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521st MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
August 12, 2015

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 1PM.)

1. **Update on Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Authority General Provisions Article, §3-104, and 3-305(b)(7)**
2. **Consultation with Legal Counsel on Contested Care Implications – General Provisions Article, §3-305(b)(7)**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting on June 10, 2015**
2. **Executive Director's Report**
3. **CRISP report on Integrated Care Network Infrastructure**
4. **New Model Monitoring**
5. **Docket Status – Cases Closed**

   None
6. **Docket Status – Cases Open**

   2298A – MedStar Health
   2299A – MedStar Health
   2300R – Washington Adventist Hospital
   2301R – Holy Cross Hospital
   2302A – University of Maryland Medical Center
   2303R – Frederick Memorial Hospital
   2304N – UM St. Joseph Medical Center
   2305A – University of Maryland Medical Center
7. **Report of the Consumer Engagement Task Force**
8. **Maryland Health Care Commission on Status of Certificate of Need Applications**
9. **Legal Report**
10. **Hearing and Meeting Schedule**

MINUTES OF THE
520th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

June 10, 2015

Chairman John Colmers called the public meeting to order at 8:05 am. Commissioners George H. Bone, M.D, Stephen F. Jencks, M.D., MPH, Jack C. Keane, Bernadette C. Loftus, M.D, and Herbert S. Wong, Ph.D. were also in attendance. Thomas Mullen joined the meeting via telephone.

ITEM I
REVIEW OF THE MINUTES FROM MAY 13, 2015 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the May 13, 2015 Executive Session and Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, noted that at the last public meeting, the utilization of BRFA funds to provide funding for the Chesapeake Regional Information System for our Patients (CRISP) to implement state-wide IT and analytic infrastructure was discussed. Since then, a 90 day planning cycle has been introduced and is under way at CRISP. Ms. Kinzer stated that staff wanted to provide an update on the funding requirements.

At the May public meeting an initial budget of $495,000 was set to fund the intense 90 day planning process. This budget was incorporated into the Memorandum of Understanding with CRISP after review by the Maryland Health Care Commission (MHCC) and HSCRC.

Ms. Kinzer noted that three additional budgets have been submitted by CRISP. The first budget of $1.08 million will provide for consulting resources to support the Regional Transformation process and the infrastructure strategic plans due from each hospital on December 1, 2015. A second budget of $.9 million will provide for consulting resources to assist in developing alignment strategies and approaches. These two budgets and scopes were reviewed and approved by staffs of HSCRC, Department of Health and Mental Hygiene (DHMH), and MHCC. A third budget of $6.2 million has been submitted to the HSCRC and MHCC staff for initial review. This budget proposes that CRISP move forward on implementing some aspects of the care and coordination infrastructure, while continuing planning on others. The budget is designed to leverage federal funding sources to support the development of the state level infrastructure. This budget and work plan will be reviewed by the CRISP Executive Committee. Once approved by CRISP, HSCRC staff will incorporate it into the Memorandum of Understanding. CRISP will engage an independent auditor to perform an audit of expenditures for these activities.

Ms. Kinzer noted that there are three streams of activity underway:

- Transformation Support
- Alignment Support
- Development of state level IT and tools to support care coordination and integration.

Ms. Kinzer stated that in the initial year of the "All-Payer" Model, hospitals and their physicians and long term care partners performed well, meeting or exceeding nearly all of the model performance objectives. Ms. Kinzer noted that in order to make the model sustainable and also to meet the aggressive timelines set forth in the model agreement, we need to accelerate the implementation of care improvements, care integration and alignment, and care coordination. Staff has worked with the hospitals, Commissioners, MHA, CRISP, DHMH, Medicaid and other commercial payers, physicians, and multi stakeholders to develop an overall strategy to augment and accelerate infrastructure.

Ms. Kinzer noted that staff has proposed an addition to rates for infrastructure as part of the annual update to global budgets for rate year 2016. Payers and purchasers have asserted that hospitals should already have adequate incentives under the All Payer Model and global budgets to make these investments with the expectation that these investments will generate savings as well as care improvement. Over time, staff expects hospitals to make investments and changes to adapt to the new model and to generate a return on investment.
Ms. Kinzer stated that staff believes that we have to accelerate the process in a way that is consistent with the approach that is outlined in the All-Payer agreement.

Staff expects investments will result in improved care and reductions in Potentially Avoidable Utilization (PAU), as well as generate a return on investment. The return on investments will be recognized in future updates, with adjustments for PAU, including shared savings

Ms. Kinzer expressed her thanks to the HSCRC staff, the Maryland Hospital Association staff, the hospitals, Commissioners, workgroups, and Alice Burton for the contributions made during the first year of the All-Payer Model.

Ms. Kinzer especially wanted to thank David Romans for guiding the Commission through the 2016 update process, including the Medicaid expansion and uncompensated care updates. Ms. Kinzer also gave a special thanks to Dr. Sule Gerovich, Ph.D., for her leadership in bringing forward the policy changes and methods of global budget administration. In addition, Ms. Kinzer thanked Jerry Schmith, Ellen Englert, and Dennis Phelps for their guidance and administration of all of the rate updates that were completed.

Chairman Colmers also expressed his appreciation for the efforts of the HSCRC staff, hospitals and payers during the 2016 Update process.

Ms. Kinzer invited the HSCRC Performance Measurement Work Group and other experts to participate in a meeting on June 22, 2015 from 9:30 to noon to discuss the future of the

Commission's performance measurement program and work plan. Staff will update the group on the status of the existing measures and the activities of the work group. Dr. Stephen Cha of the Center for Medicare and Medicaid Innovation (CMMI) will present the CMMI measurement strategy, and Dr. Thomas Valuck of Discern Health will discuss an ideal design and gap analysis.

Ms. Kinzer stated that on May 20th, DHMH, the University of Maryland, and John Hopkins Medicine co-sponsored an all day summit on the future of graduate medical education. The summit brought together over 100 graduate medical education and healthcare leaders from around the State to discuss what the goals of a new GME model should be and steps that would need to be undertaken to modernize GME in Maryland. The feedback received during the summit will be incorporated into the GME workgroup discussion.

Ms. Kinzer congratulated Dr. Gerovich on being included in the Emerging Leaders Program sponsored by the Millbank Memorial Fund and the Reforming States group. This prestigious opportunity has been extended to 25 individuals nationally who are working in leadership roles in developing and implementing health care reform.

Ms. Kinzer stated that Staff met with CMS leaders and stakeholders who have been involved in the new All-Payer Model. Ms. Kinzer noted that CMS leaders were pleased with the first year results. CMS wants Maryland to speed up the process towards Phase II with designing models outside of the hospital.

Ms. Kinzer noted that Staff will be focused on the following activities in June/July:

- Completing the update on rate orders for FY 2016. The target date for completion is the end of July;
- Continuing and accelerating the focus on the alignment models, and state level, regional and hospital transformation planning and implementation;
- Preparing the report of the Consumer Engagement and Education efforts.

ITEM III
NEW MODEL MONITORING

Mr. David Romans, Director Payment Reform and Innovation, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of April will focus on fiscal year (July 1 through June 30) as well as calendar year results.

Mr. Romans reported that for the ten months ended April 30, 2015, All-Payer total gross revenue increased by 1.50% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 2.01%; this translates to a per capita growth of 1.36%. All-Payer gross revenue for non-Maryland residents decreased by 3.60%.

Mr. Romans reported that for the four months of the calendar year ended April 30, 2015, All-Payer total gross revenue increased by 1.03% over the same period in FY 2014. All-Payer total

gross revenue for Maryland residents increased by 1.48%; this translates to a per capita growth of (0.02%). All-Payer gross revenue for non-Maryland residents decreased by 3.67%.

Mr. Romans reported that for the ten months ended April 30, 2015, Medicare Fee-For-Service gross revenue increased by 2.36% over the same period in FY 2014. Medicare Fee-For-Service for Maryland residents increased by 3.23%; this translates to a per capita growth of 0.92% Maryland Fee-For-Service gross revenue for non-residents decreased by 6.91%.

Mr. Romans reported that for the four months of the calendar year ended April 30, 2015, Medicare Fee-For-Service gross revenue increased by 2.98%. Medicare Fee-For-Service for Maryland residents increased by 4.00%; this translates to a per capita growth of 0.54 %. Maryland Fee-For-Service gross revenue for non-residents decreased by 8.28%.

According to Mr. Romans, for the ten months of the fiscal year ended April 30, 2015, unaudited average operating profit for acute hospitals was 3.13%. The median hospital profit was 3.85%, with a distribution of 1.78% in the 25th percentile and 6.82% in the 75th percentile. Rate Regulated profits were 5.69%.

Dr. Alyson Schuster, Associate Director Performance Measurement, presented a quality report update on the Maryland Hospital Acquired Conditions program based upon readmission data on discharges through February 2015.

Readmissions

- The All-Payer risk adjusted readmission rate was 12.94 % for the period of January 2014 to February 2015. This is an accumulative decrease of 5.24% from the January 2013 risk adjusted readmission rate.
- The Medicare Fee for Service risk adjusted readmission rate was 13.86% for the period January 2014 to February 2015 YTD. This is an accumulated decrease of 3.42% from the January 2013 risk adjusted readmission rate.
- Based on the New-Payer Model, hospitals must reduce Maryland's readmission rate to or below the national Medicare readmission rate by 2018. The Readmission Reduction incentive program has set the goals for hospitals to reduce their risk adjusted readmission rate by 9.3% during CY2015 compared to CY2013. Currently, only 10 out of 46 hospitals have reduced their risk adjusted rate by more than 9.3%.

There is no Potentially Preventable Complications update due to a request from hospitals for an extension on submitting the final data for the 1st quarter of CY 2015.

ITEM IV
DOCKET STATUS CASES CLOSED

2296A- Johns Hopkins Health System
2297A- University of Maryland Medical Center

ITEM V
DOCKET STATUS-NO OPEN CASES

ITEM VI
FINAL RECOMMENDATION FOR SHARED SAVINGS PROGRAM FOR RATE YEAR 2016

Dr. Schuster presented the staff's final recommendation for the Shared Savings program for Rate Year 2016 (see "Final Recommendation for Shared Savings Program for Rate Year 2016" on the HSCRC website)

The Commission approved a shared savings policy on May 1, 2013, which reduced hospital revenues based on risk adjusted readmission rates using specifications set forth in the Admission-Readmission Revenue Constraint Program (ARR). The program was developed to maintain Maryland's exemption from the CMS readmission program and required a reduction of 0.3 percent of inpatient revenues in the State during FY 2014. This recommendation proposes the continuation of the shared savings policy, but suggests aligning the measurement definition to the definitions used in the Readmission Reduction Incentive Program and implementing interim limits for hospitals with changes above a threshold in shared savings amounts and for those serving a higher proportion of adult Medicaid patients.

The staff's final shared savings program recommendations for Rate Year 2016 are as follows:

- Align the shared savings readmission rate to the measure specified in the RY 2017 Readmission Reduction Incentive Program.
- Set the value of the shared savings mount to 0.6% of total permanent revenue in the State.
- Reduce hospital specific shared savings reductions for hospitals with large changes from last year and those with a higher proportion of adult Medicaid patients:

    1. Hospitals with an increase in the shared savings penalty of greater than 0.3% and who had an improvement in readmissions from CY 2013 and CY 2014 will have the shared savings penalty capped at 0.3% for this year and will return to full shared savings amounts in subsequent years.
    2. Hospitals that are above the 75^{th} percentile on the percentage of Medicaid discharges for those over age 18 should have shared savings reductions capped at the statewide average of 0.6%.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
FINAL UPDATE FACTORS RECOMMENDATIONS FOR FY 2016

Mr. Romans presented the staff's final recommendation concerning the update factors for FY

2016 (See "Final Recommendation on Update Factors Recommendations for FY 2016" on the HSCRC website).

On July 1st of each year, the HSCRC updates hospitals' rates and approved revenues to account for inflation policy adjustments and other adjustments related to performance and settlements from prior year.

On January 10, 2014, the Center for Medicare & Medicaid Innovation (CMMI) approved the implementation of a New-All Payer Model for Maryland. The All-Payer Model has a three part aim at of promoting better care, better health, and lower cost for all Maryland patients. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the new All-Payer Model focuses on controlling increases in total hospital revenue per capita. The Model establishes both an All-Payer limit of 3.58% cumulative annual per capita growth for Maryland residents for the first three years of the Model, and a Medicare savings of $330 million over the initial five year period of the Model.

The update process needs to take into account all sources of hospital revenue that will contribute to the growth of total Maryland hospital revenues for Maryland residents in order to meet the requirements of the All-Payer Model and to assure that the annual update factor approved by the HSCRC will not result in a revenue increase beyond the limit. In addition, HSCRC needs to consider the effect of the update on the Model's Medicare savings requirement and the total hospital revenue at risk for quality, care delivery, and value enhancement. While rates and global budgets are approved on a fiscal year basis, the All-Payer revenue limits and Medicare savings are determine on a calendar year basis. Therefore, it is necessary to account for both calendar and fiscal year revenues in establishing updates for the fiscal year.

The staff's final recommendations are as follows and are offered on the assumption that the other policy recommendations that affect the overall targets are approved (including the shared savings adjustment):

- Provide updates for three categories of hospitals as follows:
    1. Revenues under global budgets, 2.4% with an additional 0.4% provided for care coordination and population health infrastructure investments;
    2. Revenues not under global budget but subject to the Medicare rate setting waiver 1.6%;
    3. Revenues for psychiatric hospitals and Mount Washington Pediatric Hospital, 1.9%. with an additional 0.30% provided for infrastructure investments to support reduction in readmissions and other potentially avoidable utilization.
- Require all acute hospitals to submit multi-year plans for improving care coordination, chronic care, and provider alignment by December 1, 2015.
- Require psychiatric hospitals and Mt. Washington Pediatric Hospital to submit a report outlining plans to reduce readmissions and other avoidable utilization by December 1, 2015 and to begin submitting admission and discharge data to CRISP by April 1, 2016.
- Provide an additional 0.25% for competitive awards to hospitals to implement or expand innovative care coordination, provider alignment, and population health strategies.

- Calculate the Medicaid deficit assessment for FY 2016 at the same total amount as FY 2015 and apportion it between hospital funded and rate funded in the same total amounts as FY 2015.

Commissioner Jencks, while supportive of the need for additional infrastructure investment, raised concerns regarding hospitals' level of accountability to report to the Commission on programs for which they are using infrastructure funds. He also expressed concern with rewarding funds through a competitive funding process while the Commission is trying to encourage hospital collaboration on care coordination to ensure success under the Medicare waiver.

The Commission voted unanimously to approve staff's recommendation

ITEM VIII
FINAL RECOMMENDATION FOR CONTINUED SUPPORT OF THE MARYLAND PATIENT SAFETY CENTER

Ms. Dianne Feeney, Associate Director Quality Initiative, presented staff's final recommendations for continued support of the Maryland Patient Safety Center (MPSC) (See "Final Recommendations on Continued Financial Support for the Maryland Patient Safety Center for FY 2016" on the HSCRC website).

In 2004, the HSCRC adopted recommendations that made it a partner in the initiation of the MPSC by providing seed funding through hospital rates. The initial recommendations provided funding to cover 50% of the reasonable budgeted costs of the Center. The Commission receives a briefing and documentation annually on the progress of the MSPC in meeting its goal as well as an estimate of expected expenditures and revenues for the upcoming fiscal year.

Based on information presented to the Commission, the staff, after evaluating the reasonableness of the budget items presented, provides the following final recommendations on the MPSC funding support policy:

- HSCRC provide funding support for the MPSC in FY 2016 through an increase in hospital rates in the amount of $972,000, a $108,000 (10%) reduction from FY 2015;
- The MPSC continues to aggressively pursue other sources of revenue, including from other provider groups that benefit from the programs of the Center, to help support the Center into the future and maintain reasonable cash reserves;
- Going forward, HSCRC continues to decrease the dollar amount of support by a minimum of 10% per year, or greater amount contingent upon:

    1. How well the MPSC initiatives fit into and line up with a broader statewide plan and activities for patient safety; and
    2. Whether new MPSC revenues should offset HSCRC funding support.

The Commission voted unanimously to approve staff's recommendation.

ITEM IX
FINAL RECOMMENDATION ON CHANGES TO THE RELATIVE VALUE UNITS SCALE FOR RADIATION THERAPY SERVICES

Mr. Chris Konsowski, Chief- Audit & Compliance, presented a recommendation for final adoption of revisions to the Relative Value Unit (RVU) scale for Radiation Therapy services to be effective July 1, 2015

The Commission voted unanimously to approve staff's recommendation.

ITEM X
FINAL RECONMMENDATION ON FY 2016 NURSE SUPPORT II COMPETITIVE INSTITUTIONAL GRANTS

Ms. Claudine Williams, Associate Director Policy Analysis, presented staff's final recommendations for the Nurse Support Program II (NSP II) FY 2016 Competitive Institutional Grants (See "Nurse Support Program II Competitive Grant Review Panel Recommendation for FY 2016" on the HSCRC website).

This recommendation summarizes the funding recommendations of the NSP II Competitive Grant Review Panel for FY 2016. It also provides a report on the activities of the NSP II workgroup, formed as part of the recommendations of the NSP II Outcomes Evaluation report for FY 2006 – FY 2015, as approved on January 14, 2015 by the HSCRC. With guidance from the workgroup, NSP II has undergone a reconfiguration with new initiatives to meet NSP II goals, and has strengthened requirements for standardized data.

Since the mid-1980's, the HSCRC has funded programs to address the cyclical nursing workforce shortages. The Nurse Education Support Program evolved, first into the hospital based NSP I program in 2001 and then into the nursing education based NSP II program in 2005. Over the last decade, the NSP I and NSP II programs worked in parallel pathways along separate tracks to ensure that nursing personnel and services are available to improve health and health care in Maryland. Since the 2012 NSP I Evaluation Report, the staff increasingly has looked for opportunities for these two programs to collaborate in meeting joint recommendations and objectives.

The staff final recommendations on the NSP II funding for FY 2016 are as follows:

- The HSCRC and the Maryland Higher Education Commission (MHEC) staff members recommend that the NSP II Competitive Grant Review Panel Recommendation funding be approved at $15,737,431 for Competitive Institutional Grants, and $7,710,328 for new Statewide Initiatives for FY 2016.
- Due to timing and process of this review, staff of the HSCRC and MHEC request that the

regular comment period of 60 days be waived so that the grants may become effective on July 1, 2105.

The Commission voted unanimously to approve staff's recommendation for Competitive Institutional Grants. Chairman Colmers recused himself from the vote.

The Commission voted unanimously to approve staff's recommendation for the new Statewide Initiative funding

ITEM XI
HEARING AND MEETING SCHEDULE

July	Commission meeting has been cancelled
August 12, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 9:53 am.

Executive Director's Report

Health Services Cost Review Commission

August 12, 2015

Federal Updates

Rate Changes and Per Beneficiary Estimates

The Centers for Medicare & Medicaid Services (CMS) issued its hospital inpatient prospective payment system (IPPS) final rule for fiscal year 2016 beginning October 1, 2015, which will increase rates by 0.9% after accounting for inflation and other adjustments required by law. This is approximately .2% lower than the preliminary estimate we reviewed in the June recommendation. After accounting for a DSH reduction, the inpatient update would be expected to be less than a 0.1% increase. We estimated an outpatient hospital increase for Medicare of approximately 1.9%. However, we note that under the proposed rule for calendar year 2016 for the hospital outpatient prospective payment system (OPPS), there would be a net decrease in OPPS payments of 0.2%. This net decrease largely results from a proposed 2.0 percentage point cut intended to account for CMS's overestimation of the amount of packaged laboratory payments under the OPPS, which indicates that it caused an overpayment for hospital outpatient payments in 2014.

The Office of the Actuary released updates to the estimates of hospital revenue increases per beneficiary in connection with the update of the Trustees Annual Report (from June 2015). HSCRC staff used the estimates from the President's Budget estimates. As shown below, there is an increase from initial estimates for CY 2015.

While the rate increases for Medicare are lower than the initial estimates we used, the per beneficiary figures are in line with the estimates we used for our calculations. HSCRC staff will monitor actual results closely.

Per Capita Hospital Spending Projections

[Based on the CY 2016 Trustees Report]

	Trustee's Report	President's Budget
CY	Per Capita Trend	Per Capita Trend
2015	0.9%	0.3%
2016	2.4%	2.4%
2017	3.8%	3.5%
2018	4.6%	5.0%

SGR Relief Legislation: The Medicare Access and CHIP Reauthorization Act (MACRA)

This past April, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 was signed into law. This law permanently eliminated the use of the Sustainable Growth Rate (SGR) formula, a mechanism originally created to control spending on Medicare physician services. The SGR formula reduced Medicare physician fees if spending exceeded a target based on the GDP. Given that it was based on a volume-driven, fee-for-service model, the formula ultimately failed to control costs because it penalized providers who controlled their costs and lacked incentives for improving the quality of care delivered. MACRA repealed use of the formula and replaced it with a new quality-driven payment system to accelerate movement from volume-based payments to value-based payments.

MACRA will be adjusting payment for all Medicare providers through a 0.5% annual update from 2015-2019, and a 0.25% update from 2026 and beyond. MACRA also establishes the Merit-Based Incentive Payment System (MIPS), under which Medicare providers' rates will be determined based on their performance in a budget neutral program. Beginning in 2019, Medicare providers will be evaluated based on their performance in four categories: quality, meaningful use of electronic health records, resource use, and clinical improvement activities. The scoring system will consider patient risk factors as well as each provider's improvement on and achievement of set goals. Each Medicare provider's calculated score will be compared to a performance threshold that is set by the Secretary of Health and Human Services prior to each performance year. The provider adjustments will then be calculated based on a linear sliding scale relative to the set threshold. Thus, providers with scores closer to the threshold will receive proportionally smaller adjustments. The best performing providers will receive positive adjustments, and the poorest performing providers will receive negative adjustments, capped at -4% in 2019 and transitioning to -9% in 2022.

However, Medicare providers will be able to opt out of MIPS if a substantial proportion of their revenue is derived from alternative payment models (APMs). Providers in APMs will receive an additional 5% Medicare payment update in 2019-2024 and an additional 0.5% update in 2026 and beyond. APMs will likely include ACOs, medical homes, bundled payment models and other payment models being tested by the Center for Medicare & Medicaid Innovation (CMMI). Although the description of APMs was written relatively loosely in the legislation for flexibility, it has been noted that CMS is moving more towards value-based payment and dual-risk models. Moreover, CMS has adopted a framework for payment to providers, and the HSCRC has a basic understanding of how models under the CMS "Category 3: Alternative Payment Models Built on Fee-for-Service Architecture" and "Category 4: Population-based Payment" might qualify as APMs (see Appendix 1 for additional information). Therefore, the HSCRC and other stakeholders should consider how transformation strategies developed in Maryland affect physician payment from Medicare, and consider developing strategies that could be classified as APMs so that we align our initiatives with the requirements that will be asked of physicians in the next decade. It is important that Maryland ensures that its providers are well positioned to receive favorable Medicare payment updates under the new legislation when they participate in aligned models. HSCRC staff will be sure to address this issue in stakeholder discussions and in meetings with CMMI.

Proposed CMS Bundled Payment Model

Hip and knee replacements (also known as lower extremity joint replacements or LEJRs) are the most common inpatient surgeries for Medicare beneficiaries and the cost and quality of care delivered for these surgeries vary widely. On July 14, CMS released a proposed payment rule for the Medicare Comprehensive Care for Joint Replacement (CCJR) model, a bundled payment model for major LEJRs. In this 5 year demonstration program, hospitals would be responsible for episodes of care for LEJRs of Medicare fee-for-service (FFS) beneficiaries, with the episode covering their hospitalization through their recovery, defined as 90 days post-discharge. Hospitals in 75 Metropolitan Statistical Areas (MSAs) would be mandated to participate and the model program, if adopted as final, would be effective for discharges on or after January 1, 2016 unless otherwise noted.

Episode targets would be set prospectively while CMS continues to pay individual providers according to Medicare FFS rules. Each hospital's target price would be discounted for Medicare savings. At the end of each performance year, the total FFS payments for each episode (Part A and Part B services related to the major LEJR) would be compared to the set episode target. Based on the hospital's performance on three quality metrics, the initiating hospital would either owe a repayment or receive payment from CMS for over-/underpayments compared to the target. CMS would reconcile solely with the initiating hospital, although hospitals may

share downside risk with some of their collaborators (e.g., physicians, home health agencies, long-term care hospitals, etc.). Hospitals may also have financial arrangements with collaborators to support their efforts for higher quality care and smarter health care spending. For instance, hospitals may make gainsharing payments to collaborators from reconciliation payments or internal cost savings. For the first year, hospitals will not be exposed to downside risk. CCJR participants would be protected from the impacts of extreme cost outliers by a high cost threshold. Any episode payments in excess of the regional 95th percentile will not count toward either target or performance period calculations. In addition, total losses (for all episodes in a given performance period) would be capped at 10% in year 2 and 20% in years 3-5. However, total gains would also be capped at 20% for all 5 years.

Data Sharing

CMS will provide baseline period claims data for episodes attributed to the hospital within 60 days of the start of Performance Year 1 and performance period data on a quarterly basis. Claims data will be available in two formats: 1) Summary claims data; and 2) Beneficiary-level raw claims data. Participants must request their data - it would not be provided automatically. CMS will provide aggregated data on average episode spending by DRG for the participant hospital and its region regardless.

Financial Arrangements and Policy Waivers

Home Health home-bound requirement: CMS does not propose to waive the home-bound requirement for receipts of home health services. However, CMS will waive the "incident to" rule to allow a CCJR beneficiary who does not satisfy requirements for home health services to receive up to 9 post-discharge home visits during an episode.

Telehealth: CMS will waive the geographic site requirement for telehealth services as well as the requirement that the eligible telehealth individual be in one of 8 eligible types of sites when the otherwise eligible individual is receiving telehealth services in his or her home.

SNF 3-day stay: Beginning in Performance Year 2, CMS will waive the 3-day hospital stay required for Skilled Nursing Facility (SNF) payment. Use of this waiver is contingent upon the SNF having an overall quality rating of three stars or better on the Nursing Home Compare website.

Implications for Maryland

Through this proposed bundled payment mechanism, the CCJR model aims to encourage hospitals and providers to work together to improve care from the initial hospitalization through recovery.

HSCRC staff notes that integration and coordination of care is critical in the Maryland All-Payer Model. Maryland stakeholders need the tools provided under this model to be successful in our current model. For instance, it is important to have waivers for sharing savings when quality

and cost targets are achieved, waivers of the SNF 3-day stay rule where total cost of care is considered and controlled, and telehealth waivers for comprehensive services. Stakeholders also need the data to evaluate opportunities to improve care and lower cost. Given the Maryland Model's all payer nature , pre-existing incentives , and important guardrails and increasing focus on total cost of care, the implementation of a CCJR-type model may take a different path in Maryland. However, the data and tools under the CCJR model are needed for successful implementation of aligned initiatives under the Maryland Model. HSCRC staff will work with stakeholders to craft a comment and request data to evaluate opportunities for Maryland patients. We will also ask in our comments to have access to the same tools, while considering how this opportunity fits into a broader picture for improving health in the State.

Moving Forward

With federal health policy in mind, the HSCRC will continue to work with stakeholders on alignment models, APM consideration, and state level, regional, and hospital transformation planning and implementation for more patient/family-centered and value-based care in Maryland.

All-Payer Model Implementation and Waivers

Embarking on Year 2 of Model implementation, the HSCRC has worked closely with stakeholders to develop strategies on four key pillars of activity for clinical improvement: statewide infrastructure, alignment, care coordination and integration, and consumer engagement. To build further momentum with the Model, the HSCRC wants to work with stakeholders to move forward on key alignment issues

Because these programs involve investments outside of the hospital and formal relationships between diverse stakeholders across various health systems, the HSCRC, Maryland Hospital Association, MedChi, and other stakeholders have requested that CMMI work with other federal agencies to provide the waivers necessary for these initiatives. CMMI has recognized that these tools are needed to not only accomplish the current goals of the Maryland Model, but also to lay the foundation for Maryland to progress in its focus to total cost of care. Moving forward, the HSCRC will work to provide CMMI the necessary information to support granting of waivers to support four areas:

1. Pay-for-performance programs with community-based providers (including primary care providers, nursing home providers, etc.);
2. Gainsharing programs with specialists with admitting privileges and hospital-based physicians;
3. Care coordination activities; and,
4. Data access for care coordination.

This process takes some period of time, and we will provide specific updates to stakeholders once we receive information from CMMI. We currently expect this process to be completed by the second quarter of CY 2016.

Planning and Implementation of Care Coordination and Alignment Activities

Funding Administration

As reported in the May Commission meeting, BRFA funds were placed in rates on May 1, 2015 to help implement initiatives that support the success of the All-Payer Model. Out of these funds, an estimated $11.5 million will be provided to CRISP, the state designated Health Information Exchange entity, to fund additional planning and start-up costs of expanded IT and analytic infrastructure as well as continued consulting support for implementation of care coordination and alignment activities. The responsibilities of CRISP and the use of these funds is defined and directed under a Memorandum of Understanding with HSCRC. MHCC administers the funds with the support of HSCRC.

As reported in the May Commission meeting, an initial budget of $495,000 was submitted for a 90-day intense planning process for state level infrastructure. This budget was incorporated into the Memorandum of Understanding (MOU) after review by MHCC and HSCRC. In the June Commission meeting, we reported that two consulting budgets, one of $1.08 million aimed at supporting the Regional Transformation process and a second budget of $0.9 million for consulting resources to assist in developing alignment strategies and approaches. These budgets were reviewed and approved by the staffs of HSCRC, DHMH, and MHCC, and subsequently incorporated into the MOU. A third budget of $6.2 million has been approved by the Executive Committee of CRISP. HSCRC and MHCC staff members are in the process of incorporating this budget into the MOU. This budget supports the development of statewide integrated care and care coordination infrastructure. HSCRC staff will provide regular updates to the Commission relative to the budgets and the associated MOU. CRISP will engage an independent auditor to perform an audit of expenditures for these activities.

CRISP will be presenting the project scope and status at the Commission meeting today.

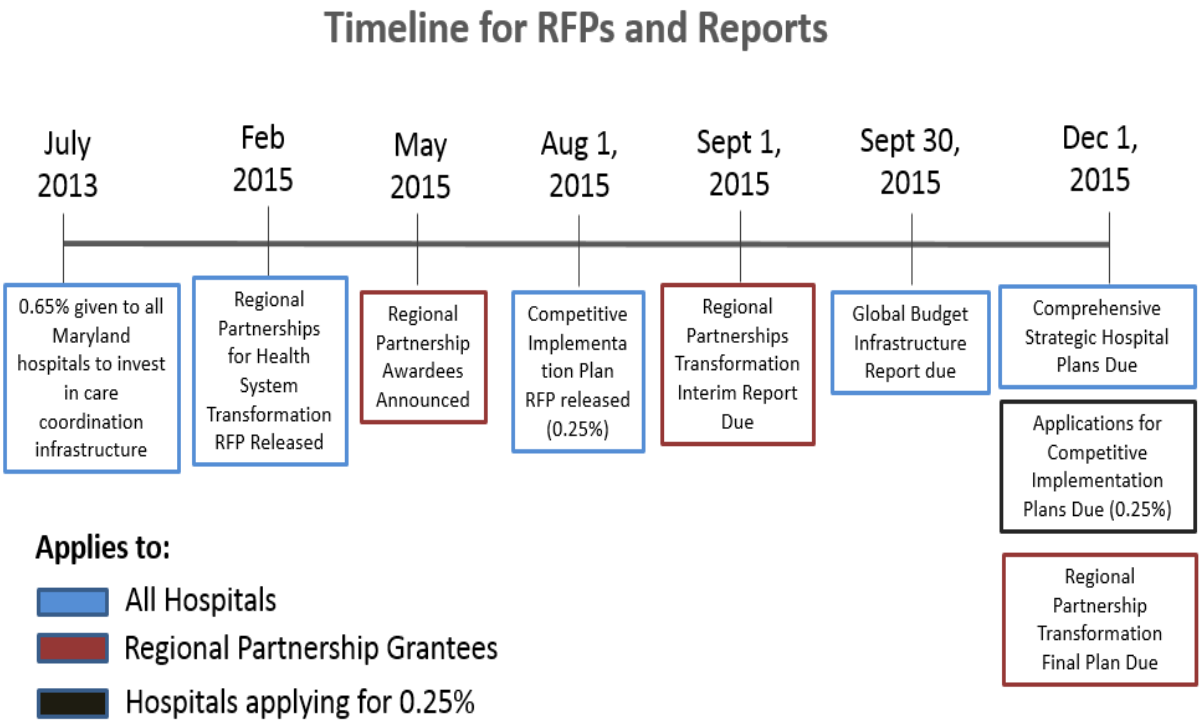
Transformation Support

The HSCRC staff members, together with consultants, are focused on transformation support activities relative to regional planning grants and infrastructure planning and implementation activities. This includes:

1. Learning Collaboratives

2. Webinars
3. Shared site for resources
4. Individual Consultation (Regional Planning Grantees)

As a reminder, the general timeline of activities is outlined below. HSCRC staff will provide a more comprehensive update on activities at the September Commission meeting. Staff expects to release an RFP in August for competitive implementation plan funds (the .25% approved by the Commission at the June meeting). A draft RFP was reviewed with over 150 webinar participants last week, and comments are being taken and considered in development of a final RFP.



Alignment Models

HSCRC, DHMH (Medicaid), and CRISP staffs have begun informal conversations with stakeholders regarding alignment strategies and approaches. In the near term, we will outline a stakeholder approach, develop a plan, and define a work group process to support these efforts.

Market Shift Adjustments

HSCRC staff finalized the calculations for market shift adjustments for all inpatient and outpatient services, except for radiation therapy, infusion and chemotherapy, for inclusion in rate year 2016 global budgets. These adjustments relate to shifts occurring during the 6 months ended December 31, 2014 as compared to the same six month period in the preceding year. These calculations were finalized after Staff received corrections of outpatient encounter data from hospitals and made some modifications to the outpatient weights based on input received through the process, in addition to other refinements. Similar to our previous report to the Commission, the revenue shifted under this calculation is approximately $28.5 million. Staff is in the process of reviewing a preliminary calculation completed for cancer services with stakeholders. We hope to finalize a shift calculation for these outpatient services by September. Sule Gerovich, PhD, will report to the Commission on the final details at the September meeting. The shift calculation, exclusive of oncology services, is being incorporated into FY 2016 rate orders now.

Laurel Regional Hospital Service Delivery Plan[1]

The Board of Dimensions Healthcare System announced that it agreed to an innovative approach to enhance the health of the population served by Laurel Regional Hospital. Dimensions Healthcare System will be reducing the scope and complexity of inpatient services while simultaneously constructing a comprehensive ambulatory medical facility dedicated to preventive care that reduces avoidable hospitalizations. The new ambulatory facility, which is expected to cost approximately $24 million, will include emergency services, outpatient surgery and comprehensive diagnostic imaging, and is expected to be built on the existing hospital campus by 2018. There are no plans to change the Laurel Regional Hospital's current emergency, diagnostic imaging and outpatient surgery services during the transition.

[1] Summarized from Dimensions Healthcare Press release data July 31, 2015

For several years, Laurel Regional Hospital has been experiencing significant declines in inpatient utilization, consistent with national trends for small community hospitals. Under the plans announced, Laurel Regional Hospital will phase out all but 30 licensed medical/surgical inpatient beds later this year. It will retain existing behavioral health, rehabilitation and chronic care beds until the new ambulatory care facility is built.

The Health System notified HSCRC of these upcoming changes. Additional details will follow. HSCRC staff will begin working with the Health System to address the service delivery reconfigurations.

Staff Focus

HSCRC staff is currently focused on the following activities:

- Completing the rate orders for rate year 2016. Draft calculations have been sent to hospitals and are being reviewed.
- Continuing the focus on waivers, alignment models, and state level, regional and hospital transformation planning and implementation.
- Reviewing Certificate of Need (CON) and rate applications that have been filed. (A general overview of CON applications filed will be presented later in the Commission meeting.)
- Beginning work on updates to value-based performance measures, including efficiency measures.
- Staff has released an RFP for support of the Phase 2 application development and application process with CMMI, which will be focused on transitioning the All-Payer Model to a greater focus on the total cost of care. HSCRC staff will bring forward a timeline and process plan for this effort in the upcoming months.

Appendix 1: CMS Framework for Payment to Providers

Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Value	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-based Payment
▪ Payments are based on volume of services and not linked to quality or efficiency	▪ At least a portion of payments vary based on the quality and/or efficiency of health care delivery	▪ Some payment is linked to the effective management of a population or an episode of care ▪ Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	▪ Payment is not directly triggered by service delivery so volume is not linked to payment ▪ Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)
▪ Limited in Medicare fee-for-service ▪ Majority of Medicare payments now are linked to quality	▪ Hospital value-based purchasing ▪ Physician Value-Based Modifier ▪ Readmissions / Hospital Acquired Conditions Reduction Program	▪ Accountable care organization ▪ Medical homes ▪ Bundled payments ▪ Comprehensive primary Care initiative ▪ Comprehensive ESRD ▪ Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	▪ Eligible Pioneer accountable care organizations in years 3-5 ▪ *Maryland All-Payer Hospital Model*

Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8. Maryland categorization added

CRISP

CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS

ICN Infrastructure Tools and Services
Update on Progress

August 12, 2015

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

Presentation Outline

1. Project Organization
2. Leadership/Governance
3. Working with Regional Partnerships and organizations that want to pilot initiatives
4. ICN Roadmap
5. Goals

Project Organization

1. AMBULATORY CONNECTIVITY

The project aims to achieve bi-directional connectivity with ambulatory practices, long-term-care and, other health providers. Multiple methods of connectivity will be employed, including HL7 interfaces, CCDA exchange, and administrative networks.

2. DATA ROUTER

A key concept of the infrastructure effort is to send relevant patient-level data to the healthcare organizations who can use it for better care management. The data router will receive and normalize health records, determine a patient-provider relationship, verify patient consent, and forward the records where they should go in near real time.

3. CLINICAL PORTAL ENHANCEMENTS

The existing clinical query portal will be enhanced with new elements, including a care profile, a link to a provider directory, information on other known patient-provider relationships, and risk scores.

4. NOTIFICATION & ALERTING

New alerting tools will be built such that notification happens within the context of a providers existing workflow. So for instance, if a patient who is part of a specific care management initiative shows up at the ER, an in-context alert could inform the clinicians that the patient has a care manager available.

5. REPORTING & ANALYTICS

Existing reporting capabilities, built on Tableau and Microsoft Reporting Services, will be expanding and made available to many more care managers. Will also plan for a potential new solution to support thousands of ambulatory practices.

6. BASIC CARE MANAGEMENT SOFTWARE

The current scope is for planning only, as the advisors help us determine an appropriate path.

7. PRACTICE TRANSFORMATION

The current scope is for planning only, as the advisors help us determine an appropriate path.

Terminology

	Definition
Clinical Query Portal Enhancements	Improvements to the existing clinical query portal including approaches to simplify access, incorporating new content such as access to care profiles, and displaying the patient's providers.
In-Context Notifications and Alerting	Inclusive of a range of alert types sent to the point-of-care or to a care manager, in a manner consumable with their workflow. Alerts may pertain to critical information about a patient, identify care gaps, indicate post-discharge follow-up care has not occurred, etc.
Care Profile View	The care profile provides, in one readily viewable place, the key characteristics of a patient and their current medical status. Key elements in the care profiles could include patient demographics, most recent clinical alerts, summary of recent hospital encounters – diagnoses and procedures, visit dates, subscribing providers, and the existence of a current care plan.
Data Router	The router is a service that includes key functionality to support connectivity, consent management, data routing to other services or data consumers, and patient-provider relationship determination. The approach may rely on connectivity through a health system, through a hosted EHR, directly to the practice, or via an administrative network.
Standardized Risk Stratification Tools	Deployment of one or more centralized risk stratification methodologies to support stratification of patients initially using HSCRC case mix data housed in CRS but expanding to include broader data sets. Predictive risk score will be shared through a range of tools, including the query portal and ENS.

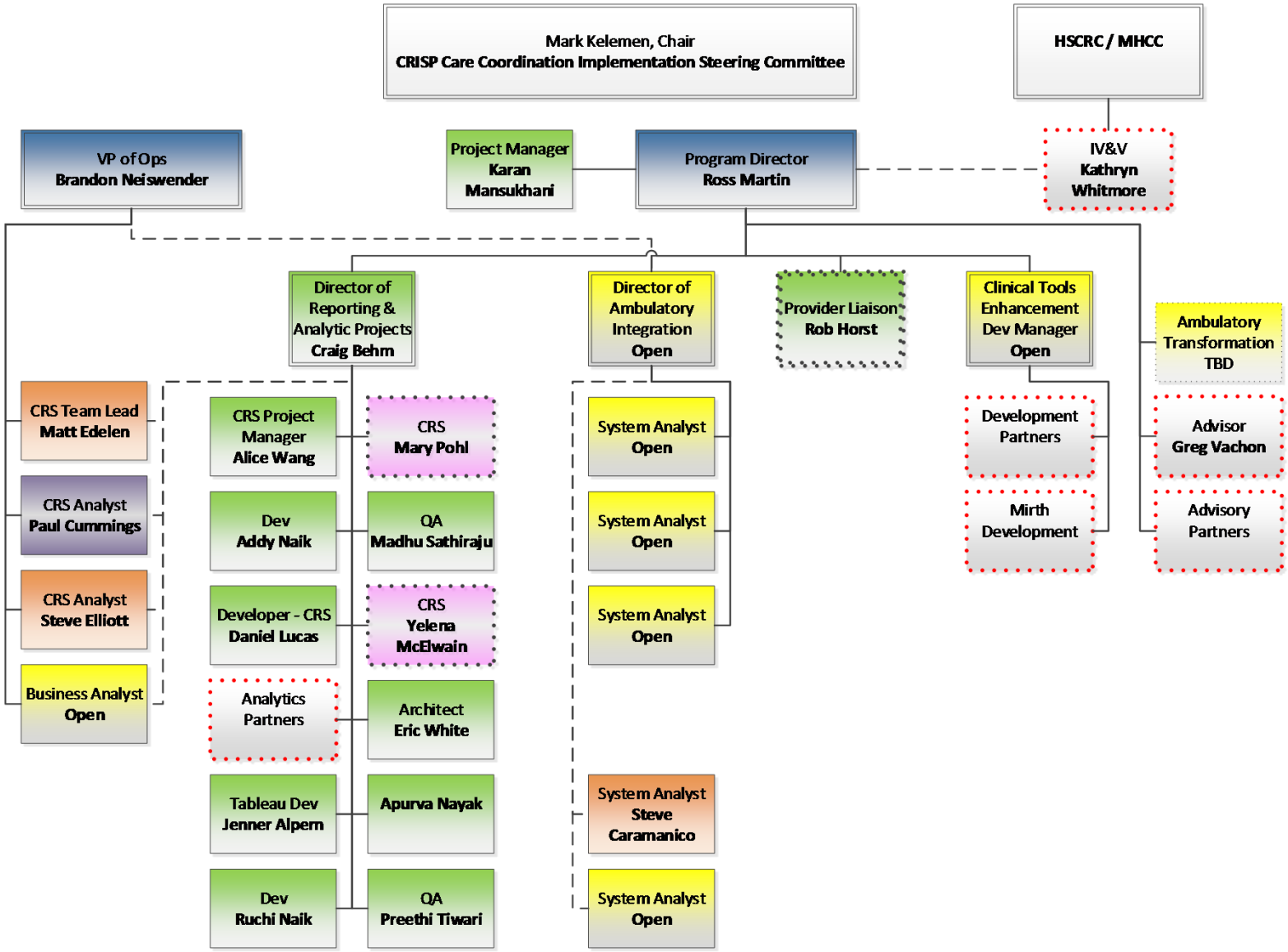
CRISP ICN Infrastructure Committee

- CRISP Board established an ICN Infrastructure Steering Committee
  - Charged with providing oversight and offering guidance on how best to pursue those services that can and should be offered as common infrastructure
  - Translating and further defining the Care Coordination Workgroup report into set of work activities
- CRISP Executive Committee is actively engaged in reviewing recommendations, reviewed budget and leadership decisions

ICN Infrastructure Steering Committee

Name	Title	Organization
Mark Kelemen, MD (Chair)	CMIO	University of Maryland Medical System
Patty Brown	SVP and President	Johns Hopkins Medicine, Johns Hopkins HealthCare LLC
Ernest Carter, MD	Deputy Health Officer	Prince George's County Department of Health
Patricia Czapp, MD	Chair of Clinical Integration	Anne Arundel Health System
DeWayne Oberlander	Executive Director	Columbia Medical Practice
Nicole Stallings	Vice President, Policy & Data Analytics	Maryland Hospital Association
Adam Kane	Senior Vice President of Corporate Affairs	Erickson Living
David Sharp	Director, Center for Health IT	Maryland Health Care Commission
Linda Dunbar	Vice President, Population Health & Care Management	Johns Hopkins Healthcare
John Kontor, MD	EVP	Advisory Board Company
Robb Cohen	CEO	Advanced Health Collaborative
John McLendon	CIO	MedStar Health System

Team Organization



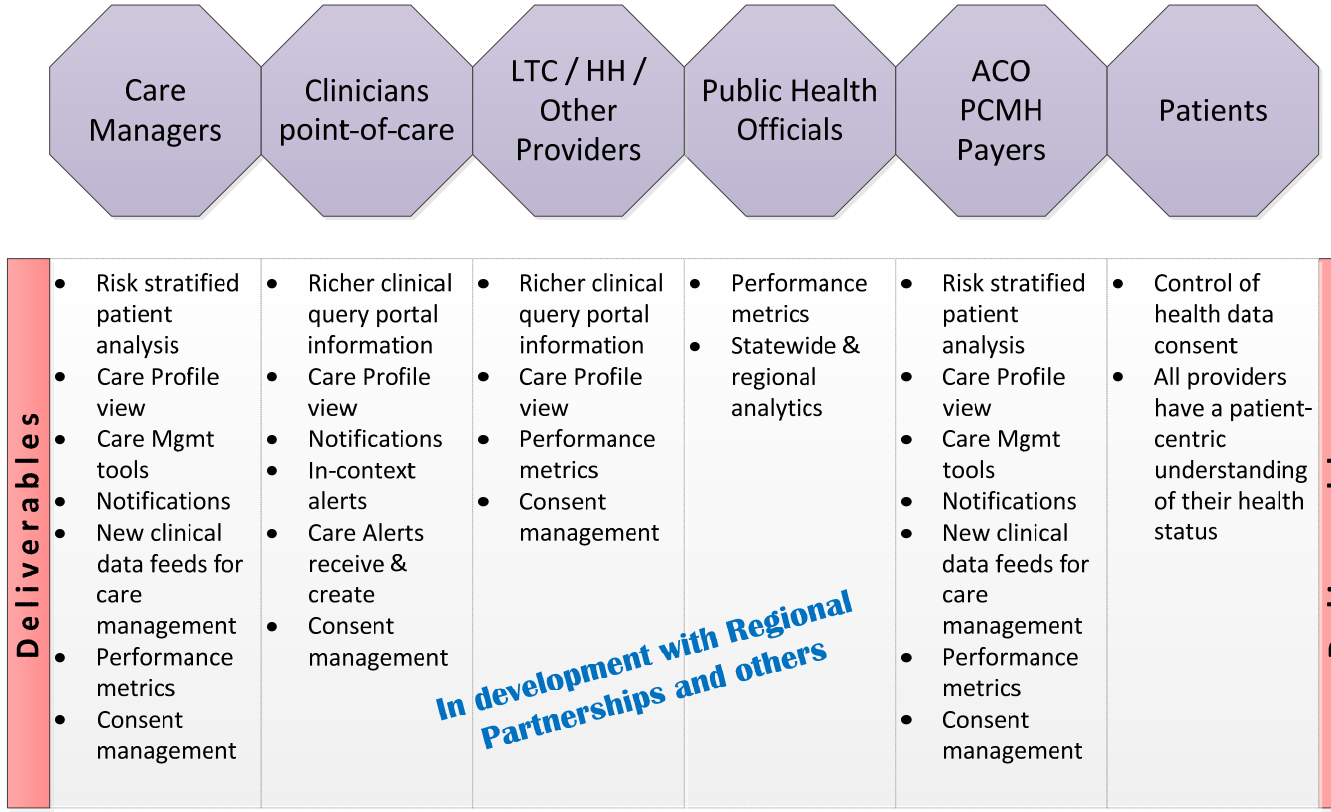
CRISP and Statewide ICN Infrastructure

- CRISP's role in pursuing ICN infrastructure and services is rooted on identifying and deploying those services that can and should be offered as common state-level infrastructure and are best pursued cooperatively.
- We are in part translating (and in some cases further defining) the Care Coordination Workgroup report into a set of work activities building towards agreed upon common infrastructure and services.
- CRISP's new tools should complement the ongoing and significant investments health systems, hospitals and ambulatory providers have already made.
- For some providers, CRISP will offer new solutions and tools. For other providers, CRISP will provide new data, make connections among different health system providers, and facilitate a shared understanding of the needs of shared patients.
- Consistent with CRISP's history and mission, we will be thoughtful about maintaining an incremental approach defined by CRISP users' needs.
- CRISP will work within its broad-based governance structure to define and prioritize work and partner with early adopters and innovators to pilot and refine initiatives.

Gaining Input and Direction from Users

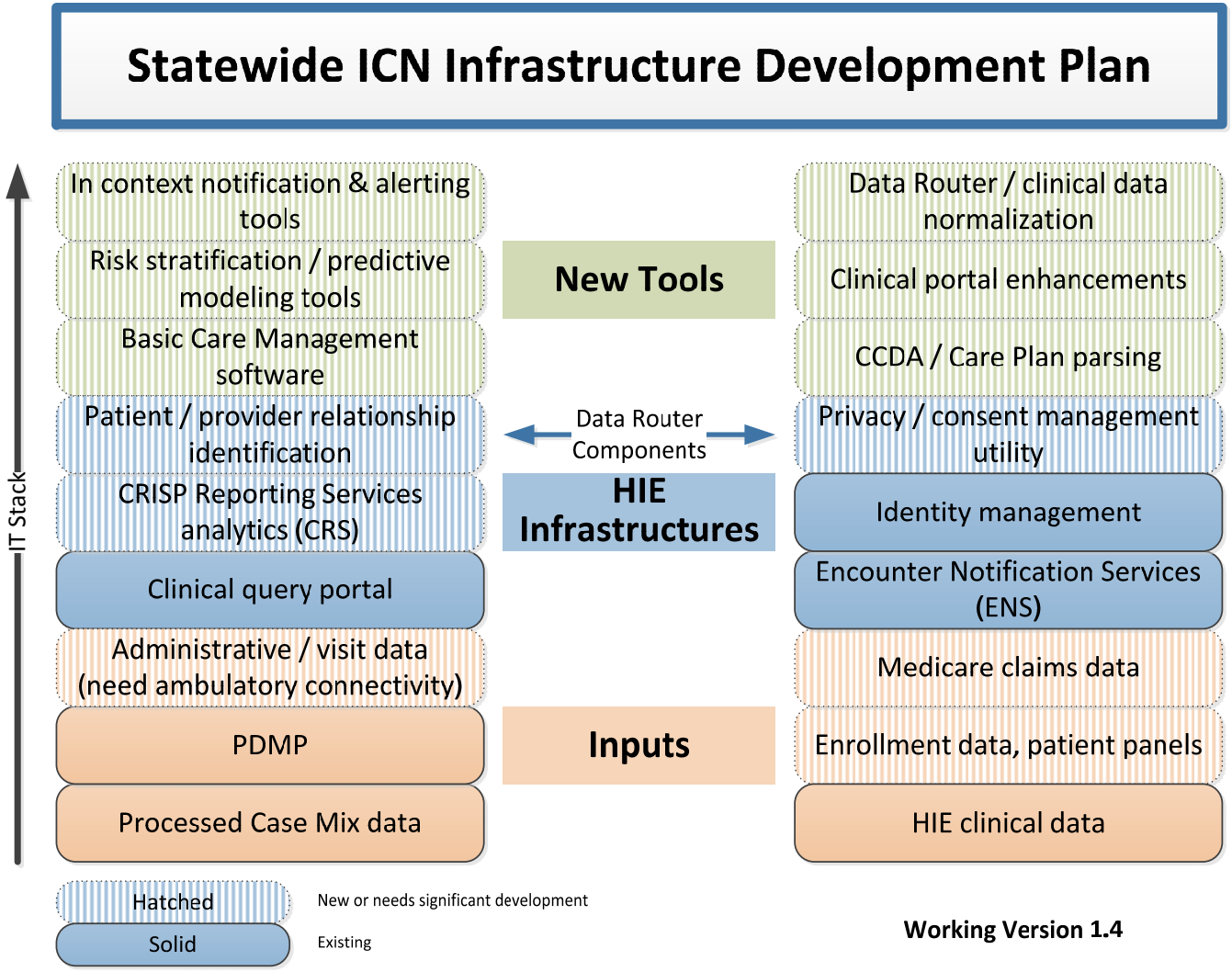
- CRISP is actively engaged with users to understand their needs and work towards better defining solutions and piloting efforts
  - Regional Partnerships have provided a good forum
  - Working with other collaborative efforts as well
- Our experience is that we can be more successful when working with partners to pilot real solutions that can be implemented quickly and improved incrementally over time
- Alignment strategies are critical to engaging ambulatory and long term care providers

ICN Infrastructure Concept



Statewide ICN Infrastructure Development Plan

ICN Infrastructure Concept



Draft Goals

Goal	6-Month Goal Dec 31. 2015	12-Month Goal Jun 30, 2016	24-Month Goal Jun 30, 2017
ICN Tools and Services			
Deploy Router	**Routing data from 40 total ambulatory practices to 2 care management programs / 150 practices**	Router supporting 1,000 providers	Router supporting 5,000 providers
Consent Utility	**Opt out for ambulatory data is made more granular and working / ENS opt out working**	Opt out for ENS is working	3,000 peope have opted out of ENS
		Better patient notification options are implemented	1,000 people are receiving notifications
		Care Managers are starting to rely on the CRISP consent utility	Consent utility is integral to many care management initiatives
Deploy Risk Stratification solution against case mix data	**Risk stratification tool selection complete and production pilot underway for 4 partners / 10 partners**	Risk stratification broadly available through reports and or query portal	Risk stratification includes clinical data inputs
Deploy uniform "base" approach for Health Risk Assessment	**Build consensus among Steering Committee on uniform "base" approach to HRAs**	TBD	TBD
Deploy standardized approach for Care Profile development and sharing	**Steering Committee agrees on standardized approach to Care Profile, Care Alert development / live in portal**	Care Profiles available prominently in the clinical query portal	TBD
Deploy approach for Care Plan viewing through HIE	**Care Plan viewable through the clinical portal from 2 organizations / 4 organizations**	Care Plans available for 10,000 patients	Care Plans available for 40,000 patients
Deploy In-Context Notifications	**In context notifications in 4 EDs, for presence of a Care Plan or recent discharge / 10 EDs**	In-context notifications available to 100 ambulatory providers	In-context notifications available to 5,000 ambulatory providers
Enhance Clinical Query Portal with new information	**ENS Provider Subscription information available in Clinical Query Portal / with provider contact info**	Provider Directory contact information integrated into Clinical Query Portal	Robust patient attribution information, for providers and care managers, feeding the Clinical Query Portal
Deploy Reporting & Analytics tools for patient panels / attributed patients	**Tableau access available to all hospitals, and used by 20 / 40**	TBD	TBD
	Regional Partnerships are meaningfully using CRS reports		

Draft Goals 2

Goal	6-Month Goal Dec 31. 2015	12-Month Goal Jun 30, 2016	24-Month Goal Jun 30, 2017
New Data Sources			
Data Sharing Framework	**Pilot data Sharing Policy in place to enable use of All Payer Report / improved approach to 42 CFR Part 2 data agreed**	PA addendum signed by a majority of hospitals	Advanced ability to filter on 42 CFR Part 2
ENS Panel Growth	**An ENS message is sent for 55% of Medicare discharges / 60%**	An ENS message is sent for 65% of Medicare discharges	An ENS message is sent for 80% of Medicare discharges
CMS Data availability	**Partner with MHA and HSCRC to formally request data**	CMS data in use	
Admin / Visit Data growth	**1,000 providers sending administrative data / 2,000**	2,000 providers sending administrative data	5,000 providers sending administrative data
Ambulatory Clinical Data growth	**500 ambulatory providers sending clinical data / 1,000**	1,000 ambulatory providers sending clinical data	TBD
Increase SNF Connectivity	**Steering committee agrees approach to coordinating with SNFs and data sharing**	TBD	TBD
Industry / Community Partner Engagement			
Operational Practice Transformation Center	**Initial funding and plan in place / statewide effort funded**	TBD	TBD
Support Regional Partnerships	**At least one goal or obligation is defined and agreed in an MOU for each regional partnership / plus 5 other than RPs**	TBD	TBD
CRS / Tableau directly leveraged by strategic partners	**At least 2 partners have direct access to Tableau in support of provider organizations / 6 partners**	TBD	TBD

Questions

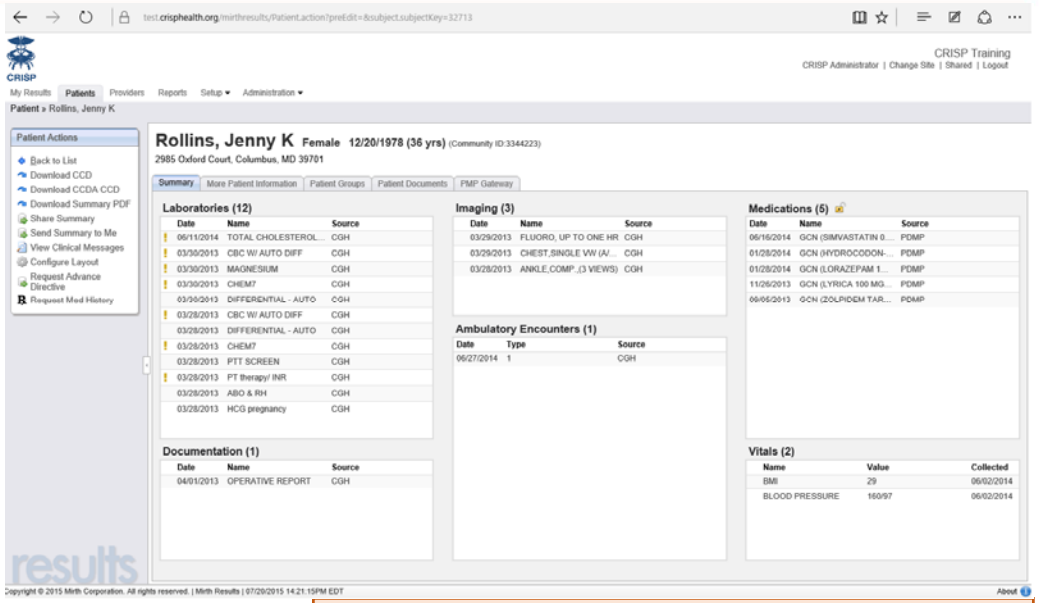
Appendix

1. Current Tools
2. New Tools and Services

Current Tools and Services

Clinical Query Portal

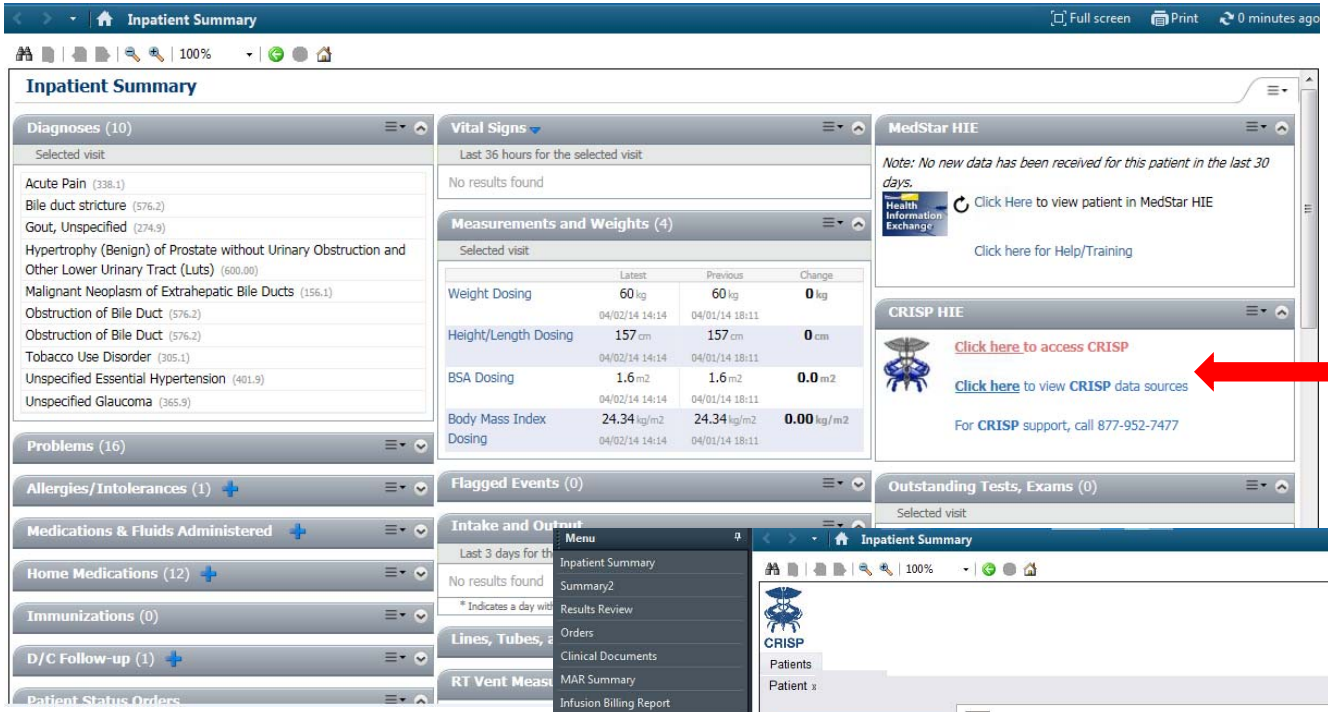
- The clinical query portal allows credentialed users to search the HIE for clinical data.
- All 47 acute care hospitals in Maryland and 6 of 8 DC hospitals share clinical data.
- There are currently over 100,000 queries per month.
- 10 hospitals have enabled "single sign-on" connectivity to the portal enabling single-click access to data in CRISP.



Types of data available:

- Patient demographics
- Lab results
- Radiology reports
- **PDMP Meds Data**
- Discharge summaries
- History and physicals
- Operative notes
- Consult notes

Clinical Query Portal - Single Sign-on



Single Sign-On (SSO) is an approach to enable faster and more efficient access to the query portal through the EHR.

By securely sending a local user's credentials and the current patient medical record number (or other demographics), CRISP can send the user directly to the patient summary screen.

Encounter Notification Service – Current Capabilities

- CRISP currently receives Admission Discharge Transfer messages in real-time from:
  - All Maryland Acute Care Hospitals
  - 6 of 8 D.C. Hospitals
  - All Delaware Hospitals

- Through ENS, CRISP generates **real - time hospitalization notifications** to PCPs, care coordinators, and others responsible for patient care.

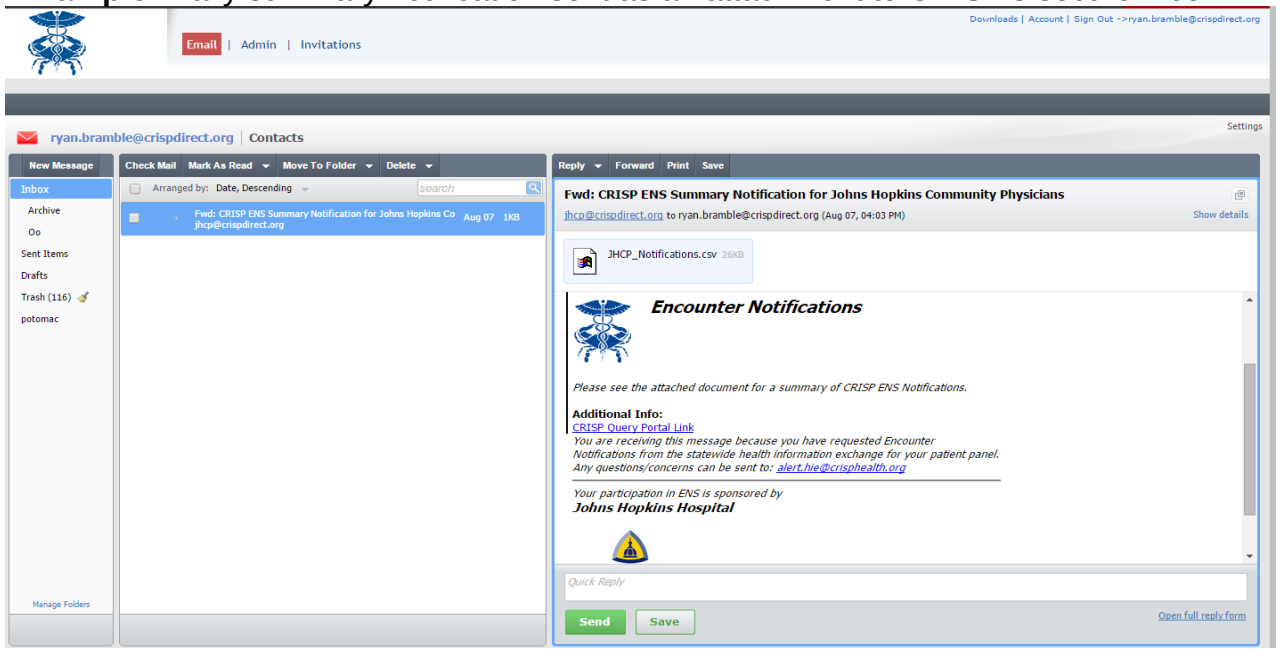
Important Current Capabilities

- Full Continuity of Care Documents (CCDs) are also routed through ENS to subscribing providers, who elect to receive them to support transitions of care.
  - 10 Hospitals currently send CCDs to CRISP
- Hospitals can “auto-subscribe” so they can be alerted when one of their past discharges is being readmitted within 30 days. This same capability allows the receiving hospital to be notified, when a patient arriving at their facility had been discharged from another facility, within the past 30 days.
  - 34 hospitals currently auto-subscribe to receive readmission notifications
- ENS was recently enhanced to include the ER and IP visits for a given patient with the past 6 months.

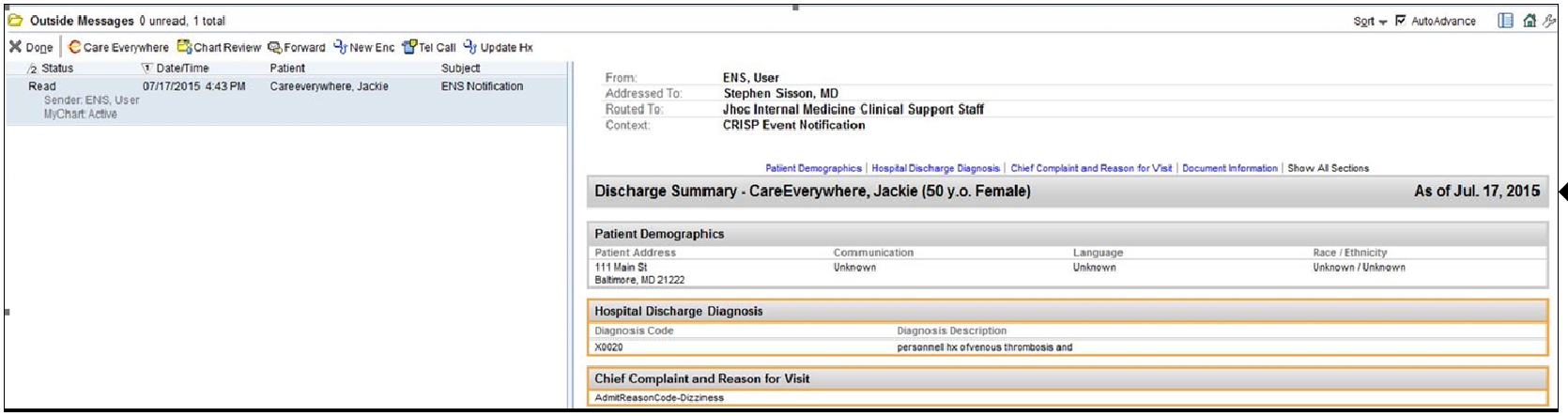
Methods to Receive Notifications

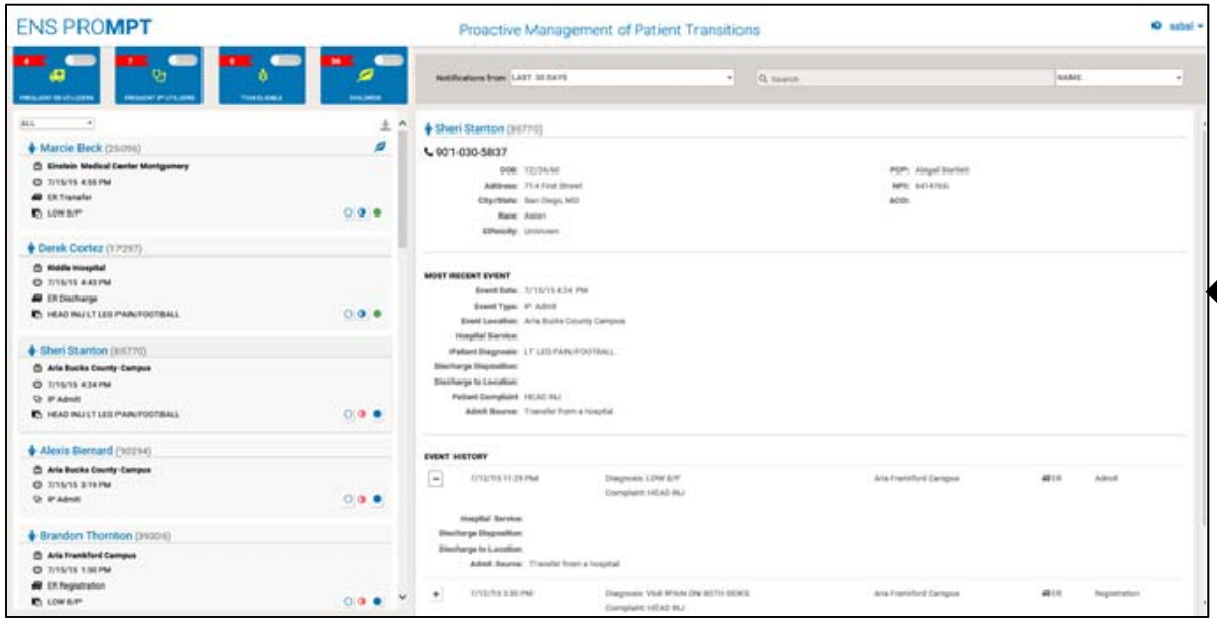
- Currently, ENS recipients can choose to receive real-time or a daily (or twice daily) summaries of the prior 24 hours of hospitalizations.
- Most notifications are sent via CRISP secure direct messaging tool (shown below).
- Some ENS subscribers choose to integrate notifications into their EHR by receiving the notifications in the form of an ADT.

Example: Daily summary notification sent as an attachment to CRISP's secure inbox



Near-term Additional Approaches for ENS

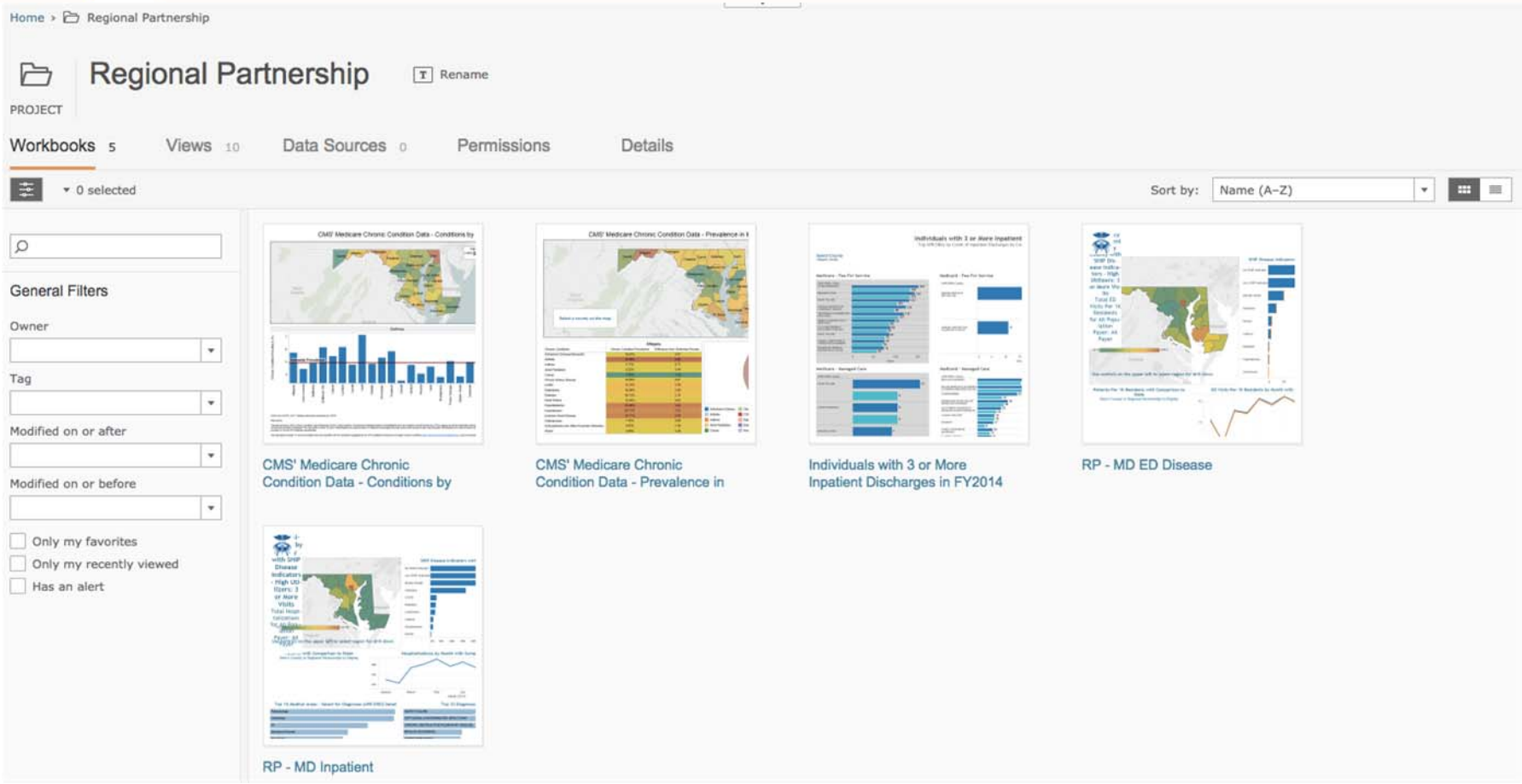




- ENS is in final testing to deliver notifications directly into Epic.
- Notifications are also currently flowing into other recipient systems in production.

- CRISP will also offer an ENS user interface beginning in early August rather than simple spreadsheet via secure email.
- Users will still have the ability to download the spreadsheet.

CRISP Reporting Services (CRS)

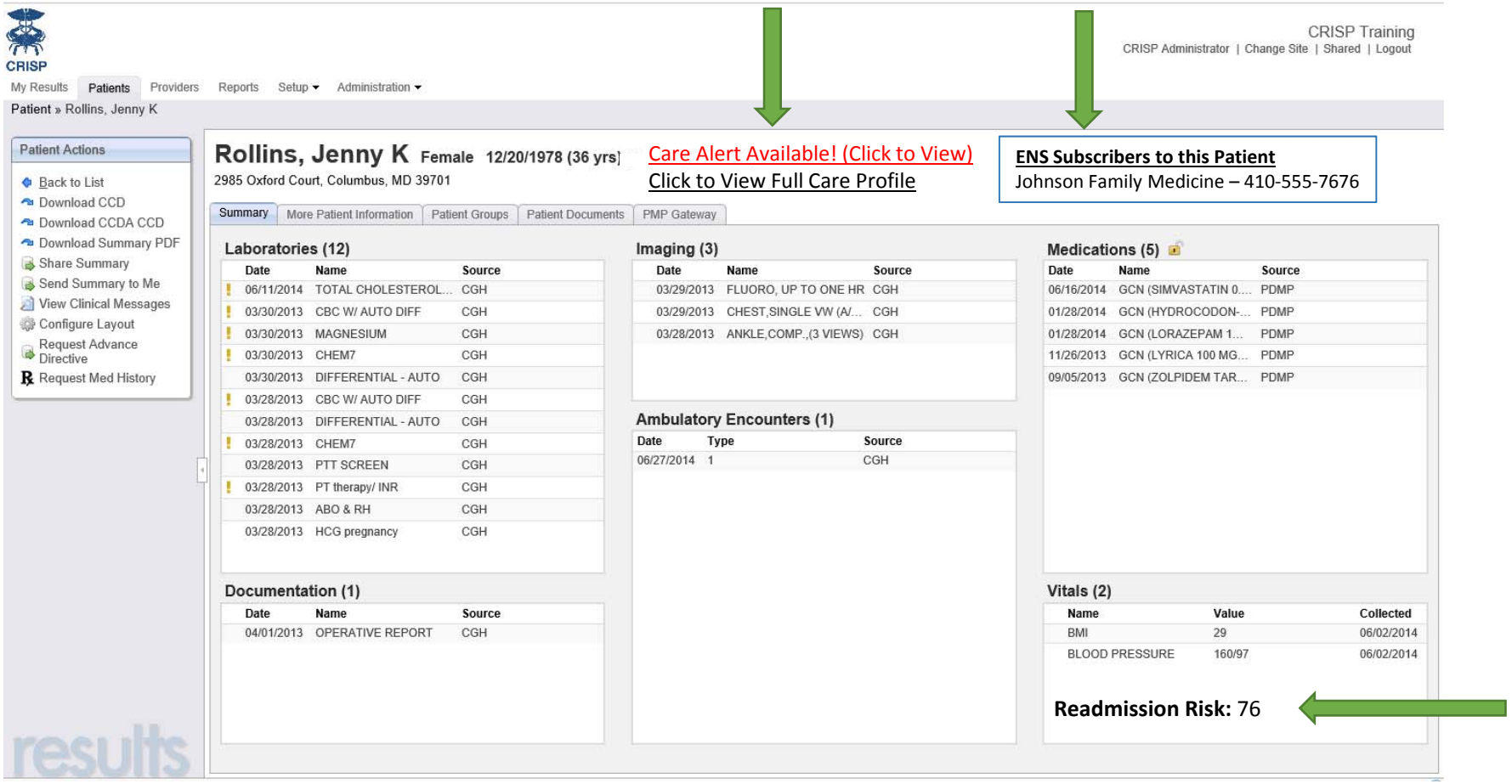


Link to July 9th Webinar Materials and Recording

http://pophealth.dhmh.maryland.gov/transformation/SitePages/Technical%20Assistance.aspx

ICN Infrastructure Tools and Services

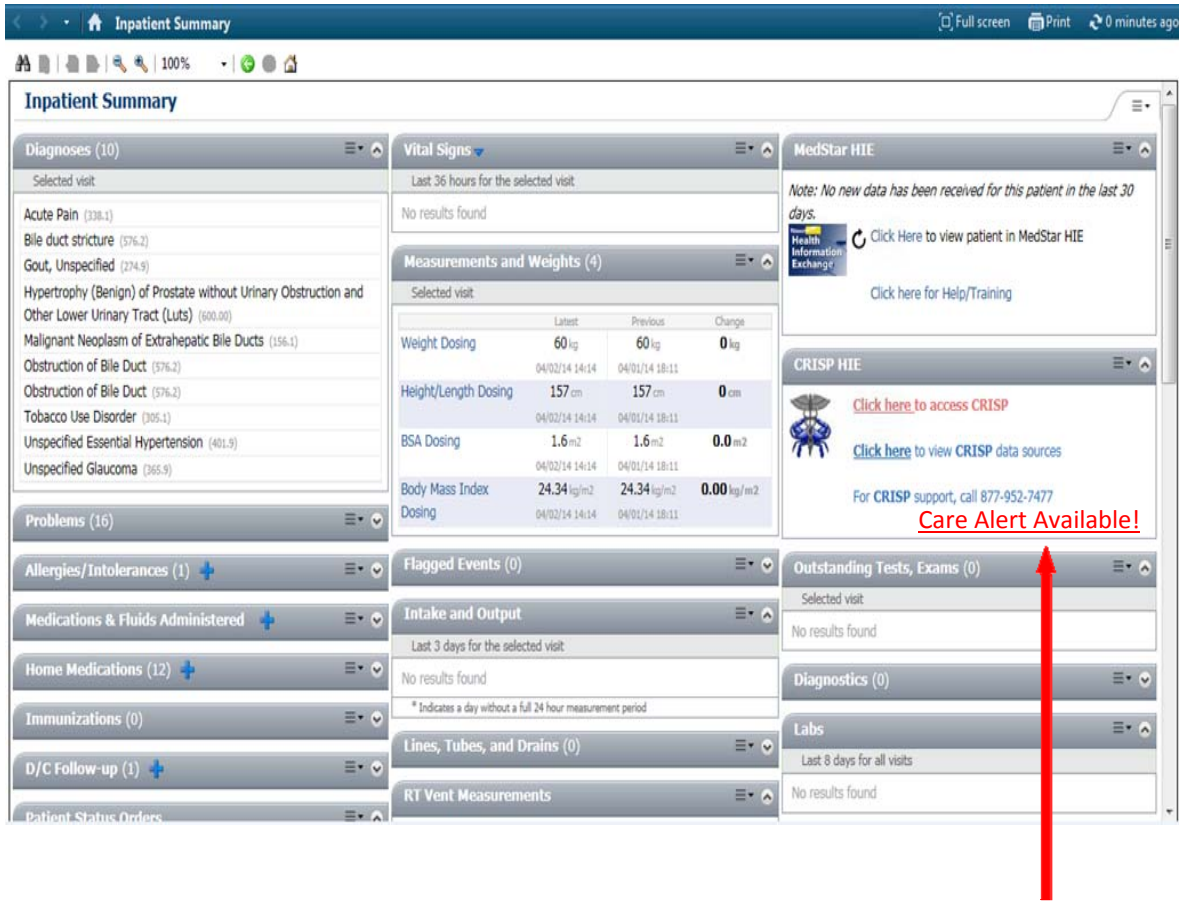
Clinical Query Portal Enhancements



Clinical Query Portal Enhancements – Improvements to the existing clinical query portal including approaches to simplify access, incorporating new content such as access to care profiles, and displaying the patient's providers.

In-Context Notifications and Alerting

- In-context alerting is intended to provide key information to clinical decision makers at the most effective point in their clinical workflows.
- An example of an in-context alert is pushing information to a hospital ER when a patient is registered indicating if a care plan is available in CRISP.
- In this in-context alert use case, a pre-defined method to access the care plan (or just key sections such as the care alert) would be established between CRISP and the receiving organization.



In-Context Notifications and Alerting – inclusive of a range of alert types sent to the point of care or to a care manager that pertains to critical information about a patient, identifies care gaps, indicates post-discharge follow-up care has not occurred, etc.

Care Profile View

Content Type / Source	Update Frequency
Patient Demographics	Daily
Clinical Alert Information	Daily
ENS Subscriber Information	Daily
ADT Data	Daily
CRS Case Mix Data	Monthly
Care Plan Availability Indicator	Daily

= to be developed

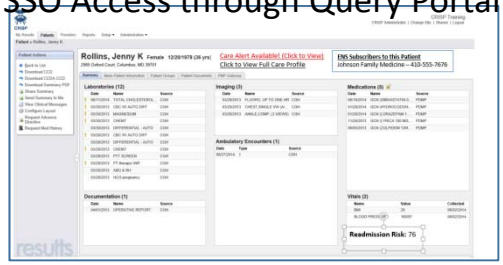
Care Profile

CRISP Care Profile Repository

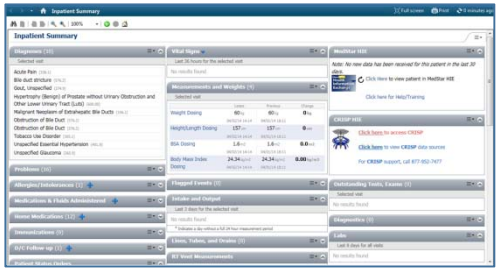
API

Access Methods

SSO Access through Query Portal



API call from EHR

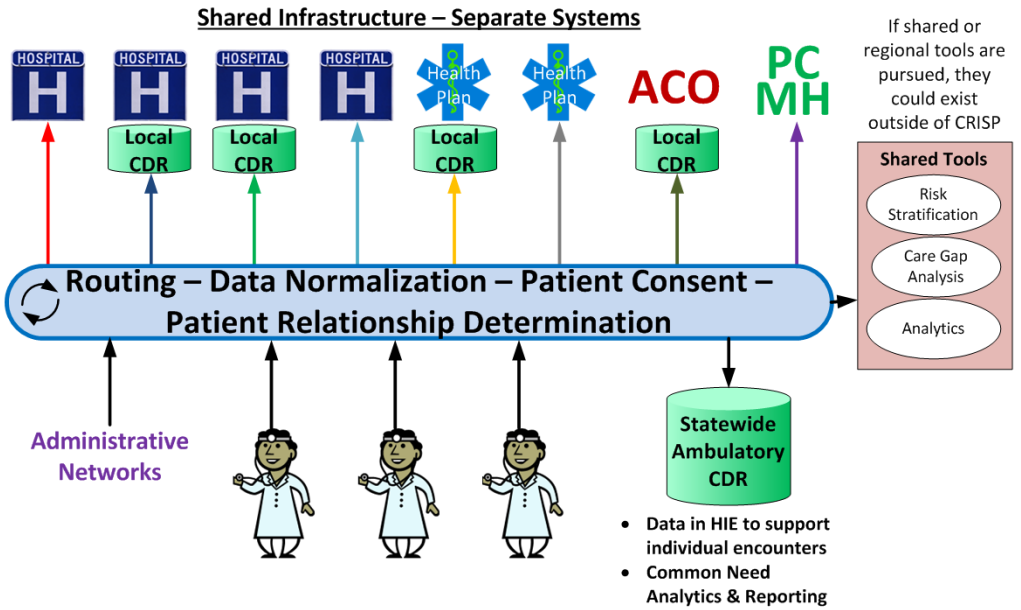


Link from ENS User Interface

Data Router and Non-Hospital Connectivity

Key Functions include:

- Consent management
- Data normalization
- Data routing
- Patient-provider relationships determination and management



Data Router - The router is a service that includes key functionality to support connectivity, consent management, data routing to other services or data consumers, and determine patient-provider relationships. These approaches may rely on connectivity through a health system, through a hosted EHR, directly to the practice, or via an administrative network.

Router Continued

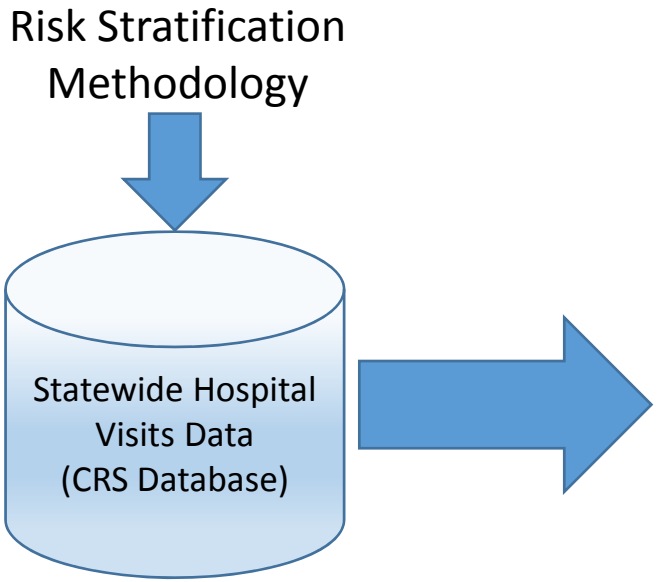
- **Connectivity and Routing** – inclusive of a range of connectivity approaches including connections to practice through health systems, direct connectivity to EHRs, hosted EHR connectivity, and administrative network connections.

- **Data Normalization** – applications of message transformation and vocabulary mapping services to inbound data.

- **Consent Engine** – the centrally managed consent engine will still require provider / care manager patient engagement and a significant patient education campaign. The consent engine will enable individuals to select more granular consent preferences that the current "all - in or all - out" choice.

- **Relationship Determination** – patient to provider relationships could be established and maintained through a range of data types flowing through CRISP, for example by using administrative claim data and ENS subscription panels. Other tools to enable management of those relationships are also planned in order to facilitate program enrollment (and consent), such as CCM.

Standardized Risk Stratification Tools



- Standardized and shared risk stratification and predictive modeling tools
- Supporting common understanding high risk patients
- Data feeds to provider care management systems
- Risk scores available through broader set of CRISP tools

Note: Over time, additional data, such as Medicare claims data, can supplement the currently available hospital case mix data.

Standardized Risk Stratification Tools - deployment of one or more centralized risk stratification methodologies to support stratification of patients initially using HSCRC case mix data housed in CRS but expanding to include broader data sets. Predictive risk score will be shared through a range of tools, including the query portal and ENS.

Monitoring Maryland Performance

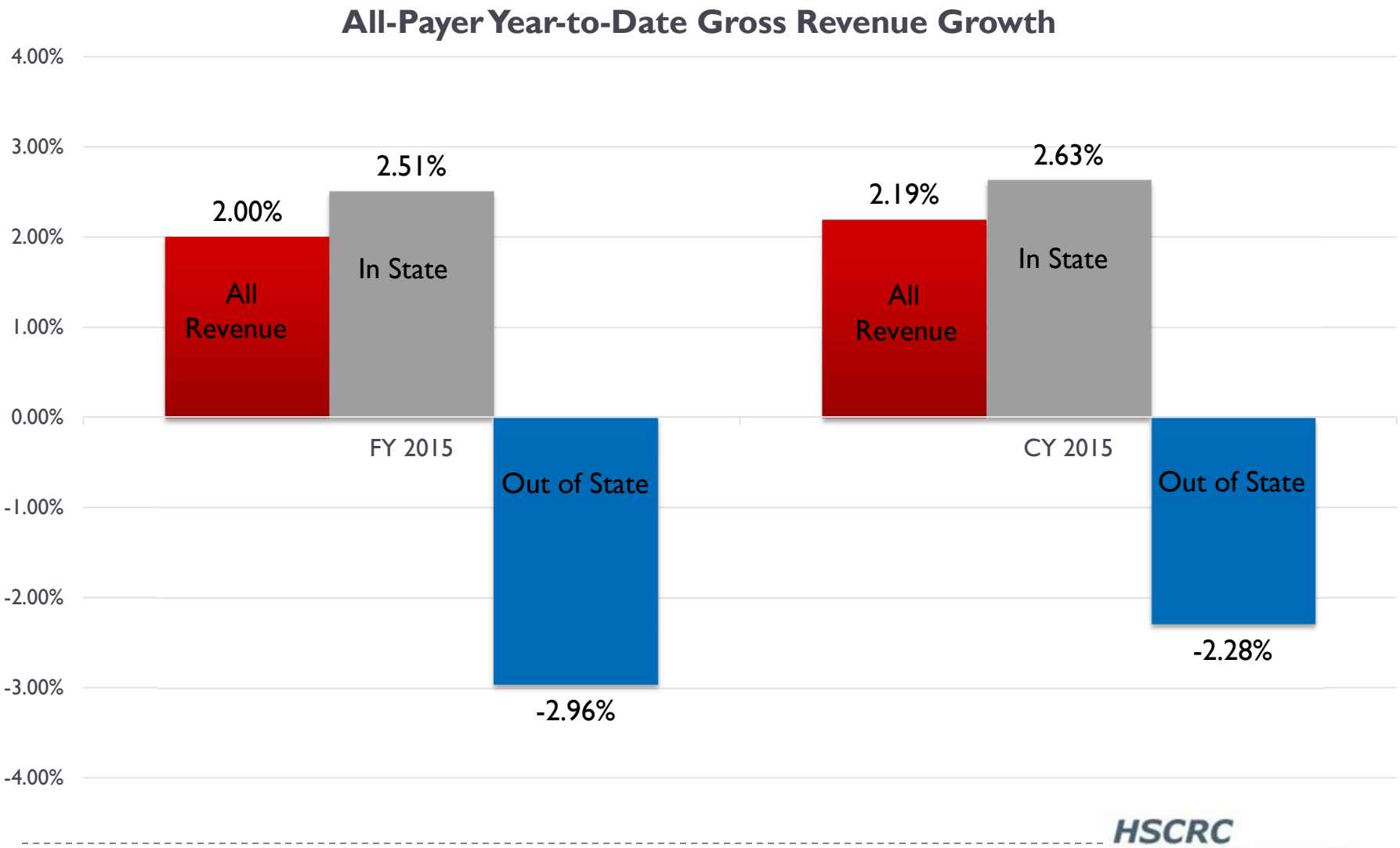
Financial Data

Year to Date thru June 2015

HSCRC
Health Services Cost Review Commission

Gross All Payer Revenue Growth

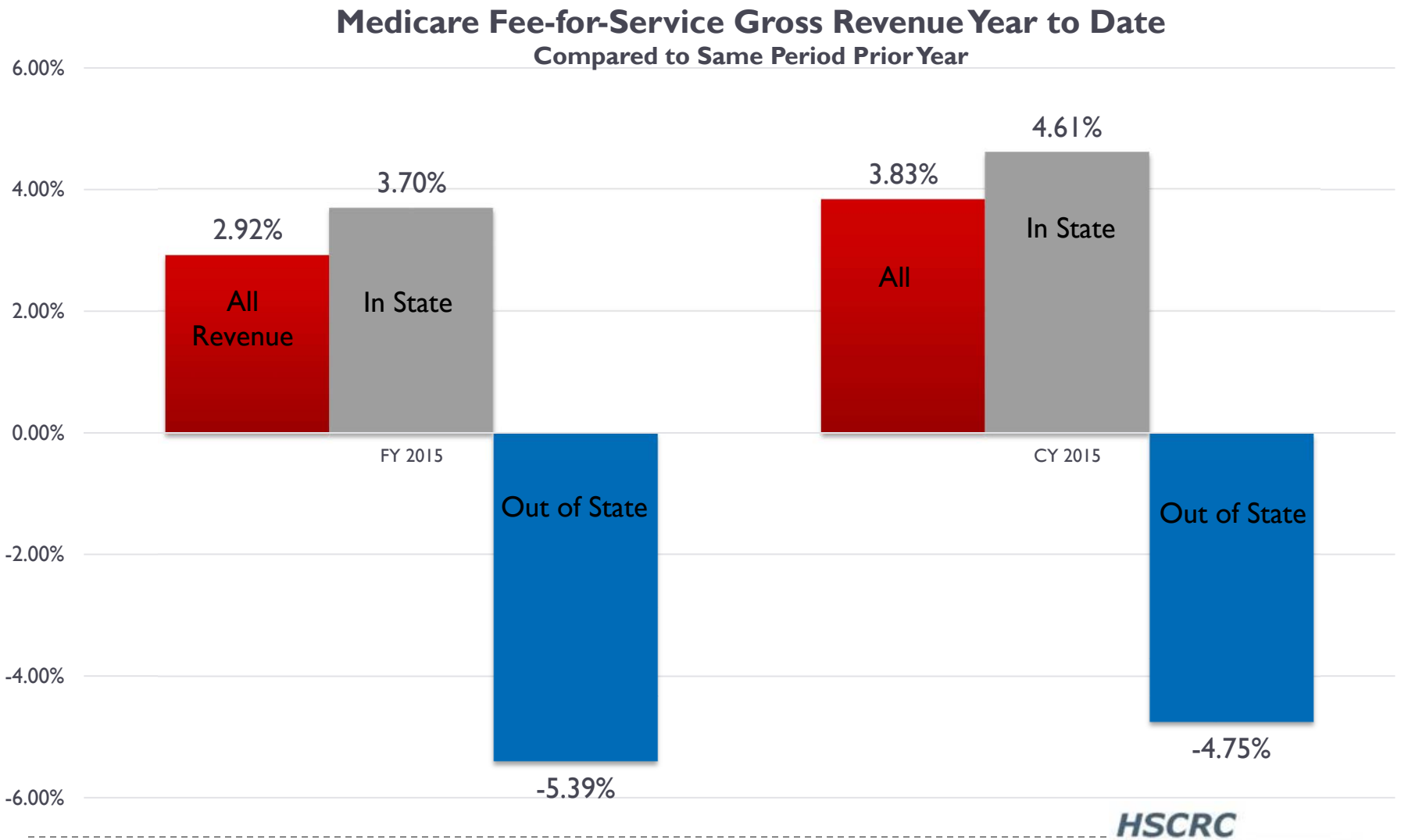
Year to Date (thru June 2015) Compared to Same Period in Prior Year



HSCRC
Health Services Cost Review Commission

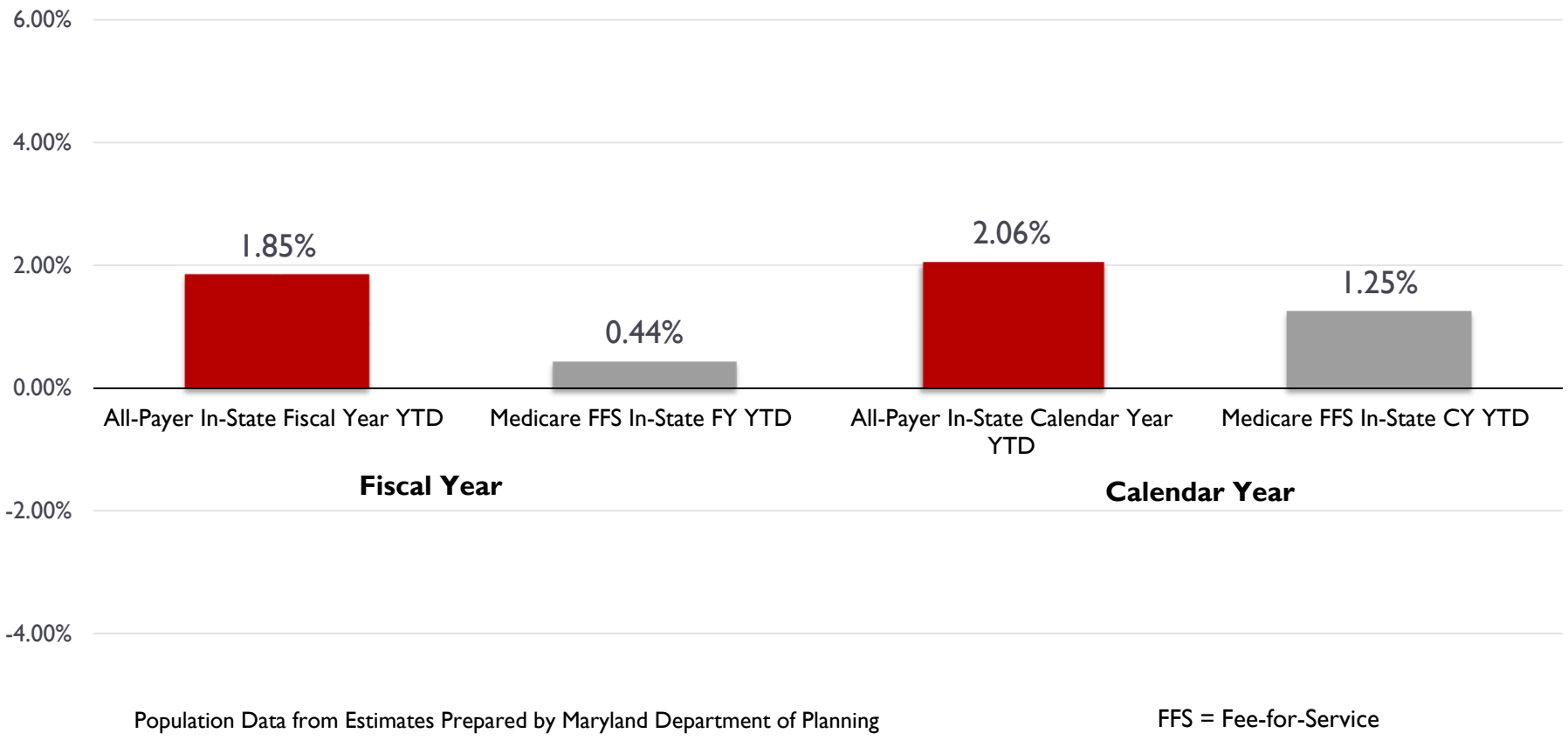
Gross Medicare Fee-for-Service Revenue Growth

Year to Date (thru June 2015) Compared to Same Period in Prior Year



HSCRC
Health Services Cost Review Commission

Per Capita Growth Rates
Fiscal Year 2015 and Calendar Year 2015



Population Data from Estimates Prepared by Maryland Department of Planning

FFS = Fee-for-Service

- **Calendar and Fiscal Year trends to date are below All-Payer Model Guardrail for per capita growth.**

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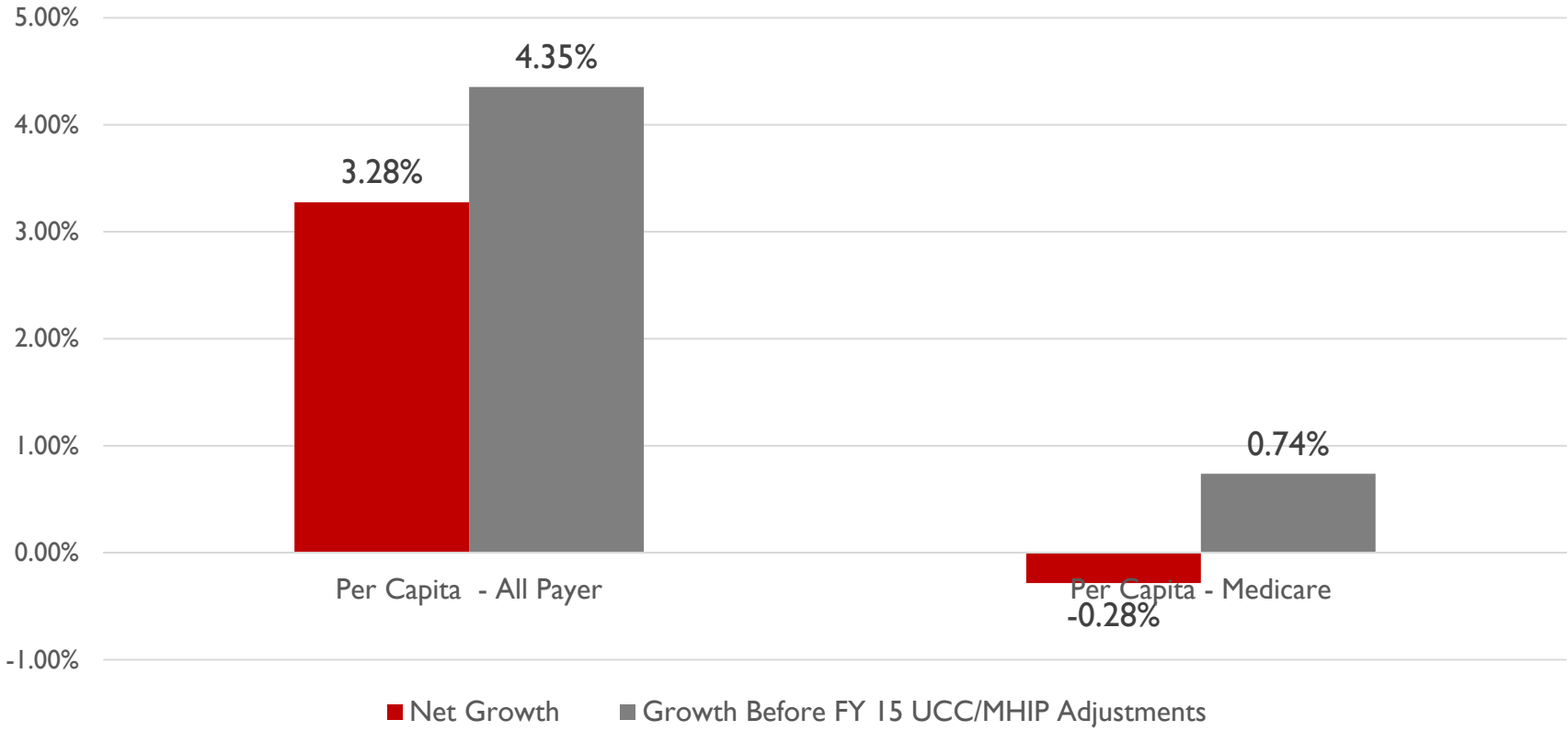
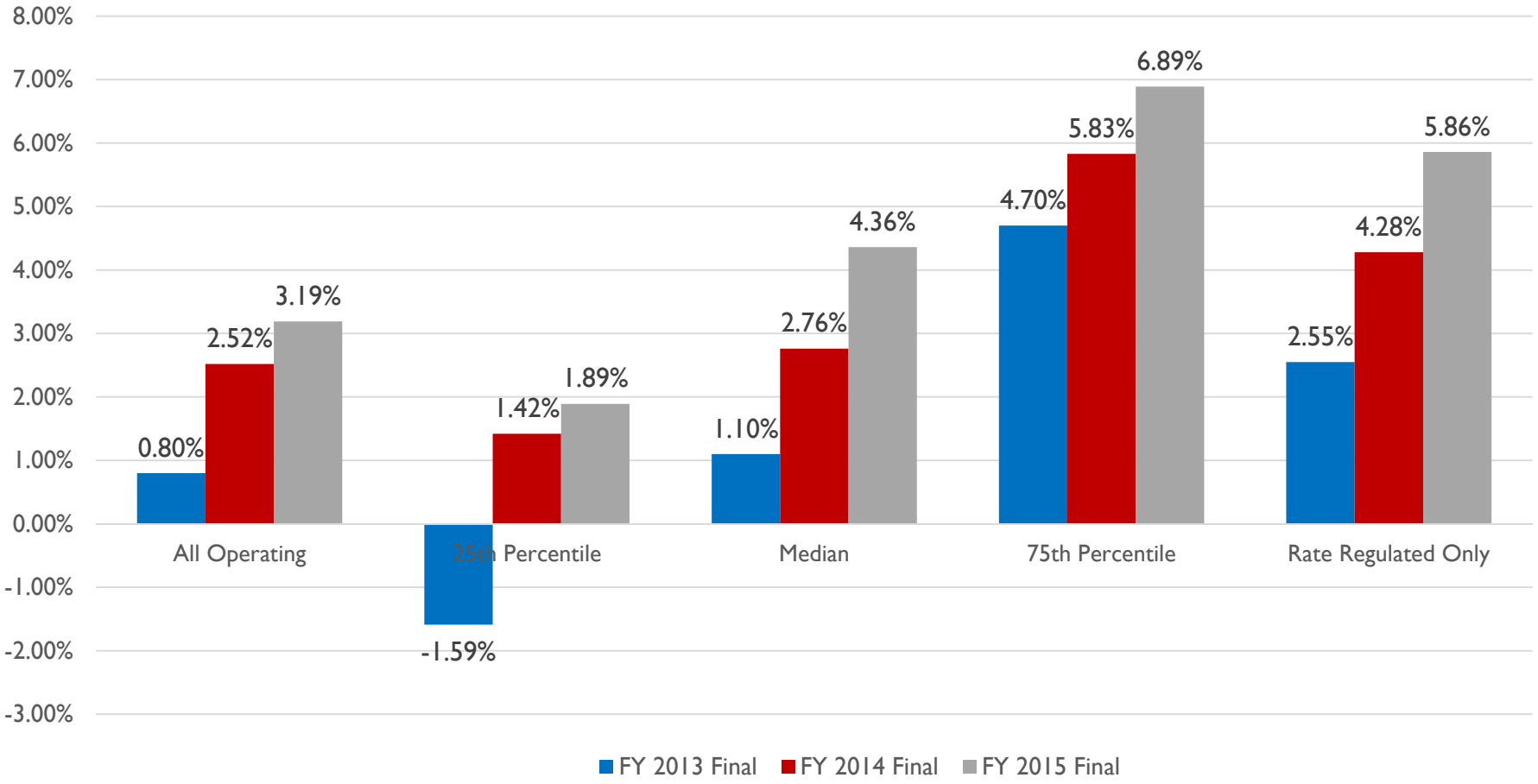
Per Capita Growth – Actual and Underlying Growth

CY 2015 Year to Date Compared to Same Period in Base Year (2013)



- Two year per capita growth rate is well below maximum allowable growth rate of 7.29% (growth of 3.58% per year)
- Underlying growth reflects adjustment for FY 15 revenue decreases that were budget neutral for hospitals. 1.09% revenue decrease offset by reduction in MHIP assessment and hospital bad debts.

Operating Profits: Fiscal 2015 (July 2014 –June 2015) Compared to FY 2013 and FY 2014



- FY 2015 hospital operating profits improved compared to FY 2013 and FY 2014.

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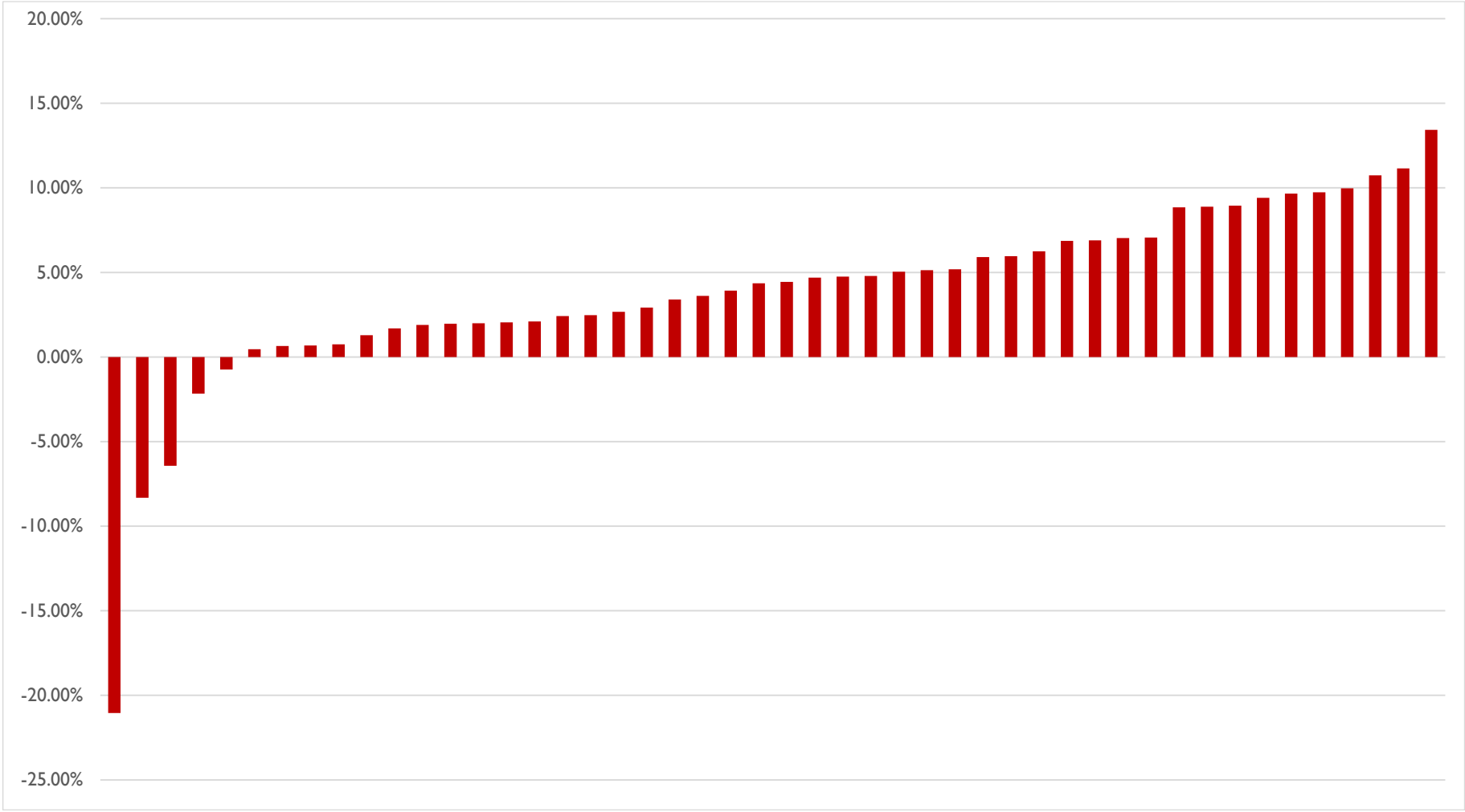
Operating Profits by Hospital

Fiscal Year to Date (July – June)



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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

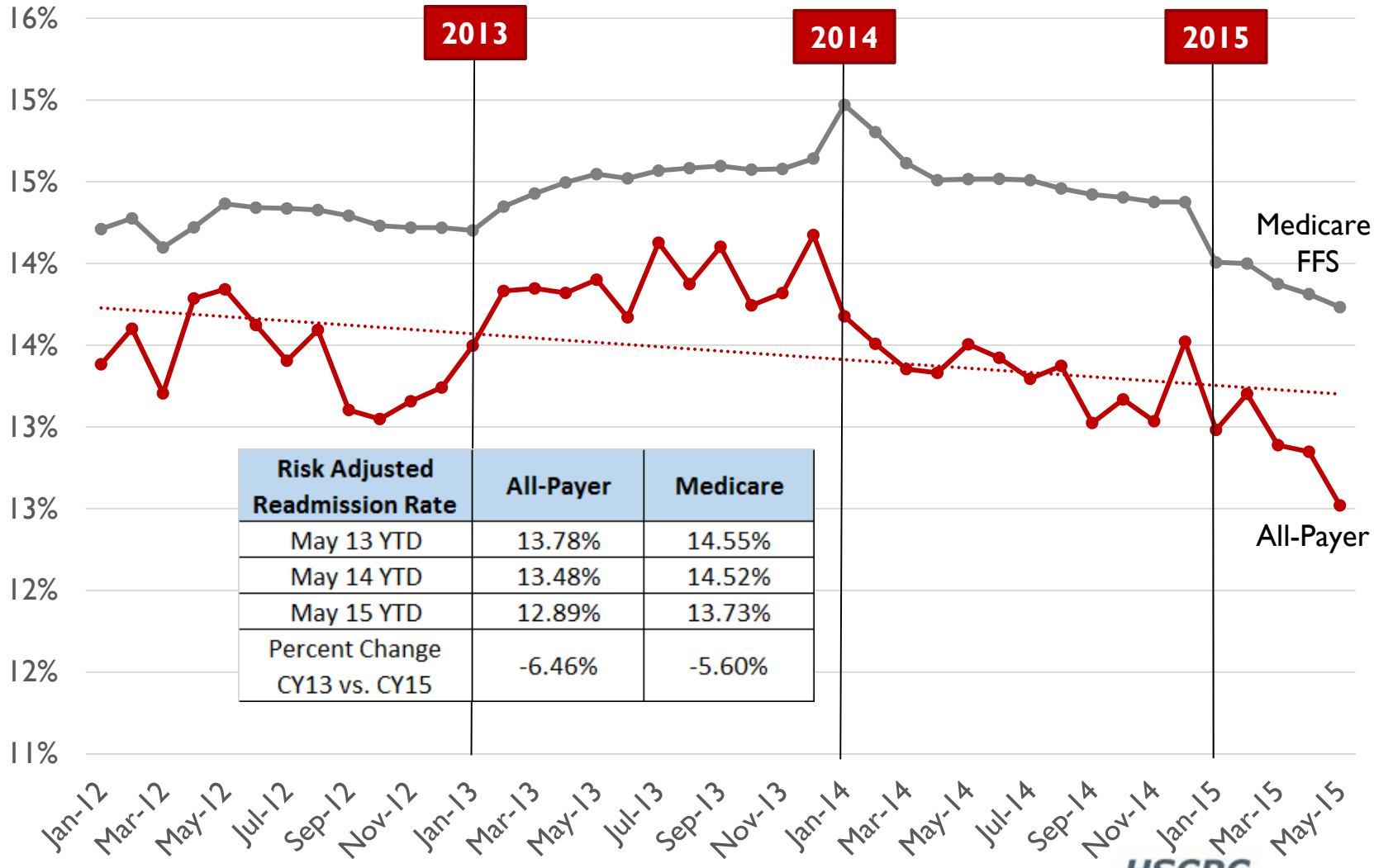
Data Caveats

- 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 2015 rely on Maryland Department of Planning projections of population growth of .64% for FY 15 and .56% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

Monitoring Maryland Performance
Quality Data

August 2015 Commission Meeting Update

Monthly Risk-Adjusted Readmission Rates



Risk Adjusted Readmission Rate	All-Payer	Medicare
May 13 YTD	13.78%	14.55%
May 14 YTD	13.48%	14.52%
May 15 YTD	12.89%	13.73%
Percent Change CY13 vs. CY15	-6.46%	-5.60%

Note: Based on final data for January 2012 - March 2015, and preliminary data through June 2015.

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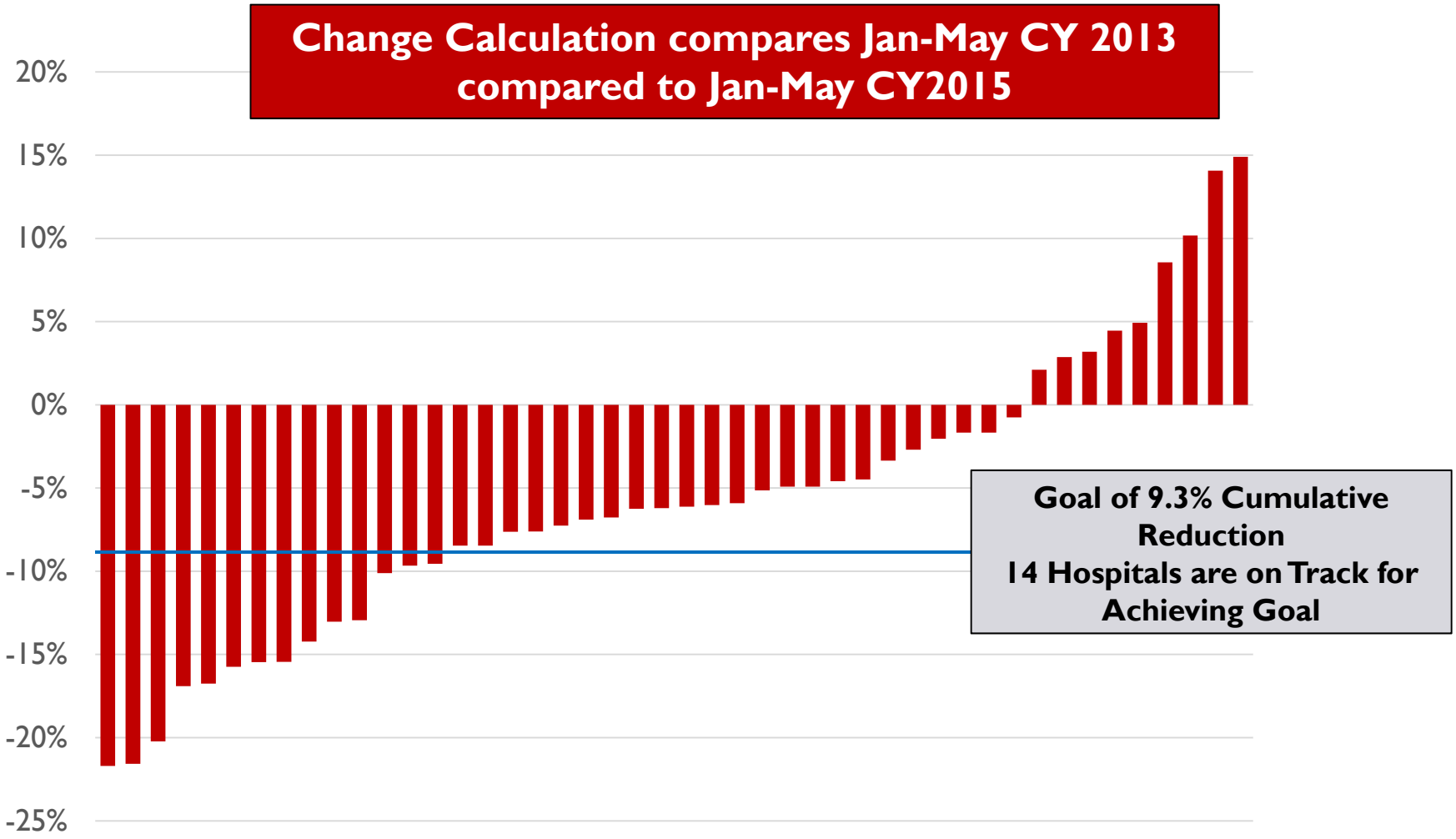
Change in All-Payer Risk-Adjusted Readmission Rates by Hospital



Note: Based on final data for January 2012 - March 2015, and preliminary data through June 2015.

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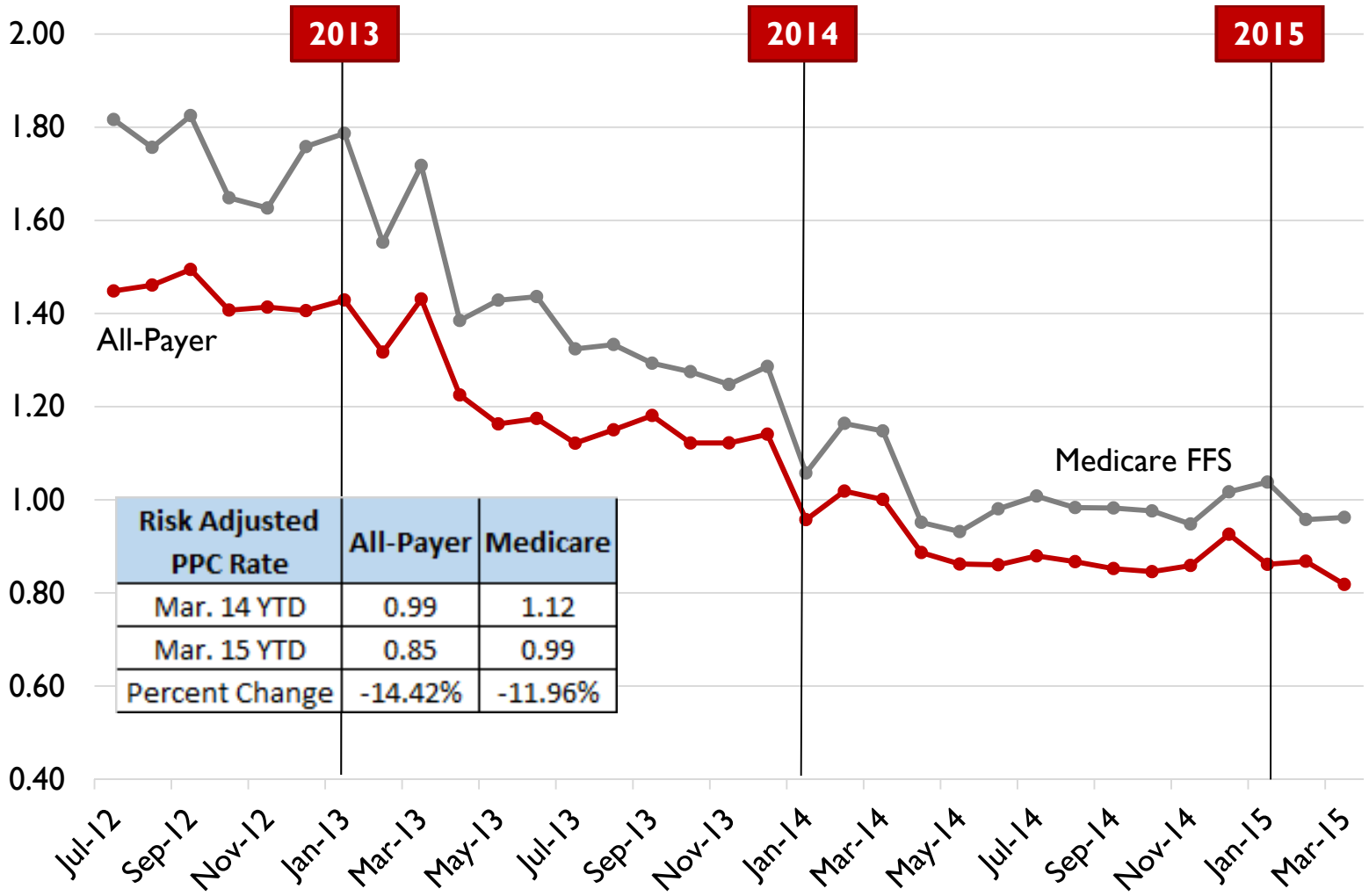
Monthly Risk-Adjusted PPC Rates



Risk Adjusted PPC Rate	All-Payer	Medicare
Mar. 14 YTD	0.99	1.12
Mar. 15 YTD	0.85	0.99
Percent Change	-14.42%	-11.96%

Note: Based on final data through March 2015. Includes PPC24.

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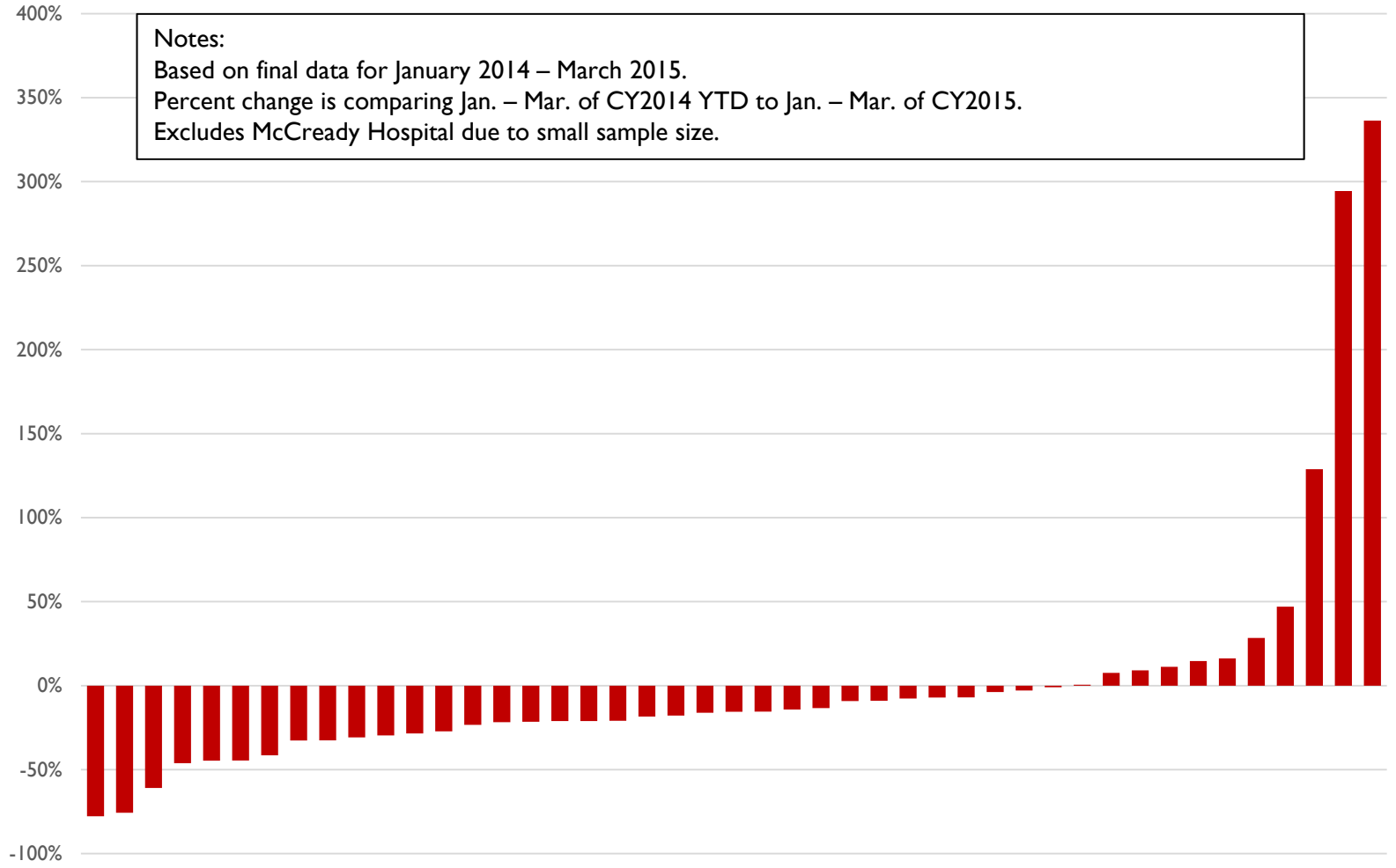
Change in All-Payer Risk-Adjusted PPC Rates YTD by Hospital



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Closed Cases

There were no closed cases from the June Commission meeting

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

AS OF AUGUST 4, 2015

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
2298A	MedStar Health	6/2/2015	N/A	N/A	ARM	DNP	OPEN
2299A	MedStar Health	6/2/2015	N/A	N/A	ARM	DNP	OPEN
2300R	Washington Adventist Hospital	6/8/2015	8/12/2015	11/5/2015	Capital	GS	OPEN
2301R	Holy Cross Hospital	6/12/2015	8/12/2015	11/5/2015	CCU/ICU	CK	OPEN
2302A	University of Maryland Medical Center	6/18/2015	N/A	N/A	ARM	DNP	OPEN
2303R	Frederick Memorial Hospital	7/10/2015	8/12/2015	12/7/2015	FULL	JS	OPEN
2304N	UM St. Joseph Medical Center	7/17/2015	8/17/2015	12/14/2015	CCU/DEF	CK	OPEN
2305A	University of Maryland Medical Center	7/30/2015	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
MEDSTAR HEALTH	*	**DOCKET:**	**2015**
	*	**FOLIO:**	**2108**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2298A**

Staff Recommendation

August 12, 2015

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on June 2, 2015 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for orthopedic services with MAMSI for a one year period beginning September 1, 2015.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. (HRMI). HRMI will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating the 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 AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff reviewed the experience under this arrangement for the last year and found that it was favorable. The staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for continued participation in the alternative method of rate determination for orthopedic services, for a one year period, commencing September 1, 2015. The Hospital 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 will formalize the understanding between the Commission and the Hospitals, and will 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**
MEDSTAR HEALTH	*	**DOCKET: 2015**
	*	**FOLIO: 2109**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2299A**

Staff Recommendation

August 12, 2015

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on June 2, 2015 on behalf of Union Memorial Hospital (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for cardiovascular services with the Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for one year beginning August 1, 2015.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. (HRMI). HRMI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was renegotiated in 2007. The remainder of the global rate is comprised of physician service costs. Also in 2007, additional per diem payments were negotiated for cases that exceed the outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff reviewed the results of last year's experience under this arrangement and found that they were favorable. Staff believes that the Hospital can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's request for continued participation in the alternative method of rate determination for cardiovascular services for a one year period commencing August 1, 2015. The Hospital 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 will formalize the understanding between the Commission and the Hospital, and will 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, and 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 PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*****	**COST REVIEW COMMISSION**
HOLY CROSS	*****	**DOCKET: 2015**
HOSPITAL	*****	**FOLIO: 2111**
SILVER SPRING, MARYLAND	*****	**PROCEEDING: 2301R**

Staff Recommendation

August 12, 2015

Introduction

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

Staff Evaluation

This rate request is revenue neutral and will not result in any additional revenue for the Hospital as it only involves the combining of two revenue centers. The Hospital wishes to combine these two centers because the majority of these services relate to medical/surgical intensive care versus coronary care; the patients have similar staffing needs; and nursing to patient staffing ratios for both patient populations are very similar. In addition, the Hospital will be consolidating these services into a single unit in November 2015. The Hospital's currently approved rates are as follows:

	Current Rate	Budgeted Volume	Approved Revenue
Medical Surgical Intensive Care	$1,714.92	12,791	$21,936,193
Coronary Care	$1,769.05	276	$488,016
Combined Rate	$1,716.09	13,067	$22,424,209

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That the Hospital be allowed to collapse its CCU rate into its MIS rate effective July 1, 2015;
2. That FY 2016 approved volume and revenue will be utilized to calculate the combined rate; and
3. That no change be made to the Hospital's Global Budget Revenue.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2015**
MEDICAL CENTER	*****	**FOLIO:**	**2112**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2302A**

Staff Recommendation

August 12, 2015

I. INTRODUCTION

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

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating 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 AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff found that the actual experience under the arrangement for the last year has been favorable. Staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The 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 a one year period commencing August 23, 2015. The Hospital 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 Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, 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**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2054**
MMEDICAL CENTER	*	**FOLIO:**	**2115**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2305A**

Staff Recommendation

August 12, 2015

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on July 30, 2015 seeking approval to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow services with Interlink Health Services for a period of one year beginning November 1, 2015.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians. Inc. ("UPI"), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital 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 solid organ and blood and bone marrow transplant services at the Hospital. 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 AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement among UPI, the Hospital, and the physicians holds the Hospital harmless from any shortfalls in payment from the global price contract. UPI maintains that it has been active in similar types of fixed fee contracts for several years, and that UPI is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under this contract for the previous year was favorable.

Staff believes that the Hospital can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The 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 a one year period commencing November 1, 2015. The Hospital 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 Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, 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.

HSCRC Consumer Engagement Taskforce Preliminary Report

Promoting Patient-Centered Approaches in the NAPM

HSCRC Meeting * August 12, 2014

CETF Members

Task Force Members

- Leni Preston, Chair
- Linda Aldoory, Herschel Horowitz Center for Health Literacy, University of Maryland
- Barbara Brookmyer, Frederick County Health Officer
- Kim Burton, Mental Health Association of Maryland
- Tammy Bresnahan, AARP
- Michelle Clark, Maryland Rural Health Association
- Shannon Hines, Kaiser Permanente
- Donna Jacobs, University of Maryland Medical System
- Michelle LaRue, CASA DE MARYLAND
- Karen Ann Lichtenstein, The Coordinating Center
- Susan Markley, HealthCare Access Maryland
- Suzanne Schlattman, Health Care for All!, MCHI
- Hillery Tsumba Primary Care Coalition of Montgomery County
- Gary Vogan, Holy Cross Hospital

DHMH Staff

- Dianne Feeney, HSCRC
- Theressa Lee, MHCC

CETF Charge #1

- Provide a rationale for health literacy and consumer engagement within the context of the New All-Payer Model (NAPM)
- Define audiences, identify messages, and propose engagement strategies as appropriate, including:
  - Systemic adjustments
  - Education and communication strategies
- Reflect the outcomes from the Communications and Community Outreach Task Force and the Care Coordination Workgroup

CETF Charge # 2

- Advise decision-makers, regulators, etc. on the impact of system transformation on individual and community health issues
- Provide guidance for ensuring an appropriate and consumer-friendly communications process
- Make recommendations for enhanced ways for consumers to provide feedback and for hospitals to act on that input

CETF Charge Fulfillment Process

- Monthly Taskforce Meetings
- Regular Subgroup Meetings
  - Charge 1-2 Subgroup
  - Consumer Outreach and Engagement Subgroup
- Weekly Leadership Meetings
- Ad-Hoc Committee Meetings and Assignments

CETF Charge Fulfillment Process

- Consultation and/or Presentations from Subject Matter Experts in:
  - Consumer Advocacy
  - Population Health
  - Consumer Engagement in Global Budget Environment
  - Consumer Complaints
  - Health Literacy
  - Consumer and Patient Advisory Boards
  - Evaluation
  - Care Coordination
  - Total Patient Revenue/Global Budgets
  - Performance Measurement

Recommendations

Consumer Engagement Goals

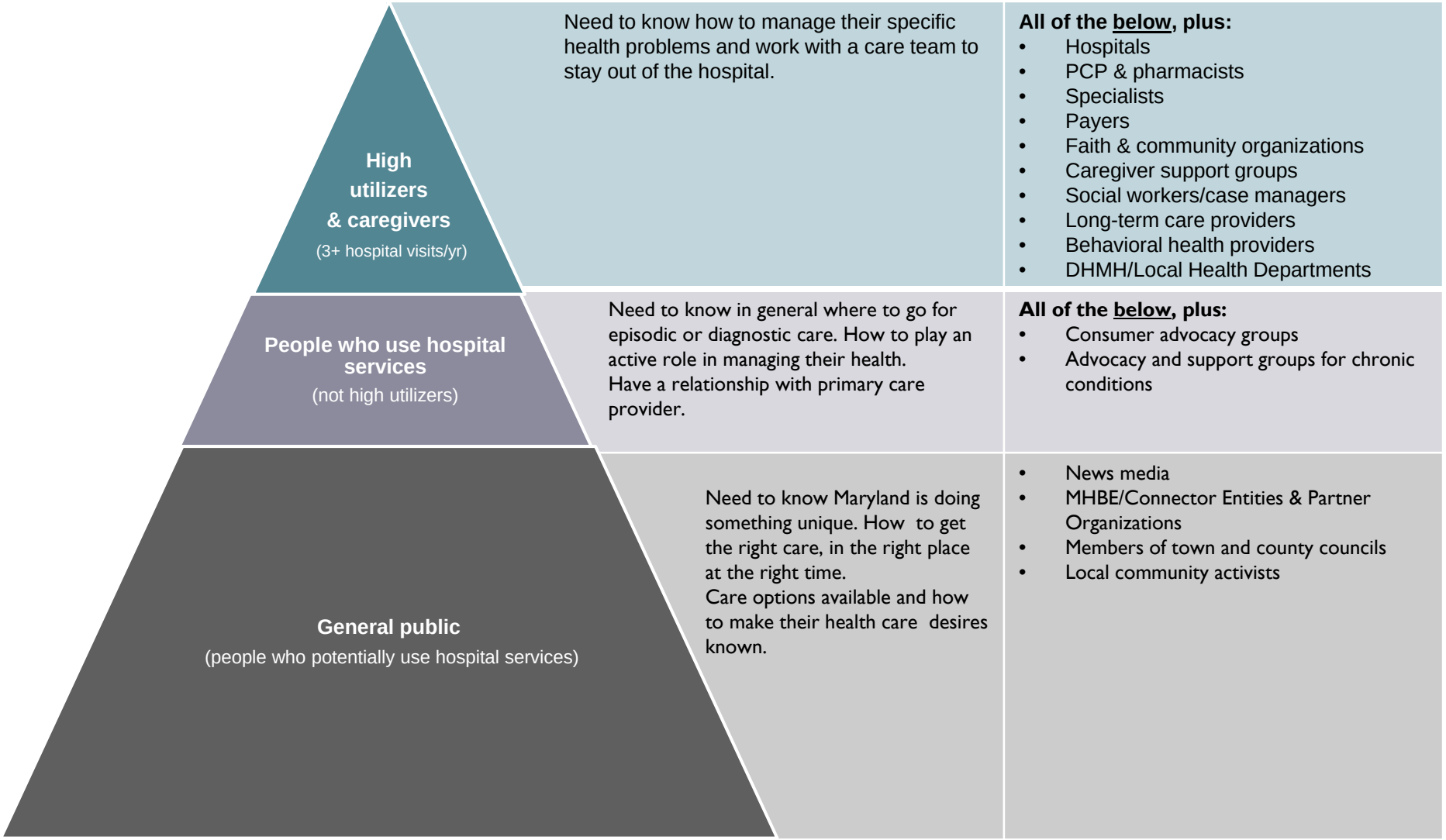
Goal #1

Establish a consumer-centered health care delivery system with an ongoing role for consumers to participate in the design and implementation of policies and procedures at all levels.

Goal #2

Engage, educate, and activate people who use or are potential users of hospital services in their own health care in order to promote efficient and effective use of the health care system.

Audiences Messages and Messengers



Communication Strategy:
Sample Recommended Strategies

Stakeholder	Strategy
All Stakeholders	Develop a statewide public education campaign to promote health and wellness.
Policymakers	Foster a consumer-centered health care system with policies and procedures informed by stakeholder involvement: • Consumer representative on HSCRC and standing advisory committee • Educate consumers on opportunities to serve on and/or interact with HSCRC and hospital patient and family advisory councils • Standardize hospital processes for receiving consumer feedback and establish data systems to aggregate and analyze feedback • Develop and promote a Consumer Gold Star system for hospitals based upon consumer engagement standards
Hospitals and Providers	Incentivize hospitals to support patients and caregivers ability to manage their own care, including access to community based health care resources.
Consumers	• Provide consumers with information and resources needed to make wise decisions and better manage their care. • Create a sense of ownership and involvement in the NAPM for the prime audiences by educating Marylanders about the NAPM and instilling pride and excitement that Maryland is creating a unique model of delivery system transformation • Engage local and regional news media to distribute frequent updates about the NAPM to their audiences

A Consumer-Centered Approach to Materials Development

- The following checklist serves as a minimum standards to ensure cultural/linguistic appropriateness of materials and accessibility of and efficacy of the messages provided:
  - Involve consumer representatives in developing materials
  - Use surveys and/or focus groups to solicit consumer feedback prior to mass production
  - Materials reflect the cultural and linguistic diversity of the populations served
  - Involve health literacy experts to ensure basic health literacy and CLAS standards are followed
  - Write materials for consumers at a 6th grade reading level
  - Ensure electronic materials are Section 508 compliant
  - All information is available in at least one format that is appropriate for all ability types and literacy levels
  - All information is available in print, online, and mobile formats allowing each consumer to select the format that is most helpful to him/her

CETF Final Report to Commission

- Overview, Vision, Mission, Principles, Goal, and Objectives
- Review of Existing Consumer Engagement Infrastructure
- Opportunities to Strengthen Infrastructure
- Recommended Communication Strategy
- Recommendations and Immediate Next Steps

CETF Next Steps

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

Questions?

Hospital CON Applications – August 5, 2015

	Applicant	Project Description	Cost	Status
Active Hospital Relocation Projects	**Washington Adventist Hospital – Takoma Park (Montgomery Co.)**	Relocation of acute general hospital (170 beds) except for psychiatric services) to Silver Spring (approx.. 6 miles NE of current location) Reconfiguration of existing campus to create special hospitals for psychiatric and acute rehabilitation services + outpatient services including 24/7 urgent care	Estimated Cost:: **$330,829,524 for** relocated general hospital **$5,223,506 for** Takoma Park Total: **$336,053,030** Source of Funds: Equity: **$51M** Debt: **$245M** Other: **$36M**	Docketed Jan. 2015 Three opposing interested parties; Laurel, Regional, Medstar Montgomery, & Holy Cross of Silver Spring City of Takoma Park is a participating entity Commissioner Phillips is Reviewer
	Prince George"s Hospital Center - Cheverly (Prince George's Co.)	Relocation of acute general and special hospital (231 beds – 216 acute general and 15 for Mt. Washington Pediatric) to Largo (approx.. 5 miles SE of current location)	Estimated Cost: **$651,223,000** Source of Funds: Equity: **$0** Debt: **$207M** Other: **$445M**	Docketed April 2015 Two opposing Interested parties: Doctors Community & Anne Arundel Prince George;s Co. HD is supportive interested party . Commissioner Moffit is Reviewer
	Sheppard Pratt at Ellicott City - Ellicott City (Howard Co.)	Relocation of special hospital-psychiatric (100 beds) to Elkridge	Estimated Cost: **$102,653,372** Source of Funds: Equity: **$18M** Debt: **$70M** Other: **$15M**	Filed April 2015 Not yet docketed
Other Active Hospital Projects	**Anne Arundel Medical Center - Annapolis (Anne Arundel Co.)**	Introduce cardiac surgery	Estimated Cost: **$2,500,381** All cash	Docketed June 2015 Interested party filing in opposition by MedStar
	University of Maryland Baltimore Washington Medical Center - Glen Burnie (Anne Arundel Co.)	Introduce cardiac surgery	Estimated Cost: **$1,259,117** All cash	Docketed June 2015 Interested party filing in opposition by MedStar
	Suburban Hospital - Bethesda (Montgomery Co.)	Major expansion & renovation Replace ORs, create new main entrance, add nursing units to create more private rooms, expand support service & mechanical space, shelled space, medical office space 300K SF in new consr. & 18K in renovation	Estimated Cost: **$200,550,831** Source of Funds: Equity: **$91M** Debt: **$70M** Other: **$40M**	Filed April 2015 Not yet docketed

	Inactive Hospital Projects			
	University of Maryland Shore Medical Center at Easton - Easton (Talbot Co.)	Relocation of general acute care hospital and special hospital unit for rehabilitation (126 beds) Approx. 2 miles NW of current site	Estimated Cost: **$283,240,375** Source of Funds: Equity: **$10M** Debt: **$243M** Other: **$31M**	Docketed Jan 2013 Inactive since 2014 – anticipated activation in late 2015
	MedStar Southern Maryland Hospital Center - Clinton (Prince George's)	Major expansion & renovation Four-story addition plus basement (165K SF) Renovation (44K SF) Modernize and expand the:ED, Surgery., ICU/CCU Establish a 32-bed dedicated Observation Unit	Estimated Cost: **$131,712,678** Source of Funds: Equity: **$37M** Debt: **$89M** Other: **$5M**	Not docketed Not responsive to questions posed in April, 2014

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Proposed Hospital Capital Projects: 2012-2015

A presentation to the Health Services Cost Review Commission

August 14, 2015

Center for Health Care Facilities Planning and Development
Maryland Health Care Commission

MARYLAND HEALTH CARE COMMISSION

Chronology

Filed in 2012

- **Fort Washington Medical Center: $20 M - Expansion/Renovation**
  Reconfigured to avoid CON regulation. Declined acceptance of "pledge" determination. Withdrawn.
- **University of Maryland Shore Medical Center at Easton: $283 M - Relocation/Replacement**
  Docketed. Inactive.

Filed in 2013

- **Washington Adventist Hospital: $331 M - Relocation/Replacement**
  Docketed. Active review.
- **Prince George's Hospital Center: $651 M - Relocation/Replacement**
  Docketed. Active review.
- **MedStar Southern Maryland Hospital Center: $132 M - Expansion/Renovation**
  Not docketed. Inactive.

Filed In 2015

- **Anne Arundel Medical Center: $2.5 M - Introduce Cardiac Surgery**
  Docketed. Active review.
- **University of Maryland Baltimore Washington Medical Center: $1.3 M - Introduce Cardiac Surgery**
  Docketed. Active review.
- **Sheppard Pratt at Ellicott City: $103 M - Relocation/Replacement**
  Not docketed. Active review.
- **Suburban Hospital: $201 M - Expansion/Renovation**
  Not docketed. Active review.

Relocation/Replacement Projects

	Gen. Acute Beds Lic.	PBC	Proposed	SF	Capital Costs	Total Costs
SMCE	112	184	112	359K	$265.6M	$283.2M
WAH	230	309	170/210	428K	$301.5M	$330.8M
PGHC	237	296	216	750K	$615.9M	$651.2M
SP/EC	92	92	100	171K	$100.7M	$102.7M

Source: MHCC/CON Applications

Relocation/Replacement Projects

	Source of Funds			Annual Interest/Depreciation/Amortization	
	Equity	Debt	Other	Most Recent	Post-Project
SMCE	$10M	$243M	$31M	$14M	$30M
WAH	$51M	$245M	$36M	$8M	$30M
PGHC	$0	$207M	$445M	$9M	$40M
SP/EC	$18M	$70M	$15M	$252K	$7M

Source: CON Applications/Audited Financial Statements

Expansion/Renovation Projects

	Source of Funds			Annual Interest/Depreciation/Amortization	
	Equity	Debt	Other	Most Recent	Post-Project
SMHC	$37M	$89M	$5M	$10M	$19M
Suburban	$91M	$70M	$40M	$16M	$31M

Source: CON Applications/Audited Financial Statements

More Information

The complete CON application filings for these projects can be found at:

http://mhcc.maryland.gov/mhcc/Pages/hcfs/hcfs_con/hcfs_con_filed_applications.aspx

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals

Authority: Health-General Article, § 19-217; Annotated Code of Maryland

NOTICE OF FINAL ACTION

On August 12, 2015, the Health Services Cost Review Commission adopted amendments to Regulation **.08** under **COMAR 10.37.01 "Uniform Accounting and Reporting System for Hospitals."** This action, which was proposed for adoption in 42:9 Md. R. 651 (May 1, 2015), has been adopted as proposed.

Effective Date: September 14, 2015

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

Statement of Purpose

The purpose of this action is to provide an exception for youth camps from those settings where a delegating nurse case manager would ordinarily be required.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

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

Youth camps will not have to have a full-time, on-site delegating nurse case manager if less than 50 percent of their campers have no medical problems. There will be a cost savings, but the savings is inestimable because the salary and number of nurses is unknown.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499 (TTY 800-735-2258), or email to dhmh.regs@maryland.gov, or fax to 410-767-6483. Comments will be accepted through June 1, 2015. A public hearing has not been scheduled.

.01 Exclusion from Regulations.

This chapter is not applicable to and does n t restrict or limit:

A.—E. (text unchanged)

F. An individual who performs nursing assistant tasks as a student while:

(1)—(2) (text unchanged)

(3) Practicing under the direct supervision of a nurse while working as a nursing assistant; [or]

G. A nurse from delegating a nursing task to an unlicensed individual if acceptance of delegated nursing tasks does not become a routine part of the unlicensed individual's job duties; *or*

H. A youth camp regulated in accordance with COMAR 10.16.06.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §19-217, Annotated Code of Maryland

Notice of Proposed Action

[15-118-P]

The Health Services Cost Review Commission proposes to amend Regulation **.08** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on March 11, 2015, notice of which was given pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about June 2, 2015.

Statement of Purpose

The purpose of this action is to conform to the requirements set forth in Ch. 263, Acts of 2014, effective July 1, 2014, that require hospitals to notify the Commission, in writing, within 30 days before executing any financial transaction, contract, or other agreement that would result in more than 50 percent of all corporate voting rights or governance reserve powers being transferred to or assumed by another person or entity.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

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

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Diana Kemp, Administrator II, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or call 410-764-2576, or email to diana.kemp@maryland.gov, or fax to 410-358-6217. Comments will be accepted through June 1, 2015. A public hearing has not been scheduled.

.08 Notification of Certain Financial Transactions.

A. General. A facility subject to the jurisdiction of the Commission shall notify the Commission, in writing, within 30 days before executing any financial transaction, contract, or other agreement that would:

(1) Pledge more than 50 percent of the operating assets of the facility as collateral for a loan or other obligation[; or]

(2) Result in more than 50 percent of the operating assets of the facility being sold, leased, or transferred to another person or entity; *or*

(3) Result in more than 50 percent of all corporate voting rights or governance reserve powers being transferred to or assumed by another person or entity.

B. Information Required. A facility shall file with the Commission within 30 days before executing a proposed financial transaction, contract, or other agreement as required in §A of this regulation, the following information:

(1) [The name and address of the person or entity to whom the operating assets of the facility are being sold, leased, transferred, or pledged as collateral for a loan or other obligations; and] *The name and address of the person or entity to whom:*

(a) The operating assets of the facility are being sold, leased, transferred, or pledged as collateral for a loan or other obligation; or

(b) The corporate voting rights or governance reserve powers are being transferred or assumed.

(2) (text unchanged)

C. — E. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

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 19-207; Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulations **.07-1** 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 August 12, 2015, notice of which was given pursuant to General Provisions Article, § 3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about November 23, 2015.

Statement of Purpose

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

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 amendments until October 5, 2015. A hearing may be held at the discretion of the Commission.

.07-1 Outpatient Services – At the Hospital Determination.

A. (text unchanged)

B. (text unchanged)

C. In accordance with Health-General Article, § 19-201, Annotated Code of Maryland, the Commission's rate-setting jurisdiction extends to outpatient services provided at the hospital. *Outpatient services associated with the federal 340B Program under the federal Public Health Service Act provided in a department of a regulated hospital that, on or before June 1, 2015, is under a merged asset hospital system, and which are physically located at another regulated hospital under the same merged asset hospital system, shall be subject to the rate-setting jurisdiction of the Commission.*

D.-J. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

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, §§ 19-207, 19-219, and 19-222; Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulations **.10** 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 August 12, 2015, notice of which was given pursuant to General Provisions Article, § 3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about November 23, 2015.

Statement of Purpose

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

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no 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 amendments until October 5, 2015. A hearing may be held at the discretion of the Commission.

.10 Docketing and Receipt.

A. – B. (text unchanged)

C. The hospital shall file an original and three copies of each rate application and its supporting documents, if any. *The Commission may prescribe the format to be used in the submission of rate applications and their supporting documents.* In addition, the hospital shall file with each rate application a certificate of service indicating that the application and supporting documents have been mailed or served upon all designated parties to that proceeding and upon the Commission at its offices.

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§ 19-207, 19-212, and 19-215; Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulations **.02** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on August 12, 2015, notice of which was given pursuant to General Provisions Article, § 3-302 (c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about November 23, 2015.

Statement of Purpose

The purpose of this action is to update the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operating Management (August, 1987), which has been incorporated by reference.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no 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 amendments until October 5, 2015. A hearing may be held at the discretion of the Commission.

02 Accounting System; Hospitals.

A. The Accounting System.

(1) (text unchanged)

(2) The “Accounting and Reporting System for Hospitals”, also known as the Accounting and Budget Manual for Fiscal and Operating Management (August, 1987), is incorporated by reference, including the following supplements:

(a)- (t) (text unchanged)

(u) Supplement 21 (June 5, 2012); [and]

(v) Supplement 22 (March 3, 2014) [.] ; and

(w) Supplement 23 (July 28, 2015).

(3) – (5) (text unchanged)

B. – D. (text unchanged)

JOHN M. COLMERS

Chairman
Health Services Cost Review Commission

State of Maryland
Department of Health and Mental Hygiene

John M. Colmers
Chairman

Herbert S. Wong, Ph.D.
Vice-Chairman

George H. Bone, M.D.

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Deputy Director
Research and Methodology

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **August 5, 2015**

RE: **Hearing and Meeting Schedule**

September 9, 2015	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
October 14, 2015	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-2015.cfm

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