Executive Session Minutes
of the
Health Services Cost Review Commission

March 7, 2012

Upon motion made, Chairman Colmers called the meeting to order at 1:00 p.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 Antos, Bone, Keane, Mullen, and Wong.

Patrick Redmon, Steve Ports, Jerry Schmith, Mary Beth Pohl, and Oscar Ibarra attended representing Commission staff.

Also attending were Leslie Schulman and Stan Lustman, Commission Counsel.

Item One

The Commission discussed issues relating to the status of the waiver and the potential modification of the waiver test.

Item Two

The Commission discussed personnel issues.

The Executive Session was adjourned at 1:42 p.m.

MINUTES OF THE
486th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

March 7, 2012

Chairman John Colmers called the meeting to order at 1:45 p.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 MARCH 7, 2012

Oscar Ibarra, Program Administration & Information Management, summarized the minutes of the March 7, 2012 Executive Session.

ITEM I
EXECUTIVE AND PUBLIC SESSIONS OF FEBRUARY 1, 2012

The Commission voted unanimously to approve the minutes of the February 1, 2012 Executive and Public Sessions.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Patrick Redmon, Ph.D., Executive Director, discussed the results of Monitoring Maryland Performance (MMP). Dr. Redmon stated that since last month's public meeting, staff has been attempting to determine what is contributing to the rate of growth in charge per case for the twelve months ending December 2011. MMP data showed that the rate of growth in charge per case was 8.8%, which was far above the 4.3% budgeted under last year's update factor discussions. We know that we have initiated several policies that have contributed to this growth, but the increase is much higher than expected. We have continued to see volume declines in admissions for the year, 3.64%, while outpatient revenue increased by 11.8%.

Dr. Redmon indicated that based on the September 2010 waiver letter and preliminary estimates from the actuary for the Center for Medicare and Medicaid Services (CMS), Maryland's estimated relative waiver position as of December 2010 stands at 9.31%. Dr. Redmon stated that the actuary's revised forecast that projects lower case mix growth nationally was further contributing to erosion in the estimated waiver cushion. With the revised numbers, our forecast indicates that Maryland is poised to exceed the cumulative growth of rate of payments per case nationally in FY 2012 by -0.05%, although Maryland would recover to 0.79% in FY 2013. However, our forecast does not include the continued erosion we have seen due to one-day stays or the possible impact of the Admission-Readmission Revenue (ARR) and Total Patient Revenue

(TPR) programs.
Dr. Redmon then reported on the update discussions and where they are leading us in response to the waiver crisis. In that regard, it is useful know the causes of the increase in charge per case in MMP above the budgeted amount. Dr. Redmon noted that: 1) the core update factor of 1.56%; 2) the Medicaid Assessment, 1.90%; 3) shift of revenue from outpatient to inpatient through rate realignment, 1.6%; and 4) seed funding for the ARR and TPR programs, 0.5%. However, the biggest single contributor has been the one-day stay policy which, by excluding one-day cases from the Charge-per Case methodology, left in the charge capacity and encouraged the conversion to outpatient observation cases. Further, two day stay cases also appear to be converting to observation cases. As a consequence, the case mix index for the remaining cases goes up, because the remaining cases are now more expensive on average. The combined impact of the changes related to one-day and two-day cases is approximately 3% of the increase in MMP charge per case for the first half of 2012 versus the first half of 2011.

Dr. Redmon stated that some of the options that we have been discussing in the update discussion for improving the waiver cushion include: 1) reversal of the one-day stay policy with the removal of the rate capacity and measuring case mix growth with the impact of one-day cases; 2) suspending the ARR and TPR programs and further seed funding; 3) increasing the fixed cost percentage of the volume adjustment; and 5) increasing the Medicare and Medicaid differential.

Dr. Redmon reported that CMS staff has discussed with HSCRC staff the Commission's letter describing the HSCRC's efforts to reduce readmissions in Maryland (the ARR and TPR programs) submitted in anticipation of Medicare's requirements for cost and readmission reductions. CMS staff has asked for clarification of the structure of the programs and a demonstration of how the HSCRC's policies would perform as well or better than Medicare's program.

Steve Ports, Principal Deputy Director-Policy & Operations, presented an update on the FY 2013 Medicaid budget deliberations in the legislature relating to Medicaid hospital cost containment measures (See Legislative Update – March 7, 2012).

Mr. Ports noted that bills have been introduced that would create a Medicaid Sustainability Commission whose recommendations on Medicaid funding would have the impact of increasing State general funds for Medicaid by at least the amount of the Medicaid Budget Deficit Assessment.

ITEM III
DOCKET STATUS CASES CLOSED

2146A – Johns Hopkins Health System 2147A - Johns Hopkins Health System
2147N – Mt. Washington Pediatric Hospital

ITEM IV
DOCKET STATUS CASES OPEN

Johns Hopkins Health System – 2149A

On December 6, 2011, Johns Hopkins Health System ("System") filed an application with the HSCRC on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for participation in a renegotiated global rate arrangement for solid organ and bone marrow transplants with United Resources Networks/Optum Health, a division of United HealthCare Services, for a period of one year beginning December 1, 2011.

Staff recommended that: 1) the requirement that an application be filed 30 days prior to the proposed effective date of an alternative method of rate determination arrangement be waived; and 2) the Hospitals' request be approved for one year beginning December 1, 2011. In addition, staff recommended that the approval be based on 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.

Johns Hopkins Health System – 2150A

On December 6, 2011, Johns Hopkins Health System (the "System") filed an application with the HSCRC on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the Hospitals') for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a renegotiated global rate arrangement for solid organ and bone marrow transplants with Coventry Transplant Network for one year beginning January 1, 2012.

Staff recommended that: 1) the requirement that an application be filed 30 days prior to the proposed effective date of an alternative method of rate determination arrangement be waived; and 2) the Hospitals' request be approved for one year beginning January 1, 2012. In addition, staff recommended that the approval be based on 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.

Johns Hopkins Health System – 2151A

On December 6, 2011, Johns Hopkins Health System ("System") filed an alternative rate application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval from the HSCRC to continue to participate in a global rate arrangement with the Canadian Medical Network for cardiovascular procedures and global rates for kidney transplant services and to add bone marrow transplants to the arrangement going forward. The Hospitals request that the Commission approve the revised arrangement for one year beginning December 1, 2011.

Staff recommended that: 1) the requirement that an application be filed 30 days prior to the proposed effective date of an alternative method of rate determination arrangement be waived; and 2) the Hospitals' request be approved for one year beginning December 1, 2011. In addition, staff recommended that the approval be based on 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.

Johns Hopkins Health System – 2152A

On December 6, 2011, Johns Hopkins Health System (the "System") filed an application with the HSCRC on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the Hospitals), requesting approval to continue to participate in a global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplant services. The Hospitals request that the Commission approve the arrangement for one year beginning January 1, 2012.

Staff recommended that: 1) the requirement that an application be filed 30 days prior to the proposed effective date of an alternative method of rate determination arrangement be waived; and 2) the Hospitals' request be approved for one year beginning January 1, 2012. In addition, staff recommended that the approval be based on 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.

Anne Arundel Medical Center – 2153N

On January 3, 2012, Mount Washington Pediatric Hospital submitted a partial rate application requesting a rate for Electrocardiography (EKG) services. The Hospital requested that the rate

be effective January 1, 2012.

Staff recommended:

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days before the opening of a new service be waived;
2. That an EKG rate of $2.89 per RVU be approved effective February 1, 2012; and
3. That the EKG 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 – 2154A

On February 2, 2012, Johns Hopkins Health System (the "System") filed an application with the HSCRC on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for participation in an updated global rate arrangement for cardiovascular procedures with Quality Health Management for a period of one year beginning March 1, 2012.

Staff recommended that: 1) the requirement that an application be filed 30 days prior to the proposed effective date of an alternative method of rate determination arrangement be waived; and 2) the Hospitals' request be approved for one year beginning March 1, 2012. In addition, staff recommended that the approval be based on 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 – 2156A

On February 23, 2012, the University of Maryland Medical Center (the "Hospital") filed an application with the Commission for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital has requested approval to continue to participate in a global rate arrangement with the Gift of Life Foundation (GOL) for the collection of bone marrow and peripheral blood stem cells from GOL on an outpatient basis, donors to facilitate Hematopoietic Stem Cell transplants into unrelated GOL recipients. The Hospital seeks approval of the arrangement for one year beginning April 1, 2012.

Staff recommended that the Hospital's request be approved for one year beginning April 1, 2012. In addition, staff recommended that the approval be based on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
FINAL RECOMMENDATION REGARDING PROPOSED CHANGES TO NURSE SUPPORT PROGRAM II (NSPII) POLICIES

Mary Pohl, Deputy Director-Research and Methodology, presented the final staff recommendation to modify NSP II statewide initiatives (staff Recommendation "Nurse Support Program II - Statewide Initiatives Modifications" on the HSCRC website). Ms. Pohl noted that there were only minor changes from the draft recommendation presented at the February public meeting.
The modifications for graduate nursing scholarships include: 1) increasing the annual maximum award from $13,000 to the amount of tuition and fees at the applicable institution; 2) removing the time limitations on how many years a scholarship can be awarded (to accommodate students pursuing Doctoral degrees); and 3) authorizing the awarding of Graduate Nursing Scholarships to graduate students pursuing nursing education certificates.

Staff also recommended that: 1) the Maryland Higher Education Commission rebalance the Living Expense Grants component of NSP II by first awarding tuition dollars and subsequently awarding the Living Expense Grants; 3) references to loan repayment assistance be removed from NSP II recommendations; and 3) doctorial dissertation support be authorized under NSP II.

In addition, Ms. Pohl stated that a component of the recommendation was to commemorate Dr. Hal Cohen's ardent support of the nurse support programs in Maryland, and that the Graduate Nursing Faculty Scholarships be named "The Hal and Jo Cohen Graduate Nursing Faculty Scholarship Program." Dr. Cohen's wife Jo and family were in attendance.
Ms. Peggy Dawes, Grant Administrator-MHEC, expressed support for staff's recommendation.

Chairman Colmers stated on behalf of the Commission that the naming of the scholarship program for Dr. Cohen and his wife Jo was a small token to acknowledge the important contribution that Dr. Cohen has made to nursing education over the years.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
DRAFT RECOMMENDATION ON MEDICARE WAIVER MARGIN TRENDS, DRIVERS, AND OPTIONS

Dr. Redmon presented staff's proposed options that if adopted would improve the waiver cushion and avoid immediate failure. He also expressed staff's desire to work through the update factor to further increase the cushion (See "FY 2012 Options for Improving the Waiver Cushion" on the HSCRC's website). The options recommended were: 1) a revenue neutral shift from inpatient to outpatient by reducing rates in routine patient care centers and increasing rates in

ancillary centers that provide services to both inpatients and outpatients retroactive to January 1, 2012; 2) suspension of the Charge per Visit (CPV) methodology for the current fiscal year; and 3) to include one-day stay cases, at the case specific weight, in the calculation of case mix for purposes of the FY 2012 case mix governor, and recalculate the FY 2011 case mix to determine the impact of excluding case weights for one-day stay cases on revenue growth.

Commissioner Antos asked Dr. Redmon if he would lay out the schedule of decision making, particularly since there will also be update recommendations to come.

Dr. Redmon stated that these proposed actions are to provide immediate waiver cushion relief. This is step one. Staff will present update factor recommendations at the April 2012 public meeting, along with policy decisions associated with the update factor. In addition, there will be recommendations for methodology changes needed to provide longer term waiver cushion relief.

Commissioner Keane stated that we absolutely need a strong outpatient revenue constraint.

Commissioner Bone asked whether there was a down-side risk for the Commission for putting the brakes on the system if later the numbers show that we didn't need to do so.

Chairman Colmers responded that there was no down-side risk. The waiver cushion that we would like to have is 10%. We were below 10% in December of 2010, and we are projected to be at zero in July of 2012.

Public Comments

Michael Robbins, Senior Vice President-Financial Policy for the Maryland Hospital Association (MHA), stated that MHA was committed to working through any technical issues associated with the implementation of any Commission action with staff and more importantly to work with the Commission to ensure that the waiver continues.

Mr. Robbins stressed the need for modernization of the waiver test. In the short term, Mr. Robbins urged the Commission to support legislation establishing a Medicaid Sustainability Commission, which would make recommendations for long term funding for the Medicaid program.

Mr. Robbins offered to share with the Commission an analysis that indicates that there is cost justification for increasing the magnitude of the current Medicare and Medicaid payer differentials. Mr. Robbins suggested that the Commission consider increasing the differentials as part of its short term waiver strategy. Mr. Robbins asserted that such an increase would have a positive effect on the waiver cushion and would decrease Medicaid's reliance on hospital assessments.

Stuart Erdman, Senior Director of Finance and Assistant Treasurer-Johns Hopkins Health System, made a presentation in which he requested that the Commission and the hospital industry initiate a technical review of the accuracy of the Medicare/Medicaid 6% discount. The

discount has not been recalculated in 35 years, and many factors have changed since then. According to Mr. Erdman, it is very likely that the governmental 6% discount is inaccurate. Mr. Erdman noted that MHA's current payment study shows that Medicare paid 23%, or $1 billion, more in Maryland in FY 2010. This situation will only get worse in FY 2011and FY 2012 as the 3% Medicaid Assessment is included in hospital rates. There is no justification to support a Medicare payment differential of 23-26%. According to Mr. Erdman, a simple analysis, using HSCRC data, demonstrates that the Medicare discount must be in the 18-20% range to appropriately balance payments between the governmental and commercial payers. This assumes that Medicare would pay hospital costs, based on HSCRC cost reports, plus its fair share of uncompensated care. Medicaid has essentially adjusted its discount through their assessments on hospitals. The assessment plus the 6% discount translates into an overall discount of approximately 20%. Mr. Erdman stated that this situation needs our full and immediate attention. Unintentionally, enormous payment liability has been inaccurately cost shifted to the government payers and is jeopardizing the Medicare waiver and causing severe Medicaid budget problems.

Barry Rosen, representing United Healthcare, presented comments on staff's recommendations. Mr. Rosen expressed understanding for the need to shift revenue for inpatient to outpatient in order to improve the inpatient waiver test, but he failed to understand why suspending the CPV program helps the waiver at all. Mr. Rosen suggested that over time there should be an overhaul of the outpatient pricing system modeled after Medicare's Outpatient Prospective Payment System. As to the third recommendation, United Healthcare believes there should be case targets and real case mix governors for one-day stay cases. With respect to the Medicare and Medicaid differentials, increasing the differentials would be increasing the cost of obtaining health insurance in Maryland dramatically. Mr. Rosen also suggested the Commission consult its counsel concerning the legality of changing the differentials.

Chairman Colmers expressed his opinion that changing the differential with proper cost justification would not necessarily violate the waiver.

Gary Simmons, Regional Vice President-United Healthcare, commented on some broader issues. According to Mr. Simmons, United Healthcare believes that that it is essential that the update factor for FY 2013 be low, including any adjustment for case mix. Mr. Simmons asserted that the HSCRC should recognize that fixed costs are really more than the 15% of total costs utilized in the volume adjustment factor calculation

Mr. Simmons stated that United Healthcare advocates the imposition of specific requirements on TPR and ARR hospitals to develop criteria for the use of observation services and for discharge planning to prevent readmissions in order to receive an update. Hospitals should also develop 24 hour clinics to reduce emergency room visits. Mr. Simmons suggested that the HSCRC utilize the foregoing of updates in a more comprehensive way to control overall hospital costs.

In addition, United Healthcare suggests that the HSCRC develop more standardized pricing of services among hospitals. United Healthcare believes that more standardization of prices would lead to more efficiency and enhance consumer choice. The concept is that while there are unique aspects in the Maryland system that should be preserved, there are also advantages in

reimbursement systems used outside of Maryland that could be emulated, such as the Medicare Ambulatory Patient Grouping system.

John Hamper, Director-Provider Reimbursement of CareFirst of Maryland, stated that CareFirst supported the staff recommendations but only as an interim step to allow time for the redesign of our reimbursement model, the waiver test, and to realign incentives.

Mr. Hamper urged the Commission to establish some reasonable waiver targets for the next few years. Such targets could be monitored quarterly, and if we fall below the target, the Commission could take necessary actions to bring us back on track.

As to the specifics of the recommendations, Mr. Hamper urged that the modified cost allocations be implemented immediately; that the CPV be suspended for just one year; and that it then be replaced with another outpatient constraint program.

In addition, Mr. Hamper suggested that the Commission consider scaling the results of the ARR program.

Ray Grahe, Vice President, Finance-Meritus Health, expressed support for staff's recommendations. Mr. Grahe noted that reallocating overhead from inpatient to outpatient is analogous to shifting the weight of the update factor from inpatient to outpatient, something with which he is in agreement. Mr. Grahe also supported Mr. Erdman's on reexamining the governmental differential.

Mr. Grahe suggested that the way forward is to reduce incentives for volume. A new expanded waiver test that would look at a per member per month, or a similar measure, would be most appropriate.

Mr. Grahe noted that although hospitals need adequate update factors, saving the waiver is preeminent. Between Medicare and Medicaid, the waiver is worth a billion and a half dollars. Without the waiver there would be chaos. This is a time when we will all have to suffer some pain.

We must reduce unnecessary utilization, and we need to drive the right volumes to the right venues. We need a methodology that aligns physician incentives with hospital incentives. We need methodologies to bundle payments of the hospital and the physician. A start would be to bring payments for physician services provided at the hospital under the jurisdiction of the HSCRC. What is needed is pay-for-performance to provide for payments to physicians in order to align their incentives with those of the hospital. Such arrangements improve quality as well as efficiency.

Commissioner Bone made a motion to approve staff's recommendation.

Commissioner Keane suggested that the Commission wait a month before suspending the CPV program. Mr. Keane also suggested that he believed if the CPV program were suspended, there

would be pressure from the hospital industry not to reinstate an outpatient constraint system especially, as long as the waiver test remains only inpatient.

Dr. Redmon noted that the reason why staff recommended suspending the CPV program is twofold. The first is that there have been significant technical problems with the implementation of the CPV methodology, which continue to hold up the issuance of rate orders for FY 2012. The second is the CPV methodology hasn't worked as a constraint system. According to Dr. Redmon, we basically have to start over and refocus perhaps on a straight forward volume constraint system or possibly a per case constraint on medical supplies and drugs.

The Chairman noted that rate orders with the modified cost allocation to lower inpatient charges and improve the waiver cushion could not be issued expediently if they were required to include the CPV component.

Dr. Redmon answered in the affirmative.

Mr. Keane stated that he would be more comfortable suspending the CPV program immediately if we had a specific commitment to developing a true outpatient constraint system by a particular time.

Commissioner Antos agreed with Mr. Keane that the Commission must set a deadline for implementing a new or revised outpatient constraint system.

Dr. Antos proposed that staff come back at the April public meeting with recommendations for a timetable for the replacement of the CPV program.
Commissioner Keane presented the motion to: 1) waive the normal 60 day comment period; and 2) approve staff's recommendation with the following amendment: "The Commission will suspend the current CPV methodology immediately for all of FY 2012 on the condition that staff come back to the Commission within 6 months with recommendations for a revised or new outpatient constraint system to be put in place not later than in FY 2014. As suggested by Commissioner Antos, and accepted by Commissioner Keane, staff will provide a timetable for developing an interim outpatient constraint methodology for FY 2013 at the April 2012 public meeting. The motion was seconded.

The Commission voted unanimously to approve the amended motion.

ITEM VII
LEGAL REPORT

Regulations

Proposed

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 forward the proposed regulations to the AELR Committee for review and publication in the Maryland Register.

ITEM VII
HEARING AND MEETING SCHEDULE

April 11, 2012	1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room
May 2, 2012	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:40 p.m.