Closed Session Minutes
of the
Health Services Cost Review Commission

August 12, 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;
2. Consultation with Legal Counsel on Contested Case Implications;

The Closed Session was called to order at 12:09 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 Bone, Jencks, Keane, and Mullen.

In attendance representing Staff were Donna Kinzer, David Romans, Steve Ports, and Dennis Phelps.

Also attending was 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

Stan Lustman, Commission Counsel, outlined and reviewed and the Commission discussed the legal process associated with Contested Cases. Authority: General Provisions Article, § 3-305(b) (7).

Item Three

Donna Kinzer, Executive Director, advised the Commission on the need for strategic planning moving forward with the Model. Authority: General Provisions Article, § 3-104.

The Closed Session was adjourned at 1:08 p.m.

MINUTES OF THE
521th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

August 12, 2015

Chairman John Colmers called the public meeting to order at 12:09 pm. Commissioners George H. Bone, M.D, Stephen F. Jencks, M.D., MPH, Jack C. Keane, and Thomas Mullen were also in attendance. Herbert S. Wong, Ph.D., joined the meeting via telephone. Upon motion made by Commissioner Jencks and seconded by Commissioner Mullen, the meeting was moved to Executive Session. Chairman reconvened the public meeting at 1:15 pm.

REPORT OF THE AUGUST 12, 2015 EXECUTIVE SESSION

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the August 12, 2015 Executive Session.

ITEM I
REVIEW OF THE MINUTES FROM JUNE 10, 2015 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the June 10, 2015 Executive Session and Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, stated that the Centers for Medicare and Medicaid Services (CMS) issued its hospital inpatient prospective payment system (IPPS) final rule for fiscal year 2016 beginning October 1, 2015. The final rule will increase rates by 0.9% after accounting for inflation and other adjustments required by law. This increase is approximately .2% lower than the staff preliminary estimate noted in its June recommendation. After accounting for a Disproportionate Share reduction of 1.0%, the inpatient update would be expected to be less than a 0.1% increase. Ms. Kinzer noted that staff estimated an outpatient hospital increase for Medicare of approximately 1.9%. Under the proposed rule for CY 2016 for the hospital outpatient prospective payment system (OPPS), there would be a net decrease in OPPS payments of 0.2%. The net decrease largely results from a proposed 2.0 percentage point cut intended to account for CMS overestimation of the amount of packaged laboratory payments under OPPS, which caused an overpayment for hospital outpatient payments in 2014.

Ms. Kinzer noted that the Office of the Actuary has released updates to the estimates of hospital revenue increases per beneficiary in connection with the update of the Trustees Annual Report. Staff used the estimates from the President's Budget estimates.

Ms. Kinzer noted that while the rate increases for Medicare are lower than initial estimates used by staff, the per beneficiary figures are in line with staff estimates.

Ms. Kinzer discussed two changes emerging from CMS relative to provider payment direction, which will affect us in Maryland as we move forward in working with partners outside as well as inside the hospital.

The first change was that in April 2015, the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) was signed into law. This law permanently eliminated the use of the Sustainable Growth Rate formula, a mechanism originally created to control spending on Medicare physician services. MACRA revised Medicare physician payments using a new quality driven payment system to move from volume based payments to value based payments. Physicians will be able to receive additional payment updates for participating in alternative payment models. HSCRC and other stakeholders will explore how Maryland's transformation strategies affect Medicare physician payments in order to align hospital and physician incentives.

The second change was that on July 14, 2015, CMS released a proposed payment rule for the Medicare Comprehensive Care for Joint Replacement (CCJR) model. This is a bundled payment model for major lower extremity joint replacements (LEJR). In this 5 year demonstration program, hospitals would be responsible for the LEJR episodes of care of Medicare fee for service beneficiaries, with the episode covering hospitalization through recovery, defined as 90 days post discharge. Hospitals in 75 Metropolitan Statistical Areas (MSAs) would be required to participate in the model. If the model program is adopted as final, it would be effective for discharges on or after January 1, 2016 unless otherwise noted.

Staff will work with stakeholders to craft comments on the proposed payment rule and request data to evaluate opportunities for Maryland patients. Staff will also requests to have access to the same tools offered in the demonstration program, while considering how this proposed rule fits into a broader picture for improving health in the State.

Ms. Kinzer noted that in the last several months, staff has worked diligently with stakeholders to develop a transformation plan built on four pillars of activities for clinical improvement: statewide infrastructure, alignment, care coordination and integration, and consumer engagement. To build further momentum with the Model, the HSCRC will work with stakeholders to move forward with key alignment issues.

In order to implement the Model fully, Maryland will need some waivers relative to such things as fraud and abuse that are typically granted to ACOs across the country. The Center of Medicare and Medicaid Innovation (CMMI) has agreed to work with us in determining how to put these waivers in place with our current Al-Payer Model. Staff is providing CMMI with additional information to support waivers in four areas that focus on being able to develop and implement: Pay for Performance programs, gainsharing programs, care coordination activities among physicians, hospitals, and nursing homes, and to provide for access to Medicare abuse and care coordination data similar to the data available to ACOs.

Ms. Kinzer next reported on the status of the planning and implementation of care coordination and alignment activities. Ms. Kinzer noted that at the May 2015 Commission meeting staff reported on the availability of Budget Reconciliation and Financing Act (BRFA) funds to support the success of the All-Payer Model. Of these funds $11.5 million will be provided to the Chesapeake Regional Information System for our Patients (CRISP) to fund expanded IT and analytic infrastructure as well as consulting support for implementation of care coordination and alignment activities. In addition, staff reported that budgets of $495,000, $1.08 million, and $0.9 million for state-level infrastructure planning, the regional transformation process, and the development of alignment strategies were reviewed and approved by staffs of DHMH, HSCRC, and MHCC. A third budget of $6.2 million, supporting the development of a statewide integrated care and care coordination infrastructure, has been approved by the Executive Committee of CRISP.

Ms. Kinzer noted that Staff and consultants are focused on transformation support activities relative to regional planning grants and infrastructure planning and implementation activities. These include: Learning Collaboratives, Webinars, Shared site for resources and Individual Consultation.

Ms. Kinzer stated that Staff has finalized the calculations for the market shift adjustments for all inpatient and outpatient services, except for radiation therapy, infusion and chemotherapy for inclusion in the rate year 2016 global budget. The revenue shifted under this calculation is approximately $28 million. Staff is in the process of reviewing a preliminary calculation completed for cancer services. Staff hopes to finalize a market shift calculation for these services by September. The market shift calculation, exclusive of oncology services, is being incorporated into FY 2016 rate orders. Dr. Sule Gerovich will report to the Commission on the final details at the September Commission meeting.

Ms. Kinzer reported that the Board of Dimensions' Healthcare System announced that it agreed to an innovative approach to enhance the health of the population served by Laurel Regional Hospital. The System will be reducing the scope and complexity of inpatient services, while simultaneously constructing a comprehensive ambulatory medical facility dedicated to preventative care that reduces avoidable healthcare. The new facility will cost approximately $24 million, which will include emergency services, outpatient surgery and comprehensive diagnostic imaging. The new hospital will be built on the existing hospital campus by 2018.

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

- Completing the rate orders for rate year 2016
- Continuing the focus on waivers, alignment models, and state level, regional and hospital transformation planning and implementation.
- Reviewing Certificate of Need (CON) and rate application that have been filed.
- Beginning work on updates to value-based performance measures, including efficiency measures.
- Staff will released 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.

ITEM III
CHESAPEAKE REGIONAL HEALTH SYSTEM FOR OUR PATIENTS (CRISP) REPORT ON INTEGRATED CARE NETWORK INFRASTRUCTURE

Dr. Mark Kelemen, Senior Vice President and Chief Medical Information Officer at the University of Maryland Medical School, and Mr. David Horrocks, CRISP President and CEO updated the Commission on the CRISP work plan (See "ICN Infrastructure Tools and Services Update on Progress" on the HSCRC website).

Mr. Horrocks characterized the work plan to develop the integrated care network infrastructure as expanding the scope and capabilities of current operations and extending the access to services to additional providers.

To oversee the development and implementation of the work plan, CRISP established a steering committee, chaired by Dr. Kelemen, and including hospital organization representatives with responsibilities in clinical integration/population health management and information technology from Johns Hopkins HealthCare LLC, Anne Arundel Health System, Advanced Health Collaborative, MedStar Health System and the Maryland Hospital Association. Other members of the steering committee include representatives from the Prince George's County Department of Health, Columbia Medical Practice, Erickson Living, the Advisory Board Company, and the Maryland Health Care Commission. The steering committee has organized the work plan into seven project activities;

- Ambulatory Connectivity- The project aims to achieve bi-directional connectivity with ambulatory practices, long-term care, and other health providers.
- Data Router- enables sending relevant patient level data to the health care organizations by normalizing health records, determine whether a patent/provider relationship exists, and verifying patient consent.
- Clinical Portal Enhancements- Enhancing existing clinical portal with new elements, including care profile, a link to a provider directory, and information on other known patient/provider relationships and patient risk scores.
- Notification and Alerting- New tools integrated within existing work flows to alert providers to relevant care events
- Reporting and Analytics- Expands existing reporting capabilities to support many more case managers and ambulatory practices.
- Basic Care Management Software- Current scope is planning only, as advisors help determine an appropriate path.
- Practice Transformation- Current scope is planning only, as advisors help determine an appropriate path.

Mr. Horrocks and Dr. Kelemen also shared timelines and goals with the Commission and will periodically update the Commission on work plan progress

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

Mr. Romans reported that for the twelve months ended June 30, 2015, All-Payer total gross revenue increased by 2.00% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 2.51%; this translates to a per capita growth of 1.85%. All-Payer gross revenue for non-Maryland residents decreased by 2.96%.

Mr. Romans reported that for the six months of the calendar year ended June 30, 2015, All-Payer total gross revenue increased by 2.19% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 2.63%; this translates to a per capita growth of 2.06%. All-Payer gross revenue for non-Maryland residents decreased by 2.28%.

Mr. Romans reported that for the twelve months ended June 30, 2015, Medicare Fee-For-Service gross revenue increased by 2.92% over the same period in FY 2014. Medicare Fee-For-Service for Maryland residents increased by 3.70%; this translates to a per capita growth of 0.44%. Maryland Fee-For-Service gross revenue for non-residents decreased by 5.39%.

Mr. Romans reported that for the six months of the calendar year ended June 30, 2015, Medicare Fee-For-Service gross revenue increased by 3.83%. Medicare Fee-For-Service for Maryland residents increased by 4.61%; this translates to a per capita growth of 1.25 %. Maryland Fee-For-Service gross revenue for non-residents decreased by 4.75%.

According to Mr. Romans, for the twelve months of the fiscal year ended June 30, 2015, unaudited average operating profit for acute hospitals was 3.19%. The median hospital profit was 4.36%, with a distribution of 1.89% in the 25th percentile and 6.89% in the 75th percentile. Rate Regulated profits were 5.86%.

Dr. Alyson Schuster, Associate Director Performance Measurement, presented a quality report update on the Maryland Hospital Acquired Conditions program based upon Potentially Preventable Complications (PPCs) data and discharges through March 2015 and readmission data on discharges through May 2015.

Readmissions

- The All-Payer risk adjusted readmission rate was 12.89 % for the period of January 2014 to May 2015. This is a cumulative decrease of 6.46% from the January 2013 risk adjusted readmission rate.

- The Medicare Fee for Service risk adjusted readmission rate was 13.73% for the period January 2014 to May 2015 YTD. This is an accumulated decrease of 5.60% 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 14 out of 46 hospitals have reduced their risk adjusted rate by more than 9.3%.

Potentially Preventable Complications

- The All-Payer risk adjusted PPC rate was 0.85 for March 2015 YTD. This is a decrease of 14.42% from the March 2014 YTD risk adjusted PPC rate.
- The Medicare Fee for Service risk adjusted PPC rate was 0.99 for March 2015 YTD. This is a decrease of 11.96% from the August 2014 YTD risk adjusted PPC rate.

ITEM V
DOCKET STATUS CASES CLOSED

NONE

ITEM VI
DOCKET STATUS- OPEN CASES

2298A- MedStar Health

MedStar Health filed an application on June 2, 2015 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") requesting approval to continue to participate in a global rate arrangement for orthopedic services with MAMSI for one year beginning September 1, 2015.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for orthopedic services for one year beginning September 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.

2299A- MedStar Health

MedStar Health filed an application on June 2, 2015 on behalf of Union Memorial Hospital (the "Hospital") requesting approval to continue to participate in a global rate arrangement for cardiovascular services with Kaiser Foundation Health Plan of the Mid-Atlantic Inc. for one year beginning August 1, 2015.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for cardiovascular services for one year beginning August 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.

2302A- University of Maryland Medical Center

The University of Maryland Medical Center (the "Hospital) filed an application on June 18, 2015 requesting approval to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with Maryland Physicians Care for one year beginning August 23, 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 services for one year beginning August 23, 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.

2305A- University of Maryland Medical Center

The University of Maryland Medical Center (the "Hospital) filed an application on July 30, 2015 requesting approval to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with Interlink Health Services for one year beginning November 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 services for one year beginning November 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.

2301R- Holy Cross Hospital

On June 12, 2015 Holy Cross (the "Hospital") submitted a partial rate application to the Commission requesting that the Hospital's Medical Surgical Intensive Care (MIS) and Coronary Care (CCU) approved rates be combined effective July 1, 2015 utilizing FY 2016 approved volumes and revenues.

After reviewing the Hospital application, Staff recommended the following:

- That the Hospital be allowed to collapse its CCU rate into its MIS rate effective July 1,

2015;

- That FY 2016 approved volume and revenue will be utilized to calculate the combined rate; and
- That no change be made to the Hospital's Global Budget Revenue.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
REPORT OF THE COMSUMER ENGAGEMENT TASK FORCE

Ms. Hillery Tsumba, Primary Care Coalition of Montgomery County, presented an update to the Commission on the activities of the HSCRC Consumer Engagement Taskforce (CETF) (See "HSCRC Consumer Engagement Taskforce Preliminary Report- Promoting Patient – Centered Approaches in the New All Payer Model" 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 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.

The next steps of the CETF are to:

- Identify and Address Gaps in Information or Learnings
- Finalize Communication Strategy
- Finalize and Submit Report to Commission

CETF will finalize and submit the report to the Commission at the September public meeting

ITEM VIII
MARYLAND HEALTH CARE COMMISSION ON STATUS OF CERTIFICATE OF NEED APPLICATIONS

Mr. Paul Parker, Director Center for Health Care Facilities Planning and Development for the Maryland Health Care Commission (MHCC) presented an update on pending hospital projects before the MHCC (See " Proposed Hospital Capital Projects: 2012 -2015" on the HSCRC website).

ITEM IX
LEGAL REPORT

Regulations

Final Action

Notification of Certain Financial Transactions – COMAR 10.37.01.08

The purpose of this action is to conform to the requirements set forth in Ch. 263, Acts of 2014, effective July 1, 2014, that require hospitals to notify the Commission, in writing, within 30 days before executing any financial transaction, contract, or other agreement that would result in more than 50 percent of all corporate voting rights or governance reserve powers being transferred to or assumed by another person or entity. This proposed regulatory change appeared in the May 1, 2015 issue of the Maryland Register (42:9 Md. R. 651)

The Commission voted unanimously to approve the final adoption of the proposed regulation.

Proposed Action

Update to Accounting and Budget Manual – COMAR 10.37.01.02

The purpose of this action is to update the Commission's Accounting and Budget Manual with Supplement 23, which has been incorporated by reference.

The Commission voted unanimously to forward the proposed regulation to the AELR Committee for review and publication in the Maryland Register.

Rate Application and Approval Procedures- COMAR 10.37.10.07-1

The purpose of this action is to conform to legislation passed in the 2015 General Assembly, which establishes that outpatient services associated with the federal 340B Program and that meet certain criteria shall be considered provided "at the hospital" and, therefore. subject to HSCRC rate jurisdiction.

The Commission voted unanimously to forward the proposed regulation to the AELR Committee for review and publication in the Maryland Register.

Rate Application and Approved Procedures- COMAR 10.37.10

The purpose of this action is to assure that rate applications are submitted in easily readable formats.

The Commission voted unanimously to forward the proposed regulation to the AELR Committee for review and publication in the Maryland Register.

ITEM X
HEARING AND MEETING SCHEDULE

September 9, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
October 14, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:35 pm.