HEALTH SERVICES COST REVIEW COMMISSION
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492nd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
October 10, 2012

EXECUTIVE SESSION
9:30 a.m.

1. **Comfort Order: Frederick Memorial Hospital**

2. **MCO Alternative Rate Methodologies**

3. **Waiver Issues**

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

1. **Review of the Executive Session and Public Meeting Minutes of the September 5, 2012 Meeting**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**

   2169A – University of Maryland Medical Center
   2170A – University of Maryland Medical Center
   2171A – University of Maryland Medical Center
   2172A – MedStar Health
   2173A – MedStar Health
   2174A – Johns Hopkins Health System
   2175A – Johns Hopkins Health System

4. **Docket Status – Cases Open**

   2168R – Garrett County Memorial Hospital
   2176R – Good Samaritan Hospital
   2177A – Maryland Physicians Care
   2178A – Johns Hopkins Health System

2179A – MedStar Health
2180N – Chester River Hospital Center
2181N – Kernan Hospital
2182A – Johns Hopkins Health System
2183A – Johns Hopkins Health System
2184A – Johns Hopkins Health System
2185A – Johns Hopkins Health System
2186A – Johns Hopkins Health System
2187A – Johns Hopkins Health System
2188A – University of Maryland Medical Center
2189A – University of Maryland Medical Center

5. **Draft Recommendation for an Outpatient Clinic Volume Adjustment**

6. **Hearing and Meeting Schedule**

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

AS OF OCTOBER 1, 2012

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
2168R	Garrett County Memorial Hospital	7/16/2012	11/7/2012	12/13/2012	FULL	GS	OPEN
2176R	Good Samaritan Hospital	8/8/2012	10/10/2012	1/7/2013	DEF/MSG	CK	OPEN
2177A	Maryland Physicians Care	8/14/2012	N/A	N/A	ARM	SP	OPEN
2178A	Johns Hopkins Health System	8/17/2012	N/A	N/A	ARM	SP	OPEN
2179A	MedStar Health	8/17/2012	N/A	N/A	ARM	SP	OPEN
2180N	Chester River Hospital Center	8/28/2012	10/10/2012	1/27/2013	RDL	CK	OPEN
2181N	Kernan Hospital	8/28/2012	10/10/2012	1/27/2013	CAT	CK	OPEN
2182A	Johns Hopkins Health System	8/23/2012	N/A	N/A	ARM	DNP	OPEN
2183A	Johns Hopkins Health System	8/23/2012	N/A	N/A	ARM	DNP	OPEN
2184A	Johns Hopkins Health System	9/7/2012	N/A	N/A	ARM	DNP	OPEN
2185A	Johns Hopkins Health System	9/7/2012	N/A	N/A	ARM	DNP	OPEN
2186A	Johns Hopkins Health System	9/21/2012	N/A	N/A	ARM	DNP	OPEN
2187A	Johns Hopkins Health System	9/21/2012	N/A	N/A	ARM	DNP	OPEN
2188A	University of Maryland Medical Center	9/28/2012	N/A	N/A	ARM	DNP	OPEN
2189A	University of Maryland Medical Center	9/28/2012	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*	**COST REVIEW COMMISSION**
MEDSTAR GOOD SAMARITAN	*	**DOCKET: 2012**
HOSPITAL	*	**FOLIO: 1986**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2176R**

Staff Recommendation

October 10, 2012

Approved

Introduction

On August 8, 2012, MedStar Good Samaritan Hospital (the "Hospital"), a member of MedStar Health, submitted a partial rate application to the Commission requesting its July 1, 2012 Medical Surgical Acute (MSG) and Definitive Observation (DEF) approved rates be combined effective October 1, 2012.

Staff Evaluation

This rate request is revenue neutral and will not result in any additional revenue for the Hospital as it only involves the combining of two revenue centers. The Hospital wishes to combine these two centers because the patients have similar staffing needs, and placement into either unit is often based on bed availability. The hospital's currently approved rates and the new proposed rate are as follows:

	Current Rate	Budgeted Volume	Approved Revenue
Medical Surgical Acute	$1,127.87	37,561	$42,363,999
Definitive Observation	$936.95	16,944	$15,875,599
Combined Rate	$1,068.52	54,505	$58,239,598

Recommendation

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

1. That the Hospital be allowed to collapse its DEF rate into its MSG rate;

2. That a MSG rate of $1,068.52 per day be approved effective October 1, 2012; and

3. That no change be made to the Hospital s Charge per Episode standard for MSG services.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
MARYLAND GENERAL HOSPITAL	*	**COMMISSION**	
SAINT AGNES HEALTH	*	**DOCKET:**	**2012**
WESTERN MARYLAND HEALTH SYSTEM	*	**FOLIO:**	**1987**
MERITUS HEALTH	*	**PROCEEDING:**	**2177A**

Draft Recommendation

August 29, 2012

I. Introduction

On August 22, 2012, 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 2131A for the period January 1, 2012 through December 31, 2012. The Hospitals are requesting to renew this contract for one year beginning January 1, 2013.

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 20.2% 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 2131A). 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 2011 and 2012, and preliminary projections for CY 2013. In recent years, the financial performance of MPC has been favorable. The actual financial experience reported to staff for CY2011 was positive, and is expected to remain positive in CY 2012. However, the MCO projects an unfavorable financial outcome for CY 2013. This is due to a proposed significant reduction in capitation payments for CY 13.

IV. Recommendation

MPC has continued to maintain consistent favorable performance in recent years. However, the MCO expects the CY 13 rate cut to present a financial challenge. Based on past and projected performance, staff believes that the proposed renewal arrangement for MPC is acceptable under Commission policy but the Commission should continue to watch the impact of the CY 13 capitation payment reductions on the MCO's future financial posture, and any related surplus.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2013.

(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 the impact of the CY 2013 H ealth Choice Program capitation payment reductions, and the MCOs expected financial status into CY 2014. Staff recommends that Maryland Physicians Care report to Commission staff (on or before the August 2013 meeting of the Commission) on the actual CY 2012 experience, preliminary CY 2013 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2014.

(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:**	**2012**
	*	**FOLIO:**	**1988**
BALTIMORE, MARYLAND	*	**PROCEEDING**	**2178A**

Draft Recommendation

August 29, 2012

I. Introduction

On August 21, 2012 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 2135A for the period from January 1, 2012 through December 31, 2012. The Hospitals are requesting to renew this contract for a one-year period beginning January 1, 2013.

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 27.5% 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 2012, and projections for CY 2013. 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 CY2011 was positive, and is expected to remain positive in CY 2012. However, the MCO projects an unfavorable financial outcome for CY 2013. This is due to a proposed significant reduction in capitation payments for CY 13.

IV. Recommendation

Priority Partners has continued to achieve favorable financial performance in recent years. However, the MCO expects the CY 13 rate cut to present a financial challenge. Based on past and projected performance, staff believes that the proposed renewal arrangement for Priority Partners is acceptable under Commission policy but the Commission should continue to watch the impact of the CY 13 capitation payment reductions on the MCO's current and future financial posture, and any related surplus.

Therefore:

1) **Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2013.**
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 the impact of the CY 2013 Health Choice Program capitation payment reductions, and the MCOs expected financial status into CY 2014. Therefore, staff recommends that Priority Partners report to Commission staff (on or before the August 2013 meeting of the Commission) on the actual CY 2012 experience, and p reliminary CY 2013 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2014.**
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**	
MEDSTAR HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2012**
	*	**FOLIO:**	**1989**
COLUMBIA, MARYLAND	*	**PROCEEDING:**	**2179A**

Draft Recommendation

August 29, 2012

I. Introduction

On August 15, 2012, 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 2128A for the period from January 1, 2012 through December 31, 2012. The Hospitals are requesting to renew this contract for one year beginning January 1, 2013.

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 3.7% 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 2128A). 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 2011 and 2012, and projections for CY 2013. In recent years, the financial performance of MFC has been favorable. The actual financial experience reported to staff for CY2011 was positive, and is expected to remain positive in CY 2012. MFC is projecting continued favorable performance in CY 2013.

IV. Recommendation

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.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2013.

(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 2013, and expected to be sustained into CY 2014. Staff recommends that MedStar Family Choice report to Commission staff (on or before the August 2013 meeting of the Commission) on the actual CY 2012 experience and preliminary CY 2013 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2014.

(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 PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*	**COST REVIEW COMMISSION**
CHESTER RIVER	*	**DOCKET: 2012**
HOSPITAL CENTER	*	**FOLIO: 1990**
CHESTERTOWN, MARYLAND	*	**PROCEEDING: 2180N**

Staff Recommendation

October 10, 2012

Approved

Introduction

On August 28, 2012, Chester River Hospital Center (the "Hospital"), a member of the University of Maryland Medical System, submitted a partial rate application to the Commission requesting a rate for inpatient Renal Dialysis (RDL) services. The Hospital requests that the RDL rate be set at the lower of a rate based on its projected costs to provider RDL services or the statewide median and be effective October 1, 2012.

Staff Evaluation

To determine if the Hospital's RDL rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all projected cost and statistical data for RDL services for FY 2013. Based on information received, it was determined that the RDL rate based on the Hospital's projected data would be $762.27 per treatment, while the statewide median rate for RDL services is $802.30 per treatment.

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 RDL rate of $762.27 per treatment be approved effective October 1, 2012; and
3. That the RDL rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

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IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*	**COST REVIEW COMMISSION**
JAMES LAWRENCE KERNAN	*	**DOCKET: 2012**
HOSPITAL	*	**FOLIO: 1991**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2181R**

Staff Recommendation

October 10, 2012

Approved

Introduction

On August 28, 2012, James Lawrence Kernan Hospital (the "Hospital"), a member of the University of Maryland Medical System, submitted a partial rate application to the Commission for a rate for Computerized Tomography (CAT) services to be provided to both inpatients and outpatients. This new rate would replace its currently approved rebundled CAT rate. A rebundled rate is approved by the Commission when a hospital provides certain non-physician services to inpatients through a third-party contractor off-site. By approving a rebundled rate, the Commission makes it possible for a hospital to bill for services provided off site, as required by Medicare. In this case, however, as of October 1, 2012, the Hospital will be providing CAT services on-site to both inpatients and outpatients. The Hospital requests that the CAT rate be set at the lower of a rate based on its projected costs to provide CAT services or the statewide median and be effective October 1, 2012.

Staff Evaluation

To determine if the Hospital's CAT rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission its CAT cost and statistical data projections for FY 2013. Based on information received, it was determined that the CAT rate based on the Hospital's projected data would be $7.03 per RVU, while the statewide median rate for CAT services is $6.92 per RVU.

Recommendation

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

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days before the opening of a new service be waived;
2. That a CAT rate of $6.92 per RVU be approved effective October 1, 2012;
3. That no change be made to the Hospital s charge per episode standard for CAT services; and
4. That the CAT rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH SYSTEM	*	**DOCKET:**	**2012**
	*	**FOLIO:**	**1992**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2182A**

Staff Recommendation

October 10, 2012

Approved

I. INTRODUCTION

Johns Hopkins Health System ("System') filed an application with the HSCRC on August 23, 2012 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 revised global rate arrangement for bone marrow transplant services with Cigna Health Corporation. The System requested approval for a period of one year beginning October 1, 2012.

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, 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

On August 3, 2011, the Hospitals were granted approval for one year for this arrangement. On May 21, 2012, the Hospitals requested a 90 day extension of the Commission's approval to finalize negotiations on revisions to the arrangement. In accordance with the authority granted to staff by the Commission, staff extended the approval to September 28, 2012, an expansion totaling the 90 days. On August 23, 2012, the Hospitals filed an application to continue the arrangement with a revised contract and requested that the original approval be extended for an additional two days so that the effective date of the revised arrangement could be October 1, 2012. The authority to extend the Commission's approval is currently limited to 90 days.

Staff found that the experience under this arrangement for the last year has been favorable.

VI. STAFF RECOMMENDATION

The staff recommends: 1) that staff be permitted to extend Commission approval on an alternative method of rate determination applications from 90 days to three full months; 2) approval of a two day extension of its August 3, 2011 approval; 3) approval of the Hospitals' application for an alternative method of rate determination for bone marrow transplant services, for a one year period commencing October 1, 2012; and 4) that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU").

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2012**
SYSTEM	*	**FOLIO:**	**1993**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2183A**

Staff Recommendation

October 10, 2012

Approved

I. INTRODUCTION

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on August 23, 2012 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, 2012.

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 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, 2012. 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:**	**2012**
SYSTEM	*	**FOLIO:**	**1994**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2184A**

Staff Recommendation

October 10, 2012

Approved

I. INTRODUCTION

On September 7, 2012, 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 a revised global price arrangement with Life Trac (a subsidiary of Allianz Insurance Company of North America) for solid organ and bone marrow transplant and cardiovascular services. The Hospitals request that the Commission approve the arrangement for one year beginning November 1, 2012.

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 solid organ and bone marrow transplants for the last year has been favorable. In addition, the hospital portion of the global rates for cardiovascular services was developed utilizing historical hospital experience for like cases. Staff is satisfied that the hospital component of the global prices for cardiovascular services is sufficient for the Hospitals to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission 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, 2012. 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.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2012**
SYSTEM	*	**FOLIO:**	**1995**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2185A**

Staff Recommendation

October 10, 2012

Approved

I. INTRODUCTION

Johns Hopkins Health System (System) filed an application with the HSCRC on September 7, 2012 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 for participation in a global rate arrangement for solid organ transplant, bone marrow transplant, and cardiovascular services with Olympus Managed Health for a period of one year beginning November 1, 2012.

II. OVERVIEW OF APPLICATION

The contract will 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 new global rates was developed by calculating mean historical charges for patients receiving kidney, bone marrow transplants, and cardiovascular services at the Hospitals. 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 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 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

Staff found that the experience under this arrangement for the last year was favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ, bone marrow transplant, and cardiovascular services for a one year period commencing November 1, 2012. 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**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2011**
SYSTEM	*	**FOLIO:**	**1950**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2186A**

Staff Recommendation

October 10, 2012

Approved

INTRODUCTION

Johns Hopkins Health System (System) filed a renewal application with the HSCRC on September 21, 2012 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, 2012.

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 2012 was favorable.

IV. STAFF RECOMMENDATION

Based on its favorable performance for the last year, staff recommends that the Commission approve the Hospital's renewal application for an alternative method of rate determination for a one year period commencing November 1, 2012.

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:**	**2012**
SYSTEM	*	**FOLIO:**	**1997**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2187A**

Staff Recommendation

October 10, 2012

Approved

I. INTRODUCTION

Johns Hopkins Health System (System) filed an application with the HSCRC on September 21, 2012 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 for participation in a global rate arrangement for cardiovascular and orthopedic services with PepsiCo, Inc. for a period of one year beginning December 1, 2012.

II. OVERVIEW OF APPLICATION

The contract will 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 new global rates was developed by calculating mean historical charges for patients receiving cardiovascular and orthopedic services at the Hospitals. 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 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 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 has been no activity under this arrangement, staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular and orthopedic services for a one year period commencing December 1, 2012. 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.

Draft Recommendation
Outpatient Volume Adjustment: Clinic

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

October 10, 2012

This is a draft recommendation for the October 10, 2012 Public Commission Meeting. The Commission is not required to take action on this item.

Purpose

This paper recommends an enhanced outpatient volume adjustment for clinic services.

To neutralize permanent system revenue increases associated with the growth in clinic services, HSCRC staff recommends the Commission approve a non-symmetric variable cost factor for outpatient clinic services in the clinic rate center (CL). We recommend the Commission apply a 50 percent variable adjustment to permanent revenue for increases in volumes. For volume decreases, we recommend applying an 85 percent variable adjustment to permanent revenue. HSCRC staff recommends applying these variable cost factors beginning in rate year 2014. HSCRC staff would determine clinic volume growth in rate year 2013 above rate year 2012 and apply the 50 percent variable adjustment for increases or 85 percent variable adjustment for decreases to the hospital's FY 2014 permanent revenue.[1]

This recommendation also aims to address site of service differentials. Payers and patients in Maryland pay substantially more for a service provided in an outpatient hospital clinic setting than for the same service provided in a professional office setting. This phenomenon is also occurring outside of Maryland. In their March 2012 Report to Congress, MedPAC recommended Medicare "move toward paying the same rates for the same service across different sites of care, (by) equalizing the rate paid for evaluation and management visits in outpatient departments and freestanding physician offices."[2] As the HSCRC's regulatory authority does not transcend hospital-based services, a volume adjustment is one means for this Commission to partially address the site of service differential.

Recent Commission Actions

The most recent Commission action regarding an outpatient constraint was the removal of the outpatient Charge Per Visit methodology during the Commission's March 7th, 2012 Public Meeting. At that time, the Commission charged staff to develop a short-term outpatient constraint approach to implement for services in the FY 2013 rate year.

In addition, HSCRC staff presented on the topic of outpatient volume growth at the July and September 2012 Commission meetings.

Workgroup Meetings

HSCRC staff held two workgroup meetings, one on September 12, 2012 and the second on September 27, 2012. In addition to HSCRC staff, hospital, MHA, and payer representatives joined the well-attended discussions both in person and via conference call.

[1] The HSCRC has implemented a case mix lag. The applicable base and performance years will follow the case mix lag implementation schedule.

[2] http://www.medpac.gov/documents/Mar12_EntireReport.pdf; accessed October 1, 2012.

Background: Large Growth in Outpatient Revenue

As displayed in Exhibit 1, hospital outpatient revenue has increased significantly over the last five years.

Exhibit 1: Percent Change in Revenue Growth, 2007-2012

Fiscal Year	Inpatient Revenue	% Change from Prior year	Outpatient Revenue	% Change from Prior year
2007	$8,047,041,255	8.6%	$3,409,790,445	8.4%
2008	$8,473,095,276	5.3%	$3,835,156,384	12.5%
2009	$8,850,106,108	4.4%	$4,184,558,946	9.1%
2010	$8,960,887,722	1.3%	$4,425,831,435	5.8%
2011	$9,171,390,572	2.3%	$4,898,656,599	10.7%
2012	$9,325,021,997	1.7%	$5,538,336,440	13.1%

Source: HSCRC, September 2012. Maryland Monitoring Performance Report, August 2012.

A portion of the outpatient growth is due to movement of cases from an inpatient to an outpatient setting. Attention from Medicare in the Federal Medicare Recovery Audits (RAC Audits) and shifts in Commission policy accelerated hospitals' transition away from short-stay inpatient cases to outpatient care, especially in the last several years. Movement of cases from inpatient to outpatient may impact a large number of hospital rate centers; however, when observing the types of cases shifting from inpatient to outpatient, HSCRC staff understand that most shifting cases will move into rate centers with directly translatable types of service, such as Same Day Surgery and Observations. These transitions are far less relevant in a discussion of the growth in outpatient clinic services.

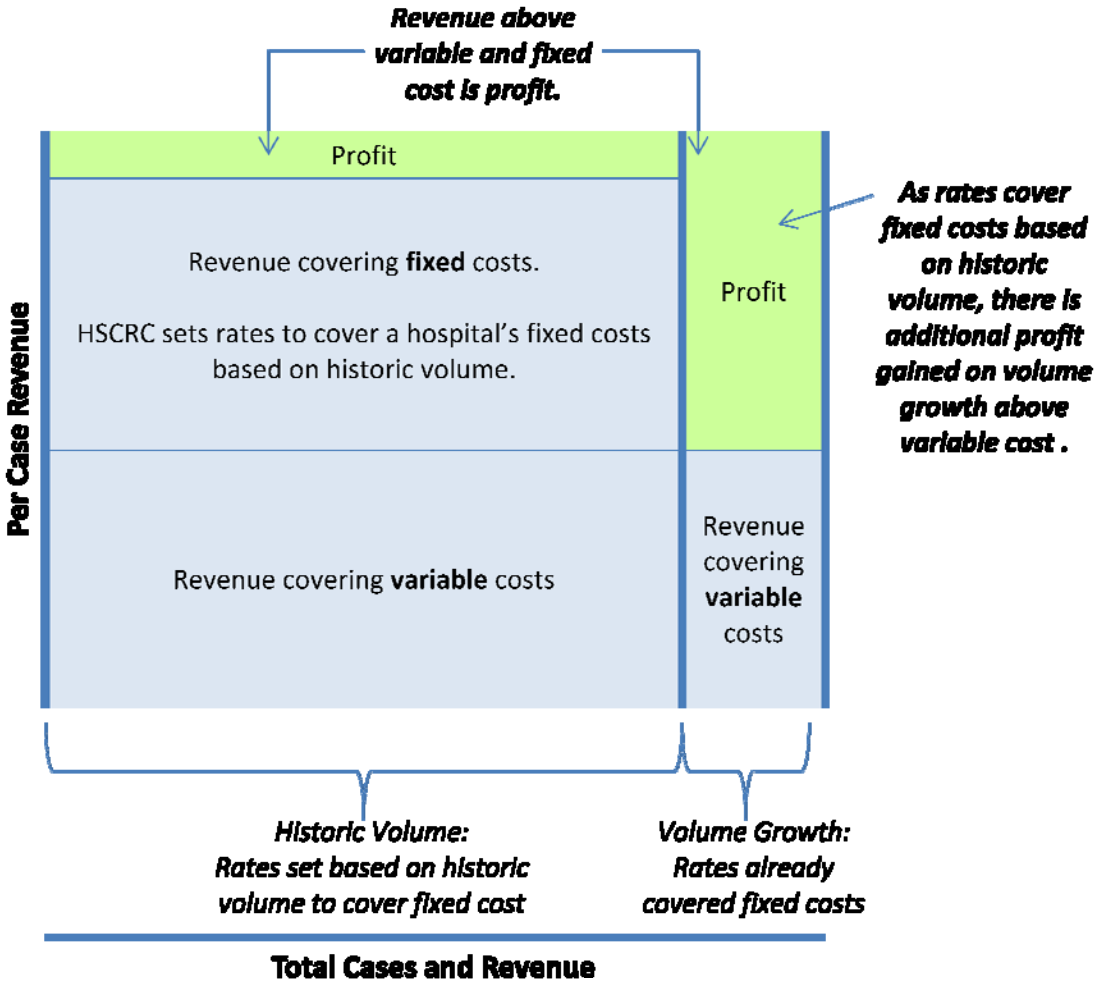
Rate Setting Provides Hospitals a Financial Incentive to Increase Volume and Capture "One-Time" Profits

The HSCRC sets each hospital's annual rates such that the rates provide sufficient dollars to cover each hospital's fixed costs at the hospital's historic volumes. In addition to the rates covering fixed cost, the rates established by the HSCRC also support the variable cost of the service. Revenue above the variable and fixed costs is profit to the hospital.

As displayed in Exhibit 2, when volumes grow above the historic level during a rate year, HSCRC's rate structures have already covered the fixed costs in the dollars attributed to the historic volumes. Therefore, for volume increases during a rate year, any revenue from the service above variable cost alone is profit to the hospital during that rate year. This provides the hospital a large incentive to grow volumes year over year.

The recommendations under this policy do not alter the one-time revenue growth associated with volume growth during a rate year. During a year of volume growth, the hospital accrues the benefit of the increased volume. However, when developing rates for the following rate year, the enhanced clinic volume adjustment will reduce the permanent revenue from the hospital’s rate base, as discussed below.

Exhibit 2: Per Case Revenue Associated with Historic Volume and Volume Growth During Rate Year



The Current Variable Cost Factor Builds 85 Percent of Revenue Growth into Permanent Rates

Under the current volume constraint policy, HSCRC staff measures total volume growth for inpatient and outpatient combined and adjusts the permanent revenue by an 85 percent variable / 15 percent fixed cost factor. For example, during rate year 2013, a hospital accrues the benefits of any additional volume growth the hospital experiences in the fiscal year. However, HSCRC staff then adjusts the hospital's rates in rate year 2014 to allow the hospital to retain only 85 percent of the incremental volume growth in rate year 2013 over the 2012 base rate year.[3] While the hospital retains revenue from the one-time adjustment, HSCRC staff do not build into the permanent revenue base the full volume growth.

Conversely, under current policy, HSCRC staff handles volume decreases in a similar fashion. For a decrease in volume in rate year 2013 from rate year 2012, the hospital would lose the full

[3] The HSCRC has implemented a case mix lag. The applicable base and performance years will follow the case mix lag implementation schedule.

revenue associated with the volume reduction. However, HSCRC staff restore 15 percent of the revenue associated with the volume decline to the hospital's permanent rate base in FY 2014.

There is currently much discussion among interested parties regarding the most appropriate aggregate volume adjustment for combined inpatient and outpatient services. We are not addressing aggregate volume adjustments in this recommendation.

50 Percent Variable Rate for Clinic Reduces Permanent Revenue Growth Built into Rates

In this recommendation, HSCRC staff would apply the same general mechanism to clinic rates in terms of the timing for one-time and permanent adjustments. The accruing of one-time revenue while partially constraining permanent revenue is consistent with the current volume constraint policy. However, under these recommendations, HSCRC staff would separate the clinic rate center (CL) from the general volume adjustment for each hospital's calculation.

Literature and Practice Support a Range of Variable/Fix Ratios

There is little recent literature attempting to determine the "actual" ratio of variable to fixed costs in a hospital. From experience, HSCRC staff appreciate that the ratio of variable to fixed differs by characteristics of each hospital such as the physical plant, the type of service, the time period, and other hospital characteristics. We also acknowledge that the ratio of variable to fixed costs are not static across a number of years, and may, over time, act as a step function instead of a static price model.

The table in Appendix A provides direct and indirect costs by hospital for the clinic rate center as reported in each hospital's financial schedules. HSCRC staff understands that this does not directly correlate to fixed and variable costs; however, it does provide a rule of thumb indicating that a 50 percent variable adjustment is reasonable for neutralizing the impact of growing revenue in this rate center.

HSCRC staff is also developing several economic elasticity models to understand the interaction of variable and fixed costs. While these models have limitations, we are hoping that these will yield results to explain the relationship of fixed to variable cost. We will present any findings of this model in the final staff recommendation at the November Commission meeting.

Growth In Clinic Services

As seen see Exhibit 3, clinic services have grown rapidly over the last five years as the number of outpatient clinic visits surged 51 percent and revenue increased 25 percent from 2007 to 2012. HSCRC staff's analysis of RVUs per visit across time demonstrate that increased clinic volume is primarily driven by increases in the number of visits, not the intensity of the visits as measured by RVUs.

Exhibit 3: Percent Change in Clinic Rate Center Visits and RVUs, 2007-2012

Year	Visits		RVUs	
	Total Visit	% Change from Prior Year	Total RVUs	% Change from Prior Year
2007	1,280,248		9,807,091	
2008	1,442,423	12.7%	10,052,457	2.5%
2009	1,586,693	10.0%	10,590,519	5.4%
2010	1,775,615	11.9%	11,089,372	4.7%
2011	1,835,331	3.4%	11,523,437	3.9%
2012	1,932,017	5.3%	12,280,526	6.6%

Source: HSCRC, October, 2012. Monthly Financial Data.
Notes: Based on non-TPR hospitals between 2011 and 2012 .
GBMC excluded due to incorrect visits in 2011.

Hospitals and payers indicate a number of reasons for this growth including regulating previously unregulated clinics on the hospital campus, building new clinic space, and purchasing of physician practices/hiring of physicians to increase the number of physicians in existing outpatient clinics. As discussed earlier in this paper, transitions from inpatient to outpatient service are not the primary driving factor for clinic volume increases. HSCRC data limitations do not provide a means to tease out the sources of this growth.

HSCRC staff do not consider this a deterrence in implementing a clinic volume adjustment. The purpose of this policy is not to penalize medically necessary incremental volume growth in clinics, but to cover the incremental costs associated with providing clinic services. As previously discussed, HSCRC builds rates such that the volumes at historic levels provide sufficient revenue to cover a hospital's fixed costs. The 50 percent volume adjustment on incremental volume growth covers the variable costs associated with incremental volumes without generating additional profit associated with volume growth by paying for fixed costs that have already been covered in base-year volumes. The policy is designed to pay for the costs of care while removing the traditional incentive for expanding volumes under fee-for-service medicine.

Hospitals have expressed some concern that this recommendation will deter hospitals from engaging in care provided in clinics with altruistic or mission-driven intents, such as prenatal or primary care clinics, because it "penalizes" clinic growth. While the policy intends to neutralize the revenue associated with increased volume, HSCRC staff does not view neutralization as a penalty.

Impacts of Clinic Growth

Under the Current Policy, Hospitals Profit from Volume Growth

As discussed above, hospitals profit from incremental volume growth during a year. Additionally, the 85 percent variable / 15 percent fixed cost factor to incremental volume growth builds much of the revenue growth into permanent rates.

Evaluation and Management Performed in the Hospital is Often Much More Expensive for the Payer

At a national level, hospital outpatient clinic services are also increasing. In recommending a site of service differential to equalize payments for outpatient hospitals and physician practices, MedPAC reacted to these trends in their March Report to Congress stating:

> *Under current policy, Medicare pays 80 percent more for a 15-minute office visit in an OPD than in a freestanding physician office. This payment difference creates a financial incentive for hospitals to purchase freestanding physicians' offices and convert them to OPDs without changing their location or patient mix. Indeed, E&M clinic visits provided in OPDs increased 6.7 percent in 2010, potentially increasing Medicare program and beneficiary expenditures without any change in patient care.*[4]

To better understand site of service differentials in Maryland, HSCRC staff requested site of service differential payments amounts from several payers, including Medicaid FFS and MCOs. Multiple payers recently submitted data to HSCRC staff and we are compiling that data now. Early evaluation demonstrates large site of service differentials, with reimbursement rates often 200 and 300 percent higher at an outpatient clinic than at a professional office setting.

CareFirst provided HSCRC with this type of data last month, as displayed in Exhibit 4.

Exhibit 4: CareFirst Average Allowed Amount Comparisons for Select Evaluation and Management Procedure Codes Across Types of Care Settings, Maryland Providers Only

CPT Code and Description	Academic Medical Centers	Urban/Suburban Community Hospital	Rural Community Hospital
	% of Office Allwd	% of Office Allwd	% of Office Allwd
99203 Office outpatient new 30 minutes	233%	296%	275%
99213 Office outpatient visit 15 minutes	298%	308%	339%
99214 Office outpatient visit 25 minutes	247%	188%	257%
99215 Office outpatient visit 40 minutes	223%	166%	177%
99244 Office consultation new/estab patient 60 min	202%	226%	252%

Source: CareFirst, August 2012.

Notes: Professional Allowed is calculated at the Code level, associated Facility Allowed includes either all allowed at the case level where indicated or at code level where indicated (4). In Network Paid Claims between 07/01/2011 to 11/30/2011. Facility case selected with E&M CPT and without any accompanying ancillary procedure. Cases where the patient visited multiple providers were excluded from the data.

Allowed amount is the reimbursed amount net of patient cost sharing.

[4] http://www.medpac.gov/documents/Mar12_EntireReport.pdf; accessed October 1, 2012.

With Co-pays and Co-insurance, Evaluation and Management Performed in the Hospital is Often Much More Expensive for the Patient

HSCRC staff evaluate all recommendations with an appreciation for the impact on the patient. In reviewing the site of service differential, it is important to note that patients often pay much higher out of pocket amounts for services in an outpatient clinic than for the same service in a professional office setting. Payers have noted that more employers are purchasing plans which require patients to pay co-insurance for outpatient hospital costs. These recent trends in health coverage structures have shifted costs to patients through increased co-payments, co-insurance, and cost associated with high-deductible plans.

Recommended Volume Adjustment

An outpatient volume adjustment for clinic services aims to neutralize the financial impact of clinic volume growth. Corresponding to efforts by MedPAC, an outpatient volume adjustment also attempts to level the large site of service differentials seen by payers and patients for clinic-type services in Maryland. HSCRC staff recommends the Commission adopt:

- *Outpatient clinic volume adjustment of 50 percent for volume increases in the clinic rate center for permanent revenue*

  As previously discussed, this attempts to neutralize the amount of permanent revenue associated with incremental volume increases.

- *Asymmetric outpatient clinic volume adjustment of 85 percent variable for volume increases to permanent revenue in the clinic rate center*

  - Staff has spent considerable time discussing the implications of an asymmetric volume adjustment. Some interested parties have suggested that we should pin the volume increase to a point in time, such as the base year for this policy (rate year 2012). HSCRC staff believe this would be administrative difficult to maintain across time. Also, as volumes have been increasing significantly for many facilities since 2007 or earlier, we feel it is consistent to remove revenue at the same variable rate for declines below the base year level.
  - Other interested parties question if an 85 percent variable cost factor for declines will provide a disincentive for hospitals to decrease volume. HSCRC staff's aim of this policy is to neutralize the financial impact of volume growth.

- *Apply these variable cost factors to the clinic rate center only*

  At the September Commission meeting, Commissioners requested that HSCRC staff review options for including ancillary services provided in the context of the clinic visit under this volume constraint. For example, during an evaluation and management service, a physician orders a comprehensive metabolic panel. If the physician provided this service in a professional setting, the laboratory services would likely be provided in an outpatient setting as well. However, if this is an outpatient clinic visit, the patient is likely to use onsite hospital laboratory services which will generate additional ancillary facility charges for, in this case, the venipuncture and laboratory services. HSCRC staff understands that in constraining the volume in the clinic rate center we are not capturing ancillary growth.

Exhibit 5 provides a breakdown of the costs by rate center for services with a clinic visit. Note that outside of drug costs, a majority of costs are in the clinic services rate center. Due to this, along with the complexities of calculating ancillary services growth, HSCRC staff recommends implementing this policy only for services in the clinic rate center (CL).

Exhibit 5: Outpatient Clinic Point of Entry - Charges by Rate Center FY 2010 to FY 2012 - Q1 and Q2

	Charges in Each Rate Center as a Percent of Total Charges for the Year		
	Q1, Q2 FY 2010	**Q1, Q2 FY 2011**	**Q1, Q2 FY 2012**
Drugs (CDS)	35%	39%	40%
Clinic Services (CL)	44%	43%	41%
Laboratory Services (LAB)	7%	7%	7%
Medical Surgical Supplies (MSS)	1%	1%	1%
Radiology – Diagnostic (RAD)	2%	2%	2%
Radiology – Therapeutic (RAT)	5%	3%	4%
Other Rate Centers	6%	5%	5%
Total	**100%**	**100%**	**100%**

Source: HSCRC, September 2012. HSCRC Outpatient Case Mix Data.
Notes: Visit selected for analysis if there were units and charges in the CL rate center.

- *Apply this policy for rate year 2014*

  When calculating permanent revenue, HSCRC staff would adjust revenue based on volume change in rate year 2013 from the rate year 2012 base.[5]

- *Hold Clinic Rate Center Out of Overall Variable Cost Factor Adjustment*

  In applying the 85 percent variable / 15 percent fixed volume adjustment for inpatient and outpatient services, HSCRC staff will hold clinic services out of the calculation.

Modeled Impact of the Clinic Volume Adjustment

HSCRC staff modeled the implications of the enhanced clinic volume adjustment on financial data from FY 2011 and FY 2012. We modeled this both with visits and RVUs. Exhibit 6 and Exhibit 7 demonstrate the calculation of this policy for hospitals with volume growth. HSCRC staff continues to discuss the merits of each volume indicator and we request comment on this topic. We will bring forward a final recommendation at the November Commission meeting.

[5] The HSCRC has implemented a case mix lag. The applicable base and performance years will follow the case mix lag implementation schedule.

Exhibit 6: RVUs - Hospitals With Volume Growth (21 Hospitals) - *Draft*

1. RVUs and Revenue, FY 2011 and FY 2012			
	RVUs	**Revenue**	
2011	8,838,956	$280,319,833	
2012	9,695,782	$323,191,290	
2. Price Level to 2011			
2011 Per RVU Price	$31.71	**2012 RVUs at 2011 Price**	$307,493,327
3. Apply Volume Adjustment			
	Total Rev Growth	**Rev Growth Due to Volume**	**Rev Growth Due to Price**
2011 to 2012 Growth	$42,871,457	$27,173,494	$15,697,963
Apply 50% Constraint on Volume		$13,586,747	
4. Impact of Volume Adjustment			
2012 Revenue without Volume Adjustment		$323,191,290	
2012 Revenue with 50% Volume Adjustment		$309,604,543	
2012 Revenue Change with Constraint		-4.2%	

Source: HSCRC, September 2012. Monthly financial data.
Notes: Based on non-TPR hospitals with volume growth in RVUs between 2011 and 2012 .
GBMC excluded due to incorrect visits in 2011.

Exhibit 7: Visits - Hospitals With Volume Growth (24 Hospitals) - *Draft*

1. Visits and Revenue, FY 2011 and FY 2012			
	Visits	**Revenue**	
2011	1,458,494	$297,584,584	
2012	1,602,625	$340,274,817	
2. Price Level to 2011			
2011 Per Visit Price	$204.04	**2012 Visit at 2011 Price**	$326,992,428
3. Apply Volume Adjustment			
	Total Rev Growth	**Rev Growth Due to Volume**	**Rev Growth Due to Price**
2011 to 2012 Growth	$42,690,233	$29,407,844	$13,282,389
Apply 50% Constraint on Volume		$14,703,922	
4. Impact of Volume Adjustment			
2012 Revenue without Volume Adjustment		$340,274,817	
2012 Revenue with 50% Volume Adjustment		$325,570,895	
2012 Revenue Change with Constraint		-4.3%	

Source: HSCRC, September 2012. Monthly financial data.
Notes: Based on non-TPR hospitals with volume growth in visits between 2011 and 2012 .
GBMC excluded due to incorrect visits in 2011.

COMMISSION ACTION

This is a draft recommendation for the October 10, 2012 Public Commission Meeting. The Commission is not required to take action on this item.

Appendix A

Clinic Cost - FY 2010 - Analysis of Cost Per RVU

Hospital Name	Visits	RVU's	Direct Cost	Patient Overhead Cost	Hospital Overhead Cost	Other Level 1 Cost	Level 1 Cost	Level 2 Cost	Level 2 Total Cost	Level 4 Unit Rate Difference	Level 4 Revenue
ANNE ARUNDEL	50,114	382,499	$17.09	$2.87	$4.29	$0.00	$24.25	$5.43	$29.68	$0.24	$29.91
ATLANTIC GEN	16,300	91,257	$15.18	$4.36	$5.52	$0.00	$25.07	$4.15	$29.22	$2.87	$32.10
BALT WASH MEDICAL CENTER	36,843	163,644	$17.59	$0.03	$5.40	$0.00	$23.03	$0.56	$23.58	$3.02	$26.60
BON SECOURS	14,869	95,261	$14.90	$6.76	$6.23	$0.00	$27.89	$6.14	$34.03	$7.35	$41.38
CALVERT	17,168	157,920	$13.18	$1.91	$5.24	$0.00	$20.34	$3.02	$23.36	$2.39	$25.75
CARROLL COUNTY	25,706	107,862	$17.64	$2.86	$6.70	$0.00	$27.20	$5.31	$32.51	$2.80	$35.31
CHESTER RIVER	3,105	36,833	$14.98	$7.30	$6.70	$0.00	$28.97	$2.89	$31.87	$6.05	$37.92
CIVISTA	6,570	49,443	$12.73	$1.04	$5.49	$0.00	$19.26	$1.61	$20.86	$2.43	$23.30
DOCTORS COMMUNITY	9,650	74,722	$21.01	$4.11	$5.36	$0.00	$30.48	$4.83	$35.31	$4.53	$39.84
DORCHESTER GENERAL	3,265	37,444	$18.94	$1.37	$9.57	$0.00	$29.88	$1.19	$31.07	$3.63	$34.70
FRANKLIN SQUARE	60,687	535,841	$12.48	$3.48	$4.48	$1.80	$22.24	$3.67	$25.91	-$1.91	$24.00
FREDERICK MEMORIAL	18,598	258,914	$7.57	$1.46	$2.80	$0.00	$11.83	$2.83	$14.66	$2.04	$16.70
G.B.M.C.	42,195	411,353	$17.79	$2.18	$6.58	$2.20	$28.74	$2.80	$31.54	$1.66	$33.21
GARRETT COUNTY	2,340	10,865	$16.60	$4.04	$4.82	-$0.01	$25.46	$3.89	$29.35	$3.78	$33.14
GOOD SAMARITAN	28,568	180,654	$18.67	$3.28	$6.58	$6.82	$35.35	$3.84	$39.19	$3.80	$43.00
HARBOR	3,606	27,166	$20.62	$2.90	$6.98	$0.72	$31.22	$2.21	$33.43	$3.64	$37.06
HARFORD	11,210	25,937	$14.62	$5.23	$6.23	$0.00	$26.08	$4.91	$30.99	$4.86	$35.85
HOLY CROSS	27,622	166,823	$13.44	$2.37	$5.58	$2.85	$24.24	$3.58	$27.82	$2.54	$30.37
HOPKINS BAYVIEW MED CTR	357,381	2,335,404	$13.48	$1.75	$2.13	$0.66	$18.02	$2.34	$20.36	$2.76	$23.12
HOWARD COUNTY	20,984	114,510	$13.37	$1.64	$3.26	$0.00	$18.28	$2.17	$20.45	$2.29	$22.74
JOHNS HOPKINS	327,232	1,534,290	$19.48	$4.28	$4.31	$2.26	$30.33	$5.14	$35.47	-$3.83	$31.65
KERNAN	45,749	213,061	$17.36	$2.59	$3.37	$2.77	$26.09	$1.36	$27.45	$3.42	$30.87
LAUREL REGIONAL	3,373	43,676	$13.93	$4.82	$3.77	$0.00	$22.52	$3.18	$25.70	$4.96	$30.66
MARYLAND GENERAL	22,911	141,636	$31.90	$7.26	$13.11	$3.57	$55.84	$6.21	$62.05	$11.36	$73.40
MCCREADY	11,192	29,186	$19.54	$7.17	$6.16	$2.82	$35.69	$4.88	$40.57	$7.64	$48.21
MEMORIAL AT EASTON	27,625	175,275	$21.49	$2.09	$10.23	$0.00	$33.81	$2.80	$36.61	$2.36	$38.97
MERCY	121,524	516,104	$4.20	$3.01	$1.77	$2.44	$11.42	$2.98	$14.40	$1.96	$16.36
MERITUS MEDICAL CENTER	28,198	280,469	$12.33	$2.21	$2.86	$0.00	$17.40	$1.89	$19.30	$2.52	$21.81

Hospital Name	Visits	RVU's	Direct Cost	Patient Overhead Cost	Hospital Overhead Cost	Other Level 1 Cost	Level 1 Cost	Level 2 Cost	Level 2 Total Cost	Level 4 Unit Rate Difference	Level 4 Revenue
MONTGOMERY GENERAL	23,075	107,367	$17.90	$5.10	$6.71	$0.00	$29.70	$5.14	$34.85	$3.66	$38.50
NORTHWEST	22,413	124,308	$24.92	$7.75	$7.68	$0.00	$40.35	$9.58	$49.93	$7.32	$57.25
PENINSULA REGIONAL	33,156	322,115	$7.84	$2.44	$2.41	$0.00	$12.68	$2.98	$15.66	$2.00	$17.66
PRINCE GEORGE	717	4,694	$3.00	$38.05	$2.90	$91.22	$135.17	$20.79	$155.97	$37.00	$192.96
SHADY GROVE	19,151	175,916	$9.46	$2.34	$3.34	$0.00	$15.13	$2.56	$17.69	$1.77	$19.46
SINAI	71,013	518,138	$22.94	$6.60	$6.37	$8.15	$44.06	$9.78	$53.85	$0.14	$53.98
SOUTHERN MARYLAND	7,265	21,934	$17.04	$1.03	$9.32	$0.00	$27.39	$2.07	$29.46	$5.19	$34.65
ST. AGNES	55,472	307,769	$12.91	$2.58	$4.83	$1.35	$21.66	$2.35	$24.02	$0.23	$24.25
ST. JOSEPH	41,324	276,803	$15.80	$2.58	$5.28	$0.00	$23.67	$2.96	$26.62	$2.23	$28.85
ST. MARY	6,348	95,056	$11.48	$1.41	$5.15	$0.00	$18.04	$2.01	$20.05	$2.19	$22.24
SUBURBAN	29,798	86,595	$19.32	$3.82	$5.47	$0.00	$28.61	$3.96	$32.58	-$1.95	$30.63
UNION HOSPITAL CECIL	3,555	40,740	$8.91	$2.09	$3.36	$0.00	$14.36	$2.76	$17.12	$1.04	$18.15
UNION MEMORIAL	33,108	175,636	$23.16	$3.54	$7.20	$13.94	$47.85	$4.10	$51.95	-$7.10	$44.86
UNIVERSITY OF MARYLAND	119,295	815,910	$18.32	$9.72	$3.69	$3.63	$35.36	$13.85	$49.21	$7.46	$56.67
UNIVERSITY OF MD CANCER	37,318	380,860	$9.93	$0.76	$5.03	$0.42	$16.14	$1.96	$18.10	$3.93	$22.03
UNIVERSITY SPECIALTY**	13,245	101,698	$19.84	$0.60	$19.20	$1.93	$41.57	$1.35	$42.91	$15.97	$58.88
UPPER CHESAPEAKE HEALTH	40,120	207,126	$15.00	$2.32	$4.65	$0.00	$21.96	$2.77	$24.73	$3.06	$27.78
WASHINGTON ADVENTIST	20,992	135,255	$11.53	$3.89	$4.39	$0.00	$19.81	$2.60	$22.41	$3.35	$25.76
WESTERN MD HEALTH	32,032	353,205	$10.50	$2.38	$4.17	$0.00	$17.05	$4.30	$21.35	$1.47	$22.83
Total	2,006,411	12,449,174	$15.28	$3.40	$4.42	$1.76	$24.85	$4.31	$29.16	$1.87	$31.03
			49.23%	10.96%	14.23%	5.66%		13.88%		6.04%	1

CareFirst BlueCross BlueShield
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www.carefirst.com

October 8, 2012

Health Services Cost Review Commission
4201 Patterson Avenue
Baltimore, Maryland 21215

Re: Draft Staff Recommendation Outpatient Volume Adjustment: Clinic

Dear Commissioners:

CareFirst has several comments and suggestions in respect to the above referenced draft recommendation. Before commenting on the specifics of the recommendation, I think it is important to acknowledge the reason this decision is before you today. At the March 7, 2012 Public Meeting, the Commission directed the staff to craft a **revised outpatient payment system aimed at reducing volumes** as a part of its agreement to terminate the Cost Per Visit (CPV) methodology. The recommendation before you considers only the Clinic component of this directive.

CareFirst agrees that the Clinic issue is a major driver in the outpatient volume issue; however, in order to align policies and incentives to make a significant change in total outpatient volumes and develop a substitute for the CPV methodology, we believe that any volume adjustment changes should be extended across all hospital outpatient services, at this time. In the very near future, we urge the Commission to expand the volume adjustment across all inpatient and outpatient hospital services to continue to encourage the movement of inpatient cases to outpatient and reduce overall volumes.

The current **Maryland hospital reimbursement system**, uses a 100% Variable Cost Factor (VCF) in the initial year of a volume change coupled with an 85% permanent VCF. We believe this has encouraged hospitals to purchase physician practices and relocate their offices to hospital campuses. If this service is then determined by staff to be "at-the-hospital," the service is officially recognized as a "regulated Clinic" within the HSCRC rate structure with the authority to bill an institutional fee in addition to the physician's professional fee.

Between RY2007 and RY2011, CareFirst experienced **a 132% increase in the number of hospital-based clinic visits** in Maryland Hospitals *(Attachment A--from 96,019 to 222,850)*. The majority of these visits were for routine office visits, previously rendered in a community-based doctor's office. The mere location change allows for an additional bill *(institutional bill)* to the payers with a significant impact to the member/patient.

On average, the costs of these hospital-based office visits can be **two to three times the cost of same service** when provided in a community-based doctor's office (an increase of 100% to 200%). *(Reference the Staff's recommendation; Exhibit #4; page 6)*. When rendered in a community-based physician office, the member usually has a small copayment *(e.g., $25)*; however, with the change in location and

designation as Regulated Clinic, the member is receiving an additional institutional bill based on RVUs and hospitals' Clinic rate per RVU, which by the way varies significantly across hospitals.

For example, **we reviewed an actual Clinic encounter** by a CareFirst member where this member received services *(CPT code 99204; 46-90 minute office visit)* at an academic Medical Institution in Maryland. In addition to the physician bill, the institutional bill was $1,136. The member had a 20% coinsurance and was responsible for $227 of the Clinic bill. Had this service been provided in a community-based doctor's office, the member would have paid $25. In this case the member paid $252 *($227 + $25).* While this bill is not typical of the majority of the Clinic bills it does illustrate the potential impact on the member. On average, our members are experiencing a similar impact as noted above *(a 100% - 200% increase).*

While the current staff recommendation addresses a potential solution to the Clinic component, it falls short of the global directive of the Commission. CareFirst believes the recommendation should be extended to all outpatient services since no other alternatives have been put forward to constrain volume increases for these services.

The Commission knows that CareFirst has long recommended the adoption of more stringent fixed cost factors (FCF) to provide strong incentives for hospitals to reduce overall service volumes. The CareFirst approach is much broader and also fundamentally different from the current staff approach.

The **Staffs' recommendation has the effect of neutralizing the impact of volume increases** and penalizing hospitals for volume decreases. **CareFirst believes the Commission should incorporate FCF/VCFs at levels that will change the incentives that caused this problem. Moreover, these incentives should not be limited to just Clinic services.**

You can see from the volume impact on Carefirst noted above, hospitals respond to incentives and the Staff recommendations are far too narrowly applied and do not contain incentives to reduce volumes. CareFirst provided testimony during this years' Update Factor negotiations and again during discussions regarding Waiver Modernization that the volume adjustment must change in order to have any success in achieving the current and future waiver targets. We stated then and **urge the Commission again today to incorporate a 60% FCF, which will dramatically change the current reimbursement model** by removing the incentive to increase total volume (inpatient and outpatient combined) while providing an incentive for volume reductions by allowing hospitals to retain 60% of revenues associated with volume reductions. We believe our recommendation for a 60% FCF and 40% VCF is necessary for all volume changes, not just Clinic, and will strongly support this change as discussions continue on the waiver modernization.

In addition to the volume adjustment, CareFirst believes there are 3 other issues that need further investigation:

1. **Policy compliance--** currently the HSCRC has a policy which requires hospitals to limit RVU billing to 2 units if the services rendered in these Clinics do not involve other hospital resources. In our investigation of routine office visit claims, our study revealed that in many situations hospitals may not be complying with this rule. An example is the case mentioned above which involved our member receiving a 45 minute office where the hospital billed 15 RVUs. Under the HSCRC policy, if no hospital services were rendered, the bill would have been for 2 RVUs, which would have reduced the charge from $1,136 to $174.
2. **Place of Service--** The physician bill that accompanies the Clinic visit should indicate a Facility Place of Service (POS). If the physician indicates an Office POS the reimbursement to the physician

includes the facility component and the hospital should not bill the Clinic Fee. Our claims analyses revealed that in many cases, the physician bill includes an Office POS while the hospital issued a Clinic bill. This should not occur and should be investigated.

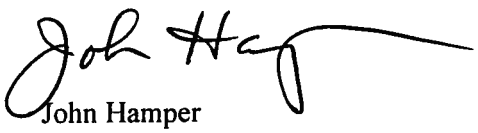
3. **Large Variation in Approved Clinic Rates--** as of the most recent rates available on the HSCRC website, the Clinic Fees range from $15 - $74 per RVU. This appears to be a significant range especially when applied to routine office visits. In the same example I referenced in #1 above, involving a 15 RVU office visit, the institutional bill would vary between $225 and $1,110. To ensure the reasonableness of any facility charge the HSCRC should consider, as a standard, the allowed rate provided by Medicare under the OPPS.

In summary, CareFirst supports a change to the volume adjustment for all services, not just clinic visits, and urges the Commission to incorporate a 60% FCF/40% VCF on all volume – inpatient and outpatient combined - since this will obviate the need for a service-specific policy as is being recommended today.

In addition, we encourage the Commission to institute audit compliance procedures, possibly through the special audit process, to review policy compliance on billing appropriate RVUs and POS, and finally, direct the Staff to review the current range in Clinic Fees to understand the cause for such wide ranges and use Medicare Fees as a standard of reasonableness.

Thank you for this opportunity to comment on the draft recommendation for an Outpatient Volume Adjustment.

Sincerely,



John Hamper

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Hospital Clinic Visit Analysis

Clinic Visit Utilization by Hospital by Year of Service

By Rate Yr Sorted by Visit

Hospital	RYE June2007	RYE June2008	RYE June2009	RYE June2010	RYE June2011	Grand Total	Avg Visits
JOHNS HOPKINS HOSPITAL	17,558	23,686	46,231	65,746	65,819	219,040	**43,808**
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	15,393	19,367	21,919	21,871	22,536	101,086	**20,217**
UNIVERSITY OF MARYLAND MEDICAL CENTER	16,470	17,994	18,507	22,867	23,942	99,780	**19,956**
MERCY MEDICAL CENTER INC	50	705	26,632	34,086	33,159	94,632	**18,926**
SAINT AGNES HOSPITAL	1,601	4,845	6,872	7,804	7,751	28,873	**5,775**
ANNE ARUNDEL MEDICAL CENTER	1,545	2,538	4,609	6,360	11,326	26,378	**5,276**
GREATER BALTIMORE MEDICAL CENTER	5,347	4,959	5,231	4,332	3,901	23,770	**4,754**
SAINT JOSEPH MEDICAL CENTER	1,533	3,259	4,509	5,340	5,414	20,055	**4,011**
JAMES LAWRENCE KERNAN HOSPITAL	3,598	3,857	4,192	3,419	3,159	18,225	**3,645**
BALTIMORE WASHINGTON MEDICAL CENTER	3,362	2,789	3,446	3,884	3,527	17,008	**3,402**
FRANKLIN SQUARE HOSPITAL CENTER INC	2,815	2,642	2,690	3,084	3,104	14,335	**2,867**
UPPER CHESAPEAKE MEDICAL CENTER	1,993	2,430	2,563	3,213	3,718	13,917	**2,783**
CARROLL HOSPITAL CENTER	2,090	2,287	2,388	2,370	2,421	11,556	**2,311**
ATLANTIC GENERAL HOSPITAL	2,077	2,335	2,321	2,331	1,825	10,889	**2,178**
EDW W MCCREADY MEM HOSPITAL	2,035	2,217	2,216	2,309	1,965	10,742	**2,148**
UNION MEMORIAL HOSPITAL	2,099	2,141	2,120	2,173	1,969	10,502	**2,100**
GOOD SAMARITAN HOSPITAL OF MARYLAND INC	1,921	1,946	2,614	1,960	1,612	10,053	**2,011**
HOWARD COUNTY GENERAL HOSPITAL	822	1,620	2,047	2,647	2,565	9,701	**1,940**
MT WASHINGTON PEDIATRIC HOSPITAL	828	951	858	2,445	2,844	7,926	**1,585**
NORTHWEST HOSPITAL CENTER	1,068	1,479	1,477	1,804	2,047	7,875	**1,575**
MEMORIAL HOSPITAL AT EASTON	683	801	1,618	1,624	2,236	6,962	**1,392**
HOLY CROSS HOSPITAL	532	1,430	1,339	1,435	1,525	6,261	**1,252**
SINAI HOSPITAL OF BALTIMORE	1,240	925	1,255	1,528	1,285	6,233	**1,247**
MARYLAND GENERAL HOSPITAL	1,332	1,315	1,128	1,089	1,104	5,968	**1,194**
WESTERN MD REGIONAL MEDICAL CENTER	1,229	1,813	900	987	959	5,888	**1,178**
FREDERICK MEMORIAL HOSPITAL	849	996	991	847	979	4,662	**932**
SHADY GROVE ADVENTIST HOSP	1,023	1,098	1,463	606	425	4,615	**923**
CALVERT MEMORIAL HOSPITAL	498	666	1,038	1,088	1,281	4,571	**914**
HARFORD MEMORIAL HOSPITAL	960	999	998	757	760	4,474	**895**
MERITUS MEDICAL CENTER INC	828	952	737	849	1,031	4,397	**879**
PENINSULA REGIONAL MEDICAL CENTER	346	417	793	1,242	1,459	4,257	**851**
DOCTORS COMMUNITY HOSPITAL	224	412	675	1,070	1,154	3,535	**707**
SUBURBAN HOSPITAL	390	715	774	829	731	3,439	**688**
SAINT MARYS HOSPITAL	673	340	285	405	660	2,363	**473**
SOUTHERN MD HOSP	75	177	230	400	431	1,313	**263**
HARBOR HOSPITAL CENTER	90	161	268	377	390	1,286	**257**
MONTGOMERY GENERAL HOSPITAL	75	124	235	302	533	1,269	**254**
LAUREL REGIONAL HOSPITAL	187	173	150	241	257	1,008	**202**
BON SECOURS BALTIMORE HEALTH SYSTEM	160	194	147	114	119	734	**147**
UNION HOSPITAL OF CECIL COUNTY	51	62	82	140	349	684	**137**
GARRETT COUNTY MEMORIAL HOSPITAL	40	38	44	139	259	520	**104**
WASHINGTON ADVENTIST HOSP	192	110	53	25	28	408	**82**
CHESTER RIVER HOSPITAL CENTER	28	55	33	77	162	355	**71**
PRINCE GEORGES HOSPITAL CENTER	51	46	62	48	73	280	**56**
CIVISTA MEDICAL CENTER	56	45	64	16	17	198	**40**
DORCHESTER GENERAL HOSP	2	4	14	50	39	109	**22**
Grand Total	**96,019**	**118,115**	**178,818**	**216,330**	**222,850**	**832,132**	**166,426**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: October 3, 2012

RE: Hearing and Meeting Schedule

Public Session:

November 7, 2012 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

December 5, 2012 Time to be Determined, 4160 Patterson Avenue, HSCRC Conference Room

Please note, Commissioner packets will be available in the Commission's office at 10:30 a.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website.
http://hscrc.maryland.gov/commissionMeetingSchedule2012.cfm

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