Maryland Health Care Commission

Thursday, November 15, 2018

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**
2. UPDATE OF ACTIVITIES
3. ACTION: 2019 MCDB Data Submission Manual
4. PRESENTATION: Diabetes Measure and the Potential of Maryland's APCD
5. ACTION: Approval for Release – Maryland Trauma Physician Services Fund Annual Report
6. ACTION: Request for Project Change After Certificate of Need Approval – Coastal Hospice & Palliative Care (Docket No. 17-22-2404)
7. ACTION: Request for Project Change After Certificate of Need Approval - Stella Maris, Inc. (Docket No. 16-03-2376)
8. PRESENTATION: Review of Preliminary Draft CON Modernization Recommendations
9. PRESENTATION: NHRI Total Cost of Care Report
10. UPDATE: Maryland Healthcare Quality Reports Website and Leapfrog Group Release
11. OVERVIEW OF UPCOMING INITIATIVES
12. ADJOURNMENT

APPROVAL OF MINUTES

(Agenda Item #1)

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UPDATE OF ACTIVITIES

(Agenda Item #2)

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ACTION:

2019 MCDB Data Submission Manual

(Agenda Item #3)

2019 MCDB Data Submission Manual

COMMISSION MEETING

NOVEMBER 15, 2018

Overview

- Background
- Refresher on MCDB Reporting Requirements
- Review changes of the 2019 Data Submission Manual
- Seek approval of the 2019 Data Submission Manual

Background

- The Maryland Health Care Commission is required in regulation (COMAR 10.25.06.15) to make MCDB Data Submission Manual available to payors by November 21 of each year.

- Payors will use the Manual for the reporting periods in the subsequent year.

- Regulation also requires a timely posting of the Manual on the Commission website each year.

What's included in the MCDB

- Commercial Reporting Entities with at least 1,000 total insured lives:
  - Life and Health Insurance Carriers and HMOs
  - TPAs, PBMs, Behavioral Health Administrators
  - Qualified Health Plans and Qualified Dental Plans
- Data reported:
  - Membership / Eligibility
  - Claims files: Professional, Institutional, Pharmacy, and Dental
  - Provider Directory
  - Non-Fee-for-Service Spending (Future)
- Medicaid MCO Data:
  - Provided by Medicaid via The Hilltop Institute
- Medicare Data:
  - Acquired through State Agency DUA with CMS

What's changing?

- No changes in Maryland's reporting requirements except for the following reminders:
  - Protection of Confidential Information in MCDB data submissions (COMAR 10.25.06.06)
  - Enforcing COMAR 10.25.06.06 via attestation to encrypt patient identifiers
  - Attestation by payors via the MCDB portal for each reporting quarter
  - Attestation excludes the CRISP demographic files
- Carrier Feedback: no negative responses on changes
- Promoting timely data submissions by:
  - Clarifying reporting final date requirements and validation checks
  - Enforcing fining authority for serious delinquent submissions

Next Steps

- Commission questions and vote on posting submission manual to Commission website
- Disseminate Manual and follow up with Payor Meetings
- Implement changes for submission starting in May 2019 for Q1 2019 Data Reports

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PRESENTATION:

Diabetes Measure and the Potential of Maryland's APCD

(Agenda Item #4)

Population Health: Diabetes Measure and the Potential of Maryland's APCD

Prepared by Judy Loren
for the Maryland Health Care Commission
November 15, 2018

Maryland's Total Cost of Care Model

- Goal 1: Improve population health
- Goal 2: Improve care outcomes for individuals
- Goal 3: Control growth of total cost of care

- http://www.hscrc.state.md.us/Documents/Modernization/7-30-18%20Announced%20Terms_FINAL.pdf

Examine Available Assets

- Maryland Medical Care Data Base (MCDB)
  - Maryland residents
  - Private, Medicaid and Medicare
- Johns Hopkins ACG® System
  - Risk adjustment
  - Population Health markers
- Population Health Example: Type 2 Diabetes
  - Privately insured adults
  - 2015/2016

Control Costs

- Monitor change in cost
  - Overall
  - Type 2 Diabetes
  - Secular trend comparison
  - Risk
    - Age group
    - Complications
- Two ways of doing year-to-year comparison
  - Compare overall utilization, cost, prevalence, etc.
  - Matched person

Monitor Change in Cost

Average Cost (in nominal dollars)

	2015	2016	% change
Total Population	$6,142	$6,428	5%
Type 2 Diabetes	$15,414	$16,554	7%

Average Risk* (relative morbidity)

	2015	2016	% change
Total Population	1.42	1.56	10%
Type 2 Diabetes	3.71	4.37	18%

Risk Adjusted Cost

	2015	2016	% change
Total Population	$4,322	$4,116	-5%
Type 2 Diabetes	$4,160	$3,790	-9%

* Average risk shown here is not an apples to apples comparison due to the change from ICD-9 to ICD-10 codes in late October 2015 .

Drivers of Cost: Aging

	Total Population								
	Average Cost			Average Risk			Count		
Age Group	2015	2016	% change	2015	2016	% change	2015	2016	% change
18-34	$4,041	$4,248	5%	0.80	0.87	9%	297,352	300,605	1%
35-44	$5,143	$5,442	6%	1.14	1.25	9%	192,975	201,132	4%
45-54	$6,439	$6,729	5%	1.55	1.70	9%	260,681	261,079	0%
55-64	$9,013	$9,302	3%	2.18	2.40	10%	270,429	281,815	4%

Estimate Potential Savings: Simple Example

Type 2 Diabetes without Complications	Per Person	Type 2 Diabetes with Complications	Per Person	Potential Savings per Person
33,909	$909	30,233	$2,001	$1,092

Drivers of Cost for Diabetes: Complications

	Number of People 2016	Average Monthly Cost	Increase in Cost	% of DM2 Population 2015	% of DM2 Population 2016
None of the following	**42,228**	**$982**	**Base**	65%	66%
Cataract	10,119	$1,711	74%	15.0%	15.8%
Diabetic Retinopathy	2,541	$2,728	178%	5.8%	4.0%
Neuropathy	5,104	$2,922	198%	8.6%	8.0%
Stroke/CVD	3,529	$3,128	219%	5.3%	5.5%
Angina	4,745	$3,294	235%	7.0%	7.4%
Peripheral Vascular Disease	2,804	$3,374	244%	4.4%	4.4%
Myocardial Infarction	744	$6,187	530%	1.1%	1.2%
Congestive Heart Failure	1,476	$6,207	532%	2.2%	2.3%
Amputation	133	$8,153	730%	0.5%	0.2%
Nephropathy and ESRD	841	$9,697	888%	1.3%	1.3%

Prevent Chronic Conditions

- Monitor prevalence and incidence
  - Compare with other sources of information
  - Estimate potential savings

Evaluate and Monitor Prevalence of Diabetes

Age	Number of People in Study	Number of People with Type 2 Diabetes	Percent of Study Population with Type 2 Diabetes	BRFSS Rate[1] (Type 1 and Type 2)
18-34	300,605	1,428	0%	3%
35-44	201,132	5,703	3%	5%
45-54	261,079	19,457	7%	10%
55-64	281,815	37,554	13%	17%
Total	**1,044,631**	**64,142**	**6%**	**10%**

[1]Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed Sep 25, 2018]. URL: https://www.cdc.gov/brfss/brfssprevalence/, select Maryland, select Chronic Health Indicators, select Diabetes, select 2016, view by age group.

Evaluate and Monitor Prevalence of Diabetes

County	Study Population	Type 2 Diabetes	Percent
Somerset	3,074	318	10%
Dorchester	4,059	382	9%
Prince George's	124,649	11,170	9%
Baltimore City	70,034	5,803	8%
Charles	29,850	2,333	8%
Wicomico	15,060	1,148	8%
Allegany	8,052	612	8%
Washington	16,667	1,188	7%
Caroline	5,338	380	7%
Saint Mary's	22,187	1,514	7%
Baltimore	110,728	7,392	7%
Kent	3,257	210	6%

County	Study Population	Type 2 Diabetes	Percent
Calvert	20,685	1,313	6%
Worcester	9,702	590	6%
Garrett	2,525	149	6%
Harford	45,234	2,661	6%
Cecil	12,470	715	6%
Anne Arundel	105,432	5,975	6%
OUT OF STATE	95,398	5,018	5%
Queen Anne's	9,711	510	5%
Talbot	6,478	325	5%
Carroll	33,972	1,701	5%
Frederick	46,934	2,225	5%
Howard	65,673	2,892	4%
Montgomery	177,462	7,618	4%

Change in Prevalence of Diabetes

Type 2 Diabetes in 2015/2016	% of Population	Cost	Risk
No	92%	$6,238	1.49
New in 2016	2%	$16,727	4.47
Continuing	6%	$16,121	4.17

Estimate Savings from Prevention

- Savings = Cost of New Case minus Cost of No Diabetes
- $16,727 - $6,238 per case

% cases	Savings
5%	0.13%
10%	0.26%
20%	0.53%
40%	1.06%
60%	1.58%
80%	2.11%

Improve Care Coordination

- How to measure care coordination
- Costs/savings

Care Coordination: Type 2 Diabetes

Unique Provider Count	Average Monthly Cost	Average Risk	Risk Adjusted Cost	Increase in Cost
0	$1,531	3.97	$386	32%
1	$544	1.86	$292	Base
2	$785	2.55	$308	5%
3-5	$1,381	4.26	$324	11%
6+	$3,144	9.39	$335	15%

Model Goals: MCDB and ACG

- Control cost
- Manage chronic conditions
- Improve care coordination

- Measure cost
- Identify chronic conditions
- Identify care coordination issues
- Identify specific complications
- Over time:
  - Monitor incidence
  - Track improvement
  - Measure savings

MARYLAND HEALTH CARE COMMISSION

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ACTION:

Approval for Release – Maryland Trauma Physician Services Fund Annual Report

(Agenda Item #5)

THE MARYLAND TRAUMA PHYSICAN SERVICES FUND

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Maryland Trauma Physician Services Fund

Background

- During the 2003 Legislative Session, the Maryland General Assembly established the Maryland Trauma Physician Services Fund (Fund, Trauma Fund) to aid Maryland's trauma system by reimbursing trauma physicians for uncompensated care losses and by raising Medicaid payments to 100 percent of the Medicare rate when a Medicaid patient receives trauma care.
- The legislation also established a formula for reimbursing trauma centers for trauma-related on-call expenses for trauma surgeons, orthopedists, neurosurgeons, and anesthesiologists. The legislation also directed the Health Services Cost Review Commission to allow trauma center hospitals to include trauma-related standby expenses in approved rates.
- The Trauma Fund is financed through a $5.00 fee on automobile registrations and renewals.

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Maryland Trauma Physician Services Fund

The Legislation expands

- 2006 - Expanded eligibility to uncompensated care and extended Medicaid reimbursement to physicians providing trauma care. Increased on-call payments to Level II and Level III Trauma Centers. Replaced the per specialty limit for on-call with a per center limit on hours. Extended uncompensated care payments to include the Johns Hopkins Burn Center, Johns Hopkins Eye Trauma at the Wilmer Institute, and the Hand Trauma Center at Union Memorial. Increased the ceiling on the stipend for Children's National Medical Center to $490,000.
- 2008 - Permitted the Level I Trauma Centers, Pediatric Trauma Center, and 3 specialty referral centers to receive a limited on-call stipend. Authorized physicians to receive uncompensated care payments for care provided at trauma center-affiliated rehabilitation hospitals. Raised the cap on uncompensated care reimbursement for emergency medicine physician practices. Increased the annual grant to Children's National Medical Center to $590,000. Permitted MHCC to award grants to Level II and Level III Centers for trauma related equipment from the fund balance. Permitted MHCC to adjust uncompensated care and on-call rates.

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Maryland Trauma Physician Services Fund

- 2009 - Permitted Level III Trauma Centers to receive on-call stipends for up to 70,080 hours per year to maintain trauma, orthopedic, neuro, plastic, vascular, thoracic, oral or maxillofacial surgeons, and anesthesiologists. Gave MHCC authority NOT to reimburse Level III Trauma Centers for on-call hours under this change for trauma on-call exceeding 35,040 until the remaining costs eligible for reimbursement for Level I, II, III, pediatric and specialty referral centers are fully funded.
- 2012 – Removed the statutory restriction that expenditures from the fund may not exceed the fund's revenues in a fiscal year.
- 2013 – Additional on-call reimbursement for Level III trauma centers noted above was abrogated and of no further force and effect as of the end of September, 2013.

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Maryland Trauma Physician Services Fund

Payments from the Fund:

- Provides payments to offset the costs of uncompensated and undercompensated medical care provided by trauma physicians to patients at Maryland's designated trauma centers.
- Provides a stipend to trauma centers to offset the trauma centers' on-call and standby expenses.
- Provides grant funding to trauma centers for certain equipment.
- Reimburses Medicaid for the State's portion of Medicaid underpayment (Difference between 100% of the Medicare Fee Schedule and Medicaid rate).

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Maryland Trauma Physician Services Fund

Our Resources

- *MIEMSS* – provides registry data
- *CoreSource, Inc.* – our third party administrator for uncompensated care claims (contract ends 6/30/19)
- *Myers and Stauffer – our* auditor for practices and trauma centers (contract ends 6/30/19)
- *Medicaid* - provides reports on the state share for Managed Care Organizations and Fee For Service reimbursement
- *Department of Motor Vehicles* – reports to the MHCC on revenues projected and collected
- *Comptroller of Maryland* – sends all reimbursements via check/ACH

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Maryland Trauma Physician Services Fund

Fiscal Year 2018 – Key Points on Revenues

- Surplus funds carried over from Fiscal Year 2017 totaled $10,413,745
- Fiscal Year 2018 revenue from DMV totaled $12,445,331
- Fiscal Year 2018 credits to the Fund totaled $87,268
- The total of surplus at the close of Fiscal Year 2018 was $11,025,142
- The Budget Reconciliation Financing Act (BRFA) reduced the fund balance by $8,000,000, leaving a surplus balance to begin FY 2019 of $3,025,142

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Maryland Trauma Physician Services Fund

Fiscal Year 2018 – Key Points on Expenditures

- Expenditures during Fiscal Year 2018 totaled $11,921,201(refund checks reduce expenditures)
- Uncompensated Care Expenditures totaled $1,599,446
- On-Call Expenditures totaled $7,914,887
- Payments to Medicaid totaled $1,109,730 (Includes adjustment for FYs 16 &17)
- Children's National Medical Center Standby totaled $590,000
- Trauma Equipment Grants totaled $599,998
- Administrative Expenses totaled $107,140

- Fiscal Year 2019 Appropriation is $12,000,000.

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Maryland Trauma Physician Services Fund

Reimbursement Rates Have Been Adjusted to Protect the Solvency of the Fund

- Fiscal Years 2003 – 2009 – Reimbursement rates were 100% of the Medicare rate for the Baltimore region.
- Fiscal Years 2010 – 2015 - Reimbursement rates were reduced to 92% of the Medicare Rate for the Baltimore region, with the exception of Medicaid. Medicaid remained at 100%
- Fiscal Year 2016 - Reimbursement rates were restored to 100% of the Medicare rate for the Baltimore region.
- Fiscal Years 2017 – 2018 – Reimbursement rates were increased to 105% of the Medicare rate for the Baltimore region, with the exception of Medicaid

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Maryland Trauma Physician Services Fund

On the Horizon

- Revamp the trauma registry data processes that support Core Source (the third party administrator).
- Redesign MHCC's trauma educational and training website.
- Work more closely with the trauma community to gather information and recommendations to allow trauma-related uses of Fund balances.

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Maryland Trauma Physician Services Fund

Recommendations for Approval by the Commission

- Continue reimbursement for uncompensated care and on-call stipends at 105% of the Medicare Fee Schedule rate for the Baltimore region.

- Pay Medicaid underpayment trauma claims using the same payment rates and policies that apply to uncompensated care claims. Reimbursement rates would become 105% of the Medicare Fee Schedule rate for the Baltimore region.

- Pay second and subsequent procedures on Medicaid trauma claims using the same payment rates and policies that apply to uncompensated care claims. Secondary procedures would be reimbursed at 105% of the Medicare Fee Schedule rate for the Baltimore region. No secondary procedure fee reduction would be applied.

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ACTION:

Request for Project Change After Certificate of Need Approval – Coastal Hospice & Palliative Care (Docket No. 17-22-2404)

(Agenda Item #6)

MARYLAND HEALTH CARE COMMISSION

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ACTION:

Request for Project Change After Certificate of Need Approval - Stella Maris, Inc. (Docket No. 16-03-2376)

(Agenda Item #7)

MARYLAND HEALTH CARE COMMISSION

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PRESENTATION:

Review of Preliminary Draft CON Modernization Recommendations

(Agenda Item #8)

CON Task Force
Draft Recommendations

Presentation to the Maryland Health Care Commission

November 15, 2018

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Context for the Recommendations

- **Successful implementation of CON reforms will proceed on three different tracks**

1. Regulatory actions that can be started immediately.
   - Modernization requires modifications to SHP chapters and the procedural regulations
   - Pace of work is dependent on…
     - Building consensus among stakeholders
     - Staff workload, a rewrite of a SHP chapter can take ~ 9-12 months
     - MHCC may wish to consider obtaining consultants to assist in rewrites
2. Statutory changes that could be sought In 2019/2020 General Assembly Session...
   - Must obtain approval from the Governor's Legislative Office and build consensus among stakeholders
   - Statutory changes will require supporting regulatory changes
3. Areas for further study from which further regulatory and statutory changes are likely to emerge...
   - Removing certain services from the scope of CON regulationwill require determining which agency will assume the "gatekeeper" role
   - Some reforms require statutory action likely to have an impact on a sister agency such as the Office of Health Care Quality (MDH) or the Health Services Cost Review Commission

- **MHCC should be focused on modernization and recognize some reforms will require time. Success or failure won't be determined in twelve months, but let's begin in 2019.**

RECOMMENDATIONS

MARYLAND HEALTH CARE COMMISSION

REGULATORY REFORMS THAT CAN BE STARTED IMMEDIATELY

MARYLAND HEALTH CARE COMMISSION

IMMEDIATE REGULATORY REFORMS: RECOMMENDATION 1

Identify the State Health Plan chapters that are most in need of updating and which offer the greatest potential to meet reform objectives and prioritize their revision

Simultaneously review and revise the procedural regulations governing CON application review

MARYLAND HEALTH CARE COMMISSION

IMMEDIATE REGULATORY REFORMS (CONTINUED): RECOMMENDATION 1a.

In updating SHP chapters, limit SHP standards to consideration of project need, viability, impact, access, and applicant qualifications

- Address the quality of care and "gatekeeper" functions by setting performance or track record qualification standards that must be met to become an applicant

- Standards that do not address these five specific criteria should only be included if absolutely necessary to the particular characteristics of a health care facility or the standard is needed to address a facility-specific problem

- Eliminate extraneous standards or redefine standards that currently have low impact (e.g., current charity care requirements for home health agencies and hospice)

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IMMEDIATE REGULATORY REFORMS (CONTINUED): RECOMMENDATION 1 b.

Revise performance requirements for approved projects to consist of deadlines for:

- obligating the capital expenditure;
- initiating construction.

Eliminate project completion deadlines for construction projects. Timely obligation and initiation of construction will result in a 12-month extension with subsequent annual requirements to report progress, each of which would result in additional 12-month extensions until project completion.

Failure to timely obligate and initiate construction will void the CON.

Projects that do not involve construction will continue to have a deadline for completing the project (e.g., 18 months to license an approved home health agency or hospice program).

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IMMEDIATE REGULATORY REFORMS (CONTINUED): RECOMMENDATION 1c.

Make the review of changes in approved projects a staff review function with approval by the Executive Director. Limit required change reviews to:

1) Changes in the financing plan that require additional debt financing and/or extraordinary adjustment of a hospital's budgeted revenue;
2) Change in project location;
3) Change in the "medical services" approved to be provided by the facility.
4) Allow applicants and interest parties an opportunity to appeal a decision of the Executive Director to the Commission.

Continue the current list of impermissible changes.

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IMMEDIATE REGULATORY REFORMS: RECOMMENDATION 2

Create:

- a waiver of CON requirements for a hospital capital project that is endorsed by the Health Care Cost Review Commission (HSCRC) staff as a viable approach for reducing the total cost of care consistent with HSCRC's Total Cost of Care model

- a docketing rule allowing consideration of a proposed project that offers an alternative model for post-acute care that is endorsed by the HSCRC staff as a viable approach for reducing the total cost of care consistent with HSCRC's model

STATUTORY CHANGES THAT COULD BE SOUGHT IN 2019/2020 LEGISLATIVE SESSION

MARYLAND HEALTH CARE COMMISSION

FUTURE STATUTORY CHANGES: RECOMMENDATION 1

Eliminate capital expenditures as an action requiring CON approval for all provider categories except hospitals; only projects fitting the categorical requirements (new health care facility, facility relocation, change in bed capacity, introduction of new medical service) would continue to require a CON no matter what capital expenditure is required.

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FUTURE STATUTORY CHANGES: RECOMMENDATION 2

Replace existing capital expenditure threshold for hospitals with a provision that hospitals must only obtain CON approval for a project if:

- its estimated expenditure exceeds a specified proportion of the hospital's annual budgeted revenue; and

- the hospital is requesting an increase to its Global Budgeted Revenue, based on an increase in capital costs.

MARYLAND HEALTH CARE COMMISSION

FUTURE STATUTORY CHANGES: RECOMMENDATION 3

Change the CON statute, as necessary, to limit required considerations in a CON project review to:

a. The project's consistency with applicable State Health Plan standards;
b. Need for the project;
c. Viability of the project and the facility;
d. Impact of the project on access to care;
e. Impact of the project on cost and charges;
f. Compliance with the terms and conditions of previous Certificates of Need.

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FUTURE STATUTORY CHANGES: RECOMMENDATION 4

Expedite CON review of changes in bed capacity in existing:

- Alcohol and drug abuse treatment intermediate care facilities
- Residential treatment centers.

Concern was expressed about giving a "free pass" on project need for established providers to expand while applying a more stringent need standard to a new market entrant. Such an approach

- could violate interstate commerce clause or
- stifle innovation

Some Task Force members argued that there should be a truncated process for an applicant that had already proven its suitability.

A compromise might be streamlining the review for a previously-vetted applicant by limiting CON review to considering the need for the project.

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FUTURE STATUTORY CHANGES: RECOMMENDATION 5

Eliminate changes in acute psychiatric bed capacity by a general hospital from CON review. (Changes in bed capacity at freestanding special psychiatric hospitals would require a CON.)

See concerns raised in slide 14.

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FUTURE STATUTORY CHANGES: RECOMMENDATION 6

Eliminate changes in general hospice bed capacity by an existing general hospice from CON review.

See concerns raised in slide 14.

MARYLAND HEALTH CARE COMMISSION

FUTURE STATUTORY CHANGES: RECOMMENDATION 7

Define *ambulatory surgical facility* as an outpatient surgical center with three or more operating rooms instead of the current definition's threshold of two operating rooms. MHCC would use a determination of coverage process administered by staff to review the proposed establishment of outpatient surgical centers with no more than two operating rooms.

Apply the rule equally to all persons regardless of ownership or organizational structure. Thus, hospitals, physicians, or joint ventures involving hospitals and physicians or other types of corporations and physicians would be eligible to establish outpatient surgical centers with up to two operating rooms.

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FUTURE STATUTORY CHANGES: RECOMMENDATION 8

Limit the requirement for CON approval of changes in operating room capacity by hospitals to the rate-regulated hospital setting, i.e., a general hospital and any other entity would have the ability, under the new definition of ambulatory surgical facility, to establish one or two-operating room outpatient surgical centers without CON approval. MHCC could issue a determination of coverage after a plan review by staff and MHCC's notification to HSCRC that the hospital's GBR may need to be reduced.

Note: the MHCC notification to HSCRC would be aimed at better coordinating the reduction in GBR to account for the migration of services into unregulated settings.

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AREAS FOR FURTHER STUDY FROM WHICH FURTHER REGULATORY AND STATUTORY CHANGES ARE LIKELY TO EMERGE

MARYLAND HEALTH CARE COMMISSION

AREAS FOR STUDY: RECOMMENDATION 1

Engage with stakeholders such as the home health, hospice, alcoholism and drug treatment, and residential treatment center sectors and the Maryland Department of Health to consider developing alternatives to CON regulation as a way to accomplish the "gatekeeper" function of keeping organizations with poor track records in quality of care and/or integrity out of Maryland and allowing only gradual expansion of such facilities.

The objectives would be to:

1. Eliminate CON-style regulation for these health care facility categories with MDH incorporating the gatekeeper function into the facility licensure process; or

2. Make MHCC's role in regulating these facility categories solely that of a gatekeeper. That is, any such facility that gets a clean bill of health in a background check and character and competence review would be issued a CON, without further review….as long as that is compatible with limits on how rapidly the number of new providers can grow.

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AREAS FOR STUDY: RECOMMENDATION 2

Engage with HSCRC on ways in which hospital CON project review and the total cost of care project can be further integrated.

The objective would be to limit hospital projects requiring CON review and to improve MHCC's use of HSCRC expertise in consideration of project feasibility and project and facility viability. Allow MHCC to delegate the review of hospital project feasibility and viability to HSCRC if both agencies agreed on the hand off.

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AREAS FOR STUDY: RECOMMENDATION 3

Consider structural changes in how the Commission handles CON project reviews to incorporate a (Commissioner) project review committee (rather than single Commissioner/Reviewers) and ways in which to increase meaningful participation by the public in the regulatory process.

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MARYLAND HEALTH CARE COMMISSION

AGENDA

1. APPROVAL OF MINUTES
2. UPDATE OF ACTIVITIES
3. ACTION: 2019 MCDB Data Submission Manual
4. PRESENTATION: Diabetes Measure and the Potential of Maryland's APCD
5. ACTION: Approval for Release – Maryland Trauma Physician Services Fund Annual Report
6. ACTION: Request for Project Change After Certificate of Need Approval – Coastal Hospice & Palliative Care (Docket No. 17-22-2404)
7. ACTION: Request for Project Change After Certificate of Need Approval - Stella Maris, Inc. (Docket No. 16-03-2376)
8. PRESENTATION: Review of Preliminary Draft CON Modernization Recommendations
9. **PRESENTATION: NHRI Total Cost of Care Report**
10. UPDATE: Maryland Healthcare Quality Reports Website and Leapfrog Group Release
11. OVERVIEW OF UPCOMING INITIATIVES
12. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

NHRI Total Cost of Care Report

(Agenda Item #9)

MARYLAND HEALTH CARE COMMISSION

Findings from the 2016 NRHI Report "Healthcare Affordability: Untangling Cost Drivers"

The Maryland Story

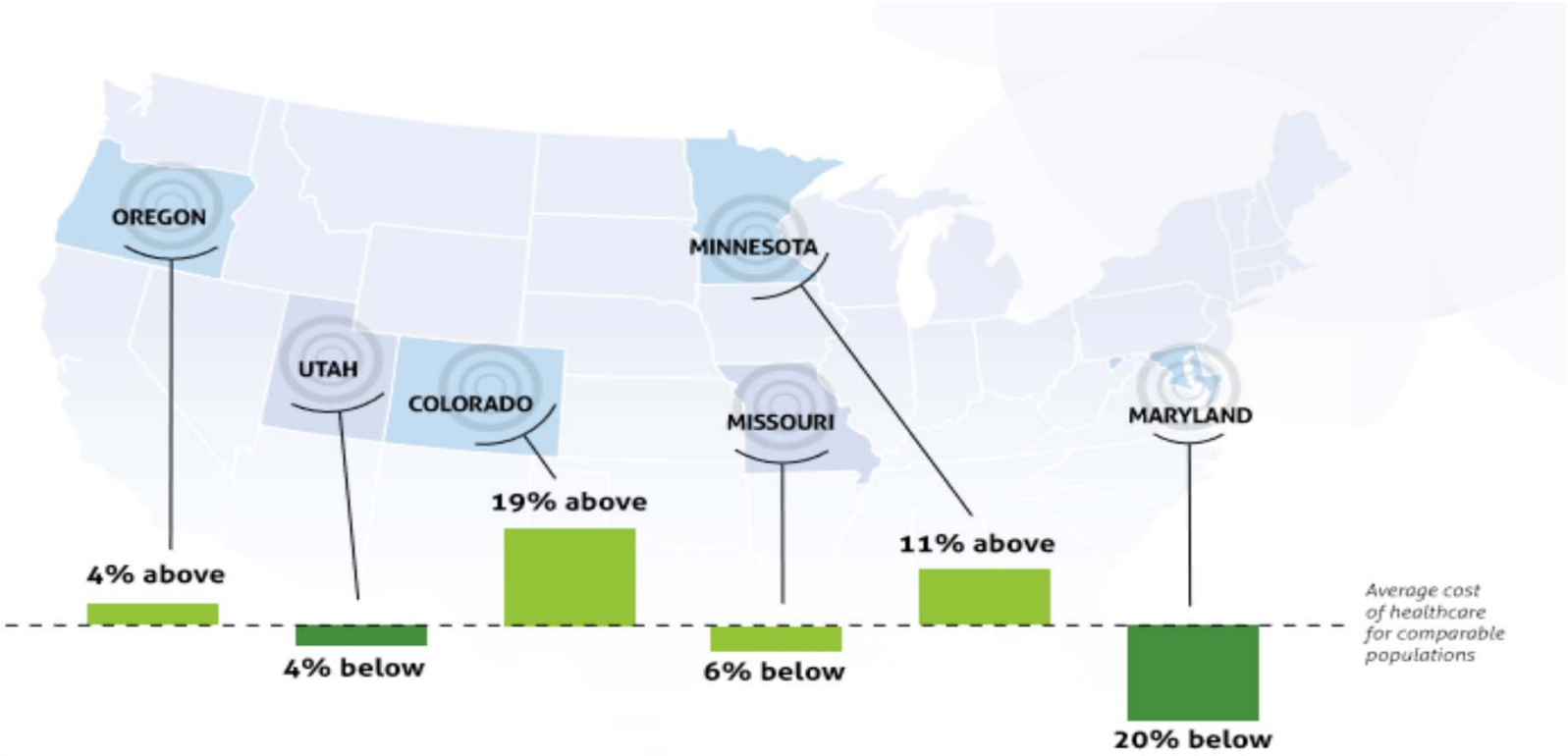
COMMISSION MEETING

NOVEMBER 15, 2018

Overview

- The Big Picture
- How does Maryland differ
- Maryland's Total Cost of Care Performance
- Maryland's Total Cost and Risk 2014 – 2016
- FAQs

The Big Picture



How does Maryland differ?

Risk Adjusted Total Cost and Resource Use Compared to Average

Commercial Population 2016

Combined Attributed and Unattributed

Measure	Colorado	Maryland	Minnesota	Oregon	St. Louis, MO	Utah
Risk Score	-7%	15%	-1%	-2%	4%	-9%
Total Cost	19%	-20%	11%	4%	-6%	-4%
Resource Use	5%	-7%	7%	-10%	10%	-5%
Price	13%	-14%	4%	16%	-15%	1%

Maryland Performance Is Mainly Due to Prices

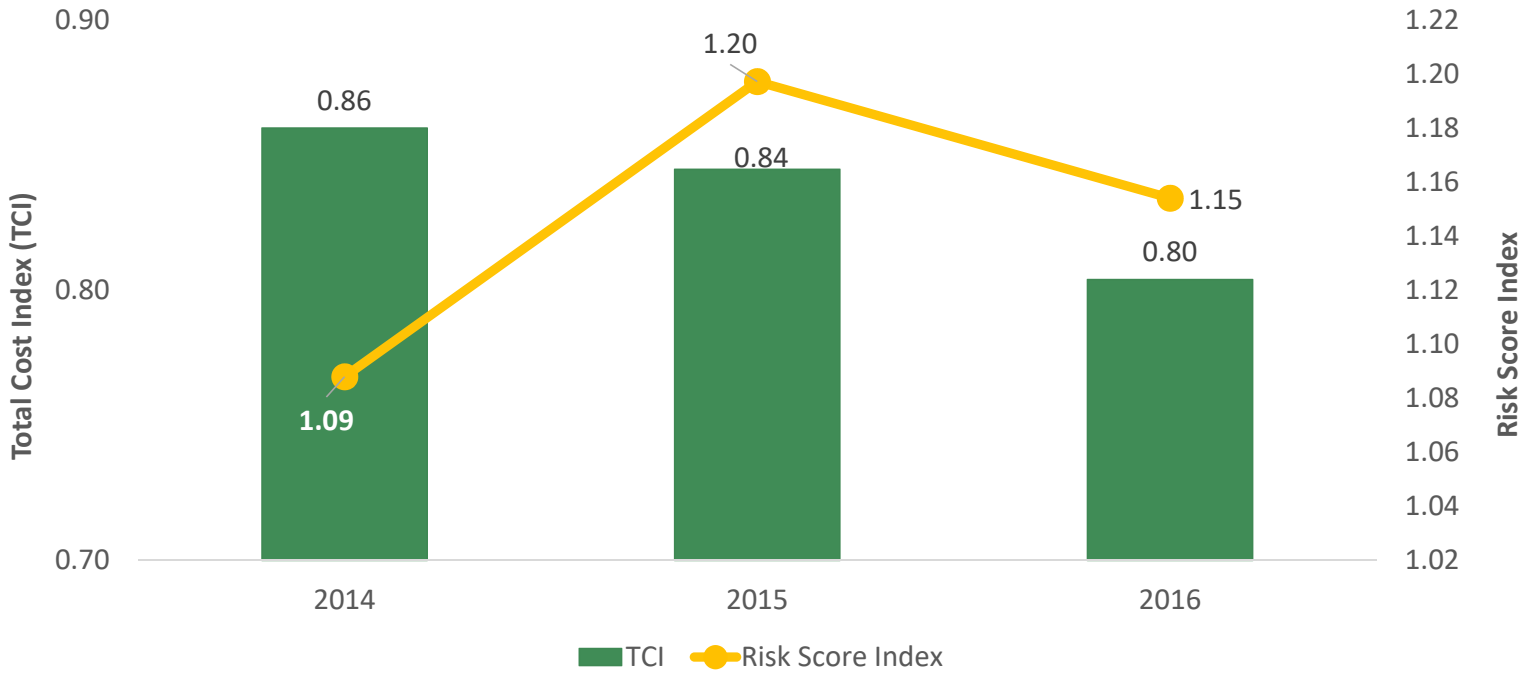
Total Cost of Care and Rankings by Service Category

Commercial Population 2016

Combined Attributed and Unattributed

Service Category	Total Cost Index		Resource Use Index		Price Index	
	Compared to Average	Rank	Compared to Average	Rank	Compared to Average	Rank
Overall	**-20%**	**1**	**-7%**	**2**	**-14%**	**2**
Inpatient	-27%	1	-10%	2	-19%	2
Outpatient	-34%	1	-26%	1	-11%	2
Professional	-16%	2	2%	5	-18%	1
Pharmacy	-3%	4	-4%	4	1%	3

Maryland's Total Cost and Risk Compared to the Average by Year (2014 – 2016)



FAQs

How do we explain Maryland's lower hospital & professional prices?

- Hospital all-payer rate-setting
  - Limits the need for hospitals to shift unreimbursed costs from Medicare & Medicaid to private payers
- Professional rates reflect a historic trend of private professional rates (overall) being at about Medicare rates
  - Ample physician supply + a dominant payer, and shadow pricing by other payers

Does this mean Maryland prices are too low?

- Not compared to prices in the rest of the developed world (OECD member countries)

How will MHCC respond to this information?

- Regarding Utilization
  - MHCC will identify & publish opportunities for reducing utilization by evaluating the use of low value care (Choosing Wisely) in Maryland's commercial population.
  - Share information with other state partners on the potential impact of the new Maryland Total Cost of Care Model on the privately insured population
- Regarding Prices
  - Center for Analysis will continue to add episode cost information to the Wear the Cost website

MARYLAND HEALTH CARE COMMISSION

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UPDATE:

Maryland Healthcare Quality Reports Website and Leapfrog Group Release

(Agenda Item #10)

MARYLAND HEALTH CARE COMMISSION

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Overview of Upcoming Initiatives

(Agenda Item #11)


ENJOY THE REST OF
YOUR DAY