HEALTH SERVICES COST REVIEW COMMISSION
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495th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
February 6, 2013

EXECUTIVE SESSION
12:00 p.m.

1. **Comfort Order – University of Maryland Medical System**
2. **Waiver Update**
3. **Waiver Implications on Update Factor Process**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Executive Session and Public Meeting Minutes from January 9, 2013.**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**

   2190N – St. Mary's Hospital
   2194A – Johns Hopkins Health System
   2195A – Johns Hopkins Health System
   2196N – Harbor Hospital
   2197A – Johns Hopkins Health System
   2198A – Johns Hopkins Health System
   2199A – Johns Hopkins Health System

4. **Docket Status – Cases Open**

   2168R – Garrett County Memorial Hospital
   2193R – Adventist Behavioral Health
   2200A – MedStar Health

5. **Status Report on Development of Admission-Readmission Revenue and One Day Stay Policy Recommendations**

6. **Legal Report**

7. **Legislative Report**

8. **Hearing and Meeting Schedule**

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

AS OF JANUARY 29, 2013

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
2168R	Garrett County Memorial Hospital	7/16/2012	2/6/2013	2/6/2013	FULL	GS	OPEN
2193R	Adventist Behavioral Health	10/2/2012	2/6/2013	3/1/2013	FULL	GS	OPEN
2200A	MedStar Health	1/4/2013	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
MEDSTAR HEALTH	*	**DOCKET:**	**2013**
	*	**FOLIO:**	**2010**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2200A**

Staff Recommendation

February 6, 2013

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on January 4, 2013 on behalf of Union Memorial Hospital (the Hospital) for an alternative method of rate determination (ARM), pursuant to COMAR 10.37.10.06. MedStar requests approval from the HSCRC to continue to participate in a global rate arrangement for orthopedic services with the NFL Player Joint Replacement Benefit Plan (the NFL Plan) for a one year period beginning December 1, 2012.

This arrangement was originally approved by the Commission at its December 5, 2007 public meeting for one year and subsequently re-approved in 2008, 2009, and 2010 with the approval expiring on December 1, 2011. The arrangement was reproved again at the December 8, 2012 public meeting. While there has never been any activity, the NFL Plan and the Hospital wish to maintain the arrangement.

II. OVERVIEW OF APPLICATION

The contract will continue to 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 all patients receiving the procedures for which global rates are to be paid. The negotiated rates are comparable to another joint replacement ARM already approved by the HSCRC. The NFL Plan agreement does not include the more costly procedures to replace prior joint replacements. In addition, the agreement does not include the post-acute rehabilitation normally included in joint replacement global pricing. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to 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 component of the global rate is reasonably related to historical experience. Staff has noted that the NFL Plan agreement has a more narrow definition of the episode of care covered under the global rates than other similar ARM arrangements. In addition, staff found that the Hospital and HRMI have a favorable history of managing joint replacement patients and performing under a global rate arrangement. The physicians' professional components of the proposed rates follow historical fee for service averages and are closely related to the professional components of the Hospitals similar global arrangement involving orthopedic surgery.

VI. STAFF RECOMMENDATION

Although there has been no activity, staff still believes that the Hospital can achieve favorable performance under this arrangement. Therefore, staff recommends that the Commission approve the Hospital's participation in the alternative method of rate determination for orthopedic services for a one year period, commencing February 4, 2013. 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, and 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.

Shared Savings in the Admission Readmissions Program with Modifications for Short Stay Cases

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
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Staff Report

Introduction

The purpose of this report is to describe for the Commission the status of staff work to revise the Admission Readmission Revenue (ARR) program. On January 24, 2013, the staff called a workgroup meeting with hospital representatives to discuss the status of the existing policy along with options for future revisions. The staff met with payer representatives from CareFirst, United Healthcare, and the State's Medicaid program to discuss the same issues on January 31, 2013.

Background

As noted in previous reports to the Commission, the Admissions-Readmissions Revenue (ARR) program requires redesign. Under the Affordable Care Act, 1814(b)(3) hospitals that are waived from the Inpatient Prospective Payment System are required to implement quality programs that meet or exceed those implemented by the Medicare Program. CMS has agreed to take a multi-year look at the existing program in Maryland, but certain differences stand out.

The HSCRC program is broader, applying to all-cause readmissions for all APR-DRGs. The CMS program applies only to Heart Attack, Heart Failure, and Pneumonia. The HSCRC program tracks only readmissions to the facility of the index admission, focusing on intra-hospital (and in some cases intra-system) readmission. Because there is no personal identifier in the HSCRC data, readmissions to unlinked facilities cannot be identified. Finally, the HSCRC program was constructed in a manner that converted existing admissions and readmissions into Charge per Episode approved revenue on a revenue neutral basis, allowing hospitals to keep the profit when readmissions are eliminated. The Medicare counterpart penalizes hospitals for high readmission rates, resulting in a system payment reduction of 0.3% of inpatient revenue.

Current Structure

The current HSCRC's ARR program is structured in the following manner:

- All cause readmissions are included in the program.
- The period for readmission is for 30 days following an initial admission.
- While a patient is billed for services charged during a specific case, the revenue allowed under the regulatory system for an average case is determined for a 30 day episode of care. This average amount was developed from hospitals' actual experience and was calculated in a revenue neutral manner in converting from the Charge per Case system.
- Hospitals have the opportunity to improve financial performance by reducing readmissions, thus eliminating costs while the revenue base has not been reduced.
- The policy was approved with the understanding that productivity expectations would be high for hospitals – profits would be generated by reducing costs through reduced readmissions while annual inflationary updates would be lower.

The ARR program is in its second year. While CMS has indicated its willingness to examine the program's operation over multiple years, representatives have indicated discomfort with the revenue neutral approach. They have noted that this approach does not share savings with the public, and while reduced update factors can recapture some of those savings, they viewed the mechanism as indirect.

Options for Incorporating Shared Savings

In the workgroup meetings, the staff discussed three options for sharing savings from reduced readmissions: scaling, the performance standard approach, and an improvement approach.

- The scaling approach may be the most straightforward approach. This would require ranking hospitals on a standard definition of readmissions. The best performing hospitals would not be adjusted, but hospitals with higher readmission rates would receive some level of reduction to rates, with higher deductions occurring for higher readmission rates.
- The performance standard approach would follow the structure of the current system, but each hospital's target would be adjusted compared to a case mix adjusted readmissions standard. Hospitals below the performance standard would have no adjustment to their Charge per Episode (CPE) target. Hospitals with high adjusted readmission rates would be adjusted downward to the required performance standard, generating lower rates to patients.
- United Healthcare representatives suggested a continuous improvement approach that would require improvement from each facility instead of a performance standard that implicitly requires no further reductions for some hospitals.

One Day Stays

In these meetings, the staff discussed the need to reincorporating short stay cases (0 or 1 day length of stay) into the CPE target. Short stay cases are currently excluded from the CPE methodology. These cases should be reincorporated into the model to prevent them from being pass through revenue to the system and to minimize their impact on the current waiver. Further, a consistent treatment of inpatient cases would make the existing model more straightforward.

Technically, bringing short stay cases back into the model is straightforward, with CPE targets and case mix weights reflecting the change when rebased at the beginning of the rate year. The policy concern is that attaching APR-DRG rate capacity to short stays could encourage an expansion of these cases and reverse the progress previously made on reducing short stays in Maryland. To the degree that these cases are denied as medically inappropriate, they would not generate rate capacity, but the staff believes that other mechanisms would be required to guarantee this result. One possible solution is to monitor the number of short stays by hospital for expansions and adjust the hospitals revenue if the rise in short stay cases were substantial.

Other Exclusions to Existing Logic

The staff also raised the issue of the current logic for exclusions and outliers in the current system. The outlier logic is complex, and this revision is an opportunity to make appropriate adjustments. These items will be modeled and discussed in future meetings.

FY2012 Adjustment for the Compositional Effect of One Day Stays

In the March 2013 Commission meeting, the Commission approved an emergency modification to the case mix policy that imposed a governor on case mix, including the one day stay cases. Because these cases have been excluded from the CPE and CPC logic for recent years, this modification was designed to reflect the effect of the one day stay policy on the State's waiver position.

Determining the impact of these cases turned into a challenge, requiring detailed staff analysis and discussions with consultants and interested parties. The staff arrived at an estimate of the impact under the case mix governor of 0.31%.

As we looked to apply this adjustment to FY2013 rate orders, however, we noted that only a small number of hospitals would receive this adjustment. Because the one day stay policy has been addressed in different ways in different years, this result appeared to treat hospitals differently who had the same experience with one day stay reductions but with different timing. The Commission's action allowed the adjustment to be treated as a case mix governor adjustment for FY2012 only, so the staff is seeking Commission approval to allow this adjustment to be applied based on a two-year look back at one day stay performance for both FY2011 and FY2012. The adjustment would be made to permanent revenue in FY2014. No one time adjustment would be required because as excluded cases, hospitals did not generate additional rate capacity for the one day stay cases.

Next Steps

The staff will continue to work with the hospital and payer work groups to model the policy options discussed above during February with a preliminary recommendation to the Commission at the March 2013 Commission meeting.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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TO: Commissioners

FROM: Legal Department

DATE: January 30, 2013

RE: Hearing and Meeting Schedule

Public Session:

March 6, 2013 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

April 10, 2013 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

Please note, Commissioner Packets will be available in the Commission's office at 12:30 p.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.
http://hscrc.maryland.gov/commissionMeetingSchedule2013.cfm

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