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Meeting Summary  
StateStat website, May 4, 2010

**Agency:** DHMH

**Date of Meeting:** May 4, 2010

Following is a summary of issues discussed at the DHMH Stat on May 4, 2010. Analysis is provided by StateStat and the Governor's Delivery Unit (GDU).

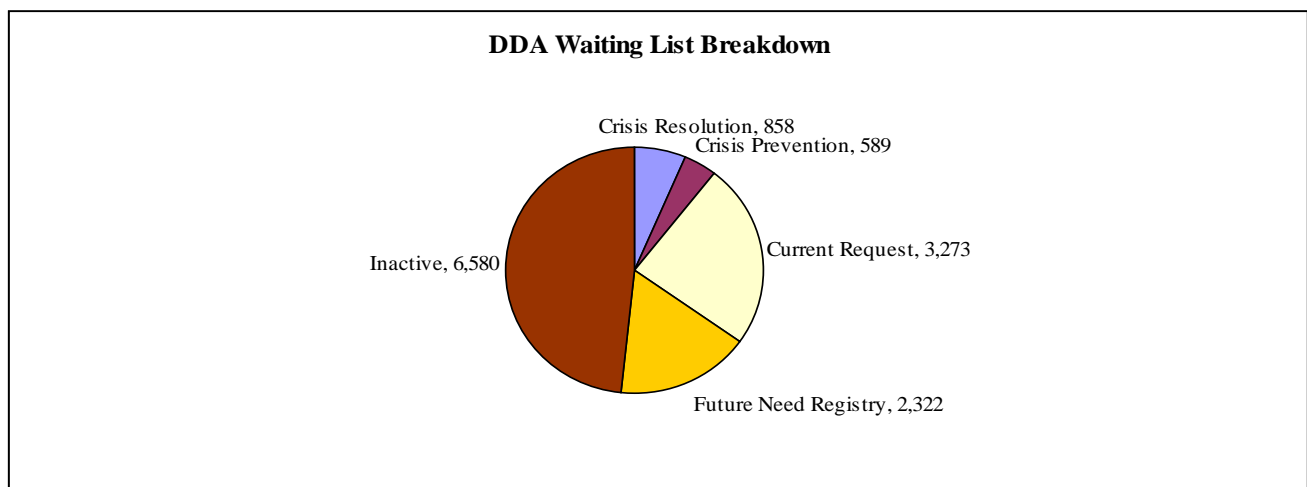
**General Observations**

(Suggested Discussion Length: 0 Minutes)

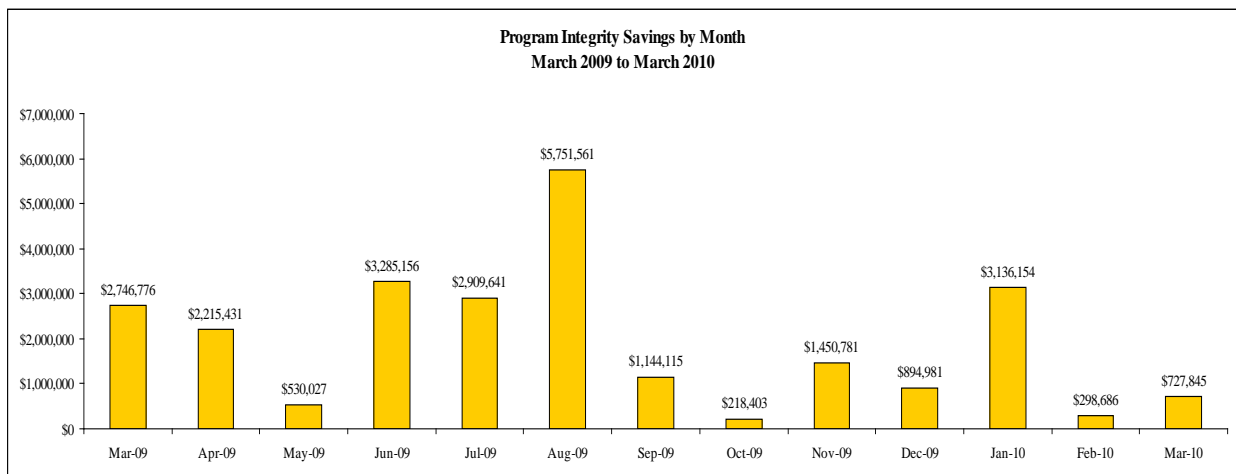
- Follow Up Items
- Governor's Delivery Unit (GDU) Items
- Infectious Disease and Environmental Health Administration (IDEHA) issues

**Follow Up Items**

- **DDA Waiting List Cleanup.** DDA met with Secretary Colmers on April 28 and provided him with a report on the completion of the Waiting List cleanup effort. As of March 31, there were 4,720 individuals awaiting services on the waiting list in the current request, crisis prevention and crisis resolution categories. Of the 858 individuals in the crisis resolution priority category, 248 individuals have received services as shown in the chart below.



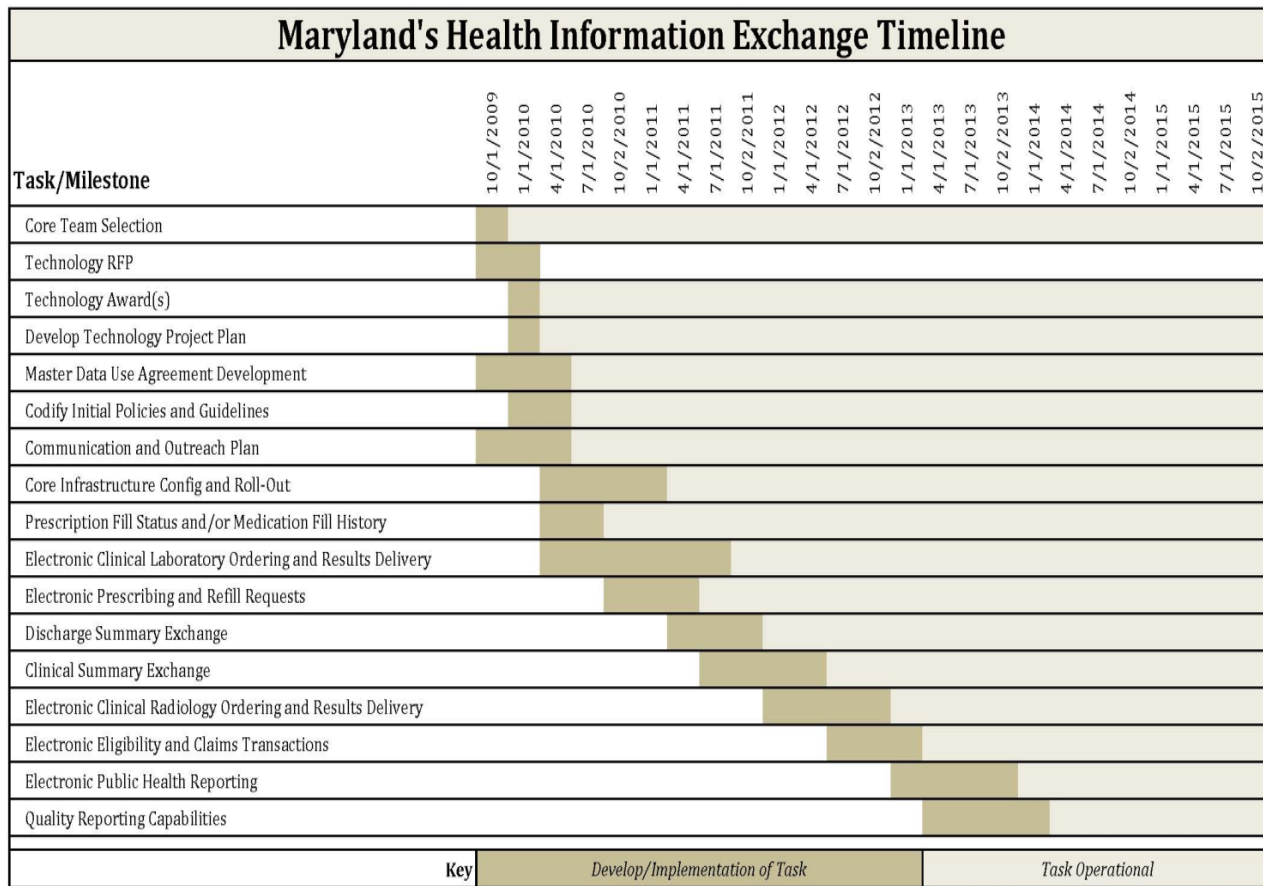
- **Priority Categories.** A series of meeting will be held with the established Waiting List Advisory Committee to seek input related to the current priority categories beginning in May 2010.
- **Program Integrity Savings.** As discussed at the DHMH Stat on April 20, both the number of active Program Integrity cases and the dollar amount of Program Integrity savings are expected to increase as a result of the passage of Maryland False Health Claims Act. In addition to these metrics, DHMH will begin reporting the State share of Medicaid recoveries from a variety of sources including fraud recoveries as part of the State Stat template beginning in FY 2011. Program Integrity Savings reached \$727,845 in March 2010—an increase of 144 percent—as shown in the chart below.



### Governor’s Delivery Unit (GDU) Items

- **Health IT ARRA Funding.** The panel may recall that DHMH and partners have applied on behalf of the State for three ARRA grants to bolster the creation of state and regional health information exchanges. The panel may recall that on April 6, the CRISP Health Information Exchange was awarded \$5.5 million in federal funding to serve as the Health IT regional extension center for Maryland. This funding is in addition to the \$9.3 million awarded to MHCC for the HIE Cooperative Agreement Program Grant. The third potential ARRA grant is described below:
- **Beacon Community Cooperative Agreement** - released in December 2009. Johns Hopkins Health System is the lead applicant for funding under this grant, in partnership with the Howard County Health Department; MHCC is a participant in the application and provided support in developing the response. This grant will provide funding to approximately 15 communities nationally that already have an HIT infrastructure in place to build and strengthen their HIT infrastructure; demonstrate where providers and patients are meaningful users of HIT; and to achieve measurable improvements in health care quality, safety, efficiency, and population health. *The funding amount available is approximately \$15 million; an award announcement is anticipated in the near future.*
- **Statewide Health Information Exchange.** The panel may recall that in August 2009 the Maryland Health Services Cost Review Commission approved the funding of the Chesapeake Regional Information System

for our Patients (CRISP) to receive \$10 million in start-up funding from Maryland’s all-payer system to implement a statewide health information exchange. CRISP serves as the designated non-profit entity responsible for the construction of the exchange, and in conjunction with the Maryland Health Care Commission (MHCC) has developed a comprehensive implementation plan for its completion. The panel may recall the following chart submitted by MHCC detailing the timetable for construction of a statewide health information exchange in Maryland:



- Master Patient Index.** CRISP has recently identified a Master Patient Index vendor that will support the clinical exchange of information through the core infrastructure. The Master Patient Index will contain identifying information for all patients listed on the information exchange. In order to proceed with the construction of the Master Patient Index, MHCC reports that data is needed from MVA to populate the patient identifying information.
- MHCC is in discussions with MVA to obtain this data, but some legal and technical issues have arisen which may delay the process of establishing the Master Patient Index. MHCC reports that if an agreement is not able to be reached with MVA about accessing MVA data in some form, the creation of a system to mine MVA data will need to be created by the Master Patient Index Vendor, potentially delaying the project for up to 90 days. MVA has suggested that a meeting be held among DHMH, MVA, and the Master Patient Index vendor to determine potential solutions to the data sharing issue.

- **Buprenorphine.** The panel may recall discussion from the previous DHMH Stat meeting on the possibility of enhanced tracking of buprenorphine services in the Department's monthly StateStat template, to better articulate the impact of the State's large-scale interventions in this area as part of the Administration's substance abuse services expansion goal.
- ADAA reports that it does not have access to data on the total numbers of prescriptions written each month for buprenorphine, or which physicians prescribe buprenorphine, as specific prescription information is confidential and privileged and is not public record. However, DHMH/ADAA has the ability to track in real-time physician certification data and proposes the following:
  - ADAA will provide an excel spreadsheet containing real time information regarding the total number of physicians certified to prescribe buprenorphine in the state by city and zip code (info provided by SAMSA). This data can be made into a map which would illustrate areas which continue to lack sufficient access to care.
- There are a few additional mechanisms by which to obtain more information that ADAA will pursue. They are as follows:
  - ARCOS data: "monitors the flow of DEA-controlled substances from their point of manufacture through commercial distribution channels to point-of-sale or distribution at the dispensing/retail level (hospitals, retail pharmacies, practitioners, midlevel practitioners, and teaching institutions)", on an annual basis. Currently, Maryland is one of the top five states in terms of dispensing of buprenorphine. This data will not indicate the number of prescriptions filled each month, only the total amount purchased by pharmacies each year.
  - MedChi Physician Survey. ADAA has contracted with MedChi to formulate, distribute, and analyze physician survey information related to the practice of prescribing, and monitoring patients on buprenorphine.
  - Discussion with Reckitt-Benckiser (manufacturer of suboxone) regarding data access. ADAA has been in contact with them to discuss potential mechanisms for determining increase or decrease in amounts of buprenorphine being purchased for distribution within Maryland on a monthly or quarterly basis.
  - SMART Data. ADAA will provide Statewide Maryland Automated Record Tracking (SMART) system trainers and Regional Coordinators with information related to the proper use of a data collection element within the SMART medication module for treatment providers to indicate when a patient has been moved to a private physician for buprenorphine services, and will monitor for provider compliance. As with any new requirement, it will take some time before data can be considered accurate, and can be evaluated. ADAA is also adding this to the monthly JurisStat meetings.
- **Repurposing funds to Medicaid.** The panel may recall that in January, DHMH transferred \$3,343,418 in FY 2010 general and special funds to the Medical Care Programs Administration to fund the substance abuse treatment benefit through the Primary Adult Care Program and the Maryland Medical Assistance Program. Through this funds transfer, the State now receives a 0.61:1 federal match on these substance abuse services funds.

- ADAA reports that as part of “a comprehensive and multi-pronged approach to ensuring the success of the Medicaid/PAC expansion,” the Department is now providing trainings in MA/PAC billing, system selection, and financial management based on the new billing requirements in 5 regions in Maryland in April, 2010. Performance management trainings will be held in 3 regions in May, 2010. These trainings were designed based on feedback from the jurisdictions about the needs of treatment program staff.
- **Efficiencies in Existing System of Care.** As part of ADAA’s strategy to increase efficiencies in its existing system of substance abuse care, two measures previously at DHMH Stat were the initiation of the ADAA “Juris-Stat” process for performance measurement by ADAA of local counterparts, and the introduction of treatment requirements as conditions of funding in ADAA contracts with jurisdictions.
- **Recovery Oriented Systems of Care Grant Application.** The panel may recall that at the beginning of March, ADAA applied for a federal Substance Abuse and Mental Health Services Administration (SAMSA) grant of \$4 million per year for 4 years to implement a Recovery Oriented Systems of Care Model (ROSC) for substance abuse treatment in Maryland.

**Infectious Disease and Environmental Health Administration (IDEHA) Issues**

- The number of new HIV case reports with diagnoses since 2007 per month is higher than the number of HIV case reports with diagnoses before 2007, as shown in the chart below. This is because of a shift to name-based HIV reporting. Beginning next month, DHMH will report the number of diagnoses as one figure.

