MINUTES
468th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

JUNE 9, 2010

Vice Chairman Sexton called the meeting to order at 9:03 a.m. Commissioners Joseph R. Antos, Ph.D., Trudy Hall, M.D., C. James Lowthers, and Herbert S. Wong, Ph.D. were also present.

ITEM I
REVIEW OF THE MINUTES OF THE EXECUTIVE AND PUBLIC SESSIONS OF MAY 5, 2010

The Commission voted unanimously to approve the minutes of the May 5, 2010 Executive and Public Sessions.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, reported that the Maryland Health Reform Council, chaired by the Lieutenant Governor and the Secretary of Health, which focuses on preparing the State for the implications of health insurance reform, had its first in a series of meetings in May. The Council will present a final report at the end of the year in time for any required legislation associated with health care reform.

In addition, Mr. Murray reported on the Commission's planned Special Session on Delivery System Transformation to be held in July. The purpose of the session is to discuss the opportunities afforded by the establishment of the new Center for Medicare and Medicaid Innovation (CMI) for the Commission to participate in innovative payment demonstration projects; e.g., gain sharing arrangements between providers (to align incentives across physicians and hospitals), bundled payment arrangements (global case rates for physicians and hospitals), bundling of admissions and readmission, bundling of acute and post-acute care (overall episodic payments), and the expansion of the global budget Total Patient Revenue methodology.

Mr. Murray announced that William Huff, Commission Rate Analyst, was leaving the Commission after three years to take a position with Civista Medical Center. Mr. Murray wished Mr. Huff well and thanked him for all of his hard work.

Mr. Murray also introduced Sule Calikoglu, Ph.D., formerly with the Maryland Health Care Commission, as the HSCRC's new Chief-Quality Analysis. Dianne Feeney, Associate Director-Quality Initiative, noted that prior to earning her doctorate in Health Care Policy from the Bloomberg School of Public Policy, Ms. Calikoglu was also a nurse.

ITEM III
DOCKET STATUS CASES CLOSED

2067R – Garrett County Memorial Hospital

ITEM IV
DOCKET STATUS CASES OPEN

University of Maryland Medical Center – 2068A

On April 28, 2010, University of Maryland Medical Center filed an application requesting approval to continue to participate in a global rate arrangement with the National Marrow Donor Program (NMDP) for the collection of peripheral blood stem cells from donors. The Hospital requested approval for a period of three years beginning July 1, 2010.

Staff recommended that the Hospital's request be approved for one year beginning July 1, 2010 based on historically favorable performance under this arrangement. 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.

University of Maryland Medical Center – 2069A

On April 28, 2010, University of Maryland Medical Center filed an application requesting approval to continue to participate in a global rate arrangement with Cigna Health Corporation for liver and blood and bone marrow transplants. The Hospital requested approval for a period of three years beginning July 1, 2010.

Staff recommended that the Hospital's request be approved for one year beginning July 1, 2010 based on historically favorable performance under this arrangement. 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.

University of Maryland Medical Center – 2070A

On May 14, 2010, University of Maryland Medical Center filed an application requesting approval to continue to participate in a global rate arrangement with Gift of Life Foundation for the collection of bone marrow and peripheral blood stem cells. The Hospital requested approval for one year beginning April 1, 2010.

Staff recommended that the Hospital's request be approved for one year beginning April 1, 2010 based on historically favorable performance under this arrangement. 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

Suburban Hospital – 2072R

On May 13, 2010, Suburban Hospital submitted a rate application requesting a rate for Lithotripsy (LIT) services to be provided in-house. The Hospital currently has a rebundled rate for LIT services. The Hospital requested that the rate be set at the state-wide median with an effective date of July 1, 2010.

After review of the Hospital's application, staff recommended:

1) That COMAR 10.37.10.07, requiring that rate applications be made 60 days prior to opening of a new service be waived;
2) That the LIT rate of $2,761.94 per procedure be approved effective July 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 realigned until a full year's experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
DRAFT RECOMMENDATION ON FY 2011 UPDATE TO HOSPITAL RATES

Mr. Murray outlined some of the topics being discussed in the Payment Work Group since the last public meeting. Mr. Murray noted that the discussions focused on five areas: 1) ways to generate Medicaid savings; 2) alternative methods for scaling a portion of the FY 2011 update; 3) the impact of the update on hospitals' financial condition; 4) the impact on the Medicare waiver; and 5) the development of a proposed 5 year efficiency target.

Mr. Murray briefly described the various methods identified to generate Medicaid savings and reduce the planned assessments on hospitals and payers. They included: potentially reducing chronic hospitals' rate structures; pooling of graduate medical education (GME) costs; and potential reductions in the level of Medicaid payments to Children's Hospital in Washington D.C. Mr. Murray stated that staff made a recommendation to the Payment Work Group that a letter be send to the Secretary of Health requesting that the portion of Medicaid payment associated with uncompensated care be reduced to the level paid all other Washington D.C. hospitals. Mr. Murray reported that although the payers agreed with staff's proposed approach, while MHA did not, that it was staff's recommendation to the Commission that such a letter be sent.

The second issue addressed by the Payment Work Group was alternative scaling. Mr. Murray described the various methods for scaling on relative measures of hospital quality [Quality-based Reimbursement initiative (QBR), Maryland Hospital Acquired Conditions (MHAC), Potentially Preventable Re-admissions (PPR)] and efficiency [the Reasonableness of Charges (ROC) analysis]. The payers proposed scaling 20% of the difference in hospitals' ROC position and their peer group average; the Maryland Hospital Association (MHA) proposed scaling 10% of the difference with a middle bracket of + - 2% which would have no scaling; and staff proposed scaling 15% of the difference, also with a middle bracket of no scaling.

In addition, the payers proposed a pool of 0.5% for QBR and MHAC scaling adjustments and 0.1% for the PPR initiative. MHA proposed a pool of 0.5% for scaling of each of the quality initiatives. Mr. Murray stated that staff advocates aggressive ROC scaling in lieu of spenddowns.

Mr. Murray reported that generally since 2003, Maryland hospitals' operating performance has improved. In FY 2009, Mr. Murray noted, regulated operating profits were quite healthy and continued to be steady through the first half of FY 2010 until Medicaid assessments and volume decreases associated with the blizzards began eroding the financial condition of hospitals. Mr. Murray stated that it is staff's presumption that the continued erosion of the overall operating margin of hospitals is likely the result of a trend we have seen since 2003, a growing increase in losses associated with unregulated services, particularly Part B physician losses.

Mr. Murray suggested to the Commission that it consider directing staff to begin collecting detailed data on hospital unregulated Part B physician costs for further analysis to determine whether losses are driven by coverage requirements or are strategically motivated to generate patient volumes to the hospital.

Mr. Murray stated that at the request of the Commission, staff spent some time trying to develop an efficiency target for the industry. As a result, staff proposes that the Commission consider setting a target for Maryland hospitals of being 6% below the U.S. on cost per Equivalent Admission (EIPA) by FY 2015. Mr. Murray noted that there are controversies associated with the use of the EIPAs statistic, which will be addressed by the payers and MHA in their comments.

Mr. Murray indicated that staff is anticipating presenting a final recommendation at the June 24th special session.

Commissioner Hall requested that data be obtained so that we can determine the losses associated with hospitalists versus Emergency Service physicians versus purchased physician practices.

In regard to physician losses, according to Michael Robbins, Senior Vice President of MHA, it is not just the inner-city hospitals that have the problem of providing physician coverage; a number of rural hospitals face the same challenge. Mr. Robbins stated that all parties should be in agreement that the issue of unregulated losses associated with Part B physician services requires in-depth study.

Mr. Robbins also asserted that in the interest of coming to agreement on the efficiency target, we must address the issue of the calculation of EIPAs and also attempt to explain the differences in the national and Maryland cost data.

Mr. Robbins reiterated MHA's commitment to hold Medicaid harmless for its share should adoption of its proposed update factor cause a Medicaid budget problem.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, agreed with Mr. Robbins that when comparing costs in Maryland hospitals versus the U.S., it might make sense to consider making some adjustments, especially for teaching costs and for the relative difference in one day stays. While advocating exploring other methodologies to calculate EIPAs, Dr. Cohen presented examples that illustrated the point that increases in outpatient volumes alone do not skew the EIPA calculation. His examples also indicated that it was appropriate to adjust the EIPA calculation for the difference in the percentage of one day stays in Maryland and the U.S. Dr. Cohen also expressed his belief that if there is any bias in the current EIPA calculation, that it favors Maryland hospitals.

Barry Rosen, representing United Health Care, stated that EIPAs, although complicated and imperfect, are the best vehicle that we have to compare Maryland to the nation.

Mr. Rosen stated that as far as the update factor is concerned, less is more. Mr. Rosen recommended that Commission be conservative because we have seen time and time again that when there is pressure on revenues, hospitals are more efficient.

ITEM VI
UPDATE ON THE MARYLAND HOSPITAL PREVENTABLE READMISSIONS INITIATIVE

Diane Feeney, Associate Director-Quality Initiative, announced that because of errors in the hospital data, i.e., hospitals not consistently assigning a unique patient identification number that is consistent over time, errors in gender, day of birth, and zip code, a six-month delay in the implementation of the Maryland Hospital Preventable Readmissions Initiative is necessary. Ms. Feeney stated that hospitals have been directed to correct and re-submit their data for FY 2010 by September 30, 2010 and will be subject to fines for both errors in their FY 2010 and FY 2009 submissions. Staff will be working to refine its algorithm used to match admissions.

In reply to Commissioner Hall's question, Ms. Feeney indicated that clinical vetting sessions will continue in the interim.

Tracie LaValle, representing MHA, described some of the challenges that hospitals face to identify patients. Ms. La Valle stated that MHA was working with Commission staff to find both short-term and long-term solutions to this problem.

ITEM VII
FINAL RECOMMENDATION ON REVISIONS TO THE REASONABLENESS OF CHARGES (ROC) AND INTER-HOSPITAL COST COMPARISON (ICC) METHODOLOGIES

Mr. Murray summarized the final recommendations on revisions to the ROC/ICC methodologies. The recommendations included: 1) that the Charge-per Case (CPC) and Charge per Visit (CPV) be blended in to a Comprehensive Charge Target (CCT); 2) that the Indirect Medical Education (IME) and Disproportionate Share (DSH) adjustments be applied as a direct strip rather than as a deviation from the state-wide average; 3) moving to a prospective state-wide capital average standard over a ten-year phase-in period and allowing for a 100% cost factor, under certain circumstances, to hospitals with major capital projects; 4) that there be no change in the profit and productivity adjustments; 5) moving to a 3 month lag in the data used to measure case-mix for RY 2012; 6) that there be no change in the Outlier methodology; 7) modifying the peer groups so that teaching hospitals are compared to teaching hospitals, and non-teaching hospitals are compared to non-teaching hospitals; 8) that the Commission approve aggressive continuous scaling in lieu of spenddowns; 9) that a study be initiated to better understand payments to physicians associated with physician recruitment, retention, and coverage; and 10) that the feasibility of establishing a peer group of Academic Medical Centers outside of Maryland to be used as a basis of comparison for Johns Hopkins Hospital and University of Maryland Medical Center be investigated.

Dr. Cohen expressed strong support for staff's peer group and capital recommendations. In addition, Dr. Cohen suggested that staff move forward on gathering information on physicians so that a determination can be made on the effect of hospitalists on the profit strip. Dr. Cohen urged the Commission to approve staff's recommendations, and that spenddowns be implemented if significant scaling is not adopted.

The Commission voted unanimously to approve staff's recommendation.

ITEM VIII
FINAL RECOMMENDATION ON REALLOCATION OF CASE MIX TO HOSPITALS THAT WERE EARLY ADOPTERS OF OBSERVATION UNITS (FROM ONE DAY LENGTH OF STAY RECOMMENDATIONS)

Mr. Murray stated that at the May 5, 2010 public meeting, the Commission approved staff's recommendation on One-Day Stay (ODS). At the request of MHA, the recommendation gave hospitals time to approve a method to reallocate revenue associated with foregone (governed) case mix increases to hospitals that were "early adopters" of observation units. MHA successfully gained a consensus of its members and, at first, proposed that the Commission approve a methodology to distribute approximately $29 million as a revenue neutral adjustment that would be accounted for through system slippage in the update factor. Subsequently, however, MHA modified its proposal and suggested that the early adopter adjustment be funded through savings that may have been realized in FY 2010 because actual case mix growth turns out to be lower than was budgeted. Staff was receptive to the modified proposal to fund the identified case mix restoration amounts by hospital to the extent that the final FY 2010 case mix, at Level III, is less than the budgeted amount of case mix in the FY 2010 update factor.

Therefore, Mr. Murray stated that staff's recommendation is: 1) that the Commission adopt the MHA-proposed method for reallocating lost case mix to hospitals that established observation units in previous years and away from hospitals that failed to establish observation capacity; and 2) that to the extent possible, the $29 million case mix restoration be funded out of any "unspent" FY 2010 case mix allowance, and that any remainder be funded through a slippage adjustment.

Mr. Robbins thanked the Commission for allowing the hospitals time to work out what they believe to be an improved method of allocation.

Dr. Cohen expressed support for staff's recommendation, however, he pointed out that the reallocation of unspent case mix would have a detrimental effect on the level of the Medicaid neutral update factor percentage.

The Commission voted unanimously to approve staff's recommendation.

ITEM IX
RESULTS ON THE PRELIMINARY RESULTS OF THE UNCOMPENSATED CARE POLICY

Andy Udom, Associate Director-Research & Methodology, provided a status report on the Uncompensated Care (UCC) Policy for FY 2011. Mr. Udom reported that staff and hospital representatives were working through several issues. They included: 1) the reconciliation of averted bad debts (ABD); 2) estimation of FY 2011 ABD provisions; 3) and revisions to the UCC regression. Mr. Udom noted staff's position that the UCC policy should remain unchanged, and that we should account for the impact of Medicaid's expansion using a methodology that parallels the Commission-approved method for handling UCC resulting from the imposition of Medicaid Day Limits, although one is a reduction of UCC and one is a reduction in payments. Mr. Udom stated that staff anticipated presenting a final recommendation at the July public meeting.

Ms. LaValle pointed out that the difference between MDLs and the Medicaid's expansion is that we knew the actual dollar impact of MDLs, and we could reconcile and adjust for it in the UCC policy by hospital. However, we have been unable to reconcile actual averted bad debts and we do not know its impact on individual hospitals. Ms. La Valle stated that the hospitals continue to work with staff to come up with an acceptable method to estimate the effect of ABD on individual hospitals for use in the UCC policy for FY 2011.

ITEM X
COMMUNITY BENEFIT REPORT UPDATE

Steve Ports, Principal Deputy Director-Policy & Operations, presented the 6th annual state-wide Community Benefit Report (CBR). Mr. Ports stated that this year, staff performed analyses comparing hospitals on: the total amount of community benefits reported, the amount of community benefits reported less community benefits provided in hospitals' rate structures, the number of staff dedicated to community benefit operations, and information regarding community needs assessments. Mr. Ports observed that the analyses indicated that in FY 2009: on average, hospitals dedicated 774 hours on community benefit operations; hospitals provided a total of $946.2 million in gross community benefits and $453 million in net community benefits (total community benefits less community benefits included in hospital in rates); and that the majority of hospitals reported conducting community needs assessments.

Mr. Ports noted that the Community Benefits Reports of Calvert Memorial Hospital, Carroll Hospital Center, Franklin Square Hospital, Holy Cross Hospital, and Johns Hopkins Bayview Medical Center stood out as being exemplary.

ITEM XI
LEGAL REPORT

Regulations

Proposed

Types and Classes of Charges Which Cannot Be Changed Without Prior Commission Approval – COMAR 10.37.03.09

The purpose of this action is to clarify that a Commission-approved rebundled rate applies to a non-physician service provided by a third-party contractor to a hospital inpatient off-sit of the hospital's campus.

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

Rate Application and Approval Procedures – COMAR 10.37.10.26A,26A-1,.26A-2, and .26B

The purpose of this action is to alter the requirements for hospital financial assistance and debt collection policies and to make the requirements applicable to chronic care hospitals that are subject to HSCRC rate-setting.

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

ITEM XII
HEARING AND MEETING SCHEDULE

June 24, 2010	Special Session on Payment Update Factor 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room
July 7, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
August 4, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:24 a.m.