Executive Session Minutes
Of the
Health Services Cost Review Commission

June 6, 2012

Upon motion made, Chairman Colmers called the meeting to order at 12:30 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, Keane, and Wong. Commissioner Bone participated by telephone.

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

Also attending was Stan Lustman Commission Counsel.

Item One

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

Item Two

Steve Ports and Dennis Phelps updated the Commissioners on the preliminary Legislative Auditors Report.

Item Three

Various personnel issues were discussed.

The Executive Session was adjourned at 12:56 p.m.

MINUTES OF THE
489th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

June 6, 2012

Chairman John Colmers called the meeting to order at 1:03 p.m. Commissioners Joseph R. Antos, Ph.D., Jack C. Keane, and Herbert S. Wong, Ph.D. were also present. George H. Bone, M.D. participated by telephone.

REPORT OF THE EXECUTIVE SESSION OF JUNE 6, 2012

Dennis N. Phelps, Associate Director-Audit & Compliance, summarized the minutes of the June 6, 2012 Executive Session.

ITEM I
EXECUTIVE AND PUBLIC SESSIONS OF MAY 2, 2012

The Commission voted unanimously to approve the minutes of the May 2, 2012 Executive and Public Sessions.

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 increased by 7.51% for the year ended March 2012 compared to the year ended March 2011, down from the 8.69% reported in last month's MMP. Dr. Redmon noted that for that same period, the number of inpatient cases declined by 4.12%; inpatient revenue increased by 3.17%; outpatient revenue increased by 10.99%; and total revenue increased by 5.86%.

Dr Redmon also updated the status of: 1) efforts to obtain an exemption from the Centers for Medicare and Medicaid Services' (CMS') readmission policy; 2) preparation of rate orders for FY 2013; and 3) discussions with representatives of the Department of Health and Mental Hygiene (DHMH) to address the requirements of the Maryland Health Improvements and Disparities Reduction Act of 2012.

Dr. Redmon announced that staff met with Dr. John Cook and representatives of CareFirst of Maryland to discuss staff's concerns with CareFirst's proposal to reintegrate short stay cases into the Charge-per-Episode (CPE) and Charge-per-Case (CPC) methodologies. Dr. Cook and CareFirst representatives acknowledged the possible unanticipated consequences of the interaction of short stay cases with the CPE methodology and the need for staff to prioritize its

limited resources to concentrate on the effort to produce FY 2013 rate orders and to work on waiver modification with CMS. Dr. Cook suggested that staff continue to monitor the effect of short stay cases on the waiver test, and that the Commission revisit this issue should a modernized waiver test not be granted in the near future.

ITEM III
DOCKET STATUS CASES CLOSED

None

ITEM IV
DOCKET STATUS CASES OPEN

Levindale Hebrew Geriatric Center and Hospital – 2157N

On April 25, 2012, Levindale Hebrew Geriatric Center and Hospital ("Hospital") submitted a partial rate application to the Commission requesting a rebundled rate for Emergency Services (EMG), Same Day Surgery (SDS), Operating Room (OR), Operating Room Clinic (ORC), Anesthesiology (ANS), Electroencephalography (EEG), Radiology-Therapeutic (RAT), Nuclear Medicine (NUC), CT Scanner (CAT), Interventional Radiology/Cardiovascular (IRC), and Magnetic Resonance Imaging (MRI) services. The Hospital has a growing population that is in need of these services that are not provided at the Hospital, but rather are provided at Sinai Hospital (Sinai), which is located in close proximity to the Hospital. The Hospital requested the rates of Sinai for these services. The Hospital also requested a new Admissions Rate (ADM) based on the lower of an admission rate based on its costs or an admission rate based on the statewide median. The effective date requested for these services is July 1, 2012

After reviewing the Hospital's application and information submitted to the Commission, the 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 a new ADM rate of $136.46 per admission be approved effective July 1, 2012;
3. That an ANS rate of $2.12, per minute, the Sinai rate, be approved effective July 1, 2012;
4. That a CAT rate of $6.58 per RVU, the statewide median, be approved effective July 1, 2012;
5. That an EEG rate of $11.91 per RVU, the statewide median, be approved effective July 1, 2012;
6. That an EMG rate of $39.96 per RVU, the statewide median, be approved effective July 1, 2012;
7. That an IRC rate of $63.86 per RVU, the statewide median, be approved effective July 1, 2012;
8. That a MRI rate of $37.93 per RVU, the Sinai rate, be approved effective July 1, 2012;

9. That a NUC rate of $12.97 per RVU, the Sinai rate, be approved effective July 1, 2012;
10. That an OR rate of $29.25 per minute, the statewide median, be approved effective July 1, 2012;
11. That an ORC rate of $14.23 per minute, the statewide median, be approved effective July 1, 2012;
12. That a RAT rate of $20.19 per RVU, the Sinai rate, be approved effective July 1, 2012;
13. That a SDS rate of $594.27 per patient, the statewide median, be approved effective July 1, 2012;
14. That ANS, CAT, EEG, EMG, IRC, MRI, NUC, OR, ORC, RAT and SDS not be rate realigned; and
15. That the ADM rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

Civista Medical Center – 2158A

On May 8, 2012, Civista Medical Center ("Hospital") submitted a partial rate application to the Commission requesting a rate for Hyperbaric Chamber (HYP) services. The Hospital requested the lower of a per hour of treatment rate based on its costs and volumes, or a per hour of treatment based on the statewide median for this service. The effective date requested is July 1, 2012.

After reviewing the Hospital's application, the 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 HYP rate of $299.66 per hour of treatment be approved effective July 1, 2012;
3. That no change be made to the Hospital's charge per episode standard for HYP services; and;
4. That the HYP rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

Civista Medical Center – 2159A

On May 8, 2012, Civista Medical Center (the "Hospital") submitted a partial rate application to the Commission requesting a rate for Operating Room Clinic (ORC) services. The Hospital requested the lower of an ORC rate based on its costs and volumes, or an ORC rate based on the statewide median.

After reviewing the Hospital's application, the 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 ORC rate of $14.23 per minute be approved effective July 1, 2012;
3. That no change be made to the Hospital s Charge per Episode standard for ORC services; and
4. That the ORC rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2161A

Johns Hopkins Health System ("System") filed an application with the HSCRC on May 15, 2012 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 requested approval from the HSCRC for participation in a global rate arrangement for solid organ and bone marrow transplant services with Blue Cross Blue Shield Blue Distinction Centers for Transplants for a period of one year beginning May 1, 2012.

The staff recommended that the Commission: 1) waive the requirement that alternative applications be filed 30 days before the proposed effective date; 2) approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period commencing May 1, 2012; and 3) approve the application contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation with Chairman Colmers recusing himself from the discussion and vote.

Johns Hopkins Health System – 2162A

On May 16, 2012, the Johns Hopkins Health System ("System") filed a renewal 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 participation in a renegotiated global rate arrangement for cardiovascular procedures with the Coventry Health Care of Delaware, Inc. for international patients only. The Hospitals request that the Commission approve the arrangement for one year effective July 1, 2012.

The staff recommended that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services for one year beginning July 1, 2012 and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation with Chairman Colmers recusing himself from the discussion and vote.

Thirty Day Extensions

Staff recommended that the Commission grant a 30 day extension of the time for review of proceeding 2160N, Maryland General Hospital.

The Commission voted to approve staff's recommendation.

ITEM V
FINAL RECOMMENDATION ON VARIABLES FOR THE UNCOMPENSATED CARE CALCULATION

Andy Udom, Associate Director-Research and Methodology, presented staff's final recommendation (see staff's "Final Recommendation on Changes to the Uncompensated Care Regression Model Outpatient Variables" on the HSCRC's website).

The recommendation proposed that the current outpatient variables be replaced with: 1) the proportion of a hospital's total charges from outpatient non-Medicare emergency department charges; and 2) the proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity care visits.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
FINAL RECOMMENDATION ON FY 2013 NURSE SUPPORT PROGRAM II (NSPII) COMPETIVE INSTITUTIONAL GRANTS

Oscar Ibarra, Chief-Program Administration & Information Management, summarized staff's final recommendation for FY 2013 Nurse Support Program II (NSP II) (see "Nurse Support Program II: FY 2013 Competitive Institutional Grants" on the HSCRC's website).

Mr. Ibarra reported that the seven-member Evaluation Committee comprised of hospital nursing administrators, community college and university nursing educators, licensing and policy leaders, along with members of the Maryland Health and Higher Education Commission (MHEC) and HSCRC staff reviewed the Competitive Institutional Grant proposals and agreed to recommend funding for twelve of the eighteen requests totaling $4,395,261. To illustrate the inclusivity and diversity across the State, Mr. Ibarra noted that with this cycle of grants, all 26 Maryland Schools of Nursing have participated in at least one of the NSP II grant cycles.

The recommendations included: 1) approval of the twelve Competitive Institutional Grants

selected by the Evaluation Committee; 2) directing the MHEC staff to evaluate the current Competitive Institutional Grant Program and recommend changes as needed; and 3) that the Commission waive the 60-day comment period so that this recommendation can be considered for final action at today's public meeting.

Peggy Daw, Nurse Support Program Coordinator for MHEC, praised the quality of the applications and stated that she wished that the Evaluation Committee could have approved them all.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
REVIEW OF THE PREVIOUS FIVE-YEAR CYCLE OF NURSE SUPPORT PROGRAM I (NSPI) AND DRAFT RECOMMENDATION ON THE CONTINUANCE OF, AND FUTURE MODIFICATIONS TO, NSP I

Claudine Williams, Associate Director-Policy Analysis and Research, summarized staff's Draft Report on Nurse Support Activities for FY 2007 – FY 2012 and Recommendations for Refunding (see "Draft Report on Nurse Support Activities for FY 2007 – FY 2012and Recommendations for Refunding" on the HSCRC's website).

Ms. Williams noted that the NSP I Program has helped reduce Maryland hospitals' dependency on agency nurses; it has increased the number of certified and advanced degree nurses; it has reduced nurse vacancy and turnover rates; and it has increased patient quality of care as indicated by the designation of five hospitals as Magnet hospitals by the American Nurses Credentialing Center.

As per the recommendation in order to raise the bar for Maryland nurses the NSP I program will: 1) set targets for the number of degree nurses, demonstrate the link between improved nursing competency and patient outcomes, and support activities that advance the practice of nursing; 2) improve the application process; 3) revise the annual report to include focused and well defined metrics; and 4) improve the oversight and monitoring of the NSP I program through routine site visits and budget audits.

Joan Warren, Ph.D., Nurse Researcher at MedStar Franklin Square Medical Center, expressed support for the continuation of the NSP I program. Dr. Warren stated that NSP I has been instrumental in funding educational advancement, recruitment and retention, and practice environment initiatives for nurses across the State of Maryland. According to Dr Warren, compelling evidence links a well educated nursing work force with positive patient outcomes. Dr. Warren provided data indicating NSP I funding has increased retention, reduced turnover, and played an integral role in Franklin Square's ability to obtain prestigious quality awards.

Sherry Councell, Nurse Support Program Specialist at Shore Health System for Memorial

Hospital in Easton and Dorchester General Hospital, spoke in support of continued funding of the NSP I program. Ms. Councell detailed what the hospitals she represents have achieved because of the availability of scholarships provided by NSP I, and why NSP I funds are necessary to improve nurse retention and continuing education.

Ms. Laani C. Florencio, RN of Sinai Hospital, expressed appreciation for the Commission funding of the NSP I program and support for its continuation.

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

ITEM VIII
DRAFT RECOMMMENATION REGARDING FY2011 AVERTED BAD DEBT RECONCILIATION, AND RECONCILIATION POLICY BEGINNING FY 2012

Jerry Schmith, Deputy Director-Hospital Rate Setting, summarized the options for the reconciliation of the estimated FY 2011 Averted Bad Debts to actual and the proposed Averted Bad Debt Policy for FY 2012 and Beyond (see "Averted Bad Debt: Options for Reconciliation of FY 2011 Averted Bad Debt Estimates to Actual and Averted Bad Debt Policies for FY 2012 and Beyond" on the HSCRC's website).

Mr. Schmith stated that there are still three issues that have to be worked out before the FY reconciliation can be completed. The issues are: 1) agreement on the amount of the final run-out, i.e., claims that are still outstanding; 2) whether to alter the crowd out and use rates factors used to calculate actual averted bad debt; and 3) to determine the most appropriate means of handling the difference between actual averted bad debts and the amount paid by hospitals to Medicaid.

Mr. Schmith noted that for FY 2012, there will be no reconciliation of expected to actual averted bad debt because legislation has locked the amount of revenue allocated for Medicaid expansion at a uniform 1.25% of projected regulated net patient revenue for each hospital. However, staff has requested input from hospitals to develop an inter-hospital reconciliation approach to equitably align the expected averted bad debt amount in each hospital's rates and the actual averted bad debt.

According to Mr. Schmith, by utilizing a crowd out rate of 18.22% rather than the original 28%, staff calculated that the difference between the amount paid to hospitals for the reduction of uncompensated care due to Medicaid expansion (averted bad debt) and the amount paid to Medicaid by hospitals in FY 2011 was approximately $30 million.

Mr. Schmith stated that staff will be working with the interested parties to reach consensus on the following decision points: 1) determine the most effective and efficient means to account for the FY 2011 run-out; 2) identify the best lower use rate; 3) determine how to handle the amount of the reconciliation of estimated FY 2011 averted bad debt payments to Medicaid to actual averted bad debt; and 4) develop a policy to reconcile actual averted bad debt to the hospital

uniform averted bad debt assessment.

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

ITEM IX
REPORT ON THE STATUS OF FY 2013 MEDICAID ASSESSMENT, AND HOSPITAL RELATED COST CONTAINMENT MEASURES

Dr. Redmon summarized the status of the FY 2013 Medicaid Assessments, as well as related cost containment measures for FY 2013 (see "Medicaid Assessments and Hospital-Related Cost-Containment Measures for FY 2013" on the HSCRC's website).

Dr. Redmon stated that in addition to the $389 million in Medicaid budget deficit assessment required in FY 2012, the FY 2013 Medicaid budget required additional savings from hospital-related policies of $99 million ($24 million in additional Medicaid budget assessment plus $75 million in cost containment measures).

According to Dr. Redmon, $97.3 million of the additional savings required would be covered by: savings from rate realignment of $13.7 million; savings of $30 million from tiering of clinic and emergency department rates; and savings to Medicaid of $53.6 million resulting from the difference between the hospital update factor approved for hospitals for FY 2013(0.3%) and the update factor budgeted by Medicaid (4.13%).

Dr. Redmon modified staff's written recommendation to state that the remaining unfunded portion of the required savings be considered jointly along with the settlement of the FY 2011 averted bad debt.

Michael Robbins, Senior Vice President-Financial Policy of the Maryland Hospital Association, expressed support for Dr. Redmon's suggestion on the handling of the remaining unfunded savings. Mr. Robbins commented that based on the FY 2011 experience, Medicaid is benefiting from a statutory 1.25% averted debt assessment, which is probably overstated. Therefore, Mr. Robbins asked the Commission to consider whether Medicaid is generating excess reserves through the FY 2012 and FY 2013 averted bad debt assessments that more than offset the $1.7 million unfunded savings.

ITEM X
FY 2011 COMMUNITY BENEFIT REPORT, AND CHANGES TO REPORTING REQUIREMENTS FOR THE FY 2012 AND FY 2013 COMMUNITY BENEFIT REPORT AND NARRATIVE

Steve Ports, Principal Deputy Director-Policy and Operations, stated that in addition to presenting the results of the FY 2011 annual Community Benefit Report (CBR), he would

present clarifications to the FY 2012 CBR and changes to the FY 2013 CBR (see "Maryland Hospital Community Benefits Report FY 2011" on the HSCRC's website).

According to Mr. Ports, the FY CBR indicated that hospitals: 1) reported a total of $1.2 billion in community benefits for FY 2011 (compared to $1 billion in FY 2010); 2) provided an average of 9.23% of total operating expenses in community benefits (compared to 7.71% in FY 2010); 3) provided net charity care of $20 million; and 4) provided net community care of $580.4 million or 4.45% of hospitals' net operating expenses (down from $ 613.5 million and 4.85% of hospitals' net operating expenses in FY 2010).

Mr. Ports noted that this was the third year that hospitals were asked to answer narrative questions regarding their community benefit programs for a Community Benefit Narrative Report (CBNR). In order to provide a standard reporting format the CBNR guidelines, wherever possible, were aligned with schedule H of IRS form 990. Mr. Ports observed that the HSCRC considers the CBNR guidelines to be a mechanism for assisting hospitals in critically examining their community benefit programs. In addition, this year for the first time' CBNR responses were evaluated as to whether they provided sufficient detail on the hospital's community benefit programs. Mr. Ports reported that the scores were uniformly high, with four hospitals receiving perfect scores, Harbor Hospital, Holy Cross Hospital, St. Mary's Hospital, and Suburban Hospital.

Mr. Ports thanked the CBNR evaluation group, Madeleine Shea, Ph.D., Director of the Office of Population Health Improvement of the Department of Health and Mental Hygiene, Anne Hubbard, Director of Financial Policy of MHA, and Amanda Greene, HSCRC Program Analyst, and asked each to provide their impressions and observations gathered during their review of the CBNRs.

Mr. Ports indicated that the revisions to the FY 2012 and FY 2013 Community Benefit reporting requirements are documented in the FY 2011 CBR. However, Ms. Greene noted that the CBR Advisory Group decided that it was appropriate to report the Medicaid Budget Assessments in the CBR.

In addition, Mr. Ports pointed out that pursuant to Senate Bill 234, hospitals will be required to provide a description of their efforts to track and reduce health disparities in their communities in their FY 2013 CBR. Mr. Ports stated that the CBR Advisory Group will meet to determine the best format and content for a description of hospitals' disparity initiative, and the Narrative Reporting Instructions will be revised to require the description of a data collection mechanism on a non-mandatory basis in the FY 2012 CBR.

ITEM XI
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 Reporting Manual for Fiscal and Operating Management (August 1987)."

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

ITEM XII
HEARING AND MEETING SCHEDULE

July 11, 2012	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
August 1, 2012	Cancelled

There being no further business, the meeting was adjourned at 2:43 p.m.