459th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

AUGUST 5, 2009

Chairman Young called the meeting to order at 9:27 a.m. Commissioners Joseph R. Antos, Ph.D., Trudy R. Hall, M.D., C. James Lowthers, Kevin J. Sexton, and Herbert S. Wong, Ph.D. were also present.

ITEM I
REVIEW OF THE MINUTES OF THE EXECUTIVE AND PUBLIC SESSIONS OF JULY 1, 2009

The Commission voted unanimously to approve the minutes of the July 1, 2009 Executive and Public Meetings.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, updated the Commission on the progress of several high priority items. They include: 1) continued interaction with the industry on Acquired Conditions (MHAC) policy issues and clinical vetting workgroups; 2) analyzing data to identify potential adjustment factors to be used in potentially preventable admissions (PPA) policy: 3) participation in a workgroup that is evaluating criteria to be used for Community Benefit Report benchmarking; 4) continuing to work with hospital representatives to evaluate methods to incentivize charity care in the Uncompensated Care methodology; 5) analyzing data on the use and coding of Observation Services and one-day length of stay admissions; 6) reviewing letters requesting methodology changes to the 2010 Reasonableness of Charges methodology; and 7) meeting with CMS regarding technical adjustments to the waiver test calculation, which may improve the waiver cushion by 1.5% - 2%.

ITEM III
DOCKET STATUS CASES CLOSED

2028A – University of Maryland Medical Center 2030R – Peninsula Regional Medical Center

ITEM IV
DOCKET STATUS CASES OPEN

Garrett County Memorial Hospital – 2031R

On June 4, 2009, Garrett County Memorial Hospital submitted a full rate application requesting a permanent increase to its permanent Total Patient Revenue (TPR) System cap of 5.98%, effective July 1, 2009. The Hospital requested a 7.11% increase for all inpatient revenue in its Comprehensive Charge Target (CCT), and a 2.89% increase for all revenue excluded from the CCT.

After review of the Hospital's application and analysis, staff recommended:

1) That the Hospital be allowed to remain on the TPR System;
2) That the Hospital's TPR cap be set at $37,881,540, a 5.28% increase over the current TPR cap;
3) That the increase in the TPR cap be effective July 1, 2009; and
4) That the Hospital's rates continue to be adjusted for inflation, population change, mark-up, and Quality Based Reimbursement scaling.

The Commission voted unanimously to approve staff's recommendation.

Baltimore Washington Medical Center – 2033R

On May 27, 2009, Baltimore Washington Medical Center filed an application requesting rates for their new Labor & Delivery (DEL), Obstetrics (OBS), and Nursery (NUR) services. The Hospital received Certificate of Need approval for these new services from the Maryland Health Care Commission on November 22, 2005.

After review of the Hospital's application, staff recommended;

1) That COMAR 10.37.10.07 requiring that rate applications be made prior 60 days to the opening of a new service be waived;
2) That DEL rate of $75.19 per RVU, OBS rate of $965.49 per patient day, and NUR rate of $631.91 per patient day be approved effective July 1, 2009;
3) That no change be made in the Hospital's Charge-per-Case standard for the new DEL, OBS, and NUR services; and
4) That the DEL, OBS, and NUR rates not be rate realigned until a full year's cost data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

University of Maryland – 2034A

On July 14, 2009, University of Maryland Medical Center submitted an application requesting approval from the Commission to continue to participate in a global rate arrangement with Aetna Health, Inc. for solid organ transplant, gamma knife, and blood and bone marrow transplants for an additional year beginning August 1, 2009.

Staff recommended that the Hospital's request be approved for a period of one year beginning August 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.

Carroll County Hospital Center – 2035R

On July 24, 2009, Carroll County Hospital Center submitted an application requesting a rate for Renal Dialysis (RDL) to be provided in-house beginning July 1, 2009. The Hospital currently has a rebundled, i.e., off-site, RDL rate. The Hospital requested that its in-house RDL rate be set at the state-wide-median rate with an effective date of July 1, 2009.

After reviewing the Hospital's application, staff recommended that;

1) That COMAR 10.37.10.07 requiring that rate application be made prior 60 days to the opening of a new service be waived;
2) That the RDL rate of $637.71 per treatment be approved effective August 1, 2009;
3) That no change be made to the Hospital's Charge-per-Case for RDL services; and
4) That the RDL rate not be rate realigned until a full year's cost experience has been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
UPDATE ON MARYLAND HOSPITAL ACQUIRED CONDINTIONS VETTING SESSIONS

Diane Feeney, Associate Director-Quality Initiative, presented a memorandum that summarized the activities of staff and representatives of the hospital industry since approval of the MHAC at the June 4th public meeting, as well as staff's observations. The memorandum reported that over the period, there were two technical workgroup meetings and three clinical vetting meetings. Ms, Feeney noted that, in all, there were five clinical vetting sessions.

Ms. Feeney stated that it was staff's observation that there was valuable industry and stakeholder participation in both the technical and clinical vetting sessions. In an effort to be conservative staff accepted many of the industry's suggestions made at the clinical vetting sessions for changes to the PPCs exclusion logic. When there was doubt, deference was given to the industry's position. Staff believes that clinical vetting has helped tighten up the PPC logic.

In response to the Maryland Hospital Association's comment that there was insufficient time to vet all 52 PPCs, staff believes that the focus of the workgroup has been "low hanging fruit," i.e., those that were most controversial, and that there will be diminishing return on further scrutiny of the remaining PPCs. However, Ms. Feeney noted that there will be an ongoing solicitation of comments, and the clinical workgroup will reconvene in the fall in an effort to continue to improve the PPCs' clinical logic. Ms. Feeney explained that rather than looking at PPCs on a case by case basis, hospitals should focus on areas that have large volume and cost implications. Ms. Feeney stated that the HSCRC will convene workshops to enable hospitals to review reports that will be helpful in targeting areas of concern at their facilities.

Ms. Feeney reported that the meetings of technical payment workgroup dealt with the issue of linking individual hospital performance on MHACs to financial incentives. It is anticipated that a scaling methodology similar to the Quality-Based reimbursement initiative will be the basis for the MHAC incentive with a moderate level of financial risk for the initial year of implementation. Other issues to be addressed by the Technical Payment workgroup are: 1) the mechanism for indexing and ranking hospital performance on the basis of MHACs; 2) the amount of revenue to be scaled in the initial year; 3) the scaling methodology; 4) potential areas of double penalties or double rewards; and 5) quantifying potential returns on investment for hospital successful in reducing complication rates.

Ms. Feeney reported that staff recommended that two PPCs be removed from the MHAC policy (PPC 64- Other In-Hospital Adverse Events, and PPC 21- Clostridium Difficile Colitis) for one year, and that they be re-evaluated for the FY 2011 policy.

Beverly Miller, Senior Vice President-Professional Services of the Maryland Hospital Association, urged that the following steps be taken: 1) that evidence-based prevention protocols be made available to all hospitals; 2) that decisions on whether to include or exclude PPCs be reviewed by an impartial and neutral third-party; 3) that more time be provided to vet all PPCs; and 4) that 3M make their proprietary software and reports available to hospitals at no cost.

Ms. Joan Gelrud, Vice President-St. Mary's Hospital, presented a letter signed by a number of physicians, which, while supporting the Commission's pay-for-performance initiative goals and the concept of ensuring safe, effective, and efficient patient care, expressed concern about the MHAC methodology. Ms. Gilrud observed that when physicians at her hospital were told that the MHAC methodology was based on the severity adjusted statistical rate of PPCs at St. Mary's compared to the statewide average, they asked where the clinical patient care part of the methodology was. Ms. Gelrud stated that the physicians were concerned about the lack of time to review the PPCs, and that, in their estimation, some of the MHAC PPCs were not based on

clinically sound judgment. Ms. Gilrud asserted that these concerns could lead to the unintended consequence of changing physician practice patterns which, in turn, could limit care to the sickest patients. Ms. Gilrud urged the Commission to consider taking the time to allow more complete analysis of the data and to consider making the changes to the inclusion and exclusion criteria recommended by MHA.

Chairman Young expressed concern as a physician with Ms. Gilrud's comment that physicians might not do the right thing because of their concern about a payment adjustment.

Commissioner Wong suggested that the PPCs that have been reviewed were probably the most problematical, and that the remaining PPCs would produce less controversy.

Commissioner Sexton observed that the Maryland Patient Safety Center should be involved in addressing hospital concerns about preventability and evidence-based protocols associated with the problems uncovered by the MHAC methodology. Commissioner Sexton suggested that the Commission be very conservative in the implementation of MHAC methodology and limit the financial risk associated with the incentive adjustments.

Commissioner Hall expressed concern about possible unintended consequences of the MHAC policy such as adverse impact on patient care. Commissioner Hall also agreed with MHA that 3M should not be vetting its own product, but that the clinical vetting should be done by a neutral and objective third party.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, urged the Commission to approve staff's recommendations. Dr. Cohen also noted that it would be inappropriate for the Commission to provide best practice guidelines to hospitals and physicians.

The Commission voted to approve staff's recommendation. Commissioner Hall opposed the recommendation.

ITEM VI
DRAFT RECOMMENDATIONS ON HOSPITAL ASSESSMENT IN LIEU OF MEDICAID DAY LIMITS FROM THE BOARD OF PUBLIC WORKS APPROVED BUDGET REDUCTIONS

Steve Ports, Principal Deputy Director-Policy & Operations, summarized the draft recommendation for an alternative method of funding amounts earmarked for budget reductions to the Medicaid Program in lieu of Medicaid Day Limits (MDL) as approved by the Board of Public Works. The recommendation included the imposition of a one-year, broad-based and uniform hospital assessment in FY 2010 in the amount of $8,897,720 to be conducted in the same manner as the $19 million assessment that was imposed in FY 2009 in lieu of MDLs. Hospitals would be instructed to remit their calculated portion of the assessment to Medicaid beginning January 1, 2010 and ending June 30, 2010.

Robert Vovak, Vice President & CFO of MHA, expressed the support of MHA's Council on Financial Policy for the alternative methodology.

Hal Cohen stated that staff's alternative method was a much better option than the re-imposition of MDLs.

Because this is a draft recommendation, no action by the Commission was required.

ITEM VII
FINAL RECOMMENDTIONS FOR FUNDING MHCC'S APPROVED IMPLEMENTATION OF A STATEWIDE HEALTH INFORMATION EXCHANGE

Steve Ports summarized the background of the initiative to develop a statewide information exchange. Mr. Ports explained that the Maryland Health Care Commission (MHCC) utilized a two-phase approach: 1) to identify and merge into a single Request for Application (RFA) the best ideas developed by two multi-stakeholder groups working independently; and 2) to select a vender to implement the plan.

Rex W. Cowdry, M.D., Executive Director of the MHCC, and David Sharp, Director of the Center for Health Information Technology of the MHCC, described the goals of the exchange and RFA review process.

Mr. Sharp stated that an evaluation committee consisting of representatives of MHCC, HSCRC, and Health Care Information Consultants, LCC reviewed the responses and concluded that the only two responders met the requirements of the RFA: Chesapeake Regional Health Information System for Our Patients (CRISP), and Deloitte. After deliberation, the committee selected CRISP as the most qualified.

Mr. Sharp presented the MHCC and HSCRC staff's recommendation that the HSCRC approve funding for CRISP to initiate the development of a statewide Health Information Exchange through an adjustment to rates of participating hospitals of up to $10 million over the next 3-5 years. MHCC and HSCRC staff will continue to review spending and funding needs and will make adjustments to annual funding as necessary. The HSCRC reserves the right to withhold or discontinue funding in the event that deliverables or expectations are not met.

Commissioner Sexton pointed out that the privacy provision is most important and must be appropriately addressed.

Commissioner Hall asked about the status of the federal initiative.

Dr. Cowdry explained that the federal initiative was still in development, and that it is the State's intention to coordinate the Maryland exchange with other state exchanges and the federal initiative.

Tracie LaValle, Assistant Vice President of Financial Policy for MHA, expressed the industry's support of the recommendation.

Dr. Cohen expressed the support of CareFirst of Maryland and Kaiser Permantente for the exchange and the recommendation.

The Commission voted unanimously to approve the recommendation

ITEM VIII
ADDITIONAL REPORTING REQUIREMENTS – ADMISSIONS DENIED FOR MEDICAL NECESSITY

Rodney Spangler, Chief –Audit & Compliance, presented a staff recommendation for an amendment to the HSCRC's Accounting and Budget Manual to require the submission of data associated with admissions denied for medical necessity.

Ms. LaValle of MHA stated that there are policy issues related to denied admissions. Ms. LaValle recommended that when the policy is developed, the following comments be considered: 1) that a denial not be recognized until the appeals process is completed and the case written off; 2) that the denials be reported only for the quarter in which they are written-off; and 3) that the Commission determine whether the number of such denials are significant enough to justify modifying the rate setting methodology.

The Commission voted unanimously to approve staff's recommendation.

ITEM IX
LEGAL REPORT

There was no Legal Report.

ITEM X
HEARING AND MEETING SCHEDULE

September 2, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
October 7, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:32 a.m.