Maryland Health Care Commission

Thursday, June 20, 2019

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**

2. UPDATE OF ACTIVITIES

3. ACTION: Adoption of the State Health Plan Chapter for Nursing Homes and State Health Plan Chapter for Special Hospital – Chronic Services
   A. ACTION: COMAR 10.24.20 – State Health Plan for Facilities and Services: Comprehensive Care Facility Services – Final Action
   B. ACTION: COMAR 10.24.08 – State Health Plan for Facilities and Services: Special Hospital – Chronic Services – Final Action

4. ACTION: Maryland Primary Care Program – Advisory Council Nomination

5. PRESENTATION: 2019 Legislation: Update on Implementation

6. PRESENTATION: Privately Insured Report

7. PRESENTATION: Health Information Technology, A 2018 Assessment of Maryland Acute Care Hospital

8. OVERVIEW OF UPCOMING ACTIVITIES

9. 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

ACTIONS:

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(Agenda Item #3)

Comprehensive Care Facility Chapter of the State Health Plan

Center for Health Care Facilities Planning and Development

June 20, 2019

Overview of Presentation

- **Review of process to date**
- **Comments received during public comment period**
- **Key issues with staff analysis and response**
- **Next steps**

Process to Date: COMAR 10.24.20; 10.24.08

- Informal public comment period (6/6/18-7/13/18)
- Background and status report at June Commission meeting
- Staff presentation and Commission adoption of proposed permanent regulations at October Commission meeting
- Formal public comment period (12/7/18-1/7/19)
- Presentation and request for removal of docketing exception at February Commission meeting
- Formal public comment period on Re-Proposed Regs (4/12/19-5/13/19)
- ***Presentation and Request for Final Action (6/20/19)***

Major Issues Raised during Comment Period

- Two docketing exceptions permit MHCC to consider applications to add beds in jurisdictions without projected bed need:
  - Exception for jurisdictions with more than 50% of its CCFs below three stars (below “average” performance)
  - Exception for small facility (<100 beds) replacement
- Quality standard requires CCF applicants to demonstrate that at least 70% of CCF facilities operated for three or more years are rated as average or better
- Other Issues

Comments: Docketing Exception for Jurisdictions with more than 50% of CCFs Rated as Below Average

- General opposition to any expansion of bed capacity not identified in bed need projections or use of “waiver” bed policy
- If exceptions maintained, more than one measurement system should be used
- CMS 5-Star ratings are too volatile in light of recent CMS updates
- Hurts facilities in identified jurisdictions that have three or more stars

Jurisdictions with more than 50% of CCFs Rated as Below Average

CMS Nursing Home Compare Overall Star Ratings by Jurisdiction
Average over Five Quarterly Refreshes (April 2018 - April 2019)

Jurisdiction	Average Star Rating over 5 CMS Quarterly Refreshes April 2018 - April 2019[1-5] # of SNFs (226)	≥ 3 Stars	< 3 Stars	Percent < 3 Stars	Qualifying Jurisdiction
Allegany	8	3	5	63%	Yes
Anne Arundel	15	10	5	33%	
Baltimore	44	33	11	25%	
Baltimore City	28	20	8	29%	
Calvert	3	3	0	0%	
Caroline	2	1	1	50%	
Carroll	10	7	3	30%	
Cecil	3	2	1	33%	
Charles	4	4	0	0%	
Dorchester	2	2	0	0%	
Frederick	9	6	3	33%	
Garrett	4	4	0	0%	
Harford	6	3	3	50%	
Howard	6	5	1	17%	
Kent	3	3	0	0%	
Montgomery	34[7]	26	7	21%	
Prince Georges	20[8]	16	3	16%	
Queen Annes	1	1	0	0%	
Somerset	2	2	0	0%	
St. Marys	3	3	0	0%	
Talbot	2	1	1	50%	
Washington	10[8]	2	7	78%	Yes
Wicomico	4	4	0	0%	
Worcester	3	3	0	0%	

Data Source: CMS Nursing Home Compare https://data.medicare.gov/data/nursing-home-compare ProviderInfo_Download

Footnotes:

1. Source: https://data.medicare.gov/data/nursing-home-compare April 2019 quarterly refresh. Download 04.24.2019
2. Source: https://data.medicare.gov/data/nursing-home-compare January 2019 quarterly refresh. Download 02.08.2019
3. Source: https://data.medicare.gov/data/nursing-home-compare October 2018 quarterly refresh. Download 10.29.2018
4. Source: https://data.medicare.gov/data/nursing-home-compare July 2018 quarterly refresh. Download 07.26.2018
5. Source: https://data.medicare.gov/data/nursing-home-compare April 2018 quarterly refresh. Download 04.24.2019
7. One Special Focus Facility - ratings suppressed by CMS
8. One facility too new to rate

“Volatility” in Five-Star Rating System

HFAM Comment on “Volatility”

Change in star rating of CCFs based only on comparison of January 2019 and April 2019:

- **28 fewer five star-rated CCFs**
- **8 more four star-rated CCFs**
- **4 more three-star rated CCFs**
- **No change in number of two star-rated CCFs**
- **16 more one star-rated CCFs**
- **32% of CCFs experienced a change in star rating – 68% did not**

Actual Application of Docketing Exception:

- **Changes from five star (“much above average”) to four star (“above average”) or three star (“average”) are not material in many cases; average performance and above is acceptable**
- **We do not use individual facility ratings; we use average ratings across the jurisdiction**
- **We use five quarterly refreshes, accounting for a two-year period**
- **Bottom line, two jurisdictions would currently qualify for the exception**

“Volatility” in 5-Star Rating System

“Volatility” of CMS 5-Star rating system suggested by commenters is overstated:

- Actual use of the docketing exception results in a change from three qualifying jurisdictions to two, both of which were qualified for the exception in both January, 2019 and April, 2019

- Actual use of the quality standard was remarkably stable, with change in one CCF chain, that minimally qualified in January, 2019, slipping below the minimum threshold in April, 2019. Very little change in the other 87% of Maryland CCFs.

CMS Five-Star Rating: Summary of Staff Response

- Using five quarterly refreshes (accounting for eight quarters of data) minimizes volatility
- Maryland Nursing Home Experience of Care measures are highly correlated with Overall Star Rating
- Nursing Home Compare rating system is national, validated, and standardized
- Star rating system is used for bundled payment, commercial payers, hospital networks, and lenders.

Comments on Docketing Exception for Replacement of CCFs < 100 beds

- General opposition to any expansion of bed capacity not identified in bed need projections or use of “waiver” bed policy
- Recommend quantitative limit on number of additional beds that can be approved
- No need for exception given ability to add bed capacity with “waiver beds”

Replacement of CCF <100 beds: Staff response

- Only 50 freestanding CCFs (about 22%) of state CCF facility total have less than 100 beds
- The exception is limited to facilities with demonstrated need for replacement based on facility age and condition
- Bed capacity is limited by requirement to demonstrate financial feasibility and viability
- Use of “waiver” bed policy is not applicable in this case – the policy should not be broadened to serve as a standard feature of replacement CCFs
- Facilitating replacement of antiquated physical plants and increasing the average size of nursing homes are important policy objectives achievable with minimal impact on overall CCF bed capacity

Next Steps

- Request adoption of COMAR 10.24.20 (CCF Chapter)
  - Effective date: July 15, 2019

- Request adoption of COMAR 10.24.08 (Chronic Hospital Chapter)
  - One non-substantive change in definition
  - Effective date: July 15, 2019

MARYLAND HEALTH CARE COMMISSION

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ACTION:

Maryland Primary Care Program – Advisory Council Nomination

(Agenda Item #4)

Maryland Primary Care Program

Advisory Council

June 20, 2019

Background

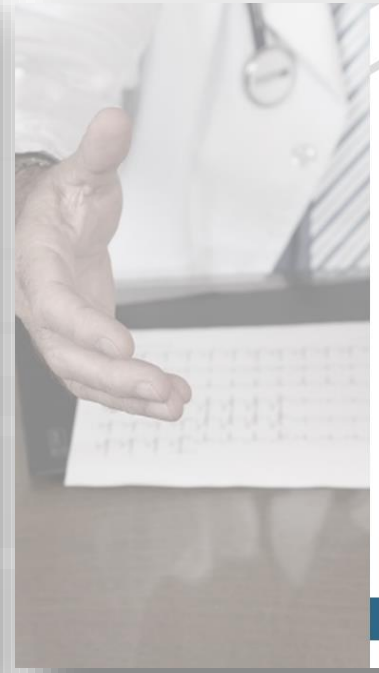
- April 18th Commission Meeting
  - Commissioners approved 20 nominations for the Maryland Primary Care Program (MDPCP) Advisory Council
  - Nomination of the Medicare beneficiary representative was deferred
  - Commissioners noted the importance of nurse practitioner perspectives on the Council and requested staff explore additional nominations
- May 16th Commission meeting
  - Commissioners approved one nomination for a nurse practitioner representative

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
- 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 examining 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 the 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

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Membership and Nomination

Medicare Beneficiary Representative Nominee: **Kevin Hayes, Ph.D.**

Membership

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

Membership (Cont.)

No. of Slots	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

Medicare Beneficiary Representative Nominee Biography

- **Kevin Hayes, Ph.D.**

  Dr. Hayes is a consultant for the Medicare Payment Advisory Commission (MedPAC) where he worked for 18 years analyzing Medicare payments for physician services. Dr. Hayes previously served as an analyst for the Physician Payment Review Commission, and as a health planner for the Veterans Administration (now the U.S. Department of Veterans Affairs) and the Southern Maryland Health Systems Agency.

Commission Action

- Staff recommends the Commission approve the nomination for Kevin Hayes.

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

2019 Legislation: Update on Implementation

(Agenda Item #5)

Legislation: Implementation Update

June 20, 2019

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Overview

Certificate of Need (CON) Legislation

- HB 626 / SB 649
- Other Bills

Chestertown Assessment

Trauma Fund

EMS New Models

2-Year Studies from 2018 Session

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Certificate of Need (CON) Legislation: HB 626 / SB 649

- Allows existing Hospice and Alcoholism and Substance Abuse Intermediate Care Facilities (ICFs) to change bed capacity without a CON (timely notice to MHCC is required)
- Actions taken to date, by the affected facilities:
  - Maryland House Detox (Anne Arundel) plans to add 24 ICF beds
  - Recovery Centers of America- Bracebridge Hall (Cecil) plans to add 87 ICF beds (These beds already exist and provide residential-level service. RCA will add ICF certification, allowing the beds to also be used for medically-monitored intensive inpatient care)
  - Carroll County Hospice plans to add six hospice beds
  - Requests are posted on the MHCC Website at https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/hcfs_con_bed_capacity_changes.aspx
- Requires MHCC to review State Health Plan on Acute Psychiatric Services in 2019
  - The Commission staff has convened a work group on psychiatric hospital services to recommend changes to the SHP chapter.
  - Commission should see proposed regulations in the Fall.

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Certificate of Need (CON) Legislation: Other Bills

- Other CON legislation is effective October 1, 2019
  - HB 646/SB 597 re: hospital capital expenditures and State Health Plan priorities
  - SB 940 re: non-hospital capital expenditures; changes in the definition of ambulatory surgical facility; and deemed approval for certain types of uncontested CON applications
- Priorities for SHP development in 2019 and 2020 were outlined to the Commission earlier this year. Staff are developing approach for SHP priority setting process required in HB 646/SB 597.
- The Commission staff will issue guidance to hospitals and ambulatory surgical facilities on changes authorized in SB 940 to become effective for October 1.

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Chestertown Assessment

- 2019 legislative session requires an assessment of services at the Chestertown hospital:
  - Senate Bill 1010 (2019)
  - The Conference Report for House Bill 100 (2019), which accepted language from the Senate Budget and Tax Committee Report on House Bill 100 withholds $500,000 from MDH budget pending complete of assessment.
- Task Order released 5/29/19; Pre-Proposal Conference 6/10/2019; Proposals due early-July.

Note that staff are limited re: discussion of ongoing procurement actions.

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Trauma Fund

- HB 607/SB 901 makes PARC/Shock Trauma eligible for stand-by and on-call costs from the Trauma Fund.
- Change is effective 7/1/2019.
- MHCC is working with PARC to obtain standby costs and to ensure PARC understands existing standby payment processes and requirements.
- MHCC staff will devise a methodology for reimbursing PARC standby costs by September.
- MHCC plans to convene a workgroup to look at all the payment methodologies used in the Trauma Fund after 7/1/2019.

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EMS New Models

- In 2018 MIEMSS and MHCC conducted a study of reimbursement for 3 models of EMS care: treat and release, alternative destination, and mobile integrated health/community paramedicine.
- 2019:
  - MIEMSS must submit report that “outlines the State’s plan for reimbursing the three models of care.”
  - HGO Chair Pendergrass asked MHCC to conduct actuarial study of models in private market insurance.
- ET3- National Model for treat and release and alternative destination announced by CMS, allowing for potential Medicare payment for EMS in some counties.

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2-Year Studies from 2018 Session

Study Topic	Status
School-Based Telehealth	On-going, expect report Fall 2019
Health Record and Payment Integration Program	Complete, report submitted
Electronic Prescription Records System	Nearly complete, expect report this summer
Infant Mortality in African American Infants and Infants in Rural Areas Study	On-going, expect report Fall 2019

Workgroup Information:
https://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups.aspx?id=0

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Privately Insured Report

(Agenda Item #6)

Privately Insured Report, 2017

Commission Meeting

June 20, 2019

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Background

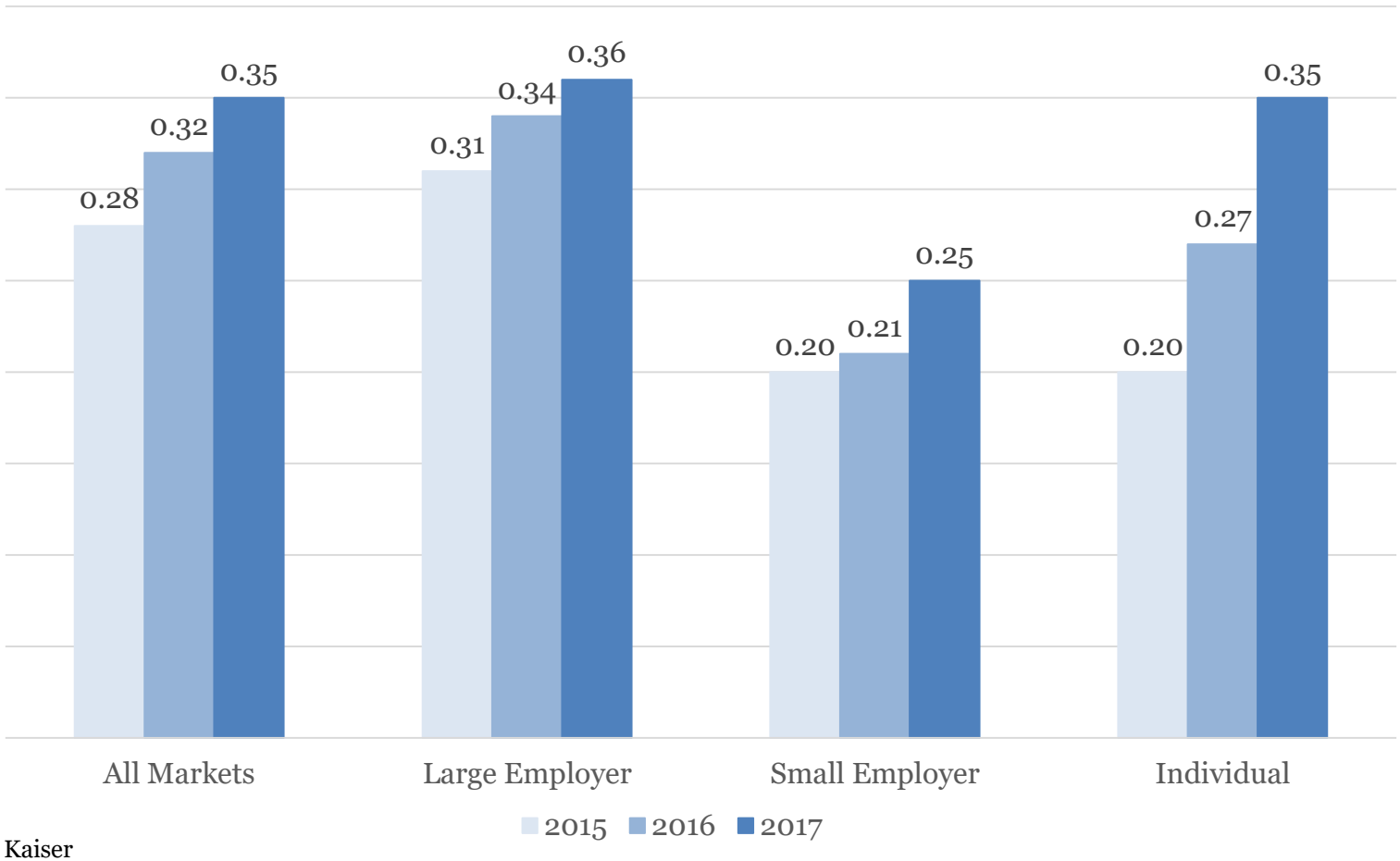
- MHCC is required to report annually on healthcare spending and utilization
  - Source: Medical Care Data Base includes data submitted by health insurance carriers, Third Party Administrators, and Pharmacy Benefits Managers for 2015, 2016 and 2017.
    - Fully-insured and Self-insured private plans, Maryland residents
  - Study variation by market segment, geography, age, and service category

Takeaway – PMPM in spending in 2017 grew at about the same rate across all markets as a year ago

- Total Per Member Per Month (PMPM) spending across all markets for all services, grew by about 6% in 2017 compared to about 5% in 2016.
- Individual market spending increased at a faster rate in 2017 (up 16%) than in 2016 which had about an 11% increase.
- Small group spending increased by about 6% in 2017 compared to no increase in 2016
- Large group spending increased by about 5% in 2017. This increase did not change from 2016.
- Illness burden across all market segments worsened from 2015 to 2017.

Median Expenditure Risk Scores by Market Segment (2015 to 2017)

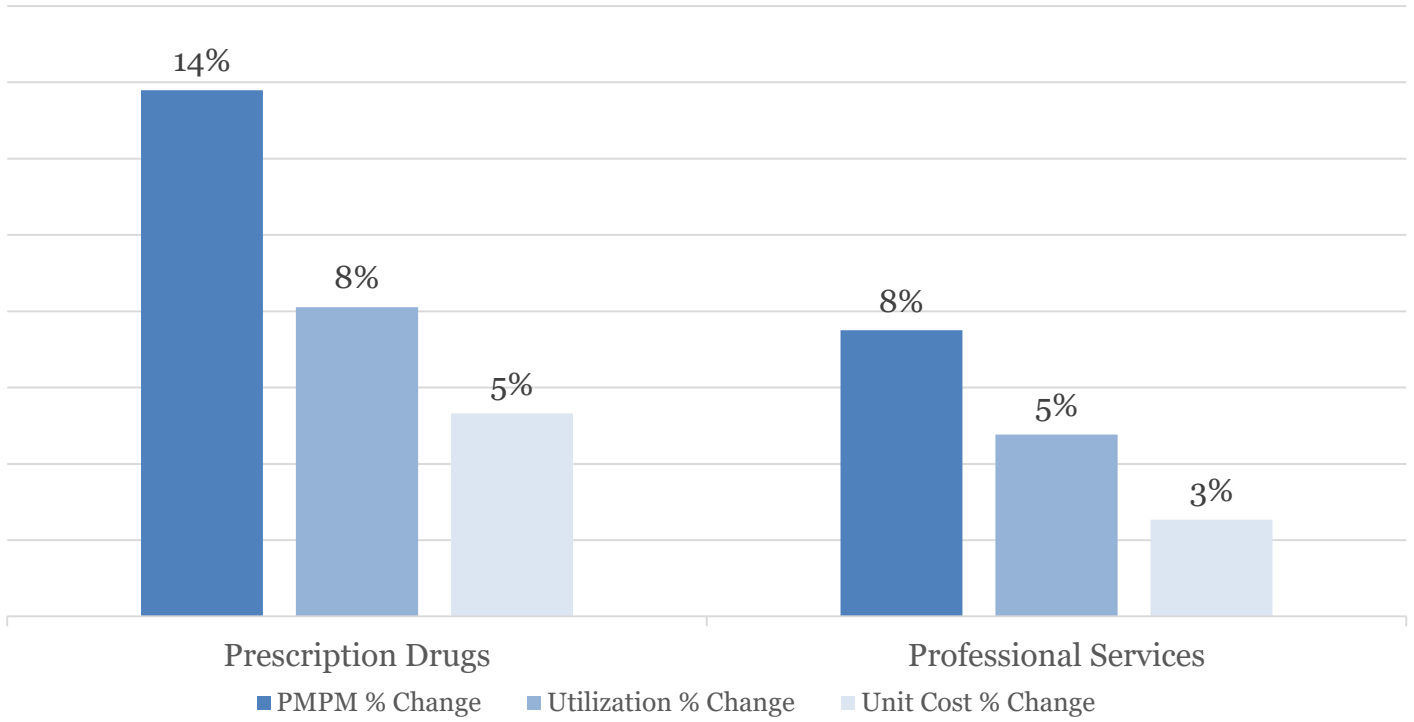
- Illness burden across all market segments worsened from 2015 to 2017



Excludes Kaiser

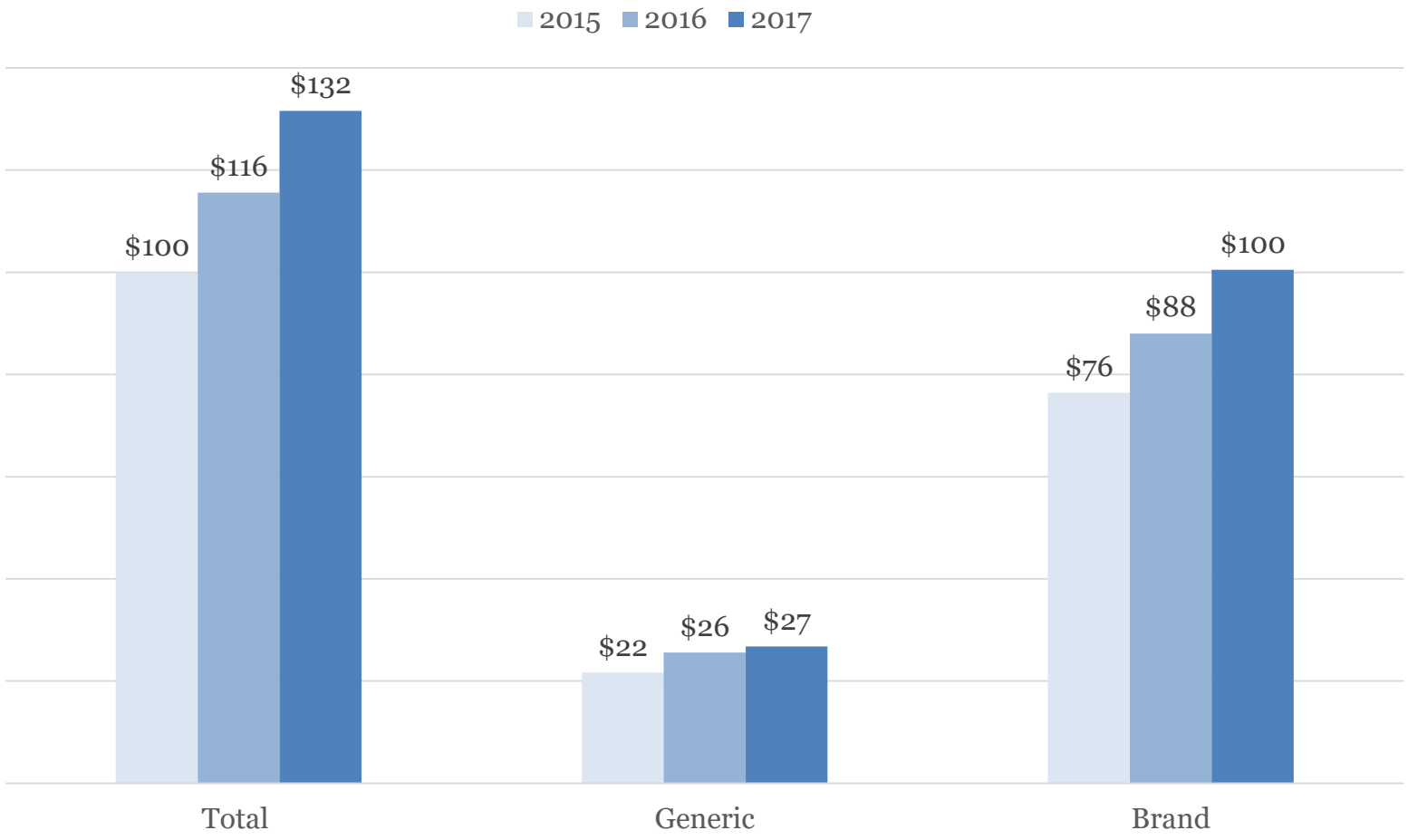
Increases in Prescription Drug and Professional Services were the main contributors to the 6% increase in spending in 2017

- Prescription drug spending increased by about 14% across all markets
- Professional services spending increased by 8% across all markets



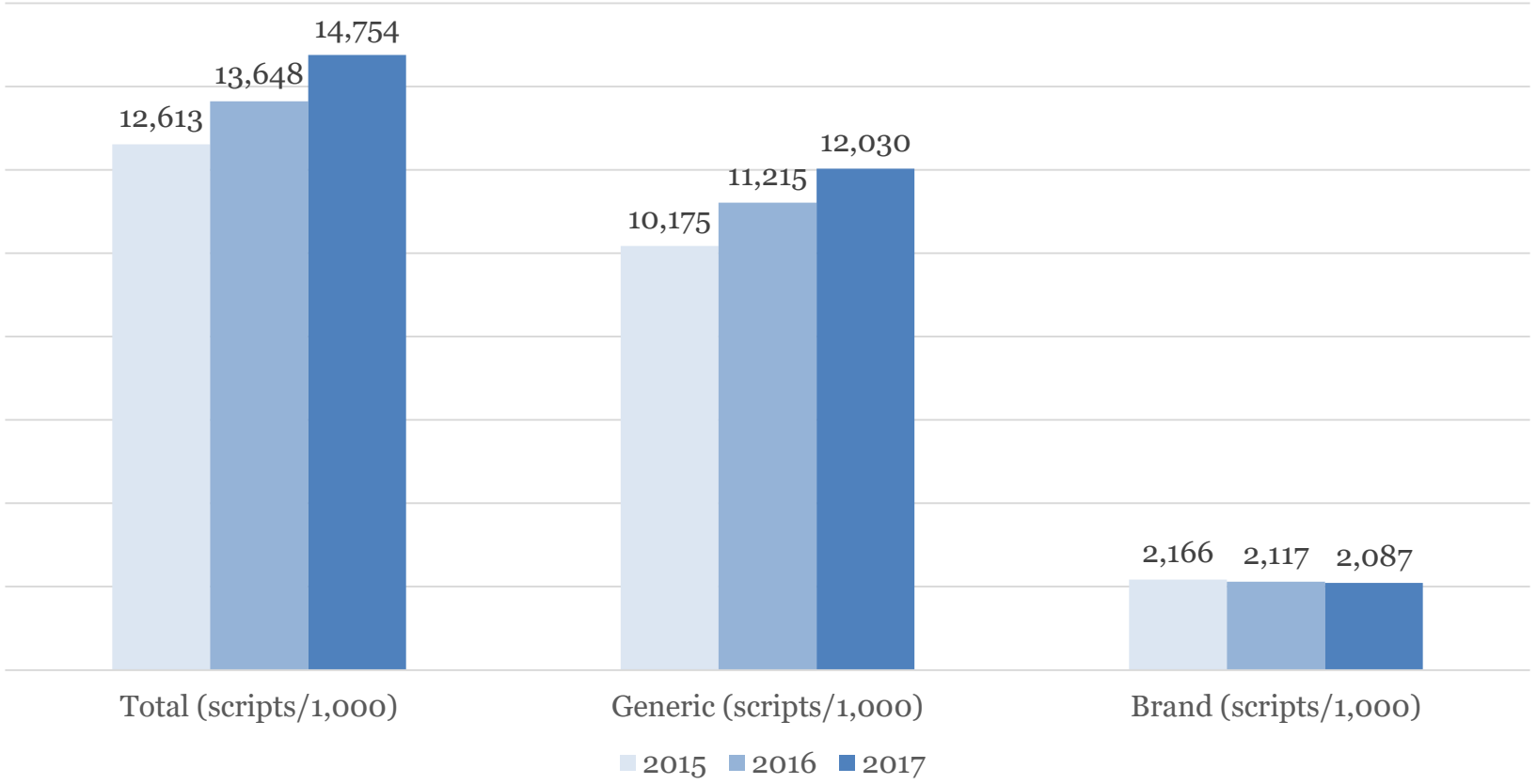
Prescription Drug PMPM spending Generic vs Brand
All Markets Combined 2015 - 2017

- Increases in Prescription drug spending is dominated by brand name drugs



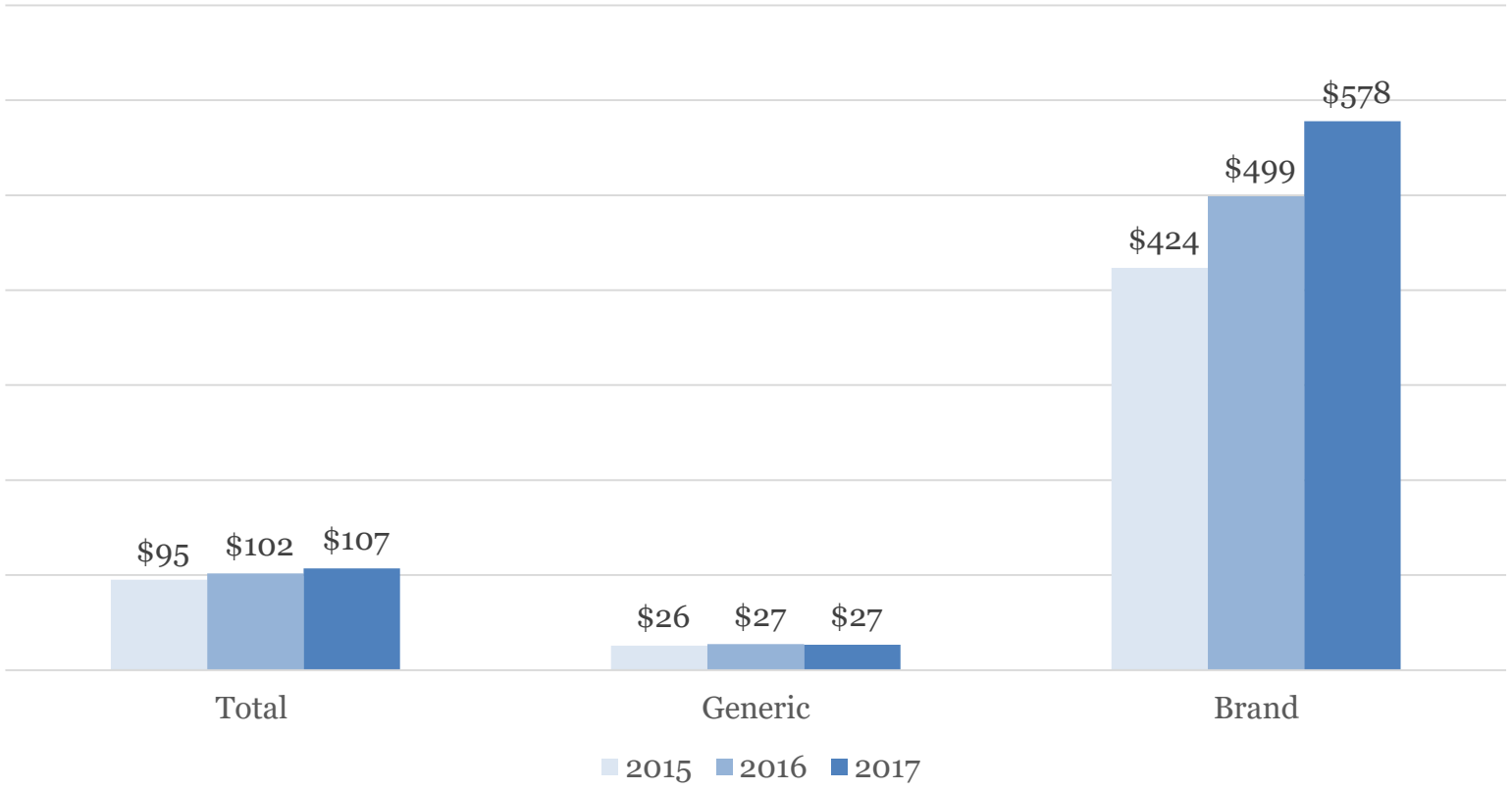
Prescription Drug Use Generic vs Brand
All Markets Combined 2015 - 2017

- Increases in Prescription drug use is influenced by increases in utilization for generic drugs.
- Brand drugs showed declines in utilization.



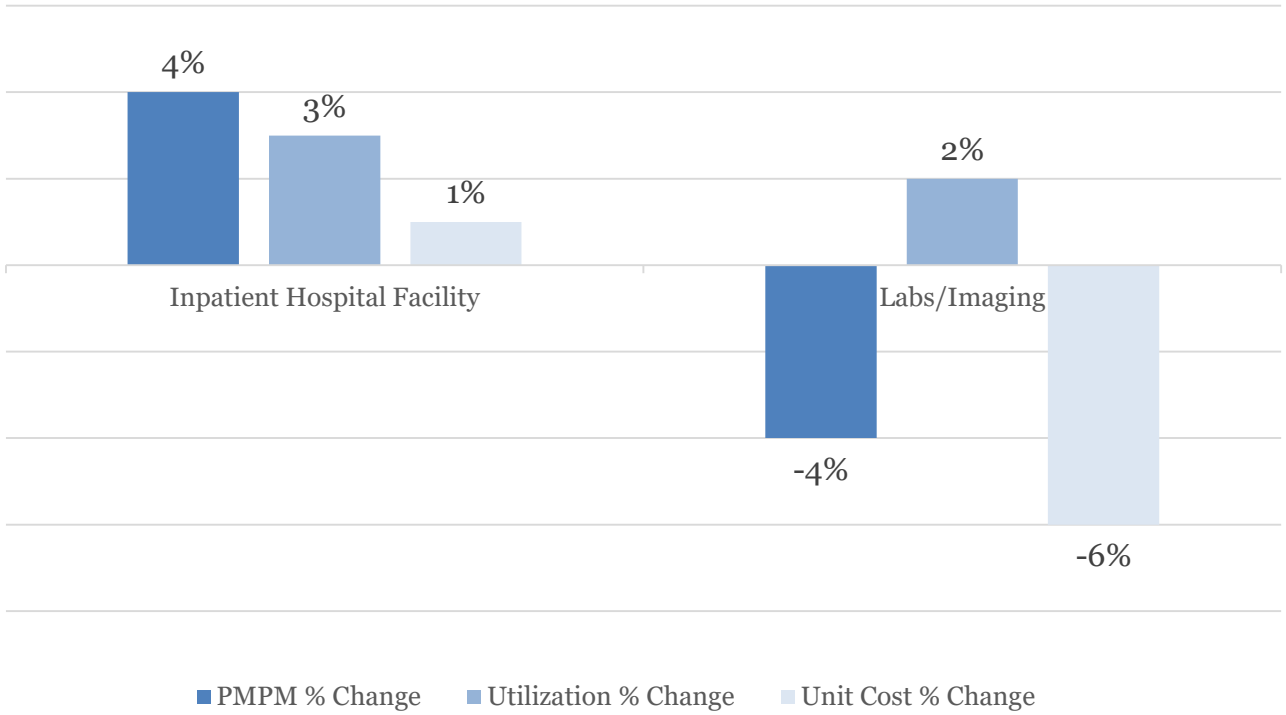
Prescription Drug Unit Cost Generic vs Brand
All Markets Combined 2015 - 2017

- Increases in Prescription drug cost per script is largely influenced by increases in brand name drug unit costs.
- Generic drug unit costs changes were flat.



Other Service Category PMPM Spending Changes Across All Markets, 2017

- Inpatient Hospital Facility rate of spending grew faster in 2017 than in 2016
- Labs/Imaging was the only service category that show a decrease in spending



How Privately Insured Per Capita Spending in Maryland Compares Nationally (Medical Only)

- Maryland's per capita spending for privately insured medical is lower than National Health Expenditures' (NHE) results.
  - Per capita spending shows similar growth for 2017. However, national results show a sharp rise in spending for 2016 compared to Maryland.
- Health Care Cost Institute (HCCI) per capita spending results are very close to the MCDB per capita results.

Benchmarking Per Capita Costs: MCDB v. National Health Expenditures (NHE) from CMS
Medical Only (2015 to 2017)

	MCDB			NHE (CMS)			% Diff (MCDB over NHE)		
	2015	2016	2017	2015	2016	2017	2015	2016	2017
Medical	$3,492	$3,516	$3,672	$3,924	$4,211	$4,403	-11.0%	-16.5%	-16.6%
Medical %Δ		0.7%	4.4%		7.3%	4.6%			

Benchmarking Per Capita Costs: MCDB v. 2017 Health Care Cost and Utilization Report (from HCCI)
Medical Only (2015 to 2017)

	Per Capita Spending			Difference Between MCDB & HCCI			% Difference Between MCDB & HCCI		
	2015	2016	2017	2015	2016	2017	2015	2016	2017
MCDB	$3,449	$3,436	$3,575						
HCCI-MD	$3,410	$3,533	$3,732	$39	-$97	-$157	1.1%	-2.7%	-4.2%

Questions?

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Health Information Technology, A 2018 Assessment of Maryland Acute Care Hospitals Workgroup Integrator

(Agenda Item #7)

Health Information Technology

An Assessment of Maryland Acute Care Hospitals

Commission Brief
June 20, 2019

The MARYLAND
HEALTH CARE COMMISSION

Overview

- Hospital health information technology (health IT) assessment conducted annually since 2008
- Assessment has evolved from evaluating hospital adoption to perceived value of health IT post-HITECH* and includes focus areas for population health and cybersecurity
- Infographic dashboards organized by five key categories and highlight findings with accompanying value statements supported by literature

Health Information Technology for Economic and Clinical Health Act of 2009

Highlights

- After a decade of investing in building a health IT infrastructure, focus is shifting toward leveraging data to improve care[1]
- Nearly all hospitals have possessed certified EHR technology since 2015 (adoption in Maryland: 100%; Nation: 96%)[2]
- Statewide, hospital use of regional HIEs (100%) exceeds the nation (52%); EHR vendor-mediated networks gaining traction[3]
- Telehealth adoption by hospitals locally (92%) exceeds the nation (76%)[4]
- Hospitals statewide consistently report security risk assessments (100%) in three key areas as compared to about three quarters of hospitals nationally (71%-75%)[5]

Note: Refer to Appendix for references (1-5)

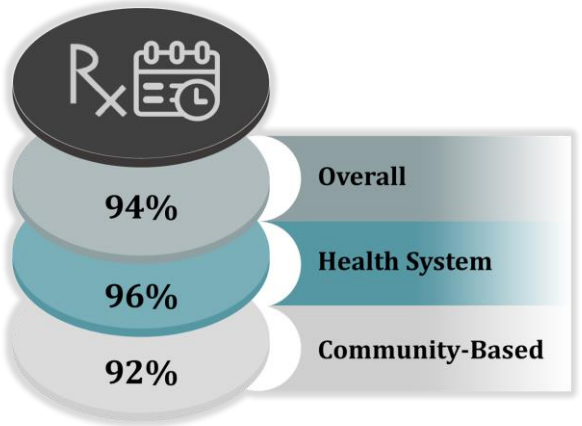
POPULATION HEALTH

Population Health

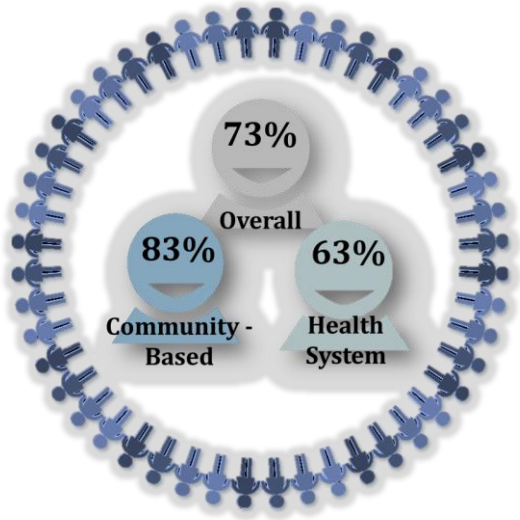
- Building population health capabilities requires more than just a firm investment in technology
  - Hospital characteristics influence focus areas for population health; alignment among areas of focus that center on collaboration, data sharing, and analysis
  - Data driven strategies fueling interest in non-traditional data (e.g., prescription medication history and socioeconomic information)

Hospital Interest in Non-Traditional Data

Patient Medication History



Social Determinants of Health



Note: See Appendix for more information on hospital top three health IT strategic focus areas

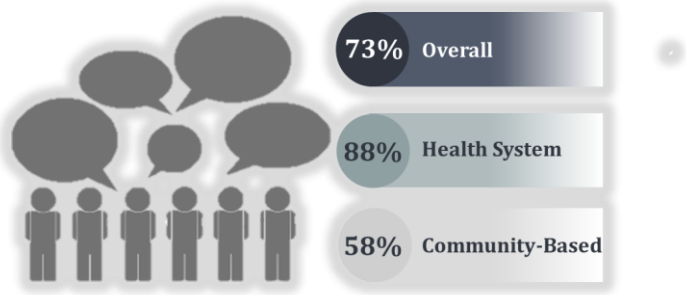
ELECTRONIC HEALTH RECORDS

Electronic Health Records

- Improving the seamless flow of information within a health care infrastructure and critical in revolutionizing how digital data can transform health care
  - Viewed favorably in supporting quality improvement through better communication, patient safety, and utilization management
  - Viewed less favorably for cost-controlling and improving physician satisfaction

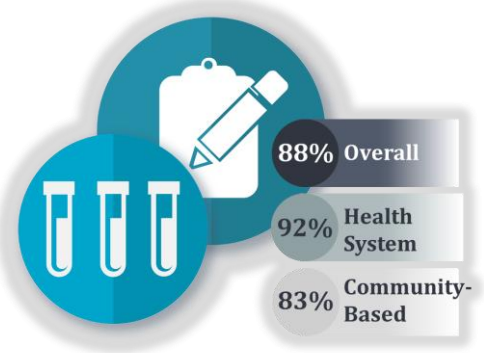
Hospital Views about Value

Enhances Interdisciplinary Communication



Reduces Adverse Medical Events

Reduces Unnecessary Utilization



Note: See Appendix for information on hospital views about EHRs lowering cost and contributing to physician satisfaction

HEALTH INFORMATION EXCHANGE

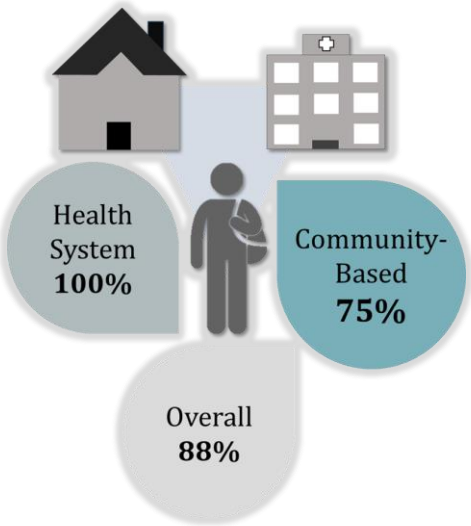
Health Information Exchange

- Critical functionality for care coordination and population health, though limited by interoperability barriers that impede keeping pace with rapidly emerging delivery system reforms
  - Viewed favorably for improvements in care coordination and transitions
  - Viewed less positively for helping increase awareness of primary care services
  - Satisfied with CRISP, with high reliance on HIE services in the emergency department

Note: See Appendix for more information on hospital views about HIE increasing awareness of primary care services

Hospital Views about Value

Improves Care Coordination

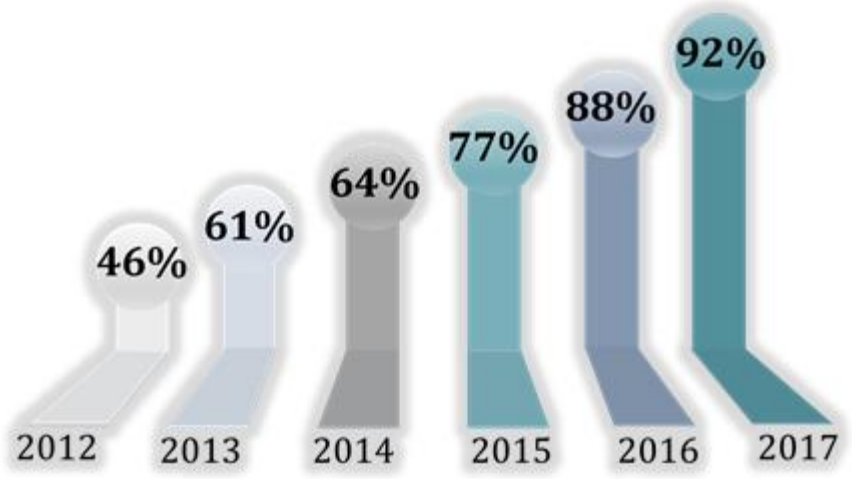


Emergency Department Reliance on CRISP

TELEHEALTH

Telehealth

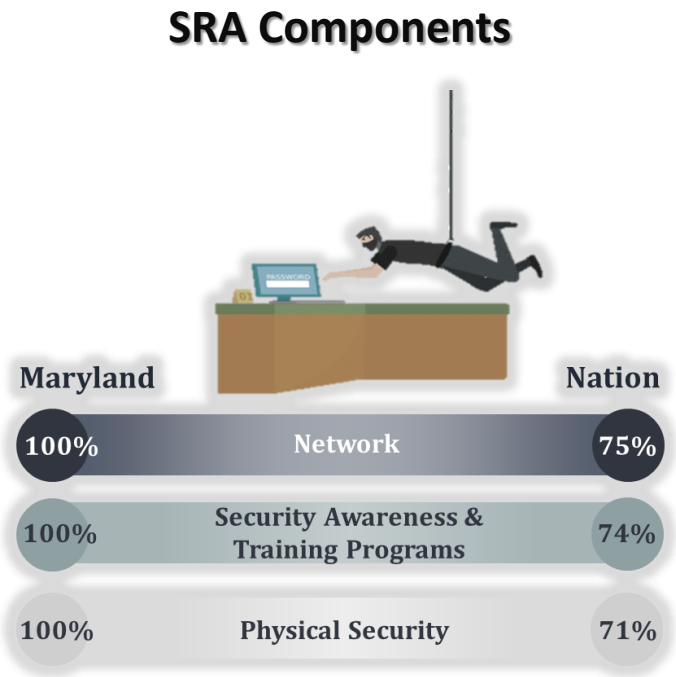
- Building momentum in its promise to address supply and demand challenges in and out of the hospital
  - Hospitals are centralizing implementation and management of telehealth across disciplines and specialties to support a broader value-based care strategy.



CYBERSECURITY

Cybersecurity

- A strategic issue for hospitals once considered easy targets with obsolete defenses
  - Hospital security risk assessments (SRA) evolving with the threat landscape that requires new and improved security measures to protect data and patient safety
  - Patient safety is a top medical device security concern requiring more uniformity among hospitals and device manufacturers to ensure protections for an array of devices connected to their networks



COMMISSIONER COMMENTS

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. APPROVAL OF MINUTES

2. UPDATE OF ACTIVITIES

3. ACTION: Adoption of the State Health Plan Chapter for Nursing Homes and State Health Plan Chapter for Special Hospital – Chronic Services
   A. ACTION: COMAR 10.24.20 – State Health Plan for Facilities and Services: Comprehensive Care Facility Services – Final Action
   B. ACTION: COMAR 10.24.08 – State Health Plan for Facilities and Services: Special Hospital – Chronic Services – Final Action

4. ACTION: Maryland Primary Care Program – Advisory Council Nomination

5. PRESENTATION: 2019 Legislation: Update on Implementation

6. PRESENTATION: Privately Insured Report

7. PRESENTATION: Health Information Technology, A 2018 Assessment of Maryland Acute Care Hospital

8. **OVERVIEW OF UPCOMING ACTIVITIES**

9. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

OVERVIEW OF UPCOMING ACTIVITES

(Agenda Item #8)


ENJOY THE REST OF
YOUR DAY