463rd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

DECEMBER 9, 2009

Chairman Young called the meeting to order at 9:39 a.m. Commissioners Joseph R. Antos, Ph.D., Steven B. Larsen, C. James Lowthers, Kevin J. Sexton, and Herbert S. Wong, Ph.D. were also present.

REPORT OF THE EXECUTIVE SESSION OF DECEMBER 9, 2009

Oscar Ibarra, Chief-Program Administration & Information Management, summarized the minutes of the December 9, 2009 Executive Session.

COMFORT ORDERS – UNIVERSITY OF MARYLAND MEDICAL SYSTEM AND ANNE ARUNDEL MEDICAL CENTER

The Commission voted unanimously to ratify the Comfort Orders for University of Maryland Medical System and Anne Arundel Medical Center approved in Executive Session.

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

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

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, summarized the status of some high priority initiatives and projects. They include: 1) finalizing payment options and revenue impact for the Maryland Hospital Acquired Conditions (MHAC) and on the final group of forty-nine MHACs; 2) finalizing the estimation of expected averted bad debts and reconciliation of actual averted bad debts associated with expansion of the Medicaid Program; 3) continuing discussions with the Maryland Hospital Preventable Readmission workgroup and performing various analyses and

simulations utilizing MedPar data: 4) analyzing the criteria and structure to be utilized to provide evaluation and feedback to hospitals on their Community Benefit Reports: 6) continuing discussions on changes to the Inter-hospital Cost Comparison (ICC) and Reasonableness of Charges (ROC) methodologies with a draft recommendation anticipated to be presented at the February 2010 public meeting; 7) finalizing technical adjustments to the waiver test calculation; 8) continuing to meet with the workgroup on discussions of the new payment arrangement for 2011 and beyond; 9) addressing one day length of stay issue at the public informational hearing requested by the hospital industry; and 10) discussing the one day length of stay issue as it relates to the Recovery Audit Contract (RAC) program with representatives of the Center for Medicare & Medicaid Services (CMS).

ITEM III
DOCKET STATUS CASES CLOSED

None

ITEM IV
DOCKET STATUS CASES OPEN

University of Maryland Medical System – 2050A

On October 7, 2009, the University of Maryland Medical System requested approval to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with United Resource Networks for a one year period, beginning November 1, 2009.

After review of the terms of the re-negotiated arrangement and the improved performance in FY 2009, staff recommended that the Hospital's request be approved for a period of one year beginning November 1, 2009. 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 – 2051A

On October 22, 2009, 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 serving persons with mental health needs under the program title "Creative Alternatives." The arrangement is between Johns Hopkins Health System and Baltimore Mental Health Systems, Inc., with the services being provided through Bayview. The requested approval was for a period of one year.

Based on its overall historically favorable performance and projections of favorable performance in FY 2010, staff recommended that the System's request be approved for a period of one year beginning November 1, 2009. 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.

MedStar Health – 2052A

On October 22, 2009, MedStar Health filed an application on behalf of Union Memorial Hospital requesting approval from the Commission to continue to participate in a global rate arrangement for orthopedic services with the NFL Player Joint Replacement Benefit Plan for a one year period beginning December 1, 2009.

Although there has been no activity, staff still believed that the Hospital could achieve favorable performance under this arrangement and recommended that the Commission approve MedStar's request for a period of one year beginning December 1, 2009. 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 – 2053A

On November 3, 2009, Johns Hopkins Health System filed an application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital requesting approval to continue to participate in a capitation arrangement serving persons insured with Tricare. The arrangement involves the Johns Hopkins Medical Services Corporation and Johns Hopkins Health Care as providers. The requested approval was for a period of one year.

Staff recommended that the System's request be approved for a period of one year beginning January 1, 2010 based on historically favorable performance under this arrangement. 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 Center – 2054A

On November 17, 2009, Johns Hopkins Health System filed an application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital requesting approval to continue to participate in an amended global rate arrangement for solid organ and bone marrow transplant services with Coventry Transplant Network for a period of three years.

Staff recommended that the Hospital's request be approved for a period of one year beginning December 1, 2009 based on historically favorable performance under this arrangement. 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.

Dorchester General Hospital – 2055R

On November 24, 2009, Dorchester General Hospital submitted a rate application requesting a rate for Renal Dialysis (RDL) services to be provided on-site to both inpatients and outpatients. The Hospital currently has a rebundled RDL rate. The Hospital requested that the state-wide median RDL rate be approved effective December 1, 2009.

After review of the application, 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 RDL rate of $638.29 per treatment be approved effective December 1, 2009;
3) That no change be made to the Hospital's Charge-per Case standard for RDL services; and
4) That the RDL rate be not be rate realigned until a full year's experience data has been reported to the HSCRC.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
FINAL RECOMMENDATION REGARDING BUDGETARY ACTIONS OF THE BOARD OF PUBLIC WORKS

Mr. Murray stated that on November 18, 2009, the Board of Public Works (BPW) approved another round of budget cuts which included a reduction of Medicaid expenditures for hospital

services by $21.3 million. This is in addition to a previous $10 million budget cut related to the funding of the Medicaid expenditure reduction from Supplemental Budget #2 of the 2009 Budget Bill associated with the Maryland False Claims Act of 2009. Similar to the July and August 2009 budget cuts, the BPW provided the option of imposing Medicaid Day Limits or an alternative plan approved by the Commission to generate the cost savings.

In October 2009, the Commission approved an alternative approach to fund the July and August budget cuts of $13.4 million, which made use of both a broad-based uniform assessment to hospital rates of $8.9 million, and a total remittance by hospitals of $13.4 million to the Department of Health and Mental Hygiene (DHMH).

Mr. Murray stated that it was important that the Commission craft an overall alternative approach that generates the needed budgetary savings in a fair and equitable way, but at the same time, minimizes negative impact on patients, hospitals, and payers. Staff proposed a 50/50 split between hospitals and payers, except for the $10 million Supplement #2 of the 2009 Budget Bill. Therefore, staff recommended that Hospitals remit a total of $17,884,061 (17,354,741 BPW cut + $539,320 feedback portion) generated through assessments on payers, plus $27,884,061 ($10,000,000 associated with the recommendations of Supplement #2 of the 2009 Budget Bill, $17,354,741 associated with a 50% share of BPW cuts, and %539,320 in associated Medicaid feedback effects), for a total amount remitted to DHMH over the period January through June of 2010 of $45,768,122.

John Folkemer, Deputy Secretary for Health Care Finance and Medicaid Director, stated that Medicaid budget cuts have been approximately $172 million in FY 2010 so far, and hospital payment cuts have been approximately $35 million. Mr. Folkemer noted that since one-third of Medicaid payments are to hospitals, the cuts in hospital reimbursement have been disproportionally low up to this point. Mr. Folkemer stated that if a decision is not made by the Commission today on an alternative method of funding the budget cuts, DHMH would have to go forward almost immediately to begin to implement its own methods of funding these budget cuts through Medicaid Day Limits.

Commissioner Larsen asked Mr. Folkemer how the hospital payment cuts compared with cuts to other major providers.

Mr. Folkemer replied that although he did not have the actual numbers with him, the largest cuts have been made to payments to nursing homes; however, there have been cuts across the board. Payments to Medicaid managed care organizations have been reduced by a couple of percentage points, and physicians have had their rates of reimbursement frozen and cut. Community providers have been cut as well. Mr. Folkemer stated that payments to hospitals and the portion of Medicaid MCOs capitation rates that go to hospitals are approximately one-third of Medicaid payments to providers, while cuts in hospital payments have been approximately 20% of total payments.

Commissioner Larsen noted that about one half of the hospital payment cuts are absorbed by the payers and not hospitals.

Mr. Folkemer agreed.

Commissioner Larsen asked Mr. Folkemer if he would provide the Commission with DHMH's analysis of the proportionality of the cuts to provider payments by Medicaid.

Mr. Folkemer agreed to do so.

Commissioner Sexton expressed concern that staff's current proposal reverses the percentages of the alternative funding voted on in October (1/3 hospitals – 2/3 payers).

Mr. Murray stated that if staff had known the full amount of the budget cuts, it would probably have recommended a 50/50 split. The $10 million associated with the Maryland False Claims Act is a separate issue.

Commissioner Sexton stated that although he realized that we are now dealing with a larger amount, we should not go beyond a 50/50 split.

Commissioner Larsen asked whether the $10 million was legally required to be absorbed by hospitals. If not, what was staff's rationale for having hospitals alone pay the $10 million?

Mr. Murray replied that it was not legally required; , however, staff's rationale for having hospitals pay the $10 million was to make the sharing of the burden of the budget cuts more equitable, and because Supplement Budget #2 that indicated that the $10 million budget cut was directly related to the defeat of the Maryland False Health Claims Act legislation.

Commissioner Larsen asked whether if the Commission agreed that hospitals should pay the $27 million in budget cuts, does $27 million represent 0.2% of total hospital revenue as the chart in staff's recommendation indicates.

Mr. Murray replied in the affirmative.

Commissioner Larsen asked Mr. Folkemer whether a 0.2% cut in hospital payments was proportional to cuts made to Medicaid reimbursement of other providers.

Mr. Folkemer replied that 0.2% is significantly less than the payment cuts to other providers.

According to Mr. Kevin Criswell, representing AmeriGroup, cuts in payments to Medicaid MCOs were 2% in FY 2010.

Mr. Folkemer agreed with Mr. Criswell's assertion and stated that some providers received not only cuts in payment increases but absolute cuts in payments over the previous year.

Commissioner Lowthers stated that he believed staff's recommendation was fair and appropriate and expressed his support for it.

Michael Robbins, Vice President of MHA, stated that the $27 million hospital payment reduction was 1.3% as a percentage of Medicaid revenue.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, asserted that no matter how the burden of the assessment is decided, the assessment methodology is vastly better than having Medicaid go forward with day limits because of the federal matching funds involved with day limits. Dr. Cohen urged the Commission to make a decision today on the alternative method of funding the Medicaid budget cuts because he believed that it was in the best interest of the citizens of Maryland.

Commissioner Larsen suggested that going forward, just because the Commission has the unique ability to do so, it should not arbitrarily assess payers for Medicaid budget cuts. Cuts in hospital payments should be made in the context of total Medicaid budget cuts.

The Commission approved staff's recommendation. Commissioner Sexton voted against the recommendation.

ITEM VI
DRAFT RECOMMENDATION ON ONE-DAY LENGTH OF STAY AND DENIED CASES

Mr. Murray announced that MHA had sent a letter to the Commission requesting a public hearing on its proposal regarding one-day length of stays (one-day stays). Mr. Murray then summarized staff's draft recommendation on one-day stays.

Mr. Murray noted that staff was proposing an overall systematic approach to reduce one-day stays in Maryland, similar to that utilized in the MHAC program, rather than a case by case approach. The objective of the proposed policy is to reduce the incentive for hospitals to admit patients for short stays and produce rate capacity and to encourage hospitals to utilize outpatient observation services (OBS). This would be done by implementing a system of rate incentives (penalties) on January 1, 2010 that would be applied to hospitals whose overall rate of performance is in excess of a one-day stay "better practice" standard.

In addition, Mr. Murray stated that all cases denied for medical necessity and associated DRG-weights be immediately removed from the calculation of the FY 2010 Charge–per-Case (CPC) system and a hospital's approved revenue base.

Dennis Phelps, Associate Director-Audit & Compliance, explained the charging mechanism currently provided in the rate system for OBS.

Dr. Cohen; Barry Rosen and Morris Jutcovich, M.D. representing United Health Care, and Kevin

Criswell spoke in support of staff's recommendation.

Dr. Cohen stated that the cases denied for medical necessity and the one-day stay issues are very different. The one-day stay issue is largely one of putting in place the appropriate incentives so that there are prospectively fewer one-day stays; however, cases denied for medical necessity should be removed from the CPC system immediately while assuring that hospitals are not double penalized.

Dr. Jutcovich asserted that in meeting with Maryland physician groups, many times he was told that their hospital does not have an OBS unit, that the HSCRC does not mandate the use of OBS; or that their hospital would not let them use OBS. According to Dr. Jutcovich, because the medical protocols and resource use are different for an inpatient admission and OBS, an OBS case is generally less expensive than an admission. Dr. Jutcovich also stated that because of health insurance co-pays and deductibles, an inpatient admission generally placed a greater burden on the patient than an OBS visit.

Mr. Rosen stated that there should be an appropriate integration between the one-day stay initiative and the casemix cap - - that is, a hospital should not be penalized twice. Mr. Rosen observed that although United Health Care believed that the use of OBS in Maryland should change, it was not wedded to a specific implementation date for the one-day stay policy. Mr. Rosen expressed disagreement with MHA' position that whatever is done in regard to one-day stays should be revenue neutral.

Mr. Criswell stated that AmeriGroup's (a Medicare managed care organization) one-day stay experience in Maryland is 23% of total admissions compared to an average of 17% in the other eleven states in which it does business. Mr. Criswell noted that Maryland should beat the nation in net patient revenue per equivalent admission because of its rate system, and it appears to be doing so because of the effect of the excess one-day stays in Maryland. This results in inappropriately higher hospital update factors and artificially distorts the Medicare waiver calculation.

Ms. Carmela Coyle, President of MHA, declined to comment on the one-day stay issue pending the public hearing.

ITEM VII
FINAL RECOMMENDATION ON NURSE SUPPORT PROGRAM II GUIDELINES

Steve Ports, Principal Deputy Director-Policy & Operations, presented staff's final recommendation for the establishment of guidelines for the Nurse Support Program II (NSP II), which was created in 2005 to alleviate the nursing shortage by expanding the capacity of Maryland nursing schools.

NSP II consists of two components: Competitive Institutional Grants that fund initiatives involving Maryland institutions of higher education and Maryland hospitals; and Statewide

Initiatives that provide funding to individual students and faculty.

Ms. Catherine Crowley, Vice President of MHA, expressed support for staff's recommendation.

Dr. Cohen expressed support for staff's recommendation on behalf of CareFirst of Maryland and Kaiser Permanente.

The Commission voted unanimously to approve staff's recommendation.

ITEM VIII
MEDICARE WAIVER UPDATE

Ms. Charlotte Thompson, Deputy Director-Research and Methodology, updated the Commission on the adjustments to the Medicare waiver test calculation. Ms. Thompson noted that the waiver test cushion as of June 2008 was at its lowest point ever, 6.5%. However, Ms. Thompson reported that the Medicare actuary has agreed to remove zero pay discharges where Medicare is the secondary payer from the calculation. This will result in an increase in the cushion of 1.4% - 1.6%. On the other hand, Ms. Thompson noted that Medicare is expected to implement "take backs" of 0.6% a year for five years associated with case mix growth beginning in FY 2011. Thus, we will see a temporary improvement in the waiver test with the removal of the zero pay discharges, but the proposed take backs may erode Maryland's position on the waiver test beginning in FY 2011.

Dr. Cohen stated that since the waiver cushion at zero would put Medicare payments to Maryland hospitals at approximately 30% higher than the national average, therefore, the real question is how much higher should Medicare payments to Maryland hospitals be than the national average. According to Dr. Cohen, if Maryland achieves its policy goal to keep Maryland's cost below the national average, Maryland should be able to beat the nation by more than the current 6.5% waiver cushion. Dr. Cohen suggested that the Commission keep this in mind when making overall policy decisions.

ITEM IX
FINAL RECOMMENDATION FOR REVISION OF THE RELATIVE VALUE UNITS SCALE OF LABOR & DELIVERY

Rodney Spangler, Chief-Audit & Compliance, presented a staff recommendation to revise the Relative Value (RVUs) scale for Labor & Delivery services. The revisions were promulgated for comment, and non-substantive corrections and enhancements were made in response to comments received.

The Commission voted unanimously to approve staff's recommendation and adopt the revisions to the Labor & Delivery services RVU scale.

ITEM X
HEARING AND MEETING SCHEDULE

January 13, 2010	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 11:37 a.m.