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HEALTH SERVICES COST REVIEW COMMISSION

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468th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

PUBLIC SESSION

June 9, 2010

9:00 a.m.

1. **Review of the Executive and Public Minutes of May 5, 2010**
2. **Executive Director's Report**
3. **Docket Status - Cases Closed**
2067R - Garrett County Memorial Hospital
4. **Docket Status - Cases Open**
2068A - University of Maryland Medical Center
2069A - University of Maryland Medical Center
2070A - University of Maryland Medical Center
2071N - James Lawrence Kernan Hospital
2072R - Suburban Hospital
5. **Draft Recommendation on FY 2011 Update to Hospital Rates**
6. **Update on Maryland Hospital Preventable Readmission Initiative**
7. **Final recommendation on Revisions to the Reasonableness of Charges (ROC) Methodology**
8. **Final Recommendation on Reallocation of Case Mix to Hospitals that were early Adopters of Observation Units (From One Day Length of Stay Recommendations)**
9. **Report on the Preliminary Results of the Uncompensated Care Policy**
10. **Community Benefit Report Update**
11. **Legal Report**
12. **Hearing and Meeting Schedule**

**IN RE: THE APPLICATION FOR
ALTERNATIVE METHOD OF RATE
DETERMINATION
UNIVERSITY OF MARYLAND
MEDICAL CENTER
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2010
* FOLIO: 1878
* PROCEEDING: 2068A**

Staff Recommendation

June 9, 2010

I. INTRODUCTION

University of Maryland Medical Center ("UMMC" or "the Hospital") filed an application with the HSCRC on April 28, 2010 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 global rate arrangement for the collection of peripheral blood stem cells from donors for a period of three years with the National Marrow Donor Program (NMDP) beginning July 1, 2010.

II. OVERVIEW OF APPLICATION

The NMDP, which coordinates the donation, collection, and transplantation of stem cells and bone marrow from unrelated donors for patients without matching donors in their families, proposes to use UMMC as a collection site for Department of Defense donors. The contract will be held and administered by University Physicians, Inc. (UPI), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The technical portion of the global rates was developed based on historical hospital charge data relative to the collection of peripheral stem cells. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff reviewed the experience for the last year under this arrangement and found that it was favorable. Staff believes that the Hospital can continue to 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 the collection of peripheral stem cells commencing July 1, 2010. The Hospital will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document will formalize the understanding between the Commission and the Hospital, and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

**IN RE: THE APPLICATION FOR
ALTERNATIVE METHOD OF RATE
DETERMINATION
UNIVERSITY OF MARYLAND
MEDICAL CENTER
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2010
* FOLIO: 1879
* PROCEEDING: 2069A**

Staff Recommendation

June 9, 2010

I. INTRODUCTION

University of Maryland Medical Center (“the Hospital”) filed an application with the HSCRC on April 28, 2010 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for liver and blood and bone marrow transplants for a period of three years with Cigna Health Corporation beginning July 1, 2010.

II. OVERVIEW OF APPLICATION

The contract will be held and administered by University Physicians, Inc. (“UPI”), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff found that the Hospital's experience under this arrangement for the previous year was favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for liver and blood and bone marrow transplant services, for a one year period commencing July 1, 2010. The Hospital will need to file a renewal application to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, 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
ALTERNATIVE METHOD OF RATE
DETERMINATION
UNIVERSITY OF MARYLAND
MEDICAL CENTER
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2010
* FOLIO: 1880
* PROCEEDING: 2070A**

Staff Recommendation

June 9, 2010

I. INTRODUCTION

On May 14, 2010, the University of Maryland Medical Center (“UMMC” or the “Hospital”) filed an application with the Commission for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital has requested approval to continue to participate in a global rate arrangement with the Gift of Life Foundation (GOL) for the collection of bone marrow and peripheral blood stem cells from GOL, on an outpatient basis, donors to facilitate Hematopoietic Stem Cell transplants into unrelated GOL recipients. The Hospital seeks approval of the arrangement for an additional year beginning April 1, 2010.

II. OVERVIEW OF APPLICATION

The contract will be continue to be held and administered by University Physicians, Inc. (“UPI”), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates for the collection of bone marrow and peripheral blood stem cells has been developed based on recent historical charges for cases performed at UMMC. The remainder of the global rates comprised of physician services has been negotiated with the participating physician group.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

Because last year's experience was favorable, staff recommends that the Commission approve the Hospital's request for an alternative method of rate determination for the collection of bone marrow and peripheral stem cells for one year commencing April 1, 2010. UMMC will be required to file a renewal application for review to be considered for continued participation in the arrangement.

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 PARTIAL RATE * BEFORE THE HEALTH SERVICES
APPLICATION OF * COST REVIEW COMMISSION
SUBURBAN HOSPITAL * DOCKET: 2010
*** FOLIO: 1882**
BETHESDA, MARYLAND * PROCEEDING: 2072R

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Staff Recommendation

June 9, 2010

Introduction

On May 13, 2010, Suburban Hospital (the “Hospital”) submitted a partial rate application to the Commission requesting a rate for Lithotripsy (LIT) services to be provided in-house. The Hospital currently has a rebundled rate for LIT services. The Hospital is requesting that the LIT rate be set at the statewide median with an effective date of July 1, 2010.

Staff Evaluation

The Hospital submitted its LIT costs and statistical projections for FY 2011 to the Commission in order to determine if the Hospital’s LIT rate should be set at the statewide median rate or at a rate based on its own cost experience. Based on the information provided, staff determined that the LIT rate based on the Hospital’s projected data would be \$2,781.86 per RVU, while the statewide median for LIT services is \$2,761.94 per RVU.

Recommendation

After reviewing the Hospital’s application, the staff has the following recommendations:

1. That COMAR 10.37.10.07 requiring that rate applications be made 60 days prior to the opening of the new service be waived;
2. That the LIT rate of \$ 2,761.94 per RVU be approved effective July 1, 2010;
3. That no change be made to the Hospital’s Charge per Case standard for LIT services; and
4. That the LIT rate not be rate realigned until a full year’s experience data have been reported to the Commission.

**Draft Staff Recommendation and Discussion Document Regarding the
FY 2011 HSCRC Hospital Payment Update**

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June 9, 2010

Update on Activities since May 9th

In the past month, discussions of the Payment Work Group have focused on the following areas:

- 1) methods for generating additional Medicaid-specific savings to help reduce the magnitude of the assessments on hospitals and payers;
- 2) alternative methods of scaling FY 2011 rate updates for relative hospital performance on quality measures and the HSCRC's Reasonableness of Charges methodology;
- 3) the impact of potential rate updates on the industry's current and future financial condition;
- 4) the impact of potential rate updates on Maryland's Medicare waiver test given projected Medicare updates for hospitals nationally; and
- 5) the development of a system-wide efficiency target on the basis of hospital cost per equivalent inpatient admission (EIPA) comparing Maryland performance to that of hospitals nationally.

This draft recommendation document will describe the deliberations and analysis of the Payment Work Group in each of the above mentioned areas and provide a summary of current rate update options and proposals.

Discussions Regarding Additional Ways to Generate Medicaid Savings

Prior to the May Commission meeting, HSCRC staff, with the assistance of the Payment Work Group identified five potential methods for reducing the amount of the planned Medicaid assessment on hospitals and payers:

- 1) Approval of an FY 2011 payment update below the Medicaid budgeted "all-inclusive" Update of 2.82% (this would require a base update of 2.16% per the analysis on Table 16 of the May 5th draft recommendation)¹;
- 2) Examination of Chronic Hospitals' Rate Structure;
- 3) Potential reductions in Maryland Medicaid's payment levels to Washington DC hospitals;
- 4) Pooling of Graduate Medical Education costs; and
- 5) Potential Changes in the Medicare/Medicaid differential.

Staff determined that of the identified methods, only items 1, 2, and 3 could potentially be implemented in FY 2011. As discussed, item 1 would require approval of a base Update of less than 2.16% for FY 2011 and would generate approximately \$900,000 of Medicaid savings for each 0.1% reduction from the 2.16% level. Item 2 will require a review by HSCRC staff and may involve subsequent staff recommended Commission action. Item

¹ Per Table 16, page 27 of this document, to achieve a 2.82% all-inclusive update for Medicaid, the Commission would need to approve a base Update of 2.16% to account for the anticipated increase in hospital markups in FY 2011 and the fact that Medicaid traditionally grows at approximately 106% of the all-payer rate.

3 requires that staff review the existing payment agreement (in Medicaid regulation) between the Maryland Department of Health and Washington DC hospitals for Maryland Medicaid patients receiving treatment in the District of Columbia.

After performing this review, the HSCRC staff concluded that the Maryland Medicaid payment arrangement with Washington DC hospitals appears reasonable with one exception. Staff concluded that the current payment arrangement between the Maryland Medicaid program and Children's Hospital of Washington DC is excessive due to the inclusion of a negotiated extra factor in the hospital's payment formula. The Department's regulation currently authorizes an extra payment multiple for Children's Hospital of 2.5 x Children's reported Uncompensated Care. All other Washington DC hospitals are paid at a multiple of 1.0 x reported Uncompensated Care. This extra payment multiple will result in approximately \$4 - 5 million in excessive and unnecessary payments by Maryland Medicaid to Children's Hospital in FY 2011. Elimination of this multiple would reduce the assessments currently imposed on Maryland hospitals and payers.

Staff suggested that the Payment Work Group make a joint recommendation to Medicaid to change their reimbursement formula for Children's Hospital of DC to adjust this factor to 1.0 (the same as exists for all other District providers). Payer members representing CareFirst, Kaiser, and United Healthcare agreed with this recommendation. The Maryland Hospital Association did not support the staff recommendation. Staff contacted Children's representatives and indicated they could have time today to respond to these recommendations. These representatives, however, declined to participate.

Staff will recommend that the Commission send a letter to the Maryland Secretary of Health recommending this change to Maryland Medicaid reimbursement methodologies. The reductions of these unnecessary payments will thus go to reduce the \$123 million assessment to be imposed on Maryland hospitals and payers in FY 2011.

Alternative Scaling Recommendations

A second area of focus for the Payment Work Group over the past 30 days was on the development of alternative methods for scaling a portion of the FY 2011 Rate Update for the performance of individual hospitals on relative measures of hospital quality and efficiency. Scaling on the basis of relative quality and efficiency performance has the impact of rewarding high quality and low cost hospitals and penalizing lower quality and high cost hospitals.

For quality of care, the HSCRC has in the past scaled proportions of the annual update for relative hospital performance on its Quality-Based Reimbursement (Evidence-based process measures – implemented FY 2009) and Maryland Hospital Acquired Conditions (Preventable Complications – implemented FY 2010) methodologies. To recognize and reward better performance on these quality scales, the Commission has in the past differentially allocated up to 0.5% of revenue from poorer performing hospitals to better performing hospitals on a revenue neutral basis.

The HSCRC has also differentially allocated up to 0.5% across hospitals on the basis of relative performance on the Commission's annual Reasonableness of Charges (ROC) analysis – which ranks hospitals on the basis of adjusted cost per case and cost per outpatient visit.

Differential scaling of this nature is an important policy tool that can provide strong incentives for hospitals to improve their overall quality of care and their operating efficiency.

Current Payer Scaling Proposal

The Payers collectively voiced belief that the adjustments for quality measures (including the QBR and MHACs) should be revenue neutral, but yet include incentives that will influence future behavior. They also believe more emphasis should be given to Potentially Preventable Admissions (PPAs), including readmissions, which we believe will have a greater quality and financial impact, and propose a pool of 0.5% for the QBR, 0.5% for the MHAC adjustment, and 1.0% for the Potentially Preventable Readmissions program in 2011, all increasing by 0.5% a year in 2012 and 2013.²

With regard to ROC scaling, the collective Payer proposal is as follows:

1. The level of scaling should be driven by the ROC rather than by the update factor. Scaling should relate to whether a hospital's charges are high or low, and that has nothing to do with the update factor.
2. Scaling should be revenue neutral.
3. Scaling should aggressively address the "stuck hospital" issue. That is, hospitals with very low rates should be approved for significant positive scaling.³
4. Hospitals should not be entitled to both scaling and a full rate review.
5. Two hospitals should be exempt from scaling (McCready Hospital because it is a TPR hospital that is above the ROC average, and Bon Secours because of financial issues).⁴
6. The Payers propose the scaling be accomplished in two steps: Step one – the hospitals subject to scaling gain or lose 20% of the difference in their ROC position and 0% (peer average). Step two – staff makes a revenue neutral adjustment by increasing or decreasing the adjustment for high-charging hospitals.
7. The Payers recognize that in conjunction with their update proposal, some very high charge hospitals will have their charges reduced in the first year. This, they believe, is entirely consistent with the Commission's mission and the payers' conception of appropriately achieving affordable hospital care and their original goal of reaching a position of 6.1% below the US in terms of cost per EIPA.
8. Note that aggressive scaling would replace Spenddowns. In a typical spenddown, a high cost hospital's ROC position is reduced to the statewide average in three years. The Payer proposal moves all hospitals to approximately 50% of their current ROC position in three years ($0.8 \times 0.8 \times 0.8 = 0.512$).

A simulation of the current Payer proposal on scaling (based on last year's ROC, QBR and MHAC results) is included in **Appendix II**.

² While the HSCRC is currently developing a methodology for linking the performance on potentially preventable re-admissions (PPRs) to payment incentives, this methodology was not contemplated to be associated with the FY2011 payment update. Staff, however, intends to present a recommendation linking PPR performance by hospital to payment incentives in the FY 2012 Update.

³ Note: the Staff's recommendations for the ROC/ICC this year include forestalling the implementation of "Spenddowns" (negotiated rate reductions to high charge hospitals over 2-3 years) in lieu of more "aggressive" scaling (that is, apply larger than historical magnitudes of scaling revenue – based on relative ROC position). In the absence of aggressive scaling, the staff will institute the HSCRC's long-standing policy of negotiating Spenddowns for high charge hospitals.

⁴ The Payers note that the HSCRC may wish to look at these two facilities separately. Bon Secours is the only non-teaching Baltimore city hospital and may be disadvantaged by being in a group with city teaching facilities. The Payers do not favor a policy that could bankrupt Bon Secours and divert patients to higher charge hospitals that only "appear" lower on the ROC because of their teaching adjustment.

Current MHA Scaling Proposal

MHA believes redistribution of a portion of the annual payment update or “scaling” based on a statewide comparison can be an effective policy tool. Scaling has been used to redistribute revenue among hospitals according to their position on the Reasonableness of Charge (ROC) analysis and the Quality Based Reimbursement (QBR) policy. For the first time, in FY 2011, payment will be scaled based on hospitals’ relative rate of potentially preventable complications (PPCs). In all cases, hospitals are ranked relative to all other hospitals in the State and rewarded or penalized based on their position in the ranking.

For FY 2011, Maryland hospitals support scaling a portion of the annual update, provided the scaling is handled in a certain manner.

Amount of Revenue to Scale

In scaling a portion of the annual payment update, it is important that the core update (GI inflation, plus forecast error, plus or minus any policy adjustment) is at least equal to inflation. MHA supports scaling for the quality-based initiatives as a first step, with ROC scaling established such that the combined scaling for all of the three comparison indices - ROC, QBR, and PPCs combined— results in no individual hospital receiving a combined negative scaling greater than 30 percent of the core inflation update. We would accept the quality-based scaling as proposed by the payers at present for 2011 (0.50% set aside for each of QBR and PPCs).

Scaling Design

For the ROC, MHA supports scaling in large bands where a group of like-ranked hospitals receives the same payment bonus or reduction, and the hospitals close to the median receive no adjustment. The peer group to which a hospital is assigned heavily influences where a hospital ranks in the ROC. How many peer groups are used and how hospitals are assigned to peer groups is currently a subject of considerable debate. The large scaling bands can mitigate the effect of the peer assignment on a hospital’s position. We would recommend use of 2% corridors for ROC scaling (those more than 2% above their peer group average or more than 2% below their peer group average would be scaled. All those within the 2% corridor would be held harmless). For current analysis, we assumed that those who would be positively scaled would receive an amount equal to 10% of the percentage that their actual ROC position is below the 2% corridor.

A copy of a simulation of this proposal is included in **Appendix II**.

The HSCRC staff will provide a side-by-side commentary and evaluation of the two scaling proposals at the June 9th Commission meeting.

Discussion of Hospital Financial Condition in FY 2010 and FY 2011

During the past month the Payment Work Group also discussed the current and potential future financial condition of Maryland hospitals. In general, the overall operating performance (both regulated operating profits and unregulated operating profits) of Maryland hospitals has improved over the period FY 2003 to FY 2009 (based on an analysis of 40 June Year End hospitals). Overall operating profits, however, consist of profits from both regulated and unregulated lines of business. While regulated operating profits have improved since FY 2003 (growing from 3.54% operating margin to 5.86% by 2009), annual increases in hospitals’ unregulated losses have, in-part, offset the improved regulated service performance (see **Table 3** below - in the body of the May 5 recommendation document).

Staff also examined year-to-date unaudited financials for 9 months ending March of FY 2010 vs. the same period in FY2009. Although unaudited data tend to closely track overall year-end performance – the allocation between regulated and unregulated revenues and expenses tends to be less accurately reported. The picture for FY 2010, however, seems to show steady overall financial performance by Maryland hospitals this year through January 2010, despite facing a very restrictive Update factor in FY 2010 (overall operating margins – both regulated and unregulated were 2.02% in FY 09 six months year-to-date, vs. 2.04% for the same period in FY 10). Operating performance did drop considerably during the month of February, however, likely due to the impacts on volume of the severe snow storms that hit the State during this month. Another factor impacting hospitals negatively in the last half of FY 2010 is the application of the \$17 million in direct remittances from hospitals to the State’s General fund associated with Medicaid Budget cuts approved by the Budget and by the Board of Public Works in the fall of 2009.

The **Table** below shows the comparison of year-to-date (YTD) performance July-January FY 2010 vs. July-March FY 2010. The Table also compares 9 months YTD performance through March in FY 2009 vs. FY 2010. While operating profits have eroded, staff would note that non-operating profits have recovered considerably over the FY 2008 and FY 2009 levels.

**Year to Date Overall Financial Performance – Maryland Hospitals
FY 2010 Jan vs. March and FY 2009 vs. FY 2010 9 months YTD**

Acute Care Hospitals F/S Data Unaudited Financial Data Regulated and Unregulated Services		Comparison 09 vs 10	
	YTD Jan. 2010	YTD March. 2010	YTD March 2009
Total Operating Profit	1.85%	1.80%	2.34%
Total Profit	5.04%	4.96%	-3.28%

MHA Discussion Regarding Current Inadequate Operating Profit Margins

During the discussions of the Payment Work Group, the hospital representatives argued that the hospital industry in Maryland was not generating sufficient levels of operating profits to cover both current factor cost inflation and projected annual increases in “unfunded” annual requirements in future years. Restoration of operating profits to a more desired level of 2.75% (which is the Commission’s current operating profit financial indicator), in addition to meeting future capital requirements through FY 2013, will require annual productivity improvements of 2.44% (under the hospital Update proposal) and 3.96% (under the current Payer Update proposal).

The Payer representatives disputed the MHA claims that current and future capital requirements are not adequately funded in rates and devised a counter example purporting to show that based on the Commission’s current desired non-operating profit indicator level of 4.0%, the hospital industry Update proposal would result in 0.40% of productivity erosion, while the Payer proposal would require 1.12% productivity savings.

The Payer representatives also indicated that the MHA emphasis on targeting profit margins for the industry was inappropriate from a policy perspective in that it was equivalent to “cost-based reimbursement” (i.e., hospitals’ future year reimbursements should be determined based on last year’s expenditures).

Staff Analysis of Growing Unregulated Losses (Particularly Physician Losses)

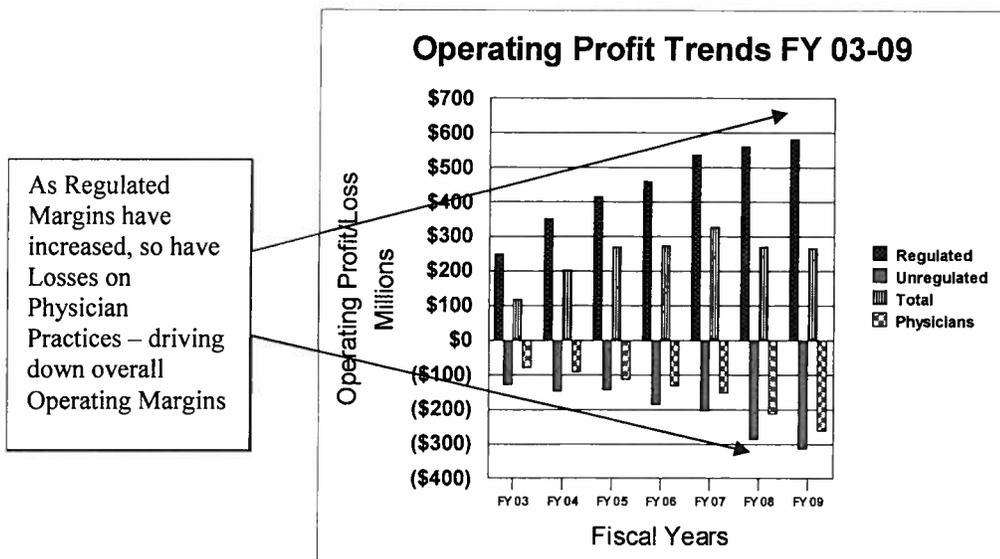
In response to these arguments, staff began to more thoroughly analyze trends in regulated and unregulated operating performance since FY 2003. As reported previously, regulated operating margins have improved steadily from FY 2003 to 2009 (from 3.54% in FY 2003 to 5.78% in FY 2009), while unregulated operating losses have increased (from -20.8% to -33.9% respectively). Based on 9 months of data for FY 2010, it appears that the erosion in total operating profits (both regulated and unregulated) may in part be a function of continued increases in unregulated operating losses (particularly physician losses).

The table on the following page shows that hospitals' steady or declining total operating margins over the past eight years are, in large part, due to the persistent erosion of operating profitability attributed to growing unregulated losses – principally growing physician “part B” losses. While the HSCRC can monitor these trends in aggregate, the Commission currently does not collect detailed data on physician related losses. Staff is thus unable to determine whether these losses are related primarily to coverage and payer-mix issues or are a function of more strategic business decisions of hospital management.

Staff is also unable to assess the reasonableness of these growing losses (either in aggregate or by hospital). It may well be that some hospitals (particularly those in inner-city environments) have no choice but to heavily subsidize physicians to provide services and provide coverage for hospital specialty care; however, staff also believes that some of these growing losses can likely be attributed to discretionary decision-making by hospital management, aimed at capturing and increasing patient volumes. Discretionary and strategically motivated decision-making of this nature should be the responsibility of the hospital, and regulated rates should not be increased to fund these types of activities.

This theory that more hospitals are making strategic decisions to fund or subsidize physician activity to increase hospital volumes is further substantiated by an analysis (performed by staff) that shows that hospitals in non-inner city and non-rural areas (where coverage subsidies would likely be required to such a degree) consistently generate the largest proportions of physician-related Part B losses and account for the largest growth in these losses over time.

The table below shows that had hospitals held unregulated losses to FY 2003 – 2005 levels, overall operating profits would be well in excess of current desired levels. It is clear from these data that growing physician losses (not restricted rate increases) represent the primary reason for less desirable hospital operating performance in recent years. The chart below also shows that as regulated operating margins have increased over time, unregulated losses have eroded in a parallel fashion.



Regulated/Unregulated Performance 2003- 2009 and Projected 2010

Column	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
line	Reg Revenue	Reg Expense	Reg Profits	Reg Op Margin	Unreg Rev	Unreg Exp	Unreg Profit	Unreg Profit %	Unreg Profit %	Total Profits	Total Op. Margin	Physician Part B Rev	Physician Part B Exp	Part B Physic. Loss	
1	Proj 2010	\$11,472,406,439	\$10,835,043,303	\$637,363,135	5.56%	\$1,133,330,828	\$1,550,569,865	-\$417,239,037	-36.82%	-3.31%	\$220,124,098	1.75%	\$323,409,918	-\$643,001,931	-\$319,592,013
2	2009	\$11,278,814,403	\$10,626,817,700	\$651,996,703	5.78%	\$1,046,295,634	\$1,395,650,033	-\$349,354,399	-33.39%	-2.83%	\$302,642,304	2.46%	\$289,847,400	-\$553,881,900	-\$264,034,500
3	2008	\$10,704,338,397	\$10,143,272,472	\$561,065,925	5.24%	\$965,944,389	\$1,256,208,481	-\$290,264,092	-30.05%	-2.49%	\$270,801,833	2.32%	\$259,767,900	-\$477,113,900	-\$217,346,000
4	2007	\$9,982,901,465	\$9,446,725,486	\$536,175,979	5.37%	\$931,397,459	\$1,138,465,982	-\$207,068,523	-22.23%	-1.90%	\$329,107,456	3.02%	\$235,973,300	-\$389,976,500	-\$154,003,200
5	2006	\$9,203,751,936	\$8,742,242,743	\$461,509,193	5.01%	\$807,268,702	\$995,408,455	-\$188,139,753	-23.31%	-1.88%	\$273,369,440	2.73%	\$211,071,400	-\$345,487,100	-\$134,415,700
6	2005	\$8,460,040,439	\$8,044,819,951	\$415,220,488	4.91%	\$739,646,635	\$885,746,140	-\$146,099,505	-19.75%	-1.59%	\$269,120,983	2.93%	\$184,288,300	-\$298,799,300	-\$114,511,000
7	2004	\$7,787,586,634	\$7,436,271,016	\$351,315,618	4.51%	\$706,133,300	\$855,791,321	-\$149,658,021	-21.19%	-1.76%	\$201,657,597	2.37%	\$171,423,800	-\$265,466,800	-\$94,043,000
8	2003	\$7,027,991,900	\$6,778,984,900	\$249,007,000	3.54%	\$646,110,200	\$777,290,800	-\$131,180,600	-20.30%	-1.71%	\$117,826,400	1.54%	\$134,027,600	-\$215,059,600	-\$81,032,000
Scenarios Projected FY 2010 Operating Performance															
9	Projected	\$11,472,406,439	\$10,835,043,303	\$637,363,135	5.56%	\$1,133,330,828	\$1,550,569,865	-\$417,239,037	-36.82%	-3.31%	\$220,124,098	1.75%	\$323,409,918	-\$643,001,931	-\$319,592,013
10	Scenario 1	\$11,472,406,439		\$637,363,135		\$1,133,330,828		-\$378,415,141	-33.39%	-3.00%	\$258,947,994	2.05%			
11	Scenario 2	\$11,472,406,439		\$637,363,135		\$1,133,330,828		-\$340,563,336	-30.05%	-2.70%	\$296,799,799	2.35%			
12	Scenario 3	\$11,472,406,439		\$637,363,135		\$1,133,330,828		-\$242,051,131	-21.36%	-1.92%	\$395,312,004	3.14%			
										Avg 03-07					
13	Expected Bad Debt Adjustment 2011											0.50%			

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Development of a Cost per EIPA Target for the Rate System

In response to a request by the Commission at the May 2010 public meeting, staff is proposing the Commission consider the adoption of a specific cost per adjusted admission target for the Maryland hospital industry. Currently, the Commission has as policy a target of being 3-6% below the national cost per adjusted admission level.

Exhibit I below provides an analysis and methodology used by staff for the proposed establishment of a goal of moving the hospital industry from a position of 0.21% below the US on Cost per EIPA (estimated FY 2010 position) to a position of 6.0% below the US on Cost per EIPA by FY 2015.

In reaching this policy target of 6.0% below the US, the staff used the following rationale:

- 1) the HSCRC's current policy is a range – to be 3-6% below the US on Cost per EIPA (although the system is currently only 0.21% below);
- 2) the Maryland system has historically been as low as 11-12% below the US on this measure (in the 1992-1993 period), so much lower levels of relative cost efficiency are achievable;
- 3) Medpac has demonstrated that the most efficient hospitals in the US (those facing broad financial constraint by both public and private payers) are currently about 9.0% below the US average cost per EIPA level;
- 4) Gradual improvement of approximately 1.25% per year relative to the US will help the system minimize an erosion of the Medicare waiver;
- 5) Improvement on an efficiency basis will result in improved relative affordability of hospital care in Maryland relative to the US, which will be vitally important in an era of massive health insurance expansion (other states such as Massachusetts, that have moved aggressively to expand access to health insurance without taking steps to improve system affordability, are in severe danger of not being able to sustain their access expansions);
- 6) Adopting a policy to improve vs. the nation in cost performance will require rate pressure. This rate pressure will provide stronger incentives for hospitals to reduce large and rapidly growing unregulated operating losses;
- 7) If the system underperforms and does not achieve the necessary year-to-year reductions – then the system will at least be moving in an appropriate direction, and the result will be consistent with current Commission policy (to be 3 to 6% below the US on Cost per EIPA).

It should be noted that both payer and hospital representatives believe that the EIPA calculation (which establishes a measure of hospital volume for outpatient services that is “equivalent” to inpatient volume on the basis of inpatient and outpatient revenue) contains distortions at a national level. Yet, payers and hospitals disagree on the direction of that distortion. The hospital representatives argue that high markups on hospital outpatient charges nationally result in artificially high EIPA counts, which make the US Cost per EIPA figure appear much lower than should actually be the case. Conversely, the Payer representatives believe that US hospitals mark up their inpatient charges more than they do their outpatient charges. This results in EIPAs being artificially understated. This would mean that Maryland's position vis-à-vis the US appears more favorable than is actually the case. Presentations from both parties on this issue are contained in **Appendix III**.

Staff does not believe it is possible to definitively confirm either theory. The staff proposal is merely advanced as a policy to improve from current levels vs. the nation. Doing so will help achieve the policy objectives stated above. Exhibit I provides a summary of the staff analysis, which will be discussed on Wednesday, June 9.

Exhibit I

Current Estimate & Forecast NOR, NPR and Cost per EIPA: Maryland vs Nation

Procedural Steps

- 1 - Used AHA data for 2000-2008 period
- 2 - Error found in University of MD submission for 2008 - adjustments made to MD data
- 3 - For 2009 - draft AHA and Disclosure per EIPA increase does not reconcile with 2009 Update or Monitoring MD performance 2009 (Update = 4.55% and MMP increase in CPC = 3.67%). FY 2009 Maryland growth estimated to be 3.67%
- 4 - FY 2010 - current MMP increase is 2.48% but update was 1.77%. FY 2010 growth estimated to be 2.0%
- 5 - National FY 2009 and FY 2010 growth based on Colorado interim data (adjusted for historical bias)

Colorado Adjustment (per AHA/CO ratio)

NOR				NPR				Cost			
	AHA	CO	Proportion AHA/CO		AHA	CO	Proportion AHA/CO		AHA	CO	Proportion AHA/CO
2003	6.66%	7.40%	90.00%	2003	6.59%	7.40%	89.05%	2003	6.69%	6.80%	98.38%
2004	5.39%	6.20%	86.94%	2004	5.57%	6.00%	92.83%	2004	5.25%	6.00%	87.50%
2005	5.24%	5.60%	93.57%	2005	5.43%	5.60%	96.96%	2005	5.01%	4.80%	104.38%
2006	5.06%	6.50%	77.85%	2006	4.80%	6.10%	78.69%	2006	5.12%	7.00%	73.14%
2007	5.37%	5.60%	95.89%	2007	5.34%	5.30%	100.75%	2007	4.85%	5.50%	88.18%
2008	3.86%	5.30%	72.83%	2008	3.99%	5.50%	72.55%	2008	4.50%	5.10%	88.24%
2009	3.96%	4.60%		2009	3.98%	4.50%		2009	4.05%	4.50%	
2010	2.93%	3.40%		2010	2.74%	3.10%		2010	1.80%	2.00%	
			86.18%				88.47%				89.97%

6 - Estimated MD current position (FY 2010) to be approximately at the National average on Cost/EIPA

7 - Looked at difference between NPR and MB (MB residual)

Market Basket vs. NPR Residual

		NPR	MB	Difference	Proportion
	2006	4.80%	3.90%	0.90%	123.11%
	2007	5.34%	3.38%	1.96%	158.03%
	2008	3.99%	3.59%	0.40%	111.24%
Estimate	2009	3.98%	3.23%	0.75%	123.26%
Estimate	2010	2.74%	1.91%	0.83%	143.60%
3 year difference 06-08				1.09%	130.79%
5 year difference				0.97%	131.85%

8 - Assumed US NPR annual increases based on projected MB 2011-2012 and future years (based on 3 year NPR/MB proportion)

		Estimated MB	Estimated NPR	Est US NPR per EIPA
Current	2011	2.30%	3.03%	\$11,265
Current	2012	2.90%	3.82%	\$11,696
Est	2013	3.00%	3.96%	\$12,158
Est	2014	3.00%	3.96%	\$12,639
Est	2015	3.00%	3.96%	\$13,139

Exhibit I (continued)

Generated Maryland Update magnitudes necessary to achieve proposed target over 5 years vis-a-vis the Nation

<u>Net Operating Revenue Per EIPA</u>						
	US		MD		Position	
	NOR/EIPA	Growth	NOR/EIPA	Growth	Above/Below	
2000	\$7,116		\$6,917		-2.80%	
2001	\$7,486	5.20%	\$7,291	5.41%	-2.60%	
2002	\$7,984	6.65%	\$7,624	4.57%	-4.51%	
2003	\$8,516	6.66%	\$7,982	4.70%	-6.27%	
2004	\$8,975	5.39%	\$8,563	7.28%	-4.59%	
2005	\$9,445	5.24%	\$9,041	5.58%	-4.28%	
2006	\$9,923	5.06%	\$9,679	7.06%	-2.46%	
2007	\$10,456	5.37%	\$10,353	6.96%	-0.99%	
2008	\$10,860	3.86%	\$10,857	4.87%	-0.03%	
2009	\$11,291	3.96% (1)	\$11,255	3.67% (3)	-0.31%	
2010	\$11,621	2.93% (2)	\$11,481	2.00% (3)	-1.21%	
2011	\$11,974	3.04%	\$11,700	1.91%	-2.29%	
2012	\$12,433	3.83%	\$11,982	2.41%	-3.63%	
2013	\$12,926	3.96%	\$12,281	2.49%	-4.99%	
2014	\$13,438	3.96%	\$12,587	2.49%	-6.33%	
2015	\$13,970	3.96%	\$12,901	2.49%	-7.65%	

<u>Net Patient Revenue Per EIPA</u>						
	US		MD		Position	
	NPR/EIPA	Growth	NPR/EIPA	Growth	Above/Below	
2000	\$6,689		\$6,620		-1.03%	
2001	\$7,035	5.17%	\$7,037	6.30%	0.03%	
2002	\$7,514	6.81%	\$7,350	4.45%	-2.18%	
2003	\$8,009	6.59%	\$7,698	4.73%	-3.88%	
2004	\$8,455	5.57%	\$8,259	7.29%	-2.32%	
2005	\$8,914	5.43%	\$8,684	5.15%	-2.58%	
2006	\$9,342	4.80%	\$9,276	6.82%	-0.71%	
2007	\$9,841	5.34%	\$9,893	6.65%	0.53%	
2008	\$10,234	3.99%	\$10,379	4.91%	1.42%	
2009	\$10,641	3.98% (1)	\$10,760	3.67% (3)	1.11%	
2010	\$10,933	2.74% (2)	\$10,975	2.00% (3)	0.38%	
2011	\$11,265	3.03% (4)	\$11,184	1.91% (5)	-0.72%	
2012	\$11,696	3.82% (4)	\$11,453	2.40%	-2.07%	
2013	\$12,158	3.96% (4)	\$11,738	2.49%	-3.46%	
2014	\$12,639	3.96% (4)	\$12,030	2.49%	-4.82%	
2015	\$13,139	3.96% (4)	\$12,329	2.49%	-6.17%	

<u>Cost per EIPA</u>						
	US		MD		Position	
	NPR/EIPA	Growth	NPR/EIPA	Growth	Above/Below	
2000	\$6,996		\$6,856		-2.00%	
2001	\$7,314	4.55%	\$7,188	4.84%	-1.72%	
2002	\$7,717	5.51%	\$7,496	4.28%	-2.86%	
2003	\$8,233	6.69%	\$7,824	4.38%	-4.97%	
2004	\$8,665	5.25%	\$8,339	6.58%	-3.76%	
2005	\$9,099	5.01%	\$8,767	5.13%	-3.65%	
2006	\$9,565	5.12%	\$9,381	7.00%	-1.92%	
2007	\$10,029	4.85%	\$10,028	6.90%	-0.01%	
2008	\$10,480	4.50%	\$10,486	4.57%	0.06%	
2009	\$10,904	4.05% (1)	\$10,871	3.67% (3)	-0.31%	
2010	\$11,101	1.80% (2)	\$11,088	2.00% (3)	-0.11%	
2011	\$11,415	2.83%	\$11,290	1.82%	-1.09%	
2012	\$11,823	3.57%	\$11,549	2.30%	-2.31%	
2013	\$12,260	3.70%	\$11,823	2.37%	-3.56%	
2014	\$12,713	3.70%	\$12,104	2.37%	-4.79%	
2015	\$13,182	3.70%	\$12,392	2.37%	-6.00% (5)	

MB
2.30%
2.90%
3.00%
3.00%
3.00%

Notes:

- (1) Adjusted Colorado (adjusted by proportion of AHA to CO rates of growth historically)
- (2) Adjusted Colorado 6 months 2010
- (3) Estimated FY 2009 and FY 2010 based on Monitoring MD Performance
- (4) Projected US based on NPR as proportion of MB (historical)
- (5) Targeting -6.0% below US over five years on Cost - this would require an update of around 1.91% in FY 2010 in order to initiate a trajectory sufficient for the system to reach its goal by FY 2015

Exhibit I shows that to initiate a trajectory sufficient to position the Maryland system to achieve a target of 6.0% below the US by FY 2015 would require an update of approximately 1.9-2.0% for FY 2011.

Summary of Current Rate Proposals and Options

The table below summarizes the current hospital and payer proposals for an update to both inpatient and outpatient hospital rates for FY 2011. The table also shows three other options based on: 1) an Update that would result in no further erosion on the Medicare waiver test for FY 2010; 2) an Update magnitude that would not result in further assessments (in excess of the currently budgeted \$123 million in assessments for FY 2011) on hospitals and payers by Medicaid; and 3) an option based on a policy goal of achieving a level of 6.0% below the US on the basis of Cost per EIPA by FY 2015. The table also shows the difference (in both percent and dollar terms) between the various options.

Staff anticipates delivering a final recommendation to the Commission during the special session of the HSCRC scheduled for June 24, 2010.

Comparison of current MHA, Payer One-Year Proposals and other Update Options⁵

	Option 1 Steady on <u>Waiver Test</u>	Option 2 Payer <u>Proposal</u>	Option 3 Update for trajectory position of 6.0% below <u>US Cost/EIPA</u>	Option 4 Peg" Medicaid Budgeted <u>Update</u>	Option 5 MHA <u>Proposal</u>
Global Insight's - 1st Qtr Book for RY 6/30/11	2.29%	2.29%	2.29%	2.29%	2.29%
Inflation Forecast Error	<u>0.38%</u>	<u>0.38%</u>	<u>0.38%</u>	<u>0.38%</u>	<u>0.38%</u>
Subtotal Inflation Allowance	2.67%	2.67%	2.67%	2.67%	2.67%
Policy Adjustment (Improvement to US)	<u>-2.65%</u>	<u>-1.85%</u>	<u>-1.29%</u>	<u>-1.04%</u>	<u>-0.10%</u>
Subtotal Update	0.02%	0.80%	1.38%	1.63%	2.57%
Slippage For RY 2010	<u>0.03%</u>	<u>0.03%</u>	<u>0.03%</u>	<u>0.03%</u>	<u>0.03%</u>
Rate Update Provided	0.05%	0.83%	1.41%	1.66%	2.60%
Volume Adjustment (RY 2010 over RY 2009)	-0.26%	-0.26%	-0.26%	-0.26%	-0.26%
CMI Adjustment (Lower of Actual or Limit)	0.75%	0.98%	0.75%	0.75%	<u>0.94%</u>
Full Update Provided	0.54%	1.58%	1.91%	2.16%	3.28%
Estimated Volume Increase (RY 2011)	1.41%	1.41%	1.41%	1.41%	1.31%
Overall expected increase in Hospital Revenue	1.95%	2.98%	3.31%	3.56%	4.64%
Difference between Option 2 & Option 5 (Payer Update Proposal vs. MHA Update Proposal)		Pct Difference	1.71%		\$230.4 million
Difference between Option 1 & Option 5 (No erosion on waiver vs. MHA Update Proposal)		Pct Difference	2.74%		\$370.0 million

⁵ It should be noted that at the last Payment Work Group meeting, the hospital and payer representatives were discussing a compromise proposal related to the level of case mix afforded hospitals for both inpatient and outpatient case mix change. The hospital representatives requested a higher cap on outpatient case mix in exchange for a lower cap on inpatient case mix. Payer representatives have recently revised their overall update proposal to reflect a 0.75% cap (changed from 1.0%) on inpatient case mix and a 1.35% cap (changed from 1.0%) on outpatient case mix.

Appendix I – Payer Scaling Proposal and Simulation

TOTAL OF QBR, MHAC AND ROC ADJUSTMENTS BY HOSPITAL (PAYER PROPOSAL)

HOSPID	HOSPITAL NAME	QUALITY BASED REIMBURSEMENT SCALED ALLOWANCE	MHAC SCALED REVENUE NEUTRAL ADJUSTMENT	ROC SCALED REVENUE NEUTRAL ADJUSTMENT	TOTAL OF ADJUSTMENTS
210017	Garrett County Memorial Hospital	-0.012%	0.230%	2.843%	3.061%
210010	Dorchester General Hospital	0.000%	-0.130%	1.677%	1.547%
210032	Union of Cecil	0.018%	-0.100%	1.592%	1.510%
210039	Calvert Memorial Hospital	-0.013%	0.210%	1.257%	1.454%
210060	Fort Washington Medical Center	-0.004%	0.500%	0.764%	1.260%
210037	Memorial Hospital at Easton	-0.032%	0.130%	1.099%	1.197%
210038	Maryland General Hospital	-0.048%	0.500%	0.625%	1.077%
210008	Mercy Medical Center	0.024%	0.310%	0.516%	0.850%
210005	Frederick Memorial Hospital	0.013%	0.210%	0.609%	0.832%
210034	Harbor Hospital Center	0.014%	0.070%	0.616%	0.700%
210001	Washington County Hospital	0.013%	-0.160%	0.823%	0.676%
210011	St. Agnes Hospital	-0.020%	0.070%	0.577%	0.627%
210033	Carroll Hospital Center	0.018%	0.260%	0.210%	0.488%
210015	Franklin Square Hospital Center	0.018%	0.230%	0.237%	0.485%
210029	Johns Hopkins Bayview Medical Center	0.000%	0.060%	0.371%	0.431%
210045	McCready Memorial Hospital	-0.027%	0.390%	0.000%	0.363%
210056	Good Samaritan Hospital	0.010%	-0.010%	0.362%	0.362%
210028	St. Mary's Hospital	0.020%	0.150%	0.122%	0.292%
210004	Holy Cross Hospital	0.025%	0.050%	0.208%	0.283%
210049	Upper Chesapeake Medical Center	0.024%	-0.010%	0.258%	0.272%
210023	Anne Arundel Medical Center	-0.027%	-0.040%	0.282%	0.215%
210044	GBMC	0.014%	0.200%	-0.049%	0.165%
210019	Peninsula Regional Medical Center	-0.024%	0.190%	-0.012%	0.154%
210013	Bon Secours Hospital	-0.082%	0.120%	0.000%	0.038%
210043	Baltimore Washington Medical Center	0.024%	0.070%	-0.121%	-0.027%
210022	Suburban Hospital	0.002%	0.080%	-0.165%	-0.083%
210035	Civista Medical Center	0.005%	-0.420%	0.311%	-0.104%
210058	James Lawrence Kernan Hospital	0.000%	0.210%	-0.340%	-0.130%
210018	Montgomery General Hospital	0.015%	0.090%	-0.300%	-0.195%
210027	Western Maryland Medical Center	-0.015%	0.310%	-0.512%	-0.217%
210057	Shady Grove Adventist Hospital	0.006%	-0.100%	-0.124%	-0.218%
210040	Northwest Hospital Center	-0.037%	0.110%	-0.371%	-0.298%
210055	Laurel Regional Hospital	-0.049%	-0.230%	-0.024%	-0.303%
210024	Union Memorial Hospital	0.010%	0.210%	-0.570%	-0.350%
210002	University of Maryland Hospital	-0.010%	-0.410%	0.041%	-0.379%
210012	Sinai Hospital	0.008%	-0.140%	-0.261%	-0.393%
210006	Harford Memorial Hospital	0.034%	-0.110%	-0.408%	-0.484%
210061	Atlantic General Hospital	0.015%	0.110%	-0.616%	-0.491%
210054	Southern Maryland Hospital Center	-0.007%	0.360%	-0.853%	-0.500%
210007	St. Joseph Medical Center	0.020%	0.060%	-0.581%	-0.501%
210009	Johns Hopkins Hospital	0.008%	-0.070%	-0.462%	-0.524%
210003	Prince Georges Hospital Center	-0.060%	-0.500%	0.026%	-0.534%
210048	Howard County General Hospital	0.026%	-0.240%	-0.484%	-0.698%
210016	Washington Adventist Hospital	-0.001%	-0.260%	-0.528%	-0.789%
210051	Doctors Community Hospital	-0.040%	-0.500%	-0.584%	-1.124%
210030	Chester River Hospital Center	-0.025%	-0.500%	-1.131%	-1.656%

Appendix II – Hospital Scaling Proposal and Simulation

Summary of Scaling Options

<u>Option</u>	<u>ROC SCALING RANGE</u>	<u># OF HOSPITALS</u>			<u>TOTAL SCALING RANGE</u>	<u># OF HOSPITALS</u>		<u># OF HOSPITALS</u>	
		<u>NEGATIVE/POSITIVE</u> <u>ROC SCALING</u>	<u>AMOUNT OF ROC</u> <u>SCALING</u>	<u>NEGATIVE/POSITIVE</u> <u>TOTAL SCALING</u>		<u>CAPPED AT 30%</u> <u>OF CORE UPDATE</u>	<u>CAPPED</u>	<u>AMOUNT</u>	<u>CAPPED AT 20% OF</u> <u>CORE UPDATE</u>
2% corridor	(.37)% TO 1.14%	17/12	7,581,213	(.81)% TO 1.06%	17/27	1	75,962	4	859,046

Hospital	FY 2010 Total Patient Revenue	FY 2010 QBR Scaling (-0.02% to 0.034%)		MHAC Scaling 0.5% continuous		Combined QBR and MHAC		10% Positive Scaling/2% corridors		Required Negative Scaling		Combined Scaling %	Combined Scaling \$	
		%	Revenue Impact	%	Revenue Impact	%	Revenue Impact	%	\$	%	\$			
								Difference (Over/Under)						
								Performance						
Anne Arundel Medical Center	403,932,357	-0.027%	(107,592)	-0.04%	(171,430)	-0.07%	(279,022)	-4.72%	2.72%	0.27%	1,098,696	-	819,674	
Atlantic General Hospital	85,483,812	0.015%	13,066	0.11%	91,645	0.12%	104,711	4.33%	-2.33%	-0.23%	0	-	(41,206)	
Baltimore Washington Medical Center	331,727,439	0.024%	78,348	0.07%	224,390	0.09%	302,738	-1.92%	-	-	-	-	302,738	
Bon Secours Hospital	126,047,615	-0.082%	(102,854)	0.12%	151,220	0.04%	48,366	6.55%	-4.55%	0.00%	0	-	48,366	
Calvert Memorial Hospital	119,677,445	-0.013%	(15,934)	0.21%	253,552	0.20%	237,618	-6.44%	4.44%	0.44%	531,368	-	768,986	
Carroll Hospital Center	201,818,957	0.018%	35,802	0.26%	528,035	0.28%	563,837	-1.93%	0.00%	0.00%	0	-	563,837	
Chester River Hospital Center	62,685,871	-0.025%	(15,543)	-0.50%	(313,429)	-0.52%	(328,972)	3.31%	-1.31%	-0.13%	0	-0.10%	(60,160)	
Civista Medical Center	109,824,091	0.005%	5,634	-0.42%	(455,901)	-0.41%	(450,267)	-2.89%	0.89%	0.09%	97,743	-	(352,524)	
Doctors Community Hospital	189,905,225	-0.040%	(75,883)	-0.50%	(949,526)	-0.54%	(1,025,409)	5.74%	-3.74%	-0.37%	0	-0.27%	(520,326)	
Dorchester General Hospital	52,554,971	0.000%	-	-0.13%	(70,399)	-0.13%	(70,399)	-13.36%	11.36%	1.14%	597,024	-	(1,545,735)	
Fort Washington Medical Center	45,612,809	-0.004%	(1,764)	0.50%	228,064	0.50%	226,300	-1.05%	-	-	0	-	526,626	
Franklin Square Hospital Center	420,146,599	0.018%	75,648	0.23%	949,119	0.24%	1,024,767	-1.56%	-	-	0	-	226,300	
Frederick Memorial Hospital	279,196,033	0.013%	35,206	0.21%	573,696	0.22%	608,902	-5.68%	3.68%	0.37%	1,027,441	-	1,024,767	
Garrett County Memorial Hospital	41,649,804	-0.012%	(5,118)	0.23%	97,277	0.22%	92,159	-10.43%	8.43%	0.84%	351,108	-	443,267	
GBMC	409,202,288	0.014%	56,885	0.20%	835,612	0.22%	892,497	3.07%	-1.07%	-0.11%	0	-0.08%	(320,766)	
Good Samaritan Hospital	295,026,237	0.010%	29,311	-0.01%	(27,390)	0.00%	1,921	-0.52%	-	-	0	-	1,921	
Harbor Hospital Center	193,053,833	0.014%	26,837	0.07%	125,659	0.08%	152,497	-4.23%	2.23%	0.22%	430,510	-	583,007	
Harford Memorial Hospital	98,065,261	0.034%	33,086	-0.11%	(107,950)	-0.08%	(74,864)	4.19%	-2.19%	-0.22%	0	-0.16%	(157,335)	
Holy Cross Hospital	413,717,947	0.025%	102,293	0.05%	200,648	0.07%	302,941	-1.07%	-	-	0	-	302,941	
Howard County General Hospital	242,845,664	0.026%	63,468	-0.24%	(582,958)	-0.21%	(519,490)	3.24%	-1.24%	-0.12%	0	-0.09%	(220,607)	
James Lawrence Kernan Hospital	86,232,000	0.000%	-	0.21%	178,291	0.21%	178,291	1.95%	-	-	0	-	178,291	
Johns Hopkins Bayview Medical Center	514,972,000	0.000%	1,974	0.06%	322,052	0.06%	324,027	-1.82%	-	-	0	-	324,027	
Johns Hopkins Hospital	1,703,904,363	0.008%	129,195	-0.07%	(1,242,901)	-0.07%	(1,113,706)	4.38%	-2.38%	-0.24%	0	-0.17%	(2,970,907)	
Laurel Regional Hospital	100,621,347	-0.049%	(49,319)	-0.23%	(234,872)	-0.28%	(284,191)	5.33%	-3.33%	-0.33%	0	-0.24%	(245,472)	
Maryland General Hospital	175,267,604	-0.048%	(84,018)	0.50%	876,338	0.45%	792,320	-3.98%	1.98%	0.20%	347,030	-	1,139,350	
McCready Memorial Hospital	18,410,616	-0.027%	(4,904)	0.39%	71,431	0.36%	66,527	52.27%	-48.84%	-	\$	-	66,527	
Memorial Hospital at Easton	160,182,101	-0.032%	(51,500)	0.13%	202,393	0.09%	150,893	-9.85%	7.85%	0.79%	1,257,429	-	1,408,322	
Mercy Medical Center	385,288,000	0.024%	92,509	0.31%	1,190,002	0.33%	1,282,510	-2.86%	0.86%	0.09%	331,348	-	1,613,858	
Montgomery General Hospital	148,061,457	0.015%	22,908	0.09%	134,167	0.11%	157,076	4.77%	-2.77%	-0.28%	0	-0.20%	(300,461)	
Northwest Hospital Center	225,618,871	-0.037%	(83,322)	0.11%	244,760	0.07%	161,438	4.18%	-2.18%	-0.22%	0	-0.16%	(380,329)	
Peninsula Regional Medical Center	390,852,887	-0.024%	(93,515)	0.19%	738,281	0.16%	644,767	0.79%	-	-	0	-	644,767	
Prince Georges Hospital Center	250,314,383	-0.060%	(151,083)	-0.50%	(1,251,572)	-0.56%	(1,402,655)	2.44%	-0.44%	-0.04%	0	-0.03%	(80,687)	
Shady Grove Adventist Hospital	335,908,624	0.006%	21,482	-0.10%	(351,947)	-0.10%	(330,464)	-0.24%	-	-	0	-	(330,464)	
Sinai Hospital	614,559,847	0.008%	46,598	-0.14%	(872,121)	-0.13%	(825,523)	3.05%	-1.05%	-0.11%	0	-0.08%	(472,738)	
Southern Maryland Hospital Center	218,169,873	-0.007%	(15,951)	0.36%	779,650	0.35%	763,699	3.46%	-1.46%	-0.15%	0	-0.11%	(233,354)	
St. Agnes Hospital	350,435,009	-0.020%	(69,804)	0.07%	245,990	0.05%	176,186	-0.72%	-	-	0	-	176,186	
St. Joseph Medical Center	376,512,116	0.020%	76,302	0.06%	216,241	0.08%	292,543	3.82%	-1.82%	-0.18%	0	-0.13%	(502,016)	
St. Mary's Hospital	110,358,536	0.020%	22,365	0.15%	167,610	0.17%	189,975	1.31%	-	-	0	-	189,975	
Suburban Hospital	228,793,491	0.002%	3,654	0.08%	175,203	0.08%	178,857	3.99%	-1.99%	-0.20%	0	-0.15%	(333,552)	
Union Memorial Hospital	394,574,151	0.010%	39,201	0.21%	830,920	0.22%	870,121	1.37%	-	-	0	-	870,121	
Union of Cecil	125,953,316	0.018%	22,344	-0.10%	(121,944)	-0.08%	(99,600)	-6.15%	4.15%	0.42%	522,706	-	423,106	
University of Maryland Hospital	997,798,580	-0.010%	(95,348)	-0.41%	(4,115,588)	-0.42%	(4,210,936)	-0.02%	-	-	0	-	(4,210,936)	
Upper Chesapeake Medical Center	221,072,232	0.024%	53,080	-0.01%	(29,320)	0.01%	23,760	0.46%	-	-	0	-	23,760	
Washington Adventist Hospital	286,850,029	-0.001%	(2,406)	-0.26%	(753,267)	-0.26%	(755,672)	4.71%	-2.71%	-0.27%	0	-0.20%	(569,497)	
Washington County Hospital	250,331,355	0.013%	32,646	-0.16%	(398,405)	-0.15%	(365,760)	-5.95%	3.95%	0.40%	988,809	-	623,049	
Western Maryland Medical Center	275,273,123	-0.015%	(41,291)	0.31%	853,347	0.30%	812,056	2.43%	-0.43%	-0.04%	0	-0.03%	(86,716)	
Statewide Total	\$ 12,579,074,000	0.000%	\$ 52,691	0.00%	\$ (565,325)	0.00%	(512,634)				0.08%	7,581,213	-0.06%	\$ (7,580,840)

*Entry for Braddock hospital uses Braddock's QBR and MHAC adjustments with Western Maryland Health System's ROC

Appendix III – Payer and Hospital Presentations on Distortions in EIPA calculations

MARYLAND VS. UNITED STATES: INPATIENT AND OUTPATIENT
COMPARISONS – MOST RECENT AHA DATA (2008)

As reported:

	<u>Inpatient Charge per Admission</u>	<u>Outpatient Charge per Visit</u>	<u>Ratio</u>
MD	\$12,590	\$609	20.7
U.S.	\$30,497	\$1,141	26.7

Inpatient: Maryland is 41.3% of U.S.
Maryland is lowest charging state.
Next lowest charging state is 32.0% above Maryland.
Four states (PA, NE, CA, NJ) and DC have charges >3times MD.

Outpatient: Maryland is 53.4% of U.S.
One state has lower charge than Maryland.
Maryland is 2.2% higher than lowest state.
No state has charges more than 3 times Maryland.

EIPA ratio: In Maryland, it takes 22.5% fewer outpatient visits to equal an EIPA.
Eleven states are below Maryland and 38 states and District are above.

OUTPATIENT VISITS PER EQUIVALENT ADMISSION
U.S. V. MD BY TIME PERIODS

1974 – 1988

<u>U.S.</u>	<u>MD</u>	<u>AVE. RATIO</u>
37.7	38.7	2.5% above

1989 – 2000

<u>U.S.</u>	<u>MD</u>	<u>AVE. RATIO</u>
31.5	24.9	21.0% below

2001 – 2004

<u>U.S.</u>	<u>MD</u>	<u>AVE. RATIO</u>
29.6	20.9	29.4% below

2005 - 2007

<u>U.S.</u>	<u>MD</u>	<u>AVE. RATIO</u>
28.6	19.8	31.0% below

2008

<u>U.S.</u>	<u>MD</u>	<u>AVE. RATIO</u>
26.7	20.7	22.5% below

Average Inpatient Charge per Admission

<u>State</u>	<u>2008 Inpt. Chg./Adm.</u>
U.S	30497.07
Maryland	12590.28
North Dakota	16622.93
West Virginia	17368.79
Vermont	17607.15
Montana	17991.07
Wyoming	18087.89
Idaho	18875.16
Iowa	19214.42
Maine	20478.82
Arkansas	21934.32
Wisconsin	22051.27
S. Dakota	22456.49
North Carolina	22740.83
Oregon	22782.93
Kentucky	22841.85
Delaware	23002.66
Utah	23978.94
Michigan	24443.59
Louisiana	24513.64
Oklahoma	25399.09
Kansas	25426.62
Indiana	25573.19
Mississippi	25625.65
Georgia	26204.02
Minnesota	26534.93
Rhode Island	26553.30
Alabama	26819.43
Massachusetts	26925.10
Missouri	27004.15
Ohio	27068.12
New Hampshire	27847.76
Nebraska	27906.53
Tennessee	27942.48
Illinois	28300.41
Virginia	28351.06
New Mexico	28452.24
Connecticut	28665.65
Hawaii	28833.52
New York	30121.89
Washington	30892.05
S. Carolina	31658.55
Arizona	33068.14
Florida	33449.79
Texas	33701.45
Alaska	35141.81
Colorado	36856.18
Penn.	38365.05
Nevada	40989.62
Dis.Col.	41425.96
California	43441.43
New Jersey	50628.49

Average Outpatient Charge per Visit

<u>State</u>	<u>2008 Outpt. Chg./Visit</u>
U.S	1140.72
Montana	595.87
Maryland	608.76
Vermont	610.19
Iowa	675.18
Maine	676.76
West Virginia	684.95
Oregon	748.22
Utah	765.35
Wyoming	794.17
New York	821.74
Idaho	833.64
Missouri	924.94
Wisconsin	926.70
Delaware	933.66
Louisiana	935.66
Nebraska	940.04
Michigan	946.03
Indiana	953.39
Alaska	958.57
New Mexico	963.92
Kansas	971.66
New Hampshire	995.16
S. Dakota	1009.31
Connecticut	1040.58
Ohio	1067.41
Massachusetts	1088.20
Illinois	1115.71
North Carolina	1117.09
Arkansas	1119.75
Penn.	1142.88
North Dakota	1152.19
Rhode Island	1164.57
New Jersey	1168.08
Kentucky	1186.48
Washington	1200.53
Dis.Col.	1203.49
Minnesota	1204.84
Hawaii	1230.69
Virginia	1280.04
Georgia	1296.71
Alabama	1325.03
Colorado	1349.17
Oklahoma	1366.66
Tennessee	1398.79
Texas	1431.02
Mississippi	1499.35
California	1521.30
Arizona	1568.25
Nevada	1593.76
S. Carolina	1732.93
Florida	1810.27

EIPA Conversion

<u>State</u>	<u>2008 Inpt. Chg./Adm.</u>	<u>2008 Outpt. Chg./Visit</u>	<u>EIPA Conversion</u>
U.S	30497.07	1140.72	26.74
North Dakota	16622.93	1152.19	14.43
Mississippi	25625.65	1499.35	17.09
S. Carolina	31658.55	1732.93	18.27
Florida	33449.79	1810.27	18.48
Oklahoma	25399.09	1366.66	18.58
Kentucky	22841.85	1186.48	19.25
Arkansas	21934.32	1119.75	19.59
Tennessee	27942.48	1398.79	19.98
Georgia	26204.02	1296.71	20.21
Alabama	26819.43	1325.03	20.24
North Carolina	22740.83	1117.09	20.36
Maryland	12590.28	608.76	20.68
Arizona	33068.14	1568.25	21.09
Minnesota	26534.93	1204.84	22.02
Virginia	28351.06	1280.04	22.15
S. Dakota	22456.49	1009.31	22.25
Idaho	18875.16	833.64	22.64
Wyoming	18087.89	794.17	22.78
Rhode Island	26553.30	1164.57	22.80
Hawaii	28833.52	1230.69	23.43
Texas	33701.45	1431.02	23.55
Wisconsin	22051.27	926.70	23.80
Delaware	23002.66	933.66	24.64
Massachusetts	26925.10	1088.20	24.74
West Virginia	17368.79	684.95	25.36
Ohio	27068.12	1067.41	25.36
Illinois	28300.41	1115.71	25.37
Nevada	40989.62	1593.76	25.72
Washington	30892.05	1200.53	25.73
Michigan	24443.59	946.03	25.84
Kansas	25426.62	971.66	26.17
Louisiana	24513.64	935.66	26.20
Indiana	25573.19	953.39	26.82
Colorado	36856.18	1349.17	27.32
Connecticut	28665.65	1040.58	27.55
New Hampshire	27847.76	995.16	27.98
Iowa	19214.42	675.18	28.46
California	43441.43	1521.30	28.56
Vermont	17607.15	610.19	28.86
Missouri	27004.15	924.94	29.20
New Mexico	28452.24	963.92	29.52
Nebraska	27906.53	940.04	29.69
Montana	17991.07	595.87	30.19
Maine	20478.82	676.76	30.26
Oregon	22782.93	748.22	30.45
Utah	23978.94	765.35	31.33
Penn.	38365.05	1142.88	33.57
Dis.Col.	41425.96	1203.49	34.42
New York	30121.89	821.74	36.66
Alaska	35141.81	958.57	36.66
New Jersey	50628.49	1168.08	43.34



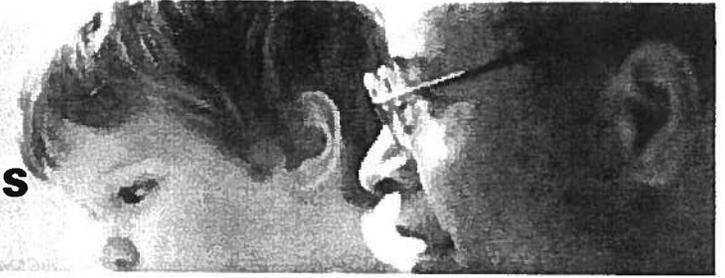
Maryland Hospital Association

Discussion of National Per Unit Comparisons

May 27, 2010

Maryland Hospital Association

Discussion of National Per Unit Comparisons



- ◆ The comparison of Cost, NOR and NPR per EIPA statistics between the US and Maryland have been acknowledged by most, if not all, parties to be of limited use and challenged with many and significant data issues, including:
 1. Computation of EIPAs – highly dependent and clearly manipulated by state and regional inpatient and outpatient charging practices.
 2. The AHA data base integrity both in terms of reporting entities and accuracy of inpatient and outpatient revenues.
 3. Use of NPR which excludes additional governmental funding that other national facilities receive that Maryland hospitals generally do not.
- ◆ In regard to EIPAs, Dr. Graham Atkinson in his October 2009 article titled “State Hospital Rate-Setting Revisited” in The Commonwealth Fund, commented:

“Although the use of EIPAs as a measure of hospital production is common, it makes an implicit assumption that inpatient and outpatient costs are proportional to inpatient and outpatient charges. This has become less true over time, as hospitals have differentially increased charges to inpatient and outpatient services in response to various incentives in the payment systems.”

Maryland Hospital Association

Discussion of National Per Unit Comparisons



- ◆ The HSCRC has recently reported the EIPA unit comparisons modifying the published AHA data for the following:
 1. Price leveling of Maryland data since most of Maryland hospitals are June 30 year ends.
 2. Use of only Maryland hospital survey results rather than the entire State data. *excludes some bad hospitals.*
- ◆ While the current adjustments may have some merit, these cause questionable data comparisons to the unadjusted national data. More importantly, many of the more critical data integrity issues are not addressed, including:
 1. Adjustments for EIPA conversion factor discrepancies.
 2. Wage factor, cost of living, case-mix and population differences.
- ◆ Without a more comprehensive adjustment methodology, the AHA comparison results should remain as reported in the AHA guide.

Maryland Hospital Association

Comparison of HSCRC "Adjusted" and AHA Published Data

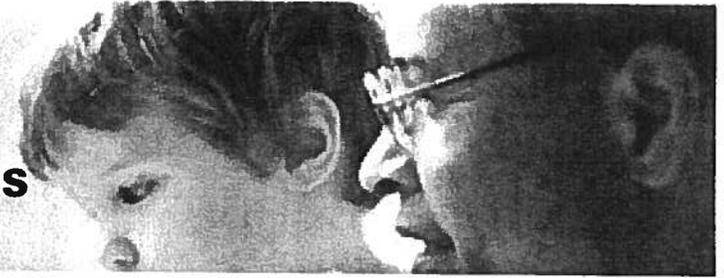


2008 Comparison

	HSCRC "Adjusted"	AHA Published	Comments
Net Operating Revenue Per EIPA	(0.03%)	(3.30%)	Accepted by HSCRC as the most appropriate statistic for comparison purposes
Net Patient Revenue Per EIPA	1.42%	(1.46%)	Comparative issues excludes: other states additional funding amounts not present in Maryland
Cost Per EIPA	0.06%	(3.00%)	Cost not revenue / payment comparison: HSCRC regulates charges not costs

Maryland Hospital Association

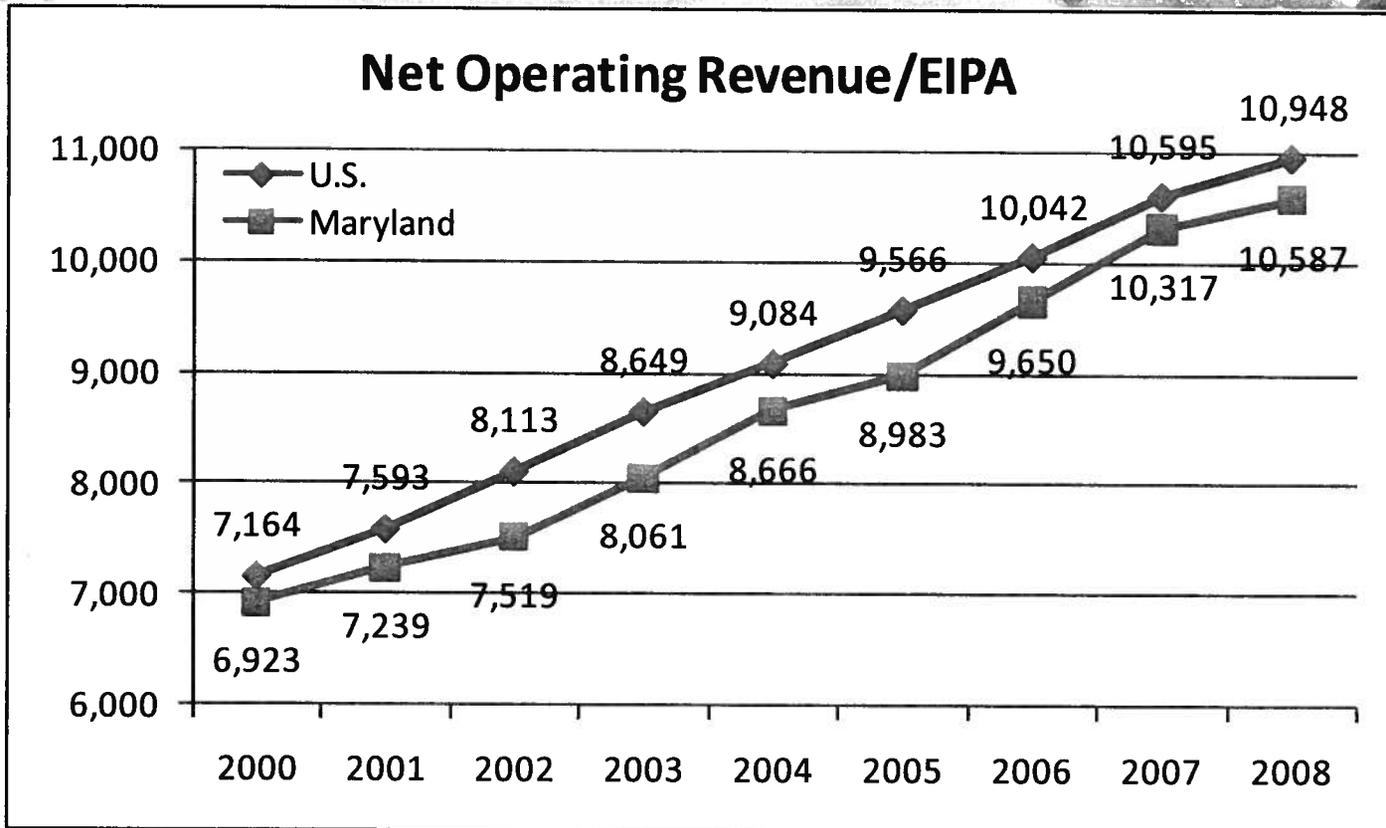
Discussion of National Per Unit Comparisons



- ◆ Finally and most importantly, the National Per Unit Comparisons are not relevant nor appropriate in this new era of healthcare transformation. The current and emerging focus on utilization and admissions / readmissions reductions does not correlate with a per unit analysis.
- ◆ Again in Dr. Atkinson's article, he suggests:

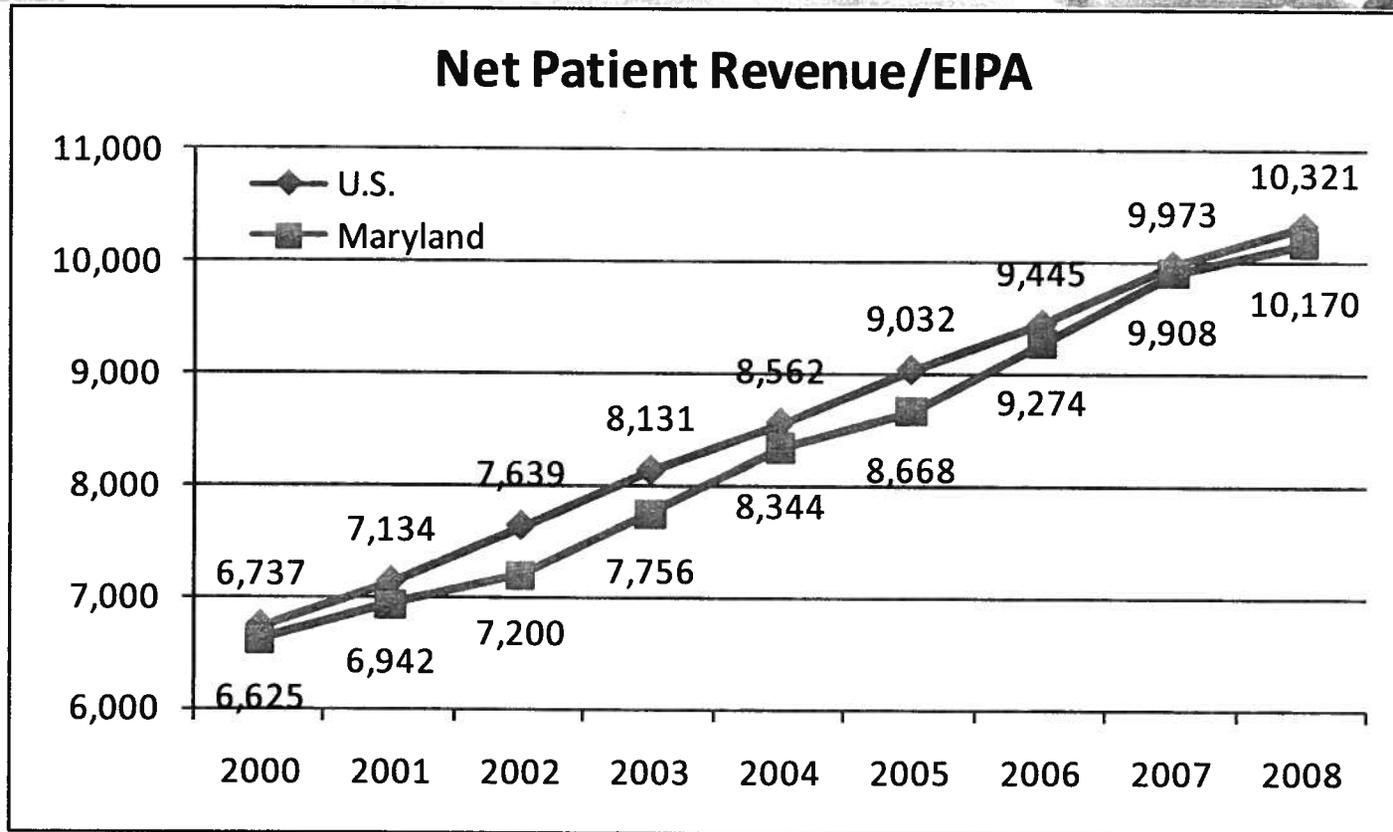
“Ideally, rate-setting approaches would be comprehensive, including both inpatient and outpatient activities as a “package.” An advantage of such an approach, or even of regulation of EIPAs rather than inpatient rates alone, is that it would encourage substitution of different types of care for traditional inpatient care and potentially encourage greater efficiency in the use of health care resources.”

Maryland Hospital Association Comparison of Maryland vs. U.S. 2000-2008



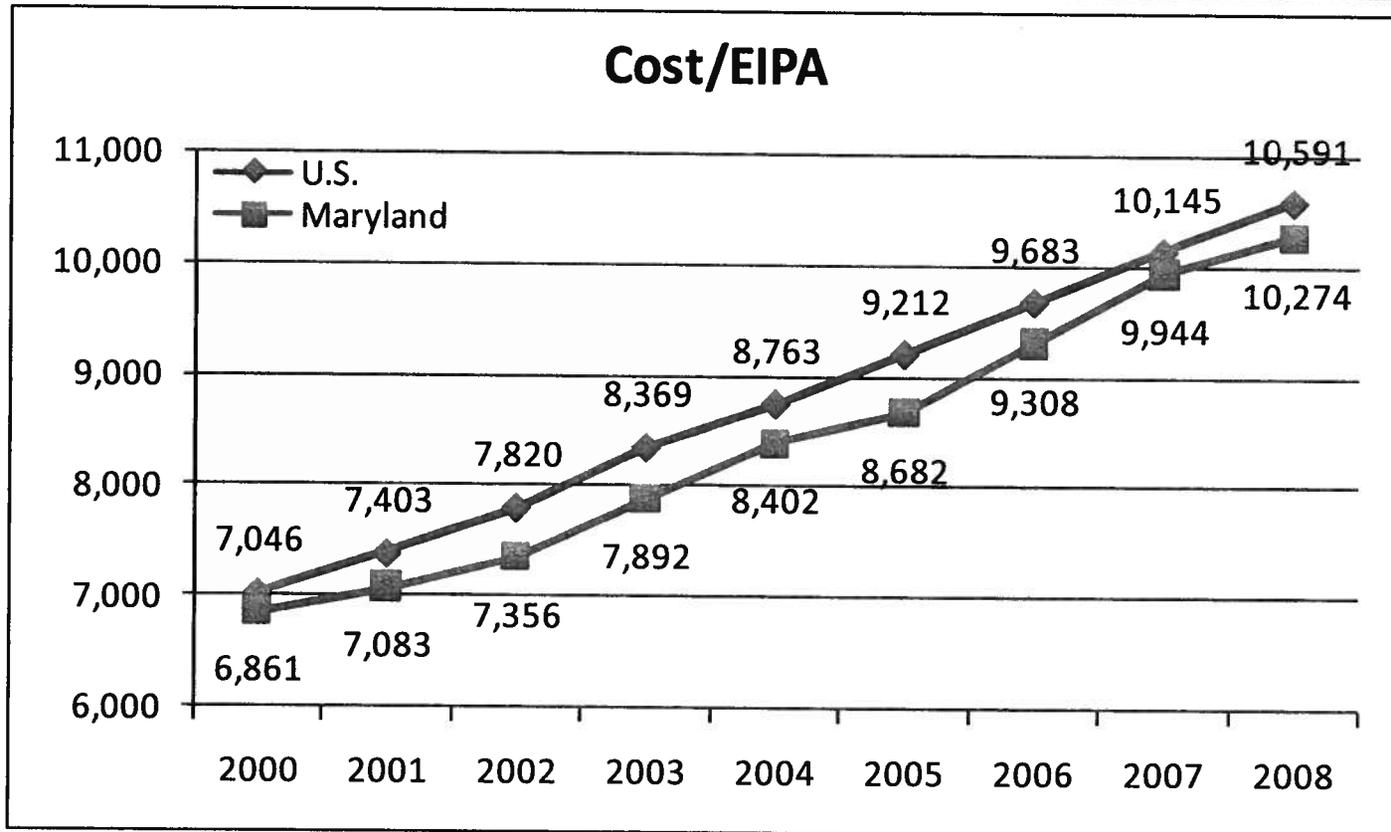
Net Operating Revenue per EIPA	2000	2001	2002	2003	2004	2005	2006	2007	2008
U.S.	\$ 7,164	\$ 7,593	\$ 8,113	\$ 8,649	\$ 9,084	\$ 9,566	\$10,042	\$10,595	\$10,948
Maryland	6,923	7,239	7,519	8,061	8,666	8,983	9,650	10,317	10,587
<i>Percent Difference - MD vs. U.S.</i>	-3.36%	-4.66%	-7.32%	-6.80%	-4.60%	-6.09%	-3.91%	-2.62%	-3.30%

Maryland Hospital Association Comparison of Maryland vs. U.S. 2000-2008



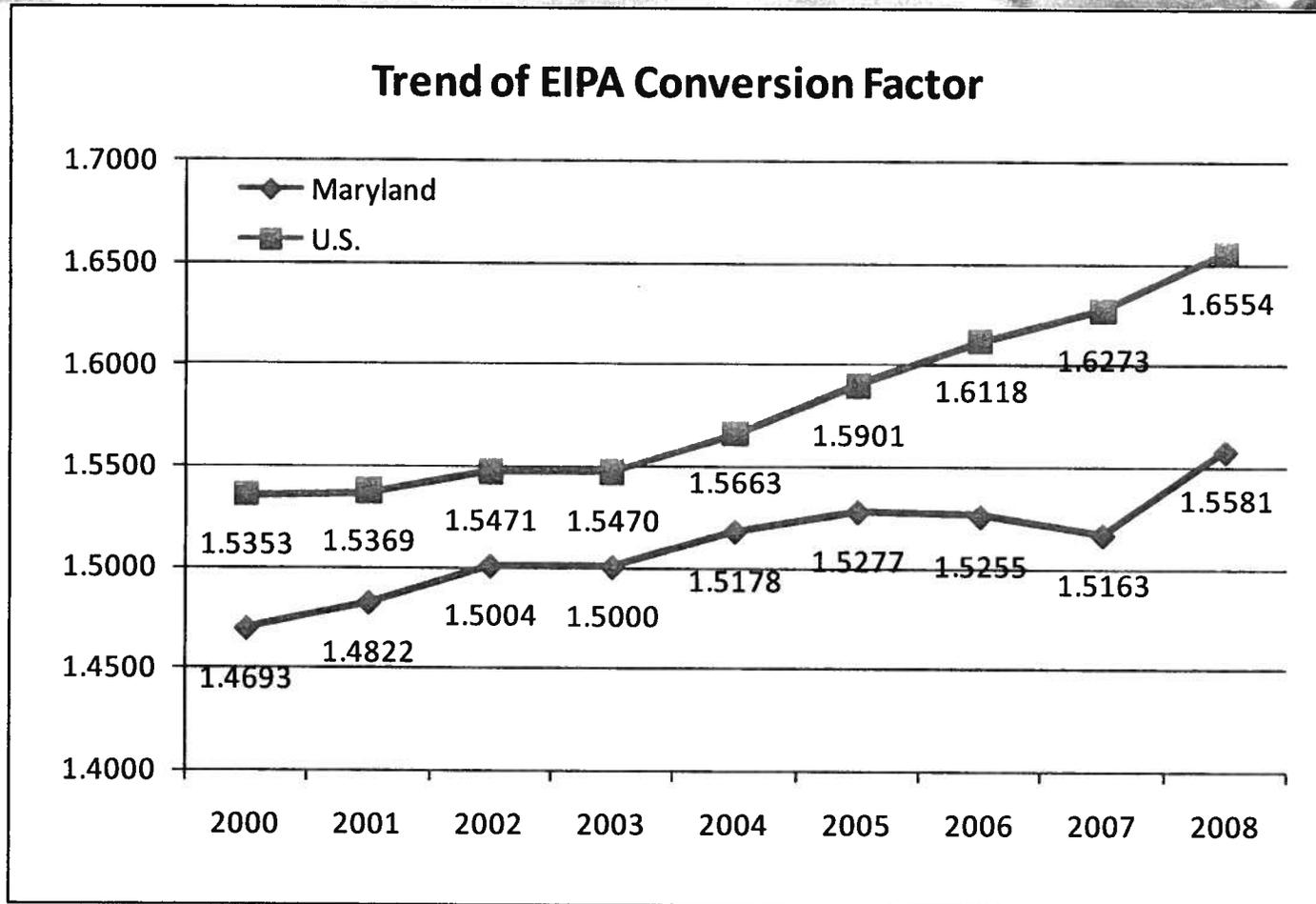
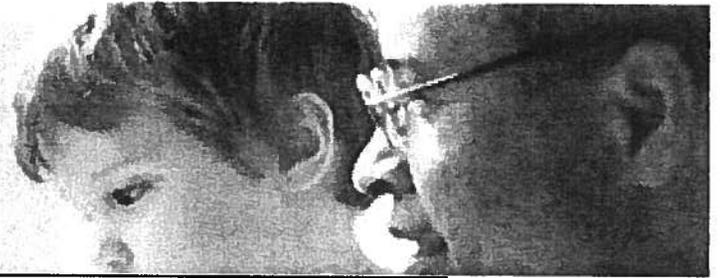
Net Patient Revenue per EIPA	2000	2001	2002	2003	2004	2005	2006	2007	2008
U.S.	\$ 6,737	\$ 7,134	\$ 7,639	\$ 8,131	\$ 8,562	\$ 9,032	\$ 9,445	\$ 9,973	\$10,321
Maryland	6,625	6,942	7,200	7,756	8,344	8,668	9,274	9,908	10,170
<i>Percent Difference - MD vs. U.S.</i>	-1.66%	-2.69%	-5.75%	-4.61%	-2.55%	-4.03%	-1.81%	-0.65%	-1.46%

Maryland Hospital Association Comparison of Maryland vs. U.S. 2000-2008



Cost per EIPA	2000	2001	2002	2003	2004	2005	2006	2007	2008
U.S.	\$ 7,046	\$ 7,403	\$ 7,820	\$ 8,369	\$ 8,763	\$ 9,212	\$ 9,683	\$10,145	\$10,591
Maryland	6,861	7,083	7,356	7,892	8,402	8,682	9,308	9,944	10,274
<i>Percent Difference - MD vs. U.S.</i>	-2.61%	-4.31%	-5.94%	-5.70%	-4.12%	-5.75%	-3.87%	-1.98%	-3.00%

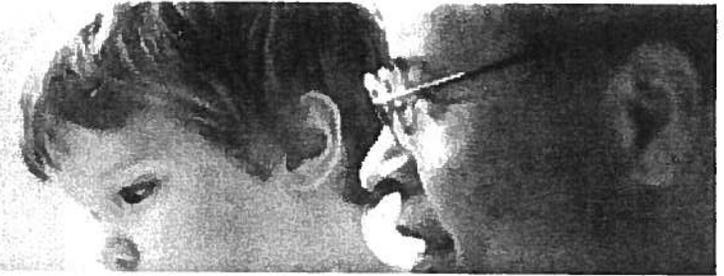
Maryland Hospital Association Comparison of Maryland vs. U.S. 2000-2008



Comment: Since 2000, the EIPA conversion factor differential between the U.S. and MD has increased from 4.50% to 6.25%

Formula: $\text{Gross Patient Revenue} / \text{Inpatient Gross Revenue}$

Maryland Hospital Association Summary of Maryland vs. U.S. Unit Cost Comparisons



	Cost Per EIPA			NOR per EIPA			NPR per EIPA		
	U.S.	MD	% MD Over (Under) U.S.	U.S.	MD	% MD Over (Under) U.S.	U.S.	MD	% MD Over (Under) U.S.
AHA: 2008	\$10,591	\$10,274	-3.00%	\$10,948	\$10,587	-3.30%	\$10,321	\$10,170	-1.46%
Est. 2009 Rate of Change	4.50% ⁽¹⁾	3.67% ⁽²⁾		4.60% ⁽¹⁾	3.67% ⁽²⁾		4.50% ⁽¹⁾	3.67% ⁽²⁾	
Projected: 2009	11,068	10,651	-3.77%	11,452	10,976	-4.16%	10,785	10,543	-2.25%
Est. 2010 Rate of Change	2.80% ⁽¹⁾	2.48% ⁽³⁾		2.80% ⁽¹⁾	2.48% ⁽³⁾		3.10% ⁽¹⁾	2.48% ⁽³⁾	
Projected: 2010	11,378	10,915	-4.07%	11,773	11,248	-4.46%	11,120	10,804	-2.84%

Note (1): U.S. Projected rate of change based on U.S. - Colorado Data Bank

Note (2): MD Projected rate of change based on June 2009 vs. June 2008 Monitoring Maryland Performance

Note (3): MD Projected rate of change based on February 2010 vs. February 2009 Monitoring Maryland Performance

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Date: June 2, 2010

To: HSCRC Commissioners

From: Dianne Feeney, Associate Director, Quality Initiatives

Re: Update on Maryland Hospital Preventable Readmissions (MHPR) Initiative

Since the last Commission meeting, based on staff's ongoing analytic work on the Maryland Hospital Preventable Readmissions (MHPR) initiative, we have learned that some hospitals are submitting patient information that is not consistently accurate in their inpatient and outpatient data submissions. Of particular concern is that some hospitals are not consistently assigning a unique medical record number that is constant over time in compliance with HSCRC inpatient and outpatient data submission requirements (COMAR 10.37.06.01 and COMAR 10.37.04.01). The unique medical record number is to be assigned permanently to the patient and may not change regardless of the number of admissions or visits for that particular patient during the patient's lifetime. In addition, we have found what we believe to be errors in the gender, date of birth and zip code fields.

These data error issues present a barrier to implementing the MHPR initiative with measurement beginning July 1, 2010 as was proposed by staff in the draft recommendation, and staff anticipates they will cause a six month delay in implementing the initiative. Please see Appendix A for a description of the analysis and findings to date on the magnitude and implications of the errors.

In a memorandum dated May 24, 2010, staff notified hospital CFOs in writing of the data issues of concern and the HSCRC's authority under COMAR 10.37.01.03(N) to assess penalties of for incorrect reporting. Additionally, hospitals were directed to correct and resubmit their data for all quarters of FY 2010 by 9/30/2010. Please refer to Appendix B, Memorandum to CFOs.

Going forward, staff will continue to conduct analysis of hospital data and provide feedback on the errors. HSCRC will also work with the MHA and the hospitals with better quality data to determine practices contributing to their success. Staff will continue to refine the patient matching algorithm for use in the MHPR initiative. For facilities submitting inaccurate data on an ongoing basis, staff will subject those facilities to audits and applicable penalties for data errors that serve to lower their PPR rates.

Appendix A:

Analysis of Potential Errors in Reporting of Medical Record Number, Gender, Date of Birth and Zip Code

1 June 2010

DRAFT

Executive Summary

The analysis was conducted to identify issues with the medical record number, date of birth, gender and zip code of residence. Some small proportions of data errors were identified in the gender and date of birth fields. The differences in the zip code field were more substantial, at 2.9%, and these suggest that this field is not suitable for use for probabilistic matching of patients.

The most significant problem identified was that there are discharges with the same provider number, date of birth, gender and zip code, but different medical record numbers. These are either cases that would be inappropriately matched using probabilistic matching, or cases in which the hospital assigned multiple medical record numbers to the same individual. Based on our analysis conducted to date, it is not possible to separate these two effects.

Probabilistic matching of patients using the date of birth and gender is inadequate, and the zip code of residence field is sufficiently unreliable to be used as an additional matching variable. As a result, it is not possible to perform a valid overall readmission rate analysis using the matching algorithm as it is currently constructed.

Introduction

The HSCRC inpatient case level data lacks a unique patient identifier. As a result the PPR analysis starts by probabilistically matching discharges to identify discharges associated with the same individual. This probabilistic match used the date of birth (DOB), gender, and zip code of residence (zip) of the patient to identify discharges for potentially the same individuals, and then further refined the match within hospitals by using the medical record number (MRN).

We have concluded that the matching algorithm was subject to random errors due to incorrect matching of individuals with the same DOB/gender/zip, and also to systematic errors due to errors in reporting of the data fields involved. Hospitals with errors in the data fields have a reduction in their calculated PPR rates.

The analysis reported here was performed in order to obtain an estimate of the magnitude of the errors in the reporting, and the error rate due to the incorrect matching of individuals.

Analysis Method

MRN/Gender

The analysis was done by hospital. The gender/MRN analysis will be used as the first example, and the other combinations of variables used the same method. The data set was for CY 2009.

Discharges were flagged if the MRN for the discharge has more than one gender associated with the various discharges within the hospital with that MRN. For example, if the hospital had 4 cases with a particular MRN, and one of these was classified as male and the other 3 as female, then all four discharges would be flagged. Similarly, if there were 2 discharges with a given MRN, and one was male, and the other was unknown or female, then both the discharges would be flagged. The number of flagged discharges was counted for each hospital, and divided by the total number of discharges for the hospital.

The percentage represents the percentage of discharges at the hospital for which the MRN has more than one gender associated with it. These mismatches are either due to data errors, or situations in which the patient changed gender between discharges.

MRN/DOB/Zip

The same analyses as above were performed using DOB and zip in place of gender individually. Since DOB does not change, the mismatches in DOB are definite data errors. The mismatches in zip are either data errors or situations in which the patient moved to a different zip code - clearly a distinct possibility.

Multiple Medical Record Numbers and Combination Errors

The last analysis was to find sets of discharges with the same provider number, DOB, gender and zip, but with multiple MRNs. All the discharges within the DOB/gender/zip combination were flagged if that combination was associated with multiple MRNs within a provider. These are situations in which there is more than one individual within the hospital with the same DOB/gender/zip combination, or cases in which the hospital assigned the same individual multiple MRNs. At this point it is not possible to differentiate whether these errors are related to errors in the combination of MRN/DOB/gender and zip fields or errors in assigning multiple MRNs to the same individual.

Results

Gender Errors

The overall weighted mean rate of multiple gender discharges was 0.01%, which is negligible. Bon Secours did have 9 such discharges, with a rate of 0.12%.

DOB Errors

The overall weighted mean rate of multiple DOB discharges was 0.22%. An examination of the data suggested that many of these are typographical errors in the date of birth. Bon Secours had a rate of 1.02%, Washington Adventist of 0.58%, Peninsula Regional of 0.91%.

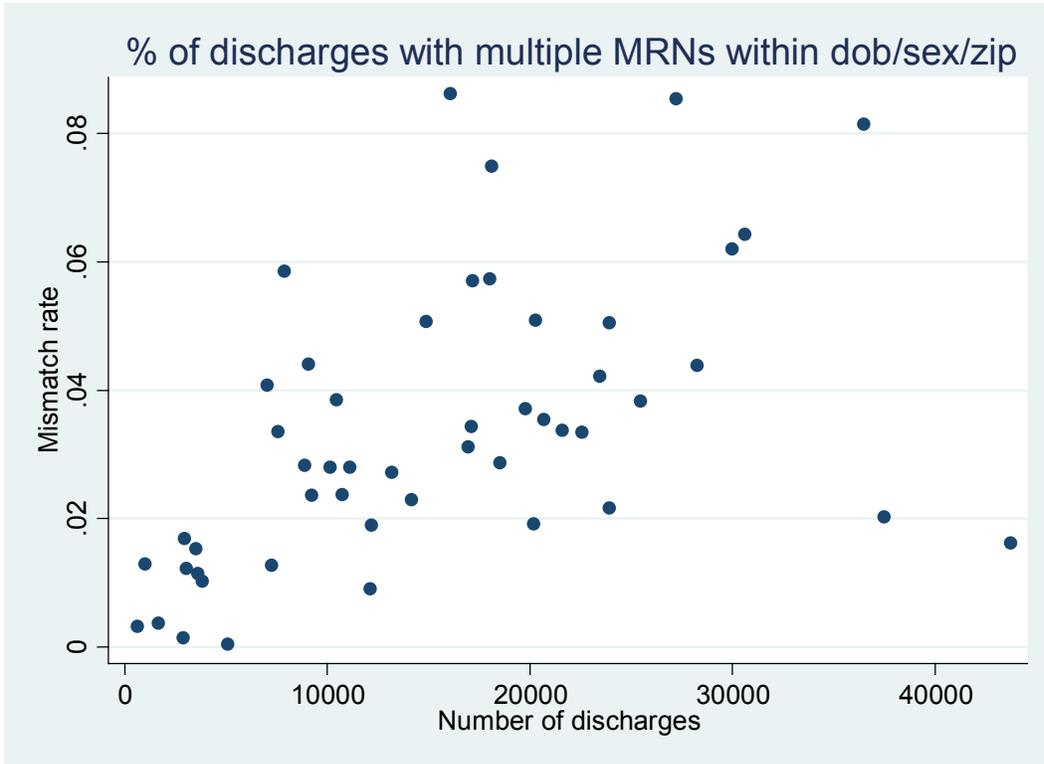
Zip Errors

The overall weighted mean rate of multiple zip code discharges was 2.9%. Bon Secours had the highest rate at 12.8%. Good Samaritan had 8.3% and Maryland General had 7.8%. There are a variety of reasons why zip code might change, for example, the patient moved residences between discharges, the patient was homeless and there is no standard discharge for homeless patients, as well as data entry errors in the zip code. The contrast between the 2.9% for zip and the 0.01% for gender and the 0.22% for DOB suggest that many of the differences in zip code are other than simply data errors.

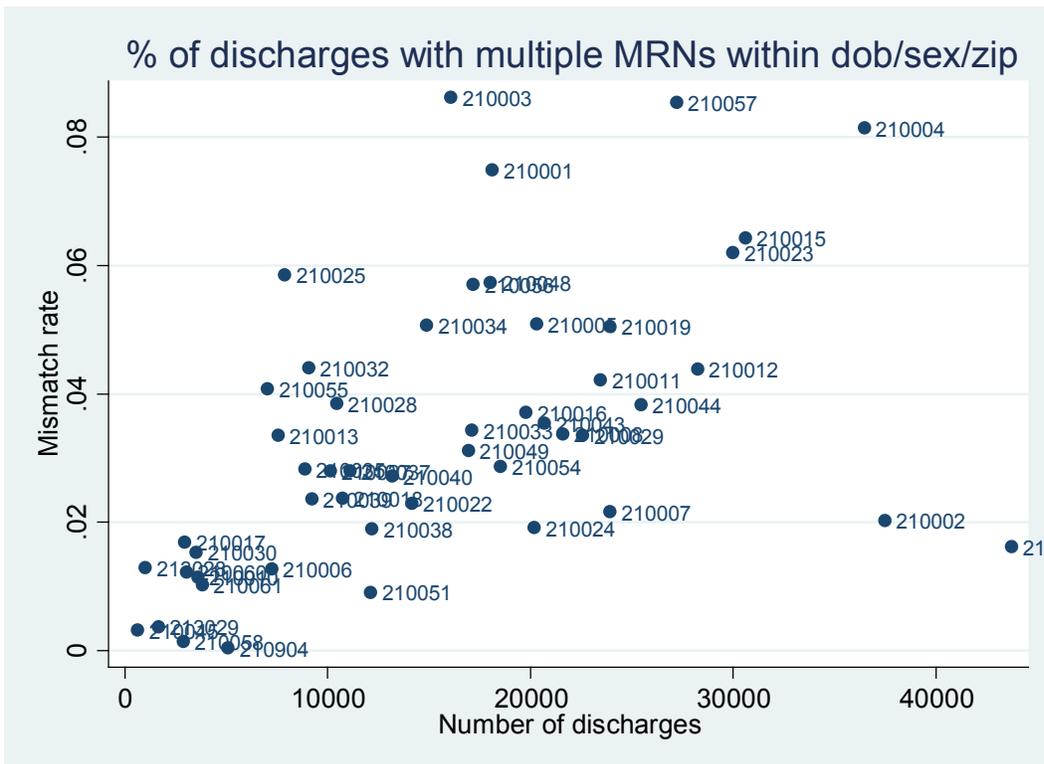
MRN or Combination Errors

There was a 4.08% mismatch rate for the discharges that had the same provider number, DOB, gender and zip code, but had multiple MRNs within these combinations. These mismatches could be due to errors in the MRN, or random incorrect matches based on the provider number/DOB/gender/zip.

The following two charts show the mismatch rate plotted against the number of discharges. The hospitals with the highest number of errors are Prince Georges Hospital with 8.62% followed by Shady Grove with 8.54%. The two outliers at the bottom right with the lowest number of errors are Johns Hopkins and University of Maryland, possibly due to a very low rate of assigning duplicate MRNs.



The following chart shows the same results, but including labels with the provider numbers of the hospitals.



An analysis using CY 2008 data yielded similar results.

Conclusions

The mismatch rates for gender and date of birth are quite low, but hospitals should be required to correct the errors.

The mismatch rate in the zip code is 2.9%, and this is partly due to legitimate reasons rather than data errors. Combining this conclusion with the fact that this mismatch rate is probably systematically different among hospitals, suggests that the zip code is not a suitable variable to be used for probabilistic matching.

4.08% of the discharges are associated with DOB/gender/zip combinations that have multiple medical record numbers associated with them. These mismatches are due to multiple individuals having the same DOB/gender/zip combination, or multiple MRNs being assigned to the same individual. At this point it is not possible to differentiate these two effects.

The errors in the gender, DOB are not contributing in any substantial way to this mismatch rate.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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Appendix B: Memorandum to CFOs

May 24, 2010

To: Chief Financial Officers

From: Robert Murray, Executive Director

Re: Requirements for Accurate Inpatient and Outpatient Data Submission

Cc: Renee Webster, Office of Health Care Quality (OHCQ)

We understand that certain hospitals are submitting patient information that is not consistently accurate in their inpatient and outpatient data submissions. Of specific concern is that hospitals are not consistently assigning a unique medical record number that is constant over time in compliance with HSCRC inpatient and outpatient data submission requirements (COMAR 10.37.06.01 and COMAR 10.37.04.01). The unique medical record number is to be assigned permanently to the patient and may not change regardless of the number of admissions or visits for that particular patient during the patient's lifetime. In addition, we have found what we believe to be errors in the sex, date of birth and zip code fields for some patients.

Reporting inaccurate data has both care and cost implications for hospitals. For example, reporting medical record numbers incorrectly – in particular, assigning and reporting multiple medical record numbers to individual patients over time – severely limits the hospitals' and the HSCRC's abilities to monitor care and to implement initiatives that improve care by targeting preventable readmissions. The HSCRC has the authority under COMAR 10.37.01.03(N) to assess penalties of \$250 per day for each day of incorrect reporting. As of 6/1/2010, potential fines for hospitals with data submissions not in compliance for FYs 2009 and 2010 would total

\$505,000 for inpatient data and \$478,750 for outpatient data, per hospital.

In addition to the HSCRC's concerns that the requirements for accurate patient information are not met by some hospitals, the HSCRC is concerned that this may impact the hospitals' abilities to meet The Joint Commission accreditation standards to maintain processes to check the accuracy of health information (Standard IM.04.01.01, Sub-standard 1) and maintain a system to store and retrieve health information that is accessible when needed for patient care, treatment and services (Standard IM.02.02.03, Sub-standard 2.). Further, The Joint Commission requires that the hospital maintain complete and accurate medical records for each individual (Standard RC 01.01.01). The Center for Medicare and Medicaid Services similarly requires at 42CFR§ 482.24 that a medical record must be maintained for every individual evaluated or treated in the hospital. Failure to provide a unique identifier for each patient may have unintended negative consequences on the continuity of care of a readmitted patient. The HSCRC will work collaboratively with the Office of Health Care Quality as needed to support remedying any deficiencies in these areas as they are identified.

Rather than assess fines at this time, the Commission has decided to grant hospitals the opportunity to correct their data submissions for FY 2010. The HSCRC is directing all hospitals to be in full compliance with its regulations and to report the unique medical record number assigned permanently to each individual patient as well as correct dates of birth, sex and zip codes for all inpatient and outpatient data for the full FY 2010, including all four quarters. All corrected data must be submitted by 9/30/2010; hospitals may resubmit their data for the prior closed quarters in order to correct the medical record numbers.

HSCRC will continue to conduct analysis of hospital data to determine those facilities that are submitting inaccurate data on an ongoing basis and will subject those facilities to audits and applicable penalties. All hospitals whose FY 2010 data are not in full compliance by 9/30/10 will be subject to penalties for both their FY 2009 and 2010 inpatient and outpatient data. As of 9/30/2010, such fines would total \$616,500 for the inpatient data and \$613,000 for the outpatient data.

If you have questions concerning the above, you may contact Dianne Feeney at 410-764-2582 or dfeeney@hscrc.state.md.us.

**Final Recommendation for Revisions to the Reasonableness of Charges (ROC)
Methodology**

Health Services Cost Review Commission
4160 Patterson Avenue
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(410) 764-2605
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June 9, 2010

This document represents a final recommendation to be presented to the Commission on June 9, 2010 for final action.

Background

ICC/ROC Methodology:

The Commission is required to approve reasonable rates for services offered by Maryland hospitals. The 'Reasonableness of Charges' (ROC) methodology is an analysis that allows for the comparison of charges at individual hospitals to those of their peer hospitals after various adjustments to the charge data have been applied. Hospitals with adjusted charges that are high compared to their peers are subject to rate decreases through spend-downs and/or negative scaling of the Update Factor. Conversely, hospitals with adjusted charges that are low compared to their peer hospitals may be allowed rate increases through positive scaling of the Update Factor based on their ROC position. The inter-hospital cost comparison (ICC) used for full rate reviews is based on the ROC methodology with additional adjustments for profit and productivity when establishing a peer standard for comparison. The ROC comparison is conducted annually in the spring or summer with ROC position scaling results impacting the July rate update for the following rate year.

ICC/ROC Workgroup:

Each year, the HSCRC solicits requests from the Maryland hospital industry for modifications to the ICC/ROC methodologies. A summary of the letters submitted on June 1, 2009 is included in Appendix A. Each fall, the ICC/ROC Workgroup, comprised of hospital, payer representatives and Commission staff, meets to discuss the ICC/ROC methodologies and the proposed modifications. This year, the ICC/ROC Workgroup met 13 times over a six month period and the following draft recommendations are the result of those deliberations.

This document represents the final set of recommendations associated with the ROC for 2010. Once approved by the Commission, these provisions will apply for both the application of ROC and ICC policy.

Issues and Draft Recommendations

1-Comprehensive Charge Target (CCT)

As approved by the Commission last year, the CCT is the starting point for the ROC methodology and is established by blending the inpatient charge per case (CPC) target and outpatient charge per visit (CPV) target. Implementation of the CPV was delayed until FY2011 and, therefore, CPV targets were not established for FY2010.

Recommendation: Staff recommends that the CPV used in the 2010 ROC be established as follows: Calculate a CPV for each hospital by using FY2009 outpatient data under the expanded CPV methodology that had been in place for FY2010. Inflate the established CPV by each hospital's outpatient rate update for FY2010 and blend the CPV and CPC targets to establish the CCT under the blending methodology approved last year.

Application of Indirect Medical Education (IME) and Disproportionate Share (DSH) Adjustment

Under the current ROC methodology, the IME and DSH adjustments are applied as a deviation from the statewide average. Therefore, using IME as an example, non-teaching hospitals with no IME costs

receive an upward adjustment to their CCT for the percent that they differ from the statewide average IME amount. Staff believes that it is technically correct and makes more intuitive sense to apply the costs associated with IME and DSH as a direct strip from hospital charges. Under this change, again using IME as an example, non-teaching hospitals would have no ROC adjustment for IME costs. At the end of last year's ICC/ROC Workgroup discussions, staff proposed this technical correction to the application of the IME and DSH adjustments. However, at that time, Workgroup members stated that it was too late in the discussion process to make this change.

Recommendation: Staff recommends the implementation of a technical correction to the IME and DSH adjustments that applies the adjustment as a direct strip instead of a deviation from the average statewide costs associated with IME and DSH.

2-Capital Adjustment

CareFirst and Kaiser proposed two changes to the HSCRC's policy on capital: 1) changes to the current capital adjustment in the ROC; and 2) a change to how capital is handled in rates in terms of the variable cost factor.

1) With regard to the ROC adjustment, the current methodology adjusts for the percentage of costs that are related to capital using 50% of the hospital-specific capital costs plus 50% of the statewide capital costs. CareFirst and Kaiser proposed a ten year phase-in to move from the 50/50 standard to 100% statewide costs plus 0.5%. At the end of the ten year phase-in period, there would be no ROC adjustment for capital. The purpose of this proposal is to gradually reduce the amount of capital provision that is specific to any individual institution and instead transition the system to a 100% prospective system plus an additional 0.5%. The additional 0.5% is an added factor to cover any and all unusual circumstances and to add a buffer for hospitals undertaking capital projects.

2) With regard to capital and the variable cost factor (currently at 85%), Care First and Kaiser proposed that Certificate of Need (CON) eligible projects be allowed to receive a different variable cost factor for three years after first use of a newly constructed facility. By proposing this policy change, CareFirst and Kaiser are attempting to recognize the difficulty faced by hospitals who undertook major capital projects just prior to the Commission's decision to move from a 100% variable cost adjustment to a more restrictive 85% variable cost adjustment for volume. Facilities who undertook these major projects when the variable cost factor was 100% were most certainly counting on these additional revenues as their volumes increased over time. Under the proposed policy change, the following variable cost factors would apply to hospitals as follows:

a) 100% variable cost adjustment if a hospital takes "the Pledge" to not file rate application;¹

b) 100% variable cost if the CON for the project in question was filed when variable cost factor was 100% and hospital did not file a rate application;

¹ The "Pledge" refers to circumstances where a hospital agrees not to request from the HSCRC an increase in rates greater than \$1.5 million associated with a capital project over the life of that project. In exchange for this Pledge, the hospital is exempt from Certificate of Need (CON) review by the Maryland Health Care Commission.

c) 100% variable cost for hospitals that filed a CON when the variable cost factor was 85%, and the hospital did not file a rate application;

d) The current variable cost adjustment (85%) will be applied for hospitals that filed a rate application that generated additional dollars in rates for capital. Hospitals that filed a rate application and received additional funding in rates for their project through this process will not be eligible for the 100% variable cost adjustment.

Additional amounts provided to hospitals as a result of these circumstances, would be accounted for as slippage in future years system Update Factors – as per current Commission policy.

Staff response: Item 1) Staff is supportive of the concept of moving to a statewide standard for capital over a ten year period. A phasing out of the hospital-specific portion of capital in rates will provide the industry with stronger incentives to control costs and improve efficiency. Members of the ROC/ICC did not voice objection to this proposal.

Item 2) Staff also supports the idea of a less restrictive variable cost factor to fund capital projects in place of funding capital through rate increases. However, the staff would like to also recognize the impact that the policy change from 100% variable cost to 85% variable cost had on major capital projects. As noted, if a CON was filed and approved, along with the related comfort order, under the 100% variable cost policy, it was assumed the incremental margin on additional volume could be used to help fund the capital requirements. When the HSCRC changed the variable cost policy to 85%, this restricted hospitals ability to generate incremental margin on additional volume. In addition, staff would propose that the application of 100% variable cost factors to hospitals with major capital projects be extended on a forward-funded basis.

Recommendation:

Item 1) Staff recommends using a ten year phase-in to move from the current capital cost standard of 50% hospital-specific plus 50% statewide to 100% statewide plus 0.5%.

Item 2) Additionally, in an attempt to recognize the impact that the change in the variable cost policy had on major capital projects, the Staff recommends that certain CON eligible projects, where no rate application that generated additional dollars for capital has been filed would be eligible for three years of 100% variable cost.

2a) Original Proposal:

The three scenarios where 100% variable cost adjustment would apply to a hospital undertaking a major capital project and articulated in the original CareFirst/Kaiser proposal include:

a) New CON and the hospital agrees to take the pledge;

b) Previously filed CON, when the variable cost factor was 100%, and the hospital did not file a rate application;

c) Previously file CON, when the variable cost factor was 85%, and the hospital did not file a rate application.

Note: hospitals that filed rate applications and received funding through this process will continue to receive the current variable cost factor of 85%.

2b) Proposed Forward Funding Modification:

In addition to the requirements laid out in the baseline proposal above, the proposed forward funding modification would apply to the following hospitals (all falling under scenario b) above):

1. Hospital must have an approved CON that was filed prior to the 85% variable cost policy change;
2. Hospital must have a significant capital project, defined as:
 - a. Capital project in excess of 50% of the hospital's annual regulated gross patient revenue
3. Hospital must be considered an efficient provider under the HSCRC's ROC methodology.

If the above qualifying criteria are met, the hospital would be eligible to forward-fund a portion of the projected volume adjustments. The forward-funding amount would be determined by the HSCRC staff after considering the following factors:

- Cumulative volume adjustment applied to the hospital since 85% policy went into effect;
- Cumulative volume adjustment applied to the state (average) for the same time period;
- Anticipated volume changes over prospective three year period.

Eligible amounts would be forward funded to fiscal year of opening. Volume adjustments (calculated under the baseline proposal) ***in excess*** of the forward-funded amounts would be awarded in the future under the same timeline as the baseline proposal.

3-Profit and Productivity Adjustment in the ICC

The cost standard used for full rate reviews in the ICC methodology begins with the hospital's peer group ROC-adjusted CCT and then excludes the peer group's average profit, and includes a 2% productivity adjustment. The Maryland Hospital Association (MHA) contended that the current ICC policy is too restrictive for hospitals to access rate relief. The MHA proposed that during full rate setting the methodology should add back the lower of the target hospital's profit or 2.75% (the Financial Condition Policy's target for operating margins). The MHA also proposed that the 2% productivity adjustment be phased-in over a multi-year period, or that a national standard be identified and used for the productivity adjustment.

Hospital payment levels and costs have increased more rapidly in Maryland compared to the rest of the nation over the last 5 years. In FY05, Maryland was 2.58% below the U.S. in Net Operating Revenue per EIPA and moved to 1.90% above the U.S. in FY09 for this measure. For the same time period, Maryland went from 4.28% to 0.38% below the U.S. for Net Patient Revenue per EIPA and 3.65% below to 0.71% above the U.S. for Cost per EIPA. Because of this erosion of Maryland hospital

payments and costs compared to the U.S., staff believes that it would not be the appropriate time to move to a less restrictive standard in the ICC methodology.

Recommendation: Staff recommends no change to the profit and productivity adjustments in the ICC. However, during the deliberations of the ROC/ICC Work Group, representatives of the G-9 pointed out an apparent inconsistency between the HSCRC's policy for Partial Rate Applications (most specifically the Commission's policy regarding the profit strip for purposes of calculating the ICC standard) and the staff's new recommendation on phasing the system to 100% prospective capital (as recommended above in section 2, Item 1). As a result, the staff will consider appropriate changes to the HSCRC's Policy governing Partial Rate applications in next year's ROC/ICC review.

4 - Exclusions

Currently, liver transplants, heart and/or lung transplants, pancreas transplants, bone marrow transplants, and kidney transplants are excluded from the CPC constraint system because past analyses indicated that there was significant variation in charges within the corresponding APR-DRGs for these cases. Staff recently analyzed the charge variation for each of the transplant APR-DRGs using FY09 inpatient data. The liver, heart, pancreas, and bone marrow transplant cases continue to experience wide variations in charges and length of stay and should continue to be excluded from the CPC system. However, analyses of the kidney transplant cases indicate that there is very little variation in charges, as measured by the coefficient of variation, within the kidney transplant APR/SOI cells. At the March Commission Meeting, staff recommended that the kidney transplant cases be included under the CPC constraint system. In a meeting subsequent to the March recommendation, representatives from the Academic Medical Centers provided Commission Staff a more detailed review of the differences in costs associated with variations in recipient and donor types within the kidney transplant APR/SOI cells.

Recommendation: Staff recommends that kidney transplant cases continue to be excluded from the CPC constraint system in FY2011 pending a review of case mix issues raised by the Academic Medical Centers. Staff is hopeful this review will address any remaining case mix comparison issues such that some or all of the kidney transplant cases can be included in CPC constraint in FY 2012.

5 - Case-mix Lag

Under current Commission policy, case-mix is measured in "real time", meaning that the calculation of case-mix change for the previous rate year and calculation of the base CMI for the new rate order use discharge data from the July-June period immediately prior to the new rate year. For example, the base CMIs in the rate orders for the fiscal year that began July 1, 2009 were calculated using discharge data from July 1, 2008 thru June 30, 2009. Discharge data from the previous rate year is not available until, at the earliest, 4 months after the beginning of the new fiscal year. Therefore, the measurement of case-mix in real time causes unavoidable delays in issuing rate orders which, in turn, impacts hospitals' ability to achieve CPC compliance. Staff recommends that case-mix change and base CMI be measured using a three month lag in the data period. The data period used to calculate case-mix change for FY10 will remain the 12-months ending June 30, 2010. However, the base CMI for the FY12 rate orders will be based on discharge data from April 1, 2010 – March 31, 2011, and case-mix change for FY12 will be

measured using discharge data from April 1, 2011 – March 31, 2012. There are technical details associated with this change that Commission staff plan to discuss at MHA’s Technical Issues Workgroup over the next several months.

Recommendation: Staff recommends incorporating a three month lag into the data periods used for case mix measurement. This change would go into effect for rate year 2012.

For rate year 2012 the reweighted base case mix index for the Charge per Case Targets for each hospital will be the twelve month period April 1, 2010 through March 31, 2011. Further, the case mix base and future measurement will incorporate the most current methodologies such as denials and one day stays. The case mix changes for rate year 2012 will be calculated for the twelve month period April 1, 2011 through March 31, 2012 and applied to the Charge per Case Targets to determine the case mix adjusted Charge per Case for rate year 2012 compliance purposes.

Any technical implementation issues will be vetted with the MHA’s Financial Technical Issues Task Force.

6 - Outlier Methodology

Under the current HSCRC high charge outlier methodology, a hospital-specific high charge outlier threshold is calculated for each APR/Severity cell. Charges above the established threshold are paid based on unit rates and not subject to the incentives of the HSCRC per case payment system.

The G-9 hospitals proposed a change to the HSCRC outlier methodology to address the following issues that they cite as consequences of the current methodology:

- Hospital charges could be structured to increase outlier charge levels
- Outlier patients are not protected by the financial incentives of the per case payment system
- Compliance with HSCRC rate orders are complicated by the segregation of outlier charges in compliance calculations

The G-9’s proposed outlier methodology establishes a prospective allowance for outlier charges using a regression that is shown to predict each hospital’s percentage of outlier costs with substantial accuracy. The following independent variables are used from previous year’s data: the hospitals’ proportion of vent cases, the hospitals’ expected outlier proportion, and an AMC dummy variable. The result of the regression for each hospital would equal the hospital’s outlier allowance for the succeeding year. A hospital’s rate year CPC target would be increased by the prospective outlier allowance. In ROC comparisons, each hospital’s target would be adjusted for the amount of the prospective outlier charges.

Although staff believes that certain aspects of the G-9 outlier proposal have merit, more study and deliberation is needed regarding this methodology.

Recommendation: Staff recommends the continuation of the current outlier methodology in FY2011.

7 - Peer Groups

The current peer group methodology uses 5 groups (based on size and location of hospital) for comparison including a virtual peer group for the Academic Medical Centers (AMCs). These peer groups were originally developed to adjust for differences in cost structures of hospitals which may not have been captured in the ROC adjustments used at that time. Because the Commission has implemented more refined adjustments for case-mix, labor market, and disproportionate share over the last several years, staff believes that this level of peer-grouping is no longer necessary. At the March Commission Meeting, staff proposed a move to three peer groups (major teaching, minor teaching, and non-teaching) based on the teaching intensity of the hospital as measured by residents per case-mix adjusted equivalent inpatient cases. In an ICC/ROC Workgroup meeting subsequent to the March recommendation, there was further discussion regarding the appropriate configuration of the two teaching peer groups. Because agreement was not reached regarding the appropriate division between major teaching and minor teaching, staff recommends that the current 5 peer groups be maintained. The payer representatives proposed that the Commission develop a national peer group for determination of reasonableness of charges for the Academic Medical Centers.

Recommendation: Staff recommends some modifications of the current peer group methodology for the spring/summer 2010 ROC. The proposed modifications seek to form peer groups that compare teaching hospitals to teaching hospitals and non-teaching hospitals to non-teaching hospitals, where-ever possible. These proposed modifications to the peer groups are as follows:

Unchanged Peer Groups: The State's two Academic Medical Centers will continue to be grouped in the existing "virtual" peer group that includes the 2 AMCs plus other large, urban, teaching facilities. This group is labeled "Peer Group 4 – AMC Virtual." The Urban and Urban teaching hospital group (which also includes Bon Secours hospital) will also remain unchanged. This group is now called, "Peer Group 3 – Urban Hospitals."

Changed Peer Groups: All non-teaching hospitals in the peer group previously referred to as Suburban and Rural Group 1 and smaller non-teaching hospitals (Atlantic General, McCready, Fort Washington, Memorial Easton, Dorchester and Chester River) previously in "Group 3," shall be grouped together in a group now labeled Group 2 - Suburban/Rural Non-Teaching Group 2. One teaching hospital (Baltimore Washington Medical Center), previously in Suburban/Rural Group 2 will now be moved to Non-Urban Teaching Group 1. The ROC results (reflecting these recommended modifications) are shown in **Appendix II**.

8 - ROC Scaling and Spend-Downs

At this time, staff recommends that the HSCRC not pursue spend-down arrangements with hospitals provided that the Commission approves a more aggressive ROC scaling methodology than has been applied in previous years. Scaling based on ROC rankings is an effective policy tool that rewards efficient hospitals (so called "stuck" hospitals – facilities that have been low on the ROC but otherwise unable to generate rate increases). Scaling also applies pressure to hospitals that have been high on the ROC. But the reductions that result from year-to-year scaling are less onerous than rate reductions applied to hospitals under spend-downs.

In the past, the HSCRC has scaled 0.5% of revenue (on a revenue neutral basis). Staff recommends that a significant portion of revenue be scaled for ROC position, and that the structure of scaling be continuous. The Payment Workgroup will ultimately decide the amount of revenue to be scaled. Staff also recommends that the Total Patient Revenue (TPR) hospitals (McCready and Garrett) be eligible for positive ROC scaling but would not be negatively scaled.

Recommendation: Staff recommends that the amount of scaling for 2010 ROC results be significant and that the structure of the scaling be continuous. Staff also recommends that TPR hospitals should be eligible for positive scaling but not receive negative scaling based on ROC results. No spend-downs based on 2010 ROC results are recommended. If the Commission does not adopt a ROC scaling methodology that is more aggressive than what has been adopted in previous years, the staff would recommend the Commission initiate spend-down agreements with all hospital in excess of 3.0% above their peer group average.

Other On-going Activity

Physician Recruitment, Retention, and Coverage

A subset of community hospitals, known as G-9, offered a review of the costs associated with providing physician subsidies for physician recruitment, retention and coverage costs at hospitals in non-urban areas. The G-9 hospitals proposed that the Commission consider defining reasonable recruitment, retention, and coverage expenditures as elements of regulated hospital cost and adjust for these costs in the ROC in a manner similar to the direct medical education adjustment. Because physician services are not regulated by the HSCRC, staff does not agree that physician subsidies associated with recruitment, retention, and coverage should be considered elements of cost which are adjusted for in the ROC. However, staff agrees that the issue of physician subsidies and the impact on community hospitals needs further study.

Recommendation: Staff recommends no proposed adjustment in the ROC methodology associated with physician recruitment, retention, and coverage costs. Staff also recommends that a concerted study be initiated to better understand physician payments associated with physician recruitment, retention, and coverage at Maryland hospitals.

Development of a Peer Group for Academic Medical Centers (AMCs)

As noted, both the ROC and ICC methodologies contain a number of adjustments to hospital charges (case mix adjustment, labor market adjustment, direct strip, adjustment for Indirect Medical Education, etc.). These adjustments are necessary to ensure a fair comparison of hospital charges (the Commission has traditionally attempted to adjust for factors that influence hospital rates but that may be beyond the control of hospitals). The use of hospital peer groups (comparisons of hospitals that share similar characteristics) is another way the Commission has attempted to ensure a fair comparison of relative performance. This method of the use of extensive adjustments to hospital charges and peer group comparisons has worked well for the implementation of the ROC and ICC over time. However, the State's two large Academic Medical Centers have consistently recommended that the HSCRC consider

the development of a national peer group of other AMCs outside of Maryland, as the basis of a ROC and ICC comparisons for Johns Hopkins Hospital and University of Maryland. It is argued that comparing the State's two AMCs to other (non-AMC) teaching hospitals in Maryland does not adequately account for costs associated with the intensive teaching and research activities of AMCs.

Recommendation: Staff recommends that the HSCRC begin to investigate the possibility of establishing a national peer group of AMCs outside of Maryland as the basis of comparison for Johns Hopkins Hospital and University of Maryland. This investigation will determine the feasibility of this proposal (i.e. identifying the existence of necessary cost data and data required for any necessary adjustments). If after this investigation staff believes the establishment of a national peer group is feasible, it will establish a Work Group to assist it in this exercise.

Summary of Draft Recommendations for Changes to the ICC/ROC Methodology

Peer Groups: Staff recommends no change to the Virtual and Urban Peer groups. Staff further recommends the formation of a Suburban/Rural Non-Teaching Peer group and a Non-Urban Teaching Peer Group as described in the body of the Recommendation and shown in Appendix II.

CPV in Blended CCT: Staff recommends that the CPV used in the 2010 ROC be established as follows: Calculate a CPV for each hospital by using FY2009 outpatient data under the expanded CPV methodology that had been in place for FY2010. Inflate the established CPV by each hospital's outpatient rate update for FY2010 and blend the CPV and CPC targets to establish the CCT under the blending methodology approved last year.

Application of IME and DSH Adjustment: Staff recommends the implementation of a technical correction to the IME and DSH adjustments that applies the adjustment as a direct strip instead of a deviation from the average statewide costs associated with IME and DSH.

Capital: Staff recommends using a ten year phase-in to move from the current capital cost standard of 50% hospital-specific plus 50% statewide to 100% statewide plus 0.5%. CON eligible projects would be allowed 100% of variable costs for three years after first use if hospital pledges to not file a rate application or if hospital filed CON previously and did not file rate application and pledges not to file in future.

Exclusions: Staff recommends that kidney transplant cases continue to be excluded from the CPC constraint system in FY2011 pending further review.

Case-mix Lag: Staff recommends moving to a 3-month lag in the data period used to measure hospital case-mix.

Outlier Methodology: Staff recommends the continuation of the current outlier methodology in FY2011.

Scaling and Spend-downs for 2010 ROC: Staff recommends that the amount of scaling for 2010 ROC results be significant and that the structure of the scaling be continuous. Staff also recommends that TPR hospitals should be eligible for positive scaling but not receive negative scaling based on ROC results. No spend-downs based on 2010 ROC results are recommended.

Physician Recruitment, Retention, and Coverage: Staff recommends that a concerted study be initiated to better understand physician payments associated with physician recruitment, retention, and coverage at Maryland hospitals.

Determining the Feasibility of Establishing a National Peer Group for AMCs: Staff recommends it undertake an investigation of the feasibility of establishing a national peer group as the basis for the ROC and ICC comparison for Johns Hopkins and University of Maryland.

Appendix I

Summary of ICC/ROC Letters

The purpose of this document is to provide a brief overview of the issues addressed in letters submitted to the Commission June 1, 2009 regarding methodology issues to be discussed in the ICC/ROC Workgroup for the coming rate year.

Peer Groups

St. Joseph Medical Center requests that the current peer groups be replaced with a statewide comparison of hospitals.

Atlantic General requests a change from the current peer groups to a statewide group or teaching/non-teaching groups.

The hospitals in 'G-9' request that the current peer groups be considered for revision.

CareFirst and Kaiser Permanente request that there be just two peer groups: 1) a statewide peer group excluding the Academic Medical Centers; and 2) a national peer group for Johns Hopkins Hospital and the University Of Maryland Medical Center.

MedStar Health and St. Agnes Hospital do not want peer groups eliminated but request that the current structure be reviewed to determine if the methodology meets the original goal.

Outlier Methodology

The Johns Hopkins Health System, University of MD Medical System, CareFirst and Kaiser request that the Commission staff revisit the outlier methodology to determine if the original objectives of this policy are being met and incentives are correct.

G-9 hospitals believe that the low charge outliers system is unnecessary, and that the incentives related to the payment for high charge outliers exacerbate the problem of complying with the waiver and, therefore, they support a review of the outlier policy.

Labor Market Adjustment

The Johns Hopkins Health System, the University of MD Medical System, and MedStar Health request a systemic review of the policy as well as suggest that a more detailed review of submitted data be put in place to ensure that the data are reasonable.

Disproportionate Share Adjustment

MedStar Health and St. Agnes Hospital request that the current DSH adjustment be re-assessed in order to confirm the measure's validity; to establish the stability over time; to understand if issues associated with urban locations are addressed; and to compare to possible alternatives.

Direct Medical Education

The Johns Hopkins Health System and the University of Maryland Medical System request that the current methodology for calculating the direct strip for DME (based on costs reported in the P4 and P5 schedules) is re-assessed due to vague P4 & P5 instructions related to ACGME approved residents and fellows which results in inconsistent reporting across hospitals.

Indirect Medical Education

CareFirst and Kaiser request that any future adjustments to the IME coefficient be based on the Commission's Update, and that the IME methodology be adjusted to support a greater amount of relative training of Primary Care Physicians who will provide care in Maryland.

Physician Coverage

The G-9 hospitals request that the differential accounting and treatment in ICC/ROC of the coverage costs at teaching hospitals (use of residents with costs carved out in DME adjustment) versus non-teaching hospitals (employed or subsidized attending staff costs not carved out) be addressed.

Partial Rate Review for Capital and Full Rate Reviews

CareFirst and Kaiser request that the partial rate process for capital be reviewed, and that the Commission consider transitioning to a statewide capital methodology that does not adjust rates for a hospital's position in its capital cycle.

The Johns Hopkins Health System and University of MD Medical System request that the partial rate process for capital be maintained; that a reasonable profit standard (2.75%) be included; and that productivity strips be eliminated from the partial rate and ICC methodologies.

The G-9 hospitals request that the criteria governing partial and full rate applications be reviewed by the Workgroup.

Scaling and Spend-Downs

CareFirst and Kaiser request an increase in the level of scaling next year and that spend-downs are resumed no later than July 1, 2010.

The G-9 hospitals request that the Workgroup review various approaches to scaling and spend-downs, including a discussion regarding the elimination of spend-downs.

Clinic Volumes

CareFirst and Kaiser request that clinic volumes, especially for multi-person behavioral health clinics, be reviewed.

Non-Comparable Services

CareFirst and Kaiser request that the Workgroup discusses objective methods of identifying and evaluating the cost of a particular service when that service differs substantially at a particular hospital compared to the peer group.

PPC Methodology

The G-9 hospitals request that the Workgroup consider issues associated with the implementation of the PPC methodology.

Case Mix Governor and Volume Adjustment

The G-9 hospitals suggest that the case-mix governor, in combination with the volume adjustment, places an undue financial burden on hospitals with both case-mix and volume increases, and that consideration should be given to handling case-mix and volume through a single measure of the hospitals' service level.

MedStar Health requests that policy decisions that impact the ROC, such as the case-mix governor, be evaluated.

Availability of Data

MedStar Health, Johns Hopkins Health System, and the University of MD Medical System request that future reports, such as those pertaining to the ROC and UCC, include the data used by staff to conduct its calculations and that a two-week comment period be implemented to allow hospitals the opportunity to correct the data in the event that errors are present.

Prospective Payment and System Stability

St. Joseph Medical Center, the Johns Hopkins Health System and the University of MD Medical System state that certain policies, such as case-mix restrictions without clear prospective rules for how case-mix will be accrued, undermine the prospective nature of the Maryland system. These hospitals also state that constant change in the system, such as revisions to the CPV to include more revenue or the proposed implementation of the PPC methodology, undermine the stability of the system.

Appendix II

Preliminary Summary of 2010 Maryland Hospitals' Reasonableness of Charges Comparison By Proposed Peer Groups

HOSPID	HOSPITAL NAME	ROC POSITION
PEER GROUP 1 - NON-URBAN TEACHING		-1.99%
210058	James Lawrence Kernan Hospital	4.02%
210022	Suburban Hospital	3.58%
210044	GBMC	2.66%
210043	Baltimore Washington Medical Center	-0.64%
210056	Good Samaritan Hospital	-0.97%
210011	St. Agnes Hospital	-1.11%
210004	Holy Cross Hospital	-1.46%
210015	Franklin Square Hospital Center	-1.95%
PEER GROUP 2 - SUBURBAN/RURAL NON -TEACHING		-1.64%
210045	McCready Memorial Hospital	53.71%
210051	Doctors Community Hospital	6.75%
210055	Laurel Regional Hospital	6.33%
210018	Montgomery General Hospital	5.76%
210061	Atlantic General Hospital	5.32%
210006	Harford Memorial Hospital	5.18%
210040	Northwest Hospital Center	5.17%
210054	Southern Maryland Hospital Center	4.45%
210030	Chester River Hospital Center	4.29%
210016	Washington Adventist Hospital	3.93%
210007	St. Joseph Medical Center	3.04%
210048	Howard County General Hospital	2.46%
210028	St. Mary's Hospital	2.27%
210027	Western Maryland Regional Medical Center	1.66%
210049	Upper Chesapeake Medical Center	1.41%
210019	Peninsula Regional Medical Center	0.04%
210060	Fort Washington Medical Center	-0.11%
210057	Shady Grove Adventist Hospital	-0.99%
210033	Carroll Hospital Center	-1.00%
210035	Civista Medical Center	-1.97%
210032	Union of Cecil	-5.26%
210023	Anne Arundel Medical Center	-5.43%
210039	Calvert Memorial Hospital	-5.55%
210005	Frederick Memorial Hospital	-6.39%
210001	Washington County Hospital	-6.65%
210037	Memorial Hospital at Easton	-8.99%
210017	Garrett County Memorial Hospital	-9.58%
210010	Dorchester General Hospital	-12.54%
PEER GROUP 3 - URBAN HOSPITALS		1.49%
210013	Bon Secours Hospital	6.55%
210012	Sinai Hospital	3.05%
210003	Prince Georges Hospital Center	2.44%
210024	Union Memorial Hospital	1.37%
210029	Johns Hopkins Bayview Medical Center	-1.82%
210008	Mercy Medical Center	-2.86%
210038	Maryland General Hospital	-3.98%
210034	Harbor Hospital Center	-4.23%
PEER GROUP 4 - AMC VIRTUAL		4.33%
210009	Johns Hopkins Hospital	4.38%
210002	University of Maryland Hospital	-0.02%

**Addendum to the May Final Staff Recommendation Rate Methods and
Financial Incentives relating to One Day Length of Stay and Denied Cases in
the Maryland Hospital Industry**

**Method for Allocation of Unfunded Case Mix provisions for “early-adopter”
Observation Unit Hospitals**

Health Services Cost Review Commission
June 9, 2009

This document represents a final recommendation to be presented to the Commission on June 9, 2010.

Introduction

At the May 5, 2010 Commission the HSCRC approved the final staff recommendation relating to the handling of One Day Stay cases and Denied Cases in the Maryland hospital rate setting system.

Appendix I to this document provides an explanation of how these provisions will be implemented.

As discussed at the May 5 Public meeting of the HSCRC, the Maryland Hospital Association (MHA) requested additional time to gain a consensus position of Maryland hospitals regarding the reallocation of foregone case mix allowance by hospitals who were “early adopter” of medical observation units. As these hospitals established observation units, cases that had previously been admitted and treated on an inpatient basis were shifted to outpatient status. This had the effect of both reducing that hospital’s overall “rate capacity” on remaining inpatient cases under their Charge per Case (CPC) target and also causing their measured inpatient case mix to increase. Because the HSCRC has imposed a limit on measured inpatient case mix in past years, many of these hospitals had some of all of this case mix increase governed away. Hospitals that have been slow to implement medical observation units were not victimized by these circumstances and have retained considerable revenues associated with excess rate capacity and ungoverned case mix.

Since the May HSCRC meeting the MHA did successfully gain a consensus of its members regarding the method to reallocate lost cases mix by the “early-adopter” hospitals. That methodology is described and presented in Appendix II to this recommendation. The copy of the email from MHA representative Mike Robbins is also included.

The MHA proposal focuses on outpatient observation coding as the basis for defining “early adopters” and only looks at medical observation cases. For 2008/2009, the total estimated rate relief for those hospitals would be approximately \$29 million and restored to individual hospitals per the schedule shown on page 10 of the MHA presentation.

It was further recommended that this \$29 million reallocation be revenue neutral to the rate setting system. This would mean that it should be accounted for as “system slippage” in future annual hospital inflation Updates (i.e., a portion of this \$29 million would be reversed out of the approved update of every hospital).

While this method would assure revenue neutrality – several hospital representatives were concerned that this approach would erase much of the restoration provided to adopter hospitals (\$29 million would be differentially allocated to a group of hospitals but then a pro-rata proportion of this \$29 million would be taken away from all hospitals – including the early adopters).

The MHA’s Council on Financial Policy thought that, if possible, perhaps some or all of this rate relief could be funded through savings that may have been realized in FY 2010 for actual case-mix being below what our budget was for this year. Current case mix growth over 3 quarters ending March 2010 at Level III (which includes growth in outliers and categorical excluded case revenue) is negative.

Staff would be receptive to this suggestion and recommend using this mechanism to fund the identified case mix restoration amounts by hospital (per page 10 of the document in appendix II) to the extent that

final FY 2010 case mix at Level III is less than the budgeted amount of case mix in the FY 2010 update factor of 0.5%.

Final Staff Recommendations

- 1) The Commission should utilize the MHA-Proposed method for reallocating lost Case-mix to hospitals who established observation units in previous years (the “early-adopters”) and away from hospitals who have failed to establish observation capacity (methodology and calculation shown in **Appendix II**);

- 2) Should actual case mix growth for FY 2010 be less than the budgeted 0.5% case mix allowance per the approved FY 2010 update, then the \$29 million in case mix restoration should be funded out of any “unspent” case mix provision. For instance, if final FY 2010 case mix at Level III shows 0% growth, then the full amount of the \$29 million restoration can be accomplished by directly increasing the rates of the early adopters for their individual proportion of the calculated Case mix restoration. If final FY 2010 case mix at level three shows a 0.4% growth however, then only 0.1% of system inpatient revenue would be available (approximately \$9 million) would be available for funding out of “unspent” case mix allowance and the balance of the \$29 million would be handled through a slippage adjustment.

Appendix I – Procedures and Methods for Implementing the Approved Recommendation relating to One Day Stay Cases and Denied Cases

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Memorandum

To: Maryland Hospitals

From: Robert Murray

Re: Implementation of Commission adopted One Day Length of Stay Recommendations

Date: June 2, 2010

The issue of the use of zero to one day length of stays (ODS) in Maryland has been the focus of discussion between both HSCRC staff and industry representatives for many months. The issue was raised in the context of:

- The national Medicare Recovery Audit Contractor (“RAC”) initiative currently authorized by federal law to identify areas of both overpayment and underpayment to acute care hospitals by the Medicare program. ODS cases have been a particular area of focus for the RAC because of concern regarding whether or not these admissions meet Medicare’s medical necessity criteria. A comparison of data on ODS nationally and in Maryland show Maryland admits 6% more one-day stays overall and 4% more Medicare one-day stay cases than hospitals in the rest of the US.
- During CY 2009, several private payers contacted HSCRC staff regarding the wide variation in the use of outpatient observation services by Maryland hospitals. These private payers believed that Maryland hospital practices were leading to an overuse of inpatient levels of care for patients that could be treated as observation cases. Overuse of inpatient services for cases that could be treated on an outpatient observation basis results in excess medical cost and potential additional clinical risks for patients.
- Over the summer of 2009 staff became aware of anomalous reporting and handling (for purposes of hospital Charge per Case development) of denied (based on medical necessity criteria) inpatient cases.

One Day Length of Stay Recommendations

After approximately six months of deliberation with the hospital and payer industries, on May 5, 2010, the Health Services Cost Review Commission (“HSCRC” or “The Commission”) took the following action related to ODS cases at Maryland hospitals:

1. Exclude all One Day Stay (ODS) cases from hospitals’ Charge per Case Standards effective July 1, 2010 (applying to the rate year FY 2011);
2. Do not explicitly link ODS impact to the Productivity Factor in the Update to Hospital Rates for FY 2011;
3. Utilize the method for reallocating lost Case-mix to hospitals who established observation units in previous years (the “early-adopters”) and away from hospitals who have failed to establish observation capacity;
4. Adopt a set of “soft” (or desired) targets for Maryland hospital industry performance for Medicare and All-payer categories in terms of the number of ODS cases as a proportion of total admissions;
5. Apply an additional \$10 million scaling incentive mechanism to continue to induce Maryland hospitals to appropriately shift ODS cases to ambulatory settings;
6. Adjust all hospitals’ FY 2011 CPCs for the presence of denied cases that generate excess rate capacity that occurred beginning January 1, 2010;
7. Establish a separate Observation (OBV) Rate Center for FY 2011 and revise the current rate method for charging for Recovery Room time;
8. OBV cases and one-day surgical cases will be subject to the CPV starting in FY 2011;
9. exempt OBV cases from the application of any case mix cap imposed on outpatient cases (based on the final approved FY 2011 Rate Update Recommendation)

Implementation

Below are details on how each policy will be implemented:

1. Exclusion of ODS cases from CPC

There are both CPC compliance and Case Mix compliance issues associated with this removing ODS cases. Case Mix compliance will apply only to the remaining CPC cases after ODS cases are removed. In calculating the CPC for FY 2011, HSCRC will remove ODS cases from both the FY 2010 base and from the FY 2011 CPC. To calculate CMI for FY 2011, HSCRC will develop two CMIs: one which removes ODS cases during 6 months of FY 2010, and a second which will remove ODS cases for FY 2011.

A question arose regarding how the low trims would be treated under this scenario. Staff has determined that there is no need to continue to calculate a low trim since these charges are included in the ODS exclusions from the CPC.

2. ODS Impact and the Productivity Factor of the FY 2011 Update

The Commission will not link the productivity factor in the FY 2011 update to ODS cases.

3. Reallocation of Case Mix based to early adopters of OBS units

This issue will be considered by the Commission during the its June Public Meeting

4. Soft Targets comparing Maryland and National trends on percentage of ODS cases

The HSCRC will continue to access data from Medicare and all-payers in both Maryland and the nation to gauge Maryland’s performance on the number of ODS cases as a proportion of total admissions compared to the nation. To compare Maryland ODS cases to national ODS cases, HSCRC staff will access the most recent data from the national Medpar file. There is a one year lag in the availability of data so CY 2009 data will be available by January 2011. In addition staff will utilize the most recent HCUP data (excluding newborns) to compare performance on an all-payer basis. Those data will be added to update the table below over time. The table below shows the aggregate targets out to 2014.

The recommendation adopted by the Commission establishes “soft targets” that would reduce Maryland’s number of Medicare ODS cases and all-payer ODS cases by 1% per year beginning in FY 2011. The table below shows the aggregate targets out to 2014. The Commission did not adopt rewards or penalties based on these targets. Staff will continue to monitor both the performance compared to the nation and achievement relative to the expected 1% annual reduction.

Proposed "Soft Targets" for Maryland
Desired Performance on One Day Stay (ODS)
Cases as a Proportion of Total Admissions

Current Medicare Performance						Proposed "soft targets" for ODS cases			
	2006	2007	2008	2009	YTD 2010	2011	2012	2013	2014
Maryland	17.83%	17.59%	17.49%	17.50%	17.00%	16.00%	15.00%	14.00%	13.00%
US Medicare	13.75%	13.68%	13.40%	NA	NA				
Difference	4.08%	3.91%	4.09%						
Maryland All-Payer	22.48%	23.26%	22.82%	23.40%	23.05%	22.05%	21.05%	20.05%	19.05%
US All-Payer	16.58%	NA	NA	NA	NA				
Difference	5.90%								

NA = "Not Available"

5. \$10 million incentive scaling for shift in ODS cases to ambulatory settings

The Commission adopted a \$10 million incentive scaling approach which will adjust hospital revenue on an overall revenue neutral basis in FY 2012. The statewide standard will be based on data from FY 2010. FY 2011 cases will be used to determine individual hospital performance

(by APR/SOI) compared to the statewide standard from FY 2011.

The methodology will quantify the statewide average number of One Day LOS cases by APR/SOI cell in FY 2010. This will be the statewide standard for FY 2011 and hospitals can track their performance compared to this standard over the course of FY 2011.

Each hospital's number of One Day LOS cases by APR/SOI in FY 2011 will be compared to the statewide standard by APR/SOI for FY 2010. For each hospital, the actual number of One Day LOS cases would be subtracted from the statewide standard for each APR SOI to determine the excess number of One Day LOS cases in each APR/SOI.

An index is established based on each facility's overall comparison to the statewide standard and hospitals would be ranked based on this index. Based on the resulting index, \$10 million would be scaled in FY 2012 on a revenue neutral basis so that high performers (in reducing One Day LOS cases) would receive additional revenue and poor performers would experience a reduction in revenue.

The calculation above would include medical and surgical cases with the exception of:

- Obstetric cases;
- Newborn cases;
- Transfers;
- Patients that left against medical advice; and
- Cases that resulted in death.

See Attachment I for a simulation using data from previous years.

6. FY 2011 CPC adjustment for the presence of denied cases after January 1, 2010

The FY 2011 CPC will be adjusted for denied cases that occur after January 1, 2010. HSCRC will match denied cases from the quarterly financial data to the case mix data tapes. Staff has identified inconsistencies in the reporting of denied cases. Please see Attachment II which outlines instructions on how to report these cases and HSCRC's plan to audit and, if necessary, fine hospital for noncompliance. Once matched, denied cases and charges occurring on or after January 1, 2010 will be removed from the financial data set and denied charges will also be removed from the case mix tapes to adjust the case mix weights. The HSCRC will then issue the FY 2011 CPC with these charges and cases removed.

7. Establish a separate Observation (OBV) Rate Center for FY 2011 and revision of the current rate method for charging for Recovery Room time

See Attachment III

8. OBV cases and one-day surgical cases will be subject to the CPV starting in FY 2011

Observation and one-day surgical cases, as identified in Attachment III, will be included in the

Charge per Visit Methodology beginning FY 2011.

9. Exemption of OBV cases from any case mix cap imposed on outpatient cases

If a case-mix governor is imposed on outpatient cases in FY 2011, hospitals will be held harmless for the increase in observation cases between FY 2010 and FY 2011. The hold harmless adjustment will be made in FY 2012. Staff will calculate the increase in the number of OBV cases between FY 2010 and FY 2011 at each hospital from the outpatient data set. If a hospital's OBV cases increased by 2% for example, HSCRC will make a 2% proportional adjustment to the hospital's outpatient case mix when determining the hospital's case mix amount for FY 2012.

Attachment I to Appendix I

Summary Results of the ODS Revenue Neutral Continued Incentive
Option 1: Scaling \$10 Million of Statewide Inpatient Revenue (weaker incentives)

Hospital	ODS Index	Rank	Percentile Rank	Proposed Adjustment	Revenue Impact
Franklin Square Hospital	1.2431	1	0%	-0.1222%	(\$350,116)
Union Memorial Hospital	1.2403	2	4%	-0.1222%	(\$379,587)
Harford Memorial Hospital	1.187	3	6%	-0.0984%	(\$59,793)
Upper Chesapeake Medical Center	1.1727	4	8%	-0.0920%	(\$128,008)
Anne Arundel General Hospital	1.1307	5	10%	-0.0732%	(\$190,485)
Calvert Memorial Hospital	1.1278	6	12%	-0.0720%	(\$44,290)
Carroll County General Hospital	1.1069	7	14%	-0.0626%	(\$89,563)
Johns Hopkins Oncology Center	1.0921	8	16%	-0.0560%	(\$40,503)
Johns Hopkins Hospital	1.0816	9	18%	-0.0513%	(\$431,357)
Mercy Medical Center, Inc.	1.0774	10	20%	-0.0494%	(\$101,810)
Sinai Hospital	1.0753	11	22%	-0.0485%	(\$177,137)
St. Josephs Hospital	1.049	12	24%	-0.0368%	(\$107,125)
Baltimore Washington Medical Center	1.0296	13	27%	-0.0281%	(\$55,975)
Univ. of Maryland Medical System	1.0293	14	29%	-0.0280%	(\$156,705)
Garrett County Memorial Hospital	1.0213	15	31%	-0.0244%	(\$4,989)
Memorial Hospital at Easton	1.0185	16	33%	-0.0231%	(\$22,278)
Union Hospital of Cecil County	1.0116	17	35%	-0.0201%	(\$13,424)
Suburban Hospital Association, Inc	1.0104	18	37%	-0.0195%	(\$32,911)
Maryland General Hospital	1.0053	19	39%	-0.0172%	(\$23,874)
St. Agnes Hospital	1.0022	20	41%	-0.0159%	(\$39,859)
Howard County General Hospital	0.9761	21	43%	-0.0042%	(\$6,113)
Washington Adventist Hospital	0.9758	22	45%	-0.0041%	(\$8,834)
Good Samaritan Hospital	0.9621	23	47%	0.0034%	\$7,075
Greater Baltimore Medical Center	0.9615	24	49%	0.0039%	\$8,947
St. Marys Hospital	0.9569	25	51%	0.0073%	\$4,872
Atlantic General Hospital	0.9448	26	53%	0.0163%	\$6,196
Harbor Hospital Center	0.9086	27	55%	0.0433%	\$65,227
Johns Hopkins Bayview Med. Center	0.9037	28	57%	0.0470%	\$121,593
Doctors Community Hospital	0.9005	29	59%	0.0494%	\$56,710
Washington County Hospital	0.8958	30	61%	0.0529%	\$84,049
Laurel Regional Hospital	0.8904	31	63%	0.0569%	\$35,207
Sinai Oncology	0.8835	32	65%	0.0620%	\$18,313
Holy Cross Hospital of Silver Spring	0.8688	33	67%	0.0730%	\$209,434
Prince Georges Hospital	0.852	34	69%	0.0855%	\$152,378
Montgomery General Hospital	0.8479	35	71%	0.0886%	\$88,799
Shady Grove Adventist Hospital	0.8448	36	73%	0.0909%	\$194,061
Dorchester General Hospital	0.8378	37	76%	0.0961%	\$28,987
Northwest Hospital Center, Inc.	0.8318	38	78%	0.1006%	\$128,075
Peninsula Regional Medical Center	0.8291	39	80%	0.1026%	\$269,514
James Lawrence Kernan Hospital	0.829	40	82%	0.1027%	\$49,766
Western Maryland Regional Medical Center	0.8258	41	84%	0.1050%	\$176,956
Civista Medical Center	0.8254	42	86%	0.1053%	\$72,148
Southern Maryland Hospital	0.8157	43	88%	0.1126%	\$177,144
Frederick Memorial Hospital	0.804	44	90%	0.1213%	\$204,337
McCready Foundation, Inc.	0.7688	45	92%	0.1475%	\$9,142
Chester River Hospital Center	0.7187	46	94%	0.1849%	\$54,794
Fort Washington Medical Center	0.6989	47	96%	0.1997%	\$47,216
Bon Secours Hospital	0.6931	48	98%	0.2040%	\$152,133
University (UMCC)	0.4963	49	100%	0.2040%	\$41,661
Statewide Total				0.0000%	\$0

Attachment II to Appendix I

URGENT

May 6, 2010

To: Chief Financial Officers
From: Robert Murray, Executive Director
Re: Admission Denied for Medical Necessity - - Reporting

After reviewing the Admission Denied for Medical Necessity reports for the first two quarters of FY 2010, it appears that some hospitals may be under-reporting these cases. Since these cases will be excluded from the Charge per Case rate system, it is imperative that all cases be reported. In the event there may be some misunderstanding as to the cases to be reported, "Admission Denied for Medical Necessity" cases means: those cases, for all payers, where the inpatient admission has subsequently been denied for medical necessity, either self denied, denied after adjudication, or when the hospital does not contest the denial. This refers to those cases where **all of the inpatient routine room and board charges and the admission charge are denied**. Whether or not the hospital is reimbursed for ancillary services provided is not a factor. Several examples are attached as Exhibit A.

Hospitals submitting inaccurate or incomplete data may be subject to fines of up to \$250 a day from the date that the report was due until complete and accurate data are **received**. However, Commission staff is providing hospitals the opportunity to review their records to be absolutely certain that they have reported all Admission Denied for Medical Necessity cases for the first two quarters of FY 2010. Revisions to the first two quarterly reports may be submitted without penalties on or before June 4, 2010. Additional cases may be included in the Third Quarter FY 2010 Report which is due on May 18, 2010.

If, after review of the Reports for the first three quarters of FY 2010 and any revisions received, the volume of cases at some hospitals still appears to be underreported, staff will require those hospitals to make available all of their data associated with denials for on-site review .

If you have any questions concerning the above, please contact Dennis N. Phelps, Associate Director-Audit & Compliance, at 410-764-2565.

Attachment III to Appendix I

April 29, 2010

To: Chief Financial Officers

From: Dennis N. Phelps – Associate Director, Audit & Compliance

Re: Establishment of an Observation Rate Center for Medical Observation Cases and Conversion of Same Day Surgery Rate Center

The purpose of this memorandum is to notify hospitals of the process for establishing an Observation (OBV) rate center and the process to for converting their Same Day Surgery (SDS) rate effective July 1, 2010. The information needed to develop the OBV rate center and for the SDS conversion must be received in the HSCRC's offices on or before June 1, 2010, in conformance with the details stated below.

Overview

The purpose of OBV is to determine whether or not a patient should be admitted to the hospital as an inpatient. The decision to provide OBV should be solely a medical decision. OBV must be ordered and documented in writing by a medical staff practitioner. OBV services include the use of a hospital bed and periodic monitoring by nursing or other hospital staff in order to evaluate the patient's condition. Because of the nature of OBV, patients may enter through the Emergency Department (EMG) or may be directly admitted to OBV from a physician's office. OBV may be provided in a distinct unit or at any location within the hospital.

There is currently a way to charge for OBV, i.e., the costs associated with observation services are compiled in EMG, and OBV is charged as EMG services (one hour of OBV services equals 1.5 EMG RVUs). However, because reducing one-day cases will result in the provision of more outpatient observation cases, the HSCRC has decided, at the suggestion of the hospital industry, that a separate and distinct OBV rate center should be established effective July 1, 2010.

Because one-day cases will be removed from the Charge per Case (CPC) system, the need to project how many one-day cases will become OBV visits in the future and to remove revenue and days from routine centers in setting up the OBV rate center has been eliminated. The most important issue in developing the OBV rate center is setting the OBV rate since, in most cases, the actual cost of an hour of OBV services will not be known until a full year's cost data are available.

Establishing a OBV Rate Center

The inconsistency in use of OBV services among Maryland hospitals dictates that there needs to be more than one methodology for the creation of the OBV rate center. For the purposes of establishing the OBV rate center, all hospitals fall into two general categories: 1) all hospitals that have been providing and charging for OBV services, i.e., they have been generating EMG units and revenue for OBV services; and 2) all hospitals that have not been providing OBV services or have been providing OBV services but not charging for them. Below you will find the methodology to be used in each case, with variations within each category. In addition, you will find the information that must be submitted in order to establish your hospital's new OBV rate

center. In the new OBV rate center, 1 hour equals 1 OBV RVU.

METHODOLOGIES

Category 1 - Hospitals that have been providing and charging for OBV services - (Generating EMG units and revenue for OBV services.)

Sub-categories:

A. Hospitals charging for OBV with all OBV costs in the EMG rate center (having accurately allocated OBV costs from routine centers):

- 1) Allocate OBV costs from EMG rate center based on EMG unit costs (unless there is a cost finding) and allocate OBV hours from EMG at 1 OBV hour
- 2) times 1.5 EMG RVU;

B. Hospitals charging for OBV that did not appropriately allocate all costs to EMG rate center:

- 1) Allocate new OBV units from EMG rate center (EMG RVUs times 1.5).
- 2) Allocate costs from EMG and routine rate centers based on cost finding or allocate from both EMG and routine rate centers based on Hospital's Medical/Surgical (MSG) cost per unit (patient day)divided by 24.
- 3) **Information to be provided to HSCRC: the rationale and supporting data for cost and unit of services reallocations, and a revised FY 2009 Schedule M so that the rate centers can be RATE REALIGNED in the IAS/PVPPI process. New CPC and Charge per Visit (CPV) targets will be established based on the underlying costs.**

The first year after creation of new OBV rate:

At same volumes, Hospital will generate less revenue in its EMG rate center and, if applicable, its routine centers based on allocation of costs; it will generate new revenue in OBV rate center.

Reconciliation of OBV rate to actual cost first year after creation of new OBV rate:

When FY 2011 cost data are available, determine whether FY 2011 OBV revenue generated is appropriate by comparing direct cost per actual OBV unit to direct cost per unit used to establish OBV rate. If OBV rate was

either understated or overstated, a one time revenue adjustment will be made to the Hospital's total rate base before rate realignment.

Category 2 - Hospitals that have not been providing OBV services or have been providing OBV services but not charging for them. (No new revenue has been generated by OBV services. Rate centers where OBV costs have been reported have been overstated - - other rate centers understated):

- 1) In the absence of any historical data, the hospital's MSG rate divided by 24 should be used to set the OBV rate at a volume of 1.
- 2) **Information to be provided to HSCRC:** the rationale and supporting data for setting the OBV rate at other than the Hospital's MSG rate divided by 24. The new OBV rate can be established at the end of the Hospital's IAS/PVPPI process, since no volume or revenue is used to determine the new OBV rate, and the new rate will not affect the CPC and CPV targets.

First year after creation of new OBV rate center:

At same volumes, the Hospital will generate the same CPC revenue; however with the expected decreases in inpatient volumes, the routine centers will generate less revenue and CPC will have fewer cases, while generating new revenue in the OBV center.

Reconciliation of OBV rate to actual cost first year after creation of new OBV rate:

Use same methodology as in Category 1.

Surgical Cases – Same Day Surgery Recovery Services

The current structure of the Same Day Surgery (SDS) rate center is a fixed "per visit" charge per case for every outpatient surgical case. As part of the Commission's initiative to reduce the number of one-day stay cases, including surgical cases, more difficult cases will migrate from inpatient to outpatient. In order to allow for more appropriate matching of resource use to charges, the SDS rate must be tiered.

- 1) The Commission has decided to permit the SDS rate to be tiered. Hospitals will be required to tier their SDS based on a reasonable matching of resources utilized to the rate charged. If the recovery costs for outpatient surgical cases have not been appropriately allocated to the SDS rate center, costs may be allocated to SDS from other rate centers.
- 2) **Information to be provided to HSCRC: the supporting data for cost reallocations, and a revised FY 2009 Schedule M so that the rate centers can be RATE REALIGNED in the IAS/PVPPI process.**

Reconciliation of SDS rate to actual cost first year after conversion of SDS rate:

When FY 2011 cost data become available, determine whether FY 2011 OBV revenue generated is appropriate by comparing direct cost per actual SDS visit to the direct cost per SDS visit used to establish the SDS rate. If SDS rate was either understated or overstated, a one time revenue adjustment will be made to the Hospital's total rate base before rate realignment.

If you have any questions about the category that your hospital belongs in or technical questions about the methodologies, you may call me, Rodney Spangler or Chris O'Brien at 410-764-2605.

Appendix II – MHA Consensus Proposal for Reallocation of Case Mix for “early –adopter” hospitals

Robert Murray

From: Robbins, Mike [mrobbins@MHAONLINE.ORG]
Sent: Wednesday, May 26, 2010 1:15 PM
To: Robert Murray
Subject: "Early adopters" policy for HSCRC consideration at June meeting
Attachments: Observation Methodology for CFP - 051810.pdf

Bob,

As I mentioned to you last Friday, this e-mail is to follow-up with you regarding the consensus decision of MHA's Council on Financial Policy regarding a means to recognize the case-mix governor-associated revenues lost by hospitals that were "early adopters" of outpatient observation. I have attached for your information a copy of the presentation that was made by those hospitals that sought to amend our original proposal. As you will note, this proposal focuses on outpatient observation coding as the basis for defining "early adopters" and only looks at medical observation cases. For 2008/2009, the total estimated rate relief for those hospitals would be approximately \$29 million. The CFP thought that, if possible, perhaps this rate relief could be funded through savings that may have been realized in FY 2010 for actual case-mix being below what our budget was for this year. In absence of your acceptance of that request, the CFP's position that this "early adopter" rate relief be funded through slippage on ALL hospitals.

I appreciate your consideration of this revised recommendation, and will be prepared to address this position at the June HSCRC meeting as needed. Thanks again for all of your help in fashioning this final ODS policy.

Mike

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Observation Services

Discussion of Alternative Methodology for
Early Adopters

May 18, 2010

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Section 1

Background

Background

- » Over the past year, the Health Services Cost Review Commission (“HSCRC”) has been looking at one-day stays and observation services in Maryland
- » The HSCRC has noted that hospitals in Maryland have a higher rate of one-day stays than the rest of the nation and less than half of the hospitals provide observation services
- » The HSCRC asked the hospital industry to recommend a reasonable plan to incentivize hospitals to implement observation services and reduce one-day stays
- » For early adopters, Observation services has resulted in a significant reduction in permanent rate capacity
 - › Lower rate capacity for Observation services
 - › By moving cases that would have resulted in a one-day inpatient stay to observation, the Hospital’s lost revenue due to the governor

Background

- » At the May 5, 2010 HSCRC public meeting, the Commission passed a number of measures relating to one-day stays and denied cases
- » The MHA has a proposed methodology to credit hospitals for lost revenue due to the casemix governor on converted observation cases
- » There are several concerns regarding the MHA proposal:
 - › Assumes that the level of one-day stay cases is an accurate measure of observation services
 - › The use of one days stays as a measure of medical observation has the potential to reward hospitals that did not provide Medical Observation services
 - › All hospitals, including “early adopters” must fund the CMI restoration
- » An alternative approach to address the “early adopters” is presented in this document

Section 2

Observation

Observation Methodology

- » An alternative methodology would be to specifically identify Observation cases for 2007, 2008 and 2009 and corresponding casemix to determine actual impact on each Hospital's CMI

- » Observation cases were identified for FY 2007, FY 2008 and FY 2009 using the following methodology:
 - › Cases with ED charges
 - › Cases with Revenue Code 760 and 762 (Observation) and charges > \$0
 - Hospitals have been inconsistent reporting Observation CPT codes especially for 2007 and 2008
 - › Excluded cases that grouped to MDC 14 – Pregnancy and Childbirth
 - This represent cases that would have Labor and Delivery Observation charges

Observation Methodology

- » Cases were then grouped under APR-DRGs to determine the case mix if each observation case had been an inpatient case
 - › Outpatient cases contain up to 15 diagnosis codes
 - › Excluded cases that grouped to MDC 14 – Pregnancy and Childbirth
 - › Excluded ungroupable cases for FY 2008 and FY 2009
 - Less than 1% of cases Statewide could not be grouped

- » The impact of the Observation cases on the CMI Governor was calculated as follows:
 - › For both FY 2008 and FY 2009, the CMI and corresponding change in CMI was calculated as if the Observation cases had been inpatient cases
 - › A revised CMI Governor was calculated for each hospital based on the adjusted CMI change
 - › The variance in the CMI Governor was then applied to the Hospitals rate base to determine the rate impact

Observation Cases

Hospital Number	Hospital	FY 2007 Excl. MDC 14		FY 2008 Excl. MDC 14		FY 2008 Excl. MDC 14		Incremental Cases			
		Cases	CMI	Cases	CMI	Cases	CMI	Incremental Cases FY 2008		Incremental Cases FY 2009	
								Cases	CMI	Cases	CMI
210001	Washington Cty. Hospital	1,630	0.3859	1,562	0.3766	1,638	0.3670	(68)	0.3766	76	0.3670
210002	U Of Md Hospital	168	0.4008	236	0.4557	304	0.3057	68	0.4557	68	0.3057
210003	Prince Georges Hosp. Ctr.	739	0.4066	727	0.4285	1,445	0.4064	(12)	0.4285	718	0.4064
210004	Holy Cross Hospital	3	0.4991	2,564	0.4202	2,711	0.4107	2,561	0.4202	147	0.4107
210005	Frederick Memorial Hospital	78	0.2565	-	-	1,361	0.4349	(78)	-	1,361	0.4349
210006	Harford Memorial Hospital	75	0.4805	71	0.4044	351	0.4648	(4)	0.4044	280	0.4648
210007	Saint Joseph Hospital	537	0.4034	839	0.4403	616	0.3602	302	0.4403	(223)	0.3602
210008	Mercy Medical Center	1,046	0.3206	1,352	0.3927	225	0.3797	306	0.3927	(1,127)	0.3797
210009	Johns Hopkins Hospital	1,776	0.4267	1,868	0.4221	2,781	0.4101	92	0.4221	913	0.4101
210010	Dorchester General Hospital	2	0.3618	3	0.3689	6	0.4341	1	0.3689	3	0.4341
210011	St. Agnes Healthcare	2	0.3757	22	0.4343	41	0.3776	20	0.4343	19	0.3776
210012	Sinai Hospital	140	0.2798	193	0.3968	136	0.3768	53	0.3968	(57)	0.3768
210013	Bon Secours Hospital	-	-	471	0.4218	317	0.4222	471	0.4218	(154)	0.4222
210015	Franklin Square Hospital	1,450	0.5621	1,453	0.3661	1,116	0.4944	3	0.3661	(337)	0.4944
210016	Wash. Adventist Hospital	294	0.3702	891	0.3547	892	0.3527	597	0.3547	1	0.3527
210017	Garrett Cty. Mem. Hospital	-	-	-	-	-	-	-	-	-	-
210018	Montgomery General Hospital	30	0.3995	34	0.3964	76	0.3698	4	0.3964	42	0.3698
210019	Peninsula Regional Med Ctr	19	0.5271	41	0.3709	28	0.3687	22	0.3709	(13)	0.3687
210022	Suburban Hospital	-	-	176	0.4551	419	0.4435	176	0.4551	243	0.4435
210023	Anne Arundel Med. Ctr.	795	0.3959	1,033	0.4206	1,490	0.4094	238	0.4206	457	0.4094
210024	Union Memorial Hospital	9	0.3536	118	0.4156	67	0.3525	109	0.4156	(51)	0.3525
210025	Memorial Of Cumberland Hosp.	-	-	-	-	-	-	-	-	-	-
210027	Sacred Heart Hospital	-	-	-	-	-	-	-	-	-	-
210028	St. Mary'S Hospital	100	0.2890	176	0.3916	198	0.2456	76	0.3916	22	0.2456
210029	Johns Hopkins Bayview Med. Ctr.	157	0.4211	1,051	0.4434	2,062	0.4389	894	0.4434	1,011	0.4389
210030	Chester River Hospital Center	-	-	-	-	-	-	-	-	-	-
210032	Union Of CeGl Hospital	-	-	-	-	-	-	-	-	-	-
210033	Carroll Cty. General Hospital	-	-	-	-	-	-	-	-	-	-
210034	Harbor Hospital Center	40	0.3404	94	0.4474	124	0.3916	54	0.4474	30	0.3916
210035	Civista Medical Center	4	0.4492	25	0.3408	180	0.3969	21	0.3408	155	0.3969
210037	Mem. Hosp. At Easton	261	0.3756	115	0.4435	105	0.3594	(146)	0.4435	(10)	0.3594
210038	Maryland General Hospital	-	-	-	-	-	-	-	-	-	-
210039	Calvert Memorial Hospital	82	0.4290	162	0.4277	189	0.3566	80	0.4277	27	0.3566
210040	Northwest Hospital Center	-	-	-	-	-	-	-	-	-	-
210043	Baltimore Washington Medical Center	1,620	0.3831	1,884	0.4603	1,997	0.3678	264	0.4603	113	0.3678
210044	Greater Baltimore Med. Ctr.	614	0.4809	3,341	0.4382	3,688	0.4772	2,727	0.4382	347	0.4772
210045	McCreedy Memorial Hospital	-	-	-	-	1	0.5658	-	-	1	0.5658
210048	Howard Cty. General Hospital	1,488	0.4334	1,349	0.4049	1,642	0.4374	(139)	0.4049	293	0.4374
210049	Upper Chesapeake Medical Center	1,233	0.3761	276	0.3952	597	0.4469	(957)	0.3952	321	0.4469
210051	Doctors Community Hospital	1,378	0.3719	1,346	0.3785	1,514	0.3543	(32)	0.3785	168	0.3543
210054	Southern Maryland Hospital	-	-	860	0.4565	820	0.4176	860	0.4565	(40)	0.4176
210055	Laurel Regional Hospital	195	0.3690	328	0.4010	366	0.3878	133	0.4010	38	0.3878
210058	Kernan Hospital	-	-	-	-	-	-	-	-	-	-
210056	Good Samaritan Hospital	-	-	-	-	-	-	-	-	-	-
210057	Shady Grove Hospital	2,241	0.3488	2,658	0.3907	2,675	0.3896	417	0.3907	17	0.3896
210904	Johns Hopkins Oncology Center	-	-	19	0.4032	2	0.4601	19	0.4032	(17)	0.4601
210061	Atlantic General Hospital	-	-	-	-	-	-	-	-	-	-
210060	Fort Washington Medical Ctr.	-	-	-	-	-	-	-	-	-	-
218994	Umd (Cancer Center)	-	-	-	-	-	-	-	-	-	-
210080	Sinai - Oncology	-	-	-	-	-	-	-	-	-	-
Total		18,206	0.4011	27,338	0.4134	32,180	0.4117	9,132	0.4333	4,842	0.4330

Case Mix Governor Impact Due to Observation

Hospital Number	Hospital Name	FY 2008	FY 2009	Total
210001	Washington Cty. Hospital	-	269,568	269,568
210002	U Of Md Hospital	219,985	729,561	949,547
210003	Prince Georges Hosp. Ctr.	-	-	-
210004	Holy Cross Hospital	2,871,402	-	2,871,402
210005	Frederick Memorial Hospital	-	4,070,614	4,070,614
210006	Harford Memorial Hospital	-	-	-
210007	Saint Joseph Hospital	-	-	-
210008	Mercy Medical Center	517,747	-	517,747
210009	Johns Hopkins Hospital	337,484	5,813,638	6,151,122
210010	Dorchester General Hospital	-	-	-
210011	St. Agnes Healthcare	5,445	86,062	91,506
210012	Sinai Hospital	147,572	-	147,572
210013	Bon Secours Hospital	767,809	-	767,809
210015	Franklin Square Hospital	-	-	-
210016	Wash. Adventist Hospital	-	-	-
210017	Garrett Cty. Mem. Hospital	-	-	-
210018	Montgomery General Hospital	5,491	145,194	150,685
210019	Peninsula Regional Med Ctr	-	-	-
210022	Suburban Hospital	83,159	1,030,229	1,113,387
210023	Anne Arundel Med. Ctr.	332,163	1,536,679	1,868,842
210024	Union Memorial Hospital	319,935	-	319,935
210025	Memorial Of Cumberland Hosp.	-	-	-
210027	Sacred Heart Hospital	-	-	-
210028	St. Mary'S Hospital	-	-	-
210029	Johns Hopkins Bayview Med. Ctr.	1,652,342	3,138,675	4,791,017
210030	Chester River Hospital Center	-	-	-
210032	Union Of Cecil Hospital	-	-	-
210033	Carroll Cty. General Hospital	-	-	-
210034	Harbor Hospital Center	67,403	101,861	169,264
210035	Civista Medical Center	27,747	429,043	456,790
210037	Mem. Hosp. At Easton	-	-	-
210038	Maryland General Hospital	-	-	-
210039	Calvert Memorial Hospital	-	64,499	64,499
210040	Northwest Hospital Center	-	-	-
210043	Baltimore Washington Medical Center	476,283	519,669	995,952
210044	Greater Baltimore Med. Ctr.	1,599,552	435,143	2,034,695
210045	Mccready Memorial Hospital	-	-	-
210048	Howard Cty. General Hospital	-	44,996	44,996
210049	Upper Chesapeake Medical Center	-	827,341	827,341
210051	Doctors Community Hospital	-	-	-
210054	Southern Maryland Hospital	-	-	-
210055	Laurel Regional Hospital	190,324	-	190,324
210058	Kernan Hospital	-	-	-
210056	Good Samaritan Hospital	-	-	-
210057	Shady Grove Hospital	546,144	47,654	593,799
210904	Johns Hopkins Oncology Center	87,679	-	87,679
210061	Atlantic General Hospital	-	-	-
210060	Fort Washington Medical Ctr.	-	-	-
218994	Umd (Cancer Center)	-	-	-
210080	Sinai - Oncology	-	-	-
	Total	\$10,255,665	\$19,290,427	\$29,546,093

2008 Governor Impact of Observation Cases

Hospital Number	Hospital	CPC Revenue	Actual		Incremental Observation		Adjusted for Observation			CMI Change		CMI Governor		Revenue Impact	
			Cases	Base CMI	Current CMI	Cases	CMI	Cases	Base CMI	Current CMI	Original	Observation Adjustment	Original		Observation Adjustment
210001	Washington Cty. Hospital	\$151,664,745	18,435	0.9611	0.9744	(68)	0.3766	18,367	0.9611	0.98	1.4%	1.6%	-0.3%	-0.5%	\$0
210002	U Of Md Hospital	518,007,525	26,355	1.3371	1.3388	68	0.4557	26,423	1.3371	1.34	0.1%	0.0%	0.0%	0.0%	219,985
210003	Prince Georges Hosp. Ctr.	163,650,221	15,893	0.9742	0.9650	(12)	0.4285	15,881	0.9742	0.97	-0.9%	-0.9%	0.0%	0.0%	-
210004	Holy Cross Hospital	265,606,740	35,628	0.7897	0.8352	2,561	0.4202	38,189	0.7897	0.81	5.8%	2.2%	-1.8%	-0.7%	2,871,402
210005	Frederick Memorial Hospital	156,326,680	20,140	0.8955	0.9163	(78)	-	20,062	0.8955	0.92	2.3%	2.7%	-0.8%	-0.8%	-
210006	Harford Memorial Hospital	53,421,417	7,317	0.8226	0.8468	(4)	0.4044	7,313	0.8226	0.85	2.9%	3.0%	0.0%	0.0%	-
210007	Saint Joseph Hospital	274,995,712	25,472	1.2172	1.2108	302	0.4403	25,774	1.2172	1.20	-0.5%	-1.3%	0.0%	0.0%	-
210008	Mercy Medical Center	185,110,914	20,158	0.8889	0.9097	306	0.3927	20,464	0.8889	0.90	2.3%	1.5%	-0.8%	-0.5%	517,747
210009	Johns Hopkins Hospital	763,882,222	42,706	1.3427	1.3724	92	0.4221	42,798	1.3427	1.37	2.2%	2.1%	-0.2%	-0.7%	337,484
210010	Dorchester General Hospital	26,828,212	3,524	0.8972	0.8814	1	0.3689	3,525	0.8972	0.88	-1.8%	-1.8%	0.0%	0.0%	-
210011	St. Agnes Healthcare	219,309,087	21,673	1.0059	1.0361	20	0.4343	21,693	1.0059	1.04	3.0%	2.9%	-1.0%	-1.0%	5,445
210012	Sinai Hospital	335,188,608	26,704	1.1857	1.2029	53	0.3968	26,757	1.1857	1.20	1.5%	1.3%	-0.5%	-0.4%	147,572
210013	Bon Secours Hospital	62,506,575	6,597	0.9624	1.0478	471	0.4218	7,068	0.9624	1.01	8.9%	4.5%	-2.7%	-1.5%	767,809
210015	Franklin Square Hospital	276,029,716	30,154	0.8961	0.9121	3	0.3661	30,157	0.8961	0.91	1.8%	1.8%	-0.6%	-0.6%	-
210016	Wash. Adventist Hospital	208,841,610	20,217	1.0728	1.0696	597	0.3547	20,814	1.0728	1.05	-0.3%	-2.2%	0.0%	0.0%	-
210017	Garrett Cty. Mem. Hospital	19,987,666	2,998	0.7939	0.8328	-	-	2,998	0.7939	0.83	4.9%	4.9%	-1.6%	-1.6%	-
210018	Montgomery General Hospital	94,542,870	11,010	0.9006	0.9148	4	0.3964	11,014	0.9006	0.91	1.6%	1.6%	-0.5%	-0.5%	5,491
210019	Peninsula Regional Med Ctr	244,209,420	23,205	1.1843	1.2250	22	0.3709	23,227	1.1843	1.22	3.4%	3.4%	-1.1%	-1.1%	-
210022	Suburban Hospital	156,625,492	14,708	1.1702	1.1971	176	0.4551	14,884	1.1702	1.19	2.3%	1.5%	-0.6%	-0.5%	83,159
210023	Anne Arundel Med. Ctr.	227,504,385	28,671	0.9098	0.9300	238	0.4206	28,909	0.9098	0.93	2.2%	1.8%	-0.7%	-0.6%	332,163
210024	Union Memorial Hospital	294,770,430	20,690	1.3365	1.3767	109	0.4156	20,799	1.3365	1.37	3.0%	2.6%	-1.0%	-0.9%	319,935
210025	Memorial Of Cumberland Hosp.	68,314,400	8,800	0.8428	0.8394	-	-	8,800	0.8428	0.84	-0.4%	-0.4%	0.0%	0.0%	-
210027	Sacred Heart Hospital	78,242,218	9,277	0.9998	1.0205	-	-	9,277	0.9998	1.02	2.1%	2.1%	-0.5%	-0.5%	-
210028	St. Mary'S Hospital	67,147,824	10,792	0.6900	0.6847	76	0.3916	10,868	0.6900	0.68	-0.8%	-1.1%	0.0%	0.0%	-
210029	Johns Hopkins Bayview Med. Ctr.	235,465,342	22,421	0.9579	0.9798	894	0.4434	23,315	0.9579	0.96	2.3%	0.1%	-0.7%	0.0%	1,652,342
210030	Chester River Hospital Center	31,389,948	3,852	0.7891	0.8116	-	-	3,852	0.7891	0.81	2.9%	2.9%	-0.6%	-0.6%	-
210032	Union Of Cecil Hospital	65,668,142	9,266	0.8181	0.8104	-	-	9,266	0.8181	0.81	-0.9%	-0.9%	0.0%	0.0%	-
210033	Carroll Cty. General Hospital	130,020,669	17,219	0.8259	0.8750	-	-	17,219	0.8259	0.88	6.0%	6.0%	-1.8%	-1.8%	-
210034	Harbor Hospital Center	141,479,073	15,447	0.8816	0.9058	54	0.4474	15,501	0.8816	0.90	2.7%	2.6%	-0.9%	-0.8%	67,403
210035	Civista Medical Center	64,383,552	8,436	0.7876	0.8043	21	0.3408	8,457	0.7876	0.80	2.1%	2.0%	-0.7%	-0.6%	27,747
210037	Mem. Hosp. At Easton	85,878,684	10,908	0.8781	0.8736	(146)	0.4435	10,762	0.8781	0.88	-0.5%	0.2%	0.0%	0.0%	-
210038	Maryland General Hospital	132,652,300	12,694	0.9398	1.0174	-	-	12,694	0.9398	1.02	8.3%	8.3%	-2.2%	-2.2%	-
210039	Calvert Memorial Hospital	58,066,784	8,972	0.7275	0.7421	80	0.4277	9,052	0.7275	0.74	2.0%	1.6%	0.0%	0.0%	-
210040	Northwest Hospital Center	116,728,864	12,788	0.9732	0.9914	-	-	12,788	0.9732	0.99	1.9%	1.9%	-0.6%	-0.6%	-
210043	Baltimore Washington Medical Center	180,596,765	18,881	1.0631	1.0736	264	0.4603	19,145	1.0631	1.07	1.0%	0.2%	-0.3%	-0.1%	476,283
210044	Greater Baltimore Med. Ctr.	205,223,520	26,080	0.8875	0.9130	2,727	0.4382	28,807	0.8875	0.87	2.9%	-2.2%	-0.8%	0.0%	1,599,552
210045	Mccready Memorial Hospital	5,689,836	732	0.8147	0.7514	-	-	732	0.8147	0.75	-7.8%	-7.8%	0.0%	0.0%	-
210048	Howard Cty. General Hospital	132,692,280	16,805	0.8772	0.8782	(139)	0.4049	16,666	0.8772	0.88	0.1%	0.6%	0.0%	0.0%	-
210049	Upper Chesapeake Medical Center	127,443,960	17,304	0.8241	0.8280	(957)	0.3952	16,347	0.8241	0.85	0.5%	3.6%	-0.2%	-0.2%	-
210051	Doctors Community Hospital	103,470,666	11,622	0.9972	1.0137	(32)	0.3785	11,590	0.9972	1.02	1.8%	1.8%	-0.5%	-0.5%	-
210054	Southern Maryland Hospital	152,905,920	19,392	0.8401	0.8291	860	0.4565	20,252	0.8401	0.81	-1.3%	-3.2%	0.0%	0.0%	-
210055	Laurel Regional Hospital	60,746,460	7,230	0.8655	0.8983	133	0.4010	7,363	0.8655	0.89	3.8%	2.8%	-1.2%	-0.9%	190,324
210058	Kernan Hospital	45,039,380	2,764	1.6885	1.7397	-	-	2,764	1.6885	1.74	3.0%	3.0%	-1.0%	-1.0%	-
210056	Good Samaritan Hospital	196,924,574	17,066	1.2003	1.1949	-	-	17,066	1.2003	1.19	-0.4%	-0.4%	0.0%	0.0%	-
210057	Shady Grove Hospital	188,069,760	25,360	0.8323	0.8472	417	0.3907	25,777	0.8323	0.84	1.8%	0.9%	-0.6%	-0.3%	546,144
210904	Johns Hopkins Oncology Center	59,290,220	2,822	1.4671	1.5145	19	0.4032	2,841	1.4671	1.51	3.2%	2.7%	-1.0%	-0.9%	87,679
210061	Atlantic General Hospital	34,818,579	3,681	1.0305	1.0936	-	-	3,681	1.0305	1.09	6.1%	6.1%	-1.9%	-1.9%	-
210060	Fort Washington Medical Ctr.	21,650,574	2,903	0.8342	0.8728	-	-	2,903	0.8342	0.87	4.6%	4.6%	-1.5%	-1.5%	-
218994	Umd (Cancer Center)	13,926,825	825	1.3160	1.3889	-	-	825	1.3160	1.39	5.5%	5.5%	-1.8%	-1.8%	-
210080	Sinai - Oncology	32,541,914	1,486	1.5342	1.5877	-	-	1,486	1.5342	1.59	3.5%	3.5%	-1.1%	-1.1%	-

Total

\$10,255,665

2009 Governor Impact of Observation Cases

Hospital Number	Hospital	CPC Revenue	Actual		Incremental Observation		Adjusted for Observation			CMI Change		CMI Governor		Revenue Impact	
			Cases	Base CMI	Current CMI	Cases	CMI	Cases	Base CMI	Current CMI	Original	Observation Adjustment	Original		Observation Adjustment
210001	Washington Cty. Hospital	\$154,156,699	18,181	0.9563	0.9666	76	0.3670	18,257	0.9563	0.96	1.1%	0.8%	-0.7%	-0.5%	\$269,568
210002	U Of Md Hospital	549,257,256	26,968	1.3119	1.3398	68	0.3057	27,036	1.3119	1.34	2.1%	1.9%	-1.4%	-1.3%	729,561
210003	Prince Georges Hosp. Ctr.	174,466,776	16,284	0.9451	0.9517	718	0.4064	17,002	0.9451	0.93	0.7%	-1.7%	0.0%	0.0%	-
210004	Holy Cross Hospital	289,988,530	36,010	0.8181	0.8031	147	0.4107	36,157	0.8181	0.80	-1.8%	-2.0%	0.0%	0.0%	-
210005	Frederick Memorial Hospital	158,732,080	19,760	0.8946	0.9662	1,361	0.4349	21,121	0.8946	0.93	8.0%	4.2%	-5.4%	-2.8%	4,070,614
210006	Harford Memorial Hospital	61,804,864	7,744	0.8221	0.8085	280	0.4648	8,024	0.8221	0.80	-1.7%	-3.1%	0.0%	0.0%	-
210007	Saint Joseph Hospital	287,005,836	25,428	1.2031	1.2322	(223)	0.3602	25,205	1.2031	1.24	2.4%	3.1%	-1.3%	-1.3%	-
210008	Mercy Medical Center	200,013,354	20,946	0.9001	0.9183	(1,127)	0.3797	19,819	0.9001	0.95	2.0%	5.4%	-1.4%	-1.4%	-
210009	Johns Hopkins Hospital	819,782,788	42,746	1.3470	1.3612	913	0.4101	43,659	1.3470	1.34	1.1%	-0.4%	-0.7%	0.0%	5,813,638
210010	Dorchester General Hospital	28,822,092	3,666	0.8498	0.9119	3	0.4341	3,669	0.8498	0.91	7.3%	7.3%	-3.7%	-3.7%	-
210011	St. Agnes Healthcare	247,111,279	23,297	1.0234	1.0304	19	0.3776	23,316	1.0234	1.03	0.7%	0.6%	-0.5%	-0.4%	86,062
210012	Sinai Hospital	351,436,800	26,400	1.1871	1.2437	(57)	0.3768	26,343	1.1871	1.25	4.8%	4.9%	-3.2%	-3.2%	-
210013	Bon Secours Hospital	71,150,680	7,060	1.0186	1.0166	(154)	0.4222	6,906	1.0186	1.03	-0.2%	1.1%	0.0%	0.0%	-
210015	Franklin Square Hospital	284,686,766	30,331	0.8922	0.9116	(337)	0.4944	29,994	0.8922	0.92	2.2%	2.7%	-1.5%	-1.5%	-
210016	Wash. Adventist Hospital	201,633,804	19,414	1.0487	1.1007	1	0.3527	19,415	1.0487	1.10	5.0%	5.0%	-3.1%	-3.1%	-
210017	Garrett Cty. Mem. Hospital	18,642,689	2,851	0.8213	0.7986	-	-	2,851	0.8213	0.80	-2.8%	-2.8%	0.0%	0.0%	-
210018	Montgomery General Hospital	97,190,280	11,110	0.8930	0.8985	42	0.3698	11,152	0.8930	0.90	0.6%	0.4%	-0.4%	-0.3%	145,194
210019	Peninsula Regional Med Ctr	258,674,864	23,344	1.2063	1.2017	(13)	0.3687	23,331	1.2063	1.20	-0.4%	-0.3%	0.0%	0.0%	-
210022	Suburban Hospital	164,473,070	14,590	1.1839	1.1949	243	0.4435	14,833	1.1839	1.18	0.9%	-0.1%	-0.6%	0.0%	1,030,229
210023	Anne Arundel Med. Ctr.	251,657,780	29,945	0.9206	0.9675	457	0.4094	30,402	0.9206	0.96	5.1%	4.2%	-3.4%	-2.8%	1,536,679
210024	Union Memorial Hospital	305,677,719	20,547	1.3686	1.3947	(51)	0.3525	20,496	1.3686	1.40	1.9%	2.1%	-1.3%	-1.3%	-
210025	Memorial Of Cumberland Hosp.	71,286,434	8,694	0.8275	0.8457	-	-	8,694	0.8275	0.85	2.2%	2.2%	-1.2%	-1.2%	-
210027	Sacred Heart Hospital	86,739,302	9,358	0.9979	1.0250	-	-	9,358	0.9979	1.02	2.7%	2.7%	-1.8%	-1.8%	-
210028	St. Mary'S Hospital	68,805,184	10,724	0.6676	0.6444	22	0.2456	10,746	0.6676	0.64	-3.5%	-3.6%	0.0%	0.0%	-
210029	Johns Hopkins Bayview Med. Ctr.	252,791,700	21,900	0.9585	0.9763	1,011	0.4389	22,911	0.9585	0.95	1.9%	-0.6%	-1.2%	0.0%	3,138,675
210030	Chester River Hospital Center	31,079,290	3,685	0.7942	0.7827	-	-	3,685	0.7942	0.78	-1.4%	-1.4%	0.0%	0.0%	-
210032	Union Of Cecil Hospital	65,013,593	9,197	0.7889	0.8133	-	-	9,197	0.7889	0.81	3.1%	3.1%	-1.4%	-1.4%	-
210033	Carroll Cty. General Hospital	141,536,646	17,307	0.8543	0.8588	-	-	17,307	0.8543	0.86	0.5%	0.5%	-0.4%	-0.4%	-
210034	Harbor Hospital Center	146,926,750	15,385	0.8891	0.8900	30	0.3916	15,415	0.8891	0.89	0.1%	0.0%	-0.1%	0.0%	101,861
210035	Civista Medical Center	66,381,994	8,561	0.7862	0.8234	155	0.3969	8,716	0.7862	0.82	4.7%	3.8%	-3.2%	-2.5%	429,043
210037	Mem. Hosp. At Easton	91,080,496	11,192	0.8590	0.9727	(10)	0.3594	11,182	0.8590	0.97	13.2%	13.3%	-8.5%	-8.5%	-
210038	Maryland General Hospital	136,156,621	12,379	0.9890	0.9783	-	-	12,379	0.9890	0.98	-1.1%	-1.1%	0.0%	0.0%	-
210039	Calvert Memorial Hospital	61,483,422	9,178	0.7234	0.7428	27	0.3566	9,205	0.7234	0.74	2.7%	2.5%	-1.8%	-1.7%	64,499
210040	Northwest Hospital Center	123,960,888	12,744	0.9643	0.9935	-	-	12,744	0.9643	0.99	3.0%	3.0%	-2.0%	-2.0%	-
210043	Baltimore Washington Medical Center	194,270,213	19,507	1.0544	1.0987	113	0.3678	19,620	1.0544	1.09	4.2%	3.8%	-2.8%	-2.6%	519,669
210044	Greater Baltimore Med. Ctr.	228,626,496	25,816	0.8998	0.9023	347	0.4772	26,163	0.8998	0.90	0.3%	-0.3%	-0.2%	0.0%	435,143
210045	Mccready Memorial Hospital	5,713,929	669	0.7256	0.6907	1	0.5658	670	0.7256	0.69	-4.8%	-4.8%	0.0%	0.0%	-
210048	Howard Cty. General Hospital	140,478,096	17,328	0.8597	0.8601	293	0.4374	17,621	0.8597	0.85	0.0%	0.0%	0.0%	0.0%	44,996
210049	Upper Chesapeake Medical Center	132,658,380	17,676	0.8123	0.8708	321	0.4469	17,997	0.8123	0.86	7.2%	6.3%	-4.8%	-4.2%	827,341
210051	Doctors Community Hospital	111,357,604	11,883	0.9892	0.9741	168	0.3543	12,051	0.9892	0.97	-1.5%	-2.4%	0.0%	0.0%	-
210054	Southern Maryland Hospital	152,276,540	18,980	0.8056	0.8405	(40)	0.4176	18,940	0.8056	0.84	4.3%	4.4%	-2.0%	-2.0%	-
210055	Laurel Regional Hospital	61,673,709	7,067	0.8726	0.8348	38	0.3878	7,105	0.8726	0.83	-4.3%	-4.6%	0.0%	0.0%	-
210058	Kernan Hospital	48,900,330	2,790	1.7717	1.6977	-	-	2,790	1.7717	1.70	-4.2%	-4.2%	0.0%	0.0%	-
210056	Good Samaritan Hospital	203,209,972	17,321	1.1764	1.1942	-	-	17,321	1.1764	1.19	1.5%	1.5%	-0.7%	-0.7%	-
210057	Shady Grove Hospital	207,201,117	26,843	0.8288	0.8391	17	0.3896	26,860	0.8288	0.84	1.2%	1.2%	-0.8%	-0.8%	47,654
210904	Johns Hopkins Oncology Center	70,457,656	2,986	1.4751	1.4548	(17)	0.4601	2,969	1.4751	1.46	-1.4%	-1.0%	0.0%	0.0%	-
210061	Atlantic General Hospital	37,993,402	3,791	1.0696	1.0751	-	-	3,791	1.0696	1.08	0.5%	0.5%	-0.3%	-0.3%	-
210060	Fort Washington Medical Ctr.	23,408,686	2,962	0.8523	0.8001	-	-	2,962	0.8523	0.80	-6.1%	-6.1%	0.0%	0.0%	-
218994	Umd (Cancer Center)	16,910,140	845	1.3457	1.4187	-	-	845	1.3457	1.42	5.4%	5.4%	-3.6%	-3.6%	-
210080	Sinai - Oncology	29,378,148	1,563	1.5513	1.6478	-	-	1,563	1.5513	1.65	6.2%	6.2%	-4.2%	-4.2%	-
Total															\$19,290,427

Section 3

Recommendations

Recommendations

- » We recommend the following methodology:
 - › Hospitals must provide evidence to the HSCRC of when they implemented Medical Observation services, including but not limited to a formal Observation policy
 - Hospitals either did or did not have Medical Observation services; take out the guesswork
 - › Based on the calculation outlined, “early adopters” that provided Observation services should be allowed to recoup lost case mix due to the governor
 - › After the “early adopters” are properly identified, the non-Observation hospitals would fund the CMI restoration
 - › This alternative calculation would also apply to FY 2010 due to a continuance of a case mix governor for 2010 “early adopters”
 - › Since one-day stay and denied cases will be excluded from the CPC methodology, no adjustment will be needed in FY 2011 and going forward

Health Services Cost Review Commission

**Report on the Preliminary Results of the Uncompensated Care Policy
for Fiscal Year 2011**

June 9, 2010

Introduction

The purpose of this report is to present the results of the Uncompensated Care policy for fiscal year 2011 and to brief the Commission on discussions surrounding the Uncompensated Care Policy.

The HSCRC's provision for uncompensated care in hospital rates is one of the unique features of rate regulation in Maryland. Uncompensated care includes bad debt and charity care. By recognizing reasonable levels of bad debt and charity care in hospital rates, the system enhances access to hospital care for those citizens who cannot pay for care. The uncompensated care provision in rates is applied prospectively and is meant to be predictive of actual uncompensated care costs in a given year.

The HSCRC uses a regression methodology as a vehicle to predict actual uncompensated care costs in a given year. The uncompensated care methodology has undergone substantial changes over the years since it was initially established. The most recent version of the policy was adopted by the Commission on May 2, 2007.

The uncompensated care regression estimates the relationship between a set of explanatory variables and the rate of uncompensated care observed at each hospital as a percentage of gross patient revenue. Under the current policy, the following variables are included as explanatory variables:

- The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room,
- The proportion of a hospital's total charges from inpatient Medicaid, self-pay, and charity cases,
- The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency room, and
- The proportion of a hospital's total charges from outpatient charges.

Discussions surrounding the Uncompensated Care Policy

In the last three months, a number of hospital representatives have met with staff to discuss various issues related to the uncompensated care methodology. Most of the discussions have focused on the impact of the ongoing Medicaid expansion and the economy on the stability of the uncompensated care regression estimates. Discussions have also taken place on the difficulty of reconciliation and settlement of monies associated with "averted bad debt" and on reconstituting the explanatory variables used in the uncompensated care regression.

There were also suggestions regarding possible revisions to the regression model as presented by representatives from the Johns Hopkins Medical System and Mercy Medical Center at the Maryland Hospital Association's April 15, 2010 Financial Technical Issues Task Force meeting. A subsequent meeting was held by hospital representatives at the behest of MHA to further discuss the proposal on April 21, 2010.

A meeting was also held on May 6, 2010 between the HSCRC staff and hospital representatives to discuss possible recommendations from the MHA. To date, hospitals and their representatives have not presented a consensus proposal.

The uncompensated care model

The model remains as specified in the current methodology. The amount of uncompensated care in rates is computed as follows:

1. Compute a three-year moving average for uncompensated care for each hospital.
2. Use the most recent three years of data to compute the uncompensated care regression (while adding “dummy” variables for each year).
3. Generate a predicted value for the hospital’s uncompensated care rate based on the last available year of data.
4. Compute a 50/50 blend of the predicted and three-year moving average as the hospital’s amount in rates.
5. Calculate the statewide amount of uncompensated care in rates from this process, and generate the percentage difference between the preliminary amount in rates and the last year of actual experience.
6. Add/subtract the statewide difference (step 5) to the hospital’s preliminary UCC rate (step 4) to get adjusted rates that tie to the State’s last year of actual UCC experience.

The result is the hospital’s UCC rate for the next fiscal year.

Medicaid’s expansion and “averted bad debts”

To account for the impact of Medicaid’s expansion and “averted bad debts” on the UCC policy, staff is now using a methodology that parallels the Commission-approved method for handling uncompensated care resulting from the imposition of day-limits in State Medicaid reimbursement to acute care hospitals. Under that methodology, adjustments were made to the UCC policy by removing the pre-funded amounts in rates for day limits from the actual uncompensated care prior to calculating the model described above. The pre-funded amounts were then added to the UCC rate calculated in step 6 to finance the day limits portion separately. Therefore, the impact of Medicaid’s expansion and “averted bad debts” is accounted for by adding the estimated “averted bad debts” to hospital reported UCC and then applying the regression and other subsequent calculations.

Newly estimated “averted bad debts” for each hospital will be calculated and the UCC policy results adjusted for these new estimates before the 100 percent UCC pooling methodology is applied. The new uncompensated care provisions will become effective on July 1, 2010 with the new charge per case targets.

Result

The result of this approach is that the prospective amount built into rates across the industry is the amount actually experienced in the last year of available data excluding any new estimates for averted bad debt due to Medicaid expansion. If, for example, uncompensated care were \$1 billion in fiscal year 2009, this model would establish rates that would deliver \$1 billion in fiscal year 2011 if volumes and rates remain the same.

Table 1 provides summary results of the UCC policy for Fiscal Year 2011 without additional offset for averted bad debt due to Medicaid expansion. Table 2 shows the results from the regression analysis and revenue neutrality adjustment. Table 3 provides details of the fiscal year 2009 data used in the regression model. Table 4 provides a statistical summary of the variables and regression results.

Table 1
Summary Results of the UCC Model for FY 2011
(Without Additional Offset for Averted Bad Debt
due to Medicaid Expansion)

Hospid	Hospital Name	UCC Provision for FY 2011
210001	Washington County Hospital	8.04%
210002	Univ. of Maryland Medical System	9.74%
210003	Prince Georges Hospital	15.17%
210004	Holy Cross Hospital of Silver Spring	7.72%
210005	Frederick Memorial Hospital	6.60%
210006	Harford Memorial Hospital	11.04%
210007	St. Josephs Hospital	3.73%
210008	Mercy Medical Center, Inc.	8.09%
210009	Johns Hopkins Hospital	6.60%
210010	Dorchester General Hospital	8.50%
210011	St. Agnes Hospital	7.78%
210012	Sinai Hospital	8.05%
210013	Bon Secours Hospital	17.61%
210015	Franklin Square Hospital	8.85%
210016	Washington Adventist Hospital	9.36%
210017	Garrett County Memorial Hospital	8.81%
210018	Montgomery General Hospital	6.75%
210019	Peninsula Regional Medical Center	6.73%
210022	Suburban Hospital Association, Inc	5.36%
210023	Anne Arundel General Hospital	4.88%
210024	Union Memorial Hospital	6.54%
210025	The Memorial Hospital	6.33%
210027	Braddock Hospital	5.11%
210028	St. Marys Hospital	7.78%
210029	Johns Hopkins Bayview Med. Center	9.33%
210030	Chester River Hospital Center	9.28%
210032	Union Hospital of Cecil County	9.15%
210033	Carroll County General Hospital	6.07%
210034	Harbor Hospital Center	10.23%
210035	Civista Medical Center	7.82%
210037	Memorial Hospital at Easton	6.21%
210038	Maryland General Hospital	13.06%
210039	Calvert Memorial Hospital	7.29%
210040	Northwest Hospital Center, Inc.	8.31%
210043	North Arundel General Hospital	8.40%
210044	Greater Baltimore Medical Center	3.92%
210045	McCready Foundation, Inc.	10.25%
210048	Howard County General Hospital	6.85%
210049	Upper Cheseapeake Medical Center	7.08%
210051	Doctors Community Hospital	10.14%
210054	Southern Maryland Hospital	8.98%
210055	Laurel Regional Hospital	11.75%
210056	Good Samaritan Hospital	6.15%
210057	Shady Grove Adventist Hospital	7.97%
** 210058	James Lawrence Kernan Hospital	4.73%
210060	Fort Washington Medical Center	12.84%
210061	Atlantic General Hospital	6.48%
	STATE-WIDE	7.80%

**** James Lawrence Kernan Hospital was excluded in the Regression Analysis**

Table 2
Policy Results from the Regression and Revenue Neutrality Adjustment for FY 2011

Hospid	Hospital Name	UCC in Rates (July 1, 2008)	Actual UCC for FY '09	Adjusted UCC for FY '09 (Includes Averted Bad Debt)	Predicted UCC	FY '07 - FY '09 UCC AVERAGE	50/ 50 BLENDED UCC AVERAGE	Revenue Neutrality Adjustment	Policy Results	Dollar Amount
210001	Washington County Hospital	6.67%	8.52%	8.89%	7.54%	8.07%	7.81%	0.23%	8.04%	19,537,736
210002	Univ. of Maryland Medical System	8.69%	9.18%	10.10%	9.31%	9.70%	9.51%	0.23%	9.74%	91,561,084
210003	Prince Georges Hospital	13.35%	15.62%	16.18%	14.49%	15.37%	14.93%	0.23%	15.17%	39,526,163
210004	Holy Cross Hospital of Silver Spring	6.43%	7.57%	7.80%	7.74%	7.24%	7.49%	0.23%	7.72%	30,459,666
210005	Frederick Memorial Hospital	5.62%	5.77%	5.97%	6.89%	5.84%	6.36%	0.23%	6.60%	17,602,471
210006	Harford Memorial Hospital	8.24%	11.76%	12.10%	10.26%	11.35%	10.81%	0.23%	11.04%	10,624,223
210007	St. Josephs Hospital	2.81%	4.09%	4.18%	3.37%	3.63%	3.50%	0.23%	3.73%	14,895,933
210008	Mercy Medical Center, Inc.	7.79%	7.98%	8.44%	7.81%	7.89%	7.85%	0.23%	8.09%	30,899,957
210009	Johns Hopkins Hospital	5.65%	6.60%	7.11%	6.41%	6.33%	6.37%	0.23%	6.60%	106,985,584
210010	Dorchester General Hospital	8.25%	8.28%	8.86%	9.12%	7.42%	8.27%	0.23%	8.50%	4,484,623
210011	St. Agnes Hospital	7.07%	6.28%	6.60%	8.53%	6.55%	7.54%	0.23%	7.78%	27,911,778
210012	Sinai Hospital	7.06%	7.74%	8.20%	7.63%	8.00%	7.82%	0.23%	8.05%	50,515,183
210013	Bon Secours Hospital	13.68%	17.93%	18.20%	18.32%	16.43%	17.38%	0.23%	17.61%	21,510,247
210015	Franklin Square Hospital	7.93%	7.26%	7.77%	9.10%	8.13%	8.61%	0.23%	8.85%	36,709,034
210016	Washington Adventist Hospital	7.29%	8.64%	8.91%	8.77%	9.49%	9.13%	0.23%	9.36%	26,617,346
210017	Garrett County Memorial Hospital	8.08%	9.14%	9.85%	8.62%	8.53%	8.58%	0.23%	8.81%	3,243,430
210018	Montgomery General Hospital	6.03%	6.02%	6.23%	7.12%	5.92%	6.52%	0.23%	6.75%	9,495,676
210019	Peninsula Regional Medical Center	5.56%	6.45%	6.73%	6.60%	6.39%	6.49%	0.23%	6.73%	25,914,344
210022	Suburban Hospital Association, Inc	4.71%	5.09%	5.19%	5.32%	4.93%	5.13%	0.23%	5.36%	12,233,324
210023	Anne Arundel General Hospital	4.36%	4.28%	4.41%	4.87%	4.43%	4.65%	0.23%	4.88%	19,164,202
210024	Union Memorial Hospital	6.33%	6.23%	6.56%	5.79%	6.82%	6.31%	0.23%	6.54%	27,066,066
210025	The Memorial Hospital	4.86%	4.55%	5.18%	6.70%	5.49%	6.09%	0.23%	6.33%	6,719,873
210027	Braddock Hospital	4.06%	5.03%	5.26%	4.80%	4.95%	4.88%	0.23%	5.11%	8,532,880
210028	St. Marys Hospital	6.51%	5.41%	5.77%	9.09%	6.01%	7.55%	0.23%	7.78%	9,658,363
210029	Johns Hopkins Bayview Med. Center	8.68%	10.49%	10.85%	8.46%	9.74%	9.10%	0.23%	9.33%	47,933,417
210030	Chester River Hospital Center	7.39%	10.60%	11.07%	6.41%	11.67%	9.04%	0.23%	9.28%	5,649,864
210032	Union Hospital of Cecil County	7.89%	10.10%	10.23%	9.51%	8.31%	8.91%	0.23%	9.15%	11,597,119
210033	Carroll County General Hospital	5.17%	4.46%	4.69%	6.67%	5.01%	5.84%	0.23%	6.07%	11,912,363
210034	Harbor Hospital Center	9.05%	8.58%	9.10%	10.94%	9.05%	10.00%	0.23%	10.23%	20,556,270
210035	Civista Medical Center	6.10%	6.02%	6.33%	8.94%	6.23%	7.59%	0.23%	7.82%	8,106,752
210037	Memorial Hospital at Easton	5.92%	4.95%	5.42%	6.76%	5.19%	5.97%	0.23%	6.21%	9,933,156
210038	Maryland General Hospital	11.59%	13.14%	13.55%	13.08%	12.57%	12.82%	0.23%	13.06%	23,750,386
210039	Calvert Memorial Hospital	6.14%	5.86%	6.07%	8.31%	5.79%	7.05%	0.23%	7.29%	8,116,977
210040	Northwest Hospital Center, Inc.	7.30%	8.28%	8.50%	8.16%	8.00%	8.08%	0.23%	8.31%	17,596,888
210043	North Arundel General Hospital	6.73%	8.01%	8.24%	8.38%	7.94%	8.16%	0.23%	8.40%	25,980,508
210044	Greater Baltimore Medical Center	2.54%	2.87%	2.97%	4.58%	2.80%	3.69%	0.23%	3.92%	15,431,030
210045	McCready Foundation, Inc.	6.84%	10.39%	12.06%	10.03%	9.99%	10.01%	0.23%	10.25%	1,723,351
210048	Howard County General Hospital	5.73%	5.70%	6.02%	7.73%	5.50%	6.61%	0.23%	6.85%	15,792,294
210049	Upper Chesapeake Medical Center	5.47%	6.97%	7.19%	7.35%	6.34%	6.85%	0.23%	7.08%	15,550,110
210051	Doctors Community Hospital	8.25%	9.61%	9.92%	9.75%	10.07%	9.91%	0.23%	10.14%	19,143,151
210054	Southern Maryland Hospital	7.39%	8.05%	8.25%	8.73%	8.75%	8.74%	0.23%	8.98%	20,180,245
210055	Laurel Regional Hospital	11.07%	11.53%	11.80%	11.04%	11.98%	11.51%	0.23%	11.75%	10,763,582
210056	Good Samaritan Hospital	5.72%	5.30%	5.59%	6.20%	5.63%	5.92%	0.23%	6.15%	17,606,120
210057	Shady Grove Adventist Hospital	6.60%	6.92%	7.23%	8.32%	7.14%	7.73%	0.23%	7.97%	26,389,779
** 210058	James Lawrence Kernan Hospital	6.30%	7.54%	7.70%	2.57%	6.90%	4.73%	0.00%	4.73%	5,007,148
210060	Fort Washington Medical Center	9.60%	14.68%	15.32%	11.40%	13.82%	12.61%	0.23%	12.84%	6,067,985
210061	Atlantic General Hospital	5.64%	6.21%	6.67%	6.61%	5.89%	6.25%	0.23%	6.48%	4,959,073
	STATE-WIDE	6.73%	7.42%	7.80%	7.70%	7.43%	7.56%	0.23%	7.80%	1,001,616,754

** James Lawrence Kernan Hospital was excluded in the Regression Analysis

Table 3
Fiscal Year 2009 Data Used in Regression for FY 2011

Hospid	Hospital Name	Inpatient Medicaid Charges	Inpatient Non-Medicare Charges through the ER	Inpatient Self-Pay and Charity Charges	Outpatient Medicaid Charges through the ER	Outpatient Self-Pay and Charity Charges through the ER	Outpatient Revenue	UCC in Rates (July 1, 2008)	Gross Patient Revenue	Uncompensated Care
210001	Washington County Hospital	15,952,474	38,632,899	7,589,685	5,408,649	6,109,283	84,404,900	6.67%	\$243,018,300	\$21,593,368
210002	Univ. of Maryland Medical System	156,245,288	211,979,816	28,714,728	20,154,582	12,315,254	230,738,600	8.69%	\$940,100,100	\$94,995,091
210003	Prince Georges Hospital	63,962,391	87,265,226	10,231,269	5,709,816	10,991,631	55,608,200	13.35%	\$260,576,400	\$42,154,785
210004	Holy Cross Hospital of Silver Spring	50,300,641	72,057,998	14,009,580	5,637,406	6,592,324	104,017,600	6.43%	\$394,466,500	\$30,778,789
210005	Frederick Memorial Hospital	16,663,408	44,789,815	7,344,206	4,025,617	4,047,916	97,939,200	5.62%	\$266,844,200	\$15,936,769
210006	Harford Memorial Hospital	6,105,545	23,121,858	2,135,544	2,896,062	3,232,698	36,652,600	8.24%	\$96,235,600	\$11,641,401
210007	St. Josephs Hospital	13,845,556	44,266,439	7,684,253	1,959,318	2,819,792	104,312,600	2.81%	\$398,844,400	\$16,656,827
210008	Mercy Medical Center, Inc.	53,470,919	39,763,371	4,712,857	10,215,339	7,265,630	172,493,300	7.79%	\$382,169,900	\$32,245,015
210009	Johns Hopkins Hospital	238,447,216	203,793,243	9,290,264	23,864,212	16,266,132	532,549,400	5.65%	\$1,620,280,400	\$115,203,491
210010	Dorchester General Hospital	4,799,161	8,208,569	1,381,188	1,990,566	1,377,072	22,093,700	8.25%	\$52,734,300	\$4,671,120
210011	St. Agnes Hospital	39,588,328	69,594,308	13,158,174	8,259,139	6,945,992	106,315,300	7.07%	\$358,890,700	\$23,693,638
210012	Sinai Hospital	74,688,549	91,976,620	4,700,656	17,154,584	11,601,406	215,542,000	7.06%	\$627,278,200	\$51,450,780
210013	Bon Secours Hospital	23,302,229	39,995,914	10,790,145	7,596,937	8,070,408	40,612,800	13.68%	\$122,144,200	\$22,233,042
210015	Franklin Square Hospital	51,714,900	87,927,827	10,213,789	10,892,263	8,053,135	119,994,200	7.93%	\$414,987,900	\$32,241,273
210016	Washington Adventist Hospital	34,902,387	60,487,456	13,133,638	4,272,179	6,973,154	67,428,566	7.29%	\$284,247,984	\$25,335,354
210017	Garrett County Memorial Hospital	2,569,214	5,106,360	760,044	1,316,094	995,786	17,444,100	8.08%	\$36,812,400	\$3,626,040
210018	Montgomery General Hospital	8,131,948	28,869,822	4,488,155	1,842,120	2,049,850	41,711,400	6.03%	\$140,619,400	\$8,759,201
210019	Peninsula Regional Medical Center	29,619,422	57,572,291	11,512,770	7,138,622	5,920,880	122,608,300	5.56%	\$385,277,000	\$25,923,176
210022	Suburban Hospital Association, Inc	8,209,895	44,127,946	4,995,636	870,181	1,788,476	61,005,500	4.71%	\$228,243,300	\$11,850,343
210023	Anne Arundel General Hospital	20,659,710	50,459,440	6,304,903	3,275,172	4,042,253	132,999,100	4.36%	\$392,507,100	\$17,321,674
210024	Union Memorial Hospital	40,583,803	60,899,926	8,631,913	5,324,091	5,188,219	100,221,800	6.33%	\$413,847,100	\$27,152,228
210025	The Memorial Hospital	11,785,336	13,764,163	2,007,720	2,663,060	1,374,985	33,350,500	4.86%	\$106,194,800	\$5,500,327
210027	Braddock Hospital	6,930,410	17,588,088	3,325,686	1,092,822	824,958	79,602,300	4.06%	\$166,869,000	\$8,772,799
210028	St. Marys Hospital	9,293,320	22,882,844	3,666,776	3,982,189	2,452,100	54,536,400	6.51%	\$124,100,600	\$7,164,802
210029	Johns Hopkins Bayview Med. Center	71,125,805	86,667,581	18,193,203	8,808,268	10,707,631	173,521,800	8.68%	\$513,495,600	\$55,718,584
210030	Chester River Hospital Center	3,436,824	6,056,727	1,072,467	1,353,039	1,182,703	29,086,800	7.39%	\$60,914,200	\$6,740,590
210032	Union Hospital of Cecil County	12,546,014	17,520,386	3,244,674	5,020,856	4,061,508	58,238,200	7.89%	\$126,780,200	\$12,973,214
210033	Carroll County General Hospital	14,129,715	42,676,156	301,680	2,459,772	2,177,565	50,496,400	5.17%	\$196,154,700	\$9,199,746
210034	Harbor Hospital Center	35,035,129	45,075,760	6,591,080	7,339,924	5,284,135	50,840,100	9.05%	\$200,915,200	\$18,278,859
210035	Civista Medical Center	7,796,477	21,574,481	2,906,586	2,865,755	2,525,992	35,240,700	6.10%	\$103,621,000	\$6,558,625
210037	Memorial Hospital at Easton	13,744,371	20,378,409	3,027,840	3,368,904	2,765,253	61,997,900	5.92%	\$160,032,300	\$8,680,775
210038	Maryland General Hospital	56,783,529	47,535,543	5,356,870	4,723,381	4,002,021	42,813,000	11.59%	\$181,868,000	\$24,647,960
210039	Calvert Memorial Hospital	7,400,040	20,900,312	2,389,963	2,811,722	1,756,944	48,468,900	6.14%	\$111,417,900	\$6,762,052
210040	Northwest Hospital Center, Inc.	16,245,186	36,683,583	1,345,729	6,197,434	4,767,011	82,674,300	7.30%	\$211,714,700	\$18,004,572
210043	North Arundel General Hospital	15,308,972	62,717,014	9,045,149	6,552,618	9,170,935	106,197,100	6.73%	\$309,341,800	\$25,485,722
210044	Greater Baltimore Medical Center	13,815,354	47,179,356	3,068,008	3,436,144	2,565,757	161,811,600	2.54%	\$393,162,100	\$11,689,422
210045	McCready Foundation, Inc.	486,406	1,224,611	426,331	1,136,093	720,464	10,582,069	6.84%	\$16,819,985	\$2,028,739
210048	Howard County General Hospital	17,381,065	42,202,983	4,965,648	4,392,680	4,412,360	84,099,600	5.73%	\$230,685,500	\$13,889,857
210049	Upper Chesapeake Medical Center	11,630,699	42,905,186	1,729,814	4,123,845	3,944,147	79,900,400	5.47%	\$219,562,700	\$15,777,938
210051	Doctors Community Hospital	13,847,690	43,847,986	4,397,256	4,484,208	5,328,727	74,494,100	8.25%	\$188,720,500	\$18,712,956
210054	Southern Maryland Hospital	22,780,234	46,802,593	8,922,996	5,496,723	4,224,846	64,202,100	7.39%	\$224,831,800	\$18,541,942
210055	Laurel Regional Hospital	11,435,159	21,086,616	2,093,103	2,109,332	4,029,663	32,799,700	11.07%	\$91,640,000	\$10,815,240
210056	Good Samaritan Hospital	24,262,041	46,127,743	5,063,008	4,404,794	3,680,740	78,515,900	5.72%	\$286,296,100	\$16,002,954
210057	Shady Grove Adventist Hospital	31,115,779	69,386,808	9,253,034	5,379,982	5,721,686	112,384,799	6.60%	\$331,274,906	\$23,967,535
** 21005	James Lawrence Kernan Hospital	4,926,932	0	841,012	0	0	36,827,500	6.30%	\$105,778,700	\$8,146,125
210060	Fort Washington Medical Center	1,007,917	11,141,181	2,189,825	1,277,259	2,394,929	23,677,252	9.60%	\$47,242,143	\$7,237,932
210061	Atlantic General Hospital	2,059,390	8,919,426	1,316,867	1,379,530	1,965,090	38,586,400	5.64%	\$76,484,900	\$5,101,931
	STATE-WIDE	1,390,072,778	2,213,742,680	288,525,722	246,663,283	224,689,443	4,171,638,986	6.73%	\$12,846,044,718	\$1,001,864,603

** James Lawrence Kernan Hospital was excluded in the Regression Analysis

Table 4
Statistical Summary of the Variables and Regression Results

R-Square	0.7091			
Adjusted R-Square	0.6958			
Variables:	Parameter Estimate	Standard Error	t Value	P-Value (Pr > t)
The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room	0.22643	0.03935	5.75	<.0001
The proportion of a hospital's total charges from inpatient Medicaid, self-pay, and charity cases	0.16134	0.03303	4.88	<.0001
The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency room	0.51025	0.11077	4.61	<.0001
The proportion of a hospital's total charges from outpatient charges	0.06799	0.02876	2.36	0.0195

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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HEALTH SERVICES COST REVIEW COMMISSION

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Deputy Director
Research and Methodology

MEMORANDUM

TO: HSCRC Commissioners

FROM: Robert Murray, Executive Director

RE: Community Benefit Report

Date: June 2, 2010

Enclosed is a copy of the FY 2009 Community Benefits Report. This will be presented during the June 9, 2010 Commission Meeting. During the Commission meeting, staff will be supplementing this report with an analytical review of the community benefits described in the report as well as a summary of the future community benefit requirements under national health care reform. Staff will also profile some of the successful community benefit programs across the State.

Maryland Hospital Community Benefits Report FY 2009

June 9, 2010

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

Introduction

Each year, the Health Services Cost Review Commission (“Commission,” or “HSCRC”) collects hospital community benefit information from individual hospitals to compile into a publicly-available statewide Community Benefit Report (CBR). The CBR process was introduced by the Maryland legislature in 2001 (Health-General Article, §19-303 Maryland Annotated Code), and the first CBR (reporting FY 2004 experiences) was released in July 2005. This document contains summary information for all submitting Maryland hospitals for FY 2009. Individual hospital community benefit reports and additional documents are available in written format at the Commission’s offices. Individual community benefit report data spreadsheets and reports will be available on the Commission’s website in June 2010.

The CBR offers an opportunity for each Maryland hospital to critically review and report its community benefit activities. As in previous years, Maryland hospitals and the Commission worked collaboratively with one another regarding issues associated with the CBR. The HSCRC commits to continuing this work to further improve the report and to refine definitions as needed.

Definition of Community Benefits:

As defined under current Maryland law, “community benefit” means an activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status, including:

- Health services provided to vulnerable or underserved populations;
- Financial or in-kind support of public health programs;
- Donations of funds, property, or other resources that contribute to a community priority;
- Health care cost containment activities; and
- Health education screening and prevention services.

As evidenced in the hospital reports, Maryland hospitals provide a broad range of health services to meet the needs of their communities, often receiving partial or no compensation. These activities, however, are expected from Maryland’s 46 not-for-profit hospitals as a result of the tax exemptions they receive.¹

Background

Since 2003, the Commission has worked with the Maryland Hospital Association and interested hospitals, local health departments, and health policy organizations and associations on the details, format, and updates to the community benefit report. The Fiscal Year 2009 report represents the HSCRC’s sixth year of reporting on Maryland Hospital Community Benefit Data.

¹ As Maryland’s only for-profit hospital, Southern Maryland Hospital is not required to submit a community benefits report under the law. Southern Maryland, however, has continued to submit a community benefit report to the HSCRC. Its FY 2009 experience has been included in this report.

The Maryland data reporting spreadsheet and instructions draw heavily on the experience of the Voluntary Hospitals of America (“VHA”) community benefit process. The VHA is a nationwide network of community-owned health care systems and their physicians, and possesses over ten years of voluntary hospital community benefit reporting experience across many states.

Changes to Community Benefit Reporting: FY 2008 to FY 2009

During the fall of 2008, the HSCRC convened a Community Benefit Advisory Group to review proposed revised guidelines for reporting, provide feedback on the current reporting process, and discuss options for a model to provide feedback to hospitals about their community benefits activities. As a result of the advisory group meetings, the Commission issued revised narrative guidelines that were optional in the filing of the FY 2008 CBR; however, they were mandatory for the FY 2009 filings. Hospitals were required to include all attachments with the FY 2009 CBR. These include a description of the hospital’s charity care policies, a copy of its Financial Assistance Policy, a description of the hospital’s mission, vision, and value statements, and a copy of the actual mission, vision, and value statements of the hospital. These attachments may be reviewed upon request at the HSCRC offices, or on the HSCRC’s website as part of the FY 2009 Maryland Hospital Community Benefits Report.

The narrative questions were developed, in part, to provide a standard reporting format for all hospitals. This uniformity not only provides readers of the individual hospital reports with more information than was previously available, but allows for comparison across hospitals. The narrative guidelines were aligned, wherever possible, with the IRS form 990, schedule H, in an effort to provide as much consistency as is practical in reporting on the state and federal levels.

In addition to providing a standard format for reporting, the HSCRC considers the narrative guidelines a mechanism to assist hospitals in critically examining their Community Benefit programs. Any examination of the effectiveness of major program initiatives may help hospitals determine which programs are achieving the desired results as well as identify programs that may not be achieving the intended results.

CBR – 2009 Highlights

The reporting period for this Community Benefit Report is July 1, 2008 – June 30, 2009. Hospitals submitted their individual community benefit reports to the HSCRC by December 15, 2009 using audited financial statements as the source for calculating costs in each of the care categories.

As shown in Table I below, Maryland hospitals provided approximately \$946 million in community benefit activities in FY 2009. Of this, over \$309 million was provided in the form of charity care, \$306.4 million in health professions education activities, just under \$210 million in mission driven health services, \$67.4 million in community health services, \$17.7 million in community building activities, \$17.4 million in financial contributions, over \$8.5 million in

foundation funded community benefits, \$5.2 million in community benefit operations, and \$3.5 million in research.²

Table I – Total Community Benefit

Community Benefit Category	Number of Staff Hours	Number of Encounters	Total Community Benefit
Community Health Services	775,825	9,977,272	\$67,402,544
Health Professions Education	5,254,635	355,400	\$306,456,178
Mission Driven Health Services	1,591,721	1,110,646	\$209,985,520
Research	52,998	19,357	\$3,593,568
Financial Contributions	36,001	167,351	\$17,461,512
Community Building	159,378	293,753	\$17,766,671
Community Benefit Operations	36,387	40,623	\$5,267,811
Charity Care	n/a	n/a	\$309,721,840
Foundation	50,255	6,008	\$8,582,520
Total	7,332,206	12,482,972	\$946,238,164

For additional detail and a description of subcategories under each community benefit category, please see the chart under Attachment I – Aggregated Hospital CBR Data.

Effect of Indirect Cost Ratio on Community Benefits

Indirect Costs are costs not attributed to products and/or services that are included in the calculation of costs for community benefits. These could include, but are not limited to, salaries for human resource and finance departments, insurance, and overhead expenses.

As in previous years, hospitals were directed to use the annual audited cost report data to calculate indirect cost ratios. In previous years, the HSCRC included a default indirect cost calculation in all categories of benefit, allowing the hospitals to override the calculated indirect

² These totals include hospital reported indirect costs, which vary by hospital from a fixed dollar amount to a calculated percentage of the hospital's reported direct costs.

costs where it was thought that the direct costs may, in part, reflect the total costs of the community benefit initiative.

As noted last year, the HSCRC and the Community Benefit Advisory Group determined that a better method for the allocation of indirect costs would be to apply the indirect cost ratio to the following community benefit categories: (A) Community Health Services; (F) Community Building Activities; and (G) Community Benefit Operations. For the remaining categories, the indirect cost calculation was defaulted to zero. A hospital had the option to override the default if it believed there were indirect costs involved with the initiative, but not accurately reflected in the direct costs. Table II, Indirect Costs as a Percentage of Total Benefit, provides the total amount of indirect costs within each community benefit category and its percentage of the total community benefit provided.

Table II – Indirect Costs as a Percentage of Total Benefit

	2008 Total Community Benefit	2008 Net Community Benefit W/O Indirect Cost	2008 Indirect Costs	Indirect Costs as a Percentage of Total Community Benefit
Community Health Services	\$67,402,544	\$41,861,265	\$25,541,279	37.89%
Health Professions Education	\$306,456,178	\$240,396,253	\$66,059,925	21.56%
Mission Driven Health Care Services	\$209,985,520	\$154,204,998	\$55,780,522	26.56%
Research	\$3,593,568	\$2,051,057	\$1,542,511	42.92%
Financial Contributions	\$17,461,512	\$16,058,907	\$1,402,605	8.03%
Community Building Activities	\$17,766,671	\$11,721,840	\$6,044,831	34.02%
Community Benefit Operations	\$5,267,811	\$3,388,013	\$1,879,798	35.68%
Charity Care	\$309,721,840	\$309,721,840	\$0	0.00%
Foundation Community Benefit	\$8,582,520	\$5,700,205	\$2,882,315	33.58%
Totals	\$946,238,164	\$785,104,378	\$161,133,786	17.03%

As a result of the changes in indirect cost reporting, the indirect costs as a percentage of total community benefits were again, as in FY 2008, held to a much lower 17.03% in FY 2009 versus 24.05% in FY 2007 before the change in reporting occurred.

Community Benefits Narrative Guidelines and Evaluation

As previously noted, the HSCRC convened a Community Benefits Advisory Group in August 2008. One of the tasks for the group was to approve the revised narrative guidelines. The intent behind the narrative guidelines was to provide a better link between the data reported in the community benefit activity categories with the identified needs within the hospitals' communities. The HSCRC again met with a review group comprised of hospital community benefit people from a few hospitals in Maryland. The group approved a review mechanism developed to provide feedback to the hospitals with regard to their community benefit reports. This first step in creating an evaluation process will be ensuring that the hospitals provide the information set forth in the narrative guidelines. This is a critical first step in creating an effective evaluation mechanism.

Hospital Rate Support for Community Benefit Programs

In Maryland, the costs of uncompensated care (both charity care and bad debt) and graduate medical education are built into rates that hospitals are reimbursed by all payers, including Medicare and Medicaid. Additionally, the HSCRC includes amounts in rates for hospital nurse support programs provided at Maryland hospitals. To avoid accounting confusion among programs that are not funded in part by hospital rate setting (unregulated), the HSCRC requested that hospitals not include revenue provided in rates as offsetting revenue on the CBR worksheet.

The following section details the amounts of nurse support program and direct graduate medical education costs that are included in rates for Maryland hospitals in Fiscal Year 2009 funded by all payers. The uncompensated care amounts are from FY 2008, but provide a reasonable estimate as to what was at least provided in rates for FY 2009.

Nurse Support Program I

The Nurse Support Program I is aimed at addressing the short and long term nursing shortage impacting Maryland hospitals. In FY 2009, approximately \$10.6 million was provided in hospital rate adjustments. For further information about funding provided to specific hospitals, please see Attachment II.

Graduate Medical Education

Another social cost funded in Maryland's rate-setting system is the cost of graduate medical education (GME), generally for interns and residents trained in Maryland hospitals. Graduate medical education direct costs are wages and benefits of residents and interns, faculty supervisory expenses, and allocated overhead. The Commission utilizes the annual cost report to quantify the direct costs of medical education in physician training programs. In FY 2009, these

direct costs totaled \$213.5 million. The Commission did not quantify the indirect costs associated with medical education for FY 2009. For further information about funding provided to specific hospitals, please see Attachment II.

Uncompensated Care

The HSCRC includes a provision in hospital rates for uncompensated care; this includes charity care (eligible for inclusion as a community benefit by Maryland hospitals in their CBRs) and bad debt (not considered a community benefit). In FY 2008, over \$ 256 million was provided in Maryland hospital rates for the provision of charity care funded by all payers. The calculations for total dollar amounts provided in rates for FY 2009 has yet to be determined, but it can be reasonably estimated to be at least the amount provided in FY 2008. Hospitals were asked not to include revenue provided through hospital rates as offsetting revenue on the CBR worksheet. For further information about funding provided to specific hospitals, please see Attachment II.

FY 2009 Maryland Hospital Community Benefit Totals

	# of Staff Hours	# of Encounters	Direct Cost (\$)	Indirect Cost (\$)	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
A Community Health Services						
A1 Community Health Education	301,686	9,006,687	\$17,237,630.68	\$9,327,988.46	\$24,674,551.24	\$15,346,562.78
Support Groups	26,218	77,221	\$993,305.34	\$530,747.27	\$1,515,459.61	\$984,712.34
Self-Help	39,518	192,922	\$2,033,472.30	\$998,249.42	\$2,347,213.22	\$1,348,963.80
A2 Community-Based Clinical Services	104,587	148,449	\$6,693,322.68	\$3,656,218.84	\$8,988,667.22	\$5,332,448.38
Screenings	47,051	116,019	\$2,004,838.52	\$1,081,116.96	\$2,951,637.06	\$1,870,520.10
One-Time/Occassionally Held Clinics	2,124	17,551	\$305,667.05	\$142,291.38	\$299,279.51	\$156,988.13
Free Clinics	4,879	7,041	\$619,353.17	\$366,315.19	\$893,765.62	\$527,450.43
Mobile Units	21,627	26,983	\$815,723.41	\$384,532.30	\$1,200,255.70	\$815,723.41
A3 Health Care Support Services	186,195	279,995	\$14,680,477.15	\$7,746,317.14	\$20,712,301.53	\$12,965,984.39
A4 Other	41,941	104,405	\$2,822,901.13	\$1,307,502.01	\$3,819,413.06	\$2,511,911.05
totals	775,825	9,977,272	\$48,206,691.42	\$25,541,278.97	\$67,402,543.77	\$41,861,264.80
B Health Professions Education						
B1 Physicians/Medical Students	4,702,916	147,547	\$218,953,311.67	\$60,189,155.69	\$277,764,318.36	\$217,575,162.67
B2 Scholarships/Funding for Professional Education	12,988	1,911	\$2,533,412.63	\$40,463.10	\$2,573,875.73	\$2,533,412.63
B3 Nurses/Nursing Students	301,651	71,535	\$11,848,109.53	\$3,901,925.08	\$15,737,221.61	\$11,835,296.53
B4 Technicians	59,002	35,871	\$2,112,654.76	\$474,710.28	\$2,402,726.31	\$1,928,016.02
B5 Other Health Professionals	152,652	93,410	\$6,008,726.07	\$1,216,859.76	\$7,173,709.83	\$5,956,850.07
B6 Other	25,427	5,125	\$570,855.40	\$236,810.72	\$804,326.13	\$567,515.40
Totals	5,254,635	355,400	\$242,027,070.07	\$66,059,924.64	\$306,456,177.97	\$240,396,253.33
C Mission Driven Health Services						
	1,591,721	1,110,646	\$258,322,755.38	\$55,780,522.17	\$209,985,520.01	\$154,204,997.84
D Research						
D1 Clinical	46,634	19,311	\$3,414,008.16	\$1,542,510.93	\$3,211,172.03	\$1,668,661.11
D2 Community Health Research	124	46	\$77,032.34	\$0.00	\$77,032.34	\$77,032.34
D3 Other	6,240	0	\$305,364.00	\$0.00	\$305,364.00	\$305,364.00
Totals	52,998	19,357	\$3,796,404.50	\$1,542,510.93	\$3,593,568.37	\$2,051,057.45
E Financial Contributions						
E1 Cash Donations	1,695	2,558	\$7,234,963.03	\$1,054,645.17	\$8,069,733.20	\$7,015,088.03
E2 Grants	9	125	\$966,026.00	\$8,794.96	\$677,975.96	\$669,181.00
E3 In-Kind Donations	31,498	161,310	\$3,162,732.84	\$246,282.06	\$3,327,027.90	\$3,080,745.84
E4 Cost of Fund Raising for Community Programs	2,800	3,358	\$573,409.57	\$92,882.81	\$666,292.38	\$573,409.57
E5 Sales Taxes, Property Taxes, Income Taxes [†]	0	0	\$4,720,482.93	\$0.00	\$4,720,482.93	\$4,720,482.93
Totals	36,001	167,351	\$16,657,614.36	\$1,402,605.00	\$17,461,512.37	\$16,058,907.36

	# of Staff Hours	# of Encounters	Direct Cost (\$)	Indirect Cost (\$)	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
F Community Building Activities						
F1 Physical Improvements/Housing	2,296	182,492	\$1,903,574.69	\$359,249.77	\$2,262,824.46	\$1,903,574.69
F2 Economic Development	17,004	5,993	\$1,359,151.63	\$776,011.96	\$1,763,004.59	\$986,992.63
F3 Support System Enhancements	31,267	19,054	\$2,811,694.79	\$1,506,039.97	\$4,127,588.76	\$2,621,548.79
F4 Environmental Improvements	9,535	427	\$333,502.37	\$198,211.02	\$531,713.39	\$333,502.37
F5 Leadership Development/Training for Community Members	7,540	4,685	\$541,318.35	\$307,860.18	\$849,178.53	\$541,318.35
F6 Coalition Building	6,840	11,035	\$502,047.86	\$282,659.61	\$784,207.47	\$501,547.86
F7 Community Health Improvement Advocacy	10,484	18,227	\$1,081,270.73	\$587,844.89	\$1,669,115.62	\$1,081,270.73
F8 Workforce Enhancement	20,678	17,123	\$2,207,522.89	\$1,126,886.93	\$3,126,565.82	\$1,999,678.89
F9 Other	53,733	34,717	\$1,798,049.34	\$900,067.07	\$2,652,472.41	\$1,752,405.34

Totals	159,378	293,753	\$12,538,132.65	\$6,044,831.41	\$17,766,671.06	\$11,721,839.65
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	# of Staff Hours	# of Encounters	Direct Cost (\$)	Indirect Cost (\$)	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
G Community Benefit Operations						
G1 Dedicated Staff	28,839	21,946	\$1,760,351.56	\$959,237.01	\$2,705,270.57	\$1,746,033.56
G2 Community Health/Health Assets Assessments	1,468	206	\$107,989.25	\$56,682.13	\$164,671.38	\$107,989.25
G3 Other Resources	6,079	18,471	\$1,533,990.29	\$863,878.67	\$2,397,868.96	\$1,533,990.29
Totals	36,387	40,623	\$3,402,331.10	\$1,879,797.81	\$5,267,810.91	\$3,388,013.10

H Charity Care (report total only) **\$309,721,840**

	# of Staff Hours	# of Encounters	Direct Cost (\$)	Indirect Cost (\$)	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
J FOUNDATION COMMUNITY BENEFIT						
J1 Community Services	6,211	1,558	\$3,172,386.63	\$437,488.08	\$3,544,910.71	\$3,107,422.63
J2 Community Building	43,924	4,433	\$3,435,638.00	\$2,433,619.14	\$4,833,435.14	\$2,399,816.00
J3 Other (Please indicate below):	120	17	\$192,966.45	\$11,207.37	\$204,173.82	\$192,966.45
Totals	50,255	6,008	\$6,800,991.08	\$2,882,314.58	\$8,582,519.66	\$5,700,205.08

	# of Staff Hours	# of Encounters	Direct Cost (\$)	Indirect Cost (\$)	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
K Total Hospital Community Benefit						
A Community Health Services	775,825	9,977,272	\$48,206,691.42	\$25,541,278.97	\$67,402,543.77	\$41,861,264.80
B Health Professions Education	5,254,635	355,400	\$242,027,070.07	\$66,059,924.64	\$306,456,177.97	\$240,396,253.33
C Mission Driven Health Care Services	1,591,721	1,110,646	\$258,322,755.38	\$55,780,522.17	\$209,985,520.01	\$154,204,997.84
D Research	52,998	19,357	\$3,796,404.50	\$1,542,510.93	\$3,593,568.37	\$2,051,057.45
E Financial Contributions	36,001	167,351	\$16,657,614.36	\$1,402,605.00	\$17,461,512.37	\$16,058,907.36
F Community Building Activities	159,378	293,753	\$12,538,132.65	\$6,044,831.41	\$17,766,671.06	\$11,721,839.65
G Community Benefit Operations	36,387	40,623	\$3,402,331.10	\$1,879,797.81	\$5,267,810.91	\$3,388,013.10
H Charity Care	0	0	\$0.00	\$0.00	\$309,721,839.94	\$309,721,839.94
J Foundation Funded Community Benefit	50,255	6,008	\$6,800,991.08	\$2,882,314.58	\$8,582,519.66	\$5,700,205.08

Total Hospital Community Benefits	7,957,199	11,970,409	\$591,751,990.55	\$161,133,785.52	\$946,238,164.06	\$785,104,378.54
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TOTAL OPERATING EXPENSE **\$12,442,727,824**

% OF OPERATING EXPENSES W/IC **7.60%**

% OF OPERATING EXPENSES W/O IC **6.31%**

Nurse Support I Funding FY 2009

Hospital Name	NSP I Amount in Rates
Washington County	194,797
University of Maryland	1,078,712
Prince George's	222,037
Holy Cross	336,674
Frederick Memorial	196,273
Harford Memorial	70,076
St. Joseph	345,175
Mercy	325,030
Johns Hopkins	1,422,729
Dorchester General	43,009
St. Agnes	136,080
Sinai	567,654
Bon Secours	94,833
Franklin Square	344,120
Washington Adventist	259,384
Garrett County	32,569
Montgomery General	119,694
Peninsula	150,000
Suburban	198,516
Anne Arundel	325,942
Union Memorial	368,210
Cumberland	64,363
Braddock	87,079
St. Mary's	98,500
JH Bayview	412,852
Chester River	57,016
Union Cecil County	94,600
Carroll Hospital	153,500
Harbor Hospital	107,810
Civista	91,366
Memorial at Easton	127,273
Maryland General	170,567
Calvert Memorial	94,109
Northwest	191,846
Baltimore Washington	210,000
GBMC	332,400
McCready	15,925
Howard County	162,389
Upper Chesapeake	154,647
Doctors	169,629
Southern Maryland	193,872
Laurel Regional	85,254
Fort Washington	43,853
Atlantic General	63,648
Kernan	89,323
Good Samaritan	253,958
Shady Grove	284,000
Total	10,641,293

DME Funding FY 2009

Hospital Name	Amount in Rates
Washington County	0
University of Maryland	50,080,100
Prince George's	3,530,200
Holy Cross	2,365,900
Frederick Memorial	0
Harford Memorial	0
St. Joseph	0
Mercy	4,204,800
Johns Hopkins	73,344,300
Dorchester General	0
St. Agnes	6,722,000
Sinai	13,161,100
Bon Secours	0
Franklin Square	8,230,100
Washington Adventist	0
Garrett County	0
Montgomery General	18,400
Peninsula	0
Suburban	195,700
Anne Arundel	0
Union Memorial	12,187,600
Cumberland	0
Braddock	0
St. Mary's	0
JH Bayview	18,696,200
Chester River	0
Union Cecil County	0
Carroll Hospital	0
Harbor Hospital	4,015,400
Civista	0
Memorial at Easton	0
Maryland General	4,060,300
Calvert Memorial	0
Northwest	0
Baltimore Washington	317,300
GBMC	4,562,300
McCready	0
Howard County	0
Upper Chesapeake	0
Doctors	0
Southern Maryland	0
Laurel Regional	0
Fort Washington	0
Atlantic General	0
Kernan	3,068,500
Good Samaritan	4,813,700
Shady Grove	0
Total	213,573,900

(UCC) Charity Care Funding FY 2008

Hospital Name	Amount in Rates
Washington County	\$7,295,799
University of Maryland	\$31,030,228
Prince George's	\$1,129,639
Holy Cross	\$8,679,120
Frederick Memorial	\$4,490,695
Harford Memorial	\$1,126,980
St. Joseph	\$3,341,397
Mercy	\$10,280,894
Johns Hopkins	\$35,459,826
Dorchester General	\$720,059
St. Agnes	\$13,610,376
Sinai	\$10,904,453
Bon Secours	\$3,614,251
Franklin Square	\$9,990,144
Washington Adventist	\$8,723,051
Garrett County	\$1,400,800
Montgomery General	\$6,244,041
Peninsula	\$7,136,141
Suburban	\$3,365,199
Anne Arundel	\$4,091,513
Union Memorial	\$9,685,280
Braddock	\$3,465,537
Cumberland	\$2,247,137
St. Mary's	\$3,123,383
JH Bayview	\$22,772,984
Chester River	\$665,919
Union of Cecil County	\$1,250,303
Carroll Hospital	\$4,180,156
Harbor Hospital	\$3,495,814
Civista	\$707,813
Memorial at Easton	\$1,042,184
Maryland General	\$1,247,722
Calvert Memorial	\$1,342,980
Northwest	\$4,031,706
Baltimore Washington	\$3,149,883
GBMC	\$1,735,949
McCready	\$434,300
Howard County	\$1,588,791
Upper Chesapeake	\$1,733,922
Doctors	\$547,414
Southern Maryland	\$853,785
Laurel Regional	\$226,793
Fort Washington	\$589,950
Atlantic General	\$1,081,820
Kernan	\$410,604
Good Samaritan	\$4,194,765
Shady Grove	\$7,571,642
Total	\$256,013,143

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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TO: Commissioners

FROM: Legal Department

DATE: June 2, 2010

SUBJECT: Hearing and Meeting Schedule

Public Session

July 7, 2010 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

August 4, 2010 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

Please note: Commissioner packets will be available in Commission offices at 8:00 a.m.

The agenda for the Executive and Public Sessions will be available for your review on the Commission's Web Site, on the Monday before the Commission Meeting. To review the agenda, visit the Commission's web site at www.hscrc.state.md.us