STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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455th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
April 15, 2009
9:00 a.m.

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

   2015R - Greater Baltimore Medical Center
   2016A - Johns Hopkins Health System

4. **Docket Status - Cases Open**

   2009A - University of Maryland Medical Center
   2014A - Johns Hopkins Health System
   2017A - University of Maryland Medical Center
   2018R - University Specialty Hospital
   2019N - Garrett County Memorial Hospital
   2020R - Franklin Square Hospital
   2021R - Johns Hopkins Bayview Medical Center
   2022R - Civista Medical Center
   2023A - University of Maryland Medical Center
   2024A - University of Maryland Medical Center

5. **Draft Recommendations from the Deliberations of the Payment Work Group**
6. **Draft Recommendations for Changes to the Quality-based Reimbursement Project**
7. **Update on Reasonableness of Charges (ROC) Methodology**
8. **Legislative Report**
9. **Legal Report**
10. **Hearing and Meeting Schedule**

454th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

MARCH 4, 2009

Chairman Young called the meeting to order at 8:54 a.m. Commissioners Joseph R. Antos, Ph.D., Raymond J. Brusca, J.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 FEBRUARY 4, 2009

The Commission voted unanimously to approve the minutes of the February 4, 2009 Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, updated the Commission on the activity of the Payment Workgroup, the group that was assembled to review the options for the 2010 Update. Mr. Murray reported that although discussions on the three-year payment arrangement have been ongoing since November, only at the most recent meeting has there been very much progress. Both the hospital industry and the payers have now presented proposals. The payers presented a three year proposal with annual updates of 1.99%, while the hospitals proposed a one-year arrangement with an update of 3.75%. Mr. Murray stated that the parties with continue to meet, hoping, as it has in the past, to forge a compromise, or a near compromise recommendation. Mr. Murray stated that the intent is to present a draft recommendation at the April public meeting with a final recommendation ready for action at the May public meeting.

Mr. Murray summarized in detail the Report to the Governor entitled Review of Financial Assistance and Credit and Collection Activities of Maryland Hospitals. The Report is a response to the Governor's request for a thorough review of Maryland hospital financial and credit and collections policies. The Report is an interim report presenting background information concerning the provision of financial assistance and credit and collection activities by hospitals. It also presents an evaluation of those activities relative to previously developed voluntary standards and current national trends. In addition, the Report provides recommendations to address the problems and inconsistencies associated with the provision of financial assistance and credit and collection activities.

Johns Hopkins Health System – 2016A

Johns Hopkins Health System filed an application on February 2, 2009 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital for approval to continue to participate in a capitation arrangement serving persons insured with Tricare. The arrangement involves the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare as providers. The requested approval is for a period of one year.

Based on historical favorable performance and projections, staff recommended that the Commission approve the Hospitals' application for a period of one year retroactive to January 1, 2009.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
FINAL RECOMMENDATIONS ON MARYLAND HOSPITAL-ACQUIRED CONDITIONS (MHAC)

Mr. Murray stated that the focus of the presentation would be the questions posed, input received, and issues raised about the proposed MHAC initiative and staff's research and response thereto.

Diane Feeney, Associate Director-Quality Initiative, reviewed staff's activity over the last month. Ms. Feeney reported that two vetting sessions were conducted. Attending were hospital quality, case-mix, financial, and medical leaders. The purpose of the sessions was to vet the clinical, exclusions, and assignment logic for the potentially preventable conditions (PPCs) being proposed in the MHAC recommendation and engage in a dialogue concerning the clinical attributes of the methodology. Ms. Feeney noted that several clinicians provided extremely helpful input.

Ms. Feeney reported that another meeting was held in which hospitals were taught step-by-step how to calculate the payment decrement that would apply if MHAC was adopted and implemented.

Ms. Feeney stated that staff has prepared a list of the questions, feedback from the industry, issued raised, and staff's responses. Norbert Goldfield, M.D., 3M Health Information Systems (3M), reviewed in detail and presented staff's responses to: 1) the global suggestions for implementing the proposed MHACs; 2) the clinical concerns regarding specific proposed MHACs; and 3) the concerns raised about preventability and the "science" of the proposed MHACs. In addition, Ms. Feeney commented on concerns about the quality of administrative data. (Attachment A).

Dr. Goldfield stated that this feedback effort should be contrasted with that of Centers for

Medicare and Medicaid Services' (CMS) Hospital Acquired Conditions (HACs) where there are no exclusions and there were virtually no comments. Dr. Goldfield asserted that if complications are ever to be dramatically decreased in this country, it must be recognized that 100% standards are not appropriate. What is appropriate, however, is to develop and utilize global and disease related clinical exclusions, and also to recognize that the evidence-base for complications is not complete. As a result, 100% payment decrements should not be imposed, and for the more contentious PPCs, the payment decrement should be ultra-conservative. Dr. Goldfield noted that one of the benefits of a DRG-based model, as opposed to a regression model, is that feedback can be utilized in an ongoing effort to improve care.

Ms. Feeney asserted that Maryland's administrative data are better than most states primarily because of the implementation in Maryland of APR-DRGs in 2005 and the huge incentive to fully code provided by the Charge-per-Case payment system. Mr. Feeney presented a schedule that showed Maryland hospitals coded more secondary diagnoses per case than any other state.

Johns O'Brien, Deputy Director-Research and Methodology, addressed the operation and payment issues raised by the industry. Mr. O'Brien pointed out that unlike CMS' HACs payment decrements, the MHACs system does not affect payment for individual cases, but is applied to a hospital's overall allowed charges. The goal of MHACs is to create a hospital level incentive to increase quality by adjusting a hospital's overall allowable charges. The MHAC methodology is very conservative, since very few cases are subject to a revenue adjustment because of categorical and clinical exclusions. In addition, for those few cases identified, the revenue adjustment is only 90% of the increase in payment related to the PPC. The other 10% is intended to reflect the fact that even after exclusions; some complications are not 100% preventable. Mr. O'Brien noted that roughly 80% of the MHACs cases will have no payment decrement. Thus, the revenue impact is quite small, with the modifications proposed by staff today; the payment decrement is less than $5 million for all hospitals, approximately 0.06% of total allowable revenue.

Mr. O'Brien also stated that staff is recommending a "back-end" review process, i.e., the review of a sample of MHAC cases to ascertain whether the 90% payment decrement is appropriate, and when it is not appropriate to modify the decrement prospectively.

Mr. Murray stated that the MHAC initiative has strong support from the Maryland Health Care Commission (MHCC), the Department of Health and Mental Hygiene (DHMH), as well as the Maryland Office of Health Care Quality. CMS sent a letter stating that Maryland was lagging behind the nation and was the only state that had not implemented a system with payment decrements for PPCs. In addition, bills have been introduced in the legislature to address the issue of "never events," which are largely covered by the MHAC methodology; staff has had discussions legislators with who have emphasized the importance of addressing flaws in the payment system that reward hospitals for reduced quality.

Mr. Murray stated that not only was there support from governmental entities for this initiative, but there also seemed to be a desire on the part of many hospital clinicians who participated in the vetting sessions for the initiative, which provides them with monitoring and management

tools to help improve quality of care and reduce preventable complications and conditions.

Mr. Murray outlined staff's modified recommendations (Attachment B). The principal modifications to the draft recommendations included: 1) excluding PPC 63, Post-Operative Respiratory Failure with Tracheostomy; 2) adding additional clinical exclusions as a result of industry input for PPCs 39, 42, 57, 58, and 63 (for 3M's overall logic); and 3) conducting retrospective chart reviews to quantify false-positive occurrences relative to identified false-negative occurrences and to identify any additional unanticipated consequences or results which may lead to modifications of the MHAC initiative for the subsequent year. The unchanged recommendations include: 1) that payment decrements of 90% be applied to eligible MHAC cases; 2) that the initiative commence on April 1, 2009 with payment decrements being reflected in the following fiscal year; and 3) that the approved methodology also be applied to the rate year beginning July 1, 2009.

Mr. Murray noted that with the proposed modifications, removing PCC 63 and adding additional exclusions, the overall revenue decrement is reduced to approximately $3 million rather than the original estimate of $9.6 million. Mr. Murray emphasized that it is not about the money; the initiative is about providing the appropriate incentives in the system. MHACs, use a categorical model (a system of averaging), just as we do now with APR-DRGs to provide the right focus and incentive for the industry

Mr. Murray stated that staff strongly supports this initiative and believes it will be a positive enhancement to the system and will result in Maryland once again resuming a position of leadership in linking quality to payment.

Commissioner Sexton asked why PPCs 57 and 58 had much higher percentages of eligible cases than the other PPCs.

Dr. Goldfield explained that one reason was that there more cases in PPCs 57 and 58, the obstetrical (OB) PPCs.

Elizabeth McCullough of 3M added that the other reason that the OB PPCs have fewer clinical and global exclusions is because the patients are generally healthier.

Commissioner Hall asked Dr. Goldfield if he had any examples of how a hospital administration would make changes and handle physicians if these preventable conditions exist in a hospital.

Dr. Goldfield replied that whether identified as a result of a sentinel event or a high rate of events associated with an individual or hospital, the hospital should first examine each of the events in detail and then when the cause is identified, a variety of interventions are possible.

Commissioner Hall asked Mr. Murray if we are implementing this initiative because of Medicare, why are we not using CMS's recommendations.

Mr. Murray replied that we are not implementing this initiative because of Medicare. We are implementing it because it provides the right incentives; it can be applied to all payers; and it can change behavior in a positive way for the industry as a whole. However, we are sensitive to the fact that we are lagging behind Medicare because of the waiver.

Dr. Goldfield stated that as a practicing clinician, he believes that the CMS HAC system implemented with no exclusions is clinically highly problematic. Dr. Goldfield observed that we are trying with MHACs to suggest a better way by identifying exclusions, and by creating a categorical model in which there will be ongoing feedback.

Carmela Coyle, President of the Maryland Hospital Association, stated that we all agree that our goal should be for Maryland to be at the head of the class in quality and patient safety, however, using the 3M methodology of withholding payment to hospitals is not the right approach. Ms. Coyle pointed out that there are three reasons why hospitals believe that this methodology is not the right approach: 1) there is no clear link between an error in care and the outcome for which payment would be withheld - - the 3M experts have just conceded that there is tension between when some of these complications are a routine part of care and when they could be preventable; 2) evidence-based prevention guidelines do not exist for most of the MHAC PPCs; and 3) the National Quality Forum's technical panel unanimous decided not to advance 35 of 3M's PPCs for endorsement because of the use of billing rather than clinical information, the lack of validation of the methodology, and lack of transparency since the methodology is proprietary.

According to Ms. Coyle, these 11 rare high-cost conditions, with no link to whether there was good or bad care delivered, have the potential to tell us very little about the quality of care in the State of Maryland. In addition, there is little overlap, only 2 conditions, between Medicare HACs and MHAC PPCs.

Ms. Coyle noted that using appropriate financial incentives to improve care is the right idea, but achieving results will take a lot of hard work. Although the 3M option is an interesting one, other options should be considered. The industry believes that the 3M methodology should not be linked to payment at this time. Since no other alternatives have been pursued, we really are not sure that this PPC methodology is the absolutely right approach.

Ms, Coyle encouraged the Commission to vote no to staff's recommendation. Ms. Coyle asserted that it would not be "no" to patient care quality improvement; rather, it should be "no" to linking hospital payments to the 3M methodology. The industry believes the Commission should vote no because: 1) the vetting process for PPCs should continue; 2) there are technical issues concerning payment decrements that have not been resolved; 3) the HSCRC does not have the expertise to perform the "back end" audits; and 4) with the recent significant modifications, the MHAC policy still is not clearly understood by the industry's clinicians.

Ms. Coyle urged the Commission to convene a group of the stake holders, as well State and national quality experts, to look at what the principles for quality improvement in the State

should be, what the options are, and then attempt to move to consensus on the right direction to pursue.

Ms. Coyle noted that while the industry suggests that the Commission vote no, if the Commission decides to pursue this methodology, and since there seems to be a fair amount of work to be done to validate the methodology, it should be pilot tested at a few hospitals at 3M's expense before making the policy state-wide.

Hal Cohen, representing CareFirst of Maryland and Kaiser Permanente, expressed strong support for staff's recommendation effective April 1st. Dr. Cohen stated that incentives are important. For example when the Guaranteed Inpatient Revenue system was implemented, hospitals claimed that they could not control physician practice. However, once the incentives were in place, practices changed, and the average length of stay for Medicare patients declined. And, although there is very little decrement involved, the payers believe that we are beginning with the right structure that recognizes that patients, payers, and the industry should have better incentives to reduce overall complication rates.

Barry Rosen, representing United Healthcare, endorsed staff's recommendation. Mr. Rosen stated that the real "back end" review is measuring whether complications go down or not. If this endeavor causes hospital complications to go down, that is success, not the $3 million payment decrement. Success is whether hospitals and physicians modify their behavior.

Scott Spier, M.D., Medical Director-Mercy Medical Center (Mercy), expressed support for Ms. Coyle's comments. Dr. Spier stated that physicians at Mercy were concerned that several of the MHAC complications can occur even with good medical care. According to Dr. Spier, the adoption of MHACs may cause unintended consequences of less appropriate care or more expensive care. Dr. Spier presented several examples of such situations involving surgical MHACs.

Robert Atlas, M.D., Chair of Obstetrics at Mercy, noted that third and fourth degree lacerations can be 100% prevented by physicians avoiding vaginal deliveries and performing Caesarean sections instead. The MHAC program may encourage Caesarean sections, and with increased caesarean sections come increased complications, morbidity, and cost. Dr. Atlas proposed that rather than implement the MHAC recommendations, the State's Perinatal Collaborative would be a better alternative for identifying approaches to decreasing lacerations that are avoidable.

Andrew Satin, M.D., Chair OB/GYN- Johns Hopkins Bayview Medical Center, stated that there were also several factors that can pose a greater risk for lacerations that are not in the control of physicians, e.g., size of the baby, size of the mother, baby in occiput posterior position (backward), history of lacerations, and prolonged labor. Dr. Satin expressed agreement with Dr. Atlas that the performance of more Caesarian sections and mediolateral episiotomies were not acceptable alternatives to vaginal deliveries that bring with them, in some cases, unavoidable lacerations.

Donovan Dietrick. M.D., Director OB/GYN Residency Program-Franklin Square Hospital, reported that since 1984, the number of OB/GYN residency programs had decreased from nine to four. Dr. Dietrick also stated that the MHAC program would have a detrimental effect on the remaining OB/GYN residency programs by encouraging Caesarean sections and super cervical hysterectomies, and thereby, resulting in graduates avoiding vaginal deliveries.

Phillip Buescher, M.D., Critical Care Medicine-Union Memorial Hospital, voiced concern about the process for determining the conditions that were included in the MHAC recommendations. Dr. Buescher stated that physicians will do what is right for the patient regardless of financial incentives. However, incentives should be put in place for physicians to do things the "right way" by paying for training and the education of physicians on the best clinical practices and techniques.

James Raver, M.D., Senior Vice President/Chief Medical Officer-Western Maryland Health System, noted that most, if not all, of the clinical measures in the MHAC list are areas of focus of the Maryland Patient Safety Center or are otherwise being addressed. Dr. Raver asserted that applying payment reductions in an already stressed environment will reduce access, and that inappropriate incentives may delay good follow-up care. Dr. Raver presented several examples illustrating the difficulty of telling distinguishing between preventable and non-preventable complications. Dr. Raver stated that while hospitals have accepted the CMS list of hospital acquired conditions, there is concern about the level of preventability for the proposed MHACs which are not on the CMS list.

Commissioner Wong made a motion to modify staff's the recommendation. The Commissioner stated that he appreciated the work that staff, the industry, and others to get this proposal closer to something that is acceptable to everyone. Commissioner Wong observed: 1) that if we wait for scientific evidence that tells us what to do, we will be waiting a long time since there is very little research being done in this field; 2) that chart review as an alternative is not practical; and 3) that Maryland is in a unique position offer an alternative to CMS HACs . As to concerns about the use of administrative data, Commissioner Wong stated that with the addition of the POA indicator, Maryland's data are among the best in the nation. However, Commissioner Wong observed that the two greatest concerns raised were that the 3M software produces false positives, i.e., complications that seem to be preventable, but on further examination are not, and benchmarks, i.e., the hospital and the physicians have done everything right, but the complication still occurs. However, the recommended payment proposal calls for a decrement of 90% of the increment between what should have been paid and what was paid. It has a built-in 10% buffer for what cannot be controlled; whether there are false positives in the software or benchmarks, 10% of the decrement is not assessed.

Commissioner Wong made the following motion: 1) that the decrement rate be lowered from 90% to 85%; 2) that the retrospective chart review be used to determine whether the decrement rate is appropriate; and 3) that implementation of the policy be delayed until July 1, 2009 to allow staff and industry to work out the details of the policy and to consider whether or not other conditions should be added to or deleted from the current list of PPCs.

Commissioner Antos seconded Commissioner Wong's motion. Commission Antos suggested that perhaps staff could monitor the benchmarks over the course of the year to ascertain whether it would be appropriate for some MHACs, in particular the obstetric PPCs, to have a more generous decrement rate.

Commissioner Lowthers expressed support for Commissioner Wong's motion; however, he expressed concern over going too slowly. Rather than engage in academic discussions, Commissioner Lowthers urged the Commission to move quickly and aggressively in this area.

Commissioner Sexton stated that we are searching to find where the benchmark is and how do you move it. Commissioner Sexton contended that you do that by sharing knowledge and applying incentives that are both positive and negative. Commissioner Sexton asserted that the proposed methodology does not measure up on those points. Commissioner Sexton proposed that rather than do chart review with the attending issue of blame, that we implement something along the traditional DRG pathway, since DRGS already provide a powerful incentive not to have problems. If you have outlier cases you usually lose money. We should explore a methodology that, for at least some of the MHACs, combines PPC up-coding cases with the other cases in the baseline to create a rate. Hospitals would be paid at that rate and could not up code to increase payment. The benefit would be that we have not blamed anyone, but we have set a normative standard with the incentive to work on ways to have fewer complications. It would reward hospitals that improve and penalize those that do worse. Commissioner Sexton urged the Commission to consider this alternative during the period before the implementation of the proposed policy.

Mr. Murray stated that penalties and rewards are implicit because of the zero-sum nature of our system. The intent of the $3 million decrement is that it generates discussion and interaction at the hospital level among administrators, financial managers, clinicians, and coders about what could be done, and what processes could be put in place to increase quality.

Commissioner Sexton stated that the if the impact was more immediate, more obvious, and more direct, more discussion would be generated about ways to increase quality.

Commissioner Hall stated that she agreed with the clinicians who spoke today that they do not believe that hospital administrations and these processes can actually make them do a better job. In addition, Commissioner Hall expressed strong concern about the inclusion of the maternal fetal MHACs and suggested that the MHACs associated with obstetrics be removed from the proposed policy.

Commissioner Brusca urged the Commission to move now and not delay. As we have done successfully in the past, we can make corrections to the policy based on experience.

Commissioner Antos stated that Commissioner Sexton's methodological alternative should be considered if it is feasible; not to do so would be wrong. However, there should be no delay in

implementation of a policy beyond July 1, 2009.

Mr. Murray stated that at this late date, it is not feasible to address an alternative using another set of indicators in two months after working on this methodology for many months. Staff believes that this is the first logical, step and staff remains very receptive to additional steps to refine and expand the methodology.

Commissioner Hall asked whether there would be an appeals process.

Mr. Murray stated that since the impact on payment of the policy is on an overall basis, it is appropriate that we have a back end review that looks at the overall impact of the policy and makes modifications on a prospective basis.

The Commission approved staff's recommendation with Commissioner Wong's modifications by a vote of 5 to 2, Commissioners Hall and Sexton opposing the motion.

ITEM VI
FINAL RECOMMENDATIONS FOR REVISIONS TO THE REASONABLENESS OF CHARGES (ROC) METHODOLOGY

Mr. O'Brien summarized the final recommendation for revisions to the ROC methodology. Mr. O'Brien noted that there were only three changes from the draft recommendation presented at the February public meeting. They are as follows: 1) staff accepted the industry's proposal that scaling of the FY 2010 Update apply to the top and bottom quartiles; 2) at the suggestion of the payers, high priority will be given to how capital is handled in the ROC, and whether partial rate review for capital are still necessary; and 3) that a direct strip of property and sales tax for the only for-profit hospital in the State be made in the ROC.

Mr. O'Brien reported that staff will meet with industry and payer representatives in the next month to discuss a technical issue as to how to apply the adjustments for Indirect Medical Education (IME) and Disproportionate Share (DHS). Mr. O'Brien stated that this issue does not change staff's recommendation or the policy; however, it does impact on a hospital's position on the ROC.

Mr. O'Brien announced that staff will report the resolution of the technical issue and will release the ROC calculation at the April 15th public meeting.

Dr. Cohen urged approval of staff's recommendation. Dr. Cohen also asked that staff look at two technical issues: 1) whether DSH should be applied as a difference from the state-wide mean, or whether it should be applied on actual costs, analogous to a strip; and 2) whether a state-wide peer group excluding academic medical centers (AMCs) and a national peer group for AMCs should replace the current peer groups.

The Commission voted unanimously to approve staff's recommendation

ITEM VII
LEGISLATIVE REPORT

Steve Ports, Principal Deputy Director-Policy and Operations, reported that CMS informed the HSCRC that there is approximately $5.3 million available to Maryland hospitals in a federal EMTALA program, which provides reimbursement to hospitals and physicians for emergency medical care provided to undocumented aliens. According to CMS, no Maryland hospitals have taken advantage of the program. Staff intends to investigate why Maryland hospitals have not participated in the program and to find a way to encourage them to do so.

Ms. Traci Phillips, representing MHA, stated that it was MHA's belief that the program provided $5 million over 4 years and that approximately $650,000 would be available before the program ends, March 31, 2009. Ms. Phillips stated that MHA had been informed that after the program ends the funds would no longer be available for Maryland hospitals.

Mr. Ports stated that it was staff's understanding that the funds would be available until expended; however, staff would contact CMS to clarify whether or not the funds were still available.

Mr. Ports presented an update on legislation of interest to the HSCRC (attachment D). The most significant health care legislation is HB 1069/SB 776 Financial Assistance and Debt Collection Policies, which mandates a minimal hospital financial assistance policy of 150% of the Federal Poverty Level (FPL) and requires hospitals to: 1) include an information sheet with hospital bills and, upon request, include certain financial information; 2) 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 3) submit to the HSCRC their policy on the collection of debts owed by patients. In addition, it requires the HSCRC to: 1) establish uniform requirements for the financial assistance information sheet; 2) review the implementation of and compliance relative to the information sheet and hospital collection policies; and 3) establish work groups to consider further changes necessary relative to hospital financial assistance and debt collection policies and for the HSCRC to review its uncompensated care policy to see if incentives can be created to provide more free or reduced-price care to the poor.

Mr. Ports stated that the HSCRC supports the legislation with following amendments: 1) that the minimal financial assistance be increased to 200% of the FPL; 2) that the issue prohibiting liens on primary residences be studied; and 3) that the rate of interest on late payment of hospital bills remain under HSCRC regulation.

Other bills of interest include: 1) SB435/HB758 - Never Events, which would require hospitals to report "never events" to the CMS and disallows payment for these cases from Medicare and

Medicaid if the hospital is responsible for the "never event." HSCRC supports the concept but prefers the MHAC approach under HSCRC's current authority; 2) SB 231/HB 487 – Annual Reports of Compensation which, would require hospitals to report to the HSCRC the annual compensation of its officers and expenditures for lobbyists; and 3) the Budget Reconciliation and Financing Act, which would reduce hospital rates for averted bad debt resulting from Medicaid expansion from 25% to 10%, and require certain Medicaid-eligible beneficiaries of the MHIP program to enroll in Medicaid in order to access federal matching funds.

Mr. Ports also announced that a Prince George's Hospital Authority bill was introduced. The bill would extend the time for the bidding process, allow the Maryland Health Care Commission to grant exemptions to the Certificate of Need process to facilitate agreements, and allow the assets to be transferred separately rather than as a single unit, when deemed appropriate by the Authority.

ITEM VIII
HEARING AND MEETING SCHEDULE

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

There being no further business, the meeting was adjourned at 11:50 a.m.

Attachment A

Proposed MHACs: Input and HSCRC Staff Responses
As of February 26, 2006

A - Global suggestions for implementing the proposed MHACs

The following suggestions were made (**Johns Hopkins Hospital (JHH)**)

- Consider excluding kidney transplant patients(**JHH- Dr. Ed Kraus,Transplant/Nephrology**)
- Utilize rate-based PPCs rather than individual cases, e.g. iatrogenic pneumothoraces
- Provide a method for appealing cases
- Transfer patients should be excluded
- A mechanism is needed to account for patients with complicated courses of care
  - Immunosuppressed patients
  - Multiple co-morbidities similar to other organ transplants – if not more so

RESPONSE: No change is recommended for the global PPC logic. It is perfectly reasonable to compare complication rates for kidney transplant patients, a very frequently performed procedure (unlike other types of transplants) across hospitals. In addition, it is important to point out that in the first month after transplantation, the usual postoperative surgical infections, similar to those seen in nonimmunosuppressed patients undergoing similar surgical procedures, are most common. Opportunistic infections, such as those due to Pneumocystis carinii and Nocardia asteroides, are rare in this time period, even though the patient is exposed to the highest degree of immunosuppression both to prevent and, in some cases, to treat acute rejection. (source: Up to Date, Differential diagnosis of infection following renal transplantation). However, these types of patients will have higher rates of complications at baseline that are less likely to be preventable. Payment policy could address this with a discussion regarding the amount of payment reduction associated with MHAC complications currently set at the 90% preventability level in future iterations of the methodology.

To address issues related to immunosuppressed patients and patients with multiple co-morbidities , the following conditions are globally excluded from the denominator for all the PPCs and the subset of proposed MHACs:

- **All Newborns**
- **Global exclusions for patients admitted for**
  - **Major Trauma**
  - **Major Organ Transplants**
  - **Major or Metastatic Malignancy**
  - **Cardiac arrest**
  - **HIV**
  - **Specific Burns**

With respect to the suggestion to focus on a methodology comparing actual rate of occurrence vs. expected rate of occurrence, staff believes a "rate-based" approach will be appropriate for the broader list of Potentially Preventable Complications. The MHAC initiative however, is tailored to address a subset of complications that are considered to be the most highly preventable (similar to the Medicare HAC initiative).

A Attachment HA

Proposed MHACs: Input and HSCRC Staff Responses

As of February 26, 2006

With respect to the suggestion of including a process for hospitals to appeal individual cases, staff believes case by case appeal will prove too cumbersome and administratively impossible to handle. Staff would remind the Commission that the MHAC methodology is an "averaging" methodology (similar to the averaging nature of DRGs). The 10% retention factor is intended to provide sufficient allowance for either "false-positive" cases or circumstances that "despite the best efforts of physicians" were not 100% preventable. That is precisely the rationale behind not adopting the CMS approach of applying a 100% "payment" reduction. Stall is however, is proposing a back-end review (sampling a representative number of cases in the next year) to quantify the number of false-positives (net of false-negatives) with the potential of adjusting the methodology moving forward.

With respect to the suggestion to eliminate transfer patients, staff believes this exclusion is not necessary given that these cases still will have all secondary diagnosis present on admission identified and coded and the PPCs selected for inclusion in the MHAC initiative do not show much variation across hospitals seeing patients with different burdens of illness.

B - Clinical concerns raised regarding some specific proposed MHACs

- **PPC63- Respiratory failure with a tracheostomy-**

Patients with chronic respiratory conditions such as bullous emphysema, chronic obstructive pulmonary disease or asthma may not be able to be weaned from a ventilator. **(Dr. Trudy Hall, Holy Cross Hospital)**

The following suggestions were made**(JHH - Dr. Elliott Haut, Trauma Surgery, and Dr. Brent Petty, Medicine)**:

- The presence of a tracheostomy does not represent a complication
- Need to be more clearly define respiratory failure and hypoventilation
- Use a narrower focus for respiratory failure, e.g. not every instance of hypoxia
  - Perhaps focus on compensated respiratory failure
- The evidence-based literature demonstrates that earlier tracheostomy placement leads to better outcomes
  - The 14-day cutoff is arbitrary
  - A possible unintended consequence may possibly be earlier tracheostomies

Suggested exclusions **(JHH- Dr. John Conte, Cardiac Surgery):**

- Ventricular assist devices (VADs) due to co-morbidities
- Re-operative surgery
- Multiple previous operations
- Hemodynamically unstable or emergent patients
- Patients who are morbidly obese
- Transfers from another institution in shock (unstable), a way to protect the receiving institution as well as hold all institutions to the same standard for the same patients

- Complex patients with heart failure and have cystic fibrosis and left ventricular dysfunction
- The elderly

The following clarifications are requested **(Holy Cross Hospital)**:

- Rationale behind the PPC is not clear.
- Why is there no PPC assignment if tracheostomy performed within 14 days of original surgery?
- What if respiratory failure did not occur immediately postoperatively?
- There is a period of time between initiation of ventilation and decision that tracheostomy must be performed.
- Why exclude merely if trach done "early?" What if family decision-making delayed tracheostomy?
- A case was coded as POA Y for polymyositis, which is an idiopathic inflammatory myopathy. Listed in Appendix O, exclusion group 85 are Myopathy NOS and Myopathies NEC. polymyositis should fall into one of those categories, thus excluding the case from PPC 63. (Alternately, polymyositis should be added to group 85 as an exclusion.)"

RESPONSE: This PPC was intended to capture a specific, very ill, subset of patients with respiratory failure who were not able to be weaned from mechanical ventilation. Based on the feedback received, staff are recommending that PPC 63 be removed from the list of proposed MHACs. In addition, 3M HIS recommends adding 710.3 (Dermatomyositis) and 710.4 (polymyositis) to exclusion group 85 Neuro-muscular disorders.

• PPC 39- Reopening of the surgical site:

- Clarify the definition of "reopening surgical site" in the context of staged procedures and when wound therapy devices are necessary. **(JHH - Dr. Elliott Haut, Trauma Surgery, Dr. Ed Kraus Transplant/Nephrology, Dr. Catherine Sargent , Orthopedics)**:

RESPONSE: No change to PPC logic is recommended. The PPC logic excludes certain spinal procedures and pituitary procedures that might indicate the need for a staged procedure. If there are specific example, 3M HIS would entertain adding exclusions for other specific staged procedures, and welcomes suggestions.

- Clarify if an institution will be penalized for cases with initial diagnosis is necrotizing fasciitis, which often requires multiple returns to OR for repeated debridement of the same surgical site. This diagnosis should be listed as an exclusion **(Holy Cross Hospital)**.

RESPONSE: 3M HIS recommends adding 728.86 (Necrotizing fasciitis) to exclusion group 76 (Septicemia and disseminated infections) to the list of exclusion codes.

- Cases in which a prior procedure has been performed on the same surgical site (e.g. repeat c-section, repeat myomectomy), should be excluded since such cases are known to have an increased risk for complications such as bleeding and may require return to the OR **(Holy Cross)**.

RESPONSE: No change to PPC logic is recommended. The issue of patients at increased risk of specific complications should be dealt with by adjustment of the percentage reduction in payment rather than attempts to modify the existing PPCs.

• PPC 41- Hemorrhage or hematoma

- Bleeding controlled intraoperatively should not be included as post-operative hemorrhage.**(JHH-Dr. Ed Kraus Transplant/Nephrology)**
- Clarification is needed on this PPC. In some instances it appears to apply only when the hemorrhage control procedure occurs at least one day later and in other instances it does not. For instance, a laparoscopically assisted myomectomy may be converted (mid-procedure) to an open procedure, due to bleeding. This is a known and common complication and will have been discovered and treated at the time of the original surgery **(Holy Cross Hospital).**

RESPONSE: No change to PPC logic is recommended. PPC 41 requires the presence of the diagnosis code "hemorrhage (or hematoma) complicating procedure" *and* a procedure code for the hemorrhage control procedure, such as "occlusion of artery (or vein)". Surgical consultants to 3M HIS advise that the surgeon should not code the hemorrhage control procedure that occurs during the initial operation, since to do so would be the equivalent of "unbundling". The hemorrhage control procedure should be considered part of the original surgery – and, again, not coded. It is extremely unlikely that a patient on anti-inflammatory medications will have a hemorrhagic problem after operation as the vast majority of the time operations under these circumstances are either postponed or the clotting problem is addressed in advance of the operation

- Cases in which a prior procedure has been performed on the same surgical site (e.g. repeat c-section, repeat myomectomy) should be excluded since such cases are known to have an increased risk for complications such as bleeding **(Holy Cross Hospital).**

RESPONSE: See answer above to the similar comment on PPC 39. No change to PPC logic is recommended. The issue of patients at increased risk of specific complications should be dealt with by adjustment of the percentage reduction in payment rather than attempts to modify the existing PPCs.

- There should be an exclusion for patients with hematologic disorders that predispose them to bleeding (e.g. bleeding diatheses, low platelet counts) who undergo surgical procedures **(Holy Cross Hospital)**. There is no mention of patients with liver disease, anticoagulation problems, or

certain drug use such as non-steroidal anti inflammatory (NSAID) or aspirin prior to the admission. **(Dr. Trudy Hall)**

RESPONSE: No change to PPC logic is recommended. Most secondary diagnoses for thrombocytopenia and significant coagulation disorders have a default severity of illness level of 3, which, in combination with other higher severity secondary diagnoses can result in the patient being assigned to severity level 4. Severity level 4 patients will not have a decrement in reimbursement unless the charges exceed the high charge outlier threshold. Of the cases with PPC 41 present, 6.9% of them have a payment decrement, significantly below the 90% preventable level.

- **PPC 42- Accidental puncture/laceration during an invasive procedure**
  - Clarification requested: If a patient is undergoing an abdominal surgery and has extensive adhesions that must be lysed, there may be an incidental cystotomy or bowel perforation. These are known and fairly common complications of this type of surgery. As long as these are identified and repaired during the original surgical procedure, then they do not fall into this PPC. Is that correct? **(Holy Cross Hospital)**

RESPONSE: No Change to PPC Logic is required. From the Coding Guidelines: Surgeons must be queried as to whether the tear was an incidental occurrence inherent in the surgical procedure or whether the tear should be considered by the surgeon to be a complication of the procedure. If not clinically significant no codes are required on the record.

Also - lysis of adhesions may be very extensive and time-consuming, or can be relatively trivial and not at all time-consuming. Obviously a laceration in the former setting is much more likely than in the latter. Unfortunately, ICD-9 codes do not allow us to make these kinds of distinctions. Of the cases with PPC 42 present, 2.1% of them have a payment decrement.

  - Clarify the PPC logic: If the laceration isn't discovered until later the same day and patient is returned to OR for repair, then it appears to fall out of the PPC as well. This doesn't seem to make sense **(Holy Cross Hospital).**

RESPONSE: This is a fair point. Since most laceration repairs listed as secondary procedures will have resulted from an intraoperative laceration, we will extend the logic to include the laceration repairs that were performed on the same day as the primary procedure.

- **PPC 49- Iatrogenic pneumothorax**
  - Clarify exclusions **(JHH)**
    - major esophageal procedures (surgical or operative)
    - intrathoracic surgical or operative procedures
    - include thoracic scoliosis procedures as an exclusion as well as

- when the thorax is part of the planned surgical field
- A certain rate of pneumothoraces is considered acceptable. The challenge lies in determining the acceptable rate.

RESPONSE: No change to PPC logic is recommended. Payment policy could address this with a discussion regarding the amount of payment reduction associated with MHAC complications (currently set at the 90% preventability level) in future iterations of the methodology.

- Should a pneumothorax resolved with oxygen still be considered a pneumothorax? **(JHH)**

RESPONSE: No change to PPC logic is recommended. From Coding Guidelines: Pneumothorax is a known risk associated with most thoracic surgeries. If the physician does not document it as significant then no code is necessary.

- There should be an exclusion for pneumothorax caused by subclavian line placement, as this is a known complication of that procedure (Holy Cross).

RESPONSE: No change to the PPC logic is recommended. This is still a complication that nonetheless should be discouraged as much as possible.

• PPCs 52- Inflammation & other complications of devices, implants or grafts except vascular infection and PPC 54 – Infections due to central venous catheters (JHH)

- Only include "confirmed" Central Venous Catheter (CVC) infections (not suspected or differential), e.g. a fever of unknown origin in a patient with a central venous catheter should not be considered an infection.
- Infections are subject to Hospital Epidemiology and Infection Control (HEIC) review
- Emphasize complications of devices, implants or grafts
- Define what constitutes a clinically important inflammation. The current definition is too broad.

RESPONSE: No change to the PPC logic is recommended. From Coding Guidelines: "If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out" or other similar terms indicating uncertainty, code the condition as if it existed or was established.

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- **PPC 52- Inflammation & other complications of devices, implants or grafts except vascular Infection**

  - It appears that if the patient is discharged and then readmitted with the "complication," then it's excluded from the PPC. What if the problem is discovered while the patient is still hospitalized after the initial procedure and the patient receives treatment? Then is the PPC? Might this encourage inappropriate discharge then readmission of patients to avoid the PPC? **(Holy Cross Hospital)**

RESPONSE: No change to PPC logic is recommended: One would hope that ethical physicians would not be discharging patients with a known complication only to readmit them almost immediately. It is certainly true that a hospital earns more from an additional admission, but that incentive is present already.

- **PPC 54- Infections due to central venous catheters:**

  - Patients admitted with intravascular infections (e.g endocarditis), and not just those with infections linked to devices, should be excluded from this PPC **(Holy Cross Hospital).**

RESPONSE: No change to PPC logic is recommended. The severity of illness for a patient with subacute bacterial endocarditis is already a level 4, and therefore the only payment decrement would be if the case has charges over the high charge outlier threshold. The 90% preventability level will address this issue.

  - Changing payment for infection PPCs may increase antibiotic prescriptions which may increase the incidence of resistant infections **(Dr. Trudy Hall).**

RESPONSE: Infections resistant to antibiotics are a much smaller problem than simply good anti-septic practices (there was recent reference to an article in the Washington Post earlier in February 09 based on articles published in the literature).

- **PPC 57- Obstetric lacerations & other trauma without instrumentation**
  AND
  PPC 58 Obstetric lacerations & other Trauma with Instrumentation

  - Consider excluding patients coded for fetal distress and unfavorable fetal heart rate **(JHH - Dr. Frank Witter, GYN/OB)**

- For PPC 57, there are multiple risk factors for significant lacerations during delivery, and they include: macrosomia (baby weighing over 4,000 gms), fetal malpresentation (e.g. OP, transverse, breech), shoulder dystocia, precipitous delivery, fetal intolerance of labor (e.g. as evidenced by bradycardia on fetal monitoring), maternal morbid obesity (which is linked to increased rates of large babies and shoulder dystocia), primiparous mom. In addition, the current standard of care for vaginal deliveries is that no episiotomy should be performed. If the physician decides to perform an episiotomy, then a mediolateral episiotomy is the preferred method **(Holy Cross Hospital)**.

RESPONSE: We agree that a mediolateral episiotomy is the preferred method when a physician decides to do an episiotomy as this results in a dramatically lower incidence of third and fourth degree tears. There is extensive Obstetrics research literature documenting the positive impact of interventions for most conditions that are mentioned above. However, with respect to extreme obesity, 3M HIS suggests adding the diagnosis code for basal metabolic index (BMI) > 40 (V854) to PPC 57 and 58 exclusion list.

- For PPC 57, cervical lacerations are also more likely in cases where the patient has previously undergone cervical surgery (e.g. cryotherapy or cerclage), as she may have cervical scarring and stenosis **(Holy Cross Hospital)**.

RESPONSE: No change to PPC logic is recommended. The diagnosis code for prior cervical surgery is 654.61 Other congenital or acquired abnormality of cervix, with delivery. There are 602 (0.9%) OB delivered cases in the Maryland data with the diagnosis code 654.61. Of these, 17 cases were assigned PPC 57. Since this is a vague code, not specific to cryotherapy or cerclage, the 90% preventability level will address this concern which occurs very rarely.

- For PPC 57, the above risk factors should exclude cases from the PPC. Performance of no episiotomy or a mediolateral episiotomy should also exclude cases. Do we risk encouraging more (inappropriate?) c-sections to avoid lacerations and PPCs? **(Holy Cross Hospital and Dr. Trudy Hall)**

RESPONSE: No change to PPC logic is recommended. We don't want to encourage more inappropriate C-sections. This issue probably requires separate strategies such as the Maryland Patient Safety Center Perinatal Collaborative work. Staff are planning meetings in the near term to discuss strategies with Collaborative leaders.

- For PPC 58, Exclusions should be the same as those suggested for PPC 57. Maternal/fetal intolerance of labor should absolutely be an exclusion, as this is a common scenario in which instrumentation must be used **(Holy Cross Hospital)**.

RESPONSE : No change to PPC logic is recommended. The complication rates for vaginal delivery with instrumentation are counted separately from unassisted vaginal deliveries.

- **PPC 60 Major puerperal infection and other major obstetric complications**

  - Consider excluding patients as follows **(JHH - Dr. Frank Witter, GYN/OB)**:
    - patients with placenta accreta, increta and percreta
    - patients with ruptured membranes present on admission
    - patients with cord prolapse

RESPONSE: No change to PPC logic is recommended. Diagnosis codes for placenta accreta, increta and percreta are:

667.02 retained placenta without hem, delivered with mention of postpartum complication
667.12 retained portions of placenta or membranes without hem, delivered with mention of postpartum complication

667.00 retained placenta without hem, unspecified as to episode of care
667.10 retained portions of placenta or membranes without hem, unspecified as to episode of care

667.04 retained placenta without hem, postpartum condition or complication
667.14 retained portions of placenta or membranes without hem, postpartum condition or complication

Diagnosis codes 667.02 and 667.12 were coded on 0.4% of the OB delivery cases and only one of these cases were assigned PPC 60. There were 2,876 cases that included the code for premature rupture of membranes (658.11 or 658.12), none of which were assigned PPC 60. Further, of the 153 cases (0.2%) that included the code for cord prolapse (663.01), none of the cases were assigned PPC 60. The 90% preventability level will address these concerns which occur very rarely.

- Endometritis occurs not uncommonly after c-sections and is not necessarily a "major" infection. However, coding guidelines apparently require its coding as 67002 (i.e. major puerperal infection...). Cases where infection is not severe (e.g. no positive blood cultures, no accompanying diagnosis of sepsis, no prolongation of hospital stay beyond that expected after delivery by c-section) should be excluded from the PPC **(Holy Cross Hospital)**.

RESPONSE: Staff recommend excluding code for acute endometritis (6150).

- Cases who received appropriate prophylactic antibiotic who had a known pre-existing condition placing them at risk for infection (e.g. beta strep carriage, morbid obesity, preterm premature rupture of membranes—which is an indication of an underlying inflammatory or infectious process, prolonged labor—requires multiple exams and thus predisposes to infection, vaginally-

assisted delivery—instrumentation increases infection risk) should be excluded from PPC for 67002 **(Holy Cross Hospital)**.

RESPONSE: No change to PP logic is recommended as there are clear studies that indicate that interventions do decrease the likelihood of infection. For example, with respect to preterm premature rupture of membranes there is an increased risk of infectious process which is significantly decreased with prophylactic antibiotics as documented in a recent Cochrane Review. Again, none of the 2,876 cases that included the code for premature rupture of membranes (658.11 or 658.12) were assigned PPC 60. The 90% preventability level will address this concern.

- Cases of uterine rupture in patients who've undergone multiple prior procedures on uterus (e.g. c-sections, myomectomies) should be excluded **(Holy Cross Hospital)**.

RESPONSE: No change to PPC logic is recommended. 25 OB delivered cases were coded with diagnosis of uterine rupture (665.01 Rupture of uterus before onset of labor, with delivery or 665.11 Rupture of uterus, with delivery) that were also coded with prior procedure on uterus (654.21 Previous cesarean delivery, with delivery, with or without mention of antepartum condition or 654.61 Other congenital or acquired abnormality of cervix, with delivery). Of these 25 (0.04%) cases, 9 were assigned PPC 60. The 90% preventability level will address this concern which occurs very rarely.

- Appropriate VTE prophylaxis should be a PPC exclusion if a pulmonary embolism develops **(Holy Cross Hospital)**.

RESPONSE: No change to PPC logic is recommended. VTE prophylaxis is not captured by ICD-9 coding in the discharge data. The 90% preventability level will address this concern which occurs very rarely.

- **PPC 16- Deep vein thrombosis (DVT)**: concerns were raised about adjusting payment for this condition occurring which has been the focus of increased screening, resulting in "10 fold increase" in the rates. **(Pronovost)**

RESPONSE: This PPC is <u>not a proposed MHAC</u> so payment decrement would not be applied through this methodology. It should also be noted that the current methodology does, in fact, add allowable charges based on the reporting of DVT.

<u>C- Concerns raised about preventability and "science" of the Proposed MHACs</u>

- Concern was raised about the general link of quality measurement to "science". Example of the human genome project was provided for how research furthered the science (Pronovost)

RESPONSE: One of the reasons for the advancement in medical areas, especially in the human genome work, is not just that science went first; it was that there were also financial drivers that led to investments and priorities that spurred the heavy lifting that led to the science. The MHAC proposal is an effort to align payment incentives so that the science of quality is supported and raised to a higher level.

- Specific example of wrong site surgery not being so easily solved with "time out" procedures **(Pronovost)**

RESPONSE: wrong site surgery is not part of the proposed MHACs. MHACs in general are an adjustment to a payment system. The MHACs do not get into the business of telling physicians or hospitals how to prevent things such a wrong site surgery – rather they raise the financial stake (at the margins) preventable events. The MHAC proposal is not prescriptive which is the criticism of the wrong site surgery rules.

- Concerns about the preventability of the PPCs **(various)**

RESPONSE: Under the PPC methodology as applied to payment, there are four conditions that must be met before a payment reduction would be applicable:

- **The case is not globally excluded**
- **None of the complication specific clinical exclusions apply to the case**
- **The case was not at severity level 4 at admission or charges above high charge outlier thresholds**
- **There are not other significant comorbid conditions present at the same level of severity as the complication**

These are very comprehensive restrictions that result in the majority of cases with a complication being excluded from any payment adjustment.

PPC	PPC Description	PPC Count	Count PPC Pay Impact	% PPC Pay Impact	% Adm SOI 1 or 2
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	81	10	12.4%	30.0%
39	Reopening Surgical Site	122	15	12.3%	40.0%
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Procedure	262	18	6.9%	22.2%
42	Accidental Puncture/Laceration During Invasive Procedure	1,971	41	2.1%	41.5%

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45	Post-procedure Foreign Bodies	30	0	0.0%	0.0%
49	Iatrogenic Pneumothrax	1,043	19	1.8%	10.5%
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	1,379	69	5.0%	23.2%
54	Infections due to Central Venous Catheters	381	43	11.3%	14.0%
57	Obstetric Lacerations & Other Trauma Without Instrumentation	1,533	634	41.4%	96.4%
58	Obstetric Lacerations & Other Trauma With Instrumentation	598	213	35.6%	98.6%
60	Major Puerperal Infection and Other Major Obstetric Complications	295	195	66.1%	86.2%
63	Post-Operative Respiratory Failure with Tracheostomy	93	91	97.8%	31.9%
		7,788	1,348	17.30%	79.5%

Of the 7,788 occurrences of one of the 12 complications in 5,767 cases only 1,348 of those occurances (in 1,305 cases) met all four criteria and would lead to a payment reduction. Thus, 17.3 percent of the occurrences of the 12 complications were considered preventable and lead to a payment reduction and 82.7 percent of these occurences did not meet all four criteria and therefore were not subject to a payment reduction. The propose payment adjustment methodology assumes an overall rate of preventability of 17.3 percent which by any standard is extremely conservative. Further, the application of the four criteria results in 79.9 percent of the case for which a payment adjustment is made being severity level one or two.

Note: the above paragraph and chart need to be updated to reflect the current staff recommendation to remove PPC 63 (Post-Operative Respiratory Failure with Tracheostomy). The numbers in the chart and paragraph will be changed when staff is able to refresh the analysis to account for the removal of PPC 63 from the proposed methodology.

D- Concern about the quality of administrative data and whether it is sufficient for application in payment decrements

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- POA indicator: Concern was raised about the accuracy of the POA. **(Trudy Hall, MD)**

RESPONSE:

Present on Admission Reporting Guidelines:

As stated in the Introduction to the ICD-9-CM Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized.

These guidelines are not a substitute for the provider's clinical judgment as to the determination of whether a condition was/was not present on admission. The provider should be queried regarding issues related to the linking of signs/symptoms, timing of test results, and the timing of findings.

Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

Reporting Options:

Y - Yes

N - No

U - Unknown

W – Clinically undetermined

Unreported/Not used (or "1" for Medicare usage) – (Exempt from POA reporting)

Timeframe for POA Identification and Documentation:

There is no required timeframe as to when a provider (per the definition of "provider" used in these guidelines) must identify or document a condition to be present on admission. In some clinical situations, it may not be possible for a provider to make a definitive diagnosis (or a condition may not be recognized or reported by the patient) for a period of time after admission. In some cases it may be several days before the provider arrives at a definitive diagnosis. This does not mean that the condition was not present on admission. Determination of whether the condition was present on admission or not will be based on the applicable POA guideline as identified in this document, or on the provider's best clinical judgment.

If at the time of code assignment the documentation is unclear as to whether a condition was present on admission or not, it is appropriate to query the provider for clarification.

- Specifically related to PPC 54- Central line associated blood stream infection: concern was raised about using administrative data for this measure when MHCC is collecting the data through the CDC's National Hospital Safety Network data collection tool. (Pronovost)

  RESPONSE: In October of 2008, a GAO report articulated concerns about the under reporting of infections to the NHSN and cited lack of incentives to fully report or ability to confirm full reporting. For this reason, MHCC does plan to audit cases of central line infections, and the use of HSCRC data to possibly identify CL infections not self-reported for the audit is under discussion. Clinical and administrative data can be used for different purposes, i.e., public reporting versus quality based reimbursement, and serve mutually complementary functions.

- General concern about the quality of administrative data (various)

  RESPONSE: Maryland has a history of using administrative data to make very fine adjustments to payment.

  Administrative data are already used for payment in MS and APR DRGs.

  - **The 12 MHACs are better than the CMS HACs from a coding perspective (cleaner and less vulnerable to POA data of questionable or bad quality)**
  - **Good quality POA data allows appropriate identification of hospital-acquired conditions, as intended.**
  - **Clinical data is always better if it is complete, but is much more difficult and labor intensive to obtain reliably and fully, particularly for outcomes.**

  A study published 2/09 in Health Services Research by Romano, et. al. examined the criterion validity of the Agency for Health Care Research and Quality (AHRQ) Patient Safety Indicators (PSIs) using clinical data from the Veterans Health Administration (VA) National Surgical Quality Improvement Program (NSQIP). Findings were that PSI sensitivities and positive predictive values were moderate. For three of the five PSIs, AHRQ has incorporated the alternative, higher sensitivity definitions into current PSI algorithms, illustrating the value of enhancement and improvement of public domain administrative measures.

  Maryland does better than other states with administrative data. The table below shows the average number of sdx codes by State from the HCUP 2006 national data. This past FY08 data in Maryland has now an average number of sdx codes at 9.16. This high level of coding in Maryland is a direct result of the introduction of the APR-DRG system in 2005, which created strong incentives for hospitals to thoroughly and completely code medical

record discharge abstracts. The HSCRC has also engaged a random review of over 8,000 records to confirm the accuracy of discharge coding against the medical record. By August,all Maryland hospital will have had an audit of sample records completed, at which time the process will begin again.

State	Number of Cases	Avg Number of Sdx Codes
MD	**172,608**	**8.1**
WI	143,776	6.8
RI	25,389	6.4
IN	175,774	6.3
MI	148,816	6.2
MO	227,748	6.2
OH	353,837	6.0
CO	104,434	5.9
FL	672,147	5.8
NH	43,170	5.8
VT	34,505	5.6
MA	167,434	5.6
CT	153,996	5.6
NV	88,680	5.5
HI	18,491	5.5
OK	189,273	5.5
KS	60,618	5.2
NC	295,986	5.2
NY	775,882	5.1
KY	160,764	5.1
CA	732,317	5.0
TN	260,086	5.0
VA	228,574	5.0
AZ	172,603	4.8
MN	156,664	4.8
GA	283,395	4.7
NJ	284,748	4.7
AR	98,684	4.7
SC	144,437	4.6
SD	11,456	4.6
TX	638,209	4.6
IL	348,273	4.6
OR	100,529	4.5
IA	101,127	4.5
NE	39,170	4.5
WV	51,299	4.5
WA	161,823	4.4
UT	79,282	4.0

- Concerns about the technical aspects of case assignments not matching the assignment logic **(Washington County Health System)**

RESPONSE: An error did occur in the initial case assignment reports in December which affected 10% of the case assignments. That error was corrected and the revised case assignments now match the assignment and exclusion logic as specified. In addition, the case assignments sent out to hospitals the week of 2/9 also contain the admission APR DRG to further help hospitals in determining whether the logic was applied properly.

In addition to the above, HSCRC and 3M are reviewing specific case assignments for which hospitals have provided the ghost ID numbers in cases where the hospital has concerns about the assignment.

E- Concern about short timeline of vetting and implementing the MHACs

- Concern has arisen from MHACs being placed on a "very fast track" beginning in December 2008 that was not collaborative with the industry **(Washington County Health System)**

RESPONSE: HSCRC staff began work on MHACs and communicated with the industry regarding this work, well before December 2008, through the following:

- **Present On Admission Data Work Group initially convened in July 08 which included MHA representatives and hospital industry stakeholders**
- **Evaluation Work Group which first presented information on PPCs in September 2008**
- **MHAC Payment Policy Work Group which first convened in October 2008 and included MHA representatives and hospital industry stakeholders.**

Attachment I

Final Staff Recommendations Regarding HSCRC Payment Policy for Highly Preventable Hospital Acquired Conditions

Health Services Cost Review Commission
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Baltimore, MD 21215
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March 4, 2009

This document represents a final recommendation to be presented to the Commission on March 4, 2009 for action at this meeting.

Maryland Hospital Acquired Conditions (MHAC) Initiative

Summary of Activities over the Past Month

Industry Input

Since the presentation of the draft staff recommendation to the Commission last month, staff has conducted two industry-wide clinical vetting sessions and a payment work session (geared to hospital financial personnel). Staff has also worked with 3M Health Information Systems and St. Paul Computer Center to ensure hospitals have a complete data set of all cases potentially flagged for inclusion in the MHAC methodology (from a prior period FY 2008). The clinical and payment sessions produced a tremendous number of ideas, questions and suggested changes. Staff has attempted to respond to each of the questions or suggestions (and also to issues and questions raised last month during the February Commission meeting discussion) and these responses are included in Appendix 9 to this final recommendation.

Clarifications

Further discussions with industry representatives also highlighted the fact that the MHAC initiative is still perceived as a "payment decrement" approach along the lines of CMS's HAC initiative. This confusion is understandable given the way we have described our methodology thus far. However, because the Maryland payment system is not a DRG or per case payment system, reductions related to the frequency of MHACs for any hospital are handled in adjustments to overall facility revenue at the end of the year, not on a per case basis. This methodology is further enhanced by the inclusion of a 90% reduction factor (10% retention factor) to account for the level of preventability of the indentified MHACs (after the extensive clinical and global exclusions). This decoupling of MHAC logic from payment for individual cases is a subtle but quite significant difference from the CMS HAC approach for several reasons.

Although individual case data are used to compile information on a hospital's overall performance, this performance represents an averaging of how it has done on all applicable cases. As such it is very similar to Maryland's DRG-based system itself – which is also an averaging system. The Maryland DRG system creates individual DRG constraints (both charge levels and average length of stay limits) that hospitals have to meet on average. For some cases, even though the DRG average length of stay is 5 days say, despite the best efforts of clinicians some cases may stay 7 days. Conversely, given the application of effective and efficient clinical and administrative protocols, some patients may stay 3 days. The point is, although we use individual case data to track the hospitals performance, it is held to the standard based on its average performance. If the hospital outperforms the standards on average, it generates savings and if it does not then it generates dis-savings. These savings and dis-savings amounts provide strong incentives for the overall institution to improve its overall efficiency and effectiveness. In the Maryland system, individual cases are still paid based on the resources used in the treatment of each individual patient.

Thus, hospital administration and care providers will be operating under the same set of incentives for MHACs as they are currently under the APR-DRG based payment method. These incentives are largely applied at an overall hospital operational level to induce hospital administrators and managers to invest in systems and methods to improve the overall efficiency and effectiveness of their

institutions, while at the same time working with clinicians and coders to ensure that they are similarly operating as efficiently and effectively as they can.

Modifications to the Staff Recommendation based on Industry Input

In response to the input received from industry representatives, staff has modified the recommendation as follows: Revised Recommendations:

1) The Commission utilize **11 PPCs** (PPC 63 ***Post-Operative Respiratory Failure with Tracheostomy*** will be excluded from the MHAC methodology) as the basis for a Maryland – specific Hospital Acquired Conditions payment initiative **(modified)**;

   Additional clinical exclusions applied as a result of industry input are as follows:

   Adding 728.86 (Necrotizing fasciitis) to exclusion group 76 (Septicemia and disseminated infections) for PPC 39w

   Extend the logic for PPC 42 to include the laceration repairs that were performed on the same day as the primary procedure.

   Adding the diagnosis code for basal metabolic index (BMI) > 40 (V854) to PPC 57 and 58 exclusion list.

   Adding 710.3 (Dermatomyositis) and 710.4 (polymyositis) to exclusion group 85 (Neuro-muscular disorders) for PPC 63 (PPC 63 is eliminated from the MHAC group but these exclusions are generally being recognized now by 3M for its overall PPC logic as a result of the input from the Maryland Hospital Industry).

   Adding Resipratory Failure Present on Admission to PPC 63 exclusion logic

2) Payment decrements of 90% be applied to both "in-lier" and "outlier" cases as defined in the methodology description and simulations described and presented above **(unchanged)**;

3) This initiative should commence April 1, 2009 with any payment-related decrements being reflected in each hospital's final rate order for the following fiscal year **(unchanged)**;

4) Both one-time and permanent payment reductions associated with the approved payment decrements for the quarter commencing April 1, 2009 will be reflected in the final CPC targets and final approved revenue for hospitals effective July 1, 2009 **(unchanged)**;

5) The approved methodology will also be applied to the Rate Year beginning July 1, 2009 (FY 2010) (unchanged);

6) The HSCRC staff will monitor the number of these highly preventable complications (MHACs) over time. The HSCRC shall conduct a retrospective chart review of a representative number of cases with the specific intent of quantifying the number of false-positive occurrences (relative to identified false-negative occurrences) and overall intent of identifying any additional unanticipated consequences or results. This formal review will take place sometime during the next rate year (optimal timing not yet determined) and the results from this review may lead to modifications of the MHAC initiative for the subsequent year **(modified)**.

Introduction

The issue of quality in health care has been considered for many years, but it was a series of Institute of Medicine (IOM) reports that made the front-page news. A 1999 IOM report, *To Err is Human: Building a Safer Health System*, found that up to 98,000 Americans die every year from preventable medical errors in hospitals. In 2000, a subsequent IOM report confirmed the findings of the 1999 report and urged greater focus, research, leadership, and expectations regarding health care quality and patient safety. The recommendations set forth in the 2002 IOM report entitled, *Crossing the Quality Chasm: A New Health System for the Twenty-first Century*, went beyond medical errors and brought the quality issue to the attention of policy-makers nationally.

While the IOM reports have helped increase the level of awareness for the need to improve quality, most of the progress, to date, has been in the area of collection and reporting of so-called "Process Measures," processes of care that represent best practices for certain medical procedures. Pay for performance (P4P), primarily utilizing process measures, is being implemented on a piecemeal basis by health plans and providers but has yet to be implemented nationally in a broad manner.[1]

Advantages/Disadvantages of Process Measures

An advantage of comparing hospitals based on evidence-based process measures is that risk adjustment is typically not required, since it is established that the relevant prescribed practices are necessary regardless of the severity of a patient's illness or the presence of other medical conditions. Therefore, results may easily be compared, and characteristics of hospitals and their profile of patients typically have little or no bearing on performance. There also has been much research around the commonly selected process measures, and there tends to be general acceptance of the related evidence-based practices by providers. Many of these best practices have been known for decades.

However, there are many disadvantages of basing a pay for performance system on process measures alone. Despite the fact that an entire industry has grown around proposing, studying, and vetting process measures, the process measures that are typically used for quality programs represent only a small portion of the cases that hospitals treat. It is clear that any scoring results from the project would not be reflective of the overall quality of care provided at a particular institution.

To capture performance of hospitals more systemically would require a much larger series of measures. Significantly expanding the number of process measures to capture the overall quality of a hospital would likely result in an unwieldy number of measures, and the program would run the risk of potentially shifting the practice of medicine to be more prescriptive than necessary. Since process measures typically require a reporting mechanism that is separate and distinct from administrative and financial functions, a move to expand the number of meaningful process measures would require a significant additional data reporting burden on hospitals.

Finally, there is a concern that given the long discussion and "vetting" process associated with the adoption of these measures at a national level, by the time specific measures are selected for incorporation into P4P initiatives, most all hospitals have already adopted these practices. In the

[1] The Maryland Health Services Cost Review Commission (HSCRC or Commission) implemented its Quality Based Reimbursement (QBR) initiative effective July 1, 2008. Nationally, Congress did not require implementation of its Value Based Purchasing (VBP) program for FY 2009 but will likely re-reconsider a similar proposal for FY 2010.

HSCRC's QBR implementation, the Commission has already discovered that many of the adopted measures are becoming "topped-off."[2] In essence, this means that performance is compressed at the high end of the performance scale. Under these circumstances, the QBR may become less indicative of relative performance. In this circumstance, P4P initiatives that rely solely on process measures may really only reward providers for reporting what is already common practice.

The advances in awareness and heightened focus on the issue of improving quality have lead to the development of data tools such as Hospital Compare, a reporting tool created through a collaboration of The Centers for Medicare and Medicaid Services (CMS) and the Hospital Quality Alliance, designed to track hospital quality information and others such as Health Grades. While these reporting tools have also raised awareness of the need to improve quality, they also show that almost 10 years after the original IOM report gaps in health care quality persist.

An Urgent Need for Outcomes Measures related to Quality of Care

Additionally, it is reasonable to believe that the use of individual process measures will not significantly alter the behavioral response of providers sufficiently to generate a meaningful improvement in the quality of care. A similarly weak behavioral link was evident in terms of the predominant cost containment efforts of the 1970s and early 1980s. For decades, cost containment efforts focused on changing the process of care delivery (individual case and utilization review). These efforts were highly labor intensive and, at times, heavy handed, yet were largely ineffective in controlling and reducing unnecessary hospital utilization and cost. By contrast, the linking of payment directly to cost outcomes through the implementation of a prospective per case payment system (cost outcome measures) dramatically changed provider incentives (and behavior) and lead to huge reductions in unnecessary service use and associated health care costs. The same behavioral shift is now needed in the area of health care quality.

Because of these and other issues, the HSCRC and other governmental agencies are now focusing on linking payment to measures that more directly represent the overall quality of care provided per inpatient episode.

Outcomes – Background/Discussion

Frustration related to the limitations of process measures, has lead to an increasing focus on outcome measures in assessing quality. Where process measures rely on whether a process of care occurred (e.g. was aspirin given on arrival for MI patients), outcome measures focus on the results of care. More specifically outcome measures related to quality are defined as changes attributable to health care, intermediate or final, such as: laboratory or vital sign values, mortality, morbidity (e.g., complications, readmissions), functional status, and efficiency (i.e., an attribute of performance that is measured by examining the relationship between a specific product of the health care system and the resources used to create that product).

[2] A "topped-off" measure is considered to be one where the 75th percentile is within 2 standard deviations of the 90th percentile.

National Focus on Outcomes

As noted, national focus has steadily increased on performance outcome measures and specifically has included attention to patient safety and medical errors by the Centers for Medicare and Medicaid Services (CMS) and by the Agency for Healthcare Research and Quality (AHRQ). Patient safety improvement efforts addressing the outcomes and costs of medical errors and their proponents such as the Medicare Payment Advisory Commission, are also increasingly advocating for the linkage of payment to improved patient safety in the hospital.[3]

The AHRQ Quality Indicators (QIs) measure health care quality by using readily available hospital inpatient administrative data. The AHRQ Patient Safety Indicators (PSIs), a subset of the AHRQ QIs, are a tool to help health system leaders identify potential adverse events occurring during hospitalization. The PSIs are a set of indicators providing information on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth. The PSIs were developed after a comprehensive literature review, analysis of ICD-9-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses. The PSIs were released in March 2003 (see **Appendix 1**).

Medicare's Link to Payment – Hospital Acquired Conditions

More recently the Center for Medicare and Medicaid Services (CMS) has taken the lead in linking payment to outcome improvement through their implementation of its Hospital Acquired Conditions (HAC) initiative.

Section 5001(c) of Deficit Reduction Act (DRA) of 2005 required the US HHS Secretary to identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.

On July 31, 2008, in the Medicare Inpatient Prospective Payment System (IPPS) Fiscal Year 2009 Final Rule, CMS included 10 categories of conditions that were selected for their "Hospital Acquired Condition" (HAC) payment provision (see **Appendix 2**). These HACs represent complications (secondary diagnoses) experienced by patients after being admitted that could have reasonably been prevented by the hospital's medical team.

Under the old IPPS system, the occurrence of a post-admission complication often resulted in a higher payment because the complication may have caused the patient to be assigned to a higher-paying DRG, in effect rewarding the hospital for poor quality care. Failure to reduce or eliminate payment increases associated with preventable complications effectively rewards hospitals for preventable mistakes and errors that lead to increased resource use and additional pain and suffering for patients. This flaw in the IPPS became even more apparent with the adoption of the Medicare MS (Severity adjusted) DRGs effective October 1, 2007.

Appendix 3 illustrates how the presence of a preventable HAC (if not adjusted for in the MS-DRG payment logic) would lead to higher overall payment for a hospital. This is clearly an unintended flaw

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[3] Medicare Payment Advisory Commission: *Medicare Payment Policy*. Report to the Congress. Washington, DC.: March, 2005.

in the existing IPPS that Medicare is moving to correct. Doing so will also cause hospitals and their medical teams to devote more attention toward preventing these of these complications. It should be noted that the Medicare payment reductions (or payment decrements) associated with the identified 10 HACs is 100%. That is, Medicare removes 100% of the payment increment associated with the identified secondary diagnoses encompassed by their HACs.

Payment adjustments for HACs began October 1, 2008 for the 10 categories of HACs not present on admission as selected by CMS. No further adjustment to account for the overall risk profile of patients treated by a given institution is required.

Advantages and Disadvantages of Medicare's HAC Initiative

Clearly, the CMS HAC initiative is valuable in that it represents the first broad-based and significant effort to revise payment incentives to be consistent with the goal of reducing preventable complications. The primary purpose of the initiative is to reduce Medicare payments and provide hospitals with financial incentives to improve quality. In doing so, it begins to correct the unintended incentives in prospective DRG-based hospital payment, which effectively reward hospitals for less desirable outcomes. The initiative uses existing administratively reported data and does not place additional data reporting burdens on hospitals. It also is now the "law of the land" and, as such, represents an important first step toward linking payment to outcome measures more broadly.

On the other hand, the CMS initiative is limited by the requirement that 100% payment decrement be applied for each of the 10 HACs. Elimination of all additional payment implies that HACs should always be preventable. This greatly restricts the scope of eligible complications. Accordingly, the financial impact of CMS's initial 10 HACs is estimated to be only 0.018% nationally (approximately $21 million in payment reductions on a base of total IPPS payments of over $110 billion per year). The 100% payment decrement also has the additional disadvantage of removing any payment-related incentive to continue to code for the presence of HACs moving forward. Continued consistent and accurate coding of HAC secondary diagnoses is necessary in order for CMS to monitor whether this payment change is indeed having the desired effect on quality (i.e., a decrease in the incidence of preventable complications and the associated improvement in quality).

Present on Admission Indicator (POA)

Essential to implementing the requirements of the DRA is hospital reporting of the present on admission (POA) indicator for each secondary diagnosis; Inpatient Prospective Payment System (IPPS) hospitals were required to begin reporting the POA indicator on all secondary diagnoses beginning October 1, 2007. By accounting for all conditions (secondary diagnoses) present upon admitting a patient, policy-makers are able to identify conditions and complications that occur post admission (secondary diagnosis not present on admission). This enables identification of conditions and complications that lead to assignment to a higher DRG payment category, but may well have been preventable.

Also, because the implementation of HACs is so dependent on accurate coding of secondary diagnosis Present on Admission, the accuracy of POA coding will heavily determine its overall success. Based on staff's discussion with CMS staff, is not clear that CMS has been able to undertake a thorough evaluation of the reliability and overall efficacy of POA coding nationally. Inaccurate and inconsistent

coding of the POA indicator will severely hamper CMS' efforts to implement their HAC-related payment reductions in a fair and consistent fashion.

Voluntary vs. Mandatory Serious Adverse Event Policies

In June of 2008, the Executive Committee of the Maryland Hospital Association (MHA) endorsed a set of voluntary payment guidelines for hospitals to follow when a serious adverse event occurs. The guidelines establish that payment should be waived for the entire stay if one or more of the following 7 serious adverse events occur, and if the event results in serious disability lasting longer than 7 days or death:

- Surgery on wrong body part;
- Surgery on the wrong patient;
- Wrong surgical procedure;
- Unintended retention of a foreign object;
- An air embolism that occurs while being treated in a hospital;
- A medication error attributable to the hospital; and
- A hemolytic reaction due to administration of incompatible blood or blood products.

The guidelines also state that beyond these seven events, hospitals will individually evaluate on a case-by-case basis whether full or partial payment should be waived based on 4 criteria:

- Whether the error or event was preventable;
- Whether the error or event was within the control of the hospital;
- Whether the error or event was the result of a mistake made in the hospital;
- Whether the error or event resulted in patient death or serious disability

Such guidelines can be helpful for hospitals in putting a structure in place to address payment issues when a serious adverse event occurs. The guidelines can standardize the practice and help consumers understand what may occur in such an event. In fact, in the past many hospitals have waived full or partial payment for adverse events in absence of these guidelines.

While the MHA voluntary guidelines represent a commendable voluntary step, they do not appear to represent a substantial change from what has been the status-quo operating policy for hospitals for many years. Discussions with several hospitals and hospital systems indicate that they have had these same policies in place over time – primarily for "risk management" purposes.

The HSCRC staff also believes that these guidelines are very limited in scope and in enforcement. First, the serious adverse events listed by MHA represent a very small number of cases in Maryland and represent just a subset of the conditions that are considered to be highly preventable. Second, the specified payment guidelines apply only when one of the serious adverse events result in serious death or serious disability lasting more than 7 days. This means that if a disability resulting from a serious adverse event lasts less than 7 days, regardless of whether additional procedures are required to address the result of the adverse event, the guidelines may not apply. And under these circumstances, hospital charges may ensue regardless of the fact that a serious adverse event occurred. Action could also be dependent on how one defines a "serious disability."

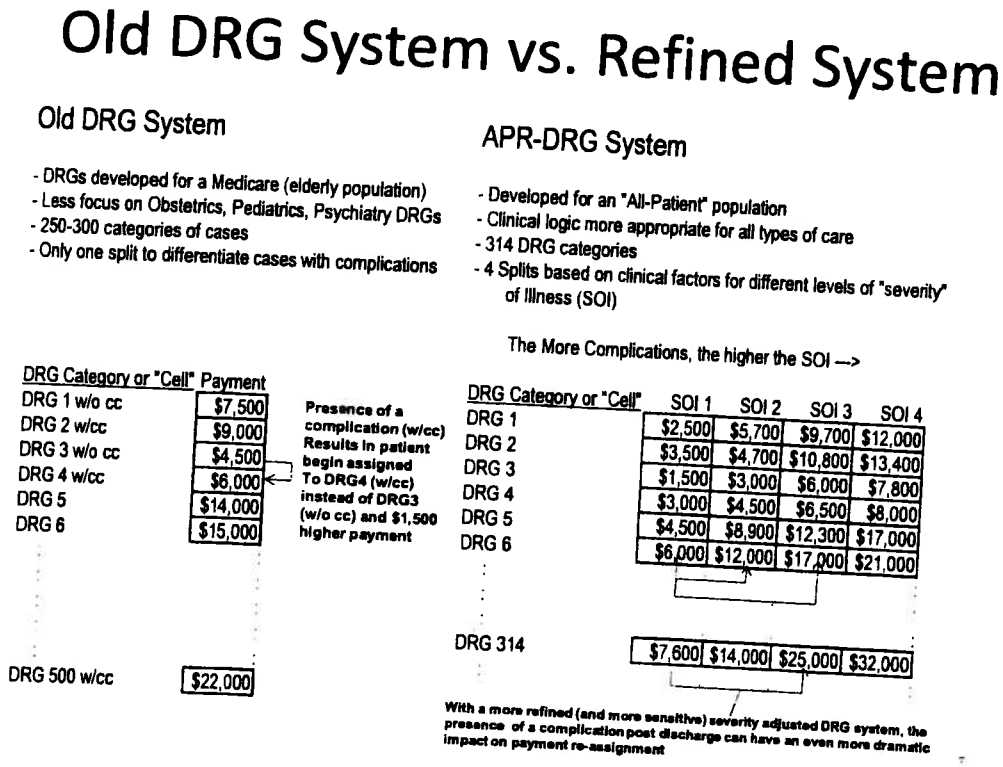
Voluntary guidelines and standards can be helpful overall, but given the narrow scope and difficulties in enforcing and monitoring behavior, staff believes that something more systematic and data-driven must be implemented. Because of Maryland's Medicare waiver, the State is exempt from the implementation of the CMS HACs. This exemption provides Maryland with an opportunity to build upon the basic structure and concept of the HAC initiative, but to craft a payment methodology that is more appropriate for an All-Payer population and consistent with the State's unique severity adjusted APR-DRG payment structure.

HSCRC Approach to Highly Preventable Hospital Acquired Conditions

In examining the various approaches to linking outcome measurement to payment, the HSCRC staff notes the following key observations:

Unintended Incentives in the Existing Payment System

As noted, there are many examples (accounting for a significant proportion of inpatient resource use and payment) where the occurrence of a post-admission complication results in a higher payment because the complication results in the patient being assigned to a higher-paying DRG. In cases where this post-admission complication was largely preventable through the practice of high quality medical practice, hospitals are effectively being rewarded for poor quality care. This phenomenon is even more prevalent with the use of refined and severity adjusted DRG systems like the All-Patient-Refined (APR) and Medicare Severity-adjusted (MS) DRGs. The Exhibit below illustrates how this unintended incentive exists under both the original DRG payment system and the recently adopted APR-DRG (severity adjusted) payment system.



Absence of Appropriate Financial Incentives and Data Undermine Quality Improvement Efforts

Staff believes that hospitals and medical teams in Maryland and across the nation are currently doing the very best job they can to prevent unintended and preventable conditions from occurring given the data tools and financial incentives available to them. However, the financial incentive structure and the current data infrastructure do not support a systematic and concerted effort to first identify the most highly preventable conditions, then monitor and finally avoid these expensive and often debilitating complications. The lack of adequate incentives and absence of identification/monitoring tools, contribute to significant unnecessary cost and substandard care. Armed with more appropriate financial incentives and systematic monitoring and tracking tools, hospitals in the State will be able to significantly reduce the incidence of preventable complications.

Backdrop of Budgetary Constraints Generally and Acutely in 2009-2011 Period

The primary focus of this initiative will be to correct the unintended flaw in payment incentives and reduce the number of preventable complications. However, this initiative will also reduce hospital expenditures. As articulated by the Maryland Secretary of Health and others, in an era of constrained budgetary resources, priority should be given on initiatives that target reducing unnecessary and wasteful expenditures rather than arbitrary and across-the-board spending cuts. The MHAC initiative has been designed specifically to promote efforts to reduce unnecessary complications that otherwise would result in higher cost and lower quality.

Maryland Uniquely Positioned to Assume a Leadership Role in Quality Promotion

Given Maryland's well-developed data infrastructure, advanced experience with sophisticated medical record documentation and coding, and its unique APR-DRG payment structure, we are uniquely positioned to assume a leadership role in quality promotion in the United States. Over the past six months considerable effort has been placed on monitoring and improving POA coding of hospitals. Another focus of the MHAC effort over the past several months has been on the development of mechanisms to allow hospitals to trace back MHAC experience to individual case medical records at their hospital. Hospitals in the State have a proven track record of using the timely and accurate medical record and financial data produced by the HSCRC to monitor their activities and respond to the financial incentives presented to them. The combination of well-developed data systems, considerable experience with, and sophistication in, the use of data systems, and a clear set of incentives that apply to all hospitals and to all payers, means that Maryland has the opportunity to demonstrably improve the quality of hospital care for all Maryland citizens.

Potentially Preventable Complication Methodology Link to APR-DRGs and MHACs

An added advantage to the State's use of the APR-DRG payment structure is the availability of 3M Health Information System's Potentially Preventable Complications (PPC) methodology, a methodology specifically developed as an adjunct to the APR-DRG grouping product. The APR-DRG payment system has been enthusiastically endorsed by the Maryland hospital industry. It represents a highly sophisticated case mix (and risk-adjustment) mechanism that is highly effective in explaining a

significant proportion of the variation in required resource use and clinical variation of hospitalized patients. The PPC methodology is an extension to the APR-DRGs that represents a conservative approach to the identification of complications. The proposed MHAC methodology makes use of a core group of 12 PPCs (out of a total of 64 mutually exclusive types of inpatient complication) that are most preventable.

Background on Potentially Preventable Complications

Potentially Preventable Complications, identify potentially preventable inpatient harmful events or negative outcomes that result from the processes of care and treatment rather than from the natural progression of underlying disease. The entire set of 64 PPCs have been identified from 1,450 ICD-9-CM secondary diagnosis codes not present on admission and from selected ICD-9-CM procedure codes. PPCs incorporate most of the specific diagnosis codes that are contained in the AHRQ Patient Safety Indicators and Hospital Acquired Conditions from CMS, but, in most cases include a much wider range of diagnoses with detailed clinical exclusions and apply to a broader range of hospital patients.

As noted, reducing preventable inpatient complications is an important component of the national health goal of eliminating waste while ensuring the delivery of appropriate care. PPCs create a comprehensive definition of inpatient complications based on a uniformly applied development methodology and criteria that can be applied to a much broader range of patients and can facilitate the national goal of reducing inpatient complications. Ultimately, accurate identification of complications and their risk of occurrence are critical to fair and useful hospital outcome comparisons, as well as fair performance-based payment initiatives.

Again, the proposed MHAC logic focuses on a subset of the 12 highly preventable complications as the basis for the related modification of payment levels (payment decrements). A more expanded description of PPCs and the related PPC methodology is provided in **Appendix 4**.

HSCRC MHAC Policy Development Process

Identification of Highly Preventable PPCs (MHACs)

Even though hospital acquired complications may become more preventable over time with improved techniques and technology, they will never be totally preventable. Furthermore, judgments about "preventability" are subjective, and there can be a varying degree of the level of preventability across the PPC. This means that except for a few "true" medical errors – so-called "never events" like foreign objects left in after surgery – eliminating the entire payment increase that is due to a complication implies that the complication is always preventable, even with optimal care. Most post-admission complications (e.g., pulmonary embolism) are not so clearly linked to medical errors, and, although they may relate to errors in judgment or lapses in execution that reflect poor quality of care, they cannot be considered always preventable.

In order to incorporate a direct case level payment adjustment, there needs to be a link between the relative preventability of a complication and the extent of the payment reduction associated with the complication. The financial consequences of a complication need to be significant enough to motivate hospitals to reduce complication rates, without penalizing them for events over which they have limited control.

This can be achieved by selecting a subset of the 64 PPCs that are highly preventable and by not eliminating 100% of the payment increase due to these PPCs.

Characteristics of MHACs and Rational for Selection

HSCRC staff, working with 3M has identified a subset of 11 highly preventable PPCs (reflecting the recent elimination of PPC 63 from the proposed analysis) for Maryland that should be preventable for the majority of patients with adherence to accepted standards of care. In order to identify and select these 11 highly preventable PPCs, an analysis of the literature available documenting the linkage of quality problems with higher occurrences of the PPCs was conducted. Next, to determine the degree to which the occurrences of the 11 PPCs vary by reason for admission and the severity of illness at the time of admission, statistical analysis on risk adjustment and its impact on rates was also conducted for each PPC. As a result of these analyses, the 11 selected highly preventable PPCs for Maryland differ from the remaining PPCs in that they represent complications that:

- Are less likely to be a consequence of the natural progression of the underlying illness or coexisting conditions that were present on admission; and,
- Statistically are not influenced by the patient's reason for admission and severity of illness at the time of admission.

The remaining 53 PPCs are more influenced by the patient's underlying disease and severity of illness at the time of admission. For a payment adjustment, these remaining PPCs require adequate risk adjustment at the time of admission in order to express an explicit recognition of their relative degree of preventability.

Exclusions from the PPC Methodology

Consistent with the larger set of PPCs, the same global exclusions of patients with certain severe or catastrophic illness who were particularly susceptible to a range of complications, including those with trauma, HIV illness, and major or metastatic malignancies, are applied to the 11 highly preventable PPCs, and these admissions are not eligible to be assigned PPCs.

Appendix 5 summarizes the literature review and findings for each of the PPCs, and provides the specific definition for each PPC, identifies any additional specific exclusions to the denominator population eligible to be assigned the PPC; identifies existing analogous CMS HACs or AHRQ PSIs; identifies the origin of the PPC; identifies the level of face validity; and if found in the literature, identifies level of sensitivity and predictive value, the preventability/hospital control, and construct validity of the PPC. Due to their length, the detailed references to the literature are not included in **Appendix 5** but are available.

The 11 selected PPCs include:

- Post-Op Wound Infection & Deep Wound Disruption w Procedure (PPC 38)
- Reopening of Surgical Site (PPC 39)
- Post-Op Hemorrhage & Hematoma w Hemorrhage Control Proc or I&D Procedure (PPC 41)
- Accidental Puncture/Laceration During Invasive Procedure (PPC 42)
- Post-Procedure Foreign Bodies (PPC 45)
- Iatrogenic Pneumothrax (PPC 49)
- Inflammation, & Other Complications of Devices, Implants or Grafts Except Vascular Infection (PPC 52)
- Infections due to Central Venous Catheters (PPC 54)
- Obstetrical Laceration & Other Trauma without Instrumentation (PPC 57)
- Obstetrical Laceration & Other Trauma with Instrumentation (PPC 58)
- Major Puerperal Infection and Other Major Obstetrical Complications (PPC 60)
- ***Post-Operative Respiratory Failure with Tracheostomy (PPC 63) – Excluded as of 3/4/09 Recommendation***

Similar to the CMS HACs, the majority of the 11 highly preventable PPCs are only assigned if they are coded as a secondary diagnosis not present on admission; the exceptions are the obstetric complications (PPCs 57, 58, and 60), which must be coded as occurring during or following the delivery at the hospital in order to be assigned.

MHAC Objectives and Principles

To guide the development of HSCRC policy related to linking payment to MHACs, staff established and articulated the following key objectives and principles:

1) The HSCRC should craft a Maryland-based solution to the problem of reducing highly preventable Hospital Acquired Conditions (in particular one that reflects the State's unique characteristics and builds on the strengths of the existing data and payment systems);

2) The primary focus of the MHAC initiative should be on correcting existing flaws in the APR-DRG payment system and improving the financial incentives around the promotion of high quality of care;

3) Any payment methodology implemented should be prospective in nature so that hospitals have some time to adapt to the new payment incentives and focus on and develop care delivery models that reduce preventable complications;

4) In addition to improving the financial incentives, an over-arching goal should be to reduce the rate of preventable complications in the system (and the HSCRC should monitor this performance over time);

5) Throughout the policy development process, there should be an emphasis on making the incentives and methodologies transparent and understandable to hospital clinical, case mix and financial personnel – with particular emphasis on providing hospitals with the data they need to track their own experience back to individual case records, calculate the payment implications and identify the conditions and events that need to be addressed in order to reduce the number of preventable complications they experience;

6) Financial incentives should be structured to motivate a behavioral change (which by definition will mean some reduced payment); however, the payment incentives should also be structured to reflect the hospitals overall ability to influence the rate of complications (in this context, a 100% payment decrement is not appropriate);

7) Consistent with this last goal, staff believes that there should be a "retention factor" that reflects the fact that conditions with the very highest preventability may not be 100% preventable. This retention factor also will provide an incentive for hospitals to continue to accurately code the incidence of MHACs, because failure to do so will result in a net revenue loss for the institution;

8) Finally, considerable effort should be directed at identifying and simulating all possible scenarios where MHCA-related payment changes might occur and precautions should be taken to avoid any unintended consequences and behavioral responses on the part of hospitals This includes the development of payment methods related to both core cases reflected in each hospital's approved Charge per Case (CPC) target and also outlier cases (excluded from hospital CPCs) for which the presence of an MHAC may have resulted in additional and unintended payments.

MHAC Payment Simulations and Methodology Development

To develop the proposed MHAC payment methodology, staff made extensive use of the FY 2008 case mix data, which contained a full year's worth of coding of the POA indicator by each hospital in the State. The ability to account for diagnoses present on admission and present on discharge is of course a necessary prerequisite for the development of the MHAC payment logic.

Staff first identified and classified all FY 2008 cases that were eligible for application of a MHAC payment decrement given the presence of one or more of the 12 highly preventable complications identified (MHACs). What follows is a description of the analysis and steps performed and a presentation of the simulation results when applying the proposed MHAC payment decrement methodology (at a 90% rate) to both included cases (reflecting all hospitals core Charge per Case (CPC) revenue and outlier cases. The application of this proposed methodology (as modified by staff) to FY 2008 data shows that hospital payments would be reduced by an estimated $4.4 million.

Description of MHAC Payment Scenarios and Simulations

Payment decrements based on MHACs will be of two types: 1) decrements based on changes in APR-DRG assignments for cases with an MHAC; and, 2) decrements based on adjustments to allowed outlier charges for cases with an MHAC. Exactly how the decrement is applied will vary depending on the specifics of the case. The payment adjustments will work as follows:

Decrement based on changes in APR-DRG assignment

This payment adjustment is based on the fact that the presence of an MHAC can result in a discharge being assigned to an APR-DRG with a higher case weight and, consequently, allow for higher overall charges. Classifying the case without the MHAC diagnoses and procedures will cause the case to be assigned to a lower weighted APR-DRG. When the removal of the MHAC leads to a case being assigned to a lower weight APR-DRG, the hospital's allowed charges will be adjusted by 90 percent of the difference between the original case weight and the new, lower case weight.

Decrements Applied to Outlier Charges

Under the HSCRC system, charges that exceed a case specific "trim point" are not included in the calculation of a hospital's CPC target. Charges above the trim point are paid on a fee for service basis and are not subject to the constraints of the CPC system. Outlier charges, therefore, are unaffected by any case weight based adjustment. Since the presence of an MHAC often leads to significantly higher charges, failure to address outlier charges ignores a significant portion of the additional charges generated by MHACs. To determine the appropriate decrement to be applied to outlier charges, 3M did a regression analysis based on Maryland data to determine the amount of additional charges generated by each of the 12 MHAC. (The analysis and the estimates of additional MHAC charges are discussed in **Appendix 6)** Outlier charges will be adjusted by 90 percent of the regression based estimates for each MHAC. In cases where more than one MHAC is present the adjustment will be applied additively.

Staff, working with 3M, has used FY 2008 discharge data to model various payment scenarios and their impacts. The simulations examined nearly 690,000 discharges from 43 Maryland hospitals.[4] Less than one percent of all discharges (roughly 5,700) had one or more MHACs. The total payment decrement that would arise from by applying the payment decrements would be $4.4 million of nearly $7.6 billion in approved revenue, or approximately 0.06 percent of allowed charges. Cases where MHACs occurred fell into one of five distinct scenarios. Note – the amounts summarized in the following tables do not reflect the impact of removing PPC 63 from the proposed methodology.

[4] Five hospitals for whose discharge data the "Present on Admission" (POA) flag was determined to be properly coded were excluded from the simulations.

Table 1

MHAC Payment Decrement Scenarios		
Scenario 1	***Case reassigned to lower weight APR-DRG. *No outlier charges**	
	Payment Adjustment	*90% of change in Case Weight * Outliers - NA
	Estimated MHAC Cases (percent)	1,056 (18.3%)
	Statewide Payment Decrement	$3,499,857
Scenario 2	***Case reassigned to lower weight APR-DRG. *No outlier charges in original assignment, outlier charges in new assignment.**	
	Payment Adjustment	*90% of change in Case Weight *90% of regression determined MHAC adjustment
	Estimated MHAC Cases (percent)	49 (0.85%)
	Statewide Payment Decrement	$3,534,644
Scenario 3	***Case reassigned to lower weight APR-DRG. *Outlier charges in original assignment and in new assignment**	
	Payment Adjustment	*90% of change in Case Weight * 90% of regression determined MHAC adjustment
	Estimated MHAC Cases (percent)	16 (0.28%)
	Statewide Payment Decrement	$253,362
Scenario 4	***No change in APR-DRG assignment. *Outlier charges associated with the case**	
	Payment Adjustment	* 90% of regression determined MHAC adjustment
	Estimated MHAC Cases (percent)	184 (3.19%)
	Statewide Payment Decrement	$2,074,828
Scenario 5	***No change in APR-DRG assignment. *No Outlier charges associated with the case**	
	Payment Adjustment	*90% of change in Case Weight * 90% of regression determined MHAC adjustment
	Estimated MHAC Cases (percent)	4,398 (76.26%)
	Statewide Payment Decrement	$0

Note: the above table has not been modified to reflect the impact of removing PPC 63 from the Proposed MHAC methodology

In examining the various payment decrement scenarios and their relative frequency, several observations can be made. First, more than three quarters of cases with one or more MHACs falls into Scenario 5, where the removal of the MHAC does not lead to a reassignment, and the case had no outlier charges. For these cases, there is no payment decrement. The next most frequently occurring scenario (18.3 percent of MHAC cases) is Scenario 1, where the case is reassigned but there are no outlier charges. In scenario 4, which involved only adjustments to outlier charges, and Scenario 2 where cases were both reassigned and had outlier charges, each had relatively few of the MHAC cases, but the adjustment per case tended to be significant.

Simulations were also run to estimate the effects of the different decrement payment scenarios by MHAC, by hospital, and by payer. The results of those simulations are presented in Tables 2 and 3 (note again the impact of removing PPC 63 is not reflected in these tables).

Table 2

MHAC Payment Change Simulation Summary by MHAC:

List of 12 PPCs	PPC Definition	Cases	Original Approved Revenue	Original Outlier Amount	Original Total Payment	New Approved Revenue	New Outlier Amount	New Total Payment	Payment Decrement
No PPCs		682,921	$7,301,268,008	$162,365,176	$7,463,633,184	$7,301,268,008	$162,365,176	$7,463,633,184	$0
63	Post-Operative Respiratory Failure with Tracheostomy	77	$12,654,391	$1,907,756	$14,562,147	$5,680,611	$3,603,767	$9,284,379	-$5,277,768
60	Major Puerperal Infection and Other Maj. Obstetric Comp.	263	$3,430,438	$45,403	$3,475,841	$2,572,401	$92,087	$2,664,489	-$811,353
54	Infections due to Central Venous Catheters	203	$7,723,680	$2,398,471	$10,122,152	$7,723,680	$1,805,020	$9,528,701	-$593,451
54,63	Inflamm. & Oth. Comp. of Devices, Implants or Grafts Except Va	900	$24,415,740	$1,948,463	$26,364,203	$24,415,740	$1,596,243	$26,011,983	-$352,220
52,63		4	$740,149	$341,509	$1,081,658	$348,320	$447,599	$795,919	-$285,738
57	Obstetric Lacerations & Other Trauma w/o Instrumentation	1,518	$8,428,332	$211,572	$857,951	$328,075	$274,926	$603,000	-$254,951
42,63		2	$361,858	$0	$8,428,332	$8,172,281	$18,181	$8,190,461	-$237,871
38	Post-Op Wound Infec & Deep Wound Disrup w. Procedure	35	$1,488,861	$179,678	$361,858	$134,685	$0	$134,685	-$227,173
39,63		2	$322,337	$0	$1,668,539	$1,488,861	$29,387	$1,518,248	-$150,290
58	Obstetric Lacerations & Other Trauma w Instrumentation	595	$3,201,254	$0	$322,337	$136,484	$44,990	$181,474	-$140,862
41	Post-Op Hemorrhage & Hematoma w/ Hemor. Control Proc. or Id	182	$6,294,550	$899,711	$3,201,254	$3,075,228	$0	$3,075,228	-$126,026
42	Accidental Puncture/Laceration During Invasive Proc.	1,493	$38,259,435	$1,749,512	$7,194,261	$6,294,550	$800,534	$7,095,085	-$99,177
49,63		1	$156,498	$0	$40,008,947	$38,259,435	$1,659,536	$39,918,971	-$89,975
52,54		12	$493,776	$292,888	$156,498	$69,172	$0	$69,172	-$87,326
49	Iatrogenic Pneumothrax	253	$6,856,184	$755,599	$786,664	$493,776	$208,739	$702,515	-$84,149
38,42		5	$227,953	$156,541	$7,611,783	$6,856,184	$675,718	$7,531,901	-$79,882
39	Reopening Surgical Site	87	$3,616,644	$217,282	$384,494	$227,953	$83,809	$311,761	-$72,733
41,52,63		1	$137,984	$0	$3,833,926	$3,616,644	$152,202	$3,768,846	-$65,079
52,60		1	$68,525	$0	$137,984	$74,259	$0	$74,259	-$63,724
39,54,63		1	$165,838	$0	$68,525	$16,877	$0	$16,877	-$51,647
39,52		14	$535,562	$57,351	$165,838	$78,067	$40,949	$119,016	-$46,822
39,42		11	$591,163	$33,987	$592,913	$535,562	$19,656	$555,219	-$37,695
41,42,52		1	$79,225	$118,210	$625,150	$591,163	$8,454	$599,617	-$25,533
41,52		4	$168,165	$30,527	$197,435	$79,225	$94,078	$173,303	-$24,132
41,49		1	$207,244	$180,387	$198,692	$168,165	$10,355	$178,520	-$20,173
41,42		18	$841,962	$26,380	$387,631	$207,244	$162,826	$370,070	-$17,561
41,42,63		1	$137,984	$13,458	$868,342	$841,962	$11,346	$853,308	-$15,034
42,49		4	$193,628	$86,871	$151,442	$137,984	$0	$137,984	-$13,458
49,52		4	$278,611	$21,777	$280,499	$193,628	$75,345	$268,973	-$11,526
39,60		5	$73,531	$4,308	$300,388	$278,611	$11,247	$289,858	-$10,530
58,60		3	$22,262	$0	$77,839	$72,318	$0	$72,318	-$5,521
38,45		1	$12,505	$0	$22,262	$18,449	$0	$18,449	-$3,813
38,52		1	$46,922	$0	$12,505	$12,505	$0	$12,505	$0
38,60		5	$61,200	$0	$46,922	$46,922	$0	$46,922	$0
39,45		2	$57,004	$0	$61,200	$61,200	$0	$61,200	$0
41,60		1	$18,327	$0	$57,004	$57,004	$0	$57,004	$0
42,52		20	$615,655	$0	$18,327	$18,327	$0	$18,327	$0
42,54		2	$93,406	$0	$615,655	$615,655	$0	$615,655	$0
42,57		4	$33,493	$0	$93,406	$93,406	$0	$93,406	$0
45	Post-procedure Foreign Bodies	15	$446,780	$0	$33,493	$33,493	$0	$33,493	$0
57,60		9	$83,804	$0	$446,780	$446,780	$0	$446,780	$0
42,60		2	$48,198	$0	$83,804	$83,804	$0	$83,804	$0
PPC 12 Total		5,767	$124,337,435	$11,677,641	$48,198	$34,926	$33,774	$68,700	$20,502
Total		688,688	$7,425,605,443	$174,042,817	$136,015,075	$114,691,616	$11,960,768	$126,652,384	-$9,362,691
					$7,599,648,260	$7,415,959,624	$174,325,944	$7,590,285,568	-$9,362,691

Note: the above table has not been modified to reflect the impact of removing PPC 63 from the Proposed MHAC methodology

Table 3

Payment Change Simulation Summary by Hospital

A	B	C	D	E	F	G	H	I	J	K	L	M	N
						E+F			H+I	J-G	K/G		M/D
Hospital ID	Name	Cases	Total Charges	Original Approved Revenue	Original Outlier Amount	Original Total Payment	New Approved Revenue	New Outlier Amount	New Total Payment	Payment Decrement	Decrement as % of Original Payment	MHAC Cases	MHAC Cases as % of Total Cases
210001	Washington County	18,483	$158,362,125	$154,344,247	$1,816,082	$156,160,329	$154,171,036	$1,789,243	$155,960,279	-$200,050	-0.13%	163	0.88%
210002	University Hospital	35,970	$862,721,990	$826,407,884	$44,624,389	$871,032,273	$824,167,726	$44,707,872	$868,875,598	-$2,156,675	-0.25%	333	0.93%
210003	Prince Georges	15,936	$167,898,373	$161,551,144	$3,008,672	$164,559,815	$160,766,129	$3,091,317	$163,857,446	-$702,369	-0.43%	125	0.78%
210004	Holy Cross	35,779	$287,513,451	$281,602,513	$4,085,876	$285,688,389	$281,337,952	$4,065,743	$285,403,695	-$284,694	-0.10%	407	1.14%
210005	Frederick	20,177	$162,689,511	$160,265,652	$1,623,393	$161,889,045	$160,247,629	$1,576,286	$161,823,915	-$65,130	-0.04%	132	0.65%
210006	Harford	7,341	$56,213,844	$55,073,642	$628,808	$55,702,450	$55,073,642	$610,925	$55,684,567	-$17,883	-0.03%	21	0.29%
210007	St. Joseph	25,531	$278,356,211	$273,639,600	$2,038,635	$275,678,235	$273,141,707	$2,084,781	$275,226,488	-$451,747	-0.16%	281	1.10%
210008	Mercy	20,213	$193,272,957	$189,788,028	$1,807,215	$191,595,243	$189,667,107	$1,801,074	$191,468,181	-$127,062	-0.07%	154	0.76%
210009	Hopkins Hospital	43,896	$893,679,304	$836,188,497	$48,336,473	$884,524,970	$834,649,679	$48,488,691	$883,138,370	-$1,386,601	-0.16%	492	1.12%
210010	Dorchester	3,534	$26,999,473	$26,379,561	$496,391	$26,875,952	$26,379,561	$496,391	$26,875,952	$0	0.00%	23	0.65%
210011	St. Agnes	21,710	$229,196,700	$225,913,219	$2,814,263	$228,727,482	$225,708,926	$2,748,849	$228,457,775	-$269,707	-0.12%	264	1.22%
210012	Sinai	28,845	$393,365,136	$373,709,813	$5,592,800	$379,302,614	$372,769,002	$5,720,204	$378,489,205	-$813,409	-0.21%	395	1.37%
210013	Bon Secours	6,611	$69,062,126	$68,133,035	$702,816	$68,835,852	$68,133,035	$695,244	$68,828,279	-$7,572	-0.01%	23	0.35%
210015	Franklin Square	30,200	$285,311,249	$281,503,860	$3,129,879	$284,633,739	$281,262,449	$3,253,927	$284,516,376	-$117,363	-0.04%	171	0.57%
210017	Garrett	3,010	$18,579,636	$22,638,787	$101,577	$22,740,365	$22,635,972	$101,577	$22,737,550	-$2,815	-0.01%	17	0.56%
210019	Peninsula Regional	23,268	$257,066,029	$253,214,132	$1,502,324	$254,716,455	$253,091,878	$1,468,905	$254,560,783	-$155,672	-0.06%	165	0.71%
210023	Anne Arundel	28,750	$235,711,682	$232,827,823	$3,038,480	$235,866,303	$232,495,936	$3,068,892	$235,564,827	-$301,476	-0.13%	377	1.31%
210024	Union Memorial	20,742	$311,765,277	$304,194,440	$3,100,126	$307,294,566	$303,626,410	$3,306,427	$306,932,836	-$361,730	-0.12%	128	0.62%
210025	Cumberland	8,844	$68,007,429	$68,090,476	$863,112	$68,953,588	$68,065,774	$847,438	$68,913,212	-$40,376	-0.06%	84	0.95%
210027	Sacred Heart	9,314	$80,585,254	$80,027,894	$503,413	$80,531,307	$79,878,210	$494,738	$80,372,948	-$158,359	-0.20%	40	0.43%
210028	St. Mary's	10,817	$67,932,719	$66,635,174	$519,819	$67,154,993	$66,632,496	$519,819	$67,152,316	-$2,677	0.00%	50	0.46%
210029	Hopkins Bayview	23,102	$280,398,118	$255,585,049	$6,245,909	$261,830,958	$255,292,278	$6,209,025	$261,501,303	-$329,655	-0.13%	179	0.77%
210030	Chester River	3,855	$32,175,064	$32,349,341	$279,964	$32,629,306	$32,345,177	$272,911	$32,618,088	-$11,217	-0.03%	15	0.39%
210032	Union of Cecil	9,309	$62,894,394	$62,298,090	$931,892	$63,229,982	$62,283,736	$925,805	$63,209,541	-$20,440	-0.03%	72	0.77%
210033	Carroll	17,275	$139,922,153	$137,863,720	$1,416,132	$139,279,851	$137,851,557	$1,416,132	$139,267,689	-$12,163	-0.01%	97	0.56%
210034	Harbor	15,486	$147,120,540	$145,537,539	$898,430	$146,435,969	$145,424,015	$941,768	$146,365,783	$70,186	-0.05%	109	0.70%
210035	Civista	8,435	$66,866,283	$65,717,355	$1,497,874	$67,215,229	$65,701,585	$1,414,050	$67,115,635	-$99,595	-0.15%	45	0.53%
210037	Easton	10,924	$87,104,876	$85,364,685	$863,839	$86,228,524	$85,347,674	$826,244	$86,173,917	-$54,607	-0.06%	103	0.94%
210038	Maryland General	12,749	$139,985,425	$143,313,928	$872,957	$144,186,885	$143,039,465	$872,957	$143,912,423	-$274,463	-0.19%	53	0.42%
210039	Calvert	8,986	$60,215,647	$59,249,275	$229,589	$59,478,864	$59,234,161	$225,282	$59,459,443	-$19,421	-0.03%	56	0.62%
210040	Northwest	12,834	$120,249,766	$119,074,101	$931,278	$120,005,379	$118,886,719	$931,278	$119,817,996	-$187,382	-0.16%	41	0.32%
210043	Baltimore Washingtc	18,957	$185,136,502	$182,622,663	$2,398,244	$185,020,907	$182,531,298	$2,330,051	$184,861,349	-$159,558	-0.09%	98	0.52%
210044	GBMC	26,110	$204,992,823	$203,315,409	$1,616,884	$204,932,292	$203,272,263	$1,512,788	$204,785,051	-$147,241	-0.07%	393	1.51%
210045	McCready	732	$5,412,998	$5,247,677	$18,569	$5,266,246	$5,247,677	$18,569	$5,266,246	$0	0.00%		0.00%
210048	Howard	16,838	$137,988,774	$133,098,876	$1,878,224	$134,977,100	$133,068,364	$1,866,400	$134,934,764	-$42,336	-0.03%	223	1.32%
210049	Upper Chesapeake	17,343	$131,032,728	$128,188,963	$1,586,161	$129,775,125	$128,179,772	$1,563,336	$129,743,108	-$32,017	-0.02%	93	0.54%
210051	Doctors	11,678	$107,903,095	$105,450,686	$2,073,203	$107,523,888	$105,291,666	$2,155,267	$107,446,934	-$76,955	-0.07%	80	0.69%
210054	Southern Maryland	19,443	$157,458,438	$151,151,901	$1,334,767	$152,486,668	$151,020,216	$1,335,892	$152,356,108	-$130,560	-0.09%	110	0.57%
210055	Laurel	7,264	$63,393,989	$63,171,996	$673,080	$63,845,076	$63,164,978	$673,080	$63,838,058	-$7,018	-0.01%	28	0.39%
210056	Good Samaritan	17,140	$201,247,143	$195,388,050	$1,718,497	$197,106,548	$195,388,050	$1,704,308	$197,092,358	-$14,189	-0.01%	68	0.40%
210058	Kernan	2,816	$46,791,845	$44,190,938	$984,990	$45,175,928	$44,190,938	$984,990	$45,175,928	$0	0.00%	7	0.25%
210061	Atlantic General	3,689	$37,224,856	$37,005,026	$195,382	$37,200,408	$37,005,026	$195,382	$37,200,408	$0	0.00%	29	0.79%
210904	Hopkins Oncology	4,752	$156,069,939	$128,290,752	$15,062,409	$143,353,161	$128,290,752	$15,012,086	$143,302,838	-$50,322	-0.04%	23	0.48%
	Total	688,688	$7,676,375,869	$7,425,605,443	$174,042,817	$7,599,648,260	$7,415,959,624	$174,325,944	$7,590,285,568	-$9,362,691	-0.12%	5767	0.84%

Note: the above table has not been modified to reflect the impact of removing PPC 63 from the Proposed MHAC methodology.

Overall Results

The tables above have not been revised for the staff's modification to remove PPC 63 from the analysis. With this modification (based on FY 2008 data) it is expected the MHAC project will result in payment reductions of approximately $4.4 million system wide.

Table 4

MHACs Payment Change Simulation Summary by Payer:

Payor ID	Payor	Total Cases	Total Charges	MHAC Cases	MHAC Cases as Percent of Total	Original Total Payment	New Total Payment	Payment Decrement	Decrement as % of Original Payment
01	Medicare	238,722	$3,163,578,557	1,575	0.66%	$3,109,701,766	$3,104,863,613	-$4,838,153	-0.16%
02	Medicaid	46,766	$566,618,934	331	0.71%	$549,211,593	$548,402,971	-$808,623	-0.15%
03	Title V	169	$839,786	2	1.18%	$895,368	$895,368	$0	0.00%
04	Blue Cross of MD	46,609	$482,964,049	508	1.09%	$479,873,968	$479,573,599	-$300,369	-0.06%
05	Commercial Insurance	66,946	$698,012,022	689	1.03%	$682,012,367	$681,457,341	-$555,026	-0.08%
06	Other Governm. Program	7,023	$67,598,535	52	0.74%	$66,068,447	$65,860,282	-$208,165	-0.32%
07	Worker's Comp	3,385	$61,939,575	39	1.15%	$57,086,953	$56,995,588	-$91,366	-0.16%
08	Self-Pay	35,986	$273,024,924	131	0.36%	$289,893,653	$289,739,834	-$153,819	-0.05%
09	Charity	2,720	$14,145,145	13	0.48%	$15,930,101	$15,929,579	-$521	0.00%
10	Other	3,465	$30,882,731	13	0.38%	$31,509,845	$31,501,596	-$8,249	-0.03%
11	Donor	125	$0	1	0.80%	$0	$0	$0	
12	Managed Care Payer	95,047	$964,527,965	1,146	1.21%	$959,058,184	$958,023,955	-$1,034,229	-0.11%
14	Medicaid Managed Care	85,523	$692,580,848	717	0.84%	$708,920,132	$708,312,737	-$607,395	-0.09%
15	Medicare Managed Care	10,841	$147,289,522	67	0.62%	$148,020,379	$147,662,564	-$357,815	-0.24%
16	Blue Cross - NCA	21,502	$219,894,419	216	1.00%	$217,769,601	$217,493,087	-$276,514	-0.13%
17	Blue Cross - other state	23,688	$289,216,671	267	1.13%	$278,288,100	$278,165,651	-$122,449	-0.04%
99	Unknown	171	$3,262,188	0	0.00%	$5,407,803	$5,407,803	$0	0.00%
Total		**688,688**	**$7,676,375,869**	**5,767**	**0.84%**	**$7,599,648,260**	**$7,590,285,568**	**-$9,362,691**	**-0.12%**

Note: the above table has not been modified to reflect the impact of removing PPC 63 from the Proposed MHAC methodology.

Data Quality and Hospital Feedback

The adjustment of Maryland hospital-allowed charges based on the presence of MHACs requires several related efforts to assure that the use of the MHAC logic is reliable and creates the intended incentives for hospitals, specifically:

1) Assurance of data quality - in particular, the coding of the 'present of admission' flag;
2) Clearly understood payment rules and procedures;
3) Dissemination of hospital and case specific information; and,
4) Availability of analytic tools.

Staff has worked with Maryland hospitals to address each of these issues.

1) Assurance of data quality

The underlying concept the MHACs is that preventable conditions that occurred while an individual was under a hospital's care should not lead to additional, inappropriate revenue. It is also true that any condition that a patient had prior to admission to the hospital should not lead to a payment penalty. Therefore, the reliable coding of whether a diagnosis was, or was not, present on admission is central to the use of MHACs. Beginning July 1, 2007, Maryland hospitals were required to include a Present on Admission indicator for each of the secondary diagnosis codes in the inpatient discharge data set that is submitted quarterly to the HSCRC. POA data quality criteria, based on the distribution across five POA indicators, were developed by Commission staff using FY 2008 Maryland hospital discharge data as well as analyses performed by 3M using 2005/2006 California data, a state that has been collecting the POA indicator for more than 10 years.

Following the initial submission of the 4th quarter FY08 inpatient discharge data, hospitals were provided a "POA Data Quality Report" that indicated for each hospital the distribution across the five POA indicators, as well as the acceptable ranges for the distribution of each indicator. Included in the quality report were additional analyses that detailed potential data issues at each hospital associated with pre-existing conditions that were not coded as present on admission along with secondary diagnoses included/not included, on the exempt list. (An example of the POA quality report is included in Appendix IV) Overall, the quality of the POA indicator for the quarter was better than expected, with the majority of hospitals' data within the acceptable ranges for each of the parameters comprising the POA indicator. Five hospitals had one or more parameters that fell outside the acceptable range for this data period. The POA data quality evaluation for the following quarter (Q1 FY09) showed further improvement, with two hospitals having POA parameters that fell outside of the acceptable ranges. Hospitals will continue to receive a POA data quality report following each initial inpatient discharge data submission. This will allow each hospital adequate time to review and edit the POA data prior to the final submission deadline.

2) Clear Payment Rules and Procedures

As was discussed above, MHAC payment decrements will be determined by a combination of case weight changes and outlier adjustments whose presence and magnitude will vary from case to case. In addition to providing hospitals with the results of the payment simulations reviewed above, staff has provided the step-by-step logic that allows the calculation of payment decrements at the case level. The methodology for calculating payment decrements is presented in Appendix III. In addition, to providing the methodology, staff has scheduled a "hands on" working session for hospitals to review the payment decrement methodology and work through specific examples.

3) Dissemination of Hospital and Case Specific Information

The use of MHACs for payment purposes requires that individual discharges be assigned and outlier charges determined with and without the presence of the MHACs. Staff, working in cooperation with 3M, (the developers the logic used for MHACs) has analyzed each hospital's FY 2008 discharges and provided individual case feedback to each hospital. This allows the hospital to examine individual records for coding accuracy. It also allows the hospital to examine the MHAC information in the context of other quality efforts in the hospital, so that actions may be taken to reduce the incidence of MHACs.

4) Availability of Analytic Tools

As noted previously, the PPC logic, of which MHACs are a subset, is a product of 3M Health Information Systems, which works in concert with the APR-DRG grouper that has been in use in Maryland since 2005. As with the APR-DRG product and the EAPG grouper for outpatient services, 3M has offered Maryland hospitals special pricing arrangements for the product. In addition, the Commission has worked with 3M and its contractor St. Paul Computer Center (SPCC) to assure that hospitals that do not choose to purchase the 3M product can still receive sufficient information to analyze and respond to the MHAC policy by having analysis done on a per-run basis. 3M will be providing the MHAC logic as part of its Maryland product beginning July 2009. Staff is currently working with 3M, hospitals, and SPCC on the details of the MHAC analysis report that will be available for the April to June 2009 period.

Additionally, in a concerted effort to explain the MHAC methodology and also generate questions and any suggested changes to the proposed methodology, the HSCRC has organized several Review and Discussion Sessions. This effort is described below.

Review of Individual Case Data/Industry Review Session

By a series of written correspondences in late December 2008, HSCRC notified all hospitals that HSCRC had been working on development of proposed Maryland Hospital Acquired Conditions (MHACs) in light of the HACs that had been implemented by CMS and the need to implement strategies, like Medicare, to correct for the unintended incentives currently inherent in the payment rate setting system. The communication also provided:

- A set of individual case reports for each hospital that included each individual patient identified as having one of the 12 proposed MHACs not Present on Admission; the case reports included a "ghost" patient ID, patient age, patient gender, discharge status, the admission and discharge APR DRG, SOI, primary diagnosis and secondary diagnoses and POA status for each;[5]
- A crosswalk of the "ghost" ID numbers used for the analysis and the medical record number assigned by the hospital to allow hospitals to pull and review the records of the identified proposed MHAC cases;
- A summary description of the various payment simulation adjustment scenarios drafted to date based on the proposed MHACs;
- A summary by hospital and payer of the original case charges and adjusted case charges based on the proposed MHAC assignments.

Hospitals were also urged by staff, of the documentation in addition to engage clinical and quality leadership staff in the review of the documentation, in addition to nursing, finance and case mix staff already involved.

Subsequent to the December correspondences and in response to feedback provided by hospitals, HSCRC staff has:

- Refined, updated and redistributed the individual case reports to correct a glitch in the initial analysis affecting about 10% of the case reports;

- To be fully transparent in the methodology used for assigning the proposed MHACs, provided an online URL and User ID and password maintained by 3M specifically set up for Maryland hospitals, which contains detailed documentation with definitions, exclusions and assignment logic for the 64 PPCs of which the proposed MHACs are a subset;

- Convened a meeting on January 16, 2009 to review the MHAC clinical content and assignment logic and to review in detail the content of the individual case reports hospitals had received; invitations were broadly sent to case mix, clinical/quality and finance staff for the meeting, and participants included ~65 people from 30 hospitals.

[5] 5 Maryland hospitals were not included in the analysis as their POA data was not of sufficient quality to be included.

Appendix 7 shows an example of a de-identified case record that is eligible for the application of the MHAC payment methodology. Applicable secondary diagnoses and the related PPCs (MHACs) are shown along with the change in the payment weight associated with the presence of these preventable complications (prior to the application of the MHAC logic payment would be increased to the hospital). With the application of the MHAC methodology, the hospital will experience a 90% payment decrement associated with the incremental DRG weight change driven by the presence of the highly preventable MHAC (or conversely the hospital now receives a 10% "retention factor" associated with the additional increase in DRG weight determined by the presence of the identified preventable complication).

In addition to coordinating with the hospital industry in the MHAC development, HSCRC staff has worked closely with the Office of Healthcare Quality (OHCQ) over the last few months to review specific data on cases, including cases identified in the MHAC analysis also reported by hospitals to OHCQ as reportable events. Data were also reviewed on cases identified in the MHAC analysis not reported to OHCQ, but on which OHCQ has been able to conduct chart reviews.

Conclusion

Staff believes that the proposed Maryland Hospital Acquired Condition methodology offers the State the ability to significantly reduce the incidence of the most highly preventable hospital acquired conditions and complications. The proposed initiative also contains the following related advantages:

- The use of less than 100% payment decrement: better reflects the ability of hospitals to influence rates of complications; provides an incentive for continued coding of MHACs in order for the HSCRC to track industry performance accurately over time; and allows for broader application of the financial incentives than would otherwise be the case;

- The use of existing administrative data means that hospitals are not saddled with additional data collection and reporting burdens (as is the case with the current process-based P4P and pay for reporting initiatives);

- The ability to identify highly preventable complications in the administrative data also opens up new opportunities for the HSCRC to collaborate with the Maryland Office of Health Care Quality (MOHCQ) in order to monitor hospital performance and the incidence of reportable adverse events over time;

- The clinical and coding-related mechanism utilized by this effort (the Potentially Preventable Complication Methodology developed by 3M Health Information Systems) was created to augment and support the existing APR-DRG grouping and payment logic (also developed by 3M) currently in use by the State of Maryland for All-Payer hospital payment. The HSCRC can use these complimentary tools to dramatically improve the payment incentives for Maryland hospitals and improve the overall quality of hospital care in the State;

- PPCs and APR-DRGs, in combination with the State's existing well-developed data infrastructure, and sophistication in medical record documentation and coding, and the use of case mix data means that hospitals now have an enhanced set of analytic tools at their disposal to further reduce complication rates and improve quality of care;

- Consistent with the implementation of other innovative payment reform initiatives in past years, the HSCRC staff will remain open to suggested modifications and refinements to the methodology both now in the initial development phase and in future years.

HSCRC Staff *Modified* (2/26/2009)Recommendations

1) The Commission utilize **11 PPCs** (PPC 63 ***Post-Operative Respiratory Failure with Tracheostomy*** will be excluded from the MHAC methodology) as the basis for a Maryland – specific Hospital Acquired Conditions payment initiative **(modified)**;

   Additional clinical exclusions applied as a result of industry input are as follows:

   Adding 728.86 (Necrotizing fasciitis) to exclusion group 76 (Septicemia and disseminated infections) for PPC 39w

   Extend the logic for PPC 42 to include the laceration repairs that were performed on the same day as the primary procedure.

   Adding the diagnosis code for basal metabolic index (BMI) > 40 (V854) to PPC 57 and 58 exclusion list.

   Adding 710.3 (Dermatomyositis) and 710.4 (polymyositis) to exclusion group 85 (Neuro-muscular disorders) for PPC 63 (PPC 63 is eliminated from the MHAC group but these exclusions are generally being recognized now by 3M for its overall PPC logic as a result of the input from the Maryland Hospital Industry).

   Adding Resipratory Failure Present on Admission to PPC 63 exclusion logic

2) Payment decrements of 90% be applied to both "in-lier" and "outlier" cases as defined in the methodology description and simulations described and presented above **(unchanged)**;

3) This initiative should commence April 1, 2009 with any payment-related decrements being reflected in each hospital's final rate order for the following fiscal year **(unchanged)**;

4) Both one-time and permanent payment reductions associated with the approved payment decrements for the quarter commencing April 1, 2009 will be reflected in the final CPC targets and final approved revenue for hospitals effective July 1, 2009 **(unchanged)**;

5) The approved methodology will also be applied to the Rate Year beginning July 1, 2009 (FY 2010) (unchanged);

6) The HSCRC staff will monitor the number of these highly preventable complications (MHACs) over time. The HSCRC shall conduct a retrospective chart review of a representative number of cases with the specific intent of quantifying the number of false-positive occurrences (relative to identified false-negative occurrences) and overall intent of identifying any additional unanticipated consequences or results. This formal review will take place sometime during the next rate year (optimal timing not yet determined) and the results from this review may lead to modifications of the MHAC initiative for the subsequent year **(modified)**.

Identified Highly Preventable Complications (MHACs)

- Post-Op Wound Infection & Deep Wound Disruption w Procedure (PPC 38)
- Reopening of Surgical Site (PPC 39)
- Post-Op Hemorrhage & Hematoma w Hemorrhage Control Proc or I&D Procedure (PPC 41)
- Accidental Puncture/Laceration During Invasive Procedure (PPC 42)
- Post-Procedure Foreign Bodies (PPC 45)
- Iatrogenic Pneumothrax (PPC 49)
- Inflammation, & Other Complications of Devices, Implants or Grafts Except Vascular Infection (PPC 52)
- Infections due to Central Venous Catheters (PPC 54)
- Obstetrical Laceration & Other Trauma without Instrumentation (PPC 57)
- Obstetrical Laceration & Other Trauma with Instrumentation (PPC 58)
- Major Puerperal Infection and Other Major Obstetrical Complications (PPC 60)
- ***Post-Operative Respiratory Failure with Tracheostomy (PPC 63) – Now recommended to be eliminated from HSCRC – MHAC list.***

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

AS OF APRIL 2 , 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
2017A	University of Maryland Medical Center	2/26/09	N/A	N/A	ARM	DNP	OPEN
2018R	University Specialty Hospital	3/5/09	4/15/09	8/3/09	FULL	GS	OPEN
2019N	Garrett County memorial Hospital	3/11/09	4/15/09	8/9/09	CLINIC	CO	OPEN
2020R	Franklin Square Hospital	3/17/09	4/18/09	8/15/09	MRI	CO	OPEN
2021R	Johns Hopkins Bayview Medical Center	3/6/09	4/15/09	8/4/09	CAPITAL	GS	OPEN
2022R	Civista Medical Center	3/25/09	4/26/09	8/23/09	ICU/CCU	CO	OPEN
2023A	University of Maryland Medical Center	4/2/09	N/A	N/A	ARM	DNP	OPEN
2024A	University of Maryland Medical Center	4/2/09	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2009**
MEDICAL CENTER	*	**FOLIO:**	**1827**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2017A**

Staff Recommendation

April 15, 2009

I. INTRODUCTION

The University of Maryland Medical Center ("UMMC", or "the Hospital") filed a application with the HSCRC on February 26, 2009 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for participation in a global rate arrangement for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. transplant network for a three-year period, effective April 1, 2009.

II. OVERVIEW OF APPLICATION

The contract will be held and administered by University Physicians, Inc.(UPI). UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement among UPI, the Hospital, and the physicians holds the Hospital harmless from any shortfalls in payment from the global price contract. UPI maintains it has been active in similar types of fixed fee contracts for several years, and that UPI is adequately capitalized to the bear risk of potential losses.

V. STAFF EVALUATION

In contrast to prior global arrangements for the provision of solid organ and blood and bone marrow transplant services, the Hospital has negotiated, what appears to be a much more favorable arrangement with provisions that mitigate risk and maximize reimbursement. Consequently, staff believes that the Hospital can achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

After review of the application and the terms of the arrangement, staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. for a one year period commencing April 1, 2009. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	BEFORE THE MARYLAND HEALTH
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW
DETERMINATION	*	COMMISSION
JOHNS HOPKINS HEALTH	*	DOCKET: 2009
SYSTEM	*	FOLIO: 1761
BALTIMORE, MARYLAND	*	PROCEEDING: 2014A

Staff Recommendation

April 15, 2009

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on January 20, 2009 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for participation in a global rate arrangement for cardiovascular services with Coventry Health Care of Delaware, Inc. for international patients only. The System requested approval for a period of three years beginning February 1, 2009.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar

types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

After review of the data utilized to calculate the case rates, staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services, for a one year period commencing February 1, 2009. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE FULL	*	BEFORE THE HEALTH SERVICES	
RATE REVIEW OF	*	COST REVIEW COMMISSION	
UNIVERSITY SPECIALTY HOSPITAL	*	DOCKET:	2009
	*	FOLIO:	1828
BALTIMORE, MARYLAND	*	PROCEEDING:	2018R

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STAFF RECOMMENDATION

April 15, 2009

I. INTRODUCTION

On February 27, 2009, University Specialty Hospital ("Hospital," or "USH") submitted a full rate application to the Health Services Cost Review Commission ("HSCRC" or "Commission"). USH is licensed as a 180 bed chronic care facility and is a member of the University of Maryland Medical System ('System" or "UMMS"). The Hospital treats patient with chronic conditions that include ventilator dependency, traumatic brain injury, and other medically complex conditions. The Levindale Hebrew Geriatric Center and Hospital is the only other licensed chronic care facility in Maryland. Three other acute care hospitals have licensed chronic care beds. They are Johns Hopkins Bayview Medical Center, Prince Georges Hospital, and James Lawrence Kernan Hospital.

II. HOSPITAL REQUEST

The Hospital is requesting that its permanent unit rate structure be increased by 8.2%, effective March 27, 2009. Due to the nature of the cases treated at USH, the Hospital is not subject to a charge per case constraint, nor is it assigned to any pre-established peer group.

III. HOSPITAL RATE HISTORY

USH has not requested a full rate review for some time. The Hospital has operated traditionally under the HSCRC's Inflation Adjustment System, which had annually updated the Hospital's average unit rates.

IV. HOSPITAL FINANCIAL SITUATION

The Hospital's fiscal year end is June 30. For the past three fiscal years, the Hospital has reported the following operating results:

University Specialty Hospital	Net Operating Revenue (Regulated)	Net Operating Profit (Regulated)	Operating Margin (Regulated)	Net Profits
FY June 2008	$54,795,000	($1,148,600)	(2.10%)	($1,250,400)
FY June 2007	$54,559,600	$1,236,900	2.27%	$2,351,900
FY June 2006	$51,301,800	$2,647,100	5.16%	$3,540,400

For the six months ending December 31, 2008, the Hospital has reported a Net Operating Loss of ($1,936,100), or (7.56%) on Net Operating Revenue of $25,597,000, and an overall Net Loss of ($3,258,000). The annualized net operating revenue for this period is significantly lower (6.6%)

than the previous year.

V. STAFF ANALYSIS

The Hospital states, "Although USH does not readily fit into the HSCRC's Full Rate Application formulas, the Hospital is filing this request by attempting to adhere within the parameters of HSCRC policy and methodologies and the current rate review policy." To that end, the Hospital provided a unit rate comparison similar to that used to calculate outpatient rates in the normal Inter-hospital Cost Comparison (ICC) Methodology. This methodology provides a hospital with the approved median cost of the peer group. USH included the five hospitals with licensed chronic beds as its defined peer group. This peer group appears to be logical; however, the staff believes that there are substantial differences between some of the cost elements of USH and some of the other acute hospitals in this peer group. The Hospital indicates that its methodology would support a $7.3 million or 13.45% increase to the rates included in its analysis. The staff believes that this result would indicate, on its face, that substantial cost differences exist between the hospitals in the peer group and USH.

Therefore, the staff developed new unit rates for USH by using the same peer group but looking at the various elements of expenses on an individual basis.

A. Direct Medical Care Expenses

Room Rates

As one may surmise, these expenses are associated with the direct care provided to the patients. The daily cost of providing care to a chronic patient is predominantly for nursing care at the bedside. These cost are influenced by the type of nursing care provided and the hours of care required. Staff believes that these cost are comparable among the peer group hospitals. Therefore, staff recommends using the peer group average cost per day for chronic care expenses. However, since USH and Levindale have separate rates for chronic care and respiratory dependent care, staff needed to combine these rates in order to make them comparable to the other hospitals in the peer group.[1]

USH, Levindale, and Kernan are the only hospitals in the group that have a room rate for

[1] Bayview, Prince Georges, and Kernan provide care to respiratory dependent patients. However, the costs of providing care to these patients are included in their chronic rates.

rehabilitative care. The direct patient care cost per day at Kernan is considerably higher ($446 per day) than the cost per day at Levindale ($289 per day) or USH ($287 per day). This would indicate either a different level of care is being provided or a different type of patient is being treated at Kernan. Therefore, staff recommends using the average cost of Levindale and USH only when establishing the unit cost allowance for this revenue center.

Ancillary Rates

The direct medical care expenses in the ancillary centers are, for the most part, based of Relative Value Units. Staff believes that the directs costs are comparable among the peer group hospitals. Therefore, staff recommends using the average cost of the peer group for the direct medical care portion of the ancillary rates.

B. Patient Care Overhead Expenses

These expenses include the cost for providing dietary services, laundry services, housekeeping services, and other similar services to the patients. Staff believes these cost are also comparable among the five peer group hospitals. Therefore, staff recommends using the peer group average cost per unit for these expenses.

C. Other Overhead Expenses

These expenses include the cost for services such as patient accounting, financial accounting, hospital administration, nursing administration, medical staff administration, medical malpractice, and other similar services. Staff believes that these costs are significantly different at USH compared with the other acute care hospitals. In fact, if the group average costs were used, it would provide USH with approximately 21% more than its actual cost for these services. Therefore, staff recommends that the Hospital's actual cost per unit be used for these expenses.

D. Adjustment for Capital

In its application, USH stated that it had a need for major capital improvements. It further stated that current capital requests total more than $50 million. The Commission's current ICC standard for capital cost is based on 50% of the applicant hospital's capital cost, and 50% of the average capital cost of the ICC comparison group expressed as a percentage of each hospital's total actual cost. The groups' average capital costs are 6.12% of total cost, while USH's capital costs are 4.53% of total cost. Staff believes that the capital needs of an acute care facility, on average, may

be higher than that of a chronic facility. Therefore, the staff recommends that 50% of the peer group average and 50% of the USH's actual capital cost be used in the calculation for capital. This will provide USH a capital allowance of 5.32% of total cost

E. Adjustment for Inflation and Productivity Offset

Since the fiscal year end June 30, 2008 cost reports were used to develop the cost per unit recommended by staff, a price leveling factor had to be applied for fiscal year 2009. The amount provided for the update factor to all hospitals for FY 2009 was 4.2%. Therefore, staff recommends that the unit cost developed be increased by 4.2%.

Additionally, the ICC analysis normally reflects a productivity offset of 2%. Staff applies this offset in order to ensure that rates produced by the analysis are reasonable. Staff recommends that this offset be applied to the unit cost developed for the Hospital.

F. Adjustment for Uncompensated Care (UCC)

The current policy for the ICC establishes the UCC in rates based on the minimum of actual year UCC or the UCC predicted by the regression. This policy maintains the UCC provision in rates for 12 months. At the end of the 12 months, the annual update UCC policy would then apply to the subject hospital.[2] The annual update UCC policy currently in effect provides a hospital with 50% of its average actual UCC for the last 3 years, and 50% of the predicted UCC based on the most current year used in calculating the 3 year average. However, because USH does not provide emergency services or provides very little in the way of outpatient care, they are not included in the regression analysis to determine a predicted level of UCC for the Hospital. Staff has some concerns regarding USH's UCC, which can increase or decrease by 1% to 2% from one year to the next. USH is normally provided its own three year average in rates. Staff believes this is a more reasonable amount to provide on a yearly bases. Therefore, staff recommends that the Hospital's own three year average be included in rates.

G. Rate Re-alignment

The final step in the full rate review process is normally the spreading of the revenue

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[2] The current policy for the treatment of UCC during a full rate review was approved by the Commission at its October 13, 2004 public meeting as part of the "Staff Final Recommendations For Revisions to the HSCRC's ICC/ROC Methodologies for FY 2005."

produced by the ICC analysis to the unique cost structure of the hospital being reviewed in order to ensure that rates are reasonably related to costs as mandated by law. Since USH is not an acute care hospital, it was exempted from submitting a full cost report until fiscal year 2007. Since this was the first time the Hospital had submitted a full cost report, it was not used at July 1, 2008 to re-align rates. While the overall rate change being recommended is 2.97%, unit rate changes for individual revenue centers would range from +34% for Chronic Care Services to -73% for Laboratory Services if the increase were spread over the Hospital's actual cost structure. This could have a substantial impact on a payer's charges. Since Medicaid represents 62% of the charges at USH, staff contacted representatives of the Medical Assistance Program in an attempt to ascertain the impact this magnitude of change would have on Medicaid payments. Unfortunately, the data needed to complete such an analysis were not readily available from Medicaid. Therefore, due to the State's current financial condition, staff recommends that the 2.97% increase be spread uniformly across USH's current permanent rates. Additionally, staff recommends that the Hospital and staff, along with representatives of the Medical Assistance Program, meet in order to determine how and when rate re-alignment should be implemented in the future.

H. Effective Date

The Hospital has requested an effective date of March 27, 2009 for the implementation of its rate requests. Under Commission law, the effective date of a permanent rate application must be at least thirty days after the date on which a properly submitted application is filed and docketed, which in this case was March 1. The staff recommends that the increase to rates be effective April 1, 2009.

VI. FINAL RATE RECOMMENDATION

In accordance with the methodology as outlined above, staff recommends the following:

1. That the permanent inpatient and outpatient unit rates at USH be uniformly increased by an overall 2.97%;
2. That these rates be adjusted by the overall update factor provided to other hospitals at July 1, 2009;
3. That the Hospital and staff, in conjunction with representatives from the Medical Assistance Program, immediately enter into discussions on how rates

should be re-aligned at July 1, 2009;

4. That the UCC provision remain in rates for 12 months; and

5. That the change to rates be made effective April 1, 2009;

IN RE: THE RATE APPLICATION	*	BEFORE THE HEALTH SERVICES
OF THE GARRETT COUNTY	*	COST REVIEW COMMISSION
MEMORIAL HOSPITAL	*	DOCKET: 2009
	*	FOLIO: 1829
OAKLAND, MARYLAND	*	PROCEEDING: 2019N

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Staff Recommendation

April 15, 2009

Introduction

On March 11, 2009, Garrett County Memorial Hospital (the "Hospital") submitted a partial rate application to the Commission requesting a new rate for Operating Room Clinic (ORC)). The Hospital would like to offer Wound Care Services to the residents of Garrett County. Currently, the Hospital claims that patients requiring more than rudimentary wound care management must travel out of the county to seek care and treatment. The Hospital is on the Commission's Total Patient Revenue (TPR) System, so the Hospital is requesting that total TPR revenue be increased by $750,985 due to the new ORC center. The Hospital is requesting that an ORC statewide median rate of $9.82 per RVU be approved effective April 1, 2009.

Staff Evaluation

The staff requested that the Hospital submit its cost and volume projections to the Commission for FY 2009 in order to determine if the Hospital's ORC rate should be set at the statewide median rate or at a rate based on its projected costs. Based on the information received, staff determined that the ORC rate based on the Hospital's projected data is $9.72 per RVU, while the statewide median for ORC services is $9.82 per procedure.

Recommendation

After reviewing the Hospital's application, the staff has the following recommendations:

1. That COMAR 10.37.10.07 requiring that rate applications be made 60 days prior to the opening of a new service be waived;
2. That the ORC rate of $9.72 per RVU be approved effective April 1, 2009;
3. That the ORC rate not be rate realigned until a full year's cost experience data have been

reported to the Commission

4. That the Hospital be held harmless for new Wound Care Service in the TPR comparison for RY 2009. Once a full year of actual wound care experience data for RY 2010 is submitted, staff will determine the appropriate permanent increase to the Hospital's TPR.

IN RE: THE PARTIAL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
FRANKLIN SQUARE	*	DOCKET: 2009
HOSPITAL	*	FOLIO: 1830
BALTIMORE, MARYLAND	*	PROCEEDING: 2020R

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Staff Recommendation

April 15, 2009

Introduction

On March 16, 2009, Franklin Square Hospital (the Hospital) submitted a partial rate application to the Commission requesting a rate for MRI services to be provided in-house beginning in April 1, 2009. The Hospital currently has a rebundled rate for MRI services. The Hospital is requesting that the MRI rate be set at the statewide median with an effective date of April 1, 2009.

Staff Evaluation

The Hospital submitted its MRI costs and statistical projections for FY 2009 to the Commission in order to determine if the Hospital's MRI rate should be set at the statewide median rate or at a rate based on its cost experience, Based on this information, staff determined that the MRI rate based on the Hospital's projected data would be $28.82 per RVU, while statewide median for MRI services is $46.09 per RVU.

Recommendation

After reviewing the Hospital's application, the staff has the following recommendations:

1. That COMAR 10.37.10.07 requiring that rate applications be made 60 days prior to the opening of the new service be waived;
2. That the MRI rate of $ 28.82 per RVU be approved effective April 1, 2009;
3. That no change be made to the Hospital's charge per case standard for MRI services; and
4. That the MRI rate not be rate realigned until a full year's experience data have been reported to the Commission.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2009**
MEDICAL CENTER	*	**FOLIO:**	**1834**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2024A**

Staff Recommendation

April 15, 2009

I. INTRODUCTION

On April26, 2009, the University of Maryland Medical Center ("UMMC or the Hospital") filed an application with the Commission for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requested approval to continue to participate in a global rate arrangement with the Gift of Life Foundation (GOL) for the collection, on an outpatient basis, of bone marrow and peripheral blood stem cells from GOL donors to facilitate Hematopoietic Stem Cell transplants into unrelated GOL recipients. The Hospital seeks approval of the arrangement for an addition year beginning May 1, 2009.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates for the collection of bone marrow and peripheral blood stem cells has been developed based on recent historical charges for cases performed at UMMC.. The remainder of the global rates comprised of physician services has been negotiated with the participating physician group.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

shortfalls in payment from the global price contract.

V. STAFF EVALUATION

Staff found that the Hospital's experience under this arrangement for the last year was favorable.

VI. STAFF RECOMMENDATION

Because last year's experience was favorable, staff recommends that the Commission approve the Hospital's request for an alternative method of rate determination for the collection of bone marrow and peripheral stem cells for one year commencing May 1, 2009. UMMC will be required to file a renewal application for review to be considered for continued participation in the arrangement.

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

Draft Staff Recommendation and Discussion Document Regarding the FY 2010 HSCRC Hospital Payment Update

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April 15, 2009

This document represents a draft recommendation to be presented to the Commission on April 15, 2009 for discussion purposes only. Comments on this recommendation are due to the HSCRC by May 6, 2009.

Background

In November of this fiscal year, the staff assembled a "Payment Workgroup" to assist staff in the development of a draft recommendation for an inflation update to hospital rates for FY 2010 (effective July 1, 2009). This Workgroup consisted of representatives of HSCRC, staff, the Maryland Hospital Association (MHA) and individual hospitals, and public and private payers (including representatives from CareFirst of Maryland, Kaiser-Permanente, United Health Care, Amerigroup, Maryland Medicaid and the State Employee Benefit Program). The goal of this effort was to develop a consensus position on the level of the hospital update for the years FY 2010-2012.[1]

Given that total hospital revenues currently approximate $13 billion annually, the magnitude of the HSCRC's annual hospital rate update has significant implications for both the financial condition of Maryland hospitals and the affordability of hospital care within the State. Each 1.0% additional increment in the update represents approximately $130 million in annual hospital payments. The Maryland Medicaid program represents approximately 15% of the hospital market and, thus, every 1.0% increase in the annual update will increase Medicaid hospital payments by approximately $20 million. Thus, hospital rate increases have a large impact on the State budget by way of increases in Medicaid hospital payments. It should also be noted that hospital payments (and thus the revenues hospitals generate) are also influenced by changes in the volume of services year to year. In recent years, growth in hospital volume (largely additional admissions and hospital visits) has ranged from 1.0% to 3.0% per year. Annual increases in volumes are now running about 1.5%.

All together, health care expenditures in the US now account for an estimated 18% of total Gross Domestic Product (GDP) and a similar proportion of Gross Domestic Product for the State of Maryland.[2] This proportion of GDP (which is more than double that of other developed countries around the world) has continued to grow over the past several decades and is now expected to increase at an accelerated rate given current and projected contractions in the rest of the economy. Hospital expenditures are a significant component of overall health spending, account for approximately 36% of overall health spending.[3] Given these factors, there is heightened concern over the economic sustainability of historical cost growth trends in Maryland and in the rest of the country.

In order to provide the HSCRC with sufficient time to receive input from all parties and deliberate over this decision, the HSCRC Chairman requested that the staff provide the Commission with a draft proposal for the FY 2010 update at the April public meeting. In past years, hospitals have also a strong desire for the Commission to discuss and decide on the next year's update factor prior to the completion of hospitals' budgeting process, which generally occurs in the March to May time frame. Given these circumstances, the staff requested update proposals from both payer and hospital representatives beginning in November 2008. More accelerated discussions have taken place since early March of 2009 in order to meet the Chairman's directive to present a staff draft recommendation to the Commission by the April meeting.

Update Proposals from Hospitals and Payers

Due to concerns regarding the uncertainty associated with the economy and the financial markets, MHA put forth a rate proposal that applied only to this upcoming rate year FY 2010. Given current uncertainty regarding financial and economic trends the MHA strongly suggested that the Commission consider a one-year update arrangement (in the past the HSCRC has adopted update proposals covering a three-year time horizon). The hospital proposal was for a blended (both inpatient and outpatient) base update of 3.84% over FY 2009 rate levels. This proposal included estimated input cost inflation (or "Market Basket") and expected case mix increases (expected year-to-year increases in the illness burden of patients due to aging of the population and other factors). The MHA proposal included a 0.26% "risk premium" increase to help cover expected additional costs stemming from the current volatility in the

[1] The Payment Work Group convened last year successfully forged a near consensus recommendation for a 4.7% rate update for FY 2009 rates over FY 2008.
[2] Congressional Budget Office and MHCC Health Spending Accounts 2008
[3] MHCC Health Spending Accounts 2008

financial markets. Assuming base revenue of $12.9 billion for FY 2009, this proposal would increase hospital payments in FY 2010 by $495 million over the FY 2009 base.

In response to the original staff request, the payer representatives initially proposed a three-year rate arrangement. This proposal was subsequently withdrawn, however, when staff concurred with the MHA view that given market and economic conditions the rate update proposals should apply only to the upcoming rate year, FY 2010. The payer one-year proposal was for a 0.80% update to hospital rates for FY 2010. This proposal would result in a $103 million increase in hospital payments over FY 2009. **Table 1** below summarizes both the MHA and the payer proposals for the HSCRC update factor for FY 2010.

Table 1

	Payer Proposal	MHA Proposal	
		Inpatient	Outpatient
Market Basket 2010 (input cost inflation estimate)		1.59%	1.59%
Adjustment for historical forecast error		0.53%	0.53%
Inflation Allowance	0.00%	2.12%	2.12%
Additional Descretionary Factor	0.00%	0.98%	0.98%
Outpatient Intensity Adjustment			0.30%
	0.00%	3.10%	3.40%
Estimated System Slippage (or Offset)	0.10%	-0.10%	-0.10%
Volume Adjustment	-0.30% (1)	0.00% (4)	0.00% (4)
Base Rate Update Provided	-0.20%	3.00%	3.30%
Case Mix Cap	1.00%	0.75%	0.75%
	0.80%	3.75%	4.05%
Blended Update (Inpatient & Outpatient)	***0.80% (2)***	***3.84%***	
Estimated Volume increase	1.51% (3)	1.51% (3)	
Expected Overall Revenue Increase	2.31%	5.35%	

Assumptions
(1) Volume adjustment 15% of 2009 volume change (both EIPAs and Case mix)
(2) Payer Proposal applies to both inpatient and outpatient rates
(3) Staff estimated volume change 2010
(4) MHA proposes elimination of the volume adjustment

In addition to a proposal for the core rate update for FY 2010, both the hospital and payer proposals covered a number of related parameters and issues affecting next year's hospital rate structure. These include supplementary proposals related to differential "scaling" of updates by hospital based on relative efficiency, retention of the 7% minimum threshold for the Medicare Waiver test, the handling of volume adjustments in the system, adjustments for so-called "system slippage" (departures from the targeted hospital revenue increase due full rate reviews and spenddowns) and other factors. A description of these additional parameters and the respective payer, hospital and staff proposals will be provided in a later section. Both proposals are shown in more detail in **Appendix I.**

HSCRC Staff Draft Update Proposal

Given the very large difference between the proposals (over a 3.0% difference in base update levels), it became clear to staff that it would be difficult to develop a consensus position for the Payment Workgroup. Accordingly, the staff examined the two industry proposals and a number of other environmental factors in the development of its own draft proposal for an update to hospital rates effective July 1, 2009 (for FY 2010). This evaluation provided the basis for the staff's current draft recommendation.

Environmental Factors Considered:

Hospital Financial Performance: Hospital operating performance in 2009 is generally stable, but the overall profit and cash position of hospitals have been negatively affected by large non-operating losses (both realized and unrealized). First, operating performance of Maryland hospitals has remained quite healthy and stable over the past two fiscal years 2007 and 2008, with some slight deterioration in 2008 (based on an analysis of 41 June Year End hospitals). This deterioration was primarily related to an increase in losses hospitals experienced on their unregulated portions of their business.[4] Table 2a shows that while regulated operating margins remained relatively stable between 2007 and 2008 (5.5% in 08 vs. 5.7% in 07), losses on unregulated services increased from -22% in 07 to -30.1% in FY 2008 (accounting for nearly all of the deterioration in total operating margin (both regulated and unregulated) from 3.23 in FY 2007 to 2.4% in FY 2008. A breakdown of unregulated losses for FY 2008 is provided in **Appendix II.**

For the current year (FY 2009) it appears that operating profitability has improved slightly over FY 2008 levels. Year-to-date operating performance in FY 2009 (both regulated and overall operating profits), are nearly identical to operating profits last year at this time (2.08% total operating profit for first 8 months of 2009 vs. 2.10% total operating profit for first 8 months of 2008).[5] This indicates to staff that Maryland hospitals are still likely generating regulated operating profits in excess of 5.0% this year. These results are summarized in **Tables 2a and 2b** below.

Tables 2a and 2b

Table 2a FY 2008 vs. FY 2007 Operating Performance (41 June Year End Hospitals)

	FY 2007 June Year End Hospitals			FY 2008 June Year End Hospitals		
	Regulated	Unregulated	Total	Regulated	Unregulated	Total
Operating Profit	5.70%	-22.00%	**3.23%**	5.50%	-30.10%	**2.40%**
Note: If unregulated loss had stayed constant in 2008				5.50%	-22.00%	**3.13%**

Source: Annual Cost Report filings to HSCRC (reconciled with audits)

Note: Last year YTD performance resulted in robust operating margins on the hospitals' regulated portion of their business. YTD 2009 overall operating performance is nearly identical to YTD 2008.

Table 2b Last Year (2008 YTD) vs. Current Year (2009 YTD) Operating Performance

	Last Year at this Time 8 months through February 2008	Current Year 8 months through February 2009
	Total	Total
Total Operating Profit (both regulated and unregulated)	2.10%	**2.08%** (1)

(1) Steady operating profits for 2009 are indicative of a similar profile of regulated and unregulated profit picture for hospitals in 2009. Anecdotal reports are that unregulated losses have increased again in 2009 which would mean that regulated operating profilts may well be higher in FY 2009 than in FY 2008.

Source: Monthly Unaudited financial statements filed with the HSCRC

[4] Unregulated losses are largely losses on physician services but also include other non-hospital lines of business. **Appendix II** provides a summary of 2008 unregulated losses by hospital.

[5] Note: While year-to-date FY 2009 unaudited F/S data do accurately reflect final audited financial performance for hospitals (once audited financials are received) there is some inconsistency in the way hospitals account for regulated and unregulated revenues and expenses on the F/S YTD unaudited reports.

While overall operating performance remains stable hospitals (along with most other businesses) have experienced large non-operating losses in FY 2009. These non-operating losses include both realized losses from investments (owing largely to liquidated equity positions following the large declines in the equity market) and unrealized losses from current investments, and large "mark-to-market" swap liabilities associated with interest rate swaps on the balance sheets of hospitals. A breakdown of these non-operating losses for 2009 (through January) is provided in **Appendix III.** The primary impact of these realized and unrealized losses is that they place pressure on the liquidity position of hospitals in that: 1) investment declines directly reduce cash positions; and 2) unrealized losses related to swap arrangements trigger collateral calls (the requirement that hospitals post additional cash as collateral as the magnitude of swap liabilities increase). A related concern is that material swap liabilities in combination with investment losses, could lead to a borrower violating bond covenants (such as liquidity covenants) which can lead to acceleration of principal payments or immediate repayment of principal.

Combined with poor investment returns in 2009, many hospitals in the US are challenged by the sudden reduction in liquidity that swap liabilities can cause. The MHA attempted to quantify this reduction in cash positions for FY 2009 and estimated that Maryland hospitals may have experienced a reduction in cash in excess of 20% relative to 2008 levels (a summary of this analysis is provided in **Appendix I**). For hospitals affected by both of these risks and unable to maintain operating margins, rating downgrades are possible. Bond rate agencies are aware of these circumstances have tended to place stressed institutions on "negative watch" rather than immediately inflicting a ratings downgrade. If hospitals hold these swap arrangements to maturity however, the unrealized balance sheet loss will evaporate however. Thus, the posting of collateral may be temporary depending upon market conditions. **Appendix IV** provides a more complete analysis from Moody's Investor Services of the impact these swap arrangements are having on hospitals' liquidity position and bond ratings.

Severe Contraction in the General Economy: General economic activity nationwide is in a state of "severe contraction" with national GDP estimated to have declined by 6.2% on an annualized basis for the last quarter of CY 2008. This contraction has impacted virtually all sectors of the economy. The growing un-affordability of hospital services has been a large concern of the HSCRC in recent years. This recent contraction in economic activity means that health care services have become even less affordable. Wage growth nationally is flat with many sectors starting to cut wages (in addition to layoffs and furloughs of employees). Flat or declining wages have created slack in the labor market, including the health care sector, which will help alleviated previous shortages of nurses and allied health professionals. A summary of reports about contractions in most sectors of the economy is contained in **Appendix V**.[6]

Trends in Hospital Input Cost Inflation: The current estimate (released in early April 2009) for increases in hospital input costs (increases in the inputs to the hospital production process) in the coming fiscal year FY 2010 is 1.59%. This forecast has remained unchanged from the previous estimate (from January 2009). The hospital input cost inflation estimate consists of both wage and non-wage components. Hospital wages, (accounting for 60% of hospital costs) were projected to increase at 2.7% while non wage items (accounting for 40% of hospital costs) were forecasted to grow at .10%. Given the increasing slack in the labor market across all sectors, staff believes hospitals may have the ability to further reduce their input cost growth by holding wage increases to levels below the projected levels in FY 2010. **Table 3** summarizes the estimated increases in hospital input costs by category.

[6] Bureau of Economic Analysis and Federal Reserve District Reports February and March 2009

Table 3 Global Insights Market Basket Components (hospital input cost inflation FY 2010)

Category	% increase	Weight
Compensation	2.70%	60.0%
Professional Fees	2.50%	6.0%
Malpractice	4.50%	2.0%
Utilities	-1.80%	1.0%
All Other costs	-0.60%	31.0%
Non- Capital	1.66%	
Capital	1.50%	
Weighted cost inflation	**1.59%**	

Significant State Budgetary Shortfalls: The State of Maryland continues to face significant budgetary shortfalls. The most recent write-down of projected State revenues (reflecting the general economic contraction) has resulted in an expected State budget shortfall in excess of half a billion dollars for FY 2010. It is expected that any additional contraction in economic activity during the course of 2009 and 2010 will result in larger budget deficits. Accordingly, the budget for FY 2010 Maryland Medicaid expenditures has been negatively impacted. Updates provided by the State Medicaid program to its non-hospital providers ranged between 0% and 0.9% for FY 2010. **Table 4** below summarizes the inflation updates provided by Medicaid to nursing homes, Personal Care, Private Duty Nurses, Medical Day Care Workers, Home Health, Living at Home Waiver, Waiver for Older Adult and Managed Care organizations and providers.

Table 4 Rate Updates for Medicaid Providers FY 2010

Proposed Rate Increases included in FY 2010 Budget	FY 2010
Managed Care Organizations	*
Personal Care	0.0%
Nursing Homes	0.0%
Private Duty Nursing	0.0%
Medical Day Care Waiver	0.9%
Home Health	0.0%
Living at Home Waiver	0.9%
Waiver for Older Adults	0.9%

* 4.3% in first six months and 0% in second six months (due to budgeting process)

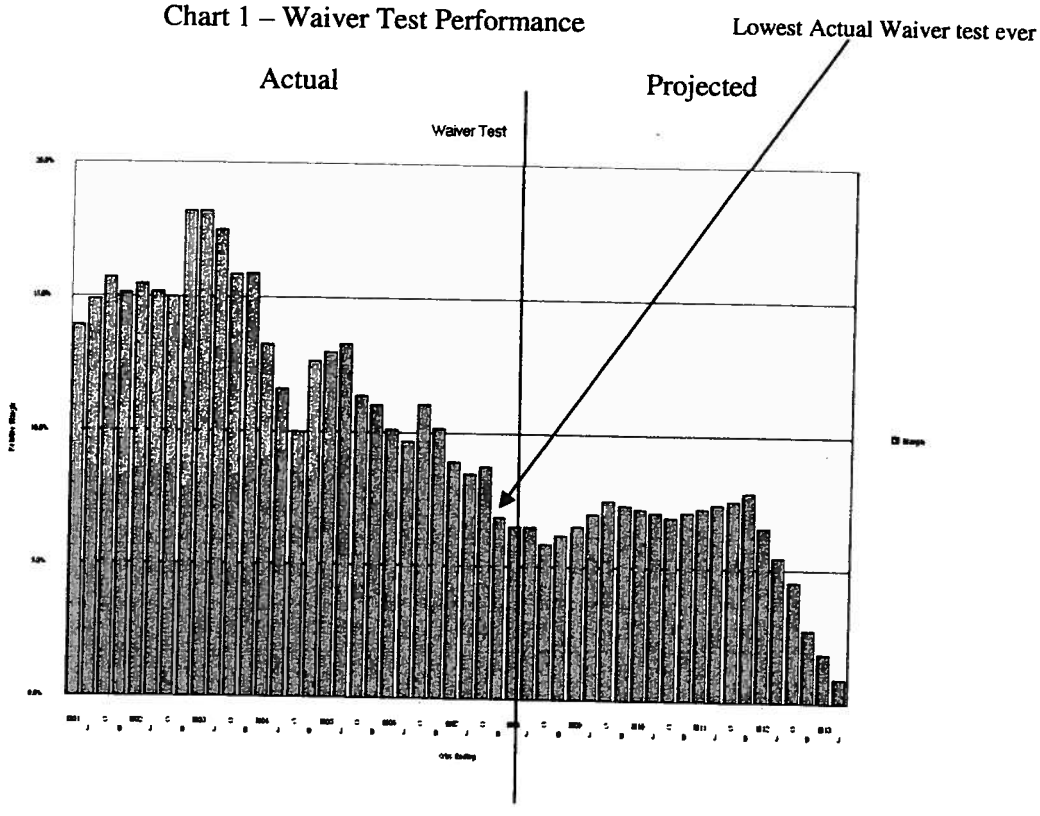
Medicare Issues: The HSCRC recently received notice of an unexpected deterioration in its Medicare Waiver test. The State must pass this financial test in order to retain its ability to have Medicare participate in the All-Payer system. Medicare's participation results in the equitable sharing of the cost of Uncompensated Care (some $980 million per year). Overall, the Medicare Waiver results in over $1 billion per year in enhanced federal reimbursements to Maryland hospitals. The most recent Waiver test (covering the year ending December 2007) shows Maryland at its lowest waiver cushion ever – a relative margin of 6.82%. The State has traditionally maintained a relative margin of between 10% - 15%. Given the likelihood of future and severe cuts in Medicare expenditures nationally, it is vital that the HSCRC seek to restore our cushion to a level of at least 10% over the next several years in order to withstand these cuts. Table 5 and Chart 1 show the unexpected deterioration in the Medicare Waiver test based on the most recent test result from the Centers for Medicare and Medicaid Services (CMS).

Table 5 Waiver Test Performance

Medicare Waiver Test Results

Qtr. Ending Waiver Test	Medicare Payment/Case Maryland	Medicare Payment/Case U.S.	Wavier Test Relative Margin
M01	$8,187	$7,196	13.90%
J	$8,244	$7,309	14.89%
S	$8,275	$7,387	15.69%
D	$8,406	$7,468	15.14%
M02	$8,471	$7,546	15.45%
J	$8,576	$7,620	15.15%
S	$8,655	$7,680	15.00%
D	$8,728	$7,959	18.18% Actual
M03	$8,728	$7,959	18.18%
J	$8,846	$8,019	17.48%
S	$9,035	$8,077	15.85% Waiver
D	$9,155	$8,185	15.86%
M04	$9,319	$8,142	13.23%
J	$9,554	$8,227	11.59% Test
S	$9,681	$8,218	10.01%
D	$9,819	$8,535	12.64%
M05	$9,895	$8,625	12.97% Results
J	$9,968	$8,713	13.28%
S	$10,107	$8,684	11.34%
D	$10,239	$8,770	11.00%
M06	$10,453	$8,881	10.10%
J	$10,620	$8,986	9.65%
S	$10,785	$9,241	11.04%
D	$10,920	$9,282	10.16%
M07	$11,137	$9,358	8.89%
J	$11,294	$9,451	8.44%
S	$11,352	$9,524	8.72%
D	**$11,501**	**$9,480**	**6.82% Last Actual Test**
M08	$11,615	$9,545	6.49% Forecast
J	$11,694	$9,608	6.48% Based on
S	$11,842	$9,672	5.85% CMS Actuary
D	$11,967	$9,811	6.18% and Maryland
M09	$12,092	$9,951	**6.52%** Projected

Chart 1 – Waiver Test Performance



The most recent report of Medpac (the federal commission that advises Congress on Medicare payment issues) to Congress (March 2009) provides some useful information about current and future policy regarding Medicare hospital payment levels nationally. While Medpac is recommending a "full" update to Medicare hospital rates nationally (Market Basket Inflation plus case mix) for federal fiscal year (FFY) 2010 this is in the context of Medicare program payments that are on average about 88% of reported hospital costs and Medicare margins that have consistently been negative over the past several years.[7] In Maryland, because of the waiver, Medicare pays closer to 112% of hospital costs. As reported, regulated operating revenues in Maryland are in excess of 5.0%.

Each year however, concern over the long term sustainability of Medicare has intensified as payment growth and projected enrollment increases are expected to result in large deficits in Medicare's Hospital Insurance trust fund in future years.[8] Based on these concerns, it is virtually certain that Congress will need to significantly reduce health expenditures in the coming years. Preliminary discussions regarding potential cuts are already occurring. The Congressional Budget Office recently submitted 115 options for reducing federal spending on health care. Option 55 would call for a 1% reduction to the Medicare update factor each year over the next 10 years.[9]

Opportunities in the Hospital Sector to Improve Efficiency

The March 2009 Medpac report is also instructive in that it points out the very large variation in hospital cost performance across the industry nationally. Overall Medicare margins are low, but on their observations hospitals facing broad financial constraint from both public and private sector payers tend to have much lower costs than hospitals that tend to have high private payer margins and thus less broad based financial pressure. Their overall conclusion is that revenue levels and constrained revenue levels tend to drive cost performance of the industry. Given the wide variation in cost performance (depending upon the market conditions faced) there is considerable opportunity for hospitals generally to improve their operating efficiency.

This observation is consistent with HSCRC staff observation that hospitals that face more stringent and broad based constraint tend to reduce costs more effectively. When the HSCRC has been provided more restricted inflation updates operating efficiency and cost performance do improve. When the HSCRC has been more generous in its update factors year-to-year, hospital cost spending increases. Similarly, hospitals who are placed on spenddowns (negotiated rate reduction arrangements) after having been identified as a "high cost hospital" on the HSCRC Reasonableness of Charges (ROC) analysis also tend to manage their costs more effectively as their annual revenue base is more tightly constrained.

Role of Payment Policy in the Context of Current Economic Conditions and Access to Capital Considerations

Medpac also commented in the March report on the most appropriate role for payment policy in the context of deteriorating economic conditions. Medpac acknowledges that declines in investment income, increasing interest rates, and flattening volumes may contribute to declining financial results. However, they also note that if hospitals do a better job of controlling their costs in response to economic conditions (constraining wage and non-wage growth) these factors should offset conditions leading to increased costs. Medpac concludes that attempting to offset overall economic conditions through increased payments would not be appropriate because the implications of the decline in overall economic conditions for Medicare payment adequacy are not straightforward, may change in the short run, and may differ by sector. Additionally, Medpac concludes that current access to capital issues caused by the extraordinary conditions in national credit markets have little to do with the adequacy of Medicare payments and payment policy is an ineffective mechanism to use to attempt to address access to capital issues in the current environment.

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[7] Medpac report to Congress, June 2007.

[8] Medpac report to Congress, March 2009 pages 16-17

[9] Congressional Budget Office Report to the House and Senate Budget Committees, Budget Options Volume I – Health Care, December 2008

Lastly, the Medpac report strongly argues that rising health care costs in the US has serious negative impacts on the rest of our economy in the form of reduced international competitiveness of US firms, lower real wage growth, and other negative distributional effects such as increased cost-sharing for employees and reductions in coverage and corresponding increases in the number of uninsured.

Staff Proposed Update

Based on the factors noted, staff proposed to the Payment Work Group for discussion, an overall 1.2% update to hospital rates for FY 2010 (one-year update). Coupled with expected volume increases of 1.5%, (a projected increase in payment levels of $153 million over FY 2009). With projected volume increases of 1.51% hospital revenues are expected to increase 2.70% over FY 2009 base hospital revenues. Table 6 provides a summary of the staff recommendation.

Table 6 – Staff Proposed Hospital Update for FY 2010

	Staff Proposal
Market Basket 2010	1.59%
Estimation Error	0.00%
Productivity Improvement Factor	-1.00%
Offset for Slippage	-0.10%
Increase to Rates	0.49%
Estimated Volume Adjustment (1)	-0.30%
Case Mix cap	1.00%
Update Factor	1.19%
Estimated Volume Change	1.51%
Estimated Total Revenue Change	2.70%

Note: The Volume Adjustment is per HSCRC approved policy in 2008 reflecting recognition of 85% variable and 15% fixed costs in the system.

While this magnitude of increase is considerably below FY 2009 rate updates, and may precipitate solvency concerns for a limited number of hospitals (the financial and liquidity challenges noted previously), the HSCRC has the flexibility to address these individual circumstances on a case by case basis, providing stop-gap rate relief for hospitals less able to respond.

Scaling and Quality Based Reimbursement (QBR) Proposal

ROC Scaling Proposal: The discussion of scaling during the development of the ROC recommendation assumed the historical experience of the workgroup participants. That experience was that in a typical year the base update factor

(not including case mix or other adjustments) would likely be between 4 and 5 percent. Under such a scenario the scaling proposal would have awarded the best performing hospitals on the ROC an addition 1-1.5 percent in rates above the update, and, conversely, the poor performing hospitals would have experienced a similar reduction relative to the update factor. In other words, the scaling would have led to real adjustments to hospital rate structure to better align resources.

The current rate negotiations are not typical. The update factor under any of the proposals currently discussed will be quite low compared to recent experience. If the update factor is very low the relative impact of scaling, as proposed in the ROC recommendation, will also be very small. This runs counter to the intent of the scaling recommendation: to give a significant positive adjustment for hospital whose charges are relatively low, and to apply a negative adjustment to hospitals whose charges are relatively high. Therefore, to maintain the goal of the scaling recommendation we propose an alternative approach to scaling.
The attached proposed scaling is based on the ROC positions of all Maryland hospital based on the methodology approved by the Commission in March. It assumes the following:

- An overall cumulative update factor of 0.5%.

- A scaling methodology based on the following:

    - The hospitals that are in the top and bottom deciles will have their update factor adjusted up or down by 0.75%. Thus, hospitals that are far above the peer group mean will have an update of -0.25%, and hospitals that are far below the peer group mean will receive an update of 1.25%.
    - Hospitals falling between the 75th and 90th percentile are continuously scaled plus or minus some portion of 0.75% depending on their relative position to their peer group mean.
    - Hospitals whose rates are set on a total patient revenue (TPR) basis receive the update factor with no scaling adjustment.
    - The adjustment for hospitals not subject to any positive or negative scaling is slightly greater than 0.5%. This is due to the fact that hospital who are being negatively scaled accounted for more revenue than those being positively scaled, thus to meet the cumulative 0.5% update target the standard update was slightly increased

Quality Based Reimbursement (QBR) Adjustment: The quality based reimbursement (QBR) adjustment is applied additively to the scaled update factor based on ROC position. The adjustment was arrived at as follows:

- 0.5% of rates is at risk for a quality based adjustment.

- The quality portion of each hospital adjustment was scaled based on the QBR methodology. The actual hospital scaled amounts range from a low of 0.448% to a high of 0.551%.

- The QBR adjustment is each hospitals variance from 0.5%, or from -0.052% to +0.051%.

Table 6 – Impact of Staff Draft QBR and Scaling Proposal

Components of the Update Factor

HOSPID	HOSPITAL NAME	ROC SCALED UPDATE FACTOR	QUALITY BASED REIMBURSEMENT SCALED ALLOWANCE	TOTAL UPDATE FACTOR
210061	Atlantic General Hospital	-0.250%	0.015%	-0.235%
210007	St. Joseph Medical Center	-0.250%	0.021%	-0.229%
210025	Memorial of Cumberland	-0.250%	0.014%	-0.236%
210054	Southern Maryland Hospital Center	-0.250%	-0.063%	-0.313%
210030	Chester River Hospital Center	-0.250%	-0.021%	-0.271%
210006	Harford Memorial Hospital	0.063%	0.018%	0.082%
210009	Johns Hopkins Hospital	0.075%	0.011%	0.086%
210051	Doctors Community Hospital	0.091%	-0.076%	0.015%
210013	Bon Secours Hospital	0.191%	-0.020%	0.170%
210024	Union Memorial Hospital	0.218%	0.016%	0.233%
210016	Washington Adventist Hospital	0.256%	0.012%	0.268%
210017	Garrett County Memorial Hospital	0.500%	-0.002%	0.498%
210045	McCready Memorial Hospital	0.500%	0.070%	0.570%
210040	Northwest Hospital Center	0.554%	-0.037%	0.518%
210043	Baltimore Washington Medical Center	0.554%	0.017%	0.572%
210044	GBMC	0.554%	0.056%	0.610%
210058	James Lawrence Kernan Hospital	0.554%	0.000%	0.554%
210048	Howard County General Hospital	0.554%	-0.027%	0.528%
210022	Suburban Hospital	0.554%	-0.009%	0.546%
210057	Shady Grove Adventist Hospital	0.554%	-0.021%	0.533%
210049	Upper Chesapeake Medical Center	0.554%	0.018%	0.572%
210056	Good Samaritan Hospital	0.554%	-0.012%	0.543%
210008	Mercy Medical Center	0.554%	0.007%	0.561%
210012	Sinai Hospital	0.554%	0.018%	0.573%
210033	Carroll Hospital Center	0.554%	0.007%	0.561%
210055	Laurel Regional Hospital	0.554%	-0.052%	0.503%
210028	St. Mary's Hospital	0.554%	0.051%	0.605%
210023	Anne Arundel Medical Center	0.554%	0.030%	0.585%
210002	University of Maryland Hospital	0.554%	0.000%	0.554%
210018	Montgomery General Hospital	0.554%	-0.048%	0.507%
210019	Peninsula Regional Medical Center	0.554%	0.012%	0.566%
210027	Braddock Hospital	0.554%	-0.009%	0.546%
210029	Johns Hopkins Bayview Medical Cente	0.554%	-0.031%	0.523%
210004	Holy Cross Hospital	0.554%	0.006%	0.560%
210003	Prince Georges Hospital Center	0.554%	-0.046%	0.508%
210015	Franklin Square Hospital Center	0.554%	0.007%	0.562%
210035	Civista Medical Center	0.619%	-0.045%	0.574%
210011	St. Agnes Hospital	1.086%	-0.026%	1.060%
210005	Frederick Memorial Hospital	1.136%	-0.004%	1.132%
210038	Maryland General Hospital	1.146%	0.012%	1.158%
210001	Washington County Hospital	1.158%	-0.043%	1.115%
210010	Dorchester General Hospital	1.250%	0.000%	1.250%
210039	Calvert Memorial Hospital	1.250%	-0.006%	1.244%
210037	Memorial Hospital at Easton	1.250%	-0.024%	1.226%
210060	Fort Washington Medical Center	1.250%	0.025%	1.275%
210032	Union of Cecil	1.250%	0.008%	1.258%
210034	Harbor Hospital Center	1.250%	0.045%	1.295%
	Statewide Total	0.497%	0.000%	0.497%

Other Provisions

The staff draft proposal also recommends the following:

1. Retention of the 15% volume adjustment (per the 2008 HSCRC approved policy)
2. Retain the 7% minimum Waiver Cushion Level (penetration of this level on an actual or projected basis will allow the Commission to take immediate action to restore the cushion to more acceptable levels – this is current Commission Policy)

Next Steps

This draft recommendation is meant for review and discussion purposes only at the April 2009 Commission meeting. The HSCRC Payment Workgroup will continue to meet during the balance of April and into May to discuss and potentially refine the proposed recommendations. Staff hopes to present a final update recommendation to the HSCRC at its May 13th Commission meeting.

Appendix I – Details on the Payer and Hospital Proposals

2010 ONE YEAR PAYER PROPOSAL
AS REQUESTED BY HSCRC STAFF

I. TERM – ONE YEAR

II. THE RATE STRUCTURE

a. Update	0.00
b. Slippage (staff est. to be developed)	0.10
c. Casemix (lower of actual or limit)*	1.00
d. Volume adjustment (85% variable cost factor)**	(0.30)
Total	0.80

*Assumes a volume increase in RY 2009, 1.25% if no volume increase
** 2010 rates are based on RY 2009 volume change and current 85% variable (2.0% volume increase, including casemix, assumed)

III. OTHER ASPECTS

a. Scaling – there would be no scaling because 1/3 of 0 is 0
b. Full rate realignment continues
c. UCC/mark-up is outside the update calculation
d. Change working capital interest assumption to 0.5% per month
e. Retain the 7% waiver trip wire
f. One day stays – examine financial and clinical reasons for the high percentage and alter where appropriate
g. Include outpatient radiology, radiation therapy, and chemotherapy services in CCT
h. Change variable cost factor for volume to 75% moving forward

RY 2010 Update Negotiation
Comparison of Payer and MHA proposals

Payer 3-year proposal was withdrawn

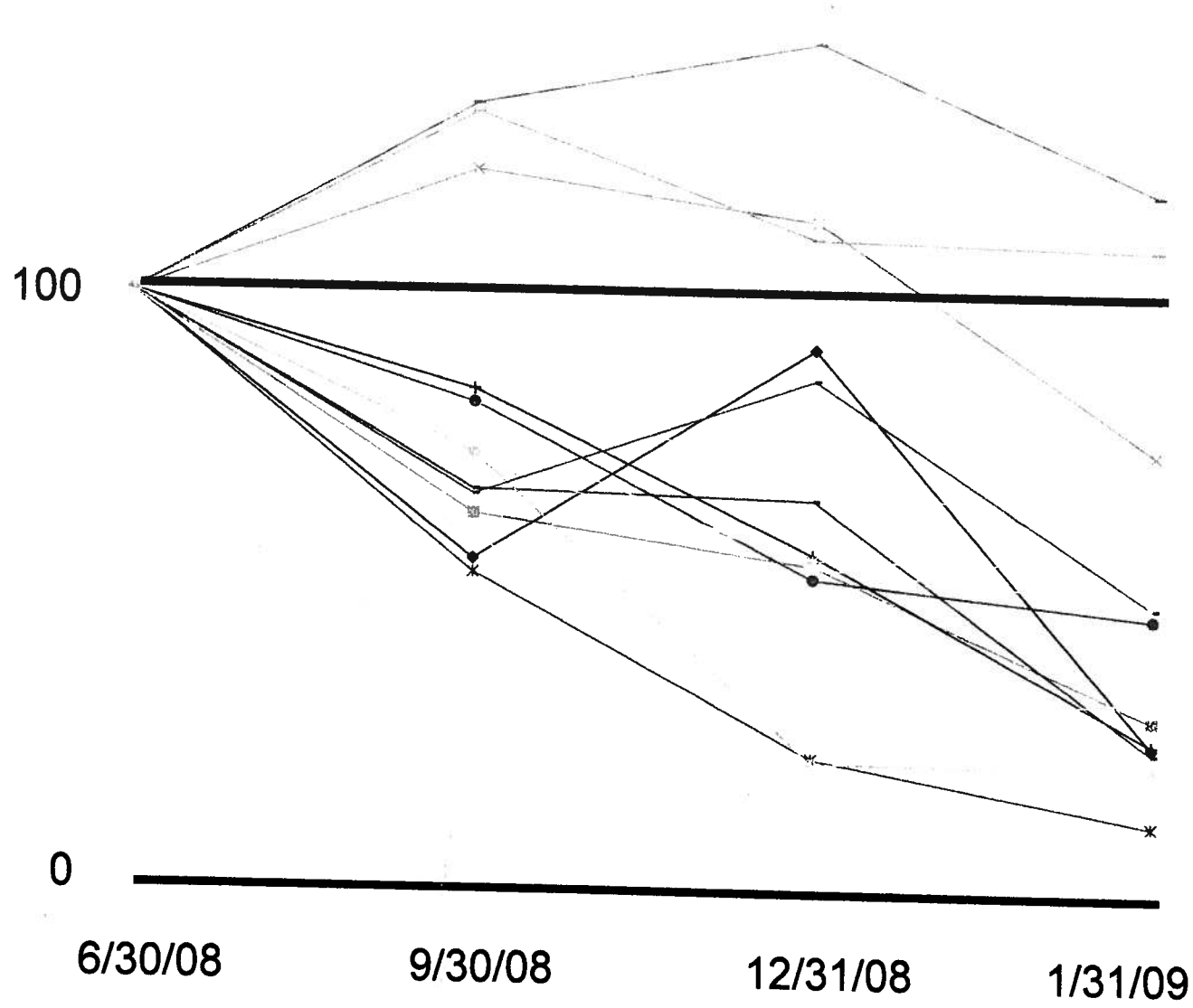
MHA PROPOSAL

I.	Term	2009 Approved Rate	Payer 2010 Position 3 years (RY 2010-2012)	MHA 2010 Position 1 year only (RY 2010)
II.	**The Revenue per Case Target**			
a.	1st quarter GII market basket		1.59	1.59
b.	Three year average error in GII projection (2005-7 for 2010)		0.53	0.53
c.	Average different between US NPR and final GII (2005-7 for 2010)		1.37	1.37
d.	Policy adjustment (fixed)		-1.5	0.26
	Total		**1.99**	**3.75**
III.	**The Rate Structure**			
a.	Update	4.20	1.64	2.9
b.	Slippage	0.00	0.1	0.1
c.	Casemix	0.50	1	0.75
d.	Volume adjustment	0	-2.75	0
	Total	**4.70**	**1.99**	**3.75**
IV.	**Other Aspects**			
a.	Scaling			
b.	PPC			
c.	Unpaid casemix			
d.	Quality			
e.	Slippage and excluded outpatient services			
f.	Rate realignment			
g.	UCC/mark-up			
h.	Working capital interest assumption			
i.	7% waiver trip wire			
j.	One day stays			
k.	Intensity allowance for outpatient charge per visit system	0.3% Outpatient Intensity allowance		

Highlights of Second *Ad Hoc* Data Request For Month Ending January 31, 2009

Day Cash on Hand

6/30/08 = 100 Basis



Components of Total Income
Survey Respondents (N=40)

	RY 2007 6/3/0/07	RY 2008 6/30/08	QI RY 09 9/30/08 ($ MM)	QII RY 09 12/31/08	January-09 1/31/09
Operating Income	$250.4	$227.1	$68.2	$40.4	$15.5
Non-Operating Income	$353.9	($99.0)	($165.7)	($583.9)	$85.5
Total Income	$604.2	$128.1	($97.5)	($543.6)	$101.1

Appendix II – Breakdown of Unregulated Losses by Category FY 2008

Hosp. ID #	Hospital (in thousands)	Physicians Part B Revenue (Net)	Physicians Part B Expenses	Physicians Part B Profit/ Loss	Freestanding Clinic Revenue	Freestanding Clinic Expenses	Freestanding Clinic Profit/ Loss	Code	Phy Asst(PA), Home Health(HH) Amb/Surg(AMS), Skilled Nursing(SNF) Revenue	Phy Asst(PA), Home Health(HH) Amb/Surg(AMS), Skilled Nursing(SNF) Expenses	Phy Asst(PA), Home Health(HH) Amb/Surg(AMS), Skilled Nursing(SNF) Profit/ Loss	All Others Unregulated Revenue	All Others Unregulated Expenses	All Others Unregulated Profit/ Loss
1	Washington Co.	$22,389.0	$23,959.3	($1,570.3)	$3,261.5	$2,861.3	$400.2	HH	$3,868.0	$3,760.2	$107.8	$2,017.7	$2,714.9	($697.2)
2	University of Md(Note)			$0.0	$11,828.0	$18,260.9	($6,432.9)	CRNA	$1,250.3	$5,380.5	($4,130.2)	$27,683.5	$31,300.6	($3,617.1)
3	Prince George's	$4,911.1	$16,797.7	($11,886.6)			$0.0	SNF	$4,399.6	$6,631.6	($2,232.0)	$6,180.9	$7,442.1	($1,261.2)
4	Holy Cross	$0.0	$5,993.7	($5,993.7)	$1,643.6	$1,741.6	($98.0)	HH	$2,339.9	$3,401.9	($1,062.0)	$20,492.3	$24,789.8	($4,297.5)
5	Frederick	$0.0	$5,144.7	($5,144.7)	$11,187.4	$13,339.6	($2,152.2)	HH/SNF	$13,624.4	$14,317.5	($693.1)	$30,462.7	$31,202.9	($740.2)
6	Harford Memorial**			$0.0			$0.0	SNF	$1,933.5	$3,396.1	($1,462.6)	($1,933.5)	($3,396.1)	$1,462.6
7	St. Joseph	$9,533.1	$21,675.0	($12,141.9)			$0.0	Community	$545.1	$1,899.9	($1,354.8)	$12,221.4	$17,060.7	($4,839.3)
8	Mercy	$7,661.1	$8,845.3	($1,184.2)	$5,922.5	$5,238.6	$683.9	N/A			$0.0	$1,918.0	$3,181.2	($1,263.2)
9	JHH	$0.0	$1,065.0	($1,065.0)	$7,269.5	$6,994.3	$275.2	MCO	$0.0	$0.0	$0.0	$91,330.4	$86,584.9	$4,745.5
10	Dorchester	($328.0)	$130.8	($458.8)	$1,576.1	$1,389.2	$186.9	N/A			$0.0	$313.8	$1,296.9	($983.1)
11	St Agnes	$26,352.8	$44,135.5	($17,782.7)	$413.2	$493.6	($80.4)	HH	$1,204.3	$1,142.8	$61.5	$14,242.2	$13,904.0	$338.2
12	Sinai	$35,901.5	$71,408.8	($35,507.3)			$0.0	N/A			$0.0	$13,414.0	$16,772.9	($3,358.9)
13	Bon Secours	$618.5	$13,856.8	($13,238.3)	$7,655.1	$10,106.5	($2,451.4)	RDL	$4,039.3	$5,815.0	($1,775.7)	$1,061.9	$1,056.6	$5.3
15	Franklin Square	$23,110.9	$28,111.1	($5,000.2)	$11,884.9	$17,740.7	($5,855.8)	PA	$0.0	$3,992.8	($3,992.8)	$4,934.8	$4,592.9	$341.9
16	Washington Adventist**	$0.0	$0.0	$0.0			$0.0	N/A			$0.0	$0.0	$0.0	$0.0
17	Garrett	$1,583.8	$1,588.5	($4.7)			$0.0	SNF/CRNA	$1,465.9	$2,652.6	($1,186.7)	$2,422.7	$1,370.9	$1,051.8
18	Montgomery General	$0.0	$2,643.3	($2,643.3)			$0.0	PA	$0.0	$828.0	($828.0)	$979.4	$1,087.7	($108.3)
19	Peninsula Regional	$4,911.3	$10,110.0	($5,198.7)	$5,677.7	$8,857.3	($3,179.6)	SNF	$3,879.6	$4,414.9	($535.3)	$5,387.0	$7,285.4	($1,898.4)
22	Suburban	$0.0	$287.3	($287.3)			$0.0	N/A			$0.0	$24,545.1	$22,901.0	$1,644.1
23	Anne Arundel	$5,805.1	$13,310.2	($7,505.1)	$8,246.4	$9,396.5	($1,150.1)	Community	$520.0	$2,547.7	($2,027.7)	$9,572.6	$8,976.5	$596.1
24	Union Mem	$18,673.7	$35,012.5	($16,338.8)			$0.0	N/A			$0.0	$16,824.8	$16,131.2	$693.7
25	Cumberland	$2,392.6	$2,921.4	($528.8)	$5,609.8	$3,400.1	$2,209.7	HH	$4,158.9	$6,083.4	($1,924.5)	$4,551.5	$3,810.2	$741.3
27	Braddock	$0.0	$3,107.0	($3,107.0)	$2,636.6	$6,728.0	($4,091.4)	SNF	$6,384.9	$5,517.6	$867.3	$5,678.5	$5,453.9	$224.6
28	St. Mary's	$1,776.8	$3,783.7	($2,006.9)	$111.8	$853.6	($741.8)	HH	$0.6	$31.3	($30.7)	$5,532.3	$5,110.8	$421.5
29	JHBMC	$752.9	$2,917.4	($2,164.5)	$0.0	$0.0	$0.0	SNF	$8,127.8	$11,209.8	($3,082.0)	$48,918.2	$48,714.5	$203.7
30	Chester River	$0.0	$0.0	$0.0			$0.0	N/A			$0.0	$0.0	$0.0	$0.0
32	Union Hospital	$4,429.2	$6,720.3	($2,291.1)	$330.0	$373.5	($43.5)	N/A			$0.0	$3,172.8	$3,192.5	($19.7)
33	Carroll	$1,516.6	$6,838.5	($5,321.9)	$0.0	$0.0	$0.0	AMS	$4,104.7	$5,212.0	($1,107.3)	$51,830.1	$50,912.8	$917.3
34	Harbor	$3,798.9	$6,400.2	($2,601.3)	$9,588.2	$11,034.4	($1,446.2)	N/A			$0.0	$10,158.6	$5,726.9	$4,431.8
35	Civista	$137.1	$32.3	$104.8			$0.0	N/A	$0.0	$0.0	$0.0	$1,134.3	$1,524.0	($389.7)
37	Easton	$0.0	$121.6	($121.6)	$2,587.3	$5,172.8	($2,585.5)	SNF	$0.0	$66.9	($66.9)	$11,111.7	$7,159.3	$3,952.4
38	Maryland General	($16.4)	$9,804.3	($9 820.7)	$155.4	$4,603.3	($4,447.9)	N/A			$0.0	$1,711.9	$1,420.8	$291.1
39	Calvert	$142.6	$1,116.7	($974.1)	$2,295.6	$2,549.2	($253.6)	SNF	$1,567.5	$4,063.6	($2,496.1)	$9,349.7	$10,501.6	($1,151.9)
40	Northwest	$4,136.7	$8,497.0	($4,360.3)	$0.0	$0.0	$0.0	SNF	$3,970.0	$5,595.9	($1,625.9)	$0.0	$308.3	($308.3)
43	Baltimore/Washington	$7,874.1	$10,944.6	($3,070.5)	$0.0	$0.0	$0.0	N/A	$0.0	$0.0	$0.0	$2,095.4	$1,076.1	$1,019.3
44	GBMC	$30,752.6	$43,970.1	($13 217.5)	$99.2	$850.3	($751.1)	SNF	$3,951.2	$4,680.8	($729.6)	$9,151.8	$7,376.4	$1,775.4
45	McCready	$1,231.9	$1,689.9	($458.0)			$0.0	SNF/CRNA	$295.9	$194.6	$101.3	$8.9	$276.8	($267.9)
48	Howard	$0.0	$112.9	($112.9)			$0.0	N/A			$0.0	$11,392.3	$15,551.1	($4,158.8)
49	Upper Chesapeake	$0.0	$0.0	$0.0			$0.0	N/A			$0.0	$0.0	$0.0	$0.0
51	Doctor's	$1,395.0	$1,970.1	($575.1)			$0.0	N/A			$0.0	$8,684.4	$7,059.5	$1,624.9
54	So. Maryland**	$0.0	$0.0	$0.0			$0.0	SNF	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
55	Laurel	$1,004.8	$6,055.1	($5,050.3)			$0.0	N/A			$0.0	$222.5	$228.1	($5.6)
60	Ft Washington**	$0.0	$0.0	$0.0			$0.0	N/A			$0.0	$0.0	$0.0	$0.0
61	Atlantic General	$6,586.7	$12,029.7	($5,443.0)	$0.0	$0.0	$0.0	N/A			$0.0	$1,177.8	$1,351.4	($173.6)
2001	Kernan			$0.0	$1,783.1	$2,793.0	($1,009.9)	N/A			$0.0	$320.5	$888.1	($567.6)
2004	Good Sam	$16,768.7	$23,193.6	($6 424.9)	$0.0	$0 0	$0.0	SNF	$5,466.8	$6,127.5	($660.7)	$18,520.0	$20,155.1	($1,635.1)
5050	Shady Grove **	$0.0	$0.0	$0.0			$0.0	N/A			$0.0	$0.0	$0.0	$0.0
	All Acute Hospitals	$245,804.7	$456,301.9	($210,497.2)	$101,762.9	$134,778.3	($33,015.4)		$77,098.2	$108,964.9	($31,866.7)	$488,794.9	$494,055.1	($5,260.2)
	Operating Margin			-85.64%			-32.44%				-41.33%			-1.08%
	Note: Includes													
8994	Cancer			$0.0	$5,353.8	$4,079.0	$1,274.8	CRNA	$1,250.3	$5,380.5	($4,130.2)	($1,250.3)	($4,061.0)	$2,810.7
8992	Meims			$0.0			$0.0	N/A			$0.0	$1,250.3	$5,380.5	($4,130.2)
2	University Hospital	$0.0	$0.0	$0.0	$6,474.2	$14,181.9	($7,707.7)	N/A	$0.0	$0.0	$0.0	$27,683.5	$29,981.1	($2,297.6)

Appendix III - Breakdown of Non-Operating Losses FY YTD 2009 (through January)

Non-Operating Income (Losses)

July 2008 through December 2008

		Realized Gain (Loss) on Investment	Realized Gain (Loss) on Swap	Unrealized Gain (Loss) on Investment	Mark to Market Swap Value	Other	Total	Reported
1	WASHINGTON COUNTY	($599,690)	$0	($6,233,754)	$0	($120,900)	($6,954,344)	($6,994,143)
2	UNIVERSITY OF MARYLAND	($13,194,000)		($36,822,000)	($128,743,000)	($9,553,000)	($188,312,000)	($188,312,000)
3	PRINCE GEORGE	$82,670				$13,325,391	$13,408,061	$14,783,833
4	HOLY CROSS	($3,512,000)		($5,273,000)	($13,557,000)		($22,342,000)	($22,341,090)
5	FREDERICK MEMORIAL			($11,084,000)	($12,304,000)	($2,285,000)	($25,673,000)	($25,674,201)
6	HARFORD MEMORIAL						$0	($12,628,672)
7	ST JOSEPH	($3,790,000)					($3,790,000)	($7,906,612)
8	MERCY	($2,472,000)	$0	($12,399,000)	($46,427,000)	($1,909,600)	($63,207,600)	($63,204,000)
9	JOHNS HOPKINS						$0	$9,573,702
10	DORCHESTER GENERAL	$142,800		$162,677		($528,223)	($222,746)	($52,214)
11	ST AGNES	$0	$0	($43,959,300)	$0	($624,916)	($44,584,216)	($44,584,216)
12	SINAI	$519,000		($9,089,000)		($835,000)	($9,405,000)	($8,195,652)
13	BON SECOURS						$0	($2,150,107)
15	FRANKLIN SQUARE	($32,932)		($98,597)		($40,952)	($172,481)	($44,930)
16	WASHINGTON ADVENTIST						$0	$516,509
17	GARRETT COUNTY					$124,176	$124,176	$124,177
18	MONTGOMERY GENERAL					($3,832,796)	($3,832,796)	($3,832,795)
19	PENINSULA GENERAL				($9,769,674)	($2,466,297)	($12,235,971)	($12,235,971)
22	SUBURBAN				($525,616)	($526,378)	($1,051,994)	($1,051,994)
23	ANNE ARUNDEL	$0	$0	($44,228,415)	($61,067,009)	$4,476,087	($100,819,337)	($100,819,337)
24	UNION MEMORIAL	($35,058)		($9,952,404)		$503,477	($9,483,985)	($4,466,074)
25	CUMBERLAND MEMORIAL			$181,344		$276,011	$457,355	$457,357
27	BRADDOCK			($7,828)		$717,112	$709,284	$709,284
28	ST MARY'S					$760,699	$760,699	$759,950
29	JOHNS HOPKINS BAYVIEW			($1,791,000)	($12,357,000)		($14,148,000)	$0
30	CHESTER RIVER	($725,000)				$38,000	($687,000)	($686,751)
32	UNION OF CECIL COUNTY					$1,138,759	$1,138,759	$1,119,998
33	CARROLL COUNTY					($15,491,803)	($15,491,803)	($15,491,803)
34	HARBOR HOSPITAL	($7,854)		($28,364)		$60,051	$23,833	$315,581
35	CIVISTA						$0	$37,708
37	EASTON MEMORIAL						$0	($11,612,847)
38	MARYLAND GENERAL	$259,000		($2,897,000)		($5,292,000)	($7,930,000)	($7,929,725)
39	CALVERT MEMORIAL	$163,003					$163,003	$163,003
40	NORTHWEST	$969,000		($13,619,000)		($275,000)	($12,925,000)	($12,925,114)
43	BALTIMORE/WASHINGTON	$784,000		($9,503,000)		($4,515,000)	($13,234,000)	($12,395,418)
44	GBMC	($3,856,675)		($83,126)		$786,728	($3,153,073)	($3,153,073)
45	MCCREADY					$85,521	$85,521	$85,521
48	HOWARD COUNTY			($777,200)	($12,959,058)		($13,736,258)	($12,852,007)
49	UPPER CHESAPEAKE						$0	$8,674,564
51	DOCTORS COMMUNITY	($10,067,000)		$2,865,000	($27,829,000)		($35,031,000)	($36,794,567)
54	SOUTHERN MARYLAND						$0	$389,703
55	LAUREL REGIONAL						$0	$288,091
60	FT WASHINGTON					$28,079	$28,079	$28,079
61	ATLANTIC GENERAL					$92,550	$92,550	$15,997
2001	KERNAN	($342,000)		($1,638,000)		($1,444,000)	($3,424,000)	($3,424,000)
2004	GOOD SAMARITAN					($16,664)	($16,664)	$630,600
5050	SHADY GROVE						$0	$1,337,078
8992	UNIVERSITY STC						$0	$991,000
8994	UNIVERSITY ONC						$0	$406,000
	Statewide	($35,714,736)	$0	($206,274,967)	($325,538,357)	($27,344,888)	($594,872,948)	($580,351,578)
3	PRINCE GEORGE	$82,670	$0	$0	$0	$13,325,391	$13,408,061	$14,783,833
13	BON SECOURS	$0	$0	$0	$0	$0	$0	($2,150,107)
55	LAUREL REGIONAL	$0	$0	$0	$0	$0	$0	$288,091
	Problem Hospitals	$82,670	$0	$0	$0	$13,325,391	$13,408,061	$12,921,817
	All Other Hospitals	($35,797,406)	$0	($206,274,967)	($325,538,357)	($40,670,279)	($608,281,009)	($593,273,395)

Appendix IV – Moody's Investor Services Discussion Document on the Impact of Swap Arrangements

Special Comment

Moody's
U.S. Public Finance

February 2009

Interest Rate Swaps Cause New Liquidity Stress for Some Healthcare, Higher Education and other Not-for-Profit Borrowers

Rating Implications Will Depend on Borrowers' Other Credit Attributes

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Summary Opinion

Mark-to-market liabilities for long-dated fixed payer interest rate swaps have grown considerably over the last few months and pose new credit risks for not-for-profit hospitals, higher education institutions, and other not-for-profit borrowers. Over the past decade, the fair value of most swap agreements fluctuated within a relatively narrow band and the majority of borrowers met collateral calls with little difficulty. However, over the last few months most borrowers have seen the fair value of their swap agreements decline significantly, in some cases resulting in large collateral posting requirements. Combined with poor investment returns over the past year and deteriorated operating results for some rated borrowers, many organizations find themselves ill prepared for the sudden drain on liquidity that swap liabilities can cause.

This special comment addresses the rating implications of large mark-to-market swap liabilities and swap collateral posting requirements and provides examples of rating actions taken over the last several months. This report will not address the impact of this risk on governmental, housing and public infrastructure issuers as collateral posting is either uncommon or structured with different terms than for not-for-profit hospitals, higher education institutions, and other not-for-profit borrowers.

Swap Risks Can Add to Liquidity Stress

The current low interest rate environment poses two primary risks to borrowers with floating-to-fixed interest rate swaps. The first risk is that collateral calls or termination payments could significantly reduce the borrower's liquidity, although we recognize that this posting may be temporary, depending on market conditions. The second is that material swap liabilities could, especially in combination with investment losses, lead a borrower to violate financial covenants, such as liquidity covenants, under the bond indenture or related documents like bank liquidity agreements. Violating financial covenants can lead to further balance sheet deterioration as the remedies under bank liquidity agreements may include acceleration of principal payments under a term loan, immediate repayment of principal, or collateral posting to the bank. For borrowers affected by both of these risks, rating downgrades are possible. In the absence of a forbearance agreement from the creditor bank, and depending on the borrower's other credit strengths, such as the ability to generate liquidity through sales of assets or higher cash flow, the rating transition could be swift and possibly result in a multi-notch rating downgrade.

Critical Factors Impacting Swap Liabilities

*LIBOR curve is flatter than at the outset of many swap agreements

*The use of long-dated swaps is more common

Some Swap Market Valuations Have Declined Substantially

Recent large declines in the market valuation of swap agreements have primarily related to LIBOR-based fixed payer swaps. In recent years, a common strategy among hospitals, universities and other not-for-profit borrowers has been to issue variable rate debt paired with a fixed payer interest rate swap with a similar maturity. While market participants often refer to the resulting net debt structure as "synthetic fixed rate" debt, Moody's has never viewed these obligations as akin to true fixed rate debt because there are significant risks associated with swaps that are variable and unpredictable. These typically include basis risk, collateral posting risk, termination risk and counterparty risk[1].

Under a fixed payer LIBOR swap, a hospital or university issues variable rate debt and then enters into an agreement with an unrelated third party, whereby the issuer pays a fixed rate to a counterparty and, in return, receives a variable rate payment from the counterparty that is tied to a percentage of LIBOR. The counterparty floating rate payment is intended to be approximately equal to the variable rate debt service the issuer pays on its variable

Figure 1

Dramatic Increase in Swap Liabilities for Fixed-Rate Payers

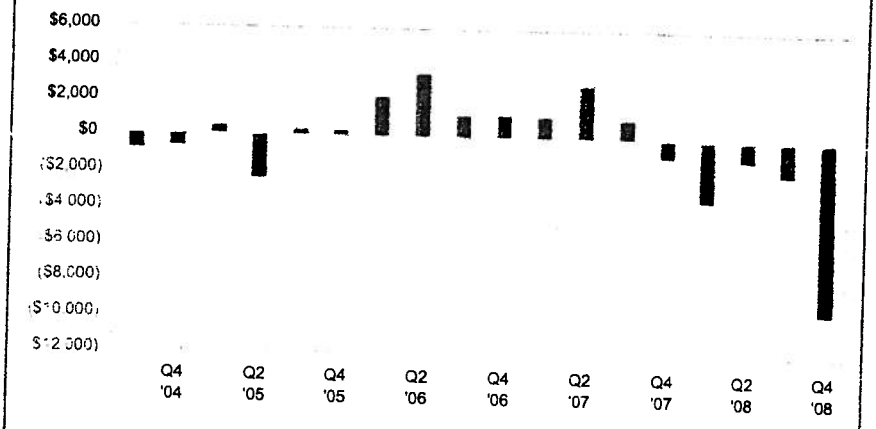


Chart depicting the historical mark-to-market value of a 20 year swap, expiring in 2023 with a notional amount of $110 million. Data provided by the hospital, which is the fixed-rate payer. Values are in $000's. Data are as of end of quarter.

[1] See the Rating Methodology: *Evaluating the Use of Interest Rate Swaps by U.S. Public Finance Issuers*, and the special comment: *Risks of Variable Rate Debt No Longer Hidden.*

rate debt[2]. Changes in the present value of the fixed and floating streams of payments will cause the market value of the swap itself to fluctuate.

A swap is valued based on the duration of the swap and the differences between the fixed rate and projections of the forward curve of the reference floating rate index. Increases in negative swap valuations have grown significantly over the past few months because long dated LIBOR rates have fallen (Figure 1). Although swap liabilities have eased from absolute lows in recent weeks, the valuations can change rapidly, and therefore collateral posting requirements could increase quickly.

Recent unprecedented developments in the debt capital markets have caused short term taxable rates and short term tax-exempt rates to trade at unusual levels. Specifically, the ratio of short term tax exempt to taxable rates (SIFMA vs. one-month LIBOR) has averaged 108% over the last four months (Figure 2), significantly higher than the 67% which is imbedded in many swap agreements (it is highly unusual for tax-exempt rates to be higher than taxable rates for significant periods of time).

Collateral Posting Absorbs Unrestricted Cash and Can Trip Bond Covenants

Posting collateral under swap agreements reduces financial flexibility for an unknown duration, and may require the borrower to issue more debt or liquidate long-term investments at unfavorable valuations to raise cash to meet collateral calls. As a result of its immediate impact on the balance sheet, collateral posting is of significant concern to all public finance borrowers, even if they are not subject to a strict liquidity covenant in related bond or bank documents. The duration and magnitude of collateral posting are key considerations in the rating impact of collateral calls.

Sample Collateral Posting Schedule For Swap With Liability of $12 million

Rating	*Threshold*	*Required Collateral Posting*
A2	Infinite	$0
A3	$10,000,000	$2,000,000
Baa1	$5,000,000	$7,000,000
Baa2 or Lower	$0	$12,000,000

Not-for-profit hospitals frequently covenant to maintain a minimum number of days cash on hand[3], as measured at specific points in time. This covenant often appears in bank liquidity agreements used to support variable rate demand bonds and sometimes in the master trust indenture. Collateral posting reduces the unrestricted cash available to meet a days cash on hand covenant and most not-for-profit hospitals, higher education institutions, and other not-for-profit institutions do not maintain sufficient lines of credit to cover collateral posting needs. Therefore, investments may need to be liquidated at distressed prices to raise cash for a collateral call. Although collateral posting will vary daily or weekly as the swaps are revalued, the duration of collateral posting is a key consideration because the days-cash and other covenants are frequently tested at the end of the fiscal year, or semi-annually (in some cases, the days cash covenant may be tested quarterly or more frequently).

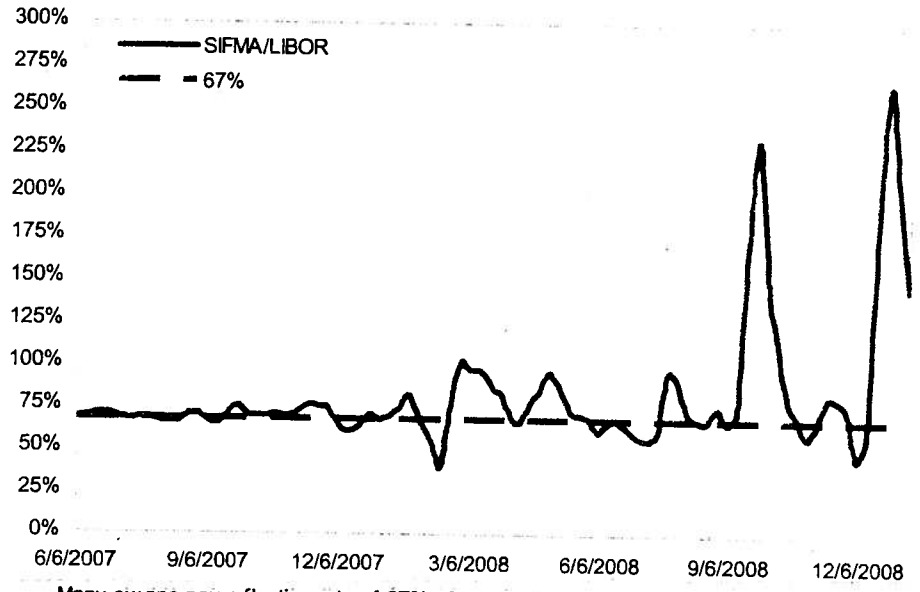
Some higher education and not-for-profit borrowers covenant to maintain a minimum net-assets to debt ratio[4] in indentures, bank or swap agreements. Swap liabilities directly reduce unrestricted net-assets and can cause borrowers to miss this covenant, even if the borrower is able to comfortably meet collateral calls (swap liabilities have no direct cash impact, unless they incorporate collateral posting or termination payments). Poor investment returns in 2008 and unusually large swap liabilities by historical standards have combined to reduce the unrestricted net assets of institutions with significant swap portfolios.

Cash or investments posted as collateral may still be recorded on the borrower's balance sheet, but will likely be presented on the face of the balance sheet as a separate line item and clearly identified as restricted. Ultimately, it is important to adhere to ratio definitions in the governing documents and verify exactly which entities are included in the obligated group when determining if a covenant violation has taken place.

[2] A risk of this strategy is basis risk—namely, that the variable rate the issuer receives is insufficient to cover the tax-exempt interest payments owed on the variable rate bonds.
[3] Unrestricted Cash and Investments x 365 divided by (Total Operating Expense – Depreciation Expense)
[4] Unrestricted Net Assets divided by Direct Debt

Figure 2

SIFMA-LIBOR Relationship More Volatile in 2008



Many swaps pay a floating rate of 67% of 1M LIBOR, which is close to the long-run SIFMA/LIBOR average of 71%. In the second half of 2008, this relationship broke down.

Source: Bloomberg, SIFMA website

Self-Liquidity Borrowers Face Special Liquidity Concerns

Collateral posting and swap termination payments may reduce a borrower's same day liquidity and could result in a downgrade of the short-term rating if the issuer has chosen to back its short-term debt obligations with its own liquidity. A key metric under the standard approach for rating self-liquidity programs is the ratio of same day liquidity to demand debt[5]. Issuers that manage self-liquidity programs need to demonstrate on an ongoing basis that they have enough same-day liquidity to meet the failed remarketing of variable rate demand bonds or the failed rollover of commercial paper, while still maintaining adequate liquidity to support the institution's ongoing operations. The need to post collateral to a swap counterparty can significantly reduce the levels of assets that were initially intended to be used for self-liquidity supported debt.

[5] For more information regarding the standard and modified approaches see the special comment: *Variable Rate Debt Instruments Supported by an Issuer's Own Liquidity*

Operational Burden of Collateral Posting

Many swaps require daily collateral posting, imposing an operational burden not planned for by most treasury operations. The treasury staff must be prepared to post collateral on short notice, and to monitor the mark-to-market valuation and request the return of collateral when the swap valuation moves in the borrower's favor.

Rating Considerations and Rating Transition Risk

The swap mark to market valuation represents the cost to the borrower to exit the swap. Some borrowers have signed agreements that do not require collateral posting unless their rating falls below Baa3. This is typical of most governmental borrowers outside the not-for-profit sectors. When collateral posting is required, it is typically only required for the portion of the swap liability that exceeds some threshold (as defined in the swap agreement). In some swap agreements, a downgrade of the borrower's rating may result in a lowering of the posting threshold, elimination of the threshold entirely, or termination of the swap.

Borrowers experiencing operating difficulties face significant risk that a downgrade by a rating agency could trigger additional collateral posting. Collateral posting that consumes a significant portion of a borrower's unrestricted liquidity, or which triggers accelerated repayment under reimbursement agreements, could result in rapid rating transitions. The impact on unrestricted liquidity is often more acute for hospitals than for higher education borrowers given hospital's more variable daily liquidity needs.

Although the rating level terms governing collateral posting in each swap are unique, many borrowers rated below Aa have relatively low thresholds and those in the Baa category may have thresholds of zero, requiring collateral posting equal to the fair-market liability of the swap. Most swaps allow the counterparty to terminate if the borrower's rating falls below investment grade. Therefore, the rating transition for lower rated borrowers could be faster and more severe than for higher rated borrowers.

The ultimate rating outcome for borrowers with large swap liabilities will depend on several factors including:

- Magnitude of the liability related to unrestricted liquidity
- Size and duration of collateral posting
- Sensitivity of swap portfolio valuation to interest rate changes
- Other demands on liquidity including self-liquidity, commitments under Letters of Credit (LOC), and ongoing capital projects
- Ability to increase cash flow through revenue increases or expense reductions
- Ability to liquidate other investments
- Likelihood of missing covenants and remedies available to creditor banks
- Diversification and ratings of swap counterparties

Conclusion

Borrowers experiencing operating difficulties, or with other significant demands on liquidity are most exposed to a rating downgrade driven, at least in part, by unfavorable swap valuations. Demands on liquidity are most pronounced for borrowers with self-liquidity, or those that are close to violating financial covenants, but can also impact borrowers with significant pending equity contributions on capital projects currently underway, or even near-term pension payments. Because most bank liquidity agreements for variable rate demand debt grant the bank broad rights to declare the principal immediately due and payable, the likelihood of missing these covenants is a key rating consideration.

Appendix V – Summary of Reports on Economic Activity 2009-2009

Inflation and changes in the GDP

16 March 2009

Inflation

The BLS reports that for the year ended January 2009 the increase in the CPI-U was 0% from the previous year.

The Producer Price Index for finished goods dropped by 1% from January 2008 to January 2009. For intermediate goods the drop was 0.7% and for crude goods the drop was 2.9%.

The price index for gross domestic purchases, which measures prices paid by U.S. residents, decreased 4.1 percent in the fourth quarter, 0.5 percentage point less of a decrease than in the advance estimate; this index increased 4.5 percent in the third quarter.

Economic Activity

The Bureau of Economic Analysis reports that GDP dropped 0.5% in the third quarter of 2008, and then 6.2% in the 4th quarter of 2008. Bloomberg predicts a drop of at least this magnitude for quarter 1 2009.

The decrease in real GDP in the fourth quarter primarily reflected negative contributions from exports, personal consumption expenditures, equipment and software, and residential fixed investment that were partly offset by a positive contribution from federal government spending.

Real personal consumption expenditures decreased 4.3 percent in the fourth quarter, compared with a decrease of 3.8 percent in the third.

Real nonresidential fixed investment decreased 21.1 percent, compared with a decrease of 1.7 percent. Nonresidential structures decreased 5.9 percent, in contrast to an increase of 9.7 percent. Equipment and software decreased 28.8 percent, compared with a decrease of 7.5 percent.

Real residential fixed investment decreased 22.2 percent, compared with a decrease of 16.0 percent.

Real exports of goods and services decreased 23.6 percent in the fourth quarter, in contrast to an increase of 3.0 percent in the third.

Real imports of goods and services decreased 16.0 percent, compared with a decrease of 3.5 percent.

Real federal government consumption expenditures and gross investment increased 6.7 percent in the fourth quarter, compared with an increase of 13.8 percent in the third. National defense increased

3.1 percent, compared with an increase of 18.0 percent. Nondefense increased 15.1 percent, compared with an increase of 5.1 percent.

Real state and local government consumption expenditures and gross investment decreased 1.4 percent, in contrast to an increase of 1.3 percent.

The real change in private inventories added 0.16 percentage point to the fourth-quarter change in real GDP, after adding 0.84 percentage point to the third-quarter change. Private businesses decreased inventories $19.9 billion in the fourth quarter, following a decrease of $29.6 billion in the third quarter and a decrease of $50.6 billion in the second.

February Report from the Federal Reserve Districts reflect a "severe contraction" in economic activity (February 2009)

Inflation

Prices and wages – Upward price pressures very limited during the reporting period, as a result of lower energy and commodity prices and weak demand for final goods. Lower input prices were passed on generally and contributed to downward pressures on final prices of various products.

Upward wage pressure eased in all Districts as a rising of hiring freezes and continued job cuts increased the degree of labor market slack. Contacts from various Districts pointed to a higher incidence of wage freezes resulting from the added slack, with a few noting outright wage reductions.

Economic Activity

Manufacturing sector seeing sharp declines in most sectors with very few bright spots

Real estate and construction – in the doldrums in most areas and housing price declines continue with no signs of deceleration

Banking and Finance – availability of credit remains tight causing large declines in this sector and across the economy

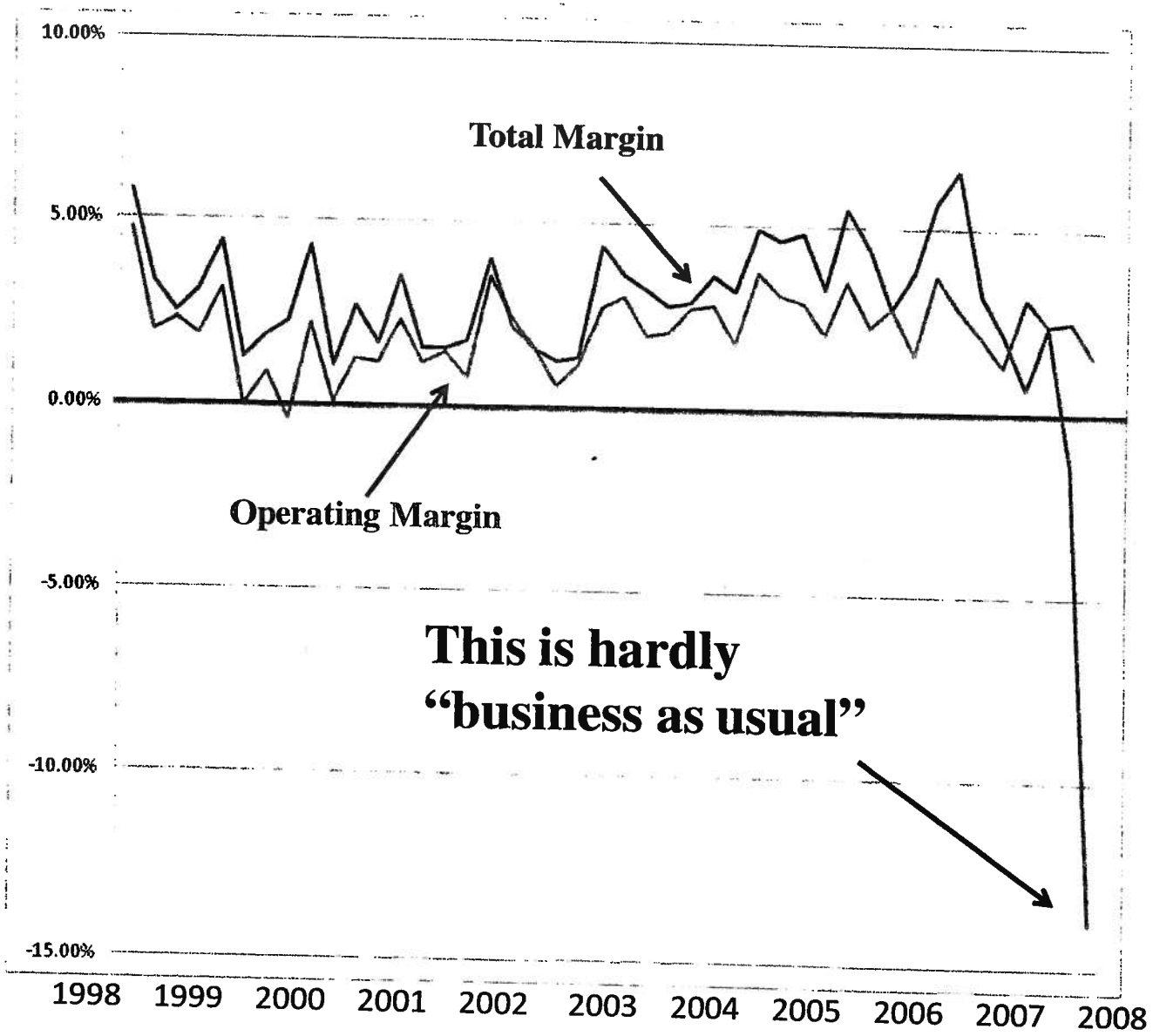
Agricultural and Natural Resources – conditions weakened in most districts as demand fell and growing conditions were mixed. Activity slowed significantly for producers of natural resource products.

Maryland
Hospital Association

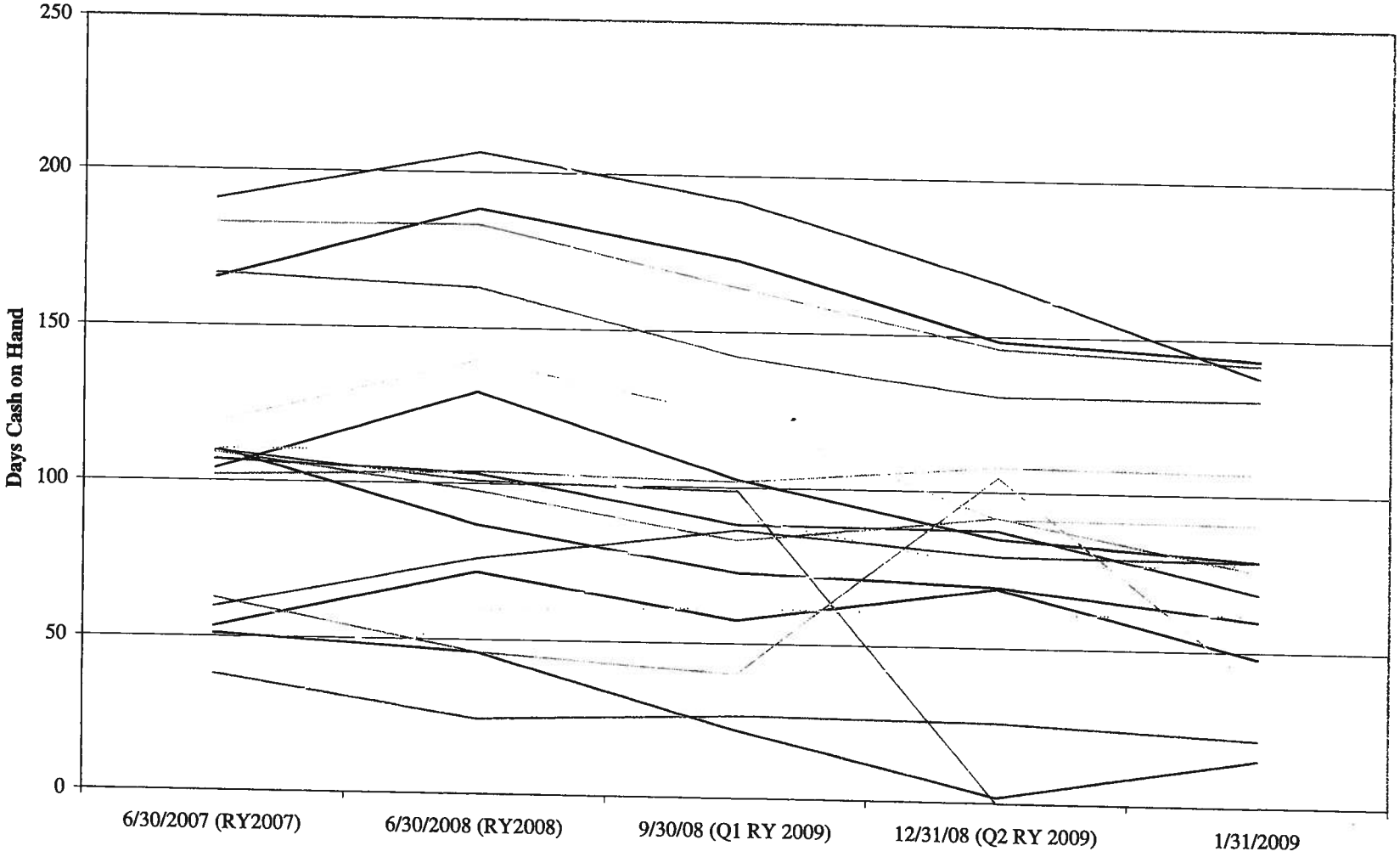
March 2009

Comparison of FY 2010 Update Proposals

	Payor Proposal	HSCRC Staff Proposal	MHA Proposal
Update	0.00%	0.49%	2.90%
Case-Mix	1.00%	1.00%	0.75%
Other Adjustments	-.20%	-.30%	0.10%
Net Patient Revenue per Case Change	0.80%	1.19%	3.75%


10.00%
5.00%
0.00%
-5.00%
-10.00%
-15.00%
Total Margin
Operating Margin
This is hardly
"business as usual"
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008

Days Cash on Hand



Note: Each line on the graph represents a hospital or, when hospital level data was not available, a hospital system.

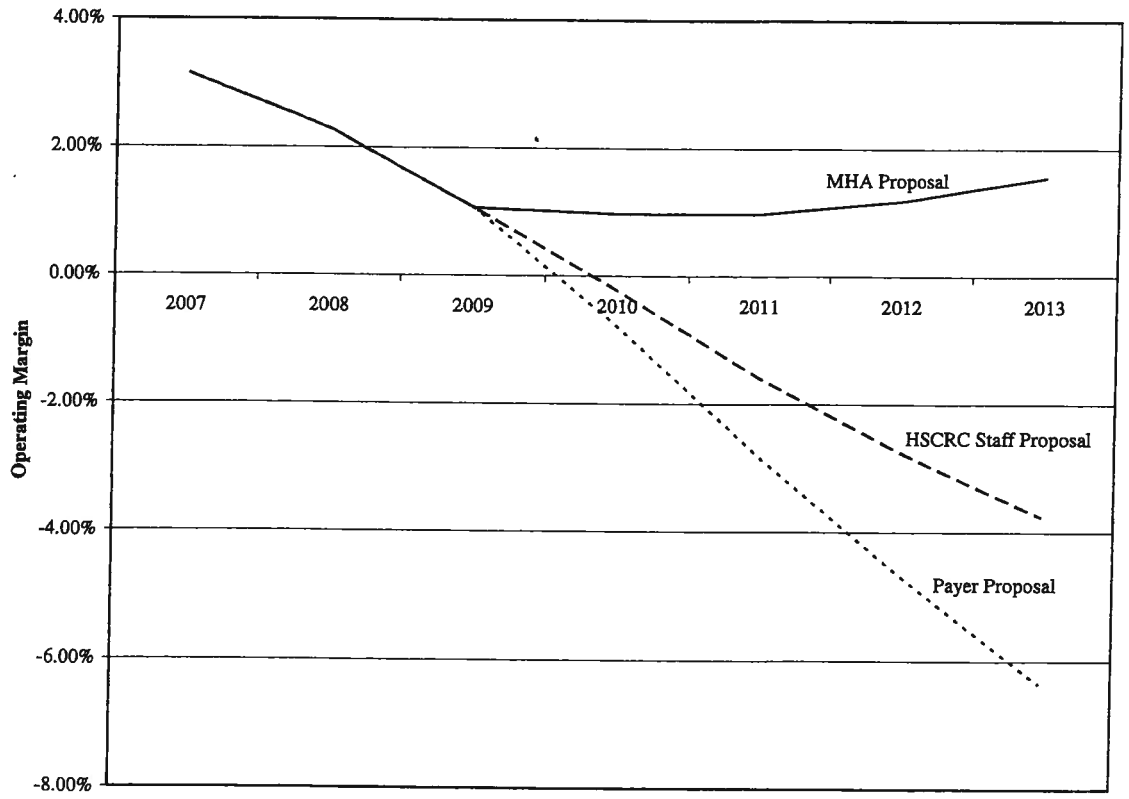
Maryland
Hospital Association

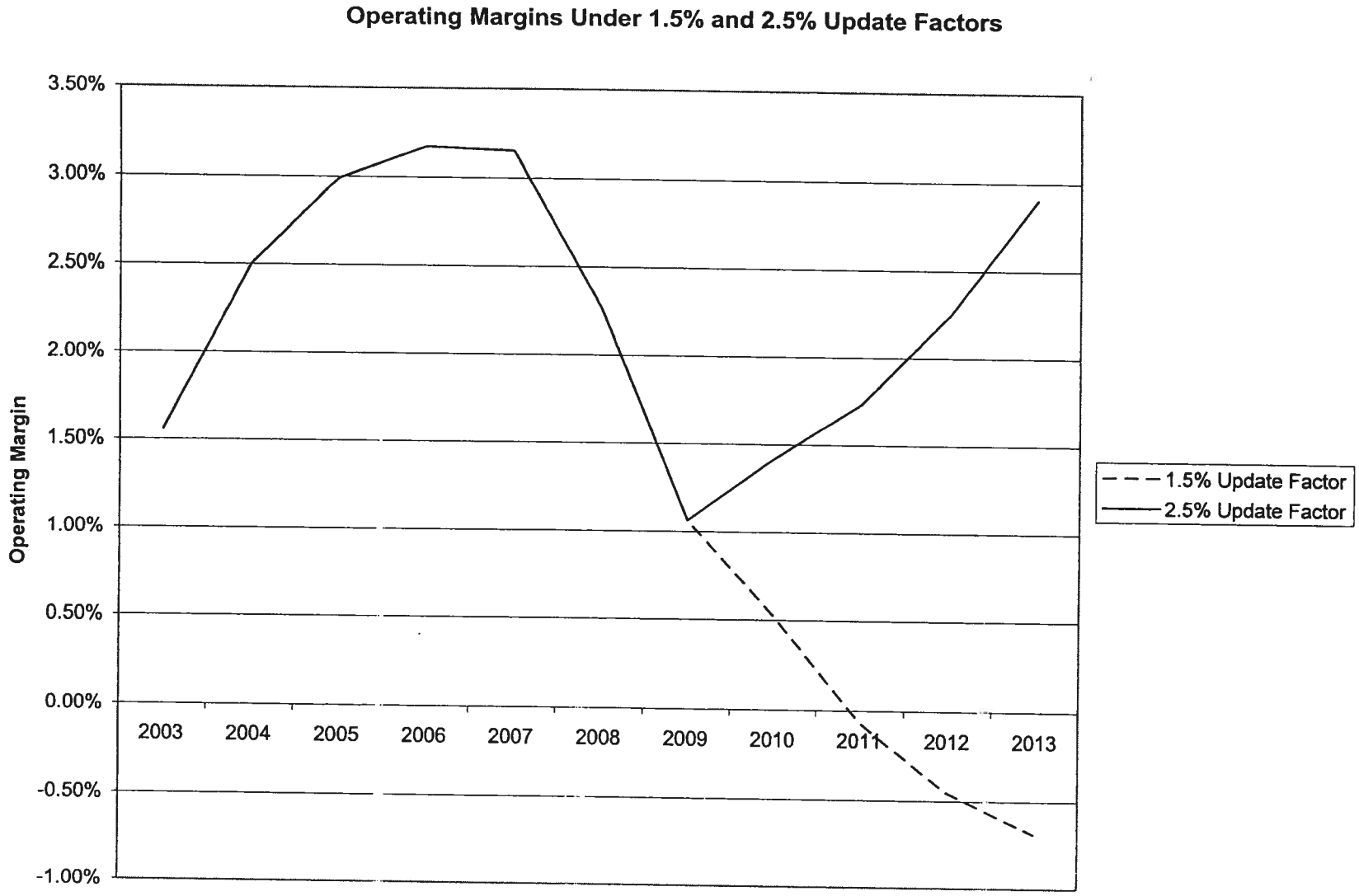
MHA
6820 Deerpath Road
Elkridge, Maryland 21075-6234
Tel: 410-379-6200
Fax: 410-379-8239

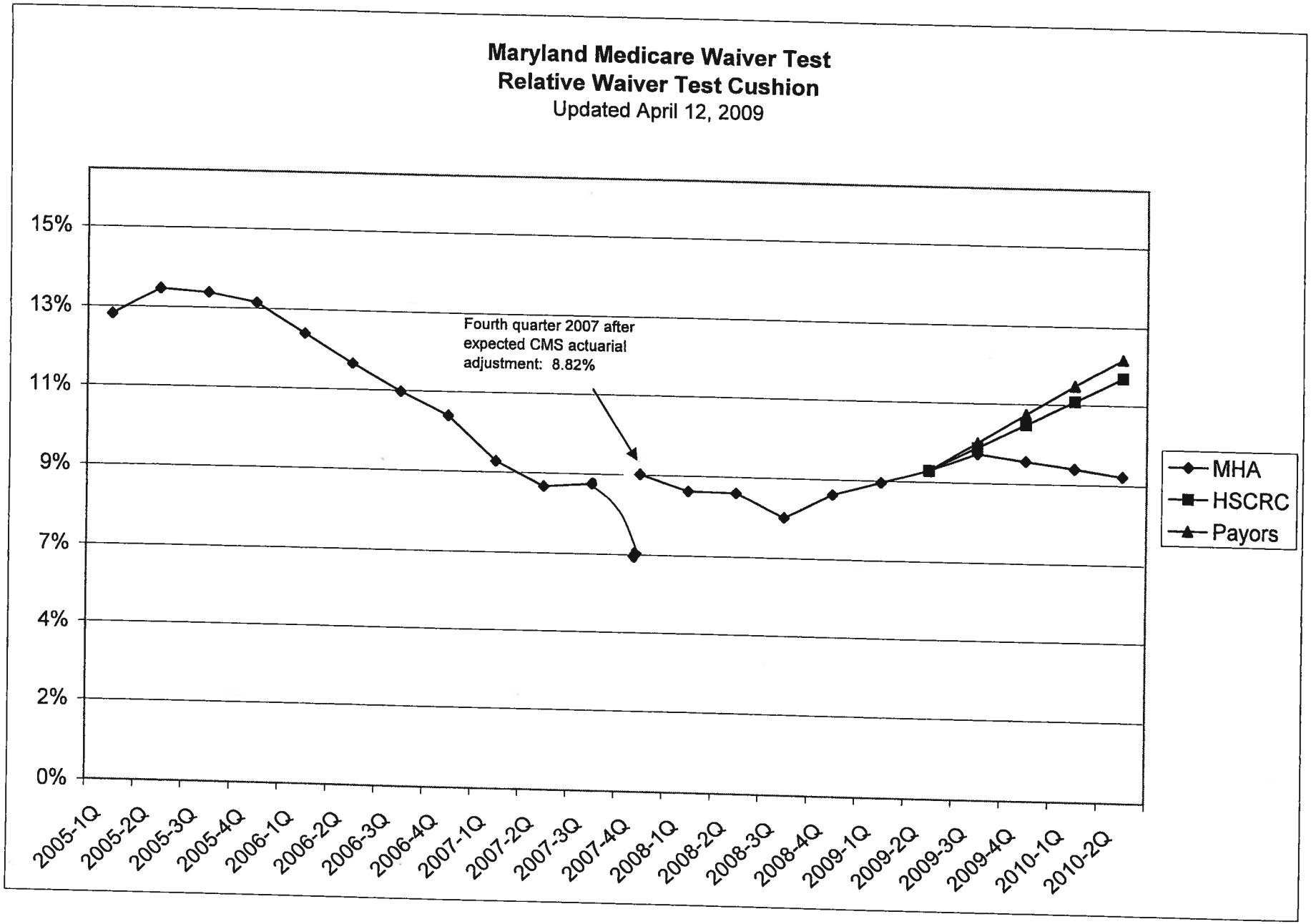
Projections show a sharp contrast between MHA and HSCRC staff proposals:

- MHA has proposed an update in revenue per case of 2.9% in 2010.
- The HSCRC staff proposal countered with a 0.49% updated factor.
- Even if hospitals can hold spending growth to 2%, deep additional cuts would be needed to prevent further deterioration of hospital finances.

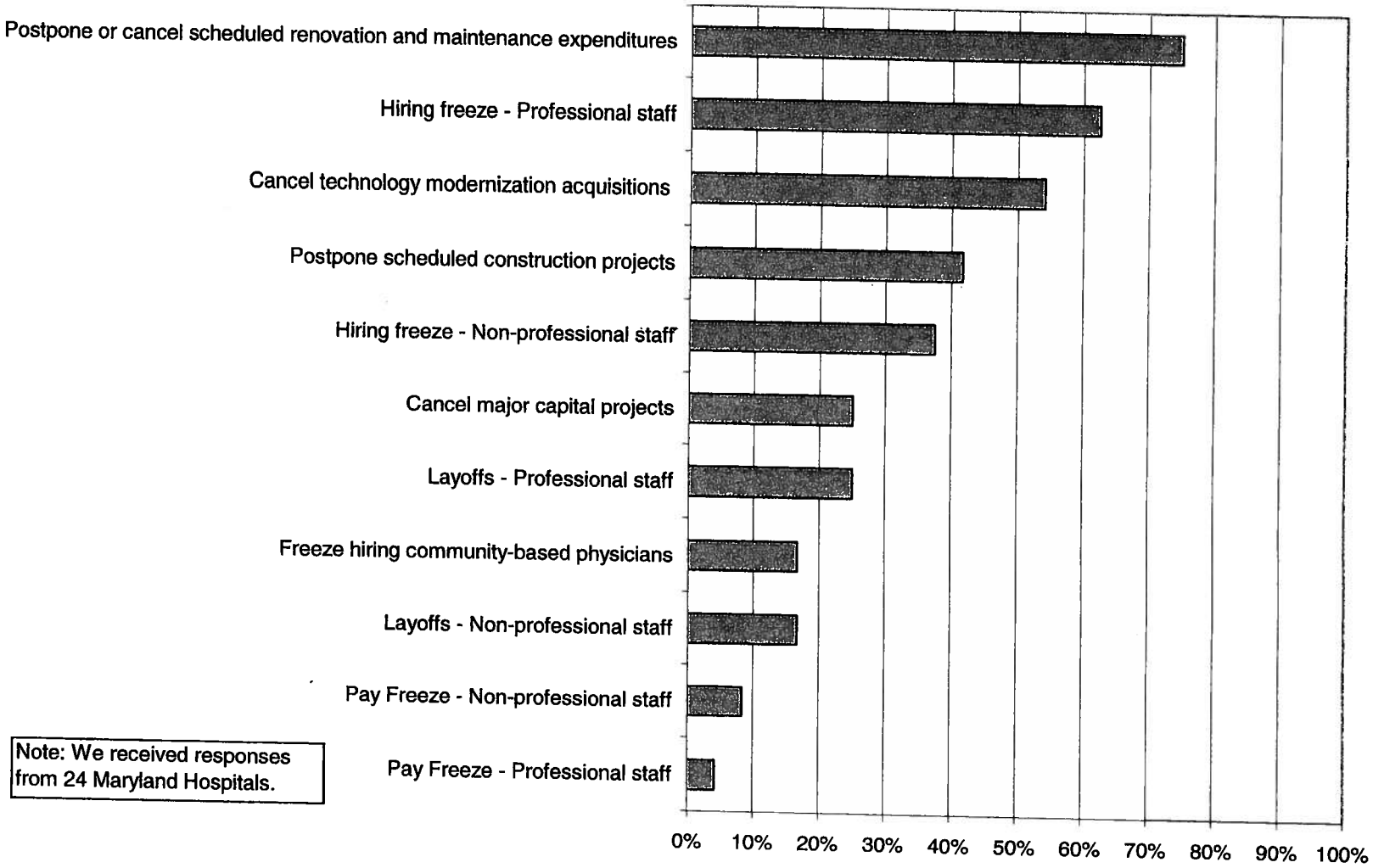
Operating Margins Under the Payer, HSCRC Staff and MHA Proposals




Operating Margins Under 1.5% and 2.5% Update Factors
Operating Margin
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
-0.50%
-1.00%
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
1.5% Update Factor
2.5% Update Factor

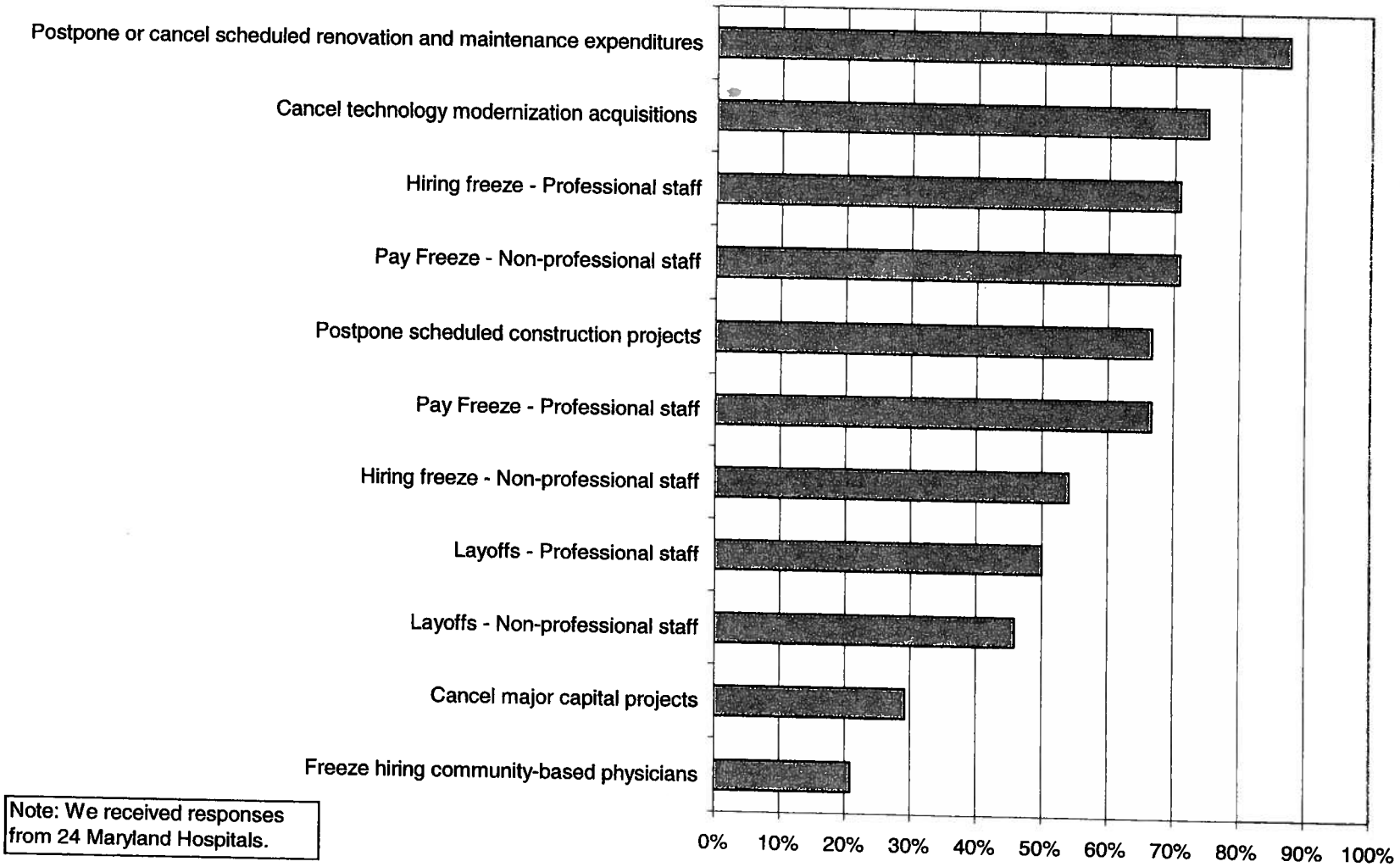

Maryland Medicare Waiver Test
Relative Waiver Test Cushion
Updated April 12, 2009
15%
13%
11%
9%
7%
4%
2%
0%
Fourth quarter 2007 after expected CMS actuarial adjustment: 8.82%
2005-1Q
2005-2Q
2005-3Q
2005-4Q
2006-1Q
2006-2Q
2006-3Q
2006-4Q
2007-1Q
2007-2Q
2007-3Q
2007-4Q
2008-1Q
2008-2Q
2008-3Q
2008-4Q
2009-1Q
2009-2Q
2009-3Q
2009-4Q
2010-1Q
2010-2Q
MHA
HSCRC
Payors

Actions Maryland Hospitals Have Taken in the Past 12 Months



Note: We received responses from 24 Maryland Hospitals.

Actions Maryland Hospitals Will Have to Take if the HSCRC Staff Proposal Goes Into Effect



Note: We received responses from 24 Maryland Hospitals.

DRAFT RECOMMENDATION REGARDING MODIFYING THE QUALITY-BASED REIMBURSEMENT INITIATIVE AFTER RATE YEAR STATE FY 2010

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

April 3, 2009

This document is a draft staff recommendation to the Commission at the April 15, 2009 public meeting.

Background

The Maryland Health Services Cost Review Commission at its June 4, 2008 meeting approved the staff recommendation titled, "Final Staff Recommendations regarding the HSCRC's Quality-Based Reimbursement (QBR) Project - based on Deliberations of the Initiation Work Group (IWG)." The QBR Initiative's development and implementation are based upon the deliberations and analysis performed by the HSCRC staff, the IWG, the Evaluation Work Group (EWG), and Commission consultants over the past several years. The IWG completed its work in June 2008 and the EWG was then established to: provide a system for developing new measures, retiring old measures, and recommending other adjustments to the data and scoring; ensure that the QBR Initiative was meeting its established goals; and to support and advance the rationale for linking hospital performance to payment.

For the first year of the QBR Initiative, the approved recommendations included using data for 19 process measures across four clinical topics including heart attack, heart failure, pneumonia and surgical care. For these measures, the additional approved recommendations included:

- incorporating new definitions for these core measures as they become available from CMS and the Joint Commission;
- weighting the scores for each process measure equally;
- establishing one index for the process measures for purposes of scoring, anticipating that reporting will be on performance for each clinical topic separately;
- utilizing the Opportunity Model for scoring purposes, whereby a hospital receives credit for each time the measure is performed, and the hospital's available points will be 10 times the number of applicable quality measures;
- utilizing calendar year 2007 as the Base Period and calendar year 2008 as the Measurement Period, establishing the scale for calibrating performance based on the prior year's experience so that thresholds and benchmarks are known in advance;
- counting (for purposes of scoring) the "higher of" either Attainment or Improvement points on each process measure for each hospital – on a 10 point scale for each measure;
- establishing the threshold for Attainment at the 50th percentile Benchmark at 95th percentile for the non-topped off measures, and for topped off measures, a score of 0.65 and 0.90 respectively;
- applying rewards and incentive payments maintaining revenue neutrality in FY 2010 as part of the FY 2010 Update Factor for individual hospitals;
- utilizing an exchange rate function (cubed-root functional form) for translating scoring into rewards/incentives without high or low restrictions on eligibility or rewards/incentives achieved;
- establishing a rule to adjust for "down and up" year to year performance on any individual process measure, establishing the base-line for improvement as that hospital's best previous score on that measure;

- establishing a mechanism where the Commission can obtain necessary data directly from hospitals through its own vendor arrangement based on work with the Maryland Health Care Commission through a contract with a data vendor to collect quality data for both MHCC's quality performance guide and the HSCRC QBR Initiative;
- moving over time toward use of complete data and away from sampling;
- assuring public accountability by providing accessibility to data with necessary restrictions on confidentiality;
- carefully planning and manage the public release of quality-related scoring information;
- determining the amount of funding "at-risk" based on further deliberations and recommendations of the HSCRC Payment Work Group comprising HSCRC staff and the hospital and payer industries, and approval of the Commission;
- scaling reward and incentive payments in the Update Factor for hospitals reporting on a minimum of 5 measures; and,
- investigating the feasibility in future years of incorporating additional funding ("new money") into the system if Maryland as a state can achieve certain benchmarks vs. the performance of hospitals nationally on the selected performance measures.

Status of QBR Initiative Implementation

Hospital rate adjustments will be made for FY 2010 within the parameters of the recommendations specified above. The amount of funding "at risk" for the first year must still be approved by the Commission, and data on the process measures for CY 2008 is in the process of being obtained by the Delmarva Foundation for analysis to calculate hospitals' improvement and attainment scores. The data vendor has been procured by MHCC, with patient-level data collection by the vendor on the process measures beginning with first quarter CY 2009. The EWG has met regularly to deliberate: measure additions, changes, and deletions; changes to the benchmark and threshold values for topped off measures; and the use of a blended Appropriateness and Opportunity Model for the process measures in order to raise the bar of performance and better distinguish hospital performance in light of the increasing number of topped off measures.

Recommendations to Complete Implementation of the QBR Initiative for the Initial Year

- The amount of funding "at risk" in the Rate Year 2010 will be determined in 2009 based on the recommendations of the HSCRC Payment Work Group and approval of the Commission.

Recommendations for Changes to the QBR Initiative For Rate Years after FY 2010

- Consistent with the Joint Commission and the CMS Reporting Hospital Quality Data for Annual Payment Update initiative changes to the core measures, adopt the following modifications to the QBR measures:
  - PN 1- Oxygenation Assessment- retire this measure from use in the QBR beginning with January 1, 2009 discharges.
  - PN 5b- Antibiotic within 4 hours- retire this measure and replace it with PN 5c, Antibiotic within 6 hours beginning with January 1, 2009 discharges.
  - AMI 6- Beta Blocker at Arrival within 24 hours- retire this measure beginning with April 1, 2009 discharges.

- Expand current surgical care SCIP 1, 2, and 3 measures beyond hip, knee and colon surgery patients to include CABG, Other Cardiac, Hysterectomy, and Vascular Surgery with discharges beginning January 1, 2009; these measures include:
  - SCIP 1- Antibiotic given within 1 hour prior to surgical incision
  - SCIP 2- Antibiotic selection
  - SCIP 3- Antibiotic discontinuance within appropriate time period postoperatively

- Add new process measures consistent with MHCC's timeframe for adding these measures to the Hospital Performance Evaluation Guide:
  - AMI 8- Percutaneous Coronary Intervention Timing for AMI patients– base CY 2008, measurement CY 2009, and rate year FY 2011
  - SCIP VTE 1- Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered - base CY 2009, measurement CY 2010, and rate year FY 2012
  - SCIP VTE 2 - Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Given 24 hours prior and after surgery–base CY 2009, measurement CY 2010, and rate year FY 2012
  - SCIP CARD-2 Surgery Patients on Beta-Blocker Therapy Prior to Admission Who Received a Beta-Blocker During the Perioperative Period – base CY 2009, measurement CY 2010, and rate year FY 2012
  - SCIP Inf – 4- Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Serum Glucose - base CY 2009, measurement CY 2010, and rate year FY 2012
  - SCIP Inf 6- Surgery Patients with Appropriate Hair Removal - base CY 2009, measurement CY 2010, and rate year FY 2012
  - Children's Asthma Care Asthma Measures (CAC-1-3)- base CY 2009, measurement CY 2010, and rate year FY 2012); these measure include:
    - CAC 1-Relievers for Inpatient Asthma Systemic
    - CAC 2- Corticosteroids for Inpatient Asthma
    - CAC 3- Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver.

- To mitigate the effects of topped off measures better distinguishing hospital performance, and to raise the performance bar, adopt a hybrid of the Opportunity and Appropriateness models where hospital scores are based 75% on Opportunity and 25 % on Appropriateness for base CY 2008, measurement CY 2009, and rate year FY 2011.

- Topped off Measures Definition – Based on analysis of the data already completed, change the definition of a topped off measure where the 75th percentile is within 2 standard errors of the 95th percentile, increased from the 90th percentile.

- Patient Experience of Care – Based upon the results of analysis of patient experience of care measures data (HCAHPS) relative to other domains of quality measures, and upon proposed modeling of incorporating the patient experience domain in the QBR formula, allow the option of including this domain for future years.

To: HSCRC Commissioners, Interested Parties
From: John O'Brien
Deputy Director, Research and Methodology
Re: Resolution of Technical issues related to the calculation of the ROC
Date: April 10, 2009

One March 11, 2009 the ROC/ICC Workgroup met to resolve a number of technical issues related to the application of the adjustments approved by the Commission for the Reasonableness of Charges analysis. At that meeting four separate topics were discussed.

Use of P4 and P5 schedules to arrive at the direct strip for Medical education.

Issue: In the past, the calculation of the direct cost of residents was a derived number based upon a statewide calculation of the average cost per resident x the number of residents allowed up to the cap.

Problem: The intent of the direct strip is to remove costs associated with resident salaries that can be measured. This is the intent of the direct strips in general: there are certain costs that need to be removed from the ROC as they are unique to a hospital and should not be the basis of a comparison with other hospitals. Taking an average resident cost and applying it across all hospitals is inconsistent with this approach.

Resolution: Since the new ROC methodology counts all residents and fellows all the direct costs for residents and fellows that the hospital reports on the P4 and P5 schedules should be used to arrive at the direct strip for medical education.

Calculate the adjustments for DSH and IME direct strips or variation from the means.

Issue: There are two alternative ways that adjustments for IME and DSH can be applied to the ROC calculation. These are:

- Direct strip. Calculate an IME and DSH per case cost from the regression and remove those costs from the CCT.
- Variation from the mean. Calculate the statewide average for IME and DSH per case, subtract that from the hospitals own DSH and IME adjustments and apply the result to the hospitals CCT

In and of themselves the choice of variation from mean or direct strip adjustment do not affect a hospital's ROC position relative to its peers. It does, however, broaden the distribution around the mean such that hospitals who are farthest from the means (either above or below) become even farther under a direct strip approach.

Resolution: Since the effect of the alternatives is strongest at the extremes the use of a direct strip will increase the potential for full rate reviews and (in future years) the severity of spenddown requirements. Therefore, a variation from the mean approach will be used. It should be noted,

however that the use of a variation from the mean, especially for IME (see the discussion of the compromise factor below) has some problems and the Commission may revisit this issue in the future.

How should profit be handled in the calculation of and adjustment for IME

Issue: In the past, when only an IME effect was determined using a regression. It was calculated and adjusted as follows:

- Adjustment Each hospital's CPC was adjusted (except for capital, which should have been) for all factors. The regression was then done using each hospital's adjusted CPC FURTHER ADJUSTED TO REMOVE PROFIT and then the cost of IME was calculated using the RESBED ratio. The reasoning for this approach is quite strong. If profit is not removed when calculating IME and teaching hospitals have systematically higher profits than non-teaching hospitals the regression will build profit into the calculation of IME and potentially lead to some very bad feedback loops – teaching hospitals with ever higher profits having an increasing IME adjustment justifying those profits.
- Application. Once the IME adjustment was calculated the effect of IME was then calculated as a percent of the hospital adjusted CPC, some argued that profit was then built back into the IME allowance

Resolution: Under the revised ROC policy, IME and DSH are determined simultaneously in the same regression. As before, profit is adjusted out of each hospital's CCT when doing the regression. This is appropriate as it should account for systematic profits for the teaching hospitals, or if high DSH hospitals have systematically lower margins. These adjustment should be apply to a hospital's CCT with no further adjustment.

Compromise factor

Issue. Under previous ROC methodologies only IME was adjusted using a regression. In addition this adjustment was applied as a variation from the mean; with non-teaching hospitals have their CCTs adjusted upward slightly. Also, because this adjustment was a constant (cost of teaching) applied to the CPC or CCT that is variable, the percentage the adjustment for non-teaching would vary slightly by hospital - a counter intuitive result. To address apparent inconsistency a compromise factor was developed to make the percentage adjustment for all non-teaching hospitals equal. Under the revised ROC methodology the IME and DSH adjustments are developed jointly and must be applied consistently.

Resolution. You must apply the DSH and IME adjustments consistently and calculate no compromise factor.

The final ROC results with all technical issues accounted for is attached.

Attachment 1
Summary of the 2009 Maryland Hospitals' Reasonableness of Charges Comparison

HOSPID	HOSPITAL NAME	ROC POSITION
210058	James Lawrence Kernan Hospital	2.63%
PEER GROUP 1		
210025	Memorial of Cumberland	4.80%
210007	St. Joseph Medical Center	3.99%
210016	Washington Adventist Hospital	3.27%
210048	Howard County General Hospital	2.93%
210027	Braddock Hospital	2.01%
210057	Shady Grove Adventist Hospital	1.04%
210022	Suburban Hospital	0.80%
210019	Peninsula Regional Medical Center	0.12%
210044	GBMC	-0.06%
210023	Anne Arundel Medical Center	-1.17%
210004	Holy Cross Hospital	-1.17%
210056	Good Samaritan Hospital	-1.22%
210015	Franklin Square Hospital Center	-1.57%
210011	St. Agnes Hospital	-3.19%
210005	Frederick Memorial Hospital	-3.34%
210001	Washington County Hospital	-3.41%
PEER GROUP 2		
210054	Southern Maryland Hospital Center	5.28%
210006	Harford Memorial Hospital	3.48%
210051	Doctors Community Hospital	3.45%
210040	Northwest Hospital Center	2.27%
210018	Montgomery General Hospital	1.73%
210055	Laurel Regional Hospital	1.09%
210043	Baltimore Washington Medical Center	0.84%
210033	Carroll Hospital Center	-0.73%
210028	St. Mary's Hospital	-0.88%
210049	Upper Chesapeake Medical Center	-1.29%
210035	Civista Medical Center	-1.78%
210037	Memorial Hospital at Easton	-5.17%
210039	Calvert Memorial Hospital	-6.65%
210032	Union of Cecil	-8.28%
PEER GROUP 3		
210045	McCready Memorial Hospital	35.14%
210030	Chester River Hospital Center	7.30%
210061	Atlantic General Hospital	3.78%
210060	Fort Washington Medical Center	-3.85%
210010	Dorchester General Hospital	-8.05%
210017	Garrett County Memorial Hospital	-14.16%
PEER GROUP 4		
210013	Bon Secours Hospital	3.34%
210024	Union Memorial Hospital	3.31%
210012	Sinai Hospital	1.11%
210003	Prince Georges Hospital Center	-0.60%
210029	Johns Hopkins Bayview Medical Center	-0.94%
210008	Mercy Medical Center	-1.29%
210038	Maryland General Hospital	-3.37%
210034	Harbor Hospital Center	-3.70%
PEER GROUP 5		
210009	Johns Hopkins Hospital	3.47%
910024	Union Memorial Hospital	1.34%
910012	Sinai Hospital	-0.81%
210002	University of Maryland Hospital	-1.59%
910003	Prince Georges Hospital Center	-2.50%
910029	Johns Hopkins Bayview Medical Center	-2.82%
910008	Mercy Medical Center	-3.17%

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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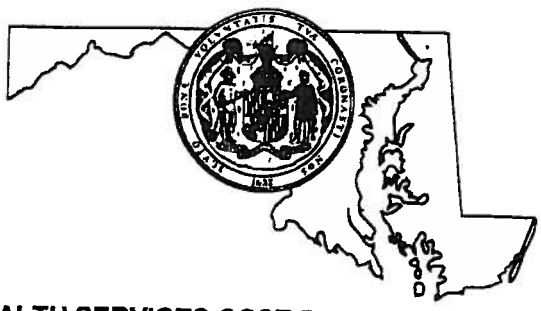

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TO: **Commissioners**

FROM: **Legal Department**

DATE: **April 10, 2009**

SUBJECT: **Hearing and Meeting Schedule**

Public Session

May 13, 2009	**Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room**
June 3, 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