

its CPC target revenue by what it would have paid for the devices. Because the system's revenue is capped, the revenue given up by HCH will be available to other hospitals.

Staff found that for the first 21 months of the project Kaiser's cost cutting activities produced savings of 3.14%. In addition, HCH gave up approximately \$1 million in approved revenue associated with the invoice costs of major medical devices supplied to Kaiser members.

Therefore, staff recommended that the Demonstration Project be continued for two additional years. HCH will be required to continue to report annually on the justification of the cost saving activities, as well as the reduction of its approved revenue associated with the provision of major medical devices to Kaiser members.

Commissioner Sexton officially recused himself from the vote on this issue and all other present Commissioners voted in favor of the staff's recommendation.

Johns Hopkins Health System – 1951A

On June 19, 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 solid organ and bone marrow transplants with the United Resources Network for a one year period beginning April 1, 2007.

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 Specialty Hospital – 1952N

On June 20, 2007, University Specialty Hospital submitted an application requesting a rate for Respiratory Therapy (RES). The Hospital requested the state-wide median rate RES be approved effective July 1, 2007.

The Hospital has developed a comprehensive outpatient Rehab program for patients with chronic lung diseases. The Hospital asserted that the Program will not only improve the patient's quality of life, but will ultimately transfer the responsibility of treatment from a clinical setting to the home, thereby decreasing hospital admissions.

The Hospital needs the new RES rate because it currently does not have an approved RES rate. When its rates were set 25 years ago, the Hospital did not provide outpatient

RES services, and the costs associated with the provision of inpatient RES services were embedded in its room and board rates.

The Hospital requested that it be permitted to charge its new RES rate only to Program outpatients for one year with the condition that it will work with staff to remove RES costs from the room and board rates and establish a RES rate for both inpatients and outpatients effective July 1, 2008.

Staff recommended that the Commission waive the regulation requiring the filing of an application 60 days prior to the opening of a new service and to approve the Hospital's request.

The Commission voted unanimously to approve staff's recommendation.

University of Maryland Medical Center – 1955A

On July 3, 2007, the University of Maryland Medical Center filed an application requesting approval to continue to participate in a global rate arrangement with the National Marrow Donor Program for a period of three years beginning August 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.

ITEM IV **SUMMARY OF FY 2006 DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA**

Chairman Kues stated that, financially, fiscal year 2006 was an excellent year for Maryland hospitals and the patients they served. Patient revenue per admission rose 5.4%, which was below the estimated national average of 6.4%. Also, the growth in revenue was less than the growth in the CPI for hospitals and related services of 6.8%. However, the most important number is that the cost per admission in FY 2006 increased by only 5.4%. This shows continued cost control by hospitals.

The Chairman observed that these results should improve the State's position in both revenue and expenses per admission to 5% below the nation.

In addition, the Chairman announced that hospital total profits increased by 4.5% in FY 2006 versus 4% in FY 2005.

The Chairman thanked the hospitals and the payers for their cooperation in making FY 2006 a successful year. This continued cooperation is responsible for Maryland being able to continue to satisfy the tenets of the Commission. It is also the key to providing patients with unparalleled access to reasonably priced, high quality hospital care in Maryland. As we will see from the next agenda item, that cooperation is about to be put to a rather serious test.

ITEM V
REVISED STAFF RECOMMENDATION REGARDING CORRECTIVE ACTION IN
RESPONSE TO THE MEDICARE WAIVER TEST RELATIVE MARGIN

Robert Murray, Executive Director, presented a revised draft recommendation urging corrective action in response to the deterioration of the Medicare Waiver Test relative margin. Mr. Murray detailed the benefits of the Medicare waiver to Maryland in terms of equity in the financing of the cost of hospital care, most specifically, the equitable financing of uncompensated care, as well as the cost constraint capability and the leverage that the waiver provides the HSCRC. Mr. Murray stated that the waiver creates uniform incentives for hospitals and aligns those incentives between payers and hospitals. The waiver also affords Maryland additional financial resources from the federal government.

Mr. Murray noted that there were two components to the waiver test: 1) the system must remain an all-payer system; and 2) that the rate of increase in Medicare payments per discharge in Maryland must be less than that in the nation for the period from 1981 to the present. The rate of increase test is the focus of staff's recommendation.

Mr. Murray reported that the results of the most recent relative margin test for the twelve months ended March 2006, which calculates how much Maryland Medicare payments per discharge can grow if national Medicare payments remain unchanged, showed a 10.01% waiver cushion. Mr. Murray indicated that staff was concerned that the approved revenue update factors of 6.25% in FY 2008 and FY 2009, coupled with the proposed CMS update for FY 2008, which includes for the first time in a number of years a "look back" provision that will adjust for potential larger than appropriate case mix creep due to the adoption of a severity adjusted grouper in October of 2007, will result in a substantial erosion in the waiver margin to approximately 6.44% by June 2009.

Mr. Murray added that all three year rate arrangements include "tolerance" or "fail safe" provisions regarding Maryland's position versus the nation on the Medicare Waiver Test. The current three year arrangement states, "If at any time the Medicare relative

waiver test cushion is estimated to be below 7%, based on HSCRC modeling procedures, using the CMS actuary's most recent projections, and HSCRC case mix data, the Commission would be authorized to take immediate action to restore this minimum waiver cushion and reverse any further deterioration."

Mr. Murray noted that this circumstance is of particular concern because there is a high expectation that there will be another correction to the Medicare program nationally in 2010 because of the large budget deficits and the deficits in the Medicare Trust Fund.

As a result, staff felt it necessary to recommend at this time a change in the update factors to 4.5% in FY 2008 and, provisionally, to 4.5% in FY 2009, while continuing to monitor the Medicare waiver situation. All other things being equal, this action will result in a position of about 10% relative margin. This would put us in a stronger position to weather the storm that will most certainly hit, if not in 2010, then in 2011. The goal is not to mirror Medicare, but to build up enough cushion that in the future, when hospitals nationally may be getting 0% or -1% updates from Medicare, the Maryland system will be able to provide 2% to 3% updates.

Mr. Murray summarized the staff's primary recommendations: 1) limit case mix growth in FY 2007 to 1.65%; 2) reduce FY 2008 approved inpatient revenue growth by 1.75%, from 6.25% to 4.5%; 3) provisionally reduce the FY 2009 approved revenue growth to 4.5%, subject to change depending upon the result of subsequent waiver cushion forecasts; and lift the moratorium on full rate reviews no later than April 1, 2008.

Paul Sokolowski, Senior Vice President of Finance - of the Maryland Hospital Association (MHA), Calvin M. Pierson, President of the MHA, and Raymond A. Grahe, Vice President of Finance, Washington County Health System, presented MHA's response to the draft staff recommendation.

Mr. Sokolowski stated that it is extremely important to the hospital industry to preserve the all-payer system and that hospitals are committed to working in a cooperative process to do so. However, the action recommended by staff would be precipitous. There needs to be a forum to discuss options. There is ample time for thoughtful, reasoned review of the data and consideration of options to address the situation. Mr. Sokolowski noted that it needs to be remembered that the 2008 planning cycle for hospitals is already over. Budgets and salary increases have been approved. Program and capital commitments have also been made. It is difficult when all these actions have occurred to look at Staff's recommendations and not realize that they would cause serious difficulties within the industry. According to Mr. Sokolowski we have lost sight of the all-payer target of being 2% below the nation on net operating revenue per admission. Staff's recommendation would take \$250 million of expected revenue out of the system on a permanent basis. That creates an incredible, if not impossible challenge for the industry.

Mr. Grahe outlined other possible options: 1) “blend” the inpatient and outpatient rates of increase in the update factor; 2) reduce Medicare utilization of resources; 3) re-examine the overhead allocation methodologies; 4) revise the Medicare differential; 5) revise the basic structure of the waiver “experiment” to reflect the changing health care environment nationally; and 6) reduce supply costs. Mr. Grahe stated that the answer may lie in a combination of options.

Calvin M. Pierson, President-Maryland Hospital Association, stated that how we respond to the waiver numbers is a significantly consequential long term issue, not a short-term quick-fix solution. This issue goes to the very heart of the continuation of our system, both in terms of the actions that are taken, as well as the consequences for hospitals, and whether they would support the system in the future.

Mr. Pierson noted that we have already heard that the actions needed to address this issue will have a painful effect on hospitals and the patients they serve, whatever we do. But the Commission’s response must be deliberate. It cannot be rushed. This is not panic exercise. If we approach it that way, we will make a mistake. The solution has to be a comprehensive evaluation of all the options, not just one option. It has to be based on high level discussions among all the parties.

Mr. Pierson presented several specific recommendations. First, the Chairman should appoint a panel of Commissioners, hospital, and payer executives to evaluate all the options for short-term and long term action to preserve the all-payer system while, most importantly, minimizing damage to the ability of hospitals to provide care. Secondly, a reasonable timeframe for short-term and long-term action should be set. Mr. Pierson stated that MHA would recommend that no short-term action should be taken before October. The study of long-term options should take four to five months. The third recommendation is to set a reasonable goal in terms of the waiver cushion. The language of the three-year arrangement says “to restore this minimum waiver cushion.” It does not say to restore 10%. It doesn’t say to do it within eighteen months. It strongly implies that the 7% minimum waiver cushion should be restored. That may not be exactly where we want to end up, but the 7% minimum waiver cushion is a lot different than staff’s proposal. What is important here is, as a former Chairman used to say, “changing the current direction of the trend” in the waiver cushion, not to get to some “magic number at some magic date.” We must develop a plan with short-term and long-term recommendations that change the curve. That is what is important.

Mr. Pierson noted Mr. Murray’s assumptions that proposed budgetary cuts will be enacted by Congress relative to the growth in the Medicare. That is the worse case scenario. The best case scenario is that none of the cuts occur. We must keep in mind that they are proposals at this time.

In conclusion, Mr. Pierson stated that the recommendations are offered in a cooperative spirit. Cooperation is an indispensable ingredient in maintaining a stable, viable, and healthy hospital system, and a healthy all-payer system as well. This demands a deliberative and cooperative process. Hospitals across the State are very concerned about this issue and uniformly opposed to staff's draft recommendation.

Vice Chairman Sexton asked Mr. Pierson whether he was concerned that waiting until October would prolong and add more uncertainty.

Mr. Pierson responded that you have to balance that concern with doing the right thing. According to Mr. Pierson, there is no substitute for looking at all the options, and that cannot be done right away. Since we are already into the rate year and hospitals know what is on the table, they will be prudent and make contingency plans. It is far more important to take the time and not make a serious mistake.

Commissioner Antos asked Mr. Pierson whether his answer implied that hospitals should be given a chance to figure out how they could accommodate staff's proposed modification of the update factor, i.e., if the decision is made to go with staff's recommendation, the industry can cope with it.

Mr. Pierson answered that the inference was wrong. What he said was that a high level waiver action group should be put in place immediately and should look at short term actions that hospitals can take, and that the Commission can take, in the first year. It should also look at this issue in a longer term context, because it is going to be with us for many years. All the options have to be addressed. Some of those options specifically have to do with what hospitals can do with their Medicare costs in response this problem. Other parts of the solution relate to things that the Commission can do in the context of the all-payer system, which are not limited to what staff has put on the table. For example, the blending of inpatient and outpatient rate increases, which, as it stands right now, puts much more pressure on the inpatient waiver test than the industry thinks it needs to.

The Chairman noted that his perception of the problem was that it is composed of two parts: 1) taking action for 2008; and 2) a longer plan, maybe a three year plan. There is much going on with the structure of the entire Medicare system that will require a high level group to look at the situation long range. However, the Chairman's immediate concern is doing something for 2008.

The Chairman asked whether MHA was going to come forth in the next month or two with some specific short term recommendations for 2008.

Mr. Pierson responded that if we take a month or two to deal with the issue and a high level group was put together to focus on the short term, MHA would come to the table with specific recommendations. Mr. Pierson reiterated his belief that it is a mistake for

the Commission to take action unilaterally, even if it is just a short term action relating to 2008 without engaging the industry and the payers. It is far too important an issue. The magnitude of the threat to hospital payments over the next two years has everyone concerned.

Hal Cohen, PhD., representing CareFirst of Maryland and Kaiser Permanente, stated that the waiver is essential for the equity and affordability aspects of the all-payer system. But, a large part of the trade-off for the waiver was cost containment. It is very important to remember how favorable the waiver test we have is. There are three aspects of the value of the waiver: 1) Medicare and Medicaid pay their fair share of inpatient full financial requirements; 2) Medicare and Medicaid pay their fair share of outpatient full financial requirements; and 3) Medicare beneficiaries pay only their fair share (20%) of Part B services as opposed to what they pay in the rest of the country. The total value of the waiver to Maryland is many hundreds of millions of dollars in federal funding.

Dr. Cohen stated that there is no good reason for the waiver margin to be as low as it is, or as low as it is projected to be. The Commission should follow the logic of its cost and profit targets. A large part of the problem is that the Commission, to some extent, has not followed its cost and profit targets; instead, it is tracking net patient revenue (NPR), which is out of control nationally. If you follow the logic of having costs that are 3% to 6% below the nation; given that the market basket is approximately 3.1% and real case mix is about 1% hospitals should be able to maintain their current profit levels at the 4.5% update factor that staff proposes. In addition, there are volume increases at 100% variable costs, as well as other sources of productivity.

Dr. Cohen asserted that staff's recommendation will enable hospitals to maintain the coverage of their full financial requirements and earn a reasonable profit. That is what is important, not where we fall relative to the nation on NPR. We all know that Medicare payments will be constrained. We just don't know when. Therefore, it is important that we go into that period with a reasonable cushion.

Dr. Cohen suggested that the Medicare waiver cushion has fallen for two reasons. One, Medicare has become a worse payer. Med Pac is projecting that in 2008, Medicare will pay about 97% of Medicare allowable inpatient costs, which may be as low as 93% of full costs. However, when you consider that Medicare in Maryland is paying its share of uncompensated care, working capital, and the mark-up, plus the 6% differential, the waiver margin should really be in the 12% to 15% range (the 3% range is the result of the target range of 3% to 6% below the nation on costs).

Again, much of the problem, according to Dr. Cohen, is the result of the misplaced emphasis on national NPR. NPR is being driven up across the country because of the great disparity between costs and charges. That is the problem of using NPR rather

than reasonable costs. When you focus on NPR, you lose track of costs, and you lose track of the profit targets. Those are the things that the Commission always financed. There is no question that the Commission should finance the full financial requirements of efficient and effective hospitals. What we don't need to do is to follow the nonsense that is going on in the rest of the country.

Dr. Cohen noted that MHA's option to blend the different rates of increase for inpatient and outpatient services would make no difference as long as rate realignment is performed. MHA's suggestion to reduce Medicare utilization of resources should also result in rate reductions so that all payers benefit. With regard to reexamining methodologies that allocate costs between inpatient and outpatient, evidence suggests that we are already over-allocating costs relative to the nation to the outpatient side. Our average outpatient charge is much higher relative to the nation than our average inpatient charge. Dr. Cohen strongly disapproved of the option to increase the Medicare differential, noting that such action is both in direct conflict with equity of the all-payer system and unnecessary. Dr. Cohen also observed that incentives to reduce supply costs, as suggested by MHA, are already in place.

Brett Lininger, representing Coventry Health Care; and Kevin Criswell, representing Amerigroup; spoke in support of staff's recommendation.

Brian Gragnolati, President and CEO of Suburban Hospital; Albert Counselman, Chairman of the Board of St. Agnes Health Care; Bonnie Phipps, President of St. Agnes Hospital; Benjamin Mason, Chairman of the Board of Bon Secours Baltimore Health System; Wayne Johnson, Chairman of the Board of Garrett County Memorial Hospital; Carl Schindelar, President and CEO of Franklin Square Hospital Center; Michael Curran, CFO MedStar Health; Ronald Peterson, President of the Johns Hopkins Health System; and G.T. Dunlop Ecker President and CEO of Dimensions Healthcare System spoke in opposition to staff's recommendation. They also expressed their concern over the reaction of capital markets to such an unanticipated change in the industry's revenue stream, the need for thoughtful deliberation by the Commission, and the deleterious effect on capital projects and other programs already committed to by hospitals. All of the speakers urged the Commission to work with the industry and to give consideration to the options suggested by MHA.

Barry Rosen, representing United HealthCare, suggested that this was an opportunity to address two other policies of the Commission which, if altered, would enhance the waiver cushion: 1) case mix increases; and 2) the increase in admissions. Mr. Rosen asserted that slight case mix increases have little impact on expenses, while dramatic increases in case mix have some impact, but many costs are fixed. Similarly, the costs associated with increases in admissions should be not treated as 100% variable because some costs are fixed.

Mr. Rosen stated that to preserve the Medicare waiver, the Commission should reduce rates for this year and next, and also stop encouraging hospitals to increase their case mix and to increase their admissions.

The Chairman thanked all the individuals for their comments. The Chairman reiterated that we have a two part problem, the FY 2008 problem and the ongoing structural problem of the entire system. The Commission will consider all of the comments and move in a rational manner on both problems.

ITEM VI
FINAL RECOMMENDATION TO EXTEND THE HOSPICE DEMONSTRATION PROJECT

In 2001, the Commission approved a two year Demonstration Project for the provision of inpatient care to registered Hospice patients. Under the Project, hospitals are allowed to enter into agreements with hospices to accept the per diem amount paid by Medicare for general inpatient hospital care for hospice patients, with the difference between HSCRC approved rates and the per diem written-off as a contractual allowance and a loss not reimbursable through the UCC policy.

The Project was subsequently extended for additional two year periods in 2003 and 2005.

Fourteen hospitals have participated in the Project. During the period from April 2005 through March 2007, 692 patients were admitted, and hospitals have written-off approximately \$1.3 million.

Because the Project provides a real benefit to the citizens of Maryland and the losses generated by participation in the project have been relatively minor, staff recommended that the Project be made permanent under the condition that losses associated with the Project continue to be manageable and do not endanger the financial condition of the participants. Staff will also continue to report to the Commission annually on the experience of the Project.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII

LEGAL REPORT

Regulations

Final Adoption

Uniform Accounting and Reporting System for Hospitals and Related Institutions – COMAR 10.37.01.06

The purpose of this action is to delete the requirement that of listing the home address of a trustee, a director, or an officer in a report required of nonprofit hospitals and related institutions.

The Commission voted unanimously to adopt the proposed regulation.

INTRODUCTION OF NEW STAFF MEMBER

Mr. Murray introduced Cynthia Saunders as the new Chief of Special Projects. Mr. Murray noted that Ms. Saunders comes to the Commission from the academic world where she taught in the area of Health Services Administration at California State University, Long Beach and the University of Maryland. While in California, she served as Principal Investigator on several quantitative and qualitative research studies on the uninsured population. Ms. Saunders has earned a PhD in Socio-Medical Sciences from Columbia University, an MPH in general public health from the University of Rochester, and a BA in Finance from the University of Cincinnati.

30th ANNIVERSARY OF MARYLAND'S MEDICARE WAIVER

The Chairman stated that this July marks the 30th anniversary of Maryland's All Payer Waiver with Medicare. The waiver represents a unique success story in the annals of public policy initiatives in the United States, which we in Maryland can all be proud. The waiver, and the All-Payer System it makes possible, confers substantial benefits to the State. They include:

- Provides unparalleled access to hospital care for our citizens
- Creates the most equitable payment system in the country – in light of the cost shifting that goes unabated nationally
- Allows for highly effective cost control mechanism (Maryland was 25% above the nation in cost per admission in 1976 – now 4% below)
- Produces highest level of financial stability and predictability for hospitals

- Brings in more federal dollars annually (approximately \$500 million)

The Chairman introduced Ms. Kirsten Soper, assistant to Senator Barbara Mikulski; Ms. Sopper presented comments from the Senator. The Senator stated that it has been both a privilege and a pleasure to have worked to secure and maintain this initiative. The Senator congratulated the Commission on its pioneering work in stabilizing equitable pricing for hospital services and in the successful evolution of our All-Payer System into a model that others only attempt to emulate. The Senator further stated that, together, we have created a system of cost effective health care delivery, especially to those who may otherwise not receive such care. The Senator thanked the Commission for its continued commitment to accessible, affordable health care for all Marylanders.

Renee Cohen, assistant to Senator Ben Cardin, presented a letter from the Senator. The Senator expressed his regrets for not being able to attend the celebration honoring the great strides made by the Commission over the last 30 years. The Commission has become a model of success across the country. The Medicare waiver made it possible for the Commission to achieve its goal of reasonable pricing for hospital services and created incentives for hospitals to deal with all payers consistently. Thanks to the Commission, hospital costs in Maryland were consistently below the national average throughout the 1980s. The Commission should also be applauded for the ability to adapt, more recently, following the revamping of its rate setting system. In an era of health insurance price hikes and skyrocketing pharmaceutical costs, the Commission serves the important role of bringing affordability to the health care consumer. The Senator stated that he looks forward to learning from the lessons that the Commissioners and staff have learned, when a universal health care system that expands access, restrains costs, and strikes a balance between the needs of patients, physicians, and payers is developed. The senator thanked the Commission for its hard work and urged it to continue its valuable efforts to provide affordable hospital care for Maryland residents.

Cal Pierson, President of the MHA, stated that because of the Commission, Maryland has surpassed all States in providing universal hospital care to all its citizens, not just paying for uncompensated care, but essentially providing universal insurance for people to get hospital care. The Commission has also been very successful in encouraging cost effective hospital care, by reducing hospital costs versus the nation by 30% in 30 years, as well as preventing cost shifting among payers. On behalf of MHA, Mr. Pierson thanked the Commissioners, past and present, for their voluntary service to the citizens of Maryland.

Former Executive Director Dr. Hal Cohen stated that it is very important to acknowledge the value of the Mikulski amendment to the Medicare waiver and how much we owe to the uniqueness of our waiver. Dr. Cohen also acknowledged the help provided by Senator Cardin in Maryland's obtaining its fair share of graduate medical education funding. Dr. Cohen noted that the Maryland legislature should also be recognized for its continued support of the Commission over the years. Dr. Cohen observed that one of the main advantages over the years that the waiver has given us is that we can equitably and uniquely address issues. The Nurse Support Program is perhaps, the clearest example of a national problem where we can be unique, have every one contribute, and do something that will have a serious positive impact. In conclusion, Dr. Cohen stated that the spirit of cooperation between the Commission and the hospital industry was based on the Commission's recognition of the importance of financing the mission of hospitals, i.e., the full financial requirements of efficient and effective hospitals, while the hospitals recognized the quid-pro-quo was to efficiently pursue that mission. Dr. Cohen expressed his hope that this understanding continues moving forward.

CHAIRMAN KUES FAREWELL

Chairman Kues announced that today's meeting was his last as a member of the Commission. The Chairman thanked his fellow Commissioners and the staff for all their cooperation during his tenure. In conclusion, the Chairman wished everyone the best of luck.

Vice Chairman Sexton noted that Chairman Kues has served through an extraordinary time in the Commission's history. The Vice Chairman praised the Chairman's leadership in moving the industry to APR DRGs, structuring a new three year update rate arrangement, and initiating a new outpatient rate system. The Vice Chairman lauded the Chairman's hard work and fair mindedness as well as the depth of his knowledge of health care gained as a result of his experience as a member of the Provider Reimbursement Review Board and his long experience in the Maryland hospital industry.

ITEM VIII **HEARING AND MEETING SCHEDULE**

August 15, 2007

Time to be determined, 4160 Patterson Avenue,
HSCRC Conference Room

September 12, 2007

Time to be determined, 4160 Patterson Avenue,
HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:45 a.m.