482nd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
AMENDED

October 12, 2011

Chairman John Colmers called the meeting to order at 10:03 a.m. Commissioners Joseph R. Antos, Ph.D., George H. Bone, M.D., Jack C. Keane, Thomas R. Mullen, and Herbert S. Wong, Ph.D. were also present. Commissioner Bernadette C. Loftus, M.D. participated by conference call.,

REPORT OF THE EXECUTIVE SESSIONS OF SEPTEMBER 27, 2011 AND OCTOBER 12, 2011

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the September 27, 2011 and October 12, 2011 Executive Sessions.

ITEM I
EXECUTIVE AND PUBLIC SESSIONS OF SEPTEMBER 14, 2011

The Commission voted unanimously to approve the minutes of the September 14, 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) the submission of a letter to the Secretary of Health and Human Services requesting an exemption from CMS' Value Based Purchasing (VBP) quality program; 2) completion of recommendation for the magnitude of Quality-based Reimbursement (QBR) and Maryland Hospital Acquired Conditions (MHAC) scaling for FY 2013; 3) ten to twelve of twenty-six Admission-Readmission Revenue (ARR) agreements for FY 2012 already signed; 4) continuing to refine the ARR operational plan including the Charge-per Episode (CPE) calculation; 5) progress on completing the various components needed in order to issue rate orders i.e., calculation of: Charge-per-Case, Charge-per-Visit, and ARR weights, inpatient, outpatient, and ARR case mix, and Uncompensated Care provision; and 6) submission of a letter of intent for HSCRC to serve as a convener in the CMS (the Centers for Medicare and Medicaid Services) Bundled Payments for Care Improvement Initiative and work with CMS to ensure that Maryland hospitals are eligible to participate in the initiative.

Mr. Ports reported that staff is deferring recommendations on the alternative rate setting applications by provider-based Managed Care Organizations (MCOs) for continued participation in the Medicaid Health Choice Program until the November public meeting to allow the

applicants to review the impact of Medicaid payment updates for CY 2012.
The Chairman asked what percentage of Maryland total hospital revenue will be under ARR and the Total Patient Revenue programs when the 26 hospitals sign up for the ARR program.

Mr. Ports stated that he thought that the number was about 55%, but indicated that he would provide a more accurate number.

ITEM III
DOCKET STATUS CASES CLOSED

2129A – Johns Hopkins Health System
2132A – University of Maryland Medical Center
2126A – MedStar Health
2120N –Suburban Hospital
2133A – MedStar Health
2127A – University of Maryland Medical Center

ITEM IV
DOCKET STATUS CASES OPEN

There were no cases requiring Commission action.

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

Mary Beth Pohl, Deputy Director-Research and Methodology, summarized the changes to staff's option paper (see staff Options for Reconciliation of FY 2010 Bad Debt Estimates to Actual on the HSCRC website). Ms. Pohl stated that last month staff was charged with engaging with the interested parties and discussing the components of the averted bad debt (ABD) calculations in order to more accurately quantify the difference between the assessment and actual ABD.

The first issue addressed was whether it is acceptable to revise assumptions made for components of the ABD calculation retrospectively. After discussion, staff believes that it is most appropriate that we change the assumptions based on our best understanding of what the assumptions should be at the current time in light of the economic conditions existent during that time period.

After meeting twice with representatives of the Department of Health and Mental Hygiene (Department), the Maryland Hospital Association (MHA), and payers, and a review of the literature in an attempt to model crowd out, staff determined that it was appropriate to modify the definition of the crowd out component of the ABD calculation to include not only persons who previously had commercial insurance, but also a portion of the Medicaid "spend down" population. Therefore, staff recommends that for purposes of calculating actual ABD a modified crowd out rate of 18.22% be used in the ABD calculation.

The “Lower Use Rate” component of the ABD calculation was also discussed with the parties. Although the Department made a logical argument based on overall expenditure trends that the use rate should decrease, staff did not believe that the supporting data supplied was sufficiently compelling to warrant a change in the ABD calculation for FY 2010. The Department was encouraged to refine the data to better quantify a modified use rate for FY 2011.

Ms. Pohl reported that staff’s recommendations for calculating actual ABD were to: 1) lower the crowd out rate from 28% to 18.22%; 2) maintain the lower use rate at 18%; and 3) correct an error in the calculation, which included savings to payers as a component in the calculation. Changing the calculation to include staff’s recommendations reduces the difference between the amount paid by hospitals to the Department and actual ABD from $25.5 million to $10.9 million.

Jerry Schmith, Deputy Director-Hospital Rate Setting, summarized the revised ABD calculation and indicated that the parties had agreed on the revised crowd out rate of 18.22% as a compromise.

Commissioner Mullen asked whether staff expected that the FY 2011 ABD estimates would be closer to the actual ABD.

Mr. Schmith answered in the affirmative.

Hal Cohen, Ph.D., representing CareFirst and Kaiser Permanente, expressed support for staff’s recommendations and for Reconciliation Option #1, which would reduce the ABD assessment to be paid by hospitals.

Barry Rosen, representing United Healthcare, also supported Reconciliation Option #1.

Traci LaValle, Assistant Vice President-Financial Policy of MHA, agreed with Dr. Cohen and Mr. Rosen that Option #1 be approved, and that the repayment be made in one year.

Trisha Roddy, Director of Planning for the Medicaid Program, stated that the Department accepted the revised crowd out rate assumption, and that there was not enough data to support a change in the use rate. Ms. Roddy also expressed support for Option #1, but that it be repaid over 2 years.

The Commission voted unanimously to approve staff’s recommendations for changes in the ABD calculation, which reduced the difference between the payment to Medicaid and the actual ABD from $25.5 million to $10.9 million.

The Commission voted to approve Reconciliation Option #1, to reduce the ABD assessment to be paid to Medicaid, with the reduction in the assessment to be made in one year. The vote was five in favor and one opposed. Commissioner Bone cast the dissenting vote.

ITEM VI
FINAL RECOMMENDATION ON FY 2013 SCALING FOR QUALITY-BASED REIMBURSEMENT AND MARYLAND HOSPITAL ACQUIRED CONDITIONS PERFORMANCE

Dianne Fenney, Associate Director-Quality Initiatives, summarized staff's recommendations (see Final Recommendation on FY 2013 Scaling for Quality-Based Reimbursement and Maryland Hospital Acquired Conditions Performance on the HSCRC website). Ms. Feeney verbally amended staff recommendations #1 and #2 to read "approved inpatient hospital revenue," since the QBR and MHAC programs apply only to inpatient services and recommendation #5 to add that the scaling be revenue neutral. The amended recommendations included:1) allocating 0.5% of hospital approved inpatient revenue for QBR relative performance; 2) allocating 2% of hospital approved inpatient revenue for MHAC; 3) using the linear scaling approach adopted by CMS for the VPB program for both the QBR and MHAC programs; 4) continuing to use the statewide average as the benchmark to establish the expected MHAC values; 5) scaling the revenue such that the maximum penalty for the poorest performing hospital is the total percentage magnitude of revenue scaled for that program, i.e., 0.5% for QBR and 2% for MHAC, and that the scaling be revenue neutral; and 6) while monitoring MHAC performance consider whether there should be methodology changes for FY 2014.

The Chairman asked if staff had performed any analyses of what the overall impact is on quality of care in Maryland hospitals since the initiation of these programs.

Ms. Feeney stated that overall, Maryland hospitals have improved 12% in the first year of the MHAC program and just over 8% in the second year in the rate of complications. For the QBR measures, Maryland hospitals have improved year after year; however, the nation is improving at a faster pace. When compared to the nation in the ARC Reports, Maryland hospitals look poor to mediocre.

The Chairman requested that the Commission be provided with additional data on Maryland hospitals' performance at the macro level at the next public meeting.

Dr. Cohen congratulated staff on its excellent work. However, Dr. Cohen suggested one change in the scaling methodology, i.e., that beginning in FY 2014 it be symmetrical (that the scaling not be truncated to force revenue neutrality).

Michael Robbins, Senior Vice President-Financial Policy for MHA, expressed support for staff's recommendations.

The Commission voted unanimously to approve staff's amended recommendation.

ITEM VII
HEARING AND MEETING SCHEDULE

November 2, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
December 8, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:17 a.m.