Executive Session Minutes
Of the
Health Services Cost Review Commission

September 5, 2012

Upon motion made, Chairman Colmers called the meeting to order at 9:34 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 Bone, Jenks, Keane, Loftus, Mullen, and Wong.

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

Joshua M. Sharfstein, Secretary and Charles Milligan, Deputy Secretary for Health Care Financing, attended representing the Department of Health & Mental Hygiene. The Secretary was subsequently joined by his Chief of Staff Patrick Dooley.

Also attending was Stan Lustman Commission Counsel.

Item One

New Commissioner Steve Jencks, M.D. was introduced to the Commissioners and staff.

Item Two

Steve Ports summarized proprietary information pertaining to the CY 2013 applications of the hospital-based MCOs.

Item Three

The Chairman updated the Commissioners on the progress of the waiver test modernization process.
Secretary Sharfstein presented and discussed with the Commission the State's outlook on waiver modernization.

The Executive Session was adjourned at 10:31 a.m.

MINUTES OF THE
491th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

September 5, 2012

Chairman John Colmers called the meeting to order at 10:36 a.m. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., Jack C. Keane, Bernadette C. Loftus, M.D., Thomas R. Mullen, and Hebert S. Wong, Ph.D. were also present.

REPORT OF THE EXECUTIVE SESSION OF SEPTEMBER 5, 2012

Dennis N. Phelps, Associate Director-Audit & Compliance, summarized the minutes of the September 5, 2012 Executive Session.

ITEM I
EXECUTIVE AND PUBLIC SESSIONS OF JULY 11, 2012

The Commission voted unanimously to approve the minutes of the July 11, 2012 Executive and Public Sessions.

INTRODUCTION OF NEW COMMISSIONER

Chairman Colmers introduced Stephen F. Jencks, M.D. as the HSCRC's newest Commissioner. Dr. Jencks was appointed by the Governor to succeed Joseph Antos, Ph.D.

Dr, Jencks described himself as a "recovering federal bureaucrat," who has focused over the last five to ten years on care transition, readmissions, and the way that they fit together (interact?).

ITEM II
COMMENTS FROM SECRETARY JOSHUA M. SHARFSTEIN, M.D

Secretary Sharfstein shared with the Commission the "bigger picture" of public health in Maryland as well as some thoughts on how and where DHMH and the HSCRC can do more to work together (See, "Health Care and Public Health in Maryland" on the HSCRC's website).

Dr. Sharfstein stated that Maryland is seeking to accomplish the "Triple Aim," that is better outcomes, lower cost, and enhancement of patient care. However, to achieve the Triple Aim there must be community engagement. To provide a mechanism for community engagement, DHMH has developed the "State Health Improvement Process" (SHIP). The objective of SHIP is to provide a framework for accountability, local action, and public engagement to advance health

care. The accountability comes from the selection of 39 health measures that provide benchmarks to measure progress. In addition, to ensure community engagement local community coalitions across the State develop local health plans and coordinate action to address key health outcomes in their communities.

DHMH is also developing Health Enterprise Zones, which involve the targeting of State resources in areas where there are measurable and documented health disparities and poor outcomes. The objective is to reduce the disparities, improve outcomes, and reduce costs, hospital admissions, and readmissions.

Dr. Sharfstein stated that DHMH is encouraging the development of Medical Homes which involve coordinated efforts and incentives to provide primary care within the community health structure. Maryland Health Care Commission (MHCC) and CareFirst of Maryland have initiated Medical Home programs.

According to Dr. Sharfstein, MHCC is evaluating options for transparency in quality reporting of non-institutional care. They are also developing an all-payer claims database to allow consumers and payers to better understand the cost and quality of care and to assist in the development of appropriate bundling of services.

Dr. Sharfstein pointed out that Maryland's rate setting system provides a terrific opportunity to align incentives for the Triple Aim. Dr. Sharfstein observed that we all agree that the goal of a modernized waiver is to take advantage of these opportunities.

Dr. Sharfstein disclosed that the Health Care Reform Subcommittee of the Health Reform Coordinating Council, co-chaired by Chairman Colmers, has been charged with tracking the implementation of health care delivery reform efforts in Maryland and promoting the sharing of best practices.

In conclusion, Dr. Sharfstein listed the potential areas for the HSCRC to participate: 1) share data to assist with public health efforts; 2) review and support community collaboration; 3) track community health outcomes; and 4) reward hospitals that make improvements in community health.

ITEM III
EXECUTIVE DIRECTOR'S REPORT

Patrick Redmon, Ph.D., Executive Director, introduced new staff member Robert Chen. Mr. Chen is a member of the Quality and Performance Measurement Team.

Dr. Redmon reported that Monitoring Maryland Performance (MMP) indicated that the rate of growth in charge per case increased by 5.27% for the fiscal year ended June 2012, and that inpatient revenue increased 1.65% to $9.32 billion. Dr. Redmon stated that for the same period, the number of inpatient cases declined by 3.43% to 704,738. FY 2012 outpatient revenue

increased 12.98% over FY 2011to $5.53 billion with total gross revenue increasing 5.60% to $14.86 billion.

According to Dr Redmon, preliminary FY 2012 unaudited operating profits for acute hospitals were 2.43% and median profits were 2.60% of net operating revenue. Individual hospital operating margins ranged from a high of 14.58% to a low of (11.60%). The 75th percentile was 4.95% and the 25th percentile was 0.78%. The 75th quartile the interquartile range (the difference between the 75th quartile and the 25th quartile) was 4.14%. Dr. Redmon noted that final corrections to the data will be received next month, and the statistics will be updated accordingly.

Dr. Redmon stated that the most recent waiver test letter from the Centers for Medicare and Medicaid Services (CMS) was received with the results for the period from January 1, 1981 through June 30, 2011. The relative waiver test cushion stands at 4.46%.

Dr. Redmon reported that the HSCRC is required to report to the legislature by January 1, 2013 the feasibility of including race and ethnicity performance data in its quality incentive programs. In order to prepare this report, hospitals were surveyed on their current collection and reporting practices of race and ethnic data. Subsequently, a work group met and reviewed the recommendations from DHMH's collaborative, which is a much broader initiative of which the HSCRC is a part. Specifically, the work group analyzed disparities in the clinical process of care measures as well as the survey results. The work group is working with the relevant stakeholders to support training on race and ethnicity data collection, as well as revising HSCRC data. In addition, the Community Benefits work group met to review requirements for racial and ethnic disparities reporting in order to facilitate the inclusion of racial and ethnic disparities information in future Community Benefits Reports.

ITEM IV
DOCKET STATUS CASES CLOSED

2160N – Maryland General Hospital
2163A - Johns Hopkins Health System
2164N - Calvert Memorial Hospital
2165A – University of Maryland Medical Center
2166A – University of Maryland Medical Center
2167A - Johns Hopkins Health System

ITEM V
DOCKET STATUS CASES OPEN

University of Maryland Medical Center – 2169A

University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on July 3, 2012 for an alternative method of rate determination pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for continued participation in global rates for

solid organ transplant, gamma knife, and blood and bone marrow transplants for three years with Aetna Health, Inc. beginning August 1, 2012.

The staff recommended that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ transplant, gamma knife, and blood and bone marrow transplants for a one year period commencing August 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.

University of Maryland Medical Center – 2170A

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on July 3, 2012 requesting approval to continue participation in a global rate arrangement with Maryland Physicians Care ("MPC") for solid organ and blood and bone marrow transplant services for a period of one year beginning August 23, 2012.

The staff recommended that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services, for a one year period commencing August 23, 2012.

The Commission voted unanimously to approve staff's recommendation.

University of Maryland Medical Center – 2171A

The University of Maryland Medical Center ("Hospital") filed a renewal application with the HSCRC on July 3, 2012 requesting approval to continue to participate in a global rate arrangement for blood and bone marrow transplants for three years with the BlueCross and BlueShield Association Quality Centers for Transplant (BQCT) beginning September 1, 2012

The staff recommended that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services, for a one year period commencing September 1, 2012.

The Commission voted unanimously to approve staff's recommendation.

MedStar Health – 2172A

MedStar Health filed an application with the HSCRC on July 25, 2012 on behalf of Union

Memorial Hospital and Good Samaritan Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for cardiovascular services with the Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for one year beginning October 1, 2012.

The staff recommended that the Commission approve the Hospitals' request for continued participation in the alternative method of rate determination for cardiovascular services for a one year period commencing October 1, 2012.

The Commission voted unanimously to approve staff's recommendation, with Commissioner Loftus recusing herself from the discussion and vote.

MedStar Health – 2173A

MedStar Health filed an application with the HSCRC on July 25, 2012 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for orthopedic services with MAMSI for a one year period beginning September 1, 2012.

The staff recommended that the Commission approve the Hospitals' request for continued participation in the alternative method of rate determination for orthopedic services, for a one year period, commencing September 1, 2012.

The Commission voted unanimously to approve staff's recommendation

Johns Hopkins Health System – 2174A

On July 30, 2012, 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, which combines two previously approved arrangements. The combined arrangement includes global rates for cardiovascular procedures, kidney transplant services, and bone marrow transplants. The Hospitals request that the Commission approve the revised arrangement for one year beginning September 1, 2012.

The staff recommended that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular procedures, kidney transplant services, and bone marrow transplant services for one year beginning September 1, 2012

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

Johns Hopkins Health System – 2175A

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on July 30, 2012 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") requesting approval from the HSCRC for continued participation in a capitation arrangement among the System, the Maryland Department of Health and Mental Hygiene (DHMH), and the Centers for Medicare and Medicaid Services (CMS). The Hospital, doing business as Hopkins Elder Plus ("HEP"), serves as a provider in the federal "Program of All-inclusive Care for the Elderly" ("PACE"). Under this program, HEP provides services for a Medicare and Medicaid dually eligible population of frail elderly. The requested approval is for a period of one year effective September 1, 2012.

Staff recommended that the Commission approve the Hospital's renewal application for an alternative method of rate determination for one year beginning September 1, 2012. The Hospital will need to file a renewal application for review to be considered for continued participation

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

Medicaid Health Choice Program

Mr. Ports summarized staff's draft recommendations for the applications of: MedStar Health System on behalf of MedStar Family Choice; Maryland General Hospital, St. Agnes Health System, Western Maryland Health System, and Meritus Health on behalf of Maryland Physicians Care; and Johns Hopkins Health System on behalf of Priority Partners, Inc. for continued participation in the Medicaid Health Choice Program for one year beginning January 1, 2013.

Mr. Ports announced that the final recommendations will be presented at the October 10, 2012 public meeting.

ITEM VI
DRAFT RECOMMENDATION ON OUTPATIENT CLINIC VOLUME ADJUSTMENT

In line with the Commission's direction to develop a revised or new outpatient constraint system to replace the Charge-per-Visit methodology, Mary Pohl, Deputy Director-Research and Methodology, presented a paper that explored the feasibility of implementing a modified volume adjustment for hospital clinics as part of an outpatient constraint system. The paper provided:1) some of the reasons for past and possible future growth in outpatient volume and revenue; 2)

analyses of the growth in clinic volume and revenue; 3) the effect of the current 85/15 volume adjustment on clinic revenue; 4) the financial impact of increases in hospital clinic volumes to patients; 5) the efficacy of implementing a 50/50 volume adjustment; and 6) a recommendation to form a work group to discuss relevant topics.

Dr. Redmon stated that the paper is not a recommendation and will be discussed in the wok group with payers and providers in the next few weeks. Specifically, the group will discuss trends in outpatient growth; review the proposed 50/50 volume adjustment; identify a base year; and consider how to account for excess revenue from prior years of volumes increases.

Commissioner Jencks suggested that staff solicit input from the industry on the reasons for the increases in clinic volumes.

Commissioner Keane stated that he thought the 50/50 volume adjustment proposed in staff's paper was too lenient.

ITEM VII
REPORT ON RATE YEAR 2013 MARYLAND HOSPITAL ACQUIRED CONDITIONS AND QUALITY-BASED REIMBURSEMENT RESULTS

Sule Calikoglu, Ph.D., Associate Director for Performance Measurement, presented the most recent results of the QBR and MHAC analytics. Dr. Calikoglu stated that QBR scores utilized for Rate Year 2013 revenue adjustments were based on hospital performance in CY 2011. The QBR program redistributed $7.9 million among 45 hospitals in a revenue neutral fashion. According to Dr. Calikoglu, average rates continued to improve in 2011, with an average improvement of 2.4% in process of care measures and 3.1% in Hospital Consumer Assessment of Healthcare Providers and systems.

Dr. Calikoglu reported that since the MHAC program is transitioning from a fiscal year performance period to a calendar base year performance period, the performance period for RY 2013 comprised the first three quarters of FY 2012. The MHAC program redistributed $16.7 million among 46 hospitals in a revenue neutral fashion.

Commissioner Jencks asked if hospital coding practices may have impacted the data utilized in the MHAC program.

Dr. Calikoglu stated that the Commission conducts audits of present-upon-admission coding in an effort to control the influence of coding practices.

ITEM VIII
HEARING AND MEETING SCHEDULE

October 10, 2012	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
November 7, 2012	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:52 a.m.