

**450TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION**

NOVEMBER 5, 2008

Vice-Chairman Kevin K. Sexton called the meeting to order at 9:16 a.m. Commissioners Joseph R. Antos, Ph.D., Raymond J. Brusca, J.D., Trudy R. Hall, M.D., James Lowthers, and Herbert Wong, Ph.D. were also present.

REPORT OF THE EXECUTIVE SESSION OF NOVEMBER 5, 2008

Oscar Ibarra, Chief-Program & Information Management, summarized the minutes of the November 5, 2008 Executive Session.

COMFORT ORDER – ANNE ARUNDEL MEDICAL CENTER

The Commission voted unanimously to ratify the Comfort Order for Anne Arundel Medical Center approved in Executive Session.

**ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC SESSION
OF OCTOBER 8, 2008**

The Commission voted unanimously to approve the minutes of the October 8, 2008 Public Meeting.

**ITEM II
EXECUTIVE DIRECTOR'S REPORT**

Robert Murray, Executive Director, reported that staff had received a second directive from the Secretary of Health and Mental Hygiene, requesting staff to look at methods of reducing expenditures in the system in response to anticipated Medicaid cut-backs in FY 2010. The Secretary suggested that the Commission focus on providing incentives to reduce medical waste, unnecessary care, preventable complications, and otherwise try to find solutions that are aligned with the policy goals of the system. In response to the Secretary's request, Mr. Murray stated that staff will present a draft recommendation at today's meeting concerning expansion in Uncompensated Care (UCC) pooling, which will reduce Medicaid expenditures while making the financing of UCC more equitable by spreading it more broadly.

Mr. Murray noted that staff is also continuing its work in the area of quality. Staff will be presenting information concerning hospital-acquired conditions, while the Quality Evaluation Work Group continues to look at ways of refining the Commission's process-based quality measures initiative, as well as incorporating outcome measures into the initiative in the future.

Mr. Murray noted that staff will shortly be starting discussions with the industry about the next 3-year rate arrangement and will update the Commission on the progress of the discussions.

In addition, Mr. Murray reported that staff continues to discuss with representatives of the hospital industry the issue of the changing reimbursement landscape for physicians and its effect on physicians and hospitals. Staff will confer with the Chairman and Vice Chairman to determine the best way to approach the short term and the long term dimensions of this issue.

Mr. Murray recognized the hard work and dedication of Paul Sokolowski, Vice President of the Maryland Hospital Association (MHA). Mr. Sokolowski is leaving MHA after 10 years of representing the hospital industry. Mr. Murray stated that Mr. Sokolowski represented not only the interest of hospitals, but more importantly the interest of the health system overall. Mr. Sokolowski's participation with rate setting issues encompassed not only his service at MHA but also more than twenty years as a hospital CFO. Among Mr. Sokolowski's many accomplishments was his intimate involvement in: the rate re-design process, the modification of the Financial Conditions Report, the transition to APR-DRGs, and the movement to a bundled outpatient payment system. Throughout his career, Mr. Sokolowski demonstrated outstanding technical expertise coupled with the willingness to roll-up his sleeves and work with the payers and the Commission's staff to forge compromises. On behalf of the Commission and staff, Mr. Murray thanked Mr. Sokolowski for his dedicated service and wished him the best in his future endeavors.

Mr. Sokolowski stated that it has been his pleasure to have represented the hospital industry for 10 years and thanked the Commission and staff for all the kindness extended to him over the years.

ITEM III

DOCKET STATUS CASES CLOSED

1992N – MedStar Health
2003A - Maryland Physician's Care
2005A – Johns Hopkins Health System

2001A – Johns Hopkins Health System
2004A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

Johns Hopkins Health System – 1994A

On July 14, 2008, Johns Hopkins Health System on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital, filed an application for approval for the continued participation in a global rate arrangement for solid organ and bone marrow transplants with Life Trac, a subsidiary of Allianz Insurance, for a period of one year retro-active to July 1, 2008.

Because the experience under this arrangement was favorable over the last year, staff recommended approval of the Hospitals' request for continued participation in the global price arrangement for one year retro-active to July 1, 2008. 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 – 2006A

On October 7, 2008, the Johns Hopkins Health System filed an application on behalf of Johns Hopkins Bayview Medical Center requesting approval to continue to participate in a capitation arrangement for mental health services under the program title, "Creative Alternatives" between Johns Hopkins Health System and Baltimore Mental Health Systems. The request is for a period of one year beginning November 1, 2008.

Because the experience under this arrangement was favorable over the last year, staff recommended that the Commission approve the request for one year effective November 1, 2008, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Extensions

Staff requested a 30 day extension of time for review of the application of Johns Hopkins Bayview Medical Center, proceeding 2007R.

The Commission voted unanimously to grant staff's request.

ITEM V
DRAFT RECOMMENDATION - CHANGES TO THE UNCOMPENSATED CARE
FUNDING METHODOLOGY

In reaction to growing State budget deficits and in response to the Secretary of Health's request that the HSCRC identify changes to the rate system, which would help reduce Medicaid expenditures, staff investigated the potential impact of two changes in the Commission's Uncompensated Care Policy: 1) including the University of Maryland Shock Trauma Center in the existing Uncompensated Care Pool; and 2) moving the system to 100% pooling of all hospital uncompensated care (UCC). Mr. Murray reported that staff's analysis indicated that because Medicaid accounts for 25% of the payments to Shock Trauma, spreading Shock Trauma's UCC costs would save Medicaid approximately \$4.2 million in Medicaid expenditures and \$1.98 million in State General Funds. However, because Medicaid patients are concentrated in hospitals with higher UCC provisions and thus higher rates, staff estimated that a move to 100% pooling of UCC, including Shock Trauma, would result in total annual saving to Medicaid of approximately \$10.9 million and \$5.1 million in General Fund savings.

Mr. Murray stated that because 100% pooling of UCC fulfills the intent of the Commission's statutory mandate to implement the broadest and most equitable mechanism for financing the burden of providing care to the uninsured, staff recommends that the change to 100% pooling be adopted by the Commission effective January 1, 2009. Mr. Murray stated that it is the intent of staff to present the final recommendation at the December 10th public meeting; however, if the recommendation is delayed, the Commission may be asked to take action in a public conference call.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, voiced his support for staff's recommendation. Dr. Cohen observed that 100% pooling, i.e., incorporating the state-wide average level of UCC in all hospitals, was equitable, since patients at hospitals with high UCC are no more responsible for the level of UCC than patients at hospitals with low UCC are responsible for the low level of UCC.

Ing-Jye Cheng, Assistant Vice President of MHA, stated that MHA supported the recommendation and would meet with staff to work out the technical problems, especially those involved with cash flow issues.

Mr. Murray stated that comments on the proposed UCC Policy change should be received at the Commission's office on or before November 26, 2008.

ITEM VI
UPDATE ON MARYLAND HOSPITAL ACQUIRED CONDITIONS (MHAC) PROJECT

Robert Murray provided a status report on the Maryland Hospital Acquired Conditions Project. Mr. Murray stated that the goal of the project is to use outcome measures to motivate hospitals to

reduce complication rates by providing appropriate financial incentives (attachment A).

Ms. Elizabeth C. McCullough, 3M Health Information Systems, summarized two of 3M's quality-based methodologies for measuring outcomes utilizing inpatient administrative data: 1) potentially preventable complications (PPCs); and 2) potentially preventable readmissions (PPRs) (attachment B).

Mr. Murray presented some examples of how the current payment system inappropriately increases a hospital's revenue when the hospital makes a preventable mistake.

Commissioner Hall asked whether the methodology accounted for the higher rate of PPCs at teaching hospitals.

Ms. McCullough replied that the risk adjustment severity should account for a part of the higher rate of incidence in teaching hospitals, while comparing teaching hospitals with each other could also be done.

Commissioner Hall also asked whether the methodology accounts for PPRs caused by patient caused complications, e.g., not filling prescriptions.

Ms. McCullough stated that the PPR tool logic can be adjusted for additional factors, e.g., disproportionate share, high rates of mental health and substance abuse, an older population, to account for higher rates of PPRs.

Ms. Cheng expressed MHA's opposition to staff's approach in using the 3M software in developing an acquired condition payment policy. Ms. Cheng reiterated MHA's position that payment policies related to serious adverse events should be driven by a methodology that determines whether the hospital should be held accountable for those events, and that 3M's software does not meet the test (attachment C). Ms. Cheng stated that there should be thoughtful discussion of this policy before it is implemented.

Commissioner Hall asked what MHA's alternative was to staff's proposed initiative.

Ms. Cheng replied that MHA believes that there needs to be further discussion on what we are trying to accomplish. She expressed MHA's concern that the proposal would penalize hospitals very broadly using an administrative data driven tool, rather than MHA's preferred approach of encouraging improvement.

Barry Rosen, representing United Healthcare, stated that he had the privilege of participating in the hospital acquired complications workgroup. Mr. Rosen asserted that this initiative shows what is possible in Maryland's unique all-payer case rate system. He observed that there is the possibility that if the Commission, hospitals, and payers take modest, incremental steps and together craft a hospital acquired complications methodology, a hospital's case rate target would

be affected, and the Commission thereby, can change hospital behavior. Mr. Rosen expressed his and his client's enthusiastic support for the project.

Dr. Cohen seconded Mr. Rosen's comments. Dr. Cohen stated that he thought it preferable to target hospitals with higher rates of PPCs and PPRs for revenue reductions to make health care more affordable than to reduce hospital revenue across-the-board. Dr. Cohen asserted that such adjustments are appropriate and urged the Commission to move forward with this initiative.

ITEM VII **UPDATE ON THE ICC/ROC METHODOLOGY DISCUSSIONS**

John O'Brien, Deputy Director-Research and Methodology, summarized the progress of the ICC/ROC workgroup. Mr. O'Brien stated that although the workgroup has come to consensus on several issues (e.g., use of a blended CPC/CPV to develop the Comprehensive Charge Target, not to change the outlier cost methodology, and inclusion of 100% of direct medical education costs in the direct medical education adjustment), several issues were still under discussion. Those issues include the adjustments for indirect medical education and disproportionate share, and whether a peer grouping methodology should be utilized.

Mr. O'Brien reported that staff intends to present a draft recommendation at either the December or January public meeting with a final recommendation to follow.

ITEM VIII **OVERVIEW OF THE COMMUNITY BENEFIT REPORT CHANGES**

Ms. Amanda Greene, Data Processing Analyst, provided a summary of the proposed changes to the Community Benefit Report recommended by the Community Benefit Advisory Group. The group recommended that the narrative portion of the Report be aligned with the data that hospitals were required to file with the Internal Revenue Service, Form 990 schedule H. Ms. Greene stated that the narrative guidelines will be optional for 2008 but will be mandatory in 2009.

Ms. Greene stated that a Review Committee will be assembled in January of 2009 to determine criteria for evaluations of the 2008 Reports filed in order to suggest changes to the Report, provide feedback to hospitals, highlight best practices, and provide training to hospitals whose Reports fall short of the standard. The Review Committee will also seek to reconcile the financial data in the Report to the data filed in the Commission's Annual Report of Revenues, Expenses, and Volumes.

Ms. Cheng thanked staff for all its work on the Report and its willingness to consider hospitals' input. Ms. Cheng expressed MHA's support for the changes in the Report and praised the inclusion of a one year ramp-up period for hospitals to provide the new information. Ms. Cheng

noted that the proposed yearly review process will be highly beneficial because for the first time, hospitals will be able to get systematic feedback from the Commission to improve their reporting.

ITEM IX **LEGAL REPORT**

Regulations

Proposed

Rate Application and Approval Procedures – COMAR 10.37.10.26

The purpose of this action is to describe the assessment process associated with averted uncompensated care and to authorize penalties for untimely or under-payment.

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

Fee Assessment for Financing Hospital Uncompensated Care - COMAR 10.37.09.01-.06

The purpose of this action is to provide for full pooling of uncompensated care amongst all hospitals.

Because these regulatory changes will likely require remittance to be made by January 1, 2009, staff requested that the Commission grant emergency status for this amendment beginning December 1, 2008, until such time as the proposed regulations are formally adopted.

The Commission voted unanimously to forward the proposed regulations to the AELR Committee for review and publication in the Maryland Register and to grant emergency status effective December 1, 2008.

ITEM XX **HEARING AND MEETING SCHEDULE**

December 10, 2008	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
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January 14, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
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There being no further business, the meeting was adjourned at 11:17 a.m.

