

Maryland Health Quality and Cost Council
Friday, June 8, 2012
Main Seminar Room, UMBC Technology Center
Baltimore, Maryland
9:30 a.m. – 12:00 p.m.

MEETING NOTES

Members present: Secretary Joshua Sharfstein (Vice Chair), James Chesley, Lisa Cooper, Barbara Epke, Roger Merrill, Peggy O’Kane, Marcos Pesquera, Kathy White, and Christine Wray.

Members absent: Lt. Governor Brown (Chair), Jill Berger, Richard “Chip” Davis, E. Albert Reece and Jon Shematek.

Staff: Laura Herrera, Katie Jones, Russell Montgomery, Frances Phillips and Grace Zaczek.

Meeting Materials

All meeting materials are available at Council’s website:
<http://dhmh.maryland.gov/mhqcc/meetings.html>

Welcome and Approval of Minutes

The Secretary called the meeting to order at 9:30 AM. He welcomed the members and said the Lieutenant Governor was not able to participate in the meeting. The March 12, 2012 meeting minutes were approved.

Health Care Reform and Implementation

Dr. Sharfstein thanked the Lieutenant Governor for his leadership on Health Care Reform and reported that Governor O’Malley signed the O’Malley-Brown Administration’s Health Benefit Exchange Act into law on May 2, 2012. The new law will allow Maryland’s exchange to become operational by the January, 2014 deadline under the federal Affordable Care Act (ACA). The Maryland legislation established a policy framework on how to engage health plans and how to set criteria for participation. It allows for competitive procurement after legislative comments. The Exchange shall seek first to achieve stable and robust enrollment and reduce the number of uninsured. It may then look to increase affordability and pursue other key objectives like high quality standards of care, delivery system reforms, and health equity.

Dr. Sharfstein reminded the Council that the Supreme Court decision on the ACA is due at the end of the month, and it could significantly impact Maryland’s plans for health care reform.

UPDATE PRESENTATIONS

Health Disparities Workgroup – Joshua M. Sharfstein

Dr. Sharfstein thanked Lieut. Governor and Dean Reece for their development and support of the “Maryland Health Improvement and Disparities Reduction Act of 2012” (House Bill 439/Senate Bill 234), which was the first bill that the Governor signed. The Secretary acknowledged tremendous credit to Dean Reece and the Council’s workgroup for the legislation. The state’s budget includes \$4 Million for implementing the legislation’s activities, both the Health Enterprise Zones (HEZ), and the non-HEZ strategies. An HEZ website is under construction, and there are three phases to the HEZ process: planning - including criteria development with public comment by mid-July, HEZ selection and HEZ implementation and evaluation.

The MD Community Health Commission (CHRC) expects to issue the initial Call for HEZ Proposals in September, with HEZs selected in December, 2012. DHMH will work with CHRC to develop eligibility criteria for HEZ designation, and to monitor progress towards the impact on health disparities by providers in the HEZs. The Secretary said the Council members would be added to the HEZ listserv.

The Secretary said the Health Services Cost Review Commission and the MD Health Care Commission (MHCC) are charged to evaluate and track the impact of HEZs and non-HEZ incentives on disparities, and report to the General Assembly on their findings and recommendations.

Health Disparities Workgroup Charge – Carlessia Hussein, DHMH

Dr. Carlessia Hussein briefly described the workgroup which will address the legislation’s charge to the Council to study standards for cultural and linguistic competency; to determine feasibility of incorporation of standards for reporting and reimbursement purposes; and to prepare a report by December 1, 2013. Dr. Hussein noted that others could be added to the workgroup, which the DHMH Office of Minority Health and Health Disparities (OMHHD) will lead. The OMHHD has a Disparities Collaborative and five subgroups already working on reducing disparities.

Dr. Sharfstein said there is a quite a bit for the Council’s workgroup to address in the months ahead before it submits its report to the Council in the Fall, 2013. Mr. Marcos Pesquera recommended that health insurance plans should be added to the workgroup.

Patient Centered Medical Home Program – Ben Steffen, MHCC

Mr. Steffen reported that 51 practices are providing quality measure data, and hybrid requirements have been created for practices serving both adult and pediatric patients. Fifty two practices have achieved National Committee on Quality Assurance recognition, with two thirds reaching Levels II or III. Mr. Steffen acknowledged the assistance of NCQA staff in helping practices achieve recognition. Practices have received \$5 Million in transformation payments.

The first stage of the program evaluation has begun, and the payment methodology has been tested on existing claims. The program's advisory panel will consider strategies for incorporating health inequalities reduction into the Shared Savings methodology. The program will continue to seek Medicare participation, and will work to include electronic medical records in coordinating patient care.

Mr. Steffen noted that while Medicaid participation is an ongoing challenge, Medicaid funding for Fiscal Year 2013 has increased to \$2.3 Million from \$1.5 Million in FY 2012. The program will explore other funding sources for the Learning Collaborative as MHCC and CHRC can't sustain the effort over the long term.

High Deductible Health Plans – Alison Galbraith, Harvard Medical School

Dr. Galbraith presented via telephone, focusing on the varied impact of High Deductible Health Plans (HDHP) across populations. Healthier and wealthier individuals may have a choice of the type of plan they select, while sicker and lower income people, and those with chronic conditions may have no choice, but to accept a HDHP, with less of an impact among Medicaid enrollees. Those at or below 400 percent of poverty are at greatest risk.

Plan enrollees often are confused by a complex benefit structure, and about what a HDHP does and doesn't cover with deductible costs a frequent barrier to care. They delay preventive care, then find they are billed for tests done during a preventive visit. Enrollees need difficult-to-obtain cost data at the point of care or of decision making. Ms. Peggy O'Kane commented that people pay differing rates for the same service, which Dr. Galbraith said could be negotiated with the plans. Dr. Lisa Cooper said that vulnerable people have the same cost issues with regular plans.

Dr. Galbraith offered Value Based Insurance as a possible solution. A strategy to control costs for individuals and the system is identifying and choosing high value vs. low value tests and procedures, as in the "Choose Wisely" campaign. Dr. Roger Merrill mentioned seven procedures of usually low value, which should have a higher cost, such a surgery for low back pain, with exceptions for true need. Dr. Merrill added that forty percent of Perdue employees participate in such a plan, which Ms. O'Kane said is unique.

Dr. Kathy White asked which states are doing well with controlling costs. Dr. Sharfstein said Colorado is a model for disclosing costs, and Dr. Galbraith added that Massachusetts is trying to provide information with aggregating costs. Dr. Sharfstein and Ms. O'Kane commented that many states have laws which make it illegal to report insurance rates. Dr. Sharfstein said better transparency would provide support for consumer decisions.

Ms. Barbara Epke agreed, saying that re-admissions are a huge topic for examination, and it would be helpful for Maryland to have a metric to measure this. Dr. Merrill said re-admissions may not be an issue for consumers' cost, as they already would have gone beyond their deductible limit. Ms. Christine Wray added the focus should be on Value-Based Purchasing (VBP) and support for consumers. Dr. James Chesley said support is important so people understand what coverage they're buying. Dr. Merrill noted that VBP could change the delivery of health care.

Dr. Sharfstein said the Council could provide the vision for change and the use of VBP. He thanked Dr. Galbraith on behalf of the Lieut. Governor for her presentation.

Evidence Based Medicine Workgroup – Robert Imhoff, Maryland Patient Safety Center

Mr. Imhoff, new President and CEO of the MD Patient Safety Center (MPSC) discussed progress in the Hand Hygiene Initiative. Forty-four Maryland acute care hospitals, or 96 percent reported data for March and April, 2012. He said MHCC has joined as a collaborator in the project, and newly recruited hospitals recently had an orientation telephone call. Site visits in March and April addressed concerns with data collection. Johns Hopkins helped resolve the issue of data omitted on the last day of the month, and the Delmarva Foundation has access to the data to help monitor the project.

The MPSC is negotiating participation with an additional hospital, and with another one which has a more robust program to adjust their data collection so it's comparable with the initiative. The MPSC will work with DHMH on data collection methodology, with a major issue being how to maintain high hospital participation. Dr. Sharfstein said DHMH would appreciate the project's collaboration in the Healthcare Acquired Infections Advisory Committee. He noted the HAI team has identified standard data reporting as an important issue, adding that the Centers for Disease Control and Prevention regards Maryland's HAI team as the best one nationwide. Ms. O'Kane said she was glad to see increased hospital participation in the initiative. Mr. Imhoff commented that he expected all hospitals to report data by July, 2012. Ms. Epke, Chair of Maryland Hospital Association's Council on Clinical Quality Issues said the group is focused on having 90 percent hospital participation, and results should be available soon.

Telemedicine – Ben Steffen, MHCC

Mr. Steffen acknowledged Dr. David Sharp for his persistent guidance on telemedicine, and Grace Zaczek for her key role in the recent taskforce's work. He said the Council's efforts were the foundation for SB 781/HB1149's passage that requires payment for telemedicine services, with Medicaid studying the feasibility of its participation. Senator Thomas Middleton was a major champion of the legislation, which had broad support in the General Assembly. Mr. Steffen explained Medicare pays 20 percent of the charge for telemedicine services to the patient's originating site and 80 percent to the consultant at the distant site.

Mr. Steffen said carriers are ready and enthusiastic to begin telemedicine services payment in December, 2012, particularly for specialty care. Johns Hopkins already provides telemedicine services across the country, though credentialing issues remain a significant challenge. The MHCC is working with the MD Board of Physicians, which will add the use of telemedicine to its licensee survey, while MHCC will align its All Claims Database to include telemedicine. Ms. Wray urged further advocacy on legislation to address credentialing, as JCAHO has allowed broader credentialing in telemedicine, and on expanding broadband and fiber optics to all areas of Maryland.

Dr. Merrill complimented the taskforce and MHCC on a great job, saying that Perdue is happy to pay for telemedicine where appropriate. He asked MHCC to tease out the four or five areas

where it could have the greatest value. Ms. Wray said Medstar St. Mary's Hospital has used telemedicine for years, and Current Procedural Technology data may not be accurate to assess telemedicine volume as physicians don't always code the encounters properly.

Wellness and Prevention Workgroup and Healthiest Maryland Businesses – Christine Wray, MedStar St. Mary's Hospital

Ms. Wray reported that Healthiest Maryland Businesses (HMB) membership is 162 companies with 212,000 employees. She offered "huge kudos" to Dr. Merrill for Perdue's sponsorship of the first HMB event on March 29th in Salisbury with over 40 participants from the Lower Shore and Delaware. The program highlighted Perdue Farms, K & L Microwave, and the Wicomico County Board of Education as having successful worksite wellness initiatives, and promoted free/low-cost resources available through DHMH, local health departments and local community partners. Additional events are planned across Maryland from June through Fall, 2012.

State government is leading by example to improve the health of its 230,000 "covered lives," with a Wellness Stat including established goals for state employee worksite wellness. Implementation will: maximize wellness opportunities, develop state agency health snapshots and launch agency pilots. Secretary Sharfstein said he was especially pleased with the recent "win" banning the sale of tobacco products on state sites, as it involved multiple state agency contracts.

Ms. Wray reported progress on the Million Hearts Campaign. Since the campaign lacks funding, the workgroup will collaborate with DHMH's Preventive Health and Human Services and Community Transformation Grant on its clinical and community prevention activities, with a focus on evidence-based obesity prevention best practices. The workgroup's collaboration with DHMH, Maryland Hospital Association, the State Health Improvement Plan, and other Council workgroups is essential to successful projects. Dr. Merrill noted that only daily Aspirin use is addressed in the ACA, so blood pressure and cholesterol control are perfect for Value Based Prevention.

Improving Maryland's Chronic Disease Outcomes - Community Transformation Grants – Donald Shell, DHMH

Dr. Shell explained Maryland received approximately \$1.9 Million from the ACA for community-level efforts to reduce chronic diseases by promoting healthy lifestyles in parts of the state outside the five most populated jurisdictions. In Maryland, heart attack and stroke cause one in three deaths, and 25 percent of deaths are from heart attacks. Activities will aim to maximize health impact through prevention, to improve health equity, and will use and expand the evidence base for local policy, environmental, and infrastructure changes.

The Institute for a Healthiest Maryland (IHM) will coordinate strategies among experts from Maryland's colleges and universities to disseminate evidence-based resources, and to host training and technical assistance opportunities with priorities of tobacco free living, healthy eating and health equity. Dr. Shell discussed clinical strategies and IT infrastructure

development. The Stanford model for diabetes care, which Ms. Wray said St. Mary's County uses, is a possibility to address diabetes statewide. Dr. Merrill said the March 29th event was the first look at what small companies are doing to impact health, which fits with IHM strategies. Dr. Shell asked the Council to advise DHMH and the IHM on approaches to community-based efforts, to serve as a champion for community transformation and to disseminate success stories.

NEXT STEPS

Secretary Sharfstein reminded members that the next meeting of the Council is September 14, 2012 from 9:30 AM to 12 noon at the UMBC Technology Center. The meeting then adjourned at 11:40 AM.