MARYLAND HEALTH SERVICES

COST REVIEW COMMISSION

REPORT TO THE GOVERNOR

FISCAL YEAR 2009

MARTIN O'MALLEY

GOVERNOR

STATE OF MARYLAND

HEALTH SERVICES COST REVIEW COMMISSION

ANNUAL REPORT TO THE GOVERNOR

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STATE OF MARYLAND

HEALTH SERVICES COST REVIEW COMMISSION

Commissioners as of June 30, 2009*

	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 July 1, 2008	June 30, 2008 June 30, 2012
Raymond J. Brusca	July 1, 2005	June 30, 2009
Trudy R. Hall, M.D., P.A.	July 1, 2002 July 1, 2006*	June 30, 2006 June 30, 2010
C. James Lowthers	July 1, 2007	June 30, 2011
Kevin J. Sexton	July 1, 2003 July 1, 2007 (Appointed Vice Chairman October, 2005)	June 30, 2007 June 30, 2010
Herbert S. Wong, Ph.D.	March 25, 2008** (Replaced William Munn)	June 30, 2009

* Reappointed

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

This Governor's Report reports on activities of the Health Services Cost Review Commission for the Fiscal Year (FY) 2009. Audited hospital data throughout the report, however, are for the most recent fiscal year available, which in most cases is FY 2008.

I. EXECUTIVE SUMMARY

Continuing to build on the significant change that began in FY 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 FY 2009. 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. In recent years, the HSCRC has also devoted considerable resources toward improving the overall quality of hospital care.

Maryland Hospital Cost Performance

The HSCRC's FY 2008 Disclosure Statement reported that the average amount paid for a hospital admission in Maryland rose from $10,039 in FY 2007 to $10,443 in FY 2008. This 4% growth in Maryland is below the anticipated national average increase of 5.5 % for the same period.

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 22%, compared to the average mark-up of 187% 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 (i.e., what hospitals expend to provide their services) shows that the average cost per admission at Maryland hospitals increased by only 4 percent compared to an estimated 5.5 percent increase for the rest of the nation for FY 2008. In FY 1976, the cost per adjusted admission to a Maryland hospital was 26 percent above the national average. In FY 2007, the year for which the most recent data are available from AHA, the average cost per adjusted admission in Maryland was at the national average. From 1977 through 2007, Maryland hospitals experienced the third 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 rate setting system increased from $928 million in FY 2007 to $1 billion in FY 2008.

Since its inception, the HSCRC has recognized reasonable levels of bad debt and charity care (uncompensated care) in hospital rates as a means to enhance access to services for those citizens who cannot pay for care. As hospital uncompensated care (UC) has increased in both relative and absolute terms the General Assembly and the HSCRC have been actively involved in efforts to modify and improve the UC funding mechanism. In FY 2009, the Commission moved to a more equitable method to finance UC in the rate setting system.

Prior to FY 2009, UC was funded through a "partial" pooling approach where a UC fund or pool was created from an assessment of 0.75% on each hospital. This fund was then reallocated to the subset of hospitals with the highest levels of UC in their rates. Those "high" UC hospitals then would finance their UC burdens in part through their rate structure (UC provisions in their rates up to some pre-determined threshold level) and in part from payments from the UC pool. The Commission moved to "full" or 100% pooling of all hospital UC in FY 2009. This funding mechanism incorporates the State-wide average level of hospital UC into the rate structures of all facilities. Hospitals with approved UC provisions that are less than the State-wide average level of UC will be remit funds to the UC pool equal to the difference between their approved UC provision and the State-wide average UC. Conversely, hospitals with approved UC provisions in excess of the State-wide average level of UC would receive payment from the UC fund equal to the difference between their approved provisions and the State-wide average UC.

In addition to the move to 100% pooling in FY 2009, the Commission approved the inclusion of The University of Maryland Shock Trauma Center's UC in the existing UC pool.

Financial Condition of Maryland Hospitals

In addition to its other statutory obligations, the Commission takes great interest in the financial performance of Maryland hospitals.

Over the years, the Commission and the hospital industry has 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.

In FY 2008, Maryland general acute hospitals' profits on regulated activities held steady at 5.2% compared to 5.4% in FY 2007. Profits on regulated and unregulated operations decreased from 3% in FY 2007 to 2.3% in FY 2008. Total excess profits (which include profits and losses from regulated and unregulated operating and non-operating activities) decreased substantially from 5.2% in FY 2007 to 1.4% in FY 2008, largely due to investment losses associated with debt financing obligations of hospitals.

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 319% from January 1, 1981, through June 30, 2008, compared to a 293% increase in Maryland over the same time period. The Commission will continue to take whatever appropriate steps are necessary to assure continuation of our all-payer system.

FY 2009 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 2009, the Commission employed 31 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 2009 was $3.98 million. Total expenditures for FY 2009 were $4.9 million. Due to prudent spending and vacancies that occurred during the last quarter of the fiscal year, the fund balance at the end of fiscal year 2009 was $651,809 (or 13% of expenditures). User fees will continue to be adjusted throughout the year as necessary to achieve a reasonable reserve threshold.

Quality Initiative

The considerable attention paid to hospital quality measurement nationally in recent years has identified quality-related measures in use or on the horizon that can serve as the basis for the development of financial incentives to dramatically improve the overall quality of Maryland hospital care. Pay for performance (P4P) and value-based purchasing (VBP) are interchangeable terms for a payment system that links providers' payment to their performance on selected quality of care measures, and a system that uses financial incentives to encourage providers to meet defined quality, efficiency, or other targets (Agency of Healthcare Research and Quality 2008).

HSCRC's Quality Initiatives work includes designing, implementing and managing statewide, all-payer hospital reimbursement adjustments based upon hospital performance on a comprehensive set of quality metrics. To date, HSCRC has engaged in a three-pronged approach, including:

- Quality Based Reimbursement (QBR) Initiative-Implemented in July 2008, performance is measured and reported on a set of effectiveness/process of care measures; patient experience of care measures will also be considered in the near term for addition to this initiative.
- Maryland Hospital Acquired Conditions (MHAC) Initiative- Implemented in July 2009, actual versus expected rates of performance on a broad set of 50 risk/severity adjusted potentially preventable complications are measured. During fiscal year 2008, these hospital-based preventable complications were present in approximately 53,000 of the State's total 800,000 inpatient cases and represented approximately $500 million in potentially preventable hospital payments.
- Maryland Hospital Preventable Readmissions (MHPR) Initiative- Actual versus expected rates of performance are measured, adjusted for specific hospital and patient characteristics, on potentially preventable readmissions within a specified time period(s), e.g., 30 days. In Maryland in 2007, there was $659.9M in associated charges for readmissions within 30 days. This initiative is currently under development and is expected to be implemented in 2010.

The overall mission of the HSCRC Quality Initiatives is to help create a health care environment where Maryland hospitals provide high quality patient care in an efficient manner.

The overarching goals of the HSCRC Quality Initiatives are to:

1. Work with Maryland hospitals to enhance the quality of patient care by providing financial support and rewards/incentives consistent with evidence-based health services research and improved patient outcomes;
2. Utilize a broad set of quality measures that appropriately reflect the delivery of quality health care services provided at Maryland hospitals;
3. Collect data that will support the generation of accurate and reliable quality measures;
4. Better understand the relationship between quality and cost; and
5. Become a model for enhancing health care quality in the hospital setting while remaining consistent with broader quality initiatives.

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. In 2004, the MHCC selected the Maryland Hospital Association (MHA) and the Delmarva Foundation for Medical Care (Delmarva) to operate a Maryland Patient Safety Center in Maryland. The MPSC is now a 501(C)(3) not for profit organization.

Each year since its inception, the Commission, in recognition of the potential for improved quality and safety resulting in reduced costs related to adverse events, approved recommendations that, in effect, increase rates to payers to cover a portion of the reasonable budgeted costs of the Center. For FY 2009, the fourth year of such funding, $1.93 million has been included in the rates of certain hospitals for this purpose.

Community Benefit Report

In June 2009, the Commission released its fifth annual report on hospital community benefit activities in Maryland. The process of collecting hospital community benefit information from individual hospitals to compile into a publicly available statewide report was introduced by the Maryland legislature in 2001.

Maryland hospitals provided approximately $861 million in community benefit activities for FY 2008. The various categories of activities include community health services at $62.5 million, health professions education at $263 million, over $191 million in mission driven health services, research activities of over $8.9 million, financial contributions of $17.8 million, community building activities of $16.9 million, over $6 million in community benefit operations, approximately $6.8 million in foundation initiatives and just over $286 million in charity care was provided to the patients of Maryland hospitals.

The HSCRC has viewed the Community Benefit reporting requirement as an opportunity for each Maryland hospital to critically review and report its community benefit activities. The development of the process has been a collaborative effort between Maryland hospitals, the HSCRC and many interested parties within Maryland. In an effort to continue providing a useful tool for reporting community benefit activities, the HSCRC has begun the process of refining the reporting requirements and developing an evaluation method with which to provide feedback to the hospitals on their activities.

II. REVIEW OF RATE REGULATION ACTIVITIES

A. Closed Docket Proceedings

Disposition of those applications acted upon by the Commission in Fiscal Year 2009 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	2	There were two requests for approval of an increase to all rates Approved:2
Partial Rate Applications	14	Four requests for approval of a rate for a new service Approved: 4

	4	One request for a rebundled rate, i.e., a rate for a service furnished by an off-site provider only to hospital inpatients, and three requests for approval to replace a rebundled rate with a rate for a service provided by the hospital to both inpatients and outpatients. Approved:4
	4	Four requests for approval to combine two rate centers in a revenue neutral fashion. Approved:4
	2	Two partial rate applications withdrawn. Approved: 0
Applications for Alternative Method of Rate Determination*	28	Twenty-two requests for approval to participate in global fixed price alternative payment arrangements** Approved: 22
		Five requests for approval to participate in capitation alternative payments arrangements*** Approved:5

		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 2009, forty-four (44) acute care hospitals and one (1) chronic specialty hospital participated in the Charge per Case Target rate setting methodology. July 1, 2008, an update factor of 4.20% was applied to Charge per Case Targets, 100% inpatient unit rates, and ancillary unit rates of each hospital.

Historically, Garrett County Memorial Hospital has been the only acute care hospital in the State not participating in the Charge per Case methodology. Effective July 1, 2008, the Edward W. McCready Memorial Hospital in Crisfield Maryland partitioned the Commission and obtained approval to convert from the Charge per Case rate setting methodology to the Total Patient Revenue ("TPR") unit rate setting methodology.

In order to qualify for the TPR 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. The Hospital's annual revenue budget is calculated and capped for the rate year and its costs are considered 100% fixed. These hospitals also qualified for a 4.20% update factor.

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 as compared to the averages 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 the 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 2009, two hospitals filed and one hospital received a full rate review during that time period. The following table summarizes the results.

FULL RATE REVIEW - FISCAL YEAR 2009

HOSPITAL	EFFECTIVE DATE	OVERALL RATE CHANGE
Greater Baltimore Medical Center	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 hospitals with charges exceeding its peer group average by three percent (3%) or more are identified as high cost hospitals 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 two years. Consequently, no additional hospitals have been identified as high cost during fiscal year 2009. McCready Memorial Hospital in Crisfield Maryland is technically on a spend down. However, the scheduled offset for fiscal year 2009 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.

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 the 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 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.

The HSCRC refines the ICC/ROC methodology annually based on input from a workgroup comprised of representatives of the Maryland hospital industry. The ICC/ROC Workgroup met several times between

October 2008 and January 2009 and agreed on the following revisions to the adjustments in the ICC/ROC methodology:

1) Blend the inpatient charge per case (CPC) target and outpatient charge per visit (CPV) target into a single comprehensive charge target (CCT) to be used as the starting point for the ICC/ROC adjustments.
2) Refine the regression based adjustment for costs associated with indirect medical education (IME) and include a regression based adjustment for disproportionate share (DSH) - additional resource use associated with treating a large share of poor patients).
3) Adjust for the direct costs of medical education programs by removing 100% of the compensation associated with residents and fellows (in the past, 75% of these costs were directly adjusted for in the ROC).
4) Adjust for capital costs based on 50% of the hospital's capital costs and 50% of the statewide standard (instead of a peer group standard).

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) be provided 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.

B. Outpatient Charge per Visit Methodology

In FY 2008, the Commission approved the Charge per Visit (CPV) methodology for implementation in FY 2009 as a means to limit the rate of increase in the revenue per outpatient visit at each Maryland hospital. A limit (CPV target) was established using base year data (FY 2008) and was used to set the allowable revenue for an outpatient case in FY 2009. The limit was adjusted for outpatient rate increases, for an intensity allowance to allow for changes in technology, and for changes in case-mix intensity. This methodology uses the Enhanced Ambulatory Patient Groups (EAPGs), developed by 3M, to measure outpatient case-mix.

C. Uncompensated Care Regression and Policy

The principle objective of the HSCRC's uncompensated care (UCC) policy is to provide reasonable rates to hospitals to cover the cost of care for patients who cannot pay their bills. The UCC policy is the lynchpin of the system for providing access to care for all Maryland citizens.

Based on a specific methodology that takes into account both actual hospital UCC and expected levels of UCC based on hospital characteristics, the Commission sets a prospective amount to be built into hospital rates for the next fiscal year. The UCC policy in place for FY 2009 utilized a 50/50 blend of a hospital's three-year moving average actual UCC and a predicted UCC amount based on the following explanatory regression variables:

1. The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room,
2. The proportion of a hospital's total charges from inpatient Medicaid, self-pay, and charity cases,
3. The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency room, and
4. The proportion of a hospital's total charges that are outpatient charges.

In the last year, public news reports have raised the issue of whether Maryland hospitals provide sufficient levels of charity care, given a policy that provides uncompensated care in rates. Commission staff has begun a review of the existing uncompensated care policy in terms of its equivalent treatment of bad debt and charity care and will develop a methodology that will adjust the amount of UCC in rates based on the amount of charity care provided by each hospital.

D. 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 were 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, that 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. Continuation of the five-year NSPI, approximately $10.8 million was approved for

FY2009.

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.

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 reviewed 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 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 expenditure of $3.3M in Statewide Initiatives, the total for FY 2009 is $6.1 over the next 5 years.

Due to the low number of proposals received for FY 2009, both the HSCRC and MHEC made concerted efforts to encourage eligible institutions to apply for grants in FY 2010. The effort was effective for 28 grants were received. After evaluation by a diverse review committee, 21 grants were recommended for funding, and HSCRC did fund those 21, for more than $20.1 million over the next five years. These grants are projected to produce over 2000 graduates, varying from Associate Degree Registered Nurses to Doctor of Nursing Practice recipients, with all intermediate degrees represented. Two programs were also funded that will address the urgent need for more simulation education throughout the State, for both faculty and

laboratory coordinators.

Statewide Initiatives are another branch of NSP II. These include the Graduate Nursing Faculty Scholarships and Living Expenses Grants, the New Nursing Faculty Fellowships and the Janet L. Hoffman Loan Assistance Repayment Program. These programs are provided to individual nursing students and new nursing faculty, in order to assist them in becoming faculty and in remaining faculty.

E. 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:

From October 1987 through June 2007, the Commission collected patient level ambulatory surgery data from hospitals. Beginning July 2007, ambulatory surgery data is submitted with other outpatient data as part of the Outpatient Database (see #4 below). The ambulatory surgery database includes demographic, clinical, and charge information for all patients that received hospital-based outpatient surgery services. Hospitals submitted ambulatory surgery data to the HSCRC within 60 days following the close of a quarter.

3. Ambulatory Care Database:

From July 1997 through June 2007, the Commission collected demographic, clinical, and charge information on hospital-based clinic and emergency department services. Beginning July 2007, ambulatory care data is submitted with other outpatient data as part of the Outpatient Database (see #4 below). Hospitals submitted ambulatory care data to the HSCRC within 60 days following the close of a quarter.

4. Outpatient Database:

Beginning July 2007, ambulatory surgery data and ambulatory care data were consolidated, along with referred ancillary visits, into one outpatient data base. The Outpatient Data Set, therefore, is comprised of all hospital outpatient services, including emergency department visits, ambulatory surgery, outpatient clinic, and referred ancillary services. These data are used to develop and monitor charge per visit targets. Hospitals submit outpatient 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 45 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 2009, 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*. During the past fiscal year, the Commission proposed and adopted several amendments to this chapter. First, on April 15, 2009, the Commission adopted an amendment to Regulation .02, which was proposed for adoption on December 10, 2008. The purpose of this amendment is to update the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operating Management" (August, 1987), which has been incorporated by reference.

On May 13, 2009, the Commission proposed for adoption an amendment to Regulation .03. The purpose of this action is to require hospitals to file with the Commission its most recent Form 990 filed with the Internal Revenue Service in compliance with recently legislation.

Finally, on June 3, 2009, the Commission proposed for adoption amendments to Regulation .03. The purpose of this action is two-fold: to shorten the time for nonprofit hospitals to submit the Annual Nonprofit Hospital Community Benefit Report to the Commission; and to increase the civil penalty associated with the failure to timely file required reports with the Commission.

COMAR 10.37.03

This regulation concerns the Commission's *Types and Classes of Charges Which Cannot Be Changed Without Prior Commission Approval*. On September 10, 2008, the Commission adopted amendments to Regulation .02, which was proposed for adoption on April 22, 2008. The purpose of this action 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*. During the past fiscal year, the Commission adopted several amendments to this chapter. First, on September 10, 2008, the Commission adopted an amendment to Regulation .01, which was proposed for adoption on April 22, 2008. The purpose of this action is to have the Hospital Outpatient Data Regulations reporting time frame conform to the Inpatient Discharge Data Regulations reporting time frame.

Later in the fiscal year, on February 4, 2009, the Commission adopted amendments to Regulation.01, the repeal of existing Regulations .03, .04, .07, new Regulations .05, and amendments to and the re-codification of existing Regulations .05 and .06 to be Regulations .03 and .04, which were proposed for adoption on October 8, 2008. The purpose of this action is to expedite the reporting process for outpatient data and thereby avoid unnecessary delay in the Commission's obtaining information, which would be invaluable in promoting greater efficiency in the provision of outpatient services.

COMAR 10.37.06

This regulation concerns the *Submission of Hospital Discharge Data Set to the Commission*. On February 4, 2009, the Commission adopted amendments to Regulation .01, the repeal of existing Regulations .02, .03, .06, new Regulations .02 and .05 to be Regulations .03 and .04, which were proposed for adoption on October 8, 2008. The purpose of this action is to expedite the reporting process for discharge data and thereby avoid unnecessary delay in the Commission's obtaining information, which would be invaluable in promoting greater efficiency in the provision of hospital care.

COMAR 10.37.09

This regulation concerns the Commission's *Fee Assessment for Financing Hospital Uncompensated Care.* On February 4, 2009, the Commission adopted amendments to Regulations .01- .04 and .06 and the repeal of existing Regulation .05, which was proposed for adoption on November 5, 2008. The purpose of this action is to provide for full pooling of uncompensated care among all hospitals. The Commission also requested and was granted emergency status to this regulation, effective December 1, 2008 to April 1, 2009.

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 September 10, 2008, the Commission adopted amendments to Regulation .26-1, entitled "Maryland Health Insurance Plan (MHIP) Assessment, which was proposed for adoption on April 22, 2008. The purpose of this action is to set forth the assessment on hospitals to operate and administer the MHIP Plan consistent with HB 1587 of 2008, which became effective July 1, 2008. The Commission also requested and was granted emergency status to this regulation, effective June 12, 2008 to October 31, 2008.

On December 10, 2008, the Commission adopted amendments to Regulation .04-2, which was proposed for adoption on September 10, 2008. The purpose of this action is to include a description of the Commission's new outpatient Charge-Per-Visit (CPV) system within the existing case target methodology description.

On February 4, 2009, the Commission adopted new Regulation .26-2, which was proposed for adopted on November 5, 2008. The purpose of this action is to describe the assessment process authorized by Ch. 7, Acts of 2007 Special Session, and associated with averted uncompensated care. This action also authorizes penalties for untimely or underpayment of the assessment.

On May 13, 2009, the Commission proposed for adoption amendments to Regulation .26A and B. The purpose of this action is to comply with recently enacted legislation. These regulatory amendments change the interest or late payment charges that a hospital may add to its self-pay patients; set forth the minimum provisions required in hospital financial assistance policies; require hospitals to develop an information sheet; and set forth those requirements to be included in hospital credit and collection policies. The Commission also requested and was granted emergency status to this regulation, effective July 1, 2009 to December 31, 2009.

Finally, on May 13, 2009, the Commission proposed for adoption and amendment to Regulation .03D. The purpose of this action is to assure that the State's all-payer Medicare waiver is not jeopardized, and that any potential action taken by the Commission in response to the establishment of hospital day limits is in the public interest. The Commission also requested and was granted emergency status to this regulation, effective July 1, 2009 to December 31, 2009.

VI. LEGISLATION AFFECTING THE HEALTH SERVICES COST REVIEW COMMISSION'S ENABLING ACT

A number of bills of interest to the Commission were introduced during the 2009 session of the General Assembly:

House Bill 487

This bill, companion to SB 231, entitled *HSCRC- Health Care Facilities- Required Forms*, would require specified health care facilities to submit to the HSCRC the most recent Form 990 that the facility filed with the Internal Revenue Service at a specified time. (Became Law- Ch. 398)

House Bill 706

This bill, companion to SB 744, entitled *Electronic Health Records- Regulation and Reimbursement*, would require the Maryland Medical Assistance Program to reimburse specified health care providers in accordance with specified provisions of the Act; require the MHCC and the HSCRC to designate a health information exchange for the State on or before October 1, 2009; require the MHCC, on or before January 1, 2010, to report on progress in implementing provisions of the Act; etc. (Became Law- Ch. 689)

House Bill 714

This bill, companion to SB 627, entitled *Loan Assistance Repayment and Practice Assistance for Physicians*, would alter the eligibility for the Janet L. Hoffman Loan Assistance Repayment Program in a specified manner; establish the Maryland Loan Assistance Repayment Program for Physicians; require the Office of Student Financial Assistance to assist in the repayment of loans owed by certain physicians; provide for the composition of the Fund and expenditures from the Fund; etc. (Became Law- Ch. 576)

House Bill 1069

This bill, entitled *HSCRC- Financial Assistance and Debt Collection Policies*, would require the HSCRC to require specified hospitals in the State to develop a financial assistance policy for providing free care and reduced-cost care to specified patients; require a hospital to post a notice in its billing office; require each hospital to develop an information sheet that meets specified requirements; require the Commission to establish uniform requirements for the information sheet and review each hospital's implementation of and compliance with requirements; etc. (Became Law- Ch. 311)

House Bill 1486

This emergency bill, companion to SB 1039, entitled *Prince George's County Hospital Authority,* would extend the Prince George's County Hospital Authority's bidding process; clarify the duration of a specified funding commitment of the State and Prince George's County; require the Authority to make specified assessments and take specified actions regarding bids for the Prince George's County health care system; require the Authority to complete its obligations by a specified time; require specified agencies to serve as consultants to the Authority; specify the role of consultants; make the Act an emergency measure; etc. (Became Law- Ch. 117)

Senate Bill 231

This bill, companion to HB 487**,** entitled *HSCRC- Health Care Facilities- Required Forms*, would require specified health care facilities to submit to the HSCRC the most recent Form 990 that the facility filed with the Internal Revenue Service at a specified time. (Vetoed by Governor- Duplicative)

Senate Bill 494

This bill, entitled *HSCRC- Limit on Interest or Late Payment Fees*, would require the HSCRC to prohibit a facility from charging a patient interest or late payment fees at a rate that exceeds a specified percentage. (Failed)

Senate Bill 627

This bill, companion to HB 714, entitled *Loan Assistance Repayment and Practice Assistance for Physicians*, would alter the eligibility for the Janet L. Hoffman Loan Assistance Repayment Program in a specified manner; establish the Maryland Loan Assistance Repayment Program for Physicians; require the Office of Student Financial Assistance to assist in the repayment of loans owed by certain physicians; provide for the composition of the Fund and expenditures from the Fund; etc. (Became Law- Ch. 575)

Senate Bill 757

This bill, entitled *HSCRC- Repeal of Commission and Study of Alternative Financing of Uncompensated Care and Undercompensated Care*, would repeal provisions of law relating to the HSCRC and its powers and duties; alter provisions of law relating to the HSCRC; repeal a requirement that specified health facilities submit specified discharge information; repeal specified requirements regarding reimbursement rates set by the HSCRC; etc. (Failed)

Senate Bill 776

This bill, entitled *Health Services Cost Review Commission - Financial Assistance and Debt Collection Policies,* would require the Health Services Cost Review Commission to require specified hospitals to develop a financial assistance policy for providing free care and reduced-cost care to specified patients; require a hospital to post a specified notice in the billing office; require each hospital to develop an information sheet that meets specified requirements; require the Commission to establish requirements for the information sheet and review each hospital's implementation of and compliance with the requirements; etc. (Became Law- Ch. 310)

Senate Bill 1039

This emergency bill, companion to HB 1486, entitled *Prince George's County Hospital Authority,* would extend the Prince George's County Hospital Authority's bidding process; clarify the duration of a specified funding commitment of the State and Prince George's County; require the Authority to make specified assessments and take specified actions regarding bids for the Prince George's County health care system; require the Authority to complete its obligations by a specified time; require specified agencies to serve as consultants to the Authority; specify the role of consultants; make the Act an emergency measure; etc. (Became Law- Ch. 116)

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 REVIEW 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, §19-216, 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 filed in 2009 fell into four general categories: 1) global pricing or case rate arrangements for selected procedures; 2) partial capitation arrangements for selected services; 3) full capitation arrangements, and 4) discount to a payer for providing cost saving services to a hospital.

FORMER COMMISSIONERS

Former Commissioner	Appointed	Term Expired
John A, Whitney, Esq.	July 19, 1971	June 30, 1972
Sidney A. Green	July 19, 1971	June30, 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)
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

[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.

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
Irvin W. Kues	July 1, 2005	June 30, 2007
William Munn	July 1, 2005	December 31, 2007 (Resigned)
Michael J. Eusebio	July 1, 2003	June 30, 2007
Raymond J. Brusca	July 1, 2005	June 30, 2009

[10] Dean Farley, Ph.D., continued to serve as Vice Chairman beyond his appointment.