456th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

MAY 13, 2009

Chairman Young called the meeting to order at 8:04 a.m. Commissioners Joseph R. Antos, Ph.D., Raymond J. Brusca, J.D., Trudy R. Hall, M.D., J.D., Kevin J. Sexton, and Herbert S. Wong, Ph.D. were also present.

ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC SESSION OF APRIL 15, 2009

The Commission voted unanimously to approve the minutes of the April 15, 2009 Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, described the major initiatives and high priority issues that the Commission and staff are working on. The principal items include: 1) finalizing and implementing the 2010 update factor; 2) revising the Maryland Hospital Acquired Conditions (MHAC) methodology based on suggestions and comments made at the last public meeting; 3) developing revised instructions for the Community Benefit Report to enable staff to benchmark hospital performance and provide feedback to hospitals; 4) evaluating various policy changes including revising the Uncompensated Care Policy with emphasis on encouraging charity care; 5) reviewing and revising the Hospital Financial Assistance Policy "information sheet"; 6) assembling a workgroup to develop standards for hospital credit and collection policies; 7) focusing on use and coding of Observation Services and frequency of one-day length of stay admissions; 8) expansion of the Outpatient Charge per Visit methodology; 9) working with the Evaluation Work Group to consider adding additional enhancements to the Quality Based Reimbursement (QBR) system by including additional measures such as patient experience of care; 10) developing an incentive-based methodology for improving performance on Potentially Preventable Readmissions; and 11) initiating the annual discussion of Reasonableness of Charges (ROC) methodology focusing on peer groups and outlier payments.

ITEM III
DOCKET STATUS CASES CLOSED

2014A – Johns Hopkins Health System
2017A – University of Maryland Medical Center
2018R – University Specialty Hospital
2019N – Garrett County Memorial Hospital
2020R – Franklin Square Hospital
2024A – University of Maryland Medical Center

ITEM IV
DOCKET STATUS CASES OPEN

University of Maryland Medical Center – 2009A

University of Maryland Medical Center filed an application on November 17, 2008 for approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services. The requested approval is for a period of one year effective November 1, 2008.

After review of the terms of the re-negotiated arrangement and the favorable performance for the first half of FY 2009.data utilized to calculate the case rates, staff recommended that the Commission approve the Hospital's application for a period of one year retroactive to November 1, 2008 with the approval contingent on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

University of Maryland Medical Center – 2023A

On April 2, 2009, the University of Maryland Medical Center filed an application requesting approval to participate in a global arrangement for solid organ and blood and bone marrow transplant services with Cigna Health Corporation for a three year period beginning April 1, 2009.

After review of the data utilized to calculate the case rates and other provisions of the arrangement, staff recommended that the Commission approve the Hospital's request for a period of one year beginning April 1, 2009, and that the approval be contingent on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Civista Medical System – 2022R

On March 23, 2009, Civista Medical Center submitted an application requesting its

Medical/Surgical Intensive Care (MIS) and Coronary Care (CCU) units be combined effective April 1, 2009.

After reviewing the Hospital's application, staff recommended that the Commission approve the Hospital's request.

The Commission voted unanimously to approve staff's recommendation.

Extensions:

Staff requested a 30 day extensions for review of the applications of the Edward W. McCready Memorial Hospital, Proceeding 2026N, and Good Samaritan Hospital, Proceeding 2027R.

The Commission voted unanimously to approve staff's request.

ITEM V
FINAL RECOMMENDATIONS FROM THE DELIBERATIONS OF THE PAYMENT WORK GROUP

Robert Murray, Executive Director, summarized the process that began in November 2008 with the formation of a payment work group made up of representatives of the HSCRC staff, the Maryland Hospital Association (MHA), hospitals, and public and private payers. The deliberations of the work group produced proposals from MHA and the payers. MHA's proposal was for a base update factor of 2.72%, a final update of 3.25%, resulting in an overall projected revenue increase of 4.33%. The payers' proposal was for a base update of 0.10%, a final update of 0.88%, resulting in an overall revenue increase of 1.87%.

In addition to the two proposals, staff considered the following factors in developing its recommendation: 1) hospital financial performance; 2) the severe contraction in the general economy; 3) trends in hospital input cost inflation; 4) significant State budgetary shortfalls; and 5) Medicare waiver issues.

Mr. Murray stated that according to Medpac data, hospitals facing broad financial constraints tend to have lower costs. Also, HSCRC's data show that hospitals budget and spend what they are given in the annual update factor. Mr. Murray reported that staff concluded from these data that approved increases in payments drive cost performance; therefore, lower update factors will lead to more cost efficient behavior on the part of hospitals.

Therefore, Mr. Murray announced that staff's final recommendation consists of: 1) a base update of 0.49%, a final update of 1.27%, resulting in an overall projected revenue increase of 2.26%; 2) continuation of the 85% variable cost adjustment for volume; 3) maximum case mix growth of 1%; 4) scaling of the update factor based on the relative efficiency of hospitals; and 5) an additive scaling of 0.5% based on performance on quality-based reimbursement.

A panel consisting of John M. Colmers, Secretary of the Department of Health and Mental Hygiene, Chester Burrell, President and CEO of CareFirst of Maryland, and Carmela Coyle, President of MHA, jointly presented a suggested compromise proposal on the 2010 update factor.

Mr. Colmers indicated that the compromise proposal was developed after conversations with representatives of CareFirst and MHA, with Mr. Murray present. The compromise proposal was developed in an attempt to narrow the gap between the broadly divergent opinions as expressed in the update proposals of MHA and the HSCRC staff. Mr. Colmers stated that the proposal is a consensus reached by CareFirst, MHA, and the Medicaid Program in an attempt to achieve a balance in which everyone compromised. Mr. Colmers explained that the compromise update factor begins with staff's final recommended update factor; however, it reduces the 1% off-set for productivity to 0.10%, eliminates the reduction for projected slippage of 0.10%, and reduces the maximum adjustment for case mix growth from 1.00% to 0.85%. This results in a proposed base update of 1.49%, a proposed final update of 2.12%, and an expected overall revenue increase of 3.11%.

Mr. Colmers asserted that most of the savings associated with improvements in the hospital sector are to be derived from matters unrelated to the size of the update factor. Adjustments for inflation and other technical issues are important; however, they pale in comparison to the issues related to unnecessary admissions, a well as unnecessary and preventable complications. That is where the money is - - that is where the savings are. Mr. Colmers noted that a component of the consensus agreement is a commitment by all parties to ensure that by January 1, 2010 a recommendation will be implemented on potentially preventable re-admissions, which can have a significant impact on outcomes and payment reform. Mr. Colmers stated that the compromise is a balanced approach and urged its approval.

Mr. Burrell reported that while increases in payments to physicians in CareFirst's network have been zero for the last 3 years, and increases in payments to hospitals are going up, increases in health insurance premiums have averaged 12-15%. According to Mr. Burrell, what is driving the increase in health care costs is increased utilization. Mr. Burrell stated that CareFirst's support for the compromise is based the on opportunity to begin a dialogue to find an approach to control preventable re-admissions and volumes. Mr. Burrell noted that it is on the strength of that idea that CareFirst supports the compromise recommendation. CareFirst would like to see a concrete proposal by January 1, 2010 on how to control re-admissions and volumes.

Ms. Coyle stated that while the compromise proposal will still present significant financial challenges for hospitals, it also includes incentives for cost efficiency. Ms. Coyle urged Commission to adopt the compromise proposal.

Mr. Colmers noted that everyone compromised, and that the challenge for the Commission is how to meet the waiver test with a payment per admission standard when the real problems are those related to volume and physician services.

An MHA panel consisting of Mark Higdon, Partner-KPMG, Raymond Grahe, CFO-Washington

County Health System, Joel Klein, M.D. - Emergency Department Physician, Baltimore Washington Medical Center, Carl Schindelar, President & CEO – Franklin Square Hospital, and Jason Sussman, Partner – Kaufman, Hall & Associates, Inc., provided comments on the financial challenges facing hospitals and expressed their support for the compromise proposal.

Mr. Sussman made a presentation on the impact of hospital creditworthiness on access to capital in today's debt market. Mr. Sussman stated that the current turmoil in the economy and capital markets has placed stress on hospital operations and their ability to fund necessary initiatives. Any actions that undermine hospital creditworthiness have direct implications in investor interest in funding capital for that hospital or market.

According to Mr. Higdon, certain pending adjustments to the waiver test average payment calculation, involving the matching of the number of discharges to payments, will potentially add as much as 2% to the waiver cushion. Therefore, it may be premature to reduce the update factor to ensure that the waiver cushion does not fall below the "trip-wire" of 7%.

Dr. Klein stated that it was vital that hospitals be able to continue to provide support to specialty physicians, to off-set uncompensated care, and to ensure that there is sufficient coverage for emergency patients in community hospitals.

Mr. Grahe and Mr. Schindelar detailed the issues facing hospitals, e.g., unfunded pension liabilities, rising malpractice premiums, capital market turmoil, reduced cash positions, and the cost containment efforts that hospitals have already made or may have to make in response, for example, to pay and benefit freezes and cuts, hiring freezes or reductions, postponement of capital projects, and mission-based program closures.

T. Eloise Foster, Secretary of the Maryland Department of Budget and Management (DBM), spoke about the impact of the economic downturn on State revenues, the State budget, and increased demand for services. Ms. Foster stated that constraining the growth in hospital costs will help to maintain the affordability of health insurance for both public and private sector purchasers. Ms. Foster asserted that staff's proposal will save State taxpayers about $30 million when compared to MHA's proposal. Ms. Foster expressed appreciation for Mr. Colmers' efforts in crafting the compromise proposal; however, she expressed DBM's support for and urged the Commission's adoption of, staff's proposal for a 1.27% update factor.

Barry Rosen, representing United Healthcare, stated that 3 years ago the Commission set a goal that hospital care should be more affordable in Maryland than in the rest of the country, i.e., Maryland would be 3% below the nation on Net Operating Revenue (NOR) per adjusted admission by 6/30/09. However, staff's best estimate is that Maryland is now 1.0% above the nation in NOR. Mr. Rosen noted that Maryland is moving in the wrong direction. In regard to the waiver test, Mr. Rosen asserted that at 6.6%, the waiver cushion is below the "trip-wire" of 7.0% and at its lowest point ever. Notwithstanding the 2.0% waiver test adjustment that may or may not be made, if Maryland is successful in solving its one day length of case problem, it will

adversely affect the waiver test and will wipe out the effect of any technical adjustment. Mr. Rosen noted that last year's update was so much higher than inflation, that the Commission could give a 0.2% update and it would still cover actual factor inflation for this year and next.

Mr. Rosen applauded the efforts of Secretary Colmers, CareFirst, and the MHA in attempting to bring about consensus. However, this is not a settlement negotiation, and the Commissioners are not here to mediate a settlement between the hospitals and the payers. After weighing all factors, it is the Commission's decision to make. Mr. Rosen asked the Commission to set the update as low as it feels comfortable with.

Commissioners Sexton and Hall indicated their support for the compromise recommendation.

Commissioner Antos stated that he believed that the question before the Commission is how the burden resulting from the current economic situation should be shared. Hospitals are suffering, but the purchasers of health care are also suffering. Therefore, Commissioner Antos made a motion proposing a slightly different update from the compromise proposal. The Commissioner proposed increasing the productivity adjustment in the compromise proposal from 0.10% to 0.50%. This would make the base update 1.09% and the final update 1.72%.

Commissioner Brusa stated that he believed that hospitals were not cutting their costs as much as other sectors of the economy and expressed support for Commissioner Antos' motion.

Commissioner Wong expressed concern about Maryland's position on the waiver test and agreed with Commissioners Antos' motion.

After discussion among the Commissioners and staff, Commissioner Antos amended his motion. The amended motion proposed that the productivity off-set adjustment to the update factor be reduced to 0.10%, as in the compromise update proposal, and that the case mix component of the update factor be decreased from 0.85% to 0.50%. These changes result in a base update of 1.49% and a final update of 1.77%. In addition, the amended motion proposed that scaling of the update factor and the QBR adjustment be performed as proposed in staff's recommendation.

The Commission voted unanimously to approve Commissioner Antos' amended motion.

ITEM VI
FINAL RECOMMENDATIONS FOR CHANGES TO THE QUALITY-BASED REIMBURSEMENT PROJECT

Diane Feeney, Associate Director-Quality Initiative, presented staff's final recommendation for Changes to the Quality-Based Reimbursement Project (QBR) (attachment A). Ms. Feeney noted that the comments received did not necessitate substantive changes to the draft recommendation. A single revision was to the draft QBR Initiative in the initial year.

The major recommended changes to the QBR Initiative included: 1) modification of several QBR measures to remain consistent with the changes made to core measures made by the Joint Commission, Hospital Compare, and/or CMS Reporting Hospital Quality Data for Payment Update initiatives; 2) expand current surgical care measurers beyond hip, knee, and colon to include CABG, Other Cardiac, Hysterectomy, and Vascular surgery; 3) adding new process measures; 4) adopt a hybrid of the opportunity and appropriateness models for base CY 2008, measurement CY 2009, and for rate year FY 2011; 5) change the definition of Topped Off Measures for FY 2011; and 6) allow the option of including patient experience of Care measures in future years.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
DRAFT REVISED RECOMMENDATIONS ON HSCRC PAYMENT POLICY FOR HIGHLY PREVENTABLE HOSPITAL ACQUIRED CONDITIONS

Mr. Murray presented revisions to the HSCRC Payment Policy for Highly Preventable Hospital Acquired Conditions approved by the Commission at the March 2009 public meeting. Mr. Murray stated that staff in cooperation with 3M, developed an alternative approach. This new approach responded to concerns that the Maryland Hospital Acquired Conditions (MHACs) are case specific, i.e., that adjustments to allowable charges are based on specific cases, and are too narrowly focused, i.e., only 11 MHACs were chosen. The new approach was also responsive to Commissioner Wong's motion at the time directing staff to consider deletions or additions to the MHACs and to look at alternative, more balanced, and more macro methods of incentives.

Mr. Murray stated that the revised policy improves on MHACs by moving from a case specific mechanism to a broader, rate-based approach and expands the number of conditions included for consideration when assessing hospitals' relative quality of care. The new approach utilizes the results of a regression to compute the dollar impact for each of 52 PPCs. The dollar impact is used to create an individual hospital index based on its rate of either adding additional resources or averting resources compared with the state-wide average for each PPC.

Mr. Murray summarized the draft recommendations: 1) adopt a broad based set of MHAC/PPCs based on their statistical significance; 2) implement a rate-based approach that compares hospitals based on their performance relative to the state-wide average for each PPC; 3) implement scaling of payment adjustments so that a hospital's performance is reflected in its update factor; 4) rank hospitals based on the amount of hospital charges that are at risk for adjustment; 5) implement this new approach with discharges beginning July 1, 2009 (FY 2010); 6) make the adjustments revenue neutral; 7) provide a mechanism to receive input from and provide feedback to the industry and other stakeholders to refine and improve the system; and 8) provide a tracking tool so that hospitals may track their performance during the measurement year.

Beverly Miller, Senior Vice President for Professional Activities-MHA, and Barbara Epke, Vice President-LifeBridge Health, and David Krajewski, Vice President, Finance-LifeBridge Health, agreed that the new methodology represented a significant improvement over the previous approach; however, they noted several technical issues that must be addressed before implementation. Those issues included: 1) conducting a focused review of all PPCs; 2) the financial magnitude of the reimbursement at risk; 3) whether or not corridors should be established; and 4) ensuring that that the financial impact of the initiative is not already being applied elsewhere in the rate system.

Mr. Murray stated that staff will continue to refine the methodology and address these and other issues; however, implementation of this initiative should not be unduly delayed.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, stated that the new methodology is a significant improvement over the original methodology and puts the right incentives in place to improve quality. Dr. Cohen expressed strong support for the new methodology.

Since this is a draft recommendation, no Commission action was required. Staff anticipates presenting the final recommendation at the June public meeting.

ITEM VIII
DRAFT RECOMMENDATIONS ON MARYLAND PATIENT SAFETY CENTER FUNDING FOR FY 2010

Steve Ports, Principal Deputy Director-Policy & Operations, summarized staff's draft recommendation for continued funding of the Maryland Patient Safety Center (MPSC). The recommendations are: 1) that FY 2010 funding cover 45% of the costs of the MPSC, less 50% of the carry-over from FY 2009 or $1.6 million; 2) that in future years the percentage of budgeted costs funded be reduced by at least 5% per year, but not exceed the amount provided in the previous year; 3) that the HSCRC maintain a reasonable base level of support (potentially 25% of budgeted costs); 4) that the MPSC update the HSCRC periodically on health care outcomes and expected savings resulting from its programs; and 5) that the MPSC aggressively pursue other sources of revenue to help support it into the future.

Mr. Ports announced that comments on the proposed recommendation will be accepted at the Commission's offices on or before May 27, 2009.

Chris Jensen, M. D., President and CEO of MPSC, and William F. Minogue, M.D., Executive Director and President of MPSC, summarized MPSC's current initiatives and thanked the Commission for its support in funding the MPSC.

Ms. Coyle expressed MHA's continued support for the MPSC.

No Commission action was required. A final recommendation will be presented at the June public meeting.

ITEM IX
FINAL RECOMMENDATIONS FOR FY 2010 NURSE SUPPORT II COMPETITIVE INSTITUTIONAL GRANTS

Oscar Ibarra, Chief-Program Administration & Information Management, presented staff's recommendation on the FY 2010 Nurse Support Program II (NSP II) Competitive Institutional Grants. The objective of NSP II, which is funded by an assessment of 0.1% in hospital rates and administered by the Maryland Higher Education Commission, is to increase the capacity of Maryland nursing schools.

Mr. Ibarra reported that 28 proposals were received and staff was recommending that 21grants, in the amount of $20 million, be approved by the Commission for FY 2010.

The Commission voted unanimously to approve staff's recommendation.

ITEM X
LEGAL REPORT

Regulations

Proposed

Uniform Accounting and Reporting System for Hospitals and Related Institutions – COMAR 10.37.01.03

The purpose of this regulation is to require hospitals to file with the Commission their most recent Form 990 filed with the Internal Revenue Service in compliance with recently enacted legislation.

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

Proposed and Emergency

Rate Application and Approval Procedures - COMAR 10.37.10.03D

The purpose of this action is to assure that the any potential action taken by the Commission in response to the establishment of hospital day limits is in the public interest and does not

jeopardize the State's Medicare waiver.

The Commission voted unanimously to forward the proposed regulations to the AELR Committee for review and publication in the Maryland Register as proposed regulations to become effective before the emergency status expires.

Rate Application and Approval Procedures – COMAR 10.37.10.26B (3), (4), and (5), and to add new regulations (6) and (7)

The purpose of this action is to comply with recently enacted legislation. These regulatory amendments change the interest or late payment charges that a hospital may add to its self-pay patients; set forth the minimum provisions required in hospital financial assistance policies; require hospitals to develop an information sheet; and set forth those requirements to be included in hospital credit and collection policies.

The Commission voted unanimously to forward the proposed regulations to the AELR Committee for review and publication in the Maryland Register as proposed regulations to become effective before the emergency status expires.

ITEM XI
HEARING AND MEETING SCHEDULE

June 3, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
July 1, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:18 a.m.