince George's County.

Determinations of Coverage

- **Ambulatory Surgery Centers**

Summit Ambulatory Surgical Center, LLC – (Baltimore County)
Relocation of the ambulatory surgery center from 21 Crossroads Drive, Suite 450, in Owings Mills to a new location at 1838 Greene Tree Road, Suite 450, in Baltimore. The office on Crossroad Drive will close with the relocation.

Advanced Surgery Center of Bethesda, LLC – (Montgomery County)
Establish an ambulatory surgery center with one sterile operating room and one non-sterile procedure room to be located at 6430 Rockledge Drive, Suite 160, Bethesda

SurgCenter at National Harbor, LLC – (Prince George's County)
Establish an ambulatory surgery center with one sterile operating room and two non-sterile procedure rooms to be located at 125 Potomac Passage, Suite 200, in National Harbor

SurgCenter of Western Maryland, LLC – (Allegany County)
Addition of a non-sterile procedure room to the existing surgery center located a 12252 Williams Road, S.E., Suite 103, in Cumberland. The facility is authorized for one sterile operating room and three non-sterile procedure rooms.

Baltimore Spine Center, LCC – (Baltimore County)
Addition of a physician to the medical staff of this surgery center

Waterfront Surgical Center, LLC – (Baltimore City)
Establish an ambulatory surgery center with two non-sterile procedure rooms to be located at 2700 Lighthouse Point East, Suite 404, in Baltimore

Towson South Surgical Center – (Baltimore County)
Change in ownership of the Baltimore Harford Surgical Center, LLC and name change to Towson South Surgical Center, an ambulatory surgery center with one non-sterile procedure room located at 7505 Osler Drive, Suite 508, Towson

- **Other**

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

SurgiCenter of Pasadena – (Anne Arundel County)
Temporary delicensure of the ambulatory surgery center

- **Lean Innovation Session**

On January 15 and 16, 2012, CON staff participated in a Lean Innovation Session applying Lean Six Sigma principles to a remapping of the CON application review process, with the goal of achieving faster turnaround on project review decisions by the Commission. The sessions were led by two Six Sigma black belts employed by United Healthcare, William Talamantes and Aparna Sathe.

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. The committee continued its discussion around best practices for patient identity proofing and authentication. The committee also discussed the eConsent trial project, which aims to develop and test innovative ways to educate patients about health information exchange (HIE). ONC provided an update of HIE activities nationwide; about 94 percent of pharmacies are actively electronically prescribing, roughly 43 states have directed exchange, and approximately 20 states have statewide query-based exchange. The committee reviewed the *Health Information Technology Patient Safety Action and Surveillance Plan* that was released by ONC for public comment in December. Public comments are due February 24th, and the final plan is anticipated to be released in early summer.

Staff continues to work with hospital Chief Information Officers in completing the 2012 Hospital Health Information Technology Survey (survey). Administered since 2008, the annual survey aims to assess the adoption and use of health IT among Maryland's 46 acute care hospitals. Nearly all hospitals have submitted responses to the online survey providing information about their adoption and use of electronic order entry systems, electronic health records (EHRs), electronic medication administration records, infection surveillance software, e-prescribing, HIE, and telemedicine. Staff collects information on hospital health IT adoption and planning efforts to evaluate hospital adoption and compare rates with those of hospitals nationwide. The findings are used to evaluate opportunities for increasing hospital health IT adoption and implementation. Staff plans to begin analyzing the survey responses in February.

Staff finalized proposed changes to the draft management service organizations (MSOs) State designation criteria in collaboration with the nationally recognized accreditation body, the Electronic Healthcare Network Accreditation Commission (EHNAC). The MSO Advisory Panel (panel) recommended updating select requirements that an MSO must meet to obtain State designation. MSOs address the financial and technical challenges associated with provider adoption of EHRs. To achieve State designation, MSOs are required to meet about 95 criteria related to privacy, security, business practices, technical performance, operations, and services. They are also required to undergo national accreditation every two years. Roughly 15 MSOs have achieved State designation and about three MSOs are in Candidacy Status. MSOs in Candidacy Status have one year to meet the established criteria.

Staff finalized the draft legislative update report regarding the implementation of electronic preauthorization of medical and pharmaceutical services. State-regulated payers and pharmacy benefit managers (PBMs) are required to meet benchmarks for standardizing and automating the preauthorization of health care services established in Health-General Article §§19-101 and 19-108.2. The law requires MHCC to work with payers, PBMs, and providers to attain 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 on select services when no additional information is required for approving preauthorization requests by July 1, 2013. In February, staff plans to seek input from payers and PBMs on the final draft of the report.

Staff finalized questions for an EHR adoption environmental scan (scan) of independent long term care (LTC) facilities in Maryland. The scan aims to assess EHR adoption, use, and the leading challenges of implementing EHRs. In 2010, staff conducted a similar scan where nearly 24 percent of independent LTC facilities reported adopting an EHR. Independent LTC facilities noted funding issues as the leading barrier to adopting EHRs. Over the next month staff plans to solicit feedback on the survey questions from various LTC administrators and the two LTC trade associations: Health Facilities Association of Maryland and Lifespan Network. Staff anticipates administering the scan in March and releasing an information brief in the fall of 2013. Findings from the scan will be used by staff to develop strategies for expanding health IT adoption among independent LTC facilities.

Staff is in the preliminary stage of updating the web-based EHR Product Portfolio (portfolio). The portfolio provides evaluative information on nationally certified EHR products and serves as a resource for health care providers in their assessment of EHR systems. Vendors participating in the portfolio are required to offer discounts to Maryland providers and submit EHR product screen shots; user references; product pricing and implementation cost projections; privacy and security policies; and relevant case studies. The portfolio features vendors that are connecting to the State-Designated HIE. About 12 vendors submitted a letter of intent to participate in the portfolio. The portfolio was first released in September 2008 and is revised twice a year; the next release is targeted for this spring.

Planning activities are underway for convening a health IT consumer advisory group (advisory group). The advisory group will suggest strategies aimed at building consumer trust and knowledge of health IT. The establishment of the advisory group was one of the recommendations in the *Health Information Technology Consumer Awareness & Education Brief* (brief), which was released in September 2012. The brief outlines the findings from several consumer focus groups convened in the fall of 2011 that assessed 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 advisory group will develop a blueprint to be used as a guide to address key challenges related to consumer awareness of health IT. Staff plans to convene the first meeting of the advisory group in May.

Health Information Exchange

Staff continues to provide guidance to the Chesapeake Regional Information System for Our Patients (CRISP), the State-Designated HIE, in implementing HIE and to its Advisory Board that consists of four committees: Finance, Exchange Technology, Clinical, and Small Practice Advisory Committees. Staff worked with the Maryland Learning Collaborative to promote the adoption of the encounter notification service (ENS), which provides ambulatory care practices with select information about hospital visits in real-time. During the month, CliftonLarsonAllen (CLA) met with staff and CRISP to define the parameters for a security audit. Each year MHCC engages an information technology audit organization to evaluate the privacy and security controls of the State-Designated HIE. The technology audit is scheduled to begin in February with the issuance of a report in May. CLA expects to review nearly 150 information security controls as part of the audit.

Staff continues developing the recommendations in the draft report, *Recommendations to Increase Ambulatory Practices' Use of Health Information Technology*. 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 CRISP; establishing courses related to health IT in coordination with the Maryland Board of Physicians and allied health care societies; educating employers on the value of EHRs and HIE; encouraging human resource groups to inform employees on the benefits of EHRs and HIE; educating the Maryland Association of Health Underwriters and other insurance brokers in Maryland about the benefits of EHRs and HIE; and enhancing the data available to physicians with more clinical content through CRISP. Audacious Inquiry, LLC (AI) was competitively selected to provide assistance in completing the work. A report is scheduled for release in April.

Staff continues collaborating with ONC to finalize a proposal that will allow MHCC to use approximately $600K remaining from the Challenge Grant (grant) to advance the use of electronic health information in LTC. The proposal to ONC seeks approval to award up to six LTC facilities funding on a match basis to implement health IT and support improved care transitions between hospitals and LTC facilities. MHCC received approximately $1.6M from ONC in 2011 to connect six LTC and post acute care facilities with CRISP. The demonstration concluded with grant funds remaining. Included in the proposal is a pilot use case for institutional pharmacies to publish data to the State-Designated HIE. 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 qualifying LTC facilities to implement an interoperable health IT infrastructure. ONC provided preliminary approval of the proposal in January, and they will complete a final review by February.

Staff is working with CRISP to develop a State-Designated Health Information Exchange Agreement (agreement). The existing Memorandum of Understanding that was in place for three years expired in the fall of 2012. The agreement under development elaborates on the work of the initial funding CRISP received through the Health Services Cost Review Commission's unique hospital all-payer rate setting system, the various ONC grants MHCC received to fund CRISP, Medicaid funding from the Centers for Medicare and Medicaid Services (CMS), and various use cases requested by the Department of Health and Mental Hygiene. The agreement serves as the framework for MHCC to enter into a sole source contract for procuring HIE services from CRISP. Over the last month, staff completed the first iteration of the agreement and met with CRISP to identify areas for enhancing the document. Staff anticipates finalizing the three-year agreement in February.

Staff continues working with the Telemedicine Technology Solutions and Standards Advisory Group (advisory group) to develop a telemedicine technology-based implementation resource guide (guide). Staff is collaborating with the advisory group to identify a range of best practices for telemedicine as it relates to infrastructure, clinical devices, video conferencing units, communication hardware, and data exchange standards, which are critical to ensuring that telemedicine networks across the state can easily communicate with each other and eventually connect to the State-Designated HIE. AI was competitively selected to provide assistance in completing the work. The guide is expected to be released in February 2013. During the month, staff also continued to assess secure text messaging networks' capabilities such as remote deletion, data storage, and group messaging. Secure text messaging is an area of interest among providers, and issues related to privacy, security, and confidentiality of the data will need to be addressed.

Planning activities are underway to develop programs that will increase the percentage of eligible providers participating in the Medicare and Medicaid EHR Incentive Program (incentive program). Eligible providers must attest to certain meaningful use (MU) requirements to receive payment for adopting an EHR. At the end of last year, about 13 percent of eligible providers have attested and received payment under the incentive program, ranking Maryland 47th in the nation. Over the next few months, staff plans to assess states similar to Maryland as it relates to physician-to-population ratio, practice ownership, size, etc. with programs aimed at increasing MU attestations. This information will be used to develop programs for accelerating participation in the incentive program that can be deployed

statewide. AI was competitively selected to provide assistance in completing the work. A final report is expected to be released this summer.

Electronic Health Networks & Electronic Data Interchange

COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks*, requires State-regulated payers with a premium value of $1M or more annually, and certain specialty payers, to report census level information about their administrative transaction activity by June 30th of each year. Staff continued to work with payers to identify appropriate contacts for the 2013 reporting cycle. Activities are underway to create the 2013 EDI Progress Report form. Electronic health networks (networks) operating in Maryland are required to be certified by MHCC as defined in COMAR 10.25.07, *Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouse.* Certification is awarded to networks that have achieved accreditation by an MHCC-recognized national accreditation organization. During the month, staff completed the recertification of CareStream Dental and Optuminsight (Ingenix). Staff also provided consultative support to Tesia PCI and The SSI Group in completing their recertification.

National Networking

Staff attended several webinars during the month. CMS presented *HIE/Private Payer CoP Medicaid EHR Incentive Program*, which focused on HIEs and the role they play in the federal incentive program; strategies employed by Massachusetts and Delaware about engaging payers in funding HIE services were also discussed. The National eHealth Collaborative presented, *Liberating Data and Fostering Innovation to Engage Patients* that included a discussion of ONC initiatives shaping the landscape of consumer engagement. Healthcare Informatics presented, *Analytics of Healthcare: Programs, Processes and Pioneers* that provided information on health care reform mandates and the operational challenges that health IT leaders face in optimizing EHRs. The Health Resources and Services Administration presented, *Upgrading and Optimizing an Electronic Health Record System for Safety Net Providers* that discussed safety net providers from rural inpatient and health center settings who have successfully upgraded or optimized their EHR.