STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

Joseph R. Antos, Ph.D.

George H. Bone, M.D.

Jack C. Keane

Bernadette C. Loftus, M.D

Thomas R. Mullen

Herbert S. Wong, Ph.D.

HEALTH SERVICES COST REVIEW COMMISSION
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

Stephen Ports
Principal Deputy Director
Policy & Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

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**
   a.) MHA Averted UCC Reconciliation
7. **Legal Report**
8. **Hearing and Meeting Schedule**

479TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

July 6, 2011

Vice Chairman Sexton called the meeting to order at 10:01 a.m. Commissioners Joseph R. Antos, Ph.D., George H. Bone, M.D., and Herbert S. Wong, Ph.D. were also present. Commissioner Lowthers participated by telephone.

ITEM I
PUBLIC SESSION OF APRIL 15, 2011

The Commission voted unanimously to approve the minutes of the June 1, 2011 Public Session.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, summarized the status of current and future initiatives. They include: 1) preparing the recommendation on the scaling of the QBR and ROC to be presented today; 2) starting to work on a letter to the Secretary of Health and Human Services requesting an exemption from CMS' Value Based Purchasing (VBP) quality program; 3) beginning to work through several issues for the FY 2012 Reasonableness of Charges (ROC) methodology, including accounting for residents and interns and the impact of the Total Patient revenue (TPR), Admission-Readmission Revenue, and other fixed payment initiatives on the ROC; 4) finalizing the ARR agreements with nineteen hospitals and documenting the ARR methodology; and 5) discussing possible TPR like arrangements with six hospitals.

Mr. Murray presented several charts which showed a reduction in hospital volumes and a reduction in the rate of revenue growth in the system, along with an increase in Charge-per-Case growth in FY 2011. Mr. Murray opined that these trends were probably related to the shift of one day stay cases to observation, the increase in the number of TPR hospitals, and the general state of the economy. These data illustrate the necessity of requesting modification to the Maryland Medicare waiver.

Mr. Murray announced the promotion of Chris Konsowski from Rate Analyst to Assistant Chief Audit and Compliance.

ITEM III
DOCKET STATUS CASES CLOSED

2110N – Western Maryland Health System

2112N – University Specialty Hospital

2113A – University of Maryland Medical Center 2115A - Holy Cross Hospital
2117A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

Carroll County Hospital – 2119R

On May 31, 2011, Carroll Hospital Center submitted a partial rate application for a rate for Radiation Therapy (RAT) services to be provided to both inpatients and outpatients. The new rate is to replace its currently approved rebundled RAT rate. The Hospital requested that the RAT rate be set at the state-wide median rate and be effective July 1, 2011.

After review, staff recommended:

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days prior to the opening of a new service be waived;
2. That a RAT rate of $26.12 per RVU be approved effective July 1, 2011;
3. That the RAT rate not be rate realigned until a full year's experience data have been reported to the Commission; and
4. That incremental regulated revenue be added to the Hospital's Total Patient Revenue.

The Commission voted unanimously to approve staff's recommendation.

Dimensions Healthcare System – 2120R

On May 31, 2011, Dimensions Healthcare System, on behalf of its member hospitals Prince George's Hospital Center (PGHC) and Laurel Regional Hospital (LRH), submitted a request for approval of a Chronic Care (CHR) rate for LRH. The new rate is necessary because on June 30, 2011, the patients at PGHC's CHR unit will be moved to LRH. The System requested that effective July 1, 2011, PGHC's CHR rate, increased by the FY 2012 core update factor of 1.56%, be approved for LRH.

After review, staff recommended:

1. That LRH's new CHR rate be based on PGHC's approved CHR rate;
2. That to ensure revenue neutrality, LRH's mark-up of 1.175109 be substituted for PGHC's mark-up of 1.213134, reducing the rate from $698.9463 to $677.0382;
3. That core inflation of 1.56% be added to the rate, increasing the CHR rate to $687.6000;
4. That a CHR rate of $687.6000 be approved for LRH effective July 1, 2011;
5. That because these cases are excluded from the Charge-per-Case (CPC) standard, there should be no change in LRH's or PGHC's CPC standard; and

6. That the ORC rate not be rate realigned until a full year's experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2121A

On June 7, 2011, the Johns Hopkins Health System filed an alternative method of rate determination application on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, requesting approval to continue to participate in a global rate arrangement for cardiovascular procedures and to add global rates for kidney transplant services with the Canadian Medical Network to the arrangement. The Hospitals requested that the arrangement be approved for one year beginning July 1, 2011.

Since the actual experience under the arrangement for cardiovascular services for the last year was favorable and the proposed global rates for kidney transplant services were based on hospital experience data utilized to develop global rates for other successful kidney transplant arrangements, staff was satisfied that the Hospitals could achieve favorable performance under this arrangement.

Therefore, staff recommended that the Commission: 1) waive the requirement that alternative rate applications be filed 30 days before the proposed effective date; 2) approve the Hospitals' request for a period of one year effective July 1, 2011, and 3) that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2122A

On June 7, 2011, the Johns Hopkins Health System filed an alternative method of rate determination application on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, requesting approval to participate in a new global rate arrangement for kidney transplant, bone marrow transplant, and cardiovascular services with Active Care Management for a period of one year beginning July 1, 2011.

Since the format utilized to calculate case rates, i.e., historical data for like cases, has been utilized as the basis for other successful transplant and cardiovascular arrangements in which the Hospitals are currently participating, staff recommended that the Commission: 1) waive the requirement that alternative rate applications be filed 30 days before the proposed effective date; 2) approve the Hospitals' request for a period of one year effective July 1, 2011, and 3) that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2123A

On June 7, 2011, the Johns Hopkins Health System filed an alternative method of rate determination application on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, requesting approval to participate in a new global rate arrangement for solid organ and bone marrow transplant services with MultiPlan, Inc. for a period of three years beginning July 1, 2011.

Since the format utilized to calculate case rates, i.e., historical data for like cases, has been utilized as the basis for other successful transplant arrangements in which the Hospitals are currently participating, staff recommended that the Commission: 1) waive the requirement that alternative rate applications be filed 30 days before the proposed effective date; 2) approve the Hospitals' request for a period of one year effective July 1, 2011, and 3) that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2125A

On June 24, 2011, the Johns Hopkins Health System filed an alternative method of rate determination application on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, requesting approval to continue to participate in a global rate arrangement for live donor kidney transplant services with National Health Services, Inc. for a period of one year beginning August 1, 2011.

Although there has been no activity under this arrangement, staff was satisfied that the Hospitals could achieve favorable performance under this arrangement. Therefore, staff recommended that the Hospitals' application be approved for a period of one year effective August 1, 2011, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
FINAL RECOMMENDATIONS ON QUALITY BASED REIMBURSEMENT METHODOLOGY FOR FY 2012 SCALING

Dianne Feeney, Associate Director-Quality Initiatives, reviewed the changes made to staff's Recommendation on Quality Based Reimbursement Methodology for FY 2012 (QBR) since the draft recommendation was presented at last month's public meeting and briefly summarized the final recommendation (see Staff Recommendation on the HSCRC website). The most significant changes were to align the QBR model and definitions with the CMS VBP program where possible and that if material changes to the QBR are necessary to secure an exemption from the VBP program, based on dialogue with CMS, that staff should recommend such changes to the Commission.

Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, urged approval of staff's recommendation and assrted that it would be very advantageous for Maryland to receive an exemption from the VBP program.

Anne Hubbard, of MHA, thanked staff for involving the hospital industry in the process of updating the QBR program. Ms. Hubbard expressed the hope that the exemption request be submitted early enough so that if further changes must be made to the QBR program in order to gain an exemption from CMS' VBP program, that they can be addressed prior to the October deadline.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
FINAL RECOMMENDATION ON THE FY 2012 RESASONABLENESS OF CHARGES (ROC) METHODOLOGY AND SCALING FOR THE ROC, QBR, AND MARYLAND HOSPITAL ACQUIRED CONDITIONS (MHAC)

Mr. Murray summarized staff's final recommendation for scaling of the ROC, QBR, and MHAC (see Staff Recommendation on the HSCRC website). Mr. Murray stated that that there was agreement by all parties on the scaling for the quality initiatives, QBR and MHAC; however, the Maryland Hospital Association (MHA) raised the issue of year-to-year instability related to ROC scaling proposed by staff. Given the concerns of MHA, staff offered an alternative scaling approach. While the original approach proposed continuous scaling of 15% of the difference between a hospital's ROC position and its peer group average, the alternative approach establishes a non-scaled bracket of plus or minus 2% from the average of the peer group with hospitals above and below scaled at 25% of their ROC position up or down to the 2% threshold.

Mr. Murray noted that in response, MHA proposed a scaling approach which would establish a non-scaled bracket of plus or minus 3% from the average of the peer group with hospitals above and below scaled at 25% of their ROC position up or down to the 3% threshold.

The staff recommendations included: 1) excluding from the ROC IME/DSH regression the extreme outlier hospital; 2) modifying the case mix lag to a weighting lag; 3) for QBR and MHAC, scaling 0.5% and 1.0% of hospital approved revenue respectively, and 4) for ROC scaling, either staff's original option, 15% of the difference between a hospital's position and the peer group average, or staff's alterative option, 25% of the difference between a hospital's position and the peer group average with a 2% +- corridor receiving 0% scaling.

A panel consisting of Michael Robbins, Senior Vice President-Financial Policy for MHA, Stuart Erdman, Senior Director of Finance of the Johns Hopkins Health System, and Patrick Redman, Ph.D., presented the hospital industry's proposal for the 2011 ROC.

According to Mr. Robbins, the ROC compares hospitals based on charges set by the HSCRC, not on hospital management decisions. Consequently, reductions in cost and increased efficiencies do not result in improved ROC positions. Shifts in hospital ROC positions are changing based on major methodology changes rather than hospital management decisions. MHA believes that the rate impact of these changes should be mitigated through limited scaling.

Mr. Robbins recommended that the Commission approve MHA's option for ROC scaling, which would establish a non-scaled bracket of plus or minus 3% from the average of the peer group, with hospitals above and below scaled at 25% of their ROC position up or down to the 3% threshold. In addition, Mr. Robbins suggested that discussions be initiated to develop a new efficiency measure.

Dr. Redman pointed out that since the payment system is undergoing numerous payment changes that move away from per case measure, the approach to measuring efficiency must be redesigned. Dr. Redman also recommended that the Commission phase in some of the new payment initiatives while we restructure the way we measure efficiency.

Mr. Erdman expressed concern that since we don't understand the interaction of the major policy changes, and we are not sure of the accuracy of the new data being utilized and because ROC scaling results in permanent revenue adjustments, we should be cautious in scaling the ROC for a year or two.

Mr. Murray stated that staff believes that the ROC methodology is sound, represents an improvement over the 2010 methodology, and is highly indicative of relative efficiency. However, Mr. Murray stated that staff agreed with MHA that because of the new payment initiatives we should take a look at the ROC methodology to determine if it should be modified to better measure hospital efficiency.

Dr. Cohen expressed support of staff's scaling options and asserted that MHA's option did not scale enough revenue.

Commissioner Bone made a motion to approve staff's recommendations on scaling the quality initiative along with MHA's option for ROC scaling.

There was no second.

Commissioner Lowthers made a motion to approve staff's recommendations for scaling the quality initiatives along with staff's alternative ROC scaling option.

Commissioner Antos seconded the motion.

The Commission voted unanimously to approve Commissioner Lowthers' motion.

ITEM VII
REPORT ON THE RESULTS OF THE UNCOMPENSATION CARE POLICY AND FINAL RECOMMENDATION TO MODIFY THE CHARITY CARE ADJUSTMENT

Andy Udom, Associate Director-Research and Methodology, summarized the results of the uncompensated care (UCC) policy and staff's final recommendation to modify the charity care adjustment (see Staff Recommendation on the HSCRC website).

Mr. Udom explained that a charity care adjustment was adopted by the Commission to incentivize Maryland hospitals to provide appropriate charity care to eligible patients. The current policy for calculating the charity care adjustment is to add 20% to the actual charity care percentage of gross patient revenue.

Mr. Udom reported that over the last six months, a workgroup reviewed and developed alternatives to the current charity care adjustment. As a result, MHA proposed two alternative calculations: 1) to add 20% of the difference between a hospital's charity care percentage of gross patient revenue and the state-wide average percentage; and 2) to add 20% of the difference between a hospital's charity care as a percentage of UCC and the state-wide average percentage.

Mr. Udom stated that staff recommends that the Commission waive the sixty day comment period for final approval and adopt MHA's option #2.

Traci LaValle, Assistant Vice President-Financial Policy of MHA, expressed the hospital industrty's support of MHA option #2.

Dr. Cohen stated that his clients supported rewarding hospitals that provide more charity care and expressed preference for MHA's option #1.

The Commission voted unanimously to approve staff's recommendation to adopt MHA's option #2.

ITEM VIII
FY 2010 COMMUNITY BENEFIT REPORT AND CHANGES TO REPORTING REQUIREMENTS FOR THE FY 2011 COMMUNITY BENEFIT REPORT AND NARRATIVE

Steve Ports, Principal Deputy Director- Policy and Operations, presented the results of the FY 2010 annual Community Benefit Report (CBR), as well as changes to be implemented for the FY 2011 CBR. Mr. Ports explained that because non-profit hospitals receive federal, state, and local tax benefits, in return the Internal Revenue Service requires hospitals to provide benefits to the community. The Maryland CBR process was enacted by the Maryland General Assembly in 2001. Mr. Ports thanked Amanda Greene, Program Analyst, for overseeing this project and putting together this report.

Mr. Ports indicated that hospitals: 1) reported a total of $1 billion in community benefits for FY 2010 (compared to $946 million in FY 2009); 2) provided an average of 7.71% of total operating expenses in community benefits (compared to 7.6% in FY 2009); and 3) provided net charity care in the amount of $133 million; and 4) provided net community care of $613.5 million, or 4.85% of total operating expenses. Mr. Ports also pointed out that this was the second year that hospitals were asked to answer narrative questions about their community benefit programs. These questions were developed to provide a standard reporting format and to allow readers to more easily understand the information in the report.

Mr. Ports indicated that the following changes were recommended by the CBR advisory group. The changes to the Reporting Guidelines were: 1) to refine the definition of a community benefit to be consistent with the Affordable Care Act and other policies; 2) to clarify the categories; and 3) to add a section to account for Medicaid provider taxes for which a hospital does not receive offsetting revenue. In addition, the following changes to the Community Benefit Narrative Reporting Instructions and related Evaluation Report were recommended: 1) to refine the definition of a community needs assessment; 2) to alter the format and provide more references to make it easier for hospitals to find and report the expected information, and for the public to understand the reports; 3) to add questions to better understand the hospital leadership involved in community benefit decisions; and 4) to change the Evaluation Report scoring to take into consideration the sufficiency of the response to the questions.

SPECIAL PRESENTATION TO VICE CHAIRMAN SEXTON

Mr. Murray noted that since his second four year term has now expired, Mr. Sexton may have had the opportunity to participate in his last public meeting as a Commissioner today. Mr. Murray stated that that we wanted to recognize Mr. Sexton‘s contribution to the system. Mr. Sexton has placed the community interest above any provincial interest. He has consistently been the “go to” Commissioner whenever there has been a controversial issue. He would “stick his neck out” to gain a compromise, which is a very difficult role for an industry representative. He has also been the inspiration for, and provided strategy and direction for, many of the Commission’s major policies such as the MHACs initiative and bundled payment initiatives. Mr.

Sexton brought to the Commission operational expertise from his years of running hospitals, as well as policy expertise from his days prior to being a hospital administrator. Mr. Murray stated that Mr. Sexton strongly supported staff and has earned the respect of everyone in the industry.

Mr. Murray congratulated Mr. Sexton and presented him with a plaque honoring his service to the citizens of Maryland.

ITEM IX
HEARING AND MEETING SCHEDULE

August 3, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
September 7, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 12:10 p.m.

Executive Director's Report **August 11, 2011**

Current and Future Projects	Status/Timing
1. Quality-based Reimbursement (QBR) and Maryland Hospital Acquired Conditions (MHAC)	
- Letter to request exemption/certification from Secretary Of HHS that QBR "meets or exceeds" national VBP	August
- Recommend magnitude of scaling for FY 2013	September meeting
2. Admission Readmission Revenue Proposals	
- Now reviewing 19 proposals	August
- 4 others have expressed interest	
3. Rate Orders	September/October
- CPC Weight complete on web	
- CPV Weights mostly resolved	
- ROC and Scaling Complete	
- Data due to St. Paul August 19	
- Apply Weights and calculate MHAC Performance	
4. Medicare Waiver Test	
5. Transition from ICD-9 to ICD-10	September
6. Personnel	

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

This recommendation was unanimously approved by the Commission on 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.

.

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**

*** ***

Staff Recommendation

August 11, 2011

This recommendation was unanimously approved by the Commission on 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.

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

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**

*** ***

<u>Staff Recommendation</u>

August 11, 2011

This recommendation was unanimously approved by the Commission on 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 SYSTEM	*	**DOCKET: 2011**
	*	**FOLIO: 1934**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2124A**

Staff Recommendation

August 3, 2011

This recommendation was unanimously approved by the Commission on August 11, 2011. The Chairman, John C. Colmers, recused himself from participation in this proceeding.

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

This recommendation was unanimously approved by the Commission on August 11, 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

This recommendation was unanimously approved by the Commission on August 11, 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.

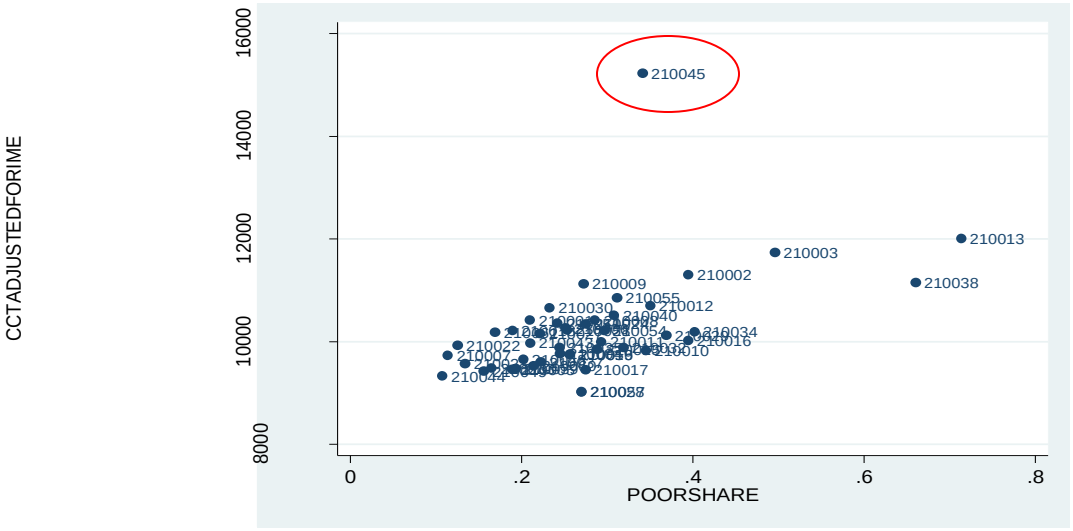
Regression Diagnostics, Outliers, and the FY 2012 ROC

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.

Overview of the HSCRC Averted Bad Debt Policy

HSCRC Staff

August 11, 2011

Outline of Presentation

- Background and History
- Summary of Calculation of Expected Averted Bad Debt in Current Year
- Summary of Reconciliation of Actual Averted Bad Debt in Future Year
- Issues

Medicaid Expansion

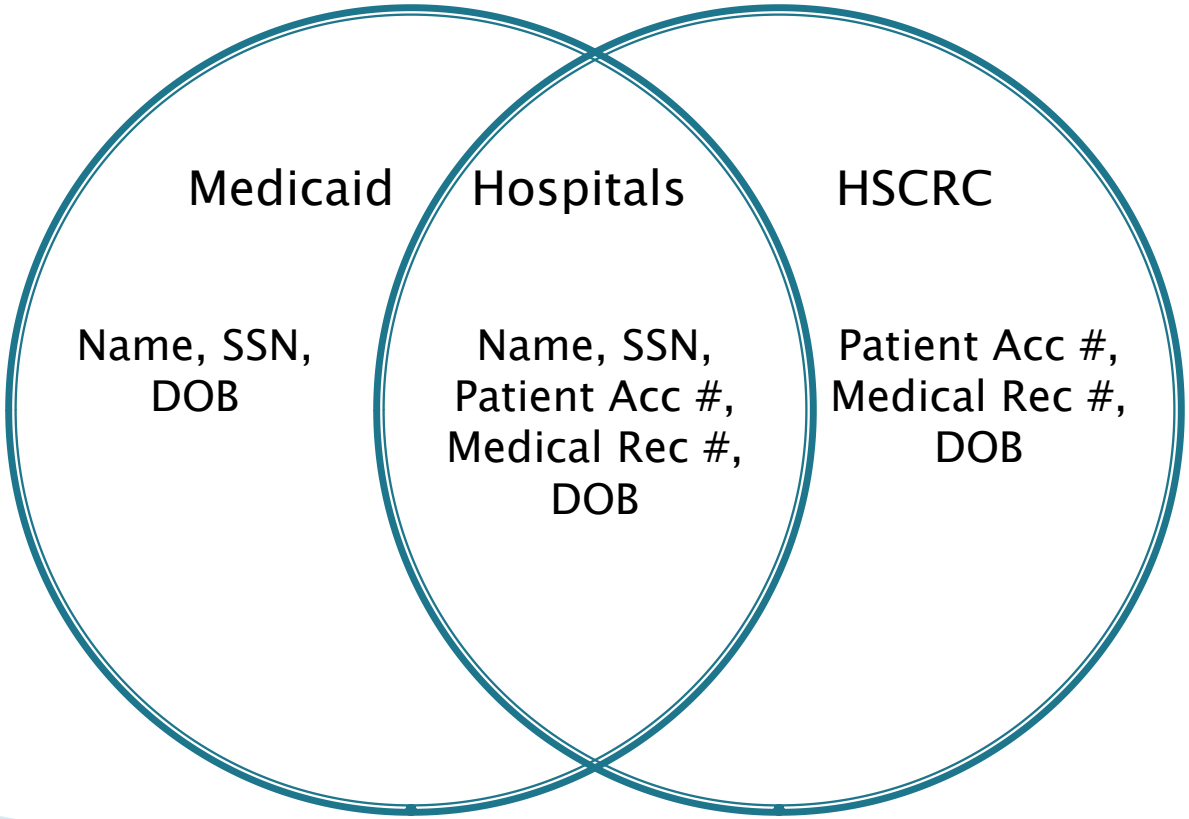
- 2007 legislation expands access to health care coverage under:
  - Medicaid to parents and caretakers from 46% of FPG to 116%
  - Primary Care Adult Care program (as funds are available) to childless adults up to 116%
  - Established a small business subsidy program administered by MHCC
- Expected to reduce the number of uninsured from 800,000 to 700,000
- 2008 legislation requires HSCRC to implement a uniform assessment to reflect the reduction in hospital uncompensated care from the Medicaid expansion

The Assessment

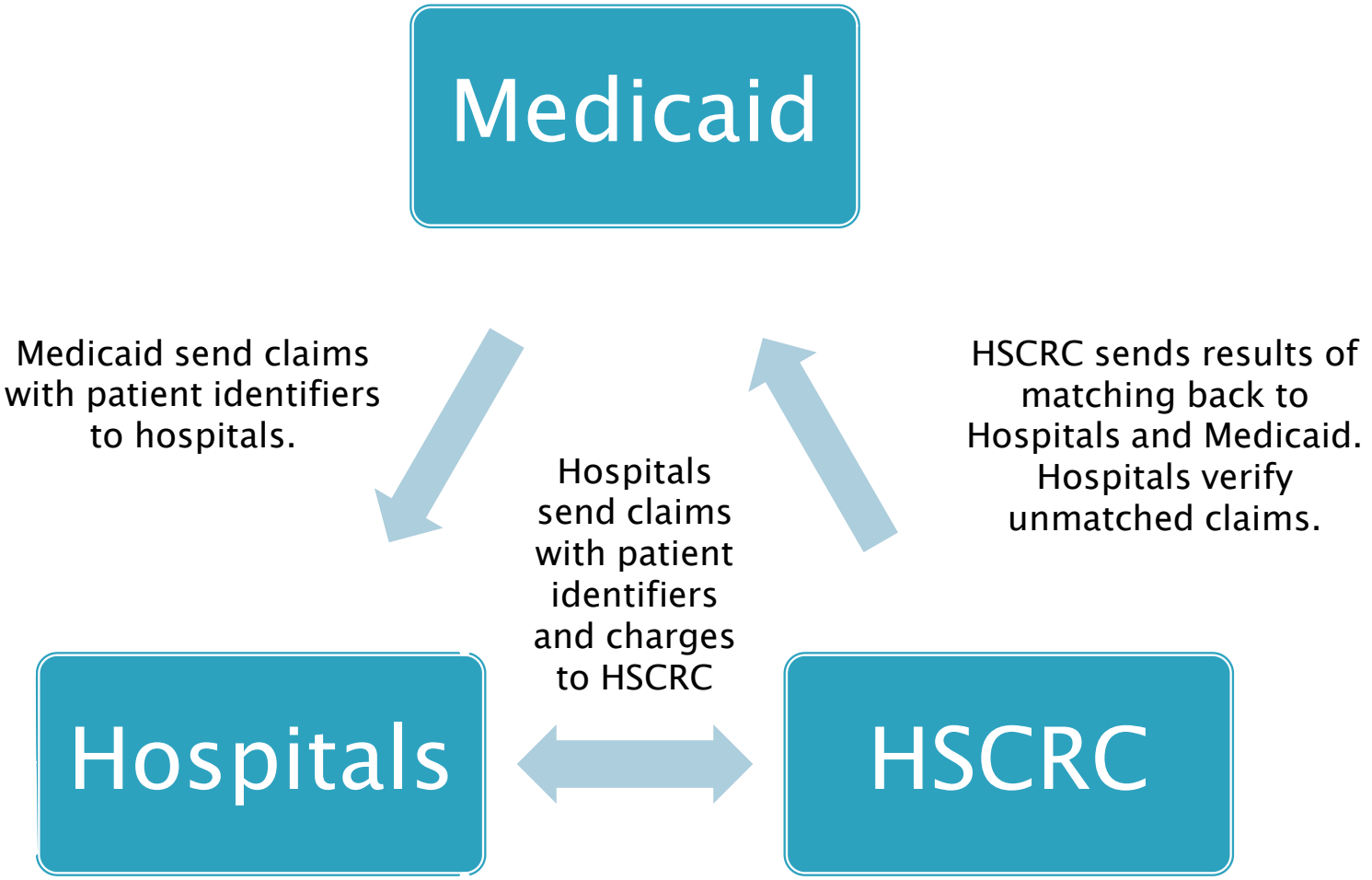
- The Medicaid and PAC expansion reduce hospital uncompensated care
- Medicaid/HSCRC calculate the expected total amount of averted bad debt in next FY using expected enrollees and PMPM costs, adjusted for:
  - Out of state admissions
  - Hospital portion
  - Crowd out
  - Lower use rates for uninsured
- This amount comes out of UC then is added back as a uniform assessment, less the amount to be saved by payers
- Medicaid (MCOs, FFS) then pays hospitals for the services rendered to Medicaid enrollees

Reconciliation Process

Reconciliation involves 3 different databases in order to calculate charges for the Expansion population



Reconciliation Process



Reconciliation

- 2 Fiscal Years later (when data is available on actual Medicaid payments to hospitals), HSCRC calculates actual payment to hospitals

- HSCRC calculates any difference between amount initially taken out of rates and the amount paid by Medicaid for services:
  - in aggregate, and
  - on a hospital by hospital basis.

Medicaid Expansion - Fiscal Year 2010
Calculations and Adjustments Made at July 1, 2009

Calculation of Estimated Reduction to Hospital Uncompensated Care

DHMH Estimated Total Expansion Expenditures			
Amount per Enrollee per Month	$535.35		
Estimated Number of Enrollees	50,500		$324,422,100
Less: Payments Made Outside of Maryland	-6%		-$19,465,326
Paymants Made Inside of Maryland			$304,956,774
Percent Paid to Maryland Hospitals	54%		$164,676,658
Hospital Gross Charges (Medicaid Pays 94% of Charges)	94%		$175,187,934
Less: Crowd Out and Lower Use Rate	-28%	-18%	-$71,756,978
Estimated Reduction to Hospital Rates for Uncompensated Care			$103,430,956

NOTE: A portion of this amount was allocated to each hospital based on the percentage of current FY09 Medicaid payments made to the hospital for the Medicaid expansion population. The allocated amount for each hospital was used to calculate a percent of revenue which was then used to reduce each hospital's approved uncompensated care (UCC). The reduced UCC was used in each hospital's calculation of approved markup and approved revenue was reduced accordingly.

Calculation of Payment Made to DHMH

Estimated Reduction to Hospital Rates for Uncompensated Care		$103,430,956
Savings Provided to Payer	-7.39%	$95,786,995
Amount Paid to Medicaid	94%	$90,039,775

NOTE: A portion of this amount was uniformly allocated to each hospital based on its estimated Approved Revenue for FY 2010. Each hospital made monthly payments to DHMH throughout the year.

Medicaid Expansion - Fiscal Year 2010
Reconciliation of Actual Averted Bad Debt
Calculations and Adjustments Made at June 30, 2011

Calculation of Adjustments Due to Hospitals

Actual Reduction to Hospital Rates for Uncompensated Care			$104,745,796
Total Hospital Charges to Medicaid Due to Expansion*			$113,195,889
Less: Crowd Out and Lower Use Rate	-28%	-18%	-$46,365,036
Actual Reduction to Uncompensated Care Due to Expansion			$66,830,853
Adjustment Due to Hospital Rates			-$37,914,943

Note: The "Total Charges to Medicaid" is preliminary. This number does not include the remaining run-out claims and does not take into account the number of claims that could not be matched to visits at the hospital. This preliminary amount would be added to hospital rates for one year only (FY 2012). At the end of the year the amount would be removed from rates.

Calculation of Overpayment/Underpayment to DHMH

Actual Reduction to Uncompensated Care Due to Expansion			$66,830,853
Less: Savings Provided to Payers	-7.39%		$61,891,786
Amount Paid by Medicaid to Hospitals	94%		$58,178,278
Amount Paid to Medicaid by Hospitals			$90,039,775
Difference			-$31,861,497
Amount Net of Savings Provided to Payers	94%		$62,821,002
Difference Without Providing Any Savings to Payers			-$27,218,773

FY2010 Reconciliation Results (Preliminary)

	N	%
Claims submitted from hospitals	119,958	100%
Claims reported with FY09 data but dos was in FY10	2,020	1.68%
Claims not found by hospitals	1,359	1.13%
Claims reported with FY10 data but dos was in FY11	482	0.40%
PAC claims (not included in FY10 Reconciliation)	34	0.03%
Unregulated claims (as reported by hospital)	1,748	1.46%
Duplicate claims	1,167	0.97%
Claims for pregnancy-related services	7,196	6.00%
Claims used in calculation of Averted Bad Debt	109,981	91.68%
Total claims matched + unmatched w/charges*	104,131	94.68%
Total unmatched claims w/o charges*	5,850	5.62%

* Charges provided by the hospital were used if the claim didn't match HSCRC data

Estimate vs Actual Averted Bad Debt

Estimated for Fiscal Years 2009-2011

	A	B	C	D
	Original Estimate FY 2009	Revised Estimate FY 2009	Estimate FY 2010	Estimate FY 2011
Estimated Enrollees		29,273	55,000	69,773
Cost per Enrollee per member month		$511	$539	$546
Medicaid Total Expenditures	$95,170,624	$160,119,126	$324,422,100	$457,646,689
In State Payment Percent	*94.00%*	*94.00%*	*94.00%*	*94.00%*
In State Payments	$89,460,386	$150,511,978	$304,956,774	$430,187,888
Medicaid Payment Percent	*94.00%*	*94.00%*	*94.00%*	*94.00%*
Charges @ Hosp Payment Rate	$95,170,624	$160,119,126	$324,422,100	$457,646,689
Hospital Portion	*61.00%*	*61.00%*	*54.00%*	*47.61%*
Hospital Charges Reported	$58,054,080	$97,672,667	$175,187,934	$217,879,100
Crowd Out (28%)	*72.00%*	*72.00%*	*72.00%*	*72.00%*
Hospital Charges after Crowd	$41,798,938	$70,324,320	$126,135,312	$156,872,952
Lower Use Rate	*82.00%*	*82.00%*	*82.00%*	*82.00%*
Averted Bad Debt	**$34,275,129**	**$57,665,943**	**$103,430,956**	**$128,635,821**
Medicaid Expenditures for PAC	$0.00	$0.00	$0.00	$26,787,574
Hospital Charges after PAC				$155,423,395
Medicaid Payment Percent	*94.00%*	*94.00%*	*94.00%*	*94.00%*
Net Medicaid Payments	$32,218,621	$54,205,986	$97,225,099	$146,097,991
Percent Returned to Medicaid	*75.00%*	*75.00%*	*92.61%*	*100.00%*
Hospital Payments to Medicaid	$24,163,966	$40,654,489	$90,039,771	$146,097,991
Difference		**$16,490,523**		
Settle up Payment			**$16,490,523**	
Total Payments to Medicaid			$106,530,295	

Issue

- Consider how to address any underpayments or overpayments to the Medicaid Program

Medicaid Expansion & Averted Uncompensated Care-- A Good Idea that is Out of Balance

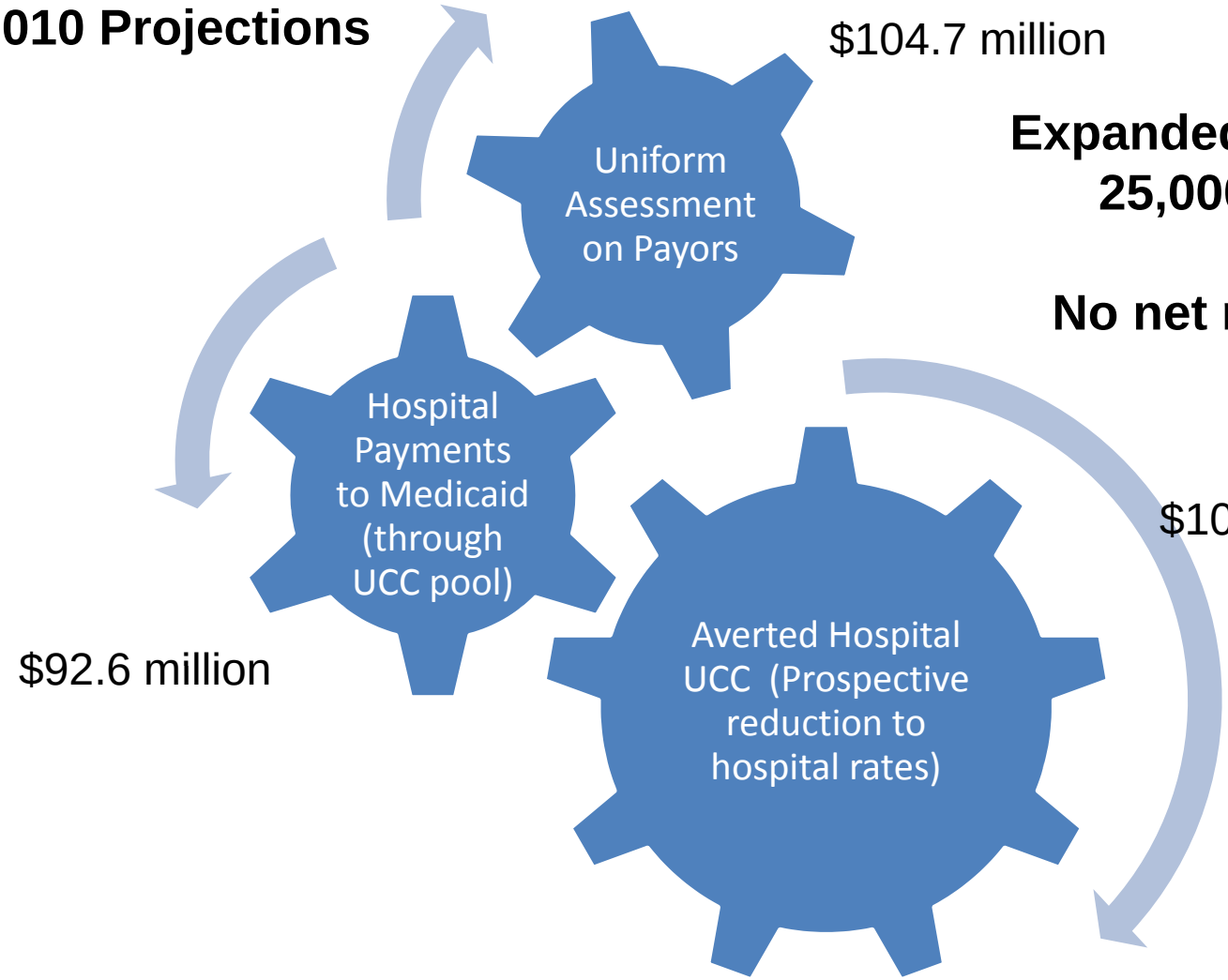
Maryland Hospital Association

August 11, 2011

Maryland
Hospital Association

Medicaid Expansion--A Good Idea

2010 Projections



Expanded coverage to 25,000+ people

No net rate change

Maryland Hospital Association

Sizing the Estimates is a Challenge

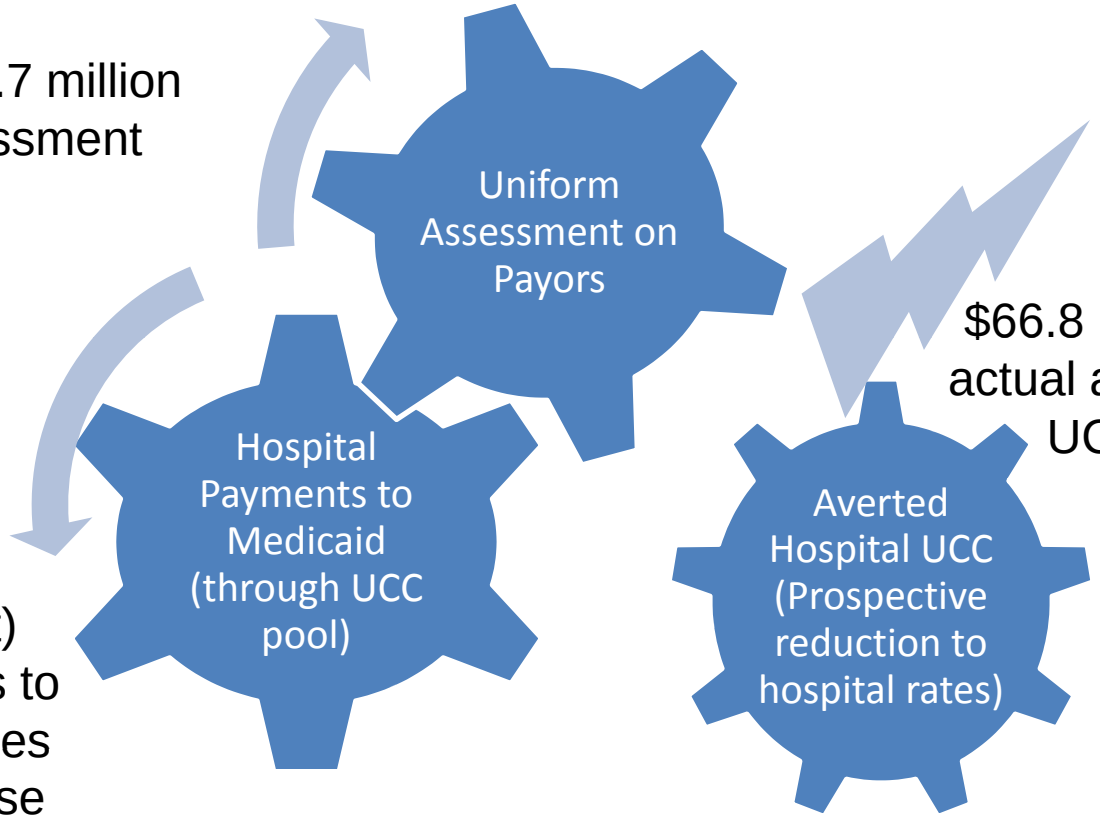
2010 Actual

$104.7 million assessment

$104.7 million rate reduction

$92.6 million (net) passed through to Medicaid...but,

$66.8 million (net) Medicaid payments to hospitals for services that would otherwise have been UCC



$66.8 million actual averted UCC

$92.6 – $66.8 = $25.8

$25.8 million overpayment to Medicaid

Maryland Hospital Association

2010 Averted UCC Net Funding

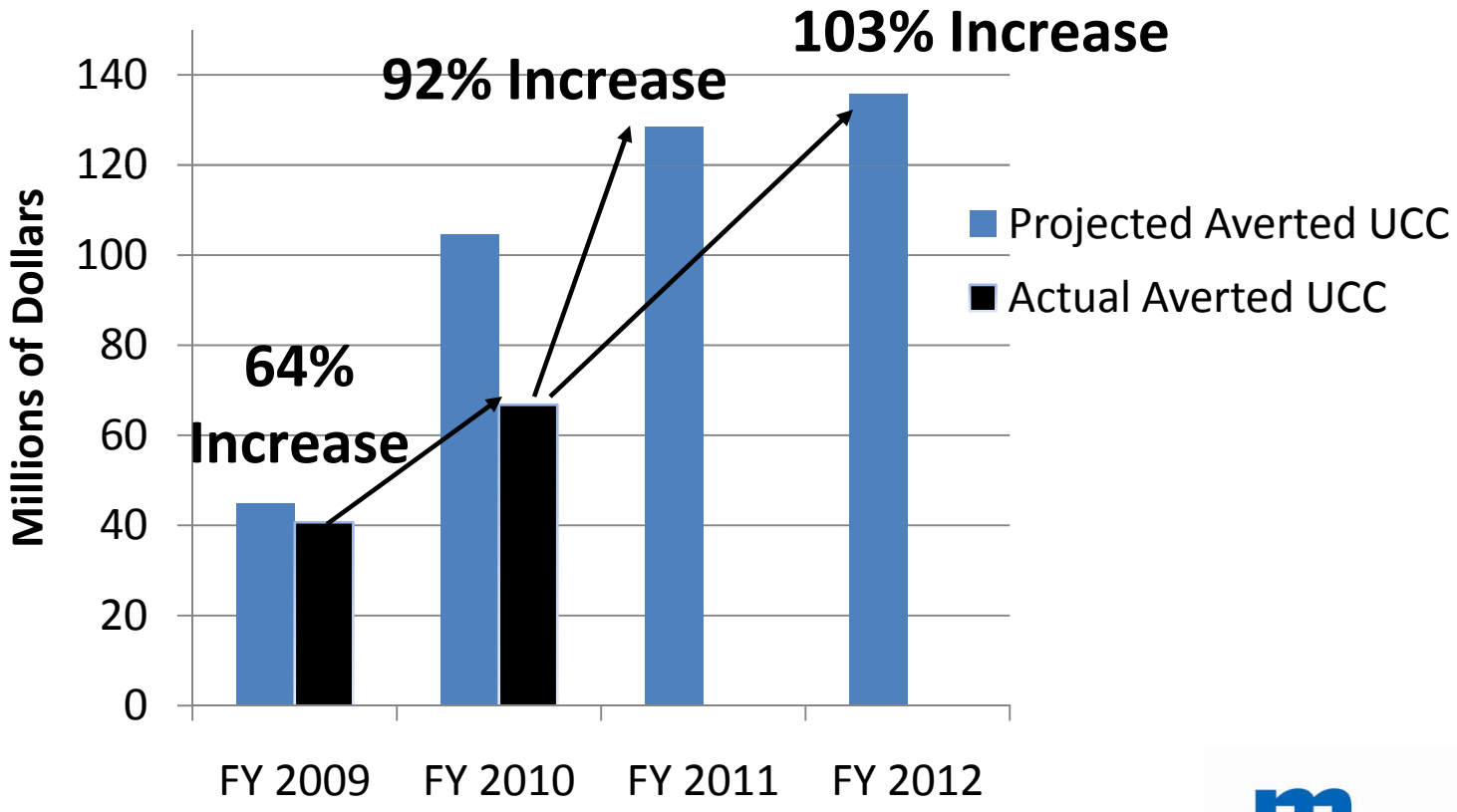
	Rate Increase (Assessment)	Rate Reduction (Prospective)	Payment to Medicaid (Net of mark-up)	Payment for Hospital Services	Net Favorable (Unfavorable)
Payors	($104.7)	$104.7	-	-	$ -
Hospitals	$104.7	($104.7)	($92.6)*	$66.8	$(37.9)
Medicaid	-	-	$92.6*	$66.8	$25.8

Averted UCC over-estimate resulted in $25.8 M overpayment to Medicaid in 2010

Maryland Hospital Association

Averted UCC Projections

The issue will need to be addressed again in 2011 and 2012



*Does not include PAC

Maryland Hospital Association

Averted UCC Overestimates

- Expanding Medicaid coverage using the payment system reduces UCC and benefits all of us. Estimating the amount of funding needed and the amount of averted UCC is a challenge;
- Averted UCC was overestimated by $37.9 million in FY 2010;
- Medicaid received $25.8 million in excess of payments for hospital averted UCC; and
- The imbalance will continue to grow in 2011 and 2012.

Maryland
Hospital Association

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 FINAL ACTION

On August 11, 2011, the Health Services Cost Review Commission adopted new Regulations **.01 - .07** under a new Chapter, **COMAR 10.37.07 Health Information Exchange Data.** This action, which was proposed for adoption in 38:12 Md. R. 722-723 (June 3, 2011), has been adopted as proposed.

Effective Date: September 19, 2011.

John M. Colmers
Chairman
Health Services Cost Review Commission

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

.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.

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

A. 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 10.37.01.03N.

FREDERICK W. PUDDESTER
Chairman
Health Services Cost Review Commission

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

Joseph R. Antos, Ph.D.

George H. Bone, M.D.

Jack C. Keane

Bernadette C. Loftus, M.D

Thomas R. Mullen

Herbert S. Wong, Ph.D.

HEALTH SERVICES COST REVIEW COMMISSION
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

Stephen Ports
Principal Deputy Director
Policy & Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

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.