451st MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

DECEMBER 10, 2008

Chairman Young called the meeting to order at 9:01 a.m. Commissioners Joseph R. Antos, Ph.D., Raymond J. Brusca, J.D., Trudy R. Hall, M.D., James Lowthers, Kevin J. Sexton, and Herbert Wong, Ph.D., were also present.

ITEM I
REVIEW OF THE MINUTES OF THE EXECUTIVE AND PUBLIC SESSIONS OF NOVEMBER 5, 2008

The Commission voted unanimously to approve the minutes of the November 5, 2008 Executive Session and Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, reported to the Commission on the status of major initiatives and issues. Mr. Murray stated that: 1) although there were delays in compiling and analyzing individual hospital data associated with the Maryland Hospital Acquired Conditions, the workgroup continued to work on payment policy approaches; 2) the Quality-Based Reimbursement workgroup is reviewing the incorporation of additional process measures, as well as examining outcome/and patient experience of care measures; 3) staff is working on payment simulation associated with preventable conditions and preventable re-admissions; 4) discussions on the 3 year Payment Arrangement have begun and staff is waiting for proposals from the hospital industry and the payers; 5) staff will be assembling a group in January to evaluate this year's Community Benefit Reports and provide feed-back to both the hospitals and the Commission; and 6) staff is reviewing the potential revision of the chronic hospitals' payment system in response to the Department of Health and Mental Hygiene's budget crisis.

John O'Brien informed the Commission that the draft ICC/ROC policy recommendation will not be presented today but will be ready for the January 2009 public meeting.

Mr. Murray introduced the newest member of the Commission's staff Christopher Konsowski. Mr. Konsowski was an auditor for Maryland's Medicare Intermediary for nine years. Most recently, he performed audits of psychiatric hospitals and residential treatment centers, including establishing Medicaid interim rates for the Maryland Medicaid contractor, Myers and Stauffer. Mr. Konsowski assumes the position of Hospital Rate Analyst.

ITEM III
DOCKET STATUS CASES CLOSED

1994A – Johns Hopkins Health System

2006A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

University of Maryland Medical Center – 1999A

On July 31, 2008, the University of Maryland Medical Center filed an application for approval for its continued participation in a global rate arrangement for solid organ and bone marrow transplants with Maryland Physicians Care for a period of three years retroactive to September 1, 2008.

Because the experience under this arrangement was favorable over the last year, staff recommended approval of the Hospital's request for continued participation in the global price arrangement for a one year period, retro-active to September 1, 2008. 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 – 2008A

On November 17, 2008, the Johns Hopkins Health System filed an application on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital, requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with Coventry Transplant Network for a period of three years effective December 1, 2008.

Because the case rates were updated and the experience under this arrangement was favorable over the last year, staff recommended that the Commission approve the request for a one year period, effective December 1, 2008, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

MedStar Health – 2010A

On December 1, 2008, MedStar Health filed an 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 effective December 1, 2008.

Although there has been no activity reported, staff continues to believe that the Hospital can achieve favorable performance under this arrangement. Therefore, staff recommended that the Commission approve the Hospital's request for continuation of the arrangement for one year effective December 1, 2008, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
FINAL RECOMMENDATION - CHANGES TO THE UNCOMPENSATED CARE FUNDING METHODOLOGY

Mr. Murray stated that the idea to develop a broader and more equitable financing of uncompensated care (UCC) burden has been considered for a long time, and in1994, the Commission received legislative authorization to do so. As a first step, a compromise partial pooling of UCC methodology was implemented. Now, the industry is moving to what was originally contemplated, full pooling of UCC, which shares the burden of UCC most broadly and most equitably.

Mr. Murray noted that there is one slight change from the draft recommendation for modifying the Commission's mechanism for funding uncompensated care (UCC). Staff is awaiting word from the AELR Committee on the effective date of the amendment to the regulation to implement the change in methodology. If the effective date of the amended regulation is made retroactive to December 1st , the move to full pooling of UCC can be made in December 2008 rather than January 2009. This would save the Medicaid Program an additional $400,000 to $500,000.

Staff's final recommendation was that contingent upon an effective date of December 1st for the amended regulation: 1) 100% of all approved levels of UCC would be pooled effective December 2008; 2) beginning December 2008 the mark-ups of high UCC hospitals would be lowered to the state-wide UCC level; 3) also beginning December 2008, the high UCC hospitals would receive monthly 1/12 of the difference between their approved UCC level and the state-wide level from the UCC fund; 4) beginning in January 2009, low UCC hospitals will remit monthly to UCC Fund 1/12 of the difference between its approved UCC level and the state-wide UCC level; and 5) staff would work closely with hospitals and payers to ensure that the proposal

is revenue neutral and cash flow neutral.

Mr. Murray noted that full pooling, although revenue neutral to hospitals, will save Medicaid money because it re-distributes the financing of UCC in a broader way.

Commissioner Sexton asked Mr. Murray to elaborate on how full pooling saves Medicaid money.

Mr. Murray explained that hospitals, particularly those in the inner city, that have the largest percentage of Medicaid patients, also have the highest UCC provisions in their rate structures, and Medicaid pays those higher rates. However, by redistributing the UCC burden equally across hospitals, the UCC provision in the rates of hospitals with a high percentage of Medicaid patients is lowered, and Medicaid, therefore, pays less.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
OVERVIEW OF THE RECOMMENDATIONS OF THE TASK FORCE ON HEALTH CARE ACCESS AND REIMBURSEMENT

Ben Steffen, Deputy Director-Data Systems of the Maryland Health Care Commission, presented an overview of the draft report of the Task Force on Health Care Access and Reimbursement on approaches to promote primary care physician practice formation in Maryland and in particular the recommendations (attachment B) pertaining to the HSCRC.

Mr. Steffen reported that over the last two years, two task forces have been studying physician access, reimbursement, and supply issues. The first task force looked at several issues including lower physician compensation because of insurance market concentration, the market for physician services, performance systems implemented by payers, and the amount of UCC contributed to physician supply and access in Maryland. The second task force focused on physician access, reimbursement, and supply issues in rural areas.

Among their recommendations, the task forces proposed that the HSCRC establish a program to allow primary care physicians practicing in state-defined shortage areas to be eligible for student loan repayment in exchange for a commitment to practice in the shortage area. Under the recommendation the Commission should establish the program provided that: 1) it is in the public interest; 2) is not in violation of the state's Medicare waiver; and 3) it does not result in significantly increasing costs to Medicare or places the Medicare waiver in jeopardy. The program would be funded by all payers through an amount included in hospital rates not to exceed 0.1 percent of hospital net patient revenue. In addition, rate setting funds may also potentially be utilized for a "grow your own program," i.e., a program to establish scholarship programs for medical students who agree to return and practice in underserved rural areas for 3 to

5 years.

The task forces suggested several funding models to implement the loan repayment program, including: 1) a Nurse Support Program I approach, i.e., one that provides additional funding to hospitals based on detailed proposals for use of funds; 2) a Nurse Support Program II approach, i.e., one that establishes a fund within the Maryland Higher Education Commission, which utilizes its expertise to administer the program; and 3) a fund within the HSCRC as utilized for other HSCRC programs.

The Chairman asked Mr. Steffen to explain why the HSCRC, a hospital rate setting body, should be involved with funding an initiative benefiting physicians not employed by hospitals.

Mr. Steffen replied that 30 states have established loan repayment programs. Since this program is targeted at under-served areas, the rationale for using hospital funds is that hospitals need an adequate supply of physicians so that they can operate effectively.

The Chairman directed Mr. Murray to come back to the Commission with an analysis of the proposed program.

ITEM VII
LEGAL REPORT

Regulations

Proposed

Uniform Accounting and Reporting System for Hospitals and Related Institutions – COMAR 10.37.01.02

The purpose of this amendment 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.

Rate Application and Approval Procedures - COMAR 10.37.10.26

The purpose of this action is to require hospitals to file their internal and external credit and collection policies with the Commission annually and to authorize penalties for failure to file on a timely and completed basis.

The Commission voted unanimously to forward the proposed regulations to the AELR Committee for review and publication in the Maryland Register.

Final Adoption

Rate Application and Approval Procedures – 10.37.10.04-2

The purpose of this action is to include a description of the Commission's new outpatient Charge-per-Visit methodology within the existing case target methodology description.

The Commission voted unanimously to adopt the amended regulation.

ITEM VIII
HEARING AND MEETING SCHEDULE

January 14, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
February 4, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 9:54 a.m.