MINUTES
466th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

APRIL 14, 2010

Chairman Young called the meeting to order at 9:06 a.m. Commissioners Joseph R. Antos, Ph.D., Trudy Hall, M.D., Steven B. Larsen, J.D., C. James Lowthers, Kevin J. Sexton, and Herbert S. Wong, Ph.D. were also present.

REPORT OF THE EXECUTIVE SESSION OF APRIL 14, 2010

Oscar Ibarra, Chief-Program Administration & Information Management, summarized the minutes of the April 14, 2010 Executive Session.

ITEM I
REVIEW OF THE MINUTES OF THE EXECUTIVE AND PUBLIC SESSIONS OF MARCH 3, 2010

The Commission voted unanimously to approve the minutes of the March 3, 2010 Executive and Public Sessions.

COMFORT ORDER – DOCTORS COMMUNITY HOSPITAL

The Commission voted unanimously to ratify the Comfort Order for Doctors Community Hospital approved in Executive Session.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, stated that at the request of Delegate Peter Hammen, Chairman of the House Health and Government Operations Committee, the HSCRC undertook a study of hospital board governance policies and practices in order to provide a report of its findings to the General Assembly regarding the stewardship of hospital resources. The HSCRC contracted with the Hilltop Institute at the University of Maryland, Baltimore County, to assist with the study. Mr. Murray noted that in conjunction with the study a review of the HSCRC's Trustee Disclosure Interest Statements was also undertaken.

Mr. Murray summarized the findings of the draft report. First, Hilltop performed a review of

existing literature to identify recommendations for best practices in hospital governance. This review was used to develop a survey tool on board governance practices and policies which was sent to Maryland's 45 nonprofit hospitals. In addition, Hilltop reviewed the FY 2008 HSCRC Trustee Disclosure of Interest Statements filed by the hospitals to evaluate the hospitals' legal compliance and the extent to which there might be conflicts of interest between trustees and the institutions they govern as board members.

The report compared recommended best practices to the five categories of information collected for the study: 1) governance structure, i.e., board size, composition, and committee structure; 2) transparence; 3) conflict of interest policy; 4) governance policies and practices, i.e., financial oversight, executive compensation oversight, quality oversight, and community benefit oversight; and 5) self-governance. Mr. Murray noted that in general the study results showed that most Maryland hospital boards seem to be in line with national trends in best practices in the five governance practices.

As for the review of the HSCRC's Trustee's Disclosure of Interest reports, staff plans to consider revisions to the report.

Mr. Murray thanked Amanda Greene, HSCRC staff, as well as Anna S. Sommers, Ph.D., Cynthia Boddie-Willis, Laura Spicer, Michael Nolin, and Chuck Milligan of Hilltop for their work on this project.

Ms. Sommers stated that Maryland is the first state to collect data on hospital governance practices. Ms. Sommers urged the Commission to consider wide dissemination of the data so that other states can learn from Maryland's experience. Ms. Sommers noted that the survey provided as many questions as answers in several areas. She suggested that the Commission follow-up on: 1) the wide variation in practice of local hospital boards that are members of large health systems to ensure that there is adequate accountability at the health system level; 2) to see if there is a relationship between hospitals that are not following national benchmarks in financial oversight and hospitals that are in financial distress; and 3) whether there are conflicts of interest in situations where physicians play dual roles as board members and as economic entrepreneurs.

Ms. Sommers recommended that the Commissioners become aware of the governance structure of the Maryland health systems and the hospitals that they oversee and understand the relationship between system boards and local hospital boards.

Mr. Murray introduced Denise Johnson who has joined the Commission's staff as Chief-Special Projects.

ITEM III
DOCKET STATUS CASES CLOSED

2056N – St. Mary's Hospital

2060 N – Union Hospital of Cecil County

2057R – Doctors Community Hospital
2059N – Union Hospital of Cecil County
2061R- Carroll County General Hospital
2062A – University of Maryland Medical Center

ITEM IV
DOCKET STATUS CASES OPEN

Carroll Hospital Center – 2063R

On March 26, 2010, Carroll Hospital Center submitted an application requesting a rate for Lithotripsy (LIT) services. The Hospital currently has a rebundled rate for LIT services provided off-site to hospital inpatients. Beginning April 1, 2010, the Hospital will be providing in-house LIT services to both inpatients and outpatients. The Hospital requested the state-wide median rate effective April 1, 2010.

After reviewing the Hospital's application, 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 LIT rate of $2,754.42 per procedure be approved effective April 1, 2010;
3) That no change be made to the Hospital's Charge per Case standard for LIT services; and
4) That the LIT 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 – 2064A

On March 26, 2010, the Johns Hopkins Health System (the System) filed an application on behalf of its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital requesting approval to continue to participate in a global rate arrangement for cardiovascular services with Coventry Health Care of Delaware, Inc. for international patients only for a period of three years beginning April 1, 2010.

Staff recommended that the System's request be approved for a period of one year beginning April 1, 2010 based on favorable performance last year. In addition, staff recommended that the approval be contingent on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2065A

On March 26, 2010, the Johns Hopkins Health System (the System) filed an application on behalf of its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital requesting approval to participate in a global rate arrangement for solid organ and bone marrow transplant services with INTERLINK, Health Services, Inc. for a period of three years beginning April 1, 2010.

After review of the data utilized to calculate case rates, staff recommended that the System's request be approved for a period of one year beginning April 1, 2010. In addition, staff recommended that the approval be contingent on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2066A

On March 26, 2010, the Johns Hopkins Health System (the System) filed an application on behalf of its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital requesting approval to participate in a global rate arrangement for bone marrow transplant services with Cigna Health Corporation for a period of three years beginning April 1, 2010.

After review of the data utilized to calculate case rates, staff recommended that the System's request be approved for a period of one year beginning April 1, 2010. In addition, staff recommended that the approval be contingent on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
UPDATE ON PAYMENT WORK GROUP DELIBERATIONS AND DRAFT RECOMMENDATIONS

Mr. Murray stated that since the first draft recommendation was presented at the March 3, 2010 public meeting staff reconvened the Payment Work Group to solicit revised proposals from both payers and hospitals in an attempt to narrow the range in the magnitude of update proposals. Staff also desired to encourage hospital representatives to submit a three-year rate arrangement and to identify additional ways to generate savings to Medicaid that might reduce the $123 million required to fund the Medicaid budget shortfall for FY 2011.

Mr. Murray reported that in response to United Health Care's willingness to support an increase

to their original update proposal equal to the FY 2010 update of 1.77%, hospital representatives lowered their one-year proposal by approximately 0.4% to 2.96%. Mr. Murray observed that now that the issue of how the Medicaid budget cuts will be handled has been resolved, staff hopes that both sides can make further progress in narrowing the gap between the proposals.

Mr. Murray reported that the Payment Work Group also discussed other ways to generate Medicaid savings that might reduce the $123 million budget shortfall. They included: keeping the update factor below that budgeted by Medicaid in its budget calculations (2.82%); 2) review of chronic hospitals' rate structures relative to the pricing structure of comparable services at skilled nursing facilities; 3) possible reductions in State payments for Maryland Medicaid patients receiving care at Washington D.C. hospitals (particularly Children's Medical Center); 4)pooling of Graduate Medical Education costs; 5) increasing the Medicare/Medicaid differentials, and 6) offer hospitals the opportunity to participate in the HSCRC's Total Patient Revenue system which offers strong incentives to control volumes and direct patients to lower cost services and providers.

Barry Rosen, representing United Health Care and Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, pointed out that the Medicare waiver cushion is the number one issue. Mr. Rosen asserted that the waiver cushion is at its lowest level ever. The Commission must compare the rate of increase in Medicare payments in the rest of the country against the effect of: 1) the one day stay policy; 2) the assessments for Medicaid budget cuts; 3) increases in uncompensated care; and 4) the magnitude of the update factor on Maryland hospital rates to determine how much the waiver cushion will erode. According to Mr. Rosen, if Medicare payments are going to go up by 2.5% in FY 2011, taking into consideration all of the other factors increasing Maryland hospital rates, the update factor cannot be higher than 1.35% or the waiver cushion will further erode. Although it will cause the waiver cushion to deteriorate, according to Mr. Rosen, United Health Care would support an update factor of 1.58% for one-year.

Dr. Cohen urged the Commission not to allow the waiver margin to deteriorate at all in FY 2011. Dr. Cohen stated that he now agreed with MHA that there should be a one-year arrangement because of two basic issues that he Commission cannot know: 1) how the waiver will be affected by how Medicare takes back revenue for up coding and; 2) the effect on hospital costs of the Maryland legislature's physician assignment of benefits bill, which increases payments to hospital based physicians by preferred provider organizations. Dr. Cohen suggested that the update factor this year contain an agreement on addressing one day stays and readmissions, which will significantly improve Maryland's performance versus the nation in FY 2011.

Michael Robbins, representing MHA, recognized and agreed on the importance of where the Medicare waiver cushion needs to be, but asked that there be a critical review of the waiver calculation to ensure that all of the appropriate actuarial adjustments have been made. Mr. Robbins noted that the latest waiver test data does not reflect much of the national up-coding. Therefore, we may see the waiver cushion actually increase in the next year or two before we see the impact of federal action to take back the revenue associated with up-coding in future rates.

ITEM VI
UPDATE ON THE ONE DAY LENGTH OF STAY WORK GROUP DELIBERATIONS AND DRAFT RECOMMENDATIONS

Mr. Murray summarized the issues considered by the One Day Length of Stay (ODS) Work Group and the degree of consensus reached on each: 1) HSCRC staff and the hospitals agree that all ODS cases should be removed from the charge per case (CPC) targets and treated as a separate category; 2) staff believes that ODS cases should have both a per case constraint and a case mix constraint, while hospitals do not agree; 3) all parties agree that a revenue-neutral reallocation of revenue should be made to hospitals that have established observation units and have shifted cases from ODS to outpatient care and away from hospitals that have not done so, although, there is still some debate over how the allocation should be done; 4) staff believes that denied cases for FY 2010 should be removed from hospital CPC targets for compliance and charging purposes, while hospital representatives disagree and recommend removal of denied cases beginning in FY 2011; 5) staff believes that the Commission should establish desired interim goals for reducing the percentage of ODS cases and implement a system of revenue neutral rewards and penalties to induce the desired behavior over time; hospital representatives expressed a willingness to consider such a system: 6) staff and hospitals continue to make progress in developing a revised rate structure for both Observation and outpatient surgery recovery room charges; and 7) staff and hospitals continue to disagree on whether or not to exclude Observation cases from the Charge per Visit (CPV) constraint system, and whether such cases should be subject to a case mix limit.

Mr. Murray noted that attached to the recommendation was a white paper by the Society of Hospital Medicine's Expert Panel on Observation Units that concluded that it was more efficient and more effective from a quality standpoint to utilize Observation services when medically appropriate.

Mr. Murray reported that staff had received data from CareFirst of Maryland, which indicated that in District of Columbia and Virginia hospitals a vastly higher percentage of simple stent cases were performed on an outpatient basis they were in Maryland hospitals. The data also revealed that the outpatient cases were performed at a much lower cost per case than the inpatient cases.

Dr. Cohen expressed support for the staff recommendations that the ODS cases have a revenue constraint. In addition, Dr. Cohen pointed out that the payers have recommended that if volumes fall, the allowed case mix growth should be higher, and that a higher fixed cost factor be applied going forward so that hospitals are protected.

Mr. Robbins addressed the two areas of disagreement, i.e., staff's proposal to remove denied cases from the hospitals CPC targets in FY 2010 and the hospital industry's proposal to exclude Observation cases from the CPV constraint methodology. Mr. Robbins stated the hospital industry has been following all the reporting requirements of the Commission as they relate to denied cases and, therefore, do not believe that they should be penalized retrospectively for that correct reporting.

In regard to Observation cases, Mr. Robbins stated that the hospital industry's position is for the first year (2011), given that a number of hospitals have not yet implemented Observation services; and that Observation cases be excluded from the CPV revenue constraint system and from a case mix governor.

ITEM VII
DRAFT RECOMMENDATIONS FOR REVISIONS TO THE REASONABLENESS OF CHARGES (ROC) METHODOLOGY

Charlotte Thompson, Deputy Director-Methodology and Research, stated that three of the draft recommendations presented at the March 3, 2010 public meeting had been for the spring 2010 ROC methodology. They include: 1) continuation of the current peer group methodology and that a group of industry representatives be assembled in May 2010 to begin work to identify a national peer group for the Academic Medical Centers (AMC) for use in next year's ROC; 2) that kidney transplants continue to be excluded from the CPC constraint system in FY 2011; and 3) the current outlier methodology be continued in FY 2011.

Ms. Thompson announced that a final recommendation will be presented at the May public meeting.

Mr. Murray stated that in a meeting of the work group subsequent to the March 3, 2010 public meeting, there was further discussion regarding the configuration of the proposed two teaching peer groups. Since agreement was not reached regarding the division between major teaching and minor teaching, staff believed that it was appropriate to maintain the current five peer groups and to recommend the development of a national peer group for the determination of reasonableness of charges for the AMCs.

Dr. Cohen acknowledged that there was no agreement on the peer groups. Whether or not there is agreement on an issue should not be the basis for a decision. The decision on what to recommend to the Commission should be made on what staff thinks is the best option. Dr. Cohen expressed disagreement with staff's decision on peer groups and suggested that there be further discussions in the ROC Work Group prior to the presentation of the final recommendations at the May public meeting.

Dr. Cohen expressed concern that staff amended its recommendation to continue to exclude kidney transplant cases based on data shared by the AMCs with the staff, but not shared in the ROC Work Group. Dr. Cohen contended that the data should be shared and the issue discussed further in the Work Group. With regard to the outlier methodology, according to Dr. Cohen, the incentives associated with the current outlier methodology are extremely poor both from a cost containment and quality standpoint. Dr. Cohen asserted that the changes proposed dramatically improved the methodology. Dr. Cohen stated that this issue should also be discussed further. In addition, Dr. Cohen's recommendations regarding capital should also be discussed further.

Dr. Cohen asked the Chairman to direct staff to hold another ROC Work Group meeting before the May public meeting to review the kidney data and to respond to staff's recommendation.

Mr. Chairman agreed that there should be another meeting of the ROC Work Group.

Mr. Murray expressed his willingness to provide the data associated with kidney transplants and to explain staff's rationale for their recommendations.

Michael Franklin, President and CEO of Atlantic General Hospital (AGH), expressed his agreement with the proposed scaling but that the scaling should not be done by peer group. Mr. Franklin stated that AGH's peer group #3 is not a reasonable peer group because of the wide inter-group variation. Mr. Franklin suggested that because of the wide variations in AGH's peer group (#3) it should be combined with peer group #2. Mr. Franklin asserted that AGH's adverse position is a result due to the structure of the peer group.

Mr. Murray responded that this is something that also could be discussed at the ROC Work Group meeting prior to the May public meeting.

ITEM VIII
DRAFT RECOMMENDATIONS ON THE MARYLAND HOSPITAL PREVENTABLE READMISSIONS INITIATIVE

Mr. Murray summarized the staff's draft recommendation on Hospital Preventable Readmissions. Mr. Murray stated that neither Medicare's nor Maryland's prospective payment systems provides incentives for hospitals to appropriately control the frequency of readmissions. Mr. Murray reported that in a recent national study on readmissions of Medicare patients, Maryland had the second highest readmission rate, 22%. The biggest reason for readmissions seems to be poor quality of care or poor transitions between different providers and care settings. Given that Maryland has an all-payer system with a highly sophisticated risk adjustment and case mix classification system, Maryland is in a unique position to link hospital performance to financial incentives to reduce readmissions.

Mr. Murray noted that in developing its methodology, staff identified a set of basic principles. They included: 1) fairness in measurement adjustment factors to account for less-controllable issues and factors that influence readmissions in all hospitals; 2) fairness in application of rewards and penalties, i.e., based on relative rate of performance; 3) prospective application of rewards and penalties based on established targets; 4) aid hospitals in the development of infrastructure and knowledge of potentially preventable readmissions (PPRs); and 5) determine an appropriate level of financial risk.

Mr. Murray described the PPR 3M logic, which identifies a subset of initial admissions that were followed by PPRs, and admissions that are at risk for a readmission but were not followed by a subsequent readmission. The identification of these sets of admissions allows meaningful PPR

rates to be computed.
Graham Atkinson, Ph.D., staff consultant, explained that 3M logic utilizes a case mix adjustment by APR-DRG severity of illness; however, in addition, staff found that other factors, i.e., age, presence of mental health/substance abuse secondary diagnoses, and Medicaid status had substantial and significant influence on the readmission rates. Mr. Atkinson noted that two other factors are still being studied, how to weigh readmission chains and out-of-state-migration.

Commissioner Hall asked how patient compliance was accounted for in the methodology.

Mr. Murray stated that the various adjustments for age, Medicaid, and mental illness would probably account for patient compliance.

Diane Feeney, Associate Director-Quality Initiative, noted that there was an April 6th vetting session with the industry. Ms. Feeney stated that hospital have been provided with state-wide reports showing, by APR-DRG, the top ten reasons for readmissions, as well as more detailed hospital specific reports. Ms. Feeney stated that staff has asked for clinical comments so that they can be addressed at clinical vetting sessions to be held on May 3rd and May 26th.

Beverly Miller, Senior Vice President-Professional Activities for MHA, expressed MHA's support for the goal of reducing PPRs. However, she expressed concern with the process and with timing issues. Ms. Miller stated that staff's recommendation was not received until last Friday and, according to Ms. Miller, there has been limited inter-action between staff and the industry on this issue. Ms. Miller pointed out that there has been no clinical vetting whatsoever. In fact, the first clinical vetting meeting is scheduled two days before the next Commission public meeting. Ms. Miller asserted that what was most troubling was that at the end of the April 6th meeting, staff requested that comments for the May 3rd vetting session should be submitted by April 16th, only10 days later. What is even more troubling and much more challenging is that no data have been provided to hospitals in advance of these clinical vetting sessions, data that would enable hospitals to prepare for the session and submit comments and questions and engage in meaningful dialogue. Ms. Miller stated that if the goal of this policy is to improve quality, it cannot be accomplished unless hospitals have data. In addition, there also has not been a commitment by staff to provide data once the policy is in place.

Ms. Miller noted that at the April 6th meeting, 3M did present the template for providing hospitals aggregate state-wide data by APR-DRG; however, as of this date, hospitals have not received hospital-specific summary reports. In addition, the corrected grouper output data provided by staff several weeks ago have not been received.

Ms. Miller stated that the last major concern is transparency. Ms. Miller asserted the 3M PPR software and methodology have not been validated and because it is proprietary, details are not publicly available.

Ms. Miller urged the Commission to outline a policy development timeline that includes providing hospitals with patient level PPR data as soon as possible, scheduling vetting sessions after hospitals have had the opportunity to review the data, and providing the 3M grouper to

hospitals at no cost.

Mr. Franklin noted that placing the rewards and incentives for preventing readmissions solely on hospitals assumes that hospitals control the clinical decision making for the care of the patient in acute care and in non-acute care settings. However, physicians have much greater impact on these decisions than do hospitals. Mr. Franklin suggested that because physicians are directly involved, perhaps the subsidies that hospitals pay to physicians associated with Medicaid patients could be linked to PPR incentives.

Commissioner Lowthers stated that he would like to see more cooperation from MHA on the PPR project and other Commission initiatives.

ITEM IX
DRAFT RECOMMENDATIONS FOR CONTINUED SUPPORT OF THE MARYLAND PATIENT SAFETY CENTER

Mr. Murray stated that the Commission has been funding 45% to 50% of the Maryland Patient Safety Center's budget through rate increases. For the first five years the dollar amount of funding has gone up. In FY 2009, the Commission provided $1.9 million, a 41% increase over the previous year. Although funding in FY 2010 decreased by 15%, it still represented 45% of the Center's budget. While there is a general policy of reducing Commission funding by 5% a year, there were discussions last year about weaning the Center off of the funding through hospital rates.

Mr. Murray reported that the recommendation for FY 2011 is for funding 45% of the Center's budget ($1,544,594), but 5% of the 45% would be contingent on the submission of a fundraising plan and evidence that the plan will begin to generate a reasonable amount of revenue in FY 2011 and FY 2012.

Mr. C. Patrick Chaulk, Executive Director & President of the Center, stated that in addition to traditional grant making searches, the Center has hired a fund raising consultant and hopes to have commitments for funding by the fall of 2010.

ITEM X
DRAFT RECOMMENDATION FOR THE FY 2011 NURSE SUPPORT II AND COMPETITIVE INSTITUTIONAL GRANTS

Mr. Murray announced that in their Draft Recommendation, the Nurse Support II Evaluation Committee and the HSCRC staff proposed that eleven Competitive Institutional Grants totaling $9,074,199 by approved by the Commission for FY 2011. Mr. Murray noted that staff would ask that the Commission's 60-day comment rule be waived, so that the recommendation may be considered for final approval at the May public meeting.

ITEM XI
LEGISLATIVE REPORT

Steve Ports, Principal Deputy Director-Policy & Operations, presented a summary of legislation of interest to the HSCRC (attachment A). The most significant healthcare legislation passed, of direct effect on the Commission's statute, was SB328/HB 933, Financial Assistance and Debt Collection Policies, and SB 593/HB 699, Freestanding Medical Facilities.

ITEM XII
HEARING AND MEETING SCHEDULE

May 5, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
June 9, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 12:03 p.m.