The Maryland Department of Health's Responses to the DLS FY 2020 Health Regulatory Commissions Budget Analysis February 7, 2019 (House) and February 11, 2019 (Senate)

Policy Questions

HSCRC should comment on the use of contractual employees for high-level directorships, the status of recruitment for existing vacancies, and if the special projects being conducted by contractual employees will be on-going. (pgs. 11-12)

The contractual employees that HSCRC is requesting for FY 2020 are in part a continuation of the contractual employees that were brought in during FY 2019. They will act as analysts, special projects coordinators, and researchers. For example, drug costs are an increasingly large part of a hospital's cost structure. We have designated one of our contractual employees to do a drug audit on hospital drug costs. We need to understand how those costs are increasing and at what rate so that funding in hospital rates is sufficient. HSCRC is also bringing in additional contractual employees to help with research around the population health, or "outcomes-based" credits that the State will apply to CMS for. These types of activities are outside of the traditional scope of the HSCRC. We need to be able to bring in contractual employees in short order to address those and meet the requirements of the TCOC Model.

We intend for these contractual employees to be short-term resources for the Commission as we build out the permanent staff and identify the expertise needed to have permanently on staff to support the new territory of the TCOC Model. At the same time, HSCRC has been working to recruit regular PINs. Over the course of FY 2019, we have filled 8 permanent PINs to address the developing needs of the Commission.

HSCRC should comment on Medicare Performance Adjustments that will be applied to nonhospital providers and population health measures under consideration. (pg. 18)

The Medicare Performance Adjustment (MPA) was created by the HSCRC and CMS to create an additional tool to hold hospitals accountable for managing the Total Cost of Care (TCOC) of the Medicare population. Under the All-Payer Model (APM), the State was accountable for reducing hospital costs, with only limited guardrails on the TCOC. As of January 1, 2019, the State is also accountable for Medicare non-hospital costs. While CMS has national programs to encourage value-based care, CMS has not deployed those programs in Maryland due to technical interactions with Maryland's unique payment system for hospital services. Recognizing that additional tools would be necessary to reduce the TCOC, however, the HSCRC and CMS created the MPA to hold hospitals accountable for Medicare TCOC by allowing the HSCRC to replicate national value-based care programs and create custom and innovative programs in Maryland.

The HSCRC is also developing a new program under the TCOC Model that will help reduce the TCOC by including non-hospital providers in value-based care. Many of CMS' national programs include physicians and other non-hospital providers, recognizing that cost efficiency and quality improvement begin with the relationship between patients and their physicians.

Unlike their national counterparts, Maryland physicians do not have the opportunity to participate in some of these national programs. HSCRC is working with CMS to develop a custom program that will allow Maryland physicians the opportunity to participate in programs that encourage value-based care. These programs will be important to the State's success under the TCOC Model by ensuring that the providers across the entire continuum of care are working together to provide high-quality, efficient care.

HSCRC should comment on how the Medicare focused TCOC model will benefit other public and private payers in Maryland. The commission should also comment on how it will monitor and mitigate potential cost shifting from Medicare to other payers. Additionally, HSCRC should comment on other population-based outcome measures being considered and the implementation of the MDPCP. (pg. 23)

Under the All-Payer Model (APM), the HSCRC set hospital rate growth at a sustainable rate for all payers, including Medicaid and commercial payers. Under the current TCOC Model, hospital rate growth will continue to be set at a sustainable rate for all payers. Further, the TCOC Model continues and expands the innovative payment approaches that incentivize value-based care and delivery system transformation. Improvements in the delivery system will benefit all residents of the State, not just those on Medicare. For example, preventable hospitalizations have declined on an all-payer basis, not just for Medicare.

The TCOC Model includes a new requirement that holds the State accountable for Medicare non-hospital growth in addition to the continued requirement to contain hospital growth. The TCOC Model also provides the State with additional Medicare-specific tools, such as the MPA, which will allow the HSCRC to manage both Medicare non-hospital and hospital costs. The HSCRC is committed to ensuring that cost allocations between payers reflects the hospital costs of treating patients. HSCRC continues to monitor the hospitals' cost data in order to ensure that there is an appropriate allocation of costs between payers and no cost shifting occurs.

The TCOC Model contract requires the HSCRC to propose methodologies to CMS for assessing the State's performance for at least three population health priorities. On January 17, 2019, the HSCRC submitted its first proposal for the State to receive outcomes-based credits for population health improvements in diabetes and estimated savings attributable to a reduction in the incidence of diabetes. The State will identify additional priorities through ongoing discussions with stakeholders and CMS. Those priorities include improving behavioral health outcomes particularly for opioid use disorder, improving prevention and management for chronic conditions such as obesity and hypertension, improving senior health and quality of life, and improving disparities in life expectancy and maternal mortality. All of these efforts are population-wide and not specific to any payer type.

The Maryland Primary Care Program (MDPCP) is another critical component of the TCOC Model. The MDPCP offers incentives and resources to primary care practices to enhance care coordination and improve preventative care and management of chronic conditions, including behavioral health disorders. About 80% of eligible Maryland practices voluntarily applied to participate in CY 2019, the first performance year of the program. CMS ultimately accepted and

enrolled 380 primary care practices that are located across every county and represent nearly 220,000 Medicare beneficiaries. While the program is measured based on Medicare, primary care practices' improvements in care delivery are intended to benefit all patients. The HSCRC continues to work closely with the MDPCP's program management office to help ensure that currently enrolled practices are successful and to recruit additional practices into the program.

Budget Questions

The Department of Legislative Services (DLS) recommends reducing the fiscal 2020 allowance by $8,095,519 to reflect the current spending authority of MHCC with regards to funds supporting ICNs. (pg. 13)

The HSCRC respectfully suggests modifying the recommendation to maintain the proposed $10.6 million appropriation with contingency language for the passage of legislation that extends the authority to use the Maryland Health Insurance Plan (MHIP) fund balance. At the time of this writing, HSCRC has pending legislation to request an extension of authority to use the remaining MHIP fund balance through FY 2022. HSCRC is currently authorized to use the fund for FY 2016 through FY 2019 but depends on continued use to support efforts to provide coordinated care for individuals dually eligible for Medicare and Medicaid, especially in support of the Maryland Primary Care Program.

THE MARYLAND HEALTH CARE COMMISSION

FY 2020 BUDGET PRESENTATION TO THE LEGISLATURE
M00R0101

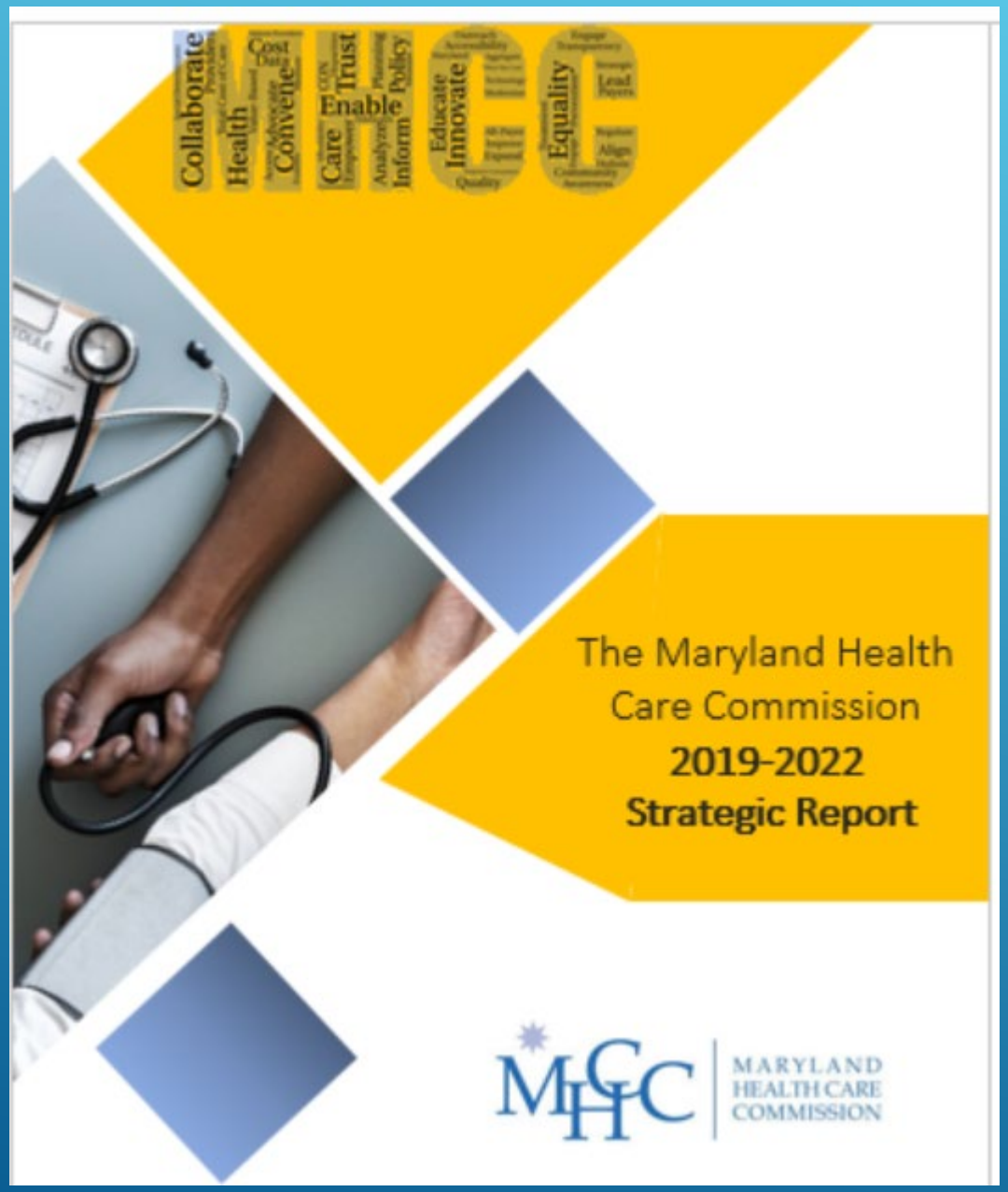
Ben Steffen,
Executive Director

How Commissioners See The Role of MHCC

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

- Educate, inform, and engage the health care community
- Make MHCC the trusted source of quality and cost information
- Modernize health planning and the Certificate of Need Program
- Enable providers to participate in value-based payment models
- Elevate telehealth in health care settings

EDUCATE, INFORM AND ENGAGE the health care community

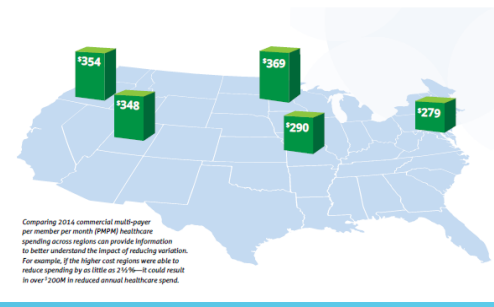
Convened workgroups:

- Physician Maintenance of Certification – concluded
- African American and Rural Community Infant Mortality - underway
- EMS Reimbursement Workgroup (co-lead with MIEMSS) - concluded
- CON Modernization Task Force - concluded
- School-Based Telehealth - underway
- Electronic Prescription Record System - underway
- Health Record and Payment Integration Program Advisory Committee – underway

Communications:

- Health Affairs – blog posts
- Washington Post /Kaiser Health News Network– Articles on Wear the Cost
- Baltimore Business Journal – Certificate of Need activities

Making MHCC the trusted source of quality and cost information



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

In 2018, these investments produced results:

- Launched the WearTheCost.org website displaying cost and quality results for four procedural episodes of care. Calendar year 2019 will bring additional years of data, new measures, and episode information for different payor/populations such as Medicare and Medicaid.
- Worked with the Network for Regional Health Improvement (NRHI)to develop a Total Cost of Care (TCoC) report that compared the TCoC in multiple regions using a national recognized TCoC methodology.
- Worked with 7 insurance companies, 9 third party administrators, and 6 pharmacy benefit managers reporting data to the APCD

Expanding Public Reporting Of Health System Performance

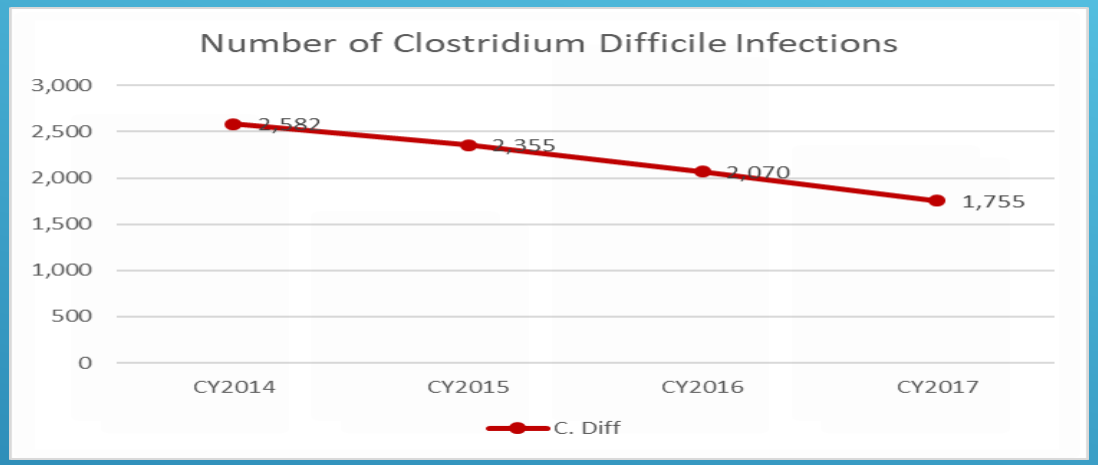
Increase quality transparency using the Maryland HealthCare Quality Report

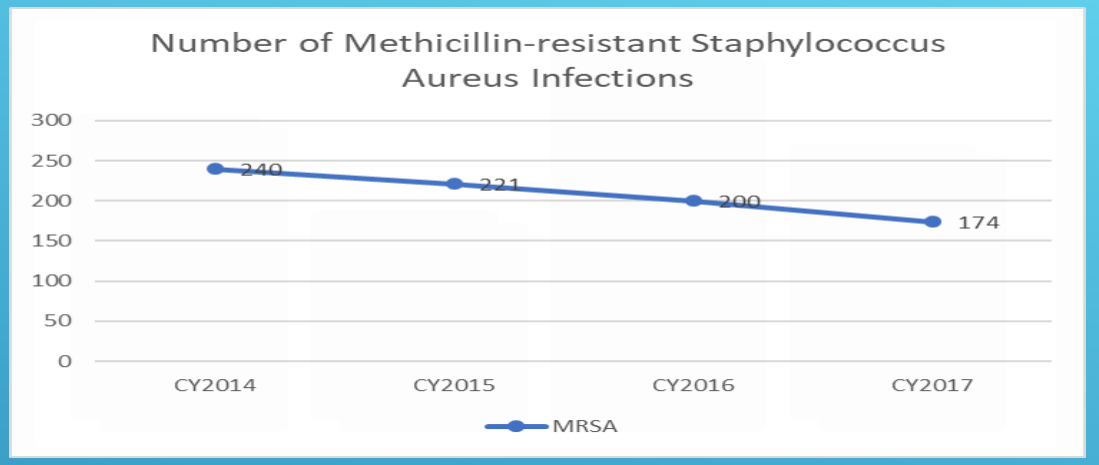
- Hospitals
- Nursing Homes
- Assisted Living (10 bed or more)
- Health Plan

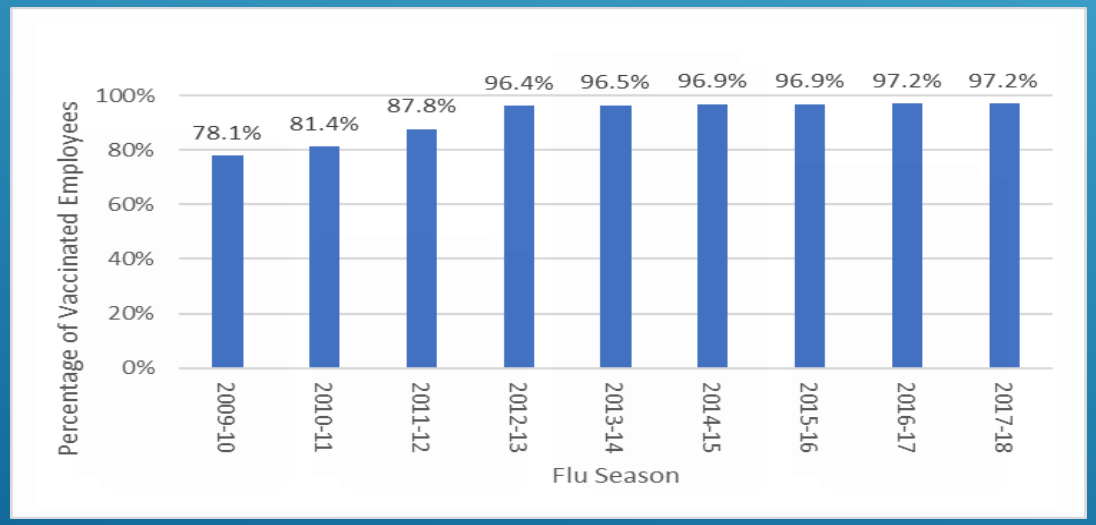
Expand Collaborations

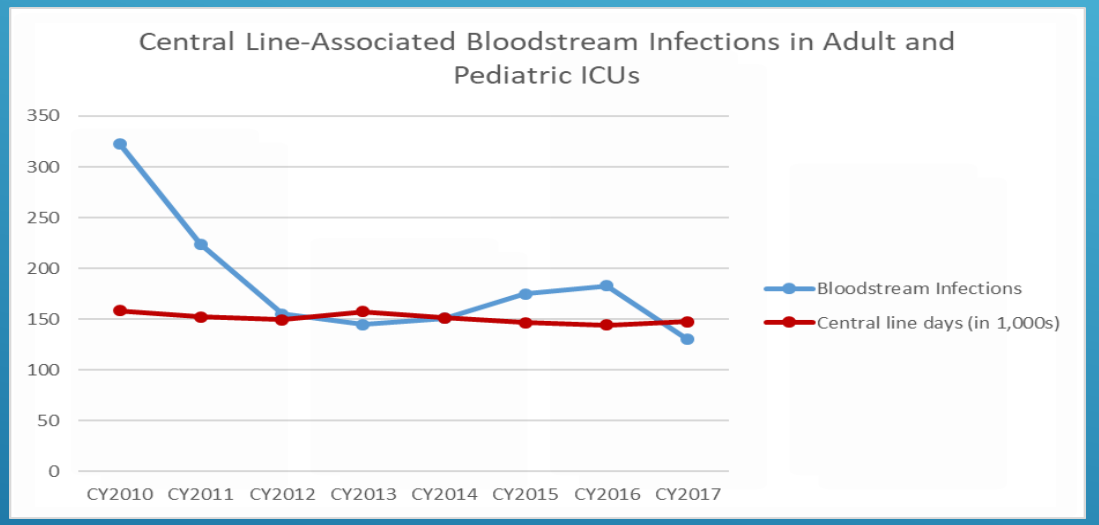
- Established a data sharing arrangement with the LeapFrog Group that enables Leapfrog to publish performance scores on Maryland Hospitals for the first time
  - Leapfrog Hospital Safety Report– First collaboration fall 2017
  - 2018 -- Maryland hospitals made substantial improvement
- Align MHCC Quality and Healthcare Associated Infection reporting with CMS requirements in Inpatient Quality Reporting, Hospital Outpatient Reporting, and Value-Based Purchasing Program.

The BENEFITS of Public Reporting









State Health Planning Operations

Updated State Health Plan Chapter 10.24.11, General Surgical Services

Completed 11 Certificate of Need applications – totaling $76,518,108

Completed 5 requests to change approved Certificate of Needs

Completed 2 requests for exemptions from Certificate of Need

- The most prominent project review completed involved the establishment of a 16-bed special psychiatric hospital in Annapolis by Anne Arundel Medical Center. This project review was one of the largest that, to date, has not provided acute inpatient care service.

Completed 2 expansions of home health agency service capacity approved under the State Health Plan update in FY 2016. - Visiting Nurses expanded its services into 4 Upper Eastern Shore jurisdictions with a limited number of existing home health agencies; Minerva Home Healthcare, Inc. - established a new home health agency and was authorized to serve Calvert and St. Mary's Counties.

Completed *Modernizing the Maryland CON Program a report adopted by MHCC in December 2018. The key health committees of the General Assembly charged MHCC with undertaking this reconsideration and this mandate resulted in a set of recommendations for change to the program.*

Accelerating The Implementation Of Health Information Technology

Issued 14 telehealth grants (demonstration projects) since 2014 with a total value of $600,000, grantee matched funds on a 2 to1 basis. These grants help to;

- Demonstrate better telehealth care delivery practices and industry implementation efforts;
- Demonstrate policies to support the advancement of telehealth;
- Demonstrate the design of larger telehealth initiatives

Developed a *Telehealth Readiness Assessment* (TRA) tool. This tool is designed to assist physician practices to determine their level of readiness for offering telehealth services.

Released the, *Summary of the Comprehensive Care Facilities: Adoption of Health Information Technology* report that assesses health IT adoption trends among comprehensive care facilities.

Conducted an assessment of security breaches in Maryland and the nation from 2010 through 2017. Released an information brief that highlighted breach trends and recommendations for enhancing security to prepare for and mitigate the effects of new and evolving cyber threats.

Advancing Care Delivery

Convened 6 practice symposiums aimed at increasing awareness of the Medicare Access and CHIP Reauthorization Act of 2015 and Merit-based incentive Payments System.

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

Established a planning effort with stakeholders to establish at Specialist Transformation Network (STN)

- Builds upon the Transforming Clinical Practice Initiative in Maryland.
- STN will provide specialty practices located in rural, urban, and underserved areas with collaborative support to transform and sustain participation in alternative care delivery models.

Advanced Primary Care Program

- The MHCC collaborated with the Maryland Department of Health (MDH) on the program design.
- MHCC will convene an Advisory Council to make recommendations to the MDH Secretary on program design refinements and program expansion.

Budget

FY 2020 Allowance - $43,081,523

1. Operation Budget - $16,136,004 & $750,000 Reimbursable

   Industries Assessed – Payers, Hospitals, Nursing Homes, and Health Occupation Boards

   FY 2018 Close on Revenue - $6 million (Reduction to the industries in assessments: 1.3 million for FY 2019 and FY 2020

   Total Staff : 54.9

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

   - Maryland Trauma Physicians Services Fund - $12,300,000
   - Shock Trauma Grant - $3,300,000
   - Integrated Care Network (CRISP) - $10,595,519

Communicating with MHCC…

See us on the Web

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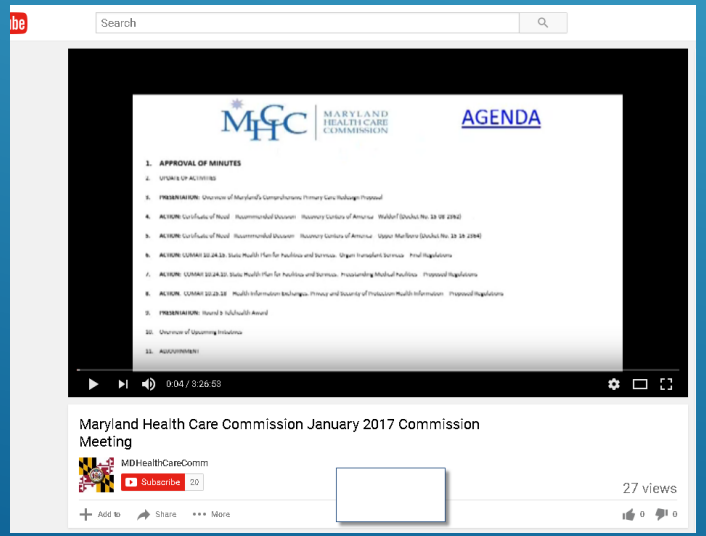
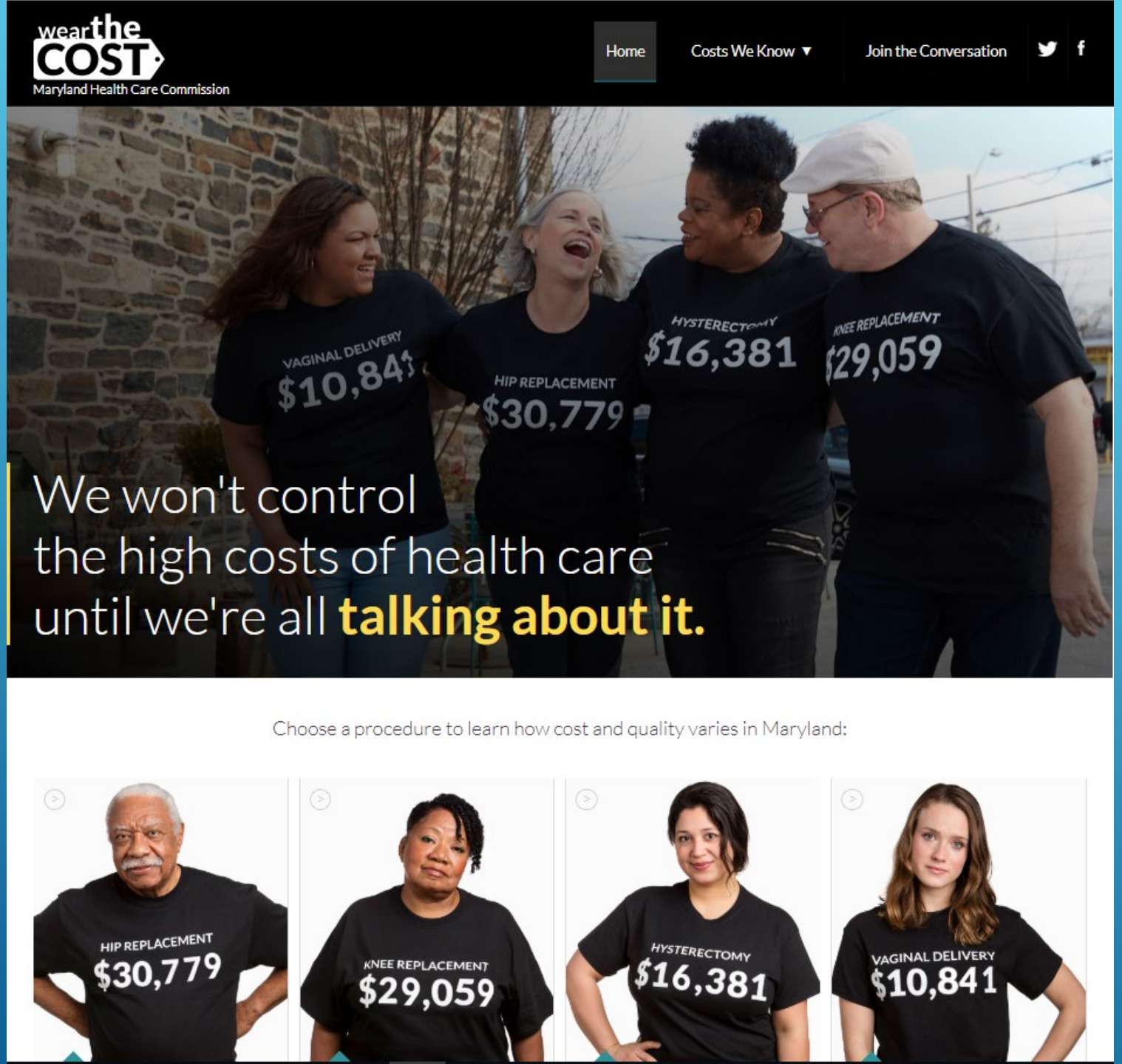


Background Slides and Linkables


wear the COST
Maryland Health Care Commission
Home
Costs We Know ▼
Join the Conversation
VAGINAL DELIVERY
$10,841
HIP REPLACEMENT
$30,779
HYSTERECTOMY
$16,381
KNEE REPLACEMENT
$29,059
We won't control
the high costs of health care
until we're all talking about it.
Choose a procedure to learn how cost and quality varies in Maryland:
HIP REPLACEMENT
$30,779
KNEE REPLACEMENT
$29,059
HYSTERECTOMY
$16,381
VAGINAL DELIVERY
$10,841

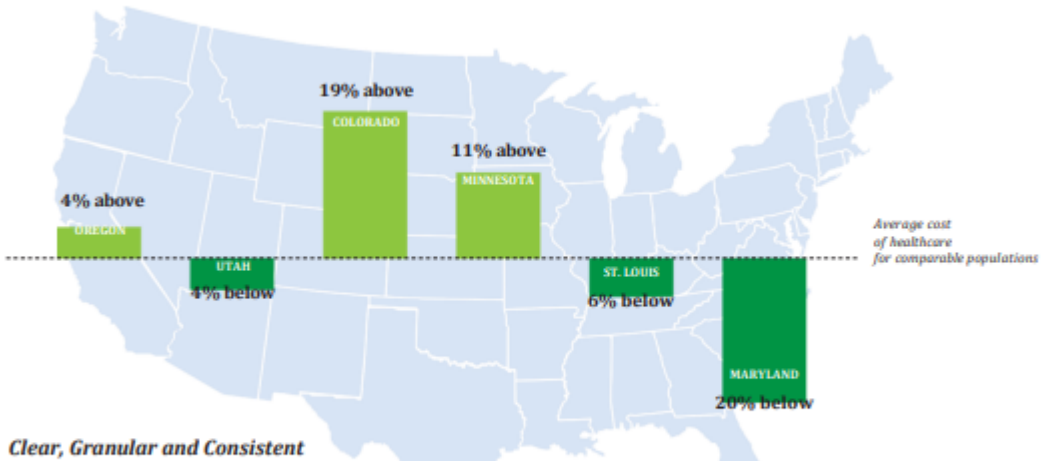
nrhi
Network for Regional Healthcare Improvement

Getting to Affordability

Healthcare Affordability: Data is the Spark, Collaboration is the Fuel

Section I: Benchmark Overview Section

II: Benchmarking Methodology



Clear, Granular and Consistent

The third release of the Getting to Affordability (G2A) Total Cost of Care (TCOC) benchmarks continues to highlight variation in the underlying drivers of healthcare costs across regions. Once again, it finds that although price is the driver of both higher and lower healthcare costs in some geographies, utilization makes the difference in others.

Although the magnitude of the contribution of price and usage varies year to year, the relativity has remained constant. This consistency reinforces the stability of this measure and its utility in informing changes in policy and care delivery.

Acknowledgments

Support for this report was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

CONTRIBUTORS

Network for Regional Healthcare Improvement (NRHI) Utah
Department of Health, Office of Health Care Statistics Judy
Loren

THE FOLLOWING ORGANIZATIONS CONTRIBUTED DATA AND ANALYSIS FOR THIS PROJECT.

Center for Improving Value in Health Care | Colorado
HealthInsight Oregon | Oregon
HealthInsight Utah | Utah
Maine Health Management Coalition | Maine *
Maryland Health Care Commission | Maryland Midwest
Health Initiative | St. Louis, Missouri Minnesota
Community Measurement | Minnesota

THE FOLLOWING ORGANIZATIONS PARTICIPATED AS DEVELOPMENT SITES.

Greater Detroit Area Health Council | Michigan
HealthInsight Nevada | Nevada
HealthInsight New Mexico | New Mexico
Health Care Improvement Foundation | Philadelphia
Integrated Healthcare Association | California
Massachusetts Health Quality Partners | Massachusetts
The Health Collaborative | Ohio
The University of Texas Health Sciences Centers at Houston | Texas
Virginia Health Information | Virginia
Washington Health Alliance | Washington
Wisconsin Health Information Organization | Wisconsin

ABOUT THE NETWORK FOR REGIONAL HEALTHCARE IMPROVEMENT (NRHI)

The Network for Regional Healthcare Improvement (NRHI) is a national organization representing more than 30 member regional health improvement collaboratives (RHICs) and state/regional affiliated partners. These multi-stakeholder organizations are working in their regions and collaborating across regions to transform the healthcare delivery system. They share the goal of improving the patient experience of care, including quality and satisfaction; improving the health of populations; and reducing the per-capita cost of healthcare. The RHICs are accomplishing this transformation by working directly with physicians and other healthcare providers, provider organizations, commercial and government payers, employers, consumers, and other healthcare-related organizations. Both NRHI and its members are non-profit, non-governmental organizations. For more information about NRHI, visit www.nrhi.org.

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For more than 45 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity for health and well-being.

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report to Linda Bartnyska, Director of Analysis and Information Services at the Maryland Health Care Commission. Linda's contributions went far beyond her knowledge of, and dedication to, healthcare cost measurement. Linda's quiet leadership and steady presence were appreciated by every member of the team. She is greatly missed.

* Maine Health Management Coalition participated in Phases I and II and is now known as the Healthcare Purchaser Alliance of Maine

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The Nation's Leading Scorecard on Hospital Safety Breaks Down Results Across Red and Blue States

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What is Patient Safety? | Your Hospital's Safety Grade | What You Can Do to Stay Safe

The MARYLAND HEALTH CARE COMMISSION

Cybersecurity

A Self-Assessment Readiness Tool

August 8, 2018

(Version 1.1)

Primary Care Telehealth Technology Grants

gilchrist

medpeds

Medication Management and Reconciliation Grant - Awarded A

University of Maryland Quality Care Network

Population Health in Rural Communities Telehealth Technology Grant

University of Maryland Shore Regional Health

Practice Transformation Telehealth Technology Grant

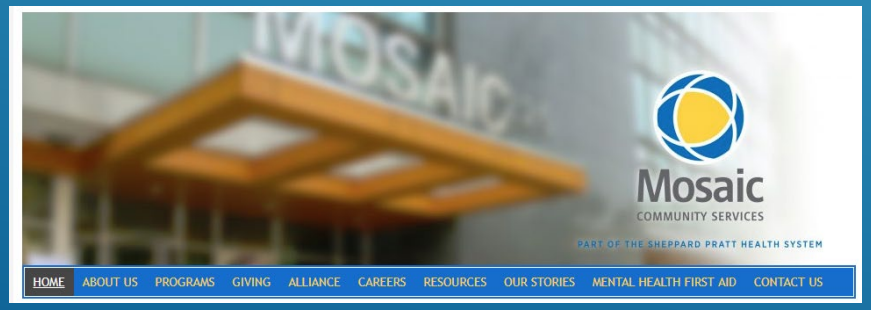
Gerald Family Care P.C.
Quality Healthcare since 1974

Long-Term Care/Hospital Telehealth Grants

University of Maryland Upper Chesapeake Health

University of Maryland Capital Region Health

Medication-Assisted Treatment for Opioid Use Disorders Supported by Mobile Devices Grant



School-Based Teletherapy for Special Education Services

Charles County Public Schools

Remote Patient Monitoring Telehealth Technology Grants

LORIEN HEALTH SERVICES
Family caring for Families

Union Hospital

Population Health in Rural Communities Telehealth Technology Grant`

University of Maryland Shore Regional Health

February 7, 2019 (House)
February 11, 2019 (Senate)

Maryland Total Cost of Care Model: *Statewide Alignment for Success*

Katie Wunderlich, Executive Director
Health Services Cost Review Commission

Agenda

1. Maryland's Unique Healthcare Delivery System
   1. All-Payer Hospital Rate-Setting
   2. All-Payer Model, 2014-2018
2. Goals of the Total Cost of Care Model, 2019-2028
   1. Hospital payment program
   2. Care Redesign Program (CRP)
   3. Population health
   4. Maryland Primary Care Program (MDPCP)
3. Opportunities for Alignment across the Healthcare Continuum

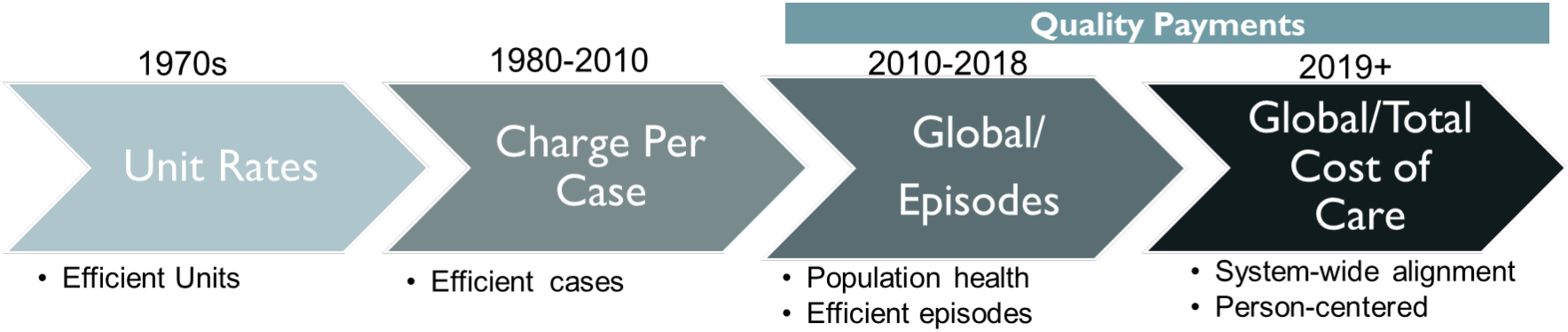
Maryland's Unique Healthcare Delivery System

Health Services Cost Review Commission

- The Health Services Cost Review Commission (HSCRC) is an independent agency, charged with regulating hospital rates for all payers in Maryland.
- 7 Commissioners
  - Chair and Vice Chair
  - Commissioners' day jobs have included hospital executive, physician, executive of long-term care facility, and health policy consultant, expert, and economist
- $14.1 million budget in FY18 that is 100% from special fund user-fees
- 50 full-time staff plus analytic support from contractors

All-Payer Hospital Rate Setting and Maryland's All-Payer Model

- Since 1977, Maryland operated an all-payer, hospital rate setting system



- In 2014, Maryland updated its rate setting approach through the All-Payer Model:
  - Contractual agreement between Maryland and federal government
  - Patient-centered approach that focuses on improving care and outcomes
  - Per capita, value-based payment framework for hospitals
  - Stable and predictable revenues for hospitals, especially those providing rural healthcare
  - Provider-led efforts to reduce avoidable use and improve quality and coordination

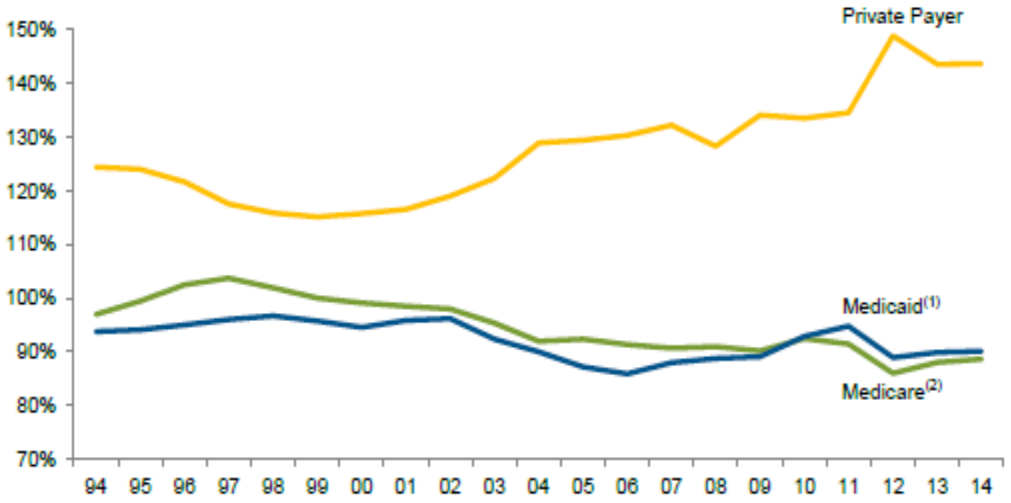
Value of the All-Payer System for Healthcare Consumers

- Links quality and payment
- Cost containment for the public
- Funding for Graduate Medical Education
- Transparency in hospital costs
- Local access to regulators
- Leverages increased federal payments
- Supports state-designated health information exchange, the Chesapeake Regional Information System for our Patients (CRISP)

Maryland All-Payer System Distributes Costs Equitably

- Nationally, cost-shifting occurs between public and private payers

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 payments

- With the all-payer system, hospitals are:
  - Paid using a common rate structure for all payers, so costs are distributed equitably
  - Less susceptible to margin deterioration with payer mix changes
  - Not dependent on volume growth
- Total costs are tackled using value-based approaches and care redesign on an all-payer basis
- Uncompensated care is funded equitably

All-Payer Model Performance from 2014 through 2017

Performance Measures	APM Requirements from CMS	2014-2017 Results	On Target
All-Payer Hospital Revenue Growth	≤ 3.58% per capita annually	2.03% average growth per capita	✓
Medicare Savings in Hospital Expenditures	≥$330M cumulative over 5 years (Lower than national average growth rate from 2013 base year to 2018)	$916M cumulative (5.63% below national average growth)	✓
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	$599M cumulative (1.36% below national average growth)	✓
All-Payer Reductions in Hospital Acquired Conditions	30% reduction over 5 years	53% reduction since 2013	✓
Readmissions Reductions for Medicare	≤ National average after 5 years	< National average after 4 years	✓
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	100%	✓

Public-Private Health Information Infrastructure through CRISP Supports the Maryland Model

- CRISP is a non-profit 501c6 entity and Maryland's state-designated health information exchange (HIE).
- CRISP works with hospitals, physicians, long-term care providers, health departments, and policymakers to deploy technology to advance health and wellness.
- *The TCOC Model will continue to leverage the HIE infrastructure through CRISP to optimize processes, achieve the goals of the TCOC Model and improve care.*

CRISP Core Services

- Information at the Point of Care
- Encounter Notifications for Care Coordination
- Reporting Services for Population Health
- Support for Public Health
- Administration of Care Redesign Programs

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 Innovation

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!

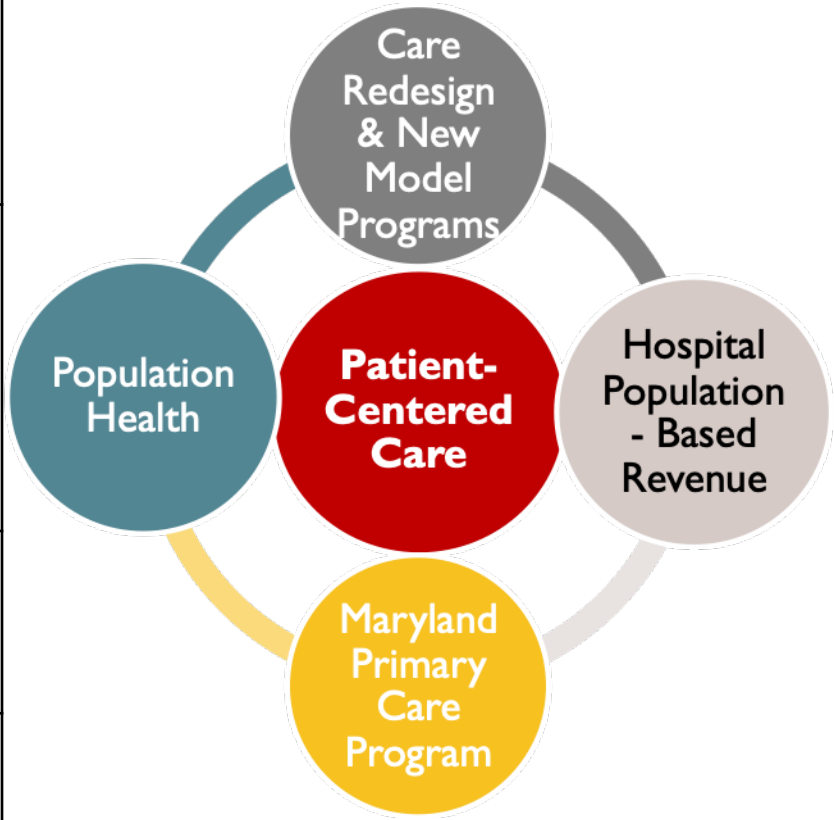
Maryland Total Cost of Care (TCOC) Model

- Designed to **coordinate care** for patients across hospital and non-hospital settings, **improve health outcomes**, and slow the growth of **total health care costs**

- TCOC Model contract is a 10-year agreement (2019-2028) between Maryland and the Centers for Medicare and Medicaid Services (CMS):
  - 5 years (2019-2023) to build up to required Medicare TCOC savings of $300 million annually, including
    - Medicare Part A and Part B fee-for-service expenditures, and
    - Non-claims based payments
  - 5 years (2024-2028) to maintain Medicare TCOC savings and quality improvements
  - 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 responsibility to control total cost through limited revenue-at-risk under the **Medicare Performance Adjustment**	Expands
Care Redesign & "New Model" Programs	Enable private-sector led programs supported by State flexibility, "MACRA-tize" the Model, incentives for hospitals to work with others, and addt'l opportunity to develop "New Model Programs"	Expands
Population Health	Improvement programs for chronic conditions such as diabetes, behavioral health integration, etc.	New
Maryland Primary Care Program	Enable advanced primary care with behavioral health integration, and care management in medical home model	New



Care Redesign Program (CRP)

- Under the TCOC Model, the Care Redesign Program is led by hospitals, with non-hospital partners, and provides tools and approaches to empower providers to improve quality and control costs

Improve Quality & Control Cost

Multiple "Tracks" available to enable hospitals to redesign care and achieve quality and TCOC goals

Increase Accountability

Increase accountability for high needs populations, across the spectrum of care.

Alignment with Non-Hospital Providers

Opportunity for hospitals to collaborate with Care Partners and make incentive payments.

Pathway to MACRA-tization

Pathway for a hospital's Care Partners to participate in an advanced alternative payment model

Potential Credits for Population Health Improvement

- The State of Maryland and providers will jointly focus on health improvement initiatives
- Improved population health may offset the cost of primary care investments

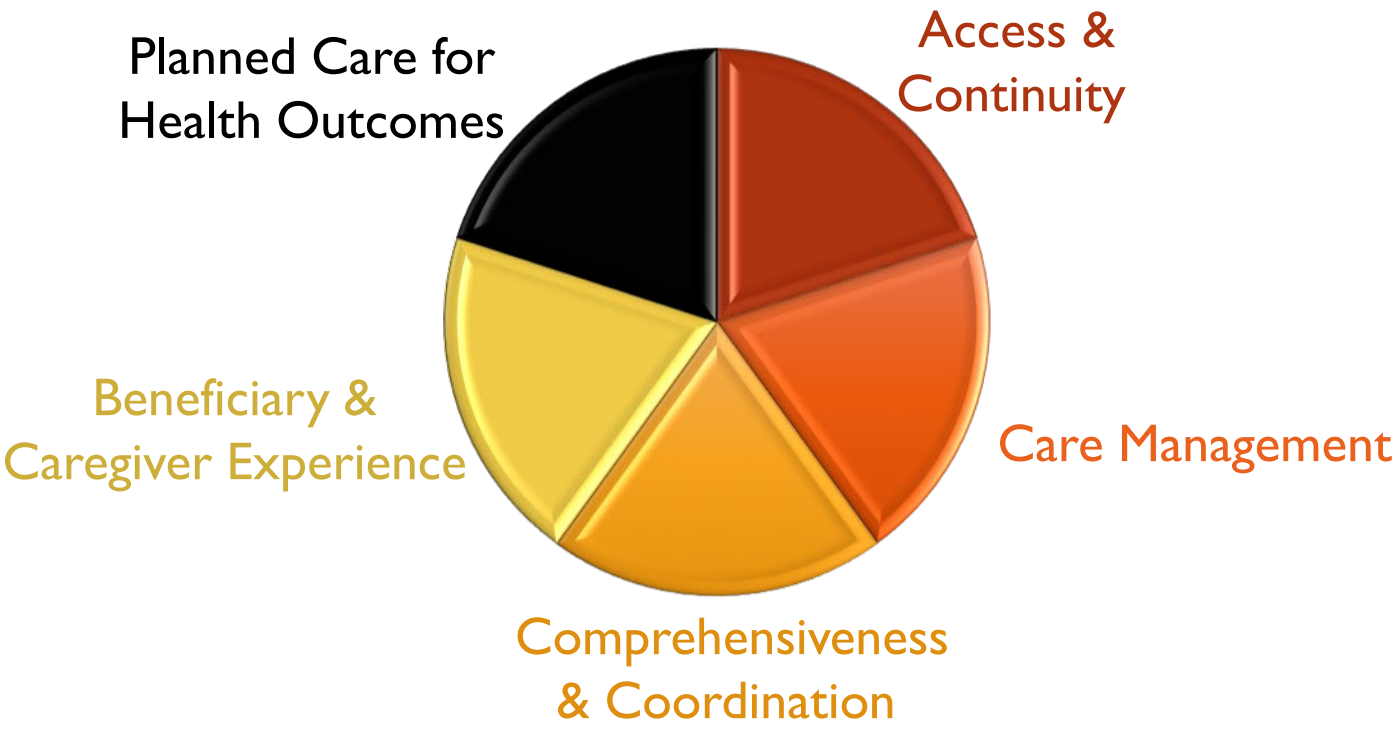
Maryland Primary Care Program (MDPCP)

- As of January 1, 2019, Maryland voluntarily enrolled 380 primary care practices serving Medicare Fee For Service (FFS) beneficiaries in order to provide advanced primary care to:
  - Provide comprehensive care to all patients with a focus on managing the health of high- and rising-risk individuals
  - Provide preventive care and state-of-the-art health information technology
  - Address behavioral health and social needs
- MDPCP strengthens and transforms primary care delivery by introducing care management and coordination supports such as:
  - Telemedicine, behavioral health and substance abuse counseling, care managers, and others
  - Care Transformation Organizations, unique to Maryland, that support small and independent practices as well as practice transformation coaches
- Care Management Fees will provide resources for chronic care improvement
- Aligns primary care providers with TCOC Model goals

MDPCP Benefits Patients

- Freedom of choice
- Team care led by my Doctor
- Care Managers help smooth transitions of care
- No cost sharing on enhanced services like care management
- Expanded office hours
- Alternative, flexible care options (e.g., telemedicine, group visits, home visits)
- Records are available to all of my providers
- Medication management support
- Community and social support linkages (e.g., transportation, safe housing)
- Behavioral health care led by my practice

Advanced Primary Care Functions



Opportunities for Alignment across the Healthcare Continuum

Optional Development of New Model Programs

- TCOC Model Agreement allows Maryland to propose payment programs that are not directly associated with a hospital, i.e. New Model Programs
  - Program details must be negotiated with CMS and the State
  - Require alternative or additional payments from CMS or other funding sources
  - Requests for waivers and MACRA eligibility will be program-specific
- Opportunity to create broad authority for non-hospital conveners with tracks underneath, similar to the Care Redesign Program structure, but may require a new mechanism to enable participants to take risk

MARYLAND DEPARTMENT OF HEALTH

COMMUNITY HEALTH RESOURCES COMMISSION

Mark Luckner, Executive Director
Community Health Resources Commission

Presented to:

House Appropriations Health and Social Services Subcommittee

February 7, 2019

Senate Budget & Taxation Health and Human Services Subcommittee

February 11, 2019

BACKGROUND ON THE CHRC

- The Community Health Resources Commission (CHRC) was created by the **Maryland General Assembly in 2005** to expand access to health care in **underserved communities** and support projects that serve **low-income Marylanders and vulnerable populations**.

- **Strategic priorities include the following objectives:**
  - Increase access to primary and specialty care through grants and technical assistance to safety net providers
  - Promote projects that are **innovative, sustainable, and replicable**
  - Build capacity of safety net providers to serve more residents
  - Address **social determinants of health** and **promote health equity**

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MARYLAND Department of Health

BACKGROUND ON THE CHRC

- **The CHRC is an independent agency operating within the Maryland Department of Health.**
- **Eleven Commissioners are appointed by the Governor.**

Allan Anderson, M.D., CHRC Chairman

Elizabeth Chung, Vice-Chair, Executive Director, Asian American Center of Frederick

Scott T. Gibson, Vice President of Human Resources, Melwood Horticultural Training Center, Inc.

J. Wayne Howard, Former President and CEO, Choptank Community Health System, Inc.

Celeste James, Executive Director of Community Health and Benefit, Kaiser Permanente of the Mid-Atlantic States

Surina Jordan, PhD, Zima Health, LLC, President and Senior Health Advisor

Barry Ronan, President and CEO, Western Maryland Health System

Erica I. Shelton, M.D., Assistant Professor, Johns Hopkins University School of Medicine, Department of Emergency Medicine

Carol Ivy Simmons, PhD

Julie Wagner, Vice President of Community Affairs, CareFirst BlueCross BlueShield

Anthony C. Wisniewski, Esq., Chairman of the Board and Chief of External and Governmental Affairs, Livanta LLC

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IMPACT OF CHRC GRANTS

- **210 grants totaling $64.1 million in all 24 jurisdictions**
- Collectively served more than **468,000 Marylanders**.
- Serve individuals with **complex health and social service needs**, and many are frequent utilizers of hospital and EMS systems.
- **Fund community-based interventions**, *i.e.,* Federally Qualified Health Centers, local health departments, free clinics, and outpatient behavioral health providers.

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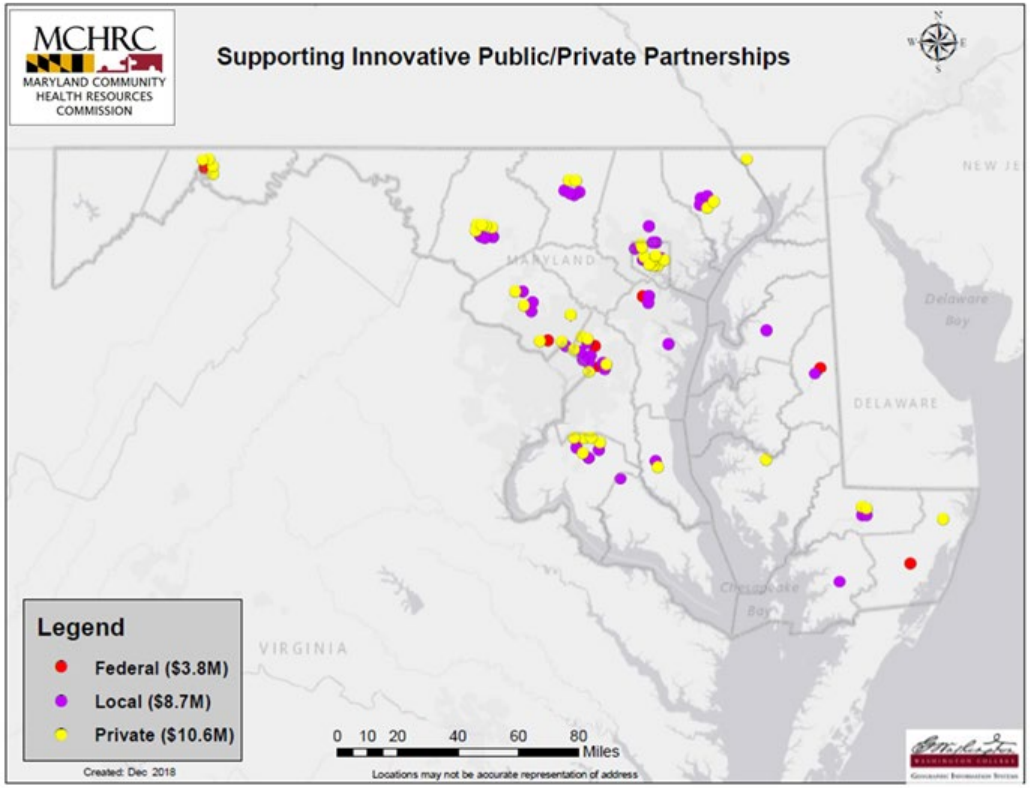
POST-GRANT SUSTAINABILITY

- **78%** of CHRC-funded programs have been **sustained at least one year** after grant funds have been expended.
- Grantees have leveraged **$23.3 million** in **additional** resources (**$19.5 million in private and local funds**).



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TYPES OF PROJECTS

Focus Area	Number of Projects	Individuals Served
Primary Care	65	304,756
Behavioral Health/Opioids	54	79,299
Dental	39	64,137
Women's Health	23	17,528
Obesity/Food Security	15	697
ED Diversion/Care Coordination and Safety-net Capacity Building*	23	16,327
School-Based Health Centers*	15	21,928

*also listed in other categories

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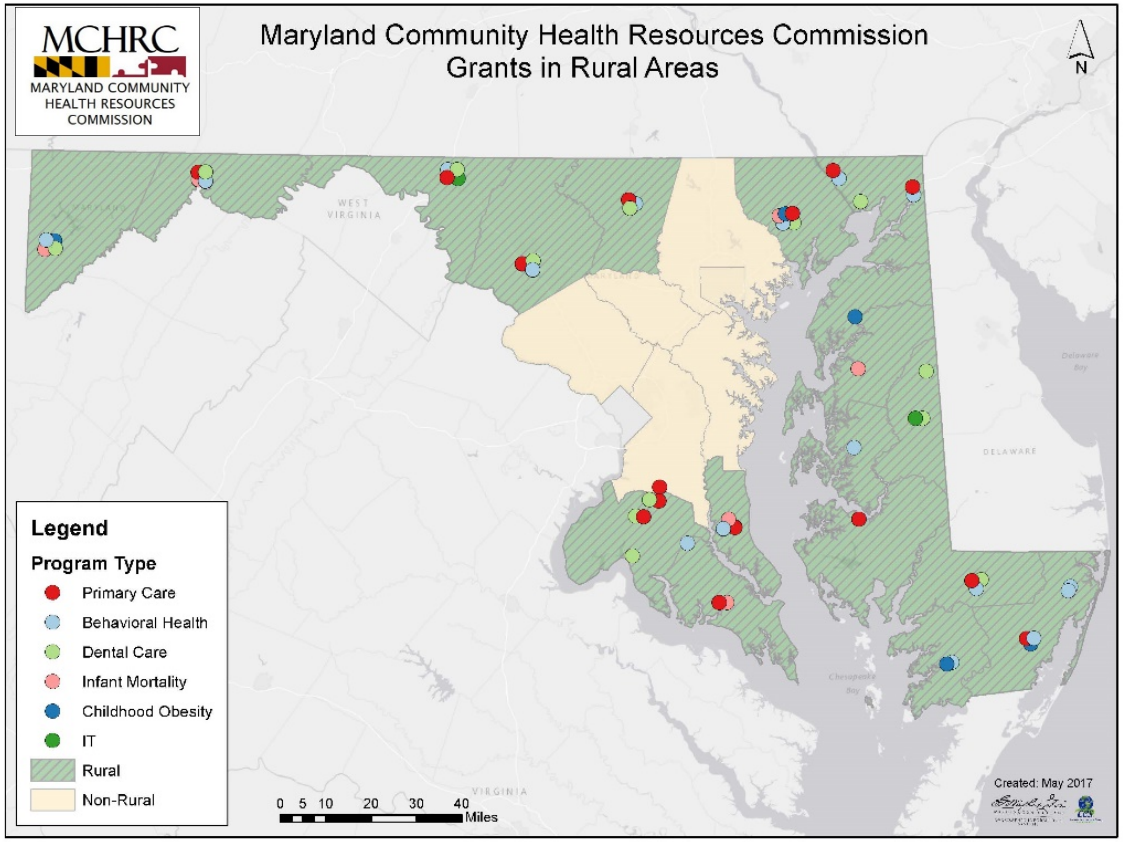
CHRC AND RURAL HEALTH

- Awarded **107 grants totaling $28 million** to support programs in rural jurisdictions.
- Projects served more than 82,000 residents.



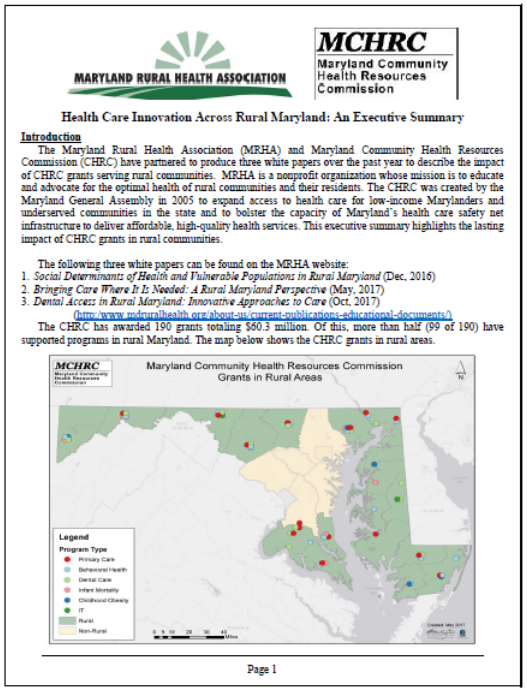
Areas of Focus:

- Primary/Preventative Care
- Dental Care
- Integrated Behavioral Health Services
- Food Security/Obesity Prevention

CHRC AND RURAL HEALTH

Lessons highlighted in MRHA-CHRC white papers:

- **Care coordination is an effective intervention strategy** for rural communities impacted by shortage of providers.
- **Supporting transportation assistance** or bringing health care to patients "where they are" can be effective tools to address barriers.
- **Integrating dental care programs** into the community is an effective strategy for managing chronic conditions.
- **Promoting health literacy** may be an effective tool in improving health outcomes.



MARYLAND RURAL HEALTH ASSOCIATION

MCHRC Maryland Community Health Resources Commission

Health Care Innovation Across Rural Maryland: An Executive Summary

Introduction

The Maryland Rural Health Association (MRHA) and Maryland Community Health Resources Commission (CHRC) have partnered to produce three white papers over the past year to describe the impact of CHRC grants serving rural communities. MRHA is a nonprofit organization whose mission is to educate and advocate for the optimal health of rural communities and their residents. The CHRC was created by the Maryland General Assembly in 2005 to expand access to health care for low-income Marylanders and underserved communities in the state and to bolster the capacity of Maryland's health care safety net infrastructure to deliver affordable, high-quality health services. This executive summary highlights the lasting impact of CHRC grants in rural communities.

The following three white papers can be found on the MRHA website:

1. *Social Determinants of Health and Vulnerable Populations in Rural Maryland* (Dec, 2016)
2. *Bringing Care Where It Is Needed: A Rural Maryland Perspective* (May, 2017)
3. *Dental Access in Rural Maryland: Innovative Approaches to Care* (Oct, 2017)

(http://www.mdruralhealth.org/about-us/current-publications-educational-documents/)

The CHRC has awarded 190 grants totaling $60.3 million. Of this, more than half (99 of 190) have supported programs in rural Maryland. The map below shows the CHRC grants in rural areas.

Page 1

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STEWARD OF PUBLIC FUNDS

- CHRC has a current portfolio of **50 open grants** (under implementation) totaling $11.4 million.
- CHRC is staffed by 3 PINS. Administrative overhead is 9%.
- Active post-award grant monitoring process
  - Programmatic progress reports
  - Fiscal expenditure reports
  - Grantee audits (programmatic and fiscal)
- **CHRC prioritizes projects that yield quantifiable outcomes, *i.e.,* clinical outcomes and cost savings**

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STEWARD OF PUBLIC FUNDS

- Grantees report twice a year as a condition of invoice payment.
- Process/outcome metrics are reported and progress towards overall goals or grant is monitored closely by CHRC staff.
- **Grantees are held accountable for performance**.

CHRC Grantee Monitoring Report

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Grantee Name:	**Anne Arundel County Mental Health Agency**
Grantee Contact Information:	Chelsea Bednarczyk, Contract Specialist (410) 222-7858 cbednarczyk@aamentalhealth.org
Grantee #:	18-013
Grant Period:	May 1, 2018 - April 30, 2020
Total Award:	$500,000
Amount Paid to Date:	$100,000
Date of this Report:	Friday, November 30, 2018
Additional Funds Leveraged:	

Grantee Payout and Report Schedule

Reporting Period	Due Date	Proposed Fund Distribution	Actual Fund Distribution	Actual Expenditures	Required Items
N/A		$100,000			Signed grant agreement and approved performance measures
Project update 1	June 4, 2018	$0			
Report Period One May 1, 2018 - October 31, 2018	November 30, 2018	$125,000			**Report 1**: narrative, M&D report, expenditures report and invoice
Report Period Two November 1, 2018 - April 30, 2019	May 31, 2019	$125,000			**Report 2**: narrative, M&D report, expenditures report and invoice
Report Period Three May 1, 2019 - October 31, 2019	November 30, 2019	$100,000			**Report 3**: narrative, M&D report, expenditures report and invoice
Final Report Period Four November 1, 2019 - April 30, 2020	May 31, 2020	$50,000			**Final Report**: final narrative, M&D report, expenditures report, and final invoice
	Total	$500,000	$0	$0	

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PUBLIC-PRIVATE PARTNERSHIPS

Way Station implemented a behavioral health homes pilot initiative. **CHRC grant for $170,000 leveraged $1 million from private sources** and laid groundwork for Maryland Medicaid Behavioral Health Home Initiative. **Currently there are 84 health homes in Maryland.**

Family Services, Inc., **Thriving Germantown** implemented multi-sectoral and multigenerational program in a highly diverse, underserved community. **CHRC grant for $250,000 leverages $2,014,832 in private and local funding.**

Charles County Health Department combined a $400,000 grant with an additional $150,000 from Charles Regional Medical Center to support a new MIH program. After implementation, ED visits among participants dropped 61%.

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IMPROVING HEALTH OUTCOMES

Shepherd's Clinic, Diabetes self-management program - 390 pre-diabetic and diabetic patients. **66% lost weight, and 70% had a reduced A1C**.

SHEPHERD'S CLINIC
Health Care for the Uninsured

Mary's Center for Maternal and Child Care, Inc. Women's health and prenatal care - 3,000 women in Prince George's County. **Prenatal care in the first trimester increased from 63.6% to 74%. Low-birth weight babies (2,500 grams or less) was 5%** (County rate is 9.1%, Maryland rate is 8.6%).

Mary's Center

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PROMOTING COST SAVINGS

Calvert County Health Department, "Project Phoenix," Substance use treatment/addressing social determinants of health. **ED visits dropped more than 70%** and Calvert Memorial continues to support the project after CHRC grant.

CALVERT COUNTY HEALTH DEPARTMENT

Catholic Charities' Esperanza Center, a free clinic in Baltimore, provided essential health services for more than 5,315 individuals and **achieved cost savings/ avoided charges of $2.3 million**.

ESPERANZA CENTER
CATHOLIC CHARITIES IN ACTION

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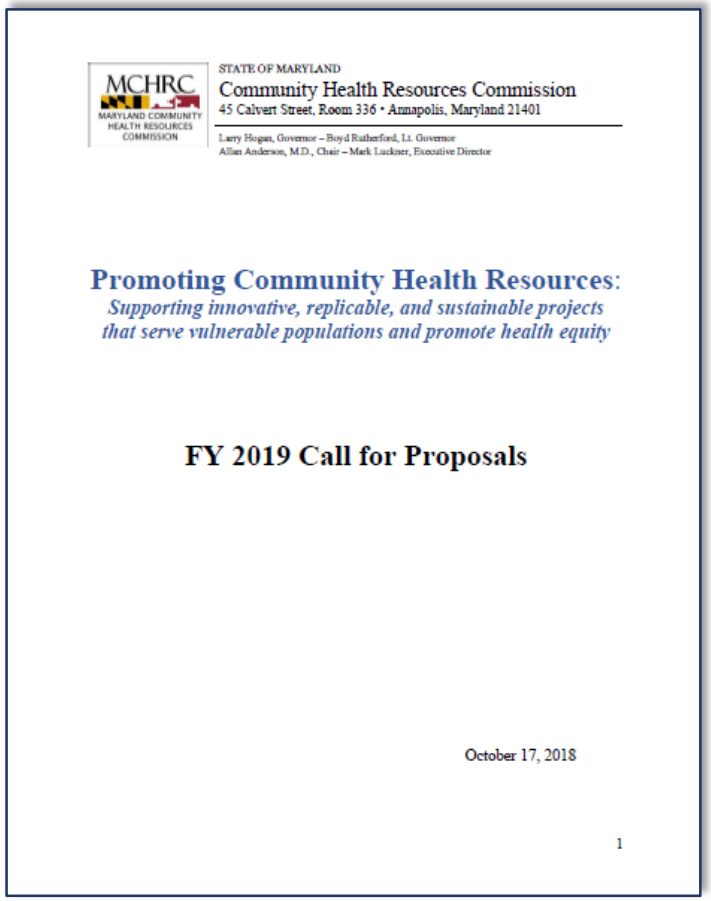
FY 2019 CALL FOR PROPOSALS



STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Room 336 • Annapolis, Maryland 21401

Larry Hogan, Governor – Boyd Rutherford, Lt. Governor
Allen Anderson, M.D., Chair – Mark Luckner, Executive Director

Promoting Community Health Resources:
Supporting innovative, replicable, and sustainable projects that serve vulnerable populations and promote health equity

FY 2019 Call for Proposals

October 17, 2018

1

- **Areas of focus:**
  - Promoting Delivery of Essential Health Services (Primary Care, Dental and Women's Health)
  - Addressing the heroin and opioid epidemic through behavioral health integration
  - Promoting food security and addressing childhood and family obesity.
- **93 proposals requesting $36 million ($5.9 million is available)**
- **26 Applicants invited to present on March 7, 2019 (next slide)**
  - Award decisions will be made following presentations

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FY 2019 - 26 Invited Applicants

ESSENTIAL HEALTH SERVICES

- Harford Health Department
- Family Healthcare of Hagerstown
- Lower Shore Clinic
- Baltimore City Fire Department
- Health Partners, Inc.
- Medstar St Mary's Hospital
- Mosaic Community Services
- Chinese Culture and Community Service Center
- Chase Brexton Health Services
- Western Maryland AHEC
- Family Services (Thriving Germantown)

BEHAVIORAL HEALTH/OPIOIDS

- Baltimore County Public Schools
- Helping Up Mission
- Shepherd's Clinic
- Associated Catholic Charities
- Cecil Health Department
- Cornerstone Montgomery
- University of Maryland Upper Chesapeake Health
- Queen Anne's Health Department (MIH/EMS)

OBESITY/FOOD SECURITY

- Korean Community Service Center of Greater Washington
- Baltimore Medical System, Inc.
- Worcester Health Department
- Charles Health Department
- Washington Health Department
- Baltimore City Public Schools
- Somerset Health Department (with Wicomico)

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CHRC GRANTS - LARGER CONTEXT

- **Support overall population health goals of the state**
  - Total Cost of Care- promote durable hospital-community partnerships
  - **Maryland Primary Care Program-** support care coordination and chronic disease management for underserved individuals
- **Opioids** – Promote integration of behavioral health and somatic care services and innovative projects to expand access in SUD treatment (**54 grants awarded; 251,142 served**)
- **Rural Health** – Offer creative solutions to address access barriers in rural communities, *i.e.,* telemedicine and transportation assistance (**107 grants awarded; 107,117 served**)
- **Dental Care** – Build community capacity and serve low-income adults and children (**39 grants awarded; 144,453 served**)

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