# Closed Session Minutes
# Of the
# Health Services Cost Review Commission

## September 9, 2015

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

1. Update on Contract and Modeling of the All-Payer Model vis-à-vis the All-Payer Model Contract;

The Closed Session was called to order at 12:07 p.m. and held under authority of - §§ 3-104 of the General Provisions Article.

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

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

Also attending were Deborah Garcey of Health Management Associates, consultant to the HSCRC, and 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.

**Item Two**

Ms. Kinzer presented and the Commission discussed an overview of the Maryland All-Payer Model alignment and integration, as well as planning for Phase II of the model agreement.

The Closed Session was adjourned at 12:59 p.m.

# Closed Session Minutes
# Of the
# Health Services Cost Review Commission

## October 1, 2015

Upon motion made by Commissioner Mullen and seconded by Commissioner Wong, Chairman Colmers called the closed session to order, prior notice of which was given, to discuss the following item:

1. Planning for Phase II of the All-Payer Model agreement;

The Closed Session was called to order at 11:34 a.m. and held under authority of - §§ 3-103 and 3-104 of the General Provisions Article.

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

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

Also attending was Stan Lustman, Commission Counsel.

### Item One

Ms. Kinzer lead a discussion with the Commissioners and staff on the development of a total cost of care vision for Phase II of the All-Payer Model by the end of the year, as requested by the Center for Medicare and Medicaid Innovation.

The Closed Session was adjourned at 12:38 p.m.

# MINUTES OF THE
# 522nd MEETING OF THE
# HEALTH SERVICES COST REVIEW COMMISSION

## September 9, 2015

Chairman John Colmers called the public meeting to order at 12:07 pm. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., MPH, Jack C. Keane, Bernadette C. Loftus, M.D., Thomas Mullen, and Herbert S. Wong, Ph.D. were also in attendance. Upon motion made by Commissioner Jencks and seconded by Commissioner Bone, the meeting was moved to Executive Session. Chairman Colmers reconvened the public meeting at 1:05 pm.

## REPORT OF THE SEPTEMBER 9, 2015 EXECUTIVE SESSION

Mr. Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the September 9, 2015 Executive Session.

## ITEM I
## REVIEW OF THE MINUTES FROM AUGUST 12, 2015 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the August 12, 2015 Executive Session and Public Meeting.

## ITEM II
## EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, reported that Staff has released the Request for Proposal (RFP) for Competitive Implementation Plans that the Commission approved for FY2016. The Plans will result in the addition of .25% of approved revenue to rates based on a review of applications to be submitted. The competitive transformation implementation awards are intended to support investments and activities related to partnerships, strategies, vision for care coordination, and provider alignment in the State. Competitive transformation implementation awards will be available to any Maryland acute care or specialty hospital that submits a successful bid.

Ms. Kinzer stated that Staff also released to hospitals and stakeholders the reporting requirements for the Strategic Hospital Transformation Plans that are due on December 7, 2015. These plans will describe each hospital's short-term and long-term strategy to support the goals of the All-Payer Model, particularly as they relate to care coordination, care transitions, and alignment.

Ms. Kinzer expressed her thanks to Steve Ports for his tremendous efforts in working with the transformation support process and bringing the RFP to completion.

Ms. Kinzer noted that Staff, CRISP, the St. Paul Group, and Social & Scientific Systems (SSS), HSCRC's Medicare data vendor, have been working together to develop and execute strategies to make analytic information more available for care coordination and monitoring.

- CRISP has been working on patient level reporting, including the production of analytic data with flags of Potentially Avoidable Utilization (PAU). These data should be available in a trial format to providers in October.
- St. Paul will develop preliminary and final quarterly reports of market shift. These reports will be provided to all hospitals. Staff will release a timeline for the process in the near term.
- Staff has been working on utilization trend analysis that combines data from hospitals' case mix data, and includes analytic information added to the case mix data by CRISP, The St. Paul Group, and Staff. Staff will be presenting some of these data to the Commission today.
- Staff and SSS has been working on reconciling the Medicare claims and enrollment data used to support the Medicare savings calculation requirement under the All-Payer Model. Ms. Kinzer noted that the reconciliation process is complete. Staff expect that the Centers for Medicare and Medicaid Innovation (CMMI) will be able to release the results in the near term.

Ms. Kinzer thanked the Staff as well as stakeholders who were involved in advancing analytics efforts to support implementation of the Model. Ms. Kinzer especially thanked Sule Gerovich and David Romans for their efforts in moving this process forward. It is now Staff's intention to focus analytic efforts on the Total Cost of Care, Cost and Utilization Per Capita, episode costs, advancing outcomes, performance and efficiency measures, and improving current models.

Ms. Kinzer noted that Staff is preparing to work with stakeholders on evaluation and development of performance measures. These will include HSCRC's quality programs, risk adjustment approaches for attainment measures for readmissions and other PAUs, and appropriate efficiency and productivity measures for the new All-Payer Model.

HSCRC has awarded a multi-year contract for professional services support for these efforts. The organization process for this work has begun, and Staff is in the process of fleshing out a work plan for this effort.

Ms. Kinzer stated that ICD-10 implementation is due to take place beginning October 1, 2015. Hospitals and payers have been busily preparing for implementation. Staff has interacted with the Maryland Hospital Association (MHA) work groups and has discussed implementation readiness with the Maryland Insurance Administration (MIA). While hospitals and payers have made strides in readiness, there is a concern that physicians are not uniformly well prepared for implementation. Staff will stay in close contact with MHA and MIA during implementation. If Staff becomes aware of situations where claims are not being processed, Staff will take appropriate steps in conjunction with the MIA.

Ms. Kinzer noted that Staff and CRISP have included addenda to their Memorandum of Understanding that detailed the initial 90-day planning process for state level Integrated Care Network (ICN) infrastructure and support. Staff will continue to work with CRISP to help in the development of the products of deliverables, timelines, benchmarks, and dashboards for continued transparency and accountability related to the ICN infrastructure and support, initially budgeted at $6.2 million.

Ms. Kinzer noted that Staff is currently focused on the following activities:

- Completing the rate orders for rate year 2016. Many rate orders have been issued. All hospitals have received files with draft revenue and rate calculations. Several rate orders have not been issued because staff is still waiting on some adjustments that require data from the hospitals.
- Reviewing radiation therapy, infusion and chemotherapy market shift adjustments with stakeholders.
- Continuing the focus on waivers, alignment models, and state level, regional and hospital transformation planning and implementation.
- Reviewing Certificate of Need (CON) and rate applications that have been filed.
- Moving forward on updates to value-based performance measures, including efficiency measures.
- Turning the focus on per capita costs and total cost of care, for purposes of monitoring, and also to progress toward a focus on outcomes and cost across the health care system.
- Staff will release an RFP for support of the Phase 2 development and application process with CMMI, which will focus on transitioning the All-Payer Model to a greater focus on the total cost of care.

## INTERIM REPORTS SUMMARY REGIONAL PARTNERSHIPS FOR TRANSFORMATION

Ms. Nancy Kamp and Ms. Deborah Gracey of Health Management Associates summarized the interim report of the regional transformation planning grants (See "Interim Reports Summary Regional Partnerships for Transformation"- on the HSCRC website).

Ms. Kamp and Ms. Gracey discussed the planning process, organization involvement, data, and considerations identified during the regional transformation planning process.

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

Mr. Romans reported that for the one month period ended July 31, 2015, All-Payer total gross revenue increased by 3.40% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 3.71%; this translates to a per capita growth of 3.13%. All-Payer gross revenue for non-Maryland residents increased by 0.31%.

Mr. Romans reported that for the seven months of the calendar year ended July 31, 2015, All-Payer total gross revenue increased by 2.44% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 2.85%; this translates to a per capita growth of 2.28%. All-Payer gross revenue for non-Maryland residents decreased by 1.70%.

According to Mr. Romans, for the one month of the fiscal year ended July 31, 2015, unaudited average operating profit for acute hospitals was 4.44%. The median hospital profit was 4.94%, with a distribution of 1.39% in the 25th percentile and 7.35% in the 75th percentile. Rate Regulated profits were 8.21%.

According to Mr. Romans, there are no Medicare Fee for Service data for July 2015 as several hospitals had difficulty with reporting the information and will resubmit the information.

## MONITORING MARYLAND PERFORMANCE PRELIMINARY UTILIZATION ANALYTICS FY 2013 –FY2015

Dr. Sule Gerovich Ph.D, Deputy Director Research and Methodology, presented the Staff's preliminary report concerning monitoring Maryland performance in regards to utilization analytics (see "Monitoring Maryland Performance Preliminary Utilization Analytics" on the HSCRC website).

Dr. Gerovich reported preliminary utilization analytics for fiscal year 2013 through fiscal year 2015. All-payer equivalent case mix adjusted discharges (ECMADs), a combined inpatient and outpatient utilization measure, declined 0.99 percent from FY 2013 to FY2014 and increased by 0.46 percent from FY2014 to FY2015. Medicare ECMADs remained unchanged from FY 2013 to FY 2014 and increased by 1.73 percent from FY 2014 to FY2015. The reported changes in utilization were not measured on a per capita or per beneficiary basis.

## ITEM IV
## OVERVIEW OF THE HEALTH EMPLOYMENT PROGRAM PROPOSAL

Mr. Ron Peterson, President of the Johns Hopkins Hospital and Health System and Executive Vice President of Johns Hopkins Medicine, presented the draft proposal of the Health Employment Program (see "Health Jobs Opportunity Program" on the HSCRC website).

According to Mr. Peterson, the All-Payer Model brings unprecedented employment challenges to Maryland hospitals. Maryland hospitals have committed to improving the overall health of the patients they serve beyond the four walls of the hospital. A shift in focus from care delivered within the hospital setting to community based care requires a broader hospital employment base such as community health workers, health care enrollment specialists, and peer support

specialists. Currently, this employment base needs to be fostered and expanded, and there are few resources available to support the long-term development of this workforce.

Recent civil unrest and rioting demonstrated the urgent need to address the issues of social inequality in Baltimore City. According to Mr. Peterson, a contributing factor to social inequality in the city is the lack of stable entry level employment with opportunities for career advancement.

In addition, Baltimore City also faces extreme poverty levels. The most recent U.S. Census Bureau data indicate that that as of 2013, 23.8% of Baltimore City residents live at or below the poverty level, compared to the statewide amount of 9.8%. The median household income for Baltimore City is $41,385 compared to $73,538 statewide. Some zip codes within Baltimore City have a median income as low as $25,500. Nearly 40% of Baltimore City residents are Medicaid eligible, with enrollment topping 242,000.

Mr. Peterson requested on behalf of the panel that the HSCRC establish a Health Employment Program effective January 1, 2016 to provide up to $40 million per year for the purpose of funding a program that will allow for the expansion of up to 1,000 hospital employed positions to be hired from low income, high unemployment areas for the purpose of:

- Improving the overall socioeconomic determinants of health community by providing entry level stable employment with advancement opportunities and
- Expanding the community health workforce to assist hospitals in improving population health.

All hospitals will be eligible to submit application proposals. Hospital specific applications must:

- Demonstrate that additional positions are needed and are incremental;
- Detail a plan to recruit employees from designated high poverty and unemployment zip codes;
- Include proposed competitive wages, benefits, and education and enrichment opportunities;
- Describe existing or planned programs for employees to improve work skills;
- Describe the role new positions will play in meeting goals of the waiver;
- Detail job readiness and skills training necessary to prepare individuals for successful employment;
- Detail employee retention strategies; and
- Other requirements to be developed by HSCRC staff.

The proposal envisions that the funding will be capped at .25% of approved revenue. HSCRC will keep track of amounts funded to assure that no more than $40 million is funded. Awarded funds will be collected by hospitals through permanent rate increases.

## ITEM V
## DOCKET STATUS CASES CLOSED

2298A- MedStar Heath
2299A- MedStar Health
2301R- Holy Cross Hospital
2302A- University of Maryland Medical Center
2305A- University of Maryland Medical Center

## ITEM VI
## DOCKET STATUS- OPEN CASES

### 2306A- University of Maryland Medical Center

The University of Maryland Medical Center (the "Hospital) filed an application on August 28, 2015 requesting approval to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with Aetna Health, Inc. for one year beginning October 1, 2015.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for one year beginning October 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
## SUMMARY OF THE CERTIFICATE OF NEED RELATED CAPITAL ADJUSTMENT PROCESS

Mr. Jerry Schmith, Deputy Director of Hospital Rate Setting, reviewed the HSCRC's current partial rate application process for major capital projects (see "Partial Rate Application for Capital" on the HSCRC website).

Mr. Schmith stated that eligible projects require a Certificate of Need (CON) filing and the project cost must be at least 50 percent of a hospital's approved revenue. Mr. Schmith reviewed the HSCRC's Reasonableness of Charges (ROC) and Interhospital Cost Comparison (ICC) methodologies, historically used to measure hospital efficiency. Under the current process, hospitals are eligible to receive a portion of incremental depreciation and interest expenses associated with major projects, subject to this efficiency measure.

Because this methodology was developed prior to implementing the new All-payer Model, Mr. Schmith noted that several issues will need to be addressed in the future. These include: amounts

provided for volume growth, other avenues for project financing, and efficiency of prices in the context of quality, per capita, and potentially avoidable utilization measures.

## ITEM VIII
## DRAFT RECOMMENDATIONS ON REVISIONS TO THE QUALITY BASED REIMBURSEMENT PROGRAM FOR RATE YEAR 2018

Ms. Dianne Feeney, Associate Director Quality Initiative, presented Staff's draft recommendation on updating the Quality Based Reimbursement (QBR) Program for FY2018 (See "Draft Recommendation for Updating the Quality Based Reimbursement Program for FY 2018" on the HSCRC website).

HSCRC quality based measurement initiatives, including the scaling methodologies and magnitudes of revenue "at risk" for those programs, are important tools for providing strong incentives for hospitals to improve their quality performance over time. HSCRC implemented the first hospital adjustments for the QBR Program performance in July 2009. Current Commission policy calls for measurement of hospital performance scores across clinical processes of care, outcome and patient experience of care domains, and scaling of hospital performance results in allocating rewards and penalties based on performance.

"Scaling" for QBR refers to the differential allocation of a pre-determined portion of base regulated hospital inpatient revenue based on assessment of the quality of hospital performance. The rewards (positive scale amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year; these scaled amounts are applied on a "one-time" basis and are not considered permanent revenue.

For FY 2018, HSCRC staff draft recommendations include adjusting the weights and updating the measurement domains to be consistent as possible with the Centers for Medicare and Medicaid Services (CMS) Value Based Purchasing Program. They also include holding steady the amount of total hospital revenue at risk for scaling for the QBR Program

The proposed draft recommendations for the QBR Program are as follows:

- Continue to allocate 2 percent of hospital approved inpatient revenue for QBR performance in FY 2018 to be finalized by the Aggregate Revenue "at risk" recommendation.
- Adjust measurement domain weights to include: 50 percent for Patient Experience Care Transition, 35 percent for Safety, and 15 percent for Clinical Care.

No Commission action is necessary as this is a draft recommendation.

## ITEM IX
## MARKET SHIFT UPDATE

Dr. Gerovich presented an update to the Commission concerning the Market Shift adjustment (see "Market Sift Adjustment Update" on the HSCRC website).

## ITEM X
## REPORT OF THE CONSUMER ENGAGEMENT GROUP

Ms. Leni Preston, Maryland Women's Coalition for Health Care Reform and Ms. Hillery Tsumba, Primary Care Coalition of Montgomery County, presented a final update to the Commission on the activities of the HSCRC Consumer Engagement Taskforce (CETF) (See "Consumer Engagement Taskforce: Final Report" on the HSCRC website).

Ms. Tsumba outlined the goals of the CETF. They are as follows:

- Establish a consumer centered health care delivery system with an ongoing role for consumers to participate in the design and implementation of policies and procedures at all levels.
- Engage, educate, and activate people who use or who are potential users of health services for their own health care to promote efficient and effective use of the health care system.

Ms. Tsumba also reviewed the communications strategy of the CETF and the development of materials for implementation from a consumer centered approach.

CETF Recommendations are as follows:

- Allow for meaningful, ongoing role for consumers at the HSCRC through continued representation of Commissioner(s) with primary consumer interest, and through a new created standing advisory committee with diverse representation.
- In collaboration with key stakeholders, develop a statewide public education campaign specific to the new All-Payer Model which is part of a broader campaign to promote health and wellness.
- Convene an interagency task force, with consumer representation to oversee the public education campaign including the development of related consumer-oriented information.
- Provide options and opportunities that support regular, longitudinal, and effective consumer engagement in the development of policies, procedures, and programs by hospitals, health care providers, health care payers, and government.
- In coordination with the Standing Advisory Committee, the MHCC and other key stakeholders, consider development of a Consumer Gold Star system for hospitals based upon consumer engagement standards.
- Define Community Benefit dollars to include consumer engagement initiatives and promote these dollars for this use, particularly for those supporting vulnerable

populations.
- Continue to encourage and incentivize independent and collaborative approaches to support people who are at risk of becoming high utilizers.
- Encourage hospitals to provide current, consistent, and transparent information on average procedure costs using the data made readily available by the Maryland Health Care Commission (www.marylandqmdc.org), and to make new pricing transparency tools available on new All-Payer Model and/or other appropriate website(s).
- Include discussions about patient and family decision making and preferences about advanced directives in the context of consumer engagement and education.

## ITEM XI
## REPORT OF THE CONSUMER OUTREACH TASK FORCE

Mr. Vincent DeMarco, Chairman Consumer Outreach and Education Task Force, presented a final update on the Consumer Outreach and Education Task Force (See "Update from Consumer Outreach and Education Task Force" on the HCRC website).

As the leader of the HSCRC Consumer Outreach Task Force (COTF), over the past seven months, the Maryland Citizens' Health Initiative Education Fund, Inc. has collaborated with the Local Health Improvement Coalitions, health departments, hospitals, local community, faith leadership and the Maryland Hospital Association to hold eleven public forums all across the State on the subject of health system transformation.

Over 800 Marylanders representing over 300 community, health, faith, business, government, union, and policy organizations have heard the message that local hospitals, healthcare providers, and community based organizations are working together to help Marylanders be as healthy as possible. Feedback shows that Marylanders are unaware of the state's unique and long standing status as an all-payer state or the new state/federal agreement that is further transforming the health system in Maryland. Once informed, however, consumers are eager to be engaged. They want a clear call to action and follow up steps for ongoing collaboration.

COTF recommendations to the Commission for continued outreach to consumers are as follows:

- Periodically convene stakeholders and consumers to provide updates on the progress of health system transformation.
- Continue to give consumers a voice in the transformation of Maryland's health system.
- Encourage local leaders to develop and join a dynamic Faith Community Health Network
- Collaborate to educate primary care providers on and engage them in health system transformation.
- Maximize communications with consumers via traditional and new media.

## ITEM XII
## SUMMARY OF FY 2014 COMMUNITY BENEFITS REPORT

Steve Ports, Principal Deputy Director-Policy and Operations, provided background and

summarized the FY 2014 Maryland Hospital Community Benefits Report (CBR) (see "Maryland Hospital Community Benefits Report FY 2014" on the HSCRC's website).

Each year, the HSCRC collects community benefit information from individual hospitals to compile into a publicly available statewide (CBR). Current year and previous CBRs submitted by hospitals are available on the HSCRC website.

According to Mr. Ports, the FY CBR indicated that hospitals: 1) reported a total of $1.5 billion in community benefits for FY 2014 (FY 2013 amount was also approximately $1.5 billion); 2) provided an average of 10.47% of total operating expenses in community benefits (compared to 11.12% in FY 2012); 3) provided net charity care of $19.9 million; and 4) provided net community care of $724.7 million or 5.14% of hospitals' net operating expenses (up from $712.4 million and 5.2% of hospitals' net operating expenses in FY 2013).

## ITEM XIII
## HEARING AND MEETING SCHEDULE

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| October 14, 2015 | Times to be determined, 4160 Patterson Avenue<br>HSCRC Conference Room |
| November 18, 2015 | Times to be determined, 4160 Patterson Avenue<br>HSCRC Conference Room |

There being no further business, the meeting was adjourned at 4:11 pm.