

Template for Review and Negotiation of an Admission-Readmission Revenue (ARR) Hospital Payment Constraint Program

FINAL STAFF RECOMMENDATION

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1.0 Introduction

The United States health care system currently experiences an unacceptably high rate of unnecessary hospital readmissions. These excessive readmission rates are a symptom of our fragmented payment system and result in considerable unnecessary cost and substandard care quality. The purpose of this document is to describe the components of a proposed Admission-Readmission Revenue (“ARR”) episode payment structure designed to provide incentives for hospitals to improve overall care coordination and substantially reduce readmission rates. The recommendation also proposes a policy framework for the evaluation and approval of an ARR pilot for any hospital who agrees to adhere to a set of prescribed conditions and responsibilities. The ARR pilot initiative thus represents an important and urgently needed step in the Commission’s attempt to utilize its current regulatory authority to better rationalize Maryland’s hospital payment and delivery system.

1.1 Utilizing the Commission’s Current Authority to Reduce Readmissions

Similar to previous episode-based payment pilots developed by the Health Services Cost Review Commission (the “HSCRC,” or “Commission”) in past years, ARR pilots apply only to hospital services, are to be offered to Maryland hospitals on a voluntary basis, and are consistent with the HSCRC’s statutory and federal waiver authority.¹ Additionally, the implementation of the ARR payment pilots is compatible with other HSCRC payment policy and should not impact non-ARR hospitals or non-hospital provider reimbursement. As such, the ARR approach represents a logical continuation of the Commission’s efforts over the past 30 years to develop innovative and voluntary payment structures that provide better financial incentives to improve care coordination, overall quality of care and reduce health care costs.

This effort is also consistent with the increased national focus on reducing unnecessary hospital readmissions.² The Patient Protection and Accountable Care Act (the “ACA”) directs Medicare to implement a series of significant payment penalties for hospitals with high readmission rates, beginning in 2012. The Maryland Hospital system will be exempt from these penalties only to the extent that it can demonstrate to the Secretary of Health and Human Services that the system’s performance on reducing unnecessary readmissions meets or exceeds what is being required of hospitals nationally.³ The ARR pilot programs provide Maryland with an opportunity to chart its own course and demonstrate its ability to once again out-perform the nation. Yet, the time to do so is very short.

1.2 Need for a Broader Approach and Strategic Direction in the Development of Broader Payment Bundles that Include both Hospital and Non-Hospital Services

While the ARR approach is both timely and is consistent with current HSCRC regulatory authority, the staff and the Commission realize that further efforts to rationalize the Maryland health care delivery system will be needed. Moving beyond GIR, TPR and ARR hospital-based payment structures will require the development of a broader approach and strategic direction by the Commission. Discussions with various stakeholders and the Commission reveal the need to establish a more formal process for developing a policy framework to enable: 1) the establishment of long-term goals and performance metrics; 2) soliciting input from key stakeholders; and 3) select and design bundled payment initiatives

¹ The HSCRC’s Guaranteed Inpatient Revenue (or “GIR”) and the Total Patient Revenue (or “TPR”) payment structures are two important pre-cursors to the ARR that embodied these same features.

² See “Defragmenting Care” Editorial by Stephen F. Jencks, MD MPH, *Annals of Internal Medicine*, December 2010 (Attached as an Appendix III to this policy recommendation).

³ See the Patient Protection and Accountable Care Act Section 3025(q)(2)(B)(ii).

that include both hospital and non-hospital services. This broader effort should be aligned with current efforts on the part of the HSCRC, Secretary of Health, hospitals and payers to “Modernize” Maryland’s All-Payer waiver.

Staff believes that this broader approach should not be either physician-centric or hospital-centric, but rather patient-centric and population-centric in nature. The realization of this goal will however, require the cooperation of both hospitals and physicians and the alignment of financial incentives of all providers. We believe the All-Payer nature of our system coupled with our commitment to better align financial incentives across the health care system will encourage hospitals and physicians to work cooperatively to help the State achieve this overarching goal.

There is currently an economic imperative to pursue these remedies, given the eroding affordability of health care in this country. There is also a clinical imperative given that our fragment payment structure all too often results in ineffective and uncoordinated care. Given Maryland’s distinct advantages, we believe the State is on the threshold of substantively addressing these deficiencies and making major strides toward the goal of ensuring and promoting the health of patient communities and populations, broadly defined.

2.0 Admission-Readmission Revenue (ARR) Hospital Payment Pilots

2.1 Background – A History of HSCRC Payment Innovation

Since the inception of hospital rate regulation in Maryland, the HSCRC has experimented with innovative methods of hospital reimbursement. Pursuant to the provisions of Health-General Article, Section 19-219 and COMAR 10.37.10.06, the Commission may approve experimental payment methodologies that are consistent with the HSCRC’s legislative mandate to promote effective and efficient health service delivery and primary policy objectives of cost containment, expanded access to care, equity in payment, financial stability, improved quality, and public accountability.

Our fragmented system for reimbursing health services in this country has, for the most part, provided large disincentives for hospitals and other providers to construct efficient and effective coordinated care models. To address these deficiencies, the HSCRC has implemented episode-based reimbursement and broad-based quality of care Pay-for-Performance (“P4P”) methods designed to promote lower cost and higher quality care. These reimbursement methods include the implementation of the following landmark payment mechanisms: 1) the Guaranteed Inpatient Revenue system - the nation’s first Diagnostic Related Group (“DRG”) based per case payment structure; 2) the Total Patient Revenue structure - a global budget or capitated payment structure covering a given hospital’s inpatient and outpatient regulated facility charges; and 3) the Charge per Visit (“CPV”) structure – a bundled payment system covering the vast majority of hospital outpatient services.⁴ The Commission’s three P4P quality of care initiatives: the Quality-Based Reimbursement (“QBR”); Maryland Hospital Acquired Condition (“MHAC”); and the planned Maryland Hospital Preventable Readmission (“MHPR”) also depart from national approaches by

⁴ The GIR, CPV, and TPR systems are examples of bundled payment structures that place hospitals at risk for service use. The GIR system which evolved into the Charge per Case system in 2001) imposed a case mix adjusted per case constraint on services used per inpatient stay. The CPV imposes a case mix adjusted constraint on services used per outpatient encounter. The TPR, the broadest of the three structures, establishes a global cap on all hospital inpatient and outpatient services for a particular hospital.

virtue of their broad-based and normative methodologies and are superior in their capacity to provide positive change.

During the era of Managed Care domination, in the mid 1990s, the Commission also used its Alternative Rate Methodology (“ARM”) authority to allow hospitals to enter into at-risk arrangements with specific commercial payers. These ARM arrangements were generally fixed payment structures that bundled both hospital and non-hospital health services around an acute episode (global case rates for specific DRGs) or were applicable to services provided for a population of patients (capitation or partial capitation). ARM arrangements, thus, differed from other core Commission reimbursement methods in that they included non-hospital services and resulted from a specific arrangement between a given hospital and commercial payer.⁵

GIR and TPR arrangements were similar to ARM contracts in that they resulted in hospitals assuming additional financial risk; however these payment structures applied to hospital services only, covered all payers, and were executed on a voluntary basis by hospitals directly with the Commission. The proposed ARR reimbursement structure similarly applies to hospital services only; it would be applied under the Commission’s all-payer rate setting authority; and it would necessitate the execution of a voluntary agreement between a pilot hospital and the HSCRC.

2.2 Historical Approval Process for Experimental Payment in Maryland

Because GIR and TPR rate structures built on the HSCRC’s all-payer unit rate setting system and were natural evolutions in the process of episode-based hospital payment, the Commission adopted a review and approval policy that included the approval of an overall Policy Template outlining the overall structures of the arrangements, including the evaluation criteria, reporting requirements, rate adjustments, and compliance and monitoring requirements. Once this Policy Template was approved, the Commission then delegated the authority to the HSCRC staff to apply the approval criteria contained in the Template and negotiate GIR and TPR arrangements with individual hospitals on a voluntary basis. This approach achieved a balance between ensuring sufficient oversight of the approval process by the Commission while maintaining the ability to be sufficiently responsive and flexible in implementation of these arrangements.

Under this approach, the staff would apply the Commission-approved terms and requirements on a consistent basis – but could have some limited flexibility to respond to unique circumstances of individual hospitals. An agreement detailing the terms and requirements was then executed between the Commission and the given hospital, and the staff was then required to summarize each negotiated arrangement publicly before the Commission.

This document proposes a similar approval policy for ARR arrangements for the upcoming Fiscal Year (FY 2012).

2.3 Factors Prompting the Development of ARRs

⁵ It should be noted that while the bundled payment structures approved under the Commission’s ARM authority were similar in principle to some of the payment arrangements contemplated in the HSCRC’s current Bundled Payment Initiative, managed care-driven payment reforms of the mid-1990s were based more on managing cost and discounting payment than they were on managing care and developing integrated delivery systems. The resulting backlash by patients and providers was major factor in the reversion of the health system to fee-for-service payment mechanisms, consumer-focused reforms, and significant provider consolidation in recent years. (Accountable Care Organizations: Will They Deliver? Marsha Gold. Policy Brief January 2010. Mathematica Policy Research Inc.).

There are a number of economic and environmental factors motivating this effort – including the recent passage of National Health Insurance reform and concerns about the affordability of care and financial sustainability of our current health care system. Dramatic slowing in hospital volume growth and the Commission’s need to mirror tight updates nationally have also brought many to the realization that we must look for other ways to ensure the financial sustainability of Maryland’s hospital/health system.

Commensurate with these events is a recognized need to transition our health care delivery system toward a more coordinated care model, focusing on promoting health of populations and, at the same time, improving efficiency and quality of the care delivered.

Given the existence of the All-Payer rate setting system, a more organized hospital system, and other key regulatory and market dynamics, the State of Maryland has a unique opportunity to restructure the health care delivery system to achieve these overarching goals.

Under the current Charge per Case reimbursement structure, payers pay for all admissions based on the patient’s diagnosis, regardless of whether we are dealing with an initial stay or a readmission for the same or a related condition. As such, our system, as currently structured provides strong financial disincentives against the establishment of coordinated care models that can successfully avert many readmissions.

Although some may call for the development of these care coordination structures before placing hospitals at financial risk for readmission performance, this argument ignores a basic lesson of hospital financing learned over 30 years of rate setting experience. Hospitals respond to financial incentives. As long as the current financial incentives remain in place, no substantive delivery system change will occur. Instead, hospitals must be sufficiently and properly incentivized in order for them to invest adequate resources in the needed care delivery models to reduce readmissions.

2.4 Substantial Evidence - Care Transition Improvements Can Reduce Readmissions

There is now substantial evidence to show that targeted interventions by hospital and other clinicians can substantially reduce the level of unnecessary rehospitalization in the U.S. health care system. According to a report to Congress by the Medpac (the Commission that advises Congress on Medicare payment and policy issues) in June 2008, many readmissions can be avoided by improving certain aspects of care:

“For example, by furnishing better, safer care during the hospital stay, providers can avoid complications that necessitate readmissions. Attending to patients’ medication needs at discharge also makes a difference. Medication errors after discharge are not uncommon and contribute to readmissions. Improving communication with patients before and after discharge also reduces the need for readmission. Patients are often not adequately informed about self-care. Similarly, improving communication with other providers is important. Too often discharge summaries are not complete and are not available at the time of the first post discharge physician visit.”

Additionally, a recent editorial by Dr. Stephen Jencks, an advisor to Medicare and the Institute for Health Improvement, identified “compelling evidence from a series of controlled studies, in which interventions to improve the transition from hospital to post hospital care have reduced rehospitalizations by 30% to 50%.” Dr. Jencks believes that this evidence shows that the readmissions problem in the United States is a function of our fragmented payment system and more a failure of those transitions, than a “willful overuse of hospital services.”⁶ Spending on readmissions in Maryland is considerable and accounts for much of the variation in spending for hospitalization episodes (see Table 1). Within 30 days of discharge, 16.6% of admissions are readmitted to the same facility (“intra-hospital” readmission), accounting for

⁶ See “Defragmenting Care” Editorial by Stephen F. Jencks, MD MPH, *Annals of Internal Medicine*, December 2010 (Attached as an Appendix III to this policy recommendation).

over \$1.2 billion in overall Maryland hospital spending in 2010 (out of a total of approximately \$9 billion spending on inpatient hospitalizations in FY 2010). Not all these readmissions are avoidable, but a high proportion of them are.⁷ Utilizing Dr. Jencks’ estimates for potential readmission reduction, the Maryland system could potentially realize annual savings of between \$360 and \$600 million annually from successful and broad-based implementation of the ARR and TPR payment pilots. These savings can be effectively redeployed to: 1) help ensure the financial sustainability of Maryland’s health care industry; 2) help finance the cost associated with the insurance expansions authorized by the ACA; and 3) be returned in part to business, labor, families and tax-payers who are increasingly demanding better value for their health care dollars.

Table 1 also illustrates the remarkable stability in intra-hospital readmission rates across hospitals overtime.⁸

Table 1

Raw Intra Hospital All-Cause 30 Day Readmissions (no adjustment for out of state readmissions)

Hospital	provno	Fiscal Years Ending						Annual Average Change 2005-2010	Hospital Type
		2005	2006	2007	2008	2009	2010		
Laurel	210055	12.5%	11.1%	11.6%	12.0%	12.0%	11.3%	-0.3%	Border
WAH	210016	14.9%	14.8%	14.6%	13.8%	14.3%	14.4%	-0.1%	Border
Suburban	210022	16.4%	16.0%	16.3%	17.1%	16.8%	16.4%	0.0%	Border
Shady Grove	210057	11.4%	11.6%	11.1%	11.6%	11.9%	11.5%	0.0%	Border
Holy Cross	210004	9.9%	9.8%	9.9%	10.1%	10.3%	10.8%	0.2%	Border
PG	210003	10.4%	10.4%	9.8%	10.2%	11.5%	11.4%	0.2%	Border
Cumberland	210025	16.7%	16.8%	15.8%	16.2%	16.0%	9.8%	-1.4%	Rural
Garrett	210017	16.4%	14.7%	16.6%	15.7%	14.2%	14.3%	-0.4%	Rural/Border
Western MC	210027	24.9%	25.1%	25.5%	24.4%	24.4%	22.9%	-0.4%	Rural
Easton	210037	18.9%	17.6%	17.9%	17.6%	18.2%	17.0%	-0.4%	Rural
Dorchester	210010	22.4%	21.7%	22.0%	22.0%	22.3%	20.8%	-0.3%	Rural
Atl General	210061	17.6%	17.7%	17.5%	17.5%	18.3%	17.2%	-0.1%	Rural
McCreedy	210045	NA	NA	NA	NA	NA	NA	0.0%	Rural
Harford	210006	21.4%	21.2%	19.9%	21.3%	22.7%	21.9%	0.1%	Rural
Carroll	210033	19.2%	18.8%	19.5%	20.0%	20.3%	19.8%	0.1%	Rural
Wash Co	210001	16.8%	16.9%	17.6%	17.3%	17.2%	17.6%	0.2%	Rural
Frederick	210005	15.8%	16.0%	16.7%	17.0%	17.6%	16.7%	0.2%	Rural
PRMC	210019	18.1%	18.6%	18.0%	18.2%	18.3%	19.0%	0.2%	Rural
Chester	210030	18.7%	19.5%	20.8%	20.0%	19.2%	19.7%	0.2%	Rural
Union Cecil	210032	19.6%	20.2%	19.5%	21.0%	21.2%	20.7%	0.2%	Rural
St. Marys	210028	15.5%	17.8%	17.7%	18.3%	18.4%	16.6%	0.2%	Rural
Civista	210035	14.8%	15.1%	15.7%	16.6%	16.9%	16.7%	0.4%	Rural
Ft. Wash	210060	14.2%	14.3%	12.7%	13.9%	14.2%	13.1%	-0.2%	Suburban
Calvert	210039	16.4%	16.7%	15.2%	15.0%	15.1%	15.5%	-0.2%	Suburban
S. Md	210054	16.8%	16.1%	16.0%	16.0%	16.6%	16.0%	-0.2%	Suburban
St. Joe	210007	14.3%	14.5%	14.7%	15.6%	15.8%	14.0%	-0.1%	Suburban
Doctors	210051	19.1%	19.5%	18.6%	19.4%	19.1%	18.9%	-0.0%	Suburban
BWMC	210043	21.5%	21.3%	21.3%	21.3%	22.2%	21.4%	-0.0%	Suburban
St. Agnes	210011	17.3%	16.4%	16.1%	15.6%	16.5%	17.2%	-0.0%	Suburban
Anne Arund	210023	12.5%	12.3%	12.0%	12.2%	12.8%	12.7%	0.0%	Suburban
GBMC	210044	11.2%	12.1%	11.3%	11.3%	11.8%	11.6%	0.1%	Suburban
Howard	210048	11.8%	12.5%	12.7%	11.7%	11.8%	12.3%	0.1%	Suburban
FSQ	210015	17.7%	17.6%	17.9%	18.1%	18.6%	18.3%	0.1%	Suburban
Northwest	210040	19.8%	20.0%	19.5%	19.9%	20.7%	20.6%	0.1%	Suburban
Montg Gen	210018	16.0%	16.5%	17.3%	16.8%	16.9%	16.8%	0.2%	Suburban
Upper Ches	210049	16.0%	16.4%	16.0%	16.0%	16.8%	17.3%	0.3%	Suburban
JHH Onc	210904	27.8%	27.4%	27.3%	27.0%	27.3%	27.3%	-0.1%	Teaching
MIEMSS	218992	NA	NA	NA	NA	NA	NA		Teaching
UMCC	218994	NA	NA	NA	NA	NA	NA		Teaching
JHH	210009	17.8%	17.8%	17.8%	18.2%	18.0%	17.9%	0.0%	Teaching
UMMS	210002	17.2%	17.3%	17.7%	16.9%	17.6%	17.9%	0.1%	Teaching
JH Bayview	210029	16.8%	16.8%	17.2%	17.2%	17.6%	18.3%	0.3%	Teaching
Kernan	210058	7.7%	9.3%	8.2%	7.6%	5.7%	6.8%	-0.2%	Urban
Bon Secours	210013	23.3%	23.9%	24.8%	23.2%	22.3%	22.7%	-0.1%	Urban
Union	210024	18.2%	18.4%	17.6%	17.2%	18.2%	18.4%	0.0%	Urban
Mercy	210008	14.3%	15.0%	14.2%	14.8%	14.9%	14.5%	0.0%	Urban
Harbor	210034	16.9%	16.7%	16.4%	17.2%	17.3%	17.3%	0.1%	Urban
Good Sam	210056	23.6%	24.0%	24.3%	24.4%	24.1%	24.0%	0.1%	Urban
Sinai	210012	15.6%	15.9%	15.2%	15.6%	16.0%	16.7%	0.2%	Urban
Md Gen	210038	18.6%	19.4%	19.8%	20.0%	20.2%	20.7%	0.4%	Urban
State		16.2%	16.3%	16.2%	16.3%	16.6%	16.6%	0.1%	

⁷ Note: “intra-hospital” readmissions are a subset of total readmissions (readmissions back to the same hospital and readmissions to other facilities – also called “inter-hospital” readmissions). Intra-hospital readmissions account for approximately 70% of total readmissions in the State.

⁸ Note: the difference in magnitudes of intra-hospital readmission rates across facilities may well reflect differences in the service area configurations and patient populations of facilities. For instance, due to their relative isolation, rural facilities will naturally experience much higher rates of readmission than would hospitals in more densely overlapping services areas.

2.5 Admission-Readmission Revenue Arrangements - General Description

Like the GIR and TPR payment arrangements that preceded it, the proposed ARR structure would build on the all-payer unit rate setting system and may be considered a natural progression in the Commission's efforts to rationalize the health care financing system in Maryland. ARRs are also consistent with the Commission's philosophy for the development of episode-based and bundled payment (one of incrementally building out payment bundles around the acute hospitalization by gradually expanding the scope of services and the window of time over which the services are provided).⁹ Additionally, ARRs are consistent with major longstanding Commission policy goals – to ensure the long-term financial sustainability of the Maryland hospital and health care system, while simultaneously achieving better outcomes and more effective and efficient care delivery over the long term.¹⁰

All bundled payment arrangements involve a transfer of financial risk from payers to providers, and the ARR is no exception. As currently conceived, the ARR structure would hold hospitals at-risk for controlling the number of cases that are readmitted to the facility following an initial admission. However, the level of financial risk transferred to providers under an ARR falls somewhere in between the level of risk transferred under the GIR and TPR (under the GIR, hospitals were at risk for controlling utilization per case, while under the TPR, hospitals are at risk for controlling all inpatient and outpatient utilization).¹¹

It is contemplated that readmissions under the ARR at-risk structure would be defined as any readmission (otherwise referred to as “all-cause readmissions”) to the same hospital facility (or groups of hospitals in a common health system) within 30 days of the most recent discharge.

2.6 Proposed Operational Structure

Like the GIR and the TPR, the ARR arrangement would impose a constraint on the amount of revenue a hospital could keep during a particular year. Hospitals would still be paid HSCRC approved unit rates – rates based on the units of service provided for any given case. These unit rates would still be updated on an annual basis per the Commission's normal inflation update process, with any associated adjustments for price compliance, case mix change, volume change and ROC, MHAC and QBR scaling provisions. Like the GIR and TPR, hospitals would then be responsible for managing utilization in order to meet their pre-established revenue constraints. But unlike the GIR (where hospitals' allowed revenues were determined by the number of admissions times a case mix adjusted CPC standard) and the TPR (where hospital revenues are constrained by a global budget revenue cap – regardless of underlying volumes),

⁹ While the rationale for bundling payment is compelling, the HSCRC staff believes that an incremental approach is necessary to improve incentives, while, at the same time, being able to adjust for the level of financial risk assumed and avoiding large-scale unintended consequences. An incremental approach is also appropriate because it will allow the Commission the ability to match the financial incentives provided to the ability of providers to operationalize the necessary coordinated care structures. Small financial incentives have less influence than large ones, but achieving effective change will require balancing financial risk and provider capabilities.

¹⁰ See the staff's discussion document entitled, “Commission-Directed Initiative to Establish a System of Bundled Payment Structures to Promote Coordinated Care Delivery and Access to Affordable and High-Quality Care,” presented to the Commission on October 13, 2010.

¹¹ Staff would further note that while the ARR structure will involve bundling more revenue than the current GIR/CPC per case constraint system, the amount of revenue under the arrangement and at risk financially is relatively small compared to that assumed by hospitals under a TPR constraint structure. ARRs could cover 7-8% of hospital revenue for a given ARR facility vs. 100% of revenue being subject to a cap under the TPR structure.

hospitals under ARR arrangements would still be held to a standard Charge per Episode (“CPE”) that would provide a combined revenue constraint for both initial admissions and subsequent readmissions, up to a limit of three readmissions.

Appendix IV provides details of the steps in the calculation of the rate for the initial admissions. Basically, this rate is increased relative to the rate that would be set under the CPC so that it includes a component to cover the charges that were associated with included readmissions in the base year. The hospital will receive this addition to cover readmissions in the rate year and it will be independent of the actual number of readmissions in the rate year. Thus, the hospital will benefit to the extent readmissions drop, and will have to absorb the costs of any increase in readmissions.

As with the GIR, hospitals may find this ARR structure attractive because it provides them with a strong financial incentive to put in place the care coordination mechanisms necessary to reduce the potential for any patient to be readmitted and keep 100% of the savings associated with that outcome. Allowing for the retention of 100% of the savings enables hospitals and related providers to generate sufficient funding to invest in the needed care coordination infrastructures. It also begins to remove the current disincentives providers face to treat in a holistic and comprehensive fashion. Patients will stand to benefit because they will likely receive better overall care and avoid additional unwanted and costly acute hospitalizations. The positive impacts of this approach are significantly enhanced by the All-Payer nature of the Maryland system in that these more rational and effective care mechanisms can be applied to all patients, public and private.

The health care system would benefit from this arrangement because hospital efforts to reduce intra-hospital readmissions will also likely reduce inter-hospital readmissions. Further savings to the system may accrue as improved discharge planning and better coordinated post-acute care help reduce repeat emergency department visits and other avoidable episodes of care.

The health system may also stand to gain if hospitals, now reaping the benefits of improved productivity in the form of better care coordination for readmission cases, are able to sustain tighter annual updates by the HSCRC. This is the same dynamic that allowed the HSCRC to outperform the rest of the nation following the implementation of the GIR. Under the GIR constraint, Hospitals “cannibalized” excess use of days and ancillaries per case and were allowed to retain these savings. These productivity gains achieved and retained by hospitals allowed for the implementation of tighter annual updates by the Commission (relative to what was experienced nationally). This basic structure enabled Maryland to move from a position of over 24% above the U.S. on hospital cost per adjusted admission in 1976 to over 11% below the U.S. in 1993.¹²

Based on preliminary discussions with several hospitals and per past practice of the Commission when implementing experimental payment methodologies, it is likely that ARR pilot programs will seek approval for a three year term of operation.

2.7 Example of an ARR

A simplified example of this ARR-CPE structure is shown in Table 2 below. It illustrates the results for two different readmission scenarios for a hospital with \$100,000,000 of inpatient revenue, 10,000 total admissions (including 1,000 readmissions) and an average charge per case of \$10,000.

¹² Over this period, Maryland hospitals received annual updates of inflation plus 1% on average vs. annual updates nationally of inflation plus 2 to 3%.

Assuming the hospital treats the same profile of patients in year 2 as in year 1, Scenario 1 contemplates a 30% reduction in the number of readmissions. Scenario 2 contemplates a 30% increase in the number of readmissions. In Scenario 1, in the absence of the ARR structure, the hospital would realize a \$1 million reduction in its revenue. This result shows why hospitals currently face strong financial disincentives to develop coordinated care models designed to reduce readmissions. However under the ARR, the hospital is guaranteed the \$1,000,000 associated with their historical readmission performance (the original CPC of \$10,000 x 1,000 historical base readmissions) or \$100,000,000 in overall inpatient revenue absent changes in the number of admissions. If the hospital successfully reduces readmissions through better care transition, it is rewarded by being allowed to keep 100% of the savings it created. The savings is realized through an increase in the approved charge per case associated with other admissions. This increase to the original \$10,000 CPC (an increase of \$345 per case in this example) is tantamount to an extra surcharge that provides a warranty to payers against having to pay for readmissions.¹³

Table 2 – ARR Example

Admission-Readmission Revenue (ARR) Example

Ground Hog's Year 2

Year 2 - reflects exact same profile of patients as Year 1 except for changes in Readmissions

Simplified Example

Line	Year1	Scenario 1 Hospital Reduces Readmissions by 333		Scenario 2 Readmissions Increase by 333	
		Year2	Year2	Year2	Year2
1 Admissions	10,000	9,667		10,333	
2 Approved charge per case (beginning of year)	\$10,000	\$10,000		\$10,000	
3 Total Inpatient Revenue Generated	\$100,000,000	\$96,666,000		\$103,333,000	
4 Bonus (loss) for readmission performance		\$3,334,000		(\$3,333,000)	
5 Total Inpatient Revenue Allowed to Keep		\$100,000,000		100,000,000	
6 Readmissions	1,000	667	RA's down by 333	1,333	RA's up by 333
7 Pct readmitted	10.00%	6.90%		12.90%	
8 Surcharge (Reduction) per case due to ARR performance		\$345		(\$323)	
9 Total Actual Charge per case Retained at end of year		\$10,345	Avg. CPC needed to "Hit" Target Revenue	\$9,677	Avg. CPC needed to "Hit" Target Revenue

In Scenario 2, the hospital realizes a 30% increase in its readmissions. Since the hospital is 100% at risk for readmissions, any increase in the number or readmissions (all other things being equal) will result in a reduction of \$323 in their approved charge per case for all other cases. This is because payers are guaranteed to pay no more than they did for the base level of readmissions (1,000 readmissions x \$10,000

¹³ In this case, however, the warranty amount is structured to provide the hospital with 100% of the savings associated with reduced readmissions.

per case) or \$100,000,000 in total inpatient revenue for the hospital (all other things being equal). In this case, the hospital must lower its average charge per case for each initial admission to avoid having payers pay for the increased level of readmissions.

2.8 Other Considerations

1) Consistency with HSCRC Rate Methods

As with the GIR and TPR – the Commission staff will make sure that the proposed ARR arrangements are structured to account for all necessary adjustments to rates through the application of the Commission’s annual rate updates and unit rate compliance during the course of the year. Any exclusions or additional adjustments must also be identified and described.¹⁴ The precise methodology for how the Charge per Episode constraints would be established is contained in Appendix III. CPE and unit rate compliance will be handled similarly to current CPC/unit rate compliance.

2) Ensuring Accountability and Quality of Care

Also, as is articulated in the Patient Protection and Accountable Care Act, it is important that as providers are gradually given more responsibility and budgetary autonomy for reducing utilization, they also be held accountable to the public for more efficient and effective operation. A concern about more bundled payment structures is that they may encourage providers to provide insufficient care. The first form of protection against this unwanted result is the use of robust risk-adjustment systems and methods to account sufficiently for variations in illness severity of patients and appropriately match payment to the required level of resource use. Beyond this, the public can be protected through the use of outlier payments and exclusions for unusual cases, while providing financial rewards and penalties to hospitals based on their performance on various process and outcome measures. Hospitals should thus be monitored on quality measures -- particularly for minority and disadvantaged populations.

As noted above, in addition to the economic imperative to inject more rational financial incentives into our payment system, there is a clear clinical imperative as well. In recent years, the Commission has initiated a number of quality measures and has plans for the addition of other metrics and analyses that will help the HSCRC better understand the interaction between various process and outcomes measures over time. These quality metrics are far broader than those in place nationally and give Maryland a further advantage in assuring that our health system will meet our goal of enhancing the overall value of the care delivered by providers in the State. Although the Commission has not found a direct relationship between the level of financial risk assumed by hospitals under various bundled payment structures and their resulting performance on current quality measures, it is important that the Commission monitor the quality performance of hospitals entering into ARR arrangements. In order to achieve maximum improvements in the value of the care delivered over the long-term, financial incentives should be focused equally on improving quality and containing cost.¹⁵

The Commission should also monitor other utilization trends and system performance metrics over time – such as the rate of emergency room visits, observation cases, and admission of ambulatory sensitive cases. If the overall goal of bundled payment initiatives is to reduce overall system utilization and expense, then

¹⁴ It is anticipated that zero and one day length of stay cases, planned readmissions, categorically excluded cases, and outlier trim revenue will be excluded from the ARR-CPE.

¹⁵ Accountable Care Organizations: Will They Deliver? Marsha Gold. Policy Brief January 2010. Mathematica Policy Research Inc.

it is important that reductions in unnecessary readmissions are not accompanied by increases in Emergency Room visits, observation cases, and rates of admission for ambulatory sensitive cases.

3) Potential Remedies for Unanticipated Events

Additionally, readmission rates may be influenced by changes in the mix of a hospital's patient population over time. Adjustments to the methodology may be required in the event of a major change to a facility's service mix or mix of indigent patients. Finally, it is important that any agreement between a hospital and the HSCRC related to the implementation of an ARR arrangement also specify potential remedies for unanticipated circumstances outside the control of the hospital. Examples of such factors include an influenza epidemic or a major natural or terrorist disaster in the area, which results in a larger than usual number of hospitalizations and potential readmissions.

3.0 Consistency with Current Commission Policy Goals

In devising and recommending a policy framework for the eventual approval of ARR arrangements with hospitals, it is important that these arrangements be consistent with the long-standing policy objectives of the HSCRC and the overarching goal of payment reform as articulated by the Accountable Care Act: that of promoting delivery system change resulting in improved value of our health care (reduced total spending and improved overall quality) and focusing more effectively on improving the health of populations broadly defined. The following discussion attempts to assess the potential for the ARR payment approach to be consistent with these policy objectives and overarching goal.

In addition to these overarching goals and objectives, the staff is optimistic that these pilot bundled payment arrangements will demonstrate the ability of hospitals and health systems to clinically integrate their care services, manage increased financial risk, and generate much needed productivity and quality improvements. This experience will be important for the Commission as it seeks to expand the number of hospitals operating under bundled payment arrangements and expand the scope and window of services contained in payment bundles in the future.

3.1 Potential for Achieving HSCRC Goals and Broader Health System Change

Staff believes that the ARR arrangements are consistent with the following long-standing objectives of the Commission:

a) Financial Stability and Access Considerations

As noted, a primary rationale for expanding the Commission's arsenal of bundled payment structures relates to the need to provide hospitals and other providers with additional incentives and opportunities to generate productivity improvements and cost savings. These cost savings (if retained by providers) can be a major source of funding and help ensure the financial sustainability of the Maryland health care industry.

Reductions in utilization realized by hospitals (such as reduced intra-hospital readmissions) operating under at-risk bundled payment arrangements should also result in a more affordable health care system and, at the same time, free up the capacity needed to treat additional patient volumes associated with future health insurance expansions authorized by the ACA and the health needs of an aging population in the State.

However, this new source of funding will only be available for hospitals and health systems that are most successful in producing higher levels of efficiency and effectiveness in operation. Ultimately, required reductions in the overall level of health care expenditures will not support our provider infrastructure as it is currently configured. And, commensurate with the ability of hospitals to generate additional productivity in their operations, the HSCRC must seek to bend the cost curve so that the paying public also benefits from these activities through more affordable health care.

Navigating through this period will prove challenging as long as the health care financing system is transitioning from a largely fee-for-service paradigm to a system that is highly integrated clinically and financially. Yet, the staff believes that the HSCRC is uniquely positioned to move the Maryland hospital industry toward this more productive fixed cost and clinically integrated model. If successful, it will allow for the financial stability of the provider industry and, at the same time, facilitate the access expansions mandated by the recently passed national health reform and necessitated by a rapidly aging population.

b) Maintaining Payment Equity

Payment equity was an issue in the context of ARMs – because they were payer specific and they potentially played into the managed care strategy of discounting to generate needed savings. Discounting without care management inevitably resulted in a transfer of an excessive amount of financial risk to providers and, in some cases, so-called cost-shifting.

While the GIR, TPR, and ARRs pilots do result in the transfer of additional financial risk to providers, staff believes that the magnitude of risk transferred has and will be commensurate with the ability of providers to manage that risk. In addition, because these programs involve hospital services, they fall under the HSCRC's all-payer rate setting authority. The Commission, therefore, has strong compliance mechanisms to ensure continued payment equity across payers.

c) Cost Containment

Gradual and incremental expansion of bundled payment systems means we are moving to largely fixed cost or global budget type system. Focus of this system will now be on controlling total expenditures or, if viewed on a population basis, on controlling the growth of health care expenditures per capita. The Commission's experience with such payment mechanisms has been very favorable. Hospitals operating under the Commission's TPR constraint system have consistently had lower use rates and lower case mix adjusted charge per case. There is some anecdotal evidence that these facilities also have experienced lower rates of readmissions as well. Outside of Maryland, global budget systems have experienced some success in the Finger Lakes region of Upstate New York.

Although these systems result in the assumption of financial risk, they also give providers significant budgetary autonomy and the ability to allocate clinical resources more efficiently and effectively, thereby achieving levels of clinical integration and care coordination that are superior to facilities that operate under more fragmented payment structures.¹⁶

¹⁶ The concept of Accountable Care Organizations (“ACO”), as articulated by the Accountable Care Act, is another example of a vertically integrated provider driven entity, organized to accept full risk for the provision of care to broad populations. The federal government is in the process of establishing rules regarding eligibility and potential for shared savings distribution to ACOs by the Medicare program.

ARR arrangements represent an incremental (albeit less powerful) step in this direction. Hospitals that have more effective working relationships with their medical staffs will be in the best position to be successful (i.e., generate savings by improving care and reducing unnecessary utilization) under bundled or fixed cost payment models. The HSCRC must then assure the public that it, too, will share in the productivity gains achieved. This can be accomplished through keeping the rate of growth of total expenditures low (and continuing to bend the cost curve downward as it has in recent years) and by eventually sharing directly in the savings generated by fixed cost and vertically integrated provider systems.

d) Ensuring overall Public Accountability and Prospects for Improved Quality of Care

Accountability, in HSCRC parlance, has traditionally meant that hospitals should be accountable to the public through rate reviews and public access to data, including the extent and nature of all trustee relationships. Additionally, the HSCRC has provided public reports on hospital financial condition, relative efficiency, and relative quality of care performance on an annual basis. Providing hospitals with increasing levels of fiscal autonomy (under payment structures like the ARR) carries with it the need to also ensure that they are accountable to the public for their overall performance. In particular, this means being able to demonstrate the increased value of the care they provide (i.e., lower cost and higher quality). ARR arrangements provide an opportunity for hospitals to achieve higher levels of value, and it is the hospitals' and the HSCRC's responsibility to report on this performance. Thus, the adoption of more bundled payment arrangements will require a higher degree of monitoring and reporting – both to demonstrate that these structures result in a higher value of care and to ensure that there are not unintended results that undermine the overall goal of improved efficiency and effectiveness.

As the system moves more toward bundled and fixed payment structures, an additional monitoring responsibility will be to make sure that the amount of financial risk transferred to a hospital under these arrangements is reasonable and manageable.

Overall Assessment

In general, the staff believes that ARR arrangements can be structured to be completely compatible with the HSCRC's primary policy objectives. Moreover, the staff believes that more bundled payment structures have the potential to improve the rate setting system's performance on all of these dimensions, while in addition to making considerable progress toward meeting the overarching goal of improving the health of populations broadly defined.

4.0 Concerns and Other Considerations

While the ARR structure presents the Commission and the hospital industry with some favorable opportunities for improving the efficiency and effectiveness of the overall health care system, there remain some concerns and uncertainties that should be acknowledged and considered:

4.1 Potential for Conflicting Incentives in a System in Transition

As noted above, the ARR bundled payment arrangements represent a natural next step in the attempts of the HSCRC to promote payment structures that improve hospital efficiency and effectiveness. While the staff views incorporating ARR at-risk structures into hospital reimbursement as a very positive

development, it would note that facilities that opt for ARR arrangements will still face a conflicting set of reimbursement incentives.¹⁷ On the one hand, these hospitals will appropriately invest in infrastructure and implement care coordination mechanisms that are geared toward reducing volumes (readmissions). On the other hand, these facilities will still be financially incentivized to continue to pursue “top-line” strategies (volume and revenue generation) for other parts of their care delivery systems.

For instance, one advantage of the ARR structure for facilities that are already operating at near-full or full-occupancy levels is that a substantive reduction in readmissions will free-up capacity that can be back-filled by additional admissions. If the particular facility generally provides care that is higher quality and lower cost (higher value), then this circumstance could reflect a positive development for the health system. Payers, physicians, and patients who are incentivized to seek out hospitals providing the highest value of care will naturally gravitate to this facility.¹⁸

However, if this new operating capacity is used to admit more marginal patients (for instance patients with ambulatory sensitive conditions - conditions that are better treated on an outpatient basis or by a primary care physician), this dynamic may end up costing the system more through higher overall expenditures. Likewise, reductions in readmissions that are accompanied by “rebounds” to emergency rooms or observation units (in lieu of being formally readmitted) could also result in the public effectively paying twice for the care being rendered. This would result because under the ARR structure, hospitals initially would retain 100% of the savings associated with readmission reductions under the contemplated Charge per Episode payment constraint. Yet, if patients who previously would have been readmitted, merely bounce back to hospitals as emergency cases or observations, then the public will be made to pay both the CPE and additional charges associated with increased Emergency Department (“ED”) or observation visits.

The current hospital-physician contracting model (which is structured to pay performance bonuses for additional billings) adopted by many facilities could undermine the potential of the ARR to ultimately produce the anticipated overall system savings. In its review of hospital ARR requests, staff will devote attention to understanding the nature and structure of physician contracting for a given facility and make appropriate adjustments to the ARR agreement where necessary.

4.2 Need to Modify the Commission’s Volume Adjustment Calculation for Readmissions

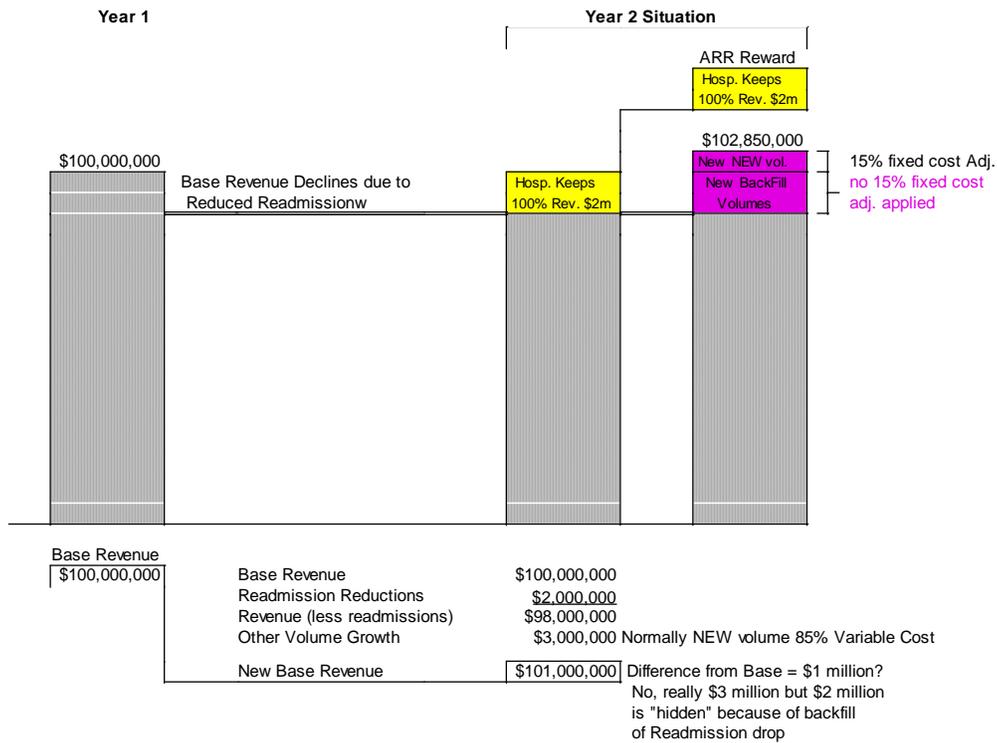
The potential for back-filled volumes is a legitimate concern for the Commission particularly in the context of the current HSCRC policy regarding the application of the fixed cost volume adjustment. Figure 1 illustrates how, under the Commission’s current policy for volume adjustments, a hospital could realize windfalls associated with volume increases that “back-filled” reductions in readmissions. Under this scenario, a hospital could receive 100% of the savings due to the reduction in re-admission and 100% of the additional revenue for the new volume.

¹⁷ This is in contrast to hospitals under a 100% fixed cost TPR structure where hospitals face a consistent incentive to reduce unnecessary utilization and provide the most efficient and effective care possible for their communities.

¹⁸ Over time, more progressive payment structures – such as those contemplated by the Primary Care Advanced Medical Home model currently championed by CareFirst Blue Cross of Maryland will contain strong financial incentives for community physicians to redirect patients to lower cost and higher quality acute care facilities.

Figure 1 – Volume Adjustment Example

Year 1	Year 2						
Hospital Base Revenue <u>\$100,000,000</u>	In Year 2, Hospital Successfully reduces Readmissions by \$2,000,000						
	The Hospital also realizes an increase in Other Volumes (admissions, outpatient volume and case mix) of \$3,000,000						
Year 1 Base Revenue \$100,000,000	<table border="0"> <tr> <td>Hospital Base Revenue</td> <td>\$98,000,000</td> </tr> <tr> <td>Volume Increase</td> <td><u>\$3,000,000</u></td> </tr> <tr> <td>New Base Revenue</td> <td><u>\$101,000,000</u></td> </tr> </table>	Hospital Base Revenue	\$98,000,000	Volume Increase	<u>\$3,000,000</u>	New Base Revenue	<u>\$101,000,000</u>
Hospital Base Revenue	\$98,000,000						
Volume Increase	<u>\$3,000,000</u>						
New Base Revenue	<u>\$101,000,000</u>						
	<table border="0"> <tr> <td>Net Volume Change</td> <td>\$1,000,000</td> </tr> <tr> <td>Fixed Cost Adj.</td> <td>15.00%</td> </tr> <tr> <td>Volume Adjustment</td> <td>\$150,000</td> </tr> </table>	Net Volume Change	\$1,000,000	Fixed Cost Adj.	15.00%	Volume Adjustment	\$150,000
Net Volume Change	\$1,000,000						
Fixed Cost Adj.	15.00%						
Volume Adjustment	\$150,000						
	Volume Adjustment should reflect 100% of Change in Volume net of Readmission Drop						
	<table border="0"> <tr> <td>Real Volume Change</td> <td>\$3,000,000</td> </tr> <tr> <td>Fixed Cost Adj.</td> <td>15.00%</td> </tr> <tr> <td>Volume Adjustment</td> <td>\$450,000</td> </tr> </table>	Real Volume Change	\$3,000,000	Fixed Cost Adj.	15.00%	Volume Adjustment	\$450,000
Real Volume Change	\$3,000,000						
Fixed Cost Adj.	15.00%						
Volume Adjustment	\$450,000						



In order to negate this, staff will propose that the fixed cost adjustment be applied to any volume increase realized by the hospital after taking into consideration changes in readmission volume.

4.3 Need to Transition the Rate System to More of “Fixed Cost” System over Time

The staff has advocated that the HSCRC pursue an incremental strategy in the implementation of its bundled payment initiative (to allow time for providers to invest in necessary infrastructure and manage the risk most effectively). However, the staff would also recommend that the Commission assist this

transition by moving the overall system to more of a fixed cost system. This can be accomplished through the approval of additional TPR arrangements with qualifying hospitals, along with changes to the fixed cost adjustment factor to hospital rates. Staff will be proposing changes to the Commission's fixed cost adjustment factor for both ARR and non-ARR, non-TPR hospitals to both counteract the negative effects of these conflicting incentives facing ARR hospitals and to help move the entire Maryland hospital system toward more of a fixed cost system (i.e., increasing the fixed cost adjustment in the future) – which ultimately is far more supportive of the articulated goal of achieving a population-centric health care financing system.

4.4 Future Rate Updates

Additionally, hospitals that do not opt for the ARR model will continue to be primarily focused on “top-line” revenue generation strategies (attempting to ensure their financial viability from continued volume growth and higher annual payment updates). This may present difficulties for the Commission if it attempts to transfer some portion of the savings associated with successful ARR implementation back to the public in the form of lower overall payment updates. Hospitals generating productivity gains through the ARR may be more willing to accept lower payment updates, while those operating on more of a variable cost basis will resist attempts by the Commission to substantively bend down the hospital cost curve. As emphasized throughout this document, bending the cost curve by gradually reducing future hospital rate updates is a key mechanism to return some of the savings generated from these initiatives to the public at large.

4.5 Concerns Raised by the Physician Community

Although the ARRs deal exclusively with hospital services (non-hospital services are not bundled into the payment structures), concerns have been raised regarding the potential impact of the ARR and other bundled payment approaches on other providers in the health care system. In particular, ARR structures will encourage a much higher degree of cooperation and coordination between hospitals and their medical staff, and between hospitals and physicians in the community. The ARR structure, then, is also favorable in that it provides strong incentives for these additional linkages to occur.

Yet, physician supply issues are a significant concern in the State given evidence of low Medicaid and Commercial Insurance reimbursement levels in Maryland relative to other states. There is a worry that these lower reimbursement levels will exacerbate shortages of physicians, particularly Primary Care Physicians (or “PCPs”). To better understand the extent of physician shortage issue and where these shortages occur, the Commission has requested that Maryland Health Care Commission perform an updated analysis of physician supply based on the results of survey question responses by physicians included in licensure renewal applications for all practicing physicians in the State. These new data can be invaluable for both Commissions and other policy makers in assessing and addressing these overall supply and mal-distribution issues and should be considered as the HSCRC contemplates bundling both hospital and non-hospital services.

Loan assistance for Primary Care Physicians and incentives to teaching programs to increase the size of PCP residency programs are two ways in which the HSCRC can help address physician supply issues in the future. The HSCRC has expressed support for programs such as the State-Only Loan Assistance Repayment Program (or “LARP”) and other modifications to Commission policy that could provide incentives to teaching programs to increase their Primary Care residency programs. The HSCRC staff is also convening a workgroup to consider modifications to the Commission's policy on Graduate Medical

Education as a means of improving the incentives for increasing the pipeline of Primary Care Physicians providing patient care in the State.

Additionally, physician representatives have raised concerns regarding existing regulations and rules that limit the ability of providers to cooperate around care delivery. These too should be re-examined in the context of the development of bundled payment initiatives that include both hospital and non-hospital services. Modifications to existing authority to allow for potential sharing of savings generated through more efficient and effective care delivery also should be considered.

Finally, it is clear that concerns about liability affect physician and hospital decisions about the way care is delivered.¹⁹ These concerns could take on greater significance if providers are now perceived as restricting the use of services under more fixed payment structures. Tort reform and/or other structural changes to how medical liability is handled under a health care system characterized by tighter clinical and financial integration will likely be required.²⁰

The HSCRC staff is very sensitive to the concerns of physicians and practitioners, particularly as the Commission moves beyond just hospital bundling. The staff understands the importance of involving physicians in discussions of future plans for gain-sharing and bundling involving physician services. We welcome continued involvement and suggestions from physicians and all providers on the best way to address these and other issues when the Commission looks to bundle payments beyond just hospital services. As the Commission moves beyond its GIR, TPR, and ARR episode payment structures, it should focus its efforts on opportunities to align incentives of physicians and hospitals to improve quality, the patient care experience, and to promote efficiency. This should include development of clearly delineated principles and approaches with input from the physician community.

4.6 Need to Address Existing Health Disparities and Special Needs Populations

Special efforts also will be needed to ensure that underserved patients – minorities, special needs patients, etc. – can benefit from the increased value provided by hospitals operating under more fixed payment structures. Here, too, there may be opportunities for large cost savings through the development of more coordinated care infrastructures. The HSCRC should consider eventually providing extra incentives for hospitals to focus on reducing health care disparities within the general framework of TPR or ARR arrangements.

4.7 Fairness in Implementation of ARR Pilots

One of the many current criticisms of the ACO and Shared Savings Program (“SSP”) model being proposed by the Centers for Medicare and Medicaid Services (“CMS”) is that Medicare’s establishment of the expected total expenditures for patient care by an ACO will be based on historical experience. Many believe that a critical weakness of the SSP model is that providers that have the most to gain from shared savings are the ones who seemingly have wasted the most resources, while those who are already doing a good job by being low cost and high quality would have to make greater investments to improve and would be less likely to be rewarded.

¹⁹ See FA Sloan, JH Shadle. Is there Empirical Evidence for “Defensive Medicine”? A Reassessment. J. Health Econ. 2009 Mar; 28(2): 481-91.

²⁰ **Appendix IV** contains a letter from a representative of organized physician groups calling for, among other things, medical liability reform efforts.

While potential ARR hospitals may also be starting from different levels of base line performance, because the ARR arrangements will be voluntary, hospitals with high historical readmission rates may not decide to opt for an ARR structure if the Commission makes any downward adjustment to their CPE. It should also be noted that it is not always clear what factors may have contributed to differences in readmission rates across hospitals. Geographic isolation of hospitals, proximity of hospitals to other states, the presence of particularly services at hospitals that tend to generate higher rates of readmission are factors that could explain the current variations in readmission rates across Maryland hospitals. Also, as is shown in Table 1 above, historical performance on intra-hospital readmission rates has been relatively stable, indicating that no one hospital or group of hospitals has likely applied much effort to reduce their steady-state readmission rates in recent years. Given these circumstances and the inability of staff to differentiate good historical performance from less favorable historical performance, the staff recommends no adjustment for variations in base-line readmission performance.

4.8 Request by Hospitals Contemplating ARR Pilots for “Upfront Funding”

During the course of previous discussions with hospitals regarding their interest in participating in an ARR arrangement, the issue of potential “Upfront Funding” was raised. Hospitals have argued that to perform successfully under an ARR, considerable additional investment in discharge planning and care management and coordination will be required. Additionally, during the initial year of operation of an ARR, there will naturally be a mismatch between costs sustained and additional revenue flow related to reducing readmissions and averting the costs associated with the unnecessary readmission.

The staff recognizes the need to provide the appropriate balance of incentives and risk in order to make sure hospitals are properly incentivized to enter into and succeed under an ARR arrangement. However, in a competitive market, firms that succeed at generating mechanisms and innovations resulting in cost reductions (which also in a competitive market later result in price reductions to consumers) generally go fully at risk for these investments. They do so generally knowing that if they are successful, they will recoup these extra upfront costs through the savings they generate under the short-term market price and additional market share they realize by out-competing all other producers.²¹

In an era of excessively high cost of hospital care (and arguably relatively poor value for current dollars expended), it is difficult to contemplate raising rates to the paying public to further incentivize hospitals to take these appropriate next steps. Higher value care is and will be increasingly demanded by patients and first party payers. Hospitals that pro-actively take steps to develop infrastructures to meet this demand (and fiscal imperative from an overall State and federal budget standpoint) will be in a position to recoup these upfront costs through savings.

To balance these conflicting priorities, the staff recommends the possibility of fronting hospitals entering into ARR arrangements up to a maximum of 0.5% of their inpatient revenue for a period of two years with the expectation that these one-time funds will be “paid back” to the public (beginning in year three and possibly also subsequent years through commensurate one-time reductions to rates).²² Handling advance funding in this fashion (as a loan) will allow for better matching of costs and revenues associated with the ARR program, ensure that hospitals retain an appropriate incentive to achieve success in their program, and not place the public at any additional risk over the short term. Additionally, staff will ask

²¹ The staff further notes that occasionally in competitive markets, producers are able to solicit upfront funding for innovative improvements to the production process from venture capitalists. This funding, however, is in the form of a loan with the promise of repayment of principal with a rate of return.

²² Staff may wish to retain some flexibility on both the magnitude of temporary up-front funding it applies up to the recommended ceiling depending on the unique characteristics and factors of hospitals requesting an ARR structure and back-end ability of that facility to in essence “pay these temporary amounts back” to the system.

ARR hospitals to provide a detailed description of planned interventions and a list of budgeted costs associated with the development of their coordinated care infrastructure.²³

4.9 Need for Continuous Monitoring and Periodic Evaluation

Given the need to evaluate the overall success of the ARR programs and the need to monitor for any unintended consequences related to unanticipated changes in hospital utilization or quality, it is important that the HSCRC and ARR hospitals devise a system of continuous surveillance of both utilization and quality metrics and establish a process for interim and final evaluation of the ARR program. Such a surveillance and evaluation structure is also important to ensure accountability and that these arrangements provide increased value for the public at large.

The staff will propose that as part of an ARR agreement, a hospital and the HSCRC track performance on a number of utilization and quality metrics on a quarterly basis. These metrics should include, but not be limited to the following: 1) rates of intra-hospital readmissions; 2) for ARR hospitals that are part of larger health systems, the tracking and reporting of patients who are admitted and readmitted to other system facilities in addition to a system for monitoring all readmissions (both intra- and inter-hospital); 3) emergency room visits and observation cases (with particular focus on any changes in the rates of so-called preventable emergency visits and observation cases and visits and cases occurring within the first 15 days after discharge); 4) admission rates and the rates of admission of ambulatory sensitive cases; and 5) quarter-by-quarter monitoring of rates of hospital acquired complications.

In addition, the HSCRC should work to enhance its quality metrics by investigating the relationship between measures of quality (such as the relationship between process measures and outcome measures and the relationships between complications, readmissions, and mortality) and incorporating other process and patient experience of care measures into the mix of factors considered by the Commission when evaluating care quality.

Finally, given current concerns regarding physician workforce issues, the Commission should require ARR pilot hospitals to report back to the HSCRC on any changes in physician workflow requirements resulting from the implementation of the ARR pilots.

4.10 Developing a Mechanism to Track and Eventual Inclusion of Inter-hospital Readmissions

Although the initial ARR arrangements will focus on “intra-hospital” readmissions only, it is important that the Commission and the hospital industry not lose sight of the disposition of patients who are not readmitted to the facility that treated them for the originating admission. The HSCRC staff believes it can establish an acceptable methodology for monitoring inter-hospital readmissions (readmissions between hospitals). ARR hospitals that are part of health systems will also be required to track and report on inter-hospital readmissions between their own facilities. The success of the entire ARR program will depend on the Commission’s ability to understand the impact of the ARR pilots on all readmissions, not just intra-hospital readmissions. Ultimately, it is contemplated that ARR pilots will be measured on the basis of both intra- and inter- hospital rehospitalizations. In an era of population-based health care, truly integrated

²³ Note: since it is contemplated that upfront funding amounts provided to ARR hospitals will be treated as “one-time adjustments” to hospital rates no additional adjustment relative to the calculation of hospital performance on the Commission’s Reasonableness of Charges is required.

clinical care models will be oriented toward treating and improving the overall health of communities, not just the health of patients within the four walls of their institutions.

4.11 Potential for Future Modifications of ARR Arrangements

While the Commission has generally entertained experimental payment programs and structures that are in effect for a three year period (to provide some degree of stability and predictability of the structure of such arrangements for hospitals and payers), the staff believes it important to allow an opportunity for both the ARR hospital and the HSCRC to propose modifications to the agreement as results are obtained and as other circumstances and opportunities present themselves. For instance, ARR hospitals may wish to expand the services included in the ARR methodology (this expansion could include additional hospital or non-hospital services or modifications to the window of time over which the services in the bundled are provided). It is also anticipated that CMS and the newly organized Centers for Medicare and Medicaid Innovation (“CMMI”) may be receptive to providing states with additional flexibility regarding the incorporation of non-hospital services in experimental payment structures of this nature. The ability to better align the incentives of hospitals and non-hospital providers creates expanded opportunities to generate savings and improve the overall quality of care.

5.0 Moving Forward - Need for a Broader Discussion and Strategic Direction Pertaining to the Bundling of Hospital and non-Hospital Services

The HSCRC staff believes that the current, proposed, and future bundled payment structures hold great potential to generate significant changes to Maryland’s hospital delivery system and result in considerable improvements in hospital efficiency and quality of care (enhance value of care). However, expanding these efforts by incorporating mechanisms that better align the financial incentives of all hospital and non-hospital providers (to be more in-line with the interests of patients and the public at large) will surely double or triple these potential benefits.

Moving beyond GIR, TPR, and ARR hospital-based payment structures will require the development of a broader approach and strategic direction by the Commission. The staff believes that the Commission should direct staff to develop an outline for process that will better inform the Commission as to how to proceed in the development of much broader payment bundles. This broader effort should be aligned with current efforts on the part of the HSCRC, Secretary of Health, hospitals, and payers to “Modernize” Maryland’s All-Payer waiver.

This broader process should include the development of a policy framework to enable: 1) the establishment of long-term goals and performance metrics; 2) a mechanism to allow input from key stakeholders; and 3) the development of priorities and principles that allow for future selection and design of bundled payment initiatives that include both hospital and non-hospital services. For instance, the process could result in an establishment of a goal, such as, Maryland will target hospital spending of _____ per risk adjusted population (absolute amount relative to U.S., or percentage change over time, etc.).

A framework for evaluating options, should include (but not be limited) to the following: 1) how much impact does the option have on achieving the goal? (potential bias toward fewer initiatives with greater impact); 2) how simple is the option to implement? (potential bias toward using existing legislation, toward lower administrative complexity and cost, and toward fewer “moving parts”); and 3) what is the appropriate timeline for implementation? (potential bias toward a mix with enough interventions front

loaded to balance longer-term, possibly more impactful initiatives). Participation in the process must be specified, whether there is a formal committee or work group structure or not, it must accommodate broad representation while including a clear timetable for completion.

While we are working toward creating a framework for approval of new methods of payment for healthcare services within the rate setting system, we should begin the waiver discussion on a parallel track. That discussion would profit from deliberating on the following: 1) how it should relate to our overarching goals for our payment and delivery system; 2) what the waiver should measure and why, and 3) what are the most appropriate mechanics and process for moving forward with waiver revisions. An approach of this nature will help the Commissions establish and clarify its long term focus and goals which will be crucial to our ability to find a working consensus.

Recommendations

Staff believes however that because of the urgency to establish strong incentives to reduce unnecessary hospital readmissions (given impending federal action and the unacceptably high rate of preventable readmissions in the State), the HSCRC should move forward at this time with an approval of the recommendations regarding the implementation of ARR pilots in Maryland.

Consistent with current Commission policy regarding voluntary episode-based payment pilots previously approved by the HSCRC (such as the GIR and TPR pilot programs), the Commission approved the following provisions related to the HSCRC's Admission-Readmission Revenue pilot payment programs:

1. ARR pilots apply only to HSCRC regulated acute care hospital services;
2. ARR pilots should be available to any non-TPR acute care hospital on a voluntary basis;
4. ARR hospital must agree to comply with the prescribed terms and conditions described in Appendix I to this recommendation;
3. ARR pilots must be subject to the execution of an ARR-Agreement with the Commission (shown in Appendix III to this recommendation);
4. The Commission should modify its volume adjustment policy to be net of any change in readmissions by ARR hospitals in a given year. The current 15% fixed cost adjustment then will be applied to volume changes (up or down) net of any change in volumes due to changes in an ARR hospital's included readmissions;
5. HSCRC staff should make necessary adjustments to the ARR target hospital's ROC or case mix calculation;
6. ARR hospitals should be provided up-fronting funding in rates of up to a maximum of 0.5% of inpatient revenue on a one-time basis over the first two years of the ARR program, and that these amounts be "paid back" to the public through commensurate one-time reductions to rates in subsequent years. The upfront funding will not be treated as "system slippage" for the purposes the annual update factor;

7. Staff may negotiate ARR arrangements that do not place the hospital at 100% risk for changes in readmissions. The upfront funding may be adjusted depending on the risk assumed by the hospital. The template under Appendix II will be altered to reflect such arrangements.

7. Additionally, the Commission should direct staff to report back to the Commission on any ARR arrangements negotiated with individual hospitals in public at a subsequent public meeting of the HSCRC;

8. Finally, the Commission direct staff to outline a process for the establishment of a broader approach and strategic direction pertaining to the potential establishment of bundled payments that may include both hospital and non-hospital services. This process should take into consideration and be complementary to the parallel efforts now in place to “modernize” Maryland’s All-Payer Waiver. Staff should solicit input from the hospitals, payers and other providers in constructing this broader policy process and should report back to the Commission on its proposed framework no later than the March, 2011 Commission public meeting.

Appendix I – Prescribed Terms and Conditions

Any non-TPR acute care hospital in Maryland may seek to enter into a voluntary Admission-Readmission Revenue agreement with the Health Services Cost Review Commission commencing with Rate Year 2012. Hospitals seeking to establish such an arrangement must at a minimum agree to the following Commission approved terms and conditions:

1. Term: ARR Hospitals must agree to that the ARR pilot will be in effect for a term of three years, beginning effective March 1, 2011 and ending March 31, 2014.

2. Cases Included in the ARR Hospital’s Charge per Episode: This agreement shall pertain to “all-cause” hospital readmissions to the target ARR hospital (or ARR Entity, where a hospital system is a signatory to this agreement) over a 30 day readmission window.²⁴

4. Exclusions: Zero and one day length of stay cases, planned readmissions, categorical exclusions and outlier trim revenue should be excluded from the development of the target hospital’s Charge per Episode constraint.

5. Exemptions: The target ARR hospital shall be exempt from any State-wide mandated readmission policy (such as the Maryland Hospital Preventable Readmission initiative) during the term of this pilot;

6. Provision of Transitional Funding: The target ARR hospital shall be eligible for a transitional funding advance of up to 0.5% percent of its approved inpatient revenue in rates in addition to the annual update factor as seed money. These funds will be provided as a temporary adjustment to rates for the first two years of the agreement and shall be paid back to the public through future and commensurate one-time rate reductions

7. Hospital Reporting Requirements: The target ARR hospital should be required to report to the Commission on the following:

a) a description of how transitional seed funding provided by the HSCRC will be used including a list of major planned clinical interventions and all budgeted costs associated with the development of their coordinated care infrastructure.

b) for ARR hospitals that are part of larger health systems, the tracking and reporting of patients who are admitted and readmitted to other system facilities in addition to a mechanism for monitoring all readmissions (both intra- and inter-hospital);

c) a report back to the Commission on any changes in physician workflow requirements resulting from the implementation of the ARR pilots.

8. Commission Monitoring Requirements: The HSCRC staff will be responsible for monitoring on the following metrics relating to the target ARR hospital:

²⁴ ARR Hospitals may petition staff for two potential modifications to these provisions (i.e., limit the definition of readmissions to Potentially Preventable Readmissions and/or applying to a readmission window of 15 days). Staff may adjust other provisions of the agreement to reflect the diminished level of financial risk associated with these modifications.

- a) rates of both intra-hospital and inter-hospital readmissions over time;
- b) emergency room visits and observation cases (with particular focus on any changes in the rates of so-called preventable emergency visits and observation cases and visits and cases occurring within the first 15 days after discharge);
- c) overall hospital admission rates with particular focus on changes in the rate of admission of ambulatory sensitive cases; and
- d) quarter-by-quarter monitoring of rates of hospital acquired complication rates.

9. Completion of an ARR Agreement with the Commission: Implementation of an ARR pilot is contingent on the execution of an ARR Agreement with the Commission.

Appendix II – Draft Template/Agreement

AGREEMENT BETWEEN THE HEALTH SERVICES COST REVIEW COMMISSION AND _____ HOSPITAL REGARDING THE ADOPTION OF THE HSCRC’s ADMISSION-READMISSION REVENUE (ARR) SYSTEM

This Agreement made this ____ day of _____, 2011, between _____ HOSPITAL (the “Hospital”) and the HEALTH SERVICES COST REVIEW COMMISSION (the “Commission,” or “HSCRC”) is subject to the following provisions:

I. General Description

The Commission’s Admission-Readmission Revenue (“ARR”) arrangement is a voluntary revenue constraint program developed by the Maryland Health Services Cost Review Commission which provides hospitals with a financial incentive to more effectively coordinate care and reduce unnecessary readmissions to their facility. ARR arrangements apply to regulated hospital inpatient services and charges only. The methodology results in the establishment of a Charge per Episode (“CPE”) constraint, which builds upon the hospital’s HSCRC approved inpatient unit rates. The CPE imposes a case mix adjusted standard Charge per Episode target for a facility, which applies to inpatient admissions and readmissions and subsequent readmissions up to a maximum of three readmissions. An inpatient case is considered a readmission to the hospital if the patient is admitted to the same facility within 30 days of the most recent previous discharge of that patient.

ARR arrangements are available to any hospital currently under the Commission’s Charge per Case (“CPC”) constraint system, and this agreement will supersede a CPC agreement.

II. Methodology

A. Cases Covered by the Agreement and Contract Period

The ARR arrangement shall be applicable to inpatient admissions and readmissions as defined in section V of this document. The program will be in effect for three years, beginning March 1, 2011 and ending March 31, 2014, unless extended by written mutual agreement between the Hospital and the HSCRC. The cases to be included in this agreement are cases included in the Commission’s CPC methodology. Categorical exclusions from the CPC methodology will be removed prior to grouping the data to determine readmissions, along with cases excluded as 0 and 1 day length of stay. Outlier cases will have their charges to the trim-point. The hospital and the HSCRC will also work to identify other appropriate exclusions (such as planned readmissions) from the development of the hospital’s CPE.

For purposes of the ARR methodology, the hospital’s revenue base will be established for the upcoming fiscal year as the permanent revenue available to the hospital at the end of the previous fiscal year, after accounting for one-time adjustments and compliance with the Commission’s regulatory price and charging targets. Each year’s revenue will be set to current experience, with 100 percent of savings or losses permanently rolled into the hospital’s revenue base during the course of this agreement. The Hospital’s unit rates and approved revenue will be increased by the annual update factors approved by the Commission during the next three fiscal years.

Under the CPC system, permanent included revenue is divided among total included discharges to generate the charge per case target. Under this ARR agreement, the permanent included revenue will be redefined as Charge per Episode of care, where an episode includes any “only admission” (admissions without any accompanying readmission within 30 days) and an initial admission along with up to three readmissions, each occurring within 30 days of the last discharge. The hospitals current CPC target would then be restated as a Charge per Episode target, and if hospitals can successfully reduce readmissions, the payment per episode remains unchanged. The hospital can generate productivity gains and associated savings if it keeps its existing revenue (as authorized under its approved CPE) and eliminates the costs associated with intra-hospital readmissions.

B. Risk Adjustment

Expected (or predicted) levels of readmissions will be based on the All Patient Refined Diagnosis Related Group Severity of Illness categories (APR-DRG/SOI). To calculate expected levels of readmissions, statewide weights will be applied to hospital specific experience. Under this methodology, weights will be established for an episode of care, which would include an initial admission along with subsequent related readmissions, up to a maximum of three readmissions. Because even at the state level a number of APR-DRG/SOI cells may not have sufficient information to construct reliable weights, rules may need to be established governing the establishment of monotonically increasing weights across severity of illness categories or a combination of such categories.

Because the staff’s research has demonstrated that expected readmission rates are not adequately captured by APR-DRG/SOI for certain types of cases, other factors will be monitored. Specifically, substantial changes in the proportion of elderly cases, Medicaid cases, and cases with mental health as a secondary diagnosis merit adjustment because they are factors associated with higher readmission rates.

C. Compliance Monitoring Under the ARR

For purposes of regulatory compliance under the HSCRC’s CPC and unit rate restrictions, a five percent (5%) corridor around the target will be established for CPE compliance and interim price compliance for 100 percent inpatient rate centers will be waived. This limit can be extended to 10% at the discretion of the Commission staff upon presentation of evidence by the Hospital that it would otherwise not achieve the approved total revenue for the year. Similarly, there will also be a 5% corridor on undercharging. This corridor may also be expanded to 10% if the Hospital can substantiate that its revenue constraint will be exceeded without this flexibility.

D. Volume and Price Adjustment

A combined volume and price adjustment will be performed for the Hospital each rate year. If the gross revenue charged by the Hospital exceeds the approved revenue, the difference between the gross revenue charged and the approved revenue will be subtracted from the revenue that would otherwise have been approved for the Hospital for the subsequent year. Conversely, if the gross revenue charged is less than the approved revenue, the difference will be added to the revenue for the subsequent year, except that undercharges below the corridor specified in subparagraph C above will not be so included. A volume adjustment consistent with approved Commission policy that recognizes volume changes net of changes in a hospital’s readmission volume, will also be applied.

E. Annual Update Adjustments

The following adjustments shall be made to arrive at the Hospital's approved Charge per Episode for the subsequent year:

- 1) Adjustment for the annual update factor approved by the Commission for this facility;
- 2) Reversal of any previous retroactive adjustments;
- 3) Changes to the Hospital's markup due to changes in mix of payers or changes in approved differential amounts and approved bad debt provision;
- 4) Volume and price adjustments as specified in subparagraph D above.

F. Calculation of an ARR Hospital's CPE

An approved Charge per Episode will be calculated per the following steps:

1. Calculate case mix weights using statewide data for the base year, as normally done.
2. Drop categorical exclusions, readmissions after the third in a chain, one day stays, and charges above the outlier threshold.
3. Calculate the case mix weight of included initial admissions for the hospital for the base year using the weights developed in step 1.
4. Calculate the total charges for included cases and charges for the hospital for the base year. These included charges can be calculated using the approved rates for the rate year times the included units from the base year, if so desired.
5. The standard charge per episode will be the total charges developed in step 4 divided by the total of the included case mix weights in step 3. Call this C.
6. The base year standard charge, C, will be increased by the update factor to price level it to the rate year (unless the units rates used in step 4 already are increased by the update factor). Let the result be C'.
7. Calculate compliance after the end of the rate year:
 - a. Drop categorical exclusions, one day stays, and readmissions after the third readmission.
 - b. Trim outlier cases at the outlier charge threshold.
 - c. Calculate remaining actual included revenue, R, and the total case mix weight for the initial admissions incurred during the rate year, D.
 - d. Calculate the approved included revenue, C' x D, and compare with R.
 - e. The difference between R and C' x D is the ARR compliance adjustment, to be added to (or subtracted from) any compliance adjustment due for price variance.
8. The subsequent year approved charge per episode will be C', increased by the update factor for that year, and adjusted further by any compliance and other appropriate adjustments.

III. Other Terms

A. Special Provision for Transition

To facilitate the development of improved discharge planning and a care coordination infrastructure, the Commission will allow the hospital up to an additional 0.5% percent of inpatient revenue in rates in

addition to the annual update factor as seed money. These funds will be provided as a temporary adjustment to rates for the first two years of the agreement and shall be paid back to the public through future and commensurate one-time rate reductions.

B. Monitoring and Reporting Requirements

The ARR hospital must supply the HSCRC with data on a number of utilization and quality metrics on a quarterly basis. These metrics should include, but not be limited to the following: 1) rates of intra-hospital readmissions; 2) for ARR hospitals that are part of larger health systems, the tracking and reporting of patients who are admitted and readmitted to other system facilities in addition to a mechanism for monitoring all readmissions (both intra- and inter-hospital); 3) emergency room visits and observation cases (with particular focus on any changes in the rates of so-called preventable emergency visits and observation cases, and on ED visits soon after an inpatient discharge); 4) admission rates and the rates of admission of ambulatory sensitive conditions; 5) quarter-by-quarter monitoring of rates of hospital acquired complications; and 6) additional metrics or data as deemed appropriate by the Commission.

C. Exclusions and other Modifications

Categorical exclusions from the CPC methodology will be removed prior to grouping the data to determine readmissions, along with cases excluded as 0 and 1 day length of stay. Outlier cases will have their charges reduced to the trim-point for compliance calculations for the rate year.

Modifications to the ROC Calculation: Because this agreement substantially alters the measurements upon which hospitals are compared for relative efficiency within the State, the Commission shall develop an adjustment to the Hospital's Charge per Case to account for the impact on the charge per case of any reduction in readmissions after adjusting for the applicable variable cost factor.

Modifications to the Case mix calculation: Staff will devise a methodology to minimize negative impacts associated with the hospitals' ARR initiative from the hospital's case mix calculation so the hospital is not treated unfairly for purposes of the application of the case mix governor.

D. Other requirements

Under this agreement, the Hospital must continue to charge HSCRC approved unit rates for facility services rendered.

System hospitals will be treated as one entity for tracking of Intra-hospital readmissions. This will necessitate that hospitals who belong to the same health system in Maryland develop a method for tracking readmissions between system hospitals.

IV. Potential Modifications, Evaluation and Cancellation Provisions

A. Possible Modifications to Allow for Better Alignment of Incentives

Under healthcare reform, a number of approaches have been mentioned to contain healthcare costs. For example, bundling services under a single payment have been identified prominently as one method for aligning incentives for the efficient delivery of healthcare services. The methodology outlined within this document is a first step in bundling by providing a single payment for an episode of care, regardless of additional readmissions that occur after the initial admission into a hospital. Because healthcare reform

efforts are progressing rapidly, the parties to this agreement may mutually agree to modify its terms to expand the services included within the methodology. Potential changes include, but are not limited to, the inclusion of hospital outpatient and emergency department services; post-acute care services; additional days within the readmission window; and gain-sharing with physicians.

B. Program Evaluation

After the first year of operation the staff will undertake an evaluation of the success of the ARR program and report back to the Commission. Success will be evaluated in the context of how well the pilot contributed to the goal of improving the overall value of care provided at the hospital (lower cost and better clinical effectiveness/quality) at both the institution and system level. Particular focus will be applied to an analysis of utilization trends post-ARR implementation (the utilization metrics discussed in section III, subsection B). Staff will report the results of this evaluation to the Commission and the hospital and discuss any appropriate mid-course modifications to the hospital (if any) at that time.

E. Cancellation

This Agreement may be cancelled by the Hospital at the end of the three year term of this Agreement by providing the Commission with 60 days written notice of intent to cancel with or without cause. The Commission reserves the right to cancel this Agreement, with cause, at any time.

V. Definition of Terms

Readmission: Readmissions covered by this agreement will be based on intra-hospital readmissions (readmissions to the same facility).

At-Risk Entity: For this purpose, the _____ and the _____ hospitals will be treated as a single unit as business plans call for an increasing interrelationship between the two facilities. The ____ staff will develop a mapping process to identify readmissions between _____ and _____, subject to HSCRC staff review.

Intra-hospital readmissions: Cases originally treated at the target ARR hospital and subsequently readmitted

Inter-hospital readmissions: Cases originally treated at the target ARR hospital but later readmitted to another facility.

Readmission Window: The period over which rehospitalizations will be counted for purposes of the ARR pilots or a defined time period between initial admission and rehospitalization. It is contemplated that ARR agreements will utilize a 30 day readmission window.

Base Period: The rate year immediately preceding the first year of the ARR pilot program (or in this case the base period is anticipated to cover the period from March 1, 2010 through March 31, 2011).

Initial Admission: The initial admission that starts a chain of subsequent readmissions or an admission that is not followed by any included readmission within the readmission window.

Charge per Episode: An ARR hospital's approved revenue constraint that includes revenues associated with both index admissions and readmissions.

Ambulatory Sensitive Conditions: Ambulatory care-sensitive conditions are those "for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease" (AHRQ 2004). Although hospitalization rates are influenced by socioeconomic factors such as poverty (Blustein et al. 1998), high or increasing rates of potentially preventable hospitalizations might indicate inadequate access to high-quality ambulatory care, including preventive and disease management services (Bindman et al. 1995).

Price Compliance and Volume Adjustments: Application of the Commission's normal one-time price and volume adjustments (after accounting for the impact of readmission volume changes).

Annual Update: The annual increase to Maryland hospital rate for the upcoming HSCRC rate year as approved by the Commission including all applicable adjustments to rates.

Maryland Hospital Acquired Conditions Initiative: The HSCRC's Hospital Acquired Condition ("HACs") measurement methodology that compares a hospital's risk-adjusted actual rate of HACs to an expected or predicted rate of HACs based on State-wide experience.

Quality-Based Reimbursement: The HSCRC's Pay-for-Performance (P4P) initiative that links hospital performance (both relative and year-to-year) on a list of 19 processes of care measures related to Acute Myocardial Infarction, Pneumonia, Heart Failure, and Surgical Infection Prevention.

In Witness Whereof, the Parties have executed this Agreement and have this date caused their respective signatures to be affixed hereto:

Attest: _____ by _____

(Date)

Chief Executive Officer
_____ Hospital

Attest: _____ by _____

(Date)

Robert Murray
Executive Director
Health Services Cost Review Commission

Editorial – December 2010

Defragmenting Care

1. [Stephen F. Jencks](#), MD, MPH

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1. *From Baltimore, MD 21210.*

Rehospitalizations that occur soon after hospital discharge are drawing increasing attention. About 2.5 million Medicare beneficiaries and about 2 million other patients are rehospitalized within 30 days of discharge, with total hospital costs (not including physician services) of about \$44 billion (1; Steiner C, Jiang J. Personal communication). From the perspectives of payers, purchasers, and policymakers, avoidable rehospitalizations represent massive and remediable waste. However, most rehospitalization is the result of clinical deterioration, occurs emergently, and is often necessary by the time the patient reaches the emergency department. Some emergency department visits might be prevented from turning into hospitalizations. However, compelling evidence from a series of controlled studies (2–4), in which interventions to improve the transition from hospital to posthospital care have reduced rehospitalizations by 30% to 50%, suggests that the rehospitalization problem represents a failure of those transitions rather than willful overuse of hospital services. It is a symptom of fragmented care.

Most clinicians easily see how these failures happen. When I ask clinicians to grade the discharge that followed the last hospitalization of a friend or family member, they give few As. My colleagues and I reported (1) that half of Medicare patients who were rehospitalized within 30 days of a medical discharge to the community had not seen a physician between discharge and rehospitalization, a finding that most clinicians find plausible. Ongoing studies provide further evidence that practitioners see rehospitalization as a clinical rather than a utilization issue. For example, almost 1000 hospitals have signed up for the Society of Hospital Medicine's Project BOOST (5) and the American College of Cardiology's Hospital-to-Home (6) project, hospital-based programs that are intended to reduce rehospitalizations. Such enthusiasm would be unlikely if clinicians saw these programs as utilization control.

The Patient Protection and Affordable Care Act (7) creates Medicare payment penalties, starting in 2012, for hospitals with higher-than-expected rates of rehospitalization among patients they discharge. Although federal rules will determine the final shape of this penalty, the legislation has clearly energized attention to rehospitalizations. Hospitals are, however, only 1 component of a fragmented system that must pull together to control rehospitalization. For years, poor in-hospital care was the assumed culprit in preventable rehospitalization, and the Medicare Peer Review Organizations were mandated to review the medical records of index hospitalizations that were followed by early rehospitalization. This process did not prove fruitful, and Weissman and colleagues (8) later showed that rehospitalization was an unreliable indicator of inpatient quality problems.

Read in this context, Kind and colleagues' report in this issue (9) is a story about a fragmented system. Their study compares hospitals whose rehospitalized patients returned to the discharging hospital with those whose patients went elsewhere. Data from fragmented systems are inherently challenging to interpret because of the noise that fragmentation superimposes on whatever underlying patterns may exist. Kind and colleagues found that patients discharged from investor-owned hospitals were more likely to be rehospitalized elsewhere than those discharged from nonprofit hospitals, and they speculate on possible profit motives. However, this speculation suggests a degree of coherent, planned behavior that would be remarkable in such a chaotic system. In addition, because the predominant reasons for rehospitalization were medical, patients probably presented to emergency departments in acute distress. Although planned diversions of undesired emergency patients can occur, a filled bed generally represents positive cash flow, particularly because all study patients had Medicare. Diverting them would not have

been a good business decision for the hospital, particularly because the penalties for excessive rehospitalizations were only a rumor when the study patients received care. A simpler explanation is that patients in acute distress go to the nearest hospital, which is often not the discharging hospital. Data available to the authors do not allow a confident determination of whether profit motives or geography drove these findings.

Rehospitalization may be better viewed as a health care system problem than a hospital problem, because care fragmentation is a property of the whole system. Focusing on the hospital is reasonable, because steps to prevent rehospitalization should begin during the index hospitalization and the hospital has more leverage on the overall system than do other system components. However, almost every institution and individual involved in a patient's care can contribute to preventing rehospitalizations. In the 3 studies mentioned, Jack and colleagues (4) focused on re-engineering the discharge process, Coleman and colleagues (2) focused on coaching patients, and Naylor and colleagues (3) focused on having advanced practice nurses provide care as the patient settled back into the community. The Centers for Medicare & Medicaid Services has developed their Home Health Quality Improvement program to increase accountability of Home Health Agencies for hospitalizations of their patients (10). Recently, community-oriented programs have been launched by both the Centers for Medicare & Medicaid Services (11) and the Institute for Healthcare Improvement (12) to improve transitions and reduce rehospitalizations. These community-oriented efforts focus on promoting efficient communications between hospital and posthospital providers.

To overcome an imperfect hospital system and poor communication between hospital and posthospital providers, a straightforward—but not easy—4-step approach may be effective. First, establish a standardized discharge process, supported by a checklist (13), because improving an undefined and nonstandardized system is almost impossible. This checklist should include, at a minimum, a reconciled medication list, a plan to obtain medications, instruction about when to seek help and who to contact, and a prompt follow-up appointment. Instructions should include written materials, and the instructors should ensure that the patient or caregiver can explain the instructions (teach-back).

Second, ask patients who are rehospitalized, their caregivers, and downstream providers to report how the system failed to meet their needs. These 3 groups have just been part of the system and its discontinuities, and their experience is invaluable in improving both the system and individual care.

Third, create effective communications between the hospital and discharging physician on one side and patients, caregivers, posthospital providers, and posthospital institutions on the other. Communication should include involving primary care physicians when their patients are being discharged and securing a follow-up appointment. The discharge summary should lay out a plan to meet the patient's needs, not just recount the hospital course.

Finally, we must empower patients and their caregivers, through coaching and system redesign, to navigate the health care system and make appropriate demands for service. These steps are only a framework; to achieve optimal outcomes for individual patients in a particular community, the process will almost always require modifications and adjustments to match local resources. Addressing such issues as fall prevention or poverty will require substantial extensions of this model.

Defragmenting health care can seem hopelessly ambitious, working against institutions, culture, and payment systems, but reducing rehospitalization is one of those magical occasions in which better care can both save money and improve outcomes (14). Is a national movement to reduce avoidable rehospitalizations possible? It may be, for several reasons: Medicare is implementing payment incentives, hospital and community engagement is growing rapidly, rehospitalization rates are being measured and published, the Patient Protection and Affordable Care Act provides \$500 million over the next 5 years (15) to assist this effort, medical homes and accountable care organizations are emerging and spreading, and a growing number of hospitals are providing systematic discharge coaching for patients. National leadership has been substantial but, thus far, as fragmented as health care itself. This is an opportunity for medical leadership at the local, state, and national levels to join other leaders in changing the system. If such national leadership coalesces, fixing rehospitalization could become a dramatic prototype for fixing our health care system.

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Appendix IV – Operational Steps in Calculating Charge per Episode for ARR Hospitals

ARR implementation steps

1. Calculate case mix weights using statewide data for the base year, as normally done.
2. Drop categorical exclusions, readmissions after the third in a chain, one day stays, and charges above the outlier threshold.
3. Calculate the case mix weight of included initial admissions for the hospital for the base year using the weights developed in step 1.
4. Calculate the total charges for included cases and charges for the hospital for the base year. These included charges can be calculated using the approved rates for the rate year times the included units from the base year, if so desired.
5. The standard charge per episode will be the total charges developed in step 4 divided by the total of the included case mix weights in step 3. Call this C.
6. The base year standard charge, C, will be increased by the update factor to price level it to the rate year (unless the units rates used in step 4 already are increased by the update factor). Let the result be C'.
7. Calculate compliance after the end of the rate year:
 - a. Drop categorical exclusions, one day stays, and readmissions after the third readmission.
 - b. Trim outlier cases at the outlier charge threshold.
 - c. Calculate remaining actual included revenue, R, and the total case mix weight for the initial admissions incurred during the rate year, D.
 - d. Calculate the approved included revenue, C' x D, and compare with R.
 - e. The difference between R and C' x D is the ARR compliance adjustment, to be added to (or subtracted from) any compliance adjustment due for price variance.
8. The subsequent year approved charge per episode will be C', increased by the update factor for that year, and adjusted further by any compliance and other appropriate adjustments.

Appendix V – Comment Letters



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January 3, 2011

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Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Mr. Murray:

On behalf of the 66 members of the Maryland Hospital Association (MHA), I am writing to support, with one caveat, your draft recommendation, a *Template for Review and Negotiation of an Admission-Readmission Revenue (ARR) Hospital Payment Constraint Program*. We are pleased that the Health Services Cost Review Commission (HSCRC) is providing hospitals an opportunity to voluntarily modify their reimbursement structures in a way that recognizes the investment needed to reduce preventable readmissions. The draft recommendation moves Maryland's hospital payment system one step closer to a reimbursement structure that supports our shared mission of delivering the right care, at the right time, in the right setting. The voluntary aspect recognizes that most hospitals are already beginning to integrate with primary care physicians and other providers in the community, and developing the information technology infrastructure necessary to support clinical integration.

We appreciate that the HSCRC's draft recommendation provides advance funding, and thereby recognizes the investment hospitals will need to make to expand discharge planning services and care coordination as patients transition from hospital care to the community. We oppose, however, treating the advance funding as "slippage" that reduces revenues to all hospitals by the amount of the up-front funding. We expect that the Maryland payment system, as well as the primary payors of health care, will recover that up-front funding and more, through reductions in hospital visits that are not measured--readmissions after a one-day stay, readmissions to other hospitals, return visits to the emergency department, and to other outpatient hospital settings.

We appreciate the opportunity to comment on your recommendation. Please contact me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Michael B. Robbins'.

Michael B. Robbins
Senior Vice President, Financial Policy

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January 5, 2011

Re: Admission-Readmission Revenue (ARR)
Hospital Payment Constraint Program

Robert Murray

Via e-mail

Dear Bob:

This letter, written on behalf of CareFirst BlueCross BlueShield and Kaiser Permanente, offers our comments on the proposal entitled “Draft Staff Recommendation: Template for Review and Negotiation of an Admission-Readmission Revenue (ARR) Hospital Payment Constraint Program” as distributed at the December 8, 2010 Commission meeting.

To a large extent, this letter reiterates the comments I made at last month’s Commission meeting.

- Both CareFirst and Kaiser Permanente recognize the misincentives associated with fee-for-service (FFS) payment systems. CareFirst’s Primary Care Medical Home (PCMH) program is designed to improve upon those incentives. Kaiser Permanente’s commercial insurance business is capitated. The more hospital incentives complement the incentives in these programs the better for making health care more affordable and coordinated.
- CareFirst and Kaiser Permanente congratulate both the staff and the hospitals for significantly expanding the number of hospitals on the Total Patient Revenue (TPR) system. Having 100% of revenue at risk flips the incentives under FFS and requires hospitals, to be successful, to adopt a culture of volume control.
- CareFirst and Kaiser Permanente support all efforts to develop a process that will ultimately reduce total readmissions and bring Maryland in-line with the nation, however, we understand the data issues that constrain our ability to identify and track patient readmissions within and between hospitals. We urge the Commission to continue to move forward with a cost effective program focusing on Potentially Preventable Readmission (PPR) that will move the industry in this direction. Given the reasons noted above, CF and KP support the ARR initiatives as an interim step that will promote volume reductions at the hospital level. In respect to

relative importance, we urge the Commission to focus on expansion of the TPR program immediately second: development and implementation of the voluntary ARR program; and third: continued improvement to resolve all data issues associated with the mandatory PPR program. Incentives to hospitals should reflect this relative importance – that is, hospitals should see the revenue constraints under the TPR as more generous than under the ARR and those under the ARR as more generous than under the PPR.

- It is important to consider the relative importance of each program when designing the variable cost percentages that apply to each program and, in the case of a mandatory program, to the system as a whole.
- We understand that the mandatory readmission program introduced by the MHA at December's Commission meeting is a potential substitute for the PPR program. Since the PPR program is on hold, we also hold our comments on this new MHA proposal other than to note that, like the PPR program it is meant to replace, it is much less important than the ARR program for purposes of bending the cost curve, improving quality and appropriate incentives.
- All these programs will be helped by increasing the pipeline of Primary Care Physicians providing patient care in Maryland. Toward that end CareFirst and Kaiser Permanente have asked that during this year's ROC/ICC process, that the IME adjustment be reviewed as a means of improving the incentives for accomplishing this end.

More specifically, with regard to the ARR program:

- We understand the current emphasis on intra-hospital and intra-system readmissions, but need to move so that inter-hospital readmissions can be measured in the near future. In the interim, we believe the Intra-system approach should be utilized since it is imperative that Hospitals identify and track readmissions within their system and to ensure there is no incentive to encourage readmissions to other hospitals within the system.
- We strongly support the “template” approach. This delegation to staff and flexibility has worked well regarding the TPR and ARA programs. Again, staff did outstanding work regarding the extension of the TPR.
- When improvement in inter-hospital readmissions are definitively measurable, we would be willing to have a percentage of savings generated from reduced inter-hospital readmissions count toward the payback of any upfront money provided within the ARR program.
- We support allowing hospitals to keep 100% of the savings from reduced intra-hospital readmissions as placed at risk under the ARR for the initial three years, but that only makes sense within the context

of constrained update factors – that way the public generates savings as well.

- We remain concerned about the incentives to refill capacity created by reducing readmissions. We encourage support for a culture of volume control as a possible condition to get ARR approval. Providing incentives, such as we identified above for reduced inter-hospital readmissions as well as for reduced intra-hospital and intra- system readmissions will encourage that culture.
- It is important that the Commission support the staff recommendations regarding slippage and payback as they relate to upfront money for hospitals entering the ARR program.
- While the handout for the meeting did not include the technical appendix, I have now reviewed it. The technical appendix correctly handles questions regarding exclusions in developing the ARR revenue constraint. The technical appendix, in two places, refers to the annual increase being the update factor without explicit mention of scaling. CareFirst and Kaiser Permanente believe that it is important that ROC scaling be applied to these hospitals as well as some quality related scaling. It is not clear to us whether the term “update factor” includes these elements of scaling and the application of these scaling factors should be made explicit.
- I have also read the staff’s discussion of the issue of “backfill” of capacity freed up through a reduction in the readmission rate. It is important that hospitals not be paid twice for the use of this capacity, once as a reward under the ARR and once as payment for refilled beds. I believe that when, for example, \$2,000,000 in charges is removed due to reduced readmissions and backfilled by \$2,000,000 in additional volume, the hospital does not experience any additional variable cost – just the same cost as before, which is paid for under the ARR. Volume changes above or below the reduction in readmissions should generate additional payment for variable costs on the up side and financing of fixed costs on the down side.

Thank you for your consideration.

Yours truly,



Hal Cohen
Consultant

Cc: Sule Calikoglu
Graham Atkinson
John Hamper
Laurie Kuiper

BARBARA MARX BROCATO & ASSOCIATES

November 8, 2010

Mr. Robert Murray
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Discussion/Input Sessions Regarding Bundled Payment Structures

Dear Bob,

We appreciate the opportunity to provide comments on the Health Services Cost Review Commission's (HSCRC) discussion series regarding the development of bundled payment structures. As you have stated, stakeholder participation is essential and we want to provide meaningful input throughout the process and have that input reflected throughout. The hospital physician community is very concerned with what the HSCRC develops as it will directly impact how care is delivered. The risk of unintended consequences is unsettling given Maryland's current health care delivery environment.

At the October 13th meeting of the HSCRC when your plans were first presented we arranged a panel from the hospital physician constituencies: emergency physicians representing the Maryland Chapter, American College of Emergency Physicians (MD ACEP) and anesthesiologists representing the Maryland Society of Anesthesiologists (MSA) and First Colonies Anesthesia Associates (FCAA), and Advanced Radiology. The focus of our testimony was to illustrate key concerns and questions that arise when new health care delivery models are being contemplated. Specifically our comments addressed:

- Concern about moving too quickly with new paradigm changing payment systems;
- The need for meaningful tort reform to offset newly acquired risk;
- The need to ease laws prohibiting physicians from sharing information and payment data for the purposes of negotiations with insurers and the creation of large groups;
- The need for fair reimbursement to enable the recruitment and retention of physicians; and
- The importance of a physician centric system.

We recognize that these issues are not entirely under the jurisdiction or control of the HSCRC but they illustrate the environment in which hospital physicians exist: namely a low reimbursement state, with a statewide shortage of physician, an unfavorable tort environment and an impending influx of patients due to expanded insurance coverage.

We feel these issues need to be reflected in the previous and future materials developed by the HSCRC in this endeavor. The future success of any new health care delivery paradigm depends on these issues being addressed in a meaningful way. While we are not assuming that the HSCRC is able to address all of these issues, it is important that the HSCRC recognize the full scope of the healthcare landscape and the pressures facing those who will ultimately be providing the care.

At the November 4th discussion session we expressed our concerns about the need for additional resources and a solid infrastructure for patient care (patient follow up services, appropriate staffing: clinical and administrative, etc.) that will enable a bundled payment system to be successful. We hope that this can be reflected as well in the materials for the future discussion sessions.

We appreciate your candor and assurance that implementation will be incremental (albeit quick) and voluntary, but as this new ground is broken we must be thoughtful about the need for continuity of care in our delivery system. Many of the current relationships between physician groups and hospitals go back many years, and the physicians have become an important part of the community for the patients that come to the hospital for care.

We need to be cautious about interfering with a physician's ability to work autonomously and as private groups, and ultimately protect against adversarial relationships developing between physician groups, hospitals and the physician community at large.

To continue providing the quality patient care that Marylanders have come to rely on physicians must be a decision maker in the bundled payment system. Quality patient care is dependent on the best possible physician staff available, not just the group that helps meet the bottom line.

Attached as an addendum are some specific bullets about the current health care landscape in Maryland and where we think they could be incorporated in the "Overview" document prepared for the HSCRC commission meeting on October 13th and that was again made available for the November 4th discussion session.

We are glad to provide additional information on these issues and others and look forward to our continued participation in this process.

Sincerely,

Barbara Marx Brocato

ADDENDUM

These comments could be included as an addendum to the document and also noted in the section titled “background” on the first page of that overview document.

- The health care delivery system in Maryland faces many challenges with a statewide physician shortage and its ranking as one of the lowest reimbursement states in the country which hinders the ability to recruit and retain physicians.
- There are barriers and disincentives both in federal and state law regarding physician’s abilities to form large practice groups and to share data for purposes of negotiation.

Recommendations:

- Any delivery system changes should reassure patients that they will continue to have access to the quality healthcare they depend on.
- A bundled payment system should be designed so that cost is controlled through the efficiencies in the system and not by the constraints of those who hold the dollars.
- Physicians are in the best possible position to facilitate efficiencies and identify measures to advance quality patient care outcomes.
- Any health care delivery changes must allow the physician community input and direction.
- Maryland’s medical liability climate must be reformed to protect and advance patient care.