STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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451st MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
December 10, 2008
9:00 a.m.

1. **Review of the Executive and Public Minutes of November 5, 2008**
2. **Executive Director's Report**
3. **Docket Status - Cases Closed**

   1994A - Johns Hopkins Health System
   2006A - Johns Hopkins Health System
4. **Docket Status - Cases Open**

   1985A - University of Maryland Medical Center
   1999A - University of Maryland Medical Center
   2007R - Johns Hopkins Bayview Medical Center
   2008A - Johns Hopkins Health System
   2009A - University of Maryland Medical Center
   2010A - MedStar Health
5. **Final Recommendations on Changes to Uncompensated Care Financing**
6. **Overview of the Recommendations of the Task Force on Health Care Access and Reimbursement (SB107)**
7. **Legal Report**
8. **Hearing and Meeting Schedule**

450TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

NOVEMBER 5, 2008

Vice-Chairman Kevin K. Sexton called the meeting to order at 9:16 a.m. Commissioners Joseph R. Antos, Ph.D., Raymond J. Brusca, J.D., Trudy R. Hall, M.D., James Lowthers, and Herbert Wong. Ph.D. were also present.

REPORT OF THE EXECUTIVE SESSION OF NOVEMBER 5, 2008

Oscar Ibarra, Chief-Program & Information Management, summarized the minutes of the November 5, 2008 Executive Session.

COMFORT ORDER – ANNE ARUNDEL MEDICAL CENTER

The Commission voted unanimously to ratify the Comfort Order for Anne Arundel Medical Center approved in Executive Session.

ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC SESSION OF OCTOBER 8, 2008

The Commission voted unanimously to approve the minutes of the October 8, 2008 Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, reported that staff had received a second directive from the Secretary of Health and Mental Hygiene, requesting staff to look at methods of reducing expenditures in the system in response to anticipated Medicaid cut-backs in FY 2010. The Secretary suggested that the Commission focus on providing incentives to reduce medical waste, unnecessary care, preventable complications, and otherwise try to find solutions that are aligned with the policy goals of the system. In response to the Secretary's request, Mr. Murray stated that staff will present a draft recommendation at today's meeting concerning expansion in Uncompensated Care (UCC) pooling, which will reduce Medicaid expenditures while making the financing of UCC more equitable by spreading it more broadly.

Mr. Murray noted that staff is also continuing its work in the area of quality. Staff will be presenting information concerning hospital-acquired conditions, while the Quality Evaluation Work Group continues to look at ways of refining the Commission's process-based quality measures initiative, as well as incorporating outcome measures into the initiative in the future.

Mr. Murray noted that staff will shortly be starting discussions with the industry about the next 3-year rate arrangement and will update the Commission on the progress of the discussions.

In addition, Mr. Murray reported that staff continues to discuss with representatives of the hospital industry the issue of the changing reimbursement landscape for physicians and its effect on physicians and hospitals. Staff will confer with the Chairman and Vice Chairman to determine the best way to approach the short term and the long term dimensions of this issue.

Mr. Murray recognized the hard work and dedication of Paul Sokolowski, Vice President of the Maryland Hospital Association (MHA). Mr. Sokolowski is leaving MHA after 10 years of representing the hospital industry. Mr. Murray stated that Mr. Sokolowski represented not only the interest of hospitals, but more importantly the interest of the health system overall. Mr. Sokolowski's participation with rate setting issues encompassed not only his service at MHA but also more than twenty years as a hospital CFO. Among Mr. Sokolowski's many accomplishments was his intimate involvement in: the rate re-design process, the modification of the Financial Conditions Report, the transition to APR-DRGs, and the movement to a bundled outpatient payment system. Throughout his career, Mr. Sokolowski demonstrated outstanding technical expertise coupled with the willingness to roll-up his sleeves and work with the payers and the Commission's staff to forge compromises. On behalf of the Commission and staff, Mr. Murray thanked Mr. Sokolowski for his dedicated service and wished him the best in his future endeavors.

Mr. Sokolowski stated that it has been his pleasure to have represented the hospital industry for 10 years and thanked the Commission and staff for all the kindness extended to him over the years.

ITEM III
DOCKET STATUS CASES CLOSED

1992N – MedStar Health
2001A – Johns Hopkins Health System
2003A - Maryland Physician's Care
2004A – Johns Hopkins Health System
2005A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

Johns Hopkins Health System – 1994A

On July 14, 2008, Johns Hopkins Health System on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital, filed an application for approval for the continued participation in a global rate arrangement for solid organ and bone marrow transplants with Life Trac, a subsidiary of Allianz Insurance, for a period of one year retro-active to July 1, 2008.

Because the experience under this arrangement was favorable over the last year, staff recommended approval of the Hospitals' request for continued participation in the global price arrangement for one year retro-active to July 1, 2008. In addition, staff recommended that the approval be contingent on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2006A

On October 7, 2008, the Johns Hopkins Health System filed an application on behalf of Johns Hopkins Bayview Medical Center requesting approval to continue to participate in a capitation arrangement for mental health services under the program title, "Creative Alternatives" between Johns Hopkins Health System and Baltimore Mental Health Systems. The request is for a period of one year beginning November 1, 2008.

Because the experience under this arrangement was favorable over the last year, staff recommended that the Commission approve the request for one year effective November 1, 2008, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Extensions

Staff requested a 30 day extension of time for review of the application of Johns Hopkins Bayview Medical Center, proceeding 2007R.

The Commission voted unanimously to grant staff's request.

ITEM V
DRAFT RECOMMENDATION - CHANGES TO THE UNCOMPENSATED CARE FUNDING METHODOLOGY

In reaction to growing State budget deficits and in response to the Secretary of Health's request that the HSCRC identify changes to the rate system, which would help reduce Medicaid expenditures, staff investigated the potential impact of two changes in the Commission's Uncompensated Care Policy: 1) including the University of Maryland Shock Trauma Center in the existing Uncompensated Care Pool; and 2) moving the system to 100% pooling of all hospital uncompensated care (UCC). Mr. Murray reported that staff's analysis indicated that because Medicaid accounts for 25% of the payments to Shock Trauma, spreading Shock Trauma's UCC costs would save Medicaid approximately $4.2 million in Medicaid expenditures and $1.98 million in State General Funds. However, because Medicaid patients are concentrated in hospitals with higher UCC provisions and thus higher rates, staff estimated that a move to 100% pooling of UCC, including Shock Trauma, would result in total annual saving to Medicaid of approximately $10.9 million and $5.1 million in General Fund savings.

Mr. Murray stated that because 100% pooling of UCC fulfills the intent of the Commission's statutory mandate to implement the broadest and most equitable mechanism for financing the burden of providing care to the uninsured, staff recommends that the change to 100% pooling be adopted by the Commission effective January 1, 2009. Mr. Murray stated that it is the intent of staff to present the final recommendation at the December 10th public meeting; however, if the recommendation is delayed, the Commission may be asked to take action in a public conference call.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, voiced his support for staff's recommendation. Dr. Cohen observed that 100% pooling, i.e., incorporating the state-wide average level of UCC in all hospitals, was equitable, since patients at hospitals with high UCC are no more responsible for the level of UCC than patients at hospitals with low UCC are responsible for the low level of UCC.

Ing-Jye Cheng, Assistant Vice President of MHA, stated that MHA supported the recommendation and would meet with staff to work out the technical problems, especially those involved with cash flow issues.

Mr. Murray stated that comments on the proposed UCC Policy change should be received at the Commission's office on or before November 26, 2008.

ITEM VI
UPDATE ON MARYLAND HOSPITAL ACQUIRED CONDITIONS (MHAC) PROJECT

Robert Murray provided a status report on the Maryland Hospital Acquired Conditions Project. Mr. Murray stated that the goal of the project is to use outcome measures to motivate hospitals to

reduce complication rates by providing appropriate financial incentives (attachment A).

Ms. Elizabeth C. McCullough, 3M Health Information Systems, summarized two of 3M's quality-based methodologies for measuring outcomes utilizing inpatient administrative data: 1) potentially preventable complications (PPCs); and 2) potentially preventable readmissions (PPRs) (attachment B).

Mr. Murray presented some examples of how the current payment system inappropriately increases a hospital's revenue when the hospital makes a preventable mistake.

Commissioner Hall asked whether the methodology accounted for the higher rate of PPCs at teaching hospitals.

Ms. McCullough replied that the risk adjustment severity should account for a part of the higher rate of incidence in teaching hospitals, while comparing teaching hospitals with each other could also be done.

Commissioner Hall also asked whether the methodology accounts for PPRs caused by patient caused complications, e.g., not filling prescriptions.

Ms. McCullough stated that the PPR tool logic can be adjusted for additional factors, e.g., disproportionate share, high rates of mental health and substance abuse, an older population, to account for higher rates of PPRs.

Ms. Cheng expressed MHA's opposition to staff's approach in using the 3M software in developing an acquired condition payment policy. Ms. Cheng reiterated MHA's position that payment policies related to serious adverse events should be driven by a methodology that determines whether the hospital should be held accountable for those events, and that 3M's software does not meet the test (attachment C). Ms. Cheng stated that there should be thoughtful discussion of this policy before it is implemented.

Commissioner Hall asked what MHA's alternative was to staff's proposed initiative.

Ms. Cheng replied that MHA believes that there needs to be further discussion on what we are trying to accomplish. She expressed MHA's concern that the proposal would penalize hospitals very broadly using an administrative data driven tool, rather than MHA's preferred approach of encouraging improvement.

Barry Rosen, representing United Healthcare, stated that he had the privilege of participating in the hospital acquired complications workgroup. Mr. Rosen asserted that this initiative shows what is possible in Maryland's unique all-payer case rate system. He observed that there is the possibility that if the Commission, hospitals, and payers take modest, incremental steps and together craft a hospital acquired complications methodology, a hospital's case rate target would

be affected, and the Commission thereby, can change hospital behavior. Mr. Rosen expressed his and his client's enthusiastic support for the project.

Dr. Cohen seconded Mr. Rosen's comments. Dr. Cohen stated that he thought it preferable to target hospitals with higher rates of PPCs and PPRs for revenue reductions to make health care more affordable than to reduce hospital revenue across-the-board. Dr. Cohen asserted that such adjustments are appropriate and urged the Commission to move forward with this initiative.

ITEM VII
UPDATE ON THE ICC/ROC METHODOLOGY DISCUSSIONS

John O'Brien, Deputy Director-Research and Methodology, summarized the progress of the ICC/ROC workgroup. Mr. O'Brien stated that although the workgroup has come to consensus on several issues (e.g., use of a blended CPC/CPV to develop the Comprehensive Charge Target, not to change the outlier cost methodology, and inclusion of 100% of direct medical education costs in the direct medical education adjustment), several issues were still under discussion. Those issues include the adjustments for indirect medical education and disproportionate share, and whether a peer grouping methodology should be utilized.

Mr. O' Brien reported that staff intends to present a draft recommendation at either the December or January public meeting with a final recommendation to follow.

ITEM VIII
OVERVIEW OF THE COMMUNITY BENENFIT REPORT CHANGES

Ms. Amanda Greene, Data Processing Analyst, provided a summary of the proposed changes to the Community Benefit Report recommended by the Community Benefit Advisory Group. The group recommended that the narrative portion of the Report be aligned with the data that hospitals were required to file with the Internal Revenue Service, Form 990 schedule H. Ms. Greene stated that the narrative guidelines will be optional for 2008 but will be mandatory in 2009.

Ms. Greene stated that a Review Committee will be assembled in January of 2009 to determine criteria for evaluations of the 2008 Reports filed in order to suggest changes to the Report, provide feedback to hospitals, highlight best practices, and provide training to hospitals whose Reports fall short of the standard. The Review Committee will also seek to reconcile the financial data in the Report to the data filed in the Commission's Annual Report of Revenues, Expenses, and Volumes.

Ms. Cheng thanked staff for all its work on the Report and its willingness to consider hospitals' input. Ms. Cheng expressed MHA's support for the changes in the Report and praised the inclusion of a one year ramp-up period for hospitals to provide the new information. Ms. Cheng

noted that the proposed yearly review process will be highly beneficial because for the first time, hospitals will be able to get systematic feedback from the Commission to improve their reporting.

ITEM IX
LEGAL REPORT

Regulations

Proposed

Rate Application and Approval Procedures – COMAR 10.37.10.26

The purpose of this action is to describe the assessment process associated with averted uncompensated care and to authorize penalties for untimely or under-payment.

The Commission voted unanimously to forward the proposed regulations to the AELR Committee for review and publication in the Maryland Register.

Fee Assessment for Financing Hospital Uncompensated Care - COMAR 10.37.09.01-.06

The purpose of this action is to provide for full pooling of uncompensated care amongst all hospitals.

Because these regulatory changes will likely require remittance to be made by January 1, 2009, staff requested that the Commission grant emergency status for this amendment beginning December 1, 2008, until such time as the proposed regulations are formally adopted.

The Commission voted unanimously to forward the proposed regulations to the AELR Committee for review and publication in the Maryland Register and to grant emergency status effective December 1, 2008.

ITEM XX
HEARING AND MEETING SCHEDULE

December 10, 2008	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
January 14, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:17 a.m.

Attachment A

Maryland Hospital-Aquired Conditions (MHACs) Project

Robert Murray, Maryland Health Services Cost Review Commission

5 November 2008

Quality of Care Initiatives (from last meeting)

- IOM Report 1999
- National Discussions followed – focus on Process Measures and Outcomes Measures
- Initial work on Process Measures for reporting and P4P
  - Don't require risk-adjustment
  - Linked to better outcomes
- National "vetting process" & Medicare Hospital Compare database
- Limited Plan-Specific P4P and Medicare Value Based Purchasing
- Maryland Quality-Based Reimbursement (19 measures)
- Progress but First and Third Party payers believe progress is very slow

Process Measures

- Focus on adopting evidenced based processes for certain high risk procedures
- Core measures: AMI, HF, PNU, SIP
- Advantages:
  - Sensitize hospitals to increased focus on quality
  - Better documentation and accountability through reporting
  - Documented evidence when processes are adopted better outcomes occur
  - Doesn't require risk adjustment
  - Can link payment to process measures (Medicare VBP proposed and HSCRC 2008)
- Disadvantages:
  - By the time core measures are vetted most providers are already doing the recommended processes (many measures are "topped off")
  - Really only "Pay for Reporting" not "Performance"
  - Potentially thousands of process measures (danger of trying to influence quality by telling providers how to practice high quality medicine – step by step)

Maryland Uniquely Positioned on Quality

- Hospital Rate System Payment Incentives/Risk Adjustment
  - Uniform incentives across all payers, all hospitals and covering all services
  - Used financial incentives to promote efficiency – they can also promote quality
- Use of APR-DRGs (All-Patient Refined)
  - First payment system to use "severity adjusted" DRGs
  - Medicare recently moved to severity based DRGs (MS-DRGs)
- Advantages of "Refined" or Severity Adjusted DRGs
  - "Refined" means DRGs do a better job of defining what each case should "cost"
  - They result in fairer payment to providers (both high-end and low-end)
  - A better DRG system means less risk to providers when they get very sick patients
- Use of APR-DRGs as a Risk Adjustment Tool
  - Traditionally used to adjusts for risk for payment/efficiency purposes
  - Now can be used to adjust for risk for payment/quality purposes
- Advantage of Severity Adjusted DRGs – more "sensitive"
  - Also a "disadvantage" however (Payment for Poor Quality too)
  - Unintended Incentive Consequences

Old DRG System vs. Refined System

Old DRG System

- DRGs developed for a Medicare (elderly population)
- Less focus on Obstetrics, Pediatrics, Psychiatry DRGs
- 250-300 categories of cases
- Only one split to differentiate cases with complications

DRG Category or "Cell"	Payment
DRG 1 w/o cc	$7,500
DRG 2 w/cc	$9,000
DRG 3 w/o cc	$4,500
DRG 4 w/cc	$6,000
DRG 5	$14,000
DRG 6	$15,000
⋮	⋮
DRG 500 w/cc	$22,000

APR-DRG System

- Developed for an "All-Patient" population
- Clinical logic more appropriate for all types of care
- 314 DRG categories
- 4 Splits based on clinical factors for different levels of "severity" of Illness (SOI)

The More Complications, the higher the SOI --->

DRG Category or "Cell"	SOI 1	SOI 2	SOI 3	SOI 4
DRG 1	$2,500	$5,700	$9,700	$12,000
DRG 2	$3,500	$4,700	$10,800	$13,400
DRG 3	$1,500	$3,000	$6,000	$7,800
DRG 4	$3,000	$4,500	$6,500	$8,000
DRG 5	$4,500	$8,900	$12,300	$17,000
DRG 6	$6,000	$12,000	$17,000	$21,000
⋮	⋮	⋮	⋮	⋮
DRG 314	$7,600	$14,000	$25,000	$32,000
⋮	⋮	⋮	⋮	⋮

Medicare Quality Initiatives

- Like the HSCRC started with Process Measures
- Medicare moving more quickly in the area of payment incentive designed to improve outcomes
- Oct 1, 2008 – Hospital Acquired Conditions (HACs)
- CMS will no longer provide "DRG/SOI" payment enhancements for Preventable Hospital-Acquired Conditions
- Identified 11 "Hospital Acquired Conditions"
- 100% payment decrement for HACs

CMS Statutory Selection Criteria

- CMS must select conditions that are:
  - High cost, high volume, or both
  - Assigned to a higher paying DRG when present as a secondary diagnosis
  - Reasonably preventable through the application of evidence-based guidelines
- Implementation requires Severity Adjusted DRG system and collection of Diagnosis "Present on Admission" (POA) indicator

MS-DRG Assignment (Examples for a single secondary diagnosis)	POA Status of Secondary Diagnosis	Average Payment
Principal Diagnosis: **MS-DRG 066** ▪ Stroke without CC/MCC	--	**$5,347.98**
Principal Diagnosis: MS-DRG 065 ▪ Stroke with CC Example Secondary Diagnosis: ▪ Injury due to a fall (code 836.4 (CC))	**Y**	**$6,177.43**
Principal Diagnosis: **MS-DRG 066** ▪ Stroke with CC Example Secondary Diagnosis: ▪ Injury due to a fall (code 836.4 (CC))	**N**	**$5,347.98**
Principal Diagnosis: MS-DRG 064 ▪ Stroke with MCC Example Secondary Diagnosis: ▪ Stage III pressure ulcer (code 707.23 (MCC))	**Y**	**$8,030.28**
Principal Diagnosis: **MS-DRG 066** ▪ Stroke with MCC Example Secondary Diagnosis: ▪ Stage III pressure ulcer (code 707.23 (MCC))	**N**	**$5,347.98**

Two Necessary Features

- Maryland – has APR-DRGs
- Started collecting Diagnosis POA July 1, 2007
- Coding in FY 2008 on this indicator compares favorably to California coding (15 years experience coding POA)
- Staff providing feed back to hospitals with questionable coding (very limited number) and establishing systematic error/edit checks
- Hospitals have ability and time to revise their data
- Very favorable experience in the State in adapting to new coding requirements

Assessment of Medicare HACs

- Advantages:
  - First major foray into linking payment to improved outcomes
  - Addresses flaws in Medicare payment (Maryland has similar flaws)
  - Proposed against a back-drop of scarcity of resources (lack of affordability of health care/budget cuts generally)
  - Establishes a "Law of the Land" (except Maryland)
- Disadvantages:
  - Restricted Scope: Structured to deal with Medicare population and
  - Very limited initial list ($20 million savings on a $110 billion base)
  - 100% payment decrement implies 100% preventability – also greatly restricts scope
  - Little focus on POA coding
  - Little incentive to report HACs

Maryland MHACs – Observations

- Given our unique position, CMS lead and other circumstances – Maryland needs to improve its payment structure around quality
- Clearly believe – Maryland hospitals are doing the best they can to improve Quality and reduce errors and complications
- In concert with their purpose and mission, and there are incentives to do move in this direction currently
- Applaud the MHA's voluntary efforts
- Staff also believes that the current payment system impedes this process (unintended incentives)
- Also a lack of analytic and empirical tools to guide this effort

Maryland MHACs – Observations (2)

- So - urgent need to move ahead - assist hospitals through appropriate incentive structures and other analytic tools
- Also – urgent need to do this given heightened focus on budget deficits and improving affordability of health care
- And keep pace with CMS
- Yet – we also need to be conservative in this approach – avoid unintended consequences
- Focus only on "Highly Preventable Complications" after applying extensive exclusions for more vulnerable cases
- Maryland "exemption" – gives us the ability to craft a local solution and overcome deficiencies associated with HACs

Maryland MHACs –Principles

- Need to craft a "Maryland Solution"
- Focus on improving the financial incentives and providing helpful data and information as well
- Should be prospective in nature – hospitals should be able to know what the targets are, monitor performance and have time to respond
- Overall goal should be to reduce complication rates – we will monitor this over time
- While we need to be logical and deliberative in our approach, also need to keep it straightforward and understandable

Maryland MHACs –Principles (2)

- Part of restructuring financial incentives will mean "reduced payment" – there needs to be a sufficient financial incentive to motivate a behavioral change
- But this incentive change should also be structured to reflect hospitals' ability to influence the rates of complication
- Would not argue for a 100% payment decrement
- Unlike the Medicare proposal – staff believes there should be a "retention factor" that reflects even conditions with the highest levels of preventability may not be 100% preventable
- Consistent with this is the need to retain an incentive for hospitals to report the incidence of Hospital Acquired Conditions/Complications

Current Status

- Staff has articulated these principles to MHAC work group
- We also have a preliminary proposal for how a Maryland-based Initiative might work (based on these principles)
- Designed around our current use of APR-DRGs and 3M's Outcome based Analytic tools
  - "Potentially Preventable Complications" (PPCs)
- Background on these Quality based Tools

Attachment B

Potentially Preventable Conditions: Complications and Readmissions

Elizabeth C. McCullough
5 November 2008

3M *Innovation*

3M Health Information Systems
from the 3M Health Care family

Potentially Preventable Complications (PPCs)

Harmful events (accidental laceration during a procedure) or negative outcomes (hospital acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease

Assumptions

- Not all inpatient complications are preventable
- Even with optimal care inpatient complications will occur
- Patients who have had a problem with the quality of care will be more likely to have an inpatient complication
- Hospitals with quality of care problems will have higher rates of inpatient complications
- A patient's risk of an inpatient complication is related to the patient's reason for admission and severity of illness at the time of admission

Determining PPCs – a General Rule

If a hospital or other health care facility has a statistically significantly higher rate of a complication (or group of complications) than comparable hospitals and facilities, reasonable clinicians would be concerned that a potential quality of care problem exists, and would suggest further investigation in order to account for the difference.

8 Groups of 64 PPCs

Extreme Complications

- Extreme CNS Complications
- Acute Pulmonary Edema & Respiratory Failure w Ventilation
- Shock
- Ventricular Fibrillation, Cardiac Arrest
- Renal Failure with Dialysis
- **Post-Operative Respiratory Failure with Tracheostomy**

Cardiovascular-Respiratory Complications

- Stroke & Intracranial Hemorrhage *
- Pneumonia, Lung Infection *
- Aspiration Pneumonia *
- Pulmonary Embolism *
- Congestive Heart Failure *
- Acute Myocardial Infarct *
- Peripheral Vascular Complications Except Venous Thrombosis *
- Venous Thrombosis *
- Acute Pulmonary Edema and Respiratory Failure without Ventilation
- Other Pulmonary Complications
- Cardiac Arrythmias & Conduction Disturbances
- Other Cardiac Complications

* Selected 35 "Major" PPCs

Gastrointestinal Complications

- Major GI Complications w Transfusion or Significant Bleeding *
- Major Liver Complications *
- Major Gastrointestinal Complications without Transfusion or Significant Bleeding
- Other Gastrointestinal Complications without Transfusion or Significant Bleeding

Perioperative Complications

- **Post-Op Wound Infection & Deep Wound Disruption w Procedure ***
- **Reopening of Surgical Site ***
- **Post-Op Hemorrhage & Hematoma w Hemorrhage Control Proc or I&D Proc ***
- **Accidental Puncture/Laceration During Invasive Proc ***
- **Post-Op Foreign Body ***
- Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Procedure
- Post-Operative Infection & Deep Wound Disruption Without Procedure
- Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body

Infectious Complications

- Clostridium Difficile Colitis *
- Urinary Track Infection *
- Septicemia & Severe Infection *
- Cellulitis
- Moderate Infectious

8 Groups of 64 PPCs (continued)

Malfunctions, Reactions Etc.

- **Iatrogenic Pneumothrax ***
- Mechanical Complication of Device, Implant & Graft *
- **Inflammation, & Other Complications of Devices, Implants or Grafts Except Vascular Infection ***
- **Infections due to Central Venous Catheters***
- Infection, Inflammation and Clotting complications of Peripheral Vascular Catheters and Infusions
- Poisonings Except from Anesthesia
- Poisonings due to Anesthesia
- Transfusion Incompatibility Reaction
- Gastrointestinal Ostomy Complications

Obstetrical Complications

- Obstetrical Hemorrhage w Transfusion *
- **Obstetrical Laceration & Other Trauma without Instrumentation ***
- **Obstetrical Laceration & Other Trauma with Instrumentation ***
- **Major Puerperal Infection and Other Major Obstetrical Complications ***
- Obstetrical Hemorrhage without Transfusion
- Medical & Anesthesia Obstetric Complications

Obstetrical Complications (continued)

- Other Complications of Obstetrical Surgical & Perineal Wounds
- Delivery with Placental Complications

Other Medical and Surgical Complications

- Post-Hemorrhagic & Other Acute Anemia w Transfusion *
- Decubitus Ulcer *
- Encephalopathy *
- Renal Failure without Dialysis
- GU Complications Except UTI
- Diabetic Ketoacidosis & Coma
- In-Hospital Trauma and Fractures
- Acute Mental Health Changes
- Accidental Cut or Hemorrhage During Other Medical Care
- Other Complications of Medical Care
- Other Surgical Complication – Moderate
- Other In-Hospital Adverse Events

* Selected 35 "Major" PPCs

12 Highly Preventable Complications

- Post-Op Wound Infection & Deep Wound Disruption w Procedure
- Reopening of Surgical Site
- Post-Op Hemorrhage & Hematoma w Hemorrhage Control Proc or I&D Procedure
- Accidental Puncture/Laceration During Invasive Procedure
- Post-Procedure Foreign Bodies
- Iatrogenic Pneumothrax
- Inflammation, & Other Complications of Devices, Implants or Grafts Except Vascular Infection
- Infections due to Central Venous Catheters
- Obstetrical Laceration & Other Trauma without Instrumentation
- Obstetrical Laceration & Other Trauma with Instrumentation
- Major Puerperal Infection and Other Major Obstetrical Complications
- Post-Operative Respiratory Failure with Tracheostomy

Impact of Major PPC Categories on Average Charges for GI Surgery

		Major GI Sugery			Other GI Sugery		
		Major PPC	Non-Major PPC	No PPC	Major PPC	Non-Major PPC	No PPC
SOI Level 1	No.	96	58	903	68	51	2,738
	Avg. Chrg	$25,911	$19,724	$14,965	$19,214	$13,643	$7,990
SOI Level 2	No.	244	136	1,234	154	99	2,859
	Avg. Chrg	$34,613	$24,875	$17,838	$27,024	$19,551	$10,173
SOI Level 3	No.	434	140	686	137	64	625
	Avg. Chrg	$55,760	$35,046	$25,797	$41,602	$26,750	$16,302
SOI Level 4	No.	115	12	103	27	5	54
	Avg. Chrg	$107,780	$167,656	$49,694	$97,709	$45,121	$26,727

Maryland data July 2007-Mar 2008

Impact of PPC Categories

Total At Risk for One or More PPCs	409,487		0.96	$10,423	1.04	$10,022
	Discharges	PPC Rate	% Died	Avg Chrg	CMI	CMI Adjusted Avg Chrg
Zero PPCs	389,948	0.00	0.55	$9,729	0.97	$10,052
One or More PPCs without Major PPCs	12,725	3.11	1.71	$18,852	1.68	$11,239
One Selected "Major" PPCs	15,175	3.71	5.48	$23,841	1.95	$12,243
Two Selected "Major" PPCs	2,692	0.66	16.05	$45,575	3.22	$14,172
Three or More Selected "Major" PPCs	1,672	0.41	32.83	$83,348	4.92	$16,943
One or More Selected 'Major" PPCs	19,539	4.77	9.17	$31,928	2.38	$13,435

Maryland data July 2007-Mar 2008

PPC Uses and Evaluations

- New York Department of Health for private reporting of select major PPCs since 2005 on five years of data
- IPRO study in New York.
- HANYS and GNYHA clinical quality committees and other committees of these two hospital associations.
- Numerous presentations all around New York state on the detail logic of PPCs.
- Direct input was provided at many of these presentations which resulted in changes in the PPC logic.
- NY DOH provided patient level data back to individual hospitals that included the PPC assignment so that hospitals could review individual medical records.

Potentially Preventable Readmissions (PPRs)

Return hospitalizations that may result from deficiencies in the process of care and treatment (readmission for a surgical wound infection) or lack of post discharge follow-up (prescription not filled) rather than unrelated events that occur post discharge (broken leg due to trauma).

Maryland Rates of PPRs

		PPR Rate
15 Day Readmission Time Interval Across Hospital Readmissions	2006	6.74
	2007	6.74
30 Day Readmission Time Interval Across Hospital Readmissions	2006	9.89
	2007	9.81

- PPR rates consistent between two years

- 45% increase in PPR rate between a 15 day and 30 day readmission time interval

Top 15 Initial Admissions followed by one or more PPR - 2007

APR DRG		Initial Admissions Followed by PPRs	Percent of Initial Admissions	PPR Rate	Initial Admissions Followed by PPRs	Percent of Initial Admissions	PPR Rate
		15 Day Window			30 Day Window		
194	HEART FAILURE	1,838	5.77%	12.03%	2,567	5.78%	18.80%
140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1,178	3.70%	10.02%	1,693	3.81%	15.67%
720	SEPTICEMIA & DISSEMINATED INFECTIONS	1,024	3.21%	10.14%	1,321	2.97%	14.31%
139	OTHER PNEUMONIA	765	2.40%	6.55%	1,078	2.43%	9.61%
175	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI	737	2.31%	8.02%	1,063	2.39%	11.81%
753	BIPOLAR DISORDERS	634	1.99%	7.53%	918	2.07%	11.56%
460	RENAL FAILURE	683	2.14%	9.85%	896	2.02%	14.01%
463	KIDNEY & URINARY TRACT INFECTIONS	606	1.90%	7.60%	836	1.88%	11.11%
201	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	604	1.90%	6.93%	830	1.87%	9.95%
173	OTHER VASCULAR PROCEDURES	489	1.53%	10.38%	752	1.69%	16.61%
198	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS	542	1.70%	5.93%	752	1.69%	8.68%
751	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	512	1.61%	6.87%	732	1.65%	10.29%
383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	505	1.58%	4.73%	724	1.63%	7.01%
221	MAJOR SMALL & LARGE BOWEL PROCEDURES	529	1.66%	10.36%	718	1.62%	14.14%
750	SCHIZOPHRENIA	506	1.59%	9.16%	709	1.60%	13.85%

Top 15 represents 35% of all initial admissions followed by PPRs

Top 15 Reasons for PPRs - 2007

APR DRG		Number of Admissions Identified as a PPR	Total Charges for PPRs	Number of Admissions Identified as a PPR	Total Charges for PPRs
		15 Day Window		30 Day Window	
720	SEPTICEMIA & DISSEMINATED INFECTIONS	1,945	$36,578,709	3,041	$57,464,024
194	HEART FAILURE	2,929	$28,621,634	4,712	$45,489,197
140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1,338	$11,695,437	2,317	$19,740,461
130	RESPIRATORY SYSTEM DIAG W VENTILATOR SUPPORT 96+ HOURS	247	$13,131,776	352	$19,531,963
460	RENAL FAILURE	993	$10,852,746	1,568	$17,288,207
133	PULMONARY EDEMA & RESPIRATORY FAILURE	755	$11,477,824	1,145	$17,236,788
721	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS	904	$9,858,735	1,241	$13,552,588
139	OTHER PNEUMONIA	878	$8,208,719	1,376	$12,538,408
711	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROC	298	$8,652,870	441	$11,882,757
137	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS	599	$7,545,054	855	$11,476,928
753	BIPOLAR DISORDERS	883	$7,083,904	1,365	$10,923,940
750	SCHIZOPHRENIA	678	$6,867,837	1,085	$10,247,781
45	CVA & PRECEREBRAL OCCLUSION W INFARCT	550	$6,946,806	796	$9,976,474
248	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS	562	$5,873,658	890	$9,544,644
890	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS	231	$6,893,043	335	$9,451,503

Top 15 PPRs represents 42% of charges on PPRs for a 30 day readmission time window

PPR Rates by APR DRG and SOI

APR DRG		APR DRG SOI 1	APR DRG SOI 2	APR DRG SOI 3	APR DRG SOI 4
		15 Day Window PPR Rate			
194	HEART FAILURE	6.02%	10.32%	13.45%	13.58%
140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	5.40%	8.52%	11.78%	15.30%
720	SEPTICEMIA & DISSEMINATED INFECTIONS	3.17%	5.74%	8.92%	13.37%
139	OTHER PNEUMONIA	2.30%	4.05%	8.70%	12.75%
175	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI	6.03%	7.72%	11.72%	19.48%
753	BIPOLAR DISORDERS	5.17%	7.26%	9.15%	6.19%
460	RENAL FAILURE	3.33%	7.97%	9.30%	14.41%
463	KIDNEY & URINARY TRACT INFECTIONS	2.65%	5.98%	9.21%	12.98%
201	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	2.97%	6.01%	9.51%	13.94%
173	OTHER VASCULAR PROCEDURES	6.42%	9.66%	12.20%	16.19%
198	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS	3.12%	5.71%	9.13%	14.62%
751	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	4.38%	6.37%	8.87%	7.55%
383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	2.10%	4.33%	7.86%	14.73%
221	MAJOR SMALL & LARGE BOWEL PROCEDURES	7.10%	9.47%	10.33%	17.06%
750	SCHIZOPHRENIA	7.36%	8.76%	10.99%	15.63%

PPR Uses and Evaluations

- Florida Public Report Card using PPRs
- Florida Collaborative (FHA sponsored): over 100 hospitals; members include medical group and SNFs; preliminary discussions regarding tie in with payment.
- Massachusetts Department of Health Care Finance and Payment: Committee evaluating PPRs and hospital collaborative to look at data and comment on logic.

Attachment C

Maryland
Hospital Association

MHA
6820 Deerpath Road
Elkridge, Maryland 21075-6234
Tel: 410-379-6200
Fax: 410-379-8239

October 10, 2008

Sent via e-mail. Hard copy to follow.

Robert Murray
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Murray:

Thank you for the opportunity to provide input on the Health Services Cost Review Commission's (HSCRC) recent discussions about developing payment policies associated with 3M's Potentially Preventable Complications (PPC) and Potentially Preventable Readmissions (PPRs) methodologies.

We strongly *oppose* using these methodologies as the basis for payment policy. While they offer valuable information that may help hospitals identify areas for important performance improvement, it should be used in the context of quality improvement and is best explored by state agencies, such as the MHCC, that monitor quality. These methodologies, and the conditions and events on which they are based, should not be used to create payment penalties for hospitals.

From a policy perspective, it is critical to separate when payment penalties should be used to hold hospitals accountable for their performance, and when payment rewards or focused education should be used to improve performance.

It is our belief that payment policies should be based on four principles of accountability. Payments should be affected when an error or event occurs, and it:

- Is preventable;
- Is within the hospital's control;
- Is the result of a mistake made by a hospital; and,
- Results in patient death or serious disability.

The hospital community developed and agreed on these principles through a statewide process as the criteria for determining whether or not to waive partial or full payment, if a serious adverse event occurs. These criteria mirror those adopted by hospitals nationally.

- more -

As a result of this process, the hospital community voluntarily agreed to waive *full payment* for the hospital stay associated with any of seven serious adverse events,[1] because they unequivocally meet the four criteria. For other events, hospitals will use these four "accountability" criteria to evaluate on a case-by-case basis whether payment, in part or in full, is appropriate. This is more expansive and progressive than the policy CMS has adopted nationally for certain conditions.

Beyond these seven events, preventability by the hospital is very unclear. Determining preventability requires a review of clinical information not available to 3M or the HSCRC in the administrative data that these tools analyze. By definition, "potentially preventable" does not mean completely preventable, and 3M has stated in its own research that not all complications identified by their tool are preventable, much less preventable by actions taken by the hospital.

The reliance of these tools on administrative data also means their accuracy hinges on data elements that are new and unaudited. The two key components of their tools are a severity-based grouper, the APR-DRG, and a present-on-admission indicator (POA). POA reporting is new for Maryland hospitals, similar to hospitals in other states. Since hospitals began reporting this on July 1, 2007, they have received no individual feedback as to the accuracy of their POA data, and the HSCRC has not created an audit mechanism to provide that feedback.

Additionally, 3M's methodologies are proprietary. Any use of these tools by a public entity, such as for analytic or reporting purposes, requires that the associated methodology be explained and validated. For example, their clinical logic and exclusion rules should be available and validated through chart review.

We emphasize that hospitals have every incentive, financial and otherwise, to minimize complications. From a mission perspective, all Maryland hospitals strive to provide the best possible care to their patients. From a quality perspective, all Maryland hospitals have staff and initiatives in place to actively monitor their performance on quality measures and manage efforts to improve patient care and experiences. The charge-per-case and charge-per-visit systems already provide financial incentives to reduce length of stay and Maryland hospitals already work to ensure that resource use is as efficiently as possible.

Most important, to hold hospitals accountable through payment penalties for events or outcomes that may or may not be preventable could reverse years of progress made to create a culture of safety in Maryland. Using penalties to assign blame when fault or responsibility is unclear will lead to a culture in which care challenges are hidden and not improved.

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[1] Starting on September 1, 2008, patients in Maryland will not be responsible for payment in the event of surgery on the wrong body part; surgery on the wrong patient; wrong surgical procedure; unintended retention of a foreign object; an air embolism that occurs while being treated in a hospital; medication error attributable to the hospital; and, a hemolytic reaction due to administration of incompatible blood or blood products. For more information, see www.mdhospitals.org/mha/Health_Policy_Issues/patient.safety.shtml.

To summarize, payment policies related to serious adverse events need to be driven by a methodology that determines whether or not "accountability" principles are met. In other words, whether those events are preventable, are preventable by the hospital, are the result of a mistake made by the hospital, and result in death or serious disability of the patient. The CMS-identified conditions do not meet that test, and 3M's tools do not meet that test. Therefore, we *oppose* their use in developing payment policy. There is nothing more important than continuing Maryland's leadership in quality, safety, and performance improvement. We need to take the time to craft a sensible Maryland solution.

Thank you again for the opportunity to provide input. We would be happy to answer any questions you may have.

Sincerely,

Carmela Coyle

Carmela Coyle
President and CEO
Maryland Hospital Association

cc: Dr. Donald A. Young, HSCRC Chairman
Dr. Trudy Hall, HSCRC Commissioner and Chair, HSCRC Quality-Based Reimbursement Evaluation Work Group
HSCRC Commissioners

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF DECEMBER 1 , 2008

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
1985A	University of Maryland Medical Center	6/4/08	N/A	N/A	ARM	DNP	OPEN
1999A	University of Maryland Medical Center	7/3108	N/A	N/A	ARM	DNP	OPEN
2007R	Johns Hopkins Bayview Medical Center	10/17/08	12/16/08	3/16/09	Capital	GS	OPEN
2008A	Johns Hopkins Health System	11/11/08	N/A	N/A	ARM	DNP	OPEN
2009A	University of Maryland Medical Center	11/17/08	N/A	N/A	ARM	DNP	OPEN
2010A	MedStar Health	12/1/08	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2008**
MEDICAL CENTER	*	**FOLIO:**	**1809**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**1999A**

Staff Recommendation

December 10, 2008

I. INTRODUCTION

University of Maryland Medical Center ("UMMC," or the "Hospital") filed an application with the HSCRC on July 31, 2008 requesting approval to continue participation in a global rate arrangement with Maryland Physicians Care for solid organ and blood and bone marrow transplant services for a period of three years beginning September 1, 2008.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

Staff found that the actual experience under the arrangement for the last year has been favorable. Staff is satisfied that the hospital component of the global price has sufficient built-in allowance for inflation to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services, for a one year period commencing September 1, 2008. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2008**
SYSTEM	*	**FOLIO:**	**1818**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2008A**

Staff Recommendation

December 10, 2008

I. INTRODUCTION

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on November 17, 2008 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplants with Coventry Transplant Network for a period of three years.

II. OVERVIEW OF APPLICATION

The contract will be continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating the most recent mean historical charges for patients receiving the procedures for which global rates are to be paid. The contract also has a stop loss clause. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any

shortfalls in payment from the global price contract. JHHC maintains that it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

After review of the updated hospital historical data, the outlier per diems, the stop loss clause threshold, as well as the experience under the arrangement for FY 2008, staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing December 1, 2008. The Hospitals will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
MEDSTAR HEALTH	*	**DOCKET:**	**2008**
	*	**FOLIO:**	**1820**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2010A**

Staff Recommendation

December 10, 2008

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on December 1, 2008 on behalf of Union Memorial Hospital (the "Hospital") for an alternative method of rate determination (ARM), pursuant to COMAR 10.37.10.06. MedStar requests approval from the HSCRC for continued participation in a global rate arrangement for orthopedic services with the NFL Player Joint Replacement Benefit Plan (the "NFL Plan") for a one year period beginning December 1, 2008, with an option to seek renewal based upon favorable performance.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. (HRMI). HRMI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating the mean historical charges for all patients receiving the procedures for which global rates are to be paid. The negotiated rates are comparable to another joint replacement ARM already approved by the HSCRC. The NFL Plan agreement includes only joint replacements and not the more costly revisions of prior joint replacements for the same joint. In addition, the agreement does not include the post-acute rehabilitation normally included in joint replacement global pricing. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to HRMI for all contracted and covered services. HRMI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between HRMI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff reviewed the methods employed to develop the hospital component of the proposed rates and believes that the hospital component of the global rate is reasonably related to historical experience. Staff has noted that the NFL Plan agreement has a more narrow definition of the episode of care covered under the global rates than other similar ARM arrangements. In addition, staff found that the Hospital and HRMI have a favorable history of managing joint replacement patients and performing under a global rate arrangement. The physicians' professional components of the proposed rates follow historical fee for service averages and are closely related to the professional components of the Hospital's similar global arrangement involving orthopedic surgery.

VI. STAFF RECOMMENDATION

Although there has been no activity under this arrangement, staff continues to believe that the Hospital can achieve favorable performance. Therefore, staff recommends that the Commission approve the Hospital's request for continued participation in the alternative method of rate determination for orthopedic services for a one year period, commencing December 1, 2008. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Final Staff Recommendations regarding Modifications to the HSCRC's Mechanism for Financing Uncompensated Care

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
(410) 764-2605
Fax (410) 358-6217

December 10, 2008

This document represents a final recommendation presented to the Commission December 10, 2008

Background

Since its inception the Health Services Cost Review Commission (the "HSCRC" or "Commission") has recognized the reasonable cost of uncompensated care ("UC") as part of a hospital's full financial requirements. Indeed, the need to finance care to the uninsured was one major health policy concern leading to the formation of the hospital rate setting system in the 1970s. Equitable financing of hospital UC is made possible because of the State's unique Medicare waiver and has traditionally been accomplished by adding a "reasonable" provision in the approved rates of every hospital. The magnitude of each hospital's UC provision (or "add-on") is a function of the characteristics of the patients its serve. As expected, hospitals in areas with relatively larger numbers of uninsured patients generate higher levels of UC and have higher provisions in their rates to cover this burden.

Studies on Alternative Financing of Hospital UC

As hospital uncompensated care 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 1992, following the elimination of the Medicaid State Only program, in response to State budget deficits, General Assembly passed HB 924, which instructed the HSCRC to study alternative methodologies in order to "promote the equitable distribution of the cost of uncompensated care among hospitals." HB 924 also gave the Commission the authority to implement an "alternative financing mechanism." The task force created by the Commission (the 1992 UC Task Force), which included broad representation from hospitals and payers in the State, concluded that the pooling of uncompensated care represented the most appropriate way of ensuring an equitable financing of the UC burden throughout the hospital system.

The 1992 UC Task Force was aware of issue related to the federal ERISA law that raised questions as to the authority of states to establish a regional pooling mechanism of this nature. For this reason, it was recommended that the Commission delay implementation of the UC pool until the ERISA issues were resolved. In April of 1995, the Supreme Court of the United States handed down its decision in the "Travelers" case, which affirmed the ability of states to required self-insured plans to participate in pooling mechanism. This effectively cleared the way for the HSCRC to resolve outstanding technical and rate-setting issues surrounding the pooling initiative.

UC Pooling Compromise and Implementation

In 1996 however, the Maryland Hospital Association (the "MHA") adopted a new policy which raised objections to the full pooling approach. In order to forge a compromise and move ahead with the pooling concept the Commission adopted and implemented a "partial pooling" approach. This approach enabled the HSCRC to create a UC fund or pool from an assessment of 0.75% on each hospital. This assessment generated a fund of approximately $90 million each year. This fund then was 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. This approach did result in a more equitable financing of the UC burden in the system and reduced the range in the UC provisions in rates from hospital to hospital, but it stopped short of 100% pooling of hospital UC. Table 1 provides a simplified and illustrative example of the Partial Pooling approach adopted in 1997 (which is currently still in effect).

Table 1
Example of Partial Pooling

Annual Patient Revenue	$11.0 Billion
State-wide Assessment	0.75% on all Hopsitals
Generates a UC Pool	$83 million
Annual Hospital UC	$770 million
State-wide Average UC	7.0%
Pre-determied UC Threshold	8.5%

Partial Pooling

High UC Hospitals	Policy Determined UC Provisions (in rates)	UC Provision (in rates)	Pool Assessment	Total UC (in rates)	Payment from UC Pool
Hospital 1	14.0%	8.5%	0.75%	9.25%	5.50%
Hospital 2	12.0%	8.5%	0.75%	9.25%	3.50%
Hospital 3	10.0%	8.5%	0.75%	9.25%	1.50%
Hospital 4	9.0%	8.5%	0.75%	9.25%	0.50%
Hospital 5	8.7%	8.5%	0.75%	9.25%	0.20%
Low UC Hospitals	Policy Determined UC Provisions	UC Provision (in rates)		Total UC (in rates)	
Hospital 1	5.0%	5.0%	0.75%	5.75%	0.00%
Hospital 2	4.0%	4.0%	0.75%	4.75%	0.00%
Hospital 3	3.5%	3.5%	0.75%	4.25%	0.00%
Hospital 4	3.0%	3.0%	0.75%	3.75%	0.00%
Hospital 5	2.0%	2.0%	0.75%	2.75%	0.00%

2008 Budget Deficits and Request from the Secretary of Health

In October of this year, in reaction to growing State budget deficits stemming from slowing economic activity and reduced State revenues, the Secretary of Health asked the staff of the HSCRC to identify modifications to the rate system that would help reduce Medicaid expenditures. In contrast to previous such requests from the Department of Health and Mental Hygiene however, there was a priority placed on focusing on initiatives that would encourage a reduction in unnecessary or inappropriate care and/or other mechanisms that could reduce Medicaid expenditures without substantially cutting hospital payments. Yet, the Secretary also

articulated a desire to avoid the use of previously employed mechanisms that reduced Medicaid expenditures by arbitrarily shifting costs to other payers (as had been done in 1991 with the elimination of the Medicaid State Only program and in 2003-2008 with the imposition of Medicaid Day Limits). Future initiatives to facilitate reductions in Medicaid expenditures should be designed based on some overarching policy rationale and/or improve overall incentives in the hospital rate system. It was clear to staff, that failure to identify initiatives of this nature would inevitably lead to more arbitrary (and possibly "capricious") cuts in Medicaid spending and eligibility. For the balance of this document the terms UC Fund and UC Pool are used interchangeably.

Pooling of Shock Trauma UC and 100% Pooling of Uncompensated Care

In response to the Secretary's request, the staff investigated the potential impact on Medicaid of : 1) including the University of Maryland Shock Trauma Center in the existing UC Pool (previously the Shock Trauma Center, which generates between 22 -24% uncompensated care annually was not included in the UC Pool); and 2) move the system to 100% pooling of all hospital UC.

When the existing UC Pool was first established in 1997, the staff was granted authority by the Commission to include Shock Trauma in the UC Pool. However, at the time, staff and the industry agreed it was not necessary to pool UC generated by the Shock Trauma Center because, as a State-wide resource, the care provide by Shock Trauma was relatively price-insensitive and not vulnerable to changes in market share due to any lack of competitiveness caused by high UC levels built into its rate structure. Given the existence of this authority however, following discussions with representatives of both the hospital and payer industries, staff decided to include the University of Maryland Shock Trauma Center UC in the existing UC pool for FY 2009 (retroactive to July 1, 2008). Because Medicaid accounts for approximately 25% of payments to Shock Trauma, a spreading of the Center's UC burden State-wide will result in a reduction overall payments by Medicaid and save the State approximately $3.5 million in total expenditures and $1.7 million in State general funds. This change will be accomplished with the issuance of FY 2009 rate orders in November of this year.

Additionally, the staff estimated that a move to 100% pooling of all Maryland hospital UC (including the pooling of Shock Trauma UC) would result in annual savings of about $10 million to Medicaid (or about $4.9 million in State General Funds).

Again, this savings results because Medicaid patients are concentrated at facilities that have higher overall levels of UC and thus higher rates due to their higher UC provisions. The 100% UC pooling proposal contemplates incorporating the State-wide average level of hospital UC into the rate structures of all facilities. Thus, after 100% pooling, hospitals treating higher proportions of the uninsured (and also higher proportions of Medicaid patients) will see their rates reduced and payers with a higher proportion of their patients being treated at these facilities will see reduced overall expenditures. Conversely, payers with patients concentrated at hospitals with previously lower UC provisions (relative to the State-wide) average will, under 100% pooling of hospital UC, see increased rate levels and will experience higher expenditures.

The staff believes this new system however is justified in that it fulfills the original intent of HB 924, namely implementation of the broadest and most equitable mechanism for financing the overall State burden of providing care to the uninsured. Table 2 below provides a simplified and illustrative example of a 100% UC pooling alternative.

Table 2
Example of Full Pooling

Annual Patient Revenue	$11.0 Billion
Annual Hospital UC	$770 million
State-wide Average UC	7.0%
Pre-determied UC Threshold	8.5%

		100% Pooling			
High UC Hospitals	Policy Determined UC Provisions (in rates)	UC Provision (in rates)	Pool Assessment	Total UC (in rates)	Payment from UC Pool
Hospital 1	15.0%	7.0%	NA	7.0%	8.0%
Hospital 2	12.0%	7.0%	NA	7.0%	5.0%
Hospital 3	10.0%	7.0%	NA	7.0%	3.0%
Hospital 4	9.0%	7.0%	NA	7.0%	2.0%
Hospital 5	8.0%	7.0%	NA	7.0%	1.0%

Low UC Hospitals	Policy Determined UC Provisions	UC Provision (in rates)		Total UC (in rates)	Remittance to UC Pool
Hospital 1	5.0%	7.0%	NA	7.0%	2.0%
Hospital 2	4.0%	7.0%	NA	7.0%	3.0%
Hospital 3	3.5%	7.0%	NA	7.0%	3.5%
Hospital 4	3.0%	7.0%	NA	7.0%	4.0%
Hospital 5	2.0%	7.0%	NA	7.0%	5.0%

Exhibits 1 and 2 to this recommendation provide more complete estimates of the impacts of a 100% pooling initiative for all Maryland hospitals.

Discussions with the Industry and Operational and Technical Considerations

As mentioned, in advance of this final recommendation the staff has discussed these two proposals (first pooling Shock Trauma UC retroactive to July 1, 2008 and full pooling of all hospital UC effective December 2008) with representatives of the hospital and payer industries. All representatives were generally supportive of these initiatives. The major concerns centered on the implementation and timing of the 100% Pooling proposal.

Timing of Full Pooling

Staff's intent is to implement 100% pooling effective December 2008 in order to capture some Medicaid savings in FY 2009. Savings from the initiation of full pooling will flow directly back to the Medicaid program for all "fee for service" Medicaid patients. To capture savings associated with payments to Medicaid Managed Care ("MCOs") patients, the Department will need to adjust Medicaid Managed Care Organization capitation rates commensurate with the anticipated change in hospital rates State-wide as a result of 100% pooling. Anticipated impacts by hospital can easily be provided to the Department to ensure appropriate MCO rate adjustments.

Additionally, in order to implement the full pooling December 2008, the HSCRC would need to authorize both an increase in all low UC hospital rates and a reduction of all high UC hospital rates effective December 1, 2008. Lower UC hospitals will require time to collect and accumulate revenues associated with their higher UC provisions (for approximately 30-60 days) prior to paying such accumulated surplus amounts into the broader State-wide pool. Owing to a current surplus in the existing UC pool staff has estimated that payments to high UC hospitals (in order to further reduce the magnitude of their UC in rate to State-wide levels) can commence December 2008. It is anticipated that additional funding (from low UC hospitals) will be available to permit continued operation of full pooling starting February 1, 2009. As articulated in the final regulations proposed November 5, 2008, the HSCRC would instruct the low UC hospitals to remit funds in excess of their approved UC provisions to the UC Fund on a monthly basis beginning in February.

Operational Considerations of Full Pooling

Full pooling of hospital UC is already authorized under the HSCRC's existing statute. To accomplish 100% pooling of hospital UC in Maryland, the Commission must issue regulations that enable HSCRC to make a special adjustment to UC provision of each hospital's "mark-up" (the mark-up between approved cost and final rates), to bring that mark-up to equal the average amount of State-wide uncompensated care. The Commission would notify each facility in writing of the amount due to be remitted from that hospital (if any) to the broader UC Fund or Pool. Conversely, hospitals which 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.

On or before the first business day of each month (beginning February 1, 2009), the HSCRC would direct the General Accounting Division to arrange for the collection of the amount due o be remitted by individual hospitals. This amount shall be based on the difference between a hospital's approved uncompensated care provision and the State-wide UC average.

Revenue Neutrality

It would be the intent of the Commission that the implementation of full UC pooling would be revenue neutral for all hospitals. That is, while some hospitals' rates will increase and some hospitals' rates will decrease as a result of 100% pooling, every hospital will continue to receive

the same net payment levels in the absence of this proposal.

The HSCRC will consult with representative of the hospital industry and the MHA's Technical Issues Task Force to ensure that hospitals do not experience net cash flow increases or reductions as a result of this initiative.

If necessary, a year-end reconciliation will be undertaken to ensure revenue and cash-flow neutrality for the FY 2009 and subsequent years.

Staff Recommendations

1. Implement 100% pooling of all approved levels of hospital uncompensated care effective December 2008[1]. This initiative will require that the Commission increase the UC mark-ups of low uncompensated care hospitals and decrease the markups of low uncompensated care hospitals effective in December 2008 in order to generate sufficient additional funding early in FY 2009 to finance additional pooled uncompensated care.

2. Beginning December 2008, the HSCRC will lower the mark-ups of high uncompensated care hospitals (hospitals with approved UC provisions based on the FY 2009 UC policy that are in excess of the State-wide average UC level).

3. Also beginning in December 2008 (and in each subsequent month), these high uncompensated care hospitals will receive a monthly proportion of the difference between the State-wide UC average and their approved UC provision directly from the UC Fund or Pool.

4. In January and subsequent months, the HSCRC staff will instruct the low UC hospitals (those with approved UC levels below the State-wide average) to remit (effective February1 and the first of all subsequent months) an amount that based on the difference between a hospitals' uncompensated care provision in its mark-up and the State-wide average UC.

5. The HSCRC staff will undertake all necessary calculations and work closely with the hospital and payer industries to ensure this proposal is revenue neutral and cash flow neutral for all hospitals (relative to what would have occurred in the absence of this initiative).

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[1] Note: The exact day of implementation is dependent on the date on which the Joint Committee on Administrative, Executive, and Legislative Review grants emergency status for the attached proposed regulations under COMAR 10.37.09 entitled Fee Assessment for Financing Hospital Uncompensated Care.

Appendix 1 – FY 2009 UC Policy Result

Uncompensated Care Policy Results for FY 2009

	Policy Results July 1, 2008	Markup	Adjustment to UCC % for Averted BD	**In Rates AFTER July 1, 2008 Adjusted for Averted BD**	**Markup**
WASHINGTON CO.	7.04%	1.126022	-0.37%	**6.67%**	**1.121443**
UNIVERSITY OF MD.	9.61%	1.159955	-0.92%	**8.69%**	**1.147950**
PRINCE GEORGE	13.91%	1.218358	-0.56%	**13.35%**	**1.210266**
HOLY CROSS	6.66%	1.114270	-0.23%	**6.43%**	**1.111479**
FREDERICK MEM.	5.82%	1.106239	-0.20%	**5.62%**	**1.103845**
HARFORD MEM.	8.58%	1.140519	-0.34%	**8.24%**	**1.136201**
ST. JOSEPH'S	2.90%	1.075303	-0.09%	**2.81%**	**1.074284**
MERCY	8.25%	1.137974	-0.46%	**7.79%**	**1.132166**
JOHNS HOPKINS	6.16%	1.109699	-0.51%	**5.65%**	**1.103578**
DORCHESTER GEN.	8.83%	1.152465	-0.58%	**8.25%**	**1.144965**
ST. AGNES	7.39%	1.132797	-0.32%	**7.07%**	**1.128787**
SINAI	7.52%	1.131441	-0.46%	**7.06%**	**1.125700**
BON SECOURS	14.33%	1.231351	**-0.27%**	**14.06%**	**1.231351**
FRANKLIN SQUARE	8.44%	1.144781	-0.51%	**7.93%**	**1.138268**
WASHINGTON ADV.	7.56%	1.133150	-0.27%	**7.29%**	**1.129762**
GARRETT CO.	8.79%	1.154621	-0.71%	**8.08%**	**1.145419**
MONTGOMERY GEN.	6.24%	1.114991	-0.21%	**6.03%**	**1.112439**
PENINSULA GEN.	5.84%	1.112759	-0.28%	**5.56%**	**1.109372**
SUBURBAN	4.81%	1.097153	-0.10%	**4.71%**	**1.095974**
ANNE ARUNDEL GEN.	4.49%	1.088280	-0.13%	**4.36%**	**1.086969**
UNION MEM.	6.66%	1.122744	-0.33%	**6.33%**	**1.118682**
MEM. CUMBERLAND	5.49%	1.107079	-0.63%	**4.86%**	**1.099563**
SACRED HEART	4.29%	1.100299	-0.23%	**4.06%**	**1.097577**
ST. MARY'S	6.87%	1.119329	-0.36%	**6.51%**	**1.114927**
BAYVIEW	9.04%	1.153680	-0.36%	**8.68%**	**1.149003**
CHESTER RIVER	7.86%	1.134281	-0.47%	**7.39%**	**1.128386**
UNION OF CECIL	8.02%	1.135078	-0.13%	**7.89%**	**1.133439**
CARROLL CO. GEN.	5.40%	1.104713	-0.23%	**5.17%**	**1.101969**
HARBOR HOSP.	9.57%	1.159666	-0.52%	**9.05%**	**1.152853**
CIVISTA	6.41%	1.116276	-0.31%	**6.10%**	**1.112503**
MEM. EASTON	6.39%	1.121774	-0.47%	**5.92%**	**1.116008**
MARYLAND GEN.	12.00%	1.201688	-0.41%	**11.59%**	**1.195914**
CALVERT MEMORIAL	6.35%	1.113469	-0.21%	**6.14%**	**1.110924**
NORTHWEST	7.52%	1.133318	-0.22%	**7.30%**	**1.130556**
BALTIMORE/WASHINC	6.96%	1.120479	-0.23%	**6.73%**	**1.117656**
G.B.M.C.	2.64%	1.067284	-0.10%	**2.54%**	**1.066169**
MCCREADY	8.51%	1.151359	-1.67%	**6.84%**	**1.130065**
HOWARD CO. GEN.	6.05%	1.105576	-0.32%	**5.73%**	**1.101756**
UPPER CHESAPEAKE	5.69%	1.104440	-0.22%	**5.47%**	**1.101816**
DR'S COMMUNITY HO!	8.56%	1.141869	-0.31%	**8.25%**	**1.137922**
SOUTHERN MD.	7.59%	1.131195	-0.20%	**7.39%**	**1.128966**
LAUREL REGIONAL	11.34%	1.178099	-0.27%	**11.07%**	**1.174438**
FORT WASHINGTON	10.24%	1.161470	-0.64%	**9.60%**	**1.153070**
ATLANTIC GENERAL	6.10%	1.114652	-0.46%	**5.64%**	**1.109079**
KERNANS	6.04%	1.113214	-0.16%	**5.88%**	**1.111274**
GOOD SAMARITAN	6.01%	1.118159	-0.29%	**5.72%**	**1.114617**
SHADY GROVE	6.91%	1.117712	-0.31%	**6.60%**	**1.113929**
ROCK TRAUMA	21.08%	1.320081	0.00%	**21.08%**	**1.320081**
CANCER CENTER	9.28%	1.148232	0.00%	**9.28%**	**1.148232**
State-wide Total	7.35%	1.133182	-0.41%	**6.97%**	**1.119121**
				-0.38%	

Appendix 2a and 2b – Medicaid Impact of Pooling Shock Trauma and Incremental Impact to Medicaid of Full Pooling

Projected Medicaid Savings for Inclusion of Shock Tra[illegible]a Center

Increased Payouts from 85,524,661 to 92,064,240 6,539,5[illegible] INCREASE
Re-establishes Limit at 7.15% (currently 6.85%)

	Gross Rev Before Redistribution	Gross Rev After Redistribution	Difference	Current Gross Rev After Redistribution	Difference	FSS Medicaid Percent	Total Medicaid Savings	**State Medicaid Savings**	Medicare Percent FY 2007	Gross Medicare Difference	Current Medicare Gross Revenue	Impact on Medicare
WASHINGTON CO.	232,488,641	232,488,641	0	232,488,641	(0)	2.61%	(0)	**(0)**	46.52%	108,163,816	(0)	
UNIVERSITY OF MD.	912,647,899	897,058,647	(15,589,251)	894,092,653	2,965,995	11.64%	345,365	**162,322**	28.43%	254,234,192	843,377	
PRINCE GEORGE	270,211,425	251,699,876	(18,511,548)	250,868,394	831,483	16.50%	137,159	**64,465**	28.48%	71,459,857	236,848	
HOLY CROSS	388,096,704	388,096,704	0	388,096,704	0	8.35%	0	**0**	28.83%	111,897,960	0	
FREDERICK MEM.	253,136,956	253,136,956	0	253,136,956	0	2.71%	0	**0**	38.49%	97,432,674	0	
HARFORD MEM.	90,235,256	89,155,124	(1,080,132)	88,861,840	293,284	2.20%	6,455	**3,034**	40.10%	35,629,549	117,593	
ST. JOSEPH'S	371,701,703	371,701,703	0	371,701,703	0	1.60%	0	**0**	47.10%	175,056,533	0	
MERCY	360,872,199	358,318,897	(2,553,302)	357,138,548	1,180,349	5.06%	59,699	**28,058**	31.53%	112,620,130	372,211	
JOHNS HOPKINS	1,546,567,464	1,546,567,464	0	1,546,567,464	0	6.03%	0	**0**	26.78%	414,129,714	0	
DORCHESTER GEN.	50,830,441	50,210,671	(619,770)	50,044,266	166,405	5.57%	9,276	**4,360**	48.32%	24,180,382	80,403	
ST. AGNES	343,444,838	343,444,838	0	342,599,188	845,650	5.47%	46,234	**21,730**	41.58%	142,467,833	351,659	
SINAI	613,959,687	613,959,687	0	612,538,610	1,421,076	6.60%	93,728	**44,052**	37.38%	228,983,911	531,238	
BON SECOURS	113,588,434	104,845,895	(8,742,539)	104,496,715	349,180	10.85%	37,871	**17,800**	41.79%	43,668,389	145,920	
FRANKLIN SQUARE	408,168,048	404,648,903	(3,519,145)	403,310,856	1,338,046	6.93%	92,765	**43,599**	38.68%	156,005,625	517,573	
WASHINGTON ADV.	277,843,776	277,415,719	(428,057)	276,498,743	916,976	7.30%	66,910	**31,448**	42.33%	117,028,797	388,112	
GARRETT CO.	35,763,942	35,394,447	(369,495)	35,276,878	117,569	13.77%	16,193	**7,611**	46.03%	16,239,634	54,122	
MONTGOMERY GEN.	134,981,914	134,981,914	0	134,981,914	(0)	1.40%	(0)	**(0)**	49.41%	66,701,013	(0)	
PENINSULA GEN.	367,879,062	367,879,062	0	367,879,062	(0)	1.45%	(0)	**(0)**	51.21%	188,385,369	(0)	
SUBURBAN	224,435,792	224,435,792	0	224,435,792	0	1.11%	0	**0**	49.15%	110,304,006	0	
ANNE ARUNDEL GEN.	359,860,248	359,860,248	0	359,860,248	0	1.90%	0	**0**	34.86%	125,463,792	0	
UNION MEM.	410,945,032	410,945,032	0	410,945,032	0	5.93%	0	**0**	43.79%	179,960,353	0	
MEM. CUMBERLAND	104,232,998	104,232,998	(0)	104,232,998	(0)	3.39%	(0)	**(0)**	43.24%	45,071,344	(0)	
SACRED HEART	156,110,810	156,110,810	(0)	156,110,810	0	5.66%	0	**0**	56.25%	87,813,316	0	
ST. MARY'S	117,748,883	117,748,883	0	117,748,883	0	2.19%	0	**0**	37.04%	43,613,893	0	
BAYVIEW	513,913,805	505,234,238	(8,679,567)	503,561,900	1,672,337	10.92%	182,630	**85,836**	33.68%	169,623,279	563,322	
CHESTER RIVER	61,554,840	61,394,279	(160,561)	61,191,808	202,472	1.46%	2,959	**1,391**	45.55%	27,871,096	92,220	
UNION OF CECIL	118,850,110	117,881,162	(968,948)	117,492,831	388,331	3.78%	14,666	**6,893**	38.90%	45,704,718	151,061	
CARROLL CO. GEN.	185,096,327	185,096,327	0	185,096,327	(0)	6.52%	(0)	**(0)**	44.10%	81,621,985	(0)	
HARBOR HOSP.	199,854,715	195,657,831	(4,196,883)	195,010,745	647,087	5.07%	32,805	**15,418**	36.93%	72,021,068	238,981	
CIVISTA	100,839,708	100,839,708	(0)	100,839,708	0	2.76%	0	**0**	42.83%	43,185,815	0	
MEM. EASTON	147,386,652	147,386,652	0	147,386,652	(0)	3.30%	(0)	**(0)**	51.26%	75,551,747	(0)	
MARYLAND GEN.	198,037,456	188,249,230	(9,788,225)	187,622,159	627,072	14.68%	92,068	**43,272**	34.16%	64,089,764	214,201	
CALVERT MEMORIAL	104,208,515	104,208,515	0	104,208,515	(0)	3.51%	(0)	**(0)**	38.12%	39,725,522	(0)	
NORTHWEST	211,970,567	211,608,438	(362,130)	210,908,610	699,827	4.76%	33,287	**15,645**	48.16%	101,563,151	337,002	
BALTIMORE/WASHING	292,923,445	292,923,445	0	292,923,445	(0)	1.04%	(0)	**(0)**	42.93%	125,739,003	(0)	
G.B.M.C.	369,778,002	369,778,002	0	369,778,002	0	1.50%	0	**0**	36.27%	134,130,123	0	
MCCREADY	17,261,804	17,261,804	0	17,261,804	(0)	1.50%	(0)	**(0)**	44.61%	7,700,735	(0)	
HOWARD CO. GEN.	208,931,226	208,931,226	(0)	208,931,226	(0)	2.85%	(0)	**(0)**	33.14%	69,234,387	(0)	
UPPER CHESAPEAKE	184,359,753	184,359,753	0	184,359,753	(0)	0.84%	(0)	**(0)**	38.94%	71,792,674	(0)	
DR'S COMMUNITY HOS	184,961,185	182,712,733	(2,248,452)	182,110,889	601,844	3.95%	23,752	**11,164**	41.26%	75,135,642	248,310	
SOUTHERN MD.	229,634,034	229,035,053	(598,981)	228,279,334	755,719	3.90%	29,468	**13,850**	38.80%	88,576,538	293,233	
LAUREL REGIONAL	100,373,201	96,042,384	(4,330,817)	95,726,118	316,266	5.79%	18,298	**8,600**	37.22%	35,631,377	117,721	
FORT WASHINGTON	48,050,781	46,756,430	(1,294,351)	46,602,701	153,729	3.55%	5,457	**2,565**	36.30%	16,918,536	55,809	
ATLANTIC GENERAL	73,192,673	73,192,673	0	73,192,673	0	0.61%	0	**0**	52.01%	38,064,146	0	
KERNANS	101,113,255	101,113,255	0	101,113,255	(0)	15.31%	(0)	**(0)**	30.75%	31,090,568	(0)	
GOOD SAMARITAN	264,716,683	264,716,683	0	264,716,683	(0)	4.84%	(0)	**(0)**	52.97%	140,228,717	(0)	
SHADY GROVE	297,576,202	297,576,202	0	297,576,202	(0)	4.95%	(0)	**(0)**	30.56%	90,929,903	(0)	
SHOCK TRAUMA	177,533,883	150,425,735	(27,108,147)	177,533,883	(27,108,147)	20.53%	(5,564,935)	**(2,615,520)**	12.11%	21,500,938	(3,283,039)	
CANCER CENTER	61,335,534	61,335,534	0	61,335,534	(0)	9.49%	(0)	**(0)**	29.17%	17,890,704	(0)	
			0									
	12,598,688,016	12,498,673,653	(100,014,363)	12,488,056,202	(10,617,451)		(4,217,890)	**(1,982,409)**	37.17%	4,642,034,215	2,667,878	0.06%

Projected Medicaid Incremental Savings for Full Pooling

Removes 0.75% UCC Fund Payment
Redistributes UCC Evenly Across All Hospitals

	Gross Rev Before Redistribution	Gross Rev After Removal of UCC Payment 75% Assessment	Gross Rev After Redistribution	Difference	Current Gross Rev After UCC Fund Redistribution	Difference	Medicaid Percent FY 2007	Gross Medicaid Savings	**Net State Medicaid Savings**	Medicare Percent FY 2007	Gross Medicare Difference	Current Medicare Gross Revenue	
WASHINGTON CO.	$232,488,641	230,744,976	231,347,324	602,347	232,488,641	(1,141,317)	10.59%	(120,901)	**(56,823)**	46.52%	(530,990)	108,163,816	
UNIVERSITY OF MD.	$912,647,899	905,803,040	887,971,412	(17,831,628)	897,058,647	(9,087,235)	29.96%	(2,722,466)	**(1,279,559)**	28.43%	(2,583,945)	255,077,569	
PRINCE GEORGE	$270,211,425	268,184,839	249,150,726	(19,034,113)	251,699,876	(2,549,150)	28.36%	(722,933)	**(339,779)**	28.48%	(726,125)	71,696,704	
HOLY CROSS	$388,096,704	385,185,979	387,230,193	2,044,214	388,096,704	(866,511)	14.25%	(123,513)	**(58,051)**	28.83%	(249,837)	111,897,960	
FREDERICK MEM.	$253,136,956	251,238,428	254,787,934	3,549,506	253,136,956	1,650,978	7.92%	130,815	**61,483**	38.49%	635,463	97,432,674	
HARFORD MEM.	$90,235,256	89,558,491	88,253,169	(1,305,322)	89,155,124	(901,955)	6.83%	(61,644)	**(28,973)**	40.10%	(361,643)	35,747,142	
ST. JOSEPH'S	$371,701,703	368,913,940	385,544,835	16,630,895	371,701,703	13,843,132	5.97%	826,259	**388,342**	47.10%	6,519,558	175,056,533	
MERCY	$360,872,199	358,165,658	354,692,601	(3,473,057)	358,318,897	(3,626,296)	18.05%	(654,411)	**(307,573)**	31.53%	(1,143,517)	112,992,342	
JOHNS HOPKINS	$1,546,567,464	1,534,968,208	1,556,099,433	21,131,225	1,546,567,464	9,531,969	18.26%	1,740,094	**817,844**	26.78%	2,552,408	414,129,714	
DORCHESTER GEN.	$50,830,441	50,449,213	49,701,724	(747,489)	50,210,671	(508,947)	14.43%	(73,463)	**(34,528)**	48.32%	(245,913)	24,260,786	
ST. AGNES	$343,444,838	340,869,002	340,253,924	(615,078)	343,444,838	(3,190,914)	18.87%	(602,134)	**(283,003)**	41.58%	(1,326,923)	142,819,491	
SINAI	$613,959,687	609,354,989	608,344,437	(1,010,552)	613,959,687	(5,615,249)	18.19%	(1,021,430)	**(480,072)**	37.38%	(2,099,136)	229,515,149	
BON SECOURS	$113,069,946	112,221,921	103,781,795	(8,440,126)	104,845,895	(1,064,100)	32.29%	(343,615)	**(161,499)**	41.79%	(444,679)	43,814,308	
FRANKLIN SQUARE	$408,168,048	405,106,788	400,549,689	(4,557,099)	404,648,903	(4,099,214)	20.07%	(822,697)	**(386,668)**	38.68%	(1,585,626)	156,523,198	
WASHINGTON ADV.	$277,843,776	275,759,947	274,605,694	(1,154,253)	277,415,719	(2,810,025)	14.85%	(417,370)	**(196,164)**	42.33%	(1,189,350)	117,416,910	
GARRETT CO.	$35,763,942	35,495,712	35,035,468	(460,244)	35,394,447	(358,978)	22.51%	(80,819)	**(37,985)**	46.03%	(165,255)	16,293,757	
MONTGOMERY GEN.	$134,981,914	133,969,550	135,259,558	1,290,009	134,981,914	277,644	4.97%	13,799	**6,485**	49.41%	137,197	66,701,013	
PENINSULA GEN.	$367,879,062	365,119,969	370,553,916	5,433,947	367,879,062	2,674,854	8.80%	235,453	**110,663**	51.21%	1,369,753	188,385,369	
SUBURBAN	$224,435,792	222,752,524	228,153,719	5,401,195	224,435,792	3,717,926	3.04%	112,876	**53,052**	49.15%	1,827,258	110,304,006	
ANNE ARUNDEL GEN.	$359,860,248	357,161,297	367,113,228	9,951,931	359,860,248	7,252,979	6.62%	480,282	**225,732**	34.86%	2,528,721	125,463,792	
UNION MEM.	$410,945,032	407,862,945	410,457,458	2,594,513	410,945,032	(487,574)	15.42%	(75,165)	**(35,328)**	43.79%	(213,518)	179,960,353	
MEM. CUMBERLAND	$104,232,998	103,451,250	105,789,565	2,338,315	104,232,998	1,556,567	13.42%	208,900	**98,183**	43.24%	673,075	45,071,344	
SACRED HEART	$156,110,810	154,939,978	159,840,276	4,900,298	156,110,810	3,729,467	15.78%	588,366	**276,532**	56.25%	2,097,849	87,813,316	
ST. MARY'S	$117,748,883	116,865,766	117,377,513	511,747	117,748,883	(371,370)	10.11%	(37,539)	**(17,643)**	37.04%	(137,554)	43,613,893	
BAYVIEW	$513,913,805	510,059,451	500,114,722	(9,944,729)	505,234,238	(5,119,516)	27.29%	(1,396,955)	**(656,569)**	33.68%	(1,724,493)	170,186,601	
CHESTER RIVER	$61,554,840	61,093,179	60,772,767	(320,412)	61,394,279	(621,512)	7.70%	(47,826)	**(22,478)**	45.55%	(283,081)	27,963,316	
UNION OF CECIL	$118,850,110	117,958,734	116,688,157	(1,270,577)	117,881,162	(1,193,005)	11.56%	(137,963)	**(64,843)**	38.90%	(464,079)	45,855,779	
CARROLL CO. GEN.	$185,096,327	183,708,104	187,235,406	3,527,302	185,096,327	2,139,079	8.92%	190,814	**89,683**	44.10%	943,270	81,621,985	
HARBOR HOSP.	$199,854,715	198,355,804	193,675,674	(4,680,131)	195,657,831	(1,982,158)	22.04%	(436,941)	**(205,362)**	36.93%	(732,047)	72,260,049	
CIVISTA	$100,839,708	100,083,410	100,969,985	886,575	100,839,708	130,277	9.39%	12,228	**5,747**	42.83%	55,793	43,185,815	
MEM. EASTON	$147,386,652	146,281,252	147,882,666	1,601,414	147,386,652	496,014	11.71%	58,075	**27,295**	51.26%	254,261	75,551,747	
MARYLAND GEN.	$198,037,456	196,552,175	186,338,556	(10,213,619)	188,249,230	(1,910,675)	41.32%	(789,402)	**(371,019)**	34.16%	(652,666)	64,303,965	
CALVERT MEMORIAL	$104,208,515	103,426,951	104,306,234	879,283	104,208,515	97,719	10.52%	10,283	**4,833**	38.12%	37,252	39,725,522	
NORTHWEST	$211,970,567	210,380,788	209,464,698	(916,090)	211,608,438	(2,143,740)	11.23%	(240,800)	**(113,176)**	48.16%	(1,032,319)	101,900,153	
BALTIMORE/WASHING	$292,923,445	290,726,519	291,297,366	570,847	292,923,445	(1,626,078)	4.49%	(72,931)	**(34,277)**	42.93%	(698,003)	125,739,003	
G.B.M.C.	$369,778,002	367,004,667	384,562,579	17,557,912	369,778,002	14,784,577	5.07%	749,156	**352,103**	36.27%	5,362,832	134,130,123	
MCCREADY	$17,261,804	17,132,341	17,144,810	12,469	17,261,804	(116,994)	24.29%	(28,421)	**(13,358)**	44.61%	(52,193)	7,700,735	
HOWARD CO. GEN.	$208,931,226	207,364,241	210,037,507	2,673,266	208,931,226	1,106,281	6.60%	73,029	**34,324**	33.14%	366,593	69,234,387	
UPPER CHESAPEAKE	$184,359,753	182,977,055	185,861,001	2,883,946	184,359,753	1,501,248	6.87%	103,092	**48,453**	38.94%	584,610	71,792,674	
DR'S COMMUNITY HO	$184,961,185	183,573,976	180,863,653	(2,710,323)	182,712,733	(1,849,080)	8.92%	(164,873)	**(77,490)**	41.26%	(762,897)	75,383,952	
SOUTHERN MD.	$229,634,034	227,911,779	226,716,155	(1,195,623)	229,035,053	(2,318,898)	14.51%	(336,361)	**(158,089)**	38.80%	(899,775)	88,869,770	
LAUREL REGIONAL	$100,373,201	99,620,402	95,070,493	(4,549,908)	96,042,384	(971,891)	12.40%	(120,510)	**(56,640)**	37.22%	(361,759)	35,749,098	
FORT WASHINGTON	$48,050,781	47,690,400	46,283,474	(1,406,926)	46,756,430	(472,956)	9.39%	(44,418)	**(20,876)**	36.30%	(171,701)	16,974,345	
ATLANTIC GENERAL	$73,192,673	72,643,728	73,657,678	1,013,951	73,192,673	465,006	4.55%	21,143	**9,937**	52.01%	241,828	38,064,146	
KERNANS	$101,113,255	100,354,905	101,492,897	1,137,991	101,113,255	379,642	24.71%	93,825	**44,098**	30.75%	116,733	31,090,568	
GOOD SAMARITAN	$264,716,683	262,731,308	266,202,374	3,471,066	264,716,683	1,485,691	13.22%	196,341	**92,280**	52.97%	787,017	140,228,717	
SHADY GROVE	$297,576,202	295,344,380	296,348,467	1,004,086	297,576,202	(1,227,735)	12.08%	(148,254)	**(69,679)**	30.56%	(375,157)	90,929,903	
SHOCK TRAUMA	$177,533,883	176,202,378	148,905,354	(27,297,025)	150,425,735	(1,520,381)	26.79%	(407,240)	**(191,403)**	12.11%	(184,132)	18,217,900	
CANCER CENTER	$61,335,534	60,875,517	59,294,028	(1,581,490)	61,335,534	(2,041,506)	15.45%	(315,502)	**(148,286)**	29.17%	(595,478)	17,890,704	
	12,598,688,016	12,504,197,856	12,493,082,292	(11,115,564)	12,488,056,202	(5,026,089)		(6,723,670)	**(3,160,125)**	37.19%	5,097,679	4,644,702,094	0.11%

Appendix 3 – Estimated Payments into and out of the UC Fund (Full Pooling)

Calculation of Payments To and From Fund

Based on Full Pooling of UCC

July 1, 2008 to June 30, 2009

	July 1, 2008 REVENUE ADJ. FOR NEW MU	July 1, 2008 REVENUE After .75% Removed	NEW MARK UP FROM ALGORITHM	NET REVENUE	POLICY FINAL RESULT 7/01/08	NEW $ AMOUNT UCC COST	NEW UCC MAXIMUM RATE 6.9700%	PERCENT DIFFERENCE	NEW APPROVED MARK UP (INCL MAX)	GROSS REVENUE AT NEW UCC $0	COLLECTED NET REV. AT NEW UCC	PAYMENT FROM (TO) HOSPITALS	OVERAGE PAYMENT FROM HOSPITALS	SHORTAGE-PAYMENT (TO) HOSPITALS
	Q		W	X	Y	Z	AA	AB	AC	AD	AE	AF	AI	AJ
WASHINGTON CO.	232,488,641	$230,744,976	1.121443	205,757,215	6.67%	13,729,794	6.91%	0.24%	1.124370	231,347,324	206,294,333	537,118	537,118	0
UNIVERSITY OF MD.	912,647,899	$905,803,040	1.147950	789,061,470	8.69%	68,606,844	6.91%	-1.79%	1.125351	887,971,412	773,528,015	(15,533,454)	0	(15,533,454)
PRINCE GEORGE	270,211,425	$268,184,839	1.210266	221,591,731	13.35%	29,584,436	6.91%	-6.44%	1.124368	249,150,726	205,864,511	(15,727,220)	0	(15,727,220)
HOLY CROSS	388,096,704	$385,185,979	1.111479	346,552,752	6.43%	22,266,252	6.91%	0.48%	1.117377	387,230,193	348,391,937	1,839,184	1,839,184	0
FREDERICK MEM.	253,136,956	$251,238,428	1.103845	227,602,920	5.62%	12,795,613	6.91%	1.29%	1.119441	254,787,934	230,818,502	3,215,582	3,215,582	0
HARFORD MEM.	90,235,256	$89,558,491	1.136201	78,822,771	8.24%	6,493,460	6.91%	-1.33%	1.119641	88,253,169	77,673,924	(1,148,848)	0	(1,148,848)
ST. JOSEPH'S	371,701,703	$368,913,940	1.074284	343,404,534	2.81%	9,658,049	6.91%	4.10%	1.122713	385,544,835	358,885,447	15,480,913	15,480,913	0
MERCY	360,872,199	$358,165,658	1.132166	316,354,358	7.79%	24,651,086	6.91%	-0.88%	1.121188	354,692,601	313,286,736	(3,067,622)	0	(3,067,622)
JOHNS HOPKINS	1,546,567,464	$1,534,968,208	1.103578	1,390,901,674	5.65%	78,642,975	6.91%	1.26%	1.118770	1,556,099,433	1,410,049,599	19,147,925	19,147,925	0
DORCHESTER GEN.	50,830,441	$50,449,213	1.144965	44,061,814	8.25%	3,635,126	6.91%	-1.34%	1.128000	49,701,724	43,408,965	(652,849)	0	(652,849)
ST. AGNES	343,444,838	$340,869,002	1.128787	301,978,096	7.07%	21,359,316	6.91%	-0.16%	1.126750	340,253,924	301,433,195	(544,901)	0	(544,901)
SINAI	613,959,687	$609,354,989	1.125700	541,312,201	7.06%	38,218,255	6.91%	-0.15%	1.123833	608,344,437	540,414,491	(897,710)	0	(897,710)
BON SECOURS	113,069,946	$112,221,921	1.225731	91,555,112	13.68%	12,524,739	6.91%	-6.77%	1.133545	103,781,795	84,669,321	(6,885,791)	0	(6,885,791)
FRANKLIN SQUARE	408,168,048	$405,106,788	1.138268	355,897,506	7.93%	28,221,353	6.91%	-1.02%	1.125464	400,549,689	351,893,969	(4,003,537)	0	(4,003,537)
WASHINGTON ADV.	277,843,776	$275,759,947	1.129762	244,086,688	7.29%	17,792,372	6.91%	-0.38%	1.125033	274,605,694	243,065,010	(1,021,678)	0	(1,021,678)
GARRETT CO.	35,763,942	$35,495,712	1.145419	30,989,288	8.08%	2,503,934	6.91%	-1.17%	1.130567	35,035,468	30,587,475	(401,813)	0	(401,813)
MONTGOMERY GEN.	134,981,914	$133,969,550	1.112439	120,428,716	6.03%	7,267,744	6.91%	0.87%	1.123150	135,259,558	121,588,338	1,159,622	1,159,622	0
PENINSULA GEN.	367,879,062	$365,119,969	1.109372	329,123,198	5.56%	18,302,143	6.91%	1.35%	1.125882	370,553,916	334,021,418	4,898,221	4,898,221	0
SUBURBAN	224,435,792	$222,752,524	1.095974	203,246,148	4.71%	9,563,945	6.91%	2.20%	1.122549	228,153,719	208,174,362	4,928,214	4,928,214	0
ANNE ARUNDEL GEN.	359,860,248	$357,161,297	1.086969	328,584,721	4.36%	15,589,585	6.91%	2.54%	1.117256	367,113,228	337,740,396	9,155,674	9,155,674	0
UNION MEM.	410,945,032	$407,862,945	1.118682	364,592,253	6.33%	23,090,162	6.91%	0.58%	1.125799	410,457,458	366,911,512	2,319,258	2,319,258	0
MEM. CUMBERLAND	104,232,998	$103,451,250	1.099563	94,083,956	4.86%	4,571,062	6.91%	2.05%	1.124417	105,789,565	96,210,541	2,126,585	2,126,585	0
SACRED HEART	156,110,810	$154,939,978	1.097577	141,165,433	4.06%	5,730,642	6.91%	2.85%	1.132290	159,840,276	145,630,083	4,464,649	4,464,649	0
ST. MARY'S	117,748,883	$116,865,766	1.114927	104,819,248	6.51%	6,824,464	6.91%	0.40%	1.119809	117,377,513	105,278,244	458,996	458,996	0
BAYVIEW	513,913,805	$510,059,451	1.149003	443,914,745	8.68%	44,251,028	6.91%	-1.77%	1.126601	500,114,722	435,259,652	(8,655,093)	0	(8,655,093)
CHESTER RIVER	61,554,840	$61,093,179	1.128386	54,142,101	7.39%	3,999,206	6.91%	-0.48%	1.122468	60,772,767	53,858,145	(283,956)	0	(283,956)
UNION OF CECIL	118,850,110	$117,958,734	1.133439	104,071,514	7.89%	8,211,242	6.91%	-0.98%	1.121231	116,688,157	102,950,522	(1,120,993)	0	(1,120,993)
CARROLL CO. GEN.	185,096,327	$183,708,104	1.101969	166,708,953	5.17%	8,610,964	6.91%	1.74%	1.123127	187,235,406	169,909,861	3,200,908	3,200,908	0
HARBOR HOSP.	199,854,715	$198,355,804	1.152853	172,056,512	9.05%	15,568,678	6.91%	-2.14%	1.125652	193,675,674	167,996,903	(4,059,609)	0	(4,059,609)
CIVISTA	100,839,708	$100,083,410	1.112503	89,962,335	6.10%	5,491,616	6.91%	0.81%	1.122358	100,969,985	90,759,254	796,919	796,919	0
MEM. EASTON	147,386,652	$146,281,252	1.116008	131,075,492	5.92%	7,759,130	6.91%	0.99%	1.128225	147,882,666	132,510,441	1,434,949	1,434,949	0
MARYLAND GEN.	198,037,456	$196,552,175	1.195914	164,353,158	11.59%	19,042,852	6.91%	-4.68%	1.133769	186,338,556	155,812,725	(8,540,432)	0	(8,540,432)
CALVERT MEMORIAL	104,208,515	$103,426,951	1.110924	93,099,961	6.14%	5,712,076	6.91%	0.77%	1.120368	104,306,234	93,891,449	791,488	791,488	0
NORTHWEST	211,970,567	$210,380,788	1.130556	186,086,198	7.30%	13,592,590	6.91%	-0.39%	1.125633	209,464,698	185,275,897	(810,301)	0	(810,301)
BALTIMORE/WASHING	292,923,445	$290,726,519	1.117656	260,121,680	6.73%	17,508,282	6.91%	0.18%	1.119850	291,297,366	260,632,434	510,754	510,754	0
G.B.M.C.	369,778,002	$367,004,667	1.066169	344,227,424	2.54%	8,743,377	6.91%	4.37%	1.117176	384,562,579	360,695,648	16,468,224	16,468,224	0
MCCREADY	17,261,804	$17,132,341	1.130065	15,160,485	6.84%	1,037,591	6.91%	0.07%	1.130888	17,144,810	15,171,519	11,034	11,034	0
HOWARD CO. GEN.	208,931,226	$207,364,241	1.101756	188,212,514	5.73%	10,786,342	6.91%	1.18%	1.115959	210,037,507	190,638,882	2,426,368	2,426,368	0
UPPER CHESAPEAKE	184,359,753	$182,977,055	1.101816	166,068,546	5.47%	9,088,430	6.91%	1.44%	1.119182	185,861,001	168,685,992	2,617,447	2,617,447	0
DR'S COMMUNITY HO	184,961,185	$183,573,976	1.137922	161,323,891	8.25%	13,314,884	6.91%	-1.34%	1.121121	180,863,653	158,942,073	(2,381,819)	0	(2,381,819)
SOUTHERN MD.	229,634,034	$227,911,779	1.128966	201,876,542	7.39%	14,911,361	6.91%	-0.48%	1.123044	226,716,155	200,817,499	(1,059,042)	0	(1,059,042)
LAUREL REGIONAL	100,373,201	$99,620,402	1.174438	84,823,898	11.07%	9,388,204	6.91%	-4.16%	1.120798	95,070,493	80,949,783	(3,874,116)	0	(3,874,116)
FORT WASHINGTON	48,050,781	$47,690,400	1.153070	41,359,488	9.60%	3,970,424	6.91%	-2.69%	1.119053	46,283,474	40,139,332	(1,220,156)	0	(1,220,156)
ATLANTIC GENERAL	73,192,673	$72,643,728	1.109079	65,499,138	5.64%	3,696,251	6.91%	1.27%	1.124560	73,657,678	66,413,366	914,227	914,227	0
KERNANS	101,113,255	$100,354,905	1.111274	90,306,138	5.88%	5,310,137	6.91%	1.03%	1.123876	101,492,897	91,330,180	1,024,041	1,024,041	0
GOOD SAMARITAN	264,716,683	$262,731,308	1.114617	235,714,369	5.72%	13,473,456	6.91%	1.19%	1.129343	266,202,374	238,828,502	3,114,133	3,114,133	0
SHADY GROVE	297,576,202	$295,344,380	1.113929	265,137,482	6.60%	17,497,342	6.91%	0.31%	1.117716	296,348,467	266,038,874	901,391	901,391	0
SHOCK TRAUMA	177,533,883	$176,202,378	1.320081	133,478,483	21.08%	28,137,264	6.91%	-14.17%	1.115576	148,905,354	112,800,184	(20,678,299)	0	(20,678,299)
CANCER CENTER	61,335,534	$60,875,517	1.148232	53,016,718	9.28%	4,919,951	6.91%	-2.37%	1.118402	59,294,028	51,639,393	(1,377,326)	0	(1,377,326)
	12,598,688,016	12,504,197,856	1.123692895	11,127,771,573	6.97%	775,646,032	6.97%	-0.00%	1.122694	12,493,082,292	11,127,768,835	(2,738)	103,943,826	(103,946,564)

Appendix 4 – Proposed Regulation

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 09 Fee Assessment for Financing Hospital Uncompensated Care

Authority: Health-General Article, §19-207; 19-213; and 19-214, Annotated Code of Maryland

.01 Definitions

A. In this chapter, the following terms have the meanings indicated:

B. Terms Defined.

[(1) "Assessment" means the dollar amount that the Health Services Cost Review Commission directs be collected from hospitals for a given month to finance the reasonable total costs of hospital uncompensated care and to reduce uncompensated care.]

[(2)] (1) "Automated clearing house (ACH)", as defined in COMAR 03.01.02.01B, means a central clearing organization that operates as a clearing house for transmitting or receiving entries between banks and bank accounts, and authorizes an electronic transfer of funds between banks or bank accounts.

[(3)] (2) "Commission" means the Health Services Cost Review Commission.

[(4)] (3) "Comptroller" means the Comptroller of the Treasury or the Comptroller's designee.

[(5)] (4) ["Fee"] "Remittance" means the amount each hospital remits to the General Accounting Division pursuant to the predetermined formula established by the Commission to provide funding for the Commission's Uncompensated Care Fund.

[(6)] (5) "General Accounting Division" means the Fiscal Services Administration for the Department of Health and Mental Hygiene.

(7) - (11) Repealed

[12)] (7) "Health Services Cost Review Commission Fund" means the special fund established under Health-General Article, §19-213 (d), Annotated Code of

Maryland.

[(13)] (8) "Hospital" means an institution that is licensed by the Department of Health and Mental Hygiene as an acute general hospital.

[(14)] (9) "Hospital Uncompensated Care Fund" means the monies that are collected from hospitals for the equitable financing of hospital uncompensated care and which are a discrete part of the Health Services Cost Review Commission Fund.

[(15)] (10) "Interest" means the investment earnings generated from the investment and reinvestment of the monies of the Hospital Uncompensated Care Fund which are separately held by the Treasury, accounted for by the Comptroller, and retained to the credit of the Health Services Cost Review Commission Fund.

(11) "Mark-up" means the mechanism used to increase hospital rates to allow for payer differentials, working capital (prompt payment) differentials, and a provision for uncompensated care.

[(16) "Request for proposals" means the documents used for soliciting proposals from hospitals for hospital sponsored programs that have the potential for reducing hospital uncompensated care.]

(12) "Special Rate Adjustment" means an adjustment to a hospital's rates, which will bring the hospital's uncompensated care provision of its mark-up to the statewide uncompensated care average.

[(17)] (13) "Treasury" means the State Treasury.

(18) - (19) Repealed

[(20)] (14) "Wire transfer" means an electronic transaction in which a hospital through the hospital's bank and an automated clearing house, or suitable alternative, originates an entry crediting the Health Services Cost Review Commission Fund's bank account and debiting the hospital's bank account on the same day the transaction is initiated.

.02 [Method of Fee Assessment and Collection.] Special Rate Adjustment and Collection.

A. The Commission shall [assess a fee on all acute general hospitals] make a special rate adjustment to the uncompensated care provision of each hospital's mark-up to pay for the financing of the reasonable costs of hospital uncompensated care. The Commission shall notify [each hospital] hospitals in writing of the amount [of the fee to be assessed] due to be remitted in a given month before the first day of that month.

B. On or before the first business day of each month, the Commission shall direct the General Accounting Division to arrange for the collection of [a monthly fee not to exceed 1.25% of the total gross operating revenue from each hospital whose rates have been approved by the Commission.] the amount due to be remitted by individual hospitals. This amount shall be based on the difference between a hospital's uncompensated care provision in its mark-up and the statewide uncompensated care average.

C. The Commission shall, at the same time, notify the General Accounting Division in writing of the:

(1) Hospitals [to be assessed a fee] due to remit for that month;

(2) Amount of the [assessment on each hospital} remittance for that month;

(3) - (5) Text Unchanged

D. Text Unchanged

.03 Payment of [Fee Assessment] Remittance Due

A. By [April 1, 1997] January 1, 2009, each hospital shall provide the Commission with sufficient banking information to facilitate the collection and disbursement of funds by the ACH or other wire transfer method. Each hospital shall initiate or authorize the ACH or other wire transfer method as directed by the Commission.

B. On or before the 5th business day of each month, each hospital [assessed a fee] identified as due to remit monies in accordance with these regulations shall make payment into the Hospital Uncompensated Care Fund in the manner prescribed by the Commission.

C. On or before the 5th business day of each month, the Comptroller shall transfer monies out of the Hospital Uncompensated Care Fund and distribute monies to hospitals in the manner prescribed by the Commission.

.04 Use of Funds

A. Funds generated through the [fee assessment] special rate adjustment and the remittance due may only be used to finance the delivery of hospital uncompensated care [and to fund the Uncompensated Care Reduction Program].

B. Interest earned from the monies collected shall be retained to the credit of the Hospital Uncompensated Care Fund.

C. Interest earned may be used to pay for the reasonable expenses associated with implementation of the alternative methodology approved by the Commission for financing the reasonable costs of hospital uncompensated care [and for reducing uncompensated care. The cost of procuring the Program Administrator is considered a reasonable expense for purposes of implementing the Uncompensated Care Reduction Program].

.05 Uncompensated Care Reduction Program. (Repealed)

.06 Failure or Delay in Paying [Fees] <u>Remittance</u>/Penalties.

(A) - (B) Text Unchanged

C. In addition to the penalties the Commission may impose on a hospital that fails to pay the [fee] <u>remittance</u> in a timely manner, the Commission may refer the hospital's delinquent account to the Department of Budget and Fiscal Planning's Central Collection Unit pursuant to the procedures in State Finance and Procurement Article, Title 3, Subtitle 3, Annotated Code of Maryland.

(D) - (F) Text Unchanged.

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §19-207, 19-214.1, Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend **Regulation .26** under **COMAR 10.37.10 Rate Application and Approval Procedures.** This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on December 10, 2008, notice of which was given pursuant to State Government Article, §10-506(c). Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about April 6, 2009.

Statement of Purpose

The purpose of this action is to require hospitals to file internal and external credit and collection policies with the Commission annually and to authorize penalties for failure to file on a timely and completed basis.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or call (410)

764-2576, or fax to (410) 358-6217, or email to dkemp@hscrc.state.md.us. The Health Services Cost Review Commission will consider comments on the proposed amendments until February 2, 2009. A hearing may be held at the discretion of the Commission.

.26 Differentials

B. Working Capital Differentials – Payment of Charges.

(1) -(5) Text Unchanged

(6) Hospital Credit and Collection Policies

(a) On or before May 1, 2009, each hospital shall develop an internal written credit and collection policy that sets forth, at a minimum:

i. when the hospital refers an account to a collection agency;

ii. whether the timing cycle for referring a patient's account to a collection agency is stopped when the patient agrees to a reasonable collection plan with the hospital;

iii. whether the hospital charges interest for payment plans for accounts in active Accounts Receivable, and if so, what are the rates and terms;

iv. whether the hospital bill clearly indicates a distinction in charges between hospital services and physician services provided;

v. whether the hospital provides a single telephone number for a patient who has bill-related questions;

vi. whether the hospital has a different credit and collection process for a patient with a history of previous non-payment, and if so, what is the difference;

vii. whether the hospital's internal collection policy is different if the hospital determines that the patient qualifies for reduced-cost care under the hospital's financial assistance policy, and if so, what is the difference;

viii. other information as prescribed by the Commission.

(b) On or before May 1, 2009, each hospital shall develop an external written credit and collection policy that sets forth, at a minimum:

i. how an account is classified once it moves to a collection agency;

ii. whether the debt is permitted to be noted on a patient's credit report while it is at the collection agency, and if so, when is it noted on the report, for how long, and under what circumstances is it removed;

iii. who determines when an account should be considered

uncollectible and after what period of time;

iv. how the hospital classifies the account (e.g., bad debt) when the account is determined to be uncollectible;

v. who determines whether or not the patient has assets available to satisfy the outstanding debt;

vi. what steps are taken by the hospital or its collection agency, and under what circumstances (e.g., patient has not responded to phone calls or letters), including the pursuit of legal judgements, garnishment of wages, lien on assets, etc., if assets are determined to be available and sufficient to satisfy in part or in whole the outstanding debt;

vii. whether the hospital charges interest for accounts in bad debt collections, and if so, what are the rates and terms;

viii. under what circumstances will the hospital execute a legal judgment;

ix. under what circumstances will the hospital or its collection agency write off the account as a bad debt;

x. whether the hospital's external collection policy is different if the hospital determines that the patient qualifies for reduced-cost care under the hospital's financial assistance policy, and if so, what is the difference;

xi. whether the hospital expends funds to enroll patients eligible for insurance coverage in such programs, and if so, what are those programs and how much is expended;

xii. what percentage of total cases is referred over to a bad-debt collection agency;

xiii. what percentage of total cases go to court;

xiv. the amount collected and its percentage to what was owed attributable to implementation of the hospital's credit and collection policies.

xv. other information as prescribed by the Commission.

(c) Each hospital shall file annually its internal and external credit and collection policies with the Commission within 30 days from the end of its fiscal year. Failure to file these policies in a timely and completed basis may subject the hospital to penalties as provided for in COMAR 10.37.01.03N.

C. (Text unchanged.)

DONALD A. YOUNG, MD
Chairman
Health Services Cost Review Commission

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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DONALD A. YOUNG, MD
Chairman
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Donald A. Young, M.D.
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Joseph R. Antos, Ph.D.
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Gerard J. Schmith
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Hospital Rate Setting

John J. O'Brien
Deputy Director
Research and Methodology

TO: **Commissioners**

FROM: **Legal Department**

DATE: **December 5, 2008**

SUBJECT: **Hearing and Meeting Schedule**

Public Session

January 14, 2009	**Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room**
February 4, 2009	**Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room**

Please note, Commissioner packets will be available in Commission offices at 8:00 a.m.

The agenda for the Executive and Public Sessions will be available for your review on the Commission's Web Site, on the Monday before the Commission Meeting. To review the agenda, visit the Commission's web site at http://www.hscrc.state.md.us