Executive Session Minutes
Of the
Health Services Cost Review Commission

April 11, 2012

Upon motion made, Chairman Colmers called the meeting to order at 9:15 a.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, Loftus, Mullen, and Wong.

Patrick Redmon, Steve Ports, Jerry Schmith, Mary Beth Pohl, and Dennis Phelps attended representing staff.

Thomas Trycinski, Director of Treasury Services of the Johns Hopkins Health System (JHHS), and Mark Higdon, Partner-KPMG, attended representing JHHS.

Also attending was Leslie Schulman Commission Counsel.

Item One

The Executive Director updated the Commissioners on the progress of the waiver test modernization process.

Item Two

Jerry Schmith, Deputy Director-Hospital Rate Setting, summarized the request of JHHS for a Comfort Order for its proposed sale of $117.5 million of bonds to finance a portion of the cost of the $1.2 billion project previously approved for a Certificate of Need by the Maryland Health Care Commission. Mr. Trycinski and Mr. Higdon represented JHHS.

After discussion, the Commission voted to approve the Comfort Order request of JHHS, ratification of the vote to take place in the public session.

Item three

Various personnel issues were discussed.

Item Four

The Commissioners discussed legal issues concerning an Alternative Method of Rate Determination procedural matter.

The Executive Session was adjourned at 10:10 a.m.

MINUTES OF THE
487th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

April 11, 2012

Chairman John Colmers called the meeting to order at 10:14 a.m. Commissioners Joseph R. Antos, PhD., George H. Bone, M.D., Jack C. Keane, Bernadette C. Loftus, M.D., Thomas R. Mullen, and Herbert S. Wong, Ph.D. were also present.

REPORT OF THE EXECUTIVE SESSION OF APRIL 11, 2012

Dennis N. Phelps, Associate Director-Audit & Compliance, summarized the minutes of the April 11, 2012 Executive Session.

ITEM I
EXECUTIVE AND PUBLIC SESSIONS OF MARCH 7, 2012

The Commission voted unanimously to approve the minutes of the March 7, 2012 Executive and Public Sessions.

COMFORT ORDER – JOHNS HOPKINS HEALTH SYSTEM

The Commission voted to ratify the Comfort Order for the Johns Hopkins Health System approved in Executive Session. Chairman Colmers recused himself from consideration of the request for a Comfort Order.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Patrick Redmon, Ph.D., Executive Director, reported that Monitoring Maryland Performance (MMP) indicated that the rate of growth in charge per case continued to increase, 8.91%, for the year ended January 2012 compared to the year ended January 2011. Dr. Redmon noted that for that same period, the number of inpatient cases declined by 3.84%; inpatient revenue increased by 4.72%; outpatient revenue increased by 12.08%; and total revenue increased by 7.23%.

Dr. Redmon announced the HSCRC's policy for unit rate, Charge-per-Case (CPC), and Charge-per-Episode (CPE) compliance for FY 2012. Consecutive month unit rate compliance penalties have been waived for FY 2012. Full year rate compliance, CPC, and CPE compliance have not been waived; however, leniency with penalties will be considered.

ITEM III
DOCKET STATUS CASES CLOSED

2149A – Johns Hopkins Health System
2150A - Johns Hopkins Health System
2151N – Johns Hopkins Health System
2152A- Johns Hopkins Health System
2153N – Anne Arundel Medical Center
2154A - Johns Hopkins Health System
2156A – University of Maryland Medical System

ITEM IV
DOCKET STATUS CASES OPEN
University of Maryland Medical Center – 2155A

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 participate in re-negotiated global rate arrangement with Life Trac, Inc. Network for the solid organ and bone marrow transplant services. The Hospital sought approval of the arrangement for one year beginning April 1, 2012.

Although the experience for last year was unfavorable, staff recommended that the Hospital's request to participate in the re-negotiated arrangement 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

Johns Hopkins Health System – 2100A

Staff recommended that the Commission grant an additional extension of its approval of the alternative rate arrangement between Johns Hopkins Health System and Blue Distinction Centers for Transplants until April 30, 2012 in order to provide time to finalize negotiations for continuation of the arrangement. Staff also recommended that the approval be subject to the condition that if negotiations are not completed before the expiration, the arrangement shall end and no services shall be provided under the arrangement until a new application is approved by the Commission.

The Commission voted to approve staff's recommendation. Chairman Colmers recused himself from consideration of this request.

ITEM V
DRAFT RECOMMENDATIONS ON THE FY 2013 UPDATE FACTOR AND WAIVER TREND MITIGATION

Dr. Redmon discussed the value of the waiver to Maryland and the negative effect on the waiver test of doing the right thing; i.e., reducing one day admissions, implementing the Admission-Readmission Revenue (ARR) and Total Patient Revenue (TPR) programs. Dr. Redmon stated that because the current waiver test is no longer the appropriate measure, and most participants in the rate system believe the system is worth saving, the HSCRC is pursuing modernization of the waiver test through the Center for Medicare and Medicaid Innovation (CMMI) States' initiatives program. Dr. Redmon noted that since the existing waiver is the only arrangement in place now, actions to preserve the current Maryland's current waiver status are of the highest priority and are the focus of staff's recommendations for the coming fiscal year.

According to Dr. Redmon, the most recent waiver test letter (December 2010) puts the relative waiver cushion at 9.18%. However, based on trends from actual HSCRC data and the Center for Medicare and Medicaid Services' (CMS') actuary's forecast for national Medicare spending, staff estimated that the relative waiver test cushion stood at 3.08% as of December 2011. Dr. Redmon noted that even with the emergency action taken by the Commission at the March public meeting, staff's estimates are that the waiver test for June 2012 will show a cushion of only 0.94%. This status creates a challenge for setting rates for FY 2013.

Dr. Redmon observed that although preserving the waiver is the primary goal, the methods used in saving the waiver must also take into account the financial condition of the hospitals as well as the affordability of hospital care. Dr. Redmon reported that although data for February 2012 show a significant uptick in profitability, unaudited data for FY 2012 indicate a trend towards lower profitability from operations.

Dr. Redmon stated that in the past, Dr. Hal Cohen often noted that the waiver was a constraint on the system, but not a binding constraint. Dr. Redmon asserted that is no longer the case. We are now in a situation where the waiver is now a binding constraint. Staff is trying to balance the recommendations between the financial health of the industry and preserving the waiver.

Dr. Redmon summarized staff's options for setting rates for FY 2013(See "Update Factor Recommendation for FY 2013" on the HSCRC website). The options include: 1) reducing inpatient rates by -1% to improve the waiver cushion; 2) the feasibility of a bifurcated Update Factor to increase outpatient revenue to improve the industry's financial condition; 3) not granting additional ARR seed funding to improve the waiver cushion; 4) streamlining system controls by implementing a 6 month lag in the data used to produce unit rates, CPC and CPE targets, and case mix weights to better monitor the system and facilitate a quicker response to system changes; 5) establishing a policy for meeting the legislative requirements for the Medicaid assessment and savings; 6) revisiting the Update Factor in January 2013 to determine the validity of the assumptions on which the Update Factor was developed; 7) setting an Update Factor for non-waiver hospitals; 8) continuing the re-allocation of revenue from inpatient to outpatient for FY 2013; 9) suspending Reasonableness of Charges (ROC) scaling for the current year; 10) making no change in the Volume Adjustment for FY 2013; and 11) making no change

in the Medicare Differential for FY 2013, but to continue to evaluate the cost justification for a modification of the current 6% Medicare Differential.

Commissioner Keane stated that it was true that the HSCRC did the right thing by incentivizing hospitals to reduce short stay cases and re-admissions, but did the wrong thing by leaving the savings in hospital rates. They should have come out. Staff has encouraged comments on how to correct these policies. Mr. Keane encouraged the industry and the payers to provide input to correct these policies, so that we get right result without having a negative effect on the current waiver. Mr. Keane noted that the correction of these polices would also be immensely beneficial if we move to a per member/per month (pm/pm) waiver test.

According to Mr. Keane, in the absence of correcting the policies, we are placing a huge amount of pressure on the Update Factor this year and next year. Mr. Keane pointed out that not only are we looking at a negative 1% Update Factor for FY 2013, but we could be looking at an Update Factor as much as a negative 3% or 4% in FY 2014. Mr. Keane asserted that low Update Factors disadvantage hospitals that have done the right thing, i.e., controlled costs, have not been generating additional volume, and have not had excessive one stay cases or re-admissions. Mr. Keane noted that shifting revenue from inpatient to outpatient is not benign, because higher rates for outpatient services are compounded by double digit volume increases. Those that are insured are very vulnerable because the highest co-pays and deductibles are on outpatient services. Pushing revenue to the outpatient area, while quite beneficial to the waiver, is not beneficial to individuals trying to purchase health insurance or to companies offering coverage and who are trying to keep the cost of health care affordable. We may well see a deterioration in coverage because of the higher cost of outpatient services.

Mr. Keane observed that hospitals recognize that the current volume adjustment encourages volume increases and generates profits. Hospitals acknowledge that they primarily rely on profits generated by volume increases to fund capital projects. Therefore, we must develop a better capital policy because continuing to fund capital through increased volumes is dangerous to the system, especially if we go to a pm/pm waiver test.

Commissioner Bone asked how the proposed outpatient tiering would affect inpatient volumes particularly those hospitals with a large Medicaid population.

Dr. Redmon stated that it would not affect inpatient volumes. However, because Medicaid has many members that utilize low cost outpatient services, tiering would result in savings to Medicaid and reduce the assessment.

A panel consisting of Chester Burrell, President and CEO of CareFirst of Maryland, Jack Cook, Ph.D., consultant representing CareFirst of Maryland, and Gary Simmons Regional Vice President of United Healthcare, presented comments on staff's recommendations.

Mr. Burrell stated that CareFirst supports the modernization of the waiver test. Mr. Burrell noted that CareFirst's recent data show that while inpatient admissions are down, hospital outpatient

services are up significantly. According to Mr. Burrell, in the individual market, applications for health care coverage are down 20%, and a third of those receiving coverage leave and go without coverage because of cost. In addition, fewer small businesses are offering health care coverage and are contributing less to the cost of the coverage. In the small group market, the percentage of groups offering high deductable coverage has gone from 5% to 60% in four years. Mr. Burrell stated that this represented a billion dollars in cost shifted from employers to employees through the higher deductable. These are signs that health care coverage is becoming increasingly unaffordable.

Mr. Burrell pointed out that the re-admission rate in Maryland is still high, chiefly because of the lack of post discharge support. He stated that 10% of CareFirst's members account for 80% of total admissions.

Mr. Burrell asserted that if a pm/pm payment waiver test were implemented, Maryland would not survive because of volume increases. Mr. Burrell stated that the current volume adjustment (85% variable cost and 15% fixed cost) provides powerful incentive for volumes to go up and powerful incentives for volumes not to go down. According to Mr. Burrell, overall hospital use in Maryland will have to decrease by 5% or 10% if we are to control health care spending and make health care affordable. Mr. Burrell stated that the way to protect and support hospitals when volumes decrease is to initiate a volume adjustment of 60% fixed cost and 40% variable cost.

Mr. Burrell stated that CareFirst advocated that, in addition to correcting the short stay case and re-admission policies and approving a stringent Update Factor, the Commission should adopt a 60% fixed and 40% variable cost factor.

Dr. Cook stated that the Commission should move now to a 60%-40% volume adjustment. According to Dr. Cook, it would not harm our current waiver position and would allow Maryland to achieve a cushion under a revised waiver test.

Dr. Cook noted that TPR hospitals will be harmed if the Update Factor is used to manage the waiver test rather than a revised volume adjustment.

Mr. Simmons indicated United Healthcare's support for the staff's recommended negative 1% Update Factor. Mr. Simmons advocated standardization of pricing utilizing MS-DRGs for inpatient services and APCs for outpatient services. According to Mr. Simmons, standard pricing would help hospitals better manage individual services. The Commission should require hospitals: to adopt recognized criteria on the appropriate use of observation services; adopt recognized discharge planning requirements to prevent re-admissions; and establish 24/7 clinics to divert non-emergent patients from the emergency room. Mr. Simmons also urged the HSCRC to move quickly to approve a workable cap on the growth of outpatient services. Mr. Simmons stated that the Commission should moderate the amount of any update provided for outpatient services. Mr. Simmons stated that to enhance affordability and to protect the waiver, United Healthcare supports staff's recommendations.

Charles J. Milligan, Deputy Secretary-Health Care Finance, expressed the Department of Health & Mental Hygiene's (DHMH) support for the Medicare waiver because it provides: equity, access to care, and predictability. Mr. Milligan stated that to achieve these benefits, the waiver is worth a subsidy. However, Mr. Milligan stated that the premise for the waiver cannot be to provide more funds from Medicare and Medicaid. Mr. Milligan asserted that federal and state taxpayers are subsidizing the waiver, since Medicare and Medicaid are now paying more in Maryland than in the U.S. Mr. Milligan noted that it is fair and should be expected that Medicare and Medicaid as payers to determine whether the benefits that the waiver provides are worth the subsidy. According to Mr. Milligan, Medicare and Medicaid are providing some of the margin for hospitals and are helping to subsidize the affordability of private insurance. Mr. Milligan noted that assessments as a tool for Medicaid financing are not unique to Maryland; 39 states now are utilizing hospital assessments.

On behalf of DHMH, Mr. Milligan proposed that the Medicare waiver be modernized, and that it is appropriate to analyze the Medicare/Medicaid differential to determine whether it should be revised. In addition, Mr. Milligan expressed support for: 1) the staff's proposed -1.0% Update Factor, 2) the payer's proposed revision of the current volume adjustment, and 3) the plan for tiering of the rates for outpatient services be finalized by June 1, 2012.

In conclusion, Mr. Milligan stated that DHMH supports the Medicare waiver, but that the value of the waiver must be demonstrated.

Commissioner Wong asked whether the assessments should be factored into the new waiver test.

Mr. Milligan replied that we not proceed as if the current assessment will continue; however, if the differential were increased, assessments may not be necessary.

Michael Robbins, Senior Vice President-Financial Policy of the Maryland Hospital Association (MHA), presented comments on staff's recommendations. Mr. Robbins stated that as far as the hospital industry is concerned, the central question is how do we ensure that hospitals are provided with the necessary resources to deliver the most efficient and effective care in the most appropriate setting. Mr. Robbins noted that because it does not have a recommendation on an outpatient Update Factor, it is impossible to determine whether staff's recommendation will provide sufficient hospital funding.

Mr. Robbins expressed concern about the proposed changes to the volume adjustment. He noted the proposals seem to label all hospital utilization as bad. The hospital industry does not believe that is true, but agrees that it is appropriate to address inappropriate utilization.

According to Mr. Robbins, the HSCRC should not differentiate between the profitability of regulated services and unregulated services because unregulated services such as hospitalists are needed to support regulated services. Mr. Robbins pointed out the decline in operating margins

in FY 2012.

Mr. Robbins provided MHA response to staff's recommendations: 1) that the industry needs an outpatient Update Factor of 2.59%; 2) that an alternative capital policy not dependent on volume be developed; and 3) that an alternative waiver test be developed.

Chairman Colmers urged staff, the hospital industry, and the payers to continue to meeting to discuss these issues between now and the next public meeting.

Dr. Redmon stated that staff would present a revised recommendation at the next public meeting.

Chairman Colmers also noted that as important as the Update Factor is, the more important long term issue for us is to identify and apply for a new waiver test.

As this was a draft recommendation, no Commission action was required.

ITEM VI
DRAFT RECOMMENDATION ON CONTINUED FUNDING SUPPORT FOR THE MARYLAND PATIENT SAFETY CENTER

Dianne Feeney, Associate Director-Quality Initiative, summarized staff's Draft Recommendations on Funding Support for the Maryland Patient Safety Center (the "Center")(see Staff Recommendation on the HSCRC website). Ms. Feeney also described some of the Center's initiatives and the results of those initiatives.

Staff's recommendations include: 1) that funding for FY 2013 in the amount of $1,225,637 be provided through hospital rates (a 7% reduction from FY 2012); 2) remove the requirement of reducing the support by half of any carryover; 3) hold in abeyance $100,000 of funding pending the submission of a feasibility study for relocating the Center outside of the Maryland Hospital Association (MHA) complex; 4) that staff consider the Center's funding request on an annual basis; and 5) that the Center continue to aggressively pursue other sources of revenue, including from other provider groups that benefit from the programs of the Center.

Robert Imhoff, President and CEO of the Center, thanked the Commission for its support of the Center and expressed his agreement with the staff's recommendations.

No Commission action was required.

ITEM VII
TIMELINE FOR IMPLEMENATION OF AN OUTPATIENT CONSTRAINT SYSTEM

Last month, the Commission suspended the Charge-per-Visit methodology for FY 2012. At that time, the Commission charged staff with developing and implementing new or modified outpatient constraint mechanisms. Mary Pohl, Deputy Director-Research and Methodology, presented a preliminary timeline for the development and implementation of both an interim and a longer-term outpatient constraint mechanism.

ITEM VIII
FY 2012 LEGISLATIVE SESSION WRAP-UP

Steve Ports, Principal Deputy Director-Policy and Operations, summarized the disposition of legislation of interest to the HSCRC (see Legislative Update-April 11, 2011 on the HSCRC website).

Mr. Ports reported that the FY 2013 Medicaid Budget passed with the assumption that the HSCRC will implement a $413 million Medicaid deficit assessment (up $24 million from FY 2012), and also provide $75 million in savings to Medicaid through hospital-related cost containment measures. According to Mr. Ports, because the Budget Reconciliation and Financing Act of 2012 did not pass before the General Assembly adjourned the total required hospital-related Medicaid cost savings have been reduced by $9.1 million. Mr. Ports noted that if a Special Session is convened, this could change.

ITEM IX
LEGAL REPORT

Regulations

Proposed

Rate Application and Approval Procedures – COMAR 10.37.10.26

The purpose of this action is to notify hospital inpatients and outpatients of the potential for separate bills for hospital and physician services provided at the hospital.

The Commission voted unanimously to forward the proposed regulations to the AELR Committee for review and publication in the Maryland Register.

Final Adoption

Rate Application and Approval Procedures – COMAR 10.37.10.26

The purpose of this action is to require hospitals to file their request for determination on the regulated or unregulated status of outpatient services at least 60 days before certain contemplated actions.

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

ITEM X
HEARING AND MEETING SCHEDULE

May 2, 2012	1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room
June 6, 2012	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 1:03 p.m.