462nd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

NOVEMBER 4, 2009

Commissioner Hall called the meeting to order at 9:35 a.m. Commissioners Joseph R. Antos, Ph.D., Steven B. Larsen, C. James Lowthers, and Herbert S. Wong, Ph.D. were also present.

ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC SESSION OF OCTOBER 14, 2009

The Commission voted unanimously to approve the minutes of the October 14, 2009 Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, updated the Commission on the projects in which staff has been involved in the last month. They include: 1) holding a clinical workgroup meeting to assist hospitals in indentifying solutions for DRGs with high hospital acquired potentially preventable condition (MHAC) rates; 2) working with the industry and Medicaid on the reconciliation of expected and actual averted bad debt; 3) held first workgroup meeting to attempt to determine the adjustments needed to identify potentially preventable readmissions: 4) developed Community Benefit Report evaluation benchmark comparisons to provide feedback to hospitals; 5) scheduled second meeting to review Inter-hospital Cost Comparison and Reasonableness of Charges methodologies to discuss the issues associated with peer groups, direct and indirect medical education adjustments, and utilization of the charge per visit; 6) met with the Centers for Medicare and Medicaid Services (CMS) actuary who agreed make a technical adjustment to the waiver test calculation, which will improve the waiver test cushion by 1.5%; 6) scheduled workgroup meeting to discuss FY 2011 payment update; 7) reached a settlement with Johns Hopkins Bayview Medical Center related to coding irregularities; and 8) detected a technical issue that will result in the Medicaid assessment of $8.9 million approved by the Commission at its October public meeting being increased by $220,000.

Mr. Murray also announced that at the request of the Maryland Hospital Association (MHA), staff agreed to delay the presentation of its draft recommendation on a One Day Length of Stay (1-day LOS) policy. However, staff would like to take some time at today's meeting to provide further background on the issue, solicit input from the industry and the payers, and discuss some potential solutions.

Mr. Murray observed that the CMS Recovery Audit Contractor Program (RAC) is also focusing on 1-day LOS cases in Maryland hospitals because of the higher proportion relative to total admissions when compared to other states and the nation.

Mr. Murray noted that staff believes that the incentives for Maryland hospitals to treat short stay patients on an inpatient basis are much too strong. Even though the cost to treat short stay patients is the same whether treated as inpatients or as outpatients hospitals are able, however, to generate much higher revenues if they are admitted under the HSCRC's Charge per Case (CPC) system than if they were treated as outpatients. In addition, for cases where the admission is denied for medical necessity, hospitals have inappropriately received the full rate capacity of the case.

Mr. Murray stated that staff recommends the removal of cases denied for medical necessity from the CPC system. In addition, staff recommends that as a possible approach to reduce the incentive to admit short stay patients, individual hospital performance should be compared to a more acceptable 1-day LOS level and penalties applied to reduce rate capacity. Staff believes that achieving savings through greater efficiency is a far better way to absorb Medicaid budget reductions than arbitrary revenue cuts. We must also recognize and take into consideration that by reducing 1-day LOS cases, there may be an impact on hospital case mix and a possible impact on the Medicare waiver. In addition, we must address the hospital industry's concern about its ability to appropriately charge for observation services.

Graham Atkinson, Ph.D., HSCRC consultant, presented analyses of data comparing the proportion of 1-day LOS cases in Maryland to New York and California. The data showed that the proportion of 1-day LOS cases in Maryland is slightly higher than New York and significantly higher than California. According to Dr. Atkinson, the Maryland payment system creates an incentive for 1-day LOS cases, and Maryland's relatively short LOS is related to the high number of 1-day LOS.

Charlotte Thompson, Deputy Director-Research and Methodology, summarized the proposed methodology for removing excess 1-day LOS revenue capacity from the CPC system as proposed by staff.

Mr. Murray stated that staff will continue to meet with hospitals and payers to discuss and receive input on this issue with the intention of presenting a draft recommendation at the Commission's December public meeting.

Ms. Carmela Coyle, President & CEO of MHA, reported that hospitals are concerned about the lack of a transparent and accountable process in the development of the 1-day LOS proposal. Ms. Coyle expressed the hope that the delay in presenting the proposed 1-day LOS policy will allow sufficient time for input by stakeholders and for consideration by the Commissioners. Ms. Coyle stated that because this is an extremely complicated issue with potentially significant financial implications, the hospital industry hopes that we can move to a process that provides a greater opportunity for broader participation and broader engagement by stakeholders and Commissioners.

Michael Robbins, Senior Vice President-Financial Policy of MHA, stated that the hospital industry agrees with staff that there should be no financial incentive in the payment system to admit patients versus placing them in an outpatient observation status. However, the industry believes that its recommendations for addressing a more comprehensive approach to this issue must be given due consideration.

Mr. Robbins noted that this is not a new issue. The level of 1-day LOS cases has been relatively unchanged for a number of years. Mr. Robbins stated that the industry has responded to a number of incentives built into the payment system many years ago - - among them, the elimination from the HSCRC payment system of a separate outpatient observation rate almost 20 years ago.

Mr. Robbins pointed out that the current DRG payment system is a system of averages and, therefore, it is inappropriate to focus on the financial impact associated with one part of the system, 1-day LOS cases, without looking at the system as a whole. Mr. Robbins noted that staff's proposed "better practice" standard to reduce 1-day LOS cases has no clinical relevance. According to Mr. Robbins, there are no industry recognized benchmarks as to the appropriate level of 1-day LOS cases. Mr. Robbins asserted that staff's proposal does not take into consideration the complexity of the issue, its impact on the case-mix index (CMI), the lack of an outpatient observation rate, impact on the CMI governor, or the potential impact on the Medicare waiver test.

Mr. Robbins urged: 1) that the Commission in fashioning a final proposal take no action until the full complexity of the issue is researched and accounted for; 2) that due consideration is given to hospital industry recommendations; and 3) that any change should be revenue neutral.

Commissioner Larsen inquired as to the possible reasons for the high proportion of 1-day LOS cases in Maryland hospitals.

Mr. Robbins speculated that it may be that the national data included proportionally more small rural hospitals than the Maryland data. And, these small hospitals, because of their limited resources, may not get short stay patients out as quickly. The result may be less 1-day LOS cases and more 2-day LOS cases than Maryland hospitals. Mr. Robbins suggested that we may want to look at the proportion of 2-day LOS cases in Maryland and the U.S.

Ms. Coyle commented that the issue that merits more consideration is what is the appropriate 1-day LOS benchmark, a clinical standard or a national average?

Commissioner Hall asked why the observation rate center was eliminated.

Dennis Phelps, Associate Director-Audit & Compliance, explained that the separate observation rate center was eliminated because it expanded the definition of observation services inappropriately. The definition included not only cases where the patient was observed in order to determine whether he or she should be admitted or not (true observation), but also included all

zero or 1-day LOS inpatient cases. Because the creation of the observation center effectively did away with all short stay inpatient cases, it adversely affected the Medicare waiver test. As a result, the observation rate center, which was established in August 1988, was abolished January 1, 1990. At that time, the mechanism for charging for true observation cases returned to the Emergency Department.

Commissioner Hall also expressed concern that elimination of 1-day LOS cases might adversely affect the treatment of patient with chest pain, i.e., cardiac cases, in some hospitals.

Mr. Murray stated that the proposed methodology to reduce 1-day LOS cases, like the MHAC methodology recently approved by the Commission, does not focus on individual cases, but attempts to push back in an aggregate manner against the creation of excessive rate capacity.

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Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, stated that there should be incentives in the payment system to treat patients, if the treatment is clinically equal, where it is less costly. Dr. Cohen asserted that observation is a perfectly appropriate way to treat many patients and should be utilized more by Maryland hospitals.

In regard to the process issue, Dr. Cohen asserted that the payers should be as involved in these discussions as the hospitals. Dr. Cohen also expressed concern that the process may become bogged down if everything has to be agreed to by all parties before a draft recommendation can be presented to the Commission. Dr. Cohen stated that with the current process where staff brings a draft recommendation to the Commission, there is ample opportunity for comment by the stakeholders Thus, when the Commission makes its decision, it is transparent, accountable, and appropriate.

Dr. Cohen stated that the "better practice" standard methodology for reducing the level of 1-day LOS in Maryland hospitals appears to be appropriate.

ITEM III
DOCKET STATUS CASES CLOSED

2041A – Johns Hopkins Health System
2045A – MedStar Health
2046A – Maryland General Hospital, St. Agnes Hospital, Western Maryland Health System and Washington County Hospital
2047A - University of Maryland Medical Center
2048A – University of Maryland Medical Center
2049A – Johns Hopkins Health

ITEM IV
DOCKET STATUS CASES OPEN

There were no cases presented for Commission action.

ITEM V
DRAFT RECOMMENDATION ON ONE DAY LENGTH OF STAY POLICY

At the request of MHA, staff agreed to delay the presentation of its draft recommendation on a proposed one day length of stay policy.

ITEM VI
DRAFT RECOMMENDATIONS FOR REVISION OF THE LABOR AND DELIVERY RELATIVE VALUE UNIT SCALE

Rodney Spangler, Chief-Audit & Compliance, requested Commission approval to promulgate for review and public comment proposed revisions to the Relative Value Unit Scale of Labor and Delivery Services.

The Commission voted unanimously to grant staff's request.

ITEM X
LEGAL REPORT

Regulations

Final Adoption

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

The purpose of this action is to correct erroneous references to "quarterly" reporting requirements when, in fact, these requirements are, and have been, monthly in nature.

The Commission voted unanimously to adopt these amended regulations.

ITEM XI
HEARING AND MEETING SCHEDULE

January 13, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

February 3, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 10:49 a.m.