MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

May 2013

CENTER FOR INFORMATION SYSTEMS AND ANALYSIS

Patient Centered Medical Home Program

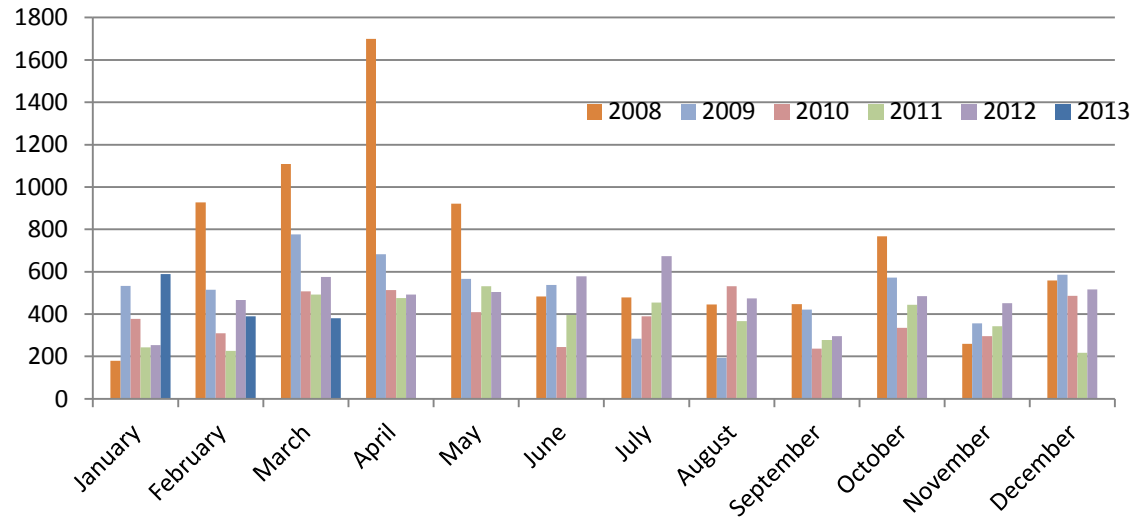
HEZ Practices
The Maryland Community Health Resources Commission and members of the MHCC staff are reviewing applications from primary care practices in the Health Enterprise Zones (HEZ) for possible participation in the Maryland Multi-payer Patient Centered Medical Home program.

MMPP Advisory Panel
The Advisory Panel met on April 25, 2013 to discuss use of the CRISP ENS (Encounter Notification System); the importance of patients' persistency in receiving care from physicians with regard to patient attribution; and the possible expansion of the program to include some of the HEZ practices.

AHRQ Presentation
Ben Steffen presented on the Maryland Multi-payer Patient Centered Medical Home program for an Agency for Health Research and Quality (AHRQ) webinar on April 25, 2013.

Maryland Trauma Physician Services Fund

Figure 1
Uncompensated Care Payments to Trauma Physicians, 2008-2013



Uncompensated Care Processing
CoreSource, Inc., the third party administrator (TPA) for the Trauma Fund, adjudicated claims with a total paid value of approximately $379,725 for March of 2013. The monthly payments for uncompensated care from January 2008 through March 2013 are shown above in Figure 1.

Cost and Quality Analysis

Meeting with Health Care Incentives Improvement Institute (HCI3)
MHCC staff met with Francois de Brantes, Executive Director of HCI3, last month to discuss pricing transparency in health care. HCI3 has created the PROMETHEUS Payment model, which combines all payments for a comprehensive episode of medical care that includes all patient services related to a single illness or condition. Covered services are determined by commonly accepted clinical guidelines or expert opinion that lay out the tested, medically accepted method for best treating the condition from beginning to end.

The costs of treatments are calculated into what is called an "Evidence-informed Case Rate" (ECR®), which creates a patient-specific budget for the entire care episode. ECRs include all the covered services related to the care of a single condition – bundled across all the providers who would treat a given patient for the given condition (such as a hospital, a physician, laboratory, pharmacy, rehabilitation facility, etc.). The ECR is adjusted to take into account the severity and complexity of the individual patient's condition.

To date, PROMETHEUS Payment has developed ECRs for a significant number of acute, chronic and inpatient procedures, including heart attacks (AMI), hip and knee replacement, diabetes, asthma, congestive heart failure and hypertension. These existing ECRs represent a significant amount of dollars spent by employers and plans.

HCI3 has offered to run their PROMETHEUS Payment model on the MHCC's privately insured claims data (MCDB) and provide the MHCC with the resulting ECRs, if the MCDB data conform to the specifications required by the model. Staff is currently examining the model requirements.

Workgroup to Define Health Care Utilization Summary Files
Staff held the first meeting of the Health Care Utilization Summary File Workgroup on May 6th. The meeting focused on defining a record for each privately insured resident that will summarize the resident's annual health care costs by service type, with counts of the occurrences of selected events, such as the number of inpatient admissions and ER visits.

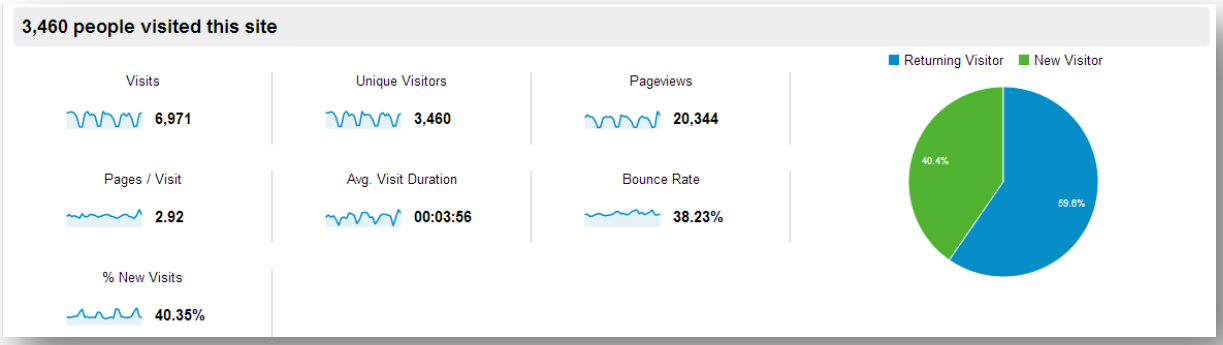
The workgroup made excellent progress in identifying how expenditures should be broken out by service type and within service type. Suggestions included having expenditures for professional services separated by practitioner specialty, including categories for primary care, OB/GYN, other physician specialties, and other practitioners. The workgroup also expressed a desire to have expenditures for prescription drugs segmented into medication classes to the extent that it is feasible and useful. For all services groups, the file will include spending by the insurer and spending by the patient.

MHCC staff will construct and test the fields recommended by the workgroup for inclusion in the summary file over the next several weeks. The workgroup will reconvene at the end of June to review the results of the testing. Once the patient summary file contents have been finalized, the workgroup will determine how the file contents should be summarized at the zip code level and county levels. Additionally, the workgroup requested that the MHCC construct chronic conditions summary files at both the patient level and the zip code and county levels. Work on the chronic conditions files will begin after the expenditure summary files have been finalized.

State Innovation Model (SIM) Activities
The MHCC awarded a contract for "Assessment and Measurement Support for Stakeholder Engagement and Planning Process for a Community Integrated Medical Home" to Discern Consulting, Inc. The purpose of the contract, funded under the SIM grant to DHMH, is to: assess the readiness of MHCC's APCD for practitioner performance measurement activities; develop a plan for a performance measurement system that conforms to CMS requirements; provide an estimate of the costs to implement the system; suggest technology solutions for public reporting; and develop a scope of work for an RFP (request for proposal) to design and implement the practitioner performance measurement system.

Data and Software Development

Figure 2 - Data from Google Analytics for the month of March 2013



- 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 April 2013 was 6,971 and of these, there were 3,460 unique visits. The average time on the site was 3:56 minutes. Bounce rate of 38.23 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 the mhcc.maryland.gov. Other government agencies include dhmh.maryland.gov, Maryland.gov and crisphealth.org. Among the most common search keywords in April were:

- "Maryland health care commission"
- "MHCC"

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 Web Applications Under Development

Board	Anticipated Start Development/Renewal	Start of Next Renewal Cycle
PCMH –HEZ Application (New)	Developed – Now Live	
PCMH Case Management Monthly Tracking web site	Live	Operational
PCMH Quality Reporting	LIVE	
PCMH Public Site	On-going Maintenance	
PCMH Portal (Learning Center & MMPP)	On-going Maintenance	
PCMH Practices Site (New)	New User Guide On-going Maintenance	Added new Clinician Update tracking log
Boards & Commissions Licensing Sites (13 sites)	On-going Maintenance	
Boards & Commissions Psych Licensing Site	Ongoing support	Live
Physician Licensing	Live – On-going Support	Preparing for 2013 M-Z Renewals in July. Adding new Health IT questions and pre-populating practice questions. This is a major addition.
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	Live
Hospital Quality Redesign	Planning	
MHCC Assessment Database	On-going Maintenance	Live
IPad/IPhone App for MHCC	Development	Ongoing
npPCI Waiver	Quarterly Report finished	(for CFHS)

Network Operations & Administrative Systems (NOAS)

Information Technology Newsletter
The May IT Newsletter has been released, containing helpful information about MHCC IT systems and services. Features:

- Notice:
  - All Gmail for Government questions will be listed in a Frequently Asked Questions (FAQ) document that will be updated periodically. The FAQ document will be made available on the MHCC intranet site.

- Helpful Hints
    - Messages deleted within the Outlook interface will also be deleted in the Chrome-based Gmail interface during the synchronization process.
    - Parts of a Word, Excel, PowerPoint, picture, map, web page, etc., can be added to a document as a gif (graphics interchange format) or jpeg (Joint Photographic Experts Group) document by using the Microsoft snipping tool.
    - Gmail has an advanced search algorithm that uses query words or symbols that perform special actions. Using symbols such as a colon with words such as "from" or "in" directs the search engine to look for specific phrases in general or specific folders/locations. (There is a video tutorial attached to the electronic newsletter)

Virtualization Infrastructure Update

The MHCC virtualization infrastructure is now 100% operational and is in use by the IT staff for file storage. The database & applications development staff is using virtual drive space to conduct tests and utilize the storage space to run large processing activities. The general MHCC data storage file folders will be migrated over during the weekend of May 18 & 19.

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

Health Plan Quality and Performance

Staff continues its collaboration with the Maryland Health Benefit Exchange (MHBE) as it relates to quality and performance reporting of commercial health benefit plans being used as a proxy for qualified health plan performance inside the MHBE. As requested by the MHBE, staff has directed its report development contractor to implement the MHBE-specific 5-star rating system recently approved by the Exchange Board, for public reporting in 2013.

The annual audits of commercial health benefit plans are completed. Performance results from the audits are currently being analyzed, and shall be the included in the public reporting documents scheduled for release in the fall of 2013.

The Maryland Health Quality and Cost Council (MHQCC) recently established a Cultural Competency Workgroup. Scharmaine Robinson, Chief of the Health Benefit Plan Quality & Performance division serves as a co-leader of the Charge 1 Subcommittee, with Dr. Yolanda Ogbolu from the University of Maryland, School of Nursing. Erin Dorrien, Chief of Media Contact/Government Relations & Special Projects serves as the lead staff support person for the Charge 1 Subcommittee. Members of the Charge 1 Subcommittee continue working together to complete the 7 action steps which have been laid out by the Office of Minority Health and Health Disparities. The MHQCC's Cultural Competency Workgroup is scheduled to meet again on May 14th. All projects related to the Charge 1 Subcommittee will be completed by fall of 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 have remained relatively steady, at approximately 6 Maryland visits per day, with users viewing about 4 pages per visit and spending an average of about 4 minutes per visit on the site. These Maryland statistics remain slightly above the national average.

Each year, carriers participating in the small group market are required to submit to the Commission completed survey forms that include enrollment and premium information in the CSHBP for the preceding calendar year. This year's analysis is based on data for the calendar year ending December 31, 2012. Commission staff is in the process of analyzing these data and will present the findings of these surveys at the June public meeting.

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 May 7, 2013 enrollment in the Partnership was as follows: 417 businesses; 1,148 enrolled employees; 1,897 covered lives. The average annual subsidy per enrolled employee is more than $2,450; the average age of all enrolled employees is 41; the group average wage is about $27,600; 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. Commission staff is currently in discussion with DHMH leadership and the Legislature to determine a transition plan for the Partnership, once state health insurance exchanges under the Maryland Health Connection become available to individuals and small employers in 2014.

Long Term Care Policy and Planning

Minimum Data Set Project
Commission staff continues 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 internally.
In addition, in response to issues raised by providers, staff contacted the Centers for Medicare and Medicaid Services (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.

Work is now underway to develop the data necessary to support the Consumer Guide for Long Term Care.

Hospice Section of the State Health Plan
Commission staff briefed the Commission on this update to the State Health Plan at its April 18th meeting. The hospice plan section was posted on the Commission's website for a 30-day Informal Public Comment period on April 10, 2013. Written comments are due no later than 4:30 p.m. on May 10, 2013.

Hospice Policy Conference
Commission staff were invited to attend Montgomery Hospice's spring conference on May 3, 2013 titled "Policy Implications of the Dementia Tsunami" presented by Joan Teno, M.D. The main objectives of the conference were to gain a better understanding of the demographic shifts and anticipated increases in the number of older Americans dying of dementia, as well as the policy implications of Medicare's and Medicaid's financial incentives for caring of persons with advanced dementia. Dr. Teno is a world renowned scientist and clinician, and has devoted her career to measuring and improving quality of end-of-life care for vulnerable populations, especially those in nursing homes. The conference was well attended by a range of health care providers, caregivers, and spiritual leaders.

Hospice Educational Initiative
One directive received from the Senate Finance Committee was to work on a plan for hospice outreach and education. In response, staff has met via conference call with the Health Officers of both Prince George's County and Baltimore City, who supported the concept.

The first meeting of the Hospice Education Initiative Workgroup was held on April 29, 2013. Membership includes: Hospice and Palliative Care Network of Maryland; Coastal Hospice; Gilchrist Hospice; Hospice of the Chesapeake; Joseph Richey Hospice; Baltimore City Office of Aging; Central Maryland Ecumenical Council; Prince George's County Dept of Family Services; Prince George's County Health Dept; Maryland Hospital Association; Med Chi; Office of Health Care Quality; University of Maryland Dept of Social Work (representing consumers); and the DHMH Office of Minority Health and Disparities.

At the first meeting, the goals and charge to the Work Group were discussed (see attached). There was also a general discussion of members' experience related to educational initiatives for end of life care and hospice, as well as outreach to minority populations. The second meeting will be held in June.

Hospice Survey
The FY 2012 Maryland Hospice Survey started effective February 19, 2013. Notices were sent out to providers on Monday, February 11th. Part I of the survey is 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. Part I of the survey has been completed by all 30 hospice providers in Maryland. Staff is now working with the hospices for data follow up.

Home Health Tables
The Home Health Agency (HHA) Utilization Tables for FY 2011 have been reviewed, edited and finalized. The data provided in these tables were obtained from the information collected by the Commission's Annual Home Health Agency Survey. The tables summarize agency and jurisdiction-specific data on the utilization and financing of home health agency services. An overview of HHAs in Maryland include: volume of admissions; referral sources; primary diagnosis on admission; length of care; average visits per Medicare client; dispositions; average cost per visit; revenues by payer type; and home health agency personnel. Data provided on Maryland resident use of home health agency care by jurisdiction include: age group; unduplicated clients by payer type; and visits by payer type. All 24 HHA Utilization Tables for FY 2011 have been posted on the Commission's website under public use data files.

FY 2012 Home Health Agency Survey
The Home Health Agency Survey collection period began on April 8, 2013 and ends on June 6, 2013. Sixty agencies are taking part in this statewide survey. Fifty-one percent have started their surveys. On May 8, 2013, staff will send out the 30-Day Reminder Notice to providers who have not yet had their surveys accepted. Staff will continue to provide technical support to providers during the data collection period.

FY 2012 Long Term Care Survey
The Long Term Care and User Fee Assessment Survey data collection period for comprehensive care facilities ended on April 9, 2013. Two hundred and thirty-three facilities participated in the statewide collection; 100% of the surveys were timely submitted and accepted by the due date of April 9, 2013. The providers gave positive feedback on the overall effectiveness of having the combined surveys. The survey began on March 11, 2013, and, for the first time, providers were given 30 days to complete the surveys. There were no requests for extensions. Numerous comments relating to the length of the collection period were positive.

The Long Term Care Survey for adult day care centers, chronic care hospitals and assisted living facilities started on March 11, 2013 and is due on May 9, 2013. Staff sent reminder notices to the facilities throughout the collection period including the 7-day reminder notice sent on May 2, 2013. Eighty-two percent of the adult day care centers, 71 % of the chronic care hospitals, and 62% of the assisted living facilities have had their surveys accepted. As the deadline approaches, Staff is following up by phone, fax, and emails with facilities that have a status of either (1) Not Started, (2) In Progress, but not submitted, or (3) Rejected and not resubmitted a corrected survey. Staff continues to provide technical support to providers during the data collection period.

Long Term Care Quality Initiative

Long Term Care Staff Influenza Vaccination Survey
The survey closes May 15, 2013. As of this report over half of all assisted living residences of 10 beds or larger and nursing homes have submitted data. Results will be shared with Commissioners at a future meeting.

Nursing Home Surveys
The telephone follow-up phase for the surveys is now in progress. Response rates to-date are 54% for the family survey and over 42% for the recently discharged resident survey.

Other
MHCC Consumer Guide to Long Term Care was featured as a model web tool at a national conference "Residential Long-Term Care Services & Supports and the Role of Public Reporting". Carol Christmyer, the Chief of LTC Quality Initiative was invited to present the Guide at the conference sponsored by the Agency for Healthcare Research and Quality and Leading Age. The purpose of the conference was to gather ideas on content and tools best suited to selecting assisted living and community support services. The two other sites that were invited to present were the Ohio Long Term Care site and a new site under development by the University of North Carolina at Chapel Hill.

Staff attended "The Role of Post Acute Services in Health Reform" sponsored by the Beacon Institute, the educational arm of LifeSpan Network. The purpose of the program is to bring together key leaders in the post-acute care to respond to two current healthcare initiatives in Maryland: preventing avoidable re-hospitalizations and the renewed focus on re-balancing home and community spending. Leaders in acute care, home care, nursing home, CCRC, adult day and assisted living met to share programs and network around these important topics.

CENTER FOR HOSPITAL SERVICES

Hospital Quality Initiatives

Hospital Performance Evaluation System (HPES)
On April 22nd, the Commission held a meeting of the Hospital Performance Evaluation Guide Advisory Committee. The staff reviewed the most recent update to the Hospital Guide as well as a proposal to include hospital specific charges on the Commission's website. The Committee recommended that the proposal be shared with hospital CFOs to obtain additional feedback. On May 2nd, the staff reviewed the informal proposal during the MHA Financial Technical Issues Task Force (FTITF) meeting. The FTITF was receptive to the idea of supplementing the current *Hospital Price Guide* with hospital specific charges for common conditions and staff committed to provide more specific information on the format and methodology for generating the hospital reports as the project progresses.

In an ongoing effort to promote effective communication with the hospital industry, the HQI staff frequently participates in programs sponsored by MHA, individual hospitals and other external

organizations. During the April 25th MHA Leadership Webinar, the staff presented an overview of upcoming hospital quality data reporting requirements. Later this month, staff will present the results of the MHCC Hospital Infection Prevention and Control Survey during a meeting of the Association of Professionals in Infection Control and Epidemiology (APIC). Also, staff has provided training on use of the CDC National Healthcare Safety Net (NHSN) surveillance system to individual hospitals and at regional and statewide meetings. Later this month, the staff will provide training on the NHSN system at an upcoming Delmarva QIO meeting.

Healthcare Associated Infections (HAI) Data

Hospital Quality Initiatives staff continues to work with Advanta Government Services on the FY2012 CLABSI and SSI data audit and quality review. The FY2012 CLABSI audit has been completed and a statewide webinar will be held on May 22nd. The purpose of the webinar is to review the audit process and findings, identify opportunities for improvement and establish an open forum for hospital questions and comments.

Beginning in July 2013, Maryland hospitals will be required to utilize the NHSN surveillance system for collection of Clostridium difficile infections data. To support this new reporting requirement, the staff is preparing to sponsor an educational webinar for Maryland hospitals in June.

Specialized Services Policy and Planning

Clinical Advisory Group for PCI and Cardiac Surgery

The eighth and final meeting of the Clinical Advisory Group (CAG) on PCI and Cardiac Surgery was held on April 11, 2013, co-chaired by Loren Hiratzka, M.D., and David Williams, M.D A major focus of this meeting was a discussion of the structural elements desirable for the new regulatory oversight process. In addition, the CAG was asked to consider a number of existing SHP standards which had not yet been discussed. Staff is working on a draft report of the CAG's recommendations, which will be circulated to the Group for review and comment, preparatory to development of a final report for the Commission.

Certificate of Need ("CON")

Pre-Application Conferences

On April 17, 2013 a pre-application conference was held with representatives of the Shady Grove Fertility Clinic, a physicians outpatient surgical center (POSC) located in Rockville, developing a planned expansion of operating room (OR) capacity.

Changes to an Approved CON

St. Agnes Hospital – (Baltimore City) – Docket No. 07-24-2188

The Commission approved a reduction in the number of older nursing units undergoing renovation and changes in the extent of the renovations to be undertaken. A condition was modified to reduce the maximum number of beds that St. Agnes can operate from 377 to 367 upon project completion and requiring that the Hospital seek Commission approval before putting beds on the 7th floor back into operation.

CON's Withdrawn by Commission

Community Care Nursing Services, Inc. – (Baltimore City) – Docket No. 10-24-2314

The applicant was informed of initiation of proceedings for the withdrawal of Certificate of Need 10-24-2314 for failure to meet performance requirements. The approved project was the establishment of a specialty home health agency dedicated to the provision of home health agency services to pediatric and mother/newborn dyads. The applicant failed to license and certify the agency within 18 months of CON approval. No reconsideration was timely requested by the applicant and, thus, the CON is void.

Application Review Conference

On April 2, 2013 Staff met with representatives of Mid-Atlantic Waldorf to review Waldorf's responses to Staff's request for additional information concerning its request to change an approved CON – Docket No. 11-08-232 – for establishment of a 67-bed comprehensive care facility ("CCF"), to be developed along with a 90-bed assisted living facility. The discussion focused on the impact of the requested changes on Medicare and Medicaid reimbursement.

An application review conference was held on April 17, 2013 with representatives of Father Martin's Ashley, an intermediate care facility for alcohol and drug abuse rehabilitation, to discuss responses to Staff's second completeness letter. The facility is proposing an expansion and renovation (15 additional beds and replacement of 36 beds).

First Use Approval

Johns Hopkins Hospital – (Baltimore City) – Docket No. 11-24-2320
Addition of a seventh OR, dedicated to the provision of outpatient ophthalmic surgery, at the Bendann Surgical Pavilion in the Robert H. and Clarice Smith Building
Approved Cost: $1,430,037

Lorien LifeCenter-Harford County – (Harford County) – Docket No. 08-12-2288
Construction of a new 78-bed CCF
Approved Cost: $9,315,563

Kaiser Permanente Baltimore Surgical Center – (Baltimore County) – Docket No. 10-03-2306
Establish a free-standing ambulatory surgical facility with two ORs located at 1601 Odensos Lane, in Baltimore
Approved Cost: $8,906,397

Massachusetts Avenue Surgical Center, LLC – (Montgomery County) – Docket No. 12-15-2328
Addition of a third OR to an existing ambulatory surgical facility located at 6400 Goldsboro Road, Suite, 400, Bethesda
Approved Cost: $710,682

Determinations of Coverage

- **Ambulatory Surgery Centers**

Box Hill Surgery Center – HDG – (Harford County)
Establish a POSC with one non-sterile procedure room to be located at 603 Revolution Street, Suite 102, in Havre de Grace (Ownership Interest: Ritu Bhambhani, M.D.)

Cecil Surgery Center – (Cecil County)
Change in the floor plan of the approved facility

Women's Surgery Center Tower Oaks P.C. – (Montgomery County)
Establish a POSC with one sterile OR and one non-sterile procedure room to be located at 3206 Tower Oaks Boulevard in Rockville (Ownership Interest: Paul Mackoul, M.D.)

Hickory Ridge Surgery Center – (Howard County)
Addition of a new mode of anesthesia, monitored anesthesia care (MAC) using Versed and Fentanyl, in a non-sterile procedure room and addition of practitioners. Introduction of MAC was denied.

Acquisitions/Change of Ownership

Nursing Enterprises, Inc.
Acquisition of Nursing Enterprises by MG Ventures, LLC. Authorized to serve Montgomery and Prince George's Counties

Holy Cross Hospital – (Montgomery County)
Consolidation of Trinity Health Corporation and Catholic Health East. Trinity is the sole member of Holy Cross Health, Inc.

NMS Healthcare of Hagerstown – (Washington County)
Acquisition of "bed rights" by NMS Healthcare of Hagerstown, LLC from Marsh Pike, LLC

Ivy Hall Geriatric Rehabilitation Center – (Baltimore County)
Acquisition of the operating entity by Oakwood Rehab and Nursing, LLC from ASLC Opco MD I and acquisition of the real property by Oakwood Nursing Building, LLC. from ASLC Realty MD I

Corporate Restructuring

Amedisys, Inc.
Corporate restructuring of Amedisys Inc.; Tender Loving Care Health Care Services Southeast, LLC d/b/a Amedisys Home Health Care, License Number HH7045, authorized to serve Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties and Baltimore City. License No. HH7149 is authorized to provide services in Montgomery and Prince George's Counties

- **Capital Projects**

UMMS – St. Joseph Medical Center – (Baltimore County)
Renovations to the seventh floor west wing of the hospital - MHA Bond Review
Cost: $1,750,000

- **Waiver Beds**

Adventist Rehabilitation Hospital of Maryland – (Montgomery County)
Addition of ten comprehensive inpatient rehabilitation beds for a total of 87 beds

Hospital Services Policy and Planning

On April 12, CHS staff met with representatives of the University of Maryland Medical Systems Hospitals to discuss current trends in outpatient surgery, regulation of outpatient surgery, and freestanding outpatient surgical center development by hospitals.

On April 24, CHS staff met with representatives of Maryland General Hospital to discuss its planned termination of obstetric and perinatal services and the transition of obstetric patients to physicians with alternative hospital privileges.

On April 24, CHS staff met with representatives of Sinai Hospital of Baltimore to discuss regulatory requirements associated with the development of general inpatient hospice facilities within general hospitals.

On April 30, information on the *MHCC Freestanding Ambulatory Surgery Survey* for the CY 2012 reporting period was distributed to 346 facilities. This included instructions for completion of this on-line survey.

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. During the month, the committee discussed potential policy levers to promote interoperability and health information exchange (HIE). The committee discussed key differences in federal and State interoperability policies and programs that have impeded the advancement of HIE and proposed solutions that could accelerate HIE nationally. The committee also discussed the impact of the proposed potential meaningful use Stage 3 requirements released by the Centers for Medicare & Medicaid Services (CMS).

Staff continued drafting the *Health Information Technology: An Assessment of Maryland Hospitals* report (report). The hospital report provides an update on the adoption and use of health IT among all 46 acute care hospitals in the State and is based on survey data collected from hospital Chief Information Officers (CIOs). Health information technologies highlighted in the report include: electronic health records (EHRs), electronic prescribing, computerized physician order entry, clinical decision support, electronic medication administration, infection surveillance software, HIE and telemedicine. This year's report includes information related to hospitals' use of patient portals, achievement on meaningful use measures and submission of data to the State-Designated HIE, the Chesapeake Regional Information System for our Patients (CRISP). The report provides an assessment of both current trends and future directions for health IT adoption among hospitals in Maryland, as well as a comparison of Maryland hospital adoption rates benchmarked against national adoption trends. The hospital report is targeted for release early this summer.

During the month, staff awarded State-Designation renewal to the Management Service Organization (MSO) Community Health Integrated Partnership, the first MSO to undergo State-Designation renewal. Staff awarded Candidacy Status to BlueNovo, Inc. COMAR 10.25.15, *Management Service Organization State-Designation*, requires MSOs to achieve State-Designation within a one-year Candidacy Status timeframe and to renew their State-Designation every two years. Currently, approximately 14 MSOs are State-Designated and about three MSOs are in Candidacy Status; MSOs assist providers in adopting EHRs. To achieve State-Designation, MSOs must meet over 90 criteria related to privacy, confidentiality, technical performance, business practices, and security and offer certain EHR adoption and use services. Working in coordination with the Regional Extension Center (REC), staff is conducting an environmental scan to assess how MSOs are supporting practices in adopting and using health IT. Staff has collected information from all State-Designated MSOs and plans to begin reviewing the information in May. The information collected will be used by staff, the MSO Advisory Panel, and the REC to enhance the MSO program.

Planning activities are underway to assess the implementation of electronic preauthorization by State-regulated payers (payers) and pharmacy benefit managers (PBMs) in compliance with Health-General Article §§19-101 and 19-108.2 (2012). The law requires the MHCC to work with payers and PBMs to attain benchmarks, in three phases, for standardizing and automating the preauthorization of medical and pharmaceutical services (health care services). Nearly all payers and PBMs have met Phase 1 and Phase 2 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. Phase 2 required payers and PBMs to implement an online process to electronically accept prior authorization requests and assign a unique electronic identification number to each preauthorization request by March 1, 2023. Phase 3 requires payers and PBMs to meet certain timeframes for processing electronic preauthorization requests by July 1, 2013. Staff is currently developing a reporting tool to

collect information from payers and PBMs regarding their progress in meeting Phase 3 that will be distributed to payers and PBMs in July. A report is due to the Governor and General Assembly in December 2013 on payer and PBM progress in implementing electronic preauthorization. Audacious Inquiry (AI) was competitively selected to provide assistance in completing the report.

Staff distributed an environmental scan (scan) survey to approximately 25 independent long term care (LTC) facilities to assess the adoption and use of EHR systems among non-chain LTC facilities. The scan includes questions related to the use of EHR systems and certain components, and the benefits and challenges of adopting an EHR system. In addition to the scan, staff plans to conduct interviews with approximately five nursing home administrators to gain a better understanding of the challenges they face in adopting health IT. Scan responses are due in May; results will be used to develop strategies to determine EHR adoption rates among independent LTC facilities. An information brief is targeted for release in the late summer.

Staff finalized updates to the web-based EHR Product Portfolio (portfolio), an online resource for health care providers to assess nationally certified EHR systems. The portfolio is updated twice a year, and currently includes 32 EHR vendors. Approximately eight vendors agreed to offering a discount to Maryland providers and all vendors submitted information on their EHR systems regarding: product functionality and pricing, privacy and security policies, product screen shots, and provider references. The portfolio also highlights vendors that are connecting to CRISP.

This month, staff finalized a preliminary draft of a meaningful use acceleration plan (plan) that aims to increase the number of eligible providers that participate in the Centers for Medicare and Medicaid Services (CMS) EHR adoption incentive program (program). The plan identifies a collaborative approach among MHCC, DHMH, CRISP, The Maryland Medical Society, MedChi, and hospitals to increase provider participation in the program. Maryland currently ranks 42nd among states in the rate of payments made to eligible providers. The plan focuses on short-term interventions to assist providers who have began participation in the program and have not yet completed the requirements for payment. During the month, staff met with hospital liaisons to discuss the challenges ambulatory practices encounter in participating in the program. Staff anticipates finalizing the plan in June. AI was competitively selected to assist in completing the work.

Staff finalized the review of approximately 29 letters received from primary care practices over the last few months regarding payer compliance with COMAR 10.25.16, *Electronic Health Records Reimbursement.* Among other things, the regulation requires payers to provide an incentive payment to primary care practices that meet requirements around the adoption and use of an EHR system. The letters generally focused on timely payments and the calculation payers' used in processing incentive payments. Staff identified that Aetna had experienced an internal problem in administering the incentive program, which has since been corrected. In general, staff determined that payers had calculated the incentives payments consistent with the regulation. Over the last 18 months, about 68 primary care practices have received a total of about $1.8M in incentives under the regulation.

Letters Received by Concern and Payer

Primary Concern	Aetna, Inc.	CareFirst BlueCrossBlueShield	CIGNA Health Care Mid-Atlantic Region	Coventry Health Care	Kaiser Permanente	United Healthcare, MidAtlantic Region	Total Letters Received
Base Incentive Calculation	0	0	10	0	2	7	**19**
Additional Incentive Calculation	0	0	2	0	0	2	**4**
Timing of Payment Received	5	0	0	1	0	0	**6**
Total	**5**	**0**	**12**	**1**	**2**	**9**	**29**

Health Information Exchange

Staff continues to provide guidance to CRISP in implementing the HIE and to its Advisory Board that consists of four committees: Finance and Sustainability, Technology, Clinical and Small Practice Advisory Committees. The Finance and Sustainability Advisory Board (advisory board), which provides guidance to CRISP on certain key decisions in the development and operations of the HIE, met during the month. The advisory board reviewed the draft fiscal year 2014 budget. In April, CRISP demonstrated the encounter notification service (ENS) to staff and at the Maryland Multi-payer Patient Center Medical Home Advisory Panel meeting. ENS enables providers to receive secure alerts in real-time when one of their patients visits a Maryland hospital, enabling providers to better coordinate care. Currently, CRISP is sending ENS alerts to about 38 practice locations, which includes roughly 520 providers. During the month, CliftonLarsonAllen (CLA) began field work to conduct a security audit of CRISP. Each year, a security audit is conducted by a competitively selected third party. CLA will evaluate approximately 150 information security controls as part of the audit. A preliminary report of the audit results is expected to be completed in late summer.

Staff met with the CIO of Union Hospital of Cecil County to discuss their community HIE initiatives and opportunities for engaging ambulatory practices in HIE. Since March, staff has been meeting with hospital CIOs around the State to identify challenges and discuss solutions to health IT implementation and interoperability with HIEs and ambulatory practices. In May, staff plans to meet with CIOs of Shady Grove Adventist Hospital and Carroll County Hospital. Planning activities continue for regional meetings with CRISP and hospital CIOs and Chief Medical Informatics Officers (CMIOs). These meetings will focus on expanding the reporting of hospital admission, discharge and transfer (ADT) data to the State-Designated HIE. Maryland acute care hospitals are currently sending select ADT data to CRISP; however, most hospitals are not including clinical information, such as diagnosis and chief complaint, in the ADT data. Regional hospital meetings are scheduled in Baltimore, Southern Maryland, Western Maryland, and the Eastern Shore.

The MHCC has awarded approximately $517K to four independent LTC facilities to adopt and use health IT to support improved transitions of care between hospitals and their facilities. In February, ONC approved the use of funds from the 2011 Challenge Grant to facilitate the adoption and use of health IT among LTC facilities. Staff, along with representatives from CRISP, the University of Maryland Center for Health Information and Decision Systems (CHIDS) and the Maryland Department of Health and Mental Hygiene (DHMH) reviewed roughly 16 applications and selected the Lions Center for Rehabilitation and Extended Care, Ingleside at King Farm, Berlin Nursing Home and Rehabilitation Center and Citizens Care and Rehabilitation Center to award funding. The facilities will implement key elements of health IT and use select CRISP services in an effort to reduce hospital readmissions. The project period is through February 2014; the work is scheduled to begin in May.

The MHCC received about $91K for FY15 from the DHMH to work with CRISP to implement a patient-managed registry for advance directives (registry) to be available through the HIE. Advance directives enable a person to appoint a health care agent to make treatment decisions on their behalf or to provide specific instructions regarding potential treatments in the event the patient is unable to make treatment decisions. Approximately $145K from the Challenge Grant will supplement the implementation of the registry. Through the registry, patients will be able to make advance directives available to treating providers that connect to CRISP. As part of the Challenge Grant, staff is working with the largest institutional pharmacies in Maryland to evaluate the feasibility of making institutional pharmacy data available through the State-Designated HIE.

Staff is developing an environmental scan to identify the barriers and workflow challenges that ambulatory practices face in the adoption and use of telemedicine. Staff plans to identify select ambulatory practices in Maryland that are using telemedicine and assess how these practices are implementing telemedicine technology. The Governor is expected to sign into law House Bill 934,

Telemedicine Task Force – Maryland Health Care Commission (HB 934), which requires MHCC to reconvene the 2010 Telemedicine Task Force (task force) with the goal of identifying opportunities to use telemedicine to improve health status and care delivery in the State through expanding telemedicine. Staff plans to reconvene the three task force advisory groups in collaboration with the Maryland Institute of Emergency Medicine Services Systems in late summer: clinical advisory group, finance and business model advisory group and technology solutions and standards advisory group. Work of the 2011 task force resulted in the Senate Bill 781, *Health Insurance – Coverage for Services Delivered through Telemedicine* (2012), which went into effect in October 2012, that requires, among other things, certain insurers, nonprofit health service plans, and health maintenance organizations to provide coverage for health care services delivered through telemedicine. An interim report of the task force is due to the Governor, Senate Finance Committee and the House Health and Government Operations Committee by January 1, 2014 and a final report is due by December 1, 2014.

Electronic Health Networks & Electronic Data Interchange

During the month, staff received electronic data interchange (EDI) progress reports from two payers. COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks* requires payers with premiums of $1M or more, and select specialty payers, to complete an annual EDI progress report (report) by June 30th of each year. The reports include information regarding electronic health care transaction volumes and electronic health networks (EHNs) operating in the State. During the month, staff provided consultative support to EDI Health Group and NovoLogiz, Inc., in completing their EHN recertification. COMAR 10.25.07, *Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouse*, requires payers to use EHNs that are certified by MHCC. Certification is awarded to EHNs that have achieved accreditation by a national accreditation organization recognized by MHCC.

National Networking

Staff attended several webinars during the month. The American Telemedicine Association presented two webinars: *Telehealth Nursing: Distance Emergency Care Using Nurse Practitioners* and *Oregon Health Network & 12 Health IT Best Practices. Telehealth Nursing: Distance Emergency Care Using Nurse Practitioners* focused on the role of advanced practice nurses in providing emergency care services using technology and the integration of nursing into other telehealth initiatives at the University of Mississippi Medical Center. *Oregon Health Network & 12 Health IT Best Practices* discussed how they addressed challenges in the health care landscape to provide better health care at reduced costs by using health IT best practices. The 1105 Government Information Group hosted *Building a Mission-Ready Cloud Infrastructure* that educated attendees on the benefits of a comprehensive approach to cloud computing and illustrated how a successful cloud solution must be flexibly tailored and aligned to individual needs.