MARYLAND
HEALTH CARE
COMMISSION

REPORT to the GOVERNOR

Fiscal Year 2011

(July 1, 2010 through June 30, 2011)

Martin O'Malley
Governor

Marilyn Moon, Ph.D.
Chair

Ben Steffen
Acting Executive Director

http://mhcc.maryland.gov/

MARYLAND
HEALTH CARE
COMMISSION

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COMMISSION

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

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

MARYLAND HEALTH CARE COMMISSION

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)

MARYLAND
HEALTH CARE
COMMISSION

EXECUTIVE STAFF

Ben Steffen
Acting 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 2011, the Commission had an appropriation for 62.6 full time positions and filled one contractual position. The Commission's staff members represent a broad range of backgrounds and skills, including public policy analysis, data management and analysis, health planning, health facilities construction and financing, Medicaid administration, quality assessment, clinical and health services research, and public performance reporting.

The Commission is organized around the health care systems we seek to evaluate, regulate, or influence, bringing a wide range of tools (data gathering, public reporting, planning and regulation) to bear 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 by requiring PPOs to report beginning in 2012.
- The Center is responsible for the development and analysis of state health policy options affecting the organization and financing of health care. Particular emphasis has been placed on both incremental and non-incremental strategies for expanding health insurance coverage and on strategies to reduce health care expenditures and increase health care value.
- The Commission's commitment to reporting disparities in health and health care is expressed in the Center's Racial and Ethnic Disparities initiative.

The **Center for 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 2011, the Commission was appropriated $28,162,173 which includes an appropriation of $11.7 million for the trauma fund and $2 million for the Partnership program. The Commission

is funded with special funds through a user fee assessment paid by Nursing Homes, Hospitals, Insurance Companies, and the Health Occupation Boards in order to accomplish its mission and program functions.

ASSESSMENT

The Maryland Health Care Commission's budget is 100% special funds and is funded through a user fee assessment on Hospitals, Nursing Homes, Payers, and through the licensing process of the Health Occupational Boards. Each of these entities contributes to the MHCC budget appropriation according to workload and the assessment is currently capped at $12 million. Currently, the Commission assesses: 1) Payers for an amount not to exceed 29% of the total budget; 2) Hospitals for an amount not to exceed 31% of the total budget; 3) The Health Occupational Boards for an amount not to exceed 18% of the total budget; and 4) Nursing Homes for an amount not to exceed 22% of the total budget. The amount is derived differently for each industry and is set every four years based on Commission work load.

Surplus

At the close of FY 2011 the Commission's surplus was $2.5 million a reduction of .5 million over FY 2011.

OVERVIEW OF FY 2011 ACCOMPLISHMENTS

July 2010

COMAR 10.25.15 – Management Services Organization State Designation was adopted as proposed permanent regulations.

Certificate of Need for NMS Healthcare of Hagerstown to expand and renovate its facility is approved.

Certificate of Need Modification for Johns Hopkins Hospital to submit final designs is approved.

Staff presented a briefing on Hospital Performance Guide Updates.

Staff presented information on Practitioner Utilization Trends Among the Privately Insured through 2008

Process for Approval of Single Payer Patient Centered Medical Home Programs was approved.

August 2010

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

Standards for a Single Carrier Patient Centered Medical Home (PCMH) Program are approved.

September 2010

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

Certificate of Need for Comprehensive Nursing Services, Inc. is approved.

CareFirst Single-Carrier Patient Center Medical Home Application is approved.

Staff presented Nursing Home Seasonal Influenza Vaccination Rate Among Health Care Workers.

Staff presented a Web-based Demonstration: Consumer Guide to Long Term Care.

October, 2010

Modified Certificate of Need for St. Agnes Hospital to change its physical plant design is approved

COMAR 10.25.15 Management Service Organization State Designation was adopted as final regulations.

Staff presented the 2010 Health Information Technology Update.

Staff presented the 2010 HMO/PPO Health Plan Performance Report.

Staff presented the Health Care Reform and the Effects on Small Group Market.

November 2010

Meeting was cancelled.

December 2010

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

Modified Certificate of Need for Govans Ecumenical Development Corporation to change financing mechanisms is approved.

Modified Certificate of Need for Lorien LifeCenter to seek a change in the financing mechanisms is approved.

Anne Arundel Medical Center's request for an Extension of Two-Year Waiver Permitting Participation in C-PORT E Research Study of Non-Primary PCI Services without On-Site Cardiac Surgery is approved.

St. Agnes Hospital's request for an Extension of Two-Year Waiver Permitting Participation in C-PORT E Research Study of Non-Primary PCI Services without On-Site Cardiac Surgery is approved.

Shady Grove Adventist Hospital's request for an Extension of Two-Year Waiver Permitting Participation in C-PORT E Research Study of Non-Primary PCI Services without On-Site Cardiac Surgery is approved.

Southern Maryland Hospital Center's request for an Extension of Two-Year Waiver Permitting Participation in C-PORT E Research Study of Non-Primary PCI Services without On-Site Cardiac Surgery is approved.

January 2011

SB 56 – Health Insurance – Evaluation of Quality of Care and Performance of Health Benefit Plans – Support with Amendments is approved.

SB 57 – Maryland Health Care Commission – Certificate of Need Requirements – Support of bill is approved.

Staff made a presentation of Health Insurance Coverage in Maryland through 2009.

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

Certificate of Need for Peninsula Regional medical Center to expand, renovate, and modernize its surgical facilities was approved.

Certificate of Need in the Matter of Proposed New Hospitals in Montgomery County, Holy Cross of Silver Spring is approved.

Certificate of Need for Holy Cross Hospital of Silver Spring for expansion and renovation is approved.

February 2011

<u>February 10, 2011 Meeting via Teleconference</u>

SB 182/HB 166 – Maryland Health Benefit Exchange Act was voted 6 in support of the bill, and 5 opposed.

SB 107/HB 516 – Health Benefit Exchanges – Establishment and Operations was voted 8 in opposition of supporting the bill and 3 supporting the bill.

SB 312 – Health Insurance Habilitative Services – Required Coverage was agreed with staff recommendation.

SB 724 – Health Insurance – Exchange Option for Small Business was agreed with staff recommendation.

<u>February 17, 2011</u>

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

Meritus Medical Center was granted a two-year primary PCI waiver.

COMAR 10.24.05 – Continuation of Non-Primary Research Waiver through Participation in the Follow-On C-PORT-E Registry was adopted as proposed and emergency regulations.

Update on 2009 Joint Chairmen's Report – Maryland Emergency Medical System Operations Fund Update.

Release of Plans for Studying the Assignment of Benefits (AOB) Law is hereby approved.

SB 722/HB 736 – Electronic Health Records – Incentives for Health Care Providers – Regulations approved for support with amendments.

SB 723/HB 784 – Medical Records – Health Information Exchanges was approved for support with amendments.

SJ 6/HJ 6 - Safe Harbor Legislation and Regulations Need to Form Accountable Care Organizations was approved for support.

HB 449 – State Government – Regulations Affecting Small Businesses and Economic Impact Analysis was agreed that the Commission would take no position.

HB 1146 - Electronic Health Records – Definition of State-Regulated Payor – State Employee and Retiree Health and Welfare Benefits Program – Commissioners agreed with staff recommendation.

HB 1182 – Certificate of Need – Percutaneous Coronary Intervention Services was approved for support with amendments.

Update on Patient Centered Medical Home Program

<u>February 28, 2011 Meeting via Teleconference</u>

SB 742/HB 690 – Maryland Cardiovascular Patient Safety Act – Commissioners agreed with staff recommendation.

HB 949/SB 879 – Health Insurance – Coverage for the Treatment of Bleeding Disorders was opposed.

HB 818 – Manufacturers of Prescribed Products – Payments of Health Care Professions – Prohibition. Commission agreed to ask staff to weigh in, informally, but to not take a formal position.

HB 821 – Hospitals – Medical Harm Disclosure Act – Commissioners agreed with staff recommendation with no opposition.

HB 974 – Health Insurance – Preauthorization of Health Care Services – Use of Electronic Health Records – Commissioners agreed with staff recommendation.

HB 815/SB 579 – Health Insurance – Limits on Copayments – Commissioners suggested taking no position.

HB 888/SB 701 – Health Insurance – Prescription Eye Drops – Refills – Commissioners suggested taking no position.

March 2011

March 14, 2011 Meeting via Conference Call.

SB 883 – Prescription Drug Monitoring Program – Commission support with amendments.

March 17, 2001 Meeting

Upper Chesapeake Medical Center request for a two-year primary PCI waiver was approved.

Patient Centered Medical Home Participation Agreement was adopted.

April 2011

COMAR 10.25.16 – Electronic Health Record Incentives are adopted as Final Regulations.

COMAR 10.25.11 – Institutional Review Board are adopted as Proposed Regulations.

Staff presentation on 2010 Nursing Home Experience of Care Survey Results.

May 2011

COMAR 10.24.05 – CONTINUATION OF Non-Primary Research Waiver through Participation in the Follow-On C-PORT-Registry regulations are adopted as Final Regulations.

Anne Arundel Medical Center was granted a two-year primary PCI waiver.

Baltimore Washington Medical Center was granted a two-year primary PCI waiver.

Franklin Square Hospital Center was granted a two-year primary PCI waiver.

Chris Hogan, Ph.D. presented the findings on the Maryland Physician Workforce Study.

Update on Central Line–Associated Bloodstream Infection (CLABSI)

Staff made a presentation of Virtual Compare web portal video.

June 2011

COMAR 10.24.05 – Continuation of Non-Primary Research Waiver through Participation in the Follow-On C-PORT-Registry was adopted as proposed permanent regulations.

COMAR 10.25.08 – Evaluation of Quality and Performances of Health Benefits Plans: Proposed Action on Permanent Regulations was adopted as proposed permanent regulations.

COMAR 10.25.16 – Electronic Health Records State Regulated Payor Incentives was adopted as proposed permanent regulations.

Shady Grove Adventist Hospital was granted a two year primary PCI waiver.

Southern Maryland Hospital Center was granted a two year primary PCI waiver with conditions.

Staff made a presentation of the Long Term Care Healthcare Worker Influenza Vaccination Survey Report.

Staff made a presentation of the Small Group Market Summary of Carrier Experience as of December 31, 2010.

Staff made a presentation of the Potential Impact of the Affordable Care Act on the Current Individual and Small Group Markets.

MARYLAND HEALTH CARE COMMISSION

The Center for Information Services and Analysis

Cost and Quality Analysis Division

Overview

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

Accomplishments

During FY 2011, the Cost and Quality Analysis division added an additional year of professional services and prescription drug data to the MCDB, expanded the data submission to include claims for institutional health care services, and provided feedback on data quality to the submitting payers. The division produced four publications, including one report and one issue brief that were legislatively mandated, and two additional reports.

Practitioner Utilization: Trends Among Privately Insured Patients, 2008–2009

This legislatively mandated annual study was completed in June and released the following month. The analysis is based on the MCDB data, and the methods used for this report include the imputation of payments for services that lack payment information (due to capitation or contracting arrangements). Among the nonelderly (under age 65) who used professional services and were enrolled in the same insurance product for the entire year, the average expenditure for professional services in 2009 was $1,238, 2% higher than in 2008. This growth was due to a 2% increase in the average payment rate for the mix of services obtained by users. In contrast, the growth per user in 2008 was 5%, driven mainly by a 3% increase in the number of professional services per user. The growth in per user spending from 2008 to 2009 varied by coverage type and was especially large, at 8%, in the individual market. By network type, the growth was concentrated almost exclusively among users enrolled in HMO plans (4%); users in non-HMO plans exhibited no increase in per user spending.

User risk status, as determined by an expenditure risk score, is an important determinant of per-user expenditures for professional services. The annual expenditure for a user with "medium" risk is about twice that of a "low-risk" user, and the annual expenditure for a "high-risk" user is about five times that of a low-risk user. The average expenditure per user in different coverage types is strongly influenced by the risk mix of the users. Users in the Maryland Health Insurance Plan (MHIP), the state's high-risk pool, had the highest average risk score and the highest average expenditure per user of all coverage types. At the other end of the risk-score distribution, users enrolled in plans in the individual market had the lowest risk scores and ranked at the bottom in average spending per user.
The overall patient cost-sharing burden, measured by the share of total spending paid out-of-pocket by full-year users, was 21% in 2009, but varied significantly by plan type. Users in consumer directed health plans (CDHPs) paid 36% of their total expenditures out-of-pocket; in comparison, among non-CDHP users, the out-of-pocket costs were 21% and 14%, respectively, for non-HMO users and HMO users.

In 2009, the overall average payment rate was $36.70 per relative value unit (RVU), 2% higher than in 2008. As in previous years, payment per RVU across all professional services was lower among the largest payers than among the other payers, $35.30 versus $40.30. However, their difference in payment rates may be narrowing as the increase in the overall average payment rate from 2008 to 2009 was mainly due to a 2% increase among the largest payers, while the payment rate increase among the other payers was lower, at 1%. Some of the difference in average payment rate is due to the fact that services covered by the largest payers are more likely to be provided by participating providers. The largest two payers accounted for about 70% of the market, whether measured by number of services, total resources (RVUS), or total payments.

Healthcare Spending in Maryland's Individual and Small Group Markets
This year's legislatively mandated health care expenditure study compared annual spending for professional, institutional, and prescription drug services by privately insured Maryland residents with health insurance obtained in three different health insurance markets: the individual market, the small employer market—the Comprehensive Standard Health Benefit Plan (CSHBP), and the state's high-risk health insurance program—the Maryland Health Insurance Plan (MHIP). The purpose of the study—released as an issue brief—was to provide information that may be useful to state policymakers in implementing Maryland's Health Benefit Exchange.

- Utilization of health care services and spending are higher for persons covered through the small group market as compared to those who purchased coverage in the individual market. Not surprisingly, spending is highest for persons covered through the high-risk pool.
- Spending by people in the MHIP is heavily influenced by greater disease burden. The typical (median) risk score for those in MHIP is over twice that of those in the small group market, and over three times that of individual purchasers.
- The age distributions in each of the markets differ considerably and partially explain the differences in health care spending.

- The income distribution in each of the markets differs considerably, but within each market, persons living in the lower-income zipcodes have somewhat higher expenditure risk scores and are more likely to use both inpatient and outpatient hospital services.
- Regional variation in spending is slightly greater in the individual than the small employer market but relatively limited overall.
- Premiums for policies offered by the Exchange will also be influenced by new entrants who will come primarily from the pool of those currently uninsured. Average spending for the age and income group that characterize the largest group of currently uninsured persons is somewhat higher in the Baltimore area than in the DC metro area, suggesting that post implementation of the ACA, there could be more geographic variation in spending than exists today.

Health Insurance Coverage in Maryland

In January 2010, the division released its biannual report on insurance coverage in Maryland. The information in the report comes from staff analysis of the Current Population Survey, Annual Social and Economic Supplement (CPS ASEC). Basic findings from the report include the following.

- During 2008–2009, 14.5% of Maryland's nonelderly population was uninsured, with an average of about 720,000 nonelderly uninsured residents per year. The uninsured rate for the total population, 13.0%, is lower because it includes the elderly, who are nearly all insured by Medicare. The average number of all uninsured residents (including the elderly) in Maryland for 2008–2009 was about 730,000.
- The Census Bureau's comparison of uninsured rates between states using the all-ages uninsured rate for 2007–2009 shows Maryland's rate to be statistically below the uninsured rate in 21 states (including New Jersey), higher than the rate in 13 states (including Delaware and Pennsylvania), and statistically similar to the rate in 15 others (including Virginia and West Virginia).
- Private insurance—including employer-sponsored and direct-purchase insurance—covered three-fourths of Maryland's nonelderly residents. Employment-based insurance accounted for the bulk of private insurance, covering 70% of the State's nonelderly; direct-purchase insurance—obtained by individuals directly from insurers—covered 7% of the nonelderly.
- Medicaid covered 11% of the nonelderly; however, survey estimates of Medicaid enrollment tend to be lower than those compiled from administrative data. Other public coverage, including military-related coverage and Medicare, was a source of insurance for 6% of the nonelderly.
- An examination of annual insurance coverage rates from 2004 to 2009—applying the 90 percent confidence interval range around each estimate—indicates considerable stability in Maryland's uninsured rate, despite fluctuating economic conditions over this time period. Only the 2008 point estimate is significantly different from any of the other years. The stability in the uninsured rate results mainly from stability in the State's total privately insured (all sources) rate; the only statistically significant difference over this period is between the 2008 and 2009 rates.

Study to Count the Supply of Physicians in Maryland in 2009-2010

The division oversaw an extramural study of physician supply in Maryland, conducted by Christopher Hogan, president of Direct Research, LLC. The study was jointly sponsored by the MHCC and the HSCRC to resolve questions of physician supply in the state. The study analyzed the latest data (2009–2010) from the Maryland Board of Physicians license renewal survey and compared the findings to the results from analyses of physician supply in Maryland based on the American Medical Association (AMA) Physician Masterfile data. The report, **Maryland Physician Workforce Study: Applying the Health Resources and Services Administration Method to Maryland Data**, was released in May.

After adjustments to make the Maryland license renewal data and the AMA Masterfile data comparable, the study found that the license renewal data yielded results very similar to those generated by the U.S. Health Resources and Services Administration (HRSA) and the Association of American Medical Colleges (AAMC) using the AMA data. Dr. Hogan's study estimates that *Maryland has 27 percent more active non-federal patient-care physicians per capita than the U.S. year 2000 average* (HRSA's benchmark). This is nearly identical to the estimates of Maryland physician supply developed by HRSA and the AAMC.[1] In addition, after adjustment, the two data sources give nearly identical counts of active non-federal patient-care physicians in Maryland. *These estimates demonstrate that Maryland's physician-to-population ratio is substantially above the U.S. average.*

Maryland active non-federal patient-care physicians appear to provide roughly as many patient-care hours per physician as the U.S. average. Using the U.S. Current Population Survey, the total work week for Maryland and U.S. physicians was essentially the same, averaging 51 hours. Using two different sources of survey data, the fraction of work hours devoted to patient care was roughly the same, around 85 percent. The study found no evidence that patient-care hours of Maryland active non-federal patient-care physicians were substantially below the U.S. average.

Beneath the broad averages, the study found significant differences by specialty and region. For the entire state, physician-to-population ratios exceeded the U.S. average for broad categories of physicians (primary care, medical specialists, surgical specialists, and others). By region, physicians tended to work slightly longer hours in areas with low physician supply. But even after adjusting for variation in patient-care hours, *the supply of physicians in Southern Maryland was significantly below the HRSA benchmark for all four broad categories of physicians studied.* All other regions were at or above the HRSA benchmark, with the Eastern Shore ranking just at the HRSA benchmark for some types of physicians.

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[1] HRSA 2008. The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand, page 72. Washington, DC: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, December 2008. Accessible as of 4/1/2011 at http://bhpr.hrsa.gov/healthworkforce/reports/physicianworkforce/requirements.htm.
AAMC 2009. 2009 State Physician Workforce Data Book, Figure 2 and Table 2. Association of American Medical Colleges, Center for Workforce Studies, November 2009. Accessible at www.aamc.org/download/47340/data/statedata2009.pdf.

The study did not, however, find systematic evidence of reduced access to care in Southern Maryland, on average, using the limited data available for this study. Physicians in Southern Maryland were as likely to be accepting new Medicare and Medicaid patients as physicians in the rest of the state. Fee-for-service Medicare beneficiaries in that region received as much physician care as those in other regions of Maryland, but were more likely to travel outside the region for care.

These results are averages for all areas within these regions, combining urbanized areas with relatively high physician supply and rural areas with lower physician supply. A finding that average physician supply in a region exceeds the HRSA benchmark does *not* imply that supply exceeds the HRSA benchmark for all areas or populations within that region.

This is a limited study, focusing on state- and region-level supply of broad classes of physicians. It should *not* be construed as showing that Maryland has no physician supply problems. In particular, the study did not examine: a) counties or sub-county areas; b) individual physician specialties; c) vulnerable populations; d) Health Professional Shortage Areas or Medically Underserved Areas; e) expected future changes in physician supply and demand based on retirement of the baby boom generation and the implementation of health reform legislation; f) market-based indicators of supply and demand for physicians, such as unfilled vacancies; or g) indicators of the process and outcomes of care, such as waiting times for care, reported difficulty in obtaining needed care, or effects on health status of Maryland residents.

That said, the results of this study can help to focus policy discussions. The absence of evidence for widespread, severe, state-wide shortage means that policy makers can return attention to a more traditional view, looking for the small geographic areas and specific specialties or patient populations for which there is strong, objective evidence of problems with access to physicians' services.

Maryland Trauma Physician Services Fund

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

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

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

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

The Maryland Health Care Commission (Commission) approved an 8 percent across the board reduction in payment rates for FY 2011 (with the exception of Medicaid) due to the downturn in automobile registration revenue and an expected increase in uncompensated care claims. A $3.8 million surplus existed at the start of FY 2011; however, current law limits total payments in any fiscal year to revenue collected in that same year. Trauma Equipment Grants were awarded to the Level II and Level III trauma centers, reducing the surplus funds' balance to $3.57 million at the close of the fiscal year.

Payments to eligible providers and the administrative costs associated with making those payments totaled about $12.7 million in FY 2011, down slightly from FY 2009. Comparing FY 2011 to FY 2009, uncompensated care payments declined and on call trauma payments increased due to implementation of statutory changes made in 2008. Administrative costs declined in 2010 due to lower uncompensated care claims payments and a reduction in the Commission's third party administrator's fee per claim processed. Transfers from the Motor Vehicle Administration (MVA) to the Fund declined by about $600,000 in FY 2011 due to a drop in the number of automobile registrations and renewals and a reduction of interest earned by the Fund per the Budget Reconciliation and Financing Act of 2010 (HB 151).

Data Base and Applications Development Division

Overview

The Data Base and Application Development Division is responsible for managing data collection efforts and developing health care provider surveys mandated by law. The Commission has the authority to collect and report on information on health care professionals, hospitals, and facilities such as nursing homes, assisted living facilities, adult day care centers, home health agencies, and hospices. This division acquires and manages external analytic databases used by the Commission, including the Maryland hospital inpatient, outpatient and emergency department data, state and private psychiatric hospital data, outpatient ambulatory surgery data, the District of Columbia (DC) hospital inpatient data, Medicare and private payer insurance claims data, pharmacy claims data, Trauma center expenditures and statistics, and several Centers for Medicare & Medicaid Services (CMS) data collections including the

Minimum Data Set, Oscar file of nursing home deficiency data, and the Nursing Home resident file. The division has primary responsibility for data processing and analysis support systems, internet application development, and public reporting of health care consumer information.

Accomplishments

Ambulatory Surgery

Data Staff worked with the hospital staff to process the data update for the online Ambulatory Surgery directory. Data Staff provided the table formats and uploaded and tested the new data. The facility compare and characteristics web pages were updated with new services for the current year.

Certificate of Need (CON) Support

Data Staff provided CON support for technical issues, maps and graphs, and data analysis to support various CON projects. Using the specifications from the CON staff and external requests, the Data Staff performed the following:

1. Compared the number of discharges and patient days by hospital defined service area for each Maryland hospital for calendar for years 2009 & 2010;
2. Analyzed the data for Psychiatric patients who were admitted from the Emergency Department for Inpatient visits from 2005 through 2009;
3. Determined the number of outpatient visits by hospital and outpatient visit types from the 2008, 2009 & 2010 outpatient data;
4. Identified total discharges and the number of patient days by 4 planner-defined services for CY2000 to CY2009 by patient's area of residence for all 24 Maryland jurisdictions;
5. Created a combined Medicare dataset of Benefit Summary and Part D patient visits;
6. Converted ascii data into SAS datasets which are used by various staff for data requests, assuring that the common variables between all datasets are the same, such as Race and the Nature of Admission in the Maryland Inpatient Discharges and the DC Inpatient Discharges;
7. Investigated whether datasets that were created with APR DRG Groups versions 20.0, 24.0, 25.0, 25.1, 26.1, 27.0 & 28.0 could be combined for analysis on various data projects; and
8. Tabulated the number of discharges, total and average charges per case with Operating Room visits from acute care hospitals in Maryland using the discharge abstract data for the years 2003, 2006, 2009 and 2010.

Clinical Risk Groups (CRGs)

Data Staff continued to work with the Clinical Risk Group (CRG) application. This application was a trial to see if resource usage could be predicted based on the MCDB Private Payer diagnostic and procedure codes using the CRG logic. CRGs (developed by the 3M company) are risk groups that can be used as the basis of risk adjustment in a capitated payment system and are also clinically precise to be usable as a management tool for Managed Care Organizations (MCOs). Data staff reran the programs, known as the Batch Grouper, for 2007 on the private pay and pharmacy data.

Documentation Project for Data Processing and Surveys
In anticipation of a staff member's retirement, documentation of all major projects was reviewed and updated and other staff were trained to take over the responsibilities. The documentation included step-by-step instructions, data dictionaries, flowcharts and catalogs of the datasets. Documentation was updated for zip code files and processing, patient discharge data processing such as Outpatient, Inpatient, Chronic, and Freestanding Facilities, Centers for Medicare and Medicaid data, Trauma Physician Fund, State and Private Psychiatric facility data, Nursing Home Guide updates and data flows, Minimum Dataset (MDS) processing, Long Term Care Survey processing, District of Columbia Inpatient data, Rehabilitation data, Patient Centered Medical Home data, Hospice, Home Health, and the Maryland Physician Database and License Renewal process.

Electronic Data Interchange (EDI) Progress Survey Update and Modifications
Data Staff met with EDI Staff to go over changes for the EDI progress report web application for the current year. Data Staff created an updated accounts file with new passwords, merged the old and new payer tables, transformed the claims and non-claims tables from last year into the web application format, and remapped the field names and the explanation fields. Data Staff set up and configured new EDI folders on the test and live servers and set up ODBC connections so that the Data Staff could use SAS to manipulate the EDI data as needed. The survey was modified, tested, and then launched. Data Staff downloaded completed survey files to the local server and converted them to SAS for use by the EDI Staff.

Encryption Project
The purpose of this project is to produce a common encrypted patient id across payers in the Medical Care Data Base, to track patient care trends. The proposal for vendors to produce an algorithm for the encryption, essentially software that MHCC will have the rights to the source code, was issued in Fiscal Year 2009/2010. Vendors were selected and coordinated to assure that the project stayed on schedule and met the stated milestones for the deliverables. The programs were tested and sent out for the MCDB vendor's review and algorithm testing, and slides were prepared in powerpoint presentation in the training webinar.

Enterprise Guide (EG) for SAS
Data Staff continued to provide group and individual training for staff in SAS Enterprise Guide using materials prepared by our staff and outside webinars. As staff in the other divisions became more familiar with SAS EG they were able to take on more complex tasks and required more advanced training.

Environmental Tracking
The data staff creates a subset of the Maryland Discharge Abstract and the Outpatient Data to DHMH Environmental Health Coordination Program for Environmental Public Health Tracking Web Application. A data subset of inpatient and outpatient data was created for 2009, and staff participated in a conference call for Maryland's Environmental Public Health Tracking (EPHT), where the progress made in the 4th year of the project was summarized, and in the Technical Advisory Group (TAG) meeting.

Fillable Forms Development
Data Staff researched and documented a method to use Adobe fillable forms, save the form data, distribute the form, collect the completed form data, and output the form data to Excel. Data Staff developed and deployed the All Payer Claims submission form to create an optimal workflow for form development, distribution and response collection. Data Staff overhauled the Patient-Centered Medical Home Expression of Interest form so that it collects data that is readily accessible in other data formats.

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

1. Locations of Practice Organizations that submitted Letters of Interest as of August 7, 2010 and as of September 1, 2010;
2. Possible Configuration of Home Health Agency (HHA) Regions for 2010;
3. Six maps were created to show the percent of physicians who have reported that they have adopted an Electronic Health Record (HER) for 2009 – All Physicians by County, All Non-Hospital Physicians by County, All Non-Hospital Primary Care Physicians in Practices of 10 Physicians or Fewer by County; All Non-Hospital Primary Care Physicians Who Accept Medicare and/or Medicaid by Jurisdiction; and All Non-Hospital Primary Care Physicians in Practices of 10 or Fewer Who Accept Medicare and/or Medicaid by Jurisdiction;
4. Primary Service Area Maps for fiscal year 2010 – All 46 acute hospitals for HSCRC, Primary Care Physicians Compared to National Average, Primary Care Physicians Compared to National Median, and Primary Care Physicians;
5. For EHR Adopters - Office-Based Physician EHR Adoption by County for 2010, Non-EHR Adopters by Zip Code, EHR Adopters by Zip Code and MMPA Practice Sites.

Graphic Work
Data Staff went over logo considerations with the Health IT staff and researched online bids for logo design for them to consider. Data Staff wrote specifications for logo development for general use by MHCC Staff. Data Staff helped the hospital staff with their central line-associated blood infection poster presentation with stock photo acquisition and report printing issues.

Health Care Worker Flu Vaccination Survey (for Hospitals, Nursing Homes and Assisted Living Facilities)
Data Staff worked with the Hospital staff to implement denominator calculation changes and new calculated fields for the 2010-2011 survey collection. Data staff developed new nursing home and assisted living health care worker surveys and reviewed and tested them extensively. Links to the new surveys were added to the MHCC website. Data Staff developed a tracking application for the flu surveys and developed the capability to download flu survey data into Excel and also a count of “fail-to-submit” facilities for staff use.

Home Health Quality Measure Reporting
Data Staff downloaded health quality measures file from CMS and converted to SAS and performed analysis of the performance values for the Long Term Care Staff. Data Staff created a sample state and facility-level table for the Long Term Care Portal.

Home Health Web-Based Survey
Data Staff installed and configured the previous year survey on the local server for Home Health Staff to make edits to the previous year data. Data Staff updated the data analysis programs, downloaded the edited data and ran the programs. Data Staff revised the application according to Home Health Staff specifications and initialized the database for the current year survey and tested all changes prior to launching the current year application. Data Staff compiled a mailing database and resolved survey tracking report issues. Data Staff troubleshot the style sheets for the web application so to prevent wide questions from running off the page. Data Staff updated the home health survey public use data and documentation and resolved discrepancies between the 2008 and 2009 raw files.

Hospice Web-Based Survey
Data Staff set up the 2009 database on the local server and worked with the Hospice Staff to develop the twelve section survey. The Data Staff wrote hundreds of javascript and server-side validations, simplified the certification process and improved the navigation. Data Staff set up test accounts, initialized validation flags and tested the application. The survey was released to outside testers and the feedback was reviewed and improvements were made accordingly prior to the survey launch.

Hospital Clinical Measures and Hospital Patient Satisfaction Survey (HCAHPS) Database
Data Staff provided technical support to the hospital vendor meetings each month. Data Staff established a sensitive data processing area on the network for the hospital databases and went over sensitive data processing procedures with hospital staff. Each quarter, the Data Staff converted the quarterly clinical abstract and HCAHPS hospital files into SAS and ran data validations and the core measures report that is sent to the individual hospitals. Changes occur frequently in the data collection which necessitates thorough review each quarter to ensure that the processing programs to pick up all clinical measures correctly over time.

Data Staff coordinated delivery of the hospital website SQL database backup to the web vendor. Data Staff provided data processing support to internal staff on the measures database as needed. Data staff conducted an inquiry and analysis on whether the hospital discharge abstract could be matched to the clinical measures database using the medical record number to determine if outcomes can be linked. Data Staff worked with the Network Staff and the hospital vendor to set up a secure method of transferring files. Data Staff wrote documentation and instructions for the Hospital Staff to compute numerator and denominator clinical measure performance on a per quarter basis. Data staff provided documentation and data processing support to the Health Services Cost Review Commission (HSCRC) on both clinical and HCAHPS data.

Hospital Discharge Data Processing

Data Staff created a data processing workbook to track all discharge abstract processing for both Maryland and DC databases with diagnosis-related groups (DRGs) included. Data Staff worked with the hospital discharge data vendor to acquire the data with both a current grouper and DRG24 added so that CON ten-year trend analysis could be supported. Data Staff conducted analysis using the 3M grouper to create the old grouper.

Institutional Review Board (IRB):

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

Project Name	Destination	Data Set Required
Determining Utilization of Acute Comprehensive Inpatient Rehabilitation of Maryland Jurisdictions.	Jeffrey L. Johnson Vice President System Planning University of Maryland Medical System 110 S. Paca Street, 8th Floor, Room 8-129 Baltimore, MD 21201	CY06-CY08 Access files - DC Inpatient Data
Analyzing Maryland Resident Hospitalizations to Assess Disease and Injury Burden in Maryland	Jeannette Jenkins Director, Office of Health Policy and Planning, DHMH, Family Health Administration, Office of Health Policy and Planning, 201 W. Preston Street, Room 315, Baltimore, MD 21201	CY2004 through 2009 SAS file - DC Inpatient Data
Utilization of DC Hospitals by Maryland Residents for Montgomery County CON Review	Richard Coughlan Vice President. Cohen Rutherford & Knight 6903 Rockledge Drive Suite 500 Bethesda, MD 20817	CY2008 & CY2009 zipped access data file - DC Inpatient data
Cardiovascular Out-Migration to Washington, DC	Ryan Snoots Director-Decision Support Anne Arundel Health System 2001 Medical Parkway Annapolis, MD 21401	CY2007 - CY2009 Zipped Access datafiles – DC Inpatient Data
Investigation of Maryland Teen Births & Infant Mortality Maternal Complications of Pregnancy	Lee Hurt, M.S. MPH Maternal & Child Epidemiology, Center for Maternal & Child Health DHMH, 201 W. Preston Street, Room 309 Baltimore, MD 21201	CY2000-CY2009 SAS DC Inpatient Data
Planning Services Study of Out-Migration from Maryland for Care in the District of Columbia	Annice Cody Vice President, Strategic Planning Holy Cross Hospital 11801 Tech Road Silver Spring, MD 20904	2008-2009 DC Hospital Discharge Data

Long Term and Community-Based Care Support
Data Staff performed the following tasks for publicly reported data on long term care facilities: prepared the data dictionary and public use data sets for the Home Health Survey; prepared programs to produce the Home Health Utilization Reports; prepared and tested the 2009 Hospice Survey; Prepared the data dictionary and public use data sets for the 2009 Hospice Survey; Rewrote the post processing program and documentation for 2009 Long Term Care (LTC) Survey data; Consulted with the center staff regarding the LTC data output and the program flow of the LTC programs; Updated the labels in the LTC datasets; Made modifications in the programs to allow side programs for variable labels, etc. to be called into the main program in place of manually running programs; and ran and documented thirteen (13) programs successfully. Data Staff documented, processed, compressed and uploaded to our website current year data for Adult Day Care, Ambulatory Surgery, Assisted Living, Home Health, Hospice, and Nursing Home Facilities.

Long Term Care (LTC) Portal Development
In preparation to launch the new portal, Data Staff prepared Long Term Care, Assisted Living, and Home Health files to pre-populate the initial portal database. Data Staff worked with the Long Term Care Staff to go over all links on the MHCC website that needed to point to the Portal to replace links to the old assisted living and nursing home applications, and developed and tested data flows to the portal for Nursing Home quality measures, deficiencies, resident and quality indicators, family satisfaction measures, and Assisted Living inspection reports. The Long Term Care Survey questions changed significantly for 2009 and as a result the workflow for the Nursing Home updates had to be modified a second time. Data Staff performed data updates to the portal for bi-monthly assisted living inspection reports and nursing home quality measures and deficiencies, and an annual update for the nursing home family satisfaction survey. Data Staff worked with the portal vendor to add new data to the portal such as a special focus facility flag, nursing home toilet configurations, home health quality measures, assisted living and nursing home health care worker vaccinations, and performed numerous iterations of development, problem solving and testing of portal revisions.

Medical Care Data Base / Support for Cost and Quality Reporting
Data Staff provided programming and technical support for the Medical Care Data Base including validation and installation of files received from the MCDB vendor for private claims, pharmacy, and Medicare and Medicare Provider Analysis and Review (MEDPAR). Data Staff provided merged variables in the Medicare Part D Enrollment file onto the Medicare Beneficiary Summary File, and provided analytical support to subsequent related questions.

Methicillin-resistant Staphylococcus Aureus (MRSA) Web-Based Survey
Data Staff performed updates to receive quarterly MRSA submissions from Maryland hospitals and updated the survey questions as needed. Data Staff uploaded informational links and documents on the MHCC website. Data Staff developed a web-based hospital survey tracking application to enable staff to track file uploads and provided instruction to Hospital Staff on using web tracking application.

MONAHRQ
MONAHRQ is a free Windows-based software product that enables host users, such as State and local data organizations, chartered value exchanges, hospitals, and health plans to input their own raw inpatient hospital administrative data and generate a data-driven website. Data Staff prepared feasibility of MONAHRQ application reports for CY2009 Maryland Discharge Abstract data and created and distributed a website version 1.1 for CY2009 Maryland Discharge Abstract data. Data staff also trained staff in the hospital center to create the 2010 MONAHRQ website.

Minimum Dataset Processing and Conversion to 3.0
The MDS Manager application converts the Minimum Dataset, a clinical assessment of all residents in Medicare or Medicaid certified nursing homes, from ASCII to SAS. Until September 30, 2010, the MDS data was in version 2.0 format. Effective October 1, 2010, the facilities began to submit the MDS data to CMS in the version 3.0 format. However, our MDS Manager application, which is used to convert the data, has not been converted to the new version. Data Staff worked with the staff from the Center for Long Term Care to review the MDS RFP and the specifications for the MDS Manager 3.0 in order to convert the old Foxpro manager to SAS, and update the documentation. Data Staff continued to perform 2.0 updates and through September 30, 2010 for 2010q1, q2, and q3 for assessment & facility data.

Nursing Home Family Satisfaction Survey
Data Staff processed the 2010 survey data to be consistent with last year's survey data and identified facilities with missing data. Data Staff modified the nursing home family satisfaction survey portal page to accept the revised data format requested by the Long Term Care Staff. Data Staff reworked county-code programming for the survey table because the merge with previous year's data in order to present a trend caused the rows to cross values.

Patient Centered Medical Home (PCMH)
Data Staff examined excel spreadsheets for the PCMH attribution study, created the file layout specifications, processed data requests, assigned a county name and planning region to the 2010 PCMH data, and took professional quality photos of a training session to be used in newsletters, brochures and printed matter.

Physician Database
Data Staff continued to clean and maintain the 2010 license renewal dataset and merge it with the 2009 data, provide analysis of the demographics of active physicians, prepared a list for the Division Chief of the ethnicity of providers, and, by combining some specialties in the national table into Maryland specialties, match the average age nationally of each specialty in the 2010 Physicians Database, and then produce excel workbooks on specialties by provider type and county. Data Staff tabulated the number of physicians in a practice or hospital who have adopted EHR and produced summary reports.

Technical Support for Internal Staff
Data Staff provided the following examples of support to internal staff:

- Performed web page updates, maintenance and structural changes to the website as needed by MHCC staff.
- Developed the capability to allow internal staff to download to excel the various listserv databases that are collected as a result of people signing up for the listserv.
- Wrote a summary of procedures to process large documents intended for the website for the staff.
- Diagnosed and resolved issues that came up frequently with non-programming staff using Dreamweaver.
- Overhauled the file structure on selected servers to create enough space to conduct hospital quality measure data processing.
- Rewrote sections of the employee data confidentiality manual and agreement so that it could be used for all sensitive data collections.
- Helped staff with various image processing issues.
- Worked continuously with the Network Staff to improve efficiency of the nightly file backups.
- Updated documentation of MHCC website locations, SQL DB locations, backup locations, account information and locations of critical documents.
- Worked with the Network Staff to manage file permissions.
- Uploaded bidboard, rfp and torfp documents as well as many other helpful administrative documents to the intranet for internal use.
- Reviewed technical components of bidboard, rfp and torfp documents for all IT-related work.
- Provided Acrobat PDF support to staff.
- Set up Contribute administration and accounts for staff who will update the Commissioner web page and provided a training session on how to use Contribute.
- Brought all project documentation up-to-date and documented all ODBC connections used for SAS to communicate with the SQL web server.

Trauma Fund

Data Staff processed 2008 and 2009 discharge and emergency department data and calculated the number of car accidents in the state in 2008 and the destination Trauma centers for the patients involved in the car accidents. Data Staff added the county code to the drive time analysis to be able to determine distances from crash sites to hospitals by county. Data Staff prepared crash reports based on driving conditions such as normal traffic, moderate traffic, heavy traffic, and heavier traffic. Data Staff performed the following on the Maryland Trauma Physician Services Fund data: created an electronic transaction file for 2011; developed a report on On-Call trauma data; processed the MIEMSS registry data for FY 2010; and updated claims processing with the electronic transaction report for payment of ongoing claims data. Data Staff updated all trauma fund programs and corrected data sets with missing cpt codes or trauma numbers.

Web Application Development - Other

Internal

- Health Insurance Partnership Support and Renewal Maintenance (multiple site application including Registry and Accounting)
- Hospital Survey 2011 for Health Information Technology
- Long Term Care Survey 2011
- Maryland Health Information Technology Resource (MHIR)
- MHCC User Fee Assessments 2011 (multiple site application including new Assessments EDI payment interface)
- Patient Centered Medical Home Design and Support (PCMH - multiple site application including provider registration, creating a portal and calculator)

External

- Board of Physician License Renewal Design and Support 2011
- Boards and Commissions License Renewal
- Created a new web application for license renewal for the Massage Therapy Board
- Ongoing website support and redesign for the following boards:
  - Board of Chiropractic & Massage Therapy Examiners
  - Board of Optometry
  - Board of Examiners of Psychologists
  - Board of Social Work Examiners

Network and Operating Systems Division

Overview

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

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

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

Accomplishments

During FY 2011, the Commission's LAN was available to staff over 99% of the time.

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

Patient Centered Medical Home Program

Overview

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

Accomplishments

Practice Selection

In November of 2010, the Commission convened a Practice Selection Committee composed of the Council's PCMH Workgroup's Chair, medical directors from the participating carriers, Medicaid staff, and Commission staff to select 60 practices from the 179 primary care practices (representing more than 1,000 physicians) that had applied to participate in the Commission's three-year Multi-payer PCMH Program (MMPP).

In selecting the invited practices, the Committee utilized a ranking procedure weighing the practice's responses across 6 domains:

- Special Requirements in legislation: geographically diverse, reflects variations in care delivery, and encompass all populations. (Commercially insured, Medicaid, Medicare) and small practices including NPs and practices that are collaborating with other small practices.
- Existing NCQA Recognition – PCMH, Back, Heart, Diabetes
- Participation in quality initiatives, employee wellness, primary care residency
- Established business functions – hours worked, extended hours of access
- PCMH features -- Use of EHR, Offer care beyond "office visits" (i.e., phone, online)
- Adaptive reserve – the capabilities and resources that can be used to further the transformation to a PCMH.[1] Adaptive reserve includes measures of leadership, diversity, mindfulness, communication, respectful interaction, learning culture, reflection and general work environment.

The MMPP Program intends to test the following value propositions:

- Enhanced primary care will improve health status and outcomes for patients (especially for the chronically ill).

- The result will be fewer complications, ER visits, and hospitalizations.
- Savings from these improved outcomes can be used to fund increased payment to primary care practices.

Participating practices must achieve NCQA PPC PCMH Level 1+ or higher by December 31, 2011 and Level 2+ or higher by December 31, 2012. In addition, the MMPP practices must report on quality measures as set forth in the chart below:

Table 5
Quality Measurement Criteria

Group One Criteria*

NQF Measure	Developer	Recommended Measure Title	Reported by Pediatric Practices	Reported by Adult Practices
0001	AMA	Asthma Assessment	YES	YES
0002	NCQA	Appropriate Testing for Children with Pharyngitis	YES	
0013	AMA	Core: Hypertension: Blood Pressure Measurement		YES
0018	NCQA	Controlling High Blood Pressure		YES
0024	NCQA	Alternate Core: Weight Assessment and Counseling for Children and Adolescents	YES	
0028a	AMA	Core: Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment		YES
0028b	AMA	Core: Preventive Care and Screening Measure Pair: b. Tobacco Cessation Intervention		YES
0034	NCQA	Colorectal Cancer Screening		YES
0036	NCQA	Use of Appropriate Medications for Asthma	YES	YES
0038	NCQA	Alternate Core: Childhood immunization Status	YES	
0041	AMA	Alternate Core: Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old		YES
0043	NCQA	Pneumonia Vaccination Status for Older Adults		YES
0047	AMA	Asthma Pharmacologic Therapy	YES	YES
0059	NCQA	Diabetes: HbA1c Poor Control		YES
0061	NCQA	Diabetes: Blood Pressure Management		YES
0067	AMA	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD		YES
0075	NCQA	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control		YES
0081	AMA	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)		YES
0105	NCQA	Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment		YES
0421	QIP	Core: Adult Weight Screening and Follow-Up		YES
0575	NCQA	Diabetes: HbA1c Control (<8%)		YES

***NOTE: Shaded rows are the CMS EHR Meaningful Use Core or Alternate Core measures.**
Non-shaded rows are additional recommended measures to be included in the Program.

Payment Methodology

Commission staff and their consultants from Discern Consulting LLC continued refinement of the program's payment model. MMPP practices will be reimbursed as usual for fee-for-service ("FFS") care, and carriers will pay practices on a per patient per month ("PPPM") basis for care coordination expenses not included in their standard FFS schedules. The reimbursement methodology is summarized below:

Fixed Payments are guaranteed and adjusted by PCMH recognition level, category of carrier (commercial, Medicaid MCO, and Medicare MCO), and practice size.

- Paid semi-annually prospectively.
- Range of $3.00 - $6.00 PPPM for commercially insured populations.
- Total fixed payment range of $40,000 - $60,000 per full-time physician annually.

Shared savings payments could be substantial, but are not guaranteed.

- Calculated based on achieved total savings from all care (IP, Rx, Outpt, and Prof).
- Separately calculated for commercial (grouped together for all carriers), Medicaid, and Medicare (if Maryland participates in the CMS demonstration).
- Baseline for savings will be the practice's patients' total medical expenses, adjusted for inflation and plan benefit changes since the start of the Pilot.
- Paid retrospectively.

Bonus, or shared savings, payments will be derived from the savings that the carriers are able to document, with the largest percentage of the savings returned to the practice. Practices would get the full payment if they are able to meet the cost and quality thresholds established for the program. Program participants agreed to the following levels for Fixed Transformation Payments and shared savings (or incentive) payments.

Table 2. Commercial Population - Fixed Transformation Payments

Physician Practice Site Size (# of patients)	Level of PCMH Recognition		
	Level 1+	Level 2+	Level 3+
< 10,000	$4.68	$5.34	$6.01
10,000 - 20,000	$3.90	$4.45	$5.01
> 20,000	$3.51	$4.01	$4.51

Note: Level 1+ applies only to the first year of the Program. In Years 2 and after, medical homes must achieve Level 2+ or better to receive Fixed Transformation Payments.

Table 3. Medicaid Population - Fixed Transformation Payments			
Physician Practice Size	Level of PCMH Recognition		
	Level 1+	Level 2+	Level 3+
All Practices	$4.54	$5.19	$5.84
Note: Level 1+ applies only to the first year of the Program. In Years 2 and after, medical homes must achieve Level 2+ or better to receive Fixed Transformation Payments. Fixed payments will NOT be available for Federally Qualified Health Centers.			

Table 4. Medicare Advantage Population - Fixed Transformation Payments			
Physician Practice Size	Level of PCMH Recognition		
	Level 1+	Level 2+	Level 3+
All Practices	$8.66	9.62	11.54

1. Fixed Transformation Payments
   a. A Carrier shall make Fixed Transformation Payments to a participating Practice semi-annually using one of the following methods:
      i. By a claim for each attributed PCMH patient using a local HCPCS code that has been approved by the Commission.
      ii. By a lump sum payment to a participating Practice for all patients attributed to that Practice in the current 6-month attribution period.
      iii. By an alternative method approved by the Commission at least 60 days prior to date when the payment is due.
   b. The sum of all claim payments or the lump sum payment shall represent the total semi-annual payment for the attributed participating patients associated with that Practice.
   c. The Carrier shall provide the Practice with sufficient information to enable the Practice to reconcile Fixed Transformation Payments with the specific patients attributed to the program.
   d. Fixed Transformation Payments shall be adjusted annually by the change in the Medicare Economic Index between the current year and the ensuing years.

2. Incentive Payments: Beginning in Year 1 and continuing through Year 3.
   a. Practices that have met the annual performance criteria specified in Tables 5 and 6 will be qualified to receive the defined percent of any savings generated by the Practice during Years 1, 2, and 3 as shown on Table 7.
   b. Practices shall report the criteria defined in Table 5 and the Commission will calculate the utilization criteria for each Practice.

c. The baseline for measuring changes in utilization for each participating Practice shall be participating patients attributed to that Practice in the calendar year preceding the start of the Program.
d. The savings shall be based on the difference between expected medical costs for the Practice's patient population and the actual total medical care spending per attributed participating patient, including the cost of the "Fixed Transformation Payments," and any existing Carrier incentive programs, including an EHR incentive paid as a result of passage of HB 706.
e. The total expected medical expenses are defined as the per participating patient medical expense in the year prior to the start of the Program, adjusted for medical inflation.
f. The Commission may adjust the shared savings algorithm to account for outliers and changing case mix in a Practice based on evidence that these factors would present a significant disadvantage to a Carrier or participating Practice.
g. In determining shared savings, separate saving calculations shall be constructed for the commercially insured population, the Medicaid population, and the Medicare population, including traditional Medicare (if CMS decides to participate) and Medicare Advantage.
h. Should there be no savings as defined herein, the Practice will not be eligible for an Incentive Payment, nor will it be required to repay the Carriers for the Fixed Transformation Payments.

3. The medical inflation factor used to adjust expected expenses will be derived by estimating the change in spending in the Maryland market for the commercially insured, the Medicaid, and the Medicare populations from the base year to the current program year using a nationally known industry source such as the Milliman Medical Index or the Medical Care Data Base. Separate medical inflation factors will be applied to base spending for the commercially insured, Medicaid, and Medicare populations.

4. Procedure for Paying the Incentive Payments
   a. The Commission will notify each participating Carrier of the shared savings achieved for its covered individuals that are attributed to a Practice.
   b. The Commission may assign Carriers the responsibility of calculating the shared savings using the Commission's calculation approach.
   c. The Carrier shall obtain the Commission's approval for making an Incentive Payment to a Practice.

5. The Commission may negotiate with self-insured employers and their representatives on the level of Fixed Transformation Payments paid by self-insured employers according to the following conventions:
   a. Any reduction in the Fixed Transformation Payment amount shall be offset by an equivalent increase in the percent of shared savings awarded to the plan.

b. The self-insured employer, or its agent, can provide a method to Practices for differentiating participating patients insured by self-insured employers and other forms of coverage.

MMPP Participation Agreement

Commission staff negotiated the terms of the Patient Centered Medical Home Program Participation Agreement, which was executed by contracting authorities with Aetna, CareFirst, CIGNA, Coventry, United Healthcare, the Medicaid MCOs and physician practices, which include a CRNP-directed practice, solo and small physician-owned practices, Federally-Qualified Health Centers, hospital-owned practices, and faculty-based practices.

Self-Insured Employer Participation

Throughout the Spring of 2011, Commission staff also conducted an outreach program recruiting interested self-insured employers to participate in the program. The Maryland State Employee Health Plan, Maryland Health Insurance Program (MHIP) and the Office of Personnel Management voluntarily agreed to participate.

Maryland Learning Collaborative

The Commission contracted with the University of Maryland, Department of Family and Community Medicine at the University of Maryland School of Medicine to plan and launch the Maryland Learning Collaborative (MLC) to foster practice transformation for practices in the program. The MLC is a partnership that combines resources from the education and research communities with the commitment and knowledge of clinicians committed to advancing primary care. It is led by Drs. David Stewart, MD, MPH, Niharika Khanna, MD, and Kathy Montgomery, PhD, RN of the University of Maryland and Norman Poulsen, MD, Scott Feeser, MD and Bruce Leff, MD of Johns Hopkins University. The first meeting of the MLC was held on May 14, 2011, with a focus on introducing the concepts of the PCMH, documentation of baseline participating practices' readiness for transformation, and meeting the NCQA requirements for recognition. The MLC has established a secure website for sharing information with practice participants and conducts numerous site visits to the practices, webinars and teleconferences, and regional meetings of the Collaborative. The second meeting of the Collaborative was held on November 11 and 12, 2011, with a focus on organizational change, care management, and quality measurement.

MMPP Advisory Panel

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

Patient Attribution

The MMPP program completed attribution of patients by carriers and the Medicaid MCOs in September. A combined investment of approximately $3 million was paid to participating

practices for the first Fix Transformation Payment. The commercial carriers accounted for approximately $2.1 million, as follows: CareFirst $1.4 million; United Healthcare $431,000, Aetna $140,000, and Coventry $33,800. Medicaid released special payments to the MCOs and approximately $900,000 was paid by the Medicaid MCOs to the practices. Commission staff estimates that an addition $100,l00 was paid to practices by several self-insured employers. Participating sites received an average payment of $56,000. As of the writing of this report, the MMPP program was in the process of the second round of attribution, with Fixed Transformation Payments due to the participating practices in January of 2012.

NCQA Recognition

47 of the 52 practice sites submitted their NCQA applications for PCMH recognition on or before the October 28, 2011 deadline. Five practices received a deferment of up to one month in order to complete their submissions.

Program Evaluation

The MHCC released an RFP for PCMH Program Evaluation services in February 2011 and revised and re-released the RFP in May. Two potential vendors responded to the revised RFP. An Evaluation Review Commission composed of Dr. Kathi White (former Chair of the Council's PCMH Workgroup) Dr. Howard Haft of Shah Associates (an MMPP participating practice), Grace Zaczek of Maryland Medicaid, and Ben Steffen, Linda Bartnyska, Susan Myers, Karen Rezabek, and Sharon Wiggins of the Commission staff reviewed the proposals and recommended approval by the Maryland Board of Public Works for the Commission to enter into a five year contract with IMPAQ International. The Maryland Board of Public Works approved the contract on September 21, 2011.

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 through December 31, 2013), that no longer allows the self-employed to enroll in the CSHBP because of their atypical loss ratio. During the 2009 legislative session, the General Assembly enacted SB 637/HB 674 (Chapter 577 of the Laws of Maryland), which imposed the following modifications to the small group market, with varying effective dates: removal of the statutory floor; elimination of the prohibition on applying pre-existing condition limitations in this market, allowing carriers to impose this exclusion for up to 12 months based on a six-month look-back period on individuals first entering the small group market; the requirement that the Commission establish an information-only web portal to publish small group premium information on its website; adjustment of the rating bands in the small group market to +/-50 percent; and allowance for carriers to rate on entry for new groups entering the small group market, adjusted annually over the first three years of enrollment.

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

benefits, but not to diminish them. The insurance reform required community rating adjusted only for age and geography. Rating bands were established and are currently set at +/-50 percent. Since its inception, this health insurance reform initiative has provided small businesses in Maryland with access to a comprehensive health insurance benefits package on a guaranteed issue, guaranteed renewal basis.

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

Accomplishments

Comprehensive Standard Health Benefit Plan

During FY 2011, the Commission enhanced the services provided under the CSHBP to conform with the federally mandated provisions required under federal health reform (the Affordable Care Act). Through regulations implemented effective September 23, 2010, the specific provisions include the following: children can remain covered on a parent's existing policy until the age of 26; certain preventive services recommended by the U.S. Preventive Services Task Force cannot be subject to the deductible and have no associated cost-sharing requirements if these services are provided in-network; the $2 million lifetime limit has been removed; the provisions for direct access to gynecologic services are changed from state provisions to federal provisions; and individuals under the age of 19 may not be subject to any pre-existing condition restrictions or limitations. With these additional benefits, the overall cost of the CSHBP remained below the affordability cap, currently at 95% of the cap as of December 31, 2010.

In June 2010, the Commission contracted with Benefitfocus to develop an information-only web portal designed to help small business owners choose a group health plan for their employees. The web portal, known as VIRTUAL COMPARE, became operational on May 3,

2011, and provides information about select health plans available to small employers in Maryland, allowing a side-by-side comparison of benefits, premiums, and out of pocket costs. VIRTUAL COMPARE also includes guidance about choosing health insurance; information about federal tax credits and state subsidies for small, low wage companies; and assistance in finding an insurance broker to apply for coverage. Throughout FY 2011, more than 600 licensed insurance producers in Maryland have registered to be listed on VIRTUAL COMPARE to assist small employers with the group application process. Moreover, the analytics indicate numerous hits to the web portal on a daily basis, with the user viewing several pages for a significant period of time during each visit.

Health Insurance Partnership

COMAR 10.25.01 established the eligibility requirements for employers and employees, as well as the process for calculating the average wage of the business and the group subsidies for the premium subsidy program, eventually named the Health Insurance Partnership. Throughout FY 2011, four major carriers (Aetna, CareFirst, Coventry Health Care, and United HealthCare), together with a number of Third Party Administrators (TPAs) continued enrolling small businesses in the Partnership, with each carrier offering various products that qualify for a premium subsidy. Annual funding for the Partnership is $2 million. On January 1, 2011, the MHCC published the 3rd annual report on the implementation of the Partnership. The report is posted on the Commission's website.

Health Plan Quality and Performance Division

Overview

The Code of Maryland Regulations (COMAR) 10.25.08 require a health benefit plan to participate in the health benefit plan quality and performance evaluation and comparison system by submitting reports to the Commission if the health benefit plan holds a certificate of authority in Maryland and has a premium volume in Maryland exceeding $1 million. Health benefit plans having more than 65 percent of their Maryland enrollees covered through the Medicare and Medicaid programs are not required to participate in the evaluation and comparison system. The Division of Health Benefit Plan Quality and Performance is charged with collecting, and making available to the public, comparative information on the performance of commercial health benefit plans 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

Legal Authority Expanded

During the 2011 legislative session, Senate Bill 56, Evaluation of Quality and Performance of Health Benefit Plans expanded the Maryland Health Care Commission's authority by repealing and reenacting with amendments, Health General Article, Section 19-134(c). Health-General Article, Section 19-134(c), et seq. is the statute that directs the Maryland Health Care Commission to establish and implement a system to evaluate and compare, on an objective basis, the quality and performance of care provided by commercial health benefit plans. The

statute also permits the Commission to solicit and publish data collected using standardized health benefit plan quality and performance measurement tools such as the Healthcare Effectiveness Data and Information Set (HEDIS), as well as permitting the Commission to solicit and publish health benefit plan member opinions of enrollee satisfaction with the performance of the health benefit plans they enrolled in, including Health Maintenance Organizations (HMOs), Point of Service (POS) organizations, Preferred Provider Organizations (PPOs), Exclusive Provider Organizations (EPOs), or any other type of health benefit plan that may be introduced in the future. The Commission is required to annually publish the findings of the evaluation and comparison system for dissemination to consumers, purchasers, academics, and policymakers.

Request for Proposals (RFP) Executed

Division staff prepared and issued two RFPs, one for a vendor to conduct the HEDIS data collection from Maryland health benefit plans and one for a vendor to conduct the CAHPS survey of health benefit plan members' satisfaction with the performance of their Maryland health benefit plan. Vendor proposals were evaluated and a qualified vendor was awarded the contract for each RFP.

2011 Report Series Executed

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

The three-part series of annual health benefit plan performance reports includes the following:

- The 2010 Health Plan Performance Report, also referred to as the *Consumer Guide*, is a consumer-oriented report providing a sub-set of measures that are of interest to a general audience. This report highlights areas of healthcare where plans had average and above-average performance, and areas that need improvement. In addition to this year's quality ratings, the report includes important information about coordination of health care – health plans, doctors and patients working together to improve the delivery of care. Improvements in coordination of care can help increase patient satisfaction, lead to better quality of care and potentially lower costs.
- The 2010/2011 State Employee Guide, is a report tailored to state employees which provides information on the subset of health benefit plans offered to Maryland state employees. In addition to presenting this year's quality ratings, the report offers guidance on what it means to be an engaged health consumer and includes additional resources and tools to help consumers navigate and manage their personal health care.
- The 2010 Comprehensive Report on Maryland Health Plans is designed to help consumers, purchasers, academics, and policy makers assess the relative quality of care delivered by health benefit plans. The report contains three years of detailed HEDIS and

CAHPS results, comparing health benefit plans to the Maryland state average and highlighting when a plan's performance significantly increased or decreased.

Historic Reporting Milestones

- **In 1997 Maryland HMOs began mandatory reporting.** Maryland became the first in the nation to provide consumers with audited, comparative analysis of clinical quality and member satisfaction with health benefit plan performance for HMO plans.
- **In 2008 Maryland PPOs voluntarily begin reporting.** 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. This voluntary participation by PPO plans signified a broad-based commitment by Maryland health plans to collectively use quality measurement and reporting to achieve a healthier Maryland; three carriers began voluntarily reporting quality information on PPOs.
- **In 2012 Maryland PPOs will begin mandatory reporting.** Maryland will be one of a few states to provide consumers with audited, comparative analysis of clinical quality and member satisfaction with health benefit plan performance for PPO plans.

2011 Report Series and Beyond

Moving forward, development of the health benefit plan performance reports will maintain a focus on increasing health benefit plan participation in quality and performance reporting in 2011. For 2012, the division plans to expand its focus from increasing health benefit plan participation, to partnering with reporting health benefit plans to help them improve their quality and performance outcomes on targeted measures that relate to the annual theme of the performance report. For 2013 and beyond, the division will expand the types of comparative measurements from general quality and performance of health benefit plans to also include comparative measurements on the efficiency and effectiveness of health benefit plans through the use of a measurement tool such as eValue8. This systematic expansion in focus will provide consumers, purchasers, academics, and policymakers with a more complete picture of overall quality and performance of Maryland health benefit plans. Additional long term goals for the report series include the development and implementation of web-based report cards that present consumer-friendly summary information.

Mandated Health Insurance Services Evaluation

Overview

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

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

Accomplishments

In FY 2011, five proposed mandates were evaluated: coverage for the treatment of spinal muscular atrophy; coverage of preventive physical therapy services for patients diagnosed with multiple sclerosis; a financial impact analysis on expansion of habilitative services; an analysis on prescription drug cost-sharing obligations; and an analysis of cost-sharing equity for cancer chemotherapy.

This analysis, prepared by Mercer, the Commission's consulting actuary, was approved by the Commission in December 2010, submitted to the General Assembly and posted on the Commission's website. The next Comparative Evaluation, which is due every four years, also will be prepared by Mercer and will be published in January 2012.

MARYLAND HEALTH CARE COMMISSION

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

Long Term Care Quality Initiative

Overview

The Long Term Care Quality Initiative, a division within the Center for Long-term Care and Community-based Services, focuses on improving long-term and community-based care through maintenance of the interactive web-based consumer guide that presents a wide range of information about long term care (LTC) services including specific performance and quality measures applicable to long term care. LTC quality staff provide oversight for administration of surveys that collect performance information. One series of surveys measures the experience and satisfaction of family members, designated responsible parties, or residents of Maryland's long-term care facilities. Other surveys are designed to collect information about infection control: facility staff influenza vaccination rate surveys have been implemented in nursing homes and assisted living settings. Division staff also works with federal agencies such as Centers for Medicare and Medicaid (CMS) and Agency for Healthcare Research and Quality (AHRQ) and other national organizations such as the National Quality Forum to insure that the tools used and measures reported are reliable, validated and suitable for public report.

Accomplishments

Consumer Guide to Long Term Care

In December 2010 the **Consumer Guide to Long Term Care** was introduced replacing two guides, the Maryland Nursing Home Guide and the Maryland Guide to Assisted Living Facilities, which were introduced in 2001 and 2004 respectively.

The new Consumer Guide is an expanded and comprehensive LTC web portal focusing on frequently used LTC services received in one's home, community, or facilities such as nursing homes with emphasis on community services. Service categories have been expanded to include: adult day care; assisted living; home-based care such as home health agencies, agencies providing non-skilled care (residential service agencies, and nursing referral agencies); hospice programs; and nursing and rehabilitation facilities.

Key features of the expanded site include:

- "Planning for Long Term Care" defines key terms and types of LTC services, offers resources for planning and links to resources for estimating the cost of long term care,

discusses ways to finance LTC, and provides Maryland-specific advance directive planning information
- Information about home modifications to allow seniors and persons with disabilities remain in their home
- Location of community support services including senior centers, meal programs, resources for family caregivers, transportation
- A resource section that includes links to federal, state, and local sites to assist in answering questions about prescription drugs, legal resources for seniors and persons with disabilities, a tool that can locate a physician near one's home, and local resources for health care such as county clinics
- Guidance on health insurance benefits, Medicare, special transportation for persons with disabilities, and resources for family members or friends who help seniors and persons with disabilities

The portal has an interactive search feature that allows users to find LTC services by facility type or geographical area (county or zip code). Within the services search function users can view information about: facility characteristics such as ownership information; agency accreditation or certification, number of beds or client capacity; clinical and assistance services available; resident characteristics; quality indicators; performance indicators; the results of annual licensing and complaint surveys; and the results of the family experience of care surveys. Pictures of nursing homes and assisted living facilities are also featured to assist Marylanders in narrowing their choice.

An analysis of consumer use for the first six months of the new website (January 1, 2011 through June 30, 2011) shows nearly 24,000 (23,896) pages were viewed and 9,444 unique visitors used the site in the first six months. Viewer type and zip code will be analyzed as part of future metrics.

The web portal was implemented as described above. Refinements to improve ease of updating the portal are continuing in FY 2012. Additions to the guide include display of vaccination rate data and home health quality measures.

Nursing Home Experience of Care Survey

FY 2011 marks the fourth year for the Nursing Home Family Survey which collects the experience and satisfaction of the family members and responsible parties of nursing home residents. Maryland is one of only a few states that conduct an annual nursing home survey; the Maryland survey consistently yields a high response rate of nearly 60% which is well above the national average. Statewide averages show that survey respondents rate satisfaction with nursing homes relatively high. The 2010 survey collection was distributed in the fall and facility-specific results were released in April 2011. The accomplishments section lists the results of the 2010 survey.

A survey to assess the experience of recently discharged short stay residents was piloted in 2011 in collaboration with AHCQ.

2010 Family Survey results show that statewide "overall satisfaction" was rated 8.4 on a 10 point scale and 90% of respondents said they would recommend the nursing home to others. Results of the experience of care survey are displayed for each nursing home within the **Consumer Guide to Long Term Care**. In addition, the results are used by the Maryland Department of Health & Mental Hygiene, Medicaid Long Term Care Division, as one of four factors in the nursing home Pay for Performance Program.

Short Stay Nursing Home Survey

Some Maryland nursing homes demonstrate increasing numbers of short stay residents and the number of people needing short stays in nursing homes is expected to continue to increase because individuals indicate a strong preference for receiving services in their home as long a possible. As a result MHCC staff collaborated with the Agency for Healthcare Research and Quality (AHRQ) by testing the ARHQ short stay survey in Maryland. This collaboration benefits AHRQ by providing additional testing of the instrument; MHCC benefits by piloting an experience survey among nursing home short stay residents; the nursing homes in Maryland that participate benefit by receiving information from short stay residents about their stay. The pilot took place in the fall 2010 survey cycle; results were reported in April 2011. Statewide results of this pilot survey shows that the overall rating given by respondents is 7.8 on a scale of 10 (10 represents the best rating). 83% of short stay respondents would recommend the nursing home.

The MHCC nursing home survey efforts have received national recognition through the invitation by the Agency for Healthcare Research and Quality (AHRQ) to Commission staff to present at two national CAHPS User Group meetings.

Additional Experience of Care Surveys

During the year, LTC Quality staff researched surveys for implementation in Maryland to report the experience of users 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.

Home Health Quality Reporting – CMS has developed a survey for the users of home health services. LTC staff participated with CMS and AHRQ staff during development of the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey. The HHCAHPS survey is mandatory for Medicare certified Home Health Agencies (HHAs) in 2011 with data expected to be available in early 2012. To improve the home health quality data available to Maryland consumers, LTC staff is currently determining the steps needed to convert the Maryland home health agency HHCAHPS data into a format suitable for display in the Consumer Guide to Long Term Care.

Assisted Living – a survey suitable for use in this setting has been developed; however, the logistics of fielding this type of survey and ensuring confidentiality need to be resolved before implementation.

Hospice Quality Reporting - LTC staff, working with the hospice community are planning to field a pilot hospice survey for FY 2012.

Influenza Survey among Nursing Home Staff

Seasonal influenza infection causes considerable morbidity and mortality among older adults; persons 65 years of age and older account for the majority of the 36,000 deaths that occur from complications of flu each year. An Influenza Vaccination Survey for staff working in nursing homes was piloted during the 2009-2010 influenza season in collaboration with the DHMH Medicaid Office of Long Term Care and Community Support. Results of the pilot survey show a 2009 statewide seasonal influenza vaccination rate of 60.2% for nursing home HCWs (85% of nursing homes responded to the pilot survey).

Completion of the nursing home staff influenza survey was mandatory during the 2010-2011 influenza season. 100% of nursing homes completed the 2010-2011 survey. Results showed a 58% vaccination rate for nursing home staff with 100% of nursing homes reporting. Nursing home facility-specific results will be displayed on the Consumer Guide to Long Term Care in the fall of 2011.

An Influenza Vaccination Survey for staff working in assisted living residences was piloted during the 2010-2011 flu season. The assisted living staff vaccination rate was 48% with only 62% of the assisted living residences reporting on the voluntary survey. During the 2011-2012 influenza seasons, assisted living residences will be required to complete the influenza vaccination survey.

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

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. Commission staff benefits by participation in this process by gaining knowledge of cutting edge public report practices that can be applied to the MHCC consumer reports.

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

MDS Quality Measure and Quality Indicator scores were frozen with data collection period ending September 2010 to accommodate the transition to MDS 3.0. The implementation of MDS 3.0 will alter the report of several nursing home quality measures and quality indicators

due to specification changes. When data becomes available in late 2011 or early 2012, LTC staff will carefully analyze the revised quality information to incorporate necessary changes and explanations within LTC Guide to enhance consumer understanding.

Long Term Care Policy and Planning

Overview

The Long Term Care Policy and Planning Division is responsible for health planning related to community-based and institutional long term care services. This includes monitoring changes in demographics, medical technology, financing and reimbursement, and their impact on current and projected utilization of long term care services in Maryland; determining where there may be gaps in the continuum of care; and promoting the development of needed services in response to identified needs, and assuring access to a full continuum of long term care services. In addition to planning, the Division is also responsible for data collection through three annual surveys, special studies, and quality assessment. The Division coordinates its long term care policy development and planning efforts with other appropriate state agencies and stakeholders, and provides leadership and direction to technical advisory committees and workgroups conducting analyses of a wide range of issues.

Accomplishments

Consultant on Use of Minimum Data Set (MDS)
On June 23, 2009 the Commission executed a one year contract for support in maximizing the utility of the Centers for Medicare and Medicaid (CMS) Minimum Data Set Resident Assessment Instrument to update data sets for planning and policy development; update current programs and address programming issues; construct variables for research projects; develop a methodology to impute missing data; create data sets that permit tracking of variables over time; and link data sets. Products developed included: detailed data documentation; data dictionary; software architecture; flow charts; and a glossary. The MDS Manager Program that was developed was used to update MDS data through 2009.

A new contract was awarded to Myers and Stauffer in June 2011 to update the MDS Manager to accommodate federally mandated changes from MDS 2.0 to 3.0 and to update programming languages from Fox Pro (no long supported) to SAS, the platform used at the Commission.

Chronic Hospital Occupancy Update
As required under COMAR 10.24.08, a notice was published in the December 3, 2010 *Maryland Register* to update "Chronic Hospital Occupancy for FY 2009." This report is required to be updated annually. It reports data on occupancy for both private and state-operated chronic hospitals. The private chronic hospitals include James Lawrence Kernan Hospital; Johns Hopkins Bayview Medical Center; Levindale Hebrew Geriatric Center and Hospital; University Specialty Hospital; and Gladys Spellman Specialty Hospital and Nursing Center. The state operated chronic hospitals include Western Maryland Center and Deer's Head Hospital Center.

Nursing Home Occupancy Rates and Utilization by Payment Source: Maryland Fiscal Year 2008

Data on nursing home occupancy and Medicaid participation rates is updated periodically and published in the *Maryland Register* to guide health planning and Certificate of Need decisions and other planning functions. The following tables were submitted to the *Maryland Register* for publication in the April 22, 2011 issue: "Nursing Home Licensed Beds Occupancy by Region and Jurisdiction: Maryland, Fiscal Year 2009"; "Required Maryland Medical Assistance Participation Rates for Nursing Homes by Region and Jurisdiction, Fiscal Year 2009." These tables are developed and published annually based on data from the MHCC Long Term Care Survey, MHCC bed inventory reports, and Medicaid cost reports.

Home Health Agency Data

Staff compiled data tables on the utilization and financing of home health agency services in Maryland for fiscal year 2009. The data was obtained from the information collected by the Commission's Home Health Agency Survey for fiscal year 2009 using an automated system, which includes data on overall agency operations and demographic characteristics, payer types, and services provided to Maryland clients by their jurisdiction of residence. The data tables for fiscal year 2009 were posted on the Commission's website in January 2011. Data tables include an overview of home health agency characteristics, utilization and costs including: volume of admissions; referral sources; primary diagnosis on admission; average visits per Medicare clients; disposition; revenues by payer types; and home health agency personnel. Staff continued to analyze home health agency utilization trend data based on information submitted to the Commission in its Home Health Annual Surveys. Data tables are available for fiscal years 2004-2008. Public use data sets are also available for fiscal years 2007-2009.

Home Health Agency Inventory

Staff conducted a verification and update of its home health agency (HHA) inventory which was completed in October, 2010. The inventory is routinely utilized for planning purposes as well as for updating the Commission's long term care website. This inventory was updated monthly to reflect both newly established and acquired home health agencies licensed and operating in Maryland.

Meetings/Collaboration:

Nursing Home Liaison Committee

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

Home Health Advisory Group

The State Health Plan for Facilities and Services, and its Home Health Agency (HHA) Services section of the Long Term Care Services Chapter (COMAR 10.24.08), is in the process of being

revised and updated to reflect more current utilization trends as well as other changes in the delivery and financing of HHA services.

To ensure stakeholder input, a Home Health Agency Advisory Group was convened to assist Commission staff by providing feedback on their analysis of utilization trends, identification of contributing factors to the changes in utilization of HHA services, and forecasting future HHA need in Maryland that maintains a robust industry while promoting consumer choice. Participants included major stakeholders in the delivery of HHA services in Maryland, including representatives from the Maryland National Capital Homecare Association (MNCHA).
The first meeting of the Home Health Agency (HHA) Advisory Group was held on September 29, 2010. An overview of HHA utilization trend data from 2002 to 2008 was presented. Illustration of the statewide trend data showed an overall decline in number of clients and visits from 2002 to 2008, with some fluctuations in alternating years. Average statewide number of visits per client, as well as client use rates per 1,000 population, have declined slightly during the same time period, and vary by age group. An alternative approach to forecasting general HHA need was presented. The Advisory Group conceptually agreed with the notion of moving away from a methodological approach based on referral rates and towards an alternative approach based on utilization rates and trends. Rather than using the number of HHA clients, use the number of HHA visits to determine projected general HHA need, which is based on client use rates and average number of visits. The Advisory Group generally agreed that an alternative approach to projecting need be age-adjusted and jurisdiction-specific. An alternative approach to the existing single capacity threshold of over 400 clients for all jurisdictions was also considered. The Advisory Group agreed that a jurisdiction-specific capacity threshold based on average historical growth in number of HHA visits, and number of HHAs authorized and serving at least seven clients, could be an alternate approach for defining a threshold beyond which a new agency may be needed to meet forecasted additional demand.

The second meeting of the Home Health Agency (HHA) Advisory Group was held on October 28, 2010. Staff presented a conceptual framework for HHA regional expansion using a two-phased approach for implementing new standards and criteria in the HHA Chapter of the State Health Plan and Certificate of Need (CON) regulations. Proposed is a transition from the current jurisdictional to a regional approach. Based on preliminary analyses of historical utilization patterns and a statistical clustering method, staff considered configuring Maryland's 24 jurisdictions into six geographic regions.

The Advisory Group generally supported staff's conceptual approach for creating expansion opportunities for certain existing HHAs with the underlying principle of enhancing consumer access to quality HHA providers and promoting consumer choice. However the details and implications of this new regional approach still remain to be worked out. The Advisory Group requested staff to consider the most recent available HHA utilization data. As the Commission moves forward with the regulatory process for updating the HHA Chapter, and before new regulations governing the CON review process for HHAs are adopted, Commission staff will be seeking additional feedback through an informal public comment period.

Presentations
Staff prepared materials for distribution at the Annual Hospice Day in Annapolis on January 26, 2011. Commission staff presented data on hospice patient profiles for FY 2009, selected hospice trends from 2005-2009, and progress made in data collection and analysis. New data was presented on the development of inpatient and residential hospice units. There was also discussion of the expansion of the nursing home website to become a long term care website that includes the development of a hospice guide for the public. Public use data sets for FY 2003-2009 have been posted on the Commission's website along with a Trend Analysis for 2006-2009, and an accompanying Statistical Guide.

Data Collection
Hospice Survey
The Commission is charged with collection of hospice data as required by SB 732 (2003). Fiscal Year 2009 hospice data was collected using an online survey 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.

Public use data files for FY 2009 hospice data were posted on the Commission's website in September, 2010. An accompanying Interpretive Guide to explain the variables in the data set was also posted. In October, 2010 work was completed on a Trend Analysis of hospice data for the time period of 2006-2009 and this was also posted on the Commission's website. This shows the differences in variables from year to year and indicates where differences are statistically significant. The Trend Analysis is accompanied by a Statistical Testing Guide that helps the reader to understand what significance tests are being applied and what caveats must be used in interpreting the data.

During 2010 the contractor utilized by the Commission was acquired with the new owners terminating the contract. Given new system development capabilities within the Commission, the annual Maryland Hospice Survey application was developed as an internal data collection tool by Commission staff.

The Fiscal Year 2010 Maryland Hospice Survey was released for online survey completion effective May 23, 2011 with a due date of July 25, 2011. Data collection, cleaning, and analysis were monitored by Commission staff.

Long Term Care Survey
The 2009 Maryland Long Term Care Survey collection period began on April 8, 2010 with a due date of June 7, 2010. Several reminder notices were sent out during the 60-day survey period. At the conclusion of the survey, the Commission received completed surveys from 100% of the nursing homes, 99% of the assisted living providers, 100% of the adult day care providers and 100% of chronic hospitals. On June 22, 2010, Fining letters were sent to four assisted living providers who did not complete the survey on time. On December 15, 2010 staff completed the

cleaning of the survey data; Public Use Data Sets were posted on the Commission's website on December 16, 2010.

For the FY 2010 survey, changes were made which were mainly administrative to enhance the efficiency of the survey data collection and increase quality in the dissemination of information to facility staff. Staff held a conference call with Lifespan Midatlantic and Health Facilities Association of Maryland to brief them on survey updates and to enlist their members' support and cooperation in completing the survey in a timely fashion.
The 2010 Long Term Care Survey data collection period began on March 28, 2011 with a due date of May 26, 2011. A total of 691 facilities completed the Long Term Care Survey. These include: nursing homes, assisted living facilities with 10 beds or more, adult day care centers, and chronic hospitals.

As of June 6, 2011, 97% had been accepted, 2% were in progress, and 1% had not started. On June 1, 2011, the "Notice of Imposition of Fines for Failure to Complete 2010 Maryland Long Term Care Survey" was sent to the 3% of the facilities that had not submitted a survey by the due date. As a result of the fining letter, 100% of the surveys were completed and filed with the Commission.

Home Health Agency Survey
Phase 1 of the FY 2010 Home Health Agency Survey was available for data entry as of November 18, 2010 with a due date of February 17, 2011. Phase 1 agencies are agencies with a fiscal year end date on or before June 30, 2010. Reminder notices were sent out during the survey collection period. During Phase 1, 21 agencies completed the survey with a 100% submission rate. Staff provided technical assistance as well as user support on survey content during the survey collection period.

Surveys to Phase 2 agencies were released on March 1, 2011 with a due date of May 26, 2011. Phase 2 agencies are agencies with a fiscal year end date of December 31, 2010. Reminder notices were sent out during the survey collection period. During Phase 2, 39 home health agencies completed the survey. Staff provided assistance to home health agency staff by telephone and emails throughout the data collection period. On June 20, 2011 the Commission received completed surveys for all 39 home health agencies with 100 % submission rate.

MARYLAND HEALTH CARE COMMISSION

The Center for Hospital Services

Hospital Services Planning & Policy

Overview

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

Accomplishments

State Health Plan

Development of a comprehensive revision of COMAR 10.24.11, the Ambulatory Surgical Services Chapter of the State Health Plan, was initiated during FY 2010. This work was aimed at expanding the scope of this SHP chapter so that it will have applicability to Certificate of Need regulation of surgical facilities and services in both the hospital and freestanding surgical facility setting, addressing both inpatient and outpatient surgery.

A draft plan chapter was posted on the Maryland Health Commission web site, for a 45-day informal review and comment period, on August 20, 2010.

In May and June of 2011, two meetings of a Surgical Services Planning Work Group were convened by Hospital Services Policy & Planning ("HSPP") staff. The group, with representatives from ambulatory surgical facilities, hospitals, and payors was formed to provide HSPP staff with input on the proposed amendments to COMAR 10.24.11, which is now an SHP chapter covering "general surgical services." It is anticipated that this SHP chapter will be adopted by the Commission in the first quarter of 2012.

In September and October, 2010, HSPP staff participated in meetings of a Home Health Agency Work Group convened by MHCC's Center for Long-Term and Community-Based Care to provide input on new approaches to planning and regulating home health agencies.

HSPP staff began initial work on amending COMAR 10.24.09, the Acute Inpatient Rehabilitation Services Chapter of the SHP late in the fiscal year. A work group was established and materials were developed for convening the first meeting of this work group in July, 2011.

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, collects information on the inventory of emergency department treatment spaces, obstetric and perinatal service facilities, surgical facilities, psychiatric facilities, and special hospital facilities and services. In July, 2010, an interim report summarizing the new acute care hospital bed licensure information for FY 2011 was published on the Commission's web site. On October 20, 2010, the full *Annual Report on Selected Maryland Acute Care and Special Hospital Services, FY 2011*, was published on the Commission's website.

For FY 2011, the number of licensed acute inpatient beds in Maryland's 47 general acute care hospitals decreased from 10,880 to 10,729. The hospitals reported that their physical acute care bed capacity for FY 201, i.e. the maximum number of acute care beds they could "physically" set up and staff, on short notice was 11,427 beds, 208 fewer beds than reported physical bed capacity in FY 2010 and 698 beds above the total acute care beds licensed for FY 2011. The decrease in licensed acute care hospital bed capacity (-1.4%) in FY 2011 was the first decline in this capacity measure in Maryland since FY 2002, when the state instituted its dynamic hospital licensure process for acute care hospital beds.

Ambulatory Surgery Provider Directory

The thirteenth edition of the Commission's Maryland Ambulatory Surgery Provider Directory was posted on the Commission's website in December, 2010. The Directory provides CY 2009

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 April, 2011, the HSPP distributed the 2010 survey to 363 potential survey respondents; 362 responses were received and, of these, 335 facilities were operational during all or a portion of the survey period.

Policy Coordination with Other Agencies

In September, 2010, HSPP staff met with consultants to the Mental Health Administration to discuss possible approaches to forecasting the need for residential treatment center beds in Maryland.

Also in September, 2010 and continuing through October, 2010, HSPP staff participated in meetings convened by the Health Services Cost Review Commission ("HSCRC") with hospital and Maryland Hospital Association representatives to develop recommendations on the details of a proposal to modify the way in which capital costs associated with major capital projects of hospitals are treated in HSCRC rate setting.

In March and April, 2011, HSPP staff participated in an HSCRC Work Group on Capital and Graduate Medical Education to provide input to HSCRC on rate setting policies in these areas.

Other

Inpatient Hospice Facilities

Upon consideration of several requests for regulatory coverage determinations from existing general hospices proposing to add inpatient hospice beds, HSPP staff determined that previous guidance concerning the regulatory requirements associated with such projects was erroneous. Hospice programs were alerted to this change in regulatory guidance in September, 2010 and a meeting was convened in October, 2010 to which all hospice programs were invited to discuss this change and its implications. Hospices which had obligated inpatient facility projects prior to the coverage determinations were provided an opportunity to seek grandfathered status for their projects.

Plan Maryland

Throughout the course of FY 2011, HSPP staff participated in an interagency work group convened by by the Maryland Department of Planning (MDP) to assist it in development of a comprehensive state plan for sustainable growth and development, Plan Maryland. The Executive Director and HSPP staff met with representatives of MDP in early 2011 to specifically

discuss coordination of MDP and MHCC policy with respect to the facilities development policies and standards of the State Health Plan.

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 and performance measures. Hospital characteristics include the location of the hospital, number of beds, services provided and accreditation status. Fifty high volume common medical conditions (Diagnosis-Related Groups or DRGs) are also featured. Marylanders are able to compare the volume and average length-of-stay by DRG for each hospital. The Guide continues to provide general information including patients' rights, how hospitals are regulated in Maryland, guidance on what to expect in a hospital setting, and a checklist to help consumers select a hospital. The Guide also includes performance data on twenty-seven 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, Childhood Asthma Care and surgical patients, including the prevention of surgical site infections.

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

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

Hospital Performance Evaluation Guide Advisory Committee

As part of the enabling legislation, MHCC was tasked to work on the design and development of a performance evaluation system in consultation with the Maryland Hospital Association, the Maryland Ambulatory Surgical Association, and interested parties including consumers, payers, and employers. The Hospital Performance Evaluation Guide Advisory Committee meets on a monthly basis and has provided expert advice to the Commission on performance measures and quality improvement strategies since inception of the Guide. This 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. 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.

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, a permanent HAI Advisory Committee was established to provide ongoing guidance and support to this project. As a result, the Commission has made significant progress towards the implementation of the Committee's recommendations. The 21-member HAI Advisory Committee represents 10 key stakeholder organizations and meets on a monthly basis.

Accomplishments

The Maryland Quality Measures Data Center (QMDC)

The Commission relies heavily on data from a variety of sources to support the hospital performance evaluation system. In FY2009, the MHCC initiated a consolidated data management strategy which entailed the establishment of a Quality Measures Data Center (QMDC). The QMDC functions as Maryland's repository of hospital performance measures data and includes a secure web portal for hospital submission of quality measures and patient experience data. The QMDC also functions as a centralized communication tool for sharing information with hospitals on upcoming reporting requirements and well as providing a vehicle for review of facility performance data prior to public release. The Commission utilizes the data collected through the QMDC for timely reporting of clinical quality and patient experience measures on the web-based Maryland Hospital Performance Evaluation Guide on a quarterly basis. In FY2011, the clinical data submitted through the Maryland QMDC was audited to ensure the integrity of the measures used to evaluate hospital performance. Quarterly on-site reviews of hospital medical records were conducted. The data validation process is intended to enhance the MHCC's understanding of the overall quality of the data as well as to identify areas for targeted performance improvement and educational activities.

Healthcare-Associated Infections

A major focus during FY 2011 has been the implementation of recommendations developed by the HAI Technical Advisory Committee (TAC). Based upon extensive discussions, expert advice and review of the medical literature by the TAC and MHCC staff, it was recommended that the HAI reporting be initiated with the reporting of measures on: (1) Central-Line-Associated Bloodstream Infections (CLABSIs) in All Intensive Care Units;(2) Health Care Worker (HCW) Influenza Vaccination; and, (3) Compliance with Active Surveillance Testing for MRSA in All ICUs. The Committee also recommended that the second phase of the HAI public reporting system include Surgical Sight Infections data. The Committee further recommended use of the National Healthcare Safety Network (NHSN) as the vehicle for collecting these data where feasible.

National Healthcare Safety Network (NHSN)

The NHSN is an internet-based surveillance system that integrates patient and healthcare personnel safety surveillance systems. It is managed by the Division of Healthcare Quality Promotion of the Centers for Disease Control and Prevention (CDC). As of July 1, 2008, Maryland hospitals report CLABSI data to the Commission and all hospitals are now using the surveillance system to collect information and monitor CLABSIs in ICUs and NICUs. In FY2010, Commission expanded its hospital data reporting requirements to include surgical site infection data collection through the NHSN surveillance system for Hip, Knee, and coronary artery bypass surgery.

HAI Data Validation Project

In 2009, the Commission initiated a procurement project to engage the services of a contractor with expertise and experience in the review of healthcare-associated infections data. The project included the on-site review of patient medical records to assess the accuracy of the

hospital data submitted through NSHN. The validation project was completed in FY2010 and the results were used to educate hospital data providers and to facilitate process improvement activities. In FY 2011, the Commission initiated the procurement process to establish a five year contract for ongoing validation of the accuracy of all healthcare associated infections data collected for public reporting purposes.

HAI Data Public Reporting

Effective January 1, 2009, Maryland hospitals were required to collect and report quarterly data on Active Surveillance Testing (AST) for methicillin resistant Staphylococcus aureus (MRSA) in Intensive Care Units (ICUs), including all units defined as inpatient adult critical care and pediatric critical care (neonatal intensive care units are excluded from this reporting requirement). Hospitals are reporting data on the total number of ICU admissions and the number of patients admitted to the ICU who had an anterior nares swab cultured for MRSA. Public reporting for two additional HAI measures implemented in FY2011, included data on Health Care Worker (HCW) Influenza Vaccination Rates and Central Line-Associated Bloodstream Infections. The Centers for Disease Control and Prevention have long recommended annual influenza vaccinations for all HCWs. The National Quality Forum includes influenza vaccination of health care workers as one of its 34 safe practices that should be utilized universally to reduce risk to patients. All Maryland hospitals are currently collecting a uniform data set on HCW influenza vaccination rates. Using an online survey instrument, hospitals collected aggregate data on all paid, full-time and part-time employees and house staff (defined as residents and interns) who received FluMist® or an injectable flu vaccine on-site or off-site between September 1, 2010 and April 15, 2011. Data on hospital HCW influenza vaccination rates for the 2010-2011 period were reported on the Hospital Guide in July 2011. In October 2010, data on central line-associated bloodstream infections (CLABSIs) in adult and pediatric intensive care units (ICUs) and Level II/III and III neonatal intensive care units (NICUs) were reported on the Hospital Guide for the first time. The Commission gathered information through use of consumer-oriented focus groups to develop the format and content for the display of the CLABSI data on the Hospital Guide.

The functionality of the Comparison Report feature on the Hospital Guide was enhanced in FY2011 to allow for comparison of hospitals on the healthcare-associated infections measures.

Cardiovascular Data Collection Initiative

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

National Cardiovascular Data Registry (NCDR) ACTION Registry-GWTG
This tool is used by all Maryland hospitals that provide primary angioplasty and seek designation by the Maryland Institute for Emergency Medical Services Systems (MIEMMS) as a Cardiac Interventional Center.

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

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

The Commission established the Maryland State Cardiac Data Advisory Committee to support the implementation of new cardiac data reporting requirements and to formulate recommendations to establish and report on a common set of process and risk-adjusted outcome measures for PCI services as part of the Maryland Hospital Performance Evaluation Guide. In addition, the Committee will work with the Commission to facilitate quality improvement initiatives for Maryland cardiac patients

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).

Maryland acute care hospitals with a waiver from the Commission to provide primary PCI are required to use the American College of Cardiology Foundation's National Cardiovascular Data Registry® (NCDR®) ACTION Registry®-GWTG™ to report quarterly data to the Commission for

eligible patients discharged on or after July 1, 2010. Effective July 1, 2010, the hospitals are also required to enroll in the NCDR CathPCI Registry®, and use the CathPCI Registry to report quarterly data to the Commission. The ACTION Registry includes data on acute coronary syndrome patients, both STEMI and non-ST-elevation myocardial infarction (NSTEMI) patients. The CathPCI Registry includes data on diagnostic cardiac catheterizations and PCI.

Thirteen hospitals have a current waiver from the Commission allowing them to provide primary PCI services without having on-site cardiac surgical backup: Anne Arundel Medical Center, Baltimore Washington Medical Center, Carroll Hospital Center, Franklin Square Hospital Center, Frederick Memorial Hospital, Holy Cross Hospital, Howard County General Hospital, Johns Hopkins Bayview Medical Center, Meritus Medical Center (formerly Washington County Hospital), Saint Agnes Hospital, Shady Grove Adventist Hospital, Southern Maryland Hospital Center, and Upper Chesapeake Medical Center. A hospital with a two-year primary PCI waiver must submit an application for the renewal of its waiver according to a schedule published by the Commission. The schedule also includes dates of submission for hospitals seeking to initiate primary PCI services, and for hospitals that have received a one-year waiver to initiate a primary PCI program. A hospital must provide primary PCI services for a one-year period before receiving a two-year waiver. In August 2010, the Commission updated its applications for renewal of a primary PCI waiver and for initiation of a new primary PCI program. Doctors Community Hospital filed an application for a primary PCI waiver; however, the hospital voluntarily withdrew its application in December 2010. By June 2011, 9 of the 13 hospitals had filed applications requesting renewal of their two-year waivers according to the published schedule. The schedule, applications, and requirements for primary PCI programs are 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. Under COMAR 10.24.05, the Commission established a process to award time-limited research waivers that permit eligible hospitals to provide non-primary PCI services as part of a research project conducted by the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT): Anne Arundel Medical Center, Saint Agnes Hospital, Shady Grove Adventist Hospital, Southern Maryland Hospital Center, Frederick Memorial Hospital, Meritus Medical Center (formerly Washington County Hospital), Baltimore Washington Medical Center, Holy Cross Hospital, and Johns Hopkins Bayview Medical Center. The C-PORT Elective Angioplasty Study, known as C-PORT E, tests the hypothesis that, for certain patient groups, outcomes of non-primary PCI performed at hospitals without on-site cardiac surgery are not inferior to outcomes of non-primary PCI performed at hospitals with cardiac surgery services. The Commission established conditions for a hospital to maintain its research waiver. In October 2010, Holy Cross Hospital notified the Commission that the hospital was not able to reach the minimum volume of 100 PCIs by the first-year anniversary of the issuance of its non-primary PCI waiver. The Commission's Executive Director issued a Notice of Relinquishment of the waiver permitting Holy Cross Hospital to participate in the C-PORT E research study; C-PORT withdrew the hospital's randomization privileges. In December 2010, the Commission extended the two-year

research waivers granted to Anne Arundel Medical Center, Saint Agnes Hospital, Shady Grove Adventist Hospital, and Southern Maryland Hospital Center. These research waivers are not intended to consider locations for non-primary PCI programs without cardiac surgery on-site beyond the study period.

As the C-PORT E research study neared the attainment of its patient accrual target, the principal investigator of the research study recommended that the Commission continue the C-PORT E research waiver of each hospital that is in good standing so that each such hospital will not have to shut down its program while the required follow-up data on C-PORT E patients is collected and analyzed. Effective March 2011, the Commission amended COMAR 10.24.05 to extend the term of an existing research waiver held by a hospital that maintains good standing under the Commission's requirements while the hospital participates in the follow-on C-PORT E Registry, thereby permitting the hospital to continue to perform non-primary PCI under the limitations and for the Registry term provided in the regulations until such time as the Commission has the information from the research study that is needed to guide State policy about the regulation of non-primary PCI. The C-PORT E Registry of Non-Primary PCI is maintained by the C-PORT E Study Principal Investigator, overseen by the Johns Hopkins Institutional Review Board (IRB), and overseen by a Data and Safety Monitoring Board. The IRB at each participating hospital has approved the hospital's participation in the Registry and the patient's informed consent form for the Registry. The research proposal, Committee report, Commission decisions, and related documents are available on the Commission's website.

Certificate of Need (CON) Program

Overview

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

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

All projects requesting CON approval are evaluated for consistency with review standards and need projections in the State Health Plan for Facilities and Services, and five additional criteria; need, viability, impact, the cost and effectiveness of alternatives to the proposed project, and the applicant's track record in complying with conditions and terms of CON approvals placed on project approvals previously issued to the applicant.

Accomplishments

Certificate of Need Applications and Modifications

During FY 2011, the Commission completed review of seven (7) CON applications, approving six (6) and denying one (1) application. It also reviewed and approved four (4) modifications to previously approved projects. Two (2) Certificates of Need that had been issued by the Commission were relinquished by the holders. One (1) CON application in review was withdrawn by the applicant before Commission action.

The level of project review activity in FY2011 was greatly reduced in terms of the number of projects proposed and considered when compared with FY2009 and 2010. This is primarily because of large competitive home health agency reviews that were conducted in those years. The number of capital projects proposed by health care facilities regulated under the CON program declined dramatically beginning in 2008 and has remained fairly modest since that year. This decline, in a period which saw a recession followed by a weak economic recovery, follows on a period of substantial hospital capital spending between 2003 and 2008. In these middle years of the last decade, Maryland general hospitals were authorized to undertake approximately $1.5 billion of capital projects and changes to hospital projects resulted in approximately $500 million in additional spending. In 2009 and 2010, proposed hospital capital spending reviewed by MHCC dropped to $121.4 and $133.7 million, respectively.

The work level in CON was high in 2011, relative to project volume, because the review of two large and contentious proposals to establish new general hospitals was completed in 2011 and a third large hospital expansion and renovation project was considered. The new hospital projects were considered in a competitive review involving an extensive amount of procedural work and analysis. The large expansion project was a contested review considered in parallel with the new hospital review. In total, the three hospital projects approved are expected to cost $448.7 million. The new hospital proposal denied had an estimated cost of $177.1 million.

Two changes to approved hospital capital project CONs were reviewed and approved in 2011. One had no project cost impact. The second involved project changes that reduced the spending previously authorized for a major expansion and modernization of a general hospital campus by $47.9 million, bringing the total project cost estimate down to $166.1 million.

There were two hospital "pledge" projects reviewed by MHCC and Health Services Cost Review Commission (HSCRC) staff in FY 2011. These are projects with estimated costs that exceeded the capital spending threshold defining reviewability that did not otherwise include elements categorically requiring CON review. Such projects avoid the need for CON review and approval by the Commission by "pledging" not to seek substantive rate adjustments related to the

project's depreciation and interest expenses. These projects are issued determinations of coverage after demonstrating to MHCC that they do not include categorically regulated elements and to HSCRC that they are financially feasible. The current hospital capital expenditure threshold, established in February, 2011, is $10.95 million. These two pledge projects involved projects with a combined estimated cost of $80.9 million.

Two nursing home, or comprehensive care facility projects, was authorized in FY 2011. One involved the establishment of a new nursing home. The second involved expansion and renovation of an existing facility. They had a combined total estimated cost of $23.4 million. Two modifications of previously approved new nursing home projects were authorized; one added $1.9 million in project costs and the other scaled back the estimated project cost by just over one million dollars.

Establishment of a specialty home health agency for pediatric patients and mother/newborn dyads, serving central Maryland jurisdictions, was approved in FY 2011. The estimated capital expenditure for this project, being undertaken by an established residential service agency, was only $139,000.

Approved CONs

NMS Healthcare of Hagerstown (Washington County)
New construction and renovation-net addition of 20 comprehensive care facility ("CCF") beds
Approved with conditions - $15,084,498

Waldorf Nursing and Rehabilitation Center (Charles County)
Establishment of a 67-bed CCF
Approved with conditions - $8,820,029

Comprehensive Nursing Services (Baltimore City and Anne Arundel, Baltimore, Carroll, Cecil, Harford, and Howard Counties)
Establishment of a specialty home health agency
Approved with conditions - $139,000

Peninsula Regional Medical Center (Wicomico County)
Add and renovate operating room capacity
Approved with conditions - $17,955,000

Holy Cross Hospital of Silver Spring (Montgomery County)
Establish a 90-bed general acute care hospital in Germantown
Approved with conditions - $201,983,857

Holy Cross Hospital of Silver Spring (Montgomery County)
Expand and renovate general acute care hospital in Silver Spring –reduction in bed capacity
Approved with conditions - $228,764,000

CON Applications Denied

Clarksburg Community Hospital (Montgomery County)
Establish a 90-bed general acute care hospital in Germantown
Estimated Cost: $177,081,000

Changes in Approved CONs

Johns Hopkins Hospital (Baltimore City)
Expansion and renovation
Change in condition – date of required submission of schematic floor plans for renovations
No cost changes.

St. Agnes Hospital (Baltimore City)
Expansion and renovation
Significant change in physical plant design
Estimated cost reduction: $47,863,878
New cost estimate: $167,067,122

Govans Ecumenical Development Corporation (Baltimore City)
Significant change in financial mechanism for project funding
Estimated cost reduction: $1,053,141
New cost estimate: $11,676,533

Lorien LifeCenter-Howard County II (Howard County)
Establish a 64-bed CCF
Estimated cost increase: $1,909,685
New Cost estimate: $9,735,958

Approved CONs Relinquished

Manor Care Health Services-Bowie (Prince George's County)
Establish a 120-bed CCF
Approved Cost: $14,897,003

Solomons Nursing Center (Calvert County)
Add 17 CCF beds
Approved Cost: $1,878,549

CON Applications Withdrawn from Review

Bethesda Eye Surgery Center (Montgomery County)
Establish an ambulatory surgical facility
Estimated Cost: $50,000

Determinations of Coverage and Other Actions

In FY 2011, the Commission issued 226 determinations involving actions proposed by persons or health care facilities requiring a decision with respect to the need for CON review or other Commission authorization. These actions were made in accordance with statutory and regulatory provisions outlining: (1) The scope of CON coverage; (2) The types of projects or actions that, while similar in their general nature to projects that require CON review and approval, can be implemented outside of the CON regulatory process; and (3) The notification requirements and attestations which must be met to obtain the Commission's determination that CON is not required. These determinations are profiled in the following table. Chief among these types of determinations are those involving establishment of outpatient surgical centers with fewer than two sterile operating rooms, acquisitions of health care facilities, temporary delicensure of beds (for up to one year), and small increases in the bed capacity of facilities ("waiver" beds), primarily nursing homes, which are allowed increases of 10% of bed capacity or ten beds, whichever is less, every two years so long as the facility maintains operation of all of its bed capacity without changes during that period of time.

Determinations of Coverage and Other Actions – FY 2011

NATURE OF DETERMINATION/ACTION	NO.
Capital projects with costs above the threshold of reviewability (hospital "pledge" projects	**2**
Capital projects with costs below the threshold of reviewability	**16**
Acquisitions of health care facilities **Comprehensive care facility (nursing home): 78** **Ambulatory surgery center: 7** **Home Health Agencies: 2** **Hospice Agencies: 2**	**89**
Establishment of new ambulatory surgery center (no more than one sterile operating room) **Baltimore (5); Montgomery (5); Anne Arundel (3); Baltimore City (3); Frederick (3); Washington (3); Calvert (2); Howard (2); Prince George's (2); Wicomico (2); Allegany (1); Charles (1) and Harford (1)**	**33**
Changes in ambulatory surgery center facilities or operation (e.g., addition of non-sterile procedure rooms, surgical staff, surgical specialties, ownership structure)	**9**
Relocation of ambulatory surgery center	**4**
Temporary delicensure of CCF beds (355 total beds)	**20**
Relicensure of temporarily delicensed CCF beds (201 total beds)	**16**
Add "waiver" beds * **Comprehensive care facility: 5 for a total of 44 beds**	**5**
Miscellaneous	**32**
TOTAL COVERAGE DETERMINATIONS	**226**
Pre-licensure and/or first use approval for completed CON projects (including partial)	**2**
Permanent delicensure of beds **Comprehensive care facility: 13 for a total of 90 beds** **Special Hospital: 1 for a total of 22 beds**	**14**

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

Additionally, the Commission reviewed 2 requests by holders of CONs to implement their projects or parts of their approved projects ("first use review"). Finally, the Commission acknowledged 14 cases in which facilities with temporarily delicensed beds did not take timely action to bring these beds back into operation or extend temporary delicensure status, thus eliminating these beds from the state's inventory. In FY 2010, all these permanently delicensed beds (90) were CCF beds.

MARYLAND HEALTH CARE COMMISSION

The Center for Health Information Technology

The Center for Health Information Technology

Overview

Effective implementation of health information technology (HIT) will assure that providers have access to accurate information at the time and place of care to improve treatment, prevent errors, and reduce health care costs. HIT utilization will also facilitate the collection of information, which can improve disease surveillance, increase health care knowledge, and shape best practice guidelines. There are two crucial components necessary for effective health IT: implementation of health information exchange (HIE) and widespread adoption of electronic health records (EHRs). The Center for Health Information Technology (Center) is responsible for advancing HIT statewide. The Center has an ambitious plan for advancing HIT that balances the need for information sharing with the need for strong privacy and security policies.

Key Center activities include:

- Plan and implement a statewide health information exchange;
- Identify challenges to health information technology adoption and use, and formulate solutions and best practices for making health information technology work;
- Increase the availability and use of standards-based health information technology through consultative, educational, and outreach activities;
- Promote and facilitate the adoption and optimal use of health information technology for the purposes of improving the quality and safety of health care;
- Harmonize service area health information exchange efforts throughout the state;
- Certify electronic health networks that accept electronic health care transactions originating in Maryland;
- Develop programs to promote electronic data interchange between payers and providers ; and
- Designate management service organizations to promote the adoption and advanced use of electronic health records.

Health Information Technology Division

The Health Information Technology Division (HIT Division) is responsible for advancing the adoption of HIT in Maryland. The HIT Division works closely with stakeholders to increase EHR adoption and meaningful use. A key function of the HIT Division is to expand the adoption of EHRs. The HIT Division and routinely provides consultative support to stakeholders as they evaluate EHRs and implement changes in workflow. Additionally, the HIT Division oversees designation of management service organizations (MSOs); promotes the adoption of electronic data interchange; and certifies electronic health networks (EHNs).

Health Information Exchange Division

The Health Information Exchange Division (HIE Division) is responsible for advancing the statewide HIE and is tasked with ensuring the development of an interoperable system for sharing electronic health information. The HIE Division works with stakeholders to develop policies for safeguarding electronic health information to ensure it 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; facilitates the development of privacy and security policies; and oversees the development, maintenance, and implementation of the State HIT Plan.

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 the third year of a five-year project designed to show that the widespread adoption and use of EHRs will reduce medical errors and improve the quality of care. The project has two groups of primary care physician practices; a treatment group of about 114 practices, and a control group of about 128 practices. Participants in the treatment group are eligible for financial incentives up to $290,000 over the five year program from CMS for EHR adoption and the reporting of select clinical quality measures. Participants in the control group will receive a modest payment for completing an annual Office System Survey in the fall of 2011. Staff provides educational support to the treatment group to accelerate the adoption of EHRs and meaningful use. During the first project year, CMS paid about $2,032,569 to practices in the four states; Maryland practices received roughly $830,697.

Electronic Data Interchange & Electronic Health Networks

COMAR 10.25.07, *Electronic Health Network Certification*, requires the certification of EHNs and medical care electronic claims clearinghouses that operate in Maryland. Payors that accept electronic health care transactions originating in Maryland may only accept electronic health care transactions from electronic health networks or medical care electronic claims clearinghouses that obtain certification. The MHCC's certification process works in coordination with the national accreditation standards developed by the Electronic Healthcare Network Accreditation Commission (EHNAC) and certification is valid for a two-year period. The certification criteria focus is on policies and processes surrounding privacy and security, technical performance, business practices, and resources. As of June 30, 2011, approximately 42 networks have received MHCC certification.

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 to the MHCC by June 30th of each year. Staff provides consultative services to assist payers in completing submissions. Staff uses the data to develop an annual information brief and analyze trends in electronic claims volume compared to paper claims and performs a review on the advanced use of electronic data interchange.

EHR Product Portfolio

The MHCC maintains a web-based EHR Product Portfolio (portfolio) that provides evaluative and comparative information on certified EHRs. The portfolio is updated semi-annually and contains a core set of product information to assist physicians in assessing, selecting, and implementing EHRs. The most recent release of the portfolio includes the estimated cost for providers to connect to the state designated HIE and information about how the EHR vendor manages sensitive health information. The MHCC negotiated price reductions from the participating vendors for Maryland providers. The portfolio includes information on the EHR product, pricing, privacy and security policies, and user references on approximately 29 nationally certified vendors. The Health Information Technology Education and Clinical Health Act, a portion of the American Recovery and Reinvestment Act of 2009, mandated that the Office of the National Coordinator for Health Information Technology (ONC) develop certification programs for EHR systems. The MHCC invites certified EHR vendors with Complete ONC certification to participate in the Portfolio.

Hospital HIT Survey

Staff administered and analyzed the results from the third annual Hospital HIT Adoption survey. The report assesses HIT adoption among Maryland's 46 acute care hospitals and benchmarks the HIT adoption progress as compared to hospitals nationally. The survey focuses on HIT that has a direct impact on patient care and has the potential to improve the quality, safety, and efficiency of health care. Specifically, hospitals are assessed on the following key functionalities: EHRs, computerized physician order entry (CPOE), electronic prescribing (e-prescribing), HIE, infection surveillance, electronic medication administration records (eMARs), and barcode medication administration (BCMA) technology. The results indicate that hospitals have continued to advance HIT adoption over the past year and that the majority plan to build on their existing functions. This year, hospitals also reported on their plans to participate in the CMS EHR incentive programs, connectivity to the state designated HIE, and ability to meet meaningful use criteria that is required to qualify for an EHR adoption incentive under Medicaid and Medicare. Overall, hospitals reported a HIT adoption rate of about 60 percent, an increase of about 16 percent since 2008.

Freestanding Ambulatory Surgical Centers HIT Assessment

Staff developed and implemented an annual Freestanding Ambulatory Surgical Center HIT survey (survey) in FY 2010 to assess HIT adoption among the 333 Freestanding Ambulatory Surgical Centers (FASCs) in Maryland. The survey is unique to Maryland and identifies the overall level of HIT adoption and planning among FASCs for the following functionalities: EHRs, CPOE, eMARs, BCMA, infection management, e-prescribing, and data exchange. The second

annual *HIT Assessment of Freestanding Ambulatory Surgical Centers in Maryland* report (report) was released in May 2011 and was highlighted on the Maryland Ambulatory Surgery Association website in June. Findings indicate that approximately 23 percent of the Centers report having an EHR; about 13 percent of the Centers reported using e-prescribing technology and about one percent reported exchanging some electronic clinical information with community providers.

Management Service Organizations

House Bill 706, *Electronic Health Records – Regulation and Reimbursement*, was signed into law by Governor Martin O'Malley in 2009. The law states that the MHCC must designate one or more management service organizations (MSOs) to offer hosted EHRs as an alternative to the traditional model where the technology is located at the provider site. MSOs have emerged as a way to address the challenges associated with provider adoption of EHRs. These challenges include the cost and maintenance required for the technology, and the responsibilities that accompany the storage of electronic data and privacy and security. Unlike the traditional EHR client-server model where the data and technology are hosted locally at the provider site, MSOs offer EHRs hosted remotely in a centralized, secure data center. The data is safeguarded through a network operating center that, by design, ensures high quality and uninterrupted service. MSOs enable physicians to access a patient's medical record wherever access to a high speed Internet connection exists, and to eliminate the costs associated with technology maintenance.

As of June 30, 2011, approximately five MSOs were State Designated and about 17 MSOs were in Candidacy Status. MSOs have 12 months in Candidacy Status to complete a self-assessment and evaluation of their data center to demonstrate they have met approximately 90 criteria related to privacy, technical performance, business practices, resources, and security required for State Designation. Staff convened an MSO Advisory Panel to evaluate the existing State Designation criteria.

Electronic Health Record Incentives

Maryland is the first state to require certain state-regulated payers to provide incentives of monetary value to select health care providers who adopt and use EHRs. Staff modified COMAR 10.25.16, *Electronic Health Record Incentives*, to comply with House Bill 736 (HB 736), *Electronic Health Records – Incentives for Health Care Providers*, that was passed by the General Assembly during the 2011 legislative session and signed into law by Governor Martin O'Malley on May 19th. The modifications to the regulations include the requirement that incentives for adopting an EHR be paid in cash unless a primary care practice and a payor agree on an incentive of equivalent monetary value. The modifications also expand eligibility of an incentive for adopting an EHR to a hospital-owned primary care practice. In addition, clarifying changes were made to the regulation based upon stakeholder comments received by staff. Staff developed the *EHR Incentive Application* (application) and *EHR Incentive Payment Request* form that will be used by primary care practices to apply to the payers for the incentive.

Telemedicine Task Force

In October 2010, the Secretary of the Department of Health and Mental Hygiene requested that the Telemedicine Task Force (task force) establish advisory groups to further expand recommendations. The advisory groups established by the task force consist of the Clinical Advisory Group, Technology Solutions and Standards Advisory Group, and Financial and Business Model Advisory Group. Staff led the Technology Solutions and Standards Advisory Group (group) that consists of hospital Chief Information Officers, representatives from the state designated HIE, MedChi, and the HIE Policy Board, and is tasked with making recommendations regarding the technology that is required to support interoperable telemedicine in Maryland. This group is tasked to evaluate technology and discuss statewide standards to support the expanded use of telemedicine in Maryland. The initial meeting occurred in June. The group will develop recommendations to report to the Task Force by the end of the year.

Health Information Exchange

On May 19, 2009, Governor Martin O'Malley signed HB 706, *Electronic Health Records – Regulation and Reimbursement*, into law. The MHCC and the Health Services Cost Review Commission (HSCRC) were named in the bill and required the Commissions to designate a multi-stakeholder group to implement the statewide health information exchange (HIE). Through a competitive process, the Commissions designated a non-profit organization, the Chesapeake Regional Information System for our Patients (CRISP), which includes Johns Hopkins Medicine, MedStar Health, University of Maryland Medical System, Erickson Retirement Communities, and more than two dozen other stakeholder groups. A statewide HIE creates an interconnected, consumer drive, electronic health care system that enables appropriate stakeholders to securely share data, facilitate and integrate care, create efficiencies, and improve outcomes.

CRISP is funded through a $10 million award from the Health Services Cost Review Commission (HSCRC) all payor rate setting and a state HIE cooperative agreement grant of approximately $9.3 million from the ONC. Approximately 35 or the 46 acute care hospitals in Maryland have signed an agreement with CRISP to begin connectivity efforts. As of June 30, 2011, about 34 hospitals had established a connection with CRISP, approximately six hospitals were sending clinical data, and roughly two hospitals were querying CRISP.

Challenge Grant

Maryland is one of ten states awarded an HIE Challenge Grant from the ONC. The award is approximately $1.6 million over a three-year period to develop innovative and scalable solutions that will improve long-term care and post-acute care transitions by leveraging the state designated HIE. The work of the Challenge Grant centers on six long term care facilities that are part of Erickson Retirement Communities, Lorien Health Systems, and Genesis Healthcare. The state designated HIE will exchange select clinical summaries and medication histories with nursing homes and acute care hospitals. The pilot includes targeted outcomes associated with the exchange of clinical information that will result in a reduction in hospital readmission rates for the pilot population. The Challenge Grant requires developing a

framework for standardized advance directives modeled on Physician Orders for Live-Sustaining Treatment Paradigm (POLST). This form includes medical orders regarding resuscitation (CPR) status as well as other life sustaining treatments. The Challenge Grant Project funds a workgroup to frame a way that such forms could be stored in a statewide electronic repository.

HIE Policy Board

House Bill 784, *Medical Records – Health Information Exchanges*, was signed into law on May 19, 2011, and required that the MHCC adopt regulations for the privacy and security of protected information exchanged through a HIE. The MHCC assembled a Policy Board in 2009 with responsibility for general oversight of the statewide health information exchange; HB 784 expanded the responsibilities of the Policy Board to include the authority to evaluate and recommend to the MHCC policies that will apply to all HIEs in Maryland. Approximately 30 individuals participate on the Board. The policies developed by the Policy Board will be turned into regulation to govern all HIEs operating in Maryland. The separation of responsibilities between HIEs and the Policy Board assures a strong role for the public in both operational oversight and policy development. Ex-officio members consist of representatives from CRISP and state government, including Medicaid, the MHCC, and the Health Services Cost Review Commission.

The Policy Board convenes on a six-week schedule and since inception has made notable progress in drafting key policies that will govern the statewide HIE. Approximately 27 policies have been identified by the Policy Board for development; nine have been recommended and adopted by the MHCC. The Policy Board establishes the prioritization of policy development with advisement from the statewide HIE and the MHCC.

Regional Extension Center Program

CRISP is the recipient of approximately $6.4M in funding under the American Recovery and Reinvestment Act of 2009 (ARRA) to develop a Regional Extension Center (REC). This program provides education, outreach, and technical assistance to priority primary care providers (PPCPs), as defined by the ONC, and supports providers in adopting EHRs and moving toward achieving meaningful use. The REC sub-contracts with state designated MSOs and has signed up more than 900 PPCPs over the last year and helped roughly 105 PPCPs to implement their EHR. The MHCC State Designation is a core component for an MSO to participate with the REC. These MSOs are expected to offer assistance to all providers in Maryland and will receive subsidies under the ARRA for assisting PPCPs in meeting established milestones, which include: provider enrollment, EHR implementation and utilization, and meeting meaningful use.

Consumers

Consumer trust is a key component to achieving a sustainable HIE; therefore, the MHCC continues to seek consumer input while building the HIE framework. During FY2011, MHCC staff began developing strategies to engage consumers regarding electronic health information and sharing protected health information. The projects seek to assess consumer awareness and trust regarding HIE; develop consumer outreach and education recommendations for HIE;

and develop a plan to implement consumer access and control over their electronic health information.

Nursing Homes in Maryland

EHR adoption holds tremendous promise for improving health care quality and increasing patient safety, as well as reducing the costs of providing care in nursing homes. Nursing home adoption of EHRs continues to increase at a slow pace. In general, nursing homes tend to lag behind in technology adoption as compared to hospitals and other health care providers. Staff released the annual *2010 Electronic Health Records: An Assessment of Maryland Nursing Homes* report. The report represents the findings from an environmental scan administered to independent and small multi-facility nursing homes on the adoption and use of EHRs. The results indicate nursing home EHR adoption is about 30 percent, an increase of approximately four percent from the previous year. Approximately 48 percent of nursing homes that responded to the scan expect to implement an EHR over the next year.

HIT State Plan

In FY 2011, Maryland released the Health Information Technology (HIT) State Plan for FY 2011 through FY 2014. Maryland has moved into the implementation phase after several years of planning. The strategic approach consisted of the following key activities: building trust and consensus; planning the statewide HIE; designating and funding Maryland's statewide HIE; and establishing a Policy Board with strong representation from the general public. While the detailed implementation of the statewide HIE is entrusted to the knowledgeable experts and informed by a broad range of stakeholder input, the governance, policy, and technical infrastructure outlined in the State Plan make certain that the general public and the federal government have strong roles in the development of fundamental policies governing the information exchange.

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

MARYLAND HEALTH CARE COMMISSION