MARYLAND
HEALTH CARE
COMMISSION

REPORT to the GOVERNOR

Fiscal Year 2012

(July 1, 2011 through June 30, 2012)

Martin O'Malley
Governor

Craig Tanio, M.D.
Chair

Ben Steffen
Executive Director

http://mhcc.maryland.gov/

MARYLAND
HEALTH CARE
COMMISSION

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COMMISSION

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

Current Commission Composition

Craig P. Tanio, M.D., Chair
Chief Medical Officer
JenCare Neighborhood Medical Centers

Garret A. Falcone, NHA, Vice Chair
Executive Director
Heron Point of Chestertown

Reverend Robert L. Conway
Retired Principal and Teacher
Calvert County Public School System

John E. Fleig, Jr.
Director
United Healthcare

Paul Fronstin, Ph.D.
Director, Health Research and Education Program
Employee Benefit Research Institute

Helene Grady
Associate Dean for Finance and Administration
Johns Hopkins University School of Nursing

Kenny W. Kan, CPA,FSA & CFA
Senior Vice President/Chief Actuary
CareFirst BlueCross BlueShield

Robert Lyles, Jr., M.D.
Medical Director
LifeStream Health Center

Barbara Gill McLean, M.A.
Retired, Senior Policy Fellow
University of Maryland School of Medicine

Kathryn L. Montgomery, Ph.D., RN, NEA-BC
Associate Dean, Strategic Partnerships & Initiatives
University of Maryland School of Nursing

Marilyn Moon, Ph.D.
Vice President and Director, Health Program
American Institutes for Research

Darren W. Petty
Vice President
Maryland State and DC AFL-CIO
General Motors/United Auto Workers

Glenn E. Schneider, MPH, BS
Chief Program Officer
The Horizon Foundation

Adam J. Weinstein, M.D.
Medical Director
Nephrology and Transplant Services
Shore Health System

MARYLAND
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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.

Craig Tanio, MD, MBA, Chair, is the Chief Medical Officer at JenCare, a physician owned group that is expanding an innovative global risk care model for moderate to low income seniors that emphasizes preventive and primary care. Previously, he was a partner at McKinsey & Company, a global management consulting firm and the Chief Operating Officer for Baltimore Medical System, a group of federally qualified community health centers serving the Baltimore area. Dr. Tanio received his MD from University of California San Francisco, his MBA from the Wharton School and completed internal medicine training and served as Chief Medical Resident at the Hospital of the University of Pennsylvania. Following his residency, Dr. Tanio held a fellowship in General Interal Medicine as a Robert Wood Johnson Clinical Scholar. He is a part-time Assistant Professor of Medicine at Johns Hopkins School of Medicine and a Senior Fellow in the Department of Health Policy at Jefferson Medical College. Dr. Tanio resides in Baltimore County.
(Term Expires 9/30/16)

Garret A. Falcone, Vice-Chair, is the Executive Director of Heron Point of Chestertown, a CCRC on the Eastern Shore. He has over 35 years experience in acute and long term care. Commissioner Falcone is a graduate in Business Management from Fairleigh Dickinson University in New Jersey and earned his Master's Degree in Health Services Administration from Russell Sage College in Albany, New York. He was awarded the MANPHA Chairmen's Award in 2001 and the Special Chairmen's Award, AEGIS Inc., in 2001. Vice Chair Falcone resides in Kent County.
(Term Expires 9/30/14)

Rev. Robert L. Conway is retired from the Calvert County Public School System where he was employed 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 and resides in Southern Maryland.
Term Expires 9/30/13)

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.
(Term Expires 9/30/16)

Paul Fronstin is a senior research associate with the Employee Benefit Research Institute, a private, nonprofit, nonpartisan organization committed to original public policy research and education on economic security and employee benefits. He is also Director of the Institute's Health Research and Education Program, and oversees the Center for Research on Health Benefits Innovation. He has been with EBRI since 1993. Dr. Fronstin's research interests include trends in employment-based health benefits, consumer-driven health benefits, the uninsured, retiree health benefits, employee benefits and taxation, and public opinion about health benefits and health care. In 2012, Dr. Fronstin was appointed to the Maryland Health Care Commission. He currently serves on the steering committee for the Emeriti Retirement Health Program and is also the associate editor of Benefits Quarterly. In 2010, he served on the Institute of Medicine (IOM) Committee on Determination of Essential Health Benefits. In 2002 he served on the Maryland State Planning Grant Health Care Coverage Workgroup. In 2001, Dr. Fronstin served on the Institute of Medicine Subcommittee on the Status of the Uninsured. Dr. Fronstin earned his Bachelor of Science degree from SUNY Binghamton and his Ph.D. in economics from the University of Miami. Commissioner Fronstin resides in Montgomery County.
(Term Expires 9/30/15)

Helene Grady serves as Associate Dean for Finance and Administration at the Johns Hopkins University School of Nursing. As the chief financial officer for the school, Ms. Grady provides strategic leadership and oversight for its financial and administrative operations. Prior to joining Johns Hopkins, Ms. Grady served as the Deputy Director of Finance for the City of Baltimore where her work contributed to the City earning its first bond rating upgrade in more than a decade; achieving significant service level and productivity improvements; transitioning from a traditional budgeting model to outcome budgeting; implementing the first annual citizen satisfaction survey; and overhauling the City's major financial systems. Previously, Ms. Grady served as Deputy Budget Director for the City of Philadelphia and served as staff to President Clinton's Working Group on Welfare Reform, whose work resulted in the President's Work and Responsibility Act, introduced in June 1994. Ms. Grady received her MPP from the Kennedy School of Government at Harvard University, serves on the boards for the College Savings Plans of Maryland and the Baltimore Efficiency and Economy Foundation, and is a resident of Baltimore City.
(Term Expires 9/30/13)

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. Commissioner Kan resides in Howard County.
(Term Expires 9/30/16)

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.
(Term Expires 9/30/16)

Barbara Gill McLean retired in 2007 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 the State's initiative for improving patient safety including the creation of the Maryland Patient Safety Center. Ms. McLean received a Masters in Sociology and completed doctoral studies in policy sciences program, specializing in health policy 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. Commissioner McLean resides in Baltimore County.
(Term Expires 9/30/14)

Kathryn Montgomery, PhD, RN, NEA-BC is the Associate Dean Strategic Partnerships & Initiatives and Assistant Professor at the University of Maryland School of Nursing since 2003. She has served in prior faculty and administrative roles at the School in 2000 – 2001 after retiring from the United States Public Health Service as Rear Admiral and Assistant Surgeon General within the Department of Health Human Services. While in this capacity, Dr. Montgomery served at NIH Clinical Center as Chief Nurse. In her academic administrative role Dr. Montgomery provides leadership in the creation of strategic partnerships, faculty practices, clinics including the Governor's Wellmobile program and professional education. Dr. Montgomery serves on the leadership team guiding the development of the Maryland Learning Collaborative Patient Centered Medical Home initiative. Dr. Montgomery teaches courses in complex healthcare systems, health policy, leadership and teamwork. Commissioner Montgomery resides in Anne Arundel County.
(Term Expires 9/30/15)

Marilyn Moon, Ph.D. 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 issues and social insurance issues including health reform and health coverage. 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. Commissioner Moon resides in Montgomery County. (Term Expires 9/30/14)

Darren W. Petty serves an International Representative for the United Auto Workers (UAW), representing 12 states from Pennsylvania down to Florida including the District of Columbia, out to Mississippi and Kentucky. 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. He has served on the Maryland Judicial Nominations Commission, Baltimore County Higher Education Commission, and the Maryland Manufacturing Jobs Task Force. 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. He is an alumna of Essex Community College and Frances Marion University. He coaches his son's soccer teams for Jarrettsville Soccer and the Northern Elite Soccer Club. Commissioner Petty is married with 3 sons and resides in Harford County.
(Term Expires 9/30/14)

Glenn Schneider, MPH is the Chief Program Officer for the Horizon Foundation, one of the largest health philanthropies on the East Coast. Prior to joining the Foundation, Commissioner Schneider served as a national consultant, executive director, community organizer, grassroots strategist, and policy director for state/local government and the non-profit sector. His work has resulted in the passage of over twenty-five state and local laws across the nation that protected public health, increased access to health care, raised tobacco prices, created smoke-free public places, and cut youth access to tobacco. In the health care arena, he spearheaded team efforts to launch the Healthy Howard Health Plan, a nationally-acclaimed health care access program for the uninsured, established a rules-based electronic application portal for state health insurance programs and previously served as executive director of the Maryland Health Care for All! Coalition. He has an MPH from the University of Pittsburgh and received his school's highest honor, the Distinguished Graduate Award, in 2002. He lives in Howard County. (Term expires 9/30/15)

Adam Weinstein., M.D. is a native of Baltimore County who completed all of his medical education and training to be a kidney specialist at the University of Maryland School of Medicine. He moved to the upper counties of the Eastern Shore in 2006 where he co-founded a private practice, the Kidney Health Center of Maryland. He is the medical director for Nephrology and Transplant Services for the Shore Health System (a University of Maryland Hospital affiliate system) as well as some of the dialysis units on the upper Eastern Shore. He is the President of the Talbot County Medical Society and active in MedChi - the Maryland Medical Society and on the board of directors of the Renal Physicians Association. Dr. Weinstein is board certified in Internal Medicine and Nephrology.
(Term Expires 9/30/13)

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Commissioners who served during FY 12

Marilyn Moon, Ph.D., Chair
Vice President and Director, Health Program
American Institutes for Research

Garret A. Falcone, NHA, Vice Chair
Executive Director
Charlestown Retirement Community

Reverend Robert L. Conway
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Calvert County Public School System

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Darren W. Petty, President
Maryland State United Auto Workers
General Motors/United Auto Workers

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Adam J. Weinstein, M.D.
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Randall P. Worthington
President/Owner
York Insurance Services, Inc.

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strategist, and policy director for state/local government and in the non-profit sector. His work has resulted in the passage of over twenty-five state and local laws across the nation that protected public health, increased access to health care, raised tobacco prices, created smoke-free public places, and cut youth access to tobacco. In the health care arena, he spearheaded team efforts to launch the Healthy Howard Health Plan, a nationally-acclaimed health care access program for the uninsured, established a rules-based electronic application portal for state health insurance programs and previously served as executive director of the Maryland Health Care for All! coalition. Commissioner Schneider has an MPH from the University of Pittsburgh and received his school's highest honor, the Distinguished Graduate Award, in 2002.

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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 the *Baltimore Business Journal* list in 2006. He owns Aquila Hall Farms located in Churchville, Maryland. A Harford County native, Commissioner Worthington earned his B.A degree in Business from Catawba College in Salisbury, North Carolina. (Term Expires 9/30/11)

MARYLAND
HEALTH CARE
COMMISSION

EXECUTIVE STAFF

Ben Steffen
Acting Executive Director

Paul E. Parker
Acting 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

Linda Bartnyska
Acting 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 2012, the Commission had an appropriation for 62.6 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 in order to 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 services 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 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 is physician services, including physician reimbursement and reporting on the cost and quality of their services. The Commission staff has served in a consultant role for the General Assembly in this regard.
- 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 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's 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 and 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 by requiring PPOs to report beginning in 2012.
- 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 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 hospitals granted waivers 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 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 a 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 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; and the Legal Services unit, composed of two Assistant Attorneys General, which provides advice to the Executive Director and the Commission.

BUDGET & FINANCES

In FY 2012, the Commission was appropriated $28,618,011, which includes an appropriation of $12.3 million for the trauma fund and trauma grant equipment, $2 million for the Partnership program, $3 million for the MD Emergency Medical Systems Operations Fund, $3.3 million in Federal Fund Income, and $284,000 as Reimbursable Fund Income. The Commission is funded with special funds through a user fee assessment 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. 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. The assessment is currently capped at $12 million.

Surplus

At the close of FY 2012 the Commission's surplus was $2.7 million.

OVERVIEW OF FY 2012 ACCOMPLISHMENTS

July 2011

COMAR 10.25.11 – Institutional Review Board – Final Action on Permanent Regulations was adopted as final regulations.

Certificate of Need Exceptions Hearing: Recommended Decision in the Matter of Expansion of the General Home Health Agency Services of Amedisys Maryland, L.L.C. was approved.

Certificate of Need for Community Care Nursing Services to establish a home health agency was approved.

Staff presented the results of the 2010-2011 Maryland Hospital Healthcare Worker Influenza Vaccination Survey.

Staff presented information on Professional Services Utilization Trends Among the Privately Insured through 2009.

Staff presented the Work Plan for the Technical Advisory Group on Oversight of PCI Services.

August 2011

There was no meeting in August.

September 2011

COMAR 10.24.05 – Continuation of Non-Primary Research Waivers through Participation in the Follow-On C-PORT E Registry was approved as Final Regulation.

COMAR 10.25.08 – Evaluation of Quality and Performance of Health Plans was approved as Final Regulation.

COMAR 10.25.16 – Electronic Health Record Incentives was approved as Emergency and Re-Proposed Regulation.

Renewal of Carroll Hospital Center Primary PCI waiver was approved.

Staff provided an overview and background on the MHCC's Institutional Review Board.

Staff presented an update on the Patient Centered Medical Home program – a Rapid Fire Review with Program Participants.

October, 2011

Certificate of Need for Solomon's Nursing Center to add 12 nursing home beds was approved.

Staff presented an update to the State Health Improvement Plan.

Staff made a presentation on the Maryland Trauma Physician Services Fund.

Staff made a presentation on healthcare spending in Maryland's individual and small group markets.

November 2011

COMAR 10.24.17 – Cardiac Surgery and Percutaneous Coronary Intervention Services Chapter of the State Health Plan Proposed and Emergency Regulations was approved.

Application of Anne Arundel Medical Center for Continuation of Non-Primary Research Waivers through Participation in the Follow-On C-PORT E Registry was approved.

Application of Baltimore Washington Medical Center for Continuation of Non-Primary Research Waivers through Participation in the Follow-On C-PORT E Registry was approved.

Application of Frederick Memorial Hospital for Continuation of Non-Primary Research Waivers through Participation in the Follow-On C-PORT E Registry was approved.

Application of Johns Hopkins Bayview Medical Center for Continuation of Non-Primary Research Waivers through Participation in the Follow-On C-PORT E Registry was approved.

Application of Meritus Medical Center for Continuation of Non-Primary Research Waivers through Participation in the Follow-On C-PORT E Registry was approved.

Application of St. Agnes Hospital for Continuation of Non-Primary Research Waivers through Participation in the Follow-On C-PORT E Registry was approved.

Application of Southern Maryland Hospital Center for Continuation of Non-Primary Research Waivers through Participation in the Follow-On C-PORT E Registry was approved.

Staff gave an update on the Prior-Authorization Report.

Staff provided an overview of proposed revisions to the Surgical Services Chapter of the State Health Plan.

December 2011

COMAR 10.25.16 – Electronic Health Record Initiatives was adopted as final regulation.

Holy Cross Hospital was granted a two-year primary PCI waiver.

Howard County General Hospital was granted a two-year primary PCI waiver.

Johns Hopkins Bayview Medical Center was granted a two-year primary PCI waiver.

St. Agnes Hospital was granted a two-year primary PCI waiver.

Certificate of Need for Knollwood Manor to relocate and replace its comprehensive care facility was approved.

Modified Certificate of Need for Lorien LifeCenter Harford for improvements in the project plan and addressing the training issues was approved.

Staff presented proposed revisions to the State Health Plan Chapter for General Surgical Services, COMAR 10.24.11.

Staff presented the report and recommendations of the Technical Advisory Group on Oversight of Percutaneous Coronary Intervention Services and briefed the Commission on next steps.

Kevin Ferentz, Associate Professor, University of Maryland School of Medicine, Director of Clinical Operations, provided a brief description of the US Preventive Services Task Force.

Presentation was made of the Study of Mandated Health Insurance Services: A Comparative Evaluation – as required under Insurance Article §15-1502.

Presentation was made of the Annual Mandated Health Insurance Services Evaluation – as required under Insurance Article §15-1501.

Staff gave an update on the status of the final report on the Prior-Authorization Report.

Staff presented the Telemedicine recommendations from the Maryland Quality and Cost Council report.

January 2012

Certificate of Need for Johns Hopkins Hospital to expand its surgical facilities was approved.

Certificate of Need for National Lutheran Home and Village of Rockville, Inc. to create a third level of accommodation and service on the campus was approved.

Release of the Report Evaluating the Configuration and Distribution of Trauma Centers in Maryland was approved.

Staff presented an update to the Hospital Performance Guide.

Staff presented an Informational Briefing on Health Information Exchange Policy Development.

Staff made a presentation of the 2011 Comprehensive Performance Report for Commercial HMO, POS, and PPO Health Benefit Plans.

Staff made a presentation of the Medical Expenditure Panel Survey – Insurance component: Maryland Sample through 2010.

Staff presented an update on the Legislative Overview.

February 2012

February 6, 2012 Meeting via Teleconference

SB 227 Maryland Health Care Commission – Assessment of Fees and Maryland Trauma Physician Services Fund – Revisions, Commissioners agreed with the staff recommendation.

SB 238 – Maryland Health Benefit Exchange Act of 2012 – Commissioners asked for more information and to have it discussed at the next Commission meeting.

SB 456 – Health Benefit Plan Premium Rate Review Commissioners agreed to support, with 2 Commissioners abstaining.

HB 470 – Preauthorization of Medical Services and Pharmaceuticals – Staff would write draft wording for the suggested amendment and Commissioners would then decide on position to take.

February 16, 2012

Certificate of Need for Johns Hopkins Bayview Medical Center to expand the Emergency Department was approved.

Certificate of Need for Johns Hopkins Bayview Medical Center to develop a comprehensive cancer program facility was approved.

COMAR 10.24.17 – Cardiac Surgery and Percutaneous Coronary Intervention Services Chapter of the State Health Plan was adopted as Final Regulation.

SB 238/HB 443 – Maryland Health Benefit Exchange Act of 2012 was approved for support.

SB 234/HB 439 – Maryland Health Improvement and Disparities Reduction Act of 2012 approved for support.

HB 532 – Military Health Care Pensions – Health Care Workforce Shortage was approved for support.

Presentation on an Overview on Health Information Exchange – Rapid Fire with Chesapeake Regional Information System for Patients (CRISP)

February 27, 2012 Meeting via Teleconference

HB 1140/SB 749 – Physicians – Sharing of Information with Maryland Health Care Commission – Commissioners agreed with staff recommendation.

HB 1141/SB 750 – Maryland Health Care Commission – Cardiac Surgery and Percutaneous Coronary Intervention Services – Commissioners agreed with staff recommendation.

HB 780 – Multicultural Health Care Equity Certification and Accreditation – Work Group – Staff recommended support with amendment and the Commissioners requested a summary to obtain feedback from Commissioners who did not participate in conference call.

SB 781 – Health Insurance – Coverage for Telemedicine Services – Staff recommended submitting a letter of information providing recommendations of the three advisory groups.

March 2012

Certificate of Need for Genesis Bayview Joint Venture, LLC to establish a 132 bed comprehensive care facility was approved.

SB 954 – Medical Records – HIPPA Consistency Act of 2012 was approved for support.

HB 1434 – Health Insurance – Coverage for Autism Spectrum Disorders - Commission did not take a position but continues to work with legislature on all mandated benefit proposals.

HB 780 – Multicultural Health Care Equity Certification and Accreditation - Work Group – All parties agreed and legislation was amended. The sponsor will withdraw HB 780.

Staff presented a briefing on State Health Plan Chapter for General Surgical Services, COMAR 10.24.11.

Staff did a presentation on Health Care Spending in Maryland.

April 2012

Hearing on Motion Seeking Issuance of an Interlocutory Non-Final Determination Authorizing Holy Cross Hospital to Continue Construction of a New Hospital in Germantown – Holy Cross Hospital of Silver Spring, Inc was tabled and unanimously approved.

May 2012

Certificate of Need – Exceptions Hearing: Recommended Supplemental Decision in the Matter of a Proposed New Hospital in Montgomery County – Holy Cross Hospital of Silver Spring, Inc. – Recommended Supplemental Decision was adopted and unanimously approved.

Staff presented the Outcomes of non-primary PCI at Hospitals with or without On-Site Cardiac Surgery: Clinical Findings of C-PORT E.

COMAR 10.24.11 – State Health Plan for Facilities and Services: General Surgical Services – Proposed Permanent Regulation.

Staff presented a briefing on the State Designated HIE – Virtual Health Record and Direct Use Case Demonstration.

June 2012

Staff presented the Small Group Market Summary of Carrier Experience as of December 31, 2011.

Staff gave an update on the All Payer Claims Database 2011 Submission.

Certificate of Need for Carroll Hospital Center to develop a comprehensive cancer program facility connected to its main hospital building was approved.

Staff presented an overview of the Summary of Comments on the Draft Proposed Hospice Regulations.

Staff presented a briefing the Report on the 2011/2012 Influenza Survey.

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 health care expenditures in Maryland and the utilization of privately insured professional health care services. 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 health insurance coverage in the state.

Accomplishments

During FY 2012, the Cost and Quality Analysis division added an additional year of professional services, institutional services, and prescription drug data to the MCDB, expanded the data submission to include data on Maryland residents enrolled in private health insurance, and provided feedback on data quality to the submitting payers. The division created Memoranda of Understanding with the Health Services Cost Review Commission and the Maryland Insurance Administration and provided these State agencies with MCDB data files for use in their own data analysis projects

The division produced three publications, including one that is legislatively mandated. The division also produced several analyses—using the MCDB data—that were requested by state legislators. The division provided information for SpeedStat on six measures for *Health Care Cost and Quality* and two measures for *Access to Care*. Additionally, the division created three SpeedStat measures for use by the Mental Health Administration.

State Health Care Expenditures Report

This legislatively mandated report was released in the May 2012. The report examines:

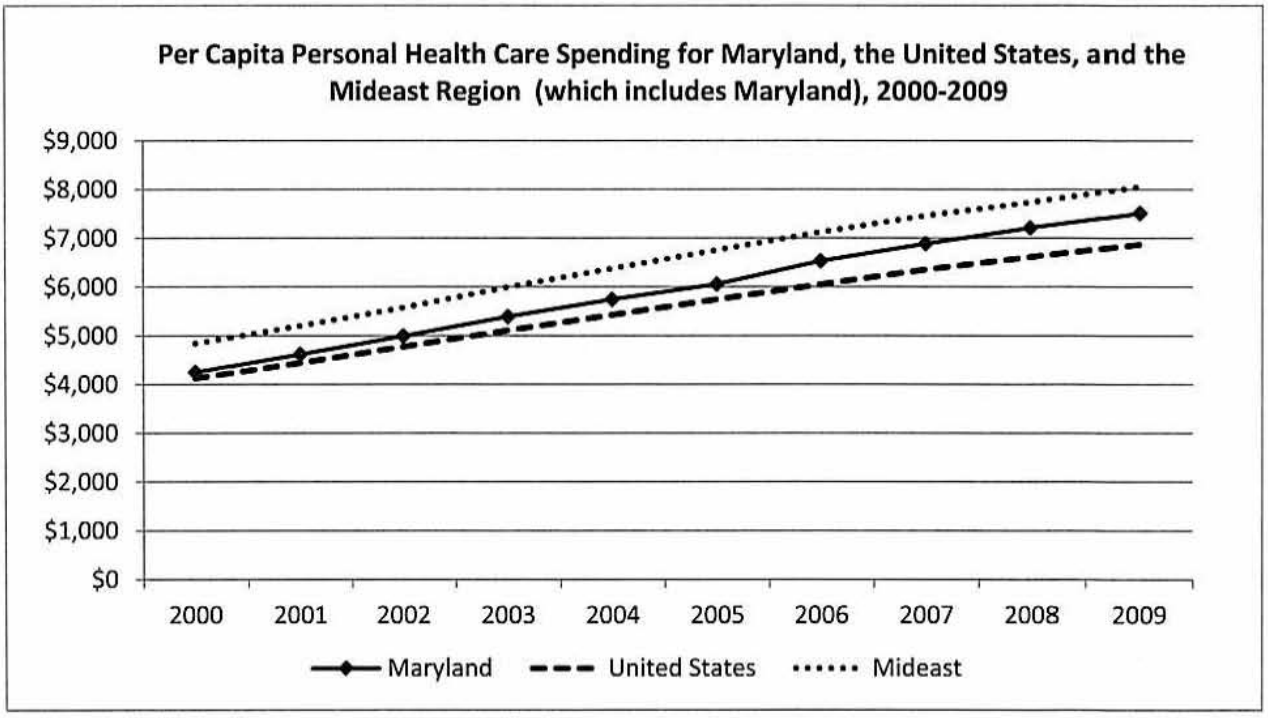
- Total and per capita health care spending in Maryland in 2010;
- The trend in the rate of increase in per capita spending over the last decade for Maryland versus the U.S.;
- Distribution of spending across the types of service in Maryland in 2010;

- Trends in the distribution of spending by type of service over the last decade for Maryland versus the U.S.; and
- Comparisons of per capita spending in Maryland to other states—using CMS data—through 2009, the most recent year available for all states.

Maryland residents spent an estimated $44.5 million on personal health care in 2010, up 3.5% from 2009. Per capita expenditures reached $7,698, which was 8.9 percent higher than the national average of $7,066. Hospital care — both inpatient and outpatient services — were the single highest category of health care expenditures in the State.

Though per capita health care expenditures continue to grow, the rate of growth has slowed since 2001, reflecting both nationwide efforts to curb health care costs and the continuing slowdown in the overall economy. In general, Maryland's growth rate over the past decade has outpaced the growth rate of the U.S. as a whole. As the economy recovers, spending growth is likely to return to its pre-recession high rate unless there are fundamental changes to the health care delivery system.

While the rate of growth in per capita personal health care spending has declined in the State in recent years, Maryland spending remained higher than the national average and the moderation in growth is likely attributed to the economic downturn. Per capita spending is generally higher in the northeastern region of the United States, followed by the Mideast region, which includes Maryland. Of the Mideast states, per capita spending in Maryland is lowest.



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 (MEPS-IC), conducted annually by the Agency for Healthcare Research and Quality. This year's report, **Medical Expenditure Panel Survey – Insurance Component, Maryland Sample through 2010,** describes key characteristics of health insurance coverage provided through Maryland private-sector employers in 2010.

The uninsured rate among Maryland's private-sector workers ages 19-64 (17 percent) is below the national rate (22 percent) due to a higher rate of employment-based coverage among the state's private sector workers (72 percent versus 66 percent). Approximately 88 percent of Maryland's private-sector employees worked in establishments that offered health insurance (offer rate), a figure that mirrors the national average. Although most private sector workers are in establishments that offer health insurance, in Maryland-to-U.S. comparisons by firm size, Maryland has a statistically higher offer rate in firms with fewer than 10 employees (57 percent versus 41 percent), likely attributable to Maryland's longstanding small group market reform. Beginning in 2014, small employers with up to 50 employees will have additional coverage options through the Maryland Health Benefit Exchange that will be established as a result of national health care reform.

From 2004 to 2010, Maryland's private sector health insurance premiums generally parallel the national premiums. The average premium for single coverage in PPO-type products (the most common type of coverage) offered by/through private employers in Maryland increased by 3.5 percent annually from $3,843 (nominal dollars) to $4,726, and the average premium for family coverage increased by 6.1 percent annually from $9,818 (nominal dollars) to $14,015.

The percent of the premium contributed by employees in Maryland in 2010 for single coverage (23 percent) and family coverage (27 percent) are statistically similar to the percents in 2008 and the national averages in 2010. The majority of all enrolled employees in 2010 had a plan with a deductible, but the percent was below the national average (65 percent versus 78 percent). The average deductibles for single and family coverage were higher for enrolled employees at small firms (fewer than 50 employees) than for enrollees at larger firms; the average deductibles were similar to the national averages. Among enrollees with a deductible in 2010, the majority of small firm enrollees had a deductible that met or exceeded the minimum for a Health Savings Account (HSA): $1,200 for individual coverage, $2,400 for family coverage. However, among enrollees at larger firms (50 or more employees), 22 percent of those with a deductible met or exceeded the HSA minimums.

Maryland's self-insured rate among private sector employers in 2010 was significantly higher than the U.S. average: 63 percent versus 58 percent. In a self-insured health plan, the financial risk for the enrollees' medical claims is assumed by the employer. Self-insured, private sector health plans operating under the Employee Retirement Security Act (ERISA) are exempt from state insurance laws, including mandated benefits.

A Profile of Maryland's Self-Insured Small Group Health Insurance Market

This study was conducted in collaboration with SHADAC (State Health Assistance Data Center), using MEPS-IC data. Funding for the study was provided through a grant from the Robert Wood Johnson Foundation's State Health Reform Assistance Network. The primary conclusions of the study are that the percent of small employers nationally and in Maryland that self-insure is relatively small (around 11 to 13 percent) and the trend has been flat. Because the Accountable Care Act increases the incentives for some small employers to self-insure, which could have a negative impact on the state's SHOP Exchange, staff will continue to track self-insurance rates in the small group market and provide the information to state policy-makers, including those in charge of running Maryland's Health Benefit Exchange. The report, released in May 2012, discusses small group health insurance market regulation in Maryland, trends in self-insurance in this market, and how trends in Maryland compare to trends nationally.

Analyses Requested By Maryland Legislators

During this fiscal year, the division conducted several analyses using the MCDB data at the request of State legislators. These studies include:

- An investigation of patient liability for specific oral chemotherapy drugs;
- A comparison of payment levels for participating versus non-participating providers (professional and institutional) in hospital outpatient departments and ambulatory surgery centers;
- A study of covered prescription drugs with high patient liability; and
- A study of coverage for habilitative services for persons under age 22 with diagnoses of delays in development.

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 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.

During the 2012 legislative session the Maryland General Assembly removed the restriction that expenditures from the Fund may not exceed the Fund's revenues in a fiscal year, which will be effective on October 1, 2012.

The Maryland Health Care 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, which continued through FY 2012. A $4.3 million surplus existed at the start of FY 2012; however, the law limiting total payments in any fiscal year to revenue collected in that same year remained in effect for FY 2012. Trauma Equipment Grants awarded to the Level II and Level III trauma centers, for a total of $298,571, were paid from surplus funds.

Payments to eligible providers and the administrative costs associated with making those payments totaled about $12 million in FY 2012, an increase of approximately $600,000 from FY 2011. Comparing FY 2012 to FY 2011, both uncompensated care payments and on call trauma payments increased by approximately $100,000. Administrative costs rose in 2012 due to an increase in uncompensated claim volume. Transfers from the Motor Vehicle Administration (MVA) to the Fund increased by about $100,000 in FY 2012.

Patient Centered Medical Home Program

Overview

The Patient Centered Medical Home Program, established by legislation enacted by the Maryland General Assembly in 2010 and effective July 1, 2010, charged the Maryland Health Care Commission to establish a program if it concluded that the program is likely to result in the delivery of more efficient and effective health care services and is in the public interest (Maryland Annotated Code, Section 19-1A.) The statute requires that the program promote the development of patient centered medical homes by adopting standards, forms and processes with consultation of stakeholders. This pilot program is known as the "Maryland Multi-Payer Patient Centered Medical Home," or "MMPP."

Accomplishments

The five (5) main achievements for the MMPP during the fiscal year were:

- 52 practices achieved NCQA Level I or better, with two-thirds of the practices achieving Level II or III;

- 52 practices submitted quality measure data using EHRs or registries;
- The comprehensive external evaluation program was launched;
- Increased Medicaid funding for FY 2012-2013 was secured (from $1.5 to $2.9 million); and
- The Shared savings methodology was confirmed using 2009-2010 data.

Maryland Learning Collaborative

The principal agent for practice transformation and quality improvement in the MMPP practices is the Maryland Learning Collaborative or "MLC." The Commission executed an MOU with the University of Maryland, Department of Family and Community Medicine at the University of Maryland School of Medicine to operate the Maryland Learning Collaborative, or "MLC." The MLC is a partnership that combines resources from the education and research communities with the commitment and knowledge of clinicians committed to advancing primary care. It is led by David Stewart, MD, MPH, Niharika Khanna, MD, and Kathy Montgomery, PhD, RN of the University of Maryland and Norman Poulsen, MD and Scott Feeser, MD of Johns Hopkins University.

The MLC deployed practice transformation coaches and conducted two large peer learning meetings and seven small regional peer learning activities. The MLC was essential in gaining the support of NCQA staff to promote full understanding of NCQA criteria and to expedite review processes.

The Commission funded the MLC at $790,000 over three years (2011-2013) via the MOU. Additional support for the MLC in the amount of $120,000 was secured in this reporting period from private sources.

Evaluation

The Maryland Board of Public Works approved a contract with IMPAQ International on September 21, 2011 to conduct a sophisticated, comprehensive evaluation of the MMPP. The evaluation plan has three prongs: analysis of costs, utilization and quality measures; patient and family (for pediatric patients) satisfaction; and, qualitative interviews with providers via site visits and an on-line survey. Preliminary findings will be available for the FY 2012-2013 annual report.

MMPP Advisory Panel

The Maryland Health Care Commission convened an MMPP Advisory Panel, composed of carrier, employer, and practice representatives in August of 2011. The purpose of the Advisory Panel is to consider and advise the Commission on administration of the program. No program modifications were recommended in August.

Business Cycle

The business cycle for this pilot program has seven components: patient attribution; payment methodology; quality measure reporting; fixed transformation payments (FTPs);

adjustments to FTP; shared savings methodology; and calculation of shared savings. The mechanisms for all seven components were confirmed in this period.

Patient Attribution
The process used to assign a patient to a practice for the purpose of calculating fixed transformation payments (defined below) was developed in FY 2010-2011 but executed in July 2011. The basis for the MMPP attribution process for commercially covered lives is the all-payer claims data base which the Commission oversees. MHCC contracts with Social and Scientific Systems ("SSS") to perform data aggregation work.

Payment Methodology
Commission staff implemented the payment methodology developed by its consultant, Discern Consulting LLC, which included adjusting control files sent to carriers to account for changes in NCQA recognition level, standardized carrier reporting of payments made to practices, and a process to supply practices with patient rosters so that payment made could be validated and accounted for by practices.

Quality Measure Reporting and Dashboard
In this period, exact specifications for a range of adult and pediatric quality measures required by the Participation Agreement were created by Discern Consulting. Practices were trained on the specifications in order to promote consistent reporting of data. Both Discern and the MLC conducted "user groups" training and relied on critical support from the Commission's Center for Health Information and Technology for use of EHRs and registries. MHCC created a web portal for secure entry of practice quality measures.

A practice "dashboard" was created to profile each practice's performance on quality measures relative to its MMPP peer group, Maryland practices generally, and national benchmarks. Utilization measures and cost data are also included in the dashboard, which was piloted in this period.

Fixed Transformation Payments are guaranteed, semi-annual prospective payments made to practices. The "per member per month ("pmpm") rate depends on size of the practice and its NCQA recognition level. These payments are, in effect, economic development funds. Practices were required to expend 35% of their FTP payments on the care management function. Approximately $6 million was invested in the program over Cycle 1 and 2 by commercial payers and Medicaid.

Adjustments to Fixed Transformation Payments
Only a few adjustments had to be made to FTP payments in Cycle 1 (July 2011) and Cycle 2 (January 2012) and were due to either programming error at a carrier or a control file error. The Commission worked with commercial carriers and the Office of Medicaid to correct these few errors.

Shared savings payment methodology

Commission staff worked with Discern Consulting and SSS to test the methodology by comparing 2009 to 2010 cost data. The results and detailed long form technical manuals were shared with commercial carriers so that they could review and possibly replicate. Carriers had several opportunities to review the methodology and provide comment. Based on the feedback, an adjustment was made on inflating the $75,000 truncation point. In a parallel process, Commission staff partnered with the Office of Medicaid to determine how the cost trend would be established and how payments would be disbursed. A short form technical paper was prepared for and disseminated to practices.

Shared savings payments

The results of the CY 2011 performance against CY 2010 baseline data will be reported in the next annual report as these calculations and disbursements were made after June 30, 2012.

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 web-based 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, home health agencies, and hospices. This division acquires and manages internal and external analytic databases used by the Commission, including the Maryland hospital inpatient, outpatient and emergency department data, state and private psychiatric hospital data, outpatient ambulatory surgery data, the District of Columbia (DC) hospital inpatient data, Medicare and private payer insurance claims data, pharmacy claims 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, internet application development, and public reporting of health care information.

Accomplishments

Administrative

Data staff completed the following administrative tasks: compiled monthly task reports; updated the FY 2013 budget projection; managed staff file permissions; maintained documentation of web applications, file locations, and associated databases; sent obsolete data disks out for destruction; shredded sensitive documents; ordered technical manuals; managed security documents; moved finalized project files from the development drive to the protected drive; attended staff meetings; developed and updated data use agreements with external data users; recommended inclusion of specific backup language in the data use agreements; helped troubleshoot SQL server connection problems; managed annual SAS licensing and home use agreements; tested the new Gmail accounts and helped with creating email signatures.

Data Processing Support

Data staff performed the following: Medical Expenditure Panel Survey file processing support; developed an intranet-based interface which allows staff to easily locate the MHCC databases and documentation; provided Google tracking code to internet programmers and to contractors; assisted staff with Google analytics and converted analytics reporting to the new SharePoint site; downloaded and processed the 2009 Area Resource File; performed disk space assessments to manage space on the server because of the delivery of the large Medical Care Data Base files; prepared a summary of the statewide range of quality indicators, quality measures, and family satisfaction overall care values for nursing homes; assisted staff with Trauma Fund processing; worked with the Long Term Care staff to standardize a zip code data provider for our database going forward; and managed the download and upload of files to and from the ftp server.

Hospital Discharge Database

Data staff performed the following: analysis of open-heart and catheter procedures by hospital; a rehabilitation hospital request; researched diagnosis codes because of the number of discharges with missing data for primary diagnosis and diagnosis codes on admission; investigated the field length for variables in the discharge abstract when it appeared that data was being truncated; and calculated operating room costs broken down by hospital. Data staff downloaded and processed inpatient and outpatient hospital discharge files quarterly.

District of Columbia (DC) Hospital Discharge Database

Data staff performed extensive programming for conversion of the DC inpatient data to SAS, which required transposing, manipulating, and joining 24 files because the file layout changed for 2010. Data staff ran frequencies of the major diagnostic category to planner defined service conversion and worked with the Certificate of Need (CON) chief to resolve discrepancies. Data staff found that the file is not coming in the preprocessed format we used to get from the DC Hospital Association and staff spent considerable time investigating how to preprocess the file. Data staff made numerous emails, calls, and participated in meetings to attempt to resolve issues with this data.

Graphic Design Support

Data staff provided logo support for the HMO report; discussed graphic issues on the health benefit plan report with NCQA; helped the Analysis staff package the MEPS-IC report for press and helped with paging issues with the report; created an MHCC logo samples cheat sheet for staff; and developed a workaround to print the self-insured small group report in tabloid format and documented this method for staff.

Hospital Clinical Measures Database Support

Data staff provided the following support: attended regularly scheduled meetings with the hospital guide contractor; downloaded quarterly hospital clinical measure and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data and processed the data into SAS analytical files; rewrote SAS code to homogenize the quarterly data so that multiple years could be merged into longitudinal data sets; reviewed Health Services and Cost Review Commission

(HSCRC) programs to count clinical measures passed and made recommendations to them to get the same counts as reported on the MHCC site; downloaded the hospital guide web tables and ran the hospital core measures report on a quarterly basis; developed a prototype for a SAS-driven dashboard using the HCAHPS survey data and created program code and mock-ups for a proposed hospital quality dashboard, including hospitals over time, and hospital-to-hospital comparisons.

IRB Coordination

Data staff provided the following support: fulfilled IRB requests, established an IRB data transmission format, worked with the Network staff to find out which large tape formats we are able to output for IRB requests and to decide how many to order; coordinated with IRB requestors to find out if they can accept the tape format we are currently using; worked with the HIT staff to straighten out the IRB requested fields on the hospital quality data and worked with them to hammer out the data transfer requirements as well as a protocol for all IRB requests that don't fit on a DVD; prepared files for IRB requests and coordinated secure courier services for IRB data deliveries.

Maryland Health Insurance Partnership (MHIP)

Data staff performed an investigation of prescription drug claims among MHIP members and an analysis by county of residence.

Medical Care Data Base (MCDB)

Data staff performed the following on the all payer claims database: processed an autism and a line item charge analysis; uploaded revised CPS data from the US Census to merge with the MCDB; created a FAQs file of instance and patient-level frequencies and included common crosstabs with age, gender, county, and coverage type; calculated the number of Medicaid-eligible Marylanders by age by fiscal year; an analysis of consumption of services by autistic youth broken down by types of therapy; analysis of in-vitro fertilization services by age; investigation of oral chemotherapy drugs and their cost/coinsurance/patient liability statistics; analysis of therapy service use by developmentally disabled youth; analysis of depression diagnoses by age, and primary vs. non-primary providers; emergency room facility consumption by payer and county for both complicated and non-complicated hypertension diagnoses; out-of-pocket cost analysis; analysis of smoking cessation counseling by age and region; and an analysis of eligibility by payer, source system, full-year coverage, and in-state/out-of-state residence.

Patient-Centered Medical Home (PCMH) Support

Data staff prepared: a report on chemotherapy drugs and drug companies from the Medicare database and then tabulated sites in the PCMH by sex and gender of patients using the selected chemotherapy drugs; a reconciliation of the PCMH file and Medicaid membership; an analysis of the overlap between PCMH membership and HIV diagnosis; an analysis of PCMH members by practice site and insurance type; an analysis of Medicare patient count by practice, and assessment of continuous enrollment and continuity in the same practice over enrollment periods.

Physician License Renewal Data Base

Data staff provided the following support: uploaded annual data; developed new SAS methods for data manipulation from Microsoft Access; performed data cleaning; implemented revised rules for defining active physicians and practice types; created a multi-year file and populated missing 2011 fields with 2010 values; revised raw data import techniques to homogenize character/number variable differences; performed analysis and data cleaning of the EIN number and identified physicians at the same practice location; created new EIN numbers for records with missing numbers; performed an analysis of electronic health record usage by physician specialty and practice type; and updated documentation and the data dictionary for the current year collection of the Physician License Renewal.

SAS Training and Support

Data staff prepared and presented weekly SAS instruction covering SAS Enterprise Guide, basic programming, troubleshooting, data management, and statistical analysis. Data staff also tutored staff on an individual basis. Staff identified on-line help sources and updated hardcopy reference manuals.

Web Development and Support for MHCC Initiatives

Ambulatory Surgery Directory

Data staff uploaded ambulatory surgery 2010 public use files after converting them to zip and pdf formats and modified the ambulatory surgery directory index page. They manipulated the 2010 directory data into the format needed for the Ambulatory Surgery directory web application and resolved missing services fields, updated the zip code distance tables, tested the application, and uploaded the new database tables.

Cardiac Registry Web-Based Data Collection

Data staff met with the Hospital staff several times to prepare for the Cardiac Registry meeting with the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and to finalize the required format for collection of the CathPCI and action files. Data staff drafted the language for the requirements to send to the hospitals and finalized the cardiac registry letter. Data staff participated in the conference call with MIEMSS and reworked the cardiac registry web application as a result of changes from the conference call. Data staff created logins and strong passwords and converted the new hospital ID file to SQL and set up an SFTP account for MIEMSS. Data staff investigated Winzip encryption which is required for hospitals to submit their data and set up a file folder on the local network to accept the cardiac registry file downloads and set up permissions for the hospital staff to get to the folder. Data staff downloaded cardiac file submissions from hospitals from the MHCC website and after they were processed, uploaded the cardiac registry files to the contractor.

Central Line-Associated Bloodstream Infection (CLABSI) Web-Based Data Collection

Data staff configured the CLABSI application to collect 2011 data. They updated the web configuration file and login dates and uploaded the revised pages and tested the application.

They downloaded CLABSI files from the server every day during the collection period and set up an SFTP folder for the CLABSI auditor.

Electronic Data Interchange (EDI) Survey
Data staff prepared the EDI Progress Survey launch for 2011, copied the 2010 final EDI survey data to a backup folder, and provided the login table to the HIT staff. Data staff converted the survey tables into Excel for HIT staff use and wrote instructions for them to make edits to the survey claims table.

Health Care Worker FLU Surveys
The Data staff revised the annual web-based health care worker flu survey and database for 2011-2012 for nursing homes and assisted living facilities. The Data staff generated a list of facility logins for internal staff to test the applications and launched the surveys.

Home Health Survey
Data staff prepared a catalog, flow charts, and utilization reports on the home health survey data collection. Data staff modified the login page to accept surveys for Phase 1 facilities and set up the 2010 survey on the live server for facilities that need to modify their 2010 surveys and downloaded the 2010 home health data after edits were completed. Data staff wrote SAS programming edits for changes that can't be fixed by data entry because of the validation checks built into the survey. Data staff prepared the data for public use and wrote code to format fields to human language and removed sensitive fields. The Data staff updated the Home Health utilization programs to work with the 2010 survey data collection. The Data staff completed all web survey modifications for the 2011 online survey.

Hospice Survey
Data staff prepared a public use data dictionary, documentation, and datasets for the Hospice staff using the 2010 hospice survey data. Data staff redeveloped major portions of the 2011 survey to gather better data from hospice agencies in order to support State health planning.

Long Term Care (LTC) Portal
Data staff performed the following support for the portal:

- Processed quarterly assisted living inspection report updates, nursing home quality measure and deficiency updates;
- Developed new data flows for the annual Assisted Living and Adult Day Care facility-level file updates;
- Set up a mirror test portal for development and testing purposes and backed up all portal SQL databases and performed restores of the databases with new names for the mirror portal; during this process Data staff worked with the portal contractor to get all the SQL scripts updated so that the mirror database exactly matched the live database;
- Wrote detailed instructions for implementing the vaccination rates for nursing homes and assisted living facilities for the contractor, including the presentation of the rates and the table structures; assisted with meetings

with the contractor on the vaccination implementation; and performed repeated testing and feedback to get the vaccination presentation working;
- Downloaded the user zip code table from the portal for internal analysis;
- Worked with the contractor and performed numerous installs, uploads, backups and testing to improve the entire administrative application and fix numerous errors when saving data updates and new facilities;
- MHCC requested that nursing home facility profile state averages be computed automatically each time a profile change is made. An enormous amount of testing went into this change;
- Reviewed and answered technical questions on the family satisfaction survey request for proposal;
- Investigated changes needed to convert fire-safety substandard of care values to zero on the Centers for Medicare and Medicaid nursing home deficiency processing; made changes to the program and tested and ran scripts on the SQL database to verify there are zero fire/safety substandard of care deficiencies;
- Tested and updated all links on the portal that were broken when our website was converted to SharePoint;
- Developed SAS processing programs for the home health CAHPS data and developed .NET application code for their web presentation;
- Worked with the LTC staff to update code for the nursing home deficiency and resident profile processing that recodes provider numbers in the federal files to match our provider numbers;
- Worked with LTC staff to determine how to handle non-functioning assisted living photo updates to the portal;
- Generated a list of assisted living and nursing home facilities with no inspection survey within the last 2 years;
- Computed and replaced missing latitudes and longitudes on all portal databases.

Long Term Care Survey

The Long Term Care Survey is a legislative mandate that requires long-term care facilities, assisted living facilities, chronic facilities, and adult day care centers to provide operational and financial information to the State. This survey is completed online annually through a web site developed by the Data staff. The data collected is analyzed and used for State planning purposes and to update the public nursing home and assisted living web sites.

Methicillin-resistant Staphylococcus Aureus (MRSA) Web-Based Data Collection

Data staff configured the application quarterly to collect MRSA data from Maryland hospitals via the survey.

MHCC Intranet
The following were added or updated in the MHCC Intranet: timesheet change forms, RFP forms and templates, data contacts, telework forms, and SharePoint training materials.

MHCC Website SharePoint Conversion
DHMH required all agencies to convert their websites over to the DHMH SharePoint server. To prepare for this process, Data staff attended SharePoint training sessions for 3 months and prepared a website architecture migration plan. The plan described the current architecture and the migration path for all folders over to the SharePoint architecture. This was necessary because under the new system, administrative permissions would be distributed among staff and the permissions needed to be assigned by sub-site. The migration plan identified permission groups and levels of permissions for MHCC staff. The plan also included a complete inventory of web applications, locations, links and databases. The plan was instrumental in directing the work of a consultant who was hired to assist with our website migration to SharePoint. Data staff prepared for the migration by removing all css, java script, templates, email encryption and old navigation from the web pages to be migrated. Data staff worked with the Network staff continuously to straighten out SharePoint logins. Data staff performed extensive testing to figure out how to link documents, efficiently clean up html, and link across folders. Data staff provided daily assistance to MHCC staff with login and editing issues, provided in-house training, and developed training materials made available on the intranet. Data staff worked with the consultant to resolve numerous administrative and technical issues. Data staff repeatedly reviewed the SharePoint site for broken links and fixed them as well as reviewing outside sites which linked to our SharePoint site. Data staff performed a massive cleanup after the migration was completed because many files were migrated into nonsensical folders. Data staff worked with DHMH to get Google analytics working and formalized file naming conventions for the Commissioner web page and for the press release site.

MONAHRQ Application Support
Data staff processed quarterly updates of the hospital discharge data into html pages for the MONAHRQ application which is used by internal DHMH staff and allows users to assess quality of care at the hospital level, health care utilization at the hospital level, preventable hospitalizations at the area level, and rates of conditions and procedures at the area level.

PCI - Non-Primary PERCUTANEOUS CORONARY INTERVENTION
Under COMAR 10.24.05 (Continuation of Non-Primary Research Waivers Through Participation in the Follow-On C-PORT E Registry), a research waiver permitting hospitals to continue to perform non-primary PCI is required. The participating hospitals apply for the waiver through a new web site developed by Data staff.

Web Development and Support for DHMH Boards and Commissions
The following license renewal sites were developed and are maintained by the Commission and allow practitioners to renew licenses and to provide data to DHMH about the health provider and collect renewal fees:

- Acupuncture
- Audiologists, Hearing Aid Dispensers and Speech Language Pathologists
- Chiropractic and Massage Therapy Examiners
- Dietetic Practice
- Morticians & Funeral Directors
- Optometry
- Physical Therapy Examiners
- Physicians
- Psychology
- Podiatric Medical Examiners
- Professional Counselors and Therapists
- Social Work Examiners

Patient-Centered Medical Home (PCMH)

The Maryland PCMH program is a model of practice in which a team of health professionals, guided by a primary care provider, provides continuous, comprehensive, and coordinated care in a culturally and linguistically sensitive manner to patients throughout their lives. The PCMH provides for all of a patient's health care needs, or collaborates with other qualified professionals to meet those needs. The Maryland PCMH program is promoted and managed through a series of coordinated online web sites developed and maintained by the Data staff.

- Public Site – provides general information about the program, and tools for providers and employers.
- Practices' Portal – registers and manages participating practices' data
- QMRP –Quality Measures Reporting - Each quarter participating practices are required to report various quality measures related to their PCMH program through an online site.
- MMPP (Maryland Multi-Payer PCMH program) and Learning Collaborative Portal – this portal provides information and schedules of events, forums, documents, and newsletters to participants.
- Site Administration - This site manages the family of PCMH online sites, including user lists.

Network and Operating Systems Division

Overview

The division's staff builds, 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 2012, the Commission's LAN was available to staff over 99% of the time.
The Commission's LAN continues to be safeguarded by keeping all systems up-to-date with the timely application of software patches and the regular upgrade of an anti-virus database engine. 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. In addition to the standard annual accomplishments listed, the following were also completed in FY 2012:

- Purchased a new network server to act as a read-only domain controller, providing a virtual link between the MHCC LAN and the DHMH primary network;
- Upgraded 33% of the desktop workstations through the annual computer refresh exercise;
- Upgraded 67% of the notebook computers through the biennial notebook refresh exercise;
- Installed publically accessible open WIFI Internet service;
- Upgraded network antivirus software to a much stronger and intelligent virus database engine;
- Upgraded the remote access software; and
- Purchased all equipment for the virtualization of the MHCC data center.

MARYLAND HEALTH CARE COMMISSION

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 health 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, Subtitle 12) 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 through December 31, 2013), that no longer allows the self-employed to enroll in the CSHBP because of their atypically high 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, with varying effective dates: 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; the requirement that the Commission establish an information-only web portal to publish small group premium information on its website; adjustment of the rating bands in the small group market to +/-50 percent; and allowance for carriers to rate on entry for new groups entering the small group market, adjusted annually over the first three years of enrollment.

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 +/-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.

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 group insurance for their employees; (2) help low and moderate wage 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 specifically 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 group coverage 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 benefit 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, branded as the Health Insurance Partnership.

Accomplishments

Comprehensive Standard Health Benefit Plan

With the enactment of the Affordable Care Act, the Commission enhanced the services provided under the CSHBP to conform to the federally mandated provisions. Through regulations implemented effective September 23, 2010, specific provisions include the following: children can remain covered on a parent's existing policy until the age of 26; certain preventive services recommended by the U.S. Preventive Services Task Force cannot be subject to the deductible nor have any associated cost-sharing requirements if these services are provided in-network; the $2 million lifetime limit has been removed; the provisions for direct access to gynecologic services are changed from state provisions to federal provisions, including the additional requirements to be effective on August 1, 2012; and individuals under the age of 19 may not be subject to any pre-existing condition restrictions or limitations. With these additional benefits, the overall cost of the CSHBP remained below the affordability cap in FY 2012, at approximately 98% of the cap as of December 31, 2011. At that time, more than 41,000 Maryland small employers purchased group insurance, covering about 355,000 of their employees and their dependents.

In June 2010, the Commission contracted with Benefitfocus to develop an information-only web portal designed to help small business owners choose a group health benefit plan for their employees. The web portal, known as VIRTUAL COMPARE, became operational on May 3, 2011, and provides information about select health benefit plans available to small employers in Maryland, allowing a side-by-side comparison of benefits, premiums, and out of pocket costs. VIRTUAL COMPARE also includes guidance about choosing health insurance; information about federal tax credits and state subsidies for small, low wage companies; and assistance in finding an insurance broker to apply for coverage. Throughout FY 2012, more than 900 licensed insurance producers in Maryland have registered to be listed on VIRTUAL COMPARE to assist small employers with the group application process. Moreover, the analytics indicate consistent consumer access to VIRTUAL COMPARE, averaging 5 to 9 visits on a daily basis, with the user viewing 3 to 6 pages per visit, and spending between 5 and 8 minutes on the site per visit.

Accomplishments

Mandated Health Insurance Services Evaluation

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, (Insurance Article Title 15, Subtitle 15, Annotated Code of Maryland). The Annual Mandated Health Insurance Services Evaluation report is due to the legislature each December 31st. 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 benefit 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.

In FY 2012, one proposed mandate was evaluated: coverage for the treatment of bleeding disorders. This analysis, prepared by Mercer/Oliver Wyman, the Commission's consulting actuary, was approved by the Commission in December 2011, submitted to the General Assembly, and posted on the Commission's website.

The Comparative Evaluation, which is due every four years, also was prepared by Mercer. It was approved by the Commission in December 2011, submitted to the General Assembly, and posted on the Commission's website.

With the enactment of the Affordable Care Act, all health benefit plans offered through the new health benefit exchange must include certain "essential health benefits" beginning January 1, 2014. Federal reform also requires that each state must pay, for every health benefit plan purchased through the exchange, the additional premium associated with any state-mandated benefit beyond the essential health benefits. Any Maryland mandates that apply to the selected benchmark plan will apply to the essential health benefits package in 2014 and 2015. The U.S. Department of Health and Human Services advised in December 2011 that any new mandate enacted during the 2012 legislative session or beyond, or any benefits that do not apply to the benchmark plan, *will not* apply to the essential health benefits package, and thus the State will be liable for the cost of the additional premiums associated with those benefits.

Accomplishments

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, the Health Insurance Partnership. Throughout FY 2012, four major carriers (Aetna, CareFirst BlueCross BlueShield, Coventry Health Care, and United HealthCare), together with a number of Third Party Administrators (TPAs) continued enrolling small businesses in the Partnership, with each carrier offering a variety of health benefit plans that qualify for a premium subsidy. Annual funding for the Partnership is $2 million. On January 1, 2012, the MHCC published the 4th annual report on the implementation of the Partnership indicating that throughout FY 2012, small employers in Maryland continued to renew their subsidized insurance for their employees and several new businesses enrolled as well. By the end of FY 2012, more than 400 businesses enrolled, covering almost 1,900 employees and their dependents. The average annual subsidy per enrolled employee was almost $2,400. The annual Health Insurance Partnership report is posted on the Commission's website.

Throughout FY 2012, Commission staff continued its outreach and education efforts by attending several meetings, seminars, and expos to inform small businesses throughout Maryland about the benefits of both state and federal health reform. Commission staff distributed materials and made presentations to various interest groups and small business professional associations to help increase awareness about the availability of small group health insurance in Maryland, premium subsidies under the Health Insurance Partnership, the Small Business Health Care Tax Credit under the Affordable Care Act, and the VIRTUAL

COMPARE web portal to assist small employers when shopping for health benefit plans or finding a health insurance producer.

Health Plan Quality and Performance Division

Overview

The Division of Health Benefit Plan Quality and Performance takes action as appropriate to develop implement and support public policy to collect and report meaningful, comparative information regarding the quality and performance of commercial health benefit plans operating in the State of Maryland. The comparative information supports employers, as well as individual purchasers, academics and policymakers, in assessing the relative quality of services provided by the segment of health benefit plans that are required to report to the Maryland Health Care Commission (MHCC). The Code of Maryland Regulations (COMAR) 10.25.08 require a health benefit plan to participate in the Health Benefit Plan Quality and Performance Evaluation System by submitting reports to the MHCC if the health benefit plan holds a certificate of authority in Maryland and has a premium volume in Maryland exceeding $1 million. Health benefit plans having more than 65 percent of their Maryland enrollees covered through the Medicare and Medicaid programs are not required to participate in the evaluation system. Health-General Article, Section 19-134(c), et seq. is the statute that directs the MHCC to establish and implement a system to evaluate and compare, on an objective basis, the quality and performance of care provided by commercial health benefit plans. The statute also permits the MHCC to solicit and publish data collected using standardized health benefit plan quality and performance measurement tools, including, but not limited to, tools such as the Healthcare Effectiveness Data and Information Set (HEDIS)®, which focuses on measuring clinical performance, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® survey, which focuses on health benefit plan members' satisfaction with their experience of care. The MHCC is required to annually publish the findings of the evaluation system for dissemination to consumers, purchasers, academics, and policymakers. All information is reported within a framework of the type of benefit design category that a health benefit plan is structured as, including categories such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Point of Service (POS) organizations, Exclusive Provider Organizations (EPOs), or any other type of benefit design category that may be introduced in the future.

Historic Reporting Milestones

MHCC and its predecessor agency has been a leader in public reporting for the last fifteen years. Data shows that health benefit plans' commitment to measurement, transparency and accountability has improved care over the years.

- **In 1997, Maryland was the first in the nation** to provide consumers with audited, comparative analyses of clinical quality and member satisfaction with health benefit plan performance for HMO plans.

- **In 2008, Maryland was the first in the nation** to provide consumers with audited, comparative analyses 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.

Accomplishments

In 2012, mandatory reporting by PPOs in Maryland became law. Maryland continues as one of a few states that provide consumers with audited, comparative analyses of clinical quality and member satisfaction for PPO plans.

In 2012, Division staff began collaborating with senior staff of the Maryland Health Benefit Exchange (MHBE) for the purpose of familiarizing them with the process for collecting and reporting on the quality and performance of health benefit plans, as the Affordable Care Act requires that the MHBE produce comparable reports for qualified health plans participating in the MHBE. We are now in the process of finalizing the execution of a Memorandum of Understanding to provide report production support to the MHBE in 2013 and potentially beyond. The MHBE benefits from MHCC experience and from the cost savings associated with utilizing the existing infrastructure.

For reporting year 2013, Maryland health benefit plans, including EPOs, will begin mandatory reporting. Maryland health benefit plans operating under any type of delivery system model, including HMOs, POSs, PPOs, EPOs, or other type of delivery system that may be introduced in the future, will begin collecting and reporting data and information related to the various aspects of healthcare quality and performance.

For reporting year 2013, Maryland health benefit plans will begin mandatory race and ethnicity reporting. Maryland health benefit plans will begin collecting and reporting data and information related to race, ethnicity, language, interpreters, and cultural competency using a newly developed Maryland RELICC Assessment tool, which has been customized exclusively for the State of Maryland to comply with the Lt. Governor's reduction of racial and ethnic disparities initiative. The Maryland RELICC Assessment tool has been selected by the Maryland Health Benefit Exchange to meet their mandatory race and ethnicity disparity reduction requirements.

Request for Proposals (RFP) Executed. Division staff prepared and issued a procurement solicitation, MHCC 13-006, Health Benefit Plan Performance Evaluation – Report Development. Vendor proposals received in response to the RFP were evaluated by a five-member panel and one qualified vendor proposal was unanimously recommended for contract award and later approved for the contract award by the Maryland Board of Public Works.

2011 Report Series Executed. Division staff continued to work in partnership with contractor staff having special expertise in health quality measurement to develop the series of annual

health benefit plan performance reports, which include information on the quality of HMO, PPO, POS, and EPO plans available to Maryland residents. The three-part series of annual health benefit plan quality and performance reports includes the following:

- The *2011 Health Benefit Plan Performance Report*, sometimes referred to as the *Consumer Guide*, is a consumer-oriented report that allows Marylanders to compare health plans on key quality measures regarding health care delivery and member satisfaction. Quality ratings show a health plan's ability to deliver high-quality care to its members. Performance data are collected from health benefit plans and include several types of delivery systems, including health maintenance organizations (HMOs), point of service organizations (POSs), and preferred provider organizations (PPOs). Key features of the different types of delivery systems are also explained in this report. This report highlights areas of healthcare where plans had average and above-average performance, as well as areas that need improvement. In addition to this year's quality ratings, the report includes important information about how to maintain wellness, which can bring multiple benefits, including a longer lifespan and fewer illnesses. Wellness can be defined as the process of becoming aware of, taking responsibility for, and making choices that directly contribute to well-being. This report also contained a new section that described the subset of health benefit plan choices offered to State of Maryland employees.
- The *2011 Comprehensive Performance Report* on commercial HMO, POS and PPO health benefit plans in Maryland is designed to help consumers, purchasers, academics, and policy makers assess the relative quality of care delivered by health benefit plans. This report contains a new Executive Summary section that highlights Maryland's performance against regional and national averages and underscores the clear trends of improvement since the year 2000. While year-to-year gains in quality and performance improvement are often quite small, they have been steady over time. Of the thirteen clinical measures and indicators that had data over ten years, twelve measures show clear trends of improvement since the year 2000. The most improvement was in the areas of childhood immunization and diabetes care. Only one measure showed a slight decline—the Breast Cancer Screening measure. The body of the report contains three years of detailed HEDIS and CAHPS results, comparing health benefit plans to the Maryland state average and highlighting when a plan's performance significantly increased or decreased.
- The *Health Benefit Plan-Specific Report Series* allows health benefit plans to preview the data and information about their plan that will be reported publicly. This series of reports offer plans a final opportunity to clarify information before it is made public in the *Health Benefit Plan Performance Report* or the *Comprehensive Performance Report*.

MARYLAND HEALTH CARE COMMISSION

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 extensive long term care service provider descriptive information and provider performance on a variety of metrics. An interactive web-based consumer guide developed and maintained by staff is the platform for presenting a wide range of information about long term care (LTC) services, including specific performance and quality measures applicable to long term care.

Consumer Guide to Long Term Care http://mhcc.maryland.gov/consumerinfo/longtermcare/

The Consumer Guide is a comprehensive web portal focusing on frequently used services across the continuum of long term care, including services received in one's home, community, or facilities such as assisted living and nursing homes, but always with emphasis on community services. Service categories include: adult day care; home-based care such as home health agencies, agencies providing non-skilled care (residential service agencies, and nursing referral agencies); nursing homes; assisted living; rehabilitation facilities; and hospice services.

Key features of the site:

- "Planning for Long Term Care" defines key terms and types of LTC services, offers resources for planning and links to resources for estimating the cost of long term care, discusses ways to finance LTC, and provides Maryland-specific advance directive planning information;
- Information about home modifications to allow seniors and persons with disabilities to remain in their home;
- Location of community support services, including senior centers, meal programs, resources for family caregivers, and transportation;
- A resource section that includes links to federal, state, and local sites to assist in answering questions about prescription drugs, legal resources for seniors and persons with disabilities, a tool that can locate a physician near one's home, and local resources for health care such as county clinics;

- 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.

The portal has an interactive search feature that allows users to find LTC services by facility type and county. Within the services search function users can view demographic information about: facility characteristics such as ownership information; agency accreditation or certification; number of beds or client capacity; clinical and assistance services available; and resident characteristics. Pictures of nursing homes and assisted living facilities are also featured to assist Marylanders in narrowing their choice. More importantly, users can also view quality indicators; performance indicators; the results of the Office of Health Care Quality (OHCQ) annual licensing and complaint surveys; and the results of the Family Experience of Care surveys. Division staff also works with federal agencies such as the Centers for Medicare and Medicaid (CMS) and the Agency for Healthcare Research and Quality (AHRQ) and other national organizations such as the National Quality Forum (NQF) to insure that the quality measures reported within the Consumer Guide are reliable, validated, and suitable for public reporting.

An analysis of LTC portal user statistics for fiscal year 2012 shows over 180,000 LTC pages viewed and over 66,000 unique pages viewed. Information about assisted living residences was the most commonly viewed topic area with 43% of the pages viewed; 22% of pages viewed were content related to nursing home topics. Viewer type and zip code were tracked through December 2011. 70% of viewers identify as seeking information for themselves or a family member; 30% of viewers are evenly divided between policy/researcher and provider viewers. Zip code stats show most viewers (80%) reside in the populous urban areas of Central Maryland and the Maryland suburbs adjacent to the District of Columbia.

Nursing Home Experience of Care Surveys

LTC quality staff designed, developed, implemented, and provides oversight for administration of surveys that collect quality and performance information. One series of surveys measures the experience and satisfaction with the nursing home's staff, care, and living environment from the perspective of a resident's family member or designated responsible party. Other surveys are designed to collect information on infection control. Annual surveys have been implemented in nursing homes and assisted living facilities to determine the staff influenza vaccination rate. Division staff collaborates with CMS and AHRQ to insure that the surveys are reliable and suitable for public reporting.

Calendar year 2012 marks the fifth survey cycle for the Nursing Home Family Experience of Care survey, which collects information on the experience and satisfaction with a nursing home's staff, care, and living environment from the perspective of family members and designated responsible parties of residents. The Maryland survey consistently yields a response rate of nearly 60%, which is well above the national average. Statewide results show survey respondents rate satisfaction with nursing homes relatively high. 2010 survey results were released in April 2011. A Request for Proposal process to select a new contractor delayed the start of the subsequent survey until January 2012. Results of the 2012 survey will be available

in FY 2013. In addition to the family survey, a survey to assess the experience of recently discharged short stay residents was conducted in 2010 and in 2012 in collaboration with AHRQ.

Results of the experience of care survey for each nursing home are displayed within the **Consumer Guide to Long Term Care** to further assist Marylanders when choosing a nursing home for themselves or a loved one. In addition, the results are used by the Medicaid Long Term Care Division within the Department of Health & Mental Hygiene as one of four factors in the Medicaid Nursing Home Pay for Performance Program.

Staff Influenza Vaccination Survey in LTC Settings

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. The Division initiated collection of influenza vaccination data for nursing home staff during the 2009-2010 influenza season. Results are reported for each facility in the Consumer Guide to Long Term Care in order to assist consumers and are used by the DHMH Medicaid Office of Long Term Care and Community Support as one of four measures in the Medicaid Nursing Home Pay for Performance Program. A question was added to the 2011-2012 survey to assess the level of adoption of a mandatory influenza vaccination policy by nursing homes.

An Influenza Vaccination Survey for staff working in assisted living residences was piloted during the 2010-2011 flu season and became mandatory during the 2011-2012 influenza season. Individual facility results are reported in the Consumer Guide to Long Term Care.

Accomplishments

Consumer Guide to Long Term Care

The web portal was expanded to include display of vaccination rate data, home health quality measures, and home health experience of care results.

Staff also focused on increasing consumer awareness of the Guide by placing links to the portal on each Maryland county and Baltimore City web site, other state agency web sites such as the Maryland Community Services Locator (MDCSL), University of Maryland elder services, and Maryland Department of Aging. Staff attended networking events of senior services providers to build connections and share information. Networking resulted in contacts with organizations serving seniors such as the Mid Atlantic Association of Professional Care Managers Association, which added a link to the Consumer Guide on their state and national site. The guide was added to the MHCC Facebook page in May, 2012 to gain a presence among the ubiquitous social media sites.

Production of MDS Quality Measure and Quality Indicator scores were frozen by CMS effective with the data collection period ending September 2010 to accommodate the transition from MDS 2.0 to MDS 3.0. Implementation of MDS 3.0 complicates the reporting of several nursing home quality measures due to measure specification changes. MDS 3.0 data became available

in June 2012 and is being analyzed by staff to incorporate necessary changes and clarifications within LTC Guide.

Nursing Home Experience of Care (satisfaction) Survey Results

2010 Family Survey results show that statewide "overall satisfaction" was rated 8.4 on a 10 point scale and 90% of respondents said they would recommend the nursing home to others.

Short Stay Nursing Home Survey

Some Maryland nursing homes demonstrate increasing numbers of short stay residents, which are expected to continue increasing with a "Baby Boomer" generation that is healthier, expected to live longer, and is very guarded about their independence. As a result, MHCC staff collaborated with AHRQ by testing the short stay survey they are developing in Maryland. This collaboration benefits AHRQ by providing additional field testing of the instrument; MHCC benefits by piloting an experience survey among nursing home short stay residents; and the nursing homes in Maryland that participate benefit by receiving information from short stay residents about their stay. Statewide results of this pilot survey shows that the overall rating given by respondents is 7.8 on a scale of 10 (10 represents the best rating). 83% of short stay respondents would recommend the nursing home. The 2012 Short Stay survey results will be reported in the next annual report.

The MHCC nursing home experience of care survey efforts have received national recognition as evidenced by the invitation by the Agency for Healthcare Research and Quality to Commission staff to present at two national CAHPS User Group meetings.

Influenza Vaccination Survey among LTC Staff

The 58% average vaccination rate reported for the 2010-2011 influenza season prompted intensive efforts on the part of MHCC LTC staff to encourage and assist nursing homes to improve their rates. These efforts consisted of informational emails from September to March to all nursing homes and arranging a webinar with a nationally known speaker entitled, "Implementing Effective Strategies to Increase Influenza Vaccination Rates and Reduce Staff Resistance to Vaccination." The slides and a recording of the presentation were made available on the MHCC web site. Participant feedback about the webinar was very positive.

Public reporting of nursing home-specific results was implemented in the fall of 2011 as an incentive for facilities to improve their vaccination rates. The 2011-2012 65.1% vaccination rate for nursing home staff represents a 7% improvement from the prior year. Staff influenza vaccination results were also added to the DHMH StateStat dashboard. The 2012 StateStat Goal is achievement of a 60% or greater staff vaccination rate for every nursing home. For the 2010-2011 influenza season, 44% of Maryland nursing homes achieved the StateStat goal. For the 2011-2012 influenza season, 60% of nursing homes achieved the goal. Staff designed and distributed recognition certificates to nineteen nursing homes that achieved a staff vaccination rate of 95% or better.

Adoption of a mandatory influenza vaccination policy -- 19% of nursing homes reported implementation of a mandatory employee influenza vaccination policy; another 18% reported no current mandatory employee influenza vaccination policy, but plan to implement a policy for the 2012-2013 flu season; and 63% of nursing homes reported no immediate plans to implement a mandatory employee influenza vaccination policy.

Additional Performance Measures

During the year, LTC Quality staff researched surveys for implementation in Maryland to report the experience of users of assisted living and hospice services. Staff is assessing the feasibility of implementing consumer surveys in each of these settings to expand the information available to consumers.

Home Health Experience of Care

Home Health Quality Reporting – CMS has implemented a mandatory survey for Medicare certified Home Health Agencies (HHAs) that serve 60 or more patients in a year. MHCC LTC Quality staff participated with CMS and AHRQ staff during development of this Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey.

The first HHCAHPS survey results were released in April 2012. Fifty-four (54) Maryland HHAs were eligible to report HHCAHPS® results in April 2012. A summary of the important findings for Maryland HHAs:

- Over 12,000 surveys were completed for all Maryland HHA residents;
- The median response rate is 33%; the range of response rates by HHAs is 18 to 59%;
- The highest average rating was 87% for the composite "Percent of patients reporting their home health team communicated well with them;" the national rating for this item was also 87%;
- The lowest average rating was 78% for the "Percent of patients reporting they would definitely recommend the HHA to friends and family;" the national rating for this item was 80%

A static report explaining the survey and listing each Maryland HHA result is posted on the Consumer Guide to LTC. To improve the searchability of home health quality data available to Maryland consumers, staff will implement an interactive feature that will allow users of the Guide to compare HHA performance on the HHCAHPS survey in the fall of 2012.

Hospice Quality Reporting

During 2012, the Centers for Medicare and Medicaid Services used its rulemaking authority to require data submission for the 2014 payment year of two hospice quality measures. The first is a pain management measure and the second is a structural measure that requires hospice programs to report whether or not they have a Quality Assessment and Performance Improvement (QAPI) program that addresses at least three indicators related to patient care. LTC Quality staff will follow developments in this area as this report is likely to result in more

definitive hospice quality measures for future reporting periods. Staff has also looked at other potential quality measures as part of the update to the Hospice State Health Plan Chapter for Certificate of Need.

Assisted Living Residences
The assisted living staff vaccination rate for the 2011-2012 influenza season was 48% with 100% of the assisted living residences reporting.

Long Term Care Quality Initiative staff is collaborating with the two nursing home associations to develop strategies to continue to increase the influenza vaccination take-up rate of staff working in LTC settings.

Participation in National Quality Efforts
Staff participated in the National Quality Forum Palliative Care Steering Committee and Long term Care Workgroup meetings. 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.

The Affordable Care Act contains several important provisions relating to quality reporting and payment incentives for LTC facilities. While these initiatives are not scheduled for full implementation until 2014-2015, MHCC is closely following the process to determine which measures will be recommended for public report.

Two current MHCC LTC staff and one former staff member authored the article *"My Eyes, Your Eyes-The Relationship between CMS Five-Star Rating of Nursing Homes and Family Rating of Experience of Care in Maryland"* published online by the Journal of Healthcare Quality in August 2011. The article analyzes the relationship between overall experience of care ratings from Maryland's experience of care survey and ratings obtained on the CMS Five-Star Quality Rating for Maryland nursing homes. The results indicated a strong positive correlation between family experience of care score and two five-star domains, namely health inspections and nurse staffing, and no relationship with the quality domain.

Long Term Care Policy and Planning

Overview
The Long Term Care Policy and Planning Division is responsible for health planning 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; promoting the development of needed services in response to identified needs, and assuring access to a full continuum of long term care services. In addition to planning, the Division is also responsible for data collection through three annual surveys, special studies, and quality assessment. The Division coordinates its long term care policy development and planning efforts with other appropriate state agencies and

stakeholders, 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 executed a one year contract for support in maximizing the utility of the Centers for Medicare and Medicaid (CMS) Minimum Data Set Resident Assessment Instrument to update data sets for planning and policy development; 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. Products developed included: detailed data documentation; data dictionary; software architecture; flow charts; and a glossary. The MDS Manager Program that was developed was used to update MDS data through 2009.

A new contract was awarded to Myers and Stauffer in June 2011 to update the MDS Manager to accommodate federally mandated changes from MDS 2.0 to 3.0 and to update programming languages from Fox Pro (no long supported) to SAS, the platform used at the Commission. The initial focus was on reviewing and updating variables and programs from MDS 2.0 to 3.0. There has also been testing to assure that the programs developed in SAS produce the output consistent with the previous MDS Manager program. Meetings are held biweekly via conference call to monitor the progress of this contract.

Commission staff also worked with the Office of Health Care Quality (OHCQ) to help assure that Section S (the state-specific portion of MDS) is accurately and completely reported. Staff consulted with OHCQ's State MDS Coordinator and the Director of Information Technology to check on the status of incomplete Section S data. Staff then developed a joint letter from OHCQ and the Commission urging nursing homes to provide complete and accurate data. This letter was also sent to the nursing home associations for their information and to ask them to encourage members to complete the data as required. Staff continues to monitor this data reporting.

Chronic Hospital Occupancy Update

As required under COMAR 10.24.08, a notice was published in the December 2, 2011 *Maryland Register* to update "Chronic Hospital Occupancy for FY 2010." 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 2010

Data on nursing home occupancy and Medicaid participation rates is updated periodically and published in the *Maryland Register* to guide health planning and Certificate of Need decisions

and other planning functions. The following tables were submitted to the *Maryland Register* for publication in the May 4, 2012 issue: "Nursing Home Licensed Beds Occupancy by Region and Jurisdiction: Maryland, Fiscal Year 2010;" and "Required Maryland Medical Assistance Participation Rates for Nursing Homes by Region and Jurisdiction, Fiscal Year 2010." These tables are developed and published annually based on data from the MHCC Long Term Care Survey, MHCC bed inventory reports, and Medicaid cost reports.

State Health Plan Draft Chapter: Hospice Services

During this year, Commission staff began work to update the State Health Plan Chapter on Hospice Services. The current Chapter (COMAR 10.24.08) covers three services: nursing home, home health agency, and hospice services. The draft regulation (COMAR 10.24.13) addresses only hospice services. The current chapter was reviewed, regulations in other states were studied, and a new draft Chapter was prepared. As a major component of this process, a Hospice Advisory Group was formed (see more detail below). Staff presented the draft Chapter at the April 19th Commission meeting. An Informal Public Comment period was held from April 14th-May 14th. In addition, in response to requests from the industry, a Public Informational Meeting was held on April 27, 2012. Updated population data were received and updated projections were published on the Commission's website on May 23, 2012.

During the Informal Public Comment period, 23 comments were received from legislators and 23 comments were received from other individuals and organizations. These comments were reviewed and analyzed and staff recommendations were made to the Commission in June. Following that meeting, the staff's analyses as well as the full text of comments received, were posted on the Commission's website.

Home Health Agency Data

Staff compiled data tables on the utilization and financing of home health agency services in Maryland for fiscal year 2010. The data was obtained from the information collected by the Commission's Home Health Agency Survey for fiscal year 2010 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 2010 were posted on the Commission's website in January 2012. 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. Data tables are available for fiscal years 2004-2008. Public use data sets are also available for fiscal years 2007-2010.

Home Health Agency Inventory

The home health agency (HHA) inventory is routinely utilized for planning purposes as well as for updating the Commission's long term care website. This inventory was updated monthly to reflect both newly established and acquired home health agencies licensed and operating in Maryland.

Meetings/Collaboration:

Nursing Home Liaison Committee

The Committee 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, 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.

Hospice Advisory Group

As the first step in updating the Hospice Services Section of the State Health Plan, the Commission convened a Hospice Advisory Group. The charge of the Hospice Advisory Group was to assist Commission staff in analyzing utilization trends, discussing factors contributing to the changes in the utilization of hospice services, identifying potential factors affecting future need for hospice services, and discussing issues for policy development. This Group is composed of: six representatives from Maryland's hospice industry, nominated by the Hospice and Palliative Care Network of Maryland to represent geographic areas as well as the for-profit and non-profit distribution of the members; an administrative representative of the Hospice Network; a representative from the Centers for Medicare and Medicaid Services (CMS) with expertise in planning, evaluation, and financing of hospice services; a representative from the Maryland Medical Care Policy Administration; and a representative of Maryland's Department of Health and Mental Hygiene's Office of Health Care Quality (OHCQ). The charge of the Hospice Advisory Group is to assist Commission staff in analyzing utilization trends, discussing factors contributing to the changes in utilization of hospice services, identifying potential factors affecting future need for hospice services, and discussing issues for policy development.

Two meetings of the Hospice Advisory Group were held. The first meeting, held on October 11, 2011 focused on data trends and policy issues. Presentations were made on hospice issues from the perspectives of CMS, Medicaid, and the Office of Health Care Quality. In addition, data depicting trends in hospice utilization were presented. The second meeting, held on November 1, 2011 began with a review of hospice methodologies used in other states, as well as a discussion about the current Maryland hospice need projection methodology. The meeting then focused on data assumptions and key variables, such as age, use rate, growth rate, and volume threshold. Based on these discussions, work began on updating the Chapter and developing draft regulations.

Hospice Regulations Workgroup:

The Office of Health Care Quality convened this work group to develop regulations to address the development of residential hospice programs, or "hospice houses." These currently do not fall under the purview of the licensing regulations. The first meeting was held on November 29, 2011. A second meeting was held in January, 2012 and draft regulations were developed. Commission staff participated in this development process.

Meetings with Office of Health Care Quality:
Beginning in May, 2012, Commission staff began holding quarterly meetings with staff of the Office of Health Care Quality (OHCQ) to discuss long term care issues of mutual interest. The first meeting was held on May 30th. Providers addressed included: home health agencies, hospices, nursing homes, assisted living providers. Topics covered, among others, included: ability to remove a license for non-performance; quality data; information on licenses; obtaining updated inventory data. Staff plans to have quarterly meetings to discuss areas of mutual interest. The Center Director and Director of OHCQ have begun monthly status meetings.

Data Collection
Hospice Survey
The Commission is charged with collection of hospice data as required by SB 732 (2003). Fiscal Year 2011 hospice data was collected using an online survey and finalized during this time period. The official start of the FY 2011 Maryland Hospice Survey was February 14, 2012 with a due date of April 16, 2012 for Part I and no later than June 7, 2012 for Part II. Since Part II is based on Medicare cost report data, a longer time period is provided.

Public use data files for FY 2010 hospice data were posted on the Commission's website in October, 2011.

During 2010, the contractor utilized by the Commission was acquired by a new ownership group that terminated the contract. Given new system development capabilities within the Commission, the annual Maryland Hospice Survey application was developed as an internal data collection tool by Commission staff.

Long Term Care Survey
In April 2012, staff finalized the cleaning of the 2010 Long Term Care Survey data which included year by year comparisons, trend analysis and verification by the providers. The data was used for several purposes, including the 2010 public use data which was made available on the Commission website in May 2012, to update the Consumer Guide, to create the Nursing Home Occupancy report, and to update the State Health Plan.

The 2011 Long Term Care Survey data collection period began on March 26, 2012 and ended on May 24, 2012. A total of 718 facilities participated in the survey collection, including Comprehensive Care Facilities (234), Chronic Care Facilities (8), Assisted Living Facilities (356), and Adult Day Care Centers (120). Throughout the survey collection period, 30-Day, 15-Day, 7-Day, and final courtesy warning reminders, referencing the ability to issue penalties for noncompliance, were sent to facilities who had not submitted their surveys by the date of each reminder. At the end of the collection period only 64% of the facilities had submitted their surveys and 22% were in progress working on their surveys. The Commission issued a grace period, an extension of the due date to June 8, 2012, with a notice that included a reminder of fines to be imposed. On June 11, 2012, staff reported that 98% of the facilities had submitted their surveys. On June 12, 2012, The Commission issued fines retroactive to the due date of

May 24, 2012 and payable to the Commission, to the 2% of the facilities that had not submitted their completed surveys by the extended due date. The facilities were notified of their rights to file an appeal of the assessment within 10 business days of receipt of the notice. As of June 25th 2012, the Commission had a 100% submission rate.

Home Health Agency Survey

Phase I of the FY 2011 Home Health Agency Survey was available for data entry as of October 11, 2011 with a due date of January 10, 2012. Phase I agencies are those with a fiscal year end date on or before June 30, 2011. Reminder notices were sent out during the survey collection period. During Phase I, 21 agencies completed the survey with a 100% submission rate. Staff provided technical assistance as well as user support on survey content during the survey collection period.

Phase II Home Health Agency Survey was available for data entry on March 1, 2012 with a due date of May 29, 2012. Phase II agencies are those with a fiscal year end date of December 31, 2011. Reminder notices were sent out during the survey collection period. During Phase II, 40 home health agencies completed the survey with 100 % submission rate. Staff provided technical assistance to home health agency staff by telephone and emails throughout the data collection period.

MARYLAND HEALTH CARE COMMISSION

The Center for Hospital Services

Hospital Services Policy & Planning

Overview

This division of the Center for Hospital Services 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

Surgical Services

Development of a comprehensive revision of COMAR 10.24.11, the Ambulatory Surgical Services Chapter of the State Health Plan, was largely completed in FY 2012. 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.[1]

A proposed repeal and replacement of this chapter was approved by the Commission in May, 2012. (This replacement was adopted as final regulations, with two non-substantive amendments, after the close of the fiscal year, in October, 2012.)

Acute Rehabilitation Hospital Services

Development of a comprehensive revision of COMAR 10.24.09, the Acute Inpatient Rehabilitation Services Chapter of the SHP was initiated in FY 2011 and work progressed in FY 2012. A series of small Work Group meetings was convened by Hospital Services Policy &

[1] This chapter does not address the specialized surgical services performed on the heart (COMAR 10.24.05) or organ transplantation surgery (COMAR 10.24.13)

Planning ("HSPP") staff to discuss proposed amendments. Publication of proposed amendments for informal review and comment is anticipated in the Fall of 2012. This work is aimed at providing a richer set of standards for the Commission's consideration of establishment, replacement, or reconfiguration of acute rehabilitation hospital facilities and capacity, in addition to routinely updating the standards to reflect the current characteristics of acute rehabilitation providers operating in Maryland. Currently, this plan drastically limits docketing of most projects falling within the ambit of this regulation.

Other

Throughout FY 2012, key Hospital Services Policy and Planning staff participated with Center for Long-Term and Community-Based Care staff and Work Groups to provide input on SHP policies and plans for general hospice services and home health agency services.

Annual Acute General Hospital Bed Licensure and Inventory Survey

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, collects information on the inventory of emergency department treatment spaces, obstetric and perinatal service facilities, surgical facilities, psychiatric facilities, and special hospital facilities and services. In August 2011, an interim report summarizing the new acute care hospital bed licensure information for FY 2011 was published on the Commission's web site. On October 3, 2011, the full *Annual Report on Selected Maryland Acute Care and Special Hospital Services, FY 2012*, was published on the Commission's website. For the second consecutive year, the licensed bed inventory for the state declined, reflecting corresponding declines in acute care hospital census. Since FY 2010, the licensed acute bed inventory statewide has dropped from 10,880 to 10,583 beds.

Ambulatory Surgery Provider Directory

The fourteenth edition of the Commission's *Maryland Ambulatory Surgery Provider Directory* was posted on the Commission's website in December, 2011. The Directory provides CY 2010 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 and surgical facilities. 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.

In April, 2012, the HSPP staff distributed the 2011 survey to 346 potential survey respondents; 346 responses were received and, of these, 331 facilities were reported to be operational during all or a portion of the survey period.[2] Fourteen facilities closed during the reporting period and one facility that had received a determination of coverage for establishment was never developed. It is projected that nine new facilities will open in 2012.

Policy Coordination with Other Agencies and Stakeholders

Health Services Cost Review Commission

Throughout FY 2012, HSPP staff has participated in the Health Services Cost Review Commission's Capital Work Group.

Office of Health Care Quality/Department of Health and Mental Hygiene

In September, 2011, HSPP staff and staff from the Center for Long-Term Care Services met with staff of the Office of Health Care Quality (OHCQ) of the Department of Health and Mental Hygiene to review planning and regulatory issues related to the emergence of residential homes by general hospice programs, which are unlicensed venues for housing terminally ill hospice clients. Problems associated with the operation of these venues were discussed and options for addressing these problems were reviewed. OHCQ has proceeded with development of "hospice house" licensure standards. In March, 2012, HSPP staff and other MHCC staff met with representatives of the Talbot Hospice Foundation and State Delegate Eckardt to discuss CON regulation of hospice inpatient facilities and the interface of CON regulation and proposed licensure rules for residential "hospice houses" and met separately with OHCQ to discuss related development issues with respect to proposed licensure rules for these facilities.

In February 2012, HSPP staff participated in a conference call with the OHCQ staff concerning the status of health care facility licenses that have not been used by their holders to provide licensed services and regulatory changes needed to address this issue. The conference was prompted by a request made to MHCC on this matter by a hospital.

Hospital Industry

In December, 2011, HSPP staff and other MHCC staff met with the Maryland Hospital Association's Legislative and Regulatory Council to discuss MHCC's work on developing a report to the General Assembly on regulatory oversight of PCI at Maryland hospitals.

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[2] Only 328 respondents reported case volume during the reporting period.

In February, 2012, the Chief for Hospital Services Policy and Planning/CON made a presentation at the Health Care Financial Management Association-Maryland Chapter Seminar on Capital Planning. The presentation focused on the current status of CON regulation, changes underway, and the future of hospital CON regulation under health care insurance reform.

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 at http://mhcc.maryland.gov/consumerinfo/hospitalguide/index.htm enables Marylanders to review information on various hospital facility characteristics and performance measures. Hospital characteristics include the location of the hospital, number of beds, services provided and accreditation status. Fifty high volume common medical conditions (All Patient Refined Diagnosis-Related Groups or APR-DRGs) are also featured. Marylanders are able to compare the volume and average length-of-stay by APR-DRG for each hospital. 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-nine process of care 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 Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN), Childhood Asthma Care (CAC) and surgical patients (SCIP), including the prevention of surgical site infections.

Patients' perspectives on the care provided by hospitals is an important and valuable indicator of hospital quality and performance. The Commission utilizes the results of a national, standardized survey of hospital patients to obtain and report on measures of hospital performance. The data from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) includes 10 measures for four hospital service categories (maternity services, medical services, surgical services, and all services combined) reflecting key topics, including: communications with doctors and nurses, responsiveness of hospital staff, pain management, communication about medicine, discharge information, cleanliness of the hospital environment, and quietness of the hospital environment. In addition, the Guide includes data on how patients rate the hospital (10 for best, 0 for worst) and whether patients would recommend the hospital to friends and family.

The Guide also includes information on healthcare associated infections (HAIs) in Maryland hospitals. HAIs are infections that patients acquire during the course of receiving medical treatment for other conditions and represent the most common complication affecting hospitalized patients.

Accomplishments

Hospital Performance Evaluation Guide (HPEG) 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 (HPEG) Advisory Committee meets on a quarterly basis and has provided expert advice to the Commission on performance measures and quality improvement strategies since inception of the Guide. This multi-disciplinary committee includes members representing health care consumers, hospitals, nursing, medical research, and organizations involved in quality and patient safety initiatives. In FY 2012, the HPEG Committee endorsed the addition of new measures for assessing hospital emergency department efficiency as well as measures to determine the percentage of patients who are provided access to appropriate immunization services for pneumonia and influenza. These measures will be publicly reported in the Hospital Guide in 2013. In addition, work is underway to collect hospital performance data on the treatment of stroke patients and patients hospitalized for Venous Thromboembolism (VTE). Data collection for VTE and Stroke will begin in January 2013. Public reporting of the performance data will begin in 2014.

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. 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.dhmh.maryland.gov/hai/Pages/healthcare_associated_infections/default.aspx.

Healthcare Associated Infections (HAI) Advisory Committee

The HAI Technical Advisory Committee (TAC) 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, a permanent 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 original TAC recommendations. Seven of the eight TAC recommendations for publicly reporting HAI data have been achieved. The 2008 Report and Recommendations for Developing a System for Collecting and Publicly Reporting Data on HAI in Maryland is available on the Commission's website: http://mhcc.dhmh.maryland.gov/hai/Pages/healthcare_associated_infections/default.aspx

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 FY 2009, 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 as well as providing a vehicle for review of facility performance data prior to public release. The Commission utilizes 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. In FY 2012, the clinical data submitted through the Maryland QMDC was audited to ensure the integrity of the measures used to evaluate hospital performance. Quarterly on-site reviews of hospital medical records were conducted. The data validation process is intended to enhance the MHCC's understanding of the overall quality of the data as well as to identify areas for targeted performance improvement and educational activities.

Healthcare-Associated Infections

A major focus during FY 2012 continues to be 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 Methicillin-resistant Staphylococcus Aureus (MRSA) in All ICUs. The Committee also recommended that the second phase of the HAI public reporting system include Surgical Sight

Infections (SSI) data. The Committee further recommended use of the National Healthcare Safety Network (NHSN) as the vehicle for collecting these data where feasible.

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 Neonatal ICUs. In FY 2010, the Commission expanded its hospital data reporting requirements to include surgical site infection (SSI) data collection through the NHSN surveillance system for Hip, Knee, and coronary artery bypass surgery (CABG).

HAI 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 FY 2010 and the results were used to educate hospital data providers and to facilitate process improvement activities. In FY 2011, the Commission initiated the procurement process to establish a five year contract for ongoing validation of the accuracy of all healthcare associated infections data collected for public reporting on the Hospital Guide. The contract includes the provision of educational webinars and training for hospital infection prevention staff to facilitate accurate and complete data reporting.

HAI Data Public Reporting

Effective January 1, 2009, Maryland hospitals were required to collect and report quarterly data on Active Surveillance Testing (AST) for Methicillin-resistant Staphylococcus Aureus (MRSA) in Intensive Care Units (ICUs), including all units defined as inpatient adult critical care and pediatric critical care (neonatal intensive care units are excluded from this reporting requirement). Hospitals are reporting data on the total number of ICU admissions and the number of patients admitted to the ICU who had an anterior nares swab cultured for detection of MRSA.

The Centers for Disease Control and Prevention have long recommended annual influenza vaccinations for all health care workers (HCWs). The National Quality Forum includes influenza vaccination of health care workers as one of its 34 safe practices that should be utilized universally to reduce risk to patients. All Maryland hospitals are currently collecting a uniform data set on HCW influenza vaccination rates. Using an online survey instrument, hospitals collected aggregate data on all paid, full-time and part-time employees and house staff (defined as residents and interns) who received FluMist® or an injectable flu vaccine on-site or off-site between September 1, 2011 and April 15, 2012. Data on hospital HCW influenza vaccination rates for the 2011-2012 reporting period were on the Hospital Guide in July 2012.

In October 2010, the Commission first reported on CLABSIs for the 12-month period from July 1, 2009 through June 30, 2010. During that data period, Maryland acute care hospitals reported 424 CLABSIs in adult ICUs and 48 CLABSIs in Neonatal ICUs (NICUs). In April 2012, the CLABSI data was updated with calendar year 2011 data. The updated data showed a 43% reduction in CLABSIs in Maryland ICUs, with 224 CLABSIs in adult ICUs and 43 CLABSIs in NICUs. Based on a performance measure (the Standardized Infection Ratio or SIR) developed by the CDC, Maryland hospitals in total performed better than the national experience for CLABSIs in ICUs.

The surgical site infections data for Hip, Knee, and CABG procedures is scheduled for public release on the Guide in October 2012.

Cardiovascular Data Collection Initiative

In order to assure high quality and timely data on specialized cardiac care (i.e., Percutaneous Coronary Intervention (PCI) or angioplasty) the Commission adopted two uniform data sets to be submitted by all hospitals that provide PCI services. Effective July 1, 2010, all hospitals that provide PCI services must participate in the following two data registries developed and maintained by the American College of Cardiology Foundation:

National Cardiovascular Data Registry (NCDR) ACTION Registry-GWTG

This tool is used by all Maryland hospitals that provide primary angioplasty and seek designation by the Maryland Institute for Emergency Medical Services Systems (MIEMMS) as a Cardiac Interventional Center.

National Cardiovascular Data Registry (NCDR) Cath/PCI Data Registry

This tool is used by all Maryland hospitals that provide primary and/or non-primary angioplasty and measures outcomes of patients undergoing diagnostic catheterization and PCIs.

The Commission established the Maryland Cardiac Data Advisory Committee (CDAC) to support the establishment of process and risk-adjusted outcome measures for publicly reporting PCI and other specialized cardiac services on the Hospital Guide. In addition, the CDAC will work with the Commission to facilitate quality improvement initiatives for Maryland cardiac patients. The Committee met several times during FY 2012 to hear presentations from other states regarding implementation of their public reporting initiatives. The Commission staff continues to work closely with the CDAC, the Maryland Institute for Emergency Medical Services System and hospital cardiac data coordinators to develop an effective performance evaluation system for hospital cardiac services.

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 (PCI), organ transplant, neonatal intensive care, 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 programs 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

Waiver program for Non-primary PCI

Under COMAR 10.24.05, the Commission established a process to award time-limited research waivers that permit eligible hospitals to provide non-primary PCI services as part of a research project conducted by the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) for: Anne Arundel Medical Center, Saint Agnes Hospital, Shady Grove Adventist Hospital, Southern Maryland Hospital Center, Frederick Memorial Hospital, Meritus Medical Center (formerly Washington County Hospital), Baltimore Washington Medical Center, Holy Cross Hospital, and Johns Hopkins Bayview Medical Center. The C-PORT Elective Angioplasty Study, known as C-PORT E, tested the hypothesis that, for certain patient groups, outcomes of non-primary PCI performed at hospitals without on-site cardiac surgery are not inferior to outcomes of non-primary PCI performed at hospitals with cardiac surgery services. C-PORT E ended active enrollment on March 31, 2011, and the Commission amended COMAR 10.24.05 to extend the term of existing research waivers at hospitals maintaining good standing under the Commission's requirements, while the hospitals participated in a follow-on C-PORT E Registry. This Registry is maintained by the C-PORT E Study Principal Investigator, overseen by the Johns Hopkins Institutional Review Board (IRB), and overseen by a Data and Safety Monitoring Board.

In 2011, the eight research non-primary PCI research waiver hospitals applied to the Commission for continuation of their npPCI research waivers through participation in the Follow-On C-PORT E Registry. On November 17, 2011, the Commission approved these applications to continue providing npPCI through the Registry.

Waiver program for Primary PCI

Thirteen hospitals have a current waiver from the Commission allowing them to provide primary PCI services without having on-site cardiac surgical backup: 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, Meritus Medical Center (formerly Washington County Hospital), Saint Agnes Hospital, Shady Grove Adventist Hospital, Southern Maryland Hospital Center, and Upper Chesapeake Medical Center.

On September 15, 2011, the Commission approved the renewal of Carroll Hospital Center's two year waiver to provide primary percutaneous coronary intervention (PCI) services without on-site cardiac surgery services. On December 15, 2011, the Commission approved the renewals of two-year waivers to provide pPCI services without on-site cardiac surgery for the following hospitals: Holy Cross Hospital; Howard County General Hospital; Johns Hopkins Bayview Medical Center; and Saint Agnes Hospital.

Amendments to COMAR 10.24.17

In November 2011, the Commission adopted amendments to the State Health Plan Chapter for Cardiac Surgery and Percutaneous Coronary Intervention (PCI) Services (COMAR 10.24.17.) These regulatory changes, which became final in March 2012, apply to interventional cardiologists who perform PCI at waiver hospitals, and provide a process by which an interventional cardiologist who has not performed the required number of PCI cases during a twelve-month period that includes a brief leave of absence from clinical practice, may resume performing PCI services.

Implementation of HB 1182

The division took responsibility for implementing House Bill 1182, *Certificates of Need – Percutaneous Coronary Interventions Services*, which took effect on July 1, 2011. From July 1, 2011, to June 30, 2012, the law prohibited a hospital from establishing a non-primary PCI program or providing non-primary PCI services unless the hospital had been operating a PCI program on January 1, 2011, through either a Certificate of Need for a cardiac surgery program, or through a non-primary waiver in good standing, issued by the Maryland Health Care Commission. The law also required that MHCC develop recommendations for statutory changes needed to provide appropriate oversight of PCI. The division convened and staffed the Technical Advisory Group on Oversight of Percutaneous Coronary Intervention (PCI) Services, which was charged with advising and assisting the Commission in making recommendations on possible statutory changes related to PCI oversight. In a series of four public meetings held in July, September, October, and November of 2011, the TAG discussed current statutory authority regarding PCI services, identified limitations in PCI oversight, and received input regarding external peer review of PCI cases. The TAG considered how oversight of PCI provided at cardiac surgery hospitals could be aligned with oversight of PCI services at hospitals without on-site cardiac surgery, how PCI data-sharing could be strengthened across State agencies, and how quality initiatives could be enhanced through the use of existing PCI data. A summary report of the TAG's activities and consensus recommendations was presented to the Commission at the public meeting on December 15, 2011. Therein the TAG recommended that:

1) PCI be added to the section of the Commission's statute that identifies the establishment of cardiac surgery services as requiring a Certificate of Need;
2) Oversight of PCI by MHCC be aligned across all hospitals, including those with cardiac surgery on-site, requiring all programs to meet a set of minimum standards;
3) Oversight and quality measurement utilize available clinical data, including that collected through the American College of Cardiology Foundation

National Cardiovascular Data Registry (NCDR) programs, now required in Maryland hospitals[3]; and

4) MHCC be added to the list of State agencies in legislation regarding the sharing of information for the purpose of investigating quality or utilization of care in regulated facilities.

Public comment regarding the TAG's report was invited, and thirteen entities submitted written comments. The division prepared a report including statutory recommendations, the Report of the Maryland Health Care Commission on Regulatory Oversight of Percutaneous Coronary Intervention in Maryland. The MHCC approved this report on December 22, 2011, and on December 28, 2011, submitted it to the Governor and General Assembly. It included the following recommendations:

1) Percutaneous coronary intervention should be identified as a service regulated by MHCC and, when provided in hospitals without cardiac surgical backup, requiring an exemption from Certificate of Need.
2) MHCC should be given statutory authority to oversee PCI and cardiac surgery, including existing cardiac surgery hospitals, on an ongoing basis after issuance of a CON or an exemption from CON. This ongoing regulatory authority will require that PCI and cardiac surgery programs meet minimum performance standards as a condition of continuing to provide PCI and cardiac surgery services.
3) MHCC should be identified in Health-General §§19-218 and 14-411 as a State agency that can receive and share information for the purpose of investigating quality or utilization of care in regulated facilities.

Implementation of HB 1141

During the 2012 legislative session the General Assembly passed HB 1141 (Maryland Health Care Commission – Cardiac Surgery and PCI Services) which addresses problems identified in the 2011 report of the Technical Advisory Group on Oversight of PCI, and directs the Maryland Health Care Commission to revise the State Health Plan chapter that provides regulatory oversight of *both* cardiac surgery and percutaneous coronary intervention (PCI). The law, which became effective July 1, 2012, establishes a new regulatory framework for the oversight of percutaneous coronary intervention (PCI) services and cardiac surgery. The new regulatory framework replaces the current waiver process for establishing and maintaining PCI services in hospitals without cardiac surgery programs, and establishes a process for on-going quality assurance in PCI and cardiac surgery as an integral part of the regulatory process for establishing and maintaining these programs. The division is responsible for implementing HB 1141, including convening a clinical advisory group (CAG) of both in-state and out-of-state

[3] The ACTION Registry includes data on acute coronary syndrome patients, both STEMI and non-ST-elevation myocardial infarction (NSTEMI) patients. The CathPCI Registry includes data on diagnostic cardiac catheterizations and PCI.

experts to provide guidance to the Commission on appropriate standards for PCI and cardiac surgery. The CAG is charged with providing expertise and recommendations on standards for emergency (also known as primary) PCI and elective (also known as non-primary) PCI and cardiac surgery services. The standards will reflect changes in the scientific consensus regarding PCI at non-surgical hospitals and will also take into account current findings regarding quality of care in cardiac surgery and related services. Per the statute, the CAG must be composed of experts in cardiac surgery services and PCI services, from both inside and outside of Maryland, and include representatives of hospitals that provide cardiac surgery and PCI, those that provide PCI without on-site cardiac surgery, and those that may wish to provide cardiac services in the future.

The division has begun development of the CAG through a nomination process involving key clinical professional and hospital organizations. Twenty-seven experts were nominated by Maryland's acute care hospitals, the American College of Cardiology, the Society for Cardiovascular Angiography and Interventions, the Society of Thoracic Surgeons, the American Heart Association, MedChi - the Maryland Medical Society, the Maryland Institute for Emergency Medical Services Systems and the Department of Health and Mental Hygiene. Division staff has scheduled six public meetings to take place between July 2012 and June 2013.

From September, 2012 through spring, 2013, the staff will facilitate the work of the CAG in developing recommendations on appropriate standards. In December 2012, the Commission will review the eight elective (non-primary) PCI follow-on registry programs for continuing compliance with research waiver/registry requirements and determine whether each program should continue to have authority to provide PCI. Over the summer of 2013, staff will use the work of the CAG to develop a new draft State Health Plan chapter for regulatory oversight of PCI and cardiac surgery, and then will post and report recommendations to the Governor, the Senate Finance Committee and House Health and Government Operations Committee for a 60-day review and comment period. Lastly, in December, 2013, the Commission will report final recommendations and initiate promulgation of final State Health Plan regulations.

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. These are need, viability, impact, the cost and effectiveness of alternatives to the proposed project, and the applicant's track record in complying with conditions and terms of CON approvals placed on project approvals previously issued to the applicant.

Accomplishments

Certificate of Need Applications and Modifications

During FY 2012, the Commission approved thirteen (13) CON applications. One of these involved the reissuance of an approval issued in FY 2011, on remand from the Circuit Court of Baltimore. No applications were denied. It also reviewed and approved one (1) modification to a previously approved project. No issued Certificates of Need were relinquished by the holders. No CON applications in review were withdrawn by applicants before Commission action.

The level of project review activity in FY 2012 increased from the previous year, in which only seven CON decisions were issued. In general, the number of regulated institutional health care facility capital projects proposed by health care facilities regulated under the CON program has declined in the last four years compared to the previous four year period, which saw a heightened level of activity for major hospital projects.[4] An average of only five hospital project reviews per year were completed during FY 2009 through FY 2012 (contrasted with an overall annual average of 20 total project reviews during this recent period) and the majority of CON reviews during this period have been non-hospital projects. By contrast, from FY 2005 to FY 2007, the majority of project reviews were hospital projects, with an average of 12 hospital project decisions per year, and hospital projects with aggregate costs in excess of $1 billion were authorized in each of those years.

The work level in CON was high in 2011 and 2012, relative to project volume, because four large and contentious hospital project reviews were completed or largely completed during these years. One of these projects was remanded on judicial appeal for further review by MHCC and this reconsideration was completed in FY 2012.

Only one change to an approved capital project was reviewed and approved in 2012, a design change and cost increase for a new nursing home project.

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[4] Forty-six (46) "non-institutional home health agency projects were reviewed between FY 2008 and 2010, as part of three competitive review cycles established through a 2007 State Health Plan update.

There was one hospital "pledge" project reviewed by MHCC and Health Services Cost Review Commission (HSCRC) staff in FY 2012, with an estimated cost of $25.1 million. These are hospital projects with estimated costs that exceeded the capital spending threshold defining reviewability that did not otherwise include elements categorically requiring CON review. Such projects avoid the need for CON review and approval by the Commission by "pledging" not to seek substantive rate adjustments related to the project's depreciation and interest expenses. These projects are issued determinations of coverage after demonstrating to MHCC that they do not include categorically regulated elements and to HSCRC that they are financially feasible. The current hospital capital expenditure threshold, established in April, 2012, is $11.35 million. These two pledge projects involved projects with a combined estimated cost of $80.9 million.

Approved CONs

Amedisys Maryland, LLC d/b/a Home Health Corporation of America, an Amedisys Company (Talbot County)
Provide home health agency (HHA) services in Talbot County through expansion of an existing home health agency
Approved with conditions - $27,350

Community Care Nursing Services (Baltimore, Harford, Howard, Montgomery, and Prince George's Counties and Baltimore City)
Establish a specialty HHA (pediatric patients only)
Approved - $3,650

Knollwood Manor (Anne Arundel County)
Relocation of a comprehensive care facility (CCF) from Millersville to Gambrills. Replacement CCF will have 110 beds.
Approved with condition - $20,403,760

Johns Hopkins Hospital (Baltimore City)
Addition of an operating room
Approved - $1,430,037

National Lutheran Home and Village of Rockville (Montgomery County)
New construction and renovation on an existing retirement community/CCF campus reducing CCF bed capacity (from 300 to 160 beds) and creating assisted living beds
Approved with condition - $22,914,700

Johns Hopkins Bayview Medical Center (Baltimore City)
Building addition to expand the emergency department
Approved - $40,098,889

Johns Hopkins Bayview Medical Center (Baltimore City)
Building addition to create a comprehensive cancer center
Approved - $26,057,437

Genesis Bayview Joint Venture (Baltimore City)
Establish a 132-bed CCF on the campus of Johns Hopkins Bayview Medical Center (relocating existing bed capacity of the hospital)
Approved with condition - $26,150,769

Magnolia Gardens (Prince George's County)
Relocation of a CCF in Lanham. Replacement CCF will have 130 beds.
Approved with condition - $20,743,511

Mid-Atlantic of Waldorf (Charles County)
Establishment of a 67-bed CCF in Waldorf
Approved with conditions - $26,062,330

Frederick Memorial Hospital (Frederick County)
Addition of ten (10) general medical/surgical beds through renovation of existing space
Approved - $2,348,587

Holy Cross Hospital of Silver Spring (Montgomery County)
Establishment of a new general hospital (93 beds) in Germantown – reissuance of a CON originally issued in January, 2011 on remand from the Circuit Court
Approved with conditions - $201,983,857

Carroll Hospital Center (Carroll County)
Building addition to create a comprehensive cancer center
Approved with conditions- $27,975,000

Changes in Approved CONs

Lorien LifeCenter Harford (Harford County)
Establishment of a new CCF
Design changes and increase in estimated cost ($169,895)
Approved with conditions: $9,485,458

Determinations of Coverage and Other Actions
In FY 2012, the Commission issued 190 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 outpatient surgical centers with fewer than two sterile operating rooms, 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.

Determinations of Coverage and Other Actions – FY 2012

NATURE OF DETERMINATION/ACTION	NO.
Capital projects with costs above the threshold of reviewability (hospital "pledge" projects)	1
Capital projects with costs below the threshold of reviewability	14
Acquisitions of health care facilities Comprehensive care facility (nursing home): 59 Ambulatory surgery center: 20 Hospitals: 1	80
Establishment of new ambulatory surgery center (no more than one sterile operating room) Baltimore County (3); Montgomery (3); Howard (2); Prince George's (2); Anne Arundel (1); Frederick (1); Carroll (1); Charles (1); and St. Mary's (1)	15
Changes in ambulatory surgery center facilities or operation (e.g., addition of non-sterile procedure rooms, surgical staff, surgical specialties, ownership structure)	7
Relocation of ambulatory surgery center	2
Voidance of determination of coverage to establish a new ambulatory surgery center	1
Temporary delicensure of CCF beds (477 total beds)	29
Temporary delicensure of special hospital-chronic beds (88 total beds)	1
Temporary delicensure of special hospital-acute rehabilitation beds (33 total beds)	1
Relicensure of temporarily delicensed CCF beds (239 total beds)	19
Add "waiver" beds* Comprehensive care facility: (45 total beds)	6
"Exceptional" CCF beds for continuing care retirement communities (20 total beds)**	1
Miscellaneous	13
TOTAL COVERAGE DETERMINATIONS	190
Pre-licensure and/or first use approval for completed CON projects (including partial)	11
Permanent delicensure of beds Comprehensive care facility: 14 for a total of 88 beds	14

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

**Continuing care retirement communities can be authorized to develop limited numbers of CCF beds without obtaining CON approval. Admission of patients to such beds who are not residents of the CCRC is restricted.

Additionally, the Commission reviewed 11 requests by holders of CONs to implement their projects or parts of their approved projects ("first use review"). Finally, the Commission acknowledged 14 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 2012, all these permanently delicensed beds (88) were CCF beds.

MARYLAND HEALTH CARE COMMISSION

The Center for Health Information Technology

The Center for Health Information Technology

Overview

The Center for Health Information Technology (Center) is responsible for the Maryland Health Care Commission's health information technology (health IT) initiatives that advance health IT statewide. Health IT facilitates the collection and exchange of health information, which can bring vital clinical information to the point-of-care and help to improve public health and the safety and quality of health care while decreasing overall health care costs. Leading elements of health IT include the implementation of a health information exchange (HIE), the adoption of electronic health records (EHRs), and expanding telemedicine.

The Center has an ambitious plan for advancing health IT that balances the need for information sharing with the need for strong privacy and security policies. The Center is tasked with:

- Planning and implementing a statewide HIE;
- Identifying challenges to health IT adoption and use, and formulating solutions and best practices for increasing the adoption and interoperability of health IT;
- Increasing the availability and use of standards-based health IT through consultative, educational, and outreach activities;
- Promoting and facilitating the adoption and optimal use of health IT for the purposes of improving the quality and safety of health care;
- Harmonizing service area HIE efforts throughout the State;
- Certifying electronic health networks that accept electronic health care transactions originating in Maryland;
- Developing programs to promote electronic data interchange between payers and providers; and
- Designating management service organizations (MSOs) to promote the adoption and advanced use of EHRs.

Health Information Technology Division

The Health Information Technology Division (Health IT Division) is responsible for advancing the adoption and use of health IT in Maryland. The Health IT Division works closely with stakeholders to increase EHR adoption and to advance the use of technology. The Health IT

Division routinely provides technical support and resources to stakeholders as they select and adopt technology. Additionally, the Health IT Division oversees designation of management service organizations (MSOs); promotes the adoption of electronic data interchange (EDI); certifies electronic health networks (EHNs); manages the Center's telemedicine initiatives; and directs the Center's consumer health IT agenda.

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 works with stakeholders to develop privacy and security policies for safeguarding electronic health information to ensure that it is delivered to authorized individuals for treatment and appropriate secondary uses. The HIE Division promotes the collection and exchange of health information for quality improvement and public health initiatives.

Accomplishments

Centers for Medicare & Medicaid Services – Electronic Health Record Demonstration

The MHCC partnered with the Centers for Medicare & Medicaid Services (CMS) to administer the EHR Demonstration Project (project). The five-year project aimed to encourage small to medium sized primary care physician practices to use EHRs. Eligible primary care practices were able to earn up to $290,000 over a five-year period for adopting EHRs and reporting to CMS on select quality measures. The project was designed to evaluate the impact of EHRs on medical errors and quality of care. The project completed its second full year on May 31, 2011, and then was scheduled to enter a new phase with the collection of clinical quality measure data.

Prior to this new phase, CMS decided it was an appropriate time to review the progress of the demonstration project and determine whether it was on track to measure the effect of a financial incentive on the adoption and use of EHRs. According to CMS, there was a significant decrease in the number of practices participating in the treatment group. For the most part, this decrease is a result of practices from other states that decided to no longer participate in the demonstration project; Maryland had roughly 11 practices that exited the project. CMS was concerned that findings from the study could be negatively impacted if the treatment group were to continue to decline. CMS made the decision to terminate the project effective August 1, 2011. Participating practices received a small incentive for completing a final survey.

Electronic Data Interchange & Electronic Health Networks

COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks,* requires State-regulated payers (payers) with annual premiums of $1 million or more and certain specialty payers to submit census level information regarding electronic administrative transactions. The MHCC uses payer electronic data interchange (EDI) information to measure the progress of EDI in the State. Approximately 51 payers submitted a progress report, including: 33 medical payers, nine specialty payers, seven MCOs, and Medicare and Medicaid. The progress reports contain census level information on administrative health care

transactions for roughly eight transaction types identified under the *Health Insurance Portability and Accountability Act of 1996, Administrative Simplification Provisions*, or HIPAA. The findings are used by health care associations in developing strategies for expanding the use of technology in Maryland.

Electronic health networks (networks) operating in Maryland are required to be certified as defined in COMAR 10.25.07 – *Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouses.* Payers that accept electronic health care transactions originating in Maryland must accept transactions from MHCC certified networks. EHNs that obtain accreditation from a nationally qualified organization receive MHCC certification for a two year period. As of June 30, 2012, about 40 networks are MHCC certified.

EHR Product Portfolio

Staff developed the EHR Product Portfolio (portfolio) in 2008 as a resource for health care providers in evaluating EHR systems. Updates to the portfolio are made twice yearly. The portfolio is a free tool that serves as a central source of comparative information from a variety of EHR vendors. Each vendor participating in the portfolio has provided information regarding their EHR system and functionality; line item pricing and pricing projections; privacy and security policies; and references that describe user satisfaction. All vendors included in the portfolio offer products that are nationally certified and are required to offer a discount to Maryland providers. EHR vendors that offer products for specialty practices were added to the spring 2012 release. Information regarding Direct messaging services currently offered by certain vendors was also included this year. Direct messaging is a method of sending a patient's protected health information electronically across a secure network to a known trusted recipient. Vendors were asked to identify if their product will offer Direct Messaging and when they plan to implement this technology. Updates were made to the portfolio in the fall and the spring during the 2012 fiscal year. Approximately 65 nationally certified vendors participated in the spring 2012 release of the portfolio, an increase of nearly 20 EHR vendors from the fall update.

Hospital HIT Survey

Staff administered the fourth annual *Hospital Health Information Technology Survey* (survey) to evaluate health IT adoption trends among Maryland's 46 acute care hospitals as compared to national hospitals. The survey is aimed at assessing the planning, adoption and use of eight technologies, including: EHRs, electronic prescribing (e-prescribing), computerized physician order entry (CPOE), electronic medication administration records (eMARs), barcode medication administration (BCMA), infection surveillance software (ISS), connectivity to the statewide HIE, and telemedicine. New to the survey this year were questions regarding telemedicine adoption and planning efforts. The survey asked hospitals to report on the number of primary care units that had implemented each of the technologies to assess the extent of adoption within hospitals. Overall, Maryland hospital health IT adoption exceeds national hospital adoption rates. Maryland hospitals reported an increase in the adoption of six out of seven previously assessed technologies: EHRs, e-prescribing, CPOE, eMAR, BCMA, and HIE connectivity. Overall,

health IT adoption in Maryland hospitals has increased about 22 percent since the data collection began in 2008.

Freestanding Ambulatory Surgical Centers HIT Assessment

Staff implemented the third annual Freestanding Ambulatory Surgical Center Health Information Technology Survey (survey) to assess the health IT adoption and planning efforts among the 335 Freestanding Ambulatory Surgical Centers (Centers) in Maryland. Assessing the Centers' adoption of health IT is the key to understanding the progress Maryland is making in maximizing the advantages of technology in health care delivery. Centers were asked to report on whether or not they used technology, in general, to manage patient health information or to report their plans to implement certain technologies, including: CPOE; EHRs; eMARs; BCMA; ISS; e-prescribing; and electronic HIE with laboratories, diagnostic centers, and outpatient physicians. During this reporting period, approximately 42 percent of Centers reported using some form of technology to manage patient health information, an increase of about 5 percent from the previous year. About 83 percent of Centers reported adopting an EHR and about 54 percent reported e-prescribing.

Management Service Organizations

MSOs have emerged as a way to address the challenges associated with physician adoption of EHRs. These challenges include the cost and maintenance of the technology and ensuring the privacy and security of data stored electronically. Unlike the traditional EHR client-server model where the data and technology are hosted locally at the physician site, MSOs offer EHRs hosted in a centralized, secure data center. MSOs enable physicians to access a patient's record wherever access to the Internet exists. Remotely hosted EHRs generally relieve physicians from dedicating staff to support the application. MSOs offer services that assist physicians in areas of EHR planning, implementation, staff training, technical support, and becoming advanced EHR users. In general, MSOs are viewed by practices as a sensible choice for EHR adoption.

A new law enacted in 2009 required the MHCC to designate one or more MSOs to offer hosted EHR products.[1] The supporting regulations, COMAR 10.25.15 *Management Services Organizations – State Designation,* became effective in November 2010. At present, about 15 of the 18 MSOs have achieved national accreditation from the Electronic Health Network Accreditation Commission, or EHNAC. To achieve EHNAC accreditation, MSOs must meet more than 95 criteria that center on technical performance, privacy and security, business practices and services. MSOs have one year from the date they are granted Candidacy Status from the MHCC to achieve EHNAC accreditation and State designation.

State-Regulated Payer Electronic Health Record Incentives

Maryland law, enacted on May 2009, aims to expand the adoption of EHRs by requiring State-regulated payers to offer incentives to select health care providers who use certified EHRs. In October 2011, supporting regulation COMAR 10.25.16, *Electronic Health Record Incentives*, was

[1] Md. Code Ann., Health-Gen. § 19-143 (2009)

amended to comply with amendments made to the law in May of 2011. The amended regulation enables primary care practices to receive a cash incentive, or an agreed upon alternative incentive, for adopting an EHR and meeting additional certain program requirements. The State-regulated payer EHR adoption incentive program was launched in October 2011 and currently ends on January 1, 2015.

Telemedicine

The Telemedicine Task Force Report for the Maryland Health Cost and Quality Council (Council) was completed in November and was presented to the Council in December of 2011. In June 2010, the Council convened a Telemedicine Task Force (Task Force) to address challenges to widespread adoption of a comprehensive statewide telemedicine system of care. The Task Force submitted its final report to the Council in September 2010. In November of the same year, former Secretary of the Department of Health and Mental Hygiene John Colmers established a Leadership Committee of the Task Force and requested that the committee develop specific recommendations to advance telemedicine in Maryland. Former Secretary Colmers requested that the Leadership Committee present its recommendations by way of a report to the Council in December 2011. Three advisory groups were formed to develop recommendations: the Financial and Business Model Advisory Group, the Technology Solutions and Standards Advisory Group, and the Clinical Advisory Group.

After nearly six months of deliberation, the advisory groups finalized their recommendations. The MHCC led the Telemedicine Technology Solutions and Standards and the Financial and Business Model Advisory Groups. Recommendations to the Maryland Quality and Cost Council were sent to the Maryland General Assembly and resulted in Senate Bill 781, *Health Insurance – Coverage for Services Delivered through Telemedicine* (SB 781). SB 781, signed into law in May 2012, requires, among other things, certain insurers, nonprofit health service plans, and health maintenance organizations to provide coverage for health care services delivered through telemedicine. The MHCC plans to reconvene the Telemedicine Technology Solutions and Standards Advisory Group (advisory group) to discuss ways to advance the technology recommendations included in the report.

Health Information Exchange

Implementation activities of the statewide HIE continued. Current law requires the MHCC and the Health Services Cost Review Commission (HSCRC) to designate a multi-stakeholder group to implement the statewide HIE. The Commissions designated a non-profit organization, the Chesapeake Regional Information System for Our Patients (CRISP) to build the infrastructure to support a statewide HIE. This multi-stakeholder group consists of Johns Hopkins Medicine, MedStar Health, University of Maryland Medical System, Erickson Retirement Communities, and more than two dozen other stakeholder groups. The statewide HIE aims to support high quality, safe, and effective health care; make certain that data is exchanged privately and securely; ensure transparency and stakeholder inclusion; support connectivity regionally and nationally; achieve financial sustainability; and serve as the foundation for transforming health care in Maryland.

In August 2009, the Health Services Cost Review Commission (HSCRC) approved $10 million in funding through the all payer rate setting system to build the statewide HIE. The MHCC also received federal funding of approximately $9.3 million from the Office of the National Coordinator for Health Information Technology. As of December 2011, all 46 acute care hospitals in Maryland established connectivity with the statewide HIE, and began to submit patient demographic and encounter information. Providers may query the information being made available from hospitals using an online CRISP Portal; about 40 provider organizations were using the CRISP Portal as of June 2012, including hospitals, ambulatory practices, and long term care facilities.

Challenge Grant

Maryland is one of 10 states to be awarded about $1.6 million from the ONC as part of the *State Health Information Exchange Cooperation Agreement Program* to address challenges experienced by long-term care facilities regarding HIE and share innovative solutions nationwide. The goal of the project is to pilot the electronic exchange of clinical documents between pairs of long-term care facilities (LTC) and proximate hospital emergency departments. Eight LTC facilities and four hospitals throughout Maryland have committed to the project to integrate the LTC facilities with the HIE and to implement the statewide HIE program with over 50 LTC facilities.

As part of the work, the statewide HIE will develop a framework for storing and exchanging advance directives in Maryland and include advance directives as a component of the electronic summary of care record. The MHCC convened a focus group to propose recommendations around establishing a repository for signed Medical Orders for Life-Sustaining Treatment (MOLST) forms, and potentially creating an electronic version of the MOLST. In March 2012, staff released a *Strategy for Implementing Electronic Advance Directives & MOLST Forms,* to propose recommendations for addressing the technical and policy challenges related to electronic advance directives and MOLST forms. The focus group deliberated on the technical and policy challenges and proposed solutions to enabling electronic advance directives and MOLST forms. The focus group agreed that a phased approach to enable the broad exchange of electronic advance directives and MOLST forms would lead to widespread adoption and use of these documents.

HIE Policy Board

Staff facilitated the HIE Policy Board (Board) in developing draft policies for the private and secure exchange of health information through an HIE. The MHCC assembled a Board in 2009 to assist in providing guidance and input to staff regarding the development and operations of the statewide HIE. Members of the Board were selected based upon their expertise, consideration regarding the breadth of stakeholder representation, and strong consumer background. The following policies were recommended by the Board: *Audit for Access, Use and Disclosure*, *Secondary Data Use*, *Primary Data Use and Disclosure*, and *Consumer Access to Audit*. State law enacted in May 2011 requires the MHCC to adopt regulations for the privacy and security of protected health information exchanged through an HIE operating in the State.

Based on feedback obtained from the Board, the MHCC developed informal draft regulations, which were released for informal public comment in February 2012.

Regional Extension Center Program

MSOs that provide assistance to practices in Maryland and are interested in receiving subsidies from the Regional Extension Center (REC) under the federal incentive program must be State Designated. CRISP received approximately $6.8M in 2010 to establish Maryland's REC under the ONC grant, *Health Information Technology Extension Program: Regional Centers*. CRISP is responsible for all aspects of the REC program, which includes education, outreach and technical assistance to priority care providers to select, successfully implement, and meaningfully use EHRs to improve the quality and value of health care. The REC partners with MSOs as the mechanism for driving EHR adoption and meaningful use. The REC's use of MSOs as the framework for advancing EHR adoption is built around the notion that MSOs will compete for physician business. The competition is based on MSO offerings such as EHR functionality and various supporting services, which include data analysis, reporting, and practice workflow redesign. The REC is tasked with enrolling at least 1,000 priority care providers into the program and meeting certain performance milestones around EHR adoptions and meaningful use. The REC has exceeded the enrollment goal by nearly 800 physicians.

Consumer Engagement in Health IT

The adoption and use of health IT by consumers may empower patients to manage their health and health care by increasing their access to their health information. A system that puts the consumer at the center of health care delivery can improve the well-being of individuals. National consumer health IT awareness and education efforts have been slow to materialize. Many states are now beginning to explore opportunities to educate the public on health IT. Effective consumer awareness and education programs related to health IT are expected to bolster public trust and confidence, which are both critical to increasing EHR and HIE adoption among providers. In the fall of 2011, staff convened a series of consumer focus groups to assess consumer awareness and confidence in electronic health information. The focus groups (focus groups or participants) provided an opportunity to engage consumers, providers, and community based organizations (CBOs) in identifying leading challenges to increasing consumer awareness and education and proposing a practical long-range strategy to build confidence in electronic health information.

Key findings that emerged from the focus group discussions included: consumers prefer to control who has access to their electronic health information; CBOs are concerned about the risk of electronic health information being lost or stolen; and concerns regarding the lack of health IT awareness and education activities in the State. The focus group discussions provided the framework to formulate a strategy to advance consumer awareness and trust of electronic health information in the State. Establishing a Consumer Advisory Council is a practical approach to addressing challenges related to consumer awareness of health IT, increase consumer outreach and education, and develop a plan for consumers to access their electronic health information.

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

MARYLAND HEALTH CARE COMMISSION