444TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

April 22, 2008

Chairman Donald A. Young, M.D. called the meeting to order at 9:04 a.m. Commissioners Joseph R. Antos, Ph.D., Raymond J. Brusca, J.D., Trudy R. Hall, M.D., Kevin J. Sexton, and Herbert Wong, Ph.D. were also present.

The Chairman introduced the new Commissioner Herbert Wong, Ph.D. Dr. Wong is currently a senior economist with the Agency for Healthcare Research and Quality. Dr. Wong received his Ph.D. and MA in Economics from Northwestern University, and his Bachelors Degree from Brandeis University.

ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC SESSION OF MARCH 5, 2008

The Commission voted unanimously to approve the minutes of the March 5, 2008 Public Meeting.

COMFORT ORDER- HOWARD COUNTY GENERAL HOSPITAL

The Commission unanimously voted to ratify their approval in Executive Session of Howard County General Hospital's request for a Comfort Order.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, introduced two new staff members Andrea Strong and Dianne Feeney. Ms. Strong is the latest addition to the Audit & Compliance staff. Ms Strong comes to us from Johns Hopkins Medicine where she was a financial analyst in the Department of Dermatology. Ms. Feeney is the new Associate Director – Quality Initiative. Ms. Feeney has extensive experience in the area of health care quality as both a clinician (she is a nurse), as well as someone with first-hand knowledge of various health care quality and reimbursement related initiatives across the country. Ms. Feeney was a senior vice president at the National Quality Forum, and also served as a vice president with the Delmarva Foundation.

Mr. Murray reported that a draft recommendation regarding the Quality-Based Reimbursement Project will be presented at the May 14th public meeting. The recommendation will describe the structure of the methodology, i.e., data measures, performance assessment model, and hospital

performance score. It will also describe funding parameters, translating scores into payment, as well as data related issues and future activity. A final recommendation is expected to be presented at the June 4th public meeting for implementation in FY 2009.

ITEM III
DOCKET STATUS CASES CLOSED

None

ITEM IV
DOCKET STATUS CASES OPEN

University of Maryland Medical Center- 1971A

On March 12, 2008, University of Maryland Medical Center submitted applications requesting approval to continue to participate in global rate arrangements: 1) for solid organ and bone marrow transplant services with United Resources Network for a period of one year, retroactive to November 1, 2007; and 2) for solid organ, gamma knife, and blood and bone marrow transplant services with Aetna Health, Inc., retroactive to August 1, 2007.

Because last year's experience under these arrangements was unfavorable, the Hospital took actions to ensure that future payments would be commensurate with costs.

After discussions with Hospital representatives, review of the terms of re-negotiated contracts, and projections of contract revenue and costs, staff recommended that the Commission approve the Hospitals' request for continuation of both arrangements for a period of one year. In addition, staff recommended that the approvals be contingent on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Mount Washington Pediatric Hospital – 1973R

On February 19, 2008, Mount Washington Pediatric Hospital submitted a partial rate application requesting an Interventional Cardiology (IVC) rate for its PICC line placement service. The Hospital requested the state-wide median IVC rate plus inflation be approved effective March 15, 2008.

After review of cost information proved by the Hospital, staff recommended that an IVC rate of $11.17 per RVU be approved rather than the state-wide median rate of $15.91 per RVU effective March 15, 2008. In addition, staff recommended that: 1) COMAR 10.37.10.07, requiring that rate applications be made 60 days prior to the opening of a new service be waived; 2) that no change be made in the Hospital's charge per case target for the new IVC service; and 3) that the

IVC 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.

Johns Hopkins Health System – 1975A

On March 17, 2008, the Johns Hopkins Health System, on behalf of its member hospitals, filed an application requesting approval for continued participation in a global rate arrangement for cardiovascular procedures with Global Excel

Because last year's experience was favorable, staff recommended that the Commission approve the Hospital's request and 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
FINAL RECOMMENDATION ON CASE MIX ADJUSTMENTS FOR FY 2008

John O'Brien, Deputy Director-Research and Methodology, presented the final recommendation on case mix adjustments for FY 2008. Mr. O'Brien reported that the rate agreement allows for case mix growth of up to 1.0%.

Mr. O'Brien stated that based on one quarter of complete final data and one quarter of preliminary data, case mix growth appears to be growing at a rate of approximately 0.3%. This means that it is highly likely that case mix growth will fall below 1%. This will allow the Commission flexibility in other areas. Therefore, staff recommends: 1) that there be no case mix governor; 2) that while there are hospitals that would be subject to spend-downs as a result of the April Reasonableness of Charges (ROC) analysis, no spend-downs should be implemented; and 3) that hospitals eligible to apply for full rate reviews be permitted to do so. Mr. O'Brien noted that the lower than anticipated case mix growth will improve Maryland's position in relation to the Medicare waiver.

Mr. O'Brien noted that consistent with FY 2007 policy, staff recommends that hospitals that experience a case mix decline in FY 2007 be allowed ungoverned case mix growth in FY 2008 for the amount of their decline in FY 2007. In addition, staff proposed that if total case mix change is 1.0% or less, hospitals will receive their measured case mix with no adjustments; if measured case mix change is greater than 1.0%, hospitals experiencing positive case mix growth will receive a case mix adjustment proportionate to their revenue, such that total case mix growth will be 1.0%.

Mr. O'Brien stated that staff's rationale for allowing case mix to be what it is, is that the 1% case mix component was an allowance that was capped in order to limit the effect of increases in

coding associated with the move to APR-DRGs. Allowing hospitals to receive their actual case mix change should reflect actual changes in resource use. Funding should not be provided to hospitals for resource use that did not occur.

Paul Sokolowski, Vice President of the Maryland Hospital Association, concurred that case mix growth in FY 2008 appears to be real, and that lower case mix growth puts money "in the bank" for other contingencies. Mr. Sokolowski stated that if case mix does exceed 1% in 2008, the industry believes that hospitals with case mix decreases should be governed symmetrically on the down side.

Mr. O'Brien stated that staff was opposed to making the governor symmetrical because it would penalize hospitals with real, demonstrated resource use increase.

Hal Cohen, representing CareFirst and Kaiser Permanente, expressed support for the staff's recommendation.

Commissioner Sexton observed that we should be cognizant of the steps that were taken to reduce revenue because of the perceived waiver test problem.

Mr. Murray agreed and stated that staff attempted in the deliberations on the FY 2009 Update Factor to reflect the fact that we were likely to come in below the 5.2% FY 2008 Update Factor as a result of rate realignment and lower case mix growth. We are making sure that the savings are being recognized, being put "in the bank," and gaining credit on the waiver test.

Commissioner Brusca expressed concern that all of the revenue constraints imposed this year may be making it impossible for hospitals to operate at a profit.

Mr. Murray replied that staff would be addressing Commissioner Brusca's concern in its draft Update Factor recommendation.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
FINAL ICC/ROC RECOMMENDATION

John O'Brien stated that the final recommendation mirrors the draft recommendation presented at the March public meeting. Mr. O'Brien noted the ICC/ROC analysis was performed using the methodology in place.

The ICC/ROC analysis identified three hospitals that would likely qualify to request a positive full rate review and also identified approximately ten hospitals that were above all the thresholds and would likely be eligible for spend-downs under normal circumstances. However, given the modest case mix growth, staff recommends that: 1) hospitals identified by the ICC/ROC analysis as eligible for positive full rate reviews be allowed to apply, and 2) that no spend-downs or

negative scaling be applied to the rates of those hospitals that fall above the 3% threshold.

Mr. O'Brien stated that the rationale for not placing hospitals on spend-downs is two fold: 1) the ICC/ROC methodology is continuing to be refined, particularly the Indirect Medical Education (IME); and 2) hospitals above the thresholds are put on notice that they may be identified by the November ICC/ROC

Paul Sokolowski expressed MHA's support for staff's recommendation.

Dr. Cohen stated that the tradeoff between the ICC/ROC proposal for no spend-downs or scaling and the Case Mix recommendation not to allocate any remainder of the 1% case mix allowance makes sense and, therefore, he supported staff's recommendation.

Dr. Cohen also expressed concern about the Commission's methodology for handling partial rate applications for capital.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
DRAFT UPDATE FACTOR RECOMMENDATION FROM THE CORRECTIVE ACTION TASK FORCE DILBERATIONS

Robert Murray outlined in detail staff's draft analysis of the Corrective Action Task Force's (CATF) deliberations on the FY 2009 Update Factor and staff's draft recommendations. Mr. Murray stated that final recommendations would be presented at the June 14th public meeting.

Mr. Murray reported that the CATF was convened in August 2007 to craft a revision to the FY 2008 Update Factor because of concerns regarding Maryland's Medicare waiver performance. The CATF recommended lowering the Update Factor for the inpatient Charge per Case in mid-year from 6.25% to 5.25%. Since then, largely because of revisions in the National CMS forecasts and the elimination of Medicaid Day Limits in FY 2009, the waiver forecast has improved. While this is good news, staff believes that we should be prepared for impending Medicare budget cuts, which could erode the waiver cushion by 8-10% in FYs 2011-13. MHA, however, believes that when the Medicare budget cuts occur, the Maryland system can quickly respond because of the CPC methodology. Mr. Murray noted that while operationally that may be true, the debate will center on whether the contemplated system revisions will preclude the quick response alluded to by the industry.

Mr. Murray pointed out that there are five components of the Update Factor: 1) Market Basket inflation (national estimate of the inflation rate of the cost of hospital inputs from Global Insights, Inc. (GII) plus a contingency for estimation error; 2) a discretionary adjustment (to allow the Commission the flexibility to adjust from underlying Market Basket inflation, e.g., to inject addition resources into the industry to help re-capitalize or, in turn, to reduce resources to

lower the rate of growth); 3) supply and drug pass-through (the costs of outpatient supplies and drugs not constrained because outpatient services remain largely fee for service); 4) case mix on inpatient services and intensity on outpatient services; and 5) volume adjustments.

Mr. Murray summarized the current MHA and payer proposals for the FY 2009 Update Factor. MHA's proposal, which has been modified over time, is for a base update of 4.5% (made up of an inflation component of 3.5% and an intensity factor of 1.0%) and a 0.5% case mix allowance and a volume adjustment applied only to inpatient volumes.

The payer proposal includes: 1) an update based on Market Basket plus 0.2% contingency for estimating errors; 2) a case mix allowance of 1.0%; 3) the volume adjustment as approved by the Commission, i.e., applying to all volume growth; and 4) a "look-back" provision to address the issue of inflation outpacing GII Market Basket estimates. The payers have indicated that their proposal is justified because of Maryland's recent unfavorable cost performance versus the nation.

Mr. Murray detailed staff's evaluation of MHA's proposal. Regarding inflation, while MHA projected large increases in several large categories of costs, staff was unable to substantiate the magnitude of cost increases projected by MHA. However, staff believes that inflation may be running slightly ahead of the GII estimates.

As to the intensity factor, MHA describes the intensity factor as relating primarily to advances in medical technology, i.e., more intense diagnostic and therapeutic procedures, and pharmaceuticals. MHA mistakenly relates these costs to those picked up by the so-called intensity provision of 1% built into rates when DRGs were first introduced. The old intensity provision, however, was designed to handle a combination of factors, e.g., as an inducement for hospitals to accept the DRG constraint system; to cover any unmeasured case mix growth; to cover the cost of establishing new services as well as new technology. Staff believes the system today is much better able to address the types of medical intensity that concerns MHA because of the much more refined grouper, a better set of outlier policy, and pass-throughs, as well as the idea that there should be some level of constraint on technology growth over time. Also, new technology is built into rates through increases in DRG weights with a lag.

In regard to the volume adjustment, staff strongly believes that the Commission should retain the volume adjustment policy covering all volume growth in the system. MHA requests that the volume adjustment be applied to inpatient volumes. Staff notes that if the volume adjustment is not applied to outpatient volumes, the additional outpatient revenue will find its way back into inpatient revenue through rate realignment.

As to industry profitability, Mr. Murray noted that in FY 2008 operating profits have decreased from last year. Staff attributes the decline in profitability chiefly to: 1) substantial undercharging; 2) increases in inflation and in intensity; 3) unanticipated increases in payments to physicians; and 4) unanticipated increases in interest cost as a result of the credit market turmoil.

As to inflation, while staff found the proposed look-back provision to be interesting as a potential policy component, the look-back provision would be symmetrical and would address

the issue of forecast error for FY 2009 in the permanent rate base attributable to future years.

A panel consisting of Brian Gragnolati, President & CEO of Suburban Hospital, Robert Chrencik, Executive Vice President & CFO of the University of Maryland Medical System, Tom Mullin, President & CEO of Mercy Medical Center, Cal Pierson, President of MHA, and Paul Sokolowski presented MHA's response to staff's analysis regarding the FY 2009 Update Factor.

Cal Pierson summarized the important events that have occurred since the spring of 2007. Mr. Pierson noted that hospitals budgeted for FY 2008 based upon the 2007-2009 arrangement. In July of 2007, we discovered that there was a threat to the Medicare waiver. In October of 2007, the 2008 and 2008 arrangement was aborted; the HSCRC imposed a 1% rate reduction and voted to implement a volume adjustment for FY 2008. The effect was that one major hospital system has already been down-graded by the bond market at least partially by the rate reduction. The goal was to "turn the ship" in terms of the Medicare waiver test. That, in fact, has been accomplished through the temporary fix in FY 2008. Recent estimates of the waiver test show an upward trend. From the industry's point of view, the fix and the focus on the Medicare waiver test was temporary and not intended to be a continuing and permanent change. In December of 2007, second quarter financial results show weakening due to the mid-year rate reductions. Operating margins are expected to decline by 0.6% and total margin by 1.9% in FY 2008. In addition, financial markets are in turmoil. This affects hospitals' investment income, pension costs and their entire cost structures. Mr. Pierson asserted this is not the time to put additional financial constraints on hospitals.

Brian Gragnolati outlined the current environment in which Maryland hospitals are operating and the pressures that are affecting hospital profitability. Mr. Gragnolati reported that hospitals were experiencing: 1) lower volume growth; 2) rate tightening (the 1% rate reduction in FY 2008); 3) chaotic financial markets that produce lower investment returns, as well as reduced access to capital markets and high capital costs; 4) tighter labor markets; 5) the effect of intensity, i.e., things that are not recognized by the rate setting system; and 5) inflationary pressures.

Mr. Gragnolati stated that because discussions of the next three-year arrangement will begin in the fall, today's discussion by MHA will focus on FY 2009 only. We must stay focused on maintaining the hospitals' financial condition so that hospitals can re-capitalize. The hospital industry's desire is to get back to a three-year arrangement for predictability and stability purposes. The Commission in working with the payers and the hospital industry must balance the Medicare waiver, hospitals' financial condition, and the affordability of care. MHA's proposal is the industry's best attempt to put together a balanced request. Mr. Gragnolati asked that the Commission not split the difference between the payer's proposal and MHA's.

Robert Chrencik outlined MHA's rate proposal for FY 2009. The inpatient proposal of 4.77% consists of core inflation of 3.5% (lower than projected but above the GII Market Basket), a 1% intensity factor for costs not picked up in the GII Market Basket, 0.5% for case mix, and a reduction of 0.23% for the volume adjustment. The outpatient proposal of 4.5% is made up of

core inflation of 3.5% and a 1% intensity factor.

Mr. Chrencik asserted that hospitals are witnessing higher rates of inflation than the 3.11% estimated by the GII Market Basket. Some examples are: 1) wages - GII shows increases at 3.4%; other indices show 4%; however, hospitals believe they will experience a higher rate; 2) food – GII estimates <3%; recent news coverage suggests a higher rate of increase; 3) blood – GII estimates <2.5%; the Red Cross has informed hospitals that the increase will be 6%; and 4) energy – GII shows 4.2% increase; recent experience and new coverage indicates otherwise. The GII is not picking up the inflation that Maryland hospitals are experiencing.

Mr. Chrencik stated that the intensity factor is there to recognize that there are a series of hospital costs, both operating and capital, that are no adequately dealt with in the rate model. These costs include: 1) new products and devices; 2) state of the art equipment; 3) replacement of buildings and plant; 4) the credit market turmoil; 5) quality improvement mandates; 6) physician expenses; and 7) changes in labor mix. Mr. Chrencik noted that in the past, when we were transitioning from the unit rate system to a constrained revenue model (the Guaranteed Inpatient Revenue (GIR) System) there was an intensity factor. The intention was that there were costs that were passing through the system in the unit rate system that would not be passed through the GIR system.

Mr. Chrencik observed that in the rest of the nation, hospitals are able to cost-shift the short-fall in the GII to commercial payers, which cannot be done in Maryland. Mr. Chrencik stated that hospitals' financial condition is weakening, and the capital markets are concerned.

According to Mr. Chrencik, if the payer's proposal is implemented, hospital operating margins would fall below 1%, and total margins below 2%, with many bond rating down-grades for hospitals. Mr. Chrencik asked that the Commission not split the difference between the payer's proposal and MHA's, because MHA's proposal is tight and will only allow the hospital industry to hold its ground.

Tom Mullen stated that the Commission should take into consideration that the current Medicare waiver test margin projections show a substantial improvement.

Mr. Mullen asserted that the outpatient volume adjustment was not necessary because; 1) hospitals have already agreed to restrict outpatient growth through the new Guaranteed Outpatient Revenue (GOR) System, which will expand to encompass almost all outpatient care; 2) there must continue to be incentives so that care is provided in the outpatient setting where appropriate; and 3) full rates are needed to fund appropriate standard of care.

Paul Sokolowski stated that if you look at the MHA proposal relative to what was originally approved; if you look at the current status of the waiver; and, if you look at hospitals' the financial condition, then the MHA proposal is eminently fair.

Commissioner Sexton asked what staff meant about rate realignment, and whether or not an outpatient volume adjustment was made.

Mr. Murray responded that a portion of the revenue generated by not having an outpatient volume adjustment would find its way to the inpatient side through rate realignment after one year.

Commissioner Sexton asked what MHA's reaction was to the proposed "look back" issue.

Mr. Mullen stated that the look back would hurt the industry in the short run because of negative cash flow, but it would help the industry in the long run.

Commissioner Brusca stated that it appears that the CATF has some more work to do to determine a common inflation factor.

Mr. Schmith replied that there is now basic agreement on core inflation; however, MHA has added the intensity factor which includes items that are much more difficult to quantify.

Commissioner Antos commented that intensity is really the product of cost and quantity. The concept of intensity is inherently inflation.

The Chairman stated that there is a real difference in mix of services, and that intensity, in part, is the change in mix of services.

Commissioner Wong asked the MHA representatives which two or three categories (in their exhibit on page 5 of their handout) were affecting their profitability the most.

Mr. Gragnolati stated the answer as the things that they could not control, such as the mid-year rate reduction, the turmoil in the financial markets, and inflationary pressure.

According to Mr. Chrencik, the most significant thing is the introduction of the volume adjustment, which takes away hospitals flexibility. When hospitals received 100% of the revenue incremental volume growth, it was used to cover many important elements, such as unfunded capital costs, tight nursing wages, etc.

A panel of payer representatives consisting of Dr. Cohen, representing CareFirst and Kaiser Permanente, Barry Rosen, Esquire, representing United Healthcare, and John Folkemer, Deputy Secretary for Health Care Finance and Medicaid Director for the Department of Health and Mental Hygiene, presented comments on staff's analysis of the CATF's FY 2009 Update Deliberations.

Dr. Cohen observed that MHA focused on the Commission's profit targets, but the Commission has many targets, one of which is a cost target, i.e., 3-6% below the nation. Current projections indicate that Maryland's costs will be above the national average. Mathematically it is obvious that if Maryland were in fact at the bottom of the 3-6% range, profits would be well above the 2.75% target. This has never been a cost plus system. Profits must be earned by being efficient. Being efficient is associated with the cost target, not the profit targets. Profits are a result of cost efficiency.

Dr. Cohen noted that the payers' proposal on the inpatient side consists of the GII Market Basket for core inflation, plus the contingency factor, plus a case mix allowance of the lower of 1% or actual growth, less the volume adjustment (applying to all volumes). The payers propose a look-back, with no corridor and a two year lag. This, in fact, would lower the FY 2009 Update Factor by 0.18% because FY 2007 core inflation was only 0.02%, while the contingency factor built in the Update was 0.2%. Dr. Cohen expressed strong support for rate realignment. According to Dr. Cohen, if a volume adjustment is not applied to outpatient volumes, hospitals will receive more revenue permanently with a portion of the additional revenue being shifted to the inpatient side as a result of rate realignment.

Dr. Cohen stated that the payers believe that the waiver should not be a binding constraint. If the Commission came close to meeting its overall targets, and if the hospitals came close to their cost targets, the waiver would not be in jeopardy. When we enter into negotiations for the next three year arrangement, the focus should not be what is the maximum amount of money we can give hospitals and still keep a comfortable waiver margin. The issue should be what is the appropriate amount of money to give the hospitals this year and for the next three years to maintain an affordable high quality hospital system.

Dr. Cohen stated the purpose of the Commission's former 1% intensity provision/ new services factor was to bring hospitals voluntarily on to the GIR. It was given to the hospitals in the context of the Commission' attempting to achieve a goal of beating the nation in cost and revenue per case by about one and one half to two and one half percent per year. Hospital costs were then increasing at inflation plus 3%. Hospitals used the 1% to fund new services and to fund CON projects. At that time, most hospitals received the Capital Facilities Allowance, i.e., actual principal and interest on their debt, and received no inflation on their capital costs. In addition, there was also a variable cost adjustor. The new severity adjusted grouper does a much better job. It moves the measurement of sicker patients from intensity, which is within the DRGs, to severity, which is captured by the grouper and paid for. In addition, the payment system now allows hospitals to adjust their rates during the year to capture revenue, which could not be done when the former intensity factor was made available. Dr. Cohen asserted that the payers' proposal gives hospitals a 1% intensity factor on the outpatient side, but includes it within the outpatient GOR.

Barry Rosen stated the United Healthcare recommends that the Commission adopt the payer recommendation. However, if the Commission considers providing hospitals with a higher Update Factor than the payers recommend it should worry about affordability. Currently, health care is unaffordable and, ultimately, the Commission sets the price that Marylanders pay for hospital care.

Mr. Rosen pointed out that the data provided by staff indicate that the difference among Maryland hospitals' net operating revenue, net patient revenue, and cost per equivalent admission and the nation have all declined substantially since 2003. It is now, by staff's best estimate, less affordable in Maryland to receive care than in the rest of the country. And, if the

Commission adopts MHA's proposal, the affordability gap will grow. The trend is unquestionable. According to Mr. Rosen, because it is a regulated state, Maryland should be beating the market. It should not mimic the market, and it should not be beaten by the market. Mr. Rosen asserted that if the Commission adopts MHA's proposal, Maryland will be under performing the market. Mr. Rosen expressed his agreement with MHA that the Commission should not split the difference between the payers' proposal and MHA's proposal. Mr. Rosen asserted that the Commission should come out closer to the payers' proposal because it needs to beat the market.

Mr. Folkemer stated that from Medicaid's concerns were primarily about affordability. Mr. Folkemer noted that Medicaid represented a "booming" business. Over a ten year period Medicaid enrollment has gone from 450,000 to 650,000 in ten years and the new Medicaid expansion program will add an additional 30,000 in July 2008. Further, if the rest of health care reform legislation goes forward, 50,000 to 60,000 people will be added in the future. Because Medicaid pays hospital approximately $2 billion a year, it is obvious that what the Commission does today, and in the future, has a significant impact on Medicaid. All of this is going on in the context of budget constraints Medicaid's greatest concern is the impact increased payments to hospitals have on other components of the health care system. Currently, community health care providers, e.g., private duty nurses, personal care assistants, medical day care centers, the lowest paid people are received no pay increase last year. This year, they are receiving a 1.5% increase. In addition, more than 10,000 elderly and persons with disabilities, who are looking for these community services, are on waiting lists. Medicaid cannot afford to expand these services. Medicaid managed care rates have been cut 1-2% a year.

According to Mr.Folkemer, the threat is that as the Medicaid Program keeps growing and as hospital rates keep going up, more and more other elements of the Medicaid health care system are getting squeezed out. The best case scenario is that Medicaid is forced to cut rates to health care providers; and the worse case scenario is that services are cut and that people who are eligible for services do not receive them.

Mr. Folkemer emphasized that what ever decisions are made by the Commission, they will have a huge impact on other parts of the health care system, particularly Medicaid, and there will be a direct relationship between rate increases given hospitals and the other coverage that Medicaid provides.

Commissioner Sexton asked Dr. Cohen what he projected case mix increase to be in FY 2009.

Dr. Cohen stated that he thought that it would be between 0.6% and 1%.

ITEM VIII
DRAFT RECOMMENDATION REGARDING IMPLEMENTATION OF CHARGE PER VISIT METHODOLOGY FOR FY 2008

John O'Brien announced that because of the schedule of data collection and analysis, final Charge per Visit (CPV) targets were not available until the fiscal year was three quarters complete. This,

combined with the effects of individual hospital rate realignment meant that hospitals were unable to mange to their FY 2008 CPV targets. Therefore, staff recommends that implementation of the CPV system be delayed until FY 2009.

Mr. O'Brien stated that the delay to FY 2009 will allow several improvements to the CPV system: 1) the Emergency Department (EMG) and Clinic (CL) services will be incorporated; 2) FY 2008 will be the base year; 3) remaining data problems will be addressed; and 4) version 3.1 of the EAPG grouper will be utilized.

Graham Atkinson, Ph.D., consultant to the Commission, summarized the technical problems that caused the delay of the CPV. They included: 1) the change in the data collection format to include the combined data reporting of all elements of outpatient activity; 2) rate realignment, 3) some "teething" problems with the new grouper; and 4) data reconciliation with several hospitals.. Dr. Atkinson expressed his belief that those problems were now resolved.

Dr. Atkinson stated that the explanatory power of the proposed case mix adjustment system is quite high.

Dr. Atkinson reported that a detailed recommendation describing the methodology will be presented to the Commission for action in the next several months.

Mr. Murray stated that with the transition to a more comprehensive CPV, including EMG and CL, staff was recommending that a 1% intensity factor be built into the methodology to pick up any unmeasured case mix growth plus medical technology.

Paul Sokolowski expressed MHA's agreement with the one year delay; however, as the new programs are implemented, we should be sensitive to how much time it provides hospitals to react and manage to the system. We should be vigilant to see if the 1% intensity factor significantly affects any hospital or number of hospitals.

Robert Vovak, Vice President of MHA, stated that because nobody has looked at the EMG and CL data, we may not be ready to use that data in the CPV in FY 2009.

Dr. Cohen noted that the payers reluctantly agree with the postponement of the CPV until 2009; however, it is also very important to include as much of the outpatient activity as feasible in the CPV.

TEM IX
LEGISLATIVE UPDATE

There was no legislative update presented.

ITEM X
LEGAL REPORT

Regulations

Proposed

Types and Classes of Charges Which Cannot Be Changed Without Prior Commission Approval - COMAR 10.37.03.02

The purpose of this action is to help assure greater equity in hospital pricing practices.

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

Submission of Hospital Outpatient Data Set to the Commission – COMAR 10.37.04.01

The purpose of this action is to have the reporting time frame of the Hospital Outpatient Data Regulations conform to the Inpatient Discharge Data Regulations reporting time frame.

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

Proposed and Emergency

Rate Application and Approval Procedures – COMAR 10.37.10.26-1

The purpose of this action is to set forth the assessment on hospitals to operate and administer the MHIP Plan consistent with recently enacted legislation.

Staff requested emergency status and also that the amendments be sent to the AELR Committee for review and promulgation in the Maryland Register as proposed regulations to become effective before the emergency status expires.

The Commission voted unanimously to approve staff's recommendation.

ITEM XI
DRAFT RECOMMENDATION FROM THE MARYLAND HEALTH CARE COMMISSION ON THE HEALTH INFORMATION EXCHANGE PLANNING GRANT

Rex W. Cowdry, Ph.D., MHCC Executive Director, and David Sharp, MHCC Deputy for Health Information Technology, summarized the draft recommendation on a Citizen-Centric Health Information Exchange for Maryland.

Dr. Cowdry explained that MHCC, together with providers and payers, has been actively looking both at information exchange and electronic health record adoption, and privacy and security issues that are essential to be able to deliver this information where and when it is needed.

David Sharp stated that on January 2, 2008, the MHCC and the HSCRC notified the public of an announcement inviting multi-stakeholder groups to participate in a planning project for a Consumer-Centric Health Information Exchange for Maryland. Over a nine month period, recipients of the planning award will develop a strategy for phased implementation of the state-wide health information exchange.

The MHCC will present a final recommendation at a future HSCRC public meeting to fund two multi-stakeholder group planning projects through an adjustment to hospital rates in the amount of $250,000 per proposal.

ITEM XII
HEARING AND MEETING SCHEDULE

May 14, 2008	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
June 4, 2008	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 12:15 p.m.