479TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

July 6, 2011

Vice Chairman Sexton called the meeting to order at 10:01 a.m. Commissioners Joseph R. Antos, Ph.D., George H. Bone, M.D., and Herbert S. Wong, Ph.D. were also present. Commissioner Lowthers participated by telephone.

ITEM I
PUBLIC SESSION OF APRIL 15, 2011

The Commission voted unanimously to approve the minutes of the June 1, 2011 Public Session.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, summarized the status of current and future initiatives. They include: 1) preparing the recommendation on the scaling of the QBR and ROC to be presented today; 2) starting to work on a letter to the Secretary of Health and Human Services requesting an exemption from CMS' Value Based Purchasing (VBP) quality program; 3) beginning to work through several issues for the FY 2012 Reasonableness of Charges (ROC) methodology, including accounting for residents and interns and the impact of the Total Patient revenue (TPR), Admission-Readmission Revenue, and other fixed payment initiatives on the ROC; 4) finalizing the ARR agreements with nineteen hospitals and documenting the ARR methodology; and 5) discussing possible TPR like arrangements with six hospitals.

Mr. Murray presented several charts which showed a reduction in hospital volumes and a reduction in the rate of revenue growth in the system, along with an increase in Charge-per-Case growth in FY 2011. Mr. Murray opined that these trends were probably related to the shift of one day stay cases to observation, the increase in the number of TPR hospitals, and the general state of the economy. These data illustrate the necessity of requesting modification to the Maryland Medicare waiver.

Mr. Murray announced the promotion of Chris Konsowski from Rate Analyst to Assistant Chief Audit and Compliance.

ITEM III
DOCKET STATUS CASES CLOSED

2110N – Western Maryland Health System

2112N – University Specialty Hospital

2113A – University of Maryland Medical Center 2115A - Holy Cross Hospital
2117A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

Carroll County Hospital – 2119R

On May 31, 2011, Carroll Hospital Center submitted a partial rate application for a rate for Radiation Therapy (RAT) services to be provided to both inpatients and outpatients. The new rate is to replace its currently approved rebundled RAT rate. The Hospital requested that the RAT rate be set at the state-wide median rate and be effective July 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 RAT rate of $26.12 per RVU be approved effective July 1, 2011;
3. That the RAT rate not be rate realigned until a full year's experience data have been reported to the Commission; and
4. That incremental regulated revenue be added to the Hospital's Total Patient Revenue.

The Commission voted unanimously to approve staff's recommendation.

Dimensions Healthcare System – 2120R

On May 31, 2011, Dimensions Healthcare System, on behalf of its member hospitals Prince George's Hospital Center (PGHC) and Laurel Regional Hospital (LRH), submitted a request for approval of a Chronic Care (CHR) rate for LRH. The new rate is necessary because on June 30, 2011, the patients at PGHC's CHR unit will be moved to LRH. The System requested that effective July 1, 2011, PGHC's CHR rate, increased by the FY 2012 core update factor of 1.56%, be approved for LRH.

After review, staff recommended:

1. That LRH's new CHR rate be based on PGHC's approved CHR rate;
2. That to ensure revenue neutrality, LRH's mark-up of 1.175109 be substituted for PGHC's mark-up of 1.213134, reducing the rate from $698.9463 to $677.0382;
3. That core inflation of 1.56% be added to the rate, increasing the CHR rate to $687.6000;
4. That a CHR rate of $687.6000 be approved for LRH effective July 1, 2011;
5. That because these cases are excluded from the Charge-per-Case (CPC) standard, there should be no change in LRH's or PGHC's CPC standard; and

6. 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.

Johns Hopkins Health System – 2121A

On June 7, 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 cardiovascular procedures and to add global rates for kidney transplant services with the Canadian Medical Network to the arrangement. The Hospitals requested that the arrangement be approved for one year beginning July 1, 2011.

Since the actual experience under the arrangement for cardiovascular services for the last year was favorable and the proposed global rates for kidney transplant services were based on hospital experience data utilized to develop global rates for other successful kidney transplant arrangements, staff was satisfied that the Hospitals could achieve favorable performance under this arrangement.

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 Hospitals' 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.

Johns Hopkins Health System – 2122A

On June 7, 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 new global rate arrangement for kidney transplant, bone marrow transplant, and cardiovascular services with Active Care Management for a period of one year beginning July 1, 2011.

Since the format utilized to calculate case rates, i.e., historical data for like cases, has been utilized as the basis for other successful transplant and cardiovascular arrangements in which the Hospitals are currently participating, 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 Hospitals' 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.

Johns Hopkins Health System – 2123A

On June 7, 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 new global rate arrangement for solid organ and bone marrow transplant services with MultiPlan, Inc. for a period of three years beginning July 1, 2011.

Since the format utilized to calculate case rates, i.e., historical data for like cases, has been utilized as the basis for other successful transplant arrangements in which the Hospitals are currently participating, 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 Hospitals' 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.

Johns Hopkins Health System – 2125A

On June 24, 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 live donor kidney transplant services with National Health Services, Inc. for a period of one year beginning August 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 August 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 QUALITY BASED REIMBURSEMENT METHODOLOGY FOR FY 2012 SCALING

Dianne Feeney, Associate Director-Quality Initiatives, reviewed the changes made to staff's Recommendation on Quality Based Reimbursement Methodology for FY 2012 (QBR) since the draft recommendation was presented at last month's public meeting and briefly summarized the final recommendation (see Staff Recommendation on the HSCRC website). The most significant changes were to align the QBR model and definitions with the CMS VBP program where possible and that if material changes to the QBR are necessary to secure an exemption from the VBP program, based on dialogue with CMS, that staff should recommend such changes to the Commission.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, urged approval of staff's recommendation and assrted that it would be very advantageous for Maryland to receive an exemption from the VBP program.

Anne Hubbard, of MHA, thanked staff for involving the hospital industry in the process of updating the QBR program. Ms. Hubbard expressed the hope that the exemption request be submitted early enough so that if further changes must be made to the QBR program in order to gain an exemption from CMS' VBP program, that they can be addressed prior to the October deadline.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
FINAL RECOMMENDATION ON THE FY 2012 RESASONABLENESS OF CHARGES (ROC) METHODOLOGY AND SCALING FOR THE ROC, QBR, AND MARYLAND HOSPITAL ACQUIRED CONDITIONS (MHAC)

Mr. Murray summarized staff's final recommendation for scaling of the ROC, QBR, and MHAC (see Staff Recommendation on the HSCRC website). Mr. Murray stated that that there was agreement by all parties on the scaling for the quality initiatives, QBR and MHAC; however, the Maryland Hospital Association (MHA) raised the issue of year-to-year instability related to ROC scaling proposed by staff. Given the concerns of MHA, staff offered an alternative scaling approach. While the original approach proposed continuous scaling of 15% of the difference between a hospital's ROC position and its peer group average, the alternative approach establishes a non-scaled bracket of plus or minus 2% from the average of the peer group with hospitals above and below scaled at 25% of their ROC position up or down to the 2% threshold.

Mr. Murray noted that in response, MHA proposed a scaling approach which would establish a non-scaled bracket of plus or minus 3% from the average of the peer group with hospitals above and below scaled at 25% of their ROC position up or down to the 3% threshold.

The staff recommendations included: 1) excluding from the ROC IME/DSH regression the extreme outlier hospital; 2) modifying the case mix lag to a weighting lag; 3) for QBR and MHAC, scaling 0.5% and 1.0% of hospital approved revenue respectively, and 4) for ROC scaling, either staff's original option, 15% of the difference between a hospital's position and the peer group average, or staff's alterative option, 25% of the difference between a hospital's position and the peer group average with a 2% +- corridor receiving 0% scaling.

A panel consisting of Michael Robbins, Senior Vice President-Financial Policy for MHA, Stuart Erdman, Senior Director of Finance of the Johns Hopkins Health System, and Patrick Redman, Ph.D., presented the hospital industry's proposal for the 2011 ROC.

According to Mr. Robbins, the ROC compares hospitals based on charges set by the HSCRC, not on hospital management decisions. Consequently, reductions in cost and increased efficiencies do not result in improved ROC positions. Shifts in hospital ROC positions are changing based on major methodology changes rather than hospital management decisions. MHA believes that the rate impact of these changes should be mitigated through limited scaling.

Mr. Robbins recommended that the Commission approve MHA's option for ROC scaling, which would establish a non-scaled bracket of plus or minus 3% from the average of the peer group, with hospitals above and below scaled at 25% of their ROC position up or down to the 3% threshold. In addition, Mr. Robbins suggested that discussions be initiated to develop a new efficiency measure.

Dr. Redman pointed out that since the payment system is undergoing numerous payment changes that move away from per case measure, the approach to measuring efficiency must be redesigned. Dr. Redman also recommended that the Commission phase in some of the new payment initiatives while we restructure the way we measure efficiency.

Mr. Erdman expressed concern that since we don't understand the interaction of the major policy changes, and we are not sure of the accuracy of the new data being utilized and because ROC scaling results in permanent revenue adjustments, we should be cautious in scaling the ROC for a year or two.

Mr. Murray stated that staff believes that the ROC methodology is sound, represents an improvement over the 2010 methodology, and is highly indicative of relative efficiency. However, Mr. Murray stated that staff agreed with MHA that because of the new payment initiatives we should take a look at the ROC methodology to determine if it should be modified to better measure hospital efficiency.

Dr. Cohen expressed support of staff's scaling options and asserted that MHA's option did not scale enough revenue.

Commissioner Bone made a motion to approve staff's recommendations on scaling the quality initiative along with MHA's option for ROC scaling.

There was no second.

Commissioner Lowthers made a motion to approve staff's recommendations for scaling the quality initiatives along with staff's alternative ROC scaling option.

Commissioner Antos seconded the motion.

The Commission voted unanimously to approve Commissioner Lowthers' motion.

ITEM VII
REPORT ON THE RESULTS OF THE UNCOMPENSATION CARE POLICY AND FINAL RECOMMENDATION TO MODIFY THE CHARITY CARE ADJUSTMENT

Andy Udom, Associate Director-Research and Methodology, summarized the results of the uncompensated care (UCC) policy and staff's final recommendation to modify the charity care adjustment (see Staff Recommendation on the HSCRC website).

Mr. Udom explained that a charity care adjustment was adopted by the Commission to incentivize Maryland hospitals to provide appropriate charity care to eligible patients. The current policy for calculating the charity care adjustment is to add 20% to the actual charity care percentage of gross patient revenue.

Mr. Udom reported that over the last six months, a workgroup reviewed and developed alternatives to the current charity care adjustment. As a result, MHA proposed two alternative calculations: 1) to add 20% of the difference between a hospital's charity care percentage of gross patient revenue and the state-wide average percentage; and 2) to add 20% of the difference between a hospital's charity care as a percentage of UCC and the state-wide average percentage.

Mr. Udom stated that staff recommends that the Commission waive the sixty day comment period for final approval and adopt MHA's option #2.

Traci LaValle, Assistant Vice President-Financial Policy of MHA, expressed the hospital industrty's support of MHA option #2.

Dr. Cohen stated that his clients supported rewarding hospitals that provide more charity care and expressed preference for MHA's option #1.

The Commission voted unanimously to approve staff's recommendation to adopt MHA's option #2.

ITEM VIII
FY 2010 COMMUNITY BENEFIT REPORT AND CHANGES TO REPORTING REQUIREMENTS FOR THE FY 2011 COMMUNITY BENEFIT REPORT AND NARRATIVE

Steve Ports, Principal Deputy Director- Policy and Operations, presented the results of the FY 2010 annual Community Benefit Report (CBR), as well as changes to be implemented for the FY 2011 CBR. Mr. Ports explained that because non-profit hospitals receive federal, state, and local tax benefits, in return the Internal Revenue Service requires hospitals to provide benefits to the community. The Maryland CBR process was enacted by the Maryland General Assembly in 2001. Mr. Ports thanked Amanda Greene, Program Analyst, for overseeing this project and putting together this report.

Mr. Ports indicated that hospitals: 1) reported a total of $1 billion in community benefits for FY 2010 (compared to $946 million in FY 2009); 2) provided an average of 7.71% of total operating expenses in community benefits (compared to 7.6% in FY 2009); and 3) provided net charity care in the amount of $133 million; and 4) provided net community care of $613.5 million, or 4.85% of total operating expenses. Mr. Ports also pointed out that this was the second year that hospitals were asked to answer narrative questions about their community benefit programs. These questions were developed to provide a standard reporting format and to allow readers to more easily understand the information in the report.

Mr. Ports indicated that the following changes were recommended by the CBR advisory group. The changes to the Reporting Guidelines were: 1) to refine the definition of a community benefit to be consistent with the Affordable Care Act and other policies; 2) to clarify the categories; and 3) to add a section to account for Medicaid provider taxes for which a hospital does not receive offsetting revenue. In addition, the following changes to the Community Benefit Narrative Reporting Instructions and related Evaluation Report were recommended: 1) to refine the definition of a community needs assessment; 2) to alter the format and provide more references to make it easier for hospitals to find and report the expected information, and for the public to understand the reports; 3) to add questions to better understand the hospital leadership involved in community benefit decisions; and 4) to change the Evaluation Report scoring to take into consideration the sufficiency of the response to the questions.

SPECIAL PRESENTATION TO VICE CHAIRMAN SEXTON

Mr. Murray noted that since his second four year term has now expired, Mr. Sexton may have had the opportunity to participate in his last public meeting as a Commissioner today. Mr. Murray stated that that we wanted to recognize Mr. Sexton‘s contribution to the system. Mr. Sexton has placed the community interest above any provincial interest. He has consistently been the “go to” Commissioner whenever there has been a controversial issue. He would “stick his neck out” to gain a compromise, which is a very difficult role for an industry representative. He has also been the inspiration for, and provided strategy and direction for, many of the Commission’s major policies such as the MHACs initiative and bundled payment initiatives. Mr.

Sexton brought to the Commission operational expertise from his years of running hospitals, as well as policy expertise from his days prior to being a hospital administrator. Mr. Murray stated that Mr. Sexton strongly supported staff and has earned the respect of everyone in the industry.

Mr. Murray congratulated Mr. Sexton and presented him with a plaque honoring his service to the citizens of Maryland.

ITEM IX
HEARING AND MEETING SCHEDULE

August 3, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
September 7, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 12:10 p.m.