434th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

May 2, 2007

Chairman Kues called the meeting to order at 9:30 a.m. Commissioners Joseph R. Antos. Ph.D., Michael J. Eusebio, Trudy R. Hall, M.D., William H. Munn, and Kevin J. Sexton were also present.

ITEM I
REVIEW OF THE MINUTES OF THE EXECUTIVE AND PUBLIC SESSIONS OF APRIL 11, 2007

Commissioner Antos pointed out that the minutes of the April 11, 2007 public session inaccurately reported that that he voted to approve the Chairman's motion concerning the Update Factors for FY 2008 and 2009. Commissioner Antos in fact voted against the motion. The Commission voted unanimously to approve the amended minutes of the April 11, 2007 Public Meeting and the minutes of the Executive session.

STATEMENT OF COMMISSIONER ANTOS ON THE DECISION MADE BY THE COMMISSION TO INCREASE HOSPITAL PAYMENTS UNDER THE CURRENT THREE-YEAR PLAN

Commissioner Antos stated that the Commission's decision to increase hospital payments under the three-year plan for FY 2007 through 2009 gives the impression of favoritism towards the hospitals. Commissioner Antos remarked that he did not vote in favor of the Commission's decision because: 1) consultation with interested parties and the public was inadequate; 2) alternatives to the proposal passed by the Commission were not discussed; and 3) the Commission's methodology is biased in favor of higher hospital payments.

While he disagreed with the Commission's decision and was dismayed by some of the procedural aspects, Commissioner Antos acknowledged the difficult circumstances surrounding the April meeting, and that the Commission was overdue in setting the course for hospital payments for the next three years.

In conclusion, Dr. Antos expressed the hope that the Commission would reflect on recent experience and redouble its efforts to manage hospital payment policy for the citizens of Maryland fairly, openly, and wisely.

ITEM II
DOCKET STATUS - CASES CLOSED

1934N – Memorial Hospital at Easton 1938N – University Specialty Hospital
1939A, 1940A, 1941A, & 1942A – Johns Hopkins Health System

ITEM III
DOCKET STATUS - CASES OPEN

University of Maryland – 1943A

On April 6, 2007, The University of Maryland Medical Center filed an application requesting approval to participate in a global rate arrangement with Gift of Life Foundation (GOL) for the collection, on an outpatient basis, of bone marrow and peripheral blood stem cells from GOL donors. The Hospital requested approval for 3 years beginning May 1, 2007.

After review of the application, staff recommended that the Commission approve the Hospital's request for one year beginning May 1, 2007. The Hospital would be required to file a renewal application for review to be considered for continued participation in the arrangement. In addition, staff recommended that the approval be contingent upon execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

University of Maryland Medical Center – 1923A

At its September 13, 2006 public meeting, the Commission voted to approve University of Maryland Medical Center's request for continued participation in a global rate arrangement for solid organ transplant, gamma knife, and blood and bone marrow transplant services with Aetna Health, Inc. for one year beginning August 1, 2006.

At its February 7, 2007 public meeting, the Commission voted to extend the approval to include a global rate for cadaveric and living donor liver transplants.

On April 6, 2007, the Hospital submitted a request to extend the approval to include global rates for heart and lung transplants.

Staff recommended that the Commission approve the Hospital's request to extend approval to include heart and lung transplant services, for the period from May 1, 2007 through July 31, 2007, when the Commission's approval of the other components of the arrangement with Aetna Health, Inc expires. Also, staff recommended that the approval be contingent upon execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendations.

ITEM IV
FINAL RECOMMEDNATIONS ON FUNDING FOR THE MARYLAND PATIENT SAFETY CENTER

Steve Ports, Principal Deputy Director-Policy & Operations, summarized the purpose, accomplishments, and outcomes of the Maryland Patient Safety Center (MPSC) (Attachment A).

On behalf of staff, Mr. Ports requested that the Commission continue to be a partner in the funding of the MPSC for the remainder of the term granted by the Maryland Health Care Commission under the existing RFP by approving the following recommendations: 1) that the MPSC periodically update the Commission on health outcomes and expected savings resulting from programs sponsored by the Center; 2) that MPSC work with the Department of Health and Mental Hygiene and other stakeholders to develop a new leadership structure designed to allow the MPSC to pursue other sources of revenue to support the Center in the future; and 3) that "seed" funding be provided through hospital rates to cover 50% of the budgeted costs of the MPSC in FY 2008, less half of any carryover from FY 2007, and that funding be provided in FY 2009, subject to further review.

The Commission voted unanimously to approve staff's recommendations.

ITEM V
FINAL REVISED UNCOMPENSATED CARE POLICY PAPER

Nduka Udom, Associate Director-Research & Methodology, summarized the revised Uncompensated Care Policy Paper (Attachment B) which incorporates the Maryland Hospital Association's (MHA's) Financial Technical Issues Tack Force's recommended measures of uncompensated care (UCC) into the methodology used in calculating the level of UCC built into rates. The new regression methodology uses four new

independent variables, two inpatient variables, and two outpatient variables, rather than the two inpatients variables previously used. The model remains as specified in the current UCC methodology, while incorporating the new variables.

On behalf of staff, Mr. Udom, recommended, that the Commission approve the incorporation of the new variables in the calculation of prospective levels of UCC, and that the method described in the "Model" section of the paper be used to establish the UCC provision for Maryland acute care hospitals, effective July 1, 2007.

Paul Sokolowski, representing the MHA, thanked Mr. Udom for his cooperation and all of his hard work on the revisions to the UCC policy.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
STAFF PROPOSED OUTPATIENT CONSTRAINT SYSTEM

Chairman Kues noted that several months ago the Commission announced that it would be giving more priority to outpatient hospital services. At that time, the thinking was that we had a good handle on the inpatient hospital services, i.e., we understood revenue and cost per admission; we had national comparisons; and we had a policy on where we wanted Maryland to be in relation to the nation.

On the outpatient side, we knew that there was high revenue growth in Maryland hospitals, and that outpatient revenue in the nation was also growing. But, we had no meaningful national comparisons. While revenue per EIPA comparisons includes outpatient revenue, we have no separate policy for state versus national outpatient revenue levels.

After discussions with staff, it appears that to achieve some understanding of outpatient revenue levels in Maryland versus the nation, we would need the help of outside consultants and the use of proprietary data bases. Achieving this understanding of outpatient revenue levels is a longer term project and could be part of the next 3 year plan. Regarding the next 3 year plan, we may find the use of a consultant in defining system performance measurements very helpful.

The Chairman stated that, in his view, this understanding would be aimed at resources and expense control and the screening of high cost activities. As a short term project, staff has been working on an ambulatory surgery rate setting methodology. This work had been reviewed at a previous public meeting and will be discussed today.

As we become more active in the outpatient area, we should keep in mind that we will have the normal start-up problems. These will include: 1) consistency of revenue and cost reporting; 2) data accuracy; 3) diagnosis coding; 4) evolving rate setting methodologies; and 5) having meaningful medical information.

Robert Murray, Executive Director, stated that the rates of growth in outpatient volumes and revenue have been accelerating very rapidly, particularly in the Emergency Department and ambulatory surgery. This is largely due to the absence of a payment structure, both in Maryland and the U.S., that encourages efficient use of resources per case. Today, we unveil a system that will create a revolution in outpatient reimbursement. Graham Atkinson, PhD, and staff, as well as many members of the industry, have worked diligently to assemble a payment structure that embodies the correct incentives. Maryland hospitals have a long track record of being able to respond appropriately and efficiently when faced with rational incentives.

Mr. Murray noted that the proposed system has the added benefit of breaking down the historical dichotomy between inpatient and outpatient services. What is revolutionary is that staff's proposal eliminates the distinction between inpatient and outpatient surgeries and paves the way for a new generation of more integrated payment structures with the potential for more efficient care and reduced administrative costs.

Mr. Murray observed that in the past the hospital industry has tended to ask the HSCRC to accelerate system modifications and changes, such as advances for Medicaid Day Limits uncompensated care, which help their financial situation, however, they have not exhibited the same sense of urgency for initiatives that placed the industry at risk. Hopefully, there will be a more balanced approach by the industry when addressing the proposed outpatient incentive system.

Graham Atkinson, PhD, consultant for the HSCRC, stated that staff is proposing an analog of the inpatient Charge per Case (CPC) system for ambulatory procedures. The proposed system would provide guaranteed revenue per adjusted ambulatory surgery (AMS) case. Dr. Atkinson observed that an AMS revenue constraint system is needed because for several years the charge per case has been increasing much faster than the outpatient update factor. In addition, based on data obtained from CareFirst of Maryland, there were much larger increases in total revenue and in revenue per case in Maryland hospitals' AMS services than in Washington, D.C. and Virginia. Dr. Atkinson noted that ambulatory surgery revenue in Maryland is approximately $1 billion and represents about 10% of total hospital revenue.

Dr. Atkinson stated that the methodology in the staff's proposal (Attachment C) utilizes 3M's Ambulatory Patient Group (APG) grouper to adjust for case mix and to establish the allowable revenue for an ambulatory surgery case with a weight of one for each hospital. Adjustments for case-mix, outpatient rate increases, and intensity (to reflect changes in technology) would be made as they are in the inpatient Charge-per-case

system. Dr. Atkinson noted that since hospitals will be measured against themselves, differences in AMS data among hospitals will not be a problem.

Dr. Atkinson noted, however, that there were still some technical issues to be addressed, i.e., the magnitude of the intensity allowance, data quality, accounting for PET scans, whether to use the current grouper or move to the new APG grouper to be released later in the year, and whether state-wide or hospital specific case weights should be utilized.

Dr. Atkinson recommended that the Commission implement the guaranteed revenue system for AMS in FY 2008, using FY 2007 as the base year, and that staff continue to meet with the Outpatient Payment Workgroup to resolve any outstanding issues.

Mr. Murray stated that comments on the proposed AMS Guaranteed Revenue system should be submitted by May 25, 2007.

Commissioner Sexton asked Dr. Atkinson if he had a sense of the magnitude of change in outcomes between the current grouper and the new grouper.

Dr. Atkinson stated that the new grouper will include all cases, but outcomes would not change on a hospital-specific basis. However, use of the new grouper would be fairer in calculating the Reasonableness of Charges screen.

The Chairman asked how much revenue would be constrained under staff's proposed AMS guaranteed revenue system.

Dr. Atkinson replied that about 8% of total hospital revenue would be constrained.

Gary Vogan, Chief Financial Officer-Holy Cross Health, and Stuart Erdman, Senior Director of Finance-Johns Hopkins Health System, presented the Maryland Hospital Association's response to staff's recommendation on ambulatory surgery revenue constraint.

Mr. Vogan stated that since growth in the volume of AMS cases is comparable between Maryland and the U.S. as a whole over time, and since the HSCRC controls price growth, the key to growth of AMS revenue per case in Maryland is to understand the cause of increases in intensity. MHA supports monitoring AMS (but not revenue constraint) beginning in FY 2008, using FY 2007 as the base year. The HSCRC should require hospitals with higher growth to demonstrate the drivers of cost. By reviewing real performance data, we will learn about potential data errors and the factors that cause cost increases. We will also continue to improve data analysis to understand the service grouping methodologies and the rationale for financial constraints. MHA

suggests targeting the rate impact at the expiration of the current 2 year agreement, FY 2010.

Mr. Vogan presented findings of an analysis of AMS data from Holy Cross Hospital, Johns Hopkins Hospital, and the Western Maryland Health System for the period 2004-2006, which attempted to identify how much intensity contributed to overall expense growth. The analysis indicated that increases in the costs of medical/surgical supplies (M/SS) cost contributed all the intensity growth over the three year period. Mr. Vogan stated that it is believed that further analysis will show that most of the intensity increase related to M/SS occurred in a few patient types, e.g., cardiac patients, musculoskeletal patients, and digestive system patients.

Mr. Erdman stated that MHA is here today in a spirit of cooperation. All parties have worked hard to try to understand what is driving outpatient revenue growth; what is controllable; and what is not controllable. However, the Commission should not rush into outpatient revenue constraint. The methodology should be based on reasonable grouping and reconcilable data. The industry is asking for the Commission to exercise patience in the implementation of a system with real rate implications.

Mr. Erdman pointed out that hospitals do not possess the same confidence in being able to manage to the AMS per case target as they have in managing to their inpatient CPC target. The major unknown is the impact of rate realignment on the rates for services utilized in AMS. In addition, Mr. Erdman asserted that the 1% intensity allowance, as recommended by staff, is not supported by the available data and is not adequate to not address changes in technology and medical practice.

In conclusion, Mr. Vogan reiterated MHA's support for:1) AMS monitoring beginning in FY 2008, using FY 2007 as the base; 2) complete outpatient reporting and development of a reconciliation process; and 3) requiring hospitals on the monitoring system to work with HSCRC staff to understand the drivers of their growth. Mr. Vogan observed that new APG grouper logic should become the basis for any AMS system that impacts rates.

Commissioner Sexton asked why M/SS are a problem on the outpatient side when they are not on the inpatient side.

Mr. Erdman explained that inpatient cases are typically more complex and have more cost components that may be managed (including length of stay) to offset increases in M/SS costs. Whereas, AMS cases typically have fewer cost components and no length of stay to manage.

Commissioner Sexton asked whether the industry was suggesting that the Commission not implement a revenue constrain system until: 1) the data is better; 2) the

Commission makes a policy call on how much intensity is reasonable; or 3) ROC comparisons among hospitals can be done.

Mr. Vogan replied that the Commission should monitor AMS services for two years so that both the industry and the Commission can better understand the causes of revenue increases and the part that intensity plays in them. At that point, we will be in position to put in place a more defined program of rate control starting with the next three year plan, in FY 2010.

Hal Cohen, PhD, representing CareFirst of Maryland and Kaiser Permanente, and Kevin Criswell, representing Amerigroup, provided comments from the payer community.

Dr. Cohen stated that the implementation of an outpatient payment system was past due, and that initiating revenue constraints with the correct incentives is appropriate. In Maryland, the number of admissions is growing much faster than the population, whereas, nationally, the number of admissions is growing slower than the population. In the rest of the country, there are real shifts from inpatient to outpatient, that is, there are fewer inpatients. However, in Maryland, the volume of both inpatients and outpatients is growing, and admissions lost when services provided in an outpatient rather than inpatient setting are being replaced by new admissions.

Dr. Cohen asserted that the methodology developed by Dr. Atkinson and staff is a huge advance. Dr. Cohen pointed out that the explanatory power of the APG grouper, no matter how old it is, is at least as good as APR-DRGs, and that the current grouper is only to be used to compare a hospital this year with that same hospital next year.

Dr. Cohen stated that staff should move as quickly as possible to add emergency room and other outpatient activities to the outpatient payment system.

Kevin Criswell stated that he was shocked to learn that Dr. Atkinson has been working on this project for ten years and, with the two year delay requested by the industry, would take it to twelve years. Considering the continued high rate of increase in outpatient revenue, we should not wait. The time to initiate the AMS payment system is now.

Commissioner Sexton asked Dr. Cohen's reaction to the M/SS issue.

Dr. Cohen stated that if you have the right incentives, hospitals will respond to them. There have been bad incentives, e.g., pass-throughs, for outpatient M/SS. Dr. Cohen asserted that we must do better, and that the proposed system is the answer.

Mr. Criswell noted that some of the cases with higher M/SS costs are excluded under the proposed system.

With regard to the issue of monitoring, Mr. Murray observed that there has been considerable monitoring to attempt to identify what was causing outpatient revenue growth. In conclusion, Mr. Murray pointed out that the problem with the current outpatient payment system is that the incentives are wrong. That is what comes out of this analysis, and now is the time to change the incentives.

ITEM VII
FINAL RECOMMENDATIONS FOR THE NURSE SUPPORT PROGRAM II (NSP II)

Marva Tan, Associate Director-Quality Initiative, presented the recommendations of the NSP II Evaluation Committee and staff for FY 2008 Competitive Institutional Grants(attachment D). The primary goal of the NSP II program is to increase the number of bedside nurses in Maryland hospitals by expanding the capacity of Maryland nursing schools. The Commission approved funding of 0.1% of regulated revenue over the ten years for NSP II.

Ms. Tan reported that in the first year of NSP II, seven out of twenty-six proposals submitted were recommended by the Committee and approved by the Commission. The estimated funding for the seven programs is estimated to be approximately $9 million over the next five years. Ms. Tan noted that the Maryland Higher Education Commission is now conducting on-site visits to these programs and expects to report their findings to the Commission in the fall.

Ms. Tan stated that twenty-three proposals were received in the second round of NSP II. Of the twenty-three, the Evaluation Committee recommended nine proposals for approval by the Commission. The recommended proposals include initiatives impacting all regions of the State and address minority recruitment and retention, as well as initiatives to encourage more men to choose nursing as a career. The budget for the recommended proposals is $8.68 million over five years.

The Commission voted unanimously to approve the recommendations of staff and the Evaluation Committee.

ITEM VII
STATUS OF COMMUNITY BENEFIT REPORT

Mr. Murray stated that a draft of the 2006 Community Benefit Report would be sent to the industry for review and comment within a week, and that it is anticipated that the final report would be presented at the June public meeting.

ITEMVIII
LEGAL REPORT

Regulations

Final Adoption

Uniform Accounting and Reporting System for Hospitals and Related Institutions – COMAR 10.37.01

The purpose of this regulation is to provide the annual update of the Accounting and Budget Manual, which is incorporated by reference.

The Commission voted unanimously to adopt the amended regulation.

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

The purpose of this action is to expand and refine the inpatient discharge data set to include diagnoses present on admission data.

The Commission voted to adopt the amended regulations.

John O'Brien, Deputy Director-Research and Methodology, reported that currently, the Commission's Hospital Discharge Data Set collects fifteen diagnoses and procedures from hospitals. The Maryland Hospital Association has requested that the number of diagnoses and procedures collected be expanded to thirty. Recognizing that the adoption of APR-DRGs requires more in-depth coding, staff believes that it is appropriate to expand the number of diagnoses and procedures to be reported on the discharge data set from fifteen to thirty. Mr. O'Brien stated that amended regulations will be proposed at the June public meeting.

Submission of Hospital Outpatient Data Set to the Commission – COMAR 10.37.04.01-.07

The purpose of this amendment is to consolidate the Commission's ambulatory surgery and ambulatory care data sets into one uniform outpatient hospital data set.

The Commission voted unanimously to adopt the amended regulation.

ITEM X
HEARING AND MEETING SCHEDULE

June 13, 2007	Time to be determined, 4160 Patterson Avenue HSCRC Conference Room
July 18, 2007	Time to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:25 a.m.