

Welcome and Introductions

The meeting began with a welcome from the Workgroup Co-Chairs Joe Ciotola and Deborah Mizeur. The chairs emphasized the comprehensive charge and goals of the Workgroup, including building on existing reports and studying the health care system in the five county region (Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties).

Senator Thomas Middleton, Chairman of the Senate Finance Committee, and Delegate Peter Hammen, Chairman of the House Health and Government Operations Committee made introductory statements focused on the legislative history of the Workgroup, which was developed during the deliberations on Senate Bill 707 during the 2016 legislative session. Chairman Middleton and Chairman Hammen were able to identify funding for the study and the Workgroup, which underscores the General Assembly's commitment to the workgroup process. Senator Middleton emphasized that he was approaching the process with an open mind and no preconceived notions on the outcome of the Workgroup. Delegate Hammen outlined the advantages awarded to Maryland with the hospital waiver administered through the Health Services Cost Review Commission (HSCRC).

After Workgroup members introduced themselves, Ms. Mizeur outlined a plan for establishing advisory groups to drill down into issues to understand the root causes. She noted that the groups will be: workforce development, the needs of special populations, transportation and the delivery system, and economic impact of transitions of health facilities in rural areas.

Overview of Senate Bill 707 and Workgroup Charge

Erin Dorrien, Chief of Government and Public Affairs for the Maryland Health Care Commission (MHCC) presented an overview of Senate Bill 707 and the Workgroup charge. Ms. Dorrien provided context for the introduction of the legislation and updated the Workgroup on the MHCC's progress toward meeting the legislative requirements.

The legislation requires the MHCC to establish a process for a hospital to convert from an acute care facility to a free standing medical facility through an exemption from Certificate of Need (CON). Ms. Dorrien outlined the national trends in hospital utilization and trends in Maryland. Ms. Dorrien noted that the Maryland Hospital Association sought to change the law to allow for conversion in order to preserve access to needed emergency services and other outpatient services.

The charge of the Workgroup was presented:

- Oversee a study of rural health care needs in the five Mid-Shore counties;
- Hold public hearings to gain community input regarding the health care needs;
- Identify policy options developed through Workgroup meetings, through public input, and from the study;
- Specifically recommend policies that address the health care needs of residents of the five study counties and improve the health care delivery system in the five Mid-Shore counties; and
- Issue a report by October 1, 2017.

Garret Falcone requested that Ms. Dorrien discuss why the University of Maryland School of Public Health was chosen to conduct the study given the fact that the University of Maryland Medical System is the owner of Shore Regional Health. Mr. Falcone wanted confirmation that there were not conflicts. Ms. Dorrien assured the group that the University of Maryland School Of Public Health (SPH) and the University of Maryland Medical System (UMMS) are two separate entities and that academics value their academic freedom. She also informed the group the SPH will be working with The Walsh Center for Rural Health Analysis. Mr. Falcone requested that it be entered into the record that there are individuals who serve on the boards of both the University of Maryland and UMMS.

Dr. Ciotola asked who determines underutilization of an acute care hospital. Ms. Dorrien and Ben Steffen, Executive Director of the Maryland Health Care Commission, explained that the hospital makes an application for exemption, and the MHCC, through its findings, determines whether the application would result in a more efficient and effective health care system as defined in regulation. The Maryland Institute for Emergency Medical Services Systems will also determine whether the application adequately maintains emergency services.

Current Profile of the Mid-Shore: Overview of Population, Health Deficits, and Distribution of Health Care Resources

Temi Oshiyoye, MPH, Director of the Office of Rural Health, presented an overview of federal and state designated rural areas in Maryland, demographic information of the mid-shore region population, and an overview of health care resources. Ms. Oshiyoye also defined some of the healthcare challenges in the mid-shore as well as shortage designations, including health professional shortage areas (HPSA) and medically underserved areas/populations. Lastly, she defined ‘adequate access to care’ as comprising of coverage, accessibility, services, timeliness, and workforce.

Susan Johnson suggested adding *understanding* as a component of adequate access to care as patients need to interact with professionals who are culturally understanding.

Dr. Shalewa Noel-Thomas, Director of the Office of Minority Health and Health Disparities, presented an analysis of the health inequities in the mid-shore region. She began by defining the social determinants of health and health inequities. Dr. Noel-Thomas then outlined the current demographic composition of the mid-shore region, including the percentage of households in poverty by race, median household income by race, the unemployment rate by race, and the percentage of uninsured. She then presented health outcomes by race, including: life expectancy, infant deaths, age-adjusted heart disease burden, cancer deaths and emergency department visits for certain ambulatory sensitive conditions. She concluded by suggesting that the group pay attention to the social determinants of health, including vulnerable communities, in planning and policy making, engaging in community outreach and education, and in embracing a “health in all policies” approach.

Dr. Kathleen Ruben, Health Policy Analyst, Maryland Health Care Commission, presented on the healthcare workforce in the mid-shore region. This included the distribution of the workforce in the five counties, including primary care physicians, physician specialists, dentists, nurses and

other health care professionals as well as the allied workforce. Dr. Ruben also outlined the problem of the aging physician population in the mid-shore region. Lastly, she discussed past recommendations to increase the workforce in rural areas.

Ms. Mizeur requested that Dr. Ruben and staff look into physician ownership and whether physician ownership has any effect on access. Dr. Ruben promised to follow up on this issue in the study.

Ms. Mizeur also asked whether any of the past recommendations have been implemented. Dr. Ruben pointed to efforts of an oral health clinic, which has been established in the Kent County school system.

Gene Ransom would like data on all practitioners who accept Medicaid patients.

Dr. Ciotola would like to know if NPs are practicing independently. Mr. Steffen mentioned that NPs are choosing to practice in specialties other than primary care.

Ms. Dorrien presented on health care facility capacity and use. She focused on the distribution of health care facilities in the five county region, specifically services regulated through a CON planning process and the unregulated category of facilities known as urgent care centers.

Garret Falcone asked that the Workgroup examine the use of observation stays by hospitals in the mid-shore region.

Susan Johnson requested data from Delaware.

Maryland All-Payer Model Overview

Mr. Steve Ports, Deputy Director Policy and Operations, Health Service Cost Review Commission, presented on the Maryland All-Payer Model contract with the Centers for Medicare and Medicaid services (CMS). He presented an overview of the CMS and national strategy, which is to promote the use of alternative payment models, increase the linkage from payment to value, encourage coordination and integration of care, and to improve population health. The old waiver, which was granted in 1977, gave rate setting authority to the HSCRC, which paid hospitals on a per admission/service basis. The new model will build on the movement toward total patient revenue and expands the approach by including specific quality and spending targets. Mr. Ports presented the plan for implementing phase two of the model, including improving care coordination and focusing on alignment among providers.

Senator Hershey requested the model performance targets by hospital.

Facilitated Discussion: Defining Access & Economic Challenges Posed by Health System Transformation

A number of important concerns and key themes emerged from the facilitated discussion.

1. Primary care practice transformation is an important challenge. A well-functioning primary care system is vital to improving the health of the population. Many people, particularly those who are uninsured, and frequently Medicaid enrollees, rely heavily on

hospital emergency departments for their routine primary care. Others neglect medical conditions, which then deteriorate and become more serious, leading to poor health outcomes and higher spending down the road. The Choptank Community Health System operates community health centers in Caroline, Dorchester, and Talbot counties, and provides dental and behavioral health services in addition to primary care. Challenges include the need to support small primary care practices (many with as few as one or two physicians), as they strive to convert to electronic health records, adapt to changing payment models, share information with other practices, and address the needs of their patient population, which frequently involve issues that fall outside of the medical model.

2. There is a corresponding need for “physician extenders,” including nurse practitioners, physicians’ assistants, and in some cases, social workers and community health workers. Other ways to extend the reach of a limited number of primary care physicians include telemedicine, co-locating behavioral health providers with primary care physician practices, and use of mobile vans. A very promising initiative is unfolding in Queen Anne’s County involving a partnership between the fields of emergency medicine and public health, which frequently operate in separate and uncoordinated spheres. The Mobile Integrated Community Health Pilot Program relies on home visits made jointly by a public health nurse and a paramedic, and in some cases, pharmacists. By addressing the ongoing conditions and health problems of people in their homes before they get out of hand, this program is now sharply reducing the incidence of patients making repeated visits to the emergency room. Another promising approach is to take advantage of loan forgiveness programs sponsored by both the State of Maryland and the federal government. Under these programs, physicians and nurses can receive reductions in their student debt if they agree to practice in an under-served area (e.g., inner city areas with many low-income patients and rural areas). Challenges facing this approach include getting young professional to locate in rural areas; obtaining the needed “preceptors” to mentor them; and finding adequate and affordable housing for medical students.
3. A number of the Workgroup members cited problems related to what they believe is the “over-regulation” of the health care delivery system. Examples included the “two-midnight rule” and the “three-day stay” requirement. Under the three-day rule, Medicare patients must have an inpatient stay of at least three days in order to be eligible for coverage in a skilled nursing facility (SNF). Days in which a patient is in an “observation unit” of a hospital do not count toward this requirement, except under certain conditions covered by waivers, such as patients enrolled in a “Next Generation” Accountable Care Organization (ACO). Under CMS’ Two Midnight Rule, inpatient admissions will generally be payable under Medicare Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation. Some believe that these types of regulation impede the flexibility of health care providers in determining the most appropriate setting for their patients to receive care.

4. There is a need to identify patients with complex medical needs, conduct health risk assessments, and develop customized care plans for them. This should be accompanied by efforts to ensure “warm handoffs” from one site of care to another, for example, as occurs when patients are discharged from a hospital to a post-acute care facility or to their homes. Another example of care coordination is the need to get patients who are discharged from a mental health facility to see a primary care physician within a week of discharge or sooner.
5. It will be important to get physicians and other providers to take advantage of the helpful services offered by the Chesapeake Regional Information System for our Patients (CRISP). CRISP can help providers share information in real time, improving care for their patients. It can provide secure text messaging and help physicians form care profiles for their patients.
6. Improving non-emergency transportation emerged as a very strong need in these five counties. A lack of affordable and accessible transportation forms barriers to timely care in areas ranging from primary care and urgent care to behavioral health. Vulnerable patients with multiple health problems frequently lack such transportation and are isolated. It is also important to learn about not only which providers are geographically accessible, but also the extent to which they are taking new patients and see patients enrolled in Medicaid or those who are uninsured.
7. The consequences of health systems’ acquisitions of physician practices needs to be better understood. Acquisitions lead to more favorable reimbursement, improved access to technology, and increased ability to deliver integrated care. Acquisitions can also eliminate high touch, always-accessible personal care that many rural communities value.

Public Comments

Senator Eckardt requested that the Workgroup examine the capacity of the behavioral health and substance use workforce.

Robyn Elliot requested that we look at the number of dental practitioners accepting insurance, including Medicaid.

Margie Elsberg requested that “the experts” go to the counties and look at the policies that drive the data.

Jerry O’Connor asked why the hospital in Kent County does not qualify as a “small rural hospital”, Ms. Oshiyoye responded that “small rural hospitals” cannot be affiliated with a larger health system.

Dr. O’Connor also commented that he began the grassroots movement to save Chestertown Hospital, which he stated was a community hospital operating in the black. He believes the Workgroup should look at decentralization as an alternative model for health care delivery to the regionalization currently occurring on the mid-shore.

Ms. Elsberg commented on promises made by Shore Regional Health that were not met and noted that Shore Regional Health has been moving physicians to Easton. She stated the reason for creation of the Workgroup is because of what happened in Chestertown. She also stated that the physicians are retiring in Chestertown and not being replaced.

A physician from Easton who is currently traveling to Chestertown to provide care believes the inpatient hospital should be maintained in that community.