MINUTES
467th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

MAY 5, 2010

Chairman Young called the meeting to order at 9:03 a.m. Commissioners Joseph R. Antos, Ph.D., Trudy Hall, M.D., C. James Lowthers, Kevin J. Sexton, and Herbert S. Wong, Ph.D. were also present.

REPORT OF THE EXECUTIVE SESSION OF MAY 5, 2010

Oscar Ibarra, Chief-Program Administration & Information Management, summarized the minutes of the May 5, 2010 Executive Session.

ITEM I
REVIEW OF THE MINUTES OF THE EXECUTIVE AND PUBLIC SESSIONS OF APRIL 14, 2010

The Commission voted unanimously to approve the minutes of the April 14, 2010 Executive and Public Sessions.

COMFORT ORDER – JOHNS HOPKINS HEALTH SYSTEM

The Commission voted unanimously to ratify the Comfort Order for the Johns Hopkins Health System approved in Executive Session.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, reported on the progress of several major projects. They included: 1) the completion of the Survey on Hospital Governance Practices as requested by Delegate Peter Hammen, Chairman of the House Health and Government Operations Committee; 2) the FY 2009 Community Benefits Report will be finalized and released by mid-May; 3) Chairman Young will be serving on the Maryland Health Reform Council which will review the requirements of federal legislation related to healthcare reform in Maryland; and 4) scheduling sessions on payment reform and innovation, i.e., cost control, payment bundling, quality, and alignment of incentives for the summer.

ITEM III
DOCKET STATUS CASES CLOSED

2063R – Carroll Hospital Center
2064A – Johns Hopkins Health System
2065A – Johns Hopkins Health System
2066A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

Garrett County Memorial Hospital – 2067R

On April 7, 2010, Garrett County Memorial Hospital submitted an application requesting a rebundled rate for Interventional Radiology/Cardiovascular (IRC) services. A rebundled rate is necessary to allow a hospital to bill inpatients for services provided off-site. The Hospital requested the state-wide median rate effective May 1, 2010.

After reviewing the Hospital's application, staff recommended:

1) That COMAR 10.37.10.07 requiring that rate applications be filed 60 days prior to the opening of a new service be waived;
2) That an IRC rate of $53.78 per RVU be approved effective May 1, 2010; and
3) That no change be made to the Hospital's Charge per Case standard for IRC services.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
DRAFT RECOMMEDNATION ON FY 2011 UPDATE TO HOSPITAL RATES

Mr. Murray summarized the draft recommendation on the FY 2011 update to hospital rates, the Payment Work Group's deliberations, the Hospitals' and Payers' most recent update proposals, as well as the alternative update options developed by staff at the request of the Chairman. Mr. Murray stated that staff will continue to meet with the payment workgroup with the anticipation of presenting a final recommendation at the June public meeting.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, expressed strong support for United Healthcare's 1.58% update proposal. Dr. Cohen stated that the payers are willing to increase their update proposal to 1.80% contingent upon the hospitals offering a concrete plan to reduce total volumes. Dr. Cohen noted that affordability is driven by volume as well as rates. The payers advocate larger updates and lower volumes.

Dr. Cohen stated that the Commission should focus on efficiency and affordability rather than

profitability and should adopt a net patient revenue (NPR) target of 6% below the nation over five years.

Barry Rosen, representing United Healthcare, stated that the Commission should focus on affordability. According to Mr. Rosen, an update factor of 1.86% is the tipping point. An update of 1.86% will maintain affordability without eroding the waiver cushion.

Michael Robbins, Senior Vice President of the Maryland Hospital Association (MHA), asserted that staff's projections of the national Medicare rate of increase is understated. However, even accepting staff's projection of Medicare's rate of increase, MHA's update proposal will result in a Medicare waiver margin of at least 11% as of June 30, 2011.

Robert Chrencik, President and CEO of the University of Maryland Medical System, stated that MHA's proposal is affordable. Mr. Chrencik pointed out that many factors influence health insurance premium increases. However, even if increases in Maryland hospital charges were the only factor, MHA's proposal would cause only about a 1.5% increase next year, well below recent premium increases.

Stuart Erdman, Senior Director-Finance of the Johns Hopkins Health System, stated that Board of Public Works cuts, averted bad debt rate reductions, the impact of February's snow storms, and the low update factor will yield operating margins of Maryland hospitals at or below 1% in FY 2010. Mr. Erdman noted that MHA's proposed update factor will maintain the current 1% operating margin. MHA's update proposal will have minor effect on the Medicare waiver margin, but it will have a big impact on Maryland hospitals' position in the credit market. In an all-payer state, hospitals and the Commission share responsibility. Hospitals must be managed efficiently and cost effectively, and the Commission must recognize that in a capital replacement cycle, rates must be fair and adequate. Mr. Erdman noted that the Commission's actions have cost consequences in the capital market.

Commissioner Sexton suggested that it is a good idea for the Commission, after discussions, to set targets as to where we want the system to be.

ITEM VI
DRAFT RECOMMENDATIONS ON THE MARYLAND HOSPITAL PREVENTABLE READMISSIONS INITIATIVE

Mr. Murray summarized the background, the basic principles to be used in establishing payment incentives to reduce unnecessary admissions, the Potentially Preventable Readmissions (PPR) logic, the necessary adjustments to PPR rates for factors not under the control of hospitals, proposed payment methodology, development of a Maryland Hospital Preventable Readmission (MHPR) improvement infrastructure, initiation of a series of educational and clinical vetting sessions, and staff's draft recommendations.

Mr. Murray stated that Graham Atkinson, Ph.D., staff consultant, continued his work on adjustments factors, especially on how to weigh readmission chains and out-of-state migration.

Dr. Atkinson reported that there was little change in the methodologies; however, there were some refinements to the calculations, but they have produced no significant changes in the results. Dr. Atkinson stated that the case level data have been shared with the MHA, and the MHA held a well attended educational and clinical vetting session for its members on May 3rd.

Dr. Atkinson noted that although there are still a number of issues, we are making good progress and expect to present a final recommendation at the June public meeting.

Diane Feeney, Associate Director-Quality Initiative, stated that prior to the May 3rd session, staff provided hospitals with the top 10 first readmission reasons for all APR-DRGs. Ms. Feeney announced that prior to the May 26th clinical vetting session, staff will provide service-line specific reports by hospital. Shortly after that meeting, staff will provide case level reports. Ms. Feeney reported that will be two more clinical vetting sessions in June and July.

Mr. Murray observed that it will be beneficial for Maryland to move forward with its own approach to preventing readmissions rather than wait to have a federal readmission prevention methodology imposed upon it.

Mr. Murray noted that because it is important to provide a support system, staff will recommend that a small assessment be included in hospital rates to generate funds to be used as the basis for funding an infrastructure and on-going resource support mechanism.

Commissioner Sexton noted that clinical vetting is necessary to make this a better product.

Commissioner Hall observed that we are doing a good thing; however, we must make sure what we are measuring makes sense.

Mr. Murray stated that clinical vetting is needed to refine the methodology. If we wait for the science we will wait years to begin this initiative. However, there is enough information now to show ranges of readmission performance among hospitals, and that there is opportunity for improvement.

Beverly Miller, Senior Vice President-Professional Activities for MHA, stated that MHA and the hospital industry are in agreement with much of the proposed readmission policy proposal, e.g. the rate based approach, prospective application, and the commitment to have a mechanism to receive input and feedback. Ms. Miller stated that the challenge is to develop a policy that focuses on unplanned readmissions where the reason for the readmission is related to the reason for the initial admission.

Ms. Miller stated that there have been a number of key questions raised about the proposed

methodology. They included: 1) the clinical reason for a 30 versus 15 day window for readmissions; 2) the clinical logic for the preventability of mental health and substance abuse and chronic disease readmissions; 3) since this is the first such policy in the nation, should it be phased-in; and 5) does the policy avoid unintended consequences. According to Ms. Miller, these questions should be answered before a final decision is made on implementing the policy.

Tracie LaValle, representing MHA, stated that we should be aware that the Commission's One-day Stay policy will affect Maryland hospitals' readmission rate and we should take that into account in comparing readmissions in the base period, FY 2010, to readmissions in the measurement period FY 2011. This raises the issue of whether payment should be linked to the policy.

Commissioner Wong asked Ms. Miller whether there seemed to be some consensus building in the vetting session or were there just more questions raised.

Ms. Miller stated that hospital clinicians were concerned that issues raised were presented to representatives of 3M who developed the methodology. Clinicians believe that it would be useful to have independent reviewers involved in the process.

Commissioner Wong agreed that the methodology should focus on unplanned related readmissions, however, whether certain readmissions fall into that category may be a matter of opinion among clinicians. Because the PPR methodology is an aggregate measure, it requires a universe of cases; so, rather than require complete agreement on all cases, it is more important that the clinical community is comfortable, through the vetting process, that we are headed in the right direction.

Steve Davis, M.D., Chairman of Psychiatry at Baltimore Washington Medical Center and Past-President of the Maryland Psychiatric Society, expressed concern that the proposed readmission methodology unreasonably links almost all medical DRGs to subsequent substance abuse/mental health admissions and substance abuse/mental health admissions to subsequent medical admissions. Dr. Davis asserted that this policy may penalize hospitals that now provide inpatient psychiatric services and provide a disincentive for other hospitals to provide psychiatric care.

Ms. Feeney expressed appreciation for the input from clinicians who really care for the population who are marginalized in the healthcare system. Ms, Feeney asked these clinicians for their help in incorporating these people into this initiative rather than pushing them aside and saying it is too difficult.

Eric Alders, M.D., of the Johns Hopkins Health System, praised the Commission for taking on the readmission issue; however, he agreed with Dr. Davis that the problem is with the methodology and the implementation of the policy. Dr. Alders recommended the adoption of a 15 day readmission window, better criteria for elective readmissions, and that implementation of the policy be phased-in.

ITEM VII
DRAFT RECOMMENDATION ON REVISIONS TO THE REASONABLENESS OF CHARGES (ROC) METHODOLOGY

Mr. Murray stated that the draft recommendation had not changed since last month. Mr. Murray reported that staff was still working with the work group on some potential modifications to the peer group methodology. Staff anticipates presenting a final recommendation at the June public meeting.

ITEM VIII
FINAL RECOMMENDATION ON ONE DAY LENGTH OF STAY POLICY

Mr. Murray stepped through the definition of One-Day Stay (ODS) and denied cases, and why these cases were the focus basis of this review, i.e., the impending Medicare Recovery Audit Contractor (RAC) audits, the concern of 3rd party payers about the hospitals in Maryland providing Observation (OBV) services, the reporting by hospitals of denied cases and their effect on the Charge-per-Case system, as well as the detrimental effect on affordability and on quality of care of admitting patients rather than providing the appropriate care on an outpatient basis.

Mr. Murray outlined the issues considered by the ODS Work Group and what consensus was reached: 1) HSCRC staff and the hospitals agree that all ODS cases should be removed from the CPC targets and established as a separate category; 2) while staff believes that ODS cases should have both a per case constraint and a case mix constraint, hospitals do not; 3) all parties agree that a revenue-neutral reallocation of revenue should be made among hospitals to reward early-adopters of OBV services, however, the method of allocation has not been determined; 4) staff recommends the establishment of a "soft target" for reducing the percentage of ODS cases and the implementation of one of two options of scaling revenue-neutral rewards and penalties to induce the desired behavior over time; 5) staff believes that denied cases for FY 2010 should be removed from hospital CPC targets for compliance and charging purposes, while hospital representatives disagree and recommend removal of denied cases beginning in FY 2011; 6) a revised rate structure for both Observation and outpatient surgery recovery room charges has been developed; and 7) staff recommends the inclusion of OBV cases in the Charge per Visit (CPV) constraint system and excluding OBV from case mix caps in FY 2011, while hospitals oppose the inclusion of OBV cases in the CPV in FY 2011.

Mr. Murray asked for Commission for action on all of the recommendations except for the method of allocation of early-adopter rewards.

Dr. Cohen expressed strong support for the staff recommendations. However, he thought that staff's "soft target" for reducing ODS cases should be more aggressive. In his view the ODS target for Medicare should be 15% of total cases by FY 2011 and 13% by FY 2013, and the all-payer target should be to reduce the ODS as a percentage of total cases by at least a 2% a year.

A panel consisting of Mr. Robbins, Peter Parvis, Special Counsel to the MHA, Kathy Talbot, Vice President-Rates and Reimbursement of MedStar Health, Henry J. Franey, Vice President & CFO of the University of Maryland Medical System, and Michele Mann, CFO of Frederick Memorial Hospital addressed the Commission.

Mr. Robbins stated that while there were many areas of agreement on ODS and denied cases, i.e., reducing the number of ODS, removing ODS from the CPC system, developing a revised charge structure for OBV cases, and reallocating monies resulting from early adoption of OBV, there are several areas of particular disagreement. They include: 1) the establishment and timing of a reward/penalty structure associated with a targeted percentage of ODS cases; 2) penalizing hospitals for denied cases in FY 2010; 3) establishing a separate target and case mix cap for ODS cases; and 4) including OBV and outpatient surgical cases under the CPV in FY 2011.

Mr. Franey stated that all parties agree that ODS admissions should be reduced and that we should have a soft target; however, a reward/penalty structure is not needed. Hospitals believe staff is underestimating the value that we have created with these policy changes. The power of the policy changes along with the pressure that the payers will exert to keep patients out of the hospital will be enough to drive change. The incentives in the rate setting mechanism are now clear. Mr. Franey asserted that staff's recommendations regarding an incentive reward/penalty structure actually sets a hard target rather than a soft target. Hospitals believe that this reward/penalty structure is not needed. In addition, staff is proposing an ODS standard for each hospital utilizing data comparing each hospital's experience on an APR-DRG severity basis. This data base has not been vetted. We do not understand whether the differences between hospitals are driven by clinical practice or are simply arithmetic differences. According to Mr. Franey, an explicit hospital specific target may interfere with clinical decision making with unintended consequences of limiting the movement of 2 and 3 day length of stay cases to ODS cases. Mr. Franey suggested that we set a soft target, examine the results at the end of the year to understand why we achieved or did not achieve our goal, and determine whether the right set of incentives are in place and whether the data are being interpreted correctly.

Mr. Parvis stated that the MHA and its hospital members agree that the Commission has spoken and that all denied cases should be removed from the CPC system. The only objection is to the timing of the removal. Hospitals believe that they have treated denials appropriately under the regulatory reporting requirements of the Commission and, therefore, do not believe that they should be penalized retrospectively for that correct reporting. Mr. Parvis asserted that following a regulator's regulations should not result in punishment. The HSCRC can not and should not change 10 years of regulatory practice retroactive to the start of the year, 9 months into a fiscal year. According to Mr. Parvis, all parties agree that the denied case issue will largely be resolved in FY 2011 through the proposed changes associated with ODS cases. There is no need for action in FY 2010. A prospective change is the only change that is fair, equitable, and consistent with law and sound policy.

Ms. Talbot stated that the hospital industry agrees that ODS cases should be excluded from all hospitals' CPC targets, and that the CPC targets should be rebased and their case mix indexes should be recalculated. However, establishing separate CPC targets and case mix constraints is unnecessary and counterproductive. Such constraints would also add unnecessary complexity to the system without any benefit.

Ms. Mann stated that hospitals are concerned with including OBV and outpatient surgery cases in the CPV system in FY 2011 because the case weights for these cases will materially change from the FY 2010 base period. The industry recommends instead the exclusion of OBV cases from the CPV for the first year, FY 2011. This will allow the system changes to mature, will provide more complete data, and ultimately result in a more robust and accurate CPV system.

Mr. Robbins summed-up the hospitals' suggestions for modifying staff's recommendations. They included: 1) postpone any decision to reallocate funds for "early adopters" until hospitals approve the method; 2) establish a "soft" system-wide target for reducing the percentage of ODS cases for FY 2011, but postpone the implementation of a reward/penalty structure until the FY 2011 results can be reviewed; 3) denied cases should not be removed retrospectively; 4) ODS cases should be treated similar to low charge exclusions; and 5) OBV cases should be excluded from the CPV system for the first year (FY 2011).

Mr. Murray observed that hospitals are sophisticated; they respond to incentives; and they have shown that they can deal with complexity. As to the denied case issue, Mr. Murray stated that what we are doing is undoing the wrong that is in the system. According to Mr. Murray, having denied cases built into the rate system is contrary to the Commission's mandate that rates should be reasonably related to costs. Staff believes that removing these cases for FY 2010 is appropriate; however, at the very least, these cases should be removed effective January 1, 2010.

Commissioner Antos asked what the impact would be of removing denied cases on January1, 2010 rather than for the entire year.

Mr. Murray replied $5 million.

Commissioner Sexton asked whether it would not be better to forgo scaling for both not achieving the soft target for reducing the percentage of ODS cases and for early adopters.

Commissioner Lowthers expressed support for staff's recommendations. Commissioner Lowthers stated that there should be no further delay. The issues have been vetted, and the Commission should vote on staff's recommendations now.

Commissioner Lowthers made a motion to approve staff's recommendations with the exception of recommendation #4, i.e., to wait for an approved method to reallocate revenue to early adopters, approve the $10 million revenue neutral scaling incentive for hospitals to shift ODS cases to outpatient, and to remove denied cases from the CPC system effective January 1, 2010.

Commissioner Sexton amended the motion to remove the recommendation that would have set CPC targets and apply case mix constraints to ODS cases.

The Commission voted unanimously to approve the amended recommendations.

ITEM IX
FINAL RECOMMENDATION FOR CONTINUED SUPPORT OF THE MARYLAND PATIENT SAFETY CENTER

Mr. Murray summarized staff's recommendations which include: 1) in FY 2011, funding should be provided through hospital rates to cover 45% of budget costs of the Center, with 5% of the 45% contingent on evidence that a viable fundraising plan is in place; 2) in the future, a percentage of budgeted costs funded should be reduced by 5% each year, but in no year shall the funding be greater than the prior year; 3) that the Commission remain a minority partner in the Center and maintain a reasonable level of support; 4) that staff communicate with the Agency for Healthcare Research and Quality to find out ways to best evaluate the value and efficacy of patient safety program options; 5) that the Center should update the Commission on health care outcomes and expected savings resulting from its activities; and 6) the Center should target other provider groups benefiting from its activities for alternative sources of revenue.
Staff also recommended waiving the 60-day comment rule to allow for Commission approval at today's meeting.

The Commission voted unanimously to approve staff's recommendation.

ITEM X
FINAL RECOMMENDATION FOR FY 2011 NURSE SUPPORT II AND COMPETETIVE INSTITUTIONAL GRANTS

Mr. Ibarra presented staff's recommendation that the Commission approve for FY 2011the funding of eleven Competitive Institutional Grants totaling $9,074,199 approved by the Nurse Support II Evaluation Committee and the HSCRC staff.

In addition, Mr. Iberra asked that the Commission's 60-day comment rule be waived, so that the recommendation may be considered for final approval.

The Commission voted unanimously to approve staff's recommendation

ITEM XI
HEARING AND MEETING SCHEDULE

June 9, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
July 7, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 12:45 p.m.