



MARYLAND
HEALTH CARE
COMMISSION

RECENT MARYLAND INNOVATION INITIATIVES

**Maryland Health Care Commission
June 17, 2021**



- **Hospice/Health System Joint Ventures – a care delivery innovation**
- **Hospital at Home – a delivery system innovation**
- **Ambulatory Surgical Facilities Within General Hospitals – a regulatory innovation**

Expanded Use-General Hospice CONs

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- **Objective:** Permit joint ventures (JVs) formed by hospitals/health systems and existing Maryland general hospices to provide a more comprehensive array of services, focusing on the total cost of care across the health care continuum
- **Guidance** was published on MHCC website for requesting a determination of coverage (May 20, 2021). Key provisions:
 - Hospice JV partner must have operated in Maryland for at least five years
 - Inter-facility or inter-provider partnership and a cost reduction agreement designed to reduce the total cost of care
 - Provision of hospice services by the JV must be provided under the existing hospice license (no new licensed hospice created)
 - Hospice JV partner must have authorization (CON or acquisition) to serve any jurisdiction served by the JV
- First proposed JV partners are **Luminis Health** (Anne Arundel Medical Center/Doctors Community Hospital) and **Gilchrist Hospice**—under review

Hospital at Home (HaH)

- **Objective:** Allow acute general hospital inpatient care to be provided in the patient's home
 - 2021 GA Budget and Tax Committee language mandates a **study report** by HSCRC & MHCC on
 - the efficacy of the HaH model
 - how the model fits into the Total Cost of Care model
 - barriers to the model in existing law and regulation &
 - cost implications of the model for payers - ***due December 2021***
 - Leff HaH model (Johns Hopkins Medicine) expected benefits
 - Reduced care cost
 - Equivalent or improved outcomes – mortality and satisfaction
 - Decanting of hospital – freeing bed capacity
 - Reduced need for capital investment – increased scalability
 - HSCRC staff taking lead on development of the report with MHCC staff reviewing and commenting as it is assembled
 - MHCC should consider and adopt a **position on CON regulation** for the report

ASFs Within General Hospitals

- **Objective:** Allow acute general hospitals to co-locate with distinctly licensed ambulatory surgical facilities while maintaining their separate status as rate-regulated (hospital) and unregulated (ASF) entities
 - MHCC issued a CON to UMMC Midtown Surgicenter, LLC to establish an ASF with three ORs on the first floor of a new building under development on the Midtown campus in **October 2020**. HSCRC determined that this project was well situated to function separately from the hospital surgical facilities and, with adequate representations from UMMS on its operational characteristics in hand, the ASF could operate as an unregulated facility.
 - MHCC issued a determination that Johns Hopkins Surgery Centers Series did not need a CON to establish an ASF with two ORs by reconfiguring existing hospital surgical facilities and ancillary space at Howard County General Hospital in **May 2021**. The hospital surgical space and proposed ASF space will be reconfigured to function independently. An HSCRC determination was not issued prior to MHCC's determination.

Hospital at Home

Overview & Background



JOHNS HOPKINS
MEDICINE

Origin of Hospital at Home

Background



Bruce Leff, MD

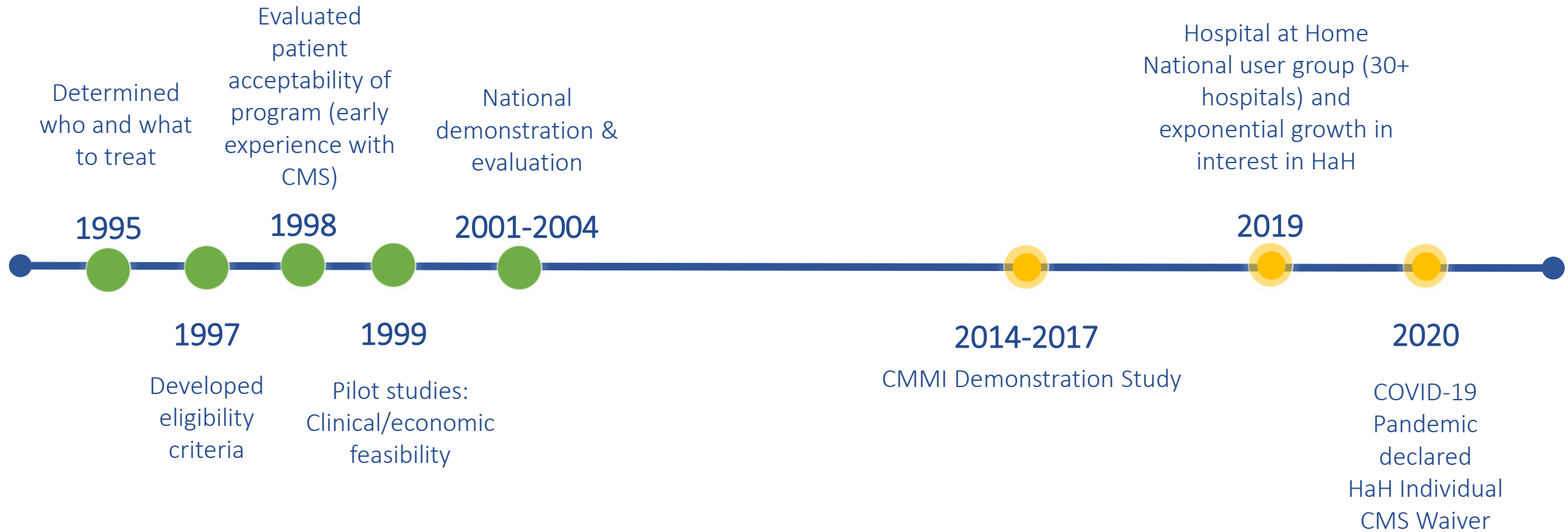
Director, Center for Transformative
Geriatric Research
Professor of Medicine
Johns Hopkins Medicine

Why Hospital at Home?

- Reduces total care costs by 25% on average
- Equivalent and improved clinical outcomes, mortality, and satisfaction
- Decants hospitals to free up capacity
- Reduces high-cost capital needed for new hospital beds increasing scalability

Evolution of Hospital at Home

Background



Hospital at Home Model Overview & Patient Flow

Hospital



1. Patient arrives in ED
2. ED physician reviews patient, identifies acute care need
3. HaH coord (RN) screens patient, qualifies, & receives consent
4. HaH coordinator arranges technology, services, and medication delivery

Patient's Home



5. Patient returns home with equipment and technology
6. Patient receives **in home, in person** services as well as **virtual services from HaH Central**
7. Within 30 days patient is discharged from HaH & equipment is collected



EMS Transport
to Home

Nursing,
therapy, IV,
Oxygen, labs,
and other
diagnostic
work



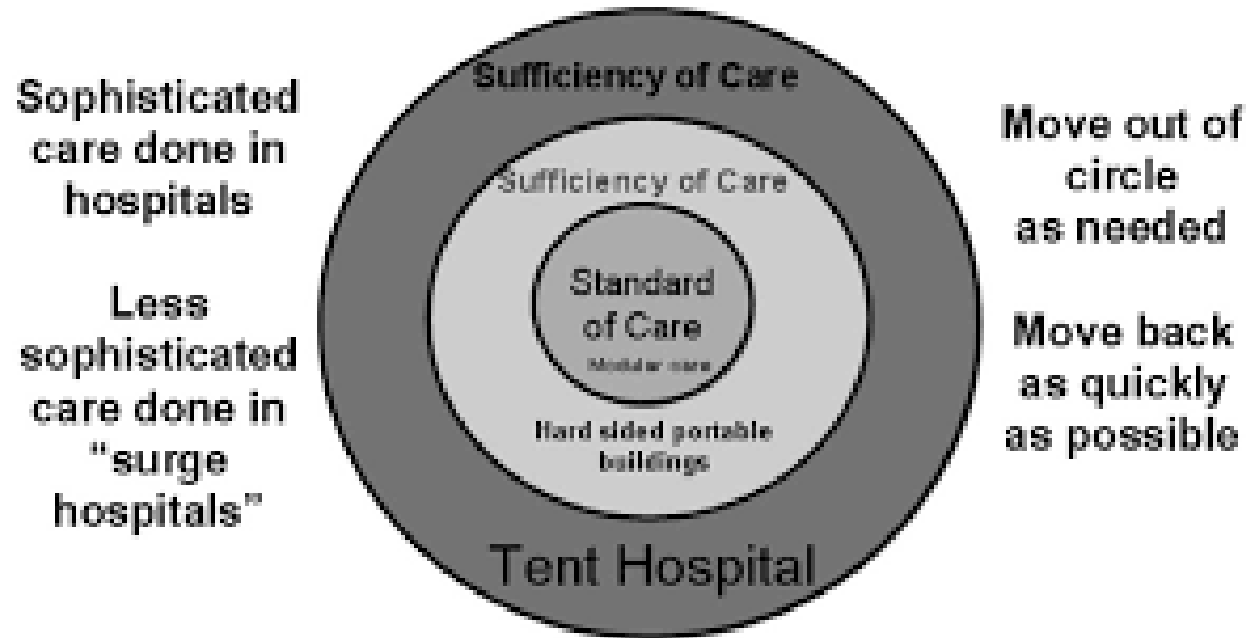
JHM Virtual Hospital



Remote hospitalist, RN, and coordinator work together
to ensure patient needs are met

Understanding Sufficiency of Care

Emphasis on making sure safe, quality care is being provided at home



Understanding Sufficiency of Care vs. Standard of Care

Limitations exist on which services can be provided in home

Understanding PPE and other equipment needs for workforce safety and satisfaction

Evaluating the needs of different home patients (acute care vs. home health)

Opportunity to utilize resources that exist in patient homes (ex. laundry, groceries, etc.)

Who is eligible?

Understanding the eligible patient population is key to building operations

Target Patient Population

Appropriate level of in-home screening:

Running water, electricity, willing caregiver, etc.

Specified oxygen stats

Functional AM-PAC Score

Non-COVID

Age: 18+

Specified DRG with limitations on disease progression

Examples include:
CAP, CHF, COPD, Cellulitis, Dehydration, Diabetes, Sepsis, UTI, Asthma
End of life/Palliative, Gout, DVT/PE, and more

Funding Mechanisms

Public Health Emergency & Beyond

	Outside of PHE	PHE Waiver	
Classification	Unregulated	Regulated – Federal (NEW – Announced 11/25)	Regulated – Maryland (Initial Proposal – 10/21)
Reimbursement Methodology	<ul style="list-style-type: none"> Negotiated bundled payment over a defined episode Typically a % historical total costs of care during the period 	100% DRG payment for hospital stay (MD not eligible)	<ul style="list-style-type: none"> New rate center with bundled rate for 30 days for all services No incremental GBR
Eligible Payors	Contracted private payors	Medicare, contracted private payors	Medicare, contracted private payors

CMS Hospital at Home

Individual Waiver Program



- As of 4/16/21 there are 56 health systems, 127 hospitals in 29 states approved for participation
- § 482.23(b) and (b)(1) of the Hospital CoPs are waived which require nursing services to be provided on premises 24 hours a day, 7 days a week and the immediate availability of a RN for care of any patient
- Individual hospital/CMS Certification Number (CCN) level requests will be evaluated by CMS
- Two-tiered application process (established vs new programs)
- Hospitals will be paid **current full DRG payment** for any AHCaH patient just as they would receive for a hospital-based patient

PHE CMS Waiver

Patient Admission Process



- Hospital must use accepted patient leveling process (Interqual, Milliman, or another accepted process) to ensure that only patients requiring an acute level of care are treated
- Admissions may occur only from an Emergency Room or inpatient hospital (if moving from hospital-based unit to AHCaH would be considered intra-facility transfer)
- Hospital must meet specific service requirements either provided by the hospital or via a contracted service
- Hospital must provide and establish specific inclusion and exclusion criteria for AHCaH admission including DRGs

Hospital at Home Resources

- Hospital at home demonstrated results: <http://www.hospitalathome.org/news-resources/publications.php>
- Hospital at home growth during pandemic: <https://www.aamc.org/news-insights/interest-hospital-home-programs-explodes-during-covid-19>
- CMS Waiver participant List: <https://qualitynet.cms.gov/acute-hospital-care-at-home/resources#tab1>
- CMS Waiver application portal/testimonials: <https://qualitynet.cms.gov/acute-hospital-care-at-home>
- CMS letter to governors: <https://www.cms.gov/files/document/covid-hospital-capacity-governors-letter.pdf>

Questions?



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health services
cost review commission

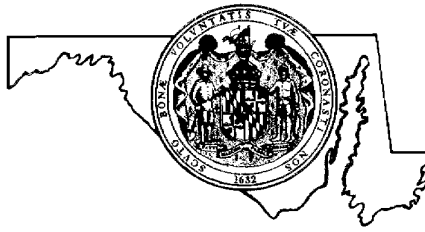
Hospital at Home Overview

Hospital at Home – Bundled Payment

- Hospital at Home programs provide hospital-level care in a patient's home as a full substitute for acute hospital care. Common characteristics include:
 - Patients are admitted by a hospital before care is provided in the home
 - Patient are evaluated daily in their home, along with necessary services such as vital signs monitoring, intravenous infusions, and wound care
 - Patient have access to the hospital, if necessary
 - Telehealth can be used to increase access to providers
- Services are reimbursed through a hospital-at-home-specific bundled payment rate
- Requirements:
 - Waiver of standard IPPS/OPPS
 - Waiver of Hospital Conditions of Participation requirement that nursing services be provided on premises 24 hours a day, 7 days a week and the immediate availability of a registered nurse for care of any patient
 - Approval of temporary locations or alternate care sites at the state level to ensure licensure requirements are met

Hospital at Home – Covered Services Payment

- Hospital at Home programs provide hospital-level care in a patient's home as a full substitute for acute hospital care. Common characteristics include:
 - Patients are admitted by a hospital before care is provided in the home
 - Patient are evaluated daily in their home, and provided necessary services such as vital signs monitoring, intravenous infusions, and wound care
 - Patient have access to the hospital
 - Telehealth can be used to increase access to providers
- Services are reimbursed at the same rate/through the same mechanism as if they were provided in person
- Requirements:
 - Waiver of Hospital Conditions of Participation requirement that nursing services be provided on premises 24 hours a day, 7 days a week and the immediate availability of a registered nurse for care of any patient
 - Approval of temporary locations or alternate care sites at the state level to ensure licensure requirements are met



MARYLAND HEALTH CARE COMMISSION

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May 20, 2021

MHCC REGULATORY GUIDANCE

Guidance Regarding Joint Venture Projects between a Licensed Maryland General Hospice and a Licensed Maryland Hospital/Health System

The Maryland Health Care Commission (Commission) is aware that there is interest among some general hospices and hospitals/health systems to establish cooperative, innovative projects along the continuum of care. This guidance is issued for a licensed Maryland general hospice that desires to establish a formal joint venture with a Maryland hospital or health system to provide hospice and specified other health care services.

The general hospice and its partner hospital/health care system must file with the Commission a request for determination of coverage that contains a detailed project description and receive a determination of coverage from Commission staff prior to implementing such a joint venture.

Please use the following guidelines to structure a request for a determination of coverage for such a joint venture:

The proposed joint venture project shall include:

1. A joint venture between a licensed Maryland general hospice and a Maryland hospital or health system;
2. The licensed Maryland general hospice shall have a minimum of five years' experience in providing Medicare-certified hospice services in Maryland;
3. The joint venture must fully detail an inter-facility (or inter-provider) partnership and a cost-reducing agreement, designed to lower the total cost of care for patients receiving hospice and other health care services provided by the joint venture;
4. The creation of the joint venture entity shall not result in the issuance of an additional Maryland hospice license, but must be done within the licensed authority of the existing Maryland hospice;

Re: Joint Venture Guidance

May 14, 2021

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5. The hospice shall possess current authority (through CON or through acquisition approved by the Commission that results in licensure as a Maryland general hospice) to serve each jurisdiction proposed to be served by the joint venture; a notation would be added to the Maryland hospice license to show that in each specifically designated jurisdiction the hospice will be providing services within the joint venture; and
6. If the joint venture ceases operations, any authority that involves the provision of hospice services shall revert to the existing Maryland general hospice on whose license the joint venture is listed.

Commission staff may seek further documentation regarding proposed joint venture projects.