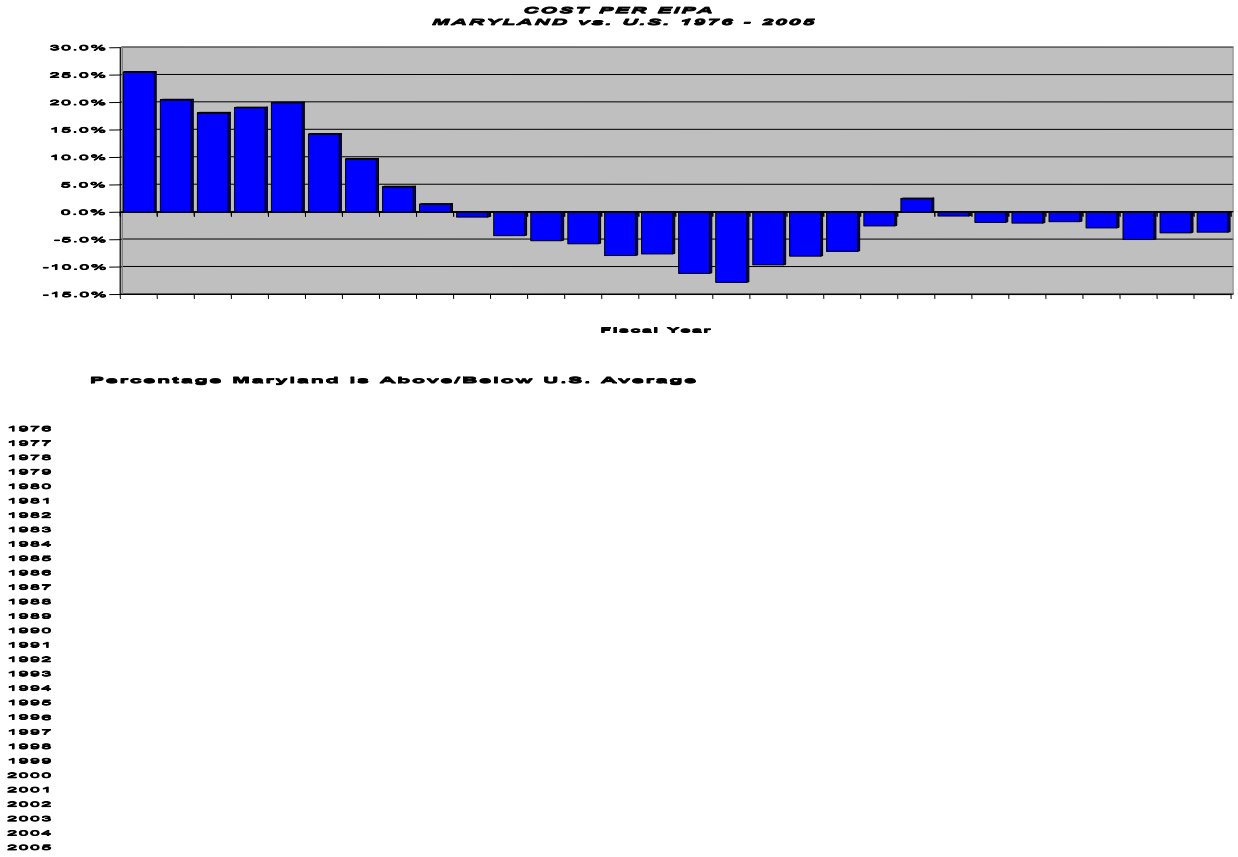
MARYLAND HEALTH SERVICES

COST REVIEW COMMISSION



REPORT TO THE GOVERNOR

FISCAL YEAR 2007

MARTIN O'MALLEY

GOVERNOR

STATE OF MARYLAND
HEALTH SERVICES COST REVIEW COMMISSION

Commissioners as of June 30, 2007 *

	Appointed	Term Expires
Irvin W. Kues Chairman	July 1, 2003 (Appointed Chairman September 15, 2003)	June 30, 2006
Joseph Antos, Ph.D.	July 1, 2004	June 30, 2008
Raymond J. Brusca	July 1, 2005	June 30, 2009
Michael J. Eusebio	July 1, 2003	June 30, 2007
Trudy R. Hall, M.D., P.A.	July 1, 2002	June 30, 2006
William H. Munn	July 1, 2005	June 30, 2009
Kevin J. Sexton	July 1, 2003 (Appointed Vice Chairman October, 2005)	June 30, 2007

* Effective July 1, 2007, Donald A. Young, M.D. and C. James Lowthers replaced Irvin W. Kues, Chairman, and Michael J. Eusebio, Commissioner respectively.

STATE OF MARYLAND

HEALTH SERVICES COST REVIEW COMMISSION

ANNUAL REPORT TO THE GOVERNOR

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This Governor's Report reports on activities of the Health Services Cost Review Commission for the Fiscal Year (FY) 2007. Audited hospital data throughout the report, however, are for the most recent fiscal year available, which in most cases is 2006.

I. EXECUTIVE SUMMARY

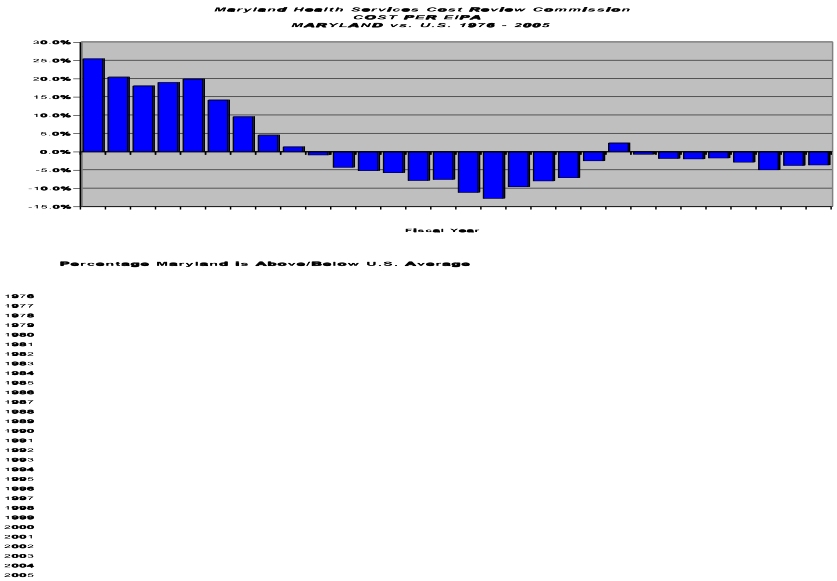
Continuing to build on the significant change that began in Fiscal Year 2000 with the redesign of the hospital rate setting system that had been place for 25 years, the Health Services Cost Review Commission ("HSCRC" or "Commission") further refined changes to the system in Fiscal Year 2007. The redesigned system has demonstrated its effectiveness in achieving the founding principles of the Maryland system - they are the principles of access, cost containment, equity, public accountability, and solvency.

Maryland Hospital Cost Performance

The HSCRC's Fiscal Year 2006 Disclosure Statement reported that the average amount paid for a hospital admission in Maryland rose 5.4% in FY 2006 to $9,440 from $8,958 in FY2005. This increase was well below the estimated national average increase of 6.4% for the same time period. These results reflect the Commission's commitment to keeping the rate of increase in what patients pay for hospital care below the nation, while maintaining the financial integrity of the hospitals it regulates.

The rate setting system has retained other unique benefits, such as keeping the mark-up, i.e., the difference between hospital costs and charges, in Maryland hospitals

the lowest in the nation at 21%, compared to the average mark-up of 172% for hospitals nationally, according to the most recent data from the American Hospital Association (AHA). In the absence of rate setting, hospitals outside of Maryland must artificially mark up their charges by 100-200 percent in an effort to compensate for shortfalls in uncompensated care, discounts to large managed care organizations (e.g., HMOs), and low reimbursement from Medicare and Medicaid. These marked-up charges make payment difficult for "self-pay" patients. This issue of charges to the "self-pay" patients remains under review by Congress. In Maryland, the payment systems builds the cost of uncompensated care into the rates, and all payers in Maryland pay the same rates for hospital care (For details, please see section entitled "Uncompensated Care" below).



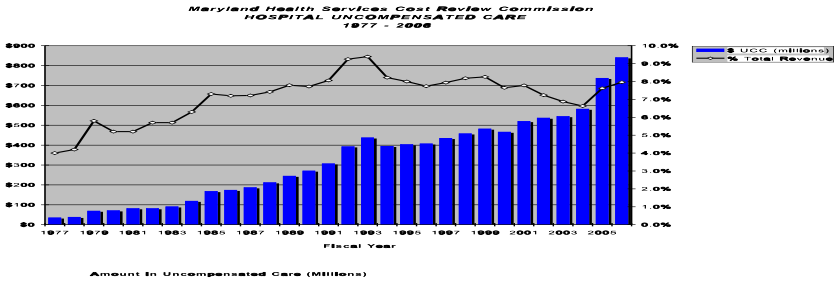
In addition, an analysis of hospital costs shows that the average cost per admission at Maryland hospitals increased by 5.4% during FY 2006. In 1976, the cost of an adjusted admission to a Maryland hospital was 26% above the national average.

Additionally, from 1977 to 2005, Maryland experienced the second lowest cumulative growth in cost per adjusted admission of any state in the nation.

Uncompensated Care

The Commission's annual Disclosure Report showed that the uncompensated care financed through the system again increased from Fiscal Year 2005 to Fiscal Year 2006. **(See Chart 2)**. In relative terms, uncompensated care financed through the system ranged from 7.65% in 2000, to 7.78% in 2001, 7.2% in 2002, 6.9% in 2003, 7.0% in 2004, 7.62% in 2005, and 8% in 2006. As in years past, approximately 85% of the statewide uncompensated care expenditure originated in Maryland's metropolitan areas.

During FY 2006, the Department of Health and Mental Hygiene (DHMH) continued to reduce funds for hospital payments with its imposition of day limits on inpatient hospital services provided to adult Medicaid participants. Initially, when Medicaid day limits were established in FY 2004, they



were to sunset by June 30, 2005. As a cost containment measure, however, the DHMH decided to continue the imposition of day limits in State Medicaid reimbursement to acute care hospitals during FY 2006. While these day limits increase savings for the Medicaid program by approximately $70 million ($35 million state funds, $35 million federal funds), this action also causes an increase in uncompensated care for Maryland hospitals. Uncompensated care increases are funded in future year hospital rates, however, so such an immediate reduction in Medicaid funding impacts short-term hospital cash flow. As a result, the HSCRC approved funding for 80% of the day limit impact to be built into hospital rates prospectively in an effort to mitigate the effect of Medicaid day limits. Hospitals may apply to the Commission for additional relief, if necessary. The existing Medicaid day limits policy is expected to end by June 2008.

Financial Condition of Maryland Hospitals

In addition to its other statutory obligations, the Commission also takes great interest in the financial performance of Maryland hospitals.

Over the years, the Commission and the hospital industry have monitored performance relative to certain targets as a means of assessing the overall financial condition of the Maryland hospital industry. In utilizing these targets, however, the Commission and the industry note that no one target, financial or operating, should be viewed as dominant. All targets should be evaluated in conjunction with each other before conclusions can be drawn as to the financial condition of the industry. As the Commission and Maryland hospitals continue the work to attain and balance these

targeted levels, it is expected that improved levels of industry financial health will be realized.

For Fiscal Year 2006, Maryland general acute hospitals' profitability continued to increase. Operating and excess margins (including both regulated and unregulated activities) were 5% and 4.50% respectively, up from 4.9% and 4.0% in Fiscal Year 2004. Thus, the HSCRC has achieved the targets that it sets for operating and excess margins. These positive results reflect, in large part, Maryland hospitals' fulfillment of their pledge to control their expenses during this period in order to accomplish the HSCRC goal of improving the financial condition of the industry.

For Fiscal Year 2005, the latest year that U.S. data were available, the cost per equivalent inpatient admission for acute hospitals in Maryland was $*8,339*, compared with the rest of the nation at $*8,665*. Thus, Maryland was approximately *3.8%* below the U.S. average, keeping it within the target of 3-6% below the national level for the cost per EIPA.

Medicare Waiver

Although the State remains in no immediate danger of losing the waiver, we continue to closely monitor our performance on the waiver test and continue to provide both positive and negative incentives to hospitals to improve Medicare utilization. In November 1990, the State was successful in modifying the language of Section 1814(b) of the Social Security Act, which determines the ability of Maryland to continue its all-payer hospital reimbursement system. The change in the law allows for a more

equitable comparison between Maryland's performance and that of the nation by taking into account savings that have been achieved since January 1, 1981. Language was also incorporated into the waiver test that would allow Maryland three years to come back into compliance with the test if, in the unlikely event, Maryland were ever to fail the rate of increase test.

The most recent waiver test information indicates that payment per admission for Medicare patients nationally increased 292% from January 1, 1981, through June 30, 2006, compared to a 257% increase in Maryland over the same time period. As evidenced by the changes to the rate setting system implemented during the Redesign effort, the Commission will continue to take whatever appropriate steps are necessary to assure continuation of our all-payer system. Recent waiver test information also indicates that immediate Commission action may be necessary in FY 08 to assure continued waiver security.

Redesign of the Rate Setting System

Over the years, the Commission's rate-setting methodologies had been changed to respond to unique hospital situations, to make the system more fair, and to incorporate more sophisticated measurement tools. These changes accumulated over the years, adding to the complexity of the rate system. In reaction to these factors and Maryland hospitals' growing cost per admission in comparison to the nation, the Commission continued work throughout Fiscal Year 2000 and 2001 on the redesign of the hospital rate-setting system. The Commission formed a workgroup consisting of

representatives from Maryland's hospital, payer, and business communities. The workgroup held many public meetings, working to maintain access to care, the system of financing social costs, and the appropriate level of equity and fairness, while keeping Maryland's cost performance in line with the nation.

In May of 2000, the Commission voted to adopt the recommendations of the work group. Since that time, the Commission continues to work together with hospitals, payers, and other interested parties to transition these broad goals into the working details that comprise the Commission's daily activities. Maryland's rate-setting system continues to meet the challenges of this new marketplace while preserving the guiding principles that have helped make Maryland the nation's leader in effectively containing hospital costs.

Transition to APR-DRGs

In June 2004, the Commission initiated a change in policy to improve its measurement of hospital efficiency. Many HSCRC methodologies include adjustments for differences in patient severity (also known as case mix) across hospitals to recognize the additional resources required to treat complex cases. Previously, case mix was measured by using the Center for Medicare and Medicaid Services' diagnosis related groups (DRGs). However, substantial variation in the costs of treating patients may occur within each DRG. To properly direct resources within the hospital system, the Commission has begun to measure case mix with a severity-adjusted classification system from 3M Health Information Systems. This classification system, or grouper, is

the APR-DRG system. Under this grouper, discharges within each DRG are further divided into four severity levels to better measure differences in average patient acuity across hospitals. Implementation began on July 1, 2005 (FY 2006), and now all general acute hospitals are under this classification system.

Other Projects

HSCRC Quality Initiative

In October 2003, the Commission established the HSCRC Quality Initiative Steering Committee to identify issues and lay the groundwork for a pay-for-performance system for Maryland hospitals. An Initiation Work Group, under the leadership of Dr. Trudy Ruth Hall, a Commissioner and practicing physician, has begun work on HSCRC's Quality Initiative design, measures, and methodology. The Initiation Work Group is comprised of representatives from the hospital industry, payer groups, academia and research, and federal agencies and will develop recommendations for the HSCRC which will make final decisions regarding the design and incentives. The Initiation Work Group, for its initial feasibility analysis using Maryland data, has selected twenty-two nationally endorsed measures that scientific evidence links with improved patient care quality. Several approaches for construction of a composite measure to rank hospitals for financial rewards and incentives are under consideration. The HSCRC anticipates that the Quality Initiative will be introduced to Maryland hospitals as a pilot program involving a few hospitals and selected measures. After analysis of pilot results and any indicated program refinement, the HSCRC will schedule full Quality

Initiative implementation. In the future, an Evaluation Work Group will conduct periodic program assessments to determine if the Initiative is meeting its goals, and recommend ways to continuously update and improve the HSCRC Quality Initiative.

The Maryland system, under the authority of the HSCRC and the Maryland Health Care Commission (MHCC), is unique in its ability to affect access to appropriate high quality care at reasonable cost. This Initiative, when fully implemented, will represent one of the broadest quality –based reimbursement systems in the nation. The Commission recognizes that the delivery of health care necessarily involves the convergence of access to appropriate health care, reasonable cost, and quality.

Patient Safety

During the 2001 Legislative Session, the General Assembly passed the "Patients' Safety Act of 2001" charging the Maryland Health Care Commission, in consultation with the Department of Health and Mental Hygiene, with studying the feasibility of developing a system for reducing incidences of preventable adverse medical event in Maryland including, but not limited to, a system of reporting such incidences. The MHCC subsequently recommended that one approach to improving patient safety in Maryland was to establish the Maryland Patient Safety Center (MPSC).

In early 2004, the MHCC selected the Maryland Hospital Association and the Delmarva Foundation for Medical Care (Delmarva) to operate the MPSC. By mid-2004, the HSCRC received a request from the MPSC for financial support through HSCRC rates for the first three years of the Center's existence. Delmarva, MHA, and

Maryland hospitals agreed to provide matching funds to support the operation of the MPSC through the initial three years.

During its July 2004 meeting, the Commission recognized the potential value of the Maryland Patient Safety Center as one component of a broad patient safety initiative in improving the quality of health care by reducing adverse health events at Maryland hospitals and nursing homes. The Commission was further intrigued by the potential for future health care savings and believes that a successful MPSC can generate such savings

The Commission, therefore, approved recommendations that, in effect, increase rates to cover 50% of the reasonable budgeted costs of the MPSC for the first three years of the project. For FY 2007, the third year of such funding, $1.14 million has been included in the rates of certain hospitals for this purpose. The Commission included $762,000 in rates in FY 2005 and $936,000 in FY 2006.

To date, the MPSC has conducted continuing and interactive collaborative programs that have resulted in reductions in ventilator-associated pneumonia and catheter-related blood stream infections at participating intensive care units (ICU) in Maryland. The MPSC is continuing to work on such programs designed to prevent hospital-associated methicillin resistant staphylococcus aureus (MRSA) infections, and promoting safe practices and culture change in high hazard settings such as the ICU, emergency department, operating room, and labor and delivery suite. The MPSC has also been conducting educational programs for hospitals and physicians, and

supporting the MEDSAFE program to promote the safe use of medications.

As a result of their work over the past three years, MPSC was honored with the 2005 John M. Eisenberg Patient Safety and Quality award for national and regional innovation in patient safety. The award recognizes achievements of individuals and organizations that have made an important contribution to patient safety and health care quality in the areas of research or system innovation.

Community Benefit Report

In June 2004, the Commission released its first ever Maryland Hospital Community Benefit Report (CBR), which summarized community benefits reported by individual Maryland hospitals. For FY 2006, Maryland hospitals reported providing a total of over $723 million in benefits to their communities. Of this, $253 million was provided in health professions education activities, $233 million in charity care, $143 million for mission driven health services, over $50 million in community health services, $14 million for donations, $13 million in community building activities, nearly $6 million in community benefit activities, $5.6 million in research efforts, and $5 million in foundation community benefit initiatives.

The HSCRC views the CBR as an opportunity for each Maryland hospital to critically examine, evaluate, and report the nature, impact, long term sustainability, and success of community benefit activities. The Commission also views the CBR as a work-in-progress and hopes to build upon the successes of the first year's efforts.

Ultimately, it is hoped that the CBR will keep pace with the changing environment of community benefits and improve its effectiveness as a public policy tool. Given the experience of other states and organizations, we expect that Maryland's initiative will take several years to mature. Maryland hospitals, the Commission, and other interested parties worked collaboratively to implement the first CBR. The HSCRC commits to continuing this work to further improve the report and to refine definitions as needed.

In conclusion, the Commission thanks you for the support that you have given us throughout the year. We look forward to working with you and continuing our efforts to improve the hospital rate system and meet our policy objectives in the upcoming fiscal year.

II. REVIEW OF RATE REGULATION ACTIVITIES

A. Closed Docket Proceedings

Disposition of those applications acted upon by the Commission in Fiscal Year 2007 is summarized below. Copies of the applications, staff recommendations, as well as the complete file in these proceedings may be obtained by contacting the Commission's offices.

CATEGORY OF RATE APPLICATION	NUMBER OF APPLICATIONS	DESCRIPTION OF TYPE OF APPLICATION
Full Rate Applications	0	Moratorium on the filing of full rate applications for two years beginning July 1, 2005 Approved:0

Partial Rate Applications	7	Four requests for approval of a rate for a new service Approved:4
		One request for capital project funding Approved:1
		Two requests to combine rate centers Withdrawn 1 Approved:1
Applications for an Alternative method of Rate Determination*	24	Eighteen requests for approval to participate in global fixed price alternative payment arrangements** Approved: 18
		Six requests for approval to participate in capitation alternative payment arrangements**** Approved:6

*Alternative Method of Rate Determination - COMAR 10.37.10.06
Under its law, Health-General Article, §19-219, the Commission may promote and approve alternative payment methodologies that are consistent with the fundamental principles inherent in its legislative mandate. This regulation effectuates the statutory authority granted and sets forth the process, reporting requirements, and penalties associated with alternative rate setting.

** Global Fixed Price Arrangement - is an arrangement that fixes a price to be charged to a payer for the combined physician and hospital services for patients who receive a specific service, e. g. transplants or cardiology services.

*** Capitation Arrangement - is an arrangement in which a fixed monthly payment is made by a payer to cover the costs of all or a specific segment of the health care services for a designated population.

B. Annual Unit Rate and Charge per Case Target Updates

During Fiscal Year 2007, forty-five (45) acute care hospitals and one (1) chronic specialty

hospital participated in the Charge per Case Target rate setting methodology. Effective July 1, 2006, these hospitals' Charge per Case Targets and all unit rate were granted 3.56% for inflation.

Garrett County Memorial Hospital is the only acute care hospital in the State that does not participate in the Charge per Case methodology. This hospital's unit rates are developed in accordance with the Total Patient Revenue ("TPR") unit rate setting methodology. A hospital must be a sole provider, with a defined population service area, with little or no competition from other acute care hospitals to participate in this rate setting methodology. The Hospital's annual revenue budget is calculated and capped for the rate year, and costs are100% fixed.

C. Full Rate Reviews

A full rate review is an extensive analysis of a hospital's unit rate structure, Charge per Case Target and underlying costs relative to the averages of its peer group. A hospital may file an application for a full review, or the Commission may initiate the review. These reviews are extremely technical, incorporating multiple Commission policies, and must be completed in the specific time frame established by regulation. Typically, a hospital files a full rate application to increase its revenue structure. The hospital must submit a detailed description of its request with supporting calculations documenting its efficiency relative to its peer group. Additionally, the hospital requesting the full rate review may attempt to demonstrate why the annual update factor is insufficient to meet its individual financial requirements.

At the June 5, 2005 public meeting, the Commission voted unanimously to adopt the staff's modified recommendation on "The Transition to APR-DRGs and Related Methodological Changes." The transition plan placed a moratorium on full rate reviews for a two year period with the exception of temporary reviews in emergency circumstances.

D. Spend Down Hospitals

Every hospital's costs and charges are monitored for monthly compliance. Two times each year, all acute care hospitals are subject to the Reasonableness of Charges calculation. Any hospital with charges exceeding its peer group average by three percent (3%) or more is identified as a high cost hospital and must negotiate a Spend Down Agreement with the Commission. These agreements are specific to each hospital and detail the reductions the hospital must make over a specified time period, usually two years.

Another provision of the staff's modified recommendation on "The Transition to APR-DRGs and Related Methodology Changes" (unanimously adopted by the Commission at its June 1, 2005 public meeting) was a moratorium on the Reasonableness of Charges calculation and any resultant spend downs for the next two years. Consequently, no additional hospitals have been identified as high cost during fiscal year 2007. McCready Memorial Hospital in Crisfield Maryland is still on a spend down; however, the scheduled offset for fiscal year 2007 was deferred.

III. SYSTEM REFINEMENTS AND CHANGES IN METHODOLOGY

The Research and Methodology Division of the HSCRC is responsible for the research, policy development, and information systems activities of the Commission. The staff devotes considerable time to developing, analyzing, and implementing policy changes to the existing payment system; coordinating activities related to policy development; developing and analyzing alternative methods of rate determination; developing data reporting requirements to ensure that the information needed for policy development and research are available; and conducting research that has policy implications for the Commission and is of general interest to the health services research community. Recent changes, refinements, and reviews are described in the following sections.

A. System Redesign

In September 1999, the HSCRC began the effort to redesign Maryland's hospital rate setting system. The efforts resulted in a permanent system change that followed the temporary measures that began on April 1, 1999. The redesign effort began in response to several years in which Maryland's overall cost performance was less favorable than national cost performance. From 1977 to 1992, Maryland had the lowest growth in cost per adjusted admission in the country. For the subsequent six years, however, Maryland led the nation with the highest growth in cost per adjusted admission. In 1992, the cost per adjusted admission was 13% below the national average; in 1998 and 1999, Maryland was near the U.S. average.

The Commission became increasingly frustrated with its inability to control charge and cost per case, the growing obfuscation of system incentives, and lack of enforcement and control of the regulatory process. Conversely, the hospital industry's frustration was largely centered on the growing complexity of the rate-setting system. This complexity resulted from a variety of factors over time, including Commission policy changes that attempted to improve the rate-setting system. Other modifications, many of which originated from the industry itself, attempted to make the system of comparing hospitals more fair and equitable. All parties were concerned about the lack of stability and predictability within the system.

To reform the system, the HSCRC formed a panel called the "Redesign Work Group" to advise on changes to the system. The group met between September 1999 and January 2000. Included in these discussions were HSCRC Commissioners and staff, industry representatives, payer representatives, labor unions, business leaders, and other interested parties from across Maryland. The Work Group's meetings resulted in a series of recommendations that covered four broad categories: structural changes to the regulatory system, long term goals for industry payment levels, administrative savings to be achieved within the system, and reductions in the complexity of administering the system.

A number of changes were implemented. As of July 1, 2000, the then current rate system was eliminated and replaced with an approach that determined inpatient case targets for each hospital. The consensus goal of the Redesign Work Group was to

develop a system that would gradually outperform the nation in the long run, but at the same time preserve payment stability for Maryland hospitals.

The agreement between the Commission, the hospital industry, and payer representatives was scheduled to run for three years, at which time the effects of the agreement would be assessed and renegotiated as necessary. When the redesign agreement was negotiated, Maryland's net patient revenue per admission was at the national average. At the end of Fiscal Year 2005, the HSCRC estimated that net patient revenue per case was four percent below the national average. The goal of outperforming the nation was met, and industry profitability showed a significant improvement. The improved profitability relative to the nation also enhanced the industry's ability to invest in capital needs (facilities, new clinical technology, and new information systems).

In preparation for Fiscal Year 2006, a number of workgroups met to address the status of the rate regulatory system, examining issues ranging from the financial status of hospitals to technical details of how hospital efficiency should be measured in the system. A number of broad issues under the original rate redesign agreement were considered and adjusted to reflect the current situation.

B. Changes to the ICC and ROC

The Inter-hospital Cost Comparison (ICC) methodology was developed as a tool for the Commission to assess the adequacy of a hospital's rates in the context of a full review of a hospital's rate structure. As the primary tool in a full rate review, the ICC

begins by comparing current charge per case (CPC) targets, adjusting for allowable cost differences across facilities. HSCRC staff compares the adjusted target to a group of peer hospitals to determine if a hospital is eligible for a rate increase during a full rate review. Hospitals with adjusted targets that are more than two percent below the group average are eligible for an increase to raise their rates to two percent below the group average. The subject hospital is also allowed to raise special issues unique to that facility.

Under the ICC methodology, outpatient rates are adjusted for differences in markup, profits, the two percent productivity deduction, and labor market differences before a standard is established for each center in a hospital's peer group. The standard is the median of the adjusted outpatient rates within each outpatient center.

The choice of the median has, at times, resulted in large swings when the subject hospital under a full rate review is the anomalous hospital in the rate center. Abnormally low rates in the rate center result in windfalls under the median, while abnormally high rates result in large reductions. To address this issue, the outpatient ICC methodology was revised in April 2003 to identify outlier hospitals within an outpatient rate center and to establish a reasonable standard when the rate is identified anomalous. For hospitals not identified as outliers, the median rate would be applied as the standard for the rate center.

The inpatient portion of the ICC has also been adopted as the tool for identifying hospitals with relatively high charges. Under this version of the ICC policy, charges –

not costs – are the subject of the review. While the ICC removes profits from approved charges and imposes a two-percent efficiency standard for hospitals undergoing a full rate review, neither of these adjustments is made under the charge comparison – a policy known as the "Reasonableness of Charges" comparison or the ROC. Under this policy, hospitals that are three percent above their peer group average will be identified as having high charges and targeted for a spend down to reduce their charges relative to their peers. While there were no major changes to the ROC policy in the current year, although a number of issues are currently under review and the ROC methodology may undergo some revisions prior to early 2008.

In October 2003, the Commission modified its ICC policy to recognize the need for capital in Maryland's hospitals. The new policy permitted hospitals to apply for additional capital costs on a certificate of need (CON) approved project through the partial rate application process. The partial rate application allows a study hospital with a reasonable rate structure rate relief associated exclusively with capital, but requires that staff run a modified ICC analysis (both inpatient and outpatient) to limit any additional rate relief to the study hospital. Hospitals that have high charges would likely not pass even a less rigorous ICC standard and, therefore, would not be eligible for this partial rate relief. The ICC standard is applied in the case of a partial rate review for capital but without the 2% productivity adjustment. This result generates rate relief for a hospital with low charges relative to its peers, and/or hospitals who have not undergone a major capital project in a number of years. There is no Phase II ICC

analysis associated with this application because the analysis is not a full analysis of the hospital's rates. The subject hospital must request a full rate review under the standard ICC process to have such issues considered.

The HSCRC's methodology allows the subject hospital to project capital costs as reflected by the depreciation and interest associated with the CON approved project and the projected routine annual capital replacement over the project period. Additionally, the Commission requires that the hospital:

1 acquire an approved CON for the requested project expenditures;

2 keep its request limited to the regulated expenditures for which the CON was granted;

3 be provided a 'ceiling amount' of rate relief that could be granted through the partial rate application; and

4 meet the HSCRC ROC criteria.

If the study hospital meets the above criteria, it would be able to receive 50% of its own capital costs and 50% of its peer group capital.

In June 2004, the Commission also initiated a change in policy to improve its measurement of hospital efficiency. As noted above, the ICC and ROC include adjustments for differences in patient severity (also known as case mix) across hospitals to recognize the additional resources required to treat complex cases. In the Maryland system, case mix has been measured by using a modified version of the Center for Medicare and Medicaid Services' (CMS) diagnosis related groups (DRGs). However, substantial variation in the costs of treating patients

may occur within each DRG. To properly direct resources within the hospital system, the Commission began to measure case mix in FY 2006 with a severity-adjusted classification system from 3M Health Information Systems. This classification system, or grouper, is the APR-DRG system. Under this grouper, discharges within each DRG are further divided into four severity levels to better measure differences in average patient acuity across hospitals.

The reporting requirements for diagnosis and procedures are the same under the CMS DRGs and the APR-DRG grouper; however, the latter is more sensitive to complete coding of a patient's medical record. Because this affects the revenue each hospital receives, the Commission initiated an annual audit procedure to verify the accuracy of hospitals' reported coding. In FY 2005, each hospital engaged an auditor and provided an audit report to the Commission.

The transition to this refined method for measuring hospitals' patient acuity required a number of other changes in the system. The most significant of these changes is the manner in which case weights are calculated. Case weights are the values that, in effect, establish the reimbursement associated with each case. Traditional methods for establishing these weights have overvalued some services and undervalued others. While the change in weight calculation is highly technical, the Commission adopted this new methodology in tandem with the introduction of APR-DRGs to provide a refined case mix system with the appropriate incentives across types of hospital services.

Other elements of social costs recognized by the rate setting system depend on how case mix is measured. Costs associated with disproportionate share (an

adjustment for hospitals serving a large poor population) and indirect medical education are affected by the degree to which differences in patient acuity are captured by the case mix index. The Commission's methodologies must be revised to account for these differences, but revisions may not be completed until the industry has improved its coding. Essentially, the results will not be stable until a stable level of coding has been reached across the State's hospitals. Consequently, the Commission has placed a moratorium on hospital full rate reviews and relative hospital comparisons under the Reasonableness-of-Charges analysis from November 1, 2005, which continues to the present. The Commission is currently engaged in a process to establish a workable ICC and ROC process, such that the moratorium can be ended in early 2008. In further recognition of this transition the Commission has, since 2006, not recognized full case mix growth as measured by the APR-DRG grouper. The Commission limited case mix growth to 1.95 percent in FY06, 1.65 percent in FY07, and will limit case mix growth to 1.0 percent in FY08. These limits were put in place because coding improvements resulted in higher measured acuity without commensurate increases in resource use.

C. Uncompensated Care Regression and Policy

An essential feature of Maryland's all-payer system is the treatment of Uncompensated Care. The Uncompensated Care Regression and Policy is used annually to determine the amount of bad debt to be included in hospital rates. At the core of this policy is a regression equation that is used to determine the expected level of uncompensated care for each hospital. In the regression model, the two variables used are the percentage of Medicaid patient days, and the percentage of patient days from non-Medicare patients admitted through the

emergency room. The regression was last amended in June 2002 to improve its explanatory power by altering the variable "percentage of Medicaid patient days" to include Medicaid, charity care, and self-pay patient days. This change increased the explanatory power of the regression by about ten percentage points. The new policy was phased in for fiscal year 2003 rates by averaging the results of the old policy with the new policy.

During Fiscal Years 2004 and 2005, in response to cuts in its budget, the State's Medicaid program implemented hospital day limits—a maximum number of days for which Medicaid would pay for a hospital stay. This Medicaid policy affected hospitals because the HSCRC uncompensated care policy is designed to work with a lag in recognizing changes in actual uncompensated experienced by hospitals. Hospitals would be expected to bear the cost of these program cuts without any relief under the Commission's uncompensated care policy until reported uncompensated care began to rise and be recognized in accordance with the normal procedures.

Given the Commission's concerns around industry profitability and the need for recapitalization, the uncompensated care policy was amended to prospectively recognize a portion of the impact of the day limits. The Commission recognized 80 percent of the incremental uncompensated care due to the Medicaid cuts, requiring the hospital to fund only 20 percent of the shortfall through the usual uncompensated care policy. Further, the Commission allowed hospitals with financial need to seek relief through a partial rate application to request the additional 20 percent.

During FY 2005, concerns over the uncompensated care policy's lag in recognizing changes in actual uncompensated experienced by hospitals led to a revised approach to uncompensated care. The revised approach is a regression model that is based on three years of data combined with a three-year moving average of each hospital's actual uncompensated care. The results of the regression are adjusted to ensure that the uncompensated care in rates for the system equals the last reported level of uncompensated care. This revised approach became effective in FY 2006. In FY 2007, the uncompensated care regression model was further modified by adding additional variables to more accurately align uncompensated care allowances with actual experience.

D. Nurse Support Programs (NSP I and NSP II)

To facilitate and encourage the implementation of hospital-based initiatives designed to increase the number of nursing professionals providing patient care in the State, the HSCRC initiated the five-year Nurse Support Program I (NSP I) effective July 1, 2001. Hospitals are eligible to receive up to 0.1% of their gross patient revenue per year, to be provided through hospital rate adjustments for approved projects that address the individual needs of the hospitals as they relate to nurse recruitment and retention. In fiscal year 2006, $8 million of NSP I funds was distributed to 50 acute care and specialty hospitals in Maryland. On April 12, 2006, the HSCRC approved a one-year extension of the NSP I through June 30, 2007. During the extension in FY 2007, approximately $9.5 million in hospital rate adjustments were provided.

On April 11, 2007 HSCRC approved a new five-year NSP I funding cycle and several NSP I updates, including a streamlined application process, redefined categories of projects

eligible for funding, and standardized annual reporting formats to improve accountability. The HSCRC published a call for applications for the new cycle on April 12 with a due date of May 11. On May 29, an Evaluation Committee composed of nurse leaders, a payer, Maryland Hospital Association representatives, Maryland Higher Education Commission (MHEC), and HSCRC staff met to review the applications from 41 institutions. At the June 13, 2007 HSCRC monthly meeting, all 41 hospital applications totaling approximately $10 million were approved for FY 2008, as recommended by the Evaluation Committee. These 41 applications provide for creative projects in nurse retention and recruitment, educational attainment, and improvement of nursing practice environment, which are areas recommended by nurse experts as most valuable in increasing and retaining the supply of nurses.

The NSP I program exposed the inability of nursing programs to accept large numbers of new nursing students because of limited capacity due to nursing faculty shortages. The Maryland Board of Nursing estimated that approximately 1,900 qualified students were denied admission in academic year 2003-2004 due to insufficient nursing faculty. In May 2005, the HSCRC approved funding of 0.1% of regulated patient revenue for use in expanding the pool of nurses in the State by increasing the capacity of Maryland nursing programs, by developing more nursing faculty, and by creating a pipeline for future nursing faculty. This funding represents approximately $9.4 million devoted to Phase II of the Nurse Support Program (NSP II) on an annual basis over the next ten years. The HSCRC has contracted with the Maryland Higher Education Commission to administer NSP II.

Under the NSP II Program, funding will support two types of initiatives: Competitive Institutional Grants and Statewide Initiatives. Institutions seeking Competitive Institutional Grants are encouraged to coordinate their proposals with the Statewide Grants which provide: (1) Graduate Nursing Faculty Scholarships and Living Expenses Grants; (2) New Nursing Faculty Grants; and (3) State Nursing Scholarships and Living Expenses Grants.

Twenty-six proposals for NSP II Competitive Institutional Grants were received by March 2006 in response to an HSCRC Request for Application (RFA). A multi-stakeholder Evaluation Committee evaluated these proposals using criteria set forth in the RFA, i.e., the comparative outcomes of each initiative, the geographic distribution across the State, and the racial diversity of Maryland residents. The Evaluation Committee unanimously recommended seven of the twenty-six proposals for funding. On April 12, 2006, the HSCRC approved funding for seven initiatives involving twenty-one Maryland university and college schools of nursing and hospitals for an estimated $4.2 million in funding in FY 2007. The HSCRC approved a grand total of $17.2 million over the next three to five years of these grants.

For the FY 2008 round of NSP II Competitive Institutional Grants, twenty-three proposals were received in response to an updated RFA. Nine proposals, including consortia representing twenty-six educational organizations, health systems, and hospitals in all regions of the State, were approved for funding. The recommended proposals will produce about 285 additional masters prepared and doctoral nursing graduates as potential nursing faculty, and approximately 455 more baccalaureate nurses as potential bedside nurses and pipeline to more faculty. The budget for the approved nine Competitive Institutional Grants proposals is $5.93

million with an estimated $2.75 additional for Statewide Initiatives for a total of $8.68 million for the 5 years of FY 2008 grants.

E. Hospital Discharge Data

1. Inpatient Discharge Database:

The HSCRC Inpatient Discharge Database is considered to be one of the most accurate, complete, and timely statewide hospital discharge data sets in the country. Maryland hospitals are required to submit inpatient discharge data to the HSCRC within 45 days following the close of each quarter. The data include demographic, clinical, and charge information on all inpatients discharged from Maryland general acute hospitals. The database is used extensively for hospital rate setting purposes, by other state agencies for health planning, program development, and evaluation functions, and is also used by individuals throughout the State and the country for various research projects.

2. Ambulatory Surgery Database:

Since October 1987, the Commission has collected patient level ambulatory surgery data from hospitals. The ambulatory surgery database includes demographic, clinical, and charge information for all patients that receive hospital-based outpatient surgery services. Hospitals submit ambulatory surgery data to the HSCRC within 60 days following the close of a quarter. The collection of this data supports the HSCRC's intention to develop an outpatient rate setting tool based on the clinical classification of data.

3. Ambulatory Care Database:

The Ambulatory Care Data Reporting Regulations, effective April 1, 1997, allow the Commission to collect demographic, clinical, and charge information on hospital-based clinic and emergency department services. Hospitals submit ambulatory care data to the HSCRC within 60 days following the close of a quarter. The collection of this data supports the HSCRC's intention to develop an outpatient rate setting tool based on the clinical classification of data.

4. Chronic Care Database:

The Chronic Care Data Reporting Regulations, effective January 1, 2003, allow the Commission to collect demographic, clinical, and charge information on hospital-based chronic care services. Hospitals submit chronic care data to the HSCRC within 60 days following the close of a quarter. The HSCRC anticipates the development of a chronic care rate setting methodology based on the data collected in this database.

IV. AUDITING AND COMPLIANCE ACTIVITIES

A. Auditing Activities

A set of specific audit procedures prescribed by the Commission, known as the "Special Audit," is performed annually at each hospital by an independent certified public accounting firm. The Special Audit tests the various data submitted by the hospitals to the Commission in their Annual Reports of Revenue, Expenses and Volumes, Annual Wage and Salary Survey, Statement of Changes in Building and Equipment Fund Balances, Monthly Reports of Achieved Volumes, and Quarterly Uniform Hospital Discharge Abstract Data Set. The Special Audit is

designed to assure the Commission that the data are being reported in a uniform and consistent format, and that the reports are accurate.

B. Monitoring Activities

During Fiscal Year 2007, the Commission staff continued to use the Monthly Report of Rate Compliance (Schedule CS) as its primary tool for monitoring hospital charging compliance. An expanded Quarterly Financial Statement Summary (Schedule FS) and the hospitals' audited financial statements continue to be used to monitor hospital solvency. The Commission continued the policy of reviewing the performance of the Maryland hospital industry on an ongoing basis.

In addition, significant transactions between hospitals and related entities continue to be reported to the Commission on an annual basis. Both the policy of reviewing the financial performance of the Maryland hospital industry and the reporting of transactions between hospitals and related entities were adopted in response to recommendations made by a joint Commission and Maryland Hospital Association committee established to study the financial condition of Maryland hospitals.

V. ACTIVITIES AFFECTING HEALTH SERVICES COST REVIEW COMMISSION'S REGULATIONS

Over the past fiscal year, the Commission proposed and adopted amendments to a number of existing regulations.

COMAR 10.37.01

This regulation concerns the Commission's Uniform Accounting and Reporting System for Hospitals. During the past fiscal year, there were a several amendments made to the Commission's regulations concerning the Accounting System. First, on

January 3, 2007, the Commission adopted an amendment to Regulation .03, which it proposed on September 13, 2006. This amendment updates Commission reporting requirements consistent with the Commission's rate methodologies.

On May 2, 2007, the Commission adopted changes to Regulation .01. This amendment updates the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operating Management" (August 1987), with Supplement 17 (March 25, 2006), which has been incorporated by reference.

On March 7, 2007, the Commission proposed for adoption an amendment to Regulation .06. The purpose of this amendment is to delete the requirement of listing the home address of a trustee, a director, or an officer in a report required of nonprofit hospitals and related institutions.

COMAR 10.37.04

This regulation concerns the Submission of Ambulatory Care Data Set to the Commission. On May 2, 2007, the Commission repealed Regulations .01 - .07 under COMAR 10.37.04 Submission of Hospital Ambulatory Care Data Set to the Commission and Regulations .01 - .07 under COMAR 10.37.07 Submission of Hospital Ambulatory Surgery Data Set to the Commission, and adopted new Regulations .01 - .07 under a new chapter, COMAR 10.37.04 Submission of Hospital Outpatient Data Set to the Commission. This new set of regulations revamps and consolidates the Commission's ambulatory surgery and ambulatory care data set into one uniform data

abstract and expands the data set to include the collection of all hospital outpatient visits and referred ancillaries.

COMAR 10.37.06

This regulation concerns the Submission of Hospital Discharge Data Set to the Commission. During this past fiscal year, the Commission promulgated a couple of amendments to this chapter. First, on May 2, 2007, the Commission adopted amendments to Regulations .02 and .03. The purpose of this action is to expand and refine the inpatient hospital discharge data set to include diagnoses present on admission data. These new data elements will ensure consistency with imminent federal reporting standards and national coding guidelines, enhance the Commission's ability to analyze various case mix related rate setting issues, improve the ability of the Commission's Patient Safety and Quality Initiatives Program to examine in-hospital complications among diagnoses that arise after admission, and assist in evaluating hospital performance.

Then, on June 13, 2007, the Commission proposed for adoption additional amendments to Regulations .02 and .03, and at the same time, granted emergency status commencing on July 1, 2007 and expiring on December 31, 2007. The purpose of this second action is to expand and refine the inpatient hospital discharge data set to capture an additional 15 diagnosis codes and up to 30 diagnosis present-on admission codes.

COMAR 10.37.10

This regulation concerns the Commission's Rate Application and Approval Procedures. During the past fiscal year, the Commission proposed and adopted several amendments to this chapter. First, on September 13, 2006, the Commission adopted amendments to two regulations-- .04-2 and.06. The purpose of the amendment to Regulation .04-2 is to require hospitals to return the executed case target methodology agreement (Charge Per Case Agreement) to the Commission offices in a timely basis and to authorize penalties for failure to comply. Also, the purpose of the amendment to Regulation .06 is to describe the process the Commission will employ to consider rate adjustments for health information technology projects recommended for approval by the Maryland Health Care Commission.

Then, on May 2, 2007, the Commission proposed for adoption new Regulation .07-1, entitled “Outpatient Services- At the Hospital Determination.” The purpose of this action is to set forth the process by which a hospital receives a determination from the Commission or its staff as to whether an outpatient service is provided at the hospital and, therefore, is subject to rate regulation.

Finally, on June 13, 2007, the Commission proposed for adoption an amendment to Regulation .03. The purpose of this action is to extend the moratorium on the filing of full rate applications for another 12 months, until November 1, 2008.

VI. LEGISLATION AFFECTING THE HEALTH SERVICES COST REVIEW COMMISSION'S ENABLING ACT

A number of bills of interest to the Commission were introduced during the 2007 session of the General Assembly:

House Bill 55

This bill, companion to SB 71, entitled *Health Services Cost Review Commission-User Fees*, would alter the maximum amount of user fees the HSCRC may assess from $4 to $5 million. (Failed)

House Bill 510

This emergency bill, entitled Prince *George's Hospital Authority PG 430-07*, would establish the Prince George's County Hospital Authority; provide for the mission of the Authority; provide that the Authority is an instrumentality of the State and a public corporation; provide that the exercise by the Authority of its powers is the performance of an essential public function; authorize the Authority to take specified actions to fulfill its mission; provide for the membership, powers, and duties of the Authority; etc. (Passed with Amendments in House; Failed in Senate)

House Bill 844

This bill, companion to SB 719, entitled *HSCRC-Sunset Extension and Program Evaluation*, would require the HSCRC to include specified items in its annual report to the

Governor and General Assembly; authorize the Secretary of DHMH to assess an administrative charge; authorize the Commission to use money from user fees to pay administrative costs; increase the total amount of user fees that the Commission may assess; and require the Board of MHIP to submit a specified report. (Ch 628)

House Bill 979

This bill, entitled *Health Information Exchange Pilot Project*, would establish a health information exchange pilot project requiring the pilot project to be operated by the Maryland-DC Collaborative; and require the pilot project to transmit specified information to participating health care providers in a specified manner and for specified purposes. (Ch. 262)

House Bill 1070

This bill, companion to SB 620, entitled *HSCRC-Repeal of Commission and Study of Alternative Financing of Uncompensated and Undercompensated Care*, would repeal provisions of law relating to the Health Services Cost Review Commission and its powers and duties; alter provisions of law relating to the Health Services Cost Review Commission; repeal a requirement that specified health facilities submit specified discharge information; repeal specified requirements regarding reimbursement rates set by the Health Services Cost Review Commission; and require nonprofit hospitals to submit a specified report to the Maryland Health Care Commission; etc. (Failed)

Senate Bill 71

This bill, companion to HB 55, entitled *Health Services Cost Review Commission-User Fees*, would alter the maximum amount of user fees the HSCRC may assess from $4 to $5 million. (Failed)

Senate Bill 620

This bill, companion to HB 1070, entitled *HSCRC-Repeal of Commission and Study of Alternative Financing of Uncompensated and Undercompensated Care*, would repeal provisions of law relating to the Health Services Cost Review Commission and its powers and duties; alter provisions of law relating to the Health Services Cost Review Commission; repeal a requirement that specified health facilities submit specified discharge information; repeal specified requirements regarding reimbursement rates set by the Health Services Cost Review Commission; and require nonprofit hospitals to submit a specified report to the Maryland Health Care Commission; etc. (Failed)

Senate Bill 719

This bill, companion to HB 844, entitled *HSCRC-Sunset Extension and Program Evaluation*, would require the HSCRC to include specified items in its annual report to the Governor and General Assembly; authorize the Secretary of DHMH to assess an administrative charge; authorize the Commission to use money from user fees to pay administrative costs; increase the total amount of user fees that the Commission may assess; and require the Board of MHIP to submit a specified report. (Failed)

Senate Bill 750

This bill, entitled Queen Anne's County - Health Care Facilities Regulation - Licensing of Freestanding Medical Facilities, would establish a freestanding medical facility pilot project in Queen Anne's County; and require DHMH to issue a freestanding medical facility license to a specified freestanding medical facility pilot project under specified circumstances. (Ch. 574)

VII. STATUS OF LITIGATION INVOLVING THE HEALTH SERVICES COST REVIEW COMMISSION

Over the past fiscal year, the Commission and hospitals were able to resolve all disagreements within the administrative process.

VIII. ACTIVITIES ASSOCIATED WITH IMPLEMENTATION OF HEALTH SERVICES COST REVIEW COMMISSION ALTERNATIVE METHODS OF RATE DETERMINATION

During the past fiscal year, the Commission had the opportunity to consider proposals from hospitals seeking alternative methods of rate determination, pursuant to the provisions of Health-General Article, §19-219, Annotated Code of Maryland and COMAR 10.37.10.06. Under its law, the Commission may promote and approve experimental payment methodologies that are consistent with the fundamental principles inherent in the Commission's legislative mandate. The applications for alternative methods of rate determination fell into one of four general categories: 1) ambulatory surgery procedure-based pricing; 2) global pricing or case rate arrangements for selected inpatient procedures; 3) partial capitation or risk sharing arrangements; and 4) full capitation.

IX ACTIVITIES ASSOCIATED WITH IMPLEMENTATION OF HEALTH SERVICES COST REVIEW COMMISSION ALTERNATIVE METHODS OF FINANCING HOSPITAL UNCOMPENSATED CARE

In September of 1996, the HSCRC approved a methodology that spreads the cost associated with uncompensated care more evenly across all hospitals in the State. The methodology called for an assessment of .75% to be made against all hospitals, with those funds being redistributed to hospitals that treat a higher proportion of Maryland's uninsured citizens. Regulations implementing this plan, embodied in COMAR 10.37.09, "Fee Assessment for Financial Hospital Uncompensated Care, " became effective on February 10, 1997. On May 1, 1997, all hospitals began making payments into the Uncompensated Care Fund. All funds collected in May and June of 1997 were used to establish the reserve fund account of the Uncompensated Care Fund. On July 1, 1997, the HSCRC began disbursing funds to hospitals that treat a higher portion of uninsured citizens. During the last fiscal year, the Uncompensated Care Fund successfully assessed all hospitals .75% and distributed the funds that were collected to hospitals with high uncompensated care percentages.

FORMER COMMISSIONERS

Former Commissioner	Appointed	Term Expired
John A, Whitney, Esq.	July 19, 1971	June 30, 1972
Sidney A. Green	July 19, 1971	June 30, 1978 (Resigned)
George J. Weems M.D.	July 19, 1971	June 30, 1978 (Resigned)
Mancur Olson, Ph.D	July 19, 1971	June 30, 1977
Bernard Kapiloff, M.D.	July 19, 1971	June 30, 1977
P. Mitchell Coale [1]	March 31, 1976	June 30, 1978 (Resigned)
W. Orville Wright	January 25, 1972	June 30, 1979
Alvin M. Powers	July 19, 1971	June 30, 1979
Natalie Bouquet	October 31, 1972	June 30, 1980
Gary W. Grove	June 29, 1979	June 30, 1983
John T. Parran[2]	July 8, 1977	June 30, 1982
Stephen W. McNierney[3]	February 8, 1983	June 30, 1986 (Resigned)
Carville M. Akehurst[4]	June 29, 1979	June 30, 1983
David P. Scheffenacker	September 6, 1977	June 30, 1985
Roland T. Smoot, M.D.[5]	July 12, 1978	June 30, 1986
Carl J. Schramm, Esq.[6]	July 8, 1977	June 30, 1985
Richard M. Woodfin[7]	August 28, 1983	June 30, 1986
Don S. Hillier[8]	February 24, 1982	June 30, 1987
Earl J. Smith[9]	August 29, 1983	June 30, 1987

[1] Appointed to fill unexpired term of Sidney Green, resigned.

[2] Appointed to fill unexpired term of George J. Weems, M.D., resigned.

[3] Appointed to replace John T. Parran, who continued to serve beyond his appointment.

[4] Carville M. Akehurst was appointed by the Governor to Chair the Maryland Health Resources Planning Commission and by law had to leave the Health Services Cost Review Commission.

[5] Appointed to fill the unexpired term of P. Mitchell Coale.

[6] Carl J. Schramm, Esq. continued to serve as Acting Chairman beyond his appointment.

[7] Appointed to fill the unexpired term of Stephen W. McNierney.

[8] Appointed to fill the unexpired term of Gary W. Grove.

Virginia Layfield	June 30, 1980	June 30, 1988
Walter Sondheim, Jr.	July 1, 1987	June 30, 1991 (Resigned)
Ernest Crofoot	September 6, 1985	June 30, 1989
Richard G. Frank, Ph.D.	October 6, 1989	June 30, 1995 (Resigned)
Barry Kuhne	July 1, 1987	June 30, 1994
William B. Russell, M.D.	July 3, 1986	June 30, 1994
James R. Wood	July 1, 1987	June 30, 1995
Susan R. Guarnieri, M.D.	March 16, 1988	June 30, 1996
Charles O. Fisher, Sr.	April 28, 1986	June 30, 1997
C. James Lowthers	July 16, 1990	June 30, 2001
Willarda V. Edwards, M.D.	July 1, 1994	June 30, 2002

[9] Appointed to fill the unexpired term of Carville M. Akehurst.

Dean Farley, Ph.D.[10]	July 1, 1994	June 30, 2003
Philip B. Down	July 1, 1995	June 30, 2003
Don S. Hillier	July 1, 1996	June 30, 2004
Dale O. Troll	July 1, 1994	June 30, 2003
Larry L. Grosser	July 1, 2001	June 30, 2005
Samuel Lin, M.D., Ph.D.	July 1, 1997	June 30, 2005

[10] Dean Farley, Ph.D., continued to serve as Vice Chairman beyond his appointment.

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