MARYLAND HEALTH CARE COMMISSION

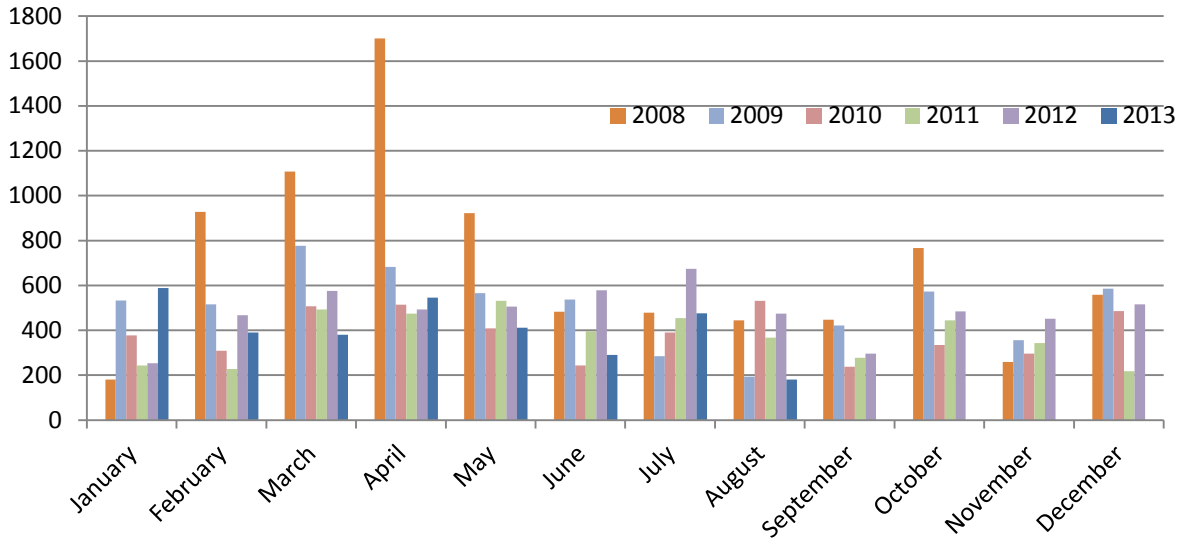
UPDATE OF ACTIVITIES

October 2013

EXECUTIVE DIRECTION

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 $181,437 for August of 2013. The monthly payments for uncompensated care from January 2008 through August 2013 are shown above in Figure 1.

Trauma Equipment Grants
The application for the 2014-2015 Trauma Equipment grant cycle has been shared with Senator Middleton, Delegate Hammen, and the MIEMSS-designated Level II and Level III trauma centers' equipment grant coordinators. The law permits the Commission to grant up to $400,000 from the Trauma Fund for this grant cycle. Applications for grant funding are due to the MHCC no later than November 1, 2013 for grants up to $57,000 for each eligible trauma center.

Report to the Maryland General Assembly, *Operations from July 1, 2012 through June 30, 2013*
The Commission, in conjunction with the Health Services Cost Review Commission, is required to annually report on the status of the Trauma Fund by November 1st. Upon the Commission's approval of its release, the report will be publicly available on the Commission's website.

CENTER FOR ANALYSIS AND INFORMATION SYSTEMS

Cost and Quality Analysis

MCDB Regulations and Submission Manual
The regulations governing the MCDB, COMAR 10.25.06, were released for informal comment on September 13, 2013. The comment period concluded on October 4, 2013. The draft 2013 Submission Manual was released along with the draft regulations, as one of the key changes in was moving field specifications out of the regulations and including a reference to the submission manual instead. Staff received 8 comments from carriers, Medicaid, and MHA. In addition to the formal written comments, Staff provided the opportunity for commenters to meet with staff to elaborate on their feedback. Meetings were held with CareFirst, United, Evergreen, and MHA. Staff has also had discussion a with Medicaid about the regulations. These informal meetings provided a valuable opportunity for staff to understand the challenges payors face and for payors to understand the intent of staff in the regulations and submission manual. Staff has conducted a formal analysis of comments received.

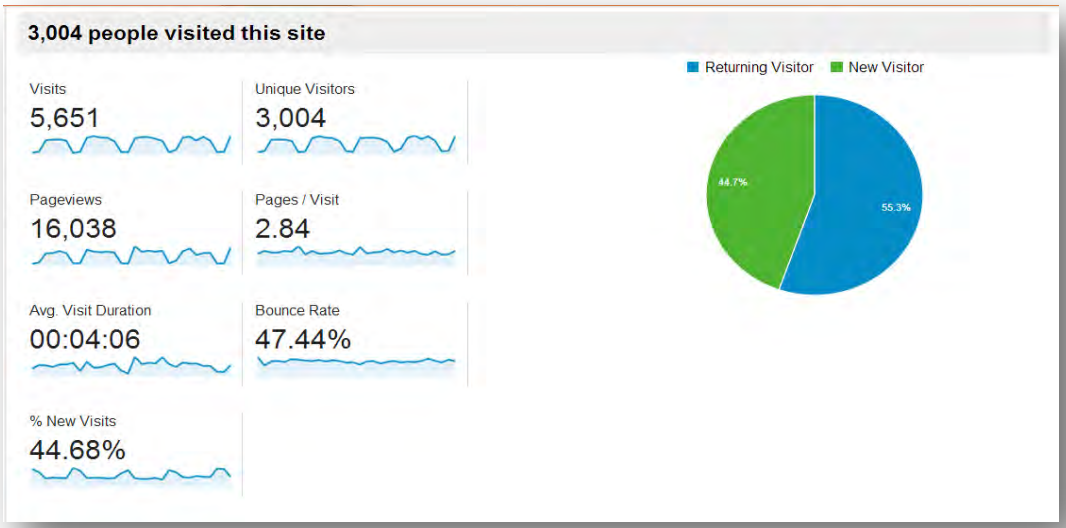
Based on the analysis of comments, some changes were made to the regulations. While most were clarifications, one important change should be noted. In the past, payors have been asked to submit paid claims for services rendered during the reporting period. This created the need for run-out periods, and delayed the submission and ultimate availability of data. In addition, payors expressed that this created an administrative challenge, as most payors focus on claims paid during a period, not services rendered. In response to this feedback, the regulation has been changed for data collected in 2014 onward to request claims paid during the reporting period. This also allowed providing two months of administrative time for payors to construct reports, instead of one month previously permitted. Of significance, this also allowed the deadline for submission of data to be two months after the quarter ends, rather than four months later. This will make the MCDB available for analysis in a more timely manner.

Analysis of comments and revised regulations will be presented at the Commission meeting on October 17, 2013. Commissioners will be asked to vote on the regulation as proposed permanent regulations and emergency regulations simultaneously. Emergency regulations are necessary to ensure that the regulation is in place in advance of January 1, 2014 when Maryland's Health Benefits Exchange enrollees will start being able to access benefits.

Resident Summary Analysis File
The workgroup for the Resident Summary Analysis File met on September 26th. Staff developed a person-level file, similar to the Medicare Master Beneficiary Summary File. At the meeting, the process of file development was discussed, and staff presented a use case for this file. A common interest among stakeholders has been to study geographic variation in utilization and costs. Staff presented statewide and county level analyses of total cost, patient liability, and provider reimbursement, and the proportion of patient liability relative to total cost, for all services, pharmacy costs, and hospital costs. These included professional services, institutional services, and pharmacy claims. These analyses were conducted using the newly created Resident Summary Analysis File. The file and the analyses were well received, and stakeholders are eager to have access to this type of data. In the coming months, Staff will engage certain stakeholders to test data and provide feedback. Staff will also develop a policy for distribution of this file, including a review of sensitive fields.

Workforce Study
Staff presented the background, study goals, and initial impressions of Board data at the Governor's Workforce Investment Board (GWIB) meeting on September 18th. The GWIB is funding a portion of this study, and its Board members were actively interested in the study and the expected reports. Study activities are ongoing, and detailed results will be presented to the Commission, when available.

Figure 2 - Data from Google Analytics for the month of September 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 September 2013 was 5,651 and of these, there were 3,004 unique visits. The average time on the site was 4:06 minutes. Bounce rate of 47.44 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 September were:

- "Maryland health care commission"
- "MHCC"

Table 1 Web Applications Under Development

Board	Anticipated Start Development/Renewal	Start of Next Renewal Cycle
PCMH Case Management Monthly Tracking web site	Completed	Live
PCMH Public Site	On-going Maintenance	Redesigning site
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	Live – On-going Support	Live – 90% licenses renewed. $6.4M collected ($6.1M by credit card)
Health Insurance Partnership Public Site	On-going Maintenance	Added information on Dec 31 deadline
Health Insurance Partnership Registry Site	Monthly Subsidy Processing	Updated site to allow for new renewals before expiration date to beat Dec 31 deadline.
Health Insurance Partnership Registry Site	Monthly Registration	
Health Insurance Partnership Registry Site	On-going Maintenance	
Hospice Survey Update	Underway	Helped create data dictionary
Long Term Care 2012 Survey	Annual Maintenance	
Hospital Quality Redesign	Planning	
MHCC Assessment Database	On-going Maintenance	2014 Assessment Completed
IPad/IPhone App for MHCC	Development	Ongoing
npPCI Waiver	Quarterly Report finished	(Ongoing)
MHCC Web Site	Under development	Completed basic design Waiting to demo on Oct 16.

Network Operations & Administrative Systems (NOAS)

Information Technology Newsletter

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

- Instructions on changing Gmail for Government password
- Information about using the Google Drive feature
    - Description
    - Basics on use, including document uploading, sharing, editing, and viewing
- Reminder that MHCC has completely migrated from using the Microsoft Outlook application to access Gmail for Government resources

- Reminder for all non-remote access users to shut down workstations at the end of each day

Server Room Updates

- MHCC virtual server farm environment passed its first quarterly technology health check; all systems were updated with the latest software upgrades; all hardware resources passed checks/tests;
- MHCC disc-based backup system passed its first quarterly technology health check; all systems were updated with the latest software upgrades; all hardware resources passed checks/tests;
- SAS System has been upgraded to include a new 4-core server with 10TB of storage, and upgraded software to the latest SAS Enterprise version;

Special Projects

Practitioner Performance Measurement Work Group

The fourth meeting of the Practitioner Performance Measurement Work Group was held on September 24th. The Commission's contractor for this project, Discern, LLC, presented findings from their next two required reports: developing a practitioner performance measurement system, and technology solutions for public reporting of practitioner performance measures. Commission staff is holding weekly meetings with Discern on the remainder of their contract deliverables.

CCIIO Grant Application

MHCC and the Maryland Insurance Administration (MIA) jointly submitted a grant application for Cycle III funding from CMS/CCIIO to assist the MIA in rate review activities and price transparency efforts. CMS awarded a Cycle III grant to Maryland in late August for nearly $3 million over a 2-year time period. The grant money will be used to speed up processing of MCDB data submissions so that the MIA has timely access to the data, and to create software that will automatically generate measures the MIA deems important for rate review. The accelerated processing of MCDB data submissions would be achieved through the use of Extract, Transform and Load (ETL) software that would screen data submissions for quality and completeness at the point of data submission and reject submissions that do not comply with the screening criteria. The ETL software will be obtained from an ETL vendor (obtained through the competitively-bid procurement process) and will include the flexibility to employ payer-specific screening criteria. The payer-specific criteria will reflect waivers granted to payers by the MHCC for deviations from established data completeness thresholds.

CENTER FOR HEALTH CARE FACILITIES PLANNING AND DEVELOPMENT

Acute Care Policy & Planning

Primary PCI Waiver Renewal

On September 19, 2013, the Commission approved renewal of the primary PCI waiver for Carroll Hospital Center.

COMAR 10.24.17, State Health Plan for Facilities and Services: Specialized Health Care Services-Cardiac Surgery and Percutaneous Coronary Intervention Services

On September 30, 2013, Commission staff posted draft regulations for informal public comment that are intended to repeal and replace COMAR 10.24.17, the State Health Plan Chapter for cardiac surgery and percutaneous coronary intervention (PCI) services. The posted draft guidelines reflect both the recommendations from the Clinical Advisory Group that met and discussed key issues regarding the future regulation of cardiac surgery and PCI services over a series of eight meetings during the past year

and Commission staff's analysis of additional data and information. Commission staff is allowing three weeks for submission of public comments. Staff will review all comments submitted and make additional changes before submitting the draft regulations for review by the Senate Finance Committee and the House Health and Government Operations Committee, as required, by the end of October.

Perinatal Care Services

The Maryland Perinatal Advisory Committee has been reconvened by DHMH in 2013 to update the State's Perinatal System Standards based on revised Guidelines on Perinatal Care issued by the American Academy of Pediatrics in 2012. These standards serve as a foundation for the standards MHCC uses in CON regulation of neonatal intensive care services and inpatient obstetric services. The Center Director is a member of this Committee, which met twice in September.

Regional Health Delivery and Health Planning in Rural Areas

The Maryland General Assembly's Joint Chairmen's Report requested that the Commission convene a group of interested stakeholders to evaluate regional health delivery and health planning in rural areas. The evaluation is to consider the appropriateness of current health planning region designations; the adequacy of the health care workforce in rural areas; barriers to accessing health care services caused by distance; adequacy of transportation to health care services; the impact of recent hospital consolidation on the availability of services in rural areas; and recommendations for change. The Group will report its findings by the end of the year.

The second meeting of the stakeholder group was held on September 3 at University of Maryland Shore Medical Center at Easton. The meeting focused on transportation barriers to accessing health care, with particular focus on the Eastern Shore. The group also heard from Shore Health System with respect to their recent community needs assessment and regional planning activities. For information on this project, you can link to the following page on the MHCC website:
http://mhcc.dhmh.maryland.gov/workgroup/Pages/Rural_Health_Workgroup.aspx

Long Term Care Policy and Planning

Minimum Data Set (MDS) Project:

Commission staff continues to work 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 update versions of MDS 3.0. The initial focus was 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 work included 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, which now includes MDS 2.0, as well as MDS 3.0 and its various updates. Work is also underway on programming MDS data to support the Consumer Guide for Long Term Care.

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 in October, 2013.

State Health Plan – Hospice Services:

At the September 19, 2013 meeting, the Commission voted to approve COMAR 10.24.13 as final regulations and to repeal the portions of COMAR 10.24.08 that cover hospice services, contingent on COMAR 10.24.13 becoming effective. This action was published in the October 4, 2013 issue of the *Maryland Register*. COMAR 10.24.13 will become effective October 14, 2013. As part of the process of

development of these regulations, work is underway in the areas of hospice education and quality measurement.

Hospice Educational Initiative:
The third meeting of the Hospice Initiative Education Work Group was held on September 24, 2013. At that meeting there were updates on educational initiatives that had been undertaken by the participating organizations. A publication by the Office of Minority Health and Health Disparities on *Maryland Cultural Competency: Technical Assistance Resource Kit* was distributed. It was decided that in lieu of monthly meetings, Commission staff will collect data quarterly from participants on educational initiatives. Staff will also post a compendium of items on the Commission's website. The group plans to reconvene next spring.

Palliative Care in Hospitals:
HB 581 "Establishment of Palliative Care Pilot Programs," passed during the past legislative session. It requires the Maryland Health Care Commission to select five palliative care pilot programs in the state and, in conjunction with the Maryland Hospital Association and the Office of Health Care Quality, establish reporting requirements for the pilot sites.

Between August 9 and September 11, 2013, MHCC staff conducted 15 phone interviews that covered palliative care programming at 19 Maryland hospitals. This was done in order to get a better understanding of the range and scope of different palliative care programs across the state. Staff plans to collect data from the ground-up and build the pilot around what currently exists in Maryland. This information, along with assistance from an advisory group, will assist in the development of recommendations for a design that is appropriate to the goal of the pilot program. The legislation became effective on October 1, 2013. The goal is to issue a Request for Applications in October and launch the pilot early in 2014.

Hospice Educational Program:
On October 1, 2013 staff attended a conference held by Montgomery Hospice entitled: "Difficult Conversations, Practice Session." Topics included: need for a legal decision maker; how to hold a family meeting; cultural differences in dealing with receiving news about a family member's condition; how to convey information and ascertain whether it was received.

Hospice Survey:
The FY 2012 Maryland Hospice Survey was available for online data entry effective February 19, 2013. Notices were sent out to providers on Monday, February 11th. Part I of the survey was due 60 days after the survey commenced. Part II was due no later than June 10, 2013.
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 by all providers. Staff has now completed follow up edits for Part II and is working on development of the Public Use Data Set.

FY 2012 Home Health Agency Survey:
Sixty agencies participated in the FY2012 Home Health Agency Survey. The Home Health Agency Survey collection period began on April 8, 2013 and ended on June 6, 2013. Staff has completed the post data cleaning and processing of the data, as well as the creation of public use data sets and reports.

All 24 Home Health Agency (HHA) Utilization Tables for FY 2012 were posted on the Commission's website under public use data files on September 24, 2013. 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 includes: 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 Long Term Care Survey:
Seven hundred and thirty-five (735) facilities participated in FY 2012 Long Term Care Survey, which concluded on May 9, 2013. The post data collection phase of the survey began with the processing and cleaning of the Medicaid Cost Report data for the FY 2012 reporting period. Staff continues the cleaning process of all the survey data which will include: creating frequencies and cross year comparisons to find any anomalies or inconsistencies from year to year; creating and reviewing the survey analysis files and various reports including the occupancy reports; and creating the Assisted Living and Adult Day Care profile data for the Consumer Guide. After final review, staff will create the public use data files, which will be posted to the Commission's website.

Certificate of Need ("CON")

CON's Approved

Father Martin's Ashley (Harford County) - Docket No. 13-12-2340
Construction of a new 2-story building to house 2 inpatient units, replacing 21 beds and adding 15 beds, increasing the facility's total capacity to 100 beds, consolidate and relocate the Admissions Department and Patient Intake functions in new building space, establish a permanent location for the Wellness/Fitness Center in the new building, and expand and consolidate other administrative and support spaces.
Approved Costs: $18,653,000

CON Letters of Intent

Charles County Nursing & Rehabilitation Center – (Charles County)
Staff determined that the request by Charles County Nursing and Rehabilitation Center to construct an addition to the facility at a cost of $6.6 million requires CON approval, but recognized the facility's request as a letter of intent to submit a CON application.

Pre-Application Conference

Charles County Nursing & Rehabilitation Center – (Charles County)
On September 20, 2013, staff met with a representative of Charles County Nursing & Rehabilitation Center to discuss plans to construct a 42,000 square foot addition to the facility to create a therapy gym, storage, administrative areas, and 30 single occupancy resident rooms to replace existing beds and space for future resident rooms.
Estimated Project Cost: $6,600,000

Meritus Medical Center
On September 23, 2013 staff met with representatives of Meritus Medical Center to discuss the hospital's request to use shell space intended for additional inpatient rooms for an observation unit. The shell space was, constructed as part of a previously approved CON.

CON Applications Filed

Lorien Bel Air – (Harford County) – Matter No. 13-12-2345
Construct a new addition to house 21 additional comprehensive care facility (CCF) beds for a total of 90 CCF beds at the facility and a two-unit expansion of the assisted living facility (not subject to CON approval) located at 1909 Emmorton Road, Bel Air.
Total Cost: $6,548,938 including $2,334,063 for the additional nursing home space.

Season's Hospice Suites at Sinai Hospital of Baltimore – (Baltimore City) – Matter No. 13-24-2346
Establishment of a 12-bed inpatient hospice unit in currently vacated space at Sinai Hospital
Proposed Cost: $70,000
Application Review Conference

Lorien Bel Air – (Harford County) – Matter No. 13-12-2345
On September 20, 2013 staff met with representatives of Lorien Bel Air to discuss completeness questions on their CON application to add 21 CCF beds to its existing 69 bed nursing bed facility in Bel Air, Maryland.

Determinations of Coverage

- **Ambulatory Surgery Centers**

Maryland Surgicenter, LLC d/b/a Alyson Wells, M.D. and Valley Plastic Surgery, LLC – (Baltimore County)
Establish an ambulatory surgery center with one sterile operating room and two non-sterile procedure rooms to be located at 10151 York Road, Suite 112-114, Hunt Valley

Shady Grove Fertility Center – (Montgomery County)
Relocation and replacement of the two sterile operating room and four non-sterile procedure room ambulatory surgery center from 15001 Shady Grove Road, Rockville to an adjacent site at 14995 Shady Grove Road, Rockville (Note: Relocation was to an immediately adjacent site and it was determined that CON review and approval would, thus, not be required.)

- **Acquisitions/Change of Ownership**

Patuxent River Health & Rehabilitation Center – (Prince George's County) - $330,883.43
Forest Hill Health & Rehabilitation Center – (Harford County) – $425,222.53
Overlea Health & Rehabilitation Center – (Baltimore City) – $146,835.51
Glen Burnie Health & Rehabilitation Center – (Anne Arundel County) – $438,019.95
Arcola Health & Rehabilitation Center – (Montgomery County) - $343,440.50
Summit Park Health & Rehabilitation Center – (Baltimore County) - $154,918.85
Bethesda Health & Rehabilitation Center – (Montgomery County) – 300,382.68
Bel Air Health & Rehabilitation Center – (Harford County) - $443,719.13
North Arundel Health & Rehabilitation Center – (Anne Arundel County) - $287,141.51
Heritage Harbour Health & Rehabilitation Center – (Anne Arundel County) - $363,748.57
Change in ownership of the entities that operate the above referenced ten Maryland nursing homes. The ownership at the highest levels will change from Murray Forman (50%) and Leonard Grunstein (50%) to Terpax, Inc., which is wholly owned by Tony Oglesby (100%). With the completion of the change of ownership, Terpax will own Proto Equity Holdings, LLC, which will own SavaSeniorCare, LLC, which will own a new entity called Master Tenant Parent Holdco, LLC, which will own SSC Equity Holdings, LLC, which will own Maryland Holdco, LLC, which will be the operating company above the individual limited liability companies that operate the ten nursing homes.

Haven Nursing Home d/b/a Arlington West Nursing & Rehabilitation Center – (Baltimore City)
The interests of the current majority owner of the operating entity and the owner of the real property of the above nursing home will be acquired by the other owners. Current owners of Haven Nursing Home, Inc. are: Richard G. Bennett, M.D. (75%); and Daren Cortese, Marvin Rabovsky, Gary Yankanich, and Irma Chapin (each with a 6.25% ownership share). After the acquisition, the four current minority owners will each own 25% of Haven Nursing Home, Inc., and Richard G. Bennett, M.D. will no longer have any ownership interest. Pennhurst Realty, LLC, the owner of the real property and improvements that are leased by the nursing home will also undergo a change in ownership. Currently, Dr. Bennett also owns a 75% share of Pennhurst Realty, LLC, with the remaining 25% owned by Brinton Woods Senior

Living III, LLC ("Brinton Woods"), which is owned by Daren Cortese, Marvin Rabovsky, Gary Yankanich, and Irma Chapin each having a 25% share. As part of the transaction, Brinton Woods will acquire 100% ownership of Pennhurst Realty, LLC.

- **Capital Projects**

Charles County Nursing & Rehabilitation Center – (Charles County)
On September 6, 2013 staff determined that a proposal to shell space for future use as patient rooms at an estimated cost of $1.3 million is directly related to patient care. Thus, the total proposed project costing $6.6 million to construct a 42,000 sq. ft. addition to the facility to create 30 single occupancy resident rooms, a therapy gym, storage, administrative areas and space for future resident rooms exceeds the CON threshold and requires CON approval.

Suburban Hospital – (Montgomery County)
On September 17, 2013, based on additional information and clarification, Commission staff determined that proposed expenditures on parking and related and required site work costing a total of $51 million are not component parts of the large building addition project contemplated by Suburban Hospital. Commission staff also determined that these expenditures are not directly related to patient care and will not increase patient charges or hospital rates. Therefore, the proposed expenditures qualify for the exception from the requirement that expenditures made as part of a replacement of any plant and equipment of a hospital exceeding $10 million, as adjusted for inflation (currently $11,550,000), requires a CON .

Other

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

Elkton Center – (Cecil County)
Temporary delicensure of 15 CCF beds

Chesapeake Shore – (St. Mary's County)
Temporary delicensure of 8 CCF beds

Signature HealthCARE at Mallard Bay – (Dorchester County)
Temporary delicensure of 21 CCF beds

Laurelwood Care Center at Elkton – (Cecil County)
Temporary delicensure of 33 CCF beds

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

Hamilton Center – (Baltimore City)
Relicensure of 19 temporary delicensed CCF beds

- **Miscellaneous**

Professional Healthcare Resources of Maryland, Inc.
Change in address of the home health agency from 10411 Motor City Drive, Suite 300, in Bethesda to 10605 Concord Street, Suite 309, in Kensington

CENTER FOR HEALTH INFORMATION and INNOVATIVE CARE DELIVERY

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 discussed recommendations for a risk-based regulatory framework for health IT to protect patient safety, promote innovation, and avoid regulatory duplication. The committee reviewed the safety risks of electronic health records (EHRs), clinical decision support systems, and health education applications, among others. The importance of product certification was discussed, and the committee noted that certification as part of a regulatory requirement can narrow creativity and innovation. The committee also discussed the importance of addressing federal regulatory deficiencies, ambiguities, and duplication among the three key agencies that have been generally involved in health IT regulation: ONC, the Food and Drug Administration, and the Federal Communications Commission.

During the month, staff finalized the draft legislative report regarding the progress of State-regulated payers (payers) and pharmacy benefit managers (PBMs) in implementing electronic preauthorization as required by law. The report presents data collected from payers and PBMs on their attainment of a three-phased process for implementing electronic preauthorization. Health-General Article §§19-101 and 19-108.2 (2012) require staff to work with payers and PBMs to standardize and automate the

preauthorization of medical and pharmaceutical services: Phase 1 required payers and PBMs to make certain information available on their website by October 1, 2012; Phase 2 required payers and PBMs to implement, by March 1, 2013, an online process for accepting preauthorization requests electronically and for assigning a unique identification number to each electronic request for tracking preauthorization status; and Phase 3 required electronic preauthorization systems to meet certain timeframes for processing preauthorization requests by July 1, 2013. All payers and PBMs that have not received a waiver have achieved all three Phases, as required by law. The report is due to the Governor and General Assembly by December 31, 2013. Staff competitively selected Audacious Inquiry (Ai) to assist in completing the work effort.

Staff is in the beginning stages of updating the EHR Product Portfolio (portfolio), which undergoes revision every year in the fall. The portfolio serves as a resource for health care providers to assess and compare a variety of EHR systems. Staff plans to streamline the portfolio to make it easier for users to locate information and compare solutions. The portfolio will also include an expanded section on EHR usability that will be based on user feedback regarding product efficiency and ease of learning how to use the software. All products included in the portfolio must be nationally certified and offer a discount to Maryland providers. Vendor participation in the portfolio is voluntary. To participate in the portfolio, vendors are required to submit functionality and pricing information about their EHR products. Staff plans to release the updated portfolio by the end of the year.

During the month, staff released an information brief, *Adoption of Electronic Health Records among Long Term Care Facilities in Maryland*. The brief describes the status of EHR adoption and implementation challenges. Data was collected from an environmental scan of 24 independent long term care (LTC) facilities across five regions of the State: Baltimore City, Central, Eastern, Southern, and Western Maryland. About 58 percent of LTC facilities surveyed have adopted an EHR, an increase of about 33 percent since 2009. This is the third year the scan has been conducted; it was previously administered in 2009 and 2010. Staff plans to use the findings from the scan to develop strategies for expanding health IT in LTC. During the month, staff convened a round table discussion with the two LTC associations in the State: LifeSpan Network and the Health Facilities Association of Maryland, as well as with LTC facility administrators to discuss opportunities for accelerating health IT diffusion among LTC facilities. Over the next six months, staff will continue to work with LTC stakeholders in an effort to finalize a strategy for expanding EHRs and health information exchange (HIE).

Staff continues to assess the impact of the State-Regulated Payer EHR Adoption Incentive Program (State incentive program) and develop program enhancements. Delegate Peter Hammen, Chair of the Health and Government Operations Committee of the Maryland General Assembly, requested staff to explore options to enhance the program and standardize EHR formats across health care settings. Staff is working with the State-Regulated Payer EHR Adoption Incentive Workgroup (workgroup) to finalize proposed modifications. Enhancements agreed upon by the workgroup would reduce administrative challenges for payers and providers, and align the State incentive program with the Medicare and Medicaid EHR Incentive Program to ensure EHR adoption incentives are aimed at improved care delivery. Workgroup participants include representatives from Aetna, Inc.; CareFirst BlueCross BlueShield; Cigna Healthcare Mid-Atlantic Region; Coventry Health Care; The Chesapeake Regional Information System for our Patients (CRISP); Kaiser Permanente; the Maryland Department of Health and Mental Hygiene; MedChi, The Maryland State Medical Society; UnitedHealthcare, Mid Atlantic Region; and the Maryland Hospital Association. COMAR 10.25.16, *Electronic Health Records Reimbursement*, requires payers to provide an incentive payment to primary care practices that meet certain requirements around the adoption and use of an EHR system. Ai has been competitively selected to assist in completion of the work.

During the month, staff received five letters from primary care practices regarding payer compliance with COMAR 10.25.16. Since the State incentive program launched in October 2011, MHCC has received roughly 38 letters of concern from practices related to payer compliance with the regulation. Concerns from practices were related to payers' calculation of their incentive payment and staff has responded to all

inquiries. Most concerns center on payers' calculation of the base incentive, as detailed in the table below. Generally, staff concluded that payers' methodology for calculating the incentive payments was in alignment with the regulation. As of April 2013, approximately 106 primary care practices have received incentive payments totaling about $2.6M.

Letters Received, by Concern and Payer

Primary Concern	Aetna	CareFirst	Cigna	Coventry	Kaiser Permanente	United	Total Letters Received
Base Incentive Calculation	0	0	13	1	2	9	**25**
Additional Incentive Calculation	0	0	3	0	0	3	**6**
Timing of Payment Received	5	1	0	1	0	0	**7**
Total	**5**	**1**	**16**	**2**	**2**	**12**	**38**

Health Information Exchange

Staff continues to provide guidance to CRISP, the State-Designated HIE on the implementation of HIE. The CRISP Clinical Advisory Board (advisory board) reviewed two new use cases. The advisory board approved expanding access to the CRISP query portal and encounter notification service (ENS) to providers within 10 miles of the CRISP service area, currently Maryland and Washington, D.C., and who provide care to patients who live within the CRISP service area. Ambulatory practices outside of 10 miles of the CRISP service area that request access to CRISP services will be evaluated on an individual basis. The advisory board also reviewed expanded encounter reporting services for hospitals that would enable hospitals to track their patients across facilities; the advisory board requested additional information before finalizing their recommendation. During the month, the results of the security audit were presented to the CRISP Board of Directors Audit Committee, MHCC, and HSCRC staff. The annual security audit, by CliftonLarsonAllen LLP (CLA), was conducted to minimize the potential for unauthorized disclosure or breach and to determine whether patient data is processed, transmitted, and stored by CRISP and its vendors securely. CLA began the fieldwork of the fourth annual financial audit of CRISP.

Staff continues to work with LTC facility grantees (grantees) awarded funding under the Independent Nursing Home Health IT Grant Program (grant program) to support the adoption and use of health IT for improved transitions of care. The grantees: Ingleside at King Farm; Berlin Nursing Home and Rehabilitation Center; and Lions Center for Rehabilitation and Extended Care received approximately $440K as part of the 2011 ONC Challenge Grant. The funding is aimed at facilitating the electronic exchange of health information between hospitals and LTC facilities. The grantees are working with State-Designated management service organizations (MSOs) and CRISP to use CRISP services, including the CRISP query portal and ENS. The CRISP query portal allows providers to access patient information that is available in the HIE, and ENS enables providers to receive automated alerts about hospital admission, discharge, and transfer of their patients. Over the first quarter of the grant program, the facilities have been able to increase the proportion of care transitions accompanied by an electronic summary of care document, and to decrease the average time to receive electronic care summary information.

Staff convened two meetings of the 2013 Telemedicine Task Force (task force): a Clinical Advisory Group meeting and a Technology Solutions and Standards Advisory Group meeting. Senate Bill 776, *Telemedicine Task Force – Maryland Health Care Commission*, signed into law in 2013, requires MHCC to reconvene the task force in coordination with the Maryland Health Quality and Cost Council. The task force consists of three advisory groups: Clinical, Finance and Business Model, and Technology Solutions and Standards. The advisory groups are evaluating opportunities for using telemedicine to improve

access to health care services, enhance patient health outcomes, reduce health care costs, and in innovative care delivery models. Staff is required to submit an interim report on the work of the task force 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. In coordination with the task force members, staff is exploring technology to develop a registry of telemedicine providers that could be made available through the State-Designated HIE. Ai has been competitively selected to assist in completing the work.

Innovative Care Delivery Models

Staff worked with TRICARE, the health care program serving Uniformed Service members, to formulate fixed transformation payments (FTPs), which is the per patient per month obligation of the Maryland Multi-Payer Patient Centered Medical Home Program (MMPP). FTPs support practice transformation by bolstering infrastructure, including hiring new staff, conducting staff training, and investing in health IT. Additionally, the participating commercial carriers distributed their FTP payments to MMPP practices. Staff also worked to develop quality measure thresholds for 2014, as well as initial shared savings estimates for performance year 2012. Next month, Medicaid FTP payments are expected to be distributed, and shared savings results will be finalized and shared with practices. Staff is in the preliminary stages of working with the Maryland Learning Collaborative to develop a program on empowerment of patients, practitioners, and the primary care workforce in Baltimore on December 5, 2013.

Electronic Health Networks & Electronic Data Interchange

During the month, staff analyzed census level data on administrative health care transactions submitted by payers and select specialty payers as part of their annual electronic data interchange (EDI) progress reports. COMAR 10.25.09 – *Requirements for Payers to Designate Electronic Health Networks* requires State-regulated payers and select specialty payers with annual premiums of $1 million or more to submit administrative health care transaction data to MHCC by June 30th of each year. Preliminary results indicate that EDI has remained relatively constant, increasing about one percent to nearly 91 percent. Staff began drafting an information brief focused on EDI activity of government payers and the six largest payers: Aetna; CareFirst; Cigna; Coventry; Kaiser Permanente; and United. Staff expects to release the information brief in the fall. Under COMAR 10.25.07 – *Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouses*, electronic health networks (EHNs) operating in Maryland must be certified by MHCC. Last month, staff recertified Emdeon Business Services, LLC.

National Networking

Staff attended several webinars during the month. The National ehealth Collaborative (NeHC) presented *North by Southeast: HIE Case Studies on CHIC and SERCH.* The Community Health Information Collaborative (CHIC) is a nonprofit collaborative of hospitals, clinics, LTC facilities, tribal health organizations, higher education institutions, and public health departments in Minnesota, and the Southeast Regional HIT-HIE Collaboration (SERCH) is a project comprised of 10 states in the Southeastern region of the U.S. convened by ONC to address HIE for disaster preparedness and response. Both CHIC and SERCH discussed their organizations' work to develop HIE policies and procedures to be employed in the event of a natural disaster. NeHC presented an *Update on ONC HIE Governance Activities* that included an overview of the ONC Governance Framework for Trusted Electronic HIE and National HIE Governance Forum efforts. Forum participants reviewed issues and topics discussed to date, including approaches to trust (i.e., duty to respond, local autonomy, and chain of trust). The Southwest Telehealth Resource Center hosted, *Lessons from Implementing a Range of Telemedicine Programs at a Rural Facility* that explained lessons learned related to implementation of telemedicine programs.

CENTER FOR QUALITY AND REPORTING

Hospital Quality Initiatives

Hospital Performance Evaluation System
In 2009, the MHCC established the web-based Quality Measures Data Center (QMDC) to support direct and timely access to detailed patient-level quality and performance measures data for public reporting. This approach has accelerated the timely receipt of data directly from hospitals and has enabled the Commission to validate the accuracy and completeness of the data as well. The data collected through the QMDC website supports the HSCRC Quality Based Reimbursement Program and efforts to modernize the Medicare Waiver.

The QMDC was established and maintained through a five-year contract. In September, the Commission initiated a new five-year contract with Advanta Government Services, LLC to support the maintenance and enhancement of the QMDC website and supporting infrastructure that generates the quality and performance information. The staff is working closely with the new vendor to transition to an expanded and enhanced infrastructure and a more consumer friendly Guide. The Commission staff intends to review the transition activities and plans for enhancements to the system and Guide during a future Commission meeting.

Healthcare Associated Infections (HAI) Data
The Hospital Quality Initiatives staff continues to work with our HAI data quality review contractor on our first audit of the surgical site infection data collected through the CDC National Safety Network Surveillance System (NHSN). The audit plan has been developed and we expect that the auditors will perform the on-site chart review activities later this year.

MHCC staff continues to work on updates to the CLABSI and SSI data. Preview reports are being generated and shared with the hospitals. The updates will be presented on the Hospital Guide once the transition with the new vendor is complete.

MHCC staff presented at the Maryland Hospital Association's statewide meeting entitled, "Moving Forward with the Future of Infection Prevention" on October 2, 2013. The MHCC presentation highlighted the progress that has been made over the past five years in terms of increased data collection initiatives, reduced central line associated bloodstream infections in ICUs, and increased hospital employee flu vaccination rates. The staff also reviewed the results of the Annual Survey of Hospital Infection Prevention and Control Programs, highlighting the expanding roles and responsibilities of hospital Infection Preventionists.

Over the past five years, MHCC has conducted an annual Hospital Health Care Worker (HCW) Influenza Vaccination Survey to report flu vaccination rates on the Hospital Guide. The most recent survey results show a 96% statewide rate for hospitals; up from 88% the year before. Effective with the 2013/2014 flu season, Maryland hospitals will be required to use the new NHSN Health Care Personnel Influenza Vaccination module for reporting HCW flu vaccination information. As a result of this new reporting requirement, we will be able to compare Maryland hospital performance on employee vaccination rates with other states and with the nation. The HQI staff have developed and distributed a FAQs document for hospitals to support compliance with these requirements.

Effective July 2013, Maryland hospitals are required to utilize CDCs National Healthcare Safety Net (NHSN) surveillance system for collection of *Clostridium difficile* infections data (CDI LabID events). CDI LabID 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

continues to work with hospitals to facilitate an effective implementation of this new reporting requirement. A FAQs document has been developed and shared with the hospitals. The document addresses hospital questions and will be updated on an ongoing basis as new issues and concerns arise.

Specialized Cardiac Services Data
The Hospital Quality Initiatives staff continues to work with the hospitals to ensure compliance with reporting clinical cardiac services data through the NCDR ACTION and CathPCI Registries. Hospitals are required to submit this detailed patient level data on a quarterly basis. The staff has recently completed the collection and preliminary data quality review of the 2nd quarter 2013 data for both registries. The reporting requirements were recently expanded to include summary metrics and performance measure data. Twenty-three Maryland hospitals and four out-of-state hospitals are required to submit this data. This data is currently used in the review of hospital PCI Waiver renewal applications..

Health Plan Quality and Performance

The 2013 Health Benefit Plan Quality and Performance Report was successfully released following the Commission Meeting on September 19, 2013; and in **collaboration with the Maryland Health Benefit Exchange (MHBE),** the Maryland Health Connection Quality Report 2013 was also timely delivered to the MHBE on September 26, 2013, one day earlier than the agreed upon deadline.

Staff is also working across divisions, with the All Payer Claims Database – Cost and Quality division, to share information on processes and outcomes on health benefit plan reporting for pilot measures surrounding race/ethnicity and language. In addition, staff also participated in a joint meeting with a new entrant Exchange carrier, Evergreen, in order to discuss opportunities for carrier preparedness regarding compliance with State reporting requirements.

Staff maintains responsibility, as co-leader, 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 have wrapped up their work together and have timely submitted an Activities Report to the leaders of the Cultural Competency Workgroup, as requested. Although projects related to the Charge 1 Subcommittee have concluded, the Cultural Competency Workgroup is continuing collaboration efforts, at the discretion of Workgroup leaders, while it combines reports received from each of three subcommittees into one summary document anticipated to be presented to the Maryland legislature by the Office of Minority Health and Health Disparities during the 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. Last month, visits to the site increased, mainly because of the launch of the state's health insurance exchange, Maryland Health Connection, on October 1, 2013. The other noted observation is that the visitors who intended to access VIRTUAL COMPARE are viewing more pages and spending significantly more time per session. Although open enrollment in the individual exchange began on October 1st, open enrollment for small businesses in the SHOP exchange was deferred to January 1, 2014. Because of the delay, VIRTUAL COMPARE will continue to operate until December 31, 2013 at which time it will be deactivated. Notice of the extension of VIRTUAL COMPARE to December 31st was sent to carriers, and to the broker community, NFIB, and the Maryland Chamber of Commerce in an effort to reach small businesses during this additional three month period.

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 October 8, 2013 enrollment in the Partnership was as follows: 425 businesses; 1,188 enrolled employees; 1,941 covered lives. The average annual subsidy per enrolled employee is about $2,400; the average age of all enrolled employees is 41; the group average wage is about $28,300; the average number of employees per policy is 4.1. Commission staff and DHMH leadership finalized a transition plan for the phase out of the Partnership, once the state health insurance exchange (Maryland Health Connection) becomes available to individuals and small employers in 2014. Staff presented this transition plan at last month's meeting and posted the notice on the Partnership website. This notice also was mailed to all small businesses currently enrolled in the subsidy program.

Long Term Care Quality Initiative

Consumer Guide to Long Term Care

Nursing Home resident characteristics and quality indicators sections of the Guide were updated with MDS 3.0 data. Due to the transition from MDS 2.0 to 3.0, several of these measures have been changed or are no longer reported.

Other Guide updates in progress include the addition of nursing home staffing information and nursing home private pay rates.

Long Term Care HCW Influenza Vaccination

1) CDC released the national end-of-season vaccination estimates for HCW on September 27, 2013 for the 2012–13 season. Vaccination coverage was highest among hospital-based HCW (83.1%) and lowest among HCW at long-term care facilities (58.9%). In comparison, the Maryland rate for nursing homes was 73.6%, nearly 15% higher than the national experience.

2) CDC stated, overall, 72.0% of HCW reported receiving an influenza vaccination for the 2012–13 season, an increase from the 66.9% for the 2011–12 season. Increases were seen within all HCW occupational settings over the three seasons, except for vaccination coverage in LTC, which was highest (64.4%) during the 2010–11 season, decreased during 2011–12 (52.0%), and then increased during the 2012–13 season (58.9%).

3) Despite better performance by Maryland LTC HCWs relative to the nation, the rate lags behind the rates for Maryland hospital HCWs. Targeted emails were sent to all nursing homes with staff vaccination rates below 50% to better understand the challenges of encouraging staff to accept influenza vaccination. The center staff continues to pursue collaboration with the Maryland Partnership for Prevention and the DHMH Center for Immunization to increase vaccination take up rates in LTC facilities with lower rates.

Other activities

Carol Christmyer presented at the annual LifeSpan/HFAM conference on the topic of: *Benchmarking, Trending and Analyzing: 3 Steps To Performance Improvement*. The presentation described statewide trends from 2006-2010 for nursing home quality measures compared to national rates, and illustrated how specific initiatives and programs may influence scores. The presentation also included a brief section on the uses of Health IT and the Maryland IT initiatives supported by the MHCC Center for Health Information and Innovative Care Delivery.

The presentation was well attended with questions and active participation among attendees.