

**430th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION**

January 3, 2007

Vice Chairman Sexton called the meeting to order at 9:02 a.m. Commissioners Joseph R. Antos, Ph.D., Raymond J. Brusca, J.D., Trudy R. Hall, M.D., and William H. Munn were also present.

ITEM I
REVIEW OF THE MINUTES OF THE EXECUTIVE AND PUBLIC SESSIONS
OF DECEMBER 6, 2006

The Commission voted unanimously to approve the minutes of the December 6, 2006 Executive and Public sessions.

ITEM II
DOCKET STATUS - CASES CLOSED

None

ITEM III
DOCKET STATUS - CASES OPEN

Johns Hopkins Health System - 1931A

The Johns Hopkins Health System, on behalf of the Johns Hopkins Bayview Medical Center filed an application on October 11, 2006 for approval for continued participation in a capitation arrangement serving persons with mental health needs. The arrangement is between the System and Baltimore Mental Health Systems, Inc., with the services coordinated through the Johns Hopkins Bayview Medical Center. The System requested that approval be granted for a one year period beginning November 1, 2006.

Staff recommended:

- 1) That continued participation in the arrangement be approved for one year commencing November 1, 2006;

2) That approval be contingent on continued adherence to the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

ITEM IV
STAFF UPDATE ON 2007 CASEMIX

Nduka Udom, Associate Director-Audit & Compliance, summarized the results of the first quarter measured case mix for Maryland hospitals and provided some preliminary alternatives for re-calibration of measured case mix. (Attachment A)

Robert Murray stated that the purpose of this report was to update the Commission. Staff plans to initiate a case mix workgroup to discuss the issues, the most important of which is the re-calibration of the case mix governor. Mr. Murray noted that because the calibration of the prior governor was too conservative, the goal this year is to relax the governor a bit in order to get as close to the budgeted case mix level as possible.

Mr. Murray observed that staff was reconsidering a possible redistribution of the components of the previously allocated case mix over the Level I (core case mix), Level III (outliers and pass-through amounts), and Programmatic categories, and was also reviewing issues relating to compliance and cash flow.

ITEM V
**DRAFT STAFF RECOMMENDATION ON 2006 UNALLOCATED CASEMIX AND 1.0%
OUTPATIENT SHIFT**

Vice-Chairman Sexton stated that in April of 2006, the Commission targeted, in the new 3 year arrangement, a position of 3.1% below the nation in net operating revenue (NOR) per equivalent inpatient admission (EIPA) in FY 2009. However, more recent data indicate that Maryland hospitals were further below the U.S. at the end of the prior 3 year arrangement, FY 2006, than the 2.0% below that was projected. The Vice-Chairman noted that this was good news because payers and patients paid less than expected under the prior arrangement, and hospitals were still able to make satisfactory progress in profitability through cost control. However, the issue before us now is, in light of this more recent data, can we afford to be more aggressive than 3.1% below the U.S. in NOR/EIPA?

The Vice-Chairman directed staff to present its proposal first, followed by the health insurance industry, and lastly by the hospital industry. Written comments will also be received in the Commission's office on or before January 30, 2007.

Robert Murray noted that it is clear that the Commission approved a rate arrangement in April 2006 to out perform the nation by 1.1% in NOR/EIPA over the period FY 2007 through FY 2009. Mr. Murray observed that staff believed that the Commission's decision to take this action was based on 3 years of steady improvement in the financial position of Maryland hospitals, with the expectation that the financial condition targets of 2.75% in operating profit and 4% total profit would be exceeded. In addition, there was a growing concern about potential drastic cuts in the Medicare budget, concerns about the increasing unaffordability of hospital care, as well as concerns about other budgetary issues such as the imposition of Medicaid Day Limits. There was also some discussion about distinguishing Maryland's rate regulated system from the rest of the U.S. by continuing to out-perform the nation. Staff interpreted the Commission's decision as indicative of its desire that the system turn from a position of eroding versus the nation, to a position of improving versus the nation. The Commission's action balanced several different positions: 1) hospital industry proposing no improvement over 3 years; 2) the payers proposing a 2% to 2.5% improvement; and 3) staff proposing a 1.5% improvement. Mr. Murray asserted that staff believed that based on past experience, the Commission's compromise decision of 1.1% improvement over 3 years was easily achievable.

Mr. Murray stated that in June of 2006, staff became aware of the implication of a shift of revenue from inpatient to outpatient, which resulted from the recalibrating of the rates of the academic hospitals after a period of dramatic case mix increase. This shift of 1% of total industry revenue from inpatient to outpatient was unanticipated by the Commission when it made its April 2006 decision. Mr. Murray observed that although the 1.0% shift did not change the amount paid by patients and payers, it artificially lowered Maryland hospitals' position on NOR/EIPA calculation versus the nation in FY 2006 so that there was 1.0% more room between Maryland and the nation. This was part of the reason why Maryland hospitals exceeded the target of 2.0% below the nation in FY 2006.

Mr. Murray noted that other reasons were: timing issues with uncompensated care provisions; increases in contractual allowances; and some case mix revenue that was not realized in FY 2006. Mr. Murray stated that these issues are largely resolved by the 1.7% "catch-up" amounts provided in FY 2007, 1.5% of which is attributable to costs incurred in FY2006.

Mr. Murray asserted that failure to account for the 1.0% revenue shift will result in an extra and unintended charge to the public over the next two years. Mr. Murray also noted that failure to account for this shift is contrary to Commission policy which mandates that rate realignment should be "budget neutral" to the rate system.

Mr. Murray observed that audited financial data from the approximately forty June fiscal year hospitals show operating profits of 2.98% and total profits of 4.84% for FY 2006. In addition, profits are expected to increase significantly in FY 2007 because of the 1.5% catch-up amounts going in to rates in FY 2007 for which there are no associated costs.

According to Mr. Murray, unlike the two prior rate realignment revenue shifts over the last 6 years (the shift to outpatient by design in the first 3 year arrangement and the reversal of that shift in the second 3 year arrangement to bring rates back in to line with costs), the 1.0% shift in FY 2006 was unanticipated. Mr. Murray asserted that it is inaccurate to link the FY 2006 revenue shift to previous revenue shifts.

Mr. Murray noted that it has also been argued that this type of shift is warranted because hospitals nationally have been experiencing the same phenomenon. Mr. Murray asserted that these shifts nationally result from the ability of hospitals to cost shift to the private sector. However, because Maryland hospitals are unable to shift revenue without Commission authorization, we are left with a policy question. Do we want to follow the nation, or do we want to decide what is appropriate for the public in Maryland?

Mr. Murray stated that staff's recommendation (Attachment B) was for the Commission to accept the revised Update Factors (adjusted for the impact of the revenue shift to outpatient rates) and that the Commission adopt the Hospital industry's approach to distribute the previously unallocated case mix from FY 2006 in the rates of hospitals in FY 2008.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, expressed support for staff's recommendations. Dr. Cohen noted that healthcare affordability is important. It is a national issue and it should be closely monitored. Dr. Cohen stated that if it were appropriate for the Commission to permit Maryland NOR/EIPA to grow faster than the nation, it is also appropriate for the Commission to mandate that Maryland NOR/EIPA grow slower than the nation, especially since the financial condition of the industry is expected to improve fairly rapidly in FY 2006.

Dr. Cohen observed that part of today's debate is whether "a deal is a deal," without using those words. In the past, we discovered that a deal is not a deal when it came to increasing hospital revenue. When new information comes in, we should use it. We are asking the Commission to make the best decision with the latest information available, i.e., to make the policy decision to outperform the nation by 1.1%.

According to Barry Rosen, representing United Healthcare, everyone agrees that the Commission's April 2006 decision was made based on incomplete information. However, it is the Commission's job to make decisions based on what it knows today.

Mr. Rosen asserted that one of the things that the Commission knows today is that health insurance is unaffordable, and that working families are paying 20% of their gross pay for health insurance. United Healthcare urges the Commission not to perpetuate decisions that were based on incomplete information. Mr. Rosen noted that the bottom line is what the Update Factor will be in July 2007. United Healthcare suggests that a 5.5% increase is much more appropriate than a 6.5% increase.

Kevin Criswell, representing Amerigroup, stated that Commission policy has been clear in the past that shifts from outpatient to inpatient revenue must be accounted for. The hospital industry wants to change the policy now because it does not benefit from them. Hospitals are attempting to poke holes in the policy from a technical point. In the past, the Commission has been consistent and fair in the application of its policies, and they should continue to do so in this instance.

Mr. Criswell noted that the hospital industry's profit margins for FY 2006 are nearly 5%, and the expected revenue arriving in FY 2007 may push margins to 6% or 8%. Mr. Criswell then asked the Commission to compare these profits levels to those of a Medicaid managed care organization whose premiums are regulated by the Department of Health and Mental Hygiene (DHMH), and whose profit margins are built in to be less than 2%.

Mr. Criswell also asserted that if the cost shift is not recognized, payers would be making duplicate payments, once through higher outpatient rates and again on inpatient Charge per Case.

Mr. Criswell agreed that a deal is a deal; however, the deal was that there was to be a 1.1% improvement versus the nation.

Mr. Criswell stated that because of the increasing cost of treating patients, the Medicaid waiver which allows DHMH to continue the Medicaid managed care program, is in jeopardy. Loss of the waiver would affect not only Medicaid managed care, but also other Medicaid programs.

Paul Sokolowski, Vice President of Finance for the Maryland Hospital Association, thanked the staff for including the hospital industry's suggested method for allocating the previously undistributed FY 2006 case mix revenue in hospital rates in FY 2008.

Mr. Sokolowski noted that today's discussion is what the NOR/EIPA target will be for the period FY 2007 through FY 2009, not what rates will be for FY 2008 and 2009. Staff asserts that Maryland hospitals will be 3.49% less than the nation on NOR/EIPA at the end of FY 2009. However, that is an adjusted figure. If all the projections hold up, Maryland hospitals will be 4.49% below the nation at the end of FY 2009. MHA asks the Commission whether or not this is a wise place to be considering all the deliberations

that took place before the Commission's decision in April 2006. The hospital industry does not believe it is.

Mr. Sokolowski stated that the comments from the hospital industry today will focus on three key areas: 1) the revenue target and rate realignment; 2) cost increase pressures in the industry; and 3) financial condition and recapitalization.

Stuart Erdman, Senior Director of Finance-Johns Hopkins Health System, stated that the threshold question is not "a deal is a deal," but what was the deal, i.e., what was the target and what was the methodology to measure against that target. Mr. Erdman observed that the HSCRC has clearly established in both of the last two rate setting arrangements that the level of hospital revenue in Maryland will be controlled based on NOR/EIPA compared to the nation. The current arrangement covering FY 2007-2009 has established a fixed target of 3.1% below the nation on NOR/EIPA to be reached by 2009. It was not a sliding scale of 1.1% from some number that we did not know. It was never a rate of change test.

Mr. Erdman noted that the EIPA statistic was used in this test because it is a widely accepted concept for adjusting overall hospital financial activity for differences in total hospital volume. EIPAs account for both inpatient and outpatient activity, and the factors used to compute EIPAs are available and reliable for Maryland and the nation; so a true comparison can be made.

Mr. Erdman stated that rate realignment is a longstanding process used to match revenue to costs each year. One of the effects of rate realignment is to redistribute revenue between inpatient and outpatient rate centers. Such revenue shifts also occur nationally. Historically, rate realignment in Maryland has always been revenue neutral, and the projected impact of rate realignment has been factored into calculations to determine where Maryland hospitals will be in relation to the national NOR/EIPA target. However, in the past, rate realignment revenue shifts have not been used in the determination of negotiated industry revenue targets. Maryland hospitals do not believe a change in the NOR/EIPA target for rate realignment is necessary or warranted at this time.

Mr. Erdman noted that rate realignment over the course of the prior 3 year arrangement represented a shift of only \$1.8 million from inpatient to outpatient. Mr. Erdman asserted that part of the artificial revenue shift phenomenon that staff refers to happened in FY 2005. All parties were aware of at least half of the shift when the current 3 year arrangement was being negotiated.

Mr. Erdman pointed out that since 1995, Maryland hospitals' gross patient revenue as a percentage of total revenue mirrored the nation, and that the conversion factor used to calculate EIPAs in the U.S since 1995 has been higher than that in Maryland. This continued to be the case in FYs 2004 and 2005. For that period, the national conversion

factor actually went up by more than .9% more than Maryland's conversion factor. Therefore, if Maryland's conversion factor had been constant, Maryland's cost per EIPA would actually look better in relation to the nation by almost 1.0%. In conclusion, Mr. Erdman asserted that rate realignment is not something unusual and should not be the reason to adjust a negotiated target.

James Lee, Chief Financial Officer – Adventist HealthCare, stated that there are a number of cost pressures facing hospitals across the nation as well as in Maryland. They include manpower shortages in many job categories. Nursing has dual cost pressures: increases in basic nursing salaries and increases in nurse agency costs. Hospitals are beginning to see a nursing shortage crisis build up again. Hospitals have done a better job in the last 2 or 3 years of managing these cost pressures; however, they will continue accelerating in the next 3 years. In addition to the nursing problem, there are higher rates of vacancies in some of the ancillary services such as respiratory therapy, physical therapy, and many other areas.

Mr. Lee noted that another key issue to hospitals is physician coverage. Coverage issues are getting more and more difficult every day. Physicians are increasingly demanding paid ER coverage. In addition, they are asking for payment for their malpractice insurance costs. This cost pressure will be a bigger factor in hospital costs in the years to come.

Mr. Lee observed that advances in health information technology, e.g., electronic medical records, digital imaging/PACS, and bar-code enabled medication administration, will also require significant one-time and ongoing costs.

Mr. Lee observed that Global Insights hospital market basket inflation has been revised from 3.36% to 3.76%. After discussions with other Maryland hospitals, the consensus was that 3.76% is low, and that actual inflation is more in the 4% to 5% range. Mr. Lee asserted that hospital profitability has already leveled off.

Kevin Kelbly, Chief Financial Officer - Carroll Hospital Center, stated that staff's projection of profitability is based on expense inflation assumptions that are not in line with what hospitals are experiencing. The MHA has modeled operating and total profits for the period FYs 2007-2009 utilizing inflation of 4% and 4.5%, and projected depreciation and interest on the \$5 to \$6 billion of recapitalization of the industry. The model utilizing 4% inflation shows an up swing in profitability from 4.5% in 2006, to 5% in 2007, to 5.2% in 2008, and 5.5% in 2009. However, this picture changes if the expense assumptions are incorrect, and if the recapitalization comes on line sooner. For example, when the recapitalization occurs, the industry believes that there will be a dramatic drop in future operating and total margins to the level of 2.5% to 4%. This steep drop in profits is not acceptable for the industry. These results are even more troubling in light of a federal Balance Budget Amendment-like event that staff has suggested could occur as soon as 2010. Therefore, it is very important that the

Commission make the right decision on payment levels. Staff has acknowledged that recapitalization is a goal and hospitals have acted in good faith in taking on significant recapitalization commitments. However, hospitals believe that recapitalization requires sustained profitability over time. For the Commission to abandon or even compromise its goal by not maintaining adequate profitability would be a mistake. Therefore, hospitals believe that the target of 3.1% below the nation, which was discussed and approved as a compromise agreement, is still the right answer, not the 4.5% below the nation in staff's most recent recommendation.

Paul Sokolowski stated that there are many uncertainties in the rate arrangement: 1) how fast will the national revenue grow; 2) how fast will cost inflation increase; and 3) how fast can the recapitalization occur. The industry does not believe that we should interject the additional uncertainty of whether the target can be changed on an annual basis. Hospitals further believe that the facts simply do not warrant a target change at this time. Therefore, the industry asks that the Commission not follow staff's recommendation, which will result at the end of the day in Maryland hospitals being close to 4.5% below the nation on NOR/EIPA.

Commissioner Munn expressed his concern with the magnitude of the gap between staff's financial projections and those of the industry and asked for an explanation.

Robert Murray stated that there were differences in the assumptions used in the projections, i.e., volumes, marginal costs, wage pressure, etc. Staff intends to itemize those differences and test them for reasonableness. At the end of the process, staff will present to the Commission MHA's model and staff's model, with the differences in assumptions highlighted.

Jerry Schmith, Deputy Director-Hospital Rate Setting, stated that the major difference between the models was that staff used cost inflation projections from Global Insights of approximately 3.25%, while the industry used 4.5%. In addition, there are differences associated with a decline in hospital collections and the amount of revenue that should be included for partial rate applications for capital projects. Mr. Schmith noted that staff will meet with representatives of the industry in an attempt to agree on reasonable assumptions.

The Vice Chairman requested that the Commission be provided with sensitivity analyses based on agreed upon assumptions.

Commissioner Munn noted that since the projections show profits at or above the HSCRC financial targets, if the targets are not acceptable, what targets are reasonable considering the capital requirements of the industry?

Kevin Kelbly replied that the industry considers HSCRC's financial targets as long term targets. The industry does not have short term targets per se; however, hospitals

believe that the payment level that is being proposed by staff will not sustain the profitability necessary to hit the long term targets.

Robert Murray noted that the thought was that profits would exceed the targets for a period of time, and then when the capital costs were incurred, profits would come back down to the targets.

Mr. Murray stated that the focus of staff would be to outline the differences in assumptions in the modeling between staff and the industry, and then hone in on the outstanding issues. In addition, staff will perform sensitivity analyses that will be included in staff's final recommendation discussion at the February 2007 public meeting.

Finally, Mr. Murray stated that staff in its recommendation attempted to reduce the discussion to two issues: 1) does the Commission desire to have hospital rates grow faster than was anticipated when the target was set in April 2006 because of the revenue shift from inpatient to outpatient, a fact not known in 2006 by the Commission; and 2) does the Commission desire to further erode Maryland hospitals' position over the next 2 years versus the nation vis-à-vis the 1.1% improvement that was approved in April 2006.

ITEM VI **LEGAL REPORT**

Regulations

Final Adoption

Uniform Accounting and Reporting System for Hospitals and Related Institutions **– COMAR 10.37.01.02**

The purpose of this action is update the Commission's reporting requirements consistent with the Commission's current rate methodology.

The Commission voted unanimously to adopt the amended regulation.

ITEM VII

HEARING AND MEETING SCHEDULE

February 7, 2007 Time to be determined, 4160 Patterson Avenue

March 7, 2007 Time to be determined, 4160 Patterson Avenue

There being no further business, the meeting was adjourned at 10:40 a.m.