Executive Session Minutes
of the
Health Services Cost Review Commission

February 10, 2011

Upon motion made, Chairman Puddester called the meeting to order at 10:05 a.m.

The Meeting was held under the authority of Section 10-508 of the State Government Article.

In attendance, in addition to Chairman Puddester, were Commissioners, Lowthers, and Sexton. Commissioners Antos, Bone, and Wong participated by telephone

Robert Murray, Steve Ports, Jerry Schmith, Dennis Phelps, Sule Calikoglu, and Oscar Ibarra attended representing Commission staff.

Also attending were Leslie Schulman and Stan Lustman, Commission Counsel.

Item One

The Commission received an update on Dimensions Health System.

Item Two

The Commission heard from David Krajewski representative of LifeBridge Health in its proposal to acquire, construct, renovate and equip certain hospital facilities involving Sinai Hospital, Northwest Hospital Center, and Levindale Hebrew Geriatric Center and Hospital at an approximate borrowing cost of $59 million. The project includes an expansion of the Children's Hospital at Sinai and expansion of the Children's Diagnostic Center, redevelopment on the Levindale campus, modernization of the operating rooms at Sinai, renovations and improvements to the fifth floor of the South Tower at Sinai, and certain infrastructure improvements at both Sinai and Northwest.

After discussion, the Commission voted to approve the Comfort Order request of LifeBridge Health- ratification of the vote to take place in public session.

Item Three

The Commission was updated briefly on budgetary matters as they affect the Medicare waiver.

The Executive Session was adjourned at 10:50 a.m.

MINUTES
475TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

February 10, 2011

Chairman Frederick W. Pudderster called the meeting to order at 10:51a.m. Commissioners C. James Lowthers and Kevin J. Sexton were also present. Commissioners Joseph R. Antos, Ph.D., George H. Bone, M.D., and Herbert S. Wong, Ph.D., participated by conference call.

REPORT OF THE EXECUITIVE SESSION OF FEBRUARY 10, 2011

Oscar Ibarra, Chief-Program Administration & Information Management, summarized the minutes of the February 10, 2011 Executive Session.

COMFORT ORDER – LIFEBRIDGE HEALTH

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

ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC AND EXECUTIVE SESSIONS OF JANUARY 12, 2011

The Commission voted unanimously to approve the minutes of the January 12, 2011 Public and Executive Sessions.

ITEM II
DOCKET STATUS CASES CLOSED

2097N – Laurel Regional Medical Hospital
2098A – Johns Hopkins Health System
2099A – Johns Hopkins Health System
2100A – Johns Hopkins Health System
21001A – Johns Hopkins Health System

ITEM III
DOCKET STATUS CASES OPEN

Maryland General Hospital – 2096N

On November 18, 2010, Maryland General Hospital submitted a partial rate application requesting a rate for Hyperbaric Chamber (HYP) services. The Hospital requested the state-wide median rate for HYP services to be effective January 1, 2011.

After review of the Hospital's application, staff recommended:

1. That COMAR 10.37.10.07 requiring rate applications be filed 60 days before the opening of a new service be waived;
2. That a HYP rate of $246.02 per RVU be approved effective February 1, 2011;
3. That no change be made to the Hospital's Charge per Case standard for HYP services; and
4. That the HYP rate not be rate realigned until a full year's experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

Washington Adventist Hospital – 2102N

On December 21, 2010, Washington Adventist Hospital submitted a partial rate application requesting a rate for Hyperbaric Chamber (HYP) services. The Hospital requested the state-wide median rate for HYP services to be effective January 1, 2011.

After review of the Hospital's application, staff recommended:

1. That COMAR 10.37.10.07 requiring rate applications be filed 60 days before the opening of a new service be waived;
2. That a HYP rate of $246.02 per RVU be approved effective February 1, 2011;
3. That no change be made to the Hospital's Charge per Case standard for HYP services; and
4. That the HYP rate not be rate realigned until a full year's experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

Washington Adventist Hospital – 2103N

On December 21, 2010, Washington Adventist Hospital submitted a partial rate application requesting a rate for Definitive Observation (DEF) services. The Hospital requested the state-wide median rate for DEF services to be effective January 1, 2011.

After review of the Hospital's application, staff recommended:

1. That a DEF rate of $1,137.59 per day be approved effective February 1, 2011;
2. That to remain revenue neutral, 21,428 patient days and revenue of $24,376,279 be removed from Medical/Surgical-Acute rate center to the new DEF rate center;
3. That no change be made to the Hospital's Charge per Case standard for DEF services; and
4. That the DEF rate not be rate realigned until a full year's experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation

Adventist Behavioral Health – 2104N

On December 21, 2010, Washington Adventist Hospital submitted a partial rate application requesting a rate for Psychiatric Geriatric (PSG) services. The Hospital requested the state-wide median rate for PSG services to be effective January 1, 2011.

After review of the Hospital's application, staff recommended:

1. That COMAR 10.37.10.07 requiring rate applications be filed 60 days before the opening of a new service be waived;
2. That a PSG rate of $937.03 per day be approved effective February 1, 2011;
3. That the HYP rate not be rate realigned until a full year's experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

ITEM IV
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, updated the Commission on the progress of several major initiatives and issues. They included: 1) focusing the annual discussion of the Reasonableness of Charges (ROC) methodology on technical issues; 2) finalizing the quality and utilization monitoring requirements for hospitals that enter into the Admission Readmission Revenue initiative; and 3) assembling a workgroup and scheduling meetings with individual workgroup members to discuss the FY 2012 update process and identify key issues.

Chairman Puddester suggested that it made sense to address the update and the Medicaid Budget assessments at the same time.

ITEM V
RESULTS OF PERFORMANCE ON MARYLAND HOSPITAL ACQUIRED

CONDITIONS

Sule Calikoglu, Ph.D., Chief Quality Analysis, summarized the results of the Maryland Hospital Acquired Conditions (MHAC) program. Dr. Calikoglu reported that in the second year of the MHAC initiative, there was an 11.92% drop in the frequency of hospital acquired complications. This resulted in the reduction of hospital costs by approximately $62.5 million associated with the preventable conditions. Dr. Calikoglu added that complications related to infections declined by 19.06% and represented $34.3 million of the hospital cost savings.

Commissioner Sexton asked whether he was right in surmising that if hospitals are successful in reducing complications, reimbursement is lower because of the incidence of the fewer complications; however, they receive relatively small scaled incentive increases through the update factor based on their performance.

Mr. Murray stated that in approximately 60% of the cases where a complication is avoided the payment is lower; however, in about 40% of the cases, there is no reduction in reimbursement because there is no movement of the case from a higher severity level to a lower severity level, plus the hospital's costs are reduced. So, there is a sharing of the savings associated with the reduction in the rate of complications. Mr. Murray noted that because the coding of Present-on-Admission conditions has not improved dramatically from one year to the next, staff believes that most of this is real performance improvement by hospitals in avoiding complications and improving infection rates.

Commissioner Bone observed that despite the $62 million in savings, the overall cost of care is still going up.

Mr. Murray agreed with Commission Bone that the cost of health care is, indeed, still going up for various reasons; however, the good news on the quality front is that we are starting to make headway in reducing costs by removing unnecessary and preventable complications.

ITEM VI
UPDATE ON POTENTIALLY PREVENTABLE READMISSIONS (PPR) METHODOLOGY

Dr. Calikoglu stated that staff advised against going forward with the final PPR initiative recommendation at this time because of issues associated with identifying individual patients across hospitals. Staff is working on an algorithm and testing using Medicare data. Staff has concluded that we need more individual patient data to strengthen the algorithm, and it is not efficient enough at this point to create a payment mechanism around it. However, staff continues working on improving the algorithm, so that we will be able to at least monitor trends in readmissions while we are collecting the additional patient data.

Dr. Bone asked when the algorithm would be good enough for us to proceed with the PPR initiative.
Dr. Calikoglu stated that it will take in excess of six months to collect the data from hospitals

and to compile enough data to track readmissions.

ITEM VII
BRIEFING ON MARYLAND STATE BUDGET

Chairman Puddester stated that in regard to the state budget deficit and its impact on the Commission and the rate setting process, we are dealing with a much different situation this year than the Commission dealt with last year. The order of magnitude is three times as great. Therefore, it is very important that the Commission receive feedback from all stakeholders so that the Commission can gather all the information needed to interact on this issue with the legislature and the Governor and his staff to reach some sort of resolution.

Mr. Murray presented the background on the history of the utilization of assessments to fund Medicaid budget shortfalls. Mr. Murray stated that this year there are two components to the proposed Medicaid budget assessments. The first is to fix the assessment for Medicaid Health Care Coverage expansion at 1.5% of total hospital revenue, even though the Commission believes that averted bad debts attributable to expansion is less than 1.5%. The second is the assessment for operating support of the Medicaid program which is fixed at 2.5% of total hospital revenue. The percentage of regulated revenue for both assessments, which is the revenue that the Commission can assess, is 4.35%. The most disturbing thing about the assessments is that they have been made permanent in the language of the budget bill. In addition, Mr. Murray noted that savings of $17 million accruing to Medicaid from the Commission's pooling of Graduate Medical Education has also been included in the budget.

Michael B. Robbins, Senior Vice President-Financial Policy of the Maryland Hospital Association (MHA), presented stated that MHA's position was that 100% of the proposed 2012 assessment of $315.4 million be put in hospital rates.

Mr. Robbins stated that hospital cost increases have not contributed to the Medicaid deficit. Mr. Robbins pointed out that the rate of increase in total hospital revenue, inpatient and outpatient including case mix and volume increases, has been on a declining trend over the last several years. In fact, based on the latest numbers, revenue growth is projected at less than 2%.

Mr. Robbins noted that the primary reason that Medicaid has this funding problem is that enrollment is growing well beyond what was expected, not just from expansion of the program but also due to the economic conditions over the last several years.

Mr. Robbins stated that it is MHA's position that for the short-term solution to Medicaid's budget deficit, the assessment should be spread over the broadest possible base. The best way to do this is by putting 100% of the proposed assessment in hospital rates. In this way, hospitals, as large employers, will bear the same burden on their health care costs as all other employers.

The hospital industry understands that this is only a short term solution and agrees with the Commission that the assessments should not be made permanent. The assessments not only have had an impact on hospital rates, but also have denigrated the Medicare waiver cushion. The

hospital industry is committed to working with the Commission and the other stakeholders to arrive at a new sustainable long term solution for funding Medicaid. In addition, at the same time, we need to begin to look for ways to modernize the waiver and the rate setting system in the event that the legislature continues to place this funding responsibility onto the Commission.

Chairman Puddester asked Mr. Robbins why hospitals could not assume the same assessment amount as last year.

Mr. Robbins stated that because they do not know the outcome of the update factor discussions, hospitals are not able to determine how much, if any, of the assessment they could absorb.

Chairman Puddester asked Mr. Robbins what he thought about making the decisions on the update factor and assessment together because they are linked.

Mr. Robbins stated that his preference would be that the update process encompass what reasonable increase in revenues is required by hospitals for their normal operating costs, separate from the assessment discussions, as we have done in the past. However, hospitals understand that when the payers come to the table, they need to know what the total hospital rate increase will be. However, we should not let the assessment decision influence the update factor.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, stated that it is inappropriate for the Commission to become a permanent taxing agent for the State. Dr. Cohen noted that one of the things that the legislature and the Commission has to consider is whether the federal government will determine that the permanent assessments to fund Medicaid are a cost-shift and a violation of the all-payer system provision of the waiver. According to Dr. Cohen, the assessment should not be made permanent; we do not know what hospital funding will look like in 2014 and thereafter as a result of federal health care legislation.

In regard to MHA's proposal to put 100% of the assessment in rates, Dr. Cohen stated that affordability is the issue. It is not appropriate to put the entire burden on the backs of people with health insurance. If you continue to raise the premiums of people who have health insurance, fewer people will be able to afford health insurance.

Dr. Cohen asked the Commission to keep in mind that because payers already pay 100% of the Medicaid expansion and MHIP assessments, using current Commission policy to split the Medicaid deficit funding 50%/50% between hospitals and the payers, the payers would still be paying 75% of the total assessments. Dr. Cohen noted that it is really not the payers paying the assessment; it is really the payers' customers who are paying it. Basically, businesses do not pay anything. Households pay everything.

Chairman Puddester expressed agreement that the Commission should not be a taxing authority; however, he pointed out that putting the assessment in rates would spread the burden across the broadest base.

Dr. Cohen asserted that hospitals should absorb some of the assessment because history has shown that hospitals are more efficient when they have less revenue. In addition, if hospitals take on some of the assessments, they will have "some skin in the game" and will be more aggressive in seeking a solution to prevent the assessments from becoming permanent.

ITEM VIII
HEARING AND MEETING SCHEDULE

March 2, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
April 13, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:53 a.m.