MINUTES
472nd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

November 3, 2010

Vice Chairman Kevin J. Sexton called the meeting to order at 9:32 a.m. Commissioners Joseph R. Antos, Ph.D., George H. Bone, M.D., C. James Lowthers, and Herbert S. Wong, Ph.D. were also present.

ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC SESSION OF OCTOBER 13, 2010

The Commission voted unanimously to approve the minutes of the October 13, 2010 Public Session.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, updated the Commission on the progress of current major initiatives and issues. The major items included: 1) final FY 2011 rate orders being provided to hospitals by mid-November; 2) case mix measurement period for FY 2012 will including a 3-month lag: 3) staff is reviewing the suggestions proposing changes in the Reasonableness of Charges (ROC) methodology and will utilize a focused analysis process so that the methodology for FY 2012 can be presented to the Commission in February or March 2011; 4) progress on the Maryland Hospital Preventable Re-admissions initiative will be presented at today's meeting; 5) the State Health Care Reform Coordinating Council is currently focusing on the expected impact of insurance reform; and 6) work continues on an evaluation structure for the Community Benefit Report.

Mr. Murray also summarized the progress of the Bundled Payment Initiative. Mr. Murray stated that five phases are currently being discussed: 1) bundled payment arrangements for hospital services only; i.e., Total Patient Revenue (TPR) and Admission Readmission Revenue (ARR) arrangements; 2) acute episodes including both hospital and physician services; 3) combinations of bundled payment categories, e.g., TPR plus pre and post hospital services including physician services; 4) expanded episode bundling around diseases; and 5) Accountable Care Organization approval mechanism.

According to Mr. Murray, next steps include: 1) a series of informational meetings to solicit input on all five phases, but particularly on phases two, three, and four of the initiative; 2) developing a Maryland Health Care Commission/HSCRC data user group to identify and explore future data needs to assist the initiative; 3) meeting with the Secretary of Health and Mental Hygiene and other stakeholders regarding possible revisions to the Medicare waiver; 4) obtaining demonstration project authority from the Centers for Medicare and Medicaid Services (CMS) where required; and 5) development of an ARR template and reporting the status of TPR

negotiations to the Commission at the December public meeting.

Commissioner Bone asked whether Mr. Murray expected that the initiative would move sequentially from phase I through phase V.

Mr. Murray replied that he expected that initially the main thrust would be in phase I with offshoots to lay the groundwork for phases II, III, and IV.

ITEM III
DOCKET STATUS CASES CLOSED

2080A- MedStar Health
2081A – Johns Hopkins Health System
2089A – Maryland Physicians Care
2091A - University of Maryland Medical
2092A - Johns Hopkins Health System
2093A - Johns Hopkins Health System
2094A - Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

Memorial Hospital at Easton – 2090N

On September 13, 2010, Memorial Hospital at Easton (the "Hospital") filed a partial rate application on behalf of the Queen Anne's Freestanding Emergency Medical Center (the "Center") requesting a Freestanding Emergency rate and rates for ancillary services to be provided at the Center. The Hospital requested that the rates be approved effective October 4, 2010.

Staff recommended that the following provisional rates be approved effective October 4, 2010:

Freestanding Emergency	$283.76	per Visit
Car Scanner	$22.55	per RVU
Laboratory	$1.22	per RVU
Radiology	$14.30	per RVU
EKG	$2.57	per RVU

The rate structure will be revisited later in the fiscal year when actual experience data are available and to consider:

1) Whether it would be appropriate to include the Center under a Total Patient Revenue structure;
2) The impact on the Medical Assistance Program's budget neutrality in FY 2011; and
3) The rates relative to those set for the Germantown Emergency Center and the Bowie Health Center that will be effective on July 1, 2011.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2095A

On October 22, 2010, the Johns Hopkins Health System filed an application for an Alternative Method of Rate Determination on behalf Johns Hopkins Bayview Medical Center (the "Hospital") requesting approval for the continued participation in capitated arrangement serving persons with mental health needs under the program title "Creative Alternative." The arrangement is between the Johns Hopkins Health System and the Baltimore Mental Health Systems, Inc, with the services coordinated through the Hospital. The requested approval is for the period of one year beginning November 1, 2010.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
REQUEST TO RESCIND PRIOR ICC/ROC RECOMMENDATION REGARDING MAJOR CAPITAL PROJECTS

Robert Murray and Jerry Schmith, Deputy Director-Hospital Rate Setting, presented staff's request to rescind the Inter-hospital Cost Comparison (ICC)/Reasonableness of Charges (ROC) methodology recommendation adopted at the June 9, 2010 public meeting. The recommendation approved would permit major capital projects to receive a 100% variable cost factor under certain conditions. After meeting with representatives of the hospitals and the payers to determine how a major capital project should be defined and how the policy should be applied, all parties agreed that since the policy applied to only a few hospitals, it would make more sense for staff to handle these situations on a case-by-case basis under the existing policy than to maintain a policy that was inconsistent with the general direction of other payment policies to constrain volumes.

In addition, staff pledged to re-visit the issue of how best to provide incentives for hospitals to take the "pledge" not to request additional revenue in rates for capital projects, in the context of the movement toward more bundled payment structures.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
FINAL RECOMMENDATION REGARDING MEDICAID CURRENT FINANCING FORMULA

The Medical Assistance Program (MAP) of the Department of Health and Mental Hygiene proposed that the FY 2011 Medicaid current financing amounts for each hospital correspond to its FY 2010 current financing deposit plus the final update factor as calculated by the HSCRC for the current rate year. MAP also proposed that changes to the current financing formula be delayed until its computer system is replaced and its new claims system has been implemented and evaluated.

Staff recommended that the Commission approve MAP's request with the stipulation that MAP be required to report annually, at the November public meeting, on the status of the implementation of its new claims system and, if necessary, apply for continuation of the application of HSCRC's update factor to hospital current financing deposits. In addition, staff recommended that the Commission direct MAP and MHA to begin development of a permanent current financing methodology for approval by the HSCRC for calculating current financing deposits for the first fiscal year after the implementation of MAP's new claims system.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
DRAFT RECOMMENDATION ON POTENTIALLY PREVENTABLE READMISSIONS METHODOLOGY

Robert Murray informed the Commission of the progress of the proposed Potentially Preventable Readmissions (PPR) Initiative (see the draft recommendation "Rate Methods and Financial Incentives Relating to Reducing Maryland Hospital Preventable Readmissions (MHPR)" on the HSCRC website).

Mr. Murray noted that the recent technical payment work group meeting held after the draft recommendation was released was very productive. Mr. Murray stated that it is anticipated that the MHPR will be implemented in April 1, 2011 commensurate with the initiation of the 3 month case mix lag with the measurement period to begin March 1st. This will allow time to try to gain consensus on the MHPR methodology.

Diane Feeney, Associate Director-Quality Initiative, identified the new portions of the draft recommendation. They include: 1) progress on Medical Record Number data issues (page 10); 2) proposal of a hybrid MHPR methodology to include both intra-hospital and inter-hospital measures (page 15); 3) a comment letter from the Maryland Hospital Association and a joint comment letter from the Johns Hopkins Health System and the University Of Maryland Medical System; and 4) reporting on related activities and next steps - - the clinical vetting session held on September 24th , the resulting convening of a mental health and substance abuse subgroup, the scheduling of a second clinical vetting session, a series of meetings with MHA, the Department of Health and Mental Hygiene, and the Maryland Patient Safety Center to discuss the organization, development, and funding of the MHPR infrastructure to assist hospitals in analyzing their own performance, as well as the re-convening of the MHPR Technical Finance Work group to address outstanding technical and payment issues (page 17).

Sule Calikoglu, Ph.D., Chief Quality Analysis, explained that intra-hospital PPR methodology measures improvement in readmissions to the same hospital while inter-hospital PPR methodology measures hospital attainment or relative improvement across hospitals. Dr. Calikoglu stated the staff advocates a hybrid MHPR methodology that gives equal weight to both intra-hospital improvement and inter-hospital attainment. Dr. Calikoglu noted that because of the problems associated with tracking patients across hospitals, MHA supports an intra-hospital only methodology.

Traci LaValle, of MHA, expressed MHA's support for the MHPR initiative; however, she stated that the incentives should be greater, and hospitals should be at risk for more revenue neutral scaling. Ms. LaValle added that MHA could not support the portion of staff's proposal that includes the measurement of readmissions across hospitals (inter-hospital) and rewards hospitals for achieving a lower readmission rate than the state-wide average. Ms. Lavalle noted that in its comment letter MHA advocates the adoption of the intra-hospital measure that rewards hospitals based on improvement compared with their own prior performance. According to Ms. LaValle, until we have reliable data to identify patients across hospitals, as well as patients readmitted to out-of state hospitals, we should focus on the intra-hospital model.

Ms. LaValle also expressed MHA's concern over the costs associated with implementing the MHPR program. Ms. LaValle presented a document based on data from Boston Medical Center and the University of Pittsburgh Medical Center (hospitals that have implemented structured readmission reduction programs) that indicated that the first year cost to Maryland hospitals for the MHPR initiative would be approximately $55 million. Ms. LaValle stated that the proposed funding to support the implementation of the MHPR initiative, 0.01% of net patient revenue (NPR), is inadequate to provide the necessary infrastructure needed.

Commissioner Wong asked whether MHA, by presenting data on the costliness of the program, was questioning whether we should move ahead with the program.

According to Ms. LaValle, MHA is trying to show that additional funding in hospital rates is needed for readmission reduction infrastructure. The data presented today are linked to the 0.44% additional funding requested by MHA in its payment update proposal for a readmission reduction program. Ms. LaValle stated that hospitals would be looking for this up-front funding in the final rate orders for FY 2011.

Commissioner Wong stated that one of the goals is to keep the start-up costs of the readmission reduction initiative revenue neutral and to put some funds at risk, whether it's an intra or inter-hospital measurement model. Dr. Wong asked whether MHA thought of the amount that should be put at risk in terms of budget neutrality.
Ms. La Valle stated that the focus has not been on this issue; however, per its comment letter MHA favors a more robust incentive rather than scaling.

Commissioner Wong observed that we should think about whether the software that produced that template presented today for implementing readmission reduction programs in Maryland hospitals applies to our situation. It may well apply to overall hospital readmissions; however,

we are narrowing the focus of our initiative to certain clinical conditions.

Ms. Feeney pointed out that the MHPR initiative does look at readmission rates across the board. Ms. Feeney noted, however, that the data presented today assume that there is no discharge planning being done at hospitals today, and that is inaccurate. Ms, Feeney noted that we do have an approach to look at the cost of the technical support portion of implementing the initiative. In addition, the State Action on Avoidable Rehospitalizations (STAAR) initiative is being implemented in 67 facilities in three states without up front funding. Ms. Feeney added that extrapolating the cost experience of Boston Medical Center, which has implemented Project RED (the Re-engineered Hospital Discharges program), to Maryland's MHPR initiative significantly overstates the resources needed.

Mr. Murray stated that it is very helpful having some level of cost detail available for the first time so that we can start discussions about the level of up front funding needed. The question becomes, if there is up front funding in rates (investment by the public), will there be a payback of the funding and some guarantee that there will be a return on the investment, i.e., future savings to the public.

Ms. LaValle agreed that there must be future system savings associated the initiative, and that those savings will compound over time.

Commissioner Bone asked why, since Maryland has a shortage of primary care physicians, there were no costs in the template associated with ensuring that physician care is available to prevent readmissions.

Mr. Murray indicated that from his discussions with hospitals that are proposing to go at 100% at risk for readmissions, there was sufficient incentive to encourage hospitals and physicians to participate in readmission reduction arrangements. Mr. Murray noted that it could be argued that all hospitals will be forced in this direction given the state of healthcare in the country.

Hal Cohen, Ph.D., representing Kaiser Permanente, expressed support for reducing readmissions. However, Dr. Cohen stated that it is important to remember that readmissions are a sub-set of the volume issue. Dr. Cohen pointed out that the payers have proposed significant incentives for reducing volumes and, of course, one way to reduce volumes is by reducing readmissions. Dr. Cohen stated that it is very important when setting the standard that the payers, as well as the hospitals should share in any savings generated by the MHPR initiative. Dr. Cohen proposed that inter-hospital system readmissions be measured along with intra-hospital readmissions as a compromise between MHA's intra-hospital readmissions only proposal and staff's inter-hospital and intra-hospital hybrid proposal.

Dr. Cohen observed that it did not seem appropriate for the Commission to provide in FY 2011 rates up-front funding for a full year, as requested by MHA, when a good portion of the year has passed.

Gary Simmons, Vice President-United Healthcare, praised the Commission and MHA for

targeting the readmission issue. Mr. Simmons stated that United Healthcare's position is that the MHPR initiative must include a process for paying back any advanced funding of the costs of implementing the program, plus a return on investment.

A panel consisting of Stuart Erdman, Senior Director of Finance of Johns Hopkins Health System, Eric Aldridge, M.D., Vice President of Medical Affairs Howard County General Hospital, Daniel J. Brotman, M.D., Director of the Hospitalist Program at the Johns Hopkins Hospital, and Amy Deutschendorf, R.N., Senior Director Utilization/Clinical Resource Management of Johns Hopkins Health System (JHHS), presented comments on the draft recommendation.

Mr. Erdman stated that the JHHS supported the MHPR initiative in principle; however, there were concerns about how it will be implemented. Mr. Erdman agreed that it was appropriate to use an incentive approach to control and reduce readmissions in the State. However, it is important to remember that initiatives to reduce readmissions represent a relatively new concept and are being aggressively studied across the nation on both a financial and clinical basis. Since we don't know the formula for success, we should take a measured approach to how we implement the program.

Mr. Erdman expressed agreement with MHA that there will have to be a significant investment over and above what hospitals are spending today in order to implement the MHPR initiative. Mr. Erdman expressed JHHS support for adoption of the intra-hospital measurement approach because of the problem with identifying patients across hospitals. Mr. Erdman noted that JHHS did not even have a unique patient identification number to identify patients among hospitals in its system. Mr. Erdman also questioned the HSCRC's ability to appropriately risk adjust across hospitals. According to Mr. Erdman, the intra-hospital measure captures 75% of readmissions and if expanded to an inter-hospital system measure, the percentage of readmissions captured will be even higher.

Dr. Aldrich stated that reducing readmissions is a wonderful idea; however, in order to motivate physicians to buy into the initiative, it must be successful from the beginning. Dr. Aldrich suggested that we start with a step-wise approach, perhaps running the intra-hospital model against the inter-hospital model and after a year see what we have learned. Dr. Aldrich stated that he was not advocating that we wait to implement the initiative, but that we start in a smart measured way because we cannot afford to get it wrong.

Dr. Brotman stated that in addition to taking care of patients directly, as Director of the Hospitalist Program he offers guidance to other practitioners and collaborates with nursing and other inter-disciplinary personnel on how best to coordinate care and take care of patients.

Dr. Brotman provided an example involving the decision of whether to insert a pacemaker in a patient or to try an incremental approach using medication. Dr. Brotman stated that in this particular case the incremental less costly care, although involving a readmission, was more cost efficient and produced the desired outcome without inserting the pacemaker. Dr. Brotman stated that he did not want physicians to believe that if they decided to take such a step-by-step approach, which involved a readmission rather a more costly treatment that would eliminate the

readmission, that they would be penalized by the initiative. According to Dr. Brotman, there needs to be simplicity and transparency so that the providers are not getting mixed signals.

Ms. Deutschendorf stated that as Chair of the JHHS Readmission Tack Force, she has been involved in developing strategies that target the things that hospitals have some control over - - care coordination and quality of care. Mr. Deutschendorf asserted that there are no national risk of readmission models that enables us to measure the potential for readmissions. According to Ms. Deutschendorf, physicians and other providers must understand the science behind the initiative and need to know that quality outcomes are evidence based.

Ms. Deutschendorf noted that since most of the national readmission strategies that have been initiated have been heavily funded by non-hospital resources, we do not know what the start-up costs of the initiative will be in Maryland.

Commissioner Bone asked Ms. Deutschendorf whether she thought that there were any of the variables in the PPR logic that hospitals could focus on to determine which cases have the risk of readmissions.

Ms. Deutschendorf stated that risk adjustment is specific to context. No one variable determines risk, you must look at multiple variables, e.g., mortality, severity of illness, co-morbidity. This makes inter-hospital comparisons, at this point, problematic.

Commissioner Bone asked if the PPR logic was adequate for intra-hospital readmissions.

Dr. Aldrich stated that the inter-hospital comparison is the “holy grail” that we hope to get to; however, at this point, the intra-hospital data are cleaner and more reliable and can be utilized now.

Mr. Erdman pointed out that the intra-hospital comparison eliminates many of the risk factors because you are dealing with a patient population whose risk variables, including chronic illnesses, co-morbidity, remain the same over time.

Commissioner Bone asked Mr. Erdman whether he had thought about the parameters for return-on-investment for the up-front costs to implement the readmission initiative.
Mr. Erdman stated that the initial costs will be substantial, and that most of the savings will not appear until year two or three. Mr. Erdman noted that hospitals are at risk because the MHRP limits payment for readmissions at the current level.
Commissioner Lowthers asked Mr. Erdman whether JHHS would stop implementing the readmission reduction infrastructure if it received no up-front funding in rates.
Mr. Erdman stated that the readmission infrastructure would still be implemented, but due to budget constrains, at a much slower pace.

Commissioner Wong stated that he appreciated the perspective of the people working on the frontline who are going to make the policy happen. Although the readmission issue is very challenging and has many moving parts, how it is implemented is really all about balance. If we were to wait for the perfect science to emerge and to understand all the components, we may

never implement the policy. The question then becomes do we have enough knowledge now to forge ahead with a policy that is fair. According to Dr. Wong, if the readmission measures are aggregated, the result is more accurate. Dr. Wong suggested that we must adopt a balanced policy that is fair and that motivates the people who have to implement the policy, but does not micro-manage their day-to-day operations.

VIII
SUMMARY OF THE FY 2009 DISCLOSURE OF FINANCIAL AND STATISTICAL DATA

Dennis N. Phelps, Associate Director-Audit & Compliance, summarized the annual disclosure of financial and statistical data for Maryland hospitals. The major highlights of the report were: 1) patients at Maryland hospitals paid on average 3% more in FY 2009 than in 2008, while the amount paid nationally was estimated to have risen by 4.5%; 2) the cost per admission in Maryland hospitals increased by 2% in FY 2009; 3) from FY 1977 through 2008, Maryland experienced the lowest growth in cost per admission of any state in the nation; 4) profits on regulated activities increased by 5.9%, up 0.7% in FY 2009; 5) profits on all operations, both regulated and unregulated, were up by 0.3% in FY 2009; 6) Maryland hospital total profits decreased substantially in FY 2009 from 1.4% to 0.65%; and 7) Maryland hospitals provided more than $999 million of uncompensated care in FY 2009.

Mr. Phelps noted that Maryland hospitals did a good job in FY 2009 in controlling expenses while increasing profits on regulated services. However, costs associated with unregulated physician services continued to be a significant problem for many hospitals.

ITEM X
HEARING AND MEETING SCHEDULE

December 8, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
January 12, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 12:08 p.m.