MINUTES
469th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

JULY 7, 2010

Chairman Young called the meeting to order at 9:00 a.m. Commissioners Joseph R. Antos, Ph.D., Trudy Hall, M.D., C. James Lowthers, Kevin Sexton, and Herbert S. Wong, Ph.D. were also present.

ITEM I
REVIEW OF THE MINUTES OF THE EXECUTIVE AND PUBLIC SESSIONS OF JUNE 9, 2010

The Commission voted unanimously to approve the minutes of the June 9, 2010 Executive and Public Sessions.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, announced that Rodney Spangler, Chief-Audit & Compliance, had retired after 27 years with the Commission. Mr. Murray and Dennis N. Phelps, Associate Director-Audit & Compliance, thanked Mr. Spangler for his invaluable service to the Commission and wished him a long, healthy, and happy retirement.

ITEM III
DOCKET STATUS CASES CLOSED

2068R – University of Maryland Medical Center
2069A -University of Maryland Medical Center
2070A- University of Maryland Medical Center
2072R- Suburban Hospital

ITEM IV
DOCKET STATUS CASES OPEN

James Lawrence Kernan Hospital – 2071N

On May 12, 2010, James Lawrence Kernan Hospital submitted a rate application requesting a rate for Interventional Cardiovascular (IRC) services. The Hospital requested that the rate be set at the state-wide median with an effective date of June 1, 2010.

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

1) That COMAR 10.37.10.07, requiring that rate applications be made 60 days prior to opening of a new service be waived;
2) That the IRC rate of $33.46 per RVU be approved effective July 1, 2010;
3) That no change be made to the Hospital's Charge-per-Case standard for IRC services; and
4) That the IRC rate not be realigned until a full year's experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

MedStar Health – 2074A

On June 21, 2010, MedStar Health filed an application on behalf of Union Memorial Hospital and Good Samaritan Hospital (collectively the "Hospitals") requesting approval to continue to participate in a global rate arrangement with Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for cardiovascular services. The Hospital requested approval for a period of one year beginning August 1, 2010.

Staff recommended that the Hospitals' request be approved for one year beginning July 1, 2010 based on historically favorable performance under this arrangement. In addition, staff recommended that the approval be based on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2075A

On June 21, 2010, the Johns Hopkins Health System filed an application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval to continue to participate in a global rate arrangement with the Canadian Medical Network for cardiovascular services. The Hospitals requested approval for one year beginning July 1, 2010.

Staff recommended that the Hospitals' request be approved for one year beginning July 1, 2010 based on historically favorable performance under this arrangement. In addition, staff recommended that the approval be based on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

30 Day Extension

Staff requested that the Commission approve a 30 day extension of the time for review of Proceeding 2076R, the rate application of St. Agnes Hospital.

The Commission voted unanimously to approve staff's request.

ITEM V
FINAL RECOMMENDATION ON FY 2011 UPDATE TO HOSPITAL RATES

Mr. Murray summarized the original staff recommendation (see HSCRC website, "Final Staff Recommendation and Discussion Document Regarding the FY 2011 HSCRC Hospital Payment Update," pp. 1-49).

Mr. Murray stated that on June 23, 2010, the Chairman received a letter signed jointly by representatives of the Maryland Hospital Association (MHA), CareFirst of Maryland, United Healthcare, and the Secretary of the Department of Health and Mental Hygiene, which indicated that they had reached a consensus proposal on an update structure. The proposal included a readmission reduction project and also a specific update factor for FY 2011.

Mr. Murray stated that although supportive of incentives to reduce readmissions, staff believes that the incentive structure outlined in the proposal is flawed. Consequently, staff proposed several modifications to the consensus readmission project should the Commission find the concept desirable.

Mr. Murray briefly described the consensus proposal. The proposed update factor would be 2.44%, 044% of which is associated with the readmission project; 0.22% is to fund the required infrastructure; and the remaining 0.22% to be an incentive or "at risk" component, which would be made permanent if hospitals achieved the goal of reducing readmissions by 10% in the 4th quarter of FY 20111. Mr. Murray noted that the additional 0.44% funding would generate $60 million of additional revenue in FY 2011 if the consensus proposal were adopted.

In addition, while the letter stated that the 0.44% was specifically targeted to fund the infrastructure for the readmission reduction programs, subsequently, this was clarified. According to Carmela Coyle, President of MHA, the 0.44% in the FY 2011 was actually intended to provide hospitals with "adequate funding in the coming year, such that they would be in a position to develop initiatives to begin reducing readmissions." Thus, contrary to what was implied in the proposal, the entire 0.44% would not be directed to the readmission initiative, nor would hospitals be compelled to spend that amount on the development of a readmission infrastructure.

Mr. Murray noted that the proposal establishes an aggressive goal of a 10% reduction in readmissions by the 4th quarter of FY 2011 and defines a readmission as occurring during a 30-day window after discharge of the initial admission. Mr. Murray noted that since readmissions

comprise about 13% of total admissions, the proposal represents a 1.3% reduction in total admissions, as well as a substantial reduction in total revenue. In comparison, HSCRC's readmission initiative focuses on providing incentives to hospitals to reduce "Potentially Preventable Readmissions" (PPRs). Mr. Murray pointed out that achieving a goal of reducing total readmissions by 10% would require the very aggressive goal of reducing PPRs by over 16%. The consensus proposal also states that if the goal of reducing readmissions by 10% in the fourth quarter of FY 2011 is not achieved, the 0.22% "incentive at-risk" component would be taken back in the following year.

Mr. Murray stated that while not recommending or endorsing the consensus proposal, staff recognized the rationale for providing some up-front funding for such an initiative if the goal could be reached and sustained over time. Staff, however, proposed several modifications to the proposal that would create a better incentive structure: 1) that the update factor be 2.00%; 2) that an additional amount to facilitate the development of a readmission reduction infrastructure (0.22%, or an amount determined by the Commission) be provided permanently effective July 1, 2010; 3) that incentives to reduce readmissions be applied at the individual hospital level by increasing the fixed cost factor to be provided for reductions in readmissions from 15% to 40%; 4) that hospitals that have submitted bad data be excluded from the initiative; and 5) that the project apply to the entire year and not just to the last quarter of FY 2011.

Mr. Murray stated that the PPR initiative, to be implemented in January 2011, may be able to operate in conjunction with this more global consensus proposal approach. However, staff is concerned about the lack of accountability for the up-front money in the consensus proposal and would be interested in hearing more details about MHA's role in the program.

A panel consisting of: Carmela Coyle, President & CEO of MHA, Chet Burrell, President & CEO of CareFirst BlueCross BlueShield, and Gary Simmons, Regional Vice-President of United Healthcare, summarized the FY 2011 payment update consensus proposal.

Ms. Coyle thanked the Commission for its willingness to delay the decision on the FY 2011 update factor until today. This not only offered the opportunity for MHA and the payers to present the consensus proposal, but allowed the parties to have the benefit of Commission staff's proposed modifications to the proposal.

Ms. Coyle noted that after fifteen meetings of the Payment Work Group, the hospital industry and the payers were still far apart. At that point, the consensus group decided to get together in an attempt to develop a common understanding of the data and the issues.

According to Ms. Coyle, the stakeholders decided not only to develop a framework to close the gap between the hospital industry's and the payers' update factor proposals, but also to determine the tools and resources hospitals needed to prevent readmissions in order to complement the work of staff on the Commission's PPR policy.

Ms. Coyle stated that the consensus group supported the changes suggested by staff for the readmission program, especially for the modification of the incentives. However, Ms. Coyle

asked that the Commission consider two additional modifications. They were that the total update amount be 2.44% for FY 2011 and that the update be composed of a core update of 2.22% permanently built into the update base, with the remaining 0.22% to be a one-time adjustment included as an incentive contingent upon hospitals achieving the goal of a 10% reduction in readmissions by the fourth quarter of FY 2011. Ms. Coyle noted that at the core of this consensus proposal was to provide hospitals with some minimum level of inflationary increase that would allow them to engage in this major undertaking. According to Ms. Coyle, the 2.44% increase contains only a core update of 1.66%, which is well below the rate of inflation of 2.09%. The second modification would be to make a revenue neutral shift of 0.25% of the inpatient case mix allowance of 0.75% to the core update.

MHA has begun to look at how it can best help hospitals learn about and understand best practices for reducing readmissions. In the update discussions, United Healthcare suggested an initiative that they had been using called Project Red. Project Red is a program developed at Boston University Medical Center that the Agency for Health Care Research and Quality (AHRQ) is interested in. The AHRQ is sponsoring an initiative with the Joint Commission Resources (JCR) in 50 hospitals to see if implementation of Project Red will reduce readmissions. Project Red has two objectives: 1) to reduce readmissions; and 2) to increase patient literacy and patient understanding of their condition at time of discharge. Some of the core components of Project Red include: 1) the hiring and training of Discharge Advocates to work with patients at discharge explaining their condition; what needs to happen after their hospital stay; and making appointments with providers for patients to provide continuity of care post discharge; 2) medication reconciliation, pharmacists working with patients to understand their medications; and 3) an after hospital care plan, i.e., a standard hospital discharge form and process that is easily understood by patients. Ms. Coyle stated that initial tests at Boston University Medical Center showed significant decreases in emergency room utilization, and a 30% deduction in hospital readmissions. If implemented, Maryland would be the first state-based test of Project Red.

Ms. Coyle stated that it was clear that something had to be done to reduce readmissions. MHA would lead the effort on identifying the “how to” tools and strategies needed to reduce readmissions, but that it was not necessary that the same program be utilized by all hospitals. Ms. Coyle noted that we should not be prescriptive. If an organization is already pursuing a set of strategies, they should not have to change their approach.

Mr. Burrell stated that from CareFirst’s point of view, the single greatest issue is the high use levels in Maryland hospitals. Maryland has admission rates and readmission rates that are among the highest in the nation. Mr. Burrell noted that a key factor in the continued increase in premiums is the rate of use, including readmissions. According to Mr. Burrell, 5% of CareFirst’s total patient base is responsible for about 50% of CareFirst’s total medical expenditures. Most of those expenditures are to treat patients with multiple chronic diseases who tend to come in and out of the hospital and in and out of the emergency room over a long period of time. Carefirst’s primary concern is what can be done to build in incentives for hospitals to reduce readmissions. In many instances, patients are discharged and readmitted within 30 days without ever seeing a physician or other provider between the admission and the readmission. Therefore, it is critical that an infrastructure be put in place within the hospitals to strengthen discharge planning and

follow-up care, particularly for those patients with multiple chronic diseases who are the most likely to be readmitted. Rather than specify what the program should be, CareFirst believes that the choice should be left to the judgment of the hospitals. CareFirst's goal is to bring readmissions down and, ultimately, to bring the total number of admissions down.

Mr. Burrell stated that when the update process came to an impasse, the stakeholders were able to close the gap through discussions and to develop the consensus proposal. The consensus proposal provides a little more revenue in the first year. The intent is that the additional 0.22% provides hospitals with the additional resources needed to focus on the infrastructure that must be put in place, whether that be staffing or other things, which are necessary to reduce readmissions in the long term. In order to achieve the suggested goal of a 10% reduction in readmissions by the fourth quarter of FY 2011, infrastructure would have to be put in place, and that infrastructure would continue to have an impact in the future. This idea was very attractive to the hospital industry because, ultimately, the system saves, including those who pay the premiums, if overall use levels can be moderated.

Mr. Burrell stated that staff's work on the consensus proposal was extremely helpful and the suggested modifications improved the proposal technically and also improved its chances of success.

Mr. Burrell expressed his support of the original consensus proposal with the changes suggested by staff and with the modifications proposed by Ms. Coyle. In regard to the data issue, Mr. Burrell noted that if we put incentives in place that focus on the data, the data will improve. Mr. Burrell observed that the up-front money is critical to "priming the pump" to get infrastructure changes in place among the hospitals.

Mr. Simmons endorsed the recommendations of Ms. Coyle and Mr. Burrell. Mr. Simmons noted that United Healthcare was asked to provide a tool that hospitals could use to reduce readmissions and also improve quality of care. Mr. Simmons stated that the consensus group believes Project Red does that, although we all recognize that understanding, learning, staffing, resourcing, and implementing Project Red will take some time; that is why the consensus proposal recommended that the results of using Project Red should not be measured until the 4th quarter of 2011. Mr. Simmons expressed United Healthcare's support of the consensus proposal.

Ms. Coyle stated that although we may not have all the pieces right, we need to take this step. With the expertise that staff will bring to this process, we can get it right.

Chairman Young asked Ms. Coyle that, since it is the physicians who admit and readmit patients and are not always willing to take advice, what can hospitals do to educate the physicians about ways to reduce readmissions.

Ms. Coyle stated that since there are a significant number of physicians employed by hospitals, this is an opportunity to bring them to the table and get them involved in the decision-making process to reduce readmissions.

Commissioner Hall asked whether the consensus proposal differentiated between preventable and non-preventable readmissions.

Ms. Coyle stated that the proposal focuses on reducing the overall rate of readmissions with the ultimate goal of reducing all admissions.

Ms. Coyle noted that access to primary care is critical in reducing readmissions, and we hope to learn what are some of the barriers to access to primary care.

Commissioner Hall asked Mr. Burrell what investment managed care organizations were going to make to help in chronic disease case management.

Mr. Burrell stated that CareFirst was currently making a substantial investment in focusing on: 1) identifying the chronic patient; 2) determining which physicians these patients see; 3) what care plan was developed; 4) notifying the primary care physician when the chronic patient was admitted and why; and 5) utilizing community based care teams to see to that patients show-up for follow-up visits, and that their visits are paid for. Mr. Burrell noted that the program proposed today aligns the incentives of the hospitals and payers toward the same goal, and that represents an important element of the overall approach towards chronic care management. This is a major tool to bend the cost curve without reducing quality of care.

Commissioner Antos asked Ms. Coyle whether the consensus group had changed its recommendation.

Ms. Coyle explained that the group had collectively changed its recommendation from the original consensus proposal to incorporate the improvements that HSCRC staff has added, along with the two modifications offered today. The modified proposal would: 1) increase staff's recommended update to 2.22% ; 2) increase the update by a one year temporary adjustment of 0.22% to 2.44%, and 3) make a budget neutral shift of 0.25% from the inpatient case mix index governor to the core update.

Mr. Murray stated that staff recommended no particular update except for the 1.91% previously recommended. Mr. Murray noted that staff suggested that if the Commission found the consensus proposal's readmission initiative desirable that it be restructured to correct its inherent flaws.

Mr. Murray asked whether he was correct in saying that although the modified consensus proposal would provide a larger update, 2.44%, there would be no change in the incentive structure, i.e., hospitals would not be at risk for readmissions in FY 2011.

Ms. Coyle replied that the measurement period, the 4th quarter of FY 2011, was selected because it will take 6 to 9 months to put the program in place, and most of the impact will be felt in FY 2012.

Ms. Coyle stated that many hours were spent trying to figure out how to bend the cost curve and manage utilization in a way that is workable for the hospital industry. The order of magnitude of

the update is critical to hospitals' ability to take on the challenges of a readmission program such as the one that we are talking about, understanding that even with the total update at 2.44%, the core update is below the rate of inflation.

Commissioner Antos asked Ms. Coyle what MHA would do as opposed to what hospitals would do to implement the readmission program.

Ms. Coyle stated that MHA would lead the effort to develop an ongoing infrastructure and support mechanism, potentially in conjunction with the Maryland Patient Safety Center, JCR, and AHRQ. This support mechanism would actually show hospitals what they had to do to implement the program. The hospital would be responsible for hiring the discharge advocates and pharmacists and implementing the program.

Commissioner Antos asked whether there was evidence that Project Red and Project Boost actually succeed, and whether they work for all hospitals.

Ms. Coyle cited a research study, published in the American College of Physicians Annals of Internal Medicine, which indicated that Project Red reduced readmissions by 30%. However, there were no studies that confirm that these programs work in all hospitals. Also, the fact that AHRQ has approved a pilot program for 50 hospitals indicates that it believes the program is promising.

Mr. Simmons stated that United Healthcare's internal data supported the research study results on Project Red.

Commissioner Hall asked what it cost to implement Project Red in a hospital.

Ms. Coyle said that the study found that one discharge advocate and 1/3 of a pharmacist could manage 28 patients per week.

Commissioner Antos asked whether there was any basis for estimating the total cost of the program, and if the costs could be translated into a rate increase. Dr. Antos asked if that was the basis for the proposed 0.22% update increase in the MHA/Payers proposal.

Ms. Coyle stated that the consensus group did not start with a budget for Project Red because there is not enough information to estimate the cost. What they decided was that there needed to be a minimal inflationary increase to create a stable enough environment for hospitals to take on this new activity.

Commissioner Antos asked what effect the 2.44% update would have on health insurance premiums.

Mr. Burrell stated that the payers would not make this investment, i.e., supporting the additional funding, if they did not believe that there was a reasonable chance that hospitals would implement this program. The hospital industry said that they could achieve a 10% reduction in readmissions in the 4th quarter of FY 2011. Any reduction in readmissions would have a small

beneficial effect on premiums. However, if the Commission does not act upon the readmission reduction initiative in the consensus proposal, we would assume the rate of readmissions will remain as high as it is now. Without putting some infrastructure in place to better control readmissions, we have no hope that the current trend in readmissions will change. CareFirst's motivation to support this proposal, which puts a relatively small amount of money at-risk, is to see whether such a program can be developed.

Commissioner Antos asked when the Commission's PPR initiative will begin.

Mr. Murray stated that the start of the PPR initiative, which deals with preventable readmissions, has been delayed until January1, 2011because of issues with the data.

Ms. Coyle stated that we can set up incentives based on outcomes, but if we do not help hospitals understand what to do and how to do it, and put an infrastructure in place, we will not be successful in terms of preventing readmissions.

Mr. Murray noted that the PPR initiative contemplated providing additional funds in rates to set-up an infrastructure resource for the State.

Commissioner Wong thanked the consensus group for getting together to try to find some common ground. Dr. Wong also expressed his support for the readmission aspect of the proposal. Dr. Wong noted that even though ARHQ is involved in Project Red, all projects have different goals, and we should find out what the objectives of Project Red are.

Dr. Wong noted that it appears that part of the proposal is to model a readmission reduction program similar to Project Red as opposed to the readmission initiatives that the Commission has discussed in the past. If that is the case, it is important to keep in mind the cost and target aspects and, the details including how readmissions are defined.

Dr. Wong asked the panel if they could explain how their proposal was integral to the basic rate update.

Ms. Coyle stated that when the consensus group came together to try to close the gap between MHA's and the Payers' proposals, there were many variables involved in the negotiations. Because they are already working on a number of initiatives, i.e., hand hygiene, bloodstream infections, urinary tract infections, or readmissions, from the hospitals' perspective, there had to be a minimal level of rate increase that would allow hospitals to continue the work that they are doing. The group was able to come together and to agree that at this level of increase, which is still below the rate of inflation, hospitals can commit to taking on the risk associated with trying to implement a program like this. MHA spent a long time in rooms with hospital leadership trying to understand, based on their budgets and financial condition, what constituted the right number. We then had to sit down with our payer colleagues who had different ideas of what the right number was. The consensus proposal was the product of many long hours to try to find an update package that would work for all of us.

Dr. Wong asked if it was possible to view this proposal in two pieces. The first piece is the basic

rate increase of 2.00%. On top of that was the readmission initiative piece that involved the additional 0.44%. Obviously, there is much discussion around the 0.44%. In terms of the decision- making process, Dr. Wong questioned whether it wouldn't be cleaner to consider those two pieces separately. Consider the basic rate increase first and then, perhaps at a later point in time, consider the readmission piece. The reason for separating the two components is that many details of the readmission initiative are left open-ended, and the Commissioners have questions about other aspects of the readmission program. Dr. Wong observed that from his point of view, the two components are separable. The base update could perhaps be decided today, and staff, in the meantime, could gather more information about the readmission program so that the Commission can make a more thoughtful decision.

Ms. Coyle stated that from the perspective of the hospitals, the idea that the proposal would be separated into two components would not have secured our willingness to collaborate in the way we hope to do. Hospitals know that they are going to have to incur costs up front; they know that they are at some risk; they would all like to know more about the readmission program; however, there is a sense, according to Ms. Coyle, that we need to get going now. We need to try something; hence, for the hospital industry a sufficient level of increase is integral.

Dr. Wong stated that he understood the time was needed to develop the infrastructure to get the readmission process going; however, if the readmission initiative was delayed a month or two months would that really cost us anything. We can't postpone making a decision on the readmission phase of the proposal at the August or September public meeting, so that we have a better understanding of all the components of the initiative, and everyone understands the actual numbers that we are making our decision on.

Ms. Coyle noted that from the hospitals' perspective, as they entered into this negotiation process, it was never about pegging an amount to pay for the readmission initiative; instead, it was about a minimal level of inflationary increase that allows hospitals to take on not only an initiative like the readmission program, but, frankly, to continue to do everything else that they have to do on a daily basis. Hospitals are currently looking at operating margins of half a percent. So the concern was, although we all know we need to do this work, the nexus that brought us together was an acknowledgement that there has to be some minimal amount of increase that can bring us to the table in a constructive open way. MHA, in fact, is going to expend a significant amount of revenue trying to lead this initiative. For the hospital industry, separating the two components would be challenging if not impossible.

Mr. Burrell stated that from the payers' point of view, the idea was to provide sufficient funding to actually get a result. We went into it with that spirit. We were looking for results; it was all outcome-oriented without being overly specific as to exactly how the hospitals were going to go about doing it. If Project Red is the best way to achieve the goal, then do Project Red. If there is a way to evaluate project Red, we are all for that. When should the program start, how should it be conducted, what is the role of individual hospitals versus the role of MHA, we are eager to talk about all of those issues. However, we wanted to get started, and we did not want financing to be an impediment.

Commissioner Lowthers stated that he believed that there was already enough money in the system the fund the readmission initiative, and that regulated margins provided over time, 2003 to 2009, have increased more than enough to fund such initiatives. It is the responsibility of hospitals and physicians to correct the readmissions problem. If they choose not to do so, that is a managerial decision. Hospitals make decisions about how to spend the monies that they have. The problem is that they are using the regulated part of the system to subsidize the unregulated part of the system.

In regard to the adoption of a cost target, Commission Lowthers noted that according to MedPac data, the costs of efficient hospitals are approximately 9% below the nation; therefore, a 3% to 6% cost target is too low. Commissioner Lowthers asserted that the target should be 9% to 12% below the nation to be achieved in three years.

Commissioner Lowthers stated that rather than the consensus proposal, the Commission should be considering staff's proposal regarding readmissions. Commission Lowthers also expressed his support for staff's Reasonableness of Charges (ROC) scaling proposal.

According to Commissioner Lowthers, the Commission must balance the cost of funding long term cost cutting initiatives such as the readmission project by increasing hospital rates, versus the current affordability of health care. Commissioner Lowthers suggested that an update factor close to that recommended by staff, 1.91%, be approved and that long term issues should be addressed with the money that is already in the system. Commissioner Lowthers stated that he would not vote to adopt the "package" consensus proposal, which includes funding the readmission initiative.

Commissioner Lowthers observed that during his tenure on the Commission, there have always been disagreements; however, the disagreements are now more confrontational. Commissioner Lowthers lamented the time when people sat down and tried to work things out, in the sunlight, in a more reasonable fashion.

Commissioner Lowthers stated that it was incumbent upon the industry to try to work within the constraints of the system; that there was enough money in the system now; and that we should hold down the update factor.

Commissioner Sexton stated that we are trying to reduce hospital spending, and the only tool that we have is the rate update factor. According to Commissioner Sexton, it is worth taking a risk by increasing the update by 0.4% or 0.5% with the hope that it will have an effect on spending. We will not achieve our goal of reducing hospital spending by cutting the update factor - - only changes in behavior will do that. However, the proposed readmission reduction project is, at least, an attempt to move in that direction. The proposed project uses economic incentives and focuses a bright light on the issue of readmissions. Staff's suggestion to combine the PPR initiative and the 40% fixed cost approach improves the incentives and, along with the short term money contained in consensus proposal, makes a good package. Reducing total hospital spending through reducing readmissions must affect use. However, we must recognize that if hospitals admit and readmit fewer people, that these people will be sicker and are going to cost more to treat. Over time, we have to evolve to a broader target than costs. If hospitals achieved

half of the target of reducing readmissions by 10% in the 4th quarter of FY 2011, we would make back the additional 0.4% or 0.5% that was put in the update factor for the project, and we would have started to set a better pattern of behavior. Commissioner Sexton expressed his support for the consensus proposal readmission project.

Mr. Murray stated that he was confused as to why Commissioner Sexton was willing to support the readmission project when there is nothing in the consensus proposal that compels hospitals, from a financial standpoint, to do anything to reduce readmissions.

Commissioner Sexton stated that there are incentives that did not exist before, there are the changes in the incentive structure suggested by staff; and there is the light of public opinion on this issue.

Mr. Murray stated that the PPR incentive will exist whether the readmission project is approved or not.

Commissioner Sexton noted that hopefully we have fashioned a context which will create the incentive for hospitals to reduce readmissions. However, if hospitals only react to financial incentives, we are in trouble. Hospitals must realize that something has to change in the way we utilize the healthcare system. The industry has committed to giving the readmission project its best shot, and failure will be an embarrassment.

Ms. Coyle asserted that there is an incentive because of the symmetrical nature of the proposal, if readmissions go up, 0.22% is removed in FY 2012.

Mr. Murray noted, however, that if readmissions stay exactly where they are, the second highest in the nation, there is no penalty, and the hospitals have the additional 0.44% in their rates.

Ms. Coyle stated the trend of readmissions has not been flat, it has been going up.

Mr. Murray noted, so at best we halt our rather dismal performance relative to the U.S.

Ms. Coyle observed that at best we are hoping to change the incentives. If spending is price times quantity, and if all we do is concentrate on holding down price, we will get around to reducing, what the payers agree is the key driver, quantity.

Mr. Murray reiterated that there is nothing compelling hospitals, from a financial standpoint, to reduce quantity. There must be an underlying structure of incentives to change direction. The consensus proposal does not get us there.

Commissioner Sexton stated that he believes that we are arguing degree. The incentives, though not compelling are greater than ever before by a significant amount, and that the readmission project is happening in a context that is very visible.

Commissioner Sexton stated that however it happened, the coming together of the consensus group represents the most collegiality and engagement across all of the different parties in a long

time. This collegiality is something we must build on, whether on the issues of the waiver or healthcare costs, we are going to have to agree to take some risks.

Commissioner Hall noted that sometimes you have to spend money to make money. Currently, there is nothing to incentivize hospitals to invest in aftercare infrastructure. We have to do something or we will be looking at the same problem over and over again. The question is how much does it cost. We have to decide whether a system that only penalizes hospitals for not doing something works.

Mr. Murray expressed concern that although we have provided a lot of money in rates, hospitals have decided to spend the money not on readmission related issues, but rather on generating more volume. Without any sort of compelling incentive, history shows that hospitals will choose to spend their money on things that generate volume not reduce volume. It is wishful thinking to expect that just because we are talking about this issue today, that hospitals will take their existing money and devote it to creating a very expensive infrastructure to reduce their revenue. That is the problem with this proposal.

Commissioner Sexton stated that we are about to give a reward to those hospitals that were early adopters of observation units. You could say that doing so is absolutely counter-productive as well, so these things do happen.

Mr. Murray pointed out that the rewards for early adopters are revenue neutral to the system.

Commissioner Sexton stated that his point was that there was no reward for hospitals to be early adopters, but there was a cost.

Ms. Coyle stated that there are clearly incentives and risks associated with the readmission program. If there weren't, she would not be arguing for a minimal inflationary increase as an incentive for hospitals to remain at this table. Once hospitals commit to this program, they are in it for better or for worse. What brought MHA and the payers together was the opportunity to create incentives in a system that does not have many incentives.

Mr. Burrell stated that there is a value to shining a bright light on this effort. The hospitals, having made this commitment, know that if nothing happens, no one will be eager to come to the table again on such an issue in this manner.

Mr. Burrell noted that the current rate system has not been successful in controlling use. Maryland has, perhaps, the highest rate of admissions and readmissions in the nation. Therefore, we are eager to try, in some modest respect, an alternative and more incentive driven way to control use. It is not so much about the mechanics of the program as it is about the principles of the program. A small reduction in readmissions will have big dollar effects.

Commission Antos observed that Maryland is in an unusual situation. Medicare's policy on unnecessary hospitalizations, effective 11/20/2011, reduces all Medicare payments by 1% to any hospital that has a re-hospitalization rate above the CMS standard. The policy increases the reduction in all Medicare payments by 2% in 2013 and 3% in 2014. The Medicare approach is

very punitive. The HSCRC's approach, no matter what we decide, does not come close to that. It is conceivable that the penalties may rise once Congress realizes the full extent of Medicare savings available by reducing preventable admissions. In other words, it is all going to look much worse outside of Maryland. That being the case, we should expect cooperation between insurers and the hospital industry because the alternative is ultimately we lose the waiver and go into that system. What we are talking about is hardly punitive.

Commissioner Antos agreed with Mr. Murray that there does not seem to be much of an incentive for a business to cut its revenue and potentially its profits just to possibly improve its reputation. In addition, because it is not generally known which hospitals have readmission problems and which do not, there is no public pressure on hospitals to do anything, and the leverage from the market on the hospitals that are not performing is really pretty low in Maryland.

Commissioner Antos asked Mr. Murray what were the barriers to dividing the consensus proposal into two components and delaying a decision on the readmission portion, as Dr. Wong suggested.

Mr. Murray stated that one of the negatives associated with postponing the decision on whether or not to include additional funds in the update factor for the readmission program is the unpredictability of what the final update factor will be, especially since we are already into the 2011 rate year.

However, Mr. Murray noted that we could potentially couple the consensus proposal readmission program with the Commission's PPR program. A draft recommendation for the PPR policy will be presented in October with a final recommendation expected in November, and implementation in January 1, 2011. So, staff could come back to the Commission in the fall with an overall readmission analysis, coupling both initiatives together for the balance of the rate year.

Commissioner Antos stated that it was his impression that it would be several months of technical discussions before actual spending commitments by the hospitals on infrastructure would occur because of the many uncertainties the insurers and the hospitals have with the process.

According to Ms. Coyle, there are costs associated with starting the program, and a decision to delay will lose willing partners.

Commissioner Hall asked whether there was any way we could make the entire 0.44% at risk.

Mr. Murray stated that it is very problematic to put money in rates conditionally, because it is very difficult to take it back when the update factors are so low. Mr. Murray noted that to put a significant portion of the update factor at risk contingent upon a 10% reduction in readmission is very aggressive. Staff has real doubts about whether hospitals can reduce all readmissions by 10%, because many readmissions are not preventable. In order to cut all readmissions by 10%, hospitals would have to cut preventable readmissions by 16%.

Ms. Coyle stated that both sides understand that we are at risk next year. According to Ms. Coyle, "we are here, we are together, and we are ready to start."

Mr. Murray asked Ms. Coyle how hospitals are at risk under the consensus proposal readmission program.

Ms. Coyle stated that, for example, the payers could suggest there be a freeze on the 2012 update, i.e., that the update factor be zero. Hospitals are at risk. We have come together with a concrete proposal that has been dramatically improved. Let's try it for a year understanding that we can start over with this conversation with next year's update.

John Folkemer, Deputy Secretary for Health Care Finance and Medicaid Director, reported that Secretary Colmers had a chance to look at staff's proposed modifications to the joint proposal and supported them.

Commissioner Antos asked Mr. Folkemer his reaction to the letter from the Department of Budget & Management that argues for a substantially lower update factor.

Mr. Folkemer stated that he agreed with the letter, that the State was going to have budget problems in the coming year.

Hal Cohen, Ph.D., representing Kaiser Permanente, stated that we have heard today that the core inflation in the update factor is less the market basket, but you must remember that there are more dollars going into the system this year than the just update factor, i.e., a retroactive increase in the uncompensated care provision, forward funding of capital, and the money for early adopters. Dr. Cohen reported that Kaiser supports: 1) a cost target of 6% below the nation; 2) staff's modifications to the readmission reduction program; 3) sending a letter to the Secretary of Health regarding Children's Hospital of Washington D.C.'s reimbursement for uncompensated care; 4) staff's scaling proposal of 15% of a hospital's position on the ROC and the peer group average; and 5) moving 0.25% from the inpatient case mix allowance to the core inflation as long as it is revenue neutral system-wide.

Dr. Cohen noted that a very important part of the payers' original update proposal was to move from a 15% fixed cost assumption to a 25% fixed cost assumption in order to provide an incentive for hospitals to reduce volumes. However, according to Dr. Cohen, at the last Payment Workgroup meeting, hospitals would not agree to the move. Kaiser believes that incentives to reduce overall admissions, such as the increase in the fixed cost assumption, are important to ensure that capacity created by reducing readmissions will not be filled with new admissions.

Finally, Dr. Cohen indicated that Kaiser definitely would not support re-negotiating the waiver agreement.

James Xinnis, President & CEO of Calvert Memorial Hospital, addressed the Commission on the

issue of scaling of the update factor based on ROC position. Mr. Xinnis stated that the HSCRC created a scaling provision a number of years ago to provide a more fair and equitable way to close the gap between high and low cost hospitals by providing rewards and penalties outside specific ranges within their peer groups. The objective was that over time hospitals within each peer group would move closer to the median on a Charge per Case (CPC) basis. In Calvert's case, this has not happened. Since 1992 Calvert has remained one of the lowest cost hospitals in the State - - despite receiving small scaling adjustments over the years. Calvert's CPC has been in the lowest 20% level for almost two decades. Mr. Xinnis asserted that Calvert was a "stuck" hospital. According to Mr. Xinnis, without aggressive scaling low cost hospitals have no other way to achieve higher rates than incurring the cost of filing a full rate application. Low cost hospitals are at a competitive disadvantage because they earn less income with which they can cover rising physician expenses not covered by the rate setting system. The subsidies associated with physicians' Part B services are the primary reason that Calvert's operating margins have declined and why Moody's has down-graded Calvert's tax-exempt bonds.

Mr. Xinnis noted that there are no incentives for low cost smaller hospitals to improve their financial margins other than by increasing volumes, which ultimately increases the cost of health care to everyone.

Mr. Xinnis asserted that more aggressive scaling will create more fairness and equity in the system by shifting revenue from high cost hospitals and re-distributing it to low cost hospitals in order to assure a more equitable distribution of medical services across the State. Mr. Xinnis requested the Commission's support for more aggressive scaling of at least 20% of the hospital's position on the ROC to the peer group average in FY 2011. This level of scaling would reduce disparity, encourage efficiency, and reward success for keeping the cost of health care delivery as low as possible and assure hospital service access across the State.

Chairman Young suggested that separate motions be voted on for each of four components of the Update Factor, i.e., the rate setting component, the re-admission reduction policy, scaling options, and Medicaid savings.

Commissioner Sexton made a motion that the Commission approve a maximum overall base rate Update Factor of 2.22% including the 0.5% for case mix increase on the inpatient portion of the update. The 2.22% included the re-admission policy with staff's modification of the incentive structure that would add 25% to the current fixed cost adjustment of 15% for changes in re-admission volumes.

The motion was not seconded.

Commissioner Lowthers made a motion that the Commission approve an overall base rate Update Factor of 2.00% which included modifying the proposed 0.75% cap for Inpatient case mix increases to 0.5% (leaving the Outpatient cap for case mix increases of 1.35% unchanged) but did not include any adjustment for the re-admission policy.

The motion was seconded by Commissioner Antos, and the Commission voted to approve the

motion by a vote of 4 to 2. Commissioners Hall and Sexton voted against the motion. Chairman Young cast the fourth affirmative vote.

Commissioner Lowthers made a motion that the Commission approve no funding for the proposed joint consensus proposal re-admission program.

Commissioner Wong proposed that the motion be amended to re-visit this issue in October or November for potentially coupling the joint consensus proposed re-admission reduction program and the Commission's Maryland Hospital Preventable Re-admission initiative (MHPR) with the possibility of increasing the update factor effective January 1, 2011. Commissioner Lowthers accepted the amendment to his motion.

The amended motion was seconded by Commissioner Antos, and the Commission voted 4-0 to approve the amended motion. Commissioner Sexton abstained.

Commissioner Sexton made a motion that the Commission approve staff's recommendation to scale: 0.5% of hospital approved revenue for the Quality-based Reimbursement Initiative relative performance; 0.5% of hospital revenue for Maryland Hospital Acquired Conditions relative performance; and 15% of the difference between a hospital's position on the Reasonableness of Charges analysis and the peer group average.

The motion was seconded by Commissioner Lowthers, and the Commission voted unanimously to approve the motion.

Commissioner Hall made a motion that the Commission approve staff's recommendation that the Commission send a letter to the Maryland Secretary of Health recommending that Medicaid change its reimbursement methodology, which authorizes an extra payment multiple of 2.5 times the reported uncompensated care of Children's Hospital of the District of Columbia.

The motion was seconded by Commissioner Antos, and the Commission voted unanimously to approve the motion.

Commissioner Lowthers made a motion that the Commission approve the adoption of a goal of moving the Maryland Rate Setting System toward a position of 6% below the U.S. on the basis of hospital cost per Equivalent Inpatient Admission with the end date to reach the goal unspecified.

The Motion was seconded by Commissioner Antos, and the Commission voted unanimously to approve the motion.

ITEM VI
REPORT ON THE RESULTS OF THE UNCOMPENSATED CARE POLICY

The Report on the Results of the Uncompensated Care Policy was postponed until the August public meeting.

ITEM VII
LEGAL REPORT

Regulations

Proposed

Uniform Accounting and Reporting System for Hospitals and Related Institutions – COMAR 10.37.01.03L-1

The purpose of this action is to extend the time frame for the submission of the annual hospital Interns and Residents Survey to the Commission from July to January.

The Commission voted unanimously to forward the proposed regulations to the AELR Committee for review and publication in the Maryland Register.

ITEM VIII
HEARING AND MEETING SCHEDULE

August 4, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
September 1, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 12:01 p.m.