STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Donald A. Young, M.D.
Chairman

Joseph R. Antos, Ph.D.
Raymond J. Brusca, J.D.
Trudy R. Hall, M.D.
C. James Lowthers
Kevin J. Sexton
Herbert S. Wong, Ph.D.

HEALTH SERVICES COST REVIEW COMMISSION
4160 PATTERSON AVENUE · BALTIMORE, MARYLAND 21215
AREA CODE 410-764-2605
FAX 410-358-6217
Toll Free 888-287-3229
Web Site: http://www.hscrc.state.md.us/

Robert Murray
Executive Director

Stephen Ports
Principal Deputy Director
Policy & Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

John J. O'Brien
Deputy Director
Research and Methodology

454th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

PUBLIC SESSION OF THE

HEALTH SERVICES COST REVIEW COMMISSION

March 4, 2009

8:45 a.m.

1. **Review of the Public Minutes of February 4, 2009**
2. **Executive Director's Report**
3. **Docket Status - Cases Closed**

   2013R - Memorial Hospital at Easton

4. **Docket Status - Cases Open**

   2009A - University of Maryland Medical Center
   2014A - Johns Hopkins Health System
   2015R - Greater Baltimore Medical Center
   2016A - Johns Hopkins Health System

5. **Final Recommendations on Maryland Hospital-Acquired Conditions (MHAC)**
6. **Final Recommendations for Revisions to the Reasonableness of Charges (ROC) Methodology**
7. **Legislative Report**
8. **Hearing and Meeting Schedule**

453rd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

FEBRUARY 4, 2009

Chairman Young called the meeting to order at 9:04 a.m. Commissioners Joseph R. Antos, Ph.D., Trudy R. Hall, M.D., Kevin J. Sexton, and Herbert S. Wong, Ph.D. were also present.

ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC SESSION OF JANUARY 14, 2009

The Commission voted unanimously to approve the minutes of the January 14, 2009 Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, briefed the Commissioners on staff's activities in response to concerns raised about hospitals' credit and collection practices. Mr. Murray stated that the Governor requested that the Commission submit a report that fully evaluated the issues raised and would at a minimum review: 1) the extent to which the policies differ among hospitals; 2) whether hospitals have become more aggressive in their collection efforts over time; and 3) whether there are regulatory or legislative changes required.

Mr. Murray summarized the interim report to the Governor and staff's on going activities to produce a final report. The interim report outlines the issues and provides a background on the rate setting system focusing on the way uncompensated care (UCC) is handled, i.e., how the treatment of uncompensated care is a balancing act between the hospitals' social mission and the expectation that they will be efficient institutions and credit and collect when people can afford to pay. The report discuses the major issues in detail and places them in the context of the current economic environment, as well as noting the federal government's interest in how non-profit hospitals are earning their tax-exempt status. The report also outlines the actions and activities taken to date: 1) proposing regulations; 2) meeting with legislators, the Secretary of Health, and representatives of : the Department of Health and Mental Hygiene; the Attorney General's Office Consumer Protection Division; hospitals; Legal Aid; Maryland Hospital Association (MHA); and credit and collection agencies; 3) reviewing what other states have done legislatively; 4) reviewing the trends in UCC funding and the mix of charity care versus bad debts and whether they can be linked back to credit and collection policies; 5) reviewing and benchmarking credit and collection policies and developing a "best practices" policy; 6) initiating special audits to

determine whether financial assistance and credit and collection policies are being applied consistently; 7) exploring ways of improving communication to patients of their legal rights on unpaid claims; 8) inquiring into the efficacy of creating an intermediate appeals, grievance, or mediation step prior to legal action; 9) reviewing and evaluating the Commission's UCC policy to determine whether there are changes that are warranted, i.e., should we differentiate between charity and bad debts; and 10) assembling a work group to move the hospital industry towards a "best practices" policy in credit and collection activity. In addition, the report will have a series of preliminary recommendations

Mr. Murray announced that Ing-Jay Cheng, of the MHA, has decided to leave MHA and take a position with the Center for Medicare and Medicaid Services (CMS). Mr. Murray thanked Ms. Cheng for her dedication and work and expressed staff's utmost respect for Ms. Chang's professional abilities. Mr. Murray congratulated Ms. Cheng and wished her good luck in her new position.

ITEM III
DOCKET STATUS CASES CLOSED

1985A – University of Maryland Medical Center
2012A - Johns Hopkins Health System
2011R – Baltimore Washington Medical Center

ITEM IV
DOCKET STATUS CASES OPEN

Memorial Hospital at Easton – 2013R

On January 9, 2009, the Memorial Hospital at Easton filed an application requesting a rate for Lithotripsy (LIT) services. The Hospital currently has a rebundled LIT rate and inpatients are transported to an off-site facility for LIT services. However, effective March 1, 2009, the Hospital will begin providing LIT services at the Hospital to both inpatients and outpatients. The Hospital requested the state-wide median LIT rate be approved

After reviewing the Hospital's application, staff recommended:

1. That the LIT rate of $2,722.83 per procedure be approved effective March 1, 2009;
2. That no change be made to the Hospital's charge per case target for LIT services; and
3. That the LIT rate not be rate realigned until a full year's experience has been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

EXTENSIONS

Staff requested a 30 day extension for review of the application of the Greater Baltimore Medical Center, proceeding 2015R.

The Commission voted unanimously to approve staff's request.

ITEM V
DRAFT RECOMMENDATIONS FOR REVISIONS TO THE REASONABLENESS OF CHARGES METHODODOLOGY

John O'Brien, Deputy Director-Research and Methodology, stated that it was the intention of staff to present a final recommendation at today's public meeting. However, all parties indicated an interest in running a simulation of the Reasonableness of Charges methodology utilizing the final recommended revisions thereto and up-to-date data before final comments are made. Therefore, Mr. O'Brien asked that hospitals file the necessary information on interns, residents, and fellows to be filed by February 13th so that the simulations can be completed by February 20th. Comments will then be submitted to the Commission's offices by February 26th and a final recommendation will be presented by staff at the March public meeting.

ITEM VI
DRAFT RECOMMENDATIONS ON REVISONS REGARDING MARYLAND HOSPITAL-ACQUIRED CONDITIONS

A panel consisting of Robert Murray, Diane Feeney, Associate Director-Quality Initiative, John O'Brien, Deputy Director Research and Methodology, Wendy Kronmiller of the Maryland Office of Health Care Quality, in addition to Norbert Goldfield, M.D., Elizabeth McCullough, and Rich Averill of 3M Health Information Systems, presented staff's draft recommendation on Maryland Hospital-Acquired Conditions (MHACs) methodology.

In his overview of the recommendation, Mr. Murray stated that one focus of this initiative is on highly preventable complications that are measurable. The other focus is on the Commission's statutory mandate to certify that rates are based on reasonable costs. It is staff's presumption that highly preventable complications that can be prevented in the vast majority of cases do not constitute reasonable costs. Staff's interpretation is that the Commission has a legal mandate to implement a policy of this nature. The presence of secondary diagnoses that are highly preventable create additional payments and reward hospitals for poor quality. In addition to these unintended payment incentives there is a lack of analytic and data tools for hospitals to improve quality. The objective of this initiative is to improve the incentives and provide the hospitals with

analytic tools and data to improve quality.

Mr. Murray noted that although the Commission has made some limited progress on quality improvement, the progress has been limited and slow. It has taken five years to develop a quality based reimbursement effort using process measures. The focus has been on performance measures, with limited linking of performance to payment. There has been virtually no activity on outcome measures, and tools to measure broad-based improvement are limited.

Mr. Murray asserted that the Commission is compelled to act because of its statutory mandate. There is an urgent need to adopt appropriate incentives to correct this reimbursement flaw. We must shift the focus away from the complications that are less preventable toward the cases with complications that are 90%, 95%, or 99% preventable. In doing so, we hope to reduce unnecessary cost, unnecessary patient suffering, and improve quality. Mr. Murray listed the factors compelling the Commission to act now: 1) there are new tools to measure quality; 2) the CMS initiative has made preventable complications initiatives the "law of the land" in every state but Maryland; 3) Maryland is uniquely positioned because of its all-patient severity adjusted APR-DRG system to be a national leader; 4) in Maryland, there is a bias against hospitals with low complication rates because of the zero sum nature of our rate system; 5) the ability to target the Commission's efforts in areas of reducing waste, in the face of huge budgetary shortfalls nationally and in Maryland, rather than waiting for arbitrary revenue cuts; and 6) the long overdue need to focus on quality improvement.

Mr. Murray summarized the objectives, principles, and approach to the MHAC initiative. Mr. Murray detailed the reasons that Maryland is uniquely positioned to undertake this quality initiative: 1) its extensive data-infrastructure and the analytic capability within the industry and best administrative data set in the nation; 2) availability of the severity adjusted ARP-DRG product, which provides the ability to make use of the new measurement tools afforded by the present-on-admission (POA) coding and the potentially preventable complications (PPCs) development tool; 3) the broad applicability and use of incentives across all-payers and hospitals because of the Medicare waiver, which allows Maryland to craft a local solution. Maryland's unique rate setting system decouples payment from actual case payments, as opposed to Medicare's per case payment system in which decrements are related to a particular case. This produces a more equitable result because hospitals are paid for resources used, which reduces the potential for access concerns, and incentives (revenue increases or decrements) are applied at an overall revenue level in order to influence overall processes in hospitals. Although the magnitude of the incentives is quite small (0.1%), it will create a behavioral response from hospitals.

The objective is to craft a Maryland based solution, specific to Maryland's characteristics and regulatory structure. We should follow CMS's lead and apply Maryland's unique strengths. The system should be prospective, with an emphasis on data efficacy, data exchange, and transparency, i.e., the ability to monitor and track performance over time. The overall goal is to reduce complication rates and to address the Commission's mandate to set rates based on reasonable costs. This differentiates this initiative from the Quality Based Reimbursement Initiative, removes unintended incentives and the flaws in current reimbursement, and reduces the bias against hospitals with lower complication rates.

Staff's approach is not untested as alleged by MHA. Staff approach is: 1) to establish appropriate incentives to change hospital behavior (which the Commission has done many times in the past); 2) to provide incentives that are focused on quality improvement by providing analytic tools; 3) to ensure that the incentives are sufficient to change behavior; and 4) to structure the incentives to reflect the hospital's ability to influence complication rates (which are broad based unlike those of CMS which are 100% payment decrements). Finally, the initiative has built-in incentives for continued reporting of complications. This is a targeted approach to reduce waste and unnecessary cost as opposed to an arbitrary imposition of cost cutting that may come in this era of budgetary constraints. This will also allow the HSCRC to achieve a leadership role in quality improvement. Mr. Murray urged the Commission to act favorably on the recommendation.

Diane Feeney stated that hospital data, communication, feedback, and transparency are critical to successful implementation of MHACs. Ms. Feeney reported that accurate coding of the POA indicator is central to the use of MHACs. Staff is providing feedback on an ongoing basis to improve POA data. The HSCRC has convened a MHAC Payment Policy Workgroup, comprising the hospital industry and payers, including Maryland Medicaid, to provide important input on content and approach to statewide vetting of MHACs and to maximize transparency. This is particularly important given that hospitals have been provided access to the complete definitions manual and exclusion and assignment logic of the MHACs, as well as hospital-specific case assignment reports since December 2008. Hospital feedback on specific findings in their case reports has allowed the Commission to refine and revise the MHAC case reports. Among other items, hospital feedback led to the removal of 2 of the PPCs as candidates for MHACs. Ms. Feeney stated that the workgroup will continue to refine the process.

Dr. Goldfield and Ms. McCullough summarized the MHAC Initiative's PPCs methodology developed specifically for our APR-DRG Payment System. Dr. Goldfield defined PPCs as harmful events that may result from the process of care and treatment rather than from a natural progression of the underlying disease. The assumptions of the methodology are that: 1) not all inpatient complications are preventable; 2) even with optimal care inpatient complications will occur; therefore, detailed global and condition-specific exclusions (which are open for examination and ongoing improvement) have been implemented for each of the twelve MHACs; 3) patients who have had problems with quality of care will be more likely to have an inpatient complication; and 4) hospitals with quality of care problems will have higher rates of inpatient complications.

Dr. Goldfield emphasized that the development of PPCs requires the availability of the POA indicator. The POA enables us to identify post admission events that represent a complication; however, we must also identify the clinical circumstances under which the complication is potentially preventable. This is done by panels of clinicians under the auspices of 3M. Dr. Goldfield noted since the New York State Department of Health has reported, confidentially, the rates of all the PPCs by hospital, feedback from other clinicians has been critical in terms of the ongoing evolution and improvement of the PPCs. Dr. Goldfield stated that the PPCs developed by 3M are much more inclusive than others, because there are numerous PPC specific clinical exclusions and extensive risk adjustments built into the PPC list. Both the PPC and the exclusion

logic use information from the current base admission APR-DRG assignment and are updated annually with the APR-DRG annual update. The PPC system was purposely designed so that patients who come in with multiple co-morbidities will have the PPC recognized but likely will have no payment decrement. In terms of global exclusions, there are groups of patients that are immediately excluded because the probability of complications is much higher, and their preventability is uncertain. They include: major trauma, organ transplants, major or metastatic malignancy, cardiac arrest, HIV, and specific burns. Of 13,367 ICD- diagnoses codes, 1450 have been identified as PPC diagnoses. Each PPC diagnosis was assigned to one of 64 mutually exclusive PPC groups based on similarities in clinical presentation and impact. In addition, a select set of ICD-9 codes was also used to identify some PPCs.

Dr. Goldfield discussed in detail the twelve highly preventable complications that make up the MHACs Initiative and their FY 2008 statewide frequency. Dr. Goldfield emphasized that the PPCs not globally or clinically excluded were "low hanging fruit" and are truly highly preventable.

Dr. Goldfield stated that continuous quality improvement tools such as PPCs should have an improvement process. This is ongoing with the PPC system and has occurred through feedback from both the New York Department of Health and clinician groups, as well as from Maryland hospitals.

Rich Averill and John O'Brien outlined the development of the proposed payment methodology. Mr. Averill noted that DRG based payments place hospitals at financial risk for use of bed days and ancillary services; by implementing MHACs, all we are doing is placing hospitals at risk for the cost of a very narrow and selected number of complications. This initiative represents a direct and logical extension of the fundamental premise of the DRG payment system. We are bundling services together and setting a fair and reasonable payment rate. Hospitals will be rewarded if they are more efficient and will suffer financial consequences if they cannot provide care efficiently. Mr. Averill observed that the financial risk associated with MHACs is very minor relative to the financial risk already in the system, and when compared with national trends towards hospitals being at financial risk for much broader payment bundles. Mr. Averill asserted that evidence shows that payment incentives do change behavior.

Mr. Averill noted that instead of removing the entire payment implications associated with the complication as in the Medicare policy, the MHAC system has the flexibility to remove a portion of the payment associated with a complication. This flexibility recognizes the fact that complications are not 100% preventable. In the context of the Maryland rate system, what is essentially a state-wide budget is set, and DRGs determine how the budget is divided among the hospitals. If the MHAC system is approved, the effect will be to shift money from hospitals that have high complication rate, relative to these MHACs, to hospitals with low complication rates. Thus, the combination of DRGs and MHACs is a way of allocating a fixed budget as fairly as possible. MHACs determine the circumstances under which a post-admission complication will be allowed to increase payment. Payment is affected only if the MHAC is the only reason a patient is assigned to a higher severity level, primarily patients admitted with severity levels I and 2. Coupled with global and clinical exclusions, the requirement that the patient is assigned to a

higher severity level because of the MHAC decreases significantly the percentage of cases identified.

John O'Brien summarized the development of the MHAC adjustment of allowable charges policy. When it comes time to look at the payment system, the MHAC adjustment is made at the end of the year to a hospital's overall allowable charges. Discussions have been held with hospital representatives, payers, and consultants to review various approaches to adjusting allowable charges and to help ensure consistency with methods currently used in the system and preventing unintended consequences. Staff has developed two adjustments to approved charges. The first is used if there is a change in the APR-DRG assignment because of the MHAC. In that instance, the case weight will be lowered by 90% of the difference between the old higher case weight and the new lower weight. The second is used if the case had outlier charges not accounted for in APR-DRG weights. In that instance, the allowable charges will be adjusted by 90% of the charges associated with the MHAC based on a regression analysis. The reason that only 90% is removed is to recognize that not all the complications are preventable. Removing only 90% of the payment increase associated with MHAC procedures also provides an incentive for hospitals to code MHAC procedures, since if the procedures are not coded, the hospital will lose 100% of the increase associated with the MHAC. Mr. O'Brien noted that over 75% of the cases with an MHAC result in no adjustment. Based on FY 2008 simulations, the overall impact of MHAC adjustments to allowable charges would have been 0.12% ($9.36 million), and the reduction to allowable charges of MHAC discharges only, is 6.84% .

Ms. Kronmiller stated that the Office of Health Care Quality (OHCQ) has a mandatory incident reporting program that requires hospitals to report deaths and serious injuries that result unexpectedly from treatment. This data are accumulated, and a report is issued which analyzes these incidents and provides constructive feedback to hospitals. There are no penalties assessed if hospitals report incidents; however, there are penalties for not reporting. Since OHCQ does not conduct routine inspections, the question becomes how to find out if hospitals are not reporting incidents. Currently, the OHCQ must rely on patient complaints. Since everyone has an interest in cost benefits and benefits to consumers, the hope is that HSCRC's and OHCQ's efforts will coalesce. By providing the OHCQ with access to MHAC data, the OHCQ will learn about unreported incidents and can investigate and provide feedback to the HSCRC about the cases. Ms. Kronmiller and Ms. Feeney provided several examples of how the systems can work together based on information of incidents as provided by the HSCRC.

Mr. Murray summarized the main points of the MHAC initiative: 1) the HSCRC has a statutory requirement to establish reasonable costs; 2) unlike CMS-HACs, the MHAC initiative focuses on the overall operations of the hospital and provides appropriate incentives to code complications; 3) the minimal magnitude of revenue reduction reflects the conservative nature of the initiative; 4) the initiative provides a responsive and targeted approach to budgetary constraints; 5) the initiative addresses a flaw in the reimbursement system and the bias against with hospitals with lower complication rates; 6) hospitals more successful in preventing complications improve quality and free-up rate capacity; 7) there are no access concerns since the payment per case is unchanged; 8) these initiatives appear to stimulate more research not less; and 9) the reduction of preventable complications is not left up to an unenforceable form of voluntary regulation.

Mr. Murray urged the prospective implementation of the MHAC Initiative, effective April 1st, and to approve staff's recommendation as presented. Mr. Murray stated that staff has attempted to show that there is a human dimension to the initiative and that it can help prevent tragic circumstances. Mr. Murray stated that staff intents to present the final recommendation at the March public meeting.

A panel consisting of Carmela Coyle, President of the Maryland Hospital Association, Ray Grahe, Vice President –Finance of the Washington County Health System, Larry L. Smith, Vice President-Risk Management of MedStar Health, and Peter Pronovost, M.D., Medical Director for the Center for Innovations in Quality Patient Care, presented the hospital industry's comments on the proposed recommendation.

Ms. Coyle stated that MHA and the hospitals it represents continue to support linking payment to performance when the original principles that provided the foundation for quality-based reimbursement are met. The industry's concern about the 3M methodology is that it takes those principles and makes a "left-hand turn." As we began out with quality-based reimbursement, the objective was to make certain that poor performers were assisted. It was about raising performance in the State; however, staff's approach does not assist poor performers - - it penalizes them. In terms of quality-based reimbursement, we always spoke about the need that it be evidence-based. The 3M methodology is not evidence-based. It is a statistical model. The industry believes that it is extremely important that these methodologies be tested and well understood before being linked to payment. There are concerns about hurrying the enactment of this proposal. It appears to be driven by budget concerns rather than by performance improvement concerns. As to involving stakeholders in its development, while there have been many invitations to participate, the industry has not received the information timely. Nevertheless, the methodology that has been proposed is very interesting and one that the industry would like to take a more in-depth look at. The industry is not opposed to linking payment and performance, nor necessarily opposed to the 3M methodology, although the industry would like to take some time to examine it. It is opposed, however, to linking payment to that specific methodology at this point in time.

Dr. Pronovost stated that he was encouraged by our common goal of improving care and reducing cost in Maryland. Dr. Pronovost noted that the National Health Care Quality report showed that progress in safety over the last decade has been pretty poor. And, what is most striking, is that we do not know how to measure outcomes; they are not even on the radar screen. Contrast that performance to the advances that we've made in biomedical science over the same time, where we sequenced the human genome; where AIDS is a chronic disease; and where we can cure most childhood leukemias. The difference is that we approached biomedical as science, and in health care quality, we put policy before the science. We are because of that. For example: wrong site surgery, operating on the wrong side of the body is devastating; it ends up in the papers. The approach taken was to establish a national standard, and that standard was made with a really superficial understanding of what the problem was, with no evidence that it would work, and with absolutely no measure to evaluate its effectiveness. Wrong site surgery has increased yearly since that policy went in place. According to Dr. Pronovost we ran before we understood

the problem. We all agree that these complications should be both measureable and preventable. However, the devil is in the details. What do we mean by being transparent, not just on the codes that go to make these measures, but how accurately we can measure them, and how sure we are that they are preventable.

For example, retained foreign body after surgery is likely coded quite well on discharge data. And hospitals shouldn't be paid for those complications because they shouldn't happen. On the other hand, there is probably over a 50% error rate in measuring catheter related blood infections and yet right down the hall, the Maryland Health Care Commission has accurate state of the art data to measure them. Why then would we think of using discharge data for these infections when we know it is going to be wrong half of the time when we have more standardized definitions? Another example is deep venous thrombosis; although it is not on our list, it is on the CMS list. Rates in our institution increased tenfold over a very short period of time. Why did they go up? Because our Doctors believed that screening for these infections was a marker of high quality care (and there is some evidence that it is), so they started routinely looking for and Finding them, and their rates went up tenfold. To get a valid measure, you need clear definitions and you need a surveillance standard; without both, you are going to have more noise than signal. According to Dr. Pronovost, can you imagine setting your reimbursement policies when costs can vary tenfold by how hard you look for something?

In thinking about preventability, there is no doubt that we all want to prevent harms; physicians went wrong for years because for years we've labeled only egregious examples of harms as preventable. If inevitable and preventable complications are lumped together, they are difficult to separate. However, if you can cull out the preventable complications you can work with them. The physician's view of preventable complications was far too limited; now the pendulum has swung in the opposite direction - - all harm is preventable. We need to find some way to allocate which complications are preventable and which are inevitable.

Dr. Pronovost posited that there are three approaches. The first is that they are all preventable. For example, it may be true that all cases of retained foreign bodies are preventable. That clearly fits the model of: there was an error and it led to harm; and the inverse that if the error were eliminated, there is no harm. And, perhaps, we shouldn't be paid for that. However, even in the catheter related infection work that we won the accolades for, we didn't eliminate all infections. We reduced them by 66 percent, but they are still happening. And that occurred without reporting and without pay for performance.

The second way to classify complications is to adjust for which complications are preventable, which is the proposed methodology. Dr. Pronovost expressed concern with a methodology that compares how often a complication is observed to how often it happened in the past. Dr. Pronovost thinks it's erroneous to equate the not expected with when an error actually occurred, because we don't have evidence that that link has been made. Dr. Pronovost has not seen it motivate performance because those who perform well typically say the model looks great and they pat themselves on the back. Those who perform poorly discredit this as a black-box risk adjustment model. They are probably correct according to Dr. Pronovost. We ought to be transparent about what estimates we are using. If 66% of catheter related infections are what we

set the threshold to be, the public ought to know that. If 100% of retained foreign bodies are preventable the public ought to know that. But, we ought to be disciplined, science based, and we must hold ourselves accountable.

The last method is the one that Dr. Pronovost believes offers the most promise in this gray area (where some complications are preventable and some are not) is to link the error with the outcome, i.e., if indeed the error occurred and led to an adverse outcome. In those cases, we should not be paid. For example, if I didn't give antibiotics on time and the patient acquired a surgical site infection, then don't pay me for it. There is evidence that I did not give the antibiotic. Does this method make our work harder? Certainly it does, but we don't really have any estimate as to whether surgical sight infections are 100% or 10% preventable. Until we get that data, we are likely to make mistakes. There is no doubt that financial incentives drive behavior. The question is whether it is going to drive wise behavior. In the complication of tracheotomy infection, there is just no logic for what error occurred. The premise is that preventable harm means an error occurred and there was harm, and the inverse if the error was removed then there would be no harm. But Dr. Pronovost does not think we should be incentivizing when we do tracheotomies, because there is pretty good data that doing them early and doing more of them is more comfortable for the patient, gets them out earlier, and is more beneficial. We have to be cautious about what incentives we create because the goal has to be to drive behavior and to align payment with wise behavior.

Dr. Pronovost thinks we have an enormous opportunity for our State to take the national lead. The country is screaming for wise approaches to linking quality to payment, and we have all the right players here in Maryland. However, we have a table of these complications where we have transparently and explicitly disclosed how accurately they were measured to the gold standard, and how much they are preventable, it appears to be premature to attempt to make policy. Perhaps, Dr. Pronovost suggested, we might start with a subset of these complications. Dr. Pronovost stated that the MHCC has valid data on some of the infections, and we may be able to virtually eliminate them. That is probably a good place to start. As far as the other complications, we should be cautious. But what we\ have learned from the wrong site surgery situation and a decade of working on quality that there is no shortcut to science.

Larry Smith stated that no one can dispute the goals being sought by this proposal; however, after reviewing the material provided by the HSCRC, MedStar's clinical staff concluded that a high percentage of the specific case information represented complications that were not preventable. Therefore, to penalize hospitals by withholding reimbursement simply because these complications arise would be both unfair and unjustified. Adopting such an approach may also result in unwelcome consequences such as negatively impacting efforts to attract and retain physicians. Mr. Smith asserted that judgments pertaining to clinical practice should be made by trained medical professionals rather than by paraprofessionals utilizing a proprietary product that has not been vetted by clinicians. According to Mr. Smith, to the extent that a list of preventable complications becomes codified by the HSCRC, it can be expected that the occurrence of one of these events will be treated by the courts as evidence of malpractice. In addition, this approach, rather than building a culture of safety, will be seen by physicians and other providers as a method of finding fault and fixing blame. Mr. Smith recommended that, at the very least, the

Commission should delay the implementation of the initiative until, as Dr. Pronovost suggested, more research can be done, or we substitute a program that targets the issue that we and our medical staff agree are truly preventable, and then hold us accountable for them.

Ray Grahe stated although he applauds the initiative to improve the quality of Maryland hospitals, there are some flaws in the methodology, e.g., certain PPCs are problematic, differences in groupers, multiple versions of data, all of which speaks to the fact that this is an incomplete methodology that bears further investigation. This methodology is not ready to be rolled out as a payment methodology today. Mr. Grahe presented several hypothetical cases to illustrate his point that a coding-based payment methodology cannot differentiate between the preventability of complications in complex cases with various levels of patient vulnerability. Mr. Grahe advocated a change in payment based on evidence-based review that demonstrates a deviation from a standard of care that led to an outcome that was preventable; was within the hospital's control; was the result of a mistake by the hospital; and resulted in enhanced payment to the hospital. Mr. Grahe also suggested the clinical review of approximately six of the MHACs, and that the data provided hospital be improved so that appropriate analysis can be undertaken. As proposed, the initiative would lead to a payment system with unintended consequences. Mr. Grahe stated that this initiative should be moved to the Patient Safety Center rather than implement an outright payment decrement.

Ms. Coyle applauded HSCRC staff and 3M for the thought and work put into this proposal; however, the industry would like to make several suggestions. MHA recognizes that pressure is on all of us because of CMS's move to limit payment for hospital acquired conditions. However, that methodology has not yet been tested. The industry believes that we would all be better served if the Maryland initiative underwent similar testing and research and analysis. Also, the industry believes that the 3M methodology is very interesting, but that it is in its infancy. We need to test the adequacy of the 3M approach and whether or not this is the right approach for Maryland. In addition, we need to convene a broader discussion in terms of the direction of quality and patient safety in the State of Maryland. The MHA desires that conversation in order to establish the right direction for us, here in Maryland.

Ms. Coyle stated that Secretary Colmers, Bob Murray, Marilyn Moon, Chairman of the MHCC, Rex Cowdry, Executive Director of the MHCC, and Dr. Pronovost have all agreed to participate in this conversation. We all share the same objective.

Ms. Coyle supported Mr. Grahe's suggestion that this might be an appropriate methodology to test within the context of the Maryland Patient Safety Center. According to Ms. Coyle, the Safety Center was designed to do just this, to learn from mistakes, to prevent them from happening again, and to keep us here in Maryland at the cutting edge.

Ms. Mary Musman, representing the Department of Health and Mental Hygiene, reported that because of the national Medicare/Medicaid quality initiative, Maryland Medicaid has received a

letter from CMS asking what they are going to do to catch up with their peers. Half of the State Medicaid programs are piggybacking onto the Medicare methodology. Maryland Medicaid believes that the proposed Maryland Quality Initiative is superior and is preferable to the Medicare methodology; however, if the Maryland Initiative is not implemented, Maryland Medicaid will be forced to adopt the Medicare methodology. Ms. Musman expressed Maryland Medicaid's support for the proposed initiative.

Hal Cohen, Ph.D., representing CareFirst and Kaiser Permanente, urged the Commission to move forward with this initiative on April 1st. Dr. Cohen stated that he and CareFirst urged that the Commission build-in incentives for improving quality of care in 2000. Also, the payers have made it very clear in the 3-year arrangement negotiations that the saving from this initiative is part of the savings that would generated from the system. Dr. Cohen observed that it appears that MHA wants a standard of proof applied, to what hospitals should not be paid for, to be significantly higher than the standard of proof for what hospitals should be paid for.

Barry Rosen, representing United Healthcare, endorsed staff's recommendation on behalf of United Healthcare. The Commission has an opportunity, because of the all-payer system and the revenue ceiling that is produced by the case-rate target system, to provide incentives to decrease preventable complications and increase quality of care. Call this a pilot program, but give it a try. If in fact it does not result in less hospital acquired complications, throw it out. But if it does result in less hospital acquired complications, Maryland will have achieved what everyone else is just talking about.

Dr. Trudy Hall voiced concerns about some of the specific potentially preventable complications proposed as MHAC.

Dr. Hall also raised a general concern about a potential unintended consequence for the academic/teaching hospitals because medical students, interns or residents may perform less procedures if the hospital would be financially penalized for complications that occur while they are in training; this could result in less trained physicians. This issue could also have greater negative impact for small teaching hospitals which may be forced to close their teaching programs if there are financial implications for certain complications. Foreign medical graduates may be particularly affected if smaller teaching programs close.

In addition, Dr. Hall raised the issue of the severe shortage of OB/GYN physicians in the state as a result of the increasing cost of malpractice insurance. Factors, such as patients' lack of insurance and the poor having no prenatal care, render patients at higher risk when they present for delivery. The PPCs involving 3rd or 4th degree lacerations during child birth, could result in OB/GYNs performing episiotomies unnecessarily or by performing more caesarean sections, thereby increasing resource use and cost. Dr. Hall noted that decreasing payment for complications can make the OB/GYN shortage worse.

Dr. Hall noted that because there are increasingly resistant strains of infections, the PPCs relating to infection rates may cause even greater antibiotic use, further worsening the problem of resistant infections.

Dr. Hall raised the question of what timeframe that the POA was accounting for, e.g., the first 24, 48, or 72 hours? Dr. Hall added that, for the POA indicator to be valid, the diagnostic tests must be sufficient for the initial diagnoses; the patient's clinical signs and systems must be present; and the patient's history must be known.

Dr. Hall suggested that the Commission consider moving forward with a very limited number of MHACs that are truly highly preventable, using Maryland clinicians to continue to craft a Maryland solution, and potentially looking at other vendors and processes.

Mr. Murray noted that it is obvious that there are significant areas of agreement and also significant areas of disagreement. Staff believes that although science is important, the question is what level of exact science must be achieved. Mr. Murray agreed that a broader discussion would be useful, but discussions should not be used as a tactic for delay. Mr. Murray stated that the urgency to implement this initiative do not arise from budgetary consideration or the fact that CMS has implemented a program, the urgency is because of the suffering of the patients who are having these preventable complications. Mr. Murray suggested that the Commission reach out to Dr. Pronovost and others to attempt to resolve the areas of perception and disagreement.

ITEM VII
LEGAL REPORT

Regulations

Final Adoption

Fee Assessment for Financing Hospital Uncompensated Care - COMAR 10.37.09.01-.04 and .06

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

The Commission voted unanimously to approve the final adoption of this amended regulation.

Rate Application and Approval Procedures – COMAR 10.37.10.26-2

The purpose of this action is to describe the assessment process authorized by Ch. 7, Acts of

2007 Special Session, and associated with averted uncompensated care. This action also authorizes penalties for untimely or underpayment of the assessment.

The Commission voted unanimously to approve the final adoption of this new regulation.

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

The purpose of this action is to expedite the reporting process for outpatient data and thereby avoid unnecessary delay in the Commission's continuing to obtain information that is invaluable towards promoting greater efficiency in the provision of outpatient services.

The Commission voted unanimously to approve the final adoption of this amended regulation.

Submission of Hospital Discharge Data Set to the Commission – COMAR 10.37.06.01-.05

The purpose of this action is to expedite the reporting process for discharge data and thereby avoid unnecessary delay in the Commission's continuing to obtain information that is invaluable towards promoting greater efficiency in the provision of hospital care.

The Commission voted unanimously to approve the final adoption of this amended regulation.

ITEM VIII
HEARING AND MEETING SCHEDULE

March 4, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
April 15, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:56 a.m.

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

AS OF FEBRUARY 25 , 2009

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
2009A	University of Maryland Medical Center	11/17/08	N/A	N/A	ARM	DNP	OPEN
2014A	Johns Hopkins Health System	1/20/09	N/A	N/A	ARM	DNP	OPEN
2015R	Greater Baltimore Medical Center	1/26/09	3/27/09	6/26/09	ICU/CCU	CO	OPEN
2016A	Johns Hopkins Health System	2/2/09	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

IN RE: THE PARTIAL RATE	*	BEFORE THE HEALTH SERVICES	
APPLICATION OF	*	COST REVIEW COMMISSION	
GREATER BALTIMORE	*	DOCKET:	2009
MEDICAL CENTER	*	FOLIO:	1825
BALTIMORE, MARYLAND	*	PROCEEDING:	2015R

* *

Staff Recommendation

March 4, 2009

Introduction

On January 23, 2009, Greater Baltimore Medical Center (the "Hospital") submitted a partial rate application to the Commission requesting that the Hospital's approved rate for Coronary Care Unit (CCU) be collapsed into its Medical/Surgical Intensive Care Unit (MIS) rate center. This rate request, which involves the combining of two revenue centers, is revenue neutral and will not result in any additional revenue for the Hospital. The Hospital wishes to combine the two centers because their respective patients have similar staffing needs, and placement into a MIS or CCU is based on bed availability or staffing rather than on a diagnosis. The Hospital's current approved rates and the new proposed rate are as follows:

	Current Rate	Budgeted Volume	Approved Revenue
Medical/Surgical ICU	2,293.2237	4,937	$11,321,646
Coronary Care	1,263.0846	5,092	6,431,627
Combined Rate	1,770.1937	10,029	17,753,273

Staff Evaluation

To determine if the Hospital's CCU rate should be combined with its MIS rate, staff reviewed the MIS and CCU staffing, costs, and statistics as reported on the Hospital's FY 2008 Annual Filing. Per Schedule D6 (MIS) and D7 (CCU), the following staffing analysis was performed.

	FTEs	Patient days	Hours of Nursing Care per Patient Day
Medical/Surgical ICU	41.60 *	4,937	17.53
Coronary Care	39.60 *	5,092	16.18

*- 2,080 hours per FTE

Based on the comparison above, the Hospital's hours of nursing care per patient day for both MIS and CCU are similar, and, thus, it appears that the level of care for both MIS and CCU is the same.

Recommendation

After reviewing the Hospital's application, the staff recommends that the Hospital be allowed to collapse its CCU rate into its MIS rate effective February 1, 2009.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2009**
SYSTEM	*	**FOLIO:**	**1826**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2016A**

Staff Recommendation

March 4, 2009

I. INTRODUCTION

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on February 2, 2009 on behalf of its member hospitals, the 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 for continued participation in a capitation arrangement serving persons insured with Tricare. The arrangement involves the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare as providers for the Tricare patients. The requested approval is for a period of one year. The Commission previously approved the capitated pricing arrangement under proceeding1969A.

II. OVERVIEW OF APPLICATION

The parties to the contract include the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare. The program provides a range of health care services for persons insured under Tricare including inpatient and outpatient hospital services. Johns Hopkins Health Care will assume the risk under the agreement, and all Maryland hospital services will be paid based on HSCRC rates.

III. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' renewal application for an alternative method of rate determination for a one year period retro-active to January 1, 2009. This recommendation is based on both historical favorable contract performance and projections.

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.

FINAL RECOMMENDATION OF REVISIONS TO THE REASONABLENESS OF CHARGES (ROC) METHODOLOGY

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

March 4, 2009

This document is a final staff recommendation to the Commission at the March 4, 2009 public meeting

INTRODUCTION

Over the past year, staff, working with payer and industry representatives, has engaged in a process to review and revise the Commission's Reasonableness of Charges (ROC) methodology.[1] This draft recommendation proposes a series of changes to the ROC process that are the result of those discussions. The recommended changes to the ROC methodology will be used to calculate a ROC in early February 2009.

BACKGROUND

The Commission's ROC process is intended to allow hospitals to be compared on an equal footing to determine if a hospital's charges are reasonable relative to other peer hospitals in Maryland. A hospital with charges that are too high relative to its peers may be subject to "spend-down" provisions, where its rates are lowered to bring the hospital's charges in line with statewide averages. Conversely, a hospital where charges are low relative its peers may apply to the Commission for a "full rate review" and see rates increased consistent with Commission policies.

The ROC and the accompanying Interhospital Cost Comparison (ICC) are central elements of the Commission's mission to promote cost effective and efficient hospital services in Maryland. In addition to triggering "spenddowns" or permitting hospitals to request "full rate reviews," the ROC also provides feedback to hospitals on their performance relative to their peers. A stable ROC/ICC process is essential if it is to have its intended effect: aligning hospital rates with the resources needed to serve patients efficiently. It is also necessary to provide hospitals with feedback on their positions relative to their peers so that the hospital may take appropriate actions improve their positions.

The ROC analysis, or something similar[2], has been a consistent feature of the Commission's rate setting process. The methods used in the analysis, however, are not static. Changes in Commission policies and practices require the ROC analysis to be revised if it is to compare hospitals fairly.

The ROC process in use in 2005 began with each hospital's approved Charge Per Case (CPC) and made a series of adjustments to arrive at an adjusted CPC. The adjusted CPC was then used to compare hospitals within five defined peer groups. The adjustments were:

- *Mark-up,* the additional charges that each hospital is allowed to bill in order to account for its unique circumstances, including payer mix and the hospital's uncompensated care experience;

---

[1] The Commission did conduct a limited ROC using the previous (2005 and earlier) methodology in the spring of 2008. As a result three hospitals with adjusted charges well below their peers filed full rate reviews and, consequently, received an upward adjustment in rates. A number of other hospitals were identified as being considerably above the mean of their peers and could have be required to "spenddown. " The Commission chose not to take spenddown action in light of the anticipated comprehensive overhaul of the ROC.

[2] Earlier versions of the ROC process were referred to as the "screens", as each hospitals charges were screened according to a number of parameters.

- *Labor Market Adjustment,* an adjustment to account for varying labor costs that Maryland hospitals are subject to;
- *Hospital Case Mix*, an adjustment to account for the varying resource needs of treating the hospitals' patient populations;
- *Direct Strips*, specific dollar amounts removed from the calculation of the hospital adjusted CPC to adjust for a portion of the costs of resident salaries (DME) and some of the incremental costs of trauma centers;
- *Indirect Medical Education,* an adjustment to account for the differing costs associated with having a teaching mission; and,
- *Capital,* an adjustment to reflect the capital cycle when comparing hospital costs.

Transition to APR-DRGs and Impact on ROC

While all of the adjustments are important to allow hospitals to be compared on an equal footing, they are not all of equal magnitude. The most significant adjustment (in terms of difference between the lowest and largest adjustment) is for hospital case mix. This is to be expected, as the relative patient acuity across hospitals should be the most significant factor in determining the resources needed to treat those patients. Since case mix is such an important factor in the ROC analysis, changes in the methods to measure case mix inevitably lead to changes in the ROC process. Improvements to case mix measurement affects other ROC adjustments that previously captured some case mix variation, requiring that those adjustments be re-examined.

The Commission's conversion from Diagnostic Related Groups (DRGs) to All Patient Refined-Diagnostic Related Groups (APR-DRGs) in 2005 represented a substantial improvement to the Commission's ability to measure hospital case mix accurately. APR-DRGs expand upon the older DRGs by breaking each DRG into 4 severity levels, each of which is then assigned a weight to account for the relative resource use of patients in each APR-DRG cell. As a practical matter, the Commission went from breaking patient care down into roughly 300 resource similar categories to 1200 clinically relevant and resource-similar categories.

The introduction of the APR-DRGs also provided hospitals with a strong incentive to improve the coding of discharge data submitted to the Commission.[3] Since the APR-DRGs more fully account for the resource use of patients based on severity, complete medical record documentation and accurate coding are vital to assuring that a hospital's rates are commensurate with the needs of its patient population. It was common to see hospitals substantially increase depth of coding in the course of a single year. That change however, did not occur in the same pace or at the same time for all hospitals. Finally, the change to APR-DRGs also led to large increases in measured case mix that were not associated with changes in underlying resource use, leading to the imposition of limits in case mix growth (governors).[4]

---

[3] All Maryland hospitals report discharge data on all patients to the HSCRC on a quarterly basis.
[4] The Maryland experience was analyzed by CMS in advance of the introduction of CMS-DRGs and has led to federal provisions to limit case mix growth during the transition to CMS-DRGs.

These changes in the completeness of medical record coding in the years immediately after the introduction of APR-DRGs caused the Commission to place a moratorium on the ROC process (and its attendant spenddowns and full rate reviews). The Commission decided that conducting the ROC analysis was inappropriate, as the measurement of the relative case mix across hospitals (a central adjustment in the ROC process) was not reliable until coding improvement reached a steady state.

Analysis of more recent submissions of hospital discharge data show that the transition in coding practices initiated by the use of APR-DRGs is now complete. In 2005 the percentage of discharges that reported 15 diagnoses was 6 percent, as of the first 6 months of FY2008 discharges that reported 15 or more diagnoses exceeded 20 percent. Furthermore, the depth of coding across hospitals is consistent.

<u>Introduction of Charge Per Visit Methodology</u>
A second major change to the rate setting system since the last ROC process in 2005 is the implementation of the Cost Per Visit (CPV) methodology for outpatient services. As with the Charge Per Case target system that has been in use since 2002, the CPV reflects the hospital's expected charge per outpatient case on a risk adjusted basis, although in this case, the risk adjustment relies on Enhanced Ambulatory Patient Groups (EAPGs). The CPV methodology for outpatient services was approved by the Commission on June 4, 2008.

The CPV methodology uses the FY2008 outpatient data as the baseline to establish CPVs for all Maryland hospitals. Prior to the introduction of the CPV, the Commission set rates for individual units of outpatient services (lab, emergency room, etc.) but did not set an overall, risk adjusted target for the visit that those outpatient services comprised. Without such a target, a ROC process for outpatient services was not possible. Instead, once a hospital's position relative to its peers was determined by using the inpatient based ROC, an assessment of the hospital outpatient charges relative to the statewide median was done prior to imposing spenddowns or considering a hospital for a full rate review.

The introduction of the CPV has provided the Commission with two comprehensive measures: one of inpatient cases; and, one of outpatient visits. It has always been the Commission's intent that outpatient charges should be assessed for their reasonableness as inpatient charges are; with the introduction of the CPV such an assessment is possible.

REVISIONS TO THE ROC METHODOLOGY
The completion of the APR-DRG transition and the implementation of the CPV methodology demanded a thorough review and revision of the ROC process. Toward that end Commission staff, along with payer and industry representatives have engaged in a year-long process to revise and update the ROC methodology. In discussing the recommended changes to the ROC, the workgroup addressed a number of disparate and complex issues. It is useful to group the issues into several broad categories:

- *Baseline Issues* These issues relate to the baseline hospital charges upon which later adjustments are made. The baseline issues addressed were the Commission's trim

point methodology and the blending of the inpatient charge per case and outpatient charge per visit;

- *ROC Adjustments* These are the adjustments are made to a hospital's baseline charge to allow a "like-to-like" comparison of peer hospitals. These can be further broken down into:
  - *Major Adjustments* Adjustments that have a significant impact on a hospitals baseline charges. Major adjustments are: Case Mix, Indirect Medical Education, and Disproportionate Share; and,
  - *Minor Adjustments* While important to assuring a fair comparison across hospitals these adjustments are relatively small. Minor adjustments are; Direct Strips (Direct Medical Education, Trauma Hospitals, Nursing Education), Labor Market, and Capital Adjustments.
- *Comparing Hospitals* This pertains to the peer groups that hospitals are broken into once charges have been adjusted it is a hospitals performance relative to its peer group that determines how the ROC effects that hospital; and,
- *Implementation Issues* These are issues that pertain to how the ROC is applied in the setting of hospital rates. Implementation issues include: the setting of spenddown thresholds and/or scaling; whether to conduct of an annual or semi-annual ROC.

Baseline Issues

The ROC process started with each hospital's allowed CPC. A series of adjustments were then made to the CPC to arrive at an adjusted CPC, which is used as the "like-to-like" comparison. The starting point at which later adjustments are made influences the outcome of the ROC.

Trim Points. Trim points are dollar thresholds[5] at which charges for a specific case are not included in the calculation of a hospital's CPC. The current HSCRC policy sets statistically defined individual trim points for each hospital and for each APR-DRG cell. An alternative trim point policy (which was considered in 2005 when the current trim point methodology was established) would have established a statewide set of trim points for each APR-DRG cell. Staff believes that the current trim point methodology is not the most desirable; it is overly complex - establishing over 100,000 trim point compared with roughly 2,400 for the alternative methodology- and its complexity to does not provide any additional policy benefit.

In addition to its complexity, the trim point methodology also influences the other adjustments that are used in the ROC. At the July 8, 2008 meeting of the ICC/ROC workgroup, the representatives of the teaching hospitals presented analyses that showed that the current trim policy of hospital specific trims had the effect of increasing the ROC adjustment for IME, compared with the alternative of individual APR-DRG trims. This was because the current trims tend to increase the charges included for the calculation of CPCs for teaching hospitals (in particular the Academic Medical Centers). The representatives of the G-9 (non-teaching hospitals) agreed that this would be the effect of such a change to the trim policy. The trim point methodology is therefore, intertwined

[5] Charges above the trim points are essentially 'pass throughs' that payers reimburse as charged; they are not subject to the constraints of the CPC system.

with the IME methodology and influences the results that are obtained from such analysis.

The current methodology however, is in place, and the hardest technical and administrative tasks are complete. Furthermore, changing the trim point policy will also create timing problems. A change in the trim policy will not take effect until the FY10 rate year, meaning that CPCs with the new trims will not be available until FY11.

STAFF RECOMMENDATION: CONTINUE TO USE THE CURRENT TRIM POINTS The current trim point methodology should remain in place. Staff does not feel that the current trim policy is optimal. The administrative burdens of the current trim methodology however, have already been absorbed by the Commission and the hospitals and a change to the trim policy will add administrative costs – without sufficient offsetting benefit. Staff may wish to revisit the trim policy at a future date, after the recommended revisions to the ROC methodology are implemented. At such a time revision of the trim policy can be considered in isolation, and not as a factor that has confounding effects on other ROC adjustments.

Blending Charge Per Case and Charge Per Visit Calculations. The Commission has an established policy for its CPV. It is also the stated intent of the Commission to analyze hospitals for their efficiency on the CPV (i.e. a CPV ROC). Measuring hospital efficiency separately on an inpatient (CPC) and outpatient (CPV) basis presents several problems:

- *Combining a positive position on inpatient with a negative position on outpatient.* While such a separate comparison is possible, and in fact has been done by the Commission over time, it is less appropriate when combining case targets such as the CPC and the CPV. The Commission and the hospitals will be engaged in two parallel activities combining them at the end.
- *Peer group comparisons.* Peer groups were based on the appropriateness of grouping similar hospitals to allow reasonable comparison. One of the key elements of a peer groups is hospital size. For outpatient departments, size (i.e., volume) of outpatient departments varies widely across hospitals and does not follow current (or proposed) peer groups. Thus a stand-alone CPV ROC would need to consider alternative peer groups, further disconnecting the analyses.
- *IME adjustment.* An IME adjustment for outpatient would also be necessary; however, determining the appropriate variables to use for the measurement of IME would be quite complex. For example, the use of a resident to bed ratio to measure the intensity of the medical teaching component for outpatient services is questionable.

STAFF RECOMMENDATION: BLEND THE CPC AND CPV INTO A SINGLE COMPREHENSIVE CHARGE TARGET (CCT) Staff believe that the best way to address these problems is not to conduct the ROC in a bifurcated manner. The purpose of the ROC is to measure the overall reasonableness of hospital charges. The introduction of the CPV, along with the current Commission practice of aligning inpatient and outpatient charges each year makes a comprehensive approach possible.

Staff recommends that each hospital's CPC and CPV be blended into a single Comprehensive Charge Target (CCT). An analogous blending of case mix (discussed below) will also be done. The CCT will be the starting point for the ROC analyses. The ROC adjustments will then be applied to the CCT to arrive at a final, adjusted CCT. The method for blending CPC and CPV is presented in Attachment 1.

The blended CCT addresses the key challenges highlighted above:

- *Conflicting inpatient and outpatient ROC results.* If a hospital is differentially efficient on an inpatient versus an outpatient basis that will be reflected in the blended CCT.
- *Peer groups.* Since inpatient revenues included in the CPC dwarf outpatient revenues included in the CPV the blended CCT does not substantially change the utility of peer groups as they are currently defined for inpatient.
- *IME adjustment.* The IME adjustment will be made on the overall CCT so there will be no need to develop separate CPC and CPV adjustments.

ROC Adjustments

Using the CCT as the starting point, the ROC analysis makes a series to adjustments. The adjustments yield a final, adjusted CCT that is used to compare hospitals to their peers. For presentation purposes, these adjustments can be classified as major adjustments – those that can substantially change a hospital's CCT, or minor adjustments – those that have a modest effect on the CCT.

Major Adjustments

Case Mix. The Commission accounts for case mix differences across hospitals on the inpatient side using the APR-DRG grouper, this system has been in use since 2005. As was discussed above, the changes in medical record documentation and coding that were induced by the introduction of APR-DRGs are complete. Outpatient case mix is determined using the EAPG grouper according to the policy approved by the Commission in June 2008. Unlike the inpatient grouper, outpatient case mix as determined by the EAPG grouper is not materially changed by changes in hospital medical record coding practices.[6] While the EAPG grouper has been in use for less time, staff believes that it accurately measures outpatient case mix across hospitals.

STAFF RECOMMENDATION: COMBINE INPATIENT AND OUTPATIENT CASE MIX INDEXES INTO A SINGLE ADJUSTMENT.

This recommendation logically follows from the blending of inpatient CPC and outpatient CPV. During the development of the outpatient Charge per Visit (CPV) system, case weights for significant procedure visits were calculated using two different methods: 1) case weights were assigned based on the principal APG (the highest weight) in the record; or 2) case weights were assigned based on 100 percent of the principal APG weight and partial weight for subsequent APGs in the record. Given the minimal increase in the explanatory power by use of multiple APGs (method 2), and the ease of monitoring when using a single APG for the case mix adjustment (method 1), HSCRC

---

[6] Unlike APR-DRGs, EAPGs make much greater use of procedure codes in assigning patient visits. The presence of additional diagnostic detail has very little effect on EAPG assignments.

staff recommended that the principal APG be used for the assignment of case weights in the CPV system.

During the ICC/ROC workgroup meetings, industry representatives expressed satisfaction with the case mix methodology used in the outpatient CPV system because each hospital's rate year performance is compared to its own base year performance. However, workgroup members stated the current CPV case mix methodology may be unfair when comparing the reasonableness of outpatient charges between hospitals considering that some hospitals may provide more multiple significant procedures within a visit compared to other hospitals. Commission staff agreed that this was a valid concern are proposing a revised outpatient case mix methodology to be used for the ROC. This methodology will provide partial weight for subsequent significant procedure APGs as follows:

The case weight will be based on 100 percent of the singleton weight for the highest weight APG, 65 percent of the singleton weight for the second highest weight APG, and 65 percent of the singleton weight for the third highest weight APG[7]. The resulting case mix index would be used in the February, 2009 ROC.

Indirect Medical Education (IME) The Commission has long recognized that a hospital's teaching mission adds some costs that need to be accounted for, if a fair comparison across hospitals is to be conducted. Some of these costs, such as the salaries of residents, can be readily quantified, and these direct costs are discussed below. In addition, the Commission recognizes that other costs associated with a teaching mission are not so easily measured. These indirect costs[8] need to be accounted for in the ROC. In the previous ROC the Commission used a regression analysis to arrive at an estimate of the impact of IME on teaching hospitals.

As in the past, the IME adjustment for the ROC was a source of considerable discussion. Part of this is due to the use of regression analysis as a tool to measure the IME effect. It is the nature of a regression that when there are a limited number of observations (such as 47 Maryland hospitals) only a limited number of variables can be tested, and those variables may end up capturing other, unrelated, effects.

Several participants in the workgroup argued that the methodology used to estimate IME for the previous ROC would result in an adjustment that would be too large, i.e., it would attribute more cost to a hospital's teaching mission than was appropriate. One source of this problem is the fact that many teaching hospitals are in urban settings and tend to serve more disadvantaged patients. A portion of the IME estimate was therefore, likely to be a measurement of services to this disadvantaged population.

---

[7] It is also staff's plan to revise the CPV methodology for the upcoming rate year to reflect this more refined approach to outpatient case mix. Assuming this change, future ROC analyses will not require that this additional case mix modification be made.

[8] The Commission is not alone in its recognition of the added costs associated with a hospital's teaching mission. The Medicare Prospective PaymentSsystem (PPS) has included an adjustment for teaching since its inception in 1982.

Disproportionate Share (DSH) adjustment. The Commission has a history of making what it calls a disproportionate share adjustment to account for the additional resource needs associated with treating large shares poor, high need patients. [9]The purpose of this adjustment is to account for additional costs (additional discharge planning, social work staff, etc) that hospitals treating a poorer population may incur. At different times in the past, the Commission has used a regression analysis a variable for the share of hospital charges to Medicaid patients to measure this burden. In ROC analyses prior to 2005 however, this adjustment had ceased to have any statistical validity, or worse, produced results that were illogical. For these reasons, the DSH adjustment was dropped from the calculation of the ROC.[10]

During the course of this year's ROC review analysis by staff, the teaching hospital group and the G-9 (non-teaching hospitals) have shown that regression analyses that adjust for teaching status and include a measure of the level of poor served by the hospital are statistically significant and logically consistent.[11] Staff strongly believes that a DSH adjustment should be reintroduced to the ROC with the IME adjustment. This adjustment is especially important, as staff hold that without a DSH adjustment the allowance for IME calculated by a regression will overstate the IME effect and distort the ROC comparisons.

STAFF RECOMMENDATION: INCLUDE REGRESSION BASED ADJUSTMENTS FOR IME AND DSH IN THE ROC ANALYSES The ROC should include adjustments for IME and DSH. These adjustments should be calculated via a regression analysis that introduces teaching intensity and high need share as separate independent variables. The measures used for teaching intensity and high need share have a substantial impact on the ROC. Staff recommends that these variables be calculated as follows:

- *Teaching intensity.* Teaching intensity will be measured by the number of trainees (residents and fellows) per risk adjusted discharge. For the ROC, a resident or fellow is defined as someone who is actively enrolled in an Accreditation Council for Graduate Medical Education (ACGME) accredited training program (the number not to exceed the limit set by ACGME), and who is actively engaged in patient care at the hospital (either inpatient or in a hospital based clinic) on the first Tuesday after Labor Day. This measure of teaching intensity differs significantly from the one used in earlier ROC analyses. Those analyses used a resident per bed ratio, where residents were limited to those who had not yet finished a residency (e.g. physicians in sub-specialty programs were not counted). Staff believes that this earlier approach was

[9] Disproportionate Share Hospitals (DSH) is a term used by the federal Medicaid program to allow for specific payment arrangements by state Medicaid programs. The Commission's rate setting process largely eliminates such payment arrangements in Maryland, and the Commission's use of the term DSH should not be confused with the federal Medicaid policy.
[10] No DSH adjustment was made in the Spring 2008 ROC.
[11] There are several possible reasons why estimates of a DSH effect are statistically valid using current data, including: the blended CCT is a better basis for comparing hospital charges than inpatient alone; or, the variable to measure teaching intensity is different from previous ROC analyses.

incorrect as it artificially limited the number of individuals involved in medical training (especially at the Academic Medical Centers) and had the effect of overweighting the IME effect of each resident.

- *High need share.* The high need share will be calculated as the percentage of a hospitals included charges accounted for by the following groups: inpatient and outpatient charges for individuals where Medicaid is the primary payer; inpatient and outpatient charges for individuals where self pay or charity care is the primary payer; and, inpatient charges where Medicare is the primary payer and Medicaid is the secondary payer.[12]

Minor Adjustments

Adjustment for Direct Medical Expenses: The current methodology uses a calculation to determine the cost of residents and then removes 75 percent of these costs from hospital revenue when calculating the ROC. There has been discussion as to whether the amount of revenue adjusted for should be increased to 100 percent and the calculation revisited. This issue directly bears on the IME discussion. Direct medical costs that are stripped will not be accounted for in an IME methodology and, conversely, direct medical costs that are not stripped will be picked up by an IME methodology.

Adjustment for Property and Sales Taxes. All but one Maryland hospital is a not-for-profit and therefore not subject to property and sales taxes. Southern Maryland Hospital Center is a for profit institution and therefore is subject to two unavoidable costs that the remainder of Maryland hospitals are not. Staff recommends that these specific costs be removed from Southern Maryland's revenue base as a direct strip.

STAFF RECOMMENDATION: THE DIRECT COST PER RESIDENT SHOULD CALCULATED AND 100 PERCENT THOSE COSTS REMOVED FROM A HOSPITAL'S CHARGES WHEN CALCULATING THE ROC.

Labor Market Adjustment. Each year the Commission gathers data from hospitals on the cost of various personnel categories in the hospital and the zip codes in which staff live. This data is then analyzed to create a labor market index that accounts for differing personnel costs the hospital faces.

STAFF RECOMMENDATION. THERE SHOULD BE NO CHANGE TO THE CALCULATION OR USE OF THE LABOR MARKET INDEX.

Adjustment for Capital In the 2005 ROC, a capital adjustment was the final step in the ROC, performed after hospital charges had been adjusted for Indirect Medical Expenses. The adjustment takes hospital capital costs (interest, depreciation, and certain leases) as reported on the hospital's ACS schedule of the annual report as a percentage of reported total costs. The hospital ROC charges are then adjusted by taking the sum of one half the

[12] Including Medicaid as secondary payer this measure captures poor elderly individuals who have Medicare as the primary payer.

hospitals capital costs plus one half of the hospital's peer group average capital costs. The effect of this adjustment is to improve a hospital's relative position on the ROC at the beginning of its capital cycle when capital costs are high, and, conversely, a hospital with low capital costs would see its ROC position deteriorate.

During the ROC review staff raised questions as to whether any capital adjustment was needed to compare hospitals under the ROC. Staff argued that hospitals should manage their capital cycle as they manage other costs. Under this reasoning, capital costs are but one, relatively small element of a hospital's costs within the control of the hospital.

Others in the workgroup held that a capital adjustment was necessary to maintain consistency between the ROC methodology, which compares hospital relative efficiency, and the ICC, which is used to determine rate adjustments for specific hospitals. Since the Commission has a process to adjust rates specifically for changes in capital costs (Partial Rate Reviews for Capital) it is possible that were it not for the capital adjustment, a hospital that was given an upward rate adjustment under the ICC process could subsequently see its rates reduced due to poor performance on the ROC.

STAFF RECOMMENDATION: CREATE AND APPLY A STATEWIDE CAPITAL ADJUSTMENT IN THE ROC Staff recommends that the ROC continue to have a capital adjustment but that the method and order of the adjustment be modified. The capital adjustment should be an index that is created by the sum of one half the hospital's capital costs plus one half of the statewide average capital cost. In the ROC process, all adjustments are either hospital specific or based on statewide analysis. The peer group specific capital adjustment is inconsistent with the rest of the methodology. Furthermore, the capital adjustment should be made prior to doing the regression analysis to estimate the IME and DSH adjustments. The ROC methodology is a series of adjustments that, in the end, lead to an adjusted charge per case number for each hospital that is used to compare the relative efficiency of hospitals. In such an analysis, the order of operation influences the results. The mechanics of regression are such that any effect (such as capital) that is not measured or accounted for will, to some extent, be captured by what is measured, i.e., if the capital adjustment is done after the regression adjustment for IME and DSH, the capital effect is double counted.

Staff also feels that the how capital is handled for the ROC and for partial rate applications needs to be carefully reviewed. A high priority for staff in the coming year will be to review how capital is handled in the ROC and whether a partial rate reviews for capital are still a necessary part of the rate setting system.

Comparing Hospitals.

Peer Groups The current ROC analysis compares hospitals against one and other in one of five distinct 'peer groups.' These peer groups match hospitals according to several factors (size, location, etc) and are intended to assure the ROC goal of a like-to-like comparison. The peer groups have long been used by the Commission for it ROC and ICC processes. The original need for the peer groups was that the tools that the Commission had to compare hospital were not sufficient to capture the differing

circumstances of all hospitals. The average charge of different peer groups could be quite different.

The use of the APR-DRG system substantially improves the Commission's ability to measure the relative differences in hospital case mix.[13] Likewise, the DSH adjustment proposed earlier accounts for other difference in patient characteristics that can drive hospital costs. One result of these and other ROC adjustments is the difference in the average adjusted charge among peer groups is relatively small. During the workgroup discussions two points were made regarding peer groups. First, if the variation in peer group average is small does analysis by peer groups serve any purpose? A second point made the G-9 (a group of non-teaching hospitals) was that these small variations in peer group means were, in fact, unfair as they held some hospitals to a lower adjusted charge standard than other hospitals in a different peer groups. Some in the workgroup argued that peer groups remain necessary as they continue to account for some unmeasureable variation among hospitals that is not accounted for in the ROC analysis.

STAFF RECOMMENDATION: THE UPCOMING ROC ANALYSIS SHOULD CONTINUE TO BE DONE ON A PEER GROUP BASIS, BUT THAT THE ISSUE OF PEER GROUPS SHOULD BE REVIEW IN THE COMING YEAR AND THE OPTION OF NO LONGER USING PEER GROUPS BE SERIOUSLY CONSIDERED. Staff is very skeptical about the continued utility of peer groups for the ROC process. Staff feels that with the improvements in case mix measurement and the accounting for DSH the major reasons for the creation of peer groups has been addressed. Staff will engage in discussion and analysis with the industry and payers to assess whether the ROC should be conducted on statewide basis, or whether an alternative from the current grouping is more appropriate.

ICC and Implementation Issues

These issues relate to how the ROC is applied and the actions the Commission may take based upon the results of the ROC. These issues are not methodological, but rather pertain to the application of the ROC and its results.

Scaling and Spenddowns One likely effect of the ROC moratorium that has been in effect since 2005 is that the differences among hospitals as determined by the ROC analysis are likely to have increased. This is likely due to two factors: first, the APR-DRG system may have identified case mix differences among hospitals that the earlier less precise DRG system did not; and, second, the moratorium means that for four years the Commission took no actions (aside from the limited ROC in January 2008) to adjust the rates of hospitals that were falling less in line with their peers. An early concern of the workgroup was that a revised methodology could lead to spenddown orders of a magnitude that would be extremely difficult for hospitals to comply with. As an alternative to spenddowns the workgroup discussed the use of scaling, whereby a hospital's yearly rate update is adjusted up or down depending on the outcome of the ROC.

[13] Unmeasured patient severity was consistently cited as one of the factors that required hospitals to be grouped by peer group.

STAFF RECOMMENDATION: THE COMMISSION SHOULD IMPOSE NO SPENDDOWNS BASED ON THE 2009 ROC, BUT IT SHOULD INSTEAD SCALE THE FY 2010 UPDATE FACTOR. Staff recommends that there be no spenddowns based upon for the upcoming ROC. This recommendation only applies to 2009 ROC analysis. Based on the results of that ROC, staff proposes that the Rate Year 2010 update include a scaling methodology based on the hospital's position on the ROC. The use of spenddowns and scaling in later years is still to be determined.

The MHA has proposed a scaling methodology that is a revision of staff's January 14, 2009 recommendation. Staff agrees that the MHA proposal is reasonable and achieves the same ends as the earlier proposal. There staff recommends that the scaling methodology should apply according to the following parameters:

- Upper and lower bounds of scaling. The scaling should apply to the top and bottom hospital quartiles. Hospital's whose ROC position placed them in either the highest or lowest quartile will be subject to a scaling adjustment. Hospitals in the highest and lowest deciles will be should be subject to the maximum scaling reward or penalty.
- Relationship of scaling to the rate update factor. The highest reward or penalty should be 33percent of the base update factor.
- Scaling should be continuous. MHA proposed two level of either positive or negative scaling between the upper and lower bounds. Staff feels that the differentials between those "notches" is too great - 0.9% in the MHA example. Such a large differential effect among hospitals that have almost identical results has two problems: first it is inequitable; and, second, it will inevitably lead to contentious disputes between hospitals and Commission staff. Staff recommends that continuous scaling be applied between the 75th and 90th percentiles.

Annual vs. semi-annual ROC/ICC Historically, the Commission has conducted the ROC twice a year. This twice a year schedule allowed for new information to be accounted for and appropriate actions to be taken. During the review process hospitals have suggested that a single annual ROC may be an appropriate schedule.

STAFF RECOMMENDATION: THERE SHOULD ONLY BE A SINGLE ROC ANALYSIS CONDUCTED IN 2009 Since the Staff is recommending that no spenddowns be imposed based on this ROC, and that a scaling methodology be applied to the update factor, there is no need to conduct a semi-annual ROC in the upcoming year. Staff further recommends that there continue to be discussions with payer and the industry in the coming year to consider the most appropriate schedule for the ROC analysis and action based on that analysis.

Intergrating the ROC and the ICC The ROC analysis determines hospital position relative to one another. The ICC is the process that the Commission uses to determine the exact magnitude of any rate adjustment that may result from the ROC. It is therefore, important that these processes are integrated to give consistent results. Some of the revisions to the ROC methodology require adjustments to the current ICC methods to maintain consistency.

STAFF RECOMMENDATION: CONTINUE TO WORK WITH THE INDUSTRY AND PAYERS TO ADDRESS ISSUES RELATED TO THE INTEGRATION OF THE ROC AND THE ICC.

SUMMARY OF RECOMMENDATIONS

Establishing hospital baseline charges

- Continue to use the current trim points.
- Blend the CPC and CPV into a single comprehensive charge target (CCT).

ROC adjustments

Major adjustments

- Combine inpatient and outpatient case mix indexes into a single adjustment.
- Include regression based adjustments for IME and DSH in the ROC analyses.

Minor adjustments

- The direct cost per resident should calculated and 100 percent those costs removed from a hospital's charges when calculating the ROC.
- There should be no change to the calculation or use of the labor market index.
- Create and apply a statewide capital adjustment in the ROC.

Comparing hospitals

- The upcoming ROC analysis should continue to be done on a peer group basis, but peer groups should be reviewed in the coming year and the option of no longer using peer groups should be seriously considered.

Implementation issues

- The commission should impose no spenddowns based on the upcoming ROC, but it should instead scale the FY 2010 update factor.
- There should only be a singly ROC analysis conducted in 2009.
- Work with the industry and payers to address issues related to the integration of the ROC and the ICC.

Maryland
Hospital Association

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

January 23, 2009

Sent via e-mail. Hard copy to follow.

John O'Brien
Deputy Director, Research and Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. O'Brien:

On behalf our 47 acute care hospital members, thank you for the opportunity to comment on the proposed changes to the Interhospital Cost Comparison and Reasonableness of Charges (ICC/ROC) methodologies. We appreciate the work that has gone into this year's review.

The changes being proposed represent the culmination of methodology revisions that began over five years ago. Severity-based grouping, hospital-specific relative-value case weights, and hospital-specific All Patient Refined Diagnosis Related Group (APR-DRG) severity level specific trim points were the starting point of this effort. By developing new adjustments for indirect medical education and disproportionate share, the Health Services Cost Review Commission (HSCRC) continues to make strides towards keeping the goal of equity in mind. We hope this process will continue.

While we remain silent on the nature of the proposed adjustments, our comments focus on two things: 1) ICC revision and 2) scaling in lieu of spenddowns.

First, the changes being proposed to the ROC, particularly the incorporation of outpatient revenue, necessitate a look at the ICC methodologies. Several major technical issues will need to be resolved, and we believe this is an opportunity to look at the standards within the ICC that historically have been set at restrictive levels. ***We ask that the HSCRC staff, with hospital participation, undertake an equally rigorous process to review and propose changes to the ICC and consider both technical and policy issues. Specifically, we continue to advocate that the HSCRC's operating margin target be added back after the profit strip, and that the productivity factor be changed to one percent.***

Second, we agree with the staff recommendation to forego spenddowns, given the large disparities within groups in ROC positions. ***We support scaling as a method for recognizing hospitals for their efficiency, both positive and negative, in lieu of spenddowns***. However, we propose a slightly different method for developing the scaling thresholds. By definition, standard deviations will be smaller as more and more accurate adjustments are developed and used.

- more -

Therefore, we believe that a standard deviation-based approach to calculating thresholds for scaling would over-identify hospitals for adjustments. Instead, we recommend the thresholds be developed based on quartiles. Under this approach, hospitals at the bottom and top quartiles would be scaled, with hospitals in the bottom and top deciles receiving the maximum scaling adjustments. We would be happy to share our calculations and simulations.

Thank you again for the opportunity to comment. As always, I look forward to working with you on this issue and others critical to the integrity of Maryland's hospital rate-setting system.

Sincerely,

Ing-Jye Cheng
Assistant Vice President

Attachment

To: Chairman Donald A. Young

From: Paul Nicholson, VP CFO

Date: February 25, 2009

RE Support of new ICC/ROC Methodology Proposal

On behalf of Washington Adventist Hospital in Takoma Park, I would like to thank John O'Brien and the HSCRC staff for their leadership and hard work on this year's proposed changes to the ICC/ROC methodology. The staff along with Mr. O'Brien led a thorough process that allowed many long standing issues to be addressed. The ICC/ROC workgroup's agenda took into account factual information and related arguments from many sides and came up with a process that was open and collaborative.

Continuous scaling represents a balanced effect on hospitals, limiting severe rate reductions at community hospitals and providing rate relief to the "stuck" hospitals. I am concerned that spend downs under the previous methodology were inequitable to the non-teaching hospitals.

The inclusion of a DSH adjustment is a significant step towards fairness for non-teaching hospitals that have a considerable proportion of indigent patients. In the years since DSH was excluded from the methodology, the costs associated with these patients were a residual captured by the IME regression and mischaracterized as IME. Because only teaching hospitals were given a ROC adjustment for these costs, the non-teaching hospitals were left without recognition of their poor share patients.

Counting of all the residents and using the statistic of residents per severity weighted discharge more accurately reflect the IME cost of care in teaching hospitals. This is especially true when comparing our two large academic medical centers with other smaller community based teaching programs.

As a member of Adventist HealthCare and the G-9, I will continue to work with the Commission staff and the MHA on issues that will lead to a more fair and transparent system. We support the staff's willingness to discuss the continued use of the ICGs. We are also very concerned about the ever increasing costs of physician coverage that non-teaching hospitals have to carry. Thank you for the opportunity to comment on the staff recommendations and I thank the staff for their thoughtful approach to the reformulation of the ICC/ROC methodology.

February 26, 2009

John O'Brien
Deputy Director for Research and Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear John:

The purpose of this letter is to offer our comments on the staff recommendation "Draft Recommendations of Revisions to the Reasonableness of Charges (ROC) Analysis," presented to the Commission at the January 14, 2009 meeting. Generally, we support the approach proposed by the staff. However, we would like to take this opportunity to voice additional supporting explanations for some recommendations and to note our reservations on some other points discussed in the document. In this letter, we will address the issues for which our group has reached a consensus. For other issues, each hospital will present its own position separately.

The first recommendation calls for the continued used of the current trim points in the CPC methodology. We believe this methodology brought unnecessary complication to the system. Given that it is in place and the system is now calibrated to operate under these outlier rules, however, we concur with the staff that the benefit of changing the policy is not worth the cost. However, we do not agree with the staff's assertion that changes can be made in the future to these trim points without a reconsideration of the IME regression. In these workgroup discussions, we have demonstrated that changes in the outlier definitions changes the amount of revenue at risk under the CPC targets and therefore the size of the IME adjustment. If future changes are made to the outlier policy, the effect on the IME adjustment will need to be considered to avoid misalignments in the IME policy.

The second recommendation proposes a blend of the CPC and CPV targets into a single comprehensive target that will be subject to the Reasonableness of Charges analysis, and the third recommendation proposes a methodology for combining inpatient and outpatient case mix indexes into a single adjustment. We believe that this CPC-CPV blend is a logical extension of the ROC analysis and that the proposed case mix blend preserves the intent of a refined case mix adjustment system. The proposed method gives full credit for a singleton outpatient procedure and the second and third procedures in the visit each receive 65 percent of the singleton weight. Further procedures would not be given any credit. To capture differences in relative resource use, the recognition of secondary procedures for an outpatient visit makes the case mix measure more refined and better captures relative resource use.

While the staff has developed a logical approach to combining inpatient and outpatient CPC/CPV data as they currently exist, this methodology should be monitored closely for unintended consequences. This is a new policy, and there remain concerns regarding the

integrity of the of the outpatient data. It is also important to monitor the case mix measurement around the inclusion of secondary procedures to be sure that the inclusion of only two secondary procedures at 65 percent of their singleton weight captures differences in resource utilization across facilities appropriately.

In the fourth recommendation, the staff proposes a regression-based approach to determine an adjustment for indirect medical education and disproportionate share. The staff proposes an expanded measure for teaching programs and a new measure for disproportionate share. In the past, the HSCRC has measured IME from a regression model that measured teaching based on the number of qualified residents at the facility per occupied bed. Qualified residents were included up to the cap approved for the program. Hence, the IME measure in the regression had captured cost variations across programs and attributed them to differences in the number of capped residents who qualified under HSCRC rules. However, costs included the entire cost of the hospital's teaching effort. These costs were therefore spread over too few residents, making the IME adjustment larger than it would otherwise be.

Clearly the costs of the teaching effort are not limited to the approved residents and the cap imposed under HSCRC policy. Including residents and fellows engaged in patient care better represents the relative size of the teaching programs and allocates the costs per resident more accurately. (While the Commission has not recognized fellows in the past, the Medicare program has given credit for fellows as part of its IME adjustment) Likewise, removing 100 percent of direct teaching costs prior to the regression estimation removes these costs for the IME adjustment and attributes them directly to the facility incurring the costs, a more accurate reflection of the resource use within the system. We would ask that the staff clarify in its proposal how residents and fellows would be addressed if a hospital opens a new program.

While we concur with the staff proposal for the IME adjustment, particularly the revision of the teaching measure, we have two specific concerns around the details of its implementation. Our first concern relates to the method the staff has adopted for the DME adjustment. In its modeling, the staff has altered the method from the statewide average cost per resident by specialty to using the actual costs from the P4 and P5 schedules of the annual filing. While this sounds like a logical, straightforward choice, it masks a number of policy issues as well. The instructions for the P4 and P5 schedules are vague in regards to the inclusion of only ACGME residents and do not address the inclusion of fellows. As a result it is unclear whether reporting for fellows is consistent from one hospital to the next. Further, the data on the schedules may include both ACGME approved and unapproved residents and fellows, and there is no method in the current data collection instrument to separate approved positions from those that are not approved. Finally, hospitals were given a brief period to revise these data for the staff's policy simulations. The limited timeframe for revision and assessment of these schedules calls into question the accuracy of the results of the staff's simulations. We are not opposed to the concept of using the P4 and P5 schedules for the DME adjustment, but at this juncture, the quality of the data is suspect. We propose maintaining the DME calculation as calculated under existing policy.

Another concern relates to the shortened time frame for analyzing the disproportionate share measure and potential alternatives. DSH measures have shown a high degree of instability over time. Further, the high degree of correlation between variables combined with a limited number of observations in the State make precise estimates of these relationships difficult. We believe that the DSH measure deserves further consideration in the future as we gain further experience with this new ROC methodology.

The teaching group also supports the Maryland Hospital Association's position regarding the staff recommendations as outline in its letter dated January 23, 2009.

As of the date of this letter we are unable to reconcile to the Staff's ROC results. Prior to a final ROC being issued any variances between our ROC calculations and the Staff's ROC calculations need to be resolved.

We appreciate the opportunity to comment on this recommendation and to have participated in the discussions leading to this recommendation. Generally, we congratulate the staff on this policy. It reflects a variety of interests in a complex policy context. The staff is to be commended for an open and balanced process, and we look forward to expressing our views in any continuing discussions around this policy.

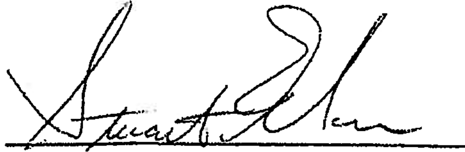
Sincerely,

The Teaching Hospital Group
(signatures on following page)

Feb 25, 2009

Eric Melchior
Executive Vice President and CFO
Greater Baltimore Medical Center

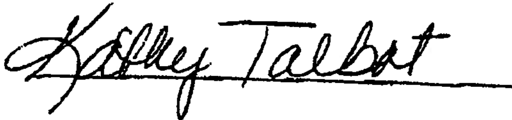
Date



2/25/09

Stuart Erdman
Senior Director Finance
Johns Hopkins Health System

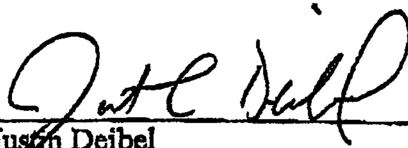
Date



2/25/09

Kathy Talbot
Vice President Rate and Reimbursement
MedStar Health

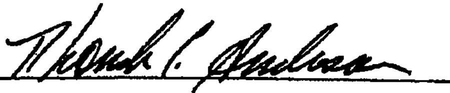
Date



2/26/09

Justin Deibel
Mercy Medical Center
Vice President, Clinical Economics

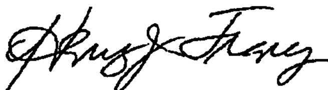
Date



2/23/09

Rhonda Anderson
Senior Vice President and CFO
St. Agnes Hospital

Date



2/26/09

Henry J. Franey
Senior Vice President &
Chief Financial Officer
University of Maryland Medical System

Date

Department of Finance
Mason F. Lord. Center Tower, Suite 2200
Johns Hopkins Bayview Campus
5200 Eastern Avenue
Baltimore, MD 21224

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

February 26, 2009

Dear John:

The purpose of this letter is to express our concerns over recent decisions regarding the Reasonableness of Charges (ROC) analyses and the policy changes that are under review. As you know, we have participated in the process with the other teaching hospitals in the State, and we have attempted to offer suggestions and analyses in good faith to achieve a stable, reliable ROC methodology. As the Commission staff made its recommendation to the Commission, we thought we had achieved that goal. As the staff has made its preliminary results available for review, however, we are discovering a number of differences between the results of our modeling and the staff's results.

First, we have been unable to reconcile our results with the preliminary ROC. While we have attempted to work through these details, it has become clear to us that the staff has changed the ROC calculation substantially. While the calculations have been characterized as "technical details," these details matter. We modeled proposed policy changes under the expectation that the ROC calculation would follow established methods. Now we are learning that the staff has changed some calculations substantially from the method used during the workgroup discussions.

The disproportionate share adjustment (DSH) is an important example of these changes. As the DSH was included in the regression, we presented results to the workgroup that modeled DSH in the same manner as the IME adjustment. The results were applied as a deviation from the statewide mean value, and revenue neutrality was applied. Whether this is the best method for this calculation was never discussed by the group. The staff's change in the calculation is a material departure from the good-faith discussions pursued in the ROC/ICC workgroup. Furthermore, it is a departure from the method that has been used by the Commission historically. The deviation-from-the-mean approach was used in the screening methodology which predated the current ROC analysis. While these changes may be technical, they result in substantial shifts in ROC position that were not contemplated in the workgroup discussions. To change the calculation without open discussions and analysis violates the spirit of cooperation that was part of the workgroup meetings. We strongly object to what can only be seen as an arbitrary, last-minute change in implementing the proposed policy.

A similar issue arises with the method for calculating the direct medical education (DME) adjustment. The Commission has used statewide average costs for residents to calculate the DME adjustment. There are two important policy benefits to this approach. First, hospitals cannot pass through resident costs if they pay more than the statewide average. Second, hospitals with relatively low costs are rewarded for their efficiency in providing educational services. Both of these benefits have been discarded, however, in the staff's current ROC calculation. To calculate the DME adjustment now, the staff plans to use the actual costs from hospitals P4 and P5 schedules from the annual report.

The use of actual costs instead of the statewide average loses both of the benefits mentioned above. Furthermore, this issue was not discussed in the workgroup meetings. Again, it is being imposed at the last minute as a technical adjustment. Again, we object to these changes and their last-minute nature.

Finally, we would like to note a final concern around the staff's proposed scaling methodology. While we endorse the idea of using scaling to realign industry revenue, we are concerned that in the process of scaling, hospitals should receive at least the projected cost increases for the coming year under the Global Insights forecast. While the Commission's methodologies are designed to realign revenue within the industry, the costs of covering hospital operations and capital investments are concerns for the State's hospitals, and the limited access to capital markets have added to the pressure to generate funds through operations. Having the update factor cover costs is vital in these economic times.

We appreciate your consideration of these matters.

Sincerely,

Ed Beranek

MEDICAL CENTER

A University Affiliated Center Conducted by the Sisters of Mercy

February 26, 2009

John O'Brien
Deputy Director for Research and Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear John:

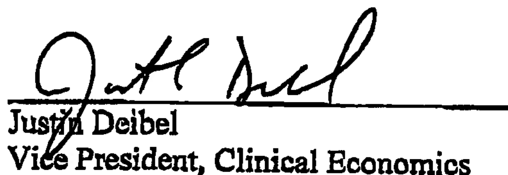
The purpose of this letter is to offer comments on behalf of Mercy Medical Center related to the staff's proposal for updates to Reasonableness of Charges (ROC) methodologies. Generally, we support the recommendations made by the teaching hospital group and the Maryland Hospital Association. In addition, we generally support the approach proposed by the staff. However, I would like to make a few quick points about the data for your consideration.

Staff is recommending a direct adjustment for medical education (DME) using the actual costs from the P4 and P5 schedules of the annual filing. Mercy feels strongly that this data is untested and not consistently reported among hospitals. Providing hospitals their own actual expense creates perverse incentives related to pass-throughs, a topic that has been hotly debated in the past. This proposed change in policy has not been discussed thoroughly in our industry meetings, so we cannot support it at this time. We are not necessarily opposed to the concept of using the P4 and P5 schedules for the DME adjustment, but further analysis needs to be done before making the change. Therefore, we propose maintaining the DME calculation from the existing policy.

Historically, Mercy has advocated strongly for a disproportionate share adjustment (DSH), and we continue to feel it is a necessary adjustment. The DSH calculation proposed by the HSCRC is a good starting point, but we would like to see additional analysis of the variables and the application prior to future ROC releases. The variables have shown instability over time and the method used to apply the adjustment can sway results significantly. We recommend the HSCRC move forward with a DSH adjustment while leaving the methodology open to future refinement.

We appreciate the opportunity to comment and would be happy to discuss these issues further.

Sincerely,



Justin Deibel
Vice President, Clinical Economics

2/26/09
Date

301 St. Paul Place · Baltimore, Maryland 21202-2165 · (410) 332-9000

Civista Medical Center
5 Garrett Ave.
P.O. Box 1070
La Plata, Maryland 20646-1070

301.609.4000 Phone

February 25, 2009

Dear Chairman Young,

This letter represents the position of Civista Health, Inc., a hospital affiliated with the G-9 hospital group, relative to the changes recommended by the HSCRC staff in connection with the ICC/ROC methodology.

We believe that the HSCRC staff, under the leadership of Mr. O'Brien, worked effectively in organizing, overseeing, and evaluating the deliberative process that led to the staff's recommendations. Our group, the G-9, and a 17 hospital group (the 17 Hospital Group) that included the two academic medical centers (AMCs) provided competing recommendations. Each group was given ample time to make its case and the staff, supported by its consultants, made thoughtful evaluations of the cases presented. In more than one instance the staff – correctly in our view – expanded the ICC/ROC workgroup's agenda to account for factual information and related arguments that had a bearing on the course of the deliberations.

The HSCRC staff did, however, exclude from the workgroup's agenda some issues that are critical to the community hospitals, including the reformulation of the interhospital comparison groups (ICGs). Our understanding that the ICGs would be maintained in the 2009 ROC influenced our positions on the three key recommendations of the staff; we discuss each of the positions in the following sections.

Spenddowns versus Scaling:

One weakness of the proposals from the 17 Hospital Group was that it placed a highly disproportionate number of non-teaching hospitals on spenddown, while providing no rate relief for the "stuck" hospitals that were evaluated as highly efficient under the ICC/ROC system. Within the context of the Workgroup's deliberations, including the maintenance of the prior ICG scheme, the inequitable treatment of the non-teaching hospitals under the rules governing spenddowns appeared unavoidable.

Faced with this dilemma, the staff chose to waive spenddowns in FY 2010, in favor of scaling and to request that the MHA recommend a scaling approach. The approach proposed by the MHA had a far more balanced effect on the hospitals, limiting the rate reductions of the "high cost" community hospitals and providing some rate relief to the "stuck" hospitals. Pursuant to a critique of Mr. Murray, the MHA's proposal was modified so that it became continuous, meaning that hospitals that were of approximately the same

Civista Medical Center
5 Garrett Ave.
P.O. Box 1070
La Plata, Maryland 20646-1070
301.609.4000 Phone

level of efficiency under the ROC evaluation would receive approximately the same level of scaling adjustment.

We support the staff's acknowledgement that the application of the prior spenddown methodology was inequitable to the non-teaching hospitals, the staff's decision to waive spenddowns in FY 2010, and the proposed approach to scaling, whereby it is required to be continuous.

ICGs and DSH Expenditures:

As we noted above, the staff had opted to postpone the reformulation of the ICGs until the next round of ICC/ROC policy deliberations. However, even with the elimination of spenddowns in FY 2010, the ICG scheme resulted in the inequitable treatment of certain hospitals through the operation of the scaling adjustments. In particular, with a reasonable IME allowance per resident, the Urban 1 hospitals had an average adjusted charge per case that was approximately 10 percent above the Suburban and Rural 1 average. This meant that the scaling threshold (the rate level that would trigger scaling reductions) for, say, Mercy hospital was 10 percent above the scaling threshold for, say, St. Agnes hospital.

To alleviate the inequitable effect of the ICGs, the staff elected to adopt a recommendation of the G-9 whereby an additional independent variable measuring each hospital's burden of indigent patients would be included in the IME regression. The resulting DSH adjustment would then be included in the interhospital comparisons used to determine the scaling adjustments.

We support the staff's decision to consider a DSH adjustment in the ROC, to derive it as a part of an IME/DSH regression, and to measure the hospital's burden of indigent patients in accordance with its current recommendation.

The IME Allowances:

Historically, the methodology for calculating the IME allowances had been controversial for three (3) reasons. First the IME allowance levels were excessive when measured against the MedPac estimates. Second, the IME allowances increased at a rate well beyond the HSCRC's general inflation allowances. Finally, the IME allowances were essentially determined by the differential adjusted costs per case of the AMCs. This meant that as the AMCs' costs per case rose disproportionately, the differential increases would largely be classified as IME, producing a pass-through of the AMCs' costs.

We believe than an IME (or IME/DSH) methodology must meet two tests. The IME allowance per resident should be in line with the MedPac estimates; otherwise there is no assurance that the IME allowances are reasonable. In addition, the methodology should

Civista Medical Center
5 Garrett Ave.
P.O. Box 1070
La Plata, Maryland 20646-1070

301.609.4000 Phone

operate so that the pass-through feature of the previous methodologies is limited to the maximum extent possible; otherwise the differential cost increases of the AMCs will increase the IME allowance to the detriment of the non-teaching hospitals.

Two IME methodologies appeared to result in IME allowances per resident that were in line with the MedPac estimates, a proposal by the 17 Hospital Group and a staff approach (the Total Resident Approach). In the Total Resident Approach the size of each hospital's teaching program would be based on its total residents including fellows, rather than on its "qualified residents" as previously defined by the HSCRC.

For most hospitals there is only a small difference between the total residents and the qualified residents; in fact, there is usually no difference. However, each of the AMCs has a large number of fellows and other non-qualified residents. Therefore since the aggregate amount of the AMCs' IME allowances are largely fixed, independent of the measure of the size of their teaching programs, the addition of a large number of residents to the resident count reduced the IME costs per resident of the AMCs. Since the AMCs essentially determine the IME regression's allowances, the reduction in the AMCs' costs per resident resulted in a commensurate reduction in the IME allowance per resident.

We support the IME methodology because the derived IME allowance per resident ($258,000) appears to be in line with the MedPac estimates. We would suggest that the updated IME allowances for FY 2010 should be limited to the currently derived allowances increased by the HSCRC FY 2010 annual allowance. This limitation will ensure that the AMC pass through effect described above does not cause the allowances to spike in FY 2010.

We thank you for the opportunity to comment on the staff recommendations and we thank the staff for their thoughtful and resilient approach to the reformulation of the ICC/ROC methodology.

Yours truly,

Noel A. Cervino, Interim Chief Executive Officer

Hal Cohen, Inc.
Health Care Consulting
17 Warren Road, 13B
Baltimore, Maryland 21208
(410) 602-1696; Fax: (410) 602-1678: e-mail: JandHCohen@AOL.com

February 26, 2009

Don Young, Chairman
Health Services Cost Review Commission
4201 Patterson Avenue
Baltimore, MD 21215

Re: Staff recommendation regarding ICC/ROC and other issues

Dear Don:

I am writing this letter on behalf of CareFirst Blue Cross Blue Shield and Kaiser Permanente.

We would like to thank the staff for conducting a very open and professional process for looking at ICC/ROC and other methodological issues. We are particularly pleased with the addition of the disproportionate share variable and the addition of much outpatient revenue to the ROC. CareFirst and Kaiser Permanente is supportive of most of the recommendations staff is making. We believe many issues warrant revisiting next year. We do, however, propose some changes and want to register some proposals for the future.

Disproportionate Share: As noted above, we are very pleased that DSH was added as a variable. We understand that there is an issue regarding whether DSH should be applied, as previously, as a difference from the statewide mean, or whether DSH should be applied analogous to a strip. We also understand that there is no difference in the results regarding scaling. As a result, while our preference is for the difference from the mean approach, we think it is much more important that the new ROC be approved. Therefore, we recommend that staff recommend what it believes is best, recommend that the Commission adopt the ROC, but have whatever process is appropriate to make a final decision regarding which method to use. While there is little impact between the two methods, either method generates results that are a very significant improvement over the current ROC and we urge the Commission to adopt either one of them.

Peer Groups: We originally recommended doing away with the peer groups and having two peer groups 1) a statewide Peer Group excluding the AMCs; and 2) a national peer group for The Johns Hopkins University and the University of Maryland Medical System. We think it important to develop such a peer group and for staff to get input on the methodology for using such a Peer Group of distinguished AMCs. While, for the most part, we can support staff's delay until next year in examining Peer Groups, we recommend that the small hospital group (Suburban 3) be combined with Suburban 1. The only reason for creating the small hospital group peer group was that diseconomies

of small scale were expected to grant them a higher standard cost per case. In fact, they have a lower standard cost per case. Since this result differs from the basis for creating the group, we suggest eliminating the group.

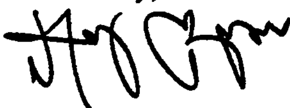
IME: We support one year at the proposed amounts. Any adjustment forward should be based on the Commission's update. We are still concerned by the ratio of high non-teaching to high teaching hospitals (11 – 2). The vast bulk of teaching hospitals are near the mean, while many non-teaching hospitals are quite high and many are quite low. We suspect this is more methodology driven than reality driven.

Scaling and Spenddowns: We made, and staff adopted, an adjustment to the MHA scaling proposal. We support the staff recommendations to not have spenddowns this year and to scale as proposed. We urge the Commission to significantly increase the level of scaling next year and to begin spenddowns after the next round of methodology changes.

Capital: The methodological change of adjusting for capital on the ROC prior to the regression is a sound improvement and we endorse it. However, we raised many issues regarding partials for capital, and, while they were discussed at one meeting, they took a back seat to other issues. We recommend one adjustment this year and that the Commission ask staff to give the Partial for Capital methodology higher priority next year. The partial for capital methodology includes a 1% offset for money included in past updates. We are willing to support the end of this offset if it is timed with the application of the other methodological changes being proposed – including the new ROC. We also would like the Commission to consider a transition to a statewide capital methodology that does not adjust rates for the place on the capital cycle that a particular hospital happens to be. We are not aware of any other industry where prices reflect the capital cycle as they do in Maryland's hospital industry. Given that we already have a 50% statewide standard, a transition of 10 years or less should be acceptable.

Thank you for your consideration.

Yours truly,



Hal Cohen
Consultant

Cc: Bob Murray
John O'Brien
Andy Udom
Ellen Englert
Steve Ports
Stan Lustman

Greg Vasas
Debra Collins

FINAL RECOMMENDATION OF REVISIONS TO THE REASONABLENESS OF CHARGES (ROC) METHODOLOGY

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

March 4, 2009

This document is a final staff recommendation to the Commission at the March 4, 2009 public meeting

INTRODUCTION

Over the past year, staff, working with payer and industry representatives, has engaged in a process to review and revise the Commission's Reasonableness of Charges (ROC) methodology.[1] This draft recommendation proposes a series of changes to the ROC process that are the result of those discussions. The recommended changes to the ROC methodology will be used to calculate a ROC in early February 2009.

BACKGROUND

The Commission's ROC process is intended to allow hospitals to be compared on an equal footing to determine if a hospital's charges are reasonable relative to other peer hospitals in Maryland. A hospital with charges that are too high relative to its peers may be subject to "spend-down" provisions, where its rates are lowered to bring the hospital's charges in line with statewide averages. Conversely, a hospital where charges are low relative its peers may apply to the Commission for a "full rate review" and see rates increased consistent with Commission policies.

The ROC and the accompanying Interhospital Cost Comparison (ICC) are central elements of the Commission's mission to promote cost effective and efficient hospital services in Maryland. In addition to triggering "spenddowns" or permitting hospitals to request "full rate reviews," the ROC also provides feedback to hospitals on their performance relative to their peers. A stable ROC/ICC process is essential if it is to have its intended effect: aligning hospital rates with the resources needed to serve patients efficiently. It is also necessary to provide hospitals with feedback on their positions relative to their peers so that the hospital may take appropriate actions improve their positions.

The ROC analysis, or something similar[2], has been a consistent feature of the Commission's rate setting process. The methods used in the analysis, however, are not static. Changes in Commission policies and practices require the ROC analysis to be revised if it is to compare hospitals fairly.

The ROC process in use in 2005 began with each hospital's approved Charge Per Case (CPC) and made a series of adjustments to arrive at an adjusted CPC. The adjusted CPC was then used to compare hospitals within five defined peer groups. The adjustments were:

- *Mark-up,* the additional charges that each hospital is allowed to bill in order to account for its unique circumstances, including payer mix and the hospital's uncompensated care experience;

[1] The Commission did conduct a limited ROC using the previous (2005 and earlier) methodology in the spring of 2008. As a result three hospitals with adjusted charges well below their peers filed full rate reviews and, consequently, received an upward adjustment in rates. A number of other hospitals were identified as being considerably above the mean of their peers and could have be required to "spenddown. " The Commission chose not to take spenddown action in light of the anticipated comprehensive overhaul of the ROC.

[2] Earlier versions of the ROC process were referred to as the "screens", as each hospitals charges were screened according to a number of parameters.

- *Labor Market Adjustment,* an adjustment to account for varying labor costs that Maryland hospitals are subject to;
- *Hospital Case Mix*, an adjustment to account for the varying resource needs of treating the hospitals' patient populations;
- *Direct Strips*, specific dollar amounts removed from the calculation of the hospital adjusted CPC to adjust for a portion of the costs of resident salaries (DME) and some of the incremental costs of trauma centers;
- *Indirect Medical Education,* an adjustment to account for the differing costs associated with having a teaching mission; and,
- *Capital,* an adjustment to reflect the capital cycle when comparing hospital costs.

Transition to APR-DRGs and Impact on ROC

While all of the adjustments are important to allow hospitals to be compared on an equal footing, they are not all of equal magnitude. The most significant adjustment (in terms of difference between the lowest and largest adjustment) is for hospital case mix. This is to be expected, as the relative patient acuity across hospitals should be the most significant factor in determining the resources needed to treat those patients. Since case mix is such an important factor in the ROC analysis, changes in the methods to measure case mix inevitably lead to changes in the ROC process. Improvements to case mix measurement affects other ROC adjustments that previously captured some case mix variation, requiring that those adjustments be re-examined.

The Commission's conversion from Diagnostic Related Groups (DRGs) to All Patient Refined-Diagnostic Related Groups (APR-DRGs) in 2005 represented a substantial improvement to the Commission's ability to measure hospital case mix accurately. APR-DRGs expand upon the older DRGs by breaking each DRG into 4 severity levels, each of which is then assigned a weight to account for the relative resource use of patients in each APR-DRG cell. As a practical matter, the Commission went from breaking patient care down into roughly 300 resource similar categories to 1200 clinically relevant and resource-similar categories.

The introduction of the APR-DRGs also provided hospitals with a strong incentive to improve the coding of discharge data submitted to the Commission.[3] Since the APR-DRGs more fully account for the resource use of patients based on severity, complete medical record documentation and accurate coding are vital to assuring that a hospital's rates are commensurate with the needs of its patient population. It was common to see hospitals substantially increase depth of coding in the course of a single year. That change however, did not occur in the same pace or at the same time for all hospitals. Finally, the change to APR-DRGs also led to large increases in measured case mix that were not associated with changes in underlying resource use, leading to the imposition of limits in case mix growth (governors).[4]

---

[3] All Maryland hospitals report discharge data on all patients to the HSCRC on a quarterly basis.

[4] The Maryland experience was analyzed by CMS in advance of the introduction of CMS-DRGs and has led to federal provisions to limit case mix growth during the transition to CMS-DRGs.

These changes in the completeness of medical record coding in the years immediately after the introduction of APR-DRGs caused the Commission to place a moratorium on the ROC process (and its attendant spenddowns and full rate reviews). The Commission decided that conducting the ROC analysis was inappropriate, as the measurement of the relative case mix across hospitals (a central adjustment in the ROC process) was not reliable until coding improvement reached a steady state.

Analysis of more recent submissions of hospital discharge data show that the transition in coding practices initiated by the use of APR-DRGs is now complete. In 2005 the percentage of discharges that reported 15 diagnoses was 6 percent, as of the first 6 months of FY2008 discharges that reported 15 or more diagnoses exceeded 20 percent. Furthermore, the depth of coding across hospitals is consistent.

Introduction of Charge Per Visit Methodology

A second major change to the rate setting system since the last ROC process in 2005 is the implementation of the Cost Per Visit (CPV) methodology for outpatient services. As with the Charge Per Case target system that has been in use since 2002, the CPV reflects the hospital's expected charge per outpatient case on a risk adjusted basis, although in this case, the risk adjustment relies on Enhanced Ambulatory Patient Groups (EAPGs). The CPV methodology for outpatient services was approved by the Commission on June 4, 2008.

The CPV methodology uses the FY2008 outpatient data as the baseline to establish CPVs for all Maryland hospitals. Prior to the introduction of the CPV, the Commission set rates for individual units of outpatient services (lab, emergency room, etc.) but did not set an overall, risk adjusted target for the visit that those outpatient services comprised. Without such a target, a ROC process for outpatient services was not possible. Instead, once a hospital's position relative to its peers was determined by using the inpatient based ROC, an assessment of the hospital outpatient charges relative to the statewide median was done prior to imposing spenddowns or considering a hospital for a full rate review.

The introduction of the CPV has provided the Commission with two comprehensive measures: one of inpatient cases; and, one of outpatient visits. It has always been the Commission's intent that outpatient charges should be assessed for their reasonableness as inpatient charges are; with the introduction of the CPV such an assessment is possible.

REVISIONS TO THE ROC METHODOLOGY

The completion of the APR-DRG transition and the implementation of the CPV methodology demanded a thorough review and revision of the ROC process. Toward that end Commission staff, along with payer and industry representatives have engaged in a year-long process to revise and update the ROC methodology. In discussing the recommended changes to the ROC, the workgroup addressed a number of disparate and complex issues. It is useful to group the issues into several broad categories:

- *Baseline Issues* These issues relate to the baseline hospital charges upon which later adjustments are made. The baseline issues addressed were the Commission's trim

point methodology and the blending of the inpatient charge per case and outpatient charge per visit;

- *ROC Adjustments* These are the adjustments are made to a hospital's baseline charge to allow a "like-to-like" comparison of peer hospitals. These can be further broken down into:

  Major Adjustments Adjustments that have a significant impact on a hospitals baseline charges. Major adjustments are: Case Mix, Indirect Medical Education, and Disproportionate Share; and,

  Minor Adjustments While important to assuring a fair comparison across hospitals these adjustments are relatively small. Minor adjustments are; Direct Strips (Direct Medical Education, Trauma Hospitals, Nursing Education), Labor Market, and Capital Adjustments.
- *Comparing Hospitals* This pertains to the peer groups that hospitals are broken into once charges have been adjusted it is a hospitals performance relative to its peer group that determines how the ROC effects that hospital; and,
- *Implementation Issues* These are issues that pertain to how the ROC is applied in the setting of hospital rates. Implementation issues include: the setting of spenddown thresholds and/or scaling; whether to conduct of an annual or semi-annual ROC.

<u>Baseline Issues</u>

The ROC process started with each hospital's allowed CPC. A series of adjustments were then made to the CPC to arrive at an adjusted CPC, which is used as the "like-to-like" comparison. The starting point at which later adjustments are made influences the outcome of the ROC.

Trim Points. Trim points are dollar thresholds[5] at which charges for a specific case are not included in the calculation of a hospital's CPC. The current HSCRC policy sets statistically defined individual trim points for each hospital and for each APR-DRG cell. An alternative trim point policy (which was considered in 2005 when the current trim point methodology was established) would have established a statewide set of trim points for each APR-DRG cell. Staff believes that the current trim point methodology is not the most desirable; it is overly complex - establishing over 100,000 trim point compared with roughly 2,400 for the alternative methodology- and its complexity to does not provide any additional policy benefit.

In addition to its complexity, the trim point methodology also influences the other adjustments that are used in the ROC. At the July 8, 2008 meeting of the ICC/ROC workgroup, the representatives of the teaching hospitals presented analyses that showed that the current trim policy of hospital specific trims had the effect of increasing the ROC adjustment for IME, compared with the alternative of individual APR-DRG trims. This was because the current trims tend to increase the charges included for the calculation of CPCs for teaching hospitals (in particular the Academic Medical Centers). The representatives of the G-9 (non-teaching hospitals) agreed that this would be the effect of such a change to the trim policy. The trim point methodology is therefore, intertwined

[5] Charges above the trim points are essentially 'pass throughs' that payers reimburse as charged; they are not subject to the constraints of the CPC system.

with the IME methodology and influences the results that are obtained from such analysis.

The current methodology however, is in place, and the hardest technical and administrative tasks are complete. Furthermore, changing the trim point policy will also create timing problems. A change in the trim policy will not take effect until the FY10 rate year, meaning that CPCs with the new trims will not be available until FY11.

STAFF RECOMMENDATION: CONTINUE TO USE THE CURRENT TRIM POINTS The current trim point methodology should remain in place. Staff does not feel that the current trim policy is optimal. The administrative burdens of the current trim methodology however, have already been absorbed by the Commission and the hospitals and a change to the trim policy will add administrative costs – without sufficient offsetting benefit. Staff may wish to revisit the trim policy at a future date, after the recommended revisions to the ROC methodology are implemented. At such a time revision of the trim policy can be considered in isolation, and not as a factor that has confounding effects on other ROC adjustments.

Blending Charge Per Case and Charge Per Visit Calculations. The Commission has an established policy for its CPV. It is also the stated intent of the Commission to analyze hospitals for their efficiency on the CPV (i.e. a CPV ROC). Measuring hospital efficiency separately on an inpatient (CPC) and outpatient (CPV) basis presents several problems:

- *Combining a positive position on inpatient with a negative position on outpatient.* While such a separate comparison is possible, and in fact has been done by the Commission over time, it is less appropriate when combining case targets such as the CPC and the CPV. The Commission and the hospitals will be engaged in two parallel activities combining them at the end.
- *Peer group comparisons.* Peer groups were based on the appropriateness of grouping similar hospitals to allow reasonable comparison. One of the key elements of a peer groups is hospital size. For outpatient departments, size (i.e., volume) of outpatient departments varies widely across hospitals and does not follow current (or proposed) peer groups. Thus a stand-alone CPV ROC would need to consider alternative peer groups, further disconnecting the analyses.
- *IME adjustment.* An IME adjustment for outpatient would also be necessary; however, determining the appropriate variables to use for the measurement of IME would be quite complex. For example, the use of a resident to bed ratio to measure the intensity of the medical teaching component for outpatient services is questionable.

STAFF RECOMMENDATION: BLEND THE CPC AND CPV INTO A SINGLE COMPREHENSIVE CHARGE TARGET (CCT) Staff believe that the best way to address these problems is not to conduct the ROC in a bifurcated manner. The purpose of the ROC is to measure the overall reasonableness of hospital charges. The introduction of the CPV, along with the current Commission practice of aligning inpatient and outpatient charges each year makes a comprehensive approach possible.

Staff recommends that each hospital's CPC and CPV be blended into a single Comprehensive Charge Target (CCT). An analogous blending of case mix (discussed below) will also be done. The CCT will be the starting point for the ROC analyses. The ROC adjustments will then be applied to the CCT to arrive at a final, adjusted CCT. The method for blending CPC and CPV is presented in Attachment 1.

The blended CCT addresses the key challenges highlighted above:

- *Conflicting inpatient and outpatient ROC results*. If a hospital is differentially efficient on an inpatient versus an outpatient basis that will be reflected in the blended CCT.
- *Peer groups*. Since inpatient revenues included in the CPC dwarf outpatient revenues included in the CPV the blended CCT does not substantially change the utility of peer groups as they are currently defined for inpatient.
- *IME adjustment*. The IME adjustment will be made on the overall CCT so there will be no need to develop separate CPC and CPV adjustments.

ROC Adjustments

Using the CCT as the starting point, the ROC analysis makes a series to adjustments. The adjustments yield a final, adjusted CCT that is used to compare hospitals to their peers. For presentation purposes, these adjustments can be classified as major adjustments – those that can substantially change a hospital's CCT, or minor adjustments – those that have a modest effect on the CCT.

Major Adjustments

Case Mix. The Commission accounts for case mix differences across hospitals on the inpatient side using the APR-DRG grouper, this system has been in use since 2005. As was discussed above, the changes in medical record documentation and coding that were induced by the introduction of APR-DRGs are complete. Outpatient case mix is determined using the EAPG grouper according to the policy approved by the Commission in June 2008. Unlike the inpatient grouper, outpatient case mix as determined by the EAPG grouper is not materially changed by changes in hospital medical record coding practices.[6] While the EAPG grouper has been in use for less time, staff believes that it accurately measures outpatient case mix across hospitals.

<u>STAFF RECOMMENDATION: COMBINE INPATIENT AND OUTPATIENT CASE MIX INDEXES INTO A SINGLE ADJUSTMENT.</u>

This recommendation logically follows from the blending of inpatient CPC and outpatient CPV. During the development of the outpatient Charge per Visit (CPV) system, case weights for significant procedure visits were calculated using two different methods: 1) case weights were assigned based on the principal APG (the highest weight) in the record; or 2) case weights were assigned based on 100 percent of the principal APG weight and partial weight for subsequent APGs in the record. Given the minimal increase in the explanatory power by use of multiple APGs (method 2), and the ease of monitoring when using a single APG for the case mix adjustment (method 1), HSCRC

---

[6] Unlike APR-DRGs, EAPGs make much greater use of procedure codes in assigning patient visits. The presence of additional diagnostic detail has very little effect on EAPG assignments.

staff recommended that the principal APG be used for the assignment of case weights in the CPV system.

During the ICC/ROC workgroup meetings, industry representatives expressed satisfaction with the case mix methodology used in the outpatient CPV system because each hospital's rate year performance is compared to its own base year performance. However, workgroup members stated the current CPV case mix methodology may be unfair when comparing the reasonableness of outpatient charges between hospitals considering that some hospitals may provide more multiple significant procedures within a visit compared to other hospitals. Commission staff agreed that this was a valid concern are proposing a revised outpatient case mix methodology to be used for the ROC. This methodology will provide partial weight for subsequent significant procedure APGs as follows:

The case weight will be based on 100 percent of the singleton weight for the highest weight APG, 65 percent of the singleton weight for the second highest weight APG, and 65 percent of the singleton weight for the third highest weight APG[7]. The resulting case mix index would be used in the February, 2009 ROC.

Indirect Medical Education (IME) The Commission has long recognized that a hospital's teaching mission adds some costs that need to be accounted for, if a fair comparison across hospitals is to be conducted. Some of these costs, such as the salaries of residents, can be readily quantified, and these direct costs are discussed below. In addition, the Commission recognizes that other costs associated with a teaching mission are not so easily measured. These indirect costs[8] need to be accounted for in the ROC. In the previous ROC the Commission used a regression analysis to arrive at an estimate of the impact of IME on teaching hospitals.

As in the past, the IME adjustment for the ROC was a source of considerable discussion. Part of this is due to the use of regression analysis as a tool to measure the IME effect. It is the nature of a regression that when there are a limited number of observations (such as 47 Maryland hospitals) only a limited number of variables can be tested, and those variables may end up capturing other, unrelated, effects.

Several participants in the workgroup argued that the methodology used to estimate IME for the previous ROC would result in an adjustment that would be too large, i.e., it would attribute more cost to a hospital's teaching mission than was appropriate. One source of this problem is the fact that many teaching hospitals are in urban settings and tend to serve more disadvantaged patients. A portion of the IME estimate was therefore, likely to be a measurement of services to this disadvantaged population.

---

[7] It is also staff's plan to revise the CPV methodology for the upcoming rate year to reflect this more refined approach to outpatient case mix. Assuming this change, future ROC analyses will not require that this additional case mix modification be made.

[8] The Commission is not alone in its recognition of the added costs associated with a hospital's teaching mission. The Medicare Prospective PaymentSsystem (PPS) has included an adjustment for teaching since its inception in 1982.

Disproportionate Share (DSH) adjustment. The Commission has a history of making what it calls a disproportionate share adjustment to account for the additional resource needs associated with treating large shares poor, high need patients. [9]The purpose of this adjustment is to account for additional costs (additional discharge planning, social work staff, etc) that hospitals treating a poorer population may incur. At different times in the past, the Commission has used a regression analysis a variable for the share of hospital charges to Medicaid patients to measure this burden. In ROC analyses prior to 2005 however, this adjustment had ceased to have any statistical validity, or worse, produced results that were illogical. For these reasons, the DSH adjustment was dropped from the calculation of the ROC.[10]

During the course of this year's ROC review analysis by staff, the teaching hospital group and the G-9 (non-teaching hospitals) have shown that regression analyses that adjust for teaching status and include a measure of the level of poor served by the hospital are statistically significant and logically consistent.[11] Staff strongly believes that a DSH adjustment should be reintroduced to the ROC with the IME adjustment. This adjustment is especially important, as staff hold that without a DSH adjustment the allowance for IME calculated by a regression will overstate the IME effect and distort the ROC comparisons.

STAFF RECOMMENDATION: INCLUDE REGRESSION BASED ADJUSTMENTS FOR IME AND DSH IN THE ROC ANALYSES The ROC should include adjustments for IME and DSH. These adjustments should be calculated via a regression analysis that introduces teaching intensity and high need share as separate independent variables. The measures used for teaching intensity and high need share have a substantial impact on the ROC. Staff recommends that these variables be calculated as follows:

- *Teaching intensity.* Teaching intensity will be measured by the number of trainees (residents and fellows) per risk adjusted discharge. For the ROC, a resident or fellow is defined as someone who is actively enrolled in an Accreditation Council for Graduate Medical Education (ACGME) accredited training program (the number not to exceed the limit set by ACGME), and who is actively engaged in patient care at the hospital (either inpatient or in a hospital based clinic) on the first Tuesday after Labor Day. This measure of teaching intensity differs significantly from the one used in earlier ROC analyses. Those analyses used a resident per bed ratio, where residents were limited to those who had not yet finished a residency (e.g. physicians in sub-specialty programs were not counted). Staff believes that this earlier approach was

[9] Disproportionate Share Hospitals (DSH) is a term used by the federal Medicaid program to allow for specific payment arrangements by state Medicaid programs. The Commission's rate setting process largely eliminates such payment arrangements in Maryland, and the Commission's use of the term DSH should not be confused with the federal Medicaid policy.

[10] No DSH adjustment was made in the Spring 2008 ROC.

[11] There are several possible reasons why estimates of a DSH effect are statistically valid using current data, including: the blended CCT is a better basis for comparing hospital charges than inpatient alone; or, the variable to measure teaching intensity is different from previous ROC analyses.

incorrect as it artificially limited the number of individuals involved in medical training (especially at the Academic Medical Centers) and had the effect of overweighting the IME effect of each resident.

- *High need share.* The high need share will be calculated as the percentage of a hospitals included charges accounted for by the following groups: inpatient and outpatient charges for individuals where Medicaid is the primary payer; inpatient and outpatient charges for individuals where self pay or charity care is the primary payer; and, inpatient charges where Medicare is the primary payer and Medicaid is the secondary payer.[12]

Minor Adjustments

Adjustment for Direct Medical Expenses: The current methodology uses a calculation to determine the cost of residents and then removes 75 percent of these costs from hospital revenue when calculating the ROC. There has been discussion as to whether the amount of revenue adjusted for should be increased to 100 percent and the calculation revisited. This issue directly bears on the IME discussion. Direct medical costs that are stripped will not be accounted for in an IME methodology and, conversely, direct medical costs that are not stripped will be picked up by an IME methodology.

Adjustment for Property and Sales Taxes. All but one Maryland hospital is a not-for-profit and therefore not subject to property and sales taxes. Southern Maryland Hospital Center is a for profit institution and therefore is subject to two unavoidable costs that the remainder of Maryland hospitals are not. Staff recommends that these specific costs be removed from Southern Maryland's revenue base as a direct strip.

STAFF RECOMMENDATION: THE DIRECT COST PER RESIDENT SHOULD CALCULATED AND 100 PERCENT THOSE COSTS REMOVED FROM A HOSPITAL'S CHARGES WHEN CALCULATING THE ROC.

Labor Market Adjustment. Each year the Commission gathers data from hospitals on the cost of various personnel categories in the hospital and the zip codes in which staff live. This data is then analyzed to create a labor market index that accounts for differing personnel costs the hospital faces.

STAFF RECOMMENDATION. THERE SHOULD BE NO CHANGE TO THE CALCULATION OR USE OF THE LABOR MARKET INDEX.

Adjustment for Capital In the 2005 ROC, a capital adjustment was the final step in the ROC, performed after hospital charges had been adjusted for Indirect Medical Expenses. The adjustment takes hospital capital costs (interest, depreciation, and certain leases) as reported on the hospital's ACS schedule of the annual report as a percentage of reported total costs. The hospital ROC charges are then adjusted by taking the sum of one half the

[12] Including Medicaid as secondary payer this measure captures poor elderly individuals who have Medicare as the primary payer.

hospitals capital costs plus one half of the hospital's peer group average capital costs. The effect of this adjustment is to improve a hospital's relative position on the ROC at the beginning of its capital cycle when capital costs are high, and, conversely, a hospital with low capital costs would see its ROC position deteriorate.

During the ROC review staff raised questions as to whether any capital adjustment was needed to compare hospitals under the ROC. Staff argued that hospitals should manage their capital cycle as they manage other costs. Under this reasoning, capital costs are but one, relatively small element of a hospital's costs within the control of the hospital.

Others in the workgroup held that a capital adjustment was necessary to maintain consistency between the ROC methodology, which compares hospital relative efficiency, and the ICC, which is used to determine rate adjustments for specific hospitals. Since the Commission has a process to adjust rates specifically for changes in capital costs (Partial Rate Reviews for Capital) it is possible that were it not for the capital adjustment, a hospital that was given an upward rate adjustment under the ICC process could subsequently see its rates reduced due to poor performance on the ROC.

STAFF RECOMMENDATION: CREATE AND APPLY A STATEWIDE CAPITAL ADJUSTMENT IN THE ROC Staff recommends that the ROC continue to have a capital adjustment but that the method and order of the adjustment be modified. The capital adjustment should be an index that is created by the sum of one half the hospital's capital costs plus one half of the statewide average capital cost. In the ROC process, all adjustments are either hospital specific or based on statewide analysis. The peer group specific capital adjustment is inconsistent with the rest of the methodology. Furthermore, the capital adjustment should be made prior to doing the regression analysis to estimate the IME and DSH adjustments. The ROC methodology is a series of adjustments that, in the end, lead to an adjusted charge per case number for each hospital that is used to compare the relative efficiency of hospitals. In such an analysis, the order of operation influences the results. The mechanics of regression are such that any effect (such as capital) that is not measured or accounted for will, to some extent, be captured by what is measured, i.e., if the capital adjustment is done after the regression adjustment for IME and DSH, the capital effect is double counted.

Staff also feels that the how capital is handled for the ROC and for partial rate applications needs to be carefully reviewed. A high priority for staff in the coming year will be to review how capital is handled in the ROC and whether a partial rate reviews for capital are still a necessary part of the rate setting system.

Comparing Hospitals.

Peer Groups The current ROC analysis compares hospitals against one and other in one of five distinct 'peer groups.' These peer groups match hospitals according to several factors (size, location, etc) and are intended to assure the ROC goal of a like-to-like comparison. The peer groups have long been used by the Commission for it ROC and ICC processes. The original need for the peer groups was that the tools that the Commission had to compare hospital were not sufficient to capture the differing

circumstances of all hospitals. The average charge of different peer groups could be quite different.

The use of the APR-DRG system substantially improves the Commission's ability to measure the relative differences in hospital case mix.[13] Likewise, the DSH adjustment proposed earlier accounts for other difference in patient characteristics that can drive hospital costs. One result of these and other ROC adjustments is the difference in the average adjusted charge among peer groups is relatively small. During the workgroup discussions two points were made regarding peer groups. First, if the variation in peer group average is small does analysis by peer groups serve any purpose? A second point made the G-9 (a group of non-teaching hospitals) was that these small variations in peer group means were, in fact, unfair as they held some hospitals to a lower adjusted charge standard than other hospitals in a different peer groups. Some in the workgroup argued that peer groups remain necessary as they continue to account for some unmeasureable variation among hospitals that is not accounted for in the ROC analysis.

STAFF RECOMMENDATION: THE UPCOMING ROC ANALYSIS SHOULD CONTINUE TO BE DONE ON A PEER GROUP BASIS, BUT THAT THE ISSUE OF PEER GROUPS SHOULD BE REVIEW IN THE COMING YEAR AND THE OPTION OF NO LONGER USING PEER GROUPS BE SERIOUSLY CONSIDERED. Staff is very skeptical about the continued utility of peer groups for the ROC process. Staff feels that with the improvements in case mix measurement and the accounting for DSH the major reasons for the creation of peer groups has been addressed. Staff will engage in discussion and analysis with the industry and payers to assess whether the ROC should be conducted on statewide basis, or whether an alternative from the current grouping is more appropriate.

ICC and Implementation Issues

These issues relate to how the ROC is applied and the actions the Commission may take based upon the results of the ROC. These issues are not methodological, but rather pertain to the application of the ROC and its results.

Scaling and Spenddowns One likely effect of the ROC moratorium that has been in effect since 2005 is that the differences among hospitals as determined by the ROC analysis are likely to have increased. This is likely due to two factors: first, the APR-DRG system may have identified case mix differences among hospitals that the earlier less precise DRG system did not; and, second, the moratorium means that for four years the Commission took no actions (aside from the limited ROC in January 2008) to adjust the rates of hospitals that were falling less in line with their peers. An early concern of the workgroup was that a revised methodology could lead to spenddown orders of a magnitude that would be extremely difficult for hospitals to comply with. As an alternative to spenddowns the workgroup discussed the use of scaling, whereby a hospital's yearly rate update is adjusted up or down depending on the outcome of the ROC.

---

[13] Unmeasured patient severity was consistently cited as one of the factors that required hospitals to be grouped by peer group.

STAFF RECOMMENDATION: THE COMMISSION SHOULD IMPOSE NO SPENDDOWNS BASED ON THE 2009 ROC, BUT IT SHOULD INSTEAD SCALE THE FY 2010 UPDATE FACTOR. Staff recommends that there be no spenddowns based upon for the upcoming ROC. This recommendation only applies to 2009 ROC analysis. Based on the results of that ROC, staff proposes that the Rate Year 2010 update include a scaling methodology based on the hospital's position on the ROC. The use of spenddowns and scaling in later years is still to be determined.

The MHA has proposed a scaling methodology that is a revision of staff's January 14, 2009 recommendation. Staff agrees that the MHA proposal is reasonable and achieves the same ends as the earlier proposal. There staff recommends that the scaling methodology should apply according to the following parameters:

- Upper and lower bounds of scaling. The scaling should apply to the top and bottom hospital quartiles. Hospital's whose ROC position placed them in either the highest or lowest quartile will be subject to a scaling adjustment. Hospitals in the highest and lowest deciles will be should be subject to the maximum scaling reward or penalty.
- Relationship of scaling to the rate update factor. The highest reward or penalty should be 33percent of the base update factor.
- Scaling should be continuous. MHA proposed two level of either positive or negative scaling between the upper and lower bounds. Staff feels that the differentials between those "notches" is too great - 0.9% in the MHA example. Such a large differential effect among hospitals that have almost identical results has two problems: first it is inequitable; and, second, it will inevitably lead to contentious disputes between hospitals and Commission staff. Staff recommends that continuous scaling be applied between the 75th and 90th percentiles.

Annual vs. semi-annual ROC/ICC Historically, the Commission has conducted the ROC twice a year. This twice a year schedule allowed for new information to be accounted for and appropriate actions to be taken. During the review process hospitals have suggested that a single annual ROC may be an appropriate schedule.

STAFF RECOMMENDATION: THERE SHOULD ONLY BE A SINGLE ROC ANALYSIS CONDUCTED IN 2009 Since the Staff is recommending that no spenddowns be imposed based on this ROC, and that a scaling methodology be applied to the update factor, there is no need to conduct a semi-annual ROC in the upcoming year. Staff further recommends that there continue to be discussions with payer and the industry in the coming year to consider the most appropriate schedule for the ROC analysis and action based on that analysis.

Intergrating the ROC and the ICC The ROC analysis determines hospital position relative to one another. The ICC is the process that the Commission uses to determine the exact magnitude of any rate adjustment that may result from the ROC. It is therefore, important that these processes are integrated to give consistent results. Some of the revisions to the ROC methodology require adjustments to the current ICC methods to maintain consistency.

STAFF RECOMMENDATION: CONTINUE TO WORK WITH THE INDUSTRY AND PAYERS TO ADDRESS ISSUES RELATED TO THE INTEGRATION OF THE ROC AND THE ICC.

SUMMARY OF RECOMMENDATIONS

Establishing hospital baseline charges

- Continue to use the current trim points.

- Blend the CPC and CPV into a single comprehensive charge target (CCT).

ROC adjustments

Major adjustments

- Combine inpatient and outpatient case mix indexes into a single adjustment.

- Include regression based adjustments for IME and DSH in the ROC analyses.

Minor adjustments

- The direct cost per resident should calculated and 100 percent those costs removed from a hospital's charges when calculating the ROC.

- There should be no change to the calculation or use of the labor market index.

- Create and apply a statewide capital adjustment in the ROC.

Comparing hospitals

- The upcoming ROC analysis should continue to be done on a peer group basis, but peer groups should be reviewed in the coming year and the option of no longer using peer groups should be seriously considered.

Implementation issues

- The commission should impose no spenddowns based on the upcoming ROC, but it should instead scale the FY 2010 update factor.

- There should only be a singly ROC analysis conducted in 2009.

- Work with the industry and payers to address issues related to the integration of the ROC and the ICC.

Maryland
Hospital Association

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

January 23, 2009

Sent via e-mail. Hard copy to follow.

John O'Brien
Deputy Director, Research and Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. O'Brien:

On behalf our 47 acute care hospital members, thank you for the opportunity to comment on the proposed changes to the Interhospital Cost Comparison and Reasonableness of Charges (ICC/ROC) methodologies. We appreciate the work that has gone into this year's review.

The changes being proposed represent the culmination of methodology revisions that began over five years ago. Severity-based grouping, hospital-specific relative-value case weights, and hospital-specific All Patient Refined Diagnosis Related Group (APR-DRG) severity level specific trim points were the starting point of this effort. By developing new adjustments for indirect medical education and disproportionate share, the Health Services Cost Review Commission (HSCRC) continues to make strides towards keeping the goal of equity in mind. We hope this process will continue.

While we remain silent on the nature of the proposed adjustments, our comments focus on two things: 1) ICC revision and 2) scaling in lieu of spenddowns.

First, the changes being proposed to the ROC, particularly the incorporation of outpatient revenue, necessitate a look at the ICC methodologies. Several major technical issues will need to be resolved, and we believe this is an opportunity to look at the standards within the ICC that historically have been set at restrictive levels. ***We ask that the HSCRC staff, with hospital participation, undertake an equally rigorous process to review and propose changes to the ICC and consider both technical and policy issues. Specifically, we continue to advocate that the HSCRC's operating margin target be added back after the profit strip, and that the productivity factor be changed to one percent.***

Second, we agree with the staff recommendation to forego spenddowns, given the large disparities within groups in ROC positions. ***We support scaling as a method for recognizing hospitals for their efficiency, both positive and negative, in lieu of spenddowns***. However, we propose a slightly different method for developing the scaling thresholds. By definition, standard deviations will be smaller as more and more accurate adjustments are developed and used.

- more -

Therefore, we believe that a standard deviation-based approach to calculating thresholds for scaling would over-identify hospitals for adjustments. Instead, we recommend the thresholds be developed based on quartiles. Under this approach, hospitals at the bottom and top quartiles would be scaled, with hospitals in the bottom and top deciles receiving the maximum scaling adjustments. We would be happy to share our calculations and simulations.

Thank you again for the opportunity to comment. As always, I look forward to working with you on this issue and others critical to the integrity of Maryland's hospital rate-setting system.

Sincerely,

Ing-Jye Cheng
Assistant Vice President

Attachment

To: Chairman Donald A. Young

From: Paul Nicholson, VP CFO

Date: February 25, 2009

RE Support of new ICC/ROC Methodology Proposal

On behalf of Washington Adventist Hospital in Takoma Park, I would like to thank John O'Brien and the HSCRC staff for their leadership and hard work on this year's proposed changes to the ICC/ROC methodology. The staff along with Mr. O'Brien led a thorough process that allowed many long standing issues to be addressed. The ICC/ROC workgroup's agenda took into account factual information and related arguments from many sides and came up with a process that was open and collaborative.

Continuous scaling represents a balanced effect on hospitals, limiting severe rate reductions at community hospitals and providing rate relief to the "stuck" hospitals. I am concerned that spend downs under the previous methodology were inequitable to the non-teaching hospitals.

The inclusion of a DSH adjustment is a significant step towards fairness for non-teaching hospitals that have a considerable proportion of indigent patients. In the years since DSH was excluded from the methodology, the costs associated with these patients were a residual captured by the IME regression and mischaracterized as IME. Because only teaching hospitals were given a ROC adjustment for these costs, the non-teaching hospitals were left without recognition of their poor share patients.

Counting of all the residents and using the statistic of residents per severity weighted discharge more accurately reflect the IME cost of care in teaching hospitals. This is especially true when comparing our two large academic medical centers with other smaller community based teaching programs.

As a member of Adventist HealthCare and the G-9, I will continue to work with the Commission staff and the MHA on issues that will lead to a more fair and transparent system. We support the staff's willingness to discuss the continued use of the ICGs. We are also very concerned about the ever increasing costs of physician coverage that non-teaching hospitals have to carry. Thank you for the opportunity to comment on the staff recommendations and I thank the staff for their thoughtful approach to the reformulation of the ICC/ROC methodology.

February 26, 2009

John O'Brien
Deputy Director for Research and Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear John:

The purpose of this letter is to offer our comments on the staff recommendation "Draft Recommendations of Revisions to the Reasonableness of Charges (ROC) Analysis," presented to the Commission at the January 14, 2009 meeting. Generally, we support the approach proposed by the staff. However, we would like to take this opportunity to voice additional supporting explanations for some recommendations and to note our reservations on some other points discussed in the document. In this letter, we will address the issues for which our group has reached a consensus. For other issues, each hospital will present its own position separately.

The first recommendation calls for the continued used of the current trim points in the CPC methodology. We believe this methodology brought unnecessary complication to the system. Given that it is in place and the system is now calibrated to operate under these outlier rules, however, we concur with the staff that the benefit of changing the policy is not worth the cost. However, we do not agree with the staff's assertion that changes can be made in the future to these trim points without a reconsideration of the IME regression. In these workgroup discussions, we have demonstrated that changes in the outlier definitions changes the amount of revenue at risk under the CPC targets and therefore the size of the IME adjustment. If future changes are made to the outlier policy, the effect on the IME adjustment will need to be considered to avoid misalignments in the IME policy.

The second recommendation proposes a blend of the CPC and CPV targets into a single comprehensive target that will be subject to the Reasonableness of Charges analysis, and the third recommendation proposes a methodology for combining inpatient and outpatient case mix indexes into a single adjustment. We believe that this CPC-CPV blend is a logical extension of the ROC analysis and that the proposed case mix blend preserves the intent of a refined case mix adjustment system. The proposed method gives full credit for a singleton outpatient procedure and the second and third procedures in the visit each receive 65 percent of the singleton weight. Further procedures would not be given any credit. To capture differences in relative resource use, the recognition of secondary procedures for an outpatient visit makes the case mix measure more refined and better captures relative resource use.

While the staff has developed a logical approach to combining inpatient and outpatient CPC/CPV data as they currently exist, this methodology should be monitored closely for unintended consequences. This is a new policy, and there remain concerns regarding the

integrity of the of the outpatient data. It is also important to monitor the case mix measurement around the inclusion of secondary procedures to be sure that the inclusion of only two secondary procedures at 65 percent of their singleton weight captures differences in resource utilization across facilities appropriately.

In the fourth recommendation, the staff proposes a regression-based approach to determine an adjustment for indirect medical education and disproportionate share. The staff proposes an expanded measure for teaching programs and a new measure for disproportionate share. In the past, the HSCRC has measured IME from a regression model that measured teaching based on the number of qualified residents at the facility per occupied bed. Qualified residents were included up to the cap approved for the program. Hence, the IME measure in the regression had captured cost variations across programs and attributed them to differences in the number of capped residents who qualified under HSCRC rules. However, costs included the entire cost of the hospital's teaching effort. These costs were therefore spread over too few residents, making the IME adjustment larger than it would otherwise be.

Clearly the costs of the teaching effort are not limited to the approved residents and the cap imposed under HSCRC policy. Including residents and fellows engaged in patient care better represents the relative size of the teaching programs and allocates the costs per resident more accurately. (While the Commission has not recognized fellows in the past, the Medicare program has given credit for fellows as part of its IME adjustment) Likewise, removing 100 percent of direct teaching costs prior to the regression estimation removes these costs for the IME adjustment and attributes them directly to the facility incurring the costs, a more accurate reflection of the resource use within the system. We would ask that the staff clarify in its proposal how residents and fellows would be addressed if a hospital opens a new program.

While we concur with the staff proposal for the IME adjustment, particularly the revision of the teaching measure, we have two specific concerns around the details of its implementation. Our first concern relates to the method the staff has adopted for the DME adjustment. In its modeling, the staff has altered the method from the statewide average cost per resident by specialty to using the actual costs from the P4 and P5 schedules of the annual filing. While this sounds like a logical, straightforward choice, it masks a number of policy issues as well. The instructions for the P4 and P5 schedules are vague in regards to the inclusion of only ACGME residents and do not address the inclusion of fellows. As a result it is unclear whether reporting for fellows is consistent from one hospital to the next. Further, the data on the schedules may include both ACGME approved and unapproved residents and fellows, and there is no method in the current data collection instrument to separate approved positions from those that are not approved. Finally, hospitals were given a brief period to revise these data for the staff's policy simulations. The limited timeframe for revision and assessment of these schedules calls into question the accuracy of the results of the staff's simulations. We are not opposed to the concept of using the P4 and P5 schedules for the DME adjustment, but at this juncture, the quality of the data is suspect. We propose maintaining the DME calculation as calculated under existing policy.

Another concern relates to the shortened time frame for analyzing the disproportionate share measure and potential alternatives. DSH measures have shown a high degree of instability over time. Further, the high degree of correlation between variables combined with a limited number of observations in the State make precise estimates of these relationships difficult. We believe that the DSH measure deserves further consideration in the future as we gain further experience with this new ROC methodology.

The teaching group also supports the Maryland Hospital Association's position regarding the staff recommendations as outline in its letter dated January 23, 2009.

As of the date of this letter we are unable to reconcile to the Staff's ROC results. Prior to a final ROC being issued any variances between our ROC calculations and the Staff's ROC calculations need to be resolved.

We appreciate the opportunity to comment on this recommendation and to have participated in the discussions leading to this recommendation. Generally, we congratulate the staff on this policy. It reflects a variety of interests in a complex policy context. The staff is to be commended for an open and balanced process, and we look forward to expressing our views in any continuing discussions around this policy.

Sincerely,

The Teaching Hospital Group
(signatures on following page)

Feb 25, 2009

Eric Melchior
Executive Vice President and CFO
Greater Baltimore Medical Center

Date

2/25/09

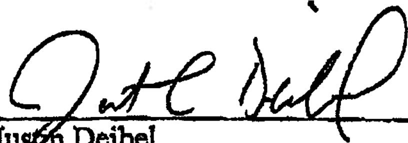
Stuart Erdman
Senior Director Finance
Johns Hopkins Health System

Date

2/25/09

Kathy Talbot
Vice President Rate and Reimbursement
MedStar Health

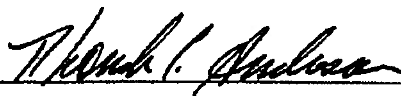
Date



2/26/09

Justin Deibel
Mercy Medical Center
Vice President, Clinical Economics

Date



2/23/09

Rhonda Anderson
Senior Vice President and CFO
St. Agnes Hospital

Date

2/26/09

Henry J. Franey
Senior Vice President &
Chief Financial Officer
University of Maryland Medical System

Date

Department of Finance
Mason F. Lord, Center Tower, Suite 2200
Johns Hopkins Bayview Campus
5200 Eastern Avenue
Baltimore, MD 21224

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

February 26, 2009

Dear John:

The purpose of this letter is to express our concerns over recent decisions regarding the Reasonableness of Charges (ROC) analyses and the policy changes that are under review. As you know, we have participated in the process with the other teaching hospitals in the State, and we have attempted to offer suggestions and analyses in good faith to achieve a stable, reliable ROC methodology. As the Commission staff made its recommendation to the Commission, we thought we had achieved that goal. As the staff has made its preliminary results available for review, however, we are discovering a number of differences between the results of our modeling and the staff's results.

First, we have been unable to reconcile our results with the preliminary ROC. While we have attempted to work through these details, it has become clear to us that the staff has changed the ROC calculation substantially. While the calculations have been characterized as "technical details," these details matter. We modeled proposed policy changes under the expectation that the ROC calculation would follow established methods. Now we are learning that the staff has changed some calculations substantially from the method used during the workgroup discussions.

The disproportionate share adjustment (DSH) is an important example of these changes. As the DSH was included in the regression, we presented results to the workgroup that modeled DSH in the same manner as the IME adjustment. The results were applied as a deviation from the statewide mean value, and revenue neutrality was applied. Whether this is the best method for this calculation was never discussed by the group. The staff's change in the calculation is a material departure from the good-faith discussions pursued in the ROC/ICC workgroup. Furthermore, it is a departure from the method that has been used by the Commission historically. The deviation-from-the-mean approach was used in the screening methodology which predated the current ROC analysis. While these changes may be technical, they result in substantial shifts in ROC position that were not contemplated in the workgroup discussions. To change the calculation without open discussions and analysis violates the spirit of cooperation that was part of the workgroup meetings. We strongly object to what can only be seen as an arbitrary, last-minute change in implementing the proposed policy.

A similar issue arises with the method for calculating the direct medical education (DME) adjustment. The Commission has used statewide average costs for residents to calculate the DME adjustment. There are two important policy benefits to this approach. First, hospitals cannot pass through resident costs if they pay more than the statewide average. Second, hospitals with relatively low costs are rewarded for their efficiency in providing educational services. Both of these benefits have been discarded, however, in the staff's current ROC calculation. To calculate the DME adjustment now, the staff plans to use the actual costs from hospitals P4 and P5 schedules from the annual report.

The use of actual costs instead of the statewide average loses both of the benefits mentioned above. Furthermore, this issue was not discussed in the workgroup meetings. Again, it is being imposed at the last minute as a technical adjustment. Again, we object to these changes and their last-minute nature.

Finally, we would like to note a final concern around the staff's proposed scaling methodology. While we endorse the idea of using scaling to realign industry revenue, we are concerned that in the process of scaling, hospitals should receive at least the projected cost increases for the coming year under the Global Insights forecast. While the Commission's methodologies are designed to realign revenue within the industry, the costs of covering hospital operations and capital investments are concerns for the State's hospitals, and the limited access to capital markets have added to the pressure to generate funds through operations. Having the update factor cover costs is vital in these economic times.

We appreciate your consideration of these matters.

Sincerely,

Ed Beranek

A University Affiliated Center Conducted by the Sisters of Mercy

February 26, 2009

John O'Brien
Deputy Director for Research and Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear John:

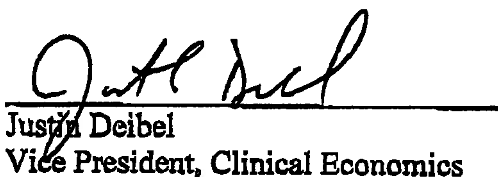
The purpose of this letter is to offer comments on behalf of Mercy Medical Center related to the staff's proposal for updates to Reasonableness of Charges (ROC) methodologies. Generally, we support the recommendations made by the teaching hospital group and the Maryland Hospital Association. In addition, we generally support the approach proposed by the staff. However, I would like to make a few quick points about the data for your consideration.

Staff is recommending a direct adjustment for medical education (DME) using the actual costs from the P4 and P5 schedules of the annual filing. Mercy feels strongly that this data is untested and not consistently reported among hospitals. Providing hospitals their own actual expense creates perverse incentives related to pass-throughs, a topic that has been hotly debated in the past. This proposed change in policy has not been discussed thoroughly in our industry meetings, so we cannot support it at this time. We are not necessarily opposed to the concept of using the P4 and P5 schedules for the DME adjustment, but further analysis needs to be done before making the change. Therefore, we propose maintaining the DME calculation from the existing policy.

Historically, Mercy has advocated strongly for a disproportionate share adjustment (DSH), and we continue to feel it is a necessary adjustment. The DSH calculation proposed by the HSCRC is a good starting point, but we would like to see additional analysis of the variables and the application prior to future ROC releases. The variables have shown instability over time and the method used to apply the adjustment can sway results significantly. We recommend the HSCRC move forward with a DSH adjustment while leaving the methodology open to future refinement.

We appreciate the opportunity to comment and would be happy to discuss these issues further.

Sincerely,



2/26/09
Date

Justin Deibel
Vice President, Clinical Economics

301 St. Paul Place · Baltimore, Maryland 21202-2165 · (410) 332-9000

Civista Medical Center
5 Garrett Ave.
P.O. Box 1070
La Plata, Maryland 20646-1070

301.609.4000 Phone

February 25, 2009

Dear Chairman Young,

This letter represents the position of Civista Health, Inc., a hospital affiliated with the G-9 hospital group, relative to the changes recommended by the HSCRC staff in connection with the ICC/ROC methodology.

We believe that the HSCRC staff, under the leadership of Mr. O'Brien, worked effectively in organizing, overseeing, and evaluating the deliberative process that led to the staff's recommendations. Our group, the G-9, and a 17 hospital group (the 17 Hospital Group) that included the two academic medical centers (AMCs) provided competing recommendations. Each group was given ample time to make its case and the staff, supported by its consultants, made thoughtful evaluations of the cases presented. In more than one instance the staff – correctly in our view – expanded the ICC/ROC workgroup's agenda to account for factual information and related arguments that had a bearing on the course of the deliberations.

The HSCRC staff did, however, exclude from the workgroup's agenda some issues that are critical to the community hospitals, including the reformulation of the interhospital comparison groups (ICGs). Our understanding that the ICGs would be maintained in the 2009 ROC influenced our positions on the three key recommendations of the staff; we discuss each of the positions in the following sections.

<u>Spenddowns versus Scaling:</u>

One weakness of the proposals from the 17 Hospital Group was that it placed a highly disproportionate number of non-teaching hospitals on spenddown, while providing no rate relief for the "stuck" hospitals that were evaluated as highly efficient under the ICC/ROC system. Within the context of the Workgroup's deliberations, including the maintenance of the prior ICG scheme, the inequitable treatment of the non-teaching hospitals under the rules governing spenddowns appeared unavoidable.

Faced with this dilemma, the staff chose to waive spenddowns in FY 2010, in favor of scaling and to request that the MHA recommend a scaling approach. The approach proposed by the MHA had a far more balanced effect on the hospitals, limiting the rate reductions of the "high cost" community hospitals and providing some rate relief to the "stuck" hospitals. Pursuant to a critique of Mr. Murray, the MHA's proposal was modified so that it became continuous, meaning that hospitals that were of approximately the same

Civista Medical Center
5 Garrett Ave.
P.O. Box 1070
La Plata, Maryland 20646-1070

301.609.4000 Phone

level of efficiency under the ROC evaluation would receive approximately the same level of scaling adjustment.

We support the staff's acknowledgement that the application of the prior spenddown methodology was inequitable to the non-teaching hospitals, the staff's decision to waive spenddowns in FY 2010, and the proposed approach to scaling, whereby it is required to be continuous.

ICGs and DSH Expenditures:

As we noted above, the staff had opted to postpone the reformulation of the ICGs until the next round of ICC/ROC policy deliberations. However, even with the elimination of spenddowns in FY 2010, the ICG scheme resulted in the inequitable treatment of certain hospitals through the operation of the scaling adjustments. In particular, with a reasonable IME allowance per resident, the Urban 1 hospitals had an average adjusted charge per case that was approximately 10 percent above the Suburban and Rural 1 average. This meant that the scaling threshold (the rate level that would trigger scaling reductions) for, say, Mercy hospital was 10 percent above the scaling threshold for, say, St. Agnes hospital.

To alleviate the inequitable effect of the ICGs, the staff elected to adopt a recommendation of the G-9 whereby an additional independent variable measuring each hospital's burden of indigent patients would be included in the IME regression. The resulting DSH adjustment would then be included in the interhospital comparisons used to determine the scaling adjustments.

We support the staff's decision to consider a DSH adjustment in the ROC, to derive it as a part of an IME/DSH regression, and to measure the hospital's burden of indigent patients in accordance with its current recommendation.

The IME Allowances:

Historically, the methodology for calculating the IME allowances had been controversial for three (3) reasons. First the IME allowance levels were excessive when measured against the MedPac estimates. Second, the IME allowances increased at a rate well beyond the HSCRC's general inflation allowances. Finally, the IME allowances were essentially determined by the differential adjusted costs per case of the AMCs. This meant that as the AMCs' costs per case rose disproportionately, the differential increases would largely be classified as IME, producing a pass-through of the AMCs' costs.

We believe than an IME (or IME/DSH) methodology must meet two tests. The IME allowance per resident should be in line with the MedPac estimates; otherwise there is no assurance that the IME allowances are reasonable. In addition, the methodology should

Civista Medical Center
5 Garrett Ave.
P.O. Box 1070
La Plata, Maryland 20646-1070

301.609.4000 Phone

operate so that the pass-through feature of the previous methodologies is limited to the maximum extent possible; otherwise the differential cost increases of the AMCs will increase the IME allowance to the detriment of the non-teaching hospitals.

Two IME methodologies appeared to result in IME allowances per resident that were in line with the MedPac estimates, a proposal by the 17 Hospital Group and a staff approach (the Total Resident Approach). In the Total Resident Approach the size of each hospital's teaching program would be based on its total residents including fellows, rather than on its "qualified residents" as previously defined by the HSCRC.

For most hospitals there is only a small difference between the total residents and the qualified residents; in fact, there is usually no difference. However, each of the AMCs has a large number of fellows and other non-qualified residents. Therefore since the aggregate amount of the AMCs' IME allowances are largely fixed, independent of the measure of the size of their teaching programs, the addition of a large number of residents to the resident count reduced the IME costs per resident of the AMCs. Since the AMCs essentially determine the IME regression's allowances, the reduction in the AMCs' costs per resident resulted in a commensurate reduction in the IME allowance per resident.

We support the IME methodology because the derived IME allowance per resident ($258,000) appears to be in line with the MedPac estimates. We would suggest that the updated IME allowances for FY 2010 should be limited to the currently derived allowances increased by the HSCRC FY 2010 annual allowance. This limitation will ensure that the AMC pass through effect described above does not cause the allowances to spike in FY 2010.

We thank you for the opportunity to comment on the staff recommendations and we thank the staff for their thoughtful and resilient approach to the reformulation of the ICC/ROC methodology.

Yours truly,

Noel A. Cervino, Interim Chief Executive Officer

Hal Cohen, Inc.
Health Care Consulting
17 Warren Road, 13B
Baltimore, Maryland 21208
(410) 602-1696; Fax: (410) 602-1678: e-mail: JandHCohen@AOL.com

February 26, 2009

Don Young, Chairman
Health Services Cost Review Commission
4201 Patterson Avenue
Baltimore, MD 21215

Re: Staff recommendation regarding ICC/ROC and other issues

Dear Don:

I am writing this letter on behalf of CareFirst Blue Cross Blue Shield and Kaiser Permanente.

We would like to thank the staff for conducting a very open and professional process for looking at ICC/ROC and other methodological issues. We are particularly pleased with the addition of the disproportionate share variable and the addition of much outpatient revenue to the ROC. CareFirst and Kaiser Permanente is supportive of most of the recommendations staff is making. We believe many issues warrant revisiting next year. We do, however, propose some changes and want to register some proposals for the future.

Disproportionate Share: As noted above, we are very pleased that DSH was added as a variable. We understand that there is an issue regarding whether DSH should be applied, as previously, as a difference from the statewide mean, or whether DSH should be applied analogous to a strip. We also understand that there is no difference in the results regarding scaling. As a result, while our preference is for the difference from the mean approach, we think it is much more important that the new ROC be approved. Therefore, we recommend that staff recommend what it believes is best, recommend that the Commission adopt the ROC, but have whatever process is appropriate to make a final decision regarding which method to use. While there is little impact between the two methods, either method generates results that are a very significant improvement over the current ROC and we urge the Commission to adopt either one of them.

Peer Groups: We originally recommended doing away with the peer groups and having two peer groups 1) a statewide Peer Group excluding the AMCs; and 2) a national peer group for The Johns Hopkins University and the University of Maryland Medical System. We think it important to develop such a peer group and for staff to get input on the methodology for using such a Peer Group of distinguished AMCs. While, for the most part, we can support staff's delay until next year in examining Peer Groups, we recommend that the small hospital group (Suburban 3) be combined with Suburban 1. The only reason for creating the small hospital group peer group was that diseconomies

of small scale were expected to grant them a higher standard cost per case. In fact, they have a lower standard cost per case. Since this result differs from the basis for creating the group, we suggest eliminating the group.

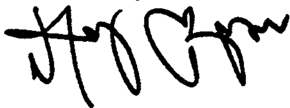
IME: We support one year at the proposed amounts. Any adjustment forward should be based on the Commission's update. We are still concerned by the ratio of high non-teaching to high teaching hospitals (11 – 2). The vast bulk of teaching hospitals are near the mean, while many non-teaching hospitals are quite high and many are quite low. We suspect this is more methodology driven than reality driven.

Scaling and Spenddowns: We made, and staff adopted, an adjustment to the MHA scaling proposal. We support the staff recommendations to not have spenddowns this year and to scale as proposed. We urge the Commission to significantly increase the level of scaling next year and to begin spenddowns after the next round of methodology changes.

Capital: The methodological change of adjusting for capital on the ROC prior to the regression is a sound improvement and we endorse it. However, we raised many issues regarding partials for capital, and, while they were discussed at one meeting, they took a back seat to other issues. We recommend one adjustment this year and that the Commission ask staff to give the Partial for Capital methodology higher priority next year. The partial for capital methodology includes a 1% offset for money included in past updates. We are willing to support the end of this offset if it is timed with the application of the other methodological changes being proposed – including the new ROC. We also would like the Commission to consider a transition to a statewide capital methodology that does not adjust rates for the place on the capital cycle that a particular hospital happens to be. We are not aware of any other industry where prices reflect the capital cycle as they do in Maryland's hospital industry. Given that we already have a 50% statewide standard, a transition of 10 years or less should be acceptable.

Thank you for your consideration.

Yours truly,



Hal Cohen
Consultant

Cc: Bob Murray
John O'Brien
Andy Udom
Ellen Englert
Steve Ports
Stan Lustman

Greg Vasas
Debra Collins

March 2009 – Legislative Update

Bill Number and Title	Provisions	Status
HB 1069/SB 776 - Financial Assistance and Debt Collection Policies	Establishes a minimal hospital financial assistance policy of 150% of FPL and requires hospitals to: • include an information sheet with hospital bills and, upon request, include certain financial assistance information; • make hospital staff available to assist patients and their families in understanding the hospital bills and how to apply for other health care programs; and • submit to the Commission their policy on the collections of debts owed by patients. The bill also requires the HSCRC to establish uniform requirements for the financial assistance information sheet (which in includes notification material that will be provided to patients), review the implementation and compliance relative to the information sheet and hospital collection policies, and establish a work group to consider further changes necessary relative to hospital financial assistance and debt collection policies. **HSCRC Position**: Support with Amendments Suggested Amendments – increase minimal financial assistance to 200%; study the issue of prohibiting liens on primary residences; leave interest on late payments under Commission regulation	Heard in Senate 2/26 House Bill Hearing 3/5
SB 494 – Limit on Interest or Late Payment Fees	Requires the Commission to prohibit a hospital from charging a patient interest or late payment fees at a rate that exceeds 5% per year. **HSCRC Position:** Prefers the approach in SB 776 which allows Commission to establish interest rate in regulation	Heard in Senate 2/26
HB 1204 – Financial Assistance Policy and Financial Assistance Application and Notices	Requires hospitals post their financial assistance policies in EDs, billing offices, admission offices and outpatient facilities. The bill also requires hospitals to provide patients with written notice of the financial assistance policies ad that the notice must be available in Spanish and other languages.	House Hearing 3/5
SB 435/HB 758 – Reporting and Reimbursement of "Never Events"	Requires hospital and long-term care facilities to report certain events that occur during the course of a stay at a hospital or long-term care facility to the Secretary of the Centers for Medicare and Medicaid Services (CMS) within a certain time frame. The bill also prohibits Medicaid and Medicare from providing reimbursement if a hospital or related institution is responsible for a "never event." **HSCRC Position**: supports the payment concept but prefers the MHAC approach taken under current authority.	Heard in Senate 2/25 House Bill Hearing 3/5

SB 231/HB 487 – Annual Reports of Compensation	Requires each Maryland hospital to annually submit to the HSCRC the amount of compensation provided to each officer, director and executive of the facility and the facility's parent company and subsidiaries, as well as, the amount provided to regulated lobbyists for the purpose of lobbying the Maryland General Assembly.	Heard in Senate 2/25 Passed Committee House Bill Hearing 3/5
SB 757 – HSCRC Repeal	Repeals the HSCRC and requires MHCC to consider ways to finance the cost of Uncompensated Care	Not Scheduled
HB 89 – CON and Rate Setting – High Performance Buildings	Mandates that regulations adopted by the Maryland Health Care Commission (MHCC) regarding certificate of need (CON) incorporate "high performance building" requirements for hospital projects that include the construction or "major renovation" of a building that is at least 7,500 square feet. Further, the HSCRC must take into account the costs of hospital projects that incorporate such requirements in the determination of reasonable hospital rates.	House Hearing 2/12
SB 744/HB 706 – Electronic Health Records – Regulation and Reimbursement	Requires the Maryland Health Care Commission (MHCC) to adopt regulations by specified dates regarding adoption and certification of electronic health records (EHR) and reimbursement of providers by "State-regulated payers" for costs associated with adopting EHR. MHCC must also designate a State health information exchange and a management service organization to host EHR. Beginning October 1, 2014, all providers, including health care facilities, must use HER in order to receive reimbursement. State-regulated payers are prohibited from reimbursing a health care provider that does not meet this requirement.	House Hearing 3/3 Senate Hearing 3/11
SB 627/HB714 – Loan Assistance Repayment and Practice Assistance for Physicians	Establishing a separate Maryland Loan Assistance Repayment Program (MLARP) for physicians. The bill sets program eligibility standards, prioritizes funding for loan repayment, and specifies a role for the Department of Health and Mental Hygiene (DHMH) in identifying additional physician shortages. Amendments were proposed by MHA which creates a fund where funds from hospital rates, as approved by the Commission, may be used for this program	House Hearing 2/24 Senate Hearing 3/11
HSCRC Budget	No Issues	
Budget Reconciliation and Financing Act (BRFA) – Uniform Assessment	The FY 2009 policy was to capture 25% of the averted bad debt from FY 2009 Medicaid Expansion as reductions to overall hospital rates. BRFA would provide reduce that amount to 10%, saving Medicaid about $9 million in FY 2010 only.	
Budget Reconciliation and Financing Act (BRFA) – "Medicaiding" some MHIP enrollees	Medicaid, under a new waiver, could obtain eligibility for MHIP enrollees with income under 200% of FPL. This would allow the Medicaid program to obtain a federal match on these enrollees and transfer funds back to MHIP to make them whole. It is expected to save Medicaid about $9 million each year.	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Donald A. Young, M.D.
Chairman

Joseph R. Antos, Ph.D.
Raymond J. Brusca, J.D.
Trudy R. Hall, M.D.
C. James Lowthers
Kevin J. Sexton
Herbert S. Wong, Ph.D.

HEALTH SERVICES COST REVIEW COMMISSION
4160 PATTERSON AVENUE · BALTIMORE, MARYLAND 21215
AREA CODE 410-764-2605
FAX 410-358-6217
Toll Free 888-287-3229
Web Site: http://www.hscrc.state.md.us/

Robert Murray
Executive Director

Stephen Ports
Principal Deputy Director
Policy & Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

John J. O'Brien
Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: February 27, 2009

SUBJECT: Hearing and Meeting Schedule

Public Session

April 15, 2009	**Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room**
May 6, 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