478TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

June 1, 2011

Chairman Frederick W. Puddester called the meeting to order at 10:00 a.m. Commissioners Joseph R. Antos, Ph.D., George H. Bone, M.D., Kevin J. Sexton, and Herbert S. Wong, Ph.D. were also present.

THE RESIGNATION OF THE CHAIRMAN

Frederick W. Puddester announced his resignation as Chairman of the Health Services Cost Review Commission. Mr. Puddester has accepted the position of Vice President of Finance at Williams College in Williamstown, Massachusetts. Mr. Puddester expressed his appreciation for the assistance he received from staff and his fellow Commissioners during his tenure as Chairman.

ITEM I
PUBLIC SESSION OF APRIL 15, 2011

The Commission voted unanimously to approve the amended minutes of the April 15, 2011 Public Session.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, updated the Commissioners on the status of current and future projects in which staff has been involved. They include: 1) redesigning the structure of the Quality Based Reimbursement (QBR) program in order to obtain an exemption from CMS' Value Based Purchasing quality program; 2) working through the technical issues and changes of the Reasonableness of Charges (ROC) methodology; 3) developing a recommendation on the scaling of the QBR and ROC; 4) finalizing the pilot Admission-Readmission Revenue (ARR) agreements; 5) continuing negotiation of Total Patient Revenue agreements with several hospitals; and 6) anticipating meeting with the Secretary of Health and stakeholders to develop a strategy for requesting modification of the Maryland Medicare waiver.

ITEM III
DOCKET STATUS CASES CLOSED

2108N – Adventist Behavioral Health
2111 A – Johns Hopkins Health System
2109A – University of Maryland Medical Center

ITEM IV
DOCKET STATUS CASES OPEN

Western Maryland Health System – 2110N

On March 25, 2011, Western Maryland Health System submitted an application requesting a new rate for Hyperbaric Chamber (HYP) services. The Hospital requested the statewide median HYP rate to be effective May 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 HYP rate of $180.24 per RVU be approved effective May 1, 2011; and
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.

University Specialty Hospital – 2112N

On May 9, 2011, University Specialty Hospital submitted a partial rate application requesting a new rate for Operating Room-Clinic (ORC) services. The Hospital requested the statewide median ORC rate to be effective June 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 an ORC rate of $12.25 per RVU be approved effective June 1, 2011; and
3. 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.

University of Maryland Medical Center – 2113A

On April 22, 2011, the University of Maryland Medical Center filed an alternative method of rate determination application requesting approval to continue to participate in a renegotiated global rate arrangement with the Gift of Life Foundation (GOL) for the collection of bone and blood marrow and peripheral blood stem cells transplant services from GOL donors on an outpatient basis to facilitate hematopoietic stem cell transplants to GOL recipients. The Hospital seeks approval of the arrangement for one year beginning April 1, 2011.

Staff found the experience under this arrangement to be slightly unfavorable for the last year; however, in addition to recalibrating the hospital portion of the global rate, the Hospital has implemented several utilization reduction initiatives.

After review of the revised global rates and recognizing the efforts undertaken to reduce hospital charges through utilization reductions, staff recommended that the Hospital's request be approved for one year beginning April 1, 2011, with the approval to be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Holy Cross Hospital – 2115A

On May 18, 2011, Holy Cross Hospital requested that the Commission approve its continued participation in the alternative method of rate determination arrangement with the Kaiser Health Plan of the Mid-Atlantic States, Inc.

This arrangement approved for two years in July 2005 and subsequently extended an additional two years in July 2007 and again in July of 2009, grants a reduction in rates of 3.15% to Kaiser members to reflect the cost savings to Holy Cross generated by activities performed by Kaiser. In addition, Kaiser was allowed to use its greater purchasing power to reduce the cost of major medical devices for its members; in return Holy Cross, agreed to reduce its total Allowable Revenue by the cost of the devices.

Based on a letter of attestation and data provided by Holy Cross, the activities of Kaiser continued to justify the rate reduction provided to Kaiser members, and Holy Cross' Total Allowable Revenue for FY 2009 and FY 2010 was reduced by $652,724 and $589,994 respectively.

Therefore, staff recommended that the Commission approve Holy Cross' request to participate in this arrangement for an additional two years beginning July 1, 2011.

The Commission voted unanimously to approve staff's recommendation. Commissioner Sexton abstained from the vote.

Johns Hopkins Health System – 2117A

On May 19, 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 continue to participate in a global rate arrangement for solid organ and bone marrow transplants with INTERLINK Health Services, Inc. for a period of three years beginning June 1, 2011.

Although there has been no activity under this arrangement, staff was satisfied that the Hospitals could achieve favorable performance under this arrangement. Therefore, staff recommended that the Hospitals' application be approved for a period of one year effective June 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 RECOMMENDATIONS ON FUNDING SUPPORT FOR THE MARYLAND PATIENT SAFETY CENTER

Dianne Feeney, Associate Director-Quality Initiative, summarized staff's Final Recommendations on Funding Support of the Maryland Patient Safety Center (the "Center") (see Staff Recommendation on the HSCRC website). The purpose of the Center is to reduce the occurrences of adverse events, and to improve the culture of patient safety at Maryland health care facilities.

Staff's recommendations include: 1) that funding for FY 2012 in the amount of $1,314,433 be provided through hospital rates; 2) that, in the future, the Commission reconsider the policy of reducing the percentage of the Center's costs funded by 5% and either propose a new plan or consider evaluating the efficacy of the Center's funding request annually; 3) that the Center continue to aggressively pursue other sources of revenue, including from other provider groups that benefit from the programs of the Center; and 4) that the 60-day comment rule be waived so that the recommendations may be considered for final approval.

C. Patrick Chaulk, M.D., Executive Director and President of the Center, thanked the Commission for its support of the Center and expressed his agreement with the staff's recommendations.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
FINAL RECOMMENDATION FOR FY 2012 NURSE SUPPORT PROGRAM II COMPETITIVE INSTITUTIONAL GRANTS

Oscar Ibarra, Chief-Program Administration & Information Management, summarized staff's Final Recommendations for FY 2012 Nurse Support Program II (NSP II) (see Staff Recommendation on the HSCRC website). The objective of NSP II, which is funded by the an assessment of 0.1% in hospital rates and administered by the Maryland Higher Education Commission (MHEC), is to increase the number of bedside nurses by increasing the capacity of Maryland nursing schools.

Mr. Ibarra reported that 18 proposals were received, and staff was recommending that 16 grants, in the amount of $7.7 million, be funded for FY 2012.

Ms. Peggy Daw, of MHEC, stated that her goal was to ensure that the NSP II Program is working together with the other State programs to achieve the best outcomes.

According to Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, CareFirst and Kaiser recommended the creation of the NSP II Program to the Commission. Dr. Cohen stated that his clients believe asked that the impact of rate reform will result in a significant shortage of nurse case managers and would ask the Commission to consider using the NSP II or a new program to encourage nursing schools to train nurse case managers.

Ms. Catherine M. Crowley, Ed.D., Vice President of the Maryland Hospital Association (MHA), reported that she is now managing the "Who Will Care" program, which is a grant funded program to support expansion of nursing education capacity. Who Will Care complements the NSP II Program by providing funding for assistive services to those students obtaining their first nursing degree.

Ms. Crowley stated that the hospital industry values and appreciates the NSP II program and urges the Commission to continue its support.

The Chairman asked whether there was an issue with financial aid at the undergraduate level.

Ms. Crowley stated that federal financial aid has been cut especially to community colleges which graduate half of our R.N.s. This makes the NSP II scholarships all the more valuable. According to Ms. Crowley, we still have almost two qualified applicants for each undergraduate nursing school program slot in Maryland in spite of the progress made by these programs.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
DRAFT RECOMMENDATION ON QUALITY BASED REIMBURSEMENT METHODOLOGY FOR FY 2012

Ms. Feeney summarized staff's Draft Recommendation on Quality Based Reimbursement Methodology for FY 2012 (QBR) (see Staff Recommendation on the HSCRC website).

Ms. Feeney reported that Maryland hospitals' QBR performance in process measures improved in the second year over the initial year; however, the U.S. is improving more quickly. Consequently, Maryland's performance, based on our National Healthcare Quality Report ("Dashboard on Health Care Quality Compared to All States"), on acute care and hospital measures is declining from average to weak.

Ms. Feeney stated that in order to obtain an exemption from the Centers for Medicare and Medicaid Services' (CMS') Valued Based Purchasing (VBP) program, a QBR Expansion Workgroup has been analyzing the proposed rule and requirements to determine the updates and expansions that should be made to the QBR Program to meet or exceed the patient health and cost outcomes of the VBP program. According to Ms. Feeney, the Maryland Hospital Acquired Conditions (MHAC) and an updated QBR program must be proposed together to CMS as meeting or exceeding the VBP program to gain the exemption.

The draft recommendations included: 1) continue to use the 17 process measures utilized in FY 2011, as well as the new measures added for FY 2012; 2) use a hybrid of the Opportunity and Appropriateness models, where hospital scores are based 50% on opportunity and 50% on appropriateness; 3) apportion 70% of the hospital scores to process measure performance, and 30% to patient satisfaction performance; 4) continue to require hospitals to report a minimum of 5 process measures with a minimum of 10 cases for each process measure; 5) use a linear function to translate hospital scores into payment adjustments; and 6) prepare and submit to the Secretary of the U.S. Department of Health and Human Services a VBP program exemption request letter by October 1, 2011.

Ms. Feeney indicated that the final recommendations to update and expand the QBR Initiative will be presented at the July public meeting.

Dr. Cohn expressed support for staff's recommendation.

Anne Hubbard, of MHA, expressed the support for the expansion of the QBR program and pledged to work with the HSCRC to gain an exemption from CMS' VBP program for Maryland hospitals.

ITEM VIII
UPDATE ON THE STATUS OF SCALING METHODOLOGIES FOR THE FY 2012 UPDATE

According to Mr. Murray, the hospital efficiency measure, Reasonableness of Charges (ROC), and the quality measures, QBR and MHAC, together are a good assessment of the value of care provided by hospitals. The hospitals providing the most value are those that are most efficient and provide the highest quality of care. What we are attempting to accomplish through scaling is to provide revenue neutral rewards and penalties within the rate setting system to incentivize hospitals and to reward performance.

To put in context the relative magnitude of scaling last year, Mr. Murray pointed out that the amount of revenue scaled for the ROC adjustment is significant, i.e., 15% of the difference between a hospital's ROC position relative to the peer group average, which could be as much as 0.3% of hospital revenue. On the other hand, the amount of revenue that could be taken away from an individual hospital was limited to 0.5% of inpatient revenue for each quality initiative. Unfortunately, as a result of linear scaling this resulted in only $3 million or 0.02% of revenue being negatively scaled, with the same amount available as a reward for favorable MHAC performance. The amount scaled for QBR was less than $3 million. Mr. Murray noted that without knowing what the magnitude of the incentives would be, hospitals, nevertheless, responded favorably to the quality initiatives.

This year, staff proposes increasing the amount of revenue scaled from the poorer performing hospitals and reallocating the revenue to the better performing hospitals in the quality initiatives. Mr. Murray then summarized staff's first attempt at adding these three proposed scaling structures together. The structures include: 1) ROC scaling at 15% of the difference between a hospital's ROC position relative to the peer group average; 2) scaling for QBR to remain at 0.5%, split 70%/30% between process measures and patient satisfaction scores; and 3) scaling the MHAC initiative from a minimum of 0.75% up to a maximum of 1.5% of inpatient revenue. Mr. Murray stated that at the maximum scaling (1.5%), as much as $20 million would be scaled from the poorer performing hospitals to the better performing hospitals.

Chairman Puddester asked how much would be scaled at the 0.75% level.

Mr. Murray stated approximately $13 million.

Mr. Murray presented an analysis to the Commissioners which showed the result of adding all three proposed scaling structures together. Mr. Murray noted that the rewards and penalties were, in many cases, significant.

Mr. Murray reported that there are still issues with the ROC methodology and staff is continuing to meet with the Payment Work group.

Commissioner Sexton asked whether scaling for the quality initiatives would affect hospitals' ROC position as scaling the ROC does.

Mr. Murray stated that scaling for quality would not affect hospitals' ROC position as ROC scaling does, because revenue is permanent, while the scaling revenue for the quality initiatives is "one-time" revenue.

Commissioner Bone noted that the analysis indicated that there seemed to be more poorly performing hospitals in the Washington metropolitan area than one would expect. He asked whether staff thought there were problems with the peer groups or other technical issues that biased those hospitals.

Mr. Murray stated that he believed that the methodologies contained the appropriate adjustments so that hospitals in the Washington metropolitan area were not disadvantaged in the analysis.

The Chairman asked whether the differences between hospitals were statistically significant enough to warrant the increases in scaling for the quality initiatives proposed by staff.

Mr. Murray suggested that increasing the scaling 0.02% to 1.5% of a $13 billion industry is not all that substantial. Mr. Murray pointed out that rewarding good quality and penalizing poor quality is the direction that the nation is headed, and Maryland happens to be out front.

Michael Robbins, Senior Vice President-Financial Policy for MHA, stated that MHA recognizes that none of these measurements is perfect, but that they are directional. MHA is supportive of a number of the changes and improvements in the system. Mr. Robbins also requested that the range of the scaling of the quality programs for both FY 2012 and 2013 be determined at the July public meeting, so that hospitals will know the magnitude of possible rewards and penalties for FY 2013 in advance.

Dr. Cohen expressed support for staff's recommendation not to change the scaling for the ROC and to the increase the scaling for the quality initiatives. Dr. Cohen also agreed with Mr. Robbins that the range of FY 2013 scaling for the quality programs should be determined in advance.

James J. Xinis, President and Chief Executive Officer of Calvert Memorial Hospital, and Raymond A. Grahe, Vice President, Finance of Meritus Medical Center, expressed support for the staff's proposed scaling of the ROC and quality initiatives.

ITEM IX
SUMMARY OF MARYLAND PHYSICIAN WORK FORCE STUDY

Steve Ports, Principal Deputy Director, stated that a 2008 Task Force to Review Physician Shortages in Rural Areas recommended that a state-only Loan Assistance Reimbursement Program (LARP) be established funded by an HSCRC assessment to hospital rates. The recommendation was supported by a physician workforce study sponsored by MHA and MedChi, the Maryland State Medical Society. The MHA/MedChi study indicated that contrary to traditional U.S. Health Resources and Services (HRSA) and Association of American Medical

Colleges (AAMC) studies, which showed Maryland physician supply to be well above the national average, Maryland physician supply was actually 15% below the national average with significant and widespread physician shortages. The study utilized compared Medicare license renewal data to a standard based on American Medical Association Physician (AMA) Masterfile data. The task force also changed some of the physician licensing requirements so that Maryland physician licensing data could be accessed for comparison with national data. Now that there are two years of physician licensing data, the Maryland Health Care Commission has contracted with Direct Research, LLC for this study.

Christopher Hogan, Ph.D., President of Direct Research, LLC, summarized the Maryland Physician Workforce Study: Applying the Health Resources and Services Administration Method to Maryland Data (see, "Physician Workforce Study: Applying the Health Resources and Services Administration Method to Maryland Data" on the HSCRC website).

Dr. Hogan stated that the purpose of this study was to estimate an accurate count of physicians delivering patient care. After reconciling and adjusting for the differences between data and Maryland physician license renewal data, the study results aligned with the HRSA and AAMC studies that state that Maryland's physician-to population ratio is well above the national average, and the "gold standard" for U.S. physician supply information, the AMA Masterfile, appears to match the Maryland license renewal data well, as long as we make the necessary and relevant adjustments. According to Dr. Hogan, the study suggests that there is no immediate state-wide crisis in physician supply. Instead, the historical estimates of Maryland as a relatively well-supplied state appear to remain true. However, a low physician-to-population ratio in Southern Maryland was identified, and the study did not address physician shortages in small areas, or in individual physician specialties.

Dr. Hogan stated that an accurate physician head count is just a good start. What is needed is further analysis using the physician data now available to get a better picture of adequacy of regional physician supply.

ITEM X
LEGAL REPORT

Regulations

Final Adoption

Uniform Accounting and Reporting System for Hospitals and Related Institutions – COMAR 10.37.01.02

The purpose of this action is to update the Commission's Manual entitled, "Accounting and Budget Manual for Fiscal and Operating Management" (August 1987), which has been incorporated by reference.

The Commission voted unanimously to approve the final adoption of this amended regulation.

SPECIAL PRESENTATION TO CHAIRMAN PUDDESTER

Mr. Murray stated that Mr. Puddester's many decades in state service made him well equipped to deal with the arcane language, formulas, and acronyms. Mr. Puddester's experience served him well and provided him with the capacity to address monumental issues in his tenure as Chairman. Mr. Murray stated that staff believed he handled those issues masterfully. Mr. Murray praised Mr. Puddester for how much work he put in during his short tenure as Chairman and for his protection of the Commission and of staff in discussions with members of the legislature.

Mr. Murray expressed the best wishes of staff and the Chairman's fellow Commissioners and presented a plaque honoring Mr. Puddester for his service to the citizens of Maryland as Chairman of the Health Services Cost Review Commission.

ITEM XI
HEARING AND MEETING SCHEDULE

July 6, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
August 3, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:54 a.m.