MINUTES
471st MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

October 13, 2010

Chairman Fred W. Puddester called the meeting to order at 9:03 a.m. Commissioners Joseph R. Antos, Ph.D., George H. Bone, M.D., C. James Lowthers, Kevin Sexton, and Herbert S. Wong, Ph.D. were also present.

ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC SESSION OF SEPTEMBER 1, 2010

The Commission voted unanimously to approve the minutes of the September 1, 2010 Public Session.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

There was no Executive Director's Report.

ITEM III
DOCKET STATUS CASES CLOSED

2073A – University of Maryland Medical Center
2077A – Johns Hopkins Health System
2078A- MedStar Health
2079R – Montgomery General Hospital
2082A - University of Maryland Medical Center
2083A - University of Maryland Medical Center
2084A - University of Maryland Medical Center
2085A - Johns Hopkins Health System
2086A - Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

MedStar Health – 2080A

On August 16, 2010, MedStar Health filed an application for an Alternative Method of Rate Determination on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital requesting approval for the continued participation of MedStar Family Choice Program in the Medicaid Health Choice Program. The Hospitals

requested approval for an additional year beginning January 1, 2011.

Staff found that actual financial experience for CY 2009 was unfavorable; however, interim experience data for CY 2010 are positive and projections for CY 2011 are favorable. Staff believes that the proposed renewal arrangement is acceptable under Commission policy and recommended that the request for renewal of the arrangement for one year, beginning January 1, 2011, be approved. In addition, staff recommended that the approval be contingent on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2081A

On August 10, 2010, the Johns Hopkins Health System filed an application for an Alternative Method of Rate Determination on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval for the continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. The Hospitals requested approval for an additional year beginning January 1, 2011.

Staff found that actual financial experience for CY 2009 was unfavorable; however, interim experience data for CY 2010 are positive and projections for CY 2011 are favorable. Staff believes that the proposed renewal arrangement is acceptable under Commission policy and recommended that the request for renewal of the arrangement for one year, beginning January 1, 2011, be approved. In addition, staff recommended that the approval be contingent on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Maryland Physicians Care – 2089A

On August 17, 2010, Maryland Physicians Care on behalf of Maryland General Hospital, St. Agnes Health System, Western Maryland Health System, and Washington County Hospital (the "Hospitals") filed an application requesting approval for continued participation of Maryland Physicians Care in the Medicaid Health Choice Program. The Hospitals requested approval for an additional year beginning January 1, 2011.

Staff found that actual financial experience for CY 2009 was favorable and, based on interim data and forecasts, is expected to improve in CY 2010 and CY 2011. Therefore, staff recommended that the request for renewal of the arrangement for one year, beginning January 1, 2011, be approved. In addition, staff recommended that the approval be contingent on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

University of Maryland Medical Center – 2091A

On September 24, 2010, the University of Maryland Medical Center filed an application requesting approval to continue to participate in a global rate arrangement with United Resource Networks for solid organ and blood and bone marrow transplants services. The Hospital requested approval for one year beginning November 1, 2010.

Staff recommended that the Hospital's request be approved for one year beginning November 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 – 2092A

On September 24, 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 United Resources Networks for solid organ and bone marrow transplant services for a period of one year beginning October 1, 2010.

Staff recommended that the Hospitals' request be approved for one year beginning October 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 – 2093A

On September 24, 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 Global Excel Management, Inc. for cardiovascular procedures for a period of one year beginning October 1, 2010.

Staff recommended that the Hospitals' request be approved for one year beginning October 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 – 2094A

On September 24, 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 Life Trac, a subsidiary of Allianz Insurance Company of North America, for solid organ and bone marrow transplant services for a period of one year beginning October 1, 2010.

Staff recommended that the Hospitals' request be approved for one year beginning October 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.

ITEM V
REQUEST FOR COMMISSION TO GRANT STAFF AUTHORITY TO EXTEND APPROVAL OF CERTAIN ALTERNATIVE METHOD OF RATE DETERMINATION ARRANGEMENTS

Dennis N. Phelps, Associate Director- Audit & Compliance, presented a recommendation requesting that the Commission grant staff the authority to extend approval of certain alternative method of rate determination arrangements.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
CLARIFICATION OF DEFINITION OF MAJOR CAPITAL PROJECTS ELIGIBLE FOR 100% VARIABLE RATE ADJUSTMENT

Item removed from agenda.

ITEM VII
DRAFT RECOMMENDATION ON POTENTIALLY PREVENTABLE READMISSIONS

METHODOLOGY

Robert Murray, Executive Director, summarized the draft staff recommendation on "Rate Methods and Financial Incentives Relating to Reducing Maryland Hospital Preventable Readmissions" (see HSCRC website).

Mr. Murray noted that in developing its method for the incorporation of payment incentives to reduce unnecessary readmissions staff first identified a set of basic principles to help guide the overall effort. They included: 1) fairness in measurement; 2) fairness in the application of rewards and penalties; 3) prospective application of the incentive programs; 4) development of infrastructure to assist hospitals in reducing potentially preventable readmissions (PPRs); and 5) establishing an appropriate level of financial incentive.

Mr. Murray pointed out that given the HSCRC's experience with APR-DRGs for both risk adjustment and revenue constraint, Maryland is uniquely positioned to use 3M Health Information Systems' PPR tool to measure and monitor preventable hospital readmission rates. The PPR logic identifies initial admissions, PPR, and at-risk Only Admissions and allows for meaningful PPR rates to be computed.

Mr. Murray stated that the primary question is whether to have a payment model that focuses on readmissions to the hospital of the initial admission (intra-hospital readmissions) and rewards year-to-year improvement, or one that evaluates readmissions to all hospitals (inter-hospital readmissions) and rewards absolute attainment. Mr. Murray noted that although focusing on readmissions to the same hospital would avoid most problems associated with tracking patients across hospitals, using admissions to all hospitals is clearly a more comprehensive approach.

Mr. Murray described the data issues associated with tracking patient both within hospital (assigning patients multiple Medical Record Numbers) and across hospitals (developing unique patient ID's as well as the use of an algorithm using elements of patient data now available to identify patients) and staff's efforts to address those issues.

Mr. Murray stated that while there were several ways to calculate weights for re-admission chains, i.e., the relative weights given to re-admissions, staff was recommending one that was analogous to that utilized in the Maryland Hospital Acquired Condition methodology, i.e., that PPR weight would be that associated with chains starting with the weight of the initial admission.

Mr. Murray detailed the staff recommended methodology for adjusting inter-hospital re-admission performance utilizing age split, presence of mental health/substance abuse secondary diagnosis; the effect of disproportionate share; and out-of-state migration.

Mr. Murray stated that staff recommended the following: 1) implement a rate-based approach for measuring how PPRs are revaluated based on both their relative ranking on inter-hospital re-admission rates and on their intra-hospital year-to-year performance; 2) implement a hybrid system of rewards and penalties that will be given equal weight to inter- hospital attainment and intra-hospital year-to-year improvement; 3) utilize a 15-day re-admission window; 4) adjust

inter-hospital re-admission performance by factors relating to age split, presence of mental health/substance abuse secondary diagnosis; the effect of disproportionate share; and out-of-state migration; 5) limit the at-risk revenue for scaling for inter-hospital to actual number of re-admissions ; 6) use PPR rates for evaluating intra-hospital re-admission rate; 7) implement scaling of hospital payment rewards and penalties with the magnitude of funds scaled to be determined ; 8) the base measurement period be 1/1/10-3/31/11and the performance measurement period be 3/1/11-3/31/12 with rewards and penalties applied in rate year 2013; 9) provide a mechanism for input and feed-back from the industry; 10) make a tracking tool available to hospitals so that they can monitor their performance during the measurement year; and 11) work to develop and secure funding for a state-wide initiative PPR infrastructure and Quality Improvement project utilizing the STAAR model to provide assistance in implementing the best methods for reducing preventable readmissions and for decreasing the rate of hospital readmissions.

Tracie LaValle and Beverly Miller of the Maryland Hospital Association (MHA) commented on the draft recommendation. Ms. LaValle stated that although hospitals supported the PPR initiative, they had concerns about the lack of out-of-state data needed to measure re-admissions; that factors affecting readmission are too complex to adjust for; and that the funding to support the implementation of the initiative, 0.01% of net patient revenue (NPR), is inadequate to provide the necessary infrastructure needed. Because of the data problems, Ms. LaValle indicated that MHA advocated the intra-hospital payment model.

Ms. Miller voiced MHA's clinical concerns with the initiative. Ms. Miller stated that it was very important that there be additional clinical vetting sessions with industry clinicians to discuss in depth the adjustment factors, e.g., mental health/substance abuse, planned admissions, sickle cell, etc.

The Chairman asked Ms. LaValle what MHA thought was the appropriate level of funding for infrastructure.

Ms. LaValle stated that the necessary funding would be approximately $56 million, or 0.44% of NPR.

Hal Cohen, representing CareFirst of Maryland and Kaiser Permanente, expressed support for staff's PPR recommendation but added that he thought that PPRs should be a part of the larger initiative to decrease hospital admissions overall. Dr. Cohen added that data from MedPac indicated that hospitals can achieve low re-admission rates, provide high quality care, and be low cost. Dr. Cohen stated that although, as a general rule, he preferred attainment to improvement, he had no problem starting out with the intra-hospital model of rewarding improvements in hospital performance.

Commissioner Sexton asked Mr. Murray about the next steps.

Mr. Murray replied that the biggest unanswered question relates to the inter-hospital data issues.

Staff anticipates coming back to the Commission at the November public meeting with a solution to the data issue and a final recommendation in December.

VIII
LEGAL REPORT

Regulations

Final Adoption

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 admission of the annual hospital Interns and Residents Survey to the Commission from July to January.

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

Rate Application and Approval Procedures – COMAR 10.37.10.26

The purpose of this action is to alter the requirements for hospital financial assistance and debt collection policies and to make the requirements applicable to chronic care hospitals that are subject to HSCRC rate-setting.

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

ITEM IX
STAFF PRESENTATION AND DISCUSSION REGARDING THE COMMISSION'S BUNDLED PAYMENT INITIATIVES

Mr. Murray summarized the Presentation and Discussion Session paper (see HSCRC website, "Commission-Directed Initiative to Establish a System of Bundled Payment Structures to Promote Coordinated Care Delivery and Access to affordable and High-Quality Care," pp.1-13).

Mr. Murray stated that the purpose of the session is to engage the Commission and key stakeholders on potential ways to promote a more effective and comprehensive payment system to better achieve the systems goals of: affordability; access to care; equity; accountability; financial stability; quality of care; and to ensure the long-term sustainability of the Maryland Health Care System. Mr. Murray noted that the paper provided background information to help structure and guide the initial discussions with the goal of developing a specific proposal for moving toward a more effective and comprehensive payment system.

Mr. Murray observed that the recent passage of National Health Insurance Reform, among other economic and environmental factors, as well as concerns about the affordability of care and the financial sustainability of the current health care system have motivated the effort toward a coordinated care model. The focus of the current initiative is to find a way to ensure the long-term financial viability of the Maryland hospital and health care system, while achieving better outcomes and greater efficiency.

According to Mr. Murray, because of its robust data infrastructure, experience with risk management tools, flexible HSCRC statute, all-payer payment structure, and strong hospitals and hospital systems that provide a natural locus for potential coordinated care, Maryland is uniquely positioned to implement the transition in payment reform.

Mr. Murray stated that in moving toward more a more coordinated episodic bundled payment system the HSCRC must focus on: 1) increased emphasis on quality measurement and accountability; 2) alignment of incentives across providers; 3) keeping payment growth constrained; and 4) incrementally expanding the scope and window of provider payments. Mr. Murray noted that the HSCRC must also look to expand the number of hospitals under the current Total Patient Revenue payment structure (most applicable to hospitals serving well-defined communities), as well as explore the development of a per member per month (pmpm) based model that would bundle payment for individual hospitals or groups of hospitals in more densely overlapping services areas.

Mr. Murray stated that going forward, the HSCRC needs a goal, a framework, a timetable, and a process for soliciting input from all involved parties. Mr. Murray asserted that today begins the process to encourage all stakeholders to provide input to the HSCRC. In addition, staff will recommend that multiple additional forums be held to gather information and input from those who will be most impacted by potential payment reform.

Staff will then propose a plan of action for the Commission at the December 2010 public meeting to include: articulation of the objectives and key principles of the initiative; a set of 2 to 4 well-defined bundled payment pilot options; the criteria for review and approval of these options; a strategy to purse additional and necessary authority from the Centers for Medicare and Medicaid Services (CMS) to enable further experimentation with bundled payment systems; and a strategy to determine how the current Medicare waiver arrangement can best be changed to ensure continuation of the all-payer rate-setting authority in an environment of episodic provider payment.

Comments

Stuart Altman, Ph.D., Professor of National Health Care Policy at Brandeis University and former Chairman of the Medicare Prospective Payment Assessment Commission stated that he was the number one fan of what the HSCRC has accomplished; however, he expressed the belief that time is running out for what is basically a hospital-centric 1970’s 1980’s system with new trappings.

According to Dr. Altman, the HSCRC ideally should move to a physician-centered Accountable Care Organization (ACO) model. The objective of the ACO model is to integrate care at all levels; from the physician's office, to the clinic, to the outpatient department of the hospital, to post-acute care, and to create either episode of care or pmpm payment structures. Dr Altman asserted that in order to survive, hospitals need to take advantage of being a part of a larger "team," so that the savings on the non-hospital services benefit the hospital and vice versa.

Dr. Altman pointed out that the essence of the ACO model is not putting people in the hospital. The real savings is not making hospitals more efficient, but making the health care system as a whole more efficient.

Dr. Altman stated that the Commission should not believe that it has solved the health care system's problems by just bundling payments around hospital services; the real savings to the system is to go beyond the hospital.

Michael B. Robbins, Senior Vice President-Financial Policy of MHA, stated that the MHA's Task Force on the Future of Payment in Maryland recommended two priority shifts that it believes Maryland's future payment system should take: 1) change from a system that focuses solely on hospitals' financial performance to one that focuses on the health of patients and communities; and 2) that Maryland's Medicare waiver should be broadened to encompass a range of metrics that better reflect the clinical, operational, and financial realities of Maryland's health care environment.

Mr. Robbins noted that the Task Force was also concerned that staff's proposal: 1) limits the number of bundled payment pilots (MHA offered to commit resources to assist in modeling additional pilots); 2) seems to exclude the possibility of including long-term care payment bundling; and 3) may not allow the Commission sufficient the time to research any potential federal and state legal and regulatory barriers that may need to be resolved. Mr. Robbins also suggested that the Commission make sure to consider the possible interaction of new initiatives and their effect on the current payment system.

Dr. Cohen expressed support for the bundling initiative. Dr. Cohen thought that the incentives provided to reduce volumes are the key. Dr. Cohen stated that it was extremely important for the Commission to continue to maintain an overall system of cost and revenue constraints and urged consideration for going back to 3 year rate agreements.

Ms. Pam Kasemeyer, on behalf of MedChi, the Maryland State Medical Society, stated first that MedChi was perplexed about the failure of the Commission to be as aggressive in trying to get the Maryland Loan Assistance Repayment Program (LARP) approved through CMS, as it has been in looking at the bundled payment issue. This is especially the case, she asserted, since the bundled payment initiative requires physicians in the community to provide greater access to care, while the LARP program will help increase the number of primary care physicians in Maryland. Ms. Kasemeyer asserted that Maryland has a significant community physician shortage, and LARP holds tremendous promise to recruit and retain physicians in the

community. Ms. Kasemeyer urged the Commission to focus on getting LARP approved.

Ms. Kasemeyer also urged the Commission to move with great caution on the bundled payment initiative because of the risk for both hospitals and physicians. Ms. Kasemeyer stated that until the community physician access issue is resolved, the Commission will have a difficult time reducing re-admissions and emergency room volumes.

A panel consisting of Robert Rothstein, M.D., William Jaquis, M.D., Chief of Emergency Medicine at Sinai Hospital, Angelo Falcone, M.D., Jeremy Roth, M.D., Fred Thaler, M.D., and Barbara Brocato, consultant for the Maryland College of Emergency Physicians, presented their comments on the proposed bundled payment initiative.

Dr. Jaquis stated the Emergency Department (ED) is the safety net and last resort for people with no other access to care. According to Dr. Jaquis, the Health Care Reform legislation and the proposed bundling payment initiative will only increase the number of hospital Emergency Room visits. Dr Jaquis noted that until "medical homes" are in place to provide a continuum of care, EDs will continue to be the provider of choice for many people. Because they are a vital component of the health care system, it is essential to include ED physicians when bundled payment methodologies are crafted.

Ms. Brocato urged the Commission to facilitate physicians' ability to form large multi-disciplinary groups in order to create efficiencies. In addition, Ms. Brocato stated that the Commission should also support medical liability reform if the system is going to transfer risk to the physician.

Dr. Rothstein noted that ER physicians want to be part of the Commission's effort to make the health care system more efficient. Dr. Rothstein also urged the Commission to support medical liability tort reform.

Dr. Falcone expressed concern that the Commission seemed to be in a rush to develop, on a state-wide basis, something that has never been done before (the bundled payment initiative), and which may wind up penalizing the providers who have acted as the safety net for so long. Dr. Falcone also encouraged the Commission to look beyond the hospital-based physician model, which has failed in the past, as a solution to the problems of the health care system. Dr. Falcone suggested that there should be a relaxation of the restrictions on sharing payment and cost clinical information across medical practices. In addition, Dr. Falcone suggested that the Commission look to explore removing one of the biggest obstacles to lower cost of care - - access to clinical data across hospital information systems. Dr. Falcone stated that something has to be done to ensure that ED patients have access to specialists and consultants.

Dr. Thaler suggested that if hospitals are being over-utilized, rather than resorting to bundling payment to encourage efficiency, hospitals should be identifying and dealing appropriately with the physicians responsible for the excess admissions.

Dr. Roth, a practicing anesthesiologist, questioned why there was a bias against large integrated physician practices when they have proven to provide reduced cost and increased quality of care.

Commissioner Lowthers stated that the health care system in the U.S. is failing and must change. People need better health care for less money. Commissioner Lowthers observed that none of the stakeholders will likely be 100% happy with the final bundled payment initiative; however, the process must be transparent and inclusive. We must also remember why we are here, physicians, Commissioners, and hospitals. We are here to take care of the people of Maryland. They come first. Commission Lowthers stated that he welcomed the opportunity to help change the health care system.

Commissioner Sexton suggested that the Commission initiatives should build out from the hospital first with the goal to expand beyond the hospital.

Commissioner Bone urged that we make sure we are not building the perfect battleship for the last war, that is, we must be cognizant that the health care environment is always changing. Commissioner Bone noted that when we are devising systems to keep people out of the hospital, we must be aware that there must also be adequate non-hospital care available.

ITEM X
HEARING AND MEETING SCHEDULE

November 3, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
December 8, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:41a.m.