445TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

May 14, 2008

Chairman Donald A. Young,, M.D. called the meeting to order at 9:01 a.m. Commissioners Joseph R. Antos, Ph.D., Raymond J. Brusca, J.D., Trudy R. Hall, M.D., Kevin J. Sexton, and Herbert Wong, Ph.D. were also present.

REPORT OF THE EXECUTIVE SESSION OF MAY 14, 2008

Oscar Ibarra, Chief-Program Administration & Information Management, summarized the minutes of the May 14, 2008 Executive Session.

ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC SESSION OF APRIL 22, 2008

The Commission voted unanimously to approve the minutes of the April 22, 2008 Public Meeting.

COMFORT ORDER- ANNE ARUNDEL MEDICAL CENTER

The Commission unanimously voted to ratify their approval in Executive Session of Anne Arundel Medical Center's request for a Comfort Order.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, reported the status of the following activities undertaken by staff: 1) that a draft recommendation on the Quality Based Reimbursement Initiative will be presented at today's meeting with a final recommendation expected to be presented at the June 4th public meeting; 2) that the Corrective Action Task Force had completed its work,

and two proposals would be presented today for Commission action; 3) that the penultimate meeting of Financial Conditions Report Work Group would be held today with the anticipation that a draft recommendation will be presented at the June 4th public meeting; 4) three technical issues (the ROC/ICC methodology approved at last month's public meeting, the FY 2008 case-mix recommendations, and the FY 2009 volume adjustment methodology) were all approved at last month's public meeting; 5) that a draft recommendation on the Outpatient Constraint System that applies to FY 2009 will be presented at today's public meeting; 6) that the Community

Benefit Report is almost completed and will be available before the June 4th public meeting; and 7) that staff is addressing a technical issue that relates to the legislation passed this year for a uniform assessment on hospital rates associated with Medicaid expansion.

ITEM III
DOCKET STATUS CASES CLOSED

1971A & 1972A - University of Maryland Medical Center 1973R - Mt. Washington Pediatric Hospital

1975A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

Doctor's Community Hospital- 1974N

On March 12, 2008, Doctor's Community Hospital submitted an application requesting the state-wide median rate for its new Hyperbaric Chamber (HYP) service to be effective April 1, 2008.

After reviewing the application and cost and volume data subsequently submitted by the Hospital, staff recommended:

1. That COMAR 10.37.10.07 requiring that rate applications be made 60 prior to the opening of a new service be waived;
2. That the state-wide median rate for HYP services of $195.45 per hour be approved effective April 1, 2008;
3. That no change be made to the Hospital's CPC standard for HYP services; and
4. That the HYP 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.

St. Joseph Medical Center – 1978R

On April 21, 2008, St. Joseph Medical Center submitted a partial rate application requesting a rate for regular MRI services. As of May 5, 2008, the Hospital will be providing MRI services at the Hospital for both inpatients and outpatients. The Hospital requested that the MRI rate be set at the state-wide median and be effective May5, 2008.

After review of cost information provided by the Hospital, staff recommended that:

1) That COMAR 10.37.10.07, requiring that rate applications be made 60 days prior to

the opening of a new service be waived;
2) That the state-wide MRI rate be approved effective May 1, 2008;
3) That no change be made in the Hospital's charge per case target for the MRI services; and
4) That the MRI 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.

EXTENSIONS

Staff requested 30 day extensions of time for review of the applications of: University Specialty Hospital, proceeding 1976N; Union Hospital of Cecil County, proceeding 1979R; Greater Baltimore Medical Center; proceeding 1980R; and Garrett County Memorial Hospital, proceeding 1981R.

The Commission voted unanimously to approve staff's request.

ITEM V
FINAL RECOMMENDATION FROM THE CORRECTIVE ACTION TASK FORCE DELIBERATIONS

Robert Murray, Executive Director, announced that staff had prepared an addendum to its analysis provided at the May public meeting that summarizes the deliberations of the Task Force since the April 22nd public meeting. The six areas addressed were: 1) input price inflation experienced by hospitals; 2) the increase in the level of intensity of care; 3) the ability of hospitals to manage inflation and intensity increases; 4) the decline in profitability between FYs 2007 and 2008; 5) the increased financing fees and interest rate levels as a result of the turmoil in the credit market; and 6) Maryland hospitals' cost performance versus the nation.

Mr. Murray stated that the parties reached consensus that at least 3.5% was a reasonable number for price inflation for FY 2009. With regard to the term "intensity of service", the Commission has used intensity as a catchall category that has included a number of different phenomena including unmeasured case-mix growth, increases in new technology, pharmaceuticals, medical supplies, and new therapies, as well as a provision for new services. Hospitals represented that they were experiencing increases specifically in new technology, pharmaceuticals, and medical supplies. All parties acknowledged that hospitals have the ability to manage both inflation growth and intensity; however, the difficulty is getting to any precise number for what can be achieved. Mr. Murray noted that much of the decline in hospital profitability between FYs 2007 and 2008 can be attributed to four hospitals that have suffered large volume declines and to under-charging by hospitals of about 0.4% over the first eight months of FY 2008. The impact of the downgrading of bond insurers on the credit market has contributed to increases in interest rates, as well as increased financing costs for capital projects; however, since this situation applies to only a portion of the industry, it is not necessarily a pervasive issue at this time. Mr.

Murray stated that payer representatives strongly emphasized the fact the Maryland hospitals had failed to outperform the nation on rate of growth in cost per adjusted admission over the last four years.

Mr. Murray summarized the similarity and the differences between the revised Maryland Hospital Association (MHA) proposal on behalf of the hospital industry, and the payers' proposal for the FY 2009 Update Factor. In terms of similarities both proposals: 1) result in a 7.2% increase in overall revenue for the system, an\d approximate 6.6% increase for inpatient revenue, and a 8.6% increase in outpatient revenue; 2) include a limitation on case-mix growth; and 3) recognize the application of a volume adjustment.

Mr. Murray noted that the differences between the proposals relate primarily to the baseline update factor. The hospitals strongly recommend that the Commission provide at least 4% for core inflation (4.2% inflation update less 0.2% for the impact of the volume adjustment) to ensure that the update factor will cover core inflation). In contrast, the payers recommend a lower inflation update of 3.8%. The payers recommend a 0.8% cap on case-mix, while the hospitals propose a 0.5% cap. As to the intensity factor to be applied to the outpatient constraint system, the payers recommended 1%, while the hospitals recommended 0.5%.

Mr. Murray pointed out that at the last meeting, both sides offered substantial compromises from their original positions in an attempt to reach a consensus. The result is small differences in the structure between the two proposals, but virtually no difference in the ultimate revenue impact on the system.

Commissioner Sexton asked whether staff had a recommendation.

Mr. Murray stated that either of the two proposals would be acceptable to staff.

A panel consisting of Brian Gragnolati, President & CEO of Suburban Hospital, Tom Mullen, President & CEO of Mercy Medical Center, and Paul Sokolowski, Vice President of MHA, presented the hospital industry's comments on the proposals.

Mr. Sokolowski noted that the industry was concerned about FY 2009 since in the first nine months of FY 2008; more than twenty hospitals are reporting declines in operating profits. Mr. Sokolowski observed that operating profits in FY 2008 may dip below 2%.

Mr. Sokolowski observed that two proposals seem to end up in the same place; however, they get there very differently. Hospitals are willing trade a little more constraint on case-mix and outpatient growth for a little more in core inflation. Mr. Sokolowski urged the Commission to accept the hospitals' proposal. Mr. Sokolowski stated that the industry looked forward to negotiating the new three year agreement. Hospitals will approach the negotiations keeping in mind three important elements: 1) the status of the Medicare waiver; 2) affordability; and 3) hospitals' financial condition.

Mr. Gragnolati expressed the industry's concern about declining profitability. Mr. Gragnolati stated that MHA's proposal was a compromise and appealed to the Commission not to split the difference between the proposals. Mr. Gragnolati also recommended that the question of whether a volume adjustment is needed, and if it is needed how it should be applied, be addressed in the discussions for the next three year agreement since the revenue provided by 100% variability for volume increases helps offset other non-funded costs.

Mr. Mullen recommended that in the negotiations for the next three year agreement we focus on whether the Global Insights, Inc. (GII) index is the relevant index to measure core inflation for the hospital industry. Mr. Mullen stated that the hospital industry is also concerned about the three key elements for the next agreement of affordability, maintaining the Medicare waiver, and maintaining a reasonable financial condition for Maryland hospitals. According to Mr. Mullen, hospitals should be as strong as possible financially entering into a future period, when there are certain to be reductions in Medicare payments.
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The Chairman asked Mr. Gragnolati what he thought of the distributional effect of the volume adjustment, i.e., it affects different hospitals differently.

Mr. Gragnolati stated that in the past, hospitals experiencing volume increases had the ability to improve their financial position because they were able to retain 100% of the revenue associated with additional volumes. This revenue was used to improve hospitals' bottom line and to support other programs. According to Mr. Gragnolati, the volume adjustment removed a bit of the competitive dynamic out of the system by taking revenue away from hospitals that are growing and providing revenue to hospitals that are losing volumes.

Mr. Mullen stated that not having a volume adjustment helped hospitals make financial projections for building projects because the circumstance allowed hospitals to "bank" the incremental profit from volume increases, and that helped justify the cash flow to pay the debt. Removing this incremental revenue source also makes it more difficult to show financial institutions how a hospital is going to improve its margin.

A panel of payer representatives consisting of Hal Cohen, Ph.D., representing CareFirst and Kaiser Permanente, Barry Rosen, Esquire, representing United Healthcare, and John Folkemer, Deputy Secretary for Health Care Finance and Medicaid Director for the Department of Health and Mental Hygiene, presented comments on the proposals.

Dr. Cohen noted that this was a true negotiation and it was interesting that both sides ended-up giving up the same amounts. The proposals, however, are not identical. Dr. Cohen disagreed with Mr. Murray's comment that the revenue was the same under both proposals. Dr. Cohen asserted that this was only true if inpatient case-mix grows at 0.8% or more. However, if case-mix grows at 0.5%, the overall difference is 0.3% or $36 million. Dr. Cohen agreed with the hospitals that the Commission should select one proposal and not split the difference.

Dr. Cohen observed that while hospitals focus on profits, the payers focus on costs. Focusing on profits, in effect, turns it into a cost-plus system. The payers do not believe that this is a cost based system. When you focus on costs, your profits can be high if your costs are low. According to Dr. Cohen, if costs in Maryland hospitals were below the nation profits would be higher than they are. If costs in Maryland hospitals were in the Commission's target range of 3% to 6% below the nation, profits would be very high at current revenue levels.

Dr, Cohen pointed out that adding the average error in GII projections of core inflation over the last four years to the current projection of GII gives you 3.5%, which both parties agreed was reasonable. However, the payers believe it is inappropriate to get excited about GII under estimating inflation for FY 2009, when no one seems to care that the Commission over-projected inflation in FY 2007. In regard to the appropriate adjustment for intensity, according to Dr. Cohen the average adjustment recommended by ProPAC and MEDPAC (the Medicare Payment Advisory Commission and its predecessor) for scientific and technological intensity, over seventeen years, was less than the recommended offset for productivity. The payers believe that it is reasonable to finance the appropriate adjustment for scientific and technological advancement by increases in productivity. In regard to increases within DRG intensity, Dr. Cohen asserted that because of a new grouper, MEDPAC eliminated the adjustment for within DRG complexity in recent years, and Maryland's grouper is better than Medicare's new grouper. Consequently, the unmeasured intensity within DRGs in Maryland is very low. The payers believe that the update should be limited to 3.8%. This is 0.7% more than GII is projecting inflation to be and 0.3% more than GII plus a reasonable correction. Therefore, the payers urge the Commission to support their proposal.

Mr. Rosen stated that United Healthcare's message is simple: less is more. Mr. Rosen suggested that in anticipation of payment reductions in the Medicare system, rather than maximize hospital revenue now as Mr. Mullen suggests, the Commission should provide reasoned, sensible increases on a steady basis. Thus, when the Medicare payment reductions occur, the Commission will not have to take drastic action.

Mr. Rosen urged the Commission to approve the payers' proposal, which will make hospital care a bit more affordable for the citizens of Maryland.

Mr. Folkemer pointed out that the decisions the Commission makes today will have a much broader impact on the whole health care system than its effect on the hospital industry. Mr. Folkemer noted that with the demise of Medicaid Day Limits, the Commission has almost complete control of over 40% of Medicaid's budget. In contrast to today's hospital update proposals, which will determine how much above inflation hospital rates will increase, Medicaid is currently deciding how much the funding for the remaining 60% of Medicaid's activities must be cut in order to meet budget constraints. Mr. Folkemer asked the Commission to keep these broader implications in mind.

Commissioner Antos asked for confirmation that whatever the Commission approved today could severely impact our decisions on full rate applications. If the Commission approves the

hospitals' proposal, are we reducing our flexibility in the future?

Mr. Murray agreed that the hospitals' proposal provides more money to hospitals initially, while the payers' proposal is more of a wait-and-see if case-mix growth materializes. Therefore, if the Commission chooses the hospitals' proposal, it may want to be more cautious with discretionary revenue it provides in full rate reviews.

Commissioner Sexton made a motion that the Commission approve the MHA proposal.

The Commission voted unanimously to approve MHA's proposal.

ITEM VI
FINAL RECOMMENDATIONS FROM THE MARYLAND HEALTH CARE COMMISSION ON HEALTH INFORMATION EXCHANGE PLANNING GRANTS

David Sharp, Deputy for Health Information Technology for the Maryland Health Care Commission (MHCC), presented the joint recommendations of the MHCC and the HSCRC staff to fund two multi-stakeholder group planning projects to develop a strategy for a phased implementation of the state-wide health information exchange through an adjustment to hospital rates in the amount of $250,000 each.

The Commission voted unanimously to approve the staff recommendation.

ITEM VII
DRAFT RECOMMENDATIONS ON THE QUALITY-BASED REIMBURSEMENT PROJECT BASED ON DELIBERATIONS OF THE INITIATION WORK GROUP

Robert Murray summarized the draft recommendation on the Quality-Based Reimbursement Project. Vahe Kazandjian, Ph.D., and Grant Ritter, Ph.D. also presented comments on the project.

The project will develop a methodology of rewards and incentives to improve and sustain health care quality. The recommendations would apply to the first year of implementation (CY 2008 and CY 2009 data collection periods, and FY 2010 payment period). The recommendations consisted of: 1) data measures; 2) performance assessment model and constructing a hospital performance score; 3) funding parameters and translating scores into payment; and 4) data related issues and future activity.

Mr. Murray thanked Commissioner Hall, Steve Ports, Marva Tan, Dianne Feeney, as well as Dr. Kazandjian and Dr. Ritter, and other members of the Center for Performance Sciences, Inc. who collaborated in the process.

Commissioner Sexton stated that the goal of this effort should be to move from process measures to outcomes measures. The Commissioner asked how and when the move to outcome measures will be made.

Dr. Ritter noted that there are outcome measures, e.g., re-admission rates, complication rates, coordination of care, and mortality rates that are being considered now. The key component is correct case-mix adjustment.

Dr. Kazandjian stated that the goal has always been to link process measures with outcome measures. The Project decided to start with process measures because of their feasibility, acceptability, and fairness.

Mr. Murray noted that the Commission began to collect present –on-admission data with which we may be able to establish rates of preventable complications. In addition, there is technology within the ARP-DRGs grouper that may allow us to detect preventable re-admissions.

Marty Basso, CFO of Suburban Hospital, and Ing-Jye Cheng, of MHA, commented on the Quality-Based Reimbursement recommendations. Mr. Basso commended the Commission on its deliberate approach to developing this methodology, in particular its mission and goals relative to quality-based reimbursement and the unique opportunity to develop uniform quality-based incentives across all payers. The hospital industry supports: 1) using evidence-based quality measures; 2) composite measures and the opportunity model; 3) keeping "topped off" measures; and 4) providing financial incentives for both attainment and improvement,

Ms. Cheng noted, however, that the industry was concerned about: 1) the go live date, i.e., measurement should not start before FY 2009; 2) the amount and type of funding, i.e., new money; 3) the inclusion and updating of the model for new measures; and 4) the data collection process moving forward.

The Chairman asked how much the data collection would cost hospitals.

Ms. Cheng stated that the effort is rather large, although the cost has not been quantified.

Commissioner Hall asked whether it was not correct that most of the data are already being captured and reported.

Mr. Murray and Mr. Ports noted that the data for the current measures are already mandated by the MHCC.

Dr. Cohen stated that this was an excellent start and that the quality project should not be delayed. The payers also strongly support the movement to outcome measures, in particular sepsis, and the addition of measures that do not flow from Medicare, e.g., those associated with obstetrics and psychiatric admission. Also, the payers support expanding the revenue in the quality pool to start at 0.5% of the update factor. Dr. Cohen urged adoption of staff's draft recommendation.

ITEM VIII
DRAFT RECOMMENDATION ON THE OUTPATIENT PAYMENT SYSTEM

John O'Brien, Deputy Director-Research and Methodology, stated that at the public meeting of April 22nd the Commission approved a one year delay in the implementation of the Outpatient Charge per Visit (CPV) methodology. Staff advised the Commission at that time that for FY 2009 staff intended to implement an expanded CPV system. Staff is presenting today a draft recommendation for the new expanded system. Mr. O'Brien introduced Graham Atkinson, Ph.D., Commission consultant, who made a brief presentation on the new CPV system.

Dr. Atkinson pointed out that the original plan was: 1) to implement a CPV for ambulatory surgery (AMS) in FY 2008; 2) to use FY 2007 as the base period; and 3) to use APGs for case-mix grouping. However, because of several problems including a change in the collection format, rate realignment, and problems with the APG grouper, implementation was postponed until FY 2009.

Dr. Atkinson stated that he believes that we have overcome all of the problems, and that we are in a position now to implement an expanded CPV methodology including more types of services. The new proposal: 1) includes not just ambulatory surgery cases but expands the methodology to cover all cases that have either a significant procedure APG or a medical APG, with some specific exclusions, e.g., oncology, dialysis, and mental health; 2) uses FY 2008 as the base year; and 3) uses new APG grouper 3.1. According to Dr. Atkinson, the explanatory power of the proposed new case-mix system is high. Dr. Atkinson stated that a combination of the principal APG procedure and Evaluation and Management CPT Codes provided a comfortable level of explanatory power. Dr. Atkinson noted that it appears that whether the patient entered the hospital through the Emergency Department (ED) or not made a difference in resource use. The work group will discuss whether to make an adjustment for the presence of ED procedures.

Dr. Atkinson noted that because of a "within hospital" system, there were no adjustments needed for labor market, direct or indirect medical education costs, or mark-up, and the price leveling factor will deal with mark-up changes. In addition, the hospital-specific price leveling factor handles changes due to rate realignment and case weights will be revenue center specific.

Dr. Atkinson stated that the next steps are: 1) to meet with the technical work group to present the proposed methodology and interim results; 2) to refine the methodology based on discussions with the work group; and 3) to prepare a detailed final recommendation

Commissioner Sexton asked where ED procedures fit in the APG grouping system.

Dr. Atkinson stated that they would be a layer on the significant procedure APGs.

Dr. Cohen expressed the strong support of moving forward on outpatient revenue constraint.

Robert Vovak, Vice President of MHA, expressed the industry's concern with implementing the CPV system in FY 2009 utilizing ED and Clinic data that have not been analyzed for possible

issues. Mr. Vovak suggested that an AMS CPV be implemented in FY 2009, and that ED and Clinic data be analyzed for possible issues in FY 2009 for inclusion in the CPV system in FY 2010.

Tracy Phillips, representing MHA, observed that it took a year to work out the issues with the AMS data.

Commissioner Sexton asked whether there had been a decision made as to whether there would be a corridor in the CPV methodology.

Mr. O'Brien stated that no decision had been made yet on whether staff would recommend corridors.

ITEM IX
DRAFT RECOMMENDATIONS REGARDING CONTINUED FUNDING FOR THE MARYLAND PATIENT SAFETY CENTER

Mr. Murray summarized the draft staff recommendation for continued funding of the Maryland Patient Safety Center (MPSC) (attachment B). The recommendations were: 1) that the MPSC update the Commission periodically on health care outcomes and expected savings resulting from programs that the Center sponsors; 2) that the MPSC aggressively pursue other sources of revenue to support the Center going forward; and 3) that "seed" funding continue to be provided to the MPSC through hospital rates in FY 2009 to cover 50% of the budgeted costs of the Center, less half of the carry-over from the previous year.

Kathleen White, Ph.D., Chairperson of MPSC, Dr. Kazandjian, Board Member of MPSC, and Chris Jensen, M.D., Board Member of MPSC, summarized MPSC's current initiatives and thanked the Commission for funding the MPSC.

ITEM X
FINAL RECOMMENDATIONS FOR THE FY 2009 NURSE SUPPORT PROGRAM II COMPETITIVE INSTITUTIONAL GRANTS

Mr. Ibarra presented staff's recommendation on the FY 2009 Nurse Support Program II (NSP II) Competitive Institutional Grants. Competitive Institutional Grants are designed to increase the structural capacity of Maryland nursing schools through shared resources, innovative educational designs, and streamlining the process to produce more nurse faculty. The NSP II Program is funded by an assessment of 0.1% in hospital rates. The Program is administered by the Maryland Higher Education Commission.

Staff recommended that three Competitive Institutional Grants be approved by the Commission for FY 2009. The grants recommended for approval were to: 1) the University of Maryland to recruit 485 graduate nurses into the teaching certificate program; 2) the University of Maryland to improve teaching methods in its doctorate nursing program; and 3) to Allegany Community

College to establish a nursing program in Garrett County. The first year's funding totals $515,874.

The Commission voted unanimously to approve staff's recommendations.

ITEM XI
RELEASE OF THE ROC/ICC ANALYSIS

Mr. O'Brien announced that final results of the ICC/ROC analysis for Spring 2008 have been released.

ITEM XII
HEARING AND MEETING SCHEDULE

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June 4, 2008	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
July 2, 2008	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:47 a.m.