Closed Session Minutes
Of the
Health Services Cost Review Commission

May 13, 2015

Upon motion made in public session, Chairman Colmers call for adjournment into closed session to discuss the following items:

1. Status of Medicare Data Submission and Reconciliation;
2. Contract and modeling of the All-payer Model and legal consultation on potential alternative Medicare payment for hospital services vis-à-vis the All-payer Model Contract;

The Closed Session was called to order at 12:16 p.m. and held under authority of - §§ 3-104 and 3-305(b) (7) of the General Provisions Article.

In attendance, in addition to Chairman Colmers, were Commissioners Jencks, Keane, Loftus, and Mullen.

In attendance representing Staff were Donna Kinzer, David Romans, Steve Ports, Sule Gerovich, Jerry Schmith, Ellen Englert, and Dennis Phelps.

Also attending were Leslie Schulman and Stan Lustman, Commission Counsel.

Item One

David Romans, Director-Payment Reform and Innovation, presented and the Commission discussed an updated analysis of Medicare per beneficiary data. Authority: General Provisions Article, § 3-104.

Item Two

The Chairman and Executive Director updated the Commission and the Commission discussed Potential Alternative Medicare Payment for Hospital Services vis-à-vis the All-Payer Model Contract – Authority General Provisions Article, §§ 3-104, and 3-305(b)(7).

Item Three

Counsel advised the Commission on the need for certain voting recusals on the matter of Regional Partnership Grants scheduled to be ratified in the public meeting – Authority General Provisions Article, § 3-305(b)(7)

Item Four

The Chairman noted the important events that transpired in Baltimore City since the last Commission meeting.

The Closed Session was adjourned at 12:57 p.m.

REVISED
MINUTES OF THE
519th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

May 13, 2015

Chairman John Colmers called the public meeting to order at 12:16 pm. Commissioners Stephen F. Jencks, M.D., MPH, Jack C. Keane, Bernadette C. Loftus, M.D, and Thomas Mullen were also in attendance. Dr. George H. Bone M.D, and Herbert S. Wong, Ph.D. joined the meeting via telephone. Upon motion made by Commissioner Jencks and seconded by Commissioner Keane, the meeting was moved to Executive Session. Chairman Colmers reconvened the public meeting at 1:06 pm.

REPORT OF THE MAY 13, 2015 EXECUTIVE SESSION

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the May 13, 2015 Executive Session.

ITEM I
REVIEW OF THE MINUTES FROM APRIL 15, 2015 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the April 15, 2015 Executive Session and Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, updated the Commission on the staff's activities. Ms. Kinzer stated that today, staff will present:

- Draft recommendations for
  1. The rate year 2016 balanced update; and
  2. The shared savings adjustment.
- Status of the market shift adjustment;
- Selected 2014 Budget Reconciliation and Financing Act (BRFA) regional planning grant proposals for approval by the Commission;
- Final recommendations for;
  1. The Uncompensated Care Policy (UCC) for 2016; and
  2. FY 2016 Chesapeake Regional Information System for our Patients (CRISP) funding.

Ms. Kinzer stated that Staff also completed rate order updates to incorporate the BRFA funding approved at last month's Commission meeting; in addition; staff will release all of the BRFA

rate order updates after the Commission approves the regional planning grant, awards.

For the months of May and June, Ms. Kinzer noted that staff will focus on:

- Finalizing the updates for rate year 2016 and preparing rate setting files for the rate orders;
- Completing the Market Shift adjustments; and
- Implementing the care coordination report and moving forward on activities relative to provider alignment.

Ms. Kinzer noted that over the next several public meetings, staff will be presenting information to the Commission about more detailed plans, timelines, and execution approaches for care coordination infrastructure, regional and local planning activities, provider alignment activities, and as well as consumer engagement activities.

Ms. Kinzer reported that BRFA funds were placed in rates on May 1st to provide for the collection of $15 million during rate year 2015. The initial funding of $1 million was provided to CRISP, Maryland's designated Health Information Exchange, for consulting and other resources to support work activities aimed at accelerating care coordination activities. $2.5 of the funding will be retained by hospitals for implementation of regional planning grants. The remaining $11.5 will be provided to CRISP to fund additional planning and start-up costs of expanded IT and analytic infrastructure and continued consulting support for implementation of care coordination and alignment activities. The responsibilities of CRISP and use of these funds will be defined and directed under a Memorandum of Understanding with the HSCRC, and MHCC, who will administer the funds with support of the HSCRC.

Ms. Kinzer stated that the proposed rate update for rate year 2016 will include an infrastructure adjustment for Global Budget Revenue (GBR) hospitals of 0.4%. The proposed rate also includes an allowance of 0.25% on January 1st that would be available under a competitive process.

Ms. Kinzer noted that the purpose of providing funds in rates is to accelerate the process of investing in and gaining the benefit of care coordination and integration, population health, and alignment initiatives. While hospitals performed well during the initial year of implementation, it is critical to continue an accelerated scaling and implementation of additional resources to achieve the results needed under the All-Payer Model.

Ms. Kinzer noted that the Department of Health and Mental Hygiene (DHMH) has worked closely with the Maryland Hospital Association and Johns Hopkins, University of Maryland, and MedStar health systems to designate three Ebola treatment centers to serve Maryland. At DHMH's request, the health systems identified the Johns Hopkins Hospital, University of Maryland Medical Center, and MedStar Washington Hospital Center as Maryland's Designated Ebola Treatment Centers (DETCS).

The DETCs incurred one-time start-up expenses ranging from $5.3 million to $6.3 million per hospital. These costs reflect building renovations, building system upgrades, personal protective

equipment, training expenses, and management costs. The treatment centers may receive up to $1 million of federal funding for start-up costs. HSCRC staff is making an adjustment to reflect the one-time costs, net of $1 million of potential federal funding for each treatment center. Net of federal funding, the adjustment for the three systems is approximately $4.3 million to 5.3 million per hospital per markup. Staff is increasing FY 2015 GBR and the underlying rates, to be reversed in FY 2016. The MedStar Washington Hospital Center Hospital funding is placed in other MedStar hospitals' GBR, and those hospitals will pay for the start-up expenses at the MedStar Washington Hospital Center.

Ms. Kinzer stated that on May 20, 2015 a Graduate Medical Education summit will be held at Mount Washington Conference Center. DHMH, the Johns Hopkins School of Medicine, and University of Maryland School of Medicine will convene a summit to develop a plan for GME changes that need to be made for the new CMS waiver agreement.

IMPLEMENTATION OF THE MARYLAND ALL-PAYER MODEL CARE COORDINATION, INTEGRATION, AND ALIGNMENT

Ms. Kinzer presented an update on the activities of the Care Coordination work group (See "Implementation of the Maryland All Payer Model Care Coordination, Integration, and Alignment" on the HSCRC website).

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 March will focus on fiscal year (July 1 through June 30) as well as calendar year results.

Mr. Romans reported that for the nine months ended March 31, 2015, All-Payer total gross revenue increased by 1.19% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 1.80%; this translates to a per capita growth of 1.15%. All-Payer gross revenue for non-Maryland residents decreased by 4.82%.

Mr. Romans reported that for the three months of the calendar year ended March 31, 2015, All-Payer total gross revenue decreased by 0.04% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 0.50%; this translates to a per capita growth of (0.06%). All-Payer gross revenue for non-Maryland residents decreased by 5.78%.

Mr. Romans reported that for the nine months ended March 31, 2015, Medicare Fee-For-Service gross revenue increased by 1.87% over the same period in FY 2014. Medicare Fee-For-Service for Maryland residents increased by 2.80%; this translates to a per capita growth of (0.44%). Maryland Fee-For-Service gross revenue for non-residents decreased by 7.92%.

Mr. Romans reported that for the three months of the calendar year ended March 31, 2015, Medicare Fee-For-Service gross revenue increased by 1.72%. Medicare Fee-For-

Service for Maryland residents increased by 2.93%; this translates to a per capita growth of (0.49 %). Maryland Fee-For-Service gross revenue for non-residents decreased by 11.70%.

According to Mr. Romans, for the nine months of the fiscal year ended March 31, 2015, unaudited average operating profit for acute hospitals was 2.93%. The median hospital profit was 3.77%, with a distribution of 1.77% in the 25th percentile and 7.04% in the 75th percentile. Rate Regulated profits were 5.44%.

Dr. Alyson Schuster, Associate Director Data & Research, presented a quality report update on the Maryland Hospital Acquired Conditions program based upon readmission data on discharges through January 2015.

Readmissions

- The All-Payer risk adjusted readmission rate was 13.28 % for the period of January 2014 to January 2015. This is an accumulative decrease of 4.22% from the January 2013 risk adjusted readmission rate.
- The Medicare Fee for Service risk adjusted readmission rate was 14.29% for the period January 2014 to January 2015 YTD. This is an accumulated decrease of 2.38% from the January 2013 risk adjusted readmission rate.

There is no Potentially Preventable Complications update as staff has not received the final data for the 1st quarter of CY 2015.

ITEM IV
DRAFT RECOMMENDATION FOR CONTINUED SUPPORT OF THE MARYLAND PATIENT SAFETY CENTER

Ms. Dianne Feeney, Associate Director Quality Initiative, presented staff's draft recommendations for continued support of the Maryland Patient Safety Center (MPSC) (See "Draft 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 these presentations, staff has evaluated the reasonableness of the budget items presented and made recommendations to the Commission.

Based on information presented to the Commission, the staff provided the following draft 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.

This is a draft recommendation; therefore no Commission action is necessary.

ITEM V
DOCKET STATUS CASES CLOSED

2294A- Johns Hopkins Health System
2295A- Johns Hopkins Health System

ITEM VI
DOCKETT STATUS CASES OPEN

2296A- Johns Hopkins Health System

Johns Hopkins Health System filed an application on April 23, 2015 on behalf of its member hospitals (the "Hospitals") requesting approval to continue to participate in a global rate arrangement for heart failure and solid organ and bone marrow transplant services with Optum Corporation, a division of United HealthCare Services, for one year beginning July 1, 2015.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for heart failure and solid organ and bone marrow transplant services for one year beginning July 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from the discussion and vote.

2297A- University of Maryland Medical Center

University of Maryland Medical Center (the "Hospital") filed an application on April 27, 2015 requesting approval to continue to participate in a global rate arrangement for liver, kidney, lung and blood and bone marrow transplant services with Cigna Health Corporation for one year beginning June 1, 2015.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for liver, kidney, lung and blood and bone marrow transplant services for one year beginning June 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
DRAFT UPDATE FACTORS RECOMMENDATIONS FOR FY 2016

Mr. Romans presented the staff's draft recommendation concerning the update factors for FY 2016 (See "Draft 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 years.

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 fiscal years.

The staff's draft 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 adjustments for readmissions and the uncompensated care and MHIP reductions):

- 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%.

- Require all acute hospitals to submit multi-year plans for improving care coordination, chronic care, and provider alignment by December 1, 2015.
- 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.

Gary Simmons, United Healthcare, raised concerns with the impact of the infrastructure funding on the Medicaid Managed Care Organizations, which received significant rate cuts in the 2015 and 2016 state budgets.

This is a draft recommendation; therefore, no Commission action is necessary.

ITEM VIII
FINAL RECOMMENDATION ON UNCOMPENSATED CARE POLICY FOR FY 2016

Mr. Romans presented staff's final recommendation on the Uncompensated Care Policy for FY 2016 (See "Final Recommendation on Uncompensated Care Policy for 2016" on the HSCRC website).

Since it first began setting rates, the HSCRC has recognized the cost of uncompensated care (charity care and bad debt) within Maryland's unique hospital rate setting system. As a result, patients who cannot pay for care are still able to access hospital services, and hospitals are credited for reasonable level of uncompensated care provided to those patients.

Under the current HSCRC policy, uncompensated care is funded by a statewide pooling system in which regulated Maryland hospitals draw funds from the pool if they experience a greater than average level of uncompensated care, and pay into the pool if they experience a less than average level of uncompensated care . This ensures that the cost of uncompensated care is shared equally across the hospitals in the system.

The HSCRC must determine the total amount of the uncompensated care that will be placed in hospital rates for FY 2016 and the amount of funding that will be available for the uncompensated care pool. Additionally, HSCRC must review the methodology for distributing these funds among hospitals.

Based on staff's analysis, the following final recommendations are made:

- The uncompensated care provision in rates be reduced from 6.14% to 5.25% effective July 1, 2015;
- The combined results of the regression model and two years of historical data underpinning the FY 2015 uncompensated care policy be reused for FY 2016:
  1. No update to the regression results
  2. Combine the regression results with the same two years of actual data (FY 2012 and FY 2013) incorporated into the FY 2015 policy.
  3. Subtract the ACA driven decline in self pay/charity charges from CY 2013 and CY 2014 from the modeled uncompensated care result for each hospital to derive its final percentage for determining its contribution or withdrawal from the uncompensated care pool. Appendix II shows the result of this calculation.
- The Charity Care Adjustment be suspended indefinitely and not be reinstituted in FY 2016 rates;
- Data continued to be collected on write offs to guide future development of uncompensated care regression models and uncompensated care policies;
- Data continued to be collected on outpatient denials, in addition to data already collected on inpatient denials, to understand the continuing trends in denials under the new All-Payer model; and
- A new uncompensated care policy be developed for FY 2017 that reflects the patterns in uncompensated care experience, which are observed in FY 2015 and projected for FY 2016,

The Commission voted unanimously to approve staff's recommendation.

ITEM IX
DRAFT RECOMMENDATION FOR SHARED SAVINGS PROGRAM FOR RATE YEAR 2016

Dr. Alyson Schuster Ph.D., Associate Director Performance Measurement, presented the staff's draft recommendation for the Shared Savings program for Rate Year 2016 (see "Draft 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 draft 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 draft 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 higher proportion of adult Medicaid patients:

    1. Hospitals with an increase in the shared savings penalty of greater than 0.3% and who experienced improvement in readmissions from CY 2013 to 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 75th 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%.

This is a draft recommendation; therefore, no Commission action is necessary.

ITEM X
UPDATE ON MARKET SHIFT ADJUSTMENT

Dr. Sule Gerovich Ph.D., Deputy Director, Research and Methology, presented the staff's update on the Market Shift Adjustment (See "Global Budget Revenue Contacts Market Shift Adjustments Draft Technical Report" on the HSCRC website),

The Market Shift Adjustments (MSAs) mechanism is part of a much broader set of tools that link global budgets to populations and patients under the State's new All-Payer Model. The specific purpose of MSAs is to provide a criteria for increasing or decreasing the approved regulated revenue of Maryland hospitals operating under Global Budget Revenue (GBR) rate arrangements to ensure that revenue is appropriately reallocated when shifts in patient volumes occur between hospitals as result of efforts to achieve the Triple Aim of better care, better health, and lower costs. In fact, MSAs under global budget revenue arrangements are fundamentally different from a volume adjustment. Hospitals under a population based payment system, such as GBR, have a fixed budget for providing services to the population in their service area. Therefore, it is imperative that MSAs reflect shifts in patient volumes independent of general volume increases in the market.

Commissioner Keane suggested that the staff implementation of the market shift be modified to allow for staff adjustments to the market shift adjustment model in the event that a hospital can produce evidence that its decline in utilization was due to an intervention to reduce avoidable utilization rather than a shift to another hospital. Dr. Gerovich and Ms. Kinzer agreed to this modification. Commissioner Keane also encouraged staff to continue to expand the definition of potentially avoidable utilization in the model.

ITEM XI
FINAL RECOMMENDATION FOR ONGOING FUNDING SUPPORT OF CRISP IN FY 2016 FOR HIE OPERATIONS AND REPORTING SERVICE ACTIVITIES

Mr. Steve Ports, Principal Deputy Director Policy and Operations, presented staff's final recommendations for FY 2016 funding to support Health Information Exchange (HIE) Operations and the Chesapeake Regional Information System for our Patients (CRISP) (See "Final Recommendation: Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 16 Funding to Support HIE Operations and CRISP Reporting Services" on the HSCRC website).

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the All-Payer Model and the public interest (Health- General Article, Section 19-219(c)), this recommendation is to provide continued funding support in FY 2016 in the amount of $3,249,000 to CRISP, for the following purposes;

- HIE Operations; and
- Continuing CRISP reporting services to hospitals in the State.

Over the past six years, the Commission has approved funding to support the general operations of the CRISP and HIE through hospital rates.

In December 2013, the Commission approved continued funding support for CRISP during FYs 2015 through FY 2019 not to exceed $2.5 million in any year. At the May 2014 Commission meeting, staff reported that $1.65 million in funding support had been granted to CRISP for core operations in FY 2014.

In June of 2014, the Commission approved additional funding of $850,000 for specific CRISP functions related to the HSCRC's inter-hospital reporting capabilities. At that point, the Commission had approved a total of $2.5 million for HIE operations and CRISP Reporting Services.

In September of 2014, the Commission approved an additional $2 million (for a total of $4.5 million in FY 2015) to support expansion of its current monitoring capacity and engagement of resources to assist in further evaluation and planning of possible statewide infrastructure and approaches for care coordination and provider alignment, in conjunction with stakeholders.

For FY 2016, the staff is separating the funding request for HIE operations and standard CRISP reporting services from those relating to HIE connectivity expansion and ambulatory integration, statewide infrastructure needs, and related expanded reporting services, while further information can be gathered on potential needs and costs, The FY 2016 request for HIE operations and standard CRISP reporting services is $3,249,000, which exceeds the $2.5 million previously established maximum.

HSCRC and MHCC staff recommend that hospital rates be increased in FY 2016 by $3,249,000

to continue to support the ongoing costs of CRISP/ HIE operations and reporting services. The FY 2016 budget for these functions is as follows:

- CRISP HIE Operations- $1,710,000 (consistent with funding in FY 2015);
- CRISP Reporting Services - $1,539,000 (compared to $1,850,000 in FY 2015).

Additionally, HSCRC and MHCC staff will continue to work with CRISP in the development of a budget and timeline for further support of the All-Payer Model consistent with the recommendations of the Care Coordination Work Group. As necessary, it is possible that a recommendation for additional FY 2016 funding through CRISP to support the care coordination needs identified in the Care Coordination Work Group recommendations will be forthcoming.

The Commission voted unanimously to approve staff's recommendation.

ITEM XII
REPORT ON REGIONAL PARTNERSHIP FOR HEALTH SYSTEM TRANSFORMATION AWARDS

Mr. Ports presented staff's report on regional partnership for health system transformation rewards for FY 2015 (See "Report on Review Committee Recommendations for Planning Grants to Create Regional Partnerships for Health System Transformation" on the HSCRC website).

During the 2014 Legislative Session, the General Assembly adopted the Budget Reconciliation and Financing Act of 2014 (BRFA). This legislation provides that the HSCRC may include an additional $15,000,000 in hospital revenue when determining hospital rates that are effective in fiscal year 2015 for the purpose of:

- Assisting hospitals in covering costs associated with the implementation of Maryland's All-Payer Model contract; or
- Funding of statewide or regional proposals that support the implementation of Maryland's All-Payer Model contract.

Statewide or regional proposals for funding are to be submitted to the HSCRC and the Department of Health and Mental Hygiene (DHMH) for approval. The DHMH and HSCRC are required to establish a committee to review regional proposals and make recommendations to the DHMH and HSCRC for funding.

This report reflects the review committee's recommendations to award a total of $2.5 million for regional planning grants of the $15 million in BRFA funds previously approved by the HSCRC.

The review committee has recommended that eight regional grant proposals be funded from fiscal year 2015 BRFA funding. The recommended awardees along with the award amount and lead hospitals (the hospital which rates will be adjusted) are as follows:

Regional Planning Community Health Partnership-

Johns Hopkins Hospital-	$400,000
Baltimore Health System Transformation Partnership-	
University of Maryland Med. Ctr-	400,000
Trivergent Health Alliance-	
Western MD Health System-	133,334
Frederick Regional Health System-	133,333
Meritus Medical Hospital-	133.333
Bay Area Transformation Partnership-	
Ann Arundel Med. Ctr.-	400,000
Nexus Montgomery-	
Holy Cross Hospital	300,000
Howard County Regional Partnership for Health Transformation-	
Howard County General Hospital	200,000
University of MD Upper Chesapeake Health and Hospital of Cecil	
Cecil County Partnership	
University of Maryland Upper Chesapeake	$200,000
Southern Maryland Regional Coalition for Health System Transformation	
Doctors Community Hospital	200,000

The Commission voted unanimously to approve staff's reward recommendation to Trivergent Health Alliance, Bay Area Transformation Partnership, and University of MD Upper Chesapeake Health and Hospital of Cecil County Partnership.

The Commission voted unanimously to approve staff's reward recommendation to Howard County Regional Partnership for Health System Transformation, and Baltimore Health System Transformation Partnership. Chairman Colmers recused himself from the discussion and vote.

The Commission voted unanimously to approve staff's reward recommendation to Regional Planning Community Health Partnership and Baltimore Health System Transformation Partnership. Chairman Colmers and Commissioner Mullen recused themselves from the discussion and vote.

The Commission voted unanimously to approve staff's reward recommendation to Nexus Montgomery. Chairman Colmers and Commissioner Loftus recused themselves from the discussion and vote.

The Commission voted unanimously to approve staff's reward recommendation to Southern MD Regional Coalition for Health System Transformation. Commissioner Bone recused himself from the discussion and vote.

ITEM XIII
DRAFT RECOMMENDATION ON CHANGES TO THE RELATIVE VALUE UNITS SCALE FOR RADIATION THERAPY SERVICES

Mr. Chris Konsowski, Chief- Audit & Compliance, requested approval to distribute proposed revisions to the Relative Value Unit Scale for Radiation Therapy services to all hospitals for their review and comment.

The Commission voted unanimously to approve staff's recommendation.

ITEM XIV
LEGAL REPORT
REGULATIONS

Regulations

Proposed and Emergency

Rate Application and Approval Procedures

The purpose of this action is to impose a moratorium on the Commission's Maryland Health Insurance Plan (MHIP) assessment for Fiscal year 2016 in response to the Budget Reconciliation Act of 2015 changes to the program as of July 1, 2015.
The Commission voted unanimously to forward the proposed regulation to the AELR Committee for review and publication in the Maryland Register both as a proposed and emergency regulation.

ITEM XV
HEARING AND MEETING SCHEDULE

June 10, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
July 8, 2015	Cancelled
August 12, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:54 pm. no further business, the meeting was adjourned at 3:50 pm.