Maryland Health Care Commission

Thursday, July 21, 2016

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**
2. UPDATE OF ACTIVITIES
3. **UPDATE**: Health Care Quality Reports Website: Health-Associated Infections Results
4. **PRESENTATION**: Potential for including Maryland Hospitals on the Leapfrog Group's Website
5. **ACTION**: Certificate of Need: Chesapeake Treatment Center, Docket No. 15-24-2371
6. **ACTION**: COMAR 10.24.15 - State Health Plan for Facilities and Services: Organ Transplant Services Chapter – Proposed Regulations
7. **ACTION**: COMAR 10.24.19 – State Health Plan for Facilities and Services: Freestanding Medical Facilities Chapter – Proposed Regulations
8. **PRESENTATION**: Practice Transformation Network (PTN)
9. Overview of Upcoming Initiatives
10. ADJOURNMENT

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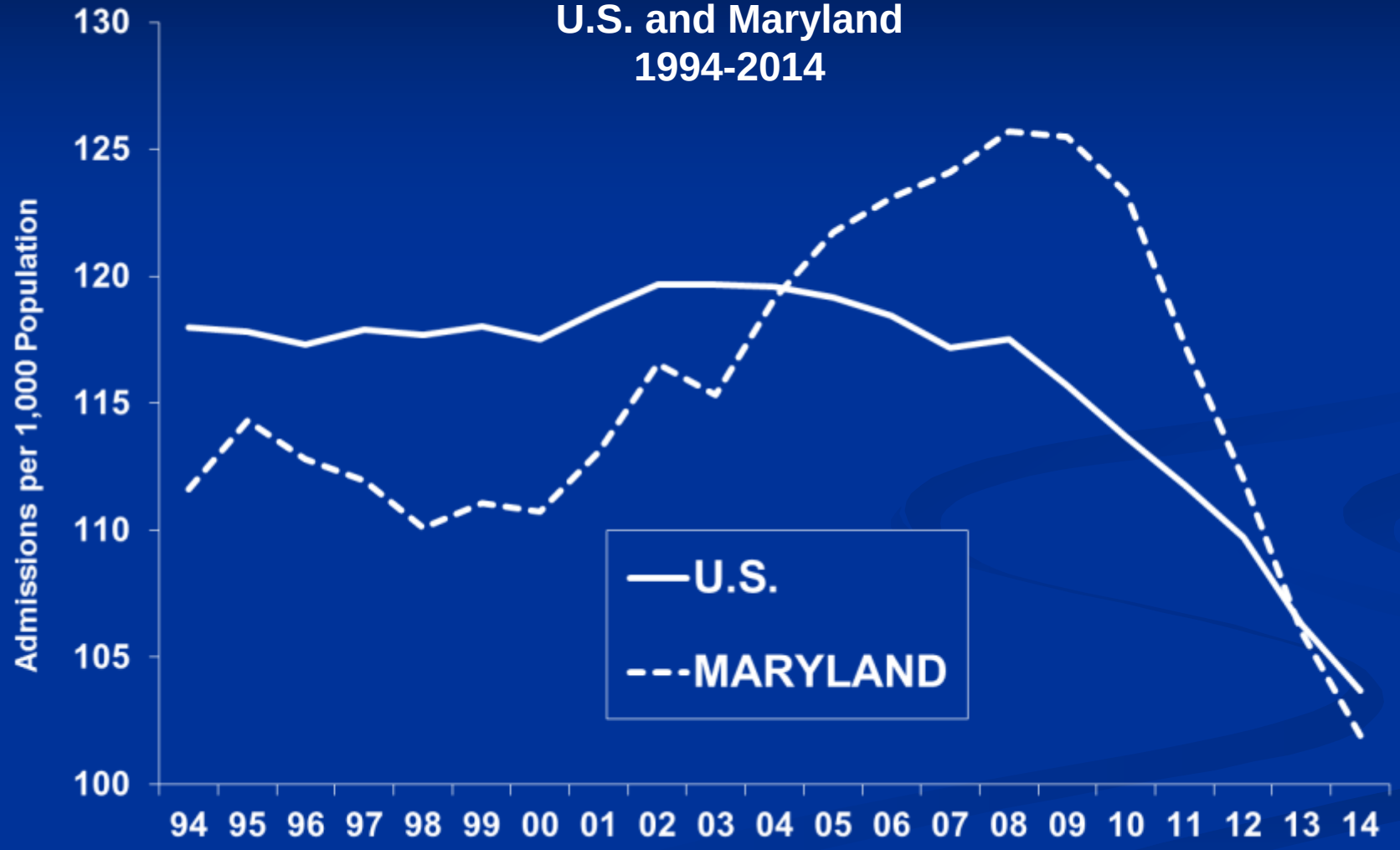
RECENT TRENDS IN DEMAND FOR GENERAL ACUTE CARE HOSPITAL BEDS

Maryland

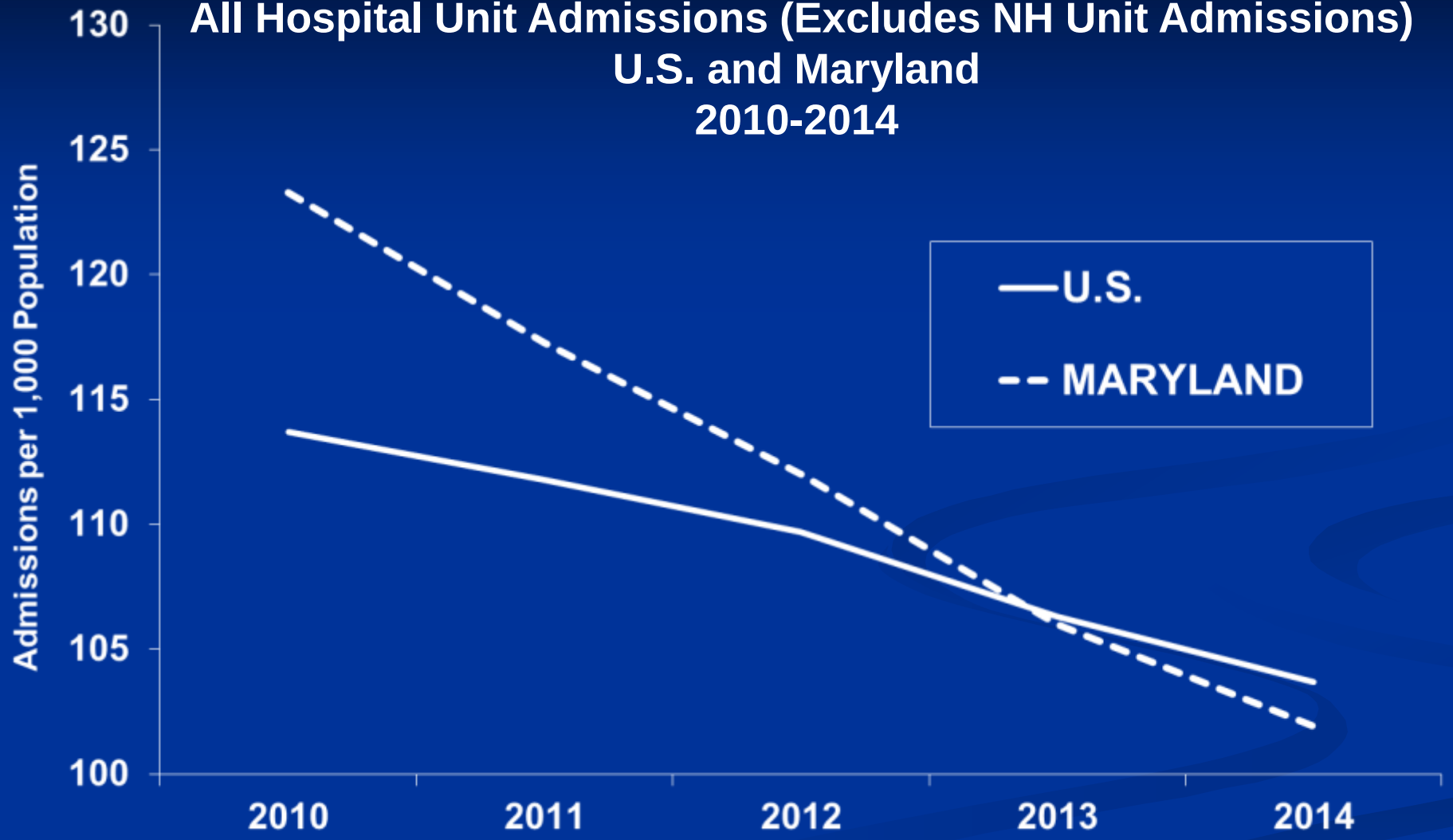
July 21, 2016

Hospital Admissions per 1,000 Population
All Hospital Unit Admissions (Excludes NH Unit Admissions)
U.S. and Maryland
1994-2014



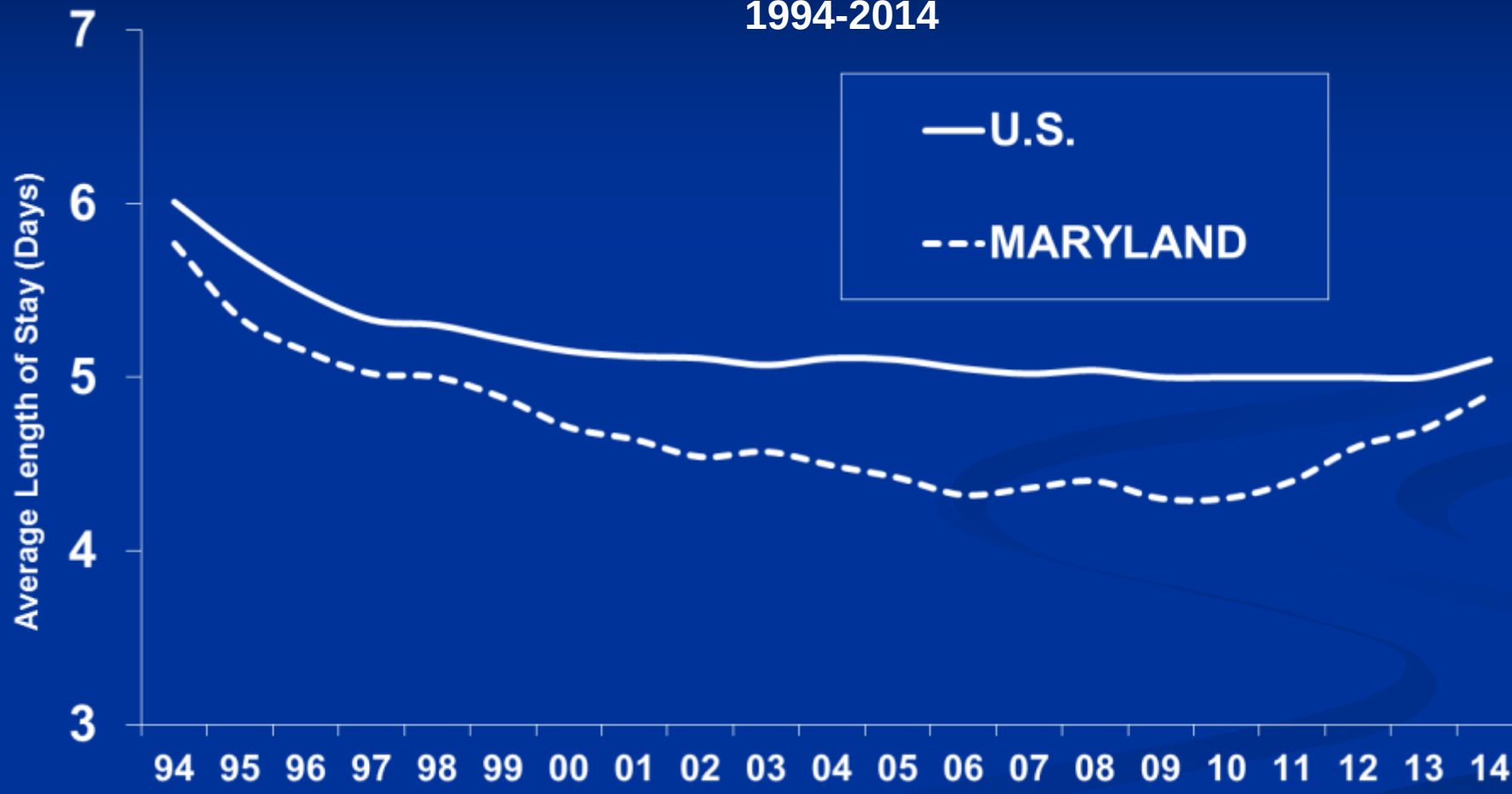
AHA Hospital Statistics

Hospital Admissions per 1,000 Population
All Hospital Unit Admissions (Excludes NH Unit Admissions)
U.S. and Maryland
2010-2014



AHA Hospital Statistics

Hospital Average Length of Stay
All Hospital Unit Admissions (Excludes NH Unit Admissions)
U.S. and Maryland
1994-2014

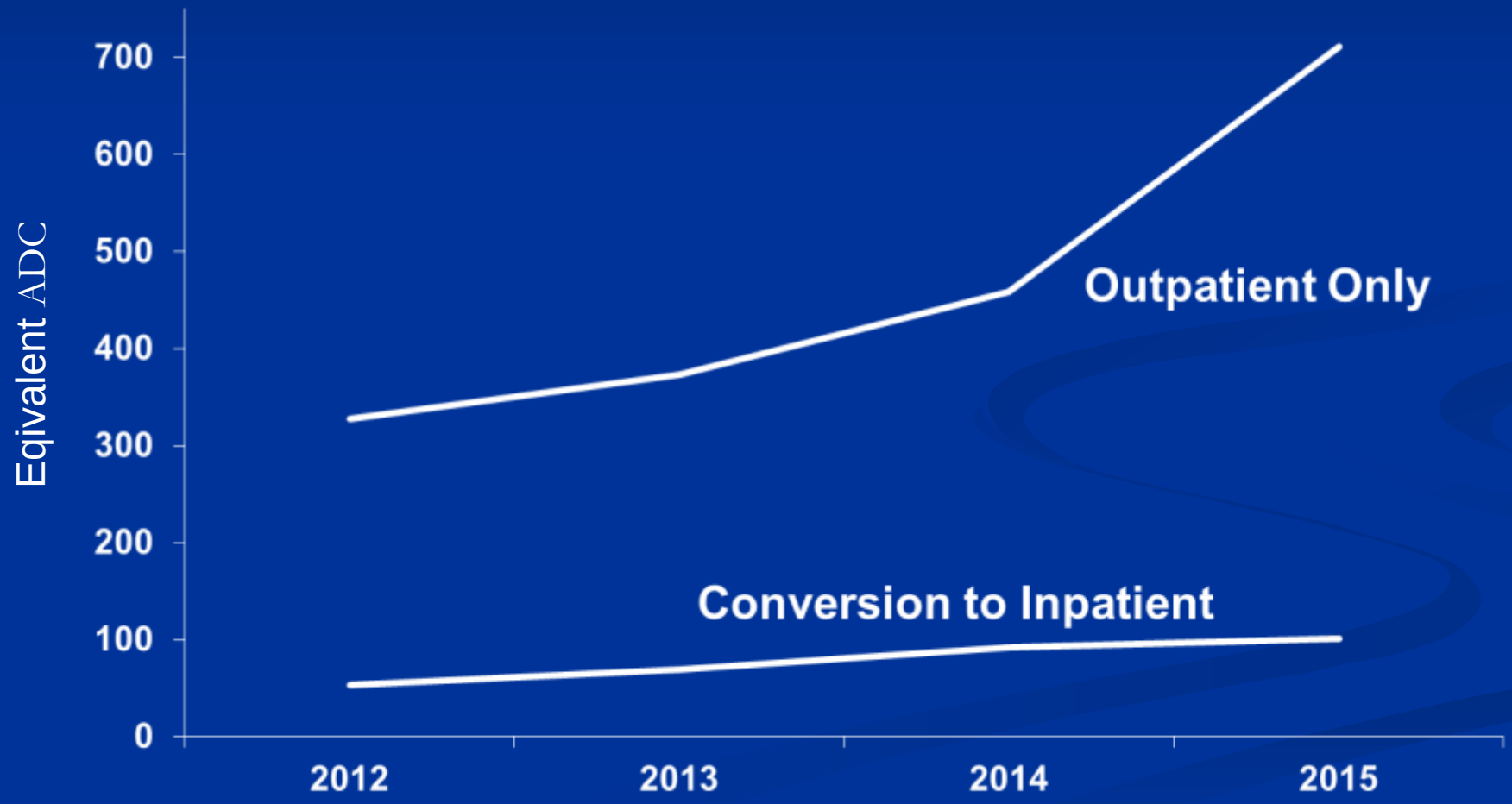


AHA Hospital Statistics

Licensed Acute Care Hospital Beds
Maryland
FY 2007 – FY 2017

MHCC/HSCRC

Equivalent Average Daily Census – Observation Patients
Maryland General Hospitals
CY 2012- CY 2015



MHCC/HSCRC

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UPDATE:

Health Care Quality Reports Website: Health-Associated Infections Results

(Agenda Item #3)

The Maryland Health Care Quality Reports

Staff Update on Improvements to the Consumer Website

Theressa Lee, Director, Center for Quality Measurement and Reporting
Eileen Witherspoon, Chief, Hospital Quality Initiatives

July 21, 2016

Presentation Outline

- Brief Overview of MHQR Consumer Website
- July 2016 Website Update
  - Patient Experience and ER Wait Times
  - Hospital Performance on Healthcare Associated Infections
    - Surgical Site Infections (SSI)
    - Catheter Associated Urinary Tract Infections (CAUTI)
    - Measurement Challenges
    - HAI Prevention
  - Healthcare Personnel Influenza Vaccination
- Promoting Consumer Awareness and Engagement
- Preparing for October Release of Health Plan Guide

The Mission

Establish a comprehensive, integrated online resource that enables consumers to access meaningful, timely, and accurate healthcare information reported by healthcare providers and payers in Maryland

Collaboration and Consumer Engagement

- **Health Services Cost Review Commission**
  - Support for streamlined quality measures data processing
  - Sharing of price transparency methodology
  - Quality measures align with new hospital payment model
- **Agency for Healthcare Research and Quality (AHRQ)** – integration of MONAHRQ quality reporting
- **Consumer Engagement**
  - Consumer involvement throughout the development process
  - Ongoing review of content, new design, format and functionality

July 2016 Website Updates: https://healthcarequality.mhcc.maryland.gov/

Hospital Guide Options

July 2016 Website Update

Maryland Hospitals continue to lag behind the national performance in certain areas

- **Hospital Patient Experience Data** (Data Period 7/2014–6/2015)

  Overall hospital rating 9 or 10 – National – 71%; MD – 65%

  Recommend hospital to others – National – 71%; MD – 66%

- **Emergency Wait Times** (Data Period 7/2014–6/2015)
  - Inpatient national average – 4 hrs,38 mins; MD average – 6 hrs,25 mins
    - 3 hospitals better than national average
    - 0 hospital same as national average
  - Outpatient national average - 2 hrs,21 mins; MD average –3 hrs,5 min
    - 7 hospitals better than national average
    - 1 hospital same as national average

Hospital HAI Performance: Surgical Site Infections CY2015

- **Hip Replacement (HPRO)**
  - 59 infections reported statewide
  - Statewide performance **better** than national benchmark with 0.71 SIR
  - 2 hospitals performed **better** than national benchmark
  - Performance similar to 2014
- **Knee Replacement (KPRO)**
  - 57 infections reported statewide
  - Statewide performance **better** than national benchmark with 0.65 SIR
  - 3 hospitals performed **better** than national benchmark
  - Performance similar to 2014
- **Coronary Artery Bypass Graft (CABG)**
  - 12 infections reported statewide
  - Statewide performance **better** than national benchmark with 0.35 SIR
  - 2 hospitals performed **better** than national benchmark
  - Performance improved from 2014 (43% decrease in number of infections)

Surgical Site Infections CY2015 (continued)

Abdominal Hysterectomy (HYST)

- 44 infections reported statewide
- Statewide performance same as national benchmark with 0.96 SIR
- No hospitals performed better than national benchmark
- 1 hospital performed **worse** than national benchmark
- Performance improved from 2014 (21% decrease in number of infections)

Colon Surgery (COLO)

- 171 infections reported statewide
- Statewide performance same as national benchmark with 0.99 SIR
- 2 hospitals performed **better** than national benchmark
- 4 hospitals performed **worse** than national benchmark
- Performance similar to 2014

SSI Trending from CY2011 to CY2015

Performance Measure	CY2011	CY2012	CY2013	CY2014*	CY2015	Difference in SIR Since Reporting Began
All SSIs	**186**	**161**	**129**	**351**	**343**	
All Procedures	**22380**	**22845**	**23485**	**34233**	**36083**	
All SSIs SIR	**1.06**	**0.9**	**0.7**	**0.86**	**0.81**	**Improvement (25% reduction)**
CABG Infections	**29**	**19**	**34**	**21**	**12**	
CABG Procedures	2813	2478	2590	2747	2861	
CABG SIR	0.87	0.68	1.12	0.64	0.35	**Improvement (52% reduction)**
HPRO Infections	**67**	**63**	**45**	**58**	**59**	
HPRO Procedures	7290	7862	8034	8516	9112	
HPRO SIR	1.02	0.89	0.66	0.76	0.71	**Improvement (31% reduction)**
KPRO infections	**90**	**79**	**50**	**50**	**57**	
KPRO Procedures	12277	12505	12861	12112	13519	
KPRO SIR	1.16	0.99	0.61	0.63	0.65	**Improvement (51% reduction)**
COLO infections	**NA**	**NA**	**NA**	**166**	**171**	
COLO Procedures	NA	NA	NA	5194	5177	
COLO SIR	NA	NA	NA	0.96	0.99	**Decline (3% increase)**
HYST infections	**NA**	**NA**	**NA**	**56**	**44**	
HYST Procedures	NA	NA	NA	5664	5414	
HYSY SIR	NA	NA	NA	1.17	0.97	**Improvement (20% reduction)**

* January 1, 2014, colon surgery (COLO) and abdominal hysterectomy (HYST) reporting started.

SSI Website Table Display

Maryland Health Care Quality Reports

Keeping Marylanders Informed

A A A | Print | Sign Up for Updates

Return to Hospital Guide

1 Select Topic: Surgical Site Infectio

2 Select Sub Topic: Hip Replacement

3 Select Period: 01/2015 - 12/2015

Surgical Site Infections

Hip Replacement

01/2015 - 12/2015

Sort by clicking column title

Help

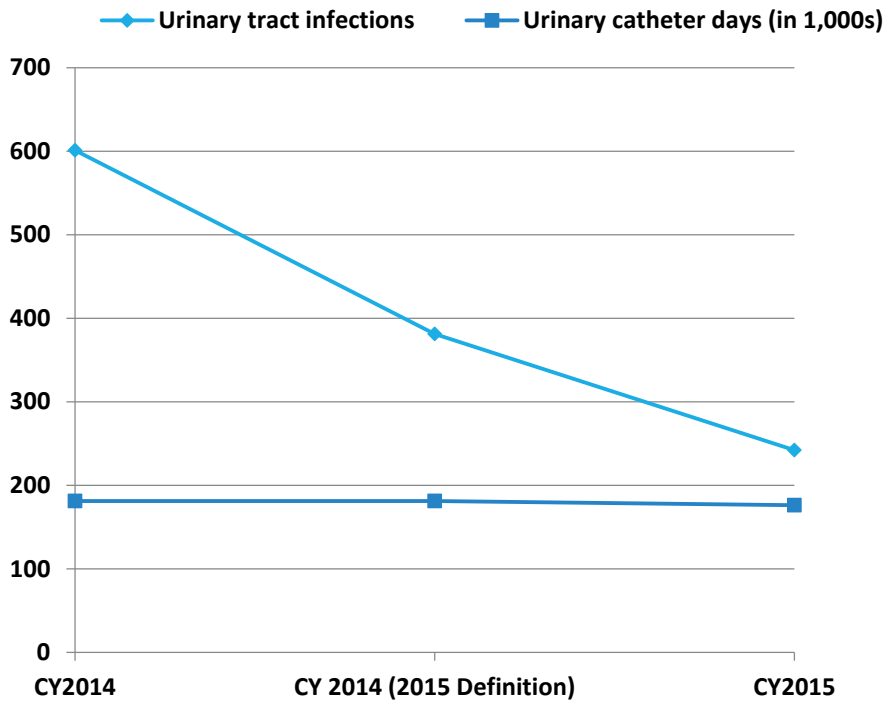
Click ▸ for more details	Select up to 5 hospitals to compare — Compare	Hospital Name	Hospital Performance
▸	☐	Suburban Hospital	Better
▸	☐	Anne Arundel Medical Center	Better
▸	☐	Greater Baltimore Medical Center	Same
▸	☐	Johns Hopkins Hospital	Same
▸	☐	MedStar Franklin Square Medical Center	Same
▸	☐	MedStar Southern Maryland Hospital Center	Same
▸	☐	St. Agnes Hospital	Same
▸	☐	University of Maryland Upper Chesapeake Medical Center	Same

Catheter-Associated Urinary Tract Infections (CAUTI) CY2015

- **ICUs Only**
  - 242 infections reported statewide
  - Statewide performance **better** than national benchmark with 0.70 SIR
  - 7 hospitals performed **better** than national benchmark
  - 1 hospital performed **worse** than national benchmark
  - Performance improved dramatically from 2014 (60% decrease in number of infections/SIR of 1.62)
- **Medical, Surgical, Med/Surg Wards Only**
  - First year of reporting these units
  - 133 infections reported statewide
  - Statewide performance **better** than national benchmark with 0.51 SIR
  - 9 hospitals performed **better** than national benchmark
  - No hospitals performed worse than national benchmark

CAUTI Trending (ICUs Only) CY2014 to CY2015

- **Definition change 2015**
  - Excluded non-bacterial pathogens
  - 2014 Data:
    - 220 non-bacterial pathogen CAUTIs (36.6% of total)
    - Use 2015 definition: 381 CAUTIs
- **Comparing 2014 data (using 2015 definition) to 2015 data:**
  - Significant **decrease** in CAUTIs (381 to 241)



HAI Measurement Challenges

- NHSN Definitions
  - Surveillance versus Clinical
  - MHAC (admin data) versus NHSN (surveillance data)
  - Ongoing Changes in Definitions and Protocol
    - CAUTI changed to exclude all non-bacterial pathogens in 2015
    - CLABSI
    - Difficult to explain to consumers as well as trend
- Comparison Data
  - Currently each HAI has a different static baseline time period (ex. 2006-08)
  - Need for "dynamic" SIR based on national data from previous year (Controversies in Infection Prevention article)
  - All HAIs: New 2015 baseline available December 2016
    - Lose ability to trend

HAI Measurement Challenges (Cont.)

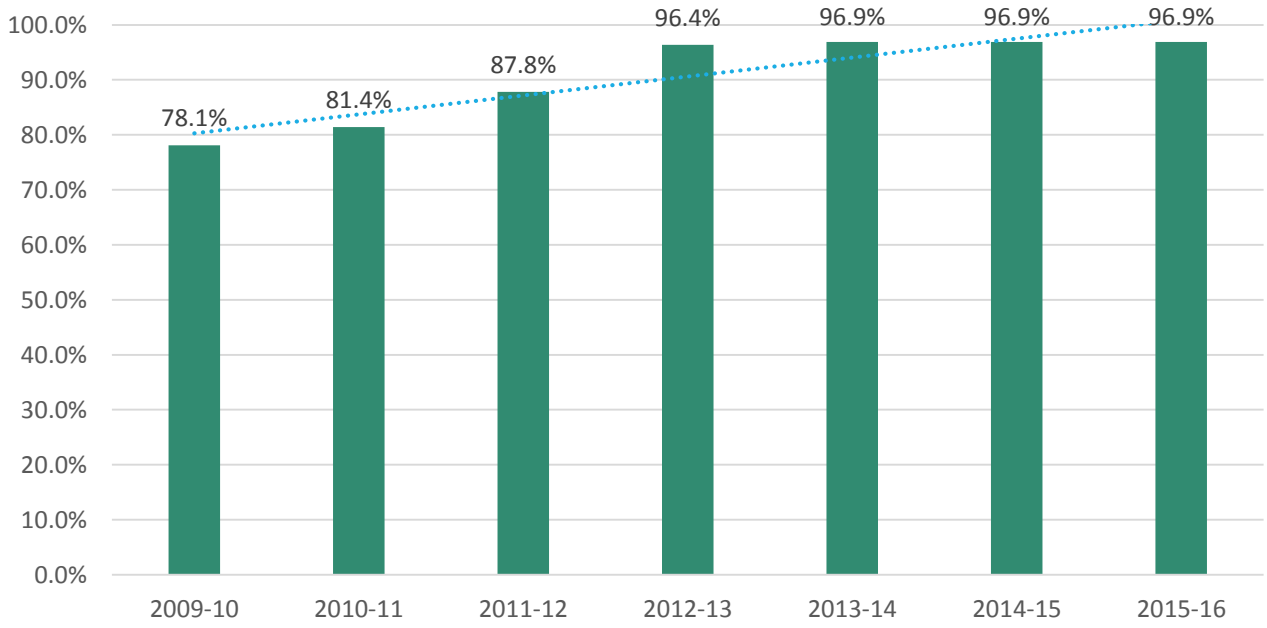
- Federal Versus Maryland Reporting Requirements: SSI
  - MHCC requirements pre-date CMS (Hip, Knee, CABG procedures)
    - MD performing **better** than the national baseline (2006-2008)
    - 2014 national SIR available in CDC's HAI Progress Report, however, state specific data is not available
      - MD CABG SIR 0.35 is 20% **lower** (better) than 2014 national SIR of 0.55
      - MD HPRO SIR 0.71 is 7% **lower** (better) than 2014 national SIR of 0.78
      - MD KPRO SIR 0.65 is 6% **higher** (worse) than 2014 national SIR of 0.59
  - COLO and HYST were not required in Maryland until 2014. Only 2 years of data available.

Staff Efforts to Facilitate HAI Improvement

- Hold quarterly HAI Advisory Committee meetings of experts and stakeholders
- Support statewide antimicrobial stewardship workgroup led by DHMH with monthly meetings at MHCC
- Perform targeted onsite audits of HAI data to assess data quality
  - Hold webinars to review results with all hospitals
- Provide ongoing education and outreach to hospitals
  - Contact facilities to ensure focus on poor performing areas
- Partner with other stakeholders to promote transparency
- Researching use of CDC tools and resources including Targeted Assessment for Prevention (TAP) Reports
- Support hospital participation in statewide collaboratives
- Promote employee flu vaccination through measurement and public reporting

Hospital Healthcare Personnel (HCP) Flu Vaccination

- Healthcare Personnel Flu Vaccination: 2015-2016 flu season
  - Hospitals Statewide Avg Vaccination Rate: 96.9% (73%-100% range)
    - NHSN Survey includes inpatient and outpatient employees, licensed independent practitioners, and adult students/trainees and volunteers
    - Total for state: 147,783 out of 152,595 HCP vaccinated
    - 46 of 47 hospitals have a mandatory policy



Nursing Home Health Care Worker (HCW) Flu Vaccination

Statewide Stats	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Vaccination Rate	**57.90%**	**65.10%**	**73.60%**	**79.30%**	**85.50%**	**87.63%**
Nursing Homes Submitting a Survey	235	225	225	230	230	229
Nursing Homes with staff vaccination rate of 95% or higher	2% (4)	8% (19)	16.4% (37)	23.5% (54)	41.3% (95)	43.7% (100)
Nursing Homes with 60% or more staff vaccinated *	42.6% (100)	60.4% (136)	70.2% (158)	78.7% (181)	84.3% (194)	88.0% (202)
Mandatory Vaccination Policy						
Mandatory policy in place	ND	19.1%	22.4%	31.3%	46.1%	48.5%
Plan to implement mandatory policy in the upcoming influenza season	ND	18.2%	14.8%	19.6%	11.3%	9.2%
No plan for mandatory policy	ND	62.7%	62.8%	49.1%	42.6%	42.3%

*** 2012 StateStat goal**
ND = No Data Available

Assisted Living Facility Staff Flu Vaccination

Statewide Stats	2012-13	2013-14	2014-15	2015-16
Vaccination Rate	**50.20%**	**53.20%**	**57.90%**	**56.20%**
Reason for Declining Vaccination				
Medical reasons	3.10%	2.70%	1.50%	2.00%
Religious reasons	1.00%	1.20%	1.30%	1.40%
Other	45.70%	42.90%	39.30%	40.3%

2016 Staff Priorities

- Promote Consumer awareness and use of the website
  - Procured the services of a Marketing firm
  - Project will focus on digital and social media promotion
  - September start up
  - Need to address the URL

- Antimicrobial Stewardship
  - Monitor CMS proposed ASP requirements for CoP
  - Review NHSN AUR (Antimicrobial Use and Resistance) Module
  - Consumer Focused Issue Brief
    - Importance of not asking for antibiotics from health care providers
    - Importance of taking antibiotics as prescribed for the duration of the medication

- Prepare for October Release of the 2016 Health Plan Guide

Questions?

Health Care Quality Reports Website: Health-Associated Infections Results

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Potential for including Maryland Hospitals on the Leapfrog Group's Website

(Agenda Item #4)

MARYLAND HEALTH CARE COST COMMISSION

July 2016

Leah Binder, President & CEO

The Leapfrog Group

- Purchaser-driven nonprofit publicly reporting on hospital quality and safety
- Founded by purchasers in 2000 in response to 1999 IOM Report *To Err is Human*
- Transparency AND smart purchasing
- Regional and national level: Mid-Atlantic Business Group on Health in Maryland

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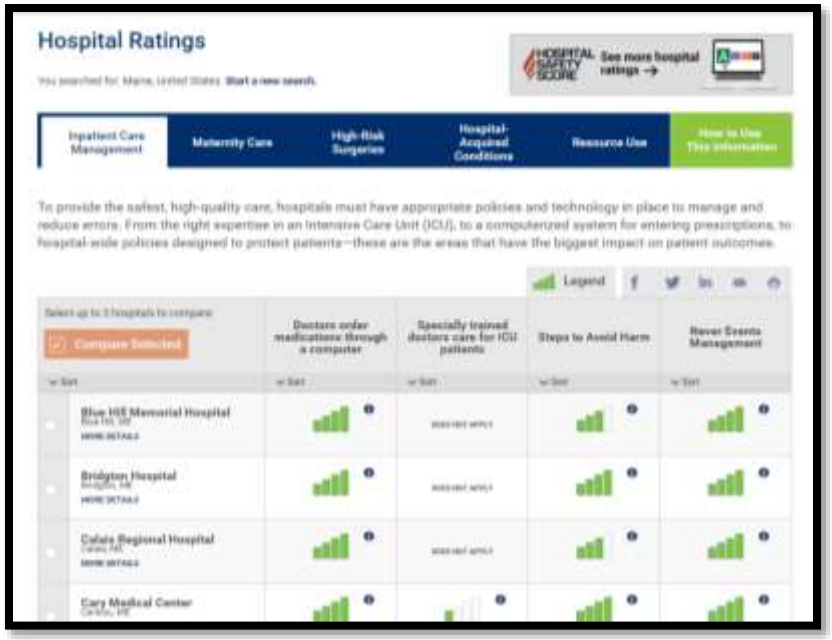
Leapfrog's Public Reporting Initiatives

Leapfrog Hospital Survey
Voluntary, 1X per year



Leapfrog Hospital Safety Score
Not voluntary, 2X per year

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2015 Voluntary Participation

LEAPFROG HOSPITAL SURVEY

State	Number of hospitals	Nu rep ho
Maryland	47	6
California	355	23
Maine	34	34
Massachusetts	71	65
National	**3811**	**1750**

That's 60% of the inpatient beds nationwide

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What we learn (and Maryland doesn't)

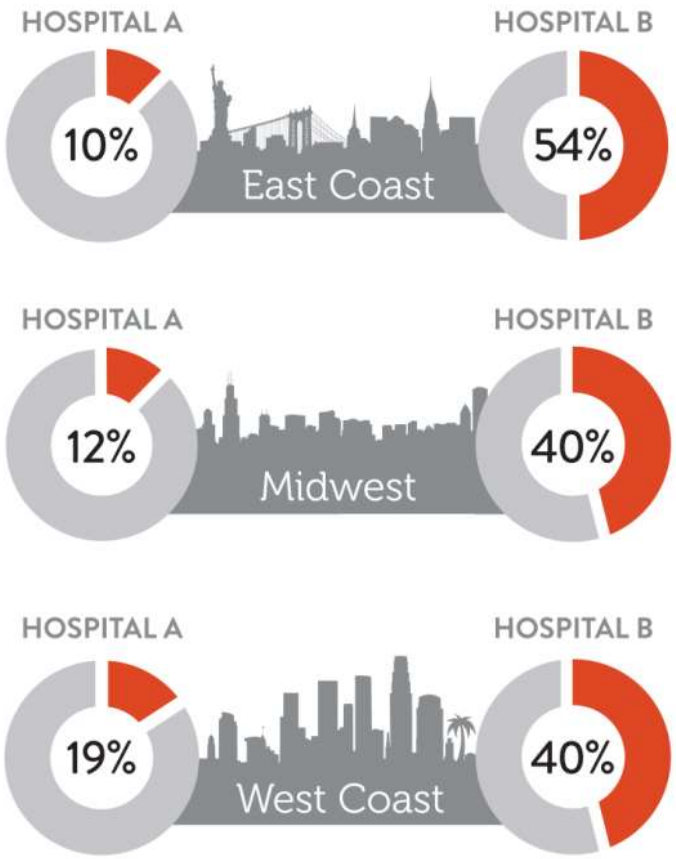
5 domains of health care quality and safety

1. Medication Safety
2. Inpatient Care Management
3. Maternity Care
4. High-risk Surgeries
5. Hospital-Acquired Conditions

Actionable & relevant

Never before have purchasers or patients had a single, standardized C-section rate to **compare by hospital at the national level.**

Using the endorsed NTSV C-section measure, Leapfrog found the C-section rate was too high at **60%** of reporting hospitals. Variation is dramatic, ranging from a low as 10% to as high as 54% in one east coast city.



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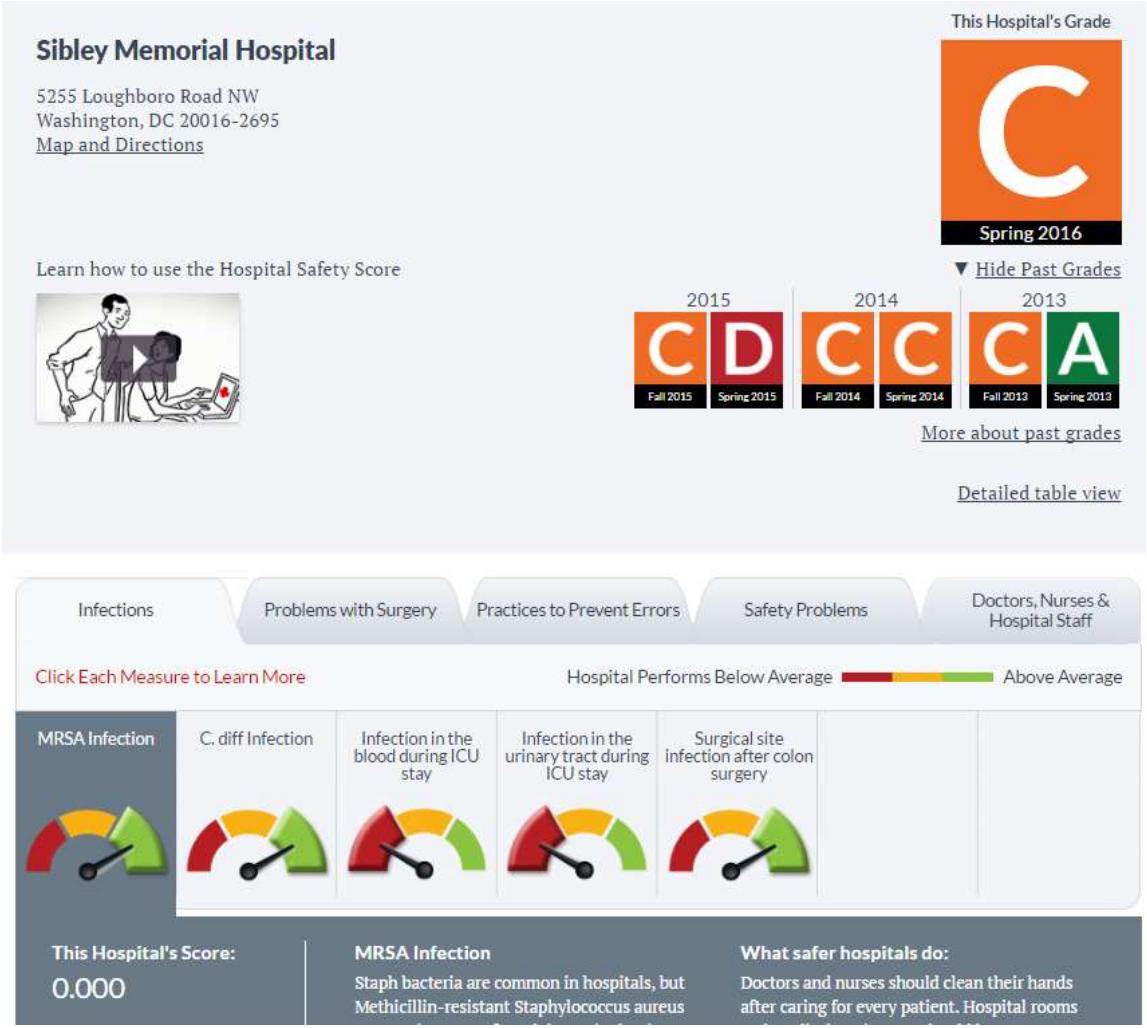
HospitalSafetyScore.org



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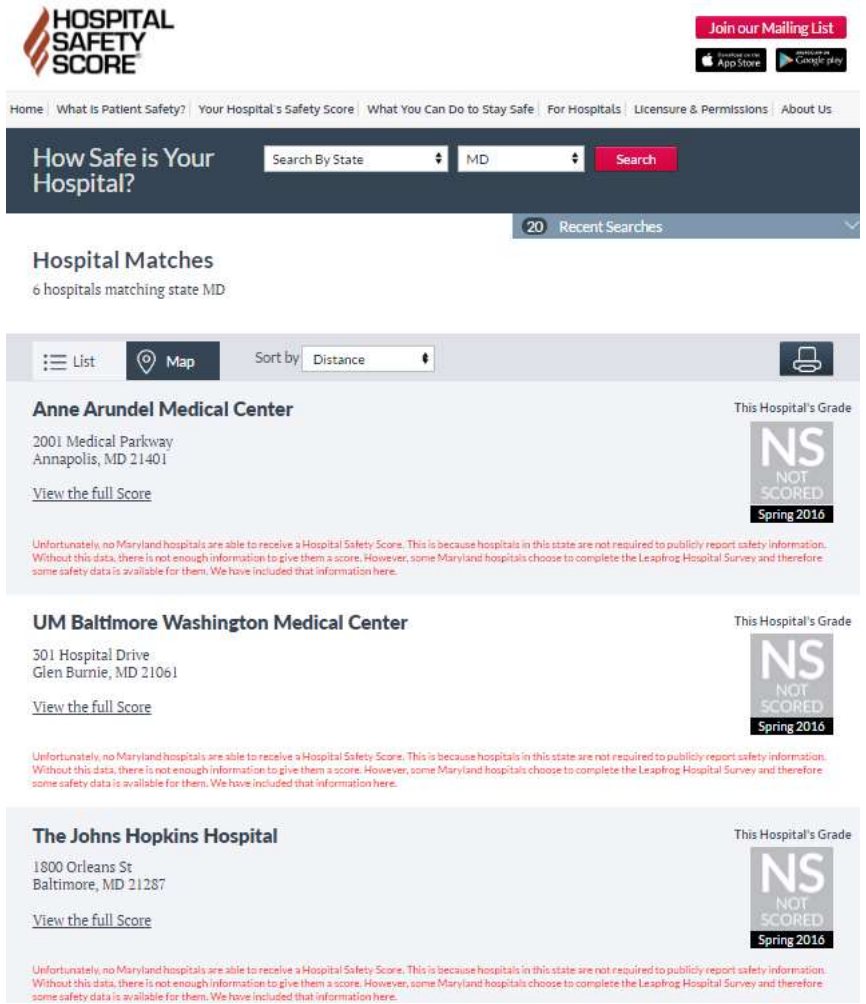
HospitalSafetyScore.org in Maryland



"Unfortunately, no Maryland hospitals are able to receive a Hospital Safety Score. This is because hospitals in this state **are not required to publicly report safety information**. Without this data, there is not enough information to give them a score. However, some Maryland hospitals choose to complete the Leapfrog Hospital Survey and therefore some safety data is available for them. We have included that information here. "

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What We Measure

Outcome Measures

MRSA

C. diff

CLABSI

CAUTI

SSI: Colon

Foreign Object Retained

Falls and Trauma

Air Embolism

PSI 3: Pressure Ulcer

PSI 4: Death Among Surgical Inpatients

PSI 6: Iatrogenic Pneumothorax

PSI 11: Postoperative Respiratory Failure

PSI 12: Postoperative PE/DVT

PSI 14: Postoperative Wound Dehiscence

PSI 15: Accidental Puncture or Laceration

Process Measures

Communication about Medicines

Communication about Discharge

Communication with Doctors

Communication with Nurses

Responsiveness of Hospital Staff

Computerized Physician Order Entry (CPOE)

ICU Physician Staffing (IPS)

Safe Practice 1: Leadership Structures and Systems

Safe Practice 2: Culture Measurement, Feedback & Intervention

Safe Practice 3: Teamwork Training and Skill Building

Safe Practice 4: Identification and Mitigation of Risks and Hazards

Safe Practice 9: Nursing Workforce

Safe Practice 17: Medication Reconciliation

Safe Practice 19: Hand Hygiene

Safe Practice 23: Care of the Ventilated Patient

How Leapfrog Is Used

Purchasers

- Public reporting with national comparisons
- Pay for value programs
- Contract negotiations
- Benefits design strategies
- Employee engagement

Hospitals

- Predict payments on value
- National benchmarking
- Quality improvement, including reaching for highly competitive performance (ie Baldridge journey)
- Gold standard for demonstrating transparency
- Direct relationships with employers/purchasers

State of Maine

- Waived deductibles for employees using high-performing hospitals
- 100% participation in the Leapfrog Hospital Survey
- Excellent improvements in quality
- Six hospitals represented on Leapfrog's 2015 Top Hospital list.

Advantages to Maryland: The Survey and The Hospital Safety Score

- Transparency for Maryland residents
- Alignment with public and private sectors
- National benchmarking
- Free to hospitals and to the public
- Unbiased, trusted source

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Next steps

- Need to obtain aligned data on patient safety indicators in order to assign MD hospitals a grade
- Need more hospitals in MD to voluntarily report to Leapfrog

Contacts/Resources

The Leapfrog Group (@LeapfrogGroup): www.LeapfrogGroup.org

Hospital Safety Score: www.HospitalSafetyScore.org

Leah Binder (@LeahBinder)

- Lbinder@LeapfrogGroup.org
- 202-292-6713

www.forbes.com/sites/leahbinder/

www.huffingtonpost.com/leah-binder/

http://blogs.wsj.com/experts/tag/leah-binder/

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Certificate of Need: Chesapeake Treatment Center
Docket No. 15-24-2371

(Agenda Item #5)

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MARYLAND HEALTH CARE COMMISSION

ACTION:

COMAR 10.24.15 - State Health Plan for Facilities and Services: Organ Transplant Services Chapter – Proposed Regulations

(Agenda Item #6)

MARYLAND HEALTH CARE COMMISSION

Draft Proposed COMAR 10.24.15 Organ Transplant Services

Maryland Health Care Commission Meeting
July 21, 2016

Staff Analysis of Informal Comments and Recommendations

- Informal Comments Received
  - MedStar Health
  - Johns Hopkins Health System

.02 Introduction

- Effective Date
  - An application or letter of intent submitted after the effective date of the regulations is subject to the provisions of this chapter.

.03 Issues and Policies

- MedStar Health commented that the discussion of the relationship between kidney transplant volume and outcomes should state that the literature fully supports the relationship between higher volume and outcomes.

- Staff recommends no change in response to this comment.

.03 Issues and Policies

- Johns Hopkins Health System (JHHS) recommended that two additional studies be cited in the discussion of access to care and the role of competition.
- JHHS also requested revisions to the description of the conclusions of another study.
- Staff revised the discussion of the literature cited in response to these comments.

.03 Issues and Policies

- Findings of Studies Regarding Competition Among Kidney Transplant Services
  - Greater market competition is associated with increased patient mortality and graft failure due to more aggressive use of riskier kidneys, but those outcomes are still an improvement for patients on chronic dialysis.[1]
  - A greater number of transplant centers is associated with a greater number of transplants, but greater competition was associated with higher patient mortality and worse graft outcomes.[2]

[1] Adler, J.T., Sethi, R.K.V., Yeh, H., Markmann, J.F., Nguyen, L.L. (2014). Market competition influences renal transplantation risk and outcomes. *Annals of Surgery*. 260: 550-557.

[2]Adler, J.T., Yeh, H., Markmann, J.F., and Nguyen, L. (2016). Temporal Analysis of Market Competition and Density in Renal Transplantation Volume and Outcome. *Transplantation.* 100(3): 670-7.

.03 Issues and Policies

- Findings of Studies Regarding Competition Among Liver Transplant Services
  - Greater competition is associated with the inclusion of higher risk patients on waiting lists and more transplants for higher risk patients, with resulting higher costs and worse patient outcomes.[3]
  - More liver transplant centers are associated with more liver transplants. Mortality was not associated with the number of transplant centers or the geographic distribution of liver transplant centers with a donor service area.[4]

[3] Halldorson, J.B., Paarsch, H.J., Dodge, J.L., Segre, A.M., Lai, J., and Roberts, J.P. (2013). Center Competition and Outcomes Following Liver Transplantation. *Liver Transplantation*. 19:96-104.

[4] Adler, J.T., Yeh, H., Markmann, J.F., Nguyen, L.L. (2015). Market Competition and Density in Liver Transplantation: Relationship to Volume and Outcomes. *Journal of the American College of Surgeons*. 221(2):524-531.

.04 Docketing Rules

- JHHS proposed deleting the requirement that all existing non-federal organ transplant programs in the health planning region have been operating at or above the applicable annual threshold case volume for at least three years prior to the filing of the application.

- Staff recommends modifying, but not deleting this requirement.

.04 Docketing Rules

- Staff recommends a requirement that organ transplant services meet the threshold volume standard on average over the three most recent years.

- Staff recommends that an organ transplant service located outside of Maryland that fails to meet and maintain minimum volume requirements may be disregarded, if the service would be considered for closure if it were located in Maryland.

.04 Docketing Rules

- Staff concluded that the three-year time period is appropriate.
  - The work group did not raise concerns about unfairly shutting out competition.
  - Poorly performing programs are unlikely to shut out competition.
  - Unnecessary duplication of resources should be avoided.
  - Access to organs is primarily driven by the supply available and national policies.

.05 Standards

- JHHS requested clarification regarding the accreditation requirement for hematopoietic stem cell bone transplant services.

- Staff clarified the requirement as requested, specifying that a program must meet accreditation requirements within the first two years of operation.

.05 Standards

- JHHS requested that the requirement in the current Chapter for organ transplant services that requires an organ transplant program to be located in, or closely affiliated with a teaching hospital, be included in the replacement Chapter.

- Staff recommends no change to address this comment. The work group considered this standard and recommended deleting it.

.06 Definitions

- JHHS commented that a definition of “adult” should be included.
- Staff recommends the change proposed by JHHS.
- Staff revised the definitions for “organ transplant” and “transplant.”
- Staff deleted the definitions for “organ” and “transplantation.”

Next Steps

- If the draft proposed regulations, COMAR 10.24.15, are approved by the Commission, a notice will be published in the *Maryland Register*.
- Formal 30-day comment period.
- Staff reviews the comments received.
- Staff requests Commission approval of proposed final regulations.

MARYLAND HEALTH CARE COMMISSION

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2. UPDATE OF ACTIVITIES
3. **UPDATE**: Health Care Quality Reports Website: Health-Associated Infections Results
4. **PRESENTATION**: Potential for including Maryland Hospitals on the Leapfrog Group's Website
5. **ACTION**: Certificate of Need: Chesapeake Treatment Center, Docket No. 15-24-2371
6. **ACTION**: COMAR 10.24.15 - State Health Plan for Facilities and Services: Organ Transplant Services Chapter – Proposed Regulations
7. **ACTION: COMAR 10.24.19 – State Health Plan for Facilities and Services: Freestanding Medical Facilities Chapter – Proposed Regulations**
8. **PRESENTATION**: Practice Transformation Network (PTN)
9. Overview of Upcoming Initiatives
10. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

ACTION:

COMAR 10.24.19 – State Health Plan for Facilities and Services: Freestanding Medical Facilities Chapter – Proposed Regulations

(Agenda Item #7)

MARYLAND HEALTH CARE COMMISSION

Draft Proposed COMAR 10.24.19 Freestanding Medical Facilities

Maryland Health Care Commission Meeting
July 21, 2016

Informal Comments Received

- December 2015 Draft
  - Adventist HealthCare
  - Anne Arundel Medical Center (AAMC)
  - LifeBridge Health
  - Maryland Institute for Emergency Medical Services Systems (MIEMSS)
  - South of Sligo Citizens' Association (SOSCA)
  - University of Maryland Medical System (UMMS)

Informal Comments Received

- June 2016 Draft
  - City of Takoma Park
  - Dimensions Healthcare System (Dimensions)
  - Maryland Hospital Association (MHA)
  - University of Maryland Medical System (UMMS)
  - David B. Paris, Esquire

.02 Introduction

Applicability

- AAMC requested clarification on whether a CON is required to close an FMF.

- Staff will be recommending changes to the procedural regulations, COMAR 10.24.01, rather than COMAR 10.24.19.

.03 Issues and Policies

Introduction

- UMMS and Dimensions requested that this section note that the the medical services authorized to be provided in an FMF are not limited to emergency services.
- MHA requested clarification on whether ambulatory surgical services are permitted.

- Staff modified the last sentence on page 14 of the draft Chapter to acknowledge that FMFs may potentially provide a range of outpatient services.

.04 Standards

General Standards

- David B. Paris, Esquire commented that MHCC should encourage applications for FMFs from qualified independent (non-hospital) medical entities.

- Staff recommends no changes to address this comment because Maryland statute requires that an FMF be operated by a hospital.

.04 Standards

Cost and Effectiveness

- UMMS requested that the time period for revenue and expense projections for an FMF include a specific time period, rather than referring to a "time period appropriate for evaluating cost effectiveness."

- Staff modified the language in .04B(3)(a)(i), as requested by UMMS, to specify that an applicant provide projections of revenue and expense for the first five years of operation of a proposed FMF.

.04 Standards

Efficiency

- UMMS and Dimensions requested deletion of the requirement that an applicant present to all affected hospitals its analysis of how the proposed FMF project will affect the efficiency of emergency services delivery.
- Staff deleted this requirement, as requested.

.04 Standards

Financial Feasibility and Viability

- UMMS and Dimensions expressed concern that the standard fails to focus on the combined financial performance of the parent hospital and FMF and proposed the following changes:

The proposed establishment, expansion, or relocation of an FMF shall be financially feasible and shall not ~~have an undue negative effect on the financial~~ jeopardize the long-term viability of the parent hospital."

- Staff recommends no change in response to the comments of UMMS and Dimensions.

.04 Standards

<u>Exemption from CON Review to Convert a General Hospital to an FMF</u>

- Staff added the language in .04C(4) that states an FMF created through the conversion of a general hospital shall remain on the site of, or on a site adjacent to, the converting general hospital, unless two requirements are met.

- This change is consistent with the statute and was added for clarity.

.04 Standards

<u>Exemption from CON Review to Convert a General Hospital to an FMF</u>

- UMMS and Dimensions proposed that .04C(7) include language that requires an applicant to demonstrate the need for operating room capacity consistent with COMAR 10.24.11.06, part of the Chapter on surgical services.
- Staff added language in a separate subsection, .04C(9) to specify the standards an applicant is required to meet, if surgical capacity is proposed in conjunction with a proposed FMF.

.04 Standards

<u>Exemption from CON Review to Convert a General Hospital to an FMF</u>

- UMMS and Dimensions commented that applicants should not be required to obtain information from other FMFs, as stated in .04C(7)(f).*

- Staff recommends no changes to address this comment.

*Note: In the draft proposed Chapter, the corresponding section is .04C(8)(f).

.04 Standards

<u>Exemption from CON Review to Convert a General Hospital to an FMF</u>

- UMMS and Dimensions proposed deleting the reference to hospital EDs in .04C(7)(h)* and proposed referencing services provided at hospitals generally.

- Staff recommends no changes to address this comment.

*Note: In the draft proposed Chapter, the corresponding section is .04C(8)(h).

.04 Standards

<u>Exemption from CON Review to Convert a General Hospital to an FMF</u>

- UMMS and Dimensions commented that .04C(2)(c) should be revised to make it clear that only one public hearing is required for the conversion of a general hospital.
- Staff recommends no changes to address this comment.

.04 Standards

<u>Exemption from CON Review to Convert a General Hospital to an FMF</u>

- Staff added language in .04C(11) that states a public informational hearing must be held, as required by Health-General 19-120, when the Commission denies an applicant's request for an exemption from CON to establish an FMF or when the request is denied as a result of a determination of the State Emergency Medical Services Board and the hospital then decides to close.

Other Comments

- David B. Paris, Esquire proposed that licensing of combined FMFs and urgent care centers be required in order to discourage inappropriate use of hospital EDs and promote the use of primary care providers and specialists instead.

- Staff recommends no additional changes in response to these comments.

Other Comments

- David B. Paris, Esquire proposed that the Chapter require the evaluation of any relocated general hospital and any FMF established on the former hospital site during a comprehensive CON process.
- The City of Takoma Park requested an expedited review process for a hospital relocating within its services area that seeks to establish an FMF on the former hospital site.
- Staff recommends no changes in response to these comments.

Other Comments

- David B. Paris, Esquire commented that the State of Maryland should mandate impact studies for any proposed hospital closing or downsizing and proposed objective medical impact studies.

- Staff recommends no additional changes in response to these comments.

MARYLAND HEALTH CARE COMMISSION

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8. **PRESENTATION: Practice Transformation Network (PTN)**

9. Overview of Upcoming Initiatives

10. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Practice Transformation Network (PTN)

(Agenda Item #8)

Briefing

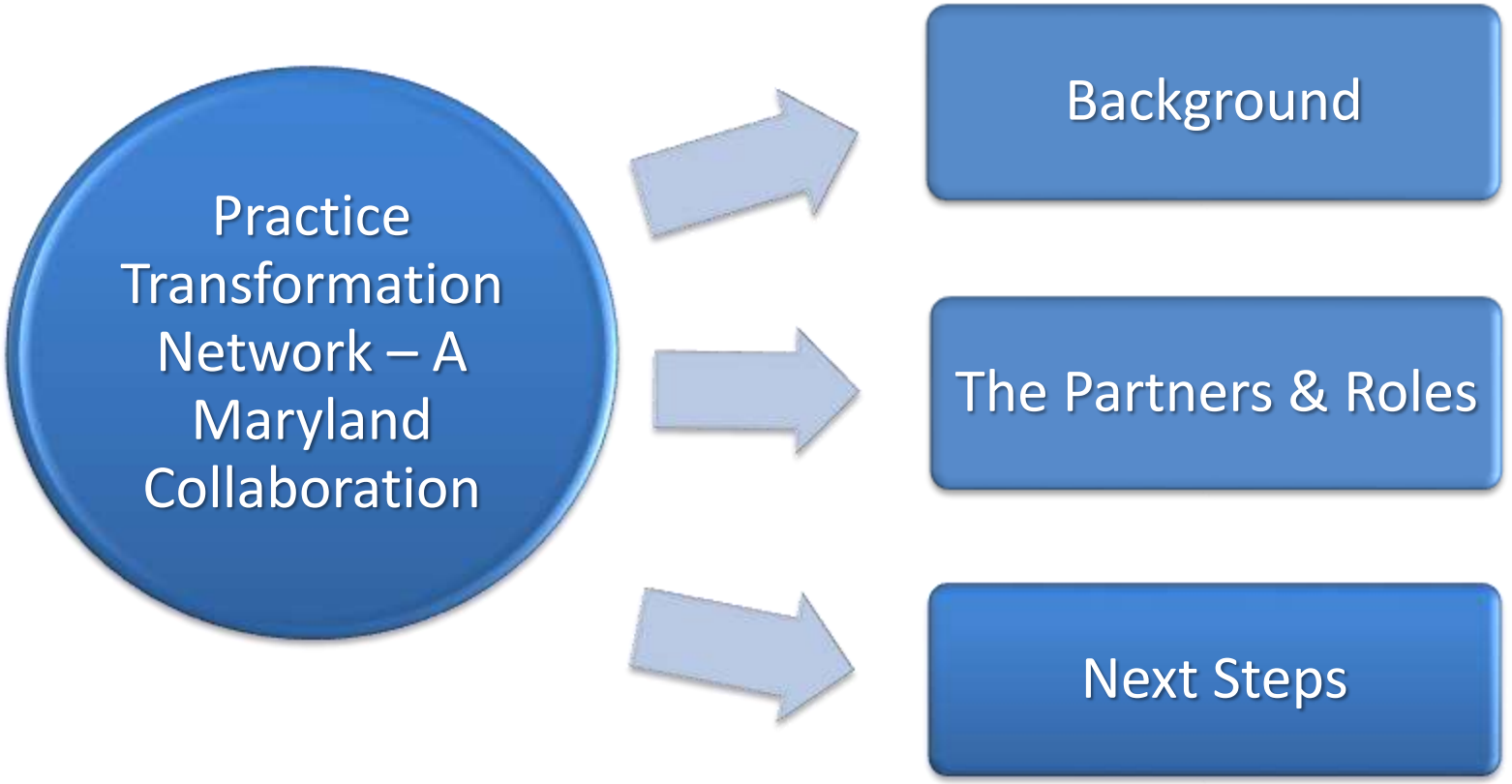
Practice Transformation Network

A Program Overview & MHCC Involvement

July 21, 2016

The MARYLAND
HEALTH CARE COMMISSION

Discussion Points



Background

- On March 23, 2010, ACA signed into law
  - Under the Act, hospitals and primary care physicians are required to transform their practices financially, technologically, and clinically to drive better health outcomes, lower costs, and improve their methods of distribution and accessibility.
- The MHCC fosters market innovation that can appropriately support clinical decision-making, reduce redundancy, enable payment reform, and help to transform care into a model that leads to a continuously improving health care system.

Leading Reform

- On April 27, 2016, the Department of Health and Human Services issued a proposed rule to implement key provisions of the Medicare Access and Summary CHIP Reauthorization Act of 2015 (MACRA), which is a new approach to paying providers for the value and quality of care they provide.

- The proposed rule would implement changes through the unified framework called the “Quality Payment Program” that includes two paths: the Merit-based Incentive Payment System (MIPS) or the Advanced Alternative Payment Models (APMs)

  - MIPS - The proposed rule would improve the relevance and depth of Medicare’s value and quality-based payments and increase providers’ flexibility by allowing providers to choose measures and activities appropriate to the type of care they provide.

  - APMs – Providers who participate in qualified APMs at certain threshold levels can receive a five percent annual lump sum payment.

A Move Toward Patient-Centered Quality Care

- In September 2015, CMS awarded funding to 29 Practice Transformation Networks (PTNs) to improve care through the use of electronic health records, care coordination, and patient monitoring
- Funding supports transformation of care in PTN practices and establishes peer-based learning networks to provide peer coaching and share best practices across practices to transform care
  - Supports140,000 clinicians in achieving large-scale health transformation
  - Provides hands-on support to practices for developing the skills and tools needed to improve care delivery and transition to alternative payment models
  - Improve health outcomes and reduce unnecessary hospitalizations for five million patients
  - Generate $1-$4B in savings to the federal government and commercial payers

MHCC Establishes PTN Participation

- New Jersey was awarded a $50M cooperative agreement from CMS to implement the requirements of the PTN; MHCC worked with New Jersey to create a PTN partnership
- The PTN partnership includes:
  - MHCC – Program management and performance assessment
  - MedChi, The State Medical Society – Recruitment
  - University of Maryland School of Medicine Department of Family & Community Medicine, Maryland Learning Collaborative – Practice transformation
- Project Length – Four years
- Estimated partnership funding based on number of participants: $1,275,000

Program Management & Performance Assessment

- Participate with New Jersey in assessing clinical performance of PTN practices
- Assess the data needed to demonstrate value and success, including comparison data on clinical performance, clinical and administrative data, and the CMS Quality and Resource Use Report.
- Provide support to New Jersey to develop strategies and contribute to work plan development to meet CMS' practice aims
- Facilitate data reporting from electronic health records between PTN practices and New Jersey through the State-Designated Health Information Exchange
- Identify innovative strategies to accelerate practice transformation

Program Recruitment

- Engage practices:
  - Primary Care providers
  - Specialists
  - Nurse practitioners
- Convene education and awareness events
- Work with other PTN networks to share lessons learned
- Assist practices in completing the participation application, which includes a practice survey pertaining to technology adoption and reporting

Program Recruitment (Continued)

- Take part in practice transformation activities, work with providers to address challenges that emerge
- Work with providers to ensure maximum performance under MPS
- Report on provider changes in PTN practices
- Current provider commitments - 1,500

Practice Transformation

- Take ownership of health care transformation to lead, guide, and influence the future of care with support of PTN physician peers
- Facilitate community-based peer groups to improve care coordination and practice transformation
- Implement solutions that work for Maryland by implementing clinical performance measurement and reporting, quality improvement, patient-centered care, and population health management
- Work with practices to encourage participation in PTN webinars sponsored by New Jersey
- Participate with New Jersey in learning sessions and share best practices with other PTNs

Practice Transformation *(Continued)*

Assess

- Collaborate with the QIO to perform practice assessments
- Create practice/physician profiles
- Baseline performance
- Evaluate practices' technical capabilities

Collect

- Establish collection methodology (DDE vs. interface)
- Build interfaces when required
- Educate practice on collection method

Transform

- Implement CMS change package
- Use best practices from Healthy NJ 2020
- Align with payer remuneration opportunities
- Implement transition of care and chronic care management

Measure

- Implement measures management process
- Central monitoring of quality measures
- Practice Coaches monitor and remediate practice deficiencies

Target Quality Measures

Metric
Adult smoking rate reduction
Hba1c poor control cost savings due to decrease cost of hospitalizations
Cost savings due to decrease cost of hospitalizations
Controlling high BP for patients with hypertension aged 18-85
Reduction of cardiac stress imaging for low risk patients
Inappropriate imaging for low back pain
Potentially preventable ER visits (PPV) – primary care related and non-emergent
Advance care planning
Third next available appointment (TNAA) - total # practices with measure fully implemented
Increase transitional care management (TCM)
Reduction in unplanned 30 day readmissions per 1,000

General Information

- Educate providers on program and eligibility requirements; exclusions:
  - Enrolled in a Medicare Shared Savings Program
  - Participate in Comprehensive Primary Care Initiative
  - Earn over 20% of revenue from Medicare Risk programs, bundled payments, etc.
- Clinicians must sign a participation agreement and complete an EHR system status questionnaire
- Report selected process and outcome metrics monthly via a reporting measures tool – to be provided later in the year
- Inform as to any clinician changes (terminations, resignations, new hires) in the practice within 30-days
- Withdrawal from the program requires a 30-day notification

Next Steps

- Continue to expand PTN participation through 2017
- Secure participation agreements from providers that have committed to participate
- Work with New Jersey to develop program materials
- Educate PTN providers on the CMS program goals
- Provide support to providers in meeting the PTN requirements
- Monitor program performance

Thank You!

Practice Transformation Demonstrations in the Application Process

CPC+

- CMS initiative announced in April 2016
- Builds on the original CPC initiative in 2012
- Improve quality for Medicare, CMS collaborated with 38 commercial and state health insurance plans across seven U.S. regions to support 500 primary care practices in testing aligned payment for the delivery of a single model of comprehensive primary care
- Up to 20 CPC+ regions
- CareFirst and Amerigroup applied in Maryland
- If Maryland is selected as a region, staff would play lead role in the statewide demonstration in oversight, alignment of payments, and quality measures and evaluation and reporting

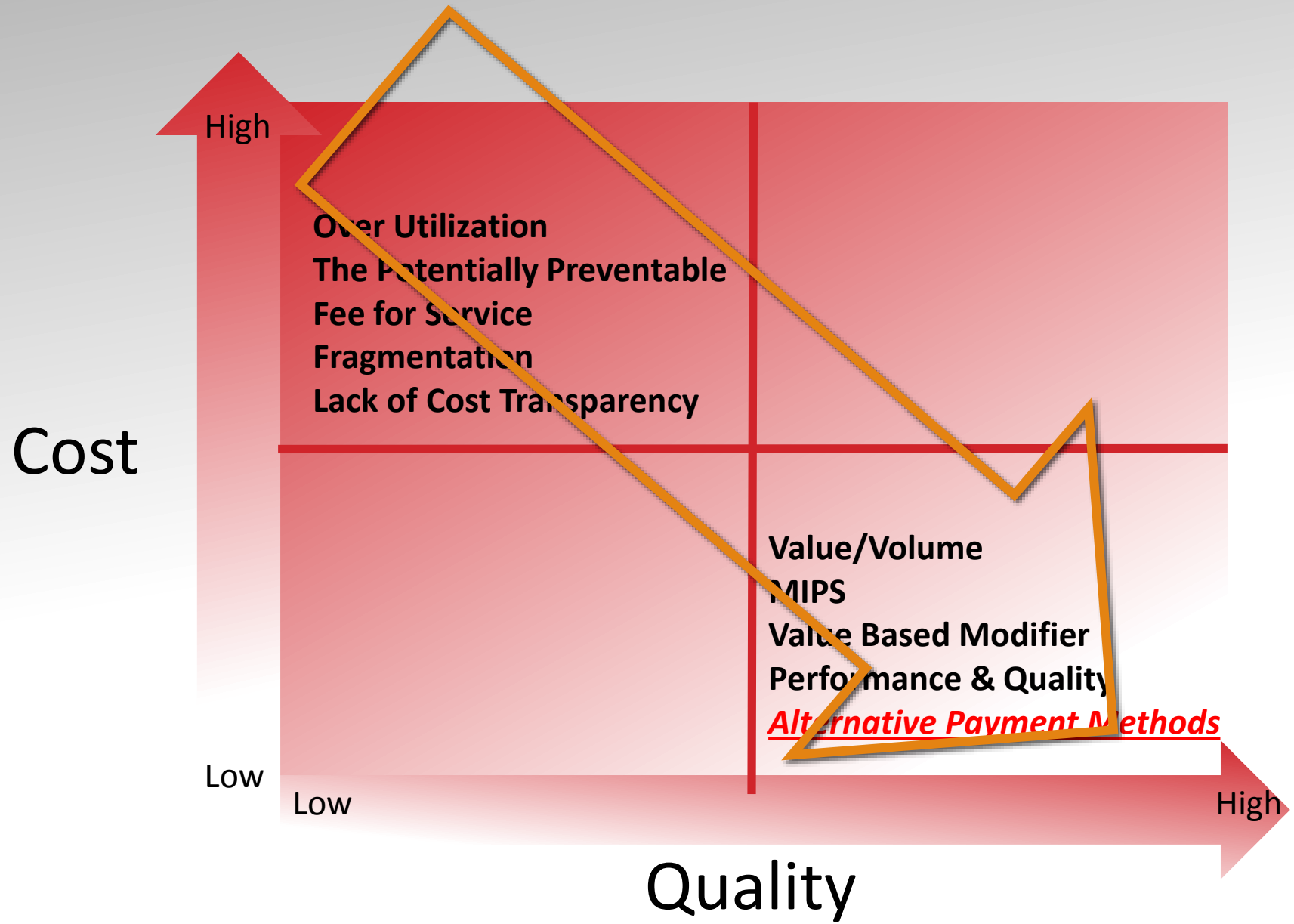
CPC+ (continued)

- Approximately 20,000 clinicians and 25 million patients
- Medicare and other CPC payers provide a non-visit-based care management fee paid per member per month and an opportunity to share in savings generated in each of the CPC regions
- Care management fee provided CPC practices with the necessary financial resources to create new workflows, hire care management staff, and develop new relationships necessary to coordinate care
- CPC+ builds on CPC with advances in payment to support primary care practices to provide more comprehensive care that meets the needs of all their patients, particularly those with complex needs
- Practices will work for five years to develop more fully the capabilities necessary to deliver comprehensive primary care

CPC+ (continued)

- Must demonstrate multi-payer support, use Certified EHR Technology (CEHRT)
- Certain advanced practices must demonstrate clinical capabilities and commitment to enhanced health IT when they apply, and commit to increasing the depth, breadth, and scope of care offered, with particular focus on patients with complex needs
- Requires efficient, advanced health IT to support its population-health focus and team-based structure
- Advanced practices to work with vendors to develop and optimize a set of health IT functions that work for their practices
- Health IT vendors will memorialize their commitment to support advanced practices in a Memorandum of Understanding (MOU) with CMS

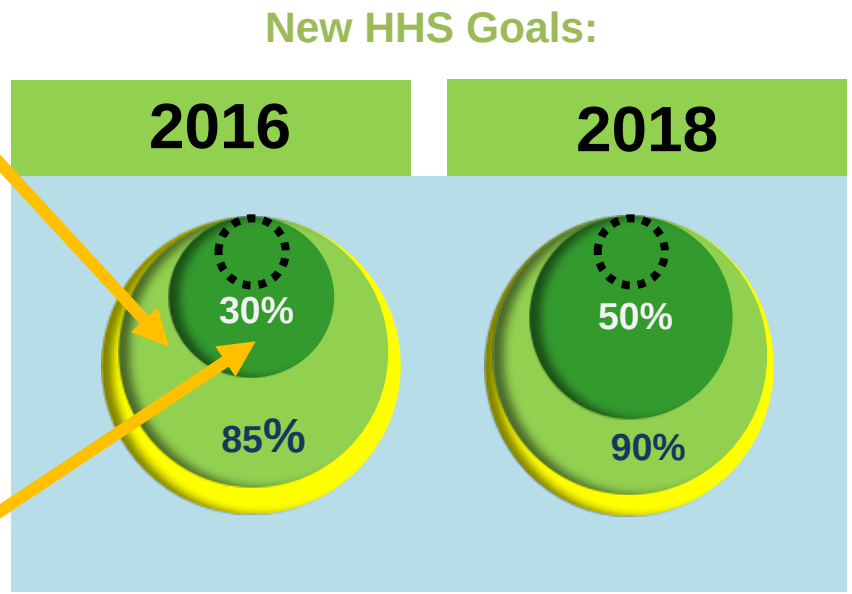
The Future


High
Cost
Over Utilization
The Potentially Preventable
Fee for Service
Fragmentation
Lack of Cost Transparency
Value/Volume
MIPS
Value Based Modifier
Performance & Quality
Alternative Payment Methods
Low
Low
High
Quality

MACRA – Supports HHS Goals

The Merit-based Incentive Payment System helps to link **fee-for-service payments** to quality and value.

The law also provides incentives for **participation in Alternative Payment Models** via the bonus payment for Qualifying APM Participants (QPs) and favorable scoring in MIPS for APM participants who are not QPs.



All Medicare fee-for-service (FFS) payments (Categories 1-4)

Medicare **FFS** payments **linked to quality and value** (Categories 2-4)

Medicare payments linked to quality and value **via APMs** (Categories 3-4)

Medicare payments to QPs in eligible APMs under MACRA

Practice Transformation in Action

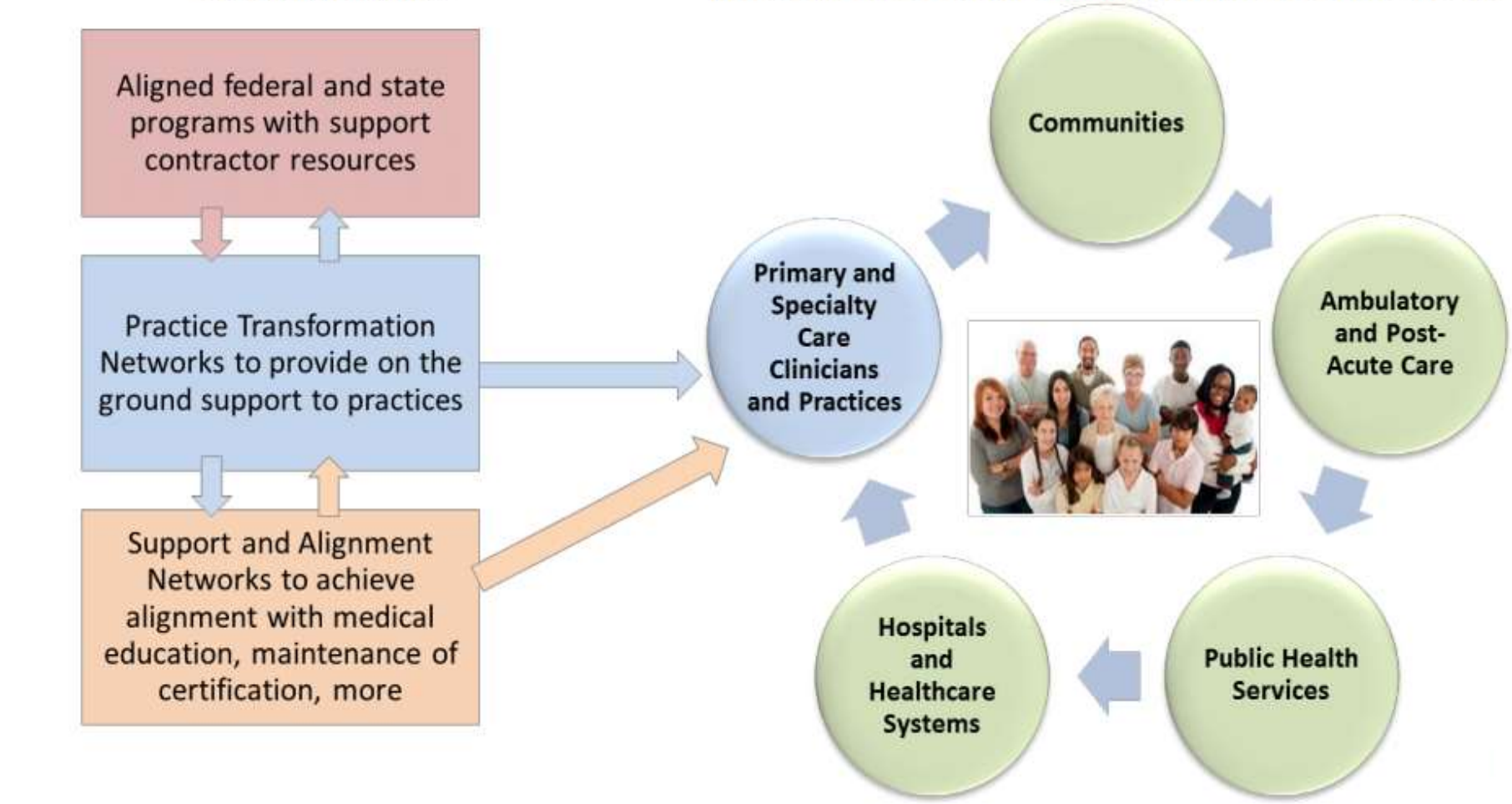
*Transforming Clinical Practice would employ a **three-prong approach** to national technical assistance.*

*This technical assistance would enable large-scale transformation of more than 150,000 clinicians' practices to deliver **better care and result in better health outcomes at lower costs.***

Aligned federal and state programs with support contractor resources

Practice Transformation Networks to provide on the ground support to practices

Support and Alignment Networks to achieve alignment with medical education, maintenance of certification, more



In January 2015, HHS announced goals for value-based payments within the Medicare FFS system

Goals

- Goal 1: **30%** of Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and **50%** by the end of 2018
- Goal 2: **85%** of all Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and **90%** by the end of 2018

Purpose

- Set **internal goals** for HHS
- Invite **private sector payers** to match or exceed HHS goals

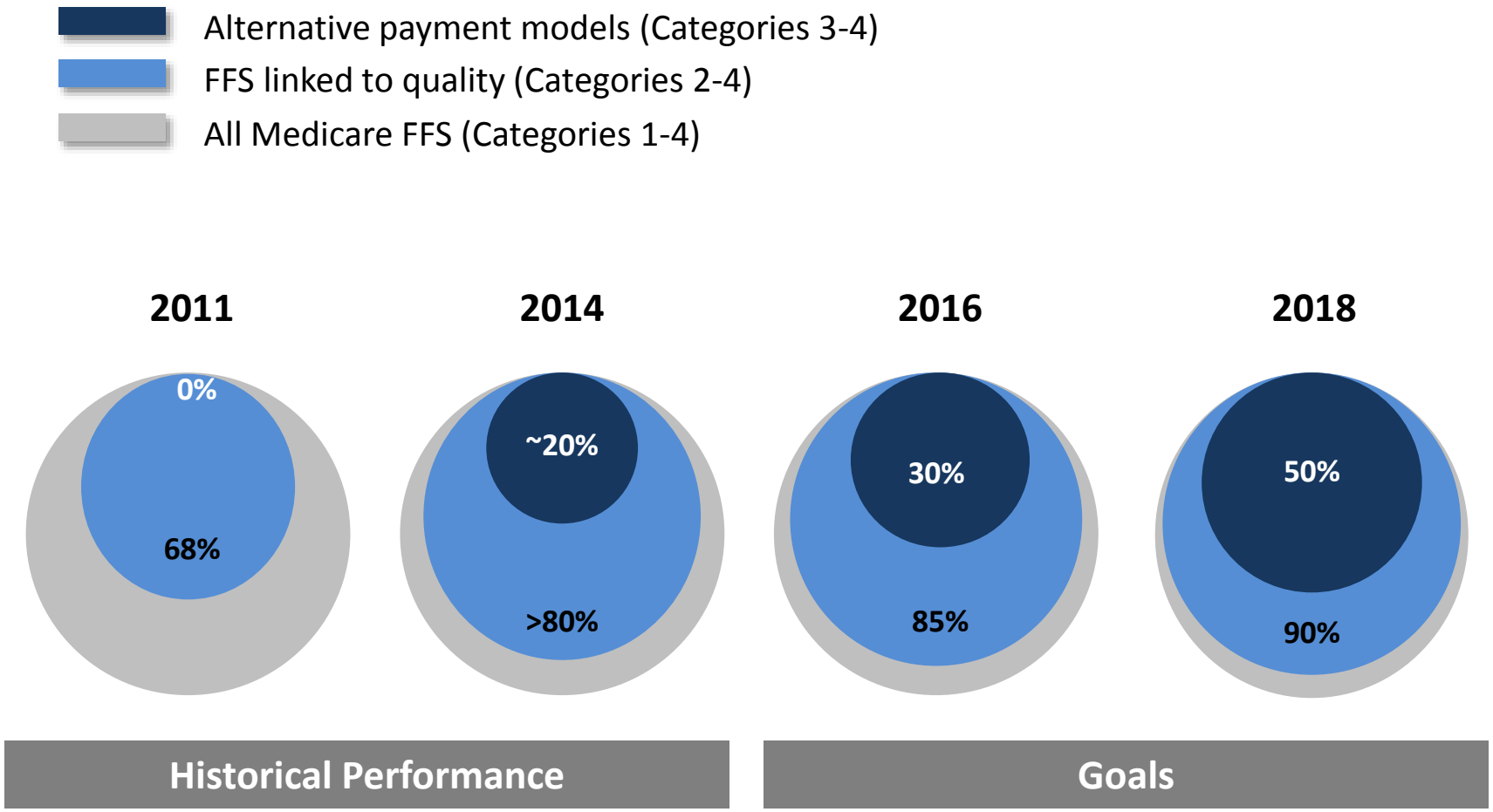
Stakeholders

- Consumers
- Businesses
- Payers
- Providers
- State and federal partners

Next steps

- **Testing of new models and expansion of existing models** will be critical to reaching incentive goals
- Creation of a Health Care Payment **Learning and Action Network** to align incentives

Target percentage of payments in “FFS linked to quality” by 2016 and “alternative payment models” by 2018



MARYLAND HEALTH CARE COMMISSION

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9. **Overview of Upcoming Initiatives**

10. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

Overview of Upcoming Initiatives

(Agenda Item #9)


ENJOY THE REST OF
YOUR DAY