Maryland Health Care Commission

Thursday, January 15, 2015

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**

2. UPDATE OF ACTIVITIES

3. ACTION: Operations, Utilization, and Financial Performance of Freestanding Medical Facilities

4. ACTION: Assignment of Benefits Study

5. ACTION: Provider Carrier Workgroup Membership and Process

6. PRESENTATION: An EHR Assessment of State Hospital and Local Health Departments EHR Systems

7. Overview of Upcoming Initiatives

8. ADJOURNMENT

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ACTION:

Operations, Utilization, and Financial Performance of Freestanding Medical Facilities

(Agenda Item #3)

REPORT ON THE OPERATIONS, UTILIZATION, AND FINANCIAL PERFORMANCE OF FREESTANDING MEDICAL FACILITIES

Maryland Health Care Commission Meeting

January 15, 2015

FREESTANDING MEDICAL FACILITY (FMF)

- Operate 24 hours a day, seven days a week
- Must comply with EMTALA
- Must comply with Medicare Conditions of Participation
- Accept patients arriving via ambulance

OBJECTIVES OF MARYLAND'S FREESTANDING MEDICAL FACILITIES

- Germantown Emergency Center
  - Reduce crowding at Shady Grove Medical Center
  - Improve access to emergency care
- Queen Anne's Emergency Center
  - Improve access to emergency care
- Bowie Health Center
  - Improve access to emergency care
  - Serve as an alternative to developing an acute care hospital

ACUITY OF PATIENTS

Percentage of Visits by Acuity Level for Freestanding Medical Facilities and Nearest Hospital Affiliated ED, FY 2014

Acuity Level	GEC	SGMC	QAEC	Shore at Easton	BHC	PGHC	All MD EDs
Level I	0.8	1.2	4.7	4.1	0.0	0.5	4.5
Level II	21.0	10.0	1.6	2.9	15.3	13.0	12.9
Level III	57.7	41.0	69.5	56.8	53.0	32.4	36.6
Level IV	19.6	35.0	20.8	30.9	22.5	17.0	31.6
Level V	0.9	8.1	3.4	5.2	9.1	35.8	12.9
Unknown	0.1	4.7	0.0	0.2	0.0	1.2	1.3

Source: MHCC staff analysis of freestanding medical facilities and outpatient data sets.

Notes: Visits resulting in admission to the hospital are not included. For this analysis, the fiscal year is defined as the twelve month period ending on June 30th.

PATIENT ADMISSIONS

Facility	Number Admitted			Percentage Admitted (%)		
	2012	2013	2014	2012	2013	2014
Germantown Emergency Center	1,886*	1,852	1,725	5.3	4.9	4.6
Queen Anne's Emergency Center	401	454	424	3.0	3.2	2.9
Bowie Health Center	1,548	1,787	2,087	4.8	5.3	5.9
Shady Grove Medical Center	13,403	13,194	10,460	18.2	17.4	14.6
UM Shore Medical Center at Easton	6,296	6,150	5,957	16.6	16.1	16.6
Prince George's Hospital Center	9,278	8,677	9,611	17.6	16.6	19.1

Sources: MHCC staff analysis of freestanding medical facilities data; Email correspondence from SGMC staff to MHCC staff, December 5, 2014.

FINANCIAL VIABILITY OF FREESTANDING MEDICAL FACILITIES

- Financial reports indicate that Maryland's freestanding medical facilities rarely have positive net revenue.
- Hospital emergency departments are generally not regarded as profitable either.
- If the revenue generated from admissions to FMFs is included, then freestanding medical facilities may be generating a small profit sometimes.

GERMANTOWN EMERGENCY CENTER: FINANCIAL PERFORMANCE, FY 2007- FY 2013

(In Thousands of Dollars)	2007	2008	2009	2010	2011	2012	2013
Gross Revenue	11,667.4	14,912.5	17,005.1	16,364.6	14,190.6	14,173.6	14,047.7
Charity	333.6	1,014.0	885.3	1,016.2	585.8	581.5	1,077.0
Bad debt	1,295.6	2,105.4	2,525.0	1,321.7	970.9	2,177.3	2,349.4
Cont. Adj.	2,223.2	2,738.0	4,278.4	3,476.3	2,307.1	1,064.7	1,232.3
Net Revenue	7,815.0	9,055.1	9,316.4	10,550.4	10,326.9	10,350.2	9,389.1
Oth. Oper. Rev.	427.3	425.0	535.1	551.8	539.0	563.6	586.5
Total Net Revenue	8,242.3	9,480.1	9,851.5	11,102.2	10,865.8	10,913.7	9,975.6
Expenses	9,236.9	10,327.4	11,363.0	11,273.1	11,209.0	11,301.9	11,874.8
Income	-994.6	-847.3	-1,511.5	-170.9	-343.2	-388.2	-1,899.1
Visits	26,113	30,302	33,737	32,258	33,805	34,352	34,477

Source: The data for 2007-2010 is from HSCRC cost reports schedule RE-R; the data for 2011-2013 is from Adventist Healthcare audited financial statements.

IMPACT OF RATE REGULATION ON THE FINANCIAL PERFORMANCE OF FMFS

- Regulating payment for freestanding medical facilities does not guarantee that they will be financially self-sufficient.

KEY CONCLUSIONS

- Development of an FMF may reduce crowding at the affiliated hospital's ED, increase access to care, and effectively serve as an alternative to developing a hospital in some cases.
- FMFs serve a patient population with less acute needs than the patient population at hospital EDs.
- The vast majority of patient visits at FMFs occurred during hours when a viable alternative for treating minor urgent problems may have been available for some patients.
- A hospital seeking to establish an FMF must justify why other less expensive models of urgent care delivery cannot meet the needs of the population to be served.

NEXT STEPS

- Present report to legislative committee in early February
- Begin working on the development of CON regulations for FMFs

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ACTION:

Assignment of Benefits Study

(Agenda Item #4)

Action on Assignment of Benefits Study

Maryland Health Care Commission Meeting

January 15, 2015

Recap of Study Results

- Overall the legislation achieved its purpose to ease the financial burden on patients who use out-of-network providers by reducing reliance on balance billing
- Increased predictability in payments for nonparticipating physicians as evidenced by majority accepting AOB
- Overall, carrier out-of-network services/reimbursements declined as a share of total services/reimbursements between 2010 and 2013
- No evidence of systematic deterioration in payer networks
- Two of five carriers reported paying billed charges in 2013, higher than required by the law

MHCC Recommendations on AOB Law

- Remove abrogation date but make no additional changes to the law
  - Changing the payment formula could resurrect old tensions between carriers and physicians
- MHCC will help carriers who are paying billed charges have an opportunity to reimburse at a lower rate consistent with the law
  - Produce carrier-specific 2009 fee schedules derived from the Medical Care Data Base consistent with the law
  - Provide the Medical Economic Index (MEI) value for each year after 2009 to be used as inflation factors

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ACTION:

Provider Carrier Workgroup Membership and Process

(Agenda Item #5)

Health Care Provider- Carrier Workgroup

Erin Dorrien

Legislation/ Chapter 614 of 2014

- Requires MHCC to establish a Health Care Provider- Carrier Workgroup
- Requires the Commission to invite professional organizations, carriers and consumers to serve on the workgroup
- Requires MHCC to solicit issues for consideration
- Beginning January 1, 2016, and annually thereafter the Commission will submit a report of the workgroup to the Governor and the General Assembly

Payer Participants

Payer	Participant
Aetna	Joe Winn
CareFirst	Deborah Rifkin
Cigna	TBD
Evergreen Health Cooperative	Alex Blum, MD
Kaiser Permanente	Laurie Kuiper
United HealthCare	John Fleig
League of Life and Health Insurers of Maryland	Kimberly Robinson

Provider/ Consumer Participants

Provider Group	Participant
American College Of Emergency Physicians	Joel Klein, MD Orlee Panitch, MD
MedChi	Stephen Rockower, MD Gary Pushkin, MD Loralie Ma, MD Francisco Ward, DO
Primary Care	Paul Andrews
Community Health Integrated Partnership	Salliann Alborn
Consumer Representative	Adrian Ellis
Office of the Attorney General	Kimberly Cammarata

Issue Solicitation and Structure

- Issues driven by Commissioners, policy makers, participants
- Workgroup meets quarterly
- Agenda distributed prior to meeting date

Questions?

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PRESENTATION:

An EHR Assessment of State Hospital and Local Health Departments EHR Systems

(Agenda Item #6)

Electronic Health Record Environmental Scan

Local Health Departments

&

State Hospitals

January 15, 2015

The MARYLAND
HEALTH CARE COMMISSION

Background

- October 2014 –Delegate Dan Morhaim, M.D. inquired about:
  - Maryland local health departments (LHDs) and State hospitals (SHs) use of an electronic health record (EHR) and plans to implement an EHR
    - LHDs and SHs interest in using an open source EHR solution, such as the Veterans Health Information Systems Technology Architecture (VistA)
  - Provide a summary detailing LHD and SH EHR adoption and opportunities to advance EHR adoption

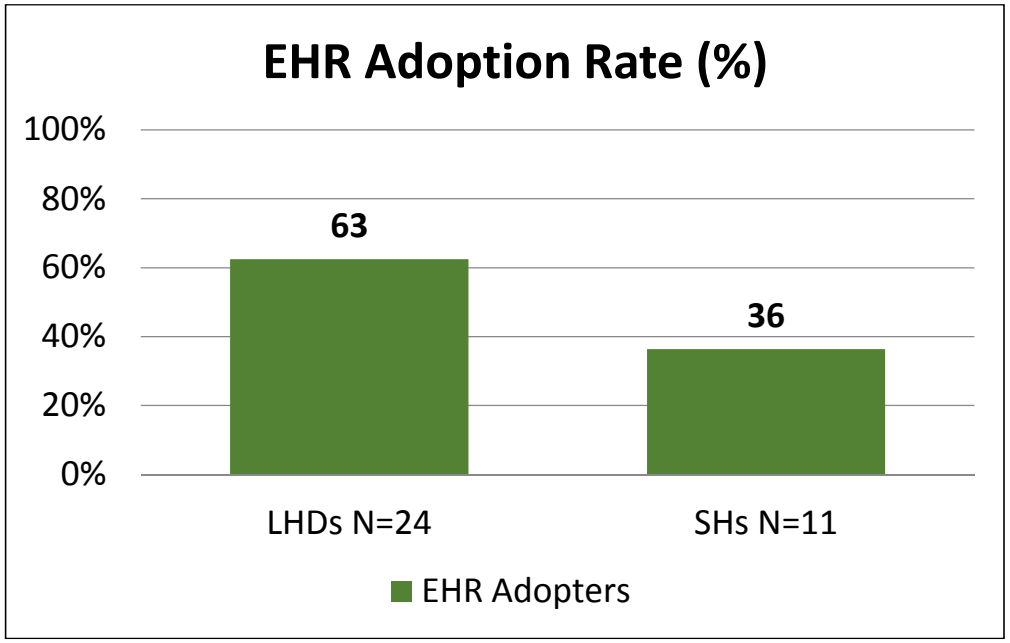
EHR Options

Open-Source	Web-Based
Benefits	
• Allows universal access to the product's source code	• Designed by programmers within a single propriety company • Ongoing maintenance and customized technical support
Challenges	
• Perceived as "free," yet costly to implement and maintain • Not ideal for smaller resource-strapped clinical settings • Lack of adequate technical support	• Typically more expensive to acquire • Source code is confidential and belongs only to the developer

EHR Environmental Scan

- Survey all 24 LHDs and 11 SHs
- Determine EHR adoption and use (i.e. EHR vendor names, length of time using EHR)
- Assess interest in open source technology
- Identify plans to adopt an EHR
- Evaluate EHR adoption challenges
- Explore potential opportunities to advance LHD and SH EHR initiatives

Key Findings

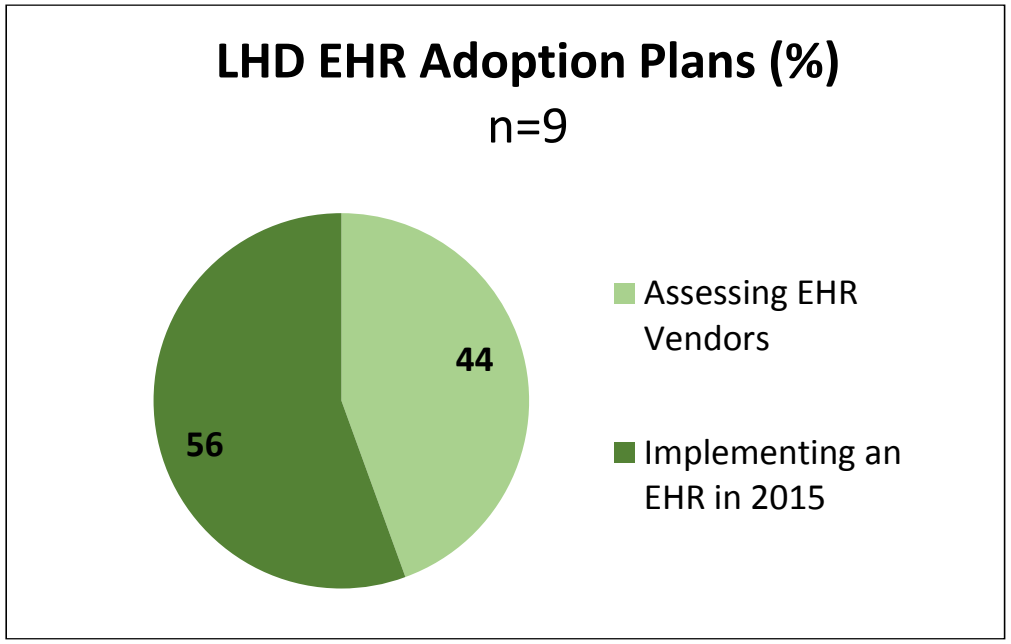


- Average length of time using an EHR ranges from 1 - 4 years
- Several LHDs utilize more than one EHR for various programs (e.g. primary care, behavioral health)

EHRs in Use
Allscripts
Celerity (Addictions/Substance abuse)
CareClix
DocTrac
eChart
NetSmart/Insight
NextGen
Patagonia
Patterson/Eaglesoft Clinician (dental)
PatTrac *
Optimus
Smart (Addictions/Substance abuse)
Visual HealthNet

* Most commonly utilized EHR among all LHDs

Key Findings *(continued…)*



Top Three EHR Adoption Challenges
Cost to acquire, update, and maintain EHR
Ability to meet the facility's needs
Limited availability of technical resources

- Several LHDs have already switched EHRs in an effort to find a product that better fits their needs
- SHs are awaiting direction from Department of Health and Mental Hygiene (DHMH)

DHMH Plans to Conduct an EHR Needs Assessment

- Information Technology Project Request (ITPR) submitted in October 2014 – awaiting approval by the Department of Information Technology
- Project goal is to identify a standard EHR solution that meets SH needs
- Among other things, the assessment will evaluate solutions that can:
  - Support various services/programs
  - Support State reporting and analytics capabilities
  - Integrate with billing systems

Recommendations

- Provide support to LHDs in:
  - Developing a LHD EHR Directory that lists current EHRs in use and other relevant information identified by users
  - Establishing various LHD user workgroups to support EHR education and awareness initiatives
    - Organize ad hoc workgroups by specific EHR products and information needs
    - Explore other collaborative health information technology opportunities

Next Steps

- **Submit the environmental scan summary document to Delegate Dan Morhaim, M.D. and other key stakeholders**

- **Implement the LHD recommendations and provide ongoing support to DHMH in identifying an EHR solution for SHs and the four LHDs that have not yet adopted an EHR**

Thank You!

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Overview of Upcoming Initiatives

(Agenda Item #7)

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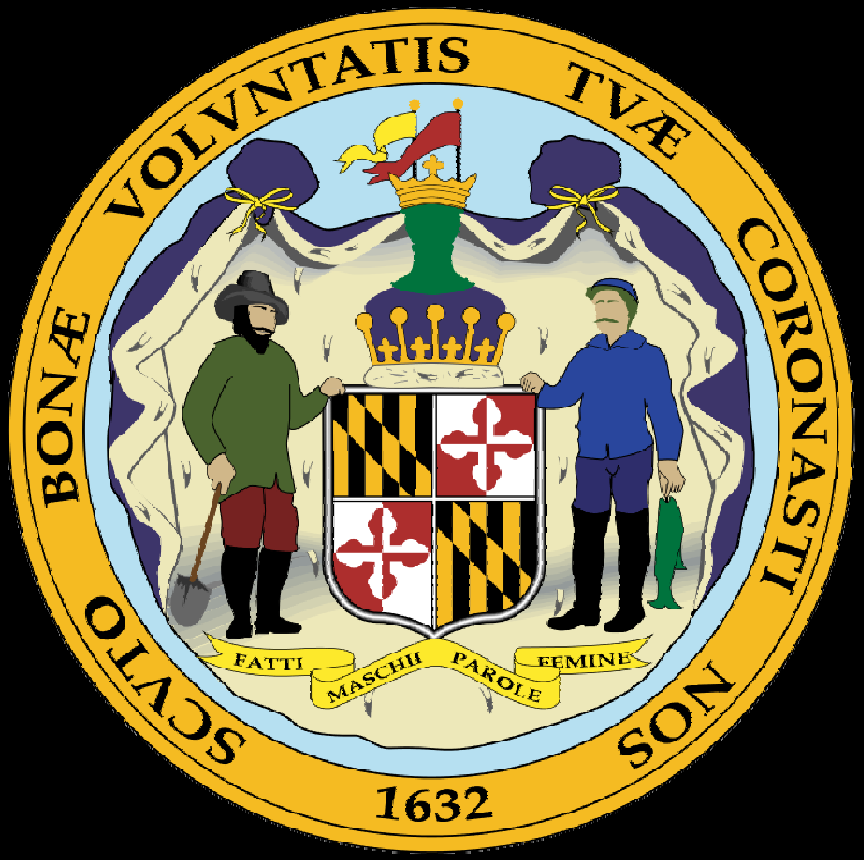

ENJOY THE REST OF YOUR DAY