MARYLAND HEALTH CARE COMMISSION

ANNUAL REPORT to the GOVERNOR

Fiscal Year 2010

(July 1, 2009 through June 30, 2010)

Martin O'Malley
Governor

Marilyn Moon, Ph.D.
Chair

Rex W. Cowdry, M.D.
Executive Director

http://mhcc.maryland.gov/

MARYLAND HEALTH CARE COMMISSION

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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.

MARYLAND HEALTH CARE COMMISSION

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)

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.

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.

John E. Fleig is Chief Operating Officer for Mid Atlantic Health Plan for United Healthcare. He is responsible for the overall operations of the health plan and responsible for all aspects of the MAMSI/United integration. Before United Healthcare, he was the Senior Vice President for Mid Atlantic Medical Services, Inc. at MAMSI. Commissioner Fleig earned his undergraduate degree in Psychology from the University of Maryland and his accounting degree from Benjamin Franklin University. He is the former Director of the Maryland Small Group Reinsurance Pool. Commissioner Fleig is a resident of Calvert 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)

Kenny W. Kan is Senior Vice President and Chief Actuary of CareFirst. He is responsible for the company's healthcare trend and pricing development, claims liability reserving, and actuarial support related to key strategic initiatives. He has more than 20 years of progressively responsible actuarial and health care experience. Commission Kan previously worked at Legg Mason Capital Management where he was a securities analyst. Prior to Legg Mason, he was Staff Vice President, Corporate Actuarial, at WellPoint, Inc. in Thousand Oaks, CA. He is a Fellow in the Society of Actuaries, a member of the American Academy of Actuaries and a Chartered Financial Analyst. Commissioner Kan holds both a Master's Degree in Professional Accounting and a Bachelor's Degree with high honors in Business Administration/Accounting from the University of Texas at Austin. Commission Kan resides in Howard County.

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.

Robert Lyles, Jr., M.D., Ph.D is the Medical Director for LifeStream Health Center an Integrated Pain Management Therapy Practice. Dr. Lyles is also a Staff Physician/Anesthesiologist for Dimensions Surgery Center. Commissioner Lyles serves as a member, president and chair of numerous boards and committees. He is Board Certified from the American Board of Anesthesiology, American Board of Anesthesiology Pain Management and from the American Board of Anesthesiology Critical Care Medicine. He earned his Master's Degree and Ph.D in Materials Science from the University of Virginia. He completed his M.D. program in Juarez, Mexico and his internship in surgery from Franklin Square Hospital in Baltimore, Maryland. Commissioner Lyles resides in Annapolis.

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 reation 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)

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)

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 STAFF

Rex W. Cowdry, M.D.
Executive Director

Pamela W. Barclay
Director, Center for Hospital Services

Bruce Kozlowski
Director, Center for Long-term Care and Community-based Services
and
Director, Center for Healthcare Financing and Policy

David Sharp
Director, Center for Health Information Technology

Ben Steffen
Director, Center for Information Services and Analysis

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 2010, the Commission had an appropriation for 64.40 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 centers - 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.

- 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.

- 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.

- 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.

- 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.

- 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 2010, the Commission was appropriated $41,256,391 which includes an appropriation of $12.2 million for the trauma fund and $15 million for the Partnership program. 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 29% of the total budget; 2) Hospitals for an amount not to exceed 31% of the total budget; 3) The Health Occupational Boards for an amount not to exceed 18% of the total budget; and 4) Nursing Homes for an amount not to exceed 22% of the total budget. The amount is derived differently for each industry and is set every four years based on Commission work load.

Surplus

At the close of FY 2010, the Commission's surplus was $3.4 million a reduction of 1.5 million over FY 2009.

OVERVIEW OF FY 2010 ACCOMPLISHMENTS

July 2009

COMAR 31.11.06 – Comprehensive Standard Health Benefit Plan was adopted as emergency and proposed regulations.

Staff presented recommendations for a multi-stakeholder group to implement a statewide health information exchange. The recommendations were approved.

COMAR 10.24.17 – State Health Plan for Cardiac Surgery and Percutaneous Coronary Intervention (PCI) Services – Update of Door-to-Balloon Time Requirement was adopted as final regulations.

Certificate of Need for Baltimore County Home Health Agencies Review is adopted and Certificates of Need are awarded to Carroll Home Care, Celtic Healthcare, Inc., and Maryland Home Health, L.L.C. to expand or establish home health agencies to serve Baltimore County residents.

Staff presented information on Maryland's utilization and spending in consumer-directed health plans (CDHP).

Staff presented the findings of the User of Practitioner Services by the Privately Insurance Nonelderly in Maryland report.

August 2009

No August meeting occurred.

September 2009

COMAR 10.25.01 – Small Employer Health Benefit Plan Premium Subsidy Program was adopted as final regulations.

COMAR 31.11.14 – Wellness Benefits under Small Employer Health Benefit Plans was adopted as final regulations.

Certificate of Need for Frederick Surgery Center is approved.

Certificate of Need for Fairland Adventist Nursing and Rehabilitation Center is approved.

Certificate of Need for Rivermont Nursing and Rehabilitation Center is approved.

Certificate of Need for St. Mary's Hospital modification is approved.

Carroll Hospital Center's application for renewal of their two-year waiver to provide primary PCI without cardiac surgery on-site was approved.

Dr. Cowdry presented on the implications for the General Assembly and the MHCC of the National Health Care Reform Proposals.

October, 2009

COMAR 31.11.06 – Comprehensive Standard Health Benefit Plan – was adopted as final regulations.

Certificate of Need for Frederick County Home Health Agencies is adopted and Certificates of Need are awarded to Carroll Home Care and Community Home Health to expand or establish Home Health Agencies to serve Frederick County residents.

An overview of the 2009 Health Plan Performance Report was presented by staff.

November 2009

COMAR 10.25.06 – Maryland Medical Care Data Base and Data Collection is approved.

A modification to the Certificate of Need for Govans Ecumenical Development Corporation is approved.

A Certificate of Need will issue to Carroll Hospital Center upon the Hospital's submission of a revised Charity Care Policy that complies with COMAR 10.14.10.04A(1).

December 2009

Holy Cross Hospital's application for renewal of their two-year waiver to provide primary PCI without cardiac surgery on-site was approved.

Howard County General Hospital's application for renewal of their two-year waiver to provide primary PCI without cardiac surgery on-site was approved.

Johns Hopkins Bayview Medical Center's application for renewal of their two-year waiver to provide primary PCI without cardiac surgery on-site was approved.

St. Agnes Hospital's application for renewal of their two-year waiver to provide primary PCI without cardiac surgery on-site was approved.

Certificate of Need for Baltimore Washington Medical Center is awarded.

The release of the Maryland Healthcare-Associated Infections Prevention Plan is approved.

Staff presented on the progress report due to the General Assembly, *Electronic Health Records – Regulation and Reimbursement.*

The release of the Annual Mandated Health Insurance Services Evaluation Report is approved.

Staff presented the Annual Report to the General Assembly on the Health Insurance Partnership.

The release of the Limited Benefit Plan Options in the Small Group Market Report is approved.

The release of the Value Based Benefit Design Report is approved.

The release of the Value Based Benefit Design Report is approved.

The release of the Feasibility of Funds for Loan Repayment and Practice Assistance for Maryland Physicians Report is approved.

January 2010

Certificate of Need for Montgomery General Hospital is awarded.

Staff presented a status report on the two freestanding Medical Facility Pilot Projects.

Staff presented the Racial, Ethnic and Language Disparities Work Group Report.

February 2010

A modification to the Certificate of Need for Lorien Life Center in Howard County is approved.

A Certificate of Need for A.F. Whitsitt Center is approved.

Staff presented the Report on the Operations, Utilization and Financing of Freestanding Medical Facilities.

March 2010

Certificate of Need for University of Maryland Medical Center is approved.

Staff presented the report Health Care Spending in Maryland: How does Maryland differ from Other States and Why?

COMAR 10.25.06 – Maryland Medical Care Data Base and Data Collection is adopted as final regulations.

Staff presented the results of the Maryland Nursing Home Family Experience of Care Survey for 2009.

Staff presented the report Medical Expenditure Panel Survey: Maryland Sample through 2008.

April 2010

The April meeting was cancelled.

May 2010

Certificate of Need for Villa Maria Residential Treatment Center is approved.

Certificate of Need for Kaiser Permanente Gaithersburg Surgical Center is approved.

Certificate of Need for Kaiser Permanente Largo Surgical Center is approved.

A modification to the Certificate of Need for Williamsport Nursing Home is approved.

Staff presented a summary of the 2010 Legislative Session. Key legislation enacted included 1) Care Delivery and Payment Reform; 2) Mandated Benefits; 3) Regulation of Healthcare Facilities; 4) Administrative Simplification; and 5) Non-preferred Providers.

Staff presented results of the annual financial surveys of carriers participating in the small group market.

June 2010

Staff presented on the relationship between CMS' Five-Star Quality Rating System and the MHCC's Family Member/Responsible Party Experience of Care survey.

COMAR 10.25.16 – Electronic Health Record Incentives – Action of Proposed Permanent Regulations is adopted as proposed permanent regulations.

Certificate of Need for Kaiser Permanente Baltimore Surgical Center is approved.

Certificate of Need for Fredericktown Ambulatory Surgical Facility is approved.

Certificate of Need for Anne Arundel Medical Center is approved.

Modification to the Certificate of Need for Holly Hill Nursing and Rehabilitation is approved.

MARYLAND HEALTH CARE COMMISSION

The Center for Information Services and Analysis

Cost and Quality Analysis Division

Overview

The Cost and Quality Analysis staff's primary responsibilities are overseeing construction and maintenance of the Commission's Medical Care Data Base (MCDB)—a data base of health insurance claims for covered services received by privately insured Maryland residents—and preparation of annual reports on professional service utilization and health care expenditures in Maryland. Both the MCDB and these annual reports are mandated by Commission statute. The staff also conducts more narrowly focused studies of health care service use and spending, such as examining use of health care services by privately insured diabetics. The division's staff members examine broader health care issues as well, including the measurement and analysis of insurance coverage in the state.

Accomplishments

During FY 2010, the Cost and Quality Analysis division added an additional year of data to the MCDB and provided feedback on data quality to the submitting payers. The division awarded a new five-year contract for the data base vendor and also revised the regulations governing the MCDB (COMAR 10.25.06) to include information on the use of institutional services and eligibility information on enrollees. The division produced six publications, including three reports (two of which are legislatively mandated) and three issue briefs.

Maryland Medical Care Data Base (MCDB) Contract

In September, the staff awarded a data base contract to continue the MCDB project over the next five years. The contract expands the information that will be included in the data base to include information on inpatient care and other institutional services, as well as eligibility information for all enrollees of the submitting payers. Four vendors submitted proposals that were assessed by a team with both internal and external reviewers, including a payer representative. The contract was been awarded to Social and Scientific Systems, Inc.

Given the current economic climate, staff aggressively sought savings in this contract by significantly reducing the number and frequency of the publicly disseminated reports to offset the increased costs of the data base expansion. We met this contracting goal with a reduction

of 10 percent in the cost of this contract compared to the previous contract. This contract also met our MBE participation goal of 25 percent, a significant increase from the 15 percent MBE share in the previous contract

Maryland Medical Care Data Base (MCDB) and Data Collection Regulations
In 2007, the Maryland General Assembly passed House Bill 800 (HB 800), Maryland Health Care Commission – Program Evaluation, (2007 Laws of Maryland, Chapter 627), which authorized the MHCC to expand the scope of information of the MCDB to include information on institutional services (primarily hospital inpatient and outpatient charges), demographic characteristics of the enrollees, and insurance contract information typically collected by the carrier at enrollment in the plan. These data when merged with information on physician services and prescription drugs will allow the Commission to provide a more complete picture of health care utilization and spending for Maryland residents. Longer term, the demographic information will enable MHCC and the Department of Health and Mental Hygiene to better assess health disparities in Maryland. The data base expansion will also bring Maryland's data collection more in line with similar initiatives now underway in Massachusetts, New Hampshire, Vermont, and Maine.

On September 11, 2009, the Commission released, for informal public comment, proposed replacement regulations (COMAR 10.25.06: Maryland Medical Care Data Base and Data Collection, Regulation .01 - .18) to modify and expand the MCDB reporting requirements for payers under existing regulations (COMAR 10.25.06: Maryland Medical Care Data Base and Data Collection, Regulation .01 - .14). The Commissioners voted to accept the proposed replacement regulations for the Maryland Medical Care Data Base (COMAR 10.25.06) at the March 2010 Commission meeting.

Health Care Expenditures Comparison Report
Staff worked with the data base contractor, Social and Scientific Systems, to design the new Health Care Expenditures Comparison Report (HCEC). This report, which will be produced every two years, replaces the legislatively mandated State Health Care Expenditures report. The purpose of the new report—like the old report—is to convey information on health care spending in Maryland. But in contrast to the old report, the new report will: compare spending in Maryland to other states; provide richer contextual data to allow better understanding of the types of factors that underlie spending patterns and trends; and make use of existing information on spending and utilization that is available from other organizations (such as the Centers for Medicare & Medicaid Services), which will make the new report less expensive to produce. The specific content of the report is expected to change over time. This will enable staff to make use of the most interesting and useful information available in any particular production year and to adjust the topics addressed in each version of the report in response to reader feedback on the report's utility.

The 2010 HCEC report, Health Care Spending in Maryland: How does it differ from other states and why? compares per capita personal health care spending in Maryland to other states—both levels of spending and changes over time. Data documenting different aspects of the health care environment—demographic and socio-economic characteristics of residents, supply side and market characteristics, and policy choices—are discussed in order to provide a multidimensional context for examining the variation in spending across states. This type of comparative analysis requires state data that are consistently generated, using identical methods. The only available source is spending estimates created by the Centers for Medicare and Medicaid Services for the years 1991 to 2004. While the data are not as current as desirable, the patterns and forces influencing spending can provide insights into current spending patterns. Regression analyses based on these data—with per capita spending as the outcome and demographic, supply, market and policy characteristics as the inputs—are used to identify the factors most strongly associated with health care spending.

Key findings from the report include:

- In 2004, per capita personal health care spending in Maryland averaged $5,590, 6 percent above the national average and 17th highest among the 50 states.
- The average annual growth rate for personal health care spending in Maryland was 4.2 percent from 1991 to 1998, increasing to 7.2 percent from 1998 to 2004. For the United States overall, the average annual rate of growth was somewhat higher than Maryland in the earlier period (4.8 percent) and somewhat lower in the later period (6.3 percent). More recent data shows the average annual growth rate in the United States continuing to decline through 2008.
- Underlying geographic variation in health care spending are differences in utilization of services and the prices paid for those services. Utilization is driven by a range of complex and interrelated factors; health status is a major determinant and is in turn influenced by health behaviors, age, income, race/ethnicity, and other sociodemographic characteristics. These interrelationships are difficult to disentangle.
- Together, the 25 factors examined in this report accounted for 90 percent of the per capita variation in health care spending; however only seven factors were found to be significantly associated with per capita spending: 1) proportion of the population in fair or poor health; 2) short-term hospital beds per capita; 3) physicians per capita; 4) SNF beds per capita; 5) Medicaid enrollment generosity; 6) hospital per diem costs; and 7) average insurance premiums.

Practitioner Utilization: Trends Among Privately Insured Patients, 2007–2008

This legislatively mandated annual study was completed in September. An important change in this year's analysis is the imputation of payments for services in the MCDB that lack payment information (due to capitation or contracting arrangements). This imputation significantly improves the accuracy of the reported professional service utilization among users with some capitated services, increasing the average expenditure per user in this group by about 20%. Among those using professional services, the average expenditure was $1,186 in 2008, 5%

higher than in 2007. This growth is principally due to a 3% increase in the total number of professional services per user, but a 1% increase in average service complexity also contributed to the increase in spending. The average payment rate—as measured by the average payment per relative value unit (RVU)—was unchanged from 2007

User risk status, as determined by an expenditure risk score, is an important determinant of per-user expenditures for professional services. The annual expenditure for a user with "medium" risk is about twice that of a "low-risk" user, and the annual expenditure for a "high-risk" user is about five times that of a low-risk user. Annual growth in the average expenditure per user did not vary by patient risk status, coverage type, or region. However, growth in average per user spending was lower in HMO plans (3%) compared to non-HMO plans (5%); about 60% of the users in the MCDB are reported to be in non-HMO plans.

Although the overall payment rate was unchanged from 2007, there were changes in the payment rate when examined by payer market share. In the services insured by the largest payers, the average payment per RVU increased by 1% between 2007 and 2008, while the average payment rate among the other payers decreased by 1%. However, the average payment rate among the largest payers, $34.3 per RVU, continues to be below the average rate paid by other payer, $39.8. Some of the difference in average payment rate is due to the fact that services covered by the largest payers are more likely to be provided by participating providers. The largest two payers insured about two-thirds of the users with a full year of coverage.

Health Insurance Coverage in Maryland

In January 2010, the division released a two-page issue brief on insurance coverage in Maryland during 2007–2008. The information in the brief comes from staff analysis of the Current Population Survey, Annual Social and Economic Supplement (CPS ASEC), the same data source used in the Commission's Health Insurance Coverage in Maryland report. (The report and brief are issued in alternate years.). The average annual uninsured rate among Maryland's non-elderly (under age 65) residents in 2007–2008 was 14.4%, with an annual average of 705,000 uninsured nonelderly residents. The uninsured rate among all Maryland residents during 2007–2008 was 12.9%, with an average of 715,000 uninsured residents of any age; the all-ages rate is lower than the nonelderly rate because nearly all of the elderly are covered by Medicare. These rates and uninsured counts are not statistically different from the uninsured values for Maryland residents in 2005–2006. The uninsured rate among children under age 19 in Maryland was also stable over this time period, remaining at 9%. The uninsured rate among the nonelderly has been statistically stable since 2002–2003; in 2000–2001 the nonelderly rate was slightly lower (12%).

As in past years, Maryland's 2007–2008 uninsured rates for the nonelderly, all-ages, and children are significantly lower than the respective national uninsured rates in this time period: 17.2% among the nonelderly, 15.3% among all ages, and 11% among children under age 19. Compared to other jurisdictions, the all-ages uninsured rate in Maryland for 2006–2008, 13.2%, is higher than the uninsured rate for the District of Columbia (10.4%) and 18 states, including

Delaware (11.4%) and Pennsylvania (9.8%) . Maryland's three-year uninsured rate is statistically similar to the rates for 10 states, including Virginia, West Virginia, and New York, and lower than the rates in the remaining 21 states, which include New Jersey (15.1%), California (18.5%), and Texas (24.9%).

Report on Insurance Coverage through Maryland's Private Sector Employers

Every other year staff produce a report on health insurance coverage through the State's private sector employers, based on results from the Medical Expenditure Panel Survey – Insurance/Employer Component, conducted annually by the Agency for Healthcare Research and Quality. The MEPS Insurance Component sends questionnaires to private and public sector employers to collect data on the number and types of private health insurance plans offered, benefits associated with these plans, premiums, contributions by employers and employees, eligibility requirements, and employer characteristics. This year's report, Medical Expenditure Panel Survey – Insurance Component, Maryland Sample through 2008, examines private-sector establishments in Maryland that offered health insurance and the number of employees in these establishments who were eligible and enrolled in 2008. The report includes new information on deductibles, including the proportion of employees whose policies include a deductible and the average size of the deductible.

The vast majority of employees in Maryland's private-sector employers—88%—work for an employer that offers health insurance. This offer rate is essentially unchanged since 1996 and the same as the national rate in 2008. The offer rate generally increases with firm size: the smallest firms (less than 10 employees) had an average offer rate of 49% while the largest firms (1000+ employees) had an average rate of 99%.

Unlike the offer rate, the enrollment rate—the percent of employees at establishments that offer health insurance who are enrolled—declined in Maryland from 2005 to 2008 (67% to 61%). This decline was due to lower enrollment rates in two industry categories: agriculture, fishing, forestry, and construction (78% to 65%) and all others* (85% to 71%). In these categories, the offer rates did not change, but the number—and likely the occupations—of workers did: construction, etc. grew by 39%, all others shrank by 32%, and their eligibility rates declined significantly. These changes are reflected in an apparent decrease in the overall percentage of private sector workers in Maryland who were enrolled in health insurance plans offered by their employers from 2005 to 2008 (59% to 53). However, most of the workers who did not enroll in their employers' plans obtained coverage from another source (spouse's employer, direct purchase, public coverage), resulting in an 82% insured rate among the state's private sector, nonelderly adult workers in 2007–2008 (Current Population Survey), a rate higher than the national average (79%). (*All Others = utilities; wholesale trade; transportation & warehousing; finance & insurance; real estate, rental & leasing; management of companies)

Issue Briefs Based on the MCDB Data

The division produced two issue briefs using MCDB data. Utilization and Spending in Consumer-Directed Health Plans (CDHPS): A look at the small group market in Maryland was released in July. It compares utilization and spending patterns for CDHP users compared to non-CDHP users in the small group market (CSHBP)), which is the only segment of the privately insured in the MCDB for which the MHCC has enrollment information. The results of the study indicate that expenditures per enrollee are an important factor in explaining the differences in premium rates for CDHP versus non-CDHP products.

Diabetes Among Maryland's Privately Insured, Non-Elderly Population: How does the use of hospital and non-hospital services affect spending? was released in January. The study examines the relationship between the number of office visits received by diabetic patients and the probability of having an inpatient admission for diabetes. The analysis looks at privately insured non-elderly adults, enrolled for all of 2007, with a diagnosis of diabetes (with or without complications). It compares the number of office (or outpatient) visits these patients had in the first six months of the year with whether or not the patients had an inpatient admission for diabetes in the last half of the year. In 2007, more than 8 in 10 persons in the study population used some outpatient, non-emergency care from health professionals related to their diabetes, and only 1 in 20 required an inpatient hospitalization. Yet, inpatient care accounted for the vast majority of diabetes-related spending. The median charge for an inpatient stay (for someone with just one stay) was nearly $8,000, and the median spending on non-emergency ambulatory care for persons in the study population with no hospitalizations was only $342. The use of non-emergency outpatient care was not only much less costly than inpatient care but, as demonstrated in a regression analysis included in the study, a small increase in the use of non-emergency ambulatory care may, in some circumstances, reduce the need for hospitalization, creating substantial cost-savings.

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.

The Maryland General Assembly took steps to increase eligibility and reimbursement levels for trauma fund payments in 2006, 2008, and 2009. House Bill 1164 (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 raising 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. In addition, Level II and Level III trauma center hospitals were awarded trauma equipment grants in FY 2007.

Senate Bill 916 (Maryland Trauma Physician Services Fund – Reimbursements and Grants) passed during the 2008 session expanded eligibility for Trauma Fund on-call payments, made the trauma equipment grant program permanent (subject to funds available), and gave the Commission authority to raise physician reimbursement levels.

In 2009, the Maryland General Assembly passed House Bill 521 (Maryland Trauma Physician Services Fund – Rural Trauma Centers – Reimbursement) which expanded on-call stipends for Level III trauma centers for maintaining maintain trauma surgeons, orthopedic surgeons, neurosurgeons, anesthesiologists, plastic, major vascular, oral or maxillofacial, and thoracic surgeons on call; however, the Commission has authority to withhold reimbursement for on-call hours exceeding 35,040 until the remaining costs eligible for reimbursement for Level I, II, III, pediatric and specialty referral centers are fully funded.

The Maryland Health Care Commission (Commission) approved an 8 percent across the board reduction in payment rates for FY 2010 (with the exception of Medicaid) due to the downturn in automobile registration revenue and an expected increase in uncompensated care claims. A $3.8 million surplus existed at the start of FY 2010; however, current law limits total payments in any fiscal year to revenue collected in that same year. Trauma Equipment Grants were awarded to the Level II and Level III trauma centers, reducing the surplus funds' balance to $3.57 million at the close of the fiscal year.

Payments to eligible providers and the administrative costs associated with making those payments totaled about $12.7 million in FY 2010, down slightly from FY 2009. Comparing FY 2010 to FY 2009, uncompensated care payments declined and on call trauma payments increased due to implementation of statutory changes made in 2008. Administrative costs declined in 2010 due to lower uncompensated care claims payments and a reduction in the Commission's third party administrator's fee per claim processed. Transfers from the Motor Vehicle Administration (MVA) to the Fund declined by about $600,000 in FY 2010 due to a drop in the number of automobile registrations and renewals and a reduction of interest earned by the Fund per the Budget Reconciliation and Financing Act of 2010 (HB 151).

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 report on information on health care professionals, hospitals, and facilities such as nursing homes, assisted living facilities, adult day care centers, and home health agencies. This division 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, the District of Columbia (DC) hospital inpatient data, Medicare, private payer outpatient claims

data, private payer pharmacy data, Trauma center expenditures and statistics, and several Centers for Medicare & Medicaid Services (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 data processing and analysis support systems, and internet application development and public reporting of health care consumer information.

Accomplishments

Certificate of Need (CON) Support

Data staff provided CON support for technical issues, mapping and graph reproductions, datasets and maps to support analysis of various CON projects such as the number of psychiatric discharges and patient days reported by age and zip code for selected acute general hospitals and private psychiatric hospitals. Using the specific requirements of in-house analysis staff and external requests, the data staff performed the following:

1. Reported the census for all 365 days in the calendar year by Planner Defined Service; identified and listed the number of discharges, patient days and Average Length of Stay for all patients and for Medical Surgery & Addictions patients;

2. Determined the frequency and total number of residents by Anne Arundel County and non-Anne Arundel County for four (4) fiscal years;

3. Comparison between Ambulatory Surgery for 2 calendar years for one facility for a Certificate Of Need;

4. Major classes of diseases of patients discharged to home with Home Health by jurisdiction;

5. Number of admissions per day to acute care hospitals via the Emergency Departments;

6. Imported Medicaid Cost Reports and compared 4 fiscal years by facility;

7. Analysis of 2007 discharge abstract data with diagnosis codes for Diabetes; and
8. Fiscal Year counts of discharges from 2000 through 2008 for a University of Maryland Medical Center Certificate of Need.

Clinical Risk Groups (CRGs)

This program was a trial to see if resource usage could be predicted based on the MCDB Private Payer diagnostic and procedure codes using the CRG logic. CRGs (developed by the 3M company) are risk groups that can be used as the basis of risk adjustment in a capitated payment system and are also clinically precise so as to be usable as a management tool for Managed Care Organizations (MCOs). The CRGs are a categorical clinical model in which each individual is assigned to a single mutually exclusive risk group which relates the historical

clinical and demographic characteristics of the individual to the amount and type of healthcare resources that individual will consume in the future. Since the CRGs are clinically based, they create a language that links the clinical and financial aspects of care. Thus, CRGs are designed to serve as the foundation of management systems which support care pathways, product line management, and case management.

Electronic Data Interchange (EDI) / Electronic Health Networks (EHN) Support
Data staff processed the final EDI Survey data collection and output the data into databases suitable for use by the EDI staff. Data staff provided technical support to both the EDI and EHN staff with use of web page editing software and assisted the EDI and EHN staff with conversion to using a full-fledged web editing program.

Encryption Project
The purpose of this project is to produce a common encrypted patient id across payers in the Medical Care Data Base. Staff put out a request for proposal from which a vendor was selected to produce an algorithm for the encryption, which is essentially software for which MHCC will have the rights to the source code.

Geographic Information Systems (Maps)
Examples of maps created by data staff:

1. The location of all physicians in Maryland;
2. Identification of the location of existing and proposed facilities for a large health insurance company;
3. Drive time analysis of existing and proposed facilities and hospitals;
4. Location of primary care physicians and their practices;
5. Cluster analysis of Maryland zip codes based on home health utilization by agency.

Graphic Design Support
Data staff supported MHCC staff with poster, brochure, press release, and advertising development, and Illustrator and InDesign technical support and upgrades. Data staff developed several prototype html and email templates for the newsletter project. Data staff researched digital printing requirements and wrote a summary of digital vs. offset printing issues for staff. Data staff provided design support for the Health Insurance and Disparity Spotlight reports.

Home Health
Data Staff prepared the 2008 home health survey data for editing, a data dictionary for the home health public use files, and public use data files in Excel format. Data staff completed initial testing and changes for the 2009 home health survey and reworked administrative

functions, locked fields and tracking portions of the survey according to specifications of the home health staff. Data staff created home health agency reports for distribution to the agencies and worked closely with the home health staff to generate reports and maps for the State Health Plan.

Hospital Guide

Data staff developed a web-based hospital profile edit application for staff to make updates to facility fields on the hospital guide. Data staff worked with the new hospital database contractor to develop access methods to the database and to work out the hospital guide transfer and updates. Data staff developed programs to read in the raw clinical quality measure and Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) files we receive from the hospital vendor and wrote programs to generate quarterly reports on hospital rankings within each clinical measure.

Data staff developed data formats for the methicillin-resistant staphylococcus aureus (MRSA) and health care worker influenza vaccination surveys to be used by the hospital guide vendor for these new sections of the hospital guide. Data staff developed, tested and deployed an online application to allow hospitals to securely submit their central line associated blood infection (CLABSI) data. For hospitals who could not submit data electronically, data staff developed software to read the required fields from OCR scans of CLABSI data which works with three different CLABSI scanned formats.

Institutional Review Board (IRB):

The table below lists IRB-approved data sets which data staff compiled for the Department of Health and Mental Hygiene researchers and other external requestors:

Project Name	Destination	Data Set Required
Discharges by County	Lisa Rosenthal Director of Health Planning HCR Manor Care	2008 Discharge Abstract
Frederick Memorial Hospital Strategic Plan	Brian Ackerman Health Planning Source 324 Blackwell Street Durham, NC 27701	2000-2004 DC data
MATCH	George Thorpe	Discharge Abstract data - Planning meeting and variable definition

	Project Manager Maryland Assessment Tool for Community Health (MATCH)	creation
Utilization of District of Columbia by Maryland Residents	Cohen Rutherford & Knight 6903 Rockledge Drive Suite 500 Bethesda, MD 20817	CY2007 ACCESS data set
Investigation of Maryland Teen Births & Infant Mortality, Maternal Complications of Pregnancy, Childhood Injuries, & Asthma Hospitalizations	Center for Maternal & Child Health Department of Health, Mental Hygiene 201 W. Preston Street Baltimore, MD 21201	CY2005 through 2008 SAS file format

Long Term Care Survey (LTCS)

Data staff performed the following tasks for publicly reported data on long term care facilities: processed quarterly assisted living inspection report updates to the Assisted Living website; processed bi-monthly quality measure and deficiency updates for the nursing home guide; developed the family satisfaction portion of the nursing home guide website; processed quarterly updates to the quality indicator and resident profile sections of the nursing home guide based on Minimum Dataset updates; and reviewed and manually processed photos submitted for the nursing home guide. Data staff provided technical support for writing the long term care portal RFP and with technical questions from the bidders. Data staff worked with the current hospice survey vendor to write the technical portions of the Hospice RFP.

Maryland Assessment Tool for Community Health (MATCH)

George Thorpe, project manager of the Maryland Assessment Tool for Community Health (MATCH), presented a demonstration of MATCH to Commission staff. 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 and Health Department staff to easily perform statistical queries of select Departmental datasets and obtain immediate data results. MHCC continued to collaborate including testing MATCH and incorporating the Maryland Discharge Abstract data set into MATCH.

Medical Care Data Base

Provided programming and technical support for the Medical Care Data Base including validation and installation of files received from the MCDB vendor for private claims, pharmacy, Medicare and Medicare Provider Analysis and Review (MEDPAR).

Minimum Data Set (MDS) from the Centers for Medicare and Medicaid (CMS)

Staff evaluates the content of the MDS data the Commission receives from the Office of Health Care Quality and processes the data in order to support various planning functions of the State Health Plan and to provide nursing home resident profile and quality indicator data for the long term care guide. Recent changes in the MDS collection from CMS resulted in staff working with the MDS Manager Contractor to provide data and technical input as the contractor is developing a new system for processing the raw MDS data. Data staff continued to use and maintain the method we developed to convert specialty codes in the Medical Care Data Base to the CMS Medicare/Medicaid Taxonomy system.

Physician Database

Using the physician database, staff continued to provide analysis of the composition of active physicians with 30 plus office hours. The Data staff synchronized the Maryland and nationwide specialties for the 2008 data to get counts of the total number of doctors and compute their average age by Maryland county compared to the nation as a whole. Data staff entered and cleaned data for the Board of Physicians for the 2,000 active physicians who completed their license renewal manually on paper and prepared documentation for the process.

Software and Administrative Support

Data staff prepared datasets for analysis, provided SAS training and program debugging, and provided analyses by specific patient populations, geographic locations, payer sources, providers, facilities and jurisdictions. Data staff worked with SAS technical support to work through issues of upgrading the Enterprise Guide software. Data staff revamped the SAS licensing to save on the cost of the desktop licensing reducing the cost of desktop licensing from $5200 to $800. Data staff wrote the new tape storage bid, evaluated all bid submissions and made a bid selection.

State Psychiatric Data File Standardization 1980-present

Data staff standardized the State Psychiatric datasets for Maryland residents from 1980 to the present to ensure that variable names, formats and sizes are consistent across datasets in order to allow data manipulation between the files and across years.

Trauma Fund

Staff continued to provide SAS programming support for analysis of emergency room physician uncompensated care claims to be paid by the Maryland Trauma Physician Services Fund, and maps of the distribution of trauma patients within the state. This analysis is included in the Annual Report to the General Assembly on the status of the Trauma Fund. Data staff audited payments made to providers and reviewed claims history including overpayments. Data staff

automated the Payment Block Memo for the Trauma Fund which allows the memo to be automatically printed, saving staff time from the previous manual process.

Web Application Development
Health Insurance Partnership Support and Renewal Maintenance
(multiple site application including Registry and Accounting)
http://mhcc.maryland.gov/partnership/

Patient Centered Medical Home Design and Support (PCMH)
(multiple site application including provider registration and calculator)
http://mhcc.maryland.gov/pcmh/

MHCC User Fee Assessments 2010
(multiple site application including new Assessments EDI payment interface)
http://mhcc.maryland.gov/mhccassessments/

Long Term Care Survey 2010
http://mhcc.maryland.gov/surveyinfo/longtermcare/LTCSurvey2009/index.aspx

MHCC Website
Data staff completed modifications to get critical web pages included in Google Analytics so that staff can track web page visits. Data staff converted the web pages to include Google Analytics tracking after the Clicktracks tracking software was no longer supported. This resulted in a savings of over $800 per year. Data staff developed a listserv sign-up so that interested parties can sign up to receive notifications on selected topics. Data staff overhauled the public use file download application to make it easier to track downloads.

Physician Renewal Design and Support 2010
https://www.mbp.state.md.us/mbp_al_2010/index.aspx
Web Application Development and Support to External Agencies
Boards and Commissions License Renewal
http://www.dhmh.state.md.us/html/proflicm.htm
Ongoing website support and redesign for the following boards:
Board of Acupuncture Members
Board of Audiology / Hearing Aid Dispensers / Speech and Language Pathologists
Board of Chiropractic & Massage Therapy Examiners
Board of Dietetic Practice
Board of Morticians
Board of Occupational Therapy Practice
Board of Examiners in Optometry
Board of Pharmacy
Board of Physical Therapy Examiners

Board of Podiatric Medical Examination
Board of Professional Counselors & Therapists
Board of Examiners of Psychologists
Board of Social Work Examiners

Network and Operating Systems Division

Overview

The division's staff built, upgrades, and maintains the Commission's local area network (LAN). The LAN 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, network printers, switches, and other infrastructure equipment. The staff configures and maintains all network equipment and installs and maintains all server and workstation software.

Division staff implement 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 2010, the Commission's LAN was available to staff over 99% of the time.
The Commission's LAN has been safeguarded by the vigilant application of software patches and the regular upgrade of anti-virus software. Security is enhanced because the LAN 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 – subsequently extended to September 30, 2011), that no longer allows the self-employed to enroll in the CSHBP because of their atypical loss ratio. During the 2009 legislative session, the General Assembly enacted SB 637/HB 674 (Chapter 577 of the Laws of Maryland), which imposed the following modifications to the small group market effective October 1, 2009: removal of the statutory floor; elimination of the prohibition on applying pre-existing condition limitations in this market, allowing carriers to impose this exclusion for up to 12 months based on a six-month look-back period on individuals first entering the small group

market; and the requirement that the Commission establish an information-only web portal to publish small group premium information on its website.

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.

In November 2007, the General Assembly held a special legislative session resulting in the enactment of SB 6, the Working Families and Small Business Health Coverage Act (Chapter 7 of the Laws of Maryland). A major component of this enabling legislation charged the MHCC with creating a Small Employer Health Benefit Plan Premium Subsidy Program, to be made available to certain Maryland small employers with low to moderate wage employees. The purpose of the premium subsidy program is to: (1) provide an incentive for small employers to offer and maintain a group health plan for their employees; (2) help low and moderate income employees of small employers afford the premiums; (3) promote access to health care services, particularly preventive services that might reduce the need for emergency room care and other acute care services; and (4) reduce uncompensated care in hospitals and other health care settings. The Act also requires that the premium subsidies be available to small businesses that (1) employ at least 2 but not more than 9 full-time employees where a group health plan has not been offered during the most recent 12 months; (2) meet salary and wage requirements established by the Commission; (3) establish a Section 125 payroll deduction plan for the employees; and (4) agree to offer a wellness benefit as part of the group health plan. This Act directed the Commission to adopt regulations (COMAR 10.25.01) to establish both the eligibility requirements and the level of subsidies for small employers under the Program. Finally, on or before January 1, 2009 and annually thereafter, the MHCC is required to report to the Governor and the General Assembly on the implementation of the Small Employer Health Benefit Plan Premium Subsidy Program, eventually named the Health Insurance Partnership.

Accomplishments

Comprehensive Standard Health Benefit Plan

During FY 2010, the Commission enhanced the services provided under the CSHBP. Through regulations implemented effective July 1, 2009, dependent children can remain covered on an existing policy until the age of 25. Moreover, coverage for the surgical treatment of morbid obesity was added to the array of benefits provided under the CSHBP. Even with these additional benefits, the overall cost of the CSHBP remained below the affordability cap, currently at 88% of the cap as of December 31, 2009.

With the enactment of HB 610, Bona Fide Wellness Program Incentives, the Commission adopted regulations effective October 2009 so that the wellness regulations (COMAR 31.11.14) comply with this new law while maintaining a provision currently in these regulations to ensure that the components of a wellness benefit include a health risk assessment, written feedback to those who complete the health risk assessment, and a financial incentive to promote preventive care, healthy behavior, or participation in a disease management or case management program.

In June 2010, the Commission contracted with Benefitfocus to develop an information-only web portal, referred to as VIRTUAL COMPARE. Benefitfocus will post on the MHCC website and update quarterly, premium comparisons of health benefit plans issued in the small group market. VIRTUAL COMPARE will be accessible to all Maryland small employers, and will include broker registration capabilities for licensed insurance producers in Maryland.

Health Insurance Partnership

COMAR 10.25.01 established the eligibility requirements for employers and employees, as well as the process for calculating the average wage of the business and the group subsidies for the premium subsidy program, eventually named the Health Insurance Partnership. Throughout FY 2010, four major carriers (Aetna, CareFirst, Coventry Health Care of Delaware, and United HealthCare) continued enrolling small businesses in the Partnership, with each carrier offering various products that qualify for a premium subsidy. On January 1, 2010, the MHCC published the 2nd annual report on the implementation of the Partnership. The report is posted 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). The 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. 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

Accomplishments

2010 Report Series

Division staff continued to work in partnership with contractor staff having special expertise in health quality measurement to develop the series of annual health plan performance reports which include information on the quality of HMO, POS and PPO plans available to Maryland residents.

In 2008 Maryland became the first in the nation to provide consumers with audited, comparative analysis of clinical and member satisfaction measures for PPO plans, giving consumers an opportunity to make distinctions about all of their managed care health plan choices on factors beyond price. This was a result of 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, CIGNA, 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. 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; three plans continue to voluntarily report quality information on PPOs.

The series of annual health plan performance reports was shortened to a two-part series:

- The 2010 Health Plan Performance Report *Consumer Guide* (released in October 2010) is a consumer-oriented report providing a sub-set of measures that are of interest to a general audience. Development of the health plan performance reports is now centered on tailoring the consumer version to become topic driven; the focus topic in 2010 was care coordination.
- The 2010 Comprehensive Report on Maryland Health Plans (released in November 2010) is designed to help plans, purchasers, and policy makers assess the relative quality of care delivered by plans. The report contains three years of HEDIS and CAHPS results, comparing plans to the Maryland state average and highlighting when plan performance significantly increased or decreased.
- The State Employee Guide, which is typically is released in the March following the other reports is discontinued. The report is a consumer-oriented report for state employees. The report mirrors the consumer guide providing information on the subset of plans offered to Maryland state employees. The final report was released in March 2010 and mirrored information provided in the 2009 Consumer Guide. The 2010 Consumer Guide now includes a section with information relevant to state employees.

2011 Report Series
Moving forward, development of the health plan performance reports will focus on providing comparative health plan web-based report cards that present consumer-friendly summary information.

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 under a typical group and individual health plan in Maryland, under the State employee plan, and under the Comprehensive Standard Health Benefit Plan (CSHBP) offered to small employers; (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 2010, two proposed mandates were evaluated: unlimited coverage of autism spectrum disorder with no age limitations; and changing the eligibility for in vitro fertilization coverage from two years of infertility to one year of infertility. This analysis, prepared by Mercer, the Commission's consulting actuary, was approved by the Commission in December 2009, submitted to the General Assembly and posted on the Commission's website. The next Comparative Evaluation, which is due every four years, will be published in January 2012.

THE CENTER FOR LONG-TERM CARE AND COMMUNITY-BASED SERVICES

Long Term Care Quality Initiative

Overview
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 guide that presents general information on the whole continuum of Long Term Care (LTC) and specific performance (quality) information for nursing homes and assisted living facilities. The division also provides oversight for surveys to measure the experience and satisfaction of family members, designated responsible parties, or residents of Maryland's long-term care facilities. The survey results are federally recognized as one of the quality indicators.

Long Term Care Performance Guides
In FY 2010 two web-based performance guides were operational: 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 the facilities by evaluating quality of care and performance and disseminating the results.
The Maryland Nursing Home Guide offers information about more than 230 comprehensive care nursing facilities and continuing care retirement communities. Users can review information about: facility characteristics such as ownership information; the number of beds by type of room; proximity of bathing & toileting to room; clinical and assistance services available; resident characteristics; quality measures derived from the Centers for Medicare and Medicaid (CMS) Nursing Home Compare data; quality indicators; the results of annual licensing and complaint surveys; and the results of the MHCC family experience of care (satisfaction) survey. Pictures of the nursing home are also featured.
The Maryland Guide to Assisted Living Facilities contains an inventory of over 350 assisted living homes with 10 or more beds. In addition to a picture of the facility, information on facility characteristics, levels of care, facility services, rates, and inspection reports can be viewed by consumers.

Nursing Home Experience of Care Survey

FY 2010 marks the third year for the Nursing Home Family Survey which collects the experience and satisfaction of the family members and responsible parties of nursing home residents. Maryland is one of only a few states that conduct an annual nursing home survey; the Maryland survey consistently yields a high response rate of nearly 60% which is well above the national average. Statewide averages show that survey respondents rate nursing homes relatively high. The survey collection takes place in the fall with individual results released in February - March of each year. The accomplishments section lists the results of the 2009 survey which were released in the spring of 2010.

2010 Accomplishments

Consumer Guide to Long Term Care

2010 was a transition year for the nursing home and assisted living guides. Long term care staff completed the procurement process to select a contractor to design and build an expanded and comprehensive LTC web portal focusing on services received in one's home and in the community. Service categories to be added include: home-based care such as home health agencies, residential service agencies, and nursing referral agencies; adult day care centers; and hospice programs. Other features of the expanded site include:

An interactive search feature will allow the user to access nursing home information by facility type or geographical area (county or zip code).

A section on "Understanding, Planning, Preparing for, and Financing Long Term Care" that includes:

- Information on home modifications to allow seniors and persons with disabilities remain in their home,
- Information on community support services including senior centers, meal programs, resources for family caregivers, transportation, and technology assistance,
- A resource section that includes links to federal, state, and local sites that assist in answering questions about long term care prescription drugs, and
- Guidance on health insurance benefits, Medicare, special transportation for persons with disabilities, and resources for family members or friends who help seniors and persons with disabilities.

Nursing Home Experience of Care (satisfaction) Survey Results

2009 Family Survey results show that statewide "overall satisfaction" was rated 8.3 on a 10 point scale and 90% of respondents said they would recommend the nursing home to others.

Results of the survey are used by the Maryland Department of Health & Mental Hygiene, Medicaid Long Term Care Division, as one of four factors in their LTC Pay for Performance initiative for nursing facilities.

Short Stay Nursing Home Survey

Some Maryland nursing homes demonstrate increasing numbers of short stay residents and the number of people needing short stays in nursing homes is expected to continue to increase because individuals indicate a strong preference for receiving services in their home as long a possible. During 2010 MHCC staff collaborated with the Agency for Healthcare Research and Quality (AHRQ) by testing the ARHQ short stay survey in Maryland. This collaboration benefits AHRQ by providing additional testing of the instrument; MHCC benefits by piloting an experience survey among nursing home short stay residents; the nursing homes in Maryland that participate benefit by receiving information from short stay residents about their stay. The pilot took place in the fall 2009 survey cycle. Statewide results of this pilot survey shows that the overall rating given by respondents is 7.6 on a scale of 10 (10 represents the best rating). 82% of short stay respondents would recommend the nursing home.

At the invitation of Agency for Healthcare Research and Quality (AHRQ), Commission staff presented on the Maryland short stay resident survey at the national CAHPS User Group meeting in April 2010 held in Baltimore.

Other Accomplishments

LTC Experience of Care Surveys

During the year, LTC Quality staff researched surveys for use in Maryland for consumers of home health, assisted living, and hospice services. Staff is assessing the feasibility of implementing consumer surveys in each of these settings to improve the information available to consumers. LTC staff have met with CMS and AHRQ staff during development of the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey. The HHCAHPS survey will be mandatory for Medicare certified Home Health Agencies (HHAs) in 2011. Data collection for HHCAHPS began in October 2010. LTC staff is currently determining the steps needed to convert the CMS HHCAHPS data into a format suitable for display in the Maryland Health Care Commission Consumer Guide to Long Term Care.

Staff is planning a pilot hospice survey for 2011-2012.

Influenza Survey Among Nursing Home Staff

A Nursing Home Healthcare Worker (HCW) Seasonal Influenza Vaccination Survey was piloted during the 2009-2010 influenza season in collaboration with the DHMH Medicaid Office of Long Term Care and Community Support. Seasonal influenza infection causes considerable morbidity and mortality among older adults; persons 65 years of age and older account for the majority of the 36,000 deaths that occur from complications of flu each year. Results of the survey show a 2009 statewide seasonal influenza vaccination rate of 60.2% for nursing home HCWs that exceeds the national estimated rate of 54%, but lags behind the Maryland rate for hospital HCWs of 78.1% (hospitals are in their second year of reporting). During the 2010-2011 influenza season, the LTC Quality Initiative will continue to collect vaccination rates of nursing homes and

will report nursing home facility-specific results on the MHCC Consumer Guide to Long Term Care in the summer of 2011.

Long Term Care Quality Initiative staff will pilot a similar influenza vaccination rate survey among the staff of Assisted Living Residences during the 2010-2011 influenza season.

Participation in National Quality Efforts

At the invitation of Agency for Healthcare Research and Quality (AHRQ) and Centers for Medicare and Medicaid Services (CMS), LTC quality staff participated in technical assistance calls throughout the year to provide advice and feedback on revisions to *CMS Home Health Compare* which reports home health services outcomes for recipients of home health services. In addition to improving the current content on the site, AHRQ and CMS are developing a web-based report format for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home Health Survey. Commission staff benefits by participation in this process by gaining knowledge of cutting edge public report practices that can be applied to the MHCC consumer reports.

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

Consultant on Use of Minimum Data Set (MDS)

On June 23, 2009 the Commission released a bit board notice for a consultant to assist Commission staff on the use of the Centers for Medicare and Medicaid Minimum Data Set Resident Assessment Instrument to update data sets for planning and policy development. The contract was awarded to Myers and Stauffer, LC in July, 2009. The focus of the contract is: update current programs and address programming issues; construct variables for research projects; develop a methodology to impute missing data; create data sets that permit tracking of variables over time; and link data sets.

Chronic Hospital Occupancy Update

As required under COMAR 10.24.08, a notice was published in the December 4, 2009 *Maryland Register* to update "Chronic Hospital Occupancy for FY 2008." 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; 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 2008

Data on nursing home occupancy and Medicaid participation rates is updated periodically and published in the Maryland Register to guide Certificate of Need decisions and other planning functions. The following tables were submitted to the *Maryland Register* for publication in the March 12, 2010 issue: "Nursing Home Licensed Beds Occupancy by Region and Jurisdiction: Maryland, Fiscal Year 2008"; "Required Maryland Medical Assistance Participation Rates for Nursing Homes by Region and Jurisdiction, Fiscal Year 2008"

Home Health Agency Data

Staff compiled data tables on the utilization and financing of home health agency services in Maryland for fiscal year 2008. The data was obtained from the information collected by the Commission's Home Health Agency Survey for fiscal year 2008 using an automated system, which includes data on overall agency operations and demographic characteristics, payer types, and services provided to Maryland clients by their jurisdiction of residence. The data tables for fiscal year 2008 were posted on the Commission's website. Data tables include an overview of home health agency characteristics, utilization and costs including: volume of admissions; 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 trend data based on information submitted to the Commission in its Home Health Annual Surveys. During this time period, data was collected from all licensed home health agencies in Maryland for the FY 2009 reporting period.

Home Health Agency Inventory

Staff conducted a verification and update of its home health agency (HHA) inventory. As part of this process, staff sent out letters to all home health agencies on May 5, 2010, requesting each agency to advise the Commission staff whether the agency agreed with their authorized service area. Should the agency disagree with the listed authority in the letter, then the agency was to provide documentation to the Commission of other jurisdictions where the HHA believed it has such authorization by June 7, 2010. Staff finalized the HHA inventory which will be used for planning purposes as well as for updating the Commission's long term care website.

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.

HB 30 Workgroup

The mission of this workgroup was to study: the types of options available in the state for hospice and palliative care; the degree to which these options are utilized within home, long term care, hospital, and hospice settings; the average length of time spent in various settings; and the types and degree of barriers that exist regarding awareness of, and access to hospice and palliative care programs. Staff participated in meetings of this group starting in July, 2009. The final report was submitted to the legislature at the end of December. One of the recommendations was that the Centers for Medicare and Medicaid Services (CMS) work with the Commission to establish quality indicators, looking at best practices approach to include data on family satisfaction with end of life care as a quality indicator.

Following the 2009 legislative session, a workgroup convened to discuss end of life options and development of an End of Life Bill of Rights. One of the recommendations of the workgroup was to distribute the End of Life Bill of Rights and to develop accompanying educational materials. This group continued to meet during 2009 and 2010.

Presentations

Staff attended the combined Lifespan and Health Facilities Association of Maryland Conference to make a presentation on October 1, 2009. The theme of the conference was "Surviving the Storm", dealing with the numerous financial, quality, and other issues faced by the Long Term Care Industry. Staff's presentation informed the providers of the tools available on the Commission's website, including many long term care reports as well as public use data sets derived from the Commission's surveys. Staff presented resident profiles for nursing home, assisted living, hospice, and home health agency settings. Staff also presented analysis of nursing home data from the Long Term Care Survey.

On January 28, 2010 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. Commission staff presented data on hospice patient profiles for FY 2008, selected hospice trends from 2004-2008, and progress made in data collection and analysis. New data was presented on the development of inpatient and residential hospice units. There was also discussion of the expansion of the nursing home website to become a long term care website that includes the development of a hospice guide for the public. Public use data sets for FY

2003-2008 have been posted on the Commission's website along with a Trend Analysis for 2005-2008, and an accompanying Statistical Guide.

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 OCS), which has developed data collection tools for the National Hospice and Palliative Care Organization (NHPCO), to develop an online hospice survey. The Fiscal Year 2008 hospice data was collected and finalized during this time period. The annual survey has been updated to include: 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. The FY 2008 data collection added items from the NHPCO Survey, added the National Provider Identifier, and added clarifications to the survey instructions.

Public use data files for FY 2008 hospice data were posted on the Commission's website in September, 2009. An accompanying Interpretive Guide to explain the variables in the data set was also posted. In October, 2009, work was completed on a Trend Analysis of hospice data for the time period of 2005-2008 and this was also posted on the Commission's website. This shows the differences in variables from year to year and indicates where differences are statistically significant. The Trend Analysis is accompanied by a Statistical Testing Guide that helps the reader to understand what significance tests are being applied and what caveats must be used in interpreting the data.

The Fiscal Year 2009 Maryland Hospice Survey was released for online survey completion effective February 23, 2010. Data collection, cleaning, and analysis were monitored by means of weekly phone conference calls.

Long Term Care Survey

The 2008 Maryland Long Term Care Survey was released on June 22, 2009. Facilities were also given a 2-week lead time (June 9, 2009) to start the survey early. In response to a request by the nursing home associations to accommodate agencies during a difficult economic period, the Executive Director extended the due date to September 20, 2009, but notified providers that as of October 1, 2009 fines would be imposed for late submission On October 5, 2009 the Executive Director issued letters imposing fines to seven facility providers who had not yet completed the 2008 Maryland Long Term Care Survey. As of October 20th, all of the outstanding surveys were completed. Of the seven facilities receiving fining notices, one was exempted, one paid the fine, and the remaining five received notices that their collections will

be sent to the Special Litigation Unit in the Office of the Attorney General. The Commission completed data collection on the 2008 Maryland Long Term Care Survey, which included comprehensive care, chronic care, assisted living, and adult day care facilities. Responses were received from 672 facilities, representing 99% of the surveyed facilities in 2008. The public use data sets for the 2008 survey were posted on the Commission's website in March, 2010.

In July 2009 staff began the process of rewriting the current survey application for the 2009 Survey to make it more consistent with the needs of the Commission, consumers, and the health care industry as a whole. It was released in April of 2010, two months earlier than past years. The staff goal was to streamline the survey, to make it shorter and easier to navigate, and to increase the efficiency and quality of the data. The ten month revision process included: reviewing the value of each question, eliminating questions that no longer aligned with the Commission's needs, combining questions, and adding questions that were vital to improve the quality of the data for staff analysis and reporting of data to the public via the public use data sets and the consumer guides. As such, staff redesigned the survey format into new logical sections allowing for ease of navigation and improving error resolution. Staff wrote validations for each question and each section, Error resolutions were done within the section and across sections. The placement of the validations was done on the actual questions and process validation on each section allowing the user to see any errors in their responses and requiring them to verify and correct their responses immediately before moving on to another question or section. These new features enhanced the ease of completion and improved the quality of the survey data.

Staff created all documentation including detailed specifications for the design and programming of the survey site. After internal testing, in February 2010, Staff consulted with the industry and facility providers by allowing 14 individuals to beta test the survey application for a week. The beta testers responses were critical and where applicable their feedback was addressed; however, overall the feedback indicated that the Commission staff had achieved their goal of making the survey easier to navigate and complete.

To further increase efficiency, staff modified the reporting requirements for nursing home financial information by allowing facilities that had submitted a Medicaid Cost Report to Medicaid to skip the questions that reference the Medicaid Cost Report data. Medicaid Cost Report data for these providers will be merged with the long term care survey data during the post collection data cleaning period. Only facilities that were in a hospital setting, a continuing care retirement community (CCRC), or those with an exemption were required to complete their financial information within the survey application. This cut back on the volume of data that most nursing homes needed to report. Staff also used the past survey feature of pre-populating survey questions with data from the previous year's survey into the 2009 survey application, which facilities could validate instead of doing data entry.

Staff made changes to the survey administration feature by giving facilities the opportunity to submit their questions in real-time within the survey via the feature called the "Message Center." Survey staff could review their concerns and respond to them creating a tracking response for both the Commission and the facility. For the entire collection period staff provided support to the facilities via the Message Center, telephone and emails. Staff also provided training to the facilities by conducting free training workshops at various locations throughout Maryland.

The new and improved 2009 Maryland Long Term Care survey commenced on April 8, 2010, with a due date of June 7, 2010. During the survey collection period, staff sent reminder notices to facilities with a 30-day warning, 45-day warning, and a final warning on June 1, 2010. As of June 8 2010, 94% of the surveys were submitted and accepted. A letter was sent by the Executive Director to 57 facilities that had not completed their survey. These providers were reminded of the due date and were given the option to submit their survey by June 21, 2010 without the penalty of fines. They were also notified that if they did not submit the survey on or before June 21, 2010 that fines would accrue retroactively from June 8, 210 to the date their survey was submitted to the Commission. On June 22, 2010, letters of fines were sent to four facilities who had not submitted their surveys. All four facilities completed the survey. Of these four facilities the Commission received payment from one facility, one was exempt due to closure and the other two have fines pending.

Home Health Agency Survey

Fiscal year 2008 home health agency data was cleaned and made available for staff analysis and reports. For fiscal year 2009, the Home Health Agency Survey was made available to agencies for online completion in two phases. Phase 1 for agencies with a fiscal year ending of March 31, 2009, May 31, 2009, and June 30, 2009 and Phase 2 for agencies with a fiscal year ending of September 30, 2009 and December 31, 2009. The FY 2009 Home Health Agency Survey for Phase 1 agencies was released via our web based application on the Commission's web site on October 13, 2009 due to the Commission on January 12, 2010. Surveys to Phase 2 agencies were released on March 1, 2010 with a due date of May 29, 2010. Responses were received from 37 agencies representing 100% of surveyed agencies. Staff provided assistance to the agency staff by telephone and emails throughout the data collection period.

MARYLAND HEALTH CARE COMMISSION

The Center for Hospital Services

Hospital Planning & Policy

Overview

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 and service projects seeking CON approval.

Accomplishments

State Health Plan

Development of a comprehensive revision of COMAR 10.24.11, the Ambulatory Surgical Services
Chapter of the State Health Plan, was initiated during FY 2010. This work was aimed at expanding the scope of this SHP chapter so that it will have applicability to Certificate of Need regulation of surgical facilities and services in both the hospital and freestanding surgical facility setting, addressing both inpatient and outpatient surgery. This work culminated, shortly after the end of the fiscal year, in the posting of a draft of the new plan on the Maryland Health Commission web site, for informal review and comment, in August, 2010.

Based on the comments received, a revised draft will be developed and a work group will be formed to assist staff in development of a draft that can serve as proposed rules for consideration by the Commissioners.

In March, 2010, pursuant to COMAR 10.24.10, the Acute Care Hospital Services Chapter of the SHP, updated projections of medical/surgical/gynecological/addictions ("MSGA") bed need and

pediatric bed need, for a target year of 2018 and based on 2008, were published in the Maryland Register and on the MHCC web site.

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.

In May of each year, licensure application forms with the new bed licensure numbers for the coming fiscal year are 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, has historically collected information on the inventory of emergency department treatment spaces, obstetric and perinatal service facilities, and surgical facilities. In 2008, the survey was expanded to collect information on psychiatric, medical rehabilitation, and special hospital bed inventories and, in 2009, the survey was expanded to include information on surgical cases and surgical case times. In July, 2009, an interim report summarizing the new acute care hospital bed licensure information for FY 2010 was published on the Commission's web site. In November, 2009, the full Annual Report on Selected Maryland Acute Care and Special Hospital Services, FY 2010, was published on the Commission's website.

For FY 2010, the number of licensed acute inpatient beds in Maryland's 47 general acute care hospitals increased from 10,827 to 10,880. The hospitals reported that their physical acute care bed capacity for FY 2010, i.e. the maximum number of acute care beds they could "physically" set up and staff, on short notice was 11,635 beds, 755 beds above the total acute care beds licensed for FY 2010. The 0.5% increase in licensed acute care hospital bed capacity was well below the 1.4% average annual increase seen from FY 2002 through FY 2010. Maryland instituted its dynamic hospital licensure process for acute care hospital beds beginning in FY 2002.

Ambulatory Surgery Provider Directory

The twelfth edition of the Commission's Maryland Ambulatory Surgery Provider Directory was posted on the Commission's website in January, 2010. The Directory provides CY 2008 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 electronic 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 and can be accessed through the Commission's web-based Public Use Files.

New areas of data collection In this survey addressed board certification of surgical facility medical staff, hospital privileges maintained by practitioners on staff at freestanding surgical facilities, and transfers of patients from freestanding surgical facilities to hospitals. Additionally, a supplemental survey on the use of health information technology by ambulatory surgical facilities was developed by the Commission's Center for Health Information Technology staff and the annual survey was used as a platform for implementing this new survey. The information gathered on these new questions was reviewed by industry representatives and, after the second year of data collection on these topics for CY2009, staff will work on incorporating this information into the Maryland Ambulatory Surgical Facility Consumer Guide.

In April, 2010, the Center for Hospital Services distributed the 2009 survey to 370 potential survey respondents; 358 responses were received and, of these, 333 facilities were operational during all or a portion of the survey period.

Policy Coordination with Other Agencies

The Chief for hospital planning and policy met with the Health Services Cost Review Commission's Rate Methodology Committee in December, 2009, to provide input on changes considered with respect to how capital costs are recognized by HSCRC in hospital rates. More generally, staff of the Center for Hospital Services and HSCRC staff consulted throughout the year on questions relating to data, the financial feasibility of hospital capital projects, and particular financial challenges confronting specific hospitals

Hospital policy and planning staff met with the staff of the Office of Health Care Quality ("OHCQ") of the Department of Health and Mental Hygiene in February, 2010. This office licenses health care facilities. A range of policy and communications issues bearing on the work of both MHCC and OHCQ in regulating health care facilities were reviewed and steps for improving inter-agency coordination were planned.

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 to 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, data reporting requirements of the law were implemented and a Data Work Group was established. In FY 2007, a second pilot freestanding medical facility was authorized by the General Assembly for development in Queen Anne's County and the first pilot facility initiated services. 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 and an Interim Report on the Operations, Utilization, and Financing of Freestanding Medical Facilities was submitted to the Chairmen of the Senate Finance and House Health and Government Operations Committees. In FY 2009, work continued on development of a final report.

This final report, a Report on the Operations, Utilization, and Financing of Freestanding Medical Facilities, was released in February, 2010.

Green Building

On October 29, 2009, Hospital Services Planning and Policy staff was given a presentation on the application of green design and sustainable design principles in hospital planning and design by Peter and Lorraine Doo of Doo Consulting, Baltimore.

Influenza – Seasonal and Pandemic (H1N1)

In August and September, 2009, Hospital Services Planning and Policy staff participated in an inter-agency work group on ICU Surge Capabilities for H1N1. This work group was established to provide guidance to the contingency planning efforts of hospitals in anticipation of their need to handle higher than normal levels of demand for emergency medical treatment and admissions during the Fall of 2009 and the Winter of 2009/2010 related to epidemic levels of H1N1 influenza virus incidence and prevalence. The Work Group developed a system for monitoring increases in ED and bed demand in order to trigger varying levels of hospital contingency plan implementation, at the institutional, regional, or statewide level. Commission staff served as a resource on hospital service capacity and baseline levels and patterns of demand to assist the group in understanding the data being monitored.

Also, in September, 2009, Center for Hospital Services staff met with representatives of the Maryland Ambulatory Surgery Association to discuss plans for surveying influenza immunization levels among the staff of Maryland's ambulatory surgical facilities and centers. To eliminate the burden of an additional survey, the seasonal influenza vaccination survey questions were incorporated into the Commissions' 2009 Maryland Freestanding Ambulatory Surgical Facility Survey and distributed to Freestanding Ambulatory Surgical Facilities in mid- April, 2010. The seasonal influenza vaccination questions were specifically directed to the 2009 – 2010 flu season (September 1, 2009 – April 15, 2010).

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. Fifty high volume diagnosis-related groups (DRGs) are also featured. Marylanders are able to compare the volume and average length-of-stay 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 twenty-three 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 Hospital Quality Alliance (HQA). These nationally endorsed process measures address hospital compliance with evidence-based standards for the treatment of AMI, Heart Failure, Pneumonia, and surgical patients, including the prevention of surgical site infections.

Hospital Performance Evaluation Guide 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, payers, 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 be 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 TAC 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 (CDC) and professional associations, evidence from the medical literature regarding appropriate measures for analyzing and reporting data on HAIs, 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.

The Final Report and Recommendations of the HAI Technical Advisory Committee was approved by the Commission in December 2007 and staff was directed by the Commission to proceed with implementation of the recommendations. A copy of the report is available on the Commission's website at http://mhcc.maryland.gov/healthcare_associated_infections/index.html.

Accomplishments

The Maryland Quality Measures Data Center (QMDC)

The Commission relies heavily on data from a variety of sources to support the hospital performance evaluation system. In FY2009, the MHCC initiated a consolidated data management strategy which entailed the establishment of a Quality Measures Data Center (QMDC). The QMDC functions as Maryland's repository of hospital performance measures data and includes a secure web portal for hospital submission of quality measures and patient experience data. The QMDC also functions as a centralized communication tool for sharing information with hospitals on upcoming reporting requirements and well as providing a vehicle for review of facility performance data prior to public release. In FY2010, the Commission began utilizing the data collected through the QMDC for timely reporting of clinical quality and patient experience measures on the web-based Maryland Hospital Performance Evaluation Guide on a quarterly basis.

Expanded Quality Measures Data Collection

In FY 2009 and FY 2010, the Commission expanded Maryland's quality measures data reporting requirements to include patient experience data and CMS mortality data for three common medical conditions; AMI, Heart Failure, and Pneumonia. To collect patient experience data, the Commission utilizes the Consumer Assessment of Health Providers and Systems (CAHPS®) Hospital Survey (also known as HCAHPS). The HCAHPS Survey, which has been formally endorsed by the National Quality Forum and Hospital Quality Alliance, includes 27 data items covering key aspects of hospital care: care from nurses; care from doctors; the hospital environment; experiences in the hospital; discharge planning; and an overall rating of the hospital. The survey provides a standardized tool for measuring patients' perspectives on hospital care. In addition to reporting overall patient experience, the Commission initiated

reporting of patient experience by major clinical service (i.e., medical, surgical, and maternity service) in FY 2010.

Healthcare-Associated Infections

A major focus during FY 2009 and FY2010 has been the implementation of recommendations developed by the HAI Technical Advisory Committee (TAC). Based upon extensive discussions, expert advice and review of the medical literature by the TAC and MHCC staff, it was recommended that the HAI reporting 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 where feasible.

Establishment of the new Healthcare Associated Infections (HAI) Advisory Committee

The HAI Technical Advisory Committee recognized that the implementation and sustainability of the Committee's recommendations would require ongoing involvement of individuals with expertise in infection prevention and control. To facilitate implementation of the recommendations, the HAI Advisory Committee was established to provide ongoing guidance and support to this project. As a result, the Commission has made significant progress towards the implementation of the Committee's recommendations. The 21-member HAI Advisory Committee represents 10 key stakeholder organizations and meets on a monthly basis.

National Healthcare Safety Network (NHSN)

The 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 Centers for Disease Control and Prevention (CDC). As of July 1, 2008, Maryland hospitals report CLABSI data to the Commission and all hospitals are now using the surveillance system to collect information and monitor CLABSIs in ICUs and NICUs. Maryland is now one of twenty-two states that require hospitals to participate in this national internet-based surveillance system.

CLABSI Data Validation Project

In 2009, the Commission initiated a procurement project to engage the services of a contractor with expertise and experience in the review of healthcare-associated infections data. The project included the on-site review of patient medical records to assess the accuracy of the hospital data submitted through NSHN. The validation project was completed in FY2010 and the results were used to educate hospital data providers and to facilitate process improvement activities. The Commission intends to publicly report the CLABSI data on the Hospital Guide in FY2011.

Other HAI Data Collection Activities

Under the continued guidance of the HAI Advisory Committee, the MHCC developed two survey instruments to collect information from hospitals on important HAI prevention and control activities. In FY2010, the Commission conducted an online survey designed to collect data on the rate of Health Care Workers Influenza Vaccination in individual hospitals. This survey was first initiated as a pilot project to provide useful information on employee vaccination rates to hospitals. The results of the pilot survey were not made publicly available, but were used to inform staff efforts geared toward the development of an annual survey of hospital employee vaccination practices. In July 2010, the Commission released the results of the Health Care Worker Influenza Vaccination survey on the Hospital Guide for the first time. The Commission intends to administer the survey on an annual basis and post the results on the Hospital Guide annually in July.

A quarterly online survey for collecting data on the level of Active Surveillance Testing (AST) for MRSA in All ICUs was also developed in FY2009. It is important to note that this is a process measure that evaluates the rate of hospital screening for MRSA in all ICUs; it is not an outcome measure that evaluates the rate of MRSA colonization or infection in the hospital. The results of these quarterly surveys were posted to the Hospital Guide in July 2010 and are updated on a quarterly basis.

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 Health 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 10.24.17.05D(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 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 provided the audited data necessary to monitor each primary PCI program's compliance with certain regulatory requirements, including patient eligibility, door-to-balloon times, and institutional volume. From January 2006 to December 2009, hospitals with a primary PCI waiver used the Commission's data registry for patients presenting with STEMI and for PCI services provided to patients meeting certain eligibility criteria. Effective July 1, 2010, Maryland acute care hospitals with a waiver from the Commission to provide primary PCI are required to use the American College of Cardiology Foundation's National Cardiovascular Data Registry® (NCDR®) ACTION Registry®-GWTG™ to report quarterly data to the Commission for eligible patients discharged on or after July 1, 2010. The hospitals are also required to enroll in the NCDR CathPCI Registry® effective July 1, 2010, and use the CathPCI Registry to report quarterly data to the Commission. The ACTION Registry includes data on acute coronary syndrome patients (STEMI and non–ST-elevation myocardial infarction (NSTEMI) patients). The CathPCI Registry includes data on diagnostic cardiac catheterizations and PCI.

In July 2009, the Commission took final action to amend COMAR 10.24.17 by requiring, effective January 1, 2010, that hospitals provide primary PCI with a door-to-balloon time within 90 minutes for at least 75 percent of appropriate patients. The amendments made the regulation consistent with the 2007 focused update of the American College of Cardiology (ACC)/American Heart Association (AHA) 2004 Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction. Data from the Commission's registry showed that, in 2009, 72% of the patients undergoing primary PCI at the hospitals with waivers received PCI in 90 minutes or less. The performance of the waiver hospitals has improved steadily since 2006, when 39% of their patients received PCI within 90 minutes.

In September 2009, the Commission convened a meeting of the hospitals with primary PCI waivers, along with the Medical Coordinator and Senior Nurse Manager of the Commission's registry, to discuss clinical and data management issues. Also in attendance were representatives of the Maryland Institute for Emergency Medical Services Systems (MIEMSS), and the American Heart Association/American Stroke Association, Mid-Atlantic Affiliate's Greater Washington Region and Maryland. Held at Frederick Memorial Hospital (FMH), the work session included a summary of January to June 2009 data from the Commission's registry; a presentation on the door-to-balloon times achieved by FMH's start-up primary PCI program, including its "Code Heart" workflow and the LIFENET System for 12-lead electrocardiogram

(ECG) transmission; a presentation on regionalization and coronary artery disease; an update on the consensus-building process begun by MIEMSS to designate hospitals as cardiac (interventional) centers; and information from the AHA about Mission: Lifeline, AHA's national initiative to improve the systems of care for patients with STEMI.

In January 2010, the Commission published in the *Maryland Register* an updated schedule for the receipt of applications to request a waiver to provide primary PCI services in a hospital without on-site cardiac surgery. The schedule includes dates of submission for hospitals seeking to initiate primary PCI services; hospitals that have received a one-year waiver to initiate a primary PCI program; and hospitals seeking to renew a two-year waiver. A hospital must provide primary PCI services for a one-year period before receiving a two-year waiver.

Following the issuance of an initial one-year waiver permitting the development of a hospital's primary PCI program, the Commission may issue a waiver for a two-year period provided that the hospital has met the requirements found in COMAR 10.24.17, Table A-1. During 2009, the Commission issued a two-year waiver to each of the 13 hospitals that currently provide primary PCI without on-site cardiac surgery services. As of June 2010, the following hospitals without on-site cardiac surgery had primary PCI programs: Anne Arundel Medical Center, Baltimore Washington Medical Center, Carroll Hospital Center, Franklin Square Hospital Center, Frederick Memorial Hospital, Holy Cross Hospital, Howard County General Hospital, Johns Hopkins Bayview Medical Center, Saint Agnes Hospital, Shady Grove Adventist Hospital, Southern Maryland Hospital Center, Upper Chesapeake Medical Center, and Washington County Hospital. The schedule for the receipt of primary PCI waiver applications is available on the Commission's website.

In March 2010, the Mid-Atlantic Affiliate of the American Heart Association invited a broad constituency of health and clinical colleagues from within the Mid-Atlantic Affiliate states to participate in the first in a series of webinars on STEMI systems of care. The Mid-Atlantic Affiliate serves Maryland, the District of Columbia, Virginia, North Carolina, and South Carolina. The webinar focused on Mission: Lifeline® from the national perspective, and on the ACTION Registry–GWTG (Get With The Guidelines) and how this registry for acute coronary syndrome patients relates to Mission: Lifeline as the data source for AHA's community-based initiative. Dr. Alice Jacobs, Professor of Medicine at the Boston University School of Medicine, Past President of the American Heart Association, and Chair of the national Mission: Lifeline Advisory Work Group, discussed the national view of Mission: Lifeline and presented a progress report. Dr. Matthew Roe, clinical cardiologist and Associate Professor of Medicine at Duke University and Chair of the ACTION Registry–GWTG Research and Publications Committee, described the premier and limited versions of the ACTION Registry–GWTG and presented national data on trends in the reperfusion of STEMI patients. Commission staff and approximately 35 attendees representing 14 hospitals in Maryland participated in the webinar.

AHA's Mid-Atlantic Affiliate allocated funding to support a state-wide Mission: Lifeline meeting, held at Anne Arundel Medical Center in May 2010, to bring together regional representatives from across Maryland to work on strengthening STEMI systems of care and improving outcomes for patients in their respective regions. Commission staff participated on the Workshop Planning Committee and presented an overview of primary PCI policy development in Maryland, the Commission's primary PCI waiver program, recommendations of the Commission's Primary PCI Data Work Group, and establishment of an ongoing Cardiac Data Advisory Committee. Other sessions included a panel discussion on improving the door-to-balloon times of patients presenting at non-PCI centers, such as the STEMI performance improvement initiatives at the Greater Baltimore Medical Center; and the TeleMedStar Quality Improvement (QI) Project at the Washington Hospital Center, which has invited non-PCI hospitals to participate in using videophone ECG transmission to expedite the transfer of patients. The workshop concluded with regional team meetings to begin discussing the planning and assessments by EMS regions that will be performed by the MIEMSS Regional STEMI Committees.

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 established 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 multi-state Atlantic C-PORT study (C-PORT E). The Commission granted research waivers to the following hospitals: Anne Arundel Medical Center, Saint Agnes Hospital, Shady Grove Adventist Hospital, Southern Maryland Hospital Center, Frederick Memorial Hospital, Washington County Hospital, Baltimore Washington Medical Center, Johns Hopkins Bayview Medical Center, and Holy Cross Hospital. The research waivers are time-limited and not intended to consider locations for non-primary PCI programs without cardiac surgery on-site beyond the study period.

Because of the type of study design employed and clinically-based assumptions about expected mortality and MACE (major adverse cardiac events, i.e., death, myocardial infarction and/or target vessel revascularization) event rates, a total of 18,360 patients who meet strictly defined

eligibility criteria are required for the successful completion of the study. Of this number, 75% (13,770) will receive non-primary PCI at hospitals without on-site cardiac surgery. The other 25% (4,590) will be randomly assigned to receive non-primary PCI at hospitals with on-site cardiac surgery. The C-PORT E study includes hospitals in both urban and non-urban areas that represent diverse patient populations, patient volumes, and varying proximities to tertiary care centers. The research proposal, Committee report, Commission decisions, and related documents are available on the Commission's website.

Certificate of Need (CON) Program

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 the 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 the 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, the cost and effectiveness of alternatives, and the applicant's track record in complying with conditions placed on previously approved projects.

Accomplishments

Certificate of Need Applications and Modifications

During FY 2010, the Commission completed review of forty-four (44) CON applications, approving nineteen (19); most with conditions, and denying twenty-five (25) applications. It also approved five (5) modifications to previously approved projects. The denied applicants were persons proposing to establish new home health agencies or to expand existing home

health agencies into two jurisdictions for which comparative reviews were concluded in FY 2010. One (1) CON application in review was withdrawn by the applicant before Commission action. Two (2) Certificates of Need that had been issued by the Commission were relinquished by the holders.

In recent years, Maryland hospitals have invested heavily in replacing, expanding, and renovating hospital physical plants. During this period, hospitals experienced steady growth in patient census. Unfortunately, this period also saw sharp upward spikes in the prices for several important construction materials and high construction contract costs, related to the strong demand for project management expertise and construction trade labor. From 2002 through 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. The hospital building boom slowed in FY 2008. However, the problem of escalating cost encountered by hospitals which planned major capital projects in previous years and initiated projects in 2006 and 2007 was a prominent theme in CON review. 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 hospital building boom that Maryland experienced between 2002 and 2007, which slowed in 2008, definitively subsided in the past two year period of FY 2009-2010. From 2002 through 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. In FY 2009, the Commission reviewed five hospital projects, but only one of these was a large expansion and renovation proposal, at an estimated cost of $89.1 million. The other four hospital projects, in the aggregate, totaled only $32.3 million in spending. No modifications to the approved cost of hospital projects were considered in FY 2009. In FY 2010, the Commission also reviewed five hospital projects, one of which was large (an estimated cost of $176 million). The other four projects, combined, totaled only $57.7 million. One modification of a previously authorized hospital project was reviewed in FY 2010. In contrast to the pattern of recent previous years, this project was scaled back in scope and cost, from $89.1 million originally approved, to a more modest $56.1 million redesigned project. Two authorized hospital projects with combined approved costs of $49 million, were abandoned in FY 2010.

There were no hospital "pledge" projects, i.e., projects exceeding the capital spending threshold defining reviewability but not otherwise including elements requiring CON review, in FY 2010. Such projects avoid the need for CON approval by "pledging" not to seek substantive rate adjustments related to the project's depreciation and interest expenses. The current hospital capital expenditure threshold, established in February, 2010, is $10.8 million.

Two nursing home, or comprehensive care facility projects, involving the establishment, replacement, or expansion of such facilities were authorized in FY 2010 at a total estimated cost of $74.2 million. Four modifications of previously approved nursing home projects were authorized; three of the modifications added $4.6 million in project costs and one nursing home expansion project was scaled back, from $24.2 million to $10.5 million.
As previously noted, 25 CON applications proposing the establishment of new general home health agencies or the expansion of existing agencies into new jurisdictions were denied as comparative reviews were completed in FY 2010 for two counties; Baltimore and Frederick. In Baltimore County, three general home health agency applicants were approved. Two will establish new agencies in the County and one existing agency based in Carroll County was authorized to expand its services into Baltimore County. In Frederick County, two existing agencies were authorized to add the County to their previously authorized service areas.

Five projects were authorized in FY 2010 involving freestanding ambulatory surgical facilities ("FASFs") The state's largest health maintenance organization was approved to establish three new surgical facilities for its membership, at a total cost of $37.6 million. An existing FASF was approved for relocation, with no change in operating room capacity. The expansion of a single operating room facility to a two-operating facility, through the merger of two existing facilities was also authorized. This project resulted in a net reduction of one operating room.

Finally, two behavioral health projects were approved; the expansion of an intermediate care facility for drug and alcohol abuse and the relocation of a residential treatment center. These projects were both negligible in cost because they involved reuse of existing building space.

Approved CONs

Carroll Home Care (Baltimore Co.)
Expansion of an existing home health agency ("HHA") into a new jurisdiction
Approved without conditions - $0

Celtic Healthcare (Baltimore Co.)
Establishment of a new HHA
Approved without conditions - $294,000

Maryland Home Health (Baltimore Co.)
Establishment of a new HHA
Approved without conditions - $210,000

Rivermont Nursing and Rehabilitation Center (Montgomery Co.)
Establish a 124-bed comprehensive care facility ("CCF") – All beds replacing existing or acquired beds
Approved with conditions- $35,699,459

Fairland Nursing and Rehabilitation Center (Montgomery Co.)
Replace, relocate, and expand an existing CCF – All 167 beds replacing existing or acquired beds
Approved with conditions -$38,505,713

Frederick Surgery Center (Frederick Co.)
Replace and relocate a 4-operating room ("OR") freestanding ambulatory surgical facility
Approved without conditions -$2,429,540

Carroll Home Care (Frederick Co.)
Expansion of an existing HHA into a new jurisdiction
Approved without conditions - $0

Community Home Health (Frederick Co.)
Expansion of an existing HHA into a new jurisdiction
Approved without conditions - $189,000

Carroll Hospital Center (Carroll County)
Add two ORs and close an existing FASF – ORs relocated from FASF
Approved without conditions -$25,000

Baltimore Washington Medical Center (Anne Arundel Co.)
Add three ORs
Approved with conditions - $36, 546,000

Montgomery General Hospital (Montgomery Co.)
Expand a bed tower addition, fitting out previously approved shell space for medical/surgical beds and constructing 3 additional floors of shell space – renovate existing medical/surgical units
Approved with conditions - $15,857,986

A.F. Whitsitt Center (Kent Co.)
Add 16 intermediate care facility bed for drug and alcohol abuse rehabilitation
Approved with conditions - $0

University of Maryland Medical Center (Baltimore City)
Construct a building addition expanding emergency medical facilities, surgical facilities (net addition of five ORs), simulation and training facilities, and intensive care bed capacity (net addition of 27 beds within licensed bed capacity)
Approved with conditions - $176,435,000

Villa Maria (Baltimore Co.)
Relocate 52 residential treatment center ("RTC") beds to renovated space, creating a second RTC (existing RTC down-sized to 43 beds)
Approved without conditions - $250,00

Kaiser Foundation Health Plan of the Mid-Atlantic States (Montgomery Co.)
Establish a two-OR FASF (ORs relocated from an existing FASF)
Approved with conditions - $9,780,233

Kaiser Foundation Health Plan of the Mid-Atlantic States (Prince George's Co.)
Establish a six-OR FASF
Approved with conditions - $18, 700,211

Fredericktown Ambulatory Surgery Facility/Physicians Surgery Center of Frederick (Frederick Co.)
Establish a two-OR FASF (by adding an OR at Physicians Surgery Center of Frederick) and close a two-OR FASF (Fredericktown Ambulatory Surgery Facility)
Approved without conditions- $102,636

Kaiser Foundation Health Plan of the Mid-Atlantic States (Baltimore Co.)
Establish a two-OR FASF
Approved with conditions - $9,091,490

Anne Arundel Medical Center (Anne Arundel Co.)
Add 20 medical/surgical beds by fitting out previously approved shell space
Approved without conditions- $5,243,815

CON-Approved Projects Modified
St. Mary's Hospital (St. Mary's Co.)
Significant change in physical plant design of an expansion/renovation project)
New Cost: $56,126,238 (a $33 million reduction in previously approved cost)
Approved with conditions

Govans Ecumenical Development Co. (Baltimore City)
Change in financing mechanism for establishment of a new CCF
$12,729,674 (a $323,228 increase in previously approved cost)
Approved with conditions

Lorien LifeCenter Howard County II (Howard Co.)
Significant change in physical plant design of a new CCF
$9,735,958 (a $1,909,685 increase in previously approved cost)
Approved with conditions

Williamsport Nursing Home (Washington Co.)
Significant change in physical plant design of a bed addition to a CCF
$10,513,100 (a $13,735,817 reduction in previously approved cost)
Approved with conditions

Holly Hill Nursing and Rehabilitation Center (Baltimore Co.)
Significant change in physical plant design of a bed addition to a CCF
$5,992,358 (a $2,334,883 increase in previously approved cost)
Approved with conditions

CON Applications Denied
Allied Alternatives Health Care (Baltimore Co.)
Establish an HHA
$30,000

American Health Care Staffing (Baltimore Co.)
Establish an HHA
$341,000

Madanguit et al (Baltimore Co.)
Establish an HHA
$200,000

FEM Nursing Services (Baltimore Co.)
Establish an HHA
$14,700

Human Touch Home Health (Baltimore Co.)
Establish an HHA
$305,500

Mid America Home Health (Baltimore Co.)
Establish an HHA
$385, 850
MISS Health Care Agency (Baltimore Co.)
Establish an HHA
$34,226

Nurses on Demand (Baltimore Co.)
Establish an HHA
$42, 800

Nursing and Health Services Training Consultants (Baltimore Co.)
Establish an HHA
$119, 600

Premier Health Services (Baltimore Co.)
Establish an HHA
$31, 380

Prime Home Health Care (Baltimore Co.)
Establish an HHA
$104,500
Speqtrum (Baltimore Co.)
Establish an HHA
$158,888

Ayesha Home Health Care (Frederick Co.)
Establish an HHA
$85,000

Celtic Healthcare (Frederick Co.)
Establish an HHA
$274,000

Compassionate Care Nursing (Frederick Co.)
Establish an HHA
$62,158

Crown Home Health (Frederick Co.)
Establish an HHA
$50,500

Homecare Rehab (Frederick Co.)
Establish an HHA
$235,000

Home Health Care Professionals (Frederick Co.)
Establish an HHA
$155,000

George Madanguit et al (Frederick Co.)
Establish an HHA
$120,000

Maxim Home Health Resources (Frederick Co.)
Establish an HHA
$158,200

Nursing and Health Services Training Consultants (Frederick Co.)
Establish an HHA
$112,654

People Now Healthcare Solutions (Frederick Co.)
Establish an HHA
$85,000

Prime Home Health Care (Frederick Co.)
Establish an HHA
$104,500

Professional Health Care Resources (Frederick Co.)
Expansion of an existing HHA into a new jurisdiction
$109,000

Reliance Home Health Care Frederick Co.)
Establish an HHA
$50,000

CON Application Withdrawn
Delmarva Surgery Center (Cecil Co.)
Establish a two-OR FASF
$217,000

Approved CONs Relinquished by Holder

Southern Maryland Hospital Center (Prince George's Co.)
Expansion and renovation
$43,516,251

Kennedy Krieger Institute (Baltimore City)
Partial relocation of inpatient facilities
$5,500,000

Determinations of Coverage and Other Actions

In FY 2010, the Commission issued 109 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), and small increases in the bed capacity of facilities ("waiver" beds), 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 reviewed 15 requests by holders of CONs to implement their projects or parts of their approved projects ("first use review"). Finally, the Commission acknowledged 15 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. In FY 2010, all these permanently delicensed beds (197) were CCF beds.

Determinations of Coverage and Other Actions – FY 2010

NATURE OF DETERMINATION/ACTION	NO.
Capital projects with costs below the threshold of reviewability	**9**
Acquisitions of health care facilities **Comprehensive care facility (nursing home): 2** **Ambulatory surgery center: 4** **Hospice: 1** **Hospital: 1**	**8**

Establishment of new ambulatory surgery center (no more than one sterile operating room) **Charles (3), Montgomery (3), Anne Arundel (2), Baltimore Co. (2), Frederick (2), Harford (2), Prince George's (2), Allegany (1), Calvert (1), Cecil (1), Howard (1), Queen Anne's (1), Talbot (1), Washington (1), and Wicomico (1)**	**24**
Changes in ambulatory surgery center facilities or operation (e.g., addition of non-sterile procedure rooms, surgical staff, surgical specialties, ownership structure)	**9**
Relocation of ambulatory surgery center	**1**
Temporary delicensure of CCF beds (313 total beds)	**21**
Temporary delicensure of RTC beds (6 total beds)	**1**
Relicensure of temporarily delicensed CCF beds (131 total beds)	**16**
Add "waiver" beds [1] **Comprehensive care facility: 2 for a total of 10 beds** **Special hospital – chronic: 1 for 6 beds**	**3**
CCF bed exemption for continuing care retirement community	**1**
Miscellaneous	**16**
TOTAL COVERAGE DETERMINATIONS	**109**
Pre-licensure and/or first use approval for completed CON projects (including partial)	**15**
Permanent delicensure of beds **Comprehensive care facility: 15 for a total of 197 beds**	**15**

[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

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Overview

Health information technology (HIT) can improve health care quality, prevent medical errors, and reduce health care costs by delivering essential information at the time and place of care. Two crucial components of successful HIT exist: electronic health records (EHRs) and health information exchange (HIE). The Center for Health Information Technology (Center) is responsible for advancing HIT statewide. The Center has an ambitious plan for advancing HIT that balances the need for information sharing with the need for strong privacy and security policies. Key Center activities include:

- Implementing a private and secure statewide HIE;
- Identifying policy challenges to HIT adoption and use, and formulating solutions and best practices for making HIT work;
- Increasing the availability and use of standards through education and outreach activities;
- Promoting the adoption and meaningful use of EHRs;
- Harmonizing service area HIE efforts throughout the state; and
- Certifying electronic health networks that accept electronic health care transactions originating in Maryland.

Health Information Technology Division

The Health Information Technology Division (HIT Division) is responsible for advancing the adoption of HIT in Maryland. The HIT Division works closely with stakeholders to increase EHR adoption and meaningful use. A key function of the HIT Division is to expand the adoption of EHRs that have a longitudinal clinical record that includes clinical decision support capabilities, allows for viewing and managing diagnostic tests results, permits computerized provider order entry, and enables electronic prescribing.

The HIT Division works with stakeholders to develop policies for safeguarding electronic health information, and routinely provides consultative support to the stakeholders as they evaluate EHRs and implement workflow changes. The HIT Division oversees the development, maintenance, and implementation of the State HIT Plan and the State Medicaid HIT Plan.

Health Information Exchange Division

The Health Information Exchange Division (HIE Division) is responsible for advancing the statewide HIE and is tasked with ensuring the development of an interoperable system for sharing electronic health information. The HIE Division provides guidance to the statewide HIE, community data sharing initiatives, and management service organizations (MSOs) to ensure that electronic health information is securely delivered to providers in real-time and that the data is available for continuous quality improvement. The HIE Division promotes the private and secure sharing of electronic patient information at the point of care; determines the appropriate secondary uses of electronic data; promotes the adoption of electronic data interchange; certifies electronic health networks; and leads the development of strong privacy and security policies.

Accomplishments

Centers for Medicare & Medicaid Services – Electronic Health Record Demonstration

Maryland is one of four states selected to participate in the Centers for Medicare and Medicaid Services (CMS) EHR Demonstration Project. This is the second year of a five-year project designed to show that the widespread adoption and use of EHRs will reduce medical errors and improve the quality of care. The project has two groups of primary care physician practices; a treatment group of about 114 practices, and a control group of about 128 practices. Participants in the treatment group are eligible for financial incentives up to $290,000 over the five year program from CMS for EHR adoption and the reporting of select clinical quality measures. Participants in the control group will receive a modest payment for completing an annual Office System Survey in 2011 and 2014. Staff provides educational support to the treatment group in trying to accelerate the adoption of EHRs and meaningful use.

Electronic Data Interchange & Electronic Health Networks

COMAR 10.25.07, *Electronic Health Network Certification*, requires electronic health networks (EHNs) that operate in Maryland to complete the certification process. The MHCC's certification process works in coordination with the national accreditation standards developed by the Electronic Healthcare Network Accreditation Commission (EHNAC) and certification is for a two-year period. The certification criteria focus is on policies and processes surrounding privacy and security, technical performance, business practices, and resources. As of June 30, 2010, 42 EHNs have obtained MHCC certification and five other EHNs are in candidacy status.

In compliance with COMAR 10.25.09, *Requirements for Payers to Designate Electronic Heath Networks*, third party payers with annual revenues greater than $1 million must report health care transaction data by June 30th of each year to the MHCC. During this reporting period, the volume of practitioner and hospital claims submitted electronically increased by approximately two percent to roughly 87 percent. Dental claim volume submitted electronically decreased during the reporting period by almost seven percent to approximately 34 percent. The sizable difference between dental and the practitioner and hospital electronic claims volume is largely due to the business decisions by payers to invest more heavily in technology to support practitioner and hospital claims.

EHR Product Portfolio

Staff revised a web-based EHR Product Portfolio (portfolio). The portfolio is located on the MHCC's website and contains a core set of product information that assists physicians in assessing and selecting an EHR system. The portfolio includes only those vendors who meet the Certification Commission for Healthcare Information Technology's (CCHIT) stringent certification standards relating to functionality, interoperability, and security, and is updated every six months. Vendors listed in the portfolio have agreed to offer financial discounts to Maryland physicians when they purchase an EHR system. Approximately 32 vendors who are CCHIT-certified were included in the portfolio as of June 30, 2010.

Consumer-Centric Health Information Exchange

The Chesapeake Regional Information System for our Patients (CRISP), a multi-stakeholder group, is designated to build the statewide HIE. In March 2010, the MHCC received a federal award of $9.3 million to develop a statewide HIE through the federally funded *State Health Information Exchange Cooperative Agreement Program*—a program funded through the American Recovery and Reinvestment Act of 2009's (ARRA) *Health Information Technology for Economic and Clinical Health* (HITECH) *Act* and administered by the Office of the National Coordinator for Health Information Technology (ONC). The goal is to establish a private, secure, and consumer-centric statewide HIE that enables appropriately authorized providers to exchange electronic health information. Maryland's approach ensures high quality, safe, and effective health care; makes certain that data is exchanged privately and securely; ensures transparency and stakeholder inclusion; supports connectivity regionally and nationally; achieves and maintains financial sustainability; and serves as the foundation for transforming health care statewide.

Hospital HIT Survey

Staff administered and analyzed the results from the second annual Hospital HIT Adoption survey. The annual Hospital HIT Adoption survey is a comprehensive survey that assesses the current level of adoption, utilization, and planning among the state's 47 acute care hospitals as it relates to HIT including EHRs, computerized physician order entry (CPOE), e-prescribing, HIE, infection surveillance, electronic medication administration records (eMARs), and barcode medication administration (BCMA) technology. The results indicate that the hospitals continue to advance HIT adoption over the past year and that the majority plan to build on their existing functions. Some notable findings include the use of eMAR and BCMA each increased by approximately 28 percent. As of November 2009, about 81 percent of hospitals reported utilizing EHRs. Nearly 45 percent of hospitals reported an increase in sharing patient data with their service providers. Hospital Chief Information Officers (CIOs) assisted in the development of this survey that was first administered in 2008.

Freestanding Ambulatory Surgical Centers HIT Assessment

Staff developed and implemented an annual Freestanding Ambulatory Surgical Center HIT survey (survey) to assess HIT adoption among the 325 Freestanding Ambulatory Surgical

Centers (FASCs) in Maryland. The survey is unique to Maryland and identifies the overall level of HIT adoption and planning. The survey assesses HIT adoption in relation to EHRs, CPOE, eMARs, BCMA, infection management, e-prescribing, and data exchange. Nearly 34 percent of FASCs reported adoption of various HIT applications.

House Bill 706, Electronic Health Records – Regulation and Reimbursement

In 2009, the Maryland General Assembly passed and Governor Martin O'Malley signed into law House Bill 706 (HB 706), *Electronic Health Records – Regulation and Reimbursement*. The purpose of this legislation is to expand EHR adoption and establish a statewide HIE. HB 706 requires the Commission to designate a statewide HIE for the private and secure exchange of electronic health information among health care providers. The Commission designated CRISP as the statewide HIE in 2009. The law states that the MHCC must designate one or more Management Service Organizations (MSOs) to offer hosted EHRs as an alternative to the traditional model where the technology is located at the provider site. HB 706 also requires the MHCC to adopt regulations that require state-regulated payers to offer incentives of monetary value to providers for implementing EHRs.

Management Service Organizations

HB 706 requires the MHCC to designate one or more MSOs that offer services throughout the state. In August 2009, staff published an MSO vision document to guide the development of MSOs. Unlike the traditional EHR client-server model where the data and technology is hosted locally at the provider site, MSOs offer EHRs hosted in a centralized, secure data center. The data is safeguarded through a network operating center that, by design, ensures high quality and uninterrupted service. MSOs enable physicians to access a patient's medical record wherever access to a high speed Internet connection exists, and to eliminate the costs associated with technology maintenance and the responsibilities assumed by the provider that accompany the private and secure storage of electronic health information. Remotely hosted EHRs enable providers to focus on practicing medicine rather than expending time and resources to support the software application and hardware. Staff convened an Advisory Panel (Panel) consisting of nearly 40 stakeholder organizations to develop the MSO State Designation Criteria. The Panel established criteria for privacy and confidentiality, technical performance, business practices, resources, security, and operations for MSOs seeking State Designation. As of June 30, 2010 approximately 13 MSOs applied for State Designation.

Electronic Health Record Incentives

Maryland is the first state to require certain state-regulated payers to provide incentives of monetary value to select health care providers who adopt and use EHRs. At present, only Medicare and Medicaid offer incentives to eligible providers for the adoption and meaningful use of EHRs. Staff convened a multi-stakeholder meeting to explore incentives that payers can offer in compliance with HB 706. Staff drafted the regulation, COMAR 10.25.16: *Electronic Health Record Incentives*, with input from the industry.

Regional Extension Center Program

CRISP received $5.5M in funding from the ONC under the HITECH Act to establish a regional extension center (REC) in Maryland. The goal of the REC is to help 1,000 priority primary care providers, as defined by the ONC, in Maryland with adopting EHRs and achieving the meaningful use requirements. Staff worked with CRISP to develop a sustainable business model that utilizes State Designated MSOs to enable the REC to meet the ONC requirements, expand EHR adoption, and provide other EHR-related services to all providers. The MHCC State Designation is a core component for an MSO to participate with the REC. These MSOs are expected to offer assistance to all providers in Maryland and will receive subsidies under the ARRA for assisting priority primary care providers in meeting established milestones, which include: provider enrollment, EHR implementation and utilization, and meeting meaningful use.

HIE Policy Board

Staff assembled a Policy Board with responsibility for general oversight of the state's HIE, including the authority to evaluate and recommend to the MHCC the policies that will govern the statewide HIE. The Policy Board is responsible for the development of privacy and security policies, which the MHCC will adopt and the HIE will implement. The Policy Board is comprised of approximately 25 members selected based upon their expertise, the breadth of stakeholder representation, and a strong consumer voice, which is essential to building trust among stakeholders. Ex-officio members consist of representatives from CRISP and state government, including Medicaid, the MHCC, and the Health Services Cost Review Commission. The Policy Board convenes on a six-week schedule and since inception has made notable progress in drafting key policies that will govern the statewide HIE. Approximately 20 policies have been identified for development. The Policy Board establishes the prioritization of policy development with advisement from the statewide HIE and the MHCC.

Medicaid Health Information Technology Planning Project

In collaboration with Medicaid, staff is developing a program for Medicaid to administer the EHR adoption and meaningful use incentives under the ARRA. Medicaid has received approximately $1.3 million from CMS to develop the State Medicaid HIT Plan that will detail the current HIT environment, the future HIT vision, and a five-year strategy to implement and oversee the EHR incentive payments. Medicaid plans to utilize the technology and management of a third party organization to administer the incentive payments. From CMS, Medicaid will receive 100 percent reimbursement on EHR adoption and meaningful use incentive payments and 90 percent of the cost to administer the program.

EHNAC HIE Advisory Panel and Recommendations

Staff was actively involved on the EHNAC's HIE Policy Accreditation Advisory Panel. This panel contained approximately 50 stakeholders from around the nation with the goal of developing criteria for accrediting HIE's infrastructure and policies related to privacy and security. The

proposed criteria went through a public comment period before being adopted by the EHNAC. The target date for the EHNAC to launch its HIE accreditation program is fourth quarter 2010.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Staff updated the *HIPAA: A Guide to Privacy Readiness* and the *HIPAA Security Standards: A Guide to Security Readiness* documents to include the 13 provisions of HIPAA that were added under the ARRA. The ARRA additions to HIPAA privacy center on the inclusion of Business Associates, notification of information breaches, and inadvertent disclosure of personal health information. The guides were originally developed in 2002 with the assistance of an industry stakeholder workgroup. Staff developed these guides to help small practices conduct a gap assessment for compliance with the HIPAA Administrative Simplification provisions.

HIE Education Program Development
Staff worked with Johns Hopkins University, a recipient of funding under the ARRA for the development of HIT-related graduate and certificate education programs. Johns Hopkins University received approximately $1.8M for the *Curriculum Development Centers Program* to develop graduate level HIT programs, and about $3.7M for the *Information Technology Professionals in Health Care: Program of Assistance for University-Based Training* to train professionals for vital, highly specialized HIT roles. Staff provides input pertaining to policy and technology based on real world experience to bolster program development.

Nursing Homes in Maryland
Staff released the first annual *Electronic Health Record Assessment of Maryland Nursing Homes* environmental scan brief. The scan assessed the adoption of EHRs among approximately 51 independent nursing homes in Maryland. The questions focused on four areas: computerized functions, EHR implementation, EHR adoption importance, and adoption barriers. Independent nursing homes overwhelmingly expressed concern about the cost of the technology, lack of technical staff, problems integrating EHRs with existing legacy systems, and difficulty in training qualified staff as the leading barriers to adoption.

APPENDIX 1 – Maryland Health Care Commission's organizational chart effective July 1, 2006