Maryland Health Care Commission

Thursday, November 21, 2019

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**

2. **UPDATE OF ACTIVITIES**

3. **ACTION:** Exemption from Certificate of Need Review – LifeBridge Health, Inc. – Change in the Acute Psychiatric Bed Capacity of Two General Hospitals Pursuant to the Consolidation of Two or More General Hospitals (Docket No. 19-24-EX011)

4. **ACTION:** Approval of the 2020 MCDB Data Submission Manual

5. **PRESENTATION:** ED Overcrowding and the Impact of EMS Operations –Theodore Delbridge, MD Executive Director, MIEMSS

6. **PRESENTATION:** Study of Mandated Health Insurance Services, required under Insurance Article §15-1502, Annotated Code of Maryland

7. **PRESENTATION**: Staff and Industry Discussion of Hospice Services

8. **PRESENTATION:** Announcement of the Grant Application for Advancing Telehealth in Nursing Homes

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)

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(Agenda Item #3)

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Approval of the 2020 MCDB Data Submission Manual

(Agenda Item #4)

MARYLAND HEALTH CARE COMMISSION

2020 MCDB Data Submission Manual

COMMISSION MEETING

NOVEMBER 21, 2019

Overview

- Background
- Refresher on MCDB Reporting Requirements
- Review changes of the 2020 Data Submission Manual
- Seek approval of the 2020 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 (most do not submit claims from ERISA plans)
  - Qualified Health Plans and Qualified Dental Plans
- Data reported:
  - Membership / Eligibility
  - Claims files: Professional, Institutional, Pharmacy, and Dental
  - Provider Directory
- Medicaid MCO Data:
  - Provided by Medicaid via The Hilltop Institute
- Medicare Data:
  - Acquired through State Agency DUA with CMS

What's changing?

- Added Fields:
  - Include ***service location zip code*** **field** on the institutional services file
  - Include ***pharmacy rebate field*** on the pharmacy services file
  - Expand policy type (contract type) field in the eligibility file from 2-Tier to 6-Tier
- 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 2020 for Q1 2020 Data Reports

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

ED Overcrowding and the Impact of EMS Operations – Theodore Delbridge, MD Executive Director, MIEMSS

(Agenda Item #5)

Maryland Emergency Medical Services

Effects of Emergency Department crowding

Maryland Health Care Commission

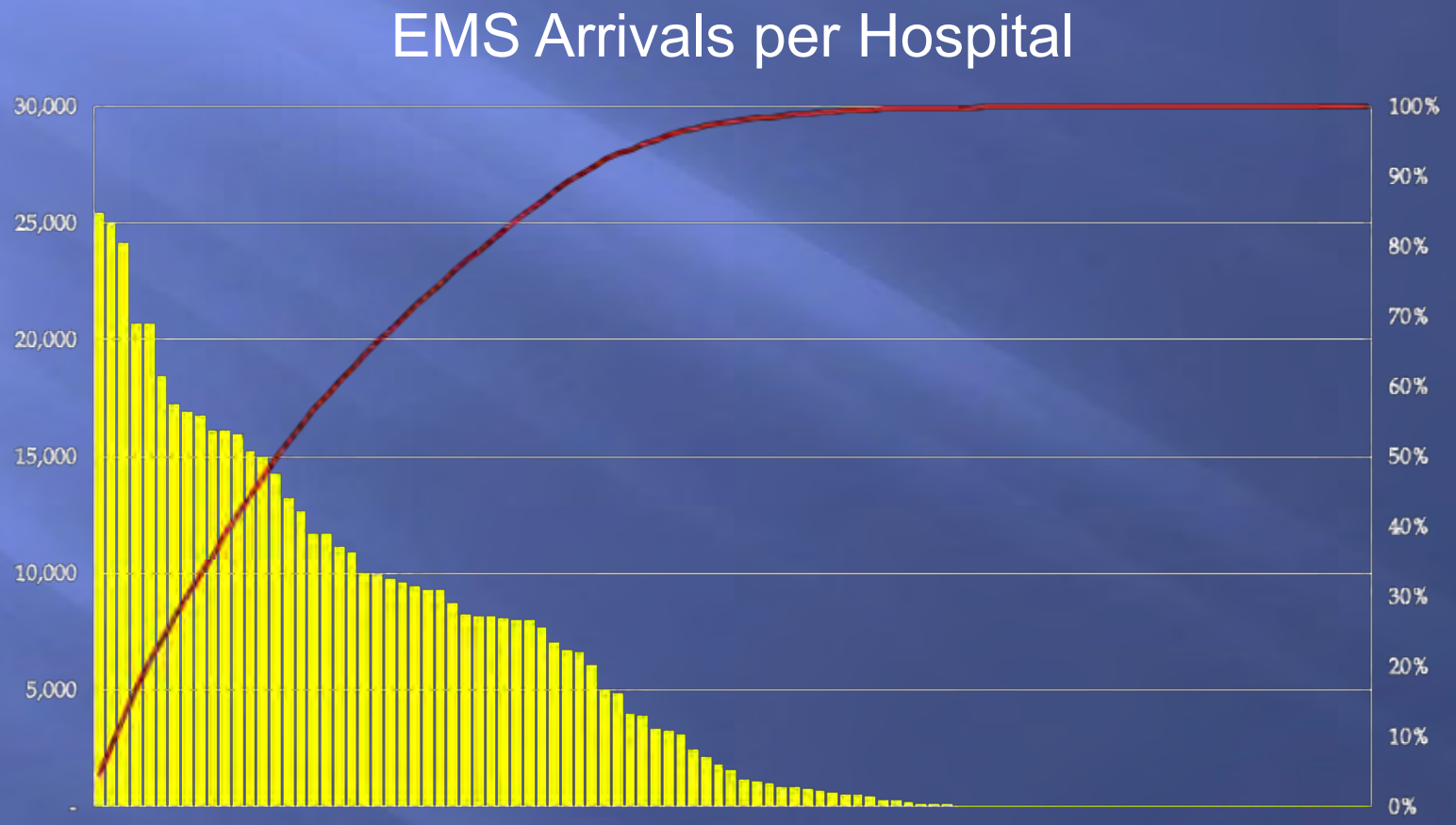
November 21, 2019

EMS Clinicians

- 19,000
- Emergency Medical Technician
  - Basic life support
- Cardiac Rescue Technician
  - Intermediate
- Paramedic
  - Advanced life support

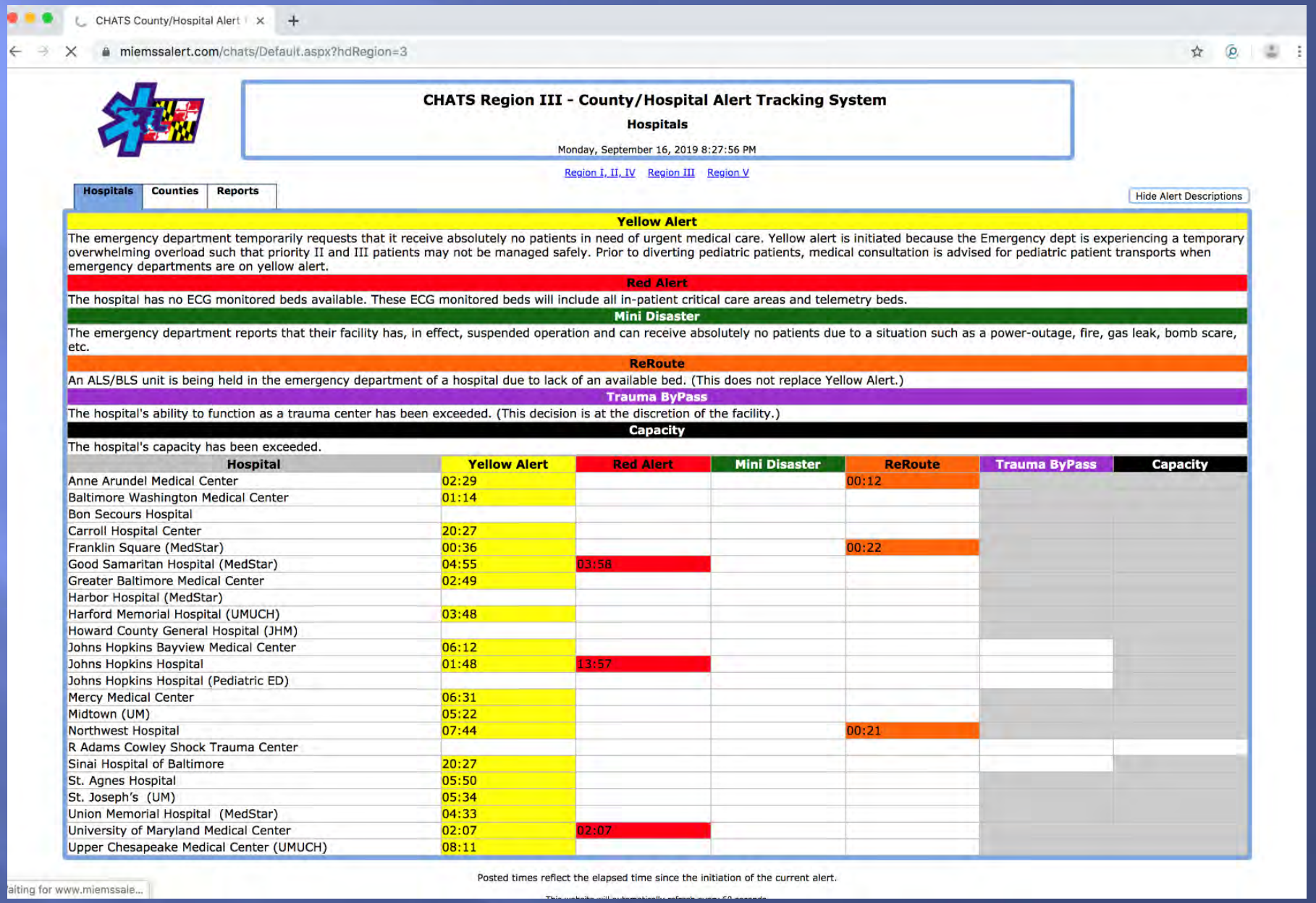
2018 EMS Patient Transports

1.2 million EMS responses; 583,000** patient transports

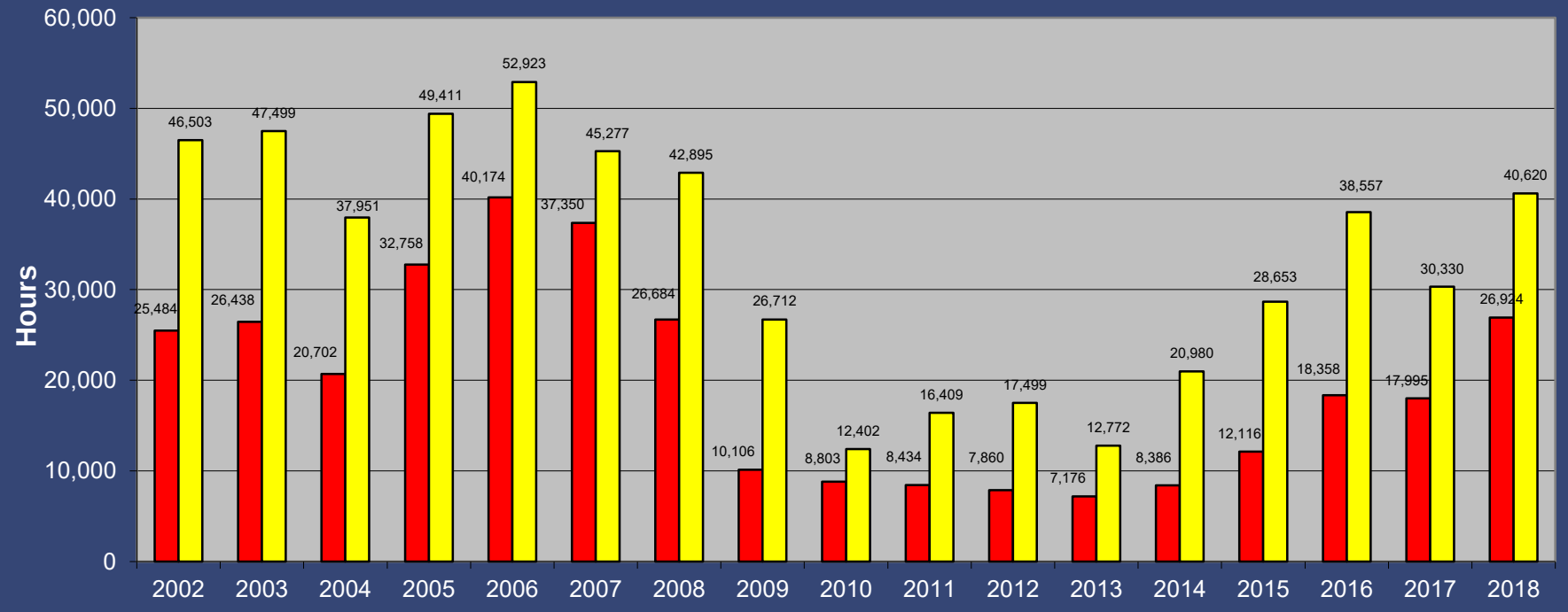


** 413,971 YTD September 30


EMERGENCY


CHATS County/Hospital Alert
miemssalert.com/chats/Default.aspx?hdRegion=3
CHATS Region III - County/Hospital Alert Tracking System
Hospitals
Monday, September 16, 2019 8:27:56 PM
Region I, II, IV
Region III
Region V
Hospitals
Counties
Reports
Hide Alert Descriptions
Yellow Alert
The emergency department temporarily requests that it receive absolutely no patients in need of urgent medical care. Yellow alert is initiated because the Emergency dept is experiencing a temporary overwhelming overload such that priority II and III patients may not be managed safely. Prior to diverting pediatric patients, medical consultation is advised for pediatric patient transports when emergency departments are on yellow alert.
Red Alert
The hospital has no ECG monitored beds available. These ECG monitored beds will include all in-patient critical care areas and telemetry beds.
Mini Disaster
The emergency department reports that their facility has, in effect, suspended operation and can receive absolutely no patients due to a situation such as a power-outage, fire, gas leak, bomb scare, etc.
ReRoute
An ALS/BLS unit is being held in the emergency department of a hospital due to lack of an available bed. (This does not replace Yellow Alert.)
Trauma ByPass
The hospital's ability to function as a trauma center has been exceeded. (This decision is at the discretion of the facility.)
Capacity
The hospital's capacity has been exceeded.
Hospital | Yellow Alert | Red Alert | Mini Disaster | ReRoute | Trauma ByPass | Capacity
Anne Arundel Medical Center | 02:29 | | | 00:12 | |
Baltimore Washington Medical Center | 01:14 | | | | |
Bon Secours Hospital | | | | | |
Carroll Hospital Center | 20:27 | | | | |
Franklin Square (MedStar) | 00:36 | | | 00:22 | |
Good Samaritan Hospital (MedStar) | 04:55 | 03:58 | | | |
Greater Baltimore Medical Center | 02:49 | | | | |
Harbor Hospital (MedStar) | | | | | |
Harford Memorial Hospital (UMUCH) | 03:48 | | | | |
Howard County General Hospital (JHM) | | | | | |
Johns Hopkins Bayview Medical Center | 06:12 | | | | |
Johns Hopkins Hospital | 01:48 | 13:57 | | | |
Johns Hopkins Hospital (Pediatric ED) | | | | | |
Mercy Medical Center | 06:31 | | | | |
Midtown (UM) | 05:22 | | | | |
Northwest Hospital | 07:44 | | | 00:21 | |
R Adams Cowley Shock Trauma Center | | | | | |
Sinai Hospital of Baltimore | 20:27 | | | | |
St. Agnes Hospital | 05:50 | | | | |
St. Joseph's (UM) | 05:34 | | | | |
Union Memorial Hospital (MedStar) | 04:33 | | | | |
University of Maryland Medical Center | 02:07 | 02:07 | | | |
Upper Chesapeake Medical Center (UMUCH) | 08:11 | | | | |
Posted times reflect the elapsed time since the initiation of the current alert.
Waiting for www.miemssale...

Hospital Use of "Alerts"



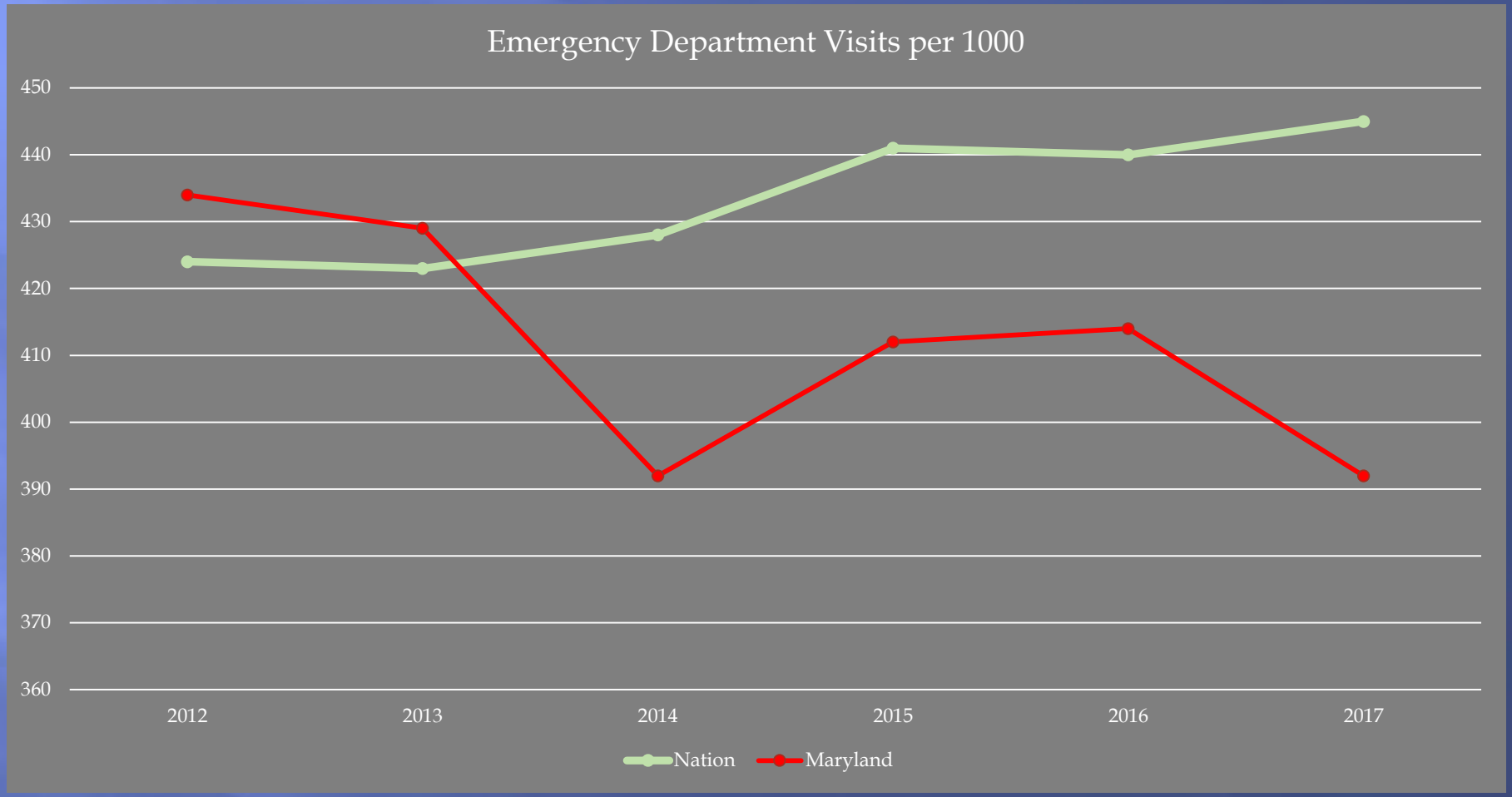
Trends in Maryland Hospital Emergency Department Utilization:

An Analysis of Issues and Recommended Strategies to Address Crowding

Report of the Joint Work Group on Emergency Department Utilization

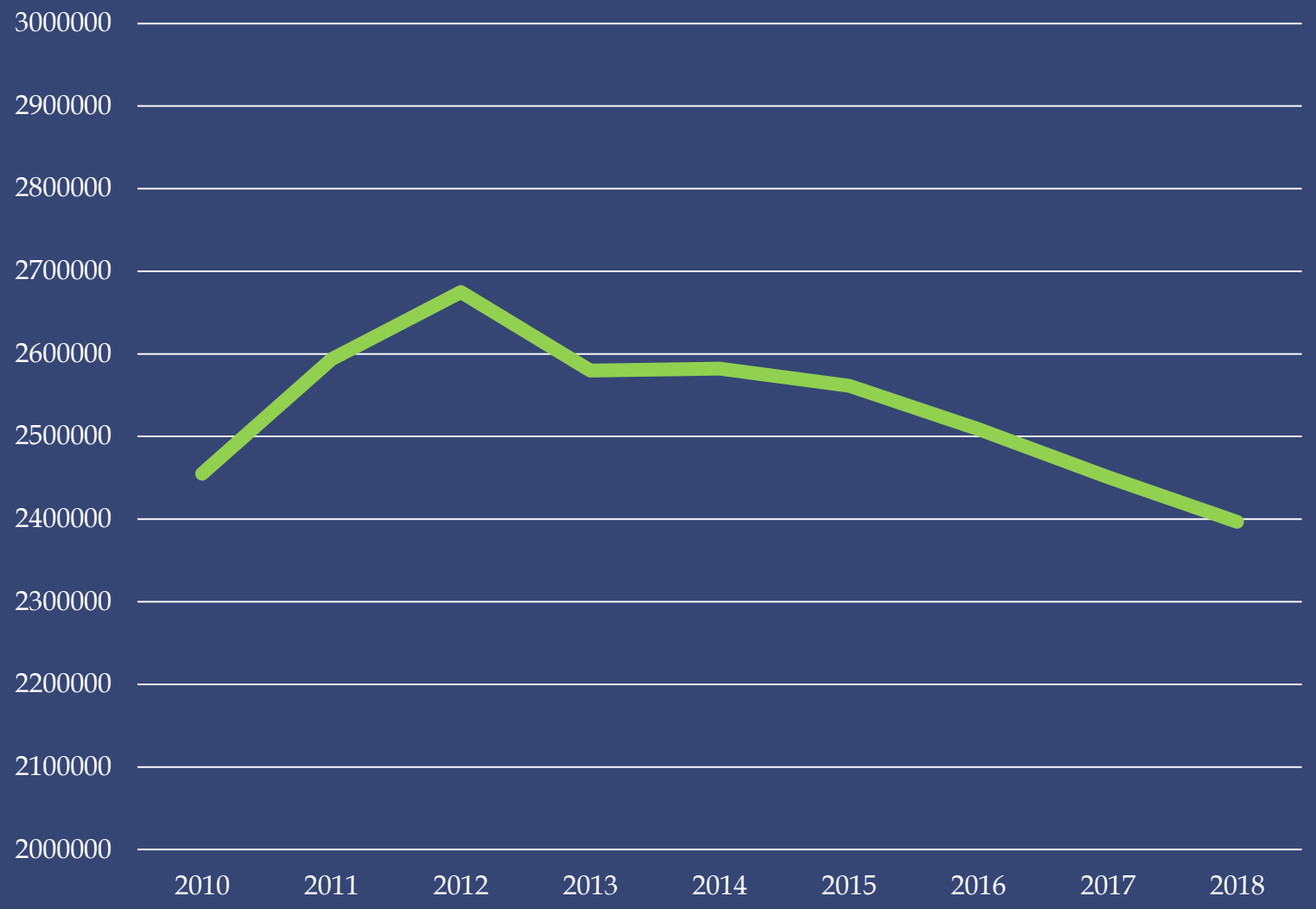
Maryland Health Care Commission
Health Services Cost Review Commission

April 2002



EMS Transports to ED: 5% increase past 4 years

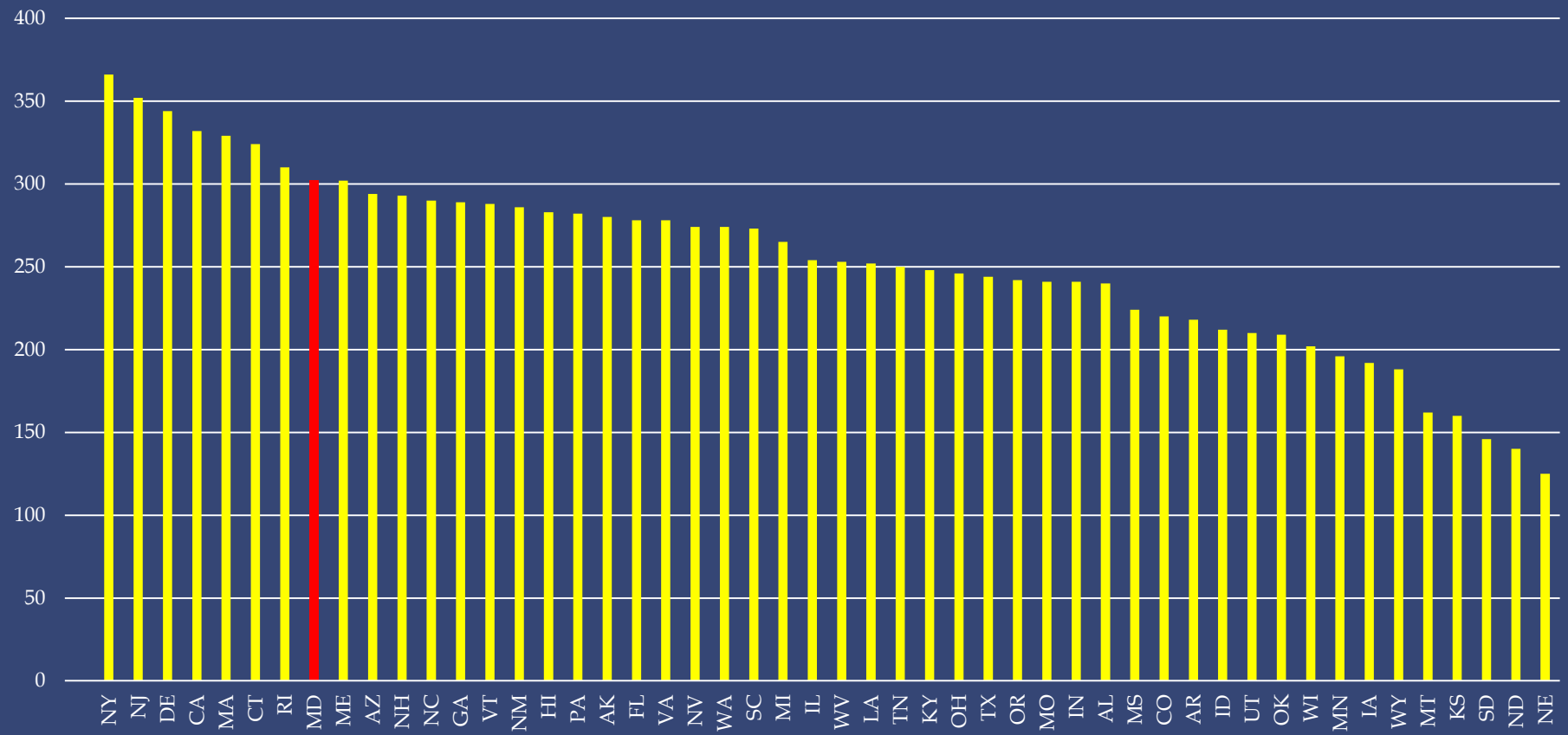
Maryland Emergency Department Cases per Year



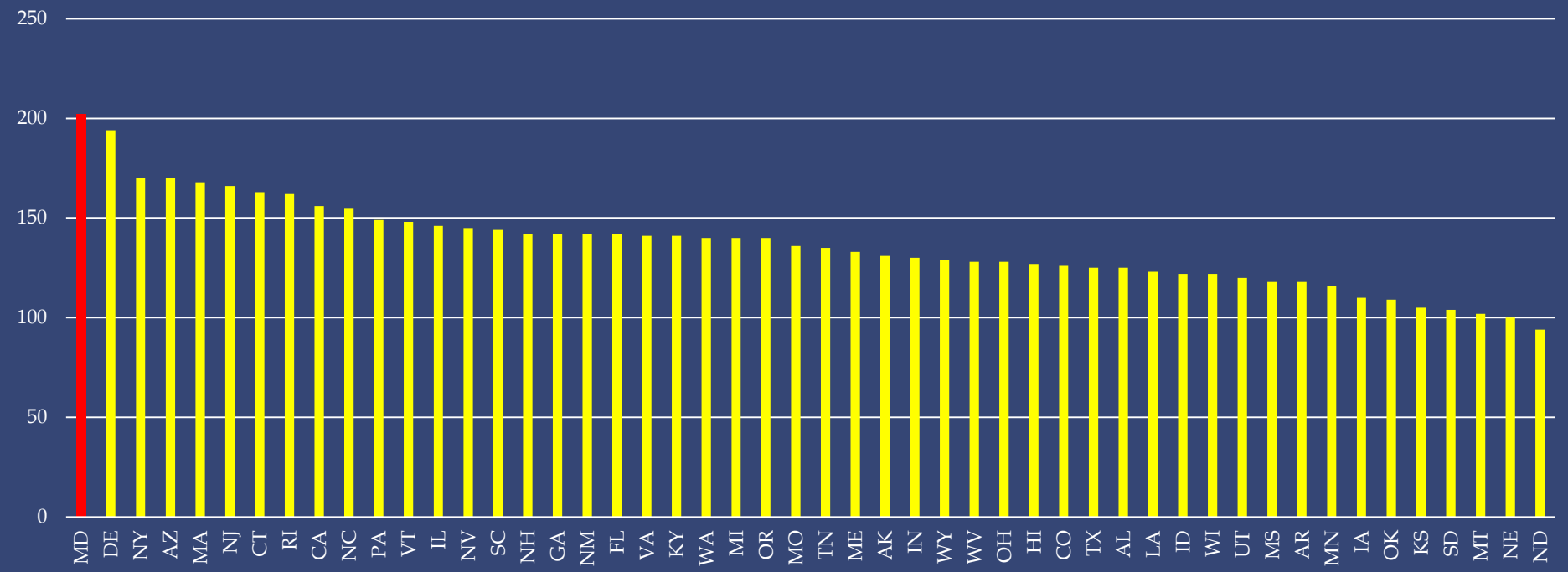
Maryland Hospitals / Emergency Departments Struggle

- Under-perform as indicated by CMS efficiency metrics
  - ED_1b: Median Time from ED Arrival to ED Departure for Admitted ED Patients
  - ED_2b: Admit Decision Time to ED Departure Time for Admitted Patients
  - OP_18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients

Time in ED to be Admitted



Time in ED for Discharged Patients

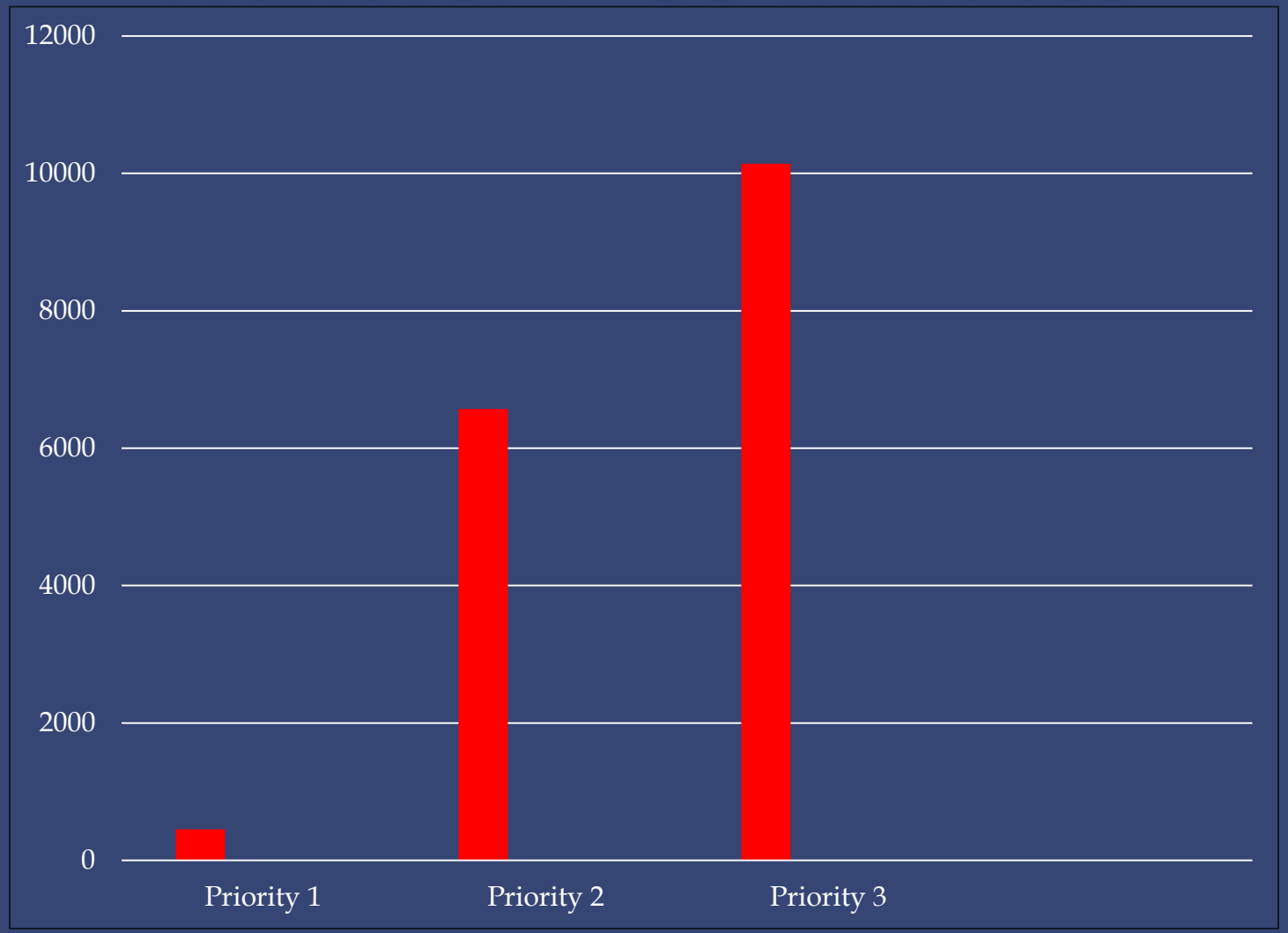


Maryland Emergency Departments Timeliness of Care Indicators

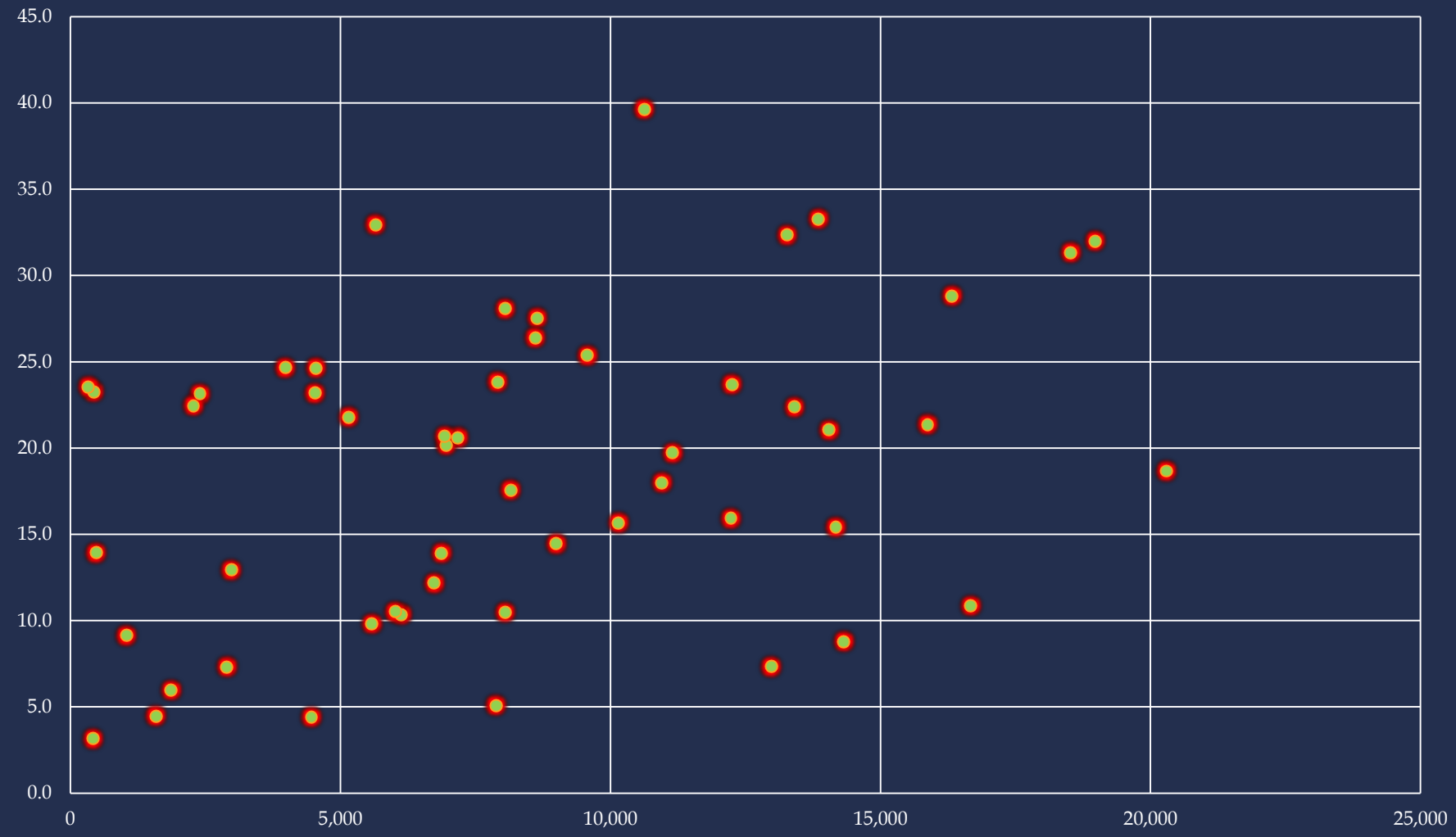
- 270 CMS indicators, collectively
- 48 (18%) are better than the national average
- Most are not as good as the national average


EMERGENCY

2019 YTD Number of Cases of EMS – ED Transfer > 60 minutes

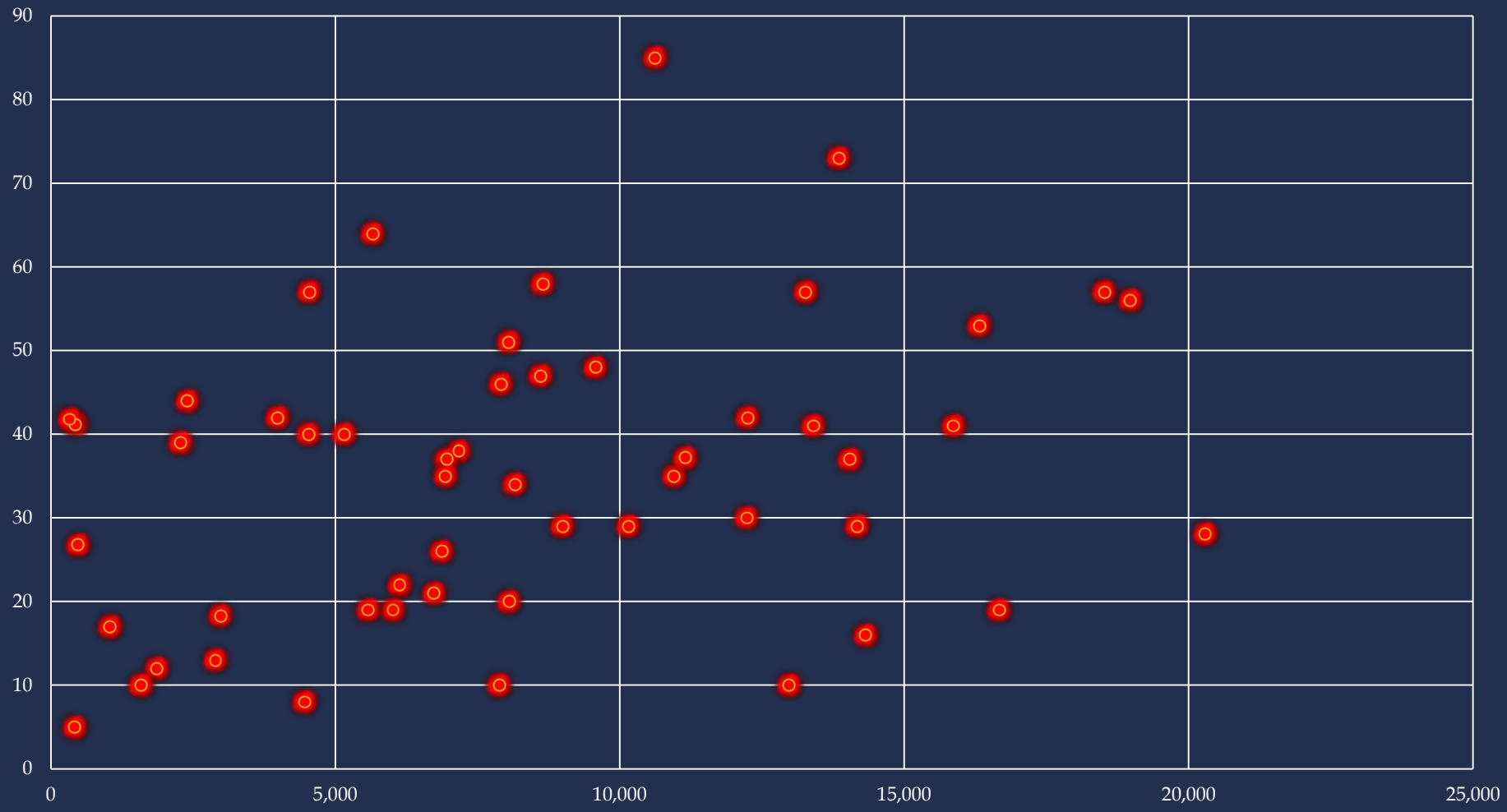


EMS – ED Transfer Intervals
per Number of EMS Arrivals per Year

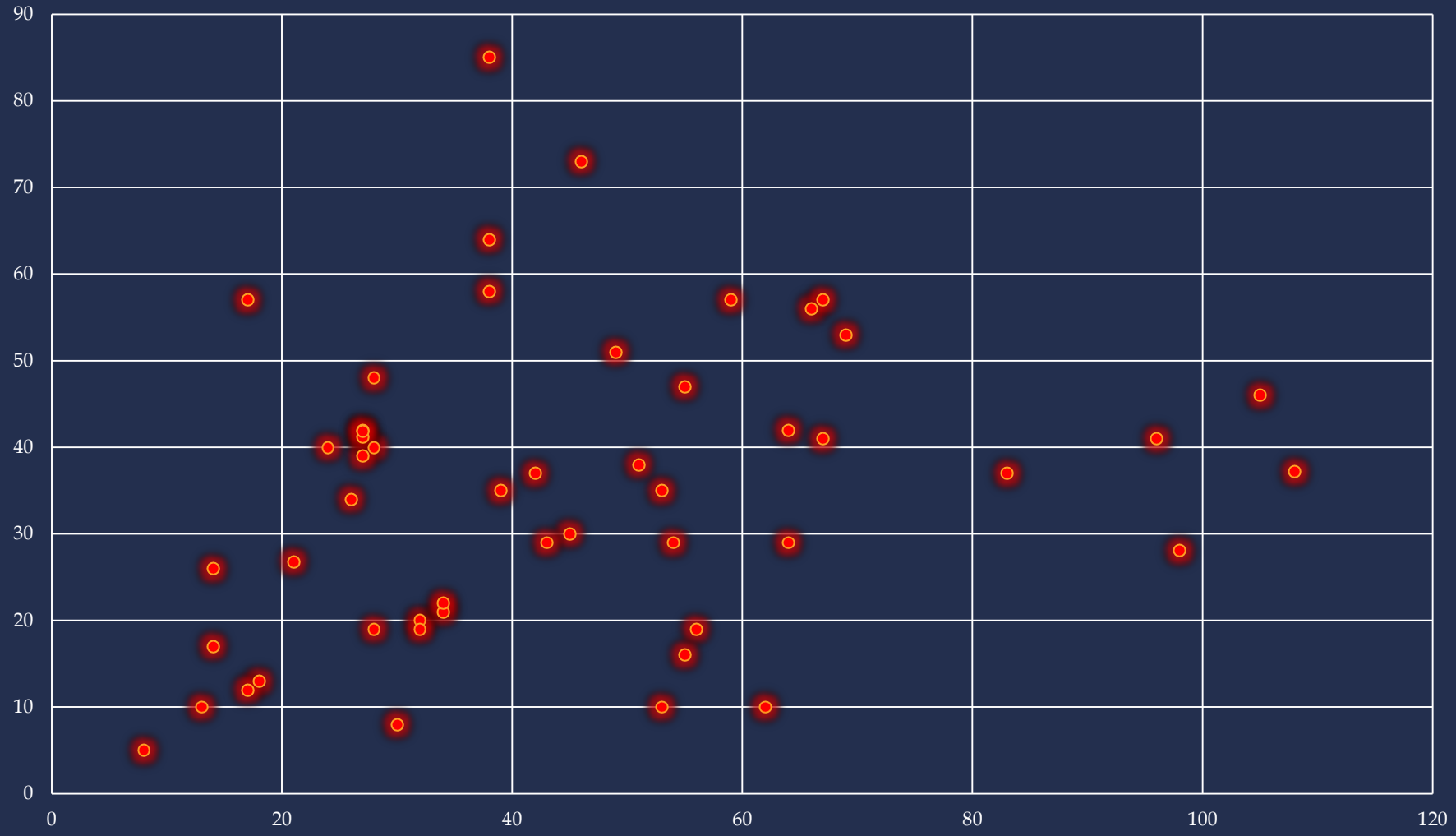


EMS – ED Transfer Interval

90th Percentile per Number of EMS Arrivals

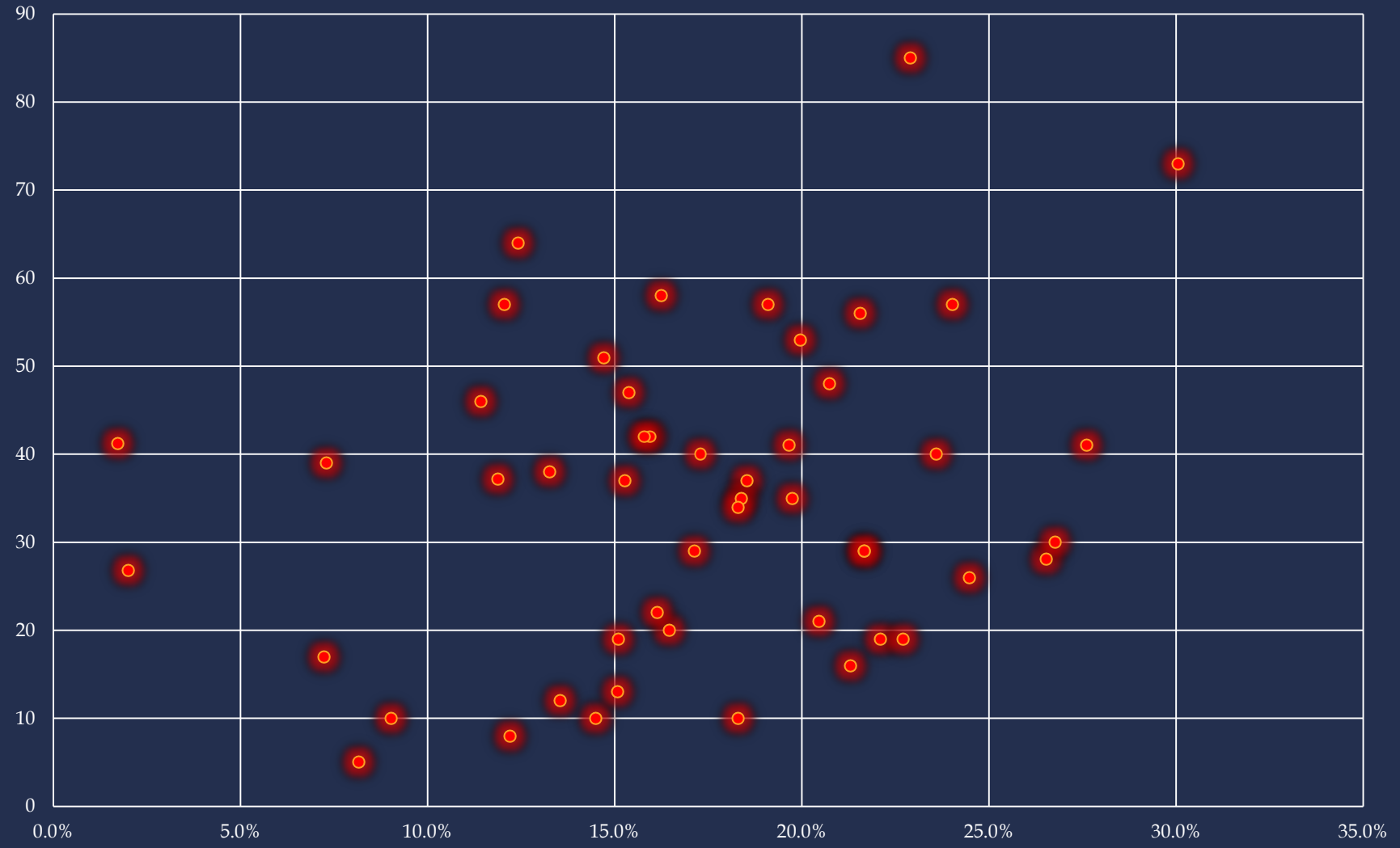


EMS – ED Transfer Interval
90th Percentile vs. ED Capacity



EMS – ED Transfer Interval

90th Percentile vs. EMS Proportion of ED Census



Maryland EDs v. "Out-of-State"

- 90th percentile EMS-ED Interval > 45 mins
  - 23% MD hospitals
  - 9% OOS hospitals

- 90th percentile EMS-ED Interval <30 mins
  - 59% OOS hospitals
  - 42% MD hospitals

What's the Problem?

- Obligation of hospital has been created
  - Not when transfer occurs
  - When patient crossed the threshold
- Failure to acknowledge obligation
- Invoke non-credentialed personnel (EMS) to deliver patient care in the hospital

Encumbered Resources

- An EMS unit "stuck" at a hospital is not available for the next emergency!
  - A real problem
  - Depletion of resources
- Municipal services and volunteer agencies are not resourced to staff hospital EDs.
  - No budget
  - No people
  - No equipment

Emergency Department

Can EMS be Different?

- Triage calls at 9-1-1?
- Treat at the scene without transport?
- Transport to non-EDs?

ETHAN
<Emergency Telehealth and Navigation>

- Houston
  - 2.3 million people
  - 250,000 EMS calls per year
- ETHAN
  - 4 years
  - Diverted 20,000 patients from ED
  - Savings: >$20million

Alternative Destination (AD) Protocol

- Low Acuity / Priority 3 Patient
- Patient is 18 years of age or older
- Able to Communicate with EMS
- Understands Consent Form/Process
- Agrees to be transported to AD

Yes

Vital Signs Acceptable?

Yes

ACCEPTABLE VITAL SIGNS

- **Respirations:** 10-20
- **Pulse:** 50-120
- **Pulse Ox:** >92%
- **Temperature:** 96-102 F
- **Blood Glucose:** 70-300

ACCEPTABLE BLOOD PRESSURES:

- **Urgent Care/PCP:** Systolic 100-160 & Diastolic 60-100
- **Stabilization/Crisis Center:** Systolic 80-220 & Diastolic 50-120

High Risk Conditions Absent?

Yes

High Risk Conditions

- Abdominal Pain, Unexplained
- Altered Mental Status
- Back Pain, Unexplained
- Chest Pain
- Dyspnea/Shortness of Breath
- Focal Neurological Deficits (Acute)
- Seizures
- Sepsis, Suspected
- Syncope
- **Requires more than minimal assistance to walk**
- **Unable to Cooperate with History and Exam**

Physical Exam without Time Dependent Needs

Yes

Physical Exam/Time Dependent Needs

- Airway
- Breathing
- Circulation (Including to Extremity)
- Disability (Deficit) or Deformity
- Severe Tenderness with Palpation/Exam
- Significant Head or Truncal Trauma
- Uncontrolled Bleeding
- **Require ALS Monitoring or Interventions**
- **Concern for Potential Deterioration in Condition**

Yes

Obtain Consent & Insurance Info from Patient

Contact & Obtain Acceptance of Patient from AD

Transport to AD

ALERT

IF ANY HIGH RISK CONDITIONS OR PHYSICAL EXAM/TIME DEPENDENT NEEDS, EMS SHALL TRANSPORT TO CLOSEST APPROPRIATE ED/FEMF

IF PATIENT IS EXCLUDED BASED ON VITALS ALONE, TRANSPORT TO CLOSEST APPROPRIATE ED/FEMF UNLESS MEDICAL DIRECTION FROM APPROVED BASE STATION AUTHORIZES TRANSPORT TO ALT DESTINATION

Rev. 06/06/2019

Direct to Waiting Room…

- Western Maryland
- Montgomery County initiative

What else is possible?

- Hospital quality metrics?
- Attention within capital improvement proposals?
- Funding for ED improvements?
  - Process
  - Physical plant

Imagine…


WHAT'S THAT NUMBER FOR 911 AGAIN?

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Study of Mandated Health Insurance Services, required under Insurance Article §15-1502, Annotated Code of Maryland

(Agenda Item #6)

Study of Mandated Health Insurance Services as Required Under Insurance Article § 15–1502

November 21st, 2019

MHCC | MARYLAND HEALTH CARE COMMISSION

NovaRest ACTUARIAL CONSULTING

1. How ACA Affected Mandated Benefits
    a. EHB and Benchmark
    b. Mandates Covered by ACA
2. Cost of Mandates
3. Mandates in Surrounding States
4. Conclusion

This presentation is a companion to the November 21, 2019 NovaRest report *"Study of Mandated Health Insurance Services as Required Under Insurance Article §15-1502."* Decisions should not be made based on the PowerPoint without also consulting the full report.

Mandates Under the Affordable Care Act (ACA)

All individual and small group plans must cover the ACA's ten essential health benefits (EHBs).[1] A State may require a carrier in the individual or small group market to provide benefits in addition to the EHBs.

1. Ambulatory patient services (outpatient care you receive without being admitted to a hospital)
2. Emergency services
3. Hospitalization (like surgery and overnight stays)
4. Pregnancy, maternity, and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care (but adult dental and vision coverage are not essential health benefits)

(1) HealthCare.gov. "What marketplace health insurance plans cover" https://www.healthcare.gov/coverage/what-marketplace-plans-cover/ Accessed August 21, 2019.

Mandates Under the Affordable Care Act (ACA)

The ACA, through EHB requirements and through the Benchmark plan, required inclusion of many benefits that were already mandated in Maryland.

Benchmark Plan:

- The Benchmark plan is the reference plan for determining what benefits must now be covered in the individual and small group markets.

- The Benchmark plan includes all EHBs and most mandated services in effect prior to 2012 for each market.

- Some mandates in effect prior to 2012 require benefits to be offered but not covered, which are not in the Benchmark plan.

- Maryland's Benchmark plan is the CareFirst HMO/HRA $1500 from 2017 for both the individual market and the small group market but differs slightly because IVF and hair protheses are not mandated benefits in the small group market.

New Mandates since 2011

The Implication of New Mandates:

- New mandates in the individual and small group markets would have to be funded by the State.
- Mandates added after December 31, 2011 only apply to the large group market (except for opioid abuse-deterrent[3]) because any new mandates to the individual and small group markets after that date would have to be funded by Maryland.
- Up to this point, the Legislature has considered mandates but has been reluctant to apply them to the individual and small group markets unless the State is not subject to defraying the added cost of the mandate.

(3) Opioid abuse-deterrent was added to the individual and small group markets since federal law permitted drug treatment benefits to be added without cost defrayal by the states.

MARYLAND HEALTH CARE COMMISSION

Cost of Current Mandates

As a Percentage of Wages ($58,769)				
Type	Individual	Small Group	Large Group	State Employee Plan
Full Cost*	1.4%	1.4%	1.4%	1.4%

As a Percentage of Premium				
Type	Individual	Small Group	Large Group	State Employee Plan
Full Cost	12.1%	14.8%	13.7%	4.9%
Marginal Cost	0.17%	0.20%	0.19%	0.07%

Marginal Cost: equals the full cost of the service minus the value of the service that would be covered either because carriers typically cover the service or the service is covered under the individual and small group EHB-Benchmark plan.

* The full cost as a percentage of wages is the same for all markets since a constant per member per month (PMPM) cost of the mandates was applied across all markets and the Maryland average wage is the same for all markets.

Mandates In Surrounding States

Number of Maryland Mandated Benefits Required in Neighboring States	
State	**2019**
Delaware	20
District of Columbia	12
Maryland*	53
Pennsylvania	15
Virginia	22

Mandates Not Required in MD
Autism spectrum disorder applied behavior treatment
Cancer monitoring test
Coverage for treatment of pediatric autoimmune neuropsychiatric disorders
Coverage for victims of rape and incest
Dental services for children with severe disabilities
Emergency department HIV screening
Hormone replacement therapy
Minimum hospital stays for hysterectomy
Pap smear
Scalp hair prosthesis as a result of alopecia areata, resulting from an autoimmune disease
School-based health centers

* Only 47 of the 53 mandates were in the scope of this report.

MARYLAND HEALTH CARE COMMISSION

Mandates In Surrounding States

Potential Cost, as a Percent of Premium, of Mandating Benefits in Maryland that are Currently Mandated in Neighboring States					
Mandates Not Required in MD	Full Cost				Total Change
	DE	DC	PA	VA	
Autism spectrum disorders applied behavior treatment services	0.30%		0.30%	0.30%	0.3%
Cancer monitoring test	0.00%				0.0%
Coverage for treatment of pediatric autoimmune neuropsychiatric disorders	0.12%				0.1%
Coverage for victims of rape and incest				0.00%	0.0%
Dental services for children with severe disabilities	0.10%				0.1%
Emergency department HIV screening		0.01%			0.0%
Hormone replacement therapy		0.01%			0.0%
Minimum hospital stays for hysterectomy				0.13%	0.1%
Pap smear	0.00%	0.00%	0.00%	0.00%	0.0%
Scalp hair prosthesis as a result of alopecia areata, resulting from an autoimmune disease	0.00%				0.0%
School-based health centers	0.00%				0.0%
Total	0.52%	0.02%	0.30%	0.43%	0.7%

MARYLAND HEALTH CARE COMMISSION

Conclusions

1. Comparison to 2012 Report
    a. A combination of the ACA EHBs and the Benchmark plan result in the mandates in effect prior to 2012 being covered in the small and individual markets.
    b. ACA has reduced the marginal cost of mandates since the EHB-Benchmark plan now covers most of the mandates in effect prior to 2012, unlike the 2012 report which could only guess on the ACA impact.
    c. Primarily the new Maryland mandates only apply to the large group market and therefore do not result in a cost to the State but do result in a cost to the large group plans and members.
2. Full Costs (see report for more details)
    a. As a percent of Premium 4.9%-14.8% depending on the market premium
    b. As a percent of Wages 1.4%

Conclusions (Cont.)

3. Comparison to Neighboring States

a. Of the 22 mandates in the neighboring states that are similar to Maryland's mandates, most are not as rich (-3% of premium impact to reduce Maryland mandates).

b. Adding the 11 mandates in other states not mandated in Maryland would result in an average cost increase of 0.7% of premium.

4. Self-Insured Market (see report for more details)

a. 12 mandates are covered by less than 1/3 of self-insured employers.

b. 81% - 90% of membership cover most[(4)] of the mandates.

(4) As determined by the primary carriers that administer health benefits for self-insured plans in Maryland.

MARYLAND HEALTH CARE COMMISSION

Conclusions (Cont.)

5. Cost of Mandates

a. The cost of each mandate is small but they add up.

b. New mandates in the individual and small group markets would have to be funded by the State.[5]

(5) Affordable Care Act § 1311(d)(3)(B) (42 U.S.C. 18031(d)(3)(B)); Department of Health and Human Services. "Federal Register/Vol. 78, No. 37." https://www.govinfo.gov/content/pkg/FR-2013-02-25/pdf/2013-04084.pdf Accessed October 16, 2019

MARYLAND HEALTH CARE COMMISSION

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9. **OVERVIEW OF UPCOMING ACTIVITIES**

10. **ADJOURNMENT**

MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Staff and Industry Discussion of Hospice Services

(Agenda Item #7)

Update on Regulation of Hospice Services and Plan for Reforming Hospice Regulations

November 21, 2019

Overview of Presentation

Regina Bodnar, Executive Director, Carroll Hospice

- An Overview of Hospice Care
  - Paying for hospice services
  - Settings where hospice services are provided
  - Relationship between hospice and the Total Cost of Care model

Linda Cole, Chief, Long Term Care Policy and Planning, MHCC

- An Overview of Hospice regulation and utilization
  - Update on implementation of Hospice Chapter
  - Profile of hospice utilization in Maryland and U.S.

Paul Parker, Director, Health Care Facilities Planning & Development, MHCC

- Ideas for updating regulation of hospice services

Discussion and Questions

An Overview of Hospice Care

What is Hospice Care?

- **Life-limiting diagnosis**
- **Life expectancy of 6 months or less**
- **Philosophy of care:**
  - **comfort rather than cure**
- **Patient and Family are the unit of care**

Who Provides Hospice Care?

- Attending Physician
- Medical Director
- Registered Nurses
- Licensed Practical Nurses
- Social Workers
- Chaplains
- Hospice Aides
- Therapists
- Volunteers
- Bereavement Counselors

Where is Hospice Care Provided?

- **Private Homes**
- **Skilled Nursing Facilities**
- **Assisted Living Facilities**
- **Continuing Care Retirement Communities**
- **Inpatient Hospice Facilities**
- **Hospice Houses**

Hospice Levels of Care

- **Routine Hospice Care**
- **Respite Care**
- **Continuous Care**
- **Inpatient Hospice Care**

Routine Care

- **Care is provided by intermittent skilled visits**
- **As disease is progressing, symptoms are managed to the patient's and family's satisfaction**
- **Care is provided in the patient's choice of residence:** *Private Home*

Facility-Based Routine Care

- **Care is provided by intermittent skilled visits**
- **As disease is progressing, symptoms are managed to the patient's and family's satisfaction**
- **Care is provided in the patient's choice of residence:**
  - *Nursing Home*
  - *Group Home*
  - *Assisted Living Facility*

Facility-Based Routine Care

- **Requires strong partnership with community of care:**
  - **Consistent goals of care**
  - **Respectful professional relationships**
  - **Collaborative energies**
  - **Hospice flexibility and acknowledgement of the uniqueness of each facility**

Respite Care

- **Family needs a break from caregiving or with balancing multiple life demands**
- **Typically up to a 5-day benefit**
- **Can be utilized multiple times**
- **Requires transfer to a hospice facility or a facility contracted with the hospice**

Continuous Care

- **Symptoms present which require skilled intervention**
- **Patient/Family desires to remain in choice of residence**
- **Hospice staff remain with patient a minimum of 8 hours/day**
- **More than one half of the care is provided by a skilled professional**

Inpatient Care

- Symptoms present which require ongoing skilled assessment and management
- Care is provided outside of the home environment
    - Hospice inpatient facility
    - Hospital scattered bed design
    - Contracted facility
    - Rental agreement

Hospice House

- **Residential care facility for hospice-eligible individuals at the routine level of care**

How is Hospice Paid For?

- **Medicare Hospice Benefit**
  - **Human services**
  - **Medications**
  - **Supplies**
  - **Medical equipment**
- **Medical Assistance**
- **Private Insurance Companies**
- **Private Pay**

Care is provided to <u>ALL</u> eligible patients regardless of their ability to pay.

Total Cost of Care

Hospice is a key player in managing the total cost of care:

- **Saves Medicare dollars in the final year of life**
- **The overwhelming majority of Maryland hospices have a hospital readmission rate of <2%**

Opportunities for Improvement

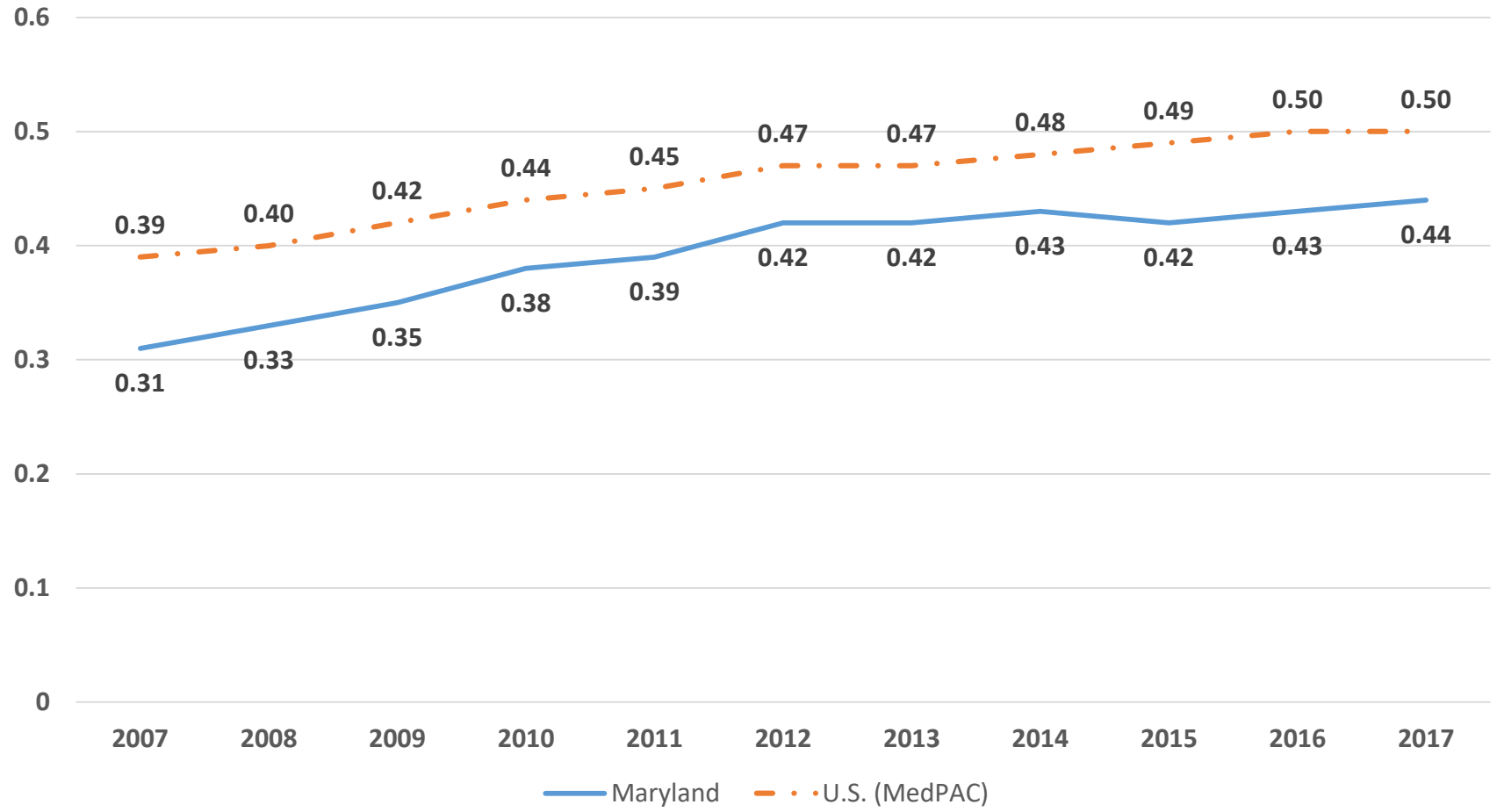
- **Earlier referrals for care**
  - **The average length of stay across the State is well below 180 days**
  - **Wide variation in referral patterns across all provider types**

An Overview of Hospice Regulation and Utilization

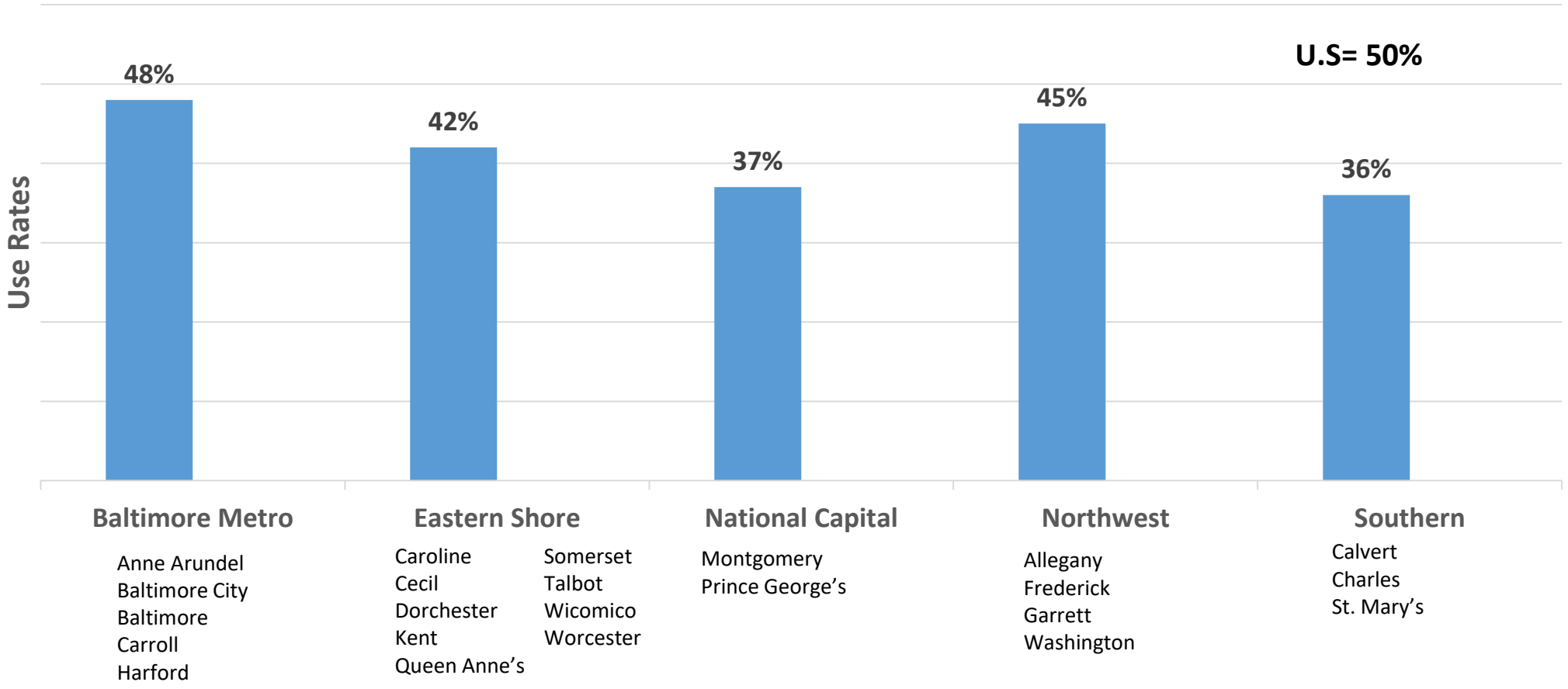
Background

- State Health Plan Chapter for Hospice Services (COMAR 10.24.13) updated in October 2013
- Mutual agreement to delay implementation, pending a three-year period for education and outreach efforts by existing hospices
- Chapter implemented in 2016- CON review cycles established for Prince George's County and Baltimore City, based on low hospice use and large populations
- CON reviews concluded in 2019 – Overall, two new hospices established and three existing hospices authorized to expand.
- Establishment of only one new general hospice was authorized in Maryland between 2000 and 2019, in Talbot County - It did not expand consumer choice since the other hospice provider authorized to serve this county has declined to compete
- MHCC's CON Modernization Report (2018) recommends allowing existing hospices to establish or add hospice bed capacity and engaging with the hospice network on further regulatory streamlining while maintaining gatekeeper functions
- Changing hospice bed capacity deregulated effective in April 2019

Hospice Use Rates, Maryland (35+ population) and U.S. (Medicare beneficiaries):2007-2017



Maryland Hospice Use Rates (Hospice Deaths/Age 35+ Population Deaths) by Region: 2017



Source: Maryland data from MHCC Hospice Survey, 2017. U.S data from MedPAC Report to Congress, 2018 (2017 data)

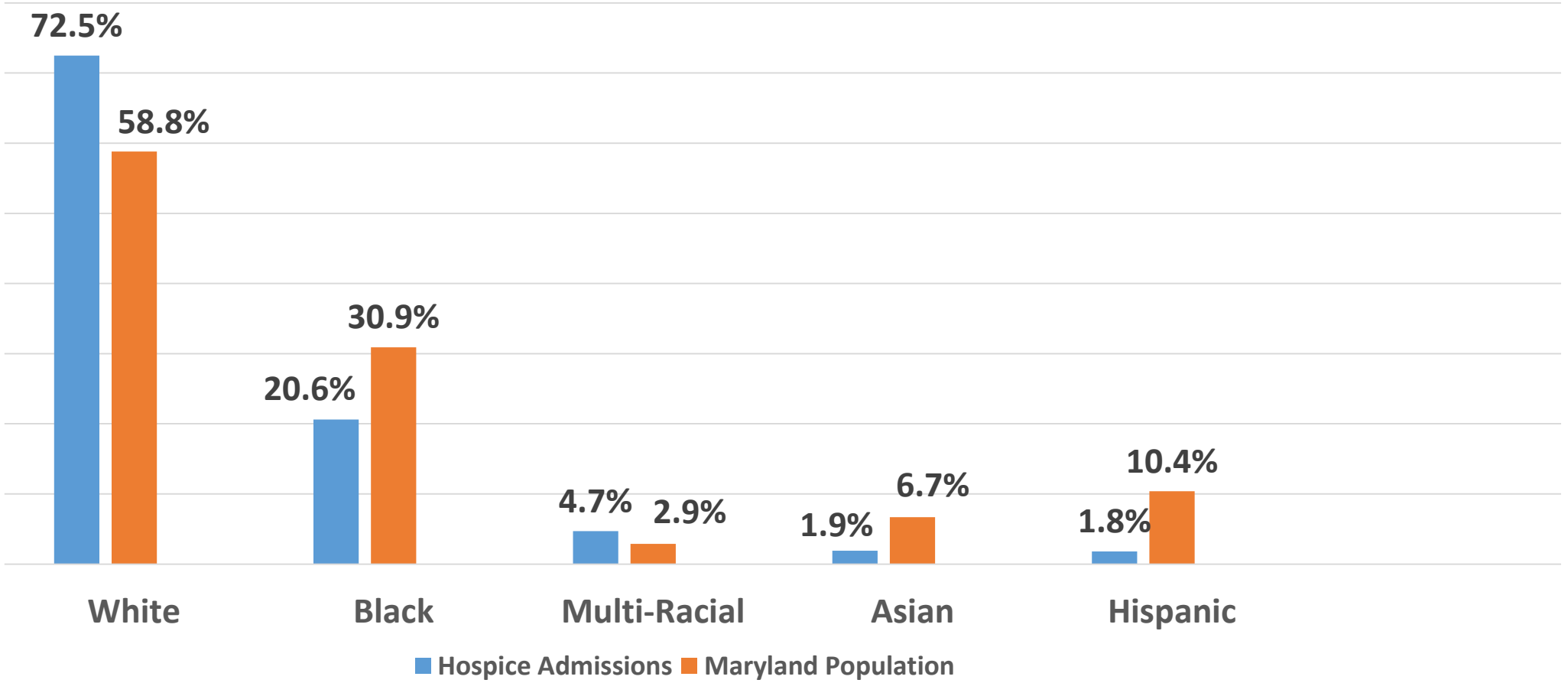
Low Use Rate Jurisdictions: Maryland, 2017

Jurisdiction	Region	Use Rate
Cecil County	Eastern Shore	38%
St. Mary's County	Southern	38%
Somerset County	Eastern Shore	30%
Baltimore City	Baltimore Metro	29%
Garrett County	Northwest	29%
Charles County	Southern	28%
Dorchester County	Eastern Shore	26%
Prince George's County	National Capital	25%
Allegany County	Northwest	23%

State use rate= 44%

Use Rate= Hospice Deaths/Age 35+ Total Deaths

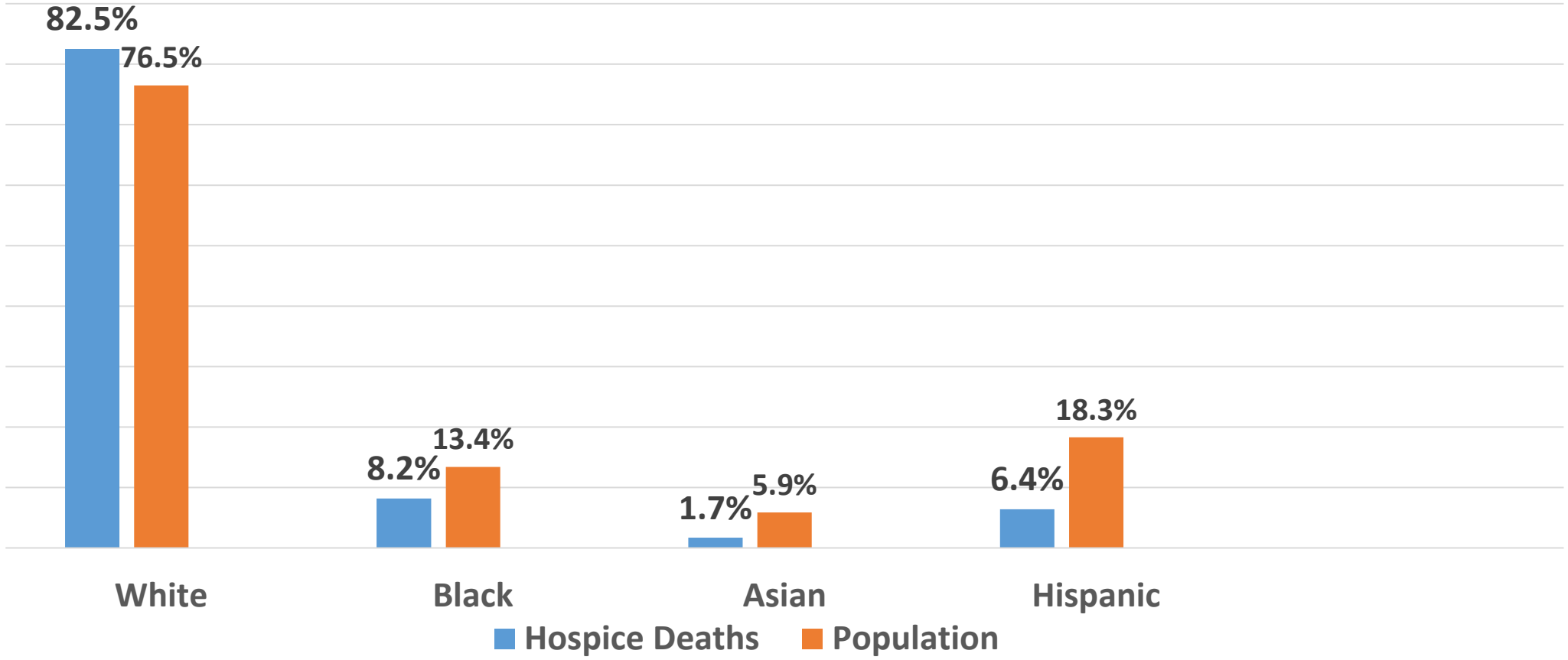
Maryland Hospice Admissions by Race/Ethnicity as Percentage of Total Admissions and Maryland Population by Race/Ethnicity as a Percentage of Total Population: Maryland, 2018



Multi-Racial includes "other."

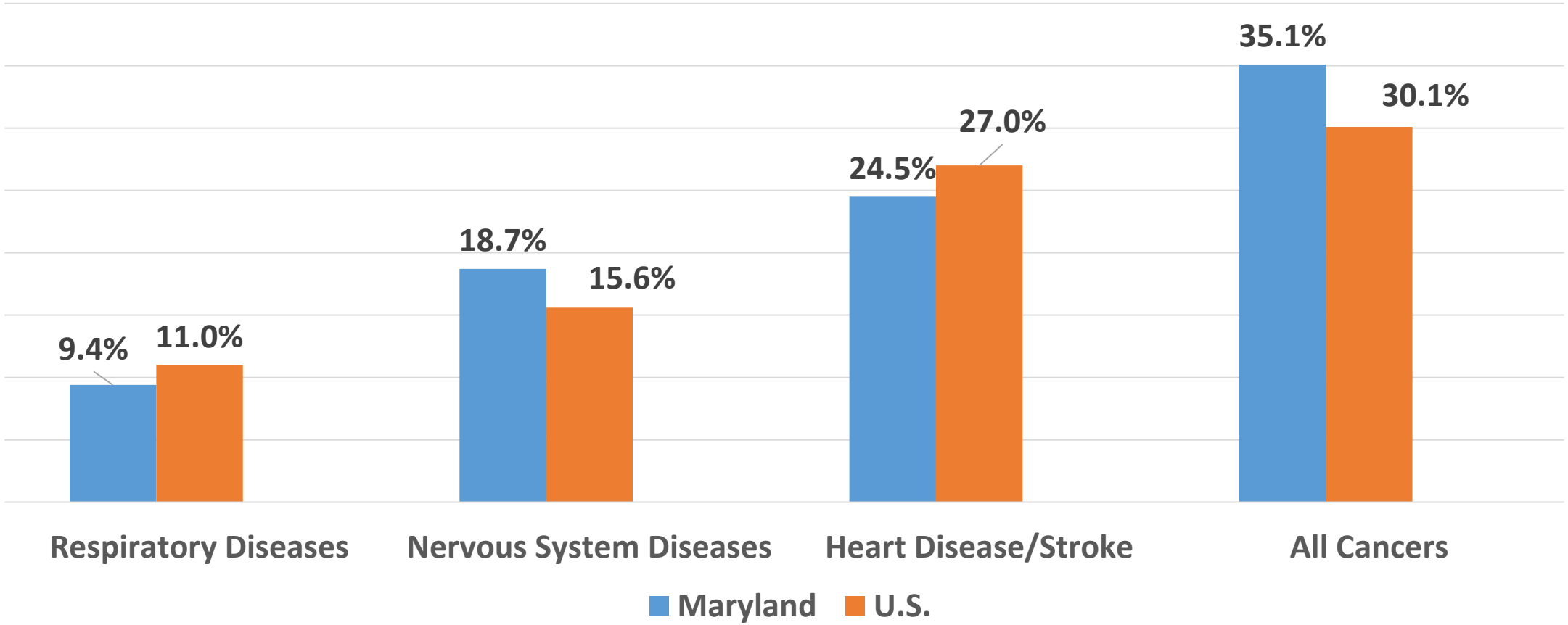
Source: MHCC Hospice Survey 2018 and U.S. Census Bureau, Quick Facts, Maryland

US Medicare Beneficiary Hospice Deaths as a Percentage of Total Medicare Beneficiary Deaths and US Population by Race/Ethnicity as a Percentage of Total Population: U.S. 2017



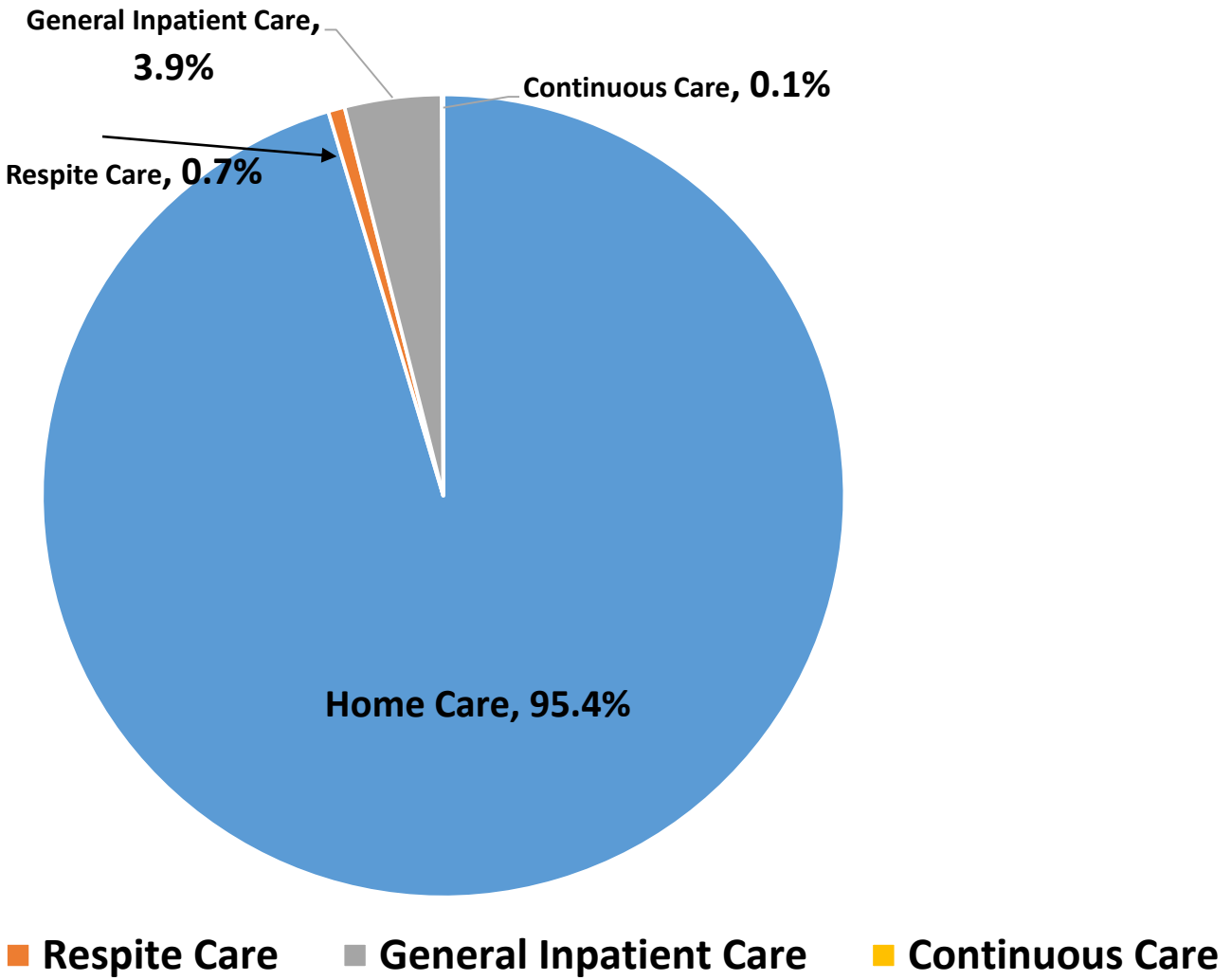
Source: NHPCO Facts and Figures, 2018 Edition and U.S. Census Quick Facts: U.S. Population, 2018

Maryland Hospice Patients Served by Diagnosis, 2018 and US Medicare Hospice Decedents by Diagnosis, 2017



Source: MHCC Hospice Survey, 2018 and NHPCO data, 2017

Maryland Hospice Patient Days by Level of Care FY 2018



Source: MHCC Hospice Survey FY 2018. Patient days by level of care.

Ideas for Updating Regulation of Hospice Services

Recommendations from MHCC CON Modernization Report

- Regulatory Changes:
  - Reduce criteria and standards
  - Allow general hospices to expand into a contiguous jurisdiction with an expedited review process
  - Modify the charity care standards to expand access to hospice care
- Statutory Changes:
  - Eliminate capital expenditure threshold defining requirement to obtain CON
  - Eliminate CON for changes in bed capacity at inpatient hospices
  - Remove hospice from the scope of CON regulation and create an alternative regulatory process to replace “gatekeeping function”

Objectives for Changing Hospice Regulation

- Increase alternative choice of providers for Marylanders
  - 12 jurisdictions have only one authorized provider of hospice services
  - 2 additional jurisdictions have only one hospice service provider (i.e., another authorized provider does not serve the county)
  - These jurisdictions have an estimated 2018 population of just under 970,000 - 16% of the state's total population

- Add new review standards
  - Preserve "gatekeeper" function, require "level playing field," and limit rate at which competition is introduced

- Streamline the CON application and review process
  - Two review cycles scheduled in 2016 were not completed until 2019

Ideas for Achieving Objectives

- Increase alternative choice of providers for Marylanders
  - Allow for regional (multi-jurisdiction) review cycles
  - Examples: an Eastern Shore (eight counties), Southern Maryland (three counties), and Western Maryland (three counties) region
  - Regional service areas could be more attractive for both expansion and new market entry
- Add New Review Standards
  - Pre-qualify applicants and allow rejection of applicants with a history of issues with licensure, certification, or Medicare fraud activity
  - Require applicants to commit to serve entire region
  - Set limits on number of expansion or new hospice establishments that can be approved for a region

Ideas for Achieving Objectives

- Streamline the CON application and review process
  - Pre-qualify applicants
  - Fast-track qualification of existing hospices proposing service area expansion
  - Reduce number of standards used in CON review

Next Steps

- Panel discussion at future Commission meeting on hospice education and outreach efforts
- Convene work group on hospice in 2020
- Reach consensus on key objectives
- Continue monitoring hospice performance and development of quality measures for hospice

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Announcement of the Grant Application for Advancing Telehealth in Nursing Homes

(Agenda Item #8)

MARYLAND HEALTH CARE COMMISSION

Grant Announcement:

Advancing Telehealth In Nursing Homes

Nikki Majewski

November 21, 2019

Telehealth Today

- States are progressively realizing the many benefits of telehealth and implementing policies to expand telehealth coverage and reimbursement
- There is growing interest in using telehealth in new and meaningful ways that identify health issues sooner and treat patients where they are, rather than having to admit or readmit them to a hospital
- The cornerstone of telehealth are the vast ways it can be leveraged to rethink care delivery and value

MHCC Grants

- MHCC has awarded 16 telehealth grants since 2014
- Grants earmark funding for innovative telehealth projects and provide lessons learned on:
  - Telehealth design and implementation tactics (e.g., assessing need, readiness, etc.)
  - Strategies to integrate telehealth within a multidisciplinary team
  - Polices to support greater diffusion of telehealth
- Some grantees used telehealth to support hospital and nursing home transitions of care for remote patient monitoring
- Key findings suggest that generally telehealth can reduce hospital encounters for non-emergent conditions, including patients that are monitored remotely from a nursing home

Grant Overview

- Aims to accelerate widespread adoption of telehealth in nursing homes and post discharge
- A key component is reengineering workflows that integrate telehealth into the standard of care to support care transitions, and curb unnecessary emergency department use and re-hospitalization (<30 days)
- A robust plan for pioneering use of telehealth is essential, including how partnerships (regional or national) will be leveraged to support statewide diffusion through a collaborative model
- A required focus is solving policy challenges related to workflow redesign, credentialing, and sustainability
- The technical infrastructure must use commercially available telehealth technology
- The grant period will be up to 24 months with a possible grant extension

Minimum Applicant Qualifications

- An organization (designated as prime) operating in the State must meet one of the following criteria:
  - Provider-led entity in an acute, post-acute, or long-term care setting
  - Vendor with a HIPAA-compliant telehealth platform (including software, technical and implementation support) and established network of physicians licensed in Maryland
  - An independent, nonprofit institute providing research, development, and technical services to the health care sector and working with a provider-led entity or vendor
- Executive leadership (champions) actively prioritizing or has a strong desire to strategically invest in workflow redesign in nursing homes and patient homes
- Prior experience implementing telehealth into the standard of care in a post-acute environment

Required Components

- Demonstrate the ability to fulfill technical (e.g., HIPAA compliance, American Telemedicine Association operating guidelines, compatibility with different end point solutions, etc.) and functional (e.g., provider and patient initiated encounters, intake process, referrals, etc.) requirements
- Configure a telehealth platform with the flexibility to support a wide-range of features, including workflow optimization, embedded video, CRISP connectivity, etc.
- Champion telehealth adoption in nursing homes through a robust outreach and education strategy
- Commit to cost sharing, scaling, and sustainability of telehealth following completion of the grant

Funding

- Up to $750,000 will be awarded to a single applicant
- A reasonable match based on the applicant's financial status is required; a minimum of a 1:1 financial match is strongly preferred

Next Steps/Timeline

- Letter of intent (required) due: December 20, 2019
- Full application due: January 31, 2020
- Grant panel review: February 2020
- Award announcement (anticipated): March 2020
- A subsequent grant may be competitively awarded to further accelerate achievement of the grant objectives

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

OVERVIEW OF UPCOMING ACTIVITES

(Agenda Item #9)


ENJOY THE REST OF
YOUR DAY