MHCC | MARYLAND HEALTH CARE COMMISSION

REPORT to the GOVERNOR

Fiscal Year 2008

(July 1, 2007 through June 30, 2008)

Martin O'Malley
Governor

Gail R. Wilensky, Ph.D.
Vice Chair

Rex W. Cowdry, M.D.
Executive Director

http://mhcc.maryland.gov/

Our vision is a state in which informed consumers hold the health care system accountable and have access to affordable and appropriate health care services through programs that serve as models for the nation.

The Maryland Health Care Commission's mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public.

The Commission is composed of fifteen members appointed by the Governor, with the advice and consent of the Senate, for a term of four years. A brief biography of each Commission member follows.

Marilyn Moon, Ph.D., Chair, is Vice President and Director of the Health Program at the American Institutes for Research. A nationally-known expert on Medicare, she has also served as a Senior Fellow at the Urban Institute and as a public trustee for the Social Security and Medicare trust funds. Marilyn Moon has written extensively on health policy, both for the elderly and the population in general, and on social insurance issues. Her most recent book, Medicare: A Policy Primer, was published in 2006. From 1993 to 2000, Moon also wrote a periodic column for the Washington Post on health reform and health coverage issues. She has served on a number of boards for non-profit organizations, the Medicare Rights Center, and the National Academy of Social Insurance. Dr. Moon earned a Ph.D. in economics from the University of Wisconsin--Madison. Previously, she was an associate professor of economics at the University of Wisconsin, Milwaukee, a senior analyst at the Congressional Budget Office, and the founding Director of the Public Policy Institute of the American Association of Retired Persons. (Term Expires 9/30/10)

Gail R. Wilensky, Ph.D., Vice Chair, is a Senior Fellow at Project Hope, an international health education foundation where she analyzes health care reform policies and changes in the medical marketplace. From 2001 to 2003, she co-chaired the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans, which covered health care for both veterans and military retirees. She also served as Assistant for Policy Development to President George Herbert Walker Bush, on health and welfare issues. Prior to that, Dr. Wilensky served as Administrator for the Health Care Financing Administration, overseeing the nation's Medicare and Medicaid programs.

Rev. Robert L. Conway was employed by the Calvert County Public School System for more than thirty years, serving as an elementary school teacher and principal. He is a graduate of Bowie State, George Washington University, and the Howard University School of Divinity. Commissioner Conway, a member of the Board of Directors of Calvert Memorial Hospital for the past nine years, has also served on Maryland's Hospital Bond Project Review Committee for

four years. A resident of Calvert County, Reverend Conway is the pastor of the United Methodist Church.

Garret A. Falcone is the Nursing Home Administrator of Renaissance Gardens, a skilled nursing home facility located in Catonsville. He has over 13 years experience in long term care. Commissioner Falcone is a graduate in Business Management from Fairleigh Dickinson University in New Jersey and earned his Masters Degree in Health Services Administration from Russell Sage College in Albany, New York. He is a member of the Mid-Atlantic Non-Profit Health and Housing Association and served as Chairman from 1996-1998. He was awarded the MANPHA Chairmen's Award in 2001 and the Special Chairmen's Award, AEGIS Inc., in 2001. He resides in Carroll County.

Tekedra McGee Jefferson is an Assistant General Counsel and Director, Public Policy, at AOL LLC. She manages AOL's state and federal public policy issues, as well as telecommunications matters. Prior to joining the Public Policy team, she headed the AOL transactional team responsible for complex technology and network services agreements. Before joining AOL in 2001, Commissioner Jefferson worked at Startec Global Communications where she managed acquisition of international Internet and technology companies. She began her legal career in the telecommunications and intellectual property groups at Washington, DC law firm of Steptoe & Johnson LLP. Commissioner Jefferson received her J.D. from the Columbia University School of Law and her B.A. magna cum laude from Trinity College. She currently serves on the advisory boards of several Maryland businesses; and she and her husband, Samuel, are Maryland business owners. (Term Expires 9/30/11)

Sharon K. Krumm, R.N., Ph.D. is the Administrator and Director of Nursing at the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins Hospital. She is jointly appointed is an Assistant Professor at the Johns Hopkins School of Nursing, and the Johns Hopkins School of Medicine. Commissioner Krumm received her Ph.D., as well as two nursing degrees, from the University of Missouri. She resides in the City of Baltimore.

Jeffrey D. Lucht, FSA, MAAA, is the general manager of Key Accounts for the Mid-Atlantic region of Aetna Health, Inc. He joined Aetna in 1985. From 1985 through 1994, he held various actuarial, financial, and underwriting positions in Aetna's Connecticut offices, including those of National Accounts Financial Officer and CHAMPUS Financial Officer. In 1994, Mr. Lucht assumed the role of Director, Sales and Customer Relations for the Maryland market.

Barbara Gill McLean recently retired from the position of Senior Policy Fellow in the Office of Policy and Planning at the University of Maryland School Of Medicine. Prior to joining the

School in January 2005, Ms. McLean served as the Executive Director of the Maryland Health Care Commission (MHCC) from 2000-2004 and as Deputy Director of Performance and Benefits at MHCC and one of its predecessor commissions from 1996-2000. Responsibilities included the design and continued development of a standard benefit plan for small employers, implementation of a system to annually evaluate the quality and performance of HMOs, hospitals and nursing homes for public reporting and oversight of the Certificate of Need program. Ms. McLean also led a State's initiative for improving patient safety including the creation of the Maryland Patient Safety Center. Ms. McLean received a Masters in Sociology and completed doctoral studies in policy sciences at the University of Maryland. She also served as principal analyst for the Environmental Matters Committee in the Maryland House of Delegates from 1983 to 1991 and as Senior Legislative Analyst for the University of Maryland, Baltimore and the University of Maryland Medical System from 1991 to 1996. (Term Expires 9/30/10)

Roscoe M. Moore, Jr., D.V.M., Ph.D., D.Sc., is the Founder and President of PH RockWood Corporation, which is focused on the prevention, treatment, and control of infectious diseases worldwide. Until his retirement in December 2003, Dr. Moore served with the U.S. Department of Health and Human Services. For the last twelve years of his career, he was the principal person responsible for development support in the Office of the Secretary, Department of Health and Human Services, with the primary emphasis on Continental Africa and other less developed countries of the world. Dr. Moore received his undergraduate degree and Doctor of Veterinary Medicine from Tuskegee Institute his Master of Public Health in Epidemiology from the University of Michigan, and his Ph.D. in Epidemiology from Johns Hopkins University.

Kurt B. Olsen is an attorney and founding partner of Klafter and Olsen LLP in Washington, D.C. The firm focuses on complex commercial litigation including securities, antitrust, consumer, and products liability litigation. A native of Annapolis, Mr. Olsen is a graduate of the U.S. Naval Academy, and a former Navy SEAL. (Term Expires 9/30/11)

Sylvian Ontaneda-Bernales is an attorney with the law firm of Ober, Kaler, Grimes, and Shriver in Baltimore City who specializes in immigration matters. Her practice also includes complex civil litigation. Sylvia is licensed in Maryland and Washington, D.C., and is a member of the Baltimore City Bar Association, the Maryland Hispanic Bar Association, and the Maryland Women's Bar Association. In addition, Sylvia is a volunteer mediator in Baltimore City District One and is engaged in various pro bono and community activities, including mentoring students from Northwestern High School and the University of Maryland, School of Law. She has received the Educator of 2007 award from the Maryland Volunteer Lawyers Service and the 2007 Public Service Award for Outstanding Contribution by an Individual from the Maryland Hispanic Bar Association. Originally from Peru, Sylvia has lived in the United States for 35 years

and in Baltimore since 2003. She earned her U.S. college degrees and J.D. after age 40. She has been a professional print and television journalist, documentary maker, minister, religious publishing editor, college professor, published poet, and jungle explorer. (Term Expires 9/30/11)

Darren W. Petty is President of the Maryland State United Auto Workers (UAW), and represents over 15,000 active and retired members of the UAW. He also serves as Vice President of the Maryland & DC AFL-CIO, which represents over 400,000 working men and women of Maryland. Darren has been with General Motors Corporation since 1989, and currently works at the Allison Transmission Facility in White Marsh serves as the Human Resources Development and Joint Training Representative for the UAW. Darren is a founding member of the Mack Lewis Foundation, an organization dedicated to enriching the lives of Inner City youths through boxing training and tutoring programs in the spirit of the legendary boxing trainer Mack Lewis. Darren is an alumna of Essex Community College and Frances Marion University. He and his wife own a restaurant in Canton, Maryland. He is the proud father of 4 sons. (Term Expires 9/30/10)

Andrew N. Pollak, MD, is the Associate Professor of Orthopaedics at the University of Maryland School of Medicine. He is also a part-time instructor of Orthopaedic Surgery at the Johns Hopkins University School of Medicine. Dr. Pollak has led major research in orthopaedic trauma surgery and emergency medical services. A Baltimore native, Dr. Pollak earned his M.D. from Northwestern University Medical School.

Nevins W. Todd, Jr., M.D. is a retired thoracic surgeon residing in Salisbury, Maryland. A graduate of the University of Maryland Medical School, he is Board Certified in Thoracic Surgery. Prior to his retirement, Dr. Todd practiced medicine for nearly forty years in Salisbury. During that time, he served as Chief of Staff, Chief of Surgery, and Chief of Thoracic Surgery at Peninsula Regional Medical Center. In 1984, Dr. Todd was appointed to the Board of Trustees of the hospital and continues to serve in that capacity today.

Randall P. Worthington, Sr. is the President/Owner of York Insurance Services, Inc., a full service insurance agency located in Forest Hill, Maryland. York Insurance Services, Inc. is the 15th largest property and casualty insurance agency in Baltimore per Baltimore Business Journal list in 2006. He owns Aquila Hall Farms located in Churchville, Maryland. A Harford County native, he earned his B.A degree in Business from Catawba College in Salisbury, North Carolina. (Term Expires 9/30/11)

EXECUTIVE SUMMARY

The Maryland Health Care Commission is an independent state agency located within the Department of Health and Mental Hygiene. Our fifteen Commissioners are appointed by the Governor with the advice and consent of the Senate, come from communities across the state, and represent both the state's citizens and a broad range of other stakeholders.

Our mission is simply stated:

> To plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public.

We pursue this mission through our information gathering and dissemination, our health planning and regulatory powers, and our health policy analyses.

MHCC STAFF AND THE FIVE CENTERS

During FY 2008, the Commission had an appropriation for 62 full time positions and filled one contractual position. The Commission's staff members represent a broad range of backgrounds and skills, including public policy analysis, data management and analysis, health planning, health facilities construction and financing, Medicaid administration, quality assessment, clinical and health services research, and public performance reporting.

The Commission is organized around the health care systems we seek to evaluate, regulate, or influence, bringing a wide range of tools (data gathering, public reporting, planning and regulation) to bear and improve quality, address costs, or increase access. Two of the center - the Center for Hospital Services and the Center for Long-Term Care and Community-based Services - are organized around provider organizations, bringing together under one leadership the expertise and tools to address cost, quality, and access in those sectors of our health care system. Two of the centers include both cross-cutting responsibilities and sector specific efforts: The Center for Healthcare Financing and Policy deals with broad policy issues relating to the organization and financing of health care and with narrower issues relating to the regulation of the small group health insurance market. The Center for Information Services and Analysis conducts broad studies using both Maryland databases and national surveys, but also has specific responsibilities relating to physician services. The fifth center, the Center for Health Information Technology, has responsibilities that cut across sectors to facilitate the adoption of electronic health records and to enable the private and secure transfer of personal health information among sectors.

The organizational chart is attached as Appendix 1. A brief description of each of the Centers follows:

The **Center for Hospital Services** focuses on improving hospital care, bringing together planning, certificate of need, and public reporting of cost and quality under the leadership of Pam Barclay, the Center Director.

- Planning for hospital services and the drafting of the acute care chapter of the State Health Plan are the responsibility of the Center for Hospital Services.

- The entire Certificate of Need program remains within the Center for Hospital Services because hospital certificates of need are the most complex and costly of projects requiring CON action. Maryland hospitals are in the midst of a dramatic rebuilding program, replacing an aging hospital infrastructure through renovation, new construction, and in some cases, consolidation or relocation of facilities.

- The Center oversees specialized inpatient services such as cardiac surgery, obstetrics, pediatrics, and psychiatry, including developing the state health plan chapters, managing certificates of need for these services, and granting appropriate waivers to allow hospitals meeting rigorous criteria to perform emergency angioplasty.

- The Center is committed to providing meaningful information to consumers about the quality and outcomes of care provided in all Maryland acute care hospitals. It publishes the Hospital Guide, containing both general information and specific quality and outcome measures. The Center currently reports on the quality of hospital efforts in surgical infection prevention and is developing strategies to gather and report the rates of key hospital acquired infections. The Center plans to expand public reporting of angioplasty quality and outcomes beyond the current waiver hospitals to include all hospitals performing emergency angioplasty and is examining public reporting of risk-adjusted data on the quality and outcomes of cardiac surgery.

- The Center serves as the lead for a report on emergency department crowding.

- As part of the MHCC's Price Transparency Initiative, the Center, working closely with the Health Services Cost Review Commission, publishes each hospital's charges for the most common Diagnosis Related Groups (DRGs).

The **Center for Long-term Care and Community-based Services** focuses on improving long-term and community-based care, bringing together planning and public reporting efforts under the leadership of Bruce Kozlowski, the Center Director.

- The Center is responsible for health planning regarding long-term and community based care, including the policies guiding the determination of need in the Certificate of Need process for nursing homes, home health agencies, and hospices.
- The Center is responsible for the Commission's study of long-term care vision and needs over the coming 25 years, required by legislation during the 2006 session.
- CON applications for nursing homes, home health agencies, and hospices are managed by the CON staff in the Center for Hospital Services, operating according to policies developed by the Center for Long-term and Community-based Care.

- The Center publishes the Nursing Home Guide for Marylanders, providing an easy way to locate and compare nursing homes on quality and outcomes measures. The Center is also pioneering the public reporting of resident and family satisfaction measures.
- The Center has responsibility for policies and information dissemination related to assisted living programs.

The **Center for Healthcare Financing and Policy** has a specific regulatory responsibility for the small group market for health insurance and a broader responsibility for the analysis of public policy options relating to the organization and financing of health care. Bruce Kozlowski also serves as the Director of this Center.

- This Center is responsible for the small group health insurance market, including regulation of the Comprehensive Standard Health Benefit Plan. Specifically, the Commission is responsible for specifying the benefits and covered services included in the core CSHBP offerings, modifying these when necessary to meet statutory affordability requirements.
- The Center reports on trends in the small group market, including the costs of plans and the degree of concentration in the market, suggesting regulatory changes that will improve affordability, innovation, and value through improved competition.
- The Center's HMO Consumer Guide reports publicly on the performance of and satisfaction with health plans. Traditionally focused on measures of the clinical performance HMOs, the Guide is expanding in two ways. MHCC will now report collaboratively with the Mid-Atlantic Business Group on Health additional measures of health plan quality and value and will soon report on PPOs in addition to HMOs.
- The Center is responsible for the development and analysis of state health policy options affecting the organization and financing of health care. Particular emphasis has been placed on both incremental and non-incremental strategies for expanding health insurance coverage and on strategies to reduce health care expenditures and increase health care value.
- The Commission's commitment to reporting disparities in health and health care is expressed in the Center's Racial and Ethnic Disparities initiative.

The **Center for Information Services and Analysis** has expertise in the creation, maintenance, and mining of large databases, in the management of information technology and networks, and in the analysis and interpretation of population surveys. Ben Steffen serves as the Director of this Center.

- The Center produces key reports to guide health policy, including reports on health expenditures, health insurance, the uninsured and uncompensated care.
- A special focus of the Center will be physician services, including physician reimbursement and reporting on the cost and quality of physician services. The Commission staff has provided consultation to the General Assembly.
- The Center oversees the Maryland Trauma Services Fund and has responsibility for development of its procedures and policy options.
- This Center provides analytic and programming services to other divisions of the

Commission and is responsible for our intranet and web site. Two individuals serve as liaisons to the Center for Hospital Services and the Center for Long-Term Care and Community-Based Services, participating as appropriate in the discussions of those Centers and assuring that the necessary expertise is brought to bear on the other Centers' data gathering, management, and analysis.

The **Center for Health Information Technology** is responsible for the Commission's initiatives in health information technology. David Sharp serves as the Director of this Center.

- The Center, in conjunction with the HSCRC, manages the joint MHCC/ HSCRC initiative to plan and implement state-wide health information exchange.
- The Center staffs the Task Force on the Electronic Health Record, established by the General Assembly.
- The Center is conducting a series of privacy and security studies across health care sectors to understand the potential barriers to widespread adoption of electronic health records and health information exchange.
- The Center conducts HIPAA awareness activities, oversees the state certification of electronic data interchange reporting, and conducts provider education on health information and HIPAA issues.

In addition to the five centers, the Executive Director directly oversees the Executive Direction unit which is responsible for the key functions of budget, user fee assessment, regulations, and procurement. The Government Relations and Special Projects unit which manages the legislative activity of the Commission responds to special requests for information by the Maryland legislature, executive departments, and other external groups and serves as an incubator for newly mandated Commission activities. Finally, the Legal Services unit, composed of two Assistant Attorneys General, provides advice to the Executive Director and the Commission.

BUDGET & FINANCES

In FY 2008, the Commission was appropriated $24,242,229 which includes an appropriation of $13.1 million for the trauma fund. The Commission is funded with special funds through a user fee assessment paid by Nursing Homes, Hospitals, Insurance Companies, and the Health Occupation Boards in order to accomplish its mission and program functions.

ASSESSMENT

The Maryland Health Care Commission's budget is 100% special funds and is funded through a user fee assessment on Hospitals, Nursing Homes, Payers, and through the licensing process of the Health Occupational Boards. Each of these entities contributes to the MHCC budget appropriation according to workload and the assessment is currently capped at $12 million. Currently, the Commission assesses: 1) Payers for an amount not to exceed 32% of the total budget; 2) Hospitals for an amount not to exceed 26% of the total budget; 3) The Health Occupational Boards for an amount not to exceed 20.5% of the total budget; and 4) Nursing Homes for an amount not to exceed 21.5% of the total budget. The amount is derived differently

for each industry and is set every four years based on Commission work load. House Bill 800 (2007) requires the Commission to study the feasibility of bringing other health care industries into the assessment. This report must be submitted to the General Assembly by December 1, 2008.

Surplus

At the close of FY 2008, the Commission's surplus was $4.9 million. The Commission will look to reduce this surplus during FY 2009.

OVERVIEW OF FY 2008 ACCOMPLISHMENTS

July 2007

The Commission approved six-month extensions for waivers to provide primary PCI without on-site cardiac surgery to Doctors Community Hospital and Holy Cross Hospital.

The Commission approved two-year waivers to provide primary PCI without on-site cardiac surgery for Shady Grove Adventist Hospital and Southern Maryland Hospital Center.

The Commission approved CON's for St. Agnes HealthCare Inc. and Maryland General Hospital for expansion and renovation.

The Commission approved Electronic Health Networks (EHNs) certifications for Affiliated Network Services, Ancillary Carey Management, EDI Health Group, Medical Claim and MD On-Line.

August 2007

The Commission adopted as final regulations COMAR 10.25.01- Small Employer Health Benefit Plan Premium Subsidy Program.

The Commission adopted as proposed permanent regulations COMAR 10.25.07 - Certification of Electronic Networks and Medical Claims Clearinghouses.

September 2007

The Commission awarded four Non-Primary PCI Research Waivers to Anne Arundel Medical Center, Shady Grove Adventist Hospital, Southern Maryland Hospital Center and St. Agnes Hospital. The Commission agreed to take no action on applications from Baltimore Washington Medical Center, Johns Hopkins Bayview Medical Center and Holy Cross Hospital. Two waivers are held in abeyance pending completion of the review of Western Maryland Hospitals.

The Commission adopted as emergency regulations COMAR 10.24.10 - Supplement 6 to the Acute Inpatient Services Chapter of the State Health Plan.

The Commission adopted the replacement chapter as proposed permanent regulations for COMAR 10.24.10 - The Acute Care Hospital Services Chapter.

The Commission approved the Certificate of Need for Franklin Square Hospital Center.

The Commission approved the Certificate of Need for Point Lookout Nursing Home in St. Mary's County.

The Commission denied the request for reconsideration from HomeCare Rehab for a Certificate of Need.

October 2007

The Commission approved the Certificate of Need for Fairland Nursing and Rehabilitation Center.

Dr. Dean Farley presented a *Spotlight on Hospital Spending.*

Staff presented the report *Assessment of Privacy and Security Policies and Business Practices: their Impact on Electronic Health Information Exchange.*

The Commission held a special session to discuss the proposed legislation of HB 6 "Working Families and Small Business Health Coverage Act" and agreed to submit a letter of support.

November 2007

The Commission repealed the existing COMAR 10.25.07 - Electronic Health Network Certification and adopted the proposed permanent regulations in COMAR 10.25.07.

The Commission adopted the proposed regulations - COMAR 31.11.06 -Comprehensive Standard health Benefit Plan as permanent regulations.

The Commission approved the Certificate of Need for Upper Chesapeake Medical Center.

The Commission approved a modification of Certificate of Need for Doctors Community Hospital.

Staff presented reports entitled *Long Term Care Report: 2010, 2020 and 2030; Considerations of the Provisions in the SGM as required by HB 1057; Guidelines for Small Employer Wellness Programs; Provisions of Habilitative Services in Maryland* as required by the Joint Chairmen's Report.

Staff presented the recommendations in the *Annual Report on the Maryland Trauma Physician Services Fund.*

December 2007

The Commission approved a Certificate of Need for Williamsport Nursing Home.

The staff released a report on *Options for Consideration on the Small Group Market Reform.*

The Commission approved the release of the *Annual Mandated Health Insurance Services Evaluation* report.

The Commission approved the release of *The Study of Mandated Health Insurance Services: A Comparative Evaluation* report.

The Commission approved the release of the *Final Report on the Limited Benefit Plan in Maryland's Small Group Market.*

The Commission accepted the Report on *Developing a System for Collecting and Publicly Reporting Data on Healthcare-Associated Infections in Maryland* and directed Commission staff to implement the recommendations.

The Commission approved the release of the Interim Report on the Operations, Utilization and Financing of Freestanding Medical Facilities report.

January 2008

The Commission voted to deny the motion filed by St. Agnes to accept its Letter of Intent for participation in the PCI study.

The Commission approved a modification to the Certificate of Need for Washington County Hospital.

The Commission approved the primary PCI Waiver for Howard County General Hospital.

February 2008

The Commission approved a Certificate of Need for Clifton T. Perkins Hospital.

The Commission approved a Certificate of Need for Devlin Manor Health Care Center.

The Commission approved a Certificate of Need for Sinai Hospital.

The Commission approved a Certificate of Need for Johns Hopkins Hospital.

The Commission approved COMAR 10.25.07 - Electronic Health Network Certification as final regulations.

The Commission approved COMAR 31.11.06 - Comprehensive Standard Health Benefit Plan as final regulations.

The Commission approved COMAR 10.25.04 - Hospital Quality and Performance Evaluation as proposed permanent regulations.

The Commission approved COMAR 31.11.14 - Wellness Benefits Under Small Employer Health Benefit Plans as Proposed Permanent and Emergency regulations.

Staff presented a report on *Characteristics of Employer-Sponsored Health Insurance: Results from the Medical Expenditure Survey: Insurance Component.*

Staff presented a report on the *State Health Care Expenditures for 2006.*

March 2008

The Commission approved a Certificate of Need for St. Mary's Hospital.

The Commission approved a modification to the Certificate of Need for Anne Arundel Medical Center.

The Commission presented a briefing on the Small Employer Health Benefit Plan Subsidy Program.

April 2008

The Commission approved a one-year waiver to provide primary PCI without cardiac surgery on-site to Carroll Hospital Center.

The Commission approved a Certificate of Need for Govans Ecumenical Development Corporation.

The Commission approved the planning projects for a Citizen-Centric Health Information Exchange.

Staff presented a spotlight on "Prescription Drug Spending" trends in Maryland.

May 2008

The Commission denied the appeal of Dynamic Visions to overturn the decision to de-docket its Certificate of Need application to establish a home health agency in Montgomery County.

The Commission adopted COMAR 10.25.04 - Hospital Quality and Performance Evaluation System as final regulations.

The Commission adopted COMAR 10.25.01- Small Employer Health Benefit Plan Premium Subsidy Program as proposed permanent and emergency regulations.

Staff presented to the *Commission Small Group Market: Summary of Carrier Experience for the year ending December* 21, *2007.*

Staff presented to the Commission *2005-2006 Practitioner Utilization: Trends Among Privately Insured Patients.*

June 2008

The Commission adopted COMAR 31.11.14 - Wellness Benefit Under Small Employer Health Benefit Plans as final regulations.

The Commission approved a modification to a Certificate of Need - Montgomery General Hospital.

The Commission approved the Certificate of Need applications to establish a General Home Health Agency to serve residents of Montgomery County by ARGOR Business Solutions, Celtic Healthcare, Maryland Home Health and MBL Associates.

The Commission approved the Certificate of Need of Home Health Corporation of America.

The Center for Information Services and Analysis

Cost and Quality Analysis Division

Overview

The Cost and Quality Analysis staff's primary responsibilities are preparation of the annual state health care expenditure and practitioner services utilization reports that are mandated by Commission statute. The staff also conducts more narrowly focused studies of health care spending and service use, such as examining changes in spending for insured prescription drugs, and changes in private insurance premiums. The division's staff members examine broader health care issues as well, including the measurement and analysis of insurance coverage in the state. The Commission's Medical Care Data Base (MCDB) is a key data source for several publications.

Accomplishments

During FY 2008, the Cost and Quality Analysis division released eight publications, including six reports and two issue briefs, which are discussed in the paragraphs that follow. Two of the reports created by the division, *State Health Care Expenditures: Experience from 2006* and *Practitioner Utilization: Trends within Privately Insured Patients, 2005-2006,* are annual reports mandated in the legislation that created the Commission.

State Health Care Expenditures: Experience from 2006

State Health Care Expenditures: Experience from 2006 forms an essential component of monitoring the performance of the state's health care system by reporting the level and growth rate of health care spending. Released in January, the report estimates that total spending for health care received by state residents increased 8% in 2006 to $32.7 billion, accelerating from 7% growth in 2005. This rise marks the end of a downward trend in spending growth that occurred in 2002-2005. Maryland's per capita rate of increase in 2006 was 7%, slightly above the longer-term trend of 6% per year since 2002. Growth in Maryland's health care spending outpaced the national averages in 2006 (7% total, 6% per capita), as it has for the past several years. However, per capita health care expenditures in the state are still below the national average, $5,823 versus $6,062. Analysis of expenditures by service type indicates that spending in three categories-outpatient hospital care, home health care, and administration and the net cost of insurance-accounted for a larger share of Marylander's total expenditures for health care in 2006 (21%) than in 2002 (17%). Conversely, Marylanders spent a lower proportion of health care dollars on physician and other professional services in 2006 (31%) than in 2002 (34%). The shares of spending allocated to hospital inpatient care (23%) and prescription drugs (15%) were the same in both years. Analysis by payer-type shows that public payers (Medicare,

Medicaid, and other government) accounted for a larger percentage of all expenditures in 2006 (44%) than in 2002 (41%), associated primarily with the implementation of the Medicare coverage for prescription drugs and, to a lesser degree, growing enrollment in Medicaid (including SCHIP) during the period. The share of health care expenditures paid directly by consumers for both covered and uninsured services was lower in 2006 (16%) than in 2002 (18%), reflecting greater insurance coverage for prescription drugs among the elderly.

Practitioner Utilization: Trends within Privately Insured Patients, 2005-2006

Practitioner Utilization: Trends within Privately Insured Patients, 2005-2006, a mandated report based on analyses of the MCDB, was released in May. The purpose of this annual analysis is to provide an understanding of the factors underlying increases in expenditures for insured practitioner services. The report examines how the volume of care for privately insured Maryland residents under age 65, and the associated payments to physicians and other health care professionals, changed from 2005 to 2006, and how private insurer payment rates compare to Medicare reimbursement rates. Across all users, the average expenditure in 2006 was $941, up 4% from $904 in 2005. The spending growth was driven by a 5% increase in average services per user, which more than offset a 1% drop in the average payment rate. Geographically, per-user spending remains highest in the National Capital Area (NCA) at $1,000. Per-user spending in NCA increased 3% from 2005 to 2006, but grew faster in the Baltimore metropolitan area (4%) and elsewhere in the state (6%). Consumer-directed health plans (CDHPs) accounted for twice as many users in 2006 as they did in 2005, but still cover less than 2% of privately insured service users. Mean spending per CDHP user was $859, with 40% paid out-of-pocket, compared to an average 18% paid out-of-pocket by non-CDHP users. Per user expenditures differ by type of private coverage, duration of enrollment, and user health care needs. To control for duration of enrollment and health care needs, the report includes information on utilization and spending among just those enrolled for the entire year, stratified by patient risk scores. (The risk score is based on the diagnoses listed on a patient's practitioner claims.) Full-year users covered by public employers have higher expenditure risk, use more services, and, consequently, average slightly higher annual spending than users in large private employer plans ($1,052 versus $1,045). However, when the comparisons are made by risk category (low, medium, and high risk users), public employers have the *lowest* per user expenditure in each risk category. Payers with large market share-consisting of CareFirst and United Healthcare-have lower per-user spending for full-year enrollees ($1,041) than other payers ($1,062), due to their lower average payment rate.

Spotlight on Maryland

Two *Spotlight on Maryland* issue briefs were produced in FY2008. *Spotlight on Hospital Spending,* released in October, examines the factors that drove hospital spending in Maryland from 2001 to 2005, compares the experience of Maryland to hospitals in the United States as a whole, and describes the prospects for continued hospital spending growth in the future. Although per capita hospital spending in Maryland continues to be below the national average, from 2001 to 2005 Marylanders lost nearly 20% of their historical advantage in per capita spending on hospital services. During this period, spending on inpatient hospital services per capita rose 7.6% (compared with 6.2% nationally), while spending on outpatient hospital services per capita grew 9.3% (compared with 8.8% nationally). In Maryland and nationwide, inflation accounted for about one half of the increase in per capita hospital spending from 2001

to 2005. The remainder of the increase appears to be driven by explicit volume increases (higher admission and visit rates) in Maryland, while nationwide increases in service intensity and case mix played a greater role. To slow growth in hospital spending in Maryland, it will be important for regulators to work with the industry-both hospitals and payers-to ensure that services are provided in the most efficient setting and to ensure that those services continue to be priced based on reasonable cost standards.

Prescription Drug Spending in Maryland: Which Therapeutic Classes Gained Share From 2004 to 2006?

Prescription Drug Spending in Maryland: Which Therapeutic Classes Gained Share From 2004 to 2006? was released in April. It identifies the 10 therapeutic drug classes with the largest growth in absolute share of prescription drug spending between 2004 and 2006 among nonelderly Maryland residents with private drug coverage (as reflected by prescription drug claims in the MCDB). The 10 fastest growing therapeutic classes together accounted for almost 15% of total drug spending for this population in 2006. Antihyperlipidemic combinations led the growth list with a 0.8% increase in share of drug spending, followed by miscellaneous anxiolytics, sedatives, and hypnotics (MASH), anti-hypertensive combinations, and antiviral combinations. In 4 of the 10 therapeutic classes, drug price inflation-measured by annualized growth in spending per medicated day-was substantial and likely a driving force behind the share growth in these classes, which included antirheumatics, insulin, MASH, and anti-hypertensive combinations. Growth in the number of users was a major factor in share growth for all but 4 of the categories. For antihyperlipidemics, the rise in volume was especially high at 56% annually. New medications also contributed to share growth: 3 of the top 4 classes had at least two new drug approvals between 2004 and 2006. Not surprisingly, there was very little generic penetration in these 10 classes, with 6 having no generic medications and just one class (antihypertensive combinations) with generic spending amounting to more than 10% of the expenditures for that class.

Medical Expenditure Panel Survey – Insurance Component

A biannual insurance report, *Medical Expenditure Panel Survey-Insurance Component (MEPS-Ie): Maryland Sample Through 2005,* was released in December. The information comes from an analysis of the MEPS-IC, an annual survey of business establishments (locations) and governments conducted by the Agency for Healthcare Quality and Research. The survey of private-sector establishments in Maryland and nationwide inquires about whether health insurance was offered and the number and types of employees who were eligible and enrolled. The report provides detailed information by selected employer and workforce characteristics with regard to offering insurance, premiums and employee contributions for individual and family coverage, and the volume and types of employees who lack access to health insurance at the workplace. The report is intended to supplement information contained in the Commission's biannual *Health Insurance Coverage Report.* The MEPS-IC data for 2005 indicates that approximately 88% of the employees in Maryland's private sector establishments worked for an employer who offered health insurance, similar to the national rate of 87%. Approximately 59% of the employees in Maryland's private sector establishments were enrolled in health insurance plans offered by their employers, compared to about 27% who were unable to obtain coverage through their employers: 15% because they were ineligible and 12% because they worked for employers who did not offer coverage. Another 14% were eligible for their employers' health

plans, but declined the coverage.

Update on the Utilization Review of the Surgical Treatment of Morbid Obesity

A second insurance-related report, *Update on the Utilization Review of the Surgical Treatment of Morbid Obesity,* was produced for the Maryland legislature in December. Chapter 486 of the 2004 Acts of the General Assembly required MHCC to staff a Task Force on Morbid Obesity, which developed the recommendations regarding surgical treatment of morbid obesity. Chapter 568 of the Laws of 2005 instructed the Task Force to report to the General Assembly by December 1, 2007 on: 1) any new findings regarding the treatment of morbid obesity since 2005, and 2) the number of complaints filed with the Maryland Insurance Administration (MIA) relating to the denial of coverage for the surgical treatment of morbid obesity and their outcomes. Since there have been no significant changes to the National Institute of Health's guidelines for surgical treatment of morbid obesity since 2005, MHCC concluded, after discussions with several Task Force members, that further meetings of the Task Force were not necessary. The report consists of an examination of complaints regarding denials of coverage and a review of recent trends in use of bariatric surgery by Maryland residents. There was a declining trend in the number of complaints filed with the MIA relating to the denial of coverage for the surgical treatment of morbid obesity from 2004 to 2006. From June 2004 through November 2004, the MIA received approximately five complaints a month. Complaints decreased to approximately three per month in 2005 and slightly over two per month in 2006. For complainants subject to the mandate of surgical treatment of morbid obesity, the MIA upheld the carrier's denial of coverage in most cases. The MIA lacked jurisdiction over a number of complaints: from June 2004 to November 2006, the MIA did not have jurisdiction in 22 cases or 24 percent of all complaints. In these instances, denials from employer self-funded ERISA plans and certain Federal employee plans were not subject to state insurance regulations. Regarding surgical trends, the report notes that laparoscopic Lap-Band R (one form of surgical treatment in which the stomach is banded to reduce size) is now performed in outpatient settings for low-risk patients. The report also notes the accreditation of six Center of Excellence in Bariatric Surgery programs at Maryland hospitals.

Plans for Collecting Enrollment, Benefit, and Institutional Claims Data

Two additional legislative reports were produced during this period. The first, *Plans for Collecting Enrollment, Benefit, and Institutional Claims Data,* pertains to an expansion of the Medical Care Data Base (MCDB). MHCC currently collects information on claims for professional services in the MCDB, and the Health Services Cost Review Commission (HSCRC) collects hospital discharge information, but there is no practical way to link these records in order to study the treatment of particular episodes of illness across inpatient and outpatient settings. This combined information is vital to developing cost-effective health systems. House Bill 800 (HB 800), Maryland Health Care Commission-Program Evaluation, (2007 Laws of Maryland, Chapter 627) expanded the types of information that may be collected as part of the MCDB to include data on eligibility (plan participation), institutional services (primarily hospital inpatient and outpatient information) and insurance product design, and required MHCC to submit a report outlining its plans to collect these data and describing how the new data would be used to promote quality and affordable health care. The report, submitted in October, discusses the value of the information to stakeholders and policymakers, data collection activities in other states, the costs of initial data development and annual submission

to payers and to MHCC, and options that would instill confidence about the additional data collection. MHCC staff recommends expanding data collection permitted under HB 800 through a three year transition process starting with the collection of information about plan participants in year one, adding institutional claims in year two, and incorporating information about benefit design in year three. Costs for the data expansions are expected to be manageable for payers and MHCC. Based on estimates provided by payers, their costs will total approximately $700,000 for initial development and $250,000 for annual submissions. MHCC's one-time development expenses could total $150,000, evenly divided between data processing contractor costs and staff technical support. Submission of new information would begin in 2009. Major details of the data submissions will be defined in consultation with payers and other stakeholders.

Interim Report, Task Force on Health Care Access and Reimbursement

Interim Report, Task Force on Health Care Access and Reimbursement, was submitted to the General Assembly in January. The Center for Information Services and Analysis is staffing the Task Force on Health Care Access and Reimbursement, created by Senate Bill 107 during the 2007 legislative session. The Task Force is charged with examining issues that have not been resolved over the past several years affecting access to and reimbursement of physicians. The General Assembly directed the Task Force to provide recommendations on broad questions affecting: 1) patients' access to providers; 2) payers' policies on participation on network panels; 3) adequacy of current reimbursement levels; and 4) alternatives to the present system of payment and approaches for linking reimbursement to quality. An Interim Report, due in January 2007, was required to provide the legislature with a recommendation on prohibiting carriers from requiring providers to participate in another carrier's network as a condition of participation. This issue arose as a result of the merger of MAMSI with United Health Care. Senate Bill 749 introduced in the 2007 Session would have barred this activity. The Interim report provided draft language that was incorporated into House Bill 1219 (Health Insurance - Health Care Provider Panels - Provider Contracts) passed as Chapter 688 of the Laws of Maryland during the 2008 Session of the General Assembly. The Task Force will issue a final report containing recommendations for addressing other areas of provider and health plan disagreement in December 2008.

Maryland Trauma Physician Services Fund

The Maryland Trauma Physician Services Fund ("Trauma Fund" or "Fund") covers the costs of medical care provided by trauma physicians at Maryland's designated trauma centers for uncompensated care patients, Medicaid enrolled patients, and trauma related on-call expenses. The Fund is financed through a $5 surcharge on motor vehicle registrations and renewals.

In the last three years, the Maryland General Assembly has taken action to increase eligibility for trauma funds. House 8ill1164 (Trauma Reimbursement and Grants) passed during the 2006 session of the Maryland General Assembly realigned spending with collections by increasing the physician specialties eligible for uncompensated care and Medicaid under-compensated care and raised the on-call reimbursement formula for trauma centers. Trauma physicians at three specialty referral centers became eligible for uncompensated care reimbursement and elevated Medicaid payments. The General Assembly directed the MHCC to award trauma equipment

grants totaling $3 million from the balance in the Trauma Fund at the end of FY 2006. Grants of $430,000 were awarded to each hospital in FY 2007. Level II and Level III trauma center hospitals had until the end of FY 2008 to use the funds. All seven centers reported disbursing their grants by the end of FY 2008. Senate Bill 916 (Maryland Trauma Physician Services Fund Reimbursements and Grants) passed in the 2008 session of the Maryland General Assembly expanding eligibility for Trauma Fund on-call payments, making the trauma equipment grant program permanent subject to funds available, and giving the MHCC authority to raise physician reimbursement levels. These changes will align spending and revenue and provide a mechanism for spending down the current Trauma Fund balance.

During FY 2008, the Maryland Motor Vehicle Administration ("MVA[N]) collected $12.9 million from the $5 surcharge on motor vehicle renewals (including interest). Payments for uncompensated care and on-call increased in FY 2008 to $12.7 million for uncompensated care, Medicaid under-compensated services, trauma on-call expenses, and administrative expenses. The Fund also held $3 million in claims for uncompensated care, on-call, and standby expenses that were incurred, but not paid during the fiscal year. The balance in the Trauma Fund remained at approximately $20 million at the end of FY 2008) or $17 million if incurred but not paid obligations were netted against the Fund.

The MHCC estimates MVA collections through the $5 fee should increase by about 2 percent per year in 2008 and 2009. Projected spending under current law will be approximately equal to collections from the MVA. The Fund is projected to be in balance over the next several years.

Data Base and Applications Development Division

Overview

The Data Base and Application Development Division is responsible for managing data collection efforts and developing health care provider surveys mandated by law. The Commission has the authority to collect and manage information on health care professionals) hospitals, nursing homes, assisted living facilities) adult day care centers, and home health agencies. This division also acquires and manages external analytic databases used by the Commission, including the Maryland hospital inpatient and emergency department data, state and private psychiatric hospital data) outpatient ambulatory surgery data, District of Columbia hospital inpatient data) Medicare and private payer outpatient claims data, large private payer pharmacy data, and several CMS data collections including the Minimum Data Set, Oscar file of nursing home deficiency data, and the Nursing Home resident file. The division has primary responsibility for development, acquisition and resource support of data processing and analysis support systems) and Internet applications for survey data collection and dissemination of health care consumer information.

Accomplishments

Bed Need Inventory
Data requests were completed providing bed need projections in assorted formats, including projections for 2016 with nine different scenarios, tabulation of the number of Skilled Nursing

Facility (SNF) patient days at Good Samaritan Hospital in FY2006, and a listing of the cardiac events at Anne Arundel Medical Center in 2006.

Data Processing
Staff has continued to improve the intranet-based application to record and manage data requests and converted the application from Filemaker to ASP to improve access by staff. Data staff continues to assist MHCC staff with technical problems and with mapping and graph reproductions. Staff provides analysis files and data requests to the other Centers and entities external to both MHCC and the State and include tabulations of the Active Maryland physicians' data for anesthesiologists by zip code and county for the years 2004-2006) household population for 2005 & 2006 by age groups, and investigation of alcohol poisoning statistics. The division continues to improve documentation in the software programs and continues cross training among its staff members to share responsibilities for data processing.

Graphic Work
Data staff updated the Comprehensive Standard Health Benefits Plan brochure. Data staff helped the EDI staff with updates of the MHCC billboards and training and support using InDesign for numerous publications. Staff assisted Commission staff with writing publication bid boards) design of report covers, press printing issues, graphic software training, publication support, graph and logo creation in Illustrator, table development in In Design, publication optimization for web format, running pre-flight and packaging for press, and review of blue-line hardcopy from press.

Guide for Future Mental Health Services in Maryland
Staff created a subset of data for calendar years 2003-07 from the private psychiatric inpatient datasets to support consultants on the mental health services project. The Data staff supported the consultants by examining trends in the use of psychiatric beds for acute patients in private and general hospitals such as length of stay, diagnoses, and disposition by county and region of patient origin. Data staff also examined trends in admissions from emergency departments for patients with and without psychiatric diagnoses, as well as resource use in the public mental health system by patient origin and by types of services. It is anticipated that this analysis will be useful for discussion by members of the task force charged with creating a plan for future mental health services. The Data staff examined data from state hospitals for nonforensic patients with length of stay (LOS) less than 61 days. This data is expected to be used by MHCC for future projections of the need for acute care in the private sector.

Health Care Access & Reimbursement (HCAR) Task Force Request
The HCAR Task Force was created to study the methodology differences in MHCCs count of physicians when compared with the MHA/MEDCHI AMA physician computation. Data staff provided counts and means for HMO & NON-HMO claims by practice and plan, and hospital services by plan and specialty and reconciled the differences in the two methodologies.

Hospital Services/Certificate of Need
Data staff provided support for studies on race disparity, health plan service areas for medically underserved areas, the number of patients admitted to acute care hospitals from ambulatory surgery facilities within 72 hours of surgery, and the total number of discharges and patient

days by Hospital by planner-defined acute care services. For the race disparities studies, tabulation and analysis was provided for data from 2003 to 2006 on emergency department use and mental health conditions by primary diagnosis, discharges by region, and by hospital. Data staff created excel spreadsheets for psychiatric diagnoses by the primary service area for areas of Chester River Medical Center, Memorial Hospital of Easton) and Dorchester General Hospital. Data staff also created maps of hospital development in selected counties and of primary service areas of three facilities on the eastern shore. Staff provided training to Hospital staff new to SAS programming.

Institutional Review Board (IRB)

The table below lists IRB-approved data sets which Data staff compiled and sent to external and DHMH researchers:

Project Name	Destination	Data Set Required
Racial Disparities in Cardiac Care and Southern MD Market Share Washington Metro	Mandell Bellmore, Ph.D. President of Block, McGivony, Bellmore & Associates, Inc.	CY 1998 to 2006 DC Inpatient Data
Planning Services Study of Out-Migration	Annice Cody, Vice President Holy Cross Hospital Strategic Planning	CY 2005 TO 2006 DC Inpatient Data
Maryland Pediatric Out-Migration to Washington DC	Karen Moody, Associate McManus Consultants	CY 2003 to 2006 DC Hospital Discharge Data
Utilization of District of Columbia Hospitals by Maryland Residents	Richard Coughlan Cohen, Rutherford & Knight	2006 DC Hospital Discharge Data
Cardiovascular Out-Migration to Washington DC	Ryan Snoots, Director Finance Decision Support	CY 2006 DC Inpatient Data
Market Study (2004 – 2006) for Suburban Hospital	Carin Bouharoun Suburban Hospital	CY 2004-2006 DC Inpatient Data
Analysis of Maryland Adults Treated or Discharged from DC Hospitals	Claudia R. Baquet, MD, MPH Professor of Medicine	CY 1999-2006 DC Hospital Discharge Data
Investigation of MD Mortality Related to Injuries, Diseases, and Obesity	Tracey Serpi, Ph.D., Chief of Injury Prevention and Epidemiology, Center for Preventive Health Services-Maryland DHMH	CY 2000 – 2006 DC Hospital Discharge Data
Analysis of Maryland Admissions in DC Hospitals	Sasa Espino, Senior Business Analyst, Doctors Community Hospital	CY 2001 – 2006 DC Inpatient Data

Long Term Care Survey (ITCS)
Data staff processed the Medicaid Cost Report Data for inclusion in the Long Term Care Survey (LTCS) and updated the LTCS programs to clean the 2006 data and run final reports. Data requests were completed to report the percentage of routine service revenue from 2000 to 2005 by county and revenue source, number of beds, number of residents, total number of patient days, and the age distribution of the patients. Staff created and uploaded 2006 hospice public use files to the website.

Maryland Assessment Tool for Community Health (MATCH)
The purpose of the MATCH project is to design, develop, test and implement a web-based data-mart analysis portal that will allow the public to easily perform statistical queries of select Department datasets and obtain immediate hypercube data results. The vision is to build a maintainable, scalable website within DHMH where internet users can build, run and download aggregate data queries from the Department's health agencies. MHCC participated in the development of this project last year and in FY2007 data staff took training and tested the MATCH application.

Medical Care Data Base (MCDB)
Data staff geocoded files for locations of specific physician specialties and performed numerous data requests on the Medical Care Data Base (MCDB) for data by physician specialty. Data staff performed data requests for National Provider Identifier (NPI) analysis including comparison of the number of physician licensees matching the NPI records with the number of licensees in the NPI data, reporting the number of Emergency Department Physicians, and merging the Center for Medicaid and Medicare Services National Provider Index with the Maryland Board of Physician's database. Other data requests were completed to report age distribution and coverage type of individuals in Maryland, the number of physicians participating in MAMSI and United Health Care for 2004-07, podiatry analysis for an external entity, and to analyze the race of selected Emergency Department Utilization by region and hospital. Data staff prepared an MCDB payer list for the data submission manual. Data staff composed tape login instructions for preparation to receive the 2006 MCDB tapes back from the MCDB contractor.

Minimum Data Set (MDS) from the Centers for Medicare and Medicaid
Data staff continued to receive MDS data from the Office of Health Care Quality for FY2007/2008. Staff processed the data, updated the documentation, and prepared the data from quarter 1, 2006 through quarter 1, 2008 for analysis by the Long Term Care Staff and updated the resident portion of the Nursing Home Guide.

National Association of Health Data Organizations
The National Association of Health Data Organizations (NAHDO) is charged with coordinating a pilot project to develop a model data use agreement for the use of hospitalization data for the Environmental Public Health Tracking Network. NAHDO's model will include provisions of data use, display, and re-release by the Tracking Network. Data staff reviewed all of the existing inter- and intra-agency agreements' key provisions and met with the NAHDO staff to provide feedback on revisions of the trading partner agreement.

Non-Primary Percutaneous Coronary Intervention (PCI) Review
The 2008 Non-Primary PCI Review project is a comparative evaluation of applications from seven hospitals in the Baltimore and Washington metropolitan areas who are seeking a waiver from the Commission to participate in a research study. As part of the comparative review, the Data staff prepared and edited five maps illustrating hospital locations and distances between applicant hospitals and supported analyses using various HSCRC data bases from calendar years 2006 and 2007 to determine primary and extended services areas, and to characterize other aspects of hospital utilization in seven selected hospitals.

Physician Database
Data staff cleaned data in the 2005/2006 Physician Licensing Renewal Database. Annually, 85% of physicians enter their license renewals on-line with the Board of Physicians Online Renewal application we developed. The remaining 15% are completed on paper and mailed in with the renewal fee. To facilitate entering the mail-in renewals for 2007, the Data staff modified the renewal application to be used for in-house entry and trained the MHCC staff to enter the data more reliably. Data staff coordinated the data entry team and reviewed the online entries for typos and consistency.

Rehabilitation Hospitals
Data staff provided statistics on patients discharged from licensed Special Rehabilitation Hospitals in Maryland for use in monitoring the availability and utilization of acute inpatient rehabilitation services in compliance with the Commission's State Health Plan for Facilities and Services (COMAR 10.24.09). The data was processed for the years 2004-2006.

Tape Archival
Data staff conducted an extensive review of the inventory of tapes in storage at our tape vendor and visited the tape vendor on-site to determine which tapes were obsolete and verified our tape inventory. Keeping tape storage to a minimum and destroying obsolete tapes saves money and reduces the risk for data loss.

Trauma Fund/Emergency Room
Staff provides SAS programming support for analysis of emergency room physician uncompensated care claims to be paid by the Maryland Trauma Physician Services Fund. This analysis is included in the Annual Report to the General Assembly on the status of the Trauma Fund. Data staff also provides programming support on the Trauma Fund such as auditing payments made to providers and reporting of payments grouping the University of Maryland physicians together regardless of the tax identification numbers reported. Data staff created maps of the Trauma Fund hospitals in Maryland in 2007.

Web Application Development

Assisted living Guide
Data staff worked with the Office of Health Care Quality to begin development of reporting on assisted living deficiency data and to enable online access to full facility inspection reports as part of the electronic Assisted Living Guide.

EDI Progress Report Application
Data staff developed and deployed a new electronic survey for electronic data vendors to fill in the annual progress report online instead of on paper. An administrative tracking function was also developed, the survey data was collected and Data staff developed programs to convert the data into the format needed by the EDI staff to analyze the data.

Health Insurance Subsidy Program
The Health Insurance Partnership (Partnership) is a coordinated effort between the Department of Health Mental Hygiene, the Maryland Health Care Commission (MHCC) and participating insurance carriers and employers. The Partnership, made possible by the 2007 passage of the Working Families and Small Business Health Coverage Act, provides a subsidy for qualified small employers to offer health insurance to their employees. Employers may enroll in the program if they have 2 to 9 full-time employees and provide an average wage of less than $50,000. The Data staff is developing the application for promoting, informing and managing the enrollment of small businesses into the program and is expected to deploy the application in the fall of 2008.

Home Health Agency Survey
Data staff completed development of the annual Home Health Agency Electronic Survey with administrative tracking in September 2007. After the 2007 data was collected, data staff developed programs for the existing State Health Plan reporting systems to run with the new electronic data collection. Staff created 2006 Home Health Public Use files for the MHCC website. The data staff also modified pages of exceptions for Home Health, reviewed the statistical profile reports, and created public use files for web download.

Hospital Guide
Data staff modified the Hospital Guide data processing programs received from the guide subcontractor to run on the local server, verified the output, converted the subcontractor's ACCESS application to SAS prior to uploading the data on our website, and worked with the guide contractor to manage medical condition updates. Data staff removed outdated text, updated the hospital price guide, posted exceptions and responses for hospital certificate of need, fixed minor errors, and downloaded the user survey data for the hospital staff. Data staff also provided technical review assistance to hospital staff on the continuation of the Hospital Guide Updates bid as well as the Hospital Guide Overhaul bid.

Licensing for Health Care Occupations
The data staff developed and deployed new web-based license renewal applications for the following State health care occupations: Acupuncture; Audiology, Hearing Aid, Speech and Language; Dietetic Practice; Morticians; Occupational Therapy Practice; Podiatric Medical Examination; and Professional Counselors and Therapists. The data staff completed updates at the request of the following boards for their web-based renewal applications: Chiropractic; Dental Examiners; Physical Therapy; Physicians; Psychologists; and Social Work.

Long Term Care Survey
The data staff made updates to the Annual Long Term Care Survey (LTCS) for the 2007 data collection and modified the SAS processing programs to prepare for data cleaning of the 2006

LTCS data and reports.

MHCC Website
Staff procured and set up a web statistics tracking application, developed project-specific reporting for several division projects, and trained staff in its use. The website was modified to use the State Google Search service. Data staff helped Commission staff with understanding how to optimize scanned documents for publication to the web. Data staff processed regular updates of external links, drop-down project headings, upload of public-use data files, and developed a new long-term care and mental health section. Data staff compiled a new technical requirements document for all RFPs requiring web development. Data staff installed and set up Contribute profiles and accounts and assisted the Electronic Health Networks staff with training to be able to manage their sections of the website.

MHCC was notified that our websites needed to be made accessible for people with physical limitations under the American Disabilities Act. Staff completed a bid process to get help and training with accessibility issues. Consequently, the data staff worked with a consultant to determine the modifications needed for our websites to be accessible, identify the appropriate accessible menu software, and develop a presentation to the Commission staff on how to make our on-line materials accessible to readers. Data staff worked with the consultant to make the main portions of the website completely accessible to people with disabilities, made the interactive portions of the website more accessible, and developed new accessible navigation and CSS templates for the website.

The web server was replaced this past year and data staff assisted the network staff in the setup and testing of the new server and all associated software and applications. Data staff worked closely with the network staff to iron out numerous small glitches that occurred with deployment of the new web server, mostly having to do with permissions, creating applications, and SQL Server operations. The MHCC web hosting service was switched to a new vendor and this necessitated considerable work to get our web tracking software (Clicktracks), web editing software (Contribute), SQL server, and all other FTP connections working with the new hosting service.

Nursing Home Report Card
Data staff continued scheduled data updates to the quality measures, quality indicators, residents, facility, and deficiency portions of the Nursing Home Guide. Data staff developed the family satisfaction survey information pages, and made the data collected from the survey available to the Long Term Care staff. A facility photo upload capability was developed and added to the Guide so facilities may showcase their main activity rooms and samples of their private rooms. Bed information fields were added to the website and the SAS programs were reworked to report quality measures by actual percentages in place of quartiles. The main facility information page was overhauled to facilitate ease of adding new fields. Data staff made changes to the Continuation of Coverage web page and met with the Office of Health Care Quality (OHCQ) to evaluate what other states are reporting for nursing home deficiencies.

Recently, nursing home facilities have come under increased scrutiny because of some with perpetual poor performance. The Governor's office launched inquiries into what could be done

with the nursing home guide to improve reporting of poor performance. Data staff participated in discussions with OHCQ the Long Term Care Staff and representatives of the Governor's Office and prepared summaries of data we have available. As a result, data staff implemented identification of Special Focus Facilities on the nursing home guide. Data staff prototyped several tables of nursing home deficiencies to foster a discussion of how to better present deficiency data.

Office Trak

Office Trak is an office management tool created to process procurements and service requests from MHCC divisions. Users add requests to the application and the Director of Administration assigns the request to a staff member for processing. The system tracks the procurement process from creating the "ticket" to final fulfillment. The system provides a communication track between requester, manager, and staff member assigned to the request throughout the process. Emails are automatically generated when a request is made and any time the status of a request changes. Office Trak has increased efficiency and accountability throughout the MHCC.

Task Force on Health Care Access & Reimbursement - Physician Pricing Application

The 2006 Medical Care Data Base data was processed to update the pricing application which allows qualified users to compare prices on physician services by provider and location. Data staff implemented changes to the application to allow for the comparison of physician data across multiple years, including calculation of percentage changes and provided data on charity hours provided by specialty in 2006.

Network and Operating Systems Division

Overview

The division's staff developed and maintains the Commission's local area network (LAN). This function encompasses a wide variety of hardware and software products. The MHCC hardware includes database, file, print, mail, Intranet and Internet servers, PCs, and peripherals such as tape and disk subsystems, switches, and other infrastructure equipment. The staff configures and maintains all network servers and workstations and installs and maintains all server and workstation software.

Division staff implements and enforce security conventions to guard against external threats and maintain the data access conventions adopted by the Commission that control staff's access to sensitive information. The division is responsible for network disaster recovery and business continuity planning.

Staff also provide technical assessment, configuration management, and capacity planning functions for the organization and is responsible for assessing new technologies and recommending and implementing changes to keep the Commission's information systems fully responsive to the Commission's needs.

Accomplishments

During FY 2008, the Commission's LAN was available to staff more than 99.9% of the time. The MHCC web server was replaced and its software upgraded. All web applications and databases successfully moved. Also, the web server was moved to a new ISP providing improved infrastructure and bandwidth. The only downtime for the web server was during its physical move to the new ISP. Staff was upgraded to the latest version of Microsoft Office with a phased roll out and no disruption to staff productivity. Professional staff received new PCs, also in a phased roll out with no loss in staff productivity.

The Commission's LAN has been safeguarded by the vigilant application of software patches and an upgrade of anti-virus software. Security is enhanced because it is a private network behind an MHCC firewall, which isolates the MHCC LAN from the DHMH wide area network, which is behind its own firewall.

The Center for Long Term Care and Community Based Services
and
The Center for Health Care Financing and Health Policy

THE CENTER FOR HEALTH CARE FINANCING AND HEALTH POLICY

Benefits Analysis Division

Overview

The initial charge to the Health Care Access and Cost Commission (HCACC -one of the predecessors of the MHCC) was to develop a benefit plan for small employers which includes benefits that are at least equivalent to those benefits required to be offered by a federally qualified HMO with an average premium cap for the basic plan that does not exceed twelve percent of Maryland's average annual wage in any year. Working with this statutory floor and ceiling, the legislation also directed the Commission to adopt regulations (COMAR 31.11.06) specifying a comprehensive standard health benefit plan (CSHBP) to apply under Maryland insurance law *(Annotated Code of Maryland,* Health-General Article 19-103(c)(6)). The Maryland Insurance Article *(Annotated Code of Maryland,* Insurance Article, Title 15) initially defined the small group market as employers with two to fifty employees. In 1996, the small group market was expanded to include the self-employed. Regulations require the Commission to review the CSHBP annually to assess the adequacy and affordability of coverage (COMAR 31.11.06.12). In 2003, the affordability cap was set not to exceed ten percent of the state's average annual wage (Chapter 93 of the Laws of Maryland, effective July 1, 2003.) The General Assembly passed SB 1014 (enacted during the 2005 legislative session, with a sunset provision of September 30, 2008), that no longer allows the self-employed to enroll in the CSHBP because of their atypical loss ratio. During the 2008 legislative session, the General Assembly enacted HB 462 to extend this sunset provision until September 30, 2011.
As of July 1, 1994, carriers participating in the small employer market can only offer a policy incorporating the CSHBP on a guaranteed issue, guaranteed renewal basis. Medical underwriting was phased out as of January 1, 1995. Riders can be issued to improve the benefits, but not to diminish them. The insurance reform required community rating adjusted only for age and geography. Rating bands were established and are currently set at + 40 percent/- 50 percent. Since its inception, this health insurance reform initiative has provided small businesses in Maryland with access to a comprehensive health insurance benefits package on a guaranteed issue, guaranteed renewal basis, without rating based on health status.

During the 2004 legislative session, the General Assembly enacted SB 570 (Chapter 287 of the Acts of 2004) that required the MHCC to develop a Limited Benefit Plan (LBP) that was

available to certain small employers beginning July 1, 2005. In specifying the LBP, the actuarial value of the LBP could not exceed seventy percent of the actuarial value of the Comprehensive Standard Health Benefit Plan as of January 1, 2004. The Act required that the LBP be offered to a small employer who: (1) had not provided the Standard Plan during the twelve-month period preceding the date of application or, if the small employer had existed for less than twelve months, from the date the small employer commenced its business; and (2) had employees with an average annual wage that did not exceed seventy-five percent of the average annual wage in the state. Finally, this Act and Chapter 627 of the Acts of 2007 required that the Commission submit a report to the Commission by January 1, 2008 on participation in the LBP, its impact on the small group insurance market and the population of uninsured individuals in Maryland, recommendations on continuing or expanding the availability of the LBP in the small group market, and alternative insurance options for individuals enrolled in the LBP.

Accomplishments

Comprehensive Standard Health Benefit Plan

Throughout FY 2008, the Commission accomplished several goals relating to the CSHBP. As a result of regulations implemented effective July 1, 2007, carriers participating in Maryland's small group market are now allowed more flexibility in product design, with the ability to offer a high deductible HMO, either as a stand-alone product or in conjunction with a Health Reimbursement Arrangement ("HRA"). This added flexibility provides consumers with more choice and allows carriers to price these products more competitively with the added goal of keeping the overall cost of the CSHBP below the affordability cap, currently at 86% of the cap as of December 31, 2007. Next, the enactment of HB 339, (effective July 1, 2007 with an abrogation date of June 30, 2011 altered the rating bands in the small group market from +/40 percent to + 40 percent/-50 percent and required the Commission to promulgate regulations requiring carriers to report enrollment in the small group market by age and the geographic location of the business. These regulations were implemented effective October 22, 2007. (The report on the effect of the 50% rate adjustment is due to the General Assembly by January 1, 2011). Finally, HB 579, enacted during the 2007 legislative session, directed the Commission to report to the General Assembly on options available to reform the CSHBP to encourage more employers to enter the small group market. This report, completed in December 2007 by Mercer, the Commission's consulting actuary, identified potential opportunities for change to encourage employer and employee participation in the small group market, both through new participants and retention of existing participants. Mercer analyzed the existing policy components of the CSHBP and provided an actuarial perspective on opportunities for effective change in this market, including the advantages and disadvantages of each policy component to support policy makers as they debate potential changes to Maryland's small group market. In this report, Mercer also indicated which changes to the CSHBP might have the most potential for creating a more flexible environment for participating carriers to develop plan design and pricing to increase employer and employee participation. This report is posted on the Commission's website.

Under Chapter 287 of the Acts of 2004 and Chapter 627 of 2007, the Commission submitted a report to the General Assembly in January 2008 on participation in the Limited Benefit Plan (LBPL) its impact on the small group market and the population of uninsured individuals in

Maryland, alternative insurance options for individuals enrolled in the LBP, and recommendations on continuing or expanding the availability of the LBP in the small group market. The report also included enrollment data between July 2005 and June 2007 on the number of carriers offering the LBP, the number of policies sold, and the number of employees covered, as well as limited data on the average age, geographic area, and average wage of each business enrolled in the LBP. This report is available on the Commission's website.

Health Plan Quality and Performance Division

Overview

The Annotated Code of Maryland, Section 19-135C, *et seq.* directs the Commission to establish and implement a system to evaluate and compare, on an objective basis, the performance and quality of care provided by commercial health maintenance organizations (HMOs). Commission is required to annually publish the findings of the evaluation system for dissemination to Marylanders, health plans, and interested parties. The statute also permits the Commission to solicit opinions on HMO performance from enrollees. Regulations require an HMO to file data collected using the standardized tool *Healthcare Effectiveness Data and Information Set* with the Commission if it holds a certificate of authority in Maryland and has a premium volume in Maryland exceeding $1 million. HMOs having more than 65 percent of their Maryland enrollees covered through the Medicare and Medicaid programs are not required to submit HEDIS reports to the Commission.

Accomplishments

2007 Report Series
The Division of Health Plan Quality and Performance is charged with collecting, and making available to the public, comparative information on the performance of commercial HMOs operating in Maryland. The comparative information supports consumers, purchasers, academics, and policymakers in assessing the relative quality of services provided by this segment of managed care plans.

Division staff worked in partnership with contractor staff having special expertise in health quality measurement to develop the eleventh series of annual HMO reports. The collection consisted of three reports having separate release dates during the fiscal period selected to coincide with audiences' timeframes for use, Public of the reports began in autumn 2007 leading with the consumer-focused *Measuring the Quality of Maryland HMOs and POS Plans: 2007/2008 Performance Report (Consumer Guide)* followed by *2007 Comprehensive Performance Report: Commercial HMOs & their POS Plans in Maryland (Comprehensive Report).*

The *Comprehensive Report* targets audiences, such as health benefit plan managers, who seek detailed content. This report assembled the collective results reported plans to form a statistical repository of HEDIS (clinical) and CAHPS (survey; *Consumer Assessment of Healthcare Providers and Systems)* data. Results for the seven plans required to submit their performance data were bench marked against the state average. The state average reflects the simple average

of the combined plan performances for each clinical and survey measure. Measurement areas span from frequency of selected medical procedures and utilization of medical facilities to rates of recommended preventive and chronic care services.

The *Consumer Guide,* a consumer-oriented comparative report, was derived from the collective data displayed in the *Comprehensive Report* and presented as a sub-set of the measures of interest to a general audience. This report was designed for employees deciding which health plan to join and for employers who are choosing which HMO or HMO-linked point-of-service plan to offer employees. HMOs and POS plans were compared on members' satisfaction with their plan and health care that they received as well as on extent to which recommended health care services were provided to members.

Two innovative features added to the *Consumer Guide* in 2007 broadened the scope of the content, thereby giving the report greater dimension to meet the information needs of a general audience. This edition adopted policy elements previously reported in a separate publication and included an enhancement to the health plan quality assessments by introducing a new, but complimentary, data comparison set. By integrating these information elements it streamlined the report development process. The resulting output yielded information beyond the familiar plan-level results by combining the traditional components with aggregate performance results for the state, region, and nation in a single report that consumers to legislators could use with equal purpose.

The enhanced health plan quality assessment information was obtained from the Mid-Atlantic Business Group on Health. MHCC purchased the data set for presentation of first tier results (global scores) collected using the proprietary tool eValue8™. This tool uses a unique information gathering process to focus on measurement of the efficiency and effectiveness of health plans' management systems.

Completing the 2007 HMO performance report series, the third and final report, *Measuring the Quality of Maryland HMOs and POS Plans: 2008/2009 State Employee Guide,* was created for Maryland's 50,000 active and retired state employees during spring 2007. This report mirrored the *Consumer Guide* but limited the plan results to only those plans available to state employees.

During the previous fiscal period, transition to paperless reports began and continued into the new fiscal year. All reports in the HMO performance report series were posted on the Commission's website in a PDF format. A limited number of the *Consumer Guide* were printed and distributed to the Maryland legislature.

2008 Report Series

A public-private partnership between MHCC and the major health insurance carriers operating in the state formed in 2006 to broaden the positive effects of quality measurement. Aetna, CareFirst, C1GNA, Coventry, Kaiser, and United Healthcare served as early collaborators with MHCC to test the feasibility of performance measurement and reporting by PPOs. Through these significant voluntary contributions, quality evaluation and reporting has expanded to include comparisons along the breadth of managed care products-HMO, POS, and PPO-in a single, independently audited source. The *2008/2009 Health Plan Performance* report series

represents a first-ever achievement that can serve as a model to other states.

Administration of the 2008 survey of HMO, POS, and PPO members was completed in the spring 2008 using the CAHPS 4.0H survey tool making this the tenth year this instrument has been used to collect member opinions-but a first-time experience surveying members enrolled in PPOs. Over the course of the first half of 2008, the seven HMOs participating, as required, in the evaluation and the four PPOs participating voluntarily underwent an audit of their HEDIS data collection processes, information systems, and rates submitted to the Commission in June. Division staff teamed with HealthcareData Company, LLC, an NCQA-certified (National Committee for Quality Assurance) auditing firm to conduct all major audit activities. The PPO plans that agreed to this public reporting initiative are Aetna, CareFirst BlueCross BlueShield, CIGNA, and United Healthcare.

For the near-term, the voluntary participation by PPO plans signifies a broad-based commitment by Maryland health plans to collectively use quality measurement and reporting to achieve a *healthier Maryland.* However, as this is relatively unchartered performance assessment territory, it is too soon to assess the influence PPO health plans can exert on clinical quality improvement.

2009 Report Series

As it currently stands, Maryland has become the first in the nation to provide consumers with audited, comparative analysis of clinical and member satisfaction measures, giving consumers an opportunity to make distinctions about their managed care health plan choices on factors beyond price. PPO comparative information will remain part of the next report series.

Development of the health plan performance reports will center on tailoring the consumer versions to become topic driven. The information will become more customized without imposing work on the user to configure the specialized reports. Possibly some interactive features will be offered.

Mandated Health Insurance Services Evaluation

Overview

In 1998, the Maryland General Assembly expanded the Commission's duties requiring the Commission to conduct an initial evaluation of the cost of existing mandated health insurance services, and requiring the Commission to assess the medical, social, and financial impact of any legislatively proposed health insurance service, (Annotated Code of Maryland, Insurance Article, Title 15, Subtitle 15). The Annual Mandated Health Insurance Services Evaluation report is due to the legislature each December 31. The mandates do not affect Medicare, Medicaid, self-insured products, or the small group market. It should be noted that the annual mandate evaluation applies only to health services and not to issues of eligibility, continuation of benefits, or reimbursement to certain providers of services, which are also sometimes considered "mandated benefits."

In 1999, the Legislature expanded these requirements to request annual reporting on whether the

fiscal impact of existing mandates exceeded a statutory income affordability cap of 2.2 percent of Maryland's average annual wage. If the 2.2 percent affordability cap was exceeded, an analysis of the medical, social, and financial impacts of all current mandates was required. That study was eliminated during the 2003 legislative session and replaced with a new study (now called the "Comparative Evaluation") which was required to be submitted to the General Assembly by January 1, 2004, and every four years thereafter. The Comparative Evaluation must include: (1) an assessment of the full cost of each existing mandated benefit as a percentage of the State's average annual wage and of premiums for individual and group health plans, the State employee health plan, and the Comprehensive Standard Health Benefit Plan; (2) an assessment of the degree to which existing mandated benefits are covered in self-funded plans; and (3) a comparison of mandated benefits provided in Maryland with those provided in Delaware, the District of Columbia, Pennsylvania, and Virginia based on the number of mandates, the type of mandates, the level and extent of coverage for each mandate, and the financial impact of differences in levels of coverage for each mandate.

Accomplishments

In FY 2008, one proposed mandate was evaluated: coverage of habilitative services, regardless of age. This analysis, prepared by Mercer, the Commission's consulting actuary, was approved by the Commission in December 2007, submitted to the General Assembly and posted on the Commission's website. The second issue of the Comparative Evaluation, due every four years, also prepared by Mercer, was approved by the Commission, submitted to the General Assembly, and posted on the Commission's website in January 2008.

THE CENTER FOR LONG-TERM CARE AND COMMUNITY BASED SERVICES

Long Term Care Quality Initiative

The Long Term Care Quality Initiative, a division within the Center for Long-term Care and Community-based Services, focuses on improving long-term and community-based care through public reporting of the performance and quality of long term care facilities. The division is responsible for developing and maintaining the interactive web-based consumer Guides that present general information on Long Term Care (LTC) topics and the specific performance of nursing homes and assisted living facilities in Maryland. The division provides oversight for administration of an annual survey that measures the experience and satisfaction of family members and other designated responsible parties of residents in Maryland's longterm care facilities.

Consumer Guides

Currently two performance guides are maintained: the Maryland Nursing Home Guide and the Maryland Guide to Assisted Living Facilities. The purpose of the guides is to assist consumers in making informed choices and to stimulate quality improvement within facilities.

The *Maryland Nursing Home Guide* offers information about 234 comprehensive care nursing facilities and continuing care retirement communities. Users can review information on facility characteristics such as ownership information, the number of beds, and clinical services; resident

characteristics including gender, age, and functional status; 18 quality measures derived from the CMS Nursing Home Compare data; eleven quality indicators; and the results of inspection surveys. The Guide also provides information about patient rights, how to pay for nursing home care, a checklist to use when choosing a nursing home; and links to additional resources. An interactive search feature allows the user to access nursing home information by facility name or geographical area (county or zip code).

The *Maryland Guide to Assisted Living Facilities* contains an inventory of over 350 assisted living homes with 10 or more beds. Information on facility characteristics, levels of care, facility services, rates, and utilization can be reviewed for individual facilities or compared for multiple facilities.

The Commission continually updates each Guide when data are available.

Nursing Home Guide

In January 2008, the following enhancements were made to the nursing home guide:

- Rates of vaccination for influenza and pneumonia for short and long stay residents added to quality measures
- Quality measure report simplified to display percentages
- 2007 Family Nursing Home Survey results added to the guide
- Option to display picture(s) of nursing homes added
- Expanded information about facility room configuration and proximity of toileting facilities to resident rooms

Explanation of the Revisions

Both influenza and pneumococcal vaccination are recommended prevention measures for older adults because of the high risk for complications among this population following an influenza infection. Influenza vaccine is recommended annually for all adults over the age of 50; a single pneumococcal vaccine is recommended for adults over age 65.

Quality measures were previously reported using a rating of one to three stars. (One star represented the bottom 10%, three stars the top 20%, and two stars represented the middle 70 %. of nursing homes) Changing to report scores by percentage represents a more straightforward calculation and reduces the confusion of symbols which need interpretation for a consumer audience.

2007 Family Nursing Home Survey Results Added to the Guide

Display of picture(s) of a nursing home is now an option the facility may choose. Space in the Guide is available for up to three pictures. Recommended views are the front facade or entry of facility, a typical resident room, and a community gathering area such as the dining area. Thirty percent of facilities added picture(s) to the guide by the end of fiscal year 2007.

Focus groups held by the Commission staff reported that type of room and proximity to toilet facilities was an important factor in choosing a nursing home. The State Health

Plan for Long Term Care requires new nursing home construction projects to build rooms with no more than two beds and no more than two residents sharing a toilet. For nursing home renovation projects the State Plan encourages a reduction in the number of resident rooms with more than two beds and a reduction in the number of instances when more than two residents share a toilet. Display of the number of rooms by type (private, semi-private, etc.) and proximity of the toilet to the room (attached to room or detached) provides this information for consumer use.

Family Survey

- The 2007 revised nursing home family survey was completed and the facility-specific results were added to the Maryland Nursing Home Guide. Maryland is one of only a few states that conduct an annual nursing home satisfaction survey.

- The 2007 survey was revised from the pilot survey used in fiscal year 2006. The 2007 survey consists of 58 multiple choice questions covering seven domains that rate the family members' overall assessment of the physical aspects of the nursing home, the care provided to residents, activities available, resident rights, assistance during mealtime, quality and variety of food, and staff.

- Nearly 60% of family members responded to the survey. Overall, survey respondents gave high marks to the nursing homes. On a 10 point scale, "overall satisfaction" was rated 8.1 and 88% of respondents said they would recommend the nursing home to others. During the latter half of fiscal year 2007 several activities were initiated to prepare for the 2008 survey. Staff reconvened the working group to review each question for appropriateness.
    - An external review of the survey was done by the Agency for Healthcare Research and Quality (AHRQ), Consumer Assessment of Healthcare Providers and Systems (CAHPS) team. Commission staff is very appreciative of AHRQ's review and feedback.
    - The procurement process was implemented to initiate the contractual arrangement for a 2008 survey. The 2008 survey collection time frame is midSeptember to mid-November 2008. Results are expected by mid-December 2008.

- Results of the survey are under consideration by the Maryland Department of Health & Mental Hygiene, Medicaid Long Term Care Division, as one of four factors to be used in a pay for performance incentive program for nursing facilities.

- Commission staff have been invited to participate in the national CAHPS User Group meeting in December to present the Maryland survey.

Assisted living Guide

Information available in the Guide was reviewed and updated in the spring of 2008. A link to the Uniform Disclosure Form was added at this time. Uniform Disclosure is a standard form describing services and policies of Assisted Living programs to inform potential consumers about the services provided by an Assisted Living facility and to assist a consumer in choosing

the most appropriate assisted living program.

The Uniform Disclosure is: 1) filed with the Office of Health Care Quality as part of an application for licensure; 2) amended by the program when services reported on the form change; 3) given to individuals as part of the program's marketing materials; and, 4) given to individuals upon request.

Future plans include display of additional information contained in the uniform disclosure within the Assisted Living Guide to enhance consumer choice.

Future Web Site Enhancements

Staff developed a comprehensive work plan to expand the web site to include community and home-based long term care services. Detailed specifications describing content of the LTC services for the web site enhancement have been written. Proposed services for inclusion are: Adult Day Care, Congregate Housing, Congregate Meals, Home Delivered Meals, Home Health Agencies, Hospice Services, Medicaid Waiver Services, Residential Service Agencies, Senior Centers, SHIP Programs, Transportation Assistance, and Technology Assistance. Written specification of structural, functional, and technical requirements for the site is also completed.

The MHCC and Office of Health Care Quality (OHCQ) were assigned by the governor's office late in the year, the task of developing a "citizen-friendly" report of survey deficiencies in Maryland assisted living facilities. A system that translates the information in a way that is easy to understand and promotes transparency is the end goal. Other state and national models were reviewed by MHCC staff to assist in this task. These changes are expected to be implemented early in fiscal year 2008.

At the invitation of Agency for Healthcare Research and Quality (AHRQ) and Centers for Medicare and Medicaid Services (CMS), staff participated in a Technical Expert Panel (TEP) throughout the year to provide advice on development of a consumer survey for recipients of home health services. When the survey is available for use, the Commission will consider adopting or adapting the survey for use in Maryland.

Long Term Care Policy and Planning

Overview

The Long Term Care Policy and Planning Unit includes health planning functions related to community-based and institutional long term care services. This includes monitoring changes in demographics, medical technology, financing and reimbursement, and their impact on current and projected utilization of long term care services in Maryland; determining where there may be gaps in the continuum of care; and promoting the development of needed services in response to identified needs, assuring access to a full continuum of long term care services. This unit not only includes planning functions, but also includes data collection, special studies, and quality assessment. The Commission coordinates its long term care policy development and planning efforts with other appropriate state agencies, and provides leadership and direction to technical

advisory committees and workgroups conducting analyses of a wide range of issues.

Accomplishments

Reports:

Long Term Services and Supports in Maryland: Planning for 2010, 2020, 2030
During this time period, work was completed on this study required under HB 1342, Long Term Care Planning Act of 2006. The Report was entitled: *Long Term Care Services and Supports in Maryland: Planning for 2010,2020,2030.* A Memorandum of Understanding (MOU) with the University of Maryland Baltimore County, Center for Health Program Development and Management, was in effect from October 5, 2006 through April 30, 2008. In addition, a second MOU was signed with George Mason University for the time period March 15, 2007 through April 30, 2008. The purpose of this MOU was to provide a futurist perspective and to assist in the development of the Long Term Care Study. Weekly conference calls were held with the consultants in the development of this study. They also made monthly presentations to the Long Term and Community Based Services Advisory Committee, which was formed in August of 2006.

The legislative mandate included the following: determination of services and programs needed by persons 65+ and the disabled by 2010, 2020, and 2030; development of population projections for the 65+ and disabled population groups; projections of services and programs operated by the State, including housing, transportation, medical needs, food subsidies; determination of the adequacy of current services and programs by jurisdiction and region; the effect of population growth on current services and programs and the areas most affected; determination of the types of services and programs most needed to support the elderly and disabled; determination of the affordability of services and programs; and the cost to the State to provide needed services and programs.

The approach to the study involved the development of separate chapters on; Institutional Care; In-Home Services and Supports; Community Services and Supports; Housing and Residential Services; Mobility and Transportation; Mental Health Services; and Services for Persons with Developmental Disabilities. There was also a separate chapter on a Survey of National Trends and Innovations as well as the Economic Impact on the State.

The report was presented to the Commission on November 15, 2007 and was completed in December, 2007.

Chronic Hospital Occupancy Update
As required under COMAR 10.24.08, a notice was published in the December 21, 2007 *Maryland Register* to update Chronic Hospital Occupancy for FY 2006. This report is required to be updated annually. It reports data on occupancy for both private and state-operated chronic hospitals. The private chronic hospitals include James Lawrence Kernan Hospital; Johns Hopkins Bayview Medical Center; Levindale Hebrew Geriatric Center and Hospital; University Specialty Hospital (formerly Deaton); and Gladys Spellman Specialty Hospital and Nursing Center. The state operated chronic hospitals include Western Maryland Center and Deer's Head

Hospital Center.

Nursing Home Occupancy Rates and Utilization by Payment Source: Maryland Fiscal Year 2005

The Commission's *2005 Nursing Home Occupancy Rates and Utilization by Payment Source* is based on data that were obtained from the 2005 Maryland Long Term Care Survey, 2005 Medicaid Cost Reports, and the Commission's nursing home bed inventory. This report and its accompanying technical notes were published in the December 21,2007 issue of the *Maryland Register* and were subsequently posted on the Commission's website.

Medicaid Patient Days and Nursing Home Occupancy Update

As required under COMAR 10.24.08, a notice was published in the December 21, 2007 *Maryland Register* to update the Percent of Total Patient Days Paid by Maryland Medical Assistance Program by Jurisdiction and Region for fiscal year 2005. In the same issue of the *Maryland Register,* the Commission also published an updated notice for nursing home operating occupancy for FY 2005.

Home Health Agency Data

Staff completed the Home Health Agency Statistical Profile for FY 2004. The report summarizes data on the utilization and financing of home health agency services in Maryland. The data was obtained from the information collected by the Commission's Home Health Agency Survey for fiscal year 2004, which includes data on overall agency operations and the demographic characteristics payer types, and services provided to Maryland clients by their jurisdiction of residence. This Statistical Profile, as well as the home health agency public use data tables for fiscal years 2004, 2005 and 2006 were posted on the Commission's website. Data tables include an overview of home health agency characteristics, utilization and costs including: volume of admission; referral sources; primary diagnosis on admission; average visits per Medicare clients; disposition; revenues by payer types; and home health agency personnel.

Staff continued to analyze home health agency utilization data based on information submitted to the Commission in its Home Health Annual Survey. During this time period, data was collected from all licensed home health agencies in Maryland for the FY 2007 reporting period using the new automated system.

Study of Health Care Services for Children with Life-Threatening Medical Conditions

HB 797 (2007) directed the Commission to work jointly with the Attorney General's Office on a Study of Health Care Services for Children with Life-Threatening Medical Conditions. The legislation required the State Advisory Council on Quality Care at the End of Life and the Commission to "jointly study the current services and potential care delivery alternatives available for the care of children with life- threatening medical conditions." The study involved a review of the literature, as well as an assessment of care models in other states. From the literature review, the following elements of a care model were drawn: 1} child-and family - centered care; 2) effective pain and symptom management; 3) concurrent palliative and curative treatment; 4) effective communication; 5) emotional and spiritual support; 6) accessible and practical care; 7) continuity of care; and 8) loss, grief, and bereavement care.

The Children's Hospice International Program for All-Inclusive Care for Children and Their Families (CHIPACC) was developed by Children's Hospice International (CHI) in coordination with the Centers for Medicare and Medicaid Services (CMS). There were demonstration models in several states and this study collected information from the following states: Florida; California; Colorado; District of Columbia; Kentucky; Maine; Massachusetts; New York; Virginia; and Washington.

Meetings/Collaboration:

Nursing Home Liaison Committee
This group is chaired by staff of the Medicaid program of the Department of Health and Mental Hygiene (DHMH) and includes representatives of the individual nursing homes, nursing home associations, and accounting firms and consultants. Division staff track changes in Medicaid regulations and receive input from representatives of the long term care industry as members of this liaison committee.

OHCQ Advisory Group on Hospice
Staff participated with the Office of Health Care Quality (OHCQ) on this group. The purpose of these meetings was to share ideas with the hospice community on more effective ways to measure compliance with OHCQ survey standards. In addition, discussion included more effective corrective measures that providers can take when deficiencies are found. This Work Group continued into the end of 2007.

Regulations on Residential Service Agencies
Commission staff reviewed the proposed regulations .01-.28 under COMAR 10.07.05 Residential Service Agencies (RSA), and submitted comments to the Department of Health and Mental Hygiene (DHMH). Standards and requirements for licensure as an RSA, as well as clarification of the nursing oversight for certain RSA clients requiring companion and other non-health related services are described in these proposed regulations. These regulations describe the initial and renewal licensure processes and requirements as well. Ongoing monitoring and inspection by DHMH of RSAs is an important component of these regulations; specifically, with regard to the appropriate training and supervision of individuals providing care to clients in their homes.

House Bill 1187 Work Group
HB 1187, passed during the 2007 legislative session, relates to the financial condition of nursing homes. This bill requires the Secretary of the Department of Health and Mental Hygiene to convene a stakeholders workgroup to make recommendations to the Secretary regarding regulations on: ownership and other information to be required from nursing homes on licensure and relicensure; information on changes in financial condition to be reported to the Department; and other items related to nursing home licensure. Staff attended these workgroup meetings starting June, 2008.

Presentations:

On January 29, 2008, staff was invited to the Annual Hospice Day in Annapolis to make a

presentation to the membership about the status of data collection and other planning issues. The presentation included a discussion of the public use data set for 2005, enhancements to the 2006 public use data set, and the schedule for the 2007 Maryland Hospice Survey.

Staff attended the Maryland-National Capital Homecare Association's Statewide Annual Conference on September 11, 2007. Staff provided background information on the Commission's activities related to home health agency planning and certificate of need (CON) regulations. The amended State Health Plan for home health agency services (COMAR 10.24.08) which became effective on March 12, 2007, was discussed, highlighting the policies, standards for review, and 2010 need projections for general home health agencies.

Data Collection:

Hospice Data Collection

The Commission was charged with collection of its own hospice data without relying on other sources, as a result of SB 732 (2003). The Commission procured a contract with Perforum (now oes), which has developed data collection tools for the National Hospice and Palliative Care Organization, to develop an online hospice survey. The Fiscal Year 2006 hospice data was collected and finalized during this time period. In addition, the Commission completed a contract modification with OCS to expand the work done on the hospice data. This covers enhancements to the Maryland Hospice Survey including: development of a web-based completion and certification process; use of electronic signature procedures to authorize survey completion; requiring full survey completion and corrections of errors prior to survey submission. In addition, there will be trend analyses of Maryland hospice data. Public use data files for hospice data were posted on the Commission's website in March, 2008. This includes the FY 2005 data and preliminary 2006 public use data sets.

The Fiscal Year 2007 Maryland Hospice Survey was released for online survey completion effective March 5, 2008. Data collection, cleaning, and analysis were monitored by means of weekly phone conference calls.

Long Term Care Survey

The 2006 Maryland Long Term Care Survey was released on July 27, 2007; the web-based Pre-Survey Facility Information Update Form was made available for updates of contact information by facility staff on June 15, 2007. The Commission completed data collection on the 2006 Maryland Long Term Care Survey, which included comprehensive care, extended care, subacute care, chronic care, assisted living and adult day care facilities. Responses were received from 690 facilities representing 99% of the surveyed facilities in 2006.

Data elements such as the Medicaid Cost Report data and prior year ending year data were pre-populated into the current year's survey increasing efficiency and reducing errors. Survey data was provided to the public via reports such as the Public Use Data Set posted on the Commission's Web Site, responses to the Nursing Home Guide and the Guide to Assisted Living Facilities. The 2007 Facility Update Form was released in 2008 notifying facility administrators that the survey would commence on July 21, 2008.

Home Health Agency Survey

The FY 2007 Home Health Agency Survey was released through an automated web based application via the Commission's web site for the first time on September 21, 2007. Staff provided training to all home health agency directors at various dates and locations throughout the State of Maryland. The Facility Information Update form served several purposes. Agencies were given the opportunity to complete and update contact information via the Facility Information Update Form; they could also request training, as well as provide feedback prior to the survey start date. By transforming the survey from the previous manual form to an automated real time web based application, which included real time error resolutions and validation prior to submission, staff increased efficiency, the overall quality of the data was higher, and there was a noticeable reduction in the time it took to complete and submit the survey to the Commission. Staff began making updates for the FY 2008 Home Health Agency survey to improve on the navigation and technical requirements of the survey application and to make it more user friendly based on feedback received from the 2007 survey. The FY 2008 survey is scheduled for release during the third quarter of 2008.

Guide to Assisted Living

The Commission surveys assisted living facilities with ten or more beds during the annual long term care survey collection process. For the 2006 survey year, 330 assisted living facilities completed the survey and were included in the Guide to Assisted Living Facilities. All data for this Guide is derived from the long Term Care Survey. These assisted living facilities were given the opportunity to update their profile on the Commission's Web Site with current rates, services and administrative information. Of the total, 25% updated their profile during that period. These facilities are also encouraged to include a photograph of their facility on their individual profile; 54% provided a current photograph of the facility.

The Center for Hospital Services

Hospital Planning & Policy

This program leads development of policies and standards contained in those components of the State Health Plan for Facilities and Services ("State Health Plan" or "SHP") which address acute care general hospitals and other providers of acute and ambulatory care services. Based on the scope of Maryland's Certificate of Need ("CON") program, policies and standards relating to the need for medical surgical inpatient services, pediatric inpatient services, obstetric inpatient services, and ambulatory surgical services, both hospital-based and freestanding, are the priority areas for this program. This program is also the lead program for development of any mandated studies, analyses, or reports addressing these types of health care facilities and services. Personnel involved in these program activities are also involved in analyzing and preparing reports and recommendations on proposed acute and ambulatory care facility service projects seeking CON approval.

Accomplishments

State Health Plan

Development of a comprehensive revision of COMAR 10.24.10, the Acute Inpatient Services Chapter of the State Health Plan, which was initiated during FY 2007, was substantively completed in FY 2008. An Acute Care Planning Work Group composed of general hospital representatives, Department of Health and Mental Hygiene representatives (Office of Health Care Quality and Medicaid), and a representative of third-party payors, completed work on an informal draft replacement plan, which was released for informal review and comment in May, 2008. Based on the nine comments received, a revised draft was developed and the work group met again in August, 2008 to review this second draft. In September, 2008, the Commission adopted proposed permanent regulations and, at the same time, adopted, on an emergency basis, a supplement to the existing State Health Plan Chapter, updating the medical/surgical and pediatric bed need projections, This latter action was taken so that these projections could be used in project review during the period required for promulgation of the new chapter as a final regulation. It is expected that the new chapter will be effective in early 2009.

Work will begin on amending COMAR 10.24.11, the State Health Plan Chapter for Ambulatory Surgical Services, in FY 2009.

Annual Acute General Hospital Bed Licensure

Each year, the Commission participates in the annual process of updating the licensed acute care bed capacity for Maryland's acute general hospitals. Acute average daily census for the twelve-month period ending in March of each year is calculated from data collected by the Health

Services Cost Review Commission. MHCC then reports the total acute care bed capacity for the upcoming fiscal year, equal to 140% of this average daily census. Each hospital then responds with the service mix designation they wish to assign for this licensed bed total, allocating the beds to up to four defined service categories, so long as they have approval for those services. The categories are medical/surgical/gynecological/addictions, obstetric, pediatric and acute psychiatric.

For FY 2008, the number of licensed acute inpatients beds in Maryland's 47 general acute care hospitals increased from 10,426 to 10,681. The hospitals reported that their physical acute care bed capacity for FY 2008, i.e. the maximum number of acute care beds they could "physically" set up and staff, on short notice was 11,530 beds, 849 beds about the total acute care beds licensed for FY 2008.

In May, 2007, the application forms with the new bed licensure numbers for FY 2008 were sent to all hospitals. Along with the allocation of their licensed capacity, hospitals are asked to provide information to the Commission on changes in the capacity of other hospital inpatient services. This annual survey, performed in conjunction with the licensure update process, collected information on the inventory of emergency department treatment space, obstetric service facilities, and surgical service capacity. A report available on the Commission's website, *Annual Report on Acute Care Hospital Services and Licensed Bed Capacity Fiscal Year 2008*, profiles the survey data.

The 2.4% increase in licensed acute care hospital beds from FY 2007 to FY 2008 was higher than the 1.6% average annual increase seen from 2001 to 2008. Maryland instituted its dynamic hospital licensure process for acute care hospital beds beginning in FY 2002.

Ambulatory Surgery Provider Directory

The tenth edition of the Commission's *Ambulatory Surgery Provider Directory, CY 2006* was posted on the Commission's website in October, 2007. The *Directory* provides CY 2006 information on freestanding and hospital-based ambulatory surgery providers in Maryland, such as inventory and utilization data, surgical specialties, and contact information.

The Commission's survey of ambulatory surgery providers (the source of the Directory's information) is updated annually with input and feedback, as necessary, from representatives of the Maryland Ambulatory Surgery Association. This survey information also serves as core data for the Commission's web-based *Maryland Ambulatory Surgical Facility Consumer Guide*.

Policy Coordination with the Health Services Cost Review Commission

Hospital planning and policy staff meet periodically with the HSCRC staff to discuss issues of interest to both agencies, such as data coordination, hospital capital projects, policy and data reports, the status of updates the State Health Plan for Facilities and Services, the status of CON reviews, rate setting policies and rate reviews. In FY 2008, the Commission's chief staff person for hospital services policy and planning served on HSCRC's Financial Conditions Work Group, which examined HSCRC's use o financial condition target values and made recommendations on maintaining existing target values and adopting new values for use in the future.

Also in FY 2008, hospital services planning and policy staff worked with HSCRC staff in developing information on hospital capacity needs and hospital development costs related to efforts for the stabilization and revitalization of Dimensions Health System in Prince George's County. Legislative action in 2008 created a hospital authority, which is currently working to identify an organization to acquire the hospital and other health care facility assets of Dimensions and implement a plan to restructure the system so that it meets the medical facility needs of Prince George's County in a financially viable manner.

Other

Freestanding Medical Facilities

Under Health-General Article §19-3A-07(c), the freestanding medical facility pilot project, the pilot facility, a freestanding emergency services facility in Germantown (Montgomery County) developed and operated by Shady Grove Adventist Hospital, is required to provide the Maryland Health Care Commission information, as specified by the Commission, on the configuration, location, operating, and utilization, including patient-level utilization, of the pilot project. In addition, Health General Article §19-131 requires other facilities that may be approved as freestanding medical facilities to provide information to the Commission. In FY 2006, the data reporting requirements of the law were implemented through regulations *(COMAR 10.24.06 Data Reporting by Freestanding Medical Facilities)* and a Data Work Group was established to provide assistance in development of the proposed patient-level data set for the pilot project freestanding medical facility.

In FY 2007, a second pilot freestanding medical facility was authorized by the General Assembly for development in Queen Anne's County. Work was also initiated on the development of a report for the General Assembly examining how the pilot projects function operationally and financially.

In FY 2008, site visits were conducted at the Germantown facility and a freestanding emergency medical center with a longer operational history in Fairfax County, Virginia. A report on the operational and financial experience of the Germantown facility, which opened in late summer 2006, will be issued in FY 2009.

Mental Health Planning

The 2007 Joint Chairmen's Report directed the Commission to develop a plan to guide the future mental health service continuum needed in Maryland. The report requires the Commission to convene a Task Force to guide development of the plan.

The Commission initiated work on this plan in FY 2008. Consultants were engaged in the fall of 2007 and the Task Force, chaired by the Commission's Executive Director, convened for its first meeting in February, 2008. A series of "White Papers" examining how mental health care services are organized, financed, and delivered in Maryland have been developed and reviewed by the Task Force. Initial plan development work by the Task Force, which will focus on the need for psychiatric hospital capacity and recommendations on developing and coordinating the operation of community-based services and programs needed to prevent or divert patients from hospitalization, including services provided in hospital emergency departments, will be

completed in FY 2009.

Hospital Quality Initiatives

Overview

Chapter 657 (HB 705) of the Acts of 1999 required the Commission to develop a performance evaluation system for hospitals to improve the quality of care and to promote informed decision making among consumers, providers, policymakers, and other interested parties. In fulfillment of this legislative requirement, the Commission released its initial version of the web based Hospital Performance Evaluation Guide (Guide) on January 31, 2002.

The Guide, which may be accessed on the Commission's website (www.mhcc.maryland.gov), enables Marylanders to review information on various hospital facility characteristics. These characteristics include the location of the hospital, number of beds, and accreditation status. Thirty-three high volume diagnosis-related groups (DRGs) are also featured. Marylanders are able to compare the volume, risk adjusted length-of-stay, and risk adjusted readmission rate for each DRG. The Guide continues to provide general information including patients' rights, how hospitals are regulated in Maryland, guidance on what to expect in a hospital setting, and a checklist to help consumers select a hospital. The Guide also includes performance data on eighteen core measures endorsed by the National Quality Forum (NQF), and adopted by the Centers for Medicare and Medicaid Services (CMS), the Joint Commission, (TJC) and the National Quality Alliance (NQA). These nationally endorsed process measures address hospital compliance with evidence-based standards for the treatment of AMI, Heart Failure, Pneumonia, and prevention of surgical site infections.

Hospital Performance Evaluation Advisory Committee

As part of the enabling legislation, MHCC was tasked to work on the design and development of a performance evaluation system in consultation with the Maryland Hospital Association, the Maryland Ambulatory Surgical Association, and interested parties including consumers, payors, and employers. The Hospital Performance Evaluation Guide Advisory Committee meets on a monthly basis and has provided expert advice to the Commission on performance measures and quality improvement strategies since inception of the Guide. This 10-member multidisciplinary committee includes members representing health care consumers, hospitals, nursing, medical research, and organizations involved in quality and patient safety initiatives.

Healthcare-Associated Infections

In response to the significant impact Healthcare Associated Infections (HAIs) have had on both patients and the health care system, a large number of States have passed or are considering legislation with regards to mandatory public reporting of HAIs. In the State of Maryland, Senate Bill 135, *Hospitals-Comparable Evaluation System-Health Care-Associated Infection Information,* became law on July 1, 2006 as Chapter 42 of Maryland law. This law required that the Hospital Performance Evaluation Guide expanded to include healthcare-associated infection information from hospitals.

To assist in developing a plan for expanding the HAI data on the Hospital Performance

Evaluation Guide, the Commission appointed an HAI Technical Advisory Committee (TAC). The purpose of the Technical Advisory Committee was to study and develop recommendations to the Commission on the design and content of a system for collecting and publicly reporting HAI data. In conducting its study, the Committee met monthly beginning in November 2006. The Committee reviewed guidelines from the Centers for Disease Control and Prevention and professional associations, evidence from the medical literature regarding appropriate measures for analyzing and reporting data on healthcare-associated infections, the work of the Maryland Patient Safety Center Intensive Care Unit Collaborative, and the work of other states in implementing legislative mandates to collect and publicly report data on infections.

Accomplishments

Healthcare-Associated Infections
During FY 2008, the HAI Technical Advisory Committee and staff met monthly to develop recommendations for HAI data collection and quality measures for public reporting of hospital performance. The *Final Report and Recommendations of the HAI Committee* was presented *to* the Commission at the December Public Meeting. The Commission approved the report and directed staff to proceed with the implementation of the Committee recommendations. A copy of the report is available on the Commission's website at http://mhcc.maryland.gov/healthcare_associated_infections/index.

Based upon the HAI Technical Advisory Committee's extensive discussions, expert advice and review of the medical literature, it was recommended that the HAI reporting expansion be initiated with the reporting of measures on 1) Central-line-Associated Bloodstream Infections (CLABSIs) in All Intensive Care Units, 2) Health Care Worker (HCW) Influenza Vaccination, and 3) Compliance with Active Surveillance Testing for MRSA in All ICUs. The Committee further recommended use of the National Healthcare Safety Network (NHSN) as the vehicle for collecting these data.

National Healthcare Safety Network (NHSN)
The National Healthcare Safety Network (NHSN) is an internet-based surveillance system that integrates patient and healthcare personnel safety surveillance systems. It is managed by the Division of Healthcare Quality Promotion of the CDC. The Commission, in partnership with the Maryland Hospital Association and the Greater Baltimore and Washington D.C. Metro Chapters of the Association for Professionals in Infection Control and Epidemiology, sponsored a Statewide NHSN Training Seminar for hospitals. The seminar was well attended with over 100 hospital representatives covering all 47 hospitals participating in the event. In accordance with the recommendations of the HAI Technical Advisory Committee, the NHSN system became the vehicle for collecting data and quality measures from Maryland hospitals.

As of July 1, 2008, Maryland hospitals are required to use the NHSN system to report CLABSI data to the Commission. All Maryland hospitals are using the surveillance system to collect information and enhance the monitoring of CLABSIs in ICUs. Maryland is now one of seventeen states that participate in this national internet-based surveillance system. An Advisory Committee has been established to provide ongoing guidance and support during the implementation phase of this project. During FY2009, the Commission plans to develop and

implement strategies to validate and audit the hospital data as well as expand data collection to capture additional measures recommended by the HAI Advisory Committee.

Specialized Services Policy and Planning Division

Overview

This division is responsible for health planning and policy functions related to cardiac surgery and percutaneous coronary intervention, organ transplant, neonatal intensive care, acute inpatient rehabilitation (including brain injury, spinal cord, and pediatric programs), and burn intensive care services. This level of health care is provided to segments of the population that are severely ill or injured, require advanced diagnostic and therapeutic services, and are at high risk for poor outcomes. The cost of staffing and equipping specialized health care services is very high. The main function of the division is to develop a State Health Plan that includes the methodologies, policies, and standards for reviewing applications for a Certificate of Need (CON). The division is responsible for administering the waiver program established under the State Helath Plan for Cardiac Surgery and Percutaneous Coronary Intervention Services (COMAR 10.24.17). the division assists in the collection of data to monitor and assess changes in health care access, quality, and cost; identify and analyze policy options; evaluate alternative approaches to regulation; and improve public knowledge about health care issues. The Commission coordinates the exercise of its functions with other State agencies.

Accomplishments

State Health Plan Provisions for Primary PCI Waiver
The State Health Plan for Cardiac Surgery and Percutaneous Coronary Intervention (PCI) Services requires that hospitals providing PCI services have on-site cardiac surgical services, however, the Commission may waive its policy if the exemption meets specific conditions. Under COMAR 10024.17.05D(1), the Commission may issue a waiver that permits hospitals without on-site cardiac surgery, upon demonstrating the ability to comply with the requirements for primary PCI programs, to provide primary PCI services. Primary PCI is a catheter-based technique used to relieve coronary vessel narrowing associated with acute ST-segment elevation myocardial infarction (STEMI).

In January 2006, the Commission established a clinical data registry for patients with STEMI who present at hospitals that provide primary PCI under a waiver. The registry provides data necessary to monitor each primary PCI under a waiver. The registry provides data necessary to monitor each primary PCI program's compliance with certain regulatory requirements, including patient eligibility, door-to-balloon times, and institutional volume. Two hospitals have relinquished their primary PCI waivers: in February 2007, Mercy Medical Center because the hospital was not on track to meet annual volume or door-to-balloon requirements; and in January 2008, Doctors Community Hospital because the hospital did not meet annual volume requirements.

From January 2006 to December 2007, the medium door-to-balloon time of the waiver hospitals declined from 118 minutes to 83 minutes. In March 2008, the Commission convened its annual

work session on clinical and data management issues, including a review of the 2007 Focused Update of the American College of Cardiology/American Heart Association (ACC/AHA) 2004 Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction, and a presentation on Emergency Medical Services (EMS) notification of STEMI and its effect on door-to-balloon time.

As of June 2008, the following hospitals without on-site cardiac surgery had active primary PCI programs: Anne Arundel Medical Center, Baltimore Washington Medical Center, Franklin Square Hospital Center, Frederick Memorial Hospital, Holy Cross Hospital, Howard County General Hospital, Johns Hopkins Bayview Medical Center, St. Agnes Hospital, Shady Grove Adventist Hospital, Southern Maryland Hospital Center, Upper Chesapeake Medical Center, and Washington County Hospital. Additionally, in April 2008, the Commission granted a one-year waiver to initiate a primary PCI program at Carroll Hospital Center. The schedule for the receipt of primary PCI waiver applications is available on the Commission's Web site.

State Health Plan Provisions for Non-Primary PCI Waiver

COMAR 10.24.17 also includes provisions for the Commission to consider a request for a waiver from its co-location policy for a well-designed, peer-reviewed research proposal. In March 2006, Thomas Aversano, M.D., Associate Professor of Medicine at the Johns Hopkins Medical Institutions, and colleagues sent to the Commission a revised proposal to study non-primary PCI (including elective angioplasty) at hospitals without cardiac surgery on-site (SOS). The comparative study aims to reject the hypothesis that outcomes of non-primary PCI performed at hospitals without SOS are inferior to outcomes of PCI performed at hospitals with SOS.

Based, in part, on the guidance of its Research Proposal Review Committee, the Commission determined that the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) study offers a means of acquiring information to support future evidence-based State health care policy and planning with regard to cardiovascular services. Effective on October 22, 2007, COMAR 10.24.05 Research Waiver Applications: Atlantic C-PORT Study of Non-primary PCI establishes a one-time process by which an eligible hospital may seek a waiver and be permitted to provide non-primary PCI services as part of the Atlantic C-PORT study. In primary PCI research waiver process. The Atlantic C-PORT Principal Investigator discussed requirements for hospital and physician participation in the study and responded to questions about study participation.

In January 2008, the Commission received letter of intent from hospitals with primary PCI programs in the Metropolitan Baltimore and Metropolitan Washington Regional Service Areas. To file a research waiver application, a hospital in a metropolitan region must have a two-year primary PCI waiver at the time of application. In February 2008; the following hospitals submitted applications for a non-primary PCI research waiver: Anne Arundel Medical Center, Baltimore Washington Medical Center, Holy Cross Hospital, Johns Hopkins Bayview Medical Center, St. Agnes Hospital, Shady Grove Adventist Hospital and Southern Maryland Hospital Center. In June 2008 the Commission published the review schedule for applications filed by eligible hospitals in the Eastern Shore and Western Maryland Regional Service Areas. Under COMAR 10.24.05.02C, the Commission may grant a non-primary PCI research waiver to no

more than six hospitals. The research proposal, Committee report, and related documents, including the criteria by which hospitals will be selected to receive a waiver, are available n the Commission's web site.

Certificate of Need (CON) Division

Overview

The Certificate of Need (CON) Program implements the Commission's statutory authority, under the *Annotated Code of Maryland,* Health-General Article §19-103 and §19-120 through §19-127, to review and approve certain new or expanded health care facilities and services. In its administration of this program, the Commission uses the policies and standards it develops and adopts as regulation in the State Health Plan for Facilities and Services. The procedural regulations that guide CON reviews, at COMAR 10.24.01, establish administrative rules and procedures under which all reviews are conducted, and all decisions are brought to Commission for action.

The Commission may approve, approve with conditions, or deny applications by health care providers to establish new facilities or services, to modify existing facilities or previously approved projects, to relocate existing service capacity, to undertake capital projects over a set dollar threshold, or to close certain facilities or services. In administering the program, the Commission also issues determinations of non-coverage for certain types of projects which, while not requiring a CON, may be required by law to provide certain information to Commission and obtain such determinations. Statute also permits the Commission to exempt certain other projects from the requirement to obtain Certificate of Need, so long as the applicants and/or their projects have specified characteristics.

All projects requesting CON approval are evaluated for consistency with review standards and need projections in the State Health Plan for Facilities and Services, and five additional criteria; need, financial viability, impact on costs, charges and other existing providers, costeffectiveness, and the applicant's track record in complying with conditions placed on previously approved projects.

Accomplishments

Certificate of Need Applications and Modifications
During FY 2008, the Commission reviewed twenty-eight (28) CON applications, approving sixteen and denying twelve. It approved nine (9) modifications to previously approved projects.

Three CON applications in review were withdrawn by applicants (one of which was withdrawn following a recommendation for denial) and five (5) CON applications were dismissed from the review process for failure to provide or disclose required information. One Certificate of Need that had been issued by the Commission was relinquished by the holder.

The era of substantial new investment in replacing, expanding, and renovating hospital physical plants, that began in Maryland in the 2002-2003 period, showed signs of slowing down in FY 2008. However, the problem of escalating cost encountered by hospitals which planned major capital projects in the 2003 to 2006 period and initiated projects in 2006 and 2007 was a prominent theme in CON review during FY 2008. In FY 2007, the Commission approved new hospital CON projects totaling over $1.167 billion in estimated project cost and also authorized additional spending of $98.5 million for previously approved hospital capital projects. In FY 2008, the Commission approved six hospital CON projects totaling $323.6 million but authorized a greater level of spending, $439 million, in cost increases for seven hospital projects previously approved. Most of this increase, which, in the aggregate, amounted to a 20.1% rise in the $2.2 billion cost previously authorized for these projects, was due to inflation in the cost of construction. The fiscal year saw no hospital "pledge" projects, Le., projects exceeding the capital spending threshold defining reviewability but not otherwise including elements requiring CON review. There were four such hospital "pledge" projects, with a total estimated cost of $78.5 million, in FY 2007.

Six nursing home, or comprehensive care facility projects were authorized at a total of $50.4 million. All involved redistribution of bed capacity within a jurisdiction through replacement and relocation of beds. None involved a net increase in bed capacity.

Four new general home health agencies were authorized to exclusively serve Montgomery County and an existing home agency was authorized to expand into Dorchester County. The new health agencies are the first authorized through the CON process in approximately 10 years.

Approved CONs

Maryland General Hospital (Baltimore City)
New construction and renovation - replacement of surgical facilities and intensive care unit net reduction of 10 medical/surgical/gynecological/addictions ("MSGA") and pediatric beds
Approved with conditions - $57,615,543

St. Agnes Hospital (Baltimore City)
Expansion and renovation - new bed tower replacing major portion of MSGA bed capacity - renovation of existing nursing units - expansion of Cancer Center - no change in bed capacity
Approved with conditions - $214,931,000

Upper Chesapeake Medical Center (Harford Co.)
Finish a floor of shell space to add 17 MSGA beds
Approved with conditions-$5,037,822

Fairland Nursing & Rehabilitation Center (Montgomery Co.)
Replace 20 comprehensive care facility ("CCF") beds previously authorized for addition at the

facility to be relocated from Springbrook Nursing & Rehabilitation Center with 20 beds acquired from Holy Cross Hospital
Approved with conditions- $215,000

Lorien LifeCenter – Howard County II (Howard Co.)
Establish a new 60-bed CCF
Approved with conditions -$7,899,747

Clifton Perkins Hospital Center (Howard Co.)
Expand forensic psychiatric bed capacity - 48 beds
Approved -$19,815,968

Williamsport Nursing Home (Washington Co.)
Expansion of CCF - 45 beds - and replacement of 27 existing CCF beds
Approved with conditions- $24,248,917

Sinai Hospital of Baltimore (Baltimore City)
Renovation to add 4 operating rooms and expand other surgical facilities
Approved - $21,907,540

Devlin Manor (Allegany Co.)
Expansion of CCF - 30 beds
Approved with conditions - $5,636,412

St. Mary's Hospital (St. Mary's Co.)
Finish shell space to add 15 MSGA beds and 2 operating rooms
Approved - $4,333,821

Govans Ecumenical Development Corporation (Baltimore City)
Establish a new 49-bed CCF
Approved with conditions - $12,406,446

Home Health Corporation of America (Dorchester Co.)
Expand existing home health agency ("HHA") services into Dorchester County
Approved - $65,000

ARGOR Business Solutions d/b/a Comprehensive Home Health Care Agency (Montgomery Co.)
Establish a new general HHA Approved - $167,000

Celtic Healthcare (Montgomery Co.)
Establish a new general HHA
Approved - $387,000

Maryland Home Health (Montgomery Co,)
Establish a new general HHA
Approved - $250,000

MBL Associates (Montgomery Co.)
Establish a new general HHA
Approved - $183,150

Denied CONs
Angel Loving Care Home Health Services
Establish a new general HHA to serve Montgomery County $94,268

Elite Health Care Agency
Establish a new general HHA to serve Montgomery County $139,055
Establish a new general HHA to serve Montgomery County $182,000

Home Health Connection
Establish a new general HHA to serve Montgomery County $90,207

Homestead Health Care
Establish a new general HHA to serve Montgomery County $258,200

Mid America Home Health of Maryland
Establish a new general HHA to serve Montgomery County $385,850

Premier Healthcare Services
Establish a new general HHA to serve Montgomery County $27,998

Reliance Home Health Care
Establish a new general HHA to serve Montgomery County $234,000

Rodriguez-Torres Home Health Agency
Establish a new general HHA to serve Montgomery County $136,185

SHO Health Services
Establish a new general HHA to serve Montgomery County $190,000

Spectrum
Establish a new general HHA to serve Montgomery County $158,138

STAR Associates
Establish a new general HHA to serve Montgomery County $48,653

CON-Approved Projects Modified

Montgomery General Hospital (Montgomery Co.)
Change in financing mechanism with $941,970 decrease in cost

Massachusetts Avenue Surgery Center (Montgomery Co.)
$238,785 increase in cost

Alice Byrd Tawes Nursing Home (Somerset *Co.)*
Change in physical plant design and financing mechanism - $10/027,662 increase in cost

Johns Hopkins Bayview Medical Center (Baltimore City)
Change in operating room equipment systems - $8,036,129 increase in cost

Mercy Medical Center (Baltimore City)
Change in physical plant design - $82,655,004 increase in cost

Doctors Community Hospital (Prince George's Co.)
Completion of space originally authorized as shell space - $7,496,019 increase in cost

Washington County Hospital (Washington Co.)
Addition of shell space - $56,189,517 increase in cost

Johns Hopkins Hospital (Baltimore City)
$252,308,549 increase in cost

Anne Arundel Medical Center (Anne Arundel Co.)
Change in physical plant design - $33,263,203 increase in cost

CON Applications Withdrawn

AMDOS Health Care Services (Montgomery Co.)
Establish a new general HHA to serve Montgomery County
$390,768

Hanover Surgery Center (Anne Arundel Co.)
Establish a freestanding ambulatory surgical facility
$5,366,982

Orthopaedic and Sports Medicine Center (Anne Arundel County)
Establish a freestanding ambulatory surgical facility
$5,366,982

Applications Dismissed from Review

Alpha Health Services
Establish a new general HHA to serve Montgomery County
$67,458

BIC Home Health Care
Establish a new general HHA to serve Montgomery County
$174,469

Dynamic Visions Home Healthcare Agency
Establish a new general HHA to serve Montgomery County
$174,539

First Choice Home Health Services
Establish a new general HHA to serve Montgomery County
$22,100

Global Home Health Agency
Establish a new general HHA to serve Montgomery County
$92,000

CONs Relinquished

Gladys Spellman Specialty Hospital and Nursing Center (Howard Co.)
Addition of 26 chronic hospital beds through conversion of 29 CCF beds
$751,505

Determinations of Non-Coverage and Other Actions

In FY 2008, the Commission issued 161 determinations involving actions proposed by persons or health care facilities requiring a decision with respect to the need for CON review or other Commission authorization. These actions were made in accordance with statutory and regulatory provisions outlining: (1) The scope of CON coverage; (2) the types of projects or actions that, while similar in their general nature to projects that require CON review and approval, can be implemented outside of the CON regulatory process; and (3) The notification requirements and attestations which must be met to obtain the Commission's determination that CON is not required. These determinations are profiled in the following table. Chief among these types of determinations are those involving establishment of single operating room ambulatory surgical facilities, acquisitions of health care facilities, temporary delicensure of beds (for up to one year), primarily nursing home beds, and small increases in the bed capacity of facilities, primarily nursing homes, which are allowed increases of 10% of bed capacity or ten beds, whichever is less every two years so long as the facility maintains operation of all of its bed capacity without changes during that period of time. Additionally, the Commission viewed twelve requests by holders of CONs to implement their projects or parts of their approved projects ("first use review"). Finally, the Commission acknowledged nine cases in which facilities with temporarily delicensed beds did not take timely action to bring these beds back into operation or extend temporary delicensure status thus eliminating these beds from the state's inventory.

Capital projects with costs below the threshold of reviewability	21
Acquisitions of health care facilities Comprehensive care facility (nursing home): 31 Ambulatory surgery center: 7 Home health agency: 4 Hospice: 3 Hospital: 2	47
Establishment of new ambulatory surgery center (no more than one sterile operating room) Baltimore County (8), Prince George's (4), Carroll (3), Cecil (3), Charles (3), Frederick (3), Harford (3), Anne Arundel (2), Montgomery (2), Baltimore City (1), Queen Anne's (1), and Washington (1)	34
Changes in ambulatory surgery center facilities or operation (e.g., addition of non-sterile procedure rooms, surgical staff, surgical specialties, ownership structure)	5
Relicensure of temporarily delicensed ambulatory surgery center	1
Temporary delicensure of comprehensive care facility (beds)	1
Temporary delicensure of CCF beds (421 total beds)	31
Relicensure of temporarily delicensed CCF beds (119 total beds)	10
Acquisition of temporarily delicensed CCF beds by another CCF (14 beds)	1
Extension of validity period for temporarily delicensed beds	1
Add "waiver" beds [1] Comprehensive care facility: 6 for a total of 41 beds Special hospital – chronic care: 1 for 7 beds Special hospital – psychiatric: 1 for 5 beds Special hospital – rehabilitation: 1 for 3 beds	9
TOTAL COVERAGE DETERMINATIONS	161
Pre-licensure and/or first use approval for completed CON projects	10
Partial pre-licensure and/or first use approval for authorized CON project	2
Delicensure of beds Comprehensive care facility: 8 for a total of 167 beds Residential treatment center: 1 for 7 beds	9

[1] Facilities other than hospitals may add beds in limited increments over time without obtaining CON approval, subject to conditions outlined in regulation.

The Center for Health Information Technology

Health information technology (HIT) promises to bring vital clinical information to the point-of care, helping to improve the safety and quality of health care, while decreasing overall health care costs. HIT requires two crucial components to be effective - the widespread use of both electronic health records (EHRs) and electronic health information exchange (HIE). The Center for Health Information Technology is responsible for the Commission's HIT initiatives that include:

- Planning and implementing a statewide HIE;
- Identifying challenges to HIT adoption and use, and formulating solutions and best practices for making HIT work;
- Increasing the availability and use of standards-based HIT through consultative, educational, and outreach activities;
- Promoting and facilitating the adoption and optimal use of HIT for the purposes of improving the quality and safety of health care;
- Harmonizing service area HIE efforts throughout the state;
- Certifying electronic health networks that accept electronic health care transactions originating in Maryland; and
- Developing programs to promote electronic data interchange between payers and providers.

Health Information Technology Division

Overview

The Health Information Technology Division is responsible for promoting the adoption of HIT among health care providers and facilities. HIT has the potential to significantly increase the efficiency of health care by helping providers and consumers adopt tools that will improve the flow of information. Widespread adoption of EHRs is considered by many as a key component in improving quality and efficiency in health care. EHRs electronically maintain patient clinical, demographic data, allows for viewing and managing results of laboratory tests, and imaging, permits order entry including e-prescribing, and includes clinical decision support. EHRs can help both providers and patients by capturing documentation to support that correct procedures were used and highlighting outliers before they become serious issues. Generally speaking, HIT offers the promise of transforming health care in many positive ways; privacy and security of patient information are paramount challenges that pose unique concerns. This division is responsible for addressing stakeholder concerns related to privacy and security to prevent unauthorized access of personal data.

Health Information Exchange Division

Overview

The Health Information Exchange Division is responsible for advancing HIE statewide. Electronic data sharing is critical to the delivery of quality patient care and increasing efficiencies in health care. An interoperable data sharing system holds many potential benefits for consumers, including better coordination of health care regardless of patient location, higher quality and more efficient care, increased system transparency, and patient access to information about providers that allows them to make better decisions. HIE holds great promise, but the many possible benefits will not be realized unless appropriate policy measures are established prior to the implementation. Data sharing raises serious concerns among consumers about privacy and security, and the potential misuse of their information. This division manages various initiatives focused on privacy and security, technology, interoperability, standards utilization, harmonization, and business information systems. The division is also responsible for promoting the adoption of electronic data interchange (EDI), and certifying electronic health networks (EHNs) that exchange transactions originating in Maryland.

Accomplishments

Centers for Medicare & Medicaid Services - Electronic Health Record Demonstration
In collaboration with MedChi, the Maryland State Medical Society, and the Medical Society of the District of Columbia (MD/DC EHR Collaborative), staff participated in the Centers for Medicare & Medicaid Services (CMS) electronic EHR Demonstration Project. Maryland is one of twelve communities selected to participate in this Demonstration Project and is one of four in the Phase One start up. The remaining states are scheduled to take part in Phase Two that will begin next year. This is a five year project designed to show that widespread adoption and use of EHRs will reduce medical errors and improve quality of care. Approximately 200 primary care physician practices with 20 physicians or less are eligible to participate in the demonstration project. Participants can receive an incentive payment ranging from $58,000 (for a single physician practice) to $290,000 (for a group physician practice). The MD/DC EHR Collaborative successfully facilitated the completion of nearly 100 applications from eligible practices. Staff expects to provide support to the CMS demonstration project throughout the five year project.

Electronic Data Interchange & Electronic Health Networks

COMAR 10.25.07, *Electronic Health Network Certification,* establishes a certification process for electronic health networks (networks) that operate in Maryland. MHCC's certification process works in coordination with the national accreditation standards developed by the Electronic Healthcare Network Accreditation Commission (EHNAC). As of November 20,2008,37 EHNs have obtained MHCC certification and four other networks are in candidacy status. MHCC certification is for a two-year period. The certification criteria focus on policies and processes surrounding privacy and security, technical performance, business practices, and resources.

Staff completed two separate revisions to COMAR 10.25.07 *Electronic Health Network Certification* during calendar year 2008. The first changes included updating the certification application fees, and a clarification of the certification requirements to more accurately reflect current industry standards. The second set of changes modified the regulations to allow the Commission to consider network certification by other nationally recognized accrediting entities other than EHNAC.

In compliance with COMAR 10.25.09, *Requirements for Payers to Designate Electronic Heath Networks,* third party payers must report health care transaction data on an annual basis to MHCC. During this reporting period, the volume of practitioner and hospital claims submitted electronically increased by approximately two percent to roughly 83 percent and dental claim volume increased by nearly two percent to about 37 percent.

Consumer-Centric Health Information Exchange - Planning Phase
Planning efforts to build a statewide clinical data sharing utility within the state continued by the Chesapeake Regional Information System for our Patients and the Montgomery County Health Information Exchange. The two multi-stakeholder groups are focused on addressing issues related to governance, privacy and security, role-based access, user authentication and trust hierarchies, architecture of the exchange, hardware and software solutions, costs of implementation, alternative sustainable business models, and strategies to assure appropriate consumer engagement, access, and control over information exchange. Both groups received approximately $250,000 through the Health Services Cost Review Commission's all-payer system to take part in the planning phase. The multi-stakeholder groups are scheduled to submit a final report by February 20, 2009. Staff plans to merge the best ideas submitted from the two groups into a single Request for Application (RFA) to build a statewide exchange that can share information across multiple provider settings. The RFA for the implementation is scheduled to be released around the third quarter of 2009.

Health Information Security and Privacy Collaboration
Staff participated on the Health Information Security and Privacy Collaboration's Adoption of Standards Collaborative Workgroup (Workgroup) to develop the *National Health Bridge (NHB): Basic Policy Requirements for Authentication and Audit.* Maryland is one of ten states that supports cross network HIE for the purpose of treatment for individuals and populations, and the development of an implementation plan that guides participating states in the adoption of the NHB. The Workgroup developed an authentication and audit policy implementation guide for HIEs that are exchanging clinical data. The Research Triangle Institute, under contract with the Office of National Coordinator for Health Information Technology is facilitating this initiative.

Hospital HIT Survey
Staff administered a comprehensive HIT adoption and utilization survey to 47 Maryland hospitals. Working with hospital Chief Information Officers (CIOs) and through a review of existing national HIT surveys, staff identified key questions that will assess the level of Health Information Technology (HIT) implementation and use within primary care units. The survey is designed for comparison with national surveys and is unique in that it assesses clinical data sharing activity within a hospital's service area. Aggregate finding are expected to be published

during the first quarter of 2009.

Privacy and Security Solutions and Implementation Workgroup
Staff convened a Privacy and Security Solutions and Implementation Workgroup (Workgroup) to formulate solutions and develop implementation activities to address organization-level business practices that affect statewide privacy and security policies in order to support interoperable HIE. The Workgroup consisted of more than 30 stakeholders who worked for about nine months to establish eight guiding principles for implementing a private and secure HIE. The final report, *Privacy and Security Solutions and Implementation Activities Report,* was released in September. The report identified nine leading barriers to data sharing, and developed proposed solutions and implementation activities to address these barriers.

Service Area Health Information Exchange
The Hospital CIO Workgroup developed a series of recommendation for including in a *Service Area Health Information Exchange (SAHIE) Resource Guide.* The purpose of the guide is to identify a policy framework for communities that are beginning to exchange patient information electronically. Components of the guide will address items related to a patient's right to access information, a range of business practice, technical standards, and key financial, organizational, and clinical challenges. The hospital CIOs are using a consensus development process to identify standards, policies, and business practices related to privacy and security of electronic health information. The guide is scheduled for release during the first quarter of 2009.

EHR Product Portfolio
Staff developed a web-based ambulatory EHR Product Portfolio (portfolio). The portfolio is located on the MHCC web site and it contains a core set of product information that will assist physicians in assessing and selecting an EHR system. The portfolio includes only those vendors that met the most stringent Certification Commission for Healthcare Information Technology (CCHIT) certification standards relating to functionality, interoperability, and security. Vendors listed in the portfolio have agreed to offer financial discounts to Maryland physicians in the purchase of an EHR system. Approximately 23 vendors who are CCHIT certified are included in the portfolio.

Managed Service Organizations
Staff completed its evaluation of various management services organization (MSOs) that offer EHRs to providers through an application service provider (ASP) business model. Approximately six different MSO business models ranging from hospital affiliation to independent organizations exist in the market. The data suggests providers that participate in an MSO are positioned better to overcome some of the traditional obstacles that exist to EHR adoption. MSOs eliminate the need for an onsite client server as the technology is stored at offsite locations and participation is on a subscription basis. Staff anticipates releasing a report during the first quarter of 2009.

Long Term Care Adoption of HIT
Staff is in the preliminary stages of assessing where long term care fits in terms of HIT adoption and use. Long term care facilities provide care to the fastest growing segment of the population, and accounts for a high portion of the health care dollars spent. To better understand HIT

readiness in the State's nursing homes, staff is exploring issues that impact this stakeholder group specifically related to privacy and security and technology to answer key questions regarding HIT planning and adoption, their readiness to invest in HIT, stakeholder involvement and the needed support for HIT adoption in long term care.