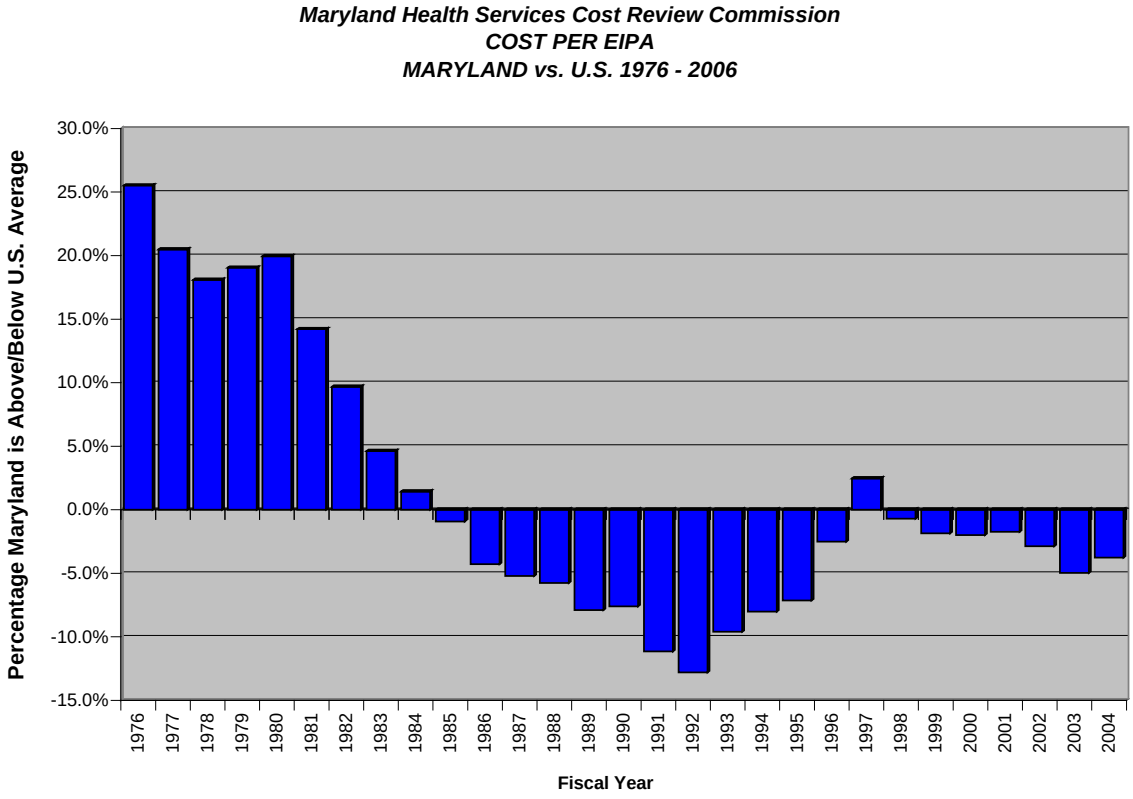
MARYLAND HEALTH SERVICES

COST REVIEW COMMISSION



REPORT TO THE GOVERNOR

FISCAL YEAR 2008

MARTIN O'MALLEY

GOVERNOR

STATE OF MARYLAND
HEALTH SERVICES COST REVIEW COMMISSION

Commissioners as of June 30, 2008 *

	Appointed	Term Expires
Donald A. Young, M.D. Chairman	July 1, 2007 (Replaced Chairman Irvin W. Kues)	June 30, 2010
Joseph Antos, Ph.D.	July 1, 2004	June 30, 2008
Raymond J. Brusca	July 1, 2005	June 30, 2009
Trudy R. Hall, M.D., P.A.	July 1, 2002	June 30, 2006
C. James Lowthers	July 1, 2007	June 30, 2011
Kevin J. Sexton	July 1, 2003 (Appointed Vice Chairman October, 2005)	June 30, 2007
Herbert S. Wong, Ph.D.	March 25, 2008*	June 30, 2009

* Effective March 25, 2008, Herbert S. Wong, Ph.D. replaced William Munn, Commissioner.

STATE OF MARYLAND

HEALTH SERVICES COST REVIEW COMMISSION

ANNUAL REPORT TO THE GOVERNOR

TABLE OF CONTENTS

This Governor's Report reports on activities of the Health Services Cost Review Commission for the Fiscal Year (FY) 2008. Audited hospital data throughout the report, however, are for the most recent fiscal year available, which in most cases is 2007.

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 2008. 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 2007 Disclosure Statement reported that the average amount paid for a hospital admission in Maryland rose 6.3% in FY 2007 to $10,038 from $9,440 in FY2006. This increase was above the estimated national average increase of 5.3% for the same time period. Maryland's rate of growth is below the national Consumer Price Index for Hospital and Related Services of 6.4 percent.

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 174% for hospitals nationally, according to the most recent data from the American Hospital Association (AHA). In Maryland, the payment systems builds the cost of uncompensated care into the rates, and all payers in Maryland pay the

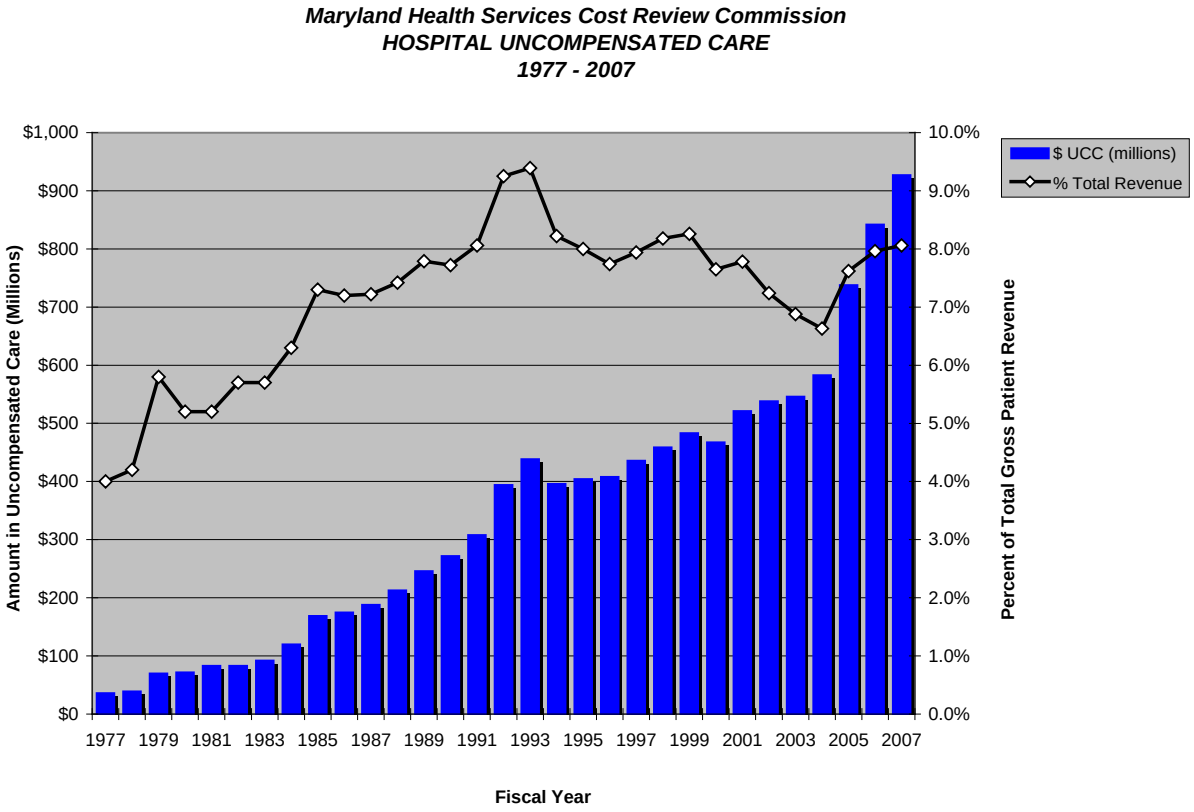
same rates for hospital care (For details, please see section entitled “Uncompensated Care” below).

In 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 especially difficult for “self-pay” patients and other third-party payers not granted discounts and present a serious dilemma in healthcare today.

In addition, an analysis of hospital costs shows that the average cost per admission at Maryland hospitals increased by 6.2% compared with an estimated 5.5% increase for the rest of the nation during FY 2007. In FY 1976, the cost per adjusted admission to a Maryland hospital was 26 percent above the national average. In FY 2006, the year for which the most recent data are available from AHA, the average cost per adjusted admission was 1.9 percent below the [illegible]. From 1977 to 2006, Maryland hospitals 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 2006 to Fiscal Year 2007. **(See Chart below)**. In relative terms, uncompensated care financed through the system ranged from 7.6% in 2000, to 7.8% in 2001, 7.2% in 2002, 6.9% in 2003, 7.0% in 2004, 7.6% in 2005, 8.0% care expenditure originated in Maryland’s metropolitan areas.



During FY 2008, the Department of Health and Mental Hygiene 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 Department of Health and Mental Hygiene decided to continue the imposition of day limits in State Medicaid reimbursement to acute care hospitals during FYs 2006, 2007, and 2008. 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 generally funded in future year hospital rates; however, 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 have the ability, under certain circumstances, to apply to the Commission for additional relief, if necessary. As a result of budget action taken during the 2008 Legislative Session to eliminate Medicaid day limits, the existing Medicaid day limits policy will terminate on January 1, 2009.

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 2007, Maryland general acute hospitals' profitability continues to increase. Operating and excess margins were 5.4% and 5.2% respectively, up from 5.0% and 4.5% in Fiscal Year 2006. 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 2006, the latest year that U.S. data were available, the cost per equivalent inpatient admission for acute hospitals in Maryland was $*9,082*, compared with the rest of the nation at $*9,255*. Thus, Maryland was approximately *1.9%* below the U.S. average.

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 312% from January 1, 1981, through June 30, 2007, compared to a 280% 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.

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 Years 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.

FY 2008 Budget

The HSCRC is supported by a non-lapsing Special Fund which is derived from user fees that are added to the rates of Maryland hospitals. Due to the technical nature of the work of the Commission, expenses are driven primarily by personnel costs and contracts. In FY 2008, the Commission employed 29 full-time staff.

During the 2007 Legislative Session, the General Assembly adopted HB 844 which, among other things, increased the maximum amount that may be assessed to support the Commission's operating budget from $4 million to $5.5 million.

In a November 2000 preliminary sunset evaluation of the HSCRC conducted under the Maryland Program Evaluation Act, the Department of Legislative Services (DLS) recommended that the Commission maintain a fund balance to 10% of its annual budget. The Commission has strived to reach this level, but the Commission's reliance on personnel and contracts has created challenges from year to year. State imposed hiring freezes and the targeted recruitment of

specialized personnel frequently result in longer than expected recruitment periods which, in turn, produce unanticipated surpluses at the end of the year.

After refunding a portion of user fee assessments in an attempt to attain an end-of-year reserve of 10%, the total user fee assessment in FY 2008 was $3.9 million. Total expenditures for FY 2008 were $4.4 million. Due to prudent spending and unanticipated delays in hiring, the fund balance at the end of fiscal year 2008 was $1.25 million (or 28% of expenditures). User fees will be reduced again in FY 2009 to achieve the 10% reserve requirement.

Other Projects

HSCRC Quality Initiative

Building on its rate setting approach, HSCRC has implemented a Quality-Based Reimbursement (QBR) Initiative, the planning of which began in 2003. For the Initiative, the baseline performance period is calendar year 2007, and the performance measurement period is calendar year 2008, with rate adjustments based on performance beginning July 1, 2009. The Initiation Work Group (IWG), comprising stakeholders from the hospital industry, payer groups, academia and research, and federal agencies, has completed its work and issued its recommendations for the HSCRC. The Commission approved the recommended design and incentives at its June 4, 2008 meeting. Initial measures used for the QBR initiative are 19 Hospital Quality Alliance (HQA) process measures posted on CMS Hospital Compare website, and also publicly reported on the Maryland Health Care Commission's Hospital Performance Evaluation Guide website.

As the percentage of patients impacted is initially small, it will be important to expand the Initiative rapidly to effectively monitor and encourage high quality care for Marylanders needing

hospital services. Successful expansion of the QBR Initiative will be accomplished through comprehensive stakeholder involvement. Going forward, the HSCRC will supplement or replace the process measures with outcome measures, and potentially patient experience and structural measures as well. In June 2008, the HSCRC established an Evaluation Work Group (EWG) with a diverse stakeholder composition similar to that of the IWG. Their mission is to evaluate the effectiveness of the QBR Initiative, considering the relevance and importance of the current measures set as well as other potential candidate measures. The goal is to make recommendations for retiring old measures and adding new measures as appropriate, since integrating various measure types-process, outcome, patient experience, structure-provides a more complete assessment of quality and helps to avoid perverse incentives.

CMS' recommendations to Congress on hospital value-based purchasing were not acted upon by Congress this past session and will not be implemented in October 2008 as was initially anticipated. Therefore, in addition to improving the quality of hospital care in Maryland, our all-payer hospital QBR system has the opportunity to influence the design of similar systems, including Medicare's value-based reimbursement system for hospitals.

Reporting to the public on quality related performance has and will continue to be an important part of any initiative designed to improve quality of care. Further deliberations must be devoted to the issue of public reporting, and going forward we expect to continue to work closely with MHCC in light of their substantial experience in public reporting of quality data and information.

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 events 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 (MHA) 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, the Maryland Hospital Association (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 broader 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, increased rates to cover 50% of the reasonable budgeted costs of the MPSC for the first three years of the project. For FY 2008, the fourth year of such funding, $1.13 million has been included in the rates of

certain hospitals for this purpose. The Commission included $762,000 in rates in FY 2005, $936,000 in FY 2006, and $1.14 million in FY 2007.

To date, the MPSC has conducted continuing and interactive collaborative programs, which have resulted in reductions in ventilator-associated pneumonia and catheter-related blood stream infections at participating intensive care units (ICUs) in Maryland. The Center 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 its 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 2007, Maryland hospitals reported providing a total of over $812 million in benefits to their communities. Of this, $270 million was provided in health professions education activities, $260 million in charity care, $170 million for mission driven health services,

over $59 million in community health services, $11 million for donations, $15 million in community building activities, nearly $6 million in community benefit operations, $13 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 years' 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 2008 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	3	Three requests for approval of an increase to all rates Approved:2
Partial Rate Applications	12	Eight requests for approval of a rate for a new service Approved:8
	2	One request for a rebundled rate, i.e., a rate for a service furnished by an off-site provider only to hospital inpatients, and one request for approval to replace a rebundled rate with a rate for a service provided by the hospital to both inpatients and outpatients. Approved:2
Applications for Alternative Method of Rate Determination*	20	Thirteen requests for approval to participate in global fixed price alternative payments arrangements** Approved:13
		Six requests for approval to participate in capitation alternative payment arrangements*** Approved: 6
		One request for approval to allow a discount to a payer to reflect hospital cost savings generated by services provided by that payer. Approved:1

*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 2008, forty-five (45) acute care hospitals and one (1) chronic specialty hospital participated in the Charge per Case Target rate setting methodology. On July 1, 2007, an update factor of 3.81% was applied to the Charge per Case Targets and 100% inpatient unit rates of each hospital, and an update factor of 4.0% was applied to each hospital's ancillary unit rates.

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 community 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 its costs are considered 100% 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 average 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 its 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. This moratorium was subsequently extended for another year.

During fiscal year 2008, two hospitals filed and received a full rate review. The following table summarizes the results.

FULL RATE REVIEWS - FISCAL YEAR 2008

HOSPITAL	EFFECTIVE DATE	OVERALL RATE CHANGE
Union Hospital of Cecil County	June 1, 2008	2.60%
Garrett County Memorial Hospital	June 4, 2008	6.71%

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, subsequently extended for a third year. Consequently, no additional hospitals have been identified as high cost during fiscal year 2008. McCready Memorial Hospital in Crisfield Maryland is technically on a spend down. However, the scheduled offset for fiscal year 2008 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% 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 below 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 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).

The Commission continues to convene a number of workgroups to discuss and refine various aspects of the system redesign.

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 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 were three percent above their peer group average were identified as having high charges and targeted for a spend down to reduce their charges relative to their peers. There were no major changes to the ROC policy in the FY 2007, it was applied on a limited basis in January 2009, and allowed three hospitals to

file full rate review applications. The Commission explicitly decided not to use the results the January 2008 ROC require spend downs by hospitals. The Commission is currently engaged in a process to extensively revise the ROC methodology.

In October 2003, the Commission modified its ICC policy to recognize the need for capital in Maryland's hospitals. The new policy permits 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. Provide 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 that 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 beginning November 1, 2005. The moratorium was ended in January 2008 when the Commission did a ROC analysis using the pre-2005 methodology and allowed a limited number of hospitals to file full rate reviews. The Commission explicitly chose not to use the results of the January 2008 ROC to impose spend downs on hospitals that showed excessive [redacted]. The Commission is currently engaged in a process to extensively revised the ICC and ROC processes by early 2009.

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, 1.0 percent in FY08. For FY09 case mix growth will be limited to 0.5 percent. These limits were put in place because coding improvements resulted in higher measured acuity without commensurate increases in resource use.

C. Outpatient Charge Per Visit Methodology

In FY 2008 the Commission approved an Ambulatory Surgery Revenue methodology. The methodology used the Enhanced Ambulatory Patient Groups (EAPGs) developed by 3M to establish risk adjusted, hospital specific per case targets for a set of outpatient services. Subsequently, the Commission chose not to implement the methodology for FY 2008, owing to challenges in the collection of data and finalizing certain aspects of the Policy's implementation. For FY 2009, the Commission approved a Charge Per Visit methodology, which expanded upon the Ambulatory Surgery Revenue Methodology to include clinic and emergency department services in the hospital specific targets.

D. 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. In

June 2002 the regression was amended 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.

E. 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. 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, Maryland Higher Education Commission (MHEC) and HSCRC staff met to review the applications from 41 institutions. The Evaluation Committee recommended, at the June 13, 2007 HSCRC monthly meeting, and all 41 hospital applications totaling approximately $10 million were approved for FY 2008. These 41 applications provide for creative projects in nursing 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 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 about 455 more baccalaureate nurses as potential bedside nurses and a 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.

For FY 2009 of NSP II, four proposals were received. The four proposals represented the eastern, central and western parts of the State. These programs will provide approximately 350 new faculty members for Maryland schools of nursing, and 120 new RNs for western Maryland, where

they are so needed. The budget for the three proposals is $2.8M over the next 5 years of the grants, with an estimated $1.7M in Statewide Initiatives, for a total of $4.5 over the next 5 years.

F. 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. Outpatient Database

The Outpatient Database Reporting Regulations, effective June 4, 2007, allow consolidating the Commission's current ambulatory surgery and ambulatory care data set into one uniform outpatient hospital data set. These new regulations will expand and refine the outpatient hospital data set to include collection of all hospital outpatient services, including emergency department visits, ambulatory surgery and referred ancillary services. The additional data will also enhance the Health Services Cost Review Commission's ability to analyze and monitor hospital based outpatient case-mix related issues, compare hospital outpatient service cost, and set case rates for hospital outpatient services. Hospitals submit outpatient care data to the HSCRC within 60 days following the close of a quarter.

5. 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 2008, 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*. On July 18, 2007, the Commission adopted an amendment to Regulation .06, which was proposed for adoption on March 7, 2007. 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 10.37.03

This regulation concerns the *Types and Classes of Charges Which Cannot Be Changed Without Prior Commission Approval*. On April 9, 2008, the Commission proposed for adoption an amendment to regulation. The purpose of this amendment is to help assure greater equity in hospital pricing practices.

COMAR 10.37.04

This regulation concerns the *Submission of Hospital Outpatient Data Set to the Commission*. On April 9, 2008, the Commission proposed for adoption an amendment to Regulation .01. The purpose of this action is to have the reporting time frame of the Outpatient Data regulations conform to the Hospital Inpatient Discharge Data regulations reporting time frame.

COMAR 10.37.06

This regulation concerns the *Submission of Hospital Discharge Data Set to the Commission*. On September 12, 2007, the Commission adopted amendments to Regulations .02 and .03. The purpose of this action is to expand the inpatient case mix discharge data set to include an additional 15 diagnosis codes and an additional 15 diagnosis-present-on-admission codes, and a new Type 4 Record. These new data elements will also 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.

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 August 15, 2007, the Commission adopted new Regulation .07-1, entitled "Outpatient Services- At the Hospital Determination," which was proposed for adoption on April 11, 2007. 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.

On September 12, 2007, the Commission adopted, with non-substantive changes, an amendment to Regulation .03. The purpose of this action is to extend the moratorium on the filing of

full rate applications, until November 1, 2008, or until an earlier date as designated by the Commission.

Finally, on April 11, 2008, the Commission proposed for adoption amendments to Regulation .26-1, entitled "Maryland Health Insurance Plan (MHIP) Assessment." The purpose of this action is to set forth the assessment on hospitals to operate and administer the MHIP Plan consistent with recently enacted legislation. The Commission also requested and was granted emergency status to this regulation, effective July 1, 2008 to December 31, 2008.

VI. LEGISLATION AFFECTING THE HEALTH SERVICES COST REVIEW ENABLING ACT

A number of bills of interest to the Commission were introduced during the 2007 special session and the 2008 regular session of the General Assembly.

A. 2007 Special Session

House Bill 1

This special session bill, companion to SB 1, entitled *Budget Reconciliation Act*, would make an adjustment to the State's funding commitments and declare the intent of the General Assembly to reduce spending in FY 2009 by $550 million which would include: reducing State health insurance expenditures; eliminate 500 vacant positions (including 1 vacant HSCRC position); freeze the per pupil inflation amount in State education aid formulas, etc. (Became Law- Ch. 2)

Senate Bill 6

This special session bill, companion to HB 6, entitled *Working Families and Small Business Health Coverage Act*, would expand eligibility for Medicaid benefits to certain parents, caretaker relatives, and childless adults with incomes up to 116% Federal Poverty Guidelines (FGP); establish a Small Employer Health Benefit Plan Premium Subsidy Program administered by MHCC, in consultation with DHMH; and provide funding for the provision of health care services in Prince George's County under specified circumstances. The bill also would establish a Health Care Coverage Fund consisting of certain monies from the MHIP Fund, monies collected from any HSCRC hospital assessment of uncompensated care savings achieved under the bill, investment earnings and any other monies from any other source accepted for the benefit of the fund. In addition, the bill authorizes the provision of an annual operating grant of up to $10.0 million to an independent entity with authority over the facilities currently operated by services currently provided by Dimensions Healthcare System in FY 2011 through 2013. Monies transferred from the MHIP fund or collected from an assessment by HSCRC on hospitals may not be used for the grants. (Became Law-Ch. 7)

B. 2008 Regular Session

House Bill 278

This bill, entitled *DHMH- Powers of the Secretary*, clarifies that if counsel and other help provided by the Secretary of Health and Mental Hygiene do not result in feasible or successful proposals to assure the public health of an identified underserved area of the State, the Secretary may

provide the needed health care facilities, staff or services by [redacted] the provision of State health care services to the underserved area, approve contracts with specified public or private health care entities; etc. (Became Law- Ch. 656)

House Bill 1037

This bill, entitled *Prince George's County Hospital Authority PG 410-08*, would establish the Prince George's County Hospital Authority; providing for the mission of the Authority; providing that the Authority is an instrumentality of the State and a public corporation; providing that the exercise by the Authority of specified powers is the performance of an essential public function; requiring the Authority to be subject to the State Open Meetings Law; exempting the Authority from specified provisions of State law; etc. (Failed)

House Bill 1039

This bill, cross-filed with SB 1007entitled *Prince George's County Hospital Authority PG 408-08*, would establish the Prince George's County Hospital Authority; providing 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 specified powers is the performance of an essential public function; require the Authority to be subject to the State Open Meetings Law; exempt the Authority from specified provisions of State law; etc. (Became Law- Ch. 680)

House Bill 1224

This bill, companion to SB 765, entitled *Hospitals - Nursing Care Committees, Staffing Plans, and Commission on Nursing Acuity*, would require specified facilities to provide the HSCRC

with specified information; require hospitals to create a nursing care committee that performs specified duties; require hospitals to adopt and implement a specified written staffing plan; require a hospital to give consideration to specified factors when adopting and implementing the staffing plan; establish the Commission on Nursing Acuity; etc. (Withdrawn)

House Bill 1587

This bill, companion to SB 974, entitled *Health Services Cost Review Commission - Averted Uncompensated Care – Assessment*, would require the HSCRC to assess an amount in hospital rates to reflect a reduction in hospital uncompensated care and to operate and administer the Maryland Health Insurance Plan; require, for the portion of the assessment related to an expansion of health care coverage, the Commission to ensure that the assessment amount not exceed specified savings and require each hospital to remit its assessment amount to the Health Care Coverage Fund; etc. (Became Law- Ch. 245)

Senate Bill 765

This bill, companion to HB 1224, entitled *Hospitals - Nursing Care Committees, Staffing Plans, and Commission on Nursing Acuity*, would require specified facilities to provide the HSCRC with specified information; require hospitals to create a nursing care committee that performs specified duties; require hospitals to adopt and implement a specified written staffing plan; require a hospital to give consideration to specified factors when adopting and implementing the staffing plan; establish the Commission on Nursing Acuity; etc. (Withdrawn)

Senate Bill 946

This bill, entitled *Hospital Regulation and Financing - Maryland Hospital Bond Program and User Fees of the HSCRC***,** would specify that specified hospital plans must be acceptable to the Secretary of Health and Mental Hygiene, in consultation with the Maryland Health Care Commission; provide that the Maryland Hospital Bond Program shall provide for the payment and refinancing of specified public obligations issued on behalf of a hospital on or after October 1, 2008, under specified circumstances; etc. (Became Law- Ch. 641)

Senate Bill 974

This bill, companion to SB 1587, entitled *Health Services Cost Review Commission - Averted Uncompensated Care – Assessment*, would require the HSCRC to assess an amount in hospital rates to reflect a reduction in hospital uncompensated care and to operate and administer the Maryland Health Insurance Plan; require, for the portion of the assessment related to an expansion of health care coverage, the Commission to ensure that the assessment amount not exceed specified savings and requiring each hospital to remit its assessment amount to the Health Care Coverage Fund; etc. (Became Law- Ch. 244)

Senate Bill 1007

This bill, cross-filed with HB 1039, entitled *Prince George's County Hospital Authority*, 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 specified powers is the performance of an essential public function; require the Authority to be subject to the State Open Meetings Law; etc. (Failed);

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 REIEW 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
Virginia Layfield	June 30, 1980	June 30, 1988
Walter Sondheim, Jr.	July 1, 1987	June 30, 1991 (Resigned)

[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.

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

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
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.