

**435th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION**

June 13, 2007

Chairman Kues called the meeting to order at 9:01 a.m. Commissioners Raymond J. Brusca, J.D., Trudy R. Hall, M.D., William H. Munn, and Kevin J. Sexton were also present.

ITEM I
REVIEW OF THE MINUTES OF THE EXECUTIVE AND PUBLIC SESSIONS
OF MAY 3, 2007

Commission voted unanimously to approve the minutes of the May 3, 2007 Public Meeting and the minutes of the Executive session.

ITEM II
DOCKET STATUS - CASES CLOSED

1923A & 1943A – University of Maryland Medical Center
1948R – Dorchester General Hospital

ITEM III
DOCKET STATUS - CASES OPEN

MedStar Health – 1944A

MedStar filed an application on behalf of Union Memorial and Good Samaritan hospitals requesting approval to continue to participate in a global rate arrangement for orthopedic services with MAMSI for a one year period beginning September 1, 2007.

Based on the favorable performance under the arrangement, staff recommended that the Commission approve the Hospitals' request, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 1946A

On May 24, 2007, Johns Hopkins Health System, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital, requested approval to continue to participate in a global rate arrangement for certain cardiovascular procedures with the Canadian Medical Network for a one year period.

Based on the favorable experience under the arrangement, staff recommended that the Commission approve the Hospitals' 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.

University of Maryland Medical Center – 1947A

On May 29, 2007, the University of Maryland Medical Center filed an application requesting approval to continue to participate in a global rate arrangement with Cigna Health Corporation for kidney and simultaneous kidney/pancreas transplants for a period of one year beginning June 1, 2007.

Based on favorable experience under the arrangement, staff recommended that the Commission approve the Hospital's request, and that the approval be contingent upon execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Union Memorial Hospital – 1949R

On May 31, 2007, Union Memorial Hospital submitted a partial rate application requesting that its currently approved rate for Other Physical Medicine be merged into its approved Physical Therapy and Occupational Therapy rates. The Hospital requested that the merger be made effective July 1, 2007. This action will be revenue neutral to the Hospital.

After review of the application, staff recommended that the Hospital's request be approved effective July 1, 2007.

The Commission voted unanimously to approve staff's recommendation.

ITEM IV
FINAL RECOMMENDATION ON GUARANTEED OUTPATIENT REVENUE SYSTEM

Robert Murray, Executive Director, summarized staff's recommendation (attachment A). Mr. Murray stated that the predominant reason for the rapid growth in Ambulatory Surgery (AMS) revenue and resource utilization per case, both in Maryland and in the nation, is due to inappropriate incentives. The proposed AMS Guaranteed Outpatient Revenue System (GOR) is intended to provide the appropriate incentives. Mr. Murray noted that the GOR is merely an extension of the Guaranteed Inpatient Revenue (GIR) concept to outpatient surgery. The intent of the GOR is to establish limits on the rate of increase in revenue per case-mix adjusted AMS case for each hospital, and to provide better incentives to control utilization and supply use. The GOR system utilizes the 3M Ambulatory Patient Groups (APGs) to adjust the AMS charge per case (CPC) for the base year for each hospital. The AMS CPC, adjusted for the impact of rate changes and for intensity, provides each hospital with its approved guaranteed revenue per AMS case. Just as with the GIR or the Inpatient CPC, if a hospital exceeds its charge per case, it incurs a penalty, if it falls below, it receives a reward. Mr. Murray stated that for the first time the dichotomy between inpatient rate regulation and outpatient rate regulation is removed with the GOR.

Mr. Murray reviewed how the major technical issues of the GOR system would be handled, i.e., case weights will use the Maryland weights for the principal Ambulatory Patient Groups (APG); the intensity allowance will be 1%; multiple visits within a record will be separated; PET scans will be grouped with CAT scans until the new grouper is utilized; new reporting regulations will alleviate the problem of missing data; new APG grouper will be adopted automatically once it becomes available; statewide case weights would be utilized in the system; the base year will be the year prior to implementation; and, most importantly, the level of variability will be limited, and penalties and rewards will be restricted by the establishment of a corridor.

Mr. Murray observed that the implications of implementing a GOR system go beyond Maryland. If the GOR system is successful, it will be a model for the nation.

Mr. Murray stated that as result of the technical issues, staff is proposing the most significant revision in its recommendation, i.e., the imposition of corridors to try to limit the highs and the lows on a revenue neutral basis. The corridors will provide some protection for hospitals resulting from variations that might exist in the first year of implementation.

Mr. Murray urged the Commission to implement the GOR system as detailed in staff's recommendation for FY 2008 using FY 2007 as the base year.

Mr. Murray stated that staff will attempt, on a case-by-case basis, to overcome any disincentives to move high supply cost one day length of stay cases from inpatient to outpatient as a result of implementation of the GOR.

Vice Chairman Sexton asked what criteria would be used to determine whether a corridor should be implemented for a particular hospital.

Mr. Murray replied that, for example, if a hospital could demonstrate that its case weights were distorted because of new cases in FY 2008 which were not in its FY 2007 base, and the distorted weights resulted in large variations, corridors might be warranted. Mr. Murray further asserted that it is difficult to determine without modeling what would trigger corridors; a variation of 2-3% plus or minus of total AMS revenue might be the trigger.

Dr. Atkinson stated that the decision on whether or not corridors were necessary or desirable would be based on an analysis of the level of variability using FY 2005 and FY 2006 data grouped under the new APG grouper. If the data reveal systematic causes of greater variation than reasonably expected, then corridors might be established to limit any gains or losses to plus or minus 2% or 3% of total AMS revenue.

John M. Colmers, Secretary of the Department of Health and Mental Hygiene, noted that this was the month before the 30th year anniversary of the Medicare waiver. It is an achievement in public policy that is without precedent. According to the Secretary, it is important at times like this to acknowledge the importance of that achievement and, at the same time recognize that it is a "living" requirement, one that imposes upon the Commission a responsibility to live up to its past. Part of its past is an acknowledgement of the need to change incentives in the payment system for hospital services. The Commission has a long record of improving data quality and performance measurement on the inpatient side. But, for far too long, little has been accomplished on the outpatient side. Indeed, the outpatient system is little different from the inpatient one that was conceived in the 1970s. And, yet, to a very large degree, the types of cases that we are talking about today in terms of outpatient ambulatory surgery were performed on an inpatient basis, or were not even conceived of back in the 1970s. So, the time is well passed for this Commission to establish new reimbursement incentives for outpatient ambulatory surgery. Staff's proposal, as amended by Mr. Murray for corridors, is eminently reasonable. It makes sense today, and it would have made sense a decade ago. It is important for the Commission to move forward in this limited way in the outpatient arena.

Mr. Colmers noted that if in 1977 the Commission had the same degree of concern about equity and case mix as many hospitals appear do, there would never have been a GIR system.

In conclusion, Mr. Colmers noted that there is ample opportunity over time for the system to be modified and adjusted, as has always been the case under the Commission's regulatory system. Secretary Colmers urged a favorable vote on staff's recommendation, as amended.

The Chairman announced that a small ceremony will be held at the next public meeting celebrating the 30th year of the Medicare waiver.

Dr. Norvert Goldfield, Medical Director of 3M, described the background of the APG ambulatory visit classification systems and presented an overview of the new APG 3.0 grouper.

Chairman Kues asked whether 3M was working with anyone else on an APG payment system besides Maryland.

Dr. Goldfield stated that 3M utilized the data bases from various states including Iowa, New York, and Maryland, and consulted with clinicians and surgeons from those and other states on the APG logic.

The Chairman also asked whether there was as much variation in complexity of outpatient cases as there is in inpatient cases.

Dr. Goldfield stated that the least complicated of the most complex surgical cases are performed on an outpatient basis. However, the range of complexity in cases is equal to or greater on the outpatient side than on the inpatient side.

Paul X. Allen, Director-Case mix Information Management, Johns Hopkins Health System, Kim Repac; Senior Vice President & CFO, Western Maryland Health System, and Gary Vogan; Senior Vice President, Finance & Information, Holy Cross Hospital, presented the Maryland Hospital Association's (MHA's) recommendations on the GOR system.

Mr. Vogan stated that although MHA supported the concept of the GOR, implementation should be postponed until FY 2009. Mr. Vogan asserted that the Commission should wait until FY 2009 because: 1) ambulatory surgery is not yet defined; 2) we do not currently have a complete, verifiable outpatient dataset for the base year; 3) we need time to analyze the performance of the new APR grouper, which is scheduled to be released three months after staff's recommended implementation date; and 4) we will have a year to examine the data and adjust the constraints to achieve the systems goals. Mr. Vogan stated that analyses of cost efficiency by hospital using FY 2006 data showed wide variances in per case revenue.

Mr. Allen stated that he was excited about the ability to assess the financial performance of the hospital by utilizing analyses and benchmarking that will be possible with the APG grouper and a complete data set. Mr. Allen asserted this cannot be done yet because the FY 2007 and prior years' data are very incomplete consisting of ambulatory surgery as defined by UB2004 codes. This will change in FY 2008 when all AMS data will be reported. As when APR DRGs were going to be adopted, hospitals should be given a year to clean up their data before they are used for rate setting. Although FY 2007 data are much improved FY 2005 and 2006 data, which will be used to answer the data questions are seriously flawed.

Ms. Repac observed that because the new APG grouper will not yet be available, hospitals will be six months into the rate year before they will be able to monitor their performance. Ms. Repac added that the unintended consequences of implementing the system too soon may result in unearned rewards and penalties, the creation of barriers to moving procedures from inpatient to outpatient, and a limitation on outpatient technology because of the inadequate intensity allowance.

Mr. Vogan reiterated the MHA recommendation to use FY 2008 to understand the new grouper logic, redefine the definition of AMS, and to develop the appropriate intensity factor. MHA supports implementation of the GOR system beginning July 1, 2008. If the GOR is implemented in FY 2008, the establishment of corridors or the phasing-in of the impact of the GOR would be helpful.

The Chairman asked Mr. Allen whether he had said that the current charging for AMS is inaccurate.

Mr. Allen responded that some Interventional Cardiovascular procedures were not picked up on the AMS data tapes because they were not assigned a surgical CPT code; however, they were being charged properly.

The Chairman asked Mr. Vogan, what the unintended consequences of implementing the system in FY 2008 would be assuming we have rational corridors.

Mr. Vogan responded that whenever the GOR is implemented, we need to evaluate over time what procedures can appropriately be moved from inpatient to outpatient and make sure the GOR system does not become a barrier to such movement.

The Vice Chairman asked whether the corridors would apply to both surprises in the results and the impact of the revenue constraint on individual hospitals.

Mr. Murray responded that the corridors would be based on the magnitude of the variances not whether they were the result of anomalies or of the impact of revenue constraints.

Hal Cohen, PhD, representing CareFirst of Maryland and Kaiser Permanente, stated as the Secretary indicated, the implementation of an outpatient payment system could have been done many years ago. Dr. Cohen pointed out that many years ago when the GIR system was adopted, the intensity factor was set at 1% when intensity nationally was 3 to 4%, and virtually every hospital every year made money under the GIR. Dr. Cohen noted that because of the incentives, there should be revenue reductions associated with behavioral changes. Dr. Cohen observed that intensity is not only financed with the built in intensity factor, but by productivity and by volume increases at 100% variable costs. Dr. Cohen added that when the GIR system was adopted, the Diagnostic Related Groups (DRGs) grouper was no better than the current APG grouper. Dr. Cohen also stated that it was critical that state-wide case weights be used in the GOR, and that the corridors be revenue neutral.

In closing, Dr. Cohen urged the Commission to adopt staff's recommendation and then to turn its focus on adding Emergency Services and other outpatient services to the GOR.

The Commission voted unanimously to approve staff's recommendation. Commissioner Antos' vote to approve staff's recommendation was cast by proxy.

ITEM V

FINAL RECOMMENDATIONS FOR THE NURSE SUPPORT PROGRAM I (NSP I)

Oscar Ibarra, Chief-Program Administration and Information Management, summarized the recommendations of the NSP I Evaluation Committee to fund requests from hospitals associated with nurse recruitment and retention, and increasing the quality of patient care (attachment B). The Committee recommended funding 43 requests for FY 2008 at the lesser of the amount requested, or 0.1% of the hospital's gross patient revenue. The amount recommended for funding for FY 2008 was \$9,478,798.

The Commission voted unanimously to approve the recommendation.

ITEM VI

STAFF RECOMMENDATION TO FUND A REPORT OF ESTIMATED CLOSURE COSTS OF THE DIMENSIONS HEALTHCARE SYSTEM

Dennis N. Phelps, Associate Director-Audit & Compliance, presented a recommendation to provide funding in the rates of Prince George's Hospital Center for the preparation of a report to identify the possible closure costs of the Dimensions Health System (DHS). While the pledge of \$30 million by Prince George's County has

stabilized the financial condition of DHS, the HSCRC believes that it is prudent to obtain a reliable estimate of closure costs so that it may be in a better position to provide DHS with assistance, if needed to assure an orderly closure.

Mr. Phelps recommended that \$50,000 representing the cost to DHS of the services of an accounting firm to prepare the closure costs estimate be funded through an increase to the rates of Prince George's Hospital Center.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII **MANAGEMENT INFORMATION SYSTEM DISCUSSION**

Chairman Kues announced that the HSCRC has instructed staff to prepare a regular report on the trend of Maryland hospitals' net operating revenue per equivalent inpatient admission utilizing data from the HSCRC FS schedules. The Chairman emphasized the need for accurate FS schedule data and implored hospital CFOs to insure that the FS schedule data improve.

ITEM VIII **LEGAL REPORT**

Regulations

Proposed

Rate Application and Approval Procedures – COMAR 10.37.10.03

The purpose of this action is to extend the moratorium on the filing of full rate applications until November 1, 2008.

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

Proposed and Emergency

Submission of Hospital Discharge Data Set to the Commission – COMAR 10.37.06.02 and .03

The purpose of this action is to expand the inpatient hospital discharge data set to capture an additional 15 diagnosis codes, an additional 15 diagnosis-present-on-admission codes, and a new Type 4 Record.

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 IX
HEARING AND MEETING SCHEDULE

July 18, 2007	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
August - 2007	The August Commission Meeting has been cancelled
September 12, 2007	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 10:51 a.m.