452nd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

JANUARY 14, 2009

Chairman Young called the meeting to order at 9:32 a.m. Commissioners Joseph R. Antos, Ph.D., Raymond J. Brusca, J.D., James Lowthers, and Kevin J. Sexton were also present.

ITEM I
REVIEW OF THE MINUTES OF THE EXECUTIVE AND PUBLIC SESSIONS OF DECEMBER 10, 2008

The Commission voted unanimously to approve the minutes of the December 10, 2008 Executive Session and Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, updated the Commission on the progress of several major projects. Mr. Murray stated that at the request of the Governor, staff will review hospital credit and collection activities as reported in the Baltimore Sun article. Staff's review will focus on: 1) variations in the policies; 2) whether there is a lack of restrictions in Maryland on the policies compared with other States; 3) whether hospitals apply their credit and collection and financial assistance policies and procedures consistently; 4) how they write-off bad debts, and what they do with recoveries of bad debts; and 4) break-downs in communication and information for patients who fall through the cracks, are overwhelmed by the court system, and did not know the rights and remedies available to them.

Mr. Murray stated that staff will address these four areas by: 1) evaluating the trends in uncompensated care, both charity care and bad debts; 2) reviewing individual hospital credit and collection and financial assistance policies to determine the range of variation; 3) evaluating the consistency by which hospitals are applying their current policies; 4) determining how hospitals are handling bad debt recoveries; 5) seeing if there are things that can be done by hospitals or by the HSCRC to ensure that patients are more adequately informed of their legal rights and remedies; and 6) evaluating the HSCRC's own Uncompensated Care Policy to determine whether there should be a differentiation in funding between charity care and bad debts.

Mr. Murray noted that staff will likely be conferring with members of the legislature to determine what can be handled through regulation and policy changes, and what changes may be effectuated through legislation. There will be a short-term component and a longer-term

component to staff's review. The short-term component will consist of getting an understanding of the problem and reporting back to the Governor in February. In the longer-term, three to six months, staff will try to complete some of the more detailed data collection and analysis. Staff will keep the Commission apprised of its progress on these issues.

Mr. Murray updated the Commission on the activities of the Maryland Hospital Acquired Conditions (MHAC) Initiative Workgroup. The MHAC initiative links quality outcomes to payment. Mr. Murray stated that the focus for the last several months has been on the data elements. Staff presented the results of a simulation using discharge abstract payment data from last year and the new present upon admission indicator in the context of the objectives and principles of the proposed policy. These results were presented to the workgroup and to individual hospitals for review. Next, the workgroup will meet with hospitals representatives to review the simulations in order to refine the methodology. Staff anticipates bringing a draft recommendation to the Commission in the near future.

Mr. Murray stated that the Evaluation Workgroup of the broader quality initiative continues to refine its process measures methodology. In addition, Steve Ports, Principal Deputy Director-Policy and Operations, reported that the workgroup is also looking at outliers in the fifty-two MHACs beyond the twelve addressed in the MHAC initiative, as well as at potentially preventable admissions for potential payment adjustment in future outcome measure quality methodologies. In addition, for FY 2011 the workgroup is examining an "appropriateness model," which would require hospitals to demonstrate satisfactory performance on several process measures simultaneously in order to achieve rewards.

Commissioner Sexton requested that staff continue to evaluate the use of payment bundling, involving other non-hospital providers via alternative rate arrangements, in future quality initiatives.

Mr. Murray announced that staff will meet with hospital and payer representatives on January 26th to discuss preliminary proposals on the new three-year payment arrangement. Mr. Murray noted that "Market Basket" inflation is currently running at 1.59%.

Mr. Murray acknowledged the outstanding efforts of staff members Brian Morton, Myles Uszerowicz, and Bill Huff in getting out final rate orders, which include the Charge-per Case targets, the new Charge-per Visit targets, as well as the re-calculation of all hospitals' rates implementing full uncompensated care pooling.

ITEM III
DOCKET STATUS CASES CLOSED

1999A – University of Maryland Medical Center 2008A – Johns Hopkins Health System
2010A- MedStar Health

ITEM IV
DOCKET STATUS CASES OPEN

University of Maryland Medical Center – 1985A

On June 4, 2008, the University of Maryland Medical Center filed an application for approval for its continued participation in a global rate arrangement for liver and blood and bone marrow transplants with Cigna Health Corp.

Staff found that the experience in FY 2008 under this arrangement was unfavorable. The Hospital pointed out that one bone marrow transplant case was responsible for unfavorable performance. The patient in this case developed a rare complication, and the case generated charges 5 times greater than the average for these cases. However, the experience for the first quarter of FY 2009 was favorable, although it included only one case.

Based on its finding, staff recommended that Commission approve the Hospital's request to continue this arrangement through June 30, 2009, but that participation beyond that date be based upon continued favorable experience in FY 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 – 2012A

On December 24, 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 participate in a global rate arrangement for cardiovascular services with Olympus Managed Health Care, Inc. for a period of three years effective January 1, 2009.

After review of the data utilized to calculate the case rates, staff is satisfied that the global price is sufficient to achieve favorable performance under this arrangement.

Therefore, staff recommended that the Commission approve the Hospitals' request for a one year period, effective January 1, 2009, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Baltimore Washington Medical Center – 2011R

On December 24, 2008, Baltimore Washington Medical Center filed an application requesting that the approved rates of its Intensive Care Unit (MIS) and its Coronary Care Unit (CCU) be combined effective December 1, 2008. The Hospital stated that the units provide similar services and have similar staffing needs. In addition, the two units will be physically combined in the Hospital's new patient tower. The request is revenue neutral and will not result in any additional revenue for the Hospital.

After reviewing the application, staff recommended that the request be approved, and that the Hospital's approved CCU and ICU rates be combined into one rate effective December 1, 2008.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
DRAFT RECOMMENDATIONS ON CHANGES TO THE ICC/ROC METHODODOLOGY

John O'Brien, Deputy Director-Research and Methodology, reviewed in detail staff's draft recommendation on changes to the Inter-hospital Cost Comparison (ICC) and Reasonableness of Charges (ROC) methodologies (attachment A). Principal changes included: 1) blending the Charge-per-Case and Charge-per-Visit targets into a single Comprehensive Charge Target; 2) combining inpatient and outpatient case-mix indices into a single adjustment; 3) including regression based adjustments for Indirect Medical Education and Disproportionate Share in the ROC methodology; 4) utilizing 100% of the direct cost per resident in the Direct Medical Education adjustment in the ROC calculation; 5) replacing the peer group capital adjustment with a state-wide capital adjustment. In addition, staff recommended: 1) that no spenddowns be imposed based on the 2009 ROC, but that, instead, the FY 2010 update factor be scaled; 2) that only one ROC be released in 2009; and 3) that staff work with the industry and payers to develop the integration of the ROC and ICC methodologies.

Comments on the proposed methodology changes are to be received at the Commission's offices on or before January 30, 2009.

Ing-Jye Cheng, Assistant Vice President of the Maryland Hospital Association, stated that since this is the first time the entire package of methodology changes has been presented, that the Commission grant a thirty day comment period, and that public comments be allowed at the February public meeting. Ms. Cheng also made a request that all hospitals be allowed to re-submit their intern and resident data for use in the FY 2009 ROC.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, expressed agreement with the draft recommendation, and that there should be a 30-day comment period. In

addition, Dr. Cohen stated that staff should explore the use of a state-wide ROC peer group for all hospitals, except for the two academic medical centers, Johns Hopkins Hospital and University of Maryland Medical Center, which should be compared to a national peer group. Dr. Cohen also supported no spenddowns and scaling this year, with the caveat that there be more definitive linking of performance and reimbursement next year.

ITEM VI
REVIEW OF ADDITIONAL ELEMENTS TO BE INCLUDED IN THE INPATIENT AND OUTPATIENT DISCHARGE DATA COLLECTION

At the October public meeting, amendments were promulgated to regulations, COMAR 10.37.04 and COMAR 10. 37.06 These regulations detail the inpatient and outpatient data sets to be submitted to the Commission. The proposed amendments give the Commission the ability to make changes in the data elements in the data sets without amending the regulations each time such a change is made. Charlotte Thompson, Associate Director-Policy Analysis and Research, presented for comment the first proposed data element changes (attachment B). Comments are to be received at the Commission's offices on or before February 13, 2009.

ITEM VII
REQUEST BY THE MEDICAL ASSISTANCE PROGRAM TO SUSPEND THE RECONCILIATION OF CURRENT FINANCING DEPOSITS

Because of the current State budget crisis, the Medical Assistance Program (MAP) requested that the Commission approve an exception to the requirement in the current financing methodology that the working capital funds deposited with each hospital be re-calculated annually in order to earn the prompt payment discount. MAP requested that the re-calculation of the deposit be suspended for one year (FY 2009).

Staff recommended approval of MAP's request.

The Commission voted unanimously to approve staff's recommendation.

ITEM VIII
STAFF RECOMMEDNATION – KENNEDY KRIEGER INSTITUTE REPORTING REQUIREMENTS

Dennis N. Phelps, Associate Director-Audit & Compliance, reported that at its July 1, 1974 public meeting, the Commission voted to exempt the Kennedy Krieger Institute from Commission rate-setting. The chief reason the Hospital was granted the exemption was because of its unique funding sources, i.e., an unusually large percentage of its revenue was provided by grants, endowments, and governmental payers who were not required to pay Commission-approved rates. When the exception was granted, the Hospital was not required to file any

financial reports.

Mr. Phelps asserted that staff believes that it is appropriate that the Commission be aware of the financial position of all hospitals under its jurisdiction, including Kennedy Krieger. In addition, staff believes that Kennedy Krieger should be required to provide evidence that its sources of revenue continue to justify its exemption from rate-setting.

Therefore, staff recommended that Kennedy Krieger Institute be required to: 1) immediately file audited financial statements for its most recent fiscal year; 2) submit the applicable schedules from its most recent Medicare Cost Report or other appropriate documentation, subject to the approval of staff, which discloses its sources of revenue for its most recent fiscal year; and 3) annually, 120 days after the end of its fiscal year, provide audited financial statements and documentation to justify its continued exemption from Commission rate-setting.

The Commission voted unanimously to approve staff's recommendation.

ITEM IX
LEGAL REPORT

Regulations

Proposed

Rate Application and Approval Procedures - COMAR 10.37.10.26

The purpose of this action is to change the interest or late payment charges that a hospital may add to a bill to those payers and self-paying patients not subject to the prompt payment claims provision of the Insurance Article.

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

ITEM X
HEARING AND MEETING SCHEDULE

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

There being no further business, the meeting was adjourned at10:45 a.m.