Maryland Health Care Commission

Thursday, May 21, 2015

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**
2. UPDATE OF ACTIVITIES
3. PRESENTATION: Care Coordination Report
4. ACTION: Institutional Review Board – Johns Hopkins University
5. ACTION: Proposed Amendments to COMAR 10.25.17 – Benchmarks for Preauthorization of Health Care Services
6. UPDATE: Telehealth Grant Awards
7. PRESENTATION: Legislative Wrap-Up and Budget Overview
8. Overview of Upcoming Initiatives
9. ADJOURNMENT

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Care Coordination Report

(Agenda Item #3)

HEALTH MANAGEMENT ASSOCIATES

May 21, 2015

Care Coordination to Support the All-Payer Model
Presentation to MHCC by Jack Meyer

HealthManagement.com

Purpose

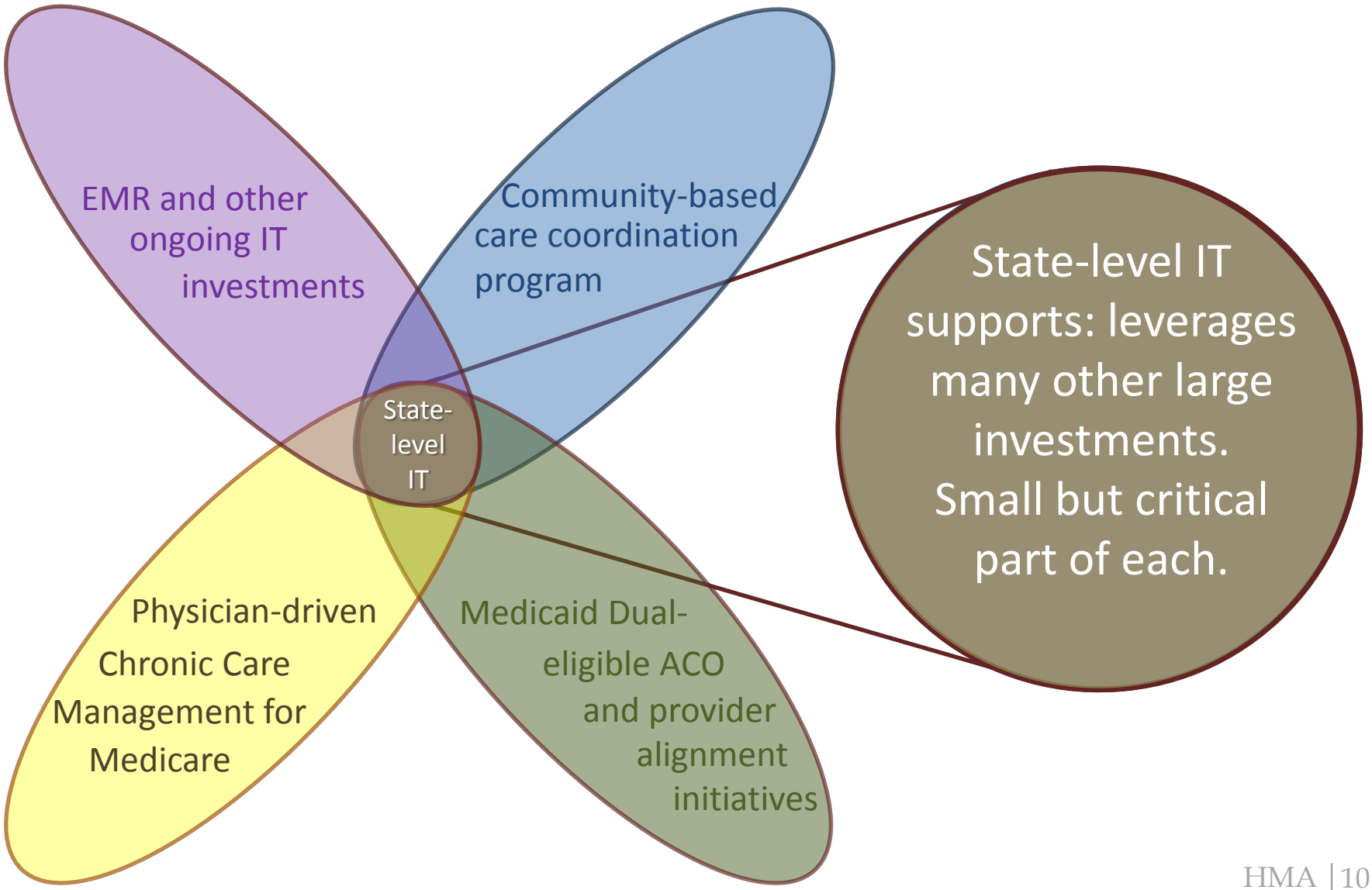
- Use care coordination, care management to help meet the All-Payer Model targets
- Better manage patients with complex medical and social needs
- Reduce complications and flare-ups
- Reduce ED use, inpatient admissions, and readmissions
- Improve health outcomes, functional status of high-needs people

Underlying Conceptual Model

- The State can serve as facilitator, catalyst for investments in infrastructure that would likely otherwise be under-resourced
  - State creates "toolkits" that all can use
  - Take advantage of scale, network economies
- Regional partnerships among hospitals, other providers, and community organizations can develop care management strategies customized to their regions
- Hospitals also build out their own programs

Initial Focus on Medicare FFS

- Half those with 3+ admissions: Medicare only
- Another 15% with 3+ are dual eligible people
- 92% of Medicare enrollees are fee-for-service
- 14% of Medicare FFS have *6 or more chronic conditions* and account for 48% of spending
- Other populations also in need: frail elderly with cognitive impairments; ESRD, trauma victims


EMR and other ongoing IT investments
Community-based care coordination program
Physician-driven Chronic Care Management for Medicare
Medicaid Dual-eligible ACO and provider alignment initiatives
State-level IT
State-level IT supports: leverages many other large investments. Small but critical part of each.

Organizing and Acquiring Data

- Dual track Approach: Use what we have and get what we need
- Track 1: Organize, synthesize data we have
- Track 2: Obtain more timely & identifiable data from CMS under MD's CMMI agreement
- Key steps: Risk stratification; health risk assessments; development of individualized care profiles/care plans; immediate alerts to medical home when patient hits ED, hospital

Investments in Care Coordination

- Build a data infrastructure
  - Develop patient consent policies/procedures
  - Engage vendor to store, clean, normalize new data
  - Facilitate interoperability across providers' EHRs
  - Develop attribution model to hospitals, PCPs, others
  - Store care profile, HRAs
  - Standardize care profiles, HRAs, discharge summaries; make readily accessible

Key Elements of Care Coordination

- Smooth transitions across the spectrum of care
- Active medication management
- Behavioral health integration
- Incorporating social services in delivery model
- Supportive HIT
- Home visits
- Embedding care managers in primary care
- Ensuring work force of adequate size and mix

Encourage Collaboration and Patient Engagement

- State-level education campaign
- Facilitate care integration between hospitals and post-acute, long-term care facilities
- Gain-sharing, P4P, statewide ACO
- Collaborations among providers, advocates, public health, and faith-based organizations
- Support practice transformation
- Encourage providers to use CCM

Regional Partnerships

- Collaboration among hospitals, physicians, and community-based organizations to improve health and reduce care in high-cost settings
- New grants to 8 Regional Partnerships from HSCRC/DHMH are now in effect
- Focus on patients with multiple chronic illnesses, frail elderly, dual eligible people
- Can be used to promote population health

Summary

- All payer model creates incentives for hospitals to keep people well; care moving upstream
- Need to identify the people with the most complex medical and social needs
- Create individualized care plans to meet those needs
- Build a platform to support care coordination
- Find the best mix of standardization and flexibility
- Address the underlying cost drivers, many of which fall outside of the medical model

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Institutional Review Board – Johns Hopkins University

(Agenda Item #4)

Request for Recognition of an Alternative IRB

MARYLAND HEALTH CARE COMMISSION MEETING

MAY 21, 2015

Background on IRB Recognition

- Commission initiative to make privately insured data in the MCDB available to Johns Hopkins Bloomberg School of Public Health (JHSPH), as a pilot to establish academic research centers with APCD focus
- Until MCDB regulations are revised to include a privacy board, all data use agreements (DUAs) for the MCDB must be reviewed by an Institutional Review Board (IRB) prior to Commission consideration
- The Commission may use any IRB recognized by the Commission in considering requests for MCDB files (10.25.11.01)
  - Currently there are two IRBs recognized by the Commission: Chesapeake IRB (Sept. 2011) and DHMH IRB (April 2015)
  - The JHSPH IRB is registered with U.S. Department of Health and Human Services (approved through 04/06/2018) and has an approved Federalwide Assurance (approved through 11/17/2019), which is a commitment to comply with the FWA Terms of Assurance.

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Proposed Amendments to COMAR 10.25.17 – Benchmarks for Preauthorization of Health Care Services

(Agenda Item #5)

Proposed Amendments

COMAR 10.25.17

Benchmarks for Preauthorization of Health Care Services

May 21, 2015

The MARYLAND
HEALTH CARE COMMISSION

Background

- State law established – 2012
  - State regulated payors (payors) and pharmacy benefit managers (PBMs) required to implement electronic preauthorization processes in a series of three benchmarks
- Amendments to the law – 2014
  - Added a fourth benchmark requiring payors and PBMs that require a step therapy or fail-first protocol to establish an electronic process to override the step therapy or fail-first protocol for pharmaceutical preauthorization requests

Proposed Amendments

- Add language requiring payors and PBMs to:
  - Implement the fourth benchmark
  - Provide notification to providers and their members regarding the fourth benchmark
  - Report to the Maryland Health Care Commission on their attainment of the fourth benchmark
  - Maintain their electronic preauthorization processes
  - Demonstrate continued compliance with all of the benchmarks upon request from the Commission

Proposed Amendments *(Continued…)*

- Remove expired payor and PBM reporting requirements pertaining to their attainment of the first three preauthorization benchmarks
- Modify the timeframe for the preauthorization benchmark wavier process by changing:
  - The length of time a waiver is valid from one to two years
  - The number of days a payor or PBM is required to submit a waiver renewal request from 45 to 30 days prior to its expiration

Next Steps

- The following timeline details next steps if proposed amendments are approved by the Commission:
  - June 26, 2015 – Publication date
  - July 27, 2015 –Public comment period ends
  - September 17, 2015 – Staff presentation to the Commission for final action
  - October 12, 2015 – Effective final date of amendments


Thank
YOU

Appendix

Preauthorization Benchmarks

1) Provide by October 1, 2012 online access to a listing of all medical services and pharmaceuticals that require preauthorization and the key criteria for making a preauthorization determination

2) Establish by March 1, 2013 an online system to receive preauthorization requests electronically and assign a unique identification number to each request for tracking purposes

3) Ensure by July 1, 2013 all electronic preauthorization requests for medical services and pharmaceuticals are approved within established timeframes

4) Establish by July 1, 2015 an electronic process to override a step therapy or fail-first protocol

Step Therapy / Fail-First Protocol

- Defined as a protocol that requires a certain prescription drug or sequence of prescription drugs to be used by an insured individual or an enrollee before another specific prescription drug ordered by a prescriber is covered

Previous Reporting Requirements

- **Payors and PBMs were previously required to report their attainment of the first three preauthorization benchmarks as follows:**

  A. On or before March 1, 2013, a payor shall report to the Commission in a form and manner specified by the Commission on:

  (1) The status of the payor's attainment of the benchmarks in Regulation .03A and B of this chapter; and

  (2) An outline of the payor's plans for attaining the benchmark in Regulation .03C of this chapter.

  B. On or before December 1, 2013, a payor shall report to the Commission in a form and manner specified by the Commission on the payor's attainment of the benchmarks in Regulation .03C.

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MARYLAND HEALTH CARE COMMISSION

UPDATE:

Telehealth Grant Awards

(Agenda Item #6)

Telehealth Grants

Thursday, May 21, 2015

The MARYLAND
HEALTH CARE COMMISSION

Telehealth Grants

- Maryland Health Care Commission is awarding grants to three telehealth projects
  - Eight grant applications received by MHCC
  - Evaluation panel reviewed applications and identified three applicants for awards
- Goal: Use telehealth technology to improve overall health of population being served, improve patient experience, and provide best possible care while lowering costs
- Up to $30,000 in grant funds available per grantee

Grant Requirements

- Use telehealth technology to improve access to care, enable early provision of appropriate treatment, and reduce hospital encounters and costs

- Use an electronic health record and services of the State-Designated health information exchange, the Chesapeake Regional Information System for our Patients

- Provide a 2:1 financial match contribution to grant funds

- Go live within 30 days of award date, with the telehealth technology implemented and clinical protocols developed

Potential Telehealth Use Cases

- Applicants required to propose one of following use cases:
  - Use telehealth to manage hospital prevention quality indicators
  - Incorporate telehealth in hospital innovative care delivery models through ambulatory practice shared savings programs
  - Use telehealth in hospital emergency departments and during transport of critically ill patients to aid in preparation for receipt of patient
  - Deploy telehealth in schools for applications including asthma management, diabetes, childhood obesity, behavioral health, and smoking cession
  - Use telehealth for routine and high-risk pregnancies

Crisfield Clinic

- Family practice clinic in Somerset County will deploy telehealth in two county schools to address asthma, diabetes, childhood obesity, and behavioral health issues
- 24/7 care will be provided via remote patient monitoring; virtual consultations will be provided via school-based telemedicine carts issued under another grant
- Goal: improve clinical data indicators, reduce lost school days, reduce emergency department visits, and improve patient's perception of health
- Requested $30,000 in grant funding and intends to provide a matching contribution of $92,983

Lorien Health Systems

- Skilled nursing facility and residential service agency in Howard County will deploy telehealth to address hospital PQI diagnoses, including uncontrolled diabetes, chronic heart failure, and hypertension
- Remote patient monitoring and videoconferencing will be provided at home post discharge from the skilled nursing facility
- Goal: improve clinical data indicators and reduce readmissions and admissions to an acute care hospital
- Requested $30,000 in grant funding and intends to provide a matching contribution of $63,220

Union Hospital of Cecil County

- Acute care hospital in Cecil County will deploy telehealth to address hospital PQI conditions, including diabetes, chronic obstructive pulmonary disease, hypertension, heart failure, angina, and asthma

- Remote patient monitoring and health education will be provided to patients at home after discharge from the hospital to improve community and population health

- Goal: improve clinical data indicators and reduce readmission rates

- Requested $30,000 in grant funding and intends to provide a matching contribution of $60,000

Next Steps

- June 2015: Telehealth projects launch
- June 2015 – June 2016: Implementation of telehealth projects with oversight by staff
- July 2016 – September 2016: Impact of telehealth projects assessed
- October 2016: Release of assessment

Thank You!

The MARYLAND
HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Legislative Wrap-Up and Budget Overview

(Agenda Item #7)

Legislative Wrap-up and Budget Overview

Bridget Zombro
Director, Administration
&
Erin Dorrien
Chief, Government and Public Affairs

Presentation outline

- SB 320/ HB 602 ~~MHCC~~ University of Maryland School of Medicine-Uterine Fibroids- Study
- Self-Referral Bills
- MHCC Funding Overview
- MHCC Expenditures
- MHCC Current Spending

SB 320/ HB 602

~~MHCC~~ University of Maryland School of Medicine- Uterine Fibroids- Study

- Requires SOM to conduct a study on the incidence of uterine fibroids by race, ethnicity, age, county of residence.
- Include types of treatments offered and physician ability to perform treatments less invasive than hysterectomy or myomectomy.
- Data on the number of women who undergo hysterectomy.

Self Referral Bills

- **SB 539/ HB 944** Patient Referrals- Oncologists- Radiation Therapy Services and Nondiagnostic Computed Tomography Scan Services

- **HB 683** Health Occupations – MRI Services and Computed Tomography Scan Services – Patient Referrals

- MHCC will use the Provider- Carrier workgroup, established during the 2014 Legislative Session to bring together Stakeholders to discuss changes to the Self Referral statute.

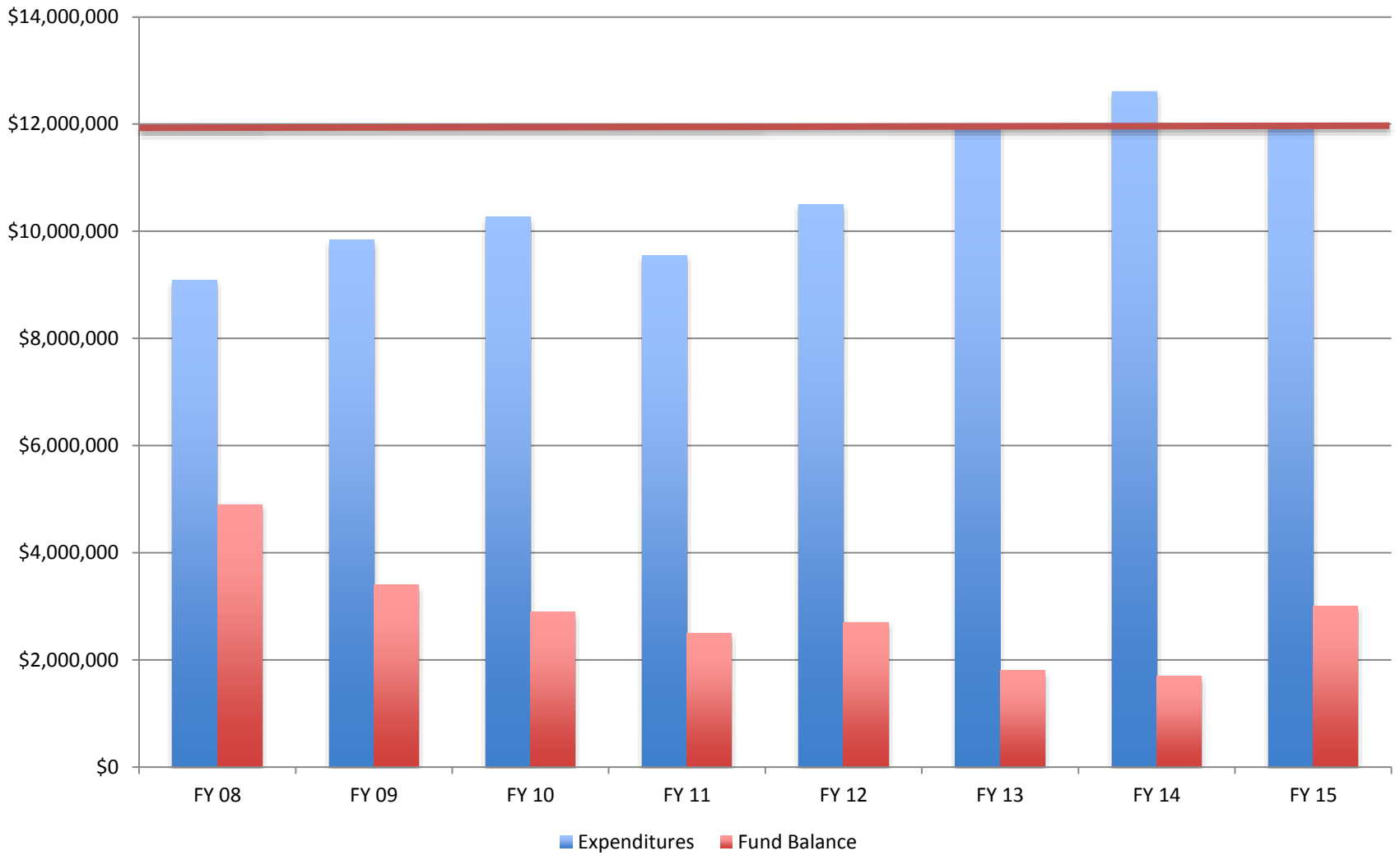
MHCC Funding

- **The $12 Million Assessment Cap was established in 2007**

- **Assessment on the four sectors that MHCC serves**
  - Hospitals
  - Insurance Companies
  - Nursing Homes
  - Health Practitioners as identified through the Licensing Boards

- **Assessment is apportioned among the four groups based on a workload assessment conducted every four years**

Maryland Health Care Commission Fund (Expenditures and Fund Balance)



Distribution of Appropriation

	Fiscal Year 2015	Fiscal Year 2016
Salaries, FICA, Fringe	$ 7,095,412	$ 7,656,340
Communication	$ 48,070	$ 47,170
Travel	$ 45,063	$ 44,761
Operating Expenses	$ 438,309	$ 471,398
Fees	$ 962,118	$ 1,021,272
Information Technology	$ 118,012	$ 118,227
Contractual Services	$ 5,565,662	$ 5,324,744
TOTAL	$14,272,646	$14,683,912

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MARYLAND HEALTH CARE COMMISSION

Overview of Upcoming Initiatives

(Agenda Item #8)


ENJOY THE REST OF
YOUR DAY