STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Frederick W. Puddester
Chairman

Kevin J. Sexton
Vice Chairman

Joseph R. Antos, Ph.D.

George H. Bone, M.D.

C. James Lowthers

Herbert S. Wong, Ph.D.

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Executive Session Minutes
of the
Health Services Cost Review Commission

March 2, 2011

Upon motion made, Chairman Puddester called the meeting to order at 10: 20 a.m.

The Meeting was held under the authority of Section 10-508 of the State Government Article.

In attendance, in addition to Chairman Puddester, were Commissioners, Bone, Lowthers, and Wong.

Robert Murray, Steve Ports, Jerry Schmith, Dennis Phelps, and Oscar Ibarra attended representing Commission staff.

Also attending were Leslie Schulman and Stan Lustman, Commission Counsel.

Item One

The Commission was updated on budgetary matters particularly as they affect the Medicaid program and the Medicare waiver.

The Commission also pondered the schedule for a decision on the update factor.

The Executive Session was adjourned at 10:40 a.m.

MINUTES
476TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

March 2, 2011

Chairman Frederick W. Pudderster called the meeting to order at 10:43a.m. Commissioners C. James Lowthers and Kevin J. Sexton were also present. Commissioners Joseph R. Antos, Ph.D., George H. Bone, M.D., and Herbert S. Wong, Ph.D. participated by conference call.

REPORT OF THE EXECUTIVE SESSION OF MARCH 2, 2011

Oscar Ibarra, Chief-Program Administration & Information Management, summarized the minutes of the March 2, 2011 Executive Session.

ITEM I
EXECUTIVE AND PUBLIC SESSIONS OF FEBRUARY 10, 2011

The Commission voted unanimously to approve the minutes of the February 10, 2011 Public and Executive Sessions.

ITEM II
DOCKET STATUS CASES CLOSED

2096N – Maryland General Hospital
2102N – Washington Adventist Hospital
2103A – Washington Adventist Hospital
2104A – Adventist Behavioral Health
2105A– Adventist Behavioral Health

ITEM III
DOCKET STATUS CASES OPEN

Johns Hopkins Health System – 2106A

On January 31, 2011, the Johns Hopkins Health System filed an alternative method of rate determination application on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, requesting approval for participation in a new global rate arrangement for certain cardiovascular procedures with Quality Health Management for a period of one year beginning February 1, 2011.

Since the format utilized to calculate the case rates, i.e., historical data for like cases, has been used as a basis for other successful cardiovascular arrangements in which the Hospitals are

currently participating, staff recommended that staff approve the Hospital's application for a period of one year effective February 1, 2011.

The Commission voted unanimously to approve staff's recommendation.

MedStar Health – 2107A

On February 3, 2011, MedStar Health filed an alternative method of rate determination application on behalf of Union Memorial Hospital, requesting approval to continue to participate in a global rate arrangement for orthopedic services with the NFL Player Joint Replacement Benefit Plan for a period of one year beginning March 1, 2011.

Although there has been no activity, staff continues to believe that the Hospital can achieve favorable performance under this arrangement. Staff recommended that staff approve the Hospital's application for a period of one year effective March 1, 2011.

The Commission voted unanimously to approve staff's recommendation.

ITEM IV
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, summarized the progress of several major initiatives and issues. They include: 1) the workgroup reviewing the Reasonableness of Charges (ROC) methodology for the Spring ROC would begin meeting soon; 2) twenty-four hospitals have expressed interest in the Admission-Readmission Revenue (ARR) initiative, and three hospitals were expected to finalize agreements in March; 3) staff met with CMS Director, Dr. Donald Berwick, to discuss Maryland hospitals' exemption from the federal quality-based payment initiatives; 4) an offer has been extended to a candidate for position of Deputy Director of Research and Methodology; and 5) it is anticipated that a final recommendation on the FY 2012 Update Factor will be presented at the May 2011 public meeting.

Mr. Murray acknowledged the retirement of Robert Vovak, Senior Vice President and Chief Financial Officer of the Maryland Hospital Association (MHA) and former HSCRC staff member. Mr. Murray observed that Mr. Vovak engendered respect and trust with his low keyed approach, his fair-mindedness, and his ability to see issues from different perspectives. Mr. Vovak's technical expertise and insight have made him most valuable resource to the industry. Mr. Murray wished Mr. Vovak a long and happy retirement.

ITEM V
FINAL RECOMMENDATION ON INCLUDING OSTEOPATHIC RESIDENTS UNDER THE GRADUATE MEDICAL EDUCATION METHODOLOGY

Christopher O'Brien, Chief-Audit & Compliance, presented a staff recommendation to revise the Accounting and Budget Manual to include the reporting of Osteopathic residents so that they could be included under the HSCRC's Graduate Medical Education methodology.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
DISCUSSION ON OF ISSUES ASSOCIATED WITH THE MARYLAND STATE BUDGET AND THE UPDATE FACTOR

Mr. Murray provided a summary of the history, background, and structure of the annual update factor. Mr. Murray stated that the update factor is the HSCRC's primary tool to control the rate of growth in hospital revenues, and it provides incentives for hospitals to control their expenditures. According to Mr. Murray, both the HSCRC and MedPac have noticed that there is a remarkable correlation between what hospitals spend relative to what they are allowed in terms of revenue. Hospitals with stronger revenue constraints have greater productivity.

Mr. Murray noted that the when deciding on the magnitude of the update factor, the Commission must balance the policy objectives of trying to maintain the affordability of hospital care and the financial solvency of the hospital industry. The tool used to achieve the balance is the component of the update known as the policy adjustment. Mr. Murray then briefly described the other components of the update factor and their purpose.

In addition, Mr. Murray discussed the impact of applying the Medicaid assessments, approximately $370 million, on hospital rates - - decrease in hospital affordability and erosion of our position versus the U.S. both on the waiver test and overall cost - - and applying the assessments directly on hospitals - - places financial pressure on hospitals and, along with the policy adjustment, potentially erodes their profitability.

Mr. Murray noted that in the past, payers and the hospital industry have agreed on formula-driven updates that covered one or more years and provided some degree of predictability. However, there has been no consensus on whether there should be a one-year or multi-year arrangement.

Hal Cohen, PhD., representing CareFirst of Maryland and Kaiser Permanente, stated that all the recent HSCRC initiatives (TPR, ARR, and population based constraints) are extremely important; however, because the hospitals get to retain the savings, they only work for the payers if the update factor is constrained.

Dr. Cohen expressed agreement with Mr. Murray's contention that if you give hospitals less

money, they tend to have lower costs. On the other hand, Dr. Cohen asserted that research shows that if you raise health insurance premiums, fewer people get insurance. To the extent that the assessments are put into hospital rates as opposed to having the hospitals absorb some of it, we are choosing between lower hospital costs on the one hand and fewer people having insurance on the other. Dr. Cohen suggested on behalf of his clients that splitting the burden of the assessments 50/50 between hospitals and the payers is the reasonable thing to do.

Barry Rosen, representing United Healthcare, expressed his client's preference for: 1) a 3 year update arrangement; 2) a modest update factor if the burden of the Medicaid levy is not shared between the payers and the hospitals; 3) a higher update factor if the levy is shared; 4) making the ARR mandatory in the future with the savings shared with the public; and 5) the fixed cost percentage of the volume adjustment increase over time from the current 15% to 40%.

The Chairman asked Dr. Cohen what he thought was the reason for the recent decrease in hospital admissions in Maryland.

Dr. Cohen attributed the decline in admissions to the state of the economy, i.e., elective surgeries are way down, and to some extent the aggressive use of outpatient observation services by some hospitals. Dr. Cohen stated if the HSCRC provides the appropriate incentives, even when the economy improves, there is a great opportunity to hold down the growth in volumes.

Mr. Rosen suggested that the initiation of the volume adjustment several years ago also may have had a positive effect in reducing volumes.

Michael Robbins, Senior Vice President-Financial Policy of the Maryland Hospital Association, presented the hospital industry's position on the 2012 payment update and the proposed Medicaid assessment. Mr. Robbins stated that the hospitals understood the challenges facing the Commission, i.e., balancing Medicaid funding needs, meeting through hospital financial requirements, and keeping hospital costs affordable. Mr. Robbins expressed support for linking the decisions on the magnitude of the update and on the split of the assessment between the hospitals and the payers. He urged that the final decision be made on a timely basis, if possible at the April public meeting. Mr. Robbins noted that both the hospitals and the payers have different views on the process; the payers are concerned about total revenue growth, while the hospitals are concerned about meeting their reasonable financial requirements. Mr. Robbins suggested that both the hospitals and the payers present a range of possible options to the Commission prior to the April public meeting so that the Commission can make a decision then.

In regard to the assessments, Mr. Robbins asserted that hospital costs are not driving the Medicaid Budget problem. According to Mr. Robbins, the Commission has bent the cost curve over the last five years. The Medicaid budget deficit is the result of increases in Medicaid enrollment. Therefore, the hospitals' position is that the assessment should be spread across the greatest number of people, and the way to do that is to put 100% of the funding of the assessment in hospital rates. Hospitals, as employers, will then pay their fair share.

Mr. Robbins stated that MHA's goals for the annual payment update include continuing the commitment to our quality improvement efforts and to ensure that the update is sufficient to allow hospitals to meet the HSCRC's hospital financial condition targets, especially the total operating margin target, which includes both regulated and unregulated services. Mr. Robbins asserted that it is not appropriate to separate the discussions on operating revenue into regulated and unregulated operating margins. In their budgets, hospitals do not differentiate between regulated and unregulated margins. Hospitals cannot operate without the relationships they have with physicians. They must have the resources to, if necessary, subsidize physicians to keep them in their communities in order to provide needed services to their patients.

According to Mr. Robbins, MHA considers the annual payment update to have three components - - the "core" update, the adjustment for volume, and the case mix budgeted amount. The core update consists of the market basket inflation forecast, slippage, and the policy adjustment. Mr. Robbins noted that of the components enumerated the only issue that MHA will debate is the magnitude of the policy adjustment. Mr. Robbins observed that MHA considers the assessments to be part of the policy adjustment. Any portion of the assessment levied on hospitals lowers the financial impact of any core update, as any other policy adjustment would do. Therefore, MHA will link the core update and the assessments in any future discussions as part of the policy adjustment.

Mr. Robbins also noted that over the last five years, the projected inflation component approved in the update has consistently been less than actual inflation. This has resulted in a permanent built-in productivity savings to the system each and every year.

Mr. Robbins stated that it is clear that the Commission has already bent the cost curve. Actual total hospital revenues have been trending below what we projected given the approved updates, projected volumes, and the effect of assessments. The savings as measured by the difference between projected revenue increases and actual revenue increases have been passed on to the public. It is clear that these savings were passed on to self-insured employers. However, it is not clear to what extent the savings that were passed on to health insurance carriers were, in turn, passed on to subscribers, unless premiums were reduced.

In regard to the issue of affordability, Mr. Robbins questioned why the rate of increase in approved premiums for CareFirst's Blue Choice HMO for the last 3 years increased by double digits, when the rate of increase in total hospital revenue was in the low single digits for the same time period. Since hospital costs represent approximately one third of the medical costs, which means that the other components (physicians and other medical costs) must be increasing by 17% to 20% to justify CareFirst's double digit premium increases. Mr. Robbins contended that there is no reason why the hospital rate setting system should be used to subsidize non-hospital cost increases.

Mr. Robbins summarized MHA's position: 1) 100% of the Medicaid assessment should be put in hospital rates; 2) the industry must work with the HSCRC and the legislature to find a long term funding solution to ensure that the assessments are not made permanent; 3) the Commission should provide a payment update that balances the hospitals' operational challenges with the public's ability to afford the increase; and 4) the Commission should allow hospitals the

opportunity to continue the progress we have made to ensure that the right care is delivered to our patients, and to continue the progress we have achieved in delivering high value service to our communities.

ITEM VIII
HEARING AND MEETING SCHEDULE

April 15, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
May 4, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 12:06 p.m.