MINUTES OF THE
520th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

June 10, 2015

Chairman John Colmers called the public meeting to order at 8:05 am. Commissioners George H. Bone, M.D, Stephen F. Jencks, M.D., MPH, Jack C. Keane, Bernadette C. Loftus, M.D, and Herbert S. Wong, Ph.D. were also in attendance. Thomas Mullen joined the meeting via telephone.

ITEM I
REVIEW OF THE MINUTES FROM MAY 13, 2015 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the May 13, 2015 Executive Session and Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, noted that at the last public meeting, the utilization of BRFA funds to provide funding for the Chesapeake Regional Information System for our Patients (CRISP) to implement state-wide IT and analytic infrastructure was discussed. Since then, a 90 day planning cycle has been introduced and is under way at CRISP. Ms. Kinzer stated that staff wanted to provide an update on the funding requirements.

At the May public meeting an initial budget of $495,000 was set to fund the intense 90 day planning process. This budget was incorporated into the Memorandum of Understanding with CRISP after review by the Maryland Health Care Commission (MHCC) and HSCRC.

Ms. Kinzer noted that three additional budgets have been submitted by CRISP. The first budget of $1.08 million will provide for consulting resources to support the Regional Transformation process and the infrastructure strategic plans due from each hospital on December 1, 2015. A second budget of $.9 million will provide for consulting resources to assist in developing alignment strategies and approaches. These two budgets and scopes were reviewed and approved by staffs of HSCRC, Department of Health and Mental Hygiene (DHMH), and MHCC. A third budget of $6.2 million has been submitted to the HSCRC and MHCC staff for initial review. This budget proposes that CRISP move forward on implementing some aspects of the care and coordination infrastructure, while continuing planning on others. The budget is designed to leverage federal funding sources to support the development of the state level infrastructure. This budget and work plan will be reviewed by the CRISP Executive Committee. Once approved by CRISP, HSCRC staff will incorporate it into the Memorandum of Understanding. CRISP will engage an independent auditor to perform an audit of expenditures for these activities.

Ms. Kinzer noted that there are three streams of activity underway:

- Transformation Support
- Alignment Support
- Development of state level IT and tools to support care coordination and integration.

Ms. Kinzer stated that in the initial year of the "All-Payer" Model, hospitals and their physicians and long term care partners performed well, meeting or exceeding nearly all of the model performance objectives. Ms. Kinzer noted that in order to make the model sustainable and also to meet the aggressive timelines set forth in the model agreement, we need to accelerate the implementation of care improvements, care integration and alignment, and care coordination. Staff has worked with the hospitals, Commissioners, MHA, CRISP, DHMH, Medicaid and other commercial payers, physicians, and multi stakeholders to develop an overall strategy to augment and accelerate infrastructure.

Ms. Kinzer noted that staff has proposed an addition to rates for infrastructure as part of the annual update to global budgets for rate year 2016. Payers and purchasers have asserted that hospitals should already have adequate incentives under the All Payer Model and global budgets to make these investments with the expectation that these investments will generate savings as well as care improvement. Over time, staff expects hospitals to make investments and changes to adapt to the new model and to generate a return on investment.
Ms. Kinzer stated that staff believes that we have to accelerate the process in a way that is consistent with the approach that is outlined in the All-Payer agreement.

Staff expects investments will result in improved care and reductions in Potentially Avoidable Utilization (PAU), as well as generate a return on investment. The return on investments will be recognized in future updates, with adjustments for PAU, including shared savings

Ms. Kinzer expressed her thanks to the HSCRC staff, the Maryland Hospital Association staff, the hospitals, Commissioners, workgroups, and Alice Burton for the contributions made during the first year of the All-Payer Model.

Ms. Kinzer especially wanted to thank David Romans for guiding the Commission through the 2016 update process, including the Medicaid expansion and uncompensated care updates. Ms. Kinzer also gave a special thanks to Dr. Sule Gerovich, Ph.D., for her leadership in bringing forward the policy changes and methods of global budget administration. In addition, Ms. Kinzer thanked Jerry Schmith, Ellen Englert, and Dennis Phelps for their guidance and administration of all of the rate updates that were completed.

Chairman Colmers also expressed his appreciation for the efforts of the HSCRC staff, hospitals and payers during the 2016 Update process.

Ms. Kinzer invited the HSCRC Performance Measurement Work Group and other experts to participate in a meeting on June 22, 2015 from 9:30 to noon to discuss the future of the

Commission's performance measurement program and work plan. Staff will update the group on the status of the existing measures and the activities of the work group. Dr. Stephen Cha of the Center for Medicare and Medicaid Innovation (CMMI) will present the CMMI measurement strategy, and Dr. Thomas Valuck of Discern Health will discuss an ideal design and gap analysis.

Ms. Kinzer stated that on May 20th, DHMH, the University of Maryland, and John Hopkins Medicine co-sponsored an all day summit on the future of graduate medical education. The summit brought together over 100 graduate medical education and healthcare leaders from around the State to discuss what the goals of a new GME model should be and steps that would need to be undertaken to modernize GME in Maryland. The feedback received during the summit will be incorporated into the GME workgroup discussion.

Ms. Kinzer congratulated Dr. Gerovich on being included in the Emerging Leaders Program sponsored by the Millbank Memorial Fund and the Reforming States group. This prestigious opportunity has been extended to 25 individuals nationally who are working in leadership roles in developing and implementing health care reform.

Ms. Kinzer stated that Staff met with CMS leaders and stakeholders who have been involved in the new All-Payer Model. Ms. Kinzer noted that CMS leaders were pleased with the first year results. CMS wants Maryland to speed up the process towards Phase II with designing models outside of the hospital.

Ms. Kinzer noted that Staff will be focused on the following activities in June/July:

- Completing the update on rate orders for FY 2016. The target date for completion is the end of July;
- Continuing and accelerating the focus on the alignment models, and state level, regional and hospital transformation planning and implementation;
- Preparing the report of the Consumer Engagement and Education efforts.

ITEM III
NEW MODEL MONITORING

Mr. David Romans, Director Payment Reform and Innovation, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of April will focus on fiscal year (July 1 through June 30) as well as calendar year results.

Mr. Romans reported that for the ten months ended April 30, 2015, All-Payer total gross revenue increased by 1.50% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 2.01%; this translates to a per capita growth of 1.36%. All-Payer gross revenue for non-Maryland residents decreased by 3.60%.

Mr. Romans reported that for the four months of the calendar year ended April 30, 2015, All-Payer total gross revenue increased by 1.03% over the same period in FY 2014. All-Payer total

gross revenue for Maryland residents increased by 1.48%; this translates to a per capita growth of (0.02%). All-Payer gross revenue for non-Maryland residents decreased by 3.67%.

Mr. Romans reported that for the ten months ended April 30, 2015, Medicare Fee-For-Service gross revenue increased by 2.36% over the same period in FY 2014. Medicare Fee-For-Service for Maryland residents increased by 3.23%; this translates to a per capita growth of 0.92% Maryland Fee-For-Service gross revenue for non-residents decreased by 6.91%.

Mr. Romans reported that for the four months of the calendar year ended April 30, 2015, Medicare Fee-For-Service gross revenue increased by 2.98%. Medicare Fee-For-Service for Maryland residents increased by 4.00%; this translates to a per capita growth of 0.54 %. Maryland Fee-For-Service gross revenue for non-residents decreased by 8.28%.

According to Mr. Romans, for the ten months of the fiscal year ended April 30, 2015, unaudited average operating profit for acute hospitals was 3.13%. The median hospital profit was 3.85%, with a distribution of 1.78% in the 25th percentile and 6.82% in the 75th percentile. Rate Regulated profits were 5.69%.

Dr. Alyson Schuster, Associate Director Performance Measurement, presented a quality report update on the Maryland Hospital Acquired Conditions program based upon readmission data on discharges through February 2015.

Readmissions

- The All-Payer risk adjusted readmission rate was 12.94 % for the period of January 2014 to February 2015. This is an accumulative decrease of 5.24% from the January 2013 risk adjusted readmission rate.
- The Medicare Fee for Service risk adjusted readmission rate was 13.86% for the period January 2014 to February 2015 YTD. This is an accumulated decrease of 3.42% from the January 2013 risk adjusted readmission rate.
- Based on the New-Payer Model, hospitals must reduce Maryland's readmission rate to or below the national Medicare readmission rate by 2018. The Readmission Reduction incentive program has set the goals for hospitals to reduce their risk adjusted readmission rate by 9.3% during CY2015 compared to CY2013. Currently, only 10 out of 46 hospitals have reduced their risk adjusted rate by more than 9.3%.

There is no Potentially Preventable Complications update due to a request from hospitals for an extension on submitting the final data for the 1st quarter of CY 2015.

ITEM IV
DOCKET STATUS CASES CLOSED

2296A- Johns Hopkins Health System
2297A- University of Maryland Medical Center

ITEM V
DOCKET STATUS-NO OPEN CASES

ITEM VI
FINAL RECOMMENDATION FOR SHARED SAVINGS PROGRAM FOR RATE YEAR 2016

Dr. Schuster presented the staff's final recommendation for the Shared Savings program for Rate Year 2016 (see "Final Recommendation for Shared Savings Program for Rate Year 2016" on the HSCRC website)

The Commission approved a shared savings policy on May 1, 2013, which reduced hospital revenues based on risk adjusted readmission rates using specifications set forth in the Admission-Readmission Revenue Constraint Program (ARR). The program was developed to maintain Maryland's exemption from the CMS readmission program and required a reduction of 0.3 percent of inpatient revenues in the State during FY 2014. This recommendation proposes the continuation of the shared savings policy, but suggests aligning the measurement definition to the definitions used in the Readmission Reduction Incentive Program and implementing interim limits for hospitals with changes above a threshold in shared savings amounts and for those serving a higher proportion of adult Medicaid patients.

The staff's final shared savings program recommendations for Rate Year 2016 are as follows:

- Align the shared savings readmission rate to the measure specified in the RY 2017 Readmission Reduction Incentive Program.
- Set the value of the shared savings mount to 0.6% of total permanent revenue in the State.
- Reduce hospital specific shared savings reductions for hospitals with large changes from last year and those with a higher proportion of adult Medicaid patients:

    1. Hospitals with an increase in the shared savings penalty of greater than 0.3% and who had an improvement in readmissions from CY 2013 and CY 2014 will have the shared savings penalty capped at 0.3% for this year and will return to full shared savings amounts in subsequent years.
    2. Hospitals that are above the 75^{th} percentile on the percentage of Medicaid discharges for those over age 18 should have shared savings reductions capped at the statewide average of 0.6%.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
FINAL UPDATE FACTORS RECOMMENDATIONS FOR FY 2016

Mr. Romans presented the staff's final recommendation concerning the update factors for FY

2016 (See "Final Recommendation on Update Factors Recommendations for FY 2016" on the HSCRC website).

On July 1st of each year, the HSCRC updates hospitals' rates and approved revenues to account for inflation policy adjustments and other adjustments related to performance and settlements from prior year.

On January 10, 2014, the Center for Medicare & Medicaid Innovation (CMMI) approved the implementation of a New-All Payer Model for Maryland. The All-Payer Model has a three part aim at of promoting better care, better health, and lower cost for all Maryland patients. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the new All-Payer Model focuses on controlling increases in total hospital revenue per capita. The Model establishes both an All-Payer limit of 3.58% cumulative annual per capita growth for Maryland residents for the first three years of the Model, and a Medicare savings of $330 million over the initial five year period of the Model.

The update process needs to take into account all sources of hospital revenue that will contribute to the growth of total Maryland hospital revenues for Maryland residents in order to meet the requirements of the All-Payer Model and to assure that the annual update factor approved by the HSCRC will not result in a revenue increase beyond the limit. In addition, HSCRC needs to consider the effect of the update on the Model's Medicare savings requirement and the total hospital revenue at risk for quality, care delivery, and value enhancement. While rates and global budgets are approved on a fiscal year basis, the All-Payer revenue limits and Medicare savings are determine on a calendar year basis. Therefore, it is necessary to account for both calendar and fiscal year revenues in establishing updates for the fiscal year.

The staff's final recommendations are as follows and are offered on the assumption that the other policy recommendations that affect the overall targets are approved (including the shared savings adjustment):

- Provide updates for three categories of hospitals as follows:
    1. Revenues under global budgets, 2.4% with an additional 0.4% provided for care coordination and population health infrastructure investments;
    2. Revenues not under global budget but subject to the Medicare rate setting waiver 1.6%;
    3. Revenues for psychiatric hospitals and Mount Washington Pediatric Hospital, 1.9%. with an additional 0.30% provided for infrastructure investments to support reduction in readmissions and other potentially avoidable utilization.
- Require all acute hospitals to submit multi-year plans for improving care coordination, chronic care, and provider alignment by December 1, 2015.
- Require psychiatric hospitals and Mt. Washington Pediatric Hospital to submit a report outlining plans to reduce readmissions and other avoidable utilization by December 1, 2015 and to begin submitting admission and discharge data to CRISP by April 1, 2016.
- Provide an additional 0.25% for competitive awards to hospitals to implement or expand innovative care coordination, provider alignment, and population health strategies.

- Calculate the Medicaid deficit assessment for FY 2016 at the same total amount as FY 2015 and apportion it between hospital funded and rate funded in the same total amounts as FY 2015.

Commissioner Jencks, while supportive of the need for additional infrastructure investment, raised concerns regarding hospitals' level of accountability to report to the Commission on programs for which they are using infrastructure funds. He also expressed concern with rewarding funds through a competitive funding process while the Commission is trying to encourage hospital collaboration on care coordination to ensure success under the Medicare waiver.

The Commission voted unanimously to approve staff's recommendation

ITEM VIII
FINAL RECOMMENDATION FOR CONTINUED SUPPORT OF THE MARYLAND PATIENT SAFETY CENTER

Ms. Dianne Feeney, Associate Director Quality Initiative, presented staff's final recommendations for continued support of the Maryland Patient Safety Center (MPSC) (See "Final Recommendations on Continued Financial Support for the Maryland Patient Safety Center for FY 2016" on the HSCRC website).

In 2004, the HSCRC adopted recommendations that made it a partner in the initiation of the MPSC by providing seed funding through hospital rates. The initial recommendations provided funding to cover 50% of the reasonable budgeted costs of the Center. The Commission receives a briefing and documentation annually on the progress of the MSPC in meeting its goal as well as an estimate of expected expenditures and revenues for the upcoming fiscal year.

Based on information presented to the Commission, the staff, after evaluating the reasonableness of the budget items presented, provides the following final recommendations on the MPSC funding support policy:

- HSCRC provide funding support for the MPSC in FY 2016 through an increase in hospital rates in the amount of $972,000, a $108,000 (10%) reduction from FY 2015;
- The MPSC continues to aggressively pursue other sources of revenue, including from other provider groups that benefit from the programs of the Center, to help support the Center into the future and maintain reasonable cash reserves;
- Going forward, HSCRC continues to decrease the dollar amount of support by a minimum of 10% per year, or greater amount contingent upon:

    1. How well the MPSC initiatives fit into and line up with a broader statewide plan and activities for patient safety; and
    2. Whether new MPSC revenues should offset HSCRC funding support.

The Commission voted unanimously to approve staff's recommendation.

ITEM IX
FINAL RECOMMENDATION ON CHANGES TO THE RELATIVE VALUE UNITS SCALE FOR RADIATION THERAPY SERVICES

Mr. Chris Konsowski, Chief- Audit & Compliance, presented a recommendation for final adoption of revisions to the Relative Value Unit (RVU) scale for Radiation Therapy services to be effective July 1, 2015

The Commission voted unanimously to approve staff's recommendation.

ITEM X
FINAL RECONMMENDATION ON FY 2016 NURSE SUPPORT II COMPETITIVE INSTITUTIONAL GRANTS

Ms. Claudine Williams, Associate Director Policy Analysis, presented staff's final recommendations for the Nurse Support Program II (NSP II) FY 2016 Competitive Institutional Grants (See "Nurse Support Program II Competitive Grant Review Panel Recommendation for FY 2016" on the HSCRC website).

This recommendation summarizes the funding recommendations of the NSP II Competitive Grant Review Panel for FY 2016. It also provides a report on the activities of the NSP II workgroup, formed as part of the recommendations of the NSP II Outcomes Evaluation report for FY 2006 – FY 2015, as approved on January 14, 2015 by the HSCRC. With guidance from the workgroup, NSP II has undergone a reconfiguration with new initiatives to meet NSP II goals, and has strengthened requirements for standardized data.

Since the mid-1980's, the HSCRC has funded programs to address the cyclical nursing workforce shortages. The Nurse Education Support Program evolved, first into the hospital based NSP I program in 2001 and then into the nursing education based NSP II program in 2005. Over the last decade, the NSP I and NSP II programs worked in parallel pathways along separate tracks to ensure that nursing personnel and services are available to improve health and health care in Maryland. Since the 2012 NSP I Evaluation Report, the staff increasingly has looked for opportunities for these two programs to collaborate in meeting joint recommendations and objectives.

The staff final recommendations on the NSP II funding for FY 2016 are as follows:

- The HSCRC and the Maryland Higher Education Commission (MHEC) staff members recommend that the NSP II Competitive Grant Review Panel Recommendation funding be approved at $15,737,431 for Competitive Institutional Grants, and $7,710,328 for new Statewide Initiatives for FY 2016.
- Due to timing and process of this review, staff of the HSCRC and MHEC request that the

regular comment period of 60 days be waived so that the grants may become effective on July 1, 2105.

The Commission voted unanimously to approve staff's recommendation for Competitive Institutional Grants. Chairman Colmers recused himself from the vote.

The Commission voted unanimously to approve staff's recommendation for the new Statewide Initiative funding

ITEM XI
HEARING AND MEETING SCHEDULE

July	Commission meeting has been cancelled
August 12, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 9:53 am.