Final Staff Recommendation on the Reasonableness of Charges (ROC) Methodology and Scaling for the ROC, QBR, and MHAC Initiatives

June 29, 2011

Option 2 - Alternate Proposal, listed in Appendix I, of this final recommendation was approved by the Commission on July 6, 2011. Comments should be sent to Robert Murray, Executive Director, HSCRC 4160 Patterson Avenue, Baltimore MD 21215.

Introduction

This document presents recommendations for: 1) a slight change to the methodology used in the FY 2011 Reasonableness of Charges (ROC) calculations; 2) a modification of an earlier approved recommendation regarding a case mix lag; and 3) the scaling of combined rewards and penalties applied to hospitals based on their relative position on the Commission's ROC ranking and Quality-based Reimbursement (QBR) and Maryland Hospital Acquired Conditions (MHACs) initiatives. The HSCRC scaling methodology is an important policy tool providing strong incentives for hospitals to improve their quality and efficiency over time. The policy has also contributed to Maryland's lower variation in hospital costs versus hospitals nationally.

Current HSCRC policy calls for the revenue neutral scaling of hospitals' position on the approved ROC comparison and allocation of rewards and penalties related to performance on the HCSRC's QBR and MHAC initiatives. The term "scaling" refers to the differential allocation of a pre-determined portion of base hospital revenue based on a distribution of hospital performance related to either relative efficiency or relative quality. The rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for that year. Thus, positive net scaling will add to a hospital's update and negative scaling will reduce a hospital's update. The total amounts scaled will be the sum of ROC and Quality scaling results. It should also be noted that ROC scaling permanently impacts a hospital's revenue base, while the scaling amounts applied for Quality performance are applied on a "one-time basis."

This allocation is performed on a "revenue neutral" basis for the system as a whole. This means that the net increases in rates for better performing hospitals are funded entirely by net decreases in rates for poorer performing hospitals.

Background

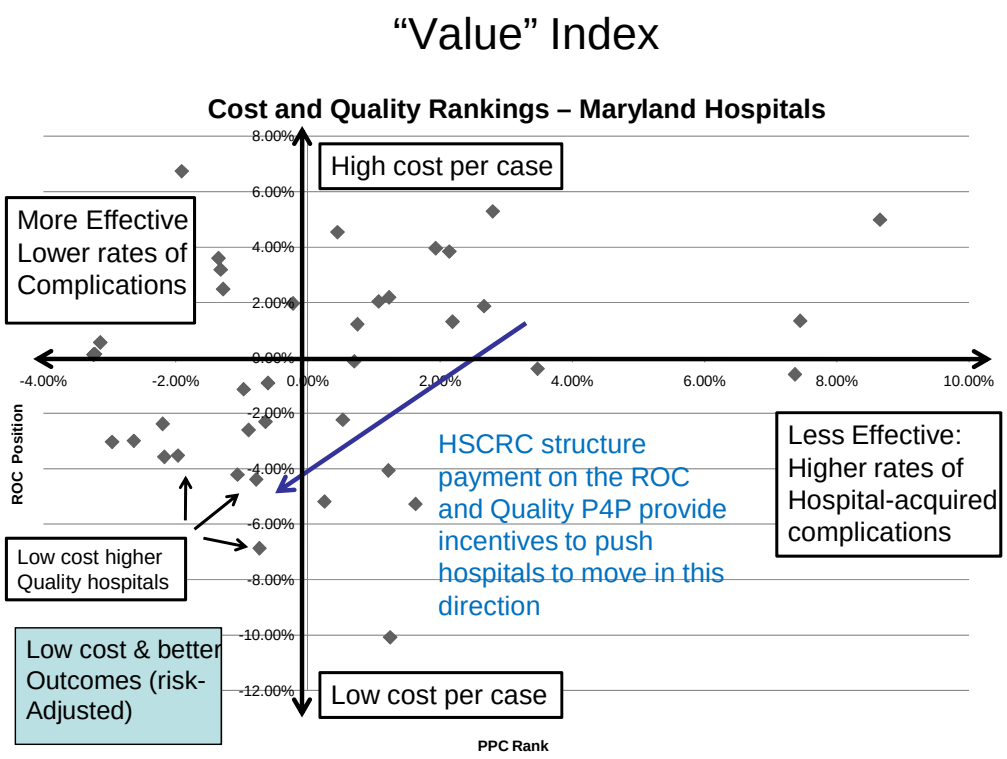
Before FY 2009, the HSCRC did not apply a scaling factor to the ROC. Instead, it set a threshold (traditionally 3.0% above the peer group average) and identified hospitals whose adjusted and combined charge per case and charge per visit were above that threshold as "high charge" facilities. The HSCRC directed staff to negotiate rate reduction agreements (or "spenddown" agreements) with these high cost hospitals. Under a spenddown, the identified hospital would receive something less than full inflation for a period of two to three years until it was at or near the average of its peer group. While negotiated spenddowns did result in the relative improvement of high charge hospitals (and overall compression of hospital adjusted costs on the ROC comparison), hospitals with ROC positions below the average had no means to change their position over time. These hospitals referred to themselves as "stuck hospitals" in that they were stuck in this lower charge position over time with no ability to change their rate structure over time.

With the advent of the HSCRC's two pay-for-performance programs (the QBR and MHACs), which utilized a continuous scaling of a proportion of each hospital's base revenue, the Commission abandoned its spenddown policy and also adopted a continuous scaling approach based on all hospitals' relative ROC positions. Both the FY 2009 and FY 2010 updates included continuous scaling provisions based on hospital relative efficiency (ROC) and relative quality (QBR and MHAC) performance.

Incentivizing Hospitals to Provide the Best Value Care

The combination of rewards and penalties for both relative efficiency and quality is an important step toward recognizing the overall "Value" of hospital care provided for each dollar expended. The chart below illustrates this concept of how the Commission can promote Value and how rewards and penalties based on relative performance can help push hospitals toward a position of providing high quality care and low cost care (lower left quadrant). Continuous scaling of ROC, QBR, and MHAC provides hospitals with strong incentives to gradually improve both efficiency and quality.

Chart 1
Scaling Relative Efficiency and Quality Provide incentives to improve overall Value of Care



Scaling on the Basis of Quality

In the past, the HSCRC scaled only up to 0.5% of base hospital revenue for both the QBR and MHAC (a total of 1.0% of hospital base revenue related to quality). The final scaling magnitudes for the QBR and MHACs were always determined at the end of a particular year because of the hospital industry's preference to see the impact of scaling on individual hospitals in the context of the overall hospital update approved by the Commission. Because of this custom, the precise magnitude scaled was not determined until the end of that year.[1]

[1] Note: over time, both the staff and the hospital and payer industries have suggested that the Commission consider gradually increasing the amount of revenue at risk for relative quality performance in future years so all participants should have anticipated that the scaling related to quality performance would be greater than the original 1.0% magnitude approved in FY 2009 and FY 2010.

More recently the Maryland Hospital Association has proposed that the precise magnitude set aside for quality scaling be determined prospectively. The HSCRC staff is supportive of prospective establishment of standards and targets and thus will recommend scaling magnitudes for QBR and MHAC for the FY 2013 Update (based on FY 2012 actual performance for ROC and MHACs, and CY 2011 performance on QBR) at the August 2011 Commission meeting.

This recommendation for scaling of ROC and Quality performance relates to rate updates applied with FY 2012 rate orders (effective July 1, 2011 for ROC and MHACs and CY 2010 for QBR) and based on hospital relative performance in FY 2011 (year ending June 30, 2011).

Scaling on the Basis of ROC Position

In the past, the staff has considered a variety of ROC scaling magnitudes and structures. In general, staff believes that a continuous scaling of at-risk revenue is the best policy approach. The continuous scaling structure reflects each hospital's relative position most directly and avoids potential inequities in scaling associated with a tiered or step function structure.[2]

As a result, the HSCRC has generally defaulted to a continuous scaling of hospital ROC position. The amount scaled for each hospital has been a proportion (15% in FY 2010) of the difference between its ROC position and its peer group average. Thus, if a hospital was 3.0% above its peer group average, it would have its update factor reduced by 0.45% (+3.0% x 15%). Likewise, a hospital 3.0% below the average would receive an additional 0.45%.[3]

In the past, payer representatives have argued for an even more aggressive scaling approach because the policy was meant to replace what was a highly aggressive spenddown approach to reducing the rate structure of high cost hospitals.

Conversely, hospital representatives have argued for a less aggressive approach based on the argument that the ROC methodology isn't precisely dispositive of a hospital's exact level of relative efficiency, and year-to-year changes in ROC methodology can create some instability in ROC positions.

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[2] Tiered or step-function approaches, which place hospitals in pre-defined brackets based on arbitrary ranges of performance, result in so-called "cliff-effects" in the application of rewards or penalties. These "effects" are the same for any given tier but can increase or drop off dramatically from one tier to another. Hospitals around the edge of the tier can be either highly advantaged or disadvantaged by this approach.

[3] It should be noted that the penalty applied under the continuous scaling approach is far less onerous than the magnitude of reduction applied to spenddown hospitals in any given year. By definition, hospitals on spenddowns would see in excess of 1.0% reductions to their rate updates per year. However, the HSCRC's continuous scaling approach is beneficial to the rate system in that it applies to all hospitals (both high charge and "stuck" hospitals), and it accomplishes the same goal as spenddown arrangements but over a longer period of time.

Concerns regarding changes in ROC position from FY 2010 to FY 2011

The issue of year-to-year instability has been of particular concern to the MHA related to this year's ROC calculation. In FY 2011, the system witnessed a number of policy changes (removal of One Day Stay cases from the Charge per Case methodology and implementation of the HSCRC's Charge per Visit constraint system). Both constitute major changes to Commission methodology and have likely contributed to unanticipated changes in the ROC positions of a number of hospitals.

While these changes in methodology do make it more difficult for hospitals to gauge their relative cost performance (as measured by the ROC), staff believes that the FY 2011 ROC represents an improvement over the FY 2010 methodology and is still highly indicative of high and low cost relative performance. Staff is fully prepared to support this assertion in more detail before the Commission in July.

However, given the concerns raised by the MHA, the staff would offer an alternative scaling approach for the FY 2011 ROC (with scaling results applicable to the FY 2012 updates). This alternative approach establishes a non-scaled bracket of plus or minus 2.0 percent from the average of any given peer group. It proposes scaling a slightly larger proportion of each hospitals position on the ROC down to the expanded 2.0 percent corridor. The result is that hospitals in the +/-2.0 percent bracket receive no ROC scaling. Hospitals above and below the +/- 2.0 percent corridor would be scaled at 25 percent of their position on the ROC down to that 2.0 percent threshold. Consequently, the amounts of revenue scaled (the amount allocated from high cost to low cost hospitals) are reduced significantly. This alternative scenario was discussed during the most recent meetings of the HSCRC Payment Work Group. In response, the MHA proposed an even more diluted scaling approach (expanding the non-scaled bracket to +/- 3.0 percent - scaled at 25 percent of the distance of a hospital's position on the ROC to that threshold). Table 1 show results (both the overall dollar magnitude scaled for the industry as a whole and the impact on individual hospitals) of these different scenarios.

Table 1
Maryland Hospitals' ROC Scaling Simulation Results for Fiscal Year 2011

HOSPID	HOSPITAL NAME	ROC POSITION	Current Policy *Continuous Scaling of 15% of ROC Positions*		Alternate Proposal *Scaling 25% of the Difference in ROC Positions and Limit of 2.00%*		MHA Proposal *Scaling 25% of the Difference in ROC Positions and Limit of 3.00%*	
			Percent Scaled	Revenue Amount Scaled	Percent Scaled	Revenue Amount Scaled	Percent Scaled	Revenue Amount Scaled
Total Amount of Scaled Revenue				**$18,375,238**		**$11,666,146**		**$7,027,763**
210003	Prince Georges Hospital Center	8.76%	-0.87%	-$1,869,716	-0.90%	-$1,942,040	-0.78%	-$1,681,864
210055	Laurel Regional Hospital	7.75%	-0.77%	-$727,672	-0.77%	-$726,720	-0.65%	-$610,192
210016	Washington Adventist Hospital	6.41%	-0.64%	-$1,545,234	-0.59%	-$1,431,472	-0.46%	-$1,125,383
210013	Bon Secours Hospital	5.36%	-0.53%	-$554,747	-0.45%	-$468,312	-0.32%	-$334,499
210061	Atlantic General Hospital	4.64%	-0.46%	-$288,007	-0.35%	-$220,766	-0.22%	-$139,558
210018	Montgomery General Hospital	4.64%	-0.46%	-$612,821	-0.35%	-$469,477	-0.22%	-$296,540
210051	Doctors Community Hospital	4.48%	-0.44%	-$774,279	-0.33%	-$576,833	-0.20%	-$349,760
210022	Suburban Hospital	4.41%	-0.44%	-$904,198	-0.32%	-$665,736	-0.19%	-$396,423
210040	Northwest Hospital Center	4.26%	-0.42%	-$802,152	-0.30%	-$573,343	-0.17%	-$325,367
210009	Johns Hopkins Hospital	3.95%	-0.39%	-$4,957,575	-0.26%	-$3,297,656	-0.13%	-$1,636,096
210058	James Lawrence Kernan Hospital	3.65%	-0.36%	-$274,162	-0.22%	-$166,863	-0.09%	-$66,841
210006	Harford Memorial Hospital	3.27%	-0.32%	-$279,616	-0.17%	-$146,296	-0.04%	-$31,750
210028	St. Mary's Hospital	3.23%	-0.32%	-$338,495	-0.16%	-$173,859	-0.03%	-$33,491
210002	University of Maryland Hospital	2.74%	-0.27%	-$1,967,751	-0.10%	-$716,790	0.00%	$0
210043	Baltimore Washington Medical Ctr	2.24%	-0.22%	-$635,580	-0.03%	-$89,981	0.00%	$0
210012	Sinai Hospital	1.83%	-0.18%	-$874,064	0.00%	$0	0.00%	$0
210054	Southern Maryland Hospital Center	1.77%	-0.18%	-$314,635	0.00%	$0	0.00%	$0
210007	St. Joseph Medical Center	1.69%	-0.17%	-$516,895	0.00%	$0	0.00%	$0
210008	Mercy Medical Center	0.36%	-0.04%	-$116,503	0.00%	$0	0.00%	$0
210011	St. Agnes Hospital	0.07%	-0.01%	-$21,136	0.00%	$0	0.00%	$0
210030	Chester River Hospital Center	0.00%	0.00%	$0	0.00%	$0	0.00%	$0
210045	McCready Memorial Hospital	0.00%	0.00%	$0	0.00%	$0	0.00%	$0
210027	Western MD Regional Medical Ctr	0.00%	0.00%	$0	0.00%	$0	0.00%	$0
210024	Union Memorial Hospital	-0.35%	0.05%	$169,665	0.00%	$0	0.00%	$0
210035	Civista Medical Center	-0.56%	0.08%	$81,876	0.00%	$0	0.00%	$0
210023	Anne Arundel Medical Center	-0.69%	0.10%	$357,701	0.00%	$0	0.00%	$0
210004	Holy Cross Hospital	-0.86%	0.13%	$483,258	0.00%	$0	0.00%	$0
210057	Shady Grove Adventist Hospital	-0.92%	0.14%	$431,728	0.00%	$0	0.00%	$0
210015	Franklin Square Hospital Center	-1.40%	0.21%	$731,075	0.00%	$0	0.00%	$0
210056	Good Samaritan Hospital	-1.41%	0.21%	$522,444	0.00%	$0	0.00%	$0
210044	Greater Baltimore Medical Center	-1.90%	0.28%	$975,865	0.00%	$0	0.00%	$0
210048	Howard County General Hospital	-1.91%	0.29%	$629,864	0.00%	$0	0.00%	$0
210038	Maryland General Hospital	-2.06%	0.31%	$477,447	0.02%	$24,594	0.00%	$0
210019	Peninsula Regional Medical Center	-2.24%	0.34%	$1,068,970	0.06%	$192,995	0.00%	$0
210033	Carroll Hospital Center	-2.48%	0.37%	$640,430	0.12%	$208,026	0.00%	$0
210032	Union of Cecil	-2.98%	0.45%	$505,044	0.24%	$276,748	0.00%	$0
210037	Memorial Hospital at Easton	-3.00%	0.45%	$632,455	0.25%	$351,106	0.00%	$0
210049	Upper Chesapeake Medical Center	-3.01%	0.45%	$830,831	0.25%	$464,472	0.001%	$2,609
210005	Frederick Memorial Hospital	-3.51%	0.53%	$1,312,183	0.38%	$939,286	0.13%	$315,444
210060	Fort Washington Medical Center	-3.79%	0.57%	$213,005	0.45%	$167,730	0.20%	$74,090
210039	Calvert Memorial Hospital	-3.81%	0.57%	$583,043	0.45%	$461,670	0.20%	$206,636
210010	Dorchester General Hospital	-4.42%	0.66%	$314,078	0.61%	$286,663	0.36%	$168,263
210034	Harbor Hospital Center	-4.99%	0.75%	$1,315,032	0.75%	$1,312,818	0.50%	$873,368
210029	Johns Hopkins Bayview Medical Ctr	-5.09%	0.76%	$2,943,195	0.77%	$2,978,958	0.52%	$2,015,774
210017	Garrett County Memorial Hospital	-6.58%	0.99%	$346,199	1.15%	$401,740	0.90%	$314,110
210001	Meritus Medical Center	-8.64%	1.30%	$2,809,851	1.66%	$3,599,340	1.41%	$3,057,468

Source: HSCRC, June 2011.

The Commission will note that each scenario varies in terms of the degree of scaling aggressiveness. Current policy (the continuous scaling approach) scales the greatest amount of revenue from poorer performing to better performing hospitals (approximately $18 million), while the MHA proposed option scales a much lower amount of system revenue (approximately $7 million). In general, staff believes that stronger incentives for improved efficiency are better than weaker incentives.

Cap on Cumulative Scaling for any given Hospital

Current HSCRC ROC Scaling Policy also contemplates a hold-harmless provision for hospitals that receive a cumulative negative scaling amount for the ROC and Quality. This provision caps the negative cumulative impact of combined scaling such that a hospital would not receive a core update of less than 0%.[4] Staff supports retention of this provision.

Revenue Neutrality

As noted above, the ROC and Quality scaling are designed to be revenue neutral for the system as a whole. This means that the amounts allocated to better performing hospitals (rewards) must precisely match the penalties applied to poorer performing hospitals. The amount of revenue available for scaling, then, is a function of both the percentage of at-risk revenue and the magnitude of revenue of the poor performing hospitals.

In the FY 2011 ROC, there are several large hospitals that are eligible for negative scaling. This circumstance results in overall penalties that are in excess of the calculated rewards for better performing hospitals. When this circumstance exists, the excess penalties are first applied to reduce the negative scaling of any individual hospital so as not to drop their update below 0% and then used to reduce proportionately the magnitude of the penalty applied to all other poorly performing hospitals. Staff recommends retention of this revenue neutrality provision.

A summary of the combined scaling amounts (the three ROC scenarios and recommended QBR and MHAC scaling) is presented in Appendix I of this document.

ROC Methodology Change

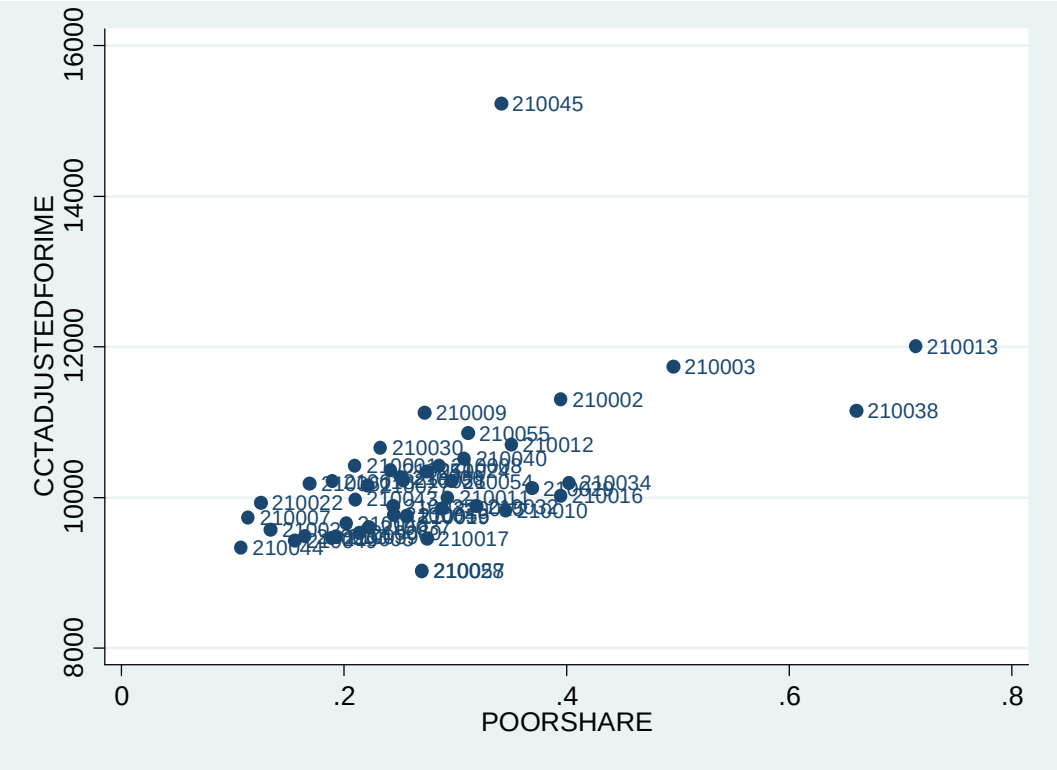
The Commissioners will recall that the ROC is a ranking of hospitals' adjusted charge per case and charge per visit. Adjustments are applied to hospital charge data to account for factors that are built into charges for which a hospital should not be held accountable. Two such examples are the estimated extra cost of a graduate medical education (indirect medical education or IME) program and the estimated additional cost of treating large proportions of indigent patients (disproportionate share or DSH). Costs associated with these activities are estimated by means of a regression. The two variables tend to be highly correlated, because many teaching hospitals are located in urban areas and also service large numbers of lower income patients.

[4] FY 2012 core update is 1.56%. Hospitals with a combined negative scaling amount (ROC plus Quality scaling) of greater than 1.56% would have their adjustment capped at this level so that they would not receive a net negative change to rates in FY 2012.

In performing diagnostics on the regression results, staff discovered that the IME/DSH regression is being unduly influenced by one hospital in particular (McCready hospital on the Eastern Shore). While the two independent variables are highly correlated, McCready does not have a teaching program, and, thus, there is an absence of a confounding effect. This observation, however, is clearly the most extreme outlier on the regression residuals as illustrated by the graph below (McCready is hospital number 21045).

The presence of this outlier observation does have a measurable impact on the regression coefficients, and, thus, staff believes that McCready should be removed from the regression analysis. The hospital, however, would still be included in the final ROC results.

Table 2
Outlier in the IME/DSH Regression Analysis



Case Mix Lag

On June 9, 2010, the Commission approved a staff recommendation to incorporate a three month lag into the data periods used for case mix measurement. This recommendation would move the data period used for case mix indexing from "real time" (the immediate prior fiscal year, July 1 - June 30) to a year period beginning April 1 of the prior year and ending March 31. Hospitals' data submission timelines associated with incorporating real time case mix measurement had delayed Commission staff production of rate orders, and the "case mix lag" aimed to accelerate rate order production. The June 9, 2010 approved recommendation also indicated that technical implementation would be vetted with the MHA Financial Technical Issues Task Force.

This spring, Commission staff worked with MHA's Financial Technical Issues Task Force to implement the case mix lag for the FY 2012 rate orders. No consensus could be reached initially, but as a result of these discussions, staff now recommends a compromise to change the case mix lag to a "case weight lag."

In this recommendation, Commission staff will calculate the case mix index (CMI) based on the prior fiscal year using quarter 1 - quarter 3 final discharge data and quarter 4 preliminary discharge data. Staff will then use the calculated CMI to determine compliance with existing charge-per-case (CPC) and charge-per-visit (CPV) targets. Once final fourth quarter case-mix data are available, compliance and targets would be recalculated, and an adjustment made for any material variance.

Staff will calculate the inpatient case weights based on data from the previous calendar year (a six month lag). Because the volume of cases within inpatient diagnosis-related group (DRG) cells is relatively large and stable, using calendar year data that lags actual experience by six months is likely to result in inpatient case weights that are substantially unchanged from those developed using more current data. However, due to known shifts in outpatient services (e.g., hospital increased utilization of observation services in lieu of inpatient admissions), Commission staff are uncertain of sufficient stability in APGs to utilize calendar year 2010 data for outpatient case weights in the 2012 rate year. Therefore, Commission staff will evaluate the outpatient weights using six and nine months of fiscal year 2011 data.

Appendix II provides a copy of MHA's response to this proposal. Staff will evaluate the efficacy of this approach in the upcoming rate year.

Table 3 indicates the inpatient case mix and weighting data sources for rate year 2012.

Table 3
Rate Year 2012 Case Mix and Case Weight Data Sources - Inpatient

Rate Year	Case Weights	Case Mix Index
July 1, 2011- June 30 2012	Final Discharge Data: • January 1 - December 31, 2010	Final Discharge Data: • July 1, 2010 - March 31, 2011 Preliminary Discharge Data: • April 1 - June 30, 2011

Staff Recommendation

1. ROC Methodology

Recommended modification to the FY 2011 ROC calculation:

The IME/DSH regression is being unduly influenced by one extreme outlier observation (McCready Hospital 210045). This hospital should be excluded from the regression used to quantify the IME and DSH adjustments.

2. Case Weight Lag

Recommended modification from a case mix lag to a weighting lag:

a) Calculate final case mix index based on the prior fiscal year using quarter 1 - quarter 3 final discharge data and quarter 4 preliminary discharge data

b) Calculate case weights -

- Inpatient - based on data from the previous calendar year (a six month lag)
- Outpatient - evaluate the outpatient weights using six and nine months of fiscal year 2011 data

3. ROC, QBR, and MHAC Scaling

a) 0.5 percent of hospital approved revenue for QBR relative performance and other provisions per the Commission approved QBR policy for FY 2011;

b) 1.0 percent of hospital approved revenue for MHAC relative performance;

c) For ROC scaling either option 1: (current policy) 15 percent of the difference between a hospital's position on the ROC and the peer group average (i.e., the peer group average = 0 percent); or option 2: 25 percent of the difference between a hospital's position on the ROC and a 2.0 percent +/- corridor with hospitals in the corridor receiving 0 percent scaling (see Table 1 above);

d) Although it is not represented in the above simulation, staff recommends limiting any given hospital's combined negative scaling to the magnitude of the Commission-approved base update for FY 2012.

e) Additionally, the scaling would be calculated to be revenue neutral for the system as a whole, with any additional amounts generated as a result of the above limitation on negative scaling, to be reallocated first to any capped hospital and second to all other negatively scaled hospitals (as reductions to their calculated offsets).

Appendix I
Combined Scaling Results across Three Different ROC Scaling Scenarios

HOSPID	Hospital Name	Rate Update Factor	Option 1 - Current Policy				Option 2 - Alternate Proposal				Option3 - MHA's Proposal			
			ROC Scaled Revenue Neutral Adjustment	Rate Update Factor (Adjusted for ROC Scaling)	Rate Update Factor (Adjusted for ROC and MHAC Scaling)	Rate Update Factor (Adjusted for ROC, MHAC and QBR Scaling)	ROC Scaled Revenue Neutral Adjustment	Rate Update Factor (Adjusted for ROC Scaling)	Rate Update Factor (Adjusted for ROC and MHAC Scaling)	Rate Update Factor (Adjusted for ROC, MHAC and QBR Scaling)	ROC Scaled Revenue Neutral Adjustment	Rate Update Factor (Adjusted for ROC Scaling)	Rate Update Factor (Adjusted for ROC and MHAC Scaling)	Rate Update Factor (Adjusted for ROC, MHAC and QBR Scaling)
210003	Prince Georges Hospital Center	1.56%	-0.87%	0.69%	-0.14%	**-0.55%**	-0.90%	0.66%	-0.17%	**-0.59%**	-0.78%	0.78%	-0.05%	**-0.47%**
210055	Laurel Regional Hospital	1.56%	-0.77%	0.79%	0.59%	**0.39%**	-0.77%	0.79%	0.59%	**0.40%**	-0.65%	0.91%	0.71%	**0.52%**
210051	Doctors Community Hospital	1.56%	-0.44%	1.12%	0.77%	**0.61%**	-0.33%	1.23%	0.88%	**0.73%**	-0.20%	1.36%	1.01%	**0.86%**
210016	Washington Adventist Hospital	1.56%	-0.64%	0.92%	0.66%	**0.61%**	-0.59%	0.97%	0.70%	**0.66%**	-0.46%	1.10%	0.83%	**0.79%**
210002	University of Maryland Hospital	1.56%	-0.27%	1.29%	0.89%	**0.68%**	-0.10%	1.46%	1.07%	**0.85%**	0.00%	1.56%	1.17%	**0.95%**
210012	Sinai Hospital	1.56%	-0.18%	1.38%	1.03%	**0.87%**	0.00%	1.56%	1.22%	**1.05%**	0.00%	1.56%	1.22%	**1.05%**
210018	Montgomery General Hospital	1.56%	-0.46%	1.10%	0.65%	**0.94%**	-0.35%	1.21%	0.76%	**1.05%**	-0.22%	1.34%	0.89%	**1.18%**
210022	Suburban Hospital	1.56%	-0.44%	1.12%	1.11%	**1.15%**	-0.32%	1.24%	1.23%	**1.26%**	-0.19%	1.37%	1.36%	**1.39%**
210027	Western Maryland Regional Medical Ctr	1.56%	0.00%	1.56%	1.44%	**1.19%**	0.00%	1.56%	1.44%	**1.19%**	0.00%	1.56%	1.44%	**1.19%**
210040	Northwest Hospital Center	1.56%	-0.42%	1.14%	1.22%	**1.19%**	-0.30%	1.26%	1.34%	**1.32%**	-0.17%	1.39%	1.47%	**1.45%**
210030	Chester River Hospital Center	1.56%	0.00%	1.56%	1.52%	**1.29%**	0.00%	1.56%	1.52%	**1.29%**	0.00%	1.56%	1.52%	**1.29%**
210054	Southern Maryland Hospital Center	1.56%	-0.18%	1.38%	1.33%	**1.30%**	0.00%	1.56%	1.50%	**1.47%**	0.00%	1.56%	1.50%	**1.47%**
210009	Johns Hopkins Hospital	1.56%	-0.39%	1.17%	1.22%	**1.34%**	-0.26%	1.30%	1.35%	**1.47%**	-0.13%	1.43%	1.48%	**1.61%**
210057	Shady Grove Adventist Hospital	1.56%	0.14%	1.70%	1.33%	**1.38%**	0.00%	1.56%	1.19%	**1.24%**	0.00%	1.56%	1.19%	**1.24%**
210061	Atlantic General Hospital	1.56%	-0.46%	1.10%	1.11%	**1.39%**	-0.35%	1.21%	1.22%	**1.50%**	-0.22%	1.34%	1.35%	**1.63%**
210015	Franklin Square Hospital Center	1.56%	0.21%	1.77%	1.42%	**1.41%**	0.00%	1.56%	1.21%	**1.20%**	0.00%	1.56%	1.21%	**1.20%**
210013	Bon Secours Hospital	1.56%	-0.53%	1.03%	1.73%	**1.45%**	-0.45%	1.11%	1.82%	**1.53%**	-0.32%	1.24%	1.95%	**1.66%**
210058	James Lawrence Kernan Hospital	1.56%	-0.36%	1.20%	1.47%	**1.47%**	-0.22%	1.34%	1.61%	**1.61%**	-0.09%	1.47%	1.74%	**1.74%**
210043	Baltimore Washington Medical Center	1.56%	-0.22%	1.34%	1.64%	**1.49%**	-0.03%	1.53%	1.83%	**1.68%**	0.00%	1.56%	1.86%	**1.71%**
210024	Union Memorial Hospital	1.56%	0.05%	1.61%	1.46%	**1.58%**	0.00%	1.56%	1.41%	**1.53%**	0.00%	1.56%	1.41%	**1.53%**
210045	McCready Memorial Hospital	1.56%	0.00%	1.56%	1.55%	**1.63%**	0.00%	1.56%	1.55%	**1.63%**	0.00%	1.56%	1.55%	**1.63%**
210023	Anne Arundel Medical Center	1.56%	0.10%	1.66%	1.61%	**1.65%**	0.00%	1.56%	1.51%	**1.55%**	0.00%	1.56%	1.51%	**1.55%**
210007	St. Joseph Medical Center	1.56%	-0.17%	1.39%	1.24%	**1.68%**	0.00%	1.56%	1.41%	**1.85%**	0.00%	1.56%	1.41%	**1.85%**
210035	Civista Medical Center	1.56%	0.08%	1.64%	1.59%	**1.74%**	0.00%	1.56%	1.51%	**1.65%**	0.00%	1.56%	1.51%	**1.65%**
210006	Harford Memorial Hospital	1.56%	-0.32%	1.24%	1.56%	**1.75%**	-0.17%	1.39%	1.72%	**1.91%**	-0.04%	1.52%	1.85%	**2.04%**
210011	St. Agnes Hospital	1.56%	-0.01%	1.55%	1.94%	**1.81%**	0.00%	1.56%	1.95%	**1.82%**	0.00%	1.56%	1.95%	**1.82%**
210056	Good Samaritan Hospital	1.56%	0.21%	1.77%	1.74%	**1.82%**	0.00%	1.56%	1.53%	**1.61%**	0.00%	1.56%	1.53%	**1.61%**
210028	St. Mary's Hospital	1.56%	-0.32%	1.24%	1.57%	**1.89%**	-0.16%	1.40%	1.72%	**2.05%**	-0.03%	1.53%	1.85%	**2.18%**
210060	Fort Washington Medical Center	1.56%	0.57%	2.13%	2.06%	**1.90%**	0.45%	2.01%	1.94%	**1.78%**	0.20%	1.76%	1.69%	**1.53%**
210034	Harbor Hospital Center	1.56%	0.75%	2.31%	1.94%	**1.91%**	0.75%	2.31%	1.94%	**1.90%**	0.50%	2.06%	1.69%	**1.65%**
210004	Holy Cross Hospital	1.56%	0.13%	1.69%	1.87%	**1.92%**	0.00%	1.56%	1.74%	**1.79%**	0.00%	1.56%	1.74%	**1.79%**
210044	Greater Baltimore Medical Center	1.56%	0.28%	1.84%	2.04%	**1.97%**	0.00%	1.56%	1.76%	**1.69%**	0.00%	1.56%	1.76%	**1.69%**
210005	Frederick Memorial Hospital	1.56%	0.53%	2.09%	2.00%	**1.99%**	0.38%	1.94%	1.85%	**1.84%**	0.13%	1.69%	1.60%	**1.59%**
210038	Maryland General Hospital	1.56%	0.31%	1.87%	2.35%	**2.00%**	0.02%	1.58%	2.05%	**1.71%**	0.00%	1.56%	2.04%	**1.69%**
210032	Union of Cecil	1.56%	0.45%	2.01%	1.91%	**2.02%**	0.24%	1.80%	1.71%	**1.82%**	0.00%	1.56%	1.46%	**1.58%**
210048	Howard County General Hospital	1.56%	0.29%	1.85%	1.98%	**2.07%**	0.00%	1.56%	1.70%	**1.78%**	0.00%	1.56%	1.70%	**1.78%**
210008	Mercy Medical Center	1.56%	-0.04%	1.52%	1.92%	**2.16%**	0.00%	1.56%	1.96%	**2.20%**	0.00%	1.56%	1.96%	**2.20%**
210019	Peninsula Regional Medical Center	1.56%	0.34%	1.90%	2.36%	**2.20%**	0.06%	1.62%	2.09%	**1.92%**	0.00%	1.56%	2.03%	**1.86%**
210033	Carroll Hospital Center	1.56%	0.37%	1.93%	2.41%	**2.43%**	0.12%	1.68%	2.16%	**2.18%**	0.00%	1.56%	2.04%	**2.06%**
210037	Memorial Hospital at Easton	1.56%	0.45%	2.01%	2.31%	**2.43%**	0.25%	1.81%	2.11%	**2.23%**	0.00%	1.56%	1.86%	**1.98%**
210039	Calvert Memorial Hospital	1.56%	0.57%	2.13%	2.46%	**2.49%**	0.45%	2.01%	2.34%	**2.37%**	0.20%	1.76%	2.09%	**2.12%**
210029	Johns Hopkins Bayview Medical Center	1.56%	0.76%	2.32%	2.60%	**2.51%**	0.77%	2.33%	2.61%	**2.52%**	0.52%	2.08%	2.36%	**2.27%**
210049	Upper Chesapeake Medical Center	1.56%	0.45%	2.01%	2.39%	**2.58%**	0.25%	1.81%	2.19%	**2.38%**	0.00%	1.56%	1.94%	**2.13%**
210010	Dorchester General Hospital	1.56%	0.66%	2.22%	2.66%	**2.77%**	0.61%	2.17%	2.60%	**2.71%**	0.36%	1.92%	2.35%	**2.46%**
210017	Garrett County Memorial Hospital	1.56%	0.99%	2.55%	2.92%	**2.93%**	1.15%	2.71%	3.08%	**3.09%**	0.90%	2.46%	2.83%	**2.84%**
210001	Meritus Medical Center	1.56%	1.30%	2.86%	2.92%	**3.15%**	1.66%	3.22%	3.28%	**3.51%**	1.41%	2.97%	3.03%	**3.26%**
	Statewide Total	1.56%	0.00%	1.56%	1.56%	**1.56%**	0.00%	1.56%	1.56%	**1.56%**	0.00%	1.56%	1.56%	**1.56%**

Source: HSCRC, June 2011.

Appendix II
Maryland Hospital Association Response to Proposed Case Weight Lag

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

June 23, 2011

Robert Murray
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Mr. Murray:

On behalf of our 66 member organizations, the Maryland Hospital Association (MHA) appreciates the opportunity to comment on your June 13 memo outlining changes to the process and data submissions required to establish rate orders for fiscal year 2012. We appreciate your efforts to identify and address factors that delay the issuance of final rate orders, and we believe the approach you have outlined for the coming year is practical and reasonable.

We request that you clarify three points:

1. **Case-mix Data Submission**

   The proposed approach uses preliminary fourth quarter case-mix data to calculate final case-mix index, included cases and visits, and excluded cases and visits for all categories. These calculations are then used to determine compliance with existing charge-per-case (CPC) and charge-per-visit (CPV) targets and to calculate the subsequent year's CPC and CPV targets. Once final fourth quarter case-mix data is available, compliance and targets would be recalculated, and an adjustment made for any material variance.

   We agree with this approach, but ask that you either define "material variance" or settle all variances.

2. **Case-weight lag**

   The proposed approach uses calendar year data to develop case weights for the subsequent year. Because the volume of cases within inpatient diagnosis-related group (DRG) cells is relatively large and stable, using calendar year data that lags actual experience by six months is likely to result in inpatient case weights that are substantially unchanged from those developed using more current data.

   In fiscal year 2011, many hospitals began aggressively utilizing observation services in lieu of inpatient admissions. As a result, it may be important to capture those volumes in the outpatient ambulatory patient group (APG) weights. As the proposed approach appears to recognize, it is unclear whether outpatient volumes within APGs are sufficiently stable to result in similar weights when using calendar year 2010 data compared to fiscal year 2011data. The memo states that HSCRC staff will evaluate the outpatient weights using six and nine months of fiscal year 2011 data.

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We believe it is important to evaluate whether material differences exist between outpatient APG weights based on six months and twelve months of fiscal year 2011 data.

3. **Admission-Readmission Policy**

   We agree that any Admission-Readmission Revenue (ARR) arrangements with the measurement period defined as March 1, 2010 - March 31, 2011 should be modified to coincide with the start of rate year 2012. HSCRC Commissioners approved the final staff recommendation on January 12, 2011; however, the details of how the policy would be implemented are not public.

   We urge Commission staff to publish the operational and technical details of the ARR policy.

Thank you for the opportunity to comment on changes to the process that supports calculation of rate orders. Please contact me at 410-540-5087 with any questions.

Sincerely,

Traci Lynn La Valle

Traci La Valle
Vice President, Financial Policy

cc: Commissioners