STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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480th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
August 11, 2011

EXECUTIVE SESSION
9:30 a.m.

Personnel Issues

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
10:00 a.m.

1. **Review of the Public Meeting Minutes of July 6, 2011**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**
   2119R – Carroll County Hospital
   2120R – Dimensions Healthcare System
   2121A – Johns Hopkins Health System
   2122A – Johns Hopkins Health System
   2123A – Johns Hopkins Health System
   2125A – Johns Hopkins Health System

4. **Docket Status – Cases Open**
   2114N – Adventist Behavioral Health
   2116N – Germantown Emergency Center + Previous Letter to Chairman from Hal Cohen
   2118N – Bowie Emergency Center
   2124A – Johns Hopkins Health System
   2126A – University of Maryland Medical Center
   2127A – University of Maryland Medical Center
   2128A – MedStar Health

5. **Draft Recommendation on Residual Outlier Policy for Update Factor Scaling Based on Reasonableness of Charges (ROC) report beginning in FY 2013**

6. **Overview of the Averted Bad Debt Policy**
7. **Legal Report**
8. **Hearing and Meeting Schedule**

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

AS OF AUGUST 1, 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
2114N	Adventist Behavioral Health	5/18/2011	8/11/2011	10/17/2011	PSI	CO	OPEN
2116N	Germantown Emergency Center	5/18/2011	8/11/2011	10/17/2011	FSE	GS	OPEN
2118N	Bowie Emergency Center	5/24/2011	8/11/2011	10/23/2011	FSE	GS	OPEN
2124A	Johns Hopkins Health System	6/10/2011	N/A	N/A	ARM	DNP	OPEN
2126A	University of Maryland Medical Center	7/8/2011	N/A	N/A	ARM	DNP	OPEN
2127A	University of Maryland Medical Center	7/8/2011	N/A	N/A	ARM	DNP	OPEN
2128A	MedStar Health	7/29/2011	N/A	N/A	ARM	SP	OPEN

PRCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*	**COST REVIEW COMMISSION**
ADVENTIST BEHAVIORAL	*	**DOCKET: 2011**
HEALTH	*	**FOLIO: 1924**
ROCKVILLE, MARYLAND	*	**PROCEEDING: 2114N**

Staff Recommendation

August 11, 2011

Introduction

On May 18, 2011, Adventist Behavioral Health (the "Hospital") submitted a partial rate application to the Commission requesting a rate for Psychiatric Intensive Care (PSI) services. As an acute psychiatric facility, the Hospital is the largest provider of mental health services in Montgomery County. The Hospital is requesting the lower of $989.25 per patient day or the current statewide median rate for this service, to be effective June 1, 2011.

Staff Evaluation

The Hospital requested the new PSI rate because under an arrangement with the federal government, it will soon be treating patients referred by the U.S. military, who have more severe psychiatric conditions than the Hospital's current patient population. Due to the severity of their illnesses, these patients, at times, require 1:1 nursing care.

Since there are currently no other approved PSI rates in Maryland hospitals, staff requested financial projections from the Hospital. Based on the data provided by the Hospital, staff determined that the projected PSI rate is reflective of the projected increased costs and appears to be reasonable in light of the greater intensity of service required.

In addition, Staff determined that the Hospital was not required to obtain Certificate of Need approval to provide PSI services, since there are no new beds associated with this service.

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 an PSI rate of $989.25 per day be approved effective July 1, 2011; and
3. That the PSI rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

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IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF SHADY GROVE	*	**COST REVIEW COMMISSION**	
ADVENTIST HOSPITAL -	*	**DOCKET:**	**2011**
GERMANTOWN EMERGENCY CENTER	*	**FOLIO:**	**1926**
GERMANTOWN, MARYLAND	*	**PROCEEDING:**	**2116N**

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<u>Staff Recommendation</u>

August 11, 2011

Introduction

On May 13, 2011, Shady Grove Adventist Hospital (the "Hospital," or "SGAH") submitted a partial rate application to the Commission on behalf of the Germantown Emergency Center ("GEC") requesting a rate for emergency and related ancillary services provided at the Center. The Hospital is requesting that the rates be approved effective July 1, 2011.

Chapters 505 and 506 of the 2010 Laws of Maryland require the Commission to set rates for all payers for emergency services provided at two freestanding medical facilities operating as pilot projects under legislation passed in 2005 and 2007. The pilot facilities are the Queen Anne's Freestanding Emergency Medical Center and the Germantown Emergency Center. The 2010 legislation also requires the Commission to set rates for all payers for emergency services provided at the Bowie Health Center.

Specifically, the 2005 freestanding medical facility legislation (Chapters 549 and 550 of the 2005 Laws of Maryland):

- Defined a freestanding medical facility as one:
    - in which medical and health services are provided;
    - that is physically separated from a hospital or hospital grounds;
    - that is an administrative part of a hospital or related institution; and
    - that is open 24 hours a day, 7 days per week.
- established a licensure category and process for freestanding medical facilities;
- set standards for freestanding medical facilities;
- created a freestanding medical facility pilot project in Montgomery County which:
    - required private carriers and MCOs to reimburse the pilot project facility based on a contract executed between the facility and the payer; and

- required Medicaid, when paying on a fee-for services basis, to reimburse a project at a rate no less than what is paid by Medicare; and

- required the Maryland Health Care Commission (MHCC) to collect data and report on the operations and utilization of the pilot facility.

The 2010 legislation removed many of these provisions and requires HSCRC to set rates for the pilot projects and the Bowie Health Center, and prohibits any additional freestanding facilities to be established until after July 1, 2015. However, a Certificate of Need would be required.

After the Germantown Emergency Center became the first pilot project in 2005, it attempted to obtain provider-based status from Medicare in order to receive facility fee reimbursement. Ultimately, after various administrative and legal proceedings, it was determined that if the HSCRC did not set a rate for the freestanding medical facility, Medicare would not pay a facility fee. Since the HSCRC will be setting rates for these facilities pursuant to the 2010 legislation, Medicare will begin paying the corresponding facility fee.

In February 2010, MHCC released a report on the operations of the GEC. Some of the key findings include:

- In comparison with hospital emergency departments, a larger proportion of visits to GEC were low acuity, while a smaller proportion were high acuity.
- Data reported on the mode of arrival indicate that the vast majority of patients using GEC walk in for service. In fiscal year 2009, 97% of discharged patients walked in for service, while approximately 3% arrived via public safety ground ambulance.
- GEC did not generate a net profit in its first two years of operation. In fiscal year 2007, losses in the amount of $994,700 were reported. In fiscal year 2008, losses declined to $847,300.

- Data on the use of the Hospital emergency department showed that opening GEC reduced demand for care at the hospital emergency department. Over the period 2000 to 2006, emergency department visits at the Hospital increased by an average of 4.5% annually. With the opening of the GEC in fiscal year 2007, volumes at the SGAH emergency department declined by about 10,000 visits or 11.4 percent. In fiscal year 2008, SGAH visits declined another 4.2%, and in 2009 such visits increased slightly.

In compliance with 2010 legislation, on November 3, 2010, the Commission approved provisional rates for the Queen Anne's Freestanding Emergency Center effective October 1, 2010 (HSCRC Proceeding 2090N). These rates will be revisited following the availability of data on actual experience at the Queen Anne's Freestanding Emergency Medical Center, and the outcome of this rate application.

Staff Evaluation

The Commission typically provides a hospital with the lesser of the state-wide median rate or the hospital's requested rate based on projected cost for new services. The Hospital requested that rates be set for Emergency Room, CT Scanner, Laboratory, Radiology Diagnostic, Electrocardiography, Medical Supplies, and Drugs revenue centers based on the actual cost structure of GEC. The staff believes that the approved cost per unit of service for this facility should not be more than that approved at SGAH, since the overhead associated with the freestanding facility should be less than that of the Hospital. Therefore, the staff conducted its review by comparing the requested GEC cost per unit, by revenue center, to the approved cost per unit of SGAH and provided GEC with the lower of the two. Additionally, the staff believes that the cost of GEC should be no more than the statewide median cost. Therefore the staff provided GEC with the lesser of the cost per unit

previously calculated (GEC versus SGAH) and the approved statewide median cost per unit. The cost per unit for each revenue center was then increased by the approved update factor of 1.56%.

Finally, in order to arrive at the approved rate per unit for each revenue center, a markup was calculated based on GEC's actual payer mix and uncompensated care (UCC) for FY 2010. UCC for FY 2010 was $2,337,961 or 14.89% of charges. The approved markup for FY 2012 is 1.2154.

Recommendation

Based on the above calculations, the staff recommends the following rates at GEC effective July 1, 2011:

	Approved Rate	Units of Service	Approved Revenue
Free Standing Emergency	$40.80	153,094	$6,245,579
CT Scanner	$6.24	97,097	$605,513
Laboratory	$1.55	643,170	$997,042
Radiology Diagnostic	$29.44	74,029	$2,179,563
Electrocardiography	$3.04	32,724	$99,414
Medical Supplies	Overhead of $32,918 plus the cost of medical supplies times 1.2154 markup		
Cost of Drugs	Overhead of $94,362 plus the cost of drugs times 1.2154 markup		

Staff further recommends that the UCC for FY 2013 be based on GEC's actual UCC for FY's 2010 and 2011 and that the UCC for future years be based on the most current three year average. Finally, the staff recommends that the facility report to the Commission all applicable data and information required of all other hospitals regulated under the all-payer system in the time frames dictated by the Commission.

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June 9, 2011

Fred Puddester, Chairman
Health Services Cost Review Commission
4201 Patterson Avenue
Baltimore, MD 21215

Re: Germantown Emergency Center (GEC) – ~~2115N~~ 1

Dear Chairman Puddester:

I am writing this letter on behalf of CareFirst Blue Cross Blue Shield in regard to the partial rate application filed by GEC on May 13, 2011 and docketed on May 18, 2011. In its rate application, GEC asks that its rates be set as follows (all rates are per RVU):

Emergency Room (ER)	$53.7759
Electrocardiography (EKG)	$4.1103
Laboratory (LAB)	$2.8523
Radiology Diagnostic (RAD)	$38.4339
CAT Scan (CAT)	$8.8721

In addition, GEC asks approval to charge for Medical Supplies at invoice cost plus markup plus overhead of $26,669 and for Drugs at invoice cost plus markup plus overhead of $76,448. The requested mark-up is 1.215374.

In support of this application, GEC submits one page marked confidential which purports to show its costs. I can find no support for its markup request. While the page says confidential, staff determined that it did not meet the requirement for confidentiality and provided me with a copy. Absent this page, there would be no support whatsoever for the requested rates.

CareFirst finds that the requested rates are much too high. This is not the time, if there ever is a time, to approve a higher cost alternative to hospital emergency rooms. Much of current policy involves developing lower cost alternatives to ERs. Yet this Partial Rate Application proposes a higher cost alternative by requesting rates that are well above those at alternative ERs.

In my comments, I address the proposed rates for ER, LAB, RAD and CAT. As the GEC application (on the unnumbered page marked CONFIDENTIAL) shows, these four rates represent 96% of the request. (($6,773,858 + $1,509,442 + $2,341,025 + $708,799)/$11,802,308 = 0.960)

For very good reason, the HSCRC does not just accept costs as the basis for rates. To do so would encourage high costs and even higher projections of cost. The HSCRC uses standards. The common standard for a partial rate application is the lower of the hospital's proposed marked-up costs and the median hospital rate for that service. CareFirst believes that standard approach would be acceptable with one adjustment. Hospital rates include three different levies or taxes. These are 1) a levy to finance MHIP; 2) a levy to finance the Medicaid expansion via paying the state the lion's share (if not all) of averted bad debts; and 3) a levy to finance Medicaid's budget problems. My understanding is that these levies do not apply to freestanding ambulatory surgery centers. Therefore, the hospital median should be reduced by the total percentage of the median rate that is represented by the three levies.

I now turn to the individual rates that I address in this letter.

EMG

The EMG rate request ($53.7759 per RVU) would be higher than all but four hospitals. The four hospitals with higher rates would be Prince Georges, University, Bon Secours and Johns Hopkins. Two of these hospitals have lots of money in rates for teaching and the other two having lots of money in rates for disproportionate share, neither of which applies to GEC. The $53.7759 rate is 27.5% higher than Shady Grove Hospital's ER rate and 40.6% higher than the median rate. It is almost 80% higher than Holy Cross' EMG rate. Note EMG rates are currently set based on Relative Value Units, so the fact that GEC treats simpler cases should result in fewer RVUs per ED visit, but the rate per RVU should be lower, not much higher, than the hospital median. Since the rate goes into effect July 1, 2011, CareFirst suggests that the median be increased for the base update recently approved by the HSCRC since GEC will not be associated with any of the activities subject to revenue neutral scaling.

LAB

The LAB rate request ($2.8523 per RVU) is higher than all but one acute care hospital (McCready) which is on the Total Patient Revenue System. The request is 47.2% higher than the median, 97.1% higher than the rate at Shady Grove, 54.7% higher than Suburban, which has the median rate for Montgomery County and 34.5% higher than Holy Cross, which has the highest hospital lab rate in Montgomery County.

RAD

The RAD rate request ($38.4339 per RVU) is higher than that at all but four acute general hospitals (John Hopkins Bayview, University of Maryland, Johns Hopkins and Bon Secours). The first three do lots of teaching and the fourth has very high disproportionate share. The request is 33.9% above the median acute care hospital, 39.9% above Shady Grove, which is the median hospital rate in Mongomery County, and 66.3% above Holy Cross.

CAT

The CAT rate request ($8.8721) is higher than all but three acute general hospitals (Garrett, McCready and Kernan) two of which are on the Total Patient Revenue system

with very different incentives than those faced by GEC and one of which is so different from GEC that it does not even have an ER. The request is 54.9% above the median acute care hospital, which happens to be Shady Grove, which is also the median hospital rate in Mongomery County, and 109.2% above Holy Cross. (Yes, the requested CAT rate is more than twice Holy Cross', which, along with Shady Grove, is a relatively close alternative.)

As a result of these comparisons, we urge the Commission to approve the median hospital rate adjusted upward for the base inflation approved for RY 2012 and downward to remove the three hospital specific levies identified above.

Effective date: Given Chapters 505 and 506 of the 2010 Laws of Maryland and the hospitals timely filing of this application, CareFirst agrees with the application regarding its effective date of July 1, 2011.

Thank you for your consideration.

Yours truly,

Hal Cohen
Consultant

I certify that a copy of the enclosed comments has been mailed postage paid first class to the hospital and will be provided to the appropriate Designated Interested Parties.

Signed _____ Dated 6/9/11

CC: Jerry Schmith
Bob Murray

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF DIMENSIONS	*	**COST REVIEW COMMISSION**	
HEALTHCARE SYSTEM -	*	**DOCKET:**	**2011**
BOWIE EMERGENCY CENTER	*	**FOLIO:**	**1928**
BOWIE, MARYLAND	*	**PROCEEDING:**	**2118N**

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<u>Staff Recommendation</u>

August 11, 2011

Introduction

On May 23, 2011, Dimensions Healthcare System (the "System") submitted a partial rate application to the Commission on behalf of the Bowie Emergency Center ("BEC") requesting a rate for emergency and related ancillary services provided at the Center. The Hospital is requesting that the rates be approved effective July 1, 2011.

Chapters 505 and 506 of the 2010 Laws of Maryland require the Commission to set rates for all payers for emergency services provided at two freestanding medical facilities operating as pilot projects under legislation passed in 2005 and 2007. The pilot facilities are the Queen Anne's Freestanding Emergency Medical Center and the Germantown Emergency Center. The 2010 legislation also requires the Commission to set rates for all payers for emergency services provided at BEC.

Background

In 1979, the Bowie Health Center (now BEC) was built as a freestanding emergency room satellite service affiliated with the Prince George's Hospital Center ("PGHC"). It was not licensed by the State as a hospital but its licensure emanated from PGHC. In 1980, the HSCRC began to set rates for the Bowie Health Center as a unit of PGHC, since it was administratively part of PGHC.

The 2005 freestanding medical facility legislation (Chapters 549 and 550 of the 2005 Laws of Maryland):

- Defined a freestanding medical facility as one:
    - in which medical and health services are provided;
    - that is physically separated from a hospital or hospital grounds;
    - that is an administrative part of a hospital or related institution; and

- that is open 24 hours a day, 7 days per week.

- established a licensure category and process for freestanding medical facilities;
- set standards for freestanding medical facilities;
- created a freestanding medical facility pilot project in Montgomery County which:
  - required private carriers and MCOs to reimburse the pilot project facility based on a contract executed between the facility and the payer; and
  - required Medicaid, when paying on a fee-for services basis, to reimburse a project at a rate no less than what is paid by Medicare; and
- required the Maryland Health Care Commission (MHCC) to collect data and report on the operations and utilization of the pilot facility.

While BEC was not legislatively designated as a freestanding medical facility pilot, it did obtain freestanding medical facility licensure on June 13, 2007 pursuant to regulations as a result of the 2005 legislation. The 2010 legislation required the Commission to set rates that apply to all payers, effective July 1, 2011, for emergency services provided at a freestanding medical facility licensed before July 1, 2007. BEC is the only facility that meets this criterion.

In compliance with 2010 legislation, on November 3, 2010, the Commission approved provisional rates for the Queen Anne's Freestanding Emergency Center effective October 1, 2010 (HSCRC Proceeding 2090N). These rates will be revisited following the availability of data on actual experience at the Queen Anne's Freestanding Emergency Medical Center and the outcome of this rate application.

Staff Evaluation

The Commission typically provides a hospital with the lesser of the state-wide median rate or the hospital's requested rate based on projected cost for new services. The System requested that

rates be set for Emergency Room, Electrocardiography, Laboratory, Radiology Diagnostic, Medical Supplies, and Drugs revenue centers based on the actual cost structure of BEC. The staff believes that the approved cost per unit of service for this facility should not be more than that approved at PGHC, since the overhead associated with the freestanding facility should be less than that of the Hospital. Therefore, the staff conducted its review by comparing the requested BEC cost per unit, by revenue center, to the approved cost per unit of PGHC and provided BEC with the lower of the two. Additionally, the staff believes that the cost per unit of service of BEC should be no more than the statewide median cost per unit of service. Therefore, the staff provided BEC with the lesser of the cost per unit previously calculated (BEC versus PGHC) and the approved statewide median cost per unit. The cost per unit for each revenue center was then increased by the approved update factor of 1.56%.

Finally, in order to arrive at the approved rate per unit for each revenue center, a markup was calculated based on BEC's actual payer mix and uncompensated care (UCC) for FY 2010. UCC for FY 2010 was $2,271,109 or 22.16% of charges. The approved markup for FY 2012 is 1.3277.

Recommendation

Based on the above calculations, the staff recommends the following rates at BEC effective July 1, 2011:

	Approved Rate	Units of Service	Approved Revenue
Free Standing Emergency	$36.91	188,706	$6,966,076
Laboratory	$2.29	729,977	$1,673,331
Radiology Diagnostic	$31.40	36,487	$1,145,759
Electrocardiography	$1.60	20,232	$32,383
Medical Supplies	Overhead of $14,056 plus the cost of medical supplies times 1.3277 markup		
Cost of Drugs	Overhead of $62,905 plus the cost of drugs times 1.3277 markup		

Additionally, since these costs are currently included as part of PGHC's cost and rate structure, they need to be removed from PGHC's rates that are to be effective July 1, 2011 for FY 2012.

Staff further recommends that the UCC for FY 2013 be based on the BEC's actual UCC for FY's 2010 and 2011, and that the UCC for future years be based on the most current three year average. Finally, the staff recommends that the facility report to the Commission all applicable data and information required of all other hospitals regulated under the all-payer system in the time frames dictated by the Commission.

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: 1934**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2124A**

Staff Recommendation

August 3, 2011

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on June 10, 2011 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for bone marrow transplants services with Cigna Health Corporation. The System requested approval for a period of three years beginning July 1, 2011.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

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

V. STAFF EVALUATION

Staff found that the experience under this arrangement for the last year was unfavorable. However, the Hospitals renegotiated the contract and developed updated the global prices based on more current hospital historical data plus an inflation factor. After review of the data and the calculation of the new global prices, staff believes that the Hospitals can achieve a favorable experience under the renegotiated arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission: 1) waive the requirement that an application be filed 60 days prior to the effective date of an alternative method of rate determination arrangement; and 2) approve the Hospitals' application for an alternative method of rate determination for bone marrow transplant services, for a one year period commencing July 1, 2011. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2011**
MEDICAL CENTER	*	**FOLIO: 1936**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2126A**

Staff Recommendation

August 3, 2011

I. INTRODUCTION

University of Maryland Medical Center (“UMMC,” or “the Hospital”) filed a renewal application with the HSCRC on July 8, 2011 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 the collection of peripheral blood stem cells from donors for a period of one year with the National Marrow Donor Program (NMDP) beginning July 1, 2011.

II. OVERVIEW OF APPLICATION

The NMDP, which coordinates the donation, collection, and transplantation of stem cells and bone marrow from unrelated donors for patients without matching donors in their families, will continue to use UMMC as a collection site for Department of Defense donors. The contract will continue to be held and administered by University Physicians, Inc. (UPI), which is a subsidiary of the University of Maryland Medical System. UPI will continue to manage all financial transactions related to the contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The technical portion of the global rates was developed based on historical hospital charge data relative to the collection of peripheral stem cells. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

physicians. The Hospital contends that the arrangement between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff reviewed the experience for the last year under this arrangement and found that it was slightly unfavorable. Based on the utilization reduction initiatives undertaken by the Hospital, staff believes that the Hospital can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission: 1) waive the requirement that an application be filed 30 days prior to the effective date of an alternative method of rate determination arrangement; and 2) approve the Hospital's application for an alternative method of rate determination for the collection of peripheral stem cells for one year commencing July 1, 2011. The Hospital will need to file another renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document will formalize the understanding between the Commission and the Hospital, 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, 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**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2011**
MEDICAL CENTER *		**FOLIO: 1937**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2127A**

Staff Recommendation

August 3, 2011

I. INTRODUCTION

University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on July 8, 2011 for an alternative method of rate determination pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for continued participation in global rates for solid organ transplant, gamma knife, and blood and bone marrow transplants for three years with Aetna Health, Inc. beginning August 1, 2011.

II. OVERVIEW OF THE APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

Based on the Hospital's favorable performance, staff recommends that the Commission: 1) waive the requirement that an application be filed 30 days prior to the effective date of an alternative rate determination arrangement: and 2) approve the Hospital's application for an alternative method of rate determination for solid organ transplant, gamma knife, and blood and bone marrow transplant services, for a one year period beginning August 1, 2011. The Hospital will need to file a renewal application to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, 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.

Technical Report on Reasonableness of Charges (ROC) Regression Analysis and Draft Recommendation to Routinely Review Regression Results for Outliers

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
410-764-2605

August 11, 2011

This is a draft recommendation. Comments may be submitted to Mary Beth Pohl (mpohl@hscrc.state.md.us) by August 31, 2011.

Introduction

The purpose of this report is to review technical findings regarding the Reasonableness of Charges (ROC) regression analysis in the fiscal year (FY) 2012 ROC and recommend routine review of regression results for outliers in future ROC calculations.

After adjusting each hospital's charges through a series of hospital-specific cost factors (e.g., markup, direct strip, labor market adjustor, case mix index, and capital), HSCRC staff conducts a regression analysis on the adjusted cost per equivalent discharge. The goal of the regression is to quantify in a regression coefficient the impact of IME and DSH on the adjusted cost per equivalent discharge. Staff then applies the statewide coefficient to each hospital to produce the ROC Comparison Cost used by the HSCRC to compare hospitals within their ROC peer group.

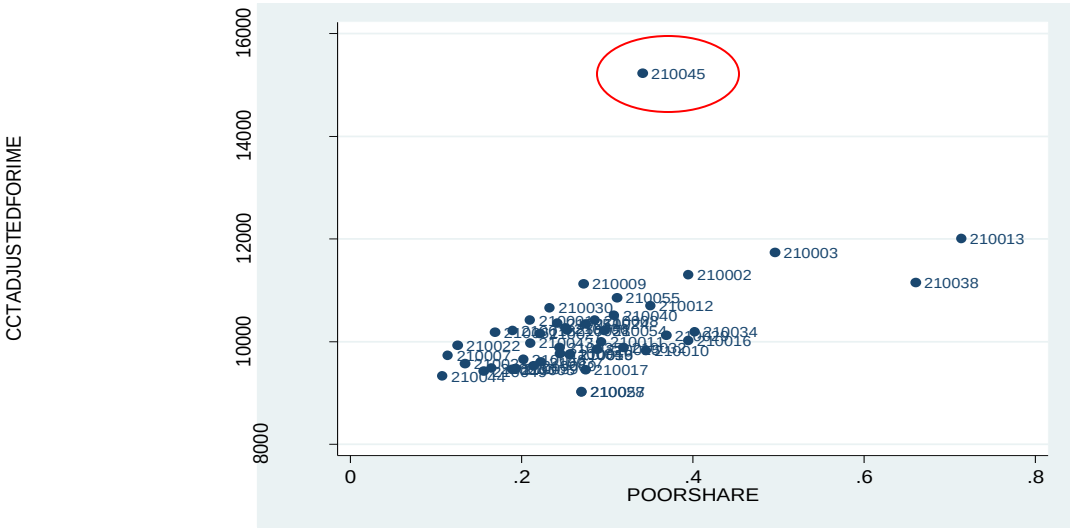
Regression Diagnostics, Outliers, and the FY 2012 ROC

In investigating preliminary ROC results for FY 2012, HSCRC staff ran multiple tests to determine the factors most influential in the ROC. In doing so, HSCRC staff conducted a regression diagnostic.

A regression diagnostic is a statistical tool that provides an understanding of potential data influencers and outliers among the observations. In the case of the ROC regression, each hospital is an equally weighted observation. If a single observation (i.e., a single hospital) is substantially different for the other observations, this one observation can greatly influence the overall regression analysis results.

The regression diagnostic, Chart 1, determined that one hospital, McCready Memorial Hospital (210045), was significantly different than the other observations in the regression.

Chart 1
Regression Diagnostic for the FY 2012 ROC IME and DHS Regression Analysis



While the regression diagnostic is an important tool in identifying potentially influential observations and outliers, HSCRC staff conducted further analysis to better understand the significance of McCready in the regression. Some examples of analysis include reviewing several years of data to understand trends and observing the overall differences of regression results both with and without McCready.

Based on our analysis, HSCRC staff concluded that McCready Memorial Hospital was an outlier in the ROC regressions. For the FY 2012 ROC, HSCRC staff recommended that the Commission remove the outlier from the regression analysis.[1] Staff then applied the resulting regression coefficient to all acute hospitals, including to McCready Memorial Hospital.

Staff Recommends a Routine Practice of Reviewing Regression Results for Outliers

HSCRC staff recommends that the Commission direct staff to routinely conduct regression diagnostics on preliminary regression results. When warranted, staff will remove significant outliers from the ROC regression analysis. HSCRC staff will apply coefficients resulting from the final regression analysis to all hospitals scaled by the ROC methodology, including those hospitals removed as outliers in the regression analysis.

HSCRC staff will clearly document any observation removed from a ROC regression analysis.

[1] Final Recommendation on the FY 2012 Reasonableness of Charges (ROC) Methodology and Scaling of the ROC, QBR, and MHACs. Commission approved the recommendation at the July 6, 2011 meeting.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Mary Beth Pohl
Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: August 3, 2011

RE: Hearing and Meeting Schedule

Public Session:

September 14, 2011 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

October 12, 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, on the afternoon, following the Commission meeting.