Closed Session Minutes
Of the
Health Services Cost Review Commission

February 10, 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 - Administration of Model Moving into Phase II – Authority General Provisions Article §3-103 and §3-104
2. Update on Hospital Rate Issue – Authority General Provisions Article, §3-305(7)

The Closed Session was called to order at 12: 06 p.m. and held under authority of § 3-104 of the General Provisions Article.

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

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

Also attending were Eric Lindeman, Commission Consultant, and Stan Lustman and Leslie Schulman, 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 reported to the Commission and the Commission discussed rate charging issues involving Johns Hopkins Hospital.

Chairman Colmers and Mr. Lindeman, Commission Consultant, left the meeting and did not witness or participate in the discussion.

The Closed Session was adjourned at 1:20 p.m.

MINUTES OF THE
527th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

February 10, 2016

Chairman John Colmers called the public meeting to order at 12:06 pm. Commissioners George H Bone, M.D., Stephen F. Jencks, M.D., MPH, Jack C. Keane, 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 1:23pm.

REPORT OF THE FEBRUARY 10, 2016 EXECUTIVE SESSION

Mr. Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the February 10, 2016 Executive Session.

ITEM I

REVIEW OF THE MINUTES FROM JANUARY 13, 2016 AND JANUARY 26, 2016 EXECUTIVE SESSIONS AND JANUARY 13, 2016 PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the January 13, 2016 and January 26, 2016 Executive Sessions and the January 13, 2016 Public Meeting.

ITEM II

EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, reported that the Health Services Cost Review Commission (HSCRC) and Department of Health and Mental Hygiene (DHMH) staffs together with the representatives from the Maryland Hospital Association (MHA) and the Maryland State Medical Society (MedChi) have been coordinating a request to the Center for Medicare & Medicaid Innovation (CMMI) to obtain approvals for incentive programs in Maryland. These incentive programs would allow hospitals to share savings from their Global Budget Revenue with hospital based physicians and physicians with admitting privileges participate in programs that results in cost savings to the hospital. Incentive programs would also extend to community providers who work together with hospitals to reduce avoidable utilization and readmissions.

HSCRC has been working with MedChi and a task force on a pay-for-outcomes approach that is organized around Medicare's Chronic Care Management fee. This approach would focus the joint efforts of hospitals and primary care and other community providers on complex high needs patients who need more intense support and interventions as well as patients with multiple chronic conditions who can benefit from chronic care management. The approach would allow

hospitals to share savings from their global budget with community providers when avoidable utilization such as Prevention Quality Indicators and readmissions are reduced. It would also allow hospitals to help support chronic care management activities in concert with community providers.

Ms. Kinzer stated that Staff is exploring a geographic total cost of care guardrail methodology for hospitals, which can be linked with global budgets for Medicare. The purpose of these guardrails is to ensure that incentive payments do not result in cost shifting to the non-hospital setting.

Ms. Kinzer noted that Staff is also seeking Medicare data, similar to that provided to Accountable Care Organizations, to be used in care coordination activities such as risk stratification, opportunity assessment, evaluation of model performance, and administering the payment model requirements of the agreement.

Ms. Kinzer reported that the Advisory Council has been reconvened to provide advice on progression of the All-Payer Model. The Council's first meeting was held on February 3, 2016. The next meeting will be held on February 19, 2016 at the HSCRC offices.

Ms. Kinzer stated that the Implementation Grant Proposals are being reviewed by a committee consisting of HSCRC, DHMH, the Chesapeake Regional Information System for Our Patients (CRISP), Maryland Community Health Resources Commission, payer staff, and two independent reviewers. The committee met on January 19th and February 1st to consider applications and evaluate their efficacy in achieving the identified transformation goals. Twenty two grant applications were received that involve 45 hospitals. The review team expressed the desire to obtain further clarification from many of the applicants and, therefore, will be sending letters to those applicants with a series of questions. Upon receipt of the responses, the review team will consider the applications and, as deemed appropriate, may meet with the applicants and their partners to discuss the grant applications in further detail. Staff anticipates submitting recommendations to the Commission during its April public meeting.

Ms. Kinzer stated that in the current year, Staff has seen several large market shifts. Staff is considering making market shift adjustments on a semi-annual basis. If shifts become smaller in the future, Staff may want to return to an annual basis. Reducing avoidable utilizations is critical to the success of the All-Payer Model. At the same time, we need to ensure that resources are aligned properly. Ms. Kinzer noted that during its review of potential market shift information, Staff found that ten hospitals have outpatient data problems, and that one hospital has an inpatient data problem.

Ms. Kinzer noted that the Commission indicated that as part of the 2016 update, it would expect to implement a return on investment from the infrastructure funds that were provided to hospitals in their rate increases. Currently, staff has several policies that are involved in this discussion. They include adjustments for shared savings of readmissions, the readmissions reduction incentives, and adjustments for Potentially Avoidable Utilizations. The Performance Work

Group has been engaged in revising the readmission reduction incentives policy to account for the relationship between low readmission rates and low readmission reductions. Staff is considering options to combine or reorganize these adjustments.

Ms. Kinzer noted that Staff has been working on a consumer dashboard. The Performance Work Group reviewed a list of potential measures that will be included on the dashboard to monitor the progress of the All-Payer Model. Staff will collaborate with the Maryland Health Care Commission (MHCC) to create a webpage to publish the dashboard.

Ms. Kinzer reported that Staff has started working on the Uncompensated Care (UCC) policy for FY 2017. Staff was able to match write off records to the case mix data by patient account number for records with service dates beginning July 1, 2014 through June 30, 2015. Staff intends to use the matched write off data in the formulation of the FY 2017 UCC Policy. Staff will be sending the unmatched records back to hospitals to allow for revisions to records with FY 2015 service dates. Staff will be releasing non-confidential patient level case mix UCC data to solicit input for the UCC methodology. Information regarding the request process will be posted on the HSCRC website.

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

- Reviewing implementation plans and conducting discussions regarding proposals, 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.
- Developing shared savings, readmission, and aggregate at risk recommendations.
- Organizing and preparing for the FY 2017 annual update.
- Reviewing several rate applications for capital that have been filed.
- Moving forward on updates to value based performance measures, including efficiency measures.
- Examining per capita costs and total cost of care, for purposes of monitoring and for progressing toward a focus on outcomes and costs across the health care system.
- Working with DHMH and stakeholders to focus on ensuring success of the All-Payer Model and providing a proposal for a new model no later than January 2017 as required under the Agreement with the CMS.
- Working on an All-Payer amendment for alignment activities.
- Working on a request to CMMI for Medicare data that can be used for care coordination, model monitoring, and other Model purposes.

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 December focuses on fiscal year (July 1 through June

30) as well as calendar year results.

Ms. Vaughn reported that for the six month period ended December 31, 2015, All-Payer total gross revenue increased by 2.99% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 2.99%; this translates to a per capita growth of 2.46%. All-Payer gross revenue for non-Maryland residents increased by 2.96%.

Ms. Vaughn reported that for the twelve months of the calendar year ended December 31, 2015, All-Payer total gross revenue increased by 2.63% over the same period in CY 2014. All-Payer total gross revenue for Maryland residents increased by 2.85%; this translates to a per capita growth of 2.31%. All-Payer gross revenue for non-Maryland residents decreased by 0.47 %.

Ms. Vaughn reported that for the six months ended December 31, 2015, Medicare Fee-For-Service gross revenue increased by 3.44% over the same period in FY 2014. Medicare Fee-For-Service gross revenue for Maryland residents increased by 3.55%; this translates to a per capita growth of 0.64%. Maryland Fee-For-Service gross revenue for non-residents increased by 2.19%.

Ms. Vaughn reported that for the twelve months of the calendar year ended December 31, 2015, Medicare Fee-For-Service gross revenue increased by 3.82% over the same period in CY 2014. Medicare Fee-For-Service gross revenue for Maryland residents increased by 4.25%; this translates to a per capita growth of 1.13%. Maryland Fee-For-Service gross revenue for non-residents decreased by 0.99%.

Ms. Vaughn reported that for the twelve months of the calendar year ended December 31, 2015 over the same period in CY2013:

- Net per capita growth was 3.80%.
- Per capita growth before UCC and MHIP adjustments was 5.58%.
- Net per capita Medicare growth was (0.06%).
- Per capita growth Medicare before UCC and MHIP was 1.63%

According to Ms. Vaughn, for the six months of the fiscal year ended December 31, 2015, unaudited average operating profit for acute hospitals was 2.91%. The median hospital profit was 3.84%, with a distribution of .93% in the 25th percentile and 5.89% in the 75th percentile. Rate Regulated profits were 6.49%.

Ms. Vaughn reported that for the twelve months of the calendar year ended December 31, 2015 over the same period in CY2014:

- All-Payer admissions decreased by 3.52%;
- All-Payer admissions per thousand decreased by 4.02%;
- Medicare Fee-For-Service admissions decreased by 1.59%;
- Medicare Fee-For-Service admissions per thousand decreased by 4.51%;

- All-Payer bed days decreased by 2.18%;
- All-Payer bed days per thousand decreased by 2.69%;
- Medicare Fee-For-Service bed days decreased by 1.23%;
- Medicare Fee-For-Service bed days per thousand decreased by 4.16%;
- All-Payer Emergency visits decreased by 0.34%;
- All-Payer Emergency per thousand decreased by 0.85%.

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

Readmissions

- The All-Payer risk adjusted readmission rate was 12.84% for November 2015 YTD. This is a decrease of 7.17% from the November 2013 risk adjusted readmission rate.
- The Medicare Fee for Service risk adjusted readmission rate was 13.67% for November 2015 YTD. This is a decrease of 6.24% from the November 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 9.3% during CY 2015 compared to CY 2013. Currently, only 15 out of 46 hospitals have reduced their risk adjusted readmission rate by more than 9.3%.

Potentially Preventable Complications

- The All-Payer risk adjusted PPC rate was 0.76 for September 2015 YTD. This is a decrease of 33.91% from the September 2013 YTD risk adjusted PPC rate.
- The Medicare Fee for Service risk adjusted PPC rate was 0.88 for September 2015 YTD. This is a decrease of 35.77% from the September 2013 risk adjusted PPC rate.
- These preliminary PPC results indicate that hospitals are on track for achieving the annual 6.89% PPC reduction required by CMMI to avoid corrective action.

ITEM IV

DOCKET STATUS CASES CLOSED

NONE

ITEM V

DOCKET STATUS- OPEN CASES

2328A- MedStar Health

On January 20, 2016, MedStar Health filed an application on behalf of Union Memorial Hospital (the "Hospital") requesting approval to continue to participate in a global rate arrangement for orthopedic and spinal services with the National Orthopedic & Spine Alliance for one year beginning February 6, 2016.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for orthopedic and spinal services for one year beginning February 6, 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.

2329A- University of Maryland Medical Center

The University of Maryland Medical Center (the "Hospital") filed an application on January 20, 2016 requesting continued participation in a global rate arrangement for blood and bone marrow transplant services with BlueCross and BlueShield Association Blue Distinction Centers beginning March 1, 2016.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for blood and bone marrow transplant services for one year beginning March 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.

2330A- University of Maryland Medical Center

University of Maryland Medical Center (the "Hospital") filed an application on January 20, 2015 requesting approval to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. Network for one year beginning April 1, 2016.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for one year beginning April 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.

2331A- Johns Hopkins Health System

On January 27, 2016, Johns Hopkins Health System filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospitals (the "Hospitals') requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant with Preferred Health Care LLC for one year beginning March 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 March 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. Chairman Colmers recused himself from the discussion and the vote

2332A- Johns Hopkins Health System

On January 27, 2016, Johns Hopkins Health System filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with MultiPlan, Inc. beginning March 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 March 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approves Staff's recommendation. Chairman Colmers recused himself from the discussion and the vote
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2333A- Johns Hopkins Health System

On January 27, 2016, Johns Hopkins Health System filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospitals (the "Hospitals) requesting approval to continue to participate in a global rate arrangement for cardiovascular procedures, solid organ, stem cell, and to add bariatric surgery, pancreatic cancer surgery, and joint replacement services to the arrangement with Corporate Medical Network for one year beginning March 1, 2016.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular procedures, solid organ, stem cell, bariatric surgery, pancreatic cancer surgery, and joint replacement services for one year

beginning March 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. Chairman Colmers recused himself from the discussion and the vote

2334A- University of Maryland Medical Center

University of Maryland Medical Center (the "Hospital") filed an application on January 27, 2016 requesting approval to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with INTERLINK for one year beginning March 1, 2016.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for one year beginning March 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.

2335A- Johns Hopkins Health System

On January 29, 2016, Johns Hopkins Health System filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with BlueCross and BlueShield Association Blue Distinction Centers for Transplants beginning March 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 March 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. Chairman Colmers recused himself from the discussion and the vote

2336A- Johns Hopkins Health System

On January 29, 2016, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospitals (the "Hospitals") requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services and cardiovascular services with LifeTrac (a subsidiary of Allianz Insurance Company of North

America) for one year beginning April 1, 2016.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services and cardiovascular services for one year beginning April 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. Chairman Colmers recused himself from the discussion and the vote

ITEM VI

ADVANCING TELEHEALTH IN MARYLAND- AN MHCC UPDATE

Mr. David Sharp, MHCC Director of Center for Health Information Technology and Innovative Care Delivery, and Ms. Angela Evatt, Chief Health Information Exchange, updated the Commission on the work the MHCC is doing to support the advancement of telehealth in Maryland (see "Advancing Telehealth in Maryland- An MHCC Update" on the HSCRC website).

Per Maryland law, enacted in 2014, MHCC is authorized to directly award telehealth grants to non-profit organizations and qualified businesses. The MHCC grants provide an opportunity to test the effectiveness of telehealth with various technology, patients, providers, clinical protocols, and settings. In three rounds of funding since October 2014, $257,888 in telehealth grants have been rewarded, and grantees have contributed $610,180 in matching funds.

Mr. Colin Ward, Vice President Population Health & Clinical Integration for University of Maryland-Upper Chesapeake Health, Mr. Michael Franklin, President and CFO Atlantic General Hospital, and Dr. Carnell Cooper, Chief Medical Officer Dimensions Healthcare System, spoke about the implementation of their programs and provided feedback on some of their successes and challenges.

Upcoming telehealth priorities from the MHCC include a fourth round of grants that advance practice transformation and continue to align with value based care models.

ITEM VII

UPDATE FROM CRISP ON IMPLEMENTATION OF INFRASTRUCTURE AND ANALYTICS

Dr. Ross Martin, CRISP Integrated Care Network Infrastructure Program Director, provided an update on integrated care network activities (see "Integrated Care Network Infrastructure- Status Update"- on the HSCRC website).

The HSCRC has provided funding and charged CRISP with implementing the Care Coordination work group recommendations to provide infrastructure necessary to enhance Maryland's health care coordination and alignment capabilities. CRISP's implementation plans for an Integrated Care Network infrastructure are well underway. One of the strategic initiatives is to expand connectivity with ambulatory providers, a step many hospitals consider critical to enhanced patient care management. In addition to the Integrated Care Network Infrastructure, CRISP is pursuing access to patient level Medicare data on two tracks, via Qualified Entity status and a Maryland specific application directly to CMMI.

ITEM VIII

LEGISLATIVE UPDATE

Mr. Steve Ports, Deputy Director Policy Management, presented a summary of the legislation of interest to the HSCRC (see" Legislative Update- February 7, 2016" on the HSCRC website).

The Bills included: 1) Senate Bill 108 Nurse Support Program Assistance; 2) Senate Bill 513/House Bill 377 Maryland No-Fault Birth Injury Fund; 3) Senate Bill 510 Termination of MHIP and Transfer of Senior Prescription Drug Assistance Program; 4) Senate Bill 336 Hospital- Designation of Caregivers; and 5) Senate Bill 324/House Bill Prince George's County Regional Medical Center Act of 2016; 6) Senate Bill 661/ House Bill 587 Hospital- Patient's Bill of Rights; 7) Senate Bill 12 Health Care Facilities- Closures or Partial Closures of Hospital- County Board of Health Approval; 8) Hospital- Community Benefit Report- Disclosure of Tax Exemptions; Senate Bill 707- Freestanding Medical Facilities- Certificates of Need, Rates, and Definition.

ITEM IX

HEARING AND MEETING SCHEDULE

March 9, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
April 13, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:31 pm.