MINUTES
465th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

MARCH 3, 2010

Chairman Young called the meeting to order at 9:43 a.m. Commissioners Joseph R. Antos, Ph.D., Trudy Hall, M.D., Steven B. Larsen, J.D., C. James Lowthers, Kevin J. Sexton, and Herbert S. Wong, Ph.D. were also present.

REPORT OF THE EXECUTIVE SESSION OF MARCH 3, 2010

Oscar Ibarra, Chief-Program Administration & Information Management, summarized the minutes of the March 3, 2010 Executive Session.

60 DAY COMMENT PERIOD BEFORE COMMISSION ACTION ON RECOMMENDATIONS TO ADOPT NEW POLICIES OR TO MODIFY EXISTING POLICIES

The Chairman stated that a work group including representative from the Maryland Hospital Association (MHA) and Commissioners met to discuss how to improve HSCRC processes. MHA suggested that the Commission mandate that there be a 60 day comment period before action on staff recommendations for the adoption of new policies or the modification of existing policies. The Chairman added that the Commission should have the option to waive the 60 day comment period for matters requiring immediate action.

The Commission voted unanimously to adopt the 60 day comment period on action on new or modified Commission policies with the option to waive the comment period if necessary.

ITEM I
REVIEW OF THE MINUTES OF THE EXECUTIVE AND PUBLIC SESSIONS OF JANUARY 3, 2010

The Commission voted unanimously to approve the minutes of the January 13, 2010 Executive and Public Sessions.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, summarized the status of major policy initiatives. They include: 1) meeting with the Maryland Hospital Preventable Readmissions workgroup and continuing to perform simulations to develop infrastructure: 2) continuing discussions on changes to the Inter-hospital Cost Comparison (ICC) and Reasonableness of Charges (ROC) methodologies with a draft recommendation to be presented at today's public meeting; 3) continuing to meet with the FY 2011 Payment Workgroup with a draft recommendation to be presented at today's public meeting; 4) reporting on the results of the Survey on Hospital Governance Practices - - the Commission will be briefed at the April public meeting; and 5) working on request from the Department of Budget Management to study and provide reports on issues relating to the appropriate division of responsibility between tax-payer supported programs and other sources of all-payer funding to hospitals.

Mr. Murray announced that Denise Johnson has joined the Commission's staff as Chief-Special Projects.

ITEM III
DOCKET STATUS CASES CLOSED

2058A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

St. Mary's Hospital – 2056N

On December 4, 2009, St. Mary's Hospital submitted an application requesting a rate for its new Pulmonary Function (PUL) service. The Hospital requested that the state-wide median rate be approved effective January1, 2010.

After reviewing the Hospital's application, staff recommended;

1) That COMAR 10.37.10.07 requiring that rate applications be filed 60 days prior to the opening of a new service be waived;
2) That a PUL rate of $3.48 per RVU be approved effective February 1, 2010;
3) That no change be made to the Hospital's Charge per Case standard for PUL services; and
4) That the PUL 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.

Doctors Community Hospital – 2057R

On December 7, 2009, Doctors Community Hospital submitted a rate application requesting a rate for inpatient and outpatient MRI services. The Hospital currently has a rebundled MRI rate for MRI services provided off-site to hospital inpatients. As of January 1, 2010, the Hospital has been providing in-house MRI services to both inpatients and outpatients. The Hospital requested the state-wide median rate effective January 1, 2010.

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

1) That COMAR 10.37.10.07 requiring that rate applications be filed 60 days prior to the opening of a new service be waived;
2) That a MRI rate of $42.32 per RVU be approved effective February 1, 2010;
3) That no change be made to the Hospital's Charge per Case standard for MRI services; and
1) 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.

Union Hospital of Cecil County – 2059N

On February 2, 2010, Union Hospital of Cecil County filed an application requesting a rate for its new Hyperbaric Chamber (HYP) service. The Hospital requested that the state-wide median HYP rate be approved effective March 1, 2010.

After reviewing the Hospital's application, staff recommended;

1) That COMAR 10.37.10.07 requiring that rate applications be filed 60 days prior to the opening of a new service be waived;
2) That a HYP rate of $246.02 per RVU be approved effective March 1, 2010;
3) That no change be made to the Hospital's Charge per Case 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.

Union Hospital of Cecil County – 2060N

On February 2, 2009, Union Hospital of Cecil County filed an application requesting a rate for its new Operating Room Clinic (ORC) service. The Hospital requested that the state-wide median ORC rate be approved effective March 1, 2010.

After reviewing the Hospital's application, staff recommended;

1) That COMAR 10.37.10.07 requiring that rate applications be filed 60 days prior to the opening of a new service be waived;
2) That an ORC rate of $9.73 per RVU be approved effective March 1, 2010;
3) That no change be made to the Hospital's Charge per Case standard for ORC services; and
4) That the ORC 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.

Carroll Hospital Center – 2061R

On February 7, 2010, Carroll Hospital Center submitted an application requesting a new MRI rate to replace its currently approved rebundled MRI rate, which was necessary in order to bill for MRI services provided off-site to hospital inpatients. As of March 1, 2010, the Hospital will be providing MRI services to both inpatients and outpatients. The Hospital requested that the state-wide median MRI rate be approved effective March 1, 2010.

After reviewing the Hospital's application, staff recommended;

1) That COMAR 10.37.10.07 requiring that rate applications be filed 60 days prior to the opening of a new service be waived;
2) That a MRI rate of $43.32 per RVU be approved effective March 1, 2010;
3) That no change be made to the Hospital's Charge per Case standard for 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.

University of Maryland Medical Center – 2062A

On February 17, 2010, the University of Maryland Medical Center (UMMC) filed an application requesting approval to continue to participate in a global rate arrangement for solid organ and blood and marrow transplant services with Life Trac, Inc. Network for a period of three years beginning April 1, 2010.

Staff recommended that the UMMC's request be approved for a period of one year beginning April 1, 2010 based on favorable performance last year. 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.

ITEM V
DRAFT RECOMMENDATION ON ANNUAL PAYMENT UPDATE

Mr. Murray presented an overview of the draft payment update proposals from the Maryland Hospital Association (MHA) and the Payer Representatives (Payers) in the format of a draft staff recommendation. Per the Chairman's request, the recommendation is a summary of the discussions that have taken place so far in the Payment Work Group and outlines the proposals of MHA and the Payers. In addition, the recommendation includes a discussion of environmental factors impacting on the rate update decision.

Mr. Murray stated that since the "Redesign" of the rate setting system in FY 2000 the Commission has generally favored arrangements that define the trajectory of hospital rates over three-years. Such multi-year arrangements can be designed to achieve the Commission's medium-term policy objectives and at the same time, provide a higher degree of predictability for hospitals and payers for financial management and budget purposes. However, Mr. Murray noted that the FY 2010 rate arrangement was an exception and applied to only one year because of the uncertainty associated with general financial conditions.

Mr. Murray observed that the annual updates are also designed to achieve multiple policy objectives. The earlier update arrangements were focused on restraining the rate of growth because of our unfavorable position in regard to the Medicare waiver, while the later arrangements were structured to provide hospitals with additional funds to facilitate recapitalization.

Mr. Murray stated that the policy implications of the update factor are significant because it is the primary tool for controlling costs in the system. The update factor also influences performance on the Medicare waiver test and impacts the affordability of hospital care, as well as a hospital's financial condition. Mr. Murray noted that every 1.0% of the update factor results in $136 million in additional annual revenue to the hospitals and represents a $13 million impact on Medicaid payments to hospitals. In addition, Mr. Murray noted that the relationship between the rate

updates and hospital profitability is influenced by hospitals' ability to control costs. MedPac, the Commission that advises Congress on payment policy for Medicare, has found that hospitals that face broad payment constraints in the marketplace, nationally, tend to manage their expenses more effectively.

Mr. Murray reported that as in previous years, the FY 2011 update process includes the formation of a payment work group consisting of representatives of HSCRC, MHA, individual hospitals, and public and private payers. The goal of the work group is to develop a consensus position on the level of the update. At the direction of the Chairman, staff requested that the Payers and MHA representing the hospitals submit update proposals.

Mr. Murray the outlined the principal components of the update factor; 1) market basket (measures underlying price changes in factor inputs used by hospitals, i.e., inflation on wages, supplies, etc.); 2) market basket forecasting error; 3) HSCRC policy adjustment (offers the Commission the opportunity to add or reduce revenue to accomplish its policy objectives); 4) rate slippage (due to full rate reviews and spenddowns); 5) case-mix allowance; and 6) volume adjustment. Other issues to be addressed in the payment update discussions were: 1) the question of one-year versus three-year arrangements; 2) scaling for Reasonableness of Charges (ROC) and quality adjustments; 3) the update factor for specialty hospitals; 4) the impact of the update factor on the Medicare waiver cushion; and 5) the generation of savings to fund FY 2011 Medicaid Budget Cuts.

Mr. Murray reported that MHA submitted a one-year proposal while the payers submitted both one-year and three-year proposals. MHA's rationale for not submitting a three-year rate proposal was the current uncertainty regarding national health care reform discussions, the State's budget situation, and the anticipation of discussions to take place over the next year concerning the potential development of a modernized Medicare waiver and future payment system.

MHA's one-year proposal resulted in a total update factor for FY 2011 of 3.37%. The major components of the proposal are: 1) an adjustment for forecasting error based on deviations from final inflation over the past five years; 2) a combined policy and volume adjustment; 3) a 1% case mix limitation on inpatient Charge per Case (CPC) growth; and 4) no limit on Charge per Visit (CPV) growth (for comparison purposes, staff inserted a 1% growth factor for CPV). MHA did not respond to staff's request for the magnitude of the update for specialty hospitals, the magnitude of scaling related to ROC position, or for the quality initiatives.

In its proposal, MHA stated that it was important to differentiate between the approved HSCRC update for FY 2010 and the actual revenue increase received by hospitals. According to MHA, hospitals have experienced near zero growth in reimbursement thus far in FY 2010. This is attributable the $27 million directly remitted by hospitals associated with the Board of Public Works' required Medicaid hospital payment reductions, and the reduction in hospitals' uncompensated care (UCC) provisions (of a collective 0.75%) for averted bad debt related to Medicaid expansion.

Mr. Murray stated that the Payers (representing United Health Care, CareFirst of Maryland,

Kaiser Permanente, Amerigroup, the Department of Health and Mental Hygiene, and the State Health Employee Benefit Program) submitted both one-year and three-year proposals. The one-year proposal produced a total update factor of 0.71%, which included no provision for factor inflation. The Payers' three-year proposal recommended a 1.39% update factor for the first year and updates of 2.29% for both years two and three. The major components of the Payers three-year proposal were: 1) an adjustment for forecasting error based on deviations from final inflation over the last three years; 2) a 1% case mix limitation on both inpatient CPC and outpatient CPV growth; and 3) 0.3% for slippage (to account for increases in volume and revenue associated with outpatient services not accounted for under the CPV methodology). In their proposal, the Payers also urged the Commission to move quickly to include as much of the remaining outpatient revenue under the CPV methodology as soon possible.

In their proposal, the Payers stated that they preferred a three-year agreement because of the stability and predictability associated with multi-year arrangements and the ability to set a system cost target to be achieved in three years. Payers also urged that the HSCRC return its focus to net patient revenue (NPR) (which relates directly to the services that the Commission regulates) rather than on net operating revenue (NOR). In addition, the Payers stated that their three-year arrangement was formulated to achieve a position of 6% below the nation in NPR per equivalent admission. This would require Maryland hospitals to outperform the nation by 2.27% per year over the next three years. The Payers believe that the target is achievable given the performance of a cohort of hospitals nationally who lowered their costs to this level in the face of financial pressure from public and private payers.

The Payers' three-year proposal recommends changing the volume adjustment from 85% to 75% in FY 2012 and FY 2013 and includes a provision that allows a case mix adjustment higher than 1% in the event that hospitals reduce admissions and overall volume in the system.

The Payers contended that if the system is in such disarray or crisis that we cannot prudently plan for three years, we should freeze the update for one year. Freezing the update would still recognize case mix, slippage, and volume adjustments and would result in an increase to rates of 0.71% for FY 2011.

The Payers also recommended that adjustments for quality measures should be revenue neutral. They should be scaled based on a pool of 0.5% of total revenue for Quality-based Reimbursement and 0.5% for Maryland Hospital Acquired Conditions to provide incentives for behavior change. However, because of its potentially greater quality and financial impact, a pool of 1% of total revenue be provided for the Potentially Preventable Admissions (PPAs) program. The Payers proposed that each of the pools be increased by 0.5% in FY 2012 and FY 2013. The

The Payers also proposed a waiver trip-wire, to be based on forecasted waiver performance, requiring Commission action would be required if the waiver cushion was projected to be less than 7% at the end of the three year arrangement. The Payers requested that the HSCRC undertake a comprehensive review of chronic hospital rates relative to the rates of non-chronic hospital providers, and that during the three-years of the rate cycle, hospital and payer representatives meet regularly to identify and recommend the implementation of "game

changers," i.e., initiatives that will materially reduce the cost of providing quality healthcare.

Mr. Murray observed that an example of a game changer would be to apply the Total Patient Revenue (TPR) methodology to more hospitals. Under TPR, a hospital's revenue is virtually 100% fixed irrespective of changes in volume and case mix, thereby providing the hospital with strong incentives to reduce volumes and shift services to more cost effective settings.

Mr. Murray noted that there is a fairly wide disparity in the one-year proposals. The Payers' one-year proposal would result in $361 million less revenue than MHA's one-year proposal, and the first year of the Payers' three-year proposal would result in $268 million less revenue than MHA's one–year proposal.

Mr. Murray summarized the environmental factors impacting on the rate update decision. They include: 1) Maryland hospital financial performance - - FY 2009 profits on regulated services appear to be slightly higher, while unregulated losses have moderated slightly; 2) the continuing rapid growth of losses on physician services; 3) some recovery in hospitals' non-operating margins; 4) continuing decrease in the affordability of hospital care in Maryland because payments to, and costs of, Maryland hospitals have increased more rapidly than U.S.; 5) lower than normal national trends in hospital input cost inflation, which have allowed hospitals to maintain relatively steady operating margins in FY 2010; and 6) the Medicare waiver cushion at a level well below historical margins, even with an adjustment for use by CMS of inaccurate data.

Mr. Murray stated that the State budgetary shortfalls will also have a significant impact on the update decision. It is the staff's view that the system of uniform assessments on hospital rates and direct hospital remittances, based on a 50/50 split, initiated by the Commission in FY 2010, is the most efficient and equitable way to fund the anticipated Medicaid budgetary shortfall. Nevertheless, the decision on the ultimate level of the Update Factor for FY 2011 will have implications for the magnitude of cuts that must be implemented elsewhere in the system to accommodate the required Medicaid budget savings. However, since the Medicaid budget shortfall of $123 million for FY 2011 was predicated on an update factor of 2.84%, a lower update factor will lower the required savings in Medicaid payments.

Mr. Murray reported that on March 2, 2010, he participated in a hearing before the Budget and Taxation Committee of the State legislature. Also in attendance were John Colmers, Secretary of Health, and hospital representatives. The focus of the hearing was to determine how the Commission and the hospital industry plan to address the $123 million Medicaid budget issue. Although the Committee generally recognized that the decision was the Commission's to make, the\Committee wanted some degree of predictability and an understanding of how the required Medicaid savings issue was going to be handled before the legislative session ended. Mr. Murray explained the current method of 50/50 sharing of the required budget savings through uniform assessments on hospital rates and direct hospital remittances and the prospect of lowering the assessment and remittance through cost saving initiatives. Mr. Murray stated that he was surprised when some of the hospital representatives recommended that the Budget Committee insert language in the budget bill that would prevent the Commission from making the decision

on how to handle the required Medicaid budget savings. Mr. Murray observed that such action is not the traditional approach of the legislature, which has always respected the independence of the Commission.

Commissioner Larsen asked what significance unregulated losses, including those associated with unregulated physicians, had in the update factor discussions.

Mr. Murray replied that even though the HSCRC does not have jurisdiction over unregulated services, they do have an impact on the update factor because they affect the financial condition of hospitals. Mr. Murray observed that because losses on unregulated services continue to grow, especially losses associated with physicians, the Commission may want to begin to gather data and talk to the industry to try to better understand this issue.

Commissioner Hall noted that many hospitals are forced to hire hospitalists because community physicians will not take care of patients in the hospital.

Michael Robbins, Senior Vice President-MHA, stated that the hospital industry preferred a one-year update arrangement rather that a three-year arrangement because of: 1) the uncertainty over economic conditions and the State budget; 2) Medicaid payment cuts, which effectively reduced the update factor by 0.2%; 3) the impact of the averted bad debt reconciliation; 4) the fact that inflation was understated in last year's update; and 5) policy issues, e.g., how one day stays are to be handled in the rate system.

Mr. Robbins pointed out that financial data for the first six months of FY 2010 data do not reflect: 1) the Board of Public Works' cuts; 2) the averted bad debt reconciliation; and 3) storm related expenses. According to Mr. Robbins, recent hospital data indicate that hospitals' net operating margins may be at or below 1% for FY 2010, which is well below the financial performance target of 2.75%.

Mr. Robbins expressed MHA's concern that the comparisons between Maryland and the nation on costs, NPR, and NOR per equivalent inpatient admission (EIPA) are not valid because of the way that EIPAs are calculated, i.e., that adjustments are not made for cost shifting from inpatient to outpatient in the national data. MHA believes that the most important target is the waiver cushion, along with the other financial performance targets of net operating margin and total margin.

Mr. Robbins stated that we must make sure that the corrections to the Medicare waiver test for Medicare as secondary payer and for Medicare HMO zero-pay discharges are adequately recognized, so that if the waiver cushion is used as a target for the update factor, that the target is accurate.

Mr. Robbins indicated that MHA is concerned about funding required Medicaid savings when Medicaid enrollment is projected to increase by 7%, and Medicaid expects to pay hospitals 2% less per enrollee. Mr. Robbins stated that it is MHA's goal to see that the required Medicaid savings are achieved in the must efficient way possible. Mr. Robbins expressed the industry's

preference for handling the entire $123 million required Medicaid savings through an assessment rather than through service cuts.

Commissioner Sexton asked if MHA was suggesting that the Commission drop NOR per EIPA as a guidepost for where rates should be.

Mr. Robbins explained that MHA believes that there are sufficient targets other than NOR; however, if NOR is going to be used as a target, we must be sure the calculation of NOR is accurate, i.e., that Maryland and national numbers are really comparable. MHA believes that the most important target is the Medicare waiver cushion.

Commissioner Sexton asked Mr. Robbins about MHA's proposal regarding how to achieve the required Medicaid savings.

Mr. Robbins stated that this is an issue that should be discussed with the Payers in context of the update negotiations. How much of the assessment hospitals can fund depends on the magnitude of the Update Factor.

Commissioner Hall asked Mr. Robbins if he had a solution for handling Medicaid budget cuts.

Mr. Robbins stated that there were no short term solutions; however, in the long term we should look at some of the so called "game changers." In addition, we should look into modernizing the Medicare waiver to accommodate such reforms as payment bundling, accountable care organizations and medical homes, as well as beginning dialogue on solving the physician issue. Such reforms, along with the PPAs initiative, are the kind of long term changes that present the opportunity to save money not only for Medicaid but for all payers.

Commissioner Larsen asked whether MHA would rather have the General Assembly make the decision on how the required Medicaid savings will be handled rather than the Commission.

Mr. Robbins replied that MHA believed that a uniform broad-based assessment represented the most effective method for handling the required Medicaid savings, and that the extent to which hospitals can share in the funding of the savings depends on their financial condition and the magnitude of the Update Factor.

Commissioner Larsen asked Mr. Robbins if he would like to comment on the issue of unregulated physician losses.

Mr. Robbins stated that in this day and age, hospitals cannot operate without dealing with the physician issue. Hospitals are taking over physician practices just to provide access and to continue to serve their current patient population. MHA is willing to work with the Commission to gather data to determine whether every hospital is doing the best job to manage all of those practices efficiently. However, we must all recognize that it is the reality of running a hospital, that more and more physician costs, both regulated and unregulated, are being shifted to hospitals.

Mr. Murray asked how MHA made the calculation that Medicaid would pay 2% less per enrollee at the same time that enrollment increased by 7%.

Mr. Robbins explained that MHA took the 2.84% that Medicaid budgeted for the Update Factor for FY 2011; times Medicaid cost per enrollee for FY 2009, less the $123 million required Medicaid savings. The result showed that Medicaid payments would be 2% less.

Mr. Murray stated that it appears that the calculation presumes the funding of the entire $123 million Medicaid savings by the hospitals.

Mr. Robbins replied that the calculation does assume that all of the $123 million would come from hospitals, because at the time the calculation was made, no agreement had been reached as to how much of the savings would be funded by hospitals. In addition, the Payers' one-year proposal showed nothing in the Update Factor for increases in cost of care.

Commissioner Lowthers noted that "payers" really are employers and citizens, not the insurance companies. When hospital rates are increased, employers lower benefits, which increase the costs to the employees. This ultimately results in the rationing of healthcare. Therefore, it is not appropriate that payers fund all of the Medicaid budget cuts

Mr. Robbins pointed out that hospitals have taken a number of other reductions in anticipated revenue because of the understatement of inflation in the FY 2010 update, the case mix governor, and volume adjustments. However, there is still the opportunity in the Payment Work Group to discuss how much of the saving should be assumed by hospitals and how much by the Payers.

Commissioner Sexton suggested that no matter how these Medicaid payment cuts are funded, the Commission make a strong statement that it is not good policy, and that it is a severe blow to rate setting principles to fund Medicaid budget cuts through the rate setting system.

John Folkemer, Deputy Secretary for Health Care Finance and Medicaid Director, reported that the Department of Health and Mental Hygiene's (DHMH's) preliminary calculation of payment reductions among providers because of Medicaid Budget cuts, as a percentage of the providers' total revenue, indicated that hospitals and physicians were the least impacted, 04% and 0.2% respectively, and that the greatest impact was to nursing homes, 6%-6.5%. Mr. Folkemer also expressed support for the funding of future Medicaid budget cuts through assessments.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, strongly expressed his preference for a three-year arrangement, and that it should be the Commission - - not MHA - - who decides on the length of the arrangement. Dr. Cohen stated that NPR should be the focus of comparisons of Maryland hospitals to the nation; also, that the goal should be that Maryland is 6% below the nation in NPR at the end of the three-year arrangement. Dr. Cohen stated that utilizing the waiver test as a constraint only matters if it is a binding constraint. If the waiver test is not a binding constraint, then the Commission should make a decision that is best for all payers. Dr. Cohen also suggested that, after all corrections have been made to the waiver test data, 7% is a reasonable tripwire.

Dr. Cohen reported that he attended the hearing before the Budget and Taxation Committee as a payer representative but was not allowed to speak. Only John Colmers, Bob Murray, and a panel of five hospital representatives were allowed to participate. Dr. Cohen noted that several of the hospital representatives suggested that after the hearing the legislature should insert language in the budget bill to require that payers to pay all of the necessary Medicaid savings. Dr. Cohen agreed with Commissioner Lowthers that in the end, individuals and not insurance companies pay for all payment increases. Payers are not advocating that hospitals pay 100% of the Medicaid savings, but are suggesting that future Medicaid budget cuts be funded through an assessment split of 50/50 between hospitals and the payers. Dr Cohen stated that it was obvious at the hearing that the legislators wanted to know how the Medicaid savings were going to be funded. Therefore, Dr. Cohen urged the Commission to act immediately to approve the use of assessments to fund the required Medicaid savings, and that the assessment be levied 50/50 between hospitals and payers.

Barry Rosen, representing United HealthCare (United), urged the Commission to adopt a set of three-year goals as a good management tool. The issue is where we want Maryland to be in three years. Mr. Rosen stated that United recommends the use of NPR rather than NOR as the goal. Mr. Rosen noted that the HSCRC sets the rates that patients are charged for hospital services, and that relates directly to NPR. In addition, there is more discretion in the definition of what is NOR and what is not, while NPR is clearly defined.

In an effort to promote compromise, Mr. Rosen stated that if the Commission decides to adopt a one-year arrangement, United would endorse a one-year arrangement that mirrors the Update Factor for last year. If the Commission adopts a three-year arrangement, United would agree to an "all in" update that is greater than last year's.

Commissioner Sexton stated that if 50/50 is the right split for funding required Medicaid savings for FY 2011, then the 50/50 split should also apply to all required Medicaid savings for both FY 2010 and FY 2011.

Dr. Cohen questioned whether the payers should pay 50% of the funding associated with the False Claims Act, which hospitals helped defeat.

Dr. Cohen urged the Commission to make a decision now, so that the legislature knows what the split in funding of the Medicaid savings between hospitals and payers will be, and that the funding will be accomplished through assessments.

Commissioner Larsen asked about when the legislature's decision on whether or not to insert language in the budget bill specifying how required Medicaid savings would be funded would be made.

Steve Ports, Principal Deputy Director-Policy & Operations, stated that the final decision on the budget bill would be made before the end of the session and, therefore, before the next Commission public meeting.

Commissioner Sexton made a motion that the Commission waive its 60-day comment period policy. In addition, in order to remove the uncertainty of how Medicaid budget cuts for FY 2011 would be handled, that the Commission mandate that any Medicaid budget cuts for FY 2011 be funded, as the FY 2010 Medicaid budget cuts were funded, by a uniform and broad-based assessment, and that the aggregate uniform assessment for FY 2010 and FY 2011 be shared equally (50%/50%) by the hospitals and the payers.

The Commission voted unanimously to approve the Commissioner Sexton's motion.

ITEM VI
DRAFT RECOMMENDATION FROM DELIBERATIONS OF THE ICC/ROC WORK GROUP

Charlotte Thompson, Deputy Director-Methodology and Research, summarized staff's draft recommendation for proposed modifications to the ROC methodology for Spring 2010. The major proposed changes were: 1) peer groups changes - - move to three peer groups based on teaching intensity; 2) calculation of the Combined Compliance Target (CCT) - - calculate a CPV for each hospital and combine with CPC to determine CCT using 2009 methodology; 3) make a technical correction to apply Indirect Medical Education (IME) and Disproportionate Shared (DSH) adjustments as a direct strip; 4) begin study of physician recruitment, retention, and coverage costs; 5) make no change to the profit and productivity adjustments in the ICC methodology; 6) adjustment for capital - - move from the current 50% hospital specific and 50% state-wide to 100% state-wide plus 50% hospital specific, and allow 100% volume variability (for 3 years) rather than 85% for Certificate of Need projects; 7) include kidney transplants in the CPC methodology in FY 2011 exclusions; 8) move to a three month case mix lag for the data period used to measure case mix change; 9) continue discussion of a prospective outlier/trim methodology; and 10) that there be continuous scaling based on the 2010 Spring ROC, and that there be no spenddowns.

Ms. Thompson announced that the work group will continue to meet, and that another draft recommendation reflecting the deliberations of the work group will be distributed at the April public meeting with a final recommendation to be presented at the May public meeting.

Dr. Cohen commended Ms. Thompson and staff for all of their work in this very fair and thorough process. Dr. Cohen expressed support for MHA's suggestion that a full review of the ICC/ROC methodology not be done annually, but that the opportunity for limited revisions be available. Dr. Cohen recommended that the Commission change its definition of high cost hospital to one standard deviation above the peer group average. Dr. Cohen suggested that teaching intensity should be calculated based on the number of residents at each hospital rather than the ratio of residents to beds when determining peer groups. Dr. Cohen also requested that the profit strip be removed in from the ICC methodology for partial capital applications. Dr. Cohen expressed strong support for significant scaling of hospitals in the absence of spenddowns.

ITEM VII
FINAL RECOMMENDATION ON MEDICAID CURRENT FINANCING

Dennis N. Phelps, Associate Director-Audit & Compliance, presented a recommendation on the request by the Medical Assistance Program (MAP) to modify the calculation of its current financing deposits for FY 2010. Mr. Phelps reported that as a result of the budget crisis in December 2009, MAP requested an exception to the requirement that the amount of current financing on deposit with hospitals be recalculated annually. MAP stated in its request that it intended to re-institute the annual recalculation for FY 2010. The Commission approved MAP's request at its January 14, 2009 public meeting.

Mr. Phelps stated that on February 5, 2010, citing the continuing budget crisis, MAP submitted a request to modify the approved current financing calculation for FY 2010. The modified calculation would provide an additional $11.2 million to the current financing now on deposit with hospitals rather than an additional $29.8 million provided by the previously approved calculation. MAP also committed to work with MHA to review the existent current financing formula with the objective of improving it prior to the FY 2011 calculation.

Based on the current condition of the economy and its effect on MAP's budget, staff recommended that the Commission approve MAP's request. Staff also recommended that the Commission strongly encourage MAP and MHA to develop a permanent financing methodology for approval before the FY 2011 calculation. In addition, because the calculation of the current financing deposits for FY 2010 was already several months late, staff requested that the Commission waive its 60 day comment period policy.

The Commission voted unanimously to approve staff's recommendation.

ITEM VIII
LEGISLATIVE UPDATE

Steve Ports, Principal Deputy Director-Policy & Operations, presented a summary of legislation of interest to the HSCRC. The most significant healthcare legislation was SB328/HB 933, Financial Assistance and Debt Collection Policies, and SB 593/HB 699, Freestanding Medical Facilities.

SB 328/HB 933 would: 1) require hospitals to provide reduced-cost medically necessary care to patients with family income below 500% of federal poverty guidelines; 2) refund any amount collected above $25 to patients found eligible for free care within 2 years; 3) prohibit the reporting of adverse information to consumer credit agencies for at least 120 days after issuing the initial bill and promptly notifying the same agencies of a patient's fulfillment of the payment obligation; 4) prohibit forcing sale or foreclosure of a patient's primary residence to collect outstanding debt; 5) require hospitals to explicitly authorize or contract outside collection agencies and specify procedures to be followed; and 6) require the approval from the hospital's board of directors for any changes to the hospital's financial assistance and debt collection

policies.

SB 593/HB 699 Freestanding Medical Facilities would: 1) require the HSCRC to set rates for hospitals services provided at freestanding medical facilities and freestanding medical facility pilot projects; 2) require all payers to pay HSCRC rates at the freestanding medical facilities; 3) alter the definition of "hospital services" in the HSCRC statute to specify that emergency services include those provided at freestanding medical facilities; and 4) require the HSCRC to report its established rates for the freestanding medical facilities by October 1, 2010.

ITEM IX
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 update the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operating Management" (August 1987), which has been incorporated by reference.

The Commission voted unanimously to approve the final adoption of this amended regulation.

Rate Application and Approval Procedures- COMAR 10.37.10.26(B)

The purpose of this action is to raise the current income threshold for receiving free or reduced medically necessary hospital care unless such increase would yield undue financial hardship to a hospital.

The Commission voted unanimously to approve the final adoption of this amended regulation.

ITEM X
HEARING AND MEETING SCHEDULE

April 14, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
May 5, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 12:29 p.m.