Maryland Health Care Commission

Tuesday, September 19, 2017

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**
2. UPDATE OF ACTIVITIES
3. PRESENTATION: Practice Transformation Network (PTN) Progress Report
4. ACTION: Certificate of Need – FutureCare – Homewood Properties, L.L.C. – (Docket No. 17-24-2396)
5. ACTION: Change in Approved Certificate of Need – Relocation of Washington Adventist Hospital and Establishment of a Special Hospital – Psychiatric (Docket No. 13-15-2349)
6. ACTION: Repeal and Replacement of COMAR 10.24.11 – State Health Plan for Facilities and Services – General Surgical Services - Proposed Permanent Regulations
7. ACTION: Appointment of Dr. Jennifer Lawton to MHCC Cardiac Advisory Committee
8. ACTION: COMAR 10.25.18 – Health Information Exchanges: Privacy and Security of Protected Health Information – Draft Regulations
9. PRESENTATION: Electronic Health Records – Physician Adoption Infographic
10. Overview of Upcoming Initiatives
11. ADJOURNMENT

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Practice Transformation Network (PTN) Progress Report

(Agenda Item #3)

Practice Transformation Network Efforts in Maryland

September 19, 2017

(DRAFT)

The MARYLAND
HEALTH CARE COMMISSION

Practice Transformation Defined

- Changing processes across clinical practices to:
  - Create a more efficient and effective care delivery system;
  - Improve quality of care for patients; and
  - Prepare clinicians to participate in new payment models.
- Successful clinician practices include:
  - Committed leadership;
  - Operational culture that emphasizes use of data to drive decision making;
  - Practice redesign, population health (managing panel of practice patients); and
  - Business strategies that integrates clinical, administrative, and financial systems as central aspects of implementing quality and process integration.

Transforming Clinical Practice Initiative

- One of the largest federal investments uniquely designed to support clinician practices through nationwide, collaborative, and peer-based learning networks that facilitate large-scale practice transformation
  - Funding opportunity announced October 2014
- Centers for Medicare & Medicaid Services (CMS) is investing up to $685M in providing hands-on support to practices for developing skills and tools needed to improve care delivery and transition to alternative payment models
- Initiative's goal is to generate up to $4B in savings to the federal government and commercial payers

Transforming Clinical Practice Initiative *(Continued)*

- Developed by CMS to assist providers to achieve practice transformation
  - Align with the innovative strategies of the Affordable Care Act (ACA)
  - Improve health outcomes for millions of Medicare, Medicaid, and Children's Health Insurance Program beneficiaries, among others
  - Reduce unnecessary hospitalizations/utilization for approximately 5M patients
  - Sustain efficient care delivery by reducing unnecessary testing and procedures
  - Build the existing evidence of practice transformation so effective solutions can be scaled
  - Ready providers to participate in incentive programs and practice models that incentivize value

Practice Transformation Networks (PTN)

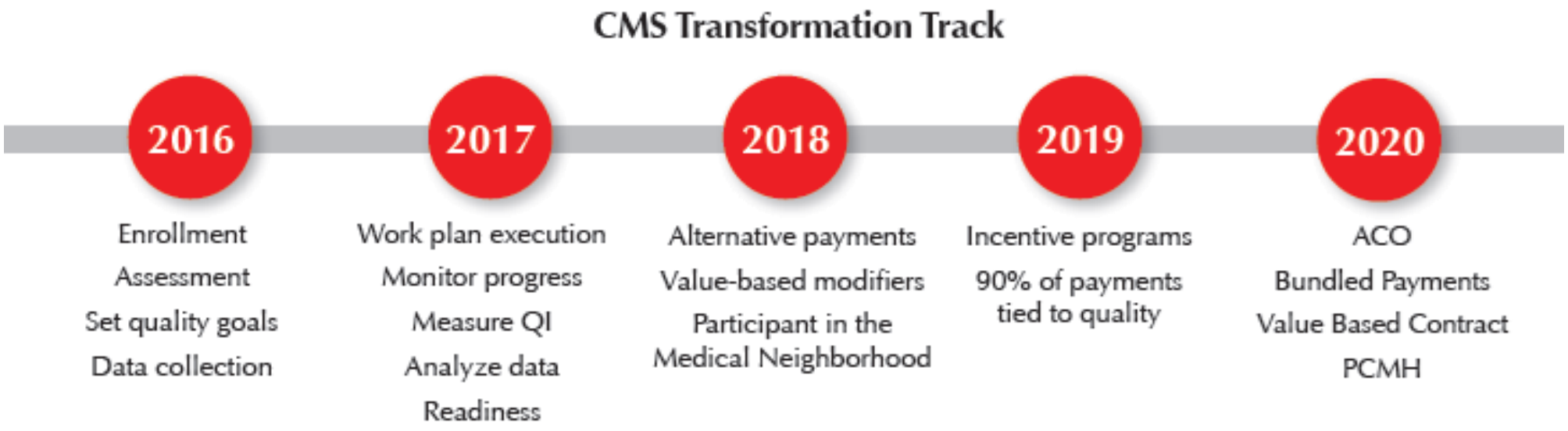
- Peer-based learning networks designed to coach, mentor, and assist physicians in developing core competencies specific to practice transformation
- Allow practices to have an active role in transformation
- Ensure collaboration among a broad community of practices
- Create, promote, and sustain learning and improvement across the health care system

Overview of PTN Services

- Transform clinicians by offering the following assistance:
  - Customized coaching;
  - Leverage meaningful use;
  - Incorporate patient centered medical home (PCMH) concepts into practice workflows;
  - Physician quality reporting support and interpretation of results;
  - Prepare practices for alternative payment models;
  - Data analysis for quality workflow and revenue improvement;
  - Measure outcomes for value-based payments under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); and
  - Utilize reporting programs under MACRA.

Objectives

- Shift the focus from quantity of care delivered to improved health outcomes and coordinated care delivery
- Implement a new fundamental strategy focused on the needs of the patient, where primary care is the foundation for maximizing value in health care delivery through better health outcomes and lower costs



The Approach

Assess	• Create practice/physician profiles • Baseline performance • Evaluate practices' technical capabilities
Collect	• Establish collection methodology in EHR • Build interfaces when required • Educate practice on collection method
Transform	• Implement CMS change package • Use best practices • Align with payer remuneration opportunities
Measure	• Implement measures management process • Central monitoring of quality measures • Practice coaches monitor/ remediate practice deficiencies

Phases of Practice Transformation

Goal: Graduate to Advanced Payment Models (APMs)

- *Phase 1*: Setting aims and developing basic capabilities
- *Phase 2*: Reporting and using data to generate improvements
- *Phase 3*: Achieving aims of lower costs, better care, and better health
- *Phase 4*: Getting to benchmark status
- *Phase 5*: Practice has demonstrated capability to generate better care, better health at lower cost

The Partnership

- New Jersey Innovations Institute (NJII) – awarded a $40M five year grant from CMS to implement PTN requirements
  - Goal - save the health care system $180M
  - NJII target - sign up about 9,000 eligible providers to participate in the PTN
  - Invited Maryland to partner in reaching CMS's goals by engaging physicians statewide
    - Goal - 700 eligible providers, annual budget around $750K
    - A collaborative partnership between the University of Maryland School of Medicine Department of Family & Community Medicine (a/k/a Maryland Learning Collaborative, or MLC); The State Medical Society (MedChi); and MHCC

Roles of the Partners

- MLC: Prime on the subcontract with NJII; responsible for practice transformation, practice education and coaching, quality improvement, health information technology optimization, and provider recruitment
- MedChi: Provider recruitment
- MHCC: Convener, program monitor, data assessor
- Partnerships: Discern Health for Quality Improvement and ZaneNet, a State designated MSO, for coach recruitment and retention

Progress Update

- Enrolled approximately 802 physicians (about 90 practices)
- Oriented practices to PTN services and programmatic requirements
- Performed practice assessments to identify baselines for transformation areas, such as patient and family engagement, team-based relationships, and population health management
- Established data collection methodology for each practice
- Worked with practices to report Physician Quality Reporting System data for 2016
- Supported practices' Meaningful Use reporting for 2016

Performance Assessment Results – Primary Care

Maryland PTN practices are performing better on select milestones than partners in Puerto Rico and New Jersey for the time period 7/1/16 through 9/1/17.

PCP – Phase 2 – 3 % of Goal	MD	NJ	PR
#9 – Identifying high risk patients	92%	79%	75%
#11 – Patients referred to community resources but no follow-up	76%	55%	51%
#13 – Practice follow up after patient visits ER	81%	74%	52%
#15 – Provides behavioral health access	76%	52%	51%
#19 – Begun to incorporate improvement methodology	86%	44%	48%
#20 – Building quality improvement skills for staff	86%	44%	51%
#21 Produces quality reports on meeting goals and shares	70%	54%	48%
Average	**74%**	**64%**	**57%**

Performance Assessment Results – Specialists

Maryland PTN practices are performing better on select milestones than partners in Puerto Rico and New Jersey for the time period 7/1/16 through 9/1/17.

Specialists – Phase 2 – 3 % of Goal	MD	NJ	PR
#1 – Practice monitors metrics; no improvement yet	82%	60%	50%
#7 – Identifies high risk but other risk levels unclear	97%	82%	70%
#8 – Refers to community resources but follow-up is inconsistent	95%	60%	33%
#10 – Identifies primary care provider but communication w/team is inconsistent	95%	75%	33%
#14 – Has begun to implement improvement methodology but not in all areas	95%	47%	32%
#15 – Building quality improvement capability for all staff	95%	52%	32%
#16 – Produces regular reports on providers' performance and quality goals, shares within organization for follow-up	90%	45%	30%
Average	**80%**	**64%**	**44%**

Practice Assessment Results

Maryland PTN practices increased their milestone assessment score, illustrating progress through the stages of practice transformation for the time period 7/1/16 through 6/30/17.

	Avg. Score at Prev. Assessment	Avg. Current Score	Avg. Rate of Change	% of Partner Sites w/ Increase in Score	% of Partner Sites w/ Decrease in Score	% of Partner Sites w/ No Change in Score
MD	25.4	34.4	35.4	100%	0%	0%
NJ	22.9	30.6	33.6	90%	2%	8%
PR	11.1	16.7	50.4	76%	1%	23%

Key Performance Indicators

Maryland PTN practices reported key performance indicators, which monitor progress on quality, utilization, and cost measures.

Measure	Q1 2016	Q2 2016	Q3 2016	Q42016	Q1 2017
Care Plan	N/A	N/A	100.0	100.0%	100.0%
Colorectal Cancer Screening	16.0%	47.5%	46.8%	19.3%	18.2%
Controlling High Blood Pressure	30.6%	64.3%	78.3%	49.9%	32.4%
Diabetes: Hemoglobin A1C Poor Control	49.3%	80.0%	91.1%	57.2%	48.5%
Diabetes: Medical Attention for Nephropathy	N/A	50.0%	91.1%	48.1%	50.9%
Tobacco Use: Screening and Intervention	82.5%	97.1%	99.0%	82.2%	80.9%

Note: The quarterly variability is attributed to a large number of new practices entering the program in the third quarter of 2016.

Program Completion

- Practices will:
  - Use their established framework to successfully plan, develop, and implement the transformation process;
  - Expand quality improvement;
  - Engage in greater peer-to-peer learning;
  - Utilize health data to determine gaps and target intervention needs;
  - Deliver care in a patient-centric and efficient manner; and
  - Achieve MACRA readiness by participation in
    - Merit-based Incentive Payment System - http://njii.com/mips-calculator/ and
    - APMs

Initiatives Underway

- Complete follow-up assessments with practices every six months for transformation benchmarks and Key Performance Indicators Quarterly
- Educate practices on changes to the MACRA Quality Payment Program, increase awareness and preparation of APMs/Advanced Alternative Payment Models (AAPMs)
- Explore *Behavioral Health and Opioid Management Program* overlay with the PTN
- Engage CRISP in providing utilization and cost data for PTN practices and in integrating EHR data

Thank You!

The MARYLAND
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MARYLAND HEALTH CARE COMMISSION

ACTION:

Certificate of Need

FutureCare – Homewood Properties, L.L.C.
(Docket No. 17-24-2396)

(Agenda Item #4)

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Repeal and Replacement of COMAR 10.24.11 – State Health Plan for Facilities and Services – General Surgical Services - Proposed Permanent Regulations

(Agenda Item #6)

MARYLAND HEALTH CARE COMMISSION

Draft State Health Plan Chapter for General Surgical Services (COMAR 10.24.11) for Consideration as Proposed Permanent Regulations

Maryland Health Care Commission
September 19, 2017

Overview of Changes to COMAR 10.24.11

- New opportunities to establish an ambulatory surgical facility (ASF) with two operating rooms (ORs) without CON review.
  - A hospital may relocate two ORs from its hospital to establish an ASF.
  - A hospital converting to a freestanding medical facility (FMF) may establish an ASF with two ORs in conjunction with the conversion.
  - An office of one or more health care practitioners or a group practice may establish an ASF with two ORs.

Exemption Request vs. CON Review

- The following general standards must be met for both exemption requests and CON reviews:
  - Information Regarding Charges
  - Information Regarding Procedure Volume
  - Charity Care Policy
  - Quality of Care
  - Transfer Agreements

- Unlike CON review, there are not interested parties who have automatic standing to appeal the Commission's decision on an exemption request.

Exemption Request vs. CON Review

- There are about half as many project review standards for an exemption request compared to a CON review. For an exemption request, an applicant must address five standards:
  - Need
  - Design Requirements
  - Location
  - Efficiency
  - Construction Cost

Summary of Informal Comments and Staff's Analysis and Recommendations

.02D Chapter Content and Applicability

Comments

- Both the University of Maryland Medical System (UMMS) and Mercy Health Services (Mercy) commented that a health system should be permitted to establish a physician outpatient surgery center (POSC) because the relevant statute refers only to hospitals.

Recommendation

- Revise the language to be consistent with statute.

.05A General Standards and .05B Project Review Standards

Comment

- UMMS commented that the language in .05A and .05B contained redundant provisions that apply to CON exemptions for ASFs that are included in .06.

Recommendations

- Revise the language in .05B to specify that the standards do not apply to projects that are eligible for an exemption under .06.

- Include a combined section .06B for general and project review standards that references the applicability of the standards in .05A.

.06A Applicability

Comments

- The Maryland Hospital Association (MHA) expressed concern that the expansion of opportunities to develop an ASF without a CON could result in supply-induced demand and unchecked growth in the total cost of care.

- Hospitals will be held accountable for the total cost of care, but others who establish ASFs will not be accountable.

.06A Applicability

Recommendation

- Staff recommends no changes for the following reasons.
  - MHA failed to present evidence that an increased supply of ambulatory surgical capacity will induce demand for surgery.
  - A surge of development of ASFs is not anticipated based on trends in the development of POSCs.
  - It is in the State's interest to encourage surgery in lower cost settings when patient safety is maintained.
  - The regulations of MHCC may be modified if trends in ASF development raise concerns regarding supply-induced demand.

.06A Applicability and .06B General and Project Review Standards

Comments

- UMMS suggested that greater flexibility in the location of an ASF is needed when a hospital is converting to an FMF and establishing an ASF in conjunction with the conversion.

- UMMS suggested that an ASF be permitted within five miles of the FMF or five miles of the parent hospital.

Recommendation

- Staff recommends no changes because the additional flexibility suggested by UMMS substantially reduces the extent to which the ASF is connected with the establishment of the FMF and would be inconsistent with statutory requirements. Staff also notes that the flexibility sought by UMMS is available if ORs are relocated before the hospital converts to an FMF, which is a new option.

.06B(4) Location

Comment

- MHA asked if a hospital relocating surgical capacity to establish an ASF is limited to the hospital's campus.

Recommendations

- The draft regulations posted for informal comment did not restrict the location of an ASF established by a hospital through relocation of ORs. However, staff recommends limiting the location of the ASF to the service area of the hospital. This approach provides flexibility while encouraging hospitals to serve the same patients, but in a lower cost setting.

.06B(4) Location

Recommendations (continued)

- Limit co-location of an ASF with two operating rooms established through exemption review with an existing or proposed ASF or POSC. An applicant should not be allowed to establish an ASF with three or more operating rooms without a CON.

.06B(5) Efficiency

Comments

- UMMS commented that MHCC should not mandate adjustment of the global budget of a hospital because HSCRC has authority over hospital budgets and expressed concern that the payment model could change, resulting in a partially obsolete standard.

- UMMS suggested that the standard be revised to be more general, with less specificity on the analysis required of an applicant. UMMS provided specific changes to the wording of the standard in its comments.

.06B(5) Efficiency

Recommendation

- Staff recommends no changes for the following reasons.
  - HSCRC will determine whether a hospital's budget will be revenue neutral or result in cost savings.
  - The inclusion of the requirement for an applicant to compare the level of efficiency and effectiveness of establishing a POSC instead of the proposed ASF stems from language in statute.
  - The regulations may be updated to address any changes to the payment model or terminology used by HSCRC.

.07A Assumptions Regarding Operating Room Capacity

Comments

- UMMS commented that the language in .07A(1)(b) is convoluted and may not cover all situations where a different optimal capacity standard should apply.

- MHA commented that it supports flexibility in determining the optimal capacity on a case-by-case basis.

Recommendation

- Staff recommends no changes because the standard is flexible and allows the Commission to make decisions on a case-by-case basis.

Additional Changes

- Staff added a section .06C to address the transferability and procedural requirements for exemption requests that are consistent with those used for Certificate of Need projects.

- Staff anticipates that the requirements in .06C may be moved to COMAR 10.24.01, when those regulations are updated.

Request for Approval

Staff requests that the Commission adopt draft COMAR 10.24.11, the General Surgical Services Chapter of the State Health Plan, as proposed permanent regulations and repeal current COMAR 10.24.11, contingent on proposed COMAR 10.24.11 becoming effective.

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ACTION:

Appointment of Dr. Jennifer Lawton to MHCC Cardiac Advisory Committee

(Agenda Item #7)

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MARYLAND HEALTH CARE COMMISSION

ACTION:

COMAR 10.25.18 – Health Information Exchanges: Privacy and Security of Protected Health Information – Draft Regulations

(Agenda Item #8)

Health Information Exchange Privacy and Security

Draft Amendments

COMAR 10.25.18

September 19, 2017

Draft

The MARYLAND
HEALTH CARE COMMISSION

Summary

- Legislative Authority - A 2011 law requires MHCC to adopt regulations for the privacy and security of protected health information exchanged through a health information exchange (HIE)
- Staff seeks Commissioner approval to release draft amendments to COMAR 10.25.18 *Health Information Exchanges: Privacy and Security of Protected Health Information* for informal public comment
- Amendments pertain to provisions for the exchange of sensitive health information (SHI) that aim to:
  - Foster and support the exchange of SHI to improve care delivery and coordination
  - Uphold current federal and State law that requires granular patient consent

Background

- The need for HIE Regulations - National concerns exist about the sufficiency of HIPAA/HITECH as the floor for privacy and security
  - Staff worked with the HIE Policy Board, a staff advisory work group, to develop policies used as a framework for the amendments
- Regulations went into effect on March 17, 2014 and amended on June 20, 2016 and June 19, 2017
- HIEs currently operating in Maryland
  - Calvert Memorial Hospital
  - Chesapeake Regional Information System for our Patients (CRISP)
  - Children's IQ Network
  - Frederick Memorial Hospital
  - Peninsula Regional Medical Center
  - Prince George's County Public Health Information Network
  - Surescripts
  - Western Maryland Health Systems

Sensitive Health Information

- Defined as a subset of protected health information that has specific federal or State legal protections in addition to those required by HIPAA and the Maryland Confidentiality of Medical Records Act

- Some examples include, Part 2 information, genetic information, psychotherapy notes, certain communicable diseases (such as HIV/AIDS), and certain conditions by age or minor's status

- Protecting sensitive health information is necessary as it carries with it unusually high risks in the event of disclosure, such as possibility of discrimination, social stigma, and physical harm

The Need for Amendments

- Ensure that patients with substance use disorders have the ability to benefit from the sharing of electronic health information for treatment and other legitimate health care purposes

- Medical and behavioral health providers are increasingly requesting access to SHI to make certain that appropriate care is provided at the point of care delivery and in care coordination

- Enable new care delivery models to be supported by information that can transform the delivery of care, making it safer, more effective, and more efficient

Proposed Amendments - An Overview

- Allows an HIE to exchange SHI through transmissions other than point-to-point
- An HIE must ensure that SHI transmitted adheres to federal and State laws with regard to required patient consent, such as the provider(s) to whom the information may be disclosed and the type of information that may or may not be disclosed
- Patient's consent choices must accompany the SHI as it's transmitted through the HIE and subsequently disclosed to an authorized requesting provider
- Align with new federal regulation and initiatives to support the sharing of sensitive health information through HIEs

Next Steps

- With Commission approval, release draft amendments for a 30-day informal comment period

- Revise the draft amendments as appropriate based on informal comments received

- Propose draft amendments to the Commission in November 2017

Thank You!

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PRESENTATION:

PRESENTATION: Electronic Health Records – Physician Adoption Infographic

(Agenda Item #9)

Electronic Health Records

Physician Adoption

An Information Brief

September 19, 2017

(DRAFT)

The MARYLAND HEALTH CARE COMMISSION

Framing the Presentation

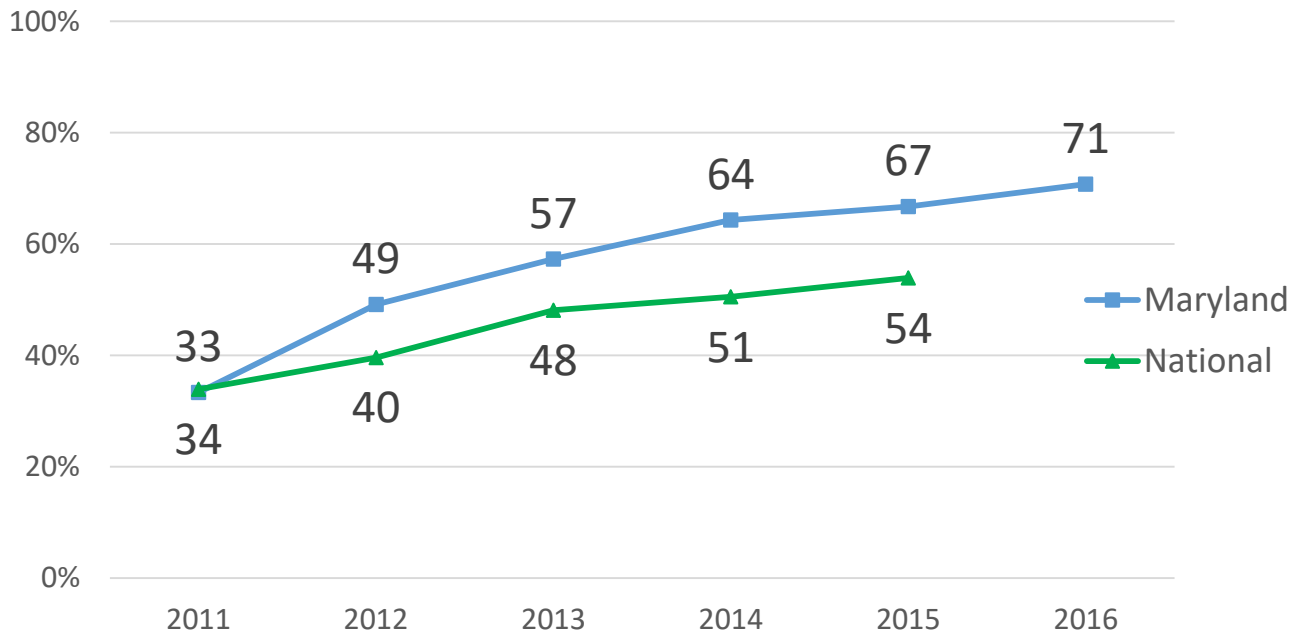
- Electronic health records (EHRs) are considered an essential tool in supporting practice transformation and value based care delivery models
- Expanded use of EHRs driven by financial incentives established under the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009
  - ~$9.7M in private payor incentives to practices (Oct. 2011-Dec. 2016)
  - ~$304M from the Centers for Medicare & Medicaid Services to eligible providers (Jan. 2011-June 2017)
- The impact of financial incentives on adoption has declined over the last three years

About the Assessment

- Staff analyzed data from the Maryland Board of Physicians (MBP) licensing renewal applications, which includes questions related to use of health information technology (health IT)
  - MBP data included in the assessment – 2011 through 2016
- Findings intended to inform:
  - Stakeholder awareness of health IT adoption trends
  - EHR adoption and program development to advance health IT

Adoption Trends

Figure 1: Growth in EHR Adoption Among Office-Based Physicians, 2011-2016



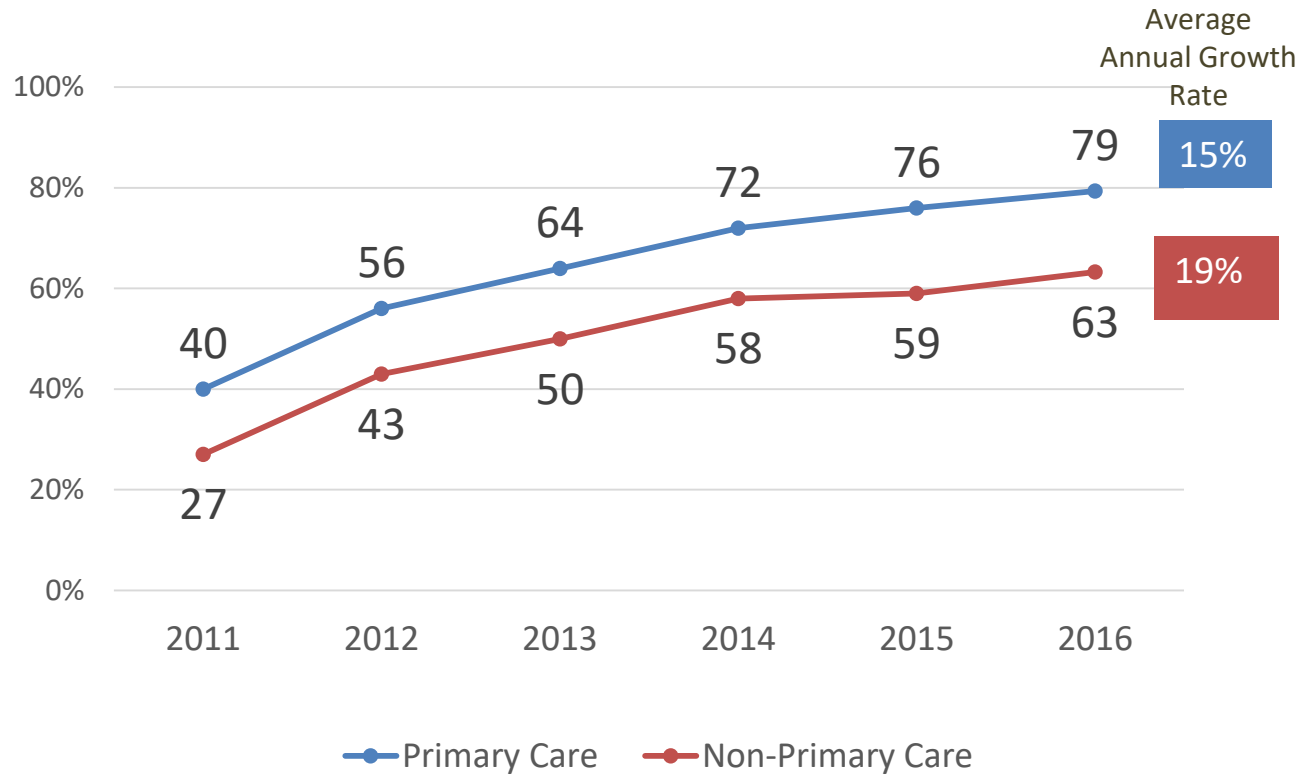
Sources:
• Maryland Data –Maryland Board of Physicians
• National Data – National Center for Health Statistics (basic EHR) - Office of the National Coordinator for Health Information Technology. 'Office-based Physician Electronic Health Record Adoption,' Health IT Quick-Stat #50. dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php. December 2016.
Note:
• N=8,034 for 2016, office-based physicians

- Maryland continues to remain ahead of the national average
- Adoption incentives were most impactful between 2012 and 2014 locally, and nationally during 2012 and 2013
- Slow growth over the last few years suggests that adoption decisions are not entirely based on incentives

Primary Care & Specialists

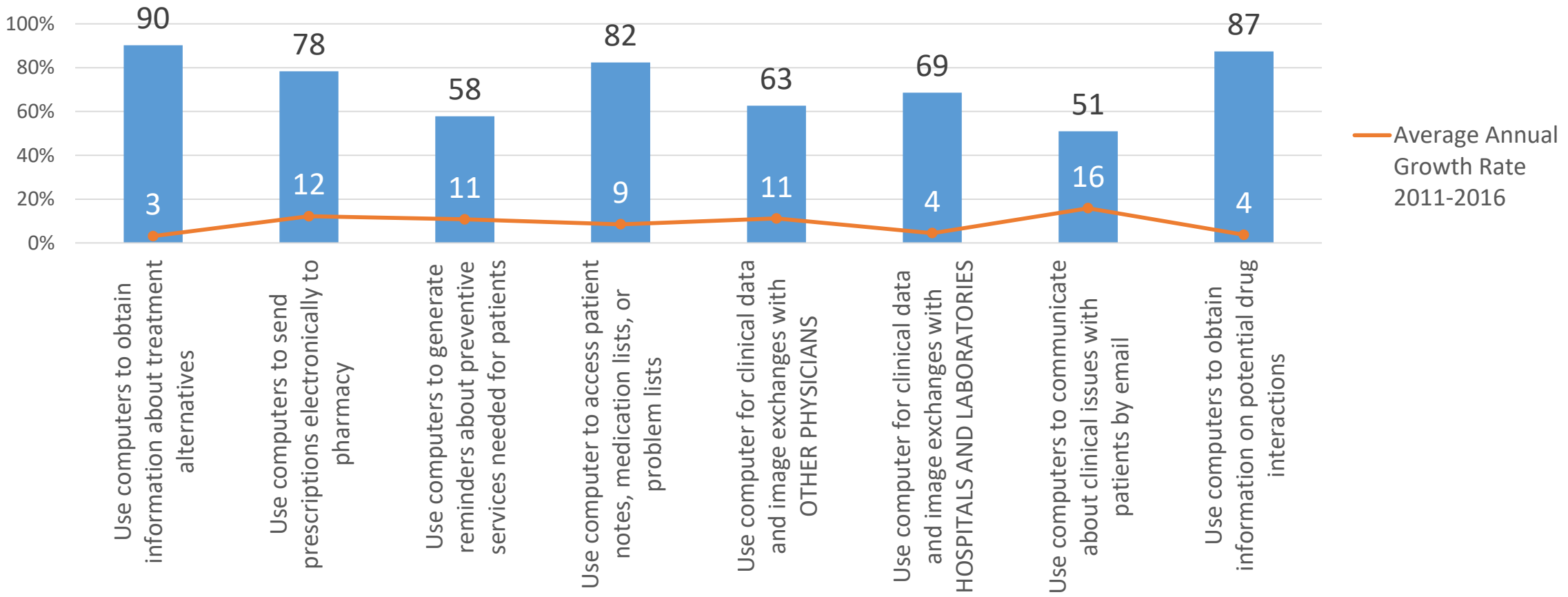
- Early adoption among primary care physicians may have been impacted by initiatives among family medicine associations, business practices, and technology
- EHR adoption has grown at a faster rate among non-primary care physicians

Figure 2: Growth in EHR Adoption Among Office-Based Primary and Non-Primary Care Physicians, 2011-2016



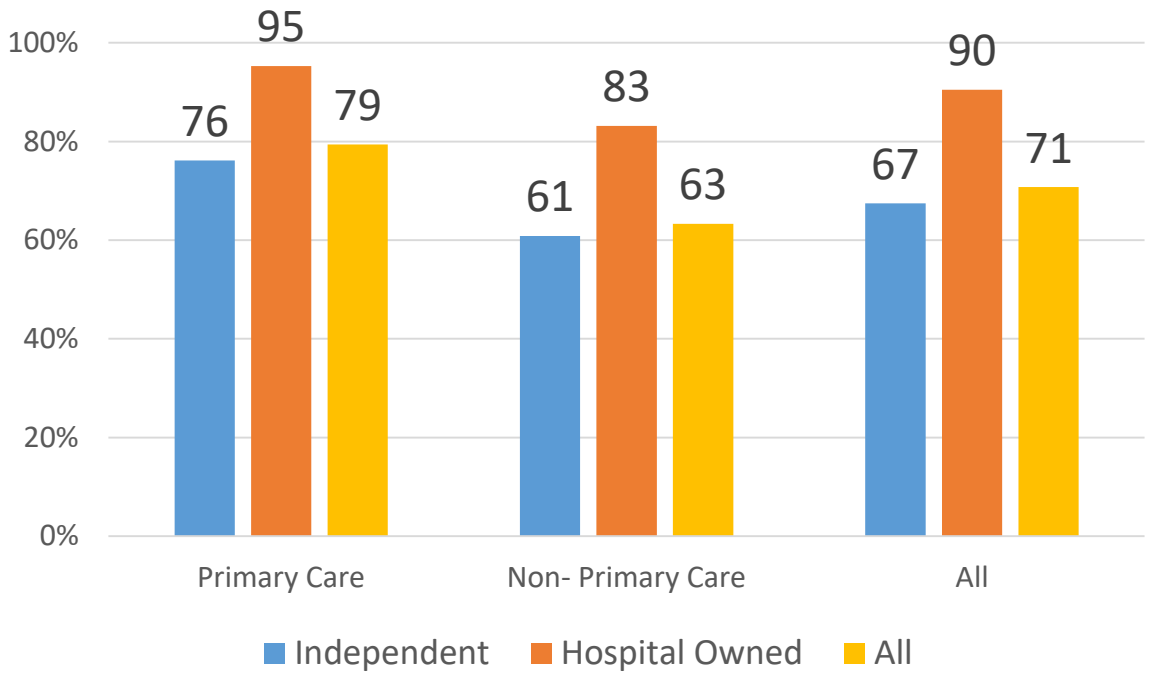
Technology Use

Figure 4: Adoption Rate by Technology Use, Office-Based Physicians, 2016
(N=8,034)



Practice Ownership Type

Figure 5: EHR Adoption by Practice Ownership Type and Primary Care, Office-Based Physicians, 2016

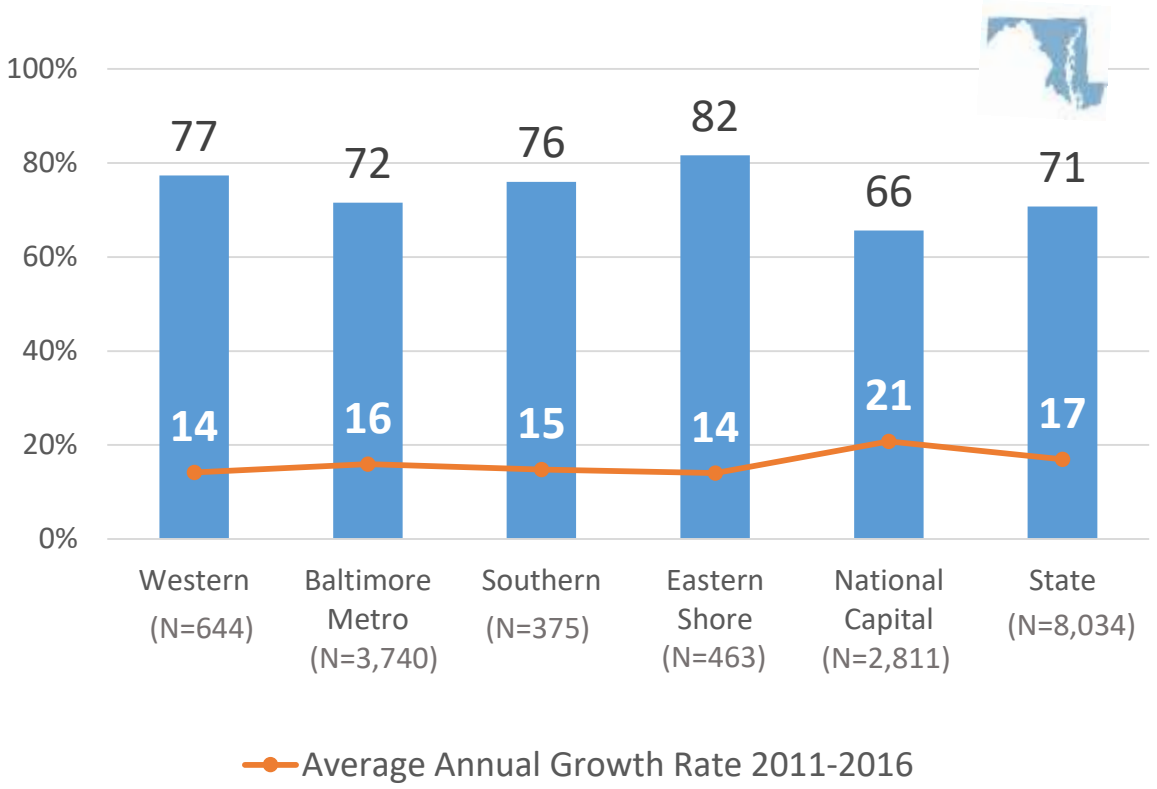


- Office-based physicians in a hospital owned practice are more likely to have adopted an EHR than those in independent practices
- Hospital owned physicians are more likely to have adopted an EHR independent of being a primary care or non-primary care physician

Regional Adoption

- EHR adoption is highest in the Eastern Shore region, but growing at a slower rate than the overall State annual growth rate
- The National Capital region has the lowest EHR adoption rate, but growing at a faster rate than the overall State annual growth rate

Figure 3: EHR Adoption Rate by Region, Office-Based Physicians, 2016



Next Steps

- Staff is in the preliminary stages of conducting an *EHR Adoption Environmental Scan* (scan) in collaboration with MedChi, The Maryland State Medical Society, Maryland Academy of Family Physicians, and the Maryland Medical Group Management Association
  - About 10 percent of physicians (anecdotal) are not expected to adopt EHRs due to practice size, plans to retire, available technology support, previously failed attempts to adopt an EHR, etc.
- Findings from the scan will be used to:
  - Validate existing challenges and identify other barriers to adoption
  - Collaborate with stakeholders in developing diffusion strategies

Thank You!

The MARYLAND
HEALTH CARE COMMISSION

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. APPROVAL OF MINUTES

2. UPDATE OF ACTIVITIES

3. PRESENTATION: Practice Transformation Network (PTN) Progress Report

4. ACTION: Certificate of Need – FutureCare – Homewood Properties, L.L.C. – (Docket No. 17-24-2396)

5. ACTION: Change in Approved Certificate of Need – Relocation of Washington Adventist Hospital and Establishment of a Special Hospital – Psychiatric (Docket No. 13-15-2349)

6. ACTION: Repeal and Replacement of COMAR 10.24.11 – State Health Plan for Facilities and Services – General Surgical Services - Proposed Permanent Regulations

7. ACTION: Appointment of Dr. Jennifer Lawton to MHCC Cardiac Advisory Committee

8. ACTION: COMAR 10.25.18 – Health Information Exchanges: Privacy and Security of Protected Health Information – Draft Regulations

9. PRESENTATION: Electronic Health Records – Physician Adoption Infographic

10. Overview of Upcoming Initiatives

11. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

Overview of Upcoming Initiatives

(Agenda Item #10)


ENJOY THE REST OF
YOUR DAY