

**449TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION**

OCTOBER 8, 2008

Chairman Donald A. Young, M.D. called the meeting to order at 9:31 a.m. Commissioners Joseph R. Antos, Ph.D., Raymond J. Brusca, J.D., Trudy R. Hall, M.D., James Lowthers, Kevin J. Sexton, and Herbert Wong, Ph.D. were also present.

**ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC SESSION
OF SEPTEMBER 10, 2008**

The Commission voted unanimously to approve the minutes of the September 10, 2008 Public Meeting.

**ITEM II
EXECUTIVE DIRECTOR'S REPORT**

Robert Murray, Executive Director, advised the Commission that he had been contacted by the Secretary of Health and Mental Hygiene who indicated that the current economic crisis would necessitate cuts in the Medicaid program's budget. In addition, the Secretary requested that the Commission, its staff, and the industry focus on ways to address Medicaid's budgetary issues in order to avoid the imposition of arbitrary across-the-board measures. Mr. Murray asserted that it was staff's goal to attempt to find ways to alleviate Medicaid's budgetary problems without resorting to cost shifting such as the imposition of Medicaid Day Limits.

Mr. Murray reported that the Commission's Quality Initiative has focused on process measures, such as smoking cessation and the provision of aspirin to emergency patients with chest pain, which, so far, are correlated to positive outcomes and higher quality of care. The Commission's current quality-based project concentrates on 19 process measures. Mr. Murray noted that although process measures are the natural place to start, outcome measures, i.e., mortality rates, complication rates (including infection rates), and potentially avoidable re-admission rates, have the potential for more directly measuring the quality of care. As a result, there has been increasing interest in the Evaluation Work Group's focusing on outcome measures.

Mr. Murray stated that it has become the charge of the Work Group to find a way to incorporate outcomes measures into our pay for performance initiative. However, outcome measures have disadvantages; the need for risk adjustment, i.e., the ability to differentiate among populations of patients, and the capacity to identify complications that occur in the hospital. Mr. Murray

observed that Maryland has the tools to overcome both of these disadvantages because of; 1) our move to a more refined payment system utilizing APR-DRGs; and 2) the mandate by Medicare for hospitals nationally to code present on admission (POA) diagnoses. The extra sensitivity associated with APR-DRGs clearly shows the perverse incentive in payment related to potentially preventable complications and conditions, i.e., the payment system pays more and virtually mandates that we begin looking at outcome measures.

The Work Group is focusing on potentially preventable complications and potentially avoidable re-admissions. Utilizing logic provided by 3M, we will be able to develop list of potentially preventable conditions and complications that occurred during the hospital stay and calculate the rate of those complications by hospital. This will allow the Commission to focus on the outlier hospitals in order to identify those hospitals with statistically significant high rates of preventable complications or re-admissions for possible punitive action; and also to identify and reward those hospitals with the lowest rates of complications and re-admissions. Staff believes with the help of the Work Group, we can focus in on these two areas, preventable complications and re-admissions, to produce something of real value and national significance.

Mr. Murray reported that effective October 1, 2008, Medicare would no longer pay for a list of 11 “Hospital Acquired Conditions” that cause higher DRG payment and are reasonably preventable by the hospital. Medicare will remove the added diagnosis from the payment logic and reduce the payment for each case. However, because of the waiver Maryland is exempt from this initiative.

Because of on the Commission’s desire to link payment to quality and to ensure that Maryland does not lag behind the nation, staff has used the potentially preventable complication logic and has preliminarily identified a Maryland based list of 14 hospital acquired conditions that might be candidates for direct removal of payment increases resulting from reasonably preventable complications. Mr. Murray noted that this is primarily a quality of care initiative focusing on payment issues, which can help influence behavior to improve the quality of care for all patients. Maryland can take an approach that applies not only to a Medicare population but to an all-payer population and do it in a responsible and deliberate way.

Chairman Young asked whether there was the danger that hospitals would focus on measures that are included in the Commission’s quality project to the detriment of other measures.

Mr. Murray observed that any time you focus on a small sub-set of measures; there is a danger that hospitals will re-allocate resources to those measures, thereby compromising other types of care. To counteract that response, the staff is suggesting a two stage strategy: i.e., concentrate on conditions that are most preventable and have the highest impact on patient care quality and couple that with a broader initiative that spans all patient populations.

Commissioner Sexton commented that the use of the word “incentive,” as in perverse incentive is inappropriate in this context.

Mr. Murray stated that the term “unintended” incentives would be the more accurate term.

Commissioner Brusca commented that large insurers were following Medicare’s lead in not paying for these events.

Carmela Coyle, President of the Maryland Hospital Association (MHA), stated that we are discussing an issue of quality improvement, not an issue of payment. MHA supports the efforts to improve the quality of healthcare; however, the Commission should act with caution. With regard to hospital accountability for these events, the Commission should think in terms of two categories. Hospitals should be held accountable for, and negative payment incentives should be employed when, an event or condition is known to be preventable, within control of the hospital, and when there are evidence-based practices for how not to make the event occur again. However, potentially preventable events that are not clearly preventable belong in another category. As this issue is explored, it is important that the Commission consider when to link potentially preventable events to payment, and when the focus should be on continued performance improvement through education and information sharing.

Hal Cohen, Ph. D., representing CareFirst of Maryland and Kaiser Permanente, agreed with Ms. Coyle on the two categories of events: those that are preventable, and those that are sometimes preventable. However, Dr. Cohen stated that both types of events should be addressed through different responses in the rate setting system. Totally preventable events should not be paid for; whereas, for events that are not totally preventable, a reasonable rate of complication can be calculated, with adequate risk adjustment, to reward or penalize hospitals for being above or below that rate.

Ms. Coyle stated that the Commission should consider how we can align the conditions that are linked to payment with the kind of health care delivery system that we have or that we would like to have.

Mr. Murray asked John O’Brien, Deputy Director-Research and Methodology, to discuss the progress on revisions to the Inter-hospital Cost Comparison/Reasonableness of Charges (ICC/ROC) methodology. Mr. O’Brien reported that a staff recommendation will be presented at the December public meeting containing changes to the ROC/ICC methodologies involving: 1) blending the Charge per Case and Charge per Visit; 2) the Indirect Medical Education adjustment; and 3) the scaling of the Update Factor based on ROC ranking in lieu of spenddowns for the next ROC period.

Mr. Murray noted that the Community Benefit Report Work Group Advisory Group was looking into aligning the data included in the Community Benefit Report with national requirements.

Mr. Murray proposed that before forming a task force to address the Commission's role in regard to subsidies provided by hospitals to physicians, that staff first investigate the issues associated with the subsidies and report back to the Commission.

Commissioner Sexton asked how the physician subsidy issue would be approached.

Mr. Murray replied that staff will attempt to assess the extent and particulars of this issue before convening meetings with the industry.

ITEM III
DOCKET STATUS CASES CLOSED

1989N – Washington Adventist Hospital	1996A – University of Maryland Medical Center
1990N – Harford Memorial Hospital	1997A – University of Maryland Medical Center
1991A - Johns Hopkins Health System	1998A – University of Maryland Medical Center
1993A – Johns Hopkins Health System	2000A – University of Maryland Medical Center
1995A – Johns Hopkins Health System	2002A – Johns Hopkins Health Center

ITEM IV
DOCKET STATUS CASES OPEN

MedStar Health System – 1992N

On July 3, 2008, MedStar Health System filed an application on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital Center, and Union Memorial Hospital seeking approval for the continued participation of MedStar Family Choice in the Medicaid Health Choice Program for one year beginning January 1, 2009.

Because the last three year's experience and the projections for CY 2009 are favorable, staff recommended approval of the Hospitals' request for continued participation in the Medicaid Health Choice Program for a period of one year period beginning January 1, 2009. In addition, staff recommended: 1) that MedStar Family Choice report to the Commission's staff, on or before the July 2009 public meeting of the Commission on the actual CY 2008 performance, preliminary CY 2009 financial performance and projections for CY 2010, and 2) 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 – 2001A

On August 6, 2008, Johns Hopkins Health System on behalf of Johns Hopkins Hospital, Johns

Hopkins Bayview Medical Center, and Howard County General Hospital filed an application for approval for the continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program for a period of one year beginning January 1, 2009.

Because the last three year's experience has been favorable, staff recommended approval of the Hospitals' request for continued participation in the Medicaid Health Choice Program for one year beginning January 1, 2009. In addition, staff recommended: 1) that Priority Partners, Inc. report to the Commission's staff on or before the July public meeting of the Commission, on the actual CY 2008 performance, preliminary CY 2009 experience, and projections for CY 2010, and 2) that the approval be contingent on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Maryland General Hospital, St. Agnes Hospital, Washington County Hospital, and the Western Maryland Health System – 2003A

On August 27, 2008, Maryland General Hospital, St. Agnes Hospital, Washington County Hospital, and the Western Maryland Health System filed an application requesting approval for the continued participation of Maryland Physicians Care in the Medicaid Health Choice Program for one year beginning January 1, 2009.

Because the experience for CY 2007 and the projections for CY 2008 are favorable, staff recommended that the Hospitals' request for continued participation in the Medicaid Health Choice Program for a one year period beginning January 1, 2009 be approved. In addition, staff recommended: 1) that Maryland Physicians Care report to the Commission's staff, on or before the Commission's July 2009 public meeting on the actual CY 2008 performance, preliminary CY 2009 experience, and projections for CY 2010, and 2) 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 – 2004A

On September 5, 2008, 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, requesting approval for participation in a re-negotiated and expanded global rate arrangement for solid organ and bone marrow transplants with the United Resources Networks for a period of one year beginning September 1, 2008.

Because the experience under the previous arrangement was favorable over the last year, and

based on the review of the new and re-negotiated global rates, staff recommended that the Commission approve the request for one year effective September 1, 2008, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2005A

On September 5, 2008, 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, for approval to offer revised prices and expanded services under a re-negotiated global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplants for one year beginning September 1, 2008.

Because the experience under the previous arrangement was favorable under the prior arrangement, and based on the review of the new and revised global rates, staff recommended that the Commission approve the request for one year effective September 1, 2008, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

ITEM V **LEGAL REPORT**

Regulations

Proposed

Submission of Hospital Discharge Data Set to the Commission – COMAR 10.37.06.01-.05

The purpose of this action is to expedite the reporting process for discharge data and thereby avoid unnecessary delay in the Commission's continuing to obtain information that is invaluable towards promoting greater efficiency and effectiveness in the provision of hospital care.

Submission of Hospital Outpatient Data Set to the Commission- COMAR 10.37.04.01-.07

The purpose of this action is to expedite the reporting process for outpatient data and thereby avoid unnecessary delay in the Commission's continuing to obtain information that is invaluable towards promoting greater efficiency in the provision of outpatient services.

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

ITEM VI
HEARING AND MEETING SCHEDULE

November 5, 2008	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
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December 10, 2008	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
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There being no further business, the meeting was adjourned at 10:12 a.m.