State of Maryland
Department of Health and Mental Hygiene

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533rd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
September 14, 2016

EXECUTIVE SESSION
12:00 p.m.
(The Commission will begin in public session at 12:00 p.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 2PM.)

1. **Update on Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-103 and §3-104**

2. **Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104**

PUBLIC SESSION
2:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on August 10, 2016**
2. **Executive Director's Report**
3. **New Model Monitoring**
4. **Docket Status – Cases Closed**

   2346A – Johns Hopkins Health System
   2347A – University of Maryland Medical Center
   2348A – University of Maryland Medical Center
   2349A – Johns Hopkins Health System

5. **Docket Status – Cases Open**
   2319R – Sheppard Pratt Health System
   2350R – Prince George's Hospital Center
   2351A – Johns Hopkins Health System
   2352N – MedStar Harbor Hospital

6. **Final Recommendation for Approval of Garrett Regional Medical Center Population Health Workforce Support for Disadvantaged Areas Award** - *Approved*
7. **CRISP Update**
8. **Legal Report**
9. **Hearing and Meeting Schedule**

Closed Session Minutes
of the
Health Services Cost Review Commission

AUGUST 10, 2016

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

1. Discussion on Planning for Model Progression - Authority General Provisions Article §3-103 and §3-104
2. Update on Contract and Modeling of the All-Payer Model vis-à-vis the All-Payer Model Contract - Administration of Model Moving into Phase II – Authority General Provisions Article §3-103 and §3-104
3. Personnel Update – General Provisions Article, §3-305(b)(1)(i) and (ii)

The Closed Session was called to order at 12:08 p.m. and held under authority of §3-103, §3-104 and §3-105
of the General Provisions Article.

In attendance in addition to Chairman Sabatini were Commissioners Antos, Bayless, Bone, Colmers, Keane, and Wong. Also Ms. Fran Phillips was in attendance in a nonvoting ex-officio capacity as an MHCC Commissioner.

In attendance representing Staff were Donna Kinzer, Steve Ports, Sule Gerovich, Ellen Englert, Claudine Williams, Liz Fracica and Chris O'Brien.

Also attending were Deborah Gracey and Eric Lindeman, Commission Consultants, and Stan Lustman, Commission Counsel.

Item One

Donna Kinzer, Executive Director, discussed the progression of the All-Payer Model, including increased interest in primary care as a driver of total cost of care. Those in attendance heard from Dr. Stephen Cha, Director Center for Medicare and Medicaid Innovation, on the potential and opportunity of Maryland to be the vanguard state in this nation's health reform efforts, including the needed focus on total cost of care.

Joining the discussion on the progression of the Model were Will Daniel, Analyst CMMI, Ron Peterson, President of Johns Hopkins Health System and Executive Vice President of Johns Hopkins Medicine, Amy Perry, President of Sinai Hospital

and Executive Vice President of LifeBridge Health, and Dr. Mohan Suntha, President and CEO of the University of Maryland Medical Center.

Item Two

Ms. Kinzer, and Eric Lindeman, Commission Consultant, presented and the Commission discussed analysis of Medicare per beneficiary and total cost of care data.

Item Three

The Commission approved adding Mr. Ron Peterson to the Advisory Council. This approval will be ratified in public session. Commissioner Colmers recused himself from the vote.

Item Four

The Commission was advised of the end of year departure of Principal Deputy Director Steve Ports. Ms. Kinzer expressed admiration for all of the uniquely invaluable work performed by Mr. Ports.

The Closed Session was adjourned at 2:07 p.m.

MINUTES OF THE
532th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
August 10, 2016

Chairman Nelson Sabatini called the public meeting to order at 12:08 p.m. Commissioners Joseph Antos, Ph.D., Victoria Bayless, George H. Bone, M.D., John Colmers, Jack C. Keane, Herbert S. Wong, Ph.D., and Fran Phillips, nonvoting ex-officio member, were also in attendance. Upon motion made by Commissioner Wong and seconded by Commissioner Keane, the meeting was moved to Executive Session. Chairman Sabatini reconvened the public meeting at 2:15 p.m.

REPORT OF THE AUGUST 10, 2016 EXECUTIVE SESSION

Mr. Chris O'Brien, Chief, Audit & Compliance, summarized the minutes of the August 10, 2016 Executive Session.

The Commissioners voted unanimously to add Mr. Ron Peterson, President of Johns Hopkins Health System and Executive Vice President of Johns Hopkins Medicine to the Advisory Council. This vote would be ratified in Public Session.

Steve Ports

Ms. Donna Kinzer, Executive Director, announced that Steve Ports, Deputy Director Policy and Operations, will be leaving the HSCRC in December.

Fran Phillips

Ms. Kinzer introduced Ms. Fran Phillips, Maryland Healthcare Commission Commissioner, as the new nonvoting ex-officio member of the Commission.

ITEM I

REVIEW OF THE MINUTES FROM THE JUNE 8, 2016 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the June 8, 2016 Executive Session and Public Meeting. The Commission ratified the earlier vote on adding Mr. Ron Peterson to the Advisory Council.

ITEM II

EXECUTIVE DIRECTOR REPORT

Ms. Kinzer updated the Commission on the progression plan of Maryland's All-Payer Model (See "Update- Progression Strategy Discussion" on the HSCRC website). The aim of the plan

over a five year period is to achieve the goals of better care, better health, and lower costs (including limiting the growth in Medicare total cost of care).

Ms. Kinzer stated that the HSCRC and the Center for Medicare and Medicaid Innovation (CMMI) are focused on limiting the growth in total spending per Medicare beneficiary, including both hospital and non-hospital spending. Ms. Kinzer presented the monthly trend of Medicare spending per beneficiary for the first five months of CY 2016 compared to the same period in CY 2015. (See "Monitoring Maryland Performance – Medicare TCOC Data" on the HSCRC website).

Ms. Kinzer noted that for the five months of the calendar year ended May 31, 2016, total spending per Medicare beneficiary is $25 million below the national growth in total spending per Medicare beneficiary. Growth in total spending per Medicare beneficiary was below the nation in January, April, and May. Growth in total spending per Medicare beneficiary was above the nation in February and March. Ms. Kinzer speculated that both volumes and hospital prices may have increased in February and March to offset January's low volumes.

Ms. Kinzer stated that Maryland's non-hospital spending per beneficiary growth was higher than the nation in each of the first five months of CY 2016. During February and March, non-hospital spending per Maryland Medicare beneficiary was significantly higher than the nation. This increase more than offset Maryland's favorable hospital performance for the same period.

Ms. Kinzer noted that non-hospital spending per Maryland Medicare beneficiary is continuing to trend further above the nation in April and May. Though Maryland's April and May hospital spending per Medicare beneficiary was favorable, the potential for total spending per Maryland Medicare beneficiary at the end of CY 2016 to exceed the All-Payer Model guardrail raised concern with the Staff. Ms. Kinzer discussed potential options to address the uncertainty in CY 2016 total spending per Medicare beneficiary. These options include:

- Changing the FY 2017 rate update to reduce the amount placed in rates from July 1, 2016 to December 31, 2016, and to increase the amount placed in rates on January 1, 2017
- Reducing overall hospital rates
- Shifting funds out of hospital Global Budgeted Revenue targets due to identified movement of hospital services to unregulated settings

Chairman Sabatini suggested Staff focus on potential shifts from regulated to unregulated services. Commissioner Colmers suggested potentially realigning revenue in specific hospital rate centers that contribute to Medicare spending growth. Commissioner Keane suggested that the Staff evaluate all options, including reducing rates to avoid any triggering event under the All-Payer Model.

Ms. Kinzer stated that Staff will continue to update the Commission on the growth in hospital, non-hospital, and total spending per Medicare beneficiary, and will review the data in upcoming public meetings.

Ms. Kinzer introduced two new staff members, Laura Mandel and Liz Fracica. Both Laura and

Liz are Health Policy Analysts with the Commission.

ITEM III

NEW MODEL MONITORING

Amanda Vaughn, Program Manager, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of June focuses on the fiscal year (July 1 through June 30) as well as calendar year results.

Ms. Vaughn reported that for the twelve month period ended June 30, 2016, All-Payer total gross revenue increased by 2.43% over the same period in FY 2015. All-Payer total gross revenue for Maryland residents increased by 2.47 %; this translates to a per capita growth of 1.94%. All-Payer gross revenue for non-Maryland residents increased by 1.98%.

Ms. Vaughn reported that for the six months of the calendar year ended June 30, 2016, All-Payer total gross revenue increased by 1.91% over the same period in CY 2015. All-Payer total gross revenue for Maryland residents increased by 2.00%; this translates to a per capita growth of 1.47%. All-Payer gross revenue for non-Maryland residents decreased by .91%.

Ms. Vaughn reported that for the twelve month period ended June 30, 2016, Medicare Fee-For-Service gross revenue increased by 1.97% over the same period in FY 2015. Medicare Fee-For-Service gross revenue for Maryland residents increased by 1.97 %; this translates to a per capita growth of (0.29%). Maryland Fee-For-Service gross revenue for non-residents increased by 1.98%.

Ms. Vaughn reported that for the six months of the calendar year ended June 30, 2016, Medicare Fee-For-Service gross revenue increased by .53% over the same period in CY 2015. Medicare Fee-For-Service gross revenue for Maryland residents increased by .45%; this translates to a per capita growth of (1.20%). Maryland Fee-For-Service gross revenue for non-residents increased by 1.52%.

Ms. Vaughn reported that for the six months of the calendar year ended June 30, 2016 over the same period in CY 2013:

- Net per capita growth was 4.77 %.
- Per capita growth before UCC and MHIP adjustments was 7.24 %.
- Net per capita Medicare growth was .67%.
- Per capita growth Medicare before UCC and MHIP was 3.07 %

According to Ms. Vaughn, for the twelve months of the fiscal year ended June 30, 2016, unaudited average operating profit for acute hospitals was 3.06%. The median hospital profit was 3.62%, with a distribution of 1.06% in the 25th percentile and 6.29% in the 75th percentile. Rate Regulated profits were 6.64%.

Ms. Vaughn reported that for the six months of the calendar year ended June 30, 2016 over the

same period in CY2015:

- All-Payer admissions decreased by 1.32%;
- All-Payer admissions per thousand residents decreased by 1.86%;
- Medicare Fee-For-Service admissions decreased by 2.74%;
- Medicare Fee-For-Service admissions per thousand residents decreased by 3.45%;
- All-Payer bed days decreased by 0.55%;
- All-Payer bed days per thousand residents decreased by 1.10 %;
- Medicare Fee-For-Service bed days decreased by 2.06%;
- Medicare Fee-For-Service bed days per thousand decreased by 4.22%;
- Emergency visits decreased by 1.09%
- Emergency visits per thousand decreased by 1.63%

Dr. Alyson Schuster, PhD., Associate Director Performance Management, presented a quality report update on the Maryland Hospital Acquired Conditions program based upon readmission data on discharges (through November 2015).

Readmissions

- The All-Payer risk adjusted readmission rate was 11.39% for April 2016 YTD. This is a decrease of 11.03% from the April 2013 risk adjusted readmission rate.
- The Medicare Fee for Service risk adjusted readmission rate was 12.29% for April 2016 YTD. This is a decrease of 9.46% from the April 2013 YTD 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 goals for hospitals to reduce their adjusted readmission rate by 9.5% during CY 2016 compared to CY 2013. Currently 25 out of 46 hospitals are on track for achieving the improvement goal.

Ms. Denise Johnson, Chief, Special Projects, presented utilization trend reports reflecting the Equivalent Case-Mix Adjusted Discharges (ECMAD) growth for the six months of the calendar year ended June 30, 2016.

Ms. Johnson reported that for the six months of the calendar year ended June 30, 2016, All Payer ECMAD growth increased by 0.88% over the same period in CY 2015. ECMAD growth for Maryland residents increased by 0.82%. This is made up of Maryland inpatient ECMAD decreasing by 0.15% and outpatient ECMAD increasing 2.44%. ECMAD growth for non-residents increased by 1.61%.

Ms. Johnson reported that for the six months of the calendar year ended June 31, 2016, Medicare ECMAD growth decreased by 0.19% over the same period in CY 2015. This is made up of Maryland Medicare inpatient ECMAD decreasing by 1.11% and Maryland Medicare outpatient ECMAD increasing 3.40%.

ITEM IV

DOCKET STATUS- CLOSED CASES

2344A- MedStar Health

2345A- MedStar Health

ITEM V

DOCKET STATUS- OPEN CASES

2346A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed an application with the HSCRC on May 31, 2016 on behalf of its member hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue participation in a global rate arrangement for solid organ and bone marrow transplant services with Cigna Health Corporation for a period of one year beginning July 1, 2016.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for one year beginning July 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2347A- University of Maryland Medical Center

University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on June 1 2016 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue participation in a global rate arrangement for solid organ and bone marrow transplant services with Maryland Physicians Care for a period of one year beginning August 23, 2016.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for one year beginning August 23, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

2348A- University of Maryland Medical Center

University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on June 1, 2016 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue participation in a global rate arrangement for solid organ and bone marrow transplant services with Aetna Health. Inc. for a period of one year beginning August 1, 2016.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow services for one year beginning August 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

2349A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed an application with the HSCRC on July 1, 2016 on behalf of its member hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue participation in a global rate arrangement for solid organ and bone marrow transplant services with Aetna Health. Inc. for a period of one year beginning August 1, 2016.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for one year beginning August 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2339A Prince George's Hospital Center

The Hospital has withdrawn its partial rate application.

ITEM VI

FINAL REVISED RECOMMENDATION FOR THE RY 2017 BALANCED UPDATE FOR PSYCHIATRIC AND SPECIALTY HOSPITALS

Ms. Ellen Englert, Associate Director Rate Regulation, presented Staff's final recommendation for the update factor for RY 2017 for Psychiatric and Specialty Hospitals (See Final Recommendation For RY 2017 Balanced Update for Psych & Specialty Hospitals- on the HSCRC website).

The final recommendation for psychiatric hospitals and Mt. Washington Pediatrics is as follows:

- Release the productivity adjustment of 0.50%. This results in a new net amount of 2.05%, which can be reviewed in the chart below.

Proposed Base Update	2.80%
ACA Adjustment	.75%
Proposed Update	2.05%

- In addition to receiving a higher update amount, these hospitals must agree to the implementation of quality measures and value based programs for psychiatric facilities/beds in RY 2018.

Mr. Mike Robbins, Senior Vice President Maryland Hospital Association, noted that the update factor is still 0.15% below the update factor of 2.20% being received by psychiatric hospital under the Medicare Inpatient Psychiatric Facility prospective payment system in the rest of the country. He also noted that the ACA adjustment that staff used was incorrectly reported as 0.75%, when the correct national adjustment should have been 0.20%.

Commissioners voted 5-1 to approve the staff recommendation. Commissioner Bayless voted against the recommendation.

ITEM VII

DRAFT RECOMMENDATION ON POPULATION HEALTH WORKFORCE SUPPORT FOR DISADVANTAGED AREAS AWARDS

Mr. Steve Ports, Deputy Director Policy and Operations, presented Staff's draft recommendation on the Population Health Workforce Support for Disadvantaged Areas Program (See "Draft Recommendation for Population Health Workforce Support for Disadvantaged Areas Program Implementation Awards" on the HSCRC website).

The Maryland Department of Health and Mental Hygiene (DHMH) and the HSCRC are recommending that two proposals for the competitive Population Health Workforce Support for Disadvantaged Areas Program (PWSDA) grants be funded beginning in fiscal year (FY) 2017. This recommendation follows the Commission's decision in December 2015 authorizing up to $10 million in hospital rates for hospitals that commit to train and hire workers from geographic areas of high economic disparities and unemployment. These workers will fill new care coordination, population health, health information exchange, health information technology, consumer engagement, and related positions. The ultimate goals of the program are to create community-based jobs that pay reasonable wages, contribute to improving population health in Maryland, and further the goals of the All-Payer Model.

The PWSDA program will continue through June 30, 2018 on a hospital-specific basis assuming the hospital's ongoing compliance with the grant requirements. The grants could be renewed as of July 1, 2018, for an additional period if the Commission finds that the program is effective.

The Commission received three proposals for award funding. Commission staff established an independent committee to review the grant proposals and make recommendations to the Commission for funding. The PWSDA Implementation Award Review Committee (Review Committee) included representatives from DHMH, the Commission, and other subject matter experts, including individuals with expertise in such areas as population health, health disparities, workforce development and adult learning, health education, healthcare career advancement, and workplace and employee wellbeing.

Following a comprehensive initial review, two of the three proposal applicants were invited to provide clarifying information related to their proposal. At this time, the Review Committee is pleased to present these recommendations to the Commission. The Review Committee is strongly encouraged that these proposals will leverage the unique position that hospitals hold as economic pillars of their communities and create strong partnerships with community-based providers to respond to ongoing socioeconomic and health disparities in Maryland.

Based on its review, the Review Committee recommends the following two grant proposals for FY 2017 funding:

Baltimore Population Health Workforce Collaborative (BPHWC):

BPHWC is made up of hospitals from Johns Hopkins, MedStar, University of Maryland Health Systems, and Sinai Hospital.

- $9,778,515 to be awarded and phased in over three years based on proposed expenses
- With the resurgence of violence in Baltimore City, HSCRC staff recommends that $300,000 be added to the Sinai portion of the proposal to expand the Safe Streets Program by one additional "pod." Sinai Hospital shall contribute $100,000 of the $300,000. Individuals hired to support this program shall be from disadvantaged areas as defined in the RFP
- Following approval of this recommendation, BPHWC shall submit an adjusted budget to reflect the reduction from the requested amount to the approved amount and to reflect the $300,000 ($200,000 in rates) for the Safe Streets Program as indicated above. The total request from rates shall not exceed $9,778,515

Garrett Regional Medical Center Health Work Force Support Program:

- $221,485 to be phased in over three years based on proposed expenses.
- At least 50 percent of hires through the program must be Maryland residents.

As this is a draft recommendation, no action is required by the Commissioners.

ITEM VIII

DISCLOSURE OF THE HOSPITAL FINANCIAL AND STATISTICAL DATA FOR FISCAL YEAR 2015

Mr. Chris O'Brien, Chief Audit & Compliance summarized the annual disclosure of financial and statistical data for Maryland hospitals for FY 2015 (See "Disclosure of Hospital Financial and Statistical Data: Fiscal Year 2015" on the HSCRC website). Major highlights of the report were:

- Gross all-payer per capita hospital revenues from services provided to Maryland residents grew by 2.2 percent, slower than the per capita growth in the Maryland economy, which was about 3.34 percent in FY 2015.
- Over the performance period of the Model, the State must achieve aggregate savings in the Medicare per beneficiary total hospital expenditures for Maryland resident Medicare fee-for-service (FFS) beneficiaries of at least $330 million. For Performance Year 1 (CY 2014), the State achieved $116 million in Medicare savings.
- Over the Model's performance period, the State must shift at least 80.00 percent of all regulated hospital revenue for Maryland residents into population-based payment arrangements. The State successfully shifted 95.04 percent of hospital revenue into population-based payments through hospital global budgets.
- Over the Model's performance period, the State must reduce the aggregate Medicare 30-day readmission rate for Medicare FFS beneficiaries to be less than or equal to the national readmission rate. The gap in the readmission rate between Maryland and the nation decreased by 0.21 percent in the first performance year.
- Over the performance period of the Model, the State must achieve an aggregate 30 percent reduction for all payers in 65 potentially preventable complications (PPCs) as part of Maryland's Hospital Acquired Conditions program. The State achieved a 26.3 percent reduction in PPCs in 2014 compared to 2013.
- Hospital profits on regulated activities increased from $938 million to $1.1 billion.
- Hospital operating profits from regulated and unregulated activities increased from $411 million to $532 million.
- Excess profits total profits from all activities operating and non-operations decreased from $896 million to $530 million
- Maryland hospitals incurred $770 million in uncompensated care, amounting to approximately five cents of uncompensated care cost for every dollar of gross patient revenue.
- Gross regulated revenue from potentially avoidable utilization (PAU) readmissions fell from $1.278 billion in FY 2014 to $1.276 billion in FY 2015. The percent of gross regulated revenue associated with PAUs in general declined from 12.1 percent in FY 2014 to 11.9 percent in FY 2015, a decrease of 0.9 percent. The case-mix adjusted PPC rate declined from 0.96 percent in FY 2014 to 0.79 percent in FY 2015, a decrease of 17.7 percent. These declines reflect improvement in the quality of care delivered in Maryland hospitals, where readmission rates declined faster than the national levels for Medicare, and the State achieved the 30 percent PPC reduction goal.
- Total direct graduate medical education expenditures increased from $292 million in FY 2014 to $300 million in FY 2015, an increase of 2.79 percent.

The Disclosure Report was a team effort. Dr. Alyson Shuster provided the quality information, Amanda Vaughn singlehandedly provided the hospital financial data, and Dennis Phelps updated the text.

ITEM IX

CHESAPEAKE REGIONAL INFORMATION FOR OUR PATIENTS (CRISP) UPDATE

Mr. David Horrocks, CRISP President, and Vice Chair Dr. Mark Kelemen updated the Commission on the progress of the Integrated Care Network (ICN) Infrastructure project (See HSCRC Commission Meeting ICN Infrastructure Progress Update).

Mr. Horrocks reviewed the progress made regarding the "four venues for which information is used": point of care, care managers/coordinators, population health team, and patients. He then shared the challenges faced during the year in implementation of these various activities. Dr. Kelemen discussed the goals the ICN steering committee hoped to achieve for the coming year.

ITEM X

LEGAL REPORT
REGULATIONS

Regulations

Proposed and Emergency

Rate Application and Approved Procedures 10.37.10.03 and .03-1

The purpose of this action is to extend a moratorium on the filing of regular rate applications given the progression of the all-payer model.

Commissioners approved revising the proposal and to revise emergency provisions to extend the moratorium on full rate applications from the original deadline of September 30, 2016, through no later than October 31, 2017.

The Commissioners also voted unanimously to forward the proposed revised regulations to the AELR Committee for review and publication in the Maryland Register both as proposed and as emergency.

ITEM XI

HEARING AND MEETING SCHEDULE

September 14, 2016 Times to be determined, 4160 Patterson Avenue

	HSCRC Conference Room
October 12, 2016	Times to be determined, 4160 Patterson Avenue
	HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:54 pm.

DRAFT FOR STAKEHOLDER INPUT

Progression Strategy Summary

September 14, 2016

HSCRC
Health Services Cost Review Commission

Background

- The All-Payer Model requires Maryland to submit a plan to CMS by December 31, 2016. The plan must address:
  - The All Payer Model's requirement to expand its focus to limit the growth in Medicare total cost of care (TCOC); and
  - The State's focus on limiting the growth in the Medicaid costs for dually eligible beneficiaries.
- Some strategies will require CMS approval and waivers before implementation and CMS could require changes
- The Advisory Council is charged with making recommendations on this strategic progression plan
- This document provides a **high level overview of potential progression plans based on initial stakeholder comments and for additional stakeholder review and comment**
- Content on Dual Eligible Model will be added in next version

Presentation Overview and Purpose

- This presentation suggests a potential outline and initial content for the Strategic Plan to be submitted by December 31, 2016

- Strategic Plan Outline:
  - Background: Current All-Payer Model and Amendment
  - Scope and Strategic Considerations
  - Draft Strategy Recommendations
  - Potential Timeline

- Background Materials in Appendix

Key Discussion Questions

- Content:
  - Are we focused on the right opportunities?
  - Are these the right strategies?
  - Are there other strategies?
  - How do these strategies align with current provider and health plan initiatives?
- Timeline:
  - How should the strategies and models be prioritized? What is the best phased approach? What is the timeline?
- Process:
  - How should we go about developing the plan and the models?

Background: Current All-Payer Model and Amendment

All-Payer Model Status

- All Payer hospital revenue growth contained, even as Medicaid expanded and marketplace enrollees grew under ACA
- Medicare hospital savings on track/non-hospital costs rising
- Quality measures on track
- Stakeholder participation contributing to success
- Delivery systems organizing and transforming
  - All hospitals on global budgets
  - Medical homes for many privately insured
  - Accountable care organizations for ~ 200k Medicare enrollees
  - Clinically integrated networks and regional partnerships forming
  - New Medicare Advantage plans forming
- Well developed hospital regulatory infrastructure
- Sophisticated health information exchange
- Generally positive feedback from CMS

Challenges and Areas to Address

- Need to address the remaining 44% of Medicare services not under global budgets
  - ~56% of Medicare costs under hospital global budgets
- Further progress for Medicare is dependent on advancing care redesign, alignment, and supporting infrastructure
- State lacks strong alignment tools to overcome largely fee-for-service model for non-hospital providers
- Ongoing delays in getting data and alignment tools from CMS
- Gaps in care supports for complex and chronically ill (including those in custodial care) Medicare fee-for-service (FFS) beneficiaries
- Variation among systems in implementation and performance

Care Redesign Amendment Coming Soon

- Providers called for alignment strategies
- Care Redesign Amendment developed and currently in CMS review to allow hospitals to participate in Care Redesign:
  - Access Medicare data
  - Implement Complex and Chronic Care Improvement Program and Hospital Care Improvement Program
  - Amendment allows flexibility for additional care redesign programs
  - Allows hospitals to share resources and pay incentives (if they choose to) based on savings within TCOC benchmarks
  - State working to align Amendment with MACRA requirements

Scope and Strategic Considerations

Progression Plan: Scope of Expenditures

Approximate CY 2015 Figures (for 6 million Marylanders)	
All Payer Hospital Revenues (Maryland Residents in Maryland hospitals)	$14.8 billion
Medicare Non-Hospital Spend (Maryland Beneficiaries anywhere)	$3.9 billion
Medicare Hospital Spend Non-Regulated	$0.5 billion
Medicaid Costs for Dual Eligible Patients	$1.7 billion
Total Costs to be Addressed in the Strategic Plan	**$19.9 billion**

Notes:

1. Hospital revenues incorporate ~$4.8 billion of Medicare spend.
2. Medicare savings requirements incorporates spend for Maryland beneficiaries in Maryland and other locales.
3. Medicare spend includes only payments by Medicare.
4. Medicare non-regulated hospital spend is primarily out-of-state hospital spend. Also includes in-state specialty hospital spend.
5. Medicaid figures are estimated and may be updated. They reflect non-I/DD full duals, but do not remove MA enrollees or ACO members.

Advisory Council Summary and Recommendations for Progression (July 2016)

- Maintain focus
- Retain and strengthen the All-Payer Model
- Set targets and allow flexibility to meet them
- Acquire needed data and use data in hand
- Promote accountability
- Foster alignment
- Modernize governance and regulatory oversight
- Ensure person-centered care

MACRA Provides New Opportunities for Aligning Providers

- Federal legislation referred to as MACRA dramatically alters physician reimbursement for Medicare
- Removes flawed across the board payment reductions for "excess" volume
- Introduces two value-based incentive approaches, both of which encourage the participation in Alternative Payment Models (APMs)
  1. MIPS (Merit-Based Incentive Payment System) provides incentives that could range from +/- 9% over time, and rewards participation in APMs
  2. With participation in Advanced Alternative Payment Models, physicians can opt out of MIPS and receive 5% lump sum bonuses and higher fee schedule updates
- MACRA provides an opportunity to engage physicians in the goals of the All-Payer Model (which is an APM) of better care, better health and lower costs
- Maryland will adapt its approaches to optimize opportunities under MACRA and the All-Payer Model to create Advanced APMs that can harmonize performance goals.
  - Final MACRA regulations are due in November

Aging of the Population Will Have A Profound Effect on Utilization in Maryland

- 18% of Maryland's population >65 years old by 2025
  - 28% increase in proportion age >65 between 2015 and 2025
  - 41% increase in proportion age >65 between 2015 and 2030

- Profound impact on federal and state budgets and delivery systems
  - E.g. the 28% potential increase in utilization/spend by 2025 in Medicare/Medicaid for dually eligible
  - Need to make significant changes in delivery system and community services to address service needs
  - Reduce medically unnecessary care and improve chronic care management in community settings

Draft Strategy Recommendations

Focus on Key Opportunities

- Incorporate/Expand tailored person-centered approach
  - Use data/information to tailor approach, focus on high needs persons
  - Engage consumers, families, community
  - Patient Designated Provider (PCP or other) in community for care coordination/chronic care management

- Approximately 3/4 of Medicare TCOC related to a hospitalization. Key opportunities:
  - Reduce unnecessary and preventable utilization in high cost settings
  - Ensure high quality efficient episodes with optimal outcomes;
  - Utilize expertise and resources of post-acute, long-term care, and home based providers in more flexible and effective ways to meet the growing needs of an aging population

- For dually-eligibles, just under 1/2 of Medicaid costs consist of custodial care in long-term care facilities, approximately 40% in home and community based services. Key opportunities:
  - Reduce the need for preventable high level custodial care
  - Ensuring high quality, well coordinated services

4 Key Strategies Maryland is Considering to Address Total Cost of Care and System-wide Outcomes

I. Incorporate Medicare patients into a Primary Care Home Model to support engaged patients in person-centered care with supporting care teams, data-driven care coordination, focus on high needs persons, and a supporting payment model

II. Incorporate Medicare TCOC targets and common system-wide outcome goals into all providers' incentive structures

III. Develop a focused portfolio of payment and delivery system transformations to support key goals

IV. Develop/support models that include upside and downside risk or increased levels of incentive tied to performance targets

1. Develop Primary Care Home Model (see separate presentation)

- Create a broadly applied model of person-centered care with supporting care teams, data-driven care coordination, and a supporting payment model.
  - Strive to have a Patient Designated Provider (usually PCP) who takes responsibility for coordinating services from all providers; this "quarterback" should be paid adequately for performing coordination role.
  - Replace CMS' FFS chronic care management fee with a risk adjusted care management payment per beneficiary, consistent performance metrics with incentive payments, and an option for upfront visit payments to facilitate alternative care delivery, similar to CMS CPC+ model
  - Focus on high needs patients and chronic care improvement with hospitals, ACOs, PCMH, payers, and other models.
  - Align with All Payer Model--Adjust MACRA bonus based on overarching provider performance measures including Medicare TCOC
  - Improve access to community-based, behavioral health services and supports

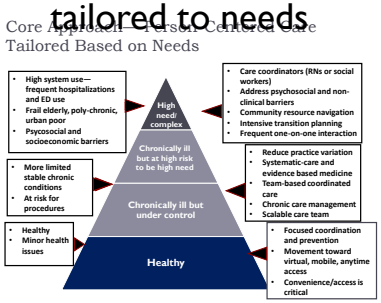
Example: Hospital Global Model Relationship with Primary Care Home Model

Hospital Global Model

Hospitals and care partners focused on population of patients within a geographic area (and their patients)

Common Approaches and Aligned Measures

Person-centered care tailored to needs



Risk stratification (esp for high needs persons)
Care coordination
Chronic care management
Reduction of avoidable utilization
All provider incentives aligned with total cost of care and outcomes goals

Primary Care Home Model

Patient Designated Providers (PDPs) are focused on their panel of patients

Patients

2. All Provider Incentives Aligned with Total Cost of Care and Outcome Goals

Goal: Create a pathway for all providers to align with key goals of All Payer Model and create opportunities for MACRA qualification for bonuses (subject to CMS approval)

Incentive Alignment Concept: Incorporate incentives for all providers based on Medicare TCOC, population health and care outcomes

- A portion of each providers payments would be based on a common set of measures
- Hospitals:
  - Beginning CY 2017/FY 2018, incorporate incentives into global budgets (similar to other quality programs) based on Medicare TCOC. Add population health and other care outcomes measures in 2019.
    - Begin with modest incentive program to allow for learning
- Physicians: (requires CMS approvals and Advanced APM qualification)
  - MACRA bonuses could be scaled up or down based on care outcomes, population health, and Medicare TCOC in a geographic area for those Advanced APMs that are created in Maryland (e.g. Care Redesign Amendment, Primary Care Home Model, Geographic Model, etc.)
- Other non-hospital providers (e.g. SNFs, etc.)
  - TBD- Need to be developed

3. Portfolio of Payment and Delivery System Transformations

- Payment and Delivery Transformation to be accomplished via:
  - Primary care/complex care/chronic care transformation
    - Care Redesign **Amendment** (Complex and Chronic Care Improvement Program) (2017)
    - **Primary Care Home Model** (develop 2016, implement 2018)
    - **Post-Acute** and **Long-Term Care** initiatives (TBD)
    - Other MACRA-eligible programs (TBD)
  - Episode-of-care focus
    - Care Redesign **Amendment** (Hospital Care Improvement Program) (2017)
    - **Post-Acute Care** initiatives (TBD)
    - Other MACRA-eligible programs (TBD)

3a. Optimize the Use of Post-Acute and Long-Term Care Services

- Post-acute and long-term facilities have significant expertise in caring for aging population
- Request that CMS grant Maryland flexibility in utilizing and optimizing these services
  - Request that Maryland be granted authority to relax the 3 day rule, where partnerships of providers agree to take on responsibility of cost and outcomes for acute and post-acute care, with no net negative impact on Medicaid
    - E.g. may be a geographic area or acute/post-acute episodes
  - Provide additional primary care and medical services in long-term care settings that will reduce preventable and unnecessary hospitalizations
- Establish a work group and set a timeline to develop specific models and timelines

4. Models to Incorporate Upside/Downside Incentives or Risk

- **Geographic Model**
  - Elements already included in Care Redesign Amendment through Hospital geographic area guardrail for physician incentive payments
  - State strategy to add +/- incentive payment based on TCOC to GBR—a MACRA qualification strategy that CMS must approve
  - Geographic Model could evolve to include larger upside/downside incentive payments over time, or develop a shared savings model with upside/downside risk similar to ACOs
- **Dual Eligibles** developing ACO/PCHH strategies also transitioning to upside/downside risk over time
- State policy strategies encourage ACO, PCMH, and Clinically Integrated Network use, including capabilities to take on upside/downside risk over time

Overview of Straw Model to Support Progression

Medicare FFS TCOC and Outcomes Focus

		ACOs	Medical Home or other Aligned Models	Duals Model (TBD)	Geographic Model
#benes in models with upside / downside incentives	2017	~50k?/200k*?	0?/35k*?	0?	830k?
	Future	250k?	150k?	80k?	400k?

Supporting Payment/Delivery Approaches with All Payer Applicability

Global Hospital Budgets
All Provider Incentive Alignment
Amendment--Complex/Chronic Care, Hospital Care/Episodes
Primary Care Home--Chronic care,Visit budget flexibility
Post-acute and Long-term Care Initiatives
Other MACRA-eligible programs

**Higher figures include all beneficiaries, including those with no downside incentives or revenue at risk*

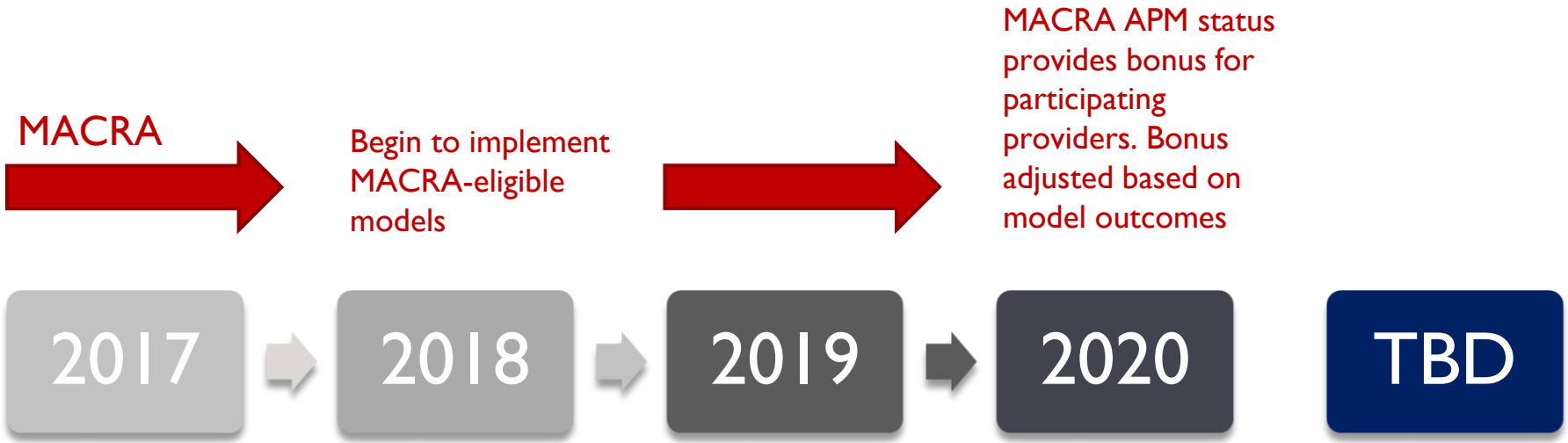
Other Needs to Address

- Develop supporting infrastructure
  - CRISP
  - Administrative/governance infrastructure
  - Transformation resources
- Linkage to public health
  - State Health Improvement Plan
  - Resources
- Consumer and community engagement
  - Patient designated provider
  - Consumer advisory
  - Breath of Fresh Care and other consumer campaigns
- Consider other strategy areas
  - Stakeholder idea, incorporate retail pharmacy savings but not risk
- Continuing refinements to global hospital model
- Integrating and harmonizing administrative, clinical, and financial aspects of care models

Potential Timeline-2016

- Develop progression plan for All Payer Model due to CMS by Dec 31, 2016
  - Develop Primary Care Model for Maryland to file with CMS by Dec 31, 2016 for possible implementation in Jan 2018
  - Develop Dual Eligibles Model for implementation in 2019
  - Progress on Population Health Plan due mid-2017
- Prepare to implement Care Redesign Amendment (no shared savings/gainsharing in 2017)
- Develop incentive approach for Medicare TCOC for implementation in 2017/2018
- Align with MACRA requirements

Potential Timeline



Note: * Indicates anticipated MACRA-eligible models (Advanced Alternative Payment Models).

Monitoring Maryland Performance
Medicare TCOC Data

Through June 2016

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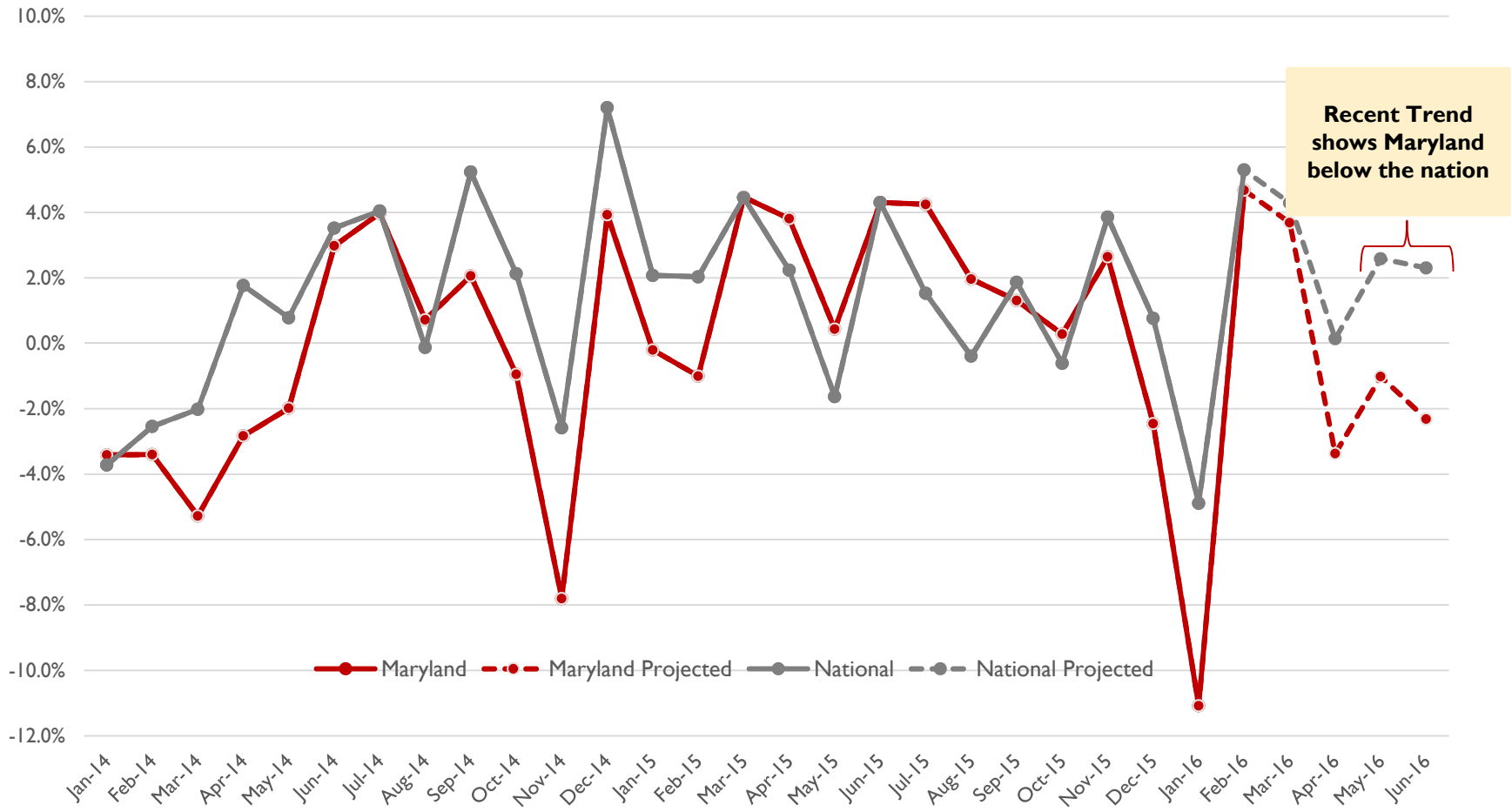
Disclaimer

Data contained in this presentation represent analyses prepared by MHA and HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

Medicare Hospital Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



Recent Trend shows Maryland below the nation

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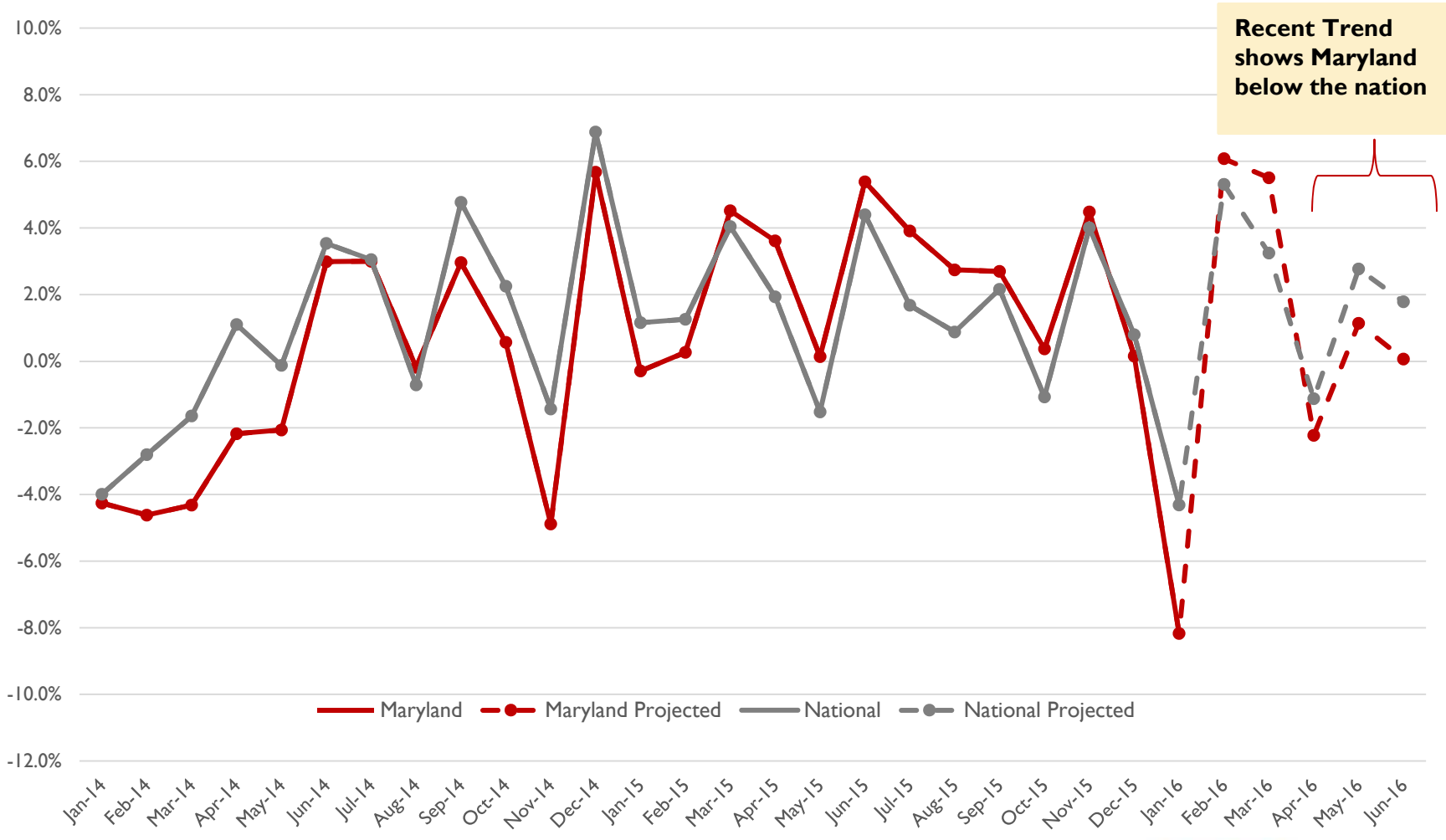
Total Cost of Care per Capita

Actual Growth Trend (CY month vs. prior CY month)



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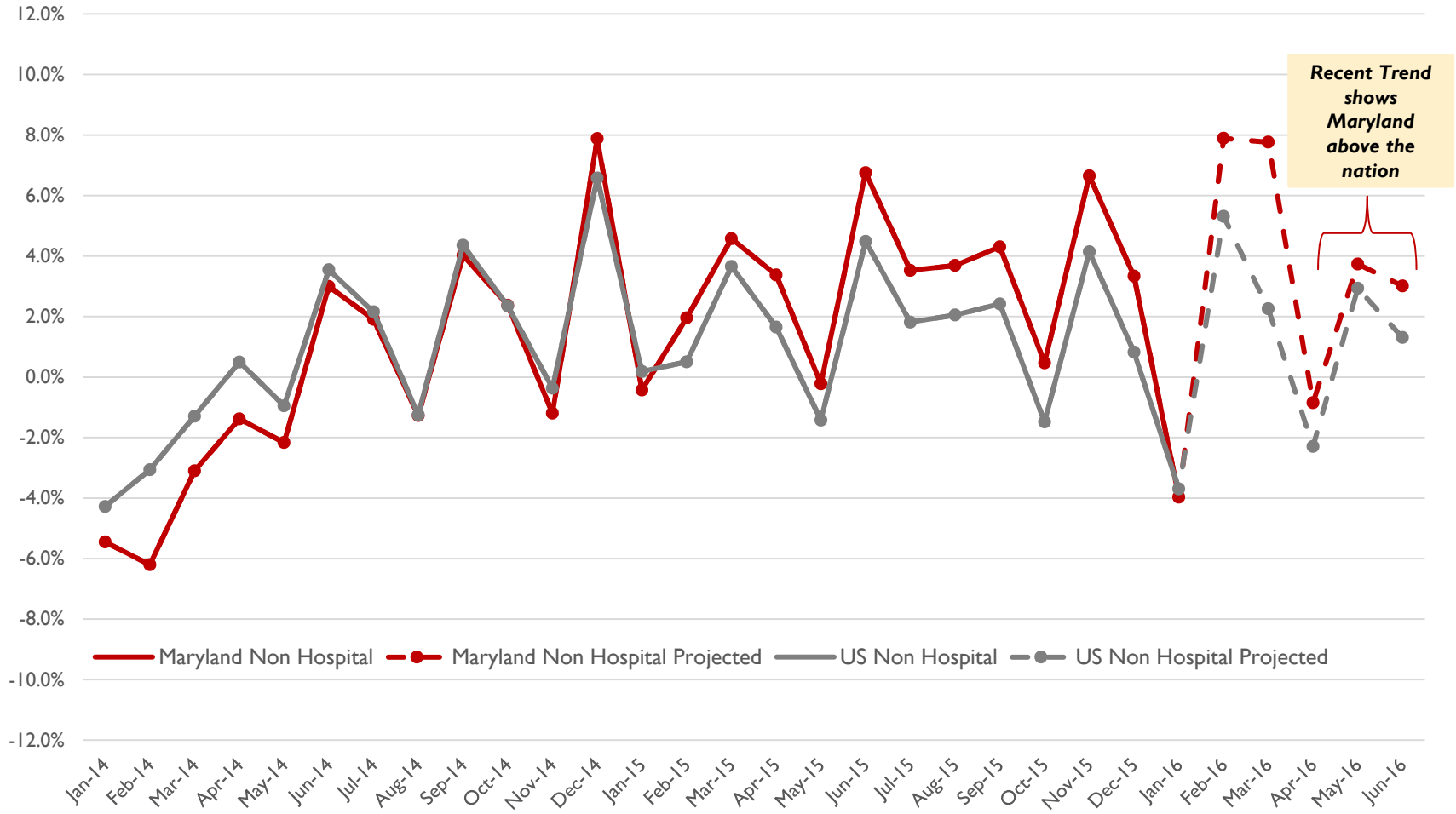
Non-Hospital Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



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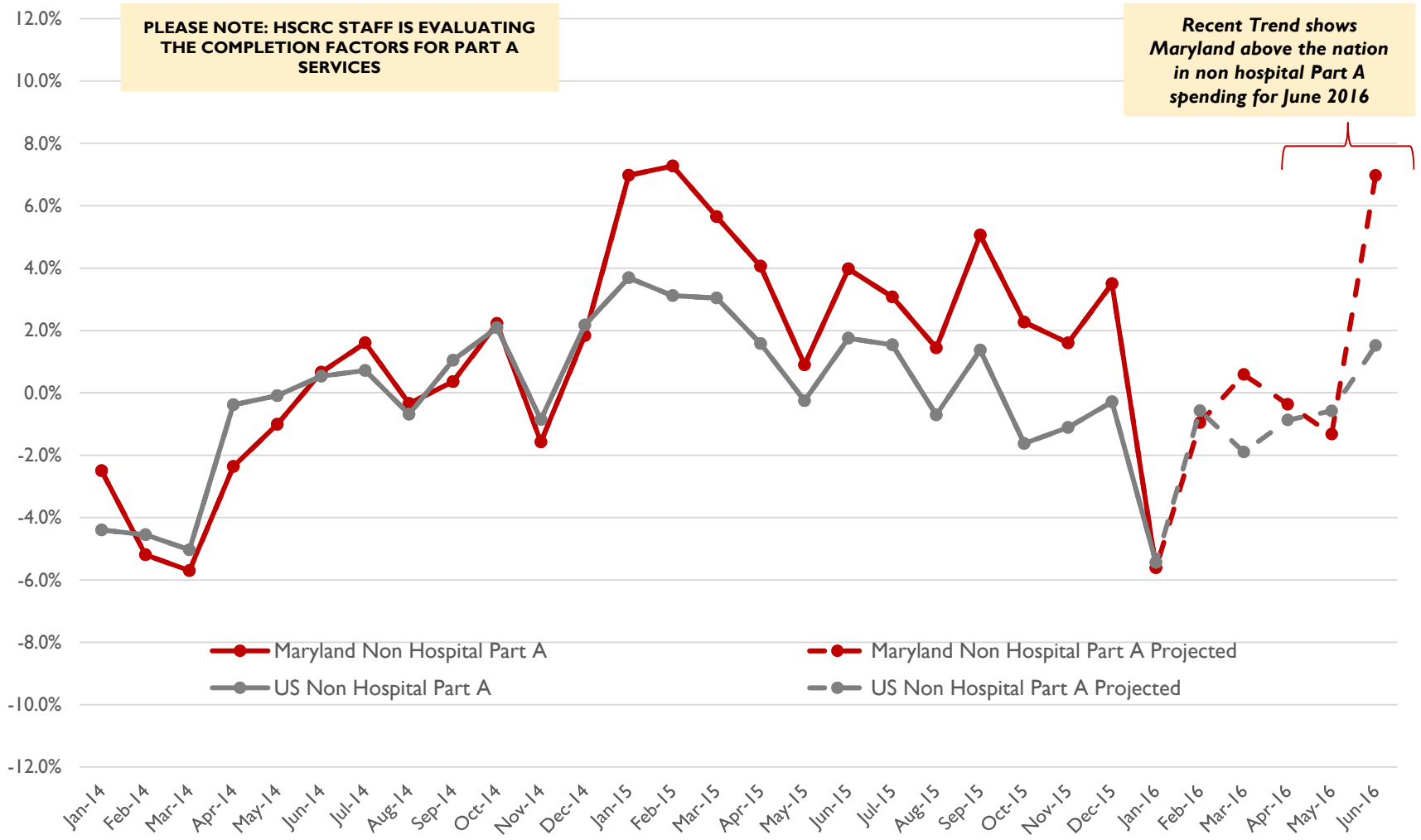
Non Hospital Part A Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



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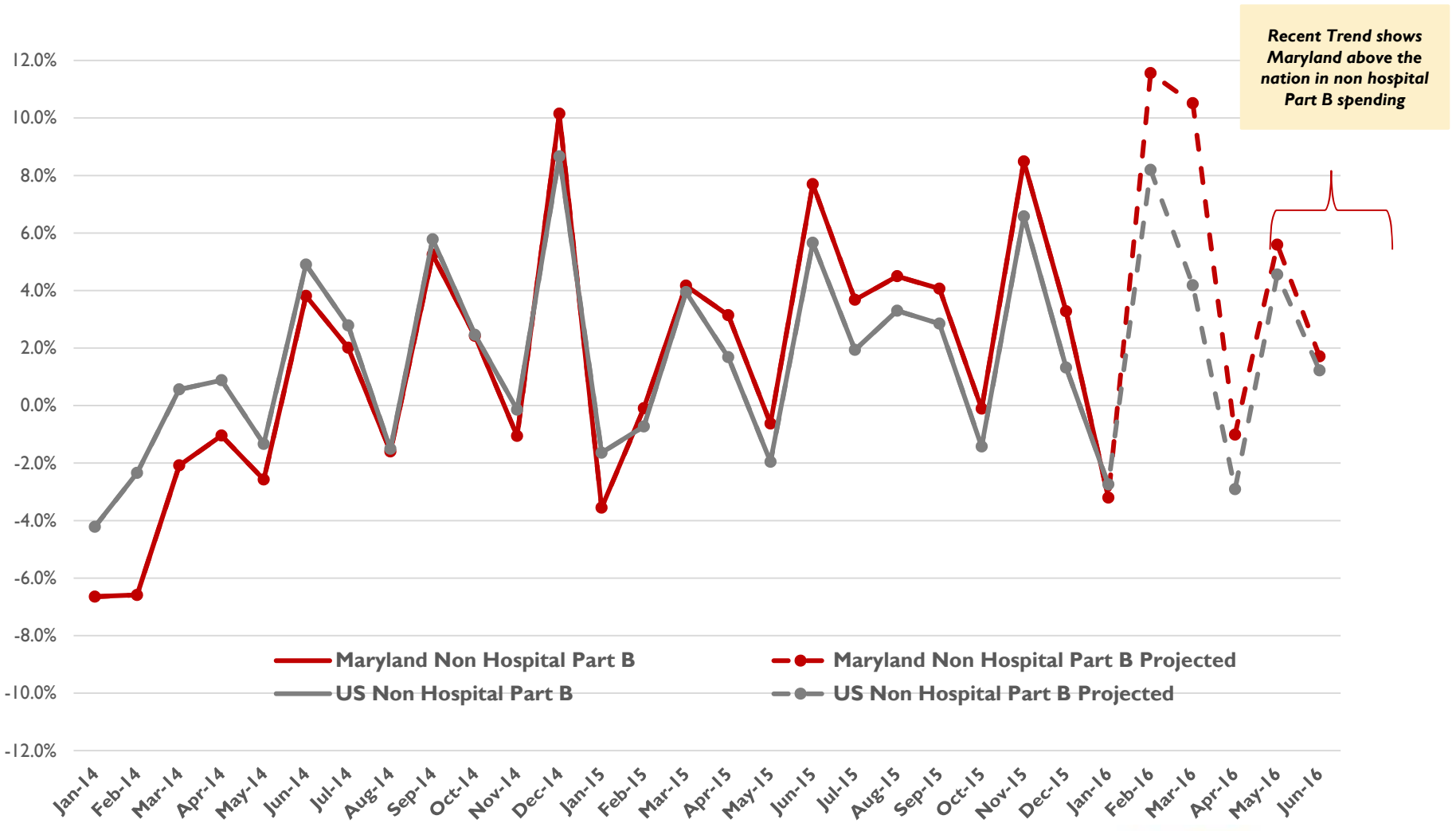
Non Hospital Part B Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



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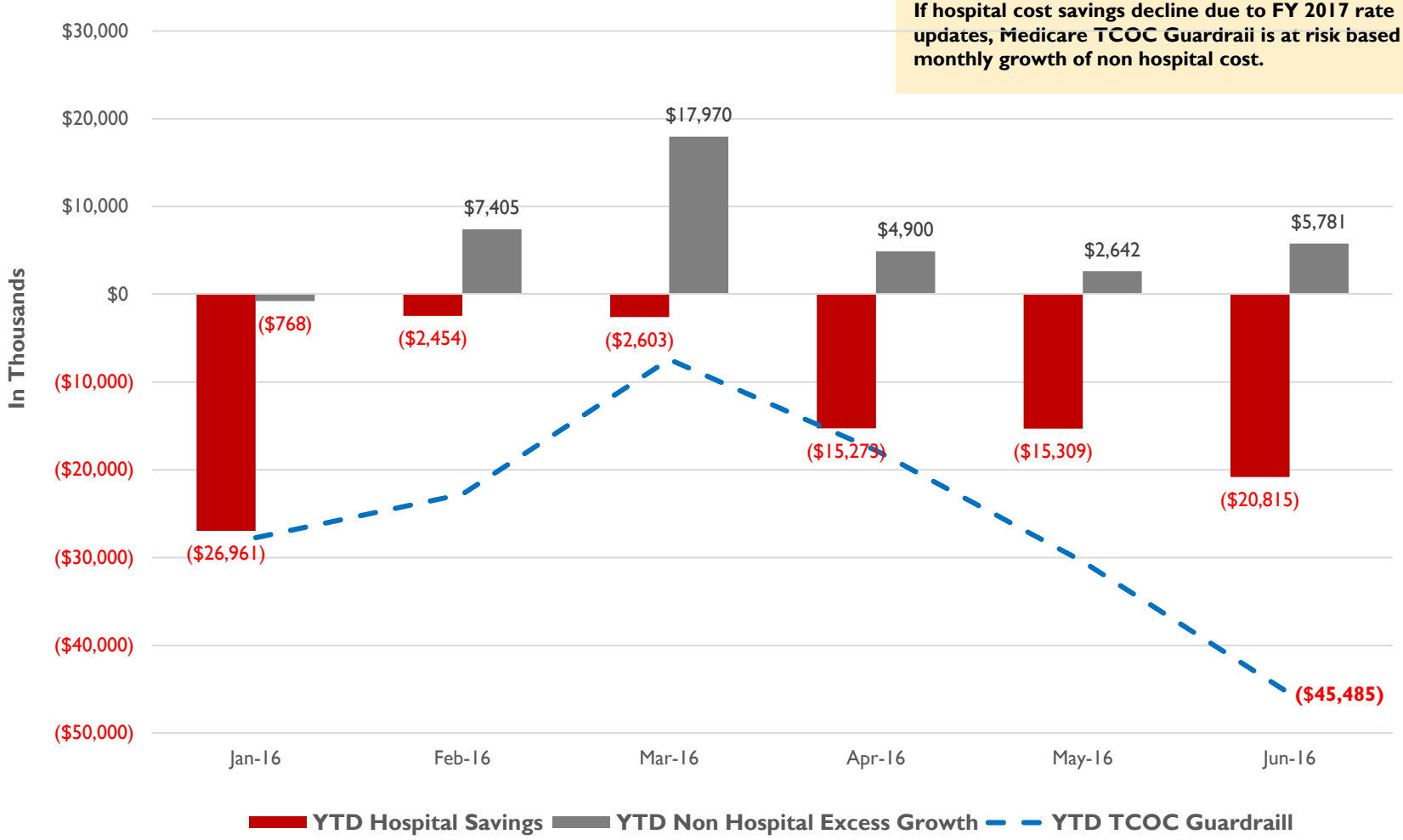
Medicare Hospital & Non Hospital Growth (with completion) CYTD through June 2016

If hospital cost savings decline due to FY 2017 rate updates, Medicare TCOC Guardrail is at risk based on monthly growth of non hospital cost.



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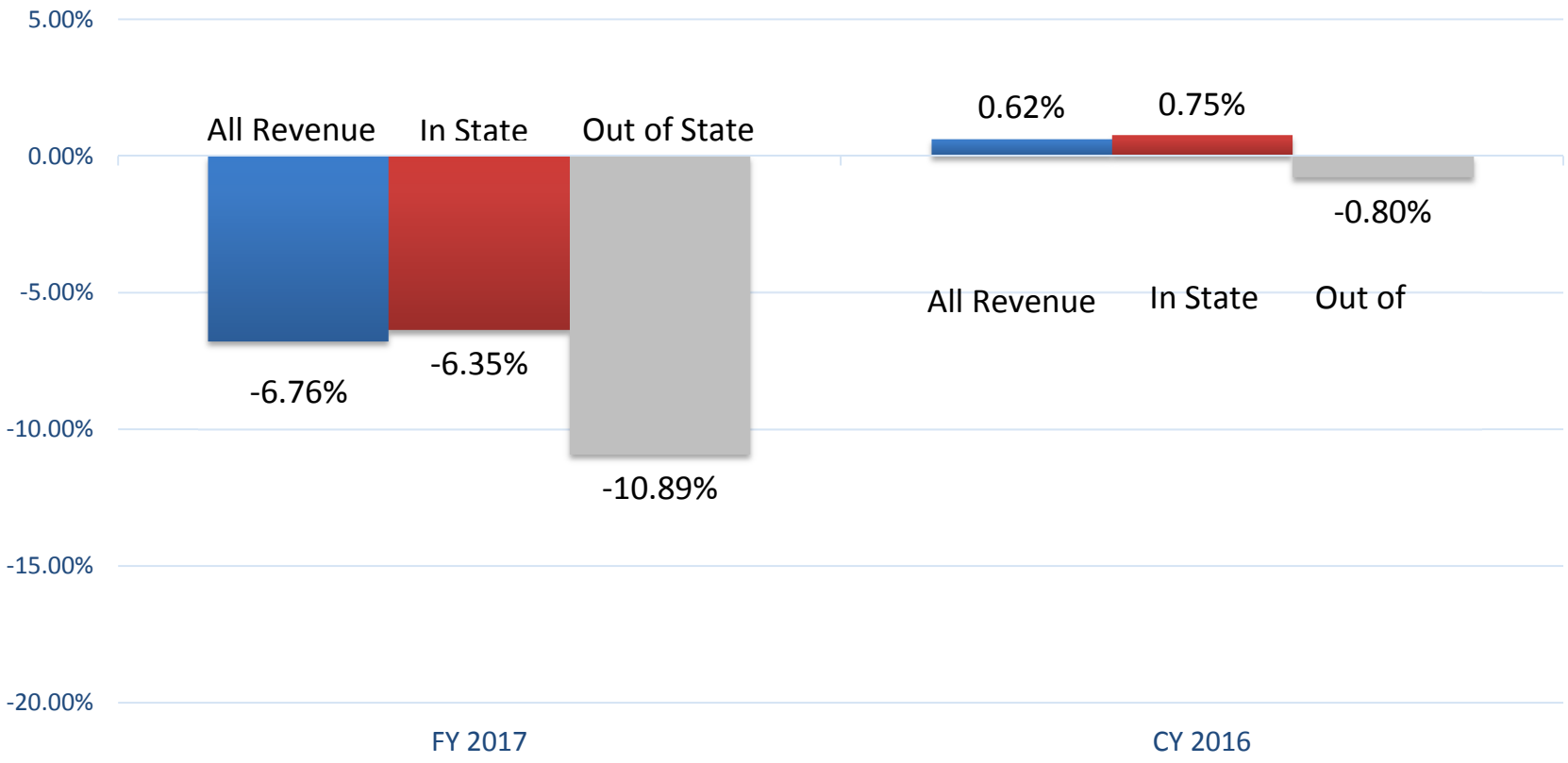
Monitoring Maryland Performance

Financial Data

Year to Date thru July 2016

Gross All Payer Revenue Growth

Year to Date (thru July 2016) Compared to Same Period in Prior Year



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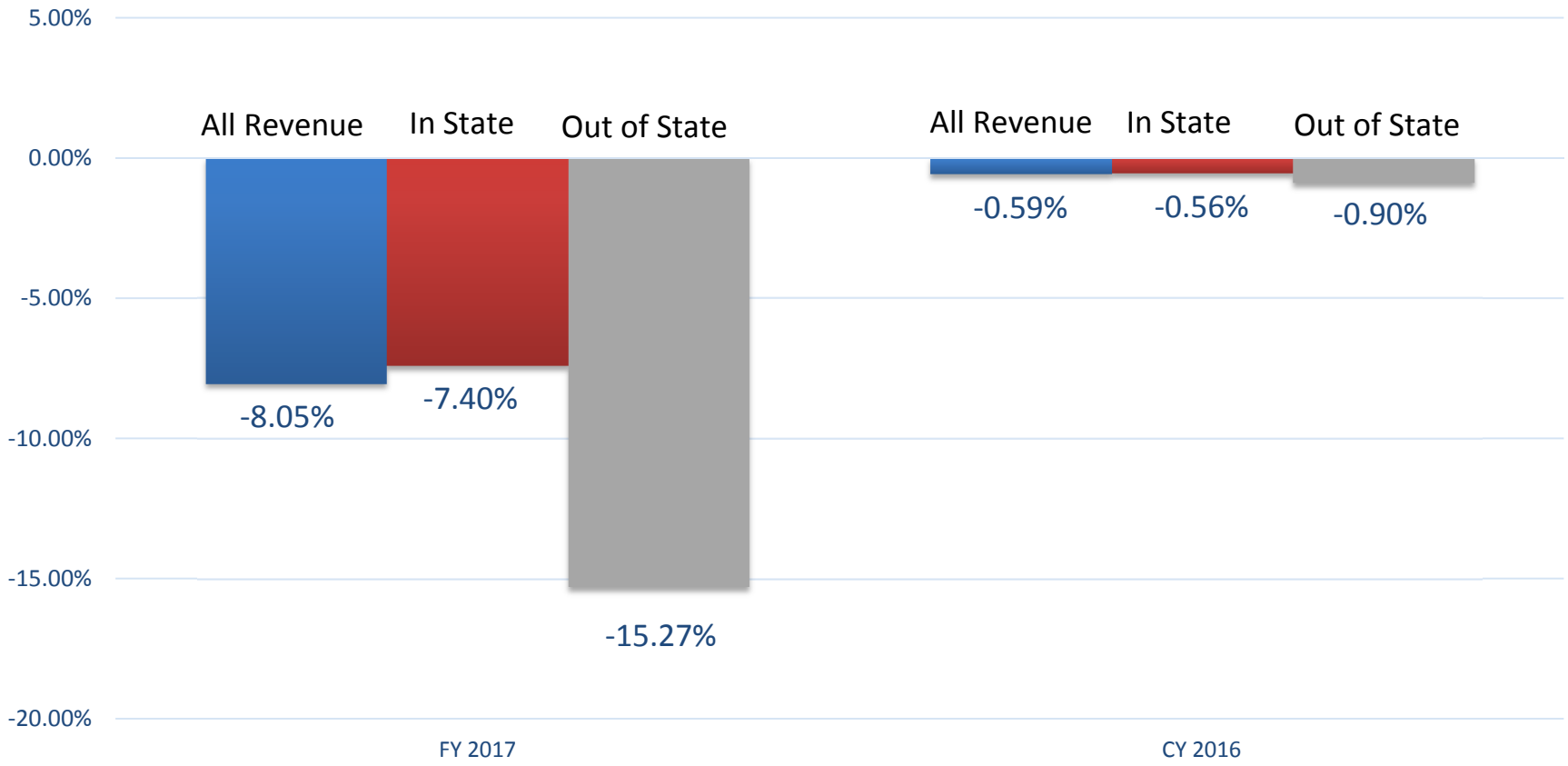
Gross Medicare Fee-for-Service Revenue Growth

Year to Date (thru July 2016) Compared to Same Period in Prior Year



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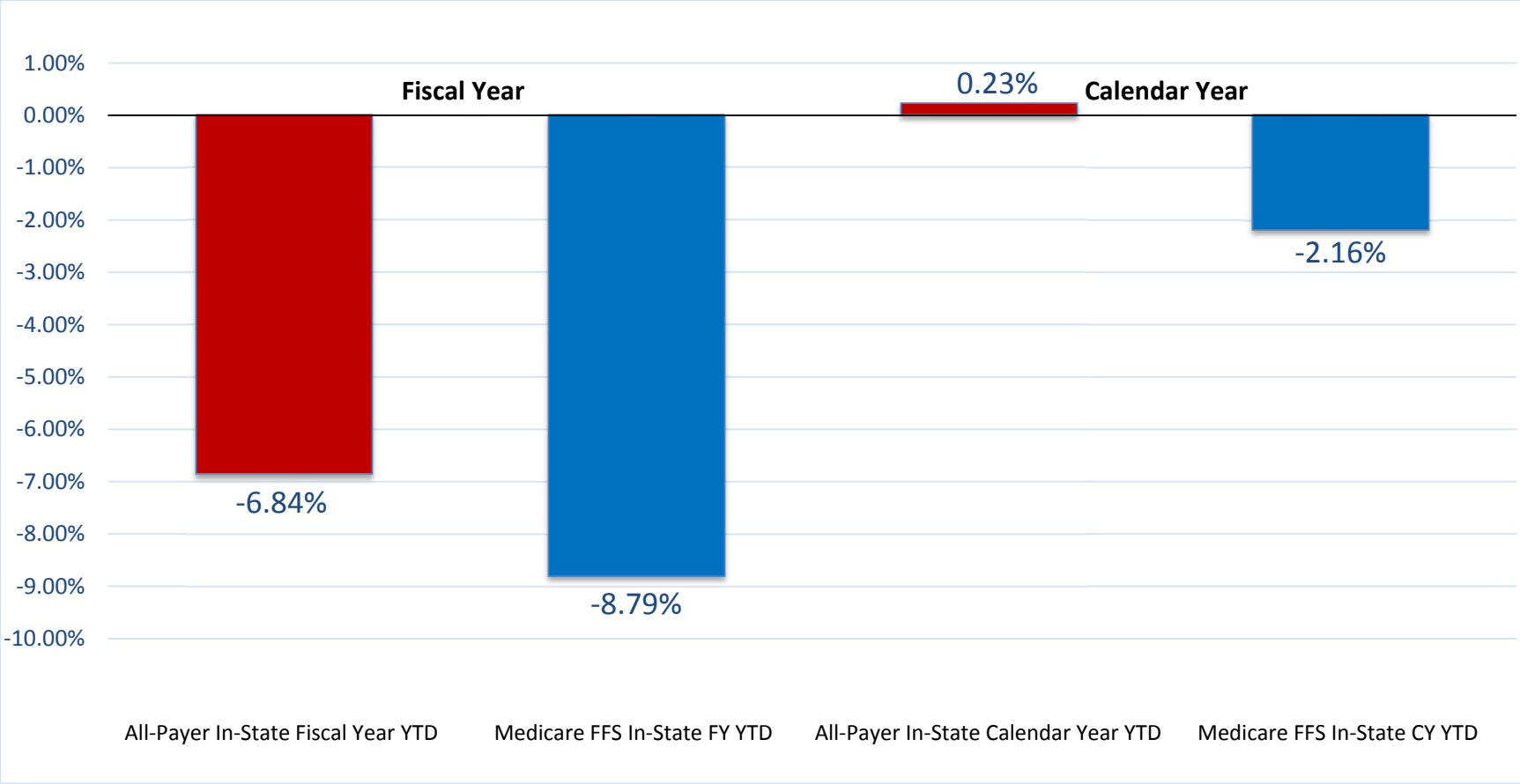
Per Capita Growth Rates

Fiscal Year 2017 (July 2016 over July 2015) and Calendar Year 2016 (Jan-Jul 2016 over Jan-Jul 2015)



- **Calendar and Fiscal Year trends through July are below All-Payer Model Guardrail of 3.58% per year for per capita growth.**

FFS = Fee-for-Service

Population Data from Estimates Prepared by Maryland Department of Planning

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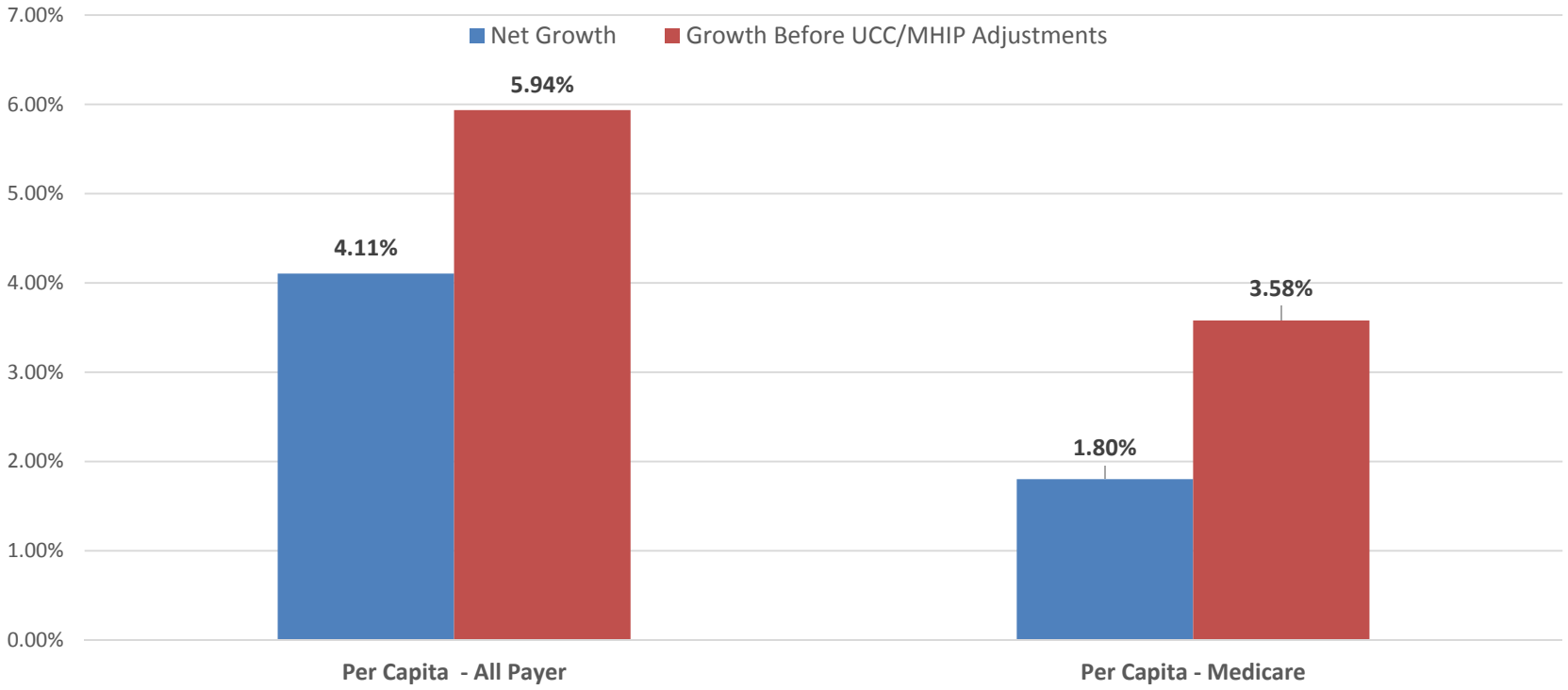
Per Capita Growth – Actual and Underlying Growth
CY 2016 Year to Date Compared to Same Period in Base Year (2013)



- Three year per capita growth rate is well below maximum allowable growth rate of 11.13% (growth of 3.58% per year)
- Underlying growth reflects adjustment for FY16 revenue decreases that were budget neutral for hospitals. 2.52% hospital bad debts and elimination of MHIP assessment.

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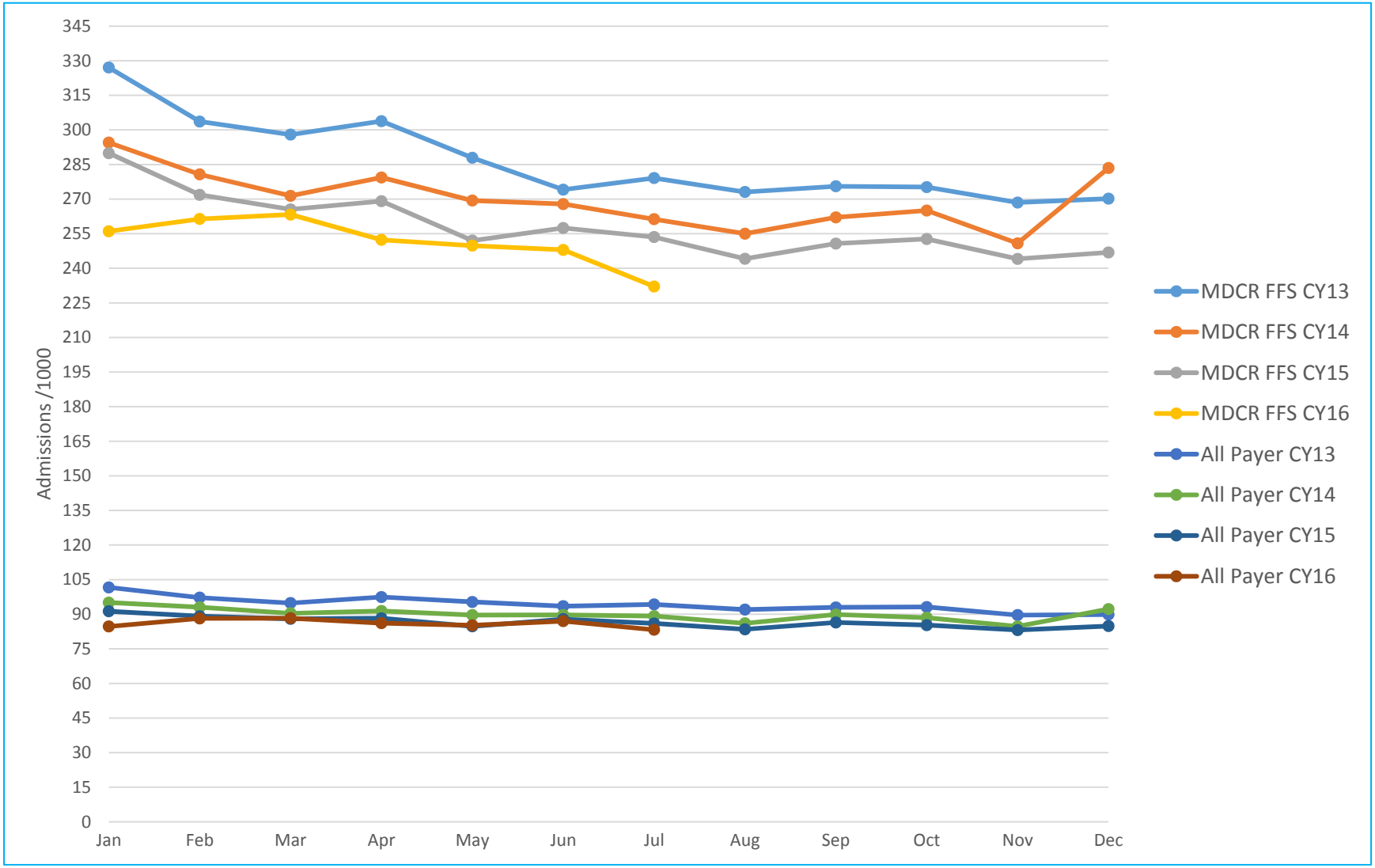
Annual Trends for Admissions/1000 (ADK) Annualized
Medicare FFS and All Payer



*Note – The admissions do not include out of state migration or specialty psych and rehab hospitals

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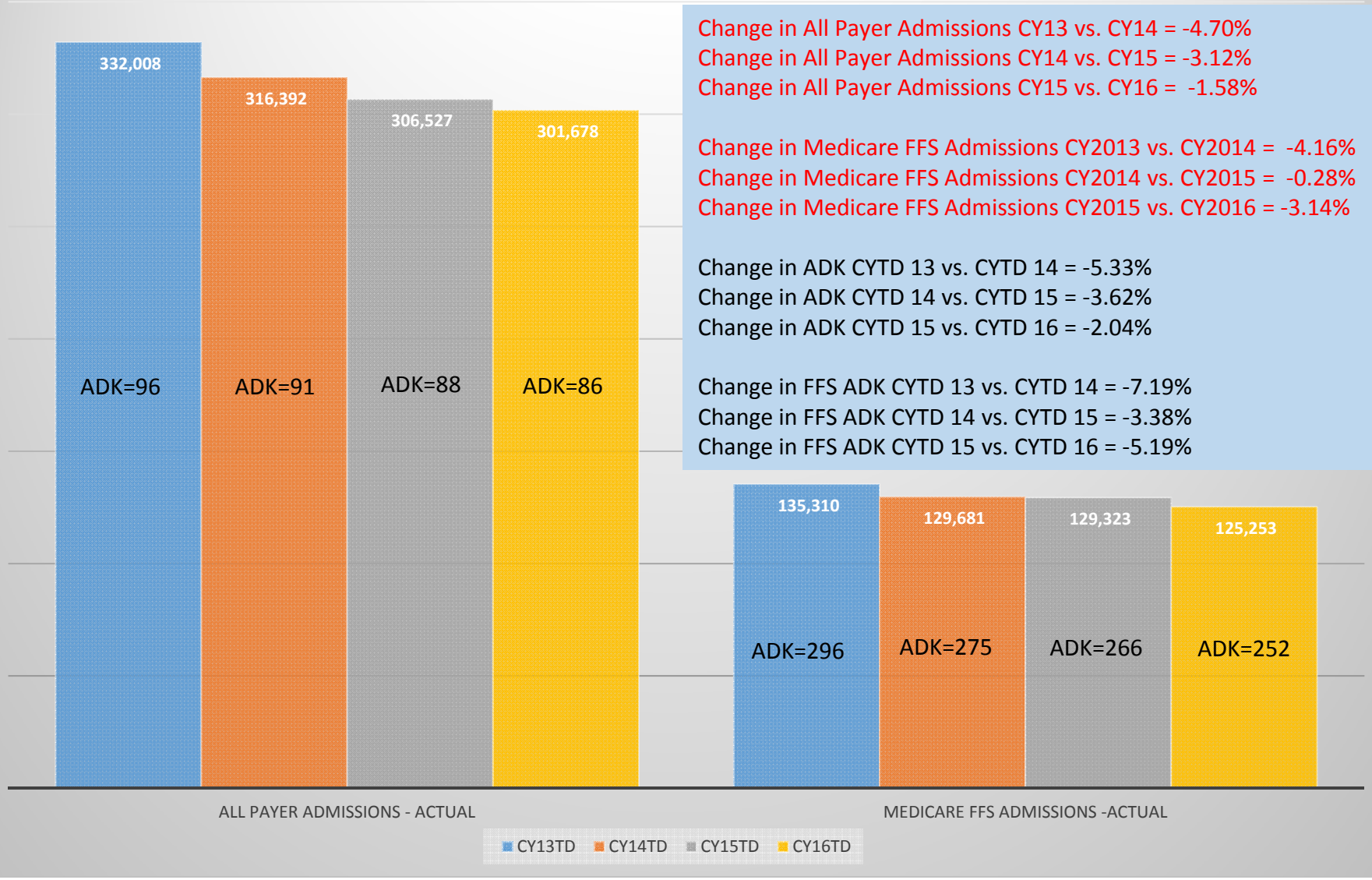
Actual Admissions by Calendar Year to Date through July



Change in All Payer Admissions CY13 vs. CY14 = -4.70%
Change in All Payer Admissions CY14 vs. CY15 = -3.12%
Change in All Payer Admissions CY15 vs. CY16 = -1.58%

Change in Medicare FFS Admissions CY2013 vs. CY2014 = -4.16%
Change in Medicare FFS Admissions CY2014 vs. CY2015 = -0.28%
Change in Medicare FFS Admissions CY2015 vs. CY2016 = -3.14%

Change in ADK CYTD 13 vs. CYTD 14 = -5.33%
Change in ADK CYTD 14 vs. CYTD 15 = -3.62%
Change in ADK CYTD 15 vs. CYTD 16 = -2.04%

Change in FFS ADK CYTD 13 vs. CYTD 14 = -7.19%
Change in FFS ADK CYTD 14 vs. CYTD 15 = -3.38%
Change in FFS ADK CYTD 15 vs. CYTD 16 = -5.19%

*Note – The admissions do not include out of state migration or specialty psych and rehab hospitals

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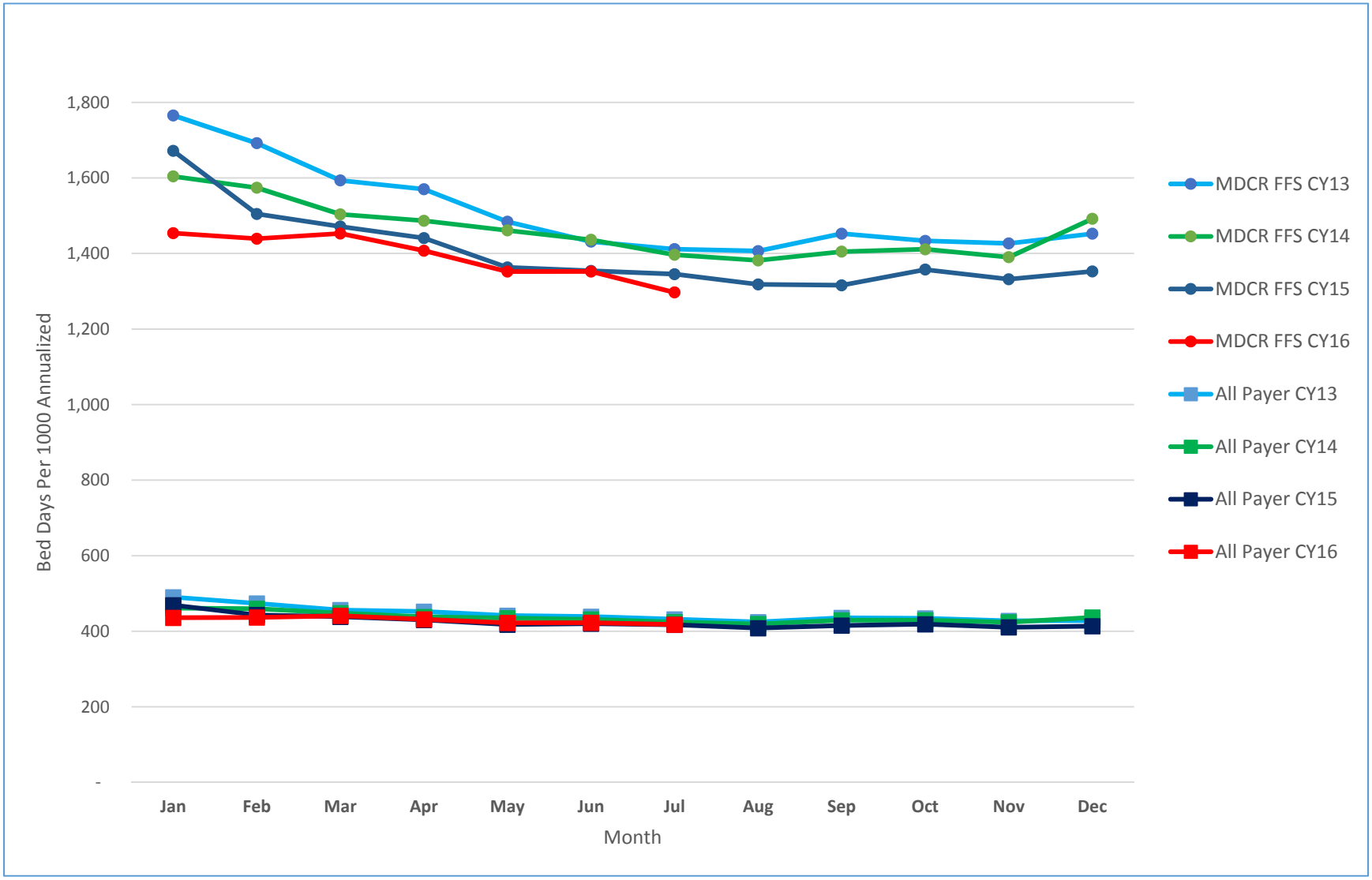
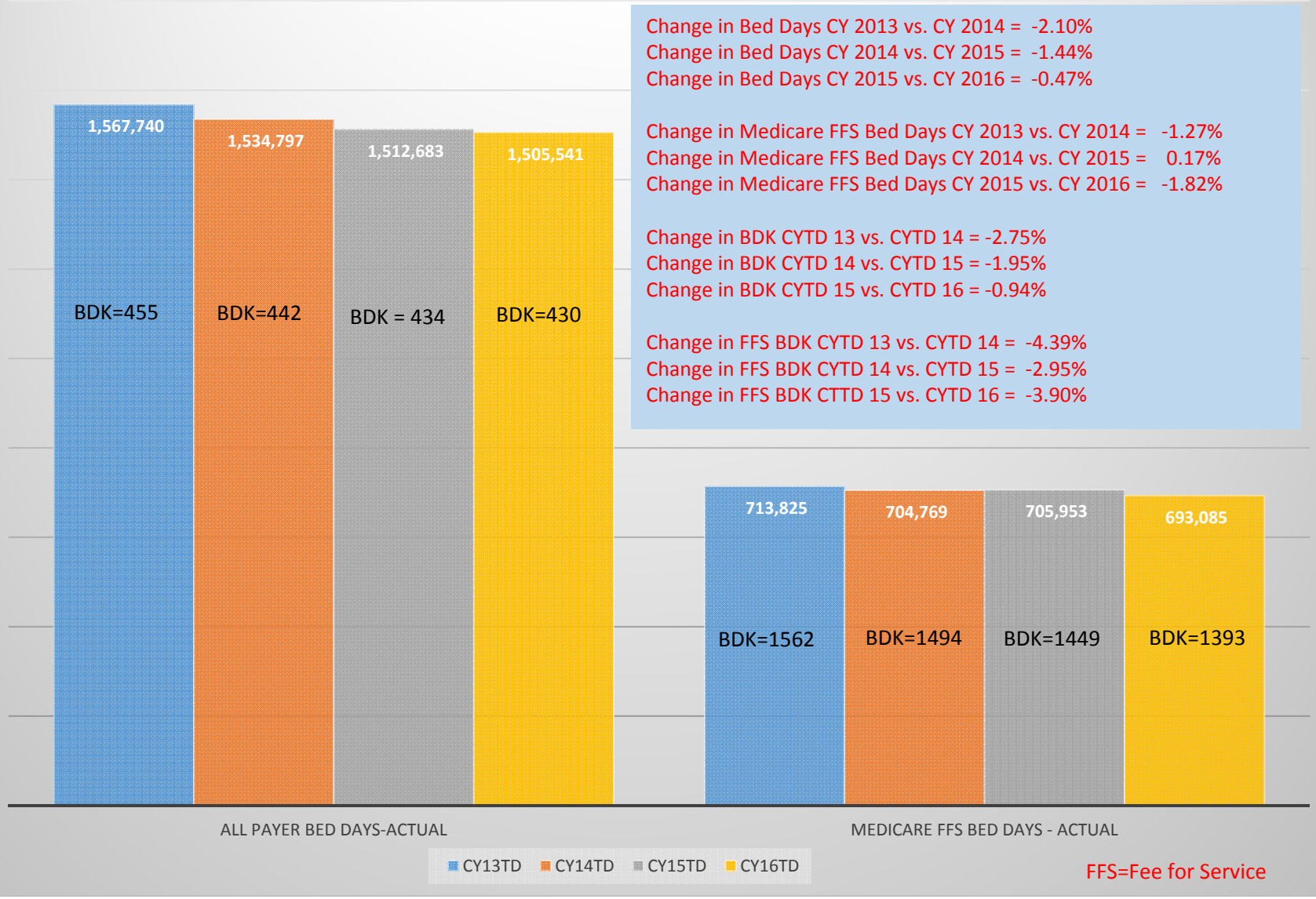
Annual Trends for Bed Days/1000 (BDK) Annualized
Medicare FFS and All Payer



*Note – The bed days do not include out of state migration or specialty psych and rehab hospitals.

Actual Bed Days by Calendar Year to Date Through July



Change in Bed Days CY 2013 vs. CY 2014 = -2.10%
Change in Bed Days CY 2014 vs. CY 2015 = -1.44%
Change in Bed Days CY 2015 vs. CY 2016 = -0.47%

Change in Medicare FFS Bed Days CY 2013 vs. CY 2014 = -1.27%
Change in Medicare FFS Bed Days CY 2014 vs. CY 2015 = 0.17%
Change in Medicare FFS Bed Days CY 2015 vs. CY 2016 = -1.82%

Change in BDK CYTD 13 vs. CYTD 14 = -2.75%
Change in BDK CYTD 14 vs. CYTD 15 = -1.95%
Change in BDK CYTD 15 vs. CYTD 16 = -0.94%

Change in FFS BDK CYTD 13 vs. CYTD 14 = -4.39%
Change in FFS BDK CYTD 14 vs. CYTD 15 = -2.95%
Change in FFS BDK CTTD 15 vs. CYTD 16 = -3.90%

FFS=Fee for Service

*Note – The bed days do not include out of state migration or specialty psych and rehab hospitals.

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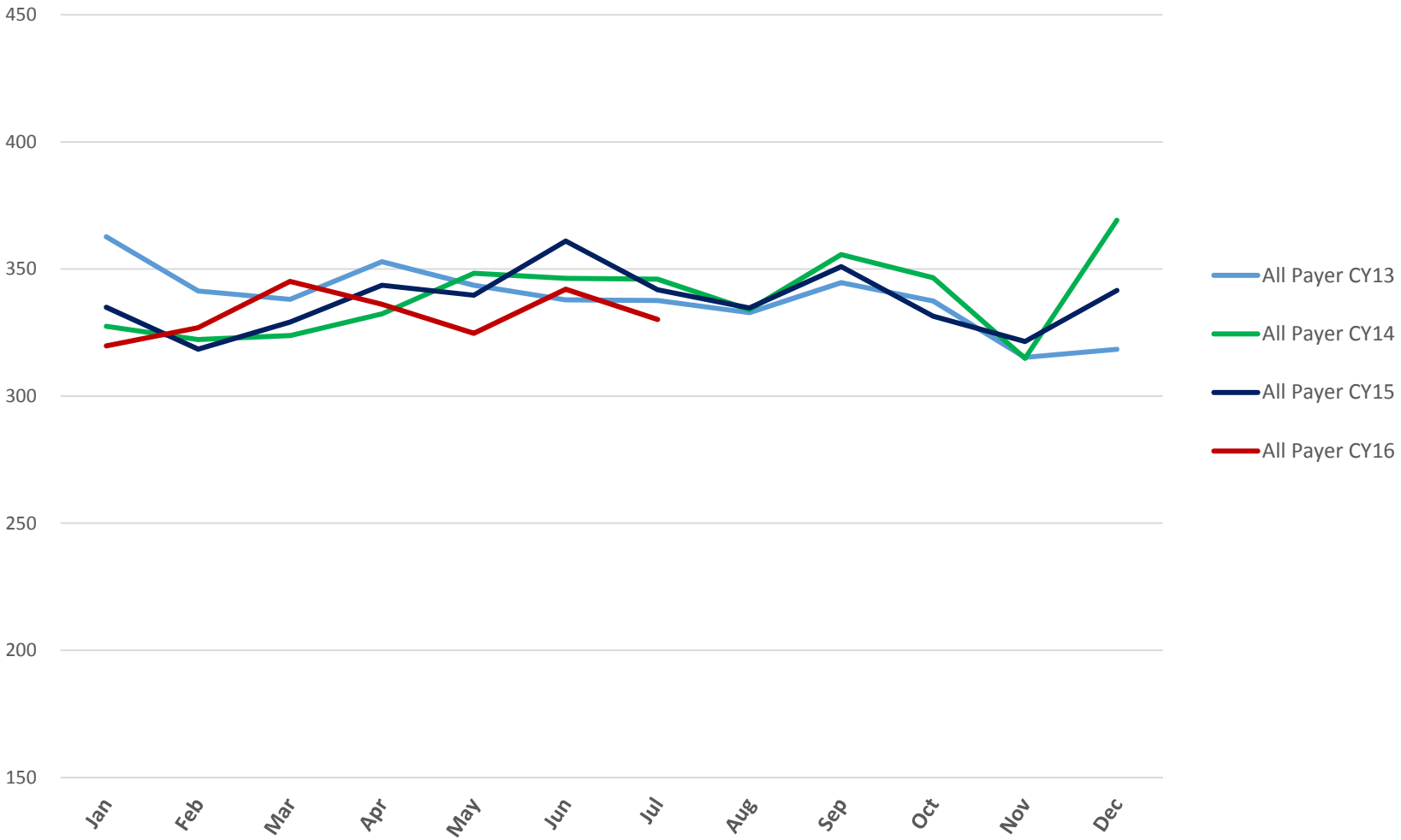
Annual Trends for ED Visits /1000 (EDK) Annualized All Payer



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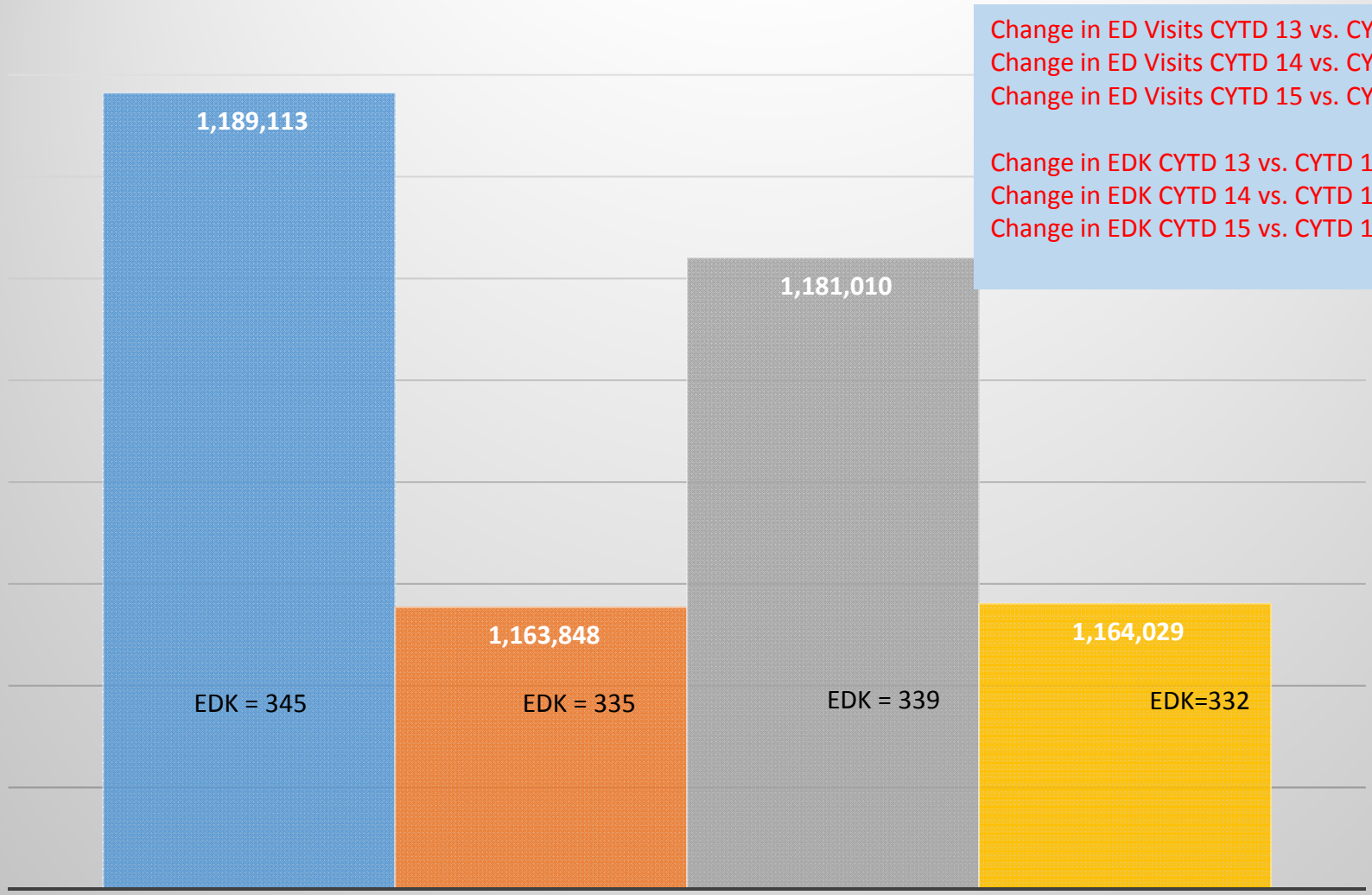
Actual ED Visits by Calendar YTD through July



Change in ED Visits CYTD 13 vs. CYTD 14 = -2.12%
Change in ED Visits CYTD 14 vs. CYTD 15 = 1.47%
Change in ED Visits CYTD 15 vs. CYTD 16 = -1.44%

Change in EDK CYTD 13 vs. CYTD 14 = -2.77%
Change in EDK CYTD 14 vs. CYTD 15 = 0.95%
Change in EDK CYTD 15 vs. CYTD 16 = -1.90%

*Note - The ED visits do not include out of state migration or specialty psych and rehab hospitals.

Purpose of Monitoring Maryland Performance

Evaluate Maryland's performance against All-Payer Model requirements:

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita
  - 3.58% annual growth rate
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of $330 million in savings over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets

Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 and Fiscal 2016 rely on Maryland Department of Planning projections of population growth of .52% for FY 16 and .52% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

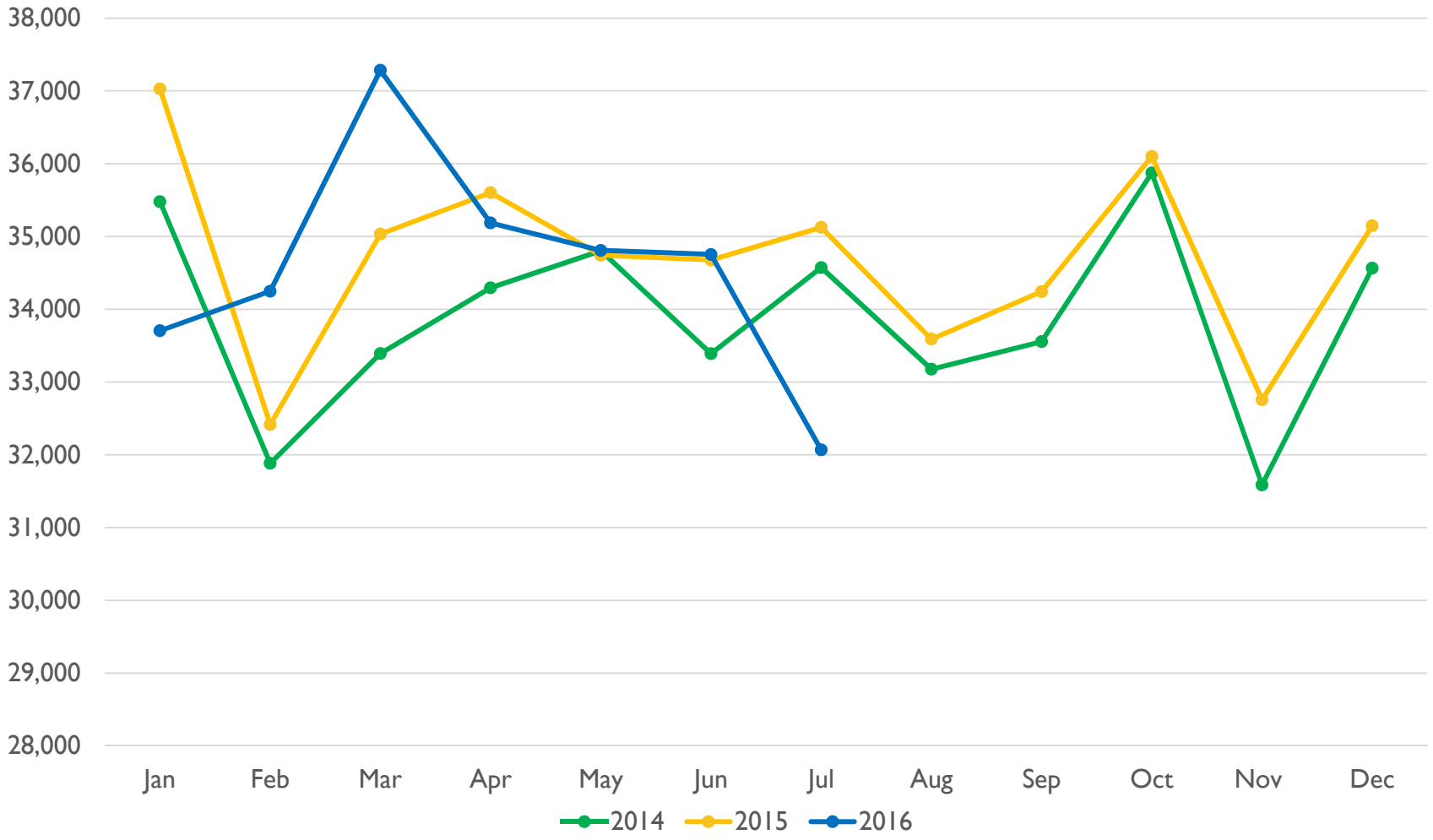
Data Caveats cont.

- The source data is the monthly volume and revenue statistics.
- ADK – Calculated using the admissions multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- BDK – Calculated using the bed days multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- EDK – Calculated using the ED visits multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- All admission and bed days calculations exclude births and nursery center.
- Admissions, bed days, and ED visits do not include out of state migration or specialty psych and rehab hospitals.

Monitoring Maryland Performance
Preliminary Utilization Trends

2016 vs 2015
(January to July)

Medicare MD Resident ECMAD Growth by Month



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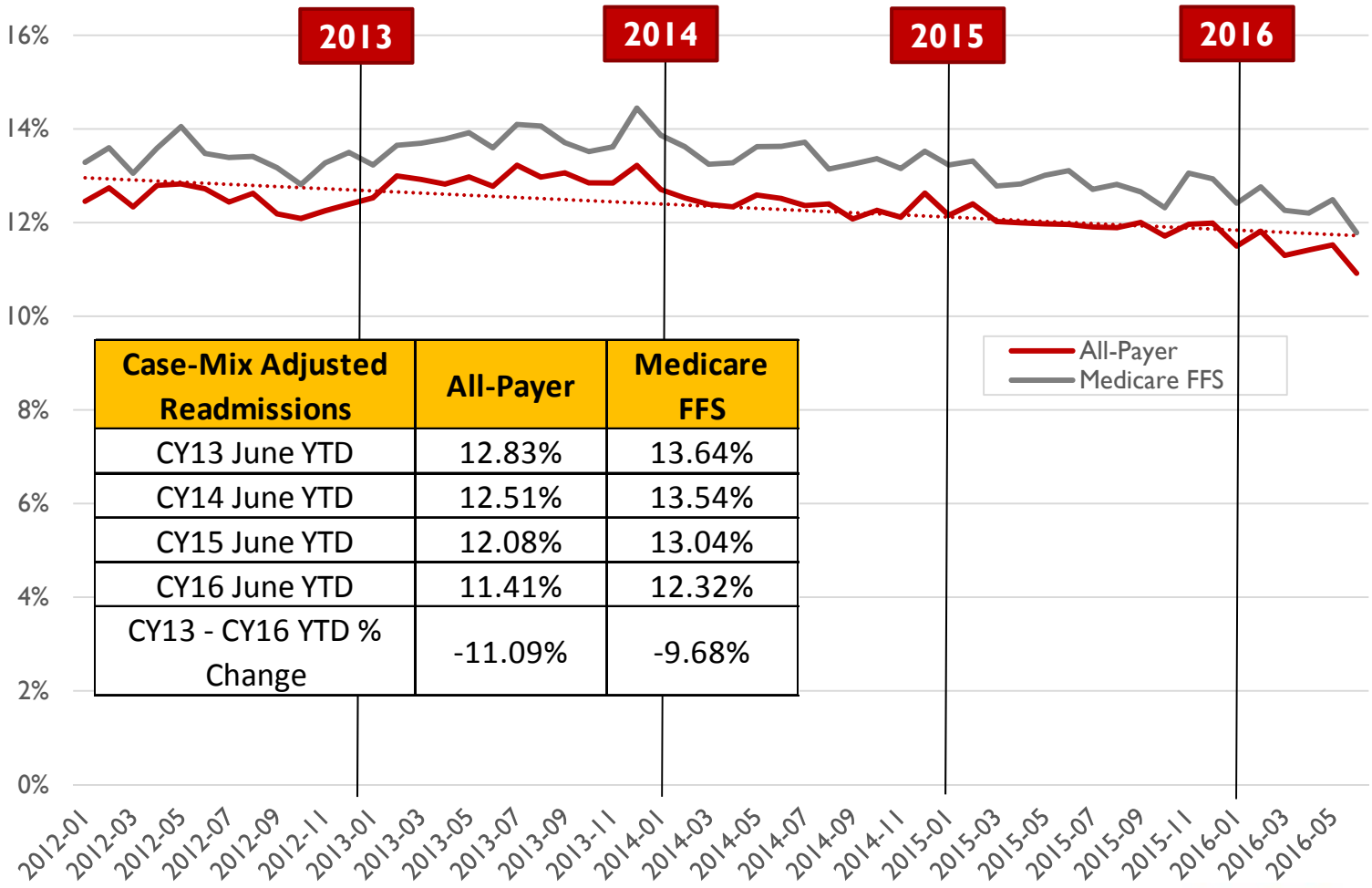
Monitoring Maryland Performance
Quality Data

September 2016 Commission Meeting Update

Monthly Case-Mix Adjusted Readmission Rates



Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
CY13 June YTD	12.83%	13.64%
CY14 June YTD	12.51%	13.54%
CY15 June YTD	12.08%	13.04%
CY16 June YTD	11.41%	12.32%
CY13 - CY16 YTD % Change	-11.09%	-9.68%

Note: Based on final data for January 2012 – March 2016, and preliminary data through July 2016.

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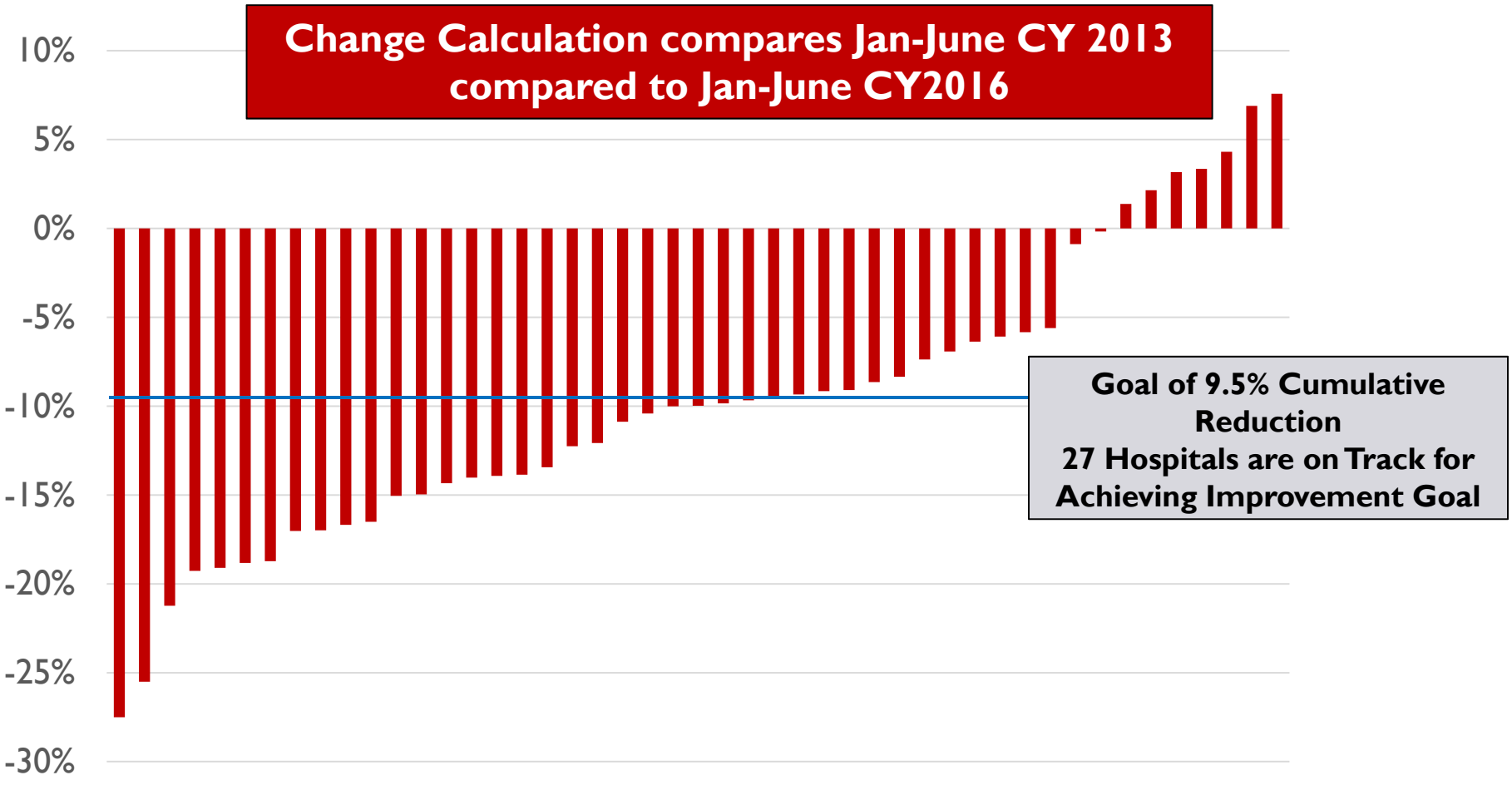
Change in All-Payer Case-Mix Adjusted Readmission Rates by Hospital



Note: Based on final data for January 2012 – March 2016, and preliminary data through July 2016.

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Potentially Avoidable Utilization Update

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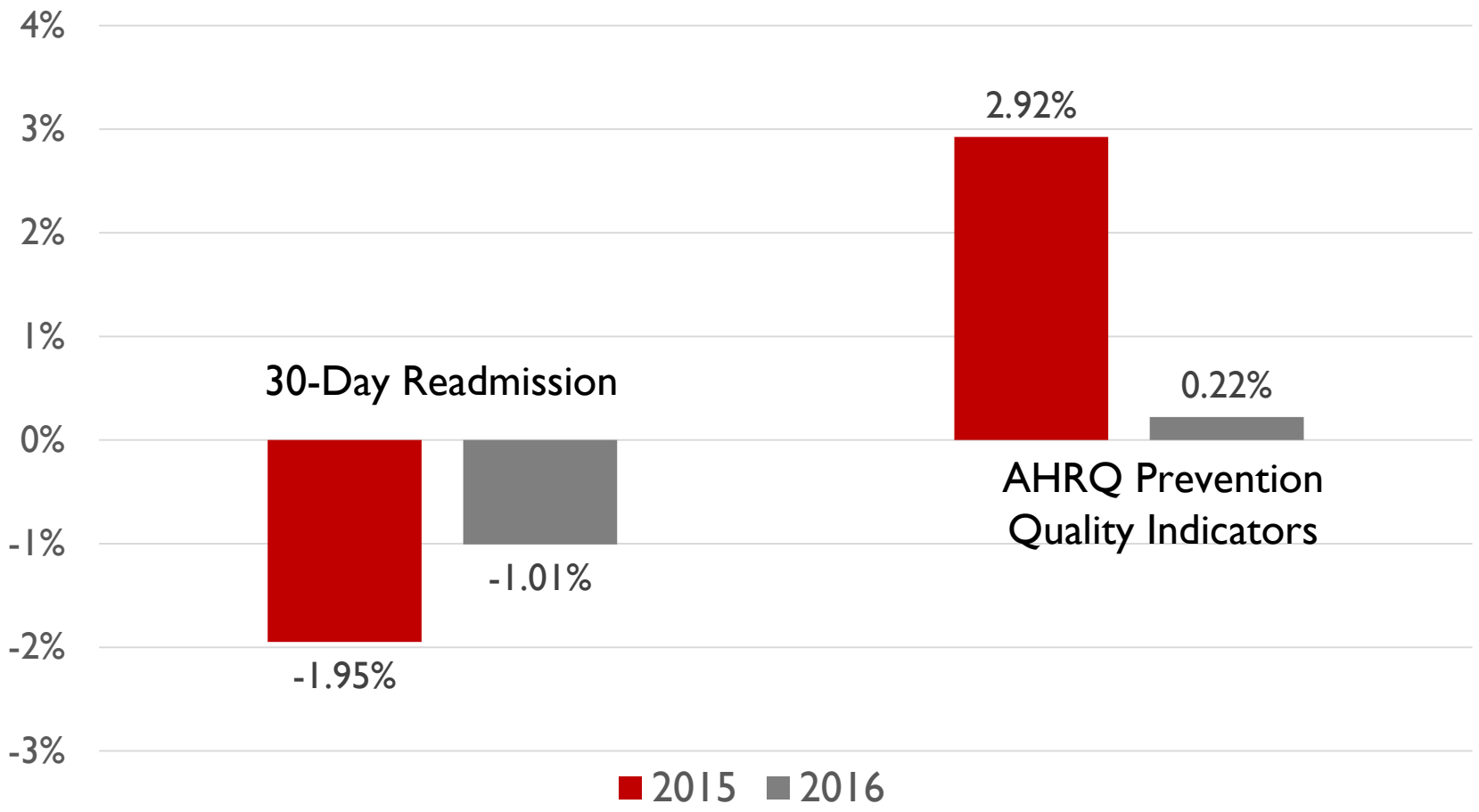
All Payer Readmission and Prevention Quality Indicator ECMAD Annual Growth – CYTD June



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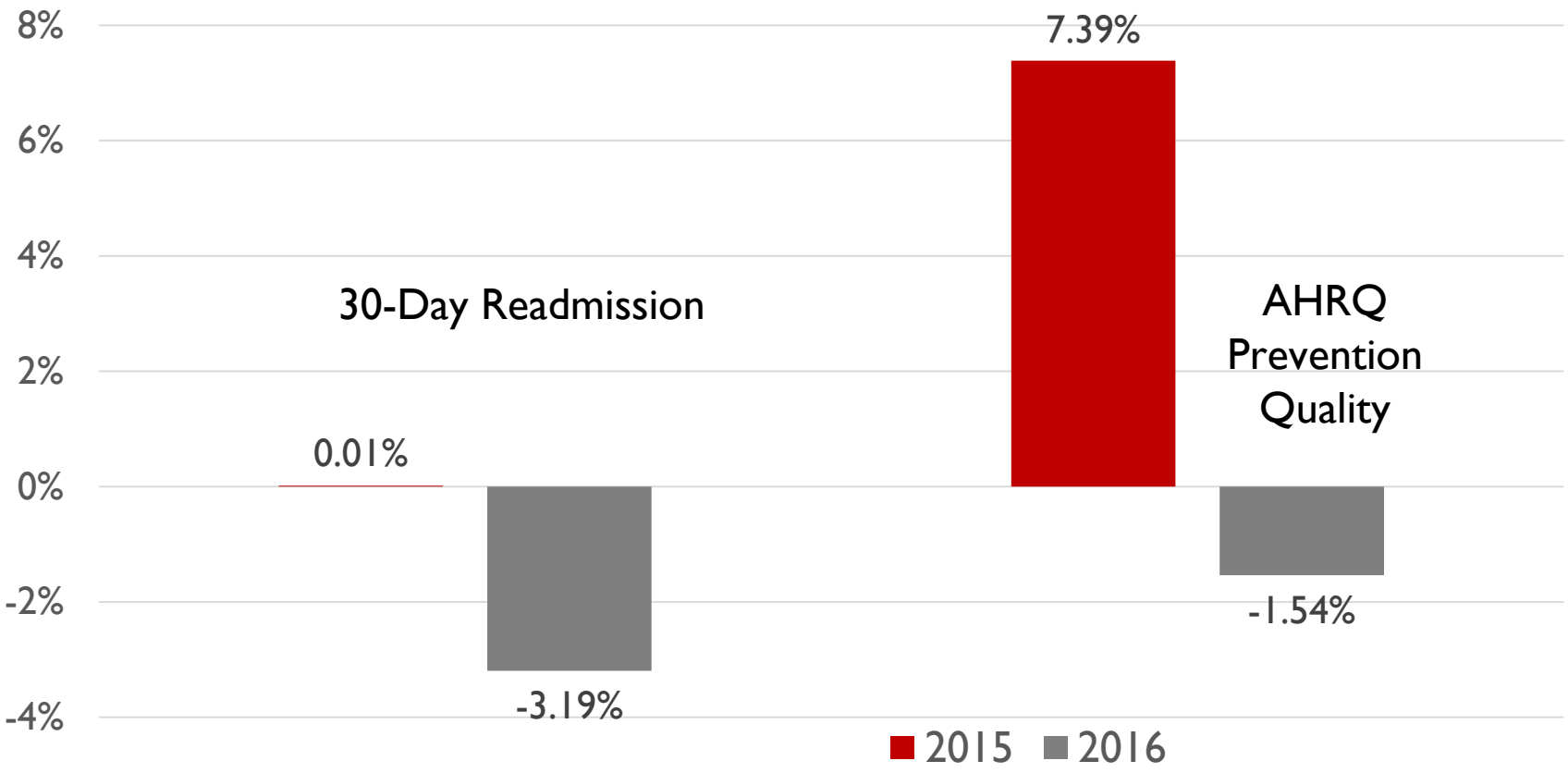
Medicare FFS Readmission and Prevention Quality Indicator ECMAD Annual Growth – CYTD June



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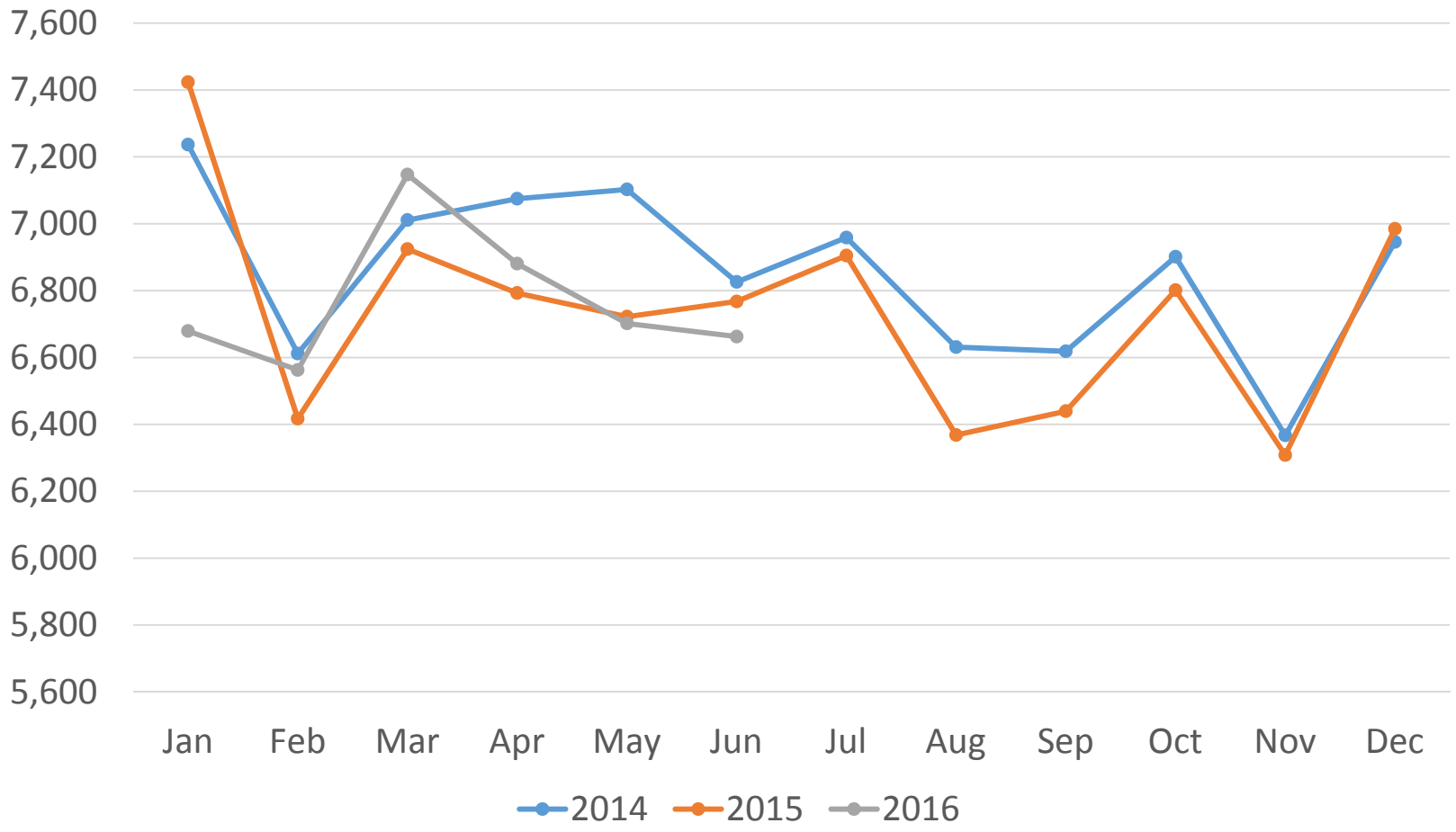
All-Payer Readmission ECMAD Growth by Month



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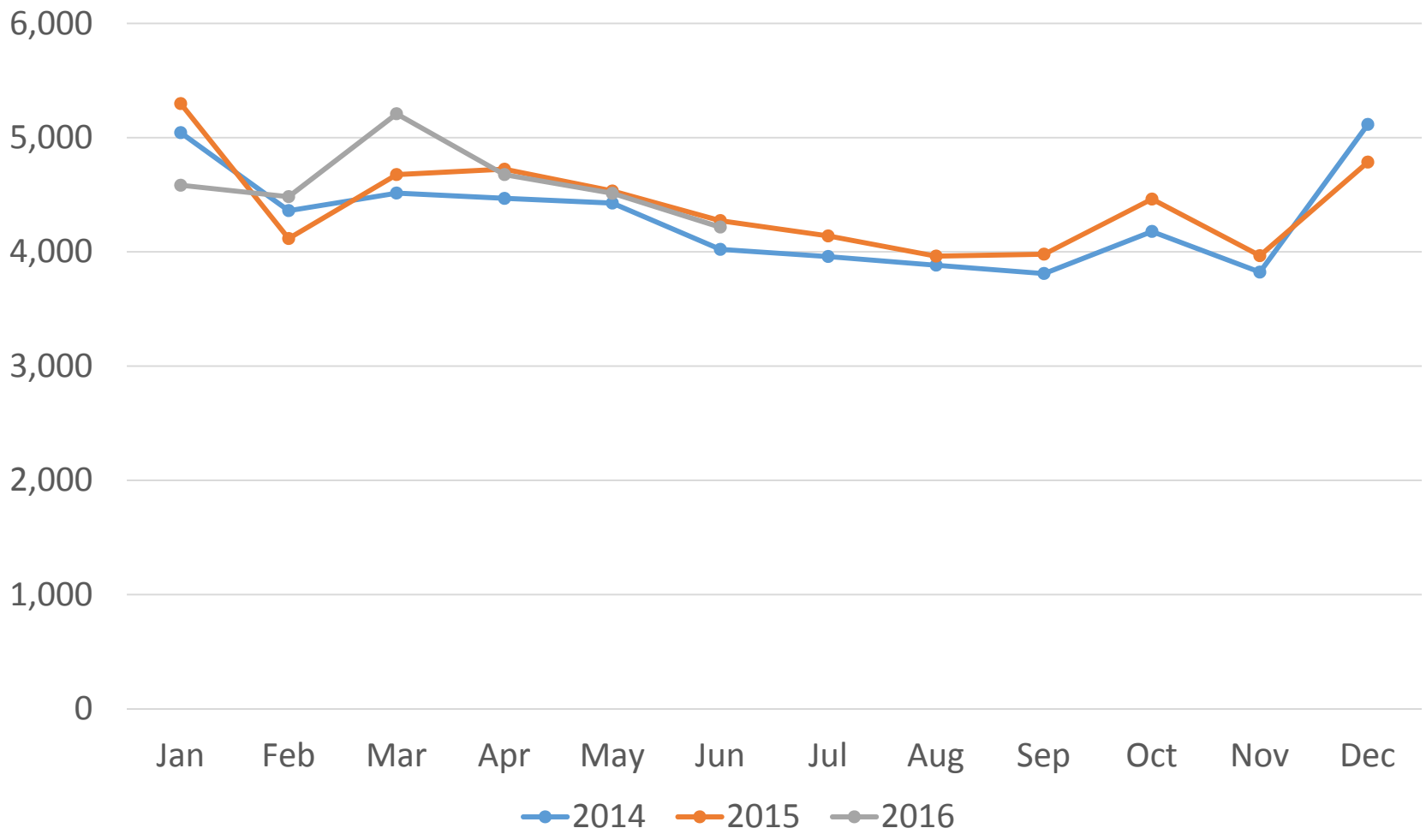
All-Payer PQI ECMAD Growth by Month



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H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF SEPTEMBER 7, 2016

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2319R	Sheppard Pratt Health System	11/24/2015	9/14/2016	9/14/2016	CAPITAL	GS	OPEN
2350A	Johns Hopkins Health System	8/30/2016	N/A	N/A	ARM	DNP	OPEN
2351A	Johns Hopkins Health System	8/30/2016	N/A	N/A	ARM	DNP	OPEN
2352N	MedStar Harbor Hospital	9/6/2016	10/6/2016	2/3/2017	PSY & PDC	CK	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION *		**COMMISSION**
JOHNS HOPKINS HEALTH	*	**DOCKET: 2016**
SYSTEM	*	**FOLIO: 2160**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2350A**

Staff Recommendation

September 14, 2016

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on August 30, 2016, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for heart failure services and solid organ and bone marrow transplants with Optum Health, a division of United HealthCare Services, for a period of one year beginning October 1, 2016.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION ANDASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC

maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

The staff found the experience for this arrangement last year to be favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for heart failure, solid organ and bone marrow transplant services for a one year period commencing October 1, 2016. The Hospitals will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION *		**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2016**
SYSTEM	*	**FOLIO:**	**2161**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2351A**

Staff Recommendation

September 14, 2016

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on August 30, 2016 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to participate in a global rate arrangement for Bariatric Surgery Procedures with the Priority Partners Managed Care Organization. Inc., the Johns Hopkins Employer Health Programs, Inc., and the Johns Hopkins Uniformed Services Family Health Plan, for a period of one year beginning October 1, 2016.

II. OVERVIEW OF APPLICATION

The contract will be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

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The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

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The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from

any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

After reviewing the Hospital experience data, staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Bariatric Surgery Procedures for a one year period commencing October 1, 2016. The Hospitals will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Final Recommendation for the Garrett Regional Medical Center Award under the Population Health Workforce Support for Disadvantaged Areas Program (PWSDA)

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

This final recommendation for the Garrett Regional Medical Center was approved at the September 14, 2016 Commission Meeting. The Baltimore Population Health Work Force Collaborative Proposal remains a Draft Recommendation and the comment period has been extended to September 30, 2016. Please submit any comments to Erin Schurmann at Erin.Schurmann@maryland.gov.

Table of Contents

OVERVIEW

The Maryland Department of Health and Mental Hygiene (Department or DHMH) and the Maryland Health Services Cost Review Commission (HSCRC or Commission) are recommending that the Garrett Regional Medical Center proposal for a competitive Population Health Workforce Support for Disadvantaged Areas Program (PWSDA) grant be funded, beginning in fiscal year (FY) 2017. This recommendation follows the Commission's decision in December 2015 authorizing up to $10 million in hospital rates for hospitals that commit to train and hire workers from geographic areas of high economic disparities and unemployment. These workers will fill new care coordination, population health, health information exchange, health information technology, consumer engagement, and related positions. The ultimate goals of the program are to create community-based jobs that pay reasonable wages, contribute to improving population health in Maryland, and further the goals of the All-Payer Model.

The PWSDA program will continue through June 30, 2018, on a hospital-specific basis assuming the hospital's ongoing compliance with the grant requirements. The grants could be renewed as of July 1, 2018, for an additional period if the Commission finds that the program is effective.

BACKGROUND

The Commission received three proposals for award funding. Commission staff established an independent committee to review the grant proposals and make recommendations to the Commission for funding. The PWSDA Implementation Award Review Committee (Review Committee) included representatives from the Department, the Commission, and other subject matter experts, including individuals with expertise in such areas as population health, health disparities, workforce development and adult learning, health education, healthcare career advancement, and workplace and employee wellbeing.

Following a comprehensive initial review, two of the three proposal applicants were invited to provide clarifying information related to their proposal. The full proposals of the two applicants that are being considered for approval (Garrett Regional Memorial Hospital being recommended for approval in this recommendation, and Baltimore Population Health Work Force Collaboration which is still in draft status) may be found on the Commission's website at http://www.hscrc.maryland.gov/rfp-pwsda.cfm.

At this time, the Review Committee is pleased to present this recommendation to the Commission. The Review Committee is strongly encouraged that this proposal will leverage the unique position that hospitals hold as economic pillars of their communities and create strong partnerships with community-based providers to respond to ongoing socioeconomic and health disparities in Maryland. This recommendation reflects the Review Committee's recommendations to grant a total of $221,485 in hospital rates to Garrett Regional Medical Center under the PWSDA program in FY 2017.

COMPETITIVE POPULATION HEALTH WORKFORCE SUPPORT FOR DISADVANTAGED AREAS PROGRAM REQUEST FOR PROPOSALS

In order to improve population health and address disparities in the community, the Department, in collaboration with the HSCRC, released a request for proposals (RFP) for funding to implement PWSDA on May 1, 2016. HSCRC received three applications by the extended due date of June 30, 2016.

The RFP invited proposals to support job opportunities for individuals who reside in neighborhoods with a high area deprivation index (ADI), and thus enable low-income urban, suburban, and rural communities to improve their socioeconomic status while working to improve population health. The overall objective is to address the social determinants of health and assist hospitals in bolstering population health and meeting the goals of the All-Payer Model.

The RFP limits the award total to $10 million in hospital rates over a three-year period, with the condition that hospitals provide matching funds of at least 50 percent of the amount included in their rates. The applicants were required to explain how they will use the increase in rates to support the training and hiring of individuals consistent with the program.

Funding will be allocated through HSCRC-approved rate increases for hospitals that train and/or hire individuals from deprived areas, with the expectation of reducing potentially avoidable utilization for Medicare and promoting population health in Maryland. Awardees will be required to report on the status of their ongoing implementation activities within six months of the initial award and annually thereafter.

THE REVIEW COMMITTEE AND EVALUATION CRITERIA

The Review Committee gave preference to those models that included the following characteristics/features:

- Specific target population that could be trained and recruited to bolster population health and help reduce hospital utilization
- Strong collaboration with community organizations that will facilitate recruitment of potential trainees who live in disadvantaged communities
- Efficient training to provide to selected individuals who will be employed in health-related positions, (e.g., community healthcare workers, peer recovery specialists, case managers, patient care workers, transport facilitators, etc.)
- Defined settings where trained workers can deliver the intended services to patients and other community members and contribute to promoting the health of the Maryland population
- Consistency with the goals of the All-Payer Model
- Focus on patient-centered care

- Valid implementation plan
- Reasonable budget

The Review Committee established evaluation and weighting criteria in each of the following categories:

1. Needs assessment (the disadvantaged community and the target workforce) -10 points
2. Work plan (partnership(s) with community organization(s), type of training, qualifications of the trainees, implementation, and employment retention) - 30 points
3. Evaluation (tracking and reporting; strategy to evaluate process and outcomes) -10 points
4. Sustainability, impact, and replicability by others -15 points
5. Resources (community resources, trainers, and organizations) -10 points
6. Support requested (budget and its justification) – 25 points

The Review Committee gave preference to those proposals that included the following characteristics/features:

- The likelihood that the proposed programs would be successful in reducing avoidable utilization and improving population health
- The operational readiness and sustainable staffing detail of the proposal
- The overall feasibility of the proposal to be successful

RECOMMENDATIONS

Recommended Awardees

Based on its review, the Review Committee is currently recommending the following grant proposal for FY 2017 funding:

- Garrett Regional Medical Center Health Work Force Support Program:
    - $221,485 to be phased in over three years based on proposed expenses.
    - At least 50 percent of hires through the program must be Maryland residents

Table 1 below lists the recommended awardee, the requested and recommended award amounts from rates, and the hospitals affected. A summary of each recommended proposal may be found in the Appendix.

Table 1. Recommended Awardee

Applicant	Award Request	Rate Award Amount	Hospital(s) in Proposal
Garrett Regional Medical Center Health Work Force Support Program	$221,485	$221,485	Garrett Regional Medical Center
Total		**$221,485**	

REPORTING AND EVALUATION

The December 2015 approved Commission recommendations required that:

- Hospitals receiving funding under this program shall report to the Commission by May 1, 2017, and each year thereafter on:
    - The number of workers employed under the program
    - How many of those workers have been retained
    - The types of jobs that have been established under the program
    - How many patients or potential patients have been assisted through these positions
    - An estimate of the impact that these positions have had in reducing potentially avoidable utilization or in meeting other objectives of the All-Payer Model
- Awardees report periodically to the Commission on their program, including an annual report beginning on May 1, 2017
- The Commission evaluate the effectiveness of the program prior to July 1, 2018, to determine if the program should be continued in general, or for individual hospitals
- The Commission utilize external resources in collecting and evaluating proposals, reporting on the results of implementing the program, and assisting in evaluating its effectiveness

Following Commission approval of the awards, staff will provide each awardee with a template for monitoring and reporting on the performance of the programs in meeting the goals of the All-Payer Model and consistency with the application proposal. The Commission reserves the right to terminate or rescind an award at any time for material lack of performance or for not meeting the letter or intent of an application. Pursuant to the Commission mandate, staff will review the program before June 30, 2018, on each hospital's compliance with program requirements and to determine whether the program overall is meeting the Commission's goals. Staff will propose recommendations to the Commission based on their findings.

APPENDIX

Garrett Regional Medical Center Health Work Force Support Program

Applicant	Garrett Regional Medical Center
Date of Submission:	05/31/2016 original submission, 06/27/2016 revised submission
Health System Affiliation	N/A
Total Rate Request ($)	$221,485

Summary of the Proposal
Garrett Regional Medical Center proposes to partner with Garrett College and the Garrett County Health Department to provide health education and care coordination for high utilizers of inpatient care. High utilizers of hospital services are enrolled in "the well patient program" that is managed by a social worker and nurse navigator, who will identify the potential recipients for the PWSDA program. They will identify high-needs patients from "the well patient program" who could be a good fit for the workforce development program, and enlist the help of Garrett College instructors to train these individuals as community healthcare workers, transport facilitators, or liaisons for medical services. The opportunity to attend the training that will focus on chronic diseases will also be offered to the recipient's family. Those who complete the training will become hospital staff to provide services in homes, community centers, and local churches. They will also be supervised by community outreach mentors under the auspice of the Garrett County Health Department. Once hospital employees, the recipients will have opportunities for continuing education with tuition remission and, eventually, when they move to other jobs, they will be replaced by other individuals from the region. Over the three year period, the Medical Center will train and hire 5 individuals from deprived areas in Maryland and neighboring West Virginia.

Work Plan	
Fall 2015	1. The Well Patient Program was initiated. 2. The hospital's designated social worker and nurse navigator identified high utilizers of the hospital resources and their specific needs.
Following HSCRC approval of the program	1. Identified patients/program recipients will be trained as CHWs by Garrett College. 2. New trainees, under the supervision of the social worker or nurse navigator, will meet with the patients they will be assisting. 3. Additional two weeks of training on safety practices and infection control. 4. Trained individuals will be deployed in the community. 5. Trainees' performance will be evaluated annually. 6. Metrics will be collected from the start.

CRISP

CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS

CRISP Medicare Data Update

HSCRC Commissioners Meeting

September 14, 2016

7160 Columbia Gateway Drive, Suite 230
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

Data Supports the Waiver Amendment

Maryland has proposed an Amendment to the All-Payer Model that will provide access to the following **tools**:

- **Detailed, person-centered Medicare data (beyond hospital data across care continuum) for care coordination and care redesign**
- **Medicare Total Cost of Care data for planning and monitoring**
- Approvals for sharing resources for care coordination and care improvement
- Approvals for hospitals to share savings with non-hospital providers

Data Supports the Waiver Amendment

Current initiatives:

- HSCRC case mix-driven PaTH and High Utilizer reporting
- GBR PSA level TCOC reports (KPMG) – available this month
- Patient-level (but not identifiable) episodes analysis (hMetrix) – available by mid-October
- CMS CCLF Data (patient identifiable) available to hospitals and CRISP as of 1/1/17

Proposed Vendor Requirements

Medicare Data System

- Land Medicare data in a secure repository where it is accessible for desired downstream uses
- Transform data to create consistent, standard elements according to industry standards and best practices
- Consume data in a variety of potential methods
- Integrate to enable appropriate flow of data across the entire system

Analytics Engine

- Provide/develop/apply an analytics engine(s) to generate a suite of reports to primarily health care provider

Conceptual Model and Analytics Sets

Analytics Set #1: Hospital Information Delivery Product: refinements and ongoing support to the hospital information delivery product; allow for certain data extracts as permissible by CMS

Analytics Set #2: Data for HSCRC Administrative and Monitoring Functions: analytics for program monitoring and administration by hospitals and the HSCRC and other program administration entities; HSCRC and CRISP will determine data specifications early in the Phase of effort

Analytics Set #3: Information Delivery Product for Other Providers: provide/develop and deliver reports to support care coordination use cases with ambulatory practices and other non-hospital providers

Analytics Set #4: Information for CRISP Functions: provide analytics for CRISP administration/ monitoring of the solution through metadata; conceptualize integration strategies with other CRISP data and services

RFP Process On Schedule

Event	Approximate Dates	Notes
CRISP Issues RFP	June 22, 2016	Any proposal updates will be issues on the CRISP website
Bidders Conference	June 29, 2016	1pm ET
Intent to Respond	July 8, 2016	Email to Laura Mandel Laura.Mandel@crisphealth.org
Clarifications and Q&A	July 15, 2016	Ongoing then finalized on CRISP website
Vendor RFP Responses Due to CRISP	August 10, 2016	Email proposals by 5pm ET to Laura Mandel Laura.Mandel@crisphealth.org
Prescreen Responses	August 16, 2016	Bill, Craig, Mary, Laura Select 6 – 8 vendors
Selection Committee Meets	August 26, 2016	Select 3 – 4 vendors
Vendor Interviews and Demonstrations, Reference Review	September 12-16, 2016	CRISP will contact selected bidders to schedule interviews
CRISP Issues Final Specifications	September 23, 2016	Final specifications emailed to selected bidders
Vendors Submit Final Response and Financial Bid/BAFO	September 30, 2016	Responses submitted to Laura Mandel Laura.Mandel@crisphealth.org
Vendor Selection and Contracting	October 9, 2016	
Prepared to Land Data	January 1, 2017	Estimated delivery date from CMMI

RFP Process Update

- Vendor selection committee selected 5 vendors for in-person interviews/product demonstrations
  - CRISP Staff and CRISP Workgroup Members, (Hospital representatives, HSCRC, MHA)
- Holding in-person interviews and product demonstrations this week, reference calls on going
  - Includes selection committee, plus any additional members of the RAC and Technology Committee
- CRISP Board briefed
- HSCRC Commissioners briefed

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-201, and 19-211; Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to add Regulation **.0 7-2** under **COMAR 10.37.10 Rate Application and Approval Procedures** . This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on September 14, 2016, notice of which was given pursuant to General Provisions Article, § 3-302(c), Annotated Code of Maryland. If adopted, the proposed regulation will become effective on or about January 16, 2017.

Statement of Purpose

The purpose of this action is to designate those outpatient services provided at a freestanding medical facility that are subject to Health Services Cost Review Commission rate regulation in conformance with newly enacted law.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

See Statement of Economic Impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or (410) 764-2576, or fax to (410) 358-6217, or email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed regulation until November 14, 2016. A hearing may be held at the discretion of the Commission.

.07-2 Outpatient Services – Freestanding Medical Facility

A. Definition. In this regulation, "freestanding medical facility" means a freestanding medical facility licensed under Subtitle 3A of Title 19 of the Health-General Article.

B. The following outpatient services provided at a freestanding medical facility are considered "hospital services" under Health-General Article §19-201:

(1) Emergency Services

(2) Observation Services

(3) Associated Ancillary Services, such as laboratory, radiology, imaging, EKG, and Medical/Surgical Supplies and Drugs

C. In accordance with Health-General Article §19-201, Annotated Code of Maryland, the Commission's rate setting jurisdiction extends to those outpatient services provided at a freestanding medical facility, as designated by the Commission.

D. A freestanding medical facility or a proposed freestanding medical facility that desires to provide a service not designated in paragraph B above (an "undesignated service") must receive a determination under the provisions of this regulation.

E. Commission Approval.

(1) A freestanding medical facility may not charge a Commission-approved rate for an undesignated service without prior Commission staff approval.

(1) A freestanding medical facility may not open a new outpatient service, relocate an existing outpatient service, or convert an existing outpatient service from regulated or unregulated status without a prior determination from the Commission's staff as to whether the service constitutes a hospital service subject to Commission rate regulation. A request for determination shall be made in writing at least 60 days before the contemplated action.

F. Upon request for a determination, the Commission's staff shall:

(1) Review the information presented;

(2) Consult with appropriate parties;

(3) Visit the site of the service as it considers necessary; and

(4) Notify the freestanding medical facility of its determination as soon as practicable.

G. In deciding whether the service constitutes a "hospital service" subject to Commission rate regulation, Commission staff shall consider, among other things, the following criteria:

(1) Cost of the service;

(2) In consultation with Maryland Health Care Commission (MHCC) staff, access to and need for the service in the community;

(3) Feasibility of providing the outpatient service in the community on an unregulated basis; and

(4) Impact of the service on the All-Payer Model including, but not limited to, the Total Cost of Care limitations as prescribed in the All-Payer Model Agreement with the Center for Medicare and Medicaid Innovation.

H. Based on the consideration of the criteria stated in §G of this regulation, the Commission staff shall make its determination on the request made under §E of this regulation within a reasonable period of time, taking into account, among other things, whether either a Certificate of Need application to establish a freestanding medical facility or a request for exemption from Certificate of Need to convert a licensed general hospital to a freestanding medical facility is pending before the MHCC and, if so, the time frame for staff to comment to MHCC on the financial feasibility of the proposed project.

I. A freestanding medical facility that fails to obtain, or violates, a staff determination on the regulated status of a given service may be subject to fines for inaccurate reporting under COMAR 10.37.01.03R and paybacks for inappropriate charges made during the time a staff determination on an outpatient service was not obtained or adhered to.

NELSON SABATINI
Chairman
Health Services Cost Review Commission

IMPACT STATEMENTS

PART A
(check one option)

ESTIMATE OF ECONOMIC IMPACT

_____ The proposed action has no economic impact.

OR

_X_ The proposed action has an economic impact.

I. Summary of Economic Impact.

The purpose of this action is to designate those outpatient services provided at a Freestanding Medical Facility that are subject to Commission rate regulation in conformance with newly enacted legislation.

II. Types of Economic Impacts.		Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A.	On issuing agency:	N/A	
B.	On other State agencies:	N/A	
C.	On local governments:	N/A	
		Benefit (+) Cost (-)	Magnitude
D.	On regulated industries or trade groups:	+	Moderate
E.	On other industries or trade groups:	-	Moderate
F.	Direct and indirect effects on public:	+	Moderate

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

D. This assumption is based on the expectation that hospitals will receive Commission approved rates for the outpatient service(s) provide, which are reasonably related to costs incurred.

E. This assumption is based on payers not being able to negotiate rates for these services, but will be required to pay Commission approved rates, which will tend to be higher than rates negotiated.

F. This assumption is based on the expectation that the public will gain access to these services, and that the charges will be certified as reasonable, to be paid by all payers, by the HSCRC.

PART B

(Check one option)

Economic Impact on Small Businesses

_X_ The proposed action has minimal or no economic impact on small businesses.

or

_____ The proposed action has a meaningful economic impact on small businesses. An analysis of this economic impact follows.

Impact on Individuals with Disabilities

(Check one option)

_X_ The proposed action has no impact on individuals with disabilities.

or

_____ The proposed action has an impact on individuals with disabilities as follows:

Opportunity for Public Comment

PART C

(For legislative use only; not for publication)

A. Fiscal Year in which regulations will become effective: FY 2017.

B. Does the budget for fiscal year in which regulations become effective contain funds to implement the regulations:

_X_ YES ___ NO

C. If "yes", state whether general, special (exact name), or federal funds will be used:

100% Special Funds, Hospital Assessments

D. If "no", identify the source(s) of funds necessary for implementation of these regulations:

N//a

E. If these regulations have no economic impact under Part A., indicate reason briefly:

N/A

F. If these regulations have minimal or no economic impact on small businesses under Part B, indicate the reason. These regulations do not target small businesses, but rather the healthcare environment generally.

N/A

State of Maryland
Department of Health and Mental Hygiene

Nelson J. Sabatini
Chairman

Herbert S. Wong, PhD
Vice-Chairman

Joseph Antos, PhD

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Donna Kinzer
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Stephen Ports, Director
Center for Engagement and Alignment

Sule Gerovich, PhD, Director
Center for Population Based Methodologies

Chris L. Peterson, Director
Center for Clinical and Financial Information

Gerard J. Schmith, Director
Center for Revenue and Regulation Compliance

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **September 14, 2016**

RE: **Hearing and Meeting Schedule**

October 19, 2016	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
November 9, 2016	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:45 a.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at http://www.hscrc.maryland.gov/commission-meetings-2016.cfm

Post-meeting documents will be available on the Commission's website following the Commission meeting.