Maryland Health Care Commission

Thursday, July 18, 2019

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**

2. **UPDATE OF ACTIVITIES**

3. **ACTION:** Certificate of Need – Maryland Surgery Center for Women, L.L.C. – Establishment of an Ambulatory Surgical Facility (Docket No. 18-15-2434)

4. **ACTION:** Certificate of Need – Johns Hopkins Surgery Centers Series – Establishment of an Ambulatory Surgical Facility (Docket No. 19-03-2437)

5. **ACTION:** CRISP HIE Designation Agreement

6. **ACTION:** Non-CDS Workgroup Report

7. **PRESENTATION:** The Maryland Model: Experience and Progress in Implementing Value-Based Health Care Reform

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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(Agenda Item #3)

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MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

ACTION:

CRISP HIE Designation Agreement

(Agenda Item #5)

CRISP STATE DESIGNATION AGREEMENT

July 18, 2019

MHCC | MARYLAND HEALTH CARE COMMISSION

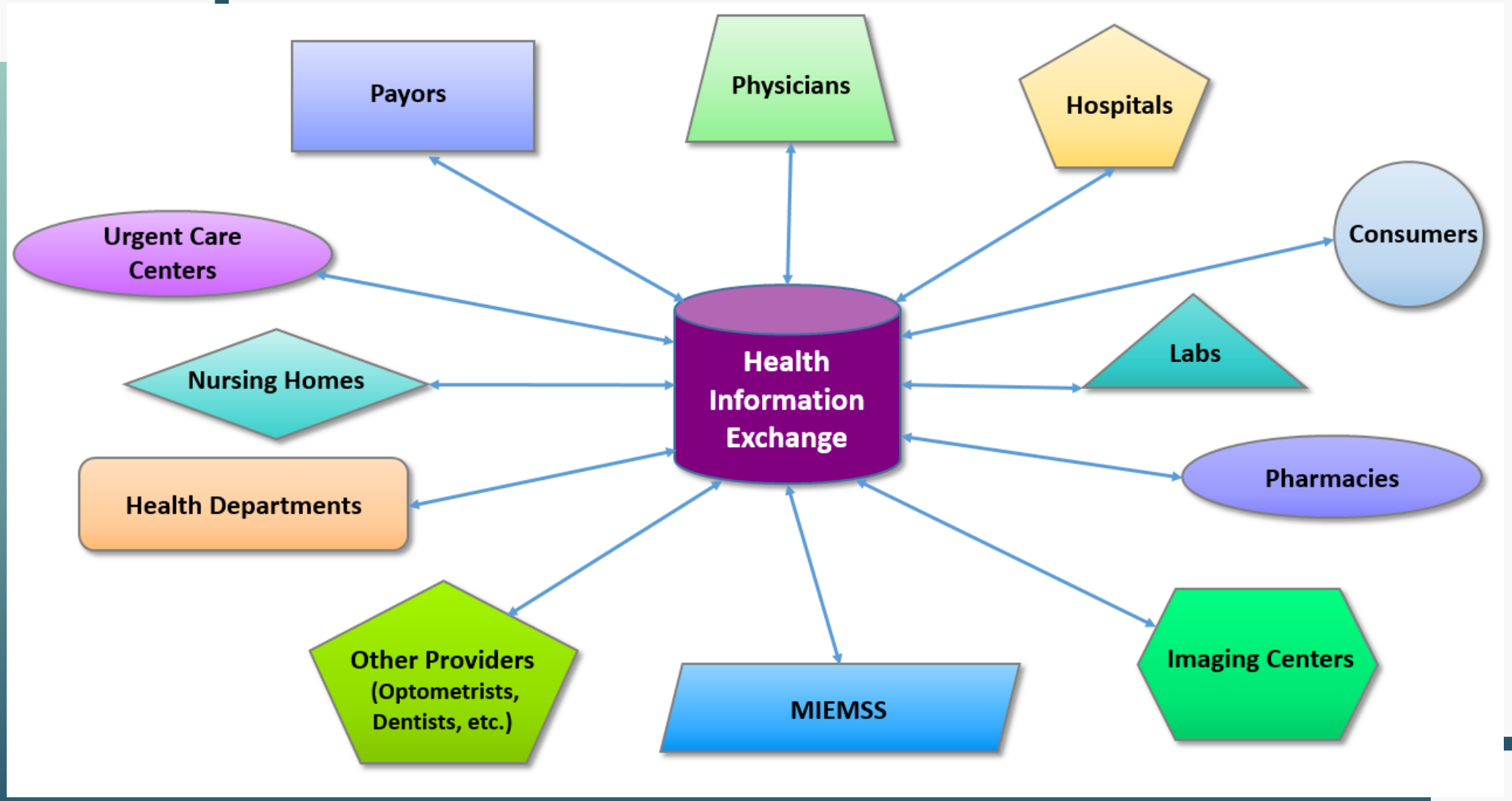
OVERVIEW

- Health General §19-143 (2009) charged MHCC and HSCRC with the designation of a statewide health information exchange (HIE)
    - CRISP was competitively selected in August 2009 to build and maintain a secure technical infrastructure that supports electronic health information exchange in the State *(see appendix for more background information)*
    - CRISP is a 501(c)(3) independent non-stock Maryland membership corporation

DESIGNATION PROCESS

- MHCC develops and executes the *State-Designated Health Information Exchange Designation Agreement* (SDA)
  - The SDA sets conditions for CRISP as Maryland's State-Designated HIE
- HSCRC votes on MHCC's action
- Re-designation builds on CRISP's accomplishments and supports MHCC in advancing a strong, flexible health IT ecosystem in the State
- SDAs previously executed with CRISP in 2009, 2013, and 2016

HEALTH INFORMATION EXCHANGE



CRISP GOVERNANCE STRUCTURE

MARYLAND HEALTH CARE COMMISSION
State agency tasked with designating a State Designated HIE and developing regulations for privacy and security exchanged through an HIE

Funding

HEALTH SERVICES COST REVIEW COMMISSION
Hospital all-payer rate setting system provides funding to the State-Designated HIE through hospital rate adjustments

CRISP BOARD OF DIRECTORS
A 17 member Board with representatives from the founding organizations: Erickson Retirement Communities, Johns Hopkins Medicine, MedStar Health, and University of Maryland Medical System, along with two representatives from MDH and various other stakeholders

CRISP ADVISORY BOARD

- Clinical Excellence Committee
- Finance & Sustainability Committee
- Reporting & Analytics Committee
- Technology Committee
- Privacy & Security Committee

CRISP STAFF
Responsible for leadership and daily operations of CRISP, this includes leading the implementation of HIE technology, statewide outreach, and administrative functions

Board Structure

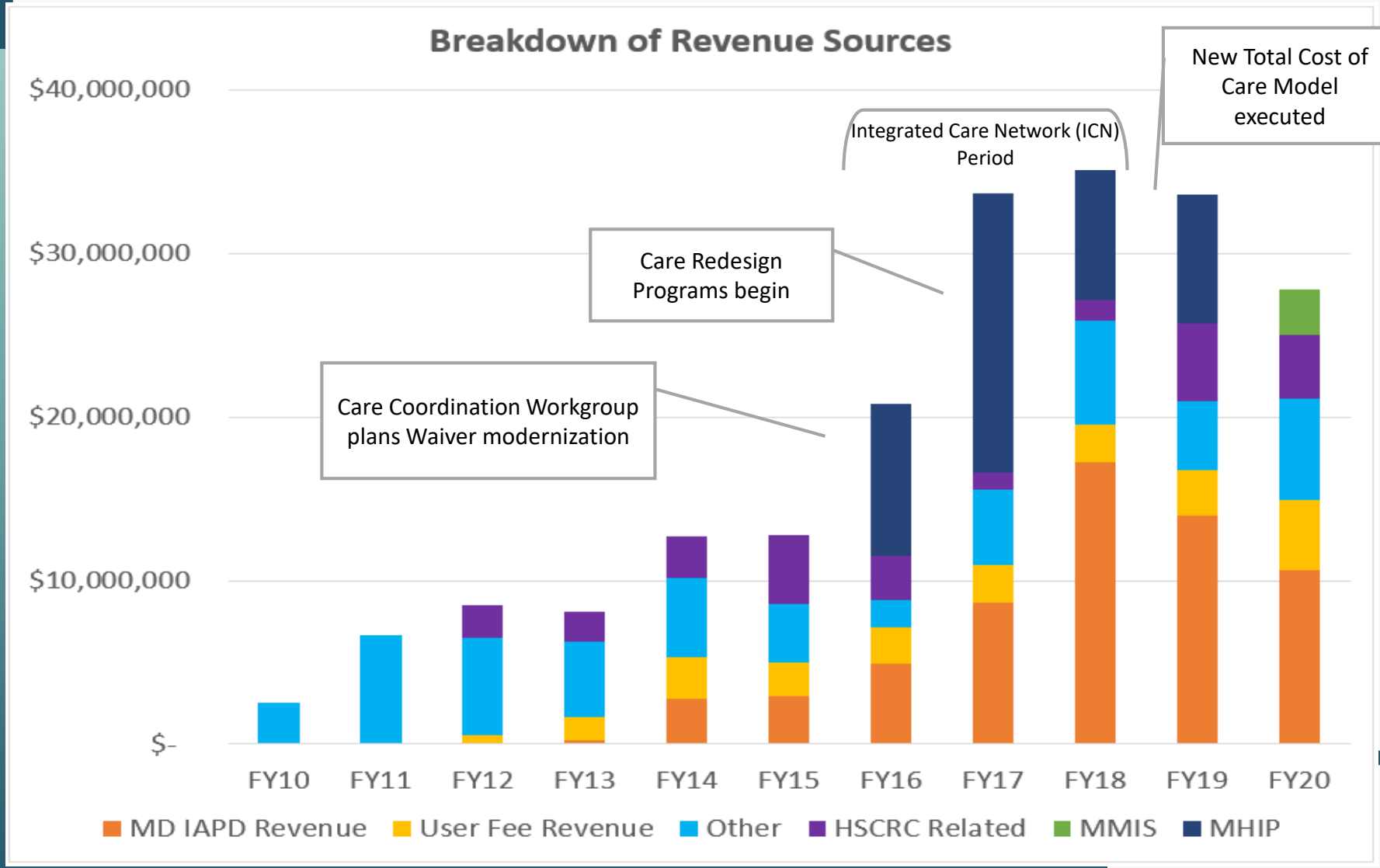
- 9 appointees of original members
- 2 payer representatives
- 2 Secretary of MDH appointees
- 2 community representatives
- 2 small practice representatives

KEY
Funding/ Authorization
Recommendation/ Coordination

CRISP CORE HIE SERVICES

- **Point of Care: Clinical Query Portal & In-context Information**
  - Search for patients' prior hospital records (e.g., labs, radiology reports, etc.)
  - Make available information on controlled dangerous substances dispensed in Maryland
- **Care Coordination: Encounter Notification Service (ENS)**
  - Alerts to a physician when their patient is hospitalized (potential readmissions)
- **Population Health Support: CRISP Reporting Services (CRS)**
  - A suite of reports made available to credentialed users to enhance the coordination and measurement of patient care throughout the State
- **Public Health Support**
  - Support Maryland Department of Health initiatives (e.g., PDMP)
  - Support research initiatives of participant organizations
- **Program Administration**
  - Support and administer Maryland Care Redesign Programs

CRISP REVENUE



KEY COMPONENTS OF THE NEW DESIGNATION AGREEMENT

MHCC OVERSIGHT

- MHCC, in consultation with other State agencies, to develop an alternative framework for procuring CRISP services within 18-months (previously done through a Memorandum of Understanding)
- Discontinue requiring MHCC approval on major technology choices
- Streamline reporting to MHCC
- Responsibility for annual privacy and security audits no longer a shared obligation with MHCC

CRISP GOVERNANCE

- Narrowing from six to three months advance notice to MHCC of an anticipated merger, sale, lease, or transfer of CRISP assets
- Note no merger, sale or transfer is under consideration at present

PRIVACY & SECURITY

Collaboration and Independent Audits

- CRISP responsible for engaging an independent firm, at least annually, to review and test internal and external controls
  - System and Organization Controls (SOC) 2, Type 2 attestation
  - HIPAA and COMAR compliance
  - Cybersecurity assessment
- Take reasonable actions to implement corrective actions on exceptions within 12-months, submit a corrective action plan within 45-days of the final audit reports to MHCC
- Support MHCC in obtaining assurance about internal controls at CRISP service organizations (vendors) and remediation of findings
- Provide notice within 24 hours a security incident

COLLABORATION OF MHCC AND CRISP

- CRISP may disperse to participants cost associated with implementing technology and/or services requested by MHCC in support of privacy and security
- Align State HIE activities to federal activities and policy as appropriate
- MHCC consideration of CRISP use case pilots when oversight is provided by CRISP's Clinical Advisory or Technical Advisory Board
- Mutual notification where reasonable and practical on legislative matters related to HIE in the State
- CRISP State indemnification clause
- Strategize on opportunities to enhance provider and consumer education about electronic health information exchange
- CRISP shall annually review ethics reporting requirements for its senior management and Board of Directors

EFFECTIVE DATE & AMENDMENTS

- SDA may be amended based on agreement between MHCC and CRISP
- Expand duration of SDA from three to five years

REQUESTED COMMISSION ACTION

- Staff recommends Commission approval to execute the SDA with CRISP

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ACTION:

Non-CDS Workgroup Report

(Agenda Item #6)

DRAFT

Electronic Prescription Records System

House Bill 115

July 18, 2019

MARYLAND HEALTH CARE COMMISSION

Framing the Presentation

- Medication reconciliation* is a key component of patient safety
- Electronic access to patient medication history improves medication reconciliation, reducing the potential for medication errors*
  - Medication errors are a common cause of morbidity and mortality in a hospital; half of preventable adverse drug events (ADEs)* within 30 days of discharge are due to medication discrepancies
- Pharmacy reporting of non-controlled dangerous substances (non-CDS) dispensed in the State and access to that information by treating providers can inform clinical decision making about diagnosis and treatment

* ***Medication reconciliation*** *is the process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route;* ***Medication errors*** *are mistakes made in prescribing, dispensing, and administering drugs;* ***Adverse drug events*** *involve harm to a patient due to medication use, including adverse drug reactions, allergic reactions, and overdoses*

Overview

- House Bill 115 passed during the 2018 legislative session
- The MHCC was tasked with conducting a policy study to assess the feasibility of developing an electronic system (system or statewide repository) of non-CDS dispensed in Maryland
- A report on the study findings and recommendations is due to the Governor and General Assembly by January 1, 2020

Approach

- Convened a workgroup of interested stakeholders as required in law (Chapter 435) to assess specific aspects of a statewide repository*
- Workgroup deliberations were guided using information gathering grids to identify benefits, barriers/challenges, and potential solutions for a system
- Existing mandates and infrastructure for Prescription Drug Monitoring Programs in Maryland and the nation informed discussions about select technology and policy matters
- Key themes that emerged informed development of the suggested recommendations

* *Refer to the appendix for a list of study requirements in law*

Suggested Recommendations By Key Category

Implementation
(Potential roles for MHCC)

- *Competitively recognize (through a State recognition process) one or more non-CDS vendors that meet and maintain required privacy and security controls and standards for technical performance*
- *Leverage existing vendor solutions for dispenser reporting of non-CDS and in making that information accessible to prescribers and dispensers within existing workflows*
- *Convene a stakeholder advisory committee to propose policy recommendations for non-CDS reporting and other operational matters*

Consumer Privacy and Education

- *Implement a consumer non-CDS opt-out process*
- *Provide consumers with opt-out information at the point of care*
- *Codify consumer protections in statute*

Governance and Funding

- *Develop non-CDS reporting regulations informed by federal and State regulations, including COMAR 10.25.18, Health Information Exchanges: Privacy and Security of Protected Health Information and COMAR 10.47.07, Prescription Drug Monitoring Program*

- *Rely on a public funding approach to support a non-CDS repository*

Costs and Funding Source

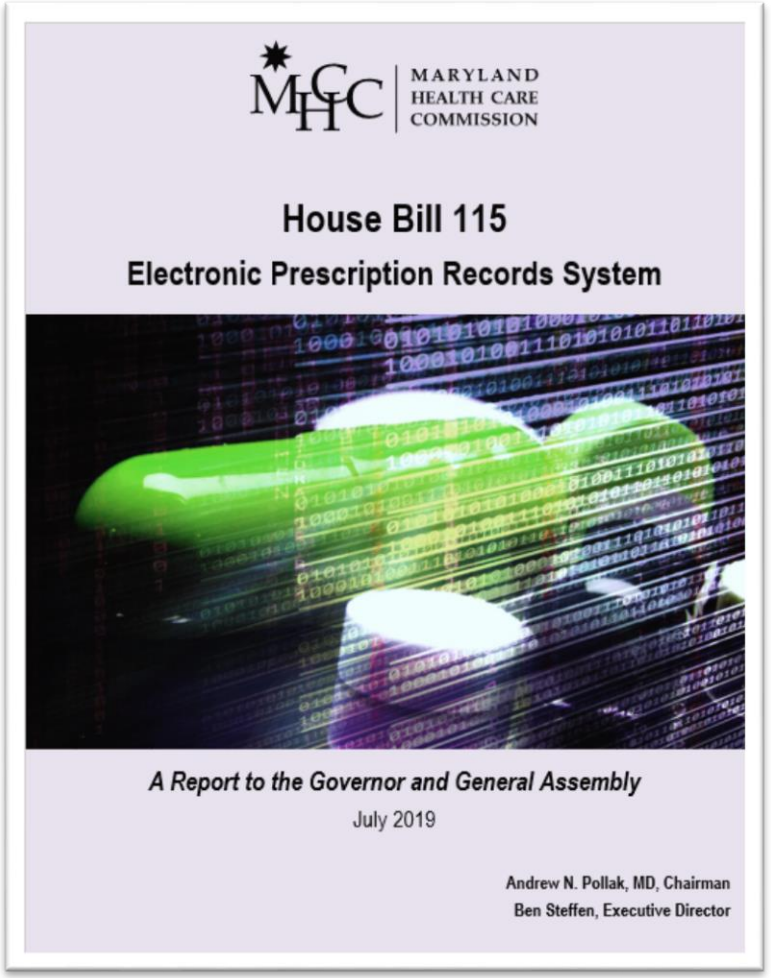
- Estimated cost to develop and implement a non-CDS repository is approximately $750,000 and cost for annual system maintenance and support is about $500,000
- An assessment of hospitals is an option to support a non-CDS repository
  - A financial model that distributes costs across 47 acute care hospitals adds about $16,000 in hospital operating cost in year one and around $11,000 each year thereafter
- Rationale based on the benefit to hospitals
  - Accrual of reduced medication errors, patient omissions, and ADEs that account for a significant number of avoidable emergency department visits and hospital admissions
  - High value proposition in the emergency department setting, the origin of at least half of all hospital admissions in Maryland and the nation

Summary

- A statewide repository for non-CDS will complement CDS reporting requirements in Maryland
- The vision is to improve patient safety; equally important is respecting consumer privacy and building provider and consumer trust through education
- The suggested recommendations are intended to provide a practical foundation for the Governor and General Assembly in developing legislation that mandates reporting of non-CDS dispensed in the State

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:

The Maryland Model: Experience and Progress in Implementing Value-Based Health Care Reform

(Agenda Item #7)

July 18, 2019

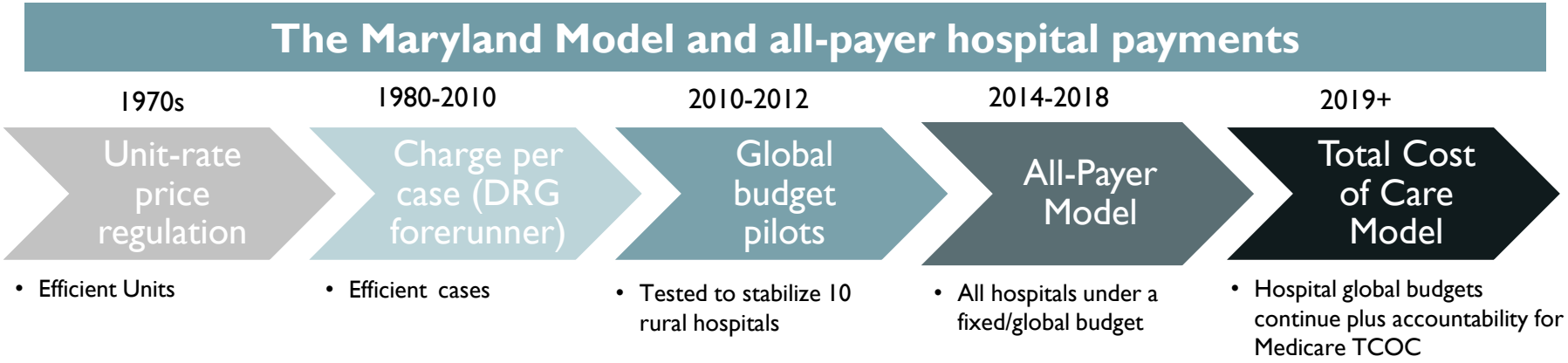
Maryland's Experience and Progress in Implementing Value-Based Healthcare Reform

Health Services Cost Review Commission
Katie Wunderlich (Executive Director) & Chris Peterson (Principal Deputy Director)

Agenda

- Background: Maryland's unique approach
  - Overview of Maryland's all-payer hospital rate-setting
  - All-Payer Model, 2014-2018
  - Maryland's Total Cost of Care (TCOC) Model, 2019-2028
- TCOC Model
  - Improving all-payer hospital payment system
  - Flexibility for coordination across care continuum, especially via Medicare
  - Maryland Primary Care Program (MDPCP)
  - Population health
- MHCC-HSCRC collaboration

Evolution of the Maryland Model



- Since 1977, Maryland has had an all-payer hospital rate-setting system
  - A given acute care hospital's charge is the same regardless of payer
  - Charges ("prices") differ across hospitals
- In 2010, ten rural hospitals were placed on Total Patient Revenue (TPR) systems
  - TPR was a pilot for what became Global Budget Revenue (GBR) for all hospitals in 2014
- In 2014, Maryland moved to the All-Payer Model with CMMI, focused on controlling hospital costs through GBR
- In 2019, Maryland moved to the Total Cost of Care (TCOC) Model, focusing on (Medicare) TCOC through system-wide alignment

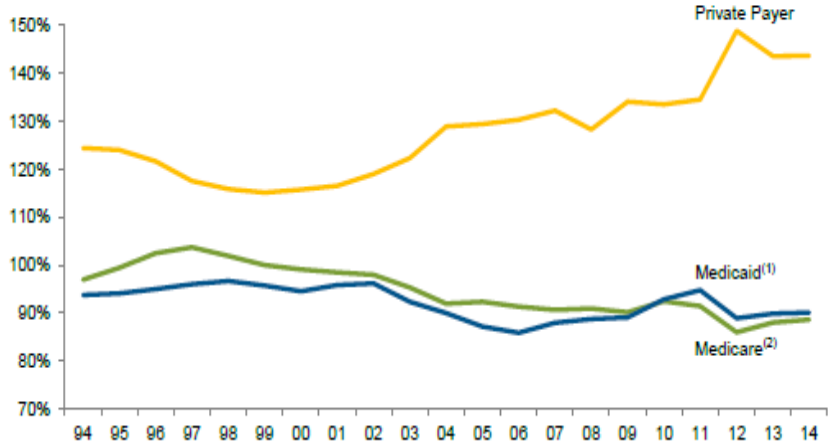
Value of Maryland's All-Payer Hospital Rate Setting System

Maryland's approach:

- Avoids cost shifting across payers
- Cost containment for the public
- Equitable funding of uncompensated care
- Stable and predictable system for hospitals
- All payers fund Graduate Medical Education
- Transparency
- Leader in linking quality and payment

While the rest of the nation sees:

Chart 4.6: Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1994 – 2014



Source: American Hospital Association
(1) and (2). Includes Disproportionate Share Hospital (DSH) payments.

Maryland's Unique Healthcare Delivery System: All-Payer Model (2014-2018)

All-Payer Model: Expansion of Hospital Global Budgets

- From 2014, all general, acute care hospitals in Maryland went under Global Budget Revenues (GBRs) set by the HSCRC
  - Fixed revenue base for 12-month period, with annual adjustments
  - Adjustments for variables including population growth, readmissions, hospital-acquired conditions, etc.
  - Reimbursement still administered on fee-for-service basis, but only for attaining GBR
  - Hospitals have flexibility to dial charges up or down (within constraints) so that, by year end, they have attained their GBR
    - Penalties for being too high or too low
- Sometimes use term: Population-Based Revenue (PBR) instead of GBR

Move from Volume to Value Transforms Hospital Incentives

- No longer chasing volumes on pressured prices
- Incentivized
  - Reduced readmissions
  - Reduced hospital-acquired conditions
  - Reduced ambulatory-sensitive conditions, or Prevention Quality Indicators (PQIs)
  - Better managed internal costs
- Results
  - Improved health care quality, lower costs, better consumer experience

But more to be done …

All-Payer Model Performance 2014-2018: Met or Exceeded CMS Contract Requirements

Performance Measures	Targets	2018 Results	Met
All-Payer Hospital Revenue Growth	≤ 3.58% per capita annually	1.92% average annual growth per capita since 2013	✓
Medicare Savings in Hospital Expenditures	≥ $330M cumulative over 5 years (Lower than national average growth rate from 2013 base year)	$1.4B cumulative (8.74% below national average growth since 2013)	✓
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	$869M cumulative* (2.74% below national average growth since 2013)	✓
All-Payer Reductions in Hospital-Acquired Conditions	30% reduction over 5 years	53% Reduction since 2013	✓
Readmissions Reductions for Medicare	≤ National average over 5 years	Below national average at the end of the fourth year	✓
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	All Maryland hospitals, with 98% of revenue under GBR	✓

*** $273 million in Medicare TCOC savings in 2018 alone – aka Medicare savings run rate** (vs. 2013 base)

Maryland Total Cost of Care Model (2019-2028)

CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 7/5/18

By: _____
Adam Boehler, Director, Center for Medicare and Medicaid Innovatio

GOVERNOR OF MARYLAND

Date: 7/9/18

By: _____
Lawrence Joseph Hogan, Jr., Governor

MARYLAND DEPARTMENT OF HEALTH

Date: 7/9/2018

By: _____
Robert R. Neall, Secretary of Health

HEALTH SERVICES COST REVIEW COMMISSION

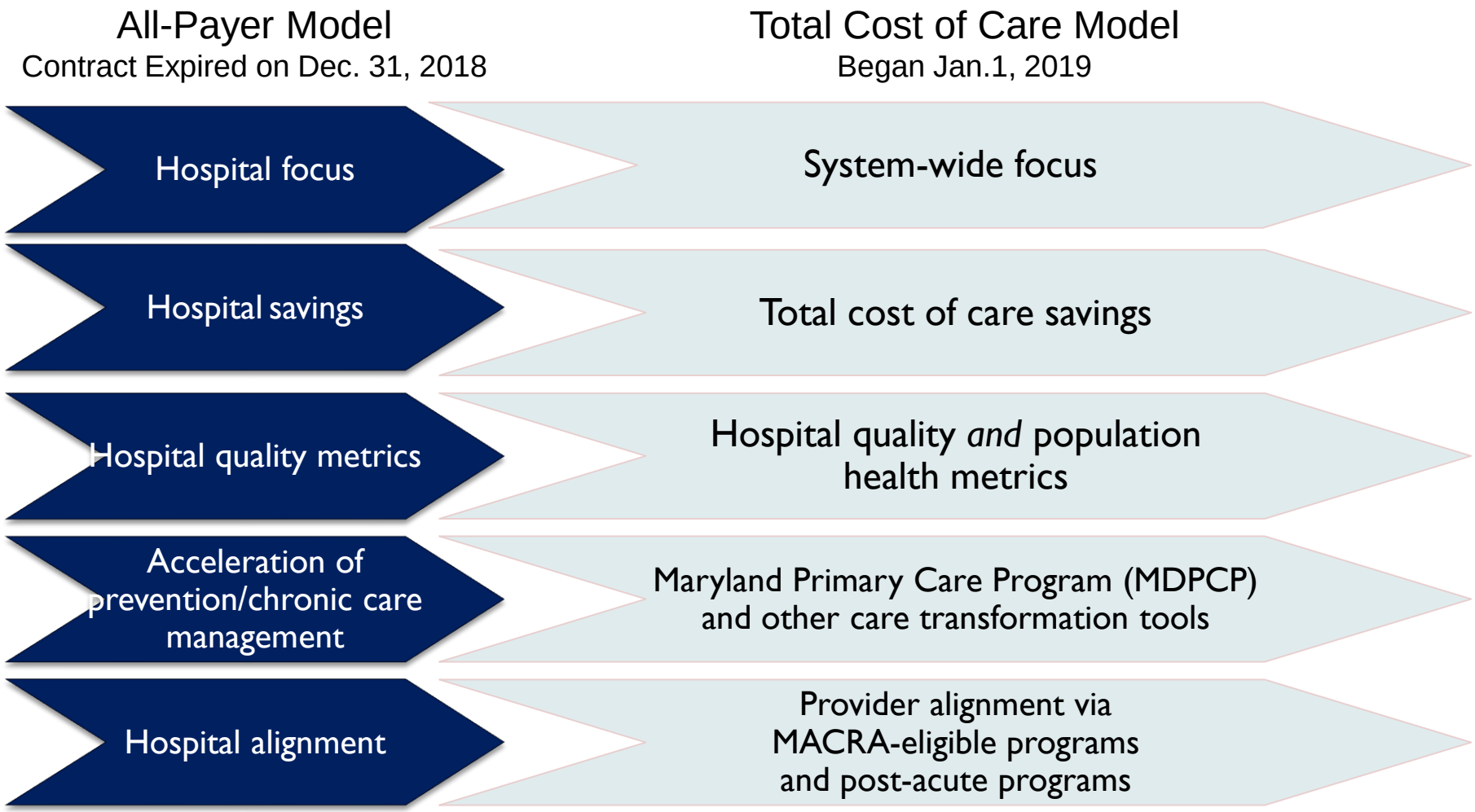
Date: 7/9/2018

By: _____
Nelson Sabatini, Chairman

TCOC Model Agreement

Signed on July 9, 2018

Changes from All-Payer Model to Total Cost of Care Model

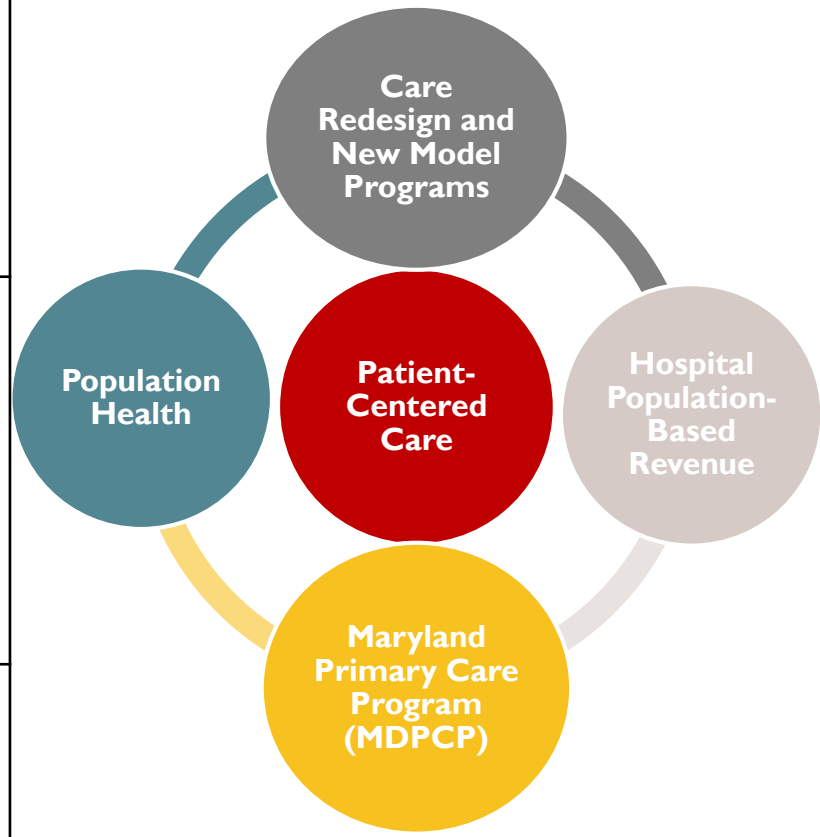


Total Cost of Care (TCOC) Model Overview

- New contract is a 10-year agreement (2019-2028) between MD and CMS
  - 5 years (2019-2023) to build up to required Medicare savings and 5 years (2024-2028) to maintain Medicare savings and quality improvements
- Designed to coordinate care for patients across both hospital and non-hospital settings, improve health outcomes and constrain the growth of costs
- Total Cost of Care (TCOC) Medicare savings building to $300 million annually by 2023 (from 2013 base)
  - Includes Medicare Part A and Part B fee-for-service expenditures, as well as non-claims based payments
  - In 2017, Maryland was at ~$135M – not quite halfway to $300M
  - By end of 2018, we are at $273M
- Continue to limit growth in all-payer hospital revenue per capita at 3.58% annually

Total Cost of Care Model Components

Component	Purpose	Status
Hospital Population-Based Revenue	Expand hospital incentives and responsibility to control total costs through limited revenue-at-risk (±1% of hospital Medicare payments) under the **Medicare Performance Adjustment (MPA)**	Expands
Care Redesign and "New Model" Programs	Enable private-sector led programs supported by State flexibility, "MACRA-tize" the model and expand incentives for hospitals to work with others, and opportunity for development of "New Model Programs"	Expands
Population Health	Programs and credit for improvement in diabetes, addiction, and other priorities	New
Maryland Primary Care Program	Enhance chronic care and health management for Medicare enrollees	New



Care Redesign Program (CRP): Aligning hospitals with non-hospital providers

Complex & Chronic Care Improv. Program (CCIP)	Hospital Care Improvement Program (HCIP)	Episode Care Improvement Program (ECIP)
Goal: Enhance care management, while reducing total costs. **Replaced by MDPCP**	**Goal**: Facilitate improvements in hospital care that boost quality and efficiency. **40 hospitals**	**Goal**: Facilitate care improvements for post-acute episodes; reduce Medicare TCOC. **16 hospitals**
Community care	*In the hospital*	*Post-hospital*

Care Redesign Program Tracks Span the Continuum of Care

- Under CRP, **hospitals**:
  - Convene the program,
  - Bear financial risk (under GBRs and the MPA, which MACRAtizes Care Partners),
  - Obtain Medicare data (CCLF like ACOs), and
  - Choose whether or not to participate and, if so, whether or not to share incentives or resources with Care Partners
- ECIP assesses 90-day post-acute (PAC) episodes triggered in inpatient
  - If hospital achieves 3% Medicare savings in PAC, hospital receives payment for savings – and can share with Care Partners

Other Hospital-Led Care Transformation Initiatives

Care Redesign and New Model Programs

- West Baltimore EMS Collaborative – Mobile Integrated Health Community Paramedicine Program
  - Aim is to comprehensively improve the health of Baltimore citizens; address gaps in the delivery of health care services to patients; and reduce the need for emergency medical services (EMS) transport, emergency department evaluations, and hospital readmissions.
  - Transitional Health Support pilot provides in home and chronic disease management services for 30 days after hospital discharge using a multidisiciplinary team, including RN, NP, pharmacist, social worker, community health worker, and EMT
  - Minor Definitive Care Now pilot provides on-scene care from an NP and BCFD community paramedic for low-acuity 911 callers
  - Partners include University of Maryland Medical Center, Baltimore City Fire Department, HSCRC

New Model Program: Enhanced Episode Program (EEP) Under Development

- Maryland is developing a non-hospital convened episode-based payment program
- The State of Maryland will administer the program
- Program will be developed to have multiple tracks, each with specialty or clinical care specific grouped episodes
- Conveners must take downside risk and will aggregate risk across engaged providers/episode initiators:
- Targeted start date of January 2021
- At the outset:
  - Would begin with 3 episodes triggered in Hospital Outpatient Department (HOPD) mirroring BPCI Advanced
  - Provider-led reform: Working with SIG and provider groups to determine what additional track and episodes may be added

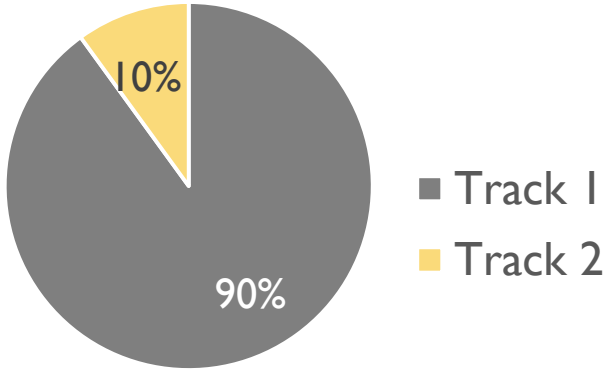
MDPCP Began January 1, 2019

Maryland Primary Care Program (MDPCP)

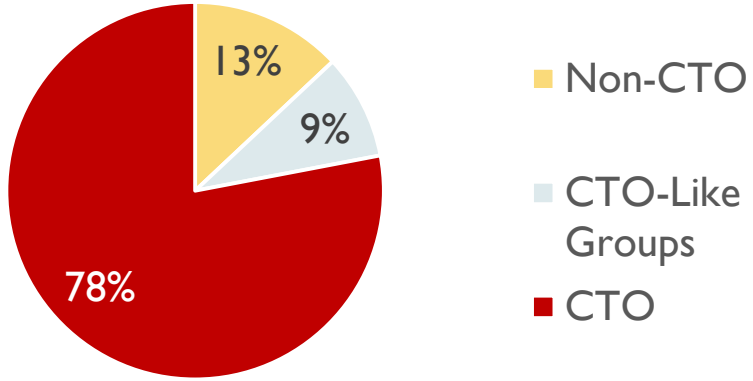
380 Practices Accepted Statewide

- ~ 220,000 beneficiaries
- ~ 1,500 Primary Care Providers
- All counties represented
- 21 Care Transformation Organizations

Practice Tracks



Practices Partnered with a CTO

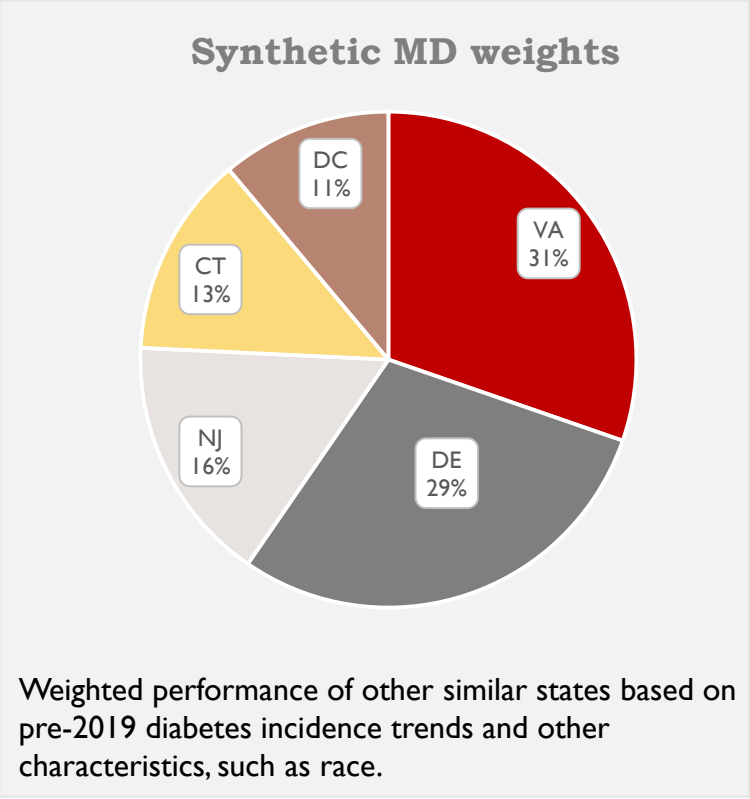


- More than $60M will go to PCPs and CTOs in MDPCP Care Management Fees (CMF) in CY 2019
- MDPCP is an investment expected to pay for itself by increased chronic care management by PCPs resulting in reduced ED utilization and hospital admissions

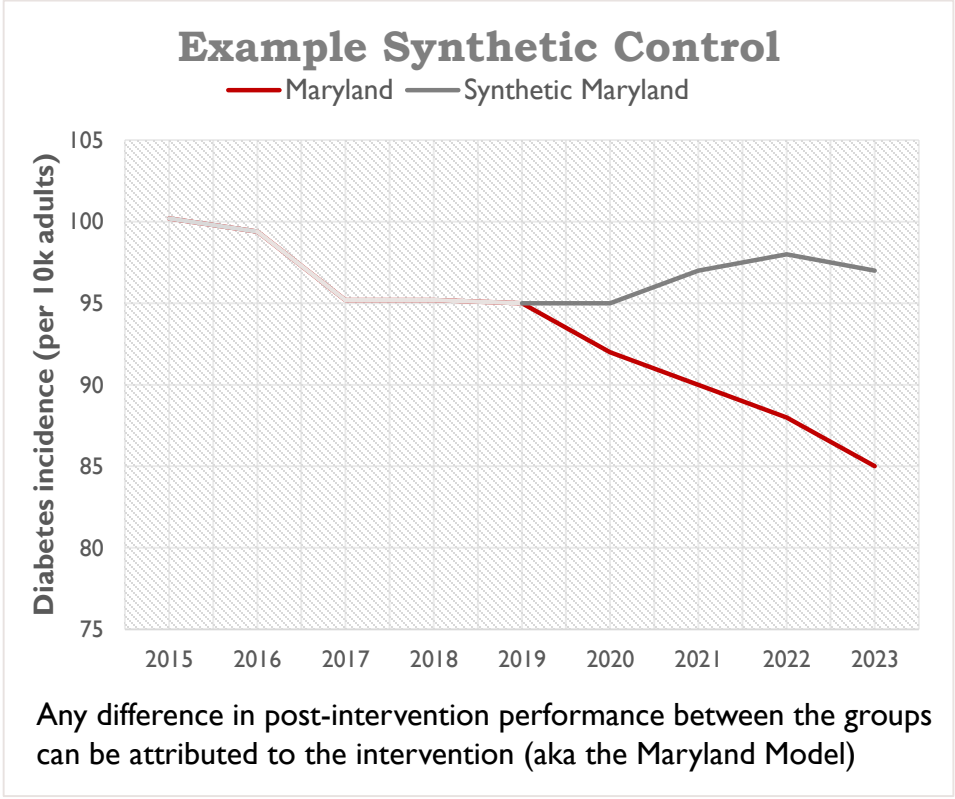
Maryland to Receive Credit (against MDPCP Costs) for Reducing Diabetes Incidence

Population Health

- Performance measure: Diabetes Incidence from BRFSS (age 35-74)
- Approach identifies a synthetic control group closely resembling Maryland
- Maryland Health Secretary and private-sector leadership now prioritizing diabetes



Weighted performance of other similar states based on pre-2019 diabetes incidence trends and other characteristics, such as race.



Any difference in post-intervention performance between the groups can be attributed to the intervention (aka the Maryland Model)

Bold **I**mprovement **G**oals (BIGs): Statewide Strategy for Population Health Improvement

Population Health

- Total Cost of Care Model requires a focus on population health improvement for all Marylanders
- Bold Improvement Goals (BIGs) are intended to align community health, provider systems, and other facets of the State's health ecosystem to improve population health and achieve success under the TCOC Model
- BIGs will leverage healthcare system focus on the TCOC Model to make meaningful investments in improving the health of Marylanders to create a sustainable healthcare system.
- Development Partners:
  - Interagency Workgroups
  - State Staff
    - Workgroups – as they are implemented into a specific program/policy
    - Commissioners, Leadership, Advisory Boards
  - Subject Matter Experts
  - Other Stakeholders

MHCC-HSCRC Collaboration

HSCRC-MHCC Collaboration

- APCD Monitoring and Enhancements
- Workgroups and Legislative Deliverables
  - Chestertown hospital and rural health delivery planning
  - EMS collaboration and reimbursement of new models of care delivery, with MIEMMS
- New TCOC Model Program Development and Provider Alignment
  - Stakeholder Innovation Group
  - Secretary's Vision Group
- Communications
  - Secretary's Vision Group Communications Subgroup
- Statewide Planning
  - Certificate of Need, Certificate of Exemption
  - Use of regulated space and operating room capacity
  - Analyze excess capacity and potential solutions

Thank you!

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**

2. **UPDATE OF ACTIVITIES**

3. **ACTION:** Certificate of Need – Maryland Surgery Center for Women, L.L.C. – Establishment of an Ambulatory Surgical Facility (Docket No. 18-15-2434)

4. **ACTION:** Certificate of Need – Johns Hopkins Surgery Centers Series – Establishment of an Ambulatory Surgical Facility (Docket No. 19-03-2437)

5. **ACTION:** CRISP HIE Designation Agreement

6. **ACTION:** Non-CDS Workgroup Report

7. **PRESENTATION:** The Maryland Model: Experience and Progress in Implementing Value-Based Health Care Reform

8. **OVERVIEW OF UPCOMING ACTIVITIES**

9. **ADJOURNMENT**

MARYLAND HEALTH CARE COMMISSION

OVERVIEW OF UPCOMING ACTIVITES

(Agenda Item #8)


ENJOY THE REST OF
YOUR DAY