Executive Session Minutes
of the
Health Services Cost Review Commission

January 12, 2011

Upon motion made, Chairman Puddester called the meeting to order at 10:00 a.m.

The Meeting was held under the authority of Section 10-508 of the State Government Article.

In attendance, in addition to Chairman Puddester, were Commissioners Antos, Bone, Lowthers, Sexton, and Wong.

Robert Murray, Steve Ports, Jerry Schmith, Dennis Phelps, Dianne Feeney, Sule Calikoglu and Oscar Ibarra attended representing Commission staff.

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

Item One

The Commission discussed scheduling for future monthly public meetings. It appears that 10:00 a.m. will become the new starting time.

Item Two

The Commission was briefed by staff on confidential financial and quality issues relating to the Dimensions Health System.

The Executive Session was adjourned at 10:20 a.m.

MINUTES
474TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

January 12, 2011

Chairman Frederick W. Pudderster called the meeting to order at 10:30 a.m. Commissioners Joseph R. Antos, Ph.D., George H. Bone, M.D., C. James Lowthers, Kevin J. Sexton, and Herbert S. Wong, Ph.D. were also present.

ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC AND EXECUTIVE SESSIONS OF DECEMBER 8, 2010

The Commission voted unanimously to approve the minutes of the December 8, 2010 Public and Executive Sessions.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, updated the Commission on the progress of current major initiatives and issues. The major items included: 1) limiting the annual discussion of the Reasonableness of Charges (ROC) methodology to technical issues and formation of a work group to discuss revised Capital Policy and work force issues; 2) draft of the Maryland Hospital Preventable Re-admissions initiative will be discussed again at today's meeting; 3) final report of the State Health Care Coordinating Council will soon be issued; 4) staff continues to work on an evaluation structure for the Community Benefit Report; 5) stakeholder input sessions associated with HSCRC bundled payment initiative continues; 6) final Admission-Readmission Revenue (AAR) recommendation will be presented today; 7) ten hospitals have agreed to participate in Total Patient Revenue (TPR) program for FY 2011; 8) staff is working on population-based revenue constraint system that would apply to hospitals with non-isolated catchment areas; and 9) meetings to discuss the FY 2012 update process will be held within the next two weeks.

Mr. Murray announced that Dr. Joshua Sharfstein has succeeded Johns Colmers as Health Secretary. Mr. Murray expressed his good wishes for the new Secretary and congratulated Mr. Colmers for a job well done and thanked him for his help and support of the Commission and staff during his tenure.

ITEM III
DOCKET STATUS CASES CLOSED

None

ITEM IV
DOCKET STATUS CASES OPEN

Laurel Regional Medical Center – 2097N

On November 22, 2010, Laurel Regional Hospital submitted a partial rate application requesting a rate for Hyperbaric Chamber (HYP) services. The Hospital requested the state-wide median rate for HYP services to be effective January 1, 2011.

After review of the Hospital's application, staff recommended:

1. That COMAR 10.37.10.07 requiring rate applications be filed 60 days before the opening of a new service be waived;
2. That a HYP rate of $246.02 per RVU be approved effective January 1, 2011;
3. That no change be made to the Hospital's Charge per Case standard for HYP services; and
4. That the HYP rate not be rate realigned until a full year's experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2098A

On December 23, 2010, Johns Hopkins Health System on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital requested approval to continue to participate in a re-negotiated global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplants. The revised arrangement covers blood and bone marrow transplants, which were covered in prior years but discontinued last year. The Hospitals requested that the arrangement be effective January 1, 2011.

Staff found that the actual experience under the prior arrangement for solid organ transplants was favorable. In addition, after review of the data submitted with the application, staff expressed confidence that the global prices for bone marrow transplant services were sufficient to enable the Hospitals to achieve a favorable result.

Based on their findings, staff recommended that the Commission approve the Hospitals' application for a period of one year beginning January 1, 2011.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2099A

On December 17, 2010, Johns Hopkins Health System on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital requested approval to continue to participate in a global price arrangement with Coventry Transplant Network for solid organ and bone marrow transplants for a period of three years effective January 1, 2011.

Based on favorable performance in the last year, staff recommended that the Commission approve the Hospitals' application for a period of one year beginning January 1, 2011.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2100A

On December 17, 2010, Johns Hopkins Health System on behalf of Johns Hopkins Hospital requested approval to participate in a new global price arrangement with Blue Cross Blue Shield's Blue Distinction Centers for Transplants for solid organ and bone marrow transplants for a period of one year beginning January 1, 2011.

Since the format utilized to calculate the case rates, i.e., historical data for like cases, has been used as a basis for other successful transplant arrangements in which hospitals are currently participating, staff recommended that the Commission approve the Hospital's application for a period of one year beginning January 1, 2011.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2101A

On December 17, 2010, Johns Hopkins Health System on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital requested approval to continue to participate in a capitation arrangement serving persons insured with TRICARE. The arrangement involves the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare as providers for TRICARE patients. The requested approval was for a period of one year beginning January 1, 2011.

Based on favorable performance in the last year, staff recommended that the Commission approve the Hospitals' application for a period of one year beginning January 1, 2011.

The Commission voted unanimously to approve staff's recommendation.

30 Day Extensions:

Staff requested that the Commission approve 30 day extensions of the time for review of proceedings 2101N and 2102N, Washington Adventist Hospital, and proceedings 2104N and 2105N, Adventist Behavioral Health.

The Commission voted unanimously to approve staff's request.

STATUS OF THE IMPLEMENTATION OF THE TOTAL PATIENT REVENUE (TPR) RATE SETTING PROGRAM FOR FY 2011

Ms. Ellen Englert, Associate Director-Hospital Rate Setting, reported that staff was in the process of finalizing the technical details of the agreement with the 10th hospital (Chester River Hospital Center) that has agreed to participate in the TPR program in FY 2011.

ITEM V
DRAFT RECOMMENDATION ON POTENTIALLY PREVENTABLE READMISSIONS (PPR) METHODOLOGY

Diane Feeney, Associate Director-Quality Initiative, stated that staff continues to analyze whether we will be able to use the current patient specific data that we have, in the short term, to develop a unique patient I.D. so that we can reliably track patients across hospitals. The analysis should be completed by the February Commission meeting. Ms. Feeney reported that in the mid-term, staff has technical assistance from the Agency for Health Care Research and Quality to develop unique patient identifiers by adding additional patient level data fields. In addition, in the longer term, staff has had discussions with David Sharp of the Maryland Health Care Commission on the development of a master patient index using health information exchange technology, which could be utilized to bundle care provided beyond the hospital walls.

Ms. Traci LaValle, Assistant Vice President-Financial Policy of the Maryland Hospital Association (MHA), presented MHA's proposal for an episode-based readmissions policy for all Maryland hospitals. Ms. LaValle stated that MHA supports the HSCRC's voluntary 100% risk model Admission-Readmission Revenue (ARR) program in conjunction with a mandatory lower-risk (60%) admission-readmission episode payment program for all hospitals that choose not to participate in the ARR program. The lower-risk admission-readmission program would be in lieu of the staff's proposed PPR initiative.

According to Ms. LaValle, in MHA's proposal both options (the voluntary ARR program and the mandatory lower-risk program) would measure intra-hospital readmissions, readmissions to the same hospital or system, and reward improvement over prior performance. Ms. LaValle noted that MHA's proposal can be implemented now because it does not require out of state data and it does not require a unique patient identifier. In the meantime, the HSCRC and the hospital

industry can continue to work towards developing an algorithm to identify readmissions to other hospitals (inter-hospital readmissions) and can take the time to better understand the risk factors that affect readmission rates among hospitals.

Ms. LaValle pointed out that significant upfront funding (approximately $55 million) would be required to enable hospitals to invest in care coordination, IT, and other resources. However, Ms. LaValle stated that based on the experience of several pilot readmission reduction programs similar to that proposed by MHA, there was the potential for significant mature annual cost saving to the payers and the public, while reducing hospital costs and improving the quality of care.

Commissioner Wong asked what the implementation costs would be after the first year.

Mr. Murray stated that staff believes that MHA's request is that the upfront funding be included in hospital rates permanently.

Commissioner Sexton asked Mr. Murray to compare and contrast MHA's mandatory 60% risk proposal to the PPR initiative.

Mr. Murray stated that staff's thinking was that the PPR initiative was the logical next step after the Maryland Hospital Acquired Conditions (MHAC) initiative. It would also be modeled after the MHAC, i.e., the scaling of a relatively small amount of revenue based on relative performance. However, in the interim there was considerable interest expressed by hospitals for the 100% risk ARR model. Staff continues to advocate the PPR initiative because it is based on relative performance, focuses on all readmissions, and provides hospitals with experience in controlling readmissions, which staff believes is valuable. Rather than adopt MHA's proposal of a mandatory 60% risk model, which was originally proposed in the context of the 2010 Update Factor discussions, it is staff's preference to focus on the ARR initiative and implement the PPR initiative this year if we are able to reliably track patients. If we find out in February that we are not able to reliably track inter-hospital patients now, we will propose postponing implementation of the PPR.

According to Mr. Murray, something similar to MHA's proposal could be accommodated as a voluntary option in the ARR initiative for individual hospitals that felt that they were not ready for the 100% risk of ARR.

Commissioner Bone asked whether staff would decide the appropriate amount when hospitals apply for upfront funding to implement the ARR.

Mr. Murray stated that staff would determine the appropriate amount of upfront money up to the cap in the proposed policy, 0.5% of net inpatient revenue, to be treated as a loan.

Commissioner Lowthers stated that the public cannot afford higher hospital charges. Although we want to get the PPR program started, we must be careful when raising hospital charges at a time when they are already too high.

Chairman Puddester noted that sometimes you have to make an investment to get the results that you desire.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, stated that in evaluating the reasonableness of upfront costs, staff should be ware of an article in "Health Affairs" which indicated that the optimal caseload per case manager is much higher than that used in MHA's projections. Staff should also consider that hospitals, as well as some third-party payers already do some discharge planning. Hospitals are not starting from scratch.

ITEM VI
FINAL RECOMMENDATION ON A TEMPLATE FOR REVIEW AND NEGOTIATION OF AN ADMISSION-READMISSION REVENUE (ARR) HOSPITAL PAYMENT CONSTRAINT PROGRAM

Mr. Murray stated that the motivation for the ARR initiative is the realization that we now have an unacceptably high rate of unnecessary hospital readmissions. These unnecessary readmissions are a symptom of our fragmented payment structure. This document outlines the rationale, lays out the terms and requirements for participation, and acknowledges and considers the concerns and uncertainties associated with implementing the ARR episode-based payment initiative. It also proposes that the Commission move forward from hospital-based payment structures to broader payment bundles that include both hospital and non-hospital services. In addition, the document suggests that staff be directed to develop a process to guide the Commission in the development of these broader-based payment bundles.

Mr. Murray summarized staff's recommendation on the Template for Review and Negotiation of an Admission-Readmission Revenue (ARR) Hospital Payment Constraint Program (see recommendation, "Template for Review and Negotiation of an Admission-Readmission Revenue (ARR) Hospital Payment Constraint Program" on the HSCRC website).

The final recommendations include: 1) that the basic policy framework be utilized as the core template for negotiating ARR arrangements; 2) that the proposed agreement provide the basic template for the agreement between the Commission and any hospital entering into an ARR arrangement; and 3) that the Commission direct staff to report back to the Commission in public session on any ARR arrangements negotiated with individual hospitals.

Commissioner Bone suggested that the recommendation be amended to solicit feedback on patient satisfaction.

Mr. Murray agreed that there was need to expand the assessment of quality of care especially as it relates to patient satisfaction.

Chairman Puddester and Commission Sexton both expressed concern that including upfront funding as slippage in the update factor was unfair since it reduced the revenue of all hospitals

including those that choose not to participate in the ARR initiative.

Mr. Murray noted that the rationale for including the upfront funding in slippage was to protect the paying public because it ensured revenue neutrality. It is, however, inconsistent with policy that one-time funds are not included in slippage.

Chairman Puddester asked whether the template would accommodate less than 100% risk arrangements.

Mr. Murray stated that staff would like the arrangements to be as generic as possible; however, staff can amend the template so that hospitals that take lower risk would receive less upfront funding.

Chairman Puddester asked what mechanisms are in the recommendation for monitoring and dealing with unanticipated events that affect hospital performance.

Mr. Murray stated that hospitals can come to staff if there is a particular problem, and we could make adjustments to the arrangement.

Stephen Jencks, M.D., Senior Fellow at the Institute for Health Care Improvement, commented on fragmentation of health care and the status of efforts to improve the transition from hospital to post-hospital care.

Dr. Jencks noted his pleasure at speaking to an organization capable of implementing methods that capture and distribute savings, as opposed to the majority of payers in the country who have no idea how to do it.

Dr. Jencks stated that the Patient Protection and Affordable Care Act provides a carrot and a stick approach to improving the transition from hospital to post-hospital care. The stick is a penalty beginning in 2102 for hospitals with elevated readmission rates. The carrot is $500 million over 5 years to assist hospitals and community-based organizations for providing services not now available to make care transitions work. The rehospitalizations are the symptoms. Dr. Jencks noted that there will also be significant investment by quality improvement organizations to work on rehospitalizations. In addition, it is likely that there will be a concerted effort to get other parts of the federal programs working on this issue. The objective is to facilitate a shift from fragmented to coordinated care.

Dr. Jencks reported that quality based organizations have been running community-based programs to reduce rehospitalizations that bring together all of the stakeholders in the community. The result has been that in every on of 14 participating communities there has been a decrease in rehospitalizations. The fact that rehospitalizations have been reduced in each community, without financial incentives is noteworthy because it suggests that the HSCRC should be thinking about how it can encourage not just hospitals but also the communities in which they are embedded to participate in this initiative.

Dr. Jencks stated that studies have also shown that 30 days from discharge does not turn out to be a magic number. The studies show in a number of communities is decreases in total hospitalizations, as well as rehospitalizations within 30 days. This has an interesting effect in that tracking the rehospitalization rate doesn't work because in many situations admissions the percentage of total admissions decreases as the percentage of readmissions. In consequence, you are saving more money then you thought you would, plus more importantly, it is the rate of decrease in total admissions that counts.

Dr. Jencks agreed with Commissioner Bone that we must learn from patients. The patient knows why they are back in the hospital much better than the physician who discharged them, the physician that sees them in the emergency room, or the home health agency. Both the hospital and the HSCRC have a common interest in knowing how to fix the problem that led to the readmission.

Chairman Puddester asked Dr. Jencks that since total admissions were decreasing in Maryland and in the nation, where he thought they were going.

Dr. Jencks stated that Medicare admissions were decreasing in part because the RAC (Recovery Audit Contractors) program has been cracking down on observation admissions. Consequently, hospitals across the country have suddenly become very cautious about admissions for observation. Dr. Jencks suggested that the HSCRC track outpatient observations.

Commissioner Antos asked Dr. Jencks if there was agreement on what patient feed-back information should be collected and if so were there good instruments for collecting the data.

Dr. Jencks the best instrument is the CTM (Care Transition Measure) 15 survey, however, it will only tell hospitals where you should look rather than what is wrong.

Commissioner Bone asked Dr. Jencks whether from a Medicare standpoint how hospitals that have overlapping marketplaces will deal with the issue of readmissions.

Dr. Jencks stated that no one has a clear answer yet, however, there is an opportunity for cooperation among hospitals in a community to benefit the patient. The bigger question is how to make the transition to dealing with readmissions as population based care issue.

Dr. Cohen reiterated his comments from last month's public meeting that CareFirst and Kaiser Permanente believe that the TPR program provides the strongest incentives for volume control, and that the Commission should, in turn, provide the greatest incentives for participation in that program.

Dr. Cohen expressed strong support for the ARR proposal and for providing staff with flexibility to negotiate individual arrangements in order to provide the appropriate incentives for hospitals to participate in the initiative.

In regard to the slippage issue, Dr. Cohen expressed concern about taxing payers by going outside of the Update Factor to pay for the cost of implementing the ARR initiative. Dr. Cohen asserted that the cost of implementation of ARR should be revenue neutral.

Michael B. Robbins, Senior Vice President-Finance of MHA, expressed MHA's support for the ARR initiative with one exception, the inclusion of upfront funding in slippage. Mr. Robbins noted that the ARR advance funding is just a small investment. According to Mr. Robbins, for the last several years there has been a reduction in hospital activity, a decline in the rate of increase in total revenue, volume, and case mix. Mr. Robbins asserted that the Commission has already taken measures to bend the cost curve. He pointed out that total hospital revenues grew by only 2.7% in FY 2010, while for the twelve month period ending October 31, 2010 the increase was only 2%, which was less than the update factor approved for FY 2011. This is another reason that the modest investment in upfront funding should be provided to hospitals and not included in slippage where it would reduce revenue to all hospitals.

In regard to comments in the ARR document concerning hospitals "back filling" reductions in readmissions with new admissions, Mr. Robbins stated that the hospital industry is committed to seeing patients in the right place at the right time. HSCRC data indicates that admissions are down over 3% in the last 12 months to some extent because of the one-day stay policy. Yet there is no evidence of back filling. Mr. Robbins suggested that the HSCRC not be concerned about some problem that might exist, but rather look at the overall issue of utilization.

Commissioner Antos observed that he believed that the downward trend in admissions had more to do with the state of the economy and if that is true, when the economy improves admissions will increase.

A panel consisting of Stuart Erdman, Senior Director of Finance of the Johns Hopkins Health System, Daniel J. Brotman, M.D., Director of the Hospitalist Program at the Johns Hopkins Hospital, and Amy Deutschendorf, Senior Director Utilization/Clinical Resource Management of the Johns Hopkins Health System presented comments on the recommendation.

Mr. Erdman stated that Johns Hopkins believes that the ARR is the most important step forward in rate setting since the Charge-per Case system was adopted. It is a logical step forward to move from a charge per case system to a charge per episode system. The incentives are appropriate to encourage hospitals to develop coordinated care with non-hospital providers. However, technical adjustments to the Reasonableness of Charges and case mix index methodologies are needed for hospitals that participate in the ARR.

Mr. Erdman stated that the Johns Hopkins System supports the ARR initiative, and its member hospitals intend to participate.

Dr. Brotman expressed his support for the ARR initiative. He noted, however, that it is clear the

initiative requires the cooperation of many people both inside and outside of the hospital. However, it is exciting because it builds in the appropriate incentives and provides the needed infrastructure to do the job right. Dr. Brotman stated that all of the interventions that Hopkins is focusing on are patient centric.

Mr. Erdman stated that reducing readmissions is a process that may take time to show results. Therefore, it is appropriate that the recommendation suggests that ARR agreements be for three years.

Ms. Deutschendorf stated that the Hopkins Health System has been working on this initiative for a year and is poised to begin. According to Ms. Deutschendorf, acute care hospitals have focused on stabilization and transition - - patient comes in the hospital patient leaves the hospital - - the scope is now broadened to the episode of care; i.e., from home to home.

The Commissioners discussed the fairness of including the upfront funding in the Update Factor slippage, and suggested that the recommendation be amended to provide the flexibility in regard to risk, with diminished risk resulting in less upfront funding.

Commissioner Antos made a motion to amend staff's recommendation so that the cost of upfront funding is not included in Update Factor slippage, and that there be flexibility for hospitals to participate at a lower level of risk with upfront funding being reduced to reflect the lower level of risk.

The Commission voted unanimously to approve the amended recommendation.

ITEM VII
LEGAL REPORT

Regulations

Proposed

Uniform Accounting and Reporting System for Hospitals and Related Organizations – COMAR 10.37.01.02

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

The Commission voted unanimously to approve the promulgation of this amended regulation.

ITEM VIII
HEARING AND MEETING SCHEDULE

February 2, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
March 2, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 12:39 p.m.