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

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Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

483rd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
November 2, 2011

EXECUTIVE SESSION
9:30 a.m.

1. **Personnel and Waiver Issues**

2. **Medicaid Managed Care Organizations**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
10:30 A.M.

1. **Review of the Executive Session and Public Meeting Minutes of October 12, 2011 Meeting**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**

   None

4. **Docket Status – Cases Open**

   2128A – MedStar Health
   2131A – St. Agnes Health Care, Maryland General Hospital, Meritus Health, And Western Maryland Health System
   2135A – Johns Hospitals Health System
   2137A – University of Maryland Medical Center
   2138A – University of Maryland Medical Center
   2139A – University of Maryland Medical Center
   2140A – The Johns Hospital Health System
   2141A – The Johns Hopkins Health System
   2142A – The Johns Hopkins Health System

5. **Presentation of Draft Revised Labor and Delivery Relative Value Units (RVUs)**

6. **Update on Results of Quality Based Reimbursement and Maryland Hospital Acquired Condition Initiatives**

7. **Hearing and Meeting Schedule**

482nd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
AMENDED

October 12, 2011

Chairman John Colmers called the meeting to order at 10:03 a.m. Commissioners Joseph R. Antos, Ph.D., George H. Bone, M.D., Jack C. Keane, Thomas R. Mullen, and Herbert S. Wong, Ph.D. were also present. Commissioner Bernadette C. Loftus, M.D. participated by conference call.,

REPORT OF THE EXECUTIVE SESSIONS OF SEPTEMBER 27, 2011 AND OCTOBER 12, 2011

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the September 27, 2011 and October 12, 2011 Executive Sessions.

ITEM I
EXECUTIVE AND PUBLIC SESSIONS OF SEPTEMBER 14, 2011

The Commission voted unanimously to approve the minutes of the September 14, 2011 Executive and Public Sessions.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Steve Ports, Acting Executive Director, advised the Commission of the progress on current major initiatives and issues. They include: 1) the submission of a letter to the Secretary of Health and Human Services requesting an exemption from CMS' Value Based Purchasing (VBP) quality program; 2) completion of recommendation for the magnitude of Quality-based Reimbursement (QBR) and Maryland Hospital Acquired Conditions (MHAC) scaling for FY 2013; 3) ten to twelve of twenty-six Admission-Readmission Revenue (ARR) agreements for FY 2012 already signed; 4) continuing to refine the ARR operational plan including the Charge-per Episode (CPE) calculation; 5) progress on completing the various components needed in order to issue rate orders i.e., calculation of: Charge-per-Case, Charge-per-Visit, and ARR weights, inpatient, outpatient, and ARR case mix, and Uncompensated Care provision; and 6) submission of a letter of intent for HSCRC to serve as a convener in the CMS (the Centers for Medicare and Medicaid Services) Bundled Payments for Care Improvement Initiative and work with CMS to ensure that Maryland hospitals are eligible to participate in the initiative.

Mr. Ports reported that staff is deferring recommendations on the alternative rate setting applications by provider-based Managed Care Organizations (MCOs) for continued participation in the Medicaid Health Choice Program until the November public meeting to allow the

applicants to review the impact of Medicaid payment updates for CY 2012.
The Chairman asked what percentage of Maryland total hospital revenue will be under ARR and the Total Patient Revenue programs when the 26 hospitals sign up for the ARR program.

Mr. Ports stated that he thought that the number was about 55%, but indicated that he would provide a more accurate number.

ITEM III
DOCKET STATUS CASES CLOSED

2129A – Johns Hopkins Health System
2132A – University of Maryland Medical Center
2126A – MedStar Health
2120N –Suburban Hospital
2133A – MedStar Health
2127A – University of Maryland Medical Center

ITEM IV
DOCKET STATUS CASES OPEN

There were no cases requiring Commission action.

ITEM V
OPTIONS FOR RECONCILIATION OF FY 2010 AVERTED BAD DEBT ESTIMATES TO ACTUAL

Mary Beth Pohl, Deputy Director-Research and Methodology, summarized the changes to staff's option paper (see staff Options for Reconciliation of FY 2010 Bad Debt Estimates to Actual on the HSCRC website). Ms. Pohl stated that last month staff was charged with engaging with the interested parties and discussing the components of the averted bad debt (ABD) calculations in order to more accurately quantify the difference between the assessment and actual ABD.

The first issue addressed was whether it is acceptable to revise assumptions made for components of the ABD calculation retrospectively. After discussion, staff believes that it is most appropriate that we change the assumptions based on our best understanding of what the assumptions should be at the current time in light of the economic conditions existent during that time period.

After meeting twice with representatives of the Department of Health and Mental Hygiene (Department), the Maryland Hospital Association (MHA), and payers, and a review of the literature in an attempt to model crowd out, staff determined that it was appropriate to modify the definition of the crowd out component of the ABD calculation to include not only persons who previously had commercial insurance, but also a portion of the Medicaid "spend down" population. Therefore, staff recommends that for purposes of calculating actual ABD a modified crowd out rate of 18.22% be used in the ABD calculation.

The “Lower Use Rate” component of the ABD calculation was also discussed with the parties. Although the Department made a logical argument based on overall expenditure trends that the use rate should decrease, staff did not believe that the supporting data supplied was sufficiently compelling to warrant a change in the ABD calculation for FY 2010. The Department was encouraged to refine the data to better quantify a modified use rate for FY 2011.

Ms. Pohl reported that staff’s recommendations for calculating actual ABD were to: 1) lower the crowd out rate from 28% to 18.22%; 2) maintain the lower use rate at 18%; and 3) correct an error in the calculation, which included savings to payers as a component in the calculation. Changing the calculation to include staff’s recommendations reduces the difference between the amount paid by hospitals to the Department and actual ABD from $25.5 million to $10.9 million.

Jerry Schmith, Deputy Director-Hospital Rate Setting, summarized the revised ABD calculation and indicated that the parties had agreed on the revised crowd out rate of 18.22% as a compromise.

Commissioner Mullen asked whether staff expected that the FY 2011 ABD estimates would be closer to the actual ABD.

Mr. Schmith answered in the affirmative.

Hal Cohen, Ph.D., representing CareFirst and Kaiser Permanente, expressed support for staff’s recommendations and for Reconciliation Option #1, which would reduce the ABD assessment to be paid by hospitals.

Barry Rosen, representing United Healthcare, also supported Reconciliation Option #1.

Traci LaValle, Assistant Vice President-Financial Policy of MHA, agreed with Dr. Cohen and Mr. Rosen that Option #1 be approved, and that the repayment be made in one year.

Trisha Roddy, Director of Planning for the Medicaid Program, stated that the Department accepted the revised crowd out rate assumption, and that there was not enough data to support a change in the use rate. Ms. Roddy also expressed support for Option #1, but that it be repaid over 2 years.

The Commission voted unanimously to approve staff’s recommendations for changes in the ABD calculation, which reduced the difference between the payment to Medicaid and the actual ABD from $25.5 million to $10.9 million.

The Commission voted to approve Reconciliation Option #1, to reduce the ABD assessment to be paid to Medicaid, with the reduction in the assessment to be made in one year. The vote was five in favor and one opposed. Commissioner Bone cast the dissenting vote.

ITEM VI
FINAL RECOMMENDATION ON FY 2013 SCALING FOR QUALITY-BASED REIMBURSEMENT AND MARYLAND HOSPITAL ACQUIRED CONDITIONS PERFORMANCE

Dianne Fenney, Associate Director-Quality Initiatives, summarized staff's recommendations (see Final Recommendation on FY 2013 Scaling for Quality-Based Reimbursement and Maryland Hospital Acquired Conditions Performance on the HSCRC website). Ms. Feeney verbally amended staff recommendations #1 and #2 to read "approved inpatient hospital revenue," since the QBR and MHAC programs apply only to inpatient services and recommendation #5 to add that the scaling be revenue neutral. The amended recommendations included:1) allocating 0.5% of hospital approved inpatient revenue for QBR relative performance; 2) allocating 2% of hospital approved inpatient revenue for MHAC; 3) using the linear scaling approach adopted by CMS for the VPB program for both the QBR and MHAC programs; 4) continuing to use the statewide average as the benchmark to establish the expected MHAC values; 5) scaling the revenue such that the maximum penalty for the poorest performing hospital is the total percentage magnitude of revenue scaled for that program, i.e., 0.5% for QBR and 2% for MHAC, and that the scaling be revenue neutral; and 6) while monitoring MHAC performance consider whether there should be methodology changes for FY 2014.

The Chairman asked if staff had performed any analyses of what the overall impact is on quality of care in Maryland hospitals since the initiation of these programs.

Ms. Feeney stated that overall, Maryland hospitals have improved 12% in the first year of the MHAC program and just over 8% in the second year in the rate of complications. For the QBR measures, Maryland hospitals have improved year after year; however, the nation is improving at a faster pace. When compared to the nation in the ARC Reports, Maryland hospitals look poor to mediocre.

The Chairman requested that the Commission be provided with additional data on Maryland hospitals' performance at the macro level at the next public meeting.

Dr. Cohen congratulated staff on its excellent work. However, Dr. Cohen suggested one change in the scaling methodology, i.e., that beginning in FY 2014 it be symmetrical (that the scaling not be truncated to force revenue neutrality).

Michael Robbins, Senior Vice President-Financial Policy for MHA, expressed support for staff's recommendations.

The Commission voted unanimously to approve staff's amended recommendation.

ITEM VII
HEARING AND MEETING SCHEDULE

November 2, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
December 8, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:17 a.m.

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

AS OF OCTOBER 24, 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
2128A	MedStar Health	7/29/2011	N/A	N/A	ARM	SP	OPEN
2131A	St. Agnes Health Care, Maryland General Hospital, Meritus Health, and Western Maryland Health System	8/18/2011	N/A	N/A	ARM	SP	OPEN
2135A	Johns Hopkins Health System	8/30/2011	N/A	N/A	ARM	SP	OPEN
2137A	University of Maryland Medical Center	10/5/2011	N/A	N/A	ARM	DNP	OPEN
2138A	University of Maryland Medical Center	10/5/2011	N/A	N/A	ARM	DNP	OPEN
2139A	University of Maryland Medical Center	10/12/2011	N/A	N/A	ARM	DNP	OPEN
2140A	The Johns Hopkins Health System	10/13/2011	N/A	N/A	ARM	DNP	OPEN
2141A	The Johns Hopkins Health System	10/13/2011	N/A	N/A	ARM	DNP	OPEN
2142A	The Johns Hopkins Health System	10/24/2011	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
MEDSTAR HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2011**
	*	**FOLIO:**	**1938**
COLUMBIA, MARYLAND	*	**PROCEEDING:**	**2128A**

Final Recommendation

October 26, 2011

Approved at the November 2, 2011 Commission Meeting.

I. Introduction

On July 26, 2011, MedStar Health filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital (the "Hospitals"). MedStar Health seeks renewal for the continued participation of MedStar Family Choice ("MFC") in the Medicaid Health Choice Program. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2080A for the period from January 1, 2011 through December 31, 2011. The Hospitals are requesting to renew this contract for one year beginning January 1, 2012.

II. Background

Under the Medicaid Health Choice Program, MedStar Family Choice, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a State-determined capitation payment. MedStar Family Choice pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MedStar Family Choice provides services to about 4% of the total number of MCO enrollees in Maryland.

The Hospitals supplied information on their most recent experience and their preliminary projected revenues and expenditures for the upcoming year based on the Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (proceeding 2080A).

Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed financial information and projections for CYs 2010 and 2011 and projections for CY 2012. In recent years, the financial performance of MFC has been favorable. The actual financial experience reported to staff for CY2010 was positive, and is expected to remain positive in CY 2011. MFC is projecting unfavorable financial performance in CY 2012.

IV. Recommendation

With the exception of FY 2009, MFC has continued to achieve favorable financial performance in recent years. Based on past performance, staff believes that the proposed renewal arrangement for MFC is acceptable under Commission policy, in that the MCO has not sustained losses over an extended. However, Staff will reevaluate MFC's projected CY 2012 financial status throughout the course of the year to understand whether unfavorable performance is expected to continue into CY 2013.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2012 since the MCO has not sustained losses over an extended period of time.

(2) Since sustained losses may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance to determine whether favorable financial performance is achieved in CY 2012, and expected to be sustained into CY 2013. Staff recommends that MedStar Family Choice report to Commission staff (on or before the August 2012 meeting of the

Commission) on the actual CY 2011 experience and preliminary CY 2012 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2013.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. T he MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
MARYLAND GENERAL HOSPITAL	*	**COMMISSION**	
SAINT AGNES HEALTH	*	**DOCKET:**	**2011**
WESTERN MARYLAND HEALTH SYSTEM	*	**FOLIO:**	**1941**
MERITUS HEALTH	*	**PROCEEDING:**	**2131A**

Final Recommendation

October 26, 2011

Approved at the November 2, 2011 Commission Meeting.

I. Introduction

On August 17, 2011, Maryland General Hospital, Saint Agnes Health System, Western Maryland Health System, and Meritus Health (the "Hospitals") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06. The Hospitals seek renewal for the continued participation of Maryland Physicians Care ("MPC") in the Medicaid Health Choice Program. MPC is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2089A for the period January 1, 2011 through December 31, 2011. The Hospitals are requesting to renew this contract for one year beginning January 1, 2012.

II. Background

Under the Medicaid Health Choice Program, MPC, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, in return for a State-determined capitation payment. Maryland Physicians Care pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. Maryland Physicians Care is a major participant in the Medicaid Health Choice program, and provides services on a statewide basis to about 19.6% of the total number of MCO enrollees in Maryland.

The Hospitals supplied information on their most recent experience and their preliminary projected revenues and expenditures for the upcoming year based on the initial revised Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (Proceeding 2089A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed financial information and projections for CYs 2010 and 2011, and projections for CY 2012. In recent years, the financial performance of MPC has been favorable. The actual financial experience reported to staff for CY2010 was positive, and is expected to remain positive in CY 2011. Projections for CY 2012 are favorable as well.

IV. Recommendation

MPC has continued to maintain consistent favorable performance in recent years. Based on past and projected performance, staff believes that the proposed renewal arrangement for MPC is acceptable under Commission policy.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2012.

(2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance to determine whether favorable financial performance is achieved in CY 2012 and expected to be sustained into CY 2013. Staff recommends that Maryland Physicians Care report to Commission staff (on or before the August 2012 meeting of the Commission) on the actual CY 2011 experience and preliminary CY 2012 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2013.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. T he MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
THE JOHNS HOPKINS HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2011**
	*	**FOLIO:**	**1945**
BALTIMORE, MARYLAND	*	**PROCEEDING**	**2135A**

Final Recommendation

October 26, 2011

Approved at the November 2, 2011 Commission Meeting.

I. Introduction

On August 30, 2011 Johns Hopkins Health System ("JHHS," or the "System") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals"). The System seeks renewal for the continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. Priority Partners, Inc. is the entity that assumes the risk under the contract. The Commission most recently approved this contract under proceeding 2081A for the period from January 1, 2011 through December 31, 2011. The Hospitals are requesting to renew this contract for a one-year period beginning January 1, 2012.

II. Background

Under the Medicaid Health Choice Program, Priority Partners, a provider-sponsored Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. Priority Partners was created in 1996 as a joint venture between Johns Hopkins Health Care (JHHC) and the Maryland Community Health System (MCHS) to operate an MCO under the Health Choice Program. Johns Hopkins Health Care operates as the administrative arm of Priority Partners and receives a percentage of premiums to provide services such as claim adjudication and utilization management. MCHS oversees a network of Federally Qualified Health Clinics and provides member expertise in the provision of primary care services and assistance in the development of provider networks.

The application requests approval for the Hospitals to continue to provide inpatient and

outpatient hospital services, as well as certain non-hospital services, in return for a State-determined capitation payment. Priority Partners pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. The Hospitals supplied information on their most recent experience and their preliminary projected revenues and expenditures for the upcoming year based on the initial revised Medicaid capitation rates.

Priority Partners is a major participant in the Medicaid Health Choice program, providing managed care services on a statewide basis through CY 2011 and serving 27% of the State's MCO population.

III. Staff Review

This contract has been operating under the HSCRC's initial approval in proceeding 2081A. Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff has analyzed Priority Partner's financial history, net income projections for CY 2011, and projections for CY 2012. The statements provided by Priority Partners to staff represent both a "standalone" and "consolidated" view of Priority's operations. The consolidated picture reflects certain administrative revenues and expenses of Johns Hopkins Health Care. When other provider-based MCOs are evaluated for financial stability, their administrative costs relative to their MCO business are included as well; however, they are all included under one entity.

In recent years, the financial performance of Priority Partners has been favorable. The actual financial experience reported to staff for CY2010 was positive, and is expected to remain positive in CY 2011. CY 2012 consolidated projections are favorable.

IV. Recommendation

With the exception of FY 2009, Priority Partners has continued to achieve favorable financial performance in recent years. Based on past and projected performance, staff believes that the proposed renewal arrangement for Priority Partners is acceptable under Commission policy.

Therefore:

1) **Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2012.**
2) **Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance to determine whether favorable financial performance is achieved in CY 2012 and expected to be sustained into CY 2013. Therefore, staff recommends that Priority Partners report to Commission staff (on or before the August 2012 meeting of the Commission) on the actual CY 2011 experience and preliminary CY 2012 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2013.**
3) **Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates,**

treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. T he MOU also stipulates that operating losses under managed care contracts may not 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**
MMEDICAL CENTER	*	**FOLIO:**	**1947**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2137A**

Staff Recommendation

November 2, 2011

Approved at the November 2, 2011 Commission Meeting.

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on October 5, 2011 to seek approval to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for participation in a global rate arrangement for solid organ and blood and bone marrow services with Interlink Health Services for a period of three years beginning November 1, 2011.

II. OVERVIEW OF APPLICATION

The contract will 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 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 solid organ and blood and bone marrow transplant services at the Hospital. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Since the format utilized to calculate the case rate, i.e., historical data for like cases, has been utilized as the basis for other successful solid organ and blood and bone marrow transplants in which the Hospital is currently participating, 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 alternative applications be filed 30 days before the proposed effective date; 2) approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period commencing November 1, 2011. The Hospital 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 Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2011**
MEDICAL CENTER *		**FOLIO:**	**1948**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2138A**

Staff Recommendation

November 2, 2011

Approved at the November 2, 2011 Commission Meeting.

I. INTRODUCTION

The University of Maryland Medical Center (“Hospital”) filed a renewal application with the HSCRC on October 5, 2011 requesting approval to continue to participate in a global rate arrangement for blood and bone marrow transplants for three years with the BlueCross and BlueShield Association Quality Centers for Transplant (BQCT) beginning September 1, 2011.

II. OVERVIEW OF APPLICATION

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 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 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

The staff found that the actual experience under this arrangement for the prior year has been favorable.

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; 2) approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services, for a one year period commencing September 1, 2011. The Hospital 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 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 cann-ot 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:**	**1949**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2139A**

Staff Recommendation

November 2, 2011

Approved at the November 2, 2011 Commission Meeting.

I. INTRODUCTION

The University of Maryland Medical Center (the Hospital) filed a renewal application with the HSCRC on October 12, 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 and blood and bone marrow transplant services with OptumHealth Care Solutions, Inc. (previously known as United Resource Networks), for a one-year period, effective November 1, 2011.

II. OVERVIEW OF APPLICATION

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 manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff found that the actual experience under this arrangement for the prior year has been favorable.

VI. STAFF RECOMMENDATION

Based on the favorable experience in the last year, 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) the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning November 1, 2011.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2011**
SYSTEM	*	**FOLIO:**	**1950**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2140A**

Staff Recommendation

November 2, 2011

Approved at the November 2, 2011 Commission Meeting.

I. INTRODUCTION

Johns Hopkins Health System (System) filed a renewal application with the HSCRC on October 13, 2011 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for continued participation in a capitation arrangement serving persons with mental health needs under the program title, Creative Alternatives. The arrangement is between the Johns Hopkins Health System and the Baltimore Mental Health Systems, Inc., with the services coordinated through the Hospital. The requested approval is for a period of one year beginning November 1, 2011.

II. OVERVIEW OF APPLICATION

The parties to the contract include the System and the Baltimore Mental Health Systems, Inc. Creative Alternatives provides a range of support services for persons diagnosed with mental illness and covers medical services delivered through the Hospital. The System will assume the risks under the agreement, and all Maryland hospital services will be paid based on HSCRC rates.

III. STAFF FINDINGS

Staff found that the experience under this arrangement for FY 2011 was favorable.

IV. STAFF RECOMMENDATION

Based on its favorable performance for the last year, 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 renewal application for an alternative method of rate determination for a one year period commencing November 1, 2011.

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

approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2011**
SYSTEM	*	**FOLIO:**	**1951**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2141A**

Staff Recommendation - Approved

November 2, 2011

I. INTRODUCTION

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on October 13, 2011 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval from the HSCRC for continued participation in a global rate arrangement for solid organ and bone marrow transplants with Preferred Health Care LLC. The Hospitals request that the Commission approve the arrangement for one year beginning October 1, 2011.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting 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 that it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Although there was no activity under this arrangement in the last year, staff is satisfied that the hospital component of the global prices, which has been updated with current data, is sufficient for the Hospitals to achieve 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 Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing October 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 will formalize the understanding between the Commission and the Hospitals, and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2011**
SYSTEM	*	**FOLIO:**	**1952**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2142A**

Staff Recommendation - Approved

November 2, 2011

I. INTRODUCTION

On October 24, 2011, Johns Hopkins Health System (“System”) filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the “Hospitals”) requesting approval to continue to participate in an existing global price arrangement with Life Trac (a subsidiary of Allianz Insurance Company of North America) for solid organ and bone marrow transplants. The Hospitals request that the Commission approve the arrangement for one year beginning November 1, 2011.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payers, 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 that it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

The staff found that the actual experience under the arrangement for the last year has been favorable. Staff is satisfied that the hospital component of the global price is sufficient for the Hospitals to continue to achieve favorable performance 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 Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for the period beginning November 1, 2011. The Hospitals must file a renewal application annually 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.

Staff Recommendation

November 2, 2011

The Commission staff recommends for review and public comment revisions to the Relative Value Unit (RVU) Scale for Labor and Delivery (DEL). These revised RVUs were developed by a sub-group of the Maryland Hospital Association's HSCRC Technical Issues Task Force. The sub-group's membership represented the Labor and Delivery department of many of the Maryland hospitals located throughout the state. The RVU scale was updated to reflect the current services provided to obstetric patients for DEL services. The revised RVUs were approved by the Maryland Hospital Association's HSCRC Technical Issues Task Force. At your direction, the staff will send the revision to all Maryland hospitals for their review and comment.

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES

Account Number	Cost Center Title
7010	Labor and Delivery Service

Labor and Delivery Service

The Labor and Delivery Relative Value Units were developed by an industry task force under the auspices of the Maryland Hospital Association. These Relative Value Units will be used as the standard unit of measure related to the output of the Labor and Delivery Revenue Center.

All time reflects standard of 1 RVU = 15 minutes of direct RN care. Charges made to Labor and Delivery RVUs must reflect an entire procedure or event occurring in the Obstetrical suite without duplication, support, or charges to other areas using RVUs, minutes, or hours per patient day at the same time. As an example a short stay D&C cannot be charged RVUs plus OR minutes; a sonogram cannot be charged RVUs to Labor and Delivery and to Radiology. Each institution should designate where a procedure is to be charged based on where that procedure is performed. For any Labor and Delivery OR suite procedure, RVUs or Minutes may be charged, but not both.

PRIMARY OBSTETRICAL Procedures:

These procedures include physical assessment, pregnancy history, and vital signs. Delivery procedures are excluded. RVUs are assigned on the basis of RN time only in relation to these procedures. Charges for these may be in addition to Obstetrical charges. (See section to follow entitled: L & D Observation/Triage services.)

Procedures:	**RVUs:**
Amniocentesis - Diagnostic	3
Biophysical Profile with NST	5
Biophysical Profile w/o NST	4
Cervical Cerclage	10
Dilation & Curettage (D&C)	9
Dilation and Evacuation (D&E)	9
Doppler Flow Evaluation	1
External Cephalic Versions	10
*Minor OR procedure, emergent or non-emergent, w/o delivery	8
*Major OR procedure, emergent or non-emergent, w/o delivery	38
Non Stress Test, Fetal	5
Oxytocin Stress Test	5
Periumbilical Blood Sampling (PUBS)	18 (+ 4 w/multiples)
Periumbilical Blood Sampling (PUBS) double set up w/OR	2
Ultrasound, OB (read by Obstetrics only)	3

* The classification of minor and major procedures is related to the complexity of the case and the nursing work load required for patient care. The lists below are examples of procedures in each category, but the classification is not limited to these examples.

Minor:	Major:
Cerclage insertion or removal	Bladder repair
Incision and Drainage (I&D)	Bowel repair
Needle membrane	Hernia repair
Tubal ligation	Hysterectomy
Wound care	Oopherectomy

***** "Minor" surgery is any invasive operative procedure in which only skin or mucous membranes and connective tissue is resected, e.g., vascular cut down for catheter placement, implanting pumps in subcutaneous tissue. Also included are procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar in combination with a "minor" surgical procedure.

* "Major" surgery is any invasive operative procedure in which extensive resection is performed, e.g., a body cavity is entered, organs are removed, or normal anatomy is significantly altered. For surgical procedures that do not clearly fall in the above categories, the chance for significant inadvertent infection of the surgical site is to be a primary consideration.

The definition of Emergent and Non-emergent is based on timing also known as the “decision to incision time”. An emergent procedure is performed within 30 minutes of the physician’s decision. A non-emergent procedure is performed after that 30 minute window has passed.

DELIVERY Procedures:

The following procedures are primarily inpatient services, however if any are performed on an outpatient basis hospitals should apply the most appropriate CPT codes.

Procedures (SELECT ONLY ONE):	**RVUs:**
Fetal Demise/Genetic Termination 2nd or 3rd Trimester	30
Fetal Demise/Genetic Termination 2nd or 3rd Trimester w/Epidural	36
Delivery outside the hospital, prior to arrival	12
Vaginal Delivery (No anesthesia, uncomplicated)	24
Vaginal Delivery w/Vacuum/Forceps Assistance	26
Vaginal Delivery w/Epidural Anesthesia	30
Vaginal Delivery w/Epidural w/Forceps/Vacuum Assistance	32
Vaginal Delivery after prior C-section (VBAC)	32
Cesarean Section, non-emergent	18
Cesarean Section, non-emergent w/minor surgery	20
Cesarean Section, non-emergent w/major surgery	31
Cesarean Section, Emergency	37
Cesarean Section, emergent w/minor surgery	39
Cesarean Section, emergent w/major surgery	61

OBSTETRICAL ADD ON TO DELIVERY Procedures:

These are procedures that are performed in addition to the core procedures listed above.

Procedures (ALL THAT APPLY):	**RVUs:**
Amnioinfusion	6
Double Set-Up/Failed Forceps/Vacuum	2
Induction/Augmentation w/delivery	4
Intrauterine Pressure Catheter Monitoring (IUPC)	2
Multiple Birth: Twins	6
Multiple Birth: Triplets	9
Multiple Birth: Quads	12
Neonatal Resuscitation (APGAR < 6 @ 1 minute; PH < 7.2)	4

POSTPARTUM OBSTETRICAL SURGICAL Procedures:

The following procedures are listed to capture RVUs for postpartum obstetrical surgeries that occur after an episode of delivery, vaginal or cesarean section. Please refer to the top of page 2 for the definition and examples of minor and major procedures.

Procedures (SELECT ONLY ONE):	**RVUs:**
Surgery, Additional minor, non-emergent	8
Surgery, Additional major, non-emergent	19
Surgery, Additional minor, emergent	16
Surgery, Additional major, emergent	38

MISCELLANEOUS Procedures:	**RVUs:**
Circumcision (even if performed in Nursery)	3
Oocyte Retrieval	10
Gamete Intrafallopian Tube Transfer (GIFT)/Tubal Embryo Transfer	16

ASSESSMENT/TRIAGE and OBSERVATION Services:

Hospitals should determine the most appropriate level of Assessment/Triage, the use of Observation, and Maternal Intensive Care; then apply the most appropriate observation and/or evaluation and management code depending on the physician order.

Services:	**RVUs:**
Assessment/Triage Service	1

Assessment/Triage services may include, but are not limited to performing a health and physical assessment, pregnancy history, and vital signs.

Outpatient Maternal Observation 1 per hour (15 min direct RN time per hour)

Observation is a valid clinical service. The primary purpose of observation services in L&D is to determine whether the patient should be admitted as an inpatient. The service includes the use of a hospital bed and monitoring, by the facility's nursing or other staff, deemed reasonable and necessary to evaluate the patient's condition to determine whether she should be admitted.

Outpatient Maternal Observation minutes should be rounded up to the nearest full hour. This should be interpreted to mean that 30 minutes = 0 RVUs, 31 minutes = 1 RVU, 75 minutes = 1 RVU, etc…

Some common examples of providing observation and triage services included but not limited to are:

1) Labor evaluation
2) Cervical ripening
3) Fetal monitoring
4) Motor Vehicle Accident
5) IV hydration

MATERNAL INTENSIVE CARE (MIC) **RVUs:**

Outpatient Maternal Intensive Care 2 RVUs per hour (30 min direct RN time per hour)

This category is reserved for patients prior to delivery requiring on-going intensive nursing care. This category may be charged only during the period of intensive interventions. Note: Patients who have been admitted and require on-going intensive nursing care should be reported with the applicable inpatient care room and board rate and not Maternal Intensive Care. Examples of disease processes with designated pharmaceutical and or nursing interventions are listed below but the examples are not all inclusive.

Diagnoses:
Cardiac Disease
Bleeding Disorders
Disseminated Intravascular Coagulation (DIC)
Diabetes Mellitus
Hypertensive Disorder of Pregnancy (HDP)
Preterm labor
Multisystem Disorders
Asthma

Examples of pharmaceuticals and nursing care for MIC include but are not limited to the following:

Pharmaceutical:
Magnesium Sulfate
Ritodrine
Terbutaline (repeated SQ doses)
Aminophylline
Insulin IV drip
Apresoline
Heparin Sulfate
Phenytoin Sodium (Dilantin)
Pitocin
Nifedipine
Labatalol
AZT drip
IVIG Drip

Nursing Care:
Blood Transfusions
Nebulizer Therapy
Invasive Hemodynamic Monitoring
Conscious Sedation procedures
- a) PUBS
- b) Fetal surgery
- c) Fetal exchange transfusion

Ventilation Therapy
Labor/Delivery care on another unit

HEALTH SERVICES COST REVIEW COMMISSION
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Date: October 26, 2011

TO: HSCRC Commissioners

From: Dianne Feeney, Associate Director, Quality Initiatives
Sule Calikoglu, Chief, Quality Analysis

Re: Quality Based Reimbursement Initiative (QBR) and Maryland Hospital Acquired Conditions (MHAC) Measurement Trends and Results

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As Commissioner Colmers requested at the October 12, 2011 Commission meeting, this memorandum summarizes staff's analysis and measurement findings of the QBR and MHAC programs as of the beginning of FY 2012.

Evaluations of two HSCRC quality payment program results show improvement and tremendous promise. Figure 1 below illustrates how all of the clinical process of care measures included in the QBR initiative have improved since the program was launched in 2008. In addition, as shown in Figure 2 the number of complications included in MHAC program declined by 20% in two years, resulting in cost savings of $105.4 million, after adjusting for changes in patient characteristics.

Figure 1. Changes in QBR Measures from Calendar Year 2008 to 2010

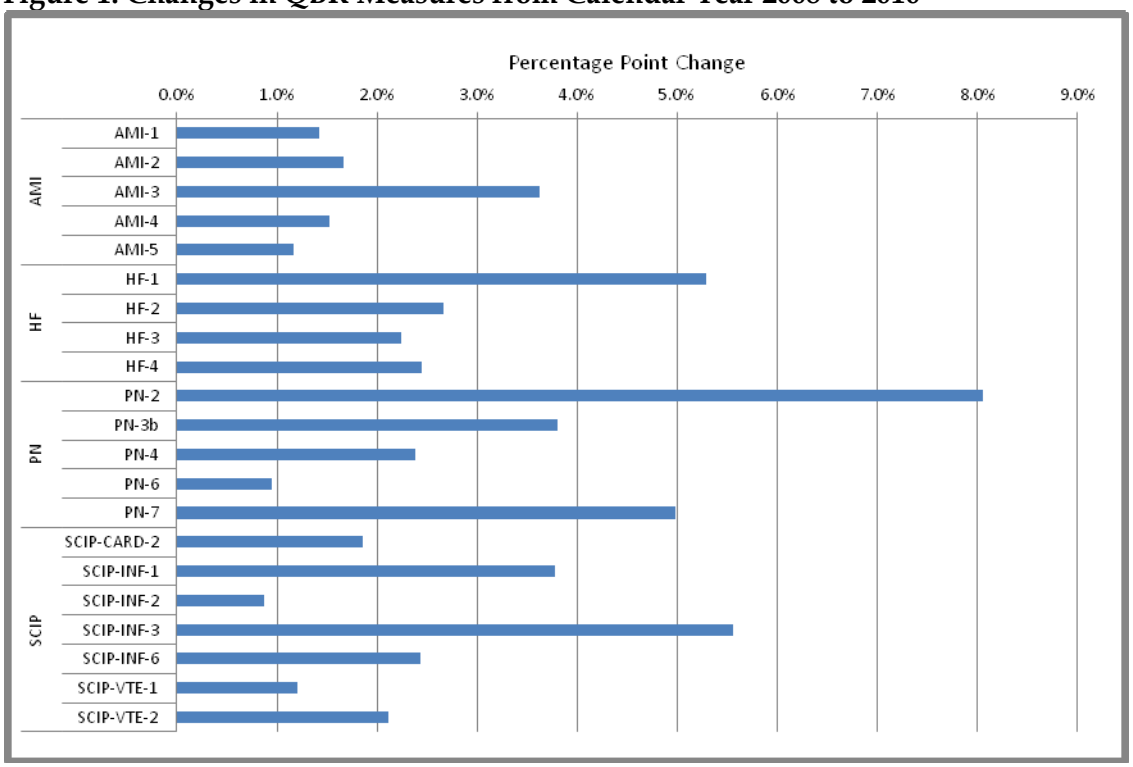
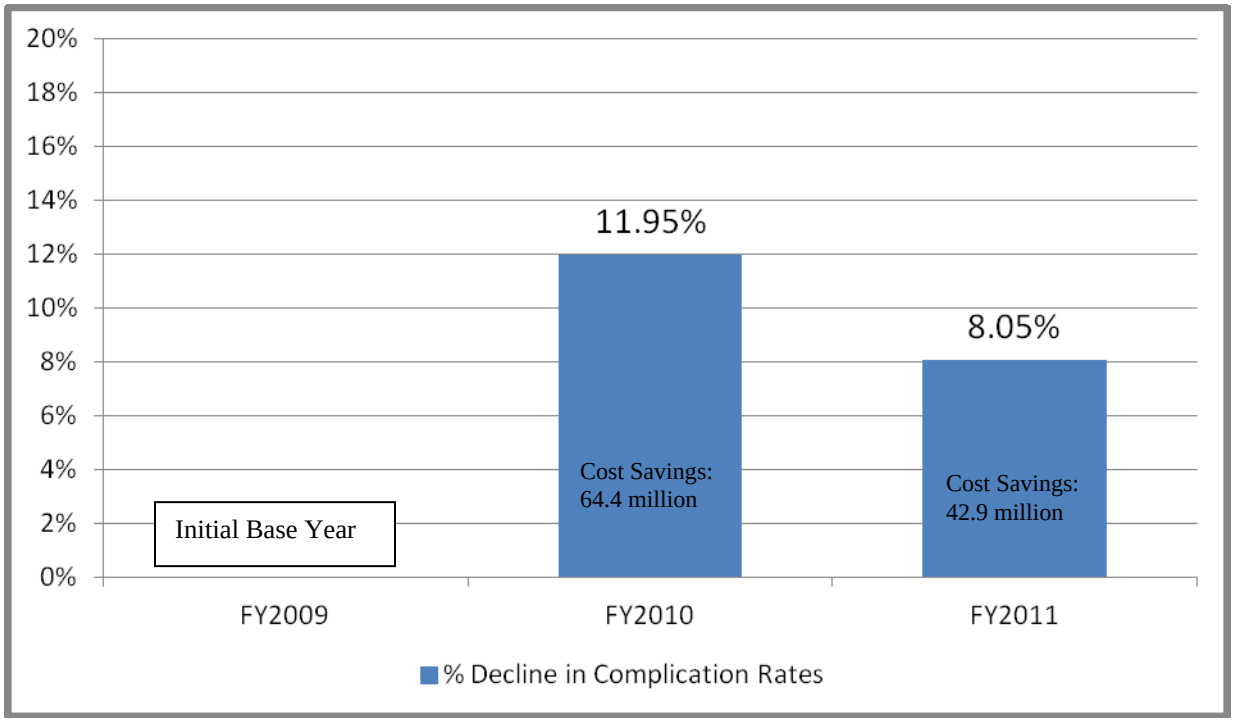


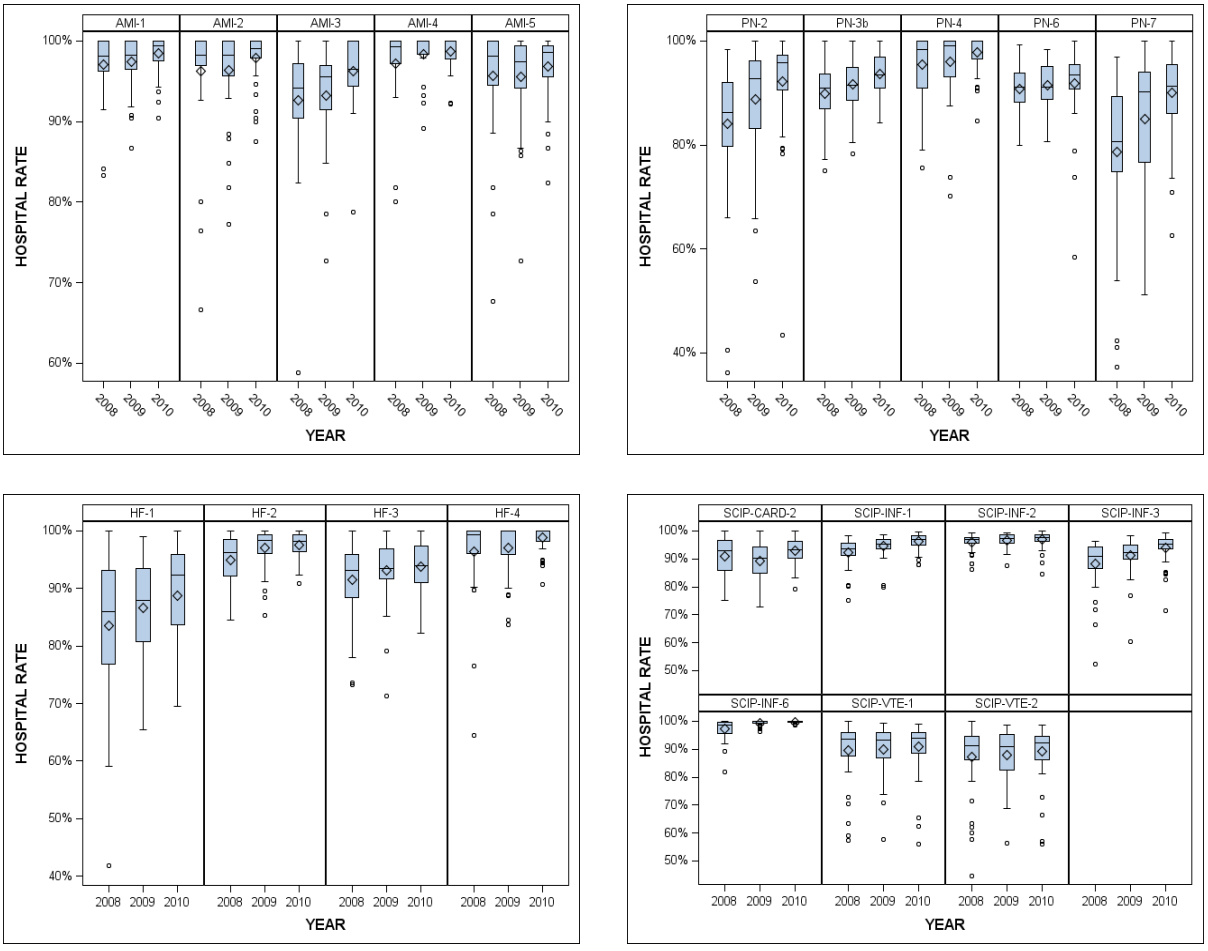
Figure 2: Percent Annual Rate Decline in Complications in MHAC



Specific Patient Quality Outcome and Cost Results

As stated above, analysis of trends in the clinical process of care measures that are included in the QBR Program are promising. Figure 3 illustrates box-plots of each measure by clinical domain-- Heart Attack (AMI), Heart Failure (HF), Pneumonia (PN) and Surgical Care Improvement (SCIP). See Appendix A for list containing the title of each measure. As previously illustrated in Figure 1, all measures are improved from 2008 to 2010, and most importantly, variation among hospitals decreased quite substantially in almost all measures as well. The highest improvement occurred in PN-2 Pneumococcal Vaccination measure, which had a state-wide average of 84.2% in 2008 and increased to 92.2% in 2010. SCIP VTE-1 and SCIP VTE-2 show smaller improvements compared to other measures; however, they were added to the program only in FY2011. SCIP CARD-2, SCIP INF-6 were also added this year. Average percentage point increase in the state-wide average of all measures is 2.9%.

Figure 3: Box Plots of Clinical Process of Care Measures by Year



In the MHAC program, staff has noted improvements in patient outcomes and costs that have been sustained based on the data from the initial two years as shown in Figure 4. The summary of the results are as follows

- Complication rates declined by 20% in the first two years of the program.
- Of the 49 PPCs used in the MHAC program:
    - 37 PPCs decreased in both years (75%);
    - 3 had declines in FY2010 with an average of 16%, and small increases in FY2011 (average increase was 6%);
    - 6 PPCs increased in FY2010 (average increase was 5%) and declined in FY2011 (average decrease was 8%); and
    - 3 PPCs showed increases in both years with an average annual increase of 11%.
- Estimated total cost savings due to reductions in complication rates in the initial two years were $105.4 million.

Figure 4: State-wide Changes in Complications Rates and Cost Savings in MHAC Program

		PERCENT ANNUAL RATE CHANGE		2 YEAR TOTAL RATE CHANGE	2 YEAR TOTAL COST CHANGE
PPC NUMBER/ NAME		FY2010	FY2011		
.	MD TOTAL	-11.95%	-8.32%	-20.27%	-$105,464,576
13	Other Cardiac Complications	-26.61%	-18.73%	-45.34%	-$364,816
53	Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infusions	-27.74%	-15.80%	-43.54%	-$2,127,790
15	Peripheral Vascular Complications Except Venous Thrombosis	-20.79%	-22.58%	-43.37%	-$1,402,442
35	Septicemia & Severe Infections	-20.97%	-20.53%	-41.50%	-$16,564,123
22	Urinary Tract Infection	-27.40%	-12.30%	-39.70%	-$17,254,363
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	-6.46%	-32.15%	-38.61%	-$448,209
36	Acute Mental Health Changes	-23.57%	-12.11%	-35.68%	-$258,851
10	Congestive Heart Failure	-15.40%	-20.13%	-35.53%	-$2,636,381
44	Other Surgical Complication - Moderate	-18.44%	-16.96%	-35.40%	-$1,600,777
54	Infections due to Central Venous Catheters	-20.97%	-12.84%	-33.81%	-$2,664,024
34	Moderate Infectious	-13.73%	-18.43%	-32.16%	-$1,626,652
23	GU Complications Except UTI	-10.96%	-20.63%	-31.59%	-$468,867
28	In-Hospital Trauma and Fractures	-8.67%	-19.06%	-27.73%	-$266,330
31	Decubitus Ulcer	-25.06%	-0.84%	-25.90%	-$5,554,086
11	Acute Myocardial Infarction	-14.67%	-10.93%	-25.60%	-$2,332,141
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc	-11.30%	-13.64%	-24.94%	-$4,154,100
17	Major Gastrointestinal Complications without Transfusion or Significant Bleeding	-23.79%	-1.13%	-24.92%	-$2,641,854
5	Pneumonia & Other Lung Infections	-12.62%	-10.73%	-23.35%	-$10,286,330

PPC NUMBER/ NAME		PERCENT ANNUAL RATE CHANGE		2 YEAR TOTAL RATE CHANGE	2 YEAR TOTAL COST CHANGE
		FY2010	FY2011		
33	Cellulitis	-18.82%	-3.70%	-22.52%	-$798,443
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	-12.00%	-9.87%	-21.87%	-$1,956,314
25	Renal Failure with Dialysis	-3.16%	-17.72%	-20.88%	-$461,888
42	Accidental Puncture/Laceration During Invasive Procedure	-16.22%	-4.49%	-20.71%	-$1,254,462
2	Extreme CNS Complications	-10.53%	-9.90%	-20.43%	-$968,065
16	Venous Thrombosis	-19.63%	0.69%	-18.94%	-$2,414,286
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	-5.88%	-11.67%	-17.55%	-$992,140
14	Ventricular Fibrillation/Cardiac Arrest	-13.96%	-3.51%	-17.47%	-$5,566,386
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	-5.25%	-10.08%	-15.33%	-$4,739,899
8	Other Pulmonary Complications	-9.93%	-4.97%	-14.90%	-$1,466,468
50	Mechanical Complication of Device, Implant & Graft	-4.03%	-10.10%	-14.13%	-$780,030
51	Gastrointestinal Ostomy Complications	-5.40%	-7.06%	-12.46%	-$484,861
47	Encephalopathy	-11.78%	-0.58%	-12.36%	-$1,543,462
9	Shock	1.21%	-13.48%	-12.27%	-$3,654,322
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	-3.27%	-8.42%	-11.69%	-$2,231,164
7	Pulmonary Embolism	-14.20%	2.61%	-11.59%	-$357,218
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	-2.12%	-9.00%	-11.12%	-$608,184
6	Aspiration Pneumonia	-6.74%	-2.48%	-9.22%	-$2,052,555
19	Major Liver Complications	-5.37%	-3.17%	-8.54%	-$338,033
24	Renal Failure without Dialysis	-3.68%	-2.04%	-5.72%	-$1,905,890
12	Cardiac Arrythmias & Conduction Disturbances	-3.97%	-0.15%	-4.12%	-$44,424
43	Accidental Cut or Hemorrhage During Other Medical Care	6.03%	-10.14%	-4.11%	$29,824
1	Stroke & Intracranial Hemorrhage	-1.47%	-2.09%	-3.56%	-$250,565
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding	6.88%	-9.65%	-2.77%	-$156,734
20	Other Gastrointestinal Complications without Transfusion or Significant Bleeding	2.00%	-4.25%	-2.25%	$107,935
26	Diabetic Ketoacidosis & Coma	3.69%	-4.86%	-1.17%	$35,470
48	Other Complications of Medical Care	-12.98%	13.97%	0.99%	-$216,874
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc	0.71%	2.33%	3.04%	$134,742
49	Iatrogenic Pneumothrax	11.69%	-8.10%	3.59%	$83,125

		PERCENT ANNUAL RATE CHANGE		2 YEAR TOTAL RATE CHANGE	2 YEAR TOTAL COST CHANGE
PPC NUMBER/ NAME		FY2010	FY2011		
56	Obstetrical Hemorrhage with Transfusion	4.68%	7.84%	12.52%	$189,077
39	Reopening Surgical Site	46.51%	6.98%	53.49%	$1,850,051

Note: Changes are adjusted for differences in patient mix over the years. The average cost of each PPC may differ in FY2010 and FY2011, resulting in cost increases despite reductions in rates or vice versa in some cases.

Ongoing Data Monitoring, Program Evaluation and Provider Feedback Efforts

In addition to the quantitative data analysis HSCRC staff conducts, staff also undertakes several efforts and activities to ensure and validate the clinical and administrative data accuracy that serves as the basis for the QBR and MHAC initiatives, as well as to evaluate and update the program currency and relevancy. HSCRC also takes steps each year to provide timely data to hospitals which are useful and actionable in enhancing their quality improvement work. Examples of these activities are outlined below.

- HSCRC staff relies on the MHCC oversight of ongoing audit and validation activities for the chart abstracted core process measures to ensure their validity and reliability.
- HSCRC has established Present On Admission (POA) coding data thresholds for data accuracy and requires hospital data submissions to fit within the established thresholds, e.g., coding all diagnosis codes as POA is not permitted.
- We evaluate on an ongoing basis the accuracy of coding, especially POA, through hospital level screening tools (Michael Pine) and targeted chart reviews (Ingenix routine Audit) and audit false negative as well as false positive MHACs.
- HSCRC provides quarterly reports to each hospital with their total count of each PPC, ranking in the State, and case level information.
- Within the last year, HSCRC has contacted two hospitals with the highest complication rates and provided more detailed analysis to help them understand the data.
- Within the last year, another high complication rate hospital contacted us and provided information voluntarily about their efforts to reduce complications.
- We also intend to continue to contact high rate hospitals of concern on an ongoing basis, and revise the routine data reports to make them more useful.
- We have provided our analysis to State Health Department Office of Health Care Quality which augments the information they receive. This analysis helps the Office target the areas in their hospital quality reviews.
- Regarding public reporting, we published FY2010 rankings on our website in a more user-friendly format, which attracted some attention from the media and others.
- HSCRC updates the list of PPCs included in the MHAC program every two years based on the statistical significance of additional cost estimates for each PPC using a regression analysis.

Summary

As staff has reported to the Commission, the above analysis has been shared with the Centers for Medicare and Medicaid Services and HHS Secretary Sebelius as part of our request for a

Maryland exemption from the federal inpatient Value Based Purchasing Program. Staff anticipates that the request will be granted based on the information submitted.

Appendix A

QBR Measures Used for FY 2012

Clinical Process of Care Measures
AMI-1 Aspirin at Arrival
AMI-2 Aspirin prescribed at discharge
AMI-3 ACEI or ARB for LVSD
AMI-4 Adult smoking cessation advice/counseling
AMI-5 Beta blocker prescribed at discharge
HF-1 Discharge instructions
HF-2 Left ventricular systolic function (LVSF) assessment
HF-3 ACEI or ARB for LVSD
HF-4 Adult smoking cessation advice/counseling
PN-2 Pneumococcal vaccination
PN-3b Blood culture before first antibiotic – Pneumonia
PN-4 Adult smoking cessation advice/counseling
PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient
PN-7 Influenza vaccination
SCIP CARD 2 Surgery Patients on Beta-Blocker Therapy Prior to Admission Who Received a Beta-Blocker During the Perioperative Period
SCIP INF 1- Antibiotic given within 1 hour prior to surgical incision
SCIP INF 2- Antibiotic selection
SCIP INF 3- Antibiotic discontinuance within appropriate time period postoperatively
SCIP INF 6- Surgery Patients with Appropriate Hair Removal
SCIP VTE 1- Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
SCIP VTE 2 - Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Given 24 hours prior and after surgery
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
Cleanliness and Quietness of Hospital Environment
Communication About Medicines (Q16-Q17)
Communication With Doctors (Q5-Q7)
Communication With Nurses (Q1-Q3)
Discharge Information (Q19-Q20)
Overall Rating of this Hospital
Pain Management (Q13-Q14)
Responsiveness of Hospital Staff (Q4,Q11)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: October 26, 2011

RE: Hearing and Meeting Schedule

Public Session:

December 8, 2011 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

January 11, 2012 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

Please note, Commissioner packets will be available in the Commission's office at 9:00 a.m.

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

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