MARYLAND HEALTH CARE COMMISSION

ANNUAL REPORT to the GOVERNOR

Fiscal Year 2009

(July 1, 2008 through June 30, 2009)

Martin O'Malley
Governor

Marilyn Moon, Ph.D.
Chair

Rex W. Cowdry, M.D.
Executive Director

http://mhcc.maryland.gov/

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

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

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

MARYLAND HEALTH CARE COMMISSION

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

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

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

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

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

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

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

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

Sharon K. Krumm, R.N., Ph.D. is the Administrator and Director of Nursing at the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins Hospital. She is jointly appointed is an Assistant Professor at the Johns Hopkins School of Nursing, and the Johns Hopkins School of

Medicine. Commissioner Krumm received her Ph.D., as well as two nursing degrees, from the University of Missouri. She resides in the City of Baltimore.

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

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

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

Sylvian Ontaneda-Bernales is an attorney with the law firm of Ober, Kaler, Grimes, and Shriver in Baltimore City who specializes in immigration matters. Her practice also includes complex civil litigation. Sylvia is licensed in Maryland and Washington, D.C., and is a member of the Baltimore City Bar Association, the Maryland Hispanic Bar Association, and the Maryland Women's Bar Association. In addition, Sylvia is a volunteer mediator in Baltimore City District One and is engaged in various pro bono and community activities, including mentoring students from Northwestern High School and the University of Maryland, School of Law. She has

received the Educator of 2007 award from the Maryland Volunteer Lawyers Service and the 2007 Public Service Award for Outstanding Contribution by an Individual from the Maryland Hispanic Bar Association. Originally from Peru, Sylvia has lived in the United States for 35 years and in Baltimore since 2003. She earned her U.S. college degrees and J.D. after age 40. She has been a professional print and television journalist, documentary maker, minister, religious publishing editor, college professor, published poet, and jungle explorer. (Term Expires 9/30/11)

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

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

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

EXECUTIVE STAFF

Rex W. Cowdry, M.D.
Executive Director

Pamela W. Barclay
Director, Center for Hospital Services

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

David Sharp
Director, Center for Health Information Technology

Ben Steffen
Director, Center for Information Services and Analysis

EXECUTIVE SUMMARY

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

Our mission is simply stated:

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

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

MHCC STAFF AND THE FIVE CENTERS

During FY 2009, the Commission had an appropriation for 64.40 full time positions and filled one contractual position. The Commission's staff members represent a broad range of backgrounds and skills, including public policy analysis, data management and analysis, health planning, health facilities construction and financing, Medicaid administration, quality assessment, clinical and health services research, and public performance reporting.

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

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

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

- Planning for hospital services and the drafting of the acute care chapter of the State Health Plan are the responsibility of the Center for Hospital Services.
- The entire Certificate of Need program remains within the Center for Hospital Services because hospital certificates of need are the most complex and costly of projects requiring CON action. Maryland hospitals are in the midst of a dramatic rebuilding program, replacing an aging hospital infrastructure through renovation, new construction, and in some cases, consolidation or relocation of facilities.
- The Center oversees specialized inpatient services such as cardiac surgery, obstetrics, pediatrics, and psychiatry, including developing the state health plan chapters, managing certificates of need for these services, and granting appropriate waivers to allow hospitals meeting rigorous criteria to perform emergency angioplasty.
- The Center is committed to providing meaningful information to consumers about the quality and outcomes of care provided in all Maryland acute care hospitals. It publishes the Hospital Guide, containing both general information and specific quality and outcome measures. The Center currently reports on the quality of hospital efforts in surgical infection prevention and is developing strategies to gather and report the rates of key hospital acquired infections. The Center plans to expand public reporting of angioplasty quality and outcomes beyond the current waiver hospitals to include all hospitals performing emergency angioplasty and is examining public reporting of risk-adjusted data on the quality and outcomes of cardiac surgery.
- The Center serves as the lead for a report on emergency department crowding.
- As part of the MHCC's Price Transparency Initiative, the Center, working closely with the Health Services Cost Review Commission, publishes each hospital's charges for the most common Diagnosis Related Groups (DRGs).

The **Center for Long-term Care and Community-based Services** focuses on improving long-term and community-based care, bringing together planning and public reporting efforts.

- The Center is responsible for health planning regarding long-term and community-based care, including the policies guiding the determination of need in the Certificate of Need process for nursing homes, home health agencies, and hospices.

- The Center is responsible for the Commission's study of long-term care vision and needs over the coming 25 years, required by legislation during the 2006 session.
- CON applications for nursing homes, home health agencies, and hospices are managed by the CON staff in the Center for Hospital Services, operating according to policies developed by the Center for Long-term and Community-based Care.
- The Center publishes the Nursing Home Guide for Marylanders, providing an easy way to locate and compare nursing homes on quality and outcomes measures. The Center is also pioneering the public reporting of resident and family satisfaction measures.
- The Center has responsibility for policies and information dissemination related to assisted living programs.

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

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

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

- The Center produces key reports to guide health policy, including reports on health expenditures, health insurance, the uninsured and uncompensated care.
- A special focus of the Center will be physician services, including physician reimbursement and reporting on the cost and quality of physician services. The Commission staff has provided consultation to the General Assembly.
- The Center oversees the Maryland Trauma Services Fund and has responsibility for development of its procedures and policy options.
- This Center provides analytic and programming services to other divisions of the Commission and is responsible for our intranet and web site. Two individuals serve as liaisons to the Center for Hospital Services and the Center for Long-Term Care and Community-Based Services, participating as appropriate in the discussions of those Centers and assuring that the necessary expertise is brought to bear on the other Centers' data gathering, management, and analysis.

The **Center for Health Information Technology** is responsible for the Commission's initiatives in health information technology.

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

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

BUDGET & FINANCES

In FY 2009, the Commission was appropriated $38,809,554 which includes an appropriation of $13.1 million for the trauma fund and $15 million for the Partnership program. The Commission is funded with special funds through a user fee assessment paid by Nursing Homes, Hospitals, Insurance Companies, and the Health Occupation Boards in order to accomplish its mission and program functions.

ASSESSMENT

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

Surplus

At the close of FY 2009, the Commission's surplus was $3.4 million a reduction of 1.5 million over FY 2009. The Commission will look to reduce this surplus during FY 2010.

OVERVIEW OF FY 2009 ACCOMPLISHMENTS

July 2008

COMAR 10.25.14.01 – Health Care Data Collection from Maryland Health Care Practitioners was adopted as proposed permanent regulations.

The Commission approved the Certificate of Need for Citizens Nursing Home of Frederick County, Docket No. 08-10-2227.

Staff presented the report Assessment of Disparities in Potentially Avoidable Hospitalization of Maryland Medicare Beneficiaries: Study Context and Methods.

August 2008

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

COMAR 10.25.07 – Certificate of Electronic Networks and Medical Claims Clearinghouses were adopted as proposed permanent regulations.

September 2008

Dr. Cowdry presented on Non-Primary PCI Research Waiver applications. Waivers were awarded to Anne Arundel Medical Center, Shady Grove Adventist Hospital, Southern Maryland Hospital Center and St. Agnes Hospital.

COMAR 10.24.10 – Supplement 6 to the Acute Inpatient Services Chapter of the State Health Plan is adopted as emergency regulations.

COMAR 10.24.10 – The Acute Inpatient Services Chapter of the State Health Plan is repealed, to be replaced by the Acute Care Hospital Services Chapter, which was adopted as proposed permanent regulations.

Certificate of Need for Franklin Square Hospital Center is approved.

The recommended decision at the exceptions hearing for Point Lookout Nursing Home is adopted and the Certificate of Need for Point Lookout Nursing Home was approved.

The request for reconsideration filed by HomeCare Rehab is denied.

October 2008

COMAR 10.25.14 – Health Care Data Collection from the Maryland Health Care Practitioners – is adopted at final regulations.

Certificate of Need for Levindale Hebrew Geriatric Center and Hospital is approved with conditions.

Certificate of Need for St. Mary's Hospital is approved subject to specified action by AELR and HSCRC, with conditions.

Certificate of Need modification for Lorien LifeCenter – Ellicott City is approved, with conditions.

Staff presented the 2008 Health Plan Performance Report.

Staff gave an update on the status of the Maryland Physician Trauma Services.

November 2008

COMAR 10.25.07 – Certification of Electronic Health Networks and Medical Claims Clearinghouses was adopted as final regulations.

Staff presented recommendations on small group market coverage policies. The recommendation that carriers provide coverage of child dependents up to age 25 in the small group market was approved.

Staff presented recommendations on covering domestic partners and their dependent children in the small group market. The recommendation to continue with the current policy which permits carriers to offer coverage to domestic partners and their dependent children as a rider was approved.

Staff from Mathematica Policy Research Institute gave a presentation on Assessing Differences in Potentially Avoidable Hospitalizations among Medicare Beneficiaries in Maryland in 2006.

Staff from Maryland Patient Safety Center, Inc. briefed the Commission on the activities of the Center and requested re-designation of the Maryland Patient Safety Center as Maryland's patient safety center for another five years beginning January 2009. The request was approved.

December 2008

Certificate of Need for Shady Grove Adventist Nursing and Rehabilitation is approved with conditions.

Certificate of Need for Kennedy Krieger is approved.

COMAR 31.11.06 – Comprehensive Standard Health Benefit Plan – Adopt as Proposed Permanent Regulations that require coverage for certain dependents to age 25 is approved.

COMAR 31.11.06 – Comprehensive Standard Health Benefit Plan – Adopt as Proposed Permanent Regulations that adds bariatric surgery as a covered benefit, subject to certain restrictions is approved.

Staff presented the Annual Mandated Health Insurance Services Evaluation. The request to release the report to the General Assembly was approved.

Staff presented the Health Insurance Coverage among College Students study. The request to release the report to the General Assembly was approved.

COMAR 10.25.02 – User Fee Assessment of Health Care Practitioners and COMAR 10.25.03 – User Fee Assessment of Payers, Hospitals and Nursing Homes, is adopted as proposed permanent regulations.

COMAR 10.24.01 – Certificate of Need for Health Care Facilities – Proposed and Emergency Action on Regulations: Definition of Participating Entity is adopted as proposed and emergency regulations.

COMAR 10.24.10 – State Health Plan for Facilities and Services: Acute Care Hospital Services is adopted as final regulations.

Staff presented An Alternative Approach to the Regulation of Home Health Agencies in Maryland. Request to release the report is approved.

January 2009

No January meeting occurred.

February 2009

Frederick Memorial Hospital is granted a two-year primary PCI waiver.

Washington County Hospital is granted a two-year primary PCI waiver.

COMAR 10.25.10 – Maryland Trauma Physician Services Fund – Adopt as Proposed Permanent Regulations is approved.

Certificate of Need for Lorien LifeCenter – Elkridge is approved, subject to the same conditions applied to the original CON.

Certificate of Need for Johns Hopkins Bayview Medical Center is hereby approved. This is subject to the condition that any future rate adjustment related to the depreciation expenses of this project must be limited to the depreciation on a maximum of $22,327,199 and no rate adjustment may be sought for non-capitalized interest expenditures associated with this project.

Staff presented the Health Insurance Coverage Report in Maryland through 2007.

March 2009

Staff presented the State Health Care Expenditures for 2007 report.

Upper Chesapeake Medical Center is granted a two-year primary PCI waiver.

Staff presented on Non-Primary Research Waiver Applications for Frederick Memorial Hospital and Washington County Hospital. The recommendation to grant PCI research waivers to both hospitals is approved.

Amendments to COMAR 10.25.05 – Research Waiver Applications: Atlantic C-Port Study of Non-Primary PCI is adopted as Emergency and Proposed Permanent Regulations.

Staff presented the results of the 2008 Long Term Care Family Experience of Care survey.

Certificate of Need for Manor Care – Bowie is approved.

Certificate of Need for Augsburg Lutheran Home of Maryland is approved.

Certificate of Need for Holly Hill Nursing and Rehabilitation Center is approved.

COMAR 10.24.01 – Definition of Participating Entity – Final Action on Proposed Permanent Regulations is adopted.

COMAR 31.11.06 – Comprehensive Standard Health Benefit Plan – Dependent Coverage up to age 25 and coverage for Bariatric Surgery is adopted.

COMAR 10.25.02 – User Fee Assessment of Health Care Practitioners is adopted.

COMAR 10.25.03 – User Fee Assessment of Health Care Practitioners is adopted.

April 2009

COMAR10.24.17 – State Health Plan for Cardiac Surgery and Percutaneous Coronary Intervention –PCI – Services – Update of Door – To – Balloon Time Requirement – Action on Proposed Permanent Regulations is adopted as Proposed Permanent Regulations.

Certificate of Need for Solomons Nursing Home is approved.

Certificate of Need for Lorien LifeCenter – Harford County is approved.

May 2009

COMAR 10.25.10 – Maryland Trauma Physician Services Fund – Action on Final Regulations was adopted as final regulations.

A request from Anne Arundel Medical Center for a two-year waiver renewal to provide primary PCI without cardiac surgery on-site is approved.

A request from Baltimore Washington Medical Center for a two-year waiver renewal to provide primary PCI without cardiac surgery on site is approved.

A request from Franklin Square Hospital Center for a two-year waiver renewal to provide primary PCI without cardiac surgery on site is approved.

Staff presented a Summary of Carrier Experience in the Small Group Market for the year ending December 31, 2008.

June 2009

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

COMAR 31.11.14 – Wellness Benefits under Small Employer Health Benefit Plans – were adopted as proposed permanent regulations.

COMAR 10.24.05 – Research Waiver Applications: Atlantic C-Port Study of Non-Primary PCI – Action on Final Regulations was adopted as final regulations.

Applications of Baltimore Washington Medical Center, Holy Cross Hospital and Johns Hopkins Bayview Medical Center for two-year Research Waivers to Provide Non-Primary PCI without On-Site Cardiac Surgery Services within the C-Port E Study are approved.

Applications of Southern Maryland Hospital Center and Shady Grove Adventist Hospital for Renewal of their two-year Waivers to provide Primary PCI without Cardiac Surgery On-Site are approved.

Certificate of Need – Harford Memorial Hospital is approved.

MARYLAND HEALTH CARE COMMISSION

The Center for Information Services and Analysis

Cost and Quality Analysis Division

Overview

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

Accomplishments

During FY 2009, the Cost and Quality Analysis division added an additional year of data to the MCDB and provided feedback on data quality to the submitting payers. The division produced nine publications, including seven reports and two issue briefs, and redesigned the Physician Renewal Questionnaire used by the Board of Physicians. Division personnel—along with the Deputy Director, Center for Analysis and Information Services—served as staff to the Governor's Task Force on Health Care Access and Reimbursement during FY 2009. Three of the reports produced by the division during this fiscal year were required for the Task Force, including a final report of the Task Force's recommendations and two investigative studies. Additionally, an issue brief was dedicated to issues that were being discussed by the Task Force. Subsequent to a Task Force recommendation on the need to improve data on physician supply, division staff modified the Physician Renewal Questionnaire to collect more detailed information on the work habits of physicians in active practice.

State Health Care Expenditures

The mandated annual report on health care expenditures contributes to monitoring the performance of the state's health care system by reporting the level and growth rate of health care spending. State Health Care Expenditures: Experience from 2007 was released in March. It provides estimates of health care spending for Maryland residents constructed from primarily administrative data sources, such insurance company filings with the Maryland Insurance Administration. It reports that estimated total spending for health care received by state residents increased 6% in 2007 to $35.8 billion. Maryland's per resident expenditure in 2007, $6,374, also grew by 6%, slightly below the state's longer term growth trend from 2003 to 2007 of 7% annually. Maryland's 2007 per resident spending level and growth rate were similar to the national averages ($6,358; 6%).

Analysis of expenditures by service type indicates that spending in three categories—hospital inpatient and outpatient care and administration & the net cost of insurance—accounted for a larger share of Maryland's total expenditures for health care in 2007 (41%) than in 2003 (38%). Over this period, per resident expenditures for hospital services grew faster than the national average, at an average annual rate of 9% versus 6% nationally. Although Maryland's per capita payment for hospital care in 2007 ($2,069) continued to be below the national average ($2,206), the gap is now relatively smaller than in 2003 due to the state's faster growth in hospital spending. Analysis by payer-type shows that Medicare and Medicaid expenditures per enrollee in Maryland are above the national averages, but per enrollee private insurance expenditures in the state are below the national average. Per capita, Marylanders pay much more out-of-pocket for health care than the national average—nearly 52% more in 2007 ($1,184 per resident versus $779). This is consistent with higher personal income in Maryland, although the state's above average growth in per resident out-of-pocket spending from 2003 to 2007 (5% versus 4%) may indicate increasing burden for residents whose incomes have not kept pace with the state average.

Practitioner Utilization: Trends within Privately Insured Patients

Practitioner Utilization: Trends within Privately Insured Patients, 2006-2007 was produced in FY 2009, but a redesign to simplify the report contents delayed its release until the fall of 2009. A mandated annual report based on analyses of the MCDB, its purpose is to provide an understanding of the factors underlying increases in expenditures for insured professional services. The report examines how the volume and cost of professional care received by a privately insured Maryland resident under age 65 changed from 2006 to 2007. It also reports private insurer payment rates by payer size and provider characteristics and examines changes in the types of coverage across the users of care.

Among users with a full year of insurance coverage, the average expenditure for insured professional services grew 3% from 2006 to 2007, to $1,081 per user. The spending growth is mainly attributable to a 3% increase in the total number of services per user; there also was a 1% increase in the average-payment-per-RVU. The average complexity of the services received

did not change. Growth in per-user spending varied considerably by coverage type, ranging from no increase in individual market plans to a 6% increase in large group private employer plans. Spending among users insured through consumer-directed health plans (CDHPs), which are now available in all market segments, increased by an average of 7%.

Expenditures for professional services differ significantly by the "expenditure risk" of the patient, which is determined by a patient's care-related illnesses. The annual expenditure for a medium-risk user is about twice that of low-risk user, and the annual expenditure for a high-risk user is about five times that of a low-risk user. High-risk users—33% of the users—generated 63% of the expenditures in 2007. The average expenditure in different coverage types is strongly influenced by the risk-mix of the users: users in the individual market have the lowest overall risk mix and the lowest average expenditure per user.

When the two largest payers were compared with the other payers, there were differences in the average payment-per-RVU, the use of out-of-network providers, and the geographic mix of their users and providers. In 2007, the average payment-per-RVU for services provided by out-of-network providers—whether overall or by payer group—was about 50% higher than the average payment-per-RVU across all services. This higher payment rate reflects the "balance billing" of non-HMO users, which results in potentially higher reimbursements for out-of-network providers. The share of professional services that is out-of-network among the other payers is more than twice the share that occurs among the largest payers (9% versus 4%) because the other payers' provider networks tend to be smaller. Average payment-per-RVU is lower in services insured by the largest payers versus the other payers, reflecting their differences in out-of-network service use, the geographic mix of patients and providers, and price-setting power, which tends to increase with market share.

Health Insurance Coverage in Maryland

In January 2009, the division released its latest biennial coverage report, Health Insurance Coverage in Maryland through 2007. This report is designed to meet the varied needs of the Maryland Department of Health and Mental Hygiene (DHMH), legislators, and stakeholders by providing information on the broad patterns and trends in insurance coverage in the state and detailed information on the characteristics of Maryland's uninsured nonelderly residents. The report also includes coverage rates for many subsets of the population, including children, young adults, workers, and racial and ethnic minorities. Information for the 36-page report is based on staff analysis of the Census Bureau's Current Population Survey, Annual Social and Economic Supplement (CPS ASEC).

The state's nonelderly uninsured and employment-based coverage rates for 2006–2007 are not significantly different from those rates in 2004–2005. In 2006–2007, about 760,000 nonelderly state residents lacked health insurance, amounting to 15.4% of Maryland's nonelderly population. However, the latest uninsured rate is significantly higher than the state's rate in 2002–2003 (14.4%). As in prior periods, Maryland's 2006–2007 uninsured rate is below the

comparable national average (17.5%) due to a higher rate of employment-based coverage in the state than in the nation as a whole.

As in the larger population, the coverage rates for most subgroups did not change from 2004–2005 to 2006–2007. The uninsured rates among children (10%) and nonelderly adults (17%) were stable, reflecting no significant changes in their private or public coverage rates. The demographic composition of the state's nonelderly uninsured shifted slightly with respect to income (relatively fewer poor residents), race/ethnicity (relatively more Hispanics), and employment (relatively fewer from families lacking an employed adult).

Age, educational attainment, and family income are closely associated with being uninsured. About 30% of young adults (age 19-29) lack insurance. Nearly half of all individuals in families where the adults have not attained a high school diploma are uninsured. About 22% of children and 43% of adults in low-income families are uninsured. Persons in families with low incomes—at or below 200 percent of the poverty level—are 19% of Maryland's nonelderly but comprise 44% of the state's uninsured. About half of Maryland's Hispanic residents lack coverage, so although they are just 8% of the state's nonelderly, they comprise 24% of the uninsured, up from 19% in 2004–2005 when they were also 8% of the nonelderly. Nine of 10 uninsured persons in Maryland live in family units with at least one working adult, and 60% are working adults. Adults working in private firms with fewer than 100 workers are 37% of adult workers, but account for 62% of the uninsured adult workers.

Assessment of Disparities in Potentially Avoidable Hospitalizations of Maryland Medicare Patients

During its 2006 legislative session, the Maryland General Assembly passed House Bill 58, charging the MHCC with investigating racial/ethnic variation in health outcomes. In response, division staff designed a study to assess disparities in hospitalization rates for ambulatory care sensitive conditions (ACSCs) among Medicare beneficiaries. ACSCs are conditions for which timely and appropriate outpatient care could prevent many hospitalizations; hospitalization for ACSCs is a frequently used marker for the quality of the outpatient care system. The study examined disparities related to race, geography, socioeconomic status, gender, and age, since all of these factors can all be predictors of health outcomes. The goal of the study was to provide Maryland policymakers, providers, and community organizations with information to document demographic and geographic differences, support targeted interventions, and ultimately improve health within the communities of Maryland. The specific objectives of the study were to: (1) produce rates of ACSC hospitalizations for various demographic and geographic subgroups, (2) estimate the costs of these hospitalizations, and (3) approximate the potential cost savings from a reduction in hospitalizations. The Commission-funded study was conducted by Mathematica Policy Research, Inc., with input from both division staff and DHMH's Office of Minority Health.

The analysis of Maryland Medicare claims data showed significant differences in rates of ACSC-related hospitalizations by race and gender that were only partially explained by factors such as disease burden, socioeconomic characteristics, and geographic location. Rates also varied significantly by county when controlling for differences in population characteristics. The differences in rates may be attributable, at least in part, to the performance of outpatient systems and suggest that opportunities exist for improving outcomes through enhancements in quality of care. Details of the study and its findings are contained in a 110-page report, Assessment of Disparities in Potentially Avoidable Hospitalizations of Maryland Medicare Patients. A summary of the study results is reported in a 10-page issue brief, Differences in Hospitalizations for Ambulatory Care Sensitive Conditions Among Maryland Medicare Beneficiaries—2006. Both the report and the issue brief were release in December 2008.

Accomplishments Related to the Task Force on Health Care Access and Reimbursement
During this fiscal year, the Deputy Director, Center for Information Services and Analysis, and division staff continued to serve as staff to the Governor's Task Force on Health Care Access and Reimbursement. The mission of the Task Force was created by Senate Bill 107 (2007 legislative session) and amended by Senate Bill 744 (2008). The Task Force was charged with examining issues that had not been resolved over the preceding several years affecting access to and reimbursement of physicians. The General Assembly directed the Task Force to provide recommendations on broad questions affecting: 1) patients' access to providers; 2) payers' policies on participation on network panels; 3) adequacy of current reimbursement levels; and 4) alternatives to the present system of payment and approaches for linking reimbursement to quality.

The division conducted several studies on topics of particular interest to the Task Force. An issue brief released in July, Paying for Physician Care in Maryland: What are the factors contributing to differences across specialties? used data in the MCDB to examine differences in physician reimbursement across specialties. The issue brief reported on the relationship between payment levels and the expected time and work involved, and reviewed alternative strategies for improving the relative compensation of primary care physicians. Two studies required by SB 744: 1) Primary Care Reimbursement of Mental Health Services by Commercial Insurance Payers; and 2) Primary Care Reimbursement of After Hours Care by Commercial Insurance Payers, were conducted on behalf of the division by Social and Scientific Systems, the database (MCDB) vendor. These studies were released in September as short reports.

Task Force on Health Care Access and Reimbursement: Final Report and Recommendations was submitted to the General Assembly in January 2009, along with a lengthy addendum to the report containing comments on the report and recommendations from stakeholders. The 72-page final report provides detailed discussions of the Task Force's recommendations and includes background information on the Task Force, an overview of the current health care market, and recent and ongoing policy initiatives focused on correcting some of the weaknesses in the health care market. The recommendations addressed the eight topics listed

below. Division staff took responsibility for implementing recommendation #8—discussed in the next paragraph—and, to date, the Maryland legislature has passed laws pertaining to all the remaining recommendations, except for #6.

1. Recommendation on Approaches to Promote Practice Formation in Maryland
2. Recommendation for Simplifying the Credentialing of Physicians by Hospitals and Health Plans
3. Recommendation for Changing the Formula for Reimbursing Nonparticipating Providers That Treat HMO Patients
4. Recommendation That Health Insurance Plans Must Agree to Use Common Nationally Recognized Measures in Performance Plans
5. Recommendation for Enhancing Delivery of Primary Care and Development of the Medical Home Model
6. Recommendation on Elevated Payment for After-Hours and Weekend Care
7. Recommendation for Reimbursing Primary Care Providers That Provide Mental Health Services
8. Recommendation on Improving Data on Physician Supply

Task Force recommendation #8 suggested that the Physician Renewal Questionnaire be modified to more accurately gauge changes in the active practice physician work force. Division staff subsequently revised the questionnaire to: 1) obtain the needed information on physician activity hours and practice characteristics (listed below), and 2) minimize the burden on physicians who have to complete the survey by deleting several questions, reorganizing the questions to have a more logical flow, utilizing skip patterns in the online survey to minimize the number of questions that a physician has to answer (based on the physician's patient care characteristics), and adding "help screens" to certain questions to clarify the expected responses. Staff consulted with both the Maryland Board of Physicians and the Office of Health Policy & Planning in DHMH's Family Health Administration in developing the survey revisions, and details of the survey revisions were sent to the Maryland Hospital Association and MedCHI for their review. The new information items on the questionnaire include:

- More detail on the number of hours worked by categories of activity;
- Identification of physicians in a residency or post-graduate training program;
- Information on practice size, including physician and non-physician providers;
- Whether the physician has admitting privileges at one or more hospitals located inside and outside of Maryland; and
- Whether physicians engaged in patient care have limited their practices by: 1) not participating in any public or private insurance plans, or 2) having a "concierge medicine" practice.

Maryland Trauma Physician Services Fund

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

The Maryland General Assembly took steps to increase eligibility and reimbursement levels for trauma fund payments in 2006, 2008, and 2009. House Bill 1164 (Trauma Reimbursement and Grants) passed during the 2006 session of the Maryland General Assembly realigned spending with collections by increasing the physician specialties eligible for uncompensated care and Medicaid under-compensated care and raising the on-call reimbursement formula for trauma centers. Trauma physicians at three specialty referral centers became eligible for uncompensated care reimbursement and elevated Medicaid payments. In addition, Level II and Level III trauma center hospitals were awarded trauma equipment grants in FY 2007.

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

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

Payments to eligible providers and the administrative costs associated with making those payments totaled nearly $13 million in FY 2009, down slightly from FY 2008. Uncompensated care payments increased and on-call and Medicaid trauma payments declined slightly from FY 2008 to FY 2009. Administrative costs increased slightly due to higher uncompensated care claim volume. In addition to payments to trauma providers, $17 million of the Fund's surplus was transferred to the State's General Fund by the Maryland General Assembly under the Budget Reconciliation Act of the 2009.

Transfers from the Motor Vehicle Administration (MVA) to the Fund declined by about $500,000 in 2009 due to a drop in the number of new automobile registrations and automobile registration renewals. To balance payments with projected revenue in 2010, the Commission voted to a impose an 8 percent across the board reduction in payment rates that became effective on July 1, 2009, as a result of the drop in revenue.

Data Base and Applications Development Division

Overview

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

Accomplishments

Bed Need Inventory

Data requests were completed providing bed need projections in assorted formats, including population ratios for 2007.

Data File Standardization 1980-present

Staff standardized the Inpatient, Outpatient, Psychiatric, and Ambulatory Surgical datasets for Maryland residents from 1980 to the present to ensure that variable names, formats and sizes are the same in all datasets. This increases efficiency of data manipulations between data sets.

Data Processing

Data staff assists Commission staff with software technical problems and creates mapping and graph reproductions for them. Staff creates data subsets to the specific requirements of in-house analysis staff and external requests. Examples include:

1. Open heart surgical procedures at selected hospitals by diagnosis codes;
2. Total number of discharges and patient days for the 47 Maryland general hospitals by payor groups such as Medicare and Non-Medicare;
3. Total number of discharges and outpatient visits for privately insured Maryland residents;
4. Statistical analysis on bloodstream infections reported in the 2007 discharge datasets;
5. Separating data reported for two free-standing facilities from their respective unique psychiatric health systems

6. Counts of patients in MSGA, pediatric, obstetric, and Maryland acute care general hospitals; and
7. Calculating the number of active physicians practicing in Montgomery County as a single specialty in contrast to those in multi-specialty practices.

Staff support other Commission staff with preparing their own datasets for analysis, SAS training and data specifications. Specifications often include: specific populations; geographic locations; payer sources; facilities; and jurisdictions.

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

1. MD Four-Year Institutions of Higher Education by Insurance Availability and Urban-Rural Status for the Insurance Availability for Young Adults in College;
2. Locations of Primary (pPCI) and Non-Primary (npPCI) Percutaneous Coronary Intervention programs in Maryland Hospitals Without On-Site Cardiac Surgery at Maryland and Washington, D.C. Hospitals and With On-Site Adult Cardiac Surgery Programs;
3. Staff created map of all hospital locations and sent it electronically to the Maryland Community Health Resources Commission;
4. Map of the 100 top MCOs in Maryland in 2008;
5. Maps of the Trauma Fund hospitals in Maryland;
6. Locations of facilities eligible and not eligible to Receive Demonstration Incentive Payments for CMS Treatment & Control Groups; and
7. Map of DC Zip Codes & Hospitals for the New Hospital in Germantown by Holy Cross Hospital.

Graphic Design & Publishing Support
Staff provided design and technical support for reports such as the Health Insurance report and the Disparity Spotlight and assisted MHCC staff with printing and graphic software issues.

Home Health
Data Staff prepared the 2007 home health data for editing, prepared a data dictionary for the home health public use files, created public use files in Excel format and updated the 2008 home health web application. Data staff created final agency reports for distribution. Data Staff worked closely with the home health staff to generate reports for the State Health Plan. Data Staff merged additional fields from the Medicare denominator file so that the Long Term Care staff could get additional fields not available on the home health extract.

Hospice
Staff created documentation and public use files of the 2006 and 2007 hospice data and uploaded same to the WEB.

Hospital Services/Certificate of Need

Staff supplied datasets and maps for analysis of various CON projects such as the number of psychiatric discharges and patient days reported by age and zip code for selected acute general hospitals and Private Psychiatric hospitals. Staff identified the total count of MSGA, pediatric, obstetric and acute Maryland acute care general hospital discharges for CY2007 & CY2008. Staff created a folder on the web to share documents with external users reducing the need for bulk emailing large documents.

IRB DC Limited Data Set:

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

Project Name	Destination	Data Set Required
Prince George's Hospital Authority Due Diligence Process.	Paul Blackwood, Vice President, Planning, Dimensions Healthcare System, Cheverly, MD	District of Columbia Inpatient data
Hospital Financial Project	Health Services Cost Review Commission	Map of Maryland Hospitals
Calvert County Nursing Home Feasibility Study	outside consultant	Produced 11 tables comparing various measures
Persons with Serious Mental Illness Served in Public Psychiatric Hospitals By Funding Source	Sarah Brumfield Associated Press	1998-2007 Psych data
Stress Test and Cardiac Catherization Analysis of Discharge Abstract & Outpatient Ambulatory Surgery By Age	Dr. Roger Leonard Montgomery General Hospital	2006-2007 Discharge Abstract & Outpatient Ambulatory Surgery
Monitoring & assessment of hospitalizations for needs assessments, program evaluation, & priority setting for Family Health Administration programs.	Family Health Administration, Maryland DHMH	CY2000 through 2006 SAS files only DC Data.
Calculating Potentially Preventable Readmission Rates for Marylanders Admitted to DC Hospitals	Dianne Feeney Associate Director Health Services Cost Review Commission	CY 2006 *.mdb DC data

Market Study 2007	Carin Bouharoun, Corporate Director of Planning, Suburban Hospital	2007 DC IRB Limited Data Set
Cardiovascular Out-migration to Washington, DC	Ryan Snoots, Director-Finance Decision Support, Anne Arundel Medical Ctr	1999-2007 DC IRB Limited Data Set
Investigate MD Teen Births and Infant Mortality, Maternal Complications of Pregnancy, Childhood Injuries, Asthma Hospitalizations	Marsha Smith, M.D., MPH, Medical Director for Peri-natal Health, Center for Maternal and Child Health, DHMH	CY2000 through 2007 DC IRB Limited Data Set

Long Term Care Survey (LTCS)
Data staff set up folders and files for the processing of the 2007 LTC survey and assisted staff with post-collection LTC survey processing including verification of accuracy of software code used to create data files. Staff assisted LTC staff with technical components for an RFP for the LTC portal which included review of the RFP and writing specifications for the technical components of the RFP.

Maryland Assessment Tool for Community Health (MATCH)
George Thorpe, project manager of the Maryland Assessment Tool for Community Health (MATCH), presented a demonstration of MATCH to the Commission. The purpose of the MATCH project is to design, develop, test and implement a web-based data-mart analysis portal that will allow the public and Health Department staff to easily perform statistical queries of select Departmental datasets and obtain immediate data results. MHCC collaboration includes testing MATCH and incorporating the Maryland Discharge Abstract data set into MATCH.

MDS - Minimum Data Set (MDS) from the Centers for Medicare and Medicaid – Nursing Home
Staff evaluates the content of datasets received from outside the commission. This resulted in staff making contact with the MDS Manager Contractor to request format changes in their program to obtain consistent data. Staff also developed a method to convert specialty codes in the Medical Care Data Base to the CMS Medicare/Medicaid Taxonomy system.

Nursing Home
Staff developed several iterations of nursing home deficiency analyses to assist the nursing home staff in coming up with new ways to help consumers view the nursing home deficiencies. Staff replicated the Massachusetts model of assigning a deficiency score to each nursing home facility. Staff worked with the nursing home staff to go over reporting of deficiencies for assisted living and nursing homes. Staff continued to process nursing home quality measures, quality indicators, resident and deficiencies to update the Nursing Home Guide and modified data processing to set a special focus flag for facilities that have the designation and added code to the Guide to indicate when a facility is under special scrutiny because of significant

deficiencies. Staff added the ability to view nursing home inspection reports from OHCQ to the Guide. A new web page was developed to report nursing home family satisfaction survey results.

Physician Database

Using the physician database, staff provided analysis of the racial composition of active Physicians with 30 plus hours who have office hours. Data staff synchronized 200 national and Maryland specialties for 2007 data, resulting in counts of the total number of doctors and their average age, and nationally by county in Maryland. Staff entered and cleaned data for the Board of Physicians for the 2,000 active physicians who completed their license renewal manually.

SAS Conversion to Enterprise Guide (EG)

The Data Staff worked with SAS to find a cheaper way to get more SAS licenses and access to the Enterprise Guide for non-programmers. We decided that getting the server-based Enterprise Guide instead of licensing the desktop version would reduce our yearly renewals fees by $7000 and allow more staff to access SAS. The Data Staff completed installation and testing in January 2009 and conducted weekly training to get users familiar with EG.

Software Purchases

Staff negotiated a contract on Grouper Software with the 3M Corp. staff for a license to acquire 5 types of groupers on the Core Grouping Software Platform on a no-fee basis for internal analysis and financial modeling, and performance reporting use.

Trauma Fund

Staff provide SAS programming support for analysis of emergency room physician uncompensated care claims to be paid by the Maryland Trauma Physician Services Fund, and maps of the distribution of trauma patients within the state. This analysis is included in the Annual Report to the General Assembly on the status of the Trauma Fund. Data staff audited payments made to providers and reviewed claims history including overpayments. Data staff automated the Payment Block Memo for the Trauma Fund which allows the memo to be automatically printed, saving staff time from the previous manual process.

Web Projects and Development

Ambulatory Surgery Online Directory

Annually, the Data Staff converts the ambulatory surgery directory database into the format needed for the ambulatory surgery guide. Additionally, the Data Staff converts the ambulatory surgery database into 3 formats and makes them available in the public use file download portion of the website.

Assessments
Data staff maintained the Maryland Health Care Commission User Fee Assessment web application. The database consists of survey data submitted annually from insurance companies, nursing homes, and hospitals. These submissions consist of premiums from insurance companies and admissions and revenues from nursing homes and hospitals. Each assessment is generated based on the applicable percentage of MHCC's budget multiplied by individual submissions over total submissions for each entity.

Assisted Living Online Inspection Reports
Data Staff worked with the Office of Health Care Quality to develop a method to get assisted living facility full inspection reports onto the web. The reports are published and updated on their server, but the application was developed to access their reports on our server as part of our Long Term Care information offerings. Staff implemented changes to the reporting to remove reports less than 90 days old, remove unlicensed facilities, and add a date last updated to the web page.

Electronic Data Interchange (EDI) Progress Survey
The 2008 EDI survey data collection was completed and the data was processed and converted to an Access database format specified by the EDI staff.

Health Insurance Partnership
Governor O'Malley proposed and signed into law a program to reduce the number of uninsured Marylanders. The Working Families & Small Business Health Coverage Act, approved during the Special Session of 2007 establishes the Health Insurance Partnership (HIP) for small employers not currently offering health insurance to their employees. Under the PARTNERSHIP, a small business that has 2 to 9 full-time employees, has not offered health insurance to its employees during the previous 12 months, and meets wage and salary requirements established by the Commission , is eligible to receive a subsidy of up to 50% of the premium. MHCC Staff developed an online application for the Partnership which helps employers calculate their subsidy and fill out the application forms online.

Home Health Agency Annual Online Survey
Data Staff made programmatic corrections and cleaning to the 2007 data collection per the Long Term Care Staff review of the completed data collection. Data Staff implemented and tested all changes requested for the 2008 survey prior to its launch in September 2008. They also improved the survey tracking application and the report generation programs. They created public use files for the website from the home health database.

Hospital Guide
Data Staff helped with the transition from the former hospital guide contractor to a new contractor. This transition included documentation, a new website flowchart, the website

database, the website asp pages and meetings to help the new vendor get an overview of the guide. Data Staff set up a folder on the web to share documents with external users in order to reduce the need for bulk emailing of large documents. Data staff made maintenance updates to bring the hospital guide into conformance with the new Governor's required format and to get the pages to view properly in current browsers. Data staff assisted the hospital staff with ongoing tasks such as web statistics, file maintenance, storage, encryption and transmission between MHCC and the hospital vendor.

MHCC Website Overhaul

The MHCC website was overhauled to accommodate the governor's office new requirements for standardization of the State websites and to direct users based on their interest area. New accessibility tools were implemented and tested in multiple browsers and staff installed and tested software for converting Powerpoint documents to accessible format for the web. Data Staff worked with the Network Staff to create a new protocol for latebreaking items and website maintenance.

Web Statistics

Data Staff researched and converted from using a proprietary web tracking software to using a free version from Google Analytics. Data Staff set up user accounts for staff and helped staff get reports with the new tracking software.

Maryland Health Care Provider Online Licensing

MHCC Staff provided web licensing application updates and support to the following licensing sites:

- Board of Acupuncture
- Board of Audiology / Hearing Aid Dispensers / Speech and Language Pathologists
- Board of Chiropractic Examiners
- Board of Dental Examiners
- Board of Dietetic Practice
- Board of Morticians
- Board of Occupational Therapy Practice
- Board of Examiners in Optometry
- Board of Pharmacy
- Board of Podiatric Medical Examination
- Board of Professional Counselors & Therapists
- Board of Examiners of Psychologists
- Board of Physicians

Collectively these licensing sites served over 100,000 licensees and collected over $15 million in fees.

Network and Operating Systems Division

Overview

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

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

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

Accomplishments

During FY 2009, the Commission's LAN was available to staff more than 99% of the time. A Network Attached Storage device was procured, configured and installed adding 1.5TB of storage allowing immediate access to data over several years for report processing. Staff procured, configured, tested and installed a new firewall replacing a discontinued five year old model. Twenty support staff received new PCs in a phased roll out with no loss in staff productivity.

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

The Center for Long Term Care and Community Based Services

and

The Center for Health Care Financing and Health Policy

THE CENTER FOR HEALTH CARE FINANCING AND HEALTH POLICY

Benefits Analysis Division

Overview

The initial charge to the Health Care Access and Cost Commission (HCACC —one of the predecessors of the MHCC) was to develop a benefit plan for small employers which includes benefits that are at least equivalent to those benefits required to be offered by a federally qualified HMO with an average premium cap for the basic plan that does not exceed twelve percent of Maryland's average annual wage in any year. Working with this statutory floor and ceiling, the legislation also directed the Commission to adopt regulations (COMAR 31.11.06) specifying a comprehensive standard health benefit plan (CSHBP) to apply under Maryland insurance law (Annotated Code of Maryland, Health-General Article 19-103(c)(6)). The Maryland Insurance Article (Annotated Code of Maryland, Insurance Article, Title 15) initially defined the small group market as employers with two to fifty employees. In 1996, the small group market was expanded to include the self-employed. Regulations require the Commission to review the CSHBP annually to assess the adequacy and affordability of coverage (COMAR 31.11.06.12). In 2003, the affordability cap was set not to exceed ten percent of the state's average annual wage (Chapter 93 of the Laws of Maryland, effective July 1, 2003.) The General Assembly passed SB 1014 (enacted during the 2005 legislative session, with a sunset provision of September 30, 2008 – subsequently extended to September 30, 2011), that no longer allows the self-employed to enroll in the CSHBP because of their atypical loss ratio. During the 2009 legislative session, the General Assembly enacted SB 637/HB 674 to remove the statutory floor, effective October 1, 2009.

As of July 1, 1994, carriers participating in the small employer market can only offer a policy incorporating the CSHBP on a guaranteed issue, guaranteed renewal basis. Medical underwriting was phased out as of January 1, 1995. Riders can be issued to improve the

benefits, but not to diminish them. The insurance reform required community rating adjusted only for age and geography. Rating bands were established and are currently set at + 40 percent/- 50 percent. Since its inception, this health insurance reform initiative has provided small businesses in Maryland with access to a comprehensive health insurance benefits package on a guaranteed issue, guaranteed renewal basis, without rating based on health status.

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

Accomplishments

Comprehensive Standard Health Benefit Plan

During FY 2009, the Commission added another plan type available to small businesses under the CSHBP. As a result of regulations implemented effective July 1, 2008, carriers participating in Maryland's small group market are now allowed even more flexibility in product design, with the ability to offer an Exclusive Provider Organization (EPO), either as a stand-alone product or in conjunction with a Health Savings Account (HSA). This additional product offering provides consumers with more choice and allows carriers to price these products more competitively with the added goal of keeping the overall cost of the CSHBP below the affordability cap, currently at 85% of the cap as of December 31, 2008.

Health Insurance Partnership

In FY 2009, the MHCC promulgated regulations (COMAR 10.25.01), which established the eligibility requirements for employers and employees, as well as the process for calculating the average wage of the business and the group subsidies for the premium subsidy program,

eventually named the Health Insurance Partnership. Four major carriers (Aetna, CareFirst, Coventry Health Care of Delaware, and United HealthCare) began enrolling businesses in the Partnership on October 1, 2008, each offering various products that qualify for a premium subsidy. On January 1, 2009, the MHCC published the first annual report on the implementation of the Partnership. This report is posted on the Commission's website.

Health Plan Quality and Performance Division

Overview

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

Accomplishments

2009 Report Series

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

In 2008 Maryland became the first in the nation to provide consumers with audited, comparative analysis of clinical and member satisfaction measures for PPO plans, giving consumers an opportunity to make distinctions about all of their managed care health plan choices on factors beyond price. This was a result of a public-private partnership between MHCC and the major health insurance carriers operating in the state formed in 2006 to broaden the positive effects of quality measurement. Aetna, CareFirst, CIGNA, Coventry, Kaiser, and United Healthcare served as early collaborators with MHCC to test the feasibility of performance measurement and reporting by PPOs. Through these significant voluntary contributions, quality evaluation and reporting has expanded to include comparisons along the breadth of managed care products—HMO, POS, and PPO—in a single, independently audited

source. For the near-term, the voluntary participation by PPO plans signifies a broad-based commitment by Maryland health plans to collectively use quality measurement and reporting to achieve a healthier Maryland; three plans continue to voluntarily report quality information on PPOs.

The series of annual health plan performance reports remained a collection of three reports:

- The 2009/2010 Health Plan Performance Report (released in October 2009) is a consumer-oriented report providing a sub-set of measures that are of interest to a general audience. Development of the health plan performance reports is now centered on tailoring the consumer version to become topic driven; the focus topic in 2009 was consumer engagement.
- The 2009 Comprehensive Report on Maryland HMO and POS Plans (released in February 2010) is designed to help plans, purchasers, and policy makers assess the relative quality of care delivered by plans. The report contains three years of HEDIS, CAHPS and eValue8 results, comparing plans to the Maryland state average and highlighting when plan performance significantly increased or decreased. This report was reduced in scope from previous years eliminating information about the public health benefit of each measure category.
- The 2010/2011 State Employee Guide (released in March 2010) is a consumer-oriented report for state employees. The report mirrors the consumer guide providing information on the subset of plans offered to Maryland state employees.

2010 Report Series

Moving forward, development of the health plan performance reports will focus on providing comparative health plan web-based report cards that present consumer-friendly summary information. As a part of this effort division staff are reaching out to Maryland employers to better understand how the health plan reports can be more useful to them and their employees in selecting health plans.

Mandated Health Insurance Services Evaluation

Overview

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

In 1999, the Legislature expanded these requirements to request annual reporting on whether the fiscal impact of existing mandates exceeded a statutory income affordability cap of 2.2 percent of Maryland's average annual wage. If the 2.2 percent affordability cap was exceeded, an analysis of the medical, social, and financial impacts of all current mandates was required. That study was eliminated during the 2003 legislative session and replaced with a new study (now called the "Comparative Evaluation") which was required to be submitted to the General Assembly by January 1, 2004, and every four years thereafter. The Comparative Evaluation must include: (1) an assessment of the full cost of each existing mandated benefit as a percentage of the State's average annual wage and of premiums under a typical group and individual health plan, under the State employee health plan, and under the Comprehensive Standard Health Benefit Plan; (2) an assessment of the degree to which existing mandated benefits are covered in self-funded plans; and (3) a comparison of mandated benefits provided in Maryland with those provided in Delaware, the District of Columbia, Pennsylvania, and Virginia based on the number of mandates, the type of mandates, the level and extent of coverage for each mandate, and the financial impact of differences in levels of coverage for each mandate.

Accomplishments

In FY 2009, five proposed mandates were evaluated: coverage of autism spectrum disorder; coverage of in vitro fertilization; coverage for a 48-hour hospital inpatient stay following a mastectomy; coverage of prosthetic devices; and coverage of the shingles (Herpes Zoster) vaccine. This analysis, prepared by Mercer, the Commission's consulting actuary, was approved by the Commission in December 2008, submitted to the General Assembly and posted on the Commission's website. The next Comparative Evaluation, which is due every four years, will be published in January 2012.

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

Long Term Care Quality Initiative

Overview

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

members and other designated responsible parties of residents in Maryland's long-term care facilities.

Long Term Care Performance Guides

In 2009 two performance guides were operational: the Maryland Nursing Home Guide and the Maryland Guide to Assisted Living Facilities. The purpose of the guides is to assist consumers in making informed choices and to stimulate quality improvement within the facilities.

The Maryland Nursing Home Guide offers information about 237 comprehensive care nursing facilities and continuing care retirement communities. Users can review information about: facility characteristics such as ownership information, the number of beds by type, and proximity of toileting facilities to resident rooms; clinical and assistance services available; resident characteristics including gender, age, and functional status; the quality measures derived from the CMS Nursing Home Compare data; quality indicators; and the results of inspection surveys. A section also features pictures of the nursing home.

The Guide also provides information about patient rights, how to pay for nursing home care, a checklist to use when choosing a nursing home; and links to additional resources. An interactive search feature allows the user to access nursing home information by facility name or geographical area (county or zip code).

The Maryland Guide to Assisted Living Facilities contains an inventory of over 350 assisted living homes with 10 or more beds. Information on facility characteristics, levels of care, facility services, rates, and inspection reports can be found in the Guide to Assisted Living.

The Commission updates each Guide on a regular schedule.

Nursing Home Experience of Care Survey

2009 marks the third year for the Nursing Home Family Survey which collects the experience and satisfaction of the family members and responsible parties of nursing home residents. Maryland is one of only a few states that conduct an annual nursing home survey; the Maryland survey consistently yields a high response rate of nearly 60%. Overall, survey respondents give high marks to the nursing homes. The survey collection time frame is mid-September to mid-November with results released in February or March of each year. The accomplishments section lists the results of the 2008 survey which were released in the spring of 2009.

Accomplishments

LTC Web Portal

Staff developed detailed specifications to transition the Maryland Nursing Home Guide and Maryland Guide to Assisted Living into a robust and expansive web site for long term care services focusing on services received in the community and in one's home. Service categories

to be added include adult day care, congregate housing, congregate meals, caregiver resources, home delivered meals, home health agencies hospice, residential service agencies, nursing referral service agencies, respite services, senior centers, and technology and transportation assistance. Additional sections of the site will be devoted to "General Information & Assistance" and resources for "Preparing for the Future."

Detailed specifications describing content of the LTC services for the web site enhancement were translated into an RFP, which will be released in FY 2010, to secure a vendor to design and build the expanded portal. The expanded web portal is expected to debut in calendar year 2010.

Outreach

Staff sought opportunities to promote the various products of the LTC Quality Initiative. In the spring of 2009 the results of the Nursing Home Family survey were featured on two local television news and radio stations through on-air interviews with Commission staff. Press releases resulted in placement of stories in weekly or monthly local newspapers throughout the state. All media presented the survey and its uses in a positive light. Phone and email inquiries to LTC staff and visits to the Guides increased during and after the media attention.

Staff also developed a display aimed at educating consumers about the Guides and to introduce the expanded LTC site. The display will be featured in the two-day Maryland Senior Expo scheduled for the fall of 2009. The annual expo typically attracts over 10,000 visitors and more than 500 vendors. Staff will assess the impact of the display at the expo and, if positive results, will seek similar opportunities to promote the LTC web site.

Family Survey Results

2008 results show that statewide "overall satisfaction" was rated 8.2 on a 10 point scale and 89% of respondents said they would recommend the nursing home to others.

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

- At the invitation of Agency for Healthcare Research and Quality (AHRQ) and Centers for Medicare and Medicaid Services (CMS), Commission staff presented the Maryland family survey at the national CAHPS User Group meeting in December 2008.

Other Accomplishments

LTC Experience of Care Surveys

During the year, LTC Quality staff researched surveys for use in Maryland for consumers of home health, assisted living, and hospice services. Staff is assessing the feasibility of

implementing consumer surveys in each of these settings to improve the information available to consumers.

Short Stay Nursing Home Survey

Trending of data has shown that a number of Maryland nursing homes have increasing numbers of short stay residents. The number of people needing short stays in nursing homes is expected to increase with the aging of the baby boomers. During this fiscal year, MHCC staff explored the feasibility of collaborating with the Agency for Healthcare Research and Quality (AHRQ) to utilize the ARHQ short stay survey in Maryland. This collaboration will benefit AHRQ by providing additional testing of the instrument; MHCC will benefit by piloting an experience survey among nursing home short stay residents. If the pilot is approved by both agencies, it will take place in the fall 2009 survey cycle.

Participation in National Quality Efforts

At the invitation of Agency for Healthcare Research and Quality (AHRQ) and Centers for Medicare and Medicaid Services (CMS), LTC quality staff participated in technical assistance calls throughout the year to provide advice and feedback on revisions to CMS Home Health Compare which reports home health services outcomes for recipients of home health services. In addition to improving the current content on the site, AHRQ and CMS are developing a web-based report format for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home Health Survey. CMS has indicated the home health survey will be voluntary for Medicare-certified home health care agencies beginning in the spring/summer of 2009 with public report of results expected by late 2010. Commission staff benefits by participation in this process by gaining knowledge of cutting edge public report practices that can be applied to the MHCC consumer reports.

Long Term Care Policy and Planning

Overview

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

leadership and direction to technical advisory committees and workgroups conducting analyses of a wide range of issues.

Accomplishments
Reports:
HB 558: Home Health Report
During the 2008 legislative session, HB 558 was introduced, but did not pass. Following a hearing on the bill, the Chairman of the Health and Government Operations Committee asked the Commission and the Office of Health Care Quality to recommend, in the absence of certificate of need (CON) for home health agencies, how best to assure regulatory oversight and quality, how possible adverse effects could be mitigated, and what the fiscal implications of the change would be.

Three meetings of the group were held between September and November, 2008. Membership of the Advisory Group included: home health agencies, residential service agencies, Medicaid, Centers for Medicare and Medicaid Services, the Board of Nursing, AARP, the Maryland National Capital Homecare Association, as well as staff of the Office of Health Care Quality, and the Commission. At the first meeting, there were presentations on how current regulations under CON as well as licensing are implemented. Data comparing Maryland's home health agency utilization with that of neighboring states and the nation as a whole were also presented. There was also a review of current measures of home health agency performance as well as a discussion of options for regulation.

At the second meeting, a survey of state licensing agencies was presented. There were a wide range of responses from no licensure to licensure of programs as well as of individuals providing care. There was also a presentation of results from a survey of the top performing states on home health measures. Using the Agency for Healthcare Research and Quality (AHRQ's) snapshots, nine states were selected that had a meter score of 75 or higher, since Maryland's score was 75. The data showed that there is not a direct relationship between a state's high performance on home health care with that of a state having or not having a Certificate of Need (CON) program. The only consistent observation was that for those states with a CON program for home health, the number of Medicare certified home health agencies per 100,000 beneficiaries was lower than for states without a CON program.

The third meeting was held on November 17, 2008. The discussion focused on proposals for regulatory oversight. The report was submitted to the House Halth and Government Operations Committee prior to the December 31st due date. In addition, Dr. Cowdry presented this report to the Health Facilities and Occupations Subcommittee of the Health and Government Operations Committee on January 21, 2009.

Goals were set to guide the development of an alternative regulatory process:

1. Provide greater choice for Medicare beneficiaries while maintaining high quality.

2. Assure that home health agency applicants have a track record of clinical quality, client satisfaction, and financial strength.
3. Improve information about quality and satisfaction in all skilled residential services.
4. Promote competition on the basis of quality, innovation, and satisfaction.
5. Use quality, satisfaction, and service volume data in making licensure and relicensure decisions.
6. Have a limited impact on the state budget.

Various regulatory options were offered for both MHCC and the Office of Health Care Quality to pursue.

Chronic Hospital Occupancy Update

As required under COMAR 10.24.08, a notice was published in the January 2, 2009 Maryland Register to update "Chronic Hospital Occupancy for FY 2007." This report is required to be updated annually. It reports data on occupancy for both private and state-operated chronic hospitals. The private chronic hospitals include James Lawrence Kernan Hospital; Johns Hopkins Bayview Medical Center; Levindale Hebrew Geriatric Center and Hospital; University Specialty Hospital (formerly Deaton); and Gladys Spellman Specialty Hospital and Nursing Center. The state operated chronic hospitals include Western Maryland Center and Deer's Head Hospital Center.

Nursing Home Occupancy Rates and Utilization by Payment Source: Maryland Fiscal Year 2006-2007

Data on nursing home occupancy and Medicaid participation rates is updated periodically and published in the Maryland Register to guide Certificate of Need decisions and other planning functions. The following tables were submitted to the Maryland Register for publication in the April 10, 2009 issue: "Nursing Home Licensed Beds Occupancy by Region and Jurisdiction: Maryland, Fiscal Year 2006"; "Required Maryland Medical Assistance Participation Rates for Nursing Homes by Region and Jurisdiction, Fiscal Year 2006"; "Nursing Home Licensed Beds Occupancy by Region and Jurisdiction: Maryland, Fiscal Year 2007"; "Required Maryland Medical Assistance Participation Rates for Nursing Homes by Region and Jurisdiction, Fiscal Year 2007."

Home Health Agency Data

Staff compiled data tables on the utilization and financing of home health agency services in Maryland for fiscal year 2007. The data was obtained from the information collected by the Commission's Home Health Agency Survey for fiscal year 2007 using the new automated system, which includes data on overall agency operations and the demographic characteristics, payer types, and services provided to Maryland clients by their jurisdiction of residence. The data tables for fiscal year 2007 were posted on the Commission's website. Data tables include an overview of home health agency characteristics, utilization and costs including: volume of admission; referral sources; primary diagnosis on admission; average visits per Medicare

clients; disposition; revenues by payer types; and home health agency personnel. Staff continued to analyze home health agency utilization trend data based on information submitted to the Commission in its Home Health Annual Surveys. During this time period, data was collected from all licensed home health agencies in Maryland for the FY 2008 reporting period.

Meetings/Collaboration:
Nursing Home Liaison Committee

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

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

House Bill 1187 Work Group
HB 1187, passed during the 2007 legislative session, relates to both ownership and the financial condition of nursing homes. This bill requires the Secretary of the Department of Health and Mental Hygiene to convene a stakeholders workgroup to make recommendations to the Secretary regarding regulations on: ownership and other information to be required from nursing homes on licensure and relicensure; information on changes in financial condition to be reported to the Department; and other items related to nursing home licensure. Staff attended these workgroup meetings from June, 2008 through October, 2008. The Workgroup reviewed current documents and regulations including: Medicare Enrollment Applications; Medical Care Program (Medicaid) Provider Application Instructions; Licensure Renewal Application Packet; Assisted Living regulations; and the Certificate of Need Application form. Discussion also

focused on triggers to indicate significant financial changes in nursing homes. The Office of Health Care Quality then drafted regulations to address the issues identified.

Presentations:
On February 24, 2009 staff was invited to the Annual Hospice Day in Annapolis to make a presentation to the membership about the status of data collection and other planning issues. Commission staff presented data on hospice patient profiles for FY 2007, selected hospice trends from 2004-2007, and progress made in data collection and analysis. Public use data sets for FY 2003-2007 were posted on the Commission's website along with a Trend Analysis for 2004-2007, and a Statistical Guide.

Data Collection:
Hospice Data Collection

The Commission was charged with collection of its own hospice data without relying on other sources, as a result of SB 732 (2003). The Commission procured a contract with Perforum (now OCS), which has developed data collection tools for the National Hospice and Palliative Care Organization, to develop an online hospice survey. The Fiscal Year 2007 hospice data was collected and finalized during this time period. The annual survey has been updated to include: development of a web-based completion and certification process; use of electronic signature procedures to authorize survey completion; requiring full survey completion and corrections of errors prior to survey submission. In addition, there will be trend analyses of Maryland hospice data.

Public use data files for FY 2007 hospice data were posted on the Commission's website in December, 2008. This year there was also the addition of an Interpretive Guide to explain the variables in the data set. In January 2009, work was completed on a Trend Analysis of hospice data for the time period of 2004-2007. This shows the differences in variables from year to year and indicates where differences are statistically significant. The Trend Analysis is accompanied by a Statistical Testing Guide that helps the reader to understand what significance tests are being applied and what caveats must be used in interpreting the data.

The Fiscal Year 2008 Maryland Hospice Survey was released for online survey completion effective February 20, 2009. Data collection, cleaning, and analysis were monitored by means of weekly phone conference calls.

Long Term Care Survey
The 2007 Maryland Long Term Care Survey was released on July 23, 2008; the web-based Pre-Survey Facility Information Update Form was made available for updates of contact information by facility staff on June 23, 2008. The Commission completed data collection on the 2007 Maryland Long Term Care Survey, which included comprehensive care, extended care, subacute

care, chronic care, assisted living and adult day care facilities. Responses were received from 683 facilities, representing 98% of the surveyed facilities in 2007. The public use data sets for the 2007 survey were posted on the Commission's website in March, 2009.

Data elements such as the Medicaid Cost Report data and prior year ending year data were pre-populated into the current year's survey increasing efficiency and reducing errors. Survey data was provided to the public via reports such as the Public Use Data Set posted on the Commission's Web Site, responses to the Nursing Home Guide, and the Guide to Assisted Living Facilities. The 2008 Maryland Long Term Care Survey was released on June 22, 2009; the survey was released a month earlier than in previous years to expedite data collection and cleaning. In addition, survey participants were given a two-week lead time (June 9, 2009) to start the survey process early.

Home Health Agency Survey

For fiscal year 2008, the Home Health Agency Survey were made available to agencies for online completion in two phases instead of four iterations used in the past. Phase 1 for agencies with a fiscal year ending of March 31, 2008, May 31, 2008, and June 30, 2008 and Phase 2 for agencies with a fiscal year ending of September 30, 2008 and December 31, 2008. The FY 2008 Home Health Agency Survey for Phase 1 agencies was released via our web based application on the Commission's web site on September 8, 2008 due to the Commission on December 8, 2008. Responses were received from 27 agencies representing 100% of surveyed agencies. Staff provided training to all home health agency directors at various dates and locations throughout the State of Maryland.

MARYLAND HEALTH CARE COMMISSION

The Center for Hospital Services

The Center for Hospital Services

Hospital Planning & Policy

Overview

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

Accomplishments

State Health Plan

Development of a comprehensive revision of COMAR 10.24.10, the Acute Inpatient Services Chapter of the State Health Plan, was initiated during FY 2007 and was completed in FY 2009. An Acute Care Planning Work Group composed of general hospital representatives, Department of Health and Mental Hygiene representatives (Office of Health Care Quality and Medicaid), and a representative of third-party payors, completed work on an informal draft replacement plan, which was released for informal review and comment in May, 2008.

Based on the comments received, a revised draft was developed and the work group met again on August 4, 2008 to review this second draft. On September 18, 2008, the Commission adopted proposed permanent regulations and, at the same time, adopted, on an emergency basis, a supplement to the existing State Health Plan Chapter, updating the medical/surgical and pediatric bed need projections. This latter action was taken so that these projections could

be used in project review during the period required for promulgation of the new chapter as a final regulation.

On December 18, 2008, the Commission adopted the new COMAR 10.24.10, State Health Plan for Facilities and Services: Acute Care Hospital Services, as final regulations. The regulations took effect on January 26, 2009.

Annual Acute General Hospital Bed Licensure

Each year, the Commission participates in the annual process of updating the licensed acute care bed capacity for Maryland's acute general hospitals. Acute average daily census for the twelve-month period ending in March of each year is calculated from data collected by the Health Services Cost Review Commission. MHCC then reports the total acute care bed capacity for the upcoming fiscal year, equal to 140% of this average daily census. Each hospital then responds with the service mix designation they wish to assign for this licensed bed total, allocating the beds to up to four defined service categories, so long as they have approval for those services. The categories are medical/surgical/gynecological/addictions, obstetric, pediatric and acute psychiatric.

In May of each year, licensure application forms with the new bed licensure numbers for the coming fiscal year are sent to all hospitals. Along with the allocation of their licensed capacity, hospitals are asked to provide information to the Commission on changes in the capacity of other hospital inpatient services. This annual survey, performed in conjunction with the licensure update process, has historically collected information on the inventory of emergency department treatment spaces, obstetric and perinatal service facilities, and surgical facilities. In 2008, the survey was expanded to collect information on psychiatric, medical rehabilitation, and special hospital bed inventories. On October 31, 2008, a report summarizing the licensure and related survey data, the Annual Report on Selected Maryland Acute Care Hospital Services, FY 2009, was published on the Commission's website.

For FY 2009, the number of licensed acute inpatient beds in Maryland's 47 general acute care hospitals increased from 10,681 to 10,827. The hospitals reported that their physical acute care bed capacity for FY 2009, i.e. the maximum number of acute care beds they could "physically" set up and staff, on short notice was 11,561 beds, 734 beds above the total acute care beds licensed for FY 2009. The 1.4% increase in licensed acute care hospital bed capacity was below the 1.6% average annual increase seen from FY 2002 through FY 2009. Maryland instituted its dynamic hospital licensure process for acute care hospital beds beginning in FY 2002.

In May, 2009, the hospital inventory survey conducted in conjunction with the bed licensure renewal process was expanded to include information on surgical cases and surgical case times.

Ambulatory Surgery Provider Directory

The eleventh edition of the Commission's Maryland Ambulatory Surgery Provider Directory was posted on the Commission's website in on December 5, 2008. The Directory provides CY 2007 information on freestanding and hospital-based ambulatory surgery providers in Maryland, such as inventory and utilization data, surgical specialties, and contact information.

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

In early 2009, Commission staff developed several new questions for the ambulatory surgery survey relating to board certification of medical staff, hospital privileges maintained by practitioners on staff at freestanding surgical facilities, and transfers of patients from freestanding surgical facilities to hospitals. Additionally, a supplemental survey on the use of health information technology by ambulatory surgical facilities was developed by the Commission's Center for Health Information Technology staff and the annual survey was felt to be an appropriate vehicle for implementing this survey. On March 6, 2009, these additions to the survey were previewed by Commission staff for a group of surgical facility representatives to gain input on how to incorporate these additions into the 2009 survey. Eventually, material gathered in response to the new questions will be incorporated in the Maryland Ambulatory Surgical Facility Consumer Guide.

On April 21, 2009, the Center for Hospital Services distributed the 2009 survey to 364 potential survey respondents.

Policy Coordination with Other Agencies

Hospital planning and policy staff meet periodically with the Health Services Cost Review Commission staff to discuss issues of interest to both agencies, such as data coordination, hospital capital projects, policy and data reports, the status of updates to the State Health Plan for Facilities and Services, the status of CON reviews, rate setting policies and rate reviews, and particular financial challenges confronting specific hospitals. In FY 2009, a significant issue requiring coordination was the change made in how hospital outpatient service episodes are recorded in HSCRC data bases and the implications for MHCC work requiring interpretation of this data.

Hospital policy and planning staff also meet periodically with the staff of the Office of Health Care Quality of the Department of Health and Mental Hygiene, which licenses health care facilities, to discuss and coordinate, as necessary, on issues bearing on Commission planning and regulatory activity and facilities licensure.

Other

Freestanding Medical Facilities

Under Health-General Article §19-3A-07(c), the freestanding medical facility pilot project, the pilot facility, a freestanding emergency services facility in Germantown (Montgomery County) developed and operated by Shady Grove Adventist Hospital, is required to provide to the Maryland Health Care Commission information, as specified by the Commission, on the configuration, location, operating, and utilization, including patient-level utilization, of the pilot project. In addition, Health General Article §19-131 requires other facilities that may be approved as freestanding medical facilities to provide information to the Commission. In FY 2006, the data reporting requirements of the law were implemented through regulations (COMAR 10.24.06 Data Reporting by Freestanding Medical Facilities) and a Data Work Group was established to provide assistance in development of the proposed patient-level data set for the pilot project freestanding medical facility. In FY 2007, a second pilot freestanding medical facility was authorized by the General Assembly for development in Queen Anne's County. Work was also initiated on the development of a report for the General Assembly examining how the pilot projects function operationally and financially. In FY 2008, site visits were conducted at the Germantown facility and a freestanding emergency medical center with a longer operational history in Fairfax County, Virginia and an Interim Report on the Operations, Utilization, and Financing of Freestanding Medical Facilities was reviewed by the Commission and submitted to the Chairmen of the Senate Finance and House Health and Government Operations Committees.

In FY 2009, work continued on development of a final report, planned for completion and release in FY 2010.

Mental Health Planning

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

The Commission initiated work on this plan in FY 2008 and work continued into FY 2009. With the aid of consultants, a series of three "White Papers" examining the "framework for planning" mental health care services, the roles of state and private hospitals in service provision, and "best practices" were developed and reviewed by the Task Force between February and August, 2008.

On August 19, 2008, the Task Force held a wide-ranging session to discuss issues that Task Force members felt had not been given adequate or appropriate attention in the Task Force work done up to that time, to obtain points of view that had not yet been represented in Task Force deliberations, and to obtain recommendations for adoption by the Task Force.

On September 23, 2008, a fourth White Paper, addressing "gaps in data available to assess need for service, to understand use of services across settings, and to plan for an integrated mental health system" was developed and the Task Force met to review and discuss this paper.

On December 16, 2008, a draft Interim Report of the Task Force on the Development of a Plan to Guide the Future Mental Health Service Continuum was reviewed and discussed by the Task Force, with recommendations for revision and further sub-Task Force work on specific issues.

Hospital Quality Initiatives

Overview

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

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

Hospital Performance Evaluation Guide Advisory Committee

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

Healthcare-Associated Infections

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

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

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

Accomplishments

The Maryland Quality Measures Data Center (QMDC)

The Commission relies heavily on data from a variety of sources to support the hospital performance evaluation system. In FY2009, the MHCC initiated a consolidated data management strategy which entailed the establishment of a Quality Measures Data Center (QMDC). The QMDC functions as Maryland's repository of hospital performance measures data and includes a secure web portal for hospital submission of quality measures and patient experience data. The QMDC provides direct and timely access to detailed patient-level quality and performance measures data and enables the Commission to validate the accuracy and completeness of the data as well. The QMDC also functions as a centralized communication tool for sharing information with hospitals on upcoming reporting requirements and well as providing a vehicle for review of facility performance data prior to public release. The Commission intends, when feasible, to utilize the QMDC as the repository for all future quality data collection activities including outpatient and emergency services, and HAI data.

Expanded Quality Measures Data Collection

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

Healthcare Associated Infections

A major focus during FY 2009 was the implementation of recommendations developed by the HAI Technical Advisory Committee (TAC). Based upon extensive discussions, expert advice and review of the medical literature by the TAC and MHCC staff, it was recommended that the HAI reporting expansion be initiated with the reporting of measures on 1) Central-Line-Associated Bloodstream Infections (CLA-BSIs) in All Intensive Care Units, 2) Health Care Worker (HCW) Influenza Vaccination, and 3) Compliance with Active Surveillance Testing for MRSA in All ICUs. The Committee further recommended use of the National Healthcare Safety Network (NHSN) as the vehicle for collecting these data.

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

The HAI Technical Advisory Committee recognized that the implementation and sustainability of the Committee's recommendations would require ongoing involvement of individuals with expertise in infection prevention and control. To facilitate implementation of the recommendations, the HAI Advisory Committee was established to provide ongoing guidance and support to this project. As a result, the Commission has made significant progress towards the implementation of the Committee's recommendations.

National Healthcare Safety Network (NHSN)

The NHSN is an internet-based surveillance system that integrates patient and healthcare personnel safety surveillance systems. It is managed by the Division of Healthcare Quality Promotion of the CDC. As of July 1, 2008, Maryland hospitals report CLABSI data to the Commission and all hospitals are now using the surveillance system to collect information and monitor CLABSIs in ICUs. Maryland is now one of twenty-one states that participate in this national internet-based surveillance system.

CLABSI Data Validation Project

During FY2009, the Commission initiated a procurement project to engage the services of a contractor with expertise and experience in the review of healthcare infections data. The contract was initiated with on-site hospital audits of patient medical records. The Commission anticipates the audit process will be completed in FY 2010 and plans to use the audit results to educate hospital data providers and facilitate process improvement activities.

Other HAI Data Collection Activities

Under the continued guidance of the HAI Advisory Committee, the MHCC developed the 2009 Annual Survey of Maryland Hospital Infection Prevention and Control Programs. The web-based survey was designed to collect information on the staffing, operations, and activities of hospital infection prevention and control programs in Maryland. The survey assisted the Commission in understanding the basic characteristics of hospital programs and will be used to inform future HAI public reporting and quality improvement initiatives.

In FY2009, the Commission also developed an online survey for collecting data on the rate of Health Care Workers Influenza Vaccination in hospitals. This survey was initiated as a pilot project to provide useful information on employee vaccination rates to hospitals and to show how individual hospitals compare to one another and to the State as a whole. The results of the pilot survey were not made publicly available, but were used to inform staff efforts geared toward the development of an annual survey of hospital employee vaccination practices.

An online survey for collecting data on the level of Active Surveillance Testing (AST) for MRSA in All ICUs was also developed in FY2009. It is important to note that this is a process measure that evaluates the rate of hospital screening for MRSA in all ICUs; it is not an outcome measure that evaluates the rate of MRSA colonization or infection in the hospital. The results of these quarterly surveys will be posted to the Hospital Performance Evaluation Guide in FY2010.

Specialized Services Policy and Planning Division

Overview

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

Accomplishments

State Health Plan Provisions for Primary PCI Waiver

The State Health Plan for Cardiac Surgery and Percutaneous Coronary Intervention (PCI) Services requires that hospitals providing PCI services have on-site cardiac surgical services; however, the Commission may waive its policy if the exemption meets specific conditions. Under COMAR 10.24.17.05D(1), the Commission may issue a waiver that permits hospitals without on-site cardiac surgery, upon demonstrating the ability to comply with the requirements for primary PCI programs, to provide primary PCI services. Primary PCI is a catheter-based technique used to relieve coronary vessel narrowing associated with acute ST-segment elevation myocardial infarction (STEMI).

In January 2006, the Commission established a clinical data registry for patients with STEMI who present at hospitals that provide primary PCI under a waiver. The registry provides the audited data necessary to monitor each primary PCI program's compliance with certain regulatory requirements, including patient eligibility, door-to-balloon times, and institutional volume. In March 2009, the Commission received informal public comments on draft proposed amendments to COMAR 10.24.17 that were designed to bring the regulation into compliance with the current guidelines of the American College of Cardiology and the American Heart Association. In April 2009, the Commission approved the adoption of proposed permanent regulations to require, effective January 1, 2010, that hospitals provide primary PCI as soon as possible and not to exceed a 90-minute door-to-balloon time for 75% of appropriate patients. The registry data showed that, from January to June 2009, 70% of the patients undergoing primary PCI at the hospitals with waivers received PCI in 90 minutes or less. The performance

of the waiver hospitals has improved steadily since 2006, when 39% of their patients received PCI within 90 minutes.

In March 2009, the Commission convened a work session on clinical and data management issues related to primary PCI. All of the hospitals with primary PCI waivers attended the meeting, which included a summary of 2008 data from the Commission's registry, a presentation on one hospital's Code STEMI process, a presentation on Institutional Primary PCI Volume and Mortality: The C-PORT Experience, and a discussion of the current and proposed requirements for door-to-balloon times.

As of June 2009, the following hospitals without on-site cardiac surgery had primary PCI programs: Anne Arundel Medical Center, Baltimore Washington Medical Center, Carroll Hospital Center, Franklin Square Hospital Center, Frederick Memorial Hospital, Holy Cross Hospital, Howard County General Hospital, Johns Hopkins Bayview Medical Center, Saint Agnes Hospital, Shady Grove Adventist Hospital, Southern Maryland Hospital Center, Upper Chesapeake Medical Center, and Washington County Hospital. The schedule for the receipt of primary PCI waiver applications is available on the Commission's website.

State Health Plan Provisions for Non-Primary PCI Waiver

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

Based, in part, on the guidance of its Research Proposal Review Committee, the Commission determined that the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) study offers a means of acquiring information to support future evidence-based State health care policy and planning with regard to cardiovascular services. Effective on October 22, 2007, COMAR 10.24.05 Research Waiver Applications: Atlantic C-PORT Study of Non-primary PCI established a one-time process by which an eligible hospital may seek a waiver and be permitted to provide non-primary PCI services as part of the multi-state Atlantic C-PORT study (C-PORT E). The regulations set up a two-phase review of applications and provided that the Commission may grant non-primary PCI research waivers to a maximum of six hospitals statewide. In the first phase of the review, the Commission considered applications from hospitals in the Metropolitan Baltimore and Metropolitan Washington regional service areas. In September 2008, the Commission granted research waivers to Anne Arundel Medical Center, Shady Grove Adventist Hospital, Southern Maryland Hospital Center, and Saint Agnes Hospital, and held two waivers in abeyance pending the completion of the second phase of the review, which involved applications from eligible hospitals in the more rural Western Maryland and

Eastern Shore regional service areas. At that time, the Commission took no action on the applications of Baltimore Washington Medical Center, Johns Hopkins Bayview Medical Center, and Holy Cross Hospital.

In October 2008, the Commission received research waiver applications from two hospitals in the Western Maryland Regional Service Area; in March 2009, the Commission awarded non-primary PCI research waivers to Frederick Memorial Hospital and Washington County Hospital. The Commission also approved the adoption of emergency and proposed permanent regulations to increase the number of hospitals that may perform non-primary PCI as part of the C-PORT E study from not more than six to not more than nine. The amendments provided that a hospital whose application was docketed and pending as of March 18, 2009 may be considered for a non-primary PCI waiver. Available for the Commission's consideration at that time were the hospital-specific data in the 2008 primary PCI report and information about the status of the C-PORT E study as of February 3, 2009. Additionally, the Commission required the eligible hospitals to provide updated data on actual and estimated case volumes. In June 2009, the Commission approved the applications of Baltimore Washington Medical Center, Johns Hopkins Bayview Medical Center, and Holy Cross Hospital for research waivers to provide non-primary PCI without on-site cardiac surgery services within the C-PORT E study.

The Commission's staff and the principal investigator of the C-PORT E study met with each hospital before the hospital started to implement the C-PORT E development program and enroll patients in the study. The purpose of the meetings was to review key issues related to the research waiver program, including protocol requirements and waiver conditions. The research waiver is time-limited and not intended to consider locations for non-primary PCI programs without cardiac surgery on-site beyond the study period. The research proposal, Committee report, Commission decisions, and related documents are available on the Commission's website.

State Health Plan for Neonatal Intensive Care Services

In 2008, the Department of Health and Mental Hygiene reconvened its Perinatal Clinical Advisory Committee to review and update the Maryland Perinatal System Standards; the Department issued the recommendations of the Perinatal Clinical Advisory Committee in October 2008. The Commission's staff participated in revising the standards to be consistent with the latest edition of the Guidelines for Perinatal Care, which is issued jointly by the American Academy of Pediatrics (AAP) Committee on Fetus and Newborn and the American College of Obstetricians and Gynecologists (ACOG) Committee on Obstetric Practice, as well as the AAP 2004 Policy Statement on Levels of Neonatal Care. The most current version of the Maryland Perinatal System Standards is incorporated by reference in the Commission's State Health Plan for Neonatal Intensive Care Services (COMAR 10.24.18), which identifies Level III as neonatal intensive care services. The revised standards are available at http://www.fha.state.md.us/pdf/mch/perinatal_standards.pdf.

Certificate of Need (CON) Division

Overview

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

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

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

Accomplishments

Certificate of Need Applications and Modifications

During FY 2009, the Commission completed review of fifteen (15) CON applications, approving all fifteen; most with conditions. It also approved one (1) modification to a previously approved project. One (1) CON application in review was withdrawn by the applicant and seventeen (17) CON applications were dismissed from the review process for failure to provide or disclose required information or, in one case, because material taken from another applicant was used in an application without the other applicant's authorization. Three (3) Certificates of Need that had been issued by the Commission were relinquished by the holders. One of these projects had been initiated and partially completed prior to a decision by the holder to abandon the balance of the project. The other two CONs involved a single project. The Commission considered one (1) request for reconsideration of a CON application it had previously denied (in FY 2008). The Commission did not find good cause for reconsideration of the denial.

In recent years, Maryland hospitals have invested heavily in replacing, expanding, and renovating hospital physical plants. During this period, hospitals experienced steady growth in patient census. Unfortunately, this period also saw sharp upward spikes in the prices for several important construction materials and high construction contract costs, related to the strong demand for project management expertise and construction trade labor. From 2002 through 2007, the Commission approved new hospital CON projects totaling over $1.167 billion in estimated project cost and also authorized additional spending of $98.5 million for previously approved hospital capital projects. The hospital building boom slowed in FY 2008. However, the problem of escalating cost encountered by hospitals which planned major capital projects in previous years and initiated projects in 2006 and 2007 was a prominent theme in CON review. In FY 2008, the Commission approved six hospital CON projects totaling $323.6 million but authorized a greater level of spending, $439 million, in cost increases for seven hospital projects previously approved. Most of this increase, which, in the aggregate, amounted to a 20.1% rise in the $2.2 billion cost previously authorized for these projects, was due to inflation in the cost of construction.

The hospital building boom definitively subsided in FY 2009. The Commission reviewed five hospital projects, but only one of these was a large expansion and renovation proposal, at an estimated cost of $89.1 million. The other four hospital projects, in the aggregate, totaled only $32.3 million in spending. No modifications to the approved cost of hospital projects were considered in FY 2009.

There was one hospital "pledge" project, i.e., a project exceeding the capital spending threshold defining reviewability but not otherwise including elements requiring CON review, in FY 2009, at an estimated cost of $54.9 million. Such projects avoid the need for CON approval by "pledging" not to seek substantive rate adjustments related to the project's depreciation and interest expenses.

Nine nursing home, or comprehensive care facility projects, involving the establishment, replacement, or expansion of such facilities were authorized in FY 2009 at a total estimated cost of $120 million. One modification of a previously approved nursing home project was authorized, adding $1.2 million in project cost and one approved nursing home project was authorized to have more beds. The total cost estimate for this new facility declined slightly from its original approved cost.

Approved CONs

Citizens Nursing Home of Frederick County (Frederick Co.)
Replacement on site of a 170-bed comprehensive care facility ("CCF") – No new bed capacity
Approved with conditions - $35,275,419

Franklin Square Hospital Center (Baltimore Co.)

Introduce inpatient adolescent psychiatric services – terminate inpatient child psychiatric services
Approved with a condition - $0

Point Lookout Nursing Center (St. Mary's Co.)
Establish a 124-bed CCF – All new bed capacity
Approved with conditions-$11,811,420

Levindale Hebrew Geriatric Center and Hospital (Baltimore City)
Expansion and renovation of a CCF – Add 38 beds (acquired from other CCFs) and replace 46 beds
Approved with conditions- $32,149,178

St. Mary's Hospital (St. Mary's Co.)
Expansion and renovation – Add 22 medical/surgical, 6 obstetric, and 2 psychiatric beds (all new bed capacity) – Expand emergency department and relocate pediatric unit – New hospital entrance and lobby – Expanded laboratory and materials management – Shell space
Approved with conditions -$89,126,328

Shady Grove Adventist Nursing and Rehabilitation Center (Montgomery Co.)
Add 4 CCF beds (acquired from other CCF)
Approved with conditions -$343,270

Kennedy Krieger Institute (Baltimore City)
Renovate space to relocated two inpatient units with 22 total special hospital beds
Approved -$5,500,000

Lorien LifeCenter Howard County II (Howard Co.)
Add 4 CCF beds to approved project (new bed capacity)
Approved with conditions - $0

Johns Hopkins Bayview Medical Center (Baltimore City)
Add 4 operating rooms
Approved with conditions - $24,352,934

Manor Care Bowie (Prince George's Co.)
Establish a 120-bed CCF – All beds relocated from existing Manor Care facilities
Approved with conditions - $14,897,003

Augsburg Lutheran Home of Maryland (Baltimore Co.)
Expansion and renovation – No new bed capacity
Approved with conditions - $10,712,690

Holly Hill Nursing and Rehabilitation Center (Baltimore Co.)
Expansion and renovation – Add 20 CCF beds (acquired from other facility)
Approved with conditions - $3,657,475

Solomons Nursing Center (Calvert Co.)
Add 17 CCF beds – All new bed capacity
Approved with conditions - $1,878,549

Lorien LifeCenter – Harford (Harford Co.)
Establish a 78-bed CCF – All new bed capacity
Approved with conditions- $9,315,563

Harford Memorial Hospital (Harford Co.)
Renovation - Add 16 medical/surgical beds – All new bed capacity
Approved - $2,443,755

CON-Approved Projects Modified
Lorien-Howard, Inc. (Howard Co.)
$1, 162,240 increase in cost of a new 63-bed CCF
Approved with conditions

CON Application Withdrawn
Carroll Hospital Center (Carroll Co.)
Expansion and renovation
$69,229,885

CON Applications Dismissed from Review
Abibank Home Care Services
Establish a new general HHA to serve Baltimore County
$160,000

The Angels Home Health Services
Establish a new general HHA to serve Baltimore County
$6,500

Abibank Home Care Services
Establish a new general HHA to serve Frederick County
$160,000

The Angels Home Health Services
Establish a new general HHA to serve Frederick County

$6,500

Kahak Health Care Services
Establish a new general HHA to serve Frederick County
$26,500

K & K Health Care Services
Establish a new general HHA to serve Frederick County
$200,000

Vivian Kemngang
Establish a new general HHA to serve Frederick County
$465,000

Quality Home Health Agency
Establish a new general HHA to serve Frederick County
$344,000

Shadon, Inc.
Establish a new general HHA to serve Frederick County
$95,000

Abraham Healthcare Services
Establish a new general HHA to serve Frederick County
$14,000

American Health First
Establish a new general HHA to serve Frederick County
$792,000

BMA Healthcare Services, Inc.
Establish a new general HHA to serve Frederick County
$40,000

Boyo Home Health Care Services Agency, Inc.
Establish a new general HHA to serve Frederick County
$348,000

FEM Nursing Services, Inc.
Establish a new general HHA to serve Frederick County
$52,500

Home Health Connections
Establish a new general HHA to serve Frederick County
$38,810

JPS Services
Establish a new general HHA to serve Frederick County
$23,000

Speqtrum, Inc.
Establish a new general HHA to serve Frederick County
$158,888

Approved CONs Relinquished by Holder
University of Maryland Medical Center (Baltimore City)
Construction of an 8-story Ambulatory Care Center
$357,462,000 (UMMS reports that $87,656,476 was spent in constructing the below grade components of this project, which include a completed underground parking garage.)

Fairland Nursing and Rehabilitation Center (Montgomery Co.)
Expansion and renovation – add 65 CCF beds (55 acquired and 10 "waiver" beds)
$24,190.742

Fairland Nursing and Rehabilitation Center (Montgomery Co.)
Replacement of 20 acquired CCF beds with beds acquired from another facility (See previous project)
$215,000

Determinations of Coverage and Other Actions
In FY 2009, the Commission issued 123 determinations involving actions proposed by persons or health care facilities requiring a decision with respect to the need for CON review or other Commission authorization. These actions were made in accordance with statutory and regulatory provisions outlining: (1) The scope of CON coverage; (2) The types of projects or actions that, while similar in their general nature to projects that require CON review and approval, can be implemented outside of the CON regulatory process; and (3) The notification requirements and attestations which must be met to obtain the Commission's determination that CON is not required. These determinations are profiled in the following table. Chief among these types of determinations are those involving establishment of single operating room ambulatory surgical facilities, acquisitions of health care facilities, temporary delicensure of beds (for up to one year), and small increases in the bed capacity of facilities ("waiver" beds), primarily nursing homes, which are allowed increases of 10% of bed capacity or ten beds, whichever is less every two years so long as the facility maintains operation of all of its bed capacity without changes during that period of time. Additionally, the Commission reviewed

eight requests by holders of CONs to implement their projects or parts of their approved projects ("first use review"). Finally, the Commission acknowledged sixteen cases in which facilities with temporarily delicensed beds did not take timely action to bring these beds back into operation or extend temporary delicensure status, thus eliminating these beds from the state's inventory. In FY 2009, all these permanently delicensed beds were CCF beds.

Determinations of Coverage and Other Actions – FY 2009

NATURE OF DETERMINATION/ACTION	NO.
Hospital capital projects with costs above the threshold of reviewability ("pledge")	1
Capital projects with costs below the threshold of reviewability	12
Acquisitions of health care facilities Comprehensive care facility (nursing home): 6 Ambulatory surgery center: 2 Home health agency: 6 Hospice: 1 Hospital: 1	16
Establishment of new ambulatory surgery center (no more than one sterile operating room) Howard (6), Harford (5), Anne Arundel (4), Montgomery(4), Calvert(3), Baltimore City (2), Prince George's (2), and Worcester (1)	27
Changes in ambulatory surgery center facilities or operation (e.g., addition of non-sterile procedure rooms, surgical staff, surgical specialties, ownership structure)	7
Temporary delicensure of ambulatory surgery center	1
Temporary delicensure of CCF beds (241 total beds)	21
Relicensure of temporarily delicensed CCF beds (152 total beds)	17
Add "waiver" beds [1] Comprehensive care facility: 7 for a total of 46 beds Residential treatment center: 2 for a total of 12 beds Special hospital – psychiatric: 1 for 10 beds	10
CCF bed exemption for continuing care retirement community	1
Miscellaneous	10
TOTAL COVERAGE DETERMINATIONS	123
Pre-licensure and/or first use approval for completed CON projects (including partial)	8

Permanent delicensure of beds **Comprehensive care facility: 16 for a total of 217 beds**	**16**

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

The Center for Health Information Technology

Overview

Health information technology (HIT) can improve health care quality, prevent medical errors, and reduce health care costs by delivering essential information at the time and place of care. The two crucial components of HIT that exist are electronic health records (EHRs) and health information exchange (HIE). The Center for Health Information Technology (Center) is responsible for advancing HIT statewide. Key Center activities include:

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

Health Information Technology Division

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

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

Health Information Exchange Division

The Health Information Exchange Division (HIE Division) is responsible for advancing the statewide HIE and is tasked with ensuring the development of an interoperable system for sharing electronic health information. The HIE Division provides guidance to the statewide HIE, community data sharing initiatives, and management service organizations (MSOs) to ensure that electronic health information is securely delivered to providers in real-time and that the data is available for continuous quality improvement.

The HIE Division promotes the private and secure sharing of electronic patient information at the point of care; determines the appropriate secondary uses of electronic data; promotes the adoption of electronic data interchange; and certifies electronic health networks. Leading the development of strong privacy and security policies is also a responsibility of the HIE Division. The HIE Division also promotes the adoption of electronic data interchange and certifies electronic health networks.

Accomplishments

Centers for Medicare & Medicaid Services – Electronic Health Record Demonstration

Maryland was one of four states selected to participate in the Centers for Medicare and Medicaid Services (CMS) EHR Demonstration Project. This is a five-year project designed to show that widespread adoption and use of EHRs will reduce medical errors and improve the quality of care. Approximately 127 physicians participate in the project as the treatment group. Participants of the treatment group are eligible for financial incentives ranging from $58,000 (for a single physician practice) to $290,000 (for a group physician practice) over the five-year demonstration project. Approximately 128 physician practices participate in a control group that will receive a monetary incentive to complete a questionnaire in years two and five. Staff provides educational support to the treatment group in trying to accelerate the adoption of EHRs and meaningful use.

Electronic Data Interchange & Electronic Health Networks

COMAR 10.25.07, Electronic Health Network Certification, requires EHNs that operate in Maryland to complete the certification process. The MHCC's certification process works in coordination with the national accreditation standards developed by the Electronic Healthcare Network Accreditation Commission (EHNAC). As of June 30, 2009, 41 EHNs have obtained MHCC certification and five others EHNs are in candidacy. The MHCC certification is for a two-year period. The certification criteria focus is on policies and processes surrounding privacy and security, technical performance, business practices, and resources.

In compliance with COMAR 10.25.09, Requirements for Payers to Designate Electronic Heath Networks, third party payers with annual revenues greater than $1 million must report health care transaction data each year to the MHCC. During this reporting period, the volume of practitioner and hospital claims submitted electronically increased by approximately two percent to roughly 85 percent. Dental claim volume also increased during the reporting period

by three percent to approximately 41 percent. The sizable difference between dental and the other claims volume is largely due to business decisions by payers to invest more heavily in technology to support practitioner and hospital claims.

EHR Product Portfolio

Staff developed a web-based EHR Product Portfolio (portfolio). The portfolio is located on the MHCC's website and contains a core set of product information that will assist physicians in assessing and selecting an EHR system. The portfolio includes only those vendors who meet the Certification Commission for Healthcare Information Technology's (CCHIT) stringent certification standards relating to functionality, interoperability, and security. The portfolio is updated every six months. Vendors listed in the portfolio have agreed to offer financial discounts to Maryland physicians in the purchase of an EHR system. Approximately 23 vendors who are CCHIT-certified were included in the portfolio as of June 30, 2009.

Consumer-Centric Health Information Exchange

Two multi-stakeholder groups released their planning reports to build a statewide HIE within the state in February 2009. The two groups were the Chesapeake Regional Information System for our Patients (CRISP) and the Montgomery County Health Information Exchange. Based on their recommendations, a Detailed Specifications for the Maryland Health Information Exchange was developed in March 2009. These specifications took the best practices from the two reports and augmented them with the best practices from emerging or established HIEs. This created a blueprint for the Maryland HIE. The MHCC used The Health Information Exchange Implementation Plan as the blueprint in developing the design specifications for the HIE. This plan was used to develop the Request for Application for the Maryland HIE, which was released in April 2009. The MHCC received four responses to the RFA in June, and designated CRISP as the multi-stakeholder group to build the statewide HIE in August.

Hospital HIT Survey

In June 2009, staff released the results from a comprehensive survey that assessed the current level of adoption, utilization, and planning among the state's 47 acute care hospitals as it relates to HIT, including EHRs, computerized physician order entry (CPOE), e-prescribing, HIE, infection surveillance, electronic medication administration records (eMARs), and barcode medication administration technology. Results suggest that hospitals have made significant investments in HIT and the majority of them plan to build on their existing functions. Some notable findings include that more than 50 percent of the hospitals have EHRs, use CPOE, and eMARS. HIE is a fairly new concept and approximately 39 percent of hospitals report that they are sharing patient data with their service providers. Hospital Chief Information Officers (CIOs) assisted in the development of this survey that was first administered in 2008.

Reconvening of the Task Force to Study Electronic Health Records

Staff reconvened the Task Force to Study Electronic Health Records, which initially released 13 recommendations to the Governor and Maryland General Assembly in December 2007. The

Task Force was created under Senate Bill 251 of the 2005 Maryland General Assembly. The Task Force was reconvened to review these 13 recommendations to evaluate their validity and discuss the need for any potential modifications or new recommendations in light of recent legislation, both at the Federal and State levels. The Task Force made recommendations to modify three of the original recommendations that included balancing the relationship of HIT costs and benefits to each sector through a system of payments and subsidies; identifying incentives for e-prescribing; and developing a statewide outreach and education program. These modifications were sent to the Governor and Maryland General Assembly in June 2009.

Privacy and Security Solutions and Implementation Workgroup

Staff released the findings from the Privacy and Security Solutions and Implementation Workgroup (workgroup). The workgroup summarized the solutions and implementation activities that address organization-level business practices affecting statewide privacy and security policies in order to support interoperable HIE. The report entitled, Privacy & Security, Solutions & Implementation Activities for a Statewide Health Information Exchange was released in September 2008. The report outlines principles, barriers and solutions, implementation activities, and the desired future state for: accessibility, consumer centric exchange, emergency access, governance, misuse, security, standards, and sustainability. The workgroup findings will provide the background for implementation of the statewide HIE.

Service Area Health Information Exchange

Staff convened a workgroup of hospital CIOs to develop a series of recommendations that were included in the Service Area Health Information Exchange (SAHIE) Resource Guide (Guide). The Guide was released in February 2009 and identifies a policy framework for communities that are beginning to exchange patient information electronically. Components of the guide address items related to a patient's right to access information, a range of business practices, technical standards, and key financial, organizational, and clinical challenges. The guiding principles, that were unanimously agreed upon by the workgroup, ensure that patients should control the flow of information through an exchange, and that safeguards must be in place to govern disclosure and assure proper authorization for data access.

House Bill 706, Electronic Health Records – Regulation and Reimbursement

The Maryland General Assembly passed House Bill 706, Electronic Health Records – Regulation and Reimbursement, which was signed into law on May 19th by Governor Martin O'Malley. Staff focused on two specific areas of the law. The first area included working with payers to identify appropriate monetary incentives for physicians who adopt EHRs that include: increased reimbursement for specific services, lump sum payments, gain-sharing arrangements, rewards for quality, and efficiency. The second area is the development of criteria for state designation of management service organizations (MSOs) that are organizations who share administrative and technical functions across physician practices. MSOs have the potential to increase HIT adoption, particularly where the cost of implementing the technology is viewed as

a deterrent; and, they also eliminate the need for an onsite client server by offering subscription based EHR(s) through an Internet application service provider.

EHNAC HIE Advisory panel and recommendations
Staff was actively involved on the EHNAC's Health Information Exchange (HIE) Policy Accreditation Advisory Panel. This panel contained approximately 50 stakeholders from around the nation with the goal of developing criteria for accrediting HIEs infrastructure and policies related to privacy and security. When complete, the proposed criteria will go through a public comment period before being adopted by the EHNAC. The target date for the EHNAC to launch its HIE accreditation program is fourth quarter 2010.

Collaboration with the Office of the National Coordinator
Staff participated in a workgroup through the Office of the National Coordinator for Health Information Technology that developed a proof of concept testing analysis on specific consumer and provider policies assigned by the Health Information Security & Privacy Collaboration (HISPC) Adoption of Standards Collaborative Workgroup. Maryland was one of roughly ten states that tested various policy toolkits on privacy and security. Staff also provided support to the HISPC as it worked on developing policies for authorization and access of immunization registries.

Joint Commission Using National Accreditation Standards
Staff provided guidance to the Joint Commission in expanding their information management standards that refer to retrieving, disseminating, and transmitting information to require that these systems be consistent with the criteria developed by the CCHIT. The Joint Commission sets the standards for health care organizations and issues accreditation to organizations that meet those standards. This change reflects hospitals which use health information management systems that meet national accreditation standards.

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