Maryland Health Care Commission

Thursday, May 17, 2018

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**
2. UPDATE OF ACTIVITIES
3. ACTION: Modernization of the Maryland Certificate of Need Program – An Interim Report by the Maryland Health Care Commission
4. ACTION: Exemption from Certificate of Need – Consolidation of Adventist HealthCare Shady Grove Medical Center and Adventist HealthCare Behavioral Health & Wellness Services
5. PRESENTATION: Maryland Practice Transformation Network
6. PRESENTATION: Telehealth Grant Award – Mobile-Device-Supported, Medication-Assisted Treatment for Opioid Use Disorders
7. OVERVIEW OF UPCOMING INITIATIVES
8. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

APPROVAL OF MINUTES

(Agenda Item #1)

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

(Agenda Item #2)

MARYLAND HEALTH CARE COMMISSION

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ACTION:

Modernization of the Maryland Certificate of Need Program – An Interim Report by the Maryland Health Care Commission

(Agenda Item #3)

Modernizing Maryland's Certificate of Need Program

May 17, 2018

The MARYLAND
HEALTH CARE COMMISSION

Modernizing CON Regulation – Charge to Commission

Final Report to General Assembly Committee chairs due in December, 2018

1. **Examine major policy issues -CON regulation should reflect dynamic & evolving health care delivery**

2. Review approaches other states use to determine appropriate capacity

3. Recommend revisions to CON statute

4. Recommend revisions to State Health Plan (SHP) regulations that:

- **Create incentives to reduce unnecessary utilization**
- **Eliminate, consolidate or revise individual chapters of SHP**
- **Develop criteria that determine service need in the context of Maryland's All-Payer Model**
- **Improve clarity and appropriateness - reduce ambiguity**

Modernizing CON Regulation

5. **Consider what flexibility is needed to streamline CON project review process**

6. **Identify areas of regulatory duplication in consultation with HSCRC & MDH**

Modernizing CON Regulation - Process

- **Phase One of study – Identify problems that need to be addressed in modernizing CON regulation. Phase Two of study will focus on ideas for addressing identified problems & developing recommendations for change & implementing change**

- **Solicit comments from regulated facilities & other stakeholders**

- **Convene stakeholder task force to consider comments, provide their own perspectives, discuss identified problems and issues, & advise on problems to be addressed**

- **Prepare interim report to set agenda for recommendations on modernizing CON regulation in final study report**

Modernizing CON Regulation – Common Themes

- **Most regulated facilities see a need for CON regulation in some form – more support for keeping CON than for eliminating CON regulation**
- **Substantive discussion by Task Force of need for current scope of CON and appropriateness of current regulatory process for some types of project**
- **Literature reviewed does not provide strong support for CON regulation as effective in controlling cost or improving quality**
- **CON regulation does shape health care system (e.g. in Maryland – ambulatory surgery, home health, hospice, lower per capita numbers of facilities & levels of capacity)**

Modernizing CON Regulation – Common Themes

- **Supporters see benefit of CON regulation in reducing overcapacity, facilitating more equitable access to care & more appropriate care**

- **Some supporters also see limits on growth & new market entry as beneficial in protecting expensive investments in facilities, reducing opportunities for fraud & the potential of overwhelming the oversight capacity of licensing & certification agencies, & keeping labor shortages from becoming more acute**

- **CON regulation imposes a significant direct compliance cost on regulated facilities – Review process is complex & often involves expensive legal & other expenses**

- **CON regulation limits competition that may increase costs & may limit new competitors with innovative approaches for reshaping care delivery**

Modernizing CON Regulation – Common Themes

- **CON regulation encourages "silo" perspective on the appropriate role of particular types of facility at a time when more flexibility may be needed to encourage facilities to break out from their limited traditional roles & provide different types of service to maximize care management/coordination & reduce cost**

- **Role of CON regulation as a tool for quality improvement is limited & quality improvement objectives may be better addressed with more appropriate tools**

- **CON regulation is the primary way for MHCC to implement its objectives for health care facility services – It should be reformed to better focus on achievement of this purpose**

Modernizing CON Regulation – Key Problems

- **Scope of CON regulation is outdated**
- **Review processes for handling different types of project review are underdeveloped – not all projects need the review process currently imposed**
- **State Health Plan regulations are, in some cases, outdated & overly complex – need to be better aligned with evolving All Payer Model regulating total cost of care**
- **The average period of time needed to review & act on CON applications is too long – period for completeness review and developing recommendations is often excessive**
- **Information requirements imposed by CON regulation are excessive/duplicative**

Modernizing CON Regulation – Key Problems

- **Performance requirements for approved projects are outdated and inflexible**
- **Capability to obtain broader community perspective on projects is underdeveloped**

Modernizing CON Regulation – Phase Two of the Study

- **Reconstitute Task Force – consider mix of stakeholders & need for other perspectives – develop guiding principles to frame objectives for reform**

- **Solicit specific & detailed ideas from stakeholders to address the problems & issues identified in Phase One**

- **Develop TF meeting agendas built around key areas of reform suggested by problem identification**
  - **Scope of regulation**
  - **Reforming the project review process – imposing enforceable time limits**
  - **Fitting review processes to the project under review**
  - **Rethinking State Health Plan regulations – simplification & better prioritizing issues to be considered**
  - **Reforming the post-approval process – more flexible performance requirements & rethinking what changes need Commission approval**

Modernizing CON Regulation – Phase Two of the Study

- **Develop consensus, to the extent possible, on law & regulatory changes that are practical & best address the identified problems**

- **Develop a final study report (December 1) with recommendations to the Committee chairs**

MARYLAND HEALTH CARE COMMISSION

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ACTION:

Exemption from Certificate of Need – Consolidation of Adventist HealthCare Shady Grove Medical Center and Adventist HealthCare Behavioral Health & Wellness Services

(Agenda Item #4)

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Maryland Practice Transformation Network

(Agenda Item #5)

Practice Transformation Network Efforts in Maryland

May 17, 2018

The MARYLAND
HEALTH CARE COMMISSION

Practice Transformation

- Involves changing processes and activities across clinical practices to:
  - Provide more efficient and effective care
  - Improve patient outcomes
  - Prepare clinicians to participate in new payment models
- Transformation and care delivery redesign are essential for:
  - Effectively managing population health
  - Reducing costs
  - Promoting a patient-centered health care system

Practice Transformation *(Continued)*

- Transformation requires attention to key areas including:
  - Leadership
  - Teamwork emphasizing use of data in decision making
  - Communication
  - Use of metrics
  - Business strategies that integrate clinical, administrative, and financial systems as central aspects of implementing quality and process integration

Transforming Clinical Practice Initiative

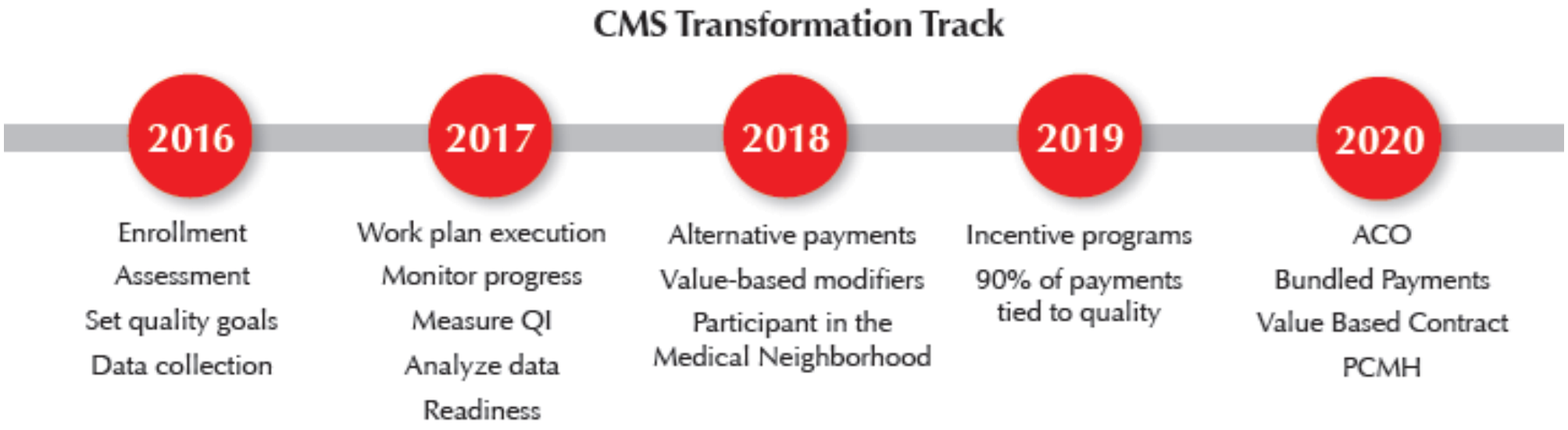
- One of the largest federal investments uniquely designed to support clinician practices via nationwide, collaborative, and peer-based learning networks that facilitate large-scale practice transformation
  - Established April 2015, concludes September 2019
- Centers for Medicare & Medicaid Services (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
- Through Practice Transformation Networks (PTNs) and Support and Alignment Networks, practices are recruited and actively engaged in transformation efforts that promote and sustain learning and improvement across the health care system

PTNs

- 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

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

Note: Blue text indicates predominant phases of work as of April 2018

The Partnership

- New Jersey Innovations Institute (NJII) – awarded a $40M five year grant from CMS to implement the 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

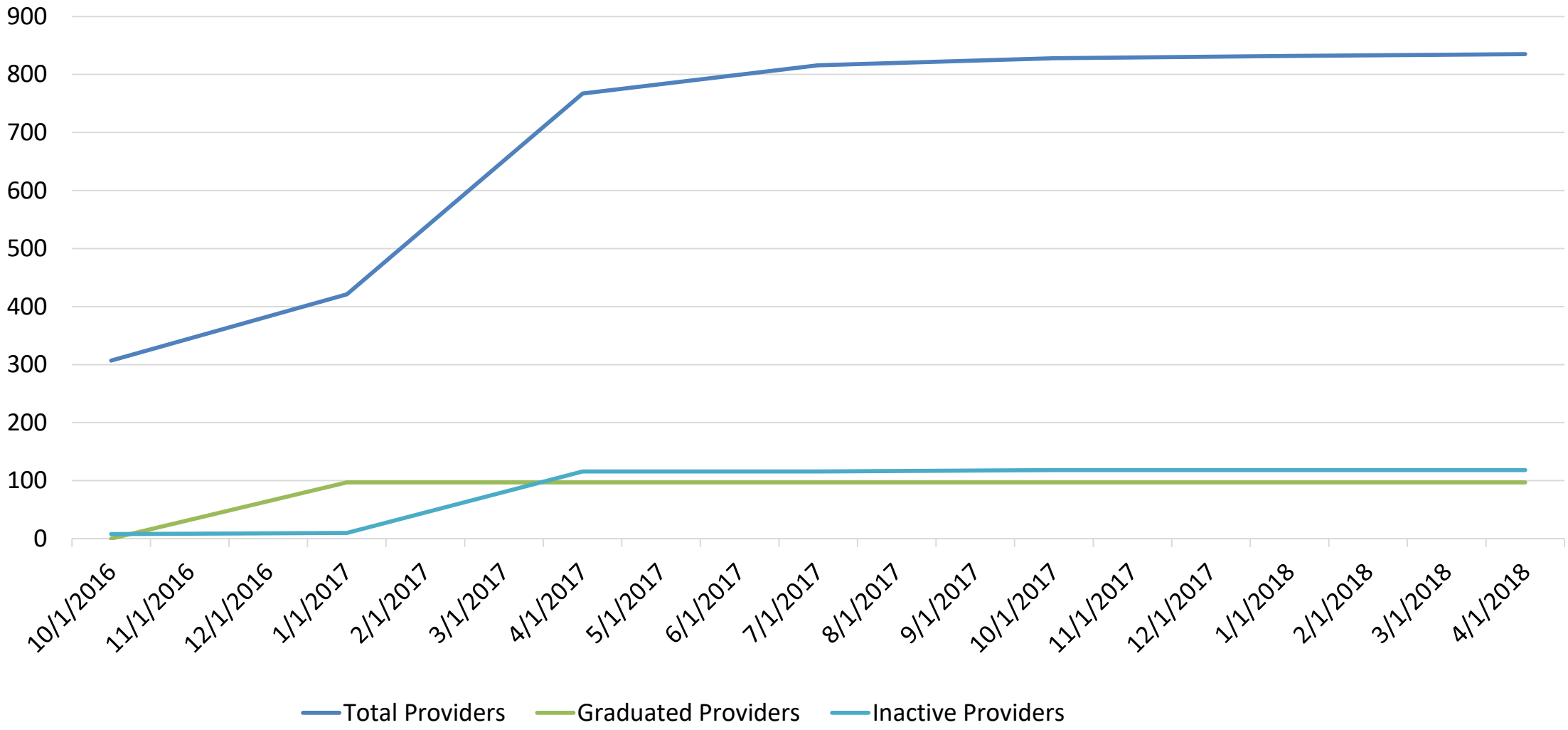
Roles of the Partners

- MLC: Prime on the subcontract with NJII; responsible for practice transformation, practice education and coaching, quality improvement, health information technology optimization, and provider recruitment
- MHCC: effectiveness Assess program impact on cost and quality, analyze the on select care delivery interventions, provide ongoing feedback to program implementers to support continuous rapid cycle quality improvement
- MedChi: Provider recruitment
- Partnerships: Discern Health for Quality Improvement and ZaneNet, a State-Designated Managed Service Organization, for coach recruitment and retention

Progress Update

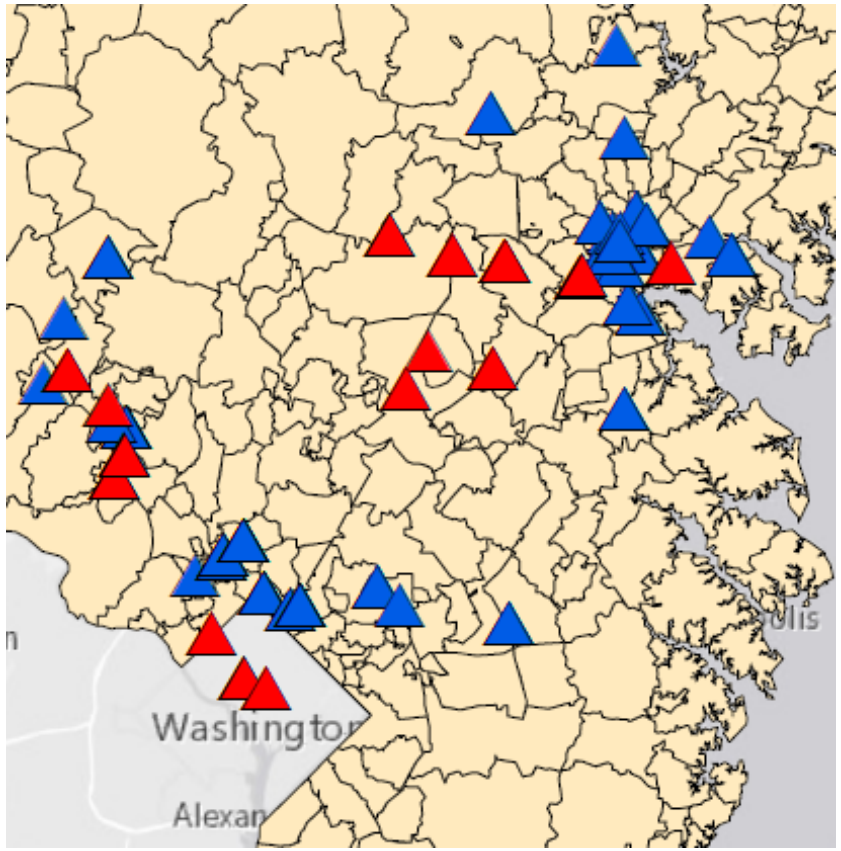
- Enrolled approximately 835 physicians (about 117 practice sites)
- Perform practice assessments quarterly to identify progress in transformation areas, such as patient and family engagement, team-based relationships, and population health management
- Collect data quarterly for each practice
- Support MIPS practice reporting

Enrollment By Month through April 2018



Enrollment By Region

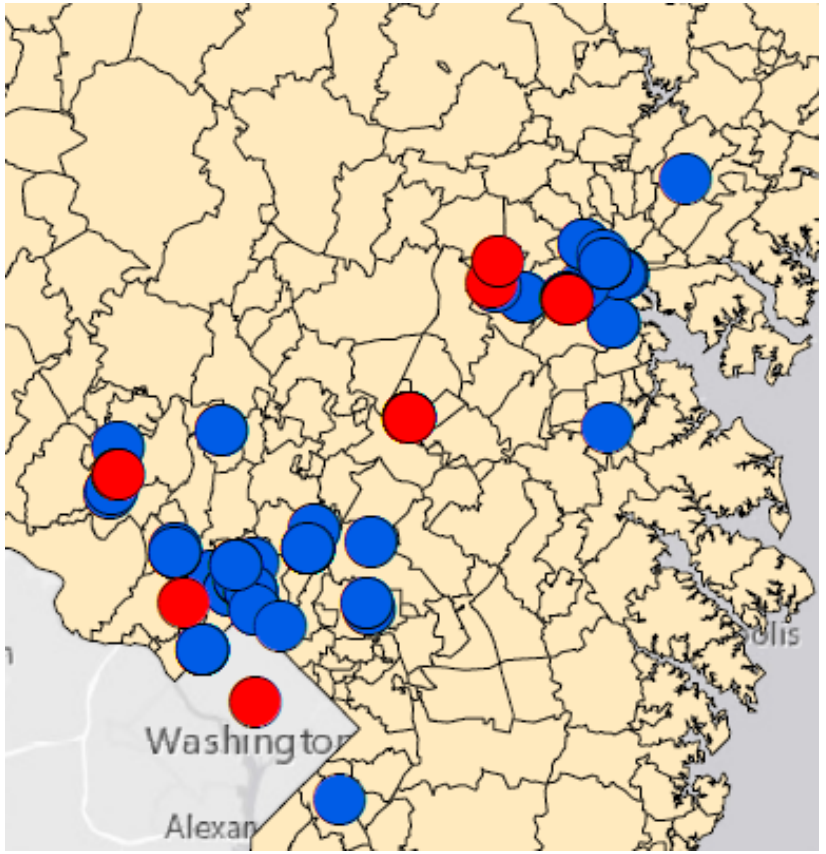
Primary Care Practices



Active practices

Joined ACOS

Specialty Practices

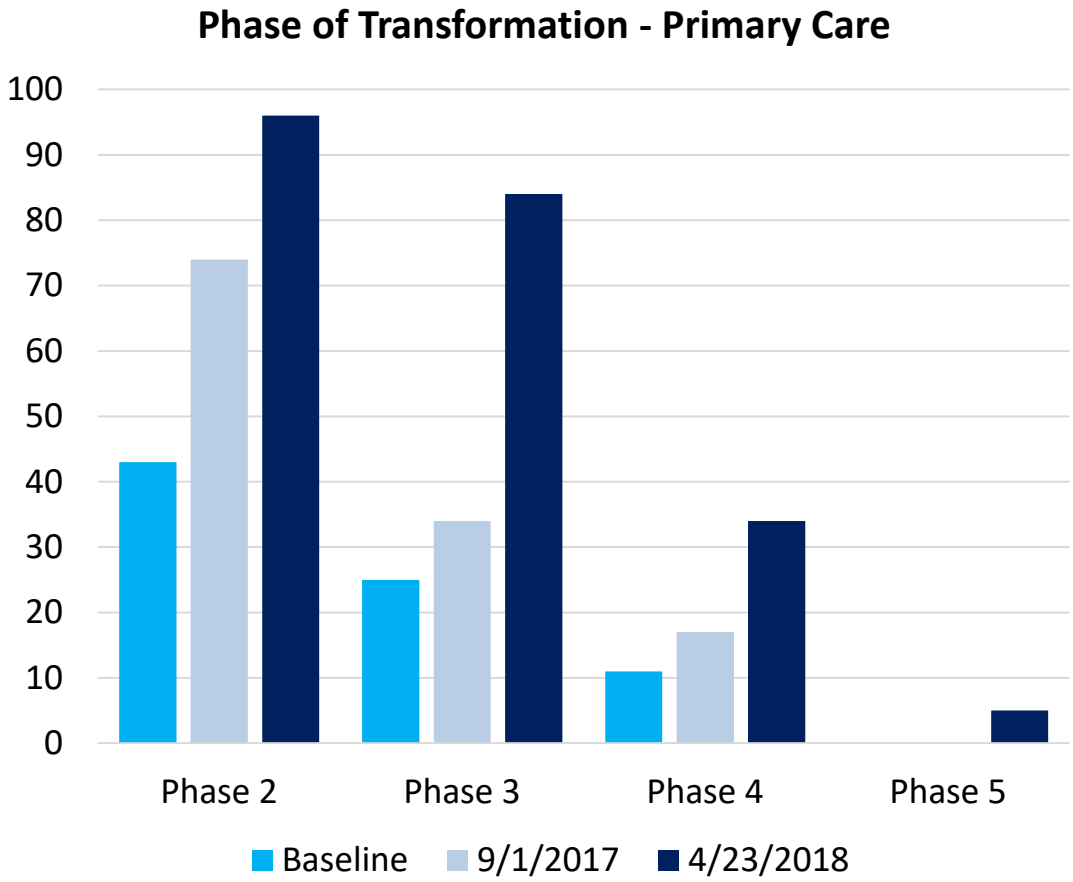


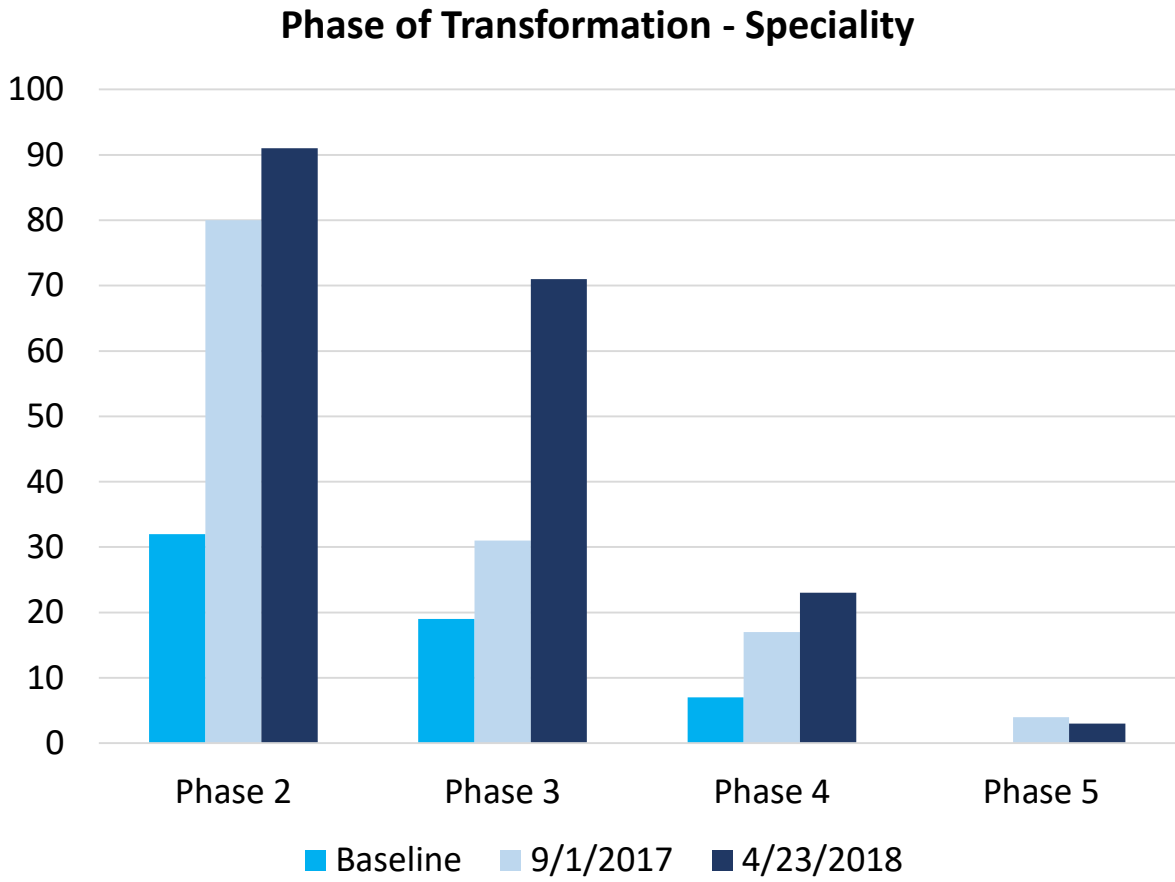
Active practices

Joined ACOs

Practice Assessment Results

PTN practices completed the Phase 1 milestones and have continued to progress through the stages of practice transformation for September 2016 through April 2018





Note: Y-axis represents the percent of practices that have completed all the milestones of that phase

Practice Assessment Results

Maryland PTN practices milestone assessment scores increased more rapidly than partners in New Jersey or Puerto Rico

PTN	Avg. Score at Baseline	Avg. Score (9/1/17)	Avg. Current Score (4/23/18)	Avg. Rate of Change (Baseline - 9/1/17)	Avg. Rate of Change (9/1/17 - Current)	Avg. Rate of Change (Baseline - Current)
MD	25	37	60	46%	61%	135%
NJ	31	31	55	2%	77%	80%
PR	17	20	24	19%	21%	44%

Performance Assessment Results – Primary Care

Maryland primary care PTN practices are performing better on select milestones for phases 3 and 4 than partners in Puerto Rico and New Jersey

PCP - Phase 3 - 4% of Goal	6/30/2017			9/1/2017			4/23/2018		
	MD	NJ	PR	MD	NJ	PR	MD	NJ	PR
#5 - Obtains patient feedback but inconsistently incorporates information	47%	21%	2%	49%	22%	28%	95%	57%	39%
#12 - Practice has standardized communication with medical partners	45%	23%	1%	49%	26%	27%	88%	74%	40%
#13 - Practice follows patient after ER visit or discharge	35%	21%	0%	37%	27%	26%	73%	75%	38%
#17 - Clinician is available to speak to patients after hours	64%	46%	0%	63%	44%	26%	83%	62%	38%
#26 - Developing internal capability for alternative payment system with deadline date	2%	26%	1%	2%	34%	27%	92%	64%	39%
#27 - Streamlined work, eliminated waste but not consistent	12%	21%	1%	17%	26%	27%	90%	47%	39%
Average	**30%**	**23%**	**1%**	**34%**	**27%**	**27%**	**84%**	**65%**	**39%**

Performance Assessment Results – Primary Care

(Continued)

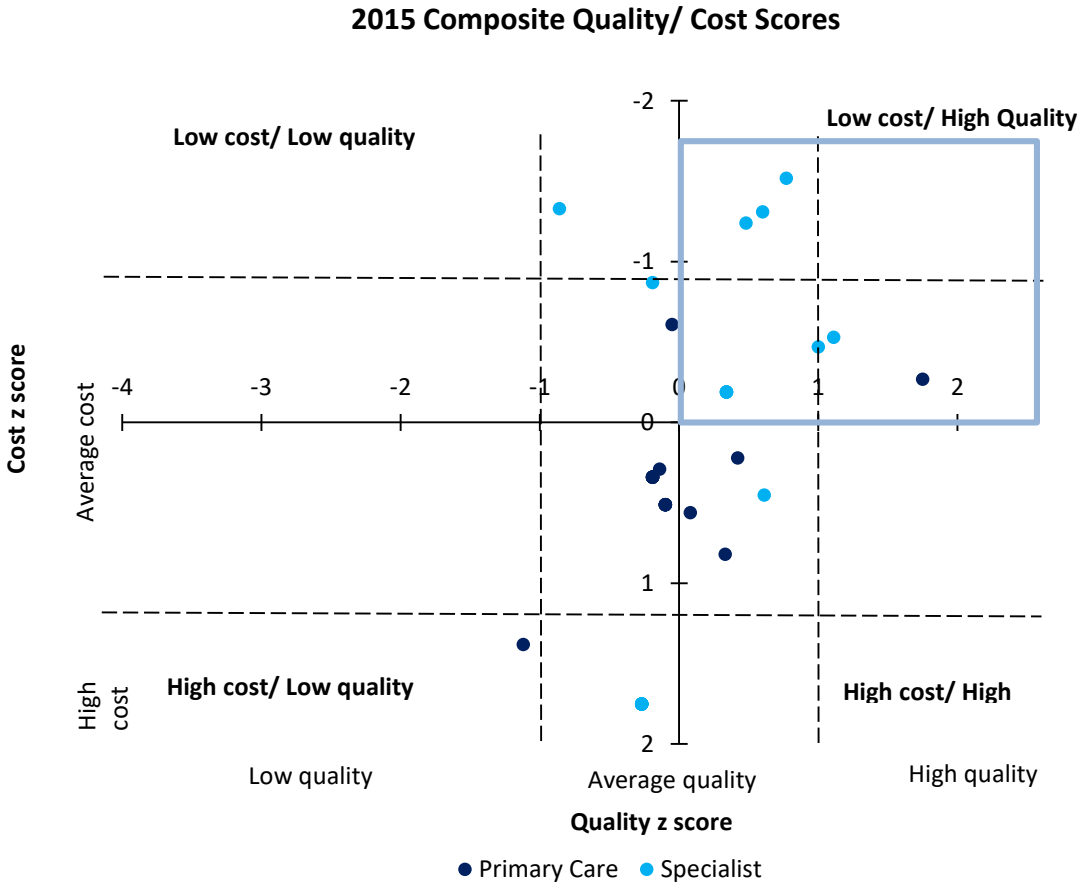
PCP - Phase 4 - 5% of Goal	6/30/2017			9/1/2017			4/23/2018		
	MD	NJ	PR	MD	NJ	PR	MD	NJ	PR
#1 - Met 75% of improvement targets for one year	0%	6%	0%	0%	6%	0%	68%	13%	0%
#4 - Patients and family can demonstrate collaborated goal setting and decision making	48%	12%	0%	51%	14%	0%	58%	38%	0%
#5 - Formal system in place for obtaining patient/family feedback with documented decisions	30%	8%	0%	30%	8%	1%	42%	27%	1%
#12 - Has identified medical neigborhood who are regularly involved and shares information, via agreement in place	27%	11%	0%	29%	12%	0%	40%	38%	0%
Average	**15%**	**9%**	**0%**	**17%**	**10%**	**0%**	**34%**	**24%**	**0%**

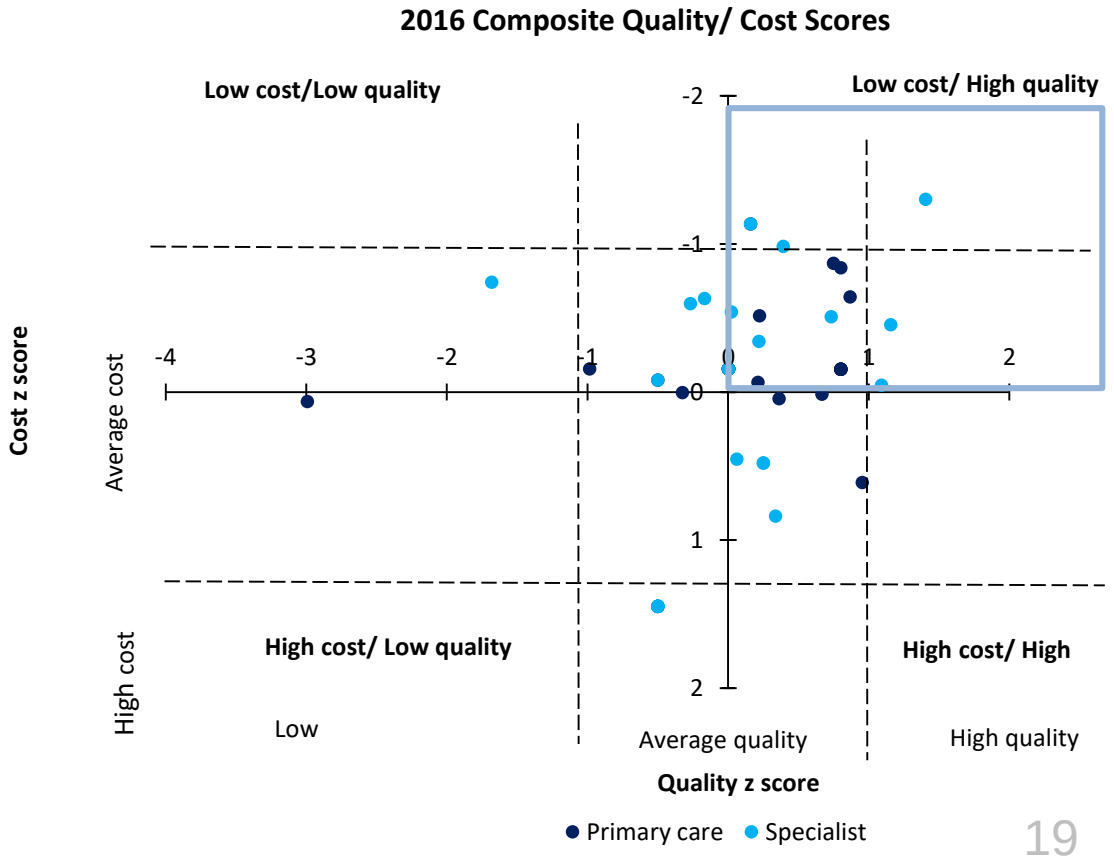
Performance Assessment Results – Specialists

Specialists - Phase 3 - 4% of Goal	6/30/2017			9/1/2017			4/23/2018		
	MD	NJ	PR	MD	NJ	PR	MD	NJ	PR
#1 - Shown improvement in metrics but not reached targets yet	0%	15%	1%	5%	25%	50%	93%	78%	53%
#5 - Obtains patient/family feedback but doesn't incorporate into quality improvement or management of practice	58%	33%	4%	62%	43%	64%	86%	77%	67%
#9 - Medical neighborhood established for co-management but processes not yet implemented	31%	33%	2%	41%	36%	33%	77%	67%	37%
#10 - System is in place to identify primary care provider and to communicate with team	29%	21%	1%	38%	26%	33%	68%	59%	37%
#11 - Identified care maps & evidence based protocols but not consistently used	44%	38%	2%	51%	48%	32%	81%	67%	37%
#22 - Efficiency of operation in place but inconsistent	19%	19%	1%	26%	25%	63%	79%	56%	67%
Average	**26%**	**25%**	**1%**	**31%**	**32%**	**44%**	**71%**	**69%**	**48%**

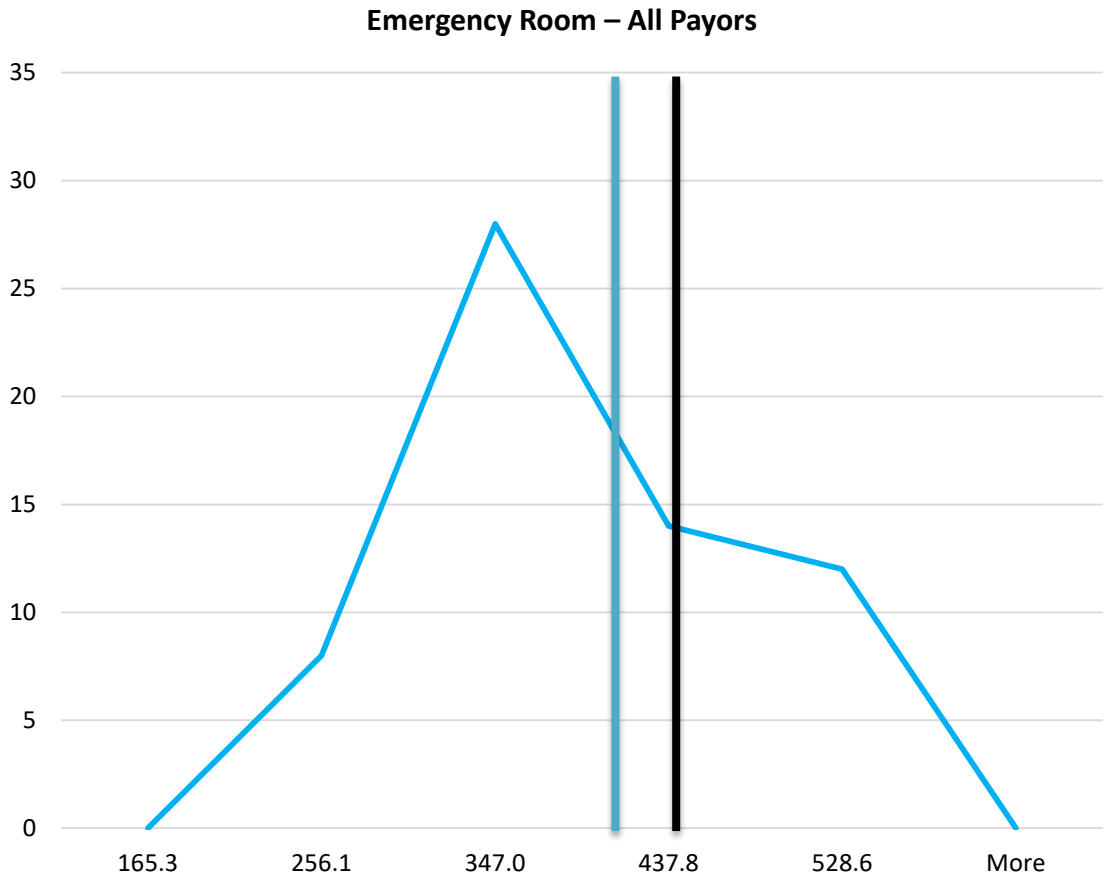
Cost and Quality Z-Scores

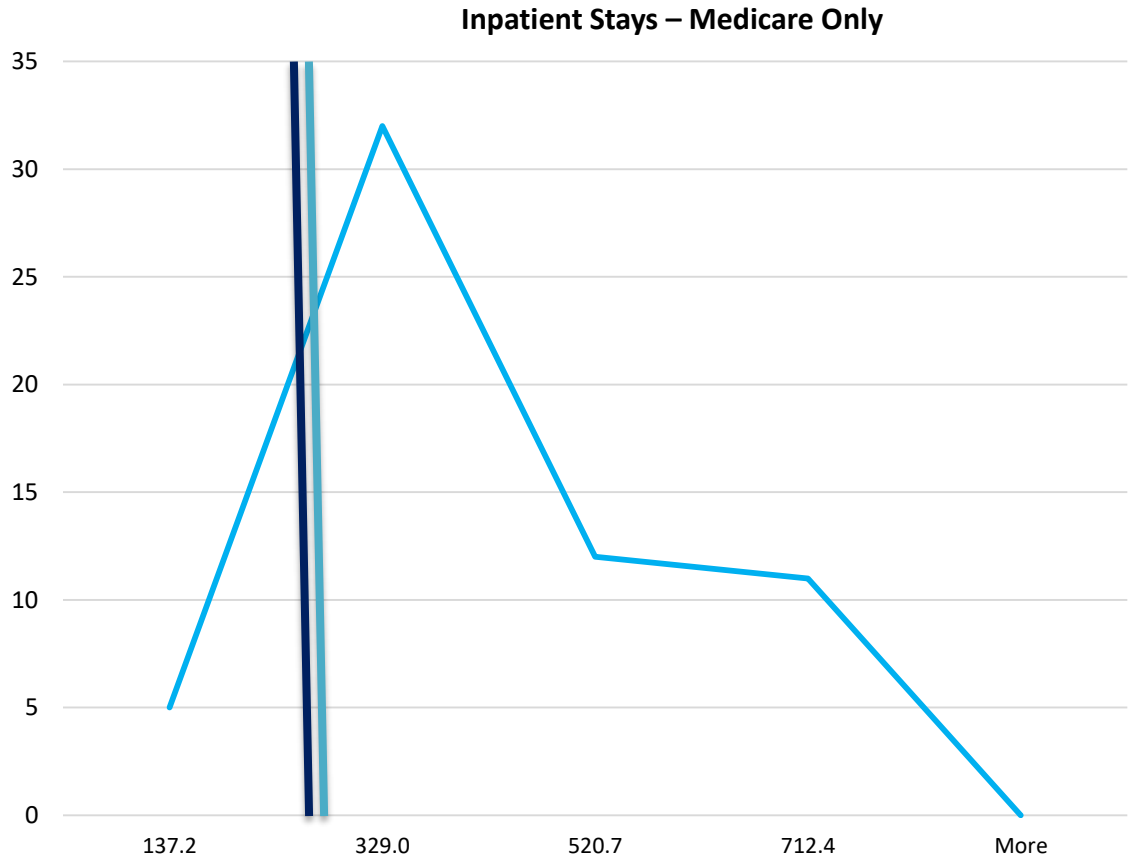
The majority of Maryland PTN practices scored favorably on the CMS composite quality measure in both 2015 and 2016 and many of those also fell into the most desirable category of delivery: low cost / high quality health care





Utilization Metrics Per 1,000 Beneficiaries - 2015

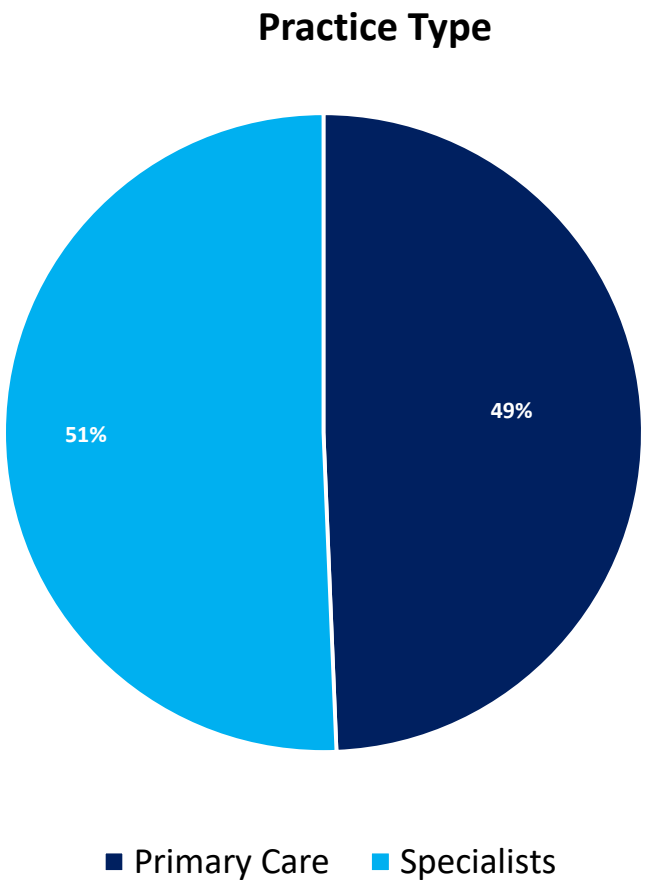


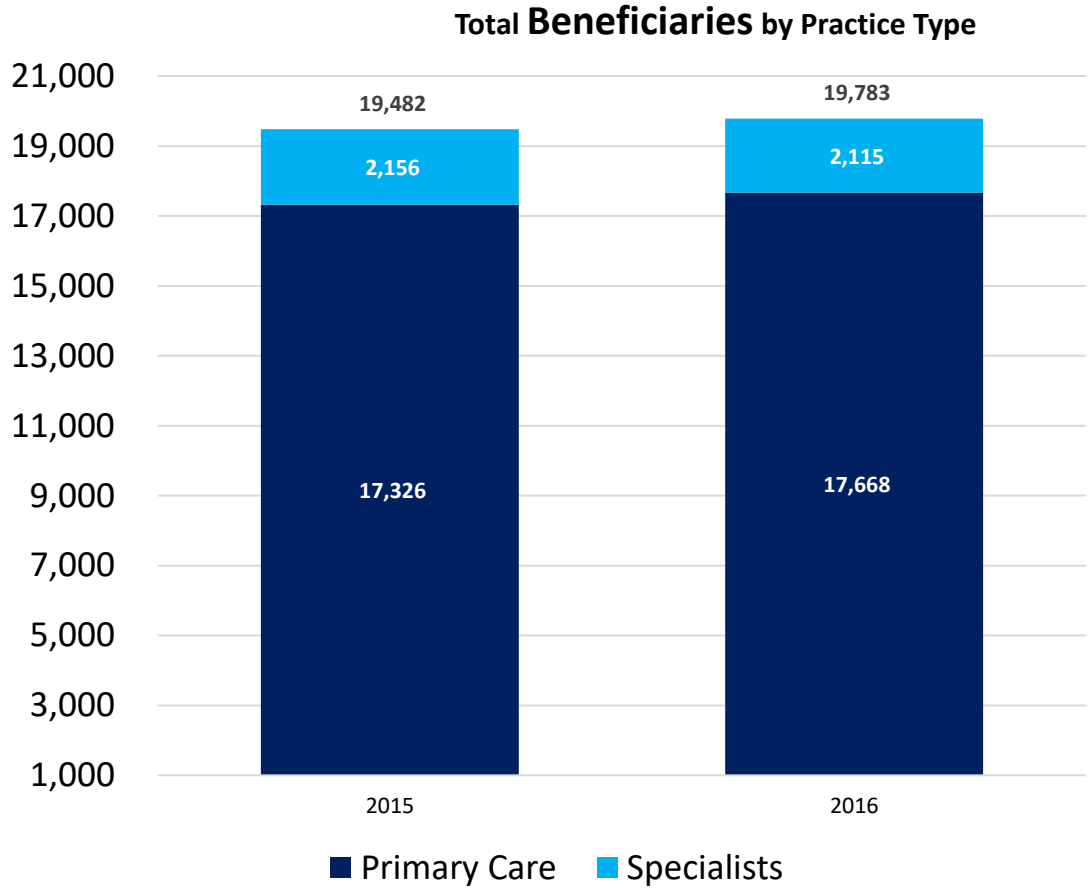


National Benchmark
State Benchmark
Source: Kaiser Family Foundation, 2018

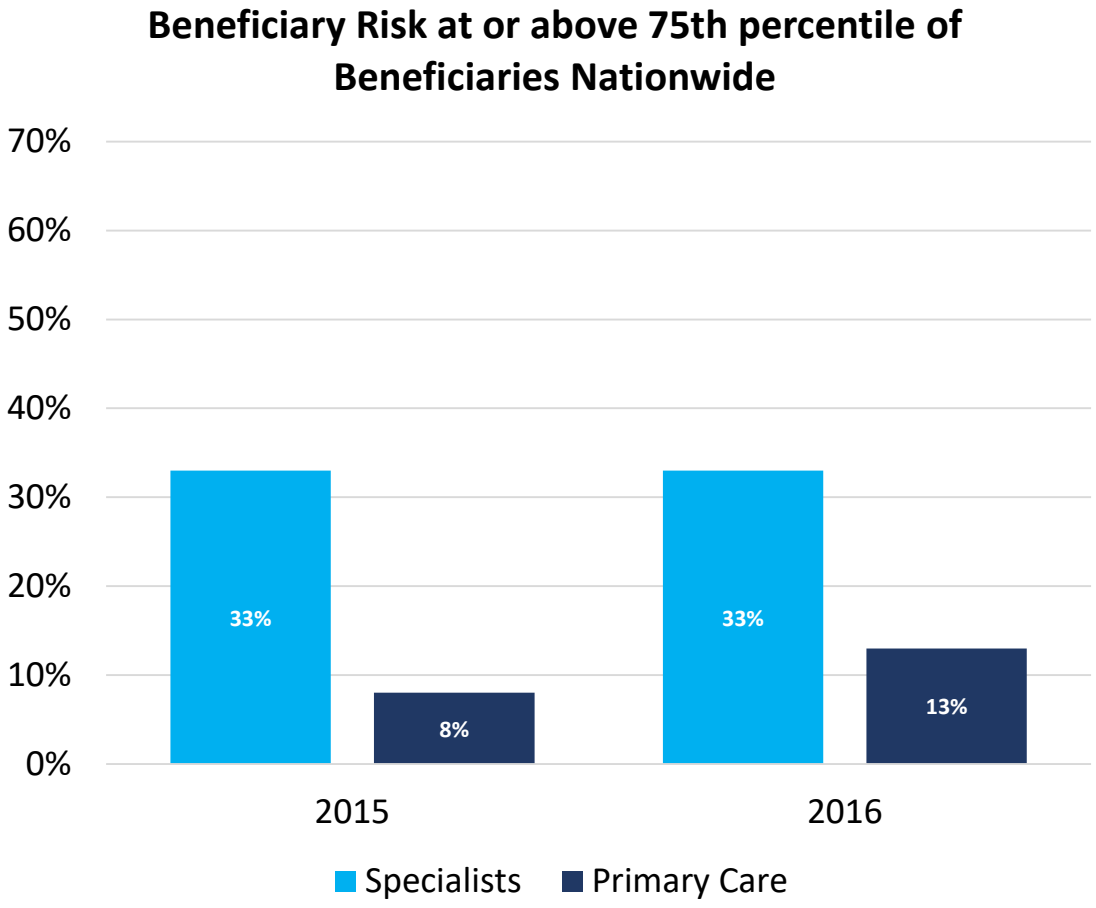
Graphs are histograms. Y-axis shows the frequency distribution.

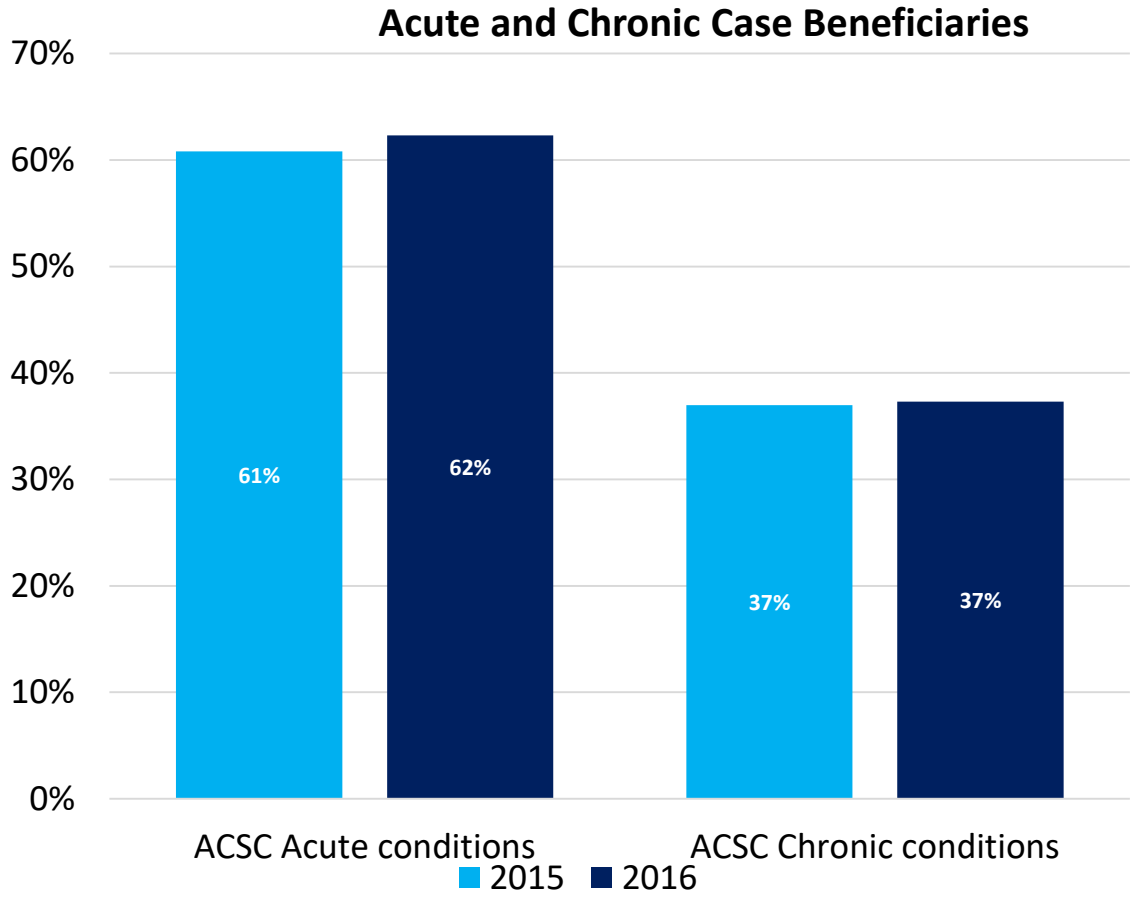
Practice and Beneficiary Demographics *(Continued)*



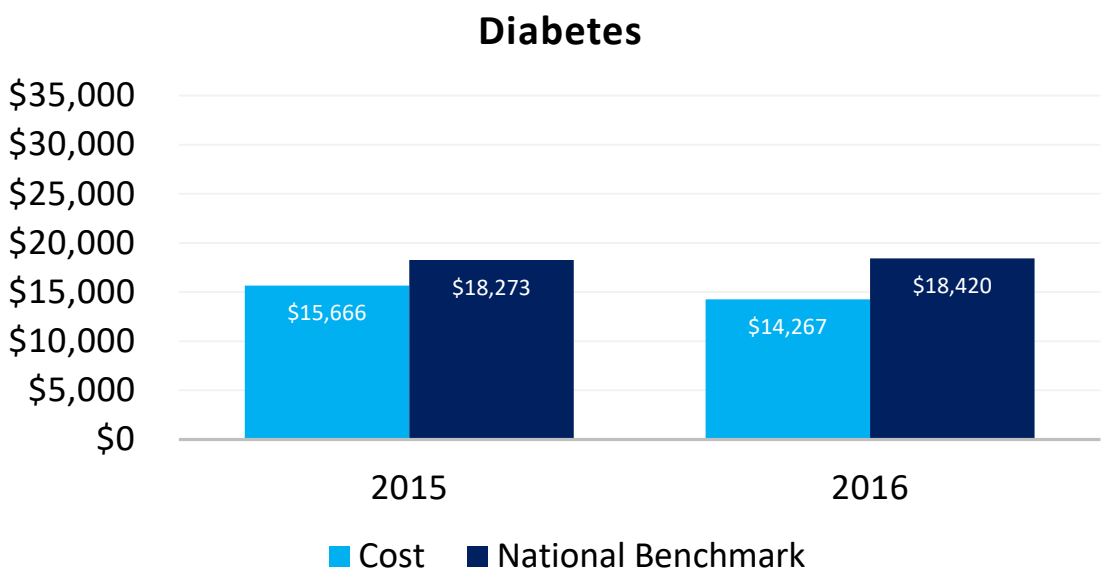


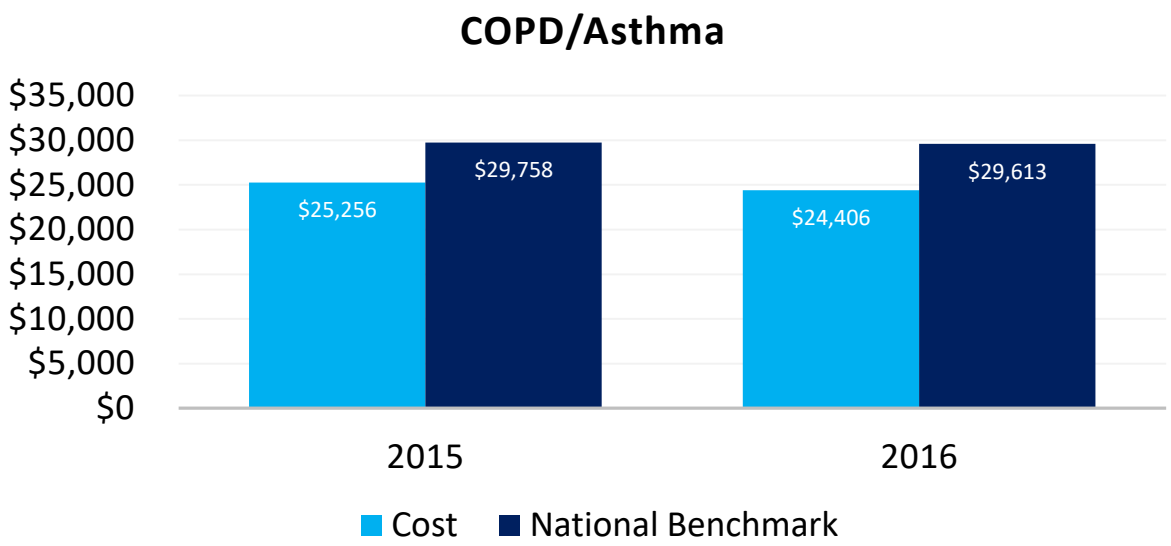
Practice and Beneficiary Demographics *(Continued)*

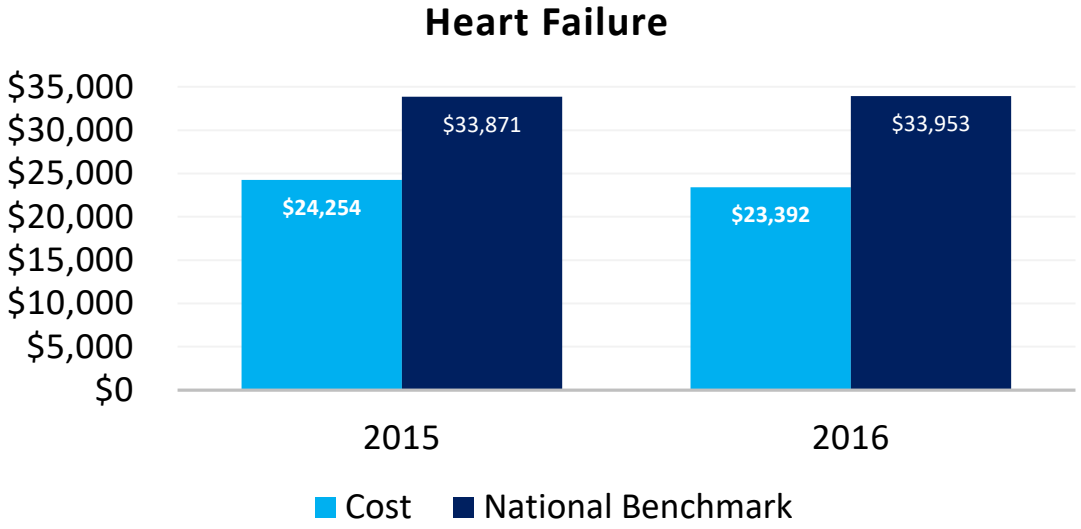


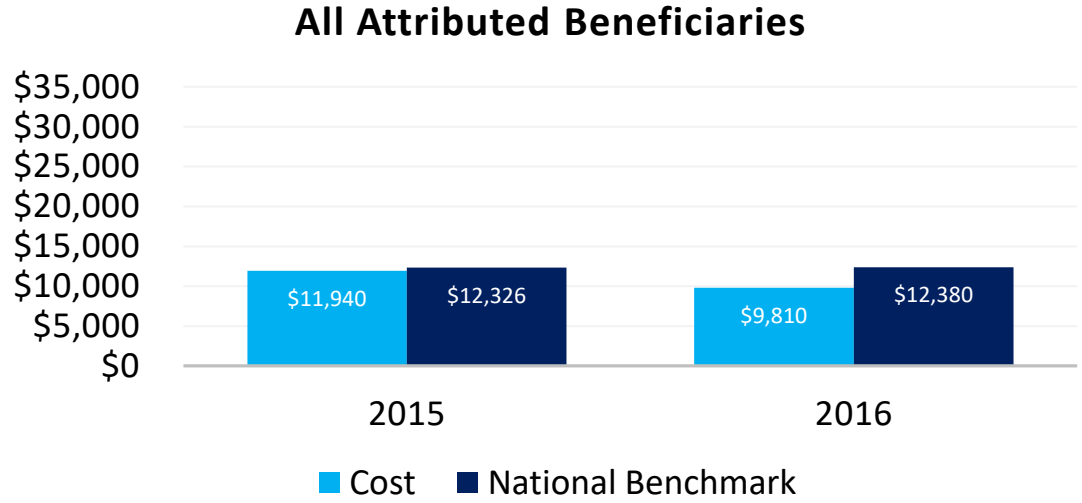


Specialty and Risk Adjusted Per Capita Costs

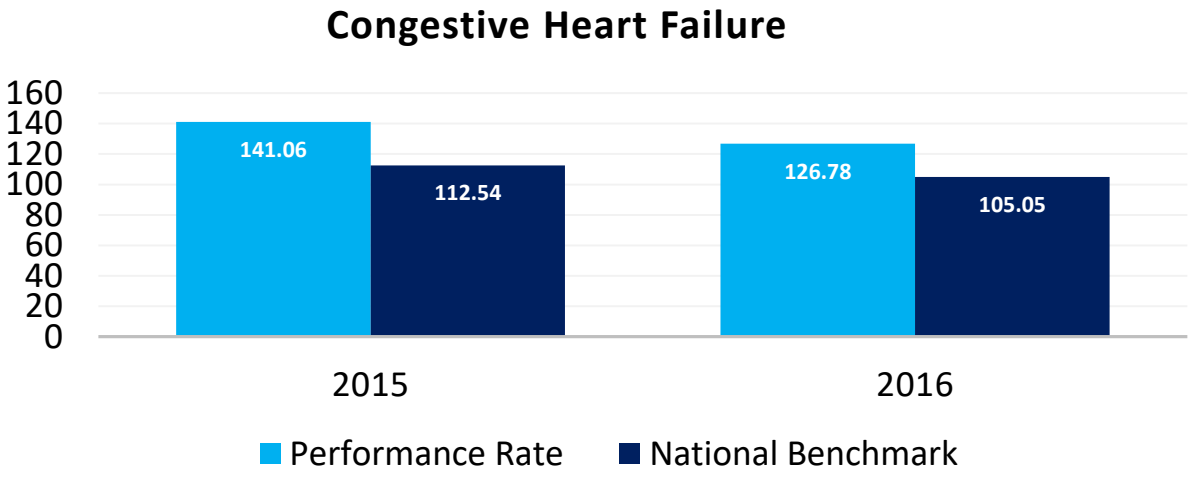


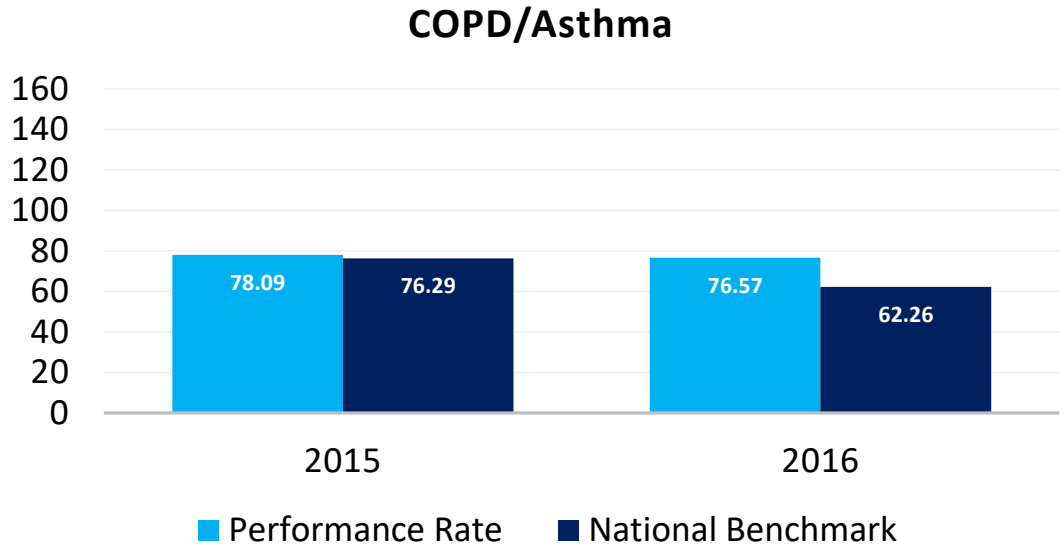


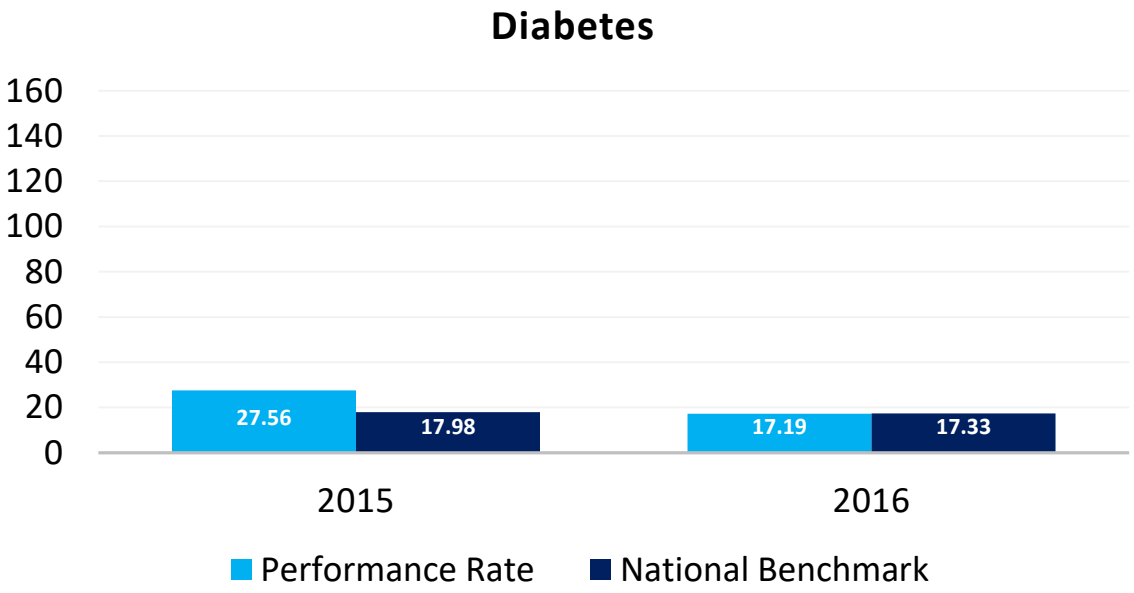


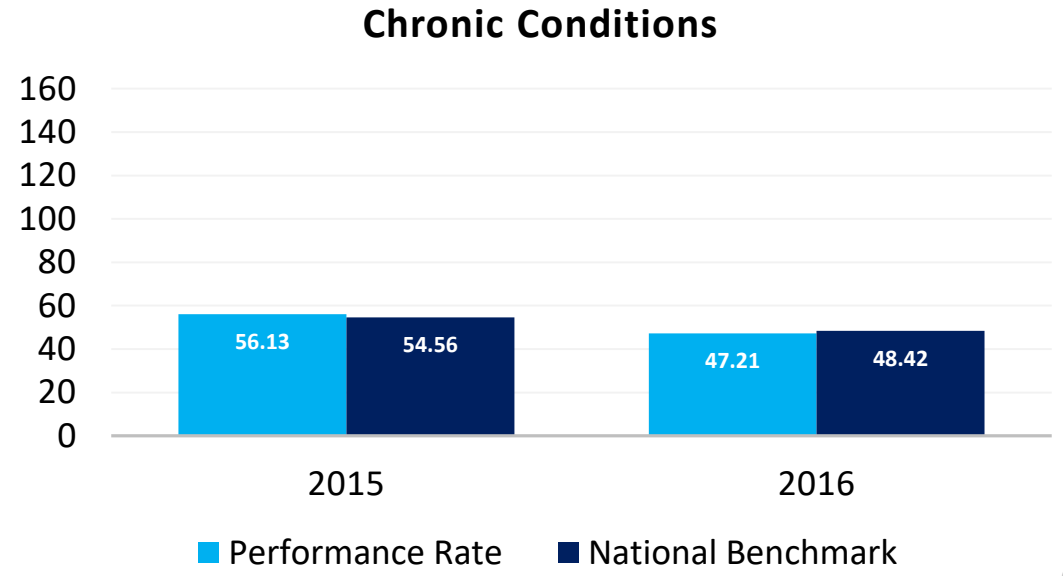


Average Performance Rate



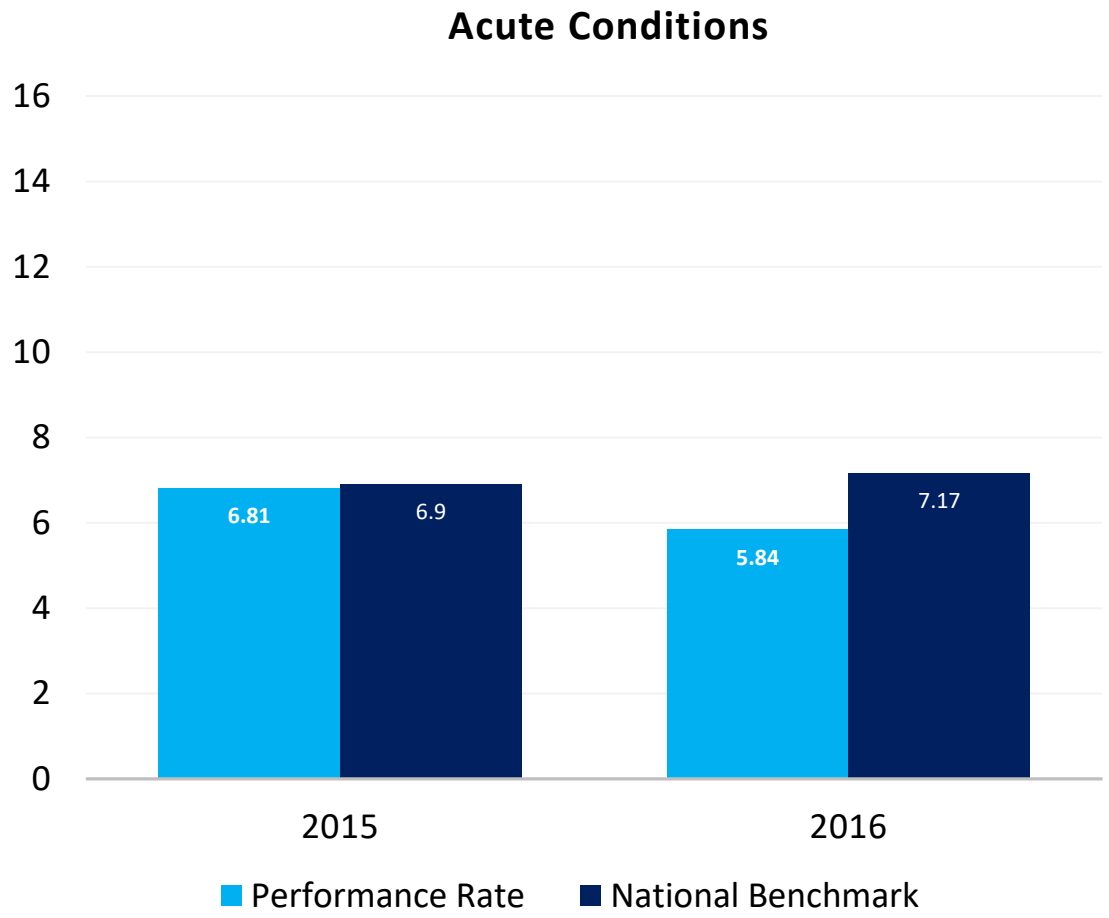


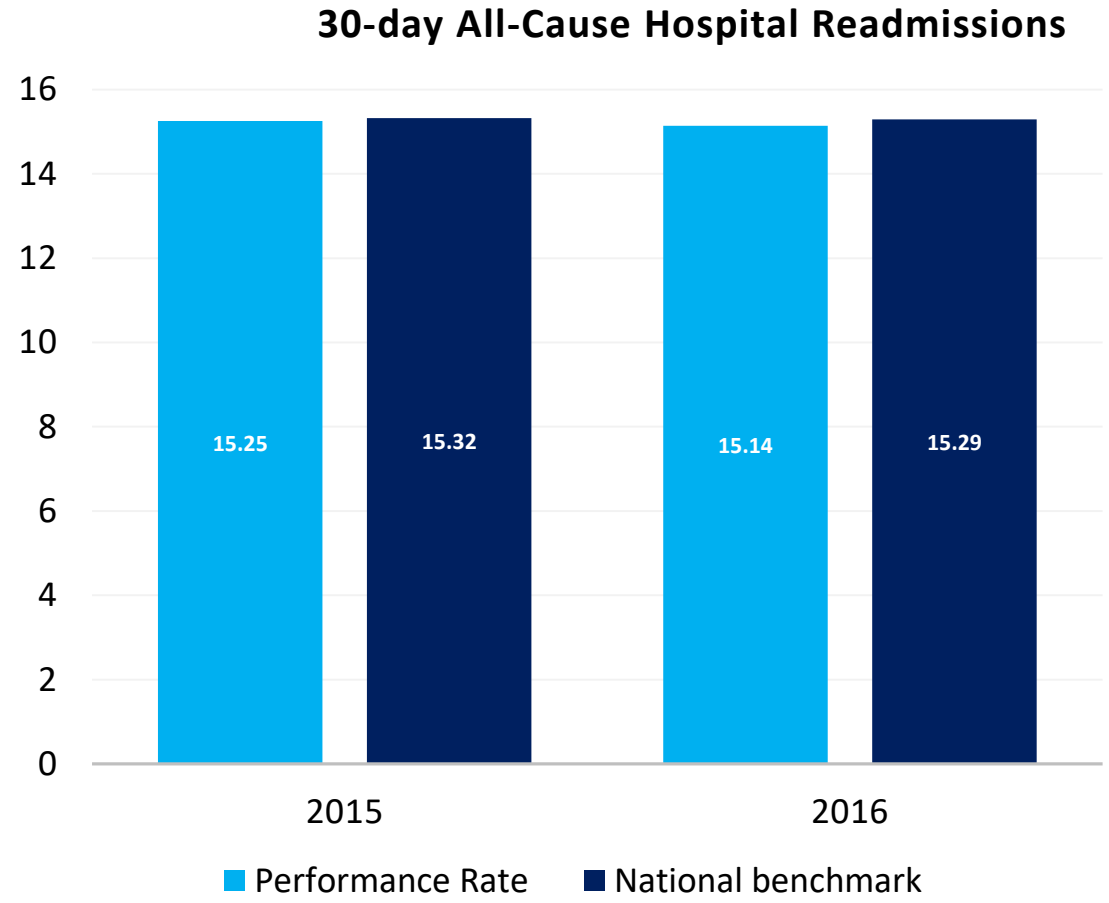




Note: Graphs represent comparisons statewide and nationally; for the conditions on this page, lower performance rates indicates better performance

Average Performance Rate *(Continued)*





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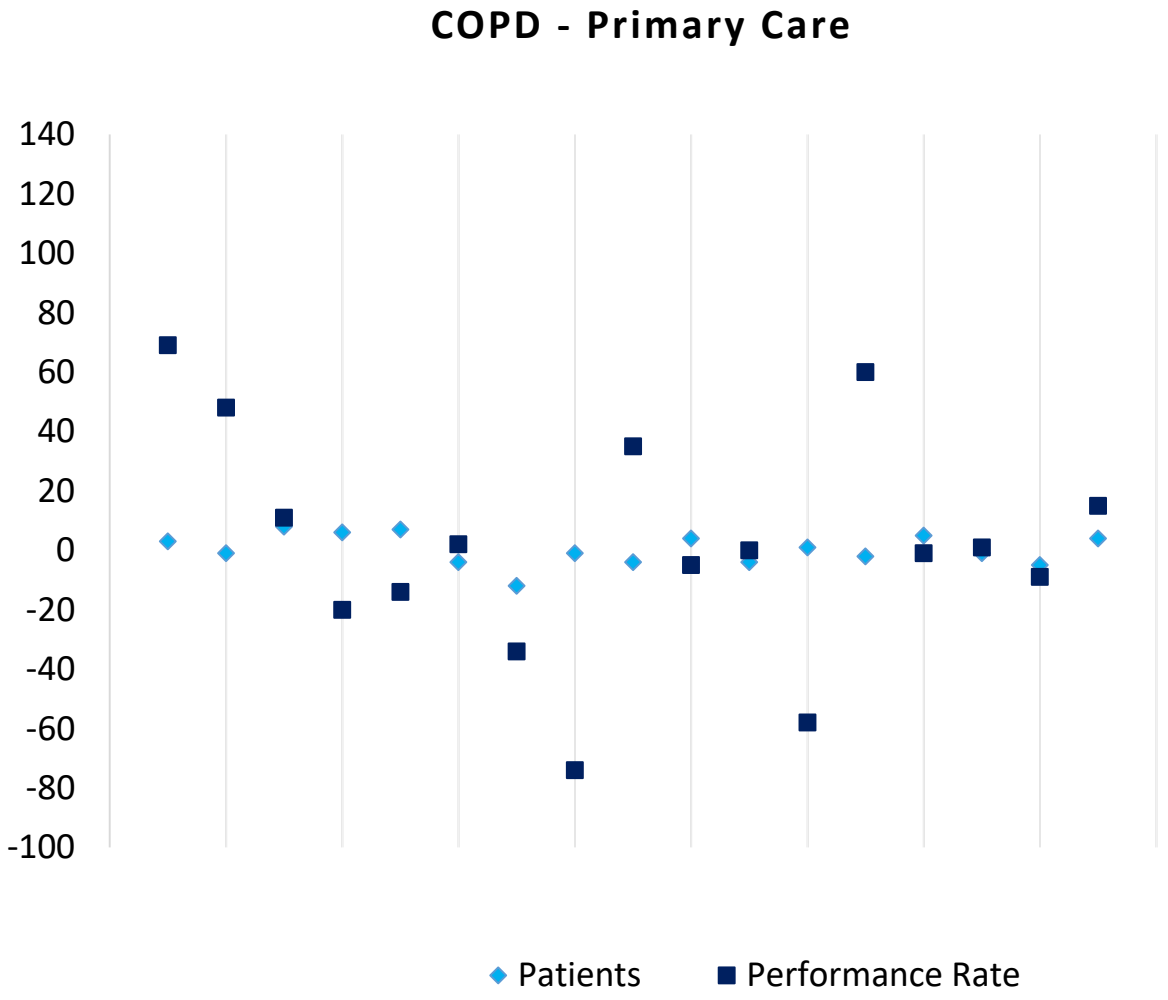
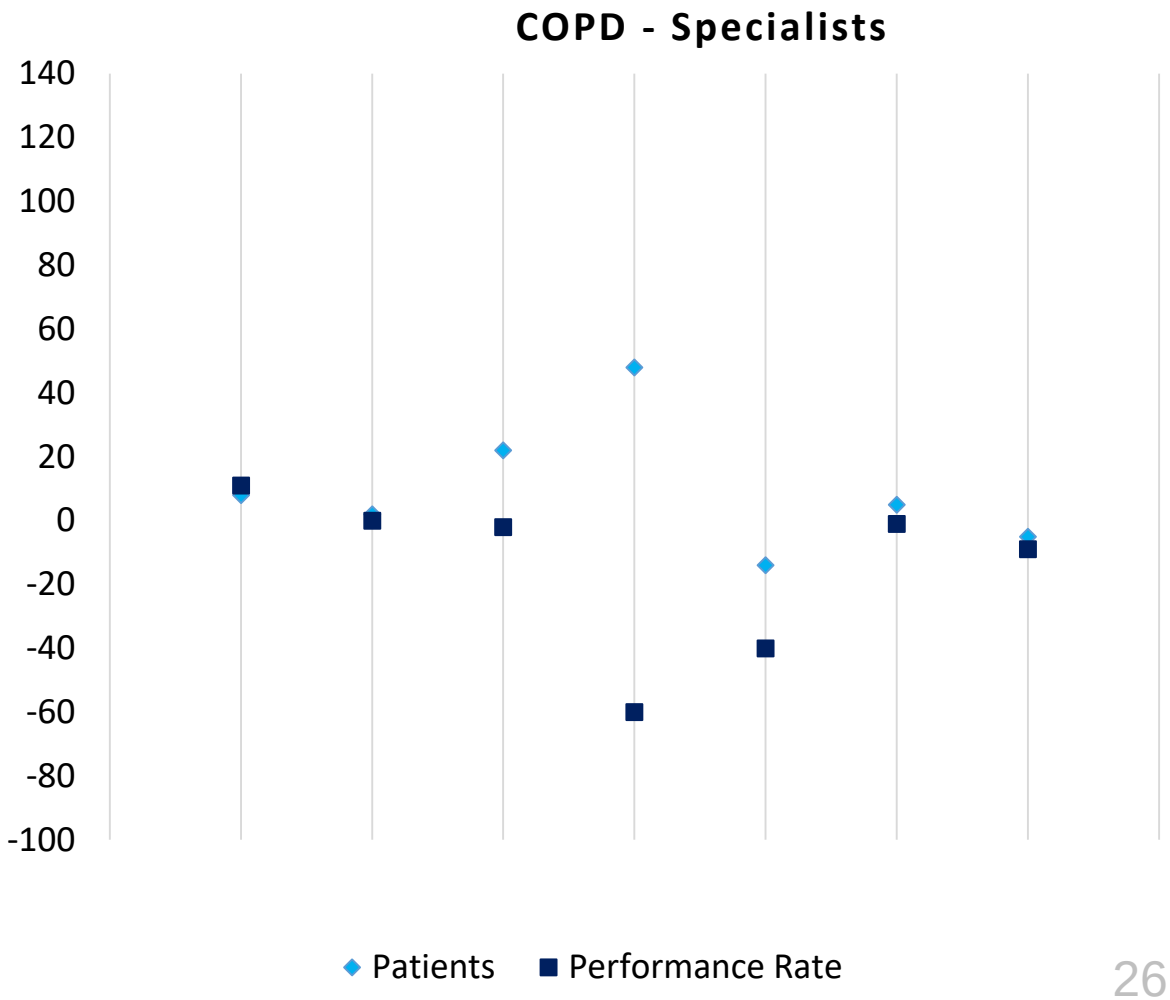
Change in Number of Patients and Performance Rate (2015 – 2016) *(Continued)*





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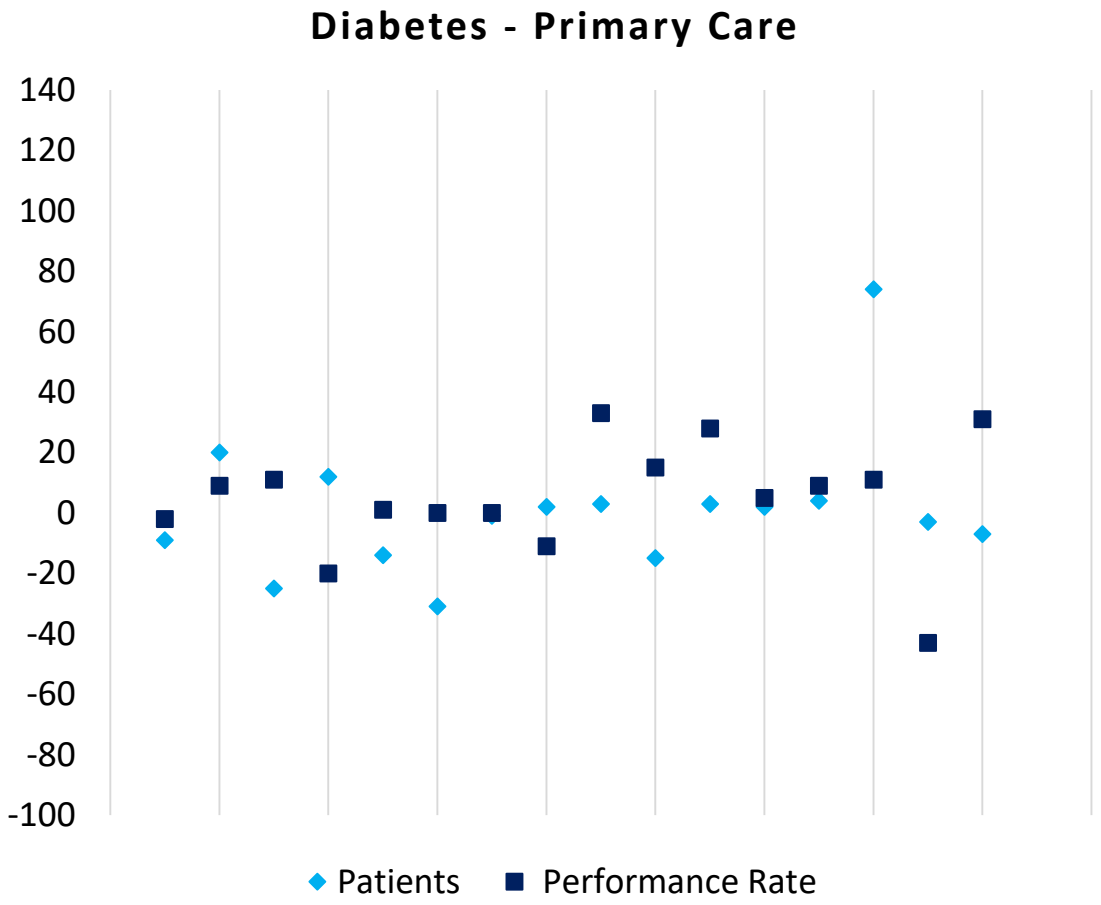

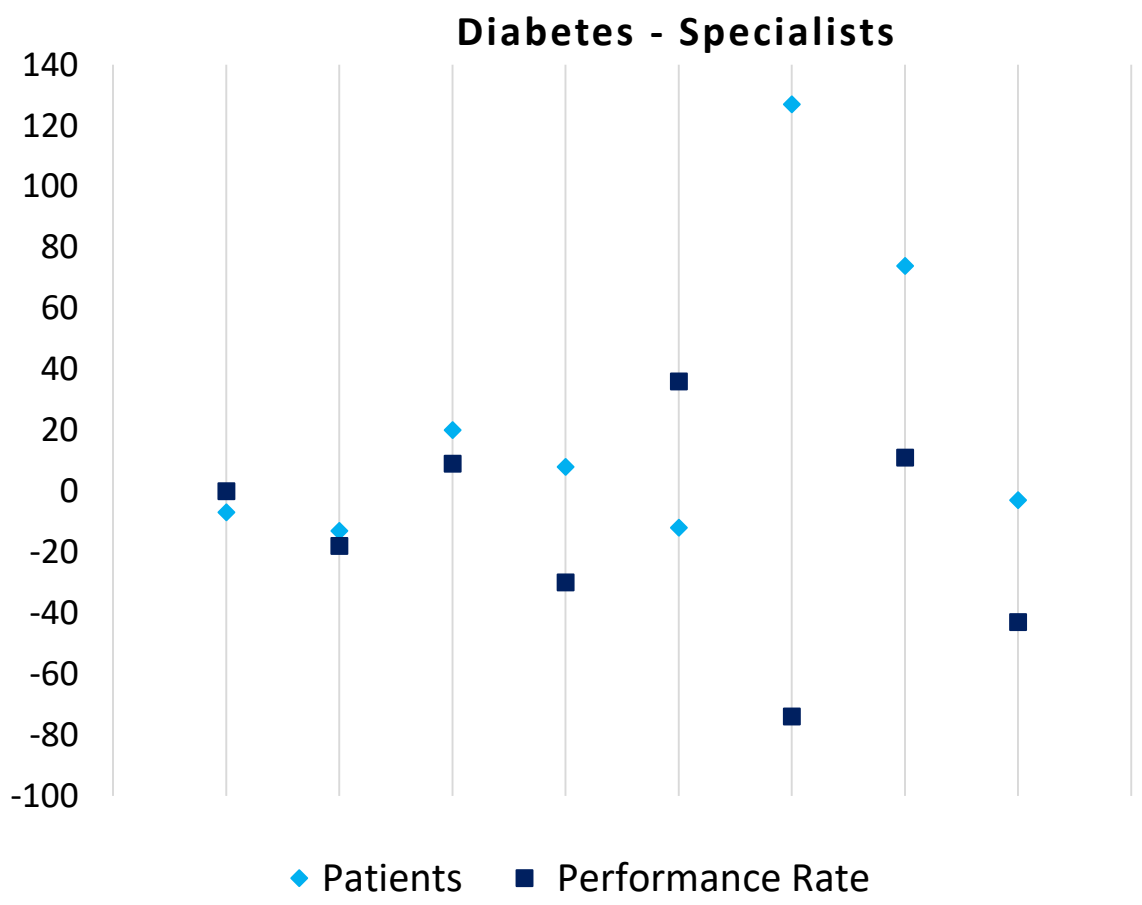

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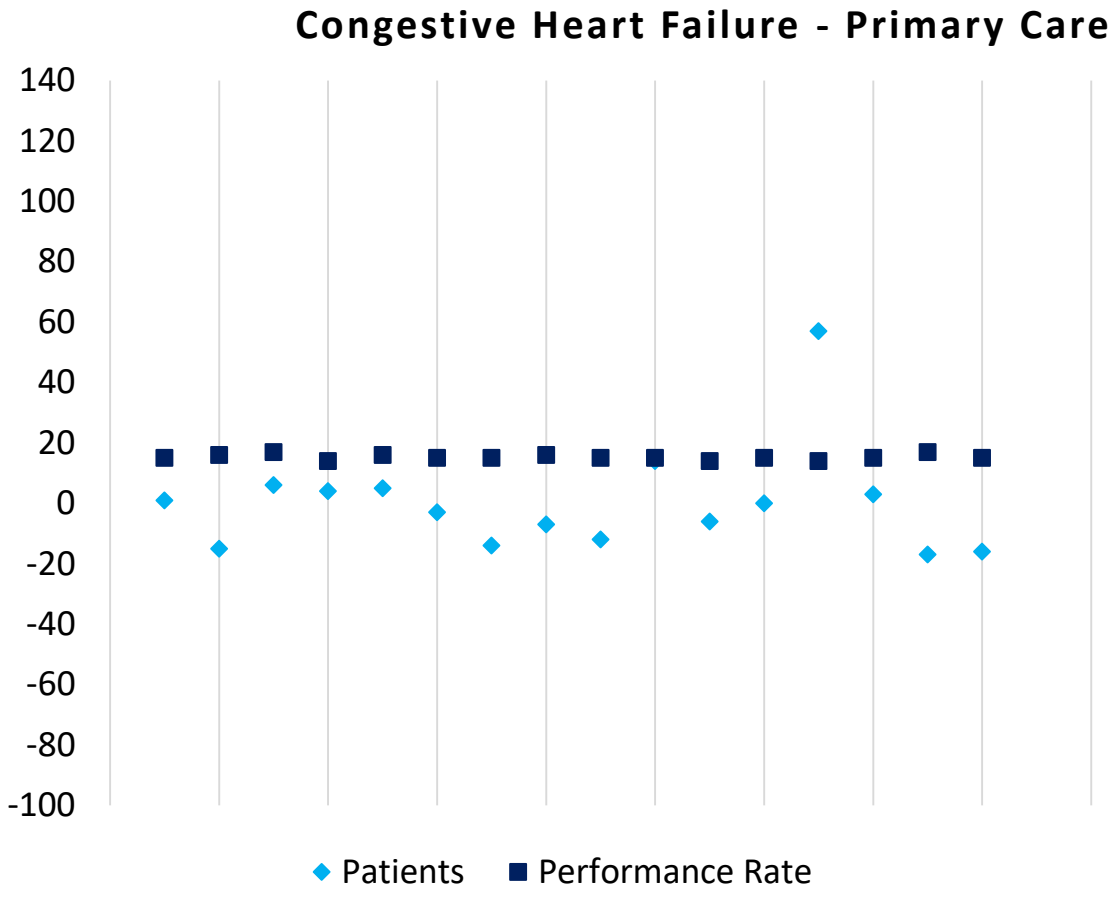

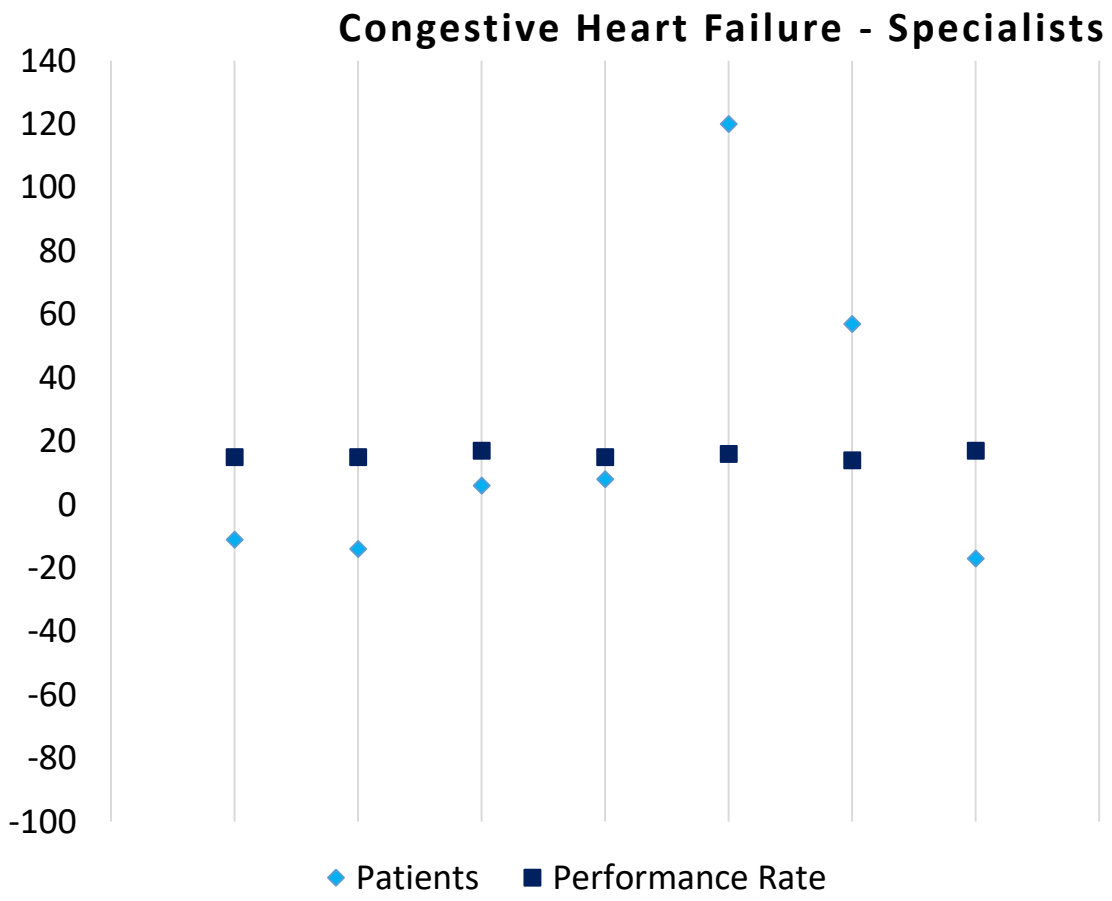

At Completion of the Program

- Practices are prepared to:
  - Use their established framework to successfully plan, develop, and implement the transformation process
  - Sustain and continue to build quality improvement initiatives
  - 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
  - Achieve MACRA readiness by participation in
    - MIPS - http://njii.com/mips-calculator/ and
    - APMs

Key Initiatives

- Complete follow-up assessments with practices every six months
- Educate practices on 2018 changes to the MACRA Quality Payment Program, and increase awareness and preparation of APMs/Advanced Alternative Payment Models (AAPMs)
- Assist practices to transition to APMs
- Develop a Maryland specific PFAC guidance to support practices that transition to an APM

Thank You!

The MARYLAND
HEALTH CARE COMMISSION

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AGENDA

1. APPROVAL OF MINUTES
2. UPDATE OF ACTIVITIES
3. ACTION: Modernization of the Maryland Certificate of Need Program – An Interim Report by the Maryland Health Care Commission
4. ACTION: Exemption from Certificate of Need – Consolidation of Adventist HealthCare Shady Grove Medical Center and Adventist HealthCare Behavioral Health & Wellness Services
5. PRESENTATION: Maryland Practice Transformation Network
6. **PRESENTATION: Telehealth Grant Award – Mobile-Device-Supported, Medication-Assisted Treatment for Opioid Use Disorders**
7. OVERVIEW OF UPCOMING INITIATIVES
8. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Telehealth Grant Award – Mobile-Device-Supported, Medication-Assisted Treatment for Opioid Use Disorders

(Agenda Item #6)

Telehealth Grant

Mobile-Device-Supported, Medication-Assisted Treatment for Opioid Use Disorders

May 17, 2018

The MARYLAND
HEALTH CARE COMMISSION

Telehealth Grants

- Since 2014, MHCC has awarded telehealth grants to 13 organizations to implement innovative projects in the State
    - Enable assessment of telehealth services across a variety of settings, including primary care practices, patient homes, and community centers
- Findings can inform stakeholders locally and nationally on:
    - Successful practices to evaluate the need, willingness, and readiness to use telehealth
    - Strategies to integrate telehealth within a multidisciplinary team
    - Existing and future telehealth projects in the State

TeleMAT

- MHCC released an *Announcement for Grant Applications* in January, and received:
  - Four letters of intent
  - Three applications
- Evaluations were conducted with the assistance of external reviewers, including a physician and representatives from Maryland Medicaid
- The grant was awarded to Mosaic Community Services, Inc. (Mosaic) to increase access to medication-assisted treatment (MAT) to underserved Maryland residents with opioid dependence through telehealth intervention
  - 18-month time frame
  - Awarding $149,774 with a $196,940 match

Rationale & Framework

Rationale

- Deaths from opioid drug overdoses have more than tripled since 2000 nationally, and have increased by 75 percent since 2007 locally
- Only 10 percent of individuals who require MAT treatment are able to access it

Framework

- The 2015 Executive Order to establish the Heroin and Opioid Emergency Task Force to prevent, treat, and reduce heroin and opioid abuse
- The Drug Addiction Treatment Act of 2000 allows qualified physicians to dispense or prescribe select schedule III, IV, and V medications outside of a Drug Enforcement Agency recognized narcotic treatment program

Sources: Centers for Disease Control and Prevention. *Opioid Data Analysis*, February 9, 2017.
Maryland Department of Health and Mental Hygiene. *Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2015*, September 2016 – Revised.

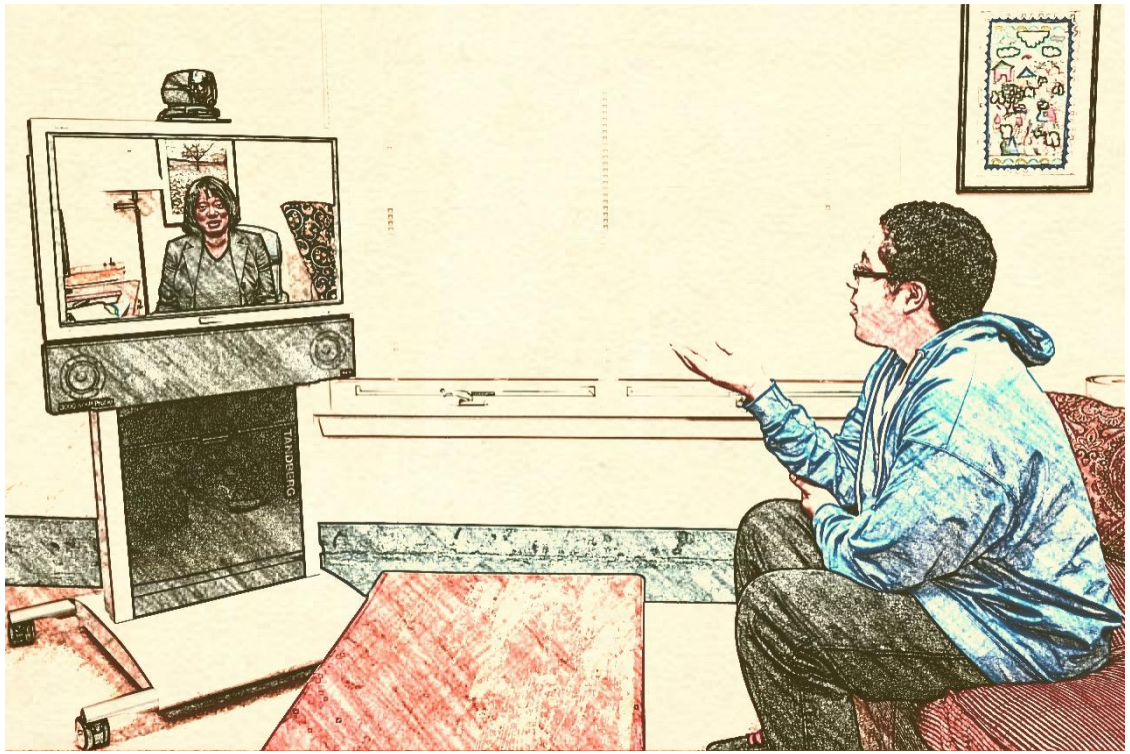
Project Goals

- Support statewide efforts by expanding treatment services to Maryland residents with opioid dependence via telehealth
- Establish telehealth capabilities and protocols for addiction treatment clients in Montgomery County
- Improve addiction treatment client outcomes
- Provide treatment in an integrated care delivery approach, utilizing the State-Designated health information exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP) to verify controlled substance prescriptions, emergency room visits, and hospitalizations

Mosaic Community Services Inc.

TeleMAT Project

May 2018 – November 2019



Restoring critically-needed addiction treatment services with Medication Assisted Treatment via telehealth in Montgomery County, Maryland

Overview

The Mosaic TeleMAT Project
provides critically needed access to Medication Assisted Treatment (MAT) using a telehealth platform to connect Mosaic Baltimore area prescribers with at least 100 patients to be served by a new Partners in Recovery addiction treatment program in Montgomery County

Project Team

Project Director: Yvette Jefferson–Program Director, Partners in Recovery

Technical Manager: Oleg Tarkovsky, Division Director–Clinical Services

Clinical Consultant: Dr. Mark J. Illuminati, Addictionologist

Expected Results

The TeleMAT Project:

- ✓ Builds on Mosaic's highly successful use of telehealth with Outpatient Mental Health Clinic patients
- ✓ Restores recently lost addiction treatment services in Montgomery County
- ✓ Addresses a critical shortage of Prescribers for MAT by connecting Baltimore area Prescribers to Montgomery County clients via telehealth
- ✓ Monitors specific Maryland Outcome Management System (OMS) clinical indicators to evaluate outcomes for telehealth vs. non-telehealth clients in the areas of:
  - "Substance Use"
  - "Functioning"
  - "Recovery"
  - "Psychiatric Symptoms - Overall"

Next Steps

- May 2018: Launch the project
- August 2018: Go-live with the technology
- March 2019: Report on implementation progress and preliminary outcomes
- October 2019: Release final outcomes

Thank You!

The MARYLAND
HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

Overview of Upcoming Initiatives

(Agenda Item #7)


ENJOY THE REST OF
YOUR DAY