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Department of Health and Mental Hygiene

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527th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
February 10, 2016

EXECUTIVE SESSION
12:00 p.m.
(The Commission will begin in public session at 12:00 p.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1PM.)

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

2. **Update on Hospital Rate Issue (JHH) - Authority General Provisions Article, §3-305 (7)**

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on January 13, 2016**

2. **Executive Director's Report**

3. **New Model Monitoring**

4. **Docket Status – Cases Closed - None**

5. **Docket Status – Cases Open**

2317R – Holy Cross Health	**2319R – Sheppard Pratt Health System**
2320N – Sheppard Pratt Health System	**2328A – MedStar Health**
2329A – University of Maryland Medical Center	**2330A – University of Maryland Medical Center**
2331A – Johns Hopkins Health System	**2332A – Johns Hopkins Health System**
2333A – Johns Hopkins Health System	**2334A – University of Maryland Medical Center**
2335A – Johns Hopkins Health System	**2336A – Johns Hopkins Health System**

6. **Advancing Telehealth in Maryland – An MHCC Update**

7. **Update from CRISP on Implementation of Infrastructure and Analytics**

8. **Legislative Update**

9. **Hearing and Meeting Schedule**

Closed Session Minutes
Of the
Health Services Cost Review Commission

January 13, 2016

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

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

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

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

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

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

Item One

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

Item Two

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

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

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

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

January 26, 2016

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

1. Strategy regarding the All-Payer Model;

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

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

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

Also participating by telephone was Stan Lustman, Commission Counsel.

Item One

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

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

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

January 13, 2016

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

REPORT OF THE JANUARY 13, 2016 EXECUTIVE SESSION

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

ITEM I

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

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

ITEM II

EXECUTIVE DIRECTOR'S REPORT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ITEM III

NEW MODEL MONITORING

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

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

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

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

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

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

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

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

ITEM IV

DOCKET STATUS CASES CLOSED

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

ITEM V

DOCKET STATUS- OPEN CASES

NONE

ITEM VI

PERFORMANCE MEASUREMENT WORK GROUP UPDATE ON READMISSIONS

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

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

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

ITEM VII

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

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

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

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

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

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

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

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

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

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

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

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

ITEM VIII

SUMMARY OF GLOBAL BUDGET INFRASTRUCTURE REPORTS

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

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

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

REGIONAL PLANNING GRANTEE SUBMISSIONS

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

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

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

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

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

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

Recommendations for next steps:

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

HOSPITAL STRATEGIC TRANSFORMATION PLAN REPORTS

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

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

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

Some of the observed strengths include:

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

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

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

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

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

ITEM IX

UPDATE FROM CRISP ON IMPLEMENTATION OF INFRASTRUCTURE

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

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

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

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

ITEM X

HEARING AND MEETING SCHEDULE

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

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

Executive Director's Report

Health Services Cost Review Commission

February 10, 2016

Progress on Requests for Data and Approval of Alignment Model Activities

The HSCRC and DHMH staffs are working with the Center for Medicare & Medicaid Innovation (CMMI) to amend the All-Payer Model Agreement. Specifically, tools that are available to Accountable Care Organizations (ACOs) and bundled payment programs need to be made available to support the alignment, integration, and care coordination activities necessary to move the Model forward.

HSCRC and DHMH staffs have been coordinating the request to CMMI with the Maryland Hospital Association and MedChi, the Maryland State Medical Society.

- Maryland Hospital Association has worked with hospitals to develop a flexible program that allows hospitals to share savings with hospital based physicians and physicians with admitting privileges. When quality is improved, care transitions are improved, and internal hospital cost savings are achieved.
- HSCRC has been working with MedChi and a task force on a pay-for-outcomes approach that is organized around Medicare's Chronic Care Management fee. This approach would focus the joint efforts of hospitals and primary care and other community providers on complex high needs patients who need more intense support and interventions as well as patients with multiple chronic conditions who can benefit from chronic care management. This would allow hospitals to share savings from their global budget with community providers when avoidable utilization such as PQIs and readmissions are reduced. It would also allow hospitals to help support chronic care management activities in concert with community providers.
- Maryland has Total Cost of Care guardrails for Medicare in its All-Payer Model agreement with CMS. However, these guardrails have not been taken to a deeper level than statewide. Although there will be no downside risk associated with guardrails, Maryland will focus on creating geographic guardrails for non-hospital costs for Medicare, which can be viewed together with global budgets for Medicare. The purpose of these guardrails is to ensure that incentive payments do not result in cost shifting to the non-hospital setting. If total costs exceed target levels, incentive payments to non-hospital providers will be limited or prohibited.

- Maryland will seek Medicare data to utilize in care coordination activities, such as risk stratification, opportunity assessment, evaluation of model performance, and administering the payment model requirements of the agreement. This is similar to data provided to ACOs.

Advisory Council

The Advisory Council has been reconvened by DHMH and HSCRC to provide advice on progression of the All Payer Model. The membership of the Advisory Council was expanded to include additional community providers, since the progression of the model focuses on system-wide participation and performance. The first meeting of the Advisory Council was held on February 3, 2016, and was facilitated by Jack Meyer of Health Management Associates. There will be another meeting on February 19 at HSCRC offices.

Progress on Review of Implementation Grant Proposals

In June 2015, the Commission authorized an increase in hospital rates of up to 0.25% in FY 2016 (approximately $40 million) to be awarded on a competitive basis to hospitals that are ready to implement community-based care coordination initiatives that will have near term reductions in potentially avoidable utilization. In response to a request for proposals, Commission staff received 22 transformation implementation grant applications that involve 45 hospitals requesting approximately $90 million in implementation funding. Many applications include multiple hospitals as well as community partners.

An independent review committee consisting of HSCRC, DHMH, CRISP, Maryland Community Health Resources Commission (MCHRC), payer staff, and two contracted independent reviewers met on January 19 and February 1 to consider the applications and evaluate their efficacy in achieving the identified transformation goals. During these meetings, the review team expressed the desire to obtain further clarification from many of the applicants, and, therefore, will be sending letters this week to those applicants with a series of questions. Upon receipt of the responses, the review team will reconsider the applications and, as deemed appropriate, may meet with the applicants and their partners to discuss the grant applications in further detail. Staff anticipates submitting recommendations to the Commission during its April public meeting.

Market Shifts

In the current year, we have seen several large market shifts. In order to ensure consumer centeredness, the HSCRC staff believes it is important to move money when patients shift from one institution to another, whereby the receiving institution receives a marginal cost adjustment of 50% to care for the larger share of patients. The staff has accelerated its ability to produce market shift reports. In order to ensure attention to consumers, HSCRC staff is considering a process to make market shift adjustments on a semi-annual basis. If shifts become smaller in the future, staff may want to return to an annual basis.

- Under a semi-annual adjustment, a 12 month adjustment would be made with the July 1 rate order, based on the shift for the preceding calendar year. A 6 month adjustment would be made with a rate order effective January 1 for the January through June period of the preceding year. The staff believes a final settlement of the adjustment using 12 months of data is important. Using the full year reduces the problems that can occur with small cells and data corrections
- Staff wants to release corridors for hospitals that are reducing avoidable utilization. However, if volumes have been shifted to other hospitals or to an unregulated setting, staff will need to reduce the global budget for these items prior to releasing corridors. Semi-annual market shift adjustments will help with this issue. We will also ask hospitals to certify at the time of release regarding any shifts to unregulated sites.
- Staff has and will continue to make market shift adjustments when significant events occur, such as closure of a service, movement of a service, or very large shifts.
- Staff received a few requests to resubmit the data for outpatient visits. As we move to a semi-annual adjustments, it is critical that hospitals submit correct and timely data to HSCRC.
- Staff has been having discussions with MIEMSS regarding ER diversions. In order to ensure that the receiving hospital has resources for taking care of diverted patients, HSCRC is requesting that MIEMSS provide information on the number of patients diverted and the receiving institution. With this information, we will be able to develop an approach to ensure that resources are aligned properly.

Reducing avoidable utilization is critical to balance the All Payer Model. HSCRC wants to encourage these activities as they are critical to the success of the Model. At the same time, we need to ensure that resources are moved when market shift occurs.

Shared Savings, Readmissions, and PAU Adjustments

As part of the 2016 update, the Commission indicated that it would expect to implement a return on investment from the infrastructure funds that were provided to hospitals in their rate increases. Currently, we have several policies that are implicated in this discussion. These include adjustments for shared savings of readmissions, the readmission reduction incentives, and the adjustment for Potentially Avoidable Utilization. The Performance Work Group has been

working on revising the readmission reduction incentives policy to account for the relationship between low readmission rates and low readmission reductions. Staff is considering options to combine or reorganize these adjustments.

Consumer Dashboard

The Performance Work Group reviewed a list of potential measures to be included in a consumer dashboard to monitor the progress of All-Payer Model. Staff will collaborate with the Maryland Health Care Commission to create a webpage to publish the dash board.

Uncompensated Care (UCC) Policy FY 2017

Staff began to analyze the account level write-off data to develop the UCC FY 2017 methodology. We were able to match write off records to the case-mix data by patient account number for records with service dates beginning July 1, 2014 through June 30, 2015. We intend to use the matched write-off data in the formulation of the FY 2017 UCC Policy and will be sending the unmatched records to hospitals to allow for revisions to records with FY 2015 service dates. We will be releasing non-confidential patient level case-mix UCC data to solicit input for the UCC methodology. Information regarding the request process will be posted on our website this week.

Staff Focus

HSCRC staff is currently focused on the following activities:

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

Monitoring Maryland Performance

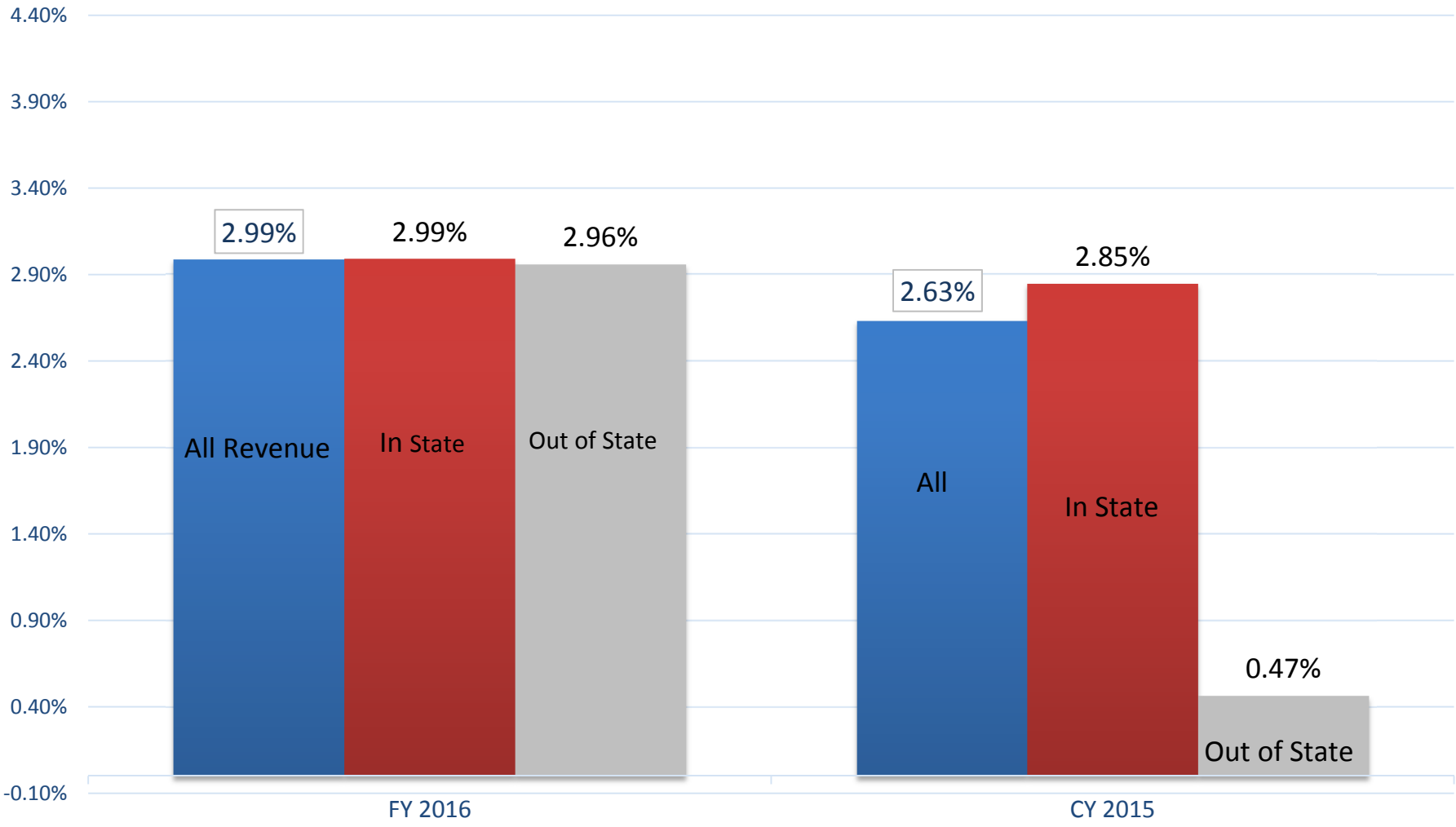
Financial Data

Year to Date thru December 2015

HSCRC
Health Services Cost Review Commission

Gross All Payer Revenue Growth

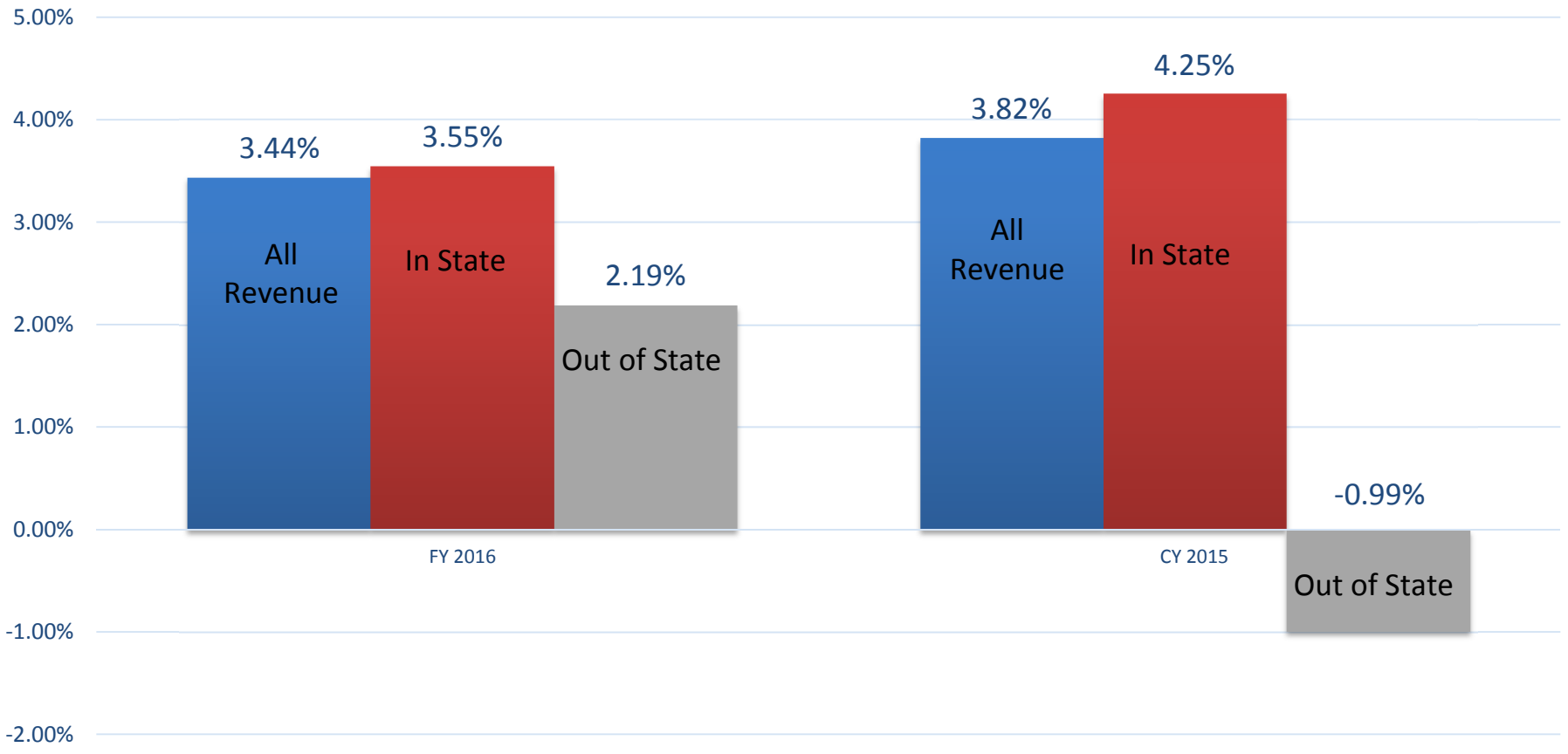
Year to Date (thru December 2015) Compared to Same Period in Prior Year



HSCRC
Health Services Cost Review Commission

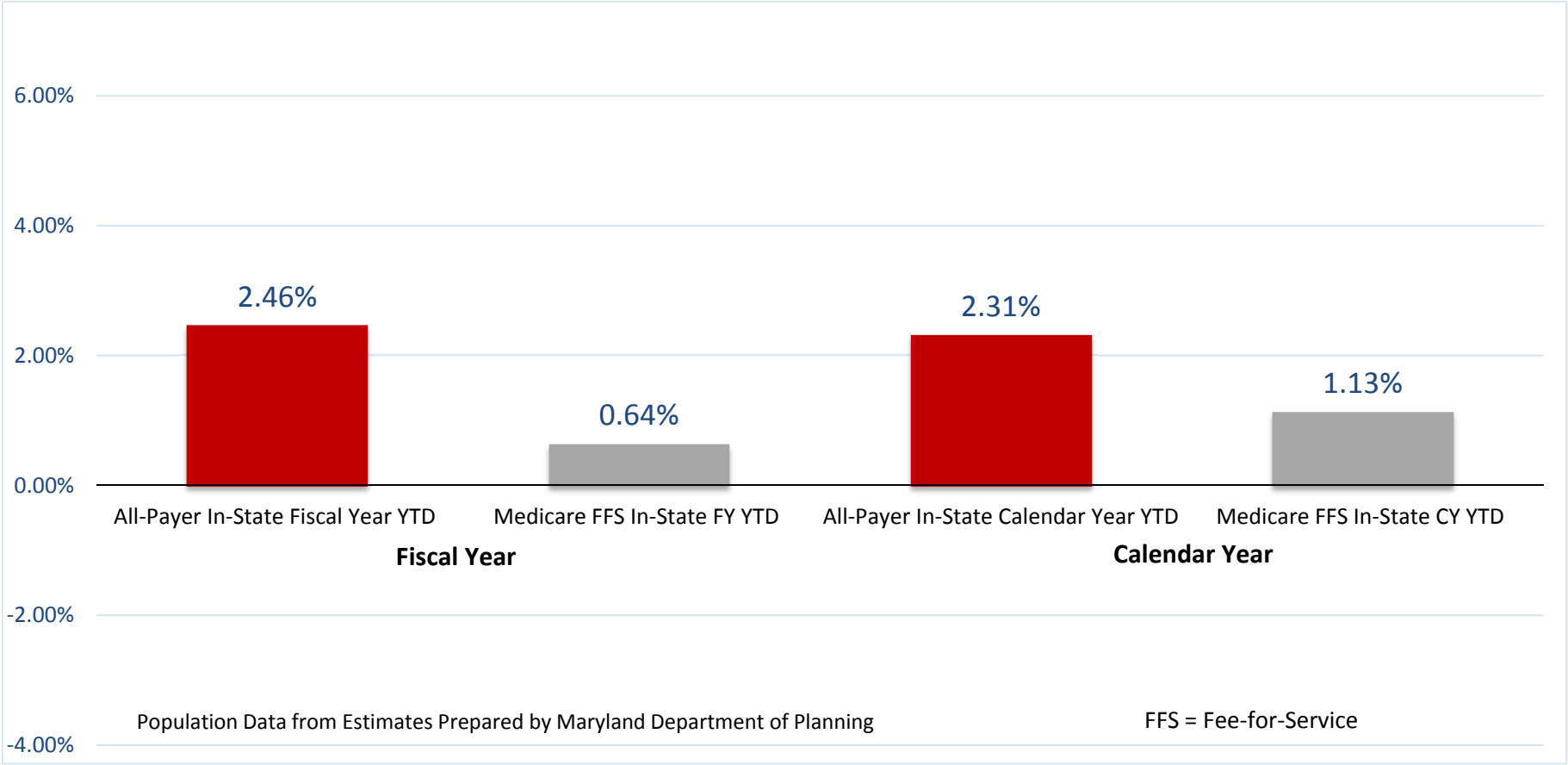
Gross Medicare Fee-for-Service Revenue Growth

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



HSCRC
Health Services Cost Review Commission

Per Capita Growth Rates
Fiscal Year 2016 and Calendar Year 2015

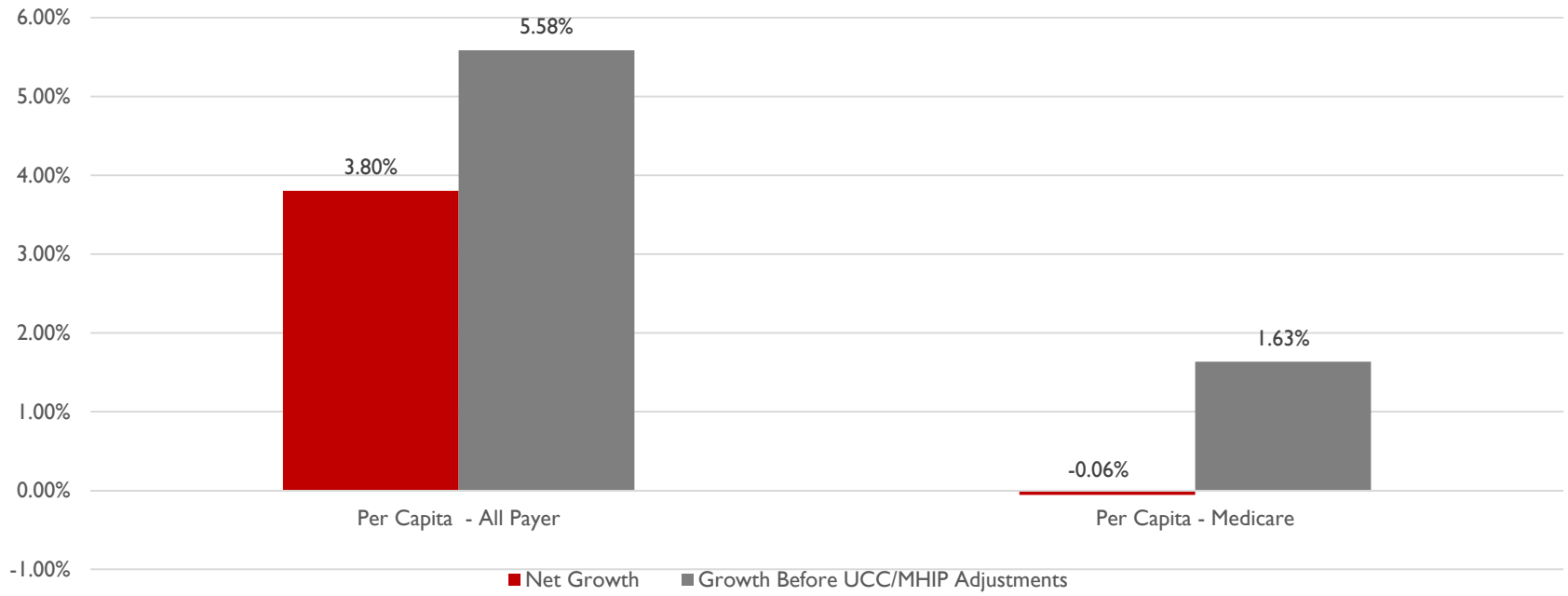


- **Calendar and Fiscal Year trends to date are below All-Payer Model Guardrail of 3.58% for per capita growth.**

HSCRC
Health Services Cost Review Commission

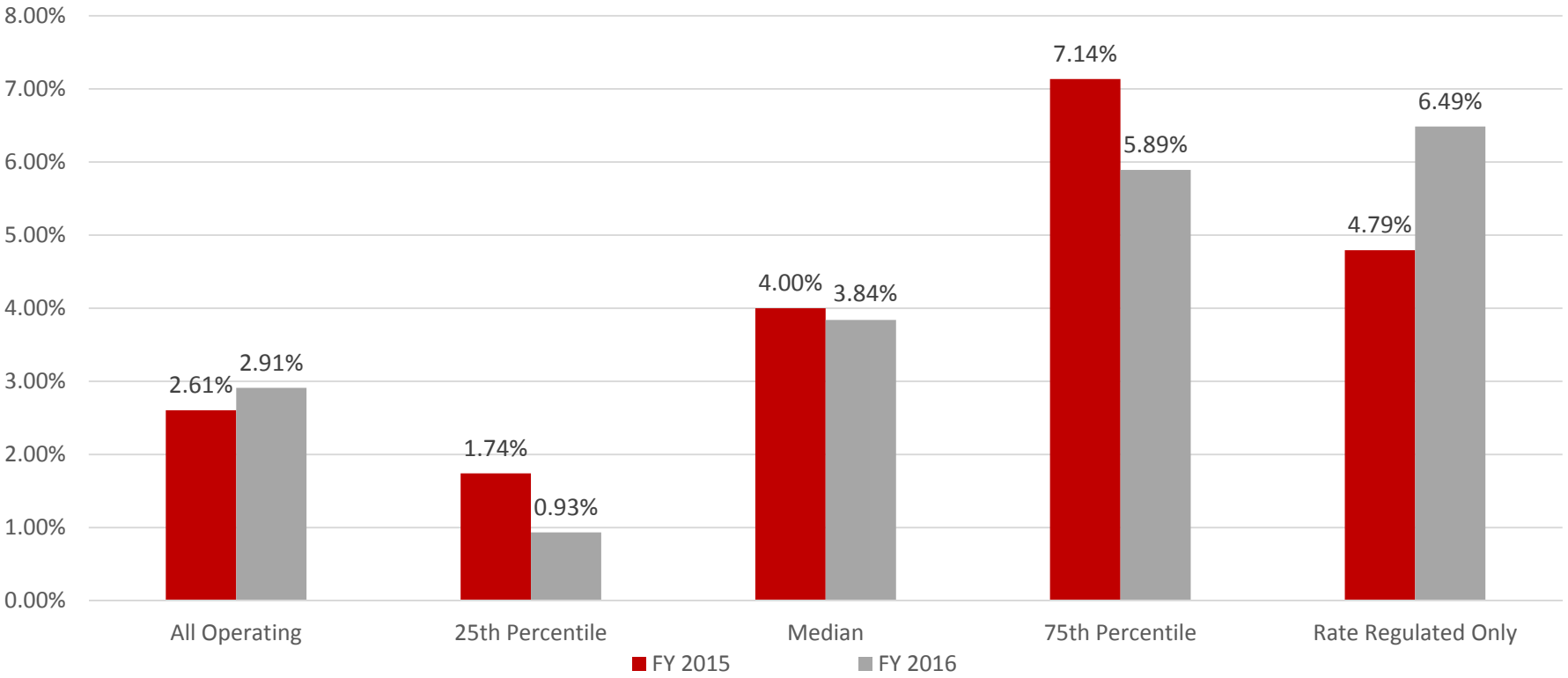
Per Capita Growth – Actual and Underlying Growth

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 & FY 16 revenue decreases that were budget neutral for hospitals. 1.09% decrease from MHIP assessment and hospital bad debts in FY 15. Additional 1.41% adjustment in FY 16 due to further reductions to hospital bad debts and elimination of MHIP assessment.

Operating Profits: Fiscal 2016 Year to Date (July-December) Compared to Same Period in FY 2015

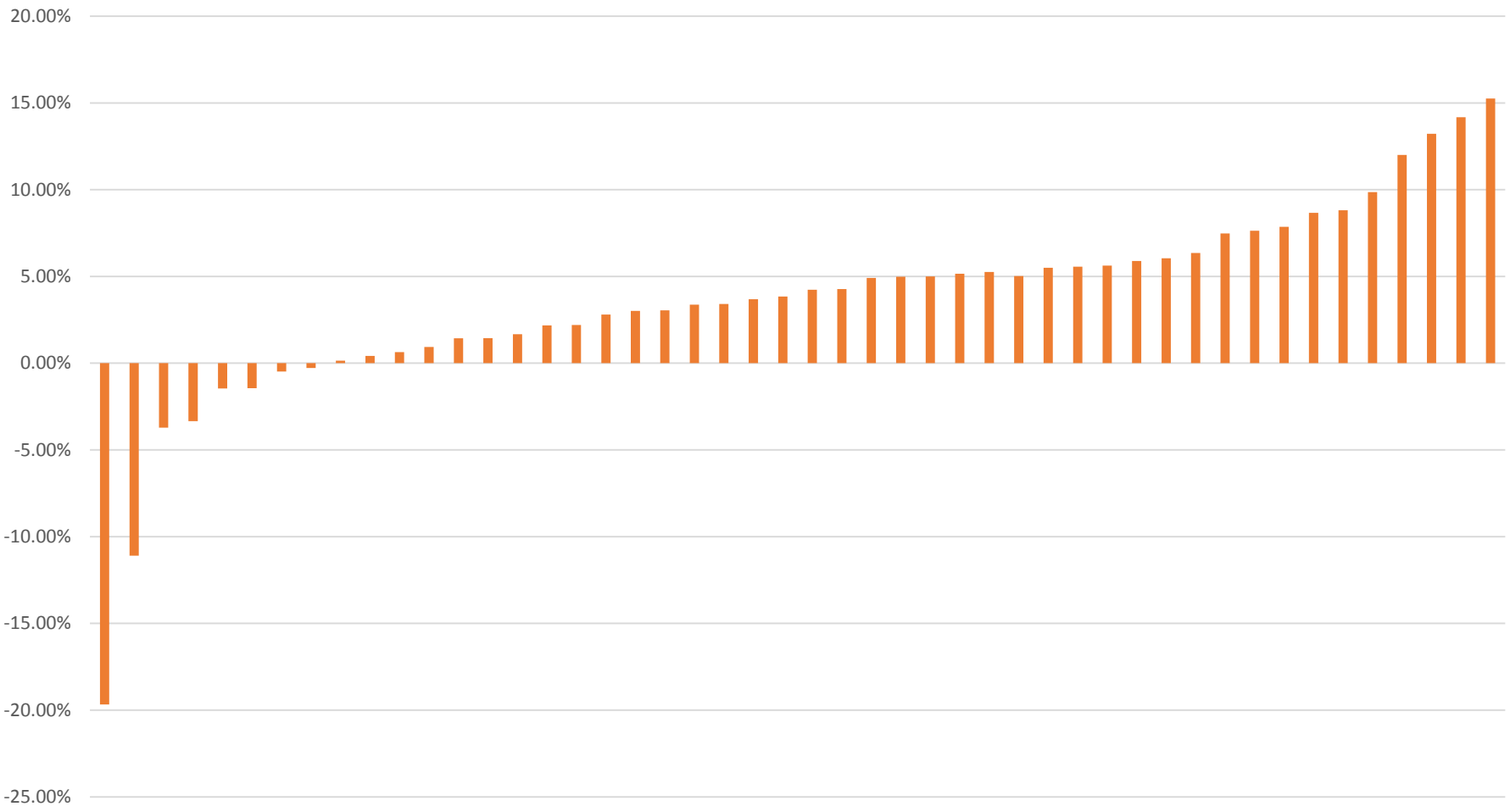


- Year to date FY 2016 unaudited hospital operating profits show a 0.3% increase in total profits compared to the same period in FY 2015. Rate regulated profits have increased by 1.7% compared to the same period in FY 2015.

HSCRC
Health Services Cost Review Commission

Operating Profits by Hospital

Fiscal Year to Date (July – December)



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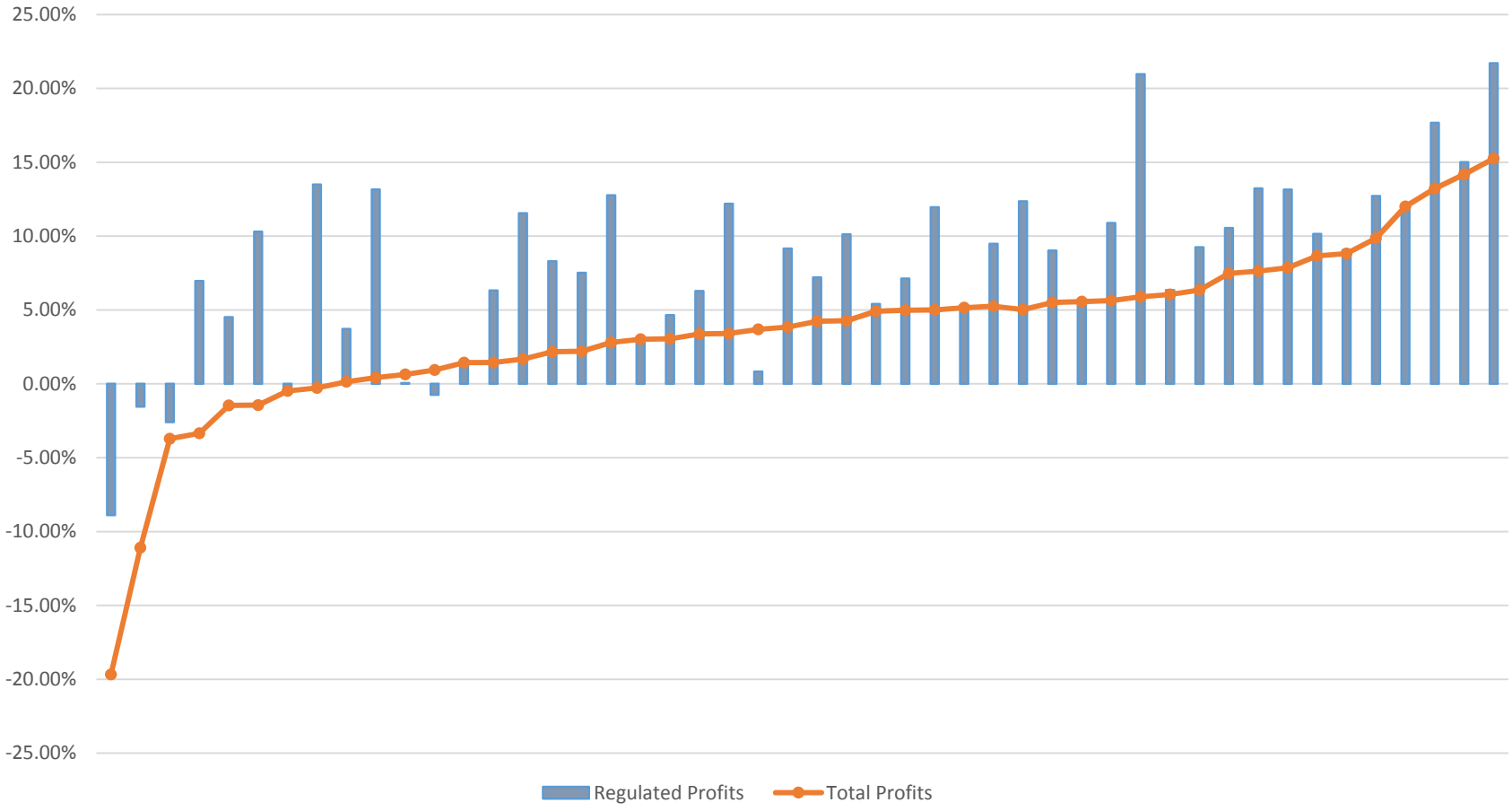
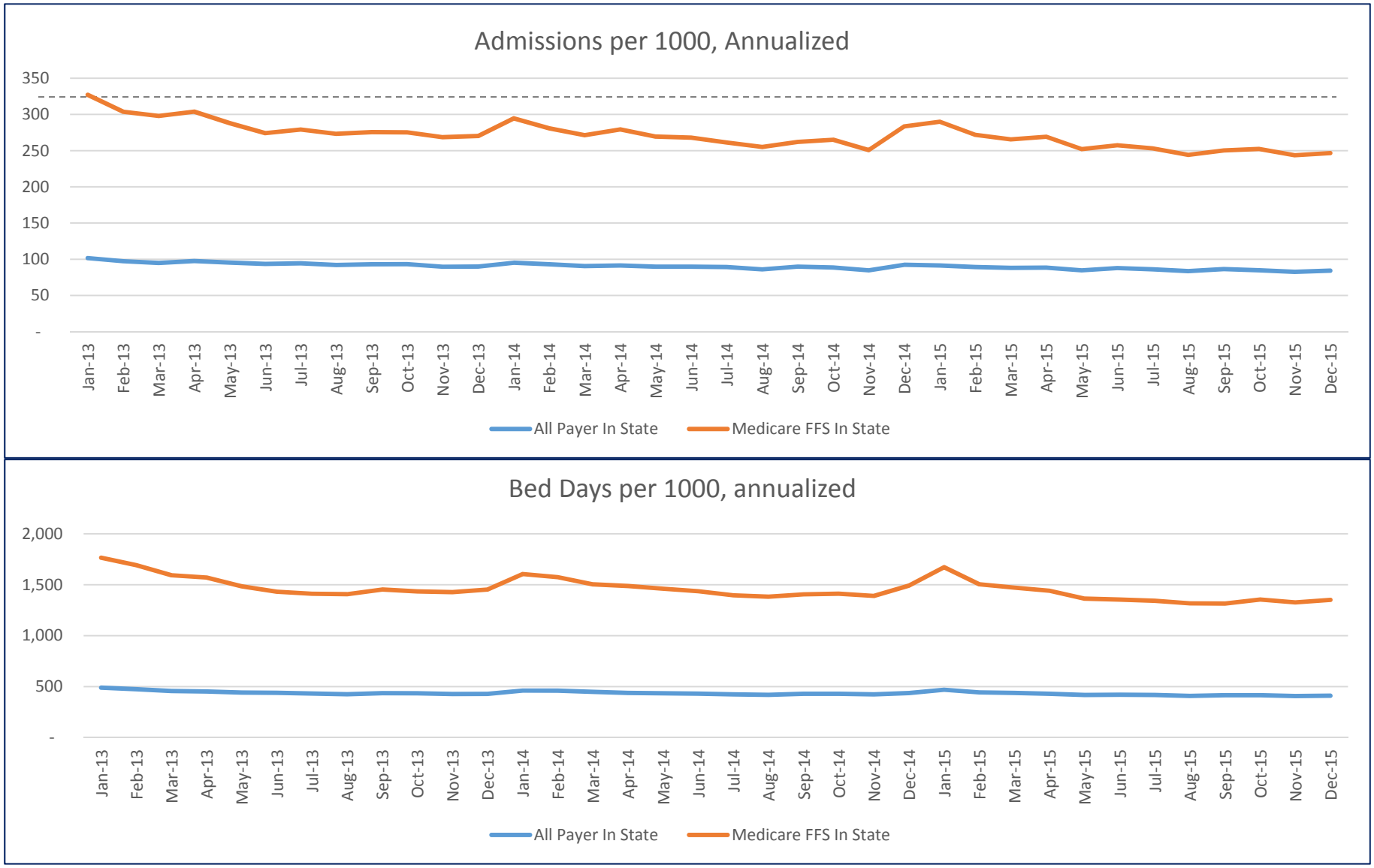
Regulated and Total Operating Profits by Hospital

Fiscal Year to Date (July – December)



HSCRC
Health Services Cost Review Commission

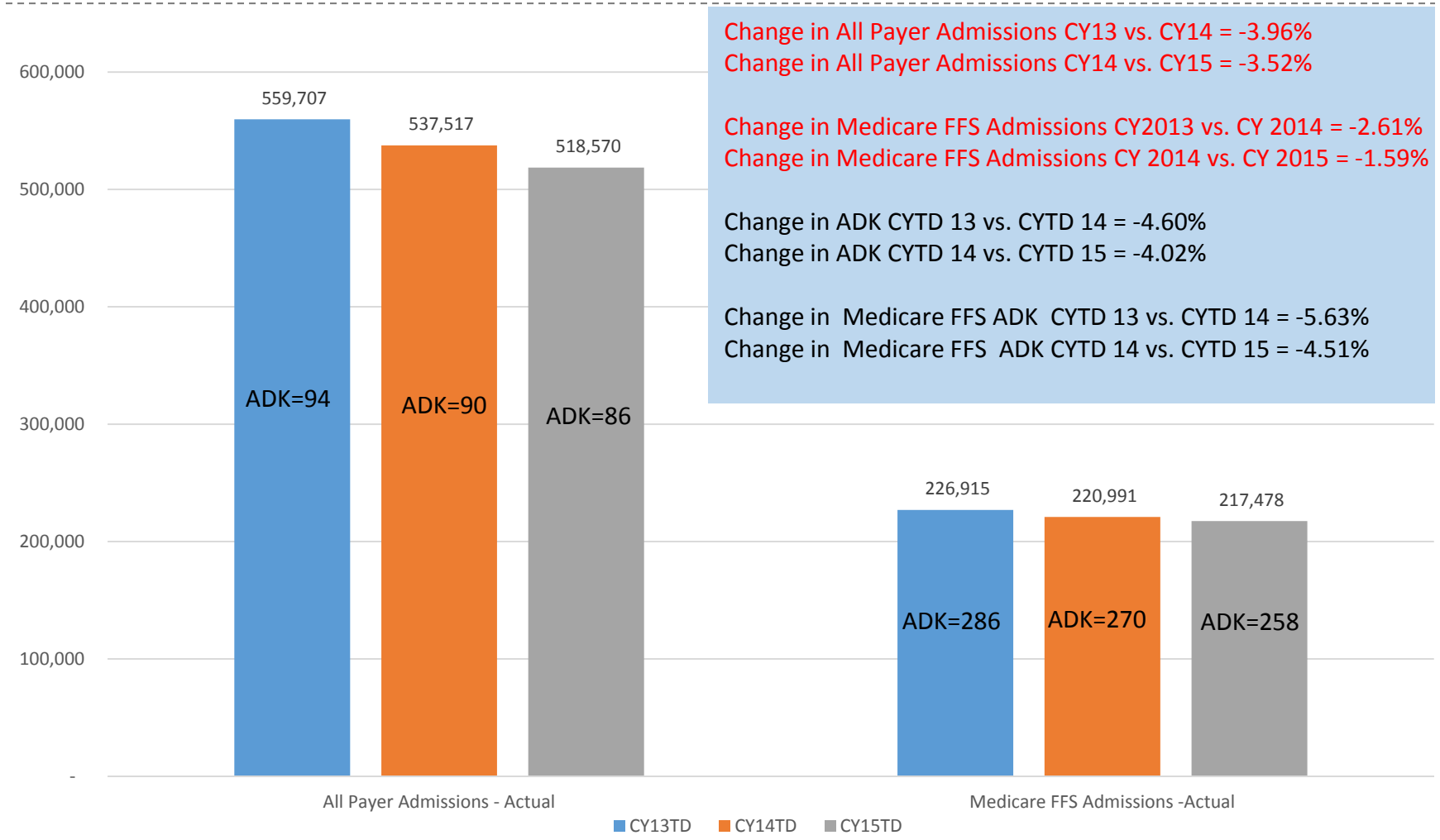
In State Admissions, Bed Days Per 1000, Annualized



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

HSCRC
Health Services Cost Review Commission

In State Admissions by CYTD through December 2015



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

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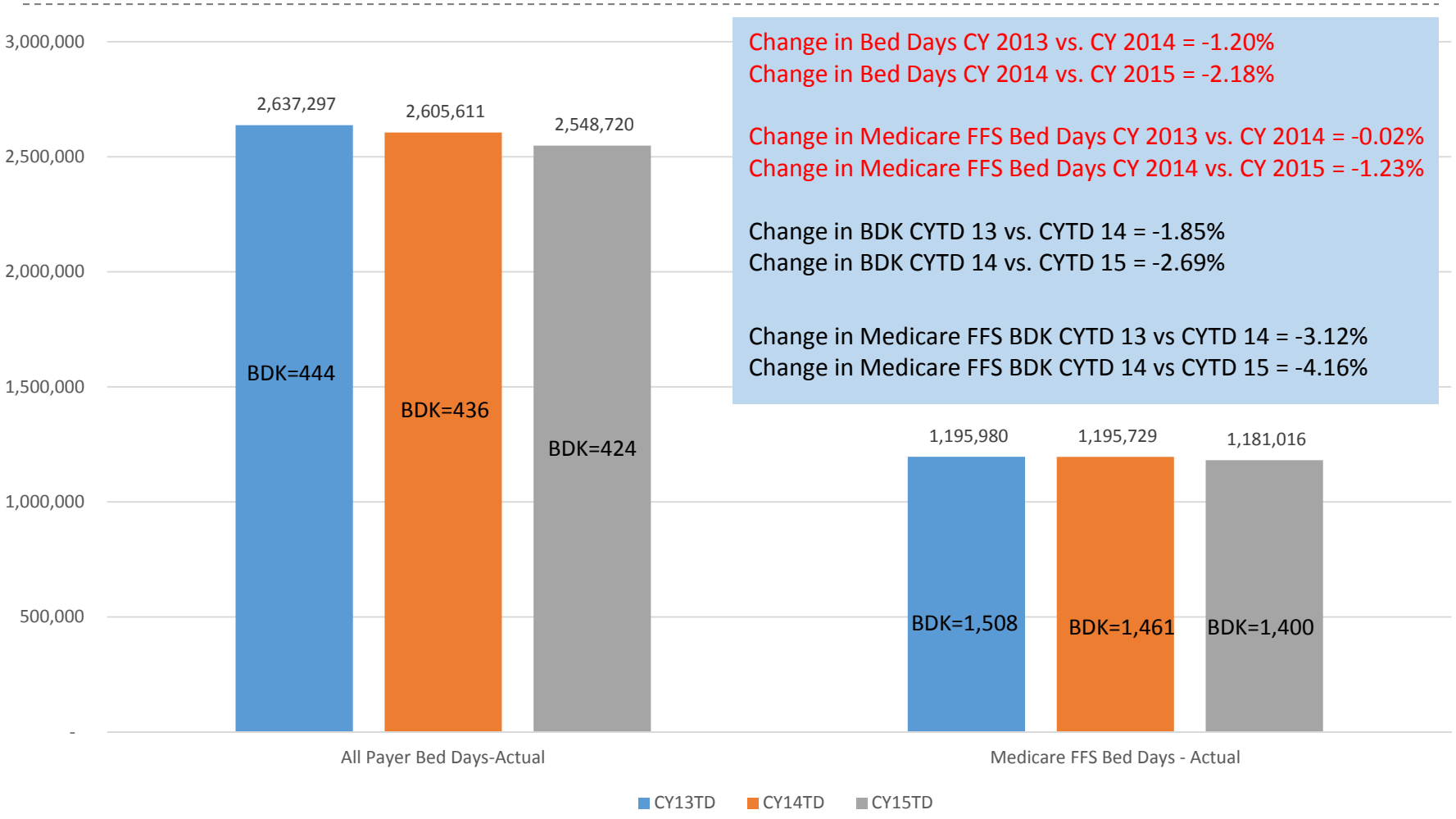
In State Bed Days by CYTD through December 2015



Change in Bed Days CY 2013 vs. CY 2014 = -1.20%
Change in Bed Days CY 2014 vs. CY 2015 = -2.18%

Change in Medicare FFS Bed Days CY 2013 vs. CY 2014 = -0.02%
Change in Medicare FFS Bed Days CY 2014 vs. CY 2015 = -1.23%

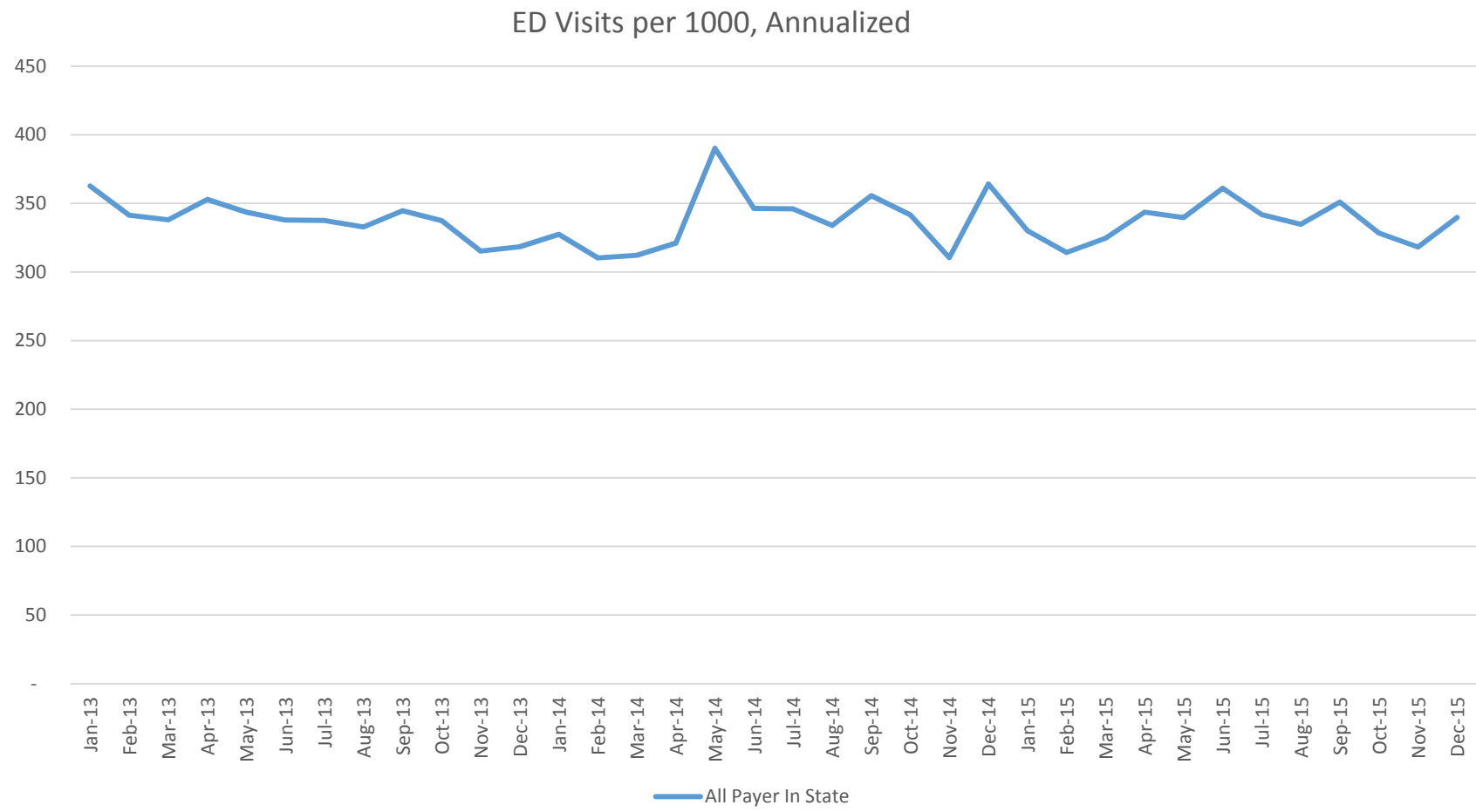
Change in BDK CYTD 13 vs. CYTD 14 = -1.85%
Change in BDK CYTD 14 vs. CYTD 15 = -2.69%

Change in Medicare FFS BDK CYTD 13 vs CYTD 14 = -3.12%
Change in Medicare FFS BDK CYTD 14 vs CYTD 15 = -4.16%

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

HSCRC
Health Services Cost Review Commission

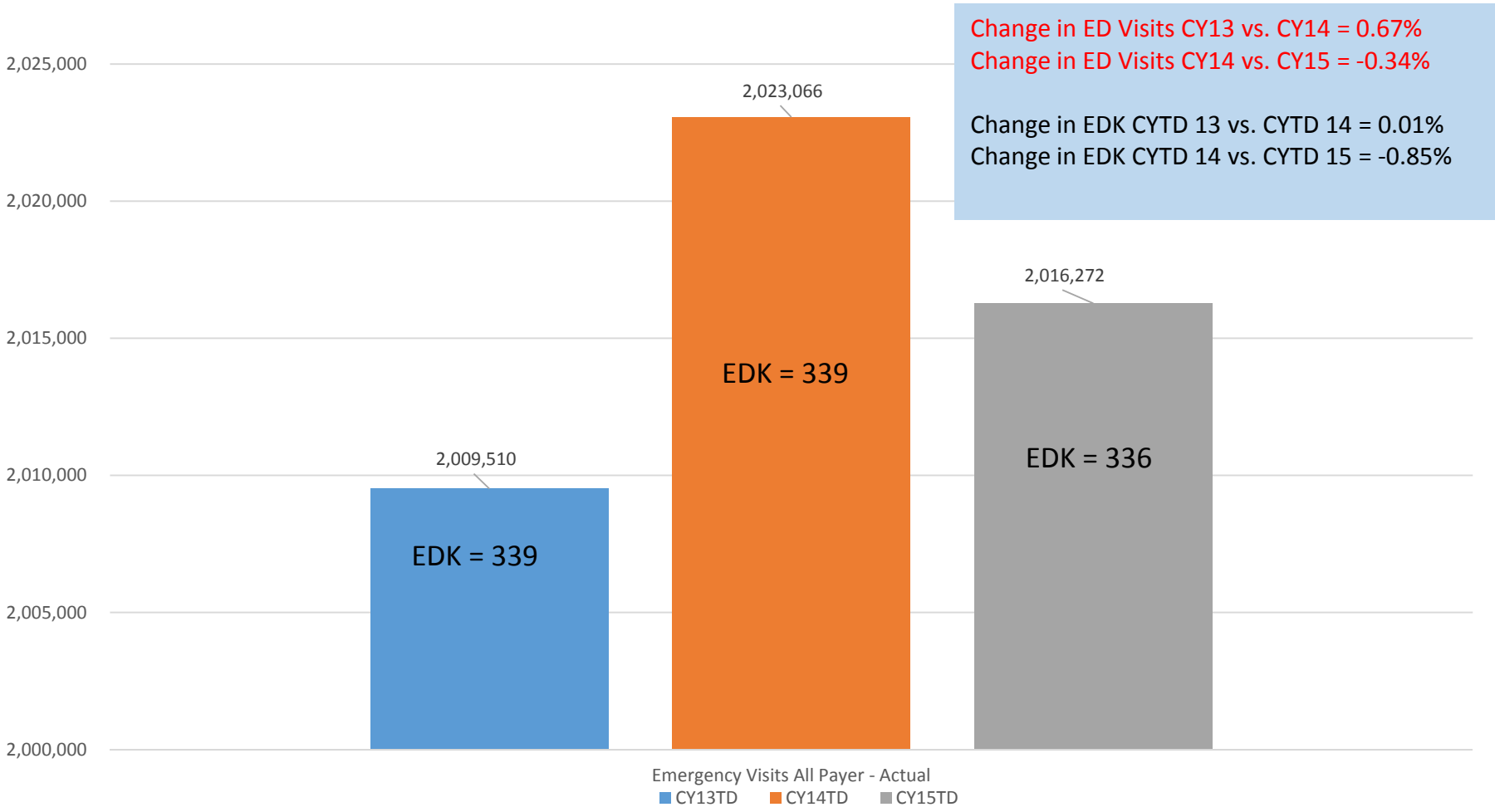
In State, All Payer ED Visits Per 1000 Annualized



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

HSCRC
Health Services Cost Review Commission

In State All Payer ED Visits by CYTD through December 2015



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

HSCRC
Health Services Cost Review Commission

Purpose of Monitoring Maryland Performance

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

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

Data Caveats

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

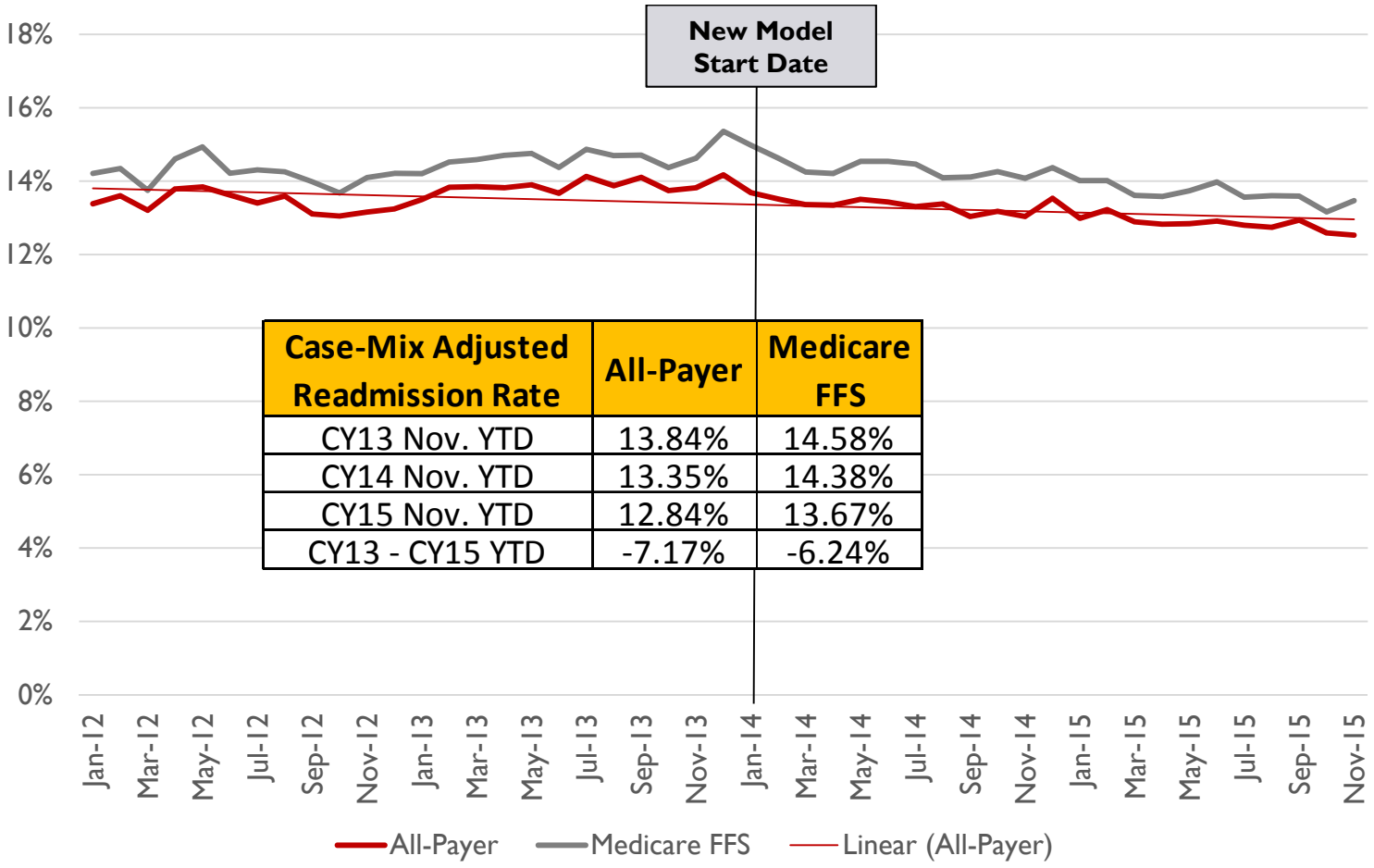
Data Caveats cont.

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

Monitoring Maryland Performance
Quality Data

February 2016 Commission Meeting Update

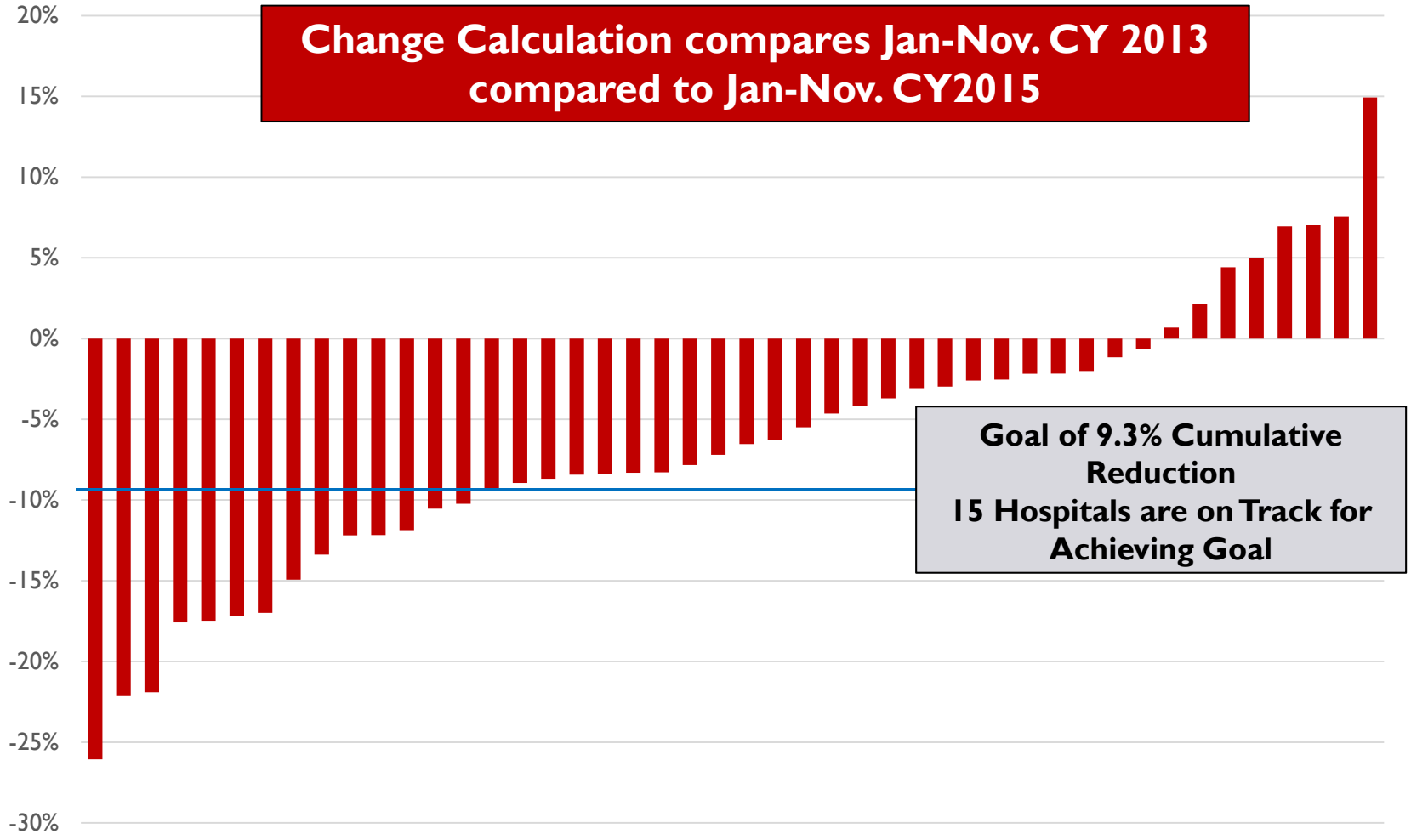
Monthly Case-Mix Adjusted Readmission Rates



Case-Mix Adjusted Readmission Rate	All-Payer	Medicare FFS
CY13 Nov. YTD	13.84%	14.58%
CY14 Nov. YTD	13.35%	14.38%
CY15 Nov. YTD	12.84%	13.67%
CY13 - CY15 YTD	-7.17%	-6.24%

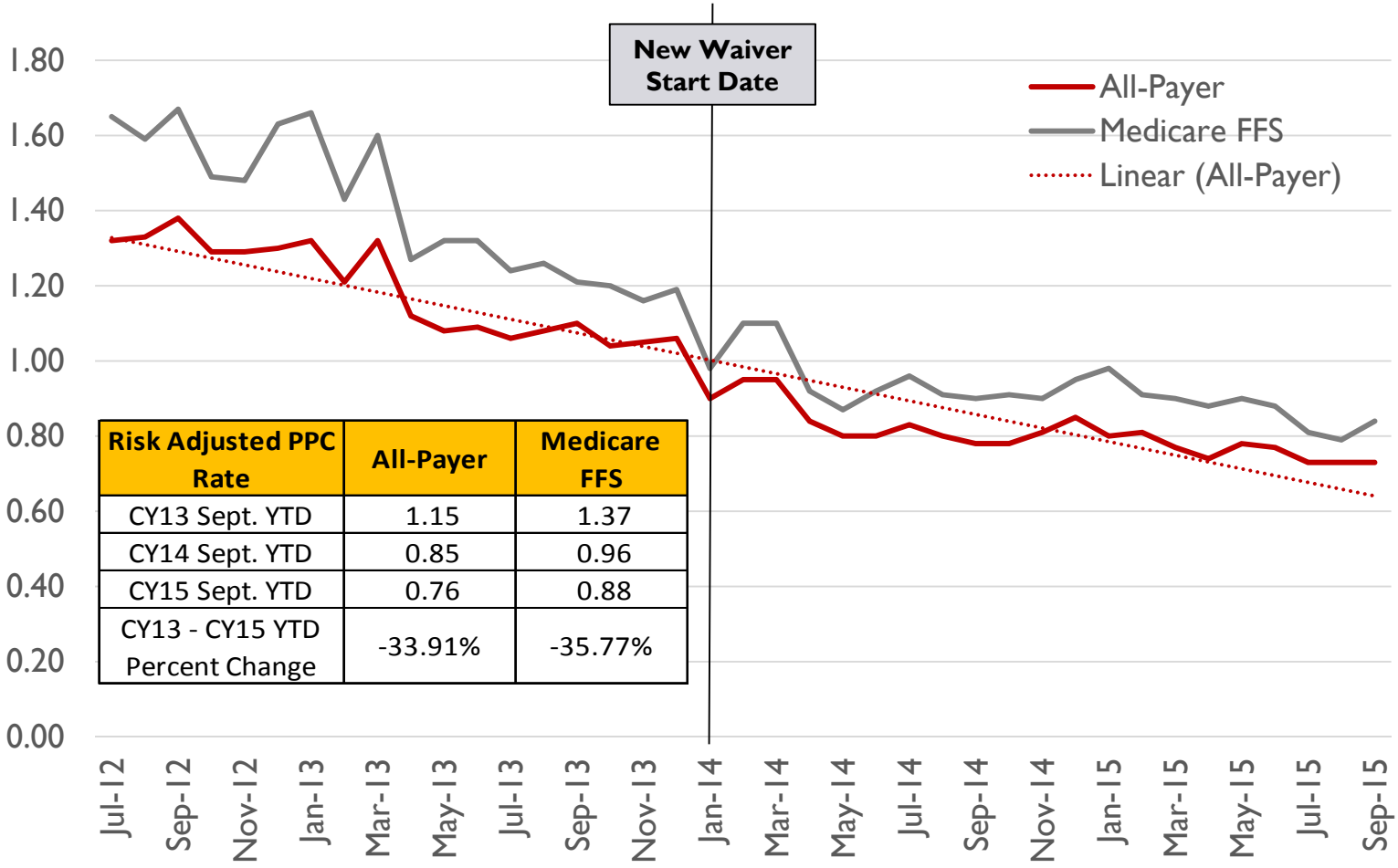
Note: Based on final data for January 2012 – Sept. 2015, and preliminary data through December 2015.

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



Note: Based on final data for January 2012 – September 2015, and preliminary data through December 2015.

Monthly Risk-Adjusted PPC Rates



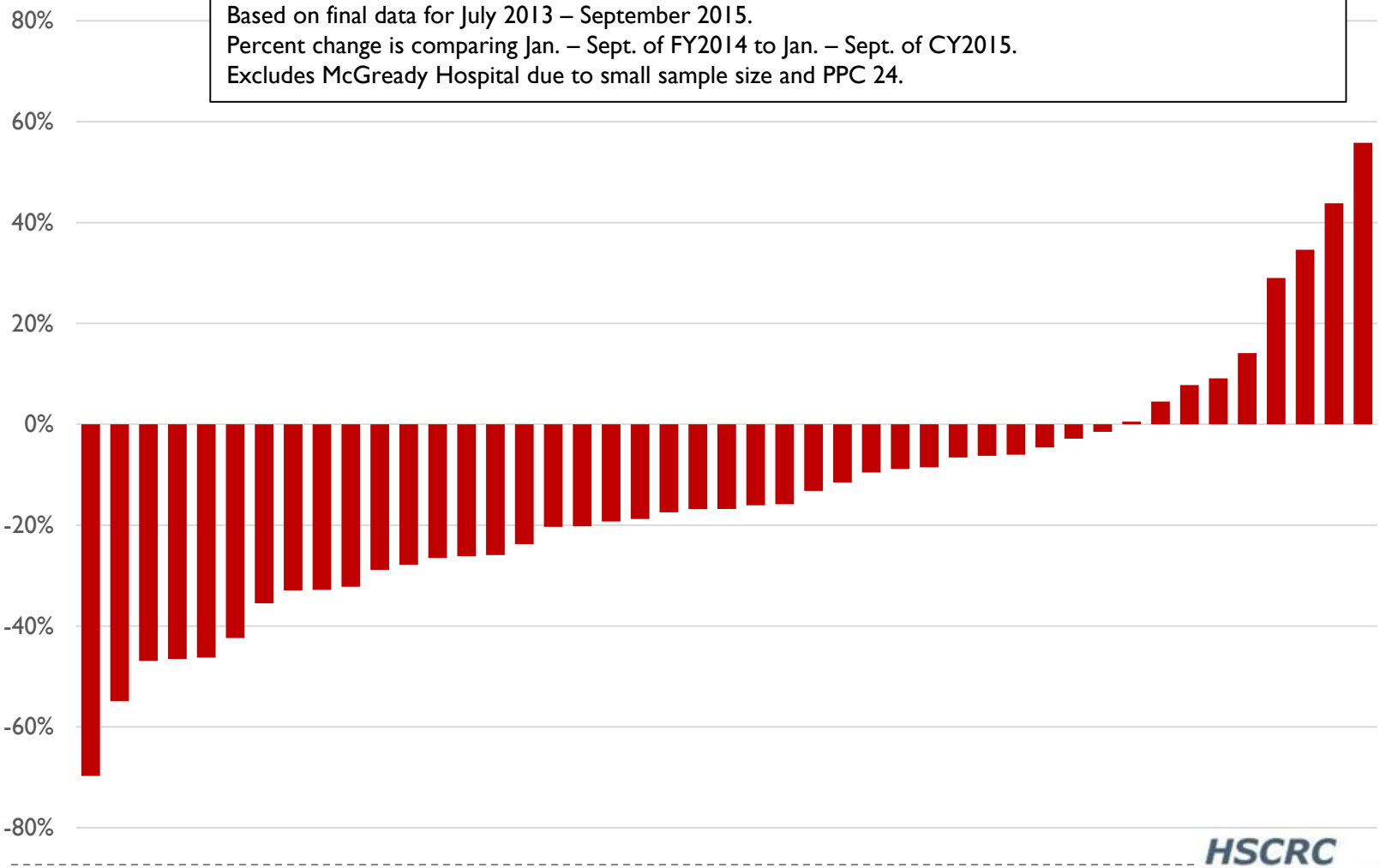
Risk Adjusted PPC Rate	All-Payer	Medicare FFS
CY13 Sept. YTD	1.15	1.37
CY14 Sept. YTD	0.85	0.96
CY15 Sept. YTD	0.76	0.88
CY13 - CY15 YTD Percent Change	-33.91%	-35.77%

Note: Based on final data through September 2015. Excludes PPC24.

HSCRC
Health Services Cost Review Commission

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

Notes:
Based on final data for July 2013 – September 2015.
Percent change is comparing Jan. – Sept. of FY2014 to Jan. – Sept. of CY2015.
Excludes McGready Hospital due to small sample size and PPC 24.



HSCRC
Health Services Cost Review Commission

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF JANUARY 29, 2016

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2317R	Holy Cross Health	11/6/2015	2/10/2016	4/4/2016	CAPITAL	GS	OPEN
2319R	Sheppard Pratt Health System	11/24/2015	2/10/2016	4/22/2015	CAPITAL	GS	OPEN
2320N	Sheppard Pratt Health System	11/24/2015	2/10/2016	4/22/2015	OBV	DNP	OPEN
2328A	MedStar Health	1/7/2016	N/A	N/A	N/A	DNP	OPEN
2329A	University of Maryland Medical Center	1/7/2016	N/A	N/A	N/A	DNP	OPEN
2330A	University of Maryland Medical Center	1/20/2016	N/A	N/A	N/A	DNP	OPEN
2331A	Johns Hopkins Health System	1/27/2016	N/A	N/A	N/A	DNP	OPEN
2332A	Johns Hopkins Health System	1/27/2016	N/A	N/A	N/A	DNP	OPEN
2333A	Johns Hopkins Health System	1/27/2016	N/A	N/A	N/A	DNP	OPEN
2334A	University of Maryland Medical Center	1/27/2016	N/A	N/A	N/A	DNP	OPEN
2335A	Johns Hopkins Health System	1/29/2016	N/A	N/A	N/A	DNP	OPEN
2336A	Johns Hopkins Health System	1/29/2016	N/A	N/A	N/A	DNP	OPEN

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION *		**COMMISSION**
MEDSTAR HEALTH	*	**DOCKET: 2016**
	*	**FOLIO: 2138**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2328A**

Staff Recommendation

February 10, 2016

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on January 20, 2016 on behalf of Union Memorial Hospital (the "Hospital") 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 and spinal services with the National Orthopedic & Spine Alliance for a one year period beginning February 6, 2016.

II. OVERVIEW OF APPLICATION

The contract will 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 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 Hospital will 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 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 participation in the alternative method of rate determination for orthopedic and spine services, for a one year period, commencing February 6, 2016. 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 would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2016**
MEDICAL CENTER	*	**FOLIO: 2139**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2329A**

Staff Recommendation

February 10, 2016

I. INTRODUCTION

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

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 continue to 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

The staff found that the experience under this arrangement for the prior year has been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for blood and bone marrow transplant services, for a one year period commencing March 1, 2016. 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:**	**2016**
MEDICAL CENTER *		**FOLIO:**	**2140**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2330A**

Staff Recommendation

February 10, 2016

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on January 20, 2016 for 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 transplant services with LifeTrac, Inc. Network for a period of one year, effective April 1, 2016.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI). 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 component of the global rates was developed by calculating mean historical charges for patients receiving like procedures. 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 among UPI, the Hospital, and the physicians holds the Hospital harmless from any shortfalls in payment from the global price contract. UPI maintains it has been active in similar types of fixed fee contracts for several years, and that UPI is adequately capitalized to the bear the risk of potential losses.

V. STAFF EVALUATION

Staff reviewed the experience under this arrangement for the last year and found it to be favorable. Staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

V I. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. for a one year period commencing April 1, 2016. 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**
JOHNS HOPKINS HEALTH	*	**DOCKET: 2016**
SYSTEM	*	**FOLIO: 2141**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2331A**

Staff Recommendation

February 10, 2016

I. INTRODUCTION

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on January 27, 2016 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval from the HSCRC for continued participation in a global rate arrangement for solid organ and bone marrow transplants with Preferred Health Care LLC. The Hospitals request that the Commission approve the arrangement for one year beginning March 1, 2016.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Although there was no activity under this arrangement in the last year, staff is satisfied that the hospital component of the global prices, which has been updated with current data, is sufficient for the Hospitals to achieve favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

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

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document 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**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2016**
SYSTEM	*	**FOLIO:**	**2142**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2332A**

Staff Recommendation

February 10, 2016

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on January 27, 2016 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with MultiPlan, Inc. for a period of one year beginning March 1, 2016.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving solid organ and bone marrow transplant services at the Hospitals. 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 JHHC for all contracted and covered services. JHHC will continue to be responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Although there has been no activity under this arrangement, staff believes that the

Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing March 1, 2016. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**
DETERMINATION *		**COMMISSION**
JOHNS HOPKINS HEALTH	*****	**DOCKET: 2016**
SYSTEM	*****	**FOLIO: 2143**
BALTIMORE, MARYLAND	*****	**PROCEEDING: 2233A**

Staff Recommendation

February 10, 2016

I. INTRODUCTION

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

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

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

V. STAFF EVALUATION

Staff finds that the actual experience for cardiovascular services, solid organ transplants, and stem cell transplants under the arrangement for the last year has been favorable. After a review of the fee development data, staff believes that the Hospitals can achieve a favorable experience under the bariatric surgery, pancreatic cancer surgery, and joint replacement services case rates.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular procedures, solid organ transplants, stem cell transplant, bariatric surgery, pancreatic cancer surgery, and joint replacement services for one year beginning March 1, 2016. The Hospitals must file a renewal application annually 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**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2016**
MEDICAL CENTER *		**FOLIO: 2144**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2334A**

Staff Recommendation

February 10, 2016

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on January 27, 2016 for 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 transplant services with LifeTrac, Inc. Network for a period of one year, effective March 1, 2016.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI). 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 component of the global rates was developed by calculating mean historical charges for patients receiving like procedures. 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 among UPI, the Hospital, and the physicians holds the Hospital harmless from any shortfalls in payment from the global price contract. UPI maintains it has been active in similar types of fixed fee contracts for several years, and that UPI is adequately capitalized to the bear the risk of potential losses.

V. STAFF EVALUATION

Staff reviewed the experience under this arrangement for the last year and found it to be favorable. After review of the application and additional information provided by the Hospital, staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

V I. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. for a one year period commencing March 1, 2016. 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**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2016**
SYSTEM	*	**FOLIO:**	**2145**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2335A**

Staff Recommendation

February 10, 2016

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on January 29, 2016 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center ("the Hospitals") for renewal of a renegotiated alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a revised global rate arrangement for solid organ and bone marrow transplant services with Blue Cross Blue Shield Blue Distinction Centers for Transplants for a period of one year beginning March 1, 2016.

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II. OVE RVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed utilizing historical charges for patients receiving solid organ and bone marrow transplants at the Hospitals. 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 JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under this arrangement was favorable for the last year. Staff believes that the Hospitals can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The 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 a one year period commencing March 1, 2016. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION *		**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2016**
SYSTEM	*	**FOLIO:**	**2146**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2336A**

Staff Recommendation

February 10, 2016

I. INTRODUCTION

On January 29, 2016, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval to continue to participate in a revised global price arrangement with Life Trac (a subsidiary of Allianz Insurance Company of North America) for solid organ and bone marrow transplants and cardiovascular services. The Hospitals request that the Commission approve the arrangement for one year beginning April 1, 2016.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT RISK

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

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

V. STAFF EVALUATION

The staff found that the experience under the arrangement has been favorable for the last year. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The 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 the period beginning April 1, 2016. The Hospitals must file a renewal application annually for continued participation.

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

Advancing Telehealth in Maryland

An MHCC Update

February 10, 2016

The MARYLAND
HEALTH CARE COMMISSION

Our Role

The MHCC is responsible to advance a strong, flexible health IT ecosystem that can appropriately support clinical decision-making, reduce redundancy, enable payment reform, and help to transform care into a model that leads to a continuously improving health system. In addition, foster innovation in a way that balances the need for information sharing with the need for strong privacy and security policies.

Challenges

- Reimbursement is available from commercial payors, Medicare and Medicaid, but little incentive exists for providers to move away from traditional models of care delivery
  - Only one-half of acute care hospitals and less than 10 percent of physicians participate in telehealth
- Lack of widespread awareness about how to incorporate the effective use of telehealth into existing practice workflows
- Use cases that demonstrate the value of telehealth on hospital encounters and in improving access to care
- Medical liability insurance for services delivered through telehealth is not always offered

MHCC Grants

- Maryland law, established in 2014, authorizes MHCC to directly award grants to non-profit organizations and qualified businesses
- Diverse use cases provide an opportunity to test the effectiveness of telehealth with various technology, patients, providers, clinical protocols, and settings
- Total telehealth grants: $257,888
- Total matching funds: $610,180

October 2014 Grants – Round One

Name	*Use Case*	*Grant Award*	*Grantee Match*
Atlantic General Hospital (Worcester County)	Video consultations between the Emergency Department (ED) and Berlin Nursing and Rehabilitation Center (BNRC) to reduce ED visits and hospital admissions of patients residing in a long term care facility (LTC).	$30,000	$87,922
Dimensions Healthcare System (Prince Georges County)	Laurel Regional Hospital and Prince Georges Hospital use mobile tablets to conduct video consultations with patients residing at two LTCs, Sanctuary of Holy Cross and Patuxent River Health and Rehabilitation Center to reduce unnecessary hospital transfers.	$30,000	$42,316
University of Maryland Upper Chesapeake Health (Harford County)	Remote telemedicine examinations and consultations between hospital and a fully equipped exam room and lab located at Lorien, Bel Air facility. Technology provides EKG monitoring, sonogram and multiple cameras.	$27,888	$45,633
	Total	**$87,888**	**$175,871**

June 2015 Grants – Round Two

Name	*Use Case*	*Grant Award*	*Grantee Match*
Crisfield Clinic, LLC (Somerset County)	Rural health clinic provides mobile devises for middle school and high school aged patients to assist children in managing chronic conditions including asthma, diabetes, childhood obesity, and behavioral health issues.	$20,000	$93,983
Lorien Health Systems (Baltimore & Harford Counties)	Skilled nursing facility and residential service agency use devices installed in patients' home to monitor chronic conditions including uncontrolled diabetes, congestive heart failure, and hypertension and providing clinical support to improve care and avoid hospital admissions.	$30,000	$63,600
Union Hospital of Cecil County (Cecil County)	Hospital provides chronic care patients with mobile tablets and peripheral devices to capture blood pressure, pulse, and weight, and provide patient education to facilitate patient monitoring.	$30,000	$60,000
	Total	**$80,000**	**$217,583**

December 2015 Grants – Round Three

Name	*Use Case*	*Grant Award*	*Grantee Match*
Associated Black Charities (Dorchester & Caroline Counties)	Community association that assists minority and rural communities with navigating the health care system will utilize mobile tablets to facilitate primary care and behavioral health video consultations with a licensed nurse care coordinator from Choptank Community Health System.	$30,000	$90,000
Gerald Family Care, LLC (Prince George's County)	Patient Centered Medical Home practice will implement telehealth video consultations and image sharing services between patients at three family practice locations, and Dimensions Health System specialists providing gastroenterology, orthopedics, neurology, and behavioral health services.	$30,000	$66,726
Union Hospital of Cecil County (Cecil County)	Builds upon the original grant providing chronic care patients with mobile tablets and peripheral devices to capture blood pressure, pulse, weight and glucose levels to facilitate patient monitoring, which will support data sharing with primary care and Emergency Department providers.	$30,000	$60,000
	Total	**$90,000**	**$216,726**

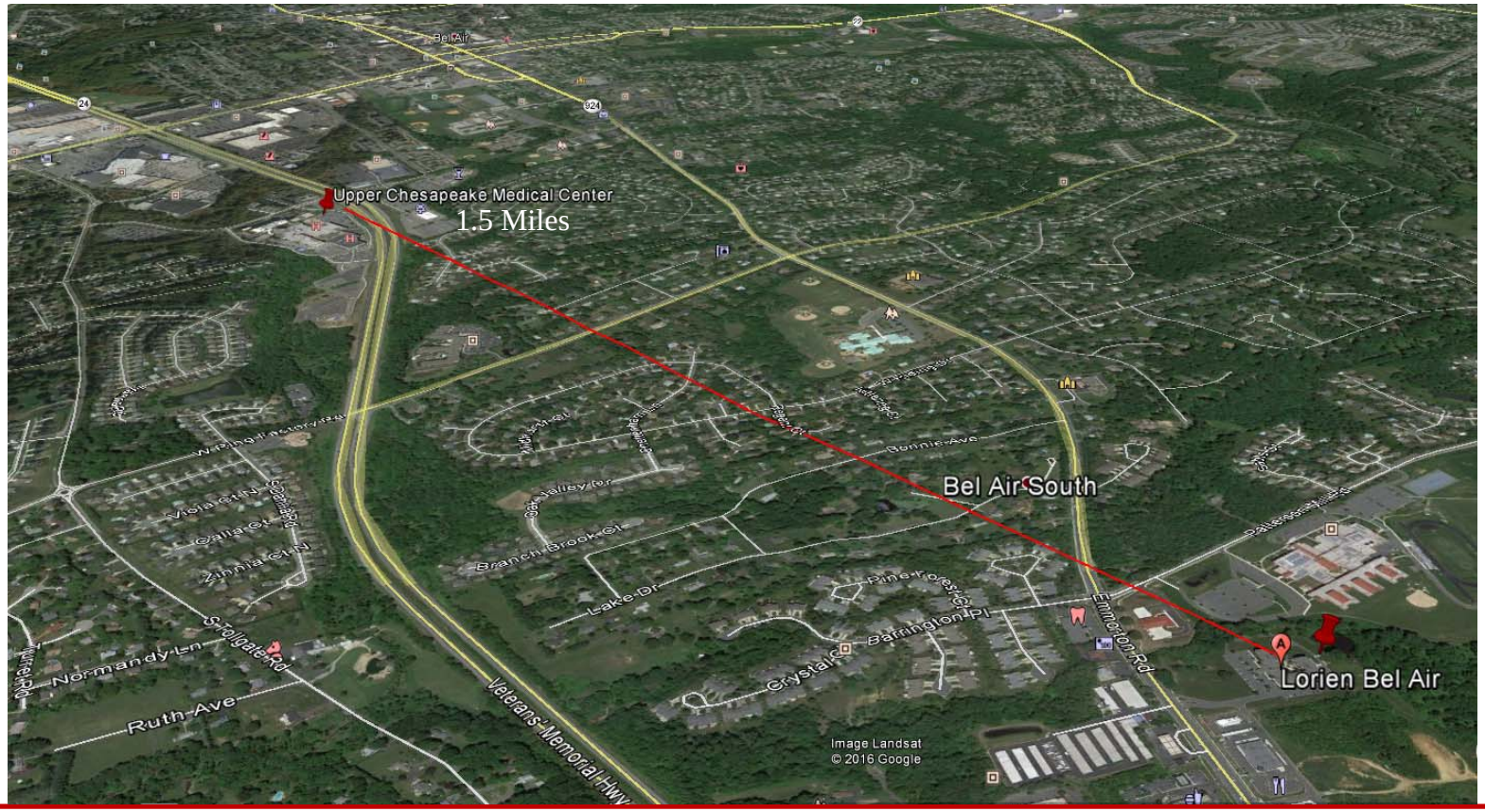
UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Telehealth Program

Presenter: Colin Ward, VP Population Health & Clinical Integration
University of Maryland – Upper Chesapeake Health

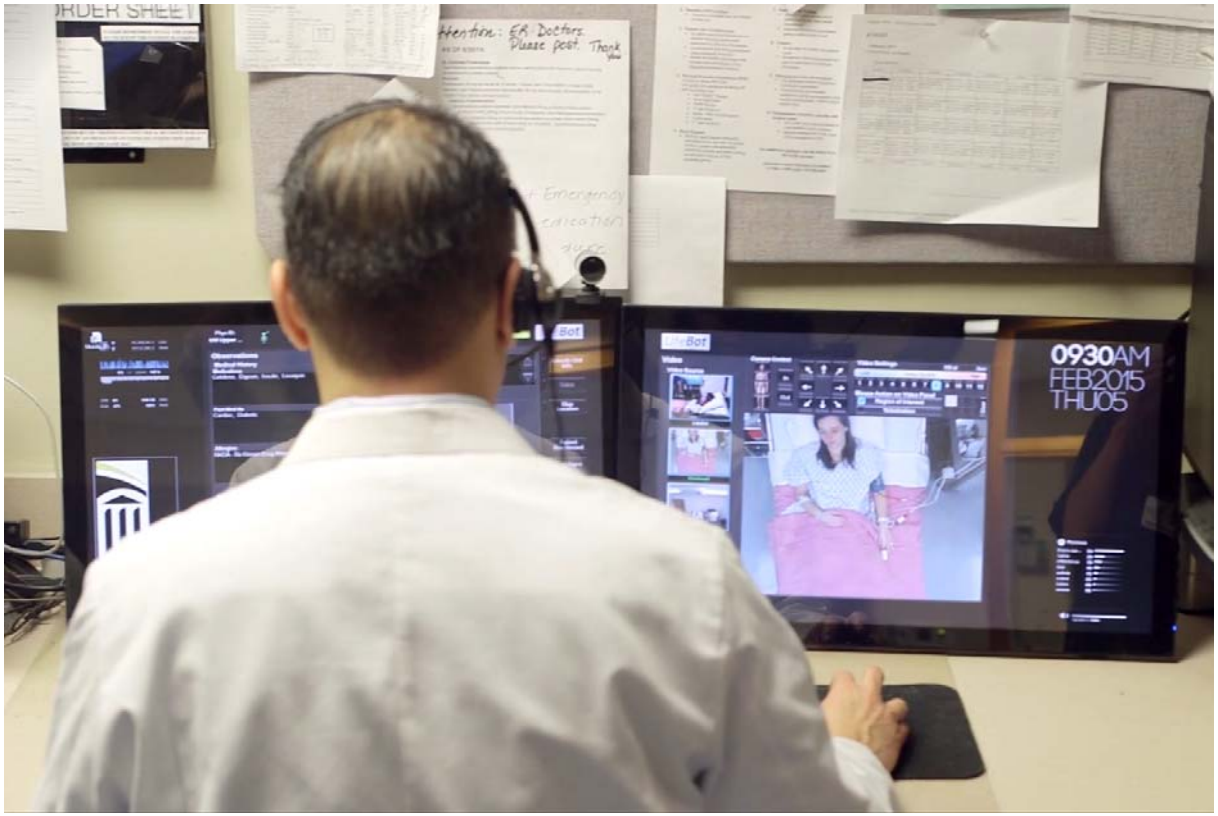
Telehealth Participants

- University of Maryland Upper Chesapeake Health (UMUCH)
- Lorien Bel Air
- Maryland Emergency Medicine Network (MEMN)
- LifeBot/ Citrano Labs



General Description

A Remote Patient Evaluation process for Skilled Nursing Patients at Lorien Bel Air



- ICU Level Monitoring
- Basic Point of Care Testing
- Medications matched to UMUCH ED inventory
- On-demand ED physician consultation using two-way video

Goal: Maintain treatment in the most appropriate location and reduce avoidable utilization

Impact on Quality

Measure	Numerator/Denominator	Baseline Data 10/1/2013-9/30/2014	Goal	11 Months	Final Rate	
30-day Readmissions	Number of patients that were admitted from an ACH to Lorien Bel Air and were re-admitted to an ACH within 30 days of hospital discharge date	83		48		
	Number of patients that were admitted to Lorien Bel Air from an ACH	610		536	**9.0%**	**34%**
	Percent	13.6%	10.2%			
Hospital Admissions	Number of patients that were admitted to an ACH from Lorien Bel Air	105		83		
	Total number of resident days for the month at Lorien Bel Air	24,743		23,034	3.6	**15%**
	Rate	4.2	3.2			
ED Transfers	Number of residents that were transferred via ambulance to an ACH	168		126		
	Total number of resident days for the month at Lorien Bel Air	24,743		23,034	5.5	**19%**
	Rate	6.8	5.1			

- Program resulted in 42 avoided trips to the UMUCH ED
- Patient and Provider satisfaction measured

Impact on Cost

UMUCH finance team estimates hospital expense savings of:

- $128 for each ED visit avoided
- $445 for each patient day avoided

(incremental reductions in imaging, labs, patient care staff hours)

- Projected Expense Avoidance of $70,000

Pilot team estimates payer cost savings of ALS Transport of:

- $650-$750 per Ambulance Trip avoided
- Approximate payer savings of $25,000

Plan for Sustainability

- Partnership is expanding to two remaining Harford County Lorien locations – Riverside and Havre de Grace

- UMUCH & Lorien sharing the capital cost

- MEMN – UMUCH agreed to payment process that allows providers to prioritize "virtual patients" as equals to patients physically in the ED

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Video- Telehealth Program

UMUCH and Lorien Lifebot Telehealth

Presenter: Colin Ward, VP Population Health & Clinical Integration
University of Maryland – Upper Chesapeake Health

Atlantic General Hospital
Telehealth Project

A collaborative effort between Atlantic General Hospital and Berlin Nursing & Rehabilitation Center with the focus of implementing telehealth services to prevent avoidable transfers, admissions and readmissions.

ATLANTIC
GENERAL HOSPITAL
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BERLIN
NURSING & REHABILITATION CENTER

Atlantic General Hospital

Vision

ATLANTIC GENERAL 2020 VISION

care.coordination

VISION

To be the leader in caring for people and advancing health for the residents of and visitors to our community.

MISSION

To create a coordinated care delivery system that will provide access to quality care, personalized service and education to improve individual and community health.

ATLANTIC GENERAL HOSPITAL

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Implementation

- Administrative Commitment
- Physician champions
- Comprehensive assessment of transfer and admission patterns
- Substantial wireless infrastructure
- Collaborative efforts among all stakeholders
- Clearly defined goals, protocols and guidelines

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Project Goals/ Metrics

- Reduce admissions from BNRC to AGH.
- Reduce readmissions from BNRC to AGH.
- Reduce transfers from BNRC to AGH for skilled patients with COPD, CHF, DM, and HTN.
- Decrease E.D. utilization by directly admitting BNRC patients requiring hire level of care.

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Approach

Strategies

- Community partnerships
- Information technology
- Selection of equipment
- Legal , credentialing, malpractice, consents, bi-directional policies
- Interact pathways
- Medical / clinical staff education
- Interact pathways

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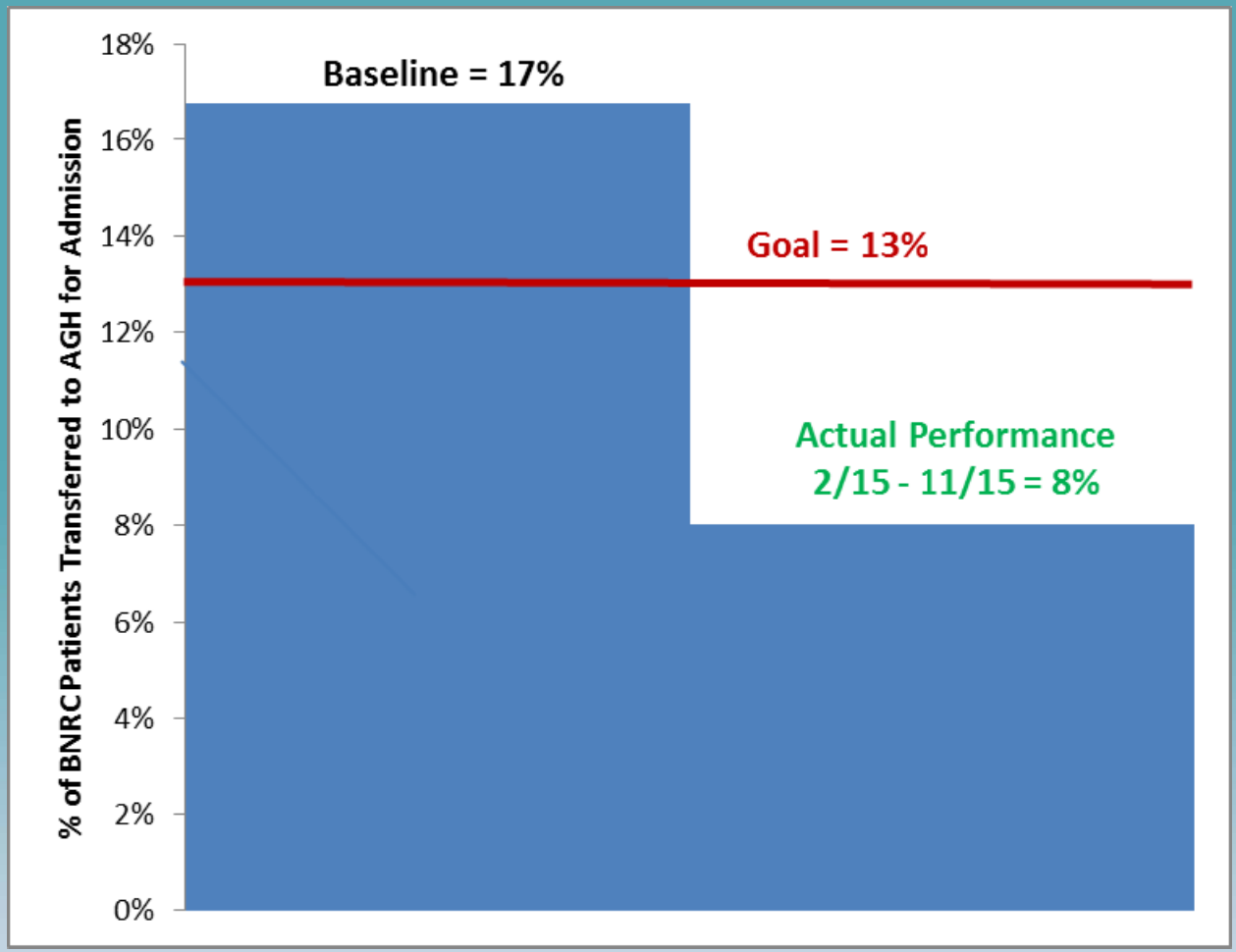
Results/ Outcomes

%BRNC Patients Admitted to AGH



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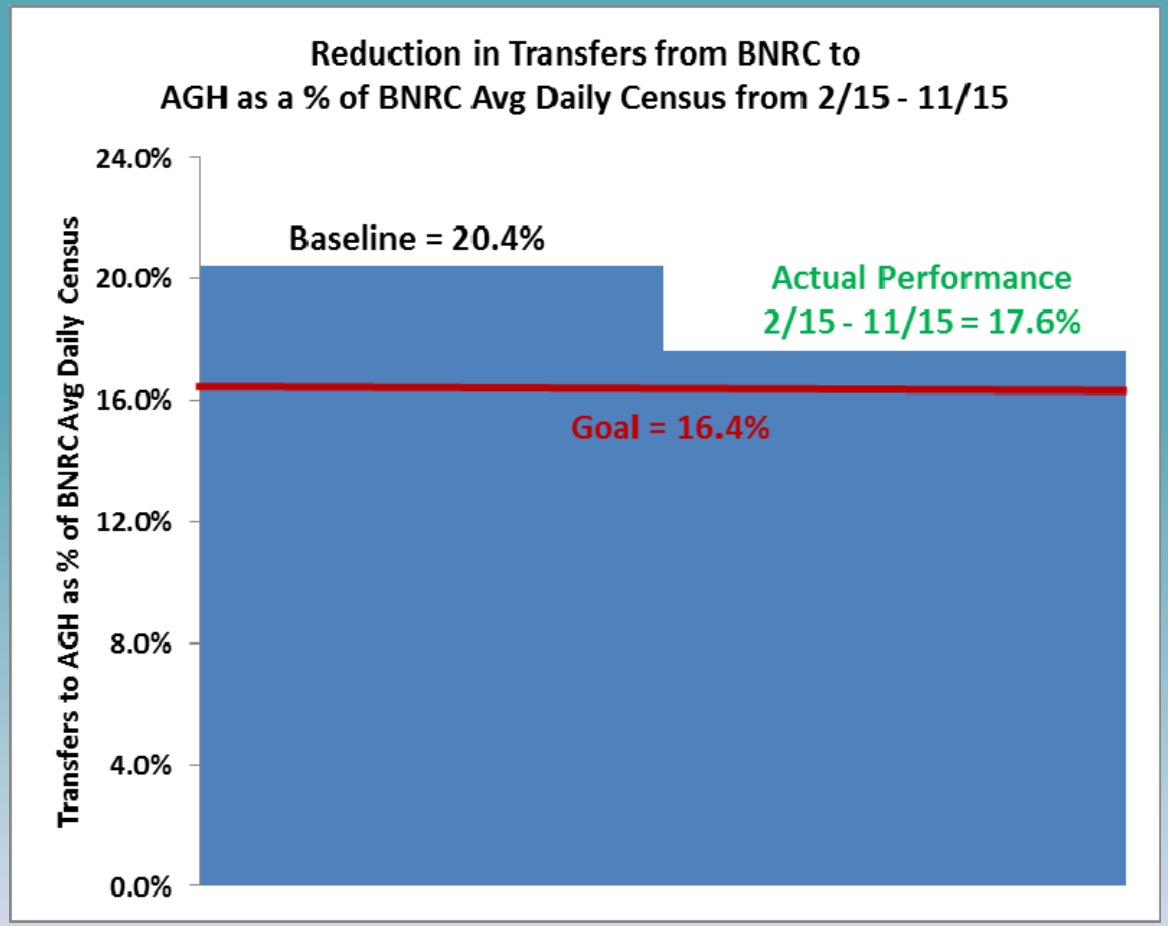
Results/ Outcomes

Reduction in Total Transfers from BNRC to AGH



Reasons for Transfers include: ER Visits, Hospital Observation, Acute Care Admission, etc…

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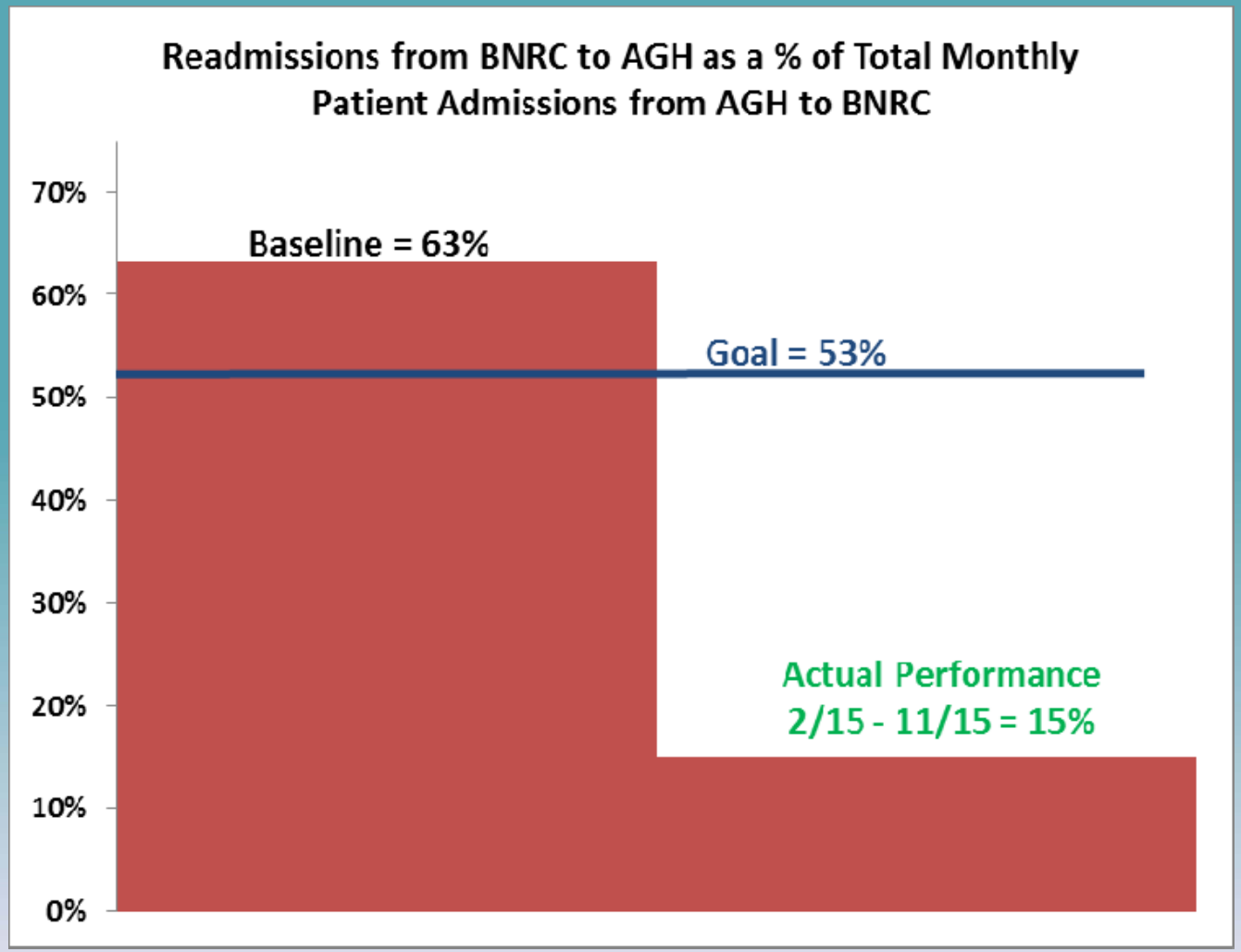
Results/ Outcomes

Re-Admissions to the Acute Care Hospital



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Cost Reduction

Hospital Costs / Savings

- The reduction in admissions resulted in a decrease of 11 admissions per month. An estimated cost of $14,313 per admission results in a savings $157,400 per month savings or 1.9 million over the 12 month period.
- The 42% reduction in re-admissions translates to a decrease of 4 re-admissions per / month at a a savings of $57,300 or $687,000 over the 12 month period.
- The 9% reduction translates into a reduction of 30 transfers over the 12 month period.

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Sustainability

The Maryland "Waiver" Program for Acute Care Hospital Payment

- **The new "Global Budget Revenue" system with the HSCRC in Maryland creates the incentives for hospitals to create programs like this telehealth initiative.**

<u>Additional Means to Sustain Telehealth Services:</u>

- **Reimbursement / billable services for physicians in Maryland.**
- **Further extension of services into primary care, long-term care and assisted living facilities.**
- **Grant funding.**

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Thank You!

Open Forum / Discussion

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INTEGRATING VIRTUAL VISITS AND REMOTE MONITORING TO IMPROVE TRANSITIONS OF CARE BETWEEN DIMENSIONS HEALTHCARE SYSTEM FACILITIES AND COMPREHENSIVE CARE FACILITIES

Carnell Cooper, M.D., FACS
Chief Medical Officer
Dimensions Healthcare System

Dimensions Healthcare System

Participating Partners

Dimensions Healthcare System

- Integrated, not-for-profit healthcare system in Prince George's County, Maryland, serving approximately 180,000 patients annually

Maryland Emergency Medicine Network

- National leader in academic and community-based emergency medicine Affiliated with the University of Maryland Medical System

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

DEPARTMENT OF EMERGENCY MEDICINE

Participating Partners

Comprehensive Care Facilities

SANCTUARY AT HOLY CROSS
A Trinity Senior Living Community

Hillhaven

Assisted Living, Nursing and Rehabilitation Center

SavaSeniorCare

Patuxent River Health and Rehabilitation Center

Genesis HealthCare®

Crescent Cities Center

Participating Partners

ZaneNet
Expect Excellence

- Certified 8(a) Company and Small and Woman-Owned Disadvantaged Business (SDB); Maryland MBE Certified woman owned SBD registered in the District of Columbia
- Accreditation by the Maryland Health Care Commission to serve as a Management Service Organization (MSO)
- Certified Professionals in Health Information Technology (CPHIT)

Clients:

The DHS project

The DHS project involved two telehealth interventions.

- Post-discharge e-visit between the CCF and a DHS hospital to track a patient's status during the first 30 days of discharge.
- Pre-transfer e-visit between the CCF and a DHS hospital emergency department to determine if emergency transfer is necessary or provide support to the CCF to avoid emergency transfer.

Purpose

The Long Term Care/Hospital Telehealth Project Pilot was designed to reduce hospital admission and 30 day readmissions for patients at comprehensive care facilities (CCF) by:

- (1) improving improve care transitions for Medicare, Medicaid and dually eligible patients who were admitted to hospital and transferred to the CCFs or who are at risk for readmission to the hospital from the CCFs
- 2) reducing unnecessary emergency department visits for Medicare, Medicaid and dually eligible residents of the CCFs.

Implementation

- The pilot integrated virtual visits to improve transitions of care between two DHS acute care facilities (PGHC and) and two CCFs, Sanctuary and Patuxent. Additional CCFs were added during the pilot.

- Patient data were exchanged among DHS and CCF providers via the HouseCall e-vist platform which permitted virtual consultations and virtual encounters and image capture

- The pilot served patients who are Medicaid, Medicare or dually eligible beneficiary residents of the CCFs and who are at risk for admission or readmission within 30 days or at risk of transfer to a hospital emergency room.

Workflow Integration

- The committee developed Telehealth Workflows for the post-discharge intervention and the ED Intervention
- A group of DHS (at PGHC) physician advisors was trained on the telemedicine tool and to manage the post-discharge intervention process.
- Zane Networks took the lead in training the hospitals' staff and providers as well as CCF staff and providers on the use of the telemedicine equipment and software.
- Hospital case managers and/or CCF staff explained the pilot to patients and families and obtained informed consent from interested patients prior to their being discharged from hospital or upon their (re)admission to the CCF.

Expected outcomes

- Reduction in the hospitalization rate for Medicare, Medicaid and dually eligible CCF residents
- Reduction in the 30 day readmission rate for CCFs
- Reduction in the emergency department transfer rate for Medicare, Medicaid and dually eligible patients who are CCF residents
- Improvements in patient experience.

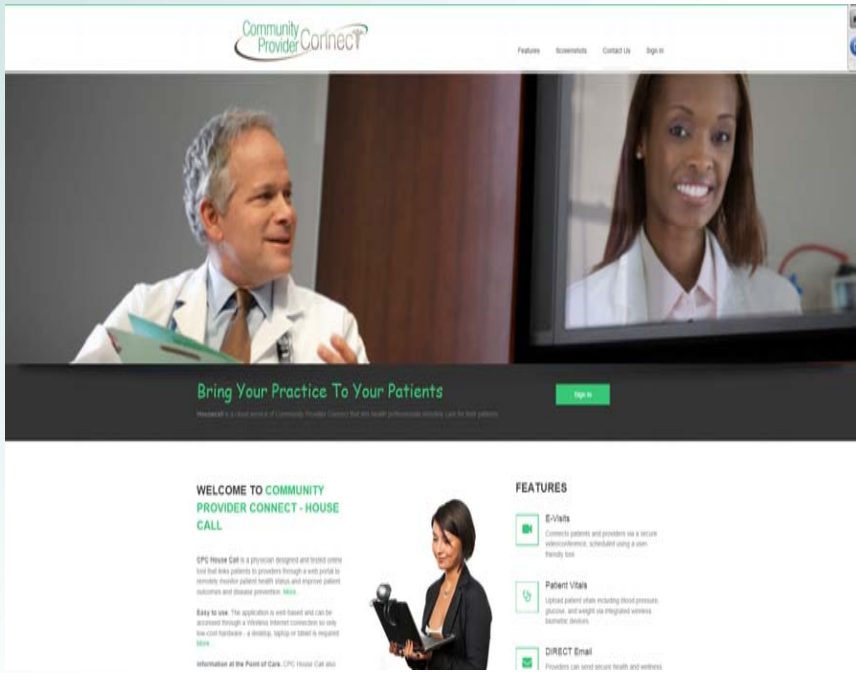
Hardware: Surface Pro Tablets

- Surface Pro 3 Tablets and IPADs were considered as hardware options
- Surface Pro 3 Tablet was selected because it provides full widows desktop capabilities along with the versatility of a tablet.
- Surface Pro 3 USB port can support future integration of devices (Stethoscope, examination camera, BP cuff, etc.).

Hardware: JACO Carts

- The JACO Cart was chosen for mobility and ease of use for end users.
- The Surface Pro 3 tablets can be mounted to the JACO carts, providing greater security for the hardware.
- With the JACO Cart clinicians can easily navigate between patients rooms to conduct Tele-Health visits.

Software: HouseCall



- HouseCall created by ZaneNetworks, a Maryland State Designated Management Service Organization
- HouseCall is a cloud-based software service, hosted in a HIPAA certified Data center
- TeleHealth Calls are encrypted and sent through the internet, securely.
- HouseCall is provider-centered and supports provider-to-provider Video conferencing
- ZaneNetworks currently developing direct integration to allow providers to send Direct Messages with documents using HouseCall.

CRISP ENS and Direct Messaging

- CRISP ENS delivered to participating providers secure emails with real-time alerts of their patients' hospitalization status during the hospital stay and at the time of discharge.

- Providers could retrieve more detailed patient information such as discharge summary, labs, medications prescribed if documented and available from the hospital information system.

- The pilot leveraged EHRs, HIE and Telehealth to allow hospital-based and CCF telehealth practitioners to schedule, manage and conduct video consults with patients; collect clinical data such as images and provider notes; exchange health information with other providers via DIRECT or through the portal; and import data into their EHR.

- The integration of telehealth and ENS increased coordination between the hospital and CCFs and enhanced the quality and accessibility of clinical information need to inform quality care.

Results

Table 1: DHS Long Term Care Hospital Telehealth Project Evaluation Findings						
Measures	**Patuxent CCF**			**Sanctuary CCF**		
	Baseline Rate (Jan-March, 2015)	Goal	Endpoint Rate (April – Oct, 2015)	Baseline Rate (Jan – June 2014)	Goal	Endpoint Rate (Jan– Sept 2015)
Hospital Admissions **Numerator =Number of patients that were admitted to an ACH from the CCFP** **Denominator= Total number of resident days for the month at the CCF**	.44%	.36%	.41%	1%	0.70%	.38%
30 day Readmissions **Numerator= Number of patients that were admitted from the CCF to an ACH and were re-admitted to an ACH within 30 days of hospital discharge date** **Denominator Number of patients that were admitted to the CCF from an ACH**	66.6%	50%	18%	15.3%	12.5%	11.38%
ED visit rate **Numerator=Number of residents that where transferred via ambulance to any ACH from the CCF** **Denominator= Total number of resident days for the month at the CCF**	.52%	.42%	.29%	.24%	.19%	.42%

Lessons Learned

- Consistent communication between the acute care hospital and the CCF results in a more in depth assessment of the resident's condition and facilitates on site interventions that eliminate transfers.
- Telehealth champions are critical to maximize the utility of telehealth among the physician and nursing staff
- There must be ongoing training and engagement of physician and facility staff to sustain provider and staff enthusiasm for the project and to integrate telehealth interventions and protocols as a natural part of the clinical workflow.
- Telehealth programs must include education for patients and their families regarding the benefits of telehealth intervention
- Clinical support and staffing resources must be available to ensure that the effective and efficient clinical management of patients

Sustainability

- To sustain a telehealth program, investment of additional resources for hardware, capital improvements and dedicated personnel to implement a more comprehensive telehealth program is required.

- To be viewed as cost effective, to the hospitals and CCFs, there must be a quantifiable return on investments (ROI). Specifically, there must be appropriate reimbursement for telemedicine services as one element of the ROI. An effective program would also like result in definitive hospital savings and better healthcare outcomes for participants.

- Telemedicine programs must be integrated into the daily work processes of the acute care hospitals and CCFs to ensure broad utilization. Staff must be trained on the benefits of the programs and utilization of the tools.

- Internal resources in the form of dedicated staff and IT support must be part of the program. Additionally, to expand CCFs' capacity to care for sick patients through collaboration with acute care hospitals, there must be a nurse champion at each CCF and strong commitment by the CCF administration to provide the training and support needed by staff to expertly care for patients.

Questions

On the Horizon

- Disseminate telehealth grant findings to inform broader telehealth projects
- Award a fourth round of telehealth grant(s) that advance practice transformation and continue to align with value base care models
- Telehealth Symposium: Remote Monitoring and Chronic Care Management of High Risk Patients on February 22, 2016 at Anne Arundel Hospital Center
- Explore opportunities with the HSCRC to diffuse telehealth under the new waiver

Thank You!

The MARYLAND
HEALTH CARE COMMISSION

CRISP

CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS

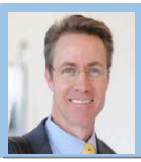
Integrated Care Network Infrastructure – Status Update

HSCRC Commission Meeting

10 February 2016

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

ICN Infrastructure Workstream Leads



Ross Martin

Program Director

Diatta Harris

Project Manager

	Calvin Ho	**1. Ambulatory Connectivity:** We are connecting more practices, physicians, long-term-care facilities, and other health providers to the CRISP network.
	Ryan Bramble	**2. Routing Data:** We are building a data router: including data normalization, patient consent management, patient-provider relationships – for sharing patient-level data.
	Steve Caramanico	**3. Clinical Portal Enhancements:** We will enhance the existing Clinical Query Portal with a care profile; a provider directory; information on other known patient-provider relationships; and risk scores.
	Ryan Bramble	**4. Notification & Alerting:** We will create new alerting tools so that notifications happen within the context of a provider's existing workflow.
	Craig Behm	**5. Reporting & Analytics:** We will expand existing CRISP reporting services and make them available to a wider audience of care managers.
	Lindsey Ferris	**6. Basic Care Management Software:** We will support care management software platforms – through data feeds, reports and potentially a basic shared care management tool.
	Cheryl Jones	**7. Practice Transformation:** We will train providers on leveraging CRISP data and service, sharing best practices and workflows, and supporting collaborative partnerships. CRISP's role is TBD and may be supportive or coordinating.

Bright Spots

- PaTH Report is live!*
  *Rollout timing is training dependent
- Receiving Care Plans!*
  *But we need more
- Care Profiles are available!*
  *More features and data sources will be added over time
- Ambulatory connectivity accelerating (>1500 connections)!*
  *Setbacks like Practice Fusion still occur
- Basic Care Management Software pilots kicked off!*
  *Keeping our options open based on outcomes
- Customer Success Program launched!*
  *Customer Success Plans need to be completed

Ambulatory Connectivity: CRISP Connectivity Tiers

Tier 1: **View Clinical Data and Receive Hospitalization Alerts (manually submit panels – 553 organizations)**

Tier 2: **Send Encounter Information About Your Patients (administrative encounter data – 229 practices)**

Tier 3: **Send Clinical Information About Your Patients (e.g., C-CDAs – 6 practices)**

Please refer to handout:

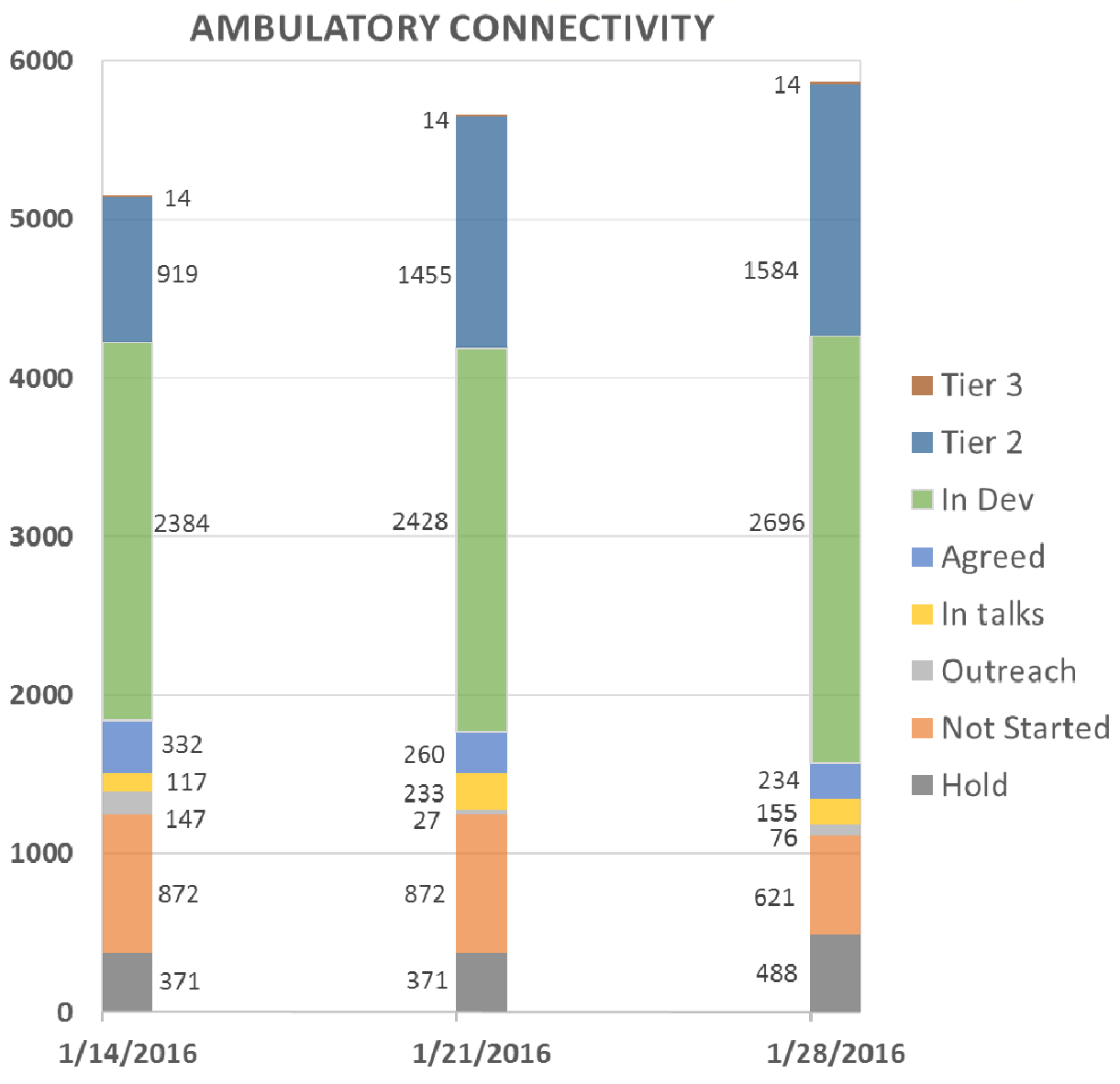
07-CRISP Connectivity Tier Sheet - 2016-01-13.pdf

Ambulatory Practice Connectivity

as of 29 January 2016

Regional Partnership Priority Practices	Practice (sites)				Physicians			
	Total	In Dev	Tier 2	Tier 3	Total	In Dev	Tier 2	Tier 3
Bay Area Transformation Part	21	0	0	0	88	0	0	0
Balto Health Sys Transform Part	6	0	0	0	17	0	0	0
Howard County Regional Part	31	12	1	0	165	48	18	0
Nexus Montgomery	25	9	0	0	156	133	0	0
Regional Planning Comm Health	7	0	0	0	25	0	0	0
Southern MD Regional Coalition/ Continuum ACO	45	9	0	0	76	28	0	0
Trivergent	0	0	0	0	0	0	0	0
Upper Chesapeake/UHCC	58	25	14	2	137	52	35	4
Tristate ACO	22	0	0	0	22	0	0	0
Hospital Owned/Managed Practices								
Johns Hopkins Health System	53	0	53	0	1040	0	1040	0
Medstar	307	0	0	0	1882	1882	0	0
UMMS	94	0	94	0	293	0	293	0
Lifebridge	193	0	0	0	362	0	0	0
Dimensions	0	0	0	0	60	0	0	0
Adventist	145	145	0	0	233	233	0	0
Independent Hospitals	257	0	62	4	852	319	166	10
Additional Outreach								
CQM Practices	27	0	0	0	34	0	0	0
Independent Practices (PCP)	85	1	1	0	222	1	23	0
Independent Practices (Specialty)	1	0	0	0	4	0	0	0
Administrative Networks								
CyFluent	32	0	4	0	22	0	9	0
Relay Health	106	0	0	0	178	0	0	0
LT/PAC								
SNF	40	1	0	0	n/a	n/a	n/a	n/a
GRAND TOTAL	1555	202	229	6	5868	2696	1584	14

Ambulatory Connectivity Trends

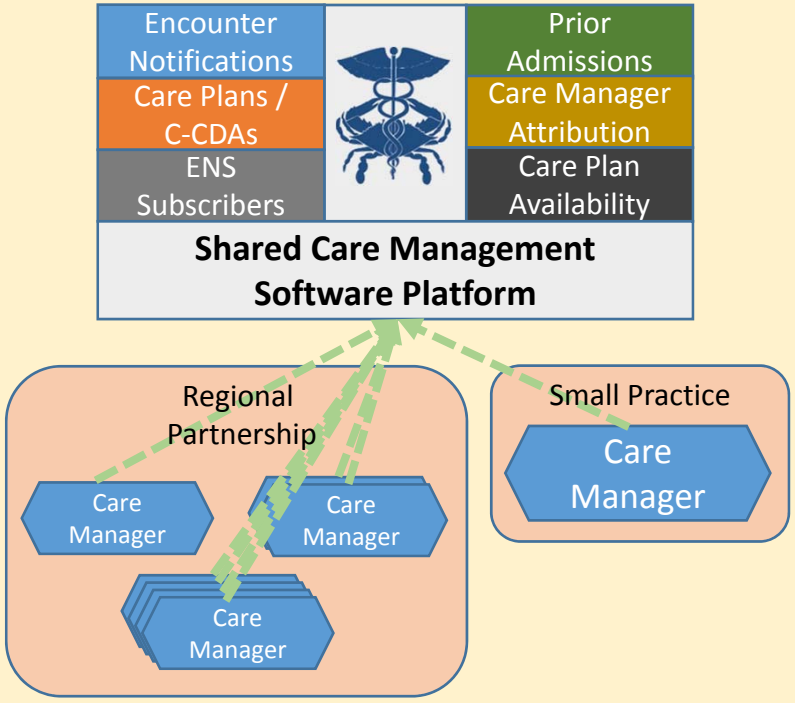


Basic Care Management Software Strategy

We are conducting pilots on two core strategies

Offer basic care management software as a shared platform

Mirth Care – Upper Chesapeake

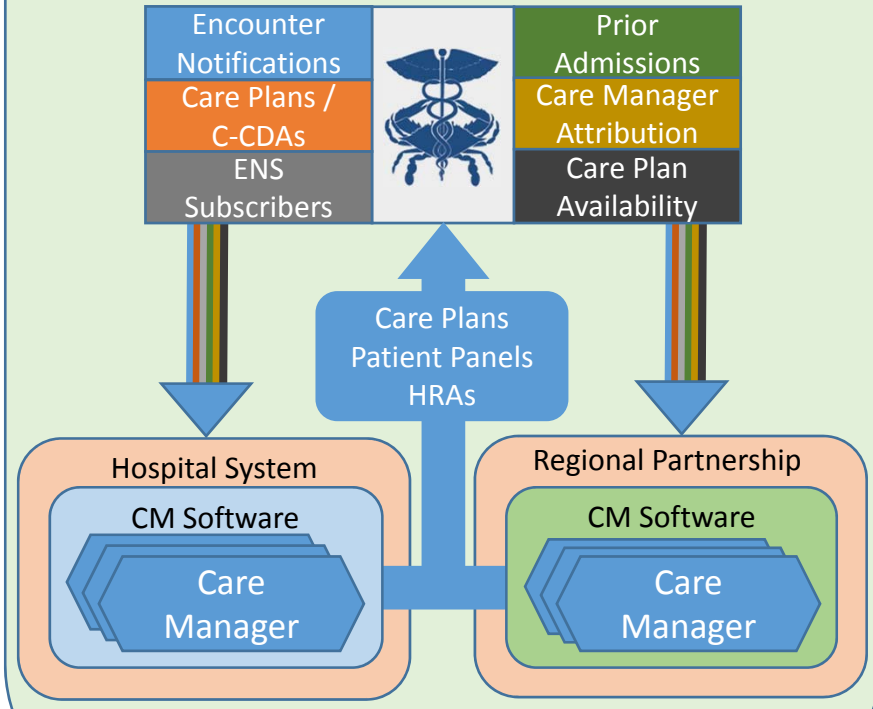


Easy to Scale One Size "Fits" All

Support customer-selected care management software with data feeds

Caradigm – Southern MD ACO / Continuum

eQHealth – TLC



Custom Fit Multiple Integrations

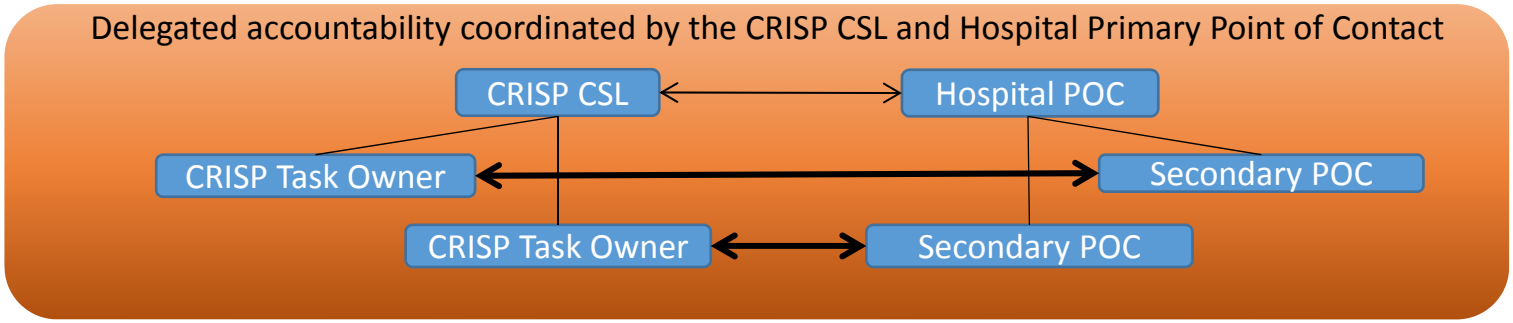
Basic Care Management Strategy Next Steps

- Report on pilot results
- Decision point options to be considered by ICNI SC after pilots:
  - Basic Care Management Software offering:
    - Continue with Mirth Care as basic solution
    - Develop RFP for broader search for best solution
    - Choose not to support a shared platform
  - Support of multiple advanced care management software platforms:
    - Continue to support new platforms as customers select options
    - Develop “certification” or pre-purchase testing program to improve vendor selection process

CRISP Customer Success Program

Our goal is to ensure that our customers have access to health information exchange tools and services that support your success and your patients' health.

- Why: Our accountability with the State and you is aligned with your success. We are becoming more complex because your needs are becoming more complex.
- What: When CRISP understands your goals and strategies, we can match our tools and services to your needs and prioritize them.
- How: Together, we will craft a Customer Success Plan that outlines our shared commitments toward your stated goals.
- Who: CRISP will assign a Customer Success Liaison to you, who will coordinate all of your touchpoints with CRISP.



Customer Success Program

- Our products, services and customer mix – especially related to care coordination – have grown in scope and complexity.
- To optimize the customer experience, we have launched a Customer Success Program and have assigned Customer Success Liaisons (CSLs) to each of our key hospital clients initially.
- We have also developed tools to support CSLs
  - Draft Customer Success Plans
  - CRISP Wiki (internal) aggregating resources and information on customer activity and progress
- We have scheduled meetings with customer leadership to present the program (many more to go)

Customer Success Liaisons

Initial Customer Assignments

Paul Gleichauf

- Anne Arundel Medical Center
- Atlantic General Hospital
- Calvert Memorial Hospital
- Doctor's Community Hospital
- Fort Washington Medical Center
- Garrett County Memorial Hospital
- Greater Baltimore Medical Center
- JH - Howard County General Hospital
- JH - Johns Hopkins Bayview Medical Center
- JH - Johns Hopkins Hospital
- JH - Sibley Memorial Hospital
- JH - Suburban Hospital
- Laurel Regional Hospital
- McCready Memorial Hospital
- Peninsula Regional Medical Center
- Prince George's Hospital Center

Rob Horst

- Bon Secours Baltimore Health System
- Carroll Hospital Center
- MedStar Franklin Square Hospital Center
- MedStar Georgetown University Hospital
- MedStar Good Samaritan Hospital
- MedStar Harbor Hospital
- MedStar Montgomery Medical Center
- MedStar Southern Maryland Hospital Center
- MedStar St. Mary's Hospital
- MedStar Union Memorial Hospital
- MedStar Washington Hospital Center
- Mercy Medical Center
- Northwest Hospital Center
- Sinai Hospital
- St. Agnes Hospital

Ross Martin

- Baltimore Washington Medical Center
- Frederick Memorial Hospital
- Harford Memorial Hospital
- Holy Cross Hospital
- Holy Cross Hospital - Germantown
- Meritus Medical Center
- Shady Grove Adventist Hospital
- Union Hospital of Cecil County
- University of MD Charles Regional Medical Center
- University of MD Medical Center
- University of MD Medical Center Midtown Campus
- University of MD Rehabilitation and Orthopedic Institute
- University of MD Shore Medical Center at Chestertown
- University of MD Shore Medical Center at Chester
- University of MD Shore Medical Center at Easton
- University of MD St. Joseph Medical Center
- Upper Chesapeake Medical Center
- Washington Adventist Hospital
- Western Maryland Health System Hospital

Critical Need for Medicare Data

- Terms of the Federal Agreement envision the need for Medicare data to support success of new model
- Increasing demand from Maryland providers for data
  - Regional Partnership Plans, Hospital Strategic Plans, and proposed Transformation Infrastructure proposals call for Medicare data to support identification of high needs patients and coordination care
  - Care Coordination Workgroup proposed shared tools requiring Medicare data such as reports identifying gaps in care, patient profiles, and risk stratification

Proposed Use of Data: Improve Patient Care through Care Coordination Support

Data Use	Justification
Develop utilization reports for ambulatory providers and hospitals	Transparency will enhance the opportunity for providers to work together to coordinate care, assure non-duplication of services and allow for the creation of tools, reports, and processes to identify utilization patterns and fill gaps in care.
Enhance existing statewide HIE tools	Reports supporting patient identification, alerts sent automatically to specific providers, and other tools to support clinical care and patient engagement.
Contribute data for risk stratification and related reports	Risk stratification tools will assist providers and coordinators of care to best target their efforts to those in need of assistance.
Populate standardized care profiles	Care profiles available through CRISP's clinical portal will give health care providers and coordinators additional information, which will increase the extent to which they will be able to anticipate and coordinate the full range of beneficiary needs, particularly in the community.

Proposed Use of Data: Performance Measurement

Data Use	Justification
Support process and outcome measurement	Statewide and local care coordination initiatives and investments require defining and tracking specific activities that will lead to improved quality and more efficient, coordinated care delivery.
Generate total cost of care benchmarks and reports	Effectiveness reporting will provide the information necessary to evaluate the performance and impact of various efforts, understand the effect of Medicare claims data access on achieving waiver goals, and prevent cost shifting.
Pay for Outcomes Management	Supporting provider enrollment; beneficiary assignment; process measurement and results analysis

Data Sharing Framework

- No data shared on any patients who have opted out of CRISP
- Data shared based on an patient-provider relationship model:
  - Hospital care managers may receive data on patients who been admitted within last 12 months; or
  - Hospital and community based care managers may receive 24 months of data on patients who have opted into a care a management relationship
- Data shared to support initial identification of patients who would benefit from Care Coordination
- Use of data limited to users specifically credentialed as care managers

Medicare Next Steps

1. Vendor selection for claims data management and analytics
   - Continued due diligence then RFP process
2. CRISP to submit data requests through multiple simultaneous tracks:
   - Qualified Entity application submission and approval process
   - Maryland-specific application process directly through CMMI

Background Slides

ICN Infrastructure Background

- As an entity established to engage in health IT initiatives best pursued cooperatively, CRISP is well positioned to manage the buildout of shared infrastructures.
- By virtue of CRISP's governance model, the stakeholders who use CRISP services direct the work efforts and decision making of the organization and provide oversight and accountability.
- This governance model extended well for building the Integrated Care Network (ICN) infrastructure, with a new Steering Committee empaneled by the Board to provide targeted oversight of the effort.
- The ICN tools and services are being developed through both new efforts and by building on the existing HIE platform that has evolved over the last 7 years.

Summary of Initial Approach

CRISP organized the ICN Infrastructure buildout into seven workstreams. They include:

1. Ambulatory Connectivity
2. Data Router
3. Clinical Portal Enhancements
4. Notifications & Alerting
5. Reporting & Analytics
6. Basic Care Management Software
7. Practice Transformation

Well developed work plans have been established for the first five workstreams. Detailed work plans for the final two workstreams are under development with the incorporating additional stakeholder direction.

Budget Status

- The current spend rate has us coming in below budget, though our rate of spend is accelerating.
- Decisions and the implementation pace of several work plans that are still under development could cause us to incur more or less costs.
- The most significant contributors to the budget are:
  - **Ambulatory Connectivity** – and the prioritization of encounter data has thus far kept costs below budget.
  - **Basic Care Management Software** – and the work plan is still under development.
  - **Practice Transformation** – the details of which will be best developed after the Ambulatory Alignment strategy is in place.
  - **Ambulatory Reporting & Analytics** – delivering robust analytics tools to 5,000 practices will be a significant undertaking if we pursue that direction.
- The original CRISP ICN Infrastructure budget for 2016 assumed roughly half of the funding would come from federal sources. A significant potential source of federal funding, called the HIE I-APD and led by DHMH, has not been finalized, though it looks promising.

Near-Term Objectives

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

Timeline and Status Highlights

◆ Completed
◆ In progress
◆ Not started

	2015					2016						
Deliverable	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**% Complete**
Program Management												
ICN Steering Committee Established	◆											100%
Workstream Lead Assinged			◆									100%
Supporting Regional Partnerships/MOUs established						◆						70%
1.0 Ambulatory Connectivity												
Identify all hospital-owned ambulatory practices							◆					50%
Complete list of ambulatory practices by Regional Partnerships						◆						80%
Establish EMR Collaboration (Athena site live)					◆							100%
ECW CRISP hub live									◆			25%
2.0 Data Router												
RFP awarded			◆									100%
v.5 Consent module deployment						◆						90%
v1.0 Consent module deployment						◆						25%
3.0 Clinical Portal Enhancements												
ENS subscriber list live						◆						90%
Care alerts available in clinical portal							◆					80%
Care plans available					◆							100%

Timeline and Status Highlights - Cont

	2015					2016						
Deliverable	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	% Complete
4.0 Alerts and Notifications												
Readmission patient notification pilot live			◆									100%
Care alerts live at AAMC							◇					75%
Care Alerts live at BWMC								◇				0%
5.0 Reporting and Analytics												
Data Sharing Policy for Interhospital care coordination					◆							100%
PaTH Detail Dashbaord available to hospital care managers						◇						95%
Pilot Risk Stratification tools							◇					75%
Request Medicare data						◇						0%
6.0 Basic Care Management Software												
Mirth pilot initiation						◆						100%
Caradigm pilot initiation						◆						100%
eQHealth pilot initiation						◆						100%
7.0 Practice Transformation												
ENS webinar						◇						25%

Pace and Funding

ICN Infrastructure BUDGET SUMMARY						
Workstream	FY2016 State & Federal Budget	FY2016 Approved HSCRC	Actual Through December	FY2016 Current Estimate	FY2016 HSCRC Change Request	Full Project "Planning Budget"
1. Ambulatory Connectivity	$4,499,326	$449,933	$351,151	$2,838,000	$2,250,000	$31,435,691
2. Data Router	$1,853,630	$463,408	$229,513	$924,000	$450,000	$2,184,206
3. Clinical Portal Enhancements	$1,550,379	$775,489	$110,817	$490,000	($300,000)	$2,409,735
4. Alerts & Notifications	$1,321,180	$1,321,180	$91,789	$682,000	($655,000)	$3,739,997
5. Reporting & Analytics	$2,468,110	$2,468,110	$884,352	$2,497,000	$0	$23,660,628
6. Basic Care Management Software	$505,804	$505,804	$119,013	$506,000	$0	$3,902,765
7. Practice Transformation	$262,411	$262,411	$68,126	$264,000	$0	$7,963,601
8. Patient & Caregiver Engagement	$0	$0	$0	$0	$0	$1,320,001
TOTAL	$12,460,840	$6,246,335	$1,854,761	$8,201,000	$1,745,000	$76,616,624

Pending IAPD funding request approval

Legislative Update – February 7, 2016

Nurse Support Program Assistance Fund - SB108

SB 108 is a Departmental bill that broadens the scope of the Nurse Support Assistance Program (NSPII) which is supported by the rates of Maryland hospitals through the authority of the HSCRC. Instead of being focused on "bedside" nurses only this bill will allow the NSPII program to improve the pipeline for nurses (through supporting facility and nursing education) with broader skills than providing care at the bedside include supporting the care coordination model.

Hearing: 1/27

Status: Bill passed the Senate. Staff Testified as Co-Sponsor with MHEC

Maryland No-Fault Birth Injury Fund – HB377/SB513

The bills establish a Fund and adjudication system for birth- related neurological injury. The Maryland birth injury fund provides an exclusive "no-fault" remedy to claimants with an injury that falls within the statutory eligibility criteria for the birth injury program. The birth injury fund program provides notification to patients and their families through Maryland hospitals regarding participation in the program, benefits, eligibility, rights under the program, and ways in which the program provides exclusive remedy. The bill also requires the Maryland Patient Safety Center to convene a Perinatal Clinical Advisory Committee to oversee the general dissemination of initiatives, guidance, and the best practices to health care facilities for perinatal care.

This bill establishes a fund as well as an adjudication system for birth related neurological injury. Moneys in the fund will derive from hospital assessments established by the HSCRC.

By July 1 of each year, HSCRC must assess premiums for all Maryland hospitals and increase hospital rates totaling the amount determined by the board to be required to finance and administer the fund. HSCRC must adopt regulations specifying the methodology for the assessment of premiums. The methodology must (1) account for geographic differences among hospitals; (2) account for differences among hospitals' historical claims experience involving births in each hospital; and (3) distinguish between hospitals that provide obstetrical services and those that do not. In determining hospital rates, HSCRC must increase rates to account fully for the amount of the premiums; the resulting increase may not be considered in determining the reasonableness of rates or hospital financial performance under HSCRC methodologies.

By September 1 of each year, each hospital must pay the assessed premiums to HSCRC. HSCRC must forward the payments to the fund.

The Bill would apply to causes of action arising on or after January 1, 2018.

Hearing: House: 2/12; Senate 2/25

Suggested Course of Action: Submit the same Letter of Information the Commission provided last year.

Termination of MHIP and Transfer of Senior Prescription Drug Assistance Program – HB510

House Bill 489 repeals the Maryland Health Insurance Program (MHIP) and transfers the duties of the Senior Prescription Drug Assistance Program (SPDAP) to the Department of Health and Mental Hygiene. The SPDAP program continues to be supported by funds transferred each year for a non-profit health service plan. HSCRC's statute is changed to eliminate the assessment on hospital rates that have been used to operate the MHIP program.

Hearing: 2/11

Suggested Course of Action: Letter of Information the need to remove the assessment when MHIP terminates.

Hospitals – Designation of Lay Caregivers – SB336

SB 336 requires hospitals to provide a patient or legal guardian with an opportunity to designate a lay caregiver before discharge. If a caregiver is designated, the hospital shall record it in the medical record, and request written consent from the patient to release medical information to the caregiver.

The hospital is required to notify the lay caregiver of the patient's discharge or transfer as soon as practicable. As soon as practicable before discharge, the hospital shall attempt to consult with the lay caregiver to prepare the caregiver for aftercare issue a discharge plan that describes the after-care tasks needed by the patient.
Hearing: 2/11

Suggested Course of Action: Same as last year - No Position

Prince George's County Regional Medical Center Act of 2016 – SB324/HB309

This bill requires the State and Prince George's County to provide specified operating and capital funding for a new Prince George's County Regional Medical Center (PGCRMC). The bill is contingent on the transfer of the governance of PGCRMC to the University of Maryland Medical System (UMMS) within 90 days after a certificate of need (CON) is approved. The bill takes effect June 1, 2016, and terminates June 30, 2021. However, if the Department of Legislative Services (DLS) has not received notice of the transfer of governance, the bill terminates on December 31, 2016.

The bill would mandate a total of $461 million for this purpose as follows:

- $55 million in State operating subsidies,
- $55 million in Prince George's operating subsidies;
- $143 million in State capital funds; and
- $208 million in Prince George's County capital funds.

Hearing: Senate 2/3, and House 2/9

Suggested Course of Action: No position

Hospital – Patient's Bill of Rights – SB661/HB587

These bills require hospitals to provide patients with a written copy of the patient's bill of rights adopted pursuant to Joint Commission guidelines, and a translator or interpreter for patients who need one. It also requires hospitals to provide annual training to certain hospital staff to ensure that there is adequate knowledge and understanding of the patient's bill of rights. The bill lists out the rights that must be included in each hospital patient's bill of rights.

Hearing: House 2/18

Suggested Course of Action: No position

Health Care Facilities – Closures or Partial Closures of Hospital – County Board of Health Approval – SB12

This bill prohibits a hospital that receives State or County funding from closing or partially closing unless the hospital notifies the local board of health at least 90 days prior the proposed closing date and receive the local health board's approval.

Before deciding to permit a closure, the local board must hold a public hearing within 5 miles of the hospital within 30 days of the notice to close and consider whether alternatives are available.

Hearing: 2/24

Suggested Course of Action: No Position

Hospitals – Community Benefit Report – Disclosure of Tax Exemptions – SB601

The bill requires hospitals to submit an itemization of the value of their tax exemptions with their community benefit reports.

Hearing: 2/24

Suggested Course of Action: Letter of Information regarding the Community Benefit reports

Freestanding Medical Facilities – Certificate of Need, Rates, and Definition – SB707

This legislation provides an option for hospitals that wish to downsize to become a freestanding medical facility which does not require a CON, would not have inpatient beds, and would be rate regulated for the emergency services and outpatient services as determined by the HSCRC.

Hearing: 2/24

Suggested Course of Action: Consult with the Secretary and Administration

Civil Actions – Noneconomic Damages – Catastrophic Injury – SB574/HB869

This bill would require triple non-economic damages for a cause of action in which the court or the health claims arbitration panel determined negligence or other wrongful conduct resulted in catastrophic injury.

Hearing: Senate 2/25

Suggested Course of Action: Submit the same letter of information as was submitted last year

Health – Collaborations to Promote Provider Alignment – SB866

This bill exempts from the State self-referral law collaborations that are established to promote provider alignment to achieve the goals of Maryland's All-Payer Model contract approved by the Federal Center for Medicare and Medicaid Innovation.

No Hearing date

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.

Stephen F. Jencks,
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Deputy Director
Research and Methodology

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **February 10, 2016**

RE: **Hearing and Meeting Schedule**

March 9, 2016	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
April 13, 2016	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room

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

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

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