Maryland Health Care Commission

Thursday, May 16, 2019

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**

2. **UPDATE OF ACTIVITIES**

3. **ACTION:** Certificate of Need - Peninsula Regional Medical Center –Introduction of Inpatient Child and Adolescent Psychiatric Hospital Services (Docket No. 18-22-2417)

4. **ACTION:** Certificate of Need - University of Maryland Medical Center- Introduction of Inpatient Adolescent Psychiatric Hospital Services (Docket No. 18-24-2429)

5. **ACTION:** Certificate of Ongoing Performance for Cardiac Surgery Services
   - A. **ACTION:** University of Maryland Medical Center (Docket No. 17-24-CP006)
   - B. **ACTION:** Sinai Hospital of Baltimore (Docket No. 17-24-CP005)

6. **ACTION:** Maryland Primary Care Program - Advisory Council Nominations

7. **ACTION:** Report: *Health Record and Payment Integration Program Advisory Committee Recommendations* (Senate Bill 896, 2018 Legislative Session)

8. **PRESENTATION:** CMS Primary Cares Initiative

9. **OVERVIEW OF UPCOMING ACTIVITIES**

10. **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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MARYLAND HEALTH CARE COMMISSION

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Certificate of Need - Peninsula Regional Medical Center –Introduction of Inpatient Child and Adolescent Psychiatric Hospital Services
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(Agenda Item #3)

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

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Certificate of Need - University of Maryland Medical Center- Introduction of Inpatient Adolescent Psychiatric Hospital Services (Docket No. 18-24-2429)

(Agenda Item #4)

MARYLAND HEALTH CARE COMMISSION

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(Agenda Item #5)

Development of Certificate of Ongoing Performance Review Standards

- Maryland legislature passed a law in 2012 directing MHCC to adopt new regulations for the oversight of cardiac surgery and percutaneous coronary intervention services.

- Clinical Advisory Group (CAG) with national and regional experts was convened to develop recommendations.

- MHCC adopted regulations consistent with the CAG's recommendations that became effective in August 2014 and then subsequently twice updated these regulations.

Certificate of Ongoing Performance Reviews for Cardiac Surgery Programs

Overview of Review Criteria

- Data collection
  - Participation in STS-ACSD Registry and other required data collection
- Quality
  - CEO certification; peer review; responsive to findings from quality assurance processes
- Performance metrics
  - STS-ACSD composite star rating for isolated CABG
  - All-cause 30-day risk-adjusted operative mortality rates
- Volume
  - Target case volume of 200 cases

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ACTION:

Maryland Primary Care Program - Advisory Council Nominations

(Agenda Item #6)

Maryland Primary Care Program

Advisory Council

May 16, 2019

Background

- At the April 17th meeting, Commissioners approved 20 nominations for the Maryland Primary Care Program (MDPCP) Advisory Council
    - Nomination of Medicare beneficiary representative deferred
- Commissioners noted the importance of nurse practitioner perspectives on the Council and requested staff explore additional nominations

Overview and Purpose

Overview of the Maryland Primary Care Program (MDPCP)

- Voluntary program open to all qualifying Maryland primary care providers
- Provides funding and support for the delivery of advanced primary care
- Supports the overall health care transformation process and allows primary care providers to play an increased role in prevention, management of chronic disease, and preventing unnecessary hospital utilization
- MDPCP is an advanced alternative payment model, which is a care delivery and payment model that incentivizes high quality care

3

Purpose of the Advisory Council

- Provide input from key stakeholders to the operations of the MDPCP
- Serve a consultative and advisory role to the Secretary of the Maryland Department of Health (MDH) and the MDPCP program office (PMO)

4

Role and Responsibilities

MHCC's Role

- Staff will provide administrative management and support services, such as:
  - Convening the Advisory Council
  - Selecting representatives and making recommendations on reappointments, in collaboration with the PMO and the Health Services Cost Review Commission, and Researching issues under consideration by the Advisory Council
  - Examining a specific issue in the Total Cost of Care Model or the Medicaid Program that affects the MDPCP, as requested by the Advisory Council

5

Advisory Council Responsibilities

- Recommendations for inclusion in the State's annual report to CMS on MDPCP
- Assess implementation and recommend improvements
- Gather data from MDPCP program participants and beneficiaries to support issue research
- Request other MDH agencies to examine specific issues

6

Membership and Nomination

Primary Care Representative Nominee

- Cathy Chapman, CRNP, RN

Membership

No. of Slots	Membership Category	Members
5	Primary Care, four of which are MDPCP Clinicians	Nkem Okeke, MD; Medicalincs Michael Riebman, MD; Maryland Primary Joseph Weidner, MD; Stone Run Family M Carol Alter, MD; Mindoula Health TBD
1	MHA	Bob Atlas; Maryland Health Association
2	Health Systems	Scott Berkowitz, MD; Johns Hopkins Patrick Dooley; University of Maryland M
1	CTO	Gene Ransom; MedChi
3	Advanced Primary Care	Debora Kuchka-Craig, MedStar Health Michael Barr, MD; National Committee fo Assurance Robert Berenson, MD; The Urban Institut
2	Private Payers	Stacia Cohen; CareFirst Mai Pham, MD; Anthem

Membership (Cont.)

No. of Slots	Membership Category	Members
1	Medicaid MCO	Laura Herrera Scott, MD; AmeriGroup
1	Medicaid Advisory Committee	Scott Rose; Way Station, Inc.
2	Medicare Beneficiary	TBD Robyn Elliot; Public Policy Partners
1	Medicaid Director	Dennis Schrader
1	MHCC	Ben Steffen
1	HSCRC	Katie Wunderlich
1	PMO	Howard Haft, MD

8

Primary Care Representative Nominee Biography

- **Cathy Chapman, CRNP, RN**

  Ms. Chapman has been a nurse since 1979 and a nurse practitioner (NP) since 1995. Ms. Chapman's nursing experience includes intensive care, home health, hospice, and sexual assault forensic examination. Ms. Chapman is certified as a family primary care NP as well as a family psych-mental health NP. Ms. Chapman is also trained as a nurse therapist.

Commission Action

- Staff recommends the Commission approve the nomination for Cathy Chapman

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Report: *Health Record and Payment Integration Program Advisory Committee Recommendations*
(Senate Bill 896, 2018 Legislative Session)

(Agenda Item #7)

Health Record and Payment Integration Program Advisory Committee

Senate Bill 896

MARYLAND HEALTH CARE COMMISSION

May 16, 2019

Overview

- Senate Bill 896 passed during the 2018 legislative session
- MHCC tasked with conducting a health information technology (health IT) policy study to assess feasibility of creating a health record and payment integration program (or program)
- A report on the study findings and recommendations is due to the Governor and General Assembly by November 1, 2019

Approach

- Convened representatives from key stakeholder groups as required in law (Chapter 452)
- Advisory Committee deliberations were guided using information gathering grids to identify benefits, barriers/challenges, and potential solutions for a program
- Ongoing State and federal efforts (HIPAA/HITECH) informed discussions about select technology and policy matters
- Key themes informed development of the proposed recommendations

Study Requirements

Recommendations

Rationale

Findings

STUDY REQUIREMENT 1

- Feasibility of incorporating administrative health care claim transactions into the State-Designated Health Information Exchange (HIE)

RECOMMENDATION

- Establish a task force to conduct an in-depth feasibility assessment of making claims data available through CRISP, and evaluate other suitable alternatives, such as improving accuracy and availability of clinical data

RATIONALE

- A prior proof of concept demonstrated it is technically feasible to incorporate claims data into CRISP; however, legal, economic, and resource related matters were identified that need to be addressed

Findings *(Continued…)*

STUDY REQUIREMENT 2

- Feasibility of establishing a free and secure web–based portal that providers can use to create and maintain health records and file for payment for health care services provided

RECOMMENDATION

- No action at this time

RATIONALE

- Additional cost to stakeholders and availability of existing health IT solutions, including widespread diffusion of electronic health records

Findings *(Continued…)*

STUDY REQUIREMENT 3

- Feasibility of incorporating PDMP data into the State-Designated HIE so that prescription drug data can be entered and retrieved

RECOMMENDATION

- No action at this time

RATIONALE

- PDMP data is already available through CRISP

Findings (*Continued…*)

STUDY REQUIREMENT 4

- Approaches for accelerating the adjudication of clean claims

RECOMMENDATION

- No action at this time

RATIONALE

- Most claims are processed in significantly less time than required by current regulations (COMAR 31.10.11.14, *Uniform Claim Forms*); payors and providers are satisfied with the current approach

Findings *(Continued…)*

STUDY REQUIREMENT 5

- A unique patient identifier and technology to support magnetic stripe cards or smart cards

RECOMMENDATION

- No action at this time

RATIONALE

- Privacy and security concerns; misalignment with national efforts focused on interoperability between systems

Summary

- The pace of health IT development and adoption has accelerated over the last decade in Maryland and the nation
- The concept of a health record and payment integration program proposed in Senate Bill 896 is laudable; however, it's inconsistent with the evolution of the industry and many stakeholders' vision of the future
- Maryland should continue exploring opportunities to leverage existing health IT solutions to foster interoperability and enhance security controls to address evolving cybersecurity vulnerabilities

Commission Action

- Staff recommends the Commission accept the draft report as final for distribution to the Governor and General Assembly

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

CMS Primary Cares Initiative

(Agenda Item #8)

The Centers for Medicare & Medicaid Services – Primary Cares Initiative

May 16, 2019

MARYLAND HEALTH CARE COMMISSION

Overview

- The Centers for Medicare & Medicaid Services' (CMS) **Primary Cares Initiative** is a new set of payment models that will provide primary care providers and other providers with five new payment model options under two paths

- A five-year demonstration meant to test whether delivery of advanced primary care can reduce total cost of care

Payment Models

- Providers with advanced primary care capabilities that are prepared to accept increased financial risk in exchange for flexibility and potential rewards based on practice performance may qualify to participate in one of five new payment models

Primary Care First (PCF)

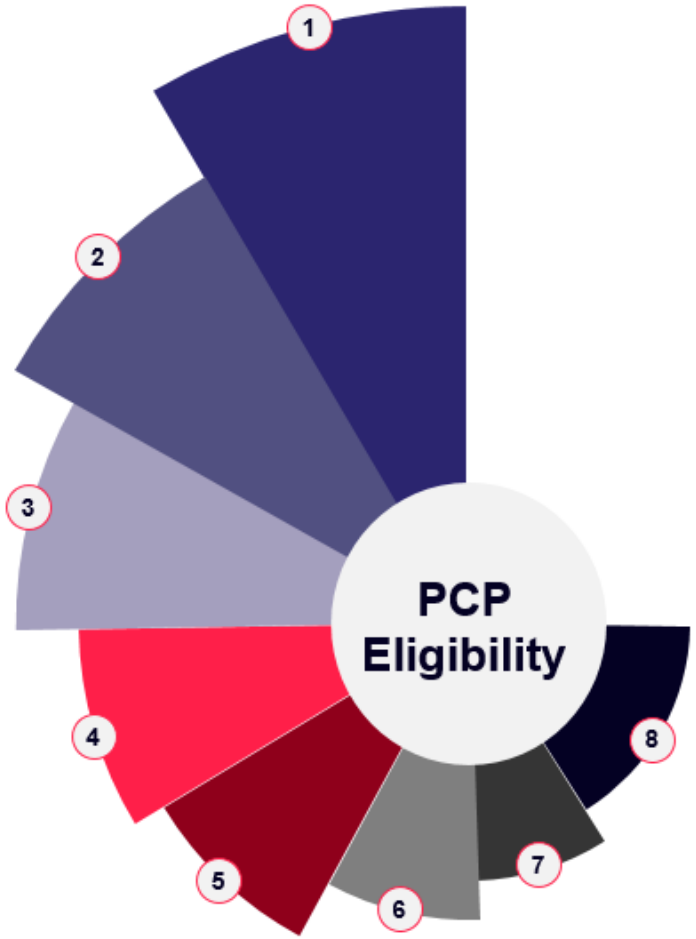
PCF Overview

- PCF is oriented around comprehensive primary care functions:
  - Access and continuity
  - Care management
  - Comprehensiveness and coordination
  - Patient and caregiver engagement
  - Planned care and population health
- PCF practices must meet quality care standards to be eligible for a positive performance-based adjustment to their primary care revenue
- Measures include:
  - A patient experience of care survey
  - Controlling high blood pressure
  - Diabetes
  - Hemoglobin A1c poor control
  - Colorectal cancer screening
  - Advance care planning

PCF Payment

- Payment to practices through a simplified total monthly payment (flat $50 office visit) to reduce hospital utilization and total cost of care and a quarterly prospective performance-based payment adjustment (five risk groups ranging from $24-$175), with an upside of up to 50 percent of revenue and a 10 percent downside of revenue

Key Eligibility Requirements



1

Primary care providers (MD, DO, CNS, NP, and PA), certified in internal medicine, general medicine, geriatric medicine, family medicine, hospice, or palliative medicine

2

Located in one of the 26 selected PCF regions (see appendix)

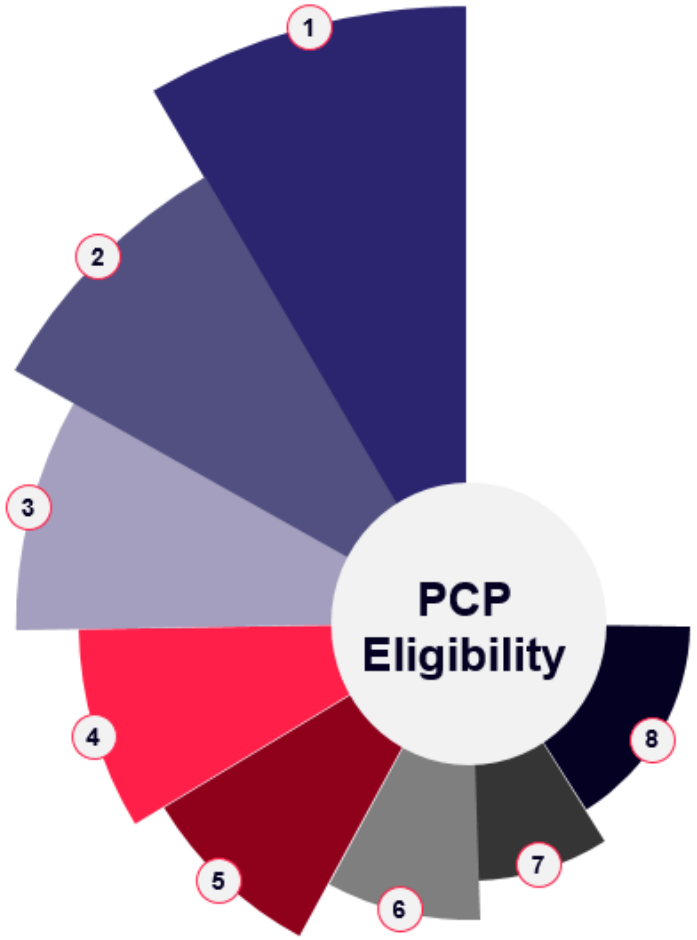
3

Provide primary care health services to a minimum of 125 attributed Medicare beneficiaries

4

Have primary care services for at least 70 percent of the practices' collective billing based on revenue

Key Eligibility Requirements (Cont.)



5

Experience with value-based payment arrangements

6

Use 2015 Edition Certified Electronic Health Record Technology, support data exchange with other providers and health systems, and connect to a health information exchange

7

Attest in the Practice Application to a limited set of advanced primary care delivery capabilities

8

Meet the (TBD) requirements in the PCF Participation Agreement

High Need Patients

- High-need patients with serious illnesses who do not have a practice participating in the model will be assigned to a model participant
  - Practices may limit their participation in PCF to exclusively caring for Seriously Ill Populations (SIP) patients
  - Practices that demonstrate relevant capabilities and care experience in their application will have the option to agree to be attributed and furnish services to the SIP patients that CMS identifies in their service area who express interest in the model; practices will also be allowed on a case-by-case basis to accept patients into SIP who are referred to the practice and deemed eligible by CMS

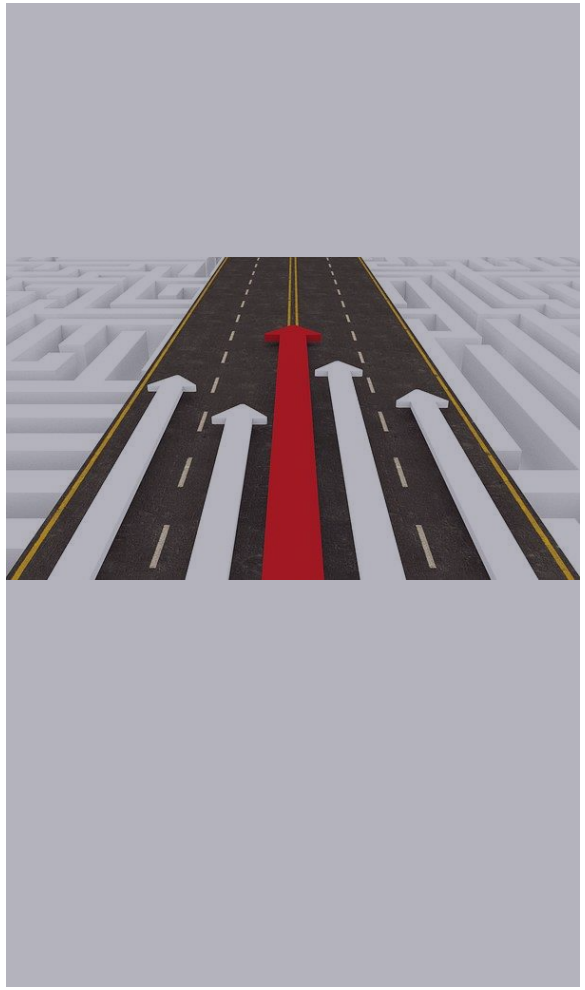
High Need Patients (Cont.)

- Payment for SIP patients will be set to reflect the high need, high risk nature of the population as well as include an increase or decrease in payment based on quality
- Providers that typically provide hospice or palliative care services will be able to provide care for SIP patients either by participating as a practice in PFC or by partnering with a PCF participating practice

PCF Timeline

CMS anticipates releasing a Request for Application in spring of 2019, participation in the model begins in January of 2020

CMS will accept another round of PCF applications during 2020; practices accepted to participate in PCF during 2020 would begin participation in the model in January of 2021



Direct Contracting (DC)

DC Overview

- A set of three voluntary population-based payment (PBP) model options aimed at reducing expenditures, and preserving or enhancing quality of care for beneficiaries in Medicare fee-for-service
- Reflects significant steps toward providing a prospectively determined revenue stream for model participants
  - Relative to existing initiatives, the payment model options include a reduced set of quality measures that focuses more on outcomes and beneficiary experience than on process
- Builds on lessons learned from initiatives involving Medicare Accountable Care Organizations (ACOs), such as the Medicare Shared Savings Program and the Next Generation ACO Model

DC Payment Model Options

- Payment model options aim to engage a wider variety of organizations that have experience taking on financial risk and serving larger patient populations such as ACOs, Medicare Advantage plans, and Medicaid managed care organizations

1) **Professional PBP** - Participating entities will bear the risk for 50 percent of shared savings/losses on the total cost of care (for Parts A/B services) for aligned beneficiaries, and will receive a capitated, risk-adjusted monthly payment for enhanced primary care services equal to seven percent of the total cost of care for enhanced primary care services (Primary Care Capitation)

DC Payment Model Options (Cont.)

2) **Global PBP -** Participating entities will bear the risk for 100 percent of shared savings/losses on the total cost of care (for all Parts A/B services) for aligned beneficiaries, and will be able to choose between two payment options:

   - Primary Care Capitation (described above)
   - Total Care Capitation, which is a capitated, risk-adjusted monthly payment for all services provided by DC participants and preferred providers with whom the DC entity has an agreement

3) **Geographic PBP -** Participating entities will bear the risk for 100 percent of shared savings/losses on the total cost of care (for all Parts A/B services) for aligned beneficiaries in a target region

   - In an effort to further refine specific design parameters, CMS is seeking additional input from the public through a Request for Information

DC Participant Selection

- CMS Innovation Center will request a Letter of Intent (LOI) from organizations interested in either the **Professional PBP** or **Global PBP** option
  - While submitting a LOI will be required in order to apply, a LOI will not bind an interested organization to participate

Thank You!

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MARYLAND HEALTH CARE COMMISSION

OVERVIEW OF UPCOMING ACTIVITES

(Agenda Item #9)


ENJOY THE REST OF
YOUR DAY