MARYLAND HEALTH CARE COMMISSION

REPORT to the GOVERNOR

Fiscal Year 2014

(July 1, 2013 through June 30, 2014)

Martin O'Malley
Governor

Craig Tanio, M.D.
Chair

Ben Steffen
Executive Director

http://mhcc.maryland.gov/

This annual report on the operations and activities of the Maryland Health Care Commission for fiscal year 2014 meets the reporting requirement set forth in Health General § 19-109(b)(4) that directs the Maryland Health Care Commission to report annually to the Governor, the Secretary of Health and Mental Hygiene, and the Maryland General Assembly.

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

MARYLAND
HEALTH CARE
COMMISSION

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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

Craig P. Tanio, MD, Chair
Chief Medical Officer
ChenMed

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

Michael S. Barr, MD, MBA, FACP
Executive Vice President
National Committee for Quality Assurance

John E. Fleig, Jr.
Chief Operating Officer
UnitedHealthcare
MidAtlantic Health Plan

Paul Fronstin, PhD
Director, Health Research and Education Program
Employee Benefit Research Institute

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

Michael McHale, MHA, NHA
Chief Executive Officer
Hospice of the Chesapeake

Barbara Gill McLean, MA
Retired Senior Policy Fellow
University of Maryland School of Medicine

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

Ligia Peralta, MD, FAAP, FSAHM
President and CEO
Casa Ruben Foundation

Frances B. Phillips, RN, MHA
Health Care Consultant

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

Diane Stollenwerk, MPP
President
StollenWerks, Inc.

Stephen B. Thomas, PhD
Professor of Health Services Administration, School of Public Health
Director, Maryland Center for Health Equity
University of Maryland, College Park

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

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

Craig Tanio, MD, MBA, Chair, is the Chief Medical Officer at JenCare, a physician owned group that is expanding an innovative global risk care model for moderate to low income seniors that emphasizes preventive and primary care. Previously, he was a partner at McKinsey & Company, a global management consulting firm and the Chief Operating Officer for Baltimore Medical System, a group of federally qualified community health centers serving the Baltimore area. Dr. Tanio received his MD from UC San Francisco, his MBA from the Wharton School and completed internal medicine training at the Hospital of the University of Pennsylvania. He is a part-time Assistant Professor of Medicine at Johns Hopkins School of Medicine and a Senior Fellow in the Department of Health Policy at Jefferson Medical College. Dr. Tanio resides in Baltimore County.
(**Term Expires 9/30/2016**)

Garret A. Falcone, Vice-Chair, is the Executive Director of Heron Point of Chestertown, a CCRC on the Eastern Shore. He has over 35 years of experience in acute and long term care. Commissioner Falcone is a graduate in Business Management from Fairleigh Dickinson University in New Jersey and earned his Master's Degree in Health Services Administration from Russell Sage College in Albany, New York. He was awarded the MANPHA Chairmen's Award in 2001 and the Special Chairmen's Award, AEGIS Inc., in 2001. Vice Chair Falcone resides in Kent County.
(**Term Expires 9/30/2014**)

Michael S. McHale has served as the President and CEO of Hospice of the Chesapeake since January 1, 2010. McHale originally joined Hospice of the Chesapeake in 2007 as the non-profit organization's Chief Operating Officer. Under McHale's leadership Hospice of the Chesapeake has grown to serve the community by launching several new initiatives including pediatric hospice care, perinatal/infant loss counseling, and Chesapeake Palliative Medicine. McHale has dedicated his professional career to healthcare with more than 15 years of management, marketing and customer service experience within the hospice and long-term care industry. He has held various leadership positions with hospices in California, Michigan, and prior to joining Hospice of the Chesapeake, McHale was the Vice President of Business Development and Sales for the Washington Home and Community Hospices. McHale holds a Master's of Health Care Administration from National University in San Diego. He currently serves on the Board of Directors for the National Hospice and Palliative Care Organization as well as the Hospice and Palliative Care Network of Maryland. Commissioner McHale resides in Anne Arundel County.
(**Term Expires 9/30/2014**)

Barbara Gill McLean is a small business owner. Previously she was a Senior Policy Fellow in the Office of Policy and Planning at the University of Maryland School of Medicine. Prior to joining the School in January 2005, Ms. McLean served as the Executive Director of the Maryland Health Care Commission (MHCC) from 2000-2004 and as Deputy Director of Performance and Benefits at MHCC and one of its predecessor commissions from 1996-2000. Responsibilities included the

design and continued development of a standard benefit plan for small employers, implementation of a system to annually evaluate the quality and performance of HMOs, hospitals and nursing homes for public reporting and oversight of the Certificate of Need program. Ms. McLean also led the State's initiative for improving patient safety including the creation of the Maryland Patient Safety Center. Ms. McLean received a Master's in Sociology and completed doctoral studies in policy sciences program, specializing in health policy at the University of Maryland. She also served as principal analyst for the Environmental Matters Committee in the Maryland House of Delegates from 1983 to 1991 and as Senior Legislative Analyst for the University of Maryland, Baltimore and the University of Maryland Medical System from 1991 to 1996. Commissioner McLean resides in Baltimore County.
(Term Expires 9/30/2014)

Frances B. Phillips, RN, MHC, is a consultant focusing on community health improvement and population health innovation after retiring from the Maryland Department of Health and Mental Hygiene where she held the position of Deputy Secretary for Public Health Services from 2008 to 2013. Prior to her appointment as Deputy Secretary, Ms. Phillips was the Health Officer for Anne Arundel County, Maryland from 1993-2008, including a term in 2004 when she served as Interim County Fire Chief. Ms. Phillips holds an undergraduate degree in community health nursing from The Catholic University of America and a master's degree in health care administration from The George Washington University. She is an Adjunct Assistant Professor in the University of Maryland's School of Nursing and an Associate in the Department of Health Policy and Management at Johns Hopkins University Bloomberg School of Public Health. Ms. Phillips is a resident of Anne Arundel County.
(Term Expires 9/30/2014)

Paul Fronstin is a senior research associate with the Employee Benefit Research Institute, a private, nonprofit, nonpartisan organization committed to original public policy research and education on economic security and employee benefits. He is also Director of the Institute's Health Research and Education Program, and oversees the Center for Research on Health Benefits Innovation. He has been with EBRI since 1993. Dr. Fronstin's research interests include trends in employment-based health benefits, consumer-driven health benefits, the uninsured, retiree health benefits, employee benefits and taxation, and public opinion about health benefits and health care. In 2012, Dr. Fronstin was appointed to the Maryland Health Care Commission. He currently serves on the steering committee for the Emeriti Retirement Health Program and is also the associate editor of Benefits Quarterly. In 2010, he served on the Institute of Medicine (IOM) Committee on Determination of Essential Health Benefits. In 2002 he served on the Maryland State Planning Grant Health Care Coverage Workgroup. In 2001, Dr. Fronstin served on the Institute of Medicine Subcommittee on the Status of the Uninsured. Dr. Fronstin earned his Bachelor of Science degree from SUNY Binghamton and his Ph.D. in economics from the University of Miami. Commissioner Fronstin resides in Montgomery County.
(Term Expires 9/30/2015)

Kathryn Montgomery, PhD, RN, NEA-BC is the Associate Dean Strategic Partnerships & Initiatives and Assistant Professor at the University of Maryland School of Nursing since 2003. She has served in prior faculty and administrative roles at the School in 2000 – 2001 after retiring from the United States Public Health Service as Rear Admiral and Assistant Surgeon General within the Department of Health Human Services. While in this capacity, Dr. Montgomery served at NIH Clinical Center as Chief Nurse. In her academic administrative role Dr. Montgomery provides leadership in the creation of strategic partnerships, faculty practices, clinics including the Governor's Wellmobile program and professional education. Dr. Montgomery serves on the leadership team guiding the development of the Maryland Learning Collaborative Patient Centered Medical Home initiative. Dr. Montgomery teaches courses in complex healthcare systems, health policy, leadership and teamwork. Commissioner Montgomery resides in Anne Arundel County.
(**Term Expires 9/30/2015**)

Ligia Peralta, MD, FAAP, FSAHM, AAHIVM is a clinician and scientist with extensive research expertise in the areas of adolescent health, HIV, sexually transmitted infections and health disparities. Dr. Peralta is President and CEO of Casa Ruben Foundation, Clinical Research Institute, and a fellow in global health care innovation. She is a retired tenured Professor of Pediatrics and Epidemiology and former Chief of the Division of Adolescent and Young Adult Medicine at the University of Maryland School of Medicine. Dr. Peralta is board certified in both Pediatrics and Adolescent Medicine and is internationally known for her work in HIV and for developing health care programs for underserved communities. She holds certification from the American Academy of HIV Medicine and serves as its representative to the National Foundation for Infectious Diseases. She has served as Principal Investigator for over 30 NIH and CDC-funded grants and has published in prestigious scientific journals. Dr. Peralta has worked with the Department of State in Africa and South America and in the development of health care programs for countries in Caribbean and the Far East including the United Arab Emirates. She is an inductee to the Maryland Women's Hall of Fame. Commissioner Peralta resides in Howard County.
(**Term Expires 9/30/2015**)

Glenn Schneider, MPH is the Chief Program Officer for the Horizon Foundation, one of the largest health philanthropies on the East Coast. Prior to joining the Foundation, Commissioner Schneider served as a national consultant, executive director, community organizer, grassroots strategist, and policy director for state/local government and the non-profit sector. His work has resulted in the passage of over twenty-five state and local laws across the nation that protected public health, increased access to health care, raised tobacco prices, created smoke-free public places, and cut youth access to tobacco. In the health care arena, he spearheaded team efforts to launch the Healthy Howard Health Plan, a nationally-acclaimed health care access program for the uninsured, established a rules-based electronic application portal for state health insurance programs and previously served as executive director of the Maryland Health Care for All Coalition. He has an MPH from the University of Pittsburgh and received his school's highest honor, the Distinguished Graduate Award, in 2002. Commissioner Schneider resides in Howard County.
(**Term Expires 9/30/2015**)

Michael S. Barr, MD, MBA, FACP board-certified internist and Executive Vice President for Research, Performance Measurement & Analysis at NCQA. His portfolio at NCQA includes performance measurement development and testing, contract/grant management and collaboration across NCQA on strategic initiatives. Prior to joining NCQA in May 2014, Dr. Barr was Senior Vice President, Division of Medical Practice for the American College of Physicians (ACP) where he was responsible for promoting patient-centered care through the development of programs, services, and quality improvement initiatives for internists and other health care professionals. In addition, Dr. Barr was directly involved in policy development on issues including the patient-centered medical home, medical home neighbor, inter-professional team-based care, and health information technology. Dr. Barr received his MD from New York University School of Medicine and completed his residency in Internal Medicine at Rush-Presbyterian-St. Luke's Medical Center in Chicago, Illinois. He received a Master's of Business Administration from Vanderbilt Owen Graduate School of Management, and a Bachelor of Science degree in Forest Biology from the State University of New York, College of Environmental Science and Forestry. Dr. Barr still practices internal medicine part-time in Columbia, Maryland. Commissioner Barr resides in Howard County.
(Term Expires 9/30/2016)

John E. Fleig is Chief Operating Officer for Mid Atlantic Health Plan for United Healthcare. He is responsible for the overall operations of the health plan and responsible for all aspects of the MAMSI/United integration. Before United Healthcare, he was the Senior Vice President for Mid Atlantic Medical Services, Inc. at MAMSI. Commissioner Fleig earned his undergraduate degree in Psychology from the University of Maryland and his accounting degree from Benjamin Franklin University. He is the former Director of the Maryland Small Group Reinsurance Pool. Commissioner Fleig is a resident of Calvert County.
(Term Expires 9/30/2016)

Kenny W. Kan is Senior Vice President and Chief Actuary of CareFirst. He is responsible for the company's healthcare trend and pricing development, claims liability reserving, and actuarial support related to key strategic initiatives. He has more than 20 years of progressively responsible actuarial and health care experience. Commission Kan previously worked at Legg Mason Capital Management where he was a securities analyst. Prior to Legg Mason, he was Staff Vice President, Corporate Actuarial, at WellPoint, Inc. in Thousand Oaks, CA. He is a Fellow in the Society of Actuaries, a member of the American Academy of Actuaries and a Chartered Financial Analyst. Commissioner Kan holds both a Master's Degree in Professional Accounting and a Bachelor's Degree with high honors in Business Administration/Accounting from the University of Texas at Austin. Commissioner Kan resides in Howard County.
(Term Expires 9/30/2016)

Stephen B. Thomas, PhD, is the director of the Maryland Center for Health Equity in the University of Maryland School of Public Health and a professor of health services administration at the School. Dr. Thomas is an internationally recognized, African American leader in minority health research and community engagement and has been a lead investigator of multiple studies

investigating racial differences in health outcomes. Dr. Thomas resides in Prince George's County. **(Term expires 9/30/2017)**

Diane Stollenwerk is a member of the Maryland Health Care Commission, and serves as a technical expert appointed by the Centers for Medicare and Medicaid Services to the panel for the National Impact Assessment of CMS Quality Measures. She is the president of StollenWerks Inc., a consulting group providing strategic, policy and planning advice to corporate, nonprofit and government clients. Diane was a vice president at the National Quality Forum, leading the team to engage and support employers, patients and family members, providers, health plans and others at the local, state and national levels regarding practical aspects of measuring and reporting on performance to improve health care. Diane was a founding director of the nationally-recognized Puget Sound Health Alliance, a successful multi-stakeholder coalition that produces the Community Checkup report to improve health and health care in the Pacific Northwest. At that time, she was the Robert Wood Johnson Foundation-funded Aligning Forces for Quality project director for the region and the Chartered Value Exchange liaison to the federal Agency for Healthcare Research and Quality. She provides leadership and expertise in strategic planning, development and sustainability, competitive intelligence, marketing, and service or product line creation. This often involves group facilitation and public affairs work such as messaging and materials, media relations, and grassroots and 'grasstops' organizing. Current and past clients and collaborators come from sectors including health care, software, transportation, manufacturing, corrections, education, utilities, community non-profits and professional associations. Diane earned a Master's degree in public policy from Harvard University. She has a bachelor's degree in English from San Diego State University where she earned national recognition in persuasive speaking. Her passion stems from a recognition and deep respect for the dignity of every individual person, and our shared responsibility to improve opportunity and equality for all. Commissioner Stollenwerk resides in Baltimore City.
(**Term Expires 9/30/2017**)

Adam Weinstein., M.D. is a native of Baltimore County who completed all of his medical education and training to be a kidney specialist at the University of Maryland School of Medicine. He moved to the upper counties of the Eastern Shore in 2006 where he co-founded a private practice, the Kidney Health Center of Maryland. He is the medical director for Nephrology and Transplant Services for the Shore Health System (a University of Maryland Hospital affiliate system) as well as some of the dialysis units on the upper Eastern Shore. He is the President of the Talbot County Medical Society and active in MedChi - the Maryland Medical Society and on the board of directors of the Renal Physicians Association. Dr. Weinstein is board certified in Internal Medicine and Nephrology. Commissioner Weinstein resides in Queen Anne's County.
(**Term Expires 9/30/2017**)

EXECUTIVE STAFF

Ben Steffen
Executive Director

Linda Bartnyska
Director, Center for Information Services and Analysis

Bruce Kozlowski
Co-Director, Center for Quality Measurement and Reporting

Theressa Lee
Co-Director, Center for Quality Measurement and Reporting

Paul E. Parker
Center for Health Care Facilities Planning & Development

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

EXECUTIVE SUMMARY

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

During FY 2014, the Commission had an appropriation for 62.7 full time positions 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.

We pursue our mission through information gathering and dissemination, our health planning and regulatory powers, and our health policy analyses. Many of the Commission's activities focus upon collaborative initiatives related to broadening Marylander's access to high quality and cost effective health care services. Particular attention is given to areas such as Access to Health Care, Quality and Patient Safety, Innovative Health Care Delivery, Health Information Technology, and Information for Policy Development. These activities are directed and managed by the Commission's Executive Director. Administrative activities, such as staffing, budget, and procurement, are managed by the Director of Administration and her staff. The Commission's Assistant Attorneys General provide legal advice and counsel to the Executive Director, the Commission members, and Commission staff. The Commission's staff members' backgrounds and skills encompass a broad range of expertise, including public policy analysis, data management and analysis, health planning, health facilities construction and financing, Medicaid administration, quality assessment, clinical and health services research, and public performance reporting.

The Commission is organized around the health care systems we seek to evaluate, regulate, or influence, bringing a wide range of tools (data gathering, public reporting, planning and regulation) to bear to improve quality, address costs, or increase access. Two of the centers - the Center for Health Care Facilities Planning and Development and the Center for Quality

Measurement and Reporting - are organized around provider organizations, bringing together under one leadership the expertise and tools to address cost, quality, and access in those sectors of our health care system. The Center for Information Services and Analysis conducts broad studies, using both Maryland databases and national surveys, but also has specific responsibilities relating to physician services. The fourth center, the Center for Health Information and Innovative Care Delivery, has responsibilities that cut across sectors to facilitate the adoption of electronic health records and to enable the private and secure transfer of personal health information among sectors as well as managing the Commission's Patient Centered Medical Home program.

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

THE CENTER FOR HEALTH CARE FACILITIES PLANNING AND DEVELOPMENT

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

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

THE CENTER FOR HEALTH INFORMATION AND INNOVATIVE CARE DELIVERY

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

- 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
- Designate management service organizations to promote the adoption and advanced use of electronic health records
- Manage the Commission's Patient Centered Medical Home Program

THE CENTER FOR ANALYSIS AND INFORMATION SERVICES

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.

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

THE CENTER FOR QUALITY MEASUREMENT AND REPORTING

- The Center is committed to providing meaningful information to consumers about the quality and outcomes of care provided in all Maryland acute care hospitals. It publishes the Hospital Guide, containing both general information and specific quality and outcome measures. The Center 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 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 Maryland assisted living programs.
- The Center reports publicly on the performance of and satisfaction with health plans in the HMO Consumer Guide. Traditionally focused on measures of the clinical performance of HMOs, the Guide is expanding in two ways. MHCC now reports on additional measures of health plan quality and value and on PPOs in addition to HMOs.
- The Center is committed to reporting disparities in health and health care and is responsible for the Commission's Racial and Ethnic Disparities initiative.
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BUDGET & FINANCES

In FY 2014, the Commission was appropriated $31,437.898, which includes an appropriation of $12.3 million for the Trauma Fund and trauma equipment grant programs, $2.6 million for the Partnership program, $3 million for the MD Emergency Medical Systems Operations Fund, $926,760 million in Federal Fund Income, and 12,611,138 in Special Fund Revenue. The Commission is funded with special funds through a user fee assessment in order to accomplish its mission and program functions.

ASSESSMENT

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

Surplus

At the close of FY 2014, the Commission's surplus was $1.7 million.

OVERVIEW OF FY 2014 ACCOMPLISHMENTS

July 2013

Certificate of Need – Seasons Hospice & Palliative Care of Maryland was approved.

COMAR 10.24.09 - State Health Plan for Facilities and Services: Acute Inpatient Rehabilitation Services was adopted.

Renewal of Primary PCI Waiver for MedStar Southern Maryland Hospital Center was approved.

August 2013

There was no Commission meeting.

September 2013

Certificate of Need – Ashley, Inc. dba Father Martin's Ashley was approved.

COMAR 10.24.13 – State Health Plan for Facilities and Services: Hospice Services was adopted.

Renewal of Primary PCI Waiver – Carroll Hospital Center was approved.

The 2013 Health Benefit Plan Quality and Performance Report was released.

October 2013

COMAR 10.25.06 - Maryland Medical Care Data Base were adopted as Emergency and Proposed Regulations.

COMAR 10.25.18 - Health Information Exchanges – Privacy and Security of Protected Health Information was adopted.

Certificate of Need Exemption – Merger of the Hospice Operations of Chester River Home Care & Hospice, LLC and Care Health Services, Inc. d/b/a Shore Home Care & Hospice was approved.

The State-Regulated Payor and Pharmacy Benefit Manager Preauthorization Benchmark Attainment report was released.

Recommendations for the State Regulated Payor Electronic Health Record Program and Electronic Health Record Usability Across Hospital Settings was released.

The Maryland Multi-Payer Patient Centered Medical Home Shared Savings Results were released.

The Maryland Trauma Physician Services Fund, Report to the Maryland General Assembly was released.

November 2013

COMAR 10.24.09, State Health Plan for Facilities and Services: Acute Inpatient Rehabilitation Services was adopted.

Certificate of Need – Cosmetic SurgiCenter of Maryland, Inc. d/b/a Bellona Surgery Center was approved.

Hospital Palliative Care Pilot Project Participation Criteria were approved.

POSTING of the Medical Care Data Base Submission Manuals was approved.

December 2013

The Transitional Plan for the Maryland Health Insurance Partnership was approved.

Renewal of Primary PCI Waiver – Holy Cross Hospital was approved.

Renewal of Primary PCI Waiver - Howard County General Hospital was approved.

Renewal of Primary PCI Waiver – Johns Hopkins Bayview Medical Center was approved.

Renewal of Primary PCI Waiver – Saint Agnes Hospital was approved.

The Report and Recommendations - Rural Area Health Delivery and Planning Report was released.

The Telemedicine Task Force Interim Report was released.

January 2014

The Commission received an Update on Hospital Performance on Central Line-Associated Bloodstream Infections and the Hospital Performance Guide Expansion

The Commission received a Review of the Enhanced Hospital Quality Data Collection and Reporting System and the New Quality Measures Data Center Website/Portal

February 2014

COMAR 10.25.06 – Maryland Medical Care Data Base and Data Collection was adopted.

COMAR 10.25.18 – Health Information Exchanges: Privacy and Security of Protected Health Information was adopted.

Certificate of Need – Lorien Health Systems, Bel Air – Expansion was approved.

March 2014

Certificate of Need – Change in Approved Project – Seasons Hospice & Palliative Care of Maryland was approved.

Study Components and Final Pilot Hospital Group – Hospital Palliative Care Pilot Project (House Bill 581, 2013 General Assembly Session) were approved.

April 2014

Certificate of Need – Change in Approved Project – Seasons Hospice & Palliative Care of Maryland was approved.

Certificate of Need – Prince George's Post Acute, LLC was approved.

May 2014

COMAR 10.25.16 – Electronic Health Record Incentives was adopted.

Certificate of Need – Change in Approved Project – Mercy Medical Center, Inc. was approved.

Certificate of Need Exemption – Relocation of SurgiCenter of Pasadena, LLC (MedStar Health System) from Pasadena (Anne Arundel County) to Brandywine (Prince George's County) was approved.

The 2012 Professional Services Report was released.

The Commission reviewed a DEMONSTRATION of the Advance Directive Registry.

June 2014

Certificate of Need: Capital Hospice, Inc. d/b/a Capital Caring was approved.

Small Group Market Summary of Carrier Experience as of December 31, 2013 was released.

The Commission reviewed Changes to the Small Business Health Options Program (SHOP).

MARYLAND HEALTH CARE COMMISSION

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 beginning in FY 2007.

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

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

The Maryland Health Care Commission approved an 8 percent across the board reduction in payment rates for FY 2010 (with the exception of Medicaid) due to the downturn in automobile registration revenue and an expected increase in uncompensated care claims, which continued through FY 2014. A $4.6 million surplus existed at the start of FY 2014.Trauma Equipment Grants awarded to the Level II and Level III trauma centers, for a total of $398,231, were paid from surplus funds.

Payments to eligible providers and the administrative costs associated with making those payments were about $12.5 million in FY 2014, an increase of nearly $500,000 from FY 20123. Comparing FY 2014 to FY 2013, uncompensated care payments and on call trauma payments, combined, increased by approximately $400,000. Transfers from the Motor Vehicle Administration (MVA) to the Fund increased by nearly $300,000 in FY 2014; and administrative costs and reimbursements to the Fund increased as well.

The Center for Analysis and Information Systems

Cost and Quality Analysis Division

Overview

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

Accomplishments

The Division worked to implement an ambitious agenda to enhance the MCDB, build partnerships, promote price transparency, and conduct timely studies. An emphasis throughout the Division's activities has been collaboration with partners and engagement of stakeholders. In addition to the Commission's budget, the Center received funding support from the Center for Medicare and Medicaid Innovation (CMMI), Center for Consumer Information and Insurance Oversight (CCIIO), the Robert Wood Johnson Foundation (RWJF), and the Governor's Workforce Investment Board (GWIB). In particular, the Center pursued and received (September 2013) a grant worth $2.9 million from the Center for Consumer Information and Insurance Oversight (CCIIO) to support the Center's activities.

In FY 2014, the Division: (1) enhanced the comprehensiveness and timeliness of data collection and worked to leverage MCDB data by linking it with other sources of health information; (2) established partnerships with other state agencies for decision support; (3) developed and explored opportunities to enhance quality and price transparency; (4) improved access to MCDB data; (5) updated its annual reports on healthcare spending and payments for professional services; (6) launched the Maryland Health Workforce Study; and (7) continued collaboration and leadership with other APCD states. The Division's accomplishments are described in the following sections.

MCDB Expansion

In order to expand the comprehensiveness and timeliness of the MCDB data collection and leverage the data by linking it to other sources of health information, the Division: (1) updated the existing MCDB regulations (COMAR 10.25.06) and MCDB Data Submission Manual; (2) added an additional year of privately insured and Medicare, and two years of Medicaid data to the database; and (3) with support of grant funds, hired an experienced actuary and developed an expanded scope of work and contract modification for the existing Database Vendor.

Updated MCDB Regulations – COMAR 10.25.06

In order to support and achieve these goals laid out in the Commission's MCDB expansion plan, the MCDB required an update. The following changes were made to *COMAR 10.25.06 – Maryland Medical Care Data Base*: (1) In addition to the current reporting entities, third party administrators, including pharmacy benefit managers and behavioral health administrators, any carriers, including qualified dental plans,

selling products in the MHBE, and Medicaid MCO's will be required to submit data. These changes were made to ensure that the MCDB is more comprehensive. (2) The frequency of data collection was increased from the current annual submissions to quarterly submissions. This will allow for more timely analysis of data to inform policy decisions. (3) In order ease the administrative burden for payors when reporting quarterly data, MCDB submission for 2014 and onward are selected based on claims paid in that period without any run-out. In the past, reports were based on claims paid for services incurred in the reporting period with a four month run-out period. (4) Three new reports were added: a) The Plan Benefit Design report is intended to provide greater detail about plan-specific service benefits, restrictions, and patient out-of-pocket obligations; b) The Non-Fee-for-Service Medical Expenses report is intended to capture lump sum payments from carriers to providers for non-claim-based services, usually as part of incentives for performance, quality of care, shared savings, etc.; c) The Dental Data report is intended to capture data from Qualified Dental Plans participating in the Maryland Health Benefit Exchange (MHBE). (5) In order to be able to link enrollee information from PBMs and behavioral health administrators to medical claims and to be able to link MCDB data to other state data systems, the Master Patient Index technology used by the State-designated Health Information Exchange (HIE) will be used to provide a universal identifier across all payers, providers, and services. (6) Technical file specifications are no longer described in the regulations; rather, they are provided in the MCDB Submission Manual. The MCDB Submission Manuals for 2013 and 2014 were released along with the regulations

These regulations were initially approved by the Commission as Emergency Regulations on October 17, 2013 and subsequently reviewed and released as Emergency Regulations by the Joint Committee on Administrative, Executive, and Legislative Review of the Maryland General Assembly. The regulations were also promulgated through the formal process and adopted as final by the Commission on February 20, 2014. Throughout the process, the Division proactively engaged stakeholders, particularly reporting entities. In addition to the formal opportunities to provide comments on the regulations and submission manual, the Division met individually with reporting entities to listen to any concerns and update the regulations, if appropriate.

Payors were also given opportunities to provide specific feedback on the planned reporting requirements through general payor meetings and two workgroups to discuss Race, Ethnicity, and Language Reporting, and to define new reports to capture Plan Benefit Design and Non-Fee-For-Service Payments. Based on recommendations of the workgroups, the Division added imputed race and ethnicity fields to supplement direct reporting of race and ethnicity. Based on the workgroup recommendations and complexity of assessing Plan Benefit Design and Non-Fee-For-Service Payments, the Division contracted with the APCD Council to support a broader analysis of the reporting options before drafting any reporting requirements. This effort is described below in the cross-state collaboration section.

Medicaid, Medicare, and Privately Insured Data added to the MCDB

The Division worked with the Hilltop Institute, Maryland Medicaid's database vendor, to develop cross-walks and programs to convert Medicaid MCO data into MCDB file formats for inclusion in the MCDB. An inter-agency MOU was established with the Hilltop Institute with funding support from the CCIIO Exchange Level II grant received by the MHBE. Hilltop developed Medicaid professional services, institutional services, pharmacy services, and provider directory files that are analogous to the MCDB file formats. Due to limitations of MMIS 2, these files include shadow pricing for encounter-level costs developed based on the Medicaid fee schedule and capitated payments to MCO's. The MCDB now includes 2011 and 2012 Medicaid MCO data, and Hilltop has committed to providing 2013, 2014, and 2015 data in similar formats. Beyond that time frame, Medicaid expects to have MMIS 3 operational, at which time direct data streams and encounter-level pricing will be possible.

In addition to the addition of Medicaid MCO data, the Division added the following data for calendar year 2012 to the MCDB: (1) eligibility, professional services, institutional services, and prescription drug data from commercial insurers; and (2) the Master Beneficiary Summary File (A/B/C), the Medicare Provider Analysis and Review file, and claims files for physicians/carriers and inpatient, outpatient, and long term care facilities.

Grant Funds and Contract Modification for Database Vendor

The Center pursued and received (September 2013) a grant worth $2.9 million from CCIIO (Rate Review, Cycle III) to support the Division's activities. The grant funds expansion of the MHCC data center for the MCDB, development of data marts from the MCDB to support the Maryland Insurance Administration's (MIA) rate review process, hiring of an actuary, and development of a price transparency tool. These funds are crucial to implementing the MCDB expansion efforts that will extend into FY 2016. In order to ensure timely and efficient implementation of the MCDB expansion plans and grant deliverables, the contract with the existing database vendor, Social and Scientific Systems, was modified to include these new activities and extended through September 2016. A key deliverable in the contract is the development of an Extraction, Transform, and Load (ETL) system with a front-end web portal to automate data submission and processing. This system is expected to substantially expedite processing and availability of MCDB data. The Board of Public Works approved this contract modification on July 2, 2014. In addition to this contract modification, the Division hired an experienced actuary to serve as the MHCC Methodologist. This staff member will develop analytic tools, such as dashboards, to support the MIA's rate review activities.

Decision Support for State Partners

The Commission prioritized decision support, as a central goal for the MCDB and its products. The Division established partnerships with other state agencies and developed decision support tools. In FY 2014, the Division: (1) released data to state partners; (2) developed a framework for analytic support for insurance rate review (MIA); (3) supported the development of total cost of care measures (HSCRC); (4) supported MHBE through enhanced data collection and data release for studies; and (5) Supported DHMH through management of a project to evaluate primary care services in Maryland (DHMH, HSIA)

MCDB Data Released to State Partners

The Division released MCDB data to the following state partners to support their programmatic goals: (1) Data was released to Optumas, a consultant for Maryland Medicaid, in support of DHMH planning and analysis activities under the State Innovations Model (SIM) planning grant. This data was used in calculating potential program return on investments. (2) Social and Scientific Systems was permitted to use the MCDB data in support of the Health Systems Infrastructure Administration's planning for primary care services in Maryland. (3) Data was released to the Hilltop Institute in support of two studies for the MHBE. The data was used to support analyses of reinsurance for the individual market and tobacco use ratings. (4) Data was released to the Health Services Cost Review Commission (HSCRC) to support their analyses of total costs of care, as part of the new CMS hospital waiver and global budget model.

Decision Support for the Maryland Insurance Administration

The Center worked to strengthen the existing relationship with the Maryland Insurance Administration to support their rate review activities. In the past, MCDB data has been released to the MIA; however, further analytic support has not been provided. A key deliverable under the CCIIO Cycle III grant is to develop analytic tools for the MIA, such that the MCDB may become integrated into the rate review process. In FY 2014, the Division: (1) established an MOU to release data to the MIA and provide analytic support; (2) developed an overarching project plan for developing the necessary tools; (3) hired an actuary to support MIA activities; and (4) began collaboration with MIA to reconcile MCDB data with data received by the by MIA in the Actuarial Memoranda that accompany rate filings. These grant-supported activities will extend through September 2016.

Decision Support for the Health Services Cost Review Commission

As the HSCRC developed its proposal for the CMS hospital waiver and for ongoing monitoring of the new global budget model, the Center and Division served on workgroups, provided technical guidance, and released MCDB data. Management of total cost of care and per-capita health expenditures are key performance measures for the HSCRC and the waiver. While initial efforts will focus on Medicare data, the MCDB is the expected source for these calculations for privately insured Maryland residents. In FY 2014, the Center released MCDB data and provided technical support in its analysis and served on the HSCRC Data and Infrastructure Workgroup. The Center provided specific analysis and feedback related to the Total Cost of Care Calculations. As the key MCDB metrics are developed, the Division will work to integrate those measures and data into the MCDB production process in future iterations of the database.

Decision Support for the Maryland Health Benefit Exchange

As Maryland developed and implemented the Exchange, in FY 2014, the Division: (1) expanded the MCDB data collection to include all plans sold on the Exchange; and (2) released data to support Exchange studies. The MCDB data is expected to be the primary source of data for Exchange analyses of cost and utilization. The updated regulations (COMAR 10.25.06) require all plans sold on the exchange to report to the MCDB in calendar year 2014 and onward. In addition to the expanded data collection, the Division released data to the Hilltop Institute, an analytic contractor to the Exchange, to support analyses of reinsurance for the individual market and tobacco use ratings.

Decision Support for DHMH Health Systems Infrastructure Administration

As part of the SIM planning process, the Division supported HSIA in an analysis of geographic distribution and variation in utilization of primary care services in Maryland using MCDB data. With support from SIM funding, the Division contracted with SSS to do the analyses, and the Division provided technical guidance and project management services for HSIA. The analysis used both privately insured and Medicare data and used the same attribution methodology as the Maryland Multi-Payor Patient Centered Medical Home Program (MMPP). In addition to producing summary tables by zip code for use in HSIA analyses, a patient level primary care attribution data set was produced to be available for future studies.

Quality and Price Transparency

The Center developed and explored opportunities to enhance quality and price transparency. In particular, the Center: (1) engaged stakeholders in the development of practitioner performance measurement; and (2) developed a provider pricing application.

Practitioner Performance Workgroup

MHCC initiated a Practitioner Performance Measurement Workgroup to identify specific primary care and specialty care areas of focus for the development of practitioner performance measurement. MHCC intends to combine privately insured, Medicare, and Medicaid claims to evaluate and report on physician performance. In order to include Medicare claims, MHCC must obtain Qualified Entity certification from CMS. The Center contracted with Discern Consulting to support the work group, identify specific measures that may be generated from the MCDB, and provide an evaluation of MHCC's readiness to apply for Qualified Entity status from CMS. Discern produced three reports and found that the MHCC was well-positioned to apply for the Qualified Entity status and that the MCDB would be able to generate many approved performance measures. The primary limitation to moving forward with this effort is identifying adequate funding for the program, which is a key requirement before CMS will certify MHCC as a Qualified Entity.

Development of Provider Pricing Transparency Web Application

In April 2014, CMS publically released Medicare physician billing data. In response to this unprecedented availability of data, MHCC embarked on an effort to combine the released Medicare data with privately insured data in the MCDB. The Center developed a web application to permit searches of physicians by name, specialty, geographic location, and type of procedure performed. The web application displays total reimbursement to physicians and average reimbursements for specific procedures. In addition, for privately insured, it displays the average out-of-pocket expenses for consumers for each procedure. The application is currently oriented toward the healthcare industry and is in a testing phase. The Center expects to enhance this application and release it to the public in FY 2015.

Revised Data Release Policy

The Division is now responsible for managing data releases for the Commission, including review of applications, verifying applicant qualifications, and release of data to applicants for all Commission data. The Division has worked to collaborate with other Divisions and staff to ensure that the appropriate experts are involved in the review of applications and release of data.

While there has been limited interest from researchers to acquire MCDB data in the past, with the advent of the Affordable Care Act and Health Insurance Exchanges, there is a growing interest, particularly from hospitals and research organizations, in accessing MCDB data. The Division organized a Data Release Policy Workgroup composed of representatives from payors, providers, consumers, and researchers to inform the Commission's policies regarding the release of data from the MCDB in two broad areas: defining data products that may be released; and developing the process for reviewing applications for data.

MHCC has a consistent track record of careful review of applications, including IRB review, and ensuring the security of data once released. The workgroup was asked to provide feedback on a proposed update to the current practices. Based on workgroup recommendations, the Division will update and finalize the Data Release Policy in FY 2015. The revised process will be more transparent to the public, involve a multi-stakeholder group for identifiable research files, charge fees for data, and recommend the formation of a privacy board in lieu of an IRB for the review of this type of data.

Annual Reports

The Division updated its annual reports on healthcare spending and payments for professional services: (1) Payments for professional services; (2) per-capita spending in the privately insured market; and (3) state-wide healthcare expenditures. In addition, the Division updated payment rates for HMO payments to non-participating providers for evaluation and management services and provided these rates to the MIA for publication.

Payments for Professional Services

The Payments for Professional Services report examines the variation in payment rates for professional services in Maryland and provides a comparison of private payment rates to Medicare and Medicaid payment rates for the same services. Payment rates for professional services are primarily based on negotiations between payers and health care providers. The payment rate had a small increase in 2012 compared to 2011 (1.1%), with the largest payors paying 12 percent less than other payors. Out-of-network payment rates were nearly twice those of in-network payment rates. The payment rate for private insurance was comparable to Medicare and about 31 percent higher than Medicaid for comparable services. As the general trends have been stable year-to-year, this report was presented in a simplified chart book style format as a monitoring report. The Division released this report in July 2013.

Per-capita Healthcare Spending

The Commission reports annually on the per capita spending in the privately insured market. There are a variety of efforts underway to address the Triple Aim via delivery and payment system reforms. This

report focused on three such areas: Maryland Multi-Payer Patient-Centered Medical Home (MMPP), Consumer-Directed Health Plans (CDHP), and prescription drug spending. PCMH programs target those with chronic conditions, who are most likely to benefit from coordinated care. Overall, predicted risk for those enrolled in PCMH programs was 23% higher, and median spending was 11% higher. The higher risk ratio, relative to the spending ratio, suggests some attenuation in risk due to the program. A variety of factors influence selection of a CDHP, including availability of such plans, expected health spending, and health status. Individuals in better health are expected to enroll. While total spending was comparable between those in a CDHP and non-CDHP enrollees, out-of-pocket spending was consistently higher for CDHP enrollees. Coverage type greatly influences use of prescription drugs. Use ranged from 39% of enrollees in the Individual Market to 89% in the State's high-risk pool, Maryland Health Insurance Plan (MHIP). Number of scripts and spending followed a similar pattern. While generic drugs accounted for 72-78% of prescriptions filled, brand-name drugs accounted for 63-80% of the spending. This report was released in January 2014.

State Health Expenditures

The Division reports annually on recent trends in personal health care (PHC) expenditure, based on data reported by CMS' National Health Expenditure Accounts. An estimated $49.4 billion in PHC expenditure occurred in Maryland in 2012. Both Maryland and national PHC expenditure continues to grow; however, the rate of growth is reducing over time. Maryland's PHC spending rate of growth remains higher than the national average. As in past years, the per capita PHC expenditure is higher (12%) in Maryland ($8,397) compared to the national average ($7,520). As the general trends have been stable year-to-year, this report was presented in a simplified chart book style format as a monitoring report. The State Health Expenditure report was published in June 2014.

HMO Payments to Non-Participating Providers

Maryland Health-General Article, §19-710.1 specifies a methodology to calculate minimum payment rates that Health Maintenance Organizations (HMOs) must pay to non-contracting (non-trauma) providers that provide a covered evaluation and management (E&M) service to an HMO patient. The Commission is required to annually update these minimum payment rates.

As specified in the law, E&M services as defined by the Centers for Medicare and Medicaid Services (CMS) in the Berenson-Eggers Type of Services (BETOS) terminology are calculated from the CMS Medicare Physician Fee Schedule that applied in August of 2008 adjusted by the cumulative Medicare Economic Index (MEI) prior to the start of each new calendar year. MHCC and MIA have agreed to modify the methodology in the event that there is a new E&M services code included in the BETOS E&M categories. Fee levels for new codes will be based on the current Medicare Physician Fee Schedule for the geographic region and inflated using the MEI in subsequent years. The Division updated the minimum HMO payment rates to non-participating providers, as specified in the law, and the MIA published these rates on its website.

Maryland Health Workforce Study

The Division engaged in two workforce related efforts in FY 2014: (1) Launch of the Maryland Health Workforce Study; (2) Annual update to the Physician Race and Ethnicity Report.

Launch of Maryland Health Workforce Study

Maryland is expected to have an increase in demand for health care services with the expansion of the insured population, as the elements of health reform are implemented. In addition, consistent with the rest of the nation, Maryland's population is aging and expected to place increased demands on the health care system and health care workforce. Recognizing this growing need, MHCC, the Governor's Work Force Investment Board, and the Governor's Office of Health Care Reform partnered to better understand the

Maryland health workforce and the systems in place. In FY 2014, the Division launched the Maryland Health Workforce Study, which has three phases: (1) assess the existing data the Maryland Health Occupation Boards (Board) collect to support workforce analysis; (2) estimate the supply of and demand for health care professionals with the best available data; and (3) enhance the existing Board data systems. This work was supported with funding from the State Health Reform Assistance Network at the Robert Wood Johnson Foundation and the Governor's Workforce Investment Board. In FY 2014, the Division contracted with IHS Global Inc. (IHS) to execute Phases 1 and 2 of the study. Overall, IHS found that the Boards collected much of the workforce data considered to be essential, with the Board of Physicians having the most comprehensive data collection. The supply of primary care physicians in Maryland was found to be adequate to meet the demand for these services in Maryland, and the supply of the mental health workforce was not found to meet the demand for services throughout Maryland. There are regional variations in the supply and demand for the health workforce, leaving some areas with greater need, even if the overall state appears to have adequate supply of health workforce.

Physician Race and Ethnicity Report

In an effort to consistently track data related to health disparities, House Bill 58 was passed in 2006 mandating MHCC to collect racial and ethnic information on the composition of the physician population compared to the racial and ethnic composition of the State's population and to provide the information compiled to the Department of Health and Mental Hygiene's (DHMH) Office of Minority Health and Health Disparities (MHHD). The Physician Race and Ethnicity Report provides state and county level summaries and data tables with race and ethnicity distribution of physicians overall and for primary vs. specialty care, by care setting, and level of adoption of electronic health records. The report also includes county fact sheets that summarize data specific to the county.

Cross-State Collaboration and Leadership

The Center continues to collaborate with other APCD states to address shared issues and challenges. In addition to participating in the APCD Council Calls and having *Ad hoc* discussions and meetings, the Division launched a study to better understand reporting on plan benefit design and non-fee-for-service. In recognition of the impact of benefit design on cost and utilization patterns and emerging non-fee-for-service payment models, the Division expanded the reporting requirements under COMAR 10.25.06 to include two new reports: Plan Benefit Design Report and Non-Fee-for-Service Total Medical Expenditure Report, as described above. The Division convened a multi-stakeholder group to inform the development of these reports. Due to the complexity of these reports and the challenges cited by payors in reporting this information, the Center contracted the APCD Council and the National Association of Health Data Organizations to conduct an analysis of payor practices and requirements in other APCD states. Center staff participated in payor interviews and discussions with other APCD states, and the report was developed as a resource, not only for Maryland, but other APCD states. Based on findings from this effort, MHCC has decided to pursue State (Insurance Exchange, MLR reports) and Federal (HIOS, SBC, and MLR reporting) as a means of establishing a use case for this data before pursuing direct reporting from payors. The report has been presented to other members of the APCD Council and disseminated to other states.

Data Base and Applications Development Division

Overview

The Data Base and Application Development Division is responsible for data collection, processing, and dissemination activities of the Commission. The Commission has the authority to collect and report information on health care professionals, hospitals, and facilities such as nursing homes, assisted living facilities, adult day care centers, home health agencies, and hospice. This division acquires and manages internal and external analytic databases used by the Commission, including the Maryland hospital

inpatient, outpatient and emergency department data, state and private psychiatric hospital data, outpatient ambulatory surgery data, the District of Columbia (DC) hospital inpatient data, Medicare and private payer insurance claims data, pharmacy claims data, cardiac catheterization data, and several Centers for Medicare & Medicaid Services (CMS) data collections including the Minimum Data Set, and long term care quality data including home health, nursing home, assisted living and adult day care. The division provides data management and analysis support, web-based application development, and public reporting of health care information.

Accomplishments

Technical Support

Data staff performed data processing and technical support as follows: managed software licensing agreements; purchased and assisted with testing of new SAS server software working with network staff to operationalize the 64-bit SAS server and to optimize 64 bit processing; helped write the web hosting bid-board; helped with the transition of the Hospital Guide to a new contractor providing file and server support and assisting with installation of new central line and surgical site infection measures; conversion to using online AMA manuals; provided network support for management of user and group file permissions, processing optimization, storage management, ODBC support, file structures, naming-conventions, and SQL server connection troubleshooting and permissions; processing of hospital clinical measures and patient satisfaction files for analytical use; processing and data requests for quarterly discharge abstract, chronic hospital, outpatient, inpatient, and psychiatric hospital files; fulfillment of IRB data requests; processing of hospital discharge abstract for the MonAHRQ web application which allows users to review quality of care at the hospital level, health care utilization at the hospital level and emergency department level, preventable hospitalizations at the area level, rates of conditions and procedures at the area level, and estimated costs and cost-savings related to the quality of care; conducted extensive research to develop a budget for development of the All Payer Claims Data Base extract, transform and load functions of the data warehouse in order to apply for grant funding from the Centers for Medicare and Medicaid *Grant to Support States in Health Insurance Rate Review and Increase Transparency in Health Care Pricing.*

Web Application Support

Internal Operations

Data staff performed work as follows: rewrote the ambulatory surgery directory application and updated the directory with 2011/2012 data and new zip code distance tables; converted the public use files to work on the new web server platform; updated all pointers to the web applications from Sharepoint after moving to the new web server; worked with hospital staff to resolve cardiac catheterization and percutaneous coronary intervention data processing issues; downloaded final 2012 data from the home health agency survey and converted to SAS format for staff use and performed all survey modifications for the 2013 survey; made all modifications for the 2013 health care worker influenza survey and deployment for assisted living and nursing home facilities; provided support for the Patient-Centered Medical Home site with updated contents, links and creation of new pages; performed data processing and web development to complete the first draft of the All Payer Claims Data Base pricing application which provides health care pricing data by providers and by procedures; moved, installed and tested all web applications to a new hosted solution when we awarded the new web hosting contract.

Data staff performed data processing and web development to support the Long Term Care Portal, including the following: quarterly and annual data updates for Assisted Living, Adult Day Care, Home Health, Hospice and Nursing Home facilities; overhaul of several types of data processing for quality measures from the Centers for Medicaid and Medicare; modifications to the navigation of the portal; addition of new data flows and data presentations for nursing home staffing and short stay measures, and

home health outcome of care measures; and development of comparison over time tables for various quality measures. Data staff redeveloped the MHCC website which required a complete overhaul of the existing Sharepoint site and working extensively with MHCC administrative staff to establish new naming conventions for documents, archive old documents, develop web page keywords and descriptions, provide training to use the new editor, and meet with center chiefs and directors to guide in reorganization of content.

Support for Health Occupations Boards

MHCC network developers have supported 10 health occupation boards in developing and maintaining their web-based license renewal applications. These renewal applications collect demographic and professional information, and gather the fitness information that are part of each renewal process. Once applications are completed, renewal fees are collected and assigned to the designated Board accounts. MHCC support to the Boards are provided at no cost. The applications meet the requirements of the State that all Boards support web-based license renewals. MHCC estimates that annual savings to the Boards totals $600,000. The following Health Occupations Boards use the MHCC's internet application infrastructure for licensing:

- Board of Physicians
- Allied Health Occupations
- Board of Acupuncture
- Board of Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists
- Board of Chiropractic & Massage Therapy Examiners
- Board of Dietetic Practice
- Board of Morticians and Funeral Directors
- Board of Examiners in Optometry
- Physical Therapy Examiners
- Board of Examiners of Psychologists
- Board of Examiners of Podiatrist
- Board of Professional Counselors and Therapists
- Board of Social Work Examiners

Network and Operating Systems Division

Overview

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

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

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

Accomplishments

During FY 2014, the Commission's LAN was available to staff 100% of the time.
The Commission's LAN continues to be safeguarded by keeping all systems up-to-date with the timely application of software patches and the regular upgrade of an anti-virus database engine. Security is enhanced because the LAN is a private network behind an MHCC firewall, which isolates the MHCC LAN from the DHMH wide area network, which is behind its own firewall. In addition to the standard annual accomplishments listed, the following were also completed in FY 2014:

- Added two (2) new domain controllers to the MHCC network. This will provide better network authentication services for users and better security for network resources.
- Added new physical server for web & database application development
- Replaced two (2) physical off-site servers with 2 virtual servers to run current web and database applications
- Dedicated off-site physical server for SFTP communications with external customers.

Benefits Analysis Division

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

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

January 1, 2009 and annually thereafter, the MHCC is required to report to the Governor and the General Assembly on the implementation of the Small Employer Health Benefit Plan Premium Subsidy Program, branded as the Health Insurance Partnership.

Accomplishments

Comprehensive Standard Health Benefit Plan and the Health Insurance Partnership (Partnership)

The MHCC phased out support for the Comprehensive Standard Health Benefit Plan in the fall of 2013 given the expected launch of insurance coverage through the ACA's Small Business Health Options Program (SHOP). The web portal VIRTUAL COMPARE, which provided information about select health benefit plans available to small employers in Maryland, was deactivated in December 31, 2013.

The Commission took steps on January 1, 2014 to phase out the Partnership (COMAR 10.25.01) a premium subsidy program for low wage small employers that was launched in 2007. The MHCC announced in the Fall of 2013 that the Partnership would close to new small employer groups effective January 1, 2014 and that employers renewing after March 1, 2014 would have to obtain coverage through SHOP. MHCC informed all employer groups and provided information on obtaining coverage through the Exchange and obtaining federal tax credits.

Problems with the implementation of the Exchange website forced the Exchange to delay implementation of the SHOP Exchange in early 2014. These delays posed particular problems to small employers that had operated under the Partnership. In the Spring of 2014, MHCC following its historical mission of supporting small employers, worked with the payors and producers to enable small employers to continue to renew products through the Health Insurance Partnership. Throughout the first five months of FY 2014, four major carriers (Aetna, CareFirst BlueCross BlueShield, Coventry Health Care, and United HealthCare), together with a number of Third Party Administrators (TPAs) continued renewing small businesses in the Partnership, with each carrier offering a variety of health benefit plans that qualify for a premium subsidy. The Commission modified the Partnership database and website to accommodate the federal rating rules required under the Affordable Care Act that became effective during the second half of FY 2014. These modifications allowed qualifying employer groups with renewal dates between January 1, 2014 through May 31, 2014 to continue receiving a state subsidy until federal subsidies become available through the purchase of SHOP-certified health benefit plans.

The Partnership will continue until May 31, 2015 at which time all employers will be expected to migrate to SHOP products, small group products sold off the Exchange, or individual insurance products available through individual products off the Exchange.

On January 1, 2015, the MHCC published the 6th annual and final report on the implementation of the Partnership indicating that many small employers in Maryland continued to renew their subsidized insurance for their employees and several new businesses enrolled as well with 423 businesses enrolled, covering 1,951 employees and their dependents. The average annual subsidy per enrolled employee exceeded $2,400. The annual Health Insurance Partnership report is posted on the Commission's website.

Mandated Health Insurance Services Evaluation

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

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

In FY 2014, one proposed mandate was evaluated: coverage of ostomy equipment and supplies. This analysis, prepared by Mercer/Oliver Wyman, the Commission's consulting actuary, was submitted to the General Assembly, and posted on the Commission's website. The most recent Comparative Evaluation was last approved and published in December 2011, and is due every four years.

With the enactment of the Affordable Care Act in 2010, all health benefit plans offered through the new health benefit exchange must include certain "essential health benefits" beginning January 1, 2014. Federal reform also requires that each state must pay, for every health benefit plan purchased through the exchange, the additional premium associated with any state-mandated benefit beyond the essential health benefits. Any Maryland mandates that apply to the selected benchmark plan apply to the essential health benefits package in 2014 and 2015. Any new mandate in effect after December 31, 2011 or any benefits that do not apply to the benchmark plan, will not apply to the essential health benefits package, and thus the State will be liable for the

cost of the additional premiums associated with those benefits. MHCC does not anticipate producing mandate studies unless specifically requested to do by the General Assembly.

MARYLAND HEALTH CARE COMMISSION

The Center for Quality Measurement and Reporting

Health Plan Quality and Performance Division

Overview

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

Using quality and performance information supports informed health care choices, and aids in the selection and purchase of the best quality of care specific to the needs of each consumer, whether the consumer is an employer, individual, or family. Public reporting of standardized quality and performance measures and indicators promotes competition among health insurance carriers and stimulates their health benefit plans' efforts toward continuous quality and performance improvement activities that target consumer needs and expectations. In theory, the result of developing and reporting quality information is that quality attains a value in the open market. As

health benefit plans begin to compete on the basis of quality, they will devote greater attention and resources to quality improvement activities. Ultimately, high performing health benefit plans should be rewarded with greater market share as quality begins to influence consumer choice. We are proud to be driving continuous health care quality improvement in the State of Maryland through publicly reporting meaningful, comparative information on health benefit plan quality and performance.

Accomplishments

MHCC annually produces a series of three Quality Reports. This 2014 Quality Report series shows that Maryland HMOs and PPOs generally performed at or near the national average. HMOs performed at or above the top 10% of plans nationally on 72 measures and PPOs performed at or above the top 10% nationally of plans nationally on 100 measures. On consumer satisfaction measures, results were mixed. Five of the eight PPOs, but only one of seven HMOs scored among the top 10% of plans nationally on the percent of patients that rated their health benefit plan a good or better. Following are brief descriptions of each of the three Quality Reports:

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

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

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

We obtain valuable key stakeholder input on issues related to public reporting on health benefit plan quality. Each year division staff launches a planning process that involves stakeholder input by employer and carrier partners for the quality and performance reporting requirements and general information on quality reporting and other public reporting documents on quality. Staff identifies presentation approaches and the quality measures that will be used in the next report. Quality measures that are no longer deemed appropriate are retired, promising new measures are added, and sometimes, existing measures are redefined. Employers and carrier representatives

play important roles in this planning effort. Employers are helpful in identifying measures that would be most useful to their employees and dependents. Groundwork has also been laid in 2014 to expand stakeholder input by convening a standing Quality Assurance and Quality Improvement Workgroup of key stakeholders that includes representation by employers and carriers and lay consumers.

We drive continuous quality improvement among health benefit plans by expanding or enhancing public reporting on quality. Each year division staff launches a planning process for identifying and implementing appropriate expansion and enhancement to the Quality and Performance Reporting Requirements and other general information on quality reporting. Specific quality metrics are also cited as "focus measures" for quality improvement in the coming year. In this manner, carrier resources can be allocated to appropriate programs and initiatives in Maryland where health benefit plans demonstrate a need for quality improvement. Such controlled expansion and enhancement facilitates continuous quality improvement on the part of each health benefit plan participating in the MHCC Quality and Performance Evaluation System and thereby reporting on required quality metrics.

MHCC's Quality and Performance Evaluation System consists of the five quality measurement instruments with distinct quality measure sets as follows:

(1) The Maryland RELICC Assessment (RELICC) ™- A Maryland-unique, quality measurement instrument which focuses on race/ethnicity, language, interpreters, and cultural competency issues. This is the first year that MHCC implemented public reporting of health benefit plan performance on disparities issues using RELICC™.
(2) The Maryland Plan Behavioral Health Assessment (BHA) – A Maryland-specific quality measurement instrument which focuses on behavioral health issues and the provider network.
(3) The Maryland Health Plan Quality Profile (QP) – A Maryland-specific quality measurement instrument which focuses on overarching disparities-focused and carrier activities and initiatives taking place in Maryland toward continuous quality improvement.
(4) National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS®) – A nationally used quality measurement instrument which focuses on clinical performance.
(5) Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey – A widely used quality measurement instrument which focuses on member satisfaction with their experience of care.

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

We continue to expand consumer awareness of MHCC resources related to health benefit plan quality by seeking out and participating in fiscally-responsible, community-based activities, including expos, conferences, etc., which provide opportunities to expand consumer awareness of the annual Quality Report series and other helpful MHCC resources. For example, we participated

in the Baltimore Business Journal's 2014 Spring Business Growth Expo, as well as produced relevant press releases and articles for the Baltimore Business Journal and the Maryland Association of Health Underwriters. We also use the Maryland Chamber of Commerce and the Maryland Retailers Association for electronic distribution of the reports to their members.

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 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. High volume common medical conditions (All Patient Refined Diagnosis-Related Groups or APR-DRGs) are also featured and performance data on process of care measures endorsed by the National Quality Forum (NQF), and adopted by the Centers for Medicare and Medicaid Services (CMS), the Joint Commission, (TJC) and the Hospital Quality Alliance (HQA) are included. These nationally endorsed process measures address hospital compliance with evidence-based standards for the treatment of Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN), Childhood Asthma Care (CAC), surgical patients (SCIP) including the prevention of surgical site infections, Emergency Department throughput, and Patient Immunization.

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

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

Accomplishments

MHCC's quality and performance data collection for Maryland hospitals continues to evolve. In FY 2013, the MHCC and the HSCRC issued a joint policy directive that significantly expanded the quality measures data that Maryland hospitals were required to collect and report. As part of Maryland's exemption from the Centers for Medicare and Medicaid Services (CMS) Value-Based Purchasing Program (VBP) for hospital reimbursement, Maryland must maintain a comparable

hospital quality program that meets or exceeds the CMS program in cost and quality outcomes standards. In response to this CMS directive, MHCC expanded its hospital quality measures data collection requirements to comply with CMS Inpatient Quality Reporting (IQR), Hospital Outpatient Quality Reporting (OQR) and VBP data collection requirements. The expanded quality data collection requirements were phased in to ensure full implementation for Maryland hospitals as of January 1, 2014.

The HQI staff also focused on two HAI initiatives in FY 2014 that were associated with significant improvement in the performance of hospitals. Central-line associated bloodstream infections in ICUs decreased by over 60% during the three years since the information was first publicly reported on the Hospital Guide. The MHCC worked in collaboration with hospitals, the Maryland Hospital Association (MHA), and a committee of experts in infection prevention and control, to facilitate implementation of evidence based patient safety activities designed to reduce hospital infections. Similarly, public reporting of hospital employee influenza vaccination rates was a major focus in FY 2014. For the past six years, MHCC has conducted an annual survey of hospitals to gather information on employee vaccination rates and hospital policies and practices designed to promote employee flu vaccination. Hospital worker flu vaccination rates have been published in the Hospital Guide for the past five years. Since the release of this information on the Hospital Guide in 2010, Maryland hospitals have achieved an 18% increase in their employee influenza vaccination rates from 78% to over 96%. The hospital flu vaccination rate for the 2013-2014 flu season was 96.5% which is about the same as 96.4% during the previous flu season. Information on hospitals with mandatory employee vaccination policies was first added to the Guide in 2012. In FY 2014, the number of hospitals that reported mandatory employee vaccination policies increased to 45 from 38 hospitals the previous year. Again, the HQI staff worked with the Maryland Hospital Association to encourage implementation of mandatory policies.

Hospital Performance Evaluation Guide (HPEG) Advisory Committee

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

The Maryland Quality Measures Data Center (QMDC)

The Commission relies heavily on data from a variety of sources to support the HPEG. In FY 2009, the MHCC initiated a consolidated data management strategy which entailed the establishment of a Quality Measures Data Center (QMDC). The QMDC functions as Maryland's repository of hospital performance measures data and includes a secure web portal for hospital submission of quality measures and patient experience data. The QMDC also functions as a centralized communication tool for sharing information with hospitals on upcoming reporting requirements as well as providing a vehicle for review of facility performance data prior to public release. The Commission utilizes the data collected through the QMDC for timely reporting of clinical quality and patient experience measures on the web-based Maryland Hospital Performance Evaluation Guide on a

quarterly basis. In FY 2014, the HQI staff initiated a major redesign of the Maryland QMDC, with renewed emphasis on providing a comprehensive consumer friendly website for health care provider quality and performance information.

The QMDC continues to serve as a repository of hospital performance data, but operates with enhanced functionality. The public facing section of the QMDC site will be transformed into a consumer website that highlights the Commission's guides on long term care and ambulatory surgery centers, as well as the quality reports on health benefit plans. Focus groups have been used throughout the development process to gather consumer feedback and guidance. The new website, *Maryland Health Care Quality Reports,* is slated for public release in November 2014.

Healthcare-Associated Infections Data Collection

Background

In response to the significant impact that Healthcare-Associated Infections (HAIs) have had on both patients and the health care system, mandatory public reporting of HAIs has become a priority for states and the federal government. 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 Final Report and Recommendations of the HAI Technical Advisory Committee was approved by the Commission in December 2007 and staff was directed by the Commission to proceed with implementation of the recommendations. A copy of the report is available on the Commission's website at http://mhcc.dhmh.maryland.gov/hai/Pages/healthcare_associated_infections/default.aspx

Healthcare Associated Infections (HAI) Advisory Committee

The HAI Technical Advisory Committee (TAC) recognized that the implementation and sustainability of the Committee's recommendations would require ongoing involvement of individuals with expertise in infection prevention and control. To facilitate implementation of the recommendations, a permanent HAI Advisory Committee was established to provide ongoing guidance and support to this project. The HAI Advisory Committee meets monthly to review data reporting requirements and other HAI initiatives. As a result, the Commission has made significant progress towards the implementation of the original TAC recommendations. Seven of the eight TAC recommendations for publicly reporting HAI data have been achieved. The 2008 Report and Recommendations for Developing a System for Collecting and Publicly Reporting Data on HAI in Maryland is available on the Commission's website at http://mhcc.dhmh.maryland.gov/hai/Pages/healthcare_associated_infections/default.aspx

HAI Data Public Reporting

With the focus shifting to align with CMS reporting requirements, several new reporting requirements occurred in FY 2014. The National Healthcare Safety Network (NHSN) continues to be the vehicle for collecting these data. The NHSN is an internet-based surveillance system that integrates patient and healthcare personnel safety surveillance systems. It is managed by the Division of Healthcare Quality Promotion of the Centers for Disease Control and Prevention (CDC).

The current reporting requirements are: (1) Central-Line-Associated Bloodstream Infections (CLABSIs) in All Intensive Care Units; (2) Surgical Site Infections (SSIs) for coronary artery bypass graft (CABG), hip (HPRO), and knee (KPRO) surgeries, and (3) Health Care Worker (HCW) Influenza Vaccination. The expanded reporting requirements that took effect in FY 2014 are: (1) *Clostridium dificile* infections (CDI) in all inpatient locations (baby locations are excluded) (effective July 1, 2013), (2) Methicillin-resistant *Staphylocccus aureus* (MRSA) bacteremia in all inpatient locations (effective January 1, 2014), and (3) the expansion of Surgical Site Infections (SSIs) to include colon (COLO) and abdominal hysterectomy (HYST) surgeries. Of note, the Health Care Worker (HCW) Influenza Vaccination reporting requirement moved from using an in-house survey to the NHSN Health Care Personnel (HCP) Influenza Vaccination module with the 2013/2014 flu season.

In October 2010, the Commission first reported on CLABSIs for the 12-month period from July 1, 2009 through June 30, 2010. During that data period, Maryland acute care hospitals reported 424 CLABSIs in adult ICUs and 48 CLABSIs in Neonatal ICUs (NICUs). In January 2014, the CLABSI data was updated with fiscal year 2013 data. The updated data showed a 63% reduction in CLABSIs in Maryland adult/pediatric ICUs, with 152 CLABSIs. Maryland NICUs saw a 27% reduction in CLABSIs with 35 CLABSIs reported for fiscal year 2012. Based on a performance measure (the Standardized Infection Ratio or SIR) developed by the CDC, Maryland hospitals in total performed better than the national experience for CLABSIs in ICUs, meaning there were less CLABSIs reported than expected.

In January 2014, the surgical site infections data for Hip, Knee, and CABG procedures were updated on the Guide. An update to the HAI data in the new Guide is scheduled with the release of the Guide in November 2014.

In February 2014, the Annual Survey of Hospital Infection Prevention and Control Programs was sent to hospitals. Responses were collected and summarized into a draft report.

In FY 2014, HQI staff participated in a multi-state workgroup to standardize HAI data display for both technical and consumer audiences. Biweekly conference calls are held and representatives from CDC and CSTE facilitate the process. MHCC presented several HAI data displays to the consumer focus groups in collaboration with the workgroup. HQI staff also presented to the Maryland Hospital Association's statewide meeting entitled "Moving Forward with the Future of Infection Prevention" on October 2, 2013. The MHCC presentation highlighted the progress that has been made over the past five years in terms of increased data collection initiatives, reduced central line associated bloodstream infections in ICUs and increased hospital employee flu vaccination rates. The staff also reviewed the results of the Annual Survey of Hospital Infection

Prevention and Control Programs, highlighting the expanding roles and responsibilities of hospital Infection Preventionists.

HQI staff hosted a graduate student intern from Johns Hopkins University School of Public Health. The project focused on the current implementation of Antimicrobial Stewardship Programs in Maryland hospitals and at the national level.

HAI Data Validation Project

In 2009, the Commission initiated a procurement project to engage the services of a contractor with expertise and experience in the review of healthcare-associated infections data. The project included the on-site review of patient medical records to assess the accuracy of the hospital data submitted through NSHN. The validation project was completed in FY 2010 and the results were used to educate hospital data providers and to facilitate process improvement activities. The final report is available online at http://mhcc.dhmh.maryland.gov/hai/Documents/sp.mhcc.maryland.gov/healthcare_associated_infections/hai/clabsi_final_rpt_20100618.pdf.

In FY 2011, the Commission initiated the procurement process to establish a five year contract for ongoing validation of the accuracy of all healthcare associated infections data collected for public reporting on the Hospital Guide. The contract includes the provision of educational webinars and training for hospital infection prevention staff to facilitate accurate and complete data reporting. In FY 2014, the first on-site chart review of the surgical site infections data occurred. The results were reported to hospitals and a statewide educational webinar was conducted in May 2014.

Long Term Care Quality Initiative

Overview

Long Term Care Quality and Performance focuses on improving long-term and community-based care through public reporting of long term care (LTC) service provider descriptive information and performance on a variety of metrics. An interactive web-based consumer guide developed and maintained by staff is the platform for presenting a wide range of information about Maryland LTC service providers, including specific performance and quality measures applicable to each service category.

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

Description of Key Programs

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

Key features of the *Consumer Guide*:

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

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

Services Search - The *Consumer Guide's* interactive search tool assists users in locating LTC services by facility type and county. Users can view information about facility characteristics such as ownership information; agency accreditation or certification; number of beds or client capacity; clinical and assistance services available; and resident characteristics. Pictures of nursing homes and assisted living facilities, as well as a location map, are displayed to assist Marylanders in narrowing their choice without having to travel.

An analysis of MHCC website analytics for fiscal year 2013 showed over 305,000 LTC pages viewed and over 30,000 unique pages viewed. Information about assisted living and searches for assisted living residences were the most often viewed, followed by searches for nursing home and home health agency services. Within the MHCC site consumer information accounts for 92% of page views. Of the consumer pages viewed LTC topics account for 87% of consumer traffic on the site; the hospital guide has the next most frequently viewed topics at 11%.

Quality and Performance Reporting - Users can view an extensive set of quality and performance measures for nursing homes and Medicare certified home health agencies, as well as

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

Nursing Home Experience of Care Surveys

Staff in the Long Term Care Quality and Performance division design, develop, and provide oversight for the administration of surveys. The Family Experience of Care Survey (Family Survey) measures the experience and satisfaction with the nursing home's staff, care, and living environment from the perspective of a resident's family member or designated responsible party. The Short Stay Resident Experience of Care Survey (Short Stay Survey) contains similar measures and is completed by recently discharged nursing home residents with a short stay for rehabilitation or following an acute illness. The 2013 Family Survey results were posted in the consumer guide in June 2014. Short Stay Survey results was posted in the late fall of 2013.

Results of the Family Survey for each nursing home are displayed within the Consumer Guide to assist Marylanders when choosing a nursing home. The Family Survey results are also used by the Medicaid Long Term Care Division within the Department of Health & Mental Hygiene as one of four factors in calculating the Medicaid Nursing Home Pay for Performance Program.

Home Health Experience of Care Survey

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

Future Hospice Experience of Care Survey

CMS has announced expansion of hospice measures beginning in calendar year 2014. MHCC staff is closely following this process so the Consumer Guide can be expanded when new measures are available. A Hospice Experience of Care survey is planned by CMS for 2015.

Staff Influenza Vaccination Survey in LTC Settings

Influenza infection causes considerable morbidity and mortality among older adults. Persons aged 65 years and older account for the majority of the 36,000 deaths that occur from flu and its complications each year. MHCC staff assumed responsibility for collection of the number of nursing home staff receiving influenza vaccination during the 2009-2010 influenza season. Results are reported for each facility in the Consumer Guide to Long Term Care in order to assist

consumers and are used by the DHMH Medicaid Office of Long Term Care and Community Support as one of four measures in the Medicaid Nursing Home Pay for Performance Program. Additional survey questions also assess:

- Adoption of a mandatory influenza vaccination policy by nursing homes;
- Measures to raise awareness among staff of the importance of influenza vaccination;
- Strategies to ensure compliance with flu policy or to limit the spread of influenza; and
- Methods used to document staff influenza vaccination status

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

National Efforts

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

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

Accomplishments

Consumer Guide to Long Term Care –

Outreach – staff conducted informal feedback sessions with the directors of senior centers and senior center participants in several counties. A standard feedback form was used to solicit opinions about selected guide features. The informal feedback provided information to guide revisions as well as an opportunity to showcase the Guide features.

Structured feedback- Formal focus groups were held in May 2014 to solicit more expansive feedback on Guide features. Participants represented a mix of gender, age, race/ethnicity, counties of residence, use of LTC, education, and household income. Suggestions were offered in thirteen major areas; the functionality area contains a number of detailed, smaller suggestions. Changes to the Guide were prioritized with changes designed for implementation beginning in July 2014.

In addition to routine annual and quarterly updates of quality measures, the Consumer Guide was revised in several important ways:

- Implemented a new home page with improved graphics, rotating photos, text featuring the major section of the Guide, and easier navigation. Added facility-specific staffing and staff stability to the nursing home section.
    - The number of registered nurse (RN), licensed practical nurse (LPN), certified nursing assistant (CNA), and physical therapists (PT) expressed in hours and minutes are shown with a comparison to the statewide average.
    - Staffing stability is shown as the % of direct care staff employed in the nursing home for more than 2 years.
- Added private pay rates for each nursing home. These are shown as minimum and maximum price by bed type (private, semi-private, etc.).
- The CMS transition from Minimum Data Set (MDS) 2.0 to 3.0 resulted in revised specifications to nursing home resident characteristics. Staff thoroughly reviewed updated MDS definitions and procedures for calculating the characteristics and updated the resident characteristics.
- Staff conducted a thorough review of nursing homes providing ventilator care. Ventilator care is provided by only 10% of nursing homes in Maryland which can create challenges in finding a bed, particularly for residents in rural parts of the state. An up-to-date list is critical to provide accurate information.
- Updated the comparative function for Home Health Experience of Care survey (HHCAHPS) results.

Nursing Home Experience of Care Survey Results

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

Maryland Statewide results on the 2013 Short Stay Survey show an overall rating of 7.9 on a scale of 1-10; a slight increase from 7.8 in 2012. 83% of short stay respondents reported they would recommend the nursing home in 2013 versus 81% in 2012. The 2014 Short Stay survey results will be reported in the next annual report.

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

Influenza Vaccination Survey among Nursing Home Health Care Workers (HCWs)

The average vaccination rate for nursing home HCWs for the 2013-2014 influenza season was 79.3%, an increase of nearly 13% from the prior year and a 27% increase since public reporting began. Maryland nursing homes report a significantly higher rate than the national estimates reported by CDC for LTC health care workers, which was 63% in 2013-2014.

Division staff continued to encourage and assist nursing homes with their efforts to improve their vaccination rates. These efforts consisted of informational emails sent from September to March to all nursing homes with links to written materials, posters and tools that could be readily downloaded from the Centers for Disease Control (CDC) website. Division staff sent targeted emails to facilities with low vaccination rates offering specific suggestions for increasing rates, and

corporate rates were sent to corporate officers. The successful webinar arranged and sponsored by the Commission in 2012 entitled, *"Implementing Effective Strategies to Increase Influenza Vaccination Rates and Reduce Staff Resistance to Vaccination"* is available on the Commission website.

Public reporting of nursing home-specific results has been in place since 2011 as an incentive for facilities to improve their HCW vaccination rates. Additionally, HCW influenza vaccination results for nursing homes are part of the DHMH StateStat dashboard. The StateStat Goal is achievement of a 60% or greater HCW vaccination rate for every nursing home. For the 2013-2014 influenza season, 181 (79%) of Maryland nursing homes achieved the StateStat goal compared to the 2012-2013 influenza season when 70% of nursing homes achieved the goal. The Commission also implemented a recognition program for nursing homes. Recognition certificates are sent to nursing homes that achieve a HCW vaccination rate of 95% or better. The number of nursing homes achieving recognition increased from 37 for 2012-2013 flu season to 54 nursing homes in 2013-2014.

Implementation of a mandatory influenza vaccination policy by nursing homes increased in the 2013-2014 collection year: 31.3 % of nursing homes reported implementation of a mandatory employee influenza vaccination policy compared to 22.4% for the prior year; another 19.6% reported no current mandatory employee influenza vaccination policy, but plan to implement a policy for the 2014-2015 flu season.

Assisted Living Staff Influenza Vaccination Survey

The average assisted living staff vaccination rate for the 2013-2014 influenza season was 53.2% compared to 50.6% for the 2012-2013 season. Assisted living staff vaccination rates are compared to the general population rather than health care workers. The general population rate for the United States reported by CDC was 42.2%; the corresponding rate for Maryland residents was 47.6%.

Home Health Experience of Care

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

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

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

Hospice Quality Reporting

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

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

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

MARYLAND HEALTH CARE COMMISSION

Center for Health Care Facility Planning and Development

At the beginning of Fiscal Year 2014, a reorganization of the Maryland Health Care Commission was implemented to improve the functional relationship between staff with related responsibilities and better align the work of the Commission with priorities identified through the Commission's strategic planning.

Among the changes implemented, a new Center for Health Care Facility Planning and Development was created, pulling together Divisions and personnel from two previous Centers, Hospital Services and Long-Term Care Services, to create a single Center with full responsibility for all aspects of State Health Plan (SHP) development, Certificate of Need (CON) regulation, and any other policy and planning work relating to health care facilities.

The new Center has three Divisions; Acute Care Policy and Planning, Long-Term Care Policy and Planning, and Certificate of Need.

Acute Care Policy and Planning

Overview

The Acute Care Policy and Planning Division is responsible for health planning and policy analysis related to acute care services. This includes general hospital and short-stay special hospital services, ambulatory surgical facility services, residential treatment center services, and intermediate care facility/substance abuse treatment services. Planning for these services is supported by data collection. The Division administers two annual surveys and receives and maintains two service registry data sets created by national organizations. It undertakes special policy and planning studies as needed. The Division coordinates its acute care policy development and planning efforts with other appropriate state agencies and stakeholders, and provides leadership and direction to technical advisory committees and workgroups conducting analyses of applicable acute care facility service issues.

Accomplishments

State Health Plan

Inpatient Acute Rehabilitation Services

The Commission completed an update of the State Health Plan Chapter for inpatient acute rehabilitation services, COMAR 10.24.09, that became effective December 23, 2013. This update was comprehensive and fundamentally altered the Commission's approach to considering changes

in the configuration of this service, establishing, for the first time in Maryland, a need methodology based on the direction and rate of change observed in regional use rates for this service. On June 27, 2014, a bed need projection for acute rehabilitation services was published.

Cardiac Services

The Commission completed substantive work on a comprehensive update of the State Health Plan Chapter for cardiac surgery and percutaneous coronary intervention (PCI) in FY 2014. On September 30, 2013, Commission staff posted draft regulations for informal public comment that were intended to repeal and replace COMAR 10.24.17. These draft regulations represented a milestone in implementing major changes in regulatory oversight of cardiac surgery and PCI mandated by 2012 legislation and reflected input gathered from a Cardiac Advisory Group that met to provide advice on implementation of the law between the Fall of 2012 and the Spring of 2013. The new law uses program performance as a primary instrument of regulatory oversight and adds requirements for satisfactory on-going performance as a necessity for maintaining authorization to provide the services.

A second draft was developed based on comments received during the informal comment period and submitted to the Senate Finance Committee and the House Health and Government Operations Committee, as required by the 2012 legislation. Work on refining the regulations, based on legislator and hospital concerns, continued through the 2013 General Assembly Session. On April 17, 2014, the Commission approved proposed permanent regulations to repeal and replace COMAR 10.24.17. The Commission subsequently adopted final regulations that became effective August 18, 2014.

Organ Transplantation

An updated forecast of organ transplantation case volume for solid organ categories was published in the *Maryland Register* on March 7, 2014. This 2016 forecast, based on 2013 case volumes reported by the United Network for Organ Sharing, replaced a 2013 forecast. Staff also began planning for a comprehensive review and update of COMAR 10.24.15. Staff developed a White Paper on issues to be addressed in an update of the SHP chapter for organ transplant services.

Acute Care Hospital Bed Supply

MHCC also published updated acute care hospital bed need projections for medical/surgical/gynecological/addictions (MSGA) and pediatric beds in the March 7, 2014 issue of the *Maryland Register*. This update uses a base year of 2012 and forecasts a bed need range for 2022, based on five year and ten year trends observed in bed demand. Consistent with the broad general downturn in demand for hospital beds which began in 2008-2009, the minimum MSGA bed need range for 2022 is lower than that for the last iteration published, a 2018 forecast, in all 24 Maryland jurisdictions. The 2022 pediatric bed need forecast range is lower or unchanged, when compared to the 2018 forecast range, for every jurisdiction. Only three jurisdictions had a higher maximum bed need for 2022 as compared to the corresponding previous forecast for 2018.

Regulatory Activity

Waiver Program for Primary PCI

Thirteen hospitals that do not provide cardiac surgery provide primary, or emergency, PCI through a "waiver" program instituted by the Commission in 1996. The "waiver" allows these hospitals to provide primary PCI services without having on-site cardiac surgical backup. In FY 2014, the Commission reviewed and approved renewal of primary PCI waivers for Carroll Hospital Center, MedStar Southern Maryland Medical Center, Holy Cross Hospital, Howard County General Hospital, Johns Hopkins Bayview Medical Center, and St. Agnes Hospital. All received the maximum two-year renewals, indicating substantial compliance with minimum requirements for the provision of primary PCI. Under the new regulatory framework for cardiac services noted above, in the future, rather than obtaining a waiver renewal, hospitals performing PCI services without cardiac surgery on-site will need to periodically obtain a Certificate of Ongoing Performance.

Society of Thoracic Surgeons' (STS) National Database

The Commission published a notice in the *Maryland Register* on April 18, 2014, pursuant to Health-General § 19-134(e), Annotated Code of Maryland, COMAR 10.24.17, and COMAR 10.25.04, mandating enrollment of all Maryland hospitals authorized to provide cardiac surgery services in the STS National Database by June 30, 2014, submission of data to the STS Database for the period beginning January 1, 2014, and submission of the same data, on a quarterly basis, and select information from the STS Composite Quality Rating reports, to MHCC. Submission of this data is necessitated by the new regulatory oversight process for cardiac surgery. The data base will be used to evaluate program performance.

Reports

Regional Health Delivery and Health Planning in Rural Areas

In 2012, the Maryland General Assembly's Joint Chairmen's Report requested that the Commission convene a group of interested stakeholders to evaluate regional health delivery and health planning in rural areas. The evaluation considered the appropriateness of the current health planning region designations, the adequacy of the health care workforce in rural areas, barriers to accessing health care services caused by distance, adequacy of transportation to health care services, and the impact of recent hospital consolidation on the availability of services in rural areas. In December 2013, staff presented its report to the Commission with recommendations and transmitted the report to the relevant General Assembly committees.

Hospital Bed Inventory

Each year, the Commission collaborates with the Department of Health and Mental Hygiene's Office of Health Care Quality in the process of updating the licensed acute care bed capacity of Maryland's general hospitals. Acute care 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 among up to four

defined service categories, corresponding to the inpatient services that the hospital is authorized to provide. The bed categories are MSGA, obstetric, pediatric and acute psychiatric.

In May of each year, staff sends to hospitals licensure application forms with the new bed licensure numbers for the coming fiscal year. Hospitals are also asked to provide information on changes in the capacity and utilization of other inpatient services, such as emergency department treatment spaces, obstetric and perinatal services, surgical capacity, psychiatric treatment capacity, and other specialized capacity and services. A report titled *Update: Licensed Acute Care Hospital Beds, Fiscal Year 2014,* was published on the MHCC web site in the Summer of 2013. This preliminary report was replaced later in 2013 with the full *Annual Report on Selected Maryland Acute Care and Special Hospital Services* for FY 2014.

Maryland Ambulatory Surgery Provider Directory

The sixteenth edition of the Commission's *Maryland Ambulatory Surgery Provider Directory*, was published on the MHCC website on March 25, 2014. It provides information for CY 2012 on 329 freestanding centers providing outpatient surgery and on outpatient surgery at the 46 general acute care hospitals operating in 2012. The Directory includes utilization data, surgical specialties, and contact information.

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

Study of the Impact of Rate Setting for Freestanding Medical Facilities

Staff began coordinating with the Health Services Cost Review Commission (HSCRC) staff to plan for development of this study, scheduled for completion by the end of 2014. Freestanding medical facilities are hospital-sponsored centers for the provision of emergency health care services that are not located on the affiliate hospital's campus and are separately licensed from their affiliate hospitals. This facility category was created in Maryland law in 2005 and two pilot facilities have been authorized for development and operation in Maryland. The study will include analyses useful for developing Certificate of Need regulations for these facilities.

Policy Coordination with Other Agencies and Stakeholders

Throughout FY 2014, staff participated in selected meetings of the following agencies, or groups convened by these agencies to assure appropriate coordination and collaboration on policy and regulatory matters: groups of legislators, individual legislators, the Health Services Cost Review Commission, the Office of Health Care Quality of the Department of Health and Mental Hygiene, the Maryland Institute for Emergency Medical Services and Systems, the Maryland Department of Planning, and other units of DHMH. In FY 2014, this included serving on the Maryland Perinatal Advisory Committee, as it worked to review changes in the State's Perinatal Systems Standards in light of a 2012 update of the American Academy of Pediatrics *Guidelines on Perinatal Care.*

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

Long Term Care Policy and Planning

Overview

The Long Term Care Policy and Planning Division is responsible for health planning and policy analysis related to community-based and institutional long term care and post-acute care services. This includes comprehensive care facility, or nursing home, services, home health services, hospice services, and special hospital-chronic services. Planning for these services is supported by data collection. The Division administers three annual surveys and undertakes special studies as needed. The Division coordinates its long term care policy development and planning efforts with other appropriate state agencies and stakeholders, and provides leadership and direction to technical advisory committees and workgroups conducting analyses of long-term care facility and service issues.

Accomplishments

State Health Plan

Hospice Services

The Commission completed an update of the State Health Plan Chapter for hospice services, COMAR 10.24.13, that became effective October 14, 2013. (Prior to this update, hospice services were addressed as one of three services in COMAR 10.24.08.) This update had a long developmental process, extending over two years, including two informal public comment periods and one formal public comment period, and included substantial policy changes with respect to needs assessment, establishing a need methodology that targets opportunities for new program development or existing program expansion in jurisdictions that lag behind the State and nation in their populations' use of hospice services.

Hospice Education and Outreach

Because of concerns raised by legislators and the industry with this new approach, use of the new Hospice Plan's need projections in establishing opportunities for new program development or existing program expansion will be delayed until 2016. Additionally, MHCC is facilitating efforts by hospices and others in Baltimore City and Prince George's County, two large jurisdictions with relatively low hospice use rates, to educate the public and providers about the benefits of hospice care and to more effectively reach the African-American population in these jurisdictions with the objective of improving the receptivity of this community to hospice services. These efforts will build on a series of meetings that spanned the period from April to September, 2013, prior to adoption of the new SHP chapter, at which hospices and other interested persons from throughout the state were invited to share their ideas on effective community education and outreach. The new education and outreach initiative, focused on Baltimore City and Prince George's County, got underway in June, 2014, with a meeting of hospice providers in the latter jurisdiction. This meeting and another that followed in July in Baltimore were used to plan larger "Workgroup"

meetings in both jurisdictions in the Fall of 2014, bringing together a wider array of participants, including state legislators.

Nursing Home Bed Occupancy and Payor Mix

MHCC published 2012 comprehensive care facility (CCF) bed occupancy rate information in the *Maryland Register* on February 21, 2014. These rates are used in assessing the need for proposed additions to CCF bed additions to jurisdictional bed inventories as part of the review of CON applications. At the same time, updated information on CCF payor mix was published. This information is used to establish required Maryland Medical Assistance (Medicaid) participation rates for CON applicants proposing to establish or expand CCF bed capacity.

Chronic Hospital Bed Occupancy

As required by the SHP, MHCC published information on FY 2012 special hospital-chronic bed occupancy in the Maryland Register on December 13, 2013. It reports data for both private chronic hospitals (James Lawrence Kernan Hospital; Johns Hopkins Bayview Medical Center; Levindale Hebrew Geriatric Center and Hospital; University Specialty Hospital; and Laurel Regional Hospital) as well as state hospitals (Western Maryland Center and Deer's Head).

Reports

Hospital Palliative Care Programs

On October 1, 2013, legislation passed in the 2012 legislative session became effective. It required the Maryland Health Care Commission to select at least five hospital palliative care pilot programs and, in conjunction with the Maryland Hospital Association (MHA) and the Office of Health Care Quality, establish reporting requirements for the pilot sites and develop a report on certain aspects of and best practices for hospital palliative care. The Division of Long-Term Care Policy and Planning is leading this work because of its policy and planning responsibilities in hospice care, services that are often part of the palliative care continuum.

After working with MHA staff, criteria were established for use in a Request for Applications (RFA) sent to all hospitals with 50 or more beds (a statutory requirement for pilot hospitals) on October 18, 2013. From among 14 pilot hospital applicants, ten pilot programs were approved for participation in the study (an 11th was added in the Spring of 2014), and between December, 2013 and April, 2014, meetings with this pilot hospital group and others chosen to serve as a Study Advisory Group, and with committees of this group, were convened to design the study. A data set developed by the Center for the Advancement of Palliative Care (CAPC) will be used for baseline information on the hospital program characteristics and an agreement between CAPC and the pilot hospitals allowing MHCC to access the data was established. A patient level data set will be created for the 12-month period ending June 30, 2015, using the HSCRC discharge data base, that will allow for comparative analysis of the in-hospital experience of patients receiving a palliative care consult, discriminating between those that accept inclusion of palliative care measures in their plan of care and those that do not. Additional study work will examine minimum program standards and best practices, ways in which to examine outpatient service delivery and use by palliative care patients and ways in which to measure patient and physician experience and satisfaction with palliative care services.

During June 2014, agreements were developed between palliative care staff and HSCRC case mix representatives to flag palliative care patients in the HSCRC database starting July 1, 2014. Data collection began July 1st.

Data

Long Term Care Data Sets

CMS Nursing Home Minimum Data Set (MDS)
FY 2014 was the third year of a four-year contract with Myers and Stauffer to update the MDS Manager Program, which had been developed between 2009 and 2011 to maximize the utility of the Center for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) Resident Assessment Instrument. This nursing home data set supports planning and policy development and related research necessary for MHCC to fulfill its responsibilities. Prior to FY 2014, federally mandated changes from MDS 2.0 to 3.0 were addressed by the Manager Program and the programming language was updated to SAS, the statistical analysis platform used at the Commission. During FY 2014, the MDS Manager Program was updated, work has been done on programming needed to support the Consumer Guide for Long Term Care, and work is underway on programming to support the MHCC Long Term Care Survey. In addition, staff worked with staff of the Office of Health Care Quality to send out a joint letter to nursing homes to assure that Section S of the Long-Term Survey (state-specific items) is fully completed. The Section S items include demographic and payer source data, which are no longer collected under MDS.

Long-Term Care Set (Comprehensive Care Facility, Assisted Living, Special Hospital-Chronic, and Adult Day Care Services)
The public use data sets for FY 2012 for the four facility categories covered by the Commission's annual Maryland Long-Term Care Survey were completed and made available on the Commission's web site in February, 2014. This data set is used to update the Commission's on-line Consumer Guide to Long-Term Care and provides basic information needed in CON regulation of capital projects by CCFs and Special Hospitals-Chronic.

2013 Long Term Care Survey data collection began on March 31, 2014 for all facility providers and ended on May 29, 2014 for Chronic Care, Assisted Living and Adult Day Care Centers. This survey incorporates the User Fee Assessment for this facility group and is also being used to gain information on use of health information technology and electronic health records by the surveyed facilities.

Home Health Agency Data Set
Staff compiled data tables on the utilization and financing of home health agency services in Maryland for fiscal year 2012. The data was obtained from the information collected by the Commission's Home Health Agency Survey for fiscal year 2012 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 2012 were posted on the Commission's website in April 2014. Included are an overview of home health agency characteristics, utilization, and costs, including: volume of admissions; referral sources; primary diagnosis on admission; average visits per Medicare client; disposition;

revenues by payer type; and home health agency personnel. Data tables are available for fiscal years 2004 - 2012. Public use data sets are also available for fiscal years 2007- 2012.

The fiscal year 2013 Home Health Agency Survey data collection period began on April 14, 2014 and ended on June 11, 2014.

Hospice Data Set

Preparation of the public use hospice data set for FY 2012 was primarily completed in FY 2014 and has now been completed and posted on the Commission's website. This data was obtained from the Commission's annual Maryland Hospice Survey, an online survey instrument. The FY 2013 Hospice Survey, with a data collection period spanning March 12, 2014 to June 11, 2014, included changes intended to provide a fuller picture of inpatient hospice service delivery in Maryland.

Policy Coordination with Other Agencies and Stakeholders

DHMH 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.

Meetings/Conferences

Division staff attended the Home Health Information Technology (IT) Summit "Crossing the Quality Chasm" organized by the Health IT Lab at University of Maryland – Baltimore County (UMBC) on May 1, 2014. Initial findings of UMBC's research on "Effective and Efficient Health IT Adoption in Home Care" were shared with the attendees. Unique characteristics of home care and some of the challenges in adoption of IT were presented and discussed. Division staff also attended the 2014 Leadership Summit: *The Role of Post-Acute Partnerships in Reducing Hospital Readmissions,* sponsored by the Maryland National Capital Homecare Association (MNCHA) and LifeSpan in May, 2014. The Summit was attended by Maryland hospitals, as well as a variety of post-acute care providers including, but not limited to: home health agencies; residential service agencies; skilled nursing facilities; assisted living facilities; retirement communities and medical adult day care centers. The presentations and discussion focused on the potential for the new hospital payment system to create new incentives for acute care hospitals to foster new and different partnerships with post-acute care providers; strategies for implementing such partnerships; the future of acute/post-acute partnerships beyond the metric of admissions and closely-following readmissions, regional networking solutions and successful approaches to reduction of hospital readmission rates.

Certificate of Need (CON)

Overview

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

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

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

Accomplishments

Certificate of Need Applications and Modifications

During FY 2014, the Commission approved six (6) CON applications. No applications were denied. It also reviewed and approved two (2) modifications to previously approved projects. One issued CON was relinquished by the holders; one issued CON was voided by the Commission for failure to comply with performance requirements; and two (2) were withdrawn by the applicants.

Three major general hospital CON applications were filed in FY 2014, two replacement hospitals and a major renovation and expansion project. All three were unable to achieve docketing in FY 2014, an unusual circumstance caused by implementation of a new hospital payment model by HSCRC halfway through the fiscal year, in January, 2014. The new payment model for general hospitals required the applicant hospitals to revise the financial projections made in their applications to align with the Global Budget Agreements negotiated with HSCRC. These agreements were not in place and/or the applicant hospitals had not yet filed revised application financial projections by the end of FY 2014. It is anticipated that modified versions of each of these applications will be docketed and brought to the Commission for action in FY 2015. Two other hospital applications filed and docketed in FY 2013 could not proceed to conclusion of the review for the same reason. One asked for active review of its application to be placed on hiatus and is still in that status, without filing updated and revised financial projections. The other has

filed material to reactivate its project review and it is anticipated that the project will be docketed and considered in FY 2015, the current fiscal year.

Approved CONs

Seasons Hospice & Palliative Care of Maryland, Inc. (Baltimore County)
Authorization to operate a 16-bed general inpatient ("GIP") hospice unit in 9,600 square feet of leased space on the campus of MedStar Franklin Square Medical Center, located at 8000 Franklin Square Drive, in Baltimore County. *Approved with a condition at a cost of $621,197.*

Father Martin's Ashley (Harford County)
Construction of a new 2-story building to house 2 inpatient units, replacing 21 beds and adding 15 beds, increasing the facility's total capacity to 100 beds, consolidate and relocate the Admissions Department and Patient Intake functions in new building space, establish a permanent location for the Wellness/Fitness Center in the new building, and expand and consolidate other administrative and support spaces. *Approved with conditions at cost of $18,653,000.*

Cosmetic SurgiCenter of Maryland, Inc. d/b/a Bellona Surgery Center (Baltimore County)
Relocation of the existing ambulatory surgery center from 8322 Bellona Avenue, Towson to a new site at 1427 Clarkview Road, Baltimore, and the addition of one sterile operating room and one non-sterile procedure room. *Approved at a cost of $890,500.*

Lorien Bel Air (Harford County)
Construct a new addition to house 21 additional CCF beds for a total of 90 CCF beds at the facility and a 2-unit expansion of the assisted living facility located at 1909 Emmorton Road, Bel Air. *Approved with a condition at a cost of $6,548,938.*

Prince George's Post Acute, LLC (Prince George's County) Establishment of a 150-bed comprehensive care facility (CCF) on Brightseat Road in Landover. *Approved with a condition at a cost of $19,070,505.*

Capital Caring - (Prince George's County)
Creation of a seven-bed inpatient hospice unit at the Residence on Greenbelt, an assisted living facility, in Lanham. *Approved at a cost of $458,343.*

Changes in Approved CONs

Seasons Hospice & Palliative Care of Maryland (Baltimore County)
Increase in the approved expenditure for the addition of beds by Seasons Hospice & Palliative Care through the development of a 16-bed inpatient hospice unit in leased space on the campus of MedStar Franklin Square Medical Center in the Rosedale area of Baltimore County.
Change in Cost: $454,014
New Approved Cost: $1,075,211

Mercy Medical Center, Inc. (Baltimore City)
An increase in the approved cost of the project, which expands and replaces surgical facilities.

Change in Cost: $1,851,835
New Approved Cost: $25,381,424

Determinations of Coverage and Other Actions

In FY 2014, the Commission issued 124 determinations involving actions proposed by persons or health care facilities requiring a decision with respect to the need for CON review or other Commission authorization. These actions were made in accordance with statutory and regulatory provisions outlining: (1) the scope of CON coverage; (2) the types of projects or actions that, while similar in their general nature to projects that require CON review and approval, can be implemented outside of the CON regulatory process; and (3) the notification requirements and attestations which must be met to obtain the Commission's determination that CON is not required. These determinations are profiled in the following table. Chief among these types of determinations are those involving establishment of outpatient surgical centers with fewer than two sterile operating rooms, acquisitions of health care facilities, temporary delicensure of beds (for up to one year), and small increases in the bed capacity of facilities ("waiver" beds), primarily nursing homes, which are allowed increases of 10% of bed capacity or ten beds, whichever is less, every two years so long as the facility maintains operation of all of its bed capacity without changes during that period of time.

Additionally, the Commission reviewed 2 requests by holders of CONs to implement their projects or parts of their approved projects ("first use review"). The Commission acknowledged eleven cases in which facilities with temporarily delicensed beds did not take timely action to bring these beds back into operation or to extend temporary delicensure status, thus eliminating these beds from the state's inventory. In FY 2014, all these permanently delicensed beds (196) were CCF beds.

Determinations of Coverage and Other Actions – FY 2014

NATURE OF DETERMINATION/ACTION	
Capital projects with costs below the threshold of reviewability	10
Acquisition of health care facilities Comprehensive-care facilities (nursing home): 20 Ambulatory surgery centers: 7 Home health agencies: 1 Hospitals: 2	30
Establishment of new ambulatory surgery centers (no more than one sterile operating room) Baltimore County (2), Anne Arundel (1), Frederick (2), Howard (1), Prince George's (1), Carroll (1), and Queen Anne's (1)	9
Changes in ambulatory surgery center facilities or operation (e.g., addition of non-sterile procedure rooms, surgical staff, surgical specialties, ownership structure)	7
Relocation of ambulatory surgery centers	5
Temporary delicensure of CCF beds (295 total beds)	21
Relicensure of temporarily delicensed CCF beds (146 total beds)	16
Add "waiver" beds* Comprehensive care facilities-6 (40 total beds)	6
Miscellaneous	3
TOTAL COVERAGE DETERMINATIONS	124
Pre-licensure and/or first use approval for completed CON projects (including partial)	3
Permanent delicensure of beds Comprehensive care facilities: 11 for a total of 196 beds	11
Closure of facility (ambulatory surgery center)	2

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

MARYLAND HEALTH CAR COMMISSION

The Center for Health Information Technology and Innovative Care Delivery

Overview

The Maryland Health Care Commission's (MHCC's) Center for Health Information Technology and Innovative Care Delivery (Center) is responsible for enhancing the adoption of health information technology (health IT) in the State to improve quality and safety in patient care. The use of health IT enables digital access to clinical information at the point of care with the goal of improving the quality of health care delivery and reducing health system costs. Key aspects of health IT include electronic health records (EHRs), health information exchange (HIE), and telehealth. The Center's initiatives focus on balancing the need for information sharing with the need for strong privacy and security policies. The Center has an ambitious plan for advancing health IT that includes:

- Identifying and addressing challenges around health IT implementation and interoperability;
- Promoting standards-based health IT through educational and outreach activities;
- Implementing a statewide HIE and harmonizing local area HIE efforts;
- Designating management service organizations (MSOs) to promote health IT diffusion and optimization;
- Supporting new models of care delivery and payment;
- Implementing an innovative pilot program for a patient centered medical home model in Maryland; and
- Promoting electronic data interchange between payors and providers, and certifying electronic health networks that accept electronic health care transactions originating in the State.

Health Information Technology Division

The Health IT Division is tasked with increasing the diffusion of health IT in Maryland by working in collaboration with stakeholders. Activities include assessing the adoption, implementation and optimization of health IT and its impact on clinical workflows among health care providers. The Health IT Division leads the Center's telehealth initiatives and oversees the implementation of electronic preauthorization. In addition, the Health IT Division is responsible for implementing a web-based advance directives registry, managing the Center's health IT initiatives in long term care, granting State Designation to MSOs, and monitoring the uptake of electronic data interchange (EDI).

Health Information Exchange Division

The HIE Division is tasked with facilitating the development of an interoperable system for the sharing of electronic health information and is responsible for monitoring the activities of and advancing the State-Designated HIE: the Chesapeake Regional Information System for our Patients (CRISP). In collaboration with stakeholders, the HIE Division also identifies strategies to advance community based HIE by working with regional HIEs and hospitals. The HIE Division develops privacy and security policies for protecting electronic health information to ensure compliance among entities impacted by current HIE regulations. The HIE Division leads the Center's HIE initiatives aimed at quality improvement and public health and certifies electronic health networks (EHNs). The HIE Division is responsible for establishing programs to increase the diffusion of EHRs, meaningful use of EHRs and oversees the implementation of the State-Regulated Payor EHR adoption incentive program.

Accomplishments

Electronic Data Interchange & Electronic Health Networks

EDI has been utilized by the health care industry for more than 30 years, enabling organizations to exchange information in a standardized electronic format. COMAR 10.25.09, *Requirements for Payors to Designate Electronic Health Networks*, requires State-regulated payors and select specialty payors (payors) whose premium volume exceeds $1 million annually to report to MHCC health care claims transaction data by June 30th each year. Approximately 39 payors were required to submit an EDI progress report this year; aggregate data is included in an information brief. In general, EDI activity among payors in Maryland has nearly doubled from roughly 48 percent in 1998 to about 92 percent in 2013.

EHNs exchange electronic health care transactions between other EHNs, payors, providers, vendors, or entities. COMAR 10.25.07, *Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouses*, requires third party payors that accept electronic health care transactions originating in Maryland to accept electronic health care transactions only from MHCC certified EHNs. EHNs must provide evidence that they achieve national accreditation and meet standards related to privacy and confidentiality, business practices, physical and human resources, technical performance, and security to achieve certification. Certification is valid for a two-year period from the date MHCC grants the certification. As of June 30, 2014, MHCC has maintained certification of approximately 40 ENHs operating in Maryland.

EHR Product Portfolio

The EHR Product Portfolio (portfolio), first introduced in 2008, is a free online resource for the public to compare and evaluate various ambulatory EHR products. Vendor participation is voluntary, and all EHR products must be nationally certified and offer a discount to Maryland providers. Information on product functionality, pricing, and usability ratings identified by EHR product users are showcased in the portfolio. Updates occur semi-annually in the Fall and Spring. The latest update included 10 ambulatory EHR products and added information for the first time on two long-term and post-acute care EHR products. The Center is exploring new ways to present the portfolio in an effort to enhance its usefulness as a resource to the health care community.

Hospital Health IT Survey

The Center released its annual *Health Information Technology, An Assessment of Maryland Hospitals* report highlighting health IT adoption trends among all 46 acute care hospitals in the State. The assessment benchmarks Maryland hospital health IT adoption against national adoption rates for the following technologies: EHRs, electronic prescribing (e-prescribing), computerized physician order entry, clinical decision support, electronic medication administration records, barcode medication administration, infection surveillance software, HIE, telehealth, and patient portals. Hospital participation in the Centers for Medicare & Medicaid Services (CMS) EHR Incentive Programs is also highlighted. Findings are used to assess opportunities for increasing the adoption and implementation of health IT in the State. Findings from the 2013 survey reveal that about 96 percent of Maryland hospitals have adopted an EHR; the remaining two hospitals indicated plans to implement an EHR by the end of 2014. In general, Maryland continues to meet or exceed most national hospital adoption rates in all but one area, e-prescribing; 17 hospitals indicated plans to implement e-prescribing in 2014.

Management Service Organizations

Md. Code Ann., Health-Gen. § 19-143 (2009), requires MHCC to designate one or more MSOs that provide hosted EHR solutions. There are ten State Designated MSOs that offer assistance to providers in the areas of EHR planning, implementation, staff training, technical support, and becoming advanced EHR users. MSOs also manage the privacy and security of electronic health information and provide education to support providers in achieving meaningful use under the CMS EHR Incentive Programs. Typically, MSOs offer services on a monthly subscription basis, and may be able to provide multiple EHR products at reduced costs through economies of scale and bulk purchasing.

COMAR 10.25.15, *Management Services Organizations–State Designation,* details the requirements for an MSO to obtain voluntary State-Designation. During the year, MHCC worked with the MSO Advisory Panel (panel) to revise program requirements for MSOs that seek State Designation. The revisions aim to ensure that MSOs are well positioned to offer health IT services to assist providers in achieving practice transformation under health care reform. The new MSO State Designation requirements include flexibility in demonstrating compliance with federal and State privacy and security laws through either national accreditation or an independent third-party assessment. The revised program became effective on April 3, 2014. MSOs have one year to demonstrate compliance with the new requirements.

State-Regulated Payor Electronic Health Record Incentives

Md. Code Ann., Health-Gen. § 19-143 (2009), aims to expand the adoption of health IT by requiring payors to offer incentives to providers who use certified EHR technology. At the request of leadership from the Maryland House Health & Government Operations Committee and in coordination with stakeholders, MHCC released a report evaluating the State-Regulated Payor EHR Incentive Program (program) to determine if changes are necessary to ensure that the intent of the law is met. The report concluded that the program had not spurred the level of EHR adoption and use initially envisioned and that the following enhancements were necessary: 1) align the program requirements with the CMS EHR Incentive program; 2) simplify the administration of the program application and payment process; 3) clarify the definition of a primary care physician practice eligible for an incentive payment; 4) extend the sunset date by two years to December 31, 2016; and 5) assess the impact of the program in 2015.

The Center proposed regulatory changes to implement the recommended enhancements, which went into effect on June 9, 2014. Under the revised regulations, primary care practices may receive an incentive of up to $15,000 if they attest to meaningful use or participate in any MHCC-approved patient centered medical home (PCMH) program that has achieved PCMH level two recognition from the National Committee for Quality Assurance (NCQA). Primary care practices could begin to request incentive payments under the new provisions of the State Incentive Program beginning October 7, 2014.

Electronic Health Records – Meaningful Use Acceleration

The CMS EHR Incentive Program (federal incentive programs) offers eligible providers (EPs) up to $44K from Medicare or $63K from Medicaid for the adoption and meaningful use of certified EHRs. EPs must meet certain requirements demonstrating their meaningful use of an EHR to receive incentive payments. As of June 2013, approximately 37 percent of Maryland EPs had achieved meaningful use and received a federal incentive payment. In collaboration with DHMH, CRISP, The Maryland State Medical Society, MedChi, and hospitals, the Center has implemented four strategies. The strategies aim to increase participation in the federal incentive programs and accelerate the achievement of meaningful use. These strategies, identified in September 2013 in coordination with stakeholders, include: 1) conduct semiannual meaningful use registration and attestation webinars; 2) engage hospitals in meaningful use outreach and education activities with community providers; 3) develop a web-based meaningful use resource center to include general meaningful use information and Maryland Medicaid state-specific information; and 4) establish a federal incentive program's single-point-of-contact to triage and address meaningful use inquiries. Over the last nine months, the Center has hosted two webinars, launched the meaningful use resource center and single-point-of contact help line, and provided technical support to hospital liaisons. The Center plans to continue implementing the aforementioned strategies over an additional nine month timeframe before evaluating the impact of the strategies on provider participation in the federal incentive programs.

Telehealth

The Center reconvened the Telemedicine Task Force (Task Force) to study the use of telehealth throughout the State and identify opportunities for telehealth expansion. Senate Bill 776, *Telemedicine Task Force – Maryland Health Care Commission* (SB 776), signed into law on May 2, 2013, required MHCC, in collaboration with the Maryland Health Quality and Cost Council, to reconvene the 2010 Telemedicine Task Force. The Task Force is comprised of three advisory groups: Clinical, Finance and Business Model, and Technology Solutions and Standards. Collectively, the Task Force advisory groups met approximately 28 times between July 2013 and June 2014. About 90 individuals, representing roughly 65 organizations from both private and public sectors, participated in the Task Force meetings.

The Task Force developed recommendations for expanding telehealth adoption in the State. The Clinical Advisory Group recommended ten telehealth use cases for implementation in pilot projects. The use cases aim to demonstrate how telehealth technology can be used in care delivery to improve patient outcomes and reduce costs, with an emphasis on vulnerable populations. The Finance and Business Model Advisory Group identified financial and business challenges of implementing the use cases and recommended that organizations develop solutions unique to their patient populations in implementing the use cases. The Technology Solutions and

Standards Advisory Group recommended the development of a telehealth provider directory, a publically available listing of telehealth practitioners that would be made available online through the State-Designated HIE. The Task Force also recommended transitioning from using the term *telemedicine* to *telehealth* as a way of encompassing a broader scope of health care delivery; the following definition for *telehealth* was proposed*: the delivery of health education and services using telecommunications and related technologies in coordination with a health care practitioner*.

An interim report on the work of the Task Force was submitted to the Governor, Senate Finance Committee, and the House Health and Government Operations Committee in December 2013; a final report is due by December 1, 2014. The final report includes a funding request for the General Assembly to provide $2.5 million to assist with the implementation of select telehealth use cases; a portion of the funding would also be used to implement the telehealth provider directory. Funding appropriated by the General Assembly would enable MHCC to award telehealth pilot project grants under its grants-making authority.

Health Information Exchange

MHCC continues to provide guidance to the State Designated HIE, CRISP. As required by law, MHCC and the Health Services Cost Review Commission (HSCRC) designated CRISP in 2009 to build and maintain the technical infrastructure to support and enable the statewide exchange of electronic health information. The State Designated HIE facilitates the secure exchange of health information between Maryland's health care organizations, providers, and public health agencies in accordance with industry recognized best practices and standards. A financial and security audit of CRISP is conducted on an annual basis; CliftonLarsonAllen LLP (CLA) was competitively selected to conduct both audits this year. The financial audit assesses the accounting practices of CRISP, including their management of certain programs funded by federal grants that are required to be audited annually. The security audit evaluates the extent to which CRISP and its vendors process, transmit, and store electronic patient data in a secure manner.

Currently in its sixth year of operation, CRISP continues to make progress towards building a robust statewide HIE. Participants in Maryland that submit clinical information to CRISP include all 46 general acute care hospitals, 2 specialty hospitals, 40 long-term care facilities, eight radiology facilities, and three laboratories. Additionally, CRISP has recently expanded to offer interstate connectivity to certain hospitals and providers in the District of Columbia and Delaware. Information made available through CRISP is accessible for query through an Internet-based portal. As of June 2014, there were about 258 health care organizations using the Query Portal, and the average number of portal queries in 2014 was roughly 36,000 per month. The State-Designated HIE also offers real-time notification alerts to providers when one of their patients has an encounter at a participating hospital—the Encounter Notification Service (ENS). As of June 2014, about 108 organizations were receiving ENS alerts, which are generally used to help coordinate care and facilitate post-acute care follow up. During the last quarter of 2013, CRISP launched services under the Maryland Prescription Drug Monitoring Program (PDMP), where all Schedule II-V drugs prescribed at any Maryland pharmacy are made available to providers through the Query Portal. Approximately 3,500 prescribers, pharmacists and delegates utilized this service as of June 2014.

Advance Directives Registry

The Center released a Request for Proposal (RFP) in December 2013 to identify a vendor to develop and implement an integrated electronic advance directives registry (registry) with the State-Designated HIE, CRISP. The contract was awarded to AdVault, Inc. (dba MyDirectives) through a competitive bidding process. MyDirectives is an established web-based registry that allows consumers to create, update, and share their advance directive electronically. Work to integrate the registry with CRISP commenced in February 2014; the registry subsequently went live with CRISP in July 2014. The registry's integration with CRISP enables authorized health care practitioners to search for patients' electronic advance directives at the point of care using the Query Portal, making advance directives more widely available. The Center is also exploring opportunities to build awareness and use of the advance directive registry.

An environmental scan conducted by the Center earlier this year indicated that while several states have established registries containing advance directives, these registries rely mostly on paper-based processes. Maryland is one of the first states to implement an online registry that is connected to a State-Designated HIE. The Center is exploring opportunities to also make the Maryland Medical Orders for Life-Sustaining Treatment (MOLST) form electronically available through CRISP. The MOLST form is standardized and different from an advance directive in that it is created and maintained by a health care practitioner. Maryland law requires that a MOLST form be completed and accompany a patient during certain transitions of care.

Regional Hospital Meetings

Two regional meetings were convened with hospital Chief Information Officers (CIOs) during the year. In general, discussions focused on defining strategies to enhance the clinical data made available by hospitals to CRISP and optimal utilization of CRISP HIE services. In particular, CRISP informed hospitals regarding use of its services to assist them in achieving the Meaningful Use Stage 2 transitions of care measure. This measure requires eligible hospitals to provide a summary of care record for a certain proportion of patients transitioned to another care setting or provider of care. In addition, discussions also centered on ambulatory connectivity strategies as value-based care delivery models continue to emerge. The Center plans to convene meetings with hospitals CIOs again prior to the end of the year.

Long Term Care

The MHCC, in collaboration with CRISP, implemented an *Independent Nursing Home Health Information Technology Grant Program* (grant program) between May 2013 and March 2014. The grant program was developed under a $1.6M Challenge Grant awarded to MHCC in 2011 from the Office of the National Coordinator for Health Information Technology. Under the grant program, three independent comprehensive care facilities (CCFs) were awarded competitive grants to support the adoption and use of HIE with the goal of improving care coordination between CCFs and local hospitals. Approximately $440K was awarded to: Berlin Nursing and Rehabilitation Center (BNRC), Ingleside at King Farm (IKF), and Lions Center for Rehabilitation and Extended Care (Lions) in partnership with Egle Nursing and Rehab Center (Egle). Each CCF worked with a State Designated MSO to assist them in their adoption and implementation of CRISP HIE services, including ENS and the Query Portal. ENS coupled with the Query Portal allows CCF staff to access

other available clinical information about their residents, such as laboratory results and radiology reports. Electronic access to residents' health information enabled CCF staff to more efficiently manage residents' transitions of care, including preparing for a resident's return to the CCF, reconciling medication lists, making treatment decisions, and avoiding duplicate testing.

The Center conducted an annual long term care survey (survey), collecting data on health IT adoption among Maryland's 233 CCFs. Specifically, the survey assessed CCFs' adoption of EHRs and HIE needs. Preliminary survey results indicate an increase in CCFs' EHR adoption from around 58 percent in 2013 to about 72 percent in 2014. EHR adoption rates were found to be similar across chain and non-chain facilities. CCFs indicated their greatest HIE needs include the ability to electronically exchange data with hospitals, pharmacies, and laboratories. Results from the survey will be used to develop strategies for enhancing health IT adoption and use among CCFs in Maryland.

HIE Policy

Maryland law requires MHCC to adopt regulations for the privacy and security of protected health information obtained and released through an HIE. The MHCC convened the HIE Policy Board (Board), a staff advisory group, to develop policy recommendations for the private and secure exchange of health information through HIEs. Staff considers the Board recommendations in drafting the regulations. MHCC adopted proposed regulations in October 2013; COMAR 10.25.18, *Health Information Exchanges: Privacy and Security of Protected Health Information* (regulation) became effective on March 17, 2014. The Center identified eight organizations that are required to comply with the regulations, which includes registering as an HIE annually. Staff launched an HIE registration and renewal website to provide instructions to those organizations that must register as an HIE in Maryland. Several meetings with the Board were held during the year. Board members discussed potential policies related to the release of secondary data from HIEs and finalized a policy specifically related to entities use of secondary data in support of population care management under new models of health care reform.

Regional Extension Center Program

In 2010, CRISP received approximately $6.8M from ONC to implement Maryland's Regional Extension Center (REC). The REC partners with State-Designated MSOs to provide direct assistance to primary care physicians in selecting, implementing and meaningfully using EHRs. The REC is tasked with enrolling at least 1,000 primary care providers into the program and achieving performance milestones regarding EHR adoption and meaningful use. As of June 2014, the REC had enrolled about 1,850 primary care providers; approximately 960 of those providers had achieved meaningful use as defined by the Office of the National Coordinator at HHS.

Electronic Preauthorization

Md. Code Ann., Health-Gen. 19-108.2 established three benchmarks which aim to create administrative efficiencies in the preauthorization process by eliminating paper-based processes and enabling the electronic submission of preauthorization requests via online portals established by payors and pharmacy benefits managers (PBMs). The law was amended in May 2014 adding a fourth benchmark requiring payors and PBMs to implement an electronic process allowing providers to override a step therapy or fail-first protocol for pharmaceutical services by July 1,

2015. The MHCC is required to report annually through 2016 to the Governor and General Assembly on payors' and PBMs' implementation and compliance with the law.

The majority of the State's largest payors and PBMs have implemented the first three benchmarks and their online portals are available to providers to submit preauthorization requests electronically. The Center plans to begin auditing payors' and PBMs' override process next spring to ensure compliance with the fourth benchmark. As the pending provider requirement to utilize payors' and PBMs' online portals approaches, the Center has begun to assess payors' and PBMs' strategies promoting the availability of their online portals. The most commonly utilized strategies include training sessions and providing information on faxes, newsletters, and websites. Preliminary feedback obtained from current users of payors' and PBMs' online portals reveals the leading benefit as being able to obtain information for preauthorization in real-time. Maryland leads the nation as the only State to require real-time approvals for electronic pharmaceutical requests.

Innovative Care Delivery

Maryland law required MHCC to establish a Patient Centered Medical Home (PCMH) Program. In 2011, MHCC launched the Maryland Multi-Payor Patient Centered Medical Home Program (MMPP, or pilot). The pilot is a three year program established to analyze the effectiveness of the PCMH model of primary care in which a team of health care professionals, guided by a primary care provider, delivers recurring, comprehensive, and coordinated care to patients in a culturally sensitive manner. The pilot consists of 52 practices and over 300 practitioners from urban, suburban, and rural settings with practices ranging from primary care to geriatric and pediatric groups. During the year, TRICARE, the health care program serving uniformed service members, executed a Memorandum of Understanding to participate in the MMPP.

The MHCC conducted an evaluation of the first year of the MMPP; *The Evaluation of the Maryland Multi-Payor Patient Centered Medical Home, First Annual Report* was released in December of 2013. Findings suggest that MMPP practices achieved pilot goals, which include: improving the patient experience, enhancing provider satisfaction, and increasing the quality of health care delivery. MMPP practices' specific reports from the 2012 performance year were distributed, which details practices' achievement of quality, utilization, and cost measures. Quality measures quantify a selected aspect of health care delivery by comparing it to evidence-based criteria that specify what constitutes better quality. Utilization measures quantify the extent to which a practice's patient population uses a particular service, such as inpatient hospitalization and emergency room services, within a specified time period. Cost measures quantify the change in health care costs from one time period to another. MMPP practices must meet or exceed the quality measure thresholds, as well as the utilization and cost measures in order to qualify for shared savings incentive payments. Shared savings are a percentage of the savings a practice generates through improved care and patient outcomes. The Center provides guidance to payors in developing and distributing shared savings incentive payments to MMPP practices. For the 2012 performance year, approximately 21 practices collectively received approximately $1.9 million in shared saving incentive payments.

During the year, the Center convened several meetings with the PCMH Transformation Workgroup (PTW). The PTW is responsible for developing recommendations for expanding

advanced primary care models in the State when the MMPP concludes at the end of 2015. PTW members consists of payor representatives, primary care providers, and industry experts, including staff from the Maryland Hospital Association and DHMH. PTW discussions focused on establishing uniformity across integrated models of care delivery, identifying key elements of advanced primary care practices, and evaluating and reporting on advanced primary care programs in Maryland. These discussion items will help the Center prepare reports to support advance care delivery legislative efforts in the 2015 session. Topics expected to be addressed in the reports include the role of advanced primary care in health system transformation, the State's promotion of advanced primary care, successes and lessons learned from State initiatives, and how the MMPP experience in Maryland compares to other state initiatives.

The Center collaborated with the MLC to offer educational sessions for MMPP practices throughout the year. Among other things, sessions focused on care transitions, CRISP's PDMP, and MMPP practices' results from the 2012 quality measures and shared savings received. Several webinars were presented to MMPP practices: one educated MMPP practices on State regulations regarding the completion and distribution of the MOLST form; another two demonstrated an electronic version of the new care plan form that includes social and mental health components of health care delivery and the associated required reporting. In addition, a new website format for the MMPP was developed and released this year; the website includes a portal, which MMPP practices use to report quality measures, care management metrics, and practice demographics. Practice-specific quality and care management reports and outgoing practice communications, such as quality measures and shared savings reports, are also posted to the portal by MHCC.

THE MARYLAND HEALTH CARE COMMISSION