Executive Session Minutes
Of the
Health Services Cost Review Commission

September 14, 2011

Upon motion made, Chairman Colmers called the meeting to order at 9:31 a.m.

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

In attendance, in addition to Chairman Colmers, were Commissioners Bone, Keane, Mullen, and Wong.

Steve Ports, Jerry Schmith, and Dennis Phelps attended representing staff.

Joseph Hoffman, Senior Vice President and CFO, attended representing Upper Chesapeake Health System.

Also attending were Stan Lustman and Leslie Schulman Commission Counsel.

Item One

The Commissioners discussed personnel and waiver issues.

Item Two

The Commission heard from Joseph Hoffman, representative of the Upper Chesapeake Health System (UCHS), in its proposal to construct a Cancer Center to be physically connected to the Upper Chesapeake Medical Center (UCMC). The total cost of the project is approximately $62.5 million with $50 million to be financed and the balance paid for by equity contributions from UCMC, Harford Memorial Hospital, and the Upper Chesapeake Health Foundation.

After discussion, the Commission voted to approve the Comfort Order request of UCHS. Ratification of the vote to take place in the public session.

The Executive Session was adjourned at 10:14 a.m.

481ST MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

September 14, 2011

Chairman John Colmers called the meeting to order at 10:18 a.m. Commissioners George H. Bone, M.D., Jack C. Keane, Thomas R. Mullen, and Herbert S. Wong, Ph.D. were also present.

REPORT OF THE EXECUTIVE SESSION OF SEPTEMBER 14, 2011

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the September 14, 2011 Executive Session.

COMFORT ORDER-UPPER CHESAPEAKE HEALTH SYSTEM

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

ITEM I
EXECUTIVE AND PUBLIC SESSIONS OF AUGUST 11, 2011

The Commission voted unanimously to approve the minutes of the August 11, 2011 Executive and Public Sessions.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Steve Ports, Acting Executive Director, advised the Commission of the progress on current major initiatives and issues. They include: 1) finalizing a letter to the Secretary of Health and Human Services requesting an exemption from CMS' Value Based Purchasing (VBP) quality program; 2) adoption of a change in methodology to utilize the statewide average for measuring hospitals' relative performance for scaling of the 1% Maryland Hospital Acquired Conditions (MHAC) initiative for FY 2012; 3) finalizing a recommendation to be presented at the October public meeting on the magnitude of MHAC scaling; 4) finalizing ARR agreements with twenty-five hospitals for FY 2012; 5) finalizing the ARR payment weights and developing an operating protocol manual; and 6) expecting the completion of rate orders in October.

Mr. Ports reported that staff is contemplating filing a letter of intent to participate in Model #1 of CMS's Bundled Payment for Care Initiative . Model #1 involves strategies for the coordination of care among health care providers for inpatient hospital care.

ITEM III
DOCKET STATUS CASES CLOSED

2114N – Adventist Behavioral Health
2116N – Germantown Emergency Center
2118N – Bowie Emergency Center
2124A – Johns Hopkins Health System
2126A – University of Maryland Medical Center
2127A – University of Maryland Medical Center

ITEM IV
DOCKET STATUS CASES OPEN

Suburban Hospital – 2130N

On August 8, 2011, Suburban Hospital submitted a partial rate application requesting a rate for Operating Room Clinic (ORC) services. The Hospital requested a rate based on its costs and volumes or the statewide median ORC rate.

After review, 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 ORC rate of $12.51 per minute be approved effective September 1, 2011;
3. That no change be made to the Hospital's charge per visit standard for ORC services; and
4. That the ORC 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. Chairman Colmers recused himself from consideration of this application.

Johns Hopkins Health System – 2129A

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on August 3, 2011 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") requesting approval from the HSCRC for continued participation in a capitation arrangement among the System, the Maryland Department of Health and Mental Hygiene (DHMH), and the Centers for Medicare and Medicaid Services (CMS). The Hospital, doing business as Hopkins Elder Plus ("HEP"), serves as a provider in the federal "Program of All-inclusive Care for the Elderly" ("PACE"). Under this program, HEP provides services for a Medicare and Medicaid dually eligible population of frail elderly. The requested approval is for a period of one year effective September 1, 2011.

Staff found that the experience under this arrangement for FY 2011 was unfavorable. However,

based on the initiatives taken by HEP, staff recommended that the Commission: 1) waive the requirement that an application be filed 30 days prior to the effective date of an alternative rate determination arrangement; and 2) approve the Hospital's renewal application for an alternative method of rate determination for one year beginning September 1, 2011, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from consideration of this application.

University of Maryland Medical Center – 2132A

On August 22, 2011, the University of Maryland Medical Center filed an alternative method of rate determination application requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with Maryland Physicians Care. The Hospital requested that the arrangement be approved for a period of one year beginning August 23, 2011.

Staff found that the experience under the arrangement for last year was favorable.

Therefore, staff recommended that the Commission: 1) waive the requirement that alternative rate applications be filed 30 days before the proposed effective date; 2) approve the Hospital's request for a period of one year effective August 23, 2011, and 3) that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

MedStar Health – 2133A

On August 22, 2011, MedStar Health filed an alternative method of rate determination application on behalf of Union Memorial Hospital and Good Samaritan Hospital requesting approval to continue to participate in a global rate arrangement for cardiovascular services with the Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for one year beginning October 1, 2011.

Staff reviewed the experience under this arrangement for the last year and found it to be favorable.

Therefore, staff recommended that the Commission approve the Hospitals' request for a period of one year effective October 1, 2011, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

MedStar Health – 2134A

On August 22, 2011, MedStar Health filed an alternative method of rate determination application on behalf of Union Memorial Hospital and Good Samaritan Hospital requesting approval to continue to participate in a global rate arrangement for orthopedic services with MAMSI for one year beginning September 1, 2011.

Staff reviewed the experience under this arrangement for the last year and found it to be favorable.

Therefore, staff recommended that the Commission approve the Hospitals' request for a period of one year effective September 1, 2011, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

University of Maryland Medical Center – 2136A

On August 30, 2011, the University of Maryland Medical Center filed an alternative method of rate determination application requesting approval to continue to participate in a global rate arrangement for liver and blood and bone marrow transplant services with Cigna Health Corporation for one year beginning July 1, 2011.

Staff found that the experience under this arrangement for the past year was favorable. Therefore, staff recommended that the Commission: 1) waive the requirement that alternative rate applications be filed 30 days before the proposed effective date; 2) approve the Hospital's request for a period of one year effective July 1, 2011, and 3) that the approval be contingent upon the execution of the standard Memorandum of Understanding.
The Commission voted unanimously to approve staff's recommendation.

Medicaid Health Choice Program

Mr. Ports summarized staff's draft recommendations for the applications of: MedStar Health System on behalf of MedStar Family Choice; Maryland General Hospital, St. Agnes Health System, Western Maryland Health System, and Meritus Health on behalf of Maryland Physicians Care; and Johns Hopkins Health System on behalf of Priority Partners, Inc. for continued participation in the Medicaid Health Choice Program for one year beginning January 1, 2012.

Mr. Ports announced that the final recommendations will be presented at the October 12, 2011 public meeting.

ITEM V
FINAL RECOMMENDATION ON RESIDUAL OUTLIER POLICY FOR UPDATE FACTOR SCALING BASED ON REASONABLENESS OF CHARGES (ROC) REPORT BEGINNING IN FY 2013

Andy Udum, Associate Director-Research and Methodology, presented the final recommendations on the treatment of outliers in the Reasonableness of Charges (ROC) regression analysis.

The final staff recommendations are to adopt as policy the method used to handle outliers in the FY 2012 ROC regression. This method is: 1) to routinely conduct regression diagnostics on preliminary ROC regression results; 2) when warranted, to remove the significant outliers, and 3) to apply the coefficients to all hospitals including the hospitals removed as outliers.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
OPTIONS FOR RECONCILIATION OF FY 2010 AVERTED BAD DEBT ESTIMATES TO ACTUAL

Mr. Ports presented an overview and history of Medicaid expansion, the Averted Bad Debt (ABD) Policy, and options for reconciliation of the FY 2010 estimates to actual (see staff Options for Reconciliation of FY 2010 Bad Debt Estimates to Actual on the HSCRC website). Mr. Ports reported that staff calculated that the actual reduction in uncompensated care (UCC) associated with Medicaid expansion of coverage was less than the estimated averted bad debt resulting in hospitals remitting $25.5 million more to Medicaid than the amount of hospital UCC actually reduced.

Mr. Ports presented staff proposed options for handling the overpayment to Medicaid. The first option is to reduce future assessment payments to Medicaid, i.e., hospitals would remit to Medicaid $25.5 million less than the uniform assessment included in rates. This would result in increasing Medicaid's budget deficit in the year that the assessment payment is reduced. The second option is to increase hospital rates in FY 2012 to reflect the overpayment above the estimated averted bad debt assessment. This would make hospitals whole, but payers would have paid the assessment twice. The third option is to reduce or eliminate the savings intended to accrue to payers as a result of the averted bad debt derived from Medicaid expansion. This option would reduce the overpayment by approximately $5 million, the amount contemplated as savings during the legislative process that created the averted bad debt assessment. The fourth option is to take no action. Under this option, hospitals would not be permitted to recover any of the FY 2010 overpayment. The overpayments negatively impacted hospital profits in FY 2010. The fifth option would be to adopt a combination of options one through four.

The Chairman noted that this was an opportunity for the Commission to hear from the various parties about the issues, and that no action would be taken today.

Commissioner Mullen inquired as to whether any hospitals were overburdened by the averted bad debt shortfall.

Jerry Schmith, Deputy Director-Hospital Rate Setting, stated that the impact varied by hospital. Some hospitals were more adversely affected than others.

A panel consisting of Joshua M. Sharfstein, M.D., Secretary of the Department of Health and Mental Hygiene (the "Department), Charles J. Milligan, Jr., Deputy Secretary-HealthCare Finance, and Trisha Roddy, Director of Planning for the Medicaid Program, presented comments.

Secretary Sharfstein stated that it was the Department's position that staff's paper, "Options for Reconciliation of FY 2010 Avert Bad Debt Estimates to Actual," does not provide an adequate basis for decision-making and was pleased that the Commission had decided to defer action and spend some more time on the issues raised.

According to the Secretary, there are several major issues not addressed in staff's paper and, as a result, does not offer the kind of options the Commission needs to make a reasonable decision. Specifically the Department has raised some very important concerns that have not been addressed. The paper does respond to the Department's assertion that actual data indicate that the 28% crowd out assumption utilized in the averted bad debt calculation is not borne out by experience. The Department believes that 28% is the wrong number and, therefore, the Medicaid overpayment of $25 million is the wrong number.

The Secretary also stated that there is actual experience showing that the Use Rate assumption used in the ABD calculation, that people will annually use 18% more hospital services when they are insured, is not correct. Evidence from the Medicaid expansion population indicates that the Use Rate is not a fixed rate and that it goes down over time. The Department believes that an adjustment should be made to the ABD calculation to reflect the actual adverted bad debt. At a minimum, staff should look at the Department's data and analysis and take that all into consideration when proposing options to the Commission.

In addition, according to the Secretary, staff's paper fails to adjust the ABD calculation's crowd out assumption to reflect the impact of people losing their health insurance because of the recession.

Secretary Sharfstein stated the Commission should give serious consideration to these issues.

Commissioner Wong asked what staff's reaction was to the Department's assertions concerning the crowd out and use rate components of the ABD calculation.

Mr. Ports stated that staff has heard these assertions, as well as opinions on the other side of the issues. Based on everything presented thus far, staff sees no reason to alter the 28% crowd out number. However, staff is willing to listen and would like to see the information that the Department and the hospital industry have to offer.

Mr. Schmith added that as of this date, staff has not received credible data one way or the other to prove that there is a better crowd out number.

Commissioner Bone asked where the data that the Department is referring to came from.

Ms. Roddy replied that it was a sample of data from 25 hospitals, which indicated that the crowd out percentage was about 10%. In addition, the Department has actual use rate data.

Traci LaValle, Assistant Vice President-Financial Policy of the Maryland Hospital Association (MHA), stated that the effect of the ABD over payment caused cash flow problems in smaller hospitals in particular. The hospital industry believes that it is important to use the same assumptions in the ABD calculation when you do the estimates at the beginning of the period as when you do the reconciliation at the end of the period.

Ms. LaValle noted that the literature on crowd out is not consistent. It ranges from 0% to 60%. The percentage utilized, 28%, was provided by Medicaid as a reasonable estimate of crowd out.

Ms. LaValle stated that the 25 hospital sample data referred to by the Department was complied by MHA. The data showed that of a sample of 2009 Medicaid expansion patients with admissions at the same hospital in 2008, 11% had been covered by private insurance and 45% were covered by Medicaid or MCOs. The dispute is over how you define crowd out. The definition that Medicaid wants to use is the one typically found in the literature and in public policy discussions - - i.e., how much private coverage is displaced. MHA, on the other hand, believes that the definition should be a little different in the context of the ABD program. Since we are not making a public policy decision as to whether or not to institute a program (the ABD program is already in place), the definition of crowd out should be how much of the care provided under the new coverage is actually ABD. Therefore, crowd out should include people who were previously covered by Medicaid.

The Chairman asked which option MHA favors.

Ms. LaValle stated that MHA favors Option #1, reducing future assessments.

Barry Rosen, representing United Healthcare, expressed support for Option #1. Mr. Rosen asserted that options 2, 3, and 5 are inappropriate because they all increase hospital rates. By increasing rates the options: 1) result in payers paying twice for an assessment that is too high; 2) make hospital care more unaffordable; and 3) cause problems with the all-payer provision of the Medicare waiver because the payments could be construed as a discount to Medicaid.

According to Mr. Rosen, HSCRC law states that it is the HSCRC's responsibility to ensure that the Medicaid Expansion assessment on hospitals does not exceed the actual savings to Medicaid resulting from expansion. Therefore, if the assessment was too high, legally, Option #1 is the HSCRC's only choice.

Mr. Rosen also stated that Chairman Colmers in his former capacity as Secretary of Health,

wrote a 2009 letter to the Chairmen of the State Budget and Taxation Committee and the House Appropriations Committee stating that what was wrong with the original assessment was that it was hospital specific, non-uniform, and retrospective. What he asked the legislature to do was to change it to a broad based, uniform, and prospective assessment. Mr. Rosen asserted that Options 2, 3, and 5 are retrospective. Chairman Colmers asked Mr. Rosen to provide the full context of his letter.

The Chairman asked whether the payers would participate in discussions on the crowd out and use rate issues.

Mr. Rosen indicated his willingness to participate in such discussions.

Hal Cohen, Ph.D., representing CareFirst and Kaiser Permanente, participating by telephone, expressed support for Option #1.

Commissioner Bone asked Mr. Rosen how the resumption of Medicaid Day Limits would affect hospital UCC.

Mr. Rosen stated that UCC would increase.

Commissioner Bone asked whether Medicaid Day Limits or the ABD assessment result in greater cost to the system.

Mr. Rosen responded that the appropriate approach is to ensure that this assessment is not greater than the savings; settle-up with the hospitals; and, then, if there is another Medicaid budget deficit to discuss, decide what the best method is to deal with it.

ITEM VII
SUMMARY OF THE FY 2010 DISCLOSURE OF FINANCIAL AND STATISTICAL DATA

Dennis N. Phelps, Associate Director-Audit & Compliance, summarized the annual disclosure of financial and statistical data for Maryland hospitals. Mr. Phelps announced that for the first time in the history of the HSCRC hospital admissions declined from the previous year (from 703,323 in FY 2009 to 693,284 in FY 2010 or 1.4%). Other major highlights of the report were: 1) patients at Maryland hospitals paid on average 2% more in FY 2010 than in 2009, while the amount paid nationally was estimated to have risen by 3%; 2) the cost per admission in Maryland hospitals increased by 1.6% in FY 2010; 3) from FY 1977 through 2009, Maryland experienced the lowest growth in cost per admission of any state in the nation; 4) profits on regulated activities increased from $669 million in FY 2009 to $715 million in FY 2010; 5) profits on all operations, both regulated and unregulated, were up from $319 million in FY 2009 to $328 million in FY 20010; 6) Maryland hospital total profits increased substantially in FY 2010 from $2 million or 0.01% to $481 million or 0.3.8%; and 7) Maryland hospitals provided more than $926 million of uncompensated care in FY 2010.

Mr. Phelps noted that Maryland hospitals did a good job in FY 2010 of controlling expenses while increasing profits on regulated services. However, costs associated with unregulated physician services continued to be a significant problem for many hospitals.

ITEM VIII
HEARING AND MEETING SCHEDULE

October 12, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
November 2, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:47 a.m.