MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

June 2013

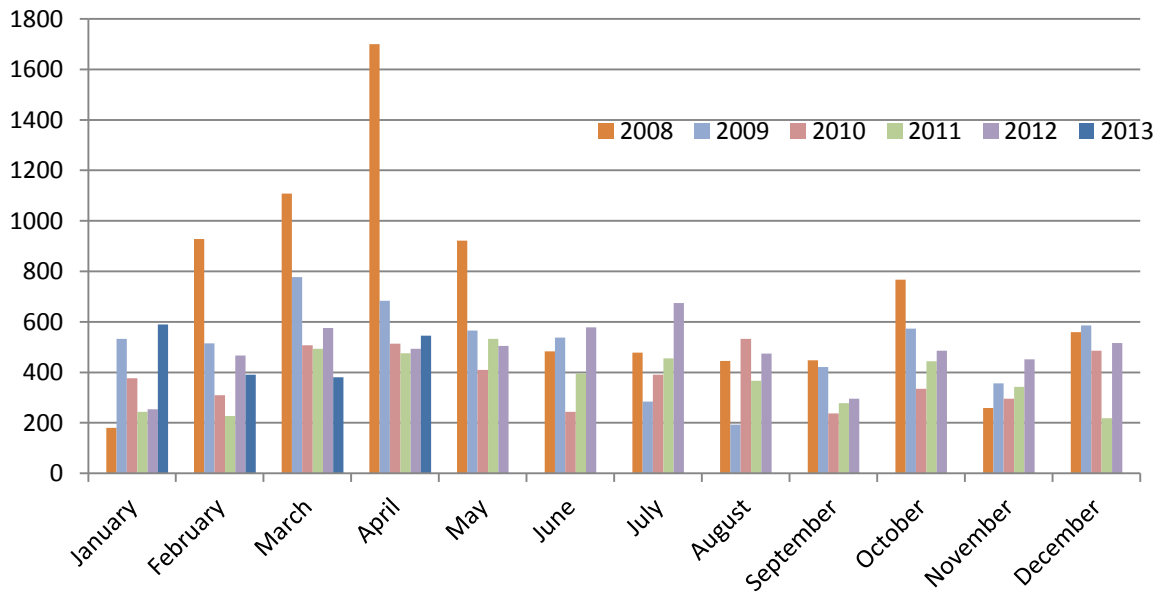
CENTER FOR INFORMATION SYSTEMS AND ANALYSIS

Patient Centered Medical Home Program

Provider Survey
Impaq International, LLC, the Commission's MMPP evaluator, is conducting a survey of the participating providers' perspectives on patient centered medical homes.

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 $545,379 for April of 2013. The monthly payments for uncompensated care from January 2008 through April 2013 are shown above in Figure 1.

Cost and Quality Analysis

SHADAC and State Network Small Group Consultation:
Data Needs and Requirements Related to State-Based Marketplaces
MHCC staff attended a two-day meeting in Minneapolis to discuss the data needs and requirements related to state-based health benefit exchanges for small businesses. The agenda included presentations on: 1) data strategies for broad-based evaluation and monitoring, with a presentation by Leslie Lyles-Smith on the measures that will be used in Maryland's health benefit exchange; 2) data used by the Massachusetts Connector; 3) CCIIO's monitoring strategy and data reporting requirements; 4) use of the MEPS-IC data to monitor the small business health options program (SHOP), with a presentation by Linda Bartnyska on the MHCC's use of MEPS-IC data; 5) use of enrollee surveys; and 6) data strategies for quality and performance measurement. Attendees included representatives from nine states, the Robert Wood Johnson Foundation, the State Health Reform Assistance Network, federal agencies, and SHADAC.

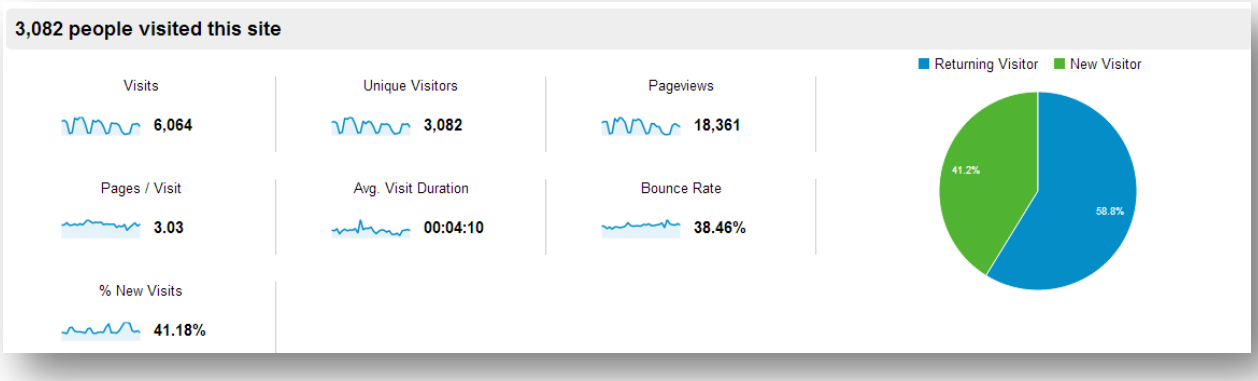
Workgroup Meetings
The first meeting of the Practitioner Performance Measurement Workgroup will be held on June 18th. The meeting will include a presentation by Discern Consulting, Inc., on their examination of possible measures that could be constructed from the existing Medical Care Data Base content and the physician specialties for which they would be appropriate. The review of measures includes both quality performance measures accepted by CMS and alternative measures for cost and efficiency that are currently in use by other organizations.

The workgroup tasked with defining the content of new health care utilization summary file, which will be constructed from the private insurer claims and eligibility data, will hold its second meeting on June 27th. At this meeting, the workgroup will review results of tests conducted by MHCC staff to determine if the various data elements requested by the workgroup can be easily constructed from the data.

Maryland Medical Care Data Base (MCDB) Webinars
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) will take place on June 26th. This meeting will introduce payer representatives to the MHCC's plans to expand the MCDB content and modify the submission process so that the MCDB can address new information demands. The purpose of the meeting is to provide payers with the rationale behind the new MCDB data regulations that will be promulgated in the near future.

Update on Annual Reports
The analysis for our annual report on payments for professional services, produced in collaboration with Social and Scientific Systems (SSS), is nearing completion. The report will make detailed comparisons of 2010 and 2011 private payer payment rates for in-network and out-of-network services, overall and by the largest versus other payers. In addition to the usual comparison of privately insured payment rates to the rates paid by Medicare, this report will include a comparison of privately insured payment rates to the rates paid by Medicaid. Key findings from the analysis will be presented at the July Commission meeting.

Figure 2 - Data from Google Analytics for the month of May 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 May 2013 was 6,064 and of these, there were 3,082 unique visits. The average time on the site was 3:03 minutes. Bounce rate of 38.46 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 May were:

- "Maryland health care commission" and
- "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 QM	Completed	December
PCMH Case Management Monthly Tracking web site	Live	Ongoing
PCMH Public Site	On-going Maintenance	
PCMH Portal (Learning Center & 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
Physician Licensing	Testing new HIT and Race questions	TESTING PHASE through June Live 7/16/2013
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	Completed changes for 2102 Survey. Testing new LTC Survey to MHCC Assessment interface. COMPLETED
Hospital Quality Redesign	Planning	
MHCC Assessment Database	On-going Maintenance	COMPLETED – next cycle begins March 2014
IPad/IPhone App for MHCC	Development	Ongoing
npPCI Waiver	Quarterly	(for CFHS)
MHCC Beta Content Management	Development	

Network Operations & Administrative Systems (NOAS)

Information Technology Newsletter

The June 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
  - Instructions how to disable automatic bulleting or numbering in Microsoft Word 2007
  - Steps to take to avoid sending email messages to the wrong person, utilizing the agency identifier associated with each name in the Global Address Book
  - Advice on how to change printer settings on staff workstations
- Announcements
  - Gmail for Government has a new compose feature (creating new messages)

Virtualization Infrastructure Update

The MHCC virtualization infrastructure is now 100% operational and is in use by all MHCC staff for file storage. The database & applications development staff continues to use virtual drive space to conduct tests and utilize the storage space to run large processing activities.

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

Health Plan Quality and Performance

Mary's Center operates as a federally qualified health center that projects to serve over 70,000 men women and children in 2013. Staff coordinated a meeting with Maria Gomez, President and CEO of Mary's Center, a local employer doing business in Montgomery and Prince George's Counties in Maryland as well as in North West, Washington D.C., in order to discuss the Center's success, and gain additional insight on employers' needs for health benefit plan quality and performance information that is presented in an easy to understand way.

Staff represented the Maryland Health Care Commission and accompanied representatives from the Maryland Health Benefit Exchange (MHBE) to the SHADAC (State Health Access Data Assistance Center) and State Network's small group consultation in Minneapolis, Minnesota. The purpose of the small group consultation was to collaborate with other states in various stages of their state's exchange implementation and to explore the varying data needs and reporting requirements related to state-based marketplaces.

Staff continues its collaboration with the 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 extended deadlines for the MHBE to provide the MHCC with information the MHBE would require to be included in the Maryland Health Connection Quality Report 2013. As requested by the MHBE, staff has also directed its report development contractor, Healthcare Data Company, to join staff in participating in a June 14th follow up teleconference to finalize workflow details with the MHBE and its web contractor, Connecture.

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.

Staff serves to co-lead members of the Charge 1 Subcommittee from the Cultural Competency Workgroup, which was established by the Office of Minority Health and Health Disparities' and the Maryland Health Quality and Cost Council (MHQCC). Charge 1 Subcommittee members continue working together to complete the pre-defined action steps that have been laid out. All projects related to the Charge 1 Subcommittee are on track for completion 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 increased, to approximately 8 Maryland visits per day, with users viewing about 4 pages per visit and spending an average of about 6 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 analyzed 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 June 10, 2013 enrollment in the Partnership was as follows: 418 businesses; 1,155 enrolled employees; 1,897 covered lives. The average annual subsidy per enrolled employee is about $2,450; the average age of all enrolled employees is 41; the group average wage is about $28,000; 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 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. A joint letter from the Commission and the Office of Health Care Quality was sent to all providers and vendors letting them know about the updates that go into effect October, 2013.

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. When updated, these will be separate Plan Chapters. The hospice Chapter (COMAR 10.24.13) continues to undergo review and update.
The Hospice Work Group was reconvened on January 16th. At that meeting, consensus was reached on the components of the methodology. The Senate Finance Committee was briefed on January 24th on progress made concerning the methodology.

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

Comments were received from 12 organizations. The Summary and Analysis of Public Comments will be presented to the Commission at the June meeting. In addition, Staff will request that the Commission approve COMAR 10.24.13 for release as proposed permanent regulations.

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; and the DHMH Office of Minority Health and Disparities. At the first meeting, the goals and charge were discussed. 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 July.

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; data follow-up has also been completed. Part II has been submitted (as of June 7) by almost all providers. Staff is now working with the hospices for data follow up on Part II.

Leadership Summit
Commission staff were invited to attend the Leadership Summit on "The Role of Post Acute Services in Health Reform" jointly sponsored by the LifeSpan Network and the Maryland National Capital Homecare Association (MNCHA) on May 9, 2013. The main objective of the summit was to bring together a panel of post acute care providers to discuss their perspectives and innovative approaches to addressing the impact of health care reform. Such post acute providers included hospitals, skilled nursing, assisted living, home health, and adult day care facilities. The summit presented an opportunity for partnerships across the continuum of care to work together, strategize, and learn from each other.

Home Health Tables
All 24 Home Health Agency (HHA) Utilization Tables for FY 2011 have been have been posted on the Commission's website under public use data files. 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.

FY 2012 Home Health Agency Survey
The Home Health Agency Survey data collection period began on April 8, 2013 and ended on June 6, 2013. Sixty agencies took part in this statewide survey. 83% of the surveys were completed by the due date. Two agencies are currently in progress, and seven agencies have been rejected for corrections. Staff will mail out Notice of Assessment of Fines to the agencies that are currently working on their surveys, but did not submit them by the due date of June 6, 2013. Staff will continue to provide technical support to providers during the data collection period.

FY 2012 Long Term Care Survey
737 facilities, including 233 comprehensive care facilities, participated in the 2012 Long Term Care Survey, with a 99% completion rate as of today (6/10). The Comprehensive Care Survey ended on April 9th with a 100% completion rate. The Long Term Care Survey for adult day care Centers, chronic hospitals, and assisted living facilities started on March 11, 2013. The survey due date was May 9, 2013. Both chronic hospitals and adult day care centers had a 100% completion rate. Ninety eight percent of the assisted living facilities have completed their survey. Six facilities have not submitted. Of these, four are currently working on the surveys. Two are nonresponsive, and the Office of Health Care Quality has

now informed us that they believe these facilities are closed. These two facilities will be exempted from the survey this year.

Thirty one facilities received Notice of Assessment of Fine letters for non-compliance by the survey due date of May 9, 2103, with notification of their rights to file an appeal of the fines. Sixteen facilities appealed the fines and the fines were waived. Nine facilities did not appeal the fine, and an invoice was sent out to these facilities. The four facilities working on their surveys will receive an invoice upon having their surveys accepted. The two exempt facilities will no longer receive notices of fines for this year. Staff will continue to follow up and provide technical assistance to the facilities still working on their surveys.

Long Term Care Quality Initiative

Long Term Care Staff Influenza Vaccination Surveys
Survey collection has ended. All nursing homes and all but a few assisted living residences submitted the required data on the annual survey. Staff is producing and formatting the individual facility, statewide and targeted rates for dissemination to providers and the public. Survey results are used by the DHMH Medicaid Long Term Care and Community Support Pay for Performance Program, the Maryland Consumer Guide to Long Term Care, and by individual nursing homes and assisted living facilities for internal quality improvement purposes.
This year's survey included additional questions to assess strategies used in nursing homes to raise awareness and provide access to influenza vaccination and strategies to ensure compliance with flu policy and limit the spread of influenza within the facility.

A presentation of the results is planned for a Commission meeting. While there is variation among nursing home rates, the statewide average increased 8% over the prior year. Although lower overall, the statewide average assisted living rate increased by 2%.

Nursing Home Surveys
The survey collection period has ended; results are being processed and formatted into the various reports for providers, consumers, and the Medicaid Long Term Care and Community Support Pay for Performance Program. Results will be available this summer.

Other
Using the long term care staff vaccination rates, staff is completing a three year analysis of the relationship between staff vaccination rates, resident vaccination rates, facility characteristics, and reported flu outbreaks in Maryland.

CENTER FOR HOSPITAL SERVICES

Hospital Quality Initiatives

Hospital Performance Evaluation Guide (HPEG) Update
In preparation for the upcoming update of the Hospital Performance Evaluation Guide, clinical and HCAHPS data for the fourth quarter of 2012 were collected through the Quality Measures Data Center. All hospitals successfully submitted their data for this time period. The next update to the Hospital Performance Evaluation Guide is scheduled for July 2013; this update will include a refresh of clinical and HCAHPS data as well as an update to Health Care Worker (HCW) seasonal influenza vaccination data.

Data validation for clinical and HCAHPS data for the third quarter of 2012 is currently underway. All hospitals have had their on-site data reviewed; some hospitals are currently in the process of receiving the preliminary results of the validation.

Staff continues to prepare for the collection, processing and reporting of new inpatient, outpatient, and HCAHPS survey measures data as we transition to our goal of aligning with CMS quality data reporting requirements.

Healthcare Associated Infections (HAI) Data

The Hospital Quality Initiatives staff continues to work with our contractor, Advanta Government Services, on the FY2012 CLABSI and SSI data audit and quality review. The Commission held a webinar on May 22, 2013 to review the findings of the FY2012 CLABSI audit and to update hospital infection prevention staff on CDC definitions and protocol. An audio version of the webinar presentation has been prepared and posted on the Commission's website.

The results of the 2012-2013 Hospital Health Care Worker Influenza Vaccination Survey have been submitted, analyzed and previewed with the hospitals for posting on our website next month. The results show continued improvement in hospital vaccination rates. The 2012-2013 statewide flu vaccination rate for hospital employees is 96%. This represents an 8% increase over last year and an 18% increase in comparison to our first reporting period (2009-2010 flu season). During our June public meeting, the staff will provide additional information on the performance and progress achieved by Maryland hospitals over the past several years.

The results of the third annual survey of hospital infection and prevention and control programs have been submitted and reviewed. The HQI staff provided a presentation to the Greater Baltimore Chapter of APIC (Association of Professionals in Infection Control) in May and a final report is being prepared.

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 and Planning

Cardiac Services

Clinical Advisory Group

A draft report with the recommendations of the Clinical Advisory Group (CAG) on Cardiac Surgery and PCI Services was circulated for comment by email. The final report is expected to be completed in June.

Primary PCI Waiver Renewals

On May 16, 2013, the Commission approved renewal of the primary PCI waivers for three hospitals: Anne Arundel Medical Center, Baltimore Washington Medical Center, and MedStar Franklin Square Medical Center.

Certificate of Need ("CON")

CON Modification Approved

Waldorf Nursing & Rehabilitation Center – (Charles County) – Docket No. 11-08-2325

On May 16, 2013 the Commission approved the request of Waldorf Nursing & Rehabilitation Center to change the physical plant design originally approved on April 19, 2012 and increase the cost of the CCF

project from $9,862,847 to $11,897,178 (a $2,034,431 increase). The design change is a result of delaying the assisted living component of the project (which is not subject to CON review) and allocating common spaces that were to be shared with the assisted living component to the CCF. The cost increase is in part a result of this reallocation of space and in part a result of design changes to enhance quality of care and address changes in regulatory requirements.

Magnolia Gardens – (Prince George's County) – Docket No. 11-16-2315
On May 16, 2013 the Commission approved the request of Magnolia Gardens to change the financing mechanism of the project that was originally approved April 19, 2012. The project as originally approved was to be financed with $20 million in funds provided by Health Care REIT and with the REIT owning the building. The project will now be financed through a conventional mortgage of $14,175,000 and $6,151,389 in cash. The building will be owned Magnolia Gardens Real Estate, LLC, a joint venture of Doctors Community Hospital and Genesis HealthCare, the same ownership structure as the operating entity.

CON Letters of Intent

Season Hospice and Palliative Care of Maryland, Inc. – (Baltimore City)
Season Hospice and Palliative Care of Maryland, Inc. submitted a letter of intent to provide inpatient hospice services in a designated unit located within Sinai Hospital of Baltimore
Bellona Surgery Center – (Baltimore County)
Recognized Bellona Surgery Center's request to modify its July 19, 2012 CON, which has not been implemented, as a letter of intent to submit a new CON application to relocate the surgery center.

Determinations of Coverage

- **Closure of an Acute General Hospital or Part Thereof**

Maryland General Hospital – (Baltimore City)
Maryland General Hospital notified the Commission of its plans to close its obstetric service and new born nursery on June 30, 2013. Maryland General met the requirement that the Commission receive 45 day advance notice of such closure. No certificate of need is required to close the units nor are any other actions required in a jurisdiction with three or more hospitals.

- **Ambulatory Surgery Centers**

MedStar Montgomery Medical Center – (Montgomery County)
It was determined that the addition of two general purpose operating rooms to MedStar Montgomery Medical Center would require CON review and approval pursuant to COMAR 10.24.01.02A(4)(d). MedStar had taken the position that CON review and approval is not necessary because the addition of the two operating rooms would not be an increase in the surgical capacity of the State health care system because the operating rooms were relocated from the hospital in 1995 by Certificate of Need to the Surgery Center of Maryland, which closed in November 2012.

Frederick UroSurgical Center – (Frederick County)
Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 110 Baughmans Lane, Suite 201, Frederick (Ownership Interest: Mohammed M. Mohiuddin, M.D.)

Bellona Surgery Center – (Baltimore County)
It was determined that Bellona Surgery Center cannot modify its July 19, 2012 CON to add a second operating room by relocating the facility, and that such a change requires a new CON as spelled out in Health-General §19-120(g) and COMAR 10.24.01.05A.

Cardiovascular Ambulatory Surgery Center of America, P.A. – (Baltimore County)
Voidance of Determination of Coverage for establish of an ambulatory surgery center at 7300 York Road, Suite L, Towson

Cardiovascular Ambulatory Surgery Center of America, P.A. – (Anne Arundel County)
Voidance of Determination of Coverage for establish of an ambulatory surgery center at 16 Crain Highway South, Suite 408, Glen Burnie

Cardiovascular Ambulatory Surgery Center of America, P.A. – (Montgomery County)
Voidance of Determination of Coverage for establish of an ambulatory surgery center at 11119 Rockville Pike, Suite 101, Rockville

Cardiovascular Ambulatory Surgery Center of America, P.A. – (Montgomery County)
Voidance of Determination of Coverage for establish of an ambulatory surgery center at 831 University Boulevard East, Suites 24-25, Silver Spring

Cardiovascular Ambulatory Surgery Center of America, P.A. – (Calvert County)
Voidance of Determination of Coverage for establish of an ambulatory surgery center at 301 Steeple Chase Drive, Suite 401, Prince Frederick

- **Acquisitions/Change of Ownership**

Bedford Court – (Montgomery County)
Corporate Restructuring and Change of ownership of parent company Sunrise Senior Living, Inc. which will become a subsidiary of Red Fox Holding Corporation

- **Capital Projects**

Asbury Methodist Village – (Montgomery County)
Asbury Atlantic, Inc. d/b/a Asbury Methodist Village ("AMV") requested a determination that implementation of a multi-year capital plan for the Wilson Health Center, which is licensed for 285 CF beds, does not require Certificate of Need ("CON") review and approval. AMV characterized the capital plan as three separate renovation projects none of which individually exceed the CON threshold of $5,750,000 for non-hospital projects. It was determined that project 3 can be viewed as a distinct individual project. However, it was determined that project 2 is dependent on project 1 because project 1 would create the space required for the relocation of beds into new rooms during project 2 and the cost of project 1 and 2 combined would exceed the threshold. Therefore, CON review and approval would be required before project 1 and 2, as described, could proceed. AMV was also given the option of revising its plans in order to avoid further consideration of its proposed expenditures as a reviewable project.

MedStar Good Samaritan Hospital – (Baltimore County)
Expansion of Geriatric Program space – 2013 MHA Bond Review Request
Proposed Cost: $750,000

MedStar Montgomery Medical Center – (Montgomery County)
Renovation of one Emergency Department treatment room and covert to a digital x-ray room – 2013 MHA Bond Review Request
Proposed Cost: $610,663

Adventist Rehabilitation Hospital – (Montgomery County)
Modify and renovate 4 patient rooms for a Bariatric Program - 2013 MHA Bond Review Request
Proposed Cost: $377,600

Washington Adventist Hospital – (Montgomery County)
Renovate and update existing office space - 2013 MHA Bond Review Request
Proposed Cost: $980,000

Shady Grove Adventist Hospital – (Montgomery County)
Expand and renovate the adult Emergency Department – 2013 MHA Bond Review Request
Proposed Cost: $5,170,000

Anne Arundel Medical Center – (Anne Arundel County)
Construction of a specialized electrophysiological room to complement existing PCI rooms - 2013 MHA Bond Review Request
Proposed Cost: $1,200,000

Holy Cross Hospital of Silver Spring – (Montgomery County)
Renovation of the surgical support area on the first floor of the hospital, which was previously approved as part of a much larger CON project (Docket #08-15-2287) - 2013 MHA Bond Review Request
Proposed Cost: $3,400,000

Sinai Hospital of Baltimore – (Baltimore City)
Relocation and expansion the Pediatric Emergency Unit – 2013 MHA Bond Review Request
Proposed Cost: $4,200,000

- **Other**

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

St. Mary's Nursing Center – (St. Mary's County)
Temporary delicensure of 20 CCF beds

Allegheny Nursing Home/Mid Atlantic of Cumberland – (Allegany County)
Temporary delicensure of 10 CCF beds

Berlin Nursing & Rehabilitation Center – (Wicomico County)
Temporary delicensure of 41 CCF beds

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

FutureCare-Cold Spring – (Baltimore City)
Relicensure of 12 temporary delicensed CCF beds

FutureCare-Chesapeake – (Anne Arundel County)
Relicensure of 4 temporary delicensed CCF beds

Oakview SNF, Inc. (formerly Apex Health of Silver Spring) – (Montgomery County)
Relicensure of 20 temporary delicensed CCF beds

Ellicott City Health & Rehabilitation Center – (Howard County)
Relicensure of 10 of 32 temporary delicensed CCF beds

Signature HealthCARE at Mallard Bay – (Dorchester County)
Relicensure of 26 temporary delicensed CCF beds

Lurelwood Care Center at Elkton – (Cecil County)
Relicensure of 33 temporary delicensed CCF beds

Chesapeake Shores – (St. Mary's County)
Relicensure of 8 temporary delicensed CCF beds

- **Disposition of Temporarily Delicensed Bed Capacity or a Health Care Facility**

Milford Manor Nursing & Rehabilitation Center – (Baltimore County)
Permanent relinquishment of 16 temporary delicensed CCF beds for a total of 100 CCF beds

- **Waiver Beds**

Northwest Hospital Center – (Baltimore County)
Increase of 10 CCF waiver beds to the sub-acute care unit for a total of 39 beds

Augsburg Lutheran Home and Village – (Baltimore County)
Increase of 8 CCF waiver beds for a total of 131 CCF beds

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 considered the need to revise provider workflows to accommodate the use of health IT and improve patient outcomes. The committee discussed electronic health record (EHR) vendor training and the importance of role-specific training for providers. In addition, the committee discussed enabling data segmentation for the electronic exchange of sensitive health information, and providing consumers with granular consent to choose how their health information is exchanged electronically.

Staff continues to develop the *Health Information Technology: An Assessment of Maryland Hospitals* report (report). First published in 2009, the annual report identifies how acute care hospitals in Maryland are adopting and using health IT and provides a comparison of all 46 acute care hospitals by size, affiliation, and geographic location. Information on the following technologies is included in the report: EHRs, electronic prescribing, computerized physician order entry, electronic medication administration, infection surveillance software, data submission to the State-Designated health information exchange (HIE) and the use of HIE services, patient portals, meaningful use, and telemedicine. The report benchmarks hospital health IT adoption in Maryland with national adoption trends. This year, the report includes an assessment of meaningful use payments for each hospital; all combined, Maryland hospitals have received about $111M in meaningful use incentive payments through March 2013. Staff plans to publish the report this summer.

Staff reviewed data collected from the management service organization (MSO) environmental scan (scan) to assess the progress MSOs have made in assisting practices with health IT adoption and implementation. Almost all MSOs participated in the scan; findings indicate that MSOs have provided services to about 579 physician practices and will be used to make enhancements to the MSO program.

Staff plans to reconvene the MSO Advisory Panel (panel) in June to discuss the financial and technical impact of State-Designation and potential revisions to the criteria. The panel convenes annually and makes policy and program improvement recommendations to MHCC. In general, MSOs must meet nearly 94 criteria related to privacy, technical performance, business practices, security, and operations to receive State-Designation. Revisions proposed by the panel and approved by MHCC will become effective in the next version of the criteria. MSOs are required by COMAR 10.25.15, *Management Service Organization State-Designation*, to achieve State-Designation within a one-year Candidacy Status and to renew their State-Designation every two years.

Staff began working with State-regulated payers (payers) and pharmacy benefit managers (PBMs) to audit the implementation of Phase 2 of the three-phased electronic preauthorization implementation process. Staff is working with payers and PBMs to standardize and automate the preauthorization of medical and pharmaceutical services (health care services), as required by Health-General Article §§19-101 and 19-108.2 (2012). Phase 1 required payers and PBMs to make available on their website, by October 1, 2012, a list of health care services requiring preauthorization and the key criteria for making a determination. Phase 2 required payers and PBMs by March 1, 2013 to implement an online process for accepting preauthorization requests electronically, and assigning a unique electronic identification number to each preauthorization request. 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 attaining the benchmarks. The reporting tool will be distributed to payers and PBMs in July. Staff is required to report to the Governor and General Assembly by December 31, 2013 on payer and PBM attainment of the Phase 3 benchmarks, and will include the results of the audit in the report. Audacious Inquiry (AI), an independent consulting firm, was competitively selected to assist in completing the work.

During the month, staff received two letters from primary care practices (practice) in response to staff's notification to them regarding payer compliance with COMAR 10.25.16, *Electronic Health Records Reimbursement* (regulation). The practice letters focus on concerns around the payment calculation; staff addressed these concerns during the month. The regulation requires select State-regulated payers to provide an incentive payment to practices that meet requirements around the adoption and use of an EHR system. Staff continues to work with practices to increase awareness of the program and how it is administered. During the month, staff discussed proposed enhancements to the incentive program with CareFirst and United Healthcare. Next month, staff plans to reconvene the EHR Adoption Incentive Workgroup to discuss potential enhancements to the program. Delegate Peter Hammen, Chair of the Health and Government Operations Committee, has asked staff to explore options to enhance the program and standardize EHR formats across health care settings in the State. Delegate Hammen has requested staff report on the findings by November 1, 2013. Approximately 68 primary care practices have received payments totaling about $1.8M. As previously reported, over the last several months nearly 29 practices raised concerns regarding payer compliance with the regulation. Staff identified that Aetna, Inc. 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.

Letters Received by Concern and Payer

Primary Concern	Aetna, Inc.	CareFirst BlueCross BlueShield	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 the Chesapeake Regional Information System for our Patients (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. Staff participated in the Clinical and Technology Advisory Committee meetings during the month. The Clinical Advisory Committee prioritizes use cases and assesses the clinical value of current use cases offered by CRISP. During the meeting, members discussed CRISP service offerings to Delaware and Washington, D.C. and opportunities to add value to the encounter notification service (ENS). ENS allows providers to receive real-time secure alerts when a patient has an encounter at a Maryland hospital. During the month, CRISP convened a Health Plan Summit with State-regulated payers to explore how CRISP services could be of value to health plans.

Staff participated in the CRISP Technology Advisory Committee review of three vendor proposals to replace the HIE's core infrastructure and participated in two vendor demonstrations. The Technology Advisory Committee selected a vendor that will improve the functionality and cost-of-ownership of the HIE's core infrastructure. The recommendation was presented to the CRISP Board of Directors at their May meeting and received unanimous support. The technical conversion process is scheduled to begin in the fall and is expected to take several months to complete. The annual HIE security audit by CliftonLarsonAllen (CLA) continued during the month. CLA is evaluating the HIE's technical, physical, and administrative system controls. The audit includes an evaluation of nearly 150 information security controls. The security audit is expected to be completed in June and a preliminary report issued in August.

Staff convened the first of four regional meetings in Southern Maryland with hospital Chief Information Officers (CIOs) and Chief Medical Informatics Officers (CMIOs). The purpose of the regional meetings is to discuss the technical challenges of expanding hospital data submission to the State-Designated HIE through admission, discharge, and transfer (ADT) data. All acute care hospitals in Maryland send select ADT data to CRISP; currently most do not include clinical information, such as discharge diagnosis, death indicator, and chief complaint. During the meeting, CIOs and CMIOs identified various technical challenges and discussed opportunities for enhanced reporting to CRISP. The next regional meeting is scheduled in Baltimore in June; Western Maryland and Eastern Shore meetings are scheduled in July. Staff has been meeting with CIOs at community hospitals throughout the State to discuss strategies for expanding EHR adoption and community-based electronic health information exchange. During the month, staff met with CIOs from Western Maryland Health System and Carroll Hospital Center.

Staff held project kick-off meetings with the four independent long term care (LTC) facilities that received grant funding from MHCC to use health IT for improved transitions of care. Approximately $517K in funding was made available through the 2011 Challenge Grant, which provides support to facilitate the electronic exchange of health information between LTC facilities and hospitals. Representatives from Berlin Nursing Home and Rehabilitation Center, Citizens Care and Rehabilitation Center, Ingleside at King Farm and the Lions Center for Rehabilitation and Extended Care participated in the kick-off meetings. The project duration is ten months, and recipients are required to meet select milestones related to care transitions and the electronic exchange of health information. Staff has been in discussions with the largest institutional pharmacies in Maryland to explore how institutional pharmacy data can be made available in the State-Designated HIE. During the month, staff met with Remedi to discuss the technical challenges to make pharmacy data available through CRISP.

Staff conducted an environmental scan (scan) to identify the barriers and workflow challenges that ambulatory practices face in the adoption and use of telemedicine. The scan consisted of interviews with physicians, both in Maryland and in other states, that are using telemedicine. Findings from the scan will be presented in a briefing document scheduled for release in the summer. Senate Bill 776, Telemedicine *Task Force – Maryland Health Care Commission* (SB 776), signed into law by Governor Martin O'Malley on May 2, 2013, requires MHCC in conjunction with the Maryland Health Quality and Cost

Council to reconvene the 2010 telemedicine task force (task force). The task force is required to identify opportunities to expand the use of telemedicine to improve health status and care delivery in the State; assess factors related to telehealth; and identify strategies for telehealth deployment in rural areas. The task force's three advisory groups, clinical, business and financial model, and technology solutions and standards, will develop legislative recommendations for innovative care delivery models, improved access to specialized health care, and for hospitals to expand the use of telemedicine. An interim report 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. The task force will begin meeting in July. AI was awarded a small procurement contract to assist with the work of the task force.

Electronic Health Networks & Electronic Data Interchange

Staff continues to collect Electronic Data Interchange (EDI) Progress Reports (progress report) from payers with premiums of $1M or more annually and certain specialty payers, which are required to submit an annual progress report by June 30th of each year under COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks*. The progress reports include information regarding administrative health care transaction volumes and electronic health networks (EHNs) operating in the State. Staff uses data from these reports to develop an annual EDI information brief, which provides an overview of government and private payer EDI activities. During the month, staff awarded EHN recertification to Mercury Data. Payers are required to use EHNs that are 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 EHNs that are accredited by a qualified accreditation organization recognized by MHCC.

National Networking

Staff attended several webinars during the month. HIStalk Webinars hosted, *Vendor Software Training: What Providers Should Demand* that described best-practice training principles on questions providers should ask prospective IT suppliers. ONC hosted two webinars: *Million Hearts*® featured how leading hospital systems and communities are using health IT to engage clinicians and consumers in increasing awareness about heart disease prevention. ONC also provided an *ONC Governance Update* on HIE and governance activities. The eHealth Initiative hosted, *A Community HIE: Optimizing Patient Care in a Secure Environment* that demonstrated how CentraState Healthcare System, a community health organization in New Jersey, succeeded in enhancing data exchange across its health care network to improve workflow, access to health care services and treatments, and provider and consumer satisfaction.