Maryland Health Care Commission

Thursday, November 19, 2015

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**
2. **UPDATE OF ACTIVITIES**
3. **ACTION:** Approval for Release – Maryland Trauma Physicians Services Fund Report
4. **ACTION**: Approval for Release - Maryland Hospital Palliative Care Programs: Analysis and Recommendation
5. **ACTION:** COMAR 10.24.16 – State Health Plan for Facilities and Services: Home Health Agency Services – Proposed Permanent Regulation
6. **ACTION:** COMAR 10.24.08 – State Health Plan for Facilities and Services: Nursing Home Services - Proposed Permanent Regulation
7. **ACTION:** Approval for Release – Report of Maryland Self-Referral Provider-Carrier Workgroup
8. **PRESENTATION:** MMPP Evaluation: Medicaid Program Impacts
9. **ACTION:** Approval for Release of MCDB Data Submission Manual
10. **ACTION:** Approval for Release of MCDB to Research Triangle Institute (RTI) for use in the evaluation of Maryland's new Hospital Payment Model Waiver
11. **ACTION:** Approval for Release of the MCDB to George Mason University for use in the evaluation of the CareFirst PCMH Program
12. **UPDATE:** Telehealth Grant Awards
13. **Overview of Upcoming Initiatives**
14. **ADJOURNMENT**

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Approval for Release – Maryland Trauma Physicians Services Fund Report

(Agenda Item #3)

Maryland Trauma Physician Services Fund

Workgroup and Staff Recommendation on Surplus in the Fund

Overview

Current status of the Fund

- At the end of FY 2015 the Fund had a $5 million surplus. The Commission will expend $300,000 in trauma equipment grants to eligible trauma centers in FY 2016.
- The Legislature recommends maintaining a 10% cushion in the Fund's surplus -- $1.2 million for FY 2016.
- Insurance expansion, 92% of Medicare reimbursement from July 1, 2009 through June 30, 2015, and small increases in revenue are principal causes for growth in the surplus.

Considerations

- Allowing the surplus to remain greater than the cushion could make it attractive for transfer.
- FY 2016 will be the first year that reimbursements will be made at 100% of the Medicare rate.
- The Commission has the statutory authority to adjust reimbursement rates.

Authority for Funding Adjustments

The Commission has the statutory authority to make adjustments in Trauma Fund reimbursement without statutory change:

Health-General §19-130(d)(4) "*Method of disbursements. … (iii) The cost of uncompensated care incurred by a trauma physician in providing trauma care to trauma patients on the State trauma registry shall be reimbursed at a rate of 100% of the Medicare payment for the service, minus any recoveries made by the trauma physician for the care;*

(iv) The Commission, in consultation with the Health Services Cost Review Commission, may establish a payment rate for uncompensated care incurred by a trauma physician in providing trauma care to trauma patients on the State trauma registry that is above 100% of the Medicare payment for the service if:

1. The Commission determines that increasing the payment rate above 100% of the Medicare payment for the service will address an unmet need in the State trauma system; and

2. The Commission reports on its intention to increase the payment rate to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2-1246 of the State Government Article, at least 60 days before any adjustment to the rate. …"

Considerations of the Workgroup

MHCC must find that increasing the payment rate above 100% of the Medicare payment for the service will address an unmet need in the State trauma system

- Physicians and hospitals received 92% of Medicare payments due to an insufficient balance in the Fund. MHCC should increase fees for a limited time to acknowledge participants' commitment to the Trauma System over the past five years. Increasing fees would provide some incentives for Trauma physicians to appropriately treat patients at Level II and Level III centers.
- Any increase in fees should take the limited fund surplus into consideration.

Staff recommended Option 2 to the Workgroup, which would add 105% of the Medicare rate to Fund payments and to reevaluate this increase annually to ensure Fund stabilization. Implementation to begin in FY 2017. The Workgroup also considered the following options:

- Option 1 -- adds 102% of the Medicare rate to Fund payments and should be reevaluated annually to ensure Fund stabilization; Consider for 1 year and reevaluate
- Option 3 -- adds 125% of the Medicare rate to Fund payments; cannot be permanent; and would significantly reduce the Fund surplus below the Legislature's recommended cushion
- Option 4 – Reduce biannual fee on automobile registrations and renewals. Requires a change in statute, cannot be permanent, has implications for MVA, must be for two years, and would result in Fund destabilization

CATEGORY	FY 2013	FY 2014	FY 2015	FY 2016 Baseline 100% of Medicare	FY 2017 -Option 1 - 102% of Medicare	FY 2017 - Option 2 - 105% of Medicare	FY 2017 - Option 3 - 125% of Medicare	FY 2017-Option 4 - lower fee from $5 to $4
Fund Balance at Start of Fiscal Year	$4,375,193	$4,673,677	$4,297,238	$5,030,574	**$4,768,524**	**$4,768,524**	**$4,768,524**	**$4,768,524**
Collections from the $5 Registration Fee (and interest)	$11,609,441	$11,957,131	$11,999,199	$12,119,191	$12,119,191	$12,119,191	$12,119,191	$9,600,000
Credit Recoveries	$332,423	$483,836	$703,279	$500,000	$500,000	$500,000	$500,000	$500,000
TOTAL FUNDS (Balance, Collections, Recoveries)	$16,317,057	$17,114,644	$16,999,716	$17,649,765	$17,387,715	$17,387,715	$17,387,715	$14,868,524
-- Uncompensated Care Payments	($4,834,368)	($4,786,633)	($4,313,477)	($4,658,555)	($4,751,726)	($4,891,483)	($5,391,846)	($4,658,555)
-- On Call Expenses	($5,774,302)	($6,568,473)	($6,323,847)	($6,829,755)	($6,966,350)	($7,171,242)	($7,904,809)	($6,829,755)
-- Medicaid Payments	($197,481)	($118,961)	($66,301)	($72,931)	($80,224)	($80,224)	($80,224)	($80,224)
-- Children's National Medical Center Standby	($542,800)	($542,800)	($542,800)	($590,000)	($590,000)	($590,000)	($590,000)	($590,000)
--Trauma Equipment Grants (disbursed from the surplus funds)	$0	($398,231)	$0	($300,000)	$0	$0	$0	$0
-- Administrative Expenses	($294,429)	($402,308)	($722,817)	($430,000)	($430,000)	($430,000)	($430,000)	($430,000)
Total Expenditures	($11,643,380)	($12,817,406)	($11,969,142)	($12,881,241)	($12,818,300)	($13,162,950)	($14,396,879)	($12,588,534)
TRAUMA FUND BALANCE, FY END	**$4,673,677**	**$4,297,238**	**$5,030,574**	**$4,768,524**	**$4,569,415**	**$4,224,765**	**$2,990,836**	**$2,279,990**
Reduction in Reserve from 2015				**($262,050)**	**($199,109)**	**($805,809)**	**($2,039,738)**	**($2,750,584)**

Recommendation

The Commission Workgroup and Staff recommend that the Commission adopt Option 2, which will increase reimbursements for uncompensated care and trauma centers' on-call costs, to be reevaluated annually to ensure Fund stabilization.

Next steps:

- Include recommendation in report
- Release the report to the General Assembly
- Inform standing committees – 60 days prior to implementation, May 1, 2016.

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Approval for Release – Maryland Hospital Palliative Care Programs: Analysis and Recommendations

(Agenda Item #4)

Maryland Hospital Palliative Care Program Final Report

Required under HB 581

Linda Cole and Rebecca Goldman
November 19, 2015
Commission Meeting

Report Takeaways

- Culmination of a 2-year study: 7,000 consultations at 11 pilot hospitals
- Profiles on pilot hospital palliative care programs
- Data on palliative care consults at pilot hospitals, compared to medical/surgical patients:
  - Older; more medically fragile; closer to death
  - Twice as likely to have been readmitted within 31 days of previous admission
- For whites and African Americans, proportion of palliative care consults conforms with the proportion of med/surg patients; African American and Hispanic patients more likely to decline palliative care recommendations
- Consensus on 37 best practices, of which 31 are recommended as minimum standards

Requirements of HB 581

- MHCC to select at least 5 palliative care pilot programs, in a manner to ensure geographic balance
- Report to General Assembly by Dec 1, 2015
- Pilot programs to:
  - Collaborate with community providers
  - Gather data on costs, savings, access, and patient choice
  - Report on best practices that can be used in the development of statewide standards
- Results to be used by OHCQ in development of regulations and palliative care standards

Pilot Study Process

- Reviewed existing data: MD Cancer Collaborative; MHA and OHCQ surveys
- Conducted 15 phone interviews with 19 hospital palliative care programs
- Established RFA process: 14 applications; 11 selected
- Convened Hospital Palliative Care Advisory Group,
- Utilized CAPC data for all pilot hospitals 2012-2013 to profile hospital programs
- Utilized NQF preferred practices, with Advisory Group review, to develop recommendations
- Reviewed work of MD Cancer Collaborative to assist in the profile of MD palliative care programs
- Flagged patients in HSCRC discharge database to provide data on utilization

History and Growth of Palliative Care

- One of the first services health care providers offered, but only recently recognized as a specialty (2007).
- Consultation model: nationally and in MD
- Growth of hospital palliative care programs since 2000.
  - Nationally, more than doubled between 2000-2010.
  - In Maryland, nearly all programs formally established since 2000.

Issues within the Specialty

- Challenges created by confusion with hospice care
- Lack of awareness and late referrals to palliative care
- Workforce shortages
- Limited resources

Evidence of Benefits and Cost Savings

- AMA highlighted challenges related to accurately measuring impacts of palliative care.
- Two published studies on cost savings:
  - AMA reported savings between $1,700 and $4,900 per stay for palliative care patients.
  - Health Affairs reported $6,900 in cost savings per stay for palliative care patients with Medicaid.
- Carroll and Union Memorial submitted evidence of lower readmission rates.
- Johns Hopkins and Union Memorial found greater patient and family satisfaction after palliative care consultation.

Efforts to Standardize and Expand

- National: Efforts to standardize screening processes in New York; efforts to increase access in New Jersey, California, New Hampshire.
- In Maryland, half of hospitals surveyed reported plans to add trained staff and provide more training.
- Maryland's Comprehensive Cancer Control Plan includes chapter on improving access to palliative care.
- HB 581 requires recommendations for statewide standards for hospitals.

Maryland Palliative Care Programs

- Palliative care programs exist at 30 hospitals across the state.
- One hospital (MedStar Union Memorial) Joint Commission certified.
- All 11 pilots reported at least one staff member with palliative care credentials.
- CAPC data included: details on each pilot's staffing, relationship to hospice, integration with ED/ICU, and funding sources.

Patient-level Study Questions

- What was the general use of palliative care at Maryland hospitals?
- What were the demographics, characteristics, and experiences of patients who received palliative care and those who did not?
- What was the average length of stay and average hospital charge for patients who received palliative care and those who did not?

HSCRC Flagging Protocol

- Code 1 = Received a palliative care consult and accepted a palliative plan of care and were not referred to hospice care.
- Code 2 = Received a palliative care consult and accepted a palliative plan of care, specifying hospice care, and were referred to hospice care.
- Code 3 = Received a palliative care consult but did not accept a palliative plan of care.
- Code 8 = All patients who received a palliative care consult with an unknown outcome.

Flagged Palliative Care Consultations by Pilot Hospital, FY 2015

Pilot Hospital		Accepted Palliative Care Plan of Care	Declined Palliative Care Recommendations	Referred to Hospice	Outcome Unknown	Total
Carroll	Frequency	249	119	267	-	635
	Percent	39.2%	18.7%	42.1%		
Doctors Community	Frequency	75	102	250	47	474
	Percent	15.8%	21.5%	52.7%	9.9%	
Greater Baltimore	Frequency	211	45	238	-	494
	Percent	42.7%	9.1%	48.2%		
Holy Cross	Frequency	312	247	398	-	957
	Percent	32.6%	25.8%	41.6%		
Howard County	Frequency	99	61	136	4	300
	Percent	33.0%	20.3%	45.3%	1.3%	
Johns Hopkins	Frequency	660	37	501	255	1,453
	Percent	45.4%	2.6%	34.5%	17.6%	
MedStar Union Memorial	Frequency	58	333	129	-	520
	Percent	11.1%	64.1%	24.8%		
Meritus	Frequency	195	106	254	-	555
	Percent	35.1%	19.1%	45.8%		
Peninsula Regional	Frequency	330	23	176	-	529
	Percent	62.4%	4.4%	33.3%		
Suburban	Frequency	208	81	172	20	481
	Percent	43.2%	16.8%	35.8%	4.2%	
Upper Chesapeake	Frequency	328	32	232	-	592
	Percent	55.4%	5.4%	39.2%		
Total	Frequency	2,725	1,186	2,753	326	6,990
	Percent	39.0%	17.0%	39.4%	4.7%	

Source: Commission staff analysis of HSCRC Maryland Inpatient Discharge Abstract

Patient Demographics & Characteristics

- PC consults skew older. 70% were older than 65, compared to 49% in the total medical/surgical patient population.
- PC patients were more likely to die in the hospital. More than 4 in 10 who accepted a palliative care plan of care died in the hospital (41%:3%).
- PC consults had higher rates of infectious/parasitic diseases/disorders (20%:8%) and respiratory diseases/disorders (18%:12%).
- PC consults were twice as likely to have been readmitted within 31 days of previous admission than medical/surgical patients.

Utilization Across Race/Ethnicity

Reported Race/Ethnicity	% of Med/Surg	% of PC Consults	Palliative Care Consult Outcomes		
			Accepted Recs (PC/Hospice)	Declined Recs	Outcome Unknown
White	59.2%	60.7%	84.6%	11.7%	3.7%
African American	26.6%	26.8%	71.3%	21.2%	7.5%
Hispanic	3.7%	2.5%	81.5%	15.7%	2.8%

- African American and Hispanic patients less likely to accept palliative care recommendations than white patients at pilot hospitals.
- Aligns with findings of lower use of hospice services by African Americans and Hispanic patients when compared to white population. Maryland hospices have acknowledged this disparity & are working to identify & address barriers.
- The Hispanic patient population/community may also benefit from more education & outreach based on lower rate of consultations at a majority of pilots.

Unadjusted Average Charge per Stay for Palliative Care Consults Compared to Medical/Surgical Discharges

Pilot Hospital	PC Consults	Medical/Surgical	Difference
Carroll	$18,879	$13,652	$5,227
Doctors Community	$25,463	$14,044	$11,419
Greater Baltimore	$21,079	$13,757	$7,322
Holy Cross	$33,183	$12,312	$20,871
Howard County	$26,970	$10,736	$16,234
Johns Hopkins	$52,220	$28,677	$23,543
MedStar Union Memorial	$39,627	$21,044	$18,583
Meritus	$19,586	$11,863	$7,723
Peninsula Regional	$25,055	$14,759	$10,296
Suburban	$21,169	$14,641	$6,528
Upper Chesapeake	$19,347	$12,173	$7,174
All Pilot Hospitals	**$30,052**	**$17,252**	**$12,800**

Source: St. Paul Group analysis of HSCRC Maryland Inpatient Discharge Abstract, FY 2015

- The average charge per stay for PC consults was more than the average for all medical/surgical discharges, for the single hospital stay observed during the study period.
- PC consults stayed 3-8 days longer, on average for the stay during which they received the consultation.

Unadjusted Average Charge per Day for Palliative Care Consults Compared to Medical/Surgical Discharges

Pilot Hospital	PC Consults	Medical/Surgical	Difference
Carroll	$3,261	$4,100	-$839
Doctors Community	$2,689	$2,969	-$280
Greater Baltimore	$2,668	$3,518	-$850
Holy Cross	$2,685	$2,967	-$282
Howard County	$2,634	$2,407	$227
Johns Hopkins	$4,026	$4,910	-$884
MedStar Union Memorial	$3,322	$4,928	-$1,606
Meritus	$2,629	$3,304	-$675
Peninsula Regional	$2,640	$3,370	-$730
Suburban	$2,337	$3,528	-$1,191
Upper Chesapeake	$2,186	$2,926	-$740
All Pilot Hospitals	**$3,020**	**$3,817**	**-$797**

Source: St. Paul Group analysis of HSCRC Maryland Inpatient Discharge Abstract, FY 2015

- The average charge per day for PC consults was less than the average for all medical/surgical discharges at 10 of 11 pilot hospitals, for the single hospital stay observed during the study period.

Case Mix Adjusted Average Charge per Stay for Palliative Care Consult Groups with Known Outcomes

Pilot Hospital	Accepted Palliative Care Plan of Care	Declined Palliative Care Recommendations	Referred to Hospice
Carroll	$20,321	$28,820	$19,655
Doctors Community	$23,958	$37,978	$23,350
Greater Baltimore	$26,046	$28,115	$21,253
Holy Cross	$34,464	$53,825	$24,751
Howard County	$49,146	$36,480	$23,709
Johns Hopkins	$43,432	$40,642	$31,755
MedStar Union Memorial	$24,573	$38,231	$30,123
Meritus	$22,182	$28,285	$23,903
Peninsula Regional	$24,396	$40,191	$23,191
Suburban	$29,912	$22,862	$22,350
Upper Chesapeake	$28,624	$24,271	$20,203

Source: St. Paul Group Analysis of HSCRC Maryland Inpatient Discharge Abstract, FY 2015

- At 9/11 pilots, hospice referrals had the lowest CMA average charge per stay, corresponding wit the shortest CMA average length of stay.
- At 8/11 pilots, patients who accepted PC were discharged sooner than those who declined. At 7/11 pilots, patients who received PC had a lower CMA average charge than those who declined, with a wide difference in charges.

Summary of HSCRC Data Findings

- 7,000 PC consults at 11 Pilot Hospitals
- PC consults were higher acuity patients
  - Older, more fragile, and closer to death
  - More likely to be readmitted within 31 days of previous admission
  - Costlier and longer average total stays compared to med/surg patients, but less costly per day, on average
- PC consults led to hospice referrals in 40% of cases, with lower costs in general.
- Patients who accepted a palliative care recommendations had lower costs at most pilots. However, definite conclusions about cost savings can not be drawn based on the single hospital visit due to several unknowns about patients' history and experiences. A longer term perspective is needed to fully understand cost savings.

Conclusions

- While the effect of palliative care is challenging to measure in a one year study of 11 diverse hospital programs, pilots provided data that led to cautious optimism regarding its effects.
- Other studies have shown that palliative care leads to lower readmission rates and charges, and increased satisfaction.
- Other states are addressing growth through statewide initiatives.
- Direction for these programs across the State would ensure a basic level of similar services across hospitals.
- The pilot hospitals have expressed consensus on best practices and minimum requirements that, if followed, would help to ensure high quality, specialized palliative care programming.
- Success relies upon hospital support for these programs to address a number of identified challenges.

37 Recommendations based on NQF Preferred Practices fall under 8 domains

- Structures (personnel and training) and Processes of Care (decision-making and records)
- Physical Aspects of Care
- Psychological and Psychiatric Aspects of Care
- Social Aspects of Care
- Spiritual, Religious, and Existential Aspects of Care (focus on availability of services)
- Cultural Aspects of Care
- Ethical and Legal Aspects of Care
- Care of the Imminently Dying Patient

Next Steps

- Commission questions
- Submission to General Assembly by December 1, 2015

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COMAR 10.24.16 – State Health Plan for Facilities and Services: Home Health Agency Services – Proposed Permanent Regulation

(Agenda Item #5)

State Health Plan for Facilities and Services: Home Health Agency Services, COMAR 10.24.16

Consideration for Adoption as Proposed Permanent Regulation

November 19, 2015

Paul Parker and Cathy Weiss
Center for Health Care Facilities Planning and Development

MHCC | MARYLAND HEALTH CARE COMMISSION

HHA Whitepaper: Key Issues Identified

- Forecasting Need
- Measuring Quality
- Acquiring an HHA

Features of the New HHA Chapter

- Rewarding quality providers
- Qualifying applicants based on past performance
- Creating opportunities for new or expanded HHAs to enhance consumer choice, market competitiveness, and/or quality performance
- Recognizing dynamic nature of quality measurements by selecting measures and performance thresholds before each review cycle
- Specifying requirements for acquisitions

Comments

Received from 3 organizations:

- Erickson Living
- Maryland National Capital Homecare Association (MNCHA)
- Maxim Healthcare Services

Categories:

- Need Determination: Regulation .04
- CON Application Acceptance Rules: Regulation .06
- Quality Measures and Performance Levels: Regulation .07
- CON Review Standards: Regulation .08
- Gradual Entry of New Market Entrants: Regulation .10
- Acquisition of an HHA: Regulation .11

Need Determination

Comments:

- Impact of new HHA providers on existing HHAs
- Establish a threshold combining HHI of 0.25 and fewer than X HHAs
- Care coordination for dually-eligible; continuity for aging out of Medicaid waiver program

Staff Recommends: No change required

- Draft HHA Chapter allows for gradual entry of new market entrants
- HHI of 0.25 or higher means a highly concentrated market; does not imply insufficient choice
- Care coordination/continuity: RSAs and HHAs, Medicare and Medicaid, best addressed by Medicaid, CMS and OHCQ

Need Determination (continued)

Comment:

- Retain the specialty HHA designation

Staff Recommends:

- Current specialty HHAs grandfathered but no new specialty HHAs will be established
- NEW language to extend authority of existing CCRC-based HHA
  - Exclusively serve residents of another CCRC with common ownership
  - Within existing authorized jurisdiction

Qualifying CON Applicants

Comments:

- Look-back period for Medicare/Medicaid fraud or abuse
- Qualify RSAs as CON applicants
- Accreditation

Staff Recommends:

- Change from 5 to 10 years; consistent with CMS regulations
- Demonstrate serving "applicable" payer types; no change required
- NEW qualification: "Has maintained accreditation through a state-recognized deeming authority, as applicable…"

Measuring Quality

Comments:

- CMS' Star Rating Scores
- Maintaining or improving in performance

Staff Recommends:

- CMS' Star Rating scores: objective quality measure; no change required
- Clarify "…average performance score will be used."
- Move "maintained or improved performance" to CON preference rules

CON Review Standards

Comment:

- Financial accessibility standard not consistent with requirement for serving all applicable payer types

Staff Recommends:

- Clarify standard "…licensed and Medicare- and Medicaid-certified, and agree to maintain Medicare and Medicaid certification…"

Gradual Entry of New Market Entrants

Comment:

- Clarify how "existing HHAs" are defined

Staff recommends:

- NEW language "…number of existing parent HHAs actually serving at least 10 or more clients in a jurisdiction during most recent three-year period…"

Acquiring an HHA

Comments:

- Change in services historically provided may be positive
- More definitive requirement for Medicare or Medicaid fraud or abuse
- Disclose involuntary terminations rather than deficiencies

Staff Recommends: clarify intent of language

- "…affirm that it will provide, at a minimum, the services historically provided…"
- "…shall not have pled guilty to, been convicted of, or received a diversionary disposition for a felony involving Medicare or Medicaid fraud or abuse within the last 10 years"
- Clarify types of deficiencies to be disclosed; add "condition-level"

Next Steps

- Approve adoption of new COMAR 10.24.16 as proposed permanent regulation
- Approve amendment of COMAR 10.24.08 to repeal sections on HHA services
- Initiate formal comment period
- Adopt/Amend final regulations after review of comments

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8. **PRESENTATION:** MMPP Evaluation: Medicaid Program Impacts
9. **ACTION:** Approval for Release of MCDB Data Submission Manual
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12. **UPDATE:** Telehealth Grant Awards
13. **Overview of Upcoming Initiatives**
14. **ADJOURNMENT**

ACTION:

COMAR 10.24.08 – State Health Plan for Facilities and Services: Nursing Home Services – Proposed Permanent Regulation

(Agenda Item #6)

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**

2. **UPDATE OF ACTIVITIES**

3. ACTION: Approval for Release – Maryland Trauma Physicians Services Fund Report

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Approval for Release – Report of Maryland Self-Referral Provider-Carrier Workgroup

(Agenda Item #7)

Provider-Carrier Workgroup Study on Maryland's Self-Referral Statute

Erin Dorrien

Chief, Government and Public Affairs

MHCC | MARYLAND HEALTH CARE COMMISSION

Takeaways from Workgroup

- Maryland Patient Referral Law (MPRL) is a broad with some uncertainty
- Agreement that Maryland Patient Referral Law should not interfere with value-based payment and provider collaboration
- General principles can be foundation on which specific reforms can be considered
- The agreement on general principles is the first step toward consensus in over 20 years

Maryland Patient Referral Law Overview

- Enacted in 1993
- Prohibits a health care practitioner (or directing an employee or person under contract) from referring a patient to a health care entity in which the health care practitioner has a beneficial interest or compensation arrangement.
- 11 specific exemptions in statute
- Broader than the federal self-referral law, known as the Stark Law
  - Applies to all health care practitioners licensed or certified under the Health Occupations Article, not just physicians
  - Applies to all payers, not just Medicare and Medicaid
  - Covers all services, not just designated health services

MHCC MRI Study

- HB 536 (2013 Legislative Session)- Required DHMH to conduct a study of ordering of MRI services by physicians in non-radiology group practices that owned an MRI prior to 2011 (No Vote)
- In a letter (dated July 10, 2013) Chairman Hammen requested MHCC conduct a study using Medicare claims data, comparing utilization of MRI services by non-radiology group practices between CY 2010 and CY 2012
- Study completed and delivered to the Health and Government Operations committee in January 2015 found:
  - No evidence that financial interest influenced MRI rates in 2010 compared to 2012
  - Practices with financial interest in MRI equipment had higher rates of MRI use in both 2010 and 2012

Maryland Health Care Commission Advice

- Changes in the MPRL could be linked to broader payment reforms, with full participation in risk-based arrangements as a first condition.
- Ownership of office-based imaging could be permitted if three conditions were met:
  1. the practice demonstrates that a very high proportion of care is reimbursed under risk-based financial arrangements;
  2. the practice can demonstrate sufficient scale as to make ownership of imaging equipment viable and agrees to bundle imaging use under the risk-based arrangement; and
  3. the practice commits to ongoing reporting of quality metrics linked to its patient outcomes.

2015 Legislative Session- Legislation Introduced to Create New Exemptions under MPRL

- HB 683- Health Occupations- Magnetic Resonance Imaging Services and Computed Tomography Scan Services- Patient Referrals

- HB 944/SB539- Patient Referrals- Oncologists- Radiation Therapy Services and Nondiagnostic Computer Tomography Scan Services

Health Care Provider Carrier Workgroup & Chairman Hammen's Request

- Chapter 614 of 2014 established the Health Care Provider-Carrier Workgroup, with MHCC as the convener.
- Workgroup was formed in the fall of 2014 with a group of "standing" members that included payors, providers, and consumers.
- Delegate Hammen concluded that this group would be a forum for discussing MPRL and charged the MHCC to:
  - "…review and recommend changes to the State's prohibition on self-referral. The workgroup, with representation from affected stakeholder groups, is the appropriate vehicle for undertaking this charge."

Workgroup Composition

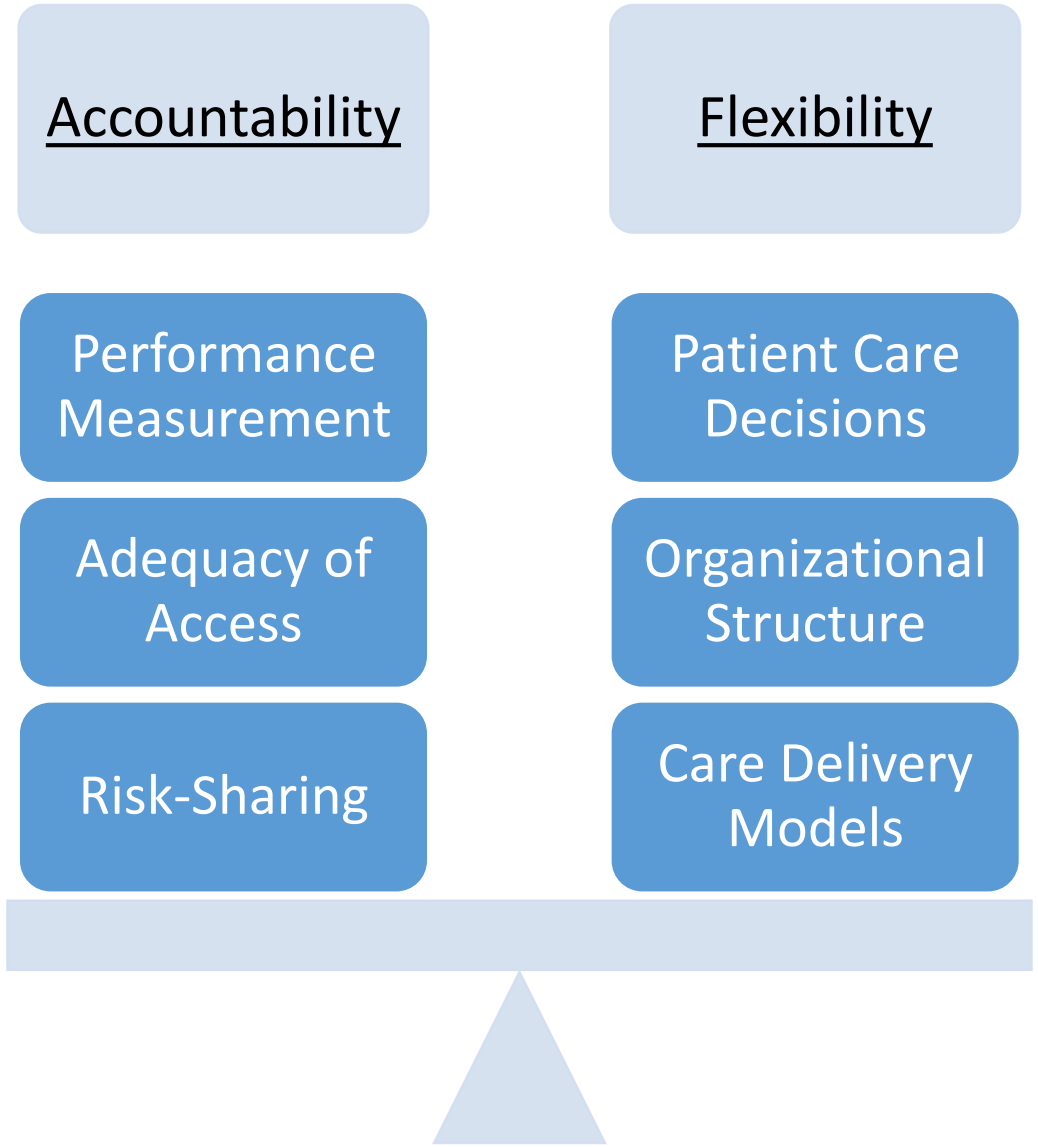
- Standing Members
  - Representatives from all major payors (7)
  - Provider Representatives including representatives from various specialties, hospitals, and community health centers (5)
  - Consumer Representatives (4)
- Additional Issue Specific Members
  - Hospital Representatives (6)
  - Maryland Patient Care and Access Coalition (3)
  - Oncology (1)
  - Radiology (1)
  - Anesthesiology (1)
  - State Agencies including; HSCRC, MBP, and Medicaid (3)
- 31 Total Members

Meetings 1 and 2

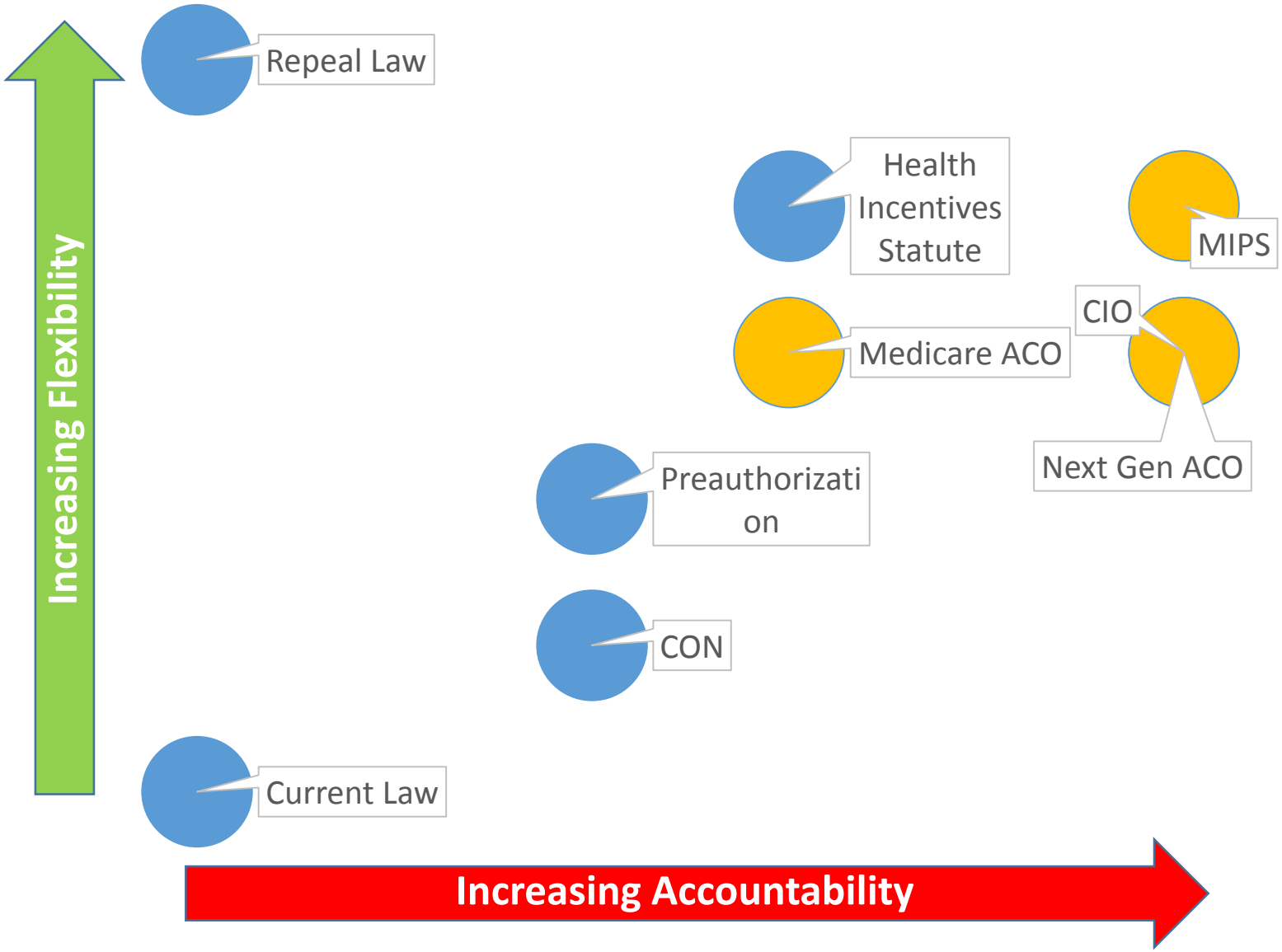
- Overview and History of MPRL
  - Background on MPRL
  - Alignment of Self-referral with Maryland's All-Payer Model Agreement
  - MHCC approach to considering exceptions to MPRL
- Existing Shared Savings Programs and Opportunities
  - Medicare and Private payer programs
  - MHA Gainsharing Approach
  - Other Models to Consider
    - Clinically integrated Organizations
    - Mandatory Preauthorization
    - Certificate of Need

Core Principle

Providers who take on greater accountability should have greater flexibility in managing their practices and patients.



Continuum of Options: Making Trade-Offs



Meetings 3 and 4

- Redefining the problem
  - Maryland's self-referral restrictions may prevent providers from testing innovative care delivery models under value-based purchasing arrangements.
- Stakeholders looking to develop models beyond MRI, CT and radiation therapy and these models may be inhibited by the MPRL
- Staff concluded that focusing on imaging was too narrow and there was a need to refocus the workgroup to achieve broader consensus.
- Stakeholders decided to build broad consensus on a set of general principals

Consensus Points

- The Affordable Care Act, innovative private payor arrangements, and Maryland's all-payor hospital model have created in Maryland a more rapid move toward value-based payment and provider integration.
- The opportunities presented by a value-based payment system are fundamentally different from those in the traditional fee-for-service system.
- The Maryland Patient Referral Law (MPRL) should be modernized to allow for the development of additional bona-fide value-based payment models, risk-sharing arrangements, and alignment models. The Workgroup effort has resulted in general consensus that greater clarity is needed to ensure that emerging compensation arrangements under these models are permissible.
- This aim can be achieved by working within the current MPRL framework, which covers referrals involving all payors (government, commercial, private), applies to all health care practitioners (not just physicians as under the federal Stark law), and applies to all health care services (not just designated health services or entities providing designated health services as under the federal Stark Law).

Consensus Points

- Maryland should consider incorporating the elements from the federal Stark law that can enhance the MPRL to provide payment clarity, predictability and stability to health care practitioners as they consider partnerships and new models designed to achieve value-based payment goals.
- Changes should neither repeal the MPRL nor replace it with the federal Stark law.
- The well-being of patients must be paramount in the evaluation of any changes to the MPRL. Accordingly, any changes considered must not diminish important protections for patients against inappropriate utilization or costs of healthcare services.
- Any revisions to the MPRL cannot jeopardize Maryland's all-payor rate setting agreement with the federal government, which requires reduction in inappropriate utilization and strict limits on health care spending, both in and outside of the hospital.

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

MMPP Evaluation: Medicaid Programs Impacts

(Agenda Item #8)

Maryland's Multi-Payor Patient Centered Medical Home Program

Medicaid Program Impacts

November 19, 2015

The MARYLAND
HEALTH CARE COMMISSION

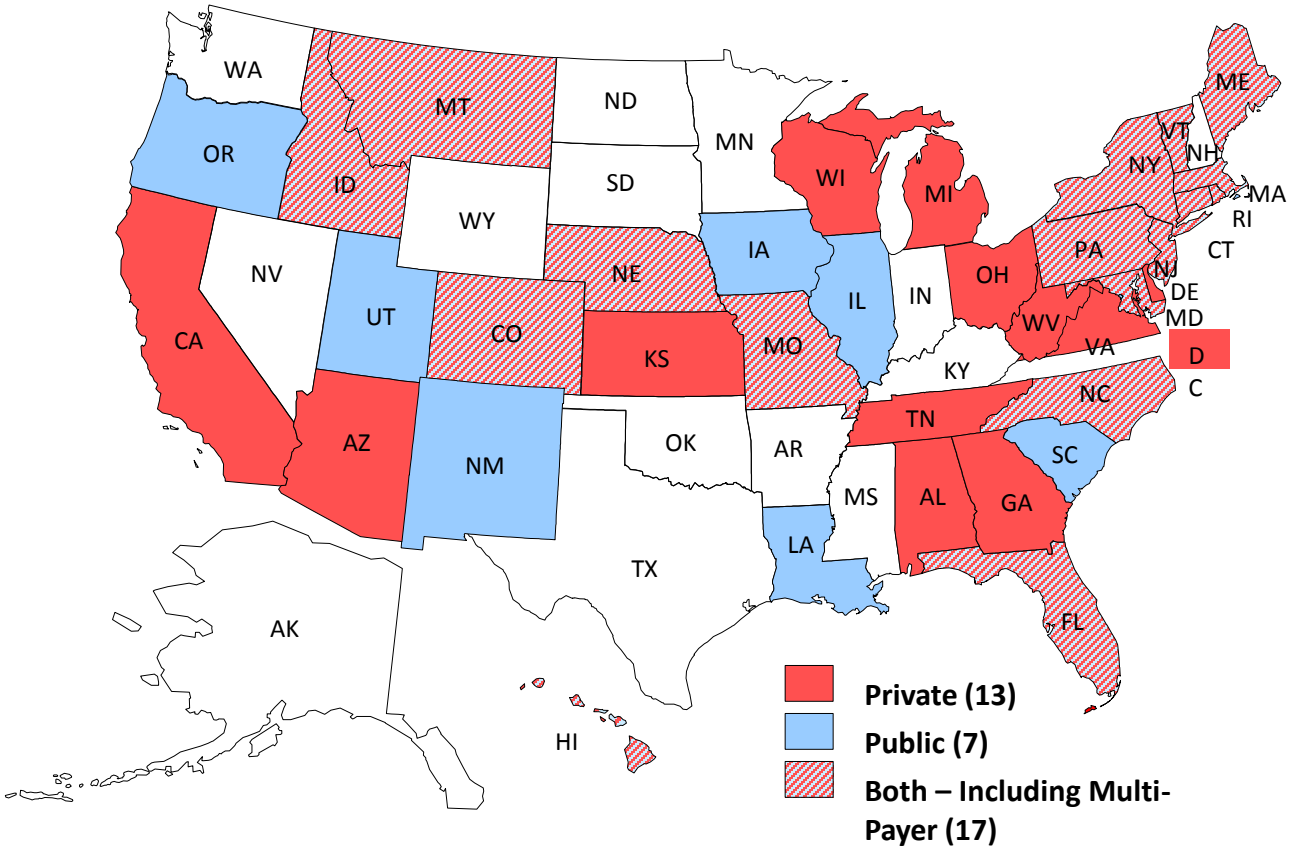
The Essential Role of Primary Care

- Fee-for-service payment systems have typically under-resourced primary care
- Effective primary care is essential to achieving the triple aim
- Around the country, state policy-makers have tackled the issue of how to foster adoption of patient-centered primary care models
- Especially important for vulnerable populations with high rates of chronic disease and with limited access to health resources

Advanced Primary Care

- **Better health outcomes**
- **Better patient experience**
- **Lower costs**
- **Improved physician experience**

States That Have Public and Private Patient-Centered Medical Home (PCMH) Initiatives That Use NCQA Recognition



Source: NCQA March 2014

MMPP Overview

- Maryland law (2010) required the MHCC to develop a three-year pilot Multi-Payor Patient Centered Medical Home (PCMH) Program to improve the health and satisfaction of patients and slow the growth of health care costs while supporting the satisfaction and financial viability of primary care providers and enabled:

  - Exemption for a cost-based incentive payment tied to PCMH; and
  - Authority for carriers to establish single carrier PCMH programs with an incentive-based reward structure (shared savings) and data sharing

- The pilot evaluation period ended June 30, 2014; however, the program continues through 2015, and with Medicaid until June 30, 2016

Participating Practices

- 52 practices from across Maryland that vary in size and ownership; includes two Federally Qualified Health Centers
- Specialties include pediatric, family practice, internal medicine, and geriatric practices
- 339 practitioners, mostly physicians and some certified registered nurse practitioners
- 100,000 attributed commercial patients
- 56,000 Medicaid patients
- For 15 of 52 practices in 2014, Medicaid enrollees were at least 20 percent of their patient mix

Key Program Components

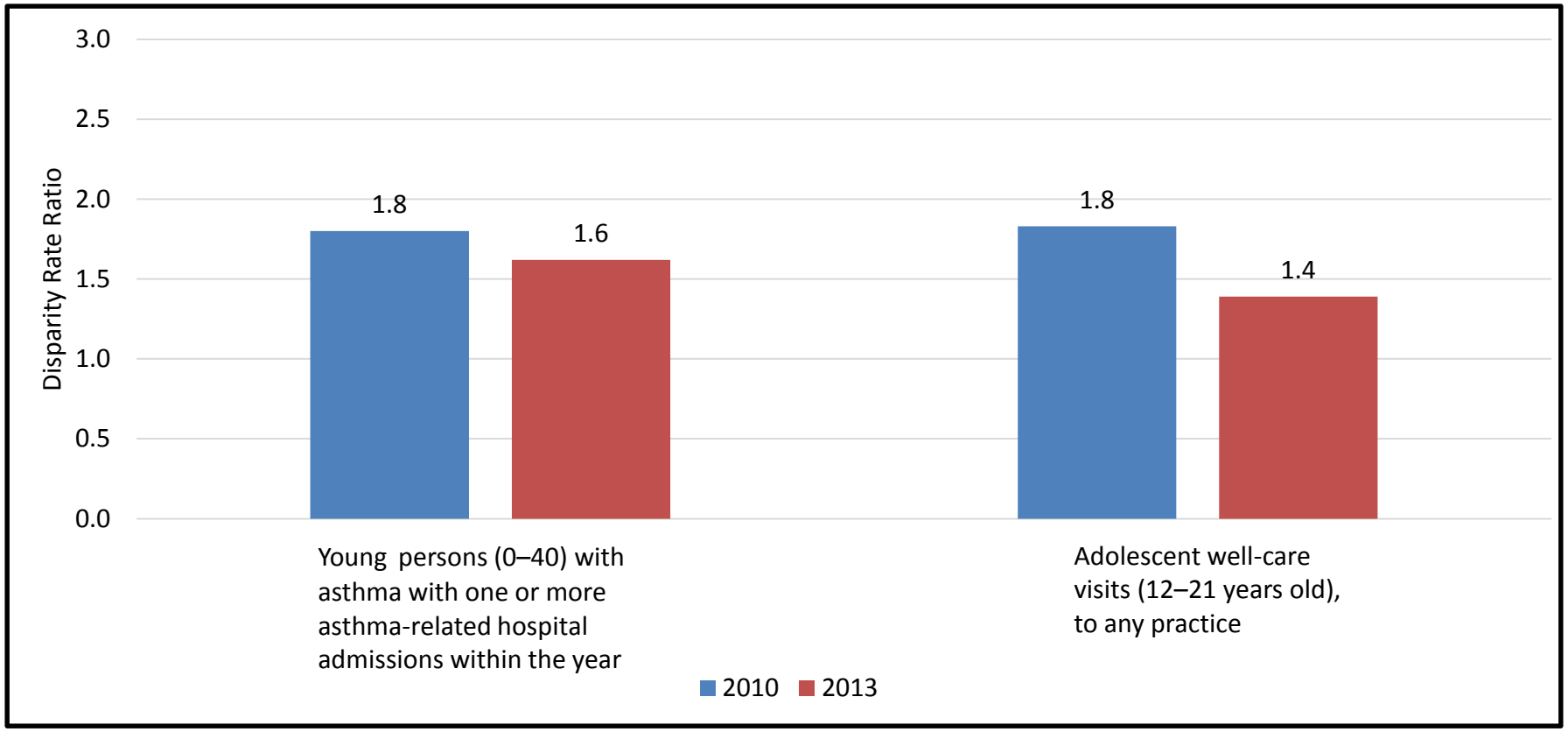
- Innovative payment reforms to support primary care;
- Multiple payor participation;
- State government convening role;
- Standards for PCMH identification;
- New staffing models for team-based primary care;
- Technical assistance to practice sites;
- Common measurement of performance; and
- Collaborative learning

Program Evaluation

- IMPAQ International conducted an evaluation of the MMPP pilot
  - The IMPAQ team includes researchers from IMPAQ International, the Johns Hopkins Bloomberg School of Public Health, Healthcare Resolution Services, and the University of Maryland School of Pharmacy

- IMPAQ developed five issue briefs:
  - Health care disparities;
  - Health care quality, utilization and costs;
  - Patient experience and satisfaction;
  - Practice transformation; and
  - Provider satisfaction

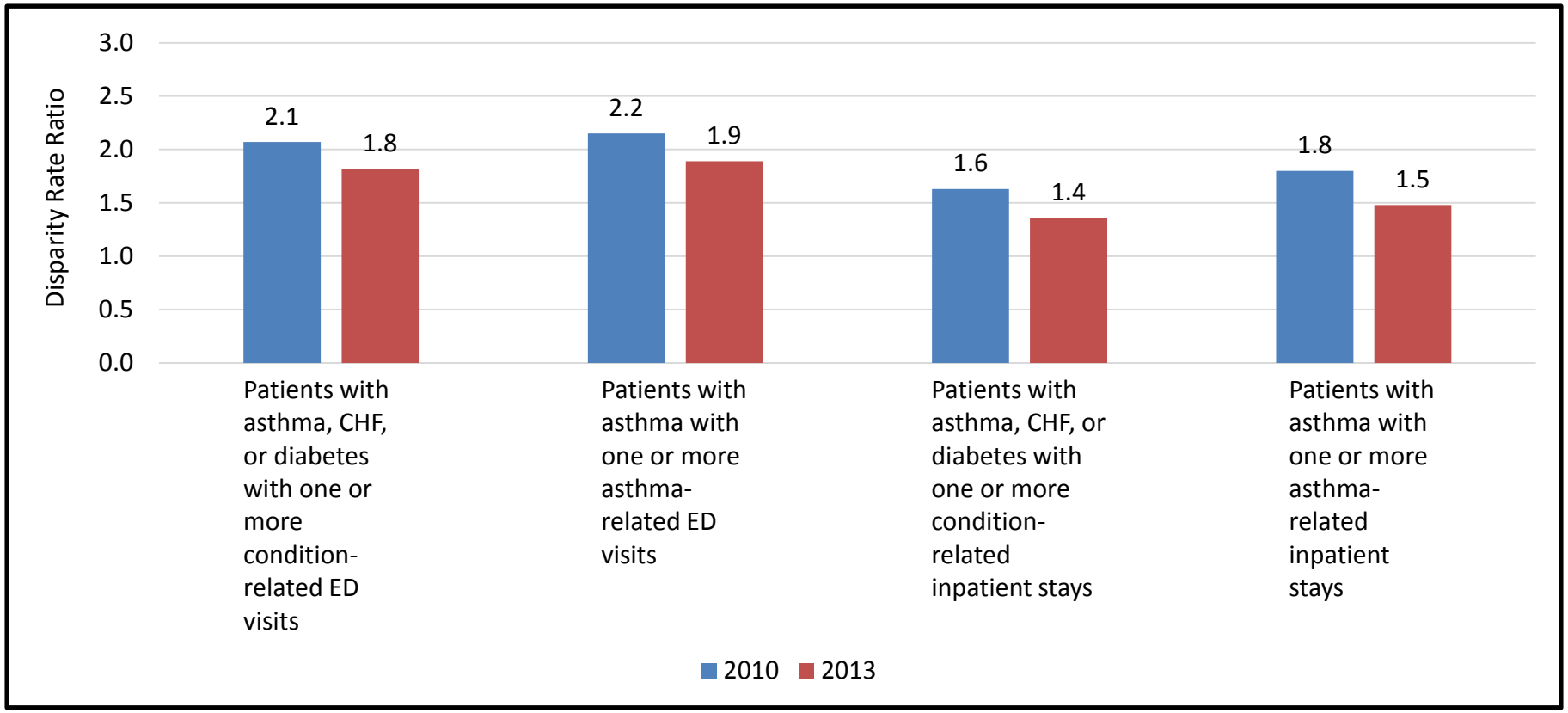
Health Care Racial Disparities In Quality 2010 Versus 2013



Racial disparity was measured using the patient race for Medicaid enrollees: non-white or white. All measures presented have a significant disparity ($p < 0.1$) in the baseline year. This graph displays changes in disparities from the baseline (2010) period to the third year (2013) of the program.

Disparity rate ratio	Interpretation
1.0-1.4	Little or no disparity
1.5-1.9	A disparity exists and should be monitored and may require intervention
2.0-2.4	The disparity requires intervention
2.5-2.9	Major interventions are needed
≥3.0	Urgent interventions are needed

Health Care Racial Disparities In Utilization 2010 Versus 2013



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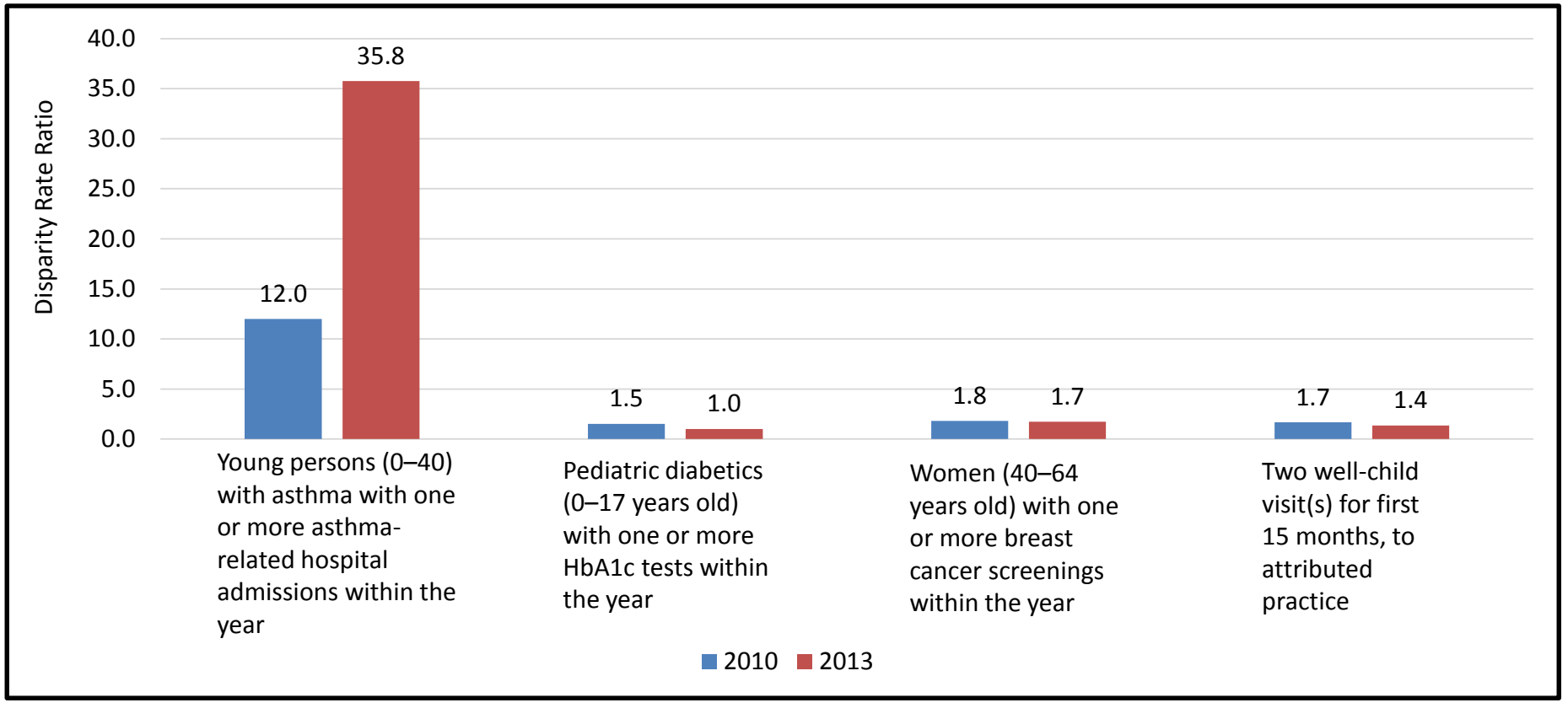
Health Care Payor Disparities In Quality 2010 Versus 2013



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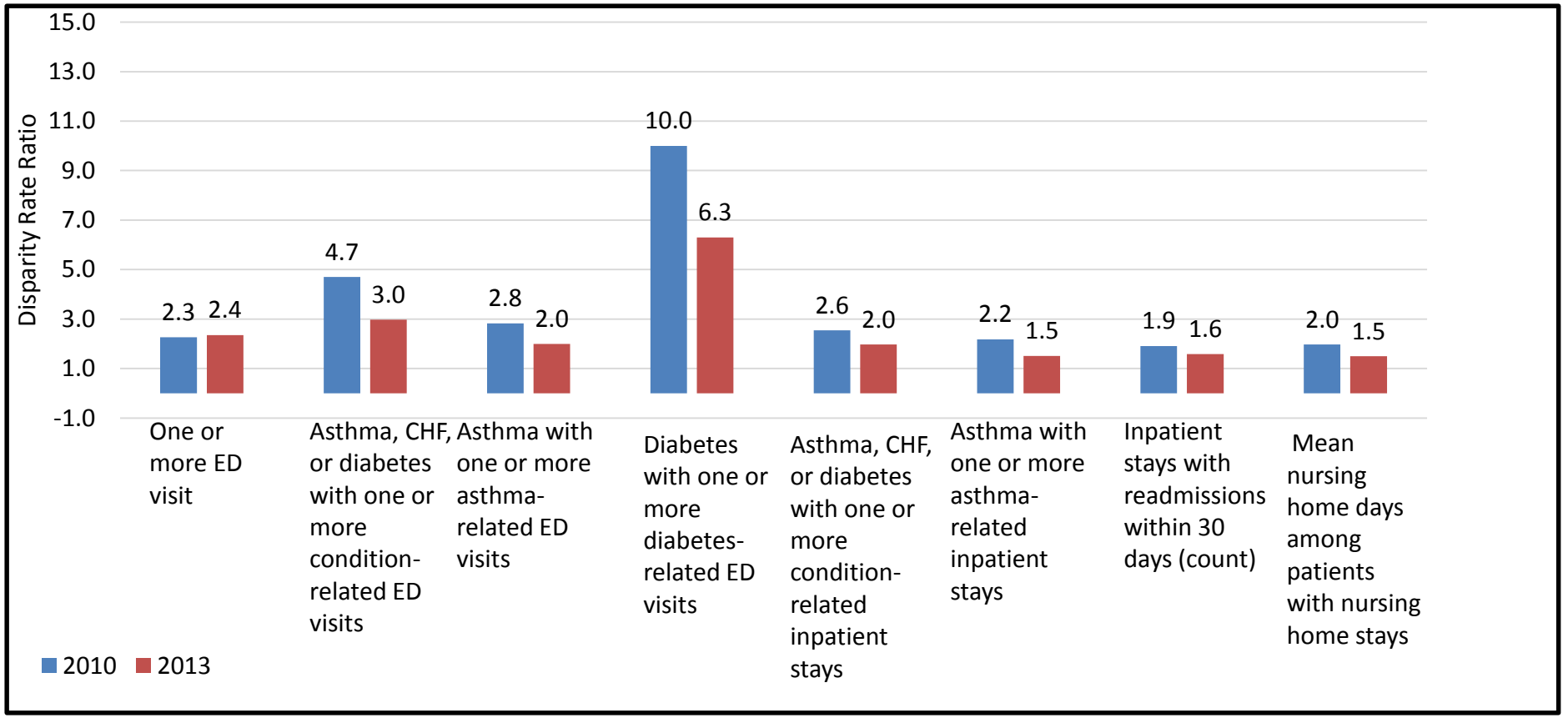

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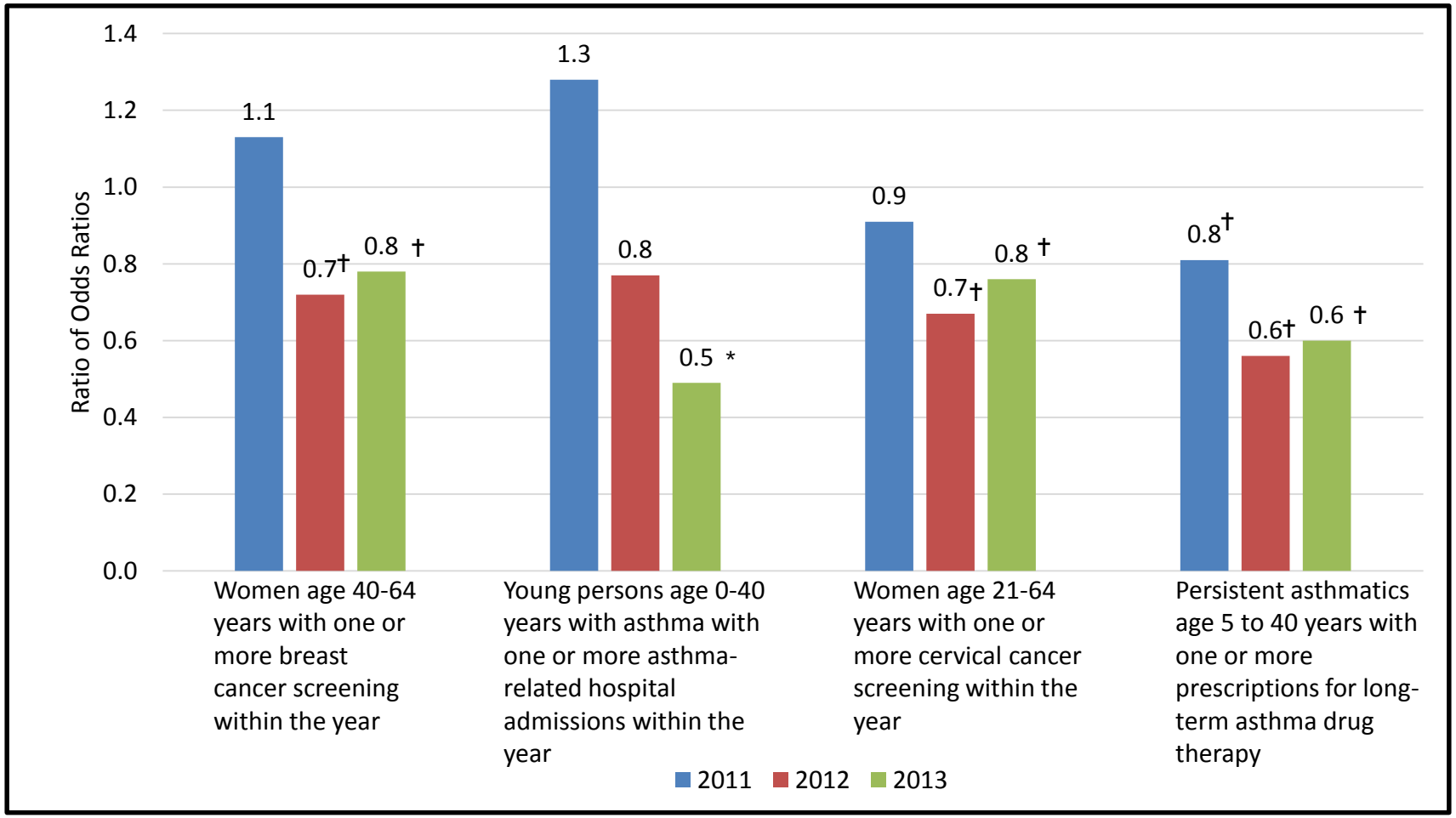
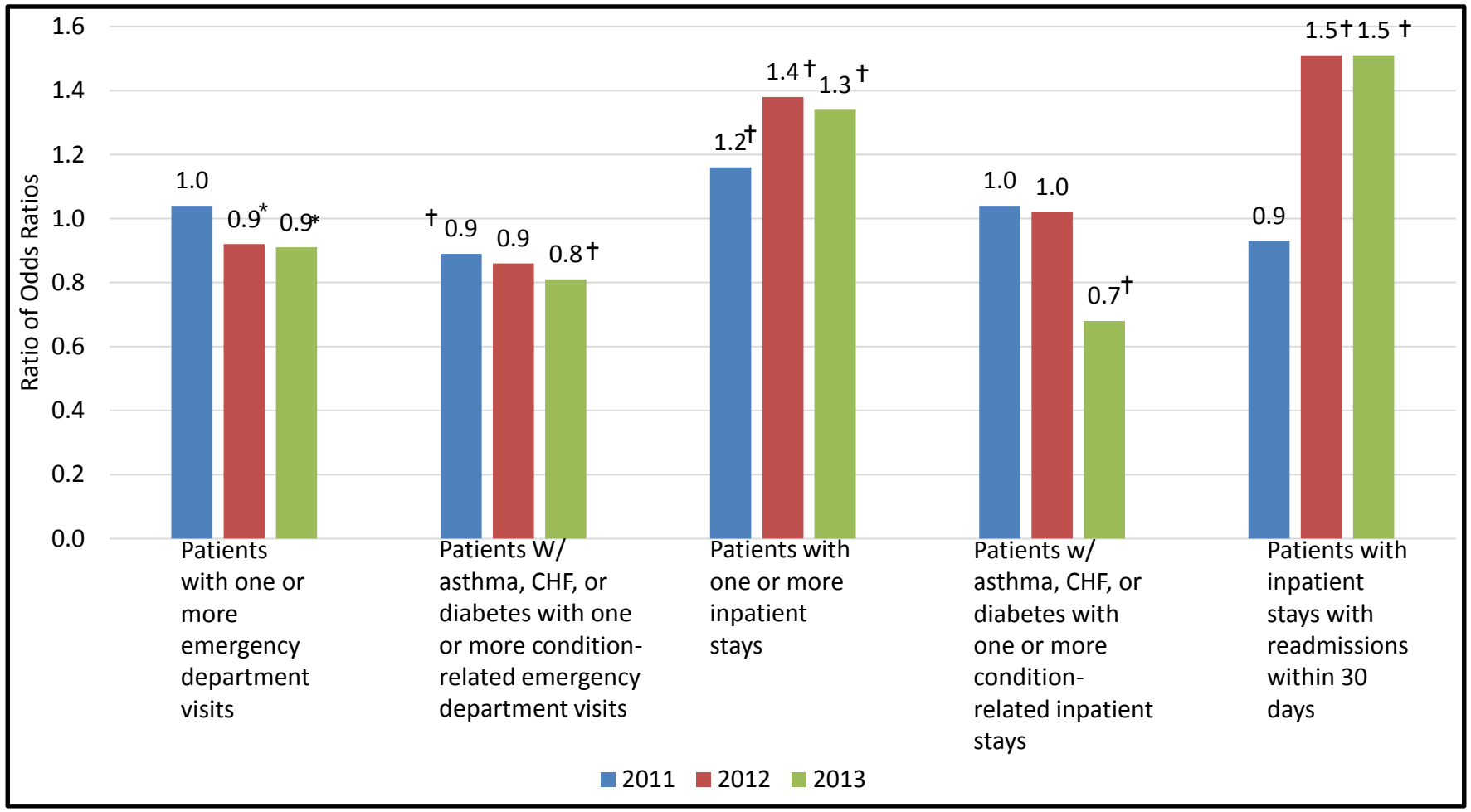
Adjusted Difference-In-Difference Estimates For Selected Quality Measures (vs. 2010)



*p<0.10 †p<0.05

Results are based on the difference-in-difference coefficients, and are adjusted for practice location (proximity to large/small metropolitan area), practice type (solo vs. other), practice use of electronic medical records, proportion of white practitioners in the practice and patient case-mix. The DID approach compares the change in the non-MMPP group to the change in the MMPP group.

Adjusted Difference-In-Difference Estimates For Selected Utilization Measures (vs. 2010)



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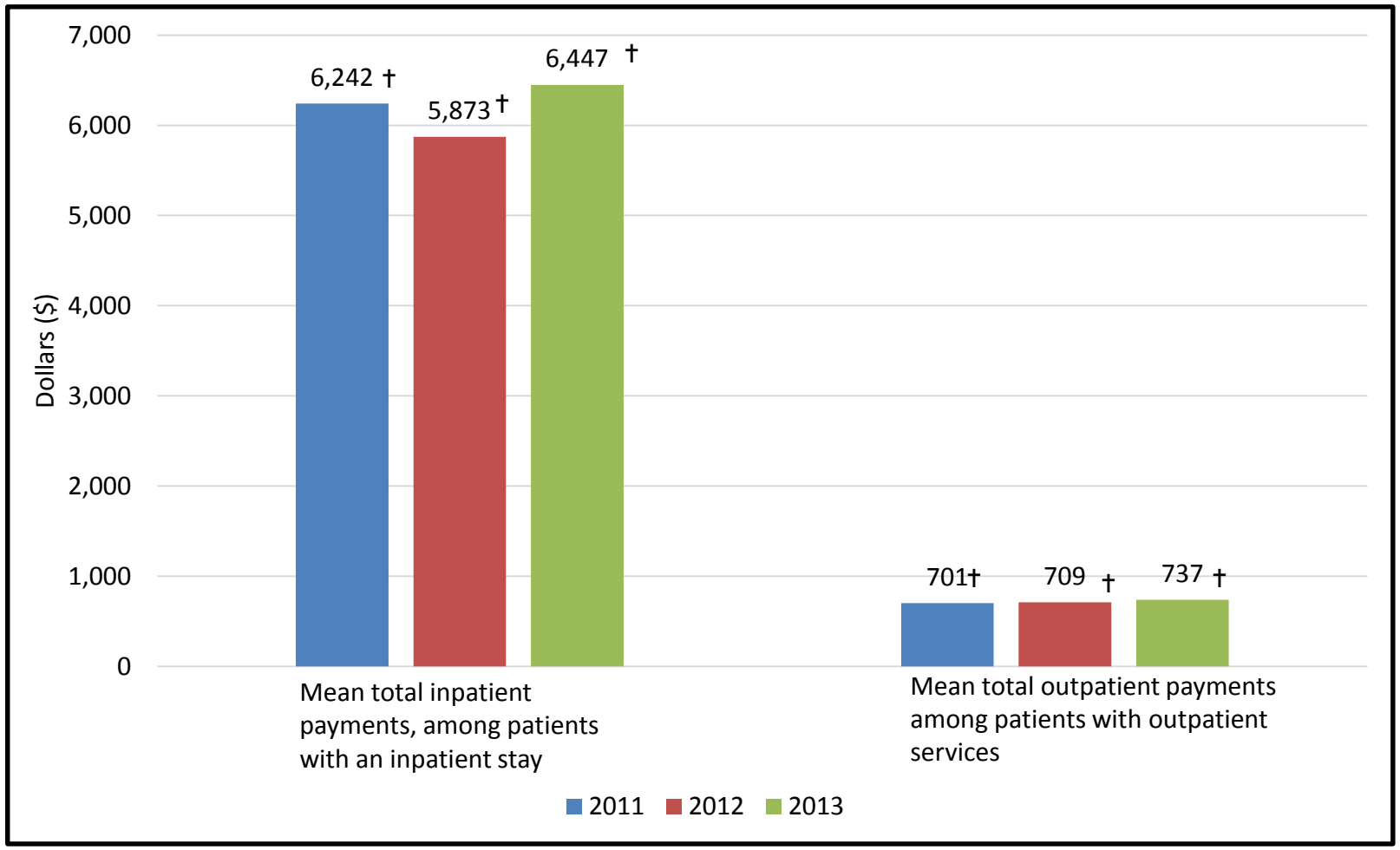
Adjusted Difference-In-Difference Estimates For Selected Cost Measures (vs. 2010)



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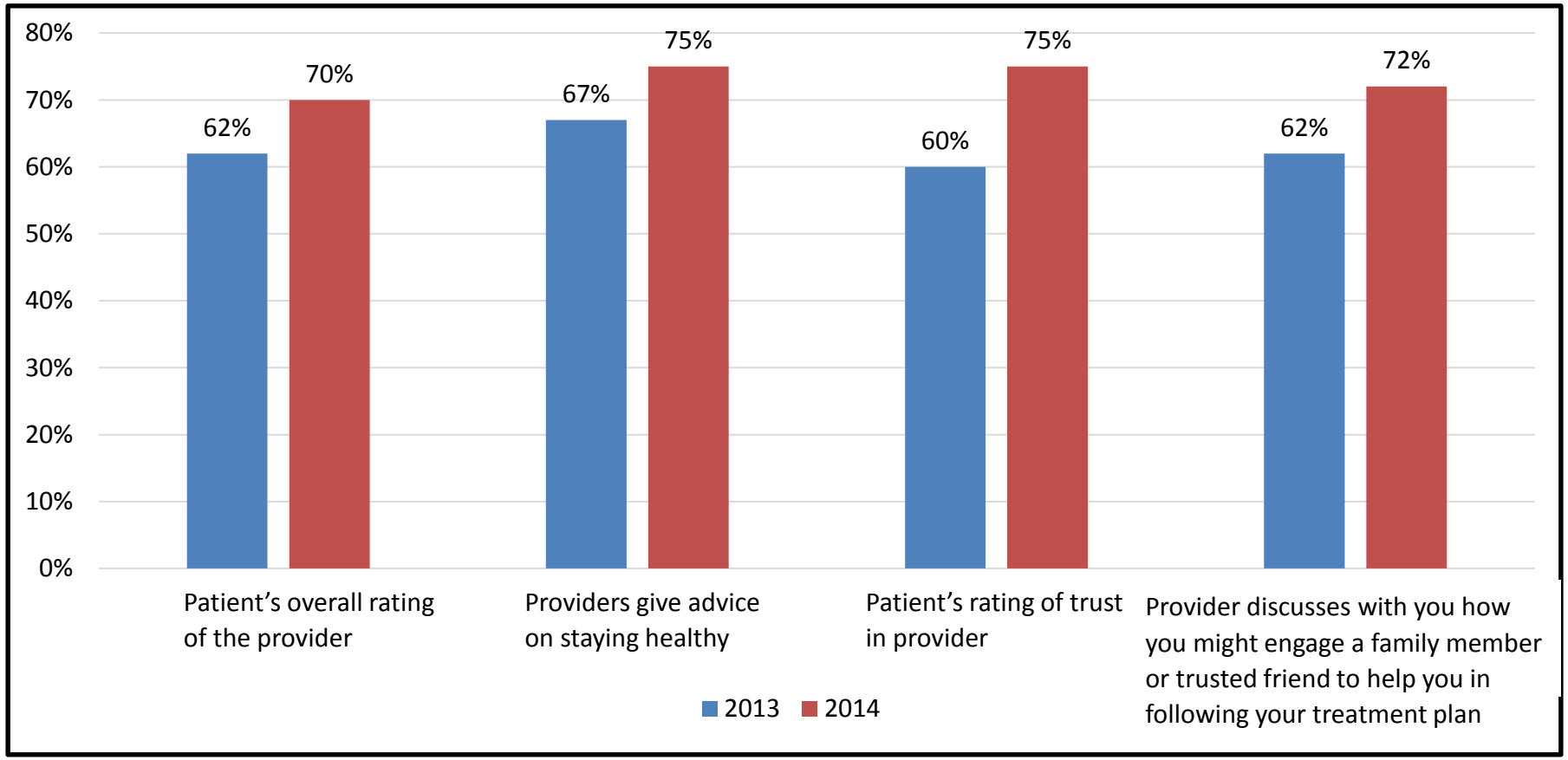
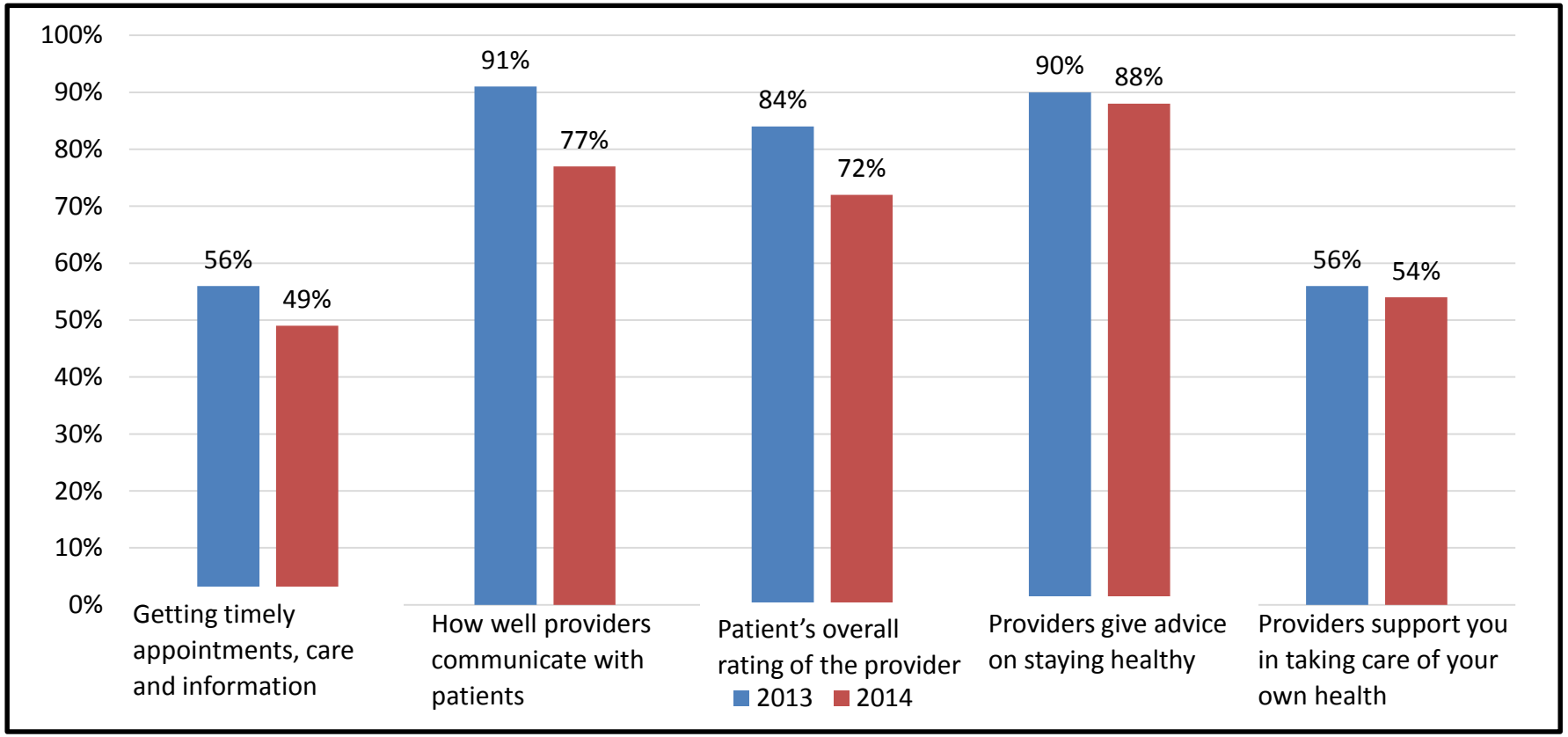
Patient Experience & Satisfaction Survey Responses Indicating Excellent Performance - Adult



For the items and scales from the CAHPS Survey, this report displays the "top box" score, referring to the percentage responding in the most positive response categories, indicating excellent performance.

Patient Experience & Satisfaction Survey Responses Indicating Excellent Performance – Respondents for Children

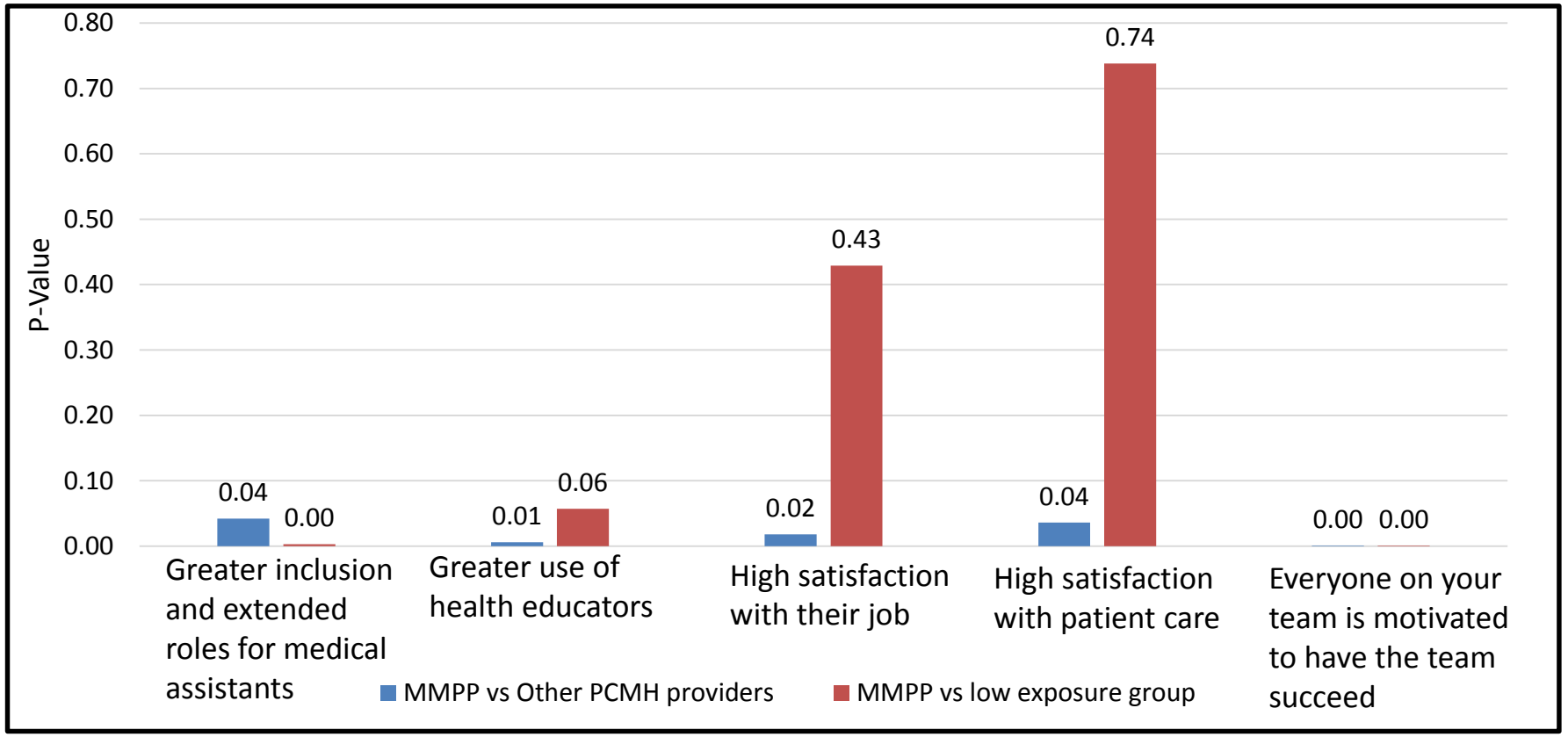


For the items and scales from the CAHPS Survey, this report displays the "top box" score, referring to the percentage responding in the most positive response categories, indicating excellent performance.

Provider Survey Results, 2014

- GreGreater inclusion and extended roles for medical assistants in MMPP practices compared to non-participating practices
- ater use of health educators
- Higher satisfaction with their job than "Other PCMH"
- Higher satisfaction with patient care than "Other PCMH"
- Positive perceptions of several team-functioning measures

Provider Survey Results, 2014



*P values from ordinal logistic regression models that adjust for age (continuous), gender (male/female), race (Caucasian/other), profession in years (<20, >=20), practice type (solo, single specialty, multi-specialty, other), EMR system (no, all electronic, partially electronic), and clustering (robust standard error).

Wrap Up – The Evaluation

- IMPAQ concluded that the program led to improved health care, which may result in improved health outcomes
- Breadth of improvements ranged from breadth of positive findings from high job satisfaction, and satisfaction with the care provided to their patients, to improving relationships between patients and providers
- One of the greatest improvements reported by IMPAQ was in reducing health care disparities; continuing to reduce health care disparities will:
  - Improve health outcomes for the Medicaid population;
  - Reduce expenditures related to medical care and indirect costs; and
  - Align Maryland's health care system with the national Healthy People Initiative

Thank You!

Melanie Cavaliere

(410) 764-3282

melanie.cavaliere@maryland.gov

MARYLAND HEALTH CARE COMMISSION

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ACTION:

Approval for Release of MCDB Data Submission Manual

(Agenda Item #9)

MARYLAND HEALTH CARE COMMISSION

MCDB Submission Manual

COMMISSION MEETING

NOVEMBER 19, 2015

Overview

- Refresher on MCDB Reporting Requirements
- Review changes in 2016 Submission Manual
- Seek approval of 2016 Submission Manual

What's included in the MCDB?

- Commercial Reporting Entities:
  - Life and Health Insurance Carriers and HMO's
  - TPA's, PBM's, Behavioral Health Administrators
  - Qualified Health Plans and Qualified Dental Plans
- Data reported:
  - Membership / Eligibility
  - Claims files: Professional, Institutional, Pharmacy, and Dental
  - Provider Directory
  - Plan Benefit Design and Non-Fee-for-Service Spending (Future)
- Medicaid MCO data provided by Medicaid via the Hilltop Institute and Medicare Data acquired through data request from ResDAC

What's changing?

- No changes in overall reporting requirements
- Institutional file format change from header-record level to line-level reporting
- Quarterly reporting for Master Patient Index
- Promoting timeliness through:
  - Clarifying reporting requirements and validation checks
  - Shortening submission and review timelines
  - Enforcing fining authority

Next Steps

- Commission questions and vote on posting submission manual to Commission website
- Disseminate Manual and follow up with Payor Meetings
- Implement changes for submission starting in May 2016 for Q1 2016 Data Reports

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Approval for Release of MCDB to Research Triangle Institute (RTI) for use in the evaluation of Maryland's new Hospital Payment Model Waiver

(Agenda Item #10)

MARYLAND HEALTH CARE COMMISSION

MCDB Data Release and IRB Review – RTI

COMMISSION MEETING

NOVEMBER 19, 2015

Overview

- Goal: Review and vote on application for MCDB Data by Research Triangle Institute
- Framework for evaluation of applications
- RTI application details
- Recognition of IRB

Framework for Evaluation

- Appropriate use of data
  - Is it a permitted use?
  - Is the data appropriate for the project?
- Qualified user
  - Does the applicant have expertise with this type of data?
  - Does applicant have expertise with the specified analyses/projects
- Data Security / Data Management Plan
  - Is there an appropriate plan for securing the data?
  - Is access restricted to qualified users?
  - Adherence to limitations on re-release and reporting of data

Research Triangle Institute Application

- Appropriate Use
  - RTI has been contracted by the CMS Innovation Center (CMMI) to conduct an independent evaluation of the Maryland hospital payment model
  - RTI plans to qualitatively evaluate hospital responses to the new payment model, such as changes to organizational structure, clinical coordination, etc. and then quantitative evaluate the impact of changes using the MCDB data to evaluate cost, utilization, revenue, service mix, market share, etc..
- Qualified User
  - RTI has extensive experience with these types of analyses and is a leading consultant nationally to federal and state agencies.
  - The project team has specific expertise in similar evaluations using claims data, such as for the State Innovation Model program.
- Data Security / Data Management Plan
  - RTI has provided appropriate documentation of its data management plan to secure MCDB Data
  - Access to MCDB data will be restricted to project staff, who will be identified to MHCC in DUA

Research Triangle Institute Application

- Data request is for Commercial Data for CY 2011-2018
- MCDB includes eligibility records and claims files (professional, institutional, and pharmacy)
  - No direct identifiers in the data, such as name, address, SSN, etc.
  - Indirect identifiers include gender, age, zip code of residence, dates of service.
  - Member ID's will be masked to permit linking across MCDB files.
    - DUA will prohibit linking beyond MCDB files at the member level
    - DUA will prohibit efforts to re-identify members
  - No individual payor identification

Recognition of RTI IRB and IRB Review

- The RTI IRB is registered with U.S. Department of Health and Human Services (approved through 08/31/2017) and has an approved Federalwide Assurance (approved through 06/16/2020), which is a commitment to comply with the FWA Terms of Assurance.
- RTI's IRB has reviewed and qualified this application as exempt from IRB review based on 45 CFR 46.101(b)(5): "*Research and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine: (i) Public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs.*"

Next Steps

- If approved by Commissioners, MHCC staff will execute a DUA with RTI and release data.
- Ongoing compliance review under DUA

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**
2. **UPDATE OF ACTIVITIES**
3. ACTION: Approval for Release – Maryland Trauma Physicians Services Fund Report
4. **ACTION**: Approval for Release - Maryland Hospital Palliative Care Programs: Analysis and Recommendation
5. **ACTION:** COMAR 10.24.16 – State Health Plan for Facilities and Services: Home Health Agency Services – Proposed Permanent Regulation
6. **ACTION:** COMAR 10.24.08 – State Health Plan for Facilities and Services: Nursing Home Services - Proposed Permanent Regulation
7. **ACTION:** Approval for Release – Report of Maryland Self-Referral Provider-Carrier Workgroup
8. **PRESENTATION:** MMPP Evaluation: Medicaid Program Impacts
9. **ACTION:** Approval for Release of MCDB Data Submission Manual
10. **ACTION:** Approval for Release of MCDB to Research Triangle Institute (RTI) for use in the evaluation of Maryland's new Hospital Payment Model Waiver
11. **ACTION: Approval for Release of the MCDB to George Mason University for use in the evaluation of the CareFirst PCMH Program**
12. **UPDATE:** Telehealth Grant Awards
13. **Overview of Upcoming Initiatives**
14. **ADJOURNMENT**

ACTION:

Approval for Release of the MCDB to George Mason University for use in the evaluation of the CareFirst PCMH Program

(Agenda Item #11)

MARYLAND HEALTH CARE COMMISSION

MCDB Data Release and IRB Review – GMU

COMMISSION MEETING

NOVEMBER 19, 2015

Overview

- Goal: Review and vote on application for MCDB Data by George Mason University
- Framework for evaluation of applications
- GMU application details
- Recognition of IRB

Framework for Evaluation

- Appropriate use of data
  - Is it a permitted use?
  - Is the data appropriate for the project?
- Qualified user
  - Does the applicant have expertise with this type of data?
  - Does applicant have expertise with the specified analyses/projects
- Data Security / Data Management Plan
  - Is there an appropriate plan for securing the data?
  - Is access restricted to qualified users?
  - Adherence to limitations on re-release and reporting of data

George Mason University Application

- Appropriate Use
  - GMU has been contracted by CareFirst to evaluate their Patient Centered Medical Home Program
  - GMU will evaluate whether the program reduced costs of care for professional services, institutional services, and pharmacy services, and utilization as visits to emergency rooms, inpatient stays, and specialty care visits. They will compare performance within CareFirst to all other payors, as a single control group.
- Qualified User
  - GMU and the Center for Health Policy Research and Ethics has extensive experience with these types of analyses and is a leading research team in the area of health policy research.
  - The project team has specific expertise with similar analyses, using both state and federal claims data.
- Data Security / Data Management Plan
  - GMU has provided appropriate documentation of its data management plan to secure MCDB Data
  - Access to MCDB data will be restricted to project staff, who will be identified to MHCC in DUA

George Mason University Application

- Data request is for Commercial Data for CY 2010-2014
- MCDB includes eligibility records and claims files (professional, institutional, and pharmacy)
  - No direct identifiers in the data, such as name, address, SSN, etc.
  - Indirect identifiers include gender, age, zip code of residence, dates of service.
  - Member ID's will be masked to permit linking across MCDB files.
    - DUA will prohibit linking beyond MCDB files at the member level
    - DUA will prohibit efforts to re-identify members
  - No individual payor identification

Recognition of GMU IRB and IRB Review

- The GMU IRB is registered with U.S. Department of Health and Human Services (approved through 08/27/2018) and has an approved Federalwide Assurance (approved through 08/26/2020), which is a commitment to comply with the FWA Terms of Assurance.
- GMU's IRB has reviewed and qualified this application as exempt from IRB review based on 45 CFR 46.101(b)(4): "*Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects*"

Next Steps

- If approved by Commissioners, MHCC staff will execute a DUA with GMU and release data.
- Ongoing compliance review under DUA

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

UPDATE:

Telehealth Grant Awards

(Agenda Item #12)

Telehealth Grants

Thursday, November 19, 2015

The MARYLAND
HEALTH CARE COMMISSION

Authority and Current Projects

- MHCC Authority
  - Maryland law, established in 2014, authorizes MHCC to directly award grants to non-profit organizations and qualified businesses
- Current Projects Assessing the Impact of Telehealth
  - Round One – coordinate care delivery between a comprehensive care facility and a general acute care hospital using video consultation
  - Round Two – demonstrate the impact of remote patient monitoring on hospital re-admission in various settings

The Value of Telehealth Grants

- Diverse telehealth use cases provide an opportunity to test the effectiveness of telehealth with various technology, patients, providers, clinical protocols, and settings
- Challenges and successes from each round of projects are shared with the next – building on successes
- Lessons learned from these projects will inform
  - Better practices and industry implementation efforts
  - Potential policies to support the advancement of telehealth
  - The design of larger telehealth programs and projects across the State

Telehealth Grants – Round Three

- MHCC plans to fund three new telehealth projects
  - Evaluation panel identified three applicants to be awarded up to $30,000 in grant funds
  - Staff worked with the grantees to enhance proposals based on evaluation panel recommendations
  - Projects will be implemented over an 18-month period
- Goal: Demonstrate the impact of using telehealth technology to improve the overall health of the population being served and the patient experience

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, (currently CRISP, the Chesapeake Regional Information System for our Patients)
- Provide a 2:1 financial match contribution to grant funds
- Implement telehealth technology in a meaningful way
- Develop clinical protocols to demonstrate improved outcomes

Associated Black Charities

- Who
  - Community association that assists minority and rural communities with navigating the health care system through health literacy and outreach within Dorchester and Caroline Counties
- How
  - Provide specialized mobile tablets to community health workers within Health Enterprise Zone (HEZ) region for use while visiting patients at home and facilitate primary care and behavioral health video consultations with a licensed nurse care coordinator from Choptank Community Health System
- Why
  - Extend a clinical telehealth presence into rural health care outreach visits and increase access to primary care and behavioral health services by patients in a HEZ region to improve care coordination and health outcomes

Gerald Family Care

- Who
  - Three family practice locations within a patient centered medical home model that provides services to residents of Prince George's County in coordination with Dimensions Health System specialists
- How
  - Implement telehealth video and image capture capabilities in each site that will support patient consultations with specialists; services will include gastroenterology, orthopedics, neurology, and behavioral health
- Why
  - To increase access to and reduce waiting times for specialty and sub-specialty care services to patients in underserved areas

Union Hospital of Cecil County

- Who
  - Care management team within acute care hospital in Elkton, MD
- How
  - Provide chronic care patients discharged to home from the hospital with specially configured mobile tablets and peripheral devices that capture blood pressure, pulse, and weight and provide on-demand patient education; allow hospital care coordinator to monitor conditions; and enable single sign-on technology to facilitate sharing of telehealth data with the hospital ED provider and participating primary care providers
- Why
  - Enhance care management, improve population health, and reduce hospital ED visits and readmissions among patients with chronic health conditions

Next Steps

- November: Launch telehealth projects
- December – May 2017: Implementation of telehealth projects with consultative support by staff
- May 2017– July 2017: Impact of telehealth projects assessed
- August 2017: Release findings from the assessment

Thank You!

The MARYLAND
HEALTH CARE COMMISSION

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

Overview of Upcoming Initiatives

(Agenda Item #13)


ENJOY THE REST OF
YOUR DAY