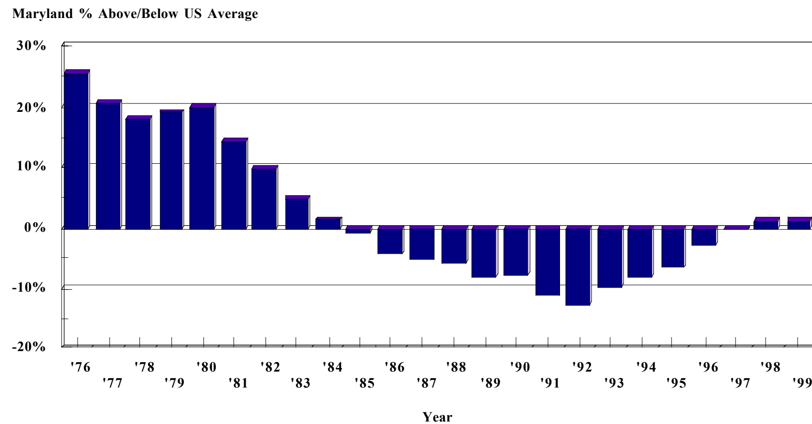
MARYLAND HEALTH SERVICES COST REVIEW COMMISSION

COMPARISON - COST PER EIPA

Maryland vs. United States 1976 - 1999



Source: HSCRC Hospital Annual Cost Report and AHA Hospital Statistics

REPORT TO THE GOVERNOR
FISCAL YEAR 2001

PARRIS N. GLENDENING
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, 2001

	Appointed	Term Expires
Don Hillier	July 1, 1996	June 30, 2000
Chairman (Appointed Chairman November 24, 1997)		July 1, 2000*
		June 30, 2004
Dean Farley, Ph.D.	July 1, 1994	June 30, 1998
Vice Chairman	July 1, 1998*	June 30, 2002
Philip B. Down	July 1, 1995	June 30, 1999
		July 1,1999*
		June 30, 2003
Willarda V. Edwards, M.D.	July 1, 1994	June 30, 1998
	July 1, 1998*	June 30, 2002
Samuel Lin, M.D., Ph.D.	July 1, 1997	June 30, 2001
C. James Lowthers	July 16, 1990	June 30, 1993
	July 1, 1993*	June 30, 1997
	July 1, 1997*	June 30, 2001
Dale O. Troll	July 1, 1994	June 30, 1995
	July 1, 1995*	June 30, 1999
	July 1, 1999*	June 30, 2003

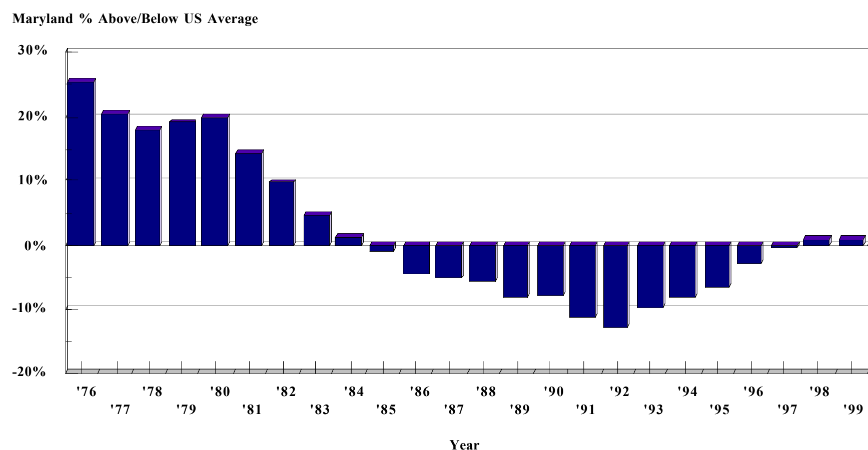
*Reappointed

I. EXECUTIVE SUMMARY

Fiscal Year 2001 proved to be another significant year for the Health Services Cost Review Commission (Commission or HSCRC). Throughout the year, the HSCRC continued the work begun in FY 2000 to redesign the regulatory system that had been in place for 25 years. It was also the second consecutive year where rapidly increasing hospital costs in Maryland were contained. The new system demonstrated its effectiveness in achieving Maryland's goals in fiscal 2000, and further refinements were enacted in FY 2001.

Some of the pressures that led to redesign were:

Chart 1



ï **Rapidly increasing hospital costs** Maryland had the lowest cost growth in the nation from 1976-1972, and improved its position from 26% above to 13% below the national average. But, from 1992 to 1999, Maryland had the highest growth rate, and ended the

period at the national average. The previous approach was no longer effective in controlling costs, in spite of significant actions during the 1992-98 period to reduce costs.

- **Medicare Waiver** Under the Waiver, Medicare pays the same rates established by the Commission for all other payers. This means, among other things, that Medicare pays its fair share of Uncompensated Care and Graduate Medical Education costs, which are included in hospital rates. Maryland is the only state in the nation that still has a waiver, which ensures that Maryland hospitals enjoy enhanced federal reimbursement and insulation from federal payment changes. Medicare continues to participate in the Maryland system so long as the rate of growth in Medicare payments to Maryland hospitals from 1981 to the present is no greater than the rate of growth in Medicare payments to hospitals nationally over the same time period. Due to the rapid escalation from 1992-1998, Maryland's system had lost significant ground in this calculation (15% over 18 months).
- **Complexity** Many changes have been made to the system since 1977 to make it as fair as possible in all circumstances, while simulating the operation of a competitive marketplace. The cumulative effect was a system that had become very complex, was understood by only a few, and was losing support.

Based on the Commission's annual hospital disclosure report from April 2001, the average charge per hospital admission dropped $5.00 from the previous twelve months. In addition, net revenue per admission decreased by 0.06% in 2000, the first decrease in Commission history. The system's performance proves that the Commission's new "Charge Per Case Methodology" is doing an excellent job of controlling hospital rates. This methodology,

implemented initially in April of 1999, was put into effect permanently in July of 2000. The charge per case methodology (CPC) focuses control on the overall average charge per case, rather than the charge for each unit (e.g., lab test, operating room minute, etc.) of care. While a new regulatory structure was designed and implemented during fiscal 2000, the Redesign Work Group established requirements that any new approach must continue to satisfy. A complete list is shown in (Exhibit I). Among them are:

ï **Access** Maryland is the only state in the nation where any citizen can obtain care in any hospital, regardless of ability to pay. We do not have a two tier system of care with charity hospitals for the poor, and every hospital's rates include a factor for social costs, including the uncompensated care it provides. This access must be maintained.

ï **All Payer, Medicare Waiver** Every payer, including Medicare, pays the same amount for a hospital service in Maryland. This not only prevents the massive cost shifting from large payers to small ones and those who pay for health care services out-of-pocket found in every other state, it is the basis for the Medicare Waiver. This equity must also be maintained.

ï **Cost Control** The previous method of controlling rates for units of care had clearly lost its effectiveness. Any new system must continue to be able to achieve cost targets.

ï **Simplicity, Predictability** Any system designed to regulate a $6 billion industry must be detailed enough to recognize variations and be fair. Yet another goal continues to be to reduce the amount of complexity and increase the predictability of results, so that hospital management is in a better position to prepare business plans and budgets.

The Commission worked throughout fiscal 2001 to finalize changes to the redesigned rate setting structure, including the interhospital cost comparison (ICC) methodology used for hospital full rate reviews, the hospital rate update formula for rate increases beginning FY 2002, and continued monitoring of the Medicare waiver.

As a result of the Redesign work, Maryland hospitals are now monitored and held to more predictable per-case targets, which are case-mix adjusted to account for patient severity. Additionally, future year rate increases are granted using an agreed-upon formula that includes the cost of hospital goods and services and inflation. The newly redesigned structure allows for rate updates beginning in fiscal year 2002 based on a formula that is directly tied to the growth in costs nationally, with a minimum annual rate increase of 1%. Maryland hospitals can also qualify for additional amounts or penalties if Maryland outperforms or underperforms the nation. Using this new methodology, hospitals received an average rate increase of 3.97% on July 1, 2001, the largest rate increase in four years.

Hospital Profits

While hospital profits also remained stable during the period, the Commission continues to work to balance the goals of efficient and effective hospitals being able to provide quality care, at reasonable rates, on a solvent basis. Despite the growing competitive pressures, the financial condition of Maryland hospitals remained steady last year. Hospital net profits, which include profits and losses from activities not regulated by the Commission, increased from $158.6 million in fiscal year 1999 (2.8% of total revenue) to $161.2 million in fiscal 2000 (2.7% of total revenue). Monthly unaudited data through April 2001 suggest that Maryland hospitals

continue to improve their profitability, with annualized total profits of approximately $184 million (3.1% margin, compared to 2.8% margin in FY 2000).

The Commission must, however, consider the financial performance of hospitals to ensure continued access for Maryland residents. Recognizing that many hospitals have been under continued financial constraints during 1999 and 2000, the Commission approved several interim rate agreements with specific hospitals which were in excess of the fiscal year 2.5% annual rate update negotiated through Redesign for fiscal 2001. Noting that the negotiated 2.5% rate increase was below inflation costs, which were approximately 3.9% during the same time period, the Commission also added a permanent $54 million supplemental increase to rates, producing an average rate increase of 3.97% for Maryland hospitals for fiscal year 2002.

Uncompensated Care

The 2000 Disclosure Report showed that the uncompensated care financed through the system decreased for the first time since 1994, from $483 million in fiscal 1999 to $469 million in fiscal 2000. This compares to $408.1 million in 1996; $436 million in 1997; and $459 million in 1998. In relative terms, uncompensated care financed through the system increased from 7.74% of revenue in 1996 to 7.94% of revenue in 1997, 8.18% in 1998, 8.29% in 1999, and 8% in 2000. Approximately 87% of the statewide uncompensated care expenditure originated in Maryland's metropolitan areas.

Waiver Performance

Although the State remains in no immediate danger of losing the waiver, the Commission continues to closely monitor Maryland's performance on the waiver test and provide both positive and negative incentives to hospitals to improve Medicare utilization. Through the

assistance of the Governor's office, and the leadership of the Maryland congressional delegation, the State was successful in November 1990 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. The most recent waiver test information indicates that ***payment per admission*** for Medicare patients nationally increased 199% from January 1, 1981, through June 30, 1999, compared to a 176% increase in Maryland over the same time period. While these test results represent the least favorable performance under the test over the past 15 years, there is preliminary evidence that suggests that the recent cost control measures initiated through the Redesign process will enable Maryland to improve its position on the test in future years. The Commission will continue to take whatever steps are necessary to assure continuation of our all-payer system.

Commissioners

In *May 2001*, Mr. Don Hillier was reappointed as Chairman of the Commission. Dr. Samuel Lin was appointed to serve a four-year term starting July 1, 1997. In addition, Commissioners Dean E. Farley, Ph.D. and Willarda V. Edwards, M.D. were reappointed to serve second four year terms beginning July 1, 1998. Dale Troll was also reappointed to serve a second four year term beginning in July, 1999. James Lowthers, whose term expired *in July 2001, was replaced by Larry Grosser.* In conclusion, the Commission thanks you for the support that you have given us this year. We look forward to working with you and continuing our efforts to improve the hospital rate system and meet our policy objectives in Fiscal Year 2002.

Exhibit I

Rate Redesign Objectives

Absolute Requirements

- Preserve the Medicare Waiver
- Preserve and improve financial access to hospital care for all citizens
- Maintain a fair payment system
- Ensure the delivery of affordable hospital care in Maryland
- Ensure and improve the delivery of high quality hospital care in Maryland
- Promote stability and predictability for hospitals, payers, regulators and patients
- Set rates that allow hospitals to be successful financially as long as they are well managed

Related Objectives

- Generate savings by eliminating the major "systematic" costs of regulation (Excess capacity, denials, unnecessary complexity, administrative inefficiencies).
- Tie system & individual hospital performance to objective and fair measures of efficiency and effectiveness.
- Establish clear and strong incentives for medical practice efficiency and align incentives (Hospital/Payer/Physician), wherever possible.
- Maintain a predictable regulatory system that provides a high degree of financial stability and allows for financial success for efficient and effective hospitals.
- Allow for differences in approaches on a regional basis, and experimentation and innovation in the delivery of affordable and high quality hospital services.
- Improve the ability of hospitals, payers, and physicians to develop best practices and improve quality and outcomes.
- Maintain hospital outpatient rate regulation that is compatible and well integrated (embodies appropriate financial and clinical incentives) with inpatient rate regulation.
- Broaden and make more fair the sharing of social costs in the system.
- Ensure the hospital rate setting system retains a balanced and open decision making process and is responsive to the needs of consumers and all interested parties.

II. REVIEW OF RATE REGULATION ACTIVITIES

A. Closed Docket Proceedings

Disposition of those applications acted upon by the Commission in Fiscal Year 2001 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.

Proceeding	Hospital	Description of the Application	Disposition
1656C	Kent & Queen Anne's Hospital	Commission initiated full rate review.	Closed
1657R	Frederick Memorial Hospital	Request for a full rate review.	Approved
*1659A	University of Maryland Medical Center	Request for approval to continue to participate in a capitated arrangement.	Approved
1660N	Levindale Hospital	Request to approve a rate for the new service of EKG.	Approved
1661N	Maryland General Hospital	Request to approve a rate for the new service of Audiology.	Approved
1664R	Holy Cross Hospital	Request for a full rate review.	Approved
*1665A	Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital	Request for approval to continue to participate in a global price arrangement.	Approved
*1666A	Fallston General Hospital	Request for approval to participate in the CPC System.	Approved
*1667A	Harford Memorial Hospital	Request for approval to participate in the CPC System.	Approved
*1668A	St. Joseph Medical Center	Request for approval to participate in a case rate arrangement.	Approved
*1669A	Doctor's Community Hospital	Request for approval to participate in the CPC System.	Approved
*1670A	Kent & Queen Anne's Hospital	Request for approval to participate the CPC System.	Approved

*1671A	St. Mary's Hospital	Request for approval to participate in the CPC System.	Approved
*1672A	Union Hospital of Cecil County	Request for approval to participate in the CPC System.	Approved
1673N	Good Samaritan Hospital	Request for a rate for the new service of Hyperbaric Oxygen Therapy.	Approved
1674R	St. Joseph Hospital Center	Request for approval to combine the rates of the hospital's Medical/Surgical-Acute and Pediatric-Acute services.	Approved
*1675A	Mercy Medical Center	Request for approval to participate in a case rate arrangement.	Approved
1676T	Dorchester General Hospital	Request for a temporary rate increase.	Denied
1677T	Memorial Hospital at Easton	Request for a temporary rate increase.	Approved
1678N	Dorchester General Hospital	Request for approval of a rate for the new service of Occupational Therapy.	Approved
1679N	Fort Washington Hospital	Request for approval of rates for the new services of Occupational and Speech Therapy.	Approved
1680R	Upper Chesapeake Medical Center	Request for rates to facilitate the transfer of Obstetric, Pediatric, Nursery, and Labor & Delivery services from Harford Memorial Hospital.	Approved
1681R	Franklin Square Hospital	Request for approval to modify the hospital's Lithotripsy service from a rebundled inpatient service to a hospital provided inpatient and outpatient service.	Approved

1682R	Union Memorial Hospital	Request for approval to modify the hospital's approved Lithotripsy service from a rebundled service to a hospital provided inpatient and outpatient service.	Approved
1683N	North Arundel Hospital	Request for approval of a rate for the new service of Hyperbaric Oxygen Therapy.	Approved
*1684A	Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital	Request to for approval to participate in a global price arrangement.	Approved
1685R	Upper Chesapeake Medical Center	Request for approval to lower the hospital's approved Obstetrics, Pediatrics, Nursery, and Labor & Delivery rates to the state-wide average.	Approved
1686N	Kessler Adventist Rehabilitation Hospital	Request by a new replacement facility to assume the rates of Eastern Neuro Rehabilitation Hospital.	Approved
1687R	Harbor Hospital Center	Request for approval to modify the hospital's Lithotripsy service from a rebundled inpatient service to a hospital provided inpatient and outpatient service.	Approved
1688R	Good Samaritan Hospital	Request for approval to modify the hospital's Lithotripsy service from a rebundled inpatient service to a hospital provided inpatient and outpatient service.	Approved
1689T	Taylor Manor Hospital	Request for temporary rate increase.	Approved
1690N	Upper Chesapeake Medical Center	Request for a rebundled rate for Therapeutic-Radiology.	Approved

1691R	Northwest Hospital Center	Request for an increase in to the hospital's approved uncompensated care provision.	Approved
*1692A	University of Maryland Medical Center	Request for approval to participate in a global price arrangement.	Approved
*1693A	Washington County Hospital	Request for approval to participate in a case rate arrangement.	Approved
*1694A	University of Maryland Medical Center	Request for approval to continue to participate in a capitated arrangement for cardiology services.	Approved
*1695A	Harbor Hospital Center, Franklin Square, Good Samaritan, and Union Memorial Hospitals	Request for approval to continue to participate in a capitation arrangement with a Medicaid Section 1115 MCO.	Approved
1696R	Union Memorial Hospital	Request for approval to modify the hospital's approved Therapeutic-Radiology service from a rebundled service to a hospital provided inpatient and outpatient service.	Approved
*1697A	Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital	Request for approval to continue to participate in a capitation with a Medicaid Section 1115 MCO.	Approved
1699R	Taylor Manor Hospital	Request for a full rate review.	Approved
*1700A	Johns Hopkins Hospital, Johns Hopkins Medical Center, and Howard County General Hospital	Request for approval to continue to participate in a capitated arrangement.	Approved
1701R	Anne Arundel Medical Center	Request for approval to modify the hospital's Lithotripsy service from a rebundled inpatient service to a hospital provided inpatient and outpatient service.	Approved

1703R	Howard County General Hospital	Request for approval to modify the hospital's Lithotripsy service from a rebundled inpatient service to a hospital provided inpatient and outpatient service.	Approved
1704T	Johns Hopkins Hospital	Request for a temporary rate increase.	Approved
1705N	Garrett County Memorial Hospital	Request for approval of rates for new MRI and CT Scanner services.	Approved
1706N	Garrett County Memorial Hospital	Request for approval of a rate for a rebundled Ambulance service.	Approved
1707T	Prince George's Hospital Center	Request for a temporary rate increase.	Approved
1708T	Upper Chesapeake Medical Center	Request for a temporary rate increase.	Approved
1709N	Garrett County Memorial Hospital	Request for approval of a rate for the new service of Speech Therapy.	Approved
1710N	Garrett County Memorial Hospital	Request for approval of a rate for Occupational Therapy.	Approved
1711R	Levindale Hospital	Request to consolidate the hospital's approved Recreational Therapy rate with its Medical\Surgical patient care rate.	Withdrawn

*** 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.

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. The major changes, refinements, and reviews made during Fiscal Year 2000 are described in the following sections.

A. System Redesign

In September 1999, the HSCRC began the effort to redesign Maryland's hospital rate setting system. The efforts resulted in a permanent system change that followed the temporary measures that began on April 1, 1999. The redesign effort began in response to several years in which Maryland's overall cost performance was less favorable than national cost performance. From 1977 to 1992, Maryland had the lowest growth in cost per adjusted admission in the country. For the subsequent six years, however, Maryland led the nation with the highest growth in cost per adjusted admission. In 1992, the cost per adjusted admission was 13% below the national average; in 1998 and 1999, Maryland was near the U.S. average.

The Commission became increasingly frustrated with its inability to control charge and cost per case, the growing obfuscation of system incentives, and lack of enforcement and control of the regulatory process. Conversely, the hospital industry's frustration was largely centered on the growing complexity of the rate-setting system. This complexity resulted from a variety of factors over time, including Commission policy changes that attempted to improve the rate-

setting system. Other modifications, many of which originated from the industry itself, attempted to make the system of comparing hospitals more fair and equitable. All parties were concerned about the lack of stability and predictability within the system.

To reform the system, the HSCRC formed a panel called the "Redesign Work Group" to advise on changes to the system. The group met between September 1999 and January 2000. Included in these discussions were HSCRC Commissioners and staff, industry representatives, payer representatives, labor unions, business leaders, and other interested parties from across Maryland. The Work Group's meetings resulting in a series of recommendations that covered four broad categories: structural changes to the regulatory system, long term goals for industry payment levels, administrative savings to be achieved within the system, and reductions in the complexity of administering the system.

A number of changes have been implemented. As of July 1, 2000, the IAS/GIR rate system was eliminated and replaced with an approach that determined inpatient case targets for each hospital. Payments are still based on unit rates to reflect resource utilization across payers, but the focus of HSCRC enforcement is charge per case.

The HSCRC has expanded its monitoring of industry performance and hospitals' financial condition. Hospitals' reporting of monthly data has been revised to allow a more detailed analysis of regulated and unregulated financial activities. Additionally, a task force of hospital representatives, payers, and Commission staff is currently meeting to determine the appropriate measures of industry performance to be monitored by the Commission.

With regard to payment levels, the consensus goal of the Redesign Work Group was to develop a system that would gradually outperform the nation in the long run, but at the same

time preserve payment stability for Maryland hospitals. The details of a broad formula proposed during the redesign process have been completed, and the update factor adopted for fiscal year 2002 was based on this completed formula. The formula has two components: the first term is hospital factor cost growth, and the second term is 50 percent of the difference between the growth in national net patient revenue per admission and factor cost growth. When net patient revenue per admission grows faster than factor costs, then Maryland hospitals receive an update equal to factor cost growth plus half of the difference in net patient revenue per admission and factor cost growth. If net patient revenue per admission grows more slowly than factor cost growth, then the hospitals reviews an update equal to the growth in net patient revenue. This formula guarantees that patients in Maryland hospitals pay charges that, over time, grow no faster than in the rest of the country.

The Commission continues to work with representatives from Baltimore City hospitals, the Medical Assistance Program, and the Maryland Health Care Commission to develop a pilot project that will enable hospitals to verify Medicaid patient eligibility real-time through a Web-based format at the hospital, thereby bypassing the current telephonic Medicaid EVS system. While the long-term goals of this group include Medicaid claims payments, adjudication, and the inclusion of other statewide payers and hospitals, a preliminary step that hospitals have identified as useful would be the inclusion of Medicaid primary care provider information, which will further facilitate Medicaid managed care organization (MCO) claims payment and preauthorization. The Commission is hopeful that Baltimore City hospitals will assume ownership of this project by the end of calendar year 2001.

B. Changes to the Screening Methodology and the ICC

Until this year, the HSCRC issued its screens that compare the relative cost performance of acute care hospitals in the State, as reflected by adjusted charge per case. Screens were issued twice each year. The results of the screens were used for a variety of regulatory purposes, both by the HSCRC and other agencies. As a result of the redesign process, the screens were eliminated with the last set of screens performed March 2001. As the redesign process proceeded, the screens became increasingly disconnected from the charge per case (CPC) methodology and the inter-hospital cost comparisons (ICC) used to establish unit rates and CPC targets for hospitals. As part of the continuing redesign process, the ICC methodology was revised, and the screens were discarded as a policy tool.

The revised ICC methodology was constructed with a dual purpose in mind. First, this policy would be used to review hospital rates in the context of a full rate review. Second, it would serve to identify high cost hospitals, replacing the screens as a standard of reasonable charges for each hospital.

As the primary tool in a full rate review, the revised ICC takes an alternative, simplified approach to establishing reasonable hospital rates. Instead of examining the detailed accounting costs and building up rates from these detailed numbers as the old ICC did (a bottom-up approach), the new methodology begins by comparing current CPC targets, adjusting for allowable cost differences across facilities. The hospital's approved CPC target is adjusted for differences in payer differentials and uncompensated care (markup), wage costs, patient severity (case mix), profits, direct medical education and related non-patient costs, the estimated costs of treating disproportionately poor populations, and the indirect costs of providing medical education. 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.

This methodology has also been adopted as the tool for identifying high cost hospitals. Hospitals that are three percent above their peer group average will be identified as high cost and targeted for a spend down to reduce their costs and charges relative to their peers. The same major factors are considered in targeting high cost hospitals under the ICC methodology as in the screens, but the comparisons are more refined by comparing hospitals to their peers under the ICC instead of a comparison to the statewide average as under the screens. Like the screens, the revised ICC results will be issued twice per year.

C. Uncompensated Care Regression and Policy

The Uncompensated Care Regression and Policy is used annually determine the amount of bad debt to be included in hospital rates and to the mark-up that is removed from hospital costs for screening purposes. Two variables were used in the 2001 uncompensated care regression (based on Fiscal Year 2000 data): the percentage of Medicaid patient days, and the percentage of patient days from non-Medicare patients admitted through the emergency room. Uncompensated care as a percentage of gross patient revenue decreased slightly from Fiscal Year 1999 (7.79%) to Fiscal Year 2000 (7.75%).

D. Uncompensated Care Fund

In Fiscal Year 2001, the Uncompensated Care Fund continued operating. A total of approximately $40.6 million was redistributed to high uncompensated care hospitals, allowing the uncompensated care mark-up in hospital rates to be no higher than 8.75% for any hospital.

E. Nurse Support Program

The Commission Staff recommended the reinstatement of the Nurse Support Program (NSP) at the November 1, 2000. The recommendation was approved at the December 6, 2000 meeting. The staff recommended the NSP funding limit be set at .10% of gross patient revenue for this statewide initiative. This cap is consistent with the funding for the previous Nurse Education Support Program (NESP). A Request for Proposal (RFP) to encourage and facilitate the implementation of hospital initiatives that address both the immediate and longer term nursing personnel requirements of Maryland hospitals was mailed to all hospitals in February 2001.

F. Inpatient Case_mix Data:

1. Confidential Data Request Review Committee:

On occasion, the HSCRC receives requests for access to the HSCRC Inpatient Discharge Data Base. The data include demographic, clinical, and charge information on all inpatients discharged from Maryland general acute hospitals. Most of these data requests are accommodated by the information available on the non_confidential version of the inpatient data base. However, in rare situations, the nature and scope of the information request requires access to data items that are not contained on the public use tape. During Fiscal Year 1997, the Commission reconvened the Confidential Data Request Review Committee in the event any request was made for access to confidential data. The Committee is comprised of a health information management professional, an ethicist, and Commission staff, to address special data requests. The Committee reviewed the HSCRC's data release policy and procedures and provided technical expertise in the development of criteria for access to data not currently

available on the standard public use file. During Fiscal Year 2000, there were no requests before the Commission for confidential data.

2. HSCRC/DHMH Data Sharing Agreement:

The HSCRC Inpatient Discharge Data Base is considered to be one of the most accurate, complete, and timely statewide hospital discharge data sets in the country. The data base is used extensively for hospital rate setting purposes, by other state agencies for health planning, program development, and evaluation functions, as well as for various research projects. During Fiscal Year 2000, the Commission staff continued a centralized data sharing arrangement with the Community and Public Health Administration to facilitate the availability and use of hospital inpatient data, as well as ambulatory surgery and ambulatory care data, among the divisions of DHMH and the Local Health Departments.

G. Ambulatory Care Database

The HSCRC Ambulatory Care Data Reporting Regulations, effective April 1, 1997, allow the Commission to collect information on hospital-based clinic and emergency room services. The reporting requirements augment the patient level data currently collected on all inpatient stays and ambulatory surgeries. The ambulatory care data enables the Commission to more effectively regulate hospital-based outpatient services and costs. The data also enable the Commission to monitor and evaluate hospital performance associated with the Alternative Methods of Rate Determination Program. In Fiscal Year 2000, the Commission continued activities related to the development and management of this important data set.

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 2001, 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.

C. Annualized Percentage Adjustments

Effective July 1, 2001, acute care hospitals were granted a 3.97% annual update factor to the Charge Per Case Target as well as outpatient and ancillary unit rates on average. In recognition of the fact that some hospitals were charging above or below predetermined averages, the update factor was scaled , allowing low charge hospitals more than the 3.97% update factor, and high charge hospitals less than th 3.97% update factor.. Those hospitals charging at the average received the 3.97% update. This scaling based on charging levels did not affect the aggregate system wide adjustment of 3.97%, but rather was applied in a revenue neutral fashion.

These hospitals' charging practices were deemed above pre-established averages and, therefore they were granted less than the 3.97% update factor.

Greater Baltimore Medical Center	3.57%

North Arundel Hospital	3.57%
Washington Adventist Hospital	3.57%
McCready Memorial Hospital	3.57%
Kent & Queen Anne's Hospital	3.57%
Laurel Regional Hospital	3.57%
Upper Chesapeake Medical Center	3.57%

These following hospitals were charging in the average range and received the average annual update factor of 3.97%.

Doctor's Community Hospital	3.97%
Suburban Hospital	3.97%
Union Memorial Hospital	3.97%
St. Joseph Medical Center	3.97%
Northwest Hospital Center	3.97%
Shady Grove Adventist Hospital	3.97%
University of Maryland Hospital	3.97%
Montgomery General Hospital	3.97%
Good Samaritan Hospital	3.97%

Prince Georges Hospital Center	3.97%
Southern Maryland Hospital Center	3.97%
Mercy Medical Center	3.97%
Franklin Square Hospital	3.97%
Fort Washington Medical Center	3.97%
Dorchester General Hospital	3.97%
Howard County General Hospital	3.97%
Harford Memorial Center	3.97%
Sinai Hospital	3.97%
Holy Cross Hospital	3.97%
Johns Hopkins Bayview Medical Center	3.97%
Peninsula Regional Medical Center	3.97%
Frederick Memorial Hospital	3.97%

These remaining hospitals were below established averages and received more than the state wide 3.97%.

Anne Arundel Medical Center	4.12%
Atlantic General Hospital	4.12%

Johns Hopkins Hospital	4.12%
Carroll County General Hospital	4.12%
Harbor Hospital Center	4.12%
Bon Secours Hospital	4.12%
Maryland General Hospital	4.12%
St. Mary's Hospital	4.12%
The Union Hospital of Cecil County	4.12%
St. Agnes Hospital	4.12%
Civista Medical Center	4.12%
Sacred Heart Hospital	4.12%
Washington County Hospital	4.12%
Memorial of Cumberland Hospital	4.12%
Memorial Hospital at Easton	4.12%
Calvert Memorial Hospital	4.12%

Only one acute care hospital in the State did not go on the Charge Per Case methodology. Garrett Memorial Hospital opted to remain on the Total Patient Revenue (TPR) system. It should be noted that there are specific requirements for remaining on the TPR. A hospital selecting this rate setting methodology must be a sole community provider with a defined

population services area, with little or no competition from other hospitals. Garrett County Memorial meets these criteria and remains on the TPR, but did not request a rate increase during the fiscal year 2001.

V. ACTIVITIES AFFECTING HEALTH SERVICES COST REVIEW COMMISSION'S REGULATIONS

Over the past fiscal year, the Commission adopted amendments to a number of existing regulations.

COMAR 10.37.01

This regulation concerns the Commission Uniform Accounting and Reporting System for Hospitals. On June 6, 2001, the Commission adopted an amendment to regulation .02. This amendment updates the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operating Management (August 1987)" with Supplement 12 (April 6, 2001), which has been incorporated by reference.

COMAR 10.37.04

______This regulation concerns the Submission of Hospital Ambulatory Care Data Set to the Commission. On May 2, 2001, the Commission proposed for adoption amendments to regulations .03, and .04. The purpose of these changes is to ensure that the Commission's ambulatory care reporting requirements are consistent and comparable with Medicare's ambulatory payment classifications, to enhance the Commission's ability to monitor hospital-based outpatient activity, and to assist the Commission in analyzing various case-mix related rate setting issues.

COMAR 10.37.07

This regulation concerns the Submission of Hospital Ambulatory Surgery Data Set to the Commission. On May 2, 2001, the Commission proposed for adoption amendments to regulations .03 and .04. The purpose these changes is to ensure consistency and comparability with Medicare's ambulatory payment classifications, to enhance the Commission's ability to monitor hospital-based ambulatory surgery, and to assist the Commission in analyzing various case-mix related rate setting issues.

COMAR 10.37.10

This regulation concerns the Commission's Rate Application and Approval Procedures. During the past fiscal year, there were several changes made to this regulation while the Commission was in the process of re-evaluating its rate setting methodologies to make them more compatible with its new CPC Target rate system. On October 4, 2000, new regulations .04-2 and .04-3, which were proposed on August 2, 2000, were adopted by the Commission. The purpose of this action is to describe generally the Commission's new case target methodology to be used in the establishment of reasonable rates for Maryland's general acute hospitals. Amendments to these regulations were then proposed on January 5, 2001 and adopted as proposed on April 4, 2001. The purpose the these changes is to have the Commission's CPC methodology conform to all the recommendations made by the Redesign Work Group.

Also, on August 2, 2000, the Commission requested and received approval by the AELR Committee for emergency status to regulation .03, ICC Methodology, commencing on July 1, 2000 and expiring on January 1, 2001. The purpose of this emergency action is to place a moratorium on the filing of full rate applications until the Commission adopted its new full rate

review methodology. On December 6, 2000, the Commission requested and received an extension of the emergency status to regulation .03, to July 1, 2001. On May 2, 2001, when the Commission adopted its new policy concerning the ICC methodology, it proposed for adoption amendments to regulation .04-1. The purpose of this regulation is to more accurately describe the Commission's new methodology in view of the policy changes that were adopted by the Commission.

The Commission also proposed and adopted several changes to regulation .05, Application for Temporary Change in Rates. On October 4, 2000, the Commission adopted amendments that clarify the conditions under which the Commission may provide for a temporary adjustment to rates and the parameters under which such an adjustment may be made. On April 4, 2001, the Commission proposed for adoption amendments to this regulation that would increase the time frames associated with an application for a temporary change in rates.

During this past fiscal year, the Commission also proposed, withdrew, and adopted several amendments to regulation .26A, the Commission's Substantial, Available, Affordable Coverage (SAAC) regulation. First, on August 5, 2000, the Commission proposed to amend its SAAC regulation. The purpose of this action is to authorize the Commission to prescribe a maximum amount for the SAAC differential on hospital rates for carriers that were not approved for the differential as of January 1, 2000; alter the information required of carriers that apply for the SAAC differential; alter the basis for the Commission's decision to grant or deny an application; provide criteria for the Commission's determination of whether a carrier has earned the SAAC differential; provide the method by which the value of a carrier's SAAC differential will be derived; require a plan of corrective action by a carrier under certain circumstances;

require the repayment of excess differential value if a carrier stops offering a SAAC product; and make technical changes. These amendments were withdrawn by the Commission on November 1, 2000. On October 4, 2000, the Commission adopted new regulation .26A(5) concerning the Short-Term Prescription Drug Subsidy Plan. The purpose of this regulation is to conform to the requirements set forth in Chapter 565, Acts of 2000, concerning the new short-term drug subsidy benefit program for Medicare Plus Choice eligible individuals who reside in medically under-served areas that takes effect July 1, 2000 and which directs the Commission to annually assess certain SAAC carriers to pay an assessment into a special fund as a condition of receiving the SAAC differential. Then, on January 5, 2001, the Commission proposed for adoption amendments to regulation .26A(5), and at the same time, requested and received emergency status, commencing on December 6, 2000 and expiring on May 31, 2001. The purpose of these amendments, which were adopted by the Commission on April 4, 2001, is to authorize the Commission to impose monetary penalties on those SAAC carriers that fail to pay their assessment into the Short-Term Prescription Drug Subsidy Fund in a timely manner. Finally, on June 6, 2001, the Commission proposed for adoption amendments to regulation .26A(5). The purpose of these changes is to conform to the changes made by the recently repealed and reenacted, with amendments Short Term Prescription Drug Subsidy Plan legislation.

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 2001 session of the General Assembly:

House Bill 6

This bill, companion to Senate Bill 236, entitled the Senior Prescription Drug Relief Act, would expand the Short-Term Prescription Drug Subsidy Program statewide to all Medicare beneficiaries without prescription drug coverage whose annual household income is at or below 300% of federal poverty guidelines; require carriers participating in the SAAC program to contribute 37.5% of the value of the SAAC differential to the Plan Fund; and prohibit the HSCRC from eliminating or altering the SAAC differential for those carriers that were approved for the differential as of January 1. 2000. In addition, the bill would sunset on the later of June 30, 2003, or the date on which a Medicare prescription drug benefit is available. (Passed)

House Bill 15

______This bill would require nonprofit hospitals, beginning October 1, 2002, to submit an annual community benefit report to the HSCRC detailing the community benefits provided during the preceding year; the HSCRC would be required to adopt regulations, in consultation with hospital representatives, that establish the standard format for reporting the information, the date on which the reports must be submitted, and the period of time that the report must cover. In addition, the bill would require the HSCRC to compile the reports and issue an annual nonprofit hospital community health benefit report to the General Assembly by (Passed)

House Bill 733

This bill would increase the maximum total user fees that the HSCRC may assess from the current cap of $3.5 million to $4 million dollars, and limits any fiscal year increase in budgeted expenses to an amount equal to, or less than, the percentage increase of the annual rate update for all acute care hospitals in the same fiscal year. The bill also clarifies that the annual

user fee cap applies to total assessments, rather than the HSCRC's budgeted expenses; and provides that the HSCRC may not increase user fee assessments until completion of a report on the future viability and financial condition of Maryland's hospitals. (Passed)

Senate Bill 236

______This bill, companion to H.B. 6, entitled the Senior Prescription Drug Relief Act, would expand the Short-Term Prescription Drug Subsidy Program statewide to all Medicare beneficiaries without prescription drug coverage whose annual household income is at or below 300% of federal poverty guidelines; require carriers participating in the SAAC program to contribute 37.5% of the value of the SAAC differential to the Plan Fund; and prohibit the HSCRC from eliminating or altering the SAAC differential for those carriers that were approved for the differential as of January 1. 2000. In addition, the bill would sunset on the later of June 30, 2003, or the date on which a Medicare prescription drug benefit is available. (Passed)

Senate Bill 317

______This bill, companion to H.B. 366, entitled the Maryland Program Evaluation Act, would extend the sunset termination date of the HSCRC and the MHCC from July 1, 2002 to July 1, 2007. (Passed)

Senate Bill 458

______This bill would require any carrier that denies medically underwritten health insurance for an individual in the nongroup market to provide the individual with information regarding the availability of SAAC coverage with a notice of declination; and specifies that a carrier offering the SAAC indemnity plan product on January 1, 2001 may continue to offer that plan to existing subscribers. (Passed)

Senate Bill 728

This bill would require HMOs to pay health care providers for services rendered in a trauma center designated by the Maryland Institute of Emergency Medical Services System (MIEMSS) at the greater of: 1) 140 percent of the Medicare rate; or, 2) the rate as of January 1, 2001, that the HMO paid in the same geographic area for the same covered service to a similarly licensed provider. In addition, the bill would permit an HMO to require a trauma physician not under contract with the HMO to submit appropriate claims documentation and to include a provider number assigned to the trauma physician on the uniform claims from submitted for payment. (Passed)

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, §19-219, Annotated Code of Maryland and COMAR 10.37.10.06. Under its law, the Commission may promote and approve experimental payment methodologies that are consistent with the fundamental principles inherent in the Commission's legislative mandate. The applications for alternative methods of rate determination fell into one of four general categories: 1) ambulatory surgery procedure-based pricing; 2) global pricing or case rate arrangements for selected inpatient procedures; 3) partial capitation or risk sharing arrangements; and 4) full capitation.

IX. ACTIVITIES ASSOCIATED WITH IMPLEMENTATION OF HEALTH SERVICES COST REVIEW COMMISSION ALTERNATIVE METHODS OF FINANCING HOSPITAL UNCOMPENSATED CARE

In September of 1996, the HSCRC approved a methodology that spreads the costs associated with uncompensated care more evenly across all hospitals in the State. The methodology called for an assessment of .75% to be made against all hospitals, with those funds being redistributed to hospitals that treat the higher proportion of Maryland's uninsured citizens. Regulations implementing this plan, embodied in COMAR 10.37.09, "Fee Assessment for Financing Hospital Uncompensated Care," became effective on February 10, 1997. On May 1, 1997, all hospitals began making payments into the Uncompensated Care Fund. All funds collected in May and June of 1997 were used to establish the reserve fund account of the Uncompensated Care Fund. On July 1, 1997, the HSCRC began disbursing funds to hospitals that treat the higher portion of uninsured citizens. During the last fiscal year, the Uncompensated Care Fund successfully assessed all hospitals .75% and distributed the funds that were collected to hospitals with high uncompensated care percentages.

FORMER COMMISSIONERS

Former Commissioner	Appointed	Term Expired
John A. Whitney, Esq.	July 19, 1971	June 30, 1972
Sidney A. Green	July 19, 1971	June 30, 1978 (Resigned)
George J. Weems M.D.	July 19, 1971	June 30, 1978 (Resigned)
Mancur Olson, Ph.D.	July 19, 1971	June 30, 1977
Bernard Kapiloff, M.D.	July 19, 1971	June 30, 1977
P. Mitchell Coale[1]	March 31, 1976	June 30, 1978 (Resigned)
W. Orville Wright	January 25, 1972	June 30, 1979
Alvin M. Powers	July 19, 1971	June 30, 1979
Natalie Bouquet	October 31, 1972	June 30, 1980
Gary W. Grove	June 29, 1979	June 30, 1983
John T. Parran[2]	July 8, 1977	June 30, 1982
Stephen W. McNierney[3]	February 8, 1983	June 30, 1986 (Resigned)
Carville M. Akehurst[4]	June 29, 1979	June 30, 1983
David P. Scheffenacker	September 6, 1977	June 30, 1985
Roland T. Smoot, M.D.[5]	July 12, 1978	June 30, 1986
Carl J. Schramm, Esq.[6]	July 8, 1977	June 30, 1985
Richard M. Woodfin[7]	August 29, 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 3, 1986	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.

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