AMENDED MINUTES
477TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

April 15, 2011

Chairman Frederick W. Puddester called the meeting to order at 10:06 a.m. Commissioners Joseph R. Antos, Ph.D., George H. Bone, M.D., C. James Lowthers, Kevin J. Sexton, and Herbert S. Wong, Ph.D. were also present.

ITEM I
EXECUTIVE AND PUBLIC SESSIONS OF MARCH 2, 2011

The Commission voted unanimously to approve the minutes of the March 2, 2011 Public and Executive Sessions.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, updated the Commissioners on the progress of major initiatives and issues in which staff has been involved. They include: 1) progress on Admission-Readmission Revenue (ARR), Total Patient revenue (TPR) arrangements, and population based bundled payment initiatives; 2) focusing on the update factor which is up for decision at today's meeting; 3) technical issues associated with the scaling of the Reasonableness of Charges (ROC) and Quality initiatives adjustments; 4) working with the legislature to gain approval of increases to the HSCRC User Fee Cap; and 5) work on the Physician Workforce Study to be finalized by the June public meeting.

Mr. Murray introduced Mary Beth Pohl as the new Deputy Director-Research and Methodology. Ms. Pohl worked most recently as a senior Consultant with the Lewin Group. Prior to that, Ms. Pohl served as a Health Policy Analyst with the Maryland Medicaid Program and as a research assistant at the Urban Institute. Ms. Pohl is a graduate of Johns Hopkins University with a B.A. degree in Public Health.

ITEM III
DOCKET STATUS CASES CLOSED

2106N – Johns Hopkins Health Care

2107A – Helix Resource Management

ITEM IV
DOCKET STATUS CASES OPEN

Adventist Behavioral Health – 2108N

On March 16, 2011, Adventist Behavioral Health submitted an application requesting a new rate for Clinic (CL) services. The Hospital requested the lower of $30.45 per RVU or the statewide median CL rate to be effective April 1, 2011.

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 a CL rate of $30.45 per RVU be approved effective April 1, 2011; and
3. That the CL 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.

University of Maryland Medical Center – 2109A

On February 17, 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 and blood marrow transplant services with LIFE TRAC, Inc. for a period of three years beginning April 1, 2011.

Staff found the experience under this arrangement to be favorable for the last year and recommended that the Hospital's request be approved for one year beginning April 1, 2011, with the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2111A

On March 26, 2011, the Johns Hopkins Health System filed an alternative method of rate determination application on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, requesting approval to participate in a re-negotiated global rate arrangement for cardiovascular services with Coventry Health Care of Delaware for a period of one year beginning May 1, 2011.

After review staff was satisfied that the Hospitals could achieve favorable performance under the re-negotiated arrangement. Therefore, staff recommended that the Hospitals' application be

approved for a period of one year effective May 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.

ITEM V
FINAL RECOMMENDATION ON UNIQUE PATIENT IDENTIFIER POLICY

Dianne Feeney, Associate Director-Quality Initiative, summarized the final staff recommendation on using health information exchange data to create a unique patient identifier that supports accurate measurement of hospital-specific readmission performance. The objective of the recommendation is to require hospitals to connect with the Chesapeake Regional Information System for our Patients (CRISP), the Maryland Health Information Exchange (MHIE), and to submit the data required so that CRISP's technology infrastructure may be utilized to create a uniform patient ID to track readmissions across hospitals.

Staff recommended that the Commission: 1) promulgate regulations to require hospitals to connect with the MHIE by December 1, 2011; 3) publish the elements, format, and time period of the data required to be submitted by hospitals to the MHIE; and 4) use these data to fully measure and compare hospital-specific performance on readmissions.

Ms. Feeney offered an amendment to the recommendation to change the date that hospitals would be required to connect to the MHIE from September 1, 2011 to December 1, 2011.

Commissioner Bone asked what the cost to hospitals would be to connect to the MHIE, and if the staff viewed that cost to be reimbursable by the Commission.

Steve Ports, Principal Deputy, stated that staff did not know the cost, but would find out and report back to the Commission. Mr. Ports also pointed out that there is federal funding available to hospitals for the "meaningful use" of electronic health records.

Mr. Murray noted that there has been no discussion concerning these costs, and that they would not be factored into the rate base at this time.

Traci LaValle, Assistant Vice President-Financial Policy of the Maryland Hospital Association (MHA), expressed the hospital industry's support for staff's recommendation to connect Maryland hospitals to the MHIE and to use the existing technology to identify readmissions across hospitals.

In regard to the cost to Maryland hospitals, Ms. LaValle estimated that there are costs associated with connecting to the MHIE and, in addition, there are ongoing subscription costs of between $10 million and $15 million annually.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, expressed support for the recommendation and urged Commission approval.

The Commission voted unanimously to waive its 60 day comment period policy so that the recommendation could be considered for final action.

The Commission voted unanimously to approve the amended recommendation.

ITEM VI
LEGAL REPORT

Regulations

Proposed

Health Information Exchange Data – COMAR 10.30.07.01-.07

The purpose of this action is to enable the Commission to fully measure and compare hospital-specific performance on readmissions and to use the data to further enhance and strengthen the financial incentives linked with performance.

The Commission voted unanimously to approve the promulgation of this new regulation in the Maryland Register.

ITEM VII
FINAL RECOMMENDATION ON ASSESSMENTS AND FY 2012 UPDATE FACTOR

Mr. Murray summarized staff's Recommendation and Discussion Document Regarding the FY 2012 Hospital Payment Update (see recommendation, "Final Staff Recommendation and Discussion Document Regarding the FY 2012 HSCRC Hospital Payment Update" on the HSCRC website).

Mr. Murray stated that the payment update is meant to cover factor inflation and any changes in the real case mix of patients, as well as provide a mechanism for the Commission to recognize fixed costs, in order to provide an incentive to control volume growth, and to achieve other policy objectives through the use of a policy/ productivity adjustment.

The final recommendation and discussion document included policy and environmental considerations including hospital industry financial performance, affordability of care, and Medicare waiver performance. It also included the key update factor components: 1) forecasted market basket inflation; 2) forecast error; 3) policy/productivity adjustment; 4) rate slippage; 5) case mix provision; 6) volume adjustment; and 7) and Medicaid assessment. In addition, the

document included FY 2012 MHA (hospitals) and payer update proposals, as well as three staff proposed options.

The update proposals utilize the same components with the exception of: 1) the magnitude of the policy/productivity adjustment; 2) the proportion of the Medicaid assessment borne by the payers in hospital rates, and, the proportion directly submitted by the hospitals; 3) the case mix adjustment; and 4) the upfront funding for ARR arrangements.

The policy/productivity adjustment (0.41%) in MHA's proposal and (2.13%) in the payer proposal produce "Base Update Provided" of 3.44% and 1.89% respectively. The staff update options are structured to induce certain levels of efficiency utilizing the magnitude of the policy/productivity adjustment. Staff's options bracket the level of financial pressure exerted by the policy/productivity adjustment in the FY 2011 update with Option #1 applying less pressure, Option #2 applying the same pressure, and Option #3 applying more pressure. The policy/productivity adjustments are: Option #1 (1.00%); Option #2 (1.15%); and Option #3 (1.29%), the resulting Base Update Provided are, respectively, 2.68%, 2.53%, and 2.39%.

MHA's and the three staff options propose that the Medicaid assessment be split with $56 million remitted directly from hospitals (the amount remitted directly by hospitals in FY 2011) and $334 million placed in hospital rates and paid by the payers, while the payers propose a 30%/70% split between hospital and payers, $117 million and $273 million, respectively.

MHA proposes a guaranteed 1% blended inpatient outpatient case mix adjustment in its proposal, while the payers add in the estimated upfront funding of ARR arrangements, 0.25%, in their proposal.

Mr. Murray stated that because of concerns about affordability of hospital care, in order to induce hospitals to move toward more bundled payment mechanisms, and as a result of our relative less favorable position versus more efficient hospitals nationally, staff prefers its Option #3 update proposal. Murray also suggested that the Commission consider a higher fixed cost volume adjustment. In addition, Mr. Murray requested that the recommendation for the scaling of the ROC and Quality performance be decoupled from the core update and assessment issues. A recommendation on scaling of those items will be presented at the May public meeting.

Joshua M. Sharfstein, M.D., Secretary of Health and Mental Hygiene, and Charles J. Milligan, Jr., Deputy Secretary-Health Care Finance, presented comments. Secretary Sharfstein stated that it is most important that the HSCRC continue to aggressively pursue payment reform. The Secretary noted that from the perspective of a payer, the State is comfortable with staff's three update options. In addition, as the various health care delivery and payment reforms occur, it is likely that large parts of the health care system, including hospitals, will experience declines in volume. The Secretary suggested that the Commission consider increasing the fixed cost percentage of the volume adjustment to cushion the effect.

Mr. Milligan stated that the Medicaid Program appreciates the efforts of the HSCRC to provide the right incentives to ensure that there is on going access and quality care for Medicaid

beneficiaries. Mr. Milligan encouraged hospitals and community based providers to work together for total patient treatment.

The Chairman asked the Secretary for his thoughts on reforming the Medicare waiver.

The Secretary stated that CMS understands the effect of payment reform on the waiver test and is interested in creating a new waiver test probably this year to allow Maryland's system to move forward aggressively on payment reform.

The Chairman urged the Secretary to continue to work with the Commission on the assessment issue.

The Secretary agreed to work with the Commission with the hope that the payment reform initiatives and an up-turn in the economy will ease Medicaid's reliance on assessments.

A panel consisting of Chester Burrell, President and CEO of CareFirst of Maryland, Dr. Harold Cohen, representing CareFirst and Kaiser Permanente, Gary Simmons, Regional Vice President of United Healthcare, and Barry Rosen, representing United Healthcare presented comments on the update proposals.

Mr. Burrell stated that the key points for the Commission to consider in making its decision on the payment update are: 1) the limits of affordability of health care and the problem of the uninsured and the under-insured (as reflected in the rise in the number of individuals cancelling health insurance and the increase in the movement of small businesses to high deductable coverage for their employees); 2) the importance of changing the fixed cost percentage of the update volume adjustment if reductions in health care use continue; and 3) the importance of the Medicare waiver and the need for a alternative waiver test.

Mr. Murray asked Mr. Burrell whether he thought the trend in volume declines would continue.

Mr. Burrell stated that we don't know the reason for the sharp decline in admissions. It could be that people are deferring care because of the general state of the economy. If that is true, there is only so long that care can be deferred and, at some point, there will be a reversion to the mean.

The Chairman asked Mr. Burrell what are the biggest drivers of premium increases.

Mr. Burrell cited increases in the use and the cost of prescription drugs and the demand associated with patients with multiple chronic diseases.

Mr. Simmons urged the Commission to keep in mind the value of the waiver and ensure that it is not jeopardized. In order to enhance affordability, he urged the Commission not to approve an update factor greater than that in the payer's proposal. Mr. Simmons stated that United Healthcare encourages the Commission to focus attention on reducing avoidable readmissions. Mr. Simmons also asked that the Commission find additional ways to reward hospitals that

provide higher quality and less costly health care while penalizing hospitals that fail to improve. Dr. Cohen stated that he believed that even staff's Option #3 does not exert enough financial pressure on hospitals to be more efficient. According to Dr. Cohen, MedPac data indicated that when financial pressure was applied to hospitals, the increase in cost per case decreased on average by 2.0%. Therefore, the payer's proposal, Market Basket factor inflation minus 1%, is achievable, especially for one year. Dr. Cohen noted that even the additional financial pressure of splitting the assessment 30/70 should be achievable by hospitals.

Dr. Cohen also suggested that it was unwise in theses economic times to attempt to get the Mikulski waiver amendment changed.

Dr. Cohen stated that MedPac data show that efficient hospitals providing quality care with low readmission rates have costs that are 8% below the national average, while Maryland hospitals are 2% below the U.S. and are achieving profits of 7%. This raises the question of whether enough financial pressure is being placed on Maryland hospitals to achieve profits through increased productivity.

Dr. Cohen stated that if the Commission could address the productivity difference between efficient U.S. hospitals and the 5% in rates from various assessments, the waiver test would not be a problem.

Dr. Cohen suggested that the Commission meet with the stakeholders outside of this process to consider a possible 3-year update arrangement beginning in FY 2013.

Mr. Rosen encouraged the Commission to raise the fixed cost percentage in the volume adjustment effective 7/1/11. This will provide hospitals with the incentive to bring volumes down.

Mr. Rosen stated the United Healthcare recommended that the Commission adopt a policy adjustment that is more negative than the staff's Option #3, which is (1.29%) for four reasons: 1) to ameliorate the erosion in the waiver test caused by the Medicaid assessment; 2) to keep pressure on hospitals to participate in the ARR initiative to reduce admissions; 3) to recognize the $70 million a year in federal stimulus money that is coming to Maryland hospitals in the next four years associated with the meaningful use of electronic health records; and 4) tp enhance the affordability of health care.

A panel consisting of Carmela Coyle, President of MHA, Stuart Erdman, Senior Director of Finance of the Johns Hopkins Health System, Henry J. Franey, Senior Vice President & CFO of the University of Maryland Medical System, Michael Robbins, Senior Vice President-Financial Policy, and Traci LaValle, of MHA presented comments on the update proposals.

According to Ms. Coyle, there are two critical issues before the Commission today. They are important because of their policy implications and because of their impact. In terms of the impact, the Commission's task is to balance affordability of care with the viability of the hospital field as we want it to be. On the policy side, the Medicaid budget assessment has increased three

fold.

The first of the critical decisions to be made today is on the assessment. MHA agrees with the Commission that assessments cannot continue to be used as an annual funding mechanism for Medicaid and is pleased that the legislature has approved a stakeholder workgroup, lead by Secretary Sharfstein, to take a look at the long term sustainability of funding for the Medicaid program. If assessments are to be used as an immediate funding solution, it is the hospital industry's view that the assessment should be placed in hospital rates so it can be spread across the largest number of individuals. However, the industry realizes that it will be asked to assume a share of the burden of the assessment and its proposal reflects a reasonable portion of the assessment.

The second decision is the magnitude of the policy adjustment in the update. In making its decision, the Commission should consider: the size of the policy adjustment in relation to the overall rate of inflation; and, in light of the large policy adjustments made in the last couple of years, we have demonstrated that we have bent the cost curve.

Mr. Robbins stated that the industry agrees to assume the burden of the portion of the Medicaid assessment as calculated in staff's proposals. Mr. Robbins pointed out that the policy adjustment of (0.41%) in the MHA proposal represents 15% of core inflation, and if slippage and the change in the assessment are included the reduction is more than 25% of core inflation.

Mr. Robbins noted MHA's position that as a result of scaling, no hospital should have a negative overall update.

Mr. Franey and Mr. Erdman detailed the impact of policy adjustments and the assumption of a portion of the Medicaid assessments on hospital operations over the last several years.

Mr. Franey stated that the financial pressure has stopped capital spending and caused hospitals to lower pension and health care benefits for employees. Mr. Franey urged the Commission to look past next year when making its decision and to take into consideration that hospitals need to make an enormous investment in information technology (I.T.) over the next several years.

Mr. Erdman noted that many hospitals, including Johns Hopkins, are in the middle of capital replacement cycles. In addition, he agreed with Mr. Franey that Maryland hospitals are behind the nation in I.T. According to Mr. Erdman, hospitals must be profitable to ensure that their bond ratings do not erode, and that they have the ability to borrow. Mr. Erdman cautioned that the Commission should be careful when applying financial pressure to push down costs because the pressure may affect the size and the number of medical programs offered by hospital. Mr. Erdman questioned whether 6% below the U.S. in cost per case is a reasonable target.

The Chairman asked what the hospital industry's position was on changing the fixed cost percentage of the volume adjustment.

Ms. Coyle stated that since there was not sufficient data to determine whether volume declines will be sustained, MHA's position was that no change be made at this time.

Kimberly Y. Robinson, Executive Director of the League of Life and Health Insurers, and Brett S. Lininger, representing Coventry Health Care, expressed support for the payer's proposal.

Commissioners Observations

Commissioner Bone stated that the options are not that far apart. However, the decision is difficult because it affects many people not at the table, e.g., patients, the uninsured, the under-insured, and physicians.

Commissioner Antos stated that from his experience with Medicare waivers, we should not be so optimistic that if we are able to obtain a favorable change in the waiver that we will be able to keep the current payment level. Dr. Antos expressed his preference for a 3 year arrangement in the future; however, since we currently are only dealing with one year, the financial pressure applied last year should not be lowered. In addition, if we intend to manage care in a holistic way we must take policy steps to encourage movement towards a more combined payment system.

Commissioner Sexton stated that although he was struggling with the range of policy options, he was concerned that there was accumulative effect of constantly applying financial pressure on hospitals. Mr. Sexton expressed concern that access to care will suffer. Mr. Sexton supported a slow and steady measured approach on the lower end of the range of policy options. Commissioner Sexton expressed agreement with Commissioner Antos that we should have 3 year arrangements.

The Chairman agreed with Commissioner Sexton that we should take a slow and steady approach, and he also favored a 3 year update arrangement.

Commissioner Wong also agreed with the idea of a 3 year arrangement. In addition, Dr. Wong stated that Maryland cost per case should be lower than the nation and sided with Commissioner Antos that we should maintain financial pressure by choosing staff Option #3.

Commissioner Lowthers stated that affordability is the major concern. Hospitals must become much more efficient and the way to accomplish this was to keep pressure on the hospital industry. According to Mr. Lowthers, we can apply more pressure because hospitals will be able to achieve profits from the ARR initiative. Commissioner Lowther expressed his support for staff Option #3.

Commissioner Bone made a motion to approve an update that split the difference between staff's Options #1 and #2.

Three Commissioners voted in favor of the motion (Commissioners Sexton and Bone, and the Chairman) while three Commissioners voted against the motion (Commissioners Antos, Wong, and Lowthers).

Commissioner Lowthers made a motion to approve an update equal to staff's Option #2 along with an increase in the fixed cost percentage of the volume adjustment from 15% to 25%.

Three Commissioners voted in favor of the motion (Commissioners Antos, Wong, and Lowthers) and three Commissioners voted against the motion (Commissioners Sexton, Bone, and the Chairman).

Commissioner Antos made a motion to approve an update equal to staff's Option #2.

The Commissioners voted 4 to 1 to approve the motion. Commissioner Lowthers voted against the motion.

FY 2012 Approved Update Factor

Market Basket Inflation (Global Insights-1st QterBook for 6/10/12)	2.68%
Adjustment to Inflation	0.21%
Subtotal-Inflation Allowance	
Policy Adjustment	(1.15%)
Subtotal- Update	1.74%
Slippage	(0.18%)
Rate Update Provided	1.56%
Volume Adjustment (Fixed Cost Factor 15%)	0.14%
CMI Adjustment	(0.83%)
Full (or Base) Update Provided	**2.53%**
Total Funds from Assessment/Remittance from Hospital	$56,465,884

ITEM VIII
HEARING AND MEETING SCHEDULE

May 4, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
June 1, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 1:25 p.m.