Closed Session Minutes
Of the
Health Services Cost Review Commission

April 15, 2015

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

1. Status of Medicare Data Submission and Reconciliation;
2. Contract and modeling of the All-payer Model and legal consultation on potential alternative Medicare payment for hospital services vis-à-vis the All-payer Model Contract;
3. Personnel matters.

The Closed Session was called to order at 12:02 p.m. and held under authority of - §§ 3-104 and 3-305(b)(7) of the General Provisions Article.

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

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

Also attending were Leslie Schulman and Stan Lustman, Commission Counsel.

Item One

David Romans, Director-Payment Reform and Innovation, presented and the Commission discussed an updated analysis of Medicare per beneficiary data. Authority: General Provisions Article, § 3-104.

Item Two

The Chairman and Executive Director updated the Commission and the Commission discussed Potential Alternative Medicare Payment for Hospital Services vis-à-vis the All-Payer Model Contract – Authority General Provisions Article, §§ 3-104, and 3-305.

Item Three

The Executive Director updated and the Commission discussed various personnel resource issues. – Authority General Provisions Article, § 3-305(b)(1)(i)(ii)

The Closed Session was adjourned at 12:41 p.m.

MINUTES OF THE
518th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

April 15, 2015

Chairman John Colmers called the public meeting to order at 12:00 pm. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., MPH, Jack C. Keane, Bernadette C. Loftus, M.D., Thomas Mullen, and Herbert S. Wong, Ph.D. were also in attendance. Upon motion made by Commissioner Jencks and seconded by Commissioner Bone, the meeting was moved to Executive Session. Chairman Colmers reconvened the public meeting at 1:01 pm.

REPORT OF THE APRIL 15, 2015 EXECUTIVE SESSION

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the April 15, 2015 Executive Session.

ITEM I
REVIEW OF THE MINUTES FROM MARCH 11, 2015 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the March 11, 2015 Executive Session and Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, updated the Commission on the staff's activities over the past month. These activities consisted of:

- Developing draft recommendations:

    1. The uncompensated care policy update for rate year 2016;
    2. Ongoing funding support in FY 2016 for CRISP/HIE operations and supporting services.

- Developing a planned approach to update global budgets for rate year 2016 for estimated utilization increases related to the Medicaid expansion.
- Preparing the draft report from the care coordination work group;
- Preparing final recommendation for 2014 Budget Reconciliation and Financing Act (BRFA) funding for FY 2015;
- Developing an overview of the balance update calculations (staff still working on this).

For the months of April and May, Ms. Kinzer noted that staff will focus on:

- Providing a draft recommendation for the rate year 2016 balanced update;
- Continuing to work on the market shift adjustment
- Developing a draft recommendation for continued funding support of the Maryland Patient Safety Center;
- Reviewing of regional planning grants proposals together with the Department of Health and Mental Hygiene and review team.

Ms. Kinzer noted that the care coordination work group will be presenting its report to the Commission at this meeting. Ms. Kinzer emphasized that the results of this report must be discussed with hospital leadership and stakeholders around the State. HSCRC has an interest in this discussion, because it affects the success of the All-Payer Model.

Ms. Kinzer noted that staff sent out an ICD-10 survey to be completed by hospitals. Once these surveys are returned, staff will focus on the need to begin further work on this topic.

Ms. Kinzer noted that the BRFA regional planning applications are due today. Staff is appreciative of the efforts of hospitals, community organizations, and others in putting forth proposals. Staff is hopeful that regional planning will help accelerate effective approaches to care coordination and optimize resources, resulting in more effective patient centered approaches.

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

Mr. Romans reported that for the eight months ended February 28, 2015, All-Payer total gross revenue increased by 0.90% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 1.52%; this translates to a per capita growth of 0.87%. All-Payer gross revenue for non-Maryland residents decreased by 5.10%.

Mr. Romans reported that for the two months of the calendar year ended February 28, 2015, All-Payer total gross revenue decreased by 1.83% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents decreased by 1.26 %; this translates to a per capita growth of (1.81%). All-Payer gross revenue for non-Maryland residents decreased by 7.85%.

Mr. Romans reported that for the eight months ended February 28, 2015, Medicare Fee-For-Service gross revenue increased by 1.60% over the same period in FY 2014. Medicare Fee-For-Service for Maryland residents increased by 2.42%; this translates to a per capita growth of (0.79%). Maryland Fee-For-Service gross revenue for non-residents decreased by 7.15%.

Mr. Romans reported that for the two months of the calendar year ended February

28, 2015, Medicare Fee-For-Service gross revenue increased by 0.44%. Medicare Fee-For-Service for Maryland residents increased by 1.43%; this translates to a per capita growth of (1.99 %). Maryland Fee-For-Service gross revenue for non-residents decreased by 10.96%.

According to Mr. Romans, for the eight months of the fiscal year ended February 28, 2015, unaudited average operating profit for acute hospitals was 2.80%. The median hospital profit was 3.51%, with a distribution of 1.65% in the 25th percentile and 7.14% in the 75th percentile. Rate Regulated profits were 5.05%.

Dr. Alyson Schuster, Associate Director Data & Research, presented a quality report update on the Maryland Hospital Acquired Conditions program based upon readmission data on discharges through December 2014.

Potentially Preventable Complications

- The All-Payer risk adjusted PPC rate was 0.93 for December 2014 YTD. This is a decrease of 25.97% from the December 2013 YTD risk adjusted PPC rate.
- The Medicare Fee for Service risk adjusted PPC rate was 1.02 for December 2014 YTD. This is a decrease of 29.07% from the December 2013 risk adjusted PPC rate.
- These preliminary PPC results indicate that hospitals are on track for achieving the annual 6.89% PPC reduction required by CMMI to avoid corrective action.

Readmissions

- The All-Payer risk adjusted readmission rate was 12.00 % for December 2014 YTD. This is a decrease of 4.16% from the December 2013 risk adjusted readmission rate.
- The Medicare Fee for Service risk adjusted readmission rate was 12.95% for December 2014 YTD. This is a decrease of 2.25% from the December 2013 YTD risk adjusted readmission rate.
- Based on the New-Payer model, hospitals must reduce Maryland's readmission rate to or below the national Medicare readmission rate by 2018. The Readmission Reduction incentive program has set goals for hospitals to reduce their adjusted readmission rate by 6.76% during CY 2014 compared to CY 2013. Currently, only 15 out of 46 hospitals have reduced their risk adjusted readmission rate by more than 6.76%.

ITEM IV
DOCKET STATUS CASES CLOSED

2288R- MedStar Southern Maryland Hospital Center
2289R- MedStar Franklin Square Hospital Center
2290A- University of Maryland Medical Center
2291A- Johns Hopkins Health System
2292A- Johns Hopkins Health System
2293A- Johns Hopkins Health System

ITEM V
2294A- Johns Hopkins Health System

Johns Hopkins Health System filed an application on March 30, 2015 on behalf of its member hospitals (the "Hospitals") requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with Cigna Health Corporation for one year beginning May 1, 2015.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for one year beginning May 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2295A- John Hopkins Health System

John Hopkins Health System filed an application on March 30, 2015 on behalf of its member hospitals (the "Hospitals") requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with Aetna Health, Inc. for one year beginning May 1, 2015.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for one year beginning May 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

ITEM VI
REPORT OF THE CARE COORDINATION WORK GROUP

Mr. Jack Meyer and Greg Vachon of Health Management Associates presented recommendations of the Care Coordination Work Group that are intended to accelerate efforts to improve patient care and patient experience and reduce costs. (See "Care Coordination Workgroup- Care Coordination to Support Integrated Value Based Patient Centered Care" on the HSCRC website).

The Care Coordination Work Group recommends these immediate next steps:

- Engage Maryland healthcare leadership;
- Develop specific budget estimates and implementation plan;
- Initiate data process;

- Tap CRISP to organize data;
- Build data infrastructure and identify target population;
- Designate CRISP to identify consistent information that can be shared among providers and support different care management platforms;
- Designate CRISP to create a consistent care management platform;
- Design standardized care profiles;
- Establish consumer outreach strategy; and
- Develop a plan for sustainability of care coordination infrastructure.

ITEM VII
FINAL RECOMMENDATION ON INCREASING RATES IN FY 2015 TO IMPLEMENT 2014 BUDGET RECONCILIATION AND FINANCING ACT (BFRA) PROVISION

Mr. Steve Ports, Deputy Director Policy and Operations, presented the staff's final recommendation for funding of statewide infrastructure and planning of regional partnerships for health system transformation. (See "Final Recommendation: FY 2015 Rate Adjustment to Implement the 2014 Budget Reconciliation and Financing Act (BRFA) Provisions" on the HSCRC website).

Staff's final recommendations were:

That hospital rates be increased in FY 2015 beginning May 1, 2015 to provide up to $15 million to support:

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- Planning grants for regional partnerships for health system transformation (up to $2.5 million) – Rates will be increased only for those hospitals that are part of a collaborative RFP chosen by the review committee and approved by the Department and the Commission pursuant to the process outlined in the RFP.
- Common care coordination infrastructure to provide support on a statewide basis for specific opportunities to improve care coordination and chronic condition management (up to $12 million) – Rates will be increased for all hospitals to support this activity.
- The existing engagement of resources to assist (in conjunction with stakeholders) in further evaluation and planning of possible statewide infrastructure and approaches for care coordination and provider alignment ($1 million) – Rates will be increased for all or a subset of hospitals to support this activity.

The Commission voted unanimously to approve staff's recommendations.

ITEM VIII
DRAFT RECOMMENDATION FOR ONGOING FUNDING SUPPORT OF CRISP IN FY 2016 FOR HIE OPERATIONS AND REPORTING SERVICE ACTIVITIES

Mr. Ports presented staff's draft recommendations for FY 2016 funding to support Health

Information Exchange (HIE) Operations and the Chesapeake Regional Information System for our Patients (CRISP) (See "Draft Recommendation: Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 16 Funding to Support HIE Operations and CRISP Reporting Services" on the HSCRC website).

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the All-Payer Model and the public interest (Health- General Article, Section 19-219(c)), this recommendation is to provide continued funding support in FY 2016 in the amount of $3.19 million to CRISP, for the following purposes;

- HIE Operations; and
- Continuing CRISP reporting services to hospitals in the State.

Over the past six years, the Commission has approved funding to support the general operations of the CRISP and HIE through hospital rates.

In December 2013, the Commission approved continued funding support for CRISP during FYs 2015 through FY 2019 not to exceed $2.5 million in any year. At the May 2014 Commission meeting, staff reported that $1.65 million in funding support had been granted to CRISP for core operations in FY 2014.

In June of 2014, the Commission approved additional funding of $850,000 for specific CRISP functions related to the HSCRC's inter-hospital reporting capabilities. At that point, the Commission had approved a total of $2.5 million for HIE operations and CRISP Reporting Services.

In September of 2014, the Commission approved an additional $2 million (for a total of $4.5 million in FY 2015) to support expansion of its current monitoring capacity and engagement of resources to assist in further evaluation and planning of possible statewide infrastructure and approaches for care coordination and provider alignment, in conjunction with stakeholders.

For FY 2016, the staff is separating the funding request for HIE operations and standard CRISP reporting services from those relating to HIE connectivity expansion and ambulatory integration, statewide infrastructure needs, and related expanded reporting services, while further information can be gathered on potential needs and costs, The FY 2016 request for HIE operations and standard CRISP reporting services is $3.19 million, which exceeds the $2.5 million previously established maximum.

HSCRC and MHCC staff recommend that hospital rates be increased in FY 2016 by $3.19 million to continue to support the ongoing costs of CRISP/ HIE operations and reporting services. The FY 2016 budget for these functions is as follows:

- CRISP HIE Operations- $1,650,000 (consistent with funding in FY 2015);
- CRISP Reporting Services - $1,539,000 (compared to $1,850,000 in FY 2015).

As this is a draft recommendation, no Commission action is necessary.

ITEM IX
DRAFT RECOMMENDATION ON UNCOMPENSATED CARE POLICY FOR FY 2016

Mr. Romans presented staff's draft recommendation on the Uncompensated Care Policy for FY 2016 (See "Draft Report on Uncompensated Care Policy Recommendations" on the HSCRC website.

Since it first began setting rates, the HSCRC has recognized the cost of uncompensated care (charity care and bad debt) within Maryland's unique hospital rate setting system. As a result, patients who cannot pay for care are still able to access hospital services, and hospitals are credited for reasonable level of uncompensated care provided to those patients.

Under the current HSCRC policy, uncompensated care is funded by a statewide pooling system in which regulated Maryland hospitals draw funds from the pool if they experience a greater than average level of uncompensated care, and pay into the pool if they experience a less than average level of uncompensated care . This ensures that the cost of uncompensated care is shared equally across the hospitals in the system.

The HSCRC must determine the total amount of the uncompensated care that will be placed in hospital rates for FY 2016 and the amount of funding that will be available for the uncompensated care pool. Additionally, HSCRC must review the methodology for distributing these funds among hospitals.

Based on staff's analysis, the following draft recommendations are made:

- The uncompensated care provision in rates be reduced from 6.14% to 5.25% effective July 1, 2015;
- The combined results of the regression model and two years of historical data underpinning the FY 2015 uncompensated care policy be reused for FY 2016:

    1. No update to the regression results
    2. Combine the regression results with the same two years of actual data (FY 2012 and FY 2013) incorporated into the FY 2015 policy.
    3. Subtract the ACA driven decline in self pay/charity charges from CY 2013 and CY 2014 from the modeled uncompensated care result for each hospital to derive its final percentage for determining its contribution or withdrawal from the uncompensated care pool. Appendix II shows the result of this calculation.

- The Charity Care Adjustment be suspended indefinitely and not be reinstituted in FY 2016 rates;
- Data continued to be collected on write offs to guide future development of uncompensated care regression models and uncompensated care policies;

- Data continued to be collected on outpatient denials, in addition to data already collected on inpatient denials, to understand the continuing trends in denials under the new All-Payer model; and
- A new uncompensated care policy be developed for FY 2017 that reflects the patterns in uncompensated care experience, which are observed in FY 2015 and projected for FY 2016,

As this is a draft recommendation no Commission action is necessary.

ITEM X
GLOBAL BUDGET UPDATE: MEDICAID UTILIZATION ADJUSTMENT

Mr. Roman presented staff's update on the Medicaid utilization adjustment in regards to the hospital global budgets (See "Impact of ACA's Medicaid Expansion on Hospital Utilization Planned Adjustments per Global Contracts Provisions" on the HSCRC website)

On January 1, 2014, the Maryland Medicaid Program extended full coverage to adults with incomes up to 138% of the poverty level who previously were ineligible for Medicaid or qualified for a limited benefit through the Primary Adult Care (PAC) Program. The coverage expansion authorized by the federal Patient Protection and Affordable Care Act of 2010 (ACA) enrolled more than 200,000 people during CY 2014.

Global budgets for FY 2015 were prospectively adjusted to capture a portion of the expected decline in uncompensated care resulting from the Medicaid expansion. No adjustments were made to capture the potential impact on volume of uninsured and underinsured individuals increasing their utilization of hospital services after enrolling in Medicaid. Global budget contracts did, however, include a provision indicating the Commission would review the impact of the Medicaid expansion on volumes and adjust funding as appropriate.

Mr. Romans noted that this report includes the results of the analysis and planned FY 2016 adjustments to rates to capture the ongoing impact of the Medicaid expansion on hospital utilization.

Based on Staff's analysis, the following adjustments will be made to the Global Budget and Total Patient Revenue agreements:

- Increase rates for FY 2016 by $57 million (0.36%) to capture the outgoing uptick in volumes associated with the calendar 2014 Medicaid expansion
- Allocate the additional funding across hospitals based on the actual growth in charges associated with the expansion population in CY 2014. Each hospital will receive about 26% of the growth in adjusted charges associated with people who enrolled in the expansion in the 1st quarter of 2014
- Continue to monitor the utilization rate of expansion enrollees and report back to Commission in six months regarding the ongoing trends

ITEM XI
WORK GROUP UPDATE

Mr. Romans updated the Commission on the activities of the Payment Models Work Group, including the review of a template Staff will use to develop the annual update factor. Dr. Sule Calikoglu, Deputy Director, Research and Methodology, outlined staff's activities to finalize the market shift policy (See "Update on Work Groups" on the HSCRC website).

ITEM XII
LEGISLATIVE REPORT

Mr. Ports presented a summary of the legislation of interest to the HSCRC (see "Legislative Update- April 15, 2015" on the HSCRC website).

The Bills included: 1) House Bill - 72 Budget Reconciliation Act of 2015; 2) Senate 513/House Bill 613 - Rate Setting- Participation in 340B Program Under the Federal Public Health Service Act; 3) Senate 585/House Bill 553 - Maryland No-Fault Birth Injury Fund; 4) Senate 479/ House Bill 398 - Civil Actions- Noneconomic Damages- Catastrophic Injury; 5) Senate 469/ House Bill 367- Public Health- Maryland Behavior Health Crisis Response System; 6) Senate 572/ House Bill 1006- Hospitals - Designation of Caregivers; 7) Senate 539/ House Bill 944 Patient Referrals - Oncologists- Radiation Therapy Services and Nondiagnostic Computer Tomography Scan Services; 8) House Bill 683- Health Occupations - Magnetic Resonance Imaging Services and Computed Tomography Services- Patient Referrals; 9) Senate 870/House Bill 1261- Garrett County – Memorial Hospital – Board of Governors.

ITEM XIII
HEARING AND MEETING SCHEDULE

May 13, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
June 10, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 2:55 pm.