

**Executive Session Minutes
of the
Health Services Cost Review Commission**

July 11, 2012

Upon motion made, Chairman Colmers called the meeting to order at 9:13 a.m.

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

In attendance, in addition to Chairman Colmers, were Commissioners Antos, Bone, Keane, Loftus, and Mullen.

Patrick Redmon, Steve Ports, Jerry Schmith, and Dennis Phelps attended representing staff.

Also attending were Stan Lustman and Leslie Schulman Commission Counsel.

Item One

The Executive Director updated the Commissioners and the Commissioners discussed the progress of the waiver test modernization process and the current status of the waiver test.

The Executive Session was adjourned at 9:37 a.m.

MINUTES OF THE
490th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

July 11, 2012

Chairman John Colmers called the meeting to order at 9:40 a.m. Commissioners Joseph R. Antos, Ph.D., George H. Bone, M.D., Jack C. Keane, Bernadette C. Loftus, M.D., and Thomas R. Mullen were also present.

END OF COMMISSIONER ANTOS' TERM

Chairman Colmers announced that today's meeting was likely the final meeting of Commissioner Antos' eight year term. The Chairman stated that Commissioner Antos served the citizens of Maryland with great commitment and distinction, and that he will be sorely missed.

REPORT OF THE EXECUTIVE SESSION OF JULY 11, 2012

Dennis N. Phelps, Associate Director-Audit & Compliance, summarized the minutes of the July 11, 2012 Executive Session.

ITEM I
EXECUTIVE AND PUBLIC SESSIONS OF JUNE 6, 2012

The Commission voted unanimously to approve the minutes of the June 6, 2012 Executive and Public Sessions.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Patrick Redmon, Ph.D., Executive Director, reported that Monitoring Maryland Performance (MMP) indicated that the rate of growth in charge per case increased by 6.65% for the year ended April 2012 compared to the year ended April 2011, which is substantially down from the 8.9% reported three months ago. Dr. Redmon noted that for that same period, the number of inpatient cases declined by 3.75%; inpatient revenue increased by 2.65%; outpatient revenue increased by 11.74%; and total revenue increased by 5.79%. According to Dr. Redmon, on a month-to-month basis, charge per case decreased 2.66% for April 2012 over April 2011 with total revenue increasing 1.57%. For the first ten months of FY 2012 (July 2011 through April 2012), charge per case increased 6.12% as cases decreased by 3.42%, while inpatient and outpatient revenue increased by 2.49% and 11.57% respectively.

Dr. Redmon related that staff recently received a waiver test letter from the Centers for Medicare and Medicaid Services (CMS) with the results for the period from January 1, 1981 through March 31, 2011. The letter indicated that the relative waiver test cushion was 6.98%, i.e., if payments nationally were unchanged going forward, payments per discharge in Maryland could rise by 6.98% before failing the test. Dr. Redmon noted that the relative waiver test cushion was down from 9.13% in the last letter. However, based on trends, recent Commission actions, and current federal law, staff estimates that the waiver cushion at the end of FY 2013 will be 1.15%.

HONORING FORMER CHAIRMAN CHARLES O. FISHER, SR

Sadly, Chairman Colmers reflected on the passing last month of Charles O. Fisher, Sr. the Commission's longest serving Chairman. Mr. Colmers stated that he felt a particular honor in occupying the seat that Mr. Fisher once held, having served as Executive Director of the Commission when Mr. Fisher was Chairman. Mr. Colmers noted that Mr. Fisher was his boss, his mentor, and his friend for many years. Mr. Colmers stated that those who knew Mr. Fisher considered him a paragon of virtue and honor. He served his community in a remarkable fashion throughout his entire life. According to Mr. Colmers, Mr. Fisher steered the Commission through some difficult times in the late 1980s and 1990s. Chairman Colmers asked that a moment of silence be observed in memory of Charles O. Fisher, Sr.

ITEM III

DOCKET STATUS CASES CLOSED

2157N – Levindale Hospital	2158N - Civista Medical Center
2159N - Civista Medical Center	2161A - Johns Hopkins Health System
2162A - Johns Hopkins Health System	

ITEM IV

DOCKET STATUS CASES OPEN

Maryland General Hospital – 2160N

On May 12, 2012, Maryland General Hospital (“MGH”) filed a partial rate application with the HSCRC requesting the establishment of new rates for Chronic Care (CHR), Respiratory Dependent Care (RDS), and Recreational Therapy (REC) to be effective July 1, 2012. This application was necessary because of the relocation of 76 chronic care beds from University Specialty Hospital which is closing.

After review and analysis, staff recommended the following:

- 1) That a CHR rate of \$478.10, per patient day, be approved effective July 11, 2012;
- 2) That a RDS rate of \$1,002.23, per patient day, be approved effective July 11, 2012;

- and
- 3) That a REC rate of \$84.02, per RVU, be approved effective July 11, 2012.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2163A

Johns Hopkins Health System ("System") filed an application with the HSCRC on May 30, 2012 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with INTERLINK Health Services, Inc. for a period of one year beginning July 1, 2012.

The staff recommended that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period commencing July 1, 2012; and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation with Chairman Colmers recusing himself from the discussion and vote.

Calvert Memorial Hospital – 2164N

On June 12, 2012, Calvert Memorial Hospital ("Hospital") submitted a partial rate application to the Commission requesting a rate for Magnetic Resonance Imaging (MRI) services to be provided on-site to both inpatients and outpatients. This rate will replace the Hospital's currently approved rebundled MRI rate utilized to bill for off-site MRI services provided to inpatients of the Hospital. The Hospital requested the lower of a rate based on its costs and volumes, or the statewide median for MRI services. The effective date requested was July 1, 2012.

After reviewing the Hospital's application, the staff recommended:

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days before the opening of a new service be waived;
2. That an MRI rate of \$42.45 per RVU be approved effective July 1, 2012;
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 cost experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

University of Maryland Medical Center – 2165A

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on June 12, 2012 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for liver and blood and bone marrow transplants for a period of one year with Cigna Health Corporation beginning July 1, 2012.

The staff recommended that the Commission: 1) waive the requirement that an application be filed 30 days prior to the effective date of an alternative rate determination arrangement; and 2) approve the Hospital's application for an alternative method of rate determination for liver and blood and bone marrow transplant services, for a one year period commencing July 1, 2012; and 3) that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

University of Maryland Medical Center – 2166A

University of Maryland Medical Center (UMMC, or "the Hospital) filed a renewal application with the HSCRC on June 12, 2012 for an alternative method of rate determination pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for the collection of peripheral blood stem cells from donors for a period of one year with the National Marrow Donor Program (NMDP) beginning July 1, 2012.

The staff recommended that the Commission: 1) waive the requirement that an application be filed 30 days prior to the effective date of an alternative method of rate determination arrangement; and 2) approve the Hospital's application for an alternative method of rate determination for the collection of peripheral stem cells for one year commencing July 1, 2012 that the approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU").

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2167A

Johns Hopkins Health System ("System") filed an application with the HSCRC on May 15,

2012 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for participation in a global rate arrangement for solid organ and bone marrow transplant services with Blue Cross Blue Shield Blue Distinction Centers for Transplants for a period of one year beginning May 1, 2012.

The staff recommended that the Commission: 1) waive the requirement that alternative applications be filed 30 days before the proposed effective date; 2) approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period commencing May 1, 2012; and 3) approve the application contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation with Chairman Colmers recusing himself from the discussion and vote.

ITEM V
FINAL RECOMMENDATION REGARDING FY 2011 AVERTED BAD DEBT
RECONCILIATION, RECONCILIATION POLICY BEGINNING FY 2012, AND
ADDRESSING NET COST CONTAINMENT AMOUNTS RELATED TO THE FY 2013
MEDICAID BUDGET

Jerry Schmith, Deputy Director-Hospital Rate Setting, summarized staff's recommendations for the reconciliation of the estimated FY 2011 Averted Bad Debts to actual and the proposed Averted Bad Debt Policy for FY 2012 and Beyond (see "Averted Bad Debt: Options for Reconciliation of FY 2011 Averted Bad Debt Estimates to Actual and Averted Bad Debt Policies for FY 2012 and Beyond" on the HSCRC's website).

Staff's recommendations for settling FY 2011 averted bad debt included: 1) projecting charges for June 2012 using claims from May 2012; 2) employing altered lower use and crowd out rates of 9% and 18.22% respectively in calculating averted bad debt for FY 2011; and 3) reducing hospitals' FY 2012 HealthCare Expansion assessment by the difference between actual averted bad debt and the assessment amount, \$18.1 million.

Mr. Schmith noted that although there will be no reconciliation of expected to actual averted bad debt for FY 2012 (legislation mandates a uniform 1.25% of projected regulated net patient revenue for each hospital), the Maryland Hospital Association and hospital representatives have expressed interest in continuing the claim-specific reconciliation process at least in FY 2012 to equitably align the expected averted bad debt amount in each hospital's rates with the actual averted bad debts.

In order to perform the claim-specific reconciliation, staff recommended that for FY 2012: 1) the Commission facilitate the dissemination of Medicare expansion claims from the Department of Health and Mental Hygiene to hospitals; and 2) the Commission apply the crowd out and lower

use rates utilized in FY 2011 to calculate actual averted bad debt.

Traci LaValle, Assistant Vice President-Financial Policy of the Maryland Hospital Association (MHA), noted that as in FY 2010 reconciliation, the key assumptions - - lower use rate and crowd out - - cannot be verified. If, for example, the lower use rate utilized in the original assumption was too high, according to Ms. LaValle, the assessment was set too high and the excess assessment funded the Medicaid budget short-fall. Ms. LaValle noted that there seems to be a trend - - i.e., the assessments in FY 2010 and 2011 were set too high, and the assessments for FY 2012 is probably set too high. Ms. LaValle observed that the line between whether the assessment are funding Medicaid expansion or are funding the overall Medicaid budget deficit has become blurry. However, in the spirit of cooperation and the need to focus on other priorities, MHA accepts staff's recommendations.

Commissioner Antos asked Ms. LaValle how do we know that hospitals overpaid if the assumptions cannot be calculated.

Ms. LaValle stated that according to the assumptions that we agree on, the assessment is still too high for FY 2011. If you look at how much the assessment has increased, how much the charges have increased, and the decline in the use rate, the trends just do not match up.

According to Mr. Schmith, both the hospitals and Medicaid made credible arguments; the problem then is deciding what number is reasonable. In the spirit of cooperation, staff, the hospitals, and Medicaid agreed to settle on these assumptions.

Commissioner Keane asked Mr. Schmith whether the change in the lower use rate is based on actual evidence.

Mr. Schmith stated that there was evidence that the use rate had declined. The problem that we had was we didn't know exactly what was causing the decline.

Commissioner Keane stated that what was concerning was that when we base a methodology prospectively on a set of assumptions and estimates, and then we retroactively change those estimates without very strong evidence that the original estimates or assumptions were wrong, two things happen: first, a lot of pressure is put on staff to acquiesce to a compromise, and secondly, the Commission undermines its own reputation as independent fact finders as opposed to Commissioners that compromise in situations where there are budgetary pressures, in this case, pressure from Medicaid. Mr. Keane stated that he strongly recommends that the Commission adopt a policy not to make such a change without strong evidence that the original estimates or assumptions were wrong. According to Commissioner Keane, it appears that there was no such strong evidence in this case.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
FINAL RECOMMENDATION ON THE CONTINUANCE OF, AND FUTURE
MODIFICATIONS TO NSP I

Claudine Williams, Associate Director-Policy Analysis and Research, summarized staff's final Report on Nurse Support Activities for FY 2007 – FY 2012 and Recommendations for Refunding (see "Final Report on Nurse Support Activities for FY 2007 – FY 2012 and Recommendations for Refunding" on the HSCRC's website).

The recommendations included: 1) work towards increasing the number of advanced degree nurses, demonstrate the link between improved nursing competency and patient outcomes; and support activities that advance the practice of nursing; 2) improve the application process; 3) revise the annual report to include 5-10 focused and well defined metrics; and 4) improve the oversight and monitoring of the NSP I program through routine site visits and budget audits.

Chairman Colmers asked what the timing was in letting hospitals know what the metrics are prior to their submission.

Ms. Williams stated that the metrics will be selected in the fall. In the winter, hospitals will submit commitment letters describing their programs and the metrics to be reported. The metrics then would be reported beginning FY 2014.

Commission voted unanimously to approve staff's recommendation.

ITEM VII
REPORT ON OUTPATIENT COST AND VOLUME TRENDS

In response to the Commission's charge to investigate, develop, and implement a new or modified outpatient revenue constraint system, Mary Beth Pohl, Deputy Director – Research and Methodology, stated that staff has begun investigating trends in the growth of outpatient services. Ms. Pohl provided several preliminary analyses indicating the overall growth of outpatient revenue versus inpatient revenue, growth in volume and revenue by rate center, and growth and volume grouped by ambulatory center (see "Outpatient Growth Analysis – July 11, 2012 – Final" on the HSCRC's website).

Chairman Colmers asked whether staff was able to determine increases in volumes associated with physician practices converting to hospital clinics.

Ms. Pohl noted that although staff believes that converting practices to clinics as well as bringing in more physicians to practice in regulated clinics are drivers of volume increases, their impact has not been determined.

Ms. Pohl also noted that TPR hospitals have the effect of dampening the volume increases in the

analyses because TPR hospitals have the incentive to reduce volumes. Consequently, staff will exclude TPR hospitals from future growth analyses.

Commissioner Keane asked how much of the increase in clinic visits is the result of recent substantial increases in the number of physicians employed by hospitals.

Ms. Pohl stated that she did not have that information; however, if hospital employed physicians were brought into practice in regulated hospital clinics, there would be volume growth.

Dennis Phelps, Associate Director-Audit & Compliance, stated that in the last five years, there had been a substantial number of hospital-owned physician practices converted to hospital clinics.

Commissioner Keane stated that it would be reasonable to assume that if a physician practice moved to a regulated clinic, the cost would increase. Commissioner Keane observed that if we move to a per capita waiver test, the Commission must provide hospitals with the incentive to control total costs, as in TPR hospitals, and not the incentive to increase revenue by moving outpatient services into hospitals as is now the case for non-TPR hospitals.

Commissioner Mullen pointed out that there is a decrease in physician reimbursement when physicians move from private practice to a clinic setting.

Commissioner Keane observed that providing outpatient services in the hospital is still, in most cases, the more costly option.

Chairman Colmers asked if staff were any closer to identifying what type of outpatient constraint system should be adopted.

Dr. Redmon stated that the purpose of this exercise is to determine what specific areas to focus on. Clinic was one of the areas. This is our first cut. We are not ready to provide the Commission with a process today. Our goal is to do more data analyses and to come back and discuss the findings.

ITEM VIII **LEGAL REPORT**

Regulations

Proposed

Rate Application and Approval Procedures – COMAR 10.37.10.26

The purpose of this amendment is to permit patients of other means-tested social service programs to be deemed presumptively eligible for free care.

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

Final Adoption

Rate Application and Approval Procedures – COMAR 10.37.10.26

The purpose of this action is to notify hospital inpatients and outpatient of the potential for separate bills for hospital and physician services provided at the hospital.

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

ITEM XII
HEARING AND MEETING SCHEDULE

August 1, 2012

Meeting Cancelled

September 5, 2012

Time to be determined, 4160 Patterson Avenue,
HSCRC Conference Room

There being no further business, the meeting was adjourned at 10:42 a.m.