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

493rd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
November 7, 2012

EXECUTIVE SESSION
12:15 p.m.

1. **Waiver Issues**

2. **MCO Alternative Rate Methodologies**

AGENDA - REVISED
PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Executive Session Minutes from October 10, 17, and 30, 2012; and Public Meeting Minutes of the October 10, 2012 Meeting**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**

   2176R – Good Samaritan Hospital
   2180N – Chester River Hospital Center
   2181R – Kernan Hospital
   2182A – Johns Hopkins Health System
   2187A – Johns Hopkins Health System

4. **Docket Status – Cases Open**

   2168R – Garrett County Memorial Hospital
   2177A - Maryland Physicians Care
   2178A – Johns Hopkins Health System
   2179A – MedStar Health
   2188A – University of Maryland Medical Center
   2189A – University of Maryland Medical Center

2190N – St. Mary's Hospital
2191A – Johns Hopkins Health System
2192A – Johns Hopkins Health System

5. **Final Recommendations regarding an Outpatient Clinic Volume Adjustment**

6. **Draft Recommendation Regarding Maryland Hospital Acquired Condition (MHAC) and Quality-based Reimbursement (QBR) Scaling Magnitudes, and MHAC Standard for Expected Values for FYs 2014 and 2015**

7. **Report on Admission-Readmission Revenue Structure, and One Day Length of Stay Policy**

8. **Legal Report**

9. **Hearing and Meeting Schedule**

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

AS OF OCTOBER 31, 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
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
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
2190N	St. Mary's Hospital	8/8/2012	11/7/2012	1/7/2013	HYP	CK	OPEN
2191A	Johns Hopkins Health System	10/19/2012	N/A	N/A	ARM	DNP	OPEN
2192A	Johns Hopkins Health System	10/22/2012	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**	
MARYLAND GENERAL HOSPITAL	*	**COMMISSION**	
SAINT AGNES HEALTH	*	**DOCKET:**	**2012**
WESTERN MARYLAND HEALTH SYSTEM	*	**FOLIO:**	**1987**
MERITUS HEALTH	*	**PROCEEDING:**	**2177A**

Final Recommendation

November 1, 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 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 primarily due to a proposed 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 result in unfavorable financial performance. 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**

Final Recommendation

October 31, 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 outlook for CY 2013. This is primarily due to a 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 result in unfavorable financial performance during that year. 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 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**	
MEDSTAR HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2012**
	*	**FOLIO:**	**1989**
COLUMBIA, MARYLAND	*	**PROCEEDING:**	**2179A**

Final Recommendation

November 1, 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 APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2012**
MMEDICAL CENTER	*****	**FOLIO:**	**1998**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2188A**

Revised

Staff Recommendation

November 7, 2012

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on September 28, 2012 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 to continue to participate 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, 2012.

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

Staff found that the experience under this contract for the last year was unfavorable. The

Hospital explained that there were only two cases under this contract in FY 2012 and one of them was an outlier. This case had a huge impact on the profitability of this arrangement. 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 recommends that the Hospital be granted approval on this arrangement to for one year to see if the Hospital can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that 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 commencing November 1, 2012. 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:**	**2012**
MEDICAL CENTER	*****	**FOLIO:**	**1999**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2189A**

Revised

Staff Recommendation

November 7, 2012

I. INTRODUCTION

The University of Maryland Medical Center (the Hospital) filed a renewal application with the HSCRC on September 28, 2012 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for participation in a revised global rate arrangement 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, 2012.

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 unfavorable.

The Hospital reported that it has significantly restructured the arrangement, therefore staff recommends that the Hospital be granted approval of the revised arrangement for one year to see if the Hospital can achieve a favorable experience under the revised arrangement.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission 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, 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:**	**2001**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2191A**

Staff Recommendation

November 7, 2012

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on October 19, 2012 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplants with United Resources Networks/Optum Health, a division of United HealthCare Services, for a period of one year beginning December 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 System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION ANDASSESSMENT 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

The staff reviewed the experience under this arrangement for the last year and found it to be favorable. After review of the contract, staff believes that the Hospitals can achieve a favorable experience under this amended 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 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.

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:**	**2002**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2192A**

Staff Recommendation

November 7, 2012

I. INTRODUCTION

Johns Hopkins Health System (the System) filed a renewal application with the HSCRC on October 22, 2012 on behalf of its member hospitals, the Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the Hospitals) 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 insured with Tricare. The arrangement involves the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare as providers for Tricare patients. The requested approval is for a period of one year beginning January 1, 2013.

II. OVERVIEW OF APPLICATION

The parties to the contract include the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare, a subsidiary of the System. The program provides a range of health care services for persons insured under Tricare including inpatient and outpatient hospital services. Johns Hopkins Health Care will assume the risk under the agreement, and the Hospitals will be paid based on their approved HSCRC rates.

III. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' renewal application for an alternative method of rate determination for a one year period beginning January 1, 2013. This recommendation is based on historical favorable contract performance.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document 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.

Final Recommendation
Outpatient Volume Adjustment: Clinic

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

November 7, 2012

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This is a final recommendation for the November 7, 2012 Public Commission Meeting.

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 does not regulate physician services, constraining revenue in the clinic rate center through a volume adjustment is one limited means for this Commission to address the site of service differential.

This recommendation is a first step in a broader discussion of volume growth as a consequence of fee-for-service incentives in the current hospital rate-setting system. Because of the expansion of clinic services due to the acquisition of physician practices by hospitals and the related issue of a site-of-service differential, clinic revenues provide a unique issue within the overall context of outpatient services. Therefore, the staff has chosen to address this issue independently, in advance of more general volume discussions related to a revised Medicare waiver and the population-based considerations likely to emerge from those discussions.

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.

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[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 understands that most shifting cases will move into rate centers with directly translatable types of service, such as Same Day Surgery and Observation. These transitions are far less relevant in a discussion of the growth in outpatient clinic services.

Recently, some hospitals have developed specialty "bridge" clinics to reduce hospital readmissions. From review of the Admissions-Readmissions Reduction Program's Year 1 Hospital Intervention Plans, HSCRC staff does not see that the scope of these programs should drive any significant volume increases to clinics. HSCRC staff also notes that the Commission's Admissions-Readmissions Reduction Program already provides a financial incentives to reduce inpatient readmissions; inpatient reductions, for example, associated with bridge clinic use will generate financial rewards on the inpatient side of revenue. Additionally, these same bridge services could be located outside of hospital clinics in physician practices.

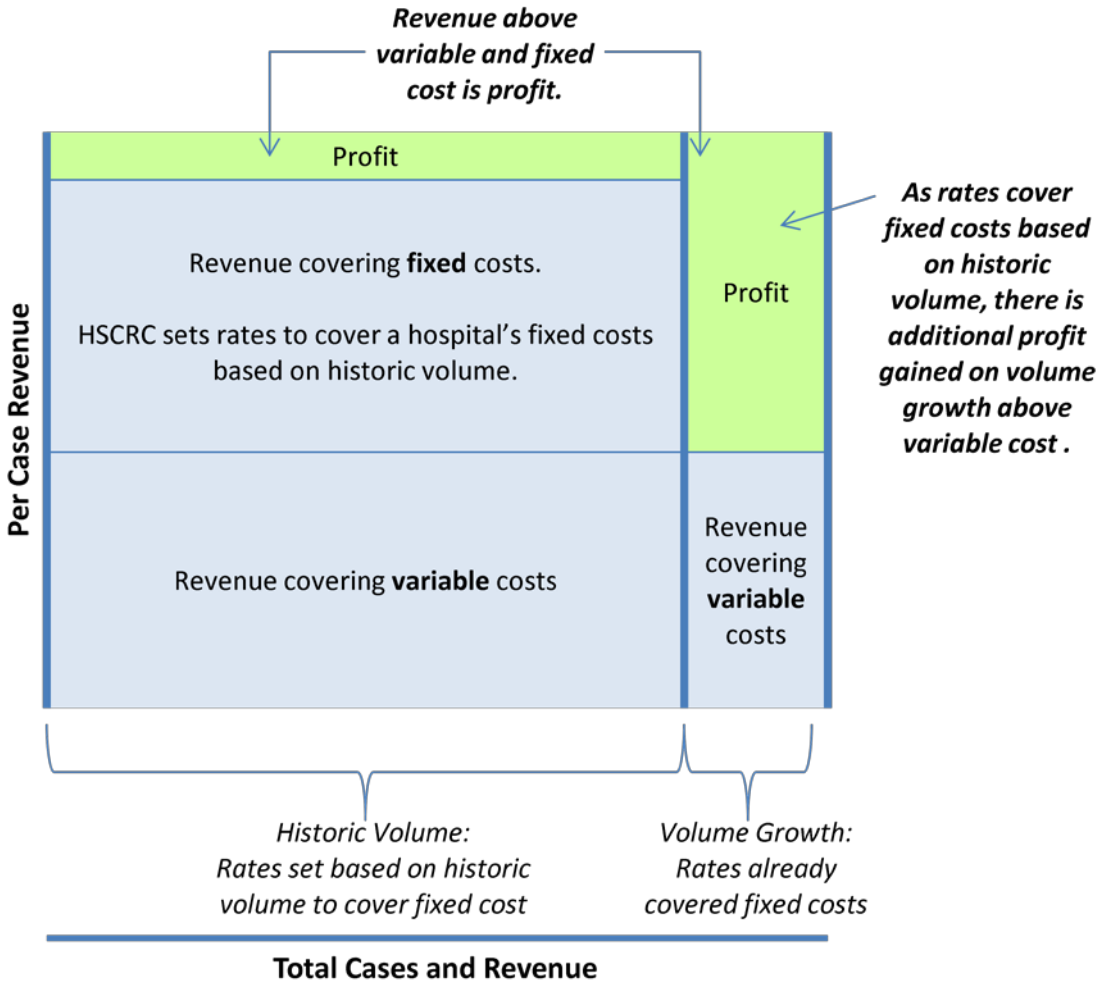
Rate Setting Provides Hospitals a Financial Incentive to Increase Volume and Capture "One-Time" Profits

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.

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

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

the hospital retains revenue from the one-time adjustment, HSCRC staff does 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 revenue associated with the volume reduction. However, HSCRC staff restores 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.

Growth In Clinic Services

In FY 2012, services in the clinic rate center accounted for 8 percent of total outpatient revenue and 3 percent of inpatient and outpatient revenue. However, 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. Here are some of the findings:

- Coventry's Diamond Plan Medicaid MCO in 2011 found that they reimbursed outpatient clinic visits (99213, 99214) at outpatients centers 286 percent more than a similar visit in a professional office.
- When accounting for the FY 2013 physician fee increases, Amerigroup's Medicaid MCO is paying for reimbursed clinic visits (99213, 99214) on average 141 percent more than for a similar visit in a professional office.
- Jai Medical Systems found that cost increases by over two hundred percent when reviewing reimbursement for a range of E&M codes.

CareFirst provided HSCRC with this type of data in September, as displayed in Exhibit 4.[5]

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

[5] Based on Commission feedback, HSCRC staff recalculated these numbers as a percent more than professional office services, similar to the wording of the MedPAC recommendation.

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 Percent More Than Professional Office	Urban/Suburban Community Hospital Percent More Than Professional Office	Rural Community Hospital Percent More Than Professional Office
99203 Office outpatient new 30 minutes	133%	196%	175%
99213 Office outpatient visit 15 minutes	198%	208%	239%
99214 Office outpatient visit 25 minutes	147%	88%	157%
99215 Office outpatient visit 40 minutes	123%	66%	77%
99244 Office consultation new/estab patient 60 min	102%	126%	152%

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.

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

HSCRC staff evaluates 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.

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. Exhibit 5 below demonstrates the calculation of this policy for hospitals with volume growth.

Exhibit 5: RVUs - Hospitals With Volume Growth (21 Hospitals)

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.

COMMISSION ACTION

This is a final recommendation for the November 7, 2012 Public Commission Meeting.

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 adjustment attempts to neutralize the amount of permanent revenue associated with incremental volume increases. The staff has discussed whether a one-time adjustment for the evaluation year should be made to capture the effects of volume growth at the same time as the permanent adjustment is made to the rate base. Currently, we are not proposing a one-time adjustment, consistent with the implementation of the 85/15 volume constraint in place for the rest of inpatient and outpatient revenue. However, we intend to explicitly revisit that policy as the broader discussion of the volume constraint is discussed in the future. We would anticipate that clinic volumes would be treated consistently with other volume growth.

- *Asymmetric outpatient clinic volume adjustment of 85 percent variable for volume decreases 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.
    - Hospitals experiencing volume declines with little or no growth in the preceding five year period may approach HSCRC staff for special consideration. The intent of this special consideration is to hold harmless hospitals with steady-state volumes that demonstrate random variability up and down. The asymmetric application of the volume constraint would penalize hospitals under those circumstances while the intent of the asymmetric constraint is to regulate the revenue growth in facilities that have experienced consistent volume growth over time.
- *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 7 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 6: 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.[6]

- *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.

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

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

Comment Letters

Maryland
Hospital Association

MHA
6820 Deerpath Road
Elkridge, Maryland 21075-6234
Tel: 410-379-6200
Fax: 410-379-8239

October 19, 2012

Mary Pohl
Deputy Director, Research and Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Mary:

On behalf of the 66 members of the Maryland Hospital Association (MHA), we appreciate the opportunity to share our views on the staff proposal to change the outpatient clinic volume adjustment. As proposed at its October meeting, the recommendation would use a non-symmetrical volume adjustment for clinic services, using a 50 percent variable cost factor (VCF) for increases in clinic utilization, while maintaining the current 85 percent VCF for declines in clinic utilization. MHA urges the staff to **withdraw** its current proposal, for the following reasons:

- The proposal fails to document the extent of the outpatient clinic volume "problem."
- The proposal fails to justify the selection of the specific VCF being recommended for either utilization increases or decreases.
- Because the proposal fails to consider the actions already taken by hospitals in the proposed performance year (fiscal year 2013), it is effectively a retrospective policy change.

Defining the extent of the "problem"

In bringing forth this proposal, HSCRC staff has provided historical clinic visit and relative-value unit data for the non-Total Patient Revenue (TPR) hospitals. By its own words, staff agrees that some of the growth in clinic services may be the result of declines in utilization (at an 85 percent VCF) in other rate centers, specifically citing potential movement from inpatient settings. In fact, this growth will be attributable to the following factors:

- Movement from inpatient settings as part of hospitals' efforts to avoid unnecessary admissions or re-admissions;
- Hospitals' interest in moving non-emergent cases from the more-expensive Emergency Department setting to the lower-cost outpatient clinic setting;
- Addition of new clinics to the overall clinic rate center to meet unmet needs identified in hospitals' community needs assessments; and,
- Growth in existing clinics.

Each of these engines of outpatient volume growth should be more fully explored by Commission staff, and consideration given to whether the same volume adjustment should be applied in each instance. MHA is also concerned that the staff proposal fails to distinguish between the various causes of these changes in outpatient clinic volume, and only considers the total volume change in isolation of other hospitals savings that have accrued in other revenue centers. It is puzzling to us

- more -

why the Commission would consider a change that may inhibit exactly the sort of activities that should be encouraged under health reform and total population health management. The fact that TPR outpatient clinic volume growth is more than double that of non-TPR hospitals is clear evidence of the appropriateness of that growth – it is part of a successful strategy for managing total population health.

Selection of the Variable Cost Factor

In proposing a reduction from 85 percent to 50 percent in the VCF for increases in outpatient clinic utilization, the staff says it is attempting to "neutralize" the amount of permanent revenue increases associated with incremental volume increases. Staff can only draw this conclusion if it can document that the selection of this specific VCF actually matches what it believes to be the actual variable costs associated with this incremental utilization change. In fact, the staff has indicated there is little, if any, research available to determine what the correct variable-to-fixed-cost ratio is. Staff also acknowledges that this ratio is not static across years, and may be more of a "step" function, rather than the static pricing model they are proposing. Given the undocumented reasons for each hospital's clinic utilization growth cited above, it is very possible this relationship varies between hospitals due to the unique reasons for each hospital's outpatient clinic utilization growth. Some, if not all, of these hospitals may actually be penalized at a level below their actual variable costs for providing these valuable programs to the communities they serve. Many of these services would otherwise not be available in the community.

Staff also proposes to continue to use the current 85 percent VCF for declines in outpatient clinic volumes, saying that "many facilities" have seen clinic utilization increases since 2007 or earlier. Again, because the Commission has not adequately documented the various reasons for these increases, it is unclear to us whether, in fact, the Commission has already adjusted for those utilization increases through its 85 percent VCF for reductions in utilization that occurred in other rate centers. Further, according to the data provided by staff, several of the non-TPR hospitals have seen consistent *declines* in outpatient clinic volume since 2007 or earlier. As proposed, such hospitals would receive a 50 percent VCF for any increase in utilization that occurs in 2013, and then, if they return to their recent trend of clinic volume reductions, see that reduction affected by an 85 percent VCF to reflect earlier years when they supposedly had *increases* in utilization that this very data demonstrate *have not occurred.* This policy proposal clearly penalizes those hospitals. MHA must object in the strongest terms to the arbitrary nature of this proposed policy change.

The retrospective nature of the change

By applying this policy to volume changes in the current April 2012 to December 2012 performance period, the Commission staff is returning to the type of retrospective policy-making to which we have previously objected. We see this retroactivity essentially in two ways: by using a non-symmetrical VCF in this proposal, the Commission is essentially suggesting that it has erred in its previous VCF policy for these clinics, and seeks to retrospectively recover a portion of that unjustified permanent revenue. In addition, hospitals made decisions about their investments in clinic services for fiscal year 2013 based on what they believed to be the VCF policy to be in place for utilization increases for that fiscal year; this is a retroactive policy decision, even though it is only being applied as an adjustment to permanent revenue reflected in fiscal year 2014 rates.

Comment Letters

Given the concerns that we have cited above, MHA strongly encourages the Commission staff to **withdraw** its proposed change to the outpatient clinic volume adjustment. If you have any questions, please contact me at the Association, at (410) 379-6200.

Sincerely,

Michael B. Robbins
Senior Vice President, Financial Policy & Advocacy

Draft Staff Recommendation on QBR and MHAC Scaling Magnitudes and Standard for Expected Values for the FY 2014 and FY 2015 Updates to Hospital Rates

November 5, 2012

This document represents a draft recommendation and to be presented to the Commission on November 7, 2012.

Introduction

The HSCRC quality-based scaling methodologies and magnitudes "at risk" are important policy tools for providing strong incentives for hospitals to improve their quality performance over time. This document presents recommendations for the scaling magnitudes and methodologies to translate scores into rate updates for the Quality-based Reimbursement ("QBR") and Maryland Hospital Acquired Conditions ("MHACs") initiatives to be applied to FY 2015 rates based on Calendar Year 2013 hospital performance periods.

Current HSCRC policy calls for the revenue neutral scaling of hospitals' position and allocation of rewards and penalties related to performance on the HCSRC's QBR and MHAC initiatives. The term "scaling" refers to the differential allocation of a pre-determined portion of base regulated hospital revenue based on a distribution of hospital performance related to relative quality. The rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year. Unlike previous scaling for Reasonableness of Charges ('ROC") results, scaling amounts applied for quality performance are applied on a "one-time" basis (and not considered permanent revenue).

The reward and penalty allocations for the quality programs are computed on a "revenue neutral" basis for the system as a whole. This means that the net increases in rates for better performing hospitals are funded entirely by net decreases in rates for poorer performing hospitals.

Since the inception of the program, clinical work groups have been meeting on on-going bases to discuss the measures, and the MHAC and QBR methodologies. The Payment Work Group meets each year to discuss the size and distribution of the scaling of the update factor. The Payment Work Group met on October 31, 2012 to review issues and modeling for changes to the MHAC and QBR scaling magnitudes and the standard for expected values for FY 2015.

Background

1. QBR and MHAC Measures, Scaling and Magnitude at Risk to Date

The QBR program uses the Centers for Medicare and Medicaid Services ("CMS")/Joint Commission core process measures, —e.g., aspirin is given upon arrival for the patient diagnosed with heart attack--and eight "patient experience of care" or Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") measure domains. Appendix I lists the measures for the QBR and MHAC programs.

The MHAC program currently uses 50 of the 65 Potentially Preventable Complications developed by 3M Health Information Systems, which computes actual versus expected rates of complications adjusted for each patient by the All Patient Refined Diagnosis Related Group ("APR DRG"), and severity of illness ("SOI") category.

For FY 2013 rates, the HSCRC scaled a maximum penalty of 0.5% of base approved hospital revenue for the QBR (which was the same level as FYs 2010 through 2012), and 2% for the MHAC program (which was 0.5% in FY 2011, and 1% in FY 12) - a total of 2.5% of hospital base revenue related to quality. Prior to FY 2013, the final scaling magnitudes for the QBR and MHAC

programs were previously determined retrospectively at the end of a particular year because of the hospital industry's preference to see the impact of scaling on individual hospitals in the context of the overall hospital update approved by the Commission.[1] However, last year the Commission agreed, to the extent practicable, to determine the scaling magnitudes and expected rates prospectively. In an effort to expedite HSCRC's issuing of rate orders, during FY 2012 and FY 2013 HSCRC is transitioning MHAC performance calculations from a fiscal year basis to a calendar year basis. To accommodate the transition, HSCRC utilized FY 2012 Q1, Q2, and Q3 case mix data for calculating FY 2012 MHAC performance results. For quality scaling applied to FY 2014 rate orders, HSCRC will again utilize three quarters of case mix data (FY 2012 Q4, FY 2013 Q1, and FY 2013 Q2) as the performance period. The performance period for QBR program had always been on a calendar year schedule, therefore no change has been implemented.

This recommendation for quality performance, relates to rate updates applied with FY 2015 rate orders (effective July 1, 2014). Since the performance year for FY 14 is nearly over (CY 2012), staff is not recommending any changes for FY 14 standards and magnitudes. In an effort to determine the parameters of each program prospectively, the staff is recommending changing the base periods for both QBR and MHAC programs to the most recent fiscal year to accommodate the data lag in the production of performance comparison benchmarks in advance of the performance period. Table 1 provides the illustration of new base and performance periods for MHAC program, including the transition in relation to case-mix lag.

Table 1: MHAC Base and Performance Periods

	FY10-Q1	FY10-Q2	FY10-Q3	FY10-Q4	FY11-Q1	FY11-Q2	FY11-Q3	FY11-Q4	FY12-Q1	FY12-Q2	FY12-Q3	FY12-Q4	FY13-Q1	FY13-Q2	FY13-Q3	FY13-Q4	FY14-Q1	FY14-Q2
	CY09-Q3	CY09-Q4	CY10-Q1	CY10-Q2	CY10-Q3	CY10-Q4	CY11-Q1	CY11-Q2	CY11-Q3	CY11-Q4	CY12-Q1	CY12-Q2	CY12-Q3	CY12-Q4	CY13-Q1	CY13-Q2	CY13-Q3	CY13-Q4
FY 2012 Rate Year	Base: FY 2010				Performance : FY 2011													
FY 2013 Rate Year					Base : FY2011				Performance: 3 Quarter									
FY 2014 Rate Year								Base : FY 11 Q4, FY12 Q1,2,3				Performance : 3 Quarter						
FY 2015 Rate Year									Base: FY12						Performance: CY 13			

2. Centers for Medicare & Medicaid Services (CMS) Value Based Purchasing (VBP) Program

Medicare Value Based Purchasing

The Patient Protection and Affordable Care Act of 2010 requires CMS to fund the aggregate Hospital VBP incentive payments by reducing the base operating diagnosis-related group (DRG) payment amounts that determine the Medicare payment for each hospital inpatient discharge. The law sets the reduction at one percent in FY 2013, rising to 2 percent by FY 2017.

For the federal FY 2013 (which began on October 1, 2012) Hospital VBP program, CMS will measure hospital performance using two domains: the clinical process of care domain and the patient experience of care domain, which is comprised of the HCAHPS survey measure. Results were weighted 70% process measures and 30% on 8 of the HCAPS measures. For federal FY 14,

[1] Note: over time, both the staff and the hospital and payer industries have suggested that the Commission consider gradually increasing the amount of revenue at risk for relative quality performance in future years.

CMS has added several mortality outcome measures (for AMI, HF and Pneumonia) as well as additional outpatient process measures. CMS will be apportioning results as follows: 30% process measures, 30% patient experience measures, and 40% outcome measures. CMS has indicated its future emphasis will increasingly lean toward outcomes in the VBP program. The clinical QBR work group will meet this month to discuss the appropriate weighting of the process, patient experience and outcome measures in the QBR for Maryland's methodology for performance year CY 2013.

Value Based Purchasing Exemption Provisions

Inpatient acute care hospitals located in the State of Maryland are not currently paid under the IPPS in accordance with a special waiver provided by section 1814(b)(3) of the Social Security Act. Despite this waiver, Maryland hospitals continue to meet the definition of a ''subsection (d) hospital" under section 1886(d)(1)(B) of the Social Security Act and are, therefore, not exempt from the CMS VBP program.

The Health and Human Services Secretary may exercise discretion pursuant to 1886(o)(1)(C)(iv) of the Social Security Act, which states that "the Secretary may exempt such hospitals from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection."

A VBP exemption request which included a report of Maryland's health outcomes and cost savings for the MHAC and QBR programs and a support letter from Secretary Sharfstein, was submitted to HHS Secretary Sebelius on September 30, 2011. The CMS letter granting the FY 13 exemption anticipated that the HSCRC would add the mortality outcome measures, and encouraged Maryland hospitals to improve patient experience of care.

3. Hospital Acquired Conditions

Medicare Hospital Acquired Conditions (HAC) Program

Beginning in FY 2015, hospitals across the country scoring in the top quartile for the rate of Hospital Acquired Conditions as compared to the national average will have their Medicare payments reduced by 1 percent for all DRGs. In calculating the rates, the secretary will establish and apply an appropriate risk-adjustment methodology. The conditions included in this provision would be those already selected for the current Medicare Hospital Acquired Conditions payment policy and any other conditions acquired during a hospital stay that the secretary deems appropriate. The ACA also requires Maryland to obtain an exemption from the federal HAC program which will be based on whether Maryland's program meets or exceeds the federal program in terms of outcomes and savings.

Maryland Hospital Acquired Conditions

The Commission began applying scaling for MHAC performance in FY 2011. The number of complications included in the MHAC program declined by 20% in two years, resulting in cost savings of $105.4 million, after adjusting for changes in patient characteristics.

Last year (for FY 13 scaling) the Commission approved an increase in the magnitude of scaling from 1% to 2%. Modeling at the time showed an expected amount to be redistributed at 2% scaling to be approximately $25 million. After final results were calculated for FY13 scaling, the actual redistributed amount was $17 million. This amount was the result of the number of hospitals that were low performers (paid penalties) and the size of those hospitals.

Staff conducted modeling using the most recent results to consider altering the magnitude of scaling and/or the standard for expected values for FY 15 (see Tables 2 through 3). Table 2 shows the amount expected to be redistributed (using current MHAC results) relative to options for the magnitude of scaling and the standard for comparison (or expected values). The magnitude of scaling refers to the maximum penalty that would be applied to the worst performing hospital. Standard for comparison refers to the computation of the expected values for each MHAC by APR DRG and SOI (severity of illness) cell. Currently the methodology uses the statewide average value as the benchmark for determining the expected rates. A 20% reduction in the standard, for example, would mean that the expected rate by APR DRG SOI cell would be 20% lower than the statewide average. So, under Table 2, moving the magnitude of scaling to 3% and the expected standard to 20% would yield (given current performance) a redistribution of $80 million under the program. Under this scenario, 28 hospitals would receive reductions where only 6 receive reductions using the current methodology and base year schedule.

Table 2: MHAC Scaling Modeling Results for FY15

	Current Base Year Schedule	6 Month Lagged Base Year	6 Month Lagged and 10 % Reduction	6 Month Lagged and 12.5 % Reduction	6 Month Lagged and 15 % Reduction	6 Month Lagged and 17.5% Reduction	6 Month Lagged and 20% Reduction
Hospitals Receiving Reductions	6	5	14	17	20	22	28
Total Scaling by Maximum Penalty							
2.00%	$13,630,529	$12,599,717	$31,018,649	$37,281,340	$42,750,992	$48,160,023	$53,267,169
2.50%	$17,038,161	$15,749,646	$38,773,312	$46,601,675	$53,438,740	$60,200,029	$66,583,962
3.00%	$20,445,793	$18,899,575	$46,527,974	$55,922,010	$64,126,488	$72,240,035	$79,900,754
3.50%	$23,853,425	$22,049,504	$54,282,637	$65,242,345	$74,814,236	$84,280,041	$93,217,546
4.00%	$27,261,058	$25,199,433	$62,037,299	$74,562,681	$85,501,984	$96,320,046	$106,534,339

Table 3 shows the distribution of hospitals using a 2% scaling magnitude. Figure 1 provides an illustration of the relationship of performance to scaling under a 2% scenario using seven different expected standard scenarios – statewide average with current base year, state-wide average with 6 month lag, 10%, 12.5%, 15%, 17.5% and 20% reductions in state-wide average combined with 6 month lag. The 15% scenario shows the most linear relationship between scaling and performance.

Table 3: MHAC Scaling Modeling Results by Hospital for FY2015

	% Scaled Revenue with Maximum Penalty of 2%						
Hospital Name	Current	6 Month Lag & 10% Reduction	6 Month Lag & 12.5% Reduction	6 Month Lag & 15% Reduction	6 Month Lag & 17.5% Reduction	6 Month Lag & 20% Reduction	6MonthlagNorm 20% Reduction
St. Joseph Medical Center	-2.00%	-1.83%	-2.00%	-2.00%	-2.00%	-2.00%	-2.00%
Anne Arundel Medical Center	-1.80%	-2.00%	-1.88%	-1.85%	-1.83%	-1.81%	-1.80%
Harbor Hospital Center	-1.54%	-1.44%	-1.74%	-1.76%	-1.77%	-1.78%	-1.78%
Southern Maryland Hospital Center	-1.52%	-1.44%	-1.83%	-1.85%	-1.86%	-1.88%	-1.89%
Chester River Hospital Center	-1.32%	-0.78%	-1.47%	-1.52%	-1.56%	-1.59%	-1.61%
Greater Baltimore Medical Center	-0.35%	0.00%	-1.05%	-1.15%	-1.22%	-1.28%	-1.33%
Washington Adventist Hospital	0.02%	0.03%	-1.00%	-1.14%	-1.26%	-1.34%	-1.41%
University of Maryland Hospital	0.05%	0.06%	-0.65%	-0.84%	-0.98%	-1.09%	-1.19%
Sinai Hospital	0.06%	0.07%	-0.54%	-0.73%	-0.88%	-0.99%	-1.08%
Union of Cecil	0.07%	0.08%	-0.22%	-0.41%	-0.55%	-0.66%	-0.75%
Suburban Hospital	0.08%	0.08%	-0.56%	-0.78%	-0.95%	-1.09%	-1.19%
Doctors Community Hospital	0.08%	0.10%	-0.22%	-0.46%	-0.64%	-0.78%	-0.90%
Shady Grove Adventist Hospital	0.08%	0.10%	-0.03%	-0.24%	-0.41%	-0.53%	-0.64%
Johns Hopkins Hospital	0.10%	0.06%	-0.58%	-0.75%	-0.89%	-0.99%	-1.07%
Franklin Square Hospital Center	0.12%	0.12%	0.01%	-0.24%	-0.43%	-0.59%	-0.72%
Western Maryland Regional Medical Center	0.13%	0.13%	0.01%	-0.26%	-0.47%	-0.64%	-0.78%
Bon Secours Hospital	0.15%	0.14%	0.13%	-0.02%	-0.22%	-0.39%	-0.52%
Howard County General Hospital	0.15%	0.16%	0.30%	0.23%	0.04%	-0.16%	-0.30%
Garrett County Memorial Hospital	0.17%	0.16%	0.26%	0.16%	-0.05%	-0.23%	-0.37%
Memorial Hospital at Easton	0.17%	0.19%	0.45%	0.47%	0.38%	0.12%	-0.11%
Baltimore Washington Medical Center	0.19%	0.18%	0.28%	0.17%	-0.08%	-0.28%	-0.45%
Peninsula Regional Medical Center	0.21%	0.21%	0.30%	0.15%	-0.14%	-0.37%	-0.57%
Good Samaritan Hospital	0.23%	0.22%	0.44%	0.38%	0.17%	-0.13%	-0.33%
St. Agnes Hospital	0.23%	0.24%	0.60%	0.65%	0.60%	0.37%	-0.05%
Montgomery General Hospital	0.23%	0.26%	0.73%	0.85%	0.90%	0.82%	0.50%
Upper Chesapeake Medical Center	0.24%	0.22%	0.57%	0.62%	0.57%	0.35%	-0.05%
Northwest Hospital Center	0.25%	0.26%	0.69%	0.76%	0.73%	0.52%	-0.01%
Meritus Hospital	0.26%	0.22%	0.57%	0.62%	0.58%	0.36%	-0.04%
Frederick Memorial Hospital	0.27%	0.26%	0.72%	0.83%	0.86%	0.76%	0.38%
Harford Memorial Hospital	0.27%	0.26%	0.82%	1.00%	1.15%	1.23%	1.16%
Holy Cross Hospital	0.30%	0.30%	1.06%	1.37%	1.71%	2.07%	2.44%
Mercy Medical Center	0.31%	0.27%	0.88%	1.10%	1.31%	1.48%	1.55%
Johns Hopkins Bayview Medical Center	0.32%	0.23%	0.57%	0.62%	0.56%	0.33%	-0.06%
Prince Georges Hospital Center	0.34%	0.29%	1.02%	1.31%	1.62%	1.95%	2.28%
Union Memorial Hospital	0.36%	0.31%	0.82%	0.92%	0.90%	0.68%	0.07%
Calvert Memorial Hospital	0.41%	0.35%	1.32%	1.76%	2.27%	2.88%	3.64%
Maryland General Hospital	0.43%	0.41%	1.54%	2.04%	2.64%	3.35%	4.23%
Laurel Regional Hospital	0.43%	0.41%	1.54%	2.06%	2.68%	3.44%	4.40%
St. Mary's Hospital	0.47%	0.37%	1.43%	1.91%	2.49%	3.21%	4.12%
Fort Washington Medical Center	0.51%	0.46%	1.78%	2.39%	3.14%	4.08%	5.30%
Civista Medical Center	0.52%	0.52%	2.04%	2.75%	3.63%	4.72%	6.16%
Carroll Hospital Center	0.54%	0.43%	1.70%	2.31%	3.07%	4.03%	5.33%
McCready Memorial Hospital	0.65%	0.70%	3.01%	4.21%	5.76%	7.86%	10.83%
Dorchester General Hospital	0.68%	0.57%	2.49%	3.49%	4.80%	6.57%	9.10%
James Lawrence Kernan Hospital	0.82%	0.73%	3.20%	4.51%	6.22%	8.57%	11.95%
Atlantic General Hospital	0.87%	0.79%	3.32%	4.60%	6.24%	8.43%	11.49%

Figure 1: The relationship between MHAC Scaling and Standard for Comparison (Expected Values)

MHAC Improvement Scoring

Last year the Maryland Hospital Association requested that the Commission consider including an element of improvement in the MHAC program. The Payment Work Group will consider options during their next meeting in November 2012.

Findings

When the program was initiated, one of the foundations of the program was to ensure that the rewards were significant enough to encourage the desired behavior which is to reduce potentially preventable readmissions. In general, staff believes that, for the purposes of both improving quality and improving the prospect of receiving a VBP exemption, stronger incentives for improved quality are better than weaker incentives. In general, staff believes that, for the purposes of both improving quality and improving the prospect of receiving a VBP exemption, stronger incentives for improved quality are better than weaker incentives.

As noted above, the quality scaling for each program is designed to be revenue neutral for the system as a whole. This means that the amounts allocated to better performing hospitals (rewards) must precisely match the penalties applied to poorer performing hospitals. Maryland has

demonstrated improvement during the first few years of the MHAC program. Even though the Maryland program is revenue neutral, the improvement in processes (best practices) and the decline in complications will yield savings to all payers over time as weighting for DRG payments decline accordingly. In order to the meet the standards set under the ACA for a Maryland exemption, the incentives in the MHAC and QBR programs will need to progress over time. Due to the current case mix transition, FY 2014 is a lost opportunity, but Maryland should move aggressively in FY 2015, to ensure continued improvement.

Staff Recommendations

For QBR and MHAC scaling, staff recommends:

1. Using the FY 13 scaling magnitudes for FY 14 for both MHACs and QBR since the performance year (CY 2012) is more than 80% complete.

2. Allocating 0.5% of hospital approved inpatient revenue for QBR relative performance in FY 2015;

3. Increasing the magnitude of scaling from the current 2.0% to 3.0% of hospital approved inpatient revenue for MHAC relative performance for FY2015 rate year, and increasing this amount each year;

4. Increasing the benchmark to establish the expected MHAC values to 15 % which represents a more linear relationship between scaling and performance;

5. Moving the base year periods for QBR and MHAC to most current fiscal year to accommodate a 6-month lag in the data production to provide performance benchmarks in advance of the performance period.

Appendix 1

QBR Measures Used for FY 2014 Payment Adjustments
Clinical Process of Care Measures
AMI-1 Aspirin at Arrival
AMI-2 Aspirin prescribed at discharge
AMI-3 ACEI or ARB for LVSD
AMI-5 Beta blocker prescribed at discharge
AMI-8a - Primary PCI Received Within 90 Minutes of Hospital Arrival
CAC-1a - Relievers for Inpatient Asthma (age 2 through 17 years) – Overall Rate
CAC-2a - Systemic Corticosteroids for Inpatient Asthma (age 2 through 17 years) – Overall Rate
CAC-3-Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver
HF-1 Discharge instructions
HF-2 Left ventricular systolic function (LVSF) assessment
HF-3 ACEI or ARB for LVSD
PN-3b Blood culture before first antibiotic – Pneumonia
PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient
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 4- Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Serum Glucose
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)

MHAC Measures used for FY 2014 Payment Adjustments

PPC Number	PPC Description
1	Stroke & Intracranial Hemorrhage
2	Extreme CNS Complications
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation
5	Pneumonia & Other Lung Infections
6	Aspiration Pneumonia
7	Pulmonary Embolism
8	Other Pulmonary Complications
9	Shock
10	Congestive Heart Failure
11	Acute Myocardial Infarction
12	Cardiac Arrythmias & Conduction Disturbances
13	Other Cardiac Complications
14	Ventricular Fibrillation/Cardiac Arrest
15	Peripheral Vascular Complications Except Venous Thrombosis
16	Venous Thrombosis
17	Major Gastrointestinal Complications without Transfusion or Significant Bleeding
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding
19	Major Liver Complications
20	Other Gastrointestinal Complications without Transfusion or Significant Bleeding
22	Urinary Tract Infection
23	GU Complications Except UTI
24	Renal Failure without Dialysis
25	Renal Failure with Dialysis
26	Diabetic Ketoacidosis & Coma
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion
28	In-Hospital Trauma and Fractures
31	Decubitus Ulcer
33	Cellulitis
34	Moderate Infectious
35	Septicemia & Severe Infections
36	Acute Mental Health Changes
37	Post-Operative Infection & Deep Wound Disruption Without Procedure
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure
39	Reopening Surgical Site
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc
42	Accidental Puncture/Laceration During Invasive Procedure
44	Other Surgical Complication - Mod
47	Encephalopathy
48	Other Complications of Medical Care
49	Iatrogenic Pneumothrax
50	Mechanical Complication of Device, Implant & Graft
51	Gastrointestinal Ostomy Complications
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection
53	Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infusions

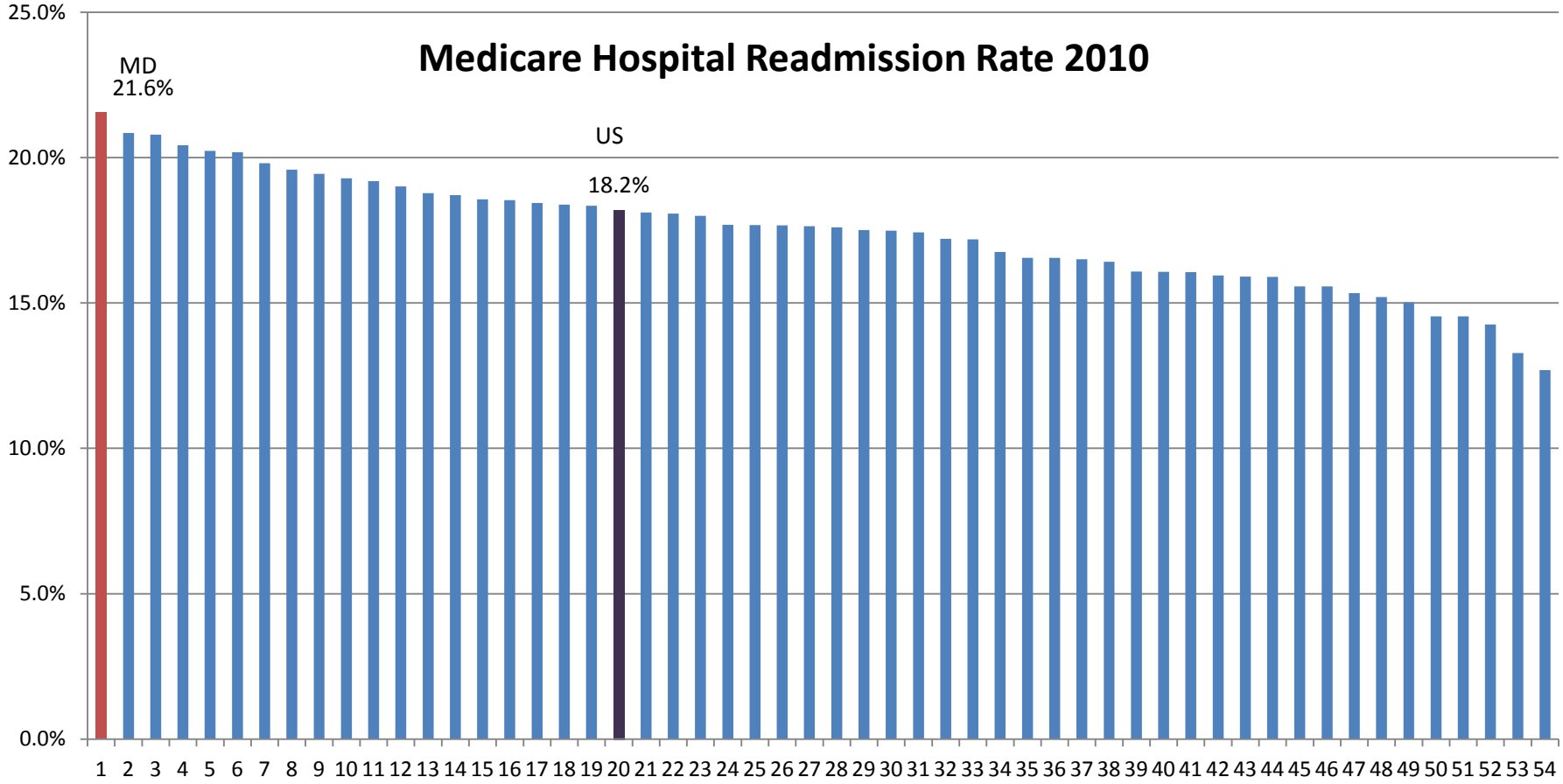
54	Infections due to Central Venous Catheters
56	Obstetrical Hemorrhage wtih Transfusion
59	Medical & Anesthesia Obstetric Complications
65	Urinary Tract Infection without Catheter
66	Catheter-Related Urinary Tract Infection
Excluded PPCs	
21	Clostridium Difficile Colitis
29	Poisonings Except from Anesthesia
30	Poisonings due to Anesthesia
32	Transfusion Incompatibility Reaction
43	Accidental Cut or Hemorrhage During Other Medical Care
45	Post-procedure Foreign Bodies
46	Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body
55	Obstetrical Hemorrhage without Transfusion
57	Obstetric Lacerations & Other Trauma Without Instrumentation
58	Obstetric Lacerations & Other Trauma With Instrumentation
60	Major Puerperal Infection and Other Major Obstetric Complications
61	Other Complications of Obstetrical Surgical & Perineal Wounds
62	Delivery with Placental Complications
63	Post-Operative Respiratory Failure with Tracheostomy
64	Other In-Hospital Adverse Events

Admissions-Readmissions Revenue Program Modifications

Staff Report to the Commission

November 7, 2012

Using Medicare Data, Maryland has the Nation's Highest Readmissions Rate



Source: Institute of Medicine Geographic Variation Data Base

HSCRC Initiated ARR Program in FY 2012

- ARR provides hospitals a financial incentive to more effectively coordinate care and reduce unnecessary readmissions to their facilities
  - Inpatient: all-cause, all-DRG, 30-day readmissions window
  - Current focus on readmissions within the facility or within the hospital system for “linked system hospitals”
- Three year program beginning in FY 2012; currently in Year 2 of three year agreements
- HSCRC provided seed funding in ARR Year 1; Commission removed seed funding for Year 2

ARR Builds Upon the Inpatient CPC to Develop Bundled Weights

- In weight development, HSCRC bundles CPC weights into Charge Per Episode (CPE) weights
  - For a given DRG-SOI, CPE approved revenue is higher than CPC equivalents
- When grouping hospital discharges, HSCRC credits hospitals with all weight associated with a 30-day episode of care window at the initial admission
  - Readmissions receive no weight
- A hospitals financially "wins" by reducing readmissions on a case mix adjusted basis by retaining 30-day CPE weight, while reducing the costs associated with the readmission

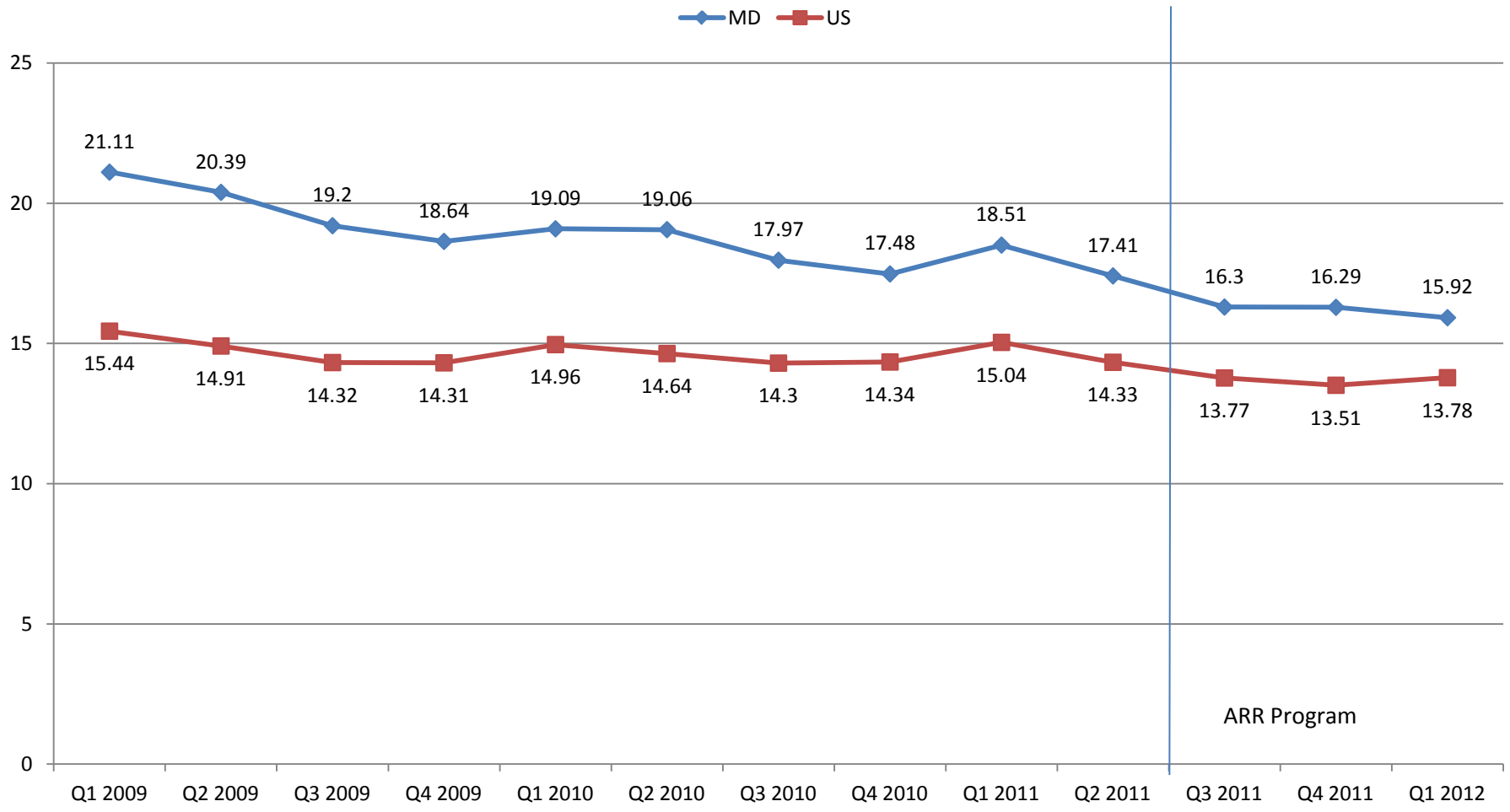
31 Hospitals Voluntarily Engaged in the ARR Program

- Mercy
- LifeBridge - Sinai
- LifeBridge - Northwest
- UMMS - Baltimore Washington Medical Center
- UMMS - Civista Medical Center
- UMMS - Harford Memorial Hospital
- UMMS - Kernan Hospital
- UMMS - Maryland General Hospital
- UMMS - Upper Chesapeake Medical Center
- UMMS - University of Maryland Medical Center
- JHHS - Johns Hopkins Hospital
- JHHS - Johns Hopkins Bayview Medical Center
- JHHS - Howard County General Hospital
- JHHS - Suburban Hospital
- Anne Arundel Medical Center
- Bon Secours
- St. Joseph Medical Center
- MedStar - Franklin Square
- MedStar - Good Samaritan
- MedStar - Harbor Hospital
- MedStar - St. Mary's Hospital
- MedStar - Montgomery General Hospital
- MedStar - Union Memorial Hospital
- Holy Cross Hospital
- Washington Adventist Hospital
- Shady Grove Adventist Hospital
- Peninsula Regional
- Doctors
- GBMC
- Frederick Regional Health System
- Saint Agnes

Same Hospital Readmissions as a % of Total Admissions

	% Readmissions			Annual Change		
	FY2010	**FY2011**	**FY2012**	**FY2011**	**FY2012**	**Difference**
ARR	9.83%	9.71%	9.40%	-0.12%	-0.31%	-0.19%
TPR	10.50%	10.46%	9.79%	-0.04%	-0.67%	-0.63%
Statewide	10.50%	9.69%	9.37%	-0.81%	-0.32%	0.49%

Medicare Readmission Rates per 1,000 Beneficiaries



Source: Delmarva Foundation

HSCRC Must Seek Exemption from CMS Readmissions Program in FY 2014

- ARR
  - Bundling of payments based on payment weights
  - Keep the savings from reduced readmissions based on historical performance
  - Seed-funding for initial year
  - Inclusive-all conditions, few exemptions
  - Case-mix adjusted
- CMS
  - Ranking of performance compared to the nation
  - Penalties for the worse performers (1% penalty for the first year)
  - 3 conditions (AMI, HF, PN)
  - Risk Adjustment using historical information

HSCRC Must Seek Exemption from CMS Readmissions Program in FY 2014

- ACA provides Maryland an avenue to gain exemption from CMS' Readmissions Reduction Program
  - FY 2013 IPPS final rule gives Maryland a pass on applying for the exemptions
- Next year, HSCRC anticipates needing to submit an exemption request demonstrating how Maryland's ARR program meets or exceeds Medicare's program
  - Savings
  - Outcomes
- HSCRC and CMS staff discussed Maryland's program structure
  - Maryland's program viewed as "all carrot and no stick"
  - Strong indication that HSCRC must move ARR into model with explicit Medicare savings to exemption in FFY 2014

Modifying ARR into a Shared Savings Model

- Calculate required savings and reduce from target. Options include:
  - Scaling approach that is not revenue neutral
  - Set targets at a threshold in line with low readmission facilities or with best practices

Issues to Address

- Readmission measurement
  - Linking patient records between hospitals
  - Out of state readmissions
  - Hospital-wide readmission rate (exclusions)
- Risk adjustment models
  - Clinical adjustments
  - Socio-economic adjustments

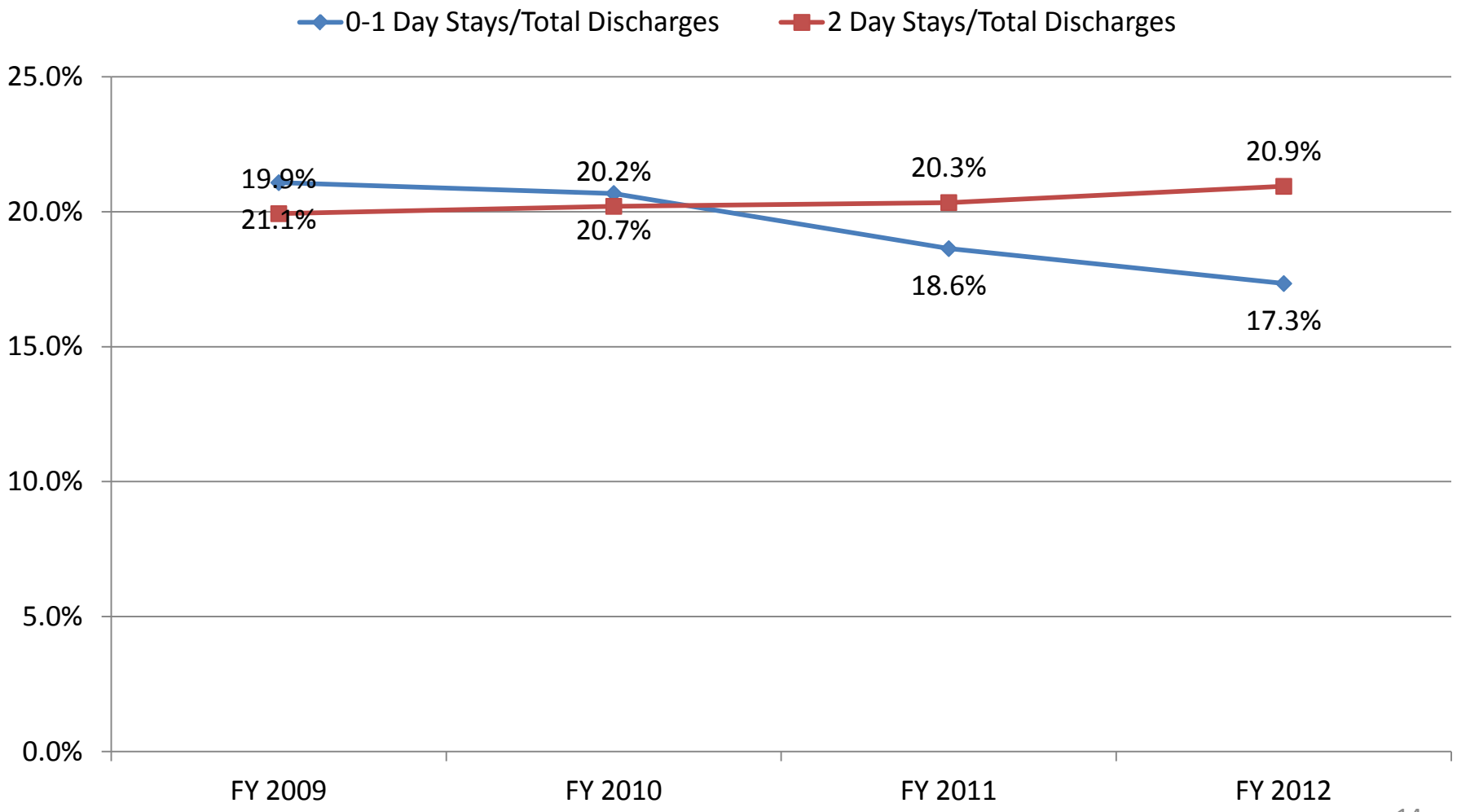
Readmissions Payment Methodology for All

- Hospitals not under an alternative agreement will adhere to payment methodologies of ARR

Move ODS Back into CPC/CPE

- Original policy intent
- ODS reductions
  - Chart of ODS reductions
- Unintended issues
- Folding in ODS Could Give Credit to Hospitals for ODS Reduction

ODS Trends


0-1 Day Stays/Total Discharges
2 Day Stays/Total Discharges
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
19.9%
20.2%
18.6%
17.3%
21.1%
20.7%
20.3%
20.9%
FY 2009
FY 2010
FY 2011
FY 2012

ODS and Readmissions

Same Hospital Readmission Rates FY2011

	% Readmissions in Total Discharges	Number of Readmissions	Ratio of Total Readmissions
Overall Readmission Rate	9.73%	70,994	
0-1 Day Stays Excluded	8.97%	53,554	75.4%
ARR Program Rate	8.81%	51,358	72.3%

Future Directions

- Linked system identifiers
  - Systematically collecting these in FY 2013
- Moving system to account for inter-hospital readmissions

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§19-207, 19-211, 19-212, 19-212.1, 19-215, 19-216, 19-218, 19-220, 19-224, and 19-303, Annotated Code of Maryland

Notice of Proposed Action

The Health Services Cost Review Commission proposes to amend Regulations **.03** and **.06**, under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on November 7, 2012, notice of which was given pursuant to State Government Article, § 10-506(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about March 18, 2013.

Statement of Purpose

The purpose of this action is to increase the civil penalties associated with the failure to timely file required reports with the Commission.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

There is economic impact. See Estimate of Economic Impact attached.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or via fax to (410)358-6217, or via email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until January 2, 2013. A hearing may be held at the discretion of the Commission.

.03 Reporting Requirements; Hospitals.

A.-M. (text unchanged)
N. Failure to File Reports.
(1) A hospital under the jurisdiction of the Commission which does not file any report under the Enabling Act of the Commission, Health-General Article, Title 19, Subtitle 2, Annotated Code of Maryland, or under the regulations of the Commission, is liable for a civil penalty up to **[$250]** *$1,000* per day for each day the filing of the report is delayed unless an extension is granted as provided in § O of this regulation.
(2)-(6) (text unchanged)
O.-Q. (text unchanged)

.06 Non-Profit Hospitals and Related Institutions: Disclosure of Interest by Trustees.

A.-C. (text unchanged)

D. Failure or Delay in Filing Statements.

(1) Any trustee who does not file the statement on the date it is due is liable for a civil penalty or fine of **[$25]** *$250* per day for each day the filing of the statement is delayed, unless an extension is granted and a stay of filing is granted as provided in §§ E, F, and G of this regulation.

(2) (text unchanged)

E.-I. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-207, 19-212, 19-216, and 19-219, Annotated Code of Maryland

Notice of Proposed Action

The Health Services Cost Review Commission proposes to amend Regulation **.06**, under **COMAR 10.37.10 Rate Application and Approval Procedures**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on November 7, 2012, notice of which was given pursuant to State Government Article, § 10-506(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about March 18, 2013.

Statement of Purpose

The purpose of this action is to increase the monetary fines the Commission may impose for those hospitals that fail to comply with the Commission's alternative rate methodology reporting requirements.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

There is economic impact. See Estimate of Economic Impact attached.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or via fax to (410)358-6217, or via email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until January 2, 2013. A hearing may be held at the discretion of the Commission.

.06 Application for Alternative Method of Rate Determination.

A.-E. (text unchanged)
F. Requires Reports under ARM System.
(1)-(5) (text unchanged)
(6) Penalties.
(a) The Commission may impose penalties of up to **[**$250**]** *$1,000* per day for failing to file reports as required under this section.
(b)-(c) (text unchanged)
G. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 12 Cross-Subsidization

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

Notice of Proposed Action

The Health Services Cost Review Commission proposes to amend Regulations **.02** and **.03**, under **COMAR 10.37.12 Cross-Subsidization**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on November 7, 2012, notice of which was given pursuant to State Government Article, § 10-506(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about March 18, 2013.

Statement of Purpose

The purpose of this action is to increase the monetary penalties the Commission may impose for those hospitals that fail to comply with the Commission's fixed-priced contracting reporting requirements.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

There is economic impact. See Estimate of Economic Impact attached.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or via fax to (410)358-6217, or via email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until January 2, 2013. A hearing may be held at the discretion of the Commission.

.02 Hospital Charges to Purchasers or Classes of Purchasers.

A. (text unchanged)

B. Without the prior approval of the Commission, neither a hospital, a related entity, nor any entity or person acting on behalf of or in concert with a hospital shall enter into a fixed-price contract, or knowingly participate in or receive the benefit of any arrangement, directly or indirectly, pertaining to the delivery of hospital services. A hospital that has knowledge of such an arrangement shall promptly notify the Commission in accordance with this section in order that the Commission may determine whether the arrangement constitutes an unapproved discount. In order to obtain prior approval of the Commission, the hospital shall file a written application in accordance with COMAR 10.37.10.06. The filing of this application constitutes the filing of a required report under Commission law and regulation. Failure to file an application before the date on which a fixed-price contract is entered into, or the hospital or related entity knowingly participates in or receives benefit of such an arrangement, may subject the organization or organizations to fines up to **[**$250**]** *$1,000* per day for each day the arrangement exists without prior approval.

C.-D (text unchanged)

.03 Penalties.

A. The Commission may impose penalties of up to **[**$250**]** $1,000 per day **[,** which shall be instead of the $100 per day penalty for failing to file reports as set forth in COMAR 10.37.01.03N,**]** for a required report submitted by a hospital that includes information which has the effect of violating Regulation .02 of this chapter. The report shall be considered substantially inaccurate and untimely filed.
B. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

Herbert S. Wong, Ph.D.
Vice-Chairman

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Stephen F. Jencks, M.D., M.P.H.

Jack C. Keane

Bernadette C. Loftus, M.D.

Thomas R. Mullen

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

Patrick Redmon, Ph.D.
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: November 1, 2012

RE: Hearing and Meeting Schedule

Public Session:

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

January 9, 2013 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

Please note, Commissioner packets will be available in the Commission's office at 12:30 p.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.