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DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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465th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

EXECUTIVE SESSION

9:00 a.m.

March 3, 2010

1. **Legal Issues**
2. **Personnel Issues**

PUBLIC SESSION OF THE HEALTH SERVICES COST REVIEW COMMISSION

9:30 a.m.

1. **Review of the Executive and Public Minutes of January 13, 2010**
2. **Executive Director's Report**
3. **Docket Status - Cases Closed**
   2058A - Johns Hopkins Health System
4. **Docket Status - Cases Open**
   2056N - St. Mary's Hospital
   2057R - Doctors Community Hospital
   2059N - Union Hospital of Cecil County
   2060N - Union Hospital of Cecil County
   2061R - Carroll County General Hospital
   2062A - University of Maryland Medical Center
5. **Draft Recommendation on Annual Payment Update**
6. **Draft Recommendations from the Deliberations of the ICC/ROC Work Group**
7. **Final Recommendation on Medicaid Current Financing**
8. **Legislative Update**
9. **Legal Report**
10. **Hearing and Meeting Schedule**

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

AS OF FEBRUARY 22, 2010

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
2056N	St. Mary's Hospital	12/7/09	3/3/10	5/3/10	PUL	CO	OPEN
2057R	Doctors Community Hospital	12/9/09	3/3/10	5/8/10	MRI	CO	OPEN
2059N	Union Hospital of Cecil County	2/5/10	3/8/10	7/6/10	HYP	CO	OPEN
2060N	Union Hospital of Cecil County	2/5/10	3/8/10	7/6/10	ORC	CO	OPEN
2061R	Carroll County General Hospital	2/8/10	3/10/10	7/8/10	MRI	CO	OPEN
2062A	University of Maryland Medical Center	2/17/10	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF	*	**COST REVIEW COMMISSION**	
ST. MARY'S	*	**DOCKET:**	**2009**
HOSPITAL	*	**FOLIO:**	**1866**
LEANORDTOWN, MARYLAND	*	**PROCEEDING:**	**2056N**

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<u>Staff Recommendation</u>

March 3, 2010

Introduction

On December 4, 2009, St. Mary's Hospital (the Hospital) submitted a partial rate application to the Commission requesting a rate for its new Pulmonary Function (PUL) service. The Hospital is requesting that the statewide median rate be approved effective January 1, 2010.

Staff Evaluation

To determine if the Hospital's PUL rate should be set at the statewide median rate or at a rate based on its projected costs, the staff requested that the Hospital submit to the Commission its cost and volume projections for FY 2010. After reviewing on the information received, staff determined that the PUL rate based on the Hospital's projected data is $ 3.48 per RVU, while the statewide median rate for PUL services is $4.03 per RVU.

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days before to the opening of the new service be waived;
2. That a PUL rate of $3.48 per RVU be approved effective February 1, 2010;
3. That no change be made to the Hospital s Charge per case standard for PUL services; and
4. That the PUL rate not be rate realigned until a full year's experience data have been reported to the Commission.

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF	*	**COST REVIEW COMMISSION**	
DOCTORS COMMUNITY	*	**DOCKET:**	**2009**
HOSPITAL	*	**FOLIO:**	**1867**
LANHAM, MARYLAND	*	**PROCEEDING:**	**2057R**

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Staff Recommendation

March 3, 2010

Introduction

On December 7, 2009, Doctors Community Hospital (the Hospital) submitted a partial rate application to the Commission requesting a rate for regular MRI services. The Hospital currently has a rebundled rate for MRI services provided off-site. As of January 1, 2010, the Hospital has been providing in-house MRI services for both inpatients and outpatients. The Hospital is requesting that the MRI rate be set at the statewide median rate with an effective date of January 1, 2010.

Staff Evaluation

To determine if the hospital MRI rate should be set at the statewide median rate or at a rate based on its own cost experience, the Hospital submitted to the Commission its MRI costs and statistical projections for FY 2010. After reviewing this information, staff determined that the MRI rate based on the Hospital's projected data would be $59.20 per RVU, while the statewide median rate for MRI services is $46.24 per RVU.

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days prior to the opening of the new service be waived;
2. That the MRI rate of $46.24 per RVU be approved effective **February 1, 2010**;
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 PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*	**COST REVIEW COMMISSION**
UNION HOSPITAL OF	*	**DOCKET: 2010**
CECIL COUNTY	*	**FOLIO: 1869**
ELKTON, MARYLAND	*	**PROCEEDING: 2059N**

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<u>Staff Recommendation</u>

March 3, 2010

Introduction

On February 2, 2010, Union Hospital of Cecil County (the Hospital) submitted a partial rate application to the Commission requesting a rate for its new Hyperbaric Chamber (HYP) service. The Hospital is requesting that the statewide median rate be approved effective March 1, 2010.

Staff Evaluation

To determine if the hospital HYP rate should be set at the statewide median rate or at a rate based on its projected costs, the staff requested that the Hospital submit to the Commission its cost and volume projections for FY 2010. Based on the information received, staff determined that the HYP rate based on the Hospital's projected data is $ 257.42 per RVU (per hour), while the statewide median rate for HYP services is $246.02 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 statewide median HYP rate of $246.02 per RVU be approved effective March 1, 2010;
3. That no change be made to the Hospital s charge per case standard for HYP services; and
4. That the HYP rate not be rate realigned until a full year's experience data have been reported to the Commission.

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF	*	**COST REVIEW COMMISSION**	
UNION HOSPITAL OF	*	**DOCKET:**	**2010**
CECIL COUNTY	*	**FOLIO:**	**1870**
ELKTON, MARYLAND	*	**PROCEEDING:**	**2060N**

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<u>Staff Recommendation</u>

March 3, 2010

Introduction

On February 2, 2010, Union Hospital of Cecil County (the "Hospital") submitted a partial rate application to the Commission requesting a new rate for Operating Room Clinic (ORC). The Hospital is requesting that the statewide median rate be approved effective March 1, 2010.

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 $12.12 per RVU, while the statewide median for ORC services is $9.73 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 a new service be waived;
2. That the ORC rate of $9.73 per RVU be approved effective March 1, 2010,
3. That no change be made to the Hospital□s charge per case standard for ORC services; and
4. That the ORC rate not be rate realigned until a full year's cost experience data have been reported to the Commission

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*	**COST REVIEW COMMISSION**
CARROLL HOSPITAL	*	**DOCKET: 2010**
CENTER	*	**FOLIO: 1871**
WESTMINSTER, MARYLAND	*	**PROCEEDING: 2061R**

* *

Staff Recommendation

March 3, 2010

Introduction

On February 7, 2010, Carroll Hospital Center (the Hospital) submitted a partial rate application to the Commission requesting a rate for MRI services to be provided to its patients. This new rate will replace the Hospital's currently approved rebundled MRI rate. A rebundled rate is approved by the Commission when a hospital provides certain non-physician services to inpatients through a third-party contractor off-site. By approving a rebundled rate, the Commission makes it possible for a hospital to bill for services provided off-site, as required by Medicare. In this case, however, as of March 1, 2010, the Hospital will be providing MRI services on-site to both inpatients and outpatients. The Hospital requests that the MRI rate be set at the statewide median rate with an effective date of March 1, 2010.

Staff Evaluation

To determine if the hospital MRI rate should be set at the statewide median rate or at a rate based on its own cost experience, the Hospital submitted to the Commission its MRI costs and statistical projections for FY 2010. After reviewing this information, staff determined that the MRI rate based on the Hospital's projected data would be $64.06 per RVU, while the statewide median rate for MRI services is $42.32 per RVU.

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days prior to the opening of a new service be waived;
2. That the MRI rate of $42.32 per RVU be approved effective **March 1, 2010**;
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:**	**2010**
MEDICAL CENTER	*****	**FOLIO:**	**1872**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2062A**

Staff Recommendation

March 3, 2010

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on February 17, 2010 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. Network for a three-year period, effective April 1, 2010.

II. OVERVIEW OF APPLICATION

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

Staff reviewed the experience under this arrangement for the last year and found it to be favorable. Staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

V I. STAFF RECOMMENDATION

Based on the Hospital's favorable performance, staff recommends that the Commission approve the Hospital's application to continue to participate in 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, 2010. 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 2011 HSCRC Hospital Payment Update

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March 3, 2010

This document represents a draft recommendation to be presented to the Commission on March 3, 2010 for discussion purposes only. Comments should be sent to Robert Murray, Executive Director, HSCRC 4160 Patterson Avenue, Baltimore MD 21215.

Background

Payment Update Discussions

Three-Year Rate Arrangements: Since the Commission's "Redesign" of the rate setting system in FY 2000, the Commission has generally favored the adoption of rate arrangements covering three year time periods. Three year arrangements were approved for the periods FY 2001-2003, FY 2004-2006, and FY 2007 – FY 2009. These arrangements specify the basic parameters and/or formulaic approach that determine the update factor for each year of the arrangement. Multi-year rate update arrangement define the general trajectory of hospital rates over three years (e.g., the FY 2004-2006 rate arrangement was structured to provide hospitals with significant additional funds to help build profitability and facilitate hospital recapitalization). As such, these multi-year arrangements can be designed to achieve medium-term policy objectives of the Commission and, at the same time, provide a higher degree of predictability for hospitals and payers for financial management and budgeting purposes.

FY 2010 Rate Update Structure: The approved update for FY 2010 was an exception to the Commission's desire to adopt three-year rate arrangements. In FY 2010, the Commission adopted a rate arrangement that applied to only one year given the uncertainty associated with general economic conditions.

Annual Rate Update Mechanism – Policy Implications

Cost Containment Tool: Since the inception of rate setting in Maryland, the HSCRC has structured its annual rate update mechanism to meet predefined policy objectives related to cost containment and the financial condition of the industry. In the early years of rate setting, the system was structured to provide hospitals with updates sufficient to cover factor cost inflation (the rate of growth of inputs to the hospital production process) plus 1% in Maryland at a time when U.S. hospitals' per case revenues were growing at factor cost inflation plus 2 to 3%. Over this period, Maryland payment levels and costs per case grew more slowly than payments and costs nationally. This dynamic contributed to the generation of considerable cost savings to the State in the form of averted hospital spending (estimated to be in excess of $42 billion over the period 1976 to 2008).

Medicare Waiver Impact: The HSCRC's update factor policy also has considerable influence over the State's performance on the Medicare "Waiver Test" (the financial test the State must pass to keep its waiver for national Medicare and Medicaid reimbursement rules). Under the relatively restrictive updates provided for FYs 2001-2003, Maryland significantly improved its performance on the Waiver Test, moving from a position of a 15% relative cushion to an over 18% relative cushion over this period. Conversely, the next three year rate arrangement (FYs 2004 – 2006) contributed to a large erosion in the relative waiver position (from 18% to 11%).

Affordability Impacts: The magnitude of the HSCRC's annual hospital rate update also has significant implications for the affordability of hospital care within the State. Each 1.0% additional increment in the update represents approximately $136 million in annual hospital payments. The approved update factor also has a significant impact on the State budget. The Maryland Medicaid and State Employee Benefits programs respectively account for approximately 17% and 3% of the hospital expenditures. Thus, every 1.0% increase in the annual update will increase State hospital payments by approximately $13 million. The recent expansion of Medicaid eligibility, along with the impact of the recent economic downturn, have contributed to rapid growth in Medicaid enrollment. As of December 2009, Medicaid enrollment has increased at an annual growth rate of nearly 20% (enrollment increased from just over 500,000 recipients as of the end of fiscal year 2008 to an estimated 700,000 recipients year end fiscal 2010. Thus, hospital rate increases have a large impact on the State budget by way of increases in Medicaid and State Employee Benefit Program payments. Hospital payments (and thus the revenues hospitals generate) are also influenced by changes in the volume of services year to year.

Impacts on Hospital Financial Condition: Finally, the magnitude of the HSCRC annual update can also have significant impact on the financial condition of the Maryland hospital industry. During the period of less restrictive rate updates, FY 2004-FY 2009, hospital regulated operating profits increased from 3.5% to 5.8%. The relationship between rate updates and profitability is also influenced by the ability of hospital managers to improve efficiency in the face of constrained revenues. Medpac (the federal Commission that advises Congress on Medicare payment policy) observed that 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.

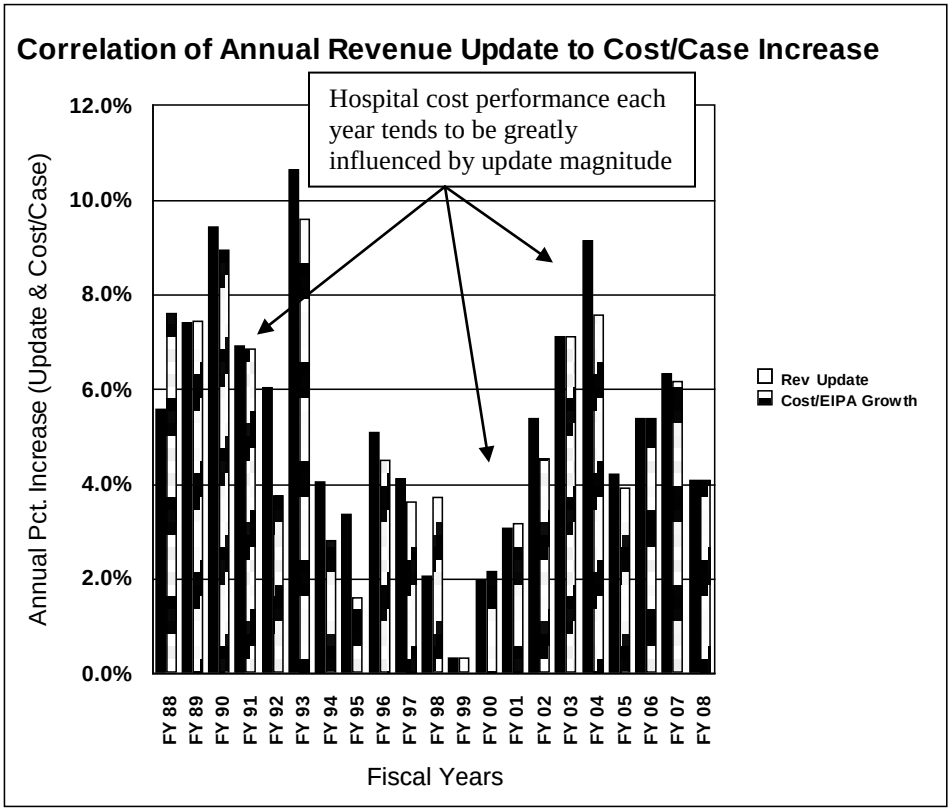
This observation is consistent with HSCRC staff observation that hospitals that face more stringent and broad based constraint tend to reduce costs more effectively. When the HSCRC has provided more restricted inflation updates, operating efficiency and cost performance has improved. When the HSCRC has been more generous in its update factors year-to-year, hospital cost spending increases.

This observation is strongly supported by actual year-to-year payment vs. cost experience in Maryland. **Table 1** and **Chart 1** show the year-to-year relationship between approved revenue increases and the resulting hospital expenditure growth over the period 1988 -2008. Most hospitals budget their expenses based on their expected income, just as most people do. If revenues are expected to go down, they will reduce their expenditures; if, on the other hand, revenues are expected to increase, they will allow costs to increase accordingly. This can be seen in the following chart, which shows expenses and net patient revenue per EIPA tracking very closely for the period 1988 to 2008. The correlation coefficient between the expense and net patient revenue per EIPA is 0.999. This analysis strongly support Medpac's conclusion in the March 2009 Report to Congress noted above, that revenues drive costs. As pressure is placed on the revenue curve facing the hospital industry, the behavioral response has and will be to improve efficiency.

Table 1
Correlation of Annual Update to Eventual Cost per Case Growth

	Rev Update	Cost/EIPA Growth
FY 88	5.59%	7.60%
FY 89	7.42%	7.44%
FY 90	9.44%	8.94%
FY 91	6.93%	6.86%
FY 92	6.05%	3.77%
FY 93	10.66%	9.61%
FY 94	4.06%	2.81%
FY 95	3.39%	1.63%
FY 96	5.09%	4.52%
FY 97	4.13%	3.65%
FY 98	2.08%	3.74%
FY 99	0.35%	0.34%
FY 00	1.97%	2.18%
FY 01	3.09%	3.17%
FY 02	5.41%	4.56%
FY 03	7.13%	7.11%
FY 04	9.14%	7.57%
FY 05	4.21%	3.93%
FY 06	5.39%	5.39%
FY 07	6.33%	6.18%
FY 08	4.08%	4.08%

Chart 1
Hospital Cost Growth Tends to Track Annual Rate Updates



FY 2011 Update Process

Payment Work Group: 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 2011 (effective July 1, 2010). 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 FYs 2011-2013.[1]

Request of HSCRC Chairman and Update Structure: In response to a request by the HSCRC Chairman, staff solicited one-year and three-year rate proposals from both the hospital and payer representatives on the Payment Work Group. Staff also requested that the proposals follow the general Update structure and key components used by the Commission since FY 2001. **Table 2** illustrates the Commission's Update Structure and key components as reflected in the HSCRC's approved FY 2010 Update. These components are also described below:

[1] The Payment Work Group that convened two years ago successfully forged a near consensus recommendation for a 4.7% rate update for FY 2009. While the FY 2010 Payment Work Group did not achieve a consensus position, the original spread in proposals was significantly narrowed during the negotiation process.

Table 2
HSCRC Approved FY 2010 Update

Market Basket (per Global Insights)	1.59%	
Forecasting Error	NA	
HSCRC "Policy Adjustment"	-0.10%	
Base Update1.49%		Note 1
Case Mix Allowance	0.50%	
Base Update Plus Case Mix1.99%		
Estimated Rate Year 2009 Volume Adjustment-0.22%		
Estimated System-wide Update1.77%		

Notes:
1) One third of base update, or 0.4967%, will be scaled for ROC purposes.
Also, 0.5% will be used to determine adjustment for Quality Based Reimbursement.

Key Components of the Update Factor

1- **Market Basket (MB):** The Market Basket is a fixed-weight index that measures price changes in the underlying factor inputs used in the hospital production process, as per HSCRC policy determined by Global Insight's 1st quarter book 2010 for the period July 1, 2010 – June 30, 2011 (and applicable time-period for a 3 year rate proposal). [2]

2- **Market Basket forecasting error**: An adjustment for historical trends in forecasting error by Global Insight [3]

3- **HSCRC Policy Adjustment**: In past years, the HSCRC Update has contained either a reduction to trend as a means of constraining revenue growth and hospital cost growth (productivity factor), or additions to trend to help improve the financial condition of the hospital industry.

[2] The market basket forecasts are developed on a quarterly basis by Global Insight Inc. (GI) under contract with the Center for Medicare and Medicaid Services (CMS). Updates to the market basket are available on a quarterly basis (lagged one quarter) with historical data also being updated at this time. Global Insight Inc. is a respected economic forecasting firm with the detailed macroeconomic and industry knowledge and expertise needed to forecast the price series used in the market basket. The forecasts are available for a 10-year period.

[3] Because many of the current payment systems adjust payments on a prospective basis, the market basket increases used in those updates are a forecast of what those increases will be. The actual market basket increase for a given period can be higher or lower than the forecasted increase available at the time a payment update is determined. This phenomenon is commonly known as forecast error. For example, in the spring of 2010, the HSCRC was required to forecast the market basket increase for fiscal year 2011. The actual change in the market basket for FY 2011 may be higher or lower than what we forecasted in the spring of 2010 depending on market conditions.

4- **Rate Slippage**: This component is an estimate of deviations from approved revenue growth as a result of other features of the rate setting system – such as rate increases granted individual hospitals, the impact of "Spend-down" agreements, or other factors.

5- **Case mix Allowance:** An allowance or limit on annual increases in measured additional resource use due to increase in measured patient severity of illness.

6- **Volume Adjustment**: Commission policy regarding recognition of fixed and variable components of hospital cost. Current Commission policy is to recognize hospital costs as 85% variable.

Additional Adjustments: Current HSCRC policy also calls for the "revenue neutral" scaling of hospital position on the approved Reasonableness of Charges (ROC) comparison and allocation of rewards and penalties related to performance on the HCSRC's Quality-Based Reimbursement (QBR) and Maryland Hospital Acquired Conditions (MHAC) initiatives.

In addition to information pertaining to the elements of both a 1-year and a 3-year update, the Commission staff requested that the submitted proposals also address each of the following questions/issues:

1 – **Scaling of ROC**: What magnitude (either dollar amount or percentage of approved revenue) should be devoted to the Commission's scaling based on hospitals' relative position on the FY 2010 ROC analysis;

2- **Scaling of Quality Initiatives**: What magnitude (either dollar amount or percentage of base revenue) should be devoted to the Commission's two quality initiatives (Quality-Based Reimbursement evidence based process measures and Maryland Hospital Acquired Conditions), and how should this magnitude be split between each initiative;

3 – **Specialty Hospital Update**: A proposed structure of the update applying to specialty (psychiatric, rehabilitation, and chronic) hospitals in the system (should it be the same or different from the overall FY 2011 update for the acute care hospitals);

4 –If a proposed 3-year arrangement is formula-based, parties were requested to provide a description of that formula and a list of all salient data sources used to calculate that formula.

5 – Other recommended action that might be related to the FY 2011 update factor.

Update Proposals from Hospitals and Payers

Maryland Hospital Association Proposal: The MHA chose to submit a one-year rate proposal only due to "current uncertainty regarding national health care reform discussions, the State's budget situation, as well as expected discussions over the next year on the development of a modernized vision for Maryland's Medicare wavier and future payment system" (the MHA Proposal). Staff has slightly modified the original MHA Proposal for purposes of comparability. This proposal is shown in **Table 3** below.

Table 3
Hospital One-Year Payment Update Proposal (no three-year proposal submitted)

Staff's Modified MHA 1 Year Proposal "all inclusive"

	67.98% Inpatient	32.02% Outpatient	Total
Staff's calc MB	2.20%	2.20%	2.20% (1)
Forecast Error	0.44%	0.44%	0.44%
Policy Adjustment	0.10%	0.10%	0.10%
Subtotal	2.74%	2.74%	2.74%
Staff calc Slippage	0.03%	0.03%	0.03% (2)
Volume Adjustment	-0.20%	-0.84%	-0.40%
Case Mix Limit or Actual	1.00%	1.00%	1.00% (3)
Total Update	3.57%	2.93%	3.37%

First year of Staff's Modified MHA 3 Year Proposal "all inclusive"

	67.98% Inpatient	32.02% Outpatient	Total
Staff's calc MB			
Forecast Error			
Policy Adjustment	MHA did not submit a 3 year Proposal		
Subtotal			
Staff calc Slippage			
Volume Adjustment			
Case Mix Limit or Actual			
Total Update			

Notes: (1) Staff calculated Market Basket Update based on GI Book
(2) Staff estimate of slippage
(3) Staff estimate of Outpatient Case mix growth (unconstrained)
These amounts differ from the original MHA submission

Explanatory Notes To the Tables and MHA Proposal: Staff notes that the MHA Proposal contains an adjustment for "forecasting error" of the Global Insight Market Basket. This forecasting error is based on deviations from actual final inflation over the past five years. Additionally, in their original submission, the MHA showed a combined Policy and Volume adjustment. For purposes of comparability, HSCRC staff has segregated these two components in the table above. Finally, MHA has proposed a 1.0% case mix limitation on inpatient Charge per Case (CPC) with no limitation on outpatient case mix. FY 2011 is expected to be the initial measurement year for the Commission's new Charge per Visit (CPV) methodology (the per-visit bundled payment system covering most hospital clinic, emergency room, and ambulatory surgery visits). Staff expects some case mix increase associated with the implementation of the CPV. Additionally, outpatient services not covered by the CPV are likely to generate increased revenues for the hospital. While the MHA is not proposing a "cap" on CPV case mix growth, in order to reflect what MHA has described as an "all-inclusive" proposal, staff has included its estimate of 1.0% case mix growth for outpatient case mix for FY 2011.

MHA's Additional Adjustments: The MHA did not respond to the staff's request for recommended update magnitudes for specialty hospitals (chronic, private psychiatric, and other), or recommended magnitudes to be scaled related to ROC position; Quality-based Reimbursement (QBR) and Maryland Hospital Acquired Conditions (MHACs).

Other MHA Observations: In developing the hospitals' proposal, the MHA thought it important to differentiate between the approved HSCRC Update for FY 2010 and what Maryland hospitals actually will receive in the way of increased revenue for the year. The Board of Public Works (BPW) required Medicaid hospital payment reductions of over $27 million during the course of FY 2010. These amounts were realized

through a direct remittance by hospitals of these funds to the Department of Health and Mental Hygiene (DHMH) in lieu of actual reductions to Medicaid payment. Additionally, the MHA wished to highlight the prospective adjustment to hospital Uncompensated Care (UC) provisions in FY 2010 related to recent Medicaid eligibility expansions. These adjustments reduced hospital UC provisions by a collective 0.75% for "averted uncompensated care" resulting from the expected increases in individuals becoming insured through the Medicaid program. The MHA believes that these two adjustments to hospital revenues resulted in "near-zero growth in reimbursement rates so far for this year." The MHA proposal is included in **Appendix 1** to this document.[4]

Payer Representatives' Proposals: Representatives from United Health Care, CareFirst & Kaiser Permanente, AmeriGroup, DHMH, and the State Health Employee Benefit Program collectively submitted both a one-year and a three-year proposal (the Payer Proposal). Again, staff presents a slightly modified version of the Payer Proposal for purposes of comparability. The Payer Proposal contained many more elements than the MHA proposal and, thus, requires more explanation. This proposal is summarized in **Table 4** and **Table 5** below. The detailed provisions of the proposal are also discussed in the section that follows.

Table 4
Payer One-Year Payment Update Proposal & First Year of Three-Year Proposal

Payer 1 year Proposal "all inclusive"

	67.98% Inpatient	32.02% Outpatient	Total
Staff's calc MB	2.20%	2.20%	2.20% (1)
Forecast Error	0.00%	0.00%	0.00%
Policy Adjustment	-2.20%	-2.20%	-2.20%
Subtotal	0.00%	0.00%	0.00%
Staff calc Slippage	0.03%	0.30%	0.12% (2)
Volume Adjustment	-0.20%	-0.84%	-0.40%
Case Mix Limit or Actual	1.00%	1.00%	1.00%
Total Update	0.83%	0.46%	0.71%

First Year of Payer 3 year Proposal "all inclusive"

	67.98% Inpatient	32.02% Outpatient	Total
Staff's calc MB	2.20%	2.20%	2.20%
Forecast Error	0.38%	0.38%	0.38%
Policy Adjustment	-1.90%	-1.90%	-1.90%
Subtotal	0.68%	0.68%	0.68%
Staff calc Slippage	0.03%	0.30%	0.12% (2)
Volume Adjustment	-0.20%	-0.84%	-0.40%
Case Mix Limit or Actual	1.00%	1.00%	1.00% (3)
Total Update	1.51%	1.14%	1.39%

Notes: (1) Staff calculated Market Basket Update based on GI Book
(2) Staff estimate of slippage (Payer estimate of O/P pass throughs)
(3) Payor proposal to constrain Inpatient and Outpatient Case mix
(1) and (2) amounts differ from the original Payer submission

[4] While the State has experienced difficulty in reconciling the expected impact of expanding Medicaid eligibility with associated uncompensated care changes, the prospective reductions to hospital UC provisions will be reconciled for FY 2010 in FY 2011. There may be a temporary cash flow impact for hospitals, but the ultimate reconciliation process will account for both one-time and permanent revenue adjustments and, thus, make all hospitals "whole" for these prospective adjustments. Thus, the averted bad debt adjustments will not result in net revenue declines for Maryland hospitals.

Table 5

Payer Three Year Rate Update Proposal

Payer - Proposed Update Factor

Rate Years Ending June 30, 2011, 2012, and 2013

	Year 1 of 3 Year Deal			Year 2 of 3 Year Deal			Year 3 of 3 Year Deal			
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total	
Global Insight's Market Basket	2.20%	2.20%	2.20%	2.77%	2.77%	2.77%	2.77%	2.77%	2.77%	Note 1
Adjustment to Inflation (if any)	0.38%	0.38%	0.38%	0.29%	0.29%	0.29%	0.29%	0.29%	0.29%	Note 7
Subtotal Inflation Allowance	2.58%	2.58%	2.58%	3.06%	3.06%	3.06%	3.06%	3.06%	3.06%	
Policy Adjustment (Improvement to US)	-1.90%	-1.90%	-1.90%	-1.87%	-1.87%	-1.87%	-1.87%	-1.87%	-1.87%	Note 5
Subtotal Update	0.68%	0.68%	0.68%	1.19%	1.19%	1.19%	1.19%	1.19%	1.19%	
Slippage For RY 2010	0.03%	0.30%	0.12%	0.10%	0.10%	0.10%	0.10%	0.10%	0.10%	Note 6
Rate Update Provided	0.71%	0.98%	0.80%	1.29%	1.29%	1.29%	1.29%	1.29%	1.29%	
Volume Adjustment (RY 2010 over RY 2009)	-0.20%	-0.84%	-0.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	Note 2
CMI Adjustment (Lower of Actual or Limit)	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	Note 3
Full Update Provided	1.51%	1.14%	1.39%	2.29%	2.29%	2.29%	2.29%	2.29%	2.29%	
Estimated Volume Increase (RY 2011)	1.33%	5.59%	2.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	Note 4
Estimated Revenue Change (RY 2011)	2.86%	6.80%	4.09%	2.29%	2.29%	2.29%	2.29%	2.29%	2.29%	
Gross Revenue from FS Schedules	$8,864,256.0	$4,175,516.7	$13,039,772.7							
Rate Year Ending June 2009	67.98%	32.02%	100.00%							
Admissions/EIPA's RY June 2009	702,640	330,979	1,033,619							
Admissions/EIPA's RY June 2008	693,412	313,444	1,006,856							
Percent Change	1.33%	5.59%	2.66%							
Fixed Cost Factor	15.00%	15.00%	15.00%	25.00%	25.00%	25.00%	25.00%	25.00%	25.00%	

Note 1: Market Basket estimates in spreadsheet reflect current Global Insights' projections for RY 2011 and RY 2012. Final update each rate year will be based on 1st quarter book for prior calendar year.

Note 2: 15% of estimated volume change for RY 2010 over RY 2009; 25% of estimated volume change for RY 2011 over RY 2010, and for RY 2012 over RY 2011.

Note 3: Payor proposal allows for additional 0.25% growth in CMI if volume does not grow.

Note 4: Estimated increase to revenue for volume change that will occur for RY 2011 over RY 2010.

Note 5: Improvement to U.S. is 2.27% per year for each of the 3 years, subject to annual reestimation to get to 6.0% below nation in NPR.

Note 6: To be calculated by HSCRC staff. Any difference from 0.10% will be offset through the rate update factor.

Note 7: To be calculated by HSCRC staff as new numbers become available.

Explanatory Notes to the Tables: Staff notes that the Payer Proposal contains an adjustment for "forecasting error" of the Global Insight's Market Basket. This forecasting error is based on deviations from actual final inflation over the past three years. Additionally, the Payers have proposed a 1.0% case mix limitation on inpatient Charge per Case (CPC), and a 1.0% limitation on outpatient case mix growth based on the CPV methodology. Additionally, the Payers reflect 0.3% "slippage" under their outpatient proposal to account for expected increases in volume and revenues associated with outpatient services not covered by the HSCRC's CPV methodology. The Payers believe it is important that the Commission implement the CPV on July 1, 2010 to include, at least, Emergency Department, Clinic and Ambulatory Surgery services and add radiation therapy and pharmico/chemotherapy services to the CPV as quickly as possible.

Preference for a three-year arrangement: The Payers indicated a very strong preference for a three-year agreement because of the stability/predictability associated with a multi-year arrangement and the ability to set a system cost target for the end of three years. This predictability was seen as helpful for both public and private payers' budgeting and premium setting activities. Additionally, the Payers note that hospitals will have more of an ability to reduce costs under a three-year arrangement given that they will know further in advance the constraints that they will be facing over the coming three years.

Description of the Proposed Three-Year Arrangement: The Payers believe the HSCRC should abandon its focus upon Net Operating Revenue (NOR) and return to focusing upon Net Patient Revenue (NPR). This recommendation is based on a belief that NPR, unlike NOR, relates directly to HSCRC rate regulation.

The Payer three-year proposal is predicated on a target for NPR per EIPA that is equal to 6% below the national average. This target was derived based on what the Payers believe is demonstrably achievable by the Maryland hospital industry given the performance of a cohort of hospitals nationally who have lowered their costs to approximately this level in the face of high financial pressure from public and private payers.[5]

To achieve the targeted position of 6% below the U.S. average in NPR per EIPA, Maryland must outperform (grow more slowly than the U.S.) by 2.27% per year over the next three years. The proposal then describes a methodology for the calculation of annual Update Factor for the years FY 2011, FY 2012, and FY 2013 that accomplishes this goal (a detailed explanation of the proposed formula determining these Updates is contained in Appendix 2).[6]

Adjustments to Volume Adjustment and Case Mix and Volume: This Proposal includes a volume adjustment per Commission policy of 85% in FY 2011, but changes this adjustment to 75% variable cost recognition in FY 2012 and FY 2013. The Proposal also describes the method for calculating allowed case mix change and recommends some allowance for higher than 1.0% case mix in the event that hospitals reduce admissions and overall volume in the system. Case mix would be set at 1% each year; however, if reported case mix is less than 1%, the following year's Update will be larger than otherwise. If overall volume falls, as measured by case mix adjusted EIPAs, the hospitals should get an additional 0.25% for case mix, and the proposed targets would be adjusted so that additional dollars would be added to the system. The same would be true for any overall positive adjustment under the variable cost adjustment.

The Payers also indicate their concern over the reporting of case mix data and suggest that the HSCRC add money to finance a competitive bid for an independent audit of case mix reporting.

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[5] MedPAC (see p. 88 of its 2009 Data Book) shows that hospitals facing high financial pressure have standardized costs that are below those facing medium financial pressure, while hospitals with low financial pressure have even higher costs. Using hospital weighting, if all hospitals had the standardized costs of the hospitals facing high financial pressure, hospital costs nationally would be 6.1% lower.

[6] This target of moving the Maryland system to a position of 6% below the U.S. on the basis of NPR/EIPA is also predicated on the assumption that Maryland's proportion of one-day stay cases will also similarly reflect the proportion of one-day stay cases nationally.

Description of the Payers' One-Year Proposal: For one year, the payers propose a 0% update. They believe that "if, in fact, the system is in such disarray or crisis that we cannot prudently plan for three years, then we should freeze the update." When case mix, slippage, and volume adjustments are taken into account, the increase in RY2011 would be approximately 0.7%.

Scaling for QBR and MHACs: The Payers believe that the adjustments for quality measures, including the QBR and MHACs, should be revenue neutral, but yet include incentives that will influence future behavior. They believe more emphasis should be given to Potentially Preventable Admissions, including readmissions (PPAs), which we believe will have a greater quality and financial impact, and propose a pool of 0.5% for the QBR, 0.5% for the MHAC adjustment, and 1.0% for the PPA program in 2011, all increasing by 0.5% a year in 2012 and 2013.[7]

Waiver "Trip-Wire": The Payers propose a waiver trip wire that is based on the HSCRC staff's forecasted waiver position after agreed upon technical corrections are accomplished. Under this structure, Commission action to reduce rates would occur if the forecasted waiver cushion were projected to be less than 7% at the end of the three-year agreement. Staff would provide a revised waiver forecast through 6/30/13 each quarter after a new waiver letter is received.

Recommended Rate Review of Chronic Care Hospitals: In response to the staff request to propose an Update for specialty hospitals, the Payers expressed reluctance to suggest a precise Update factor in the absence of data on case mix, payer mix, volume change, and profitability of these hospitals. The Payers did, however, indicate concern regarding the level of approved rates at the chronic hospitals. They recommended that the HSCRC undertake a comprehensive review of chronic hospital rates relative to the rates of comparable services at non-chronic hospital providers (particularly for Vent and Rehabilitation patients treated at Skilled Nursing Facilities) and the appropriateness of admissions resulting from transfers between acute and chronic hospitals. Finally, the Payers expressed concern regarding the "weaning" rates of vent patients in both acute and chronic facilities. This also is a recommended topic of review for the HSCRC.

Recommendation to Identify and Pursue "Game Changers": The Payers believe that both hospital and overall health care costs are much too high. While the moderation of growth rates may be helpful in stemming this tide, what is needed, according to the Payers, are so-called "Game Changers." Accordingly, the Payers recommend that during the three year rate cycle, a standing group of hospital and payer representatives and HSCRC Staff should be meeting regularly to identify and recommend the implementation of Game Changers, that is, initiatives that will materially reduce the cost of providing quality health care, by changing the way services are delivered by volume, by location, by personnel, by time, by modality, etc. Moreover, the payers are fully committed to sharing any resulting gains with the hospitals. Part of this strategy may well be encouraging hospitals, or health systems, to adopt the Total Patient Revenue (TPR) constraint. [8]

The Payer proposal is included in **Appendix 2** to this document.

Payer and Hospital Proposals Compared

The following tables present a comparison of the Payer and MHA one-year proposals as well as the first year of the Payer three-year proposal and the MHA proposal. The Commission will note there is a

[7] While the HSCRC is currently developing a methodology for linking the performance on potentially preventable re-admissions (PPRs) to payment incentives, this methodology was not contemplated to be associated with the FY2011 payment update. Staff, however, intends to present a recommendation linking PPR performance by hospital to payment incentives in the FY 2012 Update.

[8] Staff also similarly proposed pursuing methods to expand the number of hospitals operating under the TPR global budgeting system. The staff proposal is presented in **Appendix 3** to this recommendation.

large difference between these two proposals (although this difference is narrower than the starting positions of the two parties in the previous year's Update negotiation).

Table 6
Detailed Comparison of MHA and Payer One-Year Proposals and First Year of Payer Three-year Proposal

Staff's Modified MHA 1 Year Proposal "all inclusive"

	67.98% Inpatient	32.02% Outpatient	Total
Staff's calc MB	2.20%	2.20%	2.20% (1)
Forecast Error	0.44%	0.44%	0.44%
Policy Adjustment	0.10%	0.10%	0.10%
Subtotal	2.74%	2.74%	2.74%
Staff calc Slippage	0.03%	0.03%	0.03% (2)
Volume Adjustment	-0.20%	-0.84%	-0.40%
Case Mix Limit or Actual	1.00%	1.00%	1.00% (3)
Total Update	3.57%	2.93%	3.37%

Payer 1 year Proposal "all inclusive"

	67.98% Inpatient	32.02% Outpatient	Total
Staff's calc MB	2.20%	2.20%	2.20% (1)
Forecast Error	0.00%	0.00%	0.00%
Policy Adjustment	-2.20%	-2.20%	-2.20%
Subtotal	0.00%	0.00%	0.00%
Staff calc Slippage	0.03%	0.30%	0.12% (2)
Volume Adjustment	-0.20%	-0.84%	-0.40%
Case Mix Limit or Actual	1.00%	1.00%	1.00%
Total Update	0.83%	0.46%	0.71%

First year of Staff's Modified MHA 3 Year Proposal "all inclusive"

	67.98% Inpatient	32.02% Outpatient	Total
Staff's calc MB			
Forecast Error			
Policy Adjustment	MHA did not submit a 3 year Proposal		
Subtotal			
Staff calc Slippage			
Volume Adjustment			
Case Mix Limit or Actual			
Total Update			

First Year of Payer 3 year Proposal "all inclusive"

	67.98% Inpatient	32.02% Outpatient	Total
Staff's calc MB	2.20%	2.20%	2.20%
Forecast Error	0.38%	0.38%	0.38%
Policy Adjustment	-1.90%	-1.90%	-1.90%
Subtotal	0.68%	0.68%	0.68%
Staff calc Slippage	0.03%	0.30%	0.12% (2)
Volume Adjustment	-0.20%	-0.84%	-0.40%
Case Mix Limit or Actual	1.00%	1.00%	1.00% (3)
Total Update	1.51%	1.14%	1.39%

Notes: (1) Staff calculated Market Basket Update based on GI Book
(2) Staff estimate of slippage
(3) Staff estimate of Outpatient Case mix growth (unconstrained)
These amounts differ from the original MHA submission

Notes: (1) Staff calculated Market Basket Update based on GI Book
(2) Staff estimate of slippage (Payer estimate of O/P pass throughs)
(3) Payor proposal to constrain Inpatient and Outpatient Case mix
(1) and (2) amounts differ from the original Payer submission

Table 7
Current Ranges of Proposed Updates

One-Year Update Proposals:

	Inpatient	Total
MHA	3.57%	3.37%
Payer	0.83%	.071%
Difference	2.74%	2.65%
Dollar magnitude	$253 million	$361 million

Three-Year Update Proposals:

	Inpatient	Total
MHA	NA	NA
Payer	1.51%	1.39%
Difference	2.74%	2.65% (Difference between MHA one-year and Payer first year of three-year)
Dollar magnitude	$190 million	$268 million

Environmental Factors Impacting on Rate Update Decision

There are a number of environmental factors that the Work Group will be considering during its deliberations and negotiations regarding the FY 2011 Update factor. A discussion of these environmental factors both in this recommendation and during public deliberations before the HSCRC may be helpful to the Commission in its formulation of a motion and final action on the FY 2011 Update. The key environmental factors being considered are: 1) recent and current hospital financial performance; 2) recent and projected performance of the Rate Setting System on the Medicare Waiver Test; 3) the impact of the various Update Proposals in the context of recommended FY 2011 cuts to Medicaid payments; and 4) the relative affordability and efficiency of Maryland hospitals vs. hospitals nationally.

Hospital Financial Performance: With the approval of a lower than usual rate Update for FY 2010 Maryland hospitals have responded by lowering their cost growth, as has been the case in the past. As a result operating performance in 2010 is generally stable.

In general, the operating performance of Maryland hospitals has improved since FY 2003 and remained steady in recent years with some slight deterioration in 2008 (based on an analysis of 41 June Year End hospitals) but an improvement in FY 2009 (based on an analysis of 40 June Year End hospitals). This deterioration was primarily related to an increase in losses hospitals experienced on their unregulated portions of their business.[9] **Table 8a** shows that while regulated operating margins improved slightly in FY 09 over FY 08 (5.86% regulated operating margin in FY 09 vs. 5.63% in FY 08), losses on unregulated services increased from -28.9% in FY 08 to -32.9% in FY 2009. This deterioration in unregulated profits (which was driven primarily by growing losses on physician subsidies and physician practices) accounted for all of the deterioration in total operating margin. Had unregulated losses (and physician losses) remained at FY 08 levels, overall operating margins in FY 09 would have improved over FY 08 (also shown in **Table 8a**).

Table 8a
Comparison of 'FY 2009 vs. FY 2008 Profitability

	FY 2008 June YE Hospitals			FY 2009 June YE Hospitals		
	Regulated	Unregulated	Total	Regulated	Unregulated	Total
Operating Profits	5.63%	-28.86%	**2.63%**	5.86%	-32.88%	**2.44%**
				5.86%	-28.86%	**2.80%** *

* Had Unregulated profit (loss) remained constant Operating margins in 09 would have been higher = 2.80%

Table 8b
Comparison of FY 2010 vs. FY 2009 Profitability (YTD)

	FY 2009 Unaudited Financials	FY 2010 Unaudited Financials
	Last Year 6 months YTD December, 2008	This Year 6 months YTD December, 2009
Operating Profit	**2.02%**	**2.04%**

Operating Profits are level 6 months 2009 vs. 2008

Note: Operating profits are in line with the same period (6 months through December) last year. However, while uncompensated care has decreased by 0.35% of gross revenue, approved differentials and other deductions to revenue which includes denials have increased by 1.1%. Therefore, profits would have been higher if this had not occured.

Staff also examined year-to-date unaudited financials for 6 months ending December of FY 2010 vs. the same period in FY2009. Although unaudited data tend to closely track overall year-end performance – the allocation

[9] Unregulated losses are largely losses on physician services but also include other non-hospital lines of business.

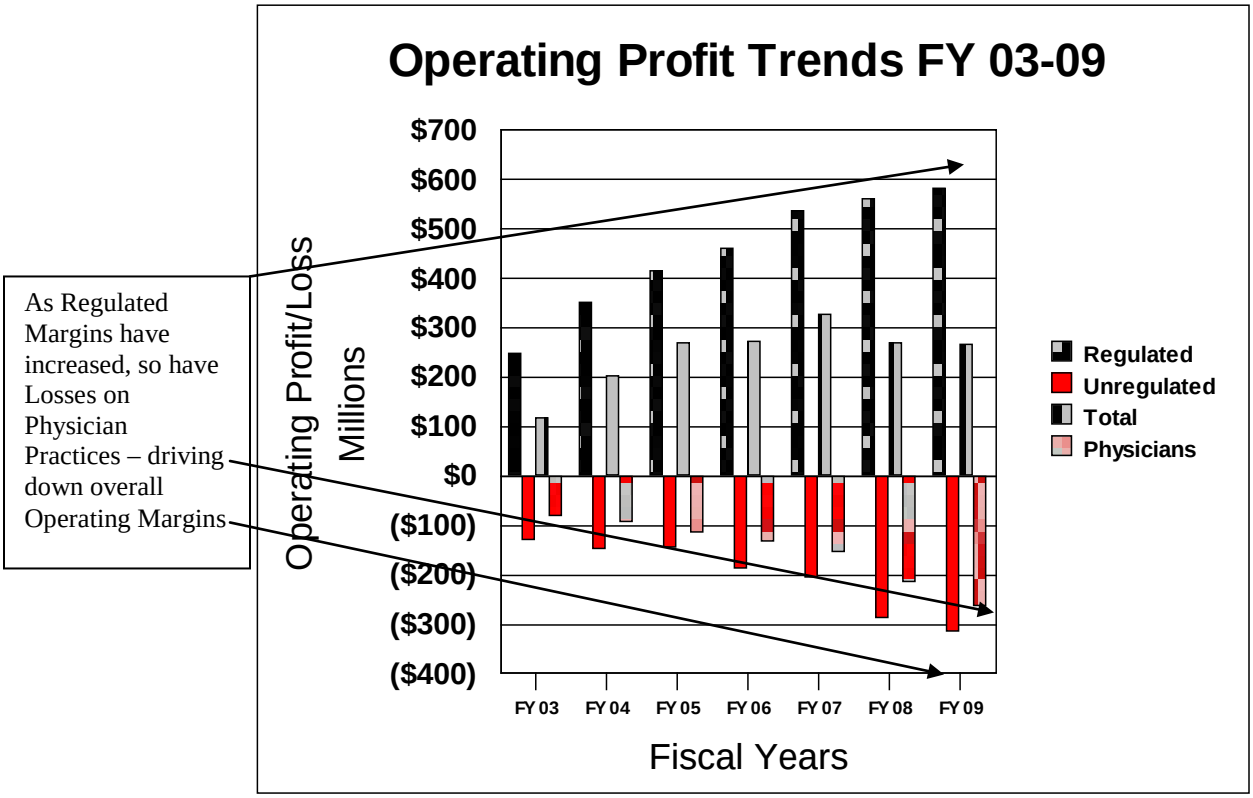
between regulated and unregulated revenues and expenses tends to be less accurately reported. The picture for FY 2010, however, seems to show steady overall financial performance by Maryland hospitals this year, despite facing a very restrictive Update factor in FY 2010 (overall operating margins – both regulated and unregulated were 2.02% in FY 09 six months year-to-date vs. 2.04% for the same period in FY 10). These results are shown in **Table 8b** above.

Rapidly Growing Losses on Physician-related Services: Growing losses on unregulated services, and specifically physician related losses, however, appear to be the largest impediment to overall hospital profitability in recent years, and this negative trend seems to be accelerating. **Table 9** and **Chart 2** present data on regulated, unregulated, physician-related, and overall profits/losses on operations from FY 2003 to FY 2009. Over this period, overall unregulated losses have more than doubled in dollar terms, while physician losses have more than tripled (thus accounting for a growing percentage of unregulated loss). These growing overall unregulated losses are largely responsible for the flattening of overall operating margins. **Chart 2** seems to show that as regulated margins have increased over time with more generous rate action, hospitals have used surplus funds from regulated services to subsidize their physician lines of business.

Table 9
Trends in Regulated Profits, Unregulated Losses (including physician losses) Total Profits

	Regulated	Unregulated	Total	Physicians
FY 03	$249,007,000	($131,180,600)	$117,826,400	($81,032,000)
FY 04	$351,315,618	($149,658,021)	$201,657,597	($94,043,000)
FY 05	$415,220,488	($146,099,505)	$269,120,983	($114,511,000)
FY 06	$461,509,193	($188,139,753)	$273,369,440	($134,415,700)
FY 07	$536,175,979	($207,068,523)	$329,107,456	($154,003,200)
FY 08	$561,065,925	($290,264,092)	$270,801,833	($217,346,000)
FY 09	$582,261,100	($316,288,700)	$265,972,400	($263,690,200)

Chart 2
Trends in Regulated Profits, Unregulated Losses (including physician losses) Total Profits



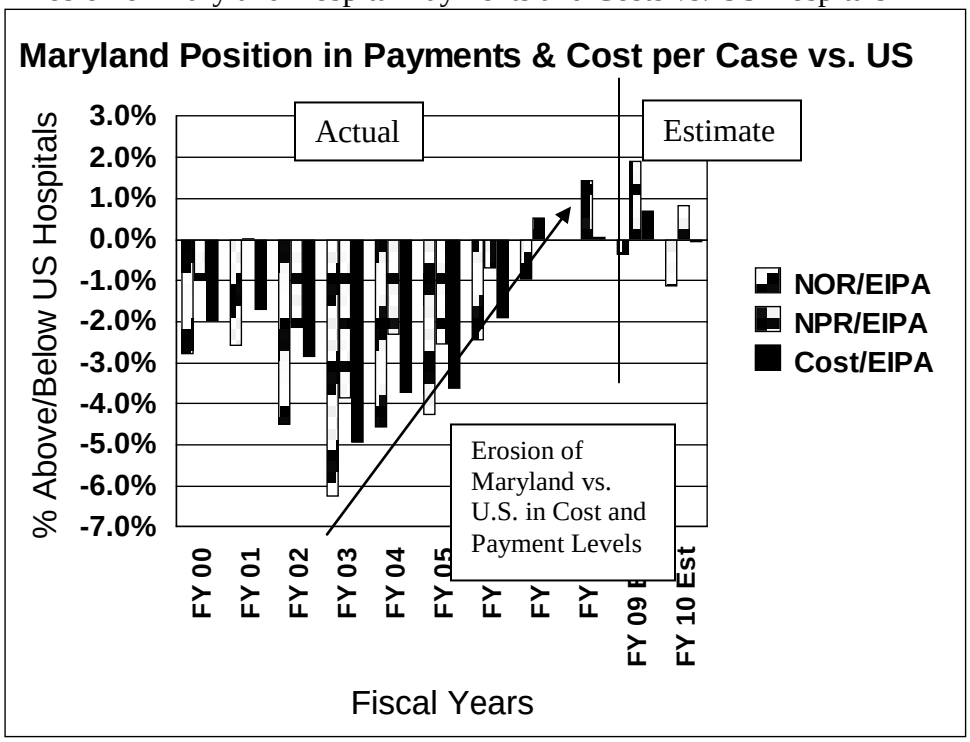
Non-Operating Margins: FY 2010 is also characterized by some recovery in hospital non-operating income and liquidity position of hospitals. While overall operating performance remained stable in FY 2009, hospitals (along with most other businesses) experienced large non-operating losses. These non-operating losses include both realized losses from investments (due largely to liquidated equity positions following the large declines in the equity market), unrealized losses from current investments, and large "mark-to-market" swap liabilities associated with interest rate swaps on the balance sheets of hospitals. The primary impact of these realized and unrealized losses in FY 09 was that they placed 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). The partial recovery in the non-operating position of hospitals and the narrowing of rate spreads have reduced the collateral requirements for hospitals in FY 2010 and have mitigated some of the liquidity pressure experienced in the previous year.

Relative Affordability of Hospital Care and Maryland's Cost Performance vs. the U.S.: General economic activity nationwide was in a state of "severe contraction" in FY 2009 with national GDP estimated to have declined significantly for much of FY 2009. While economic growth has started to recover, the severe economic downturn has pushed unemployment rates above 10% in recent months. 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. This dynamic is particularly pronounced in Maryland relative to the rest of the U.S. because hospital payments and costs have increased more rapidly here than in the rest of the country over the past 4-5 years. **Table 10 and Chart 3** below shows how Maryland hospital payment levels and costs have increased relative to payment levels and costs nationally.

Table 10
Erosion of Maryland Hospital Payments and Costs vs. US Hospitals

	Net Op. Rev Per EIPA	Net Pt. Rev Per EIPA	Cost Per EIPA
FY 00	-2.80%	-1.03%	-2.00%
FY 01	-2.60%	0.03%	-1.72%
FY 02	-4.51%	-2.18%	-2.86%
FY 03	-6.27%	-3.88%	-4.97%
FY 04	-4.59%	-2.32%	-3.76%
FY 05	-4.28%	-2.58%	-3.65%
FY 06	-2.46%	-0.71%	-1.92%
FY 07	-0.99%	0.53%	-0.01%
FY 08	-0.03%	1.42%	0.06%
FY 09 Est	-0.38%	1.90%	0.71%
FY 10 Est	-1.16%	0.82%	-0.07%

Chart 3
Erosion of Maryland Hospital Payments and Costs vs. US Hospitals



Trends in Hospital Input Cost Inflation: The economic slowdown, however, has also had the effect of curtailing the growth in factor costs (the cost of inputs to the production process). Wage growth nationally is flat, with many sectors starting to cut wages (in addition to layoffs and furloughs of employees). Flat or declining wages continue to create slack in the labor market, including the health care sector, which will help alleviate previous shortages of nurses and allied health professionals.

The current estimate (released in January 2010) for increases in hospital input costs (increases in the inputs to the hospital production process) in the coming fiscal year FY 2011 is 2.20%. 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 2.40%, while non wage items (accounting for 40% of hospital costs) were forecasted to grow at 0.87. These lower than normal trends in the inflation rate of hospital input costs have facilitated hospitals in maintaining relatively steady operating margins in FY 2010. **Table 11** summarizes the estimated increases in hospital input costs by category.

Table 11
Global Insights Market Basket Components (hospital input cost inflation FY 2011)

Global Insights Market Basket Components (hospital input cost inflation FY 2011)

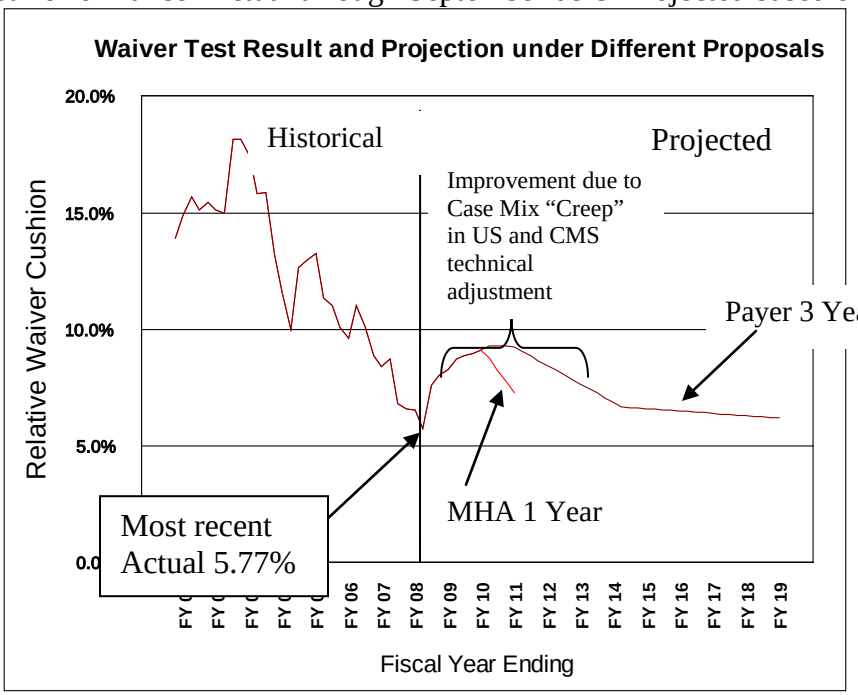
Category	% Increase	Weight
Compensation	2.40%	59.70%
Utilities	1.30%	2.10%
Professional Liability Insurance	-0.40%	1.40%
All Other Costs	2.30%	36.80%
Non-Capital Total	2.30%	
Capital	1.20%	
Weighted Cost inflation	2.20%	

Deterioration in Medicare Waiver: In recent years, the HSCRC has been concerned about unexpected deterioration in the rate system's performance on the Medicare Waiver Test. The deterioration in the test performance has continued through the quarter ending September 2008, when the relative test was at its all-time low level of 5.77% (if the relative test drops to 0%, the State will be determined to have failed the 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 costs of Uncompensated Care. Overall, the Medicare Waiver results in over $1 billion per year in enhanced federal reimbursements to Maryland hospitals. In the period FY 2001 – FY 2007, the relative test was in the 12-18% range.

It now appears that some of this unexpected erosion in the Waiver Test performance was due to the use of inaccurate data in the calculation of U.S. Medicare payments per case. In recent months HSCRC staff has been meeting with the CMS actuary regarding this inaccuracy and the actuary has agreed to a technical change that will result in an improvement in our relative cushion by 1.5%. While this is a favorable development, staff notes that even if the margin improves by this magnitude% (to 7.27%), this is still well below historical waiver margins, and, in staff's estimation, constitutes a perilously thin cushion given the specter of large future Medicare cuts. Staff further notes that Maryland's relatively high proportion of one-day length of stay cases (in Maryland, over 17% of inpatient admissions are 1 day length of stay vs. the 14% of all admissions nationally) may result in further deterioration in the Medicare waiver if some proportion of these one day admissions move to observation status.

Historical and projected Medicare Waiver Test performance is shown in **Chart 4**. The improvement in the projected test result shown in the period FY 08-10 is a result of two factors: 1) the technical correction to national data used in the calculation of the test; and 2) short term increases in Medicare hospital payments nationally as a result of anticipated increases in measured case mix nationally (Medicare's adoption of their "Severity-adjusted" Diagnostic Related Grouping system is expected to result in some level of so-called Case mix Creep over this period). Medicare, however, plans to recoup these case mix increases beginning in FY 2011 through a series of 0.66% reductions to the CMS update over a period of five years. All of these factors have been estimated (based on data received from the CMS actuary) and incorporated into the staff Waiver Test forecast. Staff has also attempted to incorporate the projected impact on our relative test performance of the MHA one-year proposal and the Payer three-year proposal (with similar magnitudes of update extended out through FY 2019).

Chart 4
Waiver Test Performance- Actual through September 08 & Projected based on Proposals



Significant State Budgetary Shortfalls: As discussed above, the Board of Public Works recommended additional Medicaid payment cuts in excess of $35 million in FY 2010. In the past, Medicaid payment savings have been achieved through the implementation of Medicaid Day Limits (limitations on payments to hospitals for Medicaid patients above some pre-determined threshold). An additional $10 million of Medicaid payment cuts (associated with the failure of last year's False Claims Act) were included in the Governor's supplemental budget. The Commission believes this approach is both a highly inefficient and inequitable method of achieving such savings. Because Medicaid is funded by both State and federal funds, a payment cut of over $117 million would be required to generate Medicaid General Fund savings of $45 million. These very high payment reductions would then have to be built into hospital UC provisions, which results in cost-shifts to all other payers. To avoid the loss of federal funds and in order to more equitably fund the required budget cuts, the HSCRC implemented a system of direct assessments and hospital remittances to achieve the required $45 million of savings.

The State of Maryland continues to face significant budgetary shortfalls. In response to the worsening budget situation, the Governor's budget allowance for FY 2011 assumes $123 million savings in Medicaid expenditures. Under a "payment cut" approach, a Medicaid payment reduction of $320 million would be required to generate the needed savings. While $123 million equates to approximately 5% of Medicaid hospital payments, $320 million is over 14% of Medicaid hospital payments. The HSCRC could not accommodate payment cuts of this magnitude (which would result in massive revenue reductions to hospitals and/or large increases in hospital UC and UC provisions and loss of federal funds).

Thus, a new challenge facing the Payment Work Group and the Commission in attempting to reach a consensus decision on an appropriate Update to hospital rates relates to how the rate system should best achieve the required targeted budget savings for FY 2011. As noted above, the FY 2010 BPW and Supplemental Budget cuts (totaling $45 million) were accomplished through a system of uniform assessments on hospital rates and direct (and additional fund) remittances directly from hospitals to DHMH. The generation of the assessed amounts and the remittances are to be accomplished over a period of six months. Thus, if these uniform percentages remain in place for 12 months, the current structure could finance $90 million of the required $123 million savings (leaving a balance of $33 million).[10]

The determination of the $123 million required savings related to Medicaid hospital payments was predicated on an assumed HSCRC hospital rate update of 2.84% for FY 2011. If the Commission adopts an Update that is below this assumed 2.84% level, additional savings (versus budgeted levels) will accrue to the Medicaid program.

Table 12 on the following page calculates the potential additional Medicaid "savings or dis-savings" resulting from the MHA one-year proposal, and the Payers' one-year and three-year proposals. Because the MHA one-year proposal is in excess of the budgeted 2.84% update factor presumed by the Department of Budget and Management (DBM), this proposal results in "dis-savings" of $6.7 million (it adds to the amount of cuts required to meet the Governor's $123 million savings requirement), leaving a balance of additional required savings of $39.7 million over and above the $90 million potentially generated through the assessment/remittance approach. Because the Payer three-year Update Proposal generates an update that is less than the presumed 2.84%, it would result in $18 million savings (relative to the DBM budget projection), leaving a balance of $14 million additional savings. The Payer one-year Update Proposal would generate a still lower Update in FY 2011, creating more savings for Medicaid relative to what was budgeted, leaving a balance of $6 million.
While representatives from DBM were clear that these budget considerations were not meant to drive the Update discussion process, the decision on the ultimate Update level for FY 2011 does have implications for the magnitude of cuts that must be implemented elsewhere in the System during the course of the year and, thus, are salient to the current discussions and negotiations.

[10] The allocation of the FY 2010 cuts were disproportionately targeted toward the hospitals because of the $10 million supplemental budget cut relating to the failure to enact the False Claims Act during the 2009 session of the Maryland General Assembly. Staff recommends that the Commission revisit this allocation when attempting to address the FY 2011 budget cuts.

Table 12
Impact of Different Update Proposals on Targeted Remaining Budget Savings

Estimated FY 2010 Hospital Revenue	$13,642,600,000
Medicaid Share	17.00%
Medicaid Est. Expenditures	$2,319,242,000
Impact of 0.1% reduction in update	$2,319,242
State Share	38.50%
State Savings for every 0.1% reduction in Update	$892,908
State Employee Benefit Program	2.75%
State Employee Benefit Program Hospital Expenditures	$375,171,500
Impact of 0.1% reduction in update	$375,172
State Share	100.00%
State Savings for every 0.1% reduction in Update	$375,172
Impact on State Expenditures for every 0.1% Reduction	$1,268,080
State Budget Forecasted Update	2.84%

Impact of each Year 1 Update on Targeted Budget Savings Required

	MHA 1 Year	1st year of MHA 3 Year	Payer 1 Year	1st year of Payer 3 Year
Hospital and Payer Proposed Updates	3.37%	NA	0.71%	1.39%
Budget Cut Implication	-0.53% Dissavings		2.13%	1.45% Savings
Savings (Dissavings)	($6,658,331)		$26,990,746	$18,367,804
Remaining Budget Savings to Generate (assuming FY 10 cuts over 12 months)	(1) **$39,658,331** Remaining Cuts Required		(2) **$6,009,254**	(3) **$14,632,196** Remaining Cuts Required

Any final action by the Commission on the FY 2011 Update Factor will need to identify ways in which the required $123 million in budgeted Medicaid cuts can be achieved (either through assessments/remittances, a lower than budgeted Update Factor, other initiatives, or a combination of all three approaches).

Staff Recommendations

This document represents the staff's attempt to provide the current range of proposals and salient environmental considerations that will weigh on the Commission as it works toward a final decision on the Update Factor for hospital rates in FY 2011. It is being provided as a draft recommendation in response to the Chairman's request to provide a draft recommendation that includes the current range of options and salient decision-making factors. It is intended to provide the basis for current discussion and deliberation at the Commission level and further discussion at the Payment Work Group level.

Current Ranges of Proposed Updates

One-Year Update Proposals:

	Inpatient	Total
MHA	3.57%	3.37%
Payer	0.83%	.071%
Difference	2.74%	2.65%
Dollar magnitude	$253 million	$361 million

Three-Year Update Proposals:

	Inpatient	Total
MHA	NA	NA
Payer	1.51%	1.39%
Difference	2.74%	2.65% (Difference between MHA one-year and Payer first year of three-year)
Dollar magnitude	$190 million	$268 million

The Payment Work Group will continue to meet during the next month, and staff will provide an updated draft recommendation to the Commission at the April 14th public meeting.

Appendix I – Hospital Proposal

MHA FY 2011 Payment Update Proposal – January 22, 2010

The Maryland Hospital Association (MHA) is pleased to submit the attached initial proposal for the hospital payment update for the fiscal year beginning July 1, 2010. As you will note from the attached proposed update, MHA will only be submitting a one-year update proposal this year. The current uncertainty regarding national health care reform discussions, the State's budget, as well as expected discussions over the next year on the development of a modernized vision for Maryland's Medicare waiver and future payment system, all contributes to our interest on focusing on the update for just the next year.

Prior to addressing the specifics of our proposed FY 2011 update, it is important that we differentiate between the update for FY 2010, and what Maryland's hospitals actually realized in the way of reimbursement increases during the current year. As the Commission is well aware, subsequent to the approved modest all-inclusive update of 1.77% for FY 2010, the Board of Public works required Medicaid payment reductions totaling $27 million. In addition the Commission has just prospectively reduced hospitals rates' statewide by 0.75% for averted uncompensated care related to the Medicaid expansion, despite the lack of timely and complete data from Medicaid, and the fact that current data appear to indicate no decline in hospitals' actual levels of uncompensated care. Thus, hospitals are actually seeing near-zero growth in reimbursement rates so far this year, as reflected on the attached spreadsheet for FY 2010.

With regard to the hospital field's proposed update for FY 2011 (attached), we would add the following comments:

1. The proposed inflation adjustment includes an adjustment for the average forecasting error over the past five years;
2. The slippage estimate reflects the approved rate relief associated with capital projects known to be coming on board in FY 2011;
3. The proposed Case-mix adjustment is exclusive of any adjustment that may be included as part of ongoing discussion on the Commission's proposed short stay policy; and,
4. We have proposed to combine the proposed volume and policy adjustment into one factor for this year's update.

We appreciate the opportunity to submit this initial recommendation for FY 2011, and look forward to our discussion of this initial proposal on February 1st.

Realized Update

Rate Year Ending June 30, 2010

	1 Year Deal		
	Inpatient	Outpatient	Total
Global Insight's Market Basket	1.59%	1.59%	1.59%
Adjustment to Inflation (if any)	0.00%	0.00%	0.00%
Subtotal Inflation Allowance	1.59%	1.59%	1.59%
Policy Adjustment	-0.10%	-0.10%	-0.10%
Subtotal Update	1.49%	1.49%	1.49%
CMI Adjustment (Lower of Actual or Limit)	0.50%	0.00%	0.34%
2009 Volume adjustment	-0.22%	0.28%	-0.06%
Original Approved Update	1.77%	1.77%	1.77%
Averted Uncompensated Care Rate Reduction	-0.75%	-0.75%	-0.75%
Board of Public Works Cuts	-0.21%	-0.21%	-0.21%
Realized update - FY 2010	0.81%	0.81%	0.81%

Proposed Update Factor

Rate Year Ending June 30, 2011

	1 Year Deal			
	Inpatient	Outpatient	Total	
Global Insight's Market Basket	2.19%	2.19%	2.19%	
Adjustment to Inflation (if any)	0.46%	0.46%	0.46%	Note 1
Subtotal Inflation Allowance	2.65%	2.65%	2.65%	
Volume/Policy Adjustment	-0.30%	-0.30%	-0.30%	
Subtotal Update	2.35%	2.35%	2.35%	
Slippage For RY 2010	-0.05%	-0.05%	-0.05%	
Rate Update Provided	2.30%	2.30%	2.30%	
CMI Adjustment (Lower of Actual or Limit)	1.00%	0.00%	0.68%	Note 2
Proposed all-inclusive update	3.30%	2.30%	2.98%	
Gross Revenue from FS Schedules	$8,864,256.0	$4,175,516.7	$13,039,772.7	
Rate Year Ending June 2009	67.98%	32.02%	100.00%	

Note 1: Represents 5-year average forecasting error in Global Insight's Market Basket

Note 2: Approximately 2/3 of most recent inpatient case-mix increase; excludes impact of potential changes in CMI due to One-day stay policy discussion

Maryland
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Global Insight Forecasts of Hospital Market Basket Inflation
January 15, 2010

Background: Global Insight's forecast of hospital market basket inflation is a component of the annual payment update. Global Insight projects hospital inflation up to three years ahead. Global Insight releases revised forecasts shortly after the end of each quarter. Actual inflation is reported after a six month lag. The hospital market basket is comprised of two components: capital and operating expenses. With the most recent forecast update, the weighting of the two components changed. Previously, the component weighting was based on 2002 actual data; the weighting is now based on 2006 actual data. The change in weighting changes the forecast by 0.13 percentage points.

The time period used in the payment update is the quarter corresponding to the rate year end. For example, for the July 2010 to June 2011 payment update, the inflation figure used is the projected inflation for the quarter ending June 2011, which Global Insight refers to as second quarter 2011. So, for the FY 2011 annual payment update, the second quarter 2011 time period is used. The most recent forecast for the second quarter 2011 is Global Insight's fourth quarter 2009 publication, released in early to mid-January 2010. In mid-April, Global Insight will release the first quarter 2010 forecast revision which can then be used in the final annual payment update. So, the first quarter 2010 forecast of the second quarter 2011 inflation is used in the annual update effective July 1, 2010 for rate year 2011. The most recent (fourth quarter 2009) forecast projects second quarter 2011 inflation at 2.32 % under the 2002 component weights and at 2.19% under the new 2006 weights.

Global Insight forecasts typically understate the final actual inflation. To understand the magnitude of the understatement, the following tables compare the first quarter forecast to the final actual inflation.

Inflation period (rate year end)	Forecast publication	Projected inflation	Actual inflation	Actual vs. projected
2004:2	2003.1	3.44%	3.52%	0.08%
2005:2	2004:1	3.06%	4.06%	1.00%
2006:2	2005:1	3.26%	3.92%	0.66%
2007:2	2006:1	3.36%	3.47%	0.11%
2008:2	2007:1	3.12%	3.67%	0.55%
2009:2	2008:1	3.11%	3.07%	-0.04%

Average Variance	
Six year	0.39%
Five year	0.46%
Four year	0.32%
Three year	0.21%

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Mr. Robert Murray
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Mr. Murray:

In response to your January 25th e-mail, the following are the hospital field's responses to your request for clarification regarding our initial update factor proposal submitted on January 22nd:

1. As stated in the narrative accompanying our proposal, the hospital field believes that given the number of issues that are currently under discussion with the payors and the Commission that remain unresolved, we feel that we cannot commit to a three-year proposal at this time. Included in these discussions are: the uncertain impact of potential changes related to the Commission's one-day stay proposal, reconciliations of averted uncompensated care, the availability of additional stimulus funds for the FY 2011 Medicaid budget, as well as the anticipated discussions regarding a modernized waiver and rate system, expected to be completed by November 2010. Thus, it is certainly very challenging to consider more than a one-year update proposal at this time given these uncertainties.
2. Attached please find a summary of the calculation of the 5-year forecasting error used in our initial proposal, using Global Insight's Market Basket data.
3. As our updated spreadsheet for FY 2010 highlights, the hospital field believes that it is important to recognize as a starting point for discussion that a number of policy decisions affecting our final rates have been made subsequent to the approval of the final update. With that in mind, the hospital field believes that these potential policy adjustments to rates needs to be limited, and recommends doing so by combining the volume and policy adjustments, with the combined policy and volume adjustment also designed to arrive at a desired overall update level.
4. The proposed inpatient case-mix allowance of 1% would recognize the use of the lower of actual case-mix increases or 1%. Now that the Charge Per Visit system has been put back on the table for FY 2011, we believe that the outpatient rates are already being controlled by the constraints of this new system and are not proposing any outpatient case-mix governor. We also believe that the outpatient case-mix cannot be addressed given the uncertainty of the one-day stay discussion and the impact of a separate outpatient observation rate on the calculation of the CPV.
5.
6. For both ROC scaling and the scaling of quality initiatives, the hospitals field is deferring any recommendation at this time. We are particularly concerned to ensure that for the quality-based initiatives, that the poorer-performing hospitals are provided with resources to make the necessary investment in performance improvement. Until we have a sense as to what the update factor will be for all hospitals, we will be unable to estimate what portion of that update should be set aside for those initiatives.
7. Update factor(s) for specialty hospitals will be addressed at a later date.

8. Over the past couple of years, a number of adjustments to hospitals' rates and/or reimbursement from payors have been made, subsequent to the approval of the update factor and hospitals' use of those update factors in their budget preparation. In FY 2009, a prospective rate adjustment of 0.38% was made for averted uncompensated care related to the Medicaid expansion, even though current data shows no decline in uncompensated care levels between 2008 and 2009. Furthermore, given Medicaid's budget problems, hospitals were asked to forego an expected increase of $11 million in working capital. For FY 2010, the averted uncompensated care was an even larger prospective adjustment of 0.75% on a statewide basis, and the Board of Public Works mandated a $27 million reduction to hospitals, which equates to an approximate 0.21% reduction in hospital reimbursement. In addition, as of this writing, no action has been taken on what we would estimate to be a potential increase of $29 million in Medicaid working capital based on the historic formula. These 2010 changes come on top of what was a historically lower than normal payment update. The hospital field believes that all of these post-negotiation adjustments need to be considered for a full understanding our initial one-year update factor proposal for FY 2011.

We look forward to further discussion of these items at our meeting on February 1st. If you have any questions, please do not hesitate to contact me at (443) 561-2030, or via e-mail at mrobbins@mhaonline.org.

Sincerely,

Michael B. Robbins
Senior Vice President, Financial Policy
Maryland Hospital Association

Attachment

Appendix II – Payer Proposal

PAYERS' PROPOSAL RY 2011-2013

The payers have a very strong preference for a three-year agreement. We prefer the stability associated with a three-year agreement, the ability to set a target for the end of three years and the predictability associated with a three-year agreement. Those payers who set premiums routinely set them well in advance of the coming rate year while those payers whose rates are set by the Federal or State government have those rates set well in advance of the coming rate year. Thus, a three-year agreement allows us to develop budgets and premiums with considerably more knowledge than if there is a series of one-year deals. Additionally, we believe the hospitals will have more of an ability to reduce costs if they know further in advance the constraints that they will be facing over the coming three years. We also note that the Commission successfully set three-year rate arrangements for the 9 years ending June 30, 2009. Many of the reasons for diverging from that successful past no longer are relevant and we urge a return to the three-year rate agreement.

We now address the elements of the three-year agreement we propose:

1. The HSCRC should abandon its focus upon Net Operating Revenue (NOR) and return to focusing upon Net Patient Revenue (NPR). While Net Patient Revenue is not exactly what the HSCRC regulates, it is much closer than NOR and does not suffer from the reporting issues surrounding NOR.

2. The HSCRC should set a target for NPR that is equal to 6% below the national average. The rate setting job of the Commission involves providing hospitals with the fiscal pressure that drives efficient delivery of the hospitals' mission. MedPAC (see p. 88 of its 2009 Data Book) shows that hospitals facing high financial pressure have standardized costs that are below those facing medium pressure and hospitals with low pressure have even higher costs. Using hospital weighting, if all hospitals had the standardized costs of the hospitals facing high financial pressure, hospital costs nationally would be 6.1% lower. That is why we set the efficiency target at 6% below the nation for NPR. That allows the same level of patient profits as is achieved nationally while having costs 6% below the national average.

3. Based upon AHA data published for 2008, Maryland increases in 2009 and 2010, and Colorado Data Bank reports through the first quarter of RY 2010, it is estimated that by the end of RY 2010, NPR for Maryland hospitals will be 0.82% higher than the national average. Therefore, to get to 6% below over three years, Maryland should beat the nation by 2.27% per year.

4. We propose the following model for projecting the national change in NPR during rate year 2011:

   Determine the average difference between the national increase in NPR in 2006, 2007 and 2008 (as developed by HSCRC staff) and the final measure of the market basket (M/B). Call this the NPR excess.

   Determine the average difference in the final market basket as determined by staff and the projection of the market basket in the prior year's 1st quarter projection for 2006, 2007 and 2008. Call this is the average M/B projection error.

5. Project the M/B for RY 2011 using the 1st quarter 2010 book and add the NPR excess and the average M/B projection error. This is the national NPR projection for RY 2011.

6. Project the M/B for RY 2011 by using 91.42% of GII's most currently based published operating cost M/B in the 1st quarter book and 8.58% for the most currently based published capital cost inflation. (The HSCRC has been using 91.12% and 8.88% based on the mix of non-capital and capital costs from many years ago. The payers believe the actual statewide capital percentage from the most current ROC should be used.)

7. The increase in NPR per case to be approved for 2011 is the national increase as developed in 5 and 6 less 2.27%.

8. For 2012 and 2013, the steps are repeated using one year updated data. In 2012, the amount approved below the national average would be one half, rather than one-third of the difference between Maryland's projected 2011 position and 6% below the average. In 2013, the adjustment would be that needed to get to 6% below after 2013 using the same projection model with another year's data. In applying each successive year's model, the Commission would assure that hospitals are not attaining the target simply through rate realignment, but through relative revenue reductions.

9. In each year, the approved increase in NPR is assigned among its various components as follows:

   a. Inpatient and outpatient slippage is as projected by HSCRC staff.
   b. There is an adjustment for volume based upon 85% variable cost in 2011 and 75% variable cost in 2012 and 2013.
   c. Case mix is set at 1% each year but if reported casemix is less than 1%, the following year's update will be larger than otherwise.
   d. If volume, as measured by financed casemix adjusted EIPAs, falls, the hospitals get an additional 0.25% for casemix and the target is

adjusted so that this is truly additional dollars. The same is true for any overall positive adjustment under the variable cost adjustment.

e. The update factor is the remaining approved increase in NPR after all the other adjustments are made.
f. As shown in the accompanying template, given current estimates, the overall increase in NPR for RY2011 is 1.41% and the update factor is 0.71%.

10. The payers are concerned about the reporting of CMI and suggest that the HSCRC add money to finance a competitive bid for an independent audit of casemix reporting.

11. The payers believe that, from a static standpoint, the adjustments for quality measures including Potentially Preventable Complications (PPCs or MHACs) should be revenue neutral but should have some incentives that will influence future behavior. We believe more emphasis should be given to Potentially Preventable Admissions, including readmissions (PPAs), which we believe will have a greater quality and financial impact. At this point, we are proposing a pool of 0.5% for the quality adjustment, 0.5% for the MHAC adjustment, and 1.0% for the PPA program in 2011, all increasing by 0.5% a year in 2012 and 2013.

12. The payers believe that Maryland hospitals have an excessive amount of 1 day stays largely driven by a reluctance on the part of some hospitals to provide observation services and a desire to take advantage of the rate capacity generated by excess one day stays. The 6% below the nation target for NPR is where Maryland should be while having the national average for one-day stays. Maryland needs to absorb the impact on NPR per case from reducing one-day stays. However, if the hospitals do this by lowering total admissions, we would raise the target as discussed in 9d above. Also, the casemix increase associated with eliminating one-day stays would be added to the casemix budget discussed above. Throughout the three years, hospitals with excessive one-day stays should have the rate capacity associated with those excessive stays removed.

13. It is very important that the Commission implement the CPV on July 1, 2010 to include at least Emergency Department, Clinic and Ambulatory Surgery services. Preferably on 1/1/11, but no later than 7/1/11, the Commission should add radiation therapy and pharmico/chemotherapy services to the CPV. In addition, we propose that transplants other than heart and lung transplants and that non-research oncology cases that are not now under the CPC be brought into the CPC. The more services that are under a revenue constraint, the better the incentives for cost containment and the less slippage will be.

14. There should be a waiver trip wire that looks to the forecasted waiver position after CMS makes the agreed to technical corrections. Action to reduce rates would occur if the forecasted waiver cushion were projected to be less than 7% at the end of the three-year agreement. Staff would provide a revised waiver forecast through 6/30/13 each quarter after a new waiver letter is received.

15. Health care costs in general, as well as hospital costs, are much too high. We really are experiencing a crisis in health care spending. Perpetuating the status quo is not appropriate. While moderating growth is better than not moderating growth, what we need are game changers. Accordingly, during the three year rate cycle, a standing group of hospital and payer representatives and HSCRC Staff should be meeting regularly to identify and recommend the implementation of game changers, that is, initiatives that will materially reduce the cost of providing quality health care, by changing the way services are delivered by volume, by location, by personnel, by time, by modality, etc. Moreover, the payers are fully committed to sharing any resulting gains with the hospitals. Part of this strategy may well be encouraging hospitals, or health systems, to adopt the Total Patient Revenue constraint.

16. The payers, by request of the HSCRC, are also making a one-year proposal. For one year, the payers propose a 0% update. If, in fact, the system is in such disarray or crisis that we can not prudently plan for three years, then we should freeze the update. When casemix, slippage and volume adjustments are taken into account, the overall increase in RY2011 would be 0.7%.

17. Staff asked that both parties indicate the increase that should apply to non-acute hospitals. We are reluctant to make such a recommendation unless staff provides information related to casemix, payer mix, volume change and profitability at such hospitals. We are very concerned about the rates at the chronic hospitals. Therefore, we recommend that beginning with rate year 2011, the HSCRC should have a substantially increased emphasis on regulated, non-acute hospitals. For example, the HSCRC should implement a substantial review of rates at the Chronic Hospitals, to ensure that rates are reasonably related to the costs of services offered at efficient providers. We believe that a review of Chronic Hospital Unit Rates, such as by analyzing Unit Rates in the context of rates and costs for comparable services at Non-Chronic Hospital settings (e.g., Vent and Rehab rates at skilled nursing facilities), will demonstrate that Chronic Hospital rates are substantially too high and/or that Chronic Hospitals are providing services that should be provided in lower cost settings if Chronic Hospitals' rates are not lowered dramatically. While most payers have moved / are moving services out of Chronic Hospitals, Medicare patients inappropriately remain in Chronic Hospitals, causing

deterioration on the Waiver Test. Additionally, we are concerned that there are volume and transfer issues related to the Chronic Hospitals (such as inappropriate and/or unnecessary hospital admissions), as a result of the relationships between Chronic Hospitals and Acute Hospitals. Therefore, the HSCRC should evaluate the appropriateness of admissions resulting from transfers between Acute and Chronic Hospitals. Finally, we believe Chronic Hospital vent patient weaning rates are another area of concern and that weaning rates and other quality measures are areas for evaluation.

DERIVATION OF 2011 NPR TARGET AND ALLOCATION AMONG CHARGE ELEMENTS

First year of three-year proposal:

Market Basket for 2011	2.21%**
Average M/B projection error	0.38%
Average NPR excess	1.09%
National NPR projection for 2011	3.68%*
Less improvement relative to nation	-2.27%** (1)
Proposed Maryland increase for 2011	1.41%*

Allocation:

Update	0.71%*
Slippage	0.10%**
Casemix	1.00%***
Volume adjustment	-0.40%**
Total	1.41%

** To be developed by staff as new numbers become available.
* To be developed through formula as new numbers become available
***1.25% if volumes fall
(1) Calculation of year 1 reduction

0.82%	Current projection for NPR above nation at 6/30/10
-6.00%	Target relative to nation
-6.82%	Required three-year reduction
/3	
=2.27%	First year reduction factor

One-year proposal:

Update	0.00
Slippage	0.10%**
Casemix	1.00%***
Volume adjustment	-0.40%**
Total	0.70%

Proposed Update Factor

Rate Years Ending June 30, 2011, 2012, and 2013

	Year 1 of 3 Year Deal			Year 2 of 3 Year Deal			Year 3 of 3 Year Deal			
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total	
Global Insight's Market Basket	2.21%	2.21%	2.21%	2.77%	2.77%	2.77%	2.77%	2.77%	2.77%	Note 1
Adjustment to Inflation (if any)	0.38%	0.38%	0.38%	0.29%	0.29%	0.29%	0.29%	0.29%	0.29%	Note 7
Subtotal Inflation Allowance	2.59%	2.59%	2.59%	3.06%	3.06%	3.06%	3.06%	3.06%	3.06%	
Policy Adjustment (Improvement to US)	-1.87%	-1.87%	-1.87%	-1.87%	-1.87%	-1.87%	-1.87%	-1.87%	-1.87%	Note 5
Subtotal Update	0.72%	0.72%	0.72%	1.19%	1.19%	1.19%	1.19%	1.19%	1.19%	
Slippage For RY 2010	0.00%	0.30%	0.10%	0.10%	0.10%	0.10%	0.10%	0.10%	0.10%	Note 6
Rate Update Provided	0.72%	1.02%	0.82%	1.29%	1.29%	1.29%	1.29%	1.29%	1.29%	
Volume Adjustment (RY 2010 over RY 2009)	-0.20%	-0.84%	-0.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	Note 2
CMI Adjustment (Lower of Actual or Limit)	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	Note 3
Full Update Provided	1.52%	1.18%	1.41%	2.29%	2.29%	2.29%	2.29%	2.29%	2.29%	
Estimated Volume Increase (RY 2011)	1.33%	5.59%	2.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	Note 4
Estimated Revenue Change (RY 2011)	2.87%	6.84%	4.11%	2.29%	2.29%	2.29%	2.29%	2.29%	2.29%	
Gross Revenue from FS Schedules	$8,864,256.0	$4,175,516.7	$13,039,772.7							
Rate Year Ending June 2009	67.98%	32.02%	100.00%							
Admissions/EIPA's RY June 2009	702,640	330,979	1,033,619							
Admissions/EIPA's RY June 2008	693,412	313,444	1,006,856							
Percent Change	1.33%	5.59%	2.66%							
Fixed Cost Factor	15.00%	15.00%	15.00%	25.00%	25.00%	25.00%	25.00%	25.00%	25.00%	

Note 1: Market Basket estimates in spreadsheet reflect current Global Insights' projections for RY 2011 and RY 2012. Final update each rate year will be based on 1st quarter book for prior calendar year.

Note 2: 15% of estimated volume change for RY 2010 over RY 2009; 25% of estimated volume change for RY 2011 over RY 2010, and for RY 2012 over RY 2011.

Note 3: Payor proposal allows for additional 0.25% growth in CMI if volume does not grow.

Note 4: Estimated increase to revenue for volume change that will occur for RY 2011 over RY 2010.

Note 5: Improvement to U.S. is 2.27% per year for each of the 3 years, subject to annual reestimation to get to 6.0% below nation in NPR.

Note 6: To be calculated by HSCRC staff. Any difference from 0.10% will be offset through the rate update factor.

Note 7: To be calculated by HSCRC staff as new numbers become available.

Proposed Update Factor

Rate Year Ending June 30, 2011

	1 Year Deal			
	Inpatient	Outpatient	Total	
Global Insight's Market Basket	2.21%	2.21%	2.21%	Note 1
Adjustment to Inflation (if any)	0.00%	0.00%	0.00%	
Subtotal Inflation Allowance	2.21%	2.21%	2.21%	
Policy Adjustment (Improvement to US)	-2.21%	-2.21%	-2.21%	
Subtotal Update	0.00%	0.00%	0.00%	
Slippage For RY 2010	0.00%	0.30%	0.10%	
Rate Update Provided	0.00%	0.30%	0.10%	
Volume Adjustment (RY 2010 over RY 2009)	-0.20%	-0.84%	-0.40%	Note 2
CMI Adjustment (Lower of Actual or Limit)	1.00%	1.00%	1.00%	Note 3
Full Update Provided	0.80%	0.46%	0.69%	
Estimated Volume Increase (RY 2011)	1.33%	5.59%	2.66%	Note 4
Estimated Revenue Change (RY 2011)	2.14%	6.08%	3.37%	
Gross Revenue from FS Schedules	$8,864,256.0	$4,175,516.7	$13,039,772.7	
Rate Year Ending June 2009	67.98%	32.02%	100.00%	
Admissions/EIPA's RY June 2009	702,640	330,979	1,033,619	
Admissions/EIPA's RY June 2008	693,412	313,444	1,006,856	
Percent Change	1.33%	5.59%	2.66%	
Fixed Cost Factor	15.00%	15.00%	15.00%	

Note 1: Market Basket estimates in spreadsheet reflect current Global Insights' projections. Final update will be based on 1st quarter book for RY 2011

Note 2: 15% of estimated volume change for RY 2010 over RY 2009

Note 3: Payor proposal allows for additional 0.25% growth in CMI if volume does not grow.

Note 4: Estimated increase to revenue for volume change that will occur for RY 2011 over RY 2010

DERIVATION OF HIGH FINANCIAL PRESSURE HOSPITAL STANDARD

Source: MedPAC June 2009 DataBook, p. 88

http://medpac.gov/
on bottom of home page select document type: Data Book
select year published 2009
select go
select acute inpatient services (click on click here)
scroll down to p. 88)

This page shows 837 hospitals facing high financial pressure with a median standardized cost per discharge of $5,800; 413 hospitals facing median financial pressure with a median standardized cost per discharge of $6,000; and 1,700 hospitals facing low financial pressure with a median standardized cost per discharge of $6,400.

The median for the high financial pressure hospitals is $5,800.

The hospital weighted average median for all the hospitals is:

$$\frac{837(\$5{,}800) + 413(\$6{,}000) + 1{,}700(\$6{,}400)}{837 + 413 + 1{,}700} = \frac{\$18{,}212{,}600}{2{,}950} = \$6{,}174$$

$\frac{\$5{,}800}{\$6{,}174}$ = 93.9%, or $5,800 is 6.1% below $6,174

Appendix III - Staff’s TPR Proposal

TOTAL PATIENT REVENUE

RATE SETTING METHODOLOGY

TOTAL PATIENT REVENUE ("TPR") RATE SETTING METHODOLOGY

- Historically, to qualify for participation in the TPR rate setting system, a hospital had to be the only acute care provider within a defined population service area, with minimal or no competition from other acute care hospitals

- The system calculates a hospital's annual regulated revenue budget for all inpatient and outpatient services irrespective of any changes in volume or case mix, thereby financially incentivizing a hospital to manage its resources efficiently and effectively

- This methodology purposely intends to reduce regulatory burdens on the hospital through
    - Relaxed unit rate compliance corridors which allow the hospital the flexibility to charge +/- 5% beyond the approved rates without penalty. Further, staff may approve extending this flexibility to +/-10% if the facility demonstrates that this is the only way to achieved approved budgeted revenues
    - Calculate a combined price/volume adjustment which compares the annual charges to the approved revenue. An under collection is added to the subsequent year's revenue budget on a one time basis, and conversely, an overcharge reduces the subsequent year's revenue budget on a one time basis
    - Provides an annual rate increase, based on the CMS hospital provider market basket inflation, previously calculated as factor cost inflation
    - Provides an annual population adjustment for 25% of the annual change in population or 1%, whichever is lower, based on the Maryland Department of Planning's Maryland State Data Center, which is an official partner of the United States Census Bureau
    - Reverses any onetime adjustments for the previous rate year
    - Includes an annual calculation of the payer differential which reflects any change in payer mix and Commission approved bad debt provision to establish the hospital's mark up
    - Incorporates a 100% fixed cost basis
    - The methodology remains in effect, through a fully executed signed TPR Agreement, for several years to the provide the hospital with a stable budgetary and management planning environment
    - Provides the hospital the opportunity to request a modification to the 1% population provision if it can be documented that the actual population growth and aging in the area serviced exceeds 1%

- Over a full twenty four month period if either the hospital or the Commission believes that changes in market share and/or case mix have change significantly, the revenue cap may be reevaluated at the request of either party (a +/- adjustment that substitutes for a case mix provision)

POLICY BENEFITS OF THE TPR SYSTEM

- Budget predictability
- Incentives for cost control based on patient volume fluctuations and site of service
- Flexibility in clinical decision making
- Provides a safety valve in that lost volumes will not adversely impact the hospital's revenue

HOSPITALS THAT HAVE PARTICIPATED IN THE TPR RATE SETTING METHODOLOGY

PRIOR TO THE CHARGE PER CASE RATE SETTING METHODOLOGY

Five hospitals managed under the TPR rate setting methodology and not the Inflation Adjustment System ("IAS") or the Guaranteed Inpatient Revenue ("GIR") rate setting methodology prior to the creation of the Charge per Case ("CPC") rate setting methodology. These hospitals were:

Garrett County Hospital
Memorial Hospital at Easton
Harford Memorial Hospital
Upper Chesapeake Medical Center (Formerly Fallston General Hospital)
Calvert Memorial Hospital

SUBSEQUENT TO THE ADOPTION OF THE CHARGE PER CASE METHODOLOGY

During the fifteen month experimental period and the first actual CPC rate year, only Memorial Hospital at Easton opted to change from the TPR rate setting system to the CPC System. The following year Calvert Memorial, Harford Memorial and Upper Chesapeake hospitals converted from the TPR methodology to the CPC methodology. Garrett County Hospital has consistently participated in the TPR methodology.

On July 1, 2008, McCready Memorial Hospital converted from the CPC methodology to the TPR methodology.

POTENTIAL INCENTIVES FOR PARTICIPATION IN THE TPR SYSTEM

The Commission staff has considered these potential incentives for expanded adoption of the TPR system

- Relax the requirement that a hospital must be the only acute care hospital in a defined service area with no competition from any other acute care hospital
- Allow a permanent revenue increase to a hospital that converts from the CPC methodology to the TPR methodology
- Reduce the fixed cost factor
- Continue all other provisions of the TPR methodology, e.g. annual CMS market basket inflation, annual population adjustment, annual calculation of the payer differential and resultant markup
- Reduction of penalties
    - Update factor will not be negatively scaled due to ROC results
    - Relaxed ROC threshold for spend down identification
    - Reduced penalties associated with other Commission policies, e.g. short stay cases

CANDIDATES FOR THE TPR RATE SETTING METHODOLOGY

The following hospitals could potentially benefit by changing from a CPC to a TPR rate setting methodology

Western Maryland Region

Washington County Hospital Association
Western Maryland Regional Medical Center
Garret County Hospital (continue current status)

Eastern Shore Region

Dorchester General Hospital
Memorial Hospital at Easton
Chester River Hospital
Peninsula Regional Medical Center
Atlantic General Hospital

Northern Shore Region

Union Hospital of Cecil County
Harford Memorial Hospital
Upper Chesapeake Medical Center

Southern Maryland

Southern Maryland Hospital
Civista Medical Center
Calvert Memorial Hospital

Draft Recommendation for Revisions to the Reasonableness of Charges (ROC) Methodology

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

March 3, 2010

This document represents a draft recommendation to be presented to the Commission on March 3, 2010 for discussion purposes only. Comments should be sent to Charlotte Thompson, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215 by April 2, 2010.

Background

ICC/ROC Methodology:

The Commission is required to approve reasonable rates for services offered by Maryland hospitals. The 'Reasonableness of Charges' (ROC) methodology is an analysis that allows for the comparison of charges at individual hospitals to those of their peer hospitals after various adjustments to the charge data have been applied. Hospitals with adjusted charges that are high compared to their peers are subject to rate decreases through spend-downs and/or negative scaling of the Update Factor. Conversely, hospitals with adjusted charges that are low compared to their peer hospitals may be allowed rate increases through positive scaling of the Update Factor based on their ROC position. The inter-hospital cost comparison (ICC) used for full rate reviews is based on the ROC methodology with additional adjustments for profit and productivity when establishing a peer standard for comparison. The ROC comparison is conducted annually in the spring with ROC position scaling results impacting the July rate update for the following rate year.

ICC/ROC Workgroup:

Each year, the HSCRC solicits requests from the Maryland hospital industry for modifications to the ICC/ROC methodologies. A summary of the letters submitted on June 1, 2009 is included in Appendix A. Each fall, the ICC/ROC Workgroup, comprised of hospital, payer representatives and Commission staff, meets to discuss the ICC/ROC methodologies and the proposed modifications. This year, the ICC/ROC Workgroup met ten times over a three month period and the following draft recommendations are the result of those deliberations. The Workgroup will have one or two additional meetings in March to discuss details of the proposed outlier methodology, and staff will provide an updated draft recommendation to the Commission at the April meeting. A final recommendation regarding changes to the ICC/ROC methodology will be presented at the May Commission meeting.

Issues and Draft Recommendations

Peer Groups

The current peer group methodology uses 5 groups (based on size and location of hospital) for comparison including a virtual peer group for the Academic Medical Centers (AMCs). These peer groups were originally developed to adjust for differences in cost structures of hospitals which may not have been captured in the ROC adjustments used at that time. Because the Commission has implemented more refined adjustments for case-mix, labor market, and disproportionate share over the last several years, staff believes that this level of peer-grouping is no longer necessary. Staff originally proposed a move to two peer groups, teaching and non-teaching. Citing disparities in the use of new technology between major teaching and minor teaching hospitals, which are not adjusted for in the ROC, the AMCs proposed to either maintain their virtual peer group or split the teaching peer group into major and minor teaching. The payer representatives proposed that the Commission develop a national peer group for determination of reasonableness of charges for the Academic Medical Centers.

Recommendation: For the spring 2010 ROC, divide hospitals into the following three peer groups based on teaching intensity as measured by residents per case-mix adjusted equivalent inpatient case: major teaching, minor teaching, and non-teaching. In March of 2010, assemble a group of industry

representatives that will work to identify a national AMC peer group for use in next year's ROC (spring 2011).

Comprehensive Charge Target (CCT)

As approved by the Commission last year, the CCT is the starting point for the ROC methodology and is established by blending the inpatient charge per case (CPC) target and outpatient charge per visit (CPV) target. Implementation of the CPV was delayed until FY2011 and, therefore, CPV targets were not established for FY2010.

Recommendation: Calculate a CPV for each hospital by using FY2009 outpatient data under the expanded CPV methodology that had been in place for FY2010. Inflate the established CPV by each hospital's outpatient rate update for FY2010 and blend the CPV and CPC targets to establish the CCT under the blending methodology approved last year.

Application of Indirect Medical Education (IME) and Disproportionate Share (DSH) Adjustment

Under the current ROC methodology, the IME and DSH adjustments are applied as a deviation from the statewide average. Therefore, using IME as an example, non-teaching hospitals with no IME costs receive an upward adjustment to their CCT for the percent that they differ from the statewide average IME amount. Staff believes that it is technically correct and makes more intuitive sense to apply the costs associated with IME and DSH as a direct strip from hospital charges. Under this change, again using IME as an example, non-teaching hospitals would have no ROC adjustment for IME costs. At the end of last year's ICC/ROC Workgroup discussions, staff proposed this technical correction to the application of the IME and DSH adjustments. However, at that time, Workgroup members stated that it was too late in the discussion process to make this change.

Recommendation: Implement a technical correction to the IME and DSH adjustments that applies the adjustment as a direct strip instead of a deviation from the average statewide costs associated with IME and DSH.

Physician Recruitment, Retention, and Coverage

A subset of community hospitals, known as G-9, offered a review of the costs associated with providing physician subsidies for physician recruitment, retention and coverage costs at hospitals in non-urban areas. The G-9 hospitals proposed that the Commission consider defining reasonable recruitment, retention, and coverage expenditures as elements of regulated hospital cost and adjust for these costs in the ROC in a manner similar to the direct medical education adjustment. Because physician services are not regulated by the HSCRC, staff does not agree that physician subsidies associated with recruitment, retention, and coverage should be considered elements of cost which are adjusted for in the ROC. However, staff agrees that the issue of physician subsidies and the impact on community hospitals needs further study.

Recommendation: No proposed adjustment in the ROC methodology associated with physician recruitment, retention, and coverage costs. Begin a concerted study to better understand physician payments associated with physician recruitment, retention, and coverage at Maryland hospitals.

Profit and Productivity Adjustment in the ICC

The cost standard used for full rate reviews in the ICC methodology begins with the hospital's peer group ROC-adjusted CCT and then excludes the peer group's average profit, and includes a 2% productivity adjustment. The Maryland Hospital Association (MHA) contended that the current ICC policy is too restrictive for hospitals to access rate relief. The MHA proposed that during full rate setting the methodology should add back the lower of the target hospital's profit or 2.75% (the Financial Condition Policy's target for operating margins). The MHA also proposed that the 2% productivity adjustment be phased-in over a multi-year period, or that a national standard be identified and used for the productivity adjustment.

Hospital payment levels and costs have increased more rapidly in Maryland compared to the rest of the nation over the last 5 years. In FY05, Maryland was 2.58% below the U.S. in Net Operating Revenue per EIPA and moved to 1.90% above the U.S. in FY09 for this measure. For the same time period, Maryland went from 4.28% to 0.38% below the U.S. for Net Patient Revenue per EIPA and 3.65% below to 0.71% above the U.S. for Cost per EIPA. Because of this erosion of Maryland hospital payments and costs compared to the U.S., staff believes that it would not be the appropriate time to move to a less restrictive standard in the ICC methodology.

Recommendation: No recommended change to the profit and productivity adjustments in the ICC.

Capital Adjustment

CareFirst and Kaiser proposed a change to the current capital adjustment in the ROC and a change to how capital is handled in rates in terms of the variable cost factor. With regard to the ROC adjustment, the current methodology adjusts for the percentage of costs that are related to capital using 50% of the hospital-specific capital costs plus 50% of the statewide capital costs. CareFirst and Kaiser proposed a ten year phase-in to move from the 50/50 standard to 100% statewide costs plus 0.5%. At the end of the ten year phase-in period, there would be no ROC adjustment for capital.

With regard to capital and the variable cost factor (currently at 85%), Care First and Kaiser proposed that CON eligible projects be subject to the variable cost factor for three years after first use as follows:

A. 100% variable if hospital takes "pledge" to not file rate application
B. 100% variable if CON was filed when variable cost factor was 100%, and hospital did not file rate application.
C. 100% variable for hospitals that filed a CON when variable cost factor was 85%, and hospital did not file a rate application.
D. Current cost factor applied for hospitals that filed a rate application generating additional dollars in rates for capital.

Staff is supportive of the concept of moving to a statewide standard for capital over a ten year period. Staff also supports the idea of a less restrictive variable cost factor to fund capital projects in place of funding capital through rate increases.

Recommendation: With a ten year phase-in, move from the current capital cost standard of 50% hospital-specific plus 50% statewide to 100% statewide plus 0.5%. CON eligible projects would be allowed 100% of variable costs for three years if hospital pledges to not file a rate application or if hospital filed CON previously and did not file rate application and pledges not to file in future.

Exclusions

Currently, liver transplants, heart and/or lung transplants, pancreas transplants, bone marrow transplants, and kidney transplants are excluded from the CPC constraint system because past analyses indicated that there was significant variation in charges within the corresponding APR-DRGs for these cases. Staff recently analyzed the charge variation for each of the transplant APR-DRGs using FY09 inpatient data. The liver, heart, pancreas, and bone marrow transplant cases continue to experience wide variations in charges and length of stay and should continue to be excluded from the CPC system. However, analysis of the kidney transplant cases indicate that there is very little variation in charges, as measured by the coefficient of variation, within the kidney transplant APR/SOI cells, and staff believe that these cases should be included under the CPC constraint system.

Recommendation: Include kidney transplant cases (as identified by APR-DRG 440) under the CPC constraint system in FY2011.

Case-mix Lag

Under current Commission policy, case-mix is measured in "real time", meaning that the calculation of case-mix change for the previous rate year and calculation of the base CMI for the new rate order use discharge data from the July-June period immediately prior to the new rate year. For example, the base CMIs in the rate orders for the fiscal year that began July 1, 2009 were calculated using discharge data from July 1, 2008 thru June 30, 2009. Discharge data from the previous rate year is not available until, at the earliest, 4 months after the beginning of the new fiscal year. Therefore, the measurement of case-mix in real time causes unavoidable delays in issuing rate orders which, in turn, impacts hospitals' ability to achieve CPC compliance. Staff recommends that case-mix change and base CMI be measured using a three month lag in the data period. The data period used to calculate case-mix change for FY10 will remain the 12-months ending June 30, 2010. However, the base CMI for the FY11 rate orders will be based on discharge data from April 1, 2009 – March 31, 2010 and case-mix change for FY11 will be measure using discharge data from April 1, 2010 – March 31, 2011. There are technical details associated with this change that Commission staff plan to discuss at MHA's Technical Issues Workgroup over the next several months.

Recommendation: Move to a 3-month lag in the data period used to measure hospital case-mix.

Outlier Methodology

Under the current HSCRC high charge outlier methodology, a hospital-specific high charge outlier threshold is calculated for each APR/Severity cell. Charges above the established threshold are paid based on unit rates and not subject to the incentives of the HSCRC per case payment system.

The G-9 hospitals proposed a change to the HSCRC outlier methodology to address the following issues that they cite as consequences of the current methodology:

- Hospital charges could be structured to increase outlier charge levels
- Outlier patients are not protected by the financial incentives of the per case payment system
- Compliance with HSCRC rate orders are complicated by the segregation of outlier charges in compliance calculations

The G-9's proposed outlier methodology establishes a prospective allowance for outlier charges using a regression that is shown to predict each hospital's percentage of outlier costs with substantial accuracy. The following independent variables are used from previous year's data: the hospitals' proportion of vent cases, the hospitals' expected outlier proportion, and an AMC dummy variable. The result of the regression for each hospital would equal the hospital's outlier allowance for the succeeding year. A hospital's rate year CPC target would be increased by the prospective outlier allowance. In ROC comparisons, each hospital's target would be adjusted for the amount of the prospective outlier charges.

Commission staff believes that this concept has merit and would provide clear incentives for hospitals to reduce outlier charges. Staff would like to schedule one or two more ICC/ROC Workgroup meetings in the next month to model and discuss details associated with the G-9 outlier proposal.

Recommendation: Schedule two additional ICC/ROC Workgroup meetings to further discuss the G-9 outlier proposal.

ROC Scaling and Spend-Downs

At this time, staff recommends that spend-downs not be initiated for the 2010 ROC results. Staff recommends that a significant portion of revenue be scaled for ROC position, and that the structure of scaling be continuous. The Payment Workgroup will ultimately decide the amount of revenue to be scaled. Staff also recommends that the Total Patient Revenue (TPR) hospitals (McCready and Garrett) be eligible for positive ROC scaling but would not be negatively scaled.

Recommendation: The amount of scaling for 2010 ROC results should be significant and the structure of the scaling should be continuous. TPR hospitals should be eligible for positive scaling but not receive negative scaling based on ROC results. No spend-downs based on 2010 ROC results.

Summary of Draft Recommendations for Changes to the ICC/ROC Methodology

Peer Groups: For the spring 2010 ROC, divide hospitals into the following three peer groups based on teaching intensity as measured by residents per case-mix adjusted equivalent inpatient case: major teaching, minor teaching, and non-teaching. In March of 2010, assemble a workgroup that will work to identify a national AMC peer group for use in next year's ROC (spring 2011).

CPV in Blended CCT: Calculate a CPV for each hospital by using FY2009 outpatient data under the expanded CPV methodology that had been in place for FY2010. Inflate established CPV by each hospital's outpatient rate update for FY2010 and blend the CPV and CPC targets to establish the CCT under the blending methodology approved last year.

Application of IME and DSH Adjustment: Implement a technical correction to the IME and DSH adjustments that applies the adjustment as a direct strip instead of a deviation from the average statewide costs associated with IME and DSH.

Physician Recruitment, Retention, and Coverage: Begin a concerted study to better understand physician payments associated with physician recruitment, retention, and coverage at Maryland hospitals.

Capital: With ten year phase-in, move from the current capital cost standard of 50% hospital specific plus 50% statewide, to 100% statewide plus 0.5%. CON eligible projects would be allowed 100% of variable costs for three years if hospital pledges not to file a rate application or if hospital filed CON previously and did not file rate application and pledges not to file in the future.

Exclusions: Include kidney transplant cases (as identified by APR-DRG 440) under the CPC constraint system in FY2011.

Case-mix Lag: Move to a 3-month lag in the data period used to measure hospital case-mix.

Outlier Methodology: Schedule one or two additional ICC/ROC Workgroup meetings to further discuss the G-9 outlier proposal.

Scaling and Spend-downs for 2010 ROC: The amount of scaling for 2010 ROC results should be significant and the structure of the scaling should be continuous. TPR hospitals should be eligible for positive scaling but not receive negative scaling based on ROC results. No spend-downs based on 2010 ROC results.

Appendix A

Summary of ICC/ROC Letters

The purpose of this document is to provide a brief overview of the issues addressed in letters submitted to the Commission June 1, 2009 regarding methodology issues to be discussed in the ICC/ROC Workgroup for the coming rate year.

Peer Groups

St. Joseph Medical Center requests that the current peer groups be replaced with a statewide comparison of hospitals.

Atlantic General requests a change from the current peer groups to a statewide group or teaching/non-teaching groups.

The hospitals in 'G-9' request that the current peer groups be considered for revision.

CareFirst and Kaiser Permanente request that there be just two peer groups: 1) a statewide peer group excluding the Academic Medical Centers; and 2) a national peer group for Johns Hopkins Hospital and the University of Maryland Medical Center.

MedStar Health and St. Agnes Hospital do not want peer groups eliminated but request that the current structure be reviewed to determine if the methodology meets the original goal.

Outlier Methodology

The Johns Hopkins Health System, University of MD Medical System, CareFirst and Kaiser request that the Commission staff revisit the outlier methodology to determine if the original objectives of this policy are being met and incentives are correct.

G-9 hospitals believe that the low charge outliers system is unnecessary, and that the incentives related to the payment for high charge outliers exacerbate the problem of complying with the waiver and, therefore, they support a review of the outlier policy.

Labor Market Adjustment

The Johns Hopkins Health System, the University of MD Medical System, and MedStar Health request a systemic review of the policy as well as suggest that a more detailed review of submitted data be put in place to ensure that the data are reasonable.

Disproportionate Share Adjustment

MedStar Health and St. Agnes Hospital request that the current DSH adjustment be re-assessed in order to confirm the measure's validity; to establish the stability over time; to understand if issues associated with urban locations are addressed; and to compare to possible alternatives.

Direct Medical Education

The Johns Hopkins Health System and the University of Maryland Medical System request that the current methodology for calculating the direct strip for DME (based on costs reported in the P4 and P5 schedules) is re-assessed due to vague P4 & P5 instructions related to ACGME approved residents and fellows which results in inconsistent reporting across hospitals.

Indirect Medical Education

CareFirst and Kaiser request that any future adjustments to the IME coefficient be based on the Commission's Update, and that the IME methodology be adjusted to support a greater amount of relative training of Primary Care Physicians who will provide care in Maryland.

Physician Coverage

The G-9 hospitals request that the differential accounting and treatment in ICC/ROC of the coverage costs at teaching hospitals (use of residents with costs carved out in DME adjustment) versus non-teaching hospitals (employed or subsidized attending staff costs not carved out) be addressed.

Partial Rate Review for Capital and Full Rate Reviews

CareFirst and Kaiser request that the partial rate process for capital be reviewed, and that the Commission consider transitioning to a statewide capital methodology that does not adjust rates for a hospital's position in its capital cycle.

The Johns Hopkins Health System and University of MD Medical System request that the partial rate process for capital be maintained; that a reasonable profit standard (2.75%) be included; and that productivity strips be eliminated from the partial rate and ICC methodologies.

The G-9 hospitals request that the criteria governing partial and full rate applications be reviewed by the Workgroup.

Scaling and Spend-Downs

CareFirst and Kaiser request an increase in the level of scaling next year and that spend-downs are resumed no later than July 1, 2010.

The G-9 hospitals request that the Workgroup review various approaches to scaling and spend-downs, including a discussion regarding the elimination of spend-downs.

Clinic Volumes

CareFirst and Kaiser request that clinic volumes, especially for multi-person behavioral health clinics, be reviewed.

Non-Comparable Services

CareFirst and Kaiser request that the Workgroup discusses objective methods of identifying and evaluating the cost of a particular service when that service differs substantially at a particular hospital compared to the peer group.

PPC Methodology

The G-9 hospitals request that the Workgroup consider issues associated with the implementation of the PPC methodology.

Case Mix Governor and Volume Adjustment

The G-9 hospitals suggest that the case-mix governor, in combination with the volume adjustment, places an undue financial burden on hospitals with both case-mix and volume increases, and that consideration should be given to handling case-mix and volume through a single measure of the hospitals' service level.

MedStar Health requests that policy decisions that impact the ROC, such as the case-mix governor, be evaluated.

Availability of Data

MedStar Health, Johns Hopkins Health System, and the University of MD Medical System request that future reports, such as those pertaining to the ROC and UCC, include the data used by staff to conduct its calculations and that a two-week comment period be implemented to allow hospitals the opportunity to correct the data in the event that errors are present.

Prospective Payment and System Stability

St. Joseph Medical Center, the Johns Hopkins Health System and the University of MD Medical System state that certain policies, such as case-mix restrictions without clear prospective rules for how case-mix will be accrued, undermine the prospective nature of the Maryland system. These hospitals also state that constant change in the system, such as revisions to the CPV to include more revenue or the proposed implementation of the PPC methodology, undermine the stability of the system.

Staff Recommendation

Request by the Medical Assistance Program to Modify the Calculation of Current Financing Deposits for FY 2010

March 3, 2010

Introduction

The Medical Assistance Program (MAP) has been providing working capital advance monies (current financing) to hospitals for many years. As a result, MAP receives the prompt pay discount as per COMAR 10.37.10.26(B). MAP is unique among third-party payers in that it is a governmentally funded program that covers qualified poor residents of Maryland. As such, it deals, to a large extent, with retroactive coverage. Recognizing the uniqueness of MAP, the Commission allowed MAP to negotiate a special formula with the hospital industry to calculate its fair share of current financing monies. The Commission approved this alternative method of calculating current financing at its February 1, 1995 public meeting. Currently, MAP has approximately $85 million in current financing on deposit with Maryland hospitals.

As a result of the budget crisis, MAP submitted a request on December 19, 2008 that the Commission approve an exception to the requirement that the amount of current financing on deposit with hospitals be re-calculated annually. MAP requested that for one year, FY 2009, the amount of current financing monies on deposit with Maryland for FY 2008 remain unchanged. In its request, MAP stated that it intended to re-institute the annual re-calculation of current financing for FY 2010. The MAP request was approved by the Commission at its January 14, 2009 public meeting.

MAP's Current Request

Because of the continuing budget crisis, MAP submitted a request on February 5, 2010 for modifying the calculation formula. MAP has requested that, rather than using the approved calculation, which would provide an additional $29.8 million to the $85 million current financing now on deposit with hospitals, a modified calculation be approved for FY 2010 only that would provide an additional $11.2 million.

MAP reported that it met with representatives of the Maryland Hospital Association (MHA) on January 8, 2010 to outline their proposed modified calculation. At the meeting, MAP also committed to work with MHA's Financial Technical Issues Task Force to review the existent current financing formula with the objective of improving the methodology before the FY 2011calculation.

Staff Recommendation

Based on the current condition of the economy and its effect on MAP's budget, staff recommends that the Commission approve MAP's request. In addition, staff recommends that the Commission strongly encourage MAP and MHA to develop a permanent current financing methodology for approval before the FY 2011 calculation.

STATE OF MARYLAND
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TO: **Commissioners**

FROM: **Legal Department**

DATE: **February 24, 2010**

SUBJECT: **Hearing and Meeting Schedule**

Public Session

April 14, 2010	**Time to be determined, 4160 Patterson Avenue, Large Conference Room**
May 5, 2010	**Time to be determined, 4160 Patterson Avenue, Large Conference Room**

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