Closed Session Minutes
Of the
Health Services Cost Review Commission

March 11, 2015

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

1. Status of Medicare Data Submission and Reconciliation;
2. Potential for Differential Adjustment in rate-setting;
3. Personnel matters.

The Closed Session was called to order at 12:04 p.m. and held under authority of -§§ 3-104 and 3-305(b)(7) of the General Provisions Article.

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

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

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

Item One

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

Item Two

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

Item Three

The Executive Director updated and the Commission discussed various personnel issues including retention and recruitment. The Commission agreed unanimously that the performance of the Executive Director has met the HSCRC's performance bonus standards and guidelines and directed the appropriate HSCRC personnel to prepare the necessary documentation for implementation of the bonus. – Authority General Provisions Article, § 3-305(b)(1)(i)(ii)

The Closed Session was adjourned at 1:00 p.m.

MINUTES OF THE
517th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

March 11, 2015

Chairman John Colmers called the public meeting to order at 12:04 pm. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., MPH, Jack C. Keane, Bernadette C. Loftus, M.D., Thomas Mullen, and Herbert S. Wong, Ph.D. were also in attendance. Upon motion made by Commissioner Jencks and seconded by Commissioner Wong, the meeting was moved to Executive Session. Chairman Colmers reconvened the public meeting at 1:02 pm.

REPORT OF THE MARCH 11, 2015 EXECUTIVE SESSION

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the March 11, 2015 Executive Session.

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

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

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, updated the Commission on the staff's on going regulatory activities. These activities consist of:

- Updating and reformulating quality policies. Ms. Kinzer noted that staff has a final recommendation that requires approval this month.
- Working on the uncompensated care analysis for FY 2016. Staff to present preliminary recommendation at the April Commission meeting.
- Evaluating the impact of Medicaid expansion on utilization and its implication on the global budget. Staff will have an update at the April Commission meeting.
- Reviewing the market shift (share) adjustment. Staff is working on verifying outpatient data. Ms. Kinzer noted that some hospitals still need to send in corrections for their outpatient data. Staff will have an update at the April Commission meeting.
- Working with the Payment Work Group on the rate year 2016 update factor. Staff to present preliminary recommendation at the May Commission meeting.

Ms. Kinzer updated the Commission on the current work group activities. These activities consist of:

- Working with the Care Coordination work group to develop recommendations regarding infrastructure and approach for high needs patients and chronic care improvements. Staff will have a draft recommendation regarding BRFA funds this month. Care Coordination work group will present their recommendations at the April Commission meeting.
- Staff working with consultants regarding alignment strategies and focusing on integration models.
- Working with consumer work groups for consumer outreach and consumer engagement and education planning.

Ms. Kinzer noted that following the completion of policy development for the year, staff will review its performance measurement policies and develop policies that are patient centered, and which measure and help drive better care, better health, and lower cost.

Ms. Kinzer updated the Commission on the status of influenza in Maryland. She noted that the flu tapered off in February, with the weekly activity reported as minimal for the entire month of February. As a result, there are no plans to adjust FY 2015 global budgets for the impact of the flu.

Ms. Kinzer announced that Jessica O'Neill was leaving the HSCRC to attend medical school and thanked her for her invaluable contributions to the Commission and its staff. Ms. O'Neill was the Commission liaison with the Centers Medicare & Medicaid Innovation (CMMI).

Ms. Kinzer introduced the following new members to the HSCRC staff

- Mr. Xavier Colo- Associate Director of Information Technology
- Ms. Irene Chen –Programmer Analyst
- Jessica Lee- Liaison with CMMI

.

ITEM III
NEW MODEL MONITORING

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

Mr. Romans reported that for the seven months ended January 31, 2015, All-Payer total gross revenue increased by 1.04% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 1.68%; this translates to a per capita growth of 1.03%. All-Payer gross revenue for non-Maryland residents decreased by 5.14%.

Mr. Romans reported that for the first month of the calendar year ended January 1, 2015, All-

Payer total gross revenue decreased by 3.35% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 2.70 %; this translates to a per capita growth of (3.25%). All-Payer gross revenue for non-Maryland residents decreased by 10.25%.

Mr. Romans reported that for the seven months ended January 31, 2015, Medicare Fee-For-Service gross revenue increased by 1.59% over the same period in FY 2013. Medicare Fee-For-Service for Maryland residents increased by 2.39%; this translates to a per capita growth (.56%). Maryland Fee-For-Service gross revenue for non-residents decreased by 6.90%.

Mr. Romans reported that for the first month of the calendar year ended January 31, 20152, Medicare Fee-For-Service gross revenue increased by .07%. Medicare Fee-For-Service for Maryland residents increased by 1.1%; this translates to a per capita growth (2.l %). Maryland Fee-For-Service gross revenue for non-residents decreased by 11.99%.

According to Mr. Romans, for the seven months of the fiscal year ended January 31, 2015, unaudited average operating profit for acute hospitals was 2.82%. The median hospital profit was 3.85%, with a distribution of 2.04% in the 25th percentile and 6.40% in the 75th percentile. Rate Regulated profits were 5.02%.

Dr. Alyson Schuster, Associate Director Data & Research, stated that there was no quality report on the Maryland Hospital Acquired Conditions program for March as several hospitals have requested extensions for submitting their data.

ITEM IV
DOCKET STATUS CASES CLOSED

2284R- Garrett County Memorial Hospital
2285R- Johns Hopkins Bayview Medical Center
2287A- University of Maryland Medical Center

ITEM V
2288R- MedStar Southern Maryland Hospital Center

On January 29, 2015, MedStar Southern Maryland Hospital Center (the "Hospital) submitted a partial rate application to the Commission requesting its July 1, 2014 Medical Surgical Acute (MSG) and Definitive Observation (DEF) approved rates be combined effective March 1, 2015.

After reviewing the Hospital application, staff recommends the following:

- That the Hospital be allowed to collapse its DEF rate into its MSG rate;
- That a MSG rate of $927.37 per day be approved effective March 1, 2015; and
- That no change be made to the Hospital's Global Budget Revenue for MSG services

The Commission voted unanimously to approve staff's recommendation.

2289R- MedStar Franklin Square Hospital Center

On January 29, 2015 MedStar Franklin Square Hospital Center (the "Hospital) submitted a partial rate application to the Commission requesting its July 1, 2014 Medical Surgical Acute (MSG) and Definitive Observation (DEF) approved rates be combined effective March 1, 2015.

After reviewing the Hospital application, staff recommends the following:

- That the Hospital be allowed to collapse its DEF rate into its MSG rate;
- That a MSG rate of $1,271.10 per day be approved effective March 1, 2015; and
- That no change be made to the Hospital's Global Budget Revenue for MSG services

The Commission voted unanimously to approve staff's recommendation.

2290A- University of Maryland Medical Center

University of Maryland Medical Center (the "Hospital") filed an application on January 30, 2015 requesting approval to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. Network for one year beginning April 1, 2015.

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

The Commission voted unanimously to approve staff's recommendation

2291A- Johns Hopkins Health System

Johns Hopkins Health System, on behalf its member hospitals Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals"), filed an application on February 25, 2015 requesting approval to participate in a global rate arrangement for joint replacement services with Health Design Plus, Inc. for Pacific Business Group on Health clients. The Hospitals are requesting approval for one year beginning April 1, 2015.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement services for one year beginning April 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2292A- Johns Hopkins Health System

Johns Hopkins Health System, on behalf its member hospitals Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals"), filed an application on February 25, 2015 requesting approval to participate in a global rate arrangement for joint replacement and cardiovascular services with Health Design Plus, Inc. for clients other than those of Pacific Business Group on Health clients. The Hospitals are requesting approval for one year beginning April 1, 2015.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement and cardiovascular services for one year beginning April 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2293A- Johns Hopkins Health System

Johns Hopkins Health System, on behalf its member hospitals Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals"), filed an application on February 25, 2015 requesting approval to continue to participate in a global rate arrangement for cardiovascular and orthopedic services with PepsiCo, Inc. The Hospitals are requesting an approval for one year beginning April 1, 2015.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular and orthopedic services for one year beginning April 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

ITEM VI
FINAL RECOMMENDATION FOR MODIFICATIONS TO THE READMISSION REDUCTION INCENTIVE PROGRAM FOR FY 2017

Dr. Schuster presented the final recommendations for the Readmission Reduction Incentive Program for FY 2017 (See "Update on the Recommendations for the Readmission Reduction Incentive Programs for FY2017" on the HSCRC website).

The US healthcare system currently experiences an unacceptably high rate of preventable hospital readmissions. Excessive readmissions are a symptom of our fragmented care system,

and they generate considerable unnecessary cost and substandard care quality for patients. Maryland's readmission rates are high compared to national levels for Medicare. The new All-Payer Model Agreement has established readmission reduction targets that require Maryland hospitals to be equal to or below the rates of Medicare readmissions by CY 2018 and to make scheduled annual progress toward this goal.

In order to incentivize hospital care improvements, encourage hospitals to meet Medicare readmission targets, and motivate hospitals to reduce readmissions for other payers, the Commission approved a hospital Readmission Reduction Incentive Program (RRIP). The RRIP established a uniform target reduction of 6.76% in all payer readmissions across all hospitals in CY 2014.

The purpose of this final recommendation is: to provide the latest available information regarding the results of the RRIP in CY 2014; to discuss the range of issues raised by Commissioners, stakeholders and Staff concerning the RRIP; including the pros and cons of various options for modifying the RRIP for RY2017; and to propose the Staff's final recommendations for changes in the RRIP for the FY 2015 performance year.

The staff's final recommendations for the RRIP for FY 2017 are as follows:

1. Adopt a readmission payment incentive program with both rewards for hospitals achieving or exceeding the required readmission reduction benchmark, and payment reductions for hospitals that do not achieve the minimum required reduction.

2. Use a continuous preset scaling approach to provide rewards and penalties in proportion to each hospital's performance relative to the required reduction on a case-mix adjusted basis.

3. Continue to set a minimum required benchmark on all-payer basis and re-evaluate the option to move to a Medicare specific performance benchmark for FY 2016 performance period.

4. Set the all-payer case-mix adjusted readmission target at a 9.5% cumulative reduction from CY 2013 base all payer case-mix adjusted readmission rates.

5. Continue to assess the impact of admission reductions, socioeconomic/demographic factors, and all payer and Medicare readmission trends and make adjustments to the rewards or penalties if necessary.

6. Seek additional Medicare benchmarks that can help guide efforts in Maryland. Evaluate recommendations from the Care Coordination Work Group and request recommendations from Maryland's new quality improvement organization (Virginia Health Quality Center) regarding specific areas for improvement.

Ms. Traci LaValle, Vice President, Rate Setting, Maryland Hospital Association, stated that the 9.5% target will be challenging for hospitals to meet. Hospitals have invested significant resources to reduce readmissions and while it's clear that the investments are working, more time is needed to see the full results of the efforts. Ms. LaValle noted that meeting the target will be more difficult for some hospitals than others, and that the provision that allows a hospital to request individual reconsideration of a penalty is important in order to take into account the complexity of measuring hospitals' readmissions and the factors affecting readmissions.

Ms. LaValle also expressed concern about the uncertainty of the year 2 waiver target noting that the slowing of the nation's readmission rate reductions in FY 2014 may represent a trend that is much different from prior years. In addition, according to the most recent CMMI and HSCRC data, Maryland's Medicare readmission rate is higher when based on HSCRC data than based on CMMI data, through it would be expected that Medicare data capture out of state readmissions. This compounds the uncertainty in the 9.5% target.

The Commissioners considered whether the payment policy should be tied to an all-payer risk adjusted readmission rate or to a Medicare unadjusted readmission rate to match the Medicare waiver test more closely.

Mr. Jonathan Blum, Executive Vice President of Medical Affairs CareFirst Inc., supported a Medicare only readmission target and addressed the concern about an all-payer readmission target by recommending that the all-payer target could be set up in addition to a Medicare only target. Mr. Blum cited the importance of surpassing Medicare's readmission targets, so that the State is well positioned to extend the All-Payer model into a second phase.

Ms. Tricia Roddy, Director of Planning Maryland Medicaid, supported the staff recommendation to set the readmission target on an all-payer basis. Ms. Roddy noted that if the HSCRC were to move to a Medicare only readmission policy, Medicaid would need to develop a separate readmission policy for Medicaid patients.

Commissioner Mullen asked why Staff was rounding up the adjusted readmission reduction target for year 2 from 9.3% to 9.5%. Ms. Kinzer modified the staff recommendation to a 9.3% readmission target.

The Commission voted 5-1 to approve staff's recommendation. Commissioners Keane voted against the recommendation.

ITEM VII
FINAL RECOMMENDATIONS FOR TOTAL AMOUNT AT RISK FOR QUALITY PROGRAMS FOR FY 2017

Dr. Sule Calikoglu presented an update on the final recommendations for the total amount at risk for Quality Programs for FY 2017 (See "Update on the Recommendations for Aggregate Revenue Amount at Risk Under Maryland Hospital Quality Programs for FY2017" on the HSCRC website).

The HSCRC quality-based payment methodologies are important policy tools with great potential to provide strong incentives for hospital to improve their quality performance over time. Each of the current policies for quality-based payment programs holds revenue at risk directly related to specified performance targets.

1. The Quality Based Reimbursement (QBR) program employs measures in several domains, namely clinical process of care, patient experience, outcomes and safety similar to the Medicare Value Based Purchasing program (VBP). Since the beginning of the program, financial adjustments have been based on revenue neutral scaling of hospitals in allocating rewards and reductions based on performance, with the net increases in rates for better performing hospitals funded by net decreases in rates for poorer performing hospitals

2. The Maryland Hospital Acquired Conditions (MHAC) program measures hospital performance using potential preventable complications observed to expected ratios compared with statewide benchmarks for each complication. Revenue allocations are performed using pre-established performance targets. The revenue at risk and reward structure is based on a tiered approach that requires statewide targets to be met for higher rewards and lower reductions.

3. The Readmission Reduction Incentive Program (RRIP) policy initiated in RY 2015 is designed to be a positive incentive program to reward hospitals that achieve a specified readmission reduction target. The statewide target is established to eliminate the gap between the national Medicare readmission rate and the Maryland Medicare readmission rate. For RY 2017, staff is proposing to strengthen this program by increasing the amount of revenue at risk and including both rewards and reductions.

4. In addition to the three aforementioned programs where hospital performance is measured for base and performance periods, two additional quality payment adjustments are implemented to hospital's revenues prospectively. The Readmission Shared Savings Program reduces each hospital's revenues prospectively based on its risk adjusted readmission rates. Potentially Avoidable Utilization efficiency reductions are applied to global budgets to reduce allowed volume growth based on percent of revenue associated with potentially avoidable utilization for each hospital.

The staff's final recommendations for the aggregate revenue amount at risk under the Maryland Hospital Quality Programs for RY 2017 are as follows:

- QBR- 2% maximum penalty- Matches Medicare's VBP program and increases the incentive for hospitals to improve Hospital Consumer Assessment of Healthcare Provider Systems (HCAHPS) scores, which continue to be low compared to the nation. Staff recommends that a preset scale be used, and rewards and penalties not be revenue neutral starting with RY 2017 results.

- MHAC: 3% maximum penalty if statewide improvement target is not met; 1% maximum penalty and up to 1% if statewide improvement target is met.
  The reduction from 4% to 3% recognizes the improvements that were made in CY 2014, but continues to place a significant amount of revenue at risk to ensure continued quality improvement.

- Removing the revenue neutrality requirement for the rate year 2016 to recognize the large improvements in PPCs achieved by hospitals during this performance period.

- RRIP - 2 % scale maximum penalty and 1% reward for hospitals that reduce readmission rates at or better than the minimum improvement.

  The decision to add reductions and increase potential rewards is based on staff and stakeholder concerns regarding the CY 2014 year to date improvement.

- Maximum penalty guardrail: Hospital maximum penalty guardrail to be set at 3.5% of total revenue for RY 2017.

  Staff uses Medicare aggregate amount at risk total as the benchmark for calculating hospital maximum penalty guardrail, e.g. 6% x % Inpatient Revenue.

Ms. LaValle stated that the hospitals are not in agreement with the staff's recommendation. She noted the amount at risk as being too high for the hospitals to accept. Ms. LaValle took exception to CMMI's interpretation that the national Medicare amount at risk must be equivalent to the same amount on an all-payer basis in Maryland, stating that the amount of financial risk on quality related performance, combined with the revenue risk under global budgets, is too great.

The Commission voted unanimously to approve staff's recommendation.

ITEM VIII
DRAFT RECOMMENDATION FOR FUNDING OF STATEWIDE INFRASTRUCTURE, AND PLANNING OF REGIONAL PARTNERHIPS FOR HEALTH SYSTEM TRANSFORMATION

Mr. Steve Ports, Deputy Director Policy and Operations, presented the staff's draft recommendation for funding of statewide infrastructure and planning of regional partnerships for health system transformation. (See "Draft Recommendation: Funding of Statewide Infrastructure, and Planning of Regional Partnerships for Health System Transformation Under the Budget Reconciliation and Financing Act of 2014" on the HSCRC website).

Staff's draft recommendations are as follows:

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

2. Planning grants for regional partnerships for health system transformation (up to $2.5 million) – Rates will be increased only for those hospitals that are part of a collaborative RFP chosen by the review committee and approved by the Department and the Commission pursuant to the process outlined in the RFP.

3. Common care coordination infrastructure to provide support on a statewide basis for specific opportunities to improve care coordination and chronic condition management (up to $12 million) – Rates will be increased for all or a subset of hospitals to support this activity.

4. The existing engagement of resources to assist (in conjunction with stakeholders) in further evaluation and planning of possible statewide infrastructure and approaches for care coordination and provider alignment ($1 million) – Rates will be increased for all or a subset of hospitals to support this activity.

Refinement of the allocation of funds to projects that support common care coordination infrastructure will be provided in further detail at the April Commission meeting.

ITEM IX
DEMONSTRATION OF MHCC's WEB-BASED CONSUMER GUIDE

Ms. Theressa Lee, Director, Center for Quality Measurement and Reporting, Maryland Health Care Commission, presented an update on the Maryland Health Care Quality Reports (See "The Maryland Health Care Quality Reports Vison, Strategy & Execution" on the HSCRC website)

ITEM X
WORK GROUP UPDATES

Mr. Leni Preston, Chairman Consumer Engagement Task Force, presented an update on the activities of the Consumer Engagement Task Force (See "Consumer Engagement Task Force- Update" on the HCRC website).

Mr. Vincent DeMarco, Chairman Consumer Outreach and Education Task Force, presented an update on the Consumer Outreach and Education Task Force (See "Update from Consumer Outreach and Education Task Force" on the HCRC website).

Ms. Diane E. Hoffman, JD, MS, Director, Law & Health Care Program at the University of Maryland Carey School of Law, presented a report on defensive medicine (See Presentation on Defensive Medicine" on the HSCRC website).

Mr. Steve Ports, Deputy Director Policy and Operations, presented an update on both the Care Coordination and Consumer Engagement and the Payment Models Workgroups (See "Update on Work Groups" on the HSCRC website).

ITEM XI
LEGISLATIVE REPORT

Mr. Ports presented a summary of the legislation of interest to the HSCRC (see "Legislative Update- March 11, 2015" on the HSCRC website).

The Bills included: 1) Senate 57/House Bill - 72 Reconciliation Act of 2015; 2) Senate 513/House Bill 613 - Rate Setting- Participation in 340B Program Under the Federal Public Health Service Act; 3) Senate 585/House Bill 553 - Maryland No-Fault Birth Injury Fund; 4) Senate 479/ House Bill 398 - Civil Actions- Noneconomic Damages- Catastrophic Injury; 5) Senate 469/ House Bill 367- Public Health- Maryland Behavior Health Crisis Response System; 6) Senate 572- Hospitals - Designation of Caregivers; 7) Senate 539/ House Bill 944 Patient Referrals - Oncologists- Radiation Therapy Services and Nondiagnostic Computer Tomography Scan Services; 8) House Bill 683- Health Occupations - Magnetic Resonance Imaging Services- Patient Referrals; 9) Senate 870/House Bill - Garrett County – Memorial Hospital – Board of Governors.

ITEM X11
LEGAL REPORT

Regulations

Proposed

Uniform Accounting and Reporting System for Hospitals - COMAR 10.37.04.01

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

The Commission voted unanimously to forward the proposed regulation to the AELR Committee for review and publication in the Maryland Register as a proposed regulation

ITEM XIII
HEARING AND MEETING SCHEDULE

April 15, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
May 13, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 5:08 pm.