# Maryland Health Care Commission

Thursday, December 15, 2016

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

# AGENDA

1. **APPROVAL OF MINUTES**

2. UPDATE OF ACTIVITIES

3. PRESENTATION: Overview of Maryland's Comprehensive Primary Care Program

4. ACTION: Annual Mandate Report

   - Coverage for Digital Tomosynthesis (3-D Mammograms)
   - Coverage for Lymphedema Diagnosis, Evaluation, and Treatment

5. ACTION: Certificate of Need – Exceptions Hearing: Recommended Decision in the Matter of 314 Grove Neck Road OPCO L.L.C. (Recovery Centers of America-Earleville) (Docket No. 15-07-2363)

6. ACTION: Certificate of Need – Maryland House Detox (Docket No. 16-02-2374)

7. ACTION: Certificate of Need – Massachusetts Surgery Center (Docket No. 16-15-2378)

8. PROPOSED ACTION: User Fee Assessments

   - Presentation of the User Fee Assessment Study
   - COMAR 10.25.02 – User Fee Assessment of Health Care Practitioners
   - COMAR 10.25.03 – User Fee Assessment of Payers, Hospitals, and Nursing Homes

9. PRESENTATION: Grant Award – Improving Patient Outcomes Using mHealth Technology

10. Overview of Upcoming Initiatives

11. ADJOURNMENT

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# PRESENTATION:

Overview of Maryland's Comprehensive Primary Care Program

(Agenda Item #3)

CHANGING Maryland *for the Better*

# DRAFT

# Maryland Primary Care Model

## Maryland Health Care Commission

Howard Haft, MD
Department of Health and Mental Hygiene
December 15, 2016

# Goals of Primary Care Model

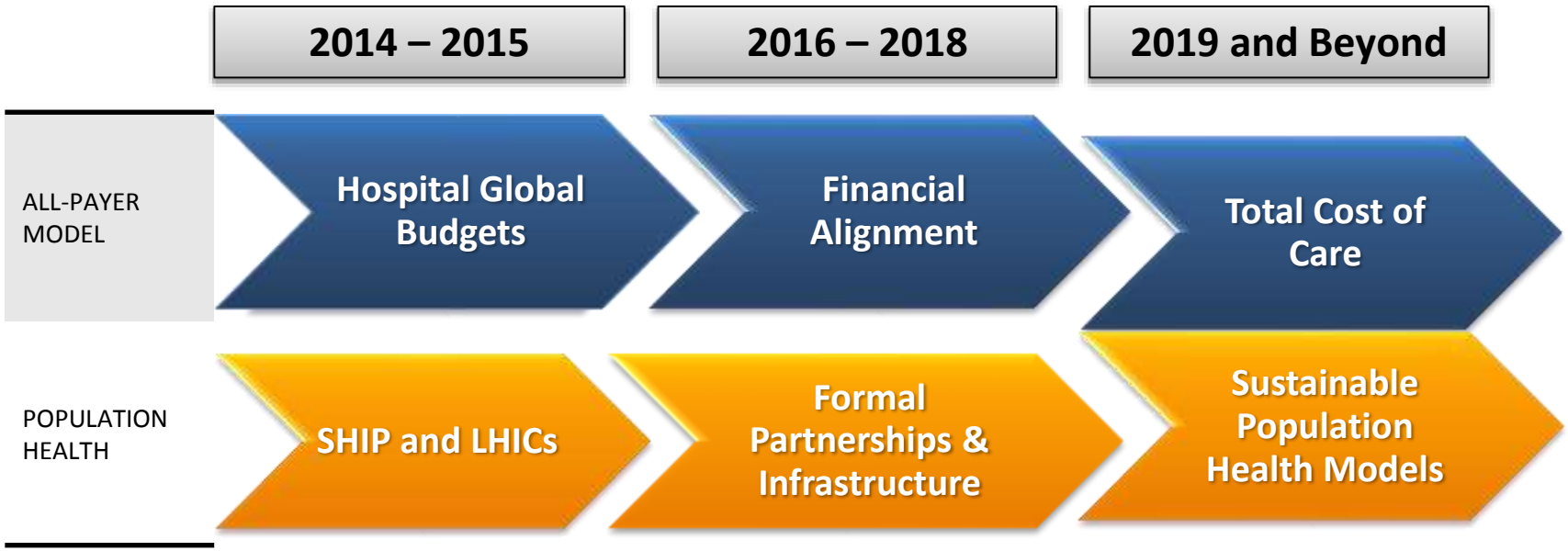
- **Improve the health of Maryland through:**
  - Person-centric healthcare
  - Team-based support
  - Evidence-based approach
  - Consistent quality and outcome metrics
  - Volume to Value
  - Reduce potentially avoidable utilization
  - Improve management of chronic illness
  - Alignment with Maryland All-Payer Model and Medicaid Duals ACO
  - Alignment with State Population Health Improvement Plan (due to CMMI: 12/31/2016)

- **Timeline:**
  - 12/31/2016: Submit Primary Care Model concept paper to CMMI
  - 2017: Enhanced Infrastructure development begins:
    - Coordinating Entity development
    - Regional Care Management Entity formation / applications
    - Practice adoption/technical assistance
    - HIE Expansion, more primary care providers achieve connectivity
  - 2019 – 2023: Sustainability achieved through long term Return on Investment

# How the Primary Care Model Can Help Physicians

- Provides funding for care managers to be embedded in primary care practices; alternative is deployment of care managers to practices on as-needed basis
- Funding for deployment of pharmacists, nutritionists, social workers, community health workers and others as needed
- Assistance with CRISP connectivity
- Assistance with medication management, care transitions
- Help with open access scheduling, telehealth, e-visits, group visits
- Funding for non-visit activities vital to good health

# Transformation Progression




**Dec 31, 2016**

Submit designs of:
- Primary Care Model
- State Population Health Plan
- All Payer Model Progression Plan
- Duals ACO

**2017**

- All Payer Model Amendment, Population Health Plan – Design
- Primary Care Model – infrastructure development

**2018**

- Primary Care Model – Year 1 Operation
- Additional Population Health Plan and VBP - Planning

# Relationship to All-Payer Model and Progression Plan

- The Primary Care Model will help sustain the early gains of the All-Payer Model as targets becoming increasingly reliant on factors beyond the hospital
  - Aligns incentives; important to design in a way that ensures hospitals are not responsible for risks they cannot control
- Complements the Care Redesign Amendment
  - Community-level alignment to CCIP
- Reduces avoidable hospitalizations and ED usage through advanced primary care access and prevention
  - Components include embedded care managers, 24/7 access to advice, medication mgt., open-access scheduling, behavioral health integration, and social services
- Enhanced version of CPC+ will complement and support hospital global budgets

# MACRA

Law *intended* to align physician payment with *value*

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**

**Quality Payment Program**

- Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)

Source: CMS webinar slides, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

# The Quality Payment Program Provides Additional Rewards for Participating in APMs

Potential financial rewards

| Not in APM | In APM | In Advanced APM (AAPM) |
|---|---|---|
| MIPS adjustments | MIPS adjustments | |
| | + | |
| | APM-specific rewards | APM-specific rewards |
| | | + |
| | | 5% lump sum bonus |

If you are a **Qualifying APM Participant (QP)**

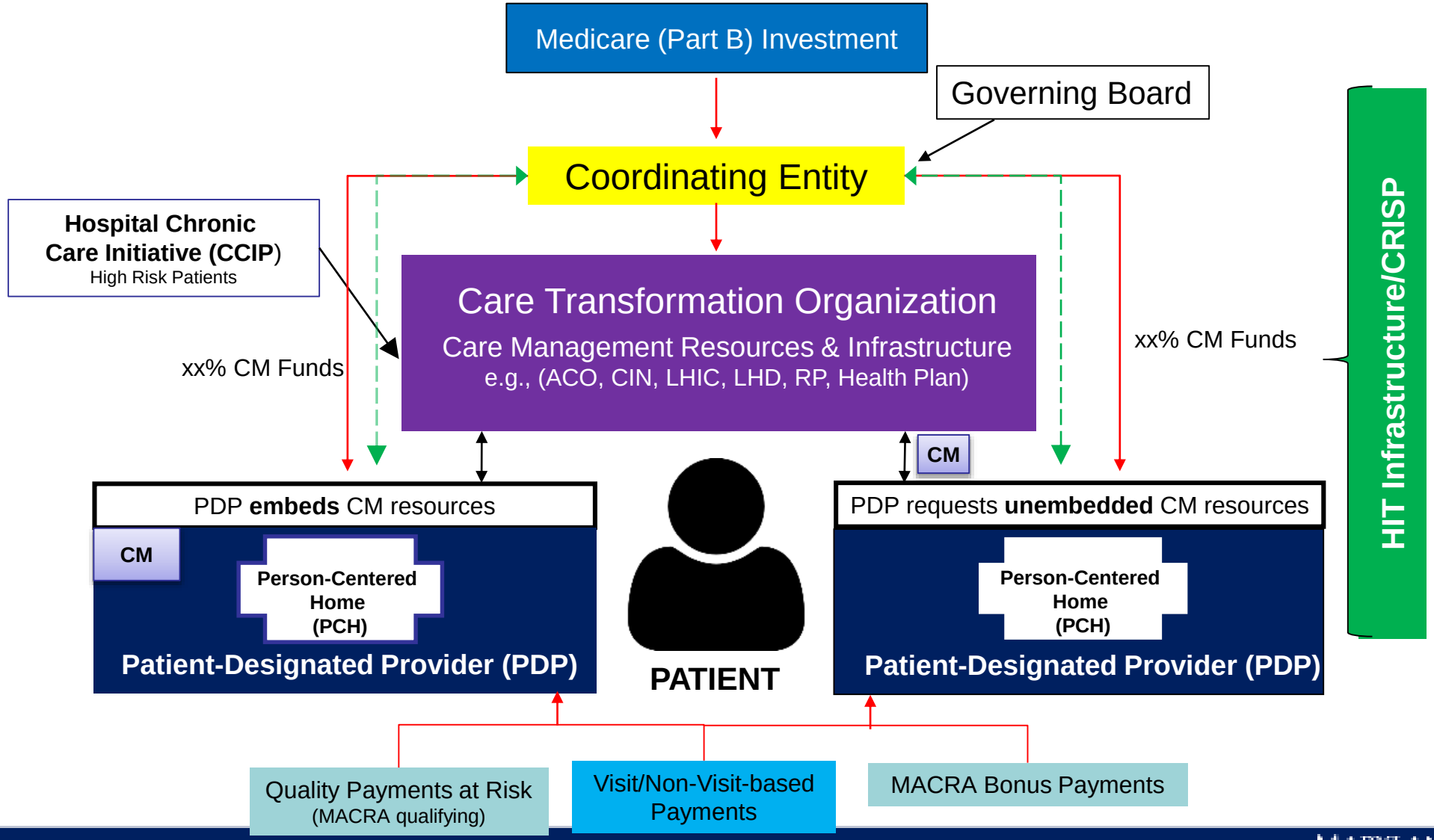
Source: CMS webinar slides, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

# Leveraging Window of Opportunity

- Federal government willing to make substantial financial investment to implement Primary Care Model and help the state manage Medicare and Duals populations
- CMMI willing to allow the State to customize CPC+, which is an approved AAPM model
- Maintaining All Payer Model and broader health transformation in State depend on primary care with strong supports
- DHMH and MHCC can collaborate on meeting goals

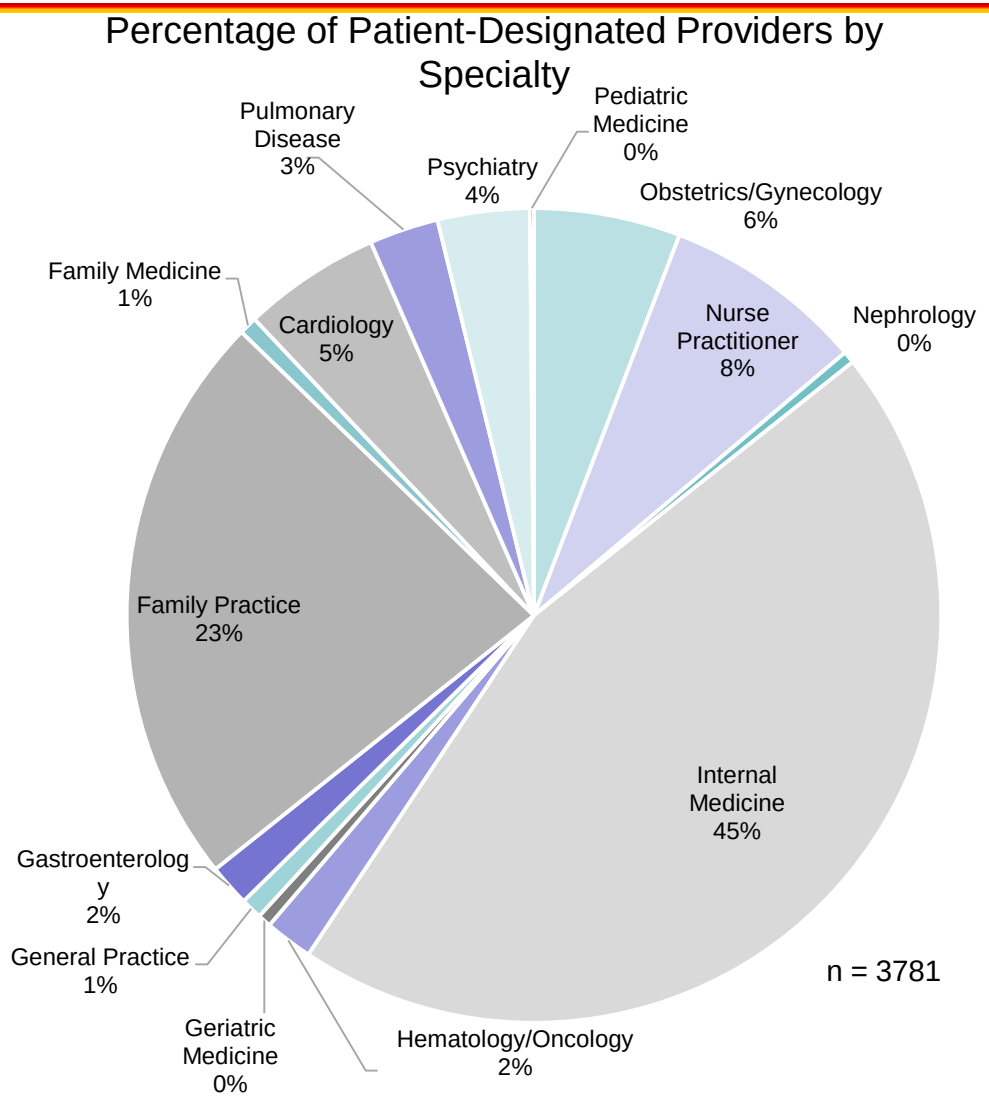
# OVERVIEW OF PRIMARY CARE MODEL

# Maryland Primary Care Model



# PDPs

- Patient Designated Providers (PDPs)
  - The most appropriate provider to manage the care of each patient
  - Provides preventive services
  - Coordinates care across the care continuum
  - Ensures enhanced access
  - Most often this is a PCP but may also be a specialist, behavioral health provider, or other depending on patients health needs





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# Person Centered Home

- Person-Centered Home (PCH)
  - An individual provider or group of providers that deliver care as a team to a panel of patients
  - The PCH must have at least one PDP
  - PCH practices must meet the requirements laid out by the Model – CPC+ like
  - Practices may span multiple physical sites in the community

# Practice Transformation is Key!

- Practices will **NOT** be expected to be transformed on day 1 or program start
- The State is committed to designing a system to provide assistance with practice transformation:
  - Care Transformation Organizations (CTOs) will be approved to assist practices
  - Practices will choose the best CTO for them
  - Practices may elect to not choose a CTO and contract directly with CE; practices need to provide evidence of sufficient infrastructure to meet requirements of PCM to contract with CE directly
  - CTOs will ensure that practices meet requirements under program by developing high functioning services including:
    - Care management resources and people
    - Technical assistance on practice transformation
    - IT supports (CTO and CRISP)

# The Role of Care Managers

- Care managers will work very closely with physicians, NPs, PAs, nurses and other members of a primary care team
- They will assist the clinicians, patients, and family members in the development and implementation of care plans tailored to each patient's needs
- Care managers will arrange for services such as transportation, nutrition, and help smooth transitions of care
- Care managers can be embedded in PDP practices; an alternative approach for the deployment of care managers to practices on an as-needed basis.

# I am a Patient: What does a transformed practice look like to me?

- I am a Medicare beneficiary
- Provider selection by my historical preference
- I have a team caring for me led by my Doctor
- My practice has expanded office hours
- I can  take advantage of open access and flexible scheduling:
  - Telemedicine, group visits, home visits
- My care team knows me and speaks my language
- My records are available to all of my providers
- I get alerts from care team for important issues
- My Care Managers help smooth transitions of care
- I get Medication support and as much information as I need
- I can get community and social support linkages (e.g., transportation, safe housing)

# I am a Provider: What does a transformed practice look like to me?

- Voluntary participation
- Able to spend more time with patients
- Patient care management support based on severity index
- Care managers embedded in my practice and part of my care team
- Practice incentives:
  - 5% MACRA participation bonus (lump sum); CPC+ participation
  - Quality and Utilization incentive bonus $2.50 or $4 PBPM (Track 1, Track 2, respectively) – Prepaid
  - Track 2 comprehensive payment – Prepaid
  - Care Management payment PBPM risk adjusted
  - Care management infrastructure
  - Practice transformation support
  - Healthier patient population
  - Reimbursement for non-office based visits

# How do I become a Care Transformation Organization?

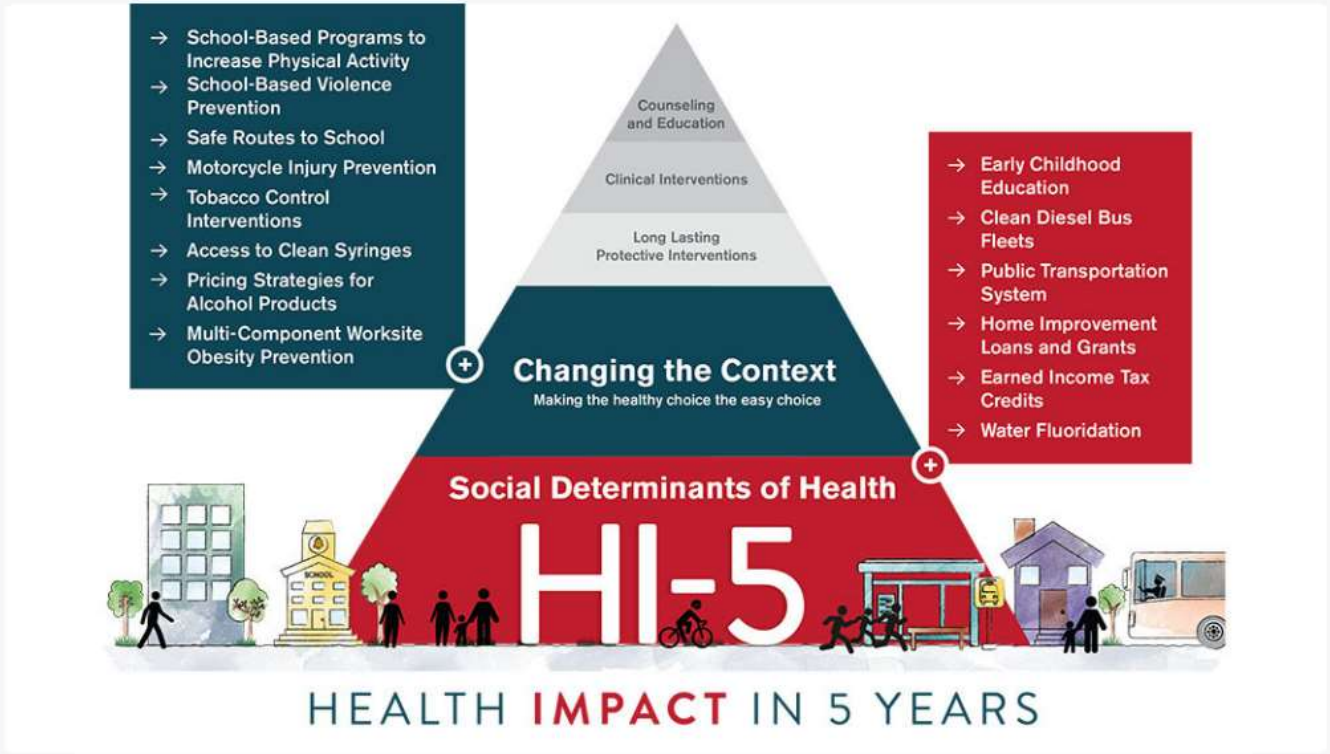
- Certification by external accrediting body
- Apply through Coordinating Entity (CE)
  - CE holds CTO accountable for requirements and outcomes
- Ability to provide following services includes:
  - Care management infrastructure
    - Nurses, pharmacists, nutritionists, Community Health Workers, LCSWs, Health educators
  - Technical assistance for 24/7 after-hours access
  - Social support connections – Community Health Workers
  - “Hot-spotting” areas with high and/or specific needs
  - Pharmacist support for medication management and consultations
  - Assisting practices in meeting Primary Care Model requirements
  - Physician training resources
  - CRISP connectivity

# Functions of Coordinating Entity

| Functions of the CE |
| --- |
| **Program Design** |
| Develop requirements for CTO and PCH participation |
| Engage stakeholders through an Advisory Board for input on program policy and outcomes |
| **Program and Budget Administration** |
| Design, review and approve CTO and PCH applications |
| Administer Medicare beneficiary attribution to PCHs |
| Run algorithms for the defined payment logic to determine distribution of care management fees |
| Financial administration (accepting the dollars from CMS or another payer and redistributing across system) |
| Enter into and monitor contracts with key partners, such as:<br>• External National Accreditation Organization for CTO certification<br>• Other partners |
| Develop boilerplate contracts for relationship between CTOs and PCHs |
| **Informatics/Data Analytics** |
| Perform ongoing reporting and analysis in support of model-specific goals (in support of Learning System) |
| Provide CTOs and PCHs with regular reports to inform decision-making (in support of Learning System) |
| Provide regional population health outcomes/metrics |
| **Model Compliance** |
| Monitor CTO and PCH performance for assessment of compliance with model participation |
| Recommends corrective action plans where needed |
| **Model Evaluation (tentative)** |
| Contract with an independent outcome evaluation group to monitor performance against goals of population health, quality of care, and cost targets |

# The Importance of Population Health to the All-Payer Model

Figure 4 | Health Impact in 5 Years




Source: U.S. Centers for Disease Control and Prevention, Health Impact in Five Years. http://www.cdc.gov/hi5

# Relationship to MHCC activities

- Primary care transformation is related to the development of a strong long-term plan for improving the health of the Maryland population
- DHMH, MHCC will further collaborate on population health
- As the All-Payer Model further develops, health care will continue to shift from inpatient to the community
- This will involve shifts across facilities and work force issues
- Addressing social determinants will also be important
- Incentives need to be aligned across the system, including hospitals, primary/specialty care, post-acute, and LTC

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# ACTION:

Annual Mandate Report

Coverage for Digital Tomosynthesis (3-D Mammograms)
Coverage for Lymphedema Diagnosis, Evaluation, and Treatment

(Agenda Item #4)

# PROPOSED MANDATED HEALTH INSURANCE SERVICES

## MARYLAND HEALTH CARE COMMISSION (MHCC)

Presented by:

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# *Our Qualifications*



NovaRest is a leading actuarial firm that specializes in aiding state insurance regulators to meet their regulatory responsibility. We have extensive knowledge of the needs of insurance regulators, and routinely demonstrate our expertise and resources to undertake the responsibility required under the proposed contract. As a sampling of this work:

- Over forty mandated benefit evaluations in Illinois, Maine, Maryland, New Jersey, New York, and South Carolina.
- We have a powerful combination of industry and regulatory experience.
- We have recognized experts in the area of rate development and rate review and the estimation of what impacts premium rates.
- We have a clear understanding of the Patient Protection and Affordable Care Act (ACA), and have advised the Department of Health and Human Services (HHS) as it developed the pertinent ACA regulations.

# Report Content



The NovaRest report:

- Includes information from several cited sources
  - Provide more than one perspective
  - Goal:  provide a totally unbiased report
- There may be some conflicting information
  - Used sources and citation that we considered credible
  - We do not offer any opinions regarding whether one source is more credible than another,
  - Let the reader develop his/her own conclusions.

# Coverage



***ACA Benchmark Plan***

The 2017 Maryland benchmark plan for ACA compliant plans is the small group CareFirst BlueChoice HMO HSA-HRA $1,500 plan.

***Women's Health and Cancer Rights Act***

This act requires that health plans provide services for the treatment of any physical complications at all stages of a mastectomy, including lymphedema.

# *Mandated Coverage for Lymphedema Diagnosis, Evaluation, and Treatment*



House Bill 113 would require insurers, nonprofit health service plans, or health maintenance organizations (collectively known as carriers) that provide hospital, medical, or surgical benefits, to provide coverage for the medically necessary diagnosis, evaluation, and treatment of lymphedema.

# Background



**According to MedicineNet.com, lymphedema is defined** as swelling in one or more extremities that results from impaired flow of the lymphatic system

**Symptoms** of mild lymphedema may be a feeling of heaviness, tingling, tightness, warmth or shooting pains in the affected extremity

# Coverage



***Medicare***

- Does not cover the medically necessary compression supplies used in lymphedema treatment since they do not fit under any Medicare benefit category.

***Maryland Medicaid Managed Care***

- The only Medicaid MCO that responded to our survey indicated that treatment for lymphedema is covered when medically necessary.

# Commercial Carrier Coverage



## Coverage results:

**Carrier 1**

Considers two pairs of compression sleeves/gloves per affected arm every six months.

**Carrier 2**

Will cover graduated compression stockings and other garments that have a pressure of 20 mm HG or more.

**Carrier 3**

Has established criteria for determining whether a pneumatic compression device with and without gradient pressure is medically necessary.

**Carrier 4**

Will cover pneumatic compression devices in the home setting for the treatment of lymphedema if the patient has undergone a four-week trial of conservative therapy.

# Financial Impact on Premiums



The **Virginia** study showed that lymphedema claims as a percent of total claims varied between 0.012% - 0.100% for individual and group contracts.

The **California** lymphedema mandate completed by the California Health Benefits Review Program in 2005 estimated an increase of 0.0003% or $0.01.

The **Massachusetts** analysis estimated a range of impacts from $0.10 PMPM to $0.11 PMPM, or 0.002% to 0.03% of premium.

**Carriers in Maryland** estimated the premium increase to be between 0.02% to 0.50% depending on the market.

***NovaRest Estimate***

Using the MCDB as the basis for utilization and costs, the 2014 PMPMs by market were:

| Market | 2014 Paid PMPM |
|---|---|
| Individual | $0.07 |
| Small Group | $0.07 |
| Large Group | $0.06 |
| Total | $0.07 |

## Additional Issues

- The proposed mandate is not expected to have significant impact on the cost of the service.
- We do not expect a significant increase in the appropriate use of the service, but there will be some increase.
- This proposed mandate is not a substitute for a more expensive service.
- This proposed mandate would have next to no impact on administrative costs.
- The total cost for this proposed mandate will not have a material impact on the total cost of health care.
- Given the low-cost impact of the proposed mandate, it is unlikely that its passage alone would cause a major shift to self-insurance.

# Questions?

**Donna Novak FCA, ASA, MAAA, MBA**
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**Karen Bender FCA, ASA, MAAA**
Snowway Actuarial and healthcare Consulting, LLC
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# *Mandated Coverage for Digital Tomosynthesis (also called 3-D Mammograms)*



House Bill 1006 would require insurers, nonprofit health service plans, or health maintenance organizations (collectively known as carriers), to provide coverage for digital tomosynthesis that, under accepted standards in the practice of medicine, the treating physician determines is medically appropriate and necessary for an enrollee or insured.  It is sometimes referred to as 3-D mammogram.

# Background



Breast cancer

- Third-leading cause of cancer death among women in the United States
- In 2016, an estimated 247,000 women will be diagnosed with the disease and 40,000 women will die of it.
- Most frequently diagnosed among women aged 55 to 64 years
- The median age of death from breast cancer is 68 years.
- Mammograms are a diagnostic tool used in the early detection and diagnosis of breast diseases, most notably cancer, in women.

# Traditional Mammograms



- Traditional mammograms use an x-ray system that takes images of the breast from two angles.
- Doctors often cannot distinguish between the lethal cancers from non-lethal categories for ductal carcinoma in situ [DCIS]; all women are treated as if the cancer will become life-threatening.
- Mammograms may also produce a “normal” result even though breast cancer is present.
- Recall rate of 104 per 1,000 women screened for 2-D mammograms

# Breast tomosynthesis/three-dimensional (3-D) mammography/digital breast tomosynthesis (DBT)



- Multiple images of the breast from different angles are captured and reconstructed ("synthesized") into a three-dimensional image set.
- Several studies have found that 3-D mammograms find more cancers and reduce the number of false positives.
- The rates of women who had to come back for more testing are reduced with 3-D mammograms.

# Research



- The National Cancer Institute indicates there have NOT been randomized studies comparing the accuracy of 3-D mammography to standard mammography.
- Rates of interval cancers (cancers that are found within 12 months after a normal mammogram) decreased slightly from 0.7 per 1,000 women screened with 2-D mammograms to 0.5 per 1,000 women screened with 3-D mammograms.
- A longitudinal study released in June 2016 shows evidence that the benefits of initial 3-D mammogram screening can be sustained and improved over time with consecutive 3-D mammogram screening.
- A study of 13 hospitals found the rates of DCIS detection did not rise, remaining at 1.4 cases per 1,000 screenings the year after the switch to 3-D screening, the same rate as with 2-D screening.

# Coverage



- US Preventive Services Task Force (USPSTF) Grade A and B Recommendations are included as covered preventive services in most ACA-complaint health plans. 2016 recommendation:
  - Biennial screening mammography (Grade B) for women aged 50 - 74 years
  - Screening for women aged 40 - 49 (Grade C) is an individual decision
  - Evidence inconclusive to assess the benefits and harms of digital breast tomosynthesis (DBT) as a primary screening method for breast cancer
- Medicare started covering 3-D mammograms in January 2015.
- Digital tomosynthesis is not currently covered by Maryland Medicaid, according to the one Medicaid MCO that responded to our survey.

# Coverage



- Commercial carriers:
  - Two carriers consider digital breast tomosynthesis experimental and investigational because of insufficient evidence of its effectiveness.
  - One carrier covers 3-D mammograms 100 percent when medically necessary.
  - Two carriers insuring the majority of the market cover 3-D mammograms the same as any other mammogram.

# Financial Impact



**California** estimated premium increases of $0.13 PMPM to $0.20 PMPM.

**ConnectiCare** (Connecticut's Insurance Exchange) estimated that a 3-D mammogram mandate would increase premiums by $1.38 PMPM. However, Anthem operating in the same state indicated there would be no impact on premium.

**Carriers' Estimates**

**Maryland carriers** estimated a premium impact ranging from $0.20 PMPM to $1.20 PMPM, or 0.1% to 0.3 %.

**NovaRest Estimate**

Depending on the assumptions, the percentage impact on premiums ranges from 0.10% to 0.18% on a gross basis and from 0.02% to 0.10% ($.05 to $.39) on a marginal basis.

**Additional Issues**

- The proposed mandate is not expected to have significant impact on the cost of the service.
- This proposed mandate would increase the appropriate use of digital tomosynthesis to the extent that it is currently not covered.
- Digital tomosynthesis would replace the less expensive mammograms.
- Having to exclude one specific test from the broader benefit category may add to the administrative cost.
- The total cost for this proposed mandate is minimal and will not have a material impact on the total cost of health care.
- Given the low-cost impact of the proposed mandate, it is unlikely that its passage alone would cause a major shift to self-insurance.

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(Docket No. 16-02-2374)

(Agenda Item #6)

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   - COMAR 10.25.02 – User Fee Assessment of Health Care Practitioners
   - COMAR 10.25.03 – User Fee Assessment of Payers, Hospitals, and Nursing Homes

9. PRESENTATION: Grant Award – Improving Patient Outcomes Using mHealth Technology

10. Overview of Upcoming Initiatives

11. ADJOURNMENT

# ACTION:

Certificate of Need – Massachusetts Surgery Center
(Docket No. 16-15-2378)

(Agenda Item #7)

MARYLAND HEALTH CARE COMMISSION

# AGENDA

1. APPROVAL OF MINUTES

2. UPDATE OF ACTIVITIES

3. PRESENTATION: Overview of Maryland's Comprehensive Primary Care Program

4. ACTION: Annual Mandate Report

   - Coverage for Digital Tomosynthesis (3-D Mammograms)
   - Coverage for Lymphedema Diagnosis, Evaluation, and Treatment

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(Agenda Item #8)

# *Report on MHCC User Fee Assessment as Required by Senate Bill 786 – Department of Health and Mental Hygiene – MHCC-Modifications and Clarifications and House Bill 800 – Maryland Health Care Commission – Program Evaluation*

**Release for Public Comment**

**December 15, 2016**

# INTRODUCTION

**Senate Bill 786 – "Department of Health and Mental Hygiene – MHCC –Modifications and Clarification"** passed during the 2001 Legislative Session requires the Commission, every four years, to study and make recommendations on the appropriate funding level for the Commission and user fee allocation among those currently assessed;

- Raised the user fee cap to $10 million;
- Remove from statute, industry allocations, and incorporate into regulation;
- Adopt regulations to permit a waiver of the fee to certain health care practitioners who earn an average hourly wage substantially below that of

  other health care practitioners

# HOUSE BILL 800 – Maryland Health Care Commission – Program Evaluation, (Chapter 627)

**House Bill 800 – "Maryland Health Care Commission – Program Evaluation"** passed during the 2007 Legislative session allowed the Commission to:

- Raise the user-fee cap to $12 million
- Study the extent to which other health care providers, not currently subject to a user-fee assessment, utilize the Commission resources and to discuss the feasibility and desirability of extending a user fee to additional types of providers regulated by the Commission.

**Recommendations from the Fiscal Year 2014 Preliminary Sunset Review**

- Explore the possibility of how the workload distribution might, at least in part, consider *future* workload requirements.

# HOW THE ASSESSMENT IS CALCULATED

- **Health Insurance Companies** (Payers) are assessed based on a ratio of total earned premium collected for health benefit plans by company over total collected earned premium of all payers in the state. (68 Insurance Companies currently paying the assessment)
- **Nursing Homes and Hospitals** are assessed one-half of the total fee times the ratio of admissions to total admissions for all nursing homes and hospitals; and one-half of the total fee times the ratio of gross operating revenue to total gross operating revenues of all nursing homes and hospitals. (230 Nursing Homes and 46 hospitals/special hospitals currently paying the assessment)
- **Health Occupation Boards** are assessed a flat fee that apportions the total amount assessed based on the number of licensees. (150,000) licensees currently paying the assessment)

# BACKGROUND OF ASSESSMENT MECHANISM

**Current Allocations**

- Payers – 28%
- Nursing Homes – 17%
- Hospitals/Special Hospitals – 33%
- Health Occupational Boards – 22%

- The amount of an individual entity's assessment is derived differently for each group assessed.

# SUMMARY OF ALLOCATION OF COSTS

**FY 17 PROJECTED EXPENDITURES – $15,026,621 BUDGET APPROPRIATION**

- Payer Specific Costs - $3,487,820 - (25%) – APCD, HMO Guide, HIE
- Nursing Home Specific Costs - $2,807,858 - (19%) - LTC Guide, Satisfaction Surveys, EHR, HIE, CON
- Hospital Specific Costs - $5,988,175- (40%) - Hospital Guide, HAI, APCD, CON, State Health Planning
- Health Occupation Boards Specific Costs - $2,382,768- (16%) – APCD, PCMH, HIE

**FY 18 REQUESTED BUDGET = $14,515,326 / FY 19 PROJECTED BUDGET – $14,857,000**

- Payer Specific Costs - $3,871,550 - (27%)/ $4,011,390 (27%) – APCD, HMO Guide, HIE
- Nursing Home Specific Costs - $2,712,250 - (19%)/ $2,795,252 (19%) – LTC Guide, Satisfaction Surveys, EHR, HIE, CON
- Hospital Specific Costs - $5,583,588 - (38%)/ $5,695,978 (38%) – Hospital Guide, HAI, APCD, CON, State Health Planning
- Health Occupation Boards Specific Costs - $2,347,939 - (16%)/ $2,388,886 (16%)– APCD, HIE, Primary Care

***Residual Costs or Operating Costs at 25% to each industry and are outlined in the report**

# NEW ALLOCATION BY INDUSTRY

- Using an average between FY 17, FY 18, and FY 19:

- **Payers -** 26%
- **Nursing Homes -** 19%
- **Hospitals -** 39%
- **Health Occupation Boards -** 16%

# BACKGROUND OF AVERAGE ANNUAL WAGE – Waiver Process – Health Occupation Boards

- Health Occupation Boards report each category of licensure
- Commission Staff:
  - Uses State Personnel Classification and Salary Guide (SPCSG)
  - Matches all categories of health care practitioners to the -state salary scale for compensation from highest to lowest
  - Determines average wage
  - The SPCSG is not an accurate reflection of salaries for an occupation, but is a consistent and transparent source of data for the benchmark test – salaries are low, but consistently so.

**The following health care practitioners are currently assessed:**

Chiropractors; Dietitians/Nutritionists, Occupational Therapists, Social Workers, Speech Language Pathologists, Nurses, Podiatrists, Physical Therapists; Physicians, Psychologists, Pharmacists, Optometrists, Professional Counselors and Therapists, Dentists, Massage Therapists, and Acupuncturists

# AVERAGE ANNUAL WAGE – Waiver Process – Health Occupation Boards

- Current average annual wage - $36,280/grade 14 on salary scale
- New average annual wage - $38,629/grade 14 on salary scale
- No additional exemptions to the fee

**The following health care practitioners remain excluded from the fee:**

Occupational Therapist Assistants; Social Worker Associates; LPNs, Nurse Psychotherapists, Nurse Assistants; Physical Therapy Assistants; Psychology Associates; Dental Hygienists; and Dental Assistants

# INCLUSION OF ADDITIONAL HEALTH CARE PROVIDERS

**Staff studied the feasibility of assessing Ambulatory Surgical Facilities (342)**

- FY 17 Projected Expenditures - $185,222 1%
- FY 18 Projected Expenditures - $205,000 1%
- FY 19 Projected Expenditures - $215,250 1%

**Staff studied the feasibility of assessing Hospice Providers**

- FY 17 Projected Expenditures - $22,466 <1%
- FY 18 Projected Expenditures - $87,550 <1%
- FY 19 Projected Expenditures - $55,008 <1%

**Staff studied the feasibility of assessing Home Health Agencies**

- FY 17 Projected Expenditures - $149,911 1%
- FY 18 Projected Expenditures - $157,406 1%
- FY 19 Projected Expenditures - $122,462 1%

# COMMISSION STATUTORY CAP INCREASE

- The current statue states the Commission cannot assess over 12 million
- The Commission is currently appropriated 15 million. However, we only assess the industries based on 12 million.
- The last statutory increase was in FY 2008
- Key drivers in the last 5 years contributing to increase are: Patient Centered Medical Home Project; The Expansion of the APCD; Reporting on Hospital and HMO quality and performance; Health Information Technology (telemedicine),
- DLS Recommended in their Final Report of the three Health Regulatory Commissions to increase the cap for both the MHCC and the HSCRC

# GLIDE PATH ON IMPLEMENTATION OF A NEW CAP AND THE IMPACT ON EACH INDUSTRY

- Assuming a 5% increase between FY 18 and FY 19 in budgetary expenditures:

- **FY 2018 Budget - $ 14,515,326**
  - Payers (26%) - $3,774,061
  - Nursing Homes (19%) - $2,757,968
  - Hospitals (39%) - $5,661,092
  - Health Occupation Boards (16%) - $2,322,450 or about $15 for an annual license or $30 for a bi-annual license

- **FY 2019 Budget - $14,857,000**
  - Payers (26%) - $3,862,820
  - Nursing Homes (19%) - $2,822,830
  - Hospitals (39%) - $5,794,230
  - Health Occupation Boards (16%) - $2,377,120 or about $16 for an annual license or $32 for a bi-annual license

# STAFF RECOMMENDATIONS

- Amend COMAR 10.25.02 – User Fee Assessment on Health Care Practitioners and COMAR 10.25.03 – User Fee Assessment of Payers to reflect the cost allocations recommended
- Continue to study the feasibility of assessing other health care providers who benefit from the services provided by the Commission
- Concur with the Department of Legislative Services to increase the user fee cap

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

# PRESENTATION:

Grant Award – Improving Patient Outcomes Using mHealth Technology

(Agenda Item #9)

# Improving Patient Outcomes using mHealth Grant

*December 15, 2016*

The MARYLAND HEALTH CARE COMMISSION

# Presentation Summary

- At the end of August, nine letters of intent were received in response to the Announcement for Grant applications
  - Seven organizations were invited to submit applications, which were due at the end of September
- A review team identified two applications for consideration; several interviews and site visits occurred in November
- Johns Hopkins Pediatrics at Home (JH PAH) was selected for funding
  - Use case tests mHealth on pediatric asthma patients in an underserved area of Baltimore City
  - Pediatric asthma is the third leading cause of hospitalization among children; use case aimed at reducing hospital admissions by empowering patients to take a proactive role in their health care

# mHealth Defined

mHealth is the delivery of health care services via mobile communication devices to improve health outcomes, health care services and health research. The ubiquity of mobile devices presents the opportunity to improve health outcomes through the delivery of innovative medical and health services with information and communication technologies. Its application ranges from targeted text messages to engaging patients in their own health, which includes patient reporting and real-time support from a physician or extended care delivery network.

# Grant Aims

- Increase access to health care services
- Improve communication between consumers and health care providers
- Improve public health
- Increase consumer access to health information and education
- Enable consumers to take more responsibility in managing their health
- Reduce health care costs

# Key Requirements

- Use case must be innovative and unique and not been previously tested
- Quality measures for established goals must be clear and verifiable
- Report monthly project milestones including specific process measures
- Demonstrated sustainability for the project
- A 2:1 financial match contribution
- Submit a final report to MHCC

# JH PAH Project

- Manage 75 inner city pediatric asthma patient receiving care at East Baltimore Medical Campus
  - An Asthma Action Plan will be developed by clinicians to identify actions and risk factors on a per-patient basis
  - Weekly check-in assessments, nurse monitoring, daily/weekly notifications, ongoing education, real-time care support
- Quantified Care, the technology partner, will provide a mobile, multimedia software platform for remote patient monitoring, management, and engagement
  - Technology enables secure communication between a patient and nurse, regular health assessments, and real-time clinical, motivational, and education feedback
- Funding request - $100,000 for 18-month project

# About JH PAH

- A not-for-profit company of Johns Hopkins Home Care Group, jointly owned by Johns Hopkins Health System and Johns Hopkins University
- Vast majority of patients are covered by Medicaid and Medicaid Managed Care Organizations
- Routinely seeks grant funding to assist in research and innovative new programs
- Sustainability model includes increased reimbursement from Johns Hopkins Priority Partners and CareFirst, consideration pending successful demonstration of project goals

# Next Steps

- December 2016:  Finalize grant award
- January 2017:  Project kick-off
- April 2017:  Go-live
- July 2018:  Final Report

# 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 #10)


ENJOY THE REST OF
YOUR DAY