Closed Session Minutes
Of the
Health Services Cost Review Commission

March 9, 2016

Upon motion made in public session, Vice-Chairman Wong called for adjournment into closed session to discuss the following items:

1. Update on Hospital Rate Issue – Authority General Provisions Article, §3-305(7)
2. Update on Contract and Modeling of the All-Payer Model vis-à-vis the All-Payer Model Contract - Administration of Model Moving into Phase II – Authority General Provisions Article §3-103 and §3-104

The Closed Session was called to order at 12:0 7 p.m. and held under authority of § 3-104 and §3-305(7) of the General Provisions Article.

In attendance were Commissioners Bayless, Bone, Jencks, Keane, and Wong. Chairman Colmers participated by telephone after the discussion on Item #2 above was concluded.

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

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

Donna Kinzer, Executive Director, first introduced the new Commissioner Victoria Bayless, President and CEO of Anne Arundel Medical Center.

Item One

Ms. Kinzer reported to the Commission and the Commission discussed rate charging, data, and other Global Budget Revenue issues involving Johns Hopkins Hospital.

Chairman Colmers was not on the telephone and did not hear or participate in the discussion.

Item Two

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

The Closed Session was adjourned at 1:39 p.m.

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

March 29, 2016

Upon motion made, Chairman Colmers called the Closed Session Conference Call to order at 2:02 p.m.

The Closed Session Conference Call was held under authority of §§3-103 and 3-104 of the General Provisions Article.

Participating in the Conference Call, in addition to Chairman Colmers, were Commissioners Bayless, Jencks, Keane, and Wong.

Participating representing Staff were Donna Kinzer, Steve Ports, Sule Gerovich, Jerry Schmith, Ellen Englert, Claudine Williams, and Amanda Vaughn.

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

ITEM

The Commissioners and staff discussed the current progression of the All-Payer Model.

The Conference Call Closed Session concluded at 3:07 p.m.

MINUTES OF THE
528th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

March 9, 2016

Chairman John Colmers called the public meeting to order at 12:07 pm. Commissioners Victoria Bayless, George H Bone, M.D., Stephen F. Jencks, M.D., MPH, Jack C. Keane, and Herbert S. Wong, Ph.D. were also in attendance. Upon motion made by Commissioner Jencks and seconded by Commissioner Keane, the meeting was moved to Executive Session. Chairman Colmers reconvened the public meeting at 1:42pm.

REPORT OF THE MARCH 9, 2016 EXECUTIVE SESSION

Mr. Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the March 9, 2016 Executive Session.

ITEM I

REVIEW OF THE MINUTES FROM THE FEBRUARY 10, 2016 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the February 10, 2016 Executive Session and Public Meeting.

VICTORIA BAYLESS and NELSON SABATINI

Chairman Colmers introduced Ms. Victoria Bayless, President and CEO of the Anne Arundel Medical Center as a new commissioner. Chairman Colmers also announced that Mr. Nelson Sabatini has been selected to be the new chairman. Mr. Sabatini will assume his duties at the April public meeting. Chairman Colmers noted that he will remain on the Commission until his term expires in July 2017.

ITEM II

EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, noted that the Advisory Council ("Council") met for the second time to discuss the progression of the All Payer Model. The Council will be presenting an interim report to the Commission.

Ms. Kinzer stated that Staff and the Department of Health and Mental Hygiene (DHMH) have been working with the Center for Medicare and Medicaid Innovation (CMMI) on a potential amendment to the All Payer Model agreement to provide the approvals needed to support

alignment activities that would allow hospitals to share savings and make available incentive payments to hospital based and community- based providers when quality is improved and avoidable utilization is reduced. Staff is also working to obtain data on a timely basis for use by providers to evaluate how care redesign might affect the total cost of care. Staff is hopeful that the new amendment will be approved by this summer

Ms. Kinzer noted that the HSCRC does not have the staff or resources to implement the new amendment. Infrastructure will need to be developed to support these activities. Some of the infrastructure will come through the implementation activities of the Chesapeake Regional Information System for Our Patients ("CRISP"). However, additional resources will be required to design and review provider implementation plans, implement data collection, calculate savings, develop total cost of care guardrails, and conduct other requirements for implementation.

Therefore, Ms. Kinzer requested approval for HSCRC staff to designate, in consultation with DHMH staff, an outside entity, in addition to CRISP, to execute the infrastructure activities necessary to implement the new amendment.

The Commission voted unanimously to approve the request.

Ms. Kinzer reported that the Dual Care Delivery Workgroup has been formed by DHMH and has held two meetings on the development of potential models for dual eligible individuals (beneficiaries with both Medicare and Medicaid coverage).

Ms. Kinzer reported that the State has approved the award of a consulting contract to Health Management Associates to assist staff and the State in planning for the progression of the All Payer Model and in the preparation of the application to be filed by the end of the year.

Ms. Kinzer stated that Staff will focus with DHMH on initiating the Alignment/Infrastructure Workgroup, as well as focusing on the initiation of other subgroups and task forces.

Ms. Kinzer updated the Commission on the review progress of the Implementation Grant Proposals. An independent review committee consisting of HSCRC, DHMH, CRISP, Maryland Community Health Resources Commission (MCHRC), payer staff, and two contracted independent reviewers, met 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. Letters have been sent to applicants with a series of questions. Also, a general survey has been prepared to send to all hospitals to gain a better understanding of care coordination resources that have been deployed to date, and how that relates to the funding that has already been provided.

Ms. Kinzer stated that staff is in the process of getting this data and scheduling meetings with applicants to discuss their proposals. With the amount of information that is needed to understand the current levels of implementation and the additional information to be obtained on

the proposals, together with other staff responsibilities, Staff does not expect to complete this process until the May Commission meeting. Ms. Kinzer observed that hospitals were given considerable resources for care coordination in their GBRs and in the FY 2016 update. The HSCRC expects hospitals and regional partnerships to work together to deploy the funding already provided.

Chairman Colmers expressed concern that decisions were moved back from the April meeting as hospitals had to submit multiple reports in a short time frame to be eligible for funding. The expectation was that these programs would start as soon as February. Chairman Colmers noted that at least one hospital has a number of individuals employed whose grant funding runs out in March. The additional month of delay results in a significant cost to the hospital.

Ms. Kinzer reported that Staff has had major problems with receiving case mix data from hospitals. She noted a number of problems with both inpatient and outpatient data missing surgical codes. This is causing delays in reporting on ECMAD volume changes and in analyzing market shifts, readmissions MHACs, and other policies. This could cause a delay in the annual update process and impede the monitoring of the Model

Ms. Kinzer noted that Staff is convening the Payment Models Workgroup to commence with the annual update process. Staff will discuss the uncompensated care (UCC) analysis that was performed this year, in anticipation of a new approach to UCC determination post ACA coverage expansion. In addition, staff will review analyses of Potentially Avoidable Utilization (PAU) as part of the Readmission FY 2018 draft recommendation. As Staff proceeds with the 2017 update, it will need to consider how to ensure that reduced PAUs are accounted for.

Ms. Kinzer noted that for the nine months ending September 2015 compared to the same period in the prior year, total non-hospital Medicare spending per Maryland beneficiary grew faster than the nation by $43 million. Staff analyzed non-hospital Part A costs, and the data reflect increases in skilled nursing referrals for several hospitals. Staff has analyzed increases in non-hospital Part A costs, which are comprised primarily of post-acute care; however, they have not yet analyzed the growth in Part B professional fees and other expenditures and plans to share data with each hospital and with post-acute facilities. Ms. Kinzer stated that even if the increases were offset against hospital savings, Maryland is still ahead of its Medicare savings requirements.

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

- Reviewing implementation plans and conducting discussions regarding proposals, plans, and reports that have been provided to HSCRC for the purpose of assessing and understanding implementation progress and gaps, and readiness to accelerate community

based care coordination and management.

- Developing shared savings, readmission, and aggregate at risk recommendations.
- Organizing and preparing for the FY 2017 annual update.
- Reviewing several rate applications for capital that have been filed.
- Moving forward on updates to value based performance measures, including efficiency measures.
- Examining Medicare per capita costs and total cost of care, for purposes of monitoring and for progressing toward a focus on outcomes and costs across the health care system.
- Working with DHMH and stakeholders to focus on ensuring success of the All-Payer Model and providing a proposal for a new model no later than January 2017 as required under the Agreement with the CMS.
- Working on an All-Payer amendment for alignment activities.
- Working on a request to CMMI for Medicare data that can be used for care coordination, model monitoring, and other Model purposes.
- Working with legislators and stakeholders in Annapolis to ensure that the budget and proposed legislation being considered during the current General Assembly session are designed to meet the goals of the All-Payer Model.

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 January focuses on fiscal year (July 1 through June 30) as well as calendar year results.

Ms. Vaughn reported that for the seven month period ended January 31, 2016, All-Payer total gross revenue increased by 2.13% over the same period in FY 2015. All-Payer total gross revenue for Maryland residents increased by 2.05%; this translates to a per capita growth of 1.52%. All-Payer gross revenue for non-Maryland residents increased by 2.98%.

Ms. Vaughn reported that for the one month of the calendar year ended January 31, 2016, All-Payer total gross revenue decreased by 2.92% over the same period in CY 2015. All-Payer total gross revenue for Maryland residents decreased by 3.38%; this translates to a per capita growth of (3.88%). All-Payer gross revenue for non-Maryland residents increased by 2.40 %.

Ms. Vaughn reported that for the seven months ended January 31, 2016, Medicare Fee-For-Service gross revenue increased by 1.91% over the same period in FY 2015. Medicare Fee-For-Service gross revenue for Maryland residents increased by 1.91%; this translates to a per capita growth of (0.76%). Maryland Fee-For-Service gross revenue for non-residents increased by 1.93%.

Ms. Vaughn reported that for the one month of the calendar year ended January 31, 2016, Medicare Fee-For-Service gross revenue decreased by 6.74% over the same period in CY 2015.

Medicare Fee-For-Service gross revenue for Maryland residents decreased by 7.13%; this translates to a per capita growth of (8.58%). Maryland Fee-For-Service gross revenue for non-residents decreased by 1.48%.

Ms. Vaughn reported that for the one month of the calendar year ended January 31, 2016 over the same period in CY 2013:

- Net per capita growth was (6.07%).
- Per capita growth before UCC and MHIP adjustments was (3.58%).
- Net per capita Medicare growth was (10.77%).
- Per capita growth Medicare before UCC and MHIP was (8.40%)

According to Ms. Vaughn, for the seven months of the fiscal year ended January 31, 2016, unaudited average operating profit for acute hospitals was 2.81%. The median hospital profit was 3.85%, with a distribution of 0.94% in the 25th percentile and 5.70% in the 75th percentile. Rate Regulated profits were 6.40%.

Ms. Vaughn reported that for the one month of the calendar year ended January 31, 2016 over the same period in CY2015:

- All-Payer admissions decreased by 7.93%;
- All-Payer admissions per thousand decreased by 4.86%;
- Medicare Fee-For-Service admissions decreased by 10.59%;
- Medicare Fee-For-Service admissions per thousand decreased by 11.96%;
- All-Payer bed days decreased by 8.12%;
- All-Payer bed days per thousand decreased by 8.12%;
- Medicare Fee-For-Service bed days decreased by 12.13%;
- Medicare Fee-For-Service bed days per thousand decreased by 13.49%;
- All-Payer Emergency visits decreased by 3.93%;
- All-Payer Emergency per thousand decreased by 3.93%.

Claudine Williams, Associate Director, Policy Analysis, updated the Commission on Staff's analysis of non-hospital Medicare Part A spending per Maryland beneficiary. Ms. Williams reported for the first nine months of the calendar year (September 2015) versus the same period in 2014, skilled nursing Medicare spending per beneficiary increased by 2.4%, while home health Medicare spending per beneficiary increased by 6.6%,and Hospice Medicare spending per beneficiary increased by 4.1% .

ITEM IV

DOCKET STATUS CASES CLOSED

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
2332A- Johns Hopkins Health System
2334A- University of Maryland Medical Center
2335A- Johns Hopkins Health System
2336A- Johns Hopkins Health System

ITEM V

DOCKET STATUS- OPEN CASES

2338A- Johns Hopkins Health System

Johns Hopkins Health System, on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals"), filed an application on February 26, 2016 requesting continued participation in an amended global rate arrangement for solid organ transplant, bone marrow transplant, and cardiovascular services with Olympus Managed Health for a period of one year beginning April 1, 2016.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services and cardiovascular services for one year beginning April 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

30 Day Extensions

2337R- LifeBridge Health

The Commission voted unanimously to approve staff's request to extend the time for review on proceeding 2337R LifeBridge Health for 30 days.

DRAFT RECOMMENDATION FOR MODIFICATION TO THE READMISSION INCENTIVE PROGRAM FOR FY 2017

Dr. Sule Gerovich Ph.D., Deputy Director Research and Methodology, presented Staff's draft recommendation on the Readmission Incentive Program for FY 2017 (see "Draft Recommendation For Updating The Readmissions Reduction Incentive Program For Rate Year 2018"- on the HSCRC website).

The United States healthcare system currently experiences an unacceptably high rate of preventable hospital readmissions. These excessive readmissions generate considerable unnecessary costs and substandard care quality for patients. A readmission is defined as an admission to a hospital within a specified time period after a discharge from the same or another hospital. Historically, Maryland's readmission rates have been high compared with the national levels for Medicare. Under authority of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) established its Medicare Hospital Readmissions Reduction Program (HRRP) in federal fiscal year (FFY) 2013. Because of its long-standing Medicare waiver for its all-payer hospital rate-setting system, special considerations were given to Maryland, including exemption from the federal HRRP. Instead, the HSCRC implements various Maryland-specific quality-based payment programs, which provide incentives for hospitals to improve their quality performance over time.

Maryland entered into a new All-Payer Model Agreement with CMS effective January 1, 2014. One of the requirements under this new agreement is for Maryland's hospital readmission rate to be equal to or below the national Medicare readmission rate by calendar year (CY) 2018. Maryland must also make scheduled, annual progress toward this goal. In order to meet this requirement, the HSCRC established the Readmissions Reduction Incentive Program (RRIP) in April 2014. The HSCRC made some further adjustments to the program in the following year, which are discussed in the background section of this report.

The purpose of this draft recommendation is to provide background information on the RRIP program and to make recommendations for updating the state rate year (RY) 2018 methodology and readmissions reduction targets. The RY 2017 approved recommendation stated that staff would assess the impact of admission reductions, socio-demographic factors, and all payer versus Medicare readmission trends and make adjustments to the rewards or penalties if necessary. This draft recommendation details these analyses, as well as analyses examining the relationship between the base period readmission rate and improvement rates since hospitals with low readmission rates may have more difficulty meeting the minimum improvement target. Based on these analyses, staff provides options for moderating adjustments in light of recent analysis for RY2017 adjustments, and a recommendation for RY 2018 to reduce the minimum improvement target for hospitals with lower base year readmission rates. Staff is also working on refining and broadening the existing Readmission Shared Savings Program (RSSP) policy for RY2017, which is currently based on inpatient readmission rates. Staff will be evaluating options to include prevention quality indicators and sepsis admissions in the shared savings program, as well as the program's impact in consonance with RY 2017 update factor analyses. The final recommendation for the RRIP may require alignment with any revisions to what is currently the RSSP policy to estimate impact of these programs overall in tandem.

One of the guiding principles for Maryland's hospital quality programs is to set the policy and benchmarks ahead of the performance periods. Last year, the Commission made an exception to allow for staff to examine the developing policy results during the performance period in light of some potential payment equity issues. In approving a policy that set improvement targets equally for all hospitals, there were concerns that individual hospitals might be penalized even though they were performing relatively well. For example, if the initial readmission rate for a

hospital was relatively low, it may be harder to reduce the same percentage of readmissions as other hospitals with higher initial rates. Staff is considering the options below for moderating adjustments in light of recent analysis.

- Recognize improvement in the Medicare readmission rates. Even though statewide numbers do not warrant a change in the overall measurement approach from the use of all-payer to Medicare-specific benchmarks, hospital-level performance may vary. We could recognize faster improvement in Medicare readmission rates if a hospital reduces its Medicare readmission rates faster than the all-payer readmission rates.

- Adjust the all-payer readmission target for hospitals whose readmission rates are lower than the statewide average as proposed for the RY 2018 policy.

- The Maryland Hospital Association is proposing to reduce the RY 2017 target to the statewide average reduction rate (current trend is at 7 percent decline) and remove all of the penalties if a hospital's readmission rate was in the lowest quintile in both CY 2013 and CY 2015. Staff does not agree with changing the overall target.

Given Maryland's high rate of readmissions, staff believe that all hospitals should aim to reduce readmissions, albeit there could be diminishing opportunity for reductions if the base year readmission rates are lower. Staff also believes that the principle of setting benchmarks and targets ahead of the performance period should be maintained. Staff will work with the Performance Measurement Workgroup to evaluate these alternatives and finalize the recommendation based on our analysis and the input from the stakeholders and Commissioners.

HSCRC staff recommends the following updates to the RRIP program for RY 2018:

1. The reduction target should continue to be set for all-payers.

2. The all-payer reduction target should be set at 9.5 percent.

3. The reduction target should be adjusted downward for hospitals whose readmission rates are below the statewide average.

Commissioner Stephen Jencks questioned the value of annual modifications to the payment policy, saying that it was difficult to know whether a policy works if it is changed each year.

Commissioner Jack Keane stated that he is sympathetic to the concern that hospitals with low starting readmissions rates have a harder time reducing readmissions; however, he believes it is necessary to evaluate base line readmission rates as they correlate with the hospital's socio-demographic situation.

Mr. Robert Murray, representing CareFirst of Maryland Inc., suggested that rather than an All Payer target a Medicare readmission target be adopted.

Ms. Traci La Valle, Vice President Maryland Hospital Association, stated that while hospitals

appreciate the Staff's recognition that base year readmission rates are associated with the opportunity to improve, and that the improvement only policy has disadvantaged hospitals with low base year rates, simply adjusting the amount of improvement required to meet the target is not enough. She noted that it is important to continue working toward an attainment and improvement policy for calendar year 2016. Ms. La Valle stated that MHA is beginning to vet a policy with the hospitals that includes both attainment and improvement; this effort may require the assistance of the HSCRC and may take more than one month to finalize. MHA's approach includes adjustments for social and demographic factors, among other predictors of readmission. However, because MHA can only access data at the zip code level, it will need HSCRC's help to refine the policy, particularly to evaluate social and demographic proxy variables.

Ms. La Valle indicated that the reduction of fiscal 2017 readmissions penalties is warranted, based on the very favorable collective performance on the annual Medicare readmissions waiver demonstration test. The fiscal year 2017 target was more aggressive than it needed to be, and it can be retrospectively reduced now that we know that a target in the range of 7 percent would have been adequate. She also pointed out that HSCRC staff is projecting that by the end of calendar year 2015, Maryland's Medicare readmissions rate will be only 0.5 percentage point above the national rate, so rhetoric about excessively high readmissions rates in Maryland is no longer accurate or appropriate.

Ms. La Valle expressed concerned about the concept of adjusting approved revenues for performance on Prevention Quality Indicators and sepsis without further study of how other factors, such as the prevalence of chronic conditions in the population and access to primary care, impact Prevention Quality Indicators. She cited the national debate on the clinical definition of sepsis and likened the lack of consensus on a sepsis definition to the experience with Maryland Hospital Acquired Conditions policy definitions.

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

ITEM VII

DRAFT RECOMMENDATION FOR TOTAL AMOUNT AT RISK FOR QUALITY PROGRAMS FOR FY 2017

Dr. Gerovich presented an update on the draft recommendations for the total amount at risk for Quality Programs for FY 2017 (See "Draft Recommendation for the Aggregate Revenue Amount at Risk Under Maryland Hospital Quality (MHAC) Programs for Rate Year 2018" on the HSCRC website).

Dr. Gerovich stated that HSCRC's quality-based payment methodologies are important policy tools with great potential to provide strong incentives for hospitals to improve their quality performance over time. These quality-based payment programs hold amounts of hospital revenue at risk directly related to specified performance benchmarks. Maryland's Quality-Based Reimbursement (QBR) programs employ measures that are similar to those in the federal

Medicare Value-Based Purchasing (VBP) program. Because of its long-standing Medicare waiver for its all-payer hospital rate-setting system, special considerations were given to Maryland, including exemption from the federal Medicare quality-based programs. Instead, the HSCRC implements various Maryland-specific quality-based payment programs, which are discussed in further detail in the background section of this report.

Maryland entered into a new All-Payer Model Agreement with the Center for Medicare and Medicaid Services (CMS) effective January 1, 2014. One of the requirements under this new agreement is that the proportion of hospital revenue that is held at risk under Maryland's quality-based payment programs be greater than or equal to the proportion that is held at risk under national Medicare quality programs. The Model Agreement also requires Maryland to achieve specific reduction targets in potentially preventable conditions, and readmissions, in addition to the revenue at risk requirement. In an effort to meet these reduction targets, Maryland restructured its quality programs in such a way that financial incentives are established prior to the performance period in order to motivate quality improvement and the sharing of best practices while holding hospitals accountable for their performance.

The purpose of this draft recommendation is to make recommendations for the amount of revenue that should be held at risk for rate year RY 2018. Except for some QBR measures that are based on CMS timelines, performance year for the quality based payments is a calendar year; the base year from which the improvement is calculated is a fiscal year; and the adjustments are applied in the following rate year. For RY 2018, which begins in July 2017, the performance year is CY 2016 and base year is FY 2015. The timeline for the RY 2018 aggregate at risk recommendation was postponed to align with the RY 2018 RRIP recommendation. Final recommendations for both policies may require alignment with the Readmission Shared Savings Policy to estimate the overall impact of all programs in tandem including shared savings adjustments, as revisions are contemplated to the shared savings policy.

HSCRC staff recommends the following maximum penalties and rewards for QBR, MHAC and RRIP for RY 2018:

1. QBR: The maximum penalty should be 2 percent, while the maximum reward should be 1 percent.

2. MHAC: There should be a 3 percent maximum penalty if the statewide improvement target is not met; there should be a 1 percent maximum penalty and a reward up to 1 percent if the statewide improvement target is met.

3. RRIP: The maximum penalty should be 2 percent, and the reward should be 1 percent for hospitals that reduce readmission rates at or better than the minimum improvement.

4. Maximum penalty guardrail: The hospital maximum penalty guardrail should continue to be set at 3.5 percent of total hospital revenue.

5. The quality adjustments should be applied to inpatient revenue centers, similar to the approach used by CMS.

Ms. La Valle noted that Maryland's hospitals have far more revenue at risk than hospitals nationally, as demonstrated by Staff's presentation. The revenue at risk for Maryland hospitals applies to all payers, whereas the national revenue at risk applies only to Medicare revenue.

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

ITEM VIII

UPDATE ON UNCOMPENSATED TRENDS

Dr. Gerovich presented an overview of uncompensated care (UCC) data and discussed its application in hospital rates (see "Overview of the Uncompensated Care Data" on the HSCRC website).

ITEM IX

LEGISLATIVE UPDATE

Mr. Steve Ports, Deputy Director Policy and Operations, presented a summary of the legislation of interest to the HSCRC (see" Legislative Update- March, 9, 2016" on the HSCRC website).

The Bills included: 1) Senate Bill 108 Nurse Support Program Assistance Fund; 2) Senate Bill 513/House Bill 377 Maryland No-Fault Birth Injury Fund; 3) House Bill 510 Termination of MHIP and Transfer of Senior Prescription Drug Assistance Program; 4) Sena**te** Bill 336 Hospital- Designation of Lay Caregivers; 5) Senate Bill 324/House Bill 309 Prince George's County Regional Medical Center Act of 2016; 6) Senate Bill 661/ House Bill 587 Hospital-Patient's Bill of Rights; 7) Senate Bill 12/ House Bill 1121 Health Care Facilities- Closures or Partial Closures of Hospital- County Board of Health Approval**;** 8) Hospital 601, House Bill 1189- Community Benefit Report- Disclosure of Tax Exemptions; 9) Senate Bill 707/ House Report 1350 Freestanding Medical Facilities- Certificate of Need, Rates, and Definition; 10) Senate Bill 574/ House Bill 869 Civil Actions – Noneconomic Damages – Catastrophic Injury; 11) Senate Bill 866/ Health Bill 1272 Health- Collaborations to Promote Provider Alignment; 12) Senate Bill 1032/ House Bill 929 Health Occupations- Prohibited Patient Referrals-Exceptions; 13) Senate Bill 739/ House Bill 1422 Integrated Community Oncology Reporting Program; 14) House Bill 908 Establishment of Substance Use Treatment Programs-Requirements

ITEM X

UPDATE FROM CRISP ON IMPLEMENTATION OF INFRASTRUCTURE AND ANALYTICS

Dr. Mark Keleman, Chief Medical Information Officer, University of Maryland Medical System, and Dr. Ross Martin, CRISP Integrated Care Network (ICN) Infrastructure Program Director, provided an update on integrated care network activities (see "Integrated Care Network Infrastructure- Status Update"- on the HSCRC website).

Among the several updates provided, Dr. Keleman stated that basic ambulatory connectivity is accelerating with more than 2,000 providers connected. Dr. Keleman also informed the Commission that the federally approved Interim Advanced Planning Document funding has been awarded to DHMH.

Dr. Martin stated that CRISP near term objectives are as follows:

- Accelerate Ambulatory Connectivity for Tier 3 clinical connections
- Expand Care Plan Exchange
    a) Engage additional partners to share Care Plans through the Care Plan Exchange capability which recently went live
- Succeed with a Medicare Data Request, working with HSCRC staff
- Make Risk Stratification tools more accessible
    a) Incorporate Hierarchical Condition Categories (HCC) into case mix data and reports per the direction of the Reporting and Analytics Committee
    b) Continue to explore Adjusted Clinical Groups (ACG), LACE, and other more advanced risk models and functionality
- Execute on Regional Partnership Projects
    a) Begin project execution against the Regional Partnership (RP) commitments included in the RP- CRISP MOUs
- Better package tools so their usefulness can be readily understood by the provider community

ITEM XI

LEGAL REPORT

Regulations

Final Action

Rate Application and Approval Procedure- COMAR 10.37.10.03 and 10.37.10.03-1

The purpose of this action is to establish a moratorium on the filing of regular rate applications pending the development and approval of rate efficiency measures that are consistent with the all payer model. This action was proposed for adoption in 43:01 Md. R 64-65 (January 8, 2016).

The Commission voted unanimously to approve the final adoption of the proposed regulation.

ITEM XII

HEARING AND MEETING SCHEDULE

April 13, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
May 11, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:42 pm.