HEALTH SERVICES COST REVIEW COMMISSION
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Post-meeting Documents
from the
495th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
February 6, 2013

EXECUTIVE SESSION
12:00 p.m.

1. **Comfort Order – University of Maryland Medical System**
2. **Waiver Update**
3. **Waiver Implications on Update Factor Process**

PUBLIC SESSION
1:00 p.m.

1. **Review of the Executive Session and Public Meeting Minutes from January 9, 2013.**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**

   2190N – St. Mary's Hospital
   2194A – Johns Hopkins Health System
   2195A – Johns Hopkins Health System
   2196N – Harbor Hospital
   2197A – Johns Hopkins Health System
   2198A – Johns Hopkins Health System
   2199A – Johns Hopkins Health System

4. **Docket Status – Cases Open**

   2168R – Garrett County Memorial Hospital - *Approved*
   2193R – Adventist Behavioral Health - *Approved*
   2200A – MedStar Health - *Approved*

5. **Status Report on Development of Admission-Readmission Revenue and One Day Stay Policy Recommendations**

6. **Legal Report**
   - **10.37.01.03 and .06 Final** - *Approved*
   - **10.37.10.06 Final** - *Approved*
   - **10.37.12.02 and .03 Final** - *Approved*

7. **Legislative Report**

8. **Hearing and Meeting Schedule**

Executive Session Minutes
Of the
Health Services Cost Review Commission

January 9, 2013

Upon motion made, Chairman Colmers called the meeting to order at 12:05 p.m.

The meeting was held under the authority of Section 10-508 of the State-Government Article.

In attendance, in addition to Chairman Colmers, were Commissioners Bone, Jencks, Keane, and Mullen. Commissioners Loftus and Wong participated by telephone.

Patrick Redmon, Steve Ports, Mary Pohl, Jerry Schmith, and Dennis Phelps attended representing staff.

Also attending were Leslie Schulman and Stan Lustman Commission Counsel.

Item One

Dr. Redmon provided the Commissioners with an update on the status of the effort to modernize the Medicare waiver. The Commissioners also discussed briefly some of the various activities to be undertaken in the future in conjunction with a modernized waiver.

Item Two

Steve Ports summarized the potential Medicaid budget shortfall.

Item Three

Mr. Ports updated the Commissioners on the release of the findings of the legislative audit.

Item Four

Mr. Ports discussed personnel issues with the Commissioners.

Item Five

Mr. Ports described the process utilized by staff to review and comment on bills that are of interest to the Commission.

The Executive Session was adjourned at 1:01 p.m.

MINUTES OF THE
494th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

January 9, 2013

Chairman John Colmers called the meeting to order at 1:05 p.m. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., Jack C. Keane, and Thomas R. Mullen were also present. Commissioners Bernadette C. Loftus, M.D. and Herbert S. Wong, Ph.D. participated by telephone.

REPORT OF THE EXECUTIVE SESSION OF JANUARY 9, 2013

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the January 9, 2013 Executive Session.

ITEM I
REVIEW OF THE MINUTES OF THE EXECUTIVE SESSIONS OF NOVEMBER 7 AND DECEMBER 5, 2012 AND THE PUBLIC MEETING OF NOVEMBER 7, 2012

The Commission voted unanimously to approve the minutes of the November 7 and December 5, 2012 Executive Sessions and the Public Meeting of November 7, 2012.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Patrick Redmon, Ph.D., Executive Director, reported that Monitoring Maryland Performance (MMP) indicated that the rate of growth in charge per case increased by 2.54% for the twelve months year ended November 2012; inpatient revenue decreased 0.91%; the number of inpatient cases declined by 3.37%; outpatient revenue increased 14.58%; and total gross revenue increased 4.55%. Dr. Redmon noted that for the 5 months through November 2011 compared to the 5 months ending November 2012, average operating profit for acute hospitals was 1.23%,with the median hospital at 1.51%.

Dr. Redmon noted that based on the latest waiver letter for the year ending September 30, 2011, the relative waiver test cushion was 2.43%. Staff had expected an adjustment to the test for cases where Medicare is the secondary payer, but the adjustment was not made in this letter.

Dr. Redmon stated that: 1) discussions concerning an alternative waiver test continued with the Center for Medicare and Medicaid Services (CMS); 2) Maryland has received an exemption from CMS' national Value Based Purchasing program; 3) the Disparities Data Report to the Governor and Legislature due January 1, 2013 has been submitted; 4) final rate orders have been

issued; and the annual Disclosure of Hospital Financial and Statistical Data for 2011 has been released and is on the HSCRC website.

Dr. Redmon introduced the newest member of the staff, Donna Perkins. Ms. Perkins comes to the HSCRC staff from the Anne Arundel County Health Department where she was an epidemiologist for the Office of Assessment, Planning, and Response. Ms. Perkins has also served as a Communicable Disease Investigator and Lead Data Epidemiologist at the Pima County Department of Health in Tucson, Arizona.

ITEM III
DOCKET STATUS CASES CLOSED

2177A – Maryland Physicians Care
2178A – Johns Hopkins Health System
2179A – MedStar Health
2188A – University of Maryland Medical System
2189A - University of Maryland Medical System
2191A - Johns Hopkins Health System
2192A - Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

St. Mary's Hospital – 2190N

On August 8, 2012, St.Mary's Hospital, a member of MedStar Health, submitted an application requesting a rate for Hyperbaric (HYP) services. The Hospital requested that the new HYP rate be effective December 1, 2012.

After reviewing the application, staff recommended:

1) That a HYP rate of $336.12 per hour of treatment be approved effective December 1, 2012;
2) That no change be made to the Hospital's Charge per Episode standard for HYP services; and
3) That the HYP rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2194A

Johns Hopkins Health System ("System') filed an application with the HSCRC on November 7, 2012 on behalf of its member hospitals requesting approval from the HSCRC to add solid organ transplant services to the current global rate arrangement for bone marrow transplant services with Cigna Health Corporation. The System requests approval for a period of one year beginning January 1, 2013.

The staff recommended that the Commission approve the System's request to add solid organ transplant services to the current approved alternative method of rate determination for bone marrow transplant services, for a one year period commencing January 1, 2013, and this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU").

The Commission voted unanimously to approve staff's recommendation, with Chairman Colmers recusing himself from the discussion and vote.

Johns Hopkins Health System – 2195A

Johns Hopkins Health System ("System") filed an application with the HSCRC on November 12, 2012 on behalf of its member hospitals requesting approval from the HSCRC for continued participation in a renegotiated global rate arrangement for solid organ and bone marrow transplant services with Coventry Transplant Network. The System requests that the Commission approve the arrangement for one year beginning January 1, 2013.

The staff recommended that the Commission approve the System's application for a one year period commencing January 1, 2013, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation, with Chairman Colmers recusing himself from the discussion and vote.

Johns Hopkins Health System – 2197A

Johns Hopkins Health System ("System") filed an application with the HSCRC on December 4, 2012 on behalf of its member hospitals requesting approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular services with Global Excell Management. The System requests that the Commission approve the arrangement for one year beginning January 1, 2013.

The staff recommended that the Commission: 1) waive the requirement that alternative rate applications be filed 30 days before the proposed effective date; and 2) approve the System's

application for a one year period commencing January 1, 2013; and 3) that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation, with Chairman Colmers recusing himself from the discussion and vote.

Johns Hopkins Health System – 2198A

Johns Hopkins Health System ("System") filed an application with the HSCRC on December 4, 2012 on behalf of its member hospitals requesting approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular services, kidney transplant, and bone marrow transplants with the Canadian Medical Network. The System requests that the Commission approve the arrangement for one year beginning January 1, 2013.

The staff recommended that the Commission: 1) waive the requirement that alternative rate applications be filed 30 days before the proposed effective date; and 2) approve the System's application for a one year period commencing January 1, 2013; and 3) that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation, with Chairman Colmers recusing himself from the discussion and vote.

Johns Hopkins Health System – 2199A

Johns Hopkins Health System ("System") filed an application with the HSCRC on December 4, 2012 on behalf of its member hospitals requesting approval from the HSCRC for continued participation in a global rate arrangement for solid organ and bone marrow transplant services with Aetna Health, Inc. The System requests that the Commission approve the arrangement for one year beginning February 1, 2013.

The staff recommended that the Commission approve the System's application for a one year period commencing February 1, 2013, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation, with Chairman Colmers recusing himself from the discussion and vote.

ITEM V
FINAL RECOMMENDATIONS REGARDING MARYLAND HOSPITAL ACQUIRED CONDITION (MHAC) AND QUALITY-BASED REIMBURSEMENT (QBR) SCALING MAGNITUDES, AND MHAC STANDARD FOR EXPECTED VALUES

Steve Ports, Principal Deputy Director-Policy and Operations, summarized staff's final recommendation, and Sule Calikoglu, Ph.D., Associate Director-Performance Measurement, presented the results of the Commission's quality initiatives, MHAC and QBR (see "Final Staff Recommendation on QBR and MHAC Scaling Magnitudes and Standard for Expected Values for the FY 2014 and FY 2015 Updates to Hospital Rates" on the HSCRC website). Mr. Ports reported that only two new elements (Sections "a" and "b" of recommendation #3) had been added. These changes proposed that 1% of the total 3% scaling factor should reflect improvement on a targeted set of measures for FY 2015, and that improvement should be scaled in a manner in which hospitals that achieve improvement better than the median improvement rate in the base year receive additional revenue under the 1% improvement scale.

Sule Calikoglu, Ph.D., discussed how the recommendations were developed, as well as how the Potentially Preventable Complications that make up the targeted set of measures in the improvement scale in Section "a" of recommendation #3 were selected.

Commissioner Jencks observed that if we really want to get hospitals to change, maybe we should focus on one or two measures rather than five.

Mr. Ports pointed out that hospitals' performance will be evaluated each year and that the hospital industry will be consulted to determine whether the measures should be changed or whether the number of measures should be reduced.

Traci LaValle, Assistant Vice President-Financial Policy of the Maryland Hospital Association (MHA), expressed support for staff recommendations numbers 1, 2, 4, and 5. Ms. LaValle suggested that certain revisions to staff recommendation #3. These revisions were that: 1) hospitals that were already performing well on the targeted measures, but did not show significant improvement, be held harmless; and 2) for the next cycle FY 2016, that the scaling methodology be re-visited.

Nicole Stallings, Assistant Vice President-Quality Policy & Advocacy of MHA, discussed some issues that were not addressed directly in staff's recommendation. They included: 1) work to be done to implement mortality measures; and 2) the need for coordination between the quality and finance departments in hospitals on quality programs.

John Hamper, Director-Provider Reimbursement, Analytics & Compliance of CareFirst of Maryland, expressed support for staff's recommendation.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
REPORT ON MARYLAND PATIENT SAFETY CENTER RESPONSES TO REQUESTS FROM THE FINAL RECOMMENDATIONS FOR CONTINUED FINANCIAL SUPPORT

Dianne Feeney, Associate Director-Quality Initiative, summarized staff's report on the Maryland Patient Safety Center's (MPSC's) responses to requests in the final recommendation for continued support of the Maryland Patient Safety Center(see "MPSC Funding Contingent Upon Estimated Relocation Expenses and Data Standardization Updates" on the HSCRC website).

The responses included: 1) several communication and education strategies as well as site visits and auditing tools to improve standardization of data collection; and 2) a schedule of expenses related to the relocation of the MPSC.

Ms. Feeney reported that based on the information received, staff recommended that the following steps be taken by the Commission: 1) that the MPSC be required to routinely report to the Commission on its efforts and results in recruiting all settings of care to engage with the MPSC and its activities; 2) release the $100,000 of MPSC funding held in abeyance; and 3) that MPSC be required to routinely report to the Commission on its efforts and results in standardization in data collection, including auditing results.

Robert Imhoff, III, President and CEO of the MPSC, expressed his support for staff's recommendation.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
PRESENTATION OF DRAFT REVISED ELECTROCARDIOGRAPHY RELATIVE VALUE UNITS (RVUs)

Chris O'Brien, Chief-Audit & Compliance, requested approval to distribute proposed revisions to the Relative Value Unit (RVU) Scale for Electrocardiography services to all hospitals for their review and comment.

The Commission voted unanimously to approve staff's recommendation.

ITEM VIII
HEARING AND MEETING SCHEDULE

February 6, 2013	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

March 6, 2013	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 2:15 p.m.

EXECUTIVE DIRECTOR'S REPORT
FEBRUARY 6, 2013

Monitoring Maryland Performance

For Year Ending November 2012

- Charge per Case increased 1.44%
  - For the month of November 2012 versus November 2011, CPC decreased 3.30%
  - For YTD ending October 2012 versus the same time period in 2011, CPC decreased 0.87%
- Cases (admissions + new born) decreased 3.45%
- Inpatient revenue decreased 2.07%
- Outpatient revenue increased 14.67%
- Total gross revenue increased 3.84%

Latest Waiver Status from CMS

On December 11, 2012, HSCRC received a new waiver letter for the year ending September 30, 2011. According to this letter, the national average cost per Medicare admission was $10,586.51 while Maryland's was $13,393.86. Maryland's cumulative growth under the waiver test was 350.72% while the nation's was 361.67%.

The relative waiver test implied from these numbers is 2.43% -- Maryland can go up 2.43% if the nation remains unchanged.

The staff had expected an adjustment to the test for cases where Medicare is a secondary payer, but that adjustment was not made in this letter. The staff met with representatives from the Office of the Actuary. We were told that the adjustment will be forthcoming in the next waiver letter, and they offered to provide documentation as to the size of the impact on the most recent letter.

We estimate that the adjustment adds approximately 1.8 - 2 percentage points to our relative waiver cushion, and these numbers were in line with the actuaries' estimates.

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

AS OF JANUARY 29, 2013

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	2/6/2013	2/6/2013	FULL	GS	OPEN
2193R	Adventist Behavioral Health	10/2/2012	2/6/2013	3/1/2013	FULL	GS	OPEN
2200A	MedStar Health	1/4/2013	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE FULL	*	BEFORE THE HEALTH SERVICES
RATE REVIEW OF	*	COST REVIEW COMMISSION
GARRETT COUNTY	*	DOCKET: 2012
MEMORIAL HOSPITAL	*	FOLIO: 1958
OAKLAND, MARYLAND	*	PROCEEDING: 2168R

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STAFF RECOMMENDATION

February 6, 2013
Approved

I. INTRODUCTION

On July 6, 2012 Garrett County Memorial Hospital ("Hospital," or "GCMH") submitted a full rate application to the Health Services Cost Review Commission ("HSCRC," or "Commission"). GCMH is a 55-bed acute care community hospital located in Oakland, Maryland.

GCMH has operated under the HSCRC's Total Patient Revenue (TPR) System since the early 1980's. Under the TPR System, the Hospital is provided a fixed revenue (CAP) amount under which it must operate each year. The CAP is updated each year for inflation based on the same inflation factor applied to all other hospitals. The CAP is also adjusted each year for a change in the Hospital's payer mix and approved uncompensated care (mark-up), as is the case with all other hospitals. However, the Hospital does not receive an adjustment for actual case mix change or an adjustment for actual volume changes as do other hospitals. Instead, the CAP is increased based on a fixed adjustment for volume changes each year. The volume adjustment provides the Hospital with the lesser of 25% of the percentage change in the population of the County, or a flat 1% increase, whichever is less. The TPR System attempts to deter unnecessary admissions by providing the Hospital with an incentive to control both the charge per inpatient case and the number of cases.

II. THE HOSPITAL REQUEST AND JUSTIFICATION

The Hospital has requested combined overall rate increases, exclusively for capital, of $789,019 at July 1, 2014, $761,429 at July 1, 2015, and $827,723 at July 1, 2016. The total amount requested over the three year period is $2,378,171. The capital costs are related to a $23.5 million project for a New Wing Expansion and Renovations. GCMH expects to receive

Certificate of Need (CON) approval from the Maryland Health Care Commission (MHCC) for the Project.

III. HOSPITAL RATE HISTORY

As stated above, GCMH has operated under the TPR system since the early 1980's, and for years was the only hospital utilizing this fixed revenue methodology. GCMH continues to be unique even with the new TPR group, which consists primarily of hospitals in larger and more suburban areas.

Under the TPR rate setting structure, a hospital's unit rates may change significantly throughout a given year depending on fluctuations in volumes. The revenue CAP places pressure on hospitals to control costs during periods of rising volumes and acts as a safety net during periods of declining volumes. While the TPR structure does provide for a predictable operating revenue stream, the TPR system does not readily address the funding of infrequent large capital building projects.

Since 2008, GCMH has applied for and received two full rate adjustments – in 2008 and 2009. In 2008, the Hospital received a $2.1 million (6%) increase of which nearly one-third was related to West Virginia Medicaid, which refused to pay HSCRC-approved rates. The other two-thirds were used to hire additional staffing and for certain technological advances.

In 2009, GCMH received a $1.9 million (5%) increase to its TPR, which was used for additional staffing and increased group health benefits.

Both the 2008 and 2009 applications were predicated on GCMH's favorable Reasonableness Of Charges (ROC) position.

IV. HOSPITAL FINANCIAL SITUATION

The Hospital's fiscal year end is June 30. For the past three fiscal years, the Hospital has reported the following audited operating results:

Garrett County Memorial	Net Operating Revenue (Regulated)	Net Operating Profit/(Loss) (Regulated)	Operating Margin (Regulated)	Net Profits
FYE June 2012	$33,733,500	$1,755,400	5.20%	$1,621,900
FYE June 2011	$32,531,200	$2,237,600	6.90%	$2,815,100
FYE June 2010	$32,921,200	$3,800,100	11.5%	$4,973,000

V. STAFF ANALYSIS

a. Timing of Rate Request

The total costs of the Wing Expansion and Renovation Project are $23.5 million. The Hospital plans to fund 32%, or $7.5 million, through equity and $1.0 million through contributions. Project debt is expected to equal $15.0 million at 5.25% interest over 20 years. GCMH has requested a phased-in approach for the rate adjustment. The requested effective dates of July 1, 2014, 2015, and 2016 are reflective of when the depreciation and interest expense related to the Project are projected to be realized.

b. Baseline ICC Calculation

The HSCRC's ICC methodology for full rate reviews was applied to GCMH's rate request. While the ICC methodology produced a 0.46% rate increase, GCMH's 3-year phased-in revenue request of $2,378,171 results in a 5.88% rate increase when applied to GCMH's current revenue base. In its application, GCMH requests that the difference between the 5.88% and 0.46% (or 5.42%) be provided as a special adjustment to rates.

c. Rate Methodology for Capital

The current HSCRC policy for funding capital in rates (either through a full or partial application[1]) limits the amount of funding to the lesser of 50% of the project capital costs or the peer group average capital costs. Hospitals are expected to generate the shortfall in capital funding through increased volumes related to the Project. Prior to this application, GCMH has never requested HSCRC funding for a major capital project.

TPR vs. Non-TPR Hospitals

While it is equitable for many HSCRC policies to be applied across-the-board to all Maryland hospitals, certain criteria should be considered when evaluating capital cost requests from hospitals with extreme circumstances such as GCMH.

A hospital's rate methodology and the related incentives of that methodology should be considered in addition to the reasonableness of costs and charges with respect to the request.

While non-TPR hospitals are able to generate additional revenue with increased volumes as a result of capital expenditures, there is no opportunity for GCMH, as a TPR hospital, to generate necessary revenues to fund capital shortfalls through volume increases.

Lack of TPR Transition Adjustment

While GCMH has been on the TPR rate system since the early 1980's, eight of the current ten TPR hospitals entered into their TPR agreements during fiscal 2011, at a time when rate adjustments were given ("Transition Adjustments") to hospitals that transitioned from the Charge Per Case ("CPC") rate methodology to TPR. These adjustments ranged between $1.1 million and $10.6 million and averaged $6.5 million per TPR hospital spread over 2 years.

[1] A partial application using the relaxed ICC (ICC adding back 2% productivity) would have resulted in funding of $978,000, or 41% of GCMH capital costs.

GCMH has no Transition Adjustment to assist with the funding of the capital project which could be used to offset a portion of this rate request. With no Transition Adjustment, GCMH has to rely on its TPR revenue and prudent spending to maintain a viable bottom line.

Reasonable Charges

A hospital's existing charge structure should be taken into account prior to the HSCRC's granting capital funding, whether it is a TPR hospital or not. There should be some offset to capital funding for TPR hospitals above the peer average on the ROC methodology. On the last published ROC in the spring of 2011, GCMH was 6.58% below its peers and had been consistently well below the average on previous ROCs.

Reasonable Cost Structure

In addition to a review of charges, staff analyzed GCMH's cost structure compared to its ROC peer group as well as the other TPR hospitals. A comparison of capital costs per EIPA and non-capital costs per case mix adjusted EIPA resulted in GCMH's costs being significantly below its peers as follows:

	GCMH (Below) Peers	
	v. TPR	v. ROC Group
Capital per EIPA	(47.8%)	(31.9%)
Non-capital per CMAEIPA	(5.7%)	(3.5%)
Combined	(9.5%)	(6.1%)

Adding the $2.1 million in Project costs to GCMH's capital costs results in GCMH remaining 6.0% below the TPR hospitals' combined average and at the ROC peer group average.

VI. FINAL RATES SUMMARIZED

Based on the analysis outlined in Section V and the unique circumstances of GCMH, the staff recommends the following:

1. That the Hospital's CAP be adjusted by $2,378,171 as follows, provided that the assets are available for use at that time:

July	1, 2014	$789,019
July	1, 2015	$761,429
July	1, 2016	$827,723

If the assets are not available for use at the times stated above, the staff recommends that the adjustments be made when the assets become available for use.

2. That these adjustments be contingent on the approval of the CON before the MHCC without any material changes.

3. That any material difference between the Hospital's assumed interest rate and the actual interest rate secured be appropriately adjusted for at the time this adjustment is to be made.

IN RE: THE FULL	*	BEFORE THE HEALTH SERVICES	
RATE REVIEW OF	*	COST REVIEW COMMISSION	
ADVENTIST BEHAVIORAL HEALTH	*	DOCKET:	2012
	*	FOLIO:	1983
ROCKVILLE, MARYLAND *		PROCEEDING:	2193R

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STAFF RECOMMENDATION

February 6, 2013
Approved

I. INTRODUCTION

Adventist Behavioral Health ("Hospital," or "ABH") is a private psychiatric hospital located in Rockville, Maryland operating 116 acute psychiatric beds. The Hospital also operates 113 residential treatment beds and 32 group home beds. These latter services are not regulated by the HSCRC. Reimbursement for private psychiatric hospitals is not covered under the Maryland HSCRC's Medicare waiver. Thus, the rates approved by the HSCRC are paid only by the commercial payers. Medicare reimburses based on its own Prospective Payment System for psychiatric hospitals. While Medicaid has agreed to reimburse psychiatric hospitals 94 % of the rates approved by the HSCRC for this fiscal year, there is nothing that mandates Medicaid to continue to reimburse this way. There are only 2 private psychiatric hospitals in the state other than ABH. They are Sheppard Pratt and Brooklane Hospital.

II. THE HOSPITAL REQUEST AND JUSTIFICATION

On August 30, 2012, ABH submitted a full rate application to the Health Services Cost Review Commission ("HSCRC," or "Commission"). The Hospital requests a 23.81% ($6,422,580) increase to its approved permanent unit rates effective October 1, 2012. Of this request16.38% is based on a Level 1 cost comparison to Sheppard Pratt and Brooklane. Level I cost includes all direct and overhead cost. It does not include the cost of capital, other financial considerations, or the cost associated with providing mark-up. The Hospital also requests a 7.43% increase to cover the estimated additional uncompensated care (UCC) due to the elimination of Purchase of Care (POC) funds provided by the State's Mental Hygiene Administration (SMHA). The HSCRC staff requested additional information, which was provided on September 12, 2012.

III. HOSPITAL RATE HISTORY

Since its initial rate setting in 1996, ABH has not filed a full rate application.

IV. HOSPITAL FINANCIAL PERFORMANCE

For the last three reported fiscal years, the Hospital has earned the following operating profits:

Adventist Behavioral Health	Net Operating Revenue (Regulated)	Net Operating Profit (Regulated)	Operating Margin (Regulated)	Net Profits
FY Dec. 2011	$21,607,000	($490,300)	(2.3%)	($3,776,000)
FY Dec. 2010	$19,018,100	($2,150,700)	(11.3%)	($4,442,700)
FY Dec. 2009	$20,630,800	$261,200	1.3%	($2,437,200)

V. STAFF ANALYSIS

a. CONSIDERATION OF LEVEL I REQUEST

ABH attempt to justify its requested 16.38% increase by comparing its Level I expenses to the average per diem expenses of the other two psychiatric hospitals in the State. While this methodology is somewhat consistent with the staff's prior Taylor Manor recommendation, the staff believes that the peer group of two other hospitals may be too small to result in a totally valid comparison and should not be the basis for such a large rate increase. Additionally, while ABH attempts to bolster its argument through the use of comparisons to regional data, these data include the cost of significant unregulated services. Although these results may indicate a favorable direction for ABH, staff does not believe that an exact amount can be reasonably assigned. However, since the Hospital's cost and rates are below those of the other two

psychiatric hospitals, it would appear that some rate increase is warranted.

Therefore, the staff compared the direct cost of providing only routine medical care (and not overhead), on a per diem basis, to those of the other two psychiatric hospitals. This comparison showed that ABH was 16.21% below the routine direct medical cost of the other hospitals. Staff set ABH's direct medical care cost at the average after adjusting for labor market differences. Staff then added ABH's actual direct cost for ancillary care, overhead, and capital cost; priced leveled through September 30, 2013; and added ABH's current markup. This resulted in a $1,167,467 increase to gross revenue, or a 4.33% increase to rates (see Exhibit 1). Since Medicare does not pay Commission approved rates here, the Hospital will only realize an $872,515 increase to net revenue after applying the discounts approved for the other payers.

b. CONSIDERATION OF POC ELIMINATION REQUEST

For some time, the State has been attempting to return patients who were previously cared

for in a State Psychiatric Hospital to community settings. For the Medicaid patients, Medicaid decides what it reimburses based on its own principles, since these private psychiatric facilities are not covered under the Medicare Waiver. In prior years, Medicaid reimbursed based on 84% of HSCRC approved charges. However, for FY 2013, as noted above, Medicaid has agreed to reimburse these hospitals based on 94% of HSCRC approved charges. This differential will be used in the Hospital calculation of markup.

For those patients who are not eligible for Medical Assistance, yet still in need of psychiatric care, the SMHA has been reimbursing private psychiatric hospitals with State dollars set aside to be used for POC agreements. These agreements provide revenue to the hospitals for

patients who would otherwise be considered UCC. The HSCRC's current methodology for covering the cost associated with UCC at private psychiatric hospitals is based on the Hospital's most recent reported three year average UCC. The elimination of POC dollars will increase UCC at the Hospital. Staff believes that the Hospital should not have to wait until the impact of these changes appear in the Hospital's most recent reported three year average for an adjustment to be made. Therefore, Staff requests that the Commission allow it to work with the Hospital to provide a reasonable amount for UCC due to the elimination of POC dollars. Staff reminds the Commission that UCC is spread across all payers, and Medicaid would pay a portion of this adjustment, while Medicare would not.

VI. FINAL STAFF RECOMMENDATION

Based on our analysis, staff recommends that the Hospital be granted a 4.33% increase to its rate structure effective October 1, 2012.

Staff further recommends that it be allowed to work with the Hospital in order to provide a reasonable amount in rates each year for uncompensated care after consideration of the impact of the State's change to its POC funds.

Adventist Behavioral Health

Exhibit 1

Full Rate Review

Proceeding # 2193R

FY 2011	Patient Days	Routine Direct Expenses	Labor Market Adjuster	Adjusted Expenses	Routine Expense Per Day
ABH	26,984	$9,859.9	1.05200	$9,372.5	$347.34
Brooklane	10,998	$3,941.2	1.00392	$3,925.8	$356.96
Sheppard	95,185	$42,096.1	1.00456	$41,905.0	$440.25
Average	133,167	$55,897.2		$55,203.4	$414.54

Labor Market Adjuster	1.05200
Adjusted Routine Direct Expenses	$436.10
Current Patient Days	27,512
Recommended Routine Direct Expenses	$11,997,941
Other ABH Expenses	
Direct Ancillary	$1,795,700
Overhead	$8,640,800
Capital	$1,283,800
Total Recommended Expenses	$23,718,241
Price leveling Inflation	4.80%
Total Recommend Expenses Inflated	$24,856,717
Mark uo	1.1320
Total Recommended Revenue	$28,137,804
Current Approved Revenue	$26,970,337
Additional Recommened Revenue	$1,167,467
Percent Increase	4.33%
Net Patient Percent	74.74%
Net Patient Revenue Increase	$872,515

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
MEDSTAR HEALTH	*	**DOCKET: 2013**
	*	**FOLIO: 2010**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2200A**

Staff Recommendation

February 6, 2013
Approved

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on January 4, 2013 on behalf of Union Memorial Hospital (the Hospital) for an alternative method of rate determination (ARM), pursuant to COMAR 10.37.10.06. MedStar requests approval from the HSCRC to continue to participate in a global rate arrangement for orthopedic services with the NFL Player Joint Replacement Benefit Plan (the NFL Plan) for a one year period beginning December 1, 2012.

This arrangement was originally approved by the Commission at its December 5, 2007 public meeting for one year and subsequently re-approved in 2008, 2009, and 2010 with the approval expiring on December 1, 2011. The arrangement was reproved again at the December 8, 2012 public meeting. While there has never been any activity, the NFL Plan and the Hospital wish to maintain the arrangement.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. (HRMI). HRMI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating the mean historical charges for all patients receiving the procedures for which global rates are to be paid. The negotiated rates are comparable to another joint replacement ARM already approved by the HSCRC. The NFL Plan agreement does not include the more costly procedures to replace prior joint replacements. In addition, the agreement does not include the post-acute rehabilitation normally included in joint replacement global pricing. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to HRMI for all contracted and covered services. HRMI 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 HRMI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff believes that the hospital component of the global rate is reasonably related to historical experience. Staff has noted that the NFL Plan agreement has a more narrow definition of the episode of care covered under the global rates than other similar ARM arrangements. In addition, staff found that the Hospital and HRMI have a favorable history of managing joint replacement patients and performing under a global rate arrangement. The physicians' professional components of the proposed rates follow historical fee for service averages and are closely related to the professional components of the Hospitals similar global arrangement involving orthopedic surgery.

VI. STAFF RECOMMENDATION

Although there has been no activity, staff still believes that the Hospital can achieve favorable performance under this arrangement. Therefore, staff recommends that the Commission approve the Hospital's participation in the alternative method of rate determination for orthopedic services for a one year period, commencing February 4, 2013. 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, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Shared Savings in the Admission Readmissions Program with Modifications for Short Stay Cases

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
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Staff Report

Introduction

The purpose of this report is to describe for the Commission the status of staff work to revise the Admission Readmission Revenue (ARR) program. On January 24, 2013, the staff called a workgroup meeting with hospital representatives to discuss the status of the existing policy along with options for future revisions. The staff met with payer representatives from CareFirst, United Healthcare, and the State's Medicaid program to discuss the same issues on January 31, 2013.

Background

As noted in previous reports to the Commission, the Admissions-Readmissions Revenue (ARR) program requires redesign. Under the Affordable Care Act, 1814(b)(3) hospitals that are waived from the Inpatient Prospective Payment System are required to implement quality programs that meet or exceed those implemented by the Medicare Program. CMS has agreed to take a multi-year look at the existing program in Maryland, but certain differences stand out.

The HSCRC program is broader, applying to all-cause readmissions for all APR-DRGs. The CMS program applies only to Heart Attack, Heart Failure, and Pneumonia. The HSCRC program tracks only readmissions to the facility of the index admission, focusing on intra-hospital (and in some cases intra-system) readmission. Because there is no personal identifier in the HSCRC data, readmissions to unlinked facilities cannot be identified. Finally, the HSCRC program was constructed in a manner that converted existing admissions and readmissions into Charge per Episode approved revenue on a revenue neutral basis, allowing hospitals to keep the profit when readmissions are eliminated. The Medicare counterpart penalizes hospitals for high readmission rates, resulting in a system payment reduction of 0.3% of inpatient revenue.

Current Structure

The current HSCRC's ARR program is structured in the following manner:

- All cause readmissions are included in the program.
- The period for readmission is for 30 days following an initial admission.
- While a patient is billed for services charged during a specific case, the revenue allowed under the regulatory system for an average case is determined for a 30 day episode of care. This average amount was developed from hospitals' actual experience and was calculated in a revenue neutral manner in converting from the Charge per Case system.
- Hospitals have the opportunity to improve financial performance by reducing readmissions, thus eliminating costs while the revenue base has not been reduced.
- The policy was approved with the understanding that productivity expectations would be high for hospitals – profits would be generated by reducing costs through reduced readmissions while annual inflationary updates would be lower.

The ARR program is in its second year. While CMS has indicated its willingness to examine the program's operation over multiple years, representatives have indicated discomfort with the revenue neutral approach. They have noted that this approach does not share savings with the public, and while reduced update factors can recapture some of those savings, they viewed the mechanism as indirect.

Options for Incorporating Shared Savings

In the workgroup meetings, the staff discussed three options for sharing savings from reduced readmissions: scaling, the performance standard approach, and an improvement approach.

- The scaling approach may be the most straightforward approach. This would require ranking hospitals on a standard definition of readmissions. The best performing hospitals would not be adjusted, but hospitals with higher readmission rates would receive some level of reduction to rates, with higher deductions occurring for higher readmission rates.
- The performance standard approach would follow the structure of the current system, but each hospital's target would be adjusted compared to a case mix adjusted readmissions standard. Hospitals below the performance standard would have no adjustment to their Charge per Episode (CPE) target. Hospitals with high adjusted readmission rates would be adjusted downward to the required performance standard, generating lower rates to patients.
- United Healthcare representatives suggested a continuous improvement approach that would require improvement from each facility instead of a performance standard that implicitly requires no further reductions for some hospitals.

One Day Stays

In these meetings, the staff discussed the need to reincorporating short stay cases (0 or 1 day length of stay) into the CPE target. Short stay cases are currently excluded from the CPE methodology. These cases should be reincorporated into the model to prevent them from being pass through revenue to the system and to minimize their impact on the current waiver. Further, a consistent treatment of inpatient cases would make the existing model more straightforward.

Technically, bringing short stay cases back into the model is straightforward, with CPE targets and case mix weights reflecting the change when rebased at the beginning of the rate year. The policy concern is that attaching APR-DRG rate capacity to short stays could encourage an expansion of these cases and reverse the progress previously made on reducing short stays in Maryland. To the degree that these cases are denied as medically inappropriate, they would not generate rate capacity, but the staff believes that other mechanisms would be required to guarantee this result. One possible solution is to monitor the number of short stays by hospital for expansions and adjust the hospitals revenue if the rise in short stay cases were substantial.

Other Exclusions to Existing Logic

The staff also raised the issue of the current logic for exclusions and outliers in the current system. The outlier logic is complex, and this revision is an opportunity to make appropriate adjustments. These items will be modeled and discussed in future meetings.

FY2012 Adjustment for the Compositional Effect of One Day Stays

In the March 2013 Commission meeting, the Commission approved an emergency modification to the case mix policy that imposed a governor on case mix, including the one day stay cases. Because these cases have been excluded from the CPE and CPC logic for recent years, this modification was designed to reflect the effect of the one day stay policy on the State's waiver position.

Determining the impact of these cases turned into a challenge, requiring detailed staff analysis and discussions with consultants and interested parties. The staff arrived at an estimate of the impact under the case mix governor of 0.31%.

As we looked to apply this adjustment to FY2013 rate orders, however, we noted that only a small number of hospitals would receive this adjustment. Because the one day stay policy has been addressed in different ways in different years, this result appeared to treat hospitals differently who had the same experience with one day stay reductions but with different timing. The Commission's action allowed the adjustment to be treated as a case mix governor adjustment for FY2012 only, so the staff is seeking Commission approval to allow this adjustment to be applied based on a two-year look back at one day stay performance for both FY2011 and FY2012. The adjustment would be made to permanent revenue in FY2014. No one time adjustment would be required because as excluded cases, hospitals did not generate additional rate capacity for the one day stay cases.

Next Steps

The staff will continue to work with the hospital and payer work groups to model the policy options discussed above during February with a preliminary recommendation to the Commission at the March 2013 Commission meeting.

Legislative Update – February 6, 2013

Senate Bill 151/House Bill 373 – Hospitals – Outpatient Services – Off-Site Facility – Rate Regulation

Senate Bill 151/House Bill 373 would remove one of four freestanding outpatient facilities owned by Shore Health System from HSCRC rate regulation. Maryland statute currently permits rate regulation of a freestanding outpatient facility under two circumstances: (1) where Memorial Hospital at Easton transferred certain outpatient services off-site prior to January 1, 1999, and (2) where several freestanding emergency centers are specifically provided for by statute (Health-General Article, Section 19-201).

Senate Bill 151 permits this hospital to send in a new notice by June 1, 2013 if it intends to eliminate rate regulation at its off-site digestive health center. The University of Maryland Medical System is required to report to the General Assembly on the utilization and payer mix of the patients using digestive disease services, both in the hospital, and at the off-site facility, before and after the deregulation of the off-site digestive health center.

Status: Senate: Heard in Senate Finance Committee on January 31.

House: Hearing on February 7

Position: No Position; Letter of information regarding TPR discussion.

Senate Bill 195 – Hospitals – Notice to Patients – Outpatient Status and Billing Implications

Senate Bill 195 requires a hospital, under specified circumstances, to provide oral and written notice to a patient of the patient's outpatient status, the billing implications of the outpatient status, and the impact of the outpatient status on the patient's eligibility for Medicare rehabilitation services. Specifically, a hospital must provide such notice if (1) the patient receives on-site services (including a hospital bed and meals provided in an area of the hospital other than the emergency room) from the hospital for more than 18 consecutive hours and (2) the patient is classified as an outpatient at the hospital for observation rather than as an admitted inpatient. The Department of Health and Mental Hygiene (DHMH) must adopt by regulation standard language for the written notice required by the bill.

MHA offered amendments to:

(1) add language in the conditions that provides that that the notification is being provided as a result of the patient's health insurance coverage (rejected by committee);

(2) increases the number hours from 18 to 23 (accepted by committee); and

(3) requires that the DHMH regulations shall not establish standard language but instead standards elements to be included in the notification (accepted by committee).

Status: Senate Bill heard in Senate Finance Committee on January 31. Passed on 2nd reading with amendments

Position: Commission to consider a letter of support for concept for House hearing

Senate Bill 274/House Bill 228 – Maryland Health Progress Fund

Senate Bill 274/House Bill 228 includes a number of provisions relating to Medicaid eligibility requirements pursuant to the Affordable Care Act (ACA), and provides additional authority and policy for the operation of the Health Benefit Exchange, and makes changes to insurance law pursuant to the ACA. The bill includes language that would permit:

- any MHIP surplus funds available in FY14 to be used for the purpose of a reinsurance pool within the Health Benefit Exchange;
- beginning 2015, funds provided to MHIP to be transferred to the Reinsurance pool pursuant to a budget plan on how much is needed to continue to operate MHIP and how much is need to operate the Reinsurance pool;
- the transition of MHIP enrollees into the Exchange including closing MHIP between 2015 and 2020.

Status: Both Bills to be heard on February 13.

Senate Bill 127/House Bill 102 – Budget Reconciliation and Financing Act of 2013

Senate Bill 127/House Bill 102 requires a study/report on expected Medicaid savings from clinic and ED tiering in FY 2014 and requires certain actions to be taken if the expectation is less than $30 million. Specifically, the bill provides that the Commission's clinic tiering policy combined with the 2014 hospital update factor shall achieve $30 million in savings in FY 2014. The Commission is required to contract with a consultant to prepare an analysis projecting the savings from tiering and the update factor in FY 2014 and submit a report to the Governor and General Assembly by December 15, 2013. If the report projects savings of less than $30 million the Commission is required to take one or a combination of the following actions:

- adjust the Medicaid deficit assessment so that the percentage of net patient revenue it represents equals that percentage in FY 2013;
- reduce the MHIP assessment by an amount sufficient to ensure that the combined Medicaid deficit and MHIP assessments do not exceed $518 million in FY 2014; or
- identify and implement other actions to provide the necessary savings.

Status: Hearing not yet scheduled

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, 19-215 19-216, 19-217, 19-220, 19-224, and 19-303, Annotated Code of Maryland

NOTICE OF FINAL ACTION

On February 6, 2013, the Health Services Cost Review Commission adopted amendments to Regulations .03 and .06 under COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions. This action, which was proposed for adoption in 39:25 Md. R. 1623-1624 (December 14, 2012), has been adopted as proposed.

Effective Date: **March 18, 2013**

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 FINAL ACTION

On February 6, 2013, the Health Services Cost Review Commission adopted amendments to Regulation .06 under COMAR 10.37.10 Rate Application and Approval Procedures. This action, which was proposed for adoption in 39:25 Md. R. 1624-1625 (December 14, 2012), has been adopted as proposed.

Effective Date: March 18, 2013

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 FINAL ACTION

On February 6, 2013, the Health Services Cost Review Commission adopted amendments to Regulations .02 and .03 under COMAR 10.37.12 Cross-Subsidization. This action, which was proposed for adoption in 39:25 Md. R. 1625-1626 (December 14, 2012), has been adopted as proposed.

Effective Date: **March 18, 2013**

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Chairman

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TO: Commissioners

FROM: Legal Department

DATE: January 30, 2013

RE: Hearing and Meeting Schedule

Public Session:

March 6, 2013 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

April 10, 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/commissionMeetingSchedule2013.cfm

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