Closed Session Minutes
Of the
Health Services Cost Review Commission

January 13, 2016

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

1. Update on Contract and Modeling of the All-Payer Model vis-à-vis the All-Payer Model Contract
2. Review of All-Payer Model Contract Progression

The Closed Session was called to order at 12: 05 p.m. and held under authority of § 3-104 of the General Provisions Article.

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

In attendance representing Staff were Donna Kinzer, Steve Ports, Sule Gerovich, Jerry Schmith, Claudine Williams, Amanda Vaughn, Jessica Lee, and Dennis Phelps.

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

Item One

Donna Kinzer, Executive Director, and Eric Lindeman, Commission Consultant, presented and the Commission discussed analyses of Medicare per beneficiary data.

Item Two

Ms. Kinzer updated the Commission on All-Payer Model progression vision and strategy.

Before adjournment, Ms. Kinzer described the need for engaging additional personnel to meet the care coordination requirements of the All-Payer Model.

The Closed Session was adjourned at 1:09 p.m.

Closed Phone Conference Session Minutes
Of the
Health Services Cost Review Commission

January 26, 2016

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

1. Strategy regarding the All-Payer Model;

The Closed Session was called to order at 5:00 p.m. and held under authority of - §§ 3-103 and 3-104 of the General Provisions Article.

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

In attendance at the Commission's office representing Staff were Donna Kinzer, Steve Ports, and Jerry Schmith. Participating by telephone were Sule Gerovich, and Dennis Phelps.

Also participating by telephone was Stan Lustman, Commission Counsel.

Item One

Donna Kinzer, Executive Director, led a discussion on strategy for proceeding with the next stages of the All-Payer Model.

The Closed Session was adjourned at 6:00 p.m.

MINUTES OF THE
526th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

January 13, 2016

Chairman John Colmers called the public meeting to order at 12:05 pm. Commissioners Stephen F. Jencks, M.D., MPH, Jack C. Keane, Bernadette C. Loftus, M.D, Thomas Mullen, and Herbert S. Wong, Ph.D. were also in attendance. Upon motion made by Commissioner Keane and seconded by Commissioner Wong, the meeting was moved to Executive Session. Chairman Colmers reconvened the public meeting at 1:14pm.

REPORT OF THE JANUARY 13, 2016 EXECUTIVE SESSION

Mr. Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the December 4, 2015 and December 9, 2015 Executive Sessions.

ITEM I

REVIEW OF THE MINUTES FROM DECEMBER 9, 2015 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the December 4, 2015 and December 9, 2015 Executive Sessions and the December 9, 2015 Public Meeting.

ITEM II

EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, stated that the HSCRC convened a multi-agency Work Group, the ICN-Care Coordination Work Group, in May 2015 to focus on how to implement care coordination in Maryland. This Work Group provided a series of recommendations regarding the aggregation, use and sharing of data as required, to facilitate this process along with other recommendations regarding infrastructure and organization of care coordination.

The Chesapeake Regional Information System for our Patients (CRISP), the State's designated Health Information Exchange, has been charged with implementing infrastructure and aggregating and distributing data that can aid care coordination activities. Ms. Kinzer noted a key part of this effort is helping providers identify patients who may benefit from care coordination based on a comprehensive understanding of patient utilization, including utilization at different hospitals. CRISP has been working on the data sharing policy framework as well as the technical solution to support this work.

Ms. Kinzer stated that CRISP worked through their Reporting and Analytic Committee to

approve a Cross Facility Data Sharing Policy in September 2015. This policy was reviewed by CRISP's legal counsel and approved by the Department of Health and Mental Hygiene (DHMH) counsel in consultation with HSCRC counsel. This policy addresses how CRISP will use hospital case mix data in care coordination efforts. CRISP has had access to confidential hospital case mix data since April 2013. Use of this data has been governed by a Data Use Agreement (DUA) between the HSCRC and CRISP. The DUA has since been updated to ensure that any user of the confidential data strictly adheres to federal and state law and regulation on protecting the confidentially of Protected Health Information. Access to this data is strictly limited in its use for the purposes of care coordination, quality assessment, and quality improvement. Users are individually credentialed and must sign an End User Agreement with CRISP, in which they attest to understanding the limitations on the use of the data

Ms. Kinzer noted at today's meeting the ICN- Care Coordination Work Group will be presenting three reports to the Commission. They are as follows:

- Global Budget Infrastructure Investment Report- This report summarizes hospital reported expenditures relative to infrastructure. The Commission required that all hospitals report on their investments for fiscal year 2014 and 2015.
- Regional Partnership (RP) Report- This report summarizes the eight regional partnership reports on plans and activities. The RPs are a critical part of the State's approach to target high need/high resource patients in order to improve outcomes, lower costs, and enhance patient experience. The purpose of the RPs is to foster collaboration among hospitals together with community based partners to target services based on patient and population needs, collaborate on analytics, and plan and develop care coordination, chronic care management, and other approaches that reduce avoidable hospitalization.
- Strategic Hospital Transformation Plans (or STPs)- During the June 2015 Commission meeting, the Commission approved a recommendation that required all acute hospitals in the State to submit a plan to the Commission summarizing their short term and long term strategies and incremental investment plans for improving care coordination and chronic care, reducing potentially avoidable utilization, and aligning with nonhospital providers. this report summarizes the STPs.

Ms. Kinzer noted that bringing care coordination to scale is a very large and complex effort. She stated that there is an estimated 25,000 to 40,000 individuals who may be considered high need complex patients and who require intensive care coordination. She also noted that there are more than 200,000 Medicare and dually eligible (eligible for both Medicare and Medicaid) individuals with multiple chronic conditions, who need care plans and chronic care management. Ms. Kinzer stated that we need to work on both groups together to bring care coordination to the level that we need to have in the State.

Ms. Kinzer stated that hospitals and their partners have been working on implementation plans. Staff has received 22 applications that involve 45 hospitals requesting an additional $90 million in implementation funding. In June 2015, the Commission designated up to a 0.25% revenue

($40 million) increase to be awarded on a competitive basis. Before moving forward with additional funding, the staff must determine that funds already provided have been effectively deployed in care coordination activities, and that the plans described in applications are ready to be implemented and will have a significant near term positive impact on avoidable hospital utilization.

An independent review committee consisting of HSCRC, DHMH, CRISP, Maryland Community Health Resources Commission, payer staff and two contracted independent reviewers are meeting January 19, 2016 to go over the applications. Staff will report back to the Commission at the February 2016 Commission meeting.

Ms. Kinzer stated that DHMH submitted recommendations for Graduate Medical Education reforms to the Center for Medicare and Medicaid Innovation on December 18, 2015. This report is a requirement of Maryland's All-Payer Model and was developed by the Innovation in Graduate Medical Education Workgroup. The report can be found on the DHMH website httb://dhmh.maryland.gov/gme/SitePages/meetingings.asp. . Please contact Russ Montgomery if you have any questions at Russ.Montgomery@maryland.gov.

Ms. Kinzer noted that we have completed Year 2 of the Maryland All-Payer Model. The preliminary All Payer results, which are based on data collected by the HSCRC, will be available at the February 2016 Commission meeting. Ms. Kinzer stated that based on data collected by HSCRC through November 2015, we expect the All Payer limits to be met.
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The Medicare trend data, which are based on data provided by the federal government will not be finalized until mid-2016, although we will have preliminary results earlier. Medicare hospital trend data that are used to calculate the savings in the growth of Medicare hospital cost through October 2015 show that our CY 2015 over CY 2014 growth is slightly above the national average. The cumulative growth rate of Medicare hospital expenditures in CY 2015 over CY 2013 is still well below the national level. In regards to the total cost of care guardrail, as reported in previous meetings, staff has recently started to see some substantial growth in non-hospital costs in CY 2015 relative to reported national growth rates, particularly in post-acute care. In addition, staff is also beginning to see some growth in non-hospital "Part B" costs, which consist of physician and other outpatient claims costs. The data staff has received from Medicare at this point are accumulated only through July 2015; therefore it is too early to reach a final conclusion regarding the amount of cost growth for CY 2015. HSCRC's consultants are preparing total cost of care breakdowns by service and county, and we hope to have these data in the next several weeks. Ms. Kinzer noted that these data are preliminary and the results may change, so we must exercise caution in their use.

With the All-Payer Model having completed its second full year of operations, Ms. Kinzer reported that DHMH and HSCRC are reconvening the Advisory Council. The Council is needed to provide advice on the potential future directions for Maryland's health care improvement and population health initiatives and the All-Payer Model progression. In order to create sustainability of the exiting All-Payer Model, the delivery system needs to develop partnerships

and infrastructure that will help it improve with a resulting reduction in avoidable hospitalization and costs. The first meeting of the Council will be held on February 3, 2016 at the Maryland Hospital Association Conference Room.

Ms. Kinzer reported that staff is currently focused on the following activities:

- Reviewing implementation plans and conducting discussions regarding proposal, plans, and reports that have been provided to HSCRC for the purpose of assessing and understanding implementation progress and gaps, and readiness to accelerate community based care coordination and management.
- Organizing and preparing for the annual update.
- Reviewing several rate applications for capital that have been filed.
- Moving forward on updates to value-based performance measures, including efficiency measures.
- Turning to focus on per capita costs and total cost of care, for purposes of monitoring and also to progress toward a focus on outcomes and cost across the health care system.
- Preparing to work with DHMH and stakeholders to focus on ensuring success of the All-Payer Model and providing a proposal no later than January 2017 as required under the Agreement with CMS.

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 November focuses on fiscal year (July 1 through June 30) as well as calendar year results.

Ms. Vaughn reported that for the five month period ended November 30, 2015, All-Payer total gross revenue increased by 3.63% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 3.69%; this translates to a per capita growth of 3.15%. All-Payer gross revenue for non-Maryland residents increased by 3.03%.

Ms. Vaughn reported that for the eleven months of the calendar year ended November 30, 2015, All-Payer total gross revenue increased by 2.89% over the same period in CY 2014. All-Payer total gross revenue for Maryland residents increased by 3.15%; this translates to a per capita growth of 2.62%. All-Payer gross revenue for non-Maryland residents decreased by 0.28 %.

Ms. Vaughn reported that for the five months ended November 30, 2015, Medicare Fee-For-Service gross revenue increased by 4.50% over the same period in FY 2014. Medicare Fee-For-Service gross revenue for Maryland residents increased by 4.64%; this translates to a per capita growth of 1.67%. Maryland Fee-For-Service gross revenue for non-residents increased by 3.05%.

Ms. Vaughn reported that for the eleven months of the calendar year ended November 30, 2015, Medicare Fee-For-Service gross revenue increased by 4.34% over the same period in CY 2014. Medicare Fee-For-Service gross revenue for Maryland residents increased by 4.81%; this translates to a per capita growth of 1.64%. Maryland Fee-For-Service gross revenue for non-residents decreased by 0.89%.

According to Ms. Vaughn, for the five months of the fiscal year ended November 30, 2015, unaudited average operating profit for acute hospitals was 3.15%. The median hospital profit was 4.21%, with a distribution of .98% in the 25th percentile and 6.36% in the 75th percentile. Rate Regulated profits were 6.71%.

Ms. Vaughn reported that for the eleven months of the calendar year ended November 30, 2015 over the same period in CY 2014:

- All-Payer admissions decreased by 3.05%;
- All-Payer admissions per thousand decreased by 3.55%;
- Medicare Fee-For-Service admissions decreased by 0.67%;
- Medicare Fee-For-Service admissions per thousand decreased by 3.64%;
- All-Payer bed days decreased by 1.88%;
- All-Payer bed days per thousand decreased by 2.38%;
- Medicare Fee-For-Service bed days decreased by 0.68%;
- Medicare Fee-For-Service bed days per thousand decreased by 3.65%;
- All-Payer Emergency visits increased by 2.38%;
- All-Payer Emergency per thousand decreased by 2.38%.

ITEM IV

DOCKET STATUS CASES CLOSED

2307A - Johns Hopkins Health System
2322A- Johns Hopkins Health System
2323A – Johns Hopkins Health System
2324A - Johns Hopkins Health System
2325A - Priority Partners
2326A - Johns Hopkins Health System
2327A – Johns Hopkins Health System

ITEM V

DOCKET STATUS- OPEN CASES

NONE

ITEM VI

PERFORMANCE MEASUREMENT WORK GROUP UPDATE ON READMISSIONS

Dr. Sule Gerovich Ph.D., Deputy Director, Research and Methodology, presented the Performance Measurement Workgroup Update (see "Performance Measurement Workgroup Update" on the HSCRC website.

Dr. Gerovich noted about 25% of the hospitals had readmission rate increases; 33 % of hospitals are meeting the 9.3% reduction target; and the remaining hospitals have reduced their readmissions by less than 9.3%.

Ms. Traci La Valle, Vice President Rate Setting, Maryland Hospital Association questioned whether hospital penalties should be so large when we are meeting the waiver goals.

ITEM VII

FINAL RECOMMENDATION FOR MARYLAND HOSPITAL ACQUIRED CONDITIONS (MHAC) POLICY FOR RATE YEAR 2018

Ms. Diane Feeney, Associate Director Quality Initiatives and Dr. Gerovich, presented the staff's final recommendation for modifications to the Maryland Hospital Acquired Conditions (MHAC) Program for FY 2018 (See "Final Recommendations for Modifying the Maryland Hospital Acquired Conditions program for FY 2018" on the HSCRC website).

The HSCRC's quality-based payment methodologies are important policy tools for providing strong incentives for hospitals to improve their quality performance over time.

A hospital acquired condition (HAC) occurs when a patient goes to a hospital for one condition but develops another condition during that hospital stay. The second condition, such as an adverse drug reaction or an infection at the site of a surgery, is referred to as a HAC. HACs can lead to increased costs and poor patient outcomes, including longer hospital stays, permanent harm, and death.

HSCRC staff recommended keeping the current FY 2017 MHAC methodology for FY 2018, as the current approach balances hospital specific incentives with State goals; sets continuous specific quality improvement goals; and focuses the payment adjustments to best and worst performers. Staff's final specific recommendations to update the MHAC policy for FY 2018 are as follows:

- The program should continue to use the same scaling approach:

a) The program should continue the contingent scaling approach, where a higher level of revenue is at risk if the statewide improvement target is not met. Rewards should only be distributed if the statewide improvement target is met.
b) Hold harmless zones should be created to focus the payment adjustments to both ends of the performance spectrum.
c) Rewards should not be limited to the penalties collected.

- The statewide reduction target should be set at 6 percent, comparing FY 2015 with FY 2016 risk adjusted PPC rates.

Commissioners Stephen Jencks and Jack Keane urged staff to eliminate the two-tier payment scale and the 'no-adjustment zone' within the payment scale to strengthen the individual hospital's incentive to further reduce complications.

Mr. Robert Murray, CareFirst consultant, elaborated on the importance of strengthening the hospital incentive, speculating that improvement is most likely due to definitional changes and increased coding of palliative care.

Ms. Traci La Valle noted that the 35% improvement in the first two years indicates that the payment policy incentive, combined with the global budget incentive to reduce avoidable costs, proves that the incentives are adequately strong. She recommended that focus be directed towards areas where hospitals are still working to show improvements, including improving care coordination and reducing avoidable utilizations for patients with high needs and complex health conditions.

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Commissioners voted 4-1 to approve staff's recommendation. Commissioner Keane cast the only dissenting vote.

ITEM VIII

SUMMARY OF GLOBAL BUDGET INFRASTRUCTURE REPORTS

Ms. Andrea Zumbrum, HSCRC Policy Analyst, presented an overview to the Commission on the infrastructure investment reports submitted by the hospitals on December 7, 2015 (see"GBR Infrastructure Investment Reports FY14 and FY15 Summary Report"-on HSCRC website).

Under global budgets, the Commission has included additional dollars in the rates of all hospitals to provide monies for investments for patients with the goals of improving care and improving health while also reducing avoidable utilization. The intent of these monies is to accelerate the development of care coordination and other interventions relative to these goals, which are referred to as infrastructure investments. The Commission required that all hospitals report on their investments for fiscal years 2014 and 2015. Staff provided a high-level analysis of reported investments for these past two fiscal years. Staff's report included an estimated range of the amount hospitals invested in infrastructure; classified the types of infrastructure investments reported; and detailed strengths and weaknesses of the reports and investments.

Based on its review, staff recommended several improvements to these reports for future years. These suggested improvements are outlined in the Staff's summary report. It should be noted that in order to get a full understanding of an individual hospital's activities, these reports and future reports should be examined in conjunction with the Strategic Hospital Transformation Plans, Community Benefit Reports, Community Health Needs Assessments, and any regional partnership reporting.

REGIONAL PLANNING GRANTEE SUBMISSIONS

Ms. Gail Miller and Ms. Deb Gracey, Health Management Associates, presented a summary of the Regional Partnerships submitted by hospitals (see "Regional Partnerships Plans- Executive Summary Report" on the HSCRC website).

In February 2015, DHMH and HSCRC released a Request for Proposal to all hospitals offering funding through increased hospital rates to support the planning and development of Regional Partnerships for Health System Transformation. Awards were made to hospitals that applied for the funding to support regional planning and development initiatives with key community partners. A multi-stakeholder review committee selected 8 of 11 proposals, and funding ranged from $200,000 to $400,000. Each grantee was required to submit a final Regional Transformation Plan to the HSCRC that described in detail:

- The proposed delivery and financing model;
- The infrastructure and staffing/workforce that will support the model;
- The target outcomes for reducing utilization/costs and improving quality and the health of the populations targeted;
- Effective strategies to continuously improve overall population health in the region.

The purpose of this summary report is to provide a high-level analysis of the submissions and suggestions for next steps.

The Regional Partnerships (RPs) are a critical part of the State's approach to target high need/high-resource patients in order to improve outcomes, lower costs, and enhance patient experience. The purpose of the RPs is to foster collaboration between hospital and community-based partners to target services based on patient and population needs, collaborate on analytics, and plan and develop care coordination and population health improvement approaches that reduce avoidable utilization of Maryland hospitals. Based on recommendations from the multi-stakeholder Care Coordination Workgroup convened by HSCRC and DHMH, the initial target populations were identified as complex, high need patients with multiple hospitalizations, patients with multiple chronic conditions who are at risk of becoming high resource users, frail elders with support requirements, and Dual Eligible patients with high resource needs. Medicare fee-for-service patients are a high proportion of the target population and need additional focus

because there are few supports available to them in the Maryland healthcare system. Each of eight RPs submitted their final Regional Transformation Plans on December 7, 2015.

Recommendations for next steps:

- Review the Implementation Grant Proposals, GBR Infrastructure Investment Reports, and Strategic Hospital Transformation Plans before taking next steps;
- Conduct interviews with a cross-representation of people from each of the RPs as well as other hospitals, including community providers and other partners that are identified in the plans/grant applications.
- Through the interviews, assess whether the RPs and other hospitals and their partners understand ongoing care management vs. care transitions, the level to which they are actually engaging community providers, their ability to scale, and the long-term sustainability and growth potential of their models.
- With the information gained through this process, determine strategic next steps with the Maryland health care system and stakeholders as a whole.

HOSPITAL STRATEGIC TRANSFORMATION PLAN REPORTS

Mr. Steve Ports, Deputy Director, Policy and Operations, presented a summary of the Strategic Transformation Plans (STP) reports submitted by 45 hospitals in December 2015 (see Strategic Hospital Transformation Plans" see HSCRC website).

During the June 2015 public meeting, the Commission approved a recommendation that requires all acute care hospitals in the State to submit a plan to the Commission by December 7, 2015. This plan should summarize their short-term and long-term strategies and incremental investment plans for improving care coordination and chronic care, reducing potentially avoidable utilization, and aligning with non-hospital providers.

To date, the Health Services Cost Review Commission has received STP reports from 45 acute care hospitals. Each report may be found on the Commission's website at: http://www.hscrc.maryland.gov/plans.cfm. Staff assembled a review team of nine individuals from the HSCRC, DHMH, Maryland Health Care Commission (MHCC), and Chesapeake Regional Information System for our Patients (CRISP).
The review team was asked to provide the strengths and weaknesses of each STP as well as any general comments.

Some of the observed strengths include:

- A clear focus on addressing the behavioral health needs.
- Hospitals are focused on addressing the needs of chronically ill Medicare patients which is important in meeting the requirements of the All-Payer Model.
- Focus on working with nursing home and long-term care providers in reducing

readmissions and potentially avoidable utilization.
- Involving community partners.
- Some have emphasis on supporting and improving primary care services.
- Some hospitals are considering telemedicine solutions.

The reviewers also recognized general weaknesses in the plans as well. Some weaknesses include:

- Limited commitment to utilize statewide resources such as CRISP, local health departments, and local health improvement coalitions.
- Lack of identified collaboration with patients and families.
- Many "care coordination" strategies are care transitions strategies that are focused on the first 90 days following an admission.
- Little discussion on supporting community-based primary care providers (including assisting providers with accessing chronic care management fees and improving alignment between hospitals and other providers).
- A tendency for hospitals to partner with hospital-based or hospital owned physicians.
- Some STPs were vague.
- Limited collaboration with other hospitals that are focused on the same target populations, creating a risk of duplicated resources and an approach that does not meet the goal of patient centered care.

As the All-Payer Model progresses, more importance will be placed on well-constructed and inclusive strategic plans that address the causes of avoidable hospitalizations and improve the health of the population. This effort will require input from a broad set of stakeholders. Hospitals should continue to develop their strategic plans and expand them to both hospital-based and non-hospital based providers, patients/families, and other social and public service entities. The review team plans to combine the evaluations from the GBR infrastructure investment reports, regional planning grants, and implementation proposals to determine what gaps exist and the extent to which we may need to obtain additional information.

ITEM IX

UPDATE FROM CRISP ON IMPLEMENTATION OF INFRASTRUCTURE

Dr. Mark Keleman, Chief Medical Information Officer, University of Maryland Medical System, and Scott Afzal, CRISP Program Director, summarized the plans and status of the Integrated Care Network (ICN Infrastructure- 6 Month Update-On the HSCRC website).

The HSCRC has provided funding and charged CRISP with the implementing the Care Coordination Work Group recommendations to provide infrastructure to enhance Maryland's health providers care coordination and alignment activities.

It was noted that CRISP's near-term objectives are:

- Accelerate Ambulatory Connectivity
    a) Target priority practices to drive both encounter and clinical
- Expand Care Plan Exchange
    a) Engage additional partners to share Care Plans through CRISP's recent Care Plan Exchange
- Medicare Data Request
    a) Finalize strategy for receiving, processing, and reporting on claims data (1-2 weeks)
    b) Rapidly execute data request process in conjunction with HSCRC and CMMI alignment efforts
- Risk Stratification
    a) Incorporating HCC into case mix data and reports per the direction of the Reporting and Analytics Committees
    b) Continuing to explore ACG, LACE, and other more advanced risk models and functionality.
- Regional Partnership Projects
    a) Begin project execution against the Regional Partnership commitments included in the RP-CRISP MOUs.

ITEM X

HEARING AND MEETING SCHEDULE

February 10, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
March 9, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:18 pm.