MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

September 2017

EXECUTIVE DIRECTION

Rural Health Workgroup – Erin Dorrien

The Workgroup met on Tuesday July 25, 2017 to consider the recommendations of the four advisory groups. Sixteen recommendations focused on workforce, economic development, meeting the needs of a vulnerable population, and improving transportation options were discussed. The most notable recommendations are to establish and support a "Rural Community Health Complex" demonstration project, to establish and support Rural Health Collaboratives in the rural regions of the State, and to create a rural hospital program for rural communities.

The model envisions the establishment of community health complexes in the five county region. Ideally, services would be co-located to create a "one-stop-shop" for patients even in smaller communities. The first goal of the model would be to ensure that all communities had access to essential primary care services. More sophisticated complexes would offer a broader range of services and would be deployed at FQHCs and medical office complexes. FMFs, a new type of small rural hospital, and regional medical centers would offer progressively more advanced specialty care along with the essential primary care services. In some of the larger communities multiple complexes might exist. Linking the region together would be a "Patient-Centered Support Hub," the backbone of which would be the technology to support integration, coordination of care, and linkage with community and social services. Staff noted that some community health complexes established either by Choptank FQHC or by Shore Health already existed in the region. However, many smaller communities lacked access, even on a periodic basis, to primary care services. The services envisioned through the Patient-Centered Support Hub could be available through the CRISP integrated care network. Some workgroup members felt that the conversion of the hospital in Cambridge could serve as a great demonstration for this type of model.

The Rural Health Collaborative (RHC), which ultimately could be the governing body for the community health complex, could be developed though the enhancement of the Local Health Improvement Coalitions. The RHC would facilitate the following:

- Data collection and analysis for Community Needs Assessments that roll into a Regional Health and Social Needs Assessment.
- Identifying needs for the region but also the pockets of special needs within the counties.
- Developing strategic directions for improvement of health in the region.
- Better integration of clinical health needs with social, behavioral, and environmental needs that impact health and clinical outcomes.
- Collaboration in seeking grant funds that are more likely won with a bigger service population.
- Collaboration in sharing services and staff across jurisdictional lines for economies of scale.
- Potential services created with pooling of resources.
- Integrating the work of the Local Health Improvement Coalitions into broader regional initiatives.

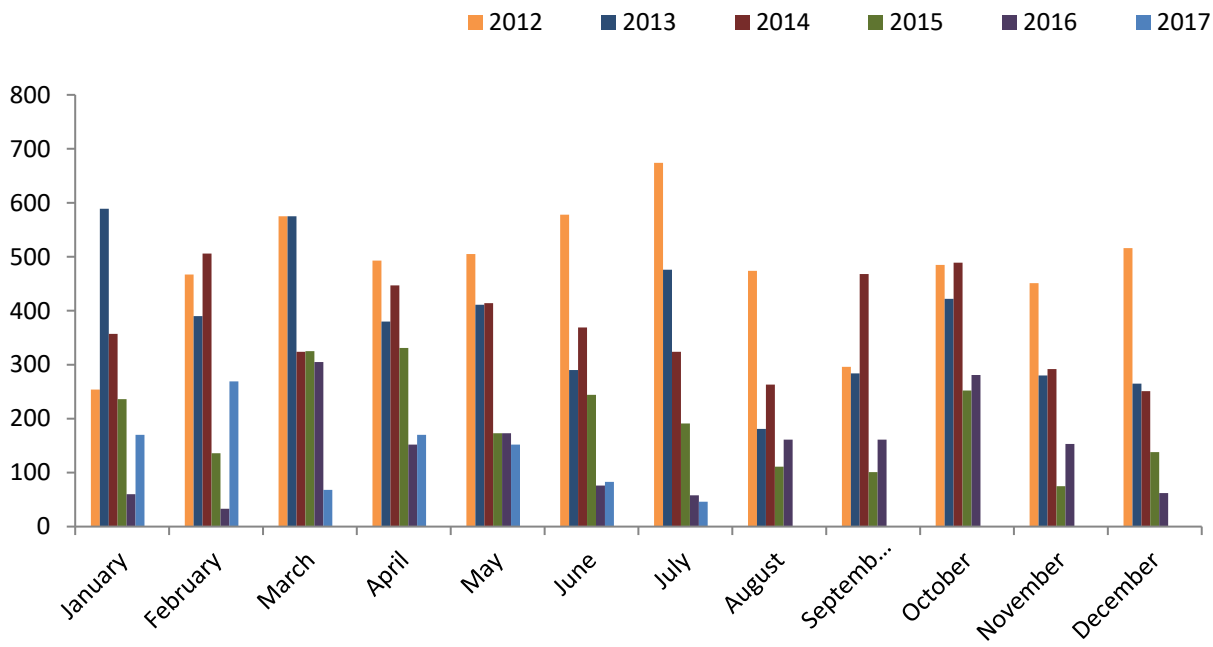
The Workgroup has also endorsed a special rural hospital designation/special hospital program for rural communities. The program should be established under HSCRC's broad authority to establish reasonable reimbursement for Maryland hospitals. The goals of the special hospital designation/special rural hospital program are to assist rural communities in aligning with phase II of the All-Payer-Model-Contract. To qualify, the hospital must specify concrete goals and plans for implementing those goals. The plans could include initiatives for improving the quality of care and establishing expanded access to advanced primary care, thereby decreasing the number of avoidable admissions, readmissions, and transfers.
The Workgroup will meet again for the final time on September 28th. They will review public comments on the recommendations and the final report submitted by the University of Maryland School of Public Health and the Walsh Center for Rural Health Analysis at NORC.

Maryland Trauma Physician Services Fund – Karen Rezabek

Uncompensated Care Processing

CoreSource, Inc., the third party administrator (TPA) for the Trauma Fund, adjudicated claims in the amount of **$83,301** for the month of June and **$46,019** for the month of July. The monthly payments for uncompensated care claims from January 2012 through July 2017 are shown below in Figure 1. The level of uncompensated care payments is below the historic trend as a result of expanded insurance coverage, particularly Medicaid coverage. MHCC staff has seen an uptick in uncompensated care payments in January and February compared to the same months for 2016. Though, as reflected in the chart below, that increase was not a trend, as payments made in 2017 have been similar to those made in 2016 for the months of April through July. Payments for uncompensated care claims increased to 105% percent of the Medicare Fee Schedule for claims dated on or after July 1, 2016.

Figure 1
Uncompensated Care Payments to Trauma Physicians, 2012-2017

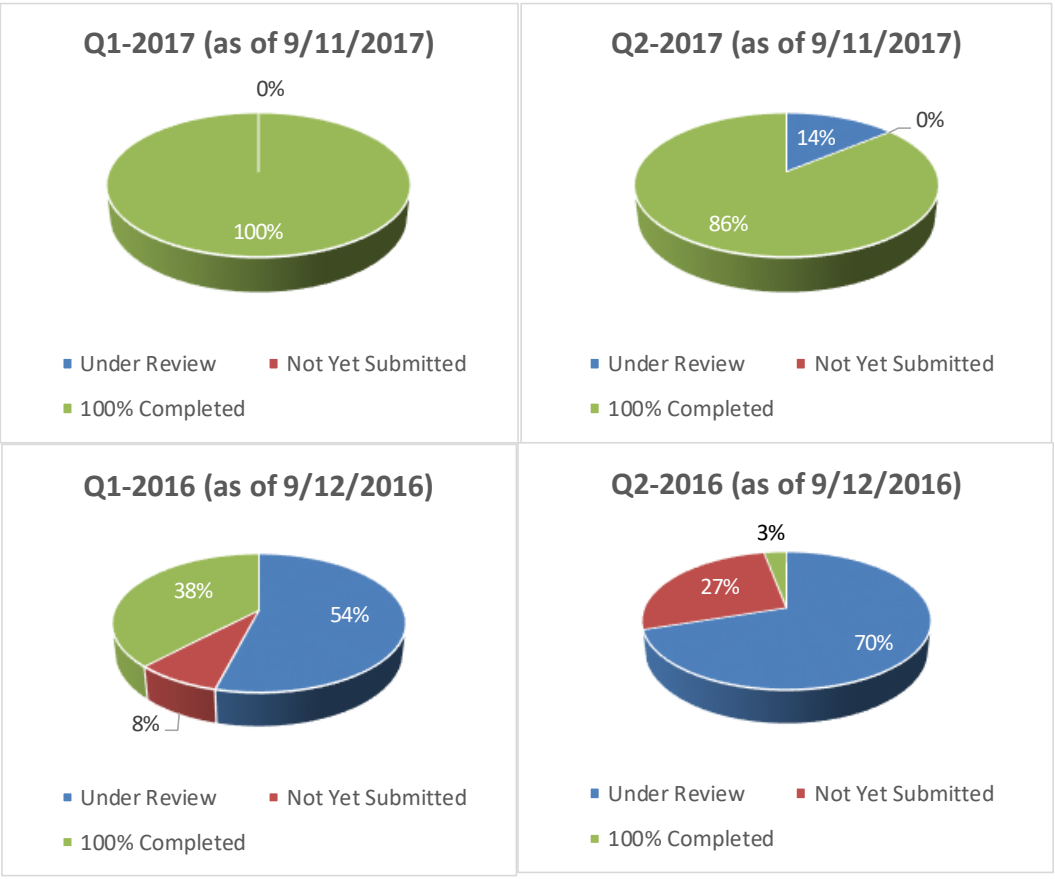


On-Call Stipends
The trauma centers' applications for on-call stipends for January through June 2017 have been received and requests for payments will be made this month.

CENTER FOR ANALYSIS AND INFORMATION SYSTEMS

Cost and Quality Analysis – Kenneth Yeates-Trotman

MCDB Data Submission Status, Payor Compliance, and Technical Support
Payors are submitting data to the MCDB portal at a faster rate with fewer mistakes than a year ago.
Results show that the quality of data submitted by most payors to the MCDB has improved when comparing submissions for 2017 vs. 2016. For example, as of 9/11/2017, 100% of all payors have passed all data validation checks performed by Social & Scientific Systems (SSS, MCDB data vendor) for the 2017 first quarter data submissions, compared to only 38% for the 2016 first quarter submissions at about the same time a year ago. Also, 86% of all payors data for second quarter 2017 has passed all data validation checks compared to only 3% for the second quarter of 2016 at the same time last year. Please see exhibit below. This improvement in data quality submissions is mainly due to more reminders sent to payors from MHCC and SSS for them to learn from prior mistakes made in prior quarterly data submissions. Also, reminders sent to payors that MHCC reserve the right to impose penalties on payors for late data submissions (COMAR 10.25.12: up to $1,000 per day per report) and that the commission has imposed such penalties on some payors recently played a role in the improvements. 2016 MCDB Data: As of 9/11/2017, 100% of all payors have successfully submitted clean data to the MCDB, and SSS is on track to provide an early version of the data by 9/30/2017. User guides for the 2016 data will be available to users by about the end of October 2017.



Collaboration with Maryland Insurance Administration (MIA) on Rate Review
MHCC staff is scheduled to meet with the MIA (Chief Actuary) on 9/14/2017 to discuss the sustainability of future MCDB data releases to the agency in support of its rate review process.
On 7/31/2017, MHCC staff has provided the MIA with 2016 MCDB data to support the agency in its 2018 rate review cycle. MHCC is scheduled to meet with the MIA's chief actuary to discuss the agency's feedback about the 2016 data and also to discuss the sustained costs of providing data to the agency as federal funding will expire at the end of this month (9/30/2017).

2018 HMO Payments to Non-Participating Providers
MHCC staff released the "2018 HMO Payments to Non-Participating Providers" to the MIA on August 17, 2017.
Maryland Health-General Article, §19-710.1 specifies a methodology to calculate minimum payment rates that Health Maintenance Organizations (HMOs) must pay to non-contracting (non-trauma) providers that provide a covered evaluation and management (E&M) service to an HMO patient. MHCC is required to annually update these minimum payment rates, which are published by the MIA. As specified in the law, E&M services as defined by the Centers for Medicare and Medicaid Services (CMS) in the Berenson-Eggers Type of Services (BETOS) terminology calculated from the CMS Medicare Physician Fee Schedule that applied in August of 2008. These fees are adjusted by the cumulative Medicare Economic Index (MEI) before the start of each new calendar year. MHCC and MIA have agreed to modify the methodology if there is a new E&M services code included in the BETOS E&M categories. Fee levels for new codes are based on the current Medicare Physician Fee Schedule for the geographic region and inflated using the MEI in subsequent years. The MHCC staff has updated these payment rates by the law. These rates are published on the MIA website (http://www.mdinsurance.state.md.us/Insurer/Pages/MHCCDataRegardingHMOPaymentstoNonParticipatingProviders.aspx) and disseminated to Maryland HMO's via this site.

Network for Regional Healthcare Improvement (NRHI) Total Cost of Care (TCoC)
MHCC staff delivered results to complete the final step of NRHI's Phase III TCOC national benchmark reporting.
The MHCC staff has completed and delivered the TCRRV (Total Care Relative Resource Value) tables for Phase III of the TCoC project on 8/25/2017. The tables were due to NRHI on 8/31/2017. Staff have reviewed feedback from NRHI on the tables and have already responded to a handful of questions about the tables. The TCRRVs is a comprehensive set of relative values designed to evaluate resource use across all types of medical services, procedures, and place of service. The values are independent of price and can be used to evaluate the resource consumption of providers, hospitals, physicians, and health plans against their peers in treating risk-adjusted populations/conditions. HealthPartners developed the TCRRV software. The TCRRV results are commonly used to identify instances of overuse/efficiency, and to measure price variations. For more information about HealthPartners, visit https://www.healthpartners.com/hp/about/tcoc/toolkit/index.html. MHCC staff also delivered attribution results (attribute members to a PCP) to NRHI which are already approved by NRHI. For more information about NRHI, visit http://www.nrhi.org/about-nrhi/. Finally, the MHCC staff is currently performing the data aggregation steps to combine ACG, TCRRV, and Attribution results into a single data set. This data aggregation is the final step for the national TCoC benchmark calculation by NRHI. The data set will be delivered to NRHI by 9/15/2017 which is about two weeks ahead of the scheduled 9/29/2017 timeline. During the next few weeks, staff will be working on a community wide TCoC reporting by county. The report will show PMPM for attributed patients (ages 18 – 64) and TCoC indices (Total Cost Index, Price Index, and Resource Use Index) by Maryland county for medical only (institutional inpatient, institutional outpatient, and professional) for the calendar year 2015. This report is due to NRHI on 9/29/2015.

Database Development and Applications – Leslie LaBrecque

Data Release

The Data Staff completed two new data use agreements, updated one, extended two, expired one, and is assisting one entity with completing a DUA:

- assisted Colorado Healthgrades with DC inpatient data release questions
- completed a data use agreement with HSCRC for their access to the DC inpatient data
- completed a data use agreement with Altarum for their access to the APCD for the upcoming total cost of care website
- worked with BRG to update their DC inpatient data use agreement and extend their APCD use
- assisting the Maryland Health Benefit Exchange and their contractor Hilltop with a new data use agreement for access to the APCD
- worked with the University of Maryland to extend their use of the APCD data for the Rural Health study and to close out the geographic variation study until a later point in time when an umbrella DUA is completed

Google Smartsheet tracking was created for all data DUAs, (including the privately insured data and the DC Inpatient file), including tracking of required quarterly reporting by data release recipient. A new member of the programming staff was trained to take over data release tracking.

Data Processing and Tech Support

The Data Staff prepared the FY2019 software budget, is assisting in the planning phase of upgrading the SAS server, performed various data processing activities, and participated in price transparency website meetings and discussions.

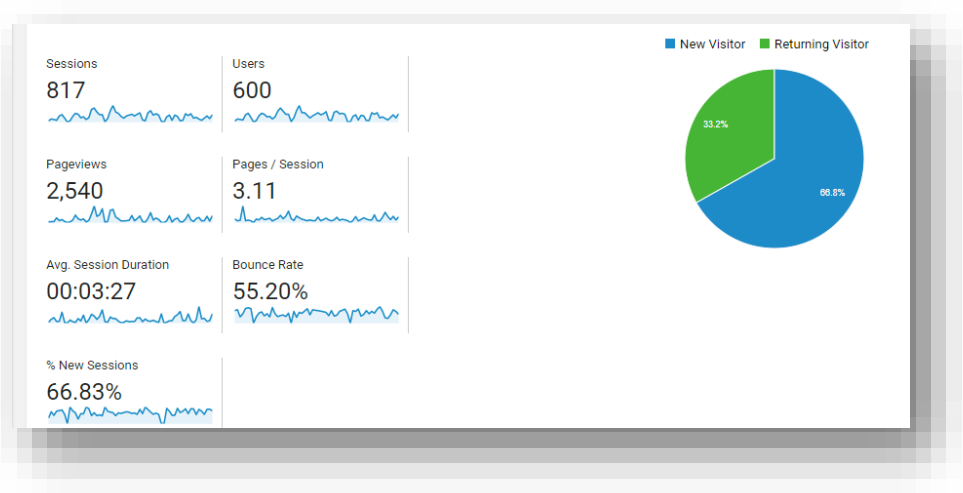
With regard to data processing, staff worked on 2017 quarter 3 hospital outpatient, inpatient and psychiatric data and extracted 2017 quarter 2 data for inpatient and outpatient to send to the hospital guide vendor. Staff augmented the DC inpatient and outpatient files with new charge fields and made them available to approved requestors. Staff processed the CathPCI 2016 quarter 4 data and began processing the 2017 quarter 1 data. Staff assisted the HIT staff with using the CMS National Plan and Provider Enumeration System file to improve the NPI on the physician database. Staff also standardized physician addresses for 2015-2016 and 2014-2015 physician data. Staff assisted Hilltop with changes in the latest Minimum Data Set download for January thru June 2017.

Web Applications

The Data Staff made various improvements to the website, web applications, Facebook and twitter accounts. These improvements included: implementation of a calendar feature on the MACRA events page; reworking of the MHCC twitter and Facebook logos; and implementation of Title IV of the civil rights act for Limited English Proficiency on our website directed towards individuals who do not speak English as their primary language.

Internet Activities

Data from Google Analytics for the months of July and August 2017



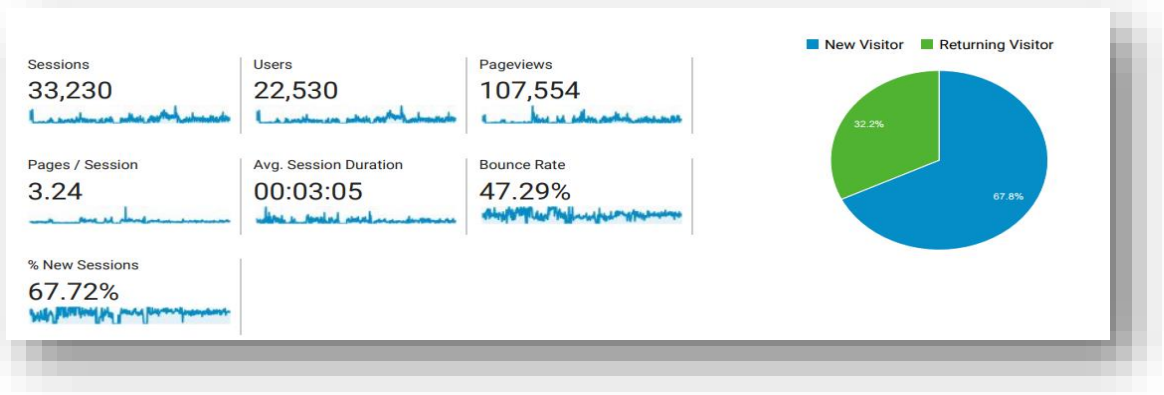
● Bounce rate is the percentage of visitors that see only one page during a visit to the site.

- As shown in the chart above, the number of sessions to the MHCC website for the months of July & August 2017 was 817 and of these, there were 66.83% new sessions. The average time on the site was 3:27 minutes. Bounce rate of 55.20% 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.

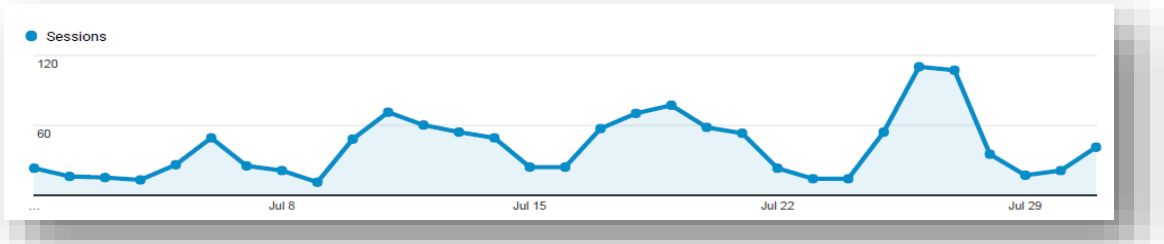
- Typically, visitors to the MHCC website arrive directly, by entering an MHCC URL or referencing our saved URL, via a search engine such as Google, or from a referral through another State site. Visitors who arrive directly are typically aware of MHCC, but visitors arriving via search engines and referrals are more likely to be new users.

- The highest referral source was from the mhcc.maryland.gov. Other government agencies include dhmh.maryland.gov, hscrc.state.md.us. Among the most common search keywords in July and August were: “Maryland Health Care Commission”, “assisted living facilities”, “home based care” and “home health care agencies”.

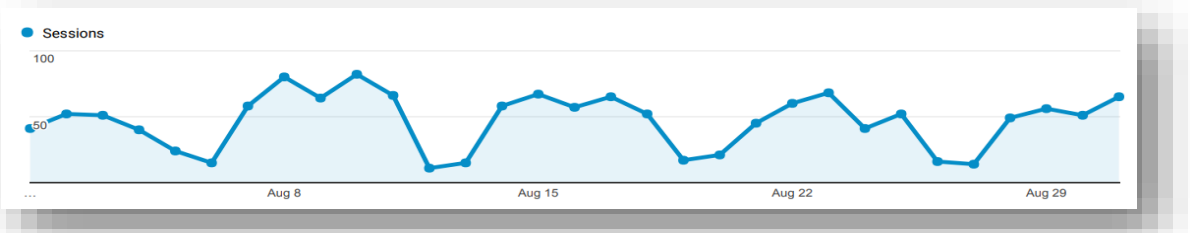
Since the site was released in December 2014, there have been 22,530 users of the consumer site and 107,554 page views. On average, 683 users per month have visited the site. About 68% of users are new visitors. In July 2017 the MHCQR site had 937 users and 4,106 page views, an increase from 839 users and 3,492 page views in June. In August 2017, the MHCQR site saw another increase in both users (1,117) and page views (5,244).



July



August



The average time spent on the site in July and August was approximately 3 minutes. A discussion of the Maryland Health Care Quality Reports can be found in the Center for Quality Measurement and Reporting section.

Special Projects – Janet Ennis

Health Insurance Rate Review and Medical Pricing Transparency:
CCIIO Cycle III and Cycle IV Grants

Staff requested a No Cost Extension from CCIIO to extend the Cycle IV grant beyond this month so that the one outstanding milestone under the grant can be completed; i.e., the launch of the consumer website displaying the total cost for four procedural episodes based on commercial data: hip replacement, knee replacement, vaginal delivery, and endoscopy which will occur next month. A grant extension will also allow staff and our contractors to develop similar data displays using Medicare data.

Mandated Health Insurance Services
Staff received a request from the Senate Finance Committee and the Health and Government Operations Committee to conduct an actuarial analysis on the medical, fiscal, and social impact of mandating insurance coverage in the fully-insured individual and large group markets for the coverage of fertility preservation procedures for iatrogenic infertility. Coverage for this service was proposed under Senate Bill 918 during the 2017 legislative session but failed to pass. MHCC contracted with NovaRest, consulting actuaries, to prepare this analysis. NovaRest will present the results of this evaluation to the Commission at the November 2017 public meeting.

Policy, Cross-Payer & Workforce Analyses– Mahlet 'Mahi' Nigatu

Episode of Care Project
The release of the Consumer website, Wear The Cost, is scheduled for October 19th.
After the decision was made to delay the website release date from July, we decided to take the opportunity to include 2015 data in the transparency tool. In the mid-October release, the cost and quality measures to be displayed will now be based on 2014 and 2015 Commercial Fully insured claims data.

The consumer website will display healthcare prices and quality measures for entire episodes of care, along with supplemental information. The site is titled "Wear the Cost" and will illustrate the variation that exists in price and quality for the same episode type across Maryland hospitals. Episodes are created using Altarum's (in the past known as HCI3) PROMETHEUS episode of care grouping software. The first public version of the site will include four procedural episodes: total hip replacement, total knee replacement, hysterectomy, and vaginal delivery.

Altarum, Social Scientific Systems (SSS), Wowza, (a subcontractor to SSS) and Freedman Healthcare LLC, our PMO contractor continued working together on implementing changes to the website design and content, creation of materials for the press conference, production of the new episode file, and the creation of an introductory boot camp for hospitals whose data will be shown on the website to provide a background on project objectives and the PROMETHEUS episode grouper used for the project. The boot camp for hospitals will be held on the last week of September.

CENTER FOR HEALTH CARE FACILITIES PLANNING AND DEVELOPMENT

Acute Care Policy and Planning - Eileen Fleck

State Health Plan: COMAR 10.24.11, General Surgical Services
Staff posted draft regulations for informal comment on July 20, 2017. Staff reviewed these comments and developed revised draft regulations for consideration at the September Commission meeting. Staff also analyzed data on surgical volume from other select states with and without Certificate of Need programs.

Rural Health Study
Center staff participated in planning activities for the Rural Health Care Study, including developing the agenda and materials for the work group meeting held on July 25, 2017. Staff also provided feedback used for the development of draft reports on three topics.

Long Term Care Policy and Planning – Linda Cole

Hospice Survey
The FY 2016 Maryland Hospice Survey has now been completed. Staff is now working on data cleaning and edits to produce an updated Public Use Data Set.

Hospice Quality Measures
A brief report was prepared to provide background on the status of hospice quality reporting and to assess the performance of Maryland hospice programs. Staff will continue to monitor this data.

Minimum Data Set (MDS)
Staff continues to work with The Hilltop Institute at UMBC, its MDS and Long Term Care Planning consultant. The following reports have been completed during the past two months: Impact of Changes in Maryland Medicaid on MDS Manager Programs; MDS Manager Design Plan; Consumer Guide Report data; and a draft report on the Quality Review Process. An updated file for CY 2016 data was also produced. In August, MHCC and Hilltop staff met to begin work on the Long Term Care Survey Programs.

Home Health Agency (HHA) Certificate of Need (CON) Applicants
Center staff held a pre-application conference on July 19, 2017 for the two applicants which submitted letters of intent to either establish an HHA or expand their authorized service area into the Lower Eastern Shore region, which consists of Dorchester, Somerset, Wicomico and Worcester Counties. Planning and CON staff clarified the CON application acceptance rules and CON review standards in the HHA Chapter (COMAR 10.24.16). Planning staff distributed information on the HHA public use data files and described how to navigate the Commission's website to access the HHA utilization tables and raw data from the Commission's HHA Annual Surveys.

Planning staff continue to provide technical assistance to CON staff in reviewing documentation submitted by the applicants to assess whether the reported information meets the Commission-approved quality measures and performance thresholds used for the 2017 HHA CON review.

Home Health Agency Inventory
Planning staff continues to coordinate with the Office of Health Care Quality to assure that the listed jurisdictions on the HHA licenses are accurate and consistent with Commission records for determining an HHA's authorized service area. Commission staff continues to monitor changes in HHA ownership.

Home Health Agency Survey
Staff is performing testing and working with the programmer to finalize the survey application. Staff expects the survey data collection to begin in the last quarter of 2017.

Long Term Care Survey
The annual Long Term Care Survey data collection for 2016 is complete with 100% of comprehensive care and chronic care facilities' data received and accepted by the due date. Ninety-nine percent of the Adult Day Care (103/104) and Assisted Living surveys (372/377) were received, with one adult day care and five assisted living facilities being fined for non-compliance. Waiver notice letters were issued to 10 facilities for submitting the survey within the 10 day grace period in response to the notice of assessment of fine and right to contest letter. Two facilities completed the survey after the fine was assessed and received a suspension of the fine. Staff is working with the state contractor by providing the long term care and Medicaid cost report data, and program demonstration to have the programs updated and reports created. Staff will be responsible for auditing and reviewing the reports prior to the creation of the final data sets and reports.

Certificate of Need – Kevin McDonald

CONs Approved

Riva Road Surgical Center, LLC – (Anne Arundel County) – Docket No. 17-02-2392
Establishment of an ambulatory surgical facility (ASF) through the addition of a second operating room at a physician outpatient surgery center (POSC).
Approved Cost: $741,499

Visiting Nurse Association – Docket No. 17-R1-2393
Expansion of an existing home health agency's (HHAs) authorized service area. Jurisdictions added are Caroline, Kent, Queen Anne's and Talbot Counties.
Approved Cost: $34,000

CON Letters of Intent

Millennium Home Care. LLC
Establish an HHA providing services on the lower Eastern Shore (Dorchester, Somerset, Wicomico and Worcester Counties).

Visiting Nurse Association of Maryland
Expand an existing HHA's authorized service area to include the lower Eastern Shore (Dorchester, Somerset, Wicomico and Worcester Counties).

Peninsula Regional Medical Center – (Wicomico County)
Expand the hospital's acute psychiatric service program by introducing child and adolescent services. The program will operate through a 15-bed psychiatric unit.

Meritus Enterprises, Inc.- (Washington County)
Relocation of a temporarily delicensed ASF (four operating rooms).

Thomas Johnson Surgery Center – (Frederick County)
Establish an ASF through the addition of a second operating room at a POSC.

Brinton Wood Nursing & Rehabilitation Center – (Carroll County)
Relocation of a 60-bed comprehensive care facility (CCF).

Maryland Baptist Aged Home – (Baltimore City)
Replacement of a 29-bed CCF with a 75-bed CCF.

Pre-Application Conference

Lower Eastern Shore HHA Projects
Millennium Home Care, LLC
Visiting Nurse Association of Maryland
July 19, 2017

Peninsula Regional Medical Center – Wicomico County
August 16, 2017

Western Maryland ASF Projects
Meritus Enterprises
Thomas Johnson Surgery Center
August 16, 2017

Central Maryland CCF Projects
Brinton Wood Nursing & Rehabilitation Center
Maryland Baptist Aged Home
August 16, 2017

CON Applications Filed

Bethesda Chevy Chase Surgery Center – (Montgomery County) – Matter No. 17-15-2401
Establish an ASF through the addition of a second operating room at a POSC.
Estimated Cost: $1,759,618

Minerva Home Health – (Southern Maryland) – Matter No. 17-R3-2402
Establish an HHA to serve Southern Maryland (Calvert and St. Mary's Counties).
Estimated Cost: $122,600

UM-Upper Chesapeake Medical Center – (Harford County) – Matter No. 17-12-2403
Establish a 40-bed special hospital-psychiatric in Havre de Grace.
Estimated Cost: $52,421,120

Coastal Hospice – (Wicomico County) – Matter No. 17-22-2404
Establish a 12-bed hospice home and outreach center..
Estimated Cost: $7,998,114

MedStar Franklin Square Medical Center – (Baltimore County) – Matter No. 17-03-2405
Introduce kidney transplantation services.
Estimated Cost: $0

MedStar Franklin Square Medical Center – (Baltimore County) – Matter No. 17-03-2406
Introduce liver transplantation services.
Estimated Cost: $75,800

Change in Approved CON Filed
Washington Adventist Hospital – (Montgomery County) – Docket No. 13-15-2349
Add a central utility plant and parking garage to the approved plan for a relocated general hospital campus in Silver Spring.
Estimated Cost: $64,145,958

Exemption from CON Requests Filed
University of Maryland (UM) Upper Chesapeake Medical Center (UCMC) and UM Harford Memorial Hospital (HMH) – (Harford County)
Conversion of UM HMH to a freestanding medical facility (FMF).
Estimated Cost: $51,962,824

UM UCMC and UM HMH – (Harford County)
Addition of medical/surgical/gynecological/addictions beds, observation beds, and shell space at UM UCMC through consolidation of UM UCMC and UM HMH. The consolidation of the two general hospitals is related to the conversion of UM HMH to an FMF.
Estimated Cost: $74,379,294

Withdrawal of Pending CON Applications
Plastic Surgery Specialist d/b/a Mid-Atlantic Surgery Center (Anne Arundel County) – Docket No. 16-02-2381
Conversion of a single specialty ASF created through a determination of coverage to a multi-specialty ASF.
Estimated Cost: $500,000
Determined to not require CON review and approval.

Determinations of Coverage

- **Ambulatory Surgery Centers**

Axis Surgery Center, LLC – (Prince George's County)
Establish an ambulatory surgery center with one non-sterile procedure room to be located at 6196 Oxon Hill Road, Suite 610A in Oxon Hill.

- **Acquisition/Change of Ownership**

Chesapeake Eye Surgery Center, LLC – (Anne Arundel County)
Acquisition of Chesapeake Eye Surgery Center, LLC, a two operating room ASF, by Chesapeake Eye Care Company, LLC.

Columbia Urological Surgery Center, LLC – (Howard County)
Change in ownership of a one operating room POSC. The Columbia center is being acquired by Chesapeake Urology.
New Name of Facility – Summit Ambulatory Surgical Center, LLC

Brinton Woods Nursing & Rehabilitation Center – (Carroll County)
Acquisition of a majority ownership share of this 60-bed Sykesville CCF by LBH Carroll County Nursing and Rehabilitation, LLC, an affiliate of LifeBridge Health, Inc.
Purchase Price: $2,750,000

Green House Residences at Stadium Place – (Baltimore City)
Acquisition of this 49-bed Baltimore City CCF by Greenhouse Residence Care and Rehabilitation Center, LLC.
Purchase Price: $70,000

Green House Residences at Stadium Place – (Baltimore City)
Acquisition of the real assets of Green House Residences at Stadium Place by 1010 East Street Realty Holdings, LLC.
Purchase Price: $3,050,000

- **Capital Projects**

MedStar Good Samaritan Hospital – (Baltimore City)
A capital expenditure for development of an outpatient service center, the Center for Chronic Disease Management, in "repurposed inpatient space."
Estimated Cost: $3,500,000 with $1,000,000 being requested from the MHA Bond Program

Howard County General Hospital – (Howard County)
A capital expenditure for a building expansion to house a 23-bed observation unit, replacing the current observation unit, and a 20-bed acute psychiatric unit, replacing the current psychiatric unit.
Estimated Cost: $38,728,619

- **Waiver Beds**

Bethesda Health & Rehabilitation Center – (Montgomery County)
Addition of 10 CCF beds bringing total CCF bed capacity to 195.

Citizen's Care & Rehabilitation Center of Frederick – (Frederick County)
Addition of two CCF beds bringing total CCF bed capacity to 172.

CENTER FOR HEALTH INFORMATION and INNOVATIVE CARE DELIVERY

Health Information Technology Division – Nikki Majewski, Division Chief

Health IT Roadmap development

Staff continue to engage stakeholders in the identification of goals for advancing health information technology (health IT) statewide. The draft framework is intended to identify actions that should be taken by stakeholders to increase health IT adoption. The roadmap is targeted for completion at the end of the year.

Electronic advance directives – building awareness

Staff assisted the Maryland Department of Health's (MDH's) in evaluating proposals for the identification of a faith-based organization to conduct community engagement activities on advance directives. HB 1385 (2016 legislative session) expands the scope of education and outreach efforts, and requires MHCC to develop a State Recognition program for electronic advance directive services. Commissioners approved, as permanent, COMAR 10.25.19: *State Recognition of an Electronic Advance Directives Service* during the June 15, 2017 meeting. The Governor announced on July 14, 2017 that promulgation of any new or pending regulations would be temporarily halted while the Regulatory Reform Commission conducts a review.

mHealth grantee expands recruitment

Staff provided guidance to the round one mobile health (mHealth) grantee, Johns Hopkins Pediatrics at Home (PAH), as they expand recruitment to include pediatric asthma patients at Johns Hopkins Community Physician practices. PAH aims to reduce hospitalizations and emergency department visits using an mHealth tool.

Privacy and security audit – CRISP

Staff worked with the independent auditors, Myers and Stauffer LC (auditors), to determine the scope and objectives for the 2018 privacy and security audit of the Chesapeake Regional Information System for our Patients (CRISP). In addition, the auditors reviewed the findings from the current audit period with CRISP's Audit Committee.

Independent Verification and Validation review

Staff provided support to Mosaica Partners, the consultant engaged by CRISP to conduct an independent review of the Integrated Care Network initiative, in finalizing the fiscal year-end review. In July 2015, the Health Services Cost Review Commission (HSCRC) requested CRISP to develop a system where multiple providers can coordinate care and integrate their efforts to better meet the needs of patients and the goals of the All-Payer Model.

Health Information Exchange Division – Angela Evatt, Division Chief

Telehealth round three report

Collaboration efforts are underway with the round three telehealth grant recipients (Gerald Family Care; Associated Black Charities; and Union Hospital of Cecil County) to identify leading project themes, outcomes, and lessons learned for the round three telehealth brief. The grant focused on increasing access to care and assisting in care management for patients with chronic diseases.

Telehealth round four and five grantee project support

Support was provided to Gilchrist Greater Living (GGL) in developing their telehealth sustainability plan. GGL is using telehealth to demonstrate the impact in primary care. Project implementation guidance was also provided to the University of Maryland Shore Regional Health (Shore Health) to increase access to palliative care and to expand behavioral health services to patients in Kent and Queen Anne's Counties.

Telehealth workgroup

Staff sought volunteers from hospital leadership to participate in a workgroup to assist in developing requirements for a round six telehealth grant opportunity. Two use cases will be considered by the workgroup: 1) remote medication management/reconciliation and 2) medication-assisted treatment of opioid addiction via telehealth. The workgroup will meet virtually through September.

HIE care alerts using claims data

The Electronic Data Interchange (EDI) Workgroup (workgroup) finalized the identification of electronic ambulatory claim transaction data segments and elements that could inform care delivery when integrated with a health information exchange (HIE). The workgroup consists of representatives from CRISP, Availity, eClinicalWorks, Columbia Medical Practice, and University of Maryland Faculty Physicians.

HIE privacy and security policy development

Staff convened the HIE Policy Board (workgroup), a staff advisory workgroup. Participants discussed potential policies for access, use, and disclosure of sensitive health information required to comply with federal regulations. The workgroup also discussed HIE policy around intrastate and inter-HIE sharing of electronic health information.

Telehealth education – cross collaboration

Planning activities are underway to convene virtual education sessions among early adopters of telehealth. Participants include MHCC grantees, about seven organizations that received funding from CareFirst BlueCross BlueShield, and physician practices using telehealth. The sessions will focus on adoption challenges and sharing of best practices.

EHR and telehealth adoption assessment

Assessments are underway to identify EHR adoption challenges among physicians and dentists and to assess telehealth adoption among physicians. Assessment findings will inform the development of Center initiatives. Staff developed an ambulatory physician electronic health records (EHRs) adoption information brief using data from the Board of Physicians (BOP) license renewal file.

EDI Progress Report – compliance

The 57 payors identified under COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks* for reporting in 2017 submitted an Electronic Data Interchange (EDI) Progress Report. Staff provided guidance to payors in completing the report, which includes census level information on electronic administrative transactions. The information is used to develop initiatives focused on increasing provider use of technology.

Innovative Care Delivery Division – Melanie Cavaliere, Division Chief

Practice Transformation Network reporting

Staff provided support to Practice Transformation Network (PTN) coaches in obtaining key performance indicators from nearly 90 practices for the first quarter of 2017. The MHCC, in partnership with MedChi, The Maryland State Medical Society, and the Maryland Learning Collaborative, are a subcontractor to the New Jersey Innovation Institute PTN, recipient of the Centers for Medicare & Medicaid Services (CMS) PTN grant.

PTN MACRA survey and report – building awareness

Staff developed a Practice Transformation Network (PTN) Medicare Access and CHIP Reauthorization Act of 2015, Quality Payment Program (QPP) practice survey. The survey aims to assess practice experiences prior to and after enrolling in the PTN. The findings will be used by staff to develop initiatives aimed at increasing practice awareness of QPP.

Maryland Primary Care Program outreach activities

Staff and MDH convened several stakeholder meetings to review the Maryland Primary Care Program (MDPCP). Staff is collaborating with MDH and HSCRC to develop an option for ambulatory providers to earn value-based incentive payments through practice transformation. The MDPCP model design is under review by CMS.

Maryland Multipayer Patient-Centered Medical Home program shared savings

Staff finalized the 2015 performance year commercial shared savings calculation payments for qualifying practices that participated in the Maryland medical home multipayor pilot program. Shared savings calculations for Medicaid shared savings for the 2015 performance year are underway.

CENTER FOR QUALITY MEASUREMENT AND REPORTING

The Maryland Health Care Quality Reports (MHCQR) website

Maintenance of MONAHRQ Software for Independent Use by MHCC

Staff has obtained access to the AHRQ MONAHRQ software source code and our contractor, AGS, LLC has begun to review the code for continued application within our consumer website. As a reminder, AHRQ will no longer support the MONAHRQ application after this federal fiscal year, but we are confident that AGS will be able to adopt and maintain the application going forward. Staff and AGS participated in the final MONAHRQ webinar held on July 12, 2017 and continue ongoing dialogue with AHRQ to ensure an efficient transition.

Website Promotion: Twenty-five social media posts initiated in July

Staff continues to focus on the promotion of the MHCQR website. There have been 25 social media posts either made or planned for future release in July. Topic posts in July 2017 include National Immunization Awareness month, along with other general summer safety tips and service information for seniors, such as transportation and assistive technology. These topics coincide with the U.S. Department of Health and Human Services National Health Observances and are also designed to link readers back to the MHCQR website. Staff has also continued to disseminate promotional rack cards at off-site meetings and conferences.

Over 20,000 users of the MHQR website since inception

Staff continues to monitor traffic to the site using Google Analytics software. Since the new site was released in December 2014, there have been 20,667 users of the consumer site and 98,204 page views. In June 2017 the MHCQR site had 839 users and 3,492 page views, a slight decrease from 861 users in May but a slight increase in page views from 3,465. Traffic to the site is presented graphically under the Center for Analysis and Information section of this update.

Maryland hospitals to be assigned Hospital Safety Scores in the fall

The staff works with stakeholders to identity website enhancements and to facilitate greater transparency. To that end, we have been working with the Leapfrog Group to facilitate inclusion of Maryland hospitals in their Hospital Safety Grading System. MHCC will generate certain Hospital Acquired Conditions (HAC) and Patient Safety Indicator (PSI) measures from the HSCRC Inpatient Discharge Data Set to support the Leapfrog transparency initiative. MHCC, in collaboration with The Leapfrog Group, held a webinar for hospital representatives on June 23rd to inform them of the new developments. The webinar was positively received and we are moving forward to formalize the data sharing process for implementation in the fall 2017.

Hospital Quality Initiatives – Courtney Carta

Hospital Initiatives

Maryland continues to lag behind the US on wait times in the ED

Maryland has the longest emergency department (ED) wait times in the country. Staff initially planned to develop a survey to identify potential challenges that contribute to the long ED wait times. However, based on discussions with hospitals and the MHA as well a review of other activities underway in the state, our plans for developing a hospital survey have been placed on hold. The staff will keep abreast of statewide activities and look for ways to add value, such as the development of an inventory of urgent care centers that can be accessed through our consumer website

Health-care Acquired Infections (HAI) Data

Maryland hospitals continue to perform better than the nation on several HAI metrics

Staff completed the final round of HAI data pulls for annual public reporting. The HAI measure results for CY2016 are now posted on the MHCQR website. Infections that were updated include CAUTI and Surgical Site Infections (SSIs) for Colon, Hysterectomy, CABG, Hip, and Knee procedures. Maryland hospitals continue to perform better than the national experience for most infection types. The exceptions are MRSA and surgical site infections associated with Colon procedures, where Maryland hospitals are performing similarly to the national experience. We are eagerly awaiting the release of the HAI CDC Annual Report for national comparisons. Hospital employee flu vaccination rates were also updated to reflect the 2016-2017 flu season. Consistent with the previous flu season, the statewide hospital employee flu vaccination rate is 97%, which is well above the Healthy People 2020 annual target goal of 90%.

Specialized Cardiac Services Data

Maryland requirements for cardiac registry use are changing

In April 2017, the American College of Cardiology and the American Heart Association announced they would end their agreement to maintain the joint (ACTION/GWTG) registry. This new development has implications for our cardiac data collection activities because our current regulations require hospital participation in the joint registry. In light of this news, the staff is working with MIEMSS and the affected hospitals to determine how to move forward. Staff have participated in separate calls with AHA and ACC to discuss advantages, disadvantages, and potential implications of choosing one registry over another.

Health Plan Quality & Performance – Sherma Charlemagne-Badal

Staff is in the process of streamlining the Health Plan Quality Reporting initiative by eliminating Maryland member specific HEDIS audits and CAHPS surveys and transitioning to use of NCQA data based on all plan member results. On July 19, 2017 staff will host a webinar to present and discuss with health plans the proposed changes to the Quality Performance Reporting Requirements (QPRR). Specifically, the MHCC reporting requirements for Healthcare Effectiveness Data Information Set (HEDIS) 2018 and the 5- star methodology used for health plan rating will be reviewed. Plans will have access to the QPRR prior to the conference call and will have until July 28, 2017 to submit formal comments.

Race, Ethnicity, Language, Interpreters, and Cultural Competency (RELICC) results and recommendations were presented to plans via webinar on July 27th and July 28th 2017.

Long Term Care Initiative – Sherma Charlemagne-Badal

The employee flu vaccination rate for Nursing Homes is 87%; 55% for Assisted Living Facilities

The MHCC 2016-2017 Health Care Worker Influenza Vaccination survey captured data from Maryland Medicare certified nursing homes and assisted living facilities licensed for ten (10) or more beds operating in the state of Maryland. Survey results indicate that nursing home and assisted living health care worker vaccination rates remained fairly stable across the 2015-16 and 2016-17 flu seasons. The survey results are presented below:

Nursing Home Statewide Stats	2012-13	2013-14	2014-15	2015-16	2016-17
Vaccination Rate	73.55%	79.34%	85.50%	87.63%	**86.90%**
Nursing Homes Submitting a Survey	225	230	230	229	**228**
Nursing Homes with a staff vaccination rate of 95% or higher	16.4% (37)	23.5% (54)	41.3% (95)	43.7% (100)	**42.8% (98)**
Nursing Homes with 60% or more staff vaccinated*	70.2% (158)	78.7% (181)	84.3% (194)	88.0% (202)	**85% (193)**
Mandatory Vaccination Policy					
Mandatory policy in place	22.4%	31.3%	46.1%	48.5%	**50.0%**
Plan to implement mandatory policy in the upcoming influenza season	14.8%	19.6%	11.3%	9.2%	**10.1%**
No plan for mandatory policy	62.8%	49.1%	42.6%	42.3%	**39.9%**

Assisted Living Statewide Stats	2012-13	2013-14	2014-15	2015-16	2016-17
Vaccination Rate	49.0%	53.2%	57.9%	56.2%	**54.7%**
Assisted Living Facilities Submitting a Survey	318	334	376	379	**370**
Reason for Declining Vaccination					
Medical	3.1%	2.7%	1.5%	2.0%	**2.9%**
Religious	1.0%	1.2%	1.3%	1.4%	**0.9%**
Other	45.7%	42.9%	39.3%	40.3%	**41.6%**

*2012 StateStat Goal

The Assisted Living Facility profile, contact, ownership, services and private pay daily rates data has been updated on the Consumer Guide. Staff continues to experience delays in updates to the guide. Consumer inquires continue to be handled by division staff.