Maryland Health Care Commission

Thursday, October 19, 2017

1:30 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**

2. **UPDATE OF ACTIVITIES**

3. **ACTION:** Certificate of Need – Exceptions Hearing on Staff Report and Recommendation - Presbyterian Senior Living Services, Inc. d/b/a Glen Meadows Retirement Community (Docket No. 17-03-2395)

4. **ACTION:** Transforming Maryland's Rural Healthcare System: A Regional Approach to Rural Healthcare Delivery

5. **UPDATE:** 2017 Health Plan Performance

6. **PRESENTATION AND DISCUSSION:** Study of the Certificate of Need Program Requested by the Maryland General Assembly

7. **OVERVIEW OF UPCOMING EVENTS**

8. **ADJOURNMENT**

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Certificate of Need – Exceptions Hearing on Staff Report and Recommendation - Presbyterian Senior Living Services, Inc. d/b/a Glen Meadows Retirement Community (Docket No. 17-03-2395)

(Agenda Item #3)

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Transforming Maryland's Rural Healthcare System: A Regional Approach to Rural Healthcare Delivery

(Agenda Item #4)

The Rural Healthcare Delivery Workgroup

Erin Dorrien
Chief, Government and Public Affairs

Joseph Ciotola, MD
Co-Chair, Rural Healthcare Delivery Workgroup

Worrisome Trends in Rural Communities

- Declining use of hospital services puts strain on existing hospitals and the health system
- Health care workforce is under stress
- Constraints in the transportation system limits access to care outside the local jurisdiction
- Declining hospital revenue and shrinking health care workforce limit the potential for innovation
- Despite increased access to insurance coverage and improved delivery models, limited improvements in health of population

SB 707 Freestanding Medical Facilities- Certificate of Need, Rates and Definitions

- Legislation established a process for a hospital to convert to an FMF
- Broadened the definition of hospital services to include observation stays and other outpatient services offered at the FMF, as determined by HSCRC in regulations.
- Defined the findings MHCC must reach before issuing the exemption from CON review for a conversion
- Legislative debate highlighted significant public concern about the appropriateness of health system changes in rural communities
- Established a moratorium on hospital conversions in Kent County until July 2020
- Established a Rural Health Delivery Workgroup

SB 707 – Rural Health Delivery Workgroup

- Membership
  - General Assembly Members
  - Secretary of DHMH
  - CEO of Rural Hospitals
  - Providers, Consumers, Local Government, Business, Labor to be appointed by MHCC
- Charge
  - oversee a study of rural health care needs in the five Mid Shore counties
  - hold public hearings to gain community input regarding the health care needs
  - Identify policy options developed through Workgroup meetings, through public input, and from the study
  - Specifically recommend policies that address:
    - the health care needs of residents of the five study counties. and
    - improve the health care delivery system in the five Mid Shore counties
  - Issue a report

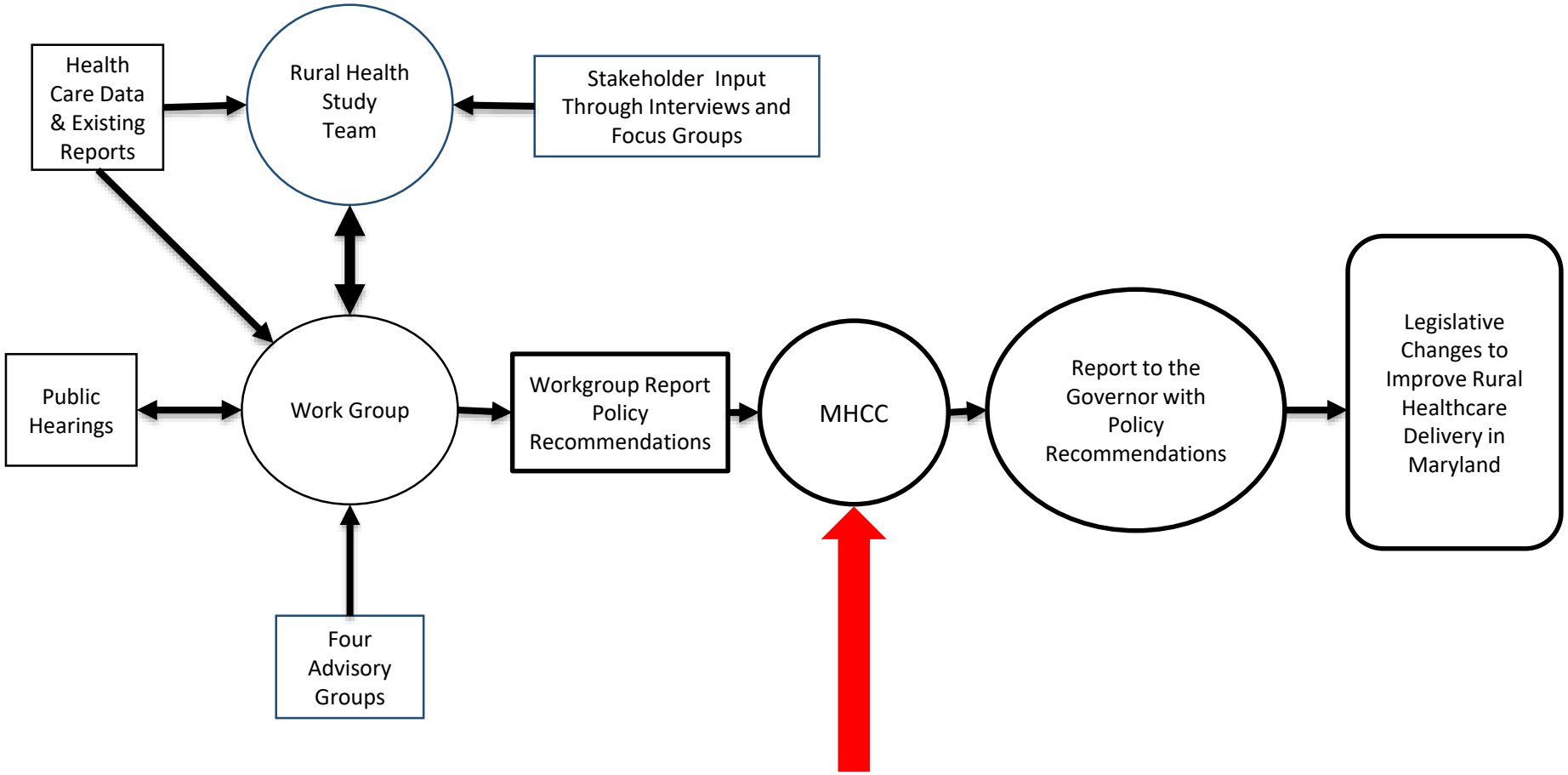
Rural Health Delivery Study

- Examine challenges to the delivery of health care in the Mid Shore area, including:
  - the limited availability of health care providers and services;
  - the special needs of vulnerable populations;
  - transportation barriers; and
  - the economic impact of the closure, partial closure, or conversion of a health care facility;
- Identify opportunities created by telehealth and the Maryland all–payer model contract for restructuring the delivery of health care services; and
- Develop policy options for addressing the health care needs of residents of, and improving the health care delivery system in, the five study counties

Activities

- Workgroup met seven times
  - Four advisory groups each met at least twice. Many of the recommendations originated in advisory group meetings.
  - Held five public hearings
  - Workgroup chairs and MHCC staff met with legislative leadership
- Research team
  - Conducted empirical research
  - Held key stakeholder interviews
  - Convened five focus groups
  - Attended all Workgroup and advisory group meeting,
  - Study team and MHCC met at least weekly to discuss progress and issue
- Workgroup and Research team recommendations are closely aligned

Framework for the Study and Development of Recommendations



Broad Categorizations of Recommendations

- Foster Collaboration and Build Coalitions in Rural Areas to Serve Rural Communities
- Bring Care as Close to the Patient as Possible to Improve Access
- Foster Participation in Statewide Models and Programs in Rural Maryland

Foster Collaboration and Build Coalitions

- Build a Rural Health Collaborative
  - Convene local stakeholders to examine the healthcare needs of a single region
  - Develop strategic directions for improvements in the health system
  - Manage data collection and analysis to develop regional health and social needs assessment
- Launch a Rural Community Health Demonstration Program- “The Complex”
  - Build a “one-stop-shop” for health and social services needs for patients
  - Ensure access to essential care throughout a region
  - Enable care coordination through the sharing of data and resources

Bring Care as Close to the Patient as Possible

- Strengthen workforce by improving both recruitment of healthcare professionals and training of healthcare professionals
  - Establish Rural Primary Care Residency and Rural Specialty Care Residency Rotation Programs
  - Establish Rural Health Scholarship Program
  - Promote Primary Care Track Program in Maryland Medical Schools
  - Streamline M-LARP program
- Expand the availability of telehealth and mobile capacity
  - Increase broadband and “last mile” connectivity
  - Establish funding source for demonstration projects throughout the State
- Expand Community Paramedicine and Mobile Integrated Community Health (MICH)
  - Diffuse MICH program to other jurisdictions
  - Identify a source for sustainable funding

Foster Participation in Statewide Models

- Develop the health care workforce needed for rural communities to succeed in Total Cost of Care Demonstration
- Establish Special Rural Community Hospital
  - Consider the needs of small rural hospitals in maintaining access points for emergency and inpatient care
  - Assist rural communities in succeeding under Total Cost of Care Demonstration
- Charge the Community Health Resources Commission with incubating pilot projects in rural communities
  - Could be an important convener of the rural health complex

Next Steps

- Report Submitted to Governor and General Assembly
  - MHCC expects legislation to be introduced in the 2018 Legislature
  - Budgetary issues will be a limiting factor
- National Rural Health Day- November 17th
- Release of the Rural Health Plan- Maryland Rural Health Association

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MARYLAND HEALTH CARE COMMISSION

UPDATE:

2017 Health Plan Performance

(Agenda Item #5)

MARYLAND HEALTH CARE COMMISSION

Center for Quality Measurement and Reporting

Division of Long Term Care and Health Plan Performance

Sherma J. Charlemagne-Badal, PhD
Division Chief

Outline

- Objectives
- Overview of health plan evaluation system
- Health plans included in 2017 evaluation
- Health plan member demographics
- Excellent performance areas
- Areas in need of improvement
- RELICC results
- Changes to reporting requirements
- Conclusion

Objectives

- **Describe the Health Plan Performance Evaluation System**
  - Key goals of system
  - Components of the system
  - Participation Requirements
  - Health plans included in 2017 evaluation
  - Member demographics
- **Discuss the 2017 Evaluation Results**
  - Health plan measures meeting NTP standards
  - Excellent clinical performance areas
  - Areas in need of improvement
  - RELICC assessment results
- **Explain Streamlining of Health Plan Reporting Requirements**
  - End to Maryland-Specific CAHPS
  - Suspension and review of RELICC
  - Move to use of measures required under NCQA accreditation plus BHA
  - Savings and plans for continuous improvement

Health Plan Performance Evaluation System

A data collection and management system established to:

- Address the information needs of consumers and purchasers

- To provide an assessment of the quality and performance of health benefit plans based on measures endorsed or implemented by nationally recognized organizations involved in quality of care and performance measurement.

Source: COMAR 10.25.08.01

Health Plan Performance Evaluation System

Components of the System:

- Maryland-Specific HEDIS and CAHPS Audit
  - Health Care Effectiveness and Data Information Set (HEDIS)
  - Consumer Assessment of Health providers and Systems (CAHPS)
  - Automated Source Code Review (ASCR)
- Plan Wide HEDIS and CAHPS Audit
  - HEDIS
  - CAHPS
- Behavioral Health Assessment (BHA)
- Race Ethnicity Language Interpreters & Cultural Competency (RELICC) Assessment
- Quality Profile (QP)
- Overall Star Rating

Participation Requirements

Participation in the health benefit plan quality and performance evaluation system requires that each carrier:

- Holds a certificate of authority in the State of Maryland
- Has a premium volume in Maryland for each category of health benefit plan that exceeds $1,000,000
- Has no more than 65 percent of it's Maryland enrollees covered through the Medicaid and Medicare Programs for each category of health benefit plan.

Source: COMAR 10.25.08.01

Health Plans Included in 2017 Quality Audit

15 NCQA Accredited Health Plans Audited in 2017 Vs. 17 plans in 2016

Health Benefit Plan Name	Health Benefit Plan Audit-level Name[1]	Report-level Name[2]	Overall Star Rating
Aetna Health Inc. Pennsylvania – (Maryland)	Aetna	Aetna HMO	3.5
Aetna Life Insurance Company (MD/DC)		Aetna PPO	4
CareFirst BlueChoice, Inc.	CareFirst	BlueChoice HMO	4
Group Hospitalization and Medical Services, Inc. (GHMSI)		GHMSI PPO	4.5
CareFirst of Maryland, Inc. - HMO		CFMI-HMO	4.5
Group Hospitalization and Medical Services, Inc. - HMO		GHMSI-HMO	4
CareFirst of Maryland, Inc.		CFMI PPO	4.5
Connecticut General Life Insurance Company	Cigna	Cigna PPO	4.5
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	Kaiser	Kaiser HMO	4.5
Kaiser Permanente Insurance Company	KPIC	KPIC PPO	4.5
MAMSI Life and Health Insurance Company	United	MAMSI PPO	4.5
Maryland Individual Practice Association, Inc.		MD-IPA HMO	3.5
Optimum Choice, Inc.		Optimum Choice HMO	4
UnitedHealthcare Insurance Company (Maryland)		United Healthcare PPO	4.5
UnitedHealthcare of the Mid-Atlantic, Inc.		United Healthcare HMO	3.5

1. The level at which the health plan underwent a HEDIS Compliance Audit
2. The HEDIS reporting Entity

2017 Audited Health Plans Member Demographics

2017 audit results reflect 2016 data
Measure date range January 1, 2016-December 31, 2016

Member Level 2017 Detail (HMO and PPO)[1]			
Metric	**Category**	**N**	**%***
Statewide Membership		2,022,987	
Counties with largest membership	Montgomery	388,574	33
	Baltimore	286,301	
Race[2]	White	516,476	26
	Black	266,247	13
	Else	163,011	8
Age	0-19	510,464	24
	20-39	606,739	30
	40-59	696,739	51
	≥60	229,133	11

*Rounded
1. Gender data unreliable, 10.9% response rate
2. 46.7% response rate

Excellent Clinical Performance Areas compared to NTP standards

Measures within the following four categories stand out for high performance and corresponding star assignment:

- Primary Care and Wellness for Children and Adolescents
- Respiratory Conditions – Adult and Child
- Primary Care for Adults – Cardiovascular Conditions and Diabetes
- Behavioral Health

Health Plans With HEDIS Clinical Measures Meeting National Top Performance Standards

Plans With Top Number of Measures Meeting NTP Standards in 2016			Plans With Top Number of Measures Meeting NTP Standards in 2017		
Plan Name	**N (80)**	**%***	**Plan Name**	**N (79)**	**%***
Kaiser Permanente HMO	35	44	Kaiser Permanente HMO	42	53
CIGNA	20	25	CareFirst CFMI HMO	19	24
CareFirst GHMSI PPO	18	23	Kaiser Permanente KPIC PPO	17	22
CareFirst CFMI HMO	13	16	CareFirst Maryland PPO	16	20
			CareFirst GHMSI PPO	15	19
Total=4 Health Plans			Total=5 Health Plans		

*Rounded

Health Plan CAHPS Global Measures Compared To National Averages

2016 Performance			2017 Performance		
Global Measure	**MD %***		**Global Measure**	**MD%***	
	HMO	**PPO**		**HMO**	**PPO**
Good (8,9,10) overall rating of health care	74 ↓	76 ↓	Good (8,9,10) overall rating of health care	77 ↔	77 ↔
Good (8,9,10) overall rating of Plans	62 ↓	61 ↑	Good (8,9,10) overall rating of Plans	69 ↑	63 ↑
Good (8,9,10) overall of personal doctor	83 ↓	83 ↓	Good (8,9,10) overall of personal doctor	83 ↑	82 ↓
Good (8,9,10) overall rating of specialist	83 ↓	84 ↔	Good (8,9,10) overall rating of specialist	83 ↓	83 ↔
• Notable improvement on all HMO global measures except overall rating of specialists					
• Notable improvement on PPO overall rating of health care only					

*Rounded

Clinical Areas In Need of Improvement

The following are areas where overall performance is less than desired:

- Human Papillomavirus vaccination rates for children and adolescents
- Body mass index (BMI) screening for adults age 18-74 years old
- Bronchitis medication management for children and adults

RELICC Assessment Results Compared to National Average

	2016 %*		2017 %*	
Measures	**HMO**	**PPO**	**HMO**	**PPO**
Plan getting accurate information	87 ↑	81 ↑	80 ↑	76 ↑
Plan knowledge of RELICC Information for their Doctors and staff	41 ↓	37 ↓	50 ↓	43 ↓
Plans making use of the data collected	85 ↓	86 ↓	98 ↑	97 ↑
Supporting the member needs with limited English proficiency	40 ↓	44 ↓	56 ↓	56 ↓
Assuring Culturally Competent Health Care is Delivered	75 ↓	78 ↓	96 ↑	97 ↑
Evaluating and measuring the impact of language assistance	38 ↓	44 ↓	67 ↔	57 ↓
Information available on provider directory	63 ↓	66 ↑	63 ↑	66 ↑
Selecting a Physician online	60 ↓	61 ↓	60 ↑	59 ↓
Health Assessment Programming	87 ↓	88 ↓	93 ↑	91 ↓

*Rounded

Changes to Reporting Requirements

- End to Maryland-specific CAHPS reporting requirement
- Move to use of CAHPS and HEDIS measures required for NCQA accreditation plus BHA
- Suspension and review of RELICC for one year
- Financial savings resulting from streamlining and plans for continuous improvement

Conclusion

Maryland's health plans are maintaining a track record of good performance across many of the measures and indicators being evaluated.

Overall the health benefit plans continue to perform well when compared to the national average.

Excellent performance areas continue to increase.

Areas needing improvement continue to decline.

Improvement continues on plan efforts to reduce health disparities.

Health Plan Performance Evaluation System

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION AND DISCUSSION:

Study of the Certificate of Need Program Requested by the Maryland General Assembly

(Agenda Item #6)

Study of Maryland's Certificate of Need Program

October 19, 2017

Focus of the Study

The Key Questions to be Answered

- **How can CON regulation better reflect the dynamic & evolving health care delivery system?**
- **Can Maryland learn from other states about means for determining appropriate capacity?**
- **How should the law change to improve the regulatory process for reviewing capital projects?**
- **How can the process of approving CON applications be streamlined through more flexibility in the law & regulation?**

Focus of the Study

<u>The Key Questions to be Answered</u>

How can the State Health Plan (SHP) be amended to

- **Create incentives to reduce unnecessary utilization?**
- **Eliminate or consolidate SHP regulations?**
- **Determine service need in the context of Maryland's All-Payer Model for regulating hospital charges?**
- **Assure clear, unambiguous, & appropriately applied criteria?**

How can duplication of hospital regulatory effort between MHCC, HSCRC & MDH be eliminated or reduced?

Are there other related matters that should be addressed?

Timeline for the Study

- Interim Report by May 1, 2018
- Final Report by December 1, 2018

Stakeholders Identified in General Assembly's Request

- Commissioners
- Hospitals/Health Systems
- Post-acute service providers
- Ambulatory surgical facility operators
- Behavioral health/substance abuse treatment providers
- Local health departments/public health experts
- Employers
- Health care payers
- Consumers

Study Intent

"It is our hope that the study propose legislative and regulatory recommendations that the State should undertake to adapt the CON process to today's health care environment. The recommendations should be reasonable, actionable, and executable."

from June 23, 2017 letter from
Senate Finance & House Health & Government Operations

Evaluation and Change in the Maryland CON Program – Recent Historical Perspective

2000-2001 – Last comprehensive review mandated by General Assembly.

2005 – Commission-directed review. Resulted in:

- **Raised capital expenditure threshold from $1.5 million to $5/$10 million;**
- **Changed some processes. Led to greater use of status conference process to seek project changes (versus binary choice of approval or denial).**

2006-2017 – Creation of freestanding medical facilities as pilots followed by addition to scope of CON regulation & option for hospitals transitioning out of inpatient service delivery.

2011-2015 – Overhaul of CON law in re cardiac surgery & PCI.

- **Expanded scope & formalized PCI regulation created by MHCC.**
- **Regulations opened up regulatory process.**

Reforming CON through SHP Development – 2013-2017

General hospice - 2013 SHP calls for higher use of service. It targets low use jurisdictions for new market entry & creates opportunities for new market entry that did not exist in previous plan.

Home health – 2016 SHP scraps conventional need projections. Opens up new market entry based on lack of consumer choice, highly concentrated markets, & prevalence of poor performing agencies.

Organ transplantation - 2017 SHP scraps need projections. Creates opportunities for new market entry that did not exist in previous plan.

Non-specialized surgery – Proposed SHP creates more opportunities for development of more & larger outpatient surgical facilities. Easier process.

Possible Statements of the Problem

- **A more integrated approach to regulating hospital spending addressing both capital spending & revenues available for operating expenses is needed**

- **By restricting market entry & making it more expensive, CON regulation:**
  - ✓ **Limits competition & the potential for more competitive markets to enhance value**
  - ✓ **Limits potential innovations in service delivery**

- **The regulatory process is slow, burdensome, & overly legalistic**

- **Some of the benefits of regulating facility & service supply might be realized through alternative forms of regulatory oversight**

Proposed Two-Stage Study Process

Stage 1 – November, 2017 to April, 2018

- **Letters to stakeholders seeking comments. Requests structured to solicit specific input on specific problems & issues.**
- **Solicitation of consultant reports. Overview of literature on value & effectiveness of CON regulation. Possible lessons from other states.**
- **Small work group process.**
  - **Includes 5-6 Commissioners and limited numbers of stakeholders**
  - **Series of meetings planned around specific industry sectors & issues.**
- **Interim Report (May 1, 2018) – Defining the problems & laying out objectives for reform.**

Proposed Two-Stage Study Process

Stage 2 – May, 2018 to November, 2018

- **Convene larger work group.**
  - ✓ **Includes 5-6 Commissioners and a broader group of stakeholders**
  - ✓ **May include subgroups**
  - ✓ **Series of meetings planned around developing consensus on recommendations addressing specific problems.**
- **Emphasis is on pragmatic solutions**
- **MHCC submits Final Report (December 2018)**

Discussion


ACCOUNTABILITY
ACCESS
QUALITY
MARYLAND
HEALTH CARE COMMISSION
creating informed consumers

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MARYLAND HEALTH CARE COMMISSION

Overview of Upcoming Initiatives

(Agenda Item #7)


ENJOY THE REST OF
YOUR DAY