STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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477th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
April 15, 2011

PUBLIC SESSION
10:00 a.m.

1. **Review of the Executive Session and Public Meeting Minutes of March 2, 2011**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**
   2106A – Johns Hopkins Health Care
   2107A – Nelix Resource Management

4. **Docket Status – Cases Open**
   2108N – Adventist Behavioral Health
   2109A – University of Maryland Medical Center
   2110N – Western Maryland Health System
   2111A – Johns Hopkins Health Care

5. **Final Recommendation on Assessments and Remittances, and FY 2012 Update Factor**

6. **Final Recommendation on Unique Patient Identifier Policy**

7. **Legal Report**

8. **Hearing and Meeting Schedule**

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)
AS OF APRIL 6, 2011

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
2108N	Adventist Behavioral Health	3/16/2011	4/15/2011	8/15/2011	CLINIC	CO	OPEN
2109A	University of Maryland Medical Center	3/31/2011	N/A	N/A	ARM	DNP	OPEN
2110N	Western Maryland Health System	3/31/2011	5/212011	8/29/2011	HYP	CO	OPEN
2111A	Johns Hopkins Health Care	4/4/2011	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 THE	*****	**COST REVIEW COMMISSION**
ADVENTIST BEHAVIORAL	*****	**DOCKET 2011**
HEALTH	*****	**FOLIO: 1918**
ROCKVILLE, MARYLAND	*****	**PROCEEDING: 2108N**

Staff Recommendation

April 15, 2011

This recommendation was unanimously approved by the Commission on April 15, 2011.

Introduction

On March 16, 2011, Adventist Behavioral Health ("the Hospital") submitted a partial rate application to the Commission requesting a new rate for Clinic (CL) services. The Hospital is requesting the lower of $30.45 or the statewide median rate for CL services to be effective April 1, 2011.

Staff Evaluation

To determine if the Hospital's CL rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all cost and statistical data for CL services for FY 2011. Based on information received, it was determined that the CL rate based on the Hospital's actual data would be $30.45 per RVU, while the statewide median rate for CL services is $32.77 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 the opening of a new service be waived;

2. That a CL rate of $30.45 per RVU be approved effective April 1, 2011; and

3. That the CL 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:**	**2011**
MEDICAL CENTER	*****	**FOLIO:**	**1909**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2109A**

Staff Recommendation

April 15, 2011

This recommendation was unanimously approved by the Commission on April 15, 2011.

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 period of one year, effective April 1, 2011.

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 the 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, 2011. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2011**
SYSTEM	*	**FOLIO:**	**1921**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2111A**

Staff Recommendation

April 15, 2011

This recommendation was unanimously approved by the Commission on April 15, 2011.

I. INTRODUCTION

On March 26, 2010, the Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval from the HSCRC to continue participation in a renegotiated global rate arrangement for cardiovascular procedures with the Coventry Health Care of Delaware, Inc. for international patients only. The Hospitals request that the Commission approve the arrangement for three additional years beginning effective May 1, 2011.

II. OVERVIEW OF APPLICATION

The Hospitals requested and received a 60-day extension of the original approval period (April 1, 2010 to March 31, 2011) in order to provide time to renegotiate the arrangement.

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

After review, staff is satisfied that the Hospitals can achieve favorable performance under the renegotiated arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services for one year beginning May 1, 2011. The Hospitals must file a renewal application annually for continued participation, with approval contingent upon a favorable evaluation of performance.

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

Final Staff Recommendation and Discussion Document Regarding the FY 2012 HSCRC Hospital Payment Update

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April 15, 2011

On April 15, 2011, by a vote of 5-1, the Commission adopted Option 2 as shown on page 23 of this document.

1.0 Introduction

The Health Services Cost Review Commission's (the "HSCRC's," or "Commission's") annual Update (the "Rate Update" or "Update Factor") applies to all payment structures under the jurisdiction of the HSCRC, including the Commission's inpatient Charge per Case (CPC) and Charge per Visit (CPV) constraints and all unit rates that do not fall under the CPC or CPV. The Update is analogous to the Centers for Medicare and Medicaid Services' (CMS') annual update to its Inpatient Prospective Payment System (IPPS) implemented October 1 of each year (the beginning of each federal fiscal year).[1]

The magnitude of the HSCRC's annual hospital Update can have significant impact on both the financial condition of hospitals and the affordability of hospital care within the State. Each 1.0% additional increment in the update represents approximately $139 million in annual hospital charges. The approved Update also has a significant impact on the cost of health care in the State paid by both private and public payers. For instance, the Maryland Medicaid and State Employee Benefits programs respectively account for approximately 20% and 3% of hospital expenditures. Thus, every 1.0% increase in the annual update will increase State hospital payments by approximately $15 million.[2]

The HSCRC Update Factor is effective July 1 of each year and is meant to cover normal factor input inflation and any changes in the real "case mix" of patients, as well as provide a mechanism for the Commission to recognize fixed costs, provide a limited incentive to control volume growth (the Volume Adjustment) and achieve other policy objectives (the Policy/Productivity Adjustment).

2.0 Policy and Environmental Considerations

As indicated, the HSCRC annual rate Update is an important policy tool for the Commission as it attempts to: 1) improve the affordability of hospital care in the State; 2) ensure the financial viability of the Maryland hospital industry; and 3) preserve the principal tenets of the rate setting system.

In attempting to most appropriately balance these policy priorities, there are a number of environmental factors that the Commission has traditionally considered in formulating its final decision regarding the magnitude of each year's Update to rates. These include: 1) the recent and current financial performance of Maryland hospitals; 2) the absolute and relative affordability of Maryland hospital care; and 3) recent and projected performance of the Rate Setting System on the Medicare Waiver Test. This section will provide some background on each of these environmental factors and attempt to discuss them in the context of the three policy considerations described above.

2.1 Financial Performance of the Maryland Hospital Industry

Despite the enactment of relatively tight Rate Updates in recent years, the overall operating performance (which covers both regulated operating profits and unregulated operating profits) of Maryland hospitals has improved in FY 2011 (overall operating profits increased from 1.26% year-to-date February 2010 to 2.96% year-to-date February 2011).[3] Current industry profitability is approximately in the range of preferred operating and total profit standards adopted by the Commission in 2006 during its review of the financial condition of the Maryland

[1] Last year's national Medicare update effective October 1, 2010 for Federal Fiscal Year (FFY) 2011 was -0.5% vs. the HSCRC's update of +2.0%.

[2] A 0.1% increase in the hospital update results in $1.1 million in additional State funded hospital services for Medicaid and $380,000 in State Employee Benefit program expenditures.

[3] Note: Operationally, February 2010 was an anomalous month due to unprecedented snow storms that affected Maryland hospitals. Operating profit eventually rebounded to 2.3% by year end FY 2010.

hospital industry (the current HSCRC preferred standards are 2.75% operating profits and 4.0% total operating and non-operating).[4]

Growing Regulated Profits and Unregulated Losses

As noted, overall operating margins are an amalgam of profits from both regulated and unregulated lines of increasing business. While regulated operating profits have experienced rapid improvements since FY 2003 (growing from 3.54% operating margin to an estimated 6.7% in 2011), annual increases in hospitals' unregulated losses have also grown. These unregulated losses dilute overall hospital operating performance**.** **Table 1** below shows these trends over time, with unregulated losses now estimated to be in excess of $400 million per year. The largest and fastest growing component of these unregulated losses are associated with the provision of Physician "Part-B" services offered by and through the hospital.

While the Commission does collect aggregate data from hospitals on Physician Part-B revenues and expenses, the data are not detailed enough to sort out the factors contributing to this increasingly negative (from an operating perspective) trend. In general, hospital representatives themselves have indicated to the HSCRC and staff that the growing losses are a combination of both the need to pay physicians to maintain adequate physician coverage of acute services (particularly in the inner cities where physicians must receive subsidies from hospitals in the face of an unfavorable payer mix) and to maintain or increase hospital volumes.

Conversations between staff and individuals involved and familiar with the contracting activity between hospitals and physicians (both in Maryland and nationally) verify the dynamic described above and offer a more detailed description and explanation of this phenomenon that appears to be taking place both in our local market and nationally. [5] A summary of these conversations and observations based on recent literature on this topic are contained in **Appendix 1** to this document.

Table 1
Regulated, Unregulated Operating Performance 2003 -2011
(Projected 2011 based on YTD 2011 performance)

Fiscal Yr	Net Patient Revenue	Reg. Op Profit	Part B Physic. Loss 2011 Est.	Total Unreg. Profit(loss) 2011 Est.	Total Op Profit Reg & Unreg.	Overall Op. Margin
Annualized 2011	$11,851,889	$779,278	($329,916)	($428,462)	$350,816	**2.96%** *
2010 Est	$11,394,076	$721,759	($302,107)	($415,396)	$306,363	2.46%
2009 Final	$11,278,814	$651,997	($264,035)	($349,354)	$302,642	2.46%
2008 Final	$10,704,338	$561,066	($217,346)	($290,264)	$270,802	2.32%
2007 Final	$9,982,901	$536,176	($154,003)	($207,069)	$329,107	3.02%
2006 Final	$9,203,752	$461,509	($134,416)	($188,140)	$273,369	2.73%
2005 Final	$8,460,040	$415,220	($114,511)	($146,100)	$269,121	2.93%
2004 Final	$7,787,587	$351,316	($94,043)	($149,658)	$201,658	2.37%
2003 Final	$7,027,992	$249,007	($81,032)	($131,181)	$117,826	1.54%

2.2 Affordability of Hospital Care

The growing cost of hospital services has been a concern of the HSCRC in recent years. As health care costs increase, the cost of insurance paid directly by individuals or through employer sponsored health plans also increases. The recent contraction in economic activity means that health care services have become even less affordable relative to available household income.

[4] Current total profits through February 2011 are 6.5% vs. 4.26% YTD February 2010.
[5] Center for Health System Change – policy briefs: Hospital Employment of Physicians Surges in Greenville-Spartanburg, S.C. Feb. 28, 2011and Transcript of HSC's 15th Annual Wall Street Comes to Washington Conference Oct. 1, 2010

Affordability can be evaluated on both an absolute and a relative basis. On an absolute basis, rising health care costs are increasingly pricing more and more individuals out of the insurance market. The acceleration of hospital and general health care costs contributes significantly to the overall erosion of the health insurance pool (i.e., as the cost of health insurance begins to become a disproportionate share of median household income, healthier individuals drop coverage, leaving the sickest and most expensive individuals with commensurate increases in the average premiums required). To forestall a complete exit from the health insurance market, individuals and employers have increasingly demanded high-deductable policies and/or other mechanisms that shift more out-of-pocket costs to policy-holders. While these policies do cover catastrophic health-related events, they also shift additional out-of-pocket costs to the public. These trends appear to be occurring both in Maryland and nationally.

On a relative basis, after a period of rapid hospital cost growth in Maryland vs. U.S the State has witnessed some improvement on its position of cost per adjusted admission over the past two years.[6] **Table 2** presents the State's actual and projected performance on hospital cost per adjusted admission over the period 2003 – 2010.

Table 2
Regulated, Unregulated Operating Performance 2003 -2011
(Projected 2011 based on YTD 2011 performance)

Recent Maryland System Performance vs. US hospital Performance (rev per case & cost case)

HSCRC current Target is to be 6.0% below the US on Cost per Adjusted Admission

MD vs. US on Cost per Case	2003 AHA Actual	2004 AHA Actual	2005 AHA Actual	2006 AHA Actual	2007 AHA Actual	2008 AHA Actual	2009 AHA Actual	2010 est.
US Hospitals	$8,233	$8,665	$9,099	$9,565	$10,029	$10,480	$10,842	$11,264
MD Hospitals	$7,824	$8,339	$8,767	$9,381	$10,028	$10,494	$10,726	$11,059
Above/Below US	-4.97%	-3.76%	-3.65%	-1.92%	-0.01%	0.13%	-1.07%	-1.82%

Despite the system's recent improvement, staff notes that Maryland's current and projected performance is still above what is demonstrably achievable from an operating efficiency standpoint. In its March 2011 report to Congress, Medpac (the Medicare Prospective Payment Commission, the independent Commission that advises Congress on Medicare payment policy) identified a cohort of some 700 hospitals with high quality scores, facing broad "financial pressure" from dominant private payers, that were operating with positive Medicare margins with costs 7-9% below the U.S. hospital average cost per adjusted admission.

As both Medpac and the HSCRC have observed over the years, hospitals that face broad financial pressure (either under the all-payer rate system or operating in a payer-dominated marketplace that forestalls the ability to "cost-shift" to the private sector) tend to manage costs far more effectively over time. Consistent with 38 years of HSCRC experience, Maryland hospitals facing diminished rate Updates in FY 2010 and FY 2011 appear to

[6] Based on reported cost trends nationally and Maryland's approved FY 2011 Update, staff would expect our relative performance on cost per EIPA to continue to improve into FY 2011.

have responded by reducing their costs, while at the same time registering improvements in their quality of care.[7]

2.3 Medicare Waiver Performance and Considerations

In recent years, the HSCRC has been concerned about unexpected deterioration in the rate system's performance on the Medicare Waiver Test. 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. These technical changes relate to the likely inclusion of two categories of "zero payment" cases (Medicare as Secondary Payer (MSP) and Medicare Advantage/HMO (MA) cases) to the US Medicare data used to calculate the US Medicare Payment per case. This US Medicare Payment per case figure is used in a comparison with Maryland Medicare Payment per case data for purposes of calculating the waiver test.

Based on discussions with the CMS actuary responsible for calculating both the Maryland and U.S. Medicare payment per case statistics used in the calculation of our Waiver Test, Medicare agreed that the U.S. payment per case data contained Medicare Advantage cases in the denominator when no such cases were in the Maryland data. Removal of these cases resulted in an approximate 1.7% favorable adjustment (favorable for Maryland) to our relative test. Thus far, however, the CMS actuary has not agreed to any proposed adjustment associated with Medicare Secondary Payer cases (although staff continues to discuss this issue with CMS).

Another short-term favorable development for the waiver performance is the projected increases in Medicare Payments to non-Maryland hospitals related to Medicare's conversion to a severity-adjusted DRG grouper and associated case mix coding and documentation improvements for FFY 2008, 2009, and 2010. While this phenomenon will result in a short-term increase in Medicare payments nationally, CMS is implementing current and future "offsets" (reductions to US hospital rate updates) to recoup both permanent and one-time amounts associated with these coding and documentation improvements. It is thus anticipated that Maryland's Medicare waiver cushion will continue to improve from the projected/adjusted levels through FY 2010. Beginning in FFY 2011, however, Medicare is proposing very large offsets to their payment updates to adjust for excessive payments related to coding and documentation improvements.[8]

Chart 1 and Table 3 below show the staff's current estimate of the CMS's actuary's "forecast" of national Medicare payments through CY 2014. They are based on the following key assumptions:

1 – Medicare Actuary Projections for Medicare payment growth FY 2010 – CY 2014 (note: the CMS update for FY 2011 was -0.5%)

2 – Maryland Medicare actual charges growth through CY 2010

3 – Adjustments for historical relationship between charges and payments for Medicare

4 – Adjustments for historical rates of growth in Medicare charges vs. All-Payer charges

5 – Assumed Maryland Update Factors FY 2012-2015

6 – Adjustments for the impact of hospital behavior under Total Patient Revenue (TPR) and Admission-Readmission Revenue (ARR) arrangements (note: it is expected that as hospitals respond to the incentives under

[7] In FY 2010, the Commission's Maryland Hospital Acquired Condition (Pay-for-Performance) initiative appeared to reduce the number of preventable hospital acquired complications by 12% with an estimated reduction in associated resource use and cost of approximately $62.5 million.

[8] Staff's current waiver projection (which is based, in part, on the CMS actuary projections of Medicare payments nationally) shows a very large drop off in U.S. Medicare payments in FY 2013 – likely reflecting anticipated and substantial one-time removals of revenue associated with coding creep in previous years.

the TPR and ARR to reduce unnecessary admissions and readmissions, Maryland hospital charge per case will increase between 0.86% and 1.6% per year over and above normal payment updates)

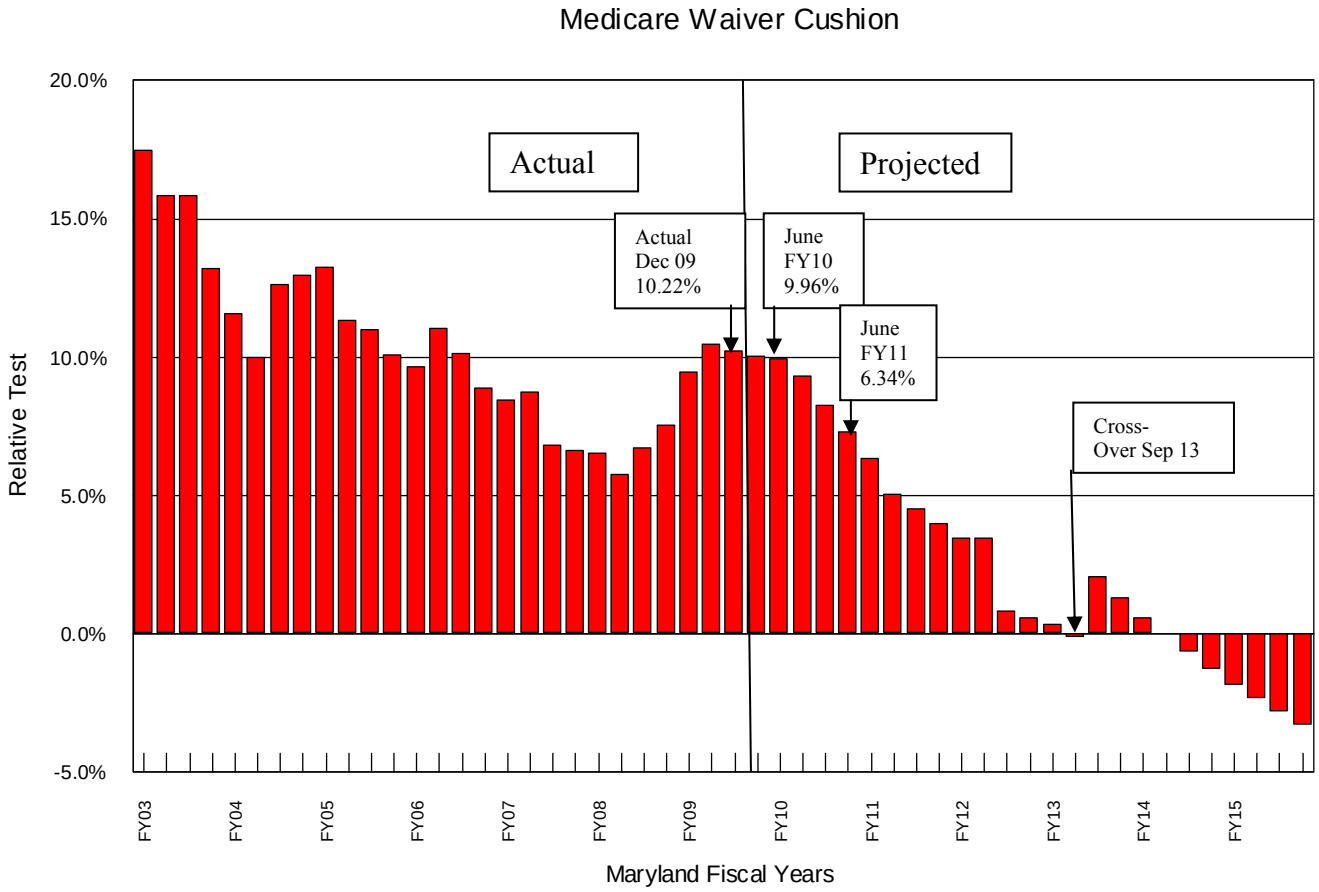
7 – Adjustments for "up-front" transitional funding provided TPR and ARR hospitals in FY 2012 and FY 2013.

Table 3
Actual and Forecasted Waiver Cushions FY2003-2015

Relative Waiver Test HSCRC Staff Projection
Based on CMS Letters

QUARTEI ENDING	MD pmt per case	MD Growth	US pmt per case	US Growth	Relative Test	
YE J03	$8,846	197.67%	$8,019	249.70%	17.48%	
YE S03	$9,035	204.04%	$8,077	252.23%	15.85%	
YE D03	$9,155	208.08%	$8,185	256.94%	15.86%	
YE M04	$9,319	213.58%	$8,142	255.07%	13.23%	
YE J04	$9,554	221.51%	$8,227	258.78%	11.59%	
YE S04	$9,681	225.77%	$8,218	258.38%	10.01%	
YE D04	$9,819	230.42%	$8,535	272.19%	12.64%	
YE M05	$9,895	232.97%	$8,625	276.15%	12.97%	
YE J05	$9,968	235.45%	$8,713	279.99%	13.28%	
YE S05	$10,107	240.12%	$8,684	278.70%	11.34%	
YE D05	$10,239	244.55%	$8,770	282.46%	11.00%	
YE M06	$10,453	251.74%	$8,881	287.28%	10.10%	
YE J06	$10,620	257.39%	$8,986	291.88%	9.65%	
YE S06	$10,785	262.91%	$9,241	302.99%	11.04%	
YE D06	$10,920	267.46%	$9,282	304.79%	10.16%	
YE M07	$11,137	274.77%	$9,358	308.09%	8.89%	
YE J07	$11,294	280.07%	$9,451	312.14%	8.44%	
YE S07	$11,352	282.01%	$9,524	315.34%	8.72%	
YE D07	$11,501	287.02%	$9,480	313.42%	6.82%	
YE M08	$11,604	290.49%	$9,547	316.32%	6.61%	
YE J08	$11,688	293.32%	$9,610	319.09%	6.55%	
YE S08	$11,849	298.72%	$9,671	321.75%	5.77%	
YE D08	$11,910	300.78%	$9,808	327.73%	6.72%	
YE M09	$11,992	303.55%	$9,954	334.09%	7.57%	
YE J09	$12,071	306.21%	$10,198	344.73%	9.48%	
YE S09	**$12,095**	**307.01%**	**$10,309**	**349.57%**	**10.46%**	
YE D09	$12,220	311.21%	$10,393	353.23%	10.22%	Most Recent
YE M10	$12,303	314.00%	$10,449	355.67%	10.07%	
YE J10	$12,379	316.57%	$10,503	358.05%	9.96%	
YE S10	$12,515	321.14%	$10,558	360.42%	9.33%	
YE D10	$12,643	325.45%	$10,562	360.59%	8.26%	
YE M11	$12,754	329.19%	$10,560	360.52%	7.30%	
YE J11	$12,866	332.95%	$10,558	360.41%	6.34%	
YE S11	$13,019	338.11%	$10,555	360.29%	5.06%	
YE D11	$13,173	343.27%	$10,624	363.32%	4.52%	
YE M12	$13,326	348.43%	$10,693	366.32%	3.99%	
YE J12	$13,479	353.59%	$10,763	369.35%	3.47%	
YE S12	$13,567	356.56%	$10,832	372.39%	3.47%	
YE D12	$13,655	359.52%	$10,627	363.42%	0.85%	
YE M13	$13,743	362.48%	$10,669	365.27%	0.60%	
YE J13	$13,831	365.45%	$10,711	367.12%	0.36%	
YE S13	$13,954	369.59%	$10,754	368.98%	-0.13%	Crossover
YE D13	$14,077	373.73%	$11,088	383.54%	2.07%	
YE M14	$14,200	377.86%	$11,102	384.14%	1.31%	
YE J14	$14,323	382.00%	$11,116	384.74%	0.57%	
YE S14	$14,430	385.59%	$11,129	385.35%	-0.05%	
YE D14	$14,537	389.18%	$11,143	385.95%	-0.66%	
YE M15	$14,644	392.78%	$11,157	386.56%	-1.26%	
YE J15	$14,750	396.37%	$11,171	387.17%	-1.85%	

Chart 1
Actual and Forecasted Waiver Cushions FY 2003-FY2015



Need to Pursue a Modification of the Medicare Waiver Test

In recent months the HSCRC working with the industry have aggressively pursued the use of more global and episode based payment mechanisms. These new payment structures will have the effect of reducing overall hospital costs because they provide strong incentives to control or reduce unnecessary volumes. As volumes moderate however, payments per unit will increase negatively impacting our payment per case performance on the Medicare waiver test. Given these circumstances, the HSCRC intends to work with the Secretary of Health and key stakeholders to develop and pursue a strategy aimed at obtaining a modification to the State's Medicare waiver test. Thus far, the Commission along with the Secretary have alerted the CMS Administrator of a desire to engage the Medicare and Medicare/Medicaid Innovation Center (CMI) staff in a process that would likely result in a proposal from the State for a revised test. This process is likely to begin in earnest this month and take several months to complete. This effort is vital to the long-term sustainability of Maryland hospitals and the Rate System and, if successful, will help rationalize the Maryland payment and delivery system.

3.0 Update Factor Components and FY 2012 Options

As noted above, the HSCRC's annual hospital Rate Update Factor is applied to approved hospital charge per case, charge per visit, and unit rates. While the Update is structured in a fashion similar to the update applied to hospitals nationally by the Medicare program, the Maryland Update also contains a number of components and adjustment specific to the Maryland system.

3.1 Key Components of the Update

The key components of the FY 12 Update that will be reflected in the 3 scenarios (**Tables 3-5**) are as follows:

1) FY 2012 Forecasted Market Basket Inflation;
2) Market Basket Forecast Error Adjustment;
3) Productivity Adjustment;
4) Rate Slippage;
5) Case Mix Provision;
6) Volume Adjustment; and
7) Medicaid Assessment.

Each of these components is described and discussed in the sections that follow.

1) Market Basket Inflation (MB): The Market Basket is a fixed-weight index that measures price changes in the underlying factor inputs used in the hospital production process (wage growth, supplies, capital, contractual services, etc.). This is the same Market Basket component used by Medicare in the calculation of its annual update effective October 1st of each year. The Market Basket estimate per HSCRC policy is determined by Global Insight's 1st quarter book 2011 for the projected period July 1, 2011 – June 30, 2012 (this estimate is from the 1st quarter book released April 2011).[9]

FY 2012 Consideration: The FY 2012 Market Basket was originally forecast to be about 2.49% (this represents an increase over previous year Market Baskets of 1.5% for FY 2010 and 2.29% for FY 2011). The final Market Basket figure used in the Update (effective July1) is available April of each year; it is taken as given and not adjusted even if the forecast changes during the course of the rate year. According to this 1st quarter 2011 estimate (just now available), the Market Basket forecast for FY 2012 has increased from 2.49% to 2.68%.

2) Market Basket forecasting error: This represents an adjustment for historical variations in the Market Basket forecast vs. the final actual Market Basket for a given year.[10] The Commission has periodically included this factor to account for inflation forecasting errors over time. Forecasting errors are usually related to the inability to predict untoward catastrophic events that impact inflation such as the Iraqi war and hurricane Katrina. CMS does not include a forecasting error in its hospital update.

FY 2012 Consideration: Although the Commission has not consistently included a forecasting error component, it did include this adjustment in the approval of the FY 2011 Update. The adjustment is based on a comparison of variations in the MB (forecast to final) for the three years for which final data are available. For

[9] The market basket forecasts are developed on a quarterly basis by Global Insight Inc. (GI) under contract with the Centers for Medicare and Medicaid Services. 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.

[10] 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 2011, the HSCRC will be required to forecast the market basket increase for fiscal year 2012. The actual change in the market basket for FY 2012 may be higher or lower than what the Commission forecasted in the spring of 2011 depending on market conditions.

the FY 2011 Update, the Commission used fiscal years 2006, 2007, and 2008. The adjustment for forecasting error for FY 2012 using the three years 2007, 2008, and 2009 is 0.21%.[11]

Staff Comment: Staff believes it is useful to include a forecasting error adjustment in the Update (particularly since we do not make changes for variations in the MB factor into the fiscal year). However, staff advocates that the Commission remain consistent from year to year in the formula used for calculating this component of the Update Factor to avoid arbitrary variation in approach and result.

3) HSCRC Policy/Productivity 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. Accordingly, the magnitude of the Policy/Productivity adjustment has varied over the years.

In the period FY 2001-2003, due to concerns regarding rapid waiver cushion erosion, the Commission approved annual updates with a negative policy adjustment (productivity adjustments in excess of -1.0% per year).

In the period FY 2004-2006, the policy adjustment was of a positive magnitude and ranged between +1 to 2% each year. Positive adjustments continued into FY 2008 (approximately+0.8%) and FY 2009 (+0.6%). These additions to rates were intended to help hospitals build profitability to facilitate a large recapitalization of the industry. This infusion resulted in approximately $5.5 billion in capital projects during FYs 2004 – 2010 (per the MHCC).

In FY 2010 and FY 2011, the Commission approved Updates with negative policy/productivity adjustments (-0.1% and -1.29% respectively) due to concerns about the increasing lack of affordability of hospital care.

Medicare and Medpac use of Productivity Adjustments: Propac (the Prospective Payment Commission – which formerly advised Congress on Medicare Policy) and Medpac (the Commission that replaced Propac) traditionally recommended a -1.0% productivity factor to be incorporated in the annual Medicare hospital Update. Over time, the actual productivity offset used has varied depending on budgetary goals. For instance, in more recent years the recommended offset increased to -1.25%. For FFY 2011, the implied productivity adjustment was well in excess of -1.0%. With a Market Basket factor of approximately 2.4%, the final approved Update was -0.5% (an implied productivity of -2.9%). A proportion of this offset, however, was related to the "take-back" of excess revenue generated by US hospitals by "up-coding."

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 through full rate reviews, the impact of "Spend-down" agreements (negotiated reductions to a high cost hospital's rates), or other factors such as variations from previous years' volume adjustments.

The factors that have affected system slippage (per current HSCRC policy) are examples of variations from the intended trajectory of revenues in the system and are directly related to actual changes in either rates or hospital costs. The case mix provision has not been included in slippage in the past for reasons discussed in the following section.

5) Case mix Provision: This is the HSCRC's limit on annual increases in measured additional resource use due to increases in intensity of care and/or patient severity of illness year to year. Hospital resource use to treat

[11] Note: The MHA had originally indicated it was going to suggest an alternative method of calculating the forecasting error. However, the official MHA Update proposal calculates this component per the approach adopted by the Commission for the FY 2011 using the variation from predicted to actual for the three most recent final years, 2007, 2008, and 2009.

patients can increase due to a variety of factors such as the aging of the population and the availability of more resource intensive technologies and treatment approaches. These provisions are intended to provide funding for real increases in the resources used to treat patients and, thus, should reflect real costs. Historically, based on HSCRC and CMS experience over the past 35 years, "real" case mix change has ranged from -0.5 to +1.0%.

Because case mix is a function of medical information on the care provided individual patients, annual measured case mix growth can also be driven by factors that do not necessarily represent year-to-year increases in actual resource use. Improvements in medical record documentation and coding can lead to significant increases in measured case mix (also referred to as coding or DRG creep).[12]

To protect the system from increases in revenue due to coding creep (reported case mix increases not associated with commensurate increases in actual resource use or cost), the HSCRC imposed limitations on inpatient case mix growth (in FY 2010 that limit was 0.5%) when the system was at risk for this phenomenon during the transition to the use of a severity-adjusted DRG grouper. A separate limitation or cap of 1.35% was placed on outpatient case mix growth in FY 2011 with the introduction of the Charge per Visit (CPV) methodology.[13]

Current and historical HSCRC policy has been to allow hospitals additional revenue at the lower of actual case mix growth or the limit. For illustrative purposes only, the staff also has shown what the impact would be in the way of an overall increase in revenue per adjusted admission should measured case mix meet or exceed these limits. **Table 4** below shows the FY 2011 approved Updates on a separate basis but also identifies the overall impact on hospital rates and revenue in the "total" column (note: this "total" case mix result on **Table 4** was not meant to represent a policy of "blending" the approved case mix limit for both inpatient and outpatient services).

Table 4
FY 2011 Approved Update to Rates (inpatient, outpatient, and overall impact)

Approved Update - Rate Year Ending June 30, 2011
One Year Arrangement

		Inpatient	Outpatient	Total
1	Global Insight's - 1st Qtr Book for RY 6/30/11	2.29%	2.29%	2.29%
2	Inflation Forecast Error	0.38%	0.38%	0.38%
3	Subtotal Inflation Allowance	2.67%	2.67%	2.67%
4	Policy Adjustment (Improvement to US)	-1.29%	-1.29%	-1.29%
5	Subtotal Update	1.38%	1.38%	1.38%
6	Slippage For RY 2010	0.03%	0.03%	0.03%
7	Rate Update Provided	1.41%	1.41%	1.41%
8	Volume Adjustment (RY 2010 over RY 2009)	-0.23%	-0.23%	-0.23%
9	**CMI Adjustment (Lower of Actual or Limit)**	**0.50%**	**1.35%**	**0.82%**
10	**Full Update Provided**	**1.68%**	**2.53%**	**2.00%**
11	Estimated Volume Increase (RY 2011)	-0.89%	4.39%	1.10%
12	Overall Projected Revenue Increase 2011			3.10%
13	Update Factor in FY 2010			1.77%

[12] This experience is based on measured case mix growth dating back to the early 1980s in Maryland and the mid-late 1980s for Medicare. During periods of DRG creep (largely due to the adoption of a severity adjusted DRG grouper), the Commission witnessed annual case mix growth of between 3.0-4.0%.

[13] The CPV uses another categorical patient grouping system, Enhanced Ambulatory Patient Groups (EAPGs). Staff believes that the introduction of this new system may also present opportunities for hospitals to up-code their cases. Thus, the HSCRC imposed a case mix limitation on outpatient case mix growth for FY 2011.

Case Mix and Slippage: Case mix also has not been included in the slippage calculation, because unlike rate increases or decreases associated with reviews/spenddowns or volume changes, case mix increases are not necessarily commensurate with real changes in underlying cost (resource use) due to the propensity of hospitals to maximize their coding over time. Thus, the Commission opted for a system whereby hospitals receive either their actual measured case mix or the limit, whichever is lower.

Report on Case Mix Growth thus far for FY 2011: Staff recently performed an analysis on measured case mix growth for both inpatient and outpatient services for the current rate year relative to the case mix limits placed separately on inpatient and outpatient services. These results are presented in **Table 5** and described in the section that follows.

Table 5
Inpatient and Outpatient Case Mix growth 2011 vs. 2010
Case mix Results for FY 2011 - data from July - December (first 2 Quarters)

Inpatient Case Mix Growth	12 mo. 2010 vs 6 mo.	6 mo. 2010 vs 6 mo.
Inpatient Charge per Case (1)	-0.50%	**-0.26%**
Total Inpatient Case Mix Growth (2)	-0.05%	-0.51%
Total Inpatient Case Mix Growth with ODS	0.84%	0.49%

Notes:
(1) CPC case mix at "Level I" - just CPC included cases excludes Zero and One Day Stay cases (excluded by policy for 2011)
(2) Total case mix growth at "Level II" - CPC included, outlier revenue and categorical case revenue also excluding ODS cases
(3) Total case mix growth including ODS cases (ODS cases not subject to the 0.5% limit for FY 2011)

Outpatient Case Mix Growth	12 mo. 2010 vs 6 mo.	6 mo. 2010 vs 6 mo.
Outpatient Charge per Visit w/o Observation cases (1)	2.02%	**3.49%**
Outpatient Charge per Visit including Observation cases (2)	3.35%	4.99%
Estimated case mix associated with Observation cases (3)		1.28% to 1.59%

Notes:
(1) CPV case mix excluding Observation Cases (excluded by policy for 2011)
(2) Total CPV growth including Observation Cases
(3) Estimated Observation case mix growth

Inpatient Case Mix and Charge Experience: As shown in **Table 5,** total inpatient measured case mix decreased by -0.26% during the first 6 months of 2011 vs. the same period in 2010. Zero and One Day Stay ("ODS") cases (which were excluded from the case mix limit when they were removed from the CPC) registered a 0.70% increase in case mix and overall charge growth of 2.48% (see **Table 6** below). Thus, after a prolonged period of higher than historical case mix growth limited by the application of case mix "governors" and limits, we now appear to be seeing more normal and expected levels of case mix change in the rate system.

It should be noted that although the case mix of ODS cases is increasing by 0.70% in FY 2011 YTD, the overall charge growth of 2.48% is in line with what was expected (i.e., inpatient rate update in FY 2011 = 1.68% - see line 10 in **Table 4**, plus 0.70% case mix growth comes very close to the actual increase in ODS charge increase = 2.48%).[14]

[14] Both Maryland hospitals operating under the Commission's Charge per Case system and U.S. hospitals operating under Medicare's per case inpatient payment system had incentives to admit less intense cases. This is because under both systems, hospitals were either rewarded or paid an average amount for each patient (in a given diagnosis category) regardless of how long a patient needed to stay. Hospitals generated large rewards by admitting less intense cases rather than treating them more cost-effectively on an ambulatory basis. Maryland hospitals, possessed an even stronger incentive to follow this practice because this incentive applied to all-patients.

Outpatient Case Mix and Charge Experience: In FY 2011, the HSCRC implemented its Charge per Visit bundled constraint methodology for most hospital outpatient services. Previously, the Commission's outpatient payment system operated under a pure "fee-for-service" (FFS) structure. FFS payment systems are notorious for their lack of any incentive to control or constrain resource use. Medicare implemented its prospective and bundled payment system in the late 1990s. Maryland's CPV represents a more effective constraint system than Medicare's, because the Maryland approach bundles services more broadly that Medicare's Outpatient Prospective Payment System (OPPS).

For this first year of CPV implementation, the Commission imposed a limit because of the concerns associated with large potential case mix growth and the need to place constraints on outpatient coding and charge increases. The imposition of CPV constraints in 2011 represents a very positive step in the Commission's development of episode based payment. This system contains incentives to manage per visit and per episode costs and utilization year to year. CPV also provides a mechanism both to constrain and to measure outpatient resource use per case. Previously, these amounts passed through to payers without constraint.

In approving the CPV methodology and associated case mix limits for outpatient services, the Commission also agreed to exclude Outpatient Observation cases from the case mix limit. This decision was related to changes in Commission policy related to ODS cases, which was expected to encourage hospitals to shift care of low intensity cases from more expensive inpatient settings to less expensive outpatient Observation. Because of these changes, the HSCRC expected to see reductions in ODS cases and commensurate increases in outpatient Observation cases. **Table 6** below shows the experience thus far in FY 2011.

Indeed, ODS cases have decreased, both in the absolute and as a proportion of total inpatient admissions. Maryland also has witnessed a large increase in the number of outpatient Observation cases in FY 2011, from 13,737 to 33,771. In response to requests from the hospital industry, the Commission agreed not to subject Observation cases (which are a part of the CPV constraint methodology) to the outpatient case mix limit of 1.35%

Table 6

One Day Stay and Observation Volume, Case Mix and Charge Results 2011 vs. 2010

Case Volume and Charges - Zero & One Day Stays and Observation Cases

	6 mo FY 10	6 mo FY 11	6 mo 2010 vs 6 mo.
Zero and One Day Stay (ODS) Cases	75,343	66,064	-12.32%
Proportion ODS of total Admissions (1)	19.93%	16.66%	
Zero and One Day Stay Case Mix (2)			0.70%
Zero and One Day Stay charges (2)			2.48%
Observation Cases	13,737	33,771	145.84%
Observation Case Mix			1.59%
Observation Charges			6.47%

Notes:

(1) Maryland's percentage of Zero and One Day Stay cases have historically been much higher than the U.S. average and much higher than other states/jurisdicitons in the Mid-Atlantic Region

(2) The charge and case mix performance for ODS in FY 2011 conforms with expectations (1.68% update of inpatient plus 0.7% case mix growth = 2.48% which seems reasonable)

Staff Observations on Overall Case Mix: The past two years of inpatient case mix growth may indicate that hospitals are "maxing out" their ability over the short term to generate case mix creep through further documentation and coding enhancements. This may argue in favor removing the case mix limit on inpatient services in future years.

The reverse situation, however, appears to apply to outpatient services. With the advent of the CPV case mix appears to be growing at a rapid rate. Therefore, a separate limit on outpatient case mix growth appears warranted.

Regarding ODS and Observation cases, it appears that the results obtained over the first 6 months of FY 2011 conform to HSCRC staff expectations (i.e., reductions in ODS cases, a corresponding increase in case mix – as the easier cases are treated as Observation cases, otherwise increases in charges appear to be commensurate with the approved inpatient update for FY 2011).

6) Volume Adjustment: The volume adjustment reflects Commission policy regarding recognition of fixed and variable components of hospital cost. Current Commission policy is to recognize hospital costs as 85% variable. As volumes grow, hospitals obtain additional revenue. However, the Commission limits the amount of additional revenue hospitals get to "keep" to 85 cents on the dollar. This adjustment is symmetrical (i.e., if volumes decline, hospitals only lose 85 cents on the dollar, and the volume adjustment in a subsequent year will be positive).

FY 2012 Consideration: The volume adjustment included in the FY 2011 update reflected the assumed change in volume from FY 2009 to FY 2010. This was forecasted during the course of FY 2010 based on 9 months of data. FY 2010 volume growth was below this original estimate, and, as a result, the original adjustment imposed in FY 2011 was too large (negative). An adjustment to reflect the actual volume change from FY 2009 to FY 2010 is a component of the "Slippage" factor for FY 2012.

Per Commission policy, the FY 2012 volume adjustment will similarly reflect the FY 2011 volume change relative to FY 2010. Currently we have 8 months of volume data through February 2011. Volumes for FY 2011 appear to be declining from FY 2010 (overall volumes declined 0.94% year-to-date through February 2011 vs. 2010). Staff believes this is an unusual circumstance that appears to be directly related to the Commission's change in policy for ODS cases and the downturn in the business cycle both here in Maryland and nationally. Nationally, health policy experts expect that volume growth will rebound in FY 2012 and future years as economic activity returns to normal.[15]

Staff Comment: The Payers have in the past proposed increasing the Fixed Cost Volume adjustment from 15% to 25%. The purposes of the volume adjustment are to: 1) reflect the fact that hospital costs are both fixed and variable; and 2) act as a partial "break" on the incentive to increase volumes. Although the precise proportion of fixed vs. variable costs in the production process for hospital care varies over time, it should be noted that the MHA argued that hospital fixed costs in the short-run are closer to 60% (see MHA's testimony related to their proposed Admission-Readmission proposal from the December 10, 2010 Commission meeting).

Volume growth is the key factor contributing to the unsustainable overall cost growth in Maryland and the United States. Service use (hospital and non-hospital) is particularly high in Maryland relative to other states as reported in the Dartmouth Health Atlas and in recent data released by CMS and the Institute of Medicine.[16]

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[15] The YTD February volume decrease reported was less than the trend through YTD January largely because February 2010 was a very unusual month due to the massive snow storms. As a result, February 2010 case and visit volumes fall dramatically. March through June of 2010 volume did bounce back considerably, however. Accordingly, staff believes that this phenomenon may mean that the overall volume trend for FY 2011 is best represented by the YTD January statistics (-1.72% vs. FY 2010).

[16] Kaiser Health News: From California To The New York Island, A New Understanding Of Higher Medicare Spending, March 8, 2011. "*CMS provided similar estimates for the states, although most researchers generally consider that less*

Although hospitals will likely oppose such a change (because industry expectations are that volumes will indeed rise once again), the Commission should consider increasing the Volume Adjustment in FY 2012 to 25% or 30%. Such a change would potentially have three beneficial impacts on the Rate Setting System. Increasing the volume adjustment for the FY 2012 Update (retroactively) and future years (prospectively) would: 1) provide a higher positive adjustment in FY 2012 for hospitals reflecting volume declines in FY 2011; 2) provide stronger incentives to reduce volume growth in future years; and 3) provide rate protection for hospitals should volumes decline in future years.

7) Medicaid Assessment/Remittances: Because of continued operating deficits in the Medicaid program, the State has imposed a series of uniform and broad-based assessments on the Rate System in recent years. The Commission has met this requirement by sharing the burden of these assessments among hospitals and payers.

FY 2012 Consideration: The current Medicaid Assessment (to support the Medicaid Operating budget) is approximately $372 million. An additional $17.5 million was to be generated by granting the HSCRC the authority to pool Graduate Medical Education (GME) in all hospital rates.[17] However, this proposal to pool GME is strongly opposed by the Maryland Hospital Association and is not likely to remain in the Budget Reconciliation and Financing Amendment (BRFA) for FY 2012. Accordingly, the total amount of the Medicaid Assessment is likely to be approximately $390 million in FY 2012 (the $372 million plus $17.5 million). An Assessment of $390 million represents approximately 3.3% of projected FY 2012 net revenue (or a 2.3% increase over the 1.1% Assessment applied in FY 2011).

Staff Comment: In FY 2009, a year when the overall assessment was approximately $45 million, the Commission voted to approve a 50/50 sharing of the burden across hospitals. Each year the magnitude of the Medicaid Assessment has nearly tripled. If the Commission were to maintain the 30/70% split approved for FY 2011, this would require hospitals to remit approximately $117 million (this amount is approximately 30% of projected operating profits for FY 2011).

From a policy perspective, the sharing of the Medicaid Assessment is important in the context of increasing the amount the public pays for hospital services in FY 2012, and its impact on our Medicare Waiver cushion. The Assessment is also important in that it (along with the Policy/Productivity Adjustment in the Update) is another factor that will induce hospitals to control their costs in FY 2012. In this sense, the amount of inducement applied by way of the share of the Assessment allocated to hospitals is, perhaps, less important than the financial pressure applied in the form of a Productivity Adjustment.

Notwithstanding the impact of the Assessment on payers and the Waiver, one approach the Commission might consider is asking hospitals to shoulder at least the amount they absorbed in FY 2011 plus the $17.5 million of additional Assessments now imposed on the System due to the MHA opposition to the GME pooling strategy. This would constitute an approximate 15/85% sharing of the Assessment burden and require hospitals to remit approximately $56.5 million to Medicaid in FY 2012.

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useful data because state boundaries don't conform to specific hospital markets. In the new risk-adjusted analysis, Maryland topped all other states in spending per Medicare beneficiary, although officials cautioned that since Congress uniquely allows Maryland to set its own hospital reimbursement rates, the state can't be fairly compared to payments set by Medicare elsewhere else."

[17] Last year, the HSCRC staff estimated that the pooling of GME could save Medicaid $35 million per year ($17.5 million of State savings). This savings would occur because current Medicaid patients are concentrated at hospitals with large teaching programs. The costs of these teaching programs are reflected directly in these hospitals' rate structures. Spreading out this cost more broadly to all Maryland hospitals would generally reduce charges at teaching hospitals and raise charge levels at other facilities. Medicaid would save its proportion of this price drop. Despite the fact that this mechanism would produce savings without painful cuts to the industry, the Maryland Hospital Association has opposed this proposal.

This proposed allocation is presented in **Table 7** below. **Table 7** also shows what percentage the Medicaid Assessment accounts for as a proportion of both Gross Revenue (charges) and Net Patient Revenue (collections). Finally, Table 7 shows the incremental change in the Assessment burden to hospitals, payers, and the system as a whole.

Table 7 – Medicaid Assessment Applied for FY 10 & FY 11
Staff Recommended Assessment Allocation for FY 2012
and Calculation of Financial Pressure applied Hospitals

Summary of Past Years' Medicaid Assessment and Staff Proposed FY 2012 Allocation and Calculation of Financial Pressure on Hospitals

	FY 2010	FY 2011	FY 2012 (6)
Gross Revenue	$13,121,911,059	$13,606,886,054	$13,885,574,118
Net Revenue	$11,153,624,400	$11,565,853,146	$11,802,738,097
Total Medicaid Assessment	$45,744,353 (1)	$129,919,614	$389,825,000
Percent of Net Revenue	0.41%	1.12%	3.30%
Percent of Gross Charges	0.35%	0.95%	2.81%
Amount paid by Hospitals (2)	$27,884,061	$33,975,884	**$56,475,884** (6)
Percent of Net Revenue	0.25%	0.29%	0.48%
Amount included in Rates to Payers (3)	$21,012,108	$107,610,488	**$374,123,558** (6)
Percent of Gross Revenue	0.16%	0.79%	2.69%
Incremental amounts of assessment to Hospitals (4)		**0.04%**	**0.18%**
Incremental amounts of assessment to Payers (5)		**0.63%**	**1.90%**
Productivity adjustment applied		-1.29%	-1.15%
Incremental assessment to hospitals		-0.04%	-0.18%
Total Financial Pressure applied to hospitals		**-1.33%**	**-1.33%** (7)

Notes:
(1) FY 2010 assessments of $45.7 million were in rates for 6 months
(2) The amount included in rates for Payers must be presented as a percentage of Gross Revenues because assessments apply to gross charges
(3) The assessment amount allocated to hospital must be presented as a percentage of Net Revenues because net revenues are the amounts collected by hospitals.
(4) & (5) The incremental increases from additional assessment burdens for both hospitals and payers represent the additional pressure placed on both parties owing to increases in the Medicaid assessment.
(6) Assumes the FY 2012 assessment is split approximately 15% to hospitals and 85% to payers
(7) This reflects the financial pressure associated with Option 2 of the staff proposal

Staff will use the proposed allocation shown in **Table 7** for FY 2012 of $56.5 million allocated to hospitals (representing an increase of 0.18% over FY 2011) and a "grossed up" to charges amount of $374.1 million in rates to Payers (representing 1.9% increase from FY 2011) as the basis for its three Update Options presented in Section 3.3 below.

3.2 Hospital and Payer Industry Proposals

Maryland Hospital Association Proposal

For FY 2012, the MHA chose to submit a one-year rate proposal, 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 waiver and future payment system" (the MHA Proposal). **Table 8** shows the MHA Update proposal. Staff has slightly modified the original MHA Proposal for purposes of comparability. The following describes each component and identifies any variations from the HSCRC staff Options shown in Section 3.3.

Table 8
Maryland Hospital Association FY 2012 Rate Update Proposal
MHA Proposal - Split between Inpatient & Outpatient (Staff Representation)

Line #		Inpatient	Outpatient	Total
1	Global Insight's - 1st Qtr Book for RY 6/30/12	2.68%	2.68%	2.68%
2	Adjustment to Inflation	0.21%	0.21%	0.21%
3	Subtotal Inflation Allowance	2.89%	2.89%	2.89%
4	**Policy Adjustment (Improvement to US)**	**-0.41%**	**-0.41%**	**-0.41%**
5	Subtotal Update	2.48%	2.48%	2.48%
6	Slippage For RY 2011	-0.18%	-0.18%	-0.18%
7	Rate Update Provided	2.30%	2.30%	2.30%
8	Volume Adjustment (RY 2011 over RY 2010)	0.14%	0.14%	0.14%
9	CMI Adjustment (Guaranteed/ Blended)	0.50%	1.78%	1.00%
10	**Full (or "Base") Update Provided**	2.94%	4.22%	3.44%
11	Change in Deficit Assessment	-0.18%	-0.18%	-0.18%
12	Full Update Minus/Plus change in Assessment	2.76%	4.04%	3.26%
13	**Volume Change in FY 2011 YTD**	-3.66%	3.62%	-0.94%
14	Estimated Hospital Revenue Change	-1.00%	7.81%	2.29%
15	**Total Financial Pressure (Policy adj. and Assessment)**	-0.59%	-0.59%	-0.59%
16	Total Funds from Assessment/Remittance from Hospitals in FY 12			($55,500,000)
	Revenue Split per F/S schedules 8 months YTD	$6,200,910	$3,981,540	$10,182,450
		60.90%	39.10%	

Components of the MHA proposal:

1) & 2) Market Basket and MB Forecast: Same as calculated by staff. Table 8 reflects the April 2011 Market Basket forecast for FY 2012 of 2.68%.

3) Productivity Adjustment: According to MHA, hospitals have operated under 2 years of tight updates and believe it is appropriate (particularly after a year of declining volumes – FY 2011) to apply less pressure than what was applied in FY 2011 (MHA proposes "financial pressure" – combined assessment and productivity – of 0.59% vs. – 1.33% applied in FY 2011).

4) Slippage: Same as calculated by staff.

5) Case Mix: MHA is proposing an overall "guaranteed and blended" level of case mix for FY 2012 of 1.0%. Unlike the case mix policy for FY 2011, which applied separate limits on inpatient and outpatient case mix, the MHA proposal will allow hospitals to receive an overall guaranteed 1.0% for case mix growth (regardless of the actual amount and split of inpatient vs. outpatient case mix growth).

6) Volume Adjustment: The MHA proposal shows the impact of the Commission's current policy for volume, which is to apply a 15% fixed cost adjustment prospectively to rates. Despite declining volumes in FY 2011, the MHA does not support a move to 25% fixed cost adjustment (a policy change supported by both the HSCRC staff and the Payers).

7) Medicaid Assessment: MHA is proposing an allocation of $55.5 million of the $390 million Medicaid Assessment directly to hospitals. This allocation closely approximates the staff proposed allocation of $56.5 million.

Payer Representatives' Proposal

Representatives from United Health Care, CareFirst & Kaiser Permanente, Amerigroup, DHMH, and the State Health Employee Benefit Program remain steadfast in calling for a renewal of the Commission's past practice of approving a multi-year rate arrangement (as was accomplished previously for rate years: FYs 2001-2003, FYs 2004-2006 and FYs 2007-2009). In response to the HSCRC Chairman's request for a one-year proposal for FYs 2012, the Payer representatives submitted the following:

Table 9
Payer Representative FY 2012 Rate Update Proposal
Payer Proposal - Split between Inpatient & Outpatient (Staff Representation)

ne #		Inpatient	Outpatient	Total	
1	Global Insight's - 1st Qtr Book for RY 6/30/12	2.68%	2.68%	2.68%	
2	Adjustment to Inflation	0.21%	0.21%	0.21%	
3	Subtotal Inflation Allowance	2.89%	2.89%	**2.89%**	(1)
4	**Policy Adjustment (Improvement to US)**	-2.13%	-2.13%	-2.13%	
5	Subtotal Update	0.76%	0.76%	0.76%	
6	**Estimated Upfront Funding of ARR Arrangements in FY 12**	**0.25%**	**0.25%**	**0.25%**	(2)
7	Slippage For RY 2011	-0.18%	-0.18%	-0.18%	
8	Rate Update Provided	0.83%	0.83%	0.83%	
9	Volume Adjustment (RY 2011 over RY 2010)	0.23%	0.23%	0.23%	
10	CMI Adjustment (Lower of Actual or Limit)	0.50%	1.35%	0.83%	
11	**Full (or "Base") Update Provided**	1.56%	2.41%	**1.89%**	(1)
12	Change in Deficit Assessment	-0.70%	-0.70%	-0.70%	(3)
13	Full Update Minus/Plus change in Assessment	0.86%	1.71%	1.19%	
14	**Volume Change in FY 2011 YTD**	0.00%	0.00%	0.00%	(4)
15	Estimated Hospital Revenue Change	0.86%	1.71%	1.19%	
16	**Total Financial Pressure (Policy adj. and Assessment)**	**-2.83%**	**-2.83%**	**-2.83%**	
17	Total Funds from Assessment/Remittance from Hospitals in FY 12			($116,947,500)	
	Revenue Split per F/S schedules 8 months YTD	$6,200,910	$3,981,540	$10,182,450	
		60.90%	39.10%		

(1) The Payer Proposal was crafted to deliver a "full or base" update (prior to the allocation of the assessment) of 1.0% below the Market Basket (plus forecast error) estimate for FY 2012.
(2) The Payer Proposal also factors in an estimate for additional "up-front" funding to potential ARR hospitals (the HSCRC policy on ARRs allowed for a 0.5% increase to inpatient rates on a temporary and loaned basis for the first 2 years).
(3) The Payers' proposed allocation of the Medicaid assessment (30% to hospitals) results in about $117 from hospitals equaling an incremental increase in assessment funding from hospitals relative to FY 2011 of 0.70%. (above the 0.29% funded in FY 11)
(4) The Payers also believe that hospital volumes will not decline in FY 2012 from FY 2011 levels and may well increase.

Components of the Payer proposal:

1) & 2) Market Basket and MB Forecast: Same as calculated by staff. **Table 9** reflects the April 2011 Market Basket forecast for FY 2012 of 2.68%.

3) Productivity Adjustment: The Payer proposal was crafted to deliver a "full or base" Update that is 1.0% below the Market Basket estimate (plus forecast error) for FY 2012 (see lines 3, 4 and 10 in **Table 9**: MB plus forecast error of 0.21% equals 2.89%; this would require a productivity adjustment of -2.13%).

4) Slippage: Same as calculated by staff.

5) Recognition of Advance Funding of ARR Arrangements (line 6 in Table 9): The Payers also included an estimate of the additional revenue allowed ARR hospitals for FY 2012. This estimate is based on the assumption that 50% of the industry will opt for ARRs and receive 0.5% additional in inpatient rates (this is estimated by the Payers to be an additional 0.25% to rates in FY 2012).[18]

6) Case Mix: Same as recommended by staff.

7) Volume Adjustment: The Payers are recommending that the HSCRC's volume adjustment be changed from 15% to 25% both prospectively and retroactively (i.e., recognize the volume drop that will occur retro to July 1, 2011 and apply the higher 25% fixed cost adjustment to both that year and future years). Application of a 25% fixed cost adjustment would result in a positive 0.23% for FY 2012 (relative to the current 15% adjustment that raises rates by only 0.14%). The rationale for increasing this adjustment is to: 1) provide an expanded disincentive for hospitals to pursue volume growth; and 2) provide some additional protection to hospitals should volumes decline in future years.

8) Medicaid Assessment: The Payers are recommending retaining the 30%/70% split in the assessment for FY 2012. This would result in the hospitals funding nearly $117 million (or an incremental increase of 0.70% relative to FY 2011, when $33.9 million or approximately 0.29% of net revenue was funded by hospitals directly). The increase in the proportion of the assessment funded by hospitals increases the amount of financial pressure considerably (see **Table 15** for a comparison of options).

3.3 HSCRC Staff Proposed Options

Tables 10 – 12 present the HSCRC staff proposed Update Options for FY 2012. These three proposed Options were structured to induce a certain level of efficiency on hospitals – similar to the magnitude applied in the FY 2011 Update which included a Productivity Adjustment of -1.29% and an incremental increase in the Medicaid assessment of -0.04% (vs. FY 2010).

Option 1 applies a slightly less efficiency inducement than FY 2011 (-1.11% vs. -1.33%); Option 2 applies the same inducement in Y 2012 (-1.33%) and Option 3 applies slightly more inducement (-1.47 vs. -1.33%). Each Option is predicated on an approximate 15%/85% sharing of the Medicaid Assessment for FY 2012 (the hospitals' portion would be $56.5, million which was derived based on the amount allocated to hospitals in FY 2011 of $38.9 million plus $17.5 million associated with Medicaid savings that would otherwise have been generated by a move to full pooling of Graduate Medical Education (GME) costs in the system).

[18] Staff notes that while 25 hospitals have indicated interest in the ARR episode of care constraint structure for FY 2012, only three hospitals have signed agreements. In addition, any upfront funding of these arrangements is intended to be provided only on a temporary basis. HSCRC policy is to have hospitals repay these loaned amounts beginning in years 3 and 4 of any ARR arrangement with the Commission.

Table 10
Option 1: Less Financial Pressure than FY 2011
(-1.0% Productivity and $56.5 million Assessment)

HSCRC Option 1 (less Financial Pressure than FY 2011)

Line #		Inpatient	Outpatient	Total
1	Global Insight's - 1st Qtr Book for RY 6/30/12	2.68%	2.68%	2.68%
2	Adjustment to Inflation	0.21%	0.21%	0.21%
3	Subtotal Inflation Allowance	2.89%	2.89%	2.89%
4	**Policy Adjustment (Improvement to US)**	-1.00%	-1.00%	-1.00%
5	Subtotal Update	1.89%	1.89%	1.89%
6	Slippage For RY 2011	-0.18%	-0.18%	-0.18%
7	Rate Update Provided	1.71%	1.71%	1.71%
8	Volume Adjustment (RY 2011 over RY 2010) (1) 15% FC Adj.	0.14%	0.14%	0.14%
9	CMI Adjustment (Lower of Actual or Limit)	0.50%	1.35%	0.83%
10	**Full (or "Base") Update Provided**	2.35%	3.20%	2.68%
11	Change in Deficit Assessment	-0.18%	-0.18%	-0.18%
12	Full Update Minus/Plus change in Assessment	2.17%	3.02%	2.50%
13	**Volume Change in FY 2011 YTD**	-3.66%	3.62%	-0.94%
14	Estimated Hospital Revenue Change	-1.57%	6.75%	1.54%
15	**Total Financial Pressure (Policy adj. and Assessment)**	**-1.18%**	**-1.18%**	**-1.18%**
16	Total Funds from Assessment/Remittance from Hospitals			($56,475,884)
	Revenue Split per F/S schedules 8 months TTD	$6,200,910	$3,981,540	$10,182,450
		60.90%	39.10%	

(1) Assumes a 15% Fixed Cost Adjustment. The final volume adjustment has changed from previous analyses because volumes YTD through February 2011 (vs. the same period FY 2010) are now down -0.94% (15% x 0.94 = 0.14% shown).

HSCRC Staff Option 1: Less Financial Pressure than FY 2011

This Option places slightly less financial pressure on hospitals than in FY 2011. It fixes the Productivity Adjustment at -1.0% (vs. -1.29% in FY 2011), but increases the magnitude of the Medicaid Assessment applied to hospitals (from $33.9 million to $56.5 million). The combination of these two components is to apply a slightly lower level of financial pressure in FY 2012 (-1.18% line 15) than was applied in FY 2011.

Table 11
Option 2: Same Level of Financial Pressure as FY 2011
(-1.11% Productivity and $56.5 million Assessment)

HSCRC Option 2 (Same Financial Pressure as in FY 2011)

Line #			Inpatient	Outpatient	Total
1	Global Insight's - 1st Qtr Book for RY 6/30/12		2.68%	2.68%	2.68%
2	Adjustment to Inflation		0.21%	0.21%	0.21%
3	Subtotal Inflation Allowance		2.89%	2.89%	2.89%
4	**Policy Adjustment (Improvement to US)**		-1.15%	-1.15%	-1.15%
5	Subtotal Update		1.74%	1.74%	1.74%
6	Slippage For RY 2011		-0.18%	-0.18%	-0.18%
7	Rate Update Provided		1.56%	1.56%	1.56%
8	Volume Adjustment (RY 2011 over RY 2010) (1)	15% FC Adj.	0.14%	0.14%	0.14%
9	CMI Adjustment (Lower of Actual or Limit)		0.50%	1.35%	0.83%
10	**Full (or "Base") Update Provided**		2.20%	3.05%	2.53%
11	Change in Deficit Assessment		-0.18%	-0.18%	-0.18%
12	Full Update Minus/Plus change in Assessment		2.02%	2.87%	2.35%
13	**Volume Change in FY 2011 YTD**		-3.66%	3.62%	-0.94%
14	Estimated Hospital Revenue Change		-1.71%	6.59%	1.39%
15	**Total Financial Pressure (Policy adj. and Assessment)**		-1.33%	-1.33%	-1.33%
16	Total Funds from Assessment/Remittance from Hospitals				($56,475,884)
	Revenue Split per F/S schedules 8 months TTD		$6,200,910	$3,981,540	$10,182,450
			60.90%	39.10%	

(1) Assumes a 15% Fixed Cost Adjustment. The final volume adjustment has changed from previous analyses because volumes YTD through February 2011 (vs. the same period FY 2010) are now down -0.94% (15% x 0.94 = 0.14% shown).

HSCRC Staff Option 2: Target the Same Level Financial Pressure as FY 2011 Update

This Scenario attempts to mirror the total efficiency inducement placed on hospitals in FY 2011. It results in a slightly lower Productivity Adjustment (-1.11% vs. -1.29% in FY 2011), but increases the magnitude of the Medicaid Assessment applied to hospitals (from $33.4 million to $56.5 million). The combination of these two components is to apply the same level of efficiency inducement in FY 2012 (-1.33% line 15) as was applied in FY 2011.

Table 12
Option 3: Greater Financial Pressure in FY 2012
(Productivity Adjustment of -1.29% and $56.5 million Medicaid Assessment)

HSCRC Option 3 (More Financial Pressure than in FY 2011)

Line #			Inpatient	Outpatient	Total
1	Global Insight's - 1st Qtr Book for RY 6/30/12		2.68%	2.68%	2.68%
2	Adjustment to Inflation		0.21%	0.21%	0.21%
3	Subtotal Inflation Allowance		2.89%	2.89%	2.89%
4	**Policy Adjustment (Improvement to US)**		-1.29%	-1.29%	-1.29%
5	Subtotal Update		1.60%	1.60%	1.60%
6	Slippage For RY 2011		-0.18%	-0.18%	-0.18%
7	Rate Update Provided		1.42%	1.42%	1.42%
8	Volume Adjustment (RY 2011 over RY 2010) (1)	15% FC Adj.	0.14%	0.14%	0.14%
9	CMI Adjustment (Lower of Actual or Limit)		0.50%	1.35%	0.83%
10	**Full (or "Base") Update Provided**		2.06%	2.91%	2.39%
11	Change in Deficit Assessment		-0.18%	-0.18%	-0.18%
12	Full Update Minus/Plus change in Assessment		1.88%	2.73%	2.21%
13	**Volume Change in FY 2011 YTD**		-3.66%	3.62%	-0.94%
14	Estimated Hospital Revenue Change		-1.85%	6.45%	1.25%
15	**Total Financial Pressure (Policy adj. and Assessment)**		-1.47%	-1.47%	-1.47%
16	Total Funds from Assessment/Remittance from Hospitals				($56,475,884)
	Revenue Split per F/S schedules 8 months TTD		$6,200,910 60.90%	$3,981,540 39.10%	$10,182,450

(1) Assumes a 15% Fixed Cost Adjustment. The final volume adjustment has changed from previous analyses because volumes YTD through February 2011 (vs. the same period FY 2010) are now down -0.94% (15% x 0.94 = 0.14% shown).

HSCRC staff Option 3: Same Productivity Adjustment in FY 2012 as used in FY 2011 (increased financial pressure from FY 2011 because of increase in allocation of the assessment)

This Option attempts to mirror the total Productivity Adjustment in the FY 2011 Rate Update (of -1.29%) while, at the same time, increasing the magnitude of the Medicaid Assessment applied to hospitals (from $33.9 million to $56.5 million). The combination of these two components is to apply a slightly higher level of financial pressure in FY 2012 (-1.47% vs. -1.33% in FY 2011 see line 15).

Components of the Staff Update Options:

1) & 2) Market Basket and MB Forecast: Tables 10-12 reflect the April 2011 Market Basket forecast for FY 2012 of 2.68%. The MB forecasting error is calculated per the method adopted by the Commission for FY 2011 (use of the three most recent final MB estimates relative to the forecasted amounts).

3) Productivity Adjustment: As indicated, Options 1-3 in Tables 10-12 vary the Productivity Adjustments to generate Updates that "straddle" the FY 2011 Update in terms of the degree of "financial pressure" applied to Maryland hospitals.

4) Slippage: Staff calculation.

5) Case Mix: In all three Options, the staff is proposing a case mix policy identical to the current HSCRC policy: separate limits on inpatient and outpatient case mix of 0.5% and 1.35% respectively, with One Day Stay cases and Observation cases not subject to this limitation.

6) Volume Adjustment: The Staff Options all reflect current Commission policy for the volume adjustment (15% fixed cost). However, staff has long recommended gradually increasing this adjustment to help transition the rate system to more of a fixed cost system. Such a change (increasing the volume adjustment from 15% to 25% both retroactively and prospectively) would be consistent with the Commission's overall payment reform strategy, which encourages the adoption of more fixed cost payment structures such as the TPR and ARR.

7) Medicaid Assessment: As noted, the staff Options all reflect an approximate 15%/85% sharing of the Medicaid Assessment for FY 2012 (between hospitals and payers respectively). Options 1-3 above also show the incremental pressure placed on hospitals by increasing the assessment remitted directly from $33.9 million in FY 2011 to $56.5 million in FY 2012 (this equals a 0.18% additional financial burden).

Staff Comment: Given growing concerns about health care cost growth, including the State and federal budgetary impacts, the significant challenges in funding future insurance expansions, along with the need to encourage higher levels of efficiency from the Maryland hospital industry (commensurate with best-practice standards nationally), the HSCRC staff recommends applying a similar magnitude of financial burden on Maryland hospitals in FY 2012 as was applied in FY 2011 (as represented by Options 1-3 in **Tables 10-12** above).

Continued rate pressure is also important to provide gradually change the incentives in the payment system away from one that rewards providers for increased volumes, toward one that provides strong incentives for managing utilization and costs.

Continued rate pressure also is beneficial (as witnessed in FY 2011) in that it more strongly encourages hospitals to aggressively pursue more episode-based and global payment structures offered by the Commission.

While Options 1-3 all represent a continuation of the Commission's intent to impose tighter constraints on the growth of hospital revenues and costs, based on these observations, the staff preference is for the adoption of Option 3.

All five proposals and options are presented and compared in **Tables 13 -15** below.

Table 13
Comparison of MHA, Payer and Staff Options
FY 2012 Update Factor – From Hospital Perspective

UPDATE OPTIONS - FROM HOSPITAL PERSPECTIVE

Assumed Options for FY 2012		MHA Option		Less Pressure as in FY 2011 HSCRC Option 1	Same Pressure as in FY 2011 HSCRC Option 2	More Pressure as in FY 2011 HSCRC Option 3	Payer Option	
Line #								
1 Global Insight's - 1st Qtr Book for RY 6/30/12		2.68%		2.68%	2.68%	2.68%	2.68%	
2 Adjustment to Inflation		0.21%		0.21%	0.21%	0.21%	0.21%	
3 Subtotal Inflation Allowance		2.89%		2.89%	2.89%	2.89%	2.89%	
4 **Policy Adjustment (Improvement to US)**		**-0.41%**		**-1.00%**	**-1.15%**	**-1.29%**	**-2.13%**	
5 Subtotal Update		2.48%		1.89%	1.74%	1.60%	0.76%	
6 Estimated Upfront Funding for ARR Arrangements		NA		NA	NA	NA	**0.25%**	(9)
7 Slippage For RY 2011		-0.18%		-0.18%	-0.18%	-0.18%	-0.18%	
8 Rate Update Provided		2.30%		1.71%	1.56%	1.42%	0.83%	
9 Volume Adjustment (RY 2011 over RY 2010)	FC Factor 15.00%	0.14%	(1)	0.14%	0.14%	0.14%	0.23%	(10)
10 CMI Adjustment (Lower of Actual or Limit)		1.00%	(2)	0.83%	(8) 0.83%	0.83%	0.83%	
11 **Full (or "Base") Update Provided**		**3.44%**		**2.68%**	**2.53%**	**2.39%**	**1.89%**	
12 Change in Deficit Assessment		-0.18%	(3)	-0.18%	-0.18%	-0.18%	-0.70%	
13 Full Update Minus/Plus change in Assessment		3.26%		2.50%	2.35%	2.21%	1.19%	
14 Volume Change in FY 2011 YTD		**-0.94%**	**(4)**	**-0.94%**	**-0.94%**	**-0.94%**	**-0.94%**	
15 Est. change in Hospital "Markup" associated with Uncomp. Care funding		-0.30%		-0.30%	-0.30%	-0.30%	-0.30%	
16 Estimated Hospital Revenue Change		1.99%	(5)	1.24%	1.09%	0.95%	-0.06%	
17 Financial Pressure = Policy Adj. & Incremental Assessment Lines 4 + 12		**-0.59%**	(6)	**-1.18%**	**-1.33%**	**-1.47%**	**-2.83%**	
18 Total Funds from Assessment/Remittance from Hospitals		($55,500,000)	(7)	($56,475,884)	($56,475,884)	($56,475,884)	($116,947,500)	

Notes:

(1) Volume adjustment based on 8 months data through February YTD (changed from 7 month estimate through January based on new data)

(2) MHA has proposed a 1.0% guaranteed amount for Inpatient and Outpatient (blended) Case Mix

(3) MHA proposed hospital funding of deficit assessment of $55.5 million representing an approximate 0.18% increase from what was funded by hospitals in FY 2011

(4) Staff has traditionally represented the future year volume change based on the current year change in volume. Currently volumes are down 0.94% owing in large part to reductions in One Day Stays (ODS) cases. This reduction relates directly to rate policy changes the Commission enacted last year. Staff does not believe these these volume declines will continue however. We would estimate that volumes may well be flat in 2012 and thus a 0% increase would be more realistic (see Table 14)

(5) This is the estimated revenue change to the hospital industry based on each option and an assumed FY 2011 volume decline

(6) Amount of "financial pressure" (combination of incremental assessment and productivity adjustment) placed on hospitals in FY 2012 under each proposal/option.

(7) Total amount of Medicaid Assessment remitted directly from Hospitals in FY 2012 under each proposal

(8) Reflects the same Case Mix amounts for inpatient and outpatient (and structure) proposed in FY 2011 (staff would recommend the same approach in FY 2012)

(9) Payer proposal reflects estimated amount of up-front funding associated with ARR arrangements (see line 6)

(10) Reflects imposition of the Payer proposed 25% fixed cost adjustment

Table 14 - Comparison of MHA, Payer and Staff Options
FY 2012 Update Factor – From Payer Perspective

UPDATE OPTIONS - FROM PAYING PUBLIC PERSPECTIVE

Line #	Assumed Options for FY 2012	MHA Option		Less Pressure as in FY 2011 HSCRC Option 1	Same Pressure as in FY 2011 HSCRC Option 2	More Pressure as in FY 2011 HSCRC Option 3	Payer Option
10	**Full (or "Base") Update Provided**	**3.44%**		**2.68%**	**2.53%**	**2.39%**	**1.89%**
11	Change in Deficit Assessment	1.91%		1.90%	1.90%	1.90%	1.41%
12	Full Update Minus/Plus change in Assessment	5.35%		4.58%	4.43%	4.29%	3.30%
13	**Volume Change in FY 2011 YTD**	**-0.94%**	(1)	**-0.94%**	**-0.94%**	**-0.94%**	**-0.94%**
14	Estimated Hospital Revenue Change	4.36%		3.60%	3.45%	3.31%	2.33%
15	**Total Financial Pressure (Policy adj. and Assessment)**	**-0.59%**		**-1.18%**	**-1.33%**	**-1.47%**	**-2.83%**
16	Total Funds from Assessment/Remittance on Payers	$375,212,948		$374,123,555	$374,123,555	$374,123,555	$306,255,203

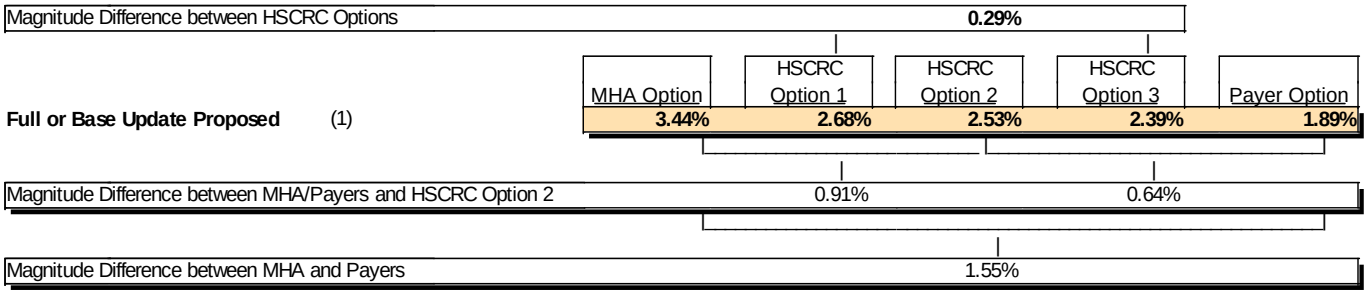
Alternative Analysis - Assuming Flat Volumes in FY 2012

13*	Staff projected Volume Change in FY 2012	0.00%		0.00%	0.00%	0.00%	0.00% (1)
14*	**Subtotal**	5.35%		4.58%	4.43%	4.29%	3.30%
15	Est. change in Hospital "Markup" associated with Uncomp. Care funding	-0.30%		-0.30%	-0.30%	-0.30%	-0.30%
16	Estimated impact on Paying Public	5.05%		4.28%	4.13%	3.99%	3.00% (2)

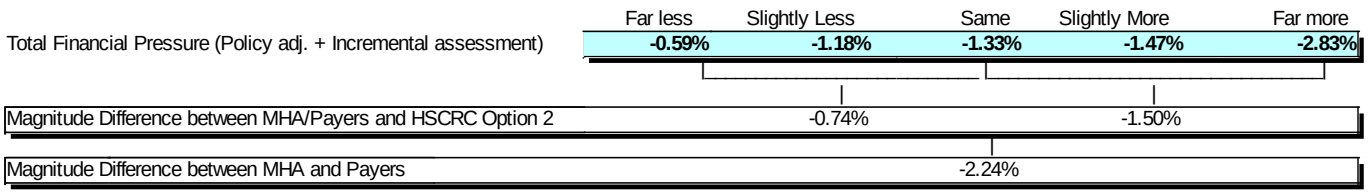
Notes:
(1) Staff has traditionally represented the future year volume change based on the current year change in volume. Currently volumes are down 0.94% owing in large part to reductions in One Day Stays (ODS) cases. This reduction relates directly to rate policy changes the Commission enacted last year. Staff does not believe these these volume declines will continue however. We would estimate that volumes may well be flat in 2012 and thus a 0% increase would be more realistic.
(2) Staff estimate of the impact on rates due to expected decreases in hospital Markups related to Uncompensated Care reductions

Table 15 – Comparison of MHA, Payer and Staff Options
FY 2012 Update Factor – Incremental Magnitude Differences

Differences Across Proposals/Options for "Base" Update and "Total Financial Pressure"



Level of Financial Pressure vs. FY 2011 Update



Note: Base Update in FY 2011 was 2.0% (see table 4 for a summary of the FY 2011 approved Update)

3.4 Additional Adjustments/Policy Decisions Associated with the FY 2012 Update

(does not require Commission action in April - to be presented at the May HSCRC meeting)

In addition to the need to approve an Update level and a split of the Medicaid Assessment (between hospitals and payers), the HSCRC must also eventually decide on the parameters associated with the revenue neutral scaling (rewards and penalties) based on hospitals' relative performance on: 1) the Reasonableness of Charges (ROC) comparison; and 2) the HCSRC's Quality-Based Reimbursement (QBR) and Maryland Hospital Acquired Conditions (MHAC) analyses.

The term "scaling" refers to the differential allocation of a pre-determined portion of base hospital revenue based on a distribution of hospital performance related to either relative efficiency or relative quality. This allocation is performed on a "revenue neutral" basis for the system as a whole. This means that the net increases in rates for better performing hospitals is funded entirely by net decreases in rates for poorer performing hospitals.

These decisions can be made at either the May or June Commission meetings after the approval of the FY 2012 Update Factor and Assessment split. Staff will continue to meet with MHA and Payer representatives in an attempt to craft a consensus proposal for the Commission on these scaling policies for the upcoming year.

Appendix 1

Summary of Conversations and Evidence from Recent Literature on the Changing nature of Hospital-Physician Contracting

- For most rural and inner-city facilities, the large majority of physician-related spending is for coverage needs, either for on-call requirements or subsidies to treat the proportionately larger number of Medicaid and uninsured patients.

- For most suburban and some large urban facilities, while these hospitals may need to provide some smaller subsidies to induce physicians to be on-call (in the range of $25,000 to 30,000 per year per physician), the majority of the contracting activity is oriented toward either increasing or maintaining a hospital's market share. Thus, these subsidies (usually in the form of pure employment with contracts that pay bonuses for additional billings) are geared toward either maintaining or increasing volumes;

- The way these employment contracts are structured is instructive as well in that the contracts tend to "front-load" the salaries/bonuses in years 1-3. These salaried amounts paid to physicians are generally much more than they have made on an independent basis. Then, in years 4-6, the contracts level out such that the physicians are more "paying for themselves." Overall however, the contracts are structured to provide bonuses (above salary) per physician using "relative value units" (or RVUs) as the basis for measuring physician productivity. Thus, these contracts are designed to encourage more case, visit and ancillary volume, over time.[19]

- This type of contracting activity applies primarily to specialists (orthopedists, cardiologists, urologists, gastroenterologists, and general surgeons). These are the physicians who can most directly influence both the volume and direction of hospital patient care.

- While some hospitals are subsidizing hospital-based physicians (radiologists, anesthesiologists, pathologists, and emergency room physicians), these subsidies do not account for as large a majority of the losses incurred. Obstetrics also contributes to some degree of loss, because malpractice expenses have grown significantly over the years. In many cases, to maintain a sufficient supply of Obstetricians, the hospital must place these physicians on salary and also pay for their malpractice expense. This allows the facility to maintain this needed service, which also has the benefit of attracting additional patients to a facility (OB traditionally has been viewed as a "gateway" service for hospitals).

- The aggregate HSCRC data collected on Physician Part-B revenues and expenses tend to be consistent with the information obtained by industry experts. The largest Physician Part-B losses are concentrated at inner-city hospitals (coverage and subsidy issues due to unfavorable payer mix) and suburban facilities (likely related to employment and performance bonus contracts to maintain or increase market share).

[19] Relative Value Units (RVUs) are a calibration system developed for the Medicare program to quantity levels of physician activity

Using Health Information Exchange Data to Create a Unique Patient Identifier That Supports Accurate Measurement of Hospital-specific Readmission Performance

FINAL STAFF RECOMMENDATION

Health Services Cost Review Commission
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April 15, 2011

This document represents a final amended recommendation approved at the HSCRC's April 15, 2011 public meeting for action by the Commission.

1. Introduction

The United States health care system currently experiences an unacceptably high rate of unnecessary hospital readmissions. These excessive readmission rates are a symptom of our fragmented payment system and result in considerable unnecessary cost and substandard care quality. According to the CMS analysis of Medicare data, the state of Maryland has among the highest all-cause readmission rate in the US. The readmission rate in Maryland for Medicare patients is 24.1% compared to a national average of 19.3%.

In 2011, The HSCRC is expanding its Total Patient Revenue ("TPR") structure - a global budget or capitated payment structure covering a given hospital's inpatient and outpatient regulated facility charges- from two hospitals to ten hospitals. At its December 2010 Commission meeting, the HSCRC approved the Admission-Readmission Revenue ("ARR") episode payment structure. Both the TPR and ARR initiatives are designed to provide incentives for hospitals to improve overall care coordination and substantially reduce readmission rates, and represent important and urgently needed steps in the Commission's attempt to utilize its current regulatory authority to better rationalize Maryland's hospital payment and delivery system. Sufficient patient identifier fields must be collected and used to create a reliable unique patient ID which is essential to fully measure readmissions, both inter- and intra-hospital readmissions, and further strengthen the financial incentives linked with performance. Leveraging the already established infrastructure of the state's designated Health Information Exchange, a structure explicitly established and mandated to electronically connect all healthcare providers in the state, offers a "win-win" solution for creating a unique patient ID that benefits the Commission, providers, payers and most importantly, consumers.

2. Variation in Inter- and Intra-Hospital Readmission Rates

Using 2008 Medicare Provider Analysis and Review (MEDPAR) data for its analysis of Maryland hospital readmissions, HSCRC staff found wide hospital variation in the unadjusted readmission rates for intra-hospital (within), inter-hospital (across) and total readmission rates. Overall, total readmission rates are 30% and 26% higher than the readmission rates for intra-hospital readmission rates for 15 day and 30 day readmission intervals, respectively. In some hospitals the difference between the intra-hospital readmission rate and the total readmission rate is as low as 2% while in others it is more than 50%.

The above findings highlight the need to measure readmissions both within and across hospitals in order to fairly and accurately assess hospital-specific performance on readmissions and ultimately support better patient care management and coordination activities that reduce readmissions and improve quality and patient care outcomes.

3. Current HSCRC Data Constraints to Develop a Unique Patient Identifier

The patient-specific -fields submitted to HSCRC by hospitals in the inpatient data set are limited to medical record number (MRN), date of birth (DOB), gender, and zip code. HSCRC staff has attempted to link patient records across hospitals using these patient-specific data elements. The comparison of the linkage results with the MEDPAR data set which does include a unique patient identifier number revealed that the data elements HSCRC currently collects are insufficient to accurately link records of unique patients across hospitals. Therefore, the Commission is unable to fully measure and compare hospital-specific performance on readmissions and use the data to further enhance and strengthen the financial incentives linked with performance.

4. Options Considered for Creating Unique Patient IDs

To determine the patient identifier fields necessary to reliably create a unique patient identifier, HSCRC staff have done substantial "fact-finding" research through interviews with 15 states that currently use unique patient IDs, and consulted with experts in the field through the Agency for Healthcare Research and Quality. Subsequently, staff evaluated two options to create a unique patient ID that will enable tracking readmissions across hospitals. The first option is to collect additional personal identifiers with the existing data collection method and create a unique ID after data are submitted to HSCRC. The second option is to benefit from data infrastructure already in progress though Chesapeake Regional Information System for our Patients (CRISP), the Maryland Health Information Exchange designated by the Maryland Health Care Commission.

While it is possible to use the first option, one major drawback is that hospitals and patients will not be able to benefit from the creation of a unique ID immediately since tracking readmissions across hospitals would have a time lag, which is between three and six months, due to submission schedules of HSCRC data. As hospitals are moving toward implementing care-coordination strategies and information exchange, tracking readmissions across hospitals in real or close to real time, which the CRISP infrastructure supports by design, will inform care personnel and improve the care for these patients.

5. CRISP Work To Date

Consistent with its chartered mandate to electronically connect all healthcare providers in the state, CRISP's infrastructure uses a hybrid-federated model that is supported by two technology vendors. Axolotl Corporation, an Ingenix company, provides the core infrastructure, and Initiate Systems, an IBM company, provides the master patient index ("MPI") technology.

In the Fall of 2010, CRISP began receiving clinical data from five hospitals, three large radiology centers, and two national labs. Since that point, CRISP has engaged with an additional 25 acute care hospitals to achieve connectivity with the statewide HIE. When connecting with CRISP,

hospitals submit admission, discharge and transfer data (primarily demographic data), as well as laboratory results, radiology reports, and a series of electronic documents such as discharge summaries.

5.1. Master Patient Index

A core component of CRISP's technology infrastructure is the MPI. This technology allows CRISP to apply probabilistic algorithms to data received from an individual hospital and across hospitals (as other healthcare facilities) to uniquely identify patients that may have varying demographic data and different medical record numbers. The MPI assigns an Enterprise Patient Identifier that cross-references all of the local medical record numbers from facilities, including from within a facility which may have not matched accurately.

6. Industry Engagement

HSCRC staff has had ongoing discussions about the unique ID issues with the Maryland Hospital Association and industry stakeholders over the last several months, and staff believe there is consensus that sufficient patient identifier fields must be collected and used to create a reliable unique patient ID. In addition, there is agreement that a unique patient ID is necessary to fully measure readmissions, both inter- and intra-hospital readmissions. In March 2011, HSCRC convened a meeting of approximately 50 hospital case mix liaison representatives and other stakeholders to review the Commission's plan to propose that hospitals be mandated to connect with CRISP and provide the fields needed to create the MPI by December 1, 2011. Several hospitals indicated that readiness to connect with CRISP was imminent, or they were already connected. As a next step, at the request of the participants of a stakeholder meeting held in March, within the next few weeks HSCRC will coordinate with MHCC and CRISP staff to convene an industry meeting to address technical questions as the process moves forward.

7. CRISP Creation of a Unique Patient ID

To create a uniform unique patient ID that can be used by HSCRC to track readmissions, the staff is proposing to require all hospitals to connect with CRISP and submit to CRISP the newly required data fields indicated below for all hospital admission / discharge related events.

Field Name	HSCRC New Requirement	HSCRC Current Requirement
Name, First	**Yes**	
Name, Middle Initial	**Yes**	
Name, Last	**Yes**	
Address	**Yes**	
Address, City	**Yes**	

Field Name	HSCRC New Requirement	HSCRC Current Requirement
Address, State	**Yes**	
Address, Zip code	**Yes**	**Yes**
Date of Birth	**Yes**	**Yes**
Gender	**Yes**	**Yes**
Social Security Number	**Yes***	
Visit/Encounter ID (VID)	**Yes****	
Medical Record Number (MRN)	**Yes**	**Yes**
Enterprise / System Level Patient ID	**Yes*****	
Admission Timestamp	**Yes**	**Yes**
Discharge Timestamp	**Yes**	**Yes**

Yes*- Field required only if information is provided by patient
Yes** -This data field should be a unique number to identify a specific visit
Yes** *- If Hospital has an Enterprise ID in addition to the Medical Record Number

Using the patient information submitted by the hospital, CRISP will create a MPI for each unique patient using a probabilistic matching algorithm. CRISP will be required to provide reports to the HSCRC at the patient level which will include at least the following fields:

- Enterprise MPI Number
- Hospital/Facility ID
- Medical Record Number
- Date of Admission
- Date of Discharge

The exact list of fields that will be required to match the report from CRISP to HSCRC's data set will be determined based on the analysis of a pilot data set. HSCRC may require CRISP to use an HSCRC algorithm to generate a supplemental HSCRC ID for the purposes of matching against other hospital reported data.

8. Proposed Timeframe

Staff are proposing that the Commission require, through regulation, hospital connectivity with CRISP by December 1, 2011 to ensure full hospital participation as well as fair and accurate measurement of readmission performance. The initial target for the first set of CRISP reports to HSCRC is CY Q3 2011. Beginning with 9-1-11, hospitals will connect "real time" with CRISP, and CRISP will provide quarterly reports to HSCRC thereafter. In addition, ideally CRISP will have the capability to initially receive a bolus of historical data from hospitals covering 3-1-10 to

3-31-11, commensurate with what would be an ARR base period for calculating inter-hospital readmissions. However, ongoing development work is needed to modify the existing CRISP infrastructure to support HSCRC requirements, and HSCRC will work with CRISP on detailed implementation steps and timelines as we move forward.

RECOMMENDATIONS

Staff recommend that the Commission approve the following recommendations:

1. Move forward the Proposed Action to promulgate regulations that require hospitals to connect with the state Health Information Exchange as stated in "Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE , Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION, Chapter 07 Health Information Exchange Data."
2. Hospitals establish connectivity with State-Designated HIE by December 1, 2011.
3. Hospitals have capability to submit the data elements outlined in Section 7 of this recommendation.
4. HSCRC publish data elements required for submission in the "Maryland Register" and on the Commission's website (http://www.hscrc.state.md.us).
5. HSCRC publish the format and data time period for submission in the "Maryland Register" and on the Commission's website.
6. To provide flexibility to make changes to the required data elements that may change over time, the changes be specified via the HSCRC website with a notice of change in the Maryland Register.
7. HSCRC use these data to fully measure and compare hospital-specific performance on readmissions and to use the data to further enhance and strengthen the financial incentives linked with performance.

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 07 Health Information Exchange Data

Authority: Health-General Article, §§19-143, 19-207, 19-212, 19-215, and 19-216, Annotated Code of Maryland

NOTICE OF PROPOSED REGULATION

The Health Services Cost Review Commission proposes to adopt new Regulations **.01- .07** under a new chapter, **COMAR 10.30.07 Health Information Exchange Data**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on April 15, 2011, notice of which was given pursuant to State Government Article, § 10-506(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about August 8, 2011.

Statement of Purpose

The purpose of this action is to enable the Commission to fully measure and compare hospital-specific performance on readmissions and to use the data to further enhance and strengthen the financial incentives linked with performance.

Comparison of Federal Standards

There are no corresponding federal standards to this proposed action.

Estimate of Economic Impact

See Attached.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or (410) 764-2576, or fax to (410) 358-6217, or email to dkemp@hscrc.state.md.us. The Health Services Cost Review Commission will consider comments on the proposed amendments until June 20, 2011. A hearing may be held at the discretion of the Commission.

.01 Purpose.

The purpose of these regulations is to enable the Commission to fully measure and compare hospital-specific performance on readmissions and to use the data to further enhance and strengthen the financial incentives linked with performance.

.02 Definitions.

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

B. Terms Defined.

(1) "Health Services Cost Review Commission (Commission)" means the independent organization within the Department of Health and Mental Hygiene that is responsible for reviewing and approving the rates for hospitals pursuant to Health-General Article, §19-201 et seq., Annotated Code of Maryland.

(2) "Maryland Health Care Commission (MHCC)" means the agency established by Health-General Article, Title 19, Subtitle 2, Annotated Code of Maryland.

(3) "Health Information Exchange (HIE)" means an infrastructure that provides organizational and technical capabilities for the exchange of protected health information electronically among entities not under common ownership.

(4) "Master Patient Index (MPI)" means an electronic database, created by the State-Designated HIE that maintains a unique index (or identifier) for every individual who has been, or who becomes, registered as a patient at a Maryland hospital.

(5) "State-Designated HIE" means an HIE designated by the MHCC.

.03 Hospital Participation.

Effective December 1, 2011, each hospital under the jurisdiction of the Commission shall electronically connect to the State-Designated HIE to enable the Commission to fully measure hospital-specific performance on readmissions using the HIE's MPI.

.04 Method of Connection.

Each hospital shall establish connectivity with the State-Designated HIE over a secure and encrypted connection. This connectivity shall be established using industry standards specified by the State-Designated HIE.

.05 Collection and Submission of Master Patient Index Data.

Each hospital under the jurisdiction of the Commission shall collect and electronically submit to the State-Designated HIE the data elements as published in the "Maryland Register" and on the Commission's website (http://www.hscrc.state.md.us). The format and data time period for submission shall also be published in the "Maryland Register" and on the Commission's website.

.06 Privacy of Information.

Data submitted in accordance with this chapter are not public information pursuant to Health-General Article, § 19-207(d), Annotated Code of Maryland. The Commission will take reasonable steps to safeguard and protect the confidentiality of protected health information consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Maryland Confidentiality of Medical Records Act, and all other applicable State and federal laws and regulations.

.07 Summary Studies, Reports, Compilations.

Summary studies, reports, or other compilations developed by the Commission or its staff from the data submitted in accordance with this chapter shall be public information except that disclosure may not be made in such a way that the data furnished can lead to the identification of an individual.

.08 Corrections to Data.

The Commission shall prescribe on its website the process for a hospital to submit corrections and revisions to the data it has submitted.

.09 Required Report

Data submitted in accordance with this chapter shall be considered a required report under COMAR 10.37.01N.

FREDERICK W. PUDDESTER
Chairman
Health Services Cost Review Commission

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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TO: Commissioners

FROM: Legal Department

DATE: April 11, 2011

RE: Hearing and Meeting Schedule

Public Session:

May 4, 2011 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

June 1, 2011 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

The Agenda for the Executive and Public Sessions will be available for your review on the Commission's website on the Thursday before the Commission meeting. To review the Agenda, visit the Commission's website at: http://www.hscrc.state.md.us/commissionMeetingSchedule.cfm.

Post-meeting documents will be available on the Commission's website following the Commission meeting.