

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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**HEALTH SERVICES COST REVIEW COMMISSION**

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*Post-Meeting Documents*  
*from the*  
**494th Meeting of the Health Services Cost Review Commission**  
**January 9, 2013**

**Executive Session**  
**12:00 p.m.**

1. Waiver Issues
2. FY 2013 Medicaid Budget Issues
3. Legislative Audit
4. Personnel Issues
5. Legislative Review Process

**Public Session**  
**1:00 p.m.**

1. **Review of the Executive Session Minutes from November 7 and December 5, 2012 Meetings; and Public Meeting Minutes of the November 7, 2012 Meeting**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**

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

4. **Docket Status – Cases Open**

2168R – Garrett County Memorial Hospital  
2190N – St. Mary's Hospital - *Approved*  
2193R – Adventist Behavioral Health  
2194A – Johns Hopkins Health System - *Approved*

2195A – Johns Hopkins Health System - *Approved*  
2196N – Harbor Hospital  
2197A – Johns Hopkins Health System - *Approved*  
2198A – Johns Hopkins Health System - *Approved*  
2199A – Johns Hopkins Health System - *Approved*

5. **Final Recommendations Regarding Maryland Hospital Acquired Condition (MHAC) and Quality-based Reimbursement (QBR) Scaling Magnitudes, and MHAC Standard for Expected Values** - *Approved*
6. **Report on Maryland Patient Safety Center Responses to Requests from the Final Recommendations for Continued Financial Support of the Maryland Patient Safety Center (May 2012)** - *Approved*
7. **Presentation of Draft Revised Electrocardiography Relative Value Units (RVUs)**
8. **Hearing and Meeting Schedule**

**Executive Session Minutes  
of the  
Health Services Cost Review Commission**

**December 5, 2012**

Upon motion made, Chairman Colmers called the phone Executive Session to order at 9:33 a.m.

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

In attendance, in addition to Chairman Colmers, were Commissioners Bone, Jenks, Keane, Loftus, Mullen, and Wong.

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

Also attending were Leslie Schulman and Stan Lustman Commission Counsel.

**Item One**

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

The Executive Session was adjourned at 10: 12 p.m.

**Executive Session Minutes  
of the  
Health Services Cost Review Commission**

**November 7, 2012**

Upon motion made, Chairman Colmers called the meeting to order at 12:22 p.m.

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

In attendance, in addition to Chairman Colmers, were Commissioners Bone, Jenks, Keane, Mullen, and Wong.

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

Also attending was Leslie Schulman and Stan Lustman Commission Counsel.

**Item One**

Chairman Colmers and Dr. Redmon provided the Commissioners with an update on the status of the effort to modernize the Medicare waiver.

**Item Two**

Steve Ports summarized proprietary information pertaining to the CY 2013 alternative rate setting applications of the hospital-based MCOs.

**Item Three**

Dr. Redmon advised the Commissioners of the potential future Medicaid payment issues.

The Executive Session was adjourned at 12: 54 p.m.

**MINUTES OF THE**  
**493rd MEETING OF THE**  
**HEALTH SERVICES COST REVIEW COMMISSION**

**November 7, 2012**

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

**REPORT OF THE EXECUTIVE SESSION OF NOVEMBER 7, 2012 AND THE**  
**CONFERENCE CALLS OF OCTOBER 17 AND 30, 2012**

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the October 17, 30, and November 7, 2012 Executive Sessions.

**ITEM I**  
**EXECUTIVE SESSIONS OF OCTOBER 10, OCTOBER 17 AND OCTOBER 30, 2012**  
**AND THE PUBLIC MEETING OF OCTOBER 10, 2012**

The Commission voted unanimously to approve the minutes of the October 10, October 17, and October 30, 2012 Executive Sessions and the Public Meeting of October 10, 2012.

**ITEM II**  
**EXECUTIVE DIRECTOR'S REPORT**

Patrick Redmon, Ph.D., Executive Director, updated the Commission on the progress of several high priority endeavors. Dr. Redmon reported that Monitoring Maryland Performance (MMP) indicated that the rate of growth in charge per case increased by 4.24% for the twelve months year ended August 2012; inpatient revenue decreased 0.86%; the number of inpatient cases declined by 3.25%; outpatient revenue increased 14.25%; and total gross revenue increased 5.55%. Dr. Redmon noted that for the same period, hospitals' average net operating profit was 4.66%; average total operating profit was 1.92%; and average total excess profit was 6.11%.

**ITEM III**  
**DOCKET STATUS CASES CLOSED**

2176R – Good Samaritan Hospital  
2181R – Kernan Hospital  
2183A - Johns Hopkins Health System  
2185A - Johns Hopkins Health System

2180N – Chester River Hospital Center  
2182A - Johns Hopkins Health System  
2184A - Johns Hopkins Health System  
2186A - Johns Hopkins Health System

**ITEM IV**  
**DOCKET STATUS CASES OPEN**

**MARYLAND PHYSICIANS CARE – 2177A**

On August 22, 2012, Maryland General Hospital, Saint Agnes Health System, Western Maryland Health System, and Meritus Health (the “Hospitals”) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06. The Hospitals sought renewal for the continued participation of Maryland Physicians Care (“MPC”) in the Medicaid Health Choice Program. MPC is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2131A for the period January 1, 2012 through December 31, 2012. The Hospitals requested renewal of this contract for one year beginning January 1, 2013.

Staff recommended:

- 1) Approval of this alternative rate application for a one-year period beginning January 1, 2013;
- 2) That Maryland Physicians Care report to Commission staff (on or before the August 2013 meeting of the Commission) on the actual CY 2012 experience, preliminary CY 2013 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2014; and
- 3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract.

The Commission voted unanimously to approve staff’s recommendation.

**JOHNS HOPKINS HEALTH SYSTEM - 2178A**

On August 21, 2012 Johns Hopkins Health System (“JHHS,” or the “System”) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the “Hospitals”). The System sought renewal for the continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. Priority Partners, Inc. is the entity that assumes the risk under the contract. The Commission most recently approved this contract under proceeding 2135A for the period from January 1, 2012 through

December 31, 2012. The Hospitals requested renewal of this contract for a one-year period beginning January 1, 2013.

Staff recommended:

- 1) Approval of this alternative rate application for a one-year period beginning January 1, 2013;
- 2) That Priority Partners report to Commission staff (on or before the August 2013 meeting of the Commission) on the actual CY 2012 experience, preliminary CY 2013 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2014; and
- 3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract.

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

### **MEDSTAR HEALTH – 2179A**

On August 15, 2012, MedStar Health filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital (the "Hospitals"). MedStar Health sought renewal for the continued participation of MedStar Family Choice ("MFC") in the Medicaid Health Choice Program. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2128A for the period from January 1, 2012 through December 31, 2012. The Hospitals requested renewal of this contract for one year beginning 2013.

Staff recommended:

- 1) Approval of this alternative rate application for a one-year period beginning January 1, 2013;
- 2) That MedStar Family Choice report to Commission staff (on or before the August 2013 meeting of the Commission) on the actual CY 2012 experience, preliminary CY 2013 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2014; and

3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract.

The Commission voted unanimously to approve staff's recommendation.

#### **UNIVERSITY OF MARYLAND MEDICAL SYSTEM- 2188A**

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on September 28, 2012 to seek approval to continue to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow services with Interlink Health Services for a period of three years beginning November, 2012.

Staff recommended that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period commencing November 1, 2012. Staff also recommended that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

#### **UNIVERSITY OF MARYLAND MEDICAL SYSTEM- 2189A**

The University of Maryland Medical Center (the Hospital) filed a renewal application with the HSCRC on September 28, 2012 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for participation in a revised global rate arrangement for solid organ and blood and bone marrow transplant services with OptumHealth Care Solutions, Inc. (previously known as United Resource Networks), for a one-year period, effective November 1, 2012.

Staff recommended that the Commission the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning November 1, 2012. Staff also recommended that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

### **Johns Hopkins Health System – 2191A**

Johns Hopkins Health System (“System”) filed an application with the HSCRC on October 19, 2012 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center requesting approval from the HSCRC to continue to participate in a global rate arrangement for bone marrow transplants services with United Resources/Optum Health. The System requested approval for a period of one year beginning December 1, 2012.

The staff recommended that the Commission approve the Hospitals' application for an alternative method of rate determination for bone marrow transplant services, for a one year period commencing December 1, 2012, and this approval be contingent upon the execution of the standard Memorandum of Understanding (“MOU”).

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

### **Johns Hopkins Health System – 2192A**

Johns Hopkins Health System (“System”) filed a renewal application with the HSCRC on August 23, 2012 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the “Hospitals”) requesting approval from the HSCRC for continued participation in a capitation arrangement for serving persons insured by TRICARE, the managed care program for CHAMPUS beneficiaries. The Hospitals request that the Commission approve the arrangement for one year beginning January 1, 2013.

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

Commissioner Bone asked why Suburban Hospital, which is a member of the Johns Hopkins Health System, was not included in staff’s recommendation

The Commission voted unanimously to approve staff’s recommendation, with Chairman Colmers recusing himself from the discussion and vote, pending clarification from staff of the inclusion or exclusion of Suburban Hospital in the recommendation.

### **ITEM V**

#### **FINAL RECOMMENDATION ON OUTPATIENT CLINIC VOLUME ADJUSTMENT**

Staff presented a final recommendation on an outpatient clinic volume adjustment, in response to the Commission’s charge to develop a short-term outpatient constraint system to replace the

Charge-per-Visit methodology (see “Final Recommendation Outpatient Volume Adjustment: Clinic” on the HSCRC website). Jerry Schmith presented the history of volume adjustments utilized in HSCRC rate setting methodology over the years.

Mary Pohl, Deputy Director-Research and Methodology, stated that the objective of the clinic volume adjustment was to neutralize the financial impact of clinic volume growth and to address the site-of-service differential in reimbursement between the same service being provided in a hospital clinic and in a physician’s office. Ms. Pohl presented staff’s final recommendation which proposes an enhanced volume adjustment for clinic services. The recommendation included: 1) a volume adjustment of 50% for outpatient volume increases in the clinic rate center for permanent revenue; 2) an asymmetric volume adjustment of 85% to permanent revenue for volume decreases in the clinic rate center; 3) that these variable cost factors be applied to the clinic rate center only; 4) that this policy be applied for rate year 2014; and 5) that the clinic rate center be held out of the overall variable cost factor adjustment calculation.

Commissioner Jencks asked whether the reasonableness of hospital clinic charges was to be considered.

Ms. Pohl replied that only changes in clinic volumes were being considered, and that the reasonableness of hospital clinic charges was being pursued on a separate track.

Commissioner Bone asked when the policy would be implemented.

Ms. Pohl stated that adjustments would be made to hospitals’ FY 2014 rates based on changes in FY 2013 clinic volumes compared to FY 2012 volumes.

Commissioner Bone asked how often clinic volume changes would be monitored.

The Chairman asked the Executive Director to provide updates monthly once the policy is implemented.

Michael Robbins, Senior Vice President-Financial Policy of the Maryland Hospital Association (MHA), referred the Commission to his letter to Ms. Pohl containing MHA’s comments on staff’s recommendation (see “MHA letter to Mary Pohl, October 19, 2012, attached to “Final Recommendation Outpatient Volume Adjustment: Clinic” on the HSCRC website).

Commissioner Jencks asked Mr. Robbins if he could focus on the things that may be accessible but are not present in staff’s recommendation.

According to Mr. Robbins, one of the things missing in staff’s recommendation was an attempt to identify the reasons for clinic volume increases. Mr. Robbins stated that it would probably require manual surveying to get to the necessary level of detail needed. However, there may be a way to gather this information from hospitals on an annual basis.

Another item missing from staff’s recommendation, according to Mr. Robbins, was a way to

identify the appropriate level of clinic volume increase so that only excessive volume increases would be addressed. We might want to look at the aging of the population and the rate of population increase.

Mr. Robbins stated that because we don't have the time to develop the data to determine the appropriate increase in clinic volumes, MHA suggests moving forward on this issue, ensuring that hospitals that have had volume declines not be inappropriately penalized, and addressing the larger concerns involving utilization in the context of the modernization of the waiver.

Kevin Criswell, representing AmeriGroup, expressed support for staff's recommendation.

John Hamper, Director-Provider Reimbursement, Analytics & Compliance of CareFirst, stated that CareFirst submitted a letter at last month's public meeting advocating a more aggressive volume adjustment than staff proposed (see "Letter from John Hamper to the Commissioners – October 8, 2012" on HSCRC's website). Mr. Hamper stated that the letter proposed a modification to staff's recommendation to the effect that the volume adjustment be 60% fixed and 40% variable. Mr. Hamper presented schedules which showed the impact of increases in clinic volumes on CareFirst. Mr. Hamper amended CareFirst's written recommendations: i.e., because of the magnitude of the cost of the hospital ancillary services associated with clinic visits that the volume adjustment should be applied to all hospital outpatient volumes.

Commissioner Bone asked whether providing ancillary services at the hospital was a question of coordination of care.

Mr. Hamper stated that it was really a question of the cost of providing care at the hospital versus at a physician's office or a free standing facility, and that coordination of care was another issue.

Commissioner Bone observed then we still have to come back to the question of what is the true cost to deliver the bundle of care.

Mr. Hamper agreed.

The Chairman noted that since the data provided by CareFirst showed that the clinic volume increases between 2007 and 2010 occurred in only five hospitals, this problem might be a concentrated issue than a broader issue.

Mr. Hamper agreed.

The Chairman observed that it is not clear how much of the increased clinic volumes are associated with physician groups moving into hospital clinics and other reasons.

Commissioner Jencks noted the types of clinics, and how they are established and grow are different in each hospital.

Commissioner Jencks asked Mr. Hamper if CareFirst has tried to reconcile the significant

difference between their data with the Commission's data on the magnitude of ancillary services associated with hospital clinic visits.

Mr. Hamper stated that CareFirst has met with the Commission staff in an attempt to do so.

Commissioner Keane noted that it is not the volume of ancillary services associated with hospital clinic visits that is of most concern; it is the higher cost of hospital ancillary services.

Commissioners Jencks and Keane expressed concern that if ancillary services associated with clinics are as substantial as CareFirst's data indicate, implementing a volume adjustment on clinic facility fees will not provide an effective constraint on clinic volumes.

Dr. Redmon noted that in the near future staff will present a more robust volume adjustment that will address the ancillary issue as well.

Mr. Schmith expressed the belief that outpatient oncology services moving into hospitals was a major reason for the difference in the drug and radiology ancillary costs associated with hospital clinics versus physician office visits.

Commissioner Keane stated that it is our responsibility to assure the purchasers of hospital services that the rates approved are reasonable. It is not satisfactory to be told that the ancillary services associated with a clinic visit are not a large component of the cost of a clinic visit and then be presented with evidence that it is a large component when we are approving a volume adjustment policy that only applies to the clinic facility fee. We have an affirmative obligation to demonstrate the efficiency of the care being provided when we approve rates - - not simply to say it is possible that the care is efficient.

Mr. Schmith also noted that the reimbursement made to free standing providers may not accurately reflect the underlying cost of the ancillary services. Since such reimbursement is negotiated, the market power of the payer must be taken into consideration.

Gary Simmons, Regional Vice President of United Healthcare (United), reported that payments for outpatient services for United patients had risen 11% in Maryland hospitals versus 4% to 6% in Washington D.C. and neighboring states. Mr. Simmons presented examples of wide variance in clinic charges among Maryland hospitals.

On behalf of United, Mr. Simmons requested that the Commission: 1) adopt a more stringent fixed cost factor to reduce the incentive to increase outpatient volumes; 2) to eliminate hospitals' ability to bill outpatient charges for services that should be performed in physicians' office setting; 3) not allow hospitals to bill more than two units of service if a hospital does bill for clinic services; and 4) move to APC pricing for outpatient services.

Commissioner Jencks asked Mr. Simmons whether United would recommend that hospitals not be able to bill for clinic services that should be performed in physician offices if the clinic charges were more in line with those in a physician's office setting.

Mr. Simmons commented that hospitals charging more in line with physicians would be economical.

Commissioner Jencks stated that the Commission should take into consideration anecdotal evidence that independent physician practices are under very serious threat. Based on the data presented today, it does not appear likely that office practices will remain viable when the differential in revenue based on where services are provided is so great. The solution appears to be to get the fees in hospital clinics and office settings more aligned. The concern is if we don't get the fees aligned, we will see very serious damage to the fabric of medicine.

The Chairman stated that in the course of the discussion he has heard: 1) that the recommendation should be modified to include a change in the volume adjustment for ancillary services; 2) that we need more study because the reconciliation of the data between CareFirst and staff is not complete; and 3) the broader questions raised with respect to impact on physician services generally within the State if this trend were to continue. However, Chairman Colmers noted that the staff recommendation is relatively narrow and is the first step of several that will be proposed with respect to volume.

Commissioner Wong stated that today's discussion showed that there were multiple sides and great complexity to this issue. Some of these complexities are under the control of the Commission. Others are simply outside the purview of the Commission. The Commission asked staff at the March 2012 public meeting to consider a very narrow interim objective, and staff has brought forth a reasonable recommendation. Commissioner Wong made a motion to accept staff's recommendation.

The motion was seconded.

Commissioner Jencks stated that the issue that concerned him the most was that staff's recommendation allows a larger fixed cost than the evidence would support. According to Commissioner Jencks, the fees charged in hospital clinics versus those charged in a physician office setting are so unaccountably larger, even assuming that office practices are underpaid. The fees in hospital clinics are much higher than can be justified because of the fact that it is really more costly to provide services in a hospital setting and because of flawed hospital accounting practices. Consequently, the actual variable costs associated with a clinic visit should be 30% rather than 50%. Commissioner Jencks also suggested that if we move forward with staff's recommendation, we should have a date certain when we are going to take up some of the related issues like the ancillaries.

Commissioner Keane pointed out that when the Charge-per-Visit constraint was lifted in March of 2012, staff was asked to come up with a recommendation of steps, not just for clinic but for overall outpatient constraint, at the April 2012 public meeting with the intention being that the new interim across-the-board outpatient constraint would be in effect for FY 2013. We are now in November of FY 2013. We don't have an interim outpatient constrain and we don't have a clear path to when we will get one. We have a recommendation on a very small portion of outpatient revenue, which will have little effect on the outpatient volume problem.

Commissioner Keane expressed his agreement with Commissioner Jencks that the differential in fees between hospital clinic fees and those in physician office setting was detrimental to the ability of physicians to operate in independent practice.

The vote on the motion was two in favor of approving staff's recommendation and three opposed.

Commission Bone made a motion to accept staff's recommendation with the amendment that staff brief the Commission, in three to six months, on the points raised in today's discussion.

The motion was seconded.

The vote was four in favor of accepting staff's recommendation with the amendment and one Commissioner (Commissioner Keane) opposed.

**ITEM VI**  
**DRAFT RECOMMENDATION REGARDING THE MAGNITUDE OF SCALING FOR**  
**MARYLAND HOSPITAL ACQUIRED CONDITIONS (MHAC) AND QUALITY BASED**  
**REIMBURSEMENT (QBR) AND THE MHAC STANDARD FOR EXPECTED VALUES**  
**FOR FYS 2014 AND 2015**

Steve Ports, Principal Deputy Director-Policy and Operations, summarized staff's draft recommendation, and Sule Calikoglu, Ph.D., Associate Director-Performance Measurement, presented the results of the Commission's quality initiatives, MHAC and QBR (see "Draft Staff Recommendation on QBR and MHAC Scaling Magnitudes and Standard for Expected Values for the FY 2014 and FY 2015 Updates to Hospital Rates" on the HSCRC website). The draft recommendations included: 1) using the FY 2013 scaling magnitudes for FY 2014 for both MHAC and QBR; 2) allocating 0.5% of approved inpatient revenue for QBR relative performance for FY 2015; 3) increasing the magnitude of scaling for MHAC from 2% to 3% of approved inpatient revenue for FY 2015, and increasing this amount annually; 4) increasing the benchmark for expected MHAC values to 15% , this represents a more linear relationship between scaling and performance; and 5) moving the base periods for QBR and MHAC to the most current fiscal year to accommodate the 6-month lag in data and to provide performance benchmarks in advance of the performance period.

Mr. Ports urged the Payment Work Group to comment on the draft recommendations with the objective of presenting the final recommendation ready for action at the Commission's January Public Meeting.

Since this was a draft recommendation, no action was required.

**ITEM VII**  
**REPORT ON ADMISSION-READMISSION REVENUE STRUCTURE AND ONE DAY LENGTH OF STAY POLICY**

Dr. Redmon stated that staff is looking at ways to alter the structure of the Admission-Readmission Revenue policy (ARR) to demonstrate savings and improvement in outcomes in order to obtain an exemption from the Centers for Medicare and Medicaid Services' (CMS') readmission initiative in FY 2014. Dr. Redmon made a presentation which included: 1) background and a summary of the achievements of the ARR program; 2) options to modify the ARR program into a shared savings model and issues to be addressed; 4) extension of the policy to all hospitals not under an alternative ARR policy or the Total Patient Revenue (TPR) program; 5) potential unexpected consequences of moving One Day Stay (ODS) cases into the Charge-per-Case and ARR programs; and 7) future directions for the ARR program (see "Admissions-Readmissions Program Modifications" on the HSCRC website).

Since this is a staff report, no Commission action was required.

**ITEMVIII**  
**LEGAL REPORT**

**Regulations**

**Proposed**

Uniform Accounting and Reporting System for Hospitals and Related Institutions –COMAR 10.37.01.03 &.06

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

The Commission voted unanimously to forward the proposed regulations to the AELR Committee for review and publication in the Maryland Register.

**Proposed**

Rate Application and Approval Procedures –COMAR 10.37.10.06

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

The Commission voted unanimously to forward the proposed regulations to the AELR Committee for review and publication in the Maryland Register.

### **Proposed**

#### **Cross-Subsidization –COMAR 10.37.12.02 &.03**

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

The Commission voted unanimously to forward the proposed regulations to the AELR Committee for review and publication in the Maryland Register.

### **Final Adoption**

#### **Rate Application and Approval Procedures –COMAR 10.37.10.26**

The purpose of this action is to permit patients of other means-tested social programs to be deemed presumptively eligible for free care or to be eligible for care at a reduced cost consistent with existing Commission regulations.

The Commission voted unanimously to approve the final adoption of this proposed regulation.

## **ITEM IX** **HEARING AND MEETING SCHEDULE**

December 5, 2012	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
January 9, 2013	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:21 p.m.

**EXECUTIVE DIRECTOR'S REPORT  
JANUARY 9, 2013**

Monitoring Maryland Performance

For Year Ending October 2012

- Charge per Case increased 2.54%
  - For the month of October 2012 versus October 2011, CPC decreased 2.01%
  - For YTD ending October 2012 versus the same time period in 2011, CPC decreased 0.11%
- Cases (admissions + new born) decreased 3.37%
- Inpatient revenue decreased 0.91%
- Outpatient revenue increased 14.58%
- Total gross revenue increased 4.55%

Financial Condition

Data are available for profits for the 5 months through November 2011 compared to the 5 months through November 2012. For year-to-date ending November 2012, average operating profits for acute care hospitals was 1.23%. The median hospital had an operating profit of 1.51%, with a distribution as follows:

- 25<sup>th</sup> percentile at -1.16%
- 75<sup>th</sup> percentile at 5.77%

The data show that operating profits are down .96% from the same period last year. This is due mostly to a reduction on regulated profits of .93%, with half of this reduction is due to a change in the collection rate. The collection rate on gross regulated revenue has decreased by .46% from 83.04% to 82.58%.

Latest Waiver Status from CMS

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

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

The staff had expected an adjustment to the test for cases where Medicare is a secondary payer, but that adjustment was not made in this letter. The staff is meeting with representatives from the CMS Office of the Actuary next week to discuss this issue.

### Progress on Demonstration Request

Discussions for an alternative waiver test continue with CMS. We had established a target date for December 17, 2012 to submit the State's application to CMMI. However, a number of issues remain to be resolved as we complete the application, so discussions continue at this time.

### VBP Exemption Request Approval

Secretary Sharfstein received a letter in late December from Patrick Conway, CMS Chief Medical Officer, indicating our VBP exemption request was granted as CMS determined that Maryland meets or exceeds the cost savings requirement of exemption from the program for FY 2014. The letter further notes that both programs reward high performers in a revenue-neutral manner, and that Maryland has achieved cost savings under its quality programs that meet any documented savings under the VBP program.

The letter also highlights the fact that the state's patient experience of care performance needs to be improved with HCAHPS scores that lag behind the national median performance levels, and encourages further analyses, and hospital collaboration with the Delmarva Foundation, the state's QIO, to target improvement. Related to HCAHPS improvement, MHA has kicked off its HCAHPS Collaborative and has a large majority of hospitals already volunteer to participate.

Finally, the letter encourages Maryland to keep pace in our program with the national VBP program going forward.

### Disparities Data Report

The Maryland Health Improvement and Disparities Reduction Act of 2012 required that HSCRC consider use of race and ethnicity data in hospital payment incentive programs. Through its work over the last 6 months, including data analyses and broad stakeholder Work Group deliberations for which Dr. Loftus served as chair, in our report to the Governor and Legislature due on January 1, 2013, HSCRC staff have concluded that:

- The HSCRC is able to track racial and ethnic performance data in its quality programs; however, based on analysis of hospital administrative discharge data, quality data, and on information collected through surveying Maryland hospitals, there is wide variation in the race and ethnicity data categories and data collection methods used across hospitals.
- The race data currently collected by hospitals do reveal some statewide differences in hospital quality data for white versus black populations; however, the need for tighter standardization in the data collected and the collection methods used by hospitals is a barrier to making hospital-to-hospital comparisons using the data at the current time.
- Targeted activities must be undertaken to improve and standardize hospital race ethnicity data collection, e.g., requiring hospitals to submit all race and ethnicity data categories in accordance with OMB requirements, add the requirement of collecting language preference of the patient when seeking healthcare, and convening hospital staff training sessions on best practices for race and ethnicity data collection.

### Rate Orders

Final rate orders for all hospitals have been issued. Final corrections to several ARR hospitals' EMPI numbers necessitated a last minute recalculation of the case mix governor. Case mix growth (including outliers and categorically excluded cases) was originally calculated at 0.91%, which would be subject to a case mix governor of 0.50%. With the revised data, the final case mix calculation is 0.86%; hence, slightly less revenue will be subject to the governor. This correction changed final CMIs and cases for some hospitals which impacted the FY 2012 compliance settlements. These changes have been reflected in the final rate orders that are being issued and every hospital will receive a new file reflecting these updates.

Note that the Commission approved an adjustment to case mix for excluded one-day stay cases in March 2012. That correction has not been reflected in these numbers. Due to complications in calculating this impact, this adjustment will be address as part of the recommendation to address the readmission and short stay policy that is forthcoming.

### Disclosure Report

The annual disclosure report has been released and is available on the HSCRC website.

### Welcome New Staff Member

Today we're welcoming Donna Perkins to the HSCRC staff. Donna joins us most recently from the Anne Arundel County Health Department where she was an epidemiologist for the Office of Assessment, Planning and Response. At the County Health Department, Donna was responsible for analyzing, synthesizing and presenting County data across a variety of health topics. Donna composed the 2012 Annual Report Card of Health Indicators which was awarded the gold medal for in-house annual publications from the National Public Health Information Coalition. As a SPSS and SAS programmer, she's well versed in working with a wide range of datasets, including HSCRC, Vital Records, and Cancer Registry data. Donna has also served as a Communicable Disease Investigator and Data Lead Epidemiologist at the Pima County Department of Health in Tucson, Arizona.

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

AS OF DECEMBER 27, 2012

A: PENDING LEGAL ACTION : NONE  
 B: AWAITING FURTHER COMMISSION ACTION: NONE  
 C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2168R	Garrett County Memorial Hospital	7/16/2012	1/6/2013	1/6/2013	FULL	GS	OPEN
2190N	St. Mary's Hospital	8/8/2012	1/6/2013	1/6/2013	HYP	CK	OPEN
2193R	Adventist Behavioral Health	10/2/2012	1/21/2013	3/1/2013	FULL	GS	OPEN
2194A	Johns Hopkins Health System	11/7/2012	N/A	N/A	ARM	DNP	OPEN
2195A	Johns Hopkins Health System	11/14/2012	N/A	N/A	ARM	DNP	OPEN
2196N	Harbor Hospital	12/3/2012	1/6/2013	5/2/2013	ORC	CK	OPEN
2197A	Johns Hopkins Health System	12/14/2012	N/A	N/A	ARM	DNP	OPEN
2198A	Johns Hopkins Health System	12/14/2012	N/A	N/A	ARM	DNP	OPEN
2199A	Johns Hopkins Health System	12/14/2012	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

<b>IN RE: THE PARTIAL RATE</b>	<b>*</b>	<b>BEFORE THE HEALTH SERVICES</b>	
<b>APPLICATION OF</b>	<b>*</b>	<b>COST REVIEW COMMISSION</b>	
<b>ST. MARY'S</b>	<b>*</b>	<b>DOCKET:</b>	<b>2012</b>
<b>HOSPITAL</b>	<b>*</b>	<b>FOLIO:</b>	<b>2000</b>
<b>LEONARDTOWN, MARYLAND</b>	<b>*</b>	<b>PROCEEDING:</b>	<b>2190N</b>



**Staff Recommendation**

**Approved  
January 9, 2013**

## **Introduction**

On August 8, 2012, St. Mary's Hospital (the "Hospital"), a member of MedStar Health, submitted a partial rate application to the Commission requesting a rate for Hyperbaric (HYP) services. The Hospital requests that the HYP rate be set at the lower of a rate based on its projected costs to provide HYP services or the statewide median and be effective December 1, 2012.

## **Staff Evaluation**

To determine if the Hospital's HYP rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all projected cost and statistical data for HYP services for FY 2013. Based on information received, it was determined that the HYP rate based on the Hospital's projected data would be \$441.62 per hour of treatment, while the statewide median rate for HYP services is \$336.12 per hour of treatment.

## **Recommendation**

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

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

**IN RE: THE APPLICATION FOR  
ALTERNATIVE METHOD OF RATE  
DETERMINATION  
JOHNS HOPKINS HEALTH  
SYSTEM  
BALTIMORE, MARYLAND**

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2012  
\* FOLIO: 2004  
\* PROCEEDING: 2194A**

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**Staff Recommendation  
Approved  
December 5, 2012**

## **I. INTRODUCTION**

Johns Hopkins Health System (“System”) filed an application with the HSCRC on November 7, 2012 on behalf of its member hospitals (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to add solid organ transplants to the global rate arrangement for bone marrow transplants services with Cigna Health Corporation approved under proceeding 2182A at the Commission’s October 10, 2012 public meeting. The System requested approval of the revised arrangement for a period of one year beginning January 1, 2013.

## **II. OVERVIEW OF APPLICATION**

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC (“JHHC”), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

## **III. FEE DEVELOPMENT**

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

## **IV. IDENTIFICATION AND ASSESSMENT OF RISK**

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

## **V. STAFF EVALUATION**

Staff found that the experience under this arrangement for the last year for bone marrow transplants has been favorable. Staff also found that the rates for solid organ transplants cases were developed based on a format, i.e., historical hospital data for like cases, which has resulted in a favorable experience in other global rate arrangements.

## **VI. STAFF RECOMMENDATION**

The staff recommends that the Commission approve the Hospitals' request for participation in an alternative method of rate determination for bone marrow and solid organ transplant services, for a one year period commencing January 1, 2013 and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). The Hospitals will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

**IN RE: THE APPLICATION FOR  
ALTERNATIVE METHOD OF RATE  
DETERMINATION  
JOHNS HOPKINS HEALTH  
SYSTEM  
BALTIMORE, MARYLAND**

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2012  
\* FOLIO: 2005  
\* PROCEEDING: 2195A**

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**Staff Recommendation**

**Approved  
December 5, 2012**

## **I. INTRODUCTION**

Johns Hopkins Health System (the "System") filed an application with the HSCRC on November 14, 2012 on behalf of its member hospitals (the Hospitals') for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a renegotiated global rate arrangement for solid organ and bone marrow transplants with Coventry Transplant Network for one year beginning January 1, 2013.

## **II. OVERVIEW OF APPLICATION**

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

## **III. FEE DEVELOPMENT**

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

## **IV. IDENTIFICATION AND ASSESSMENT OF RISK**

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains that it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

## **V. STAFF EVALUATION**

Based on the favorable performance in the last year, staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

## **VI. STAFF RECOMMENDATION**

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing January 1, 2013. Staff also recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. The Hospitals will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

**IN RE: THE APPLICATION FOR  
ALTERNATIVE METHOD OF RATE  
DETERMINATION  
JOHNS HOPKINS HEALTH  
SYSTEM  
BALTIMORE, MARYLAND**

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2012  
\* FOLIO: 2007  
\* PROCEEDING: 2197A**

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**Staff Recommendation  
Approved  
January 9, 2013**

## **I. INTRODUCTION**

On December 4, 2012, Johns Hopkins Health System (“System”) filed a renewal application on behalf of its member hospitals (the “Hospitals”) requesting approval from the HSCRC to continue participation in global rates for cardiovascular procedures with Global Excel Management, Inc. The Hospitals request that the Commission approve the arrangement for an additional year beginning January 1, 2013.

## **II. OVERVIEW OF APPLICATION**

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC (“JHHC”), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

## **III. FEE DEVELOPMENT**

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

## **IV. IDENTIFICATION AND ASSESSMENT OF RISK**

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

## **V. STAFF EVALUATION**

Staff found that the actual experience under the arrangement for the last year has been favorable, and staff is satisfied that the Hospitals can continue to achieve favorable performance under this arrangement.

## **VI. STAFF RECOMMENDATION**

The staff recommends that the Commission: 1) waive the requirement that alternative applications be filed 30 days before the proposed effective date; 2) approve the Hospitals' application for an alternative method of rate determination for cardiovascular services for a one year period commencing January 1, 2013. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

**IN RE: THE APPLICATION FOR  
ALTERNATIVE METHOD OF RATE  
DETERMINATION  
JOHNS HOPKINS HEALTH  
SYSTEM  
BALTIMORE, MARYLAND**

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2012  
\* FOLIO: 2008  
\* PROCEEDING: 2198A**

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**Staff Recommendation  
Approved  
January 9, 2013**

## **I. INTRODUCTION**

On December 4, 2012, Johns Hopkins Health System (“System”) filed an alternative rate application on behalf of its member hospitals (the “Hospitals”) requesting approval from the HSCRC to add heart transplants to its already approved global rate arrangement with the Canadian Medical Network. The current arrangement includes global rates for cardiovascular procedures, kidney transplant services, and bone marrow transplants. The Hospitals request that the Commission approve the revised arrangement for one year beginning January 1, 2013.

## **II. OVERVIEW OF APPLICATION**

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC (“JHHC”), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

## **III. FEE DEVELOPMENT**

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

## **IV. IDENTIFICATION AND ASSESSMENT OF RISK**

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

## **V. STAFF EVALUATION**

Staff finds that the actual experience for cardiovascular services, kidney transplants, and bone marrow transplants under the arrangement for the last year has been favorable.

## **VI. STAFF RECOMMENDATION**

The staff recommends that the Commission: 1) waive the requirement that alternative applications be filed 30 days before the proposed effective date; 2) approve the Hospitals' application for an alternative method of rate determination for Heart transplant, cardiovascular procedures, kidney transplant services, and bone marrow transplant services for a one year period commencing January 1, 2013. The Hospitals must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document will formalize the understanding between the Commission and the Hospitals, and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

**IN RE: THE APPLICATION FOR  
ALTERNATIVE METHOD OF RATE  
DETERMINATION  
JOHNS HOPKINS HEALTH  
SYSTEM  
BALTIMORE, MARYLAND**

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2012  
\* FOLIO: 2009  
\* PROCEEDING: 2199A**

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**Staff Recommendation  
Approved  
January 9, 2013**

## **I. INTRODUCTION**

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

## **II. OVERVIEW OF APPLICATION**

The contract will be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

## **III. FEE DEVELOPMENT**

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

## **IV. IDENTIFICATION AND ASSESSMENT OF RISK**

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

## **V. STAFF EVALUATION**

The staff found that the actual experience under the prior arrangement for the last year's

solid organ transplants has been favorable. In addition, after review of the data, staff is confident that the global prices for bone marrow transplant services are sufficient to enable the Hospitals to achieve a favorable result.

## **VI. STAFF RECOMMENDATION**

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period beginning February 1, 2013. The Hospitals must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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

January 9, 2013

This final staff recommendation was approved by the Commission on January 9, 2013.

## Introduction

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

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

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

Since the inception of the program, clinical work groups have been meeting on on-going bases to discuss the measures, and the MHAC and QBR methodologies. The Payment Work Group meets each year to discuss the size and distribution of the scaling of the update factor. The Payment Work Group met on October 31, November 14, and December 17, 2012 to review issues and modeling for changes to the MHAC and QBR scaling magnitudes and the standard for expected values for FY 2015.

## Background

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

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

The MHAC program currently uses 51 of the 65 Potentially Preventable Complications developed by 3M Health Information Systems, which computes actual versus expected rates of complications adjusted for each patient by the All Patient Refined Diagnosis Related Group (“APR DRG”), and severity of illness (“SOI”) category.

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

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

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

Table 1: MHAC Base and Performance Periods

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

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

### Medicare Value Based Purchasing

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

For the federal FY 2013 (which began on October 1, 2012) Hospital VBP program, CMS will measure hospital performance using two domains: the clinical process of care domain and the

<sup>1</sup> 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.

patient experience of care domain, which is comprised of the HCAHPS survey measure. Results were weighted 70% process measures and 30% on 8 of the HCAPS measures. For federal FY 14, CMS has added several mortality outcome measures (for AML, HF and Pneumonia) as well as additional outpatient process measures. CMS will be apportioning results as follows: 30% process measures, 30% patient experience measures, and 40% outcome measures. CMS has indicated its future emphasis will increasingly lean toward outcomes in the VBP program. The clinical QBR work group will meet this month to discuss the appropriate weighting of the process, patient experience and outcome measures in the QBR for Maryland's methodology for performance year CY 2013.

### **Value Based Purchasing Exemption Provisions**

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

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

A VBP exemption request which included a report of Maryland's health outcomes and cost savings for the MHAC and QBR programs and a support letter from Secretary Sharfstein, was submitted to HHS Secretary Sebelius on September 30, 2011. The CMS letter granting the FY 13 exemption anticipated that the HSCRC would add the mortality outcome measures and encouraged Maryland hospitals to improve patient experience of care. On November 15, 2012, HSCRC staff submitted a letter to Secretary Sebelius requesting a VBP exemption for FY 14. **The CMS letter, which is attached to this recommendation, granting the exemption from FY 14 VBP program was received on December 21<sup>st</sup>, 2012 and noted that state's patient experience of care performance continues to lag behind the national medial performance levels and anticipated that Maryland will address the patient outcome measures adopted in the VBP in a FY 15 exemption request.**

### ***3. Hospital Acquired Conditions***

#### **Medicare Hospital Acquired Conditions (HAC) Program**

Beginning in FY 2015, hospitals across the country scoring in the top quartile for the rate of Hospital Acquired Conditions as compared to the national average will have their Medicare payments reduced by 1 percent for all DRGs. In calculating the rates, the Secretary of HHS will establish and apply an appropriate risk-adjustment methodology. The conditions included in this

provision would be those already selected for the current Medicare Hospital Acquired Conditions payment policy and any other conditions acquired during a hospital stay that the Secretary deems appropriate. The ACA also requires Maryland to obtain an exemption from the federal HAC program which will be based on whether Maryland’s program meets or exceeds the federal program in terms of outcomes and savings.

### Maryland Hospital Acquired Conditions

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

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

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

Table 2: MHAC Scaling Modeling Results for FY15

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

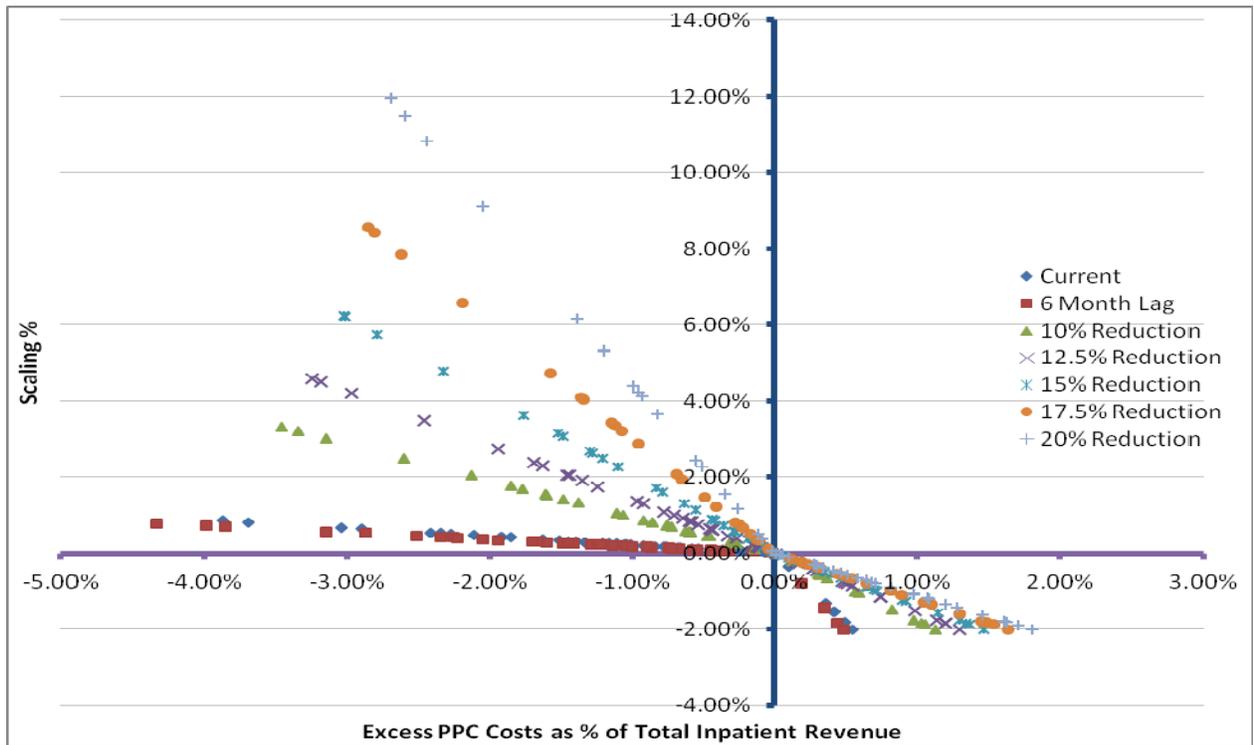
Table 3 shows the distribution of hospitals using a 2% scaling magnitude. Figure 1 provides an illustration of the relationship of performance to scaling under a 2% scenario using seven different expected standard scenarios – statewide average with current base year, state-wide average with 6

month lag, 10%, 12.5%, 15%, 17.5% and 20% reductions in state-wide average combined with 6 month lag. The 15% scenario shows the most linear relationship between scaling and performance.

Table 3: MHAC Scaling Modeling Results by Hospital for FY2015

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

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



### MHAC Improvement Scoring

Last year the Maryland Hospital Association requested that the Commission consider including an element of improvement in the MHAC program. In addition, there have been on-going discussions regarding focusing at least a portion of the MHAC program on a few targeted measures. While QBR has had an improvement factor built into its methodology, the MHAC methodology does not. Therefore, as some hospitals commented, those hospitals who have historically low performance scores find it difficult to be able to compete for MHAC scaling – even if they achieve significant improvement for several years. The rationale is to recognize improvement on a target number of PPCs through the MHAC program. Staff is proposing to accomplish this by adding a 1% scaling mechanism to the existing 2% MHAC performance scale, based on improvement in target PPC rates. The Payment Work Group discussed options during their meetings on November 14 and December 17, 2012 while MHAC/QBR clinical work group have been working on to determine the list of PPCs to be targeted and measurement of improvement.

Both work groups reviewed the existing PPCs in terms of prevalence (total PPC count), the number of hospitals that have reported these PPCs, cost per PPC case, and the total cost of each PPC. The Work Groups also discussed areas of policy focus where particular emphasis should be placed on improvement. Appendix II shows all 65 PPCs with the cost, count, and change between FY 2011 and 2012. Based on the criteria discussed above, staff initially considered a subset of 13 PPCs to apply for the improvement program with the input from the QBR/MHAC clinical work

group. After further discussion, staff limited the number of PPCs to 5. Table 4 provides the cost and count of these 5 PPCs.

Table 4: List of PPCs included in the Improvement Scale

<b>Included PPCs</b>		<b>Total Number of Complications</b>	<b>Total Cost</b>	<b>Total Cost PPC Rank (Highest=1)</b>
PPC24	Renal Failure without Dialysis	4,534	\$37,648,834	3
PPC5	Pneumonia & Other Lung Infections	1,607	\$31,799,316	4
PPC35	Septicemia & Severe Infections	1,314	\$28,600,524	6
PPC6	Aspiration Pneumonia	1,016	\$15,911,576	10
PPC16	Venous Thrombosis	916	\$15,847,716	11

The Payment Work Group also considered methods of implementing scaling of approved inpatient revenue based on improvement. While staff is proposing to implement an improvement factor for FY 15 rates using CY 13 improvement compared to the FY 12 base period, staff modeled the potential impact if improvement were included for the FY 13 update factor (FY12 improvement in PPC rates compared to FY11). Using the 5 selected PPCs, staff modeled several methods of scaling an additional 1% (over and above the existing 2% scaled for performance/attainment).

Appendices III includes three of the scaling models discussed by the Payment Work Group :

1. Scaling in a manner where all hospitals showing improvement would received additional revenue through the 1% improvement scale ; and
2. Scaling in a manner where hospitals that improved more than the statewide median improvement rate in the performance year will receive additional revenue through the 1% improvement scale.
3. Scaling in a manner where hospitals that improved more than the statewide median improvement in the base year will receive additional revenue through the 1% improvement scale.

The amount of revenue redistributed through these mechanisms is dependent on the amount of revenue represented by hospitals on either side of the scale. Based on FY 12 improvement, the first scaling mechanism (shown in Table 5) would redistribute \$2.8 million. As the benchmark to receive rewards (current median improvement rate) was lower in FY 12 compared to the benchmark using median improvement rate in the base year of FY 11, Model 2 would distribute \$6.9 million compared to \$5.2 million with Model 3.

Table 5: Comparison of Improvement Scaling Models

Scaling Options	Benchmark	Number of Hospitals with Rewards	Total Scaling Amount for Improvement	Total Scaling Amount for Attainment	Max. Improvement Reward	Maximum Total Reward	Maximum Total Reduction
1. Improvement Scale Similar to MHACs	0%	30	\$2,761,867	\$42,750,992	0.16%	6.35%	-2.04%
2. Improvement Scale - Current Median	-13.32%	23	\$6,948,670	\$42,750,992	0.67%	6.63%	-2.17%
3. Improvement Scale Base Period Median	-8.62%	26	\$5,288,566	\$42,750,992	0.42%	6.50%	-2.13%

Appendix IV shows what the impact of the combined MHAC performance scaling and the proposed 1% improvement scaling, if they were in place for FY13 rates using improvement scaling model 3.

## Findings

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

As noted above, the quality scaling for each program is designed to be revenue neutral for the system as a whole. This means that the amounts allocated to better performing hospitals (rewards) must precisely match the penalties applied to poorer performing hospitals. Maryland has demonstrated improvement during the first few years of the MHAC program. Even though the Maryland program is revenue neutral, the improvement in processes (best practices) and the decline in complications will yield savings to all payers over time as weighting for DRG payments decline accordingly. In order to meet the standards set under the ACA for a Maryland exemption, the incentives in the MHAC and QBR programs will need to progress over time. Due to the current case mix transition, FY 2014 is a lost opportunity, but Maryland should move aggressively in FY 2015, to ensure continued improvement.

Staff also believes that factoring in improvement to the MHAC scaling will establish a deeper focus on targeted PPCs, and recognize efforts of hospitals that achieve greater improvement than the statewide average.

## Staff Recommendations

For QBR and MHAC scaling, staff recommends:

- 1) Using the FY 13 scaling magnitudes for FY 14 for both MHACs and QBR since the performance year (CY 2012) has passed.
- 2) Allocating 0.5% of hospital approved inpatient revenue for QBR relative performance in FY 2015;
- 3) Increasing the magnitude of scaling for MHACs from 2.0% to a total of 3.0% of hospital approved inpatient revenue for MHAC relative performance and improvement for FY2015 rate year, and considering increasing this amount each year.
  - a) One percent of the total 3% scaling factor should reflect improvement on a targeted set of measures for FY2015. Staff recommends targeting the following measures for FY15 scaling:
    - PPC5 – Pneumonia and Other Lung Infections
    - PPC6 – Aspiration Pneumonia
    - PPC16 – Venous Thrombosis
    - PPC24 – Renal Failure without Dialysis
    - PPC35 – Septicemia and Severe Infections
  - b) Staff recommends that improvement should be scaled in a manner where hospitals that achieve improvement better than the median improvement rate in the base year shall receive additional revenue under the 1% improvement scale (as modeled in Appendix III, Model 3.);
- 4) Increasing the benchmark to establish the expected MHAC values to 85% of the state average for attainment scale which represents a more linear relationship between scaling and performance; and
- 5) Moving the base year periods for QBR and MHAC to most current fiscal year to accommodate a 6-month lag in the data production to provide performance benchmarks in advance of the performance period.

## Appendix 1

<b>QBR Measures Used for FY 2014 Payment Adjustments</b>
<b>Clinical Process of Care Measures</b>
AMI-1 Aspirin at Arrival
AMI-2 Aspirin prescribed at discharge
AMI-3 ACEI or ARB for LVSD
AMI-5 Beta blocker prescribed at discharge
AMI-8a - Primary PCI Received Within 90 Minutes of Hospital Arrival
CAC-1a - Relievers for Inpatient Asthma (age 2 through 17 years) – Overall Rate
CAC-2a - Systemic Corticosteroids for Inpatient Asthma (age 2 through 17 years) – Overall Rate
CAC-3-Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver
HF-1 Discharge instructions
HF-2 Left ventricular systolic function (LVSF) assessment
HF-3 ACEI or ARB for LVSD
PN-3b Blood culture before first antibiotic – Pneumonia
PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient
SCIP CARD 2 Surgery Patients on Beta-Blocker Therapy Prior to Admission Who Received a Beta-Blocker During the Perioperative Period
SCIP INF 1- Antibiotic given within 1 hour prior to surgical incision
SCIP INF 2- Antibiotic selection
SCIP INF 3- Antibiotic discontinuance within appropriate time period postoperatively
SCIP INF 4- Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Serum Glucose
SCIP INF 6- Surgery Patients with Appropriate Hair Removal
SCIP VTE 1- Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
SCIP VTE 2 - Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Given 24 hours prior and after surgery
<b>Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)</b>
Cleanliness and Quietness of Hospital Environment
Communication About Medicines (Q16-Q17)
Communication With Doctors (Q5-Q7)
Communication With Nurses (Q1-Q3)
Discharge Information (Q19-Q20)
Overall Rating of this Hospital
Pain Management (Q13-Q14)
Responsiveness of Hospital Staff (Q4,Q11)

## MHAC Measures used for FY 2014 Payment Adjustments

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

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

**Appendix II: RY2014 Base Period PPC Counts and Total Cost  
(Priority 13 PPCst is highlighted)**

PPC Number and Name	Cost per Case	Number of Hospitals with PPC	Total PPC Count	Change from FY2011	Total Cost	Total Case Rank	Cost per Case Rank	Total Cost Rank
4 Acute Pulmonary Edema and Respiratory Failure with Ventilation	\$32,143	44	1380	-4.4%	\$44,357,340.00	8	5	1
65 Urinary Tract Infection without Catheter	\$14,549	46	2721	-19.1%	\$39,587,829.00	3	26	2
24 Renal Failure without Dialysis	\$8,304	46	4534	-10.2%	\$37,648,833.80	1	40	3
5 Pneumonia & Other Lung Infections	\$19,788	46	1607	-14.7%	\$31,799,316.00	5	11	4
14 Ventricular Fibrillation/Cardiac Arrest	\$19,093	45	1552	-1.5%	\$29,632,336.00	6	12	5
35 Septicemia & Severe Infections	\$21,766	45	1314	-21.0%	\$28,600,524.00	9	9	6
3 Acute Pulmonary Edema and Respiratory Failure without Ventilation	\$9,256	45	2892	-16.3%	\$26,766,958.00	2	35	7
9 Shock	\$18,126	44	1397	-4.6%	\$25,322,022.00	7	16	8
40 Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc	\$8,851	44	1851	-7.1%	\$16,382,795.08	4	37	9
6 Aspiration Pneumonia	\$15,661	45	1016	-8.3%	\$15,911,576.00	11	21	10
16 Venous Thrombosis	\$17,301	44	916	-12.0%	\$15,847,716.00	13	17	11
1 Stroke & Intracranial Hemorrhage	\$14,597	44	748	-10.5%	\$10,918,556.00	18	25	12
52 Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	\$12,229	45	784	-1.8%	\$9,587,536.00	17	29	13
48 Other Complications of Medical Care	\$18,624	40	490	-19.2%	\$9,125,760.00	24	14	14
11 Acute Myocardial Infarction	\$8,256	46	1105	-14.0%	\$9,123,239.80	10	41	15
17 Major Gastrointestinal Complications without Transfusion or Significant Bleeding	\$16,044	44	551	-14.5%	\$8,840,244.00	22	19	16
8 Other Pulmonary Complications	\$10,536	45	830	-4.6%	\$8,744,880.00	16	33	17
37 Post-Operative Infection & Deep Wound Disruption Without Procedure	\$18,629	39	445	-3.8%	\$8,289,905.00	25	13	18
7 Pulmonary Embolism	\$15,855	43	520	-9.2%	\$8,244,600.00	23	20	19
31 Decubitus Ulcer	\$45,528	32	148	-27.9%	\$6,738,144.00	45	2	20
50 Mechanical Complication of Device, Implant & Graft	\$17,087	42	381	5.3%	\$6,510,147.00	27	18	21
19 Major Liver Complications	\$22,225	39	287	-1.7%	\$6,378,575.00	29	7	22

**Appendix II: RY2014 Base Period PPC Counts and Total Cost  
(Priority 13 PPCst is highlighted)**

PPC Number and Name	Cost per Case	Number of Hospitals with PPC	Total PPC Count	Change from FY2011	Total Cost	Total Case Rank	Cost per Case Rank	Total Cost Rank	
42	Accidental Puncture/Laceration During Invasive Procedure	\$6,409	42	956	-14.2%	\$6,126,564.04	12	44	23
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	\$6,752	44	860	-5.5%	\$5,806,754.19	15	42	24
10	Congestive Heart Failure	\$6,514	43	890	-30.2%	\$5,797,038.44	14	43	25
54	Infections due to Central Venous Catheters	\$34,975	36	158	-13.4%	\$5,526,050.00	44	3	26
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding	\$19,807	37	236	3.0%	\$4,674,452.00	34	10	27
25	Renal Failure with Dialysis	\$48,226	29	95	28.0%	\$4,581,470.00	47	1	28
51	Gastrointestinal Ostomy Complications	\$24,773	38	184	-8.7%	\$4,558,232.00	41	6	29
47	Encephalopathy	\$11,628	37	373	-19.3%	\$4,337,244.00	28	31	30
34	Moderate Infectious	\$22,056	37	190	-13.6%	\$4,190,640.00	40	8	31
20	Other Gastrointestinal Complications without Transfusion or Significant Bleeding	\$15,636	39	236	1.1%	\$3,690,096.00	34	22	32
2	Extreme CNS Complications	\$14,967	40	245	-7.0%	\$3,666,915.00	33	24	33
33	Cellulitis	\$8,350	42	420	-14.5%	\$3,507,105.07	26	39	34
39	Reopening Surgical Site	\$18,176	39	191	5.9%	\$3,471,616.00	39	15	35
23	GU Complications Except UTI	\$9,184	38	280	5.6%	\$2,571,395.97	30	36	36
53	Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infusions	\$13,283	38	193	-10.5%	\$2,563,619.00	38	27	37
12	Cardiac Arrhythmias & Conduction Disturbances	\$3,617	9	708	5.1%	\$2,560,699.43	19	48	38
49	Iatrogenic Pneumothrax	\$9,652	40	257	-13.9%	\$2,480,582.38	32	34	39
44	Other Surgical Complication - Mod	\$11,563	36	209	6.2%	\$2,416,667.00	36	32	40
15	Peripheral Vascular Complications Except Venous Thrombosis	\$12,667	35	168	3.5%	\$2,128,056.00	43	28	41
56	Obstetrical Hemorrhage with Transfusion	\$3,764	33	561	14.6%	\$2,111,606.40	21	47	42
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc	\$12,173	32	170	-6.0%	\$2,069,410.00	42	30	43
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	\$33,089	23	55	89.5%	\$1,819,895.00	49	4	44

**Appendix II: RY2014 Base Period PPC Counts and Total Cost  
(Priority 13 PPCst is highlighted)**

PPC Number and Name		Cost per Case	Number of Hospitals with PPC	Total PPC Count	Change from FY2011	Total Cost	Total Case Rank	Cost per Case Rank	Total Cost Rank
66	Catheter-Related Urinary Tract Infection	\$15,547	26	68	56.0%	\$1,057,196.00	48	23	45
36	Acute Mental Health Changes	\$3,572	38	269	8.2%	\$960,975.10	31	49	46
13	Other Cardiac Complications	\$4,525	40	204	19.5%	\$923,102.57	37	46	47
59	Medical & Anesthesia Obstetric Complications	\$1,209	33	650	-22.2%	\$785,956.29	20	50	48
28	In-Hospital Trauma and Fractures	\$5,535	37	123	21.3%	\$680,828.56	46	45	49
26	Diabetic Ketoacidosis & Coma	\$8,811	21	39	37.6%	\$343,637.39	50	38	50
21	Clostridium Difficile Colitis	\$17,164	44	1224	7.3%	\$21,008,736.00	Excluded		
29	Poisonings Except from Anesthesia	-\$1,413	31	99	-16.2%	-\$139,916.97	Excluded		
30	Poisonings due to Anesthesia	\$16,161	1	1	1135.3%	\$16,161.00	Excluded		
32	Transfusion Incompatibility Reaction	\$21,462	1	1	7718.8%	\$21,462.00	Excluded		
43	Accidental Cut or Hemorrhage During Other Medical Care	\$3,230	18	38	91.3%	\$122,732.75	Excluded		
45	Post-procedure Foreign Bodies	-\$1,416	16	25	54.4%	-\$35,403.63	Excluded		
46	Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body	-\$4,104	2	2	1359.7%	-\$8,208.75	Excluded		
55	Obstetrical Hemorrhage without Transfusion	\$370	34	4313	-20.6%	\$1,594,333.14	Excluded		
57	Obstetric Lacerations & Other Trauma Without Instrumentation	\$340	34	1149	-2.6%	\$390,086.42	Excluded		
58	Obstetric Lacerations & Other Trauma With Instrumentation	\$678	32	408	-2.0%	\$276,480.47	Excluded		
60	Major Puerperal Infection and Other Major Obstetric Complications	-\$591	28	125	17.5%	-\$73,840.37	Excluded		
61	Other Complications of Obstetrical Surgical & Perineal Wounds	\$1,466	29	183	6.1%	\$268,314.23	Excluded		
62	Delivery with Placental Complications	\$1,099	33	277	21.9%	\$304,317.12	Excluded		
63	Post-Operative Respiratory Failure with Tracheostomy	\$124,786	25	85	35.2%	\$10,606,810.00	Excluded		
64	Other In-Hospital Adverse Events	\$4,285	31	426	13.7%	\$1,825,336.50	Excluded		

### Appendix III: MHAC Improvement Scaling Models For Rate Year FY2013

HOSPID	HOSPITAL NAME	GROSS INPATIENT CPC/CPE REVENUE	IMPROVEMENT RATE	MODEL 1 SCALING PERCENT	MODEL 2 SCALING PERCENT	MODEL 3 SCALING PERCENT
210017	Garrett County Memorial Hospital	\$18,335,488	83.86%	-1.00%	-1.00%	-1.00%
210028	St. Mary's Hospital	\$54,639,193	28.77%	-0.34%	-0.43%	-0.40%
210044	Greater Baltimore Medical Center	\$208,875,651	23.42%	-0.28%	-0.38%	-0.35%
210022	Suburban Hospital	\$146,894,874	18.51%	-0.22%	-0.33%	-0.29%
210039	Calvert Memorial Hospital	\$57,014,942	14.90%	-0.18%	-0.29%	-0.25%
210011	St. Agnes Hospital	\$223,703,417	14.31%	-0.17%	-0.28%	-0.25%
210019	Peninsula Regional Medical Center	\$235,561,632	9.16%	-0.11%	-0.23%	-0.19%
210054	Southern Maryland Hospital Center	\$146,082,502	8.75%	-0.10%	-0.23%	-0.19%
210049	Upper Chesapeake Medical Center	\$117,444,944	8.69%	-0.10%	-0.23%	-0.19%
210048	Howard County General Hospital	\$148,552,102	7.88%	-0.09%	-0.22%	-0.18%
210008	Mercy Medical Center	\$188,060,788	4.45%	-0.05%	-0.18%	-0.14%
210013	Bon Secours Hospital	\$72,763,474	3.61%	-0.04%	-0.17%	-0.13%
210051	Doctors Community Hospital	\$121,919,094	3.61%	-0.04%	-0.17%	-0.13%
210007	St. Joseph Medical Center	\$200,080,034	3.49%	-0.04%	-0.17%	-0.13%
210023	Anne Arundel Medical Center	\$241,861,191	1.86%	-0.02%	-0.16%	-0.11%
210058	James Lawrence Kernan Hospital	\$45,951,360	1.68%	-0.02%	-0.15%	-0.11%
210004	Holy Cross Hospital	\$284,622,588	0.00%	0.00%	-0.14%	-0.09%
210038	Maryland General Hospital	\$119,697,303	-2.87%	0.01%	-0.11%	-0.06%
210006	Harford Memorial Hospital	\$46,419,174	-4.09%	0.01%	-0.10%	-0.05%
210009	Johns Hopkins Hospital	\$844,917,135	-4.82%	0.01%	-0.09%	-0.04%
210043	Baltimore Washington Medical Center	\$188,870,979	-8.65%	0.02%	-0.05%	0.00%
210029	Johns Hopkins Bayview Medical Center	\$254,179,825	-10.44%	0.03%	-0.03%	0.01%
210012	Sinai Hospital	\$365,095,082	-12.14%	0.03%	-0.01%	0.03%
210056	Good Samaritan Hospital	\$185,067,078	-14.50%	0.04%	0.02%	0.04%
210027	Western Maryland Regional Medical Center	\$162,173,440	-14.70%	0.04%	0.02%	0.05%
210030	Chester River Hospital Center	\$34,409,502	-15.01%	0.04%	0.02%	0.05%
210034	Harbor Hospital Center	\$120,286,962	-15.27%	0.04%	0.03%	0.05%
210040	Northwest Hospital Center	\$125,688,476	-19.47%	0.05%	0.08%	0.08%
210001	Meritus Hospital	\$170,280,942	-19.52%	0.05%	0.08%	0.08%
210037	Memorial Hospital at Easton	\$117,317,772	-20.73%	0.05%	0.10%	0.09%
210024	Union Memorial Hospital	\$223,141,625	-21.14%	0.05%	0.10%	0.09%
210002	University of Maryland Hospital	\$787,107,460	-21.19%	0.05%	0.10%	0.09%
210033	Carroll Hospital Center	\$133,858,715	-23.36%	0.06%	0.13%	0.11%
210005	Frederick Memorial Hospital	\$179,085,665	-31.00%	0.08%	0.23%	0.17%
210032	Union of Cecil	\$64,046,952	-31.79%	0.08%	0.24%	0.17%
210015	Franklin Square Hospital Center	\$244,662,796	-33.53%	0.08%	0.27%	0.19%
210035	Civista Medical Center	\$65,004,737	-36.53%	0.09%	0.31%	0.21%
210057	Shady Grove Adventist Hospital	\$205,252,257	-41.33%	0.10%	0.37%	0.25%
210055	Laurel Regional Hospital	\$55,032,232	-41.49%	0.10%	0.37%	0.25%
210061	Atlantic General Hospital	\$35,569,941	-42.51%	0.11%	0.39%	0.26%
210018	Montgomery General Hospital	\$86,987,493	-47.30%	0.12%	0.45%	0.29%
210060	Fort Washington Medical Center	\$20,591,728	-48.24%	0.12%	0.46%	0.30%
210016	Washington Adventist Hospital	\$172,399,246	-49.05%	0.12%	0.47%	0.30%
210045	McCready Memorial Hospital	\$5,196,783	-54.17%	0.13%	0.54%	0.34%
210010	Dorchester General Hospital	\$37,355,818	-56.48%	0.14%	0.57%	0.36%
210003	Prince Georges Hospital Center	\$175,673,564	-63.94%	0.16%	0.67%	0.42%
	Statewide Total	\$7,737,733,951		\$0	\$0	\$0

## Appendix IV: Combined MHAC Attainment and Improvement Scaling Using Model 3 for Rate Year FY2013

HOSPID	HOSPITAL NAME	MHAC Attainment Score	Revenue Adjusted Attainment Scaling %	Revenue Adjusted Attainment Scaling \$	MHAC Improvement Score	Revenue Adjusted Improvement Scaling %	Revenue Adjusted Improvement Scaling \$	Net % Scaling	Net \$ Scaling
210007	St. Joseph Medical Center	1.47%	-2.000%	-\$4,001,601	3.49%	-0.131%	-\$261,878	-2.13%	-\$4,263,479
210054	Southern Maryland Hospital Center	1.37%	-1.865%	-\$2,724,214	8.75%	-0.188%	-\$274,324	-2.05%	-\$2,998,539
210023	Anne Arundel Medical Center	1.34%	-1.831%	-\$4,427,793	1.86%	-0.113%	-\$274,064	-1.94%	-\$4,701,857
210034	Harbor Hospital Center	1.29%	-1.767%	-\$2,124,933	-15.27%	0.050%	\$60,314	-1.72%	-\$2,064,619
210030	Chester River Hospital Center	1.14%	-1.558%	-\$535,990	-15.01%	0.048%	\$16,574	-1.51%	-\$519,416
210016	Washington Adventist Hospital	0.92%	-1.255%	-\$2,163,640	-49.05%	0.305%	\$525,245	-0.95%	-\$1,638,395
210044	Greater Baltimore Medical Center	0.89%	-1.221%	-\$2,550,992	23.42%	-0.346%	-\$723,454	-1.57%	-\$3,274,446
210002	University of Maryland Hospital	0.72%	-0.980%	-\$7,714,190	-21.19%	0.095%	\$745,804	-0.89%	-\$6,968,387
210022	Suburban Hospital	0.70%	-0.951%	-\$1,396,955	18.51%	-0.293%	-\$430,851	-1.24%	-\$1,827,806
210009	Johns Hopkins Hospital	0.65%	-0.885%	-\$7,481,410	-4.82%	-0.041%	-\$346,548	-0.93%	-\$7,827,957
210012	Sinai Hospital	0.64%	-0.876%	-\$3,197,386	-12.14%	0.027%	\$97,075	-0.85%	-\$3,100,311
210051	Doctors Community Hospital	0.47%	-0.638%	-\$778,118	3.61%	-0.132%	-\$161,145	-0.77%	-\$939,263
210032	Union of Cecil	0.40%	-0.551%	-\$353,067	-31.79%	0.175%	\$111,808	-0.38%	-\$241,259
210027	Western Maryland Regional Medical C	0.35%	-0.475%	-\$770,241	-14.70%	0.046%	\$74,302	-0.43%	-\$695,938
210015	Franklin Square Hospital Center	0.32%	-0.434%	-\$1,062,488	-33.53%	0.188%	\$459,279	-0.25%	-\$603,209
210057	Shady Grove Adventist Hospital	0.30%	-0.405%	-\$831,377	-41.33%	0.246%	\$505,906	-0.16%	-\$325,471
210013	Bon Secours Hospital	0.16%	-0.224%	-\$163,209	3.61%	-0.132%	-\$96,221	-0.36%	-\$259,430
210019	Peninsula Regional Medical Center	0.10%	-0.137%	-\$321,907	9.16%	-0.192%	-\$452,646	-0.33%	-\$774,553
210043	Baltimore Washington Medical Center	0.06%	-0.076%	-\$142,846	-8.65%	0.000%	\$541	-0.08%	-\$142,305
210017	Garrett County Memorial Hospital	0.03%	-0.047%	-\$8,636	83.86%	-1.000%	-\$183,355	-1.05%	-\$191,991
210048	Howard County General Hospital	-0.02%	0.036%	\$53,648	7.88%	-0.178%	-\$264,906	-0.14%	-\$211,259
210056	Good Samaritan Hospital	-0.08%	0.170%	\$313,931	-14.50%	0.044%	\$82,017	0.21%	\$395,948
210037	Memorial Hospital at Easton	-0.18%	0.382%	\$447,646	-20.73%	0.091%	\$107,069	0.47%	\$554,715
210029	Johns Hopkins Bayview Medical Cente	-0.27%	0.563%	\$1,431,457	-10.44%	0.014%	\$35,008	0.58%	\$1,466,465
210049	Upper Chesapeake Medical Center	-0.27%	0.566%	\$664,804	8.69%	-0.187%	-\$219,721	0.38%	\$445,083
210001	Meritus Hospital	-0.28%	0.576%	\$980,050	-19.52%	0.082%	\$139,843	0.66%	\$1,119,893
210011	St. Agnes Hospital	-0.29%	0.596%	\$1,332,302	14.31%	-0.248%	-\$554,584	0.35%	\$777,718
210040	Northwest Hospital Center	-0.36%	0.733%	\$921,821	-19.47%	0.082%	\$102,833	0.82%	\$1,024,654
210005	Frederick Memorial Hospital	-0.42%	0.863%	\$1,545,164	-31.00%	0.169%	\$302,014	1.03%	\$1,847,178
210024	Union Memorial Hospital	-0.44%	0.899%	\$2,005,406	-21.14%	0.094%	\$210,524	0.99%	\$2,215,931
210018	Montgomery General Hospital	-0.44%	0.900%	\$783,026	-47.30%	0.291%	\$253,540	1.19%	\$1,036,566
210006	Harford Memorial Hospital	-0.56%	1.152%	\$534,617	-4.09%	-0.049%	-\$22,739	1.10%	\$511,879
210008	Mercy Medical Center	-0.63%	1.307%	\$2,458,547	4.45%	-0.141%	-\$265,771	1.17%	\$2,192,776
210003	Prince Georges Hospital Center	-0.79%	1.622%	\$2,849,823	-63.94%	0.417%	\$732,264	2.04%	\$3,582,087
210004	Holy Cross Hospital	-0.83%	1.709%	\$4,863,326	0.00%	-0.093%	-\$265,057	1.62%	\$4,598,268
210039	Calvert Memorial Hospital	-1.10%	2.268%	\$1,293,064	14.90%	-0.254%	-\$144,959	2.01%	\$1,148,105
210028	St. Mary's Hospital	-1.21%	2.493%	\$1,362,087	28.77%	-0.404%	-\$220,868	2.09%	\$1,141,219
210038	Maryland General Hospital	-1.28%	2.635%	\$3,154,343	-2.87%	-0.062%	-\$74,321	2.57%	\$3,080,022
210055	Laurel Regional Hospital	-1.30%	2.683%	\$1,476,366	-41.49%	0.248%	\$136,290	2.93%	\$1,612,657
210033	Carroll Hospital Center	-1.49%	3.067%	\$4,104,867	-23.36%	0.111%	\$148,720	3.18%	\$4,253,587
210060	Fort Washington Medical Center	-1.52%	3.143%	\$647,182	-48.24%	0.299%	\$61,481	3.44%	\$708,663
210035	Civista Medical Center	-1.76%	3.626%	\$2,356,950	-36.53%	0.210%	\$136,724	3.84%	\$2,493,675
210010	Dorchester General Hospital	-2.32%	4.796%	\$1,791,546	-56.48%	0.361%	\$134,720	5.16%	\$1,926,267
210045	McCready Memorial Hospital	-2.79%	5.760%	\$299,315	-54.17%	0.343%	\$17,838	6.10%	\$317,153
210058	James Lawrence Kernan Hospital	-3.02%	6.224%	\$2,859,982	1.68%	-0.111%	-\$51,155	6.11%	\$2,808,827
210061	Atlantic General Hospital	-3.02%	6.240%	\$2,219,722	-42.51%	0.255%	\$90,832	6.50%	\$2,310,554
	<b>Total Scaled</b>			<b>\$42,750,992</b>			<b>\$5,288,566</b>		<b>\$43,569,889</b>

CareFirst BlueCross BlueShield  
10455 Mill Run Circle  
Owings Mills, MD 21117  
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November 28, 2012

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



Re: Draft Staff Recommendation on QBR and MHAC Scaling Magnitudes

Dear Commissioners:

CareFirst supports the Staffs' recommended changes to the QBR and MHAC programs toward stronger overall incentives to encourage performance improvement and satisfy CMS' guidelines for a Value Based Purchasing (VBP) exemption. We encourage the Staff and Commission to push forward with expanding the metrics of outcome measures included in the quality pay-for-performance projects (e.g., preventable ED visits; preventable use of ancillaries; etc.) to continue to improve quality outcomes in the State.

Specifically, CareFirst supports the Staffs' action to increase the magnitude (amount at-risk) for the MHAC program to 3.0%, which will continue to encourage hospitals to incorporate programs and processes to improve quality measures vis-à-vis statewide benchmarks. This, coupled with the reduction in the MHAC performance target (to 85% of the statewide average) will be necessary to continue to meet CMS' targets for VBP exemption, as indicated above.

Finally, CareFirst supports staffs' efforts to incorporate both an attainment and self-improvement component to the scaling model. While we do not have a strong opinion on the specific allocation between attainment and improvement, we strongly support greater focus on attainment. We would suggest an allocation in the area of 75% attainment and 25% improvement factor blend. We also support the staffs' preference for linear scaling to better match performance with associated rewards/penalties.

Thank you for this opportunity to comment on this draft recommendation.

John Hamper

A handwritten signature in black ink that reads "John Hamper".

Director, Provider Reimbursement, Analytics & Compliance  
CareFirst  
6731 Columbia Gateway Drive, CG-43  
Columbia, MD 21046  
410-872-3501 (P)

*JMS*  
*12/26*  
*JG*  
*JHU*

DEC 19 2012

**Received**

DEC 21 2012

Department of Health  
and Mental Hygiene

Joshua M. Sharfstein, M.D.  
Secretary  
State of Maryland Dept. of Health and Mental Hygiene  
201 W. Preston Street  
Baltimore, MD 21201

Dear Dr. Sharfstein:

We thank you for the November 14, 2012 letter on behalf of the State of Maryland requesting an exemption from the FY 2014 Hospital Value-Based Purchasing (VBP) Program. The Centers for Medicare & Medicaid Services reviewed your exemption request correspondence and supporting documentation. We officially grant the State of Maryland's exemption request for its hospitals as authorized by Section 1886(o)(1)(C)(iv) of the Act.

The Maryland Quality Based Reimbursement program focuses rewarding high quality care on similar clinical areas of focus to improve heart attack, heart failure, pneumonia, surgical processes of care and infection control, and hospital acquired conditions. In general, the relevant health outcomes for your State's hospitals cited in your request achieve or surpass the current national results for comparable quality process and closely related clinical outcomes.

As you know, Section 1886(o)(1)(C)(iv) of the Act grants the Secretary discretion to exempt hospitals paid under section 1814(b)(3) from the Hospital VBP program, if the State submits "an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection."

We determined that Maryland meets or exceeds the cost savings requirement for exemption from the Hospital VBP Program for FY 2014, based on the fact that both programs reward high performers in a revenue-neutral manner. In this way, Maryland has achieved cost savings under its quality programs that meet any documented savings under the Hospital VBP Program.

We also note that your state's patient experience of care performance continues to lag behind national median performance levels. We strongly encourage your state to improve performance in the patient experience of care domain. We will continue to monitor the Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) performance of Maryland hospitals and perform additional analyses, and encourage your state's hospitals to collaborate with the Maryland Quality Improvement Organization, Delmarva Foundation for Medical Care, to improve patient experience of care.

We strongly encourage your state to closely review the FY 2015 Hospital VBP Program to familiarize yourselves with the added measures and policies added to the program. In particular, CMS anticipates that your state would address patient health outcomes in a FY 2015 exemption request related to the Agency for Health Care Research and Quality Patient Safety Indicator composite measure, the Central Line Associated Blood Stream Infection measure, and Medicare Spending per Beneficiary measure adopted for the FY 2015 Hospital VBP Program. We also anticipate that your state would address updated patient health outcomes using more current data for all measures and domains included in the FY 2014 Hospital VBP Program.

Should you have any questions, please do not hesitate to contact James Poyer, a member of my staff, at (410) 786-2261.

Sincerely,

A handwritten signature in black ink that reads "Patrick Conway, MD". The signature is written in a cursive, slightly slanted style.

Patrick Conway, M.D., M.Sc.  
CMS Chief Medical Officer  
Director, Center for Clinical Standards and Quality

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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**HEALTH SERVICES COST REVIEW COMMISSION**

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[hscrc.maryland.gov](http://hscrc.maryland.gov)

To: HSCRC Commissioners

From: Dianne Feeney, Associate Director, Quality Initiatives

Date: January 9, 2013

Re: MPSC Funding Contingent Upon Estimated Relocation Expenses and Data Standardization Updates

---

Pursuant to the May 2, 2012 Final Recommendation on Continued Support of the Maryland Patient Safety Center (MPSC), this memorandum summarizes Maryland Patient Safety Center (MPSC) reports to the HSCRC on:

- Recommendation 3- Undertake an analysis of the level of participation of hospitals and other provider settings in MPSC projects as well as the standardization of self-reported data collection. Report the findings and any next steps to improve participation and data collection standardization to the Commission no later than October 31, 2012.
- Recommendation 4- To encourage and support greater numbers of providers in settings other than hospitals to work with the MPSC, hold in abeyance \$100,000 of the requested funding until the MPSC develops and submits to the Commission a feasibility study and options for relocating the Center in a physical location other than the Maryland Hospital Association. The study and proposed options should be submitted the Commission no later than December 31, 2012.

***Summary of Project Participation and Self-Reported Data Standardization***

The MPSC October 31, 2012 report (Appendix A) to the Commission provides a summary of MPSC efforts to improve and standardize collection of self-reported data for the MPSC's Perinatal Neonatal Learning Network, SAFE from FALLS Collaborative and Hand Hygiene Collaborative.

The report outlines several communication and education strategies as well as site visits and auditing tools to improve standardization of data collection. Of specific concern for the Commission in their deliberations in the May 2012 meeting was the degree of standardization of data collected for the Hand Hygiene Collaborative. The MPSC report notes that they

transitioned the data collection software, HandStats, to the Delmarva Foundation. Upon the transition, Delmarva added edit checks for data submitted, made adjustments to software, and convened webinars of participating facilities and conferences with individual facilities to improve upon and standardize the data collected for participating hospitals.

Finally, related to participation of other settings of care, the MPSC report notes that the SAFE from FALLS Collaborative has expanded in FY 2013 to include 3 new hospitals – a total of 34, 19 new nursing homes – a total of 45, and 7 new home care agencies – a total of 16.

#### *Summary of Schedule of Expenses Related to Relocation of the MPSC*

In their November 9, 2012 report on expenses related to relocation (Appendix B), MPSC provided a schedule of expenses prepared by MPSC staff and reviewed by an independent auditor; they also retained services of a commercial real estate firm to develop the estimates. Based on an additional single event cost of \$107,000 and recurring operating cost variance of - \$101,600, MPSC management, Board, and Executive Committee concurred that they not move forward with the relocation.

#### *HSCRC Staff Recommended Next Steps*

With regard to project participation and improvement in standardization of self-reported data, staff concurs that the MPSC activities, strategies and plans will provide tighter standardization. Staff highlights and commends the increased participation of the nursing home and home health providers in the SAFE from FALLS Collaborative. Staff also agrees the cost of relocation is noteworthy; however, staff notes that the concern over location was raised in relation to the relatively low level of participation of providers other than hospitals. Therefore, staff recommends the following next steps:

- Request that MPSC report routinely to the Commission its efforts and results in recruiting all settings of care to engage with the MPSC and its activities.
- Release the \$100,000 of MPSC funding held in abeyance in May 2012.
- Request that MPSC report routinely to the Commission its efforts and results in standardization in data collection, including auditing results.

#### *Commission Action*

On January 9, 2013, the Commission voted unanimously to approve the release of the \$100,000 held in abeyance pending receipt of a report from MPSC on estimated relocation costs.

6820 Deerpath Road  
Elkridge, MD 21075



410.540.9210 (Phone)  
410.540.9139 (Fax)

October 31, 2012

Mr. Steve Ports  
Principal Deputy Director  
Maryland Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Mr. Ports:

Pursuant to the Final Recommendations on Continued Support of the Maryland Patient Safety Center dated May 2, 2102, specifically staff recommendation 3; please find enclosed the report from the Maryland Patient Safety Center.

The report is also being sent to the Commission Chair, John Colmers and the Executive Director, Patrick Redmon.

Should you have any questions or require clarifications, please do not hesitate to contact me via telephone at 410.540.5076 or via email at [rimhoff@marylandpatientsafety.org](mailto:rimhoff@marylandpatientsafety.org).

Sincerely,

A handwritten signature in blue ink, appearing to read "R. Imhoff III", is written over the word "Sincerely,".

Robert H. Imhoff III  
President & CEO



Report to the Health Services Cost Review Commission

By the Maryland Patient Safety Center:

**Collaborative Participation and Standardization of Data Collection**

*October 2012*

## **Introduction**

The Maryland Patient Safety Center (the Center) has been engaged in collaboratives and learning networks as a core strategy to achieve positive change and improvement in patient safety in the Maryland healthcare community since 2007, beginning with the Perinatal Collaborative. Since that time, the Perinatal Collaborative has joined forces with the Neonatal Collaborative (established in 2009) to become the Perinatal Neonatal Learning Network in 2011. Additionally, the Center engaged in the SAFE from FALLS Collaborative in 2008 and the Hand Hygiene Collaborative in 2010.

## **Maryland Patient Safety Center Collaboratives and Learning Networks Structural Similarities**

While the topics of the collaboratives and learning networks differ, there are some structural similarities that support the standardization of the data collection and management issues across the collaboratives. It is important to note that all collaboratives and learning networks sponsored by the Center are voluntary in nature and use self-reported data by participants. First and foremost, all three collaboratives are managed by our contractor Delmarva Foundation, the CMS-designated quality improvement organization (QIO) for Maryland who oversees data management for each of the collaboratives. While the Maryland Patient Safety Center is the lead organization for all collaboratives and learning networks, the Center's staff works closely with Delmarva to manage the operations for each of these important initiatives, which includes management and oversight of critical functions such as definition of project requirements, strategic direction, data management (including analysis and reporting) and education. Second, each collaborative includes resource materials that define the scope of the work associated with the collaborative, metric definitions, data collection requirements, reporting forms and software. In addition, collaboratives have defined communication and education strategies, which typically include monthly data submission, quarterly calls/webinars, routine contact with team leads providing technical assistance (focused on barriers and interventions), site visits, list serves, web portals and at least one face-to-face meeting or reunion a year for each collaborative. All of these communication/education strategies reinforce standardization and provide an opportunity for feedback with participants about specifications met or not met within the collaboratives/learning networks. Many of the resources described, are available and accessible on the Maryland Patient Safety Center website.

Collaborative/Learning Network	Start Date	Structural Characteristics						Notes
		Roadmap/Toolkit	Monthly Outcomes Data	Process Measures	Quarterly Conference Calls & Webinars	Technical Assistance	Face-to-Face Meetings	
Perinatal Neonatal Learning Network	2007	√	√	√	√	√	√	<ul style="list-style-type: none"> <li>• 2 Reunions per year</li> </ul>
SAFE from FALLS Collaborative	2008	√	√	√	√	√	√	<ul style="list-style-type: none"> <li>• 1 Falls Congress</li> <li>• Quarterly newsletter</li> </ul>
Hand Hygiene Collaborative	2010	√	√	√	√	√	√	<ul style="list-style-type: none"> <li>• 1 Face-to-Face Meeting</li> </ul>

## Appendix A

More specifically, there are unique attributes and processes in each individual collaborative that contribute to the quality and uniformity of the data collected and reported.

### **The Perinatal-Neonatal Learning Network – Participation and Data Standardization**

The Perinatal-Neonatal Learning Network has the involvement of 29 hospital perinatal teams and 24 neonatal teams. The Center is engaged in an effort to recruit all hospitals providing obstetric care in Maryland. During the first quarter of FY13, the program Co-chairs, Ann Burke, MD and James Rost, MD, and the Center are engaged in a process to achieve 100 percent participation of Maryland hospitals. This will be accomplished through letters of invitation, conference calls, and site visits to the four hospitals currently not participating in the program.

Also in FY13, the Learning Network has expanded its focus to: *standardization of the discharge process for mothers and infants including the late pre-term infant*. The initiative collects data on two process measures and one outcome measure:

1. (Process) The percentage of maternal and neonatal discharges where review of the clinical record of the mother and the baby reflect that a risk assessment was completed. Hospitals will review a random sample of records for each population and audit the records to assess whether risk factors were identified.
2. (Process) The percentage of records where risk was demonstrated AND there is a referral to a community provider or health department.
3. (Outcome) The percentage of patients who were determined to have risk factors, for whom referral was completed AND who kept the scheduled appointment. In order to maintain patient confidentiality, this will be assessed by hospital staff that will make follow-up calls to the patient.

Hospitals have received training on collection of discharge data use of standardized audit tools for mother and baby, randomization of charts, data entry into specialized spreadsheets for mother and baby, and submission of data into the Perinatal-Neonatal portal. All information published at the project level is aggregated. The data collection methodology incorporates collection of maternal race (by US 2010 Census category) and maternal zip code. This permits examination of results broken out by disparities in race, and other demographic factors (income, educational level, etc.) captured in data describing the population in Maryland linked to the home zip code.

The Learning Network continues a focus and collects data on inductions and C-sections less than 39 weeks. To ensure uniformity, and reduce variation in the data captured, the Learning Network establishes values, in this case 26 hospitals in the “N” each reporting period. The first face-to-face meeting (reunion) for FY13 will be held in December 2012 and there will be time built into the agenda for the teams to interact with each other sharing ideas and operational details about how they are testing and implementing the requirements at their institutions. “Roundtable” sharing has been one of the most valued parts of the face-to-face sessions.

### **SAFE from FALLS Collaborative – Participation and Data Standardization**

The SAFE from FALLS Collaborative has expanded in FY13 with 34 hospitals (3 hospitals were added); 45 nursing homes (19 nursing homes were added) and 16 home care organizations (7 facilities were added). The Center is engaged in an effort to recruit all 46 hospitals in Maryland to participate in the Collaborative. Consistent and frequent communications to stakeholders and providers is essential to recruitment. On behalf of MPSC, Delmarva has initiated coordinated communications and outreach efforts for the SAFE from FALLS program. In FY13, MPSC is working

## Appendix A

with our partners and stakeholder groups at MHA, LifeSpan, HFAM and the Maryland QIO to assist program staff in achieving 100 percent participation for Maryland hospitals and 50 percent of the Maryland Long Term Care (LTC) providers. As there are more LTC facilities than our initial goal, we will continue to have “open enrollment” for LTC providers at a less intensive effort throughout the project year.

The foundation of the Collaborative is the SAFE from FALLS Roadmap and Toolkit which provides key definitions, infrastructure and specific actions for a comprehensive falls management program. The Roadmap and Toolkit were created by the Minnesota Hospital Association and have a proven track record of reducing falls among their member hospitals. The SAFE from FALLS Collaborative has also established a falls safety points incentive program aimed at increasing the number of facilities who enter data on a regular basis and to ultimately enhance the accuracy of the aggregate statewide reporting process.

<b>SAFE from FALLS FY12 # of reporting facilities</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>AVG</b>
<b>Acute Care (hospitals)</b>	30	23	26	29	27
<b>Long Term Care</b>	14	14	15	14	14
<b>Home Care</b>	5	6	7	6	6

### **The Maryland Hospital Hand Hygiene Collaborative – Participation and Data Standardization**

The Maryland Hospital Hand Hygiene Collaborative expanded participation significantly in FY12 and now in FY13 there are 44 of 45 (97%) acute care hospitals engaged in the Collaborative. There is also one specialty hospital involved in the collaborative. Unlike the Perinatal Neonatal Learning Network and the SAFE from FALLS Collaborative, who have facilities reporting into a portal with software programming specifically created for the Maryland Patient Safety Center, the Hand Hygiene Collaborative uses the HandStats software program developed by Johns Hopkins. In October 2011, the Center signed a MOU with Johns Hopkins Health System to transition the data analysis from Hopkins to the Delmarva Foundation.

Initially, the Delmarva Foundation cleaned up the data in HandStats by verifying the data for required units and ensured consistency in reporting of the same required units each month. We found that this was not historically done within HandStats and that some hospitals had inconsistently reported data on required units and that the number of required units had changed over time. Delmarva verified the required units with each participating hospital and put a process in place to ensure that reporting was consistent from month to month for each hospital. This issue impacted the ability of some hospitals to meet the requirements of the project, specifically the 80/30 rule (80 percent of all required units must have 30 or more observations). Also, one of the more significant limitations of HandStats, was the fact that there was no “hard stop” on the system; therefore there was no way to lock users out of data entry after the deadline for data submission. Therefore, when discrepancies were reported by hospitals, there was no way to identify when data was entered into HandStats. These issues were addressed individually with hospitals and also on quarterly conference calls and webinars.

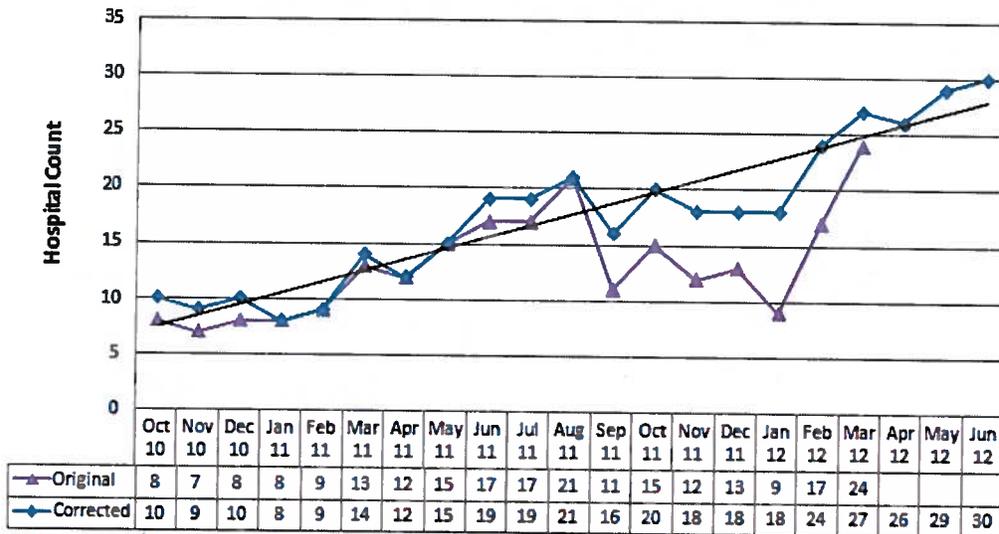
In February 2012, the Center provided hospitals with report cards that profiled their compliance with the 80/30 rule and their organization’s performance compared to the statewide aggregate. With the initial distribution of report cards, and on an ongoing basis (monthly), we have asked hospitals to verify critical information such as the number of required units, required units with 30 or more observations, and their

## Appendix A

hospital hand hygiene compliance rate. Reports of inconsistencies and discrepancies by hospitals were handled with technical assistance calls. Several hospitals raised some data discrepancies that could not be explained and as a result, several site visits were conducted in consultation with technical staff from Hopkins. At that time, the Maryland Patient Safety Center did not have access to the HandStats software to perform data verification. As a result, MPSC requested access to HandStats, and it was provided in April 2012. Similar access was granted to Delmarva in June 2012. Through the site visits, it was determined that HandStats was not counting observations entered on the last day of the month – defined as a “bracketing” issue by the analyst at Hopkins. Hopkins personnel adjusted the logic to the software on April 17, 2012, which would take care of observations going forward but required reprocessing of past data. The Delmarva Foundation adjusted data back to October 2010, which resulted in changes to the number of hospitals meeting the 80/30 rule – see table below. Corrected data reflects a steady increase of hospitals achieving the 80/30 rule over time – from a low of 8 hospitals in the “N” to a high of 30.

Overall, the fluctuations in the number of hospitals meeting the 80/30 rule can be attributed to the technical difficulties and limitation of the HandStats platform and the barriers associated with having limited access to the software program, which prevented understanding and detection of key issues on the part of hospitals. Ultimately, when appropriate access to the HandStats software was provided to the Center and then Delmarva, we became more informed and were able to troubleshoot and work more closely with our hospitals to achieve the performance requirements with the Collaborative.

**Original vs. Corrected  
Number of Hospitals Meeting the 80/30 Rule**



\*new\* hospitals represented 1, 1 and 4 respectively for April, May and June

The original 30 hospitals that have been participating in the Collaborative have been improving with an increasing number achieving the 80/30 rule, a direct result of several coaching calls and some one-on-one technical assistance. In March 2012, we began our focus on the additional 14 hospitals coming into the Collaborative and hosted an on-boarding call to gear them up for participation. Our goal was to bring hospitals into the Collaborative over the next few months, allowing them to become familiar with the specifications and requirements during that time and for them to be fully participating (achieving the 80/30 rule) with the submission of July 2012 data (the start of FY13). During the call we reviewed the specifications, provided guidance on the 80/30 rule, reviewed deadlines for data submission and

## Appendix A

suggestions for entry of observations. Most importantly, we encouraged new hospitals to enter data routinely, and suggested a weekly data entry process, that would allow them to track and manage their observations more consistently. The second group of hospitals joining the Collaborative, had clearly benefitted from the lessons learned from the original hospitals participating in the Collaborative.

Delmarva is also checking the data in HandStats on a weekly basis to see if hospitals are entering more routine observations rather than waiting to the end of the month. If there is evidence that hospitals are not entering data on a regular basis, Delmarva will contact them to discuss their situation and advise them about recommended practices. This appears to be working as we have seen progress with these new hospitals over the past several months in their compliance (see chart below). The Maryland Hospital Association, a partner in this initiative, can also be credited with assistance with CEO engagement, by sending CEO's monthly participation summaries that were the focus of discussions between hospital leadership and infection prevention staff.

Month/Year	New Hospital Participants (14)					
	Met	%	Not Met	%	NDS*	%
7/2012	6	43%	6	43%	2	14%
8/2012	10	71%	4	29%	0	0
9/2012	12	86%	2	14%	0	0

Met – hospitals meeting 80/30 rule    Not Met – hospitals not meeting the 80/30 rule    NDS – No Data Submitted

Overall in calendar year 2011, we had approximately 16 hospitals on average meeting the 80/30 rule each month with a range from 8 - 18 hospitals meeting 80/30 each month. In calendar year 2012 (January – June), we have approximately 26 hospitals on average meeting the 80/30 rule with a range 18 - 30 hospitals meeting 80/30 each month. Weekly conference calls are held with staff from MPSC, Delmarva and MHA to discuss issues and track performance within the Collaborative and have been effective in determining which hospitals might need technical assistance and/or interventions.

Finally, the Center is in the final stages of developing a software application for Hand Hygiene that will replace HandStats. Not only are some of the issues that have been cited earlier a driver to developing our own software platform, but there are several others that have been raised by staff working with the Collaborative and requests from participating hospitals. Hospitals currently have limited capabilities to run historical data for their hospital; and hospitals must enter data manually (many hospital have limited or no administrative support staff within their Infection Prevention Departments to enter data) and do not have the ability to upload a flat file. Staff would like greater capabilities to manage data submitted; have the software manage some of the edits for consistency; and we feel that down the road, more in-depth analysis will be required to get us to the Collaborative's goal of 90 percent compliance. Before we move all hospitals to the new platform, we have planned a pilot test for the new software. We have selected five hospitals to test the software over the next several months, while maintaining hospitals entry into HandStats. This will allow us to test and make modifications, as needed, with a goal to "go live" with all hospitals in January 2013.

The data being reported for all Maryland Patient Safety Center collaboratives is collected voluntarily and is self reported. The Center has incorporated structural characteristics into each collaborative, in order to ensure a satisfactory level of consistency and standardization. Those actions include: project guidelines,

## Appendix A

training, education, conference calls, webinars, site visits and regular meetings with our data management vendor (Delmarva Foundation).

### **Summary**

While we feel that a solid footing has been established with regard to data standardization, we also recognize the need to improve and advance rather than to simply maintain the status quo for all Collaboratives. In that regard, we have created a more structured approach in order to ensure that all participants are following prescribed guidelines to include: data collection/reporting compliance and proper application of methodologies. MPSC will be incorporating pro-active site visits with our participating facilities and will create an audit tool for more robust assessment of organizational compliance via staff interviews, review of documents and observation. By improving the level of data standardization we will have an even higher degree of confidence in the reported data and in turn, a stronger vehicle for action and ongoing education.

November 9, 2012

Steve Ports  
Principal Deputy Director  
Maryland Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Mr. Ports:

Pursuant to the Final Recommendations on Continued Support of the Maryland Patient Safety Center dated May 2, 2012, specifically staff recommendation 4; please find enclosed the schedule of expenses related to the proposed relocation of the Maryland Patient Safety Center (MPSC).

The schedule was prepared by MPSC staff and the MPSC internal accounting staff and reviewed by an independent auditing firm.

Based on the significant expense, it is the recommendation of the MPSC management not to go forward with the relocation. This recommendation along with supporting documentation was presented to the MPSC Board and Executive Committee with both bodies concurring with management's recommendation.

The schedule and cover letter is also being sent to the Executive Director, Patrick Redmon and the Commission Chair, John Colmers.

Should you have any question or require clarification, please do not hesitate to contact me via telephone at 410.540.5076 or via email at [rimoff@marylandpatientsafety.org](mailto:rimoff@marylandpatientsafety.org).

Sincerely,



Robert H. Imhoff III  
President & CEO

6820 Deerpath Road  
Elkridge, MD 21075



410.540.9210 (Phone)  
410.540.9139 (Fax)

November 9, 2012

Per the request of the Health Services Cost Review Commission contained in the final recommendations from the meeting of May 2, 2012, a feasibility study was conducted by the staff of the Maryland Patient Safety Center (Center) regarding the proposed relocation of the Center's offices from the current location within the Maryland Hospital Association campus. The results of that study are contained in the attached schedule of expenses.

The Center enlisted the assistance of Mr. Richie Blue of Blue & Obrecht (a commercial real estate firm), Nicole Szarko, C.P.A. of McLean, Koehler, Sparks & Hammond (independent auditors) and the Center's internal accounting staff.

The rent costs reflected in the proceeding expense chart represent an average, combined rental rate of class A, B and C properties within the Columbia / Elkridge, MD area. The Center's internal accounting staff compiled a schedule of ongoing operating costs that would be impacted by said relocation. In addition, a "best estimate" of one-time costs (i.e. moving, furniture purchase) was developed through use of historical data and researching current market costs. The data figures (and corresponding assumptions) developed by the Center staff and internal accounting staff were then sent for review and approval by the Center's independent auditors.

The figures presented in the following schedule have been deemed reasonable after having gone through the review and approval process conducted by the independent auditing firm.

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Elkridge, MD 21075



410.540.9210 (Phone)  
410.540.9139 (Fax)

## Relocation Expense Chart

	<u>Projected</u>	<u>Current</u>	<u>Variance</u>
<b><u>Recurring Operating Costs</u></b>			
Rent	\$ 44,000	\$ 23,300	\$ (20,700)
Accounting/HR Admin	55,000	35,000	(20,000)
Insurance	12,000	7,500	(4,500)
Network/Internet/Web hosting	45,000	12,600	(32,400)
Office Supplies/Admin/Payroll	14,000	12,000	(2,000)
Duplication/binding	10,000	-	(10,000)
Utilities	7,500	-	(7,500)
Copier lease	4,500	-	(4,500)
Total Recurring Operating Costs	<u>\$ 192,000</u>	<u>\$ 90,400</u>	<u>\$ (101,600)</u>
<b><u>Single Event Cost</u></b>			
Leasehold Improvements	50,000	-	(50,000)
Telephone equipment	2,500	-	(2,500)
Furniture	35,000	-	(35,000)
Moving	5,000	-	(5,000)
Contingency	15,000	-	(15,000)
Total Single Event Costs	<u>\$ 107,500</u>	<u>\$ -</u>	<u>\$ (107,500)</u>
 Total Recurring and Single Event Costs	 <u><u>\$ 299,500</u></u>	 <u><u>\$ 90,400</u></u>	 <u><u>\$ (209,100)</u></u>

**Note:**

- Projected rent expense includes \$22 per sq. ft. @ 2,000 sq. ft. and represents an average/blended rate of class A, B and C properties in the Elkridge/Columbia area.

# **Staff Recommendation**

**January 9, 2013**

The Commission staff recommends for review and public comment revisions to the Relative Value Unit (RVU) Scale for Electrocardiography (EKG). The revisions are specific to the Chart of Accounts and Appendix D of the Accounting and Budget Manual. A work group comprising of experience hospital and clinical personal was formed to address concerns regarding EKG. The workgroup decided to move Cardioversion, Automatic Implantable Cardioverter Defibrillator (AICD) and Tilt Table out of Interventional Radiology/Cardiovascular and into EKG because these services are more diagnostic in nature and a better fit with other EKG services. In addition the EKG RVU scale was updated to reflect the current services provided to patients for EKG services. The revised RVUs were approved by the Maryland Hospital Association's HSCRC Technical Issues Task Force. At your direction, the staff will send the revisions to all Maryland hospitals for their review and comment.

At the January 9, 2013 public meeting, the Commission approved that the RVU Scale for EKG revisions can be sent to the Maryland hospital industry for review and comments.

SECTION 200  
CHART OF ACCOUNTS

7290            ELECTROCARDIOGRAPHY

Function

This cost center operates specialized equipment to (1) Record graphically electromotive variations in actions of the heart muscle; (2) Record graphically the direction and magnitude of the electrical forces of the heart's action, and/or (3) Record graphically the sounds of the heart for diagnostic purposes. Additional activities include, but are not limited to, the following:

Explaining test procedures to patient; operating electrocardiograph equipment; inspecting, testing and maintaining special equipment; attaching and removing electrodes from patient; a patient may remove electrodes and remit recording data from home when appropriate.

Description

This cost center contains the direct expenses incurred in performing electrocardiographic examinations, as well as up to six hours of recovery time. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers. Cost of contrast material is included in this cost center.

Standard Unit of Measure: Relative Value Units

One RVU is equal to one minute of direct care.

Data Source

The number of Relative Value Units shall be an actual count maintained by this cost center.

Reporting Schedule

Schedule D – Line D30

**APPENDIX D  
STANDARD UNIT OF MEASURE REFERENCES**

**Account Number**  
**7290**

**Cost Center Title**  
**Electrocardiography Service**

The Electrocardiography Relative Value Units were developed by an industry task force under the auspices of the Maryland Hospital Association. These Relative Value Units will be used as the standard unit of measure related to the output of the Electrocardiography Center.

This cost center operates specialized equipment to (1) Record graphically electromotive variations in actions of the heart muscle; (2) Record graphically the direction and magnitude of the electrical forces of the heart's action, and/or (3) Record graphically the sounds of the heart for diagnostic purposes. Additional activities include, but are not limited to, the following:

Explaining test procedures to patient; operating electrocardiograph equipment; inspecting, testing and maintaining special equipment; attaching and removing electrodes from patient; a patient may remove electrodes and remit recording data from home when appropriate.

Description

All time reflects standard of 1 RVU = 1 minute of direct care. Direct patient care includes tasks or procedures that involve face-to-face contact with the patient. These tasks may include: specimen retrieval, administration of medications, family support, patient teaching, and transportation of patients requiring a nurse or other clinical personnel whose cost is assigned to the clinic. This cost center contains the direct expenses incurred in performing electrocardiographic examinations, as well as up to six hours of recovery time. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers. Cost of contrast material is included in this cost center.

Code	Description (CQ)	RVUs
92960	Cardioversion, elective, electrical conversion of arrhythmia; external	30
93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report	12
93017	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report	30
93024	Ergonovine provocation test	30

93025	Microvolt T-wave alternans for assessment of ventricular arrhythmias	30
93041	Rhythm ECG, 1-3 leads; tracing only without interpretation and report	5
93225	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; recoding (includes connection, recording, and disconnection)	10
93226	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; scanning analysis with report	50
93270	Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; recording (includes connection, recording, and disconnection)	10
93278	Signal-averaged electrocardiography (SAECG), with or without ECG	30
93279	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead pacemaker system	15
93280	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead pacemaker system	15
93281	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead pacemaker system	15
93282	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead implantable cardioverter-defibrillator system	20
93283	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead implantable cardioverter-defibrillator system	20
93284	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead implantable cardioverter-defibrillator system	20
93285	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system	20
93288	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system	15

93289	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements	20
93290	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	20
93291	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; Implantable loop recorder system, including heart rhythm derived data analysis	20
93292	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	30
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with physician analysis, review and report(s), up to 90 days	15
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	20
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	20
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	45
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	20
93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	60
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	45
93308	Echocardiography, transthoracic, real-time with image documentation (2D) includes M-mode recording, when performed, follow-up or limited study	20
93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	60
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only.	45

93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	90
93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only.	60
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete	10
93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)	8
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	5
93350	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	90
99351	Echocardiography, transthoracic, real-time with image documentation (2D) , includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision	90
99352	Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to code for primary procedure)	1
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention. A standard tilt table evaluation of 45 minutes or less qualifies for 45 RVUs. A complex tilt table evaluation of greater than 45 minutes qualifies for 90 RVUs. Evaluation time includes the time necessary to prepare the patient for the evaluation and any post evaluation services.	45/90
93662	Intercardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)	10
93701	Bioimpedance, thoracic, electrical	5
93724	Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)	15
93740	Temperature gradient studies	By Report
93745	Initial set-up and reprogramming by a physician of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events	30

93786	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only	10
93788	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 ours or longer; scanning analysis with report	30
93799	Unlisted cardiovascular services or procedure (AICD Reprogramming)	By Report
G0166	External Counterpulsation, per treatment session	90

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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**HEALTH SERVICES COST REVIEW COMMISSION**

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**TO:** Commissioners  
**FROM:** Legal Department  
**DATE:** January 2, 2013  
**RE:** Hearing and Meeting Schedule

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**Public Session:**

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

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

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

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website.

<http://hscrc.maryland.gov/commissionMeetingSchedule2013.cfm>

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