THE MARYLAND HEALTH CARE COMMISSION

FY 2019 BUDGET PRESENTATION TO THE LEGISLATURE
M00R0101

Ben Steffen,
Executive Director

The Maryland Health Care Commission

is organized around the health care systems we seek to evaluate, regulate, or influence, utilizing a wide range of tools (data gathering, public reporting, planning and regulation) in order to improve quality, address costs, or increase access.

- The Center for Health Care Facilities Planning and Development,

- The Center for Health Information Technology and Innovative Care Delivery,

- The Center for Analysis and Information Services,

- The Center for Quality Measurement and Reporting

MHCC Priorities

Modernize health planning to address changing capacity needs of a high-performing, integrated system

Expand public reporting of health system performance

Support the evolution of advanced care delivery models

Accelerate the implementation of health information technology

Modernizing State Health Planning

Convening a CON Modernization Task Force focusing on aligning CON programs with All Payer Hospital – Report Due in December 2018

Modifications to Health Plan Chapters to foster competition among quality providers

- General Surgical Services

- Workgroup convened to update Nursing Home Chapter

Convened the Rural Health Workgroup

- Completed a study of health care delivery in five counties of the Mid-Eastern Shore, Caroline, Dorchester, Ken, Queen Anne's and Talbot

- Final recommendations focus on enhancing a healthcare delivery system for rural Marylanders.

State Health Planning Operations

Approved four major projects with a combined project value of about $760 million:

- Prince George's Hospital Center and Mt. Washington Pediatric hospital - Relocation and replacement of a general hospital and special hospital-pediatric.

- Calvert Memorial Hospital - Capital expenditure for a three-story building addition.

- Sheppard Pratt Hospital at Eldridge - Relocation and replacement of a 78 bed special hospital-psychiatric with an 85-bed special hospital-psychiatric.

- MedStar Franklin Square Medical Center - Capital expenditure for replacement of surgical facilities.

Approved three nursing home projects involving additions to and/or renovations.

Approved three applications from Recovery Centers of America to establish alcohol and drug abuse intermediate care facilities; Maryland House a 16 bed facility for medically-monitored intensive inpatient detoxification.

Approved three applications to establish or expand ambulatory surgical facilities.

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Expanding Public Reporting Of Health System Performance

MHCC expansions of the data collection infrastructure to support expanded use of the data are yielding results.

In 2017, these investments continued to produce results:

- Worked in partnership with the MIA to assess use of MCDB in the MIA's expanded rate review process.

- Developed easy-to-use dashboards for examining <u>variations in costs of health care and in geographic variations in spending.</u>

- Worked with the Network for Regional Health Improvement (NRHI)to develop a <u>Total Cost of Care (TCoC)</u> report that compared the TCoC in multiple regions using a national recognized TCoC methodology.

- Designed a consumer website entitled "Wear the Cost" for display of total costs for certain 'shop-able episodes.'

Developed data sharing arrangements with HSCRC, Medicaid, and certain academic institutions that could comply with our data use requirements.

Expanding Public Reporting Of Health System Performance

Increasing greater quality transparency using the Maryland HealthCare Quality Reports:

- Expand the website to include display of Commercial Health Plan performance information – moving closer to providing interactive display of all MHCC's four performance guides, and saving over $500K.

- Expand hospital quality measures data collection requirements to comply with evolving CMS Inpatient Quality Reporting, Hospital Outpatient Reporting, and Value-Based Purchasing Program.

- Aligned Healthcare Associated Infection reporting with CMS requirements.

- Established a data sharing arrangement with the LeapFrog Group that enables Leapfrog to publish performance scores on Maryland Hospitals for the first time.

Accelerating The Implementation Of Health Information Technology

Issued <u>one telehealth grant</u> with a total value of $75,000, grantee matched funds on a 2 to1 basis;

- Demonstrate the impact of using telehealth technology to increase access to health care and improve population health in rural communities of the eastern shore.

Supported ambulatory care practices to fully use electronic health records systems, expand clinical analytics and quality reporting.

Developed value-specific HIE use cases attractive to nursing homes and other post acute care providers.

In collaboration with MDH, formed two workgroups to deliberate on policy issues related to advance directives: Criteria and Connectivity and Engagement and Special Issues.

Released a Cybersecurity Self Assessment tool to assist organizations in assessing their cybersecurity environment and offer voluntary guidance to understand, select, and implement cybersecurity controls.

Evolution of Advanced Primary Care Delivery

Continued work on the collaborative with the New Jersey Innovation Institute (NJII) for implementing CMS's practice transformation activities in Maryland.

Worked with MDH to develop the Maryland Primary Care Program that allows primary care physicians to participate in:

- Medicare reforms established through the 2015 Medicare Authorization and CHIP Reauthorization Act payment reforms; and

- Work in collaboration with hospitals to achieve the goals of the new Maryland All-Payer Model.

Convened a panel of primary care providers (Council)to identify opportunities to align primary care with the requirements of the new payment models.

Budget

FY 2019 Allowance - $60,809,628

1. Operation Budget - $14,509,628   -   (Reduction to the industries in assessments: 1.3 million for FY 2018 and FY 2019

- Industries Assessed – Payers, Hospitals, Nursing Homes, and Health Occupation Boards
- FY 2017 Close on Revenues - $4.4 million
- Total Staff : 53.9

2. Managing Critical Funds -- Trauma and HIT Operational Funds

- Maryland Trauma Physicians Services Fund - $12,000,000
- Shock Trauma Grant - $3,300,000
- Integrated Care Network (CRISP) - $31,000,000

The MHCC concurs with the analyst's recommendations.

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THE MARYLAND HEALTH CARE COMMISSION

FY 2019 BUDGET

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Ben Steffen
Executive Director

Department of Health

MARYLAND HEALTH CARE COMMISSION
BUDGET PRESENTATION

I.   OVERVIEW

The mission of the Maryland Health Care Commission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access to care in a rapidly changing healthcare environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers, and the public.

Our vision is that Maryland is a state in which informed consumers hold the health care system accountable, and have access to affordable and appropriate health care services through programs that serves as models for the nation.

II.   DETAILS-MAJOR ACCOMPLISHMENTS

The Commission's activities and accomplishments over the past fiscal year focused upon collaborative initiatives related to broadening Marylanders' access to high quality and cost effective health care services. Particular attention was given to areas such as modernizing health planning to address changing capacity needs of a high-performing, integrated system, expanding public reporting of health system performance to drive transparency, elevate advancement of primary care, and promoting use of Health Information Technology (HIT) to maximize meaningful information sharing.

Rural Health

The Rural Healthcare Delivery Workgroup (the Workgroup) was required by Chapter 420 of 2016 – Freestanding Medical Facilities – Certificate of Need, Rates and Definition, and required the MHCC to establish a Rural Health Care Delivery Workgroup to oversee a study of health care delivery in five counties of the Mid-Eastern Shore, Caroline, Dorchester, Kent, Queen Anne's and Talbot. The report, which was approved for release by the Commission in October, 2017, summarized the Workgroup's activities over fourteen months and presented the final recommendations for enhancing a healthcare delivery system for rural Marylanders.

The Workgroup achieved broad consensus on recommendations which have three aims; fostering collaboration and building coalitions in rural communities around healthcare delivery, bringing care as close to the patient as possible, and fostering participation in statewide models in rural Maryland.

The Workgroup identified innovations already under way in rural areas that could be models for the rest of the State. The Workgroup recommends expanding the Mobile Integrated Community Health (MICH) program launched in Queen Anne's County three years ago. This program utilizes the emergency medical service (EMS) providers and other skilled health care professionals, such as nurses, to care for high utilizers of the EMS system. Treating this population in their homes and linking the patient with a primary care practice or other routine source of care reduces emergency department utilization and improves the quality of life for the patient. The initial program, developed through a grant from Care First Blue Cross Blue Shield and supported by personnel from the local health departments and the EMS system, has already produced impressive results. Other jurisdictions are developing similar programs through partnerships with the hospital system. Maryland can take a step forward by developing sustainable funding mechanisms to enable MICH programs to take root in more jurisdictions.

As these recommendations move through the legislative and regulatory processes, it is imperative to consider how they can be applied more broadly to all of rural Maryland, as well as suburban and urban communities. Each community is different and the Workgroup recommendations recognize the need for community involvement in improving health outcomes.

Certificate of Need (CON)

During FY 2017, the Commission approved seventeen (17) CON applications and one (1) change to a previously approved project. One application was denied and two applications were withdrawn from the review process.

After a lengthy review process that included submission of replacement and modified applications, the relocation of Prince George's Hospital Center was approved in October 2016. As approved, the project complied with conditions set out by the Commissioner/Reviewer that mandated specific changes in project scope and cost.

Another lengthy review involved competing applications to introduce cardiac surgery services in Anne Arundel County. Anne Arundel Medical Center prevailed in that review, a decision that is currently under appeal by the University of Maryland's Baltimore Washington Medical Center and Prince George's Hospital Center. Other hospital reviews that were completed involved an addition and renovation to expand and modernize Calvert Memorial Hospital, the relocation of the psychiatric specialty hospital currently operated by Sheppard Pratt Health System in Ellicott City, and a replacement of the surgical facilities at Med Star Franklin Square Medical Center.

The Commission approved three CON applications from Recovery Centers of America to establish alcohol and drug abuse intermediate care facilities in Cecil, Prince George's, and Charles Counties. These facilities will add a total of 140 medically-monitored intensive inpatient detoxification beds and another 174 medically-monitored intensive inpatient treatment beds to the State's inventory of treatment beds. Each of these was challenged by interested parties. Another 16-bed ICF for medically-monitored intensive inpatient detoxification, Maryland House, was approved for development in Linthicum (Anne Arundel County) during FY 2017.

Three nursing home projects involving additions to and/or renovations of nursing homes were approved, as were three applications to establish or expand ambulatory surgical facilities.

Determinations of Coverage and Other Actions

In FY 2017 the Commission issued 169 determinations involving actions proposed by persons or health care facilities requiring a decision with respect to the need for CON review or other Commission authorization. These actions were made in accordance with statutory and regulatory provisions outlining: (1) the scope of CON coverage; (2) the types of projects or actions that, while similar in their general nature to projects that require CON review and approval, can be implemented outside of the CON regulatory process; and (3) notification requirements and attestations which must be met to obtain the Commission's determination that CON is not required.

Additionally, the Commission reviewed one request by a holder of a CON to acknowledge completion of their projects and readiness for operation ("first use review"). The Commission acknowledge four cases in which facilities with temporarily delicensed beds did not take timely action to bring these beds back into operation or to extend temporary de-licensure status, thus eliminating these beds from the state's inventory. In FY 2017 sixty (60) of these permanently delicensed beds were CCF beds, and 19 were residential treatment center beds.

Benchmarking Medical Care Data Base (MCDB) Data

Commission staff collaborated with the Maryland Insurance Administration (MIA) staff to (a) benchmark MCDB data to the Actuarial Memoranda data submitted to the MIA in order to enhance trust of the MCDB for use in state regulatory decisions in evaluating the MCDB for rate review activities; and (b) to develop decision support tools for the MIA rate review process. Throughout most of FY 2017, Commission staff worked closely and successfully with our largest payor to align the carrier's MCDB

data with data submitted by the company to the MIA via Actuarial Memoranda. Collaboration and partnership between the Commission staff and the company made this effort a great success. Staff continues to work with other payors to align the MCDB with Actuarial Memoranda data for the individual and small group markets. Throughout FY 2017, the Commission staff provided the MIA with trends and per member per month (PMPM) analyses to support the MIA's 2018 rate review cycle.

Total Cost of Care
The MCDB database vendor, under MHCC's guidance, continued to develop and evolve the MCDB data warehouse to meet the Commission's needs. SSS has developed DataMarts for MHCC users to access data from the structured data warehouse (an SQL database). Currently, the DataMarts have data from 2010 to 2014 for eligibility professional, institutional, and pharmacy services. The DataMarts divide data into two sections: a historical section which houses data from 2010 to 2015; and, starting with 2016 data, a dynamic section which will eventually consist of three years of data plus quarterly data for the current year. Users can access the data via SQL or SAS querying via the DataMarts, which are made available through a secure data center, where staff can access data on virtual machines. The secure data center provides a safe environment to access and analyze the sensitive healthcare data contained in the MCDB. Also new for 2016 data, staff have successfully collected line-level data for institutional services, which is very important for analyses such as the Network for Regional Healthcare Improvement Organization (NRHI) Total Cost of Care project.

The Network for Regional Healthcare Improvement (NHRI) Total Cost of Care Projection
In FY 2017, MHCC contributed to a report published by NRHI. This first-ever comparison of what commercial insurers are paying for healthcare in different regions shows wide variation in spending. The report from NHRI, a national organization representing more than 35 regional multi-stakeholder groups working to improve healthcare, analyzed spending by commercial health insurance plans in five different regions nationwide (Utah, Maryland, St. Louis, Minnesota, and Oregon). Staff, in partnership with The Hilltop Institute at the University of Maryland, Baltimore County (UMBC), participated in the NHRI study and produced the Maryland results using data from the MCDB.

Analysts found a $1,080 yearly difference in the amount plans spend, on average, per enrollee, with a high of $369 per-enrollee-per-month in Minnesota and a low of $279 in Maryland. In addition to having the lowest overall risk-adjusted PMPM cost of $279, Maryland also had the lowest overall total cost index (TCI) (0.86), which was 14 percent below the all-region average. The State's TCI reflects its lower overall service utilization (RUI) – lowest among the regions at 0.88 – and its slightly below average prices (PI) at 0.97. The study results are detailed in From Claims to Clarity: Deriving Actionable Healthcare Cost Benchmarks from Aggregated Commercial Claims Data, which was developed with support from the Robert Wood Johnson Foundation.

Wear the Cost
In October, 2017 the MHCC launched a consumer website detailing episode-based measures as part of its mission to promote price transparency. This public facing consumer website displays healthcare prices and quality measures for entire episodes of care and associated informational resources for visitors including a FAQ's section, blog posts, and the opportunity to participate in MHCC's social media campaign for the website. The site is entitled "Wear the Cost" and illustrates the variation that exists in price and quality for the same episode type across Maryland hospitals. The first public version of the site includes four procedural episodes: total hip replacement, total knee replacement, hysterectomy, and vaginal delivery. For each of these episodes, the user will be able to see, by hospital, the cost for typical/expected care, the cost that went towards potentially avoidable complications, and the annual average cost. Quality measures are also reported for each hospital's episodes. Data used to populate the first version of the website are exclusively commercial claims data (2014 to 2015) from the MCDB.

After the initial launch, Commission staff will continues working with its contractors to produce similar episode costs using Medicare data. Later in FY 2018, that information will be displayed in the second iteration of the website. The Commission will release price information on common outpatient procedures and other inpatient procedures in future years.

Hospital Quality Reporting
In FY 2017, MHCC's quality and performance data collection for Maryland Hospitals continued to evolve. Previously, the MHCC and the HSCRC issued a joint policy directive that significantly expanded the quality measures data that Maryland hospitals were required to collect and report. As part of Maryland's exemption from CMS Value-Based Purchasing Program (VBP) for hospital reimbursement, Maryland must maintain a comparable hospital quality program that meets or exceeds the CMS program in cost and quality outcome standards. In response to this CMS directive, MHCC expanded its hospital quality measures data collection requirements to comply with evolving CMS Inpatient Quality Reporting, Hospital Outpatient Quality Reporting and VBP data collection requirements.

Hospital performance on Healthcare Associated Infections (HAIs) metrics were mixed in during FY 2017. Central-line associated bloodstream infections in ICUs had decreased by over 40% during the six years since the information was first publicly reported in Maryland's Hospital Guide. For the first time since 2014, when public reporting for Clostridium Difficile (CDI) began, the statewide performance improved to "better" than the national benchmark. Methicillin-Resistant Staphylococcus Aureus (MRSA) performance was better than years past, but still highlights an area for improvement.

Influenza Vaccination Survey
For the past seven years, MHCC has conducted an annual survey of hospitals to gather information on employee vaccination rates and hospital policies and practices designed to promote employee flu vaccination. Since the release of this information on the Hospital Gude in 2010, Maryland hospitals have achieved a 19% increase in their employee influenza vaccination rates from 78% to over 97%.

Similarly public reporting of nursing home-specific results has been in place since 2011 as an incentive for facilities to improve their healthcare worker vaccination rates. Since the inception of the nursing home and assisted living survey, nursing home staff flu vaccination rates have increased from 50% during 2009-2010 flu season to 87% during the 2016-2017 flu season. The staff flu vaccination rate for Assisted Living Facilities have not been as positive as rates have increased from 50% in 2012 -2013 to 55% in 2016-2017 flu season.

Health Plan Quality and Performance
Historically, MHCC produced an annual series of three Health Plan Quality Reports. In FY 2016, the Quality Report series was transitioned into an interactive web-based guide and incorporated into the Commission's consumer website – the Maryland Healthcare Quality Reports (MHQR). The MHQR website shows that Maryland's health benefit plans are maintaining a track record of good performance across many of the measures and indicators being evaluated. When considering all measures, several stand out for high performance, including primary care for children and adolescents, adult and child respiratory conditions, and primary care for adults with respiratory and cardiovascular conditions and behavioral health.

MHCC has successfully streamlined the Health Plan Quality Reporting Initiative by eliminating Maryland member-specific HEDIS® and CAHPS® survey data collection and transitioning to the use of NCQA plan-wide results. This change was necessary to reduce redundancy in the reporting system as well as to fulfill the State mandate to report on commercial health plans utilizing the most efficient and cost effective strategy. The revised strategy for HEDIS® and CAHPS® data collection is expected to

result in significant savings to the MHCC and was implemented with the 2018 data audit and member survey cycle.

Practice Transformation Network (PTN)
Staff executed a sub-contract partnership with MedChi, the State Medical Society, and the Department of Family and Community Medicine at the University of Maryland School of Medicine. The sub-contract is with the New Jersey Innovation Institute (NJII) for implementing practice transformation activities in Maryland. CMS entered into a cooperative agreement with NHII for a PTN. The Center began enrolling practices in the Maryland PTN program, which includes advancing the exchange of healthcare information between CRISP and ambulatory practices and engaging in educational sessions. The Center continues to synchronize recruitment activities by sharing information with two other PTN awardees working with Maryland based practices. At this time 1,500 providers are enrolled in the PTN.

Statewide Designated Health Information Exchange Oversight
MHCC is responsible for advancing the adoption and meaningful use of health information technology (health IT) in the State to improve the experience of care, the health of the population, and reduce the costs of health care. Key aspects of health IT include electronic health records, health information exchange (HIE), mobile health, and telehealth. MHCC's initiatives focus on balancing the need for information sharing with the need for strong privacy and security policies, and transforming care delivery.

CRISP (Chesapeake Regional Information System for our Patients) is one of the strongest HIEs in the country. Maryland's current framework for oversight and development of health information technology has contributed to the increased adoption of electronic health records and use of CRISP by providers. MHCC and HSCRC share responsibility for the development of the HIE. The MHCC provides technical oversight of CRISP's efforts and works with stakeholders to promote the broadest use of CRISP while protecting the privacy and the security of protected health information. CRISP is playing a key role in building the information technology infrastructure needed to support essential information needs in Maryland's All Payer Model.

Currently in its ninth year of operation, CRISP continues to make progress towards building a robust statewide HIE. Participants in Maryland that submit clinical information to CRISP include all 47 general acute care hospitals, 1 specialty hospital, 102 long-term care facilities, 12 radiology facilities, and 3 laboratories. State governmental agencies also submit information to CRISP. MDH, Behavioral Health Administration collects information regarding the prescribing and dispensing of drugs that contain controlled dangerous substances (CDS). This information is shared with CRISP to support the Prescription Drug Monitoring Program (PDMP). CRISP serves as the access point for clinical providers, including prescribers, pharmacists, and other licensed healthcare practitioners for viewing filled CDS prescriptions. MDH's Infectious Disease and Environmental Health Administration also provides immunization information from ImmuNet, Maryland's Immunization Registry, to CRISP, which is available through the CRISP query portal. A wide variety of health care provider organization access data is published by CRISP; these include ambulatory practices, Federally Qualified Health Centers (FQHCs), hospitals, LTCs, and independent laboratory and radiology companies. Certain payors, pharmacy organizations, and governmental agencies also access data made available through CRISP.

Additionally, information made available through CRISP is accessible for query and Internet-based portal (Query Portal). Provider utilization of CRISP services has increased over the last fiscal year. As of June 2017, there were 1,683 health care organizations using the Query Portal, compared to 744 organizations in the previous year. Participation among ambulatory providers has increased from 1,505 providers in June 2016 to 2,527 in June 2017. Comprehensive Care Facility (nursing homes) participation has also increased from 116 facilities in 2016 to 172 facilities in 2017. The average number of portal queries per month has also grown from 104,506 to 122,223. The Encounter Notification System (ENS) offers real-

time notification alerts to providers when one of their patients has an encounter at a participating hospital, and are used to coordinate and facilitate post-acute care follow up. ENS has also seen an increase in participation from 727 to 1,006 organizations. Users of the PDMP, which provides information on all Schedule II-V drugs prescribed at any Maryland pharmacy through the Query Portal, have increased from 7,902 in 2016 to 31,312 in 2017. Users of the PDMP includes prescribers, pharmacists and their delegates. The General Assembly passed a law in 2016 that requires practitioners authorized to prescribe Schedule II-V drugs to register with the PDMP by July 1, 2017.

Comment [t1]: David -- This seems out of date

Financial audits of CRISP are conducted annually by an independent third party auditor, CliftonLarsonAllen LLP (CLA). CLA audits CRISP financial statements, which include a review of their compliance with certain provision in law, regulations, contracts, and federal grant agreements. The MHCC also facilitates the annual privacy and security audit of CRISP, which is conducted by Myers and Stauffer. The audit evaluates the extent that CRISP and its vendors process, transmit, and store electronic data in a secure manner that minimized the potential for an unauthorized disclosure or breach of protected health information. New cyber-security testing procedures were added to the audit scope this year to assess CRISP controls on preventing unauthorized access from both internal and external threats, such as hackers.

III.   BUDGET

The MHCC's budget allowance for FY 2019 is $60,809,628. Special funds of $14,509,628 supports staffing and mandated requirements of the MHCC. The Maryland Trauma Physician Services Fund accounts for $12,000,000; $3,300,000 supports the Maryland Emergency Medical System Operations grant, and $31,000,000 is for the Integrated Care Fund.

The Commission's special fund closed at the end of FY 2017 with a 4.4 million dollar surplus. Previously, it had been 10 years since we had received an increase in our assessment cap. Because of the uncertainty, of whether a cap increase would be granted, several steps were taken to curtail expenditures resulting in a surplus of revenues.

Decreasing fees to the industries that pay our assessment has always been our priority. During FY 18 and FY 19, the MHCC will be decreasing assessments by 1.3 million in each year. This decrease in collection of revenues, will bring the surplus in line with the 10% of our budget.