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CHAIR

STATE OF MARYLAND

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

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January 12, 2016

The Honorable Larry Hogan
Governor
State of Maryland
Annapolis MD 21401-1991

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis MD 21401-1991

RE: Maryland Health Care Commission, Report to the Governor, FY 2015

Dear Governor Hogan, President Miller, and Speaker Busch:

The Maryland Health Care Commission is pleased to submit the *Report to the Governor, Fiscal Year 2015,* as required by Health General § 19-109(b)(4) that directs the Maryland Health Care Commission to report annually to the Governor, the Secretary of Health and Mental Hygiene, and the Maryland General Assembly.

Please do not hesitate to contact me at 410.764.3565, if you have any questions about the report or this transmittal letter.

Sincerely,

Ben Steffen
Executive Director

Enclosure

cc: The Honorable Thomas M. Middleton
The Honorable Peter A. Hammen
Van T. Mitchell, Secretary of Health and Mental Hygiene
Sarah Albert – DLS (5 Copies)

THE MARYLAND HEALTH CARE COMMISSION

REPORT to the GOVERNOR

Fiscal Year 2015

(July 1, 2014 through June 30, 2015)

Larry Hogan
Governor

Craig Tanio, M.D.
Chair

Ben Steffen
Executive Director

http://mhcc.maryland.gov/

This annual report on the operations and activities of the Maryland Health Care Commission for fiscal year 2015 meets the reporting requirement set forth in Health General § 19-109(b)(4) that directs the Maryland Health Care Commission to report annually to the Governor, the Secretary of Health and Mental Hygiene, and the Maryland General Assembly.

This report was written by Karen Rezabek and the chiefs of service for each of the Commission's programs and was completed by the Commission's Administrative Center under the direction Bridget Zombro, Director of Administration. For information on this report, please contact Karen Rezabek at 410-764-3259 or by email at karen.rezabek@maryland.gov.

MARYLAND HEALTH CARE COMMISSION

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MARYLAND
HEALTH CARE
COMMISSION

Our vision is that Maryland 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.

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MARYLAND HEALTH CARE COMMISSION

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Executive Director

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Director, Center for Information Services and Analysis

Theressa Lee
Director, Center for Quality Measurement and Reporting

Paul E. Parker
Director, Center for Health Care Facilities Planning and Development

David Sharp
Director, Center for Health Information Technology and Innovative Care Delivery

EXECUTIVE SUMMARY

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

During FY 2015, the Commission had an appropriation for 61.7 full time positions.

Many of the Commission's activities focus upon collaborative initiatives related to broadening Marylanders' access to high quality and cost effective health care services. Particular attention is given to areas such as access to health care, quality and patient safety, innovative health care delivery, health information technology, and information for policy development. These activities are directed and managed by the Commission's Executive Director. Administrative activities, such as staffing, budget, and procurement, are managed by the Director of Administration and her staff. The Commission's Assistant Attorneys General provide legal advice and counsel to the Executive Director, the Commission members, and Commission staff. The Commission's staff members' backgrounds and skills encompass a broad range of expertise, 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, utilizing a wide range of tools (data gathering, public reporting, planning and regulation) in order to improve quality, address costs, or increase access. Two of the centers — those for Health Care Facilities Planning and Development and for Quality Measurement and Reporting —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. 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. Our fourth center, Health Information and Innovative Care Delivery, 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 as well as managing the Commission's Patient Centered Medical Home program.

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

THE CENTER FOR HEALTH CARE FACILITIES PLANNING AND DEVELOPMENT

The Center develops plans for the supply and distribution of health care facilities and services and regulates the supply and distribution of facilities and services through Certificate of Need and related oversight programs.

- The Center is responsible for the development and updating of the State Health Plan, a body of regulation that establishes criteria and standards for considering the need, costs and effectiveness, impact, and viability of health care facility capital projects.
- The Center collects information on health care facility service capacity and use. Annual data sets on the service capacity of general and special hospitals, freestanding ambulatory surgical facilities, nursing homes, home health agencies, hospices, assisted living facilities, and adult day care facilities are developed. The Center also obtains hospital registry data bases on cardiac surgery, cardiac catheterization, and percutaneous coronary intervention for use in regulatory oversight of these services.
- The Center administers the Certificate of Need, Certificate of Conformance, and Certificate of On-going Performance programs that regulate certain aspects of health care service delivery by health care facilities.

THE CENTER FOR HEALTH INFORMATION AND INNOVATIVE CARE DELIVERY

Electronic health information exchange promises to bring vital clinical information to the point-of-care, helping to improve the safety and quality of health care while decreasing overall health care costs. Health information technology requires two crucial components to be effective – widespread use of electronic health records and electronic health information exchange. The Center for Health Information and Innovative Care Delivery is responsible for the Commission's health information technology and advanced primary care initiatives.

- The Center Plans and implements a statewide health information exchange.
- Identifies challenges to health information technology adoption and use, and formulates solutions and best practices for making health information technology work.
- Increases the availability and use of standards-based health information technology through consultative, educational, and outreach activities.
- Promotes and facilitates the adoption and optimal use of health information technology for the purposes of improving the quality and safety of health care.
- Harmonizes service area health information exchange efforts throughout the State.

- Certifies electronic health networks that accept electronic health care transactions originating in Maryland.
- Develops programs to promote electronic data interchange between payers and providers.
- Designates management service organizations to promote the adoption and advanced use of electronic health records.
- Manage the Commission's Patient Centered Medical Home Program.

THE CENTER FOR ANALYSIS AND INFORMATION SERVICES

This Center 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.

- The Center focuses on physician services, including physician reimbursement and reporting on cost and quality.
- The Center provides analytic and programming services to other divisions of the Commission and is responsible for the intranet and the Commission's web site.
- The Center works closely with the Health Services Cost Review Commission, publishing each hospital's charges for the most common Diagnosis related Groups (DRGs) as part of the Commission's Price Transparency Initiative.

THE CENTER FOR QUALITY MEASUREMENT AND REPORTING

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 plans to expand public reporting of angioplasty quality and outcomes beyond the current waiver hospitals to include all hospitals performing emergency angioplasty and is examining public reporting of risk-adjusted data on the quality and outcomes of cardiac surgery.

- The Center publishes the Long Term Care Guide for Marylanders, providing an easy way to locate and compare nursing homes on quality and outcomes measures. The Center has also pioneered the public reporting of resident and family satisfaction measures.
- The Center has responsibility for policies and information dissemination related to Maryland assisted living programs.
- The Center reports publicly on the performance of and satisfaction with health plans in the Health Benefit Quality Report Series.
- The Center is committed to reporting disparities in health and health care and is responsible for the Commission's Racial and Ethnic Disparities initiative.

BUDGET & FINANCES

In FY 2015, the Commission was appropriated $30,872,646, which includes an appropriation of $12 million for the Trauma Fund, $1.6 million for the Partnership program, $3 million for the Maryland Emergency Medical Systems Operations Fund, and $14,272,646 in Special Fund Appropriation for MHCC operations. During the course of the Fiscal Year a budget amendment was completed for $3,132,418 in Federal Fund Income for the CCIIO Grants and $3,870,751 in Special Fund Revenue for the CRISP Operating Grant, increasing the Commission's Appropriation to $37,875,815. The Commission is funded with special funds through user fees 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 28% of the total budget; 2) Hospitals for an amount not to exceed 33% of the total budget; 3) the Health Occupational Boards for an amount not to exceed 22% of the total budget; and 4) Nursing Homes for an amount not to exceed 17% 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 2015, the Commission's surplus was $3 million. The Commission continues to operate within its statutory assessment cap of $12 million since FY 2008. The Commission will continue to utilize its surplus in efforts to close the gap between appropriation and revenue collection.

OVERVIEW OF FY 2015 COMMISSION ACTIONS

July 2014

The Commission granted an Exemption from Certificate of Need for the Merger of the Hospice of Queen Anne's, Inc. and the general hospice operations of Chester River Home Care and Hospice, LLC.

Certificate of Need/Change in Approved Project: 700 Toll House Avenue Operations, LLC d/b/a College View Center was approved.

Certificate of Need for Rockville Eye Surgery, LLC was approved.

COMAR 10.24.17 – State Health Plan for Facilities and Services: Cardiac Surgery and Percutaneous Coronary Intervention was adopted.

COMAR 10.25.15 – Management Service Organization State Designation was adopted.

August 2014

There was no Commission meeting.

September 2014

Exemption from Certificate of Need: Merger of the Hospice of Queen Anne's, Inc. and the general hospice operations of Care Health Services, Inc., d/b/a Shore Home Care and Hospice was approved.

Certificate of Need: Talbot Hospice Foundation was approved.

Formation of the Cardiac Standing Advisory Committee and an Update on Regulatory Oversight was approved.

October 2014

The 2014 Health Benefit Plans Quality Report Series was released.

The Commission announced the unveiling of its new website: http://mhcc.maryland.gov/mhcc/default.aspx mhcc.maryland.gov.

The Commission announced that new information that would be available from the Maryland Hospital Performance Evaluation Guide on its website.

The Commission approved the nomination of a consumer member to the Cardiac Services Advisory Committee.

The Commission approved the Telemedicine Task Force's recommendations for expanding Telehealth options in Maryland.

November 2014

The Commission announced that the new, web-based Maryland Hospital Performance Evaluation Guide was operational.

An organization for external review of Percutaneous Coronary Intervention (PCI) Services, the Maryland Academic Consortium for PCI Appropriateness and Quality, was approved.

The Appointment of a Chair and a Vice Chair of the Cardiac Services Advisory Committee was approved.

The Electronic Preauthorization - Benchmark Attainment Report was approved for release.

The Maryland Trauma Physician Services Fund, Report to the Maryland General Assembly, was approved for release.

Certificate of Need/Change in an Approved Project for Ashley, Inc. d/b/a Father Martin's Ashley was approved.

Certificate of Need/Change in Approved Project for NMS Healthcare of Hagerstown was approved.

An Update to the Medical Care Database Submission Manual was approved for posting on the Commission's website.

The 2013 Performance Year Results for the Maryland Multi-Payor PCMH Program were released.

December 2014

Certificates of Conformance for Elective Percutaneous Coronary Intervention Services for Carroll Hospital Center and the University of Maryland Upper Chesapeake Medical Center were approved.

The Commission's MRI Self-Referral Study was approved for release.

The Commission approved the re-designation of the Maryland Patient Safety Center.

Certificate of Need for Seasons Hospice & Palliative Care of Maryland, Inc. was approved.

January 2015

The Commission approved the release of Operations, Utilization, and Financial Performance of Freestanding Medical Facilities

The Assignment of Benefits Study was approved for release.

The Commission approved the proposed membership of the Provider Carrier Workgroup.

February 2015

Certificate of Need – Brooke Grove Rehabilitation and Nursing Center was approved.

The Commission's Nursing Home Short-Stay Survey Results were released.

The Commission received an update on pending legislation for 2015.

The Commission's Forecast of Cardiac Surgery Cases was updated.

March 2015

A Certificate of Need - Hospice of Washington County, Inc. was approved.

COMAR 10.25.17 – Benchmarks for Preauthorization of Health Care Services – Proposed Regulations were released for Informal Public Comment

Recommended Additions to MHCC's Data Release Policy were approved.

April 2015

Certificate of Need/Change in Approved Project: 700 Toll House Avenue Operations LLC d/b/a College View Center was approved.

Institutional Review Board - Recognition of an alternative IRB was approved.

The Commission announced the release of new data on the Maryland Health Care Quality Reports website.

May 2015

Members of the Workgroup on Care Coordination in support of Maryland's All-Payer Model presented key components of a care coordination plan to the Commission.

The Commission approved designation of the Johns Hopkins Bloomberg School of Public Health as an Institutional Review Board.

The Commission approved Proposed Amendments to COMAR 10.25.17 – Benchmarks for Preauthorization of Health Care Services.

The Commission made Telehealth Grant Awards to Crisfield Clinic, Lorien Health Systems, and Union Hospital of Cecil County.

Commission staff presented a Legislative Wrap-Up and Budget Overview.

June 2015

Certificate of Need: Lorien Harford Nursing and Rehabilitation Center was approved.

Exemption from Certificate of Need for the Seasons Hospice/Optum Hospice merger was approved.

Commission staff presented Plans for Development of the State Plan for Freestanding Medical Facilities.

Commission staff presented Results for the State EHR Incentive Program.

Commission staff presented Results of the Analysis of Payment for Professional Services.

Commission staff presented an update on the Evolution of the Small Group Market.

MARYLAND HEALTH CARE COMMISSION

Executive Direction

Maryland Trauma Physician Services Fund

Overview

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 beginning 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.

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 became effective on October 1, 2012.

Accomplishments

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 2015.

The 8 percent funding reduction for payment rates and reimbursements was rescinded at the close FY 2015. Beginning in FY 2016, reimbursement and payments will return to 100%.

Payments to eligible providers and the administrative costs associated with making those payments were about $11.9 million in FY 2015, a decrease of nearly $900,000 from FY 2014. Comparing FY 2015 to FY 2014, both uncompensated care payments and on call trauma payments, combined, decreased by approximately $700,000. Transfers from the Motor Vehicle Administration (MVA) to the Fund increased by only $40,000 in FY 2015; and administrative costs and reimbursements to the Fund increased as well.

Implementation of the insurance coverage provisions of the Patient Protection and Affordable Care Act (ACA) led to reduced financial pressure on the Fund, as a significant share of those currently uninsured have gained access to coverage. As 93.5% of Maryland residents under age 65 had health insurance in calendar year 2014, uncompensated care payments should continue to slowly decline.

The MHCC recommends raising reimbursement for uncompensated care and on-call services to 105% of the Medicare payment beginning in FY 2017. MHCC, in consultation with HSCRC, is permitted to make this adjustment under Health-General §19-130(d)(4)(iv). The small adjustment in reimbursement levels is in recognition of the significant reductions in reimbursement that trauma physicians were asked to absorb from FY 2010 through 2015. The modest increase will also provide a small incentive to Level II and Level III Centers to appropriately treat trauma patients, rather than transferring those patients to Shock Trauma or the Johns Hopkins Level I center. MHCC will recommend whether or not this adjustment should continue in the FY 2018 report due to the Maryland General Assembly in November of 2017.

MARYLAND HEALTH CARE COMMISSION

The Center for Analysis and Information Systems

Cost and Quality Analysis Division

Overview

The Division of Cost and Quality Analysis' (Division) is the unit of the Center for Analysis and Information Systems (Center) that oversees construction and maintenance of the Commission's Medical Care Data Base (MCDB)—a data base of health insurance claims for covered services received by Maryland residents enrolled in health plans from commercial insurance carriers, Medicare, and Medicaid—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 Division's staff examines broader health care issues as well, including the measurement and analysis of insurance. The Division' staff conducts more narrowly focused studies of health care service use and spending, at the discretion of the Commission and as requested by the Maryland General Assembly, the Governor's Office, and the Department of Health and Mental Hygiene. In addition to the MCDB and insurance related activities and reports, the Division's staff is responsible for studies of the healthcare workforce and for developing and implementing the Commission's data release policy.

Accomplishments

The Division's staff worked to implement an ambitious agenda to modernize the data collection process for the MCDB, enhance trust in the MCDB, develop decision support tools, promote price transparency, and conduct timely studies. An emphasis throughout the Division's activities has been collaboration with partners and engagement of stakeholders. In addition to the Commission's budget, the Center applied for and received funding from the Center for Consumer Information and Insurance Oversight (CCIIO) in FY 2014 ($2.9 million) and in FY 2015 ($1.1 million) to support the Division's activities.

In FY 2015, the Division' staff: (1) applied for and received new grant funds; (2) enhanced the MCDB by developing new IT infrastructure to automate the data collection process, expanding the comprehensiveness of the database, and adding identifiers; (3) in partnership with the Maryland Insurance Administration (MIA), worked to enhance trust in the MCDB data and develop decision support tools; (4) developed easy-to-use dashboards for workforce data and developed plans to promote price transparency; (5) updated annual reports on healthcare spending and developed two legislative reports that leveraged the MCDB data; and (6) developed and began implementation of a new data release policy.

Grant Funding
In FY 2014, MHCC received funding ($2.9 million) from CCIIO in its Cycle III rate review funding to develop an Extract, Transform, and Load (ETL) system to automate MCDB data capture and ultimately shorten the timeline for making data available for MHCC analyses and to State partners. A key deliverable of the grant is to make MCDB data and analytics available to the Maryland Insurance Administration to support its health insurance premium rate review activities. In FY 2015, the Division developed and implemented these initiatives through commitment of staff resources and a contract with the database vendor, Social and Scientific Systems (SSS).

In FY 2015, MHCC received a second grant ($1.1 million) from CCIIO to enhance the capabilities of the MCDB with price transparency tools that can be used by consumers, physicians, and other practitioners to assist in healthcare decision-making. In FY 2015, the Center worked to develop plans for these grant activities and to build a price transparency portal targeted at industry professionals.

MCDB Enhancements
The Division worked to enhance the MCDB by: (a) developing new IT infrastructure to automate the data collection process; (b) expanding the comprehensiveness of the database; and (3) adding a master patient identifier.

New IT Infrastructure
Through its contract with SSS, Division staff developed an entirely new IT infrastructure to take in, process, store, and analyze MCDB data. A secure web portal was developed to manage data intake and communications with payors. The portal allows payors to review file specifications, access training materials, submit data, request variances and extensions, review data quality reports, and communicate with the MCDB team. Data submitted on the portal is processed by an Extract, Transform, and Load (ETL) system that implements the specified validation process, supplements data with value added fields, and loads finalized data to the data warehouse. The ETL system implements a three-tier validations process to verify conformance with the MCDB Data Submission Manual: (1) Tier 1 validation checks verify the file format and layout; (2) Tier 2 validation checks field type and format and compliance with the thresholds set for completeness of fields. The thresholds checked are dynamically generated based on any approved variances on the portal; and (3) Tier 3 validation checks include cross-year trend analyses, comparisons to benchmark data, complex cross-field analyses, and other Ad hoc analyses. A key element of these processes is automation to expedite review, feedback to payors, and resubmission, if needed.

Once data has been processed, it is loaded to a structured data warehouse (a SQL database), and the data is available, both through direct access to the data warehouse and via analytic extracts made available in a secure data center, where the Division staff may access data on virtual machines. This provides a secure environment to access and analyze the sensitive health care data contained in the MCDB. While the structured data warehouse will be implemented in FY 2016, the secure data center, the portal, and ETL system were all implemented in FY 2015. Throughout FY 2015, the Division staff met with payors, both collectively and one-on-one, to explain and roll out new data intake processes and requirements, provide training on the submission portal, get feedback on development of the IT infrastructure, review and resolve data quality concerns, and to better

understand payor practices and data. This work was funded with support from the CCIIO Cycle III grant, as mentioned above.

Expanded data collection

The Division staff implemented new reporting requirements in COMAR 10.25.06 – Maryland Medical Care Data Base, which expanded the set of reporting entities and increased the frequency of reporting. In addition to the current reporting entities, third party administrators, including pharmacy benefit managers and behavioral health administrators, any carriers selling products in **the** MHBE, including qualified dental plans, and Medicaid MCO's, are required to submit data. These changes were made to ensure that the MCDB is more comprehensive. Data for all Medicaid MCO's are submitted directly by the Hilltop Institute on behalf of Maryland Medicaid. Medicare data, which is purchased from the Center for Medicare and Medicaid Services (CMS), and Medicaid data are both collected and processed once a year by individual programmers using statistical and database software. The private insurance carriers described in the MCDB regulations follow the data submission guide and submit data using the data intake process described in the previous section. In addition to expanding the designated reporting entities, payors are now required to submit data based on paid claim date, rather than service date. This allows for more timely reporting and is necessary to support the MIA's analytic needs.

Master Patient Index

The Division staff worked with the State-designated Health Information Exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP), to develop a process to add the CRISP Enterprise Identifier (EID), which is a masked version of CRISP's Master Patient Index, to the MCDB Eligibility File. This new patient identifier is expected to be helpful in linking medical and pharmacy information on members enrolled in self-insured plans where there would not be existing common identifiers. This permits a better ability to understand per member costs, a key measure for understanding healthcare spending. Beyond this use case, this identifier is expected to be useful in linking the MCDB to other administrative and clinical databases.

In FY 2015, the four largest medical insurance carriers and two largest pharmacy benefit managers were asked to participate in a pilot effort and submit demographic information to CRISP for CY 2014. CRISP assigned an EID to each member in a payor's file and then sent a cross-walk file between the CRISP EID and the payor's patient identifier to SSS. SSS tested the ability to link self-insured medical and pharmacy claim data, the key use case for the MCDB. Based on this analysis, which found good matching, MHCC decided expand this process to all payors in its CY 2015 reporting, which will be implemented in FY 2016. This work was funded with support from the CCIIO Cycle IV grant.

Collaboration with the Maryland Insurance Administration

The Division collaborated with the MIA to: (a) benchmark MCDB data to the Actuarial Memoranda data submitted to the MIA in order to enhance trust of the MCDB for use is in State regulatory decisions in evaluating the MCDB for rate review activities; and (b) develop decision support tools for the MIA premium rate review process.

Benchmarking MCDB data

MIA and MHCC plan to leverage the MCDB to support the MIA's review of rate filings. Initial internal efforts to reconcile MCDB and Actuarial Memoranda (AM) data identified some discrepancies. In order to understand these discrepancies and improve reporting from payors, the MIA and MHCC developed a two-phase approach to meet individually with payors to review data reconciliation efforts and resolve discrepancies. In FY 2015, the first phase was implemented, which focused on reconciliation of membership counts. Often different teams within each payor were involved with reporting to MHCC and MIA, which lead to differences in reporting methods, assumptions, and selection of members to report. As a result of the first phase of meetings, MHCC and MIA gained a much better understanding of payor-reported data, and several payors resubmitted data to the MCDB, which improved the data reconciliation with the AM data. In FY 2016, the second phase will commence and focus on reconciliation of cost and utilization measures. These activities were funded with support from the CCIIO Cycle III grant.

Decision support tools

In parallel with the data reconciliation and benchmarking activities, the Division staff worked to develop decision-support tools for the MIA in the form of easy-to-use dashboards. These dashboards present data for Life and Health Insurers and Health Maintenance Organizations for contracts sold in Maryland, which are under the MIA regulatory authority. The dashboards summarize MCDB data by individual payor, insurance market, and insurance product. The Division developed tabs for membership data reconciliation and cost and utilization trends by benefit category (e.g., professional services, institutional or facility-based services, and pharmacy services). The dashboards include three years of data, as required by the MIA, and provide access to both quick analytics and underlying data to the MIA rate review analysts. Version 1 of the dashboard was developed, tested, and released to the MIA in FY 2015. Further enhancements will be made in FY 2016, in collaboration with the MIA. These activities were funded with support from CCIIO Cycle III and IV grants.

Public Dashboards and Transparency Initiatives

The Division staff worked to improve access to the MCDB through dashboards and developed plans for a series of public portals to promote price transparency. In order to support the development of dashboard tools, the Center acquired Tableau software with funding support from the CCIIO Cycle IV grant, and Center and Division staff received training on the software. This software permits quick development of interactive data displays that may be published on web portals. One effort to implement a dashboard was described above, as part of the decision support tools for the MIA, which was an internal tool for the MIA. The Division staff worked to develop its first public dashboard using the Board of Physicians license renewal data. This was done as part of the Maryland Health Workforce Study. In FY 2013, the Division staff launched the Maryland Health Workforce Study, which has three phases: (1) assess the existing data Maryland Health Occupation Boards (Board) collect to support workforce analysis; (2) estimate the supply of and demand for health care professionals with the best available data; and (3) enhance the existing Board data systems. The first two phases were completed in FY 2013 and FY 2014. In FY 2015, the third phase was expanded to include development of a public dashboard. The public dashboard will be published on the MHCC website in FY 2016 and will display a profile of Maryland physicians, including demographics (e.g. age, gender, and race), specialties, supply and geographic distribution throughout the state, and comparisons of individual counties to other

county and state averages. The dashboard provides maps of the distribution of physicians overall and for primary care providers, mental health providers, and OB/GYN providers. The dashboard also allows the users to filter and explore the data by age, gender, race, EMR adoption, specialty, setting, and acceptance of Medicare, Medicaid, and private insurance members.

With growing interest in the MCDB from various stakeholders, there has been a push to make the data readily accessible to a public audience. In FY 2015, the Center developed plans to produce dashboards for specific topics and audiences: (1) an Industry Portal – this portal will display health care data, such has provider and procedure level prices and geographic distribution of services; (2) a Consumer Portal – this portal will display health care prices targeted toward a consumer audience and permit them to review costs and compare providers; (3) a Provider Portal – this portal will display health care prices, such as for testing and imaging services, targeted toward providers and will let providers better understand their own spending and compare themselves to other providers; (4) a Maryland Insurance Administration (MIA) Dashboard – this dashboard is designed specifically to support MIA rate review and will provide utilization and cost trends in custom and non-public dashboards; (5) Hospital pricing for elective procedures – this dashboard will display surgeon professional prices in conjunction with facility bills that are already displayed on the existing Maryland Health Care Quality Reports site. The Center will develop these portals in FY 2016. These activities are supported by funding from CCIIO Cycle III and IV grants.

Legislative and Annual Reports

The Division worked to produce two legislative reports and three annual reports in FY 2015: (a) an evaluation of the Assignment of Benefits (AOB) legislation; (b) an analysis of the divestment of MRI machines from physician practices and the implications for the Maryland self-referral law; (c) a report on commercially insured spending Maryland; (d) a report on the payments for professional services in Maryland; and (e) a report on HMO payments to non-participating providers.

Evaluation of Assignment of Benefits Legislation

In 2010, the Maryland General Assembly (MGA) passed legislation to amend the assignment of benefits (AOB) rules in Maryland to set certain rates of payments for hospital-based physicians if they accepted assignment of benefits from their patients. This was a reaction to reports of exceptionally high patient out-of-pocket expenses for care rendered in hospitals by out-of-network (OON) physicians, and the goal was to eliminate balance billing of patients, without reducing payments to OON physicians. MHCC was asked to evaluate this legislation and compare the baseline in 2010 to 2013, after the implementation of the legislation. The report was done by SSS under contract with MHCC. The report evaluated the legislation from three perspectives: patients, providers, and payors. Overall, the legislation achieved its purpose to ease the financial burden on patients who use out-of-network providers in hospital settings by reducing reliance on balance billing. Non-participating providers took advantage of increased predictability in payments, as evidenced by the majority accepting AOB. For most payers, out-of-network services and reimbursements declined as a share of total services & reimbursements between 2010 and 2013, and there was no evidence of systematic deterioration in payer networks. MHCC recommended removal of the abrogation date of the law and to make no other changes to the law. One important lesson learned in the reporting effort was the value of collaboration with stakeholders and opportunities to enhance the quantitative analyses with qualitative information

based on discussions with stakeholders. These discussions provided needed context to the report and helped the team conduct better analyses.

Evaluation of MRI divestment

The Maryland Patient Referral Law (self-referral law) prohibits a health care practitioner, and employees, or persons under contract to the practitioner, from referring a patient to a health care entity in which the health care practitioner has a beneficial interest or compensation arrangement. While there are several exemptions to the law, the prohibition against self-referral for MRI, CT, and radiation therapy services has received the greatest attention. Following an enforced divestment of MRI and CT equipment from practices owning them in 2011, the House Government and Operations Committee (HGO) asked MHCC to study the impact of the divestment and the role of financial incentives in utilization patterns. The study was conducted by Braides-Forbes Health Research, under a contract with MHCC. The study evaluated utilization patterns among the set of practices required to divest (case practices) and two groups of control practices (similar practices, and all orthopedic practices in Maryland). The study found that ownership was not associated with MRI higher use rates, except for Medicare patients in one practice, even after controlling for patient age, insurance design (Private only) and Medicaid status (Medicare).

After controlling for ownership, rates of MRI use were higher and statistically significant for case practices for both privately insured and Medicare in both 2010 and 2012, even after controlling for factors such as patient age and insurance design (private only) and Medicare status (Medicare only). The case practices started out higher and remained higher, though the difference in ownership status did not affect the changes in utilization patterns over the study period. There were limitations to the study, notably the short study period and inability to adjust for case-mix. MHCC recommended that any amendment to the law consider any expansion of self-referral authority for practices to be done in the context of broader payment reforms and require full participation in risk-based arrangements, as a condition. While the Maryland General Assembly took no new action in FY 2015, the HGO committee asked MHCC to convene a workgroup of stakeholders in FY 2016 to discuss opportunities to modernize the law.

Commercially Insured Spending

The Division staff reports annually on overall spending by major market segments, geographic regions, and age of enrollees. The report restricts analyses to fully-insured plans, as there has not been complete data on pharmacy benefits for the self-insured, which is being collected as of the 2014 data collection, which commenced in FY 2015. While past reports restricted analyses to full-year enrollees and reported annual per capita spending, this year part-year enrollees are included and annualized per member per month (PMPM) spending is reported. Reporting based on PMPM and including both full and part-year enrollees is consistent with actuarial reports and insurance industry practices. Consistent with previous reports, this report finds variation in spending across the market segments, with spending in the Maryland Health Insurance Partnership (MHIP), which is Maryland's high risk group, being the highest spending ($1,075 PMPM) compared to the Individual Market, which usually has younger and more healthy members, having the lowest spending ($207 PMPM). Out-of-pocket spending and spending by service categories followed a similar pattern. There was a 2.3% growth in overall spending between 2012 and 2013, with some variation by market segment. This report was done by SSS, under contract with MHCC.

Payments for Professional Services

The Division staff reports annually on pricing of professional services. The original the goal of this legislative requirement was to provide information to policymakers, providers, and payors regarding the variations in rates for professional services. These reports include analyses of variation by payor market share, in-network versus out-of-network rates, region, and type of service, and include comparisons to Medicare and Medicaid payment rates. While early reports yielded valuable insights into pricing variation, recent reports have not revealed much new information, as the trends have been stable over time. With this in mind, the Division staff shifted the focus to be a high-level monitoring report. Reported prices are based on the Medicare Relative Value Unit (RVU) to provide a standardized comparison across payors and services. The analysis found a marginal decrease in payment rates between 2012 ($35.41/RVU) and 2013 ($35.11/RVU). The largest payors pay about 9% less per RVU than other payors. Commercial plan rates are about 6% lower than Medicare rates in this analysis, which is consistent with past findings that rates are roughly equivalent. A shift was seen in the comparison of commercial rates to Medicaid. Whereas commercial rates were, on average, 30% higher relative to Medicaid rates in the past, it is now on average 8% higher. The substantial drop is attributed to increases in Medicaid payment rates for primary care evaluation and management services. These increases are required in the ACA, with the federal government paying the increase up to the Medicare rate.

HMO Payments to Non-Participating Providers

Maryland Health-General Article, §19-710.1 specifies a methodology to calculate minimum payment rates that Health Maintenance Organizations (HMOs) must pay to non-contracting (non-trauma) providers that provide a covered evaluation and management (E&M) service to an HMO patient. The Commission is required to annually update these minimum payment rates. The Division staff develops this report and provides it to the MIA annually. As specified in the law, E&M services as defined by CMS)in the Berenson-Eggers Type of Services (BETOS) terminology are calculated from the CMS Medicare Physician Fee Schedule that applied in August of 2008, adjusted by the cumulative Medicare Economic Index (MEI) prior to the start of each new calendar year. MHCC and MIA have agreed to modify the methodology in the event that there is a new E&M services code included in the BETOS E&M categories. Fee levels for new codes will be based on the current Medicare Physician Fee Schedule for the geographic region and inflated using the MEI in subsequent years. The Division updated the minimum HMO payment rates to non-participating providers, as specified in the law, and the MIA published these rates on its website.

Data Release Policy

MHCC collects data directly from health care facilities and insurance companies, and requests and maintains data from quality reporting organizations, CMS, Maryland and Washington DC hospitals, and Maryland professional licensure boards. Growing interest in these data resources, particularly data containing Protected Health Information (PHI) and Personally Identifiable Information (PII), necessitates standardization of MHCC data release practices and the development of a formal Data Release Policy (DRP). In FY 2014 and FY 2015, the Division staff engaged stakeholders in workgroups and informal conversations, surveyed practices of other states and CMS, evaluated MHCC's needs and capacity, and conducted preliminary analyses of the interest in this data. Based on this feedback, a formal Data Release Policy (DRP) was created and

approved by MHCC in FY 2015. The DRP requires a formal application process that includes staff and multi-stakeholder review committees, IRB review, and ultimately, MHCC approval. The DRP also implements MHCC's authority to charge for the release of MCDB data and provides for greater transparency in the data release process to stakeholders. The Division staff expects to release data under this new policy in FY 2016 and onward.

Data Base and Applications Development Division

Overview

The Data Base and Application Development Division is responsible for data collection, processing, and dissemination activities of the Commission. The Commission has the authority to collect and report 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, cardiac catheterization data, several Centers for Medicare & Medicaid Services (CMS) data collections, including the Minimum Data Set, and long term care quality data. The division provides data management and analysis support, web-based application development, and public reporting of health care information.

Accomplishments

The Data Base and Applications (DBA) staff supports most of the data collection used for MHCC analysis and reporting, and provides analytic support to MHCC staff, in addition to developing web-based applications for data collection and reporting. Data collection includes processing of raw data and web-based survey data into useable analysis and reporting databases. Data feeds include hospital inpatient data from the Health Services Cost Review Commission (HSCRC) and from the DC Hospital Association, Centers for Medicare and Medicaid data for long term care quality measures, health facility staffing, and the Minimum Data Set, Office of Health Care Quality health facility inspection reports, the MHCC Long Term Care Survey, the MHCC patient satisfaction surveys, the MHCC Hospice Survey and the MHCC Home Health Survey. Web-based data collection includes collection of health facility data from nursing homes, home health agencies, hospice, adult day care and assisted living facilities, as well as health facility flu vaccination rates.
The DBA staff also supports data analysis and develops web-based applications for health care reporting.

The DBA staff provided support to Commission staff in several areas, as follows:

Network Support
DBA staff helped resolve SAS disconnections for staff; management of software licenses; performed troubleshooting for various issues with the new SAS server; external file transfers; provided file transfer support for various MHCC projects; administration of hosted web server

accounts; and administration of local network permissions and permission group settings. As part of an overall data security project, programming staff planned and implemented an extensive data cleanup and file restructuring process.

Data Processing Support
DBA staff provided SAS programming expertise; uploaded and organized Medicare 2010-2012 data and converted all files to native 64 bit format; error resolution for cardiac catheterization and PCI procedures data collection from hospitals; read quarterly inpatient and outpatient hospital data into the Agency for Healthcare Research and Quality (AHRQ) healthcare performance and quality reporting software application and installed a version on the web server; quarterly processing and validation of inpatient, outpatient, chronic, psychiatric, and freestanding hospital data; resolved issues with the primary service area program; analysis and mapping support for the Certificate of Need analyses; redeveloped the program for DC inpatient data processing due to the DC Hospital Association format changes for 2013; performed data requests for ambulatory surgery facilities, emergency room, outpatient, chronic care, and psychiatric hospital data; worked with the HSCRC to include the unique patient ID on the palliative care data and linked multiple databases using the patient ID; and provided troubleshooting support for the Trauma fund. For the Price Transparency project in which service utilization by county will be displayed in a web-based graphical format, programming staff processed the National Provider Identifier registry file to pick up provider name, location, and taxonomy; worked with the medical claims database vendor to develop the pricing file filters for 2013 data; created a merged procedure file, including hcpcs with descriptors and groupings; processed the private 2013 professional services file to be reported equivalent to Medicare provider categories; downloaded and processed the Medicare 2013 provider utilization and payments file; and converted all sort/merges into hash merges due to memory restrictions.

Web Development
DBA staff posted intranet and MHCC website updates; developed and launched the nursing home and assisted living surveys for collection of 2014 flu data; made changes, created new pages, and uploaded new documents for the Maryland PCMH website; using the My Own Network Powered by AHRQ, or MONAHRQ, 5.0 software, prepared data for and generated the 2013 website; participated in beta testing of MONAHRQ 6.0 and provided feedback to AHRQ; provided assistance to the claims data warehouse vendor with the State website template for design for the claims data submission portal; added Practitioner Performance Measurement Planning documents; resolved migration errors with the former SharePoint site; update of Commission meeting schedules; redeveloped the MHCC website which required working with all staff to follow the new document naming convention and folder structure, moving and linking hundreds of documents to the new structure and developing an archive application for old documents; 2013 Home Health Survey close-out and file download; implemented changes to the Home Health Survey for 2014, created the 2014 SQL database, prepopulated the facility data, moved the application to the production web server, monitored the survey data collection until completion, and converted the survey data for analysis use; in process of development of a new data request web application - reviewed and analyzed specifications, implemented asp.net controls and visual basic.net code to allow users to upload and save file attachments, insert new requests as well as edit existing requests, and implemented email notification functionality; updated the public use file downloads with 2013 Ambulatory Surgery data and documentation; developed Tableau visualization

embedding functionality using JavaScript API for web applications; worked on development of a front-end web application for the physician dashboard; updates and new development for the Long Term Care portal, including implementation of website URLs to each facility profile page, redesign of the facility search page, development of linkage to the Maryland health care quality reports website, implementation of nursing home long stay and short stay 2014 survey reports, reporting of nursing home flu vaccination rates for 2013-2014, implementation of Goldstar recognition for nursing home facility profile flu vaccination rates, overhauled display of the nursing home health and fire safety inspection results and calculation of statewide values, update of nursing home and home health quality measure data and patient satisfaction results, update of nursing home staffing data and improvement of the staffing results display, update of the nursing home resident characteristics, update of hospice and branch office addresses, and extensive analysis of the assisted living survey inspection report database files sent by the Maryland Office of Health Care Quality (OHCQ).

Technical Support

DBA staff compiled a summary comparison of web-based business intelligence (BI) platforms with costs for use with the pricing portal; installed and tested selected BI solutions; worked with the health care claims warehouse vendor to get the selected BI software installed on staff virtual machines; worked with our web hosting contractor to install a BI server and get secure file transfer working for the new server; coordinated secure file transfer with the Medical Care database vendor; validated files upon receipt; converted all 32 bit data files to 64 bit when the server was upgraded; set up AMA online code account and instructions for access; tested SAS graph procedures for analysis staff; set up a pricing database on the local SQL server for use with development of the Maryland Insurance Administration portal; provided support to internal staff on navigating the new secure data enclave; worked with the data enclave vendor to get all application software installed and functioning; provided instruction on collection of Society of Thoracic Surgeons' data; provided extensive review and feedback on the Pricing Transparency RFP; attended meetings, reviewed documentation and data processing programs for the Long Term Care Survey and Minimum Data Set; and assisted staff with report development and technical specifications for request for proposals (RFPs).

Support for Health Occupations Boards

MHCC network developers have supported 14 health occupation board and commissions in developing and maintaining their web-based license renewal applications. These renewal applications collect demographic and professional information, and gather the fitness information from licensees that are part of each renewal process. Once applications are completed, renewal fees are collected and assigned to the designated Board accounts. MHCC staff's support to the Boards is provided at no cost. The applications meet State requirements that all Boards support web-based license renewals. Commission staff estimates that the value of network developers' services to the Boards would be $600,000 in the commercial marketplace. The following Health Occupations Boards and Commission use the MHCC's internet application infrastructure for licensing:

- Board of Physicians
- Allied Health Occupations

- Board of Acupuncture
- Board of Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists
- Board of Chiropractic & Massage Therapy Examiners
- Board of Dietetic Practice
- Board of Morticians and Funeral Directors
- Board of Examiners in Optometry
- Physical Therapy Examiners
- Board of Examiners of Psychologists
- Board of Examiners of Podiatrist
- Board of Professional Counselors and Therapists
- Board of Social Work Examiners
- Maryland Medical Cannabis Commission (MMCC)

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 Commission's 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.

Division staff also provide technical assessment, configuration management, and capacity planning functions for the organization and are 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 2015, the Commission's LAN was available to staff 100% 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 set of firewalls. In addition to the standard annual accomplishments listed, the following were also completed in FY 2015:

Added one new virtual domain controller to the MHCC network to replace a physical domain controller. This will continue to provide better network authentication services for users and

better security for network resources, as well as reduce the heat generated and power consumption in the data center.

Upgraded the physical server for web & database application development.

Added three 4TB drives to increase storage from 450GB to 12.5TB.

Increased RAM from 4GB to 96GB.

Dedicated an off-site physical server for SFTP communications with external customers.

Upgraded the primary router that connects the MHCC local area network (LAN) to the DHMH wide area network (WAN).

Rewired all workstation connections within the datacenter (connection from patch panel to connectivity switches).

Upgraded all MHCC workstations to Microsoft Windows 7 Professional.

Upgraded all MHCC workstations to Microsoft Office 2013 Professional Plus.

Purchased an additional storage area network to add 10TB storage for the physical & virtual systems to share.

Added 3 new notebook computers for user offsite use.

Benefits Analysis Division

Overview

Small Employer Health Benefit Plan Premium Subsidy Program (Health Insurance Partnership)

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 that 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 was 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 required 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 qualifying small employers under the Program. Finally, on or before January 1, 2009 and annually thereafter, the MHCC was 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

Problems with the implementation of the Exchange website forced the Exchange to delay implementation of the SHOP Exchange in early 2014. Ultimately, Maryland chose not to build a SHOP exchange but did receive federal authorization to offer a federal tax credit to qualifying small employers that purchased group coverage outside the Exchange, thus eliminating the need for a state subsidy through the Health Insurance Partnership. As a result, Maryland established a process referred to as "direct enrollment" whereby small employers utilize the services of a SHOP-authorized broker for assistance in purchasing a SHOP-certified plan through the direct enrollment process. SHOP Employer Paper Applications are submitted to Maryland Health Connection to determine eligibility for group coverage and qualification for a federal tax credit.

To minimize disruption in the small group market, MHCC developed a transition plan whereby the Partnership was closed to new entrants effective January 1, 2014. However, employers enrolled in the Partnership prior to January 1, 2014 remained eligible for this state premium subsidy until their policies expired on or before December 31, 2014. Since the SHOP Direct Enrollment Program was deferred until April 1, 2014 (and coverage deferred until June 1, 2014), small businesses enrolled in the Partnership with renewal dates between January 1, 2014 through May 1, 2014 did not have access to federal tax credits since there was no operational SHOP Exchange in Maryland. MHCC kept the Partnership program open to qualifying subsidy renewal groups until coverage began through Maryland Health Connection on June 1, 2014. MHCC continued paying state premium subsidies to employers that participated in the program until May 2015, when the last employer phased out of the Partnership and was expected to transition to the SHOP Exchange.

Beginning with the first year of implementation (2008) through 2013, the Health Insurance Partnership experienced incremental growth in enrollment. However, the availability of SHOP-certified plans through the direct enrollment process with federal tax credits for qualifying small employers resulted in the phase-out of the Partnership, causing a significant decline in enrollment in this state subsidy program during FY 2015. The 7th annual Health Insurance Partnership report was published on January 1, 2015 and is posted on the Commission's website.

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 must 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.

With the enactment of the Affordable Care Act in 2010, 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 apply to the essential health benefits package in 2014 and 2015. Any new mandate in effect after December 31, 2011, 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. MHCC does not anticipate producing mandate studies unless specifically requested to do by the General Assembly. As such, no mandate analyses were conducted during FY 2015. The most recent Comparative Evaluation was last approved and published in December 2011; the next report is due on January 1, 2016.

The Center for Quality Measurement and Reporting

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. Since its inception, the Guide has continued to evolve with new performance measures added each year, redesigned webpages to improve the display of consumer information and the establishment of a secure web portal for direct submission of quality data from Maryland hospitals. In 2009, the establishment of the Quality Measures Data Center (QMDC) website and secure portal enabled direct and timely access to detailed hospital quality and performance measures data for public reporting and for support of the HSCRC Quality Based Reimbursement (QBR) Program. The QMDC, a major component of the Hospital Guide infrastructure, was repurposed in FY 2015. The site was transformed into a single point of access to the Commission's consumer guides on hospitals, long term care facilities, ambulatory surgery centers, as well as the performance report on health benefit plans. The new and improved Maryland Health Care Quality Reports website creates a comprehensive, consumer friendly resource tool that includes information on consumer ratings of the care provided, safety and quality results, and pricing information on hospital services. The new Maryland Health Care Quality Reports (MHCQR) website was released to the public in December 2014.

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 measures reflecting key topics, including: communications with doctors and nurses, responsiveness of hospital staff, pain management, communication about medicine, discharge information, transitions of care, and cleanliness 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 MHCQR also reports hospital performance using the HCAHPS Summary 5-Star Rating, which compiles all HCAHPS reporting measures into one metric.

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

The most significant accomplishment for the Center in FY 2015 has been the transformation of the QMDC website into a single point of access to the Commission's consumer guides on hospitals, long term care facilities, ambulatory surgery centers and health benefit plans. The new and improved Maryland Health Care Quality Reports website was developed with the input and involvement of consumers and consumer advocacy groups. The site continues to evolve and expand with new information and improved functionality. Consumers will continue to play a key role in future enhancements to the site.

In FY 2015, MHCC's quality and performance data collection for Maryland hospitals continued to evolve. In January 2014, the MHCC and the HSCRC issued a joint policy directive that significantly expanded the quality measures data that Maryland hospitals were required to collect and report. As part of Maryland's exemption from the Centers for Medicare and Medicaid Services (CMS) Value-Based Purchasing Program (VBP) for hospital reimbursement, Maryland must maintain a comparable hospital quality program that meets or exceeds the CMS program in cost and quality outcomes standards. In response to this CMS directive, MHCC expanded its hospital quality measures data collection requirements to comply with CMS Inpatient Quality Reporting (IQR), Hospital Outpatient Quality Reporting (OQR) and VBP data collection requirements.

In FY 2015, two HAI metrics continue to show significant improvement in the performance of hospitals. Central-line associated bloodstream infections in ICUs decreased by over 50% during the five years since the information was first publicly reported on the Hospital Guide. The MHCC worked in collaboration with hospitals, the Maryland Hospital Association (MHA), and a committee of experts in infection prevention and control, to facilitate implementation of evidence based patient safety activities designed to reduce hospital infections. (Of note, the National Healthcare Safety Network (NHSN) has stated its intent to update the baseline time-period to CY 2015 next year for all HAIs. If this occurs, it is likely to have a negative impact on the trending, as subsequent years will be compared to a year after which much progress has already been made.) Similarly, public reporting of hospital employee influenza vaccination rates was a major focus in FY 2015. For the past six years, MHCC has conducted an annual survey of hospitals to gather information on employee vaccination rates and hospital policies and practices designed to promote employee flu vaccination. Hospital worker flu vaccination rates have been published in the Hospital Guide for the past five years. Since the release of this information on the Hospital Guide in 2010, Maryland hospitals have achieved an 18% increase in their employee influenza vaccination rates from 78% to over 96%. The hospital flu vaccination rate for the 2014-2015 flu season was 96.9%, which is about the same as 96.5% during the previous flu season. The state as a whole has maintained a rate above 96% for the past three flu seasons. Information on hospitals with mandatory employee vaccination policies was first added to the Guide in 2012. In FY 2015, the number of hospitals that reported mandatory employee vaccination policies did not change from last year with 45 of 46 hospitals having a policy in place.

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 (MHA), 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 the 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.

Healthcare-Associated Infections Data Collection

HAI Data Public Reporting
With the focus shifting to align with CMS reporting requirements, several new reporting requirements occurred in 2014. The NHSN continues to be the vehicle for collecting these data. 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).

The current reporting requirements are: (1) Central-Line-Associated Bloodstream Infections (CLABSIs) in all intensive care units with an expansion to adult and pediatric medical, surgical and medical/surgical wards effective January 1, 2015; (2) Catheter-Associated Urinary Tract Infections (CAUTIs) in all intensive care units (effective January 1, 2014) with an expansion to adult and pediatric medical, surgical and medical/surgical wards effective January 1, 2015; (3) Surgical Site Infections (SSIs) for coronary artery bypass graft (CABG), hip (HPRO), knee (KPRO), colon (COLO) and abdominal hysterectomy (HYST) surgeries; (4) Health Care Worker (HCW) Influenza Vaccination; (5) *Clostridium difficile* infections (CDI) in all inpatient locations (baby locations are excluded) (effective July 1, 2013) with an expansion to emergency departments and 24-hour observation locations (effective January 1, 2015); (6) Methicillin-resistant *Staphylocccus aureus* (MRSA) bacteremia in all inpatient locations (effective January 1, 2014) with an expansion to emergency departments and 24-hour observation locations (effective January 1, 2015). Of note, the Health Care Worker (HCW) Influenza Vaccination reporting requirement moved from using an in-house survey to the NHSN Health Care Personnel (HCP) Influenza Vaccination module with the 2013/2014 flu season.

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 2015, the CLABSI data was updated with calendar year 2014 data. The updated data showed a 50% reduction in CLABSIs in Maryland adult/pediatric ICUs, with 151 CLABSIs. Maryland NICUs saw a 29% reduction in CLABSIs with 29 CLABSIs reported for calendar year 2014. 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, meaning there were less CLABSIs reported than expected. As noted earlier, the SIR will likely be impacted negatively next year if NHSN changes the baseline time-period from 2006-2008 to 2015.

In April 2014, CY 2014 CDI data was first reported on the Maryland Health Care Quality Reports website. While six hospitals performed better than expected, 17 hospitals and the state overall performed worse than expected, with 2,536 hospital-onset CDI LabID events reported.

In July 2015, the surgical site infections data for Hip, Knee, and CABG procedures were updated on the Guide with CY 2014 data. Colon and Abdominal Hysterectomy SSI data for CY 2014 were reported for the first time as well.

CY 2014 data for CAUTI in ICUs and LabID MRSA Bacteremia will be reported for the first time in October 2015.

In FY 2015, HQI staff continued to participate in a multi-state workgroup to standardize HAI data display for both technical and consumer audiences. Biweekly conference calls are held and representatives from CDC and CSTE facilitate the process. Commission staff presented, drafted, and reviewed several sections of the toolkit.

HQI staff hosted two graduate student interns from Johns Hopkins University School of Public Health in 2015 The projects focused on health care worker influenza vaccination in long-term care facilities and ambulatory surgery centers, respectively.

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. In FY 2015, the CLABSI, CAUTI, SSI, CDI and MRSA Bacteremia data from Quarter 1 and Quarter 2 (CDI and MRSA only) 2014 in NHSN was reviewed along with hospital lab data and HSCRC administrative data. The results are being finalized and will be reported to hospitals in during the fourth quarter of 2015.

Long Term Care Quality Initiatives

Overview

Long Term Care Quality and Performance focuses on improving long-term and community-based care through public reporting of long term care (LTC) service provider descriptive information and 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 Maryland LTC service providers, including specific performance and quality measures applicable to each

service category. The Long Term Care Guide can be accessed through the new *Maryland Health Care Quality Reports* website.

Maryland Annotated Code, Health General 19-134 d requires the Commission to "implement a system to comparatively evaluate the quality of care and performance of nursing facilities on an objective basis…and annually publish summary findings…" The stated purpose is to "improve the quality of care provided... by establishing a common set of performance measurements and annually disseminating the findings…to facilities, consumers and other interested parties".

Description of Key Programs

The Commission, in 2001, developed a *Nursing Home Guide* which transformed in 2010 into the comprehensive Consumer Guide to Long Term Care. The transformation was initiated to respond to the trend to "age in place" – a consumer preference for receiving care in the home or in a home-like setting. The interactive Consumer Guide includes information on services received in one's home, community, or in facilities such as assisted living and nursing homes, with emphasis on in-home and community services. Information categories include living at home, adult day care, assisted living, home-based care such as home health agencies that provide skilled care, nursing homes and rehabilitation facilities, and hospice services. Key features of the *Consumer Guide* include:

Planning for Long Term Care - This feature defines key terms and types of LTC services; offers resources for planning, and links to resources for estimating the cost of LTC; discusses ways to finance LTC; and provides Maryland-specific advance directive planning information. It includes:

- Information about home modifications to allow seniors and persons with disabilities to remain in their home;
- Locations of community support services, such as senior centers, meal programs, resources for family caregivers, and transportation;
- A resource section that includes links to federal, state, and local websites to assist in answering questions about prescription drugs, legal resources for seniors and persons with disabilities, and local resources for health care such as county clinics; and
- Guidance on health insurance benefits, Medicare, special transportation for persons with disabilities, and resources for family members or friends who help seniors and persons with disabilities.

Services Search - The *Consumer Guide's* interactive search tool assists users in locating LTC services by facility type and county. Users can view 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, as well as a location map, are displayed to assist Marylanders in narrowing their choice without having to travel.

Quality and Performance Reporting - Users can view an extensive set of quality and performance measures for nursing homes and Medicare certified home health agencies, as well as several important measures for assisted living. Measures include: the results of the Office of

Health Care Quality (OHCQ) annual and complaint surveys; staff influenza vaccination rates; results of the Experience of Care (satisfaction) surveys; and outcome and process measures on many clinical aspects of care. Division staff work with federal agencies such as the Centers for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ) and other national organizations such as the National Quality Forum (NQF) to ensure that the quality measures reported within the Consumer Guide are reliable, validated, and suitable for public reporting.

Nursing Home Experience of Care Surveys

Staff in the Long Term Care Quality and Performance division design, develop, and provide oversight for the administration of surveys. The Family Experience of Care Survey (Family Survey) 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. The Short Stay Resident Experience of Care Survey (Short Stay Survey) contains similar measures and is completed by recently discharged nursing home residents with a short stay for rehabilitation or following an acute illness. Short Stay Survey results are also posted on the guide. Results of the Family Survey for each nursing home are displayed within the Consumer Guide to assist Marylanders when choosing a nursing home. The most recently posted are the 2014 Family Survey results, which are also used by the Medicaid Long Term Care Division within the Department of Health & Mental Hygiene as one of four factors in calculating the Medicaid Nursing Home Pay for Performance Program.

Home Health Experience of Care Survey

CMS requires all Medicare-certified home health providers to participate in the Home Health CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey. The first HHCAHPS survey results were released in April 2012. The Maryland HHCAHPS results are incorporated into the Consumer Guide for consumer use.

Future Hospice Experience of Care Survey

CMS announced expansion of hospice measures beginning in calendar year 2014. MHCC staff is closely following this process so the Consumer Guide can be expanded when new measures are available.

Staff Influenza Vaccination Survey in LTC Settings

Influenza infection causes considerable morbidity and mortality among older adults. Persons aged 65 years and older account for the majority of the 36,000 deaths that occur from flu and its complications each year. Commission staff assumed responsibility for collection of the number of nursing home staff receiving influenza vaccination 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. Additional survey questions also assess:

- Adoption of a mandatory influenza vaccination policy by nursing homes;
- Measures to raise awareness among staff of the importance of influenza vaccination;

- Strategies to ensure compliance with flu policy or to limit the spread of influenza; and
- Methods used to document staff influenza vaccination status.

An Influenza Vaccination Survey for staff working in assisted living residences was initiated by MHCC during the 2011-2012 influenza season. Data collection continued for the 2012-2013, 2013-2014 and 2014-2015 seasons. Individual facility results are reported in the Consumer Guide to Long Term Care.

National Efforts
As noted earlier, division staff collaborate with national organizations, including the Centers for Medicare and Medicaid (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the National Quality Forum to ensure that quality measures are validated, reliable, and suitable for public reporting. Division staff follow advancements taking place at the national and regional level to maintain Maryland LTC quality efforts at the cutting edge.

MHCC staff was part of a significant collaboration with AHRQ by testing the Short Stay Survey in Maryland. This collaboration benefits AHRQ by providing additional field testing of the instrument and MHCC benefits by piloting an experience survey among nursing home short stay residents which was adopted for use in Maryland. Results are now available for four survey cycles: 2012, 2013, 2014 and 2015.

Accomplishments

Consumer Guide to Long Term Care
Outreach – staff conducted informal feedback sessions with the directors of senior centers and senior center participants in several counties. A standard feedback form was used to solicit opinions about selected guide features. The informal feedback provided Commission staff with an opportunity to showcase the Guide features and provided information to guide future revisions.
Structured feedback – formal focus groups were held in FY 2015 to solicit more expansive feedback on Guide features. Participants represented a mix of gender, age, race/ethnicity, counties of residence, use of LTC, education, and household income.

Nursing Home Experience of Care Survey Results
2014 Family Survey results show that statewide "overall satisfaction" was rated 8.3 on a scale of 1-10 (10 represents the best rating); this represents no change from the prior year. Additionally, 88% of respondents said they would recommend the nursing home to others representing a slight decrease from the 90% in the prior year.

The Maryland Family Survey consistently yields a response rate of over 50%, which is well above the national average for similar surveys.

Influenza Vaccination Survey among Nursing Home Health Care Workers (HCWs)
The average vaccination rate for nursing home HCWs for the 2014-2015 influenza season was 85.5%, an increase of about 6% from the prior year and a 28% increase since public reporting began. Maryland nursing homes report a significantly higher rate than the national estimates reported by CDC for LTC health care workers, which was 64% in 2014-2015 flu season.

Public reporting of nursing home-specific results has been in place since 2011 as an incentive for facilities to improve their HCW vaccination rates. Additionally, the Commission also implemented a recognition program for nursing homes. Recognition certificates are sent to nursing homes that achieve a HCW vaccination rate of 95% or better. The number of nursing homes achieving recognition increased from 54 for the 2013-2014 flu season to 95 nursing homes in 2014-2015.

Implementation of a mandatory influenza vaccination policy by nursing homes increased in the 2014-2015 collection year: 46.1% of nursing homes reported implementation of a mandatory employee influenza vaccination policy compared to 31.3% for the prior year; another 11.3% reported no current mandatory employee influenza vaccination policy, but plan to implement a policy for the 2015-2016 flu season.

Assisted Living Staff Influenza Vaccination Survey

The average assisted living staff vaccination rate for the 2014-2015 influenza season was 57.9% compared to 53.2% for the 2013-2014 season. Assisted living staff vaccination rates are compared to the general population rather than health care workers.

Home Health Experience of Care

The Commission's Maryland Guide to Long Term Care Services has reported the 22 Home Health Compare quality measures for each Maryland Medicare-certified HHA since the fall of 2011. Public reporting allows greater transparency to the consumer of an agency's relative performance to that of others. Medicare-certified Home Health Agencies (HHAs) in Maryland that serve 60 or more patients in a year participate in the HHCAHPS Survey. HHCAHPS reports three composites: how well staff communicated, to what degree staff gave care in a professional way, and to what degree the home health staff discussed medications, pain, and home safety, and reports two overall questions: an overall rating on a scale of 1-10 (10 represents the best rating) and "would you recommend the home health agency?"

The average Maryland rating for home health providers for 2013 shows the three composites were rated above 80%. The percent of patients giving the HHA an overall rating of 9 or 10 was 82%; the percent of patients reporting that they would definitely recommend the HHA to friends and family was 77%. Comparing 2013 aggregate Maryland and national scores for the five experience of care measures, Maryland demonstrates scores equal to the nation on two measures and worse scores for three measures.

2013 results showed the HHA scores range from a high of 99.4 for the measure "checking the patient for the risk of developing pressure sores" to 53.9 for "how often patients got better at taking medications by mouth." Comparing 2013 aggregate Maryland and national scores for the 22 outcome and process measures, Maryland demonstrates better scores than the nation on 11 measures; scores equal to the nation on 6 measures; and, scores worse than the nation for 5 measures.

Hospice Quality Reporting
CMS has implemented a hospice item set ("HIS"). The HIS is a set of data elements that can be used to calculate 7 quality measures:

- NQF #1641 – Treatment Preferences;
- NQF #1647 – Beliefs/Values Addressed;
- NQF #1634 & NQF #1637 – Pain Screening and Pain Assessment;
- NQF #1639 & NQF #1638 – Dyspnea Screening and Dyspnea Treatment; and
- NQF #1617 – Patients treated with an Opioid who are Given a Bowel Regimen.

Hospices began using the HIS for all patients beginning July 1, 2014. The staff will follow developments in this area as this effort is likely to result in more definitive hospice quality measures for future reporting periods. Quality measures will be adapted to the Long Term Care Guide as appropriate.

Health Plan Quality and Performance

Overview

Health Benefit Plan Quality and Performance staff develops and implements clinical, member satisfaction, and disparities quality measure sets, then collects and reports meaningful, comparative information regarding the quality and performance of commercial health benefit plans licensed to operate in the State of Maryland. The meaningful, comparative information supports employers, employees, individual purchasers, academics, and public policymakers, in assessing the relative quality of services provided by health benefit plans that are required under COMAR 10.25.08 to report to the Maryland Health Care Commission. Health-General Article, Section 19-134(c), et seq. is the statute that gives MHCC its authority 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 MHCC to solicit and publish data collected using standardized health benefit plan quality and performance measurement instruments. MHCC currently utilizes the Healthcare Effectiveness Data and Information Set (HEDIS)®, which focuses on measuring clinical performance; the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which focuses on health benefit plan members' satisfaction with their experience of care; Maryland Race/Ethnicity, Language, Interpreters, and Cultural Competency Assessment (RELICC)™, which focuses on disparities issues; Maryland Plan Behavioral Health Assessment (BHA), which details the behavioral health care provider network; and Maryland Health Plan Quality Profile (QP), which centers on carrier-specific health care quality improvement initiatives in Maryland. 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 delivery system that a health benefit plan is structured as, including delivery system categories such as Health Maintenance Organization (HMO) plans, Preferred Provider Organization (PPO) plans, Point of Service (POS) plans, Exclusive Provider Organization (EPO) plans, or any other type of delivery system category that may be introduced in the future.

Using quality and performance information supports informed health care choices and aids in the selection and purchase of the best quality of care specific to the needs of each consumer, whether the consumer is an employer, individual, or family. Public reporting of standardized quality and performance measures and indicators promotes competition among health insurance carriers and stimulates their health benefit plans' efforts toward continuous quality and performance improvement activities that target consumer needs and expectations. In theory, the result of developing and reporting quality information is that quality attains a value in the open market. As health benefit plans begin to compete on the basis of quality, they will devote greater attention and resources to quality improvement activities. Ultimately, high performing health benefit plans should be rewarded with greater market share as quality begins to influence consumer choice. We are proud to be driving continuous health care quality improvement in the State of Maryland through publicly reporting meaningful, comparative information on health benefit plan quality and performance.

Accomplishments

MHCC annually produces a series of three Quality Reports. This 2015 Quality Report series shows that the overall performance of Maryland's health benefit plans has declined. In fact, while the majority of Maryland PPOs generally performed at or better than the national average, the majority of HMOS generally performed worse than the national average on a list of more than one hundred quality measures being publicly reported. Among the nation's top performing plans, Maryland's individual PPOs performed at or above the top 10% of plans nationally on 42 measures, while individual HMOs performed at or above the top 10% of plans nationally on 37 measures. Regarding health benefit plan performance on consumer satisfaction measures, results vary. On the all-important measure where consumers rated their health plan as good or better, while five of the eight PPOs and two of seven HMOs scored among the average of plans nationally, only three of eight PPOs and none of seven HMOs scored among the top 10% of plans nationally. Maryland's health benefit plans are highly committed to, and actively engaged it, activities and initiatives that are aimed at continuous quality improvement. The following are brief descriptions of each of the three Quality Reports:

MHCC Consumer Edition, Quality Report.
Quality measures within the new Consumer Edition focus on plan member experience and satisfaction with health care on topics such as getting needed care, getting care quickly, how well doctors communicate, plan information on costs, rating of their personal doctor and their specialist(s), and rating of their health benefit plan. The information is presented in easy to understand bar charts and provides a sketch of how members feel about their health benefit plan experience.

MHCC Comprehensive Quality Report
The Comprehensive Quality Report incorporates important information on the clinical performance of the health benefit plans along with information from the new quality measurement instrument called the Maryland RELICC Assessment™ that measures health benefit plan activities to reduce health care disparities. Combining all the quality and performance information into one Comprehensive Quality Report provides a more detailed picture of health benefit plan performance.

Maryland Health Connection Quality Report

It should be noted that the quality data reported for the commercial health benefit plans operating outside the Exchange are used as a proxy for data from legacy qualified health plans (QHPs) operating inside the Exchange, as QHPs do not currently have one year of their own performance data to report on. The Maryland Health Connection Quality Report provides consumers with a quick and easy reference to summary HDC 5-Star™ rates that reflect plan performance on a roll up of all of the quality measures from the five quality measurement instruments used for quality reporting by plans.

We obtain valuable key stakeholder input on issues related to public reporting on health benefit plan quality. Each year Commission staff launches a planning process that involves stakeholder input by employer and carrier partners for the quality and performance reporting requirements and general information on quality reporting and other public reporting documents on quality. Staff identifies presentation approaches and the quality measures that will be used in the next report. Quality measures that are no longer deemed appropriate are retired, promising new measures are added, and sometimes, existing measures are redefined. Employers and carrier representatives play important roles in this planning effort. Employers are helpful in identifying measures that would be most useful to their employees and dependents. Opportunities for stakeholder input have also expanded significantly this year by convening a standing Quality Assurance and Quality Improvement Workgroup of key stakeholders that includes representation by employers, carriers, and lay consumers.

Specific quality metrics are also cited as "focus measures" for quality improvement in the coming year. In this manner, carrier resources can be allocated to appropriate programs and initiatives in Maryland where health benefit plans demonstrate a need for quality improvement. Such controlled expansion and enhancement facilitates continuous quality improvement on the part of each health benefit plan participating in the MHCC Quality and Performance Evaluation System and thereby reporting on required quality metrics.

To ensure that reported information is accurate, audits of commercial health benefit plans are conducted annually. Quality and performance data integrity issues related to the accuracy and completeness of carrier reporting that were identified by MHCC and its audit partner were successfully resolved by staff working with the health benefit plans. This audited data provides a higher level of data validation when reporting performance results in the MHCC and MHBE quality and performance reports.

MARYLAND HEALTH CARE COMMISSION

Center for Health Care Facility Planning and Development

Acute Care Policy and Planning

Overview

The Acute Care Policy and Planning Division is responsible for health planning and policy analysis related to acute care services. This includes services for general hospital and short-stay special hospitals, ambulatory surgical facilities, residential treatment centers, and intermediate care facility/substance abuse treatment. Planning for these services is supported by data collection. The Division administers two annual surveys and receives and maintains two service registry data sets created by national organizations. It undertakes special policy and planning studies as needed. The Division coordinates its acute 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 applicable acute care facility service issues.

Accomplishments

State Health Plan

Cardiac Services

Commission staff began developing detailed regulations regarding external review for percutaneous coronary intervention (PCI) services in FY 2015, through consultation with the Cardiac Services Advisory Committee (CSAC). The CSAC is a new standing advisory committee that met for the first time in November 2014. It includes representatives from Maryland hospitals and health care systems, a consumer representative, and representatives from other key organizations. In addition to obtaining feedback from the CSAC, Commission staff posted draft regulations twice for informal public comment (in April and June of 2015). In July 2015, the Commission approved proposed regulations to amend COMAR 10.24.17. The amended regulations are essential for assuring a consistent approach to external review of PCI cases. External review requirements are intended to assure that Maryland hospitals are using PCI services appropriately.

Commission staff also evaluated two requests for Certificates of Conformance to add elective PCI services at hospitals. Carroll Hospital Center and Upper Chesapeake Medical Center already had established primary PCI services and successfully operated these services under "waiver"

authorizations from MHCC for over four years. In December 2014, both hospitals were granted approval to add elective PCI services.

A 2019 projection of cardiac surgery case volume was published in the *Maryland Register* on February 6, 2015. The projection is used to evaluate Certificate of Need applications from hospitals seeking to adding cardiac surgery services.

Organ Transplantation
Staff convened a work group to discuss issues to be addressed in an update of the Sate Health Plan (SHP) chapter for organ transplant services. This follows development of a White Paper in FY 2014, which identified problems and issues in organ transplantation services to be considered in the plan update. The work group met three times during FY 2015, and the final meeting was held in July, 2015.

Freestanding Medical Facilities
Staff developed a draft State Health Plan chapter to guide CON regulation of these facilities, which has operated under "pilot" project status for several years, but can be proposed for establishment by hospitals through CON review effective July 1, 2015. A work group was established to assist staff in further development of these regulations. The work group was first convened in August, 2015.

Regulatory Activity

Society of Thoracic Surgeons' (STS) National Database
In FY 2014, the Commission mandated that hospitals providing cardiac surgery services submit to MHCC the data that they submit to the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database. Staff began collecting this data from hospitals in FY 2015. In addition, MHCC initiated an audit of the data. The audit is expected to be completed before the end of calendar year 2015. The data base will be used to evaluate the performance of Maryland cardiac surgery programs.

Reports

Acute Care Hospital Bed Inventory
A report on the changes in licensed acute care hospital beds in Maryland was posted on the MHCC website in August 2014. This interim report was replaced in October, 2014 with a new FY 2015 edition of MHCC's Annual Report on Selected Maryland Acute Care and Special Hospital Services. The full report covers hospital bed and selected service inventories, including information on emergency department services, surgical services, obstetric and perinatal services, and psychiatric facilities and services.

For the fifth consecutive year, Maryland's licensed acute care hospital bed inventory declined. Effective July 1, 2014, Maryland's 46 acute care general hospitals were licensed for a total of 9,804 acute care beds. The licensed bed inventory in the state has shed 1,076 acute care beds since FY 2010, a 9.9% decline. The interim report can be viewed at:
http://mhcc.dhmh.maryland.gov/hospital/Documents/hospital_services/FINAL_Update_LicensedAcuteCareBeds_FY2015.pdf

Maryland Ambulatory Surgery Provider Directory
The seventeenth edition of the Commission's Maryland Ambulatory Surgery Provider Directory was published on the MHCC website in March, 2015. It provides information for CY 2013 on 334 freestanding centers providing outpatient surgery and on outpatient surgery at the 46 general hospitals operating in 2013. The Directory includes utilization data, surgical specialties, and contact information. The survey used as an information source for this directory provides the core data for the Commission's web-based Maryland Ambulatory Surgical Facility Consumer Guide. Raw data from the survey can be accessed on the Commission's web-based Public Use Files.

Study of the Impact of Rate Setting for Freestanding Medical Facilities
Staff completed this study, mandated by the General Assembly, in December 2014 and presented the study to the Commission at its January 2015 meeting. In addition, Staff presented MHCC's study of the impact of rate setting on freestanding medical facilities to the House Health and Government Operations Committee on February 10, 2015.

Policy Coordination with Other Agencies and Stakeholders

Throughout FY 2015, staff participated in selected meetings of the following agencies, or groups convened by these agencies, to assure appropriate coordination and collaboration on policy and regulatory matters: General Assembly committees, individual legislators, the Health Services Cost Review Commission, the Office of Health Care Quality of the Department of Health and Mental Hygiene and other units of DHMH, the Maryland Institute for Emergency Medical Services and Systems, and the Maryland Department of Planning.

A quality improvement organization was formed by Maryland hospital cardiac surgery programs in the latter half of 2013, known as the Maryland Cardiac Surgery Quality Initiative. The Chief of the Acute Care Policy and Planning Division serves as an ex officio (non-voting) member of MCSQI's Board, attending and participating in Board meetings of this organization. In FY 2015, MHCC hosted the Annual Meeting of this organization.

Long Term Care Policy and Planning

Overview

The Long Term Care Policy and Planning Division is responsible for health planning and policy analysis related to community-based and institutional long term care and post-acute care services. This includes comprehensive care facility, or nursing home, services, home health agency services, hospice services, and special hospital-chronic services. Planning for these services is supported by data collection. The Division administers three annual surveys and undertakes special studies as needed. 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 long-term care facility and service issues.

Accomplishments

State Health Plan

Updating the Home Health Agency (HHA) Chapter

In preparation for updating and revising the HHA Chapter to the State Health Plan, Commission staff developed a *White Paper: A New Approach for Planning and Regulatory Oversight of Home Health Agency Services in Maryland.* This background paper proposed a conceptual framework for regulating HHA services and described the landscape of Maryland's HHA industry, including the supply and geographic distribution of HHAs, as well as utilization trends and underlying factors contributing to changes in utilization. Agency-specific quality and performance scores publically reported on CMS' Home Health Compare, based on process and outcome measures as well as experience of care measures, were also reviewed. Issues regarding certain aspects of the Commission's current regulatory approach for development of HHA services in Maryland were described and addressed. An HHA Advisory Group convened for three meetings from February through April of 2015 to review the issues and possible new regulatory approaches outlined in the White Paper, as well as to discuss other relevant concerns. Participants on the HHA Advisory Group consisted of representatives from Maryland HHAs of varying size, geographic location, and type, most of whom were nominated by the Maryland National Capital Homecare Association (MNCHA), and a representative of a local health department that provides HHA services. Other representatives included a Residential Service Agency (RSA) provider, a consumer, payers, as well as State and federal regulatory agencies. More information on the White Paper and meetings of the 2015 HHA Advisory Group including agendas, meeting summaries, and presentations are available on the Commission's website at:
http://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_hha.aspx.

Hospice Education and Outreach

During the 2014 legislative session, Senate Bill 646 State Health Plan-Licensed Hospice Programs-Certificate of Need Review, was introduced, but did not pass. As a result of discussions among staff of the Commission, staff of the Hospice and Palliative Care Network of Maryland, and members of the General Assembly, it was agreed that the Commission would convene workgroups on hospice education and outreach. Since the initial hospice need projections indicated need in Baltimore City and Prince George's County, the initial workgroup focus was in those jurisdictions. In preparation for convening the workgroup, Commission staff met with providers serving those counties. In June of 2014, staff met with representatives of the nine providers authorized to serve Prince George's County. Similarly, in July of 2014, staff met with representatives of the eight hospices authorized to serve Baltimore City. Ideas and suggestions made by the hospice representatives at these meetings were used to develop the charge, membership, and format of the workgroups established.

The first meeting of the Hospice Education and Outreach Work Group was held October 10, 2014 at the Prince George's County Health Department. Invited participants included: legislators, hospice providers, representatives from hospitals, clergy, and the local health department, At that meeting, Dr. Stephen B. Thomas, Director of the Maryland Center for Health Equity at the University of Maryland School of Public Health, and a Commissioner, made a presentation entitled:

"End of Life in Black and White: Building Trust between Hospice Providers and the African American Communities." He explored reasons that African Americans might be resistant to the use of hospice services. There was also discussion of next steps for providers in reaching out to improve hospice utilization.

The second meeting was held on October 28, 2014 in Baltimore City. For this meeting, there was a three-member panel. Arnold Eppel, Director, Office of Aging and CARE Services, Baltimore City Health Department, discussed his efforts in education and outreach in the African American community. He has worked with many churches, and also has done presentations at Senior Centers and has arranged tours of hospices for clergy. G. I. Johnson, of the Church Outreach Initiative, Department of Aging, described his work with Mr. Eppel, helping him to gain entrée into the African American churches. Dr. Kerry Schnell, Johns Hopkins Bayview, presented the results of her research on the educational initiatives and their impact on participants.
During the interim, hospices were encouraged to update the Commission staff on their education and outreach activities. A meeting on Hospice Education and Outreach was held on June 9, 2015. This meeting was co-sponsored by the Commission and the Hospice & Palliative Care Network of Maryland. Unlike previous meetings which focused on Baltimore City or Prince George's County, this meeting was targeted to all hospices statewide. Speakers included Cozzie King and Diane Hill Taylor of the Diversity Council of the National Hospice and Palliative Care Organization (NHPCO) speaking on: Inclusion and Access: Engagement, Education, Evaluation and Assessment. In addition, Dr. Christina Puchalski, a palliative care physician and Director, George Washington Institute for Spirituality and Health, presented: *There is Going to Be a Miracle - Decision Making When Religious Beliefs and Medical Realities Conflict.*

Nursing Home Bed Need Projection
Corrected and updated nursing home bed need projections for 2016 were published in the Maryland Register on July 25, 2014. In the course of reviewing a Certificate of Need application, it was found that errors had occurred in the calculation of the bed need projection for St. Mary's County published in April, 2013, which gave rise to this corrected bed need projection, which was updated for changes in the nursing home bed inventory that had occurred between April of 2013 and July, 2014.

Further work related to the St. Mary's County project review process uncovered additional computational errors with respect to the way in which adjustments for cross-jurisdictional patient migration had been made in the 2013 iteration of the nursing home bed need projections. These errors were corrected in a new iteration of the 2016 bed need projections published in the *Maryland Register* on October 3, 2014.

Nursing Home Bed Occupancy and Payor Mix
MHCC published 2013 comprehensive care facility (CCF) bed occupancy rate information in the Maryland Register on March 20, 2015. These rates are used in assessing the need for proposed additions to CCF bed additions to jurisdictional bed inventories as part of the review of CON applications. At the same time, updated information on nursing home payor mix was published. This information is used to establish required Maryland Medical Assistance (Medicaid) participation rates for CON applicants proposing to establish or expand nursing home

(comprehensive care facility) bed capacity. These reports may be found at the Commission's website at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_ltc/hcfs_ltc.aspx

Chronic Hospital Bed Occupancy

As required by COMAR 10.24.08, the Commission published information on FY2013 special hospital-chronic bed occupancy in the Maryland Register on December 1, 2014 It reports data for both private chronic hospitals (University of Maryland Rehabilitation and Orthopedic Institute; Johns Hopkins Bayview Medical Center; Levindale Hebrew Geriatric Center and Hospital; University of Maryland Medical Center Midtown Center; and Laurel Regional Hospital) as well as state hospitals (Western Maryland Center and Deer's Head Hospital Center). This report is available on the Commission's website at: http://mhcc.maryland.gov/mhcc/pages/plr/plr_ltc/documents/chcf_chronic_care_occupancy_2013.pdf

Reports

Hospital Palliative Care Programs

Legislation passed during the 2013 legislative session requires the Commission to select at least five hospital palliative care pilot programs and, in conjunction with the Maryland Hospital Association (MHA) and the Office of Health Care Quality (OHCQ), establish reporting requirements for the pilot sites and develop a report on certain aspects of, and best practices for, hospital palliative care. The Division of Long-Term Care Policy and Planning staff is leading this work because of its policy and planning responsibilities in hospice care, services that are often part of the palliative care continuum.

After working with MHA and OHCQ staff, criteria were established for use in a Request for Applications (RFA) sent to all hospitals with 50 or more beds (a statutory requirement for pilot hospitals) on October 18, 2013. From among 14 pilot hospital applicants, ten pilot programs were approved for participation in the study (an 11th was added in the spring of 2014).

A Hospital Palliative Care Advisory Group, consisting of the pilot hospitals, as well as MHA, OHCQ, and other consultant advisors was formed in December 2013. During 2014-2015, the Hospital Palliative Care Advisory Group met four times (January 29, 2014; March 25, 2014; February 23, 2015; and June 2, 2015). This group met in order to develop and implement a plan for data collection and to establish subcommittees.

It was determined that a data set developed by the Center for the Advancement of Palliative Care (CAPC) would be used for baseline information on the hospital program characteristics and an agreement between CAPC and the pilot hospitals allowing MHCC to access the data was established. In addition, a patient level data set would be created for the 12-month period ending June 30, 2015, using the HSCRC discharge data base, that would allow for comparative analysis of the in-hospital experience of patients receiving a palliative care consult, discriminating between those that accept inclusion of palliative care measures in their plan of care and those that do not. Pilot hospitals agreed to flag all palliative care patients for whom a palliative care consult was done.

During 2015 additional work was done to collect data on how the pilot hospitals comply with National Quality Forum preferred practices. These will be used to make recommendations in the report. The final report is due to the General Assembly on December 1, 2015. Information on this project may be found at:
http://mhcc.dhmh.maryland.gov/Pages/HPCP_Project.aspx

Data

Long Term Care Data Sets

CMS Nursing Home Minimum Data Set (MDS)
FY 2015 was the fourth year of a four-year contract with Myers and Stauffer to update the MDS Manager Program, which had been developed between 2009 and 2011 to maximize the utility of the Center for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) Resident Assessment Instrument. This nursing home data set supports planning and policy development and related research necessary for the Commission to fulfill its responsibilities. Prior to FY 2014, federally mandated changes from MDS 2.0 to 3.0 were addressed by the MDS Manager Program and the programming language was updated to SAS, the statistical analysis platform used at the Commission.

During FY 2015, the MDS Manager Program was updated; work was done on programming needed to support the Consumer Guide for Long Term Care, programming to support the MHCC Long Term Care Survey, and various component reports. In addition, staff worked with staff of the Office of Health Care Quality to send out a joint letter to nursing homes to assure that Section S of the Long-Term Survey (state-specific items) was fully completed. The Section S items include demographic and payer source data that are no longer collected under MDS. For this year, data completion for Section S was compiled on a facility level in order to provide feedback for each facility which had a less than 90% completion rate. OHCQ staff will monitor this data completion as they conduct surveys. The data use agreement (DUA) with the Centers for Medicare and Medicaid Services (CMS) has been extended through March, 2016.

Since this four-year contract ended in June, 2015, Myers and Stauffer produced an updated End User Manual, Architectural Description, and conducted training sessions for staff. Staff has begun work on an RFP to obtain vendor support for continuation of the MDS Manager work.

Long-Term Care Set (Comprehensive Care Facility, Assisted Living, Special Hospital-Chronic, and Adult Day Care Facilities)
The public use data sets for FY 2013 for the four licensure categories, Comprehensive Care, Assisted Living, Special Hospital-Chronic, and Adult Day Care facilities, covered by the Commission's annual Maryland Long Term Care Survey were completed and made available on the Commission's web site in March, 2015. This data set is used to create the nursing home occupancy report, and participation by payer source report, both of which are published in the *Maryland Register*. Also, long term care data supports the Commission's Consumer Guide to Long-Term Care, and provides data and trend information needed to support Certificate of Need (CON) regulation.

The 2014 Long Term Care Survey data collection began on March 23, 2015 for all facility providers and ended on April 21, 2015 for Comprehensive Care Facilities (CCFs) whose collection include the User Fee Assessment and data usage of health information technology (HIT) and electronic health records (EHR) by CCF's. Chronic Care, Assisted Living and Adult Day Care Centers data collection due date was May 21, 2015.

Home Health Agency Data Set
The Home Health Agency utilization tables for fiscal year 2013 were posted on the Commission's website in December 2014. The data provides an overview of home health agency characteristics, utilization, and costs, including: volume of admissions; referral sources; primary diagnosis on admission; average visits per Medicare client; disposition; revenues by payer type; and home health agency personnel. A public use data set has also been posted. Data from this survey is used to update the Commission's Consumer Guide to Long Term Care on home based care, and provides information needed to support CON regulation.

The fiscal year 2014 Home Health Agency Survey data collection period began on May 21, 2015 and ended on July 20, 2015.

Hospice Data Set
Preparation of the public use hospice data set for FY 2013 was primarily completed by November, 2014. At that time, staff noticed anomalies in the total patient days variable. In addition, an issue was brought to our attention regarding county allocation of patients. The data was updated and the public use data set was posted in December, 2014. These data was obtained from the Commission's annual Maryland Hospice Survey, an online survey instrument. The FY 2014 Hospice Survey, with a data collection period spanning February 11, 2015 to June 11, 2015, updated the previous data collection. Staff worked with hospice providers to assure accuracy in preparation for posting of the FY 2014 hospice data in a public use data set.

Policy Coordination with Other Agencies and Stakeholders

Meetings/Conferences

MNCHA 2014 Annual Meeting
Commission staff attended the 2014 Annual Meeting of the Maryland-National Capital Homecare Association (MNCHA), "Collaborations and Innovations to Support our Region's Health Care Needs" held in September of 2014. Three speakers addressed the audience during the morning session. Carmela Coyle, President and CEO, Maryland Hospital Association, kicked off the meeting with her presentation *"Maryland on the Leading Edge: Transforming Healthcare"* during which she spoke about the changes in the hospital payment system creating challenges and opportunities for acute care hospitals to foster new and different partnerships with post-acute care providers. Chet Burrell, President and CEO, CareFirst BlueCross BlueShield, provided an overview of its Patient-Centered Medical Home (PCMH) Program established in 2011 for non-Medicare patients, which has resulted in a reduction in hospital utilization as well as the overall rate of increase of medical spending for its members. Mary Ellen Conway, President, Capital Healthcare Group, presented *"Thinking Outside the Box: The Challenges of Finding Alternative Revenue Sources for Home Care,*

Hospice and DME." Software company representatives demonstrated some of the latest in home care innovation and information technology. During the afternoon's breakout session, meeting participants were able to choose from three different tracks based on type of provider: HHAs, RSAs, and DMEs. Topics related to HHAs included: *"Episode Management – Driving Better Patient Outcomes and Reducing Re-Hospitalizations;" "Building a Strong Compliance Program: Avoiding the 2014 Top 10 Deficiencies;" and "Crossing the Quality Chasm in Home Care with Health Information Technology."*

Palliative Medicine Symposium
Staff attended the 3rd Annual Baltimore-Washington Palliative Medicine Symposium in October of 2014. Carmela Coyle, President of the Maryland Hospital Association presented an overview of health policy changes in Maryland. Other presentations included: Jill Johnson, who presented the personal impact of dealing with end of life issues; Dr. Christopher Kearney discussing "Transdisciplinary Teams," which includes a team composed of varied disciplines who "reach into the spaces between disciplines" to learn from each other; Rene Mayo, who presented background on preparation for The Joint Commission accreditation process for palliative care; Dr. Simran Malhorta, who described the personal issues of dealing with end-of-life care in various cultures; Dr. Kathryn Walker, who described an innovative project funded by Verizon which provided wireless tablets to patients experiencing heart failure to permit them to have clinical conferences via Skype to check educational resources and physician recommendations to update medications; and Terry Altilio of Beth Israel Hospital in New York, who discussed the need to focus on the patient and family needs during family conferences.

Hospice and Palliative Care Network Annual Meeting
Staff attended the annual meeting of the Hospice and Palliative Care Network of Maryland in November of 2014. The opening session was presented by Dr. Joan Harold, who explained how changing CMS requirements and oversight affect coding and patient care for hospices. Following that, breakout sessions were held on administrative, clinical, psycho-social/spiritual, program innovation, and billing. Staff attended sessions on: "Moving Hospice Upstream", which discussed opportunities for hospices to partner with providers such as hospitals and health systems; "Upstreaming Palliative Care: The Experience of a Community Cancer Center," which described the development of palliative care in an outpatient cancer center and some issues with physician referral; *"Challenging Conversations: Amen and the Hope for a Miracle",* which explained different religious perspectives in death and dying; and *"New All-Payer Model for Maryland Population-Based and Patient-Centered Payment Systems,"* which presented the new HSCRC waiver and its impact on hospices. Topics discussed at this conference covered hospice, education and outreach, and hospital palliative care.

Certificate of Need (CON)

Overview

The Certificate of Need (CON) Division implements the Commission's statutory authority 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: (1) establish new facilities or services; (2) relocate facilities; (3) modify existing facilities or previously approved projects: (4) incur capital expenditures for projects that exceed a set dollar threshold, or: (5) close certain facilities or services. In administering the program, the Commission also issues determinations of coverage, providing guidance on the regulatory requirements for health care facility capital projects and validating compliance of persons undertaking health care facility projects that, while not requiring a CON, may be required by law to provide certain information to the Commission in a prescribed form.

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 are also evaluated against five additional general criteria. These are need, viability, impact of the project, 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 previously issued to the applicant.

Accomplishments

Certificate of Need Applications and Modifications

During FY 2015, the Commission approved six (6) CON applications. No applications were denied. It also reviewed and approved three (3) modifications to previously approved projects. One CON application was withdrawn by the applicant.

During FY 2015, applicants for two major general hospital replacement and relocation projects submitted replacement applications for CON applications originally filed in FY 2014. The replacement applications contained financial projections that were re-worked by the applicants to reflect the implications of a new hospital payment model implemented by HSCRC after their initial applications were filed. This new payment model required the applicant hospitals to revise the financial projections made in their applications to align with the Global Budget Agreements negotiated with HSCRC. These applications were docketed in the second half of FY2015 and it is anticipated that both will be brought to the Commission for action in FY 2016. Two other hospitals filed major renovation or replacement applications late in the fiscal year and are also expected to be acted on in FY2016.

Approved CONs

Palisades Eye Surgery Center (Montgomery County)

Relocation of the surgery center within the same office building and addition of two operating rooms. *Approved cost of $3,637,265.*

Talbot Hospice Foundation (Talbot County)

Establishment of a general hospice providing services in Talbot County. *Approved cost of $225,000.*

Seasons Hospice & Palliative Care of Maryland (Baltimore City)
Establishment of a 12-bed general inpatient hospice in leased space at Sinai Hospital. *Approved cost of $70,000.*

Brook Grove Rehabilitation & Nursing Center (Montgomery County)
Addition of 22 comprehensive care facility beds through replacement of a 48-bed wing, with a 70-bed wing. (Beds acquired from National Lutheran/Village at Rockville). *Approved with a condition. Cost: $25,025,000.*

Hospice of Washington (Washington County)
Establishment of a 12-bed general inpatient hospice through new construction in Hagerstown. *Approved cost of $7,015,000*

Lorien Harford Nursing & Rehabilitation Center (Harford County)
Establishment of a 70-bed comprehensive care facility in Forest Hill. *Approved cost of $12,215,376.*

Changes in Approved CONs

Father Martin's Ashley (Harford County)
Project cost increase of 12.2%. Project is construction of a new building to house inpatient units, a wellness center, and a centralized admissions office, adding 15 Intermediate Care Facility-Chemical Dependency beds. *Change in Cost: $2,275,056. New Approved Cost: $20,928,056.*

NMS Healthcare of Hagerstown (Washington County)
Project cost increase of 8.5% and extension of final performance requirement. The project includes the addition of 20 beds through new construction and renovations. *Change in Cost: $971,728. New Approved Cost: $12,426,019.*

College View Center (Frederick County)
Project cost increase of 40% and extension of final performance requirement. Project is replacement of a 119-bed comprehensive care facility with a 130-bed facility. (Beds acquired from Frederick Memorial Hospital). *Change in Cost: $5,841,944. New Approved Cost: $20,466,811.*

CON Projects Withdrawn

Ingleside at Kings Farm (Montgomery County)
Conversion of 20 comprehensive care facility beds from "exceptional" status, with limitations on direct admissions from outside the residential population of this continuing care retirement community to beds available to the general public. (Beds acquired from National Lutheran/Village at Rockville.) *Estimated cost: $160,000 for bed acquisition*

Determinations of Coverage and Other Actions

In FY 2015, the Commission issued 176 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.

Additionally, the Commission reviewed 10 requests by holders of CONs to implement their projects or parts of their approved projects ("first use review"). The Commission acknowledged four cases in which facilities with temporarily delicensed beds did not take timely action to bring these beds back into operation or to extend temporary delicensure status, thus eliminating these beds from the state's inventory. In FY 2015, all these permanently delicensed beds (220) were CCF beds.

Determinations of Coverage and Other Actions – FY 2015

NATURE OF DETERMINATION/ACTION	
Capital projects with costs below the threshold of reviewability	20
Acquisition of health care facility	74
Comprehensive-care facility(nursing home):	568
Ambulatory surgery center:	5
Home health agency:	2
Hospice agency:	1
Hospital:	2
Intermediate care facility for substance abuse treatment:	
Establishment of new physician outpatient surgery center (no more than one sterile operating room) Baltimore County (2), Baltimore City (1) , Cecil County (1), Frederick (1), Harford County (2), Prince George's (3), Montgomery County (6), and Washington County (1)	17
Changes in ambulatory surgery center facilities or operation (e.g., addition of non-sterile procedure rooms, surgical staff, surgical specialties, ownership structure)	18
Relocation of physician outpatient surgery center	1
Voidance of previously approved determination of coverage	2
Temporary delicensure of an ambulatory surgery facility	1
Temporary delicensure of comprehensive care facility beds (139 total beds)	9
Relicensure of temporarily delicensed comprehensive care facility beds (259 total beds)	19
Permanent delicensure of comprehensive care facility beds (220 total beds)	4
Addition of "waiver" beds* Comprehensive care facilities-5 (30 total beds)	4
Miscellaneous	7
TOTAL COVERAGE DETERMINATIONS	176
Pre-licensure and/or first use approval for completed CON projects (including partial first-use)	10

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

MARYLAND HEALTH CARE COMMISSION

The Center for Health Information Technology and Innovative Care Delivery

Overview

The Commission's Center for Health Information Technology and Innovative Care Delivery (Center) is responsible for advancing the adoption and meaningful use of health information technology (health IT) in the State to improve the experience of care, the health of the population, and reduce the costs of health care. The use of health IT enables electronic access to clinical information at the point of care delivery. Key aspects of health IT include electronic health records (EHRs), health information exchange (HIE), and telehealth. The Center's initiatives focus on balancing the need for information sharing with the need for strong privacy and security policies, and transforming care delivery. The Center has an ambitious plan for advancing health IT and innovative care delivery that involves:

- Advancing value-based care delivery programs;
- Identifying and addressing challenges regarding health IT implementation and interoperability;
- Promoting standards-based health IT through educational and outreach activities;
- Implementing a statewide HIE and harmonizing local area HIE efforts;
- Diffusing telehealth in long term care (LTC), ambulatory care, and in hospitals;
- Designating management service organizations (MSOs) that meet select health IT requirements; and
- Promoting electronic data interchange (EDI) between payors and providers, and certifying electronic health networks.

Health Information Technology Division

The Health IT Division is tasked with increasing the diffusion of health IT in Maryland by working in collaboration with stakeholders. Activities include assessing the adoption, implementation and optimization of health IT and its impact on clinical workflows among health care professionals. The Health IT Division works to advance the implementation and meaningful use of electronic preauthorization among health care professionals. In addition, the Health IT Division is responsible for managing the Center's health IT initiatives in LTC and diffusing EDI. The Health IT Division also establishes the criteria for MSOs that seek State designation in Maryland. MSOs focus their business model on expanding the use of EHRs and telehealth to improve the overall health of the population being served and the patient experience, while lowering cost of care.

Health Information Exchange Division
The HIE Division is tasked with facilitating the development of an interoperable system for the sharing of electronic health information and developing programs to expanding the use of health IT statewide. This includes collaborating with the State Designated HIE: the Chesapeake Regional Information System for our Patients (CRISP). The HIE Division also develops strategies to advance community-based HIE with the regional HIEs in Maryland. The HIE Division develops privacy and security policies that lead to regulations for protecting electronic health information that is exchanged through an HIE in Maryland. The HIE Division leads the Center's HIE initiatives aimed at quality improvement and public health and certifies electronic health networks (EHNs). The HIE Division is responsible for establishing programs to increase the diffusion of EHRs, meaningful use of EHRs, and manages the implementation of the State-Regulated Payor EHR Incentive Program (State incentive program).

Innovative Care Delivery Division
The Innovative Care Delivery Division supports, facilitates, and administers advanced care delivery initiatives with the aim to improve quality and efficiency of health care delivery. Advanced care delivery models include Patient Center Medical Homes (PCMH), Accountable Care Organizations (ACOs), and value-based purchasing models. The Innovative Care Delivery Division is tasked with advancing existing care delivery models and developing new models that support higher quality health care delivery, higher patient satisfaction, and health care cost control. The Innovative Care Delivery Division uses health IT as the framework for building successful innovative care delivery programs. The Innovative Care Delivery Division develops operational strategies for advanced care delivery programs statewide in support of health care reform initiatives.

Accomplishments

Electronic Data Interchange & Electronic Health Networks
The health care industry has used EDI for more than 30 years as a means for organizations to exchange information in a standardized electronic format. State-regulated payors and select specialty payors (payors) whose premium volume exceeds $1 million annually are required by COMAR 10.25.09, Requirements for Payors to Designate Electronic Health Networks to report to MHCC health care claims transaction data by June 30th each year. A total of 36 payors were required to submit an EDI progress report this year; aggregate data is included in an information brief released in December. Over the past 10 years, EDI activity among Maryland payors has grown on average by roughly 4.3 percent annually to about 92 percent in 2013. This growth is attributed to payor adoption of the electronic transaction standards established by Health Insurance Portability and Accountability Act of 1996 (HIPAA).
EHNs are involved in the transmission of electronic health care claims and other health care transactions between different entities such as providers, payors, and other EHNs. All third party payors that accept electronic health care transactions originating in Maryland can only accept transactions from MHCC certified EHNs, as required by COMAR 10.25.07, Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouses. In order to achieve MHCC certifications, EHNs must provide evidence that they achieve national accreditation and meet standards related to privacy and confidentiality, business practices, physical and human

resources, technical performance, and security. Certification is valid for a two-year period. As of June 30, 2015, approximately 40 EHNs operate in Maryland.

Hospital Health IT Survey

The Center completed its annual Health Information Technology, An Assessment of Maryland Hospitals report, which evaluates health IT adoption and planning trends of all 47 acute care hospitals in the State in comparison to hospitals nationally. The report highlights diffusion of the following technologies: EHRs, computerized physician order entry, clinical decision support, electronic medication administration records, bar code medication administration, infection surveillance software, electronic prescribing. Participation in the Centers for Medicare & Medicaid Services (CMS) EHR Incentive Programs (federal incentive programs) and use of HIE services, telehealth, and patient portals is also highlighted. This year's survey also assessed hospitals use of data analytics tools for population health management. Findings from the 2014 survey revealed that approximately 85 percent of Maryland hospitals allow patients to view test results via patient portals and 40 percent of hospitals report using data analytics tools. In general, Maryland continues to meet or exceed most national hospital health IT adoption rates. Findings from the assessment are used to identify opportunities for increasing the adoption and implementation of health IT in the State.

Electronic Health Records – Meaningful Use Acceleration

Eligible providers (EPs) can earn up to $44K from Medicare or $63K from Medicaid for the adoption and meaningful use of EHRs through the federal incentive programs. EPs must meet certain requirements demonstrating their meaningful use of an EHR to receive federal incentive payments. In June 2013, approximately 37 percent of EPs had achieved meaningful use and received a federal incentive. In an effort to accelerate participation in the federal incentive programs, the Center hosted two webinars that provided an overview of the federal incentive programs. Further, the Center, in collaboration with the Department of Health and Mental Hygiene (DHMH), CRISP, and The Maryland State Medical Society, MedChi, developed a web-based meaningful use resource center (resource center) and established a statewide single point of contact to address inquiries from Maryland EPs regarding meaningful use. The Center worked with DHMH to inform practices about the resource center and the availability of the single point of contact; EPs that registered for the federal incentive program, and had not achieved meaningful use were targeted. As of December 2014, about 54 percent of Maryland EPs had achieved meaningful use and received a federal incentive.

State-Regulated Payor Electronic Health Record Incentives

Maryland law enacted in 2009, Md. Code Ann., Health-Gen. § 19-143, requires MHCC to establish incentives from certain State-regulated payors as a way to promote EHR adoption and use among practices in Maryland. At that time, roughly 19 percent of office-based physicians in Maryland had adopted an EHR compared to 22 percent nationally. The State incentive program was implemented in October 2011 through regulations. In the summer of 2013, the Center assessed the progress of the State incentive program to ensure its continued progress in meeting the intent of the law. Findings from the assessment suggested that participation rates could be increased by more closely aligning the State incentive program requirements with the requirements for the federal incentive programs. The Center, in coordination with stakeholders, simplified the program

requirements and aligned the State incentive program with the federal incentive programs; program changes were implemented on October 7, 2014.

As of March 2015, the State incentive program has provided incentives of over $8.3M to primary care practices in Maryland; participation increased by about 14 percent since April 2013, which was the last assessment period. Approximately 38 percent of the eligible primary care practices that received a federal incentive have also received a State incentive; an increase of about 27 percent from April 2013. The Center plans to target outreach and education efforts to 407 practices that have received a federal incentive but have not received a State incentive to encourage their participation. The Center also plans to continue increasing awareness of the federal and State incentive programs among the 1,248 primary care practices that have not yet participated in either of the programs.

Regional Extension Center and Management Service Organizations

CRISP received approximately $6.8 million from the Office of the National Coordinator for Health IT, with the assistance of the Center, to implement Maryland's Regional Extension Center (REC) in 2010. Under Maryland law, Md. Code Ann., Health-Gen. § 19-143 (2009), MHCC is required to designate one or more MSOs that provide hosted EHR solutions. The REC partners with State Designated MSOs to provide direct assistance to primary care physicians in selecting, implementing and meaningfully using EHRs. The REC is tasked with enrolling at least 1,000 primary care providers into the program and achieving performance milestones regarding EHR adoption and meaningful use. As of May 2015, the REC had enrolled about 1,780 primary care providers; approximately 1,100 of those providers had achieved meaningful use.

COMAR 10.25.15, Management Services Organizations–State Designation, details the requirements for an MSO to obtain voluntary State-Designation. The revised MSO State Designation requirements, effective on April 3, 2014, include flexibility in demonstrating compliance with federal and State privacy and security laws through either national accreditation or an independent third-party assessment. During the year, the Center re-certified five of the eight State Designated MSOs under the new criteria; the remaining MSOs are expected to re-certify under the new criteria by February 2016. State Designated MSOs offer services to providers in the areas of EHR planning, implementation, staff training, technical support, and becoming advanced EHR users. Additional MSO services include: 1) providing assistance with redesigning workflows and care delivery processes for optimized use of health IT, and 2) supporting providers in achieving meaningful use under the federal incentive programs. MSOs are able to provide multiple EHR products often at a reduced costs through economies of scale and bulk purchasing.

Local Health Departments

This year, the Center implemented initiatives aimed at advancing health IT adoption and use among local health departments (LHDs). In the fall of 2014, the Center conducted an environmental scan (scan) to assess EHR adoption, use and challenges among Maryland LHDs. Nearly 63 percent of LHDs have implemented an EHR; however, several challenges to health IT adoption were identified such as: cost, limited technical resources, and the ability of an EHR system to meet LHD needs. As a result of the scan, the Center began a collaborative effort with LHDs around peer-to-peer learning opportunities. The Center also launched a virtual learning series to provide peer-to-peer learning opportunities for LHDs featuring select topics of interest identified by LHDs and held the first of three planned Lunch & Learn webinars in July 2015. The

Center also developed a LHD EHR Resource Guide to facilitate learning across LHDs regarding how LHDs are using their EHR for somatic care, behavioral health, and billing.

Telehealth

In October 2014, the Center awarded three LTC telehealth grants, totaling $87,888, to implement telehealth applications to improve transitions of care between hospitals and nursing homes. The three LTC grantees are: (1) Atlantic General Hospital Corporation in partnership with Berlin Nursing and Rehabilitation Center (Worcester County); (2) Dimensions Healthcare System in partnership with Sanctuary of Holy Cross and Patuxent River Health and Rehabilitation Center (Prince George's County); and (3) University of Maryland Upper Chesapeake Health in partnership with the Bel Air facility of Lorien Health Systems (Harford County). The grantees are using telehealth technology to coordinate care delivery between a comprehensive care facility and a general acute care hospital. In order to qualify for an award, applicants were required to use a nationally certified electronic health record and the services of CRISP. A dollar for dollar match was required from each grantee. Implementation began in November 2014 with projects ending approximately one year later. The Center provides support to grantees through regular status call meetings and site visits individually with grantees, and shared learning calls with all grantees. Outcomes from the projects are used to assess the impact of using telehealth to reduce hospital emergency department visits and inpatient admissions and readmissions.

The Center hosted, The Advancing Telehealth through Innovative Transitions of Care Symposium (symposium) in February 2015, which showcased the work of all three LTC telehealth projects to the public. During the symposium, LTC grantees presented their project goals, telehealth technology implementation processes, and challenges and successes of integrating telehealth technology within their clinical workflows. Maryland's Senator Susan Lee participated as the introductory speaker for the symposium. The symposium also included several presentations from telehealth industry leaders on opportunities to advance telehealth, the use of telehealth in stroke care, and telehealth in rural primary care settings. In June 2014, the Center also hosted a stakeholder webinar update for interested parties on the grantees' work.

In June 2015, the Center awarded a second round of telehealth project funding. A combined total of $90,000 was awarded to: (1) Crisfield Clinic, LLC (Somerset County); (2) Lorien Health Systems (Howard County); and (3) Union Hospital of Cecil County (Cecil County). Crisfield Clinic is a family practice clinic in Somerset County that is using remote patient monitoring to address asthma, diabetes, childhood obesity, and behavioral health issues among students in two county schools. Lorien Health Systems has a skilled nursing facility and residential service agency in Howard County that are using remote patient monitoring and videoconferencing to address certain hospital prevention quality indicator (PQI) conditions among discharged residents, including uncontrolled diabetes, congestive heart failure, and hypertension. Union Hospital of Cecil County is also using remote patient monitoring to address PQI conditions among discharged patients, including angina, asthma, chronic obstructive pulmonary disease, diabetes, heart failure, and hypertension. The experience gained from implementing the projects will inform the design of large telehealth programs in the State.

Community and Consultant Pharmacists

The Center convened a Community Pharmacy HIE Access Workgroup (workgroup), including leadership from the Maryland Pharmacists Association (MPhA), to develop a plan for implementing a pilot between community pharmacies and CRISP. The goal of the pilot is to help

inform efforts to expand CRISP services to nearly 1,600 community pharmacies in the State. Currently, authorized pharmacists that work in community settings can access data through the CRISP Query Portal pertaining to the Prescription Drug Monitoring Program (PDMP). The PDMP contains information on prescriptions previously filled for controlled dangerous substances. The recommendations developed by the workgroup aim at expanding access to other available medication history, as well as laboratory results, radiology reports, and transcribed reports to help support care delivery. The workgroup's plan outlines: (1) pilot scope and participants; (2) privacy and security policies; (3) sites and number of authorized users; and (4) assessment metrics for the pilot. Approximately five community pharmacy sites will be selected to participate in the pilot. The Center is also collaborating with representatives from the Maryland Chapter of the American Society of Consultant Pharmacists to explore opportunities to develop a similar pilot for consultant pharmacies.

Long Term Care

The Center conducted an annual assessment of EHR adoption and use among comprehensive care facilities (CCFs) in Maryland, based on data collected through Maryland's Annual Long Term Care (LTC) Survey. Results indicate that while nearly 72 percent of CCFs have purchased an EHR, implementation of system functionality varies across CCFs. The Center worked with stakeholders to identify a core set of EHR features that constitute a basic level of EHR use by CCFs. Stakeholders agreed that basic EHR use includes activities of daily living, allergy list, care plans, demographic characteristics of residents, diagnosis or condition list, discharge summaries, vital signs and laboratory data. Using this categorization, approximately 33 percent of CCFs have implemented an EHR at the basic level. CCFs also reported that their top HIE needs for exchanging data are with hospitals, pharmacies, and laboratories. The report presents the 2013 survey results and the broader health IT landscape of CCFs in Maryland and nationally, including health IT adoption challenges and opportunities to advance health IT adoption among CCFs, particularly within the context of health care reform. Results from the survey are used to inform broad strategies for enhancing health IT adoption and use among CCFs in Maryland.

Health Information Exchange

The MHCC provides guidance to the State Designated HIE, CRISP in advancing health information exchange statewide. The MHCC and the Health Services Cost Review Commission (HSCRC) designated CRISP in 2009, as required by law (Md. Code Ann., Health-Gen. § 19-143 (2009)), to build and maintain the technical infrastructure to support and enable the exchange of electronic health information statewide. In accordance with industry recognized best practices and standards, the State Designated HIE facilitates the secure exchange of health information between Maryland's health care organizations, providers, and public health agencies. Annually, the Center participates in a financial and security audit of CRISP. CliftonLarsonAllen LLP (CLA) was competitively selected to conduct both audits this year. The financial audit assesses the accounting practices of CRISP, including their management of certain programs funded by federal grants that are required to be audited annually. The security audit evaluates the extent to which CRISP and its vendors process, transmit, and store electronic patient data in a secure manner. Currently in its seventh year of operation, CRISP continues to make progress towards building a robust statewide HIE. Participants in Maryland that submit clinical information to CRISP include all 47 general acute care hospitals, 2 specialty hospitals, 41 long-term care facilities, 12 radiology facilities, and 3 laboratories. Additionally, CRISP offers interstate connectivity to certain hospitals

and providers in the District of Columbia and Delaware. In April 2014, CRISP began receiving summary of care documents from hospitals which are made available to users of CRISP to support transitions of care and care coordination.

Information made available through CRISP is accessible for query through an Internet-based portal (Query Portal). Provider utilization of the Query Portal and other CRISP services has generally increased from June 2014. As of June 2015, there were 884 health care organizations using the Query Portal, which is more than twice as many organizations during the same time last year. Participation among ambulatory providers has increased by 59 percent from 386 providers in 2014 to 613 providers in 2015; comprehensive care facility participation has also increased from 68 facilities in 2014 to 114 facilities in 2015, an increase of 68 percent. The average number of portal queries per month has also grown from 24,635 to 72,203. The Encounter Notification System (ENS) offers real-time notification alerts to providers when one of their patients has an encounter at a participating hospital and are used to coordinate and facilitate post-acute care follow up. ENS has also seen an increase in participation from 184 to 424 organizations. Users of the Prescription Drug Monitoring Program, which provides information on all Schedule II-V drugs prescribed at any Maryland pharmacy though the Query Portal, have increased by approximately 74 percent from 1,233 in 2014 to 2,141 in 2015.

Since 2014, CRISP has offered reporting services to all Maryland hospitals regarding readmissions patterns. CRISP is working to enhance its analytic services to support the new Medicare waiver in coordination with HSCRC. The goals under the new Medicare waiver include: reducing hospital readmission rates and hospital acquired conditions, improving population health, and reducing hospital cost growth. CRISP aims to provide partners of the Regional Partnership for Health System Transformation initiative with interactive reports and tools that may be used to identify and address health concerns to help meet the goals of the new Medicare waiver.

Ambulatory Information Exchange Project

The Center worked with CRISP to implement a proof-of-concept framework (pilot) that would enable CRISP to receive electronic administrative transactions from ambulatory practices. Three EHNs doing business in Maryland are targets for the pilot. Cyfluent, a Maryland-based EHN, will automatically send select data elements from administrative transactions of the nearly 500 practices that use Cyfluent's network. The data will be repurposed by CRISP in the form of electronic alerts that will be available to care managers when their patient has an encounter with another provider. The Center, in coordination with CRISP, began discussions with Emdeon and RelayHealth to engage them in a similar pilot to test the feasibility of using information from administrative transactions to help inform the care delivery process. Emdeon and RelayHealth are considered to be two of the largest EHNs in Maryland and nationally. Emdeon plans to focus their pilot effort on providers in Harford County. The pilot is scheduled to begin in the summer with a six-month timeframe.

HIE Policy Development

The MHCC was given the authority in law, Md. Code Ann., Health-Gen. §§4-301 and 4-302 (2011), to adopt regulations for the privacy and security of protected health information obtained and released through an HIE. The MHCC convened the HIE Policy Board (Board), a staff advisory group, to develop policy recommendations for the private and secure exchange of health information through HIEs. The recommendations of the Board are used by the Center to help guide the development of the regulations. The MHCC adopted COMAR 10.25.18, Health

Information Exchanges: Privacy and Security of Protected Health Information (regulation), which became effective on March 17, 2014. Several meetings with the Board were held during the year. Board members finalized policies related to the release of secondary data from HIEs for research purposes and entities use of secondary data in support of population care management under new models of health care reform. An HIE Regulations workgroup was also convened, which identified provisions of the regulations that: 1) need more clarification and/or strengthening to ensure the privacy and security of protected health information exchanged by HIEs, and/or 2) should be revised to ensure that requirements are technically and financially viable for HIEs to implement. The Center drafted amendments based on the recommendation of these two workgroups, to be released in September 2015 for informal comment.

National concerns exist about the sufficiency of HIPAA; the regulations that help to ensure that consumers' information is protected. HIEs that operate in Maryland are required to safeguard consumers' information and register as an HIE annually with MHCC. Information for HIE registration includes HIE's current audited financial statements, HIE's core education content and other necessary provisions detailed in the application form. The Center launched an HIE registration and renewal website to provide instructions to organizations applying as a registered HIE in Maryland. All eight organizations have completed their initial registration process. In preparation for renewal, the Center convened the HIE Registration and Renewal workgroup to identify opportunities to streamline the HIE registration and renewal process.

Electronic Preauthorization

In 2012, Maryland law (Md. Code Ann., Health-Gen. 19-108.2) established three benchmarks aimed at standardizing and automating the preauthorization process for medical and pharmaceutical services in order to minimize administrative burdens for health care professionals, payors, and pharmacy benefit managers (PBMs). These benchmarks were required to be implemented by July 1, 2013. The law was amended in May 2014 adding a fourth benchmark requiring payors and PBMs to implement an electronic process to allow providers to override a step therapy or fail-first protocol for pharmaceutical services by July 1, 2015. The MHCC is required to report annually through 2016 to the Governor and General Assembly on payors' and PBMs' implementation and compliance with the law.

All payors and PBMs have implemented the first three benchmarks and their online portals are available to providers to submit preauthorization requests electronically. Almost all payors and PBMs have implemented the fourth benchmark by July 1, 2015 as required by the law. Electronic preauthorization for medical services increased by nearly 52 percent between 2012 and 2014. In comparison, pharmaceutical electronic preauthorization requests experienced much smaller growth during this same time period, due to the move towards standards that allow submission via an EHR or electronic prescription system. Payors and PBMs report using a variety of communication techniques to promote the availability of online preauthorization systems.

PCMH

Maryland law, Md. Code Ann., Health-General. § 19-1A-02 (2010) required MHCC to establish a PCMH program to analyze the effectiveness of the PCMH model of primary care in which a team of health care professionals, guided by a primary care provider, delivers recurring, comprehensive, and coordinated care to patients in a culturally sensitive manner. In April 2011, MHCC launched the Multi-payor PCMH program (MMPP or pilot). The pilot included 52 primary care practices, spanning a range of geographical areas, patient populations, and organizational demographics.

Two Federally Qualified Health Centers (FQHCs) participated, as well as private primary care practices in urban, suburban, and rural settings. By law, the program includes participation by Medicaid and the four largest commercial health insurance carriers in the State: CareFirst BlueCross Blue Shield; Aetna, Inc. (now merged with Coventry); CIGNA Health Care; and UnitedHealthcare. In addition, the military care plan, TRICARE, the Federal Employees Health Benefits Program, and the Maryland State Employee and Retiree Health and Welfare Benefits Program elected to participate in the pilot.

During the year, the Center developed a migration plan for practices in the MMPP, as the pilot concludes at the end of 2015. The migration plan aims to assist participating practices with transitioning from the MMPP into an existing commercial carrier's advance care delivery program. The goal is to enable practices to make informed decisions about enrolling into an advanced care delivery program based on their business needs. The Center convened commercial carrier advanced care delivery program education sessions to help practices learn about the different aspects of each program. Enrollment in a commercial carrier program allows practices to continue delivering advanced primary care in a long term model with financial incentives for achieving the triple aim: improving quality of care, increasing patient satisfaction, and controlling cost. Based on input received from different states as well as providers, payors, and other stakeholders, the Center provides practices with several other options to enroll in opportunities beyond PCMH programs. One of these options includes enrollment in an Accountable Care Organization (ACO), which also aims to catalyze continued growth in advanced care delivery.

PCMH Practice Transformation Workgroup

The Center convened a PCMH Practice Transformation Workgroup (PTW) to develop an action plan to expand advanced care delivery models to support the delivery of health care in a long term model with financial incentives for achieving the triple aim: improving quality of care, increasing patient satisfaction, and controlling cost in the State upon conclusion of the existing pilot. The PTW consists of representatives from payors, consumers, state agencies and providers. The Center continues to explore additional participation in the PTW, particularly among providers already participating in a PCMH recognized by the National Committee for Quality Assurance (NCQA).

MMPP Evaluations

The Center released two information briefs highlighting key findings from MMPP evaluations. The first information brief highlights the results of an assessment of nine primary care practices participating in the MMPP that consistently achieved MMPP quality and cost goals over two consecutive years. The assessment identified three key factors that attributed to MMPP goal achievement: (1) incorporating a care manager into the practice, (2) tracking patient outcomes, and (3) improving access to patients outside of normal office hours. Three notable responses from practices that influenced their success were leadership, care coordination, and use of an EHR. The findings from the assessment will inform other practices in adopting these best practices to help them maximize their performance in PCMH programs.

The second information brief is a summary of the Evaluation of the MMPP First Annual Report (report); the report was authored by IMPAQ and released in December 2013. The report details the progress of the MMPP during the first year of the pilot from July 2011 through June 2012. Generally, results of the first year evaluation show improvements in outcomes among patients with chronic conditions. Specific findings include increases in preventative services, such as well-

care visits by adolescents and office visits to primary care physicians, and improvements in the management of asthma for young adults that led to a decrease in hospital admissions and office visits to specialists.

Quality Measure Reporting and Shared Savings

The MHCC provides practice-specific quality and shared savings reports. Quality measure thresholds for the 2014 performance year are calculated and distributed to the MMPP practices. Quality measures quantify a selected aspect of health care delivery by comparing it to an evidence-based criterion that specifies what constitutes better quality. Utilization measures quantify the extent to which a practice's patient population uses a particular service, such as inpatient hospitalization and emergency room services, within a specified time period. Cost measures quantify the change in health care costs from one time period to another. Quality improvement generally requires MMPP practice staff to create new processes or reengineer current processes to meet targeted goals. The MMPP practice quality measure reports identify specific areas to focus future quality improvement efforts. Based on MMPP practices' achievement of the quality benchmarks, practices can earn shared savings payments.

The Center provided guidance to payors in developing and distributing the 2013 shared savings incentive payments of approximately 1.8 million earned by MMPP practices. The shared savings payments are a percentage of the savings they generate through improving care delivery and patient outcomes. A shared savings payment can be zero, 30, 40 or 50 percent of the savings generated by the MMPP practice based on the number of quality measures for which an MMPP practice achieved a certain performance level.

Single Carrier PCMH Programs

The Center worked with Aetna, Inc. and UnitedHealthcare on single carrier PCMH program applications for recognition by MHCC. Maryland law at Md. Code Ann., Health-General. § 19-1A-02., (2010) requires a single carrier to obtain MHCC recognition of its proposed PCMH program, among other things. The MHCC recognition helps to ensure that the single carrier programs align with industry best standards adopted by the Patient Centered Primary Care Collaborative (PCPCC), NCQA, National Quality Forum and others. In addition, it preserves measures and methodologies achieved through consensus and those developed and tested through the MMPP. It also helps to increase transparency from carriers regarding attribution methods, quality metrics, cost calculations, and components included in their incentive determinations. A single carrier PCMH program must conform to the Guidelines for PCMH Demonstration Programs (guidelines). The guidelines are endorsed by the PCPCC, a multi-stakeholder national coalition, and contain key standards that a PCMH program must implement. The MHCC has previously approved proposed PCMH programs from CareFirst BlueCross BlueShield and Cigna Health Care.

APPENDIX 1 – Maryland Health Care Commission's organizational chart

THE MARYLAND HEALTH CARE COMMISSION